The Politics of Women's Empowerment in Nigerian HIV/AIDS Prevention Programmes: 2003-2007

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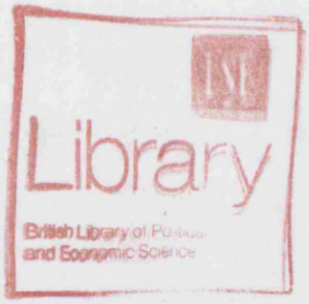
DECLARATION

I, Chinweokwu Uzoamaka Madubuike, hereby certify that the work presented in this thesis is the result of my own investigation except where reference has been made to published literature and where acknowledgement is made for unpublished data. During the course of this research programme I have not been registered or enrolled for another award from any academic or professional institutions.



ABSTRACT

During the 1990s, empowerment through collective action became widely referred to by feminist anthropologists and health behaviouralists as a potential approach towards reducing HIV and AIDS amongst African women. However, conflicting understandings of empowerment ultimately positions African women as too disempowered to protect themselves from HIV and AIDS, but empowered enough through collective participation to challenge structural and gender inequalities that facilitate HIV transmission. By the next decade, many prevention programmes around the world were said to have been unsuccessful. This thesis explores these issues; first, by examining different understandings of empowerment; second, by investigating a potentially alternative model of participation underpinned by post-modern, feminist post-colonial and social psychological theory; and finally, by analysing women's own narratives of empowerment.

To do so, this thesis reviews life histories of forty-five women aged between their twenties and sixties, participating in one of five women's associations. The movements and individuals were selected in order to consider the diversity of experiences across age, ethnicity, sexual identity, social class and religion. This consideration of the realities of women's lives found that gender and social identities shape women's individual and collective responses to HIV and AIDS in ways that extend beyond employing traditional prevention methods which are said to police sexual behaviour. Nevertheless, their diverse experiences also suggest alternative notions and sites of power, thus enabling them to employ strategies and charter avenues of agency that facilitate AIDS prevention in some contexts, but hinder it in others. These alternative notions of power and agency have implications for reconfiguring and expanding HIV and AIDS prevention and, possibly, gender relations. The thesis considers the extent to which alternative empowerment strategies, executed between the contours of donor-driven programmes and everyday reality, contribute to disrupting dominant discourses as well as gender norms and expectations predicated on tensions around representations of respectability, 'African' sexuality, spirituality, health and illness, and AIDS citizenship.

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CHAPTER ONE

Women's Empowerment and HIV and AIDS Prevention in Africa

The Problem of Prevention

BACKGROUND AND IMPETUS FOR THE RESEARCH

In the early 1990s, social scientists (mainly feminist anthropologists and sociologists) began to recommend African women's collective action[1] as an essential strategy to prevent HIV and AIDS transmission. Specifically, they argued that collective action could improve women's status and address the gender inequalities that impede their ability to negotiate 'safe sex'[2] (de Bruyn, 1992; Schoepf, 1992; Ulin, 1992). This strategy, drawn from an analysis of the social and cultural contexts in which women and men engage in sex, would serve as an alternative to the behavioural approaches which aim to improve people's knowledge, attitudes and practices (KAPs)[3] towards sex by organising campaigns to distribute condoms, as well as to inform, educate and communicate[4] around how to prevent HIV and AIDS.

Feminist researchers recognised the limits of behavioural approaches early on, particularly for women in a number of African countries. They suggested that factors other than behavioural affected women's vulnerability to HIV infection in different ways than they affected men's vulnerability. Biological (de Bruyn, 1992), cultural and economic (Heise and Elias, 1995) factors began to emerge in reported accounts of sexual behaviour and HIV prevention. A host of studies began to cite cultural and social reasons for which women in Africa were remaining abstinent, unable to insist upon condom use, or stay faithful or monogamous with their partners. The studies gave details of violence, vaginal drying techniques, early marriage, polygamy, exchanging sex for gifts and money to pay school fees or support families, etc. But whether these

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1 The term 'collective action' is often used interchangeably with 'empowerment', the latter being contested, as I will demonstrate in Chapter Two. However, I will use this term to refer to group activities in which women address gender inequality.

2 'Safe sex' is a term used to connote sexual activity where people use condoms and consistently engage in monogamous and faithful relationships.

3 Many HIV/AIDS prevention specialists refer to this as 'KAP', which I will refer to as the KAP model or approach from this point in the thesis.

4 As with KAP and even HIV/AIDS, many prevention specialists refer to information and education as IEC.

factors translated into actual HIV and AIDS prevention programmes in Africa at the time is unclear, as different governments levied varying responses to the epidemic.

In 1993, Nigeria fell under the military dictatorship of General Sani Abacha, which led to a vacuum in services in areas such as health. HIV and AIDS received little political attention until 1997, when former Health Minister Professor Olikoye Ransome-Kuti announced that his brother, popular musician Fela Anikulapo-Kuti, had died of AIDS-related complications that year. Until Obasanjo was elected as President, there was very little discussion about HIV and AIDS in general and even less discussion about its relationship with gender.

However, the lack of discussion around HIV and AIDS did not reflect a lack of discourse on gender itself. Two international conferences on gender issues were responsible for placing gender on Nigeria's national development agenda: the International Conference on Population and Development in Cairo (1994) and the Fourth World Conference on Women in Beijing (1996). Perhaps as a result of his wife's interest, the Abacha government allowed women's civil society groups to begin implementing the Beijing Platform for Action (BPFA),[5] which outlined strategies for removing barriers to women's equality with men. However, from 1994, many international donor agencies began withdrawing support in response to the Abacha regime's growing record of corruption and human rights violations.

The United States Agency for International Development (USAID) funded a handful of child survival and population control programmes, which required a few international groups to remain in Nigeria to implement them. One of these groups was the Centre for Development and Population Activities (CEDPA), a US-based non-governmental organisation (NGO) whose organisational mission is to "empower women at all levels of society to be full partners in development".[6] Their mandate at the time was to increase women's access to family planning through community participation. Many women's groups anticipated that this approach would incorporate HIV and AIDS for two main reasons. First, perhaps due to Fela Anikulapo-Kuti's death, HIV and AIDS was beginning to receive attention due to a small number of advocates, including Professor Ransome-Kuti who came out of retirement to incorporate HIV and AIDS

5 See http://www.un.org/womenwatch/daw/beijing/platform/plat1.htm

6 See CEDPA (2003).

programmes into the services of the NGO he had founded in 1985.[7] At the same time, sentinel studies established HIV and AIDS testing facilities in antenatal clinics around the country, which began to reveal a high number of women testing positive for the virus which caused what had popularly been referred to as the 'mysterious illness'.

The second reason for the anticipated integration of community participation and HIV and AIDS programmes was that, internationally, women's groups had begun to advocate for a more integrated approach towards reproductive health and HIV and AIDS. This integration would help to minimise the barriers women faced while trying to access services, including time and distance. This had been demonstrated in the areas of health such as reproductive health and family planning (CEDPA, 2003). HIV and AIDS seemed a natural progression for these participation-driven health initiatives, but was not - for reasons explored throughout the thesis.

These events converged with my personal experiences and professional interests in women's health, HIV and AIDS and social change to form the impetus for this research. After my first degree, I obtained a Masters Degree in Public Health through a World Health Organisation Fellowship in Holland. Upon completion, I moved to Washington, D.C. and began working with health projects sponsored by USAID that allowed me to draw on my areas of specialization, health systems management and health promotion. I eventually found a job with CEDPA as a reproductive health specialist and desk officer for programmes in Nigeria and Nepal.[8] In 1998, a year after I had joined CEDPA, General Abacha died, relieving Nigeria of years of military oppression. The prospect of a democratically elected government raised questions about the role women would play in the new government. CEDPA drew upon this interest by assessing whether women's participation in political activities (i.e. voting, civic education, etc.) would influence their decision to use family planning. It found that women who registered to vote and participated in voter education were more likely to use family planning contraceptives (CEDPA, 2003).

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7 His small NGO, Society for Family Health, eventually developed a partnership with Family Health International, a US-based organisation which is the largest recipient of US funds earmarked for HIV/AIDS. Together, they manage one of the largest HIV/AIDS programmes in the Nigeria.

8 I worked with CEDPA from 1997 to 2000 in a role that included designing health strategies and administering funds to local NGOs.

This dynamic between population and HIV prevention created the impetus for my research to explore whether women's empowerment through collective action would also have any influence on women's ability to negotiate safe sex to prevent HIV.

After discussing this with colleagues, a theme began to arise. I became acutely aware that the women that CEDPA and USAID were meant to 'empower' differed greatly from the women that I was meeting and working with in Nigeria. Indeed, they differed greatly from the women who had raised me, taught me (formally and informally), attended school with me, and had inspired me. Were they not empowered? How did their empowerment differ from the empowerment USAID wanted to 'give' them - through people like me as a consultant 'expert' who had learned to develop workplans with indicators in the hope of delivering results? Moreover, how was the type of participation generated from these programmes supposed to help women adopt behaviours like 'condom negotiation' which were outlined in the indicators and had been informed by Western behavioural models? Was there any other type of participation that could produce this desired behaviour? Were women going to willingly participate and - by the way - which women were we talking about in the first place?

AIMS AND OBJECTIVES OF THE STUDY

Clearly, this was not an uncommon research interest. In *AIDS, Sexuality and Gender in Africa*, Baylies and Bujra set out to explore "how AIDS had impacted on and been informed by gender relations" (2000:53). They approached their work with the view that women in Tanzania and Zambia have organizational skills that can be harnessed in campaigns organised around HIV and AIDS. From my reading of their work, they found groups that were effective in raising awareness around HIV and AIDS, as well as those who provided care and support for people living with HIV/AIDS (PLWHA), but found a mixed feedback when investigating how these types of activities influenced women's sexual lives. Some women were able to negotiate safe sex with their partners and attributed this to being members of their respective groups. Other women were not able to do so, which led Baylies and Bujra (2000) to conclude that collective action around HIV and AIDS must challenge gendered power relations if it is going to have any impact on women's individual lives.

Around the same time as Baylies and Bujra were exploring the impact of women's collective action around HIV and AIDS, other researchers began to question the effectiveness of HIV and AIDS programmes in general. While some argue that HIV and AIDS prevention has been successful (for example, Green, 2003), this position seems to have found limited support (Caldwell, 2003). Instead, there have been emerging accounts of how biomedical approaches which focus on changing people's behaviour have proved to be ineffective (Caldwell, 2000; 2003). The limitations of the biomedical approach have also been linked to the manner in which organisations espousing HIV and AIDS prevention from a biomedical approach actually implement the programmes.

In *Letting Them Die*, Campbell (2003) suggests that HIV and AIDS prevention programmes may be ineffective because their objectives can be undermined by competing priorities of people within the organisations implementing them, or by competing priorities between such organisations as a whole and the communities with which they partner. As I understand Campbell's work, this discord reflects the lack of political will on the part of those working within "a more complex range of micro- and macro-level sites in which power operates" (Campbell, 2003:19), a theme she demonstrates with several studies based on an HIV and AIDS prevention programme in a South African mining town.

Both Campbell's evaluation and Baylies and Bujra's ethnography raise a number of questions. What theoretical explanations can lend themselves to the power dynamics that account for gaps between policy and practice, such as those identified by Campbell and Baylies and Bujra? In particular, what implications might these findings have in the context of women's empowerment and HIV prevention in Nigeria? How do 'experts' and people in 'communities' position themselves, if at all, in the production of knowledge around HIV and AIDS, gender and sexuality?

In *Discipline and Punish* (Foucault, 1977), power relies on communication channels to help accumulate and centralise knowledge, as well as to construct individuals. By drawing on this idea and extending it to the context of HIV and AIDS prevention, and by exploring women's engagement, contestation or even their agency to live their lives despite expert framing, this research extends the analyses of previous research which

has situated people within a more political analysis of how they and their sexual experiences are shaped and represented, particularly by AIDS experts and the media (Patton, 1991; Epstein, 1996; Treichler, 1999; Parker *et al.*, 2000).

For example, Treichler (1999) argues that discourses (mainly biomedical) construct sexual identity and sex in relation to HIV and AIDS. For her, AIDS is an 'epidemic of meaning' that maps social and cultural divisions that existed before it was recognised as a global epidemic. She challenges the authority of statistics and those who produce them, by demonstrating how the content of statistical analyses were actually political and reproduced social divisions, particularly for 'gay' and 'straight' populations and 'Western' and 'African' populations.

While I do not want to discount the contribution that more materialist accounts of HIV prevention provide, or mitigate the enormity of HIV and AIDS by indulging in theoretical debates, I believe that these types of cultural analyses frame men and women as sexual subjects that are "both the subject-matter for politically committed investigation and the subject-agent of conscious struggles for social and sexual exchange" (Parker *et al.*, 2000:2-3). Therefore, what I would like to argue is that women's empowerment may need to be situated in the broader social organisation around prevention programmes, with two aims in particular. The first is centred on how expert constructions of sex and identity facilitate or hinder prevention; while the second is around how women might then take up, contest or negotiate these constructions. As a result, I address both HIV and AIDS prevention and treatment, where treatment is understood to include the prevention of secondary infections.

In the light of this focus, the subject of this thesis is women's responses to HIV and AIDS prevention in Nigeria. In particular, the study is based on women's prevention strategies, barriers and challenges to these strategies, and the consequences of these strategies. The analysis is based on in-depth interviews with women having membership affiliations to various groups, including rural associations, the Girl Guides, a Pentecostal church, an underground network of women in same-sex relationships and a network of support groups for women living with HIV and AIDS. The study aims to explore the utility of women's empowerment as a strategy for HIV and AIDS prevention amongst these groups of women. It questions the notion that women's empowerment is taken up by women in the same way, particularly amongst women

who come from different social backgrounds and locations. It critically examines the way women define empowerment for themselves within the opportunities and constraints of their different locations.

In this chapter, I present an overview of the approaches to HIV and AIDS prevention that have been identified by experts, particularly against the backdrop of gender inequality in Africa. I present the review in four sections. In the first section, I describe the context of gender inequality as it relates to health and HIV and AIDS prevention internationally, regionally and in Nigeria. In this section I also review empirical evidence that shows that prevention programmes are not working, and suggest that this depicts a divide between programme planners and lay people. In the second section, I present a brief history of HIV and AIDS prevention in Nigeria and examine ways in which the epidemic differs between several African countries, with the aim of deconstructing the monolithic conceptualisation of 'HIV and AIDS in Africa'. In the third section, I present the normative community-based model of HIV prevention and of women's collective action and demonstrate how these, too, can show a divide between expert and lay perspectives on prevention. This divergence suggests unequal power relations between experts and lay knowledge and experiences. In the fourth section, I argue that the women's empowerment approach, while well-meaning and key to the fight against HIV and AIDS, runs the risk of ignoring the power dynamics that exist outside of gender relations. This includes power involved in the use of biomedical data, as well as the politics of gender as a framework for analysis, which may lead to cultural and gender essentialism. Finally, the chapter concludes with a brief overview of the Foucauldian notion of 'biopower' as part of a broader conceptualisation of power which may help to characterize the failure of prevention programmes. The organization of the thesis is also outlined.

GENDER AND HIV/AIDS PREVENTION

Within development and academic discourses, gender inequality is cited as one of the main factors driving HIV and AIDS transmission. This is loosely based on social inequality and health models, in which health promoters have identified similar inequalities that contribute to health disparities between different social groups, particularly amongst different racial and class groups (Wilkinson, 1996). Taking into

account the interconnectedness between gender equity and socioeconomic inequality, Moss (2002) offers a unified framework that draws on the sources of each paradigm to explore how they contribute to patterning women's health. Combined, gender and socioeconomic disparities foster psychosocial burdens, hinder productivity and create health risks that contribute to poor health (*op. cit.*), but they can be mediated by harnessing women's social capital. For Moss, this can be achieved by understanding the environment in which social connections are nurtured, and by carefully understanding the geopolitical environment, culture, norms and sanctions, women's roles in reproduction and production, health related mediators and health outcomes.

From the perspective of HIV and AIDS as a health issue, it is understandable how a similar paradigm can be drawn within the context of women and HIV prevention. Drawing on the principles of heath promotion, Tawil *et al.* (1995) extend the argument of creating support environments by suggesting 'enabling approaches' for HIV prevention. Describing enabling factors as "those that make a desired change in behaviour possible" (1995:1300), Tawil *et al.* argue that prevention efforts should not only motivate people, but should also remove barriers to healthy behaviour by advocating and initiating economic and policy level changes, which would be implemented in a way that would also affect local practices. Hence, from a gender and health perspective, researchers may argue that economic and policy level changes contribute to gender inequalities to present barriers to safe sex and shape women's sexual behaviour.

Arguably, one of the main factors that led researchers and practitioners to focus on gender as an analytical frame were the AIDS experts' identification of the primary modes of transmission in Africa, including heterosexual contact, blood transfusions, mother-to-child transmission and injected drug use (Akeroyd, 2004). Clearly, women are directly implicated in all modes to some extent (except blood transfusions). Interestingly, a small minority of scientists argue that blood transfusions and other iatrogenic modes of transmission (such as unsafe injections), actually accounted for up to 40% of HIV infections in Africa (Gisselquist *et al.*, 2002). Others scientists within this group also argue that the solution, addressing broader health systems, is needed in addition to preventing HIV through sexual transmission (Tahir *et al.*, 2007). They also assert that addressing health systems should be a global priority in fighting HIV and AIDS (Prati, 2006). Gisselquist *et al.* (2003) suggest four policies to achieve this:

public education about unsterile health care; promoting transparent injection practices; promoting safe practices for staff; and monitoring iatrogenic infections.

Despite evidence and recommendations, this area remains under-researched and largely unsupported. Emphasis on sexual modes of transmission (which tend to accompany 'vulnerability' or 'deviant' sexual behaviour) suggests that expert constructions of gender and sex at the centre of analysis privilege the notion of helping vulnerable women to hold governments accountable for their health care systems. In other words, a singular focus on gender purports the discourse of the 'vulnerable African woman'.

Seminal research on women and HIV and AIDS supports the dominant discourse of sexual transmission, by overlooking the role of health systems in iatrogenic transmission and focusing instead on other biological and social factors said to facilitate women's vulnerability to HIV. De Bruyn (1992), for example, argues that there are four main reasons that HIV and AIDS affects women more than men: stereotypes which blame women for the disease, gender-related factors that increase women's risk of exposure, greater psychological and social burdens, and an inferior social position which hinders prevention. The stereotypes position HIV and AIDS as either a prostitute's disease or a woman's disease (De Bruyn, 1992:250). Interestingly, the four factors together construct a heteronormative discourse of vulnerability to sexual transmission which is not taken into account in De Bruyn's analysis.

Biological and social factors not only provide the basis from which to construct women's vulnerability to HIV through sexual transmission, they are also used to help to construct solutions to reduce this vulnerability. In Ulin's article "African Women and AIDS: Negotiating Behavioural Change" (1992), which is widely cited and considered to be one of the pioneering works that explores the influence of gender on AIDS prevention in Africa (Baylies and Bujra, 1995), such vulnerabilities are reducible through collective action. It is this recommendation that may also be responsible for the dualisms that persist in gender and HIV and AIDS discourses, which position women as simultaneously vulnerable to HIV and AIDS and empowered to prevent it. On one hand, Ulin (1992) draws on the notion of cultural barriers to prevention to argue that condom use in Africa can only be done by persuasion or force, which would be difficult for women who are trained not to oppose their male partners. As a result, African women do not believe that they have control over their sexual decision-

making, which makes them more vulnerable. On the other hand, Ulin presents the arguments of African writers who insist that women do have power, which is often developed in women's groups where women possess the personal and collective ability to protect themselves.

However, several of the works cited were produced before the HIV/AIDS epidemic (e.g. Steady, 1981; March and Taqqu, 1982). For Ulin (1992), the power acquired through group membership, which is likely to be influenced by the group's goals and expectations, is enough to break the 'mould' of training and empower women to negotiate safe sex - a goal which may run counter to the associational goals. Yet, as she proposes collective action as *the* solution to women's disempowerment, Ulin's framing of women within this double-bind creates another problematic of a discursive nature (rather than of a material nature in the examples discussed above), which is addressed throughout the thesis. Nevertheless, the material factors which are said to both drive and result from HIV and AIDS must be considered, and are done so below.

For instance, over the years there has been enough evidence to support the argument that some women find it difficult to negotiate safe sex with their partners. This is understandable, as HIV and AIDS prevention programmes espouse the 'ABC' model to prevent strategy transmission: *A*bstain, *B*e faithful and wear a *C*ondom, which are difficult to implement. Unlike the female condom and microbicides, these strategies are said to be male-controlled because they depend on male cooperation, whereas the female condom and microbicides could be used without partner knowledge.[9] Moreover, unlike readily available male-controlled methods, female condoms are costly and microbicides are still in the development and testing stages.

While some groups have included addressing female condom pricing and microbicide development as parts of the strategy in the fight against HIV and AIDS, most have focused on the ABC model. The first strategy, abstinence (or refraining from sex altogether), has had some success, especially in Uganda. Adolescents were said to have reported a decrease in sexual activity following a health education programme that

[9] Vaginal microbicides are products whose common function is to prevent infection by HIV and other sexually transmitted pathogens. Researchers and women's health advocates are pushing for microbicides to be in forms that can be controlled solely by the user (e.g. vaginal gels). Currently, they do not exist on the market, but are being tested, with planned clinical trials against HIV and the following: human papilloma virus and herpes virus (Carraguard™); herpes virus and sperm (BufferGel™); chlamydia, gonorrhoea and herpes virus (PRO 2000™); and gonorrhoea, syphilis and sperm (Savvy®) (Farrington, 2003).

promoted abstinence as a strategy (Shuey *et al.*, 1999). However, both young men and women tend to shun young virgins or sexually inactive girls, causing them great psychological distress. (Meekers and Calvès, 1997). Among married couples, post-partum abstinence (a common practice during which couples abstain from sex with their spouses or long-term sexual partner) has proved to be an unsuccessful strategy, because it provides an opportunity for husbands to engage in extramarital affairs (Awusabo-Asare and Anarfi, 1997; Bond and Dover, 1997; Orubuloye *et al.*, 1997).[10] Moreover, some researchers have argued that abstinence is an unlikely option for groups, for whom sexual relationships serve as procreative acts or as a means through which full adulthood, masculinity, femininity and culturally accepted notions of successful sex (e.g. physically pleasurable, or with 'quality' semen deposited) are achieved (Bond and Dover, 1997). Alternately, if sex is seen as an expression of love, then to abstain from sex with a partner may be interpreted as denying that partner love. The psychological effect is pressure on young women to conform to a notion of femininity that is associated with providing love, care and nurturing.

The second strategy, faithfulness, has also proved to be a less successful and unreliable method, particularly for married women in many parts of Africa. Sixty-four per cent of married women in Zambia were said to be at risk of contracting HIV because their husbands have multiple partners (Baylies and Bujra, 2000). While the study does not indicate whether the women interviewed were HIV-positive, it suggests that faithfulness is an ineffective strategy for women whose husbands expose them to HIV through multiple sexual relationships. However, this does not mean that young and single people are less vulnerable to HIV and AIDS, nor does it mean that married men are not at risk of contracting HIV from their wives.

Examples of this reverse order are found in Nigeria, where both men and women reported having extramarital affairs, suggesting that women sometimes have multiple sex partners as well (Ladebo and Tanimowo, 2002) and are therefore also responsible for putting their partners at risk of contracting HIV. In Kenya, young single men and women reported more risky sexual behaviour than older and married men and women (Akwara *et al.*, 2003). In addition, wives were found to have infected their husbands, suggesting that they contracted the virus before marriage (Glyne *et al.*, 2003). While

[10] In some parts of Africa, it is believed that semen in a woman's body can interfere with breast milk and that women should not become pregnant until the baby is weaned (Bond and Dover, 1997).

these studies are perhaps best suited to highlight women's increased risk of HIV infection versus actual prevalence rates, they also provide evidence that shows that, as a stand-alone strategy, faithfulness fails to completely prevent HIV transmission, regardless of the direction of that transmission.

The third AIDS prevention strategy (condom use) presents one of the most challenging barriers to safe sex for several reasons. First, condoms are difficult to access in many developing countries, particularly for young people. Campbell and McPhail (2001) found that South African women complained about the lack of privacy in shops and the negative attitudes of clinic staff who provided condoms, thus indicating the potential social stigma that women sometimes face whilst simply purchasing or requesting condoms.

Second, women report condoms as difficult to use (Volk and Koopman, 2001), as women are dependent on men's ability to use condoms properly. If men are unable to use them, then women's motivation to use them decreases (Campbell and McPhail, 2001). The female condom, currently debated as a tool for women's empowerment due to the fact that it is a female-controlled strategy, has also been reported by Kenyan and South African women as difficult to use and too costly (Kaler, 2001). What this suggests is that women's economic status, attitudes towards young women, and the power they have in their relationships, influence whether they purchase or use condoms.

Third, the desire to experience or provide pleasure may lead to ineffective or lack of condom use (Bond and Dover, 1997). Furthermore, condoms need to be used consistently and correctly to successfully prevent HIV transmission. Practices such as polygamy, adultery, clitoridectomy, vaginal infibulation, dry sex, levirate or wife-inheritance, can inhibit consistent and correct condom use.[11] Even when condoms are available and used properly, a couple's (shared or separate) desire for pregnancy, or social expectations of women as mothers, can efface the use of condoms, if only temporarily (Bond and Dover, 1997; Runganga *et al.*, 2001; Van Rossem *et al.*, 2001; Mill and Anarfi, 2002).

[11] In some instances, women insert drying agents into the vagina to tighten it as a means to increase pleasure (Gausset, 2001).

Fourthly, like abstinence, condom use also carries with it psychological consequences such as fear of partner acceptance (Pelzer, 2000) or it may insinuate mistrust that may, in turn, corrode intimacy, inhibiting potential discussions about condom use (Bond and Dover, 1997). It also has negative associations with prostitution (Mill and Anarfi, 2002). Finally, women who experience violence within sexual relationships are highly unlikely to be able to insist on condom use or any other measure to protect themselves from HIV and AIDS (Wood *et al.*, 1998), while others simply do not feel confident enough to insist on condom use (Abdool-Karim, 2001).

The point of reviewing these examples is to highlight the real material challenges women (and men) face in the broader context of their everyday lives, as well as the implications on the discourses describing such material challenges. These barriers suggest an environment of powerlessness within which women are expected to negotiate safe sex and, to a certain degree, balance unequal power relationships. However, these barriers seem to have been taken for granted - the way epidemiological data has been used suggests that gender is very much at the core of analysis of HIV/AIDS in many parts of Africa. The internationally recognised authority on HIV/AIDS, the Joint United Nations Programme on HIV and AIDS (UNAIDS) has been active in promoting the role of gender in HIV transmission (see UNAIDS, 1999, 2000, 2002, 2004). However, even in popular discourse this recognition has raised the question of whether AIDS in Africa has been 'feminised' and whether this ignores other groups of people affected by HIV and AIDS (New York Times, 2004a).

For example, the US-based newspaper, the *Washington Post*, ran an editorial to this effect on 1 December 2004. It argued that high infection rates amongst women were driven by a number of factors, including social customs that kept women ignorant of sex until marriage, promiscuous husbands who infect their wives, and women in developing countries having no other marketable resource other than sex. This claim constructs a perfect scenario within which fits Spivak's critique of colonial discourse, which positions "Westerners [as] saving brown women from brown men" (1988:296). The article generated interesting responses from international HIV and AIDS experts, which were facilitated through an Internet forum, GENDER-AIDS.[12] While some of

[12] This is a forum sponsored by a Swiss charity group which "provides a virtual meeting place for organizations and people to network, share experiences and ask for advice on issues related to gender and HIV/AIDS". Its members consist of women's organizations, groups of people living with HIV/AIDS, and other international organizations working in the area of gender and HIV/AIDS.

the experts argued that high risk groups (such as drug users and sex workers) were not being ignored by prevention programmes, one writer challenged the *Washington Post* for being insensitive to "the plight of Third World women" (Cecire, 2004), while another argued that the emphasis was not misplaced as "many drug users and most sex workers in the US and globally are women" (Fleischman, 2004). What these responses depict is a misuse of gender as a category for analysis, not only by the media but by 'experts', and it does so in two ways. First, while I do not want to make generalisations based on emails by one or two people, the emails do suggest evidence of applying gender in a way that can perpetuate monolithic conceptualisations of 'Third World' and 'global' women within HIV and AIDS prevention discourses, thereby suggesting that all women in these categories are vulnerable to HIV and AIDS in the exact same way, which is based on their 'plight' of being in the 'Third World'. Secondly, arguing that women form the majority of groups such as drug users and sex workers may also perpetuate a certain idea of 'global' women within HIV and AIDS prevention discussions that is less than accurate, and may even serve to introduce or reproduce negative stereotypes. Furthermore, doing so may lead prevention efforts to exclude people who do not fall within these categories - most notably, men, but also women who do not fit into these descriptions.

This concern has not eluded academics concerned with HIV and AIDS. The term 'gender' is often used in ways that overlook the differences in women's vulnerability, men's accountability, sexual interests and marginalised sexual identities (Mane and Aggleton, 2001; Dowsett, 2003). Specifically, in development and AIDS discourse, 'gender' is used synonymously with 'women', which is useful in describing sex differences but overlooks other structural and relational factors contributing to these differences, (Baden and Goetz, 1997) such as age, sexual orientation, inequality between developed and developing countries, inequalities between women, etc. (Dowsett, 2003). While there are studies that focus on some of these aspects, such as masculinities or youth (e.g. Campbell, 2003), what can be learned from these studies seems yet to be translated into actual HIV and AIDS prevention programmes. This may be due to the fact that these programmes are primarily based on biomedical evidence (i.e. bio-statistics and epidemiology) and thus serve as one of the entry points in which power is exercised and manifests in ways that produce culturally and potentially gendered essentialist views that inform HIV prevention.

UNAIDS obtains much of its data on seroprevalence from antenatal clinics where women (and, to a lesser extent, sex workers) are tested, which means that most of the data on women with HIV and AIDS in Nigeria is based on women who are (or who soon will be) mothers. The rationale for this sampling is to prevent mother-to-child transmission; however, this rational is based on two main assumptions. Data sampling from antenatal clinics demonstrates how this might occur. The data is based on a few assumptions. One such assumption is of the heterosexual female. The second is the assumption that the heterosexual female is being infected by her male partner. The generality of the data is achieved by extrapolating the findings to account for women who were not tested in antenatal clinics. Extrapolation sustains the implicit argument against iatrogenic transmission and perpetuates the assumption of an HIV-free, pregnant, heterosexual woman infected by her positive male partner. The result is that we know little about the HIV and AIDS status of women who are not mothers or who do not fit the hetero-normative constructions of African women.

With a view of extending this argument to include geographic essentialism, I turn first to a brief analysis around the situation of HIV and AIDS in Africa, and then Nigeria, highlighting how even gender disaggregated statistical data ignores variations in the AIDS epidemic across the continent, as well as structural factors contributing to this variation, such as governmental responses.

DECONSTRUCTING A CONTINENT: HIV/AIDS IN AFRICA

Current popular debates around HIV and AIDS in sub-Saharan Africa depict the continent as a monolithic, homogeneous society, equally affected by the epidemic in the same way, rather than as a region of Africa with 48 countries, each displaying cultural, political and linguistic diversity between them and within them. For Patton (1989), political and social violence is accomplished by collapsing the many ethnic groups and languages of the African continent into the invention, 'Africa'. Although there are questions concerning how representative epidemiological data is (Kalipeni *et al.*, 2004), the numbers show that Eastern and Southern Africa have experienced a higher percentage of people with HIV and AIDS than countries in Western and Central Africa. However, higher percentages do not translate into more people. The data in Table 1.1 illustrate this point. For example, in 2006, UNAIDS estimated that 17.0% of

Zambians (approximately one million) were infected with HIV, while estimating a low prevalence rate of 3.9% in Nigeria (translating into nearly 3 million people being infected). This situates Nigeria as having the third largest number of people living with HIV and AIDS (UNAIDS, 2006:22).

This is not to say that to the Zambian government, the morbidity rate has had the same social and economic impact as, say Nigeria. Nor does this mean that, even if the impact were the same, the governments would respond in the same way or that the families of the deceased would respond any differently. What it might tell us is that different prevalence rates may present windows of opportunities for further research before the problem escalates to the point where national governments with currently low numbers of people living with HIV and AIDS are unable to respond to any sort of national-level 'explosion'.

Table 1.1: Comparison of HIV/AIDS Data for Nigeria, South Africa, Tanzania and Zambia

Countries[13]	Adults aged 15-49 with HIV - Prevalence Rate %	Adults Aged 15 and Over Living with HIV	Number of Women Living with HIV and AIDS (aged 15-49)	Number of Men Living with HIV and AIDS[14]
Nigeria	3.9	2.6 million	1.6 million	1.0 million
South Africa	18.0	5.3 million	3.1 million	2.2 million
Tanzania	6.5	1.3 million	0.71 million	0.59 million
Zambia	17.0	1.0 million	0.57 million	0.43 million

Source: UNAIDS (2006).

13 These countries were selected for the following reasons. Nigeria, because it is the locus of my research; South Africa, because of the its experience with AIDS and because it is the locus of Campbell's book *Letting Them Die* (2003); Tanzania and Zambia, because they are the locus of research for *AIDS, Sexuality and Gender in Africa*, a book on women's collective action by Baylies and Bujra (2000). I will discuss these two books more in the final section of this chapter.

14 UNAIDS does not include a category for men. I derived these figures by subtracting the UN number for women with HIV/AIDS from the number of population living with HIV/AIDS. This omission alone could be interpreted as contributing to a small discourse of silence concerning the role of masculinities and HIV/AIDS.

Relationships between governments and their citizens shape the enabling environments that influence gender relations and promote or hinder environments in which safe behaviour flourishes. African governments have responded to HIV and AIDS in different ways, with varying levels of intensity. Similarly, African women (or men) experience vulnerability to HIV and AIDS in different ways. While countries like South Africa have experienced increasing levels, other countries like Nigeria are said to be on the verge of a terrible epidemic if prevention measures are not strengthened. Senegal has been cited as a country experiencing one of the continent's lowest prevalence rates, which has been attributed to the fact that it is 98% Muslim (Caldwell, 2004).

Only one country is cited widely as having experienced a decline in prevalence and that is Uganda (Green, 2003; Caldwell, 2004). This is largely attributed not to traditional AIDS awareness around staying abstinent, being faithful and using condoms, but to two other factors. The first is to the strong leadership by Ugandan President Yoweri Musoveni from the late 1980s when AIDS was scourging the nation. The second is that Musoveni's government regarded church institutions as political players, who in turn supported his administration in delivering safe sex messages. Compared to other women's movements across the continent, the women's movement in Uganda seemed to gather much momentum in the 1980s and is still often held as an example of progressive gender relations in Africa (Tripp and Kwesiga, 2002). Arguably, the political climate in which HIV is transmitted and reduced needs to be conducive to activism and gender equality. In particular, the players within a political climate exercise power in ways that can facilitate powerful and effective responses to HIV and AIDS.

Conversely, a politically unstable climate may not do much to hinder HIV transmission, and may even contribute to factors that fuel transmission. Since Nigeria gained independence in 1960, it has experienced only 18 years of civilian leadership.[15] Despite the Nigerian government identifying the first person living with HIV and AIDS in 1986, and subsequently establishing a National AIDS control programme between 2000 and 2003, it took only limited measures to control and/or address the issues.

[15] Civilian rule occurred in three waves: the first was immediately after independence from 1960 to 1966, the second wave was from 1979 to 1984, and the third was recently from 2000 to present.

Nigerian health policy analyst and medical sociologist, Ogoh Alubo, argues that the government's lack of support led to a distortion of the reality of HIV and AIDS on the ground (2002). He attributes this distortion or silence concerning AIDS to several factors. Firstly, the uncertainty associated with frequent changes in administration meant that there was little political leadership and institutional continuity to garner support for most initiatives. Secondly, structural adjustment programmes introducing user fees meant that many people were not being tested for HIV. This then begs the question about testing and the bio-statistical data that show HIV and AIDS prevalence rates, which academics have raised (Barnett and Whiteside, 2002). UNAIDS obtains most of its data from antenatal clinics where women are tested and, to a lesser extent, sex workers, which means that most of the data on women with HIV and AIDS in Nigeria is based on women who are (or soon will be) mothers. The rationale for this may be to 'catch' women who have HIV and prevent them from giving it to their babies. However, this also means that we know little about the HIV/AIDS status of women who are not mothers or sex workers.

Thirdly, despite people knowing about HIV/AIDS and even having information about HIV/AIDS available in several local languages, Alubo suggests that both government and laity believe AIDS to be an "American initiative to discourage sex" (2002:555). Denial changed when the popular musician Fela Anikulapo-Kuti died of AIDS. His brother has described the family's struggle over publicly announcing that AIDS caused Fela's death (personal communication), which he eventually announced in 1997. For Alubo, this still did not do much for what he refers to as a 'public denial' of HIV/AIDS with the national AIDS programme only receiving one million Naira or the equivalent of ten thousand US dollars that year, presumably a tiny fraction of the government's budget.

Alubo (2002) does not mention the reigns of human rights abuses with which military leader Sani Abacha ruled from 1993 to 1998. Nigeria was in the spotlight when General Abacha ordered the public hanging of journalist and Ogoni human rights activist, Ken Saro-Wiwa, along with several colleagues, for speaking out about the marginalisation and environmental damage caused by oil production companies in the south-eastern region of Nigeria. At the same time, there were allegations of gross corruption on the part of the military, which translated into fuel shortages and economic inflation. Civil servants were often on strike, demanding to be paid, as the

government froze salaries for no apparent reason. Secondary schools and universities were often shut down, leaving a vacuum in academic activity, including teaching and research. In this environment, survival was a priority for many Nigerians, which sometimes meant taking two jobs or starting a business to supplement low salaries.

To date, there do not seem to be studies overtly highlighting the relationship between General Abacha's dictatorship and the structural conditions fostering gender inequality and HIV/AIDS transmission. However, after his death in 1998, the subsequent fall of his regime marked a transition in the government to address many issues, including those of health and gender. In 2000, Nigeria ushered in a civilian government led by President Olusegun Obasanjo. Brought in, along with the new government, was renewed support from international agencies in the form of technical advice and economic support to foster the growth of civil society. As mentioned earlier, where there seemed to be a gap in the provision of basic services like health and education under Abacha's regime, civil society groups were called upon to provide support for these services under Obasanjo's administration. In the area of HIV/AIDS, part of the result of this was the formation of the National Action Committee on AIDS (NACA), the parastatal responsible for planning and implementing HIV and AIDS programmes around the country.

It is within this context that the empowerment of women is supposed to occur. Specifically, the 1997 National Policy on HIV/AIDS/STI control lists as one of its priorities women's empowerment "in the area of education, work, choice in marriage, and sexual life" (NPC, 1997:7). The policy is complemented by the 2001 HIV/AIDS Emergency Action Plan (HEAP), which declared HIV and AIDS as a "national emergency" (NACA, 2001a:1) and also lists women's empowerment as one of its sub-strategies. Empowerment here means that women should be able to "determine their own standards of sexual behaviour" (NACA, 2001b:6). This notion of empowerment was informed by NACA, who received financial and technical support from the Federal Ministry of Health in Nigeria, the World Bank and United Nations agencies, as well as bilateral agencies like the Department for International Development (DFID) and the United States Agency for International Development (USAID).

This last section has demonstrated how addressing HIV/AIDS in Nigeria could entail power dynamics other than those between men and women. This is important when

comparing the situation of women across Africa and within countries. For instance, within Nigeria, how do we explain anomalies within HIV and AIDS prevention, such as there being evidence of relatively high incidences of gender violence in northern Nigeria where there also happens to be a lower HIV/AIDS rate? Are there differences between the way prevention is perceived by women in urban and rural areas? How would the strategies for prevention address gender inequality within diverse settings? In the following section I demonstrate how the current HIV and AIDS campaign paradigms highlight, in yet another way, that power is mediated through prevention programmes, due to their own approaches to empowerment.

COMMUNITY PARTICIPATION IN HIV AND AIDS PREVENTION

Most approaches to HIV prevention can be traced to health promotion, a sub-discipline of public health, which promotes empowerment through participation in health projects. This principle was taken on as one of five health promotion strategies in the Ottawa Charter (WHO, 1986), which was released after the First International Conference on Health Promotion, held in Canada. During this, the sphere of health determinants was widened from medical and behavioural to include psychological, social, environmental and political (Boutilier *et al.*, 2000). The implication of this was that participation in health promotion became a means to achieve the "empowerment of communities, their ownership and control of their own endeavours and destinies" (WHO, 1986:ii).

Against this understanding, AIDS was addressed through both behavioural models and community models of health promotion. Implicit in the community models of health promotion is the theory of participation, developed by Green and Kreuter (1999) and based on Freire's (1990) conceptualisation of *conscientização* or conscientization, which refers to "...learning to perceive social, political and economic contradictions, and to take action against the oppressive elements against reality" (Freire, 1990:23).

Theoretically, he draws from Freire's discussion of the contrasting approaches towards 'cultural invasion' and 'cultural synthesis'. In the former, outsiders inject their 'homegrown' knowledge and practices into a culture that fails to see anything beyond the models given to them and which rarely internalise the new knowledge into their

existing social fabric. In the latter approach, outsiders come to learn about a new world, allowing collaboration in the guidelines for action. It is in his assessment of health promotion practice that Green gives away the paradoxical position and epistemological bind in which practitioners[16] find themselves (Green and Kreuter, 1999).

Despite the Freirian call for a spirit of cultural synthesis to bridge the gap between practitioners and communities, the above statement implies that practitioners disregard their personal values and ideologies when they develop interventions. As I have argued in previous sections, behavioural determinants such as knowledge, attitudes and health practices serve to inform interventions. In fact, they do accomplish this, but only to the extent to which they provide a baseline against which a post-intervention strategy is measured. In other words, prevention programmes that focus on behaviour may do so because this gives them measurable results in the short term, possibly without making any sustainable long-term impact on the structural factors that shape people's behaviour.

Nonetheless, the Ottawa Charter (WHO, 1986) clearly states that the subjective indicators of social, emotional and spiritual dimensions are said to determine health outcomes significantly and an understanding of which, according to Green (Green and Kreuter, 1999), is held by lay people. What this indeed suggests, in turn, is that lay people hold knowledge and thus, the key, to their own health. However, based on this theory of participation, empowerment has less to do with people's priorities or knowledge than, in the context of HIV and AIDS, those structural factors that influence their sexual behaviour.

Boutilier *et al.* highlight work that shows how use of the term 'community' conjures up images of a stable group with homogenous values that are confined to a geographical space, with little space for conflict or power struggles, giving rise to an abstract or idealised notion relegated to "common bureaucratic use in which it is often used simply as an adjective... or is implied to be a solution to health problems" (2000:253). This, the authors note, gives rise to concerns about the practice of citizen participation, leading to the marginalisation of certain groups, the blaming of groups for not participating, and providing solutions that rest in hands outside the community (i.e. the political and economic machinery).

[16] As a health promoter, I include myself in this category.

The problem is compounded by the two co-existing approaches within health promotion. The first is more biomedical and disease prevention oriented, in which the community becomes a venue for health promotion. The second, a more "phenomenological and socially critical socio-environmental orientation" positions the community as the site for "organising efforts to shift broader public and private socioeconomic policies and practices" (Boutilier *et al.*, 2000:257). Some of the latter practices result in identifying communities in ways that do not mesh with they way they form their own group identity. Again, there is a mismatch between the perspectives of lay people and those of professionals that, depending on the approach taken to community development, can lead to a redistributive rather than transformative politic (*op. cit.*:260).

Just as the terms 'gender' and 'AIDS in Africa' can be used in essentialist ways, thereby ignoring the power this use has in shaping HIV prevention discourse, the terms 'empowerment' and 'community' can also be used in ways that highlight power dynamics, particularly between professionals and the very people they seek to empower. In this context, empowerment means that community members comply with the goals and objectives of the health promoter, which can sometimes be in conflict with the goals of community members.

WOMEN'S COLLECTIVE ACTION IN HIV AND AIDS PREVENTION

My argument around the politics of empowerment is based on the notion that women's collective action may be an effective strategy in fostering an environment in which women, who wish to practice safe sex with their partners, are enabled to do so. This claim follows several commentators who have called upon the collective action of women in the fight against AIDS (de Bruyn, 1992; Schoepf, 1992; Ulin, 1992; Heise and Elias, 1995; Baylies and Bujra, 2000). They advocate the following activities as having the most impact: including women in policy-making, budget allocations and research (de Bruyn, 1992); building a collective capacity to assess risks and foster social support (Schoepf, 1993); and awareness-raising and action around the gender implications of HIV and AIDS (Heise and Elias, 1995). These analyses have helped pave an avenue that established an impetus for exploring the impact that collective

action might have in contributing to reducing gender inequalities that mitigate against safe sex for women.

Building on that impetus, Baylies and Bujra conducted studies in Tanzania and Zambia to lay truth to the claim that the success of HIV and AIDS prevention programmes depends on acknowledging gendered power relations and that:

> "Women in Africa had always organised themselves in networks and groups of mutuality and that this organisational capacity meant that women might not only be considered victims but also the authors of their own protection against AIDS" (Baylies & Bujra, 2000:xi).

Baylies and Bujra investigated a number of organisations to which women belonged (some were solely women's groups and others were groups such as churches) to explore how class and gender dynamics influenced community management of grassroots programmes, which the authors note, "need to be remarked on and critically appraised" (2000:112). There were two cases that focussed on women's groups only. In the first case study, girls who were identified as marginalized due to age, failed to be empowered to successfully negotiate safe sex. While nothing is known about the sexual practices of those who were identified as being more empowered, the study does highlight how organisational dynamics reinforce gender norms, which can alienate women's organisations or other organisations attempting to address HIV and AIDS within their community. In the second case, women's groups were found to have a positive impact on their community by improving AIDS awareness and communication, and disseminating skills on how to care for family members living with HIV and AIDS. Some members even found it possible to negotiate safe sex with their partners (*op. cit.*:147-148).

To contribute to the shift in HIV prevention from one that focuses on individuals to one that accounts for the dynamic between individuals and their social environments, Campbell's (2003) analysis of HIV and AIDS prevention in South Africa is one of the few that explores a complex web of factors contributing to sexual behaviour (including individual and community perspectives), as well as programme stakeholder perspectives. While her work does not focus on women's empowerment *per se*, it does go beyond normative gender analysis in HIV and AIDS by exploring masculinity among South African mine workers in relation to sexual behaviour. Furthermore, by

drawing on theories in social psychology, Campbell contributes to the theoretical evolvement of approaches that go beyond the 'ABC' model for HIV/AIDS prevention, discussed in the first section of this chapter. Concepts here include empowerment, critical consciousness, identity and social capital.

The concepts of empowerment and critical consciousness seem to go hand-in-hand and are necessary factors in helping people renegotiate social identities. Furthermore, people are more likely to be healthy if they live in communities that produce high levels of social capital (Campbell, 2003:51). In applying her framework for participation, she identifies a range of groups (sports clubs, youth groups, church groups, women's groups, etc.) as networks and organisations that exhibit social capital and thus influence members' sexual behaviour by providing people with a setting in which they can positively renegotiate social identities. For example, internal power dynamics within education, as well as external structural constraints (such as poverty, gender inequality and cultural discrimination against young people), mean that youth peer groups do not produce enough positive social capital conducive to empowering young people to have safe sex (Campbell, 2002). These power dynamics and structural constraints are what she refers to as "anti-social capital".

For Campbell, many health promotion approaches to HIV prevention fail for two main reasons: (1) they neglect "the wider community and social determinants of sexuality and of health seeking behaviour" (2003:184), and (2) they are difficult to implement due to different dynamics amongst and between the stakeholders, project designers and researchers which, in turn, lead to mistrust between the project team and the community. Although these studies focus on the relationship between gender relations, collective action and HIV and AIDS, the following gaps in their work have been identified: the main messages made from details of local conditions were difficult to identify; and there is little reflexivity and analysis of researcher positions and backgrounds (Allen, 2004).

Baylies and Burja have an explanation for the first gap. As a descriptive study, the research "while necessarily rigorous in its design and execution... oriented toward action, so far as possible" was understandably inspired more by practical urgency than by theoretical interest (2000:51), which is reflected in the minimal use of conceptual tools, frameworks or definitions to help clarify the mechanisms through which women

are empowered through their associational memberships in such a way that enables them to negotiate safe sex with their partner. In fact, Baylies and Bujra seem to be more aware of the multiple sites of power operating within HIV and AIDS prevention programmes that seek to address gender inequality. They also note that this type of challenge is likely to be met with male resistance, suggesting that the only power relation that women can change is the one between men and women. However, they begin their analysis by acknowledging and situating their work in the context of other power relations:

> "Our own focus on collective action at community level, and more specifically on women's contribution, is best seen within the context of competing discourses and a broader evolution of thinking about what makes interventions effective. This has involved a transition from reliance on medical knowledge and technologies, first towards an emphasis on behaviour, which alternatively facilitates or inhibits transmission and, second, towards consideration of the structural context in which behaviour occurs" (Baylies & Bujra, 2000:13).

Hence, as I understand their position, Baylies and Bujra (2000) recognise the power of medical discourse and people's reliance on this, but then in their analysis of the transition from medical to behavioural and structural, seem to take for granted the power that is implicit in behavioural and structural approaches that informs people's sexual activity and is also taken as knowledge. Without addressing this as a power relation, it would be difficult to reflexively position themselves and *vice versa*. Baylies and Burja say that empowerment is ambiguous, insofar as its boundaries are diffuse and its levels of application specified (*op. cit.*:186).

> "...greater awareness, self confidence and psychological strength can be important outcomes of collective activity, but we regard empowerment as more than this. In signifying a challenge to existing patterns of dominance and subordination, it is most appropriately couched in terms of a change in power relations" (*op. cit.*:188).

Similarly, while Campbell's (2003) work marks a well-researched contribution to understanding the ways in which social contexts influence sexual behaviour, the only criticism that has emerged from a number of positive reviews (van Wyk, 2003; Barnett, 2004; Hansen, 2004; Klouda, 2004) is that, like Baylies and Bujra's (2000) work, it lacks reflexive positioning and locating which does not allow readers to know how the author is related to the project, and whether the author positions herself as an

"unobtrusive academic chronicler [or] one of the international experts" (Elder, 2004:680).

Given that both Baylies and Bujra and Campbell have pointed to power dynamics that go beyond the structural accounts of sexual behaviour normally found in HIV/AIDS prevention programmes, the notion of 'competing discourses' is not often found in biomedical accounts of why people engage in sexual behaviour. Similarly, the notion of 'political will', Campbell (2003) argues, is a component missing from internationally funded, biomedically-oriented HIV and AIDS prevention programmes - not just among community members as the health promotion paradigm advocates, but among 'expert' staff designing and implementing health promotion programmes. Nevertheless, the gap in reflexivity in HIV and AIDS research is bridged by drawing on discussions of post-modern and post-colonial theories on knowledge and power to attempt to address complex power dynamics, particularly around how experts frame gender inequality and women's empowerment within AIDS prevention programmes.

SYNOPSIS

While I agree with Treichler (1999), who draws on the Foucauldian conceptualisation of power as a discourse to argue that HIV and AIDS is an epidemic of meanings, I am relieved that she turns to community organising as the arena in which people can negotiate meanings about their sexual identity and behaviour. Treichler does not outline how this should happen, nor does she base her arguments on empirical evidence, although she argues that organising may provide the setting for democratic debates around sex and sexuality to occur. On one hand, this could bring the discussion back to Baylies and Bujra's (2000) ethnography, which included accounts of young girls who participated in groups but still felt unable to engage in safe sex. On the other hand, it could bring the discussion back to one of the features of Campbell's (2003) psychosocial theory of participation, in which she argues that for people to feel empowered to engage in safe sex, they need to be in environments in which they can renegotiate (harmful) identities that have been constructed in their everyday lives, through social and cultural norms.

In the context of women's collective action against HIV and AIDS in Nigeria and the production of knowledge, perhaps the renegotiation of identities can include, if necessary, the identities shaped through HIV and AIDS prevention discourses, such as 'Africa', 'African woman', 'community' and 'empowerment'. Without this opportunity, I would find it difficult to look at the effect of women's empowerment in HIV and AIDS without embedding it in the wider context of power relations between AIDS experts and lay people, in particular. If women's empowerment needs to framed within the power dynamics that shape or change ideas women have of themselves and of the men around them, then is not the discourse in which they are constructed situated within those power dynamics? Thus, framed within the politics of knowledge around HIV and AIDS prevention, empowerment might entail that women identify positive identities associated with their sexual behaviour, decide on whether or not these identities contribute to or reify negative power dynamics within their lives, and accumulate enough resources that would enable them to renegotiate identities that do not acknowledge their knowledge as power. Empowerment might include challenging dominant discourses and stereotypes that influence programmatic responses on the ground. Whether this happens collectively or individually depends on whether women organise themselves in this regard.

Placing women's empowerment, or any HIV and AIDS prevention strategy, in the wider context of power relations between experts and lay people may be difficult for two reasons. The first is the trust that people have in biomedical knowledge, to the extent that they often incorporate that knowledge into everyday life and practices, particularly as a way to regulate behaviour. According to Foucault (1990), *biopower* involves a 'clinical gaze' which is cast through institutions to monitor population functions and the processes of life, such as birth, death, illness and sexual relations. Biopower is implemented in two ways: the first through biopolitics, which puts regulatory processes in place to manage populations; the second through anatomo-politics, which Foucault also refers to as disciplinary power. Anatomo-politics privileges the knowledge of health professionals so much that this knowledge is disseminated widely through schools, hospitals, families, communities, etc. Not only does this form of biopower occur with the body, for instance, as in practising safe sex, it also occurs with the mind. In other words, people become aware of themselves through the knowledge of health professionals. It is this power and knowledge over

women (and men) that is explored within the broader Foucauldian notion of power, particularly governmentality.

The second challenge in framing women's empowerment against HIV and AIDS prevention involves the politics of feminism, or the way in which terms such as 'gender' are practically taken for granted within HIV and AIDS prevention discourses. Debates around feminism and representation have occurred outside the context of HIV/AIDS (Mohanty, 1991). However, despite the prevalence of feminist perspectives in writings on HIV and AIDS prevention in Africa in the early 1990s, a seemingly universal conceptualisation of gender and gender inequality dominates these texts. I do not aim here to engage extensively on variations in feminist thinking, as this is a large topic; therefore in Chapter Two, I focus on how African women's sexuality has been characterised within HIV and AIDS and development discourses.

Therefore, what needs to be explored are the beliefs underlying HIV and AIDS prevention discourse, particularly in relation to Africa and to women and men. Highlighting the need to address gender inequality is assumed to be good (and only good) for African women who are characterised as being 'poor' or 'vulnerable', yet with an immense capacity to facilitate social transformation. These perspectives emanate from faith in biomedicine, as well as in a growing faith in social science. As will be demonstrated in this thesis, the failure to recognise biopower is shared by AIDS experts and women alike, particularly those caught up in the governmentality of HIV prevention and development. Some scholars in Nigeria have started to examine the nature of NGOs in Nigeria, while other scholars have begun to evaluate their role in addressing HIV and AIDS in other parts of Africa (Seckinelgin, 2004); but feminist analyses from Nigeria or other countries in Africa have not yet been taken up.

ORGANISATION OF THE THESIS

This thesis is organised as follows:

Chapter Two provides an extended discussion on biopower and health promotion. In particular, it is argued that HIV and AIDS prevention is situated in the context of power relations. I draw on Foucault's notion of biopolitics and anatomopolitics, but

emphasise how people become complicit in their self-regulation. In particular, I demonstrate how the current model of HIV and AIDS prevention (that is, its implementation in African countries) is caught up in power inequalities, dependent upon countries that provide financial support to the NGOs, who carry out activities often decided upon by these international donor agencies. I also argue that women in Africa have been constructed in a certain way within HIV prevention discourses and this can be approached by recognising that HIV prevention is not the first instance in which women in Africa were constructed in these terms.

Chapter Three (methodology) focuses on the epistemological, ethical questions and challenges arising from the research process. An analysis of the processes adopted to locate and recruit participants illustrates the ways in which potential participants deploy active strategies to negotiate different local contexts, particularly against the backdrop of post-militarism and political transitions. Interviews took place with forty-five participants who were recruited through five women's associations varying in formal structures (ten each from Christ World Church Women's Association, the Nigerian Girl Guide Association, support groups of the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), a Rural Women's Association and five from an 'underground' network of women in same-sex relationships). The larger size of the first four groups signifies the relative ease with which participants were recruited, compared to the 'underground' network. The chapter explores the possible reasons for this in relation to the study's ethical considerations. The reasons for these differences in sample size suggest that the political context for research informs a range of decisions, including safety and censorship.

Chapter Four (urban and rural women's responses to HIV and AIDS) focuses on the ways social locations influence subjective notions of risk and vulnerability, as well as the strategies participants deploy to manage or deny those risks in ways that protect their social identity. This chapter also highlights the ways in which these social protection strategies work to undermine solidarity-based efforts to generate income, which had been envisioned as a means to improve participants' ability to prevent HIV and AIDS. A consideration of participants' discursive strategies contributes a new dimension to the existing literature on gender, sexuality and space, which has been largely concerned with the ways in which material and/or gendered inequalities facilitate vulnerability. Research findings suggest that an exclusive focus on material

and gender inequalities may be unsuitable for theoretical analysis of everyday empowerment in the face of HIV and AIDS.

Chapter Five (discursive tensions: negotiating sexuality and agency in HIV and AIDS prevention) examines identity negotiations among women in same-sex relationships and the implications on their ability to prevent HIV and AIDS. Here, the influence of hegemonic constructions of femininity in Nigeria is apparent. Participants' ambivalence around engaging in identity politics is illustrative of the sociopolitical context which provides a picture of the genealogy of sexuality in Nigeria. The discursive tensions among participants suggest the salience of cultural understandings of gender to the sexual and political choices of participants. The ways in which these tensions are negotiated are explored.

Chapter Six (Christian women's responses to HIV and AIDS prevention) explores the way HIV and AIDS prevention is taken up by participants who have embraced abstinence as part of a lifestyle, rather than in response to HIV. Of particular salience is the way in which Christian religious identity was constructed, not as political or moral, but as spiritual. Christian identity in this regard is an important focus, because it is not widespread throughout the country, but is profoundly gendered and productive of new identities. In the case of HIV and AIDS, abstinence can be seen as strongly implicated in the creation of moral identities and this chapter aims to explore the identities produced by abstinence within the context of Christianity/Pentecostalism. Christian identities are also strongly associated in HIV and AIDS discourses with vulnerability, which seems at odds with the notion of empowerment. However, it offers a set of discursive strategies through which prevention can be negotiated while assuaging partner anxieties. This chapter aims to explore the way participants managed and negotiated competing discursive expectations of gender and Christianity/spirituality in relation to HIV and AIDS prevention.

Chapter Seven (engendering AIDS citizenship? Personal strategies and public struggles) focuses on (HIV-) positive participants'[17] experiences with HIV and AIDS

[17] I use the term 'positive participants' interchangeably with people or participants living with HIV and AIDS (PLWHAs). However, I find the use of the acronym somewhat problematic, even though it is shorter and simpler than the full description. The term 'positive participants' is an adaptation of the term 'positive people' which was used by NEPWHAN staff and amongst support group members, and seems to be preferred probably due to the ambiguous nature of the word 'positive'. Also, there was a huge resistance by support group members and their collaborators against being referred to by politicians and the press as

prevention, and how they negotiate their identities through treatment and support accessed as a result of their group membership. This negotiation should be conceptualized as a long and iterative process, subject to changes and interpretations based on individual location and on wider politics. In their accounts, participants drew on the desire to be perceived as 'normal', in spite of their HIV status. This was achieved by demonstrating personal strategies towards the aim of health citizenship, which is defined as 'taking responsibility'. This was further advanced by taking part in public forms of AIDS citizenship and negotiating social capital in ways that help to manage normalcy. The chapter concludes by looking at the implications of these strategies on gender norms, stigma and AIDS citizenship.

The final chapter (Chapter Eight: concluding discussion) sets out the key findings of the research, implications of the analysis for HIV and AIDS policy and programmes, and areas of future research.

'AIDS patients' or 'AIDS people'. The article, "Genevieve, Betty Irabor and AIDS PEOPLE" provides an example of the term's impact on reinforcing stigma and widening the class gap which already exists in the society. See http://www.nigeriansinamerica.com/articles/1888/1/Genevieve-Betty-Irabor-and-AIDS-PEOPLE/Page1.html

CHAPTER TWO

Power and HIV and AIDS Prevention

Politics and Perceptions of Prevention: A Framework for Analysis

INTRODUCTION

While HIV/AIDS prevention is implemented through development programmes at an international level, at a national and local level it is primarily managed within the domain of public health, with behaviourist paradigms rooted in psychological theory. As discussed in Chapter One, more recent interrogations of HIV and AIDS prevention have included gender analyses largely informed by feminist theory. It is frequently assumed that social psychological theory is concerned with individual levels of power, while feminist theory takes gender power relations as a broader area of inquiry, particularly in the context of HIV and AIDS where feminist analysis is largely informed by gender and development theory. As a result, other notions of power relations are overlooked.

This chapter draws on critical social theory to explore other dimensions of contested notions of power that characterise HIV and AIDS prevention programmes. It addresses the relationships between behavioural public health and feminist theory as opportunities to draw on post-modernism and critical theory to develop a theoretical framework in which to explore notions of power in people's experiences with participatory prevention. Critical researchers have noted the dissonance between international HIV and AIDS programmes and other axes of difference. A critical analysis facilitates an exploration of women's narratives in which differences such as sexuality and spirituality are included, rather than ignored, thus allowing for a nuanced contestation of gender norms and broader power relations. In this chapter, an analysis of power within social psychology (a public health correlate) and within gender and development theory is delineated, as well as critical theories of power.

The chapter begins with exploring ways in which public health and behavioural health approaches to HIV prevention fail to account for the various power relations. The

second section turns to post-modernism and the social construction of knowledge. Despite attempts by some social psychologists to account for this notion of power, it has failed to be fully incorporated into health psychology paradigms. Next, the chapter explores a more reflexive notion of power, drawing on the work of Michel Foucault. It is argued that positing prevention within the context of biopower and governmentality helps to identify areas of dissonance between expert and lay approaches to prevention, using multiple power relationships that are inherent in implementing empowerment programmes for women. The fourth section explores feminist notions of empowerment, in the light of reconceptualising power in prevention. Finally, some of the expert discourses prevalent within Nigerian HIV and AIDS programmes are explored.

POWER IN PUBLIC HEALTH APPROACHES TO HIV/AIDS

Public health is informed by a number of disciplines, but is primarily concerned with looking at populations and their "psychological, social, and physical elements" (Petersen and Lupton, 1996:ix). This, in turn, informs behavioural and social psychological understandings of empowerment. However, research on gender and empowerment in HIV and AIDS prevention in Africa emphasises analyses of power (a) between men and women, and (b) between women in NGO groups addressing HIV and AIDS. Hence, those researchers examining gender, empowerment and HIV and AIDS in Africa have been concerned with establishing how unequal power relationships between men and women contribute to, and are sometimes reproduced by, the epidemic. In particular, they are concerned with assessing "how far collective activity around AIDS could itself provide some of the support needed by individuals in pursuing change in their personal relationships" (Baylies and Bujra, 2000:xii). There is little discussion on other dimensions of contested notions of power.

Although health promotion is largely responsible for lending its perspective of empowerment to AIDS prevention, it assumes an implicit power dynamic between scientists and lay people, in which scientists are perceived as experts and having a superior knowledge to that of lay people. A brief historical analysis may explain the reason for this. Medical historians link preventive medicine and public health to the enlightenment era (Hays, 1998; Lindemann, 1999), a time when philosophers and thinkers such as Hume, Newton, Voltaire and others moved to use scientific methods to

separate fact from fiction. Public health's heavy reliance on quantifiable and 'objective' epidemiological and bio-statistical data is attributed to this thinking, which also espoused government responsibility for citizens' health.

Since public health and health promotion's community empowerment models privilege expert knowledge over lay knowledge, related disciplines may offer useful models which critically explicate the relationship between HIV and AIDS 'expertise' and lay knowledge. Although social psychology examines the social behaviour and social consciousness of the individual (Allport, 1924), recent writers have suggested that the discipline has been dominated by behaviourism, cognitivism and individualism (Farr, 1996; Moscovici, 2000). Some have attributed this hegemony to a 'positivist repudiation' of the social from social psychology (Danziger, 1979), while others have attributed this to its origins which are situated in the context of Cartesian philosophy (Howarth, 2000). The result has been "a social psychology without the networks of 'others' to which we sometimes belong - communities, nations, cultures" (Howarth *et al.*, 2004:228). Without the context of the social, the notion of power becomes mute.

What positivism and Cartesian thoughts are said to have taken from social psychology, social representations (and its Durkheimian roots) are said to have replaced. This, however, is not without problems. For Moscovici (2000), social representations empower people to orientate themselves in their social environment and master it, and also provide a code for naming and grouping aspects of their individual and group histories. For Durkheim, collective representations constitute a body of knowledge.[18] For both scientists, sociology uses collective representations as explanatory devices, while social psychology studies the structure and dynamics of these explanatory devices (Durkheim, 1895; Moscovici, 1984:16). However, for Farr (1996), Durkheim's separation of individual representations from collective representations has led to a situation where studying the social in social psychology has represented a pollution of scientific psychology. Again, we run into the notion of power being mute in the case where there is no 'social' but only the individual.

Preventative interventions usually function at the level of social representations rather than at the level of behaviour (Parker *et al.*, 2000). In framing HIV and AIDS prevention within the context of knowledge and power, the concern of social

[18] Moscovici points out that Durkheim used 'collective' and 'social' interchangeably (Moscovici, 2000).

representation theorists on understanding everyday common sense (Moscovici, 1984) is useful for exploring women's experiences. For Moscovici, social representation occurs through two mechanisms. The first is anchoring, which refers to the process by which people take in new information, attempt to code it and then relate this new information to a concept that is already familiar. Not only does this acknowledged the presence of pre-existing knowledge, but it also suggests that people do not readily adapt knowledge, because the presence of already familiar stock limits people's understanding of the new concept. The second process is objectification, which is when a concept is transformed into an image. This allows an abstract idea to take shape into something tangible and recognisable. In turn, people are able to understand the concept and eventually discuss it with others. Hence, even from a social psychological perspective, social representations are seen as forming the 'substance' of public discourses through the process of social construction.

THE SOCIAL CONSTRUCTION OF KNOWLEDGE

Before I address the issue of power in social representations of HIV and AIDS prevention, I wish to briefly explain the link between expert knowledge which is socially constructed as everyday knowledge and Schutz's (1964) framework in which (a) lay people construct ideas within their social groups, and (b) experts base their constructions on lay people's knowledge. Flick (1998) offers an account of the way that social representations and social constructionism (which are usually seen as opposed to one another) are relevant to one another. In particular, Flick demonstrates that social constructionism allows the relationships between theoretical, scientific and professional to be highlighted in ways that shows their combined influence on lay discourses of health (1998:659).

Although the relationship between expert knowledge and lay knowledge has also been configured in such a way that lay knowledge informs expert knowledge (Heider, 1958), the explanations of HIV originate from biomedical science and thus lead me to draw on Schutz's (1964) configuration of lay knowledge which sets it up as a binary to expert knowledge. What this means in relation to Moscovici's social representations is that mundane stocks of knowledge in the format of common sense (or myths in the

'classical') gradually cease to exist when sciences are established and their theories and results popularised (Moscovici, 1984; Flick, 1994).

In the context of gender, empowerment and HIV prevention, this would mean that men and women's lay knowledge about gender and sexuality gradually fades when (a) women re-negotiate their gender identities through collective empowerment, and (b) health promoters introduce HIV and AIDS prevention messages. This may be true to an extent, but it ignores the possibility of any competing power systems in which women are caught up and of which they sometimes drive.

The idea that knowledge is bound up in power dynamics plays an important part in the debates on women's empowerment against HIV infection. These dynamics occur primarily when a presumed trust in public health medicine, which overlooks the relations between Western thought and power, is predominant. However, there is a growing awareness of the link between knowledge and power, particularly with reference to development (the main vehicle through which HIV and AIDS prevention is implemented in Africa). In this respect, Harding's (1998) work on women's knowledge, multiculturalism and science, and standpoint epistemology is a useful starting point. She critiques Western science for not locating itself historically and advocates researcher reflexive investigations into how research projects may contribute to "culturally distinctive patterns of systematic knowledge and systematic ignorance" (Harding, 1998:67). While her work makes an enormous contribution to feminist social theory and philosophy by drawing on feminist, post-colonial critiques of knowledge and science, it has been criticised for suggesting a universalism in women's experience with science that post-colonial theory has challenged. In other words, her attempt to amend feminist standpoint epistemology (Flax, 1983; Hartsock, 1983; Haraway, 1985; Harding, 1986) to account for racial, ethnical, class, national or cultural differences assumes a certain unity amongst various epistemic communities who may have different interpretations of gender inequality.

With respect to women's empowerment framed within issues of knowledge and power dynamics in HIV and AIDS prevention, only part of Harding's (1998) argument is helpful. While I agree that it may be useful to create alternative epistemologies (such as advocating that HIV and AIDS research incorporates knowledge and experience of people living with the virus), it does not help to explain the power dynamics that exist

between different epistemic groups, particularly between the experts' HIV and AIDS prevention knowledge and women's lay knowledge, which is embedded in a social context with its own power dynamics.

RECONCEPTUALIZING POWER AND HIV/AIDS PREVENTION

Since I have formulated HIV and AIDS prevention and education as social representations, how women in groups come to form their own representations may have something to do with how they are socially constructed, both by the group and by the 'expert'. To characterise this relationship, I turn my attention to post-modern and post-structural critiques of enlightenment-esque Western medicine and public health, and particularly the work of Foucault.

In Foucault's critique of enlightenment, he identifies ways in which institutions from the seventeenth century, once responsible for either taking life or letting people live, became entrusted with the power to "foster life or disallow it to the point of death [by public administration and] the calculated management of life" (Foucault, 1984:261-262). For Foucault, this occurred through two processes: biopolitics and anatomopolitics.

Biopolitics of the population is the arm of biopower that employs regulatory controls and interventions to manage the population (Foucault, 1990:139). These are linked to economic and social issues (for example, an epidemic that attacks the labour force of a region), thus social policy becomes a visible strategy to implement collective processes concerned with the population's life and health. The other arm, anatomopolitics, focuses on the body as a machine. Deployment of disciplinary power penetrates relations in families, schools, hospitals, work, etc. "Focusing on individual bodies or on the social body, health professionals are entitled by scientific knowledge/power to examine, interview and prescribe 'healthy' lifestyles" (*op. cit.*:116). This occurred as a result of the development of a number of disciplines:

> "...universities, secondary schools, barracks, workshops; there was also the emergence, in the field of political practices and economic observation, of the problems of birthrate, longevity, public health, housing, and migration. Hence there was an explosion of numerous and diverse techniques for achieving the subjugation of bodies and

> the control of populations, marking the beginning of an era of 'bio-power'" (Foucault, 1990:140).

From this, we can assume several things about biopower. First, it is a type of disciplinary power - that is, power exercised by institutions to address public sector and socioeconomic issues. Secondly, by addressing public sector issues like birthrate, mortality and public health, this suggests an interface between health systems and people, in the vein of 'letting live'. By making disease surveillance routine and entrusting governments to provide health facilities and treatment, the health care system (made up of people who are there by virtue of the administrative set up) employed some type of control over bodies and populations.

This is not to declare that such control is bad or good; after all, these systems dealt with disease outbreaks in an organised way for the first time, and this was a marked improvement on the way things had been previously. A reconciliation of Foucault's claims and a brief flashback in time may actually show how the control of cholera in London 150 years ago may have established public health as biopower. During previous recurrent outbreaks, Snow (1965) had suspected that water from a pump on Broad Street caused the disease. After reviewing death records and interviewing household members, he found his suspicions to be true, which he reported to community leaders who, in turn, removed the pump handle. Cholera was controlled and epidemiological methods of record review and household surveys were cemented as the cornerstone of public health practice.

Thirdly, biopower seems to appear in waves or eras, perhaps depending on the social change occurring at a given time. For Foucault, biopower was a key element in the growth of capitalism which, he argues, depended on the former for the provision of bodies for labour and production, as well as associating aspects of population with economic progression (1990:140-141). During the 1990s, feminists such as Sawicki (1991) and Braidotti (1994) drew on the concept to examine social and political implications around the emergence and use of reproductive technologies for women. More recently, Agamben (1998) describes the Holocaust as a penultimate example of biopower. Negri and Hardt (2000) have also used biopower to explain the dynamics of and resistance to globalisation, in which mass media is biopower's main instrument to generate and combat the politics of everyday life. For Rabinow and Rose (2003), Negri and Hardt's (2000) assumption of biopower as a sovereign power over life is

misleading because health, they argue, is no longer a state set agenda and they apply the notion of biopower to 'techno-medicine' (e.g., reproductive technologies and genomic medicine).

Having seen how these areas provide examples of how the notion of biopower has been applied to key events in this era, perhaps it is now possible to see how HIV and AIDS prevention can be viewed as a biopower when it is seen as a function of health promotion. For Gastaldo, biopower proved to be useful in demonstrating ways that health promotion and education "manage individual and social bodies" by making them wait in long queues - or the rules and norms that biopower establishes, thus "disciplining the body" (1997:113). I agree with her observation that health education influences people through two sets of power relations: liberation from ignorance and subjugation to health knowledge. Furthermore, it establishes, through the expert, norms and systems of rewards and punishments, and helps build up representations of what is expected from sick and healthy people, gradually working itself (depending on the ailment of intervention) into aspects of everyday life.

Despite the interest in examining the biopowers of this era, the concept has been criticised for several reasons. First, the Foucauldian construction of women in their bodily and sexual being does not allow a clear picture of the interrelationship between the biopolitical and socioeconomic dimensions of female subordination (Soper, 1993:35). In other words, biopower does not explain why women are at its mercy. Second, some researchers have found Foucault's conception to be negative and have argued for a more 'double-edged' notion of power, one that accounts for positive as well as negative power relations (Jovchelovitch, 1997). Finally, other researchers have found the concept helpful in framing questions of ethics, but caution against using it as a tool for thanatology (Rabinow and Rose, 2003).

Despite these criticisms, HIV and AIDS prevention is an appropriate field to see how biopower may or may not be implemented as a biopower to which people have different reactions (i.e., whether to engage in safe sex all of the time, some of the time, or never) for several reasons. In the first instance, HIV and AIDS prevention shares all the characteristics of biopower because it: is linked to economic and social issues; depicts an expansion of the health system into private life; aims to make things better; and involves experts. Furthermore, it allows for women to be framed in a web of power

relations that extend beyond relations between men and women. Finally, women may be caught between embracing new knowledge that could, on one hand, 'liberate' them from ignorance or traditional knowledge that prevents them from negotiating safe sex. On the other hand, HIV prevention subjects them to a set of knowledge that is in conflict with values which they, and people in their various networks, hold dear. Hence, this study is concerned with people who are living with or without HIV and who are committed to using strategies that are instrumental to their survival, whether these include safe sex or not.

Moreover, these criticisms separate the notion of biopower from the rest of Foucault's conceptualisation of power. With respect to HIV and AIDS prevention in Nigeria, it is necessary to consider multiple sites of power and power relations, including gender power relations, and expert and lay power relations. In practice, most of these are embedded within the context of sexual partnerships, family, urban and rural affiliations, membership affiliations, local politics and governance, and donor relationships. Such dispersal of power relations lends itself to Foucault's overall conceptualisation of power, which includes disciplinary power and governmentality.

Disciplinary Power

The Foucauldian notion of power is decentralised and constituted by the "multiplicity of force relations" deployed through the processes of struggles and confrontations (1990). The relations can either form a system or be isolated from one another. Nevertheless, their strategies are deployed through law or through various social hegemonies.

> "...power is not an institution, and not a structure; neither is it a certain strength we are endowed with; it is the name that one attributes to a complex strategical situation in a particular society" (Foucault, 1979:93).

It is, therefore, not possessed by a single organisation or person, but operates through its omnipotence and multiplicity.

There are several conceptualisations of Foucault's power that have resonance within the context of HIV and AIDS. It is perhaps in his earlier works that the notion of power

can be found applicable to situations such as HIV/AIDS prevention as managed by public health and development experts. In *Discipline and Punish*, Foucault describes discipline as a form of power, "comprising a whole set of instruments, techniques, procedures, levels of application, targets; it is a 'physics', an 'anatomy' of power, a technology" (1997:215). Its objective is to ensure cost-efficiency and effectiveness with respect to managing populations and is therefore linked with institutional apparatuses. Although Foucault has argued elsewhere that power is "everywhere", he notes that disciplinary power is a unique technology because people are both its objects and instruments (*op. cit.*:170). Moreover, due to the mechanisms used to objectify, this technique of power both reduces individuals to units and homogenizes them at the same time.

It is this dualistic effect that is characteristic of HIV and AIDS discourses; women are meant to be empowered collectively, but are also individually responsible for managing safe sex. Moreover, the implicit assumptions of 'aberrant' yet controllable African sexuality (explored later in this chapter) are also effects of disciplinary power. For Foucault, what is central to this dualistic effect of discipline occurs through normalization, which "compares, differentiates, hierarchizes, homogenizes and excludes" (1977:183). Disciplinary power determines norms, which in turn, determine deviance from norms. The use of this technique of power demonstrates how science, truths, bodies of knowledge and discourses create norms that are used to judge people and their actions, thereby decreeing their normalcy or abnormality for which they are rewarded or punished accordingly. Through another technique referred to as 'examination', the constitution of individuals as "describable, analysable objects" (*op. cit.*:187) allows them to placed into systems constructed for comparison.

This normalizing and comparative effect can also take place within groups of people, constituencies or nations, and is characteristic of Western medicine. Medical sociologists have written about the effect that the medicalization process has on lay people or patients, particularly in North America and Europe. They argue that despite its lack of effectiveness and side effects, it has accrued power and authority (Zola, 1972; Illich, 1975). Medical sociologists have offered the solution of patient empowerment. Lupton (1997) criticizes medicalization arguments as failing to note positive aspects of medicine experienced by patients and also the role that patients have in participating in or contributing to medical dominance. For her, Foucault's notion of

power is useful in several ways. First, it opens up the understanding of the body's construction through medical discourses, then takes medical knowledge as a belief system shaped through social and political relationships; seeing power not as something held over or transferable to patients, but as a relational strategy transmitted through different social groups. For Lupton, it is Foucault's later work on technology of the self (rather than technology of dominance) that was helpful in charting lay resistance to medicalization and the gaze. She argues that both medical sociological and Foucauldian perspectives of medicalization fail to take account of the more emotional aspects of personal interactions between lay and medical people (*op. cit.*:108). Despite this, she concludes that Foucault's approach helps show how discourses and the power of medicine permeate everyday experiences.

Helpful though this is in explaining the gap between lay people and experts, it does not account for intersections of sexuality, disease and power. Historians of colonial medicine have also drawn on the Foucauldian notion of (bio)power to African illnesses and the body. Vaughan (1991) explores the limits of biopower by examining the ways in which colonial medical discourses were used to construct a notion of 'the African'. For her, missionaries blamed diseases like syphilis on the inherent sinful nature of the African. She notes how the Africans' ready response and compliance with treatment elicited airs of superiority from the Europeans (*op. cit.*:150) Their lack of shame was construed as evidence of their backwardness, which tied in with their "primitive sexual behaviour" (*op. cit.*:151). In particular, these took on gendered discourses, focusing the discussions of colonial administrators, physicians and local elders around the topic of uncontrolled female sexuality. However, African male sexuality also posed a problem, because syphilis and venereal disease had an impact on labour forces.

Vaughan (1991) offers that discourses around African sexuality should be seen in the light of successful efforts to tame female sexuality within the metropole. This effort was held as a parallel to the successes in pre-colonial Buganda, in which the men controlled the women (a time before the outbreak of syphilis). Hence, deteriorating control over female sexuality was said to be the problem of the outbreak of syphilis in Uganda. Interestingly, the men agreed that the disease had been allowed to flourish as a result of the introduction of Christianity and civilization. It symbolized loss of control over the whole of African society. Vaughan argues that proponents of curing the disease drew on European discourses that emphasized controlling female sexuality.

Conversely, polygyny was also blamed by the medical missionaries. The chiefs implored the government for anti-venereal campaigns, because they feared their tribes being wiped out. They also welcomed the idea that the disease could be traced to a weakening of their control over women. However, the British made the issue more than one about gender relations, and focused on sexual relations, thus reflecting "a very European preoccupation with sexuality" (1991:140). Their strategy was not to increase the chiefs' control but to educate mothers. The socio-cultural aspects of what was seen as 'African-ness' by colonial medics and administrators is the thrust of what Vaughan argues is the limit of biomedical discourses' power to individualize. Rather, she argues that the application of a biomedical discourse involves a "specification of the features of groups" (*op. cit.*:141).

As an anthropologist of colonial history, Stoler (1995) points out that this regulation of collective groups is precisely what Foucault (1990) referred to in his notion of biopower. She responds to Vaughan's (1991) assertion that colonial discourses did not individualize members of African populations, by drawing on Foucault's collective work to highlight his shift from individualizing disciplinary power to the power of regulating entire collective groups. Her emphasis on this aspect of power is part of a larger project to link race and sexuality through Foucault's writings and lectures which, she argues, were implicit rather than explicit. She does so to respond to several gaps in his work; the most major being the colonial settings as an overlooked site in which eighteenth and nineteenth century discourses were produced in Europe. Stoler points out that, for Foucault, the discourses of sexuality produced four objects of knowledge: the hysterical woman, the masturbating child of the bourgeois, the Malthusian couple and the perverse adult. The overlooked "libidinal energies of the savage, the primitive, the colonized" (1995:6-7) was a missed opportunity to explore the proliferation of sexuality discourses around colonial instruction, servants and hygiene. Foucault's omission of the colonial encounter from his writings (1979, 1990) also meant that the notion of how the formation of the European self was overlooked. This is important, Stoler argues, not for exploring the hegemony of European discourses but for exploring the vulnerabilities of that hegemony.

Stoler situates her analysis in colonial Dutch Indonesia, where intermarriage created "internal enemies" against whom society must protect itself. For her, these include the "not-quite-white" biracial children, European educated natives and the lower class

European colonizers who were targets of internal purification (1995:93). This was in line with Foucault's implicit claim that the state's biological regulation was achieved through targeting sex, the effect of which was racism (1995:96). The purity of race would allow the Dutch state to exercise its sovereign power. Contradictory sexual regulation (such as keeping concubines) confined breeding and warded off venereal diseases as well as homosexuality (Stoler, 1995:129). This was done in the name of nationalism, more than race (*op. cit.*:93). Similarly, the government's management of domestic space was necessary because this posed a threat to European security. Racial (European) membership, she argues, was assured by middle-class morality, nationalism, bourgeois sensibilities and normalized sexuality. Hence, these normalized characteristics grounded colonial expertise and domination.

Governmentality and Development

Both Vaughan (1991) and Stoler analyse the effects that biopower played in the colonial discourses on disease, sexuality and race, and in the regulation of the health, sexuality and ethnicity of not only the colonized but also the colonizers (Stoler, 1995). However, several anthropologists (Pels, 1997; Scott, 1995; Prakash, 1999; Li, 2007) have drawn on other strands of thought within Foucault's notion of power to describe the governing of colonies as part of the anthropology of modernity, which is referred to as 'colonial governmentality'. Similarly, some have extended the ethnography of modernity by drawing on governmentality to characterise the hegemony of development discourses and certain dominant discourses within HIV and AIDS programmes (Burchell *et al.*, 1991).

> "Governmentality is the ensemble formed by the institutions, procedures, analyses, reflections, calculations and tactics that allow the exercise of this very specific (albeit complex) form of power, which has as its target population, as its principal from of knowledge political economy, and as its essential technical means apparatuses of security" (Foucault, 1991:102).

In particular, governmentality could include any body of organizations, policies, research, data and methodologies which target the population based on political economy through security means. For Foucault, population management was the goal of government and was made possible through the needs of the population (such as

health or welfare). The government's instrument and target is both individual and collective consciousness, which are targets to new tactics and techniques. Governmentality therefore results in the formation of 'specific government apparatuses' and to the development of a "whole complex of *savoirs*" or government knowledges (Foucault, 1991:103) which are implemented by individuals or experts.

Given Foucault's claim that governmentality is "the tendency which, over a long period and throughout the West, has steadily led towards the pre-eminence over all other forms [...] of this type of power which may be termed government" (1993:103), it is not surprising that several writers have drawn on governmentality to critique international development paradigms - the vehicle through which HIV and AIDS prevention is implemented in Nigeria and other developing countries.[19]

Several writers have drawn on the notion of governmentality to critique the development paradigm. Escobar (1995) deconstructs development discourse by constructing a picture of development within the history of the anthropology of modernity, beginning in the nineteenth century. During this time, he argues, the social aspects of everyday life including poverty, health, education, etc., became a domain of knowledge and intervention through the establishment of "apparatuses of knowledge and power which improved life within the context of science" (1995:23). He notes how economic growth and development were heralded as solutions to the defining problem of the Third Word - poverty.

In Escobar's analysis, development discourse was 'birthed' with a visit to Colombia in 1949 by a team of social experts from the then International Bank, who promised to save Columbia and make it an example for other underdeveloped nations to emulate. For Escobar, this development "conformed to the ideas and expectations of the affluent West, to what the Western countries judged to be a normal course of evolution and progress" (1995:26). In Africa, he argues, the intention of development was made more clearly, and was more ominous. Development emerged as a strategy in the 1930s to reconfigure relationships between metropoles and their colonies. Escobar also positions development as a post-war political strategy, which escalated into competition between

[19] None of the writers address the governmentality of HIV and AIDS prevention and development *per se*. Watts (2003) explores the relationship between Islam and alternative development, as well as the political economy of oil under governmentality and rule in Nigeria. Ferguson and Gupta (2002) refer to the transnational governmentality that characterises development. Ferguson (1994) has also drawn on disciplinary power to show how discursive formations are made in the fields of anthropology and development.

the United States and the Soviet Union for modernization projects in which the Third World was implicated (1995:34). In the 1950s, development was the answer yet again, but this time as a means of rescuing Third World countries from poverty (which made them susceptible to communism).

From Escobar's analysis, there are three features of governmentality which also characterize international development. The first feature is development methods and approaches as a techniques of power. The escape from poverty would arrive from what Escobar implies is a form of biopower - population control. Demographic data was used to compare progress between nations, and featured in discussions around race. Yet, similar to the US HIV and AIDS prevention discourses of the early 1980s, South African HIV and AIDS discourses of the late 1990s indicated that "the discourses of population were being redeployed within the 'scientific' realm provided by demography, public health, and population biology" (1995:41). In other words, sciences become technologies or instruments of population management.

The second feature is development as discourse. For Escobar, the system of relations of institutions, socioeconomic processes and forms of knowledge form a discursive practice that establishes and "sets the rules of the game: who can speak, from what points of view, with what authority, and according to what criteria of expertise" (1995:41). He draws on Foucault's concept of multiplicity of (power) points to further characterise the governmentality of development; these included new international organizations and government agencies.

Once experts had drawn up plans, programmes and evaluations, development was able to create what Escobar refers to as 'abnormalities'. These correspond to client categories within development; he provides examples of these abnormalities, which include the *illiterate*, *underdeveloped*, *malnourished*, *small farmers* and *landless peasants* (1995:41). These maladies are correctable by development interventions which would deliver "badly needed goods [to] target" populations (*op. cit.*:44). The public health correlate in this research is the delivery of empowering AIDS prevention programmes to vulnerable people.

The third feature is professionalization or the development of expertise. Several writers have commented on the role that professionals or experts have in producing

power/knowledge. Escobar argues that professionalization occurs through the acquisition of techniques and mechanisms "through which a politics of truth is created and maintained, through which certain forms of knowledge are given the status of truth" (1995:46). Through this professionalization, political and cultural aspects of problems were repackaged in 'neutral' scientific vehicles, which were then disseminated through academic disciplines, conferences, consultant services, etc., thus forging the business of development which benefited the West as much as it proposed to benefit the Third World nations.

Power and Experts

HIV and AIDS prevention, due to its relationships with development and public health (and to biostatistics, psychology, nutrition, etc.) operates through the notion of professionalism and expertise, which are central to the Foucauldian notion of rule-governed networks of power/knowledge and to biopower. Drawing on criminal cases during the nineteenth century, Foucault identifies the role of experts as providing mechanisms for what could be referred to as 'justified judgment' about individuals' actions and the individuals themselves, simply because it is possible to obtain scientific knowledge about either (1977:18). Such expert mechanisms, grounded in scientific knowledge, include "a whole set of assessing, diagnostic, prognostic, normative judgments" (*op. cit.*:19). As a result, there are many different types of expertise drawn upon in order to implement a single decision; in the case of implementing a prison sentence, experts may include psychological experts, magistrates, members of the prison service, etc. Since the sheer number of experts "fragment" power (*op. cit.*:21), they do not have power in themselves, but facilitate the deployment of discipline. For Foucault, experts may advise on disciplinary techniques by: declaring individuals as 'dangerous', suggesting ways of protecting the public from dangerous individuals, recommending ways to improve (him), or coercing or encouraging compliance (*op. cit.*:23). In essence, expertise is refined in a machinery that develops and revolves around implementation and also suggests a range of prescriptions for treatment with effects reaching further than the treatment itself.

As in many cases with HIV and AIDS (particularly in clinical settings), these techniques are deployed with some level of cooperation from individuals. For Foucault, it is characteristic of the West to develop techniques for telling the truth of sex towards

power knowledge or "*scientia sexualis*" (1979:58). At the core of this is the technology of confession or a 'ritual of discourse', which takes place within a power relationship where one party confesses and the other "prescribes and appreciates it, and intervenes in order to judge, punish, forgive, console, and reconcile". By taking part in this 'dialogue', experts are pivotal in helping individuals tell the truth about themselves (Dreyfuss and Rabinow, 1982:175). What the ritual enables is the ability for people to perform a number of operations on themselves, thereby deploying 'technologies of the self', such as being responsible, staying healthy, being 'normal', achieving normalcy or being empowered (Foucault *et al.*, 1988). Of course, there is an assumption among some Western philosophers (e.g. Rose, 1986) that people have the freedom and autonomy to deploy technologies of the self as a means to align personal objectives with political ones. However, within the context of HIV and AIDS, deployment of technologies of the self, such as empowerment, occurs with the guidance of development experts and HIV and AIDS experts.

Power, Gender and Development Experts

For Parpart (1995), the development expert has been complicit in extending and refashioning colonial discourse, which represents Third World women as primitive and held back, by tradition, from achieving progress and modernity. She examines the perpetuation and variations of this representation within Woman in Development (WID), Women and Development (WAD) or alternative development, and Gender and Development (GAD) discourses. Drawing on documents and examples from mainstream development agencies such as the World Bank, Parpart describes how WID discourse reinforced representations of women who are vulnerable due to both traditional gender norms and due to sluggish and economic management of Third World nations. The former is ossified as 'culture', while the latter was met with what can be read as a new set of apparatuses with which women could be rescued from pernicious World Bank policies. This scenario clearly justified the need for Northern expertise and for excluding local knowledge that could only cause retrogression and developmental stagnancy. Even when local knowledge was called upon, organisational and project structures showed how Northern expertise was privileged above local 'expertise'.

For Parpart, the WAD and GAD approaches have fared minimally better. The WAD approach is characterised by examples of a few experts with long-term projects who had experienced negative repercussions due to excluding local knowledge and, as a result, had taken painstaking steps to reconfigure their approaches (1995:235). GAD, despite being populated with Southern experts, still portrays Third World women in ways similar to WID and WAD, but this time as a result of the capitalist system (*op. cit.*:236). Expert knowledge is still required, particularly in areas which require gendered approaches. The way out, for Parpart, can be found in the "empowerment approaches" which are "grounded in the experience(s) and knowledge(s) of women in the South" (*op. cit.*:237), which resonates with feminist post-modern imperatives to resurrect subjugated 'knowledges' as well as post-colonial and post-development exercises of decolonizing development discourses.

Power and HIV and AIDS Experts

With respect to HIV and AIDS prevention, the WID/WAD/GAD discourses have fuelled hegemonic discourses about women's vulnerability to HIV and AIDS. However, unlike GAD or development in general, HIV and AIDS *is* able to fray the binary between expert and lay knowledge to a certain extent, particularly with regards to HIV treatment.[20] The power of expertise becomes diffused in the context of HIV and AIDS in several ways. First, expertise is conferred and knowledge regarded as 'serious speech acts', with knowledge being validated by a community of co-experts, and experiential AIDS knowledge becomes validated by other people living with HIV and AIDS. Similarly, prevention expertise becomes validated by people who have been at risk of infection. Second, AIDS expertise becomes blurred when experiential knowledge is privileged or seen as being on a par with professional knowledge. Third, expertise can be frayed when an individual possesses both professional and experiential expertise, whether within the context of treatment or prevention, or both.

Nevertheless, it is interesting to note the array of experts and knowledges constructed within the domain of development and HIV and AIDS. In the Nigerian context, the field of AIDS is characterised by a diverse band of experts. It includes social scientists, biomedical scientists, health care professionals, traditional healers and pastoral

[20] Based on empirical evidence from this research, HIV and AIDS treatment is reconceptualised in Chapter Eight as incorporating the prevention of secondary infections.

advisors, but also advocates for community mobilizers, sensitizers and gender specialists. This contrasts markedly with the array of experts which Epstein (1995) describes as populating the AIDS movement in the USA at the beginning of the epidemic. In that context, expertise was comprised of an array of scientists. What is interesting within this comparison is the way that development expertise almost displaces biomedical and scientific expertise in the West. While the type of expertise differs, what remains in common is the diversity of experts: the promoters, educators, mobilizers and advocates. Interestingly, both treatment and prevention are domains in which the binary between lay and expert can be frayed. However, this was not the case in the USA in the early to mid-1990s, Epstein argues. For him, debates over clinical HIV trials and research created new sites for activists to exercise political influence, as well as new mechanisms through which they could present themselves as being credible contributors to scientific knowledge within the domain of professional scientific expertise (1995:409). Similar patterns are emerging with respect to treatment activism in other parts of the world, including Brazil (Biehl, 2004), Burkina Faso (Nguyen, 2005) and South Africa (Robins, 2005).

However, this post-modern approach to development issues is still contested by feminists. Lazreg (2002) draws on Bourdieu's (1996) concept of the field to emphasize development's constitution as a system of knowledge/power (Lazreg, 2002:123). Lazreg confines her analysis to post-modernist feminism's concern with the impact of globalization on Third World women. In it, she takes up several issues. First, Escobar's (1995) perspective on development, she argues, is drawn into a singular knowledge/power system espoused by international organizations and deployed against poor peasants and women. This, she argues, eclipses the ways in which development is mediated by interactions between local and international forces (1994:125). Secondly, for Lazreg, post-modernist critiques of WID dismissed the importance of including women in development at a time when they were ignored by policy makers and donors. This suggests a hypocrisy within this criticism against WID, because it suggests that post-WID approaches have resolved the issue of modernity (Lazreg, 2002).

For Lazreg, further contradictions can be found in post-modernist development's unproblematised assumptions about the role of experts and the women they seek to help. Taking globalization as the ailment, development seeks to resolve this through gender and development training in empowerment - Lazreg argues that these efforts

'graduate' women through the process of being beneficiaries, participants and then agents of civil society. She points out that this creates competition for women who decide to set up their own NGOs and compete for funding, without which they are unlikely to function. Being caught up in this dynamic steers women and development practitioners away from making systemic changes because "the causes of their woes are the anonymously '*global*'" (Lazreg, 2002:136, her emphasis).

Despite Lazreg's (2002) cogent and persuasive argument, there are some comments which have more resonance with this research than with her chosen example of globalization. She argues that while the 'global' is an anonymous factor in exacerbating women's subordination, it is the number of identifiable players who disempower both men and women by perpetuating negative discourses and assumptions about their identity as a means of "creating public awareness" which refuels and reconfigures the very stigma that people living with HIV and AIDS face and challenge alongside activists. As Lazreg rightly states, there is a concern over the "labelling of what is happening to them" (*op. cit.*:136) by development practitioners, public health researchers and HIV and AIDS researchers, including myself. Yet, within HIV and AIDS, it is still unclear as to what effect such labelling (either from family, the public, biomedical and behavioural experts, or development practitioners) has on its 'targets' and the ways in which 'targets' take up, negotiate or challenge messages and programmes driven by labels. Moreover, this research is concerned with self-labelling, as with the 'invisibility' and rejection of these within mainstream discourses.

Hybridity and Mimicry

To theorise the fray between lay and expert knowledge, I draw on the work of Bhabha (1994). His notion of hybridity may be useful for theorising engagement and contestation of the governmentality of HIV and AIDS and development.

> "[Hybridity] reveals the ambivalence at the source of traditional discourses on authority and enables a form of subversion, founded on that uncertainty, that turns the discursive conditions of dominance into the grounds of intervention. It is traditional academic wisdom that the presence of authority is properly established through the nonexercise of private judgement and the exclusion of reasons, in conflict with the authoratative reason. The recognition of authority, however, requires a validation of its source that must be immediately, even intuitively apparent - 'You have that in your

> countenance which I would fain call master' - and held common (rules of recognition). What is left unacknowledged is the paradox of such a demand for proof and the resulting ambivalence for positions of authority" (Bhabha, 1994:112).

For him, such colonial authority requires modes of either cultural, racial or administrative discrimination; therefore, when drawing on the notion of hybridity, I do so in the context of the governmentality of HIV and AIDS and development as implemented by teams of professionals from Nigeria, other African countries and from around the world.

Bhabha's (1994) work is similar to Foucault's notion of power, in that hybridity is useful in interrogating the origins of expert knowledge and allows for some type of resistance as a response to the uncertainty of those origins. This, in turn, transforms practices of dominance into interventions. It is typical to assume that expert knowledge, for instance, is taken for granted and not challenged, and provides reasons for accepting it. In order for expert knowledge to be recognised, there must be an immediate or intuitive apparent and common validation of its source of authority. Anything which is not seen as apparent and common expert advice is not taken seriously and is doubted as such. Hybridity does not resolve tensions because:

> '...it has no such perspective of depth or truth to provide: it is not a third term that resolves the tension between two cultures... in a dialectical play of recognition" (Bhabha, 1994:114).

In other words, it is difficult to disregard traditional knowledge entirely, because when it does not mirror the expert knowledge, it eventually reveals itself when experts check to see whether their ideas have been taken up (for example, in an evaluation). It is at this point that the hybrid asks: 'How can you recognise in the mirror what you do not acknowledge away from it?'.

This could then be useful in explaining why, in HIV and AIDS prevention, there is often a dissonance between what is implemented and what is adopted. It could be that HIV and AIDS experts refuse to recognise the failure of prevention programmes as a sign of resistance, because they do not believe there is anything to resist or any reason to resist. It may also be difficult to recognise resistance, because it can manifest itself through mimicry or "the desire for a reformed, recognizable Other, as a subject of a

difference that is almost the same, but not quite.' (Bhabha, 1994:126). Hence, with respect to HIV and AIDS prevention, mimicry may occur when experts, Western or non-Western, espouse development discourses in order to implement programmes, but do not actually practise safe sex themselves.

This conceptualisation is not without criticism. Feminist post-colonialists have asserted that mimicry needs to be injected with the notion of agency, so that it is seen as a conscious choice of the mimic and acknowledges that there are other ways to resist (Spivak, 1993; Parry, 1994). Brah and Coombes (2000) point out that in gender theory the 'similar but not identical' concept of masquerade (Rivière, 1929; Irigaray, 1985) has a stronger sense of agency. 'Hysterical mimicry', as Irigaray (1985) refers to it. For Irigaray, mimicry situates women as a mirror to the male, reflecting and confirming his identity, erasing any recognizable reference. However, like Bhabha's (1994) conception, Rivière and Irigaray both base their notions of masquerade on Lacan's conceptualisation of mimicry:

> "Mimicry reveals something in so far as it is distinct from what might be called 'an itself' that is behind. The effect of mimicry is camouflage, in the strictly technical sense. It is not a question of harmonising with the background but, against a mottled background, of being mottled - exactly like the technique of camouflage practiced in human warfare" (Lacan, 1978:99).

The imagery of human warfare does not evoke a low sense of agency, but rather a careful one. Nonetheless, it is possible that women who are empowered, having an array of options from which to choose, may use their agency to respond in ways other than mimicry, or participating in HIV and AIDS prevention programmes without engaging in safe sex. They may choose to negotiate safe sex, or may choose not to negotiate safe sex. From a psychosocial perspective, this may depend not only on women's empowerment and how they manage their identities, but also on how much social power (or social capital) they gain from being in their groups.

Another critique of Lazreg's which has resonance within the field of HIV and AIDS and expertise is that of hybridity (2002), which she dismisses as belonging to the language of 'underdevelopment/development'. While deconstructing the notion of a monolithic Western culture, she sets up cultural identities as only being capable of being hybridized by Western culture, rather than as ethnically, culturally, spiritually

and politically diverse within geographical and spatial boundaries as large as Africa or (even) a single country like Nigeria is. On the other hand, the development imperative to make 'them' be like 'us' (which, using Lazreg's (2002) language, assumes that 'they' can never be 'us'; 'they' want to be like us; 'they' are not like 'us'; and that this is a bad thing, all the time, in every way) may very well be what drives the debates amongst 'experts' or African feminists' ambivalence around topics like sexuality and HIV and AIDS. This ambivalence is reflected by a dearth of competing discourses about issues such as African feminism, gender, sexuality and HIV and AIDS.

For some African feminists, this hybridity or ambivalence stems from perspectives on the professionalization of feminism through gender and development training. The African feminist and human rights lawyer, Sylvia Tamale, argues that development has depoliticized feminist activism in the continent (2006). Lack of funding and heavy workloads force women to turn to the 'development industry', in ways that improve the lives of the activists more than it does the lives of the beneficiaries. In a plenary speech given during a conference convened by the Association for Women's Rights in Development (AWID) in 2005, she remarked:

> "Presently, many of us are in the 'business' of women's rights not as political activists but mainly to advance our personal interests. We sit and strategize not on how to genuinely transform society but on how our positions will benefit us financially. 'Careerism' has eaten so deeply into the African women's movement that many of us do not even practice what we preach as feminist principles" (Tamale, 2006:39).

'Careerism' sometimes separates the academics from the practitioners, thereby divorcing theory from practice. For Tamale, an example of a development area in which this lack of theorising and feminist engagement is evident is HIV and AIDS. The feminist vacuum results in the proclamation of HIV and AIDS as a biomedical disease rather than a societal disease impacting upon women's sexuality (1996:40). But, having just highlighted African women's reluctance to practise preached feminist principles, how likely is it that all women will share in the assumption she makes later that African women's liberation must be linked to discussions of sexuality (*Ibid.*)?

Other feminists note that this ambivalence is interpreted as "socio-sexual anxiety" (McFadden, 2003:1). McFadden argues that this anxiety is characterised by the

response to the notion that sexual pleasure and choice are political tools for feminist agency, being central to human and sexual rights. For her, a focus on issues on HIV and AIDS suppresses issues of sexuality which stifle feminist agency. Recent discussions of sexuality (as it intersects with reproductive health, safe sex and safe motherhood) mark an improvement, but are still in what she considers to be 'safe' zones.

Pereira (2003) takes up McFadden's argument by pointing out how the latter's call for women to reclaim sexual choice and pleasure, mistakenly assumes that all African women are repressed and that they are repressed in the same ways. The zone which McFadden refers to as safe can sometimes be nothing but that for different women (Pereira, 2003). For Pereira, this dismissal of the contradictions and complexities of African women's everyday and sexual lives, mirrors the masculinist and positivist approaches that feminism seeks to transform. The issue in highlighting these two different arguments is not to take sides with them, but to show the different perspectives on sexuality that exist amongst (two) African feminists or experts. Hence, hybridity can occur horizontally within expertises as well as vertically (i.e., not only *amongst* experts but also *between* experts and lay people).

EMPOWERMENT

Having argued for the notion of governmentality to theorise and explore the power dynamics in the construction of HIV and AIDS prevention discourses, empowerment against HIV transmission is positioned in this research as a 'technology of self' by which women (and men) discipline themselves under the guidance of both lay and professional experts, which sometimes includes themselves. This position is complicated by the various empowerment approaches that exist across a number of disciplines and fields, including public health and HIV and AIDS, feminism, gender and development. Gender and development experts often recommend that empowerment occurs at the levels of collective and individual empowerment (Kabeer, 1994; Rowlands, 1997; Parpart *et al.*, 2002). Similarly, health experts draw on the idea of disempowerment occurring at multiple layers (Dowsett, 1999; Greig and Koopman, 2003). Because empowerment is a label given to any and all HIV prevention strategies (e.g., information about HIV and AIDS, access to condoms, etc.), it is often difficult to

measure the impact. It is also difficult to measure the ways empowerment initiatives intersect with people's lay understandings of what empowerment means to them in their everyday lives. With a view to demonstrating the role of empowerment against the governmentality of HIV and AIDS prevention, the following section explores different empowerment approaches in gender and development and how they could be applicable to HIV and AIDS and therefore interpreted as a disciplining technology at different levels of society.

Rowlands' (1995, 1997) overview of empowerment includes personal, relational and collective dimensions. The first dimension, personal empowerment, refers to confidence, capacity or developing a critical consciousness (1997:15). Within the context of safe sex, this might mean improved self-efficacy that leads to condom use (Wilson *et al.*, 1991; Meekers and Klein, 2002; Taffa *et al.*, 2002; Ao *et al.*, 2003) or increased access to health facilities and information (van der Straten *et al.*, 1995; Ukwuani *et al.*, 2003). These are some of the HIV-related aspects that we might associate with feeling personally empowered.

The second level at which a woman might feel empowered is at the relational level, whereby she might be able to negotiate and influence relationships around her and the decisions made within them (Rowlands, 1997:15). Again, within the context of HIV and AIDS, this could refer to women's ability to negotiate monogamy and abstinence, or to demand bodily integrity. Sexual health experts have attributed financial autonomy to what could be interpreted as relational empowerment. For example, financial independence was just one of the reasons that Yoruba women are able, without violent retribution, to insist on abstinence with partners who had STDs (Orubuloye, 1997b). Material wealth and class were also factors affecting young women's sexual behaviour in Mozambique (Machel, 2001). Safe sex negotiation was reportedly more successful with Ugandan sex workers who were financially independent from men who were not their clients (Gysels *et al.*, 2002).

The third and final level of empowerment is at the collective level (Rowlands, 1997). Here, women work with others to achieve certain objectives they have identified. For example, sex workers in Nigeria refused to have sex with clients without condoms as a result of collective action (Williams *et al.*, 1991; Abubakar *et al.*, 2006). Similarly, social support also play a role in women's confidence to insist on abstinence with

partners who had contracted STDs (Heise and Elias, 1995). At each of these levels, but particularly the collective level, there is an implied recognition of responsibility for protecting one's self, through a number of means including accessing health care, generating enough income to command respect, or participating in collective action.

If these are good objectives that have as successful outcomes as those in the examples above, then why are HIV and AIDS programmes still said to be failing? Part of the reason may stem from aspects of empowerment approaches that are not applied in development. In her work on empowerment, Rowlands offers a notion of empowerment which often goes un-cited:

> "Empowerment must involve undoing negative social constructions, so that people affected come to see themselves as having the capacity and the right to act and have influence" (1995:103-104).

It assumes that they cannot and will not, and relegates any reason for not doing so (in the way subscribed) as being cultural or traditional and therefore of little benefit.

Feminist conceptions of empowerment are more helpful than those from health promotion whose sole objective is to achieve positive health outcomes, as meeting community health programme objectives sometimes means subjecting women's other needs to these outcomes. Kabeer's (1999) conceptualisation incorporates a notion of transformative change that may run counter to expert guidance and programmatic goals. She arrives at this by conceptualising power as the ability to choose from a number of alternatives, recognising that some choices are more strategic than others (e.g. choice of livelihood). For Kabeer, empowerment is "The expansion in people's ability to make strategic life choices in a context where this was previously denied to them" (1999:437), and has three components: resources, agency and achievements. In the context of the governmentality of HIV and AIDS prevention, these components (particularly agency) are essential for framing women's experience of empowerment.

The process through which women might be empowered by resources utilises the second component, agency, or "the ability to define one's goals and act upon them" (Kabeer, 1999:438). Although it refers to noticeable deeds of either individuals or groups, it also refers to the motives and meanings behind those deeds. For Kabeer, not only can agency 'add' power to a person, it can also operate negatively whereby rules

and norms of social conduct can reproduce outcomes without using agency. This type of agency could be seen in contexts where agents obtain personal gain through a project without actually achieving the goals of the project.

Combined resources and agency lead to her final component of empowerment: achievements. These refer to "the particular ways of being and doing which are realised by different individuals" (Kabeer, 1999:438). Stressing a focus on the inequalities constraining people's abilities to make choices rather than on the difference in choices they make, Kabeer suggests a tension related to the choices women have. On one hand, she cautions against focusing solely on 'universally-valued' achievements, such as health, because doing so portrays women as being disempowered primarily by material lack, and moves us away from the criteria of women's achievements. This serves to work against the 'if you build it they will come' attitude by recognising how women's interests can be superseded by external planners' interests.

On the other hand, she draws on Bourdieu's (1997) notion of doxa to explain how women might make choices that reinforce their subservient status. She interprets doxa as "the aspects of tradition and culture which are so taken-for-granted that they have become naturalised" (Kabeer, 1999:441). This may characterise part of the social representation of HIV and AIDS prevention (the lay knowledge), some of which can be oppressive or liberating, or both simultaneously. One way of balancing this tension between power and choice is to determine whether or not the choices were made within the context of possibility. Hence, women exercise agency to make choices that challenge their subordination.

Extending Kabeer's (1994/1995, 1999) notion of empowerment to the field of HIV and AIDS, the empowerment of women who are caught between basing sexual decisions on expert knowledge or traditional knowledge, or a bit of both, depends partially on whether the decisions they make are done with a host of options available or missing. Empowerment also depends on making what Kabeer (1999) refers to as strategic life choices and second-order choices. A strategic life choice may be in conflict with choosing to have safe sex (Campbell, 2003). Choice can also be transformatory or merely mimicking desired outcomes.

Moreover, in relation to achievements, resources and agency, concepts of choice in the context of HIV and AIDS prevention's biopower, as well as conflicting social power derived from groups, are key in determining what constitutes an empowerment achievement and to whom. What HIV and AIDS prevention experts recognize as a beneficial resource to help women achieve prevention, a woman's family or association may see as a hindrance to achieving goals that benefit her family or group. This opens up the issue of competing empowerment goals and, as a consequence, the need for empowerment to be reconceptualised.

Parpart *et al.* (2002) offer an analysis of empowerment that, in many ways, resonates with the approach of this research. Highlighting the situation of what could be understood as the disempowerment of women's empowerment itself, they make a strong case for reconceptualising empowerment in a way that incorporates a clear understanding of power. For Parpart *et al.*, acknowledging different sites and dimensions of power may help to overcome the dualism of people with power versus people without power. Drawing on Foucault's thought (Rabinow, 1991), it is argued that empowerment is a process which takes place in institutional, material and discursive contexts (Parpart *et al.*, 2002:6). Interestingly, they argue that empowerment must take into consideration cultural practices and identities (*op. cit.*:15), which differs greatly from feminist critics of empowerment, such as Davis (1998) who expresses caution about identity politics that homogenize. This consideration could be interpreted as an attempt to resurrect subjugated knowledges that are lost in the construction of knowledge about empowerment in the field of gender and development.

Efforts at post-modernist approaches to reconceptualising empowerment are not without contestation. Lazreg argues that empowerment approaches which seek to give voice to women's experiences often involve the exercise of power in a "confessional mode" (2002:126). For Lazreg, this exercise serves the purpose of advancing development professionals' aims to maintain their own relevance by developing strategies that 'respond' to women's confessed development needs which, she argues, objectifies women (*op. cit.*:127). She questions the need to use problematic terms and recommends simply addressing "women's accounts of poverty and struggles to survive" (*op. cit.*:137). For Lazreg, a huge problem remains in the dissonance between recognising development as a discourse and recognising the social construction of female subjectivity (*Ibid.*). However, implicit in her cogent critique is the assumption

of a dichotomy between lay people and experts that, as argued above, is frayed in the context of HIV and AIDS. As seen with Epstein's (1996) work, there is the possibility to 'confess' and harness confessions into the social construction of discourses around gender, sexuality and identity that challenge dominant discourses in HIV.

Critiques similar to Lazreg's (2002) have been made about participation in development. Cooke and Kothari argue that notions of power have been absent from participation, while at the same time its practices have been hierarchical and privilege "dominant power structures" (2001:171). In particular, development interventions are fashioned and constructed within the context of unequal power relations between Western or Northern donors and aid recipients. Specifically, like Lazreg (2002), experts are implicated in these relationships by highlighting their tendency to ignore power relations between themselves and the local people, and also tend to ignore the possibility of communities as sites of power struggles (Cooke and Kothari, 2001:45).

Dominant power structures can sometimes be local as well as international. Lucas (2000) compares two women's development programmes: the Nigerian government's seminal women's development programme, 'Better Life for Rural Women' (locally known as the 'Better Life Project' or BLP) and a non-governmental programme, 'Country Women's Association of Nigeria' (COWAN). For her, COWAN was better at practising and implementing inclusive participation. She attributes BLP's failure to include its rural 'beneficiaries' on its organisational style which, Lucas argues, was based on the model of Nigeria's national development plans. These, she argues, were developed by urban technocrats to address the living situation of rural people without their consultation. She argues that this model took on another dimension because President Babangida's wife, Maryam, was credited with conceiving the idea of the nationwide project, and therefore was made its national president in 1987 with her officers including the state governor's wife as the state chair and the local government chairperson's wife as the local chair (Lucas, 2000:85-86). Lucas contends that the rural women were included "almost as an afterthought" (*op. cit.*:86). The First Lady's frequent perusal of government resources to promote herself and to fund her project (from which she denied access to rural women's participation) was a unique approach involving a steering committee for planning purposes (Bola, 1995; Mama, 1997) which differed from that of COWAN's leader, Chief Bisi Ogunleye, who involved rural women directly in development planning. Eventually COWAN attracted a number of

international partners, and is still actively working with rural women. However, the extent to which a different set of dominant structures affects COWAN's new partnerships is yet to be researched.

Public health, gender and development are not the only disciplines in which empowerment is debated. Social work researchers have written about the notion of power inherent in the relationship between professionals and clients in yet another helping profession - social work. Like HIV and AIDS, social work is comprised of less than egalitarian power relations between professionals and their clients. In social work, empowerment is viewed as "another tool in the kitbag of the professional" (Baistow, 1994/5:45). It is also referred to as something done to others or as something that is spoken (Pease, 2002:137). Post-modernism has drawn attention to the potentially oppressive role of social work professionals in relation to their clients (Chambon *et al.*, 1997; Pease and Fook, 1999; Healy, 2000). As a result, some writers have drawn on Foucault's notion of power to reconfigure empowerment as the "resurrection of subjugated knowledges" (Pease, 2002:141). Additionally, concepts prominent in social work, such as 'self-esteem', were interpreted as being technologies of citizenship. He offers a practical example based on his work on 'empowering' Australian aborigines whose relatives had died in police custody. Given both the colonial and recent history in which Aboriginal perspectives have been discredited, Pease agreed that the best way to counsel was to involve the group in identifying past injustices, which included eliciting stories which identified both negative and positive aspects of Aboriginal history. These stories were fed back into the community (Pease does not elaborate how) to re-build collective self-worth and to change the negative discourses circulating about them (*Ibid.*).

Like HIV and AIDS activism, which is discussed in Chapter Seven, this example of empowerment in social work involves a disciplinary technology facilitated by experts which helps to achieve goals that were either driven by or shared by the participants. Clearly, the method of participation differs from those discussed in Chapter One; therefore it is unclear to what extent the type of participation has on achieving empowerment against HIV and AIDS. For example, participatory rural appraisal is an approach used in gender and development (Parpart, 2002), but very little empirical research exists on the role it might play in the context of HIV and AIDS.

The concern of this research with the women's re-negotiation of identity draws on a notion of social identity informed by social psychological theory, but also draws on a notion of social capital informed by social theory. While this configuration is similar to Campbell's (2003) social psychology of participation, each of the main themes (empowerment, identity and social capital) are underpinned by the Foucauldian notion of power and draw on aspects of critical theory, including hybridity and mimicry. Since the women in this study are based in groups, a psychosocial approach to identity is still warranted and refers to social identity. Social identity:

> "...applies to those aspects of an individual's image of himself - positive or negative - which derive from his membership of groups that are salient to him and include facets of self-definition that result from membership in specific social groups or from one's place within systems of power relations produced by gender, ethnicity, or socio-economic background" (Tafjel, 1978:61).

This provides a useful warrant to link collective empowerment to identity vis-à-vis group membership. In addition, it provides a reading of the dominant discourses that exist or are being shaped.

Against the background of a Foucauldian notion of power, the means through which empowerment is exercised as a 'technology of self' in a way that affects identity is elucidated through social capital, despite the criticism (Putzel, 1997; Fine, 2001; Molyneux, 2002; Harriss, 2002) aimed toward Putnam, who defines social capital as "features of social organisation, such as networks, norms, and trust, that facilitate coordination and cooperation for mutual benefit" (1995:67). In other words, successful social groups must have strong networks, exhibit trust and possess norms that generate social conditions for the communal benefit of all the groups' members, making it an iterative concept that has the ability to reproduce. Having identified several other features, Putnam's argument reads almost like an equation of two parts. The first part could read:

> "If a community has networks, norms, trust, honest and egalitarian leaders, horizontal relationships and high civic engagement, then it will improve the quality of public life, the performance of social institutions and governance through..." (1995:66).

The mechanisms would be described by the second part of the equation, as (a) fostered reciprocity, (b) communication and (c) examples of best practice. However, it is Putnam's claim that this equation can be applied universally and always yields the same positive results that catapults the concept into a realm of contestation. Moreover, this notion is at odds with Foucault's notion of power, because Putnam's social capital contributes to institutional powers rather than challenges them. However, for Bourdieu, social capital is:

> "...the aggregate of the actual or potential resources which are linked to a possession of a durable network of more or less institutionalised relationships of mutual acquaintance and recognition - or in other words, to membership in a group - which provides each of its members with the backing of the collectively-owned capital, a 'credential' which entitles them to credit, in the various senses of the word" (1986: 248-249).

In other words, for Bourdieu, woman in groups may have access to their group's collective resources. It helps if the groups are socially instituted, bearing a common name such as a family name, tribe or party (1986:249). Groups with Bourdieu's conception of social capital exchange material and symbolic gestures to establish and maintain relationships which are binding and cannot be confined geographically or reduced to sheer economics, even socially. Implicit in his notion is the idea that social capital transcends neighbourhood relationships, as they are not always necessarily institutionalised by norms or names (*op. cit.*:256). In the broader context of participating with the aim of empowerment to renegotiate identities, social capital allows the chance for either taking up or resisting normalised and institutionalised technologies of power, such as the discourses which dominate HIV and AIDS prevention.

AFRICAN WOMEN IN HIV AND AIDS DISCOURSE

HIV and AIDS discourse has an interesting pedigree which contributes to what can be referred to as the 'double-frame' that defines women's empowerment within the context of prevention (the first frame being local gender norms and expectations, and gender relations). The primary voice of AIDS expertise can be found in international and national policies outlining strategies to combat the epidemic (and discipline those transmitting the virus as well as those 'vulnerable' to it). These strategies often rely on

biomedical data and approaches which, as described in Chapter One, have been criticized by researchers as being ineffective because of their assumptions of individual rationality and failure to contextualize gender and sexuality within socio-political and historical frameworks. This failure or silence can be read as a discursive strategy, following Foucault's theses (1973, 1991) on the role of the 'expert' in defining personhoods. In the following section, I argue that HIV and AIDS expertise deploys a hegemonic discourse which constructs African women in three ways: first, as both hyper-sexual and yet sexually passive; second, as either pregnant, prostitute or promiscuous (and therefore heterosexual); and finally, as poor, vulnerable and helpless.

The Hyper-Sexual/Passive Dualism

Researchers have argued that representations of African and Third World women's sexuality take their cues from colonial encounters with the British Empire (McClintock, 1995; Stoler, 1995; Stillwaggon, 2003). In her genealogy of Black (American) women's sexuality, Hammonds (1997) draws on the work of historians to trace the 'origins' of its constructions to South Africa, and colonial encounters with Hottentot females, citing Sarah Bartmann ('the Hottentot Venus') as the most well-known example. For Hammonds, Bartmann was exhibited in public displays due to her physiognomy which was taken as a sign of her "primitive" and "uncontrollable" sexual appetite (1997:172). She argues that black women's primitiveness was set against white women's sexuality which was constructed as 'respectable'. For her, this scripted black women out of the discourse of acceptable 'womanhood', thus rendering them invisible. She argues that invisibility became a political strategy of protection and acceptability for black women - a strategy, she maintains, which is still used by black women in response to the ways in which black sexuality has become "invisible, visible (exposed)" (Hammonds, 1997:172), hypervisible and pathologised in dominant discourses.

Hammonds' (1997) analysis only begins to highlight the implications on the dominant discourses of HIV and AIDS and its transmission through heterosexual sex, without any reference to non-sexual modes of transmission. However, HIV and AIDS is not the first infectious disease with an emphasis on racialised sexuality. A historical review of the power of biomedical discourses shows some similarities between the ways in which colonial medicine and HIV and AIDS prevention have constructed women's sexuality.

First is the monolithic construction of African women. Vaughan describes how biomedical discourses were central in colonial medicine's construction of 'the African' (1991:8), and differentiates between colonial medicine and colonial administration by highlighting how colonial administrators used medical discourses to construct notions of 'otherness'.

> "The need to maintain this overriding 'Otherness' meant that other sites of difference, and especially class differences amongst Africans were addressed only hesitantly, and with a great deal of ambiguity, by colonial administrators" (Vaughan, 1991:11).

This is similar to the homogeneity of 'vulnerable' African women represented in HIV and AIDS discourses, amongst whom there are no class differences.

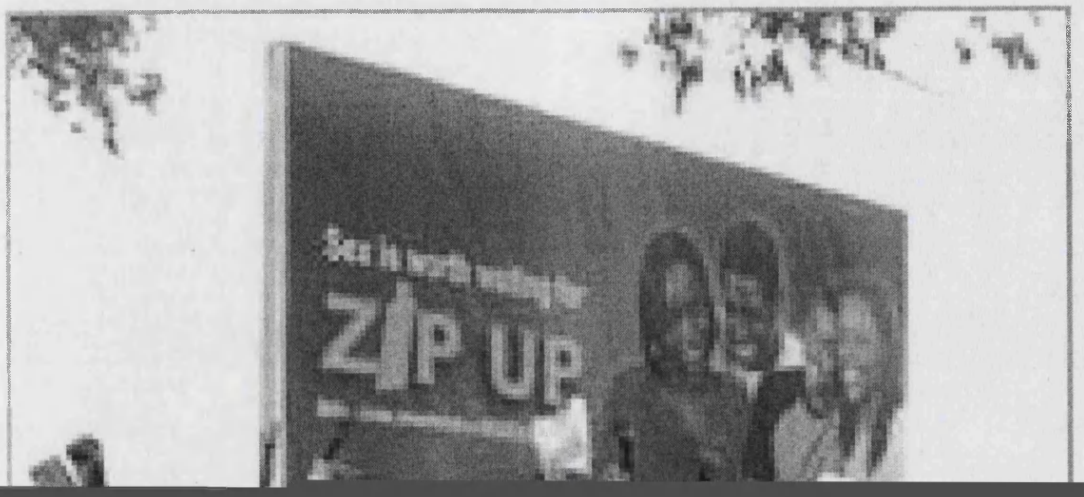
Second, is the way women are positioned as being in flux. Vaughan highlights ways in which medical discourses were used in ways that positioned "a people in flux". While Vaughan's example (1991:11) concerns consumerism versus 'resourcefulness' (Africans were encouraged to be consumers of new foreign products, but were also encouraged to use 'traditional knowledge' to make their own soap), it mirrors AIDS discourse tendencies to position women between their 'vulnerability' and capacity to shoulder the responsibility of HIV and AIDS in their communities. For Vaughan, colonial medical discourses served as a way to articulate ideas about 'African sexuality'. She points to how the discourses positioned Aryan males in both saviour and conquering roles, either as missionaries and doctors or as colonial administrators (*op. cit.*:25). These themes are also represented in current discussions on gender, sexuality, HIV and AIDS and development. An example of this can be found in a fact sheet developed by the US President's Emergency Plan for AIDS Relief (PEPFAR, 2007), which summarizes its approach to "addressing the vulnerabilities of women" as follows:

> "The Emergency Plan recognizes the critical need to challenge gender inequities, including male behaviours that often place female partners at greater risk of infection. PEPFAR prevention programs also focus on giving women and girls skills, information, and support they need to protect themselves. PEPFAR-supported ABC programs address gender issues, including violence against women, poverty, cross-generational sex, and transactional sex" (PEPFAR, 2007).

This two-page fact sheet is interesting because it is aimed at audiences concerned with HIV and AIDS prevention in general, but I will raise some points about its text before contrasting the representation in this directive with the way it takes shape in programmes that it funds in Nigeria. First, the text highlights male behaviour as central to women's infection, thereby constructing women as passive receptacles for HIV, transmitted by their male partners. Next, the text insinuates an inert woman without skills (although it is uncertain which type of skills she lacks) and who is ignorant due to lack of knowledge. However, once she obtains skills and information from PEPFAR, they will also provide her with "the support [she] need[s]" (which, it seems, she can only get from PEPFAR) to protect herself. Finally, the text is clear on whom it targets with its ABC programmes: poor women who have sex in exchange for money or gifts, from older men (presumably, not younger) who beat them.

The billboard campaign which PEPFAR funds in Nigeria shows four happy-looking young people (two young men and two young women) who are possibly university students (see Figure 2.1). The slogan "Zip Up!" is written in large letters with a picture of a zip representing the letter 'i' in 'zip'. Written just above it is the phrase "Sex is worth waiting for". This billboard was developed by international experts at PEPFAR in collaboration with local experts from the Society for Family Health (SFH), a Nigerian NGO.

There are two main differences between the representations of women in the text and the representations on the billboard: the women on the billboard are smiling, as are the men, who seem to be within the same age-bracket - and the men are not beating them.


ZIP UP

tamed or 'controlled', in accordance with modernity. This can be interpreted by the reference to jeans or trousers in the slogan 'Zip Up' which the young women are wearing, as opposed to the traditional 'wrapper' which is tied around the waist or sewn as skirts and worn with a matching top and head-wrap.

When compared to the text in the two-page fact sheet, the representation becomes slightly more disturbing and can be read to assume that the women on the billboard are safe and happily smiling *because* of PEPFAR's intervention (of skills, information and support which enabled them to 'Zip Up'). It does not allow for the possibility that some young women may have been able to decide whether or not to have sex before or despite the 'Zip Up' campaign, because of a presumed notion of (un)controllable sexuality.

Pregnant Women, Prostitutes and Promiscuous Young Women

While there is an imperative to prevent HIV and AIDS transmission from mother to child, the representation of African pregnant women in dominant HIV and AIDS discourses can be seen as an extension of those discourses constructed in the field of population (control and studies). In their oft-cited and problematic analysis of the barriers to HIV and AIDS prevention in Africa, Caldwell *et al.* drew on numerous ethnographic texts to argue that the biggest 'barrier' was what they defined as the "distinct and internally coherent African system embracing sexuality, marriage and much else..." (1989:187). This seems fairly innocuous, except for the totality of this definition on an entire continent. However, pertinent to the discussion on negative representations within dominant HIV and AIDS discourses are several claims that reinforce a hyper-sexualised and monolithic notion of African women as promiscuous and pregnancy-prone. For Caldwell *et al.*, Africa is different because it is permissive towards premarital relations and exhibits an acceptance that extramarital relations should not be punished. They support their argument with ethnographic evidence of societies in which sexual freedom of girls is permitted with "little worry in the traditional society about pregnancy" (1989:206). Furthermore, they perceive female extramarital relationships to be acceptable, not because of a possible sense of morality but they fear encroaching upon "husband's rights" (*op. cit.*:212). It is unsurprising that Caldwell *et al.*'s (1989) publication elicited a spate of responses and reactions from researchers across various disciplines (Le Blanc *et al.*, 1991; Ahlberg, 1994; Heald,

1995). A general critique concerned the methodology deployed, as well as a disregard for data, including ethnographies which they selected but which may not have supported their argument around chastity (Ahlberg, 1994:223).

With this perception of promiscuity, it is of little surprise that women would eventually appear in their analysis as pregnant. For Caldwell *et al.*, the 'African system' is "responsible for maintaining high and constant fertility over the region in a way that no longer has any parallel elsewhere in a whole world region" (1989:188). High and constant fertility not only evokes images of women who are constantly pregnant, but suggests a notion of constant sexual activity. Hence, the presence of pregnant woman within HIV and AIDS discourses can be read as further evidence of uncontrollable sexuality. These representations are also taken up within further research on HIV and AIDS, within development institutions and within the media (Stillwaggon, 2003).

The discourses on young women and pregnancy show up in USAID's Country Strategic Plan for 2004-2009, which mentions that:

> "Almost two million Nigerians aged 15-29 are HIV positive, out of four million total infections. Young women are especially vulnerable to HIV infection because they lack information, services, and the power to protect themselves against risk. Half of these same young women will be mothers by the age of 20, and in the absence of quality health services, are more likely to die of maternal causes than their sisters in industrialized countries" (USAID, undated:52).

From my understanding of this excerpt, women are taken through a depressing trajectory of lifetime possibilities, which begins with HIV infection and ends with motherhood by the age of 20. However, it is difficult to establish which women will become young mothers. Is it the women who are vulnerable to HIV and AIDS or is it the two million women aged 15-19 who are already infected with HIV? There are two possible readings that can be drawn from this information. First, if it is the group that is vulnerable to HIV and AIDS, then it ignores the possibility that some young women may choose to prevent pregnancy through oral contraceptives (Barden-O'Fallen *et al.*, 2003), or may opt for an abortion rather than contraception, as suggested by research findings in a study on rural Osun State (Otoide *et al.*, 2001). Erasing women's options and agency creates a missed opportunity to explore reasons behind the preference of abortion over contraception.

However, a second and closer reading highlights the anti-abortion rhetoric espoused by the donors. Perhaps the reason that women die maternal deaths by the age of twenty is because the absence of quality care encompasses the absence of safe abortion facilities. Either reading would still present a missed opportunity for experts to engage with Nigerian legislators, rights groups, service providers, and women and their partners, over the issue of safe abortion. It also fails to address the low intake or availability of oral and emergency contraception (Aziken *et al.*, 2003).

Win narrates how monolithic representations of poor and pregnant African women commodify this image and notes implications on local non-poor 'experts'.

> "Like the fly-infested and emaciated black child that is so often used by international news agencies, the bare-footed African woman Sells. Without her uttering a word, this poor woman pulls in financial resources. Any researcher worth her salt has to go to the 'most remote' village to find her for their statistics on issues like access to water, to be valid" (Win, 2004:61).

This excerpt has further implications on the construction of women's sexuality and agency. Patton (1989) outlines the ways in which certain 'taken-for-granted' texts produced by Western experts form representations of heterosexuality and inefficient health systems (and staff) that inscribe difference in ways that privilege advanced industrialized nations in the West over underdeveloped post-colonial nations in Africa, and influence international AIDS research and policy. In relation to gender, dominant representations of pregnant and promiscuous women often render invisible the male partner(s), implicitly constructing him as being more hyper-sexualised than his multiple female partners. Furthermore, the imagined sexual relationship is argued to take on a transactional nature, often devoid of love, desire and pleasure (Patton, 1989). Inherent in these perspectives are two underlying assumptions within HIV and AIDS and development. The first is that African women, despite being hyper-sexualised, are incapable of experiencing desire, pleasure and love. This assumption, following the perspectives of Cornwall (2006) and Correa and Jolly (2006), denies women their sexual rights and well-being. These aspects of sexuality constitute findings from an ethnographic study by Smith (2001) on courtship and marriage amongst Nigerian Igbos. His participants' decisions to draw on notions of romantic love challenges the notion of a loveless marriage or relationship which, he argues, has been dominant

within cross-cultural research. The study highlights the ways in which notions of romantic love and economic expectations can shape relationships without contradicting one another. His findings show examples of couples who court and marry for love, a trend found with participants who were in their sixties. Furthermore, instead of the construction of a hapless victim in need of financial assistance, Smith's study shows how married Igbo men constructed their girlfriends as either 'razor blades' or 'handbags' (2001:142), with the former extracting, not only money, but love as well. Smith considers that these constructions delineate different notions of women's agency, "one active and dangerous, the other passive and under control, both objectifying and neither particularly attractive" (*Ibid.*). Nevertheless, the representations in his study provide a slightly different picture of women whose sexuality is reduced to a transaction, and has implications for seeking solutions other than income-generation.

While Smith's (2001) study highlights the centrality of poverty in the construction of women and transactional sex or prostitution, Leclerc-Madlala (2004) argues against the assumption of subsistence as the sole facilitator of transactional sex. Instead, for her, exchanging sex for 'things' is not unique to any part of the world, and is therefore open to a diverse and complex sets of motivations. She finds accounts within other South African studies that move beyond the discourse of 'survival sex'. Particularly salient is the way young men in one study described girls who were "obsessed with luxuries" (Leclerc-Madlala, 2004:5). This comment is not unlike that made earlier about Smith's study on romantic relationships in Nigeria, albeit without the 'love'. Such comments point to an understanding of the relationship between money and sex that is not necessarily related to poverty (Leclerc-Madlala, 2004:6). Moreover, the author interprets women's discourses about sex and money or gifts as a 'continuum of needs' which takes on specific characteristics in an urban setting (*op. cit.*:12-13) and ranges from using men as commodities that enhance women's status in ways that benefit both parties, to using their knowledge about HIV as a means of justifying their lifestyles: "We want nice things, to go to nice places, and to live a good life" (*op. cit.*:5). The contradictions inherent in women's agency, when it is deployed in ways that create barriers to their own prevention, warrant new ways of thinking about empowerment and HIV and AIDS.

Finally, underlying these constructions of pregnancy, promiscuity and prostitution is the assumption that all African women are heterosexual. Dominant HIV and AIDS

discourses have been silent on the possibility of sexual diversity. There is not only a dearth of research to establish the diversity of African women's sexual identity, but a dearth of research highlighting the implications that hetero-normative assumptions of sexuality have on their sexual lives.

The Poor and Vulnerable Woman

Parpart's (1995) problematization of the development expert's role in constructing and defining Third World women as poor and vulnerable has significant import for HIV and AIDS prevention research and practice. She outlines the complicity of Northern development experts in constructing and disseminating images of Third World women as vulnerable, passive and impoverished, awaiting salvation from the West. From my reading of her work, Parpart recognizes that there are indeed social and development concerns that create the "sea of negative numbers" (1995:229). For her, however, these dominant representations not only stifle the possibility of human agency, but also stifle development thinking and practice itself by ignoring opportunities for new theories and knowledge. Instead, the homogeneity of 'the poor hapless' Third World woman serves as justification for Western development assistance.

> "Similarly, the gender programme officer in any institution has to always demonstrate that her work is about the very poor and marginalized woman, for her to be regarded as legitimate" (Win, 2004:61).

For Parpart (1995), this construction is less than helpful in the era of rights-based approaches, which assume poverty to be the only lens with which to view women's rights. These assumptions appear within HIV and AIDS statistics, which remain aggregated and rarely disaggregated by class, thus painting a very distorted image of infection rates as well as the burden of care and support. The role of middle-class women is completely erased, whom Win argues:

> "...is the one with access to money, so she pays fees for the orphan here, takes the dying relative to hospital the next day, and generally the whole clan looks to her to pay for everything that is needed. She even sponsors the funerals. If she is married, she has to do this for her own family and for his family" (Win, 2004:62).

While some feminists have referred to critiques of representation as a First World preoccupation, Win points out the impact it has on silencing the efforts of 'non-poor' African activists who have to legitimate their professional expertise through what she refers to as "villagisation" or having "one foot at micro level and the other in macro spaces". This relegation to the village, she argues, has led to the often-heard refrain "Africa has no policy analysis capacity" (Win, 2004:63).

Win goes further, to say that the opportunities to strengthen these macro-level capacities are therefore minimal for women who are "busy running small projects" (2004:63). However, Win makes a very important point on the impact that erasure and villagisation have on non-poor activists' inability to position themselves within the solutions that arise from development. Giving the example of HIV and AIDS, she argues that the struggles articulated are no longer those of the non-poor activist who goes on to 'prescribe' solutions (such as prevention messages) for others. She concludes by suggesting that a rights-based approach may help development practitioners to go beyond the "magic bullet solutions that they often see for African women, examples of which include income-generating activities and awareness-raising campaigns" (*op. cit.*:64).

Both Parpart's and Win's analyses of the effect that dominant discourses have on representing women as 'poor other' may have implications for exploring the way HIV and AIDS programmes are organized in Nigeria. HIV and AIDS programmes receive significantly more funding than women's empowerment and gender-equality programmes. The visibility and accessibility to HIV and AIDS programme funding is also greater than that of women's empowerment, which can be read as donor assertion of its role as 'saviour' (as opposed to the democratic characteristic of 'transparency'). For example, donor websites and documents highlight how much funding they have 'invested' in Nigeria over the years. President Bush's Emergency Plan for AIDS Relief granted funds of US$45.3 million in 2003, $70.9 million in 2004, $110.2 million in 2005, $163.6 million in 2006 and $304.9 million in 2007 (USAID, 2007). The Global Health Fund increased its spending from approximately US$19.5 million in 2003 when it first began operations, to $180.4 million in 2006 (The Global Fund, undated).

Interestingly, the USAID record on gender and empowerment issues is less visible.[21] However, the Canadian International Development Agency (CIDA) is the only agency whose funding is visible. CIDA provided the Canadian High Commission with US$550,000 for a two-year pilot project on gender equality (CIDA, undated). These examples of funding patterns highlight the discursive strategies of the international funding of AIDS, which position women at the centre of the HIV and AIDS epidemic, but simultaneously sideline women's empowerment and gender equality - the strategies proposed to enable prevention. The poor funding of women's empowerment and gender programmes creates a competition for resources, as well as a hierarchy amongst HIV and AIDS experts and every other type of development expert, but particularly gender experts.

If funding practices are read discursively, then gender experts can be interpreted as being discursively positioned in ways which are similar to the positioning of African women in HIV and AIDS discourses. Gender experts are responsible for the third of eight Millennium Development Goals (MDGs), namely: promoting gender equality and women's empowerment (UNDP, 2002). However, due to the dominant discourses associated with Third World women, gender experts are implicated in four other MDGs, which include eradicating poverty, reducing child mortality, improving maternal health, and combating HIV and AIDS (UNDP, 2002).

Despite the challenges to meet these goals, a general complaint from international women's groups has been that the international funding mechanisms have been insufficient (United Nations, 2007). Therefore, like Third World and African women, gender experts have been rendered invisible by multilateral and bilateral funding agencies and their mechanisms. On the other hand, they are held responsible for achieving a number of goals, but must pressure donors for firm commitments and must also find new and creative ways to raise the required funds.

[21] This finding is based on my interaction with a USAID staff member who repeatedly referred me to PEPFAR's website and the Internet when I requested a breakdown of AIDS funding. This was a rather quick and straightforward process. However, my request for information concerning funding on gender issues at USAID/Nigeria led to my being directed back and forth between the staff in different units, which eventually resulted in the end of the search for this information.

In Nigeria, several gender specialists told me the practical challenges this entailed, with some of them working in more than one capacity because "gender doesn't pay".[22] However, due to their commitment, some taught at universities and also worked as consultants. Some had started their own NGOs but also had their own businesses. The result of tracking multiple sources of income to sustain their commitment to gender issues was that, for many, there was very little time to become involved in anything else - including HIV and AIDS prevention. The result is that HIV and AIDS work in Nigeria is quite male-dominated. However, there still remains a space for different configurations of what counts as expertise. The remainder of this thesis explores the possibility for such configurations, through interviews with members of five women's associations in Abuja. In the next chapter, I discuss the methodological approach used during the study.

SYNOPSIS

Adherence to HIV and AIDS prevention messages depends on two things: whether people want to prevent HIV and AIDS and whether they have access to the economic, human and social resources that help them feel supported enough to do so. In the first case, whether people want to prevent HIV and AIDS may depend on whether they perceive HIV and AIDS prevention programmes as an imposition on the lifestyle they currently lead. In the second case, support may depend on the construct of gender that says that the use of a condom (etc.) with a sex partner collaborates with or challenges an existing social construction of gender.

Central to my argument is that the social representation of HIV and AIDS prevention programmes as biopower may help to explain the success or failure of such programmes. On one hand, they are designed by experts who are well-meaning and well-intentioned, with the aim of saving lives. On the other hand, experts may deploy changes which could have adverse effects for both men and women. Women who are members of informal groups involved in the women's movement in Nigeria may have identities which may lead them to adopt hybrid behaviours, including mimicry (Bhabha, 1990). However, this depends on whether such women belong to a group

[22] All participants agreed to be interviewed on the basis of anonymity; as a result, gender specialists and their organizational affiliations are not given in this thesis, except for the Girl Guides, who gave their permission for the organizational name to be used. Also, staff of the HIV and AIDS organizations permitted me to refer to their names and organisational affiliation.

which empowers them (Kabeer, 1999), or provides them with resources greater than those obtainable through other affiliations. In addition, women must have the agency to navigate through choices that help them obtain the achievements they have identified for themselves, collectively and individually.

Furthermore, women may be affected differently because the biopower of AIDS prevention has marked them as deviant and has, thus, tainted their identities (as sex workers, girlfriends to 'sugar daddies', or mothers with HIV and AIDS). Women may feel as though they need to respond, so that they can look like 'good women' or 'healthy citizens' who are rewarded with new and improved identities. Conversely, men who are labelled as deviant by the biopower of HIV anAIDS prevention are not labelled as badly, because they are simultaneously rewarded for adhering to social constructions of masculinity that privilege male sexuality.

In essence, in the context of the biopower of HIV and AIDS prevention programmes, there is a tension between the gender identity constructed in the realm of traditional patriarchy that espouses marriage, motherhood and kinship, and the gender identity of a more 'enlightened' woman who accesses her choices through agency. These identities operate in a discursive space that positions identity within the broader politics of ethnicity, religion and national locations. Within this space, women also have to contend with a notion of biopower that advocates abstinence, monogamy and condoms, which may remove the option of having children, and may cause a backlash with sex partners and perhaps even other social capital (e.g., kinship capital). In this case, choice and agency are tested. Where do women place themselves?

CHAPTER THREE

Methodology

INTRODUCTION

In the previous chapter I outlined an intersectional approach to women's empowerment and HIV and AIDS, which seeks to understand women's relationships to prevention as framed by both the biopower of HIV and AIDS prevention and the governmentality of international development, and is therefore under constant negotiation. At the same time, it is deeply embedded in dominant social and cultural discourses of gender, sexuality and identity. This chapter focuses on the methodological approach to the research in light of perspectives outlined in the previous chapter, and discusses the practical implementation of this approach. The first section discusses the epistemological underpinnings of the research and explores the utility of analyzing women's experiences in the context of knowledge and power. The second section considers research ethics, while the next section describes the design and implementation of the study, along with some of the problems encountered. Finally, the last two sections discuss the analysis, and provide some descriptive information about the research sample.

FEMINIST EPISTEMOLOGY

This research takes the epistemological position that knowledge is situated in and relies upon "partiality and not universality" in order to establish knowledge claims (Haraway, 1991: 99). It takes the position of feminist and post-modern critiques of science, which challenge the androcentric bias of knowledge production, as well as its claims to objectivity (or that 'it knows what it knows' without being related to a particular position). Feminists have challenged this assumption of objectivity, which is central in the production of positivist forms of knowledge (Stanley and Wise, 1983). For decades, they have engaged in contestation over what counts as valid, reliable knowledge and over who determines what counts as legitimate or authoritative knowledge (Ramazanoglu and Holland, 2002). Moreover, feminists have also been able to call into

question issues of power involved in the production of knowledge and the implications these issues have on both the researcher and the researched. By drawing on situated knowledge, rather than pursuing truth from an 'all-knowing' vantage point, feminists propose that knowledge is partial, contradictory and grounded in experience.

The objective of challenging male-centred perspectives does not mean that feminist epistemology is a homogeneous and unified project. This research also takes into consideration the challenges levied by black and non-Western feminist researchers on the presumed universalism of white and Western feminism. Black feminists call for the reconceptualization of domination and power by race, class and gender, not as additive approaches to oppression, but as an interlocking system of oppression (hooks, 1981; Steady, 1981; Hill-Collins, 1990). Rather than maintaining the view that knowledge produced within this system results in a power over women, Hill-Collins (2004) argues that the power produced is creative and stimulates positions such as the 'outsider-within'. This is similar to Braidotti's (1994) notion of nomadic identities, discussed in the previous chapter, because both tropes share the notion of dual or plural identities formed as a result of being positioned within a community from which one is simultaneously excluded. Outsiders-within are able to gain knowledge without being able to do so authoritatively (Hill-Collins, 1998:5). This status creates a paradoxical tension for researchers whose work stimulates an examination of one's own experiences, which also help to elucidate the anomalies within their field of study (Hill-Collins, 2004:122).

Post-colonial feminist researchers also try to reconcile similar inconsistencies within feminist and social research with the efforts of oppressed groups who try to "reclaim for themselves the value of their own experience" (Narayan, 2004:214). Therefore, they challenge the treatment of 'Third World women' as a homogeneous group based on an ahistorical notion of the sameness of oppression (Mohanty, 1991:56). These women are viewed as victims of underdevelopment, oppressive traditions, illiteracy, poverty and religious fanaticism (*op. cit.*:5). Feminists have argued that this victimhood results from a "collary insistence" on being positioned as "the only ground for insight, [which] has done enough damage" (Haraway, 1991:157). Hence, although there is an agreement with post-modern assumptions of difference, this assumption is problematic when it is not used to analyse the unified category of 'black' or 'Third World' women. The damage of constructing a homogeneous notion of black women can be traced to

feminism's attempts to challenge positivist science while overlooking difference, but can also be addressed by engaging with different standpoints.

Experience

I would argue that the accounts in this research provide a useful perspective from which to explore women's experiences with empowerment and HIV and AIDS prevention and the discourses that construct and are produced by these experiences. To begin with, for several reasons I will focus on the construction of these experiences rather than the experiences alone. Firstly, experience is often taken as self-evident and can be used in an essentialist way when women as a group are said to share the same experiences shaped by conditions of power, privilege and domination (Gouws, 1996). Secondly, women's experiences are constituted by men on an ongoing basis in interactions, which also constitute men's own experiences (Lazreg, 1994:51),[23] and since each experience is mutually constituted it cannot be used as the only source of truth. Thirdly, the notion of women's experience adheres to the possibility of greater and lesser truths (Throsby, 2003:70). Finally, experience can often reproduce ideological systems if it is decontextualized from the historical processes which shape it (Scott, 1992). In essence, I agree with Scott, who argues that subjects not only have experiences but are constituted by them. Hence, it is helpful to take into account how those experiences are established.

Situated Knowledges

I return to Haraway's notion of 'situated knowledges' as a starting point for exploring how the experiences relayed in accounts of this study's research participants are constructed. For Haraway, one objective of identifying situated knowledges is to have "faithful accounts of a 'real' world... that can be **partially** shared" (my emphasis) (Haraway, 1991:187). These accounts allow for "a critical practice for recognizing our own 'semiotic technologies' for making meanings..." (*Ibid.*). This practice would not contribute to an unhelpful "theory of innocent powers to represent the world" (*Ibid.*), but would, instead, contribute to "an ability partially to translate knowledges among

[23] I have found development mantras such as 'male involvement in reproductive health' rather surprising; men have always been 'involved', but perhaps they are not involved in the ways that programme and policy developers have outlined.

very different - and power-differentiated - communities" (*Ibid.*). This recognition of different knowledges allows for a move from reliance on what Foucault (1973) refers to as 'the gaze' and Haraway refers to as "a conquering gaze from nowhere [that claims] the power to see and not be seen, to represent while escaping representation" (1991:188). The gaze thus signifies power positioning, which can only be left behind through a commitment of "mobile positioning" (*op. cit.*:192). Hence, it is positioning (those that are situated and those that are universal) that grounds knowledge and exposes the power relations in the production of knowledge, as well as those relations that are produced by knowledge.

Following Haraway's argument that critical positioning produces knowledge suggests that positioning has as much to do with the researcher as it does with the position of the researched. Accordingly, participants are involved in producing knowledge as well as being produced by that knowledge based on their 'epistemic advantage', which feminists claim women have. For Tate, knowledge production takes place in everyday conversation as a "negotiation of identity positions in talk" (2005:6). Here, women may produce identities that counter normative identities found within a certain discourse (for example, black identity or women's empowerment). These hybrid identities are constructed in conversation based on lived experiences (*Ibid.*). This notion is salient for this research, because participants rarely used the word 'empowerment'. They did not say "I'm empowered due to..." or "To me, empowerment means...". As a result, interviews with participants are seen as a "dialogical space [in which] identity re-positions emerge" (*op. cit.*:58). It is in this space that participants construct meanings of gender, identity and power. But it is also a space in which the researcher plays an active role by contributing to dialogue through questions, comments and clarifications (Alldred, 1998). In other words, the everyday lives of the participants are doubly mediated by the presence of researchers and by participants' responses to the presence of researchers (Englund, 1994). This mediation can be accounted for through feminist ethics methods, including reflexive thinking about power, positionality and representation, which are outlined in the following section.

FEMINIST ETHICS: POWER, REFLEXIVE, POSITIONALITY AND REPRESENTATION

For feminist researchers, recognizing that knowledges are situated implies a need for the awareness of our own positionality and the power dynamics that are possible during the research process (Stanley, 1993; Finlay, 2002; Ramazanoglu and Holland, 2002). Power and representation are research issues, especially when the different identities of the researcher and participants create differences in power. Feminist researchers have been argued to be capable of reproducing marginalization of participants at different stages of research (Mohanty, 1991; Patai, 1991). The reproduction of marginalization can occur while developing texts, or in the final 'product of knowledge' itself. On one hand the researcher is seen as the author, owner and originator of the text, while on the other hand neither researcher nor participants are more privileged because:

> "...the concept of author is an ideological construction many abstractions removed from the way in which ideas emerge and become material forces" (Alcoff, 1996:115).

However, this explanation would do little to appease research participants, who may feel that aspects of their personal lives have been used to further the researchers' professional lives rather than improve the lives of others or advance politics. Nevertheless, the researcher strikes a balance between improving lives and doing this in a way that propagates 'epistemic violence' or through ways by which 'Western' knowledge is used to justify the (violent) exercise of political or military force over non-Western cultures (Spivak, 1990).

An example of this is how, on the one hand, the representation of 'cultural' explanations (and antithetical to modernity, and therefore 'backwards') of practices that are said to facilitate HIV prevention, such as female genital cutting, are seen as reproducing images of 'barbaric' Africa (Njambi, 2004), while, on the other hand, such studies may be used by advocates (local and international) to strategically further their argument for laws that would protect women's rights (Koso-Thomas, 1987; Horn, 2005). Both perspectives highlight the roles researchers play within the context of HIV and AIDS, which is framed by the double-bind of international and local interpretations of gender and power.

Implicit in the debates about representation is the assumption that differences between researchers and participants constitute power-imbalances which privilege the researcher. In particular, a key assumption is that of the Western researcher studying 'Third World' women (Patai, 1991). While Hill-Collins' 'outsider-within' and Braidotti's 'nomadic consciousness' offer utility of 'epistemic advantage' for researchers whose situatedness crosses boundaries between themselves and participants, very little has been documented on the challenges and dilemmas faced by researchers who conduct studies with women of the same or similar status. Narayan warns of the "dark side of double vision", which can lead to "a sense of totally lacking roots" and is mitigated by involvement in "ongoing critical politics" (1990:222). For Narayan, the disadvantages of epistemic advantage or double vision can be costly and even lead to "ambivalence, uncertainty, despair, and even madness" (*Ibid.*). Perhaps the former two emotions (rather than the latter two) can be found in the following example of researcher-participant similarities. Kakuru and Paradza found that as African women researching rural women in Uganda and Zimbabwe, they were often drawn into family situations by their narrators who regarded them as "sister, mother, granddaughter, or aunt" (2006:295). However, one of the authors also found that her status as a married Christian woman made it difficult for her to hear and empathize with narrators who were unmarried or single mothers or engaged in sex work, a stance which she says was reflected in those very narratives (*op. cit.*:293).

Like Kakuru and Paradza (2006), I also found myself at times being drawn into participants' family situations, although it was difficult to attribute this solely to cultural identity. Interestingly, some researchers have found that their religious and Western identity facilitated their entry in contexts in which political change was taking place (Berdahl, 2000). As a Christian woman born in the United States to Nigerian parents and raised in both the United States and Nigeria, I was used to being referred to as '*oyinbo*' or 'African *oyinbo*' (white person or African white person in Pidgin English).[24] Hence, my personal status involved a number of variables which could have mediated my interactions with participants, which were intertwined with the geographic and religious backdrop of the research. For instance, in addition to my

[24] It is difficult at times to determine whether *oyinbo* refers to Western affiliations, mannerisms or even complexion. I have also been referred to by other names in Nigerian vernacular which refer to my complexion such as '*afiama*' (Efik for 'yellow' skinned woman) or socio-cultural background, '*aje-buta*' (Yoruba/Pidgin for 'soft like butter') as opposed to '*aje-kpako*' ('hard like a biscuit' or a 'tough cookie').

research interest in HIV and AIDS, my visits to my sister's 'funky' church in Abuja (in the northern and more Muslim part of Nigeria) facilitated my access to an 'underground' community of women in same-sex relationships. This was because the key 'go-between', who was the coordinator for a sexual minority group in Abuja, was also a member of my sister's church. The combination of variables, particularly my '*oyinbo*-ness' and church attendance, appeared to serve as reassurance that they would not be subject to judging attitudes. Firstly, participants assumed that my 'outsider-ness' would make me more empathetic. But secondly, my visits to this particular church, being not one of the more traditional conservative churches, added to the assumed empathy. Given the religious nature of Nigeria, many participants also seemed to regard my church attendance as an 'insider' activity, although it may have had other implications on the small number of Muslim participants.[25] These points are taken up again later in the chapter.

Although I can understand why the feminist researcher Gilbert (1994) did not claim insider status while researching welfare mothers in her US hometown, I was reluctant to ignore or minimize the insider status I may have had, for several reasons: for one, I was advised to obtain a Nigerian passport to facilitate my movement through the country and to provide a form of identification, since the police had been known to stop people randomly. Also, this would protect the coveted American passport from theft and fraud. Secondly, I had to turn away a participant recruit who recognized my surname and identified herself, not only as a fellow villager, but also as a distant cousin of my father's. It is highly unlikely that I would have had this experience in any other country.

Nonetheless, markers of my different situation existed, such as my tertiary education in the USA, Holland and the United Kingdom. However, while Western feminist researchers (Ramazanoglu and Holland, 2000) highlight the power differentials between educated researchers and less-educated participants, one Nigerian sociologist argues that the autonomy that educated women achieve through education is mediated by the "social boundaries and expectation they must adhere to" (Okeke, 2000:53). I found this to be the case during my fieldwork in Nigeria; my role as a researcher did not exclude me from meeting family obligations, particularly in terms of time and

[25] Rose, one of the leaders of the underground group of women, told me that "We know that we might attract empathy from Americans and Europeans, but we do not want the type that ignores the fact that some of us have faith as well".

money, and led me to take on odd jobs while there and, indeed, throughout the course of my studies. Also, in many cases, participants took a special interest in my single status, which side-tracked our interviews at times, with several participants keen to marry me to their male relations. This invariably affected the power-dynamics and highlights the different possible meanings of privilege across cultures.[26] Moreover, it points towards the centrality of marriage, respectability and responsibility in Nigerian culture, which emerge as key themes throughout the empirical chapters.

Coy (2006) notes that a further dilemma for researchers who are also practitioners is that they are involved in an ongoing negotiation between these two roles. In some interviews, participants asked to be shown how to use a condom, or what a female condom or dental dam looked like. While condoms were often available at research sites, I usually carried other sexual prevention supplies, so I could demonstrate their usage when asked. It was sometimes unclear whether being asked was a result of a participant's knowledge of my role as a public health promoter and lay sexual health counsellor (through informants or go-betweens), or if this was a natural progression during the interview, or if I unconsciously (or perhaps even consciously) displayed a knowledge of barrier methods.[27] However, the questions were not solely limited to prevention methods, but also included topics such as immunization, communicable diseases, child health and nutrition. As I was not employed as a counsellor during my fieldwork, participants' questions perhaps point to the lack of quality primary health care services available, and to a need to integrate prevention services into a more holistic service for women and mothers. The latter may increase accessibility and convenience, and decrease stigma against HIV itself.

Risks and Danger

Another ethical dilemma highlighted by researchers is the issue of intrusion and risk to participants (Homan, 1991). As a result of this intrusion, participants may have raised expectations of the researcher's role, which may arise out of the interest shown to participants who are otherwise unaccustomed to the attention (Oakley, 1981). Skeggs

[26] However, while I realize that educational status contributes a notion of the privileged researcher, I knew that, to my Nigerian counterparts, pursuing a doctorate was a type of 'social suicide' which would make it difficult for me to obtain the more desired and acceptable letters of 'Mrs'.

[27] I draw on Ryan-Flood's (2004) use of the term 'go-between' to describe people who facilitate access to researchers or who were key in sharing helpful information.

(1994:81) discusses the difficulties for struggling doctoral students to offset this intrusion by reciprocating or offering services and materials in exchange for time. In addition to taking up additional work or justifying one's overdraft as an investment, the author suggests "providing support and a mouthpiece against injustices" (*Ibid.*). This, however, has particular implications in politically sensitive research contexts and may only further amplify the differences between researchers and participants, especially if the research is in a different geographical space. As noted in a consideration of feminist ethical research:

> "For no matter how welcome, even enjoyable the fieldworker's presence may appear to 'natives', fieldwork represents an intrusion and intervention into a system of relationships, a system of relationships that the researcher is far freer than the researched to leave" (Stacey, 1988:22-23).

In my research, fieldwork posed risks for participants and also for myself (albeit to a lesser extent, because it was possible for me to leave the fieldwork process). Although I lived with my family in their Abuja home, not only was it possible for me to leave the country, but it was also possible for me to retreat to my village in the south-eastern part of the country. This latter option was available to many participants, since most had migrated to Abuja for a number of reasons. However, this would not have been an option for rural participants and those who migrated to Abuja to escape unsupportive families or even dangerous scenarios due to their sexual identity or HIV status. In particular, the political climate around sexuality changed just as I had begun conducting interviews with members of the underground network of women in same-sex relationships.

This policy change stimulated intense stigma and policing against men and women in same-sex relationships and being seen in public could have been interpreted as a breach of the law which forbade meetings or associations, as explained further in Chapter Five. Englund, who halted her study on sexual identity in Toronto in the early nineties, argues that "self-exposition is not without its dangers" (1994:83). Recognizing the danger to participants as well as myself, I eventually stopped conducting interviews after meeting with five members. While they were happy to remain in the study and to introduce me to other potential participants, it had become difficult to maintain access

because of heightened surveillance at the time. This seemed to have dissipated by the end of my sixteen-month stay, due to interest in the forthcoming elections.

A further and more emotional reason for ceasing that line of inquiry was that one of my male go-betweens had become increasingly ill during my stay. Despite his enthusiasm, it was difficult to justify his involvement with the research when his illness became more apparent. The emphasis of our relationship shifted to maintaining his health and quality of life. Since he was happier to do the latter than the former, we spent several occasions eating and conversing with his partner in the park, or listening to live music in one of Abuja's many garden-bars. It is difficult even now to write that he died several months after my return to London.

Researchers have debated the ethical dilemma that emotion poses in research. For some, having a non-hierarchical relationship with participants requires an investment of the researcher's personal identity to the extent that friendships are formed (Oakley, 1981). For others, forging friendships with participants as a means of eliciting information is considered unethical (Cotterill, 1992). Holland (2007) regards emotion as useful in several ways. First, it can be used as data and gives greater depth and insights into aspects of fieldwork. Second, emotion can be used to interpret data and, third, it can impact on a researchers' professional and personal identity. As a new researcher, the emotion experienced (by myself and participants) while exploring women's responses to HIV and AIDS, is seen as valuable in the production of knowledge around HIV and AIDS. This is partly because it adds depth to the peculiarity of the data presented, which only captures snippets of women's lives. A commitment to that granularity hopefully emerged during the design, implementation and analysis stages of the research.

Dissemination Audiences

A final ethical dilemma that feminist researchers face is how to disseminate research (Ramazanoglu and Holland, 2002). For non-western researchers, or those studying their own cultures, the dilemma is extended by fears of complicity in reproducing hegemonic representations (Thapar-Bjorkert, 1999). After completing fieldwork with Irish lesbian parents, Ryan-Flood not only questioned how best to represent participants, but whether to "write about them at all" (2004:105). This was certainly a

consideration taken into account in my own research, and raised challenging questions about the purpose in the first place, and what my role would be in achieving this purpose. I identify with Alcoff who, while considering the implications that the differences between herself and her participants might have on articulating research issues to wider audiences, asked if her greatest political contribution should then be to "move over and get out of the way?" (1996:100). However, as Ribbens and Edwards suggest, the purpose of exploring private lives is to:

> "...transform and modify dominant patriarchal forms of representation and to make visible a different, alternative, social, and cultural order within which to define our identity and subjectivity" (1998:13).

In the previous two sections of this chapter, I have introduced the epistemological and ethical approaches to this research study. The following section describes the project and includes some of the problems that I encountered during its implementation.

STUDY DESIGN

The main goal in designing this study was to engender a corpus of data reflecting a broad range of experiences with HIV and AIDS prevention and empowerment in an ethical manner. From the beginning, it was decided that in order to explore the ways in which gender and power was understood and comprised a key factor in participant experiences, the study would involve in-depth, semi-structured interviews. However, as Englund notes, "the 'field' is constantly changing and ...researchers may find that they have to manoeuvre around unexpected circumstances" (1994:81). Indeed, several features of the research design changed between the initial design development phase following a reconnaissance visit in 2002 and the start of fieldwork in 2005.

It had been hoped that members of Women in Nigeria (WIN), Nigeria's feminist organization, would participate. However, several former members informed me that the organization had been co-opted by men and women who appeared to be steering it away from the original vision.[28] Nevertheless, interviews with two members of its former leadership helped to elucidate the factors behind WIN's recent inertia. I had

[28] For an overview of WIN, see Imam (1997).

been made aware of the problems with WIN before I began fieldwork, so I selected the Girl Guides instead. I established contact by going to the office of the National Council of Women's Societies, the first umbrella group for women's associations. I explained my research and requested the number of the Secretary of the Guides, who agreed over the telephone to arrange a meeting with me and the Guides at their next quarterly meeting (in March 2006).

At the initial design stage of the project, it had been intended to recruit men as a way of exploring relationships between masculinities, power and prevention in Nigeria. I further planned to incorporate focus groups to explore how collective notions of empowerment are derived. However, despite precautions taken to mitigate any risk involved in interviewing men about HIV and AIDS, I still encountered unforeseen problems which led me to focus on the potential diversity of women's groups. The following describes the background of one problem encountered, including an introduction to Abuja in the context of local development. I also describe the problem itself and possible explanations as to why I encountered it.

Abuja, Urban Development and Resettlement

During fieldwork, one of the issues that characterised living in Abuja was the long-running problem of planning and development within the city and surrounding areas of the Federal Capital Territory (FCT). The problem stemmed from several policy changes around the initial city planning design, drafted in 1976, when General Murtallah Mohammed's military government drew up a Master Plan detailing the gradual shift of the nation's capital from Lagos to Abuja. The current capital is one of six area councils comprising the FCT, the other five being Abaji, Bwari, Gwagwalada, Kuje and Kwali. This territory was 'carved' out of regions which now belong to three states: Kogi, Nassarawa and Niger.[29]

Nigerian geographers note that the intention of the Mohammed administration was twofold: first, to avoid the gridlock and overcrowding of Lagos and, second, to avoid tribal ownership claims over the capital, which the Yoruba were often accused of in

[29] In 1976, the government created 19 states from the previous 12 that had been created in 1967. Hence, the move to making Abuja the capital coincided with the creation of these 19 states. In subsequent years the states would be further divided into a total of 21 states (1987), then 30 states (1991), and finally 36 states (1996).

Lagos (Jibril, 2006). However, due to the constant changes in military regimes, the policies on resettlement changed several times accordingly. Jibril (2006) notes four policy changes and phases that characterise the plans to move the capital to Abuja and provides a background for the resettlement and related issues that occurred during fieldwork.

The first policy of 1976 called for the government's complete ownership of the land which was relinquished by the indigenous Gbagyi tribe,[30] a minority ethno-linguistic group in the northern and middle-belt regions of Nigeria, [31] who were to be compensated and resettled to another area of the FCT. In addition, the host villages in the proposed resettlement areas were also earmarked for compensation. However, the government underestimated the number of Gbagyis to be resettled and compensated (over 300,000 instead of the initially anticipated 50,000), so they changed the policy. The second policy provided an option for those who wished to remain within Abuja. General Obasanjo's military administration ordered that those who remained should be considered as citizens of the FCT and administered by the Federal Capital Development Authority (FCDA). Those who chose to leave would have no claim to resettlement (Jibril, 2006:5). Thus, it is under this policy that the Gbagyi people of Garki Village, an area in which I had initially conducted interviews, were permitted to remain in Abuja. However, at the time of fieldwork, the village was earmarked for complete demolition and the inhabitants scheduled for resettlement.

With the third (or 'Integration') policy of 1999, the government reverted to the first policy, which stipulated that inhabitants were to leave Abuja and settle in a satellite town constructed for resettlement. In 2003, Obasanjo's civilian administration decided to implement the 1976 Master Plan, in which the original intention was to evacuate the city and resettle inhabitants, many of whom were indigenous to the area.

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30 The Gbagyi are also referred to as the 'Gwari'. However, this is mostly by the Hausa and means 'slave' in Hausa language. This is because the Hausas had enslaved the Gbagyi during pre-colonial Nigeria. Hence, there is a feeling of domination and oppression by the Hausas and other groups in the North. The Gbagyi are usually referred to as one of two designations - the Gbagyi *Matai* or Gbagyi *Yamma* - which depicts both slight geo-cultural and linguistic differences.

31 The term 'middle-belt' is used within Nigeria to designate the ethno-geographical areas surrounding the confluence of the country's major rivers: the Niger and Benue. The middle-belt is comprised of seven of Nigeria's thirty-six states (Adamawa, Benue, Kogi, Kwara, Niger, Plateau and Taraba), as well as the Federal Capital Territory. It is largely home to minority ethnic groups in which many languages are spoken and religions practised. It is politically complex due to several groups' long-standing relationships with northern Nigeria despite colonial resistance to Islam, and it also manages constrained political alliances with groups in southern Nigeria.

However, due to the number of policy changes and an increase in the population (up to six million) since the original Master Plan had been drawn up, implementation was difficult. Furthermore, the government neglected to provide enough housing, which led to inhabitants setting up squatter settlements which continue to attract migrants seeking employment in Abuja, or who previously relocated as civil servants but could not afford the rising housing prices of downtown Abuja. Of its six million inhabitants, only 1.7 million are said to be able to afford to live within Abuja (This Day, 2004). The remainder either bought land from the Gbagyi or simply built houses without government land permits or ownership deeds. Some of those who built houses reside in them, but most let them out for rent or have resold them for a quick profit, thus forming an illegal system of land acquisition. As a result, settlements ranged from small shanty towns to larger residential suburbs with schools, churches, town centres and markets. Therefore, when the government issued evacuation and demolition notices, there were multiple claims for compensation for the same plot of land.

During fieldwork, the most visible and disturbing manifestation of this policy reversal to the Master Plan were the actual evacuations and demolitions of houses and businesses that had been illegally erected on the land. These evacuations were carried out on the orders of the FCT Minister Nasir el-Rufai, sometimes referred to popularly as 'Mr. Demolition' or 'Hurricane el-Rufai'.[32] Reasons offered for evacuations include claims that inhabitants had built illegal structures in areas that had been designated for parks, or built upon water or sewage pipes (SERAC, 2006). In addition, such evacuations would also help to divest holdings of allegedly corrupt civil servants who also had multiple plots. Evacuations involved the police and often occurred without notice, although the FCDA usually claimed that it had sent notices. In some cases, the notice would simply arrive in the form of a big red 'X' painted on the building marked for demolition. Days, weeks or months later would see the arrival of the FCDA and police to evacuate the inhabitants. I witnessed the demolition of several make-shift restaurants (or '*bukas*') by the side of the road, some five minutes from my family residence, during which the police exerted brutal force upon both the sellers and patrons.[33] The following day the sellers returned, lamenting that their entire livelihoods had been lost, as the police had seized and confiscated goods and consumables.

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32 The role of the FCT Minister is mayoral in nature.

33 '*Bukas*' sell food to employees and residents who cannot afford to eat at the larger food establishments in the area, which normally cater to the middle-class who also work and live in the area.

Pastoral Power at Play

Because of the location and fecundity of Abuja and its surrounding territories, its indigenous inhabitants (the Gbagyi) have had a complex history of dominance, oppression and marginalisation, despite the political relevance their land made. The Gbagyis also owned Kaduna, the capital of the state with the same name, located three hours north of Abuja. Kaduna had also been designated the 'Northern Headquarters' by Lord Lugard, Nigeria's first colonial governor.

More recently, the Gbagyi began to make formal and concerted demands for recognition of their traditional rulership in both Abuja and Kaduna. Between 2000 and 2004, the governor of neighbouring Kaduna State, where many Gbagyi still live, created additional chiefdoms alongside the existing Hausa chiefdoms throughout the state. This formation was in response to years of civil unrest caused by Gbagyi demands for autonomy and recognition, which sometimes resulted in violence and further displacement. The creation of chiefdoms marked recognition of the needs and contributions of the Gbagyi as an ethnic group in Kaduna, as well as greater autonomy. It also validated the traditional mandate and efforts of Sa Gbagyi, the overall Gbagyi ruler, to form chiefdoms in villages where chiefdoms of the dominant tribe already existed.

This could be seen as a way of resolving the clash of power systems, pastoral in nature, which is sometimes characterised by (or what can be interpreted as) collusion or cooperation. For example, many go-betweens accused local government chairpersons (government officials) of striking deals with villages to divide each in half (or more), in order to access the land for development (or for constructing more buildings for sale and rent). In return, in most cases they would appoint a chief to preside over the fragment (and allow developments to take place). More chiefs and more villages allowed the politicians to argue for more funds for the council or to create new councils altogether. This dynamic characterised part of my own experience in Abuja's Garki Village.

At the start of fieldwork, participants were to be drawn from a opportunistic sample of men and from four women's groups (a church group, the Girl Guides, the women living with HIV and AIDS, and the Garki Women's Association). The Garki Women's Association was a unique group, because they were members of the minority ethnic

group that had originally inhabited Abuja, which had been carved from four states when it was declared as the new capital in 1976. Garki was unique because it was a village within the city and had a population which comprised of indigenous Gbagyi people as well as migrants who had moved to Abuja from other parts of the country. It also had its own 'red light district' and was considered to be one of the city's AIDS hotspots. I was told that this was one of the main reasons that the Federal Capital Territory Action Committee on AIDS (FACA) had established its offices there. FACA's manager (Dr. Vatsa) and his team felt that Garki Village would be suitable for my study. Moreover, they graciously offered FACA as a base to which I could retreat after conducting interviews in the neighbourhood.

Before proceeding, Dr. Vatsa introduced me to Sister Doris, a coordinator of one of the partner NGOs, the Catholic Association for HIV/AIDS in Nigeria (CACA). She in turn introduced me to Mila, a long-time women's group mobilizer, who lived directly beside the chief's palace in Garki Village. When we discussed obtaining permission and making introductions, she informed me that he had travelled and so she accompanied me to meet him in Abaji. This was done during a 'sensitization' meeting with another group working on HIV prevention, as well as with Dr. Vatsa and his CACA counterpart. I also met regularly with members of his palace, whom I saw each time I visited Mila's house. During my visits with Mila, I would help her and her children assemble beads for the trinkets she sold. Afterwards, we would have drinks at the canteen outside her house, which also served as a meeting point for sex workers and their patrons. As I got to know her and her family, she began to share experiences of being a mobilizer. She had been key in many development projects since the 1980s, but said she was never 'developed' herself. She told me of her plans to send one of her daughters to nursing school, so that she could work on development projects. I had to assure her that mine was not one of the many assessment visits which often preceded development projects. Nevertheless, she sought my advice on how to develop a resume, which I was able to do based on our interviews.

Within a month I had conducted two focus groups and several interviews with both men and women from the neighbourhood, with the help of Mila and Razaq.[34]

[34] I had also began conducting interviews with go-betweens who recruit members for the underground group of women in same-sex relationships.

On the day I encountered problems in Garki, I had gone to Razaq, a resident guide who a former colleague had introduced me to. He had overslept that morning and wanted to take a bath. Since I felt comfortable and familiar with the area, we agreed to meet up after my interview with his neighbour, Chief Alake, who lived six doors away.[35] On my way back from the Chief's house, I received a telephone call on my mobile, and sat on what I thought were the steps of an abandoned house. I later learned that this was an abandoned part of a school building. As I sat there, three small boys came up to me. They were in school uniforms and could not have been more than four or five years old. One of them approached me and stroked my head. Because of my complexion, I am often mistaken as biracial or Caribbean. Hence, I am used to children trying to 'find out' where I am from. Therefore, I continued with my conversation while they stared at me, played with my hair and tried to sit on my lap.

Then I did something which I normally did with children - I gave them sweets.

As I continued talking, a man approached and asked what I was doing. I replied that I was conducting research. When he asked to see some identification, I showed him a business card, which proved insufficient for his purposes. Since I was not about to hand over my passport, I offered to take him to Razaq's house. He followed me, along with the children. But just as I reached the gate of Razaq's house, someone shouted something to the man in Gbagyi language. He asked, "Did you give the children sweets?" I replied, "Yes" and turned to open Razaq's gate.

All of a sudden he stepped in front of me. I heard people begin to approach me from behind. When I turned around, I was faced with a large group of people accusing me of bewitching the children so that I could take them abroad and sell their body parts. Fortunately, a drunken police officer strolled past at this time, saw the crowd, and suggested we take the matter to the police station located on the next street.

The short version of the story was that I was detained in the police station until that evening. I was assigned an IPO (Investigating Police Officer) who was in charge of my case. I convinced him to escort me to a kiosk where I could purchase some telephone credit, just so that I could call *anyone*. When we returned to the police station, he tried

[35] Chief Alake was from South-eastern Nigeria and not a local chief of Garki, but insisted on being called 'Chief' because it was a title he held in his hometown.

to force me into the only prison cell which held about twelve men who were wearing nothing but their underwear. When I refused, the deputy senior police officer overheard the commotion and ordered me to wait in his office, where I stayed while he and his colleagues ransacked my bag, listened to my tapes, and hurled abuses at me for "talking to people about bedroom matters".

Eventually, ten former colleagues (three representatives from the Network of People Living with HIV/AIDS in Nigeria (NEPWHAN), including their lawyer, and members of the Garki Women's Association) arrived to identify me. The proprietress of the school had also been called and came, accompanied by their local pastor, who called me a 'devil' and tried to physically attack me. We were ordered to stay until the senior police officer arrived. When he did, he called all of us into his office and asked to see the contents of my bag to prove that I was a researcher. He said that he would like to release me, but would face criticism from the neighbourhood if I did not prove that the children had not been initiated into a witchcraft cult. When I responded that I had become friendly with a pastor of a certain church which was known for dealing with issues of the occult, he agreed to release me. He then suggested that I be allowed to go home to collect further identification containing my photograph, after which I would be released on the condition that I agreed to appear at the station every day until the proprietress was satisfied that the children were alright.

The following day, the colleague who had introduced me to Razaq took me to the proprietress' house, so that I could 'beg' her to drop charges. When we reached her house, she came out and apologized profusely. People from the neighbourhood, including members of the women's group, had called and told her how I had interviewed them in their homes and played with their own children, who, to their knowledge, had not become witches. We then went to the police station so that she could officially drop the charges against me. It was several weeks before I could go into Garki Village again.

Conflicting Explanations

Family, colleagues, friends and community members have offered several different explanations for the incident. Some felt that the incident was blown out of proportion,

while others lamented over the culture of suspicion that was beginning to sweep Nigeria as a result of the local media and film industry's portrayal of the occult. However, this did not explain why I had been apprehended after having spent a month within the community. Mila seemed both saddened and surprised at the incident, and attributed the incident to 'enemies of progress'. Much later, she informed me that she had heard that the headmaster responded to complaints that I was speaking to both the sex workers *and* 'respectable' people within the community. This explanation seemed plausible: by interviewing the more respectable or even powerful people (non-sex workers) in Garki Village, I had implicated them in 'immoral' sexual activity. Yet another go-between told me that the vacuum of power left by the dethroned chief may have left some of the villagers feeling vulnerable to the increasing possibility of displacement and resettlement. As a result, they may have feared that any information could be used against them. Taken cumulatively, the explanations reflect the multiple sites and systems of power exercised within the research context, as well as the different knowledges situated within this context.

Due to the notoriety the incident had attracted and for fear of my own safety, it seemed best not to continue with the interviews in Garki Village. To say the least, I was extremely traumatized by the incident. However, I still wanted to include Gbagyi women in the research, so members of the Garki Women's Association informed me of a similar women's association in their natal village in Kuje, located one hour outside Abuja. Despite the distance, I was able to interview the women there without any problems, and it allowed me to maintain the relationship with the Garki Women's Association, who were pleased that members of their minority ethnic group were still included in the study. Furthermore, I decided against focus group discussions to ensure that participants felt that their accounts were confidential and to give each participant the chance to talk (or not) in private about what could be a highly emotive topic in some instances.

Around this time, I had begun to build a rapport with the male go-between who had introduced me to members of the underground network of women in same-sex relationships. I contacted him after noticing one of his emails on an AIDS/HIV e-list (electronic mailing list). He had initially been included in the cohort of men I had begun to interview. Perhaps because of his own interview experience and our growing rapport, he introduced me to the leader of the underground network, whom I

interviewed. Although she suggested names of women I could interview, I was able to meet other members of the network through members of other groups I had encountered, including a male church member whom I had interviewed as part of the male cohort in the study.

The e-list list proved to be useful for initiating and maintaining contact with two other associations whose members I eventually interviewed: Christ World Church (CWC)/Global JOY and NEPWHAN. Contact with these groups occurred well in advance of implementation of the study, in order to establish trust and a rapport, and to determine whether or not alternative recruitment methods needed to be developed. Although I had been familiar with CWC/Global JOY since 2000, formal contact for the purpose of the study was made in 2002. My initial inquiry to NEPWHAN was in 2003, with follow-up contact made again in May 2005.

The staff at FACA, who supported NEPWHAN's efforts by providing assistance to people living with HIV and AIDS, expressed concern over any potential consequences arising from the interviews. There was initial reluctance on their part to facilitate interviews and there was doubt over whether members would be willing to participate or discuss their personal sex lives, due to an incident that had occurred around the time I was due to begin my interviews with them (February 2006). Two journalists from a national newspaper had befriended a woman living with HIV and AIDS who belonged to one of the support groups. Staff described how they had conversed with her at length, then were shocked to find details of an alleged discussion published in a newspaper article the following day. The article claimed that the woman had told the journalists that senior officials in certain HIV and AIDS organizations continuously solicited her for sex, despite her HIV status. There was a debate within NEPWHAN and FACA over whether these comments had been made or not, but they were publicly denied. Hence, I was advised to postpone the interviews until the matter had been resolved. I responded to these concerns by agreeing to postpone the interviews and by ensuring that participants with HIV and AIDS were interviewed either at FACA or NEPWHAN, where a counsellor with whom they were already familiar was available should any possibly distressing issues emerge during the interview. At first, I suspected that the managers wanted to control the content of the interviews and they did to some extent - to protect their members and possibly themselves. However, I soon realized that most participants were more comfortable at FACA and NEPWHAN than in their

own homes, as some were still trying to hide their HIV status. Also, all participants were told beforehand that the interviews would require them to discuss aspects of their sexual lives. Furthermore, they were assured of their right to decline to answer particular questions, or to withdraw from the study at any time. This assurance was also repeated during the interview if participants became distressed.

The possible reluctance to talk in depth about HIV prevention was addressed by the structure of the interview guide I adopted, which followed a life histories approach. This gave participants the chance to speak descriptively about their own lives, with more intimate aspects coming later, after we were more familiar with one another. It was also assumed that a flexible approach to the guide would allow for a more conversational style, rather than a more rigid question-and-answer format. Finally, participants seemed to be reassured when told that pseudonyms would be used in place of their names in order to ensure anonymity.

Introducing Groups

The women's associations were selected to facilitate a demographic mix that would potentially reflect a broad range of ideologies and perspectives. Groups which had little or no external funding were selected in the hope that they would reflect a more 'organic' meaning and discourse of empowerment. I was granted access to two of the groups due to previous affiliations: as a child, I had been a member of the Girl Guides (albeit for less than a month); and I had friends who were members of CWC and had attended their services in London. I had also worked with its NGO, Global JOY, on a project in the UK and Afghanistan which was unrelated to HIV and AIDS. However, I did not know anyone in the Abuja branches, although I eventually ran into two members whom I had known in London and who had decided to move back to Nigeria.

While Global JOY's Lagos office received funds from international donors such as USAID, its Abuja counterparts relied on membership dues, which was a point of contention for the coordinator of the Abuja branch who realized that funding offered a means by which he could professionalize his volunteerism. CWC also received funds from its 'parent' church in London, where members took up a collection to send to fellow churches in developing countries. I came to learn that funding was a point of

contention for NEPWHAN and FACA; they receive funds to support workshops for people living with HIV and AIDS, but these funds do not go directly to the support groups. While these criteria may reflect a bias towards groups with which I am familiar, it was useful in negotiating access and establishing trust concerning my handling of very sensitive and personal information. Furthermore, having prior affiliations, as well as engaging in negotiations over several days or months, ensured accountability on my part. Finally, although some of the negotiations over access were lengthy, working with groups with which I was previously affiliated may have reduced the time it would have otherwise taken to involve five different women's groups.

Christ World Church (CWC) Women's Group

CWC is a group of approximately forty women who meet regularly outside church to discuss ways in which they can help themselves and help other women. They are part of a non-denominational church established in the United States in the 1980s and which has set up branches in nearly 100 countries. In the early 1990s they set up Global JOY, to respond to the social needs of people in the cities where CWC had been established. Around the same time, a branch of CWC/Global JOY was established in Lagos and quickly became active in addressing HIV and AIDS in Lagos State. To respond to the needs in Lagos, CWC/Global JOY called upon their 'sister programme' in South Africa, where the branch had been recognized for their involvement in HIV and AIDS prevention, care and treatment. When the final phase of the transition to Abuja commenced, CWC Lagos decided to set up a branch in Abuja. These 'church plantings' often involve members moving away from the base church for several years to help establish newer churches, and quite a number of the members of the women's group had moved to Lagos for this purpose. However, the branch in Abuja did not appear to develop in the same way as their Lagos branch - a factor which grew to become a point of frustration, particularly for one of the project coordinators of Global JOY/Abuja. This did not seem to bother his female counterpart as much - a characteristic which I took to be related to the gendered organizational practices of CWC which had spilled over into Global JOY.

Researchers have long documented the popularity of religion in Nigeria, particularly Pentecostalism among Christians (Marshall, 1991; Marshall, 1995; Ojo, 1995; Smith, 2001). The CWC women's group was included in the hopes that it would be useful in

exploring how the biopower of HIV and AIDS prevention might be mediated through social and gender identities shaped by religion in ways that facilitate or hinder prevention. Like the feminist geographer Melissa Gilbert (1994:92), I expected Christians to be conservative about gender and empowerment and was surprised at the 'brand' of power which women drew on in order to challenge gender relations and social issues.

Girl Guides[36]

The Girl Guides were first established in Nigeria in 1919 as the female counterpart to the Boy Scouts, which had been introduced earlier that year. Guides everywhere undertake an oath to serve God and their country, to help others and to keep the Guide Law.[37] In Nigeria, the Girl Guides are structured as an extracurricular programme in schools and supervised by teachers who are also Guides and wear uniforms, conduct meetings and participate in activities like camping trips. It was the 'teacher-Guides' who were participants, rather than the students who would have required permission to be included in the study.[38] When I approached the Commissioner,[39] she expressed interest because she had received complaints from teachers who wanted to respond to increasing numbers of unwanted pregnancies among students and were also concerned about HIV and AIDS. However, although they had not received permission from their headquarters in the United Kingdom to implement sexual health programmes, many had gone ahead to enrol in workshops to learn about HIV and AIDS and were more or less dispensing prevention advice to their students. Providing sexual health information was not a new role for them, because several indicated that they provided family planning counselling in other settings, mainly within their communities, churches or in rural settings. As a result, the Guides are seen here as potential experts on prevention. At the time of fieldwork, the Guides relied on their own funding mechanisms, which was supported through membership dues and fundraising efforts.

The Guides were selected because of the underlying gender ideologies around domesticity, which informed its activities closer to the time of inception. While Guides were permitted to engage in similar activities to the Boy Scouts, they were also

36 I use the Girl Guides and Guides interchangeably throughout the thesis.

37 See http://www.girlguiding.org.uk/guides/ready/promise.asp accessed 11 December 2007.

38 This study does not include women under the age of 16, to avoid potential complications involving parental consent.

39 'Commissioner' is the title given to the most senior officer in the Girl Guide organizational structure.

constantly reminded that they were to guide "from the kitchen, the nursery, the sick-bed - the natural habitat of woman" (Barne, 1946:14). It is unclear to what extent these ideas have been taken up in the 100 countries that have Girl Guides today. However, the interviews reflected participants' beliefs that Guiding was the best preparation for becoming a woman. I was interested in how this preparation helped to challenge (or to reify and ossify) existing gender norms of domesticity and the ways in which this hindered or enabled participants to prevent HIV and AIDS in their own lives.

Support Groups for People Living with HIV and AIDS

The Network of People Living with HIV/AIDS in Nigeria (NEPWHAN) was established in Ibadan in 1998. Since then, it has moved its headquarters to Abuja and is the umbrella group for some 240 support groups throughout the country. The senior officers at NEPWHAN are actively involved in developing the National Strategic Framework for HIV/AIDS, along with NACA who are responsible for all HIV/AIDS-related activities in Nigeria. In particular, NEPWHAN has been instrumental in working with the government, international agencies and local human rights groups to demand treatment and to challenge stigma and discrimination against HIV and AIDS.

From the outset, I was interested in exploring the factors that challenged or facilitated prevention amongst HIV-positive people.[40] Emphasis on positive people is centred primarily on treatment issues, which can make it appear as if they do not have any prevention needs or intentions themselves. Therefore, rather than asking how they would suggest HIV-negative people prevent transmission, emphasis was on exploring how belonging to a support group under NEPWHAN had shaped identities in ways that are empowering or limiting.

The Rural Women's Association

As mentioned earlier, the Rural Women's Association comprised of participants who were members of the Gbagyi that had been systematically displaced from their indigenous homes by the Federal Government and resettled either back to their natal village or to temporary sites within the FCT. One natal village, Sundaba, is located in the Kuje Local Government Council within the FCT of Abuja. These two groups co-

[40] In Chapter One, I explained the use of the term 'positive people'.

exist in Sundaba, along with a few people from the larger ethnic groups (Hausa, Igbo and Yoruba) who had migrated to be in Abuja but had left either due to high cost of living, eviction arising from the re-zoning activities in Abuja, or to take advantage of agricultural opportunities in the area. Most inhabitants worked as subsistence farmers, whilst a few worked in the pottery trade for which the Gbagyi are well-known. Some were also involved in petty trade and small businesses.

The women had decided to work together to find ways to generate income collectively and were coordinated by a young man who worked as a community health worker. Interestingly, his involvement was seen as welcome, because many of the members complained that the lack of coordination within the group had hindered them from achieving certain major goals, as well as minor tasks (including agreeing upon a name). However, part of this lack of coordination stemmed from the political fissures that had occurred among the ethnic group as a whole. Politically, the villagers disagreed on how best to move forward and align themselves in the 2006 elections. Some resented that the local government chairman was a member of Obasanjo's PDP (People's Democratic Party), who they blamed for their marginalization and accused of colluding with the government to relinquish the people of their land. Others believed the chairman to be progressive and recognized his role in what could be interpreted as 'facilitating modernity'. This conflict may have contributed to the air of suspicion described in my analysis in Chapter Four. Particularly of interest was whether women reflected these divergent views and would find ways to work within them, help them prevent HIV and AIDS or meet their own goals of generating income to educate their children.

The Underground Network of Women in Same-Sex Relationships

The 'underground' network of women in same-sex relationships is an informal gathering of women of different ages and ethnicities who were currently, or had previously been, in relationships with other women. These were not necessarily exclusive relationships, as some of the women were also involved in marital or intimate sexual relationships with men. It was envisioned from the outset that members of the underground network would be included, although it was not clear at the time that such a network existed or that the women would agree to participate. Part of the challenge in gaining access was not only safety and issues around secrecy and disclosure, but over

the lack of nomenclature and subsequently, sexual identity. As a result, they participated in response to policymakers who insisted that they could not and did not exist because same-sex relationships were un-African. Furthermore, their experiences with prevention (like those of HIV-positive women's experiences) remain invisible within AIDS literature and policy in Nigeria. Indeed, how do they negotiate, contest or resist this invisibility in ways that help or hinder HIV and AIDS prevention?

Recruiting Participants

Despite establishing contact with associations, access to members still required negotiation. Despite an increased engagement and dialogue amongst civil society and government claims of heightened awareness of HIV and AIDS in Abuja (90%), it became clear early on that women's empowerment, particularly in relation to sex(uality), elicited contradictory responses. Accurate statistics are difficult to obtain, but UNAIDS (2006) suggest that of those infected, 61% are women and 39% are men. This represents a significant increase from the 57% prevalence rate found in women in 2004. However, the federal government has also claimed that prevalence rates have dropped twice since 2000 - in 2003 and 2005.

There are also conflicting perceptions on sexual attitudes in Nigeria. Researchers have described the southern part of Nigeria as being fairly sexually liberal (Smith, 2001; Shisana and Davids, 2004). However, it would appear that the prevailing social climate in Abuja was not conducive to openly discussing sexuality without stigmatizing it, despite the availability of information and services. Many participants, apart from those in CWC or NEPWHAN's support groups, did not know anyone living with HIV and AIDS. Conversely, several participants, who were not in the underground network, said that they knew or had known a man or woman involved in a same-sex relationship. At the beginning of my fieldwork, I met a lawyer who reportedly provided legal services to several politicians. He commented that a few of his clients were HIV positive, but were not compelled to publicize their status because they could afford treatment abroad. I also met a woman who told me that she came to Abuja periodically just so she could meet other women. These encounters reinforced my suspicions that the AIDS and sexuality discourses circulating around Abuja were full of contradictions and complexities that people did not discuss (in order to repress them, but possibly because it was difficult to make sense of them).

But these complexities and contradictions may not be the only factor influencing a seemingly repressive social climate as far as HIV and AIDS, gender and sexuality are concerned. From the perspective of 'home-grown traditional knowledge', it was easy to understand why some people found it challenging to share aspects of their private and intimate lives. It could be used against them in one of two ways which were not entirely separable: through witchcraft or through politics. There were two (of several) incidents that occurred during fieldwork in which people drew on spiritual or witchcraft explanatory models in ways that seem to highlight anxieties around the presidential elections. The first could be the incident with the sweets described earlier in this chapter. The second incident occurred outside a market in Abuja. While driving with a friend to a funeral, I noticed a suspicious looking plastic bag at a highway intersection on a road leading to Aso Rock, a 400-meter monolith, after which the presidential compound is named. We decided to take a closer look and realized that the bag was full of blood and body parts. My friend explained that the previous evening, a crowd had gathered around a similar looking bag containing a severed head. The explanation given was that the deceased person had been sacrificed by one of the many presidential candidates who aspired to live in Aso Rock.[41] In these cases, the sacrificed person is usually said to have been sacrificed by an 'insider' or someone known to him or her. These spiritual discourses help explain the phenomena of increasing social disparities and also help to explain why some people accumulate wealth and power, and others do not.

These explanations can be said to have contributed to the social climate in ways that fuelled suspicion and mistrust. However, they were countered by two significant factors: the first being the proliferation of Pentecostalism (or what is sometimes referred to 'the new church' which was seen as a means by which wealth and justice can be redistributed). I have already described situations in which church attendance facilitated access and negotiations during fieldwork. The second counter to the social climate at the time was what seemed to be a growing consumption of local and international 'celebrity culture'. The media was filled with shows charting the successful life histories of political candidates, business people and entertainers. This may have been one of the reasons that people agreed to be interviewed. There were

[41] Similar stories circulated around the death of the former first lady, who was allegedly sacrificed by her husband in order to ensure a third term.

three instances where it seemed as if participants performed parts of the interview as if it were being recorded for television or radio. One participant had asked if I had a camera crew and seemed disappointed with my reply. These responses conflict with the actual nature of the interviews, in which many participants who seemed eager at the outset later tried to evade personalizing comments about HIV and AIDS. It also suggests that the conflicting responses are linked to apathy regarding independent or academic research, particularly since the academic institution was based abroad. However, this could be interpreted in Foucauldian terms as participants' negotiation with the disciplinary power of public discourse. They agreed to participate in the research, but on their own terms - which was consistent with the ethical approach of the study.

Recruitment within the groups took place in several ways. With CWC and the Guides, I was invited to church services and meetings respectively. Coordinators of each group made an announcement at the end of their respective meetings and asked people to contact me in person or by telephone.[42] In both cases, people volunteered to participate at the meetings, so I took down names and numbers and began scheduling interviews.

Recruiting support group members from NEPWHAN and FACA was a slower process. FACA's office was a two-storey building with a large sitting room on the lower floor, and offices and a conference room on the upper floor. The receptionist was located at the back of the ground floor, so that people could tell her the purpose of their visit in private. She would then direct them to be seated in the sitting room and wait to see the manager or counsellor, or receive treatment. However, many people simply walked in, sat in the sitting room and watched the huge television for a few hours, and then left again. I often sat, tucked away in a corner of the sitting room, while the receptionist attended to visitors and asked if they would like to participate in an independent study. If they said 'yes', then she introduced them to me. If they declined, they were free to continue with their visit without the discomfort of having to sit near me knowing that they had refused to take part in my study. Great care was taken to ensure that both participants and non-participants from NEPWHAN/FACA felt as comfortable as

[42] I initially had one 'multi-purpose' telephone, but began receiving calls from male participants whom I had interviewed. Two participants called regularly just to chat, which eventually became annoying. However, one participant called every other day for several weeks to ask for a date. The calls eventually stopped, so I retained the number for research purposes and obtained a separate line for personal calls.

possible, since I was aware that I was intruding into one of the few spaces where they were free from stigma and discrimination. Only two people declined to participate.

A similar process was followed while recruiting members of the Rural Women's Association. However, unlike the other research sites that were within a twenty-minute drive from my residence, Kuje, the women's village, was nearly two hours away from the city by road. The go-between and coordinator for the women's group, Friday, had informed the villagers at a meeting that I would be conducting interviews. During my initial visit I met the local chief and was invited to set up a temporary office and residence in the tiny health post that Friday used for his outreach work. I declined, but rode to the village every day for two to three weeks. I often waited in the health post until women stopped by and announced that they wanted to be interviewed. Midway through the interviews, I changed my approach and walked (escorted) through the village and randomly approached women, chatted and asked if they would like to participate. Three women declined, saying that they had to go to the farm. Many of the women were busy with farm work, selling firewood, or looking after their home and children.

Recruitment within the underground network of women in same-sex relationships involved a snowball technique, but from different sources. The male go-between for this group introduced me to one participant who then offered to introduce me to others. I was also introduced to a participant by one of the male participants I had interviewed. His 'referral' then introduced me to two more participants. As mentioned earlier, and as I will describe in Chapter Five, the aftermath of the Nigerian Same Sex Marriage (Prohibition) Act placed participants in danger and I decided to stop recruiting.

INTERVIEWS, DISCOURSE ANALYSIS AND LANGUAGE

The interviews conducted consisted largely of open-ended questions and explored a number of themes identified as important during the literature review (see Appendix 1). They lasted from 45 minutes to almost four hours.[43] As described earlier, the interviews took place in different sites to accommodate participants' needs and schedules.

[43] The length of the interviews varied and depended on how communicative participants were. While I had anticipated 1-2 hours, some interviews lasted just 45 minutes, while others lasted much longer. For example, one woman insisted that the interview only last an hour but seemed unperturbed when it lasted nearly four hours.

Although I had prepared an interview guide, participants' narratives followed a life history trajectory and answered many of my questions without additional prompting. The interviews were quite informal and relaxed, sometimes taking place over a snack or beverage. In introducing the research, I provided information about my own history and location as a single woman. However, I was conscious that I was providing less than I required of participants, and did not always offer intimate details of my life or health challenges. To create a more egalitarian interview dynamic, I concluded each interview by asking if the participant had any questions to ask (about) me. However, many people asked questions at the beginning of the interview, to which I responded. Some were interested in the fact that I was still single, while others were interested in learning more about my profession and the reasons for carrying out such a "challenging study by myself".[44] Some asked for advice and details about HIV testing.

As mentioned earlier, some participants asked for counselling or for condom demonstrations. I provided all the information that I could, and also undertook some demonstrations. I followed up with one rural participant who had been tested for HIV a day before our interview, who later called to tell me that her result was confirmed to be positive and then asked to see me. I worked with NEPWHAN and FACA to locate a support group and treatment facilities, and paid visits to her and her children. I was also called upon to give talks on HIV and AIDS in the village church and school, as well as to other groups. While it was sometimes difficult to draw the line between my roles as a public health person and researcher, it seemed unethical for me to turn down these requests for information and advice because of my research on HIV and AIDS prevention. Instead, I considered it the *least* I could do for people who had agreed to spend as much as nearly four hours with me, sharing intimate details of their lives with a relative stranger. As such, I found part of the interview process quite difficult due to the sensitive and at times emotional nature of narratives, which was to be expected. However, interviews were also punctuated by laughter, jokes, teasing, etc. and often took on a convivial tone. In essence, the willingness to share their lives with me, both within and outside of the interview process, highlighted the confidence participants placed in me.

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[44] There were mixed responses to my singleness, ranging from 'pity' to petitions to marry participants' sons or brothers. I also received requests to befriend or mentor participants' daughters or nieces. Most participants seemed impressed that I had chosen to conduct research in Nigeria. Thapor-Bjorkert's (1999) decision to research women's lives in her native India, after having lived in the UK for many years, elicited similar responses from participants in her study.

I have gone to considerable lengths to maintain anonymity by altering identifying details and by providing participants with the right to veto material during the interview process and after transcribing (which I did in Abuja). I communicated with many participants on several occasions after the interview process and shared, as best as I could, summaries of information before leaving Nigeria and as I wrote empirical chapters. I have subsequently kept in touch with participants by telephone or email, sometimes using FACA or NEPWHAN staff as messengers to participants without telephones or email access. I have also learned that one go-between and one participant have died. This exchange about the progress of the study and about the lives of the participants forms an important ethical dimension of this research.

Discourse analysis provides a useful, interpretive frame to examine how women position themselves within HIV and AIDS prevention, and for exploring notions of everyday empowerment and determining how the two may or may not intersect. Although it is used within a number of disciplines, a feature common to all approaches is its perspective on language as an active means of constructing reality (Parker, 1992:5; Gill, 1996:41). It draws on a Foucauldian notion of power, which is both productive and limiting, and therefore takes language and texts as rhetorically organized to make certain things happen. Exploring participant accounts of prevention and empowerment experiences through discourse analysis is a useful way of understanding what participants 'do' through their accounts and how they do it.

The recognition of participants as active producers and resisters of meaning is consistent with feminist and post-colonial research approaches, which warn against reifying notions of passive, innocent or apolitical participants. Discourse analysis also allows for difference amongst constructed accounts, because it acknowledges that discursive strategies may be deployed simultaneously, albeit directed towards achieving varying goals. This opens up an opportunity to characterize the:

> "gap between marginalized interest and consciousness... and the ways the dominant social schemes organize social relations, including those of scientific and technological change" (Harding, 1998:159).

> "[The importance of this gap is that] it enables new positions to emerge. It displaces the histories that constitute it... hybridity puts

> together the traces of certain other meanings, or discourses (Bhabha, 1990:211).

Hence, a discourse analytic approach to participants' accounts of HIV and AIDS prevention accommodates an exploration of the complexities and contradictions that illustrate the intricacies of everyday social life. It does not, however, lend itself to broad empirical generalizations. Gill (1996:147) argues that the findings of discourse analysis are specific to the particular historical context in which they are embedded. As such, this study does not promise broad generalisability or universality of findings, which is in keeping with the epistemological approach of situated knowledges outlined earlier in this chapter.

The process itself allows for an exploration of meanings produced by texts. It involved reading the transcripts carefully ten times to facilitate familiarity with the texts. I then created eight themed binders of transcript extracts, which I marked with coloured highlighters and 'post-it' notes. Although I had access to NUDIST,[45] I did not always have access to electricity. Moreover, it seemed more effective to take a more 'tactile' approach to coding. This method allowed for the excerpts to be generated from the wider interview text and still maintain the embedded meanings therein. Through this process, I was able to identify themes which form the basis of the four empirical chapters of the thesis.

Although Abuja is located in the Hausa-speaking part of Nigeria, it is home to many languages, being a capital city. I possess rudimentary knowledge of Hausa, having studied it in secondary school, but this was insufficient for conducting interviews on my own, although it improved during the course of fieldwork. The participants came from all parts of the country and, as a result, English or Pidgin English were spoken in all the interviews except those conducted with rural women. Seven of the ten interviews with rural women required someone to interpret from Gbaji or Hausa. This turned out to be the same interpreter. Also, participants who were Igbo spoke English, but sometimes switched between English and Igbo. Although English is Nigeria's official language and is used in prevalent aspects of everyday life, the excerpts may reflect that it is the second language for the participants.

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[45] Computer software package for data analysis.

Finally, the period of fieldwork in Nigeria was considerable. I lived in Abuja for fourteen months, during which time I adopted an ethnographic attitude (Haraway, 1997; Skeggs, 2001). As I had not lived in Abuja before and had only lived in Nigeria for a short period after concluding secondary school, I was fortunate to be able to stay with my father and his wife for the first three months. During the rest of the time, I relied on the hospitality of friends and relatives who lived in Abuja. Towards the end of my fieldwork, I had the opportunity to visit and interview the Director of the Centre for Gender and Social Policy Studies at the Obafemi Awolowo University, where the programme was experiencing a number of administrative changes. Also, during this time, the University of Abuja was in the process of developing a programme for Gender and Women's Studies. Under more stable circumstances, either would have provided the type of local institutional support required (and often demanded of me) for this kind of study, and several representatives expressed interest in collaborating on potential future projects.[46]

ILLUSTRATIVE SAMPLE CHARACTERISTICS

As argued in the previous chapter, dominant representations on women and HIV and AIDS suggest that they are a monolithic group with a similar socioeconomic background, that they are disempowered in the same way, have a hyper/passive sexuality, are poor and vulnerable, and are either pregnant, prostitutes or promiscuous. These representations are inaccurate and may reflect sampling strategies. For example, much of this research has focused on women with associational memberships. By doing so, the study excludes women who choose not to join a group. Similarly, previous studies have predominantly poor sample populations, which again might be a result of methodology. It may also be a result of what Baylies and Bujra (2000:115) refer to as "target practice" or targeting AIDS prevention methods at social categories perceived to be at risk, which can be used to justify stigmatization of those groups and may inhibit investigating relationships to others within a social setting. Accounts of African women who are not perceived to be at risk and may not self-identify as poor or disempowered (e.g. Mbugua, 2007), who are disempowered in ways other than

[46] The need for institutional affiliation became apparent whenever I called or visited another organization. Upon introduction, during which I provided my name, receptionists or staff would immediately reply "Chinwe, from where?" or "Chinwe, with who(m)?". My inability to provide a local institution sometimes prolonged the amount of time it took to obtain a meeting. However, once people learned of my previous local institutional affiliations, securing a meeting took considerably less time and sometimes took place immediately.

economic, or whose relationships are not exclusively defined by transactional sex (e.g. Longfield, 2004) exist, but are relatively rare.[47] In this study, some participants followed slightly different profiles than the women found in much of the previous research. Table 3.1 outlines the marital status of participants.

Table 3.1: Marital Status

Marital Status	Single Never Married	Single Dating	Co-habiting	Married	Separated	Divorced	Widowed	Total
CWC	2	2		3	2	1	0	10
Girl Guides		1	1	8				10
NEPWHAN Support Groups	2		1	3		2	2	10
Rural Women's Association	2			5	1	1	1	10
Underground Network	2	1			1	1		5
Total	8	4	2	19	4	5	3	45

At first glance, Table 3.1 suggests that most of the participants were married - either by customary (traditional) or civil law. However, the majority (n=26) reported that they were unmarried at the time of the interview. This possibly reflects increased acceptance (or tolerance) of unmarried women and increased opportunities for women to generate personal income. It may also reflect a possible delay in age of first marriage.

Table 3.2 outlines the educational levels attained by participants.

[47] Examples of women being disempowered in 'ways other than economically' include women who face homophobia or discrimination for religious beliefs.

Table 3.2: Educational Attainment of Participants

Educational Level	CWC	Girl Guides	NEPWHAN Support Groups	Rural Women's Association	Underground Network of Women in Same-sex Relationships	Total
Analphabetic				3		3
Reading/Writing			1	2		3
Primary School			2	2		4
Junior Secondary School				1		1
Senior Secondary School Leaving Certificate	1		2	2		5
Clerical Training	1		1			2
Two-Year Polytechnic	2	3	2		1	8
University Degree	4	5	2		4	15
Post-graduate Degree	2	2				4
Total	10	10	10	10	5	45

While the exact figure on the number and sex of professionals with HIV and AIDS is unavailable, the recent debates in Nigeria over workplace discrimination and the development of national policy against work-based stigma and discrimination suggests that professionals are a large but missed 'target' group.

Table 3.3 presents data on participants' occupational classifications, based on the International Standard Classification of Occupations from the International Labour Organisation (ILO).[48]

[48] The International Standard Classification does not include students or the unemployed. Furthermore, the participants' data in Table 3.3 does not reflect the common phenomena of having a source of supplementary income, usually from a trade or small business (n=14). Nor does it reflect participants who left jobs or work to look after children or ill relatives (n=3) or participants who were in career transitions, i.e. leaving one line of work for another, but involved in both simultaneously (n=4).

Table 3.3: Participants' Occupational Classifications

Group	Description	CWC	Girl Guides	NEPWHAN Support Groups	Rural Women's Ass'n	Underground Network of Women in Same-sex Relationships	Total
1	Legislators, senior officials and managers						
2	Professionals	5	10				15
3	Technicians[49] and associate professionals	3		3	2	2	10
4	Clerks						
5	Service workers and shop & market sales workers			4		1	5
6	Skilled agricultural and fishery workers				8		8
7	Craft and related trades workers	2					2
8	Plant/machine operators						
9	Elementary occupations						
10	Armed forces						
11	Housewife						
12	Student					2	2
13	Unemployed			3			3
	Total	10	10	10	10	5	45

Clearly, participants are concentrated primarily in the upper half of Table 3.3, with many falling into the professional and associate professional categories. The professional group includes a lawyer, a doctor, an architect, a computer specialist and a religious professional. The fact that all of the Girl Guides are teachers also increases the number of professionals in the study. Most of the rural women were farmers, but some also brewed and sold local beverages. Interestingly, there were no housewives in this study, which is perhaps reflective of its predominantly urban setting.

Table 3.4 presents data on participants' religious affiliations.

[49] Recent graduates undertaking their National Youth Service appear in this category, since many are usually assigned to offices which eventually become their permanent place of employment.

Table 3.4: Religious Affiliation

Religious Affiliation	Muslim	Traditional Churches[50]	ECWA	Non-denomina-tional	Pentecostal ('New' Churches)	Total
CWC Women's Group				10		10
Girl Guides		4			6	10
NEPWHAN Support Groups	1	3	1		5	10
Rural Women's Association	2	1	7			10
Underground Network of Women in Same-sex Relationships	1	1			3	5
Total	4	9	8	10	12	45

Only a few Muslims participated in this study, which could be a result of the sampling strategy that focused on association membership which, in turn, assumes freedom of movement. Pentecostal churches were most attended by participants, followed by traditional churches. Since the CWC Women's Group is part of a non-denominational church, all members fell into this category. However, during interviews, half of the CWC participants reported attending a second church as well.

Table 3.5: Participants' Knowledge of HIV and AIDS Issues

Description	CWC	Girl Guides	NEPWHAN Support Groups	Rural Women's Association	Underground Network * (N=5)	Total
Know difference between HIV and AIDS	9	8	10	2	2	31
Know conventional prevention methods (ABCs)?	10	10	10	3	5	37
Other?	10	0	10	0	2	22
Ever tested for HIV?	8	2	10	5	1	26
Voluntarily?	2	0	3	5	0	10
Know status?	8	1	10	2	1	22
Know someone with HIV and AIDS?	10	0	10	0	1	22

* = Underground Network of Women in Same-sex Relationship

[50] Catholic, Anglican or Methodist.

Table 3.5 presents data on participants' knowledge of HIV and AIDS issues. While most groups seemed to be informed about the ABC model, the figures clearly indicate that rural women had the highest number of voluntary testing. Low numbers for other groups point to the role of antenatal testing amongst women, which may also account for a larger percentage of women positive for HIV. It was also interesting that neither the Guides nor the rural participants knew anybody with HIV, which suggests the role that social location plays in certain aspects of HIV and AIDS knowledge. The data, when compared to data in Table 3.2, also hints that educational attainment is not always predictive of positive HIV/AIDS knowledge and outcomes.

SYNOPSIS

This chapter has outlined the methodological approach for this research and its implementation. The approach complements the intersectional approach to power, described in the previous chapter, and aims to facilitate a critical analysis of the gaps between dominant discourses and the ways in which women manoeuvre them. It is envisaged that this approach may be useful in pointing out alternative ways of thinking about empowerment and HIV and AIDS prevention that take into account other conceptualizations of power (relations) than those solely centred on a heteronormative notion of gender relations.

CHAPTER FOUR

Urban and Rural Women's Responses to HIV and AIDS Prevention

INTRODUCTION

"*Start the tape over!*" Lolo Faith reached across the desk and snatched the recorder pressing various buttons. The shock rendered the recording at that point irretrievable.

LF: *There. I didn't realise that you weren't schooling here. We as women have to present a good image of Nigeria. Crooks and politicians have made us a laughing stock to the world. And you can see that most of them are men. That is only part of the gender issue we face in this country.*

This interaction almost typifies the orienting prism through which many urban middle-class participants and informants responded to the interview questions. Despite the fact that I had lost almost three minutes of what I considered to be the beginning (and possibly the end) of an 'ingenuous' dialogue, this was only the beginning of the sense of the burden of respectability that I perceived the participants negotiated. This could be picked up from the above quote in a few key ways. First, it was striking that Lolo Faith changed her story once she remembered my geographical and institutional affiliations. Second, her comment was one of the most direct insinuations made by a female participant against men in general. However, it is unclear whether she meant that men have made women the subject of ridicule or that they have made Nigerians the subject of ridicule. Regardless of who experienced social humiliation, for Lolo Faith, the blame rests squarely on men's shoulders.

While it seemed to be a general perspective pertaining to social issues, I eventually realised that this also almost inevitably pertained to more personal issues, such as marriage and, specifically, to sexuality in relation to HIV and AIDS prevention. Although Lolo Faith was ready to shift the blame for some of the 'embarrassing' aspects of Nigerian social life onto men, the majority of her fellow Girl Guide teachers and informant counterparts from similar backgrounds blamed HIV less directly on men. Rather, they suggested that prevention programmes should be directed at young women and rural women, thereby evading any direct mention of their own sexual

relationships. In contrast, rural participants had very little problem discussing their situation and implicating their own husbands[51] as possible sources of risk and disease. Despite the emphasis on marital relationships, rural women's concerns were also grounded in the context of forced migration.

In this chapter, I describe the way both rural and urban women participants were of the view that the source of HIV was a reflection of how they viewed their social roles and identities, and assessed the strengths and benefits (and disadvantages) resulting from them. Protecting these roles and identities, as well as mediating the related benefits, has implications on how participants perceived their risk to HIV and what sort of precautions (if any) they took to prevent infection. I also describe how urban Girl Guide teachers (or Guides) and rural women participants in either group had different ways of emphasising their various sources of strengths and how these were channelled into ways that affected their sexual behaviour and lives.

Specifically, this chapter looks at (a) the ways in which participants projected and protected an identity of respectability by blaming other groups for the spread of HIV, (b) their motives for participation, and (c) how all of this was either channelled from within their personal lives or outside of their personal lives.

Due to the overwhelming emphasis that urban participants placed on rural women's prevention of HIV and AIDS, it seemed useful to bring both analyses into the same chapter. Furthermore, the Guides bore a resemblance in social class, education, etc to a majority of the informants who were 'experts', and could easily be perceived as an 'everyday educated Nigerian woman' or even the elite. Moreover, as explained in the previous chapter, the Guides were becoming active in providing sexual health advice (including HIV and AIDS prevention) to the student Guides in the schools in which they (the Guide teachers) worked.

Fieldwork with the Guides took place in three locations. The first was at the site of the annual meeting held by their umbrella organisation, the National Council for Women's Societies (NCWS) in Garki, Abuja. They held a workshop in the conference room, but most of the interviews took place outside in the courtyard. The other two locations were primary schools in the two affluent areas of Abuja: the busier Wuse II and the

[51] Only one rural participant was unmarried, but said that she was celibate.

more secluded area of suburban Asokoro. The former was in the hub of the town, five minutes from Abuja's central market and surrounded by major banks, offices and two of the city's major shopping plazas. Asokoro is primarily a residential area, although it also hosts a number of foreign embassies, state liaison offices and residences.

Fieldwork with the rural participants was carried out in Sundaba and Wuru, two villages in Kuje, one of the Federal Capital Territories. Kuje is situated an hour's drive from the outskirts of Abuja. The only way to get from the main road to the villages is by motorcycle taxi or *okada* (the 'poor man's taxi') because the roads are narrow, unpaved and uneven due to erosion. Kuje has two primary schools, one Koranic school, a secondary school and a health clinic situated fifteen minutes away in the centre of the local government area. It also has six churches. The main profession of the men and women is farming, although the women are also engaged in other livelihood activities such as gathering and selling firewood and making *kunu*[52] or *zobo*[53] (locally brewed refreshments) which they sell outside the schools, by the churches or by the side of the main road to travellers. People also have small shops from which they sell cold drinks and snacks, such as biscuits and sweets. There is no major industry in Sundaba nor Wuru, and therefore no organized formal work.

ELITE IDENTITY AND HIV AND AIDS PREVENTION

Anthropologists and social psychologists have argued that 'othering' is one way in which group members defend their identity. In instances of considerable risk or threat, this defence can take place by way of a number of strategies. Within the context of the HIV and AIDS epidemic, defence can occur through denial (Joffe, 1999) or blame (Farmer, 1992). This section focuses on the way certain members of the Girl Guides in Abuja blamed rural people for the spread of HIV and AIDS and thus negotiated a maintenance of respectability which is one of the features of the elite-petite culture (a sociocultural subgroup of elites whose membership is based on marriage rather than personal income). It is in this group that the Guides' identity has been embedded since the organisation was introduced to the elite in colonial Nigeria.

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52 *Kunu* is a cereal-based, non-alcoholic beverage which is usually made from millet and spices.

53 *Zobo* is a non-alcoholic beverage made from dried *Hibiscus sabdariffa* (Roselle) plants, as well as ginger and spices.

Elites in Nigeria

Although power is a key element in the gender analysis of HIV and AIDS, it does not always account for power relations across and between different social strata. In particular, with the exception of Baylies and Bujra's (2000) emphasis on generational differences, much of the earlier research on gender equality and HIV and AIDS prevention ignored power relations between different groups of women. As a result, I include the concept of elites based on the configuration and characteristics that I believe the Guides hold in common with the female elites described by sociologists, anthropologists and researchers of African history. Sociological analysis of elites often includes dimensions, including the means of recruitment, their organisational structure and how elites exercise power (Giddens, 1974:349-351). Following this and other sociological analyses of elites (e.g. Nadel, 1956; Bottomore, 1964), historians of elites in colonial Africa have explored and documented marriage as one of the institutions through which elites in Ghana (Oppong, 1974), Sierra Leone (Cohen, 1981) and Nigeria (Mann, 1985) are recruited, structure their activities, and exercise or amass social and economic power.

In addition to marriage, issues surrounding the genesis of the Guides in Nigeria, along with Guide members' narratives, share a characteristic which features in analyses of African elites relating to hybridity: lifestyles lived between the fluid and frayed binaries of traditional and Western cultures (Smythe and Smythe, 1960). However, more specific characteristics (such as Mann's [1985] list of professions) appear to be somewhat obsolete given the social, political and economic changes that have taken place since the emergence of elite groups or culture in colonial Nigeria. For example, teachers were considered to be elites in colonial Nigeria, but based on the more recent pay structures of teachers they might now be excluded from that category. Furthermore, while economic power plays a part in influencing "the fate of the community of which one is a part" (Smythe and Smythe, 1960:4), the recent post-military 'democratic' institutions in Nigeria assume that teachers and other professionals constitute part of an increasingly influential civil society (at least in theory). Nevertheless, the principle means by which women are able to occupy a powerful subgroup in society or an elite-petite (other than via their profession) is through marriage.

Respectable Identity and Marriage

The protection of a respectable identity is partially maintained through the appearance of a 'good marriage' or partnership (based on moralistic constructions of gender and sexuality). Respectability for women in the context of this study involves being in a marital relationship, or a relationship leading to or resembling marriage (e.g. cohabitation, or a conjugal relationship with children, etc.).[54] If marriage or relationships with men are looked upon in ways that yield the social and financial benefits of stability and respectability through status and motherhood, then I would argue that the form of social capital under analysis in this study is an *intimate* social capital or even fraternal capital (see Chari, 2004). In other words, conjugal relationships are the means by which many women and men gain respectability from members of their families and communities.

Furthermore, the way in which one marries or portrays marriage is of particular importance, as this can be grounds for membership of elite groups. The importance of marriage and its benefits is demonstrated in Mann's (1985) historical analysis of elite marriages in colonial Lagos. She traced the changes between traditional and Western-style marriages which took place when repatriated slaves from Brazil and Sierra Leone returned to Lagos via Freetown, forming a group of educated elites. This repatriation immediately preceded the expansion of British colonial administration from the 1880s. Based on a review of the administrative records and interviews with descendents of elite families and colonial administrators, Mann argues that repatriated slaves introduced Western education upon which the foundations of Christian marriage were laid. Eventually, "belief in the moral and cultural superiority of Christian marriage formed a central tenet in the ideology of the group" (Mann, 1985:53). It is, therefore, of little surprise that many women and men sought to be in Christian marriages.

In Nigeria, as well as in other parts of Africa, Christian marriages are still a symbolic sign of one's status. A study of Creoles in Sierra Leone in the 1980s saw marriage as providing elites with social cohesion through cultural ceremonies which distinguished them from other groups (Cohen, 1981). However, despite the elite marriage goals and social benefits which thereby accrued, many men still maintained 'traditional' conjugal

[54] However, this is not to say that cohabitation is acceptable. Generally, it seems to be frowned upon, as is having children 'out of wedlock' or single parenting. Nevertheless, there seems to be a hierarchy of respectability because cohabitation, children without marriage and single parenting are typically viewed as being somewhat better than being single and having no children at all.

ties by having additional or 'outside' wives as well as girlfriends (Oppong, 1974). Researchers of African elite cultures argue that outside wives were rarely mentioned by the Christian wife (e.g., Oppong, 1974; Cohen, 1981; Mann, 1985). It should be noted that currently the practice of multiple conjugal and sexual relationships persists in Nigeria and is said to contribute to the spread of HIV and other STDs in the country (Orubuloye, 1992b).

Respectable Identity and the Girl Guides

The link between elite culture and Guiding may be less than immediately evident. However, the historical overlap between the formation of the early elite groups in Lagos (1880-1931)[55] and the introduction of Scouting into Lagos in 1919 suggests that early Guide recruits may have been selected from elite groups. Moreover, in many countries, Boy Scouts were seen as a vehicle through which British culture could be inculcated (Proctor, 2000:607) and the elites were the very group who were eagerly seeking to adopt elements of the culture (Mann, 1985). Finally, since much of this inculcation took place in formal educational institutions, such as primary and secondary schools which housed children of the elite, I argue that the emergence of the elite culture is bound up with the introduction of the Boy Scouts and Girl Guides into Nigeria.

Being affiliated with Guides had many benefits; there was affiliation with members of the Royal family who were Guides, such as Princess Margaret. In colonial Kenya, the uniform was even appropriated by many non-scouts to "re-imagine the conceptions of legitimacy, respectability and citizenship" (Warren, 1986a:241-242). Many Scouts gained privilege and status within African communities (Parsons, 2004: 378). However, explicit in their practices, in countries such as South Africa, was an ideology of discrimination evident from the separation of Scouts and Guides by race, class and gender (Parsons, 2004; Proctor, 2000). In fact, the Guides were established only as an afterthought, after the Boy Scouts had been formed. The founder, Sir Robert Baden-Powell, was keen on keeping them separate and from having the girls act like 'tomboys'. They were therefore trained in the responsibilities of being wives and mothers, although Warren maintains that girls often wanted to engage in the more

[55] Different historians of elites in colonial Lagos have covered the development of elite cultures at different times within the period; Mann's study covers 1880-1915, while Cole's study covers 1880-1931.

rugged activities that their male counterparts engaged in (1986b:244-245). In the meantime, in South Africa and India, British Guides and Scouts were kept separate from the local boys and girls. It is unclear from reviewing the literature and speaking with Guide officials whether a similar segregation existed in the earlier years within Nigeria.

It is also unclear whether local Guides still uphold the same separatist and elitist ideology. What seems more clear is that the early aims of the Guides, which were to teach women how to carry out their sex role, have not changed. Save for two of the Guide teachers who taught mathematics, most of the Guide teachers taught either home economics (n=6) or languages (n=2). Moreover, although several were attracted to the outdoor and camping activities sponsored by the Girl Guides Association, the majority of Guide teachers reported that they were attracted by the Association's emphasis on domestication and training of young women to 'always be prepared' (as per the Nigerian Girl Guide's motto, which Guide teachers often quoted during introductions at the beginning of our interviews). Depending on how these aims have been received and interpreted by student Guides, it is likely that the Scout and Guide Associations in Nigeria (perhaps unwittingly) reproduced early Baden-Powell ideologies about women and domesticity, among other things.

Respectability and HIV and AIDS Prevention

The repercussions of transgressing norms of respectability are demonstrated in Campbell's research on HIV prevention amongst sex workers in South African mines. Women reported feeling embarrassed by their work and of being taunted in public places by children, neighbours and mineworkers who called them "whores, bitches and many names for women's private parts" (2003:74).

While Campbell's study explores issues of respectability within the context of what might be popularly considered in many parts of Africa to be a less-than-respectable profession, the penalties for women who fail to meet the norms of respectability in many African societies may take on different forms and may lead women to adopt strategies to mitigate the negative effects. One such strategy involves blaming rural women for the spread of HIV and AIDS, thereby protecting the respectability identity.

PREVENTION AND BLAME: TARGETING PEOPLE 'OUT THERE'

A second phenomenon that I interpreted from the interviews was Guide members' tendencies to refer to rural women as the people most in need of HIV and AIDS prevention programmes, particularly sensitizing or outreach. This reference is one that also resonated mostly with members of the Christian women's group and was certainly one of the main features of conversations that I had with five key informants from mainstream women's NGOs. Among the Guides, seven out of ten employed what I interpreted as engaging in a battle of blame. When I asked how they felt about the government's HIV and AIDS prevention programmes, several would begin by saying the government was "trying" but would eventually launch into a discourse around the rurality of HIV and AIDS and infer to what I interpreted to be the ignorant promiscuity of rural men and women.

A common narrative in eight of the ten Guides' self-representations was that they were happily married with children.[56] One particularly salient instance of blame arose during an interview with Lolo Faith. She was a 42-year old married woman with a 21 year-old daughter who taught at Uloma Prep School (where I had interviews with three of the Guides). It appeared to be a very good school with modern facilities and courtyards which enclosed well-tended gardens. Lolo Faith was a Home Teacher to pupils in the second form whom, upon my arrival, she had banished to the classroom next door. However, the classrooms were separated by very thin walls that did not completely reach the ceiling, so we could still hear the students and their teacher.[57] Over the din of the lecture next door, I discovered early in the discussion that she was from Enugu (in the South-East of Nigeria and inhabited predominantly by the Igbos) which is an hour's drive from my village, so there was an instant rapport soon after we began the interview. I found her comments (see below) were congruent with her earlier actions of seizing my tape recorder in order to render an account that presents a 'positive image' of Nigerians.

C: *So how do you think the government's doing on this issue?*

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56 This was so even among the non-participants - there was a Guide who happened to be from my home town (the reason I did not interview her) who portrayed an image of being happily married, even though I knew that she had been estranged from her husband for some time.

57 The students and their teacher eventually left the classroom, leaving Lolo Faith and I to converse in a quiet space. Initially, I had been concerned about privacy, given the interview topics but she, like several other teachers, insisted that they were comfortable to be interviewed at their workplace, because they often had to discuss similar issues amongst themselves.

LF: *They should make that drug* [antiretrovirals or ARVs] *cheap so that they can reach the poor. Then* [they should] *go about preaching awareness and self-control themselves. Start these conversations and treatments in the local government. Everybody doesn't have to come to the ministry* [Federal Ministry of Health in Abuja]. *How many people know the Minister of Health? When those* [people] *in the villages contract it* [HIV and AIDS] *they feel their life is over.* [The government should] *Have officials who will go into the grassroots to counsel them* [rural people] *so that some can be exposed and know their status. Some don't even know. Some don't know.*

C: *Do you know your status?*

LF: *Ah! One woman* [who] *came to my house in the village was pointing out to me someone who has contracted the disease. She said that, in fact, women there no longer differentiate who are coming from the township. They don't want it to enter the village and contract it. What they don't know is that it is already there! It's already there - they are lying at their feet. So the people out there - they need counselling.*

In posing the question about the Nigerian government's performance, I sought to elicit the participant's discourse on the government's use of images and media messages that portray vulnerable women as either young university students, uneducated rural women or one of the dominant representations outlined in Chapter Two. As a result, I interpreted Lolo Faith's response as a form of resistance against being identified by such representations. Indeed her 'proposal' to improve the government's provision entailed several actions that enabled her to resist or mis-identify with dominant representations while reinforcing them through her own discourse. They include: making drugs available to 'the poor', controlling alleged ignorance and poverty-fuelled promiscuity through preaching, introducing treatment at the local level, and sending officials to rural areas to disseminate HIV and AIDS information and awareness. Taken either singularly or collectively, these mandates serve the purpose of distancing herself from the dominant representations in prevention messages.

This distancing was further reinforced in her response to my query regarding knowledge of her HIV status, which she answered by trying to counter her fellow village woman's insistence that city dwellers bring HIV back to the village with them. While asking women about their HIV status served a similar purpose in seeking whether they identified with representations at risk, it was also one of the most difficult aspects of the interview. As mentioned in Chapter Three, given my own 'traditional knowledge' about how people might perceive such questions, as well as the memory of

my detention, I was admittedly perhaps more uneasy than the participants. In many cases I did not ask this question at the point where it came up in my interview schedule, but I often 'stuck' it in somehow. The question embarrassed me at times and there were a few instances where I did not ask it. Asking if women felt vulnerable or knew their status not only meant that the women had to share with me very intimate and potentially embarrassing aspects about their (sexual) lives, but also meant that they had to potentially expose their husbands and, perhaps more importantly, they had to admit or ask themselves certain questions not just about their health, but about their marriage and fidelity.

As a result of these tensions, there are several striking aspects of this excerpt. The first is that she avoided answering the question by deflecting the issue of her own potential vulnerability and blaming rural people. By doing so she exempts herself from the possibility of being a source of AIDS or being blamed. While it is easy to focus directly on the account that the village woman relayed to her, it is her simple but poignant exclamation that warrants closer attention. This was relayed with a combination of what I interpreted to be shock and indignation at having been the 'target' of my question. With the expression of "Ah!", she seemed to say "How dare you ask about my HIV status (and question my character, moral behaviour and that of my husband!)".

The strategy by which she exempted herself from the discourse of blame is the second striking feature. By focusing on her fellow village woman's narrative, she did two things. First, she positioned herself close enough to 'know' what is happening in the rural area. But at the same time she took sides in the battle of blame (which is based on geography) by ascribing blame to people in her village and perhaps other villages. In essence, although she resists negative stereotypes, she also reinforces them, thereby widening the gap between their social positions.

However, Lolo Faith's claim contradicts her argument about the village woman, which seems to suggest that people 'bring' HIV with them from the cities to the village, which in itself presents the third striking feature about this account. The village woman herself was ascribing urban blame. Although I did not have the privilege of speaking with her, I took the rural woman's account to be positioned on the side of the blame game opposite that of Lolo Faith. Even popular local observations are based on the assumption that city dwellers, who originally hail from the village, return to their

village home and either infect villagers or they return home 'to die' because they can no longer maintain their livelihoods and have no-one to care for them once they fall ill. Lolo Faith's insistence on her own perspective positions herself as more knowledgeable than her fellow villagers who live there and clearly observe the migration and illness trends, even if they are not formally trained to do so. However, she does this by completely contradicting the source of her 'knowledge' (her fellow village woman) and by insisting that it is rural people, not the urbanites, who need to be educated and know their status.

Returning to her emphasis on (other people's) HIV status highlights a fourth striking feature. Knowledge was something that was 'good for the goose but not for the gander'. Even at the end of the interview, it was still unclear as to whether Lolo Faith knew her own status. It would be easy to assume that she was simply in denial, based perhaps upon fear of the very stigmatisation that was relayed to her and which she in turn relayed to me. This fear of stigma resulting in denial through blame is not unique to Lolo Faith, or to other participants in this study. Airhihenbuwa *et al.* (2006) observe that othering in South Africa was mediated through race, gender, homophobia and xenophobia, which they believed contributed to social climates in which disclosure of HIV status would most likely have resulted in discrimination. A person's social group can influence whether she volunteers to be tested for HIV or considers herself to be at risk.

Many of the more educated informants and participants were quick to identify rural women as being in need of HIV prevention services. Within some of these accounts (such as Lolo Faith's) were the voices of rural women who blamed the spread of HIV on urban living and return migration. By engaging in a battle of blame, urban Guides and rural participants configured social protective strategies affecting their respectability. While this reflected a low risk assessment for the Guides, it did not seem to serve the same function for the rural women. By emphasising migration from urban towns, rural women were also highlighting the possibility of their own vulnerability. Guides, on the other hand, continued to deploy strategies to exempt themselves from this positioning.

STRATEGIES OF SILENCE: EMOTIONAL AND SOCIAL SELF-DEFENCE

Rural and Guide participants resorted to using silence as strategies of emotional self-defence and social self-defence. In some instances, silence was a paradoxical expression of emotion. Nussbaum argues that emotions are "intelligent responses to the perception of value" (2001:1). In this study, I interpreted the women's silence as strategies to manage such responses. Such expressions or responses are intelligent because they incorporate:

> "the idea of cognitive appraisal or evaluation; the idea of one's own flourishing or one's own important goals and projects; and the idea of salience of external objects as elements in one's own scheme or goals" (Nussbaum, 2001:4).

In other words, emotions involve a thoughtful assessment of how important something is to a person. In the context of this study, value could be attached to marriage, health and resources; the loss of or threat to any of these could trigger a range of emotions.

AIDS researchers have often found that diagnosis or risk assessment can evoke emotions such as fear, which is a widely researched concept (e.g. Green and Witte, 2006). Often this is evoked through the media. The scare campaigns of the 1980s that were prevalent in Western countries still persist in developing countries today. Often laden with images of gaunt and sickly-looking people, such campaigns forced people to think about death and isolation, thereby attempting to frighten audiences into compliance with the 'Abstain, Be Faithful, use Condoms' (ABC) prevention model. Otherwise, engagement with emotions had been limited to discussions of post-HIV test stigma and coping with the new burdens placed upon the family as a result of illness.

Among the different women's groups, interview transcripts of the rural women and Guides stood out because of the number of silences and the length of some of these silences. Among the questions resulting in the most silences (8 out of 10 Guides and 2 out of 10 rural women) were those that suggested high vulnerability or risk of contracting HIV. As I argued in the previous chapter, the difficult and delicate subject of HIV and AIDS is one of the factors that may have helped shape some of the responses the women provided, including silences. The others include the shrinking cloak of censorship, as a residue from the military era which many Nigerians seemed to be shedding, as well as the researcher-participant dynamic of the interview itself.

In some instances the silences clearly revealed the vulnerability, but in other instances these silences were drawn upon as strategies of evasion which, like blame, could be used as a means of emotional self-defence rather than social self-defence. Hence, the women seemed to be able to occupy a position as both vulnerable and powerful, simultaneously. This was because while they were grappling with the very plausible notion of risk vulnerability and the immediate consequences this could have on themselves and their families; their assessment of the implications on their social standing provided them the option to decide whether to acknowledge their vulnerability or not. As an interviewer, it was a challenge to penetrate these walls, because it was difficult to ascertain what type of defence was being used and when.

Mrs. Anali's interview stood out because of the number of silences and its overall quiet 'tone'. It is still unclear whether this was due to factors such as her personality or the interview itself. She was a petite 45 year-old married woman with one adult daughter. She taught at one of the local primary schools and was a devout Anglican. During the interviews, she would look at me intently while I asked the questions and, after looking down briefly, she would look up (sometimes past me) and answer slowly and deliberately. Therefore, I found it difficult to read the silence with which I was met after I had asked whether or not she felt she was at risk of contracting HIV. During this particular question she did not look up when she answered.

C: *So how would you say HIV and AIDS is spread in Abuja?*

MA: [Sighs] *This HIV is avoidable. Things are difficult but one can try and work. I just thank God... I mean... someone like [name of daughter], my daughter, she was able to find a job after* [National Youth] *service. It's very sad... these young girls of nowadays... I don't know why they feel that [they have to] follow men* [about for money]. *And what of the wives? It's sad.*

C: *Yes, and it puts the wives at risk.*

MA: *Yes.*

C: *I hope you don't mind my asking but... is that something you think ever about... for yourself?*

MA: [Silence].

C: *I mean... do you ever think that you... might be at risk?*

MA: [Silence].

C: *Because, you know, HIV/AIDS is spread through other means [than sex].*

MA: *Mmm....*

Mrs. Anali's silences struck me for a number of reasons. First, like Lolo Faith, she embarked on a tale of blame. However, this time, rather than rural people, the blame rests squarely with young women and presumably men who are better off financially than their female 'followers'. However, instead of positioning herself as the highly moral and knowledgeable wife, the rest of her account - her silence - lends itself to painting a picture of victimhood, not valour.

This was because, secondly, though she was silent there was a 'melancholic tone' that filled her silence. Earlier in the interview, she had informed me that she attended church regularly, often alone or with her daughter, as her husband was often away on business. He had recently 'slowed down' and begun attending with her. Therefore her narrative, like many of the Guides', seemed to paint a picture of the 'respectable family'. Yet the tone of her silence and the preceding comment seemed to express an empathy with the wives that could have easily been interpreted as identifying with them through sympathy rather than empathy. However, this was difficult to ascertain.

The next compelling feature arises from a comparison of Mrs. Anali's interview with that of Monica, a lay health counsellor in rural Sundaba. Monica was in her early 20s and had recently moved to Sundaba because she had married a local man two years previously. She had a child who attended the primary school where she prepared *kunu*, a local non-alcoholic beverage, on her days off from the clinic. On many accounts she was different from Mrs. Anali. However, their (silent) responses to potential risks were almost identical except for one point. When I ended the silence with the comment about alternative routes of transmission, Monica then confided that it was possible for her to be infected. Mrs. Anali, on the other hand, barely seemed to acknowledge this comment. Again it was frustratingly unclear what this meant; could it be that she was convinced that if she were at risk then it was due to her husband's behaviour or could it be that she was convinced that she could never be at risk? Or could she be at risk from other means of transmission, but feared that this risk would be attributed to her husband? Or was she the source of the risk? Perhaps there were other possibilities, but these were not vocalized.

Next, there was the length of the silences, especially the second one (nearly two minutes long). Since Mrs Anali was a deliberate speaker, I wanted to make sure I had given her enough time to respond, as this subject was particularly difficult - for both of us, albeit in different ways. As soon as I had posed the question, she looked down then up again, opened her mouth, shut it and looked down again. Taking into consideration the sensitive nature of this question, as well as her openness to other (difficult) questions, I interpreted this action as a decision not to speak, rather than an inability to speak.

It is within this decision (not to acknowledge by speaking) that Mrs Anali demonstrated a certain power, which was the power to refuse to answer my question (and thereby defend or protect herself). Sociolinguist Gregory Nwoye argues that "there is a potential and unfathomable decision or action in silence" (1985:191). I took Mrs. Anali's silence to mean this (a decision) because of two things: firstly, compared to other participants who rendered similar silences, Mrs. Anali had 'more' to defend socially. During the interview, Mrs. Anali explained how she wanted me to help her daughter get a better job and even proposed to take me to meet her daughter that day. In doing so, she would have been giving me more access to her life. In other words, Mrs. Anali was attempting to build upon the interview to establish a form of social capital. As a result, there was the possibility that I could, in my introduction, divulge aspects of the mother's interview to the daughter. Therefore, there were both emotional and social implications for her answer. On the emotional side, were we discussing her possible exposure to an incurable disease with a profound stigma attached to it. On the social side, we were discussing the status of her marriage, the possibility of infidelity and, indeed, their morality and respectability (that was, of course, until I reminded her that there were also non-sexual modes of transmission).

Hence, her position as a respectable wife within her social circles could have been jeopardized. If her capital for accessing contacts, connections and networks (for mobilization) was her 'respectable' family, then divulging information that would mar that image or negate her construction of respectability could have (she may have felt) a negative impact on my decision to help or not to help (or anyone else that I may have decided to refer her to).

Finally, within the context of this study, the expressions of emotion were sometimes silent, in that they could be read not only through lack of speech, but also in the 'atmosphere' and from the countenance or body language of the participant. I interpreted the silences as particularly 'expressive' when they were read against other parts of the interview transcripts and against the relationship between participant and researcher by drawing on a feminist engagement with the concept of emotions. This latter reading, in particular, is consistent with the psychoanalytic perspective suggesting that emotions are not simply intra-psychic, but are constituted through interaction with objects outside of the self (Chodorow, 1999).

My analysis supports Ahmed's view (2004:12) that emotions help to shape "how we become invested in social norms". It is in this regard that I uphold silence to be a strategy for defending oneself socially as well as emotionally. Due to the high stigmatisation levels that people living with HIV/AIDS receive, many informants expressed their awareness of this and sometimes appeared to try to evade this stigma before they were tested themselves. As a result, the function that silence served was to highlight a person's state of ambivalence within the HIV voluntary counselling and testing context. During risk assessment there is a liminal or hybrid dialectic state between power and powerlessness. Powerlessness seems to persist when a participant suspects that she may have been infected or is at risk. However, in some instances participants are able (i.e. powerful enough) to choose to either deny the fact or to seek confirmation through counselling and testing. Emotions serve as a resource that helps to point people towards their eventual choice and are, therefore, reservoirs of knowledge. But this depends on the investments people have in social norms. In the case of many participants, this was interpreted as being high, and was focused on defending their social status. In the case of the Guides, respectability and elite-petitism were at stake.

Yet another example of social self-defence can be found in the analysis of the transcript of Mrs. Mitti, a rural woman who was married to a local politician. She seemed young and bright, and asked me a number of questions related to HIV and family planning (as I will explore further in the final section of this chapter). She was in her early 20s with four children. She told me that she wished that she had gone to nursing school instead of marrying as early as she did. She insisted that the marriage was her choice and that she was not forced into it. She was not an active member of the local women's group

because, as she said, she belonged to women's groups in both her village and her husband's village. Moreover, she was busy participating in events around her husband's re-election as the local government chairman. Therefore, because she was so engaged, inquisitive and, immediately prior to the excerpt below, had just confided in me that her husband drank a bit too much and she did not like him coming near her "to make more children", her silence stood out from the rest of the interview transcript.

C: *So when he comes to you, do you have to be with him if you don't feel like it?*

MM: *Sometimes. It is difficult to refuse your husband.*

C: *So how do you...*

MM: *Well, I'm always nursing, so I can tell him I'm tired. Or that I must be with the child* [who she is nursing at the time].

C: *And he's okay with that?*

MM: *Sometimes.*

C: *Mm-hmm.*

MM: *And sometimes I push him away... carefully.... But of course I have to be careful not to provoke him.*

C: *Provoke him how?*

MM: *Ah!* [Laughs]. *Annoy him, of course!*

C: *What happens when you annoy him?*

MM: *Hmph!* [Laughs]. [Silence].

C: *So, can you manage to use a condom then?*

MM: [Silence].

C: *Will your husband agree to use it?*

MM: *Maybe. But how can he use it for me? Unless I get child for hand* [am nursing], *he cannot use it with me.*

As with the other accounts, there were several prominent features related to this particular excerpt. The first was that although the silence here was prompted by a different question, like the other silence accounts, I read this to reveal vulnerability. But like Monica (and unlike Mrs. Anali) it was a vulnerability that she openly acknowledged as a risk factor. By engaging in the possibility of her husband using a condom with her (and with other women), she was engaging in a positive assessment of her own risk. Also, she acknowledged that there was a possibility that he would use a condom with her during the period when she "*get child for hand*", an expression in

Pidgin English indicating a post-partum period during which couples abstain from sex while the woman focuses on nursing or breastfeeding the baby. This awareness could make it easier to introduce the notion of prevention than it would with someone (like Mrs. Anali) who was not ready to verbally engage in the same sort of assessment at the time of the interview.

The second prominent feature was perhaps more troubling, because it was as silent as it was pronounced through her body language. While this was not one of my interview questions,[58] two participants had said that they had experienced physical violence in previous relationships. None of the women 'openly' mentioned domestic violence. This was the case with Mrs. Mitti, whose sarcastic laughter and looks in my direction, to me seemed to be saying 'that I should know' or that there was no need to mention what was bound to happen. In any case, drunkenness and anger (whether expressed verbally, emotionally, physically or all three) seemed to pose potential threats to Mrs. Mitti. How her silence positioned her can best be illustrated by what took place the day after the interview and what serves as the third prominent feature of her account.

What occurred the following day is actually what led me to perceive her silences as strategies of social self-defence (for her and her husband) and perhaps even physical protection (for herself). However, it was unclear whether the social self-defence impetus was entirely hers. After the interview that day, I met a very 'friendly' man who asked about my work and what I was doing in the village. It was only the following day that I found out that this man was Mr. Mitti. Coincidentally, I was also taken to the neighbouring hamlet of Wuru to continue my interviews. When I asked why, I was told that the decision had come as a result of an 'impromptu' meeting the local leaders had had with my informants and how they felt that this new area would be 'better' for me. This move could be interpreted as the outcome of a clash of power systems, including intimate gender relations, local government politics, the implementation of national HIV/AIDS programming informed by international policy and support, and international research on HIV/AIDS prevention. It appeared that my line of questioning potentially exposed Mrs. Mitti to 'external ideas' about sex and possible ways to address her husband's behaviour outside the home. This interpretation had implications for how the Mittis were perceived socially by the rest of the villagers and perhaps

[58] Asking this would have been 'forcing' the issue of domestic violence and therefore, for me, would have been unethical as there were no organizations to which I could refer participants if they needed further assistance.

fellow members of the PDP, particularly given the upcoming local government elections in which he sought the chairmanship. The move to the village reflected Mr Mitti's influence over his wife as well as his influence over people in the village, including community HIV/AIDS workers. Such dynamics possibly contributed to the phenomenon of suspicion and insulation that sought to undermine the effectiveness of collective action against HIV/AIDS in Sundaba.

'I NO GET FRIEND!' SOCIAL INSULATION AND WOMEN'S SOLIDARITY

The notion of female solidarity is implicit in the idea of women's empowerment as a strategy to prevent HIV/AIDS. However, participants in this study narrated and demonstrated behaviour that disrupts this myth and further extends their aim of self-protection. Several described themselves as avoiding close relationships with other women or maintaining relationships with just one or two other women, which I interpreted as social insulation, which could either be self-imposed or forced, as well as individual or collective. Whereas participants used blame and silence to protect themselves, the symptoms of this protection were interpreted as a result of the way some participants constructed their relationships and interactions with women in their group. These issues follow from the previous section, in which I demonstrated how participants used silence as emotional and social self-defence strategies. Here, participants constructed issues of mistrust and directed this towards other members or other social networks. While this contributed to undermining participation, it also served a broader function of maintaining 'harmony'. Given the ethno-political history and background of the Gbagyi in Sundaba, I took participant silence to be another self-protection strategy that seemed necessary for emotional and social survival 'harmony' in the community, but which had an adverse impact on both participation and HIV-related knowledge and practices. It was easier and safer to remain silent and insulated than to inadvertently offend a person in power or his or her affiliates, as maintaining the semblance of good relations had implications on access and distribution of resources such as land and employment.

Researchers have argued that social capital (and related factors such as trust and solidarity) are key factors in reducing HIV among young people through community initiatives (Campbell, 2003; Gregson *et al.*, 2004). In this study, insulation had profound effects on the way each group perceived and carried out its said objectives

and activities. The leaders of both groups expressed a desire for their organizations to grow, as this would help secure more funding. The Guides were self-funded through membership fees and philanthropic donations, while the rural group received a small amount of support from FACA by way of capacity building for its male founder, Friday. Some of the Guides commented on the decline in membership by glorifying the former days when registration was high. The Commissioner insisted that there was a renewed interest, but mainly from young girls 'seeking adventures' such as camping or hoping to make friends from other countries. One Guide told me that it was becoming a place where busy parents enrolled their children, similar to a summer camp. Adult women rarely joined the association, unless they were recruited through the schools where they taught. Amongst the group I interviewed there was one Guide in her 20s, two in their 30s, three in their 40s and the remaining four were over 50 years old. Such differences in age and background alone pose challenges to group solidarity and participation (Baylies and Bujra, 2000).

In terms of organization, the Guides met regularly and were understandably much more structured than the rural women or any of the other groups, due to their longevity and size as a group. However, although they were better equipped infrastructurally than their rural counterparts (i.e., office, transportation costs, etc.), ideologically, they were still coming to terms with how to develop a strategy to help young girls and women prevent HIV and unwanted pregnancies. This was not only because of the wide breadth of activities they engaged in, but also because, until July 2007, even their parent group in Britain had not received or been given a mandate to embark upon AIDS activities.

The origins and mechanics of the Rural Women's Association were quite different in a number of ways. The founder of the group and native of the village, Friday, told me he had to rely on kinship and personal contacts to initiate the group, after he had decided to start the group after attending one of several government-sponsored capacity-building workshops. As a result, membership was dependent upon residence in the village and, although new people were settling regularly (one or two families a year), membership remained stagnant and inconsistent. Both members and non-members cited the following among the reasons for missing meetings: lack of time, lack of interest, or competing interests such as other social group meetings. A few residents who did not participate in the interviews told me that they travelled back to their

villages to attend women's meetings and that the pressure to attend every meeting was 'too much'.

The varied commitment was evident from women's narratives of the group. Some complained that they were not always informed of meetings or were unable to keep abreast of information being passed. However, others seemed to be constantly 'in the know'. Four participants who attended regularly lived within the same corner of the village. One factor that stood out was that not everyone was aware of the name of the group, so it often seemed that there was more than one meeting taking place. For example, when I asked how long each had been members of the women's association, two participants said they did not know the name of the group they belonged to. However, this was quickly resolved by tracing the group back to Friday. Friday later told me that they had initially argued over the name, because the women wanted a name that did not favour one dialect over another. So the initial name was changed to reflect this, as well as the aim of the group which literally translated means 'to put mouths or voices together'.

One common feature among both the Guides and rural participants was that a few from each group told me that they did not have 'friends' among the other members. Several rural participants told me that they insulated their lives from friendships in order to avoid gossip, slander or 'too much talk'. One such example, Moriamo, was the Christian wife of a Muslim man who had five other wives. He had been divorced from his most recent wife under local customary law and awarded custody of the children, who then became the responsibility of Moriamo, his first wife. Therefore, in addition to her four children, she was responsible for the four left from the divorce(s), although the other wives shared responsibility in raising them. However, her husband was unhappy with her and had cut her off financially, so she depended on the help of the co-wives for minimal support as she had no living relatives (she was one of two children from her own mother). She also sold firewood or exchanged it with other women for salt, which seemed to be a big practice in that area. Her own children ranged from 18 months to 29 years, but she was not sure of their exact ages or her own age. She had no formal education, but had been exposed to reading at Bible school where she helped her aunt who taught there. Since she had her first child young, I would put her at 45 years old or less, as she looked quite young. She informed me how she regretted her marital choice, even though she had married a bit later than most of her peers.

C: *What helps you manage this situation with your husband?*

M: *Business.*

C: *Are you part of the association?*

M: *I have been a few times.*

C: *Do you have friends to help or to talk to?*

M: *My husband forbids me to have friends outside.*

C: *Why?*

M: *Because they gossip.*

C: *So what about the other wives? Are they friends?*

M: *Yes. We help each other look after the house and keep the compound. And if someone dies, we go and visit together.*

C: *Is there another example? Since people don't die everyday?* [Laughter].

M: *Another example? Well, actually it's not so easy. We greet each other. We do speak but when it comes to lack or to needing something, nobody likes to... nobody wants to help because we all share the same husband. We do it but this one feels 'my husband loves that one more than me'. That one feels 'My husband loves her more than he loves me'....*

C: *But that's how things are with co-wives, no?*

M: *Yes, and you don't know what they're doing to your children behind your back or if they're doing something to turn your husband against you.*

C: *Something like, oh ok. Not nice?*

M: *Hmm* [barely audible]

C: *But is that co-wives? Or all women, too?*

M: *Hmph! Women can do anything* [good or bad].

What is striking about her account is how it positions her as both isolated and independent simultaneously, thus debunking myths of female solidarity that is often ascribed to poor African women. Firstly, she was quick to respond that what enables her to face her situation at home was her business, or economic empowerment. Despite the problems she faced, she was still able to trade her wares and actively look for sources of income. Although her independence is as a result of marital problems, she seems to use it to her advantage to maximize her mobility in order to trade rather than to build social networks for support. The very people that were in an immediate position to offer support and actually did so to an extent were the same people that she

suggested may be threats to her: the co-wives and women in the village. Interestingly, although she was severely neglected by her husband, she still heeded his advice to be wary of gossips (which I initially read as a strategy to keep wives from hearing about husbands' infidelities, and still think this to be so in some ways). However, while her statement at the end of the excerpt "women can do anything" could easily be mistaken as a declaration of female empowerment, a reading of her preceding statements about what women do to you behind your back suggests that her concerns about other women extended beyond gossip and were more to do with suspicions of witchcraft.

Others rural participants said that they found it was difficult to maintain friendships due to gossip or suspicions (n=7). In fact, in three instances, participants said they felt more comfortable asking a male resident of the village to intervene in a dispute for them. Two mentioned that they would rather obtain sexual health information from male relatives. It would be easy to explain this away by insisting that women were simply drawing on 'habitus' (Bourdieu, 1997) and that they were used to these gendered forms of information gathering. However, this explanation would not account for the lived experiences of these participants. For Moriamo and some other rural participants, a lack of female relationships was not a deficit but yet another form of defence.

Cornwall's ethnography on gender relationships in Western Nigeria also highlighted other women, not men, as the source of her participants' concerns. Women in Ado-Odo actually depicted other women as enemies who were trying to keep them from progressing with their business or marriage (2005:155-156). This picture is further propelled by serving as the main thrust of storylines in the popular media, such as in Nollywood films (films produced in Nigeria). Indeed, the presence of what Friday informed me was the local witch-doctor's 'clinic' immediately opposite the health post, helped to cement the plausibility of its patronage. It is one thing to hear of a witch-doctor's premises and another to actually see it. It was an imposing two-storey building painted with graffiti-like colours and images, and enclosed with a high gate. The sheer size and well-kept compound seemed to provide evidence that 'business was booming'. Two informants told me that people visit the health post by day to deal with physical problems and visit the witch-doctor by night to deal with spiritual problems.

Since it is difficult to know which members of the women's groups (or their co-wives or female relatives) are actually clients of the witch-doctor, it is difficult to ascertain

what impact their alleged patronage of the clinic has on the women's group or on preventing HIV. However, it is clear that the suspicions of other women undermine any goal of providing a context where women can openly negotiate identities in relation to sexual behaviour. Fortunately, this prescription is not their goal. However, participant mistrust had implications on the actual goal which was, as stated earlier, to come together to seek ways to earn additional income to enable them to deal with the effects of HIV and to obtain information on prevention. It seemed as though suspicions would undermine the collective purpose of the group. However, the need for additional income outweighed the potential costs of being exposed to gossip and witchcraft, because participants still expressed a desire to meet. They also asked to learn about additional ways to earn income. Therefore, analysis of these strategies of insulation highlight how Moriamo and some rural participants drew upon their own personal sources rather than those prescribed by an agency or experts.

While there were women in the other study groups who insulated themselves from relationships with group members, only two women in the Guides described themselves as doing the same. A feisty dark-complexioned stocky woman, Rhiela, said she kept away from others, but she also often insulated herself from interactions with other women because she was a single mother and did not want to have to expose herself to gossip, since she did not fit in with the married members. She also argued that she was not taken seriously because she was young for her age, despite the fact that she had a teenage son. She relayed this after an altercation that she had with some members of the group with whom she was working on a solar energy cooking project. She had been in charge of collecting cardboard and aluminium to make reflectors and was accused of collecting pieces that were not 'good enough'. She felt badly about this and stormed off to commiserate with a friend. She told me that she had one other friend in the group who was also single, who she felt she could be herself with and watch football and drink. She had been in a relationship with a man for several years, but had only just introduced him to her son because she felt the relationship was getting serious. When I eventually came to ask her during our interview how she protected herself from HIV, she replied "*I keep him* [her boyfriend] *close to me - like a handbag*". With further exploration, Rhiela said that she worried about other women "*chasing him*", but felt it was silly for her to feel insecure. She also referred to herself several times during the interview as "*silly*" or as a "*small girl*", and recounted several situations in which she believed people had taken advantage of her because of this

behaviour. She included her ex-husband and other women as people who had taken advantage of her, and attributed these experiences to the reason she stayed away from others.

Insulation from members and other women can stem from reasons other than gossip and witchcraft, which are just two manifestations of poor relationships. Not having friends was sometimes a function of personality clashes or negative peer-group type pressures in which members who were different were excluded on the basis of that difference. Because the Guides' goals were so different from those of the rural participants (or any other group for that matter), it was unclear whether or how situations like Rhiela's worked to nullify efforts made towards achieving organizational aims and objectives. Because AIDS prevention was only one of the group's newer activities, rather than a goal as it was in other groups, it was also unclear whether or how the relationships within the group had any bearing on Rhiela's perceptions on AIDS prevention or on her sexual behaviour. What did seem to be clear was that group members do not always get along just because they are in the same group.

Rhiela's and rural participants' self-exclusion from friendship not only served as a means of defence from gossip and stigmatisation, but also helped to maintain an harmonious equilibrium. Specifically, due to suspicions of gossip and witchcraft, they may struggle to achieve 'empowerment' together as an identity group, but may be able to achieve collective economic empowerment as an income-generating group. As a result, efforts to achieve empowerment against AIDS based on identity and women's solidarity were undermined, perhaps because this was not their goal in the first place, but was a goal that had been assumed by Friday, their male coordinator. Nonetheless, the desire to improve and expand individual economic portfolios sustained women's interest and participation in the group.

OUTWARD CHANNELLING: TEACHING RURAL WOMEN

When asked about protection measures for themselves, several Guides (by my interpretation) channelled their knowledge and skills outwardly by focusing on teaching others. By answering my question with a focus on teaching, they positioned themselves as immune and positioned others as diseased. Although teaching was their profession, outward channelling, like blame, further revealed low risk assessment. However, I took channelling to differ from the blaming discourses discussed earlier for two reasons. First, channelling outwards was the response given to the question on how they protected themselves from HIV, whereas blame was the response given to questions about the government's response to HIV or about how HIV is spread. So while it was almost excusable for participants to blame others when asked about external factors relating to HIV and AIDS prevention, it was striking to find that 6 out of 10 participants still emphasised the sexual behaviour of others when asked about their own actions.

Second, while there was very little that they could 'do' in response to the former set of questions, the question about protection could have created a context in which concepts are "strongly influenced by group-based social identities" (Campbell, 2004:48). It seems that the negotiation that took place only did more to help them evade their own risk and cement their position as immune (and therefore respectable and responsible) and the position of others as diseased.

A compelling example of outward channelling comes from the extract of Christiana ('Christy'), a 42-year old teacher who was married to a doctor. She served as one of the senior administrators of the primary school where she taught and where I interviewed her. She was also the Supervising Guide at the school. Upon my arrival at her office, she offered me sweets, biscuits and any other *kola*[59] she could think of, after which she introduced me to the principal and several staff, and showed me around the school. Her office, which was airy and spacious, overlooked a well-tended courtyard where the children played. She went as far as kindly but firmly ordering them to 'keep it down', before we returned to her office and desk which was strewn with papers, clips and a picture of Mother Mary.

[59] *Kola* is word used in Igbo to reflect any refreshment used to welcome guests. The name is derived from the traditional refreshment of the kola nut and its fruit.

C: *So what can you do to protect yourself from HIV?*

Chr.: *Hmmm... Well, what I'd say is that the reason one engages in unsafe sex is because one does not have adequate information. Even when people are educated they are not necessarily learned.*

C: *So you have information and therefore you're able to –*

Chr.: [Interrupting]. *Information is extremely important. That's why I see teaching as so important for women and that we - are you Catholic?*

C: *No.*

Chr.: *Aren't you from Enugu?*

C: *No, we're from Abia. For some reason the Methodist* [missionaries] *came to our village while Catholics were in other parts of the region.*

Chr.: *Eeh? Well, I don't know if you know much about the Catholic Church but we believe in natural family planning. So, like I was saying it's important to teach about these things to women - and AIDS prevention too - especially where one may not have any of the other options people are normally used to.*

There are several aspects of this excerpt that are of importance. First, the way in which she evaded the question and immediately responded with her reasons for unsafe sex. By using "*one*" as a pronoun, she excludes herself from groups who need protection due to unsafe sex. While the use of 'one' as a pronoun is common in the popular use of English in Nigeria, it is also a convenient way of othering. As mentioned earlier, othering may be only one facet of a process influencing how or whether some participants choose to protect themselves from HIV.

The second important feature of this excerpt is how the emphasis she places on the 'learned' is a strategy I interpreted as one that serves a self-exclusionary function. At first, her comment about being educated yet not learned seemed to me like a random saying that she had heard and incorporated into the conversation because it 'sounded good'. But upon further review, the meaning that I attached to this statement changed. Drawing on her position as a teacher, I interpreted the use of this statement as a way in which she positioned herself among the learned, thereby excluding herself from the 'merely' educated who she saw as more likely to have unsafe sex.

The contradiction, however, is that natural family planning shares some features with unsafe sex, perhaps the most obvious being the absence of a condom. While she is

adopting expert discourse of the 'unsafe', the use of this positions her as an expert (albeit, a lay expert) who is somehow exempt from the standards she sets for lay people. Moreover, encrypted in the doctrine of Catholicism, condom-less sex becomes safe, primarily for two reasons: first, it is safe because its aim is creative – to reproduce. Second, in the era of AIDS, it becomes even safer if it is taught alongside other methods of family planning which share features with 'A' in the ABC model of prevention: abstinence.

Next, since condom-less is 'natural' it is also therefore permissible for 'the learned'- and perhaps for Christy. Consequently, she was able to use this to justify her public or outward activities as an acceptable replacement (or auxiliary) of any personal action (i.e. protection). Hence, not only are 'the unlearned' unable to protect themselves, they are unable to contribute meaningfully towards adopting prevention methods because the unlearned probably do not teach either.

Finally, it became clear that teaching did not necessarily mean HIV teaching. Three Guide participants told me they engaged in other types of teaching, mainly related to family planning. Coincidentally, they are all active in their faiths (all three were Christian). This was motivated by personal experience, which suggests that personal experiences may have an influence on how participants decide to channel those experiences.

This was the case of Gabi, a 28-year old mother of two who was tall and attractive, and who dressed like an *al maryia.*[60] Like Christy, she and her husband were also active in religious activities but in a Pentecostal church, where they hosted weekly Bible studies and attended pastoral leadership meetings, along with two regular services a week. Apart from these and her normal membership activities, she has her own 'quasi'-NGO which she registered as a women's organization under the same umbrella organisation as the Guides - the NCWS. Registration was as far as she had progressed to, and she expressed interest in learning how to better structure her organization. She explained that her NGO provided skills training and support to rural adolescent girls. She had thought that belonging to the Guides would provide her with ideas on how to run her own organization more efficiently but found this not to be so, partly because the Guides' funding mechanisms were dependent on membership dues and money from

[60] A young (often well-to-do) bride or newlywed.

central office. Their prevention activities came from these rather than from national and international governments and agencies.

At the start of the interview, she relayed in a soft-spoken manner how her personal experience motivated her work with young rural women. She relayed the following: when her father lost his job, he pretended everything was fine for a year before her mother found out and took over the running of the household. Fortunately, she had various skills and she also encouraged them to learn skills. Gabi learned how to bake and consequently she baked pastries which she sold to bakeries before school each morning. What alarmed her, she said, was that despite their financial setbacks, her mother looked after her cousins and friends from the village who were less well off, often raising them and sending them to school or for vocational training. Despite the inputs her mother made, one of her cousins became pregnant.

Based on this experience, I interpreted the following excerpt of Gabi's interview transcript to mean that Gabi channels her knowledge and skills outwardly, but also adopts a wilful inclusion strategy, whereby she identifies with the people that she teaches in such a way that she sees herself as vulnerable enough to need to take action in her own life.

C: *So since your group is called Real Women, do you think you're a real woman or* do you think they [rural women] are 'real' women and are different?

G: *They're just like us but it's just that...* [silence] *...they didn't have the kind of life that I have. And we only had it because my mother struggled to maintain that life by imparting us with skills. I mean... my dad owned a ship one day and the next day we didn't even have a car. My parents made sure that I went to school. My parents didn't allow me to have* [a] *boyfriend. Even if you go on a date [they would ask] "You have a boyfriend?"* [we laugh]. *You can't think of talking about that. And when you meet one, it means you've finished with school and school means university. It's a problem!!! But we're all the same. It's just that they didn't have the opportunities that we have. They are exposed to adult life too quickly without their permission. Without their permission.* [her emphasis] *They were not ready. They just had to. They didn't have a choice for their life, they didn't have a choice to their health. They didn't have a choice for anything. Anything just goes.*

C: *Yeah.*

G: *Like me, I have a choice. I'm the one who told myself "I think I want to get married now". I'm the one that told* [name] *my husband and I agreed we*

should start having children. We agreed: "We should go on family planning". With my consent. I told him. Do you understand?

C: *Mm-hmm.*

G: *I made this choice. I said, "Oh, there's... um... HIV/AIDS everywhere, we have to have a proper lifestyle. We have to have a healthy lifestyle... Safe. We have a right. I can decide to use protection, and it will be so. I have a right... to my own life. So I can make these choices.*

Gabi's process of channelling empowerment differs from Christy's, in that Gabi's perspective on rural women is important for several reasons. First, Gabi was the only Guide participant who acknowledged any similarity between herself and the rural women that most Guide participants and informants throughout the study positioned as women in need of AIDS awareness and prevention. I attributed her ability to identify with rural women based on the experiences she had of her young cousins coming to live with her family when she was younger, as well as her more recent experience with her organization. This identification puts her on a par with the young rural women, rather than the othering expressed by her fellow Guides.

Second, however, she was quick to point out the differences between herself and the women; namely, skills with which she could earn an income and parental emphasis on education. I did not interpret this as a means by which she 're-others' rural women, but as a means by which she defines the social chasms that exist between her and rural women. Similarities existed based on elements of Gabi's personal experience, as well as her fear of being in a position that would make it challenging for her to make decisions (i.e. poverty and lack of education). But, from Gabi's excerpt it seems that other factors including culture, parental support and marital relationship dynamics also contribute to shaping her sexual and overall decisions in life.

Finally, Gabi was the only Guide who alluded to actually discussing AIDS prevention and other sexual health issues with her husband. In doing so, she was vulnerable in the interview in ways the other participants were not. She could narrate her experience with negotiating protection (although it is unclear whether she means protection from pregnancy or from HIV) by drawing on a discourse of 'rights'. Yet, while she was explicit about her own rights, it is unclear whether she was referring to herself and her husband, herself and the rural girls that she worked with, or herself and women in

general. What seemed to be evident was the notion that she was not the only one entitled to these rights.

As a result, I took Gabi's use of the discourse of rights to mean that for her, a person must have rights (or at least be aware of them) if they are to be able to make reproductive and sexual health choices. As much as she wanted to be unified with the rural girls she was helping, her knowledge (and that of her husband) separates her at least from the rural women in this study. Of course, while none of them mentioned rights, this does not mean that rural participants were not aware of them. However, during the interviews there was the indication of participants being able to make the same sort of reproductive and sexual health choices as Gabi had, particularly in the area of birth-spacing.

However, this also brings into question how Gabi would access those rights if they were violated. While advocates of Beijing and beyond have argued that human rights are essential to reproductive and sexual health, others have questioned the usefulness of rights discourse in state systems like Nigeria's which fail to provide basic rights such as rights to health care, as well as basic amenities such as water and education (Ewelukwa, 2005). Particularly, it is striving to make up for this very lack which puts rural girls in situations which leave them economically, physically or sexually vulnerable (Babalola and Nwashili, 2005), such as street-hawking. Whatever the case, the lack of implementation and enforcement would not guarantee that these rights would be immediately accessible to Gabi's rural counterparts.

Perhaps what needs to be made more accessible to Christy and Gabi's counterparts, as well as many of the rural participants in this study such as Mrs. Mitti, is increased access to family planning services and information. While outward channelling seems to deflect any potential risk of HIV from Guides who engage in both family planning teaching and AIDS outreach, this (along with the responses of rural participants) highlights the fact that there is an unmet need in rural women's sexual and reproductive health. Eight of the ten rural women made reference to family planning or the desire to plan their families more effectively. This suggests that family planning is a higher priority amongst Sundaba women than HIV prevention. It also suggests the need to integrate HIV and AIDS and family planning together into a comprehensive service for women, so that women who seek family planning services can be counselled on HIV at

the same time, instead of having to go elsewhere which would pose an inconvenience and therefore reduce their utilisation of HIV prevention services.

For many of the Guides, their activities of teaching and outreach seem to reflect their belief that AIDS is about other people. If rural participants were to be the seekers of complementary services to HIV prevention, then the Guides could be seen as the providers - although not to the rural women in this study, as the two groups were not in the same area of Abuja.[61] While the Guides channelled their knowledge and skills outwardly, only one of them reflected on how these addressed their own vulnerability and affected their sexual behaviour. With so much emphasis placed on rural women and other groups, there appeared in this study to be a gap in how AIDS prevention might suit middle-class women, such as the Guides, who are concerned with preserving the semblance of respectability and thus have a low self-assessment of their risk and vulnerability. There also appeared to be a 'confirmation' that many of the rural women's health needs are still unmet.

INWARD CHANNELLING: SEEKING HEALTH INFORMATION

Many rural participants engaged in 'seeking behaviours', which I took to be their tacit response to the rhetorical question many of them posed "*Wetin person go do?*" ('What else can I do?'). In adopting seeking behaviours, rural participants channelled knowledge and resources into their lives by doing what they could do, even though this fell outside the boundaries of the prescription of ABCs (abstinence, being faithful and condom use). Although their knowledge of prevention differed from the rest of the participants in the overall study and they found the ABCs difficult to implement in their lives, rural participants took other measures to protect their health (such as participating in the first rally held in their village, seeking family planning advice and methods, asking questions, and going for voluntary HIV counselling and testing).

[61] The Guides in this study did not necessarily provide services to the rural women in this study. They frequently visited women in other rural areas in the Federal Capital Territory and in neighbouring states. However, these visits might be the extent of the interaction between these geographically, socially and culturally distant groups of women.

Seeking HIV and Family Planning Information

Rural participants seemed as interested, if not more interested, in learning how they could control their fertility as they were in learning how they could prevent HIV and AIDS. Children were a reality of which they had experience, and the burden of bearing too many children was felt more readily to them than the idea of HIV. This was not only because the symptoms were evident immediately (within nine months), but because the implications were acutely felt by the women, many of whom had the primary responsibility for food, clothing and education. During the interviews, in addition to asking me to adopt their children, several asked me if I knew ways that they could prevent them from having more. Of these, four participants asked me to demonstrate how to apply a male condom (after I had asked them if they knew how to prevent HIV, and if they knew what condoms were and whether they had ever used them before). They responded in the negative to both questions, saying that they did not know how to prevent HIV and that although they had seen condoms, either with their husbands or in the clinic, they did not know how they were used. Mrs. Mitti, the wife of the local council chairman (discussed earlier) was one of the four. The following excerpt was preceded by a conversation about care and support for people with HIV.

C: *Have you heard of the ways to prevent it [HIV]?*

MM: [Shakes head].

C: *Like a condom?*

MM: *I've seen it but I don't know how to use it....Can you show me?*

C: *Do you think your husband will agree to use it?*

MM: *Eh... maybe... as I said before... if he goes to another person. But I heard there's one for women. What about that one?*

C: *I had one but didn't bring it today. It's very difficult to find here* [in Nigeria]. *Wow - how did you hear about that?*

MM: *I don't know... but maybe that one would have been better.*

As with the previous excerpts, there are several striking features here. First, although this excerpt highlights the dual protection that the male condom offers against pregnancy and HIV, it also demonstrates how Mr. Mitti could accept condoms for one of its preventive benefits (unwanted pregnancy) but not the other (HIV). Therefore, it would be acceptable for her husband to use one (if she insisted) when she was

breastfeeding, which would indicate that she believed that she could become pregnant even while breastfeeding. However, the meaning that Mrs. Mitti (and perhaps her husband) seemed to ascribe to condom-use was infidelity, which could be one reason for his refusal to use condoms with his wife.

The second feature was that Mrs. Mitti was 'bold' enough to ask me to demonstrate how condoms are worn (although I also suspected that it might be mildly amusing for anyone to watch me maintain any sense of decorum while trying to place a condom over one of the bananas we had bought from a nearby girl-child vendor). It did not surprise me in the sense that she seemed quite outgoing and vocal but, compared to another participant, had shied away from her request after I had opened a condom packet and removed the condom.

Third, Mrs Mitti was the only participant throughout the entire study who had mentioned the female condom. This had only otherwise come up during conversations with informants who were leaders of NGOs dealing with HIV or with gender. Mrs. Mitti's inquiry suggested that, despite her non-committal participation in the women's group and her low self-efficacy as to whether she could actually negotiate condom use with her husband, she was exercising agency and actively seeking information (possibly to arm herself with in the future). This example offered counter-narratives to those put forth, not only by the Guides but by local and international experts, about women's empowerment and their reproductive and sexual health. While Mrs. Mitti is unique, she does present an alternative to the notion that the campaigns should focus on women 'out there who just don't know'.

Furthermore, her query suggests that if there were a female-controlled method, such as female condoms or microbicides, then this might be a more likely option from which to choose. As Kaler (2004) notes in her evaluation of female barrier methods in North America and South Africa, "An ideal technology should be low-cost, free of side effects, effective against both HIV and other STDs, and undetectable by male sexual partners". Her definition arose from an earlier analysis of the female condom's success in Kenya, where it was found to be both easy–to-use and accessible, but it had one failure: men saw it as a marker of "some sort of women's empowerment" or control of their sexuality, which they did not like (Kaler, 2001:784).

Pool *et al.* share the findings of similar perspectives in Uganda, where men expressed anxiety at the idea of not having control over female sexuality. However, their concerns also included those regarding the ascetics of the condom interfering with male pleasure "it is like having sex with a plastic bag" (Pool *et al.*, 2000b:202); women's pleasure; and the idea of HIV-positive women piercing the condom to wilfully infect male partners. Overall, men preferred the male condom, but welcomed the introduction of vaginal microbicides as the best method.

With this in mind, campaigns that focus on negotiation and improving self-efficacy (or empowerment) may not be as successful as those introducing and scaling up undetectable female-controlled methods, as well as working to change men's perspectives.

Seeking Information on Child Health and HIV-related Illness

While controlling fertility may not seem to have many obvious links with HIV and AIDS prevention, other than that they share condoms as a form of prevention, the fact that women were interested in controlling fertility suggests that they believe this is an area of their lives over which a) they *desire* control and/or b) they *can exercise* control. This appeared to me to be in stark contrast with the Guides, who seemed to regard themselves as 'providers' of information. However, the rural counsellors (who were also providers within their contexts) expressed a desire to learn as much they could about HIV and AIDS and family planning. This suggests that information on HIV is taken for granted by my more urban participants (as is 'expertise'), probably as a result of information saturation or overload in Abuja. In contrast, 7 out of 10 rural participants did not own a radio, none of them owned a television and, at the time of the interview, 60% had never left their village. Their quest for knowledge suggests an unmet need for service delivery, not only for family planning information but also for information concerning HIV and child health.

This lack of information came up in a number of ways. For example, Aisha, who was a member of the women's group but who had not attended the rally, had responded that she did not know what HIV was when I asked. However, after a few minutes of discussing childhood diseases, she returned to the subject of HIV and asked "*How does one know that they have it?*". I took this to be a sign of interest because we had just

been discussing childhood diseases which she was more familiar with - not by name, but by the symptoms her baby daughter had had.

Most of the rural women exhibited 'seeking' behaviours, which could be interpreted as a means of doing all they could to channel empowerment into their own lives and prevent HIV/AIDS, even if they found the ABCs difficult to put into practice. The first of these (which was discussed in the last section) was attending meetings for networking purposes and, more specifically, to seek material or financial support. Seeking behaviours also included attending the first AIDS rally which had been held in Sundaba the day before I arrived. Other seeking behaviours were having an HIV test or expressing interest in doing so, seeking family planning advice and asking how to apply condoms.

Finding Strength in Vulnerability: Going for Voluntary Testing

While they could not control their husbands' behaviour or negotiate condom use and other safe sex measures, the rural women displayed empowerment by recognizing and admitting their vulnerability as well as taking steps to control their health, thereby preparing for any future eventualities. While they did not have the same access to information, education and health resources enjoyed by other research participants in Abuja, once exposed to similar information during the rally, some rural participants were able to assess their risk situation honestly and accurately. As a result, they were then able to gauge the implications this would have on the family and then take steps to do what they could to make the most of their situation. In doing so, they demonstrated agency and choice, which I interpreted as making them empowered in ways which their Guide counterparts were not. In fact, across the groups, the rural women were the only ones, other than the women in the support group from HIV-positive women and a few in the Christian group, who had voluntarily gone for HIV counselling and testing. Of those participants of the other groups who were tested, many had been 'forced' to test due to requirements related to employment, premarital proceedings, or pre-natal and obstetric care, even though mandatory HIV testing is not legal in Nigeria.

Monica, one of the SNR counsellors, informed me during an interview that approximately 85% of both the men and women who had attended a rally agreed to be tested for HIV after being shown mini-dramas about HIV and AIDS and receiving

short lectures by two or three health professionals, including Monica herself. The drama and lecture were followed by a question-and-answer session and on-the-spot HIV counselling and testing. Of those who agreed to be tested, one man and two women were found to be positive, although they were to be taken for a confirmation test the following day.

The number of people who agreed to be tested was extremely high considering the fears that people around the continent have expressed concerning testing. In Botswana, some of these fears include loss of employment and stigma (Wolfe *et al.*, 2006), while Tanzanian women expressed concern over their partners' reactions to a positive test result (Urassa *et al.*, 2006). They also feared any lack of confidentiality (de Paoli, 2004), while participants of a study in Mali refused to be tested because they were sceptical of the existence of AIDS and believed it to be a Western plot to thwart the ever-burgeoning population growth in Africa (Castle, 2003). Indeed, in this study a rural participant told me that her reason for not joining the women's group and participating in the rally was "*We keep hearing it but don't see anybody with it. It's as if they're wasting our time*".

Nearly all of the female participants who went for testing gave reasons for testing which I interpreted as channelling empowerment inwardly for her own use, as a means to do what she could do to protect herself from HIV and its consequences. Evangelina was the only wife to a Christian farmer and was mother of eight children, including a set of twins and triplets. Despite this she was clearly energetic, because she told me that she needed to go and help her mother after the interview and, when I visited her compound, she had just returned from fetching water after a morning of gathering and selling firewood. She had never left her village and had received very little education. Like many of the rural participants, she was unsure of her age, which was also hard to assess because she was small and quick but spoke in an understandably tired tone which, to me, could be read as a bit cynical or wise. Although she had asked me for money and work at the end of the interview, during the majority of the interview she spoke in a way that I took as positioning herself as a woman of immense strength, resilience and empowerment.

C: *So you've been tested for HIV?*

E: *Yes.*

C: *Really?! At the rally? What made you go for the test?*

E: *I want to boast that I'm HIV-free! My husband moves about with other women. I need to know this thing* [health status] *because he's all over this place* [the village]. *Then I will know how to manage myself. At least for my children... and for my peace of mind.*

C: *Knowing what you know* [that he moves around], *would you want to protect yourself with condoms or is that possible...?*

E: *Actually, I see him with condoms. But he doesn't use them with me!* [Laughs].

C: *So do you want more children?*

E: *No, no, no!* [emphatically] *They're too much wahala* [trouble]*!*

C: *So does your husband want more children? Is that why he doesn't use condoms?*

E: *If that man wants more children he'll have to get another wife!*

C: *So you wouldn't mind?*

E: *I beg!*[62]

There are several striking aspects about Evangelina's comments which position her as powerful, particularly when compared to informants throughout the study and participants who were members of the Guides or other groups. First, whether the main reason that she went for the test was so that she could "boast" about her status. This boasting served to protect her from the stigma of not one but two 'dis-eases': HIV and AIDS and philandering. Earlier in the interview, Evangelina had told me that she did not have a single friend in the village, due to gossip. While this was a common remark during the interviews, when compared to other parts of the interviews in which women said that their husbands were either polygamous or polyamorous, the string of uniform responses seemed to point to the husbands' relationships as partial fodder for the gossip. In other words, against the background of her entire interview, it seemed that Evangelina wanted to be able to say that her husband had not infected her with HIV as a result of his infidelity. It was a reclamation of her social standing that seemed to drag "*all over this place*".

Second, she was concerned about her children, but it is unclear in which regard she was concerned. On one hand, perhaps the most obvious regard she had was for their welfare

[62] A common expression in Pidgin English which is similar to a rhetorical 'Are you kidding?' In this context, it was interpreted as "Absolutely not, I wouldn't mind. I really wish he would [take another wife if he wants more children]".

(i.e. feeding, education, development, etc.). While mothering is perceived as a gendered role and one could ask whether the father has a similar concern for his children, it would appear that by thinking of her own health in relation to her childrearing, Evangelina was exercising agency within the patriarchal structure that frames her life. Speculatively speaking, if infected, she would have to look after herself and take up the household duties she performed for her family and her mother. Her concern, on the other hand, may be the extent to which her children would experience the double-edged effects of stigma: the first stemming from HIV and the second from their father's affairs. It is unclear to what extent they had already experienced the latter type of stigma. Nevertheless, Evangelina's concern for her children further positions her as one doing all she can to channel empowerment inwardly.

When viewing her actions within the frame of HIV biopower, then the goal of empowerment that she deploys (encouraging her husband to take another wife to bear him children) can be interpreted as being at odds with the goal of preventing HIV and AIDS. Her strategy to avoid further pregnancies is to allow her husband to have affairs, in the hope that he might take another wife with whom he can have more children. In one way, it poses a resistance to gender expectations of being a 'baby machine', while reinforcing the norm of infidelity typically ascribed to men. It also protects her health from any complications that could arise from having more children. Moreover, it protects her from any possible physical and social ramifications she could encounter if she were to confront her husband about his affairs (i.e. domestic violence, separation or divorce). Yet, in another way, this strategy exposes her, her husband and his partners to HIV. Furthermore, it is by no means the most effective family planning measure. Therefore, her strategy to take an HIV test reveals strength, and she can use the presumably negative result to prove that she was 'wise' enough to escape having HIV through her own tactics.

In lieu of structured meetings or media information, the rural participants' agency was evident through the seeking behaviours they adopted. By inquiring about family planning methods, asking questions about nutrition, child health, infectious diseases *and* AIDS, as well as by going for voluntary testing, participants fed into a more holistic view of their health and their lives. The strategies they designed actually mirror those recommended by experts who have called for more 'integrated services' pertaining to women's health, particularly as mothers (UNIFEM, 2000). In terms of

empowerment, the women extended the range of options beyond those provided to them by the ABC measures espoused by their government-endorsed group. It is one thing to have choices, but the *creation* of choices as a means of empowerment is an area that warrants further exploration.

SYNOPSIS

A specific analysis of sexual behaviour is challenging to collect without access to observation and HIV testing. It is also insufficient to conclude upon analysis based on surveys that assess knowledge of the ABC model or even modes of HIV transmission. Rather, the subjective risk evaluations of Guides and rural participants (about their own vulnerability to infection) and subjective mapping of strengths and resources are more important from a gender perspective of HIV and AIDS and power. The evaluations reveal that women not only adopt strategies to defend themselves emotionally, but also defend the social roles and identity that they deem valuable. Specifically, some Guide participants related the vulnerability of other (rural) women to lack of knowledge and poor education, while rural participants related their vulnerability to their husbands' sexual behaviour. These evaluations indicate that AIDS surveillance practices of targeting certain populations may reduce the risk perception of members of other groups.

Risk of HIV may also be related to identity, as suggested by Joffe (1999), and may also be linked to power relations as suggested by Farmer (1992). Although the emphasis on prevention amongst the Guides and rural participants was placed on the women, this emphasis did not seem to be the successful cornerstone for identity-based prevention. Despite the implied or open acknowledgement of partner infidelity by rural participants, they preferred to focus on ways to increase their income, albeit to carry out tasks related to their gender roles, such as cooking and childrearing. Furthermore, cultural, social and personal meanings of power and relationships sometimes meant that solidarity-based strategies were undermined. In other words, local politics and elections, a history of ethnic marginalisation, suspicion of witchcraft and personality conflicts were some of the barriers to group-based prevention and income-generating activities.

Finally, participants narrated strategies that transcended the options that the ABC model provided for them and channelled these into either providing information to others (Guide participants) or seeking information outside of conventional health facilities (rural participants). These strategies were related to women's perceptions of the social norms of respectability.

Chapter Five explores what options and strategies are chartered by women who attempt to transgress these norms. These discussions further highlight the social, cultural and gender perspectives that shape women's responses to HIV, and serve to illuminate how these perspectives challenge or facilitate the strategies and choices that influence their sexual health and lives in general.

CHAPTER FIVE

Discursive Tensions: Negotiating Sexuality and Agency in HIV and AIDS Prevention

INTRODUCTION

As highlighted in Chapter Two, the notion of HIV/AIDS discourse polices women by charging them with the responsibility to become empowered to negotiate the 'ABCs' of safe sex (i.e., ***A***bstaining, ***B***eing faithful and insisting on ***C***ondom use) with their partners. More specifically, much of the discourse is based on research that tends to neglect the diversity of women's realities and is centred on a monolithic notion of African women as heterosexual, poor and HIV-negative. This research has been politically strategic because it has galvanised international attention and advocacy around gender-based issues contributing to women's vulnerability to HIV/AIDS, not only as women who may become *infected* but who may also become *affected* by having to provide home-based care for infected family members. However, some researchers have been critical of the tendency of dominant AIDS research to ignore the discursive contributions it makes in reifying negative constructions of HIV/AIDS in Africa and of Africans (Patton, 1991; Stillwaggon, 2001). Policy documents and programmes in Nigeria have included women's empowerment as one of its HIV/AIDS prevention strategies - although it remains conceptually unclear.

Efforts have been made by the Nigerian government to empower civil society by engaging them in dialogue and establishing partnerships with international agencies, members of the public and private sectors, as well as women's groups and youth groups. As discussed in Chapter Three, the government, partnered with the World Bank, established the National Action Committee on HIV/AIDS (NACA) to develop policy and coordinate all activities on AIDS. One of NACA's aims was to design HIV/AIDS prevention strategies throughout the country through programmes which empower its participants. Such programmes aimed at empowering participants to prevent HIV/AIDS usually include income-generating activities, attending capacity-building trainings, or organising community-based events such as street dramas and rallies. While efforts were made to target groups traditionally labelled in AIDS research

as high-risk (i.e., commercial sex workers and lorry drivers), many groups remained unrecognised, such as the physically challenged and people in same-sex relationships. The argument of this chapter is that the discursive tensions that exist within women in same-sex relationships pose a practical challenge to the effectiveness of women's empowerment - either as a means to HIV/AIDS prevention or as an end in itself.

The process of being politically marginalised and of being 'written out' of dominant discourse is both problematic and productive. On the one hand, it confirms the epistemic violence that women face with regards to sexuality, particularly when it conflicts with the patriarchal ideology of domesticity. On the other hand, the resulting invisibility can produce resistant agency and subversive forms of organising. This invisibility has implications for individual and collective empowerment, and how these are perceived. Furthermore, economic and legislative decisions framing and contributing to these discursive tensions are made outside of the institutions that seek to facilitate empowerment. Hence, in this chapter, I will illustrate that research on HIV/AIDS prevention rarely addresses the role of the state in mediating the agency of women in same-sex relationships to negotiate safe sex, or to participate in collective action around HIV/AIDS.

In this chapter, I examine research on same-sex relationships in the Nigerian context, with a view to exploring its relationship with the concept of women's empowerment. These issues will be explored with reference to empirical material that highlights discursive and ideological tensions along with their practical outcomes.

EMPOWERMENT AND SAME-SEX RELATIONSHIPS

Central to my argument on HIV/AIDS is the notion that due to a lack of clarity around the type of empowerment recommended for prevention, the idea of empowering women to protect themselves from HIV/AIDS remains unclear and problematic. Other constraints include the diversity of women's groups, collective aims and activities. As demonstrated in Chapter One, women's empowerment through collective action in HIV/AIDS has been espoused as a means to reduce HIV transmission by feminist scholars (Baylies and Bujra, 2000), AIDS experts (Campbell, 2004), development agencies (UNIFEM, 2000) and policy-makers in Nigeria (NACA, 2005). However,

women's empowerment is conceptualised in different ways, depending on the field of expertise, which results in its indiscriminate application into programmes. More specifically, within NACA, its conceptualisation is vague. Its strategy on AIDS (NACA, 2005) mentions women's empowerment three times without offering any explanation of what it means, or as to whether it espouses public health for women and a development notion of empowerment.[63]

Similarly, although women's empowerment is popularly offered as a panacea for gender inequality and other social issues, there do not seem to be any policy documents which explain how the government perceives empowerment.[64] This could be explained by the efforts of both the government and civil society to move beyond the rhetoric of post-Beijing programmes, many of which focused on empowerment and reproductive health (e.g. Klugman, 2000), and respond to the current challenge posed by the United Nation's Millennium Development Goals (UNDP, 2002). In other words, the lack of clarity around empowerment that characterises international documents only highlights how both the initial understandings of feminist and collective movements, as well as more rigorous understandings (e.g. Kabeer, 1999; Parpart, 2002), give way to the opacity that is now also reflected in Nigerian literature and policy documents. However, this ambiguity also provides an opportunity for self-definition, a point raised in Chapter Two and also interpreted from some of the policy-directed activities observed during this fieldwork. Given the numbers of HIV/AIDS initiatives implemented since 2003 and the level of international donor support the government receives, it would seem that the Obasanjo administration has prioritised the HIV/AIDS goal over the women's empowerment goal. Recognising this, a number of women's groups convened in July 2005 to begin to draft a manifesto that would consolidate their concerns over being side-lined. In addition, two informants who serve as directors for two of the women's groups drafting the manifesto shared preliminary plans to work on internationally-led programmes to draft a national policy on gender equality. Until these are produced and published, for groups like NACA there is much value in the ambiguity around empowerment, because this frees them to include it in programme documents without having to define it. For other groups, the ambiguity allows them to implement programmes based on self-defined notions of empowerment.

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63 Chapter One traces both notions of empowerment to Paolo Freire's conceptualisation of *conscietacion*, describing how both models deviate from Freire's notion by emphasising specific activities that sharpen the divide between lay and expert, and ignore broad structural power dynamics.

64 CIDA has plans to work with a few women's NGOs to develop a national policy document on gender equality (Personal Communication with Ejiro Otive Ebuzor, May 2006).

As explained in previous chapters, most of the participants in this study were members of various women's groups who drew on a range of different meanings of empowerment. Many of them referred to activities often mentioned in AIDS discourse, such as activities that help women generate income, learn a new skill or trade, or improve their capacity to lead groups. If women are able to exact agency and make decisions concerning these activities (Kabeer, 1999:444), then these could be considered as resources, one of the measurements of Kabeer's conceptualisation of empowerment. Other dimensions of empowerment include decision-making agency and achievements (*op. cit.*:437). Again, as mentioned earlier in this thesis, there are studies which show that these sources of empowerment contribute to HIV/AIDS prevention (e.g., Green, 2003) while others show that these sources have minimal or no effect (e.g., Campbell, 2004).

However, these studies draw on notions of empowerment that are based on community participation and do not consider contexts where governments criminalise certain forms of participation, and where it is consequently driven underground and therefore is not always observable or indeed measurable. This measurability is a feature of most social change processes required by feminists (Kabeer, 1999:442) who advocate both individual and collective empowerment.

While there may be individual and collective notions of empowerment, the same could be said of notions of disempowerment. While disempowerment is denial of choice, it is not concerned with differences in choice or preference but with inequalities faced in making choices about, for example, using family planning or seeking health care (Kabeer, 1999:448). Also, indicators of decision-making empowerment tend to be heteronormative. While agency is often considered to be successful when it contributes to the empowerment of women as a group (*op. cit.*:457), this may not hold true for women who face legal, social or religious repudiation and punishment as a result of their sexual choices – a point which will be explored by analysing women's experiences later in this chapter. The more immediate aim is to explicate the inequalities women in same-sex relationships face *as a group* in making decisions about their sexuality and health, drawing on popular discourse around same-sex relationships in Nigeria to demonstrate the group's subalterity.

SAME-SEX RELATIONSHIPS, GENDER AND SEXUALITY

The issue of gender and sexuality is one that marks debates on same-sex relationships in Africa. African feminist scholars like Oyewunmi (1997) and Amadiume (1987) have both documented how gender roles have not always been determined by sex and were once marked by a fluidity that has since become more rigid. This research has been used to advocate gender equality in social, economic and political spheres of life. In her ethnography of gender organization in her village of Nnobu, Amadiume introduces the notion of female husbands (where two women are married) to demonstrate how gender construction among this clan of the Igbos meant that "gender was separate from biological sex" (1987:15). Being a female husband was usually a reflection of one's wealth and was used to acquire 'titles', which were the ultimate markers of wealth and power in Nnobu and which was open to both men and women (*op. cit.*:31).

In Nnobu, becoming titled meant that the goddess governing the village had selected a person to become a powerful mouthpiece for the village, and had right of veto over constitutional assemblies. Female husbands were women who were usually wealthy and "first daughters, barren women, rich widows, wives of rich men and successful female farmers and traders" (Amadiume, 1987:7) who married other women for the purpose of acquiring them as labour to work in the female husband's trade. Furthermore, since women with wives did not adopt a masculine role, this practice did not have any bearing on sex/gender roles and relationships (*op. cit.*:7). Female husbands were seen as wives with 'wives' or wives with labourers who could be paired off with a man to provide the male husband with a child. This was usually practised where the female husband was barren or bore only daughters.

Post-colonial and queer researchers have questioned whether Amadiume's (1987) ethnography of gender-flexibility was not suggesting something about the sexuality of female husbands. For Carrier and Murray (1998), the notion of marriage without sex seems implausible. Yet Amadiume resists what she refers to as "prejudiced interpretations of African situations to justify their choices of sexual alternatives" (1987:7). This claim has been interpreted by researchers of homosexuality in Africa as homophobic (Murray and Roscoe, 1998; Blackwood and Wieringa, 1999; Gaudio, 1998). However, I refer to her work in order to show (a) the documentation of same-sex marriage in Nigeria and (b) how same-sex marriage was used to extend the notion

that polygamous marriage not only displayed a male husband's wealth but a female husband's wealth. Amadiume's analysis does more to describe the pre-colonial class structure and gender norms in her village than it does to describe sexuality or desirability within same-sex marriages or, for that matter, heterosexual marriages.

Nevertheless, in a separate study in Lesotho, Kendall (1999) suggests discursive reasons that prevented sexuality from featuring in women's same-sex relationships. Similar to Amadiume's (1987) research, Kendall describes relationships in which married women were allowed to engage in same-sex relationships and, with the support of their husbands, often legitimised them in a ceremony much like a wedding. The women in these relationships (with one of the women being a mother) did not refer to their intimate relationship as sexual. Kendall (1999) argues that, as a result, women's same-sex relationships were viewed as complementary rather than threatening or taboo. Interestingly, both Amadiume and Kendall's conclusions on male supportiveness is based on women's fulfilment of reproductive expectations placed on them by the dominant patriarchal structures of the time. Therefore, women exercised agency by maintaining same-sex relationships within the hetero-normative paradigm of family, which were then perceived as non-threatening and were therefore acceptable because they fed into the patriarchal ideology of domesticity. To an extent, these findings complement Akenova's (2000) study on same-sex relationships in Nigeria, in which she documents the existence of words within several Nigerian languages that do more than suggest that same-sex practices exist and were recognised among the speakers of the languages.

Some African feminist theorists have argued that the patriarchal ideology of domesticity poses an enormous challenge to sexual rights and sexual health for women in Africa (Horn, 2006). Indeed, as Horn (2006) suggests, domesticity has been useful for organising around identity-based rights in various parts of the continent. However, Mama (1997) has argued that this ideology has been used to limit women's agency through the policing of public space and through legislation.

SAME-SEX RELATIONSHIPS, GENDER AND STATE POLICY

The relationship between sexuality, gender and state policy has been played out practically in Nigeria through the introduction of legislation banning same-sex marriages, as well as the freedom of association around same-sex relationships. It is important to note the paradoxical relationship with colonial law and colonial views on homosexuality, along with the anti-imperialist ban against same-sex marriages. Introduced in January 2006, the Bill was seen as a reaction to the protest march organised the previous month by sexual minorities to demand fair access to HIV/AIDS services at the International Conference on HIV/AIDS in Africa (ICASA). The government's expansion of the Bill to include a ban on entry for same-sex couples who marry outside the country can be read as nationalist resistance to pressure from certain groups in the West. President Obasanjo confirmed this through a statement offered by the Minister of Information, who represented him in a press conference in which it was relayed that the ban was a pre-emptive step against developments that have occurred in other countries (BBC, 2006). 'Other countries' can only be taken to mean countries in which same-sex marriages are legal (such as South Africa).[65]

Hence, nationalistic tones of the newer Prohibition Act subsume the colonial flavour of the previous anti-gay law as part of the state's stance against homosexuality. It can also be seen as a stance alongside other African governments (such as Zimbabwe) who have distanced themselves from the South African government's move to allow same-sex marriages, which is viewed as embracing what some authors see as the sequellae of (neo)-liberal ideology as a result of its post-apartheid relations with the West, which has resulted in ambivalent relations with other African countries whose resistance of South African ideology and hegemony is reflected somewhat in the latter's bilateral economic relationships (Alden and Soko, 2005). Here, the state has taken a stand against the popular claims that homosexuality did not exist. However, the government's perspective appeared to suggest that, if it did, it was a Western phenomenon. Again, similar expressions of this sentiment have occurred in other parts of Africa, particularly Zimbabwe (Epprecht, 1998; Aarmo, 1999). Hence, since patriarchy is embedded in the procedures of a state's way of functioning (Connell, 1990:517), I would argue that beneath the laws and culture lies a popular anti-Western

[65] Newspaper editorials commented on the possibility for Nigerians in same-sex relationships to travel to South Africa to wed.

assumption and a growing anti-hegemonic sentiment that homosexuality inverts gender roles in a way that threatens family life, masculinity and nation. In particular, men and women in same-sex relationships (especially those who are exclusively in same-sex relationships) are regarded by the government to be challenging hetero-normative gender roles and what is seen to be accepted as Nigerian values, and more broadly, values associated with 'African' or 'black' identity.

SAME-SEX RELATIONSHIPS, GENDER AND COLLECTIVE EMPOWERMENT

How then, can empowerment be characterised in research on same-sex relationships and HIV/AIDS? As discussed in Chapter Two within feminist development studies, Kabeer (1999) argues that empowerment can be characterised by resources, achievements and agency. Agency, in the context of empowerment, includes not only the ability to choose, but also the availability of options to choose from. In situations in which women's social status is increased, agency takes on a transformatory character, while in situations in which there are social constraints impeding decision-making, agency is said to take on effective characteristics. Choice is qualified by referring to inequalities rather than difference:

> "An observed lack of uniformity in functioning achievements cannot be automatically interpreted as evidence of inequality because it is highly unlikely that all members of a given society will give equal value to different possible ways of being and doing" (Kabeer, 1999:439).

Choice is further qualified by the possibility that women may not regard the inequalities they experience as unjust, and instead internalise them. These two qualifications, Kabeer acknowledges, pose a challenge to the equation between power and choice.

This challenge underlies a central component to my argument, part of which rests on identifying how the government's legislation, which is steeped in the patriarchal ideology of domesticity, contributes to the tension between demanding recognition on the basis of collective identity or sub-alterity. First, by removing the right to the freedom of association, the Bill forces advocates of same-sex relationships to organise

on a basis other than their sexuality, which has had profound effects on organising around HIV/AIDS. For example, the effort to manoeuvre between effective and transformatory agency was evident in the different ways two 'senior' members of an underground network of women in same-sex relationships participated in the International Conference on AIDS and Sexually Transmitted Infections in Africa (ICASA). Inside the main conference, some of the more senior members of the lesbian group demonstrated their effective agency by participating alongside members of mainstream women's groups as speakers or facilitators on topics related to sexual rights, pleasure and choice, which were positioned as prerequisites for reducing HIV/AIDS. They were able to do so because they were each affiliated with a formal NGO that implemented programmes on gender and sexual health in partnership with other women's NGOs. The underground network maintained relationships with mainstream women's groups on the one hand, and the network of homosexual males on the other.

Outside the main meeting hall of the conference, another senior member exercised transformatory agency by rallying for HIV/AIDS services. Mainstream women's groups' rallies, which were open to everyone, were used to draw attention to the way in which gender mediated risk and treatment around HIV/AIDS, yet only a few members of the underground network participated. Gender mediated formal participation, while sexuality mediated less formal participation.

However, this transformatory agency has been restricted in a number of ways. During the ICASA conference, men and women in same-sex relationships rallied for access to fair and appropriate HIV/AIDS services that were tailored to their needs, based on their sexuality. They were among several groups, including the physically challenged and women living with HIV/AIDS, who staged mini-protests to demand access to HIV/AIDS services, yet it was the rally organised by men and women in same-sex relationships that triggered additional anti-gay legislation. The effects of such legislation are perhaps made more noticeable over a period of time. In 1995, in response to the public display of book stands by gays and lesbians in Zimbabwe (GALZ) at the International Book Fair in 1995, President Mugabe made public reference to gays and lesbians being 'lower than pigs'. After ten years of government harassment, his Non-Governmental Organizations Act removed the right for many groups to organise, thus thwarting their collective empowerment. GALZ, in particular,

continued to be targeted and was eventually forced to work with a lower profile. This 'lesbian-baiting' or 'sexuality-baiting' occurs when women's groups are harassed to the extent that they limit their expression (IGLHRC, 2005).

The Same Sex Marriage Prohibition Act serves as a vehicle of sexuality-baiting and thus restricts the choice of women in same-sex relationships to organise, based on their identity. The practical (and gendered) effect of this is evident in funding mechanisms. The government recently allocated a grant to the network of homosexual males to assist in documenting HIV/AIDS prevalence rates among the group. The members of the underground women's group have received funding in the past, but only as it relates to issues of heteronormative sexuality. This is often received in partnership with a mainstream women's group. The receipt of these grants is predicated on the adherence to the ideological notion of domesticity that serves as a platform for women's participation (as noted in Chapter Two). Hence, I would argue that the anti-gay legislation has contributed to a setting of competition for scarce resources as well as homophobia, whereby women in same-sex relationships risk further collective marginalisation in relation to other marginalised groups who are able to receive funding or support on the basis of their identity.

It is against this background that the following section seeks to explore how women construct their same-sex relationships, with a view to understanding how features of these relationships impede or facilitate their empowerment either individually, collectively or both. Particular interest is paid to how participants negotiate between subalterity and identity and how this, in turn, might influence their ability or desire to negotiate safe sex with partners. Rather than provide an account which 'witnesses' the occurrence of lesbianism or same-sex relationships amongst women, this chapter aims to draw attention to the challenges that exist in trying to empower *all* women with current modalities of HIV/AIDS prevention.

DISCURSIVE TENSIONS AND SAME-SEX RELATIONSHIPS

As noted in Chapter Three, the data relies on interviews with women who agreed to be interviewed *and* for their accounts to be included in the study. Furthermore, the extracts in this section illustrate the tension that exists between subalterity and identity-based collective empowerment. All but one expressed fear of being recognised as being associated with the network or with its members. Each participant also expressed the fear that the interviews could be interpreted as one of the types of meetings or activities mentioned in the Same Sex Marriage Prohibition Act. While conversations were held with a small number of women in same-sex relationships who had no affiliation with the underground group, transcripts of these were not included in the analysis. Selection criteria included that the participants must (a) live or work in Abuja and (b) have an affiliation with, or be a member of, the network in Abuja.

This was for two reasons. First, there was a need to distinguish between the accounts of women who participated in what is, in popular discourse, considered a fad among the members of elite groups. Some conduct business between the major cities (such as Abuja, Lagos and Kano) where they 'keep' partners or girlfriends. More importantly, members of this group could afford private health care overseas, and as such may not feel the need to demand services as a collective group. While these conversations have contributed to the knowledge about same-sex relationships in Nigeria, these accounts have not been included in this analysis. However, this dynamic suggests that the burden for protest rests squarely on the shoulders of those who do not have the money or position to seek health care outside the country - a point which will be explored towards the end of this chapter.

Second, the view was taken that Abuja-based participants would more likely be able to offer insight into HIV/AIDS programmes which are rated quite high in comparison to other cities. Therefore, if people feel disempowered and disenfranchised from services in Abuja, it would be unlikely that they would feel more empowered elsewhere. However, during the course of the research it became clear that the presence of government officials and services has the opposite effect in that people, and indeed participants, felt policed in Abuja. This sentiment is one that is described in Chapter

Three as being what was interpreted from informants' comments as a consequence of living in a post-military state.

As also mentioned in Chapter Three, Abuja has a population of 1.3 million which seems large, but the majority of the population live in the ever-expanding peri-urban areas of Abuja, as opposed to the urban centre where many people work and engage in leisure activities. It is also a commuter town, because people travel from different areas to work, have meetings or attend conferences. As a result of this and its size, Abuja has yet to develop many leisure centres and, as such, has few public meeting areas. Consequently, many people use fast food restaurants and hotel lobbies to hold meetings (which is where the interviews took place, at the suggestion of the participants).

Some areas of Abuja are informally and unofficially known as 'gay areas', such as parks (for homosexual men) and a certain hotel (for women in same-sex relationships). Hence, it is easy to run into people or even recognise people one may have seen in any of these few public meeting areas. More and more, participants said they wanted to avoid any harassment. Also, the first day of interviews with members of the group happened to be the same day the Bill was announced. Holding the first interviews on the same day as the Bill being announced was purely coincidental, as I actually learned of the announcement during the interviews. As a result, the number of interviews which had been scheduled months earlier with the help of the leaders of the homosexual and underground lesbian groups decreased, as it was agreed that it would be safer for all parties concerned to keep interviews to a minimum. Finally, like many other groups interviewed, they felt it best to conduct the interviews after ICASA. As a result of these concerns and considerations, the names of participants have been changed and their confidentiality and anonymity guaranteed.

Participants seemed marked by some level of ambivalence, which could be interpreted as a survival strategy or effective agency. On the one hand, they were involved in relationships with other women, and on the other hand they were also in or sought relationships with men, thereby appearing to adhere to the ideology of domesticity. Given the restrictions on collective identity-based empowerment which is highlighted by the Same Sex Marriage Prohibition Act and imposed by Section 214 (the law against homosexuality), the following section seeks to explore pathways for empowerment through an analysis of participants' representations, which include

physical and social vulnerability, intimacy and risk, resisting judgement, identity and behaviour, support and acceptance, and empowerment and rights.

Pragmatic Identity Alignment

Along with the prevailing political, cultural and religious norms that castigate same-sex relationships, pragmatic identity alignment is one of the conditions that creates a context in which safe sex is not practised, even when it is desired by one partner. Across the various groups, one of the factors upon which women based their risk assessments (i.e. whether or not they were at risk of being infected with HIV) is their identity. Women tended to adhere to an identity that was socially acceptable, not just broadly but within their immediate community, including the women's organisation to which they belonged. With respect to women in same-sex relationships, refusing to identify as lesbians decreased their risk perception which, in turn, meant it was less likely that they would consider safe sex an option.

Etoro, a shop attendant in her twenties, was a participant whose interview exemplified discursive tensions through her description of sex between her friends as a marker of friendship, rather than one of sexual identity. At the time of the interview, she had been forced to leave university due to lack of funding and had taken up work as a shop attendant. She had recently joined a church and started dating a young man whom she worked with and took to church. While she rejected the term 'lesbian', the sexual behaviour was one she both recognised and had practised:

C: *Okay, one of the last questions... do you know of any women who have relationships with other women...*

E: *You mean... like... how?*

C: *Mmm... like the way you have a boyfriend, instead you'd have a girlfriend... Someone who practises lesbianism.*

E: *I have a friend who sleeps with other girls. In fact quite a number of my friends in uni.... You know how girls are. Especially the one I was talking about.* [Pause]. *Ah! But does that make a person a lesbian?!* [laughs].

C: *Well, what do you think a lesbian is?*

E: *I mean someone who... Well, like for example, the friend I'm talking about... the* [physical description] *one... she has a boyfriend.*

C: *Okay, so she had a boyfriend and a girlfriend?*

E: *They're not her girlfriends like that* [romantic relationship]. *We're all friends, so we just used to move together like that. In another way, sh...* [unclear].

C: *You too?*

E: [Smiles then looks away].

All the participants, at some level, resisted labelling. This resistance to identify as being lesbian or in a romantic or 'serious' relationships poses a challenge for any collective empowerment through political recognition for the few who wish to demand rights on the basis of their sexual orientation. Though these terms are used in popular discourse in Nigeria, the term (in English) could be seen to have more resonance with members of the middle to upper classes, some of whom may recognise the terms from sensationalist articles in newspapers and magazines about unidentified celebrities who are rumoured to be bisexual (Gaudio, 1998). Trivialising lesbian behaviour and sex features in Gaudio's ethnography on male lesbians in northern Nigeria. Here, he describes how male lesbians trivialise their behaviour as 'playing' in order to disassociate themselves from the female role in relationships, which was derided by more masculine homosexuals. As in many societies, the English word 'lesbian' is also trivialised and often used in a derogatory manner to describe women who hate men, or is used to speculate about the lifestyles of successful women who are unmarried past a certain age. Therefore, the term is met with resistance. However, discursive strategies may exist in local languages, but this would require further research.

What was striking was the simultaneous recognition of the term alongside her choice not to identify. This mis-recognition (Fraser, 1997) has been explored in urban studies on participation and empowerment (Perrons and Skyers, 2003) and could be useful for characterising similar tensions that exist within marginalised groups, such as same-sex networks. Etoro offers her friends as an example of lesbians whom she knew, but rejects the term 'lesbian' as an identity category. However, she qualifies her response by laying emphasis on friendship. This pointed marker sets out a difference between behaviour and identity, while also highlighting friendship as a source of empowerment.

Assessing Risks

There were two instances in which participants expressed concern over partners' perceptions that they were not having sex. Sadatu, another sexual health educator, described herself as having same-sex relationships with women, some of whom she said referred to their physical relationship as play rather than as sex. Sadatu was a mother in her late twenties and, at the time of the interview, had recently separated from her husband. Despite the separation, her 'modern' husband had granted her possession of their marital home. She argued that this was because he rarely stayed at home in the first place, so it was easy for him to leave her with the house. Moreover, she said that being left with the house hid the fact that they were separated - a fact she said neither of them were ready to share with their family and friends, particularly because of their infant son. Similar to Rose (see later), Sadatu earned a living working as a health educator with various NGOs. Following the birth of her son, she began supplementing her income by selling both conventional and traditional sex aids, which she referred to as "*toys and enhancers*".[66] She recognised that her status as a married woman allowed her to engage in her trade and discuss sexual issues more openly than if she were single. Sadatu was one of the few women in this group (and throughout the entire study) who said she could negotiate condom use (n=2). However, she describes her experience with female partners differently. Based on her own success with her husband:

C: *So, how do you protect you and your partners from HIV?*

S: *Some of them* [partners] *don't think we're having sex because there is no penis entering the vagina. Even them, they need to know what it is we're doing... A game, eh?! Then I start to ask "when you have sex, where do you touch? When you play, where do you touch?"* [Exasperated gasp]. *You know?!*

C: *And how do they answer?*

S: *Well...?* [shrugs] *Some laugh* [...] *Like it's* [physical relationship] *just playing.*

C: *So no protection?*

S: *...n-no. From what? When there's no sex?*

C: *But you said you could do it* [use protection] *with your husband. How did you manage that?*

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[66] Sexual aids are customarily sold in Abuja and other cities in Northern Nigeria. It is common to see male vendors selling them by the roadside, along with cigarettes and other wares. Women also sell them, but from their stalls. A few participants confirmed that, as part of their preparation for marriage, young women or brides were given sexual aids (such as potions to enhance sensation) and advised on how to use them.

S: *You know, when I tell other women about condoms, those who know us* [my husband and me] *say it's because he trained over there* [abroad in the UK] *and stayed for so long. Then I ask them "if he's so different, then why are we using condoms? Oooooh! But aside from that, there's a way that a woman can convince her husband and he won't even know what's happening. She can use it to play with her husband, you know...* [laughs]. *"Darling, come here"* [she simulates swinging a condom in circles]. *And you just... you know...* [silence].

C: *Ah, but can everyone do that?*

S: *Well, not everyone can do that. My own* [problem] *is that... well, anyway. I was just tired of having to do that* [having to negotiate safe sex with her husband].

Sadatu's example is similar to one of two studies in which same-sex relationships were explored in other parts of Africa. Kendall (1999) notes similar behaviour among lesbians in Lesotho, where she describes lesbian relationships as having occurred alongside heterosexual relationships during the period before Lesotho's independence. She describes relationships in which married women were allowed to engage in same-sex relationships and, with the support of their husbands, often legitimised them in a ceremony much like a wedding. She suggests that these relationships were permitted because the women did not refer to their intimate relationships as being sexual. For them, sex was not possible without a penis. Therefore, by characterising their relationship by the absence of *koai* (penis), women were able to maintain relationships with both men and other women. Like the Lesotho women, participants adhered to the ideology of domesticity by dating or marrying men while maintaining their same-sex relationships.

However, unlike the participants in Kendall's study (1999), participants in the current study reported that their male partners were suspicious ("*That's what girls do in secondary school*"), although their suspicions were not confirmed. Thus, same-sex relationships were carried out in secret as a means to keep the heterosexual relationship intact. Indeed, the ambivalent nature of this 'bi-sexuality' can be seen as a subversive strategy that resists the limits of categorization (Hemmings, 2005c) and naming, thereby serving to protect individuals from criminalization, social ostracism, as well as from divorce.

Sadatu's example is striking in that, on one hand, she seemed able to speak openly and candidly about sex in her personal and professional life and was even able to 'play'

with her husband as a way of negotiating condom use. On the other hand, she found such negotiation with her female partners difficult, precisely because they referred to it as 'play' and not sex. With her husband, negotiation is discussed in relation to personal attributes, such as creativity, education, etc. That is, safe sex negotiation sometimes depends on the personality and background of couples, as well as the consent of both partners. At the same time, however, negotiation with same-sex partners was relayed in a way that could be interpreted as lacking power, skill or knowledge. From the excerpt, one can see that, in Sadatu's case, lack of skill was not the problem. In fact, as an educator, she was quite knowledgeable. In addition, personality and background cannot be interpreted as barriers to safe sex because in her same-sex relationships, Sadatu considered herself to be equally or even more empowered in terms of finance or education when compared to her partners. Furthermore, it would be simplistic to say that Sadatu lacked knowledge about HIV/AIDS transmission, because she displayed knowledge about safe sex methods used by heterosexual couples. Perhaps a fairer assessment would be that her knowledge is incomplete. Therefore, I would argue that what the above-mentioned contradiction (being able to negotiate safe sex with her husband but not with her female partners) points to is a lack of information on alternative safe sex measures.

The lack of information on alternative safe sex measures goes beyond Nigerian borders. Research on same-sex relationships has focussed on homosexual males or 'men who have sex with men'. Most research on bisexuality and HIV/AIDS is focused on men (Aggleton, 1996). This may be due to the biomedical evidence indicating a causal link between bisexual behaviour amongst men and HIV/AIDS infection. There is considerably less evidence linking women in same-sex relationships to HIV/AIDS. The only evidence of this type of transmission was published as a clinical report as recently as 2003, where it describes one of the partners as being bisexual (Kwakwa and Gohbrial, 2003). While it appears that this single publication diminishes any causal link, the biomedical parameters around what can be considered a causal link influence the publication of HIV/AIDS research. In other words, a link between sexual behaviour and HIV/AIDS was established because their research 'subject' was not involved in any other behaviours which the United States Centers of Disease Control (CDC) regard as risk factors, such as intravenous drug use or commercial sex work. Interestingly, while sexual activity with another woman is considered by CDC to be a 'minimal' or

'undetermined' risk, the CDC do not consider heterosexual sex to be a risk factor in HIV transmission.

However, while it appears that discursive tensions, in particular negotiations over what constitutes sex and play, pose challenges to safe sex, it is evident that other enabling factors (such as personality, couple consent and skills) can be harnessed in safe sex negotiations amongst heterosexual partners.

Balancing

A number of strategies ensue as a result of discrimination, some of which do not empower women to engage in safe sex, but do empower them in other aspects of their lives, such as avoiding the sometimes pernicious effects of being identified as a woman who participates in same-sex relationships.

There were only two instances in which public identity-based rallies were advocated by participants. Rose had links with mainstream women's groups because of her feminist activism and sexual health education, yet she was extremely discreet and protective of the identities of other members of the underground network, facilitating more tacit ways of organising. On the one hand, Rose expressed (see later) concern about public organising, because of the potentially disruptive and dangerous consequences it could have on members' personal lives and safety. However, on the other hand, she appeared to be frustrated with what she perceived to be members' "*comfort in the closet*" and their reluctance to fight for their sexual rights and forgo the "*so-called privileges*" associated with heterosexual marriages or relationships.

R: *It's just like we need air, these* [sexual issues] *are natural necessities of being who we are. They talk about morality. Whose morality? Morality is shaped by certain contexts. So we need to know whose context is shaping these moralities.*

C: *Do you find that, it's like they say? That Nigerians are too conservative to have these discussions?*

R: *Is it not the same Nigerians who are doing it [*having same-sex relationships]*? If it were the foreigners who were coming in to do it here and going away, then we'll take it* [same-sex relationships] *away. But when you say that Nigerians are conservative, yet we're the ones who are doing it...*

C: *So how do you get people together?*

R: *Let me tell you what. When we had the meeting around the rally, we discussed this. Sometimes we are so comfortable in our little closets but no one needs it to be politicized... because you could be stoned! So we hold onto so-called privileges. But instead of enjoying the sex, you're there thinking of the legalities of the sex! So leaving it in the closet creates that peace... or even a fantasy for you.*

C: *It makes it* [life] *better for you.*

R: *Exactly! This is a safer option for some of us. I mean, the question was: why is it that the girls* [in the network] *who have relationships with other girls engage in all this secrecy? It's so that people don't target them! They're creating safety nets for themselves.*

C: *And what about you?*

R: *Me?*

C: *M-hmm.*

R: *Well... what else can I do? So many girls come to me for help. Even me, I still need help. Like now, after this* [interview] *I'm going to* [venue] *to see my mentor. How won't I help another person? They go through all sorts: they're beaten, thrown out of the house, forced to be in marriages they don't want to be in... For what?!*

So, for Rose, the participation in the HIV/AIDS activity network may not be as much about protection as it is about recognition. She is frustrated with the reluctance of network members in same-sex relationships to identify, yet is simultaneously sympathetic to the consequences endured by those who choose to do so. However, she appears to say that she has no choice but to choose: "*What else can I do?*". While empowerment may not exist collectively on the basis of identity, or HIV/AIDS, I would argue that subalterity is potentially empowering in that it can be used to mediate protection from violence.

Support and Acceptance

Most participants in same-sex relationships in this research described their relationships in terms of friendship and nurturing, which could be seen as an active strategy to mitigate the discrimination people in same-sex relationships fear and experience, which creates a condition leading to pragmatic identity alignment and consequently low risk perceptions regarding HIV/AIDS transmission.

An interesting example of an oft-cited source of support and acceptance was Rose, who appeared to be a central figure in the network. This was particularly striking as Rose was also a mother as well as a women's rights advocate and sexual health educator within a formal NGO. At the time of the interview, Rose received a monthly stipend due to her affiliation with the NGO, which she said she used to educate her children and fund her underground work. She ascribed this to her experience of social exclusion that she receives as a result of her sexuality, which poses a challenge for income generation.

The importance of having support and acceptance from a mentor was one that Rose said played a role in her own life. For example, Rose said that she met regularly with a mentor who advised her on family life, making money, how to survive social ridicule for being in same-sex relationships and how to advocate in subtle ways (strategically yet carefully). Rose was concerned about money, which she got through income as an educator, through her affiliation with an NGO, and from her children's father. This contradictory role (and contradiction) was one that she was aware of. Contradictory because her advocacy for same-sex was funded because of her past relationship with a man and from her work and affiliation with mainstream (heterosexual) women's rights advocacy groups. Furthermore, funding the group in this way led to potential romantic encounters.

C: *So now that you're in town, how will you coordinate with the others?*

R: *Well, like now, I've not called any of them. If I call one, then all of them will call me. And I'll have to share my monthly budget.*

C: *Oh, so do you always do that?*

R: *No. I have* [number and sex of children]. *I pay all the school fees, I pay the rent. Feeding alone is* [amount in Naira] *every month. And you know what he's* [father of her children] *sending to me, there are things we need* [in the house] *and I have to send things* [to the kids at school]. *Then he* [pointing to male alongside] *sends me someone and he's telling me to buy four types of books for her. So I have to dodge those girls. I can't put my primary responsibilities away so I just have to flow with them.* [Imitating a younger girl's voice] *"Oh come. We'll take you out" and some. Before I come down, the motherless* [the girls] *will ask me "Do you want to take a drink?". I say no but...*

Male[67]: *I've stopped all of that. I tell them I'm going nowhere. 'Just leave me alone'.*

[67] This was an impromptu interview which developed as a result of my meeting with the male participant. When I explained my interest in including women who sleep with women, he phoned a few members of the

C: *So what do you do?* [Directing my question to Rose]

R: *They just hang around. Just to supplement, supplement, supplement. That's the primary thing. The relationship has been designed for you in seconds.*

R: *Why is it that every girl referred to me always thinks it's for a relationship?* [Pause] *I'm surprised, I wonder where...* [Unclear].

Male: [Unclear] *...because they always come to me... most of them have been girls who have been starved of affection and all that.*

R: *So you're the one advertising...!*

Male: *No, I'm telling you! They find out that when I say "there's a lady who will listen to you, who will speak with you". Then see the way you talk on the phone 'hello darling' or 'hello dear, how are you?' you sound so accommodating and all that so it raises their hopes.*

In one way, Rose identifies with women in the informal group, but through her formal group and the small assistance she receives from the father of her children for their support, Rose provides for other women. This is interesting in that collective empowerment is problematised and discussed in terms of marginalisation and withheld income, acceptance, etc., but is channelled through Rose's affiliation with non-network and heterosexual means of support. However, it would be a mistake to say that the women are simply mercenary, although Rose makes it seem like that at first - "*supplement, supplement, supplement*". Her experience shows the subversive ways of keeping informal networks active but, more importantly, looking after the girls. Perhaps greater than her monthly budget is Rose's ability to relate to the situations faced by other women within the network. They risk losing material and affective aspects of empowerment, such as money and family support, which they are denied when they 'come out' or are 'found out'. Hence, support and acceptance is a central feature of the network and a potential source of empowerment.

Another participant who resisted 'lesbianism' as an identity category simultaneously identified her relationships as a marker, not only of friendship, but also of choice. Therefore, in contrast to Smiths' (2000) study, if female university students were more sexually promiscuous as a result of modernity, it was with men. In this example, the choice was expanded to include both men and women. Fola, a university student, had had sexual relationships in secondary school and continued to do so in university. At

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underground lesbian network, one of whom joined us immediately. As this meeting took place on the day the Same Sex Marriage Prohibition Bill was announced, we all agreed it would be safer if he stayed. Also, the conversation was much more productive with him there since it was the first time Rose and I had met.

first, she described her relationships with her female friends as exercising personal choice and agency, but then she suggested that her relationships were characterised by other features:

C: *So, you mean....you - oh, so you have both* [boyfriends and girlfriends]

F: *Of course. Who doesn't want to catch their fun?*

C: *So what does your boyfriend think about that?*

F: *Is it his business? After all, I'm sure he has other girlfriends, too. You know how guys are. Don't get me wrong, I like him but I don't think he's the one for me. But like, most girls have a boyfriend on campus so it's* [unclear] *nice to have him, you know, we go to parties, hang out, etcetera, etcetera. But I don't think he's like, my life partner or anything like that. I mean, both of us are too young to marry now... She's not going tell all these things right? You told her about...* [looking at Etoro]. *Well like she* [Etoro] *told you, there's somebody else but he doesn't stay in Abuja. He's based in Lagos.*

C: *Oh, dear. Long-distance!* [sigh]. *So is he the one?*

F: [Sighs and smiles]

C: *That must be hard. So how do you manage* [the distance]*?*

F: *Hmph! It's better for me. I'm so busy with uni*[versity]. *Besides when he comes in, he takes me out, you know, buys me things....*

C: *But don't you think your boyfriend suspects.*

F: *I'm sure he knows in deep down in his heart... just like I know when he takes calls from other girls.*

C: *So do you get worried? What about protection?*

F: *Ah, I play safe! One has to because you never can tell what these guys are up to.*

C: *Do you think he knows about you and your friends?*

F: *Which one?*

C: *Which one?! The one here. The uni one.*

F: *One time he said something like it... because we're* [Fola and her friends] *always together, and sometimes we talk in code around him, so that he doesn't know what we're talking about. We do that with most people. You heard us, right?*

C: *Like a gang.*

F: *Yeah,* [laughs] *they're my peeps, you know what I'm sayin'?!* [says in 'American' accent].

Fola's portrayal of a 'catching fun' is unmistakably a Nigerian discourse, commonly used by university students and graduates and referred to in HIV/AIDS media campaigns which often highlight the risk behaviours of university students. But her choice is to also pinpoint the government's role in promoting or hindering sex messages that move beyond penetrative heterosexual sex.[68] For some participants, sex between women was safer because it did not involve penetration, which experts believe to be the main cause of HIV/AIDS transmission.

Mainstream media such as television, radio and billboards were the source of prevention information for all participants; although two were dissatisfied with messages that 'did not really concern them'. In order to obtain alternative messages, they sought advice from the Internet when they could afford to use an internet café. They had also begun to seek ways to channel their information more broadly. For example, with the hope of developing an alternative radio programme, one participant began interviewing other same-sex couples to document practices, part of the aim being to identify how couples could protect themselves. Another participant chose to subtly introduce her new knowledge with friends and other members of her immediate network by weaving it into the conversations that take place during bridal preparations. In her village, the focus of these preparations was advice to the bride (and her friends) on sex, marriage and childbirth. For the participant, this traditional practice created an alternative venue for disseminating information. This could be considered a form of peer-education, which researchers have found to be successful in countries like South Africa (Campbell, 2004). While the impact of these alternative strategies requires further research and evaluation, the interim effect is that individuals may be under pressure to develop and finance these strategies if they are to have any far-reaching effects.

Resisting Judgement

Of all of the participants in this group, only one had been tested and knew her status. The rest of the participants expressed reluctance at having an HIV/AIDS test due to the fear of judgemental attitudes of the staff, thereby echoing the fears and confirmations

[68] There was anecdotal evidence of men and women engaging in anal sex and other non-penetrative modes of sex, as these were seen to be safer. Smith, who obtained similar evidence, points out that by ignoring anal sex from safe sex messages, prevention efforts may be encouraging it (2004:435).

of women who had already been diagnosed as positive. The challenge expressed most often was the need to be completely honest about their sexual history, thereby risking judgement from health workers. According to Sadatu, a sexual health educator, during an interview:

Male: *I'm saying that some people go down drastically, maybe there's a strain that takes gay people very fast. Those are the types of things we need to know.*

C: *Yes, and it's good to go for testing early...*

S: *Testing early... you know there are some other issues we need to discuss. Like, when you test, you need to know your sexual history.*

C: *Yes, that's true. If I were counselling you for testing now, I would ask you about your history.*

S: [As a patient] *you have to be sure that you don't provide the information* [your sexual history] *so that the next time you go for a session, they* [health workers] *are not judgemental.*

C: *It's true. So many people have complained about that.*

S: *I mean - they're so rude in the first place. If they don't want to do the job, they should leave it for others who want to do it.*

Male: *You're supposed to be looking after people, meanwhile you're making their lives hell. That's why most of us don't bother going back. Even if you've been found positive. That's the worst! They* [health workers] *should go* [away]*!*

C: *Ah, but where will they go? It's so hard to find work.*

S: *Hmph! Not in HIV!*

C: *So has it* [judgemental treatment] *happened to you?*

F: *No. Fortunately for me, they tested me when I had my son.*

C: *Did they tell you they were going to test you or just give you the results after the test?*

S: *I had my son in* [name of hospital]. *So it's not like all these* [government] *hospitals where they hand you your baby and your* [unclear] *test results. No, they asked me, although I thought it was compulsory, more or less.*

C: *Had you been tested before that?*

S: *No! It was just because of my son that I felt it would be good to know* [HIV status].

The striking aspect here is that Sadatu was, like most new mothers, tested for HIV/AIDS when she gave birth to her son, but suggests that she would not have been tested if it had not been for her maternal status. She also suggests that this is due to the

'confessional' (Foucault, 1990) aspect of HIV/AIDS counselling and testing, whereby sexual history is obtained to determine the possible spread of the virus and to recommend appropriate prevention methods. Furthermore, the discussion about testing is initiated through the trope of same-sex identity while testing occurred, but in practice, through choosing not to identify. However, while it would be easy to dismiss this as passivity, this experience is predicated on exercising subversive agency in resistance to policing, as well as Sadatu's strategic adherence to notions of domesticity.

This example also raises the issue of the quality of health care and the type of capacity-building offered to health workers. Health workers' discriminatory attitudes and practices towards people with HIV/AIDS have been documented (Letamo, 2005; Reis *et al.*, 2005), while evidence of these practices is well-circulated in popular discourses. Much of the evidence includes reports of health workers who refuse to attend patients with HIV status, or who use patient histories of sexual behaviour to ridicule and reprimand patients.[69] While NACA's chief promised that the agency would undertake measures to ensure that homosexuals and lesbians would be tested and counselled without discrimination, it remains unclear how this would happen, or what the consequences would be to people who reveal their sexual history in health centres - the vast majority of which belong to a government for whom the issue of rights appears to be of little consequence. Finally, it is true that agencies (such as Engender Health) have offered health worker training, but this addresses clinical issues of infection, prevention and control rather than health worker attitudes.

This example raises the second issue - that of affordability of care. A few informants expressed their lack of interest in participating in AIDS-related rallies, due to the fact that they could afford treatment if they had HIV. Hence, this suggests that economic empowerment or, conversely, poverty and class, could be an issue simultaneously underlying and contributing to the discursive tensions that exist amongst women in same-sex relationships.

SYNOPSIS

[69] Personal Communication with colleagues and journalists. For empirical accounts from female participants living with HIV, please refer to Chapter Six of this thesis.

These examples highlight the contested nature of participation, as opposed to more essentialist notions. Not all of the respondents chose to identify. They show ambivalence rather than set predetermined ways that fall on one side of a binary or the other. However, since most participants indicated subversive modes of interacting, this suggests that sexuality and gender are negotiated in efficient ways of empowerment, rather than by transformatory ways, at least amongst the women in same-sex relationships in this study and in the way that Baylies and Bujra (2000) suggest through their research on women's participation in Tanzania. Nonetheless, AIDS experts and researchers need to acknowledge complexity of participation around identity and address the dynamics that mediate individual and collective empowerment within marginalised groups.

CHAPTER SIX

Christian Women's Responses to HIV/AIDS Prevention

INTRODUCTION

In contrast to the underground lesbian group discussed in the last chapter, Christian participants described what could be interpreted as an enabling environment in which they were able to reconfigure their identity in a way (as I aim to demonstrate in this chapter) that positively influences their decision and ability to engage in safe sex. In the previous chapters, particularly the last one, we have seen how identity, along with other factors such as access to information and services, can either have a positive or negative influence on how a woman assesses her risk of contracting HIV. In this chapter, I describe how single and married Christian women draw on particular discourses, which I understand to be some of the ways in which they mediate church membership to reconfigure meanings associated with their gender identity, sexuality and vulnerability to disease.

To establish how Christian participants' reconfigurations of gender identity through church membership influenced their sexual decisions, I present and analyse evidence elicited through participant observation and semi-structured interviews conducted in Abuja. Each participant interviewed said that she practised some form of safe sex and attributed this to her religious beliefs, as well as to church membership. Moreover, some participants delineated the church activities and processes that they believed contributed to their sexual behaviour to some extent. I also observed some of these activities and interpreted the ways in which they may have either contributed to, or hindered, participants' sexual decisions and reported behaviour. As a result, participants' responses to HIV prevention contrast sharply from those described in previous chapters.

In this chapter, I will demonstrate that this difference is due to the ways participants drew on aspects of their involvement in church activities and, in particular, how they drew on a spiritual conceptualization of power to not only reconstitute gender norms

and navigate gender relationships, but also to give meaning to broader political and socioeconomic situations which shape these norms and relationships.

As argued in Chapter Two, the failure of AIDS prevention programmes has led researchers to reconsider the appropriateness of biomedical models in explaining behaviour and to move towards exploring the influence of social factors, such as identity, on sexual behaviour. For example, Campbell argues that identity re-negotiation, along with empowerment and social capital, is pivotal in creating enabling environments in which women and young people can freely negotiate safe sex (2004:45-60).[70] However, a broader reading of her work demonstrates the complexities and contradictions around religious participation, identity and sexuality. In one study, Campbell *et al.* identify the church as the central figure in the policing of women's sexuality in South Africa and argue that it contributes to the climate of stigma towards sex, people living with HIV/AIDS, their families and towards young people in general (2006). Yet, in a separate study exploring the effects of various group memberships on sexual behaviour, she highlights the positive influence that church membership has on participants' ability to negotiate safe sex (Campbell *et al.*, 2002).

This complex relationship between religious participation and sexual behaviour is further compounded by Smith's (2004) study, which explores how Christianity intersects with HIV/AIDS in south-eastern Nigeria. He articulates three different ways in which this intersection plays out. In the first, some young people used a moral framework which fed into ambivalence and denial about HIV/AIDS, while in the second way some used the same framework to justify the morality for certain sexual relationships. Finally, others drew on moral prohibitions as reasons for abstinence (2004:426). While these studies make important contributions to understanding the relationship between religion and sexual behaviour, they tend to overlook the potential for power that may be negotiated and harnessed through church membership. Consequently, this suggests that exploring the impact of moral frameworks on sexual behaviour provides a partial explanation of the complex and contradictory relationship between AIDS and Christianity.

[70] See Chapters One and Two for a fuller discussion of Campbell's theory on the social psychology of participation. Also refer to *Letting Them Die* (Campbell, 2004) for case studies that reflect the findings from testing the theory in South Africa.

If the intersection between Christianity and HIV/AIDS is complex, then the relationship between Pentecostalism (or evangelical or charismatic Christianity) and HIV/AIDS may be more so, because of its increasing (and contradictory) influence on gender in Africa. On one hand, some researchers are quick to point out how churches promote female subordination and dissuade individuality by encouraging women's roles as mothers and helpers, and how this is exploited within patriarchal societies (Kambarami, 2006:5). On the other hand, other researchers have attempted to expand and recapitulate ethnographies on religion and gender, by establishing how women in Africa have long been central to moral, spiritual and church organizational life (Hodgeson, 2005) and how women have accessed and levered their spiritual 'power' to augment their own status (Sackey, 2006:199-200; Soothill, 2007:216). These arguments are centred mainly on Pentecostal churches, suggesting that there is a possibility for women to define power in ways that they may not be able to in more traditional churches.[71]

In this chapter, I establish the ways in which Christian participants drew meaning from their church membership in ways that helped them reconfigure both social and religious gender norms and identities, thus enabling them to prevent HIV/AIDS. To this effect, I organize the chapter by describing how participants draw on church ideology and beliefs to engage in discourses that (a) contribute to creating an environment in which participants opt for safe sex by drawing on their lifestyles to provide insurance against sexual and societal malevolencies; (b) attempt to restore self-worth and ability within a social context of female subordination; and (c) reconfigure participants as equal or even gender-neutral with regard to their spiritual status and identities. Finally, I conclude the chapter by describing (d) the implications that the reconfiguration of gender norms has on the gendered nature of the church's HIV/AIDS service provision.

Christian participants were members of the Christ World Church (CWC), which is a small non-denominational church in Abuja and also a branch of an international church that has other branches in over 80 countries. Within Nigeria, it has its headquarters in Lagos, with several smaller branches throughout the country (Abuja being the second largest with around 150 members). CWC originated in the USA in the 1980s, before

[71] There are slight exceptions to the focus on Pentecostalism and reconstructing gender norms. Hodgeson's study was on the interaction between evangelical Catholic missions and women in Tanzania (2005:154). Pentecostalism does not accept traditions (like sheep slaughter), but Catholicism does.

opening branches in the United Kingdom during the following decade. The churches in Nigeria were 'planted' by an international missions team comprising of Americans, Britons, Afro-Caribbeans and Nigerians. The lead pastors of the Abuja branch were a married Nigerian couple who met while pursuing post-graduate studies in London, where they also become active in the church. On returning to Abuja, they established a branch of CWC, with the help of members from the Lagos branch and the missions team.

As mentioned in Chapter Four, I became aware of CWC's HIV/AIDS programmes while working on a reproductive health project in Lagos. They implement their AIDS programmes through their charity (Global JOY), which was set up to respond to the socioeconomic challenges that missions teams had reported during their church-planting trips (some of which lasted for several years). Global JOY is usually staffed by volunteers ranging from professionals to students, most of whom are members of CWC, although they also attract external support from people who do not attend the church. Their South African AIDS programmes has garnered some international attention, the result of which led to their efforts to replicate the programme in Lagos in 2003. Both South African and Lagos efforts had been sustained by donations from CWC members but soon attracted donor support (mainly from the USA, but also some from private businesses and local philanthropists). While CWC received support to establish the church in Abuja, Global JOY in Abuja received little support from either their South African or Lagos counterparts to replicate the HIV/AIDS projects in the capital.

As discussed earlier (see Chapter Four), the CWC stands out as a church for two main reasons. Firstly, when I initially encountered them in 2000, it appeared to have an organizational structure (through Global JOY) that responded to development and community issues without external or international donor support. Secondly, not only does it preach sexual abstinence, but members seem to readily adopt mechanisms which they said enabled them to successfully maintain their lifestyle-related choice of abstinence. It seems that CWC's ideology influenced their community organization as well as members' sexual attitudes, knowledge and practices. Therefore, I was interested in exploring this further in order to understand how its action helps prevent HIV transmission.

I elicited the data analysed in this chapter by using the same semi-structured interview guide that I used with the groups discussed in the last two chapters. I also participated in church services, relevant NGO meetings and outreach activities. The interviews and meetings were either held at the church premises in Maitaima (a suburb of Abuja) or in the Global JOY offices in Garki (which is predominantly a business zone in central Abuja). Finally, some interviews also took place in participants' homes or offices.

IT'S NOT BECAUSE OF AIDS: LIFESTYLE MECHANISMS, SOCIETAL MALEVOLENCIES AND THE INSURANCE OF ABSTINENCE

Compared to other groups, Christian participants were the second most compliant with AIDS prevention messages. The first and most compliant were participants who had already contracted HIV, which I will discuss in Chapter Eight. Seven single women reported that they were abstinent, while the three married women reported that they were monogamous and faithful. Of the three, all but one believed that her husband was faithful (the implications of which I will discuss later - see spiritual welfare discourse). Moreover, six participants mentioned that they had adopted techniques to prevent non-sexual transmission, which included sterilizing hair equipment, visiting salons that sterilized equipment, or opting to do their hair at home. Since more than half reported that they were not currently in a sexual relationship but knew about or were involved in Global JOY's AIDS campaigns, I found that this was a high level of response to participants' construction of de-sexualized HIV/AIDS transmission and prevention, which invariably had little to do with AIDS.

Instead, participants' compliance with AIDS prevention messages was as an unintended but useful consequence of their lifestyles, rather than a direct attempt to avoid HIV. Each Christian participant (as well as at least one participant in each of the other groups) asserted that their decision to engage in safe sex was influenced by a desire to fulfil spiritual requirements, rather than by a fear of contracting HIV.

Despite their self-reported abstinence and faithfulness to their sexual partners (always a spouse in this case), none of the participants ever described their behaviour in terms of 'safe sex' or other AIDS prevention jargon. Rather, they discussed their sexual choices within a range of other activities that I interpreted as constituting their overall

lifestyles. This range of activities included individual and collective praying, fasting (or abstaining from certain food or activities), helping the poor, inviting friends and colleagues to church, and socializing with fellow church members. When I asked how they identified which activities to include in their (Christian) lifestyle, several referred me to the Bible and cited the Book of Acts or the Pauline epistles and teachings – all documents which predate AIDS.

Just as abstinence was part of their lifestyles, AIDS was just one of the potential social or personal malevolencies that participants could avoid; including other preventable communicable diseases such as polio or meningitis, financial problems, lawsuits, marital and family strife, and even car or aeroplane accidents.[72] As will be discussed later (see spiritual welfare discourse), half of the participants offered the notion that certain *advanced* or *spiritual* lifestyle maintenance mechanisms afford them spiritual power which provides divine indemnity against personal and societal malevolencies. Others relied on more deductive powers and concluded that they would rather adhere to a lifestyle which they felt brought them stability and assurance, rather than gamble with the uncertainty. In essence, both sets of explanations highlighted ways in which participants tried to make sense of the predictable unpredictability that occurs in their everyday lives.

Despite the available information about AIDS prevention and treatment possibilities, this information is still popularly regarded with scepticism and enmeshed in a web of suspicion, confusion and, possibly, denial. Examples of this are to be found in the following excerpt from an interview with Temi. Temi was a 34-year old single mother who worked as an administrative assistant to support herself and her daughter. She also sold clothes and self-made accessories to supplement her income. Following her daughter's birth, Temi became estranged from her (now) 10-year old daughter's father, an army officer until recently. Fellow church members had encouraged her to re-establish contact with him for their daughter's sake. She describes her ex-boyfriend as having recently stopped attempting to persuade her to have sex with him, which is something (she says) she had less power to resist before joining CWC. In the following

[72] Analysing a classic example of this, Asamoah-Gyadu (2005) cites how a Pentecostal preacher who is popular in Ghana and Nigeria, was invited to provide a 'healing and deliverance' service for an aircraft and passengers just before departure. In the wake of the airplane crashes that occurred six weeks apart, it was popularly believed that these crashes were not coincidences, but were malevolent spiritual activities in which the lives of the passengers were sacrificed in exchange for either economic or political power. Shortly after these plane crashes, I travelled from Lagos to Abuja. Most passengers were relieved to find out that the German evangelist, Reinhardt Bonnke, known for his large crusades against the occult, was on the flight.

excerpt from an interview conducted in her home, she explains her misgivings over the stories circulating about AIDS and how she uses her lifestyle as coverage to circumvent the confusion they cause her.

C: *So how do you think the government is doing in the area of AIDS?*

T: *Well, they're actually trying but I don't know how much of their efforts go outside of the cities, especially a place like Abuja. But sometimes, I'm not sure I about AIDS.*

C: *How do you mean?*

T: *There are so many stories. I was speaking with* [Henry], *my daughter's father when he last came on leave... any time he comes here, somehow the issue of AIDS will arise. Anyway,* [Henry] *does - not - want - to hear about it* [emphatically]. *To him, AIDS doesn't exist. It just doesn't exist.*

C: *Why do you think he says that?*

T: *He says it's propaganda for the whites to exterminate the black race. That they just went into the lab and concocted some virus and other things to deal with us* [punish us]. *That's why they* [the government] *said all these processed foods that are being brought into Africa should be stopped. Even polio vaccines - people say we should stop giving to our children because they're spreading AIDS.*

C: *Do you believe that though?*

T: *I know. Sometimes I wonder where the stories come from. But even people who go to* [other] *church*[es] *don't believe* [AIDS exists] *so they still do these things* [leading to unsafe sex]. *Like I said before, the government's trying by and large through TV, jingles... We know all about AIDS. But then you can't even trust things on the ground.*

C: *Things like what?*

T: *There are condoms but I don't know if the manufacturers make the ones that are really good* [effective]. *Why risk it? If you're married, stick to your wife or husband. If you're not, then just wait. There are Christians like me who've waited - and it's not because of AIDS. I've been waiting seven years!*

Temi's reference to the three stories (or AIDS conspiracy narratives) as sources of her own confusion around AIDS is just one of the several compelling elements of this excerpt. The first story about AIDS as a weapon for African population reduction is one which I associate with masculinity, because it was echoed by several male informants. This association is one that also has resonance in other parts of the continent and is sometimes embedded in the local political landscape, such as in

Zimbabwe (Kaler, 1998:351; Rodlach, 2006:149).[73] However, her ex's theories spread beyond the specific issue of AIDS to a wider discourse about population, trade and consumption which includes discussions around the safety of polio vaccines[74] as well as the government's ban on importing processed food.[75] While it is beyond the scope of this research to explore masculinities and AIDS in depth, I would argue that these narratives contribute to a wider culture of blame which reflect feelings of political and socioeconomic exclusion but also forge a resistance to sanctions on male sexual behaviour and, consequently, masculinity.

Perhaps just as interesting as Henry's theorizing is Temi's interaction with it. On the one hand, she engages with it enough to mention the stories in the interview. On the other hand, she still seems to struggle with completely internalizing them and voicing them as her own. She does, however, seem to lend more credence to the second story in which condoms are characterized as faulty. Like other conspiracy theories, the potency of confusion surrounding condom safety resonates in other pockets of the continent. In Malawi, the government was suspected of colluding with international donors to annihilate the population by contaminating condoms with HIV and a cancer-causing substance (Kaler, 2004; PlusNews, 2005). Kaler, the sociologist who conducted the study that produced those findings in Malawi, describes these myths as constituting only part of the grounds on which men and women rejected condoms. Other reasons include aesthetics and the connotations they conjure in the minds of partners. Hence, they were less likely to be used by the participants in her study (Kaler, 2004:295). Based on these other reasons, she might also disagree with the argument I raised earlier concerning conspiracies and masculinities. For her, the resistance of condom use is not explainable by masculinity alone, but by other more consumerist reasons. However, I

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73 Perhaps the most publicized conspiracy theories emanate from the quarters of South African President, Thabo Mbeki, and centre around his doubt as to whether HIV causes AIDS. This in turn fuels accusations from activists and experts who claim that he is in denial about the pandemic. In contrast, his predecessor (Nelson Mandela) admitted to losing his son to AIDS in 2005. How does this link to non-political males?

74 The prevalence of suspicion and quest for accountability can be seen in the Nigerian government's recent lawsuit against Pfizer, where it accused the company of failing to obtain parental permission to test vaccine on children in the mid-1990s (MSNBC, 2007). Eleven children died during the vaccine trials. This exacerbated fears in the Northern part of Nigeria, where polio prevalence is particularly high and was said to lead to a boycott of polio vaccination campaigns. Allegedly, polio vaccinations are popularly believed to spread AIDS and cancer, and lead to infertility. The boycott has been blamed for an outbreak in Nigeria, spreading through West Africa and said to be costing the WHO billions of dollars and jeopardizing their goal of a polio-free world (AFROL, 2007).

75 I was unable to link the government's ban on imported food (an effort to increase agricultural productivity) to stories concerning any particular disease or event. However, at the risk of starting my own conspiracy theory, the suspicion around the ban could also be linked to the National Agency for Food and Drug Administration Control's (NAFDAC) efforts to strengthen quality control by prohibiting the import of fake items and those with expired sell-by dates, including pharmaceutical drugs and vaccines. The head of NAFDAC, Dr. Dora Akunyili, was so effective that she reportedly received death threats (BBC, 2007).

would maintain that 'sex with condoms' or 'not having sex at all' elicit very different reactions for men and women, because the act of not having sex is embedded in meanings that have economic, social, psychological, emotional and now spiritual implications, some of which I hope to elaborate on within this chapter. Furthermore, a woman's decision to have sex with condoms involves her partner's consent, hence an emphasis on negotiation. Her decision not to have sex at all is more individual and involves negotiation only minimally or temporarily, which is why participants in this study drew on different discourses in order to defend their actions in a way that would be perceived culturally and spiritually acceptable.

The confusion over condoms is multifaceted and cannot be traced to a single particular source. For Catholic Christians, the Vatican's statement against condom safety contributed to confusion over the efficacy of condoms (Chikwendu *et al.*, 2004). This efficacy had already been the subject of debate within scientific communities (Van de Pierre *et al.*, 1987; Carey *et al.*, 1992), who had to defend the accusations that latex condoms were inherently full of holes (Bradshaw, 2003). Counter-narratives explained how latex was layered and reinforced in ways which prevented HIV and other viruses from permeating the material through the small holes. Hence, there was an element of truth to the conspiracy about latex condoms, but these are negligible. However, the most recent contribution to the condom conundrum is the South African government's two recalls in 2007 of some twenty million faulty condoms, after an official of the South African Bureau of Standards (SABS) received bribes to approve the defective condoms (Bate, 2007).

The condom controversies appear to pose more of a real threat to Temi because of the gap that faulty condoms place between the rhetoric and reality of prevention in everyday life. As a result, I interpreted her engagement with conspiracy theories as a situation of potential societal malevolency, in which she uses abstinence to absolve herself. In doing so, she simultaneously insures herself against disease. I would add that she may also be insuring herself from any emotional and psychological 'dis-ease' that could have emanated from staying in a sexual relationship with Henry, her daughter's father.

The nature of their relationship provides the second striking element, as it is the nexus within which Henry's AIDS conspiracy theories are embedded. I perceived this to be a

complex relationship from which she would like to extricate herself for one reason or another, perhaps physical and emotional vulnerability. Elsewhere in the interview she had alluded to his role in the military as a contributing factor to their relationship's demise. Moreover, although it was not made explicit, his conspiracy theory may have been a tactic used to dissuade her from resisting his sexual advances or from insisting that he wear a condom. If indeed she was concerned with her physical vulnerability (and his), her fears could be further fuelled by the following study results. In a study on HIV and the Nigerian military, Ekong (2006:561) notes that 15% of military personnel had reported having at least two sexual partners during the previous year. Of those partners, a third included non-regular sexual partners. Condoms were only used in half of these encounters. Some 63% of those surveyed believed they had very little or no risk of contracting HIV. While this interpretation about her possible perceptions of Henry's fidelity is not based on any one particular strand of her account, it is evident that she would like to be able to have an intimate and safe relationship. Temi's own words "*I've been waiting for seven years*" meant to me that she was not only waiting to have sex again, but was waiting to do so within a stable, secure relationship. This hint at a future of faithfulness suggests that she was happy to leave what may have well been a problematic relationship, even though it appeared to be difficult to do so.

From analysis of this excerpt, I conclude that abstinence (as a lifestyle choice) is one that yields dividends, but also one that presents its own set of challenges. In a culture that valorizes conjugal relationships and motherhood, the choice to abstain serves as a marker of dis-identification from notions of respectability. It is not only the denial of the act of sex but what sex means to participants, partners and relatives, especially if it involves (as it did in Temi's and other participants' lives) walking away from a relationship. This is a conscious factor in their decision-making and one which I likened to putting one's personal life on hold to focus on a career, both of which can yield immense pressure from family and friends. When I asked one participant how she handled the pressure she received from potential partners to have sex, Nana, a 30-year old architect, responded "*It's definitely a relationship breaker. You just have to pray that you will meet someone who understands... shares the same values*".

Perhaps it is this sensitivity to social pressure, as well as participants' own beliefs about marriage, that encouraged Temi, Nana and other church members to establish what I refer to as 'lifestyle maintenance mechanisms'. These involve both self and collective

policing of behaviour and emotions, whereby members encourage one another to maintain and derive spiritual meaning from their lives. They have implications for how women view themselves (whether single or married), and include encouraging intermarriage within the church, fostering de-sexualised relationships with members of the opposite sex, and what the CWC refers to as 'discipling' or spiritual mentoring.

The married members of CWC had either met as a result of belonging to the church or had encouraged their prospective spouses to become members while they were still dating. Although I was told that such encouragement helped to ensure that couples had the same understandings and expectations of Christianity and marriage, it also seemed to be a way in which any fissures or reduction in membership could be prevented. Only one of the married women I interviewed was dissatisfied with her marriage, a situation which she blamed, coincidentally, on marrying "*outside*" (of the church). In contrast, however, several of the participants shared with me that they found the prospect of only being able to marry within the church a stifling one. Two participants (Nana and Ebisong) admitted to "*having special friends*" who were not members of the church. Both found their male co-members to be 'boring' or 'brotherly'.

While 'boringness' is subjective and may seem an unappealing quality to contend with in any relationship, 'brotherliness' is precisely what the leaders at CWC wanted to encourage between the sexes. Victoria, the pastor's wife, instructed me on the different types of love: *eros* (romantic), *philia* (brotherly) and *agape* (divine). According to her, most Nigerian men had not even learned the art of *eros*, which is why CWC encouraged the more brotherlv love between members:

V: *How can you say you love a woman if you're not her friend? This is why you have situations like marital rape, because the husband and wife may be operating from two completely different understandings of love.*

Since this was the underlying theme in the few relationship sessions that I attended (led by Victoria and her husband), I understood these teachings to be one of the ways in which participants and female church members used church doctrine to address constructions, gender norms and relationships.

Men, too, faced similar pressures to settle down and often solicited the female participants' company and advice on relationships. Temi, for instance, was close to Maxwell, a fellow member whom she described as being like "*a little brother*". During my visits to the church, I usually saw them together, and encountered them a few times in town. Temi told me that they spoke daily and that they had helped one another through events which, she argued, other men would have taken advantage of. Interestingly, she was not the only participant to uphold these relationships as useful (as long as they were unromantic in nature). Others participants said that they even encouraged non-member friends to meet male church members in order to experience non-sexual relationships with the opposite sex and just simply relax. One participant said of these new-found companionships, "*I never knew I could just be **friends** with a man! I either had to serve them or sleep with them*". In her case, maintenance mechanisms had the potential to change men's expectations of their female co-members, as well as change female co-members' expectations of themselves.

Finally, participants sought lifestyle maintenance support through weekly 'discipling' meetings, where they met individually with a more spiritual mentor or partner. This was usually someone who had attended CWC longer and had similar backgrounds or interests to them (but not always). Meetings were scheduled at the convenience of both parties and usually took place over a meal or snack at a residence, office, canteen or in the park. Participants described these sessions as instrumental to their education, career or business, because of the exchange of ideas and information that took place. Participants with families said that they also sought and offered advice to one another relating to their marriage and childrearing. During these meetings, they could also 'confess' the challenges they faced as single abstainers, which sometimes included discussions around their sexual urges and what they were doing to suppress them (or not). Single members cited these sessions, in addition to prayer and Bible reading, as most influential in maintaining abstinence. They also attended weekly group meetings with other women, where they took part in social activities such as picnics, barbecues, games, breakfast meetings, hiking, etc. These also took place with male church members. Hence, lifestyle mechanisms helped to build and expand social networks for many participants (most of whom were migrants to Abuja).

In sum, the experiences of Temi and other Christian participants suggest that they chose to participate in a setting that has great influence over their lifestyles. In

particular, this helps them to actively engage in reconfiguring gender relations, particularly by de-sexualising them - at least until marriage. While lifestyle maintenance mechanisms may echo tones of religious and moral policing, they do, however, meet some of Campbell's criteria for a context in which "participants were safe to renegotiate gender norms" (2004:52). For participants like Temi, who was already a parent and still expected to marry, lifestyle maintenance mechanisms not only help with this renegotiation but also provide insurance which can be levered in the face of potential personal and societal malevolencies.

The following section will demonstrate some ways in which several participants lever their lifestyle maintenance mechanisms to negotiate a positive single gender identity.

FOR GOODNESS SAKE, I HAVE A BRAIN! DISCOURSES OF SELF-WORTH, ABILITY AND THE RECONFIGURATION OF GENDER NORMS AND IDENTITIES

One of the most influential factors on a participant's choice to abstain is the way CWC's lifestyle maintenance mechanisms converge with a host of other factors (such as a participant's individual personality, local and Pentecostal perceptions about gender relations) to reveal actions and discourses which I took as providing an identity marker for Christian participants.

In this section, I analyse the first of these discourses and their practical (and spiritual) implications on participant perceptions of gender, power and sexual behaviour. The first discourse highlights participants' frustrations with the reaction their choice to abstain elicited at times. In addition to experiencing broken relationships as a result of their choice, participants recounted instances in which they were accused of frigidity, waywardness, lesbianism or barrenness. These accusations reflect masculine interpretations of sexual abstinence - as deviance from long-standing norms or respectability. In other words, participants were branded as being wicked. Implied in this masculinist reaction and interpretation could be the perception of sex as a site of negotiation, with women being the disadvantaged bargainer since sex is typically offered in exchange for financial assistance or steps towards social mobility. As a result, when participants engaged in discourses about self-worth and ability, I

interpreted this as (a) resisting such negative and sexist gender stereotypes, and (b) an effort to negotiate and reclaim bodily integrity. These discourses helped to cement the choice to abstain in the notion of respect and dignity that is usually framed within human rights discourses but, in its absence, is framed within spiritual discourses instead.

While participants contended with derogatory terms attacking their choice to abstain they, because they were women, also had to contend with derogatory terms associated with (sexually active) women. 'Wicked woman' is a predominant stereotype, with its own discourse and vocabulary centred mainly around three local derogatory terms: *ashawo, aristos* and *bottom power*. These are used with reference to women who are believed to be involved in exchanging sex for money, gifts and social mobility (usually career advancement), respectively. The term *ashawo* in particular is used in reference to commercial sex work, but also ascribed to women and men who are perceived to be sexually promiscuous (Dayo-Aiyetan, 2007). *Aristos* (as in aristocrat) is a term usually associated with the younger affluent men whom women (mainly university students and graduates) seek out in order to be showered with cash, expensive gifts and trips abroad. This is the newest of the three and has already been incorporated into AIDS prevention campaigns.[76] *Bottom power* is perhaps the most contested of the three terms. It refers to women's use of their sexuality to gain "access to social opportunities and privileges" and has been argued to be the means by which (elite) women in Nigeria negotiate social independence (Steady, 1981:235).[77] These terms came up several times during interviews with women across the different groups and were described in many

[76] While working as a consultant with an NGO, I was involved in drafting the script for a radio spot which told the story of a girl who received a call from one of her *aristos* to inform her that he was HIV positive. My co-writer and I based the idea on stories from his time at university. We then tested the initial draft on a focus group containing friends of two of my younger siblings who were in university at the time. They agreed that the idea of a university student with several *aristos* was accurate. However (and unsurprisingly) the likelihood of him informing her that he was HIV positive, was not.

[77] While I agree with Steady, who suggests that women defended *bottom power* as a means of mobility within fluctuating labour economies, the reaction it has elicited in the new millennium positions it as indefensible by both men and women in positions of power (Statesman, 2007). Of all of the priorities that a Senate President could comment upon during the first two quarters of his term, David Mark issued a warning to banks to stop using beautiful girls as receptionists and business development officers who visit offices of potential clients to 'lure' them into opening accounts. Taking up the same issue, the General Secretary of the Trade Union Congress of Nigeria accused banks of handing out condoms to young female marketers and receptionists, and discriminating against pregnant or married women who apply for the same positions (Nigerian Vanguard, 2007). But perhaps most notable and relevant to Steady's discussion and this chapter is Senator Chris(tina) Anyanwu's statement, in which she denies using *bottom power* to get elected (Nigerian Punch, 2007). Nominated as one of nine women to the Senate, she co-chairs the Committee on Army Defense, but has stepped beyond her remit to introduce a Bill on sexual violence. Nevertheless, it is argued that she had to defend her long-standing career (which had started in broadcasting and was marked by her political detention during the Abacha regime) due to her 'unorthodox' marriage to her husband, an academic based in the United States. It was also argued that the stories to which she had access and published in her political news magazine, *TSM*, were as a result of affairs with senior male politicians, who she allegedly eventually called on to back her bid for the Senate.

interviews without being referred to by name. This could be for two reasons: first, they are considered derogatory and second, participants may have assumed that I would not know what these colloquialisms meant.

Discourses of Ability and Self-worth

The following excerpt represents what I argue is both a challenge and contribution to the 'wicked woman' discourse. As a single mother in her forties, Auntie Bukky (pronounced Book-ee, rhymes with cookie) was the most vocal progenitor of the self-worth and ability discourse. Embedded in a larger discourse within Pentecostalism which emphasizes prosperity achievable by self-determination, discourses of self-worth and ability acknowledged participants' skills and their potential to generate income and contribute to the welfare of people around them.

Auntie Bukky seemed to exemplify this by mentoring many women at CWC, and was known within the church for her life experience and frank advice. Whenever I saw her, she usually sported a suit and a 'Grace Jones' style of haircut, which she said helped her command respect from her clients, most of whom were reportedly male. Her 'look' seemed to play down the fact that being a mother of two boys in secondary school had not stopped her from being a business woman *and* look like the former model that she was. She owned an interior design business, but narrated how she had previously struggled to support herself and her children before entering the 'fast life' of fashion, where she began to command a good income as a designer and model. She commented on how rather than enhance her status, her marriage to her ex-husband nearly thwarted it, because she had been encouraged to abandon her business degree to raise a family. Divorce had liberated her to nurture her talents, increase her sense of self-worth and ability, and channel them into running her business and helping others; yet she was angry that she was still solicited for sexual favours from her clients. Below, she addresses the sociocultural factors framing her earlier situation:

AB: *I should be the one who says they can't live without a man. When I married, I had people working for me, I had a cook, a steward, a driver... I was a madam! At 22! That was everyone's dream back then. So when he* [ex-husband] *began to chase other women, I had to continue* [with my life]. *I had two sons by then, so I went back to school. It was actually his mother who insisted that I stop*

schooling when we married. My father was so unhappy... what did I know then?...

But I tell you when I went back to school, the situation was enough to send anyone into prostitution. And I could have done it! Me?! I've always been a hustler. And I had every justification because the man refused to support us until after I'd graduated. Can you imagine that type [of] *wickedness?*

The choice to become separated or divorced is regarded as encompassing a range of consequences for participants whose pre-Christian life is conceptualized in terms of their attitudes towards gender (or marital and sexual) relations and the mediation of expectations placed on them by parents and peers. One of the themes that emerged from participant narratives was the role that parents and senior relatives played in their marital decision-making. Several cited how senior female relatives in their lives influenced their decision to marry, but also cited how their fathers had influenced their decision to attend school. For Auntie Bukky, her early financial hardship was just as much the fault of her mother-in-law as it was her ex-husband's. It is a critique on the role that senior women have in allowing patriarchal structures to affect younger women's livelihoods. It also highlights the expectations around marriage that prevailed in her youth and the ways in which women are valued, value themselves and value other women within marriage. 'Madam-ism', being a 'big woman' or being a respectable woman governing the affairs of her household, is a norm (real or imagined) which Auntie Bukky's experiences disrupt. She goes on to identify avenues of agency:

AB: *But I got through it with God. He has always been my strength - even when I didn't know him. So I don't see any reason that a woman cannot do things for herself. For goodness sake, I've got a brain! Read my lips: for every woman there is something - a gift, a skill. Call it whatever you like. You can tap into to it and turn it into a money-making venture. God has not created that for men only. He created every one of us with something we can do. No woman worth her salt has to sleep with a man for maintenance. Not one!*

One of the prominent tones underlying Auntie Bukky's excerpt, and indeed of our whole three-hour interview, was one of indignation. Therefore, while she draws on her own experience in the previous excerpt to level a critique of the cultural and social factors contributing to situations in which women may be forced to rely on men, it would be easy to assume this part of her account to be a critique of the agency she feels some women exact within similar circumstances. However, I interpreted the

combination of these excerpts to be a critique of the options on offer for women to define themselves. On the one hand, there is the socially accepted identity of respectability for which women make sacrifices that ultimately can influence their self-worth and ability. On the other hand, there is the socially expected identity of deviance which is reserved for women who opt out of the former category. Both constructions of femininity and modernity pivot around a dependence on men that does not accurately reflect the independent lives of many women who are not involved in a conjugal union. Hence, as Soothill demonstrates in her study on gender and charismatic churches in Ghana, spiritual gender discourses (like self-worth and ability) provide opportunities for participants who often feel that their lives are shaped more by external factors and actors than they are shaped by themselves (2007:127-128). Moreover, they may be used by women to reconfigure previously sullied identities into those that are socially and spiritually palatable.

Articulating Spiritually-Influenced Notions of Bodily Integrity

Self-worth discourses not only highlighted ways in which the participants regarded themselves, they also highlighted how they *wished* to be regarded. Participants and informants narrated incidents which reflected the prevalence of sexual violence against women and often cited the Bible (referencing 1 Corinthians 6:19 where the body is described as the temple of God) to refute this practice. They also cited how verses that advocated mutual respect were taken out of context by both Christian men and critics of Christianity. Even the much-touted verse on female submission to male household leadership was met with a range of interpretations that ran counter to the dominant interpretation, in which submission implies inferiority and inequality or was forced. For example, participants pointed out that the controversial verse, Ephesians 5:22 ("Wives, submit to your husbands as to the Lord") was preceded and followed by texts they claimed some men ignored in order to justify spousal or partner abuse. In one Bible class, the teacher explained that in the preceding verse, the audience is instructed to submit to one another, or to respect one another. In the proceeding text (verse 23) men are advised to love their wives as themselves because "After all, no one ever hated his own body, but he feeds and cares for it, just as Christ does the church". "*That,*" the teacher concluded, "*is why no man should dare hit a woman. Have you ever seen a man punch himself? Wouldn't they call him a mad man?*".

Discussions and responses such as these led me to interpret them as ways in which participants levered the self-worth discourse to articulate bodily integrity - a right that is not protected by Nigeria's judicial and law enforcement agencies. Instead, reports of how police and military forces perpetuate sexual violence against women have been documented by local journalists and agencies, including Amnesty International (2006).

For Geraldine, the campaigns in Abuja did not fully address the number of ways bodily integrity could be violated. A 27-year old communications graduate, she had been posted to Abuja from Lagos to participate in the National Youth Service Corp (NYSC). She told me that although she had left home to attend university, she still missed her family whom she described as being "*very close*". She credited her involvement with Global JOY's outreach programme to her father, a medical doctor who taught her about HIV and was actively involved in a separate community project back in Lagos. Geraldine was also active in church, and often gave presentations on issues such as self-esteem and assertiveness, although she did not initially come across as assertive. During the course of the interview, I soon learned why this was so and why, for her, the relevance of these issues was not limited to AIDS prevention only, but was something she felt was important for women in general.

G: *Well they* [people in media campaigns on AIDS] *make it look like it can't happen to you. They take it* [unsafe sex] *out of the situations that it can occur in. You see posters of some young guy with his babe and it says 'Zip Up!' But it's not always like that.*

C: *M-hmm.*

G: *Like in my case...* [pause] *I was molested by my uncle.*

C: *Your uncle?!*

G: *Well, he was more like a family friend.*

C: *Did you tell anyone in your family?*

G: *I told my mother.*

C: *What did she say?*

G: [Shakes her head].

C: *We don't have to continue...*

G: [Silence]. *It's okay. It's hard... but it's good for me to get it out; I've only told a few people in church* [mentions two names]. *I guess the painful thing is that I was a virgin. And he knew. He even used to advise about guys, how to spot the 'snakes' and we used to laugh and laugh. Hmph! And calls himself a Christian,*

but he wasn't a real one, obviously. After all, he didn't remember God when he betrayed my family and defiled me... It was my first sexual encounter and I contracted chlamydia. I just thank God for His mercy that it wasn't HIV or pregnancy. But sometimes I wonder: so if I had not been a virgin and had been carrying a condom, should I have insisted that he use it? And I knew how to insist [negotiate] *even then. After all, I'd managed to stay a virgin all these years... but...* [unclear]... [silence].

There are clearly a number of compelling factors about Geraldine's excerpt. The first is the openness with which she narrated this particular experience in her life. While participants in previous chapters either alluded to experiencing gender violence or knew of women who had experienced gender violence, Geraldine was the only participant who had openly disclosed a personal experience with sexual violence or a sexually transmitted infection. While such silence is unsurprising, Geraldine's account raised a few ethical issues relating to practical and policy implications, which I shall discuss shortly.

The second compelling aspect of this excerpt was the juxtaposition of Geraldine's background and her experience with gender violence which, like AIDS, is argued to be attributed to poverty. Poverty is argued to be a driving force in gender violence, because the latter is likely to take place in a context in which transactional sex is involved (Jewkes and Abrahams, 2002:1239). Other factors contributing to rape are best situated within a broader sociopolitical landscape. For instance, the little yet extremely valuable research on rape in Africa is based primarily on South African experiences which are embedded in a broader culture and history of violence (*Ibid.*). While Nigeria also has a culture and history of violence, the nature and background of this differs and even takes on different forms in various parts of the country (e.g., the riots over petroleum resources in the south-east versus the religious outbreaks in the north). These may shape the contours of sexual violence in different ways, which reflect the impact that the broader context has on the nature of sexual violence in those areas (e.g. sexual slavery and trafficking in oil-producing regions compared with Sharia-related gender violence in the north). Nevertheless, Nigeria and South Africa do share similar cultures of pervasive gender power inequalities which include both male and female assumptions of sexual entitlement. I would argue that sexual entitlement may explain and underline the complex relationship between the causal and

contributing factors of rape, and may help understand the nature of acquaintance rape in which there was no sex and no reported transaction.

Therefore, I take Geraldine's narrative as one which confounds the causal links between poverty, gender violence and AIDS. On the one hand, Geraldine was like many other university students who had been raised in what might be considered a middle-class family. [78] Furthermore, her own educational status and imminent employment provide many of the economic empowerment factors which are argued to contribute to women's ability to negotiate safe sex. Moreover, she had had a lifetime of 'saying no' to unwanted sexual advances and went as far as teaching other women the assertiveness skills which she acquired after the violent encounter.

On the other hand, there were a number of factors over which she had little or no control. Nowhere in her training or experience had she received preparation to be raped by her uncle, just as few women in Nigeria do. Furthermore, discourses on gender violence tend to pivot around patriarchal institutions such as marriage (i.e., domestic violence) and the military, perhaps because they are the most common forms of gender violence despite the silence that is said to surround them (Amnesty International, 2006:3). However, the silence attributed to victims of these more common forms of gender violence could also be extended to victims of other forms, including acquaintance rape, forced incest or molestation. The less common forms may be just as difficult to prosecute, or even more difficult given the psychological and social involvement of the perpetrator and his victim. Perhaps this is why they are perceived to be less common; they tend to be underreported because women fear retaliation, that they will not be believed or that the perpetrator will go unpunished (*op. cit.*:33). Compounding the issue for Geraldine is that the rape was also a forced sexual initiation. This is what makes her own question about condom negotiation so compelling and poignant; Geraldine, with some help from her father, had concentrated on arming herself with the right weapons, but ultimately found herself a victim of a very different and unexpected war.

[78] I did not obtain the salary information of Geraldine or her father, but given the history of strikes by the National Medical Association and the migration of doctors abroad for better salaries, it is possible that his salary was not commensurate with his skills and education, as many Nigerian doctors have argued (VoA, 2007). Geraldine had not yet been assigned to a position with an employer for her National Youth Service and had not begun to earn a salary at the time of the interview.

Third, I took her use of Christian discourses as a way in which she could frame her assumptions regarding bodily integrity. This was evident in what I interpreted as two instances in which her uncle breached the lifestyle codes which Geraldine believed were implicit in the Christian lifestyle. The first was the code of sincerity which he breached by his entire act. His actions were contrary to the lifestyle teachings regardless of who the victim was. Although he was not a member of CWC, a pastor I spoke with at CWC insisted that rape was not permitted within Christianity under any circumstances, but felt that this, like murder, was a prohibition that was taken for granted and not discussed because "*everyone knows not to do it*". It became evident that while CWC was able to contribute to reconfiguring gender norms and provide both material and discursive spaces in which members could articulate a notion of bodily integrity, it was understandably limited in forcing members (and non-members) to 'enforce' bodily integrity and physically prevent acts of gender and sexual violence. This was beyond their scope.

The second code that was breached is the issue of trust. Geraldine described her uncle's action as a betrayal, which I took to mean as a commentary of not only Christian relationships but kinship relationships. It is not uncommon in Nigeria to refer to colleagues, friends and distant relatives of parents as 'uncle' or 'auntie'. From her excerpt, I understood that his knowledge of her virginity reflected more than a mere piece of information but also a shared belief. It also reflected an intimacy which could be attributed to shared religious beliefs, kinship ties or both. Regardless, his relationship with her and her family was something that she felt he had manipulated and abused.

The third breach, and most relevant to this regarding prevention, is what could be easily be read as a breach of the code of chastity or purity. The defilement which took place could be interpreted in reference to disease as well as spirituality. Again, the shared knowledge of her virginity was not only reflected as a shared belief but also the spiritual meaning attached to it. As with the other codes, there were biblical references that contributed to a notion of bodily integrity - albeit a notion with spiritual meaning (i.e., the body as a temple). However, this spiritual notion of bodily integrity functioned the way that a rights-based notion might function to an extent, by establishing boundaries of personal space that need to be respected between men and women.

Finally, this interview and particular excerpt amplified the lack of services available for women who do experience sexual or gender violence. It was this lack of service that led me to consider whether or not I should continue with the interview because, unlike people living with HIV or who suspected they had the virus, there were no obvious centres in Abuja which could provide her with adequate support. However, I soon learned that the pastoral counselling at CWC included counselling, informal support for domestic violence victims, testing for HIV, and referral testing for other STDs and pelvic examination referrals. While these were features that had been in place informally since CWC's inception, Victoria, the pastor's wife, informed me that they were slowly trying to establish a model similar to that of their sister church in South Africa where, despite a progressive constitution on gender equality and human rights, the prevalence of rape had reached endemic proportions.

With these types of contradictions around gender, rights and rape, along with the paucity of services available for survivors of gender violence, it is of little wonder that Geraldine would rely on an existing institution to provide not only practical support but also discursive space in which she could begin to articulate a need for bodily integrity and rights against gender violence. The following section describes ways in which participants utilize spiritual discourses in ways which actually allow them to draw on their spiritual power to prevent possible repercussions associated with abstaining from sex in the face of gang violence or within marriage.

SPIRITUAL WARFARE DISCOURSE

Pastor (to congregation): *What types of things can people get from having unprotected sex?*

Congregation member 1: *Unwanted pregnancy!*

Pastor: *Yes, what else?*

Congregation member 2: *HIV/AIDS!*

Pastor: *Absolutely, that's right. Anything else?*

[There is whispering and a light rustling throughout congregation].

Congregation member 3: *Demons?!!*

Pastor: [Laughs] *Wonderful! Now you've got it! Demons or what we refer to as 'spirits'.*

This excerpt from fieldnotes on a sermon I observed not only represents the dynamic exchange between preachers and their congregations of Pentecostal churches in Nigeria, but also provides an emerging discourse around spirituality and HIV/AIDS. This differs from the cosmological ideologies researchers have described in ethnographies on cultural explanations and meanings around HIV/AIDS which centre primarily around witchcraft (Forster, 1998; Mshana *et al.*, 2006; Rodlach, 2006). Similar explanations have found their way into discourses around AIDS and spirituality in Nigeria, but are not limited to this. The excerpt above was from a sermon given as part of a month-long seminar on health, not at CWC, but at another church sometimes attended by CWC members who felt that they needed extra 'spiritual insight' into the situations they faced in their everyday lives. Problems addressed during the sermons were similar to phenomena explained by local cosmology including illness, poverty, barrenness, mental illness and involuntary singleness (or 'marital delay' as it is referred to in local vernacular). Since Pentecostal churches often promised solutions to these social problems, it was common to find people attending more than one church, hoping to find those solutions. This 'church-hopping' was discouraged by CWC, but reflects participants' interest and involvement in spiritual warfare, which I analyse in this section.

Prayer Warriors, Spiritual Power and Transgressing Gender Norms

Central to my argument in this chapter is that women mediate gender norms and identity through particular mechanisms and discourses. Lifestyle mechanisms (discussed earlier in this chapter) explore one of the discourses and its influence on gender norms and identity for participants. In this section, I analyse a second set of discourses which I refer to as 'spiritual warfare' discourses. Spiritual warfare involves the belief that positive and negative forces (or spirits) are at war over every aspect of a person's life, including finances, health, marriage, career and relationships. These negative forces or spirits can be 'assigned' to a person through witchcraft or through sex. However, participants of spiritual warfare believe that they can 'defeat' the negative through a number of spiritual lifestyle mechanisms, which include a combined programme of fasting (abstaining from food and drink for a period of time), individual prayer and attending a number of special prayer sessions up to four or five times a week. Christians who were able to sustain this lifestyle were often referred to locally as

prayer warriors - a position that participants described to me as "*powerful*" and which could be attributed to both men or women. Prayer warriors pray to combat evil or to break links with their ancestral past, which are typically blamed by many Pentecostal preachers for what are regarded as hindrances to social mobility and progress.

Some of these preachers were women, like the preacher in this section's opening excerpt. Given the potential power accessible to both men and women through prayer warriorship, it is not surprising that women would find this aspect of Christianity and Pentecostalism appealing. However, enthusiasm varied across churches. For example, CWC did not practise spiritual warfare, although it advocated spiritual lifestyle mechanisms to a minor extent, in that it prescribed individual prayer as a means of spiritual communication and psychological relief. As a result, participants secretly attended other churches to learn about spiritual warfare and how to become powerful prayer warriors.

Ugo, a 31-year old IT consultant, was one such participant. She was short, of average build and had an average complexion. I recall her being extremely friendly and she offered to assist me in any way she could. She was Igbo, but had been schooled in Northern Nigeria because her father was in the military and had been posted to Kaduna, Kano and Jos. Ugo had moved to Abuja from Jos in search of employment. Just before narrating events in the excerpt below, Ugo explained that she had also left home for Abuja due to a number of events that had taken place while she was at university. There, she discovered that her brother was in a cult when she had borrowed his hat and tie without realizing that they were the cult's colours (red and black). After being confronted by a member from a rival cult, she became fearful and paranoid due to the threats she received at that time, which included threats of rape, disfigurement and death. Nothing eventually came of these threats, which Ugo attributes to warfare:

U: *It's because of my mother that I'm becoming a prayer warrior. She knew my dad was in a cult, of course, so she dealt with that. Ah, but my brother's own* [cult membership]*...! She was obviously considered about our safety. These are guys who have no problem carrying guns and axes around campus. They could do anything: rape, kill... pour acid on you* [to disfigure your face]*... And since my brother was a leader, I was a target. I thought of transferring but we thought "Why should I go?" And my mother started teaching me how to pray powerful prayers. Where you see the result with your koro-koro eye! So I*

started attending one fellowship on campus. I became very serious; left my boyfriend and everything... If not, I would have been a dead person.

C: *Wow... but can we just rewind for a minute? What do you mean by prayer warrior?*

U: *Spiritual warfare. There are so many things that we take for granted. When you hear there's an accident, it may not be an accident. It could be a ritual sacrifice for fast money. But if you know about these things and you know what to do, it will give you power over them. For example, the cult could have had a negative impact on our family - we wouldn't have known except that God revealed things to my mother. That's why I love my mother's way. That's why when I arrived* [in Abuja] *I knew I had to be really serious. CWC doesn't really believe in all these things, but you can't ignore how our society is. So even though I'm a member of CWC, I attend another church to learn how to pray and have more power.*

Ugo's excerpt is interesting on a number of levels. First, is how the gender-neutral category of a prayer warrior is juxtaposed with the male-dominated institution of campus cults, which are steeped in patriarchal traditions.[79] From what we can see of her mother's warfare experience, the prayer warrior role can mediate influence within a spectrum of interrelated events, ranging from familial to societal to spiritual. While Ugo's mother could not physically intervene in the campus cult wars, Ugo believes that her mother's warfare at home brought about her protection on campus and her brother's eventual self-extrication from the cult. Furthermore, her mother's prayers may have had an impact on her father's involvement with his cult. As Igbos, these prayers are particularly potent, as it is rare that (in what can sometimes be a patriarchal structure) a woman will challenge her husband. Hence, I interpreted the prayer warrior status of Ugo's mother as a means of resistance against gender victimization, as well as a rearrangement of positions in institutions associated with masculinity. Moreover, Ugo's emulation of the prayer warrior status could be interpreted as her own interest in transgressing the limits of culture and society. In a study on spiritual warfare churches in Nigeria, Bastian observes that traditional religious practices (like ancestor worship or worship of water priestesses) were being blamed for 'spiritual' conditions like possession of a mermaid spirit - which was believed to prevent marriage and childbirth (Bastian, 1997; Bastian, awaiting publication). Spiritual warfare and prayer warriorship were the means by which people broke ties with traditional patriarchal institutions.

[79] For effects of cults on their fellow students at university, see Azelama *et al.* (2005).

This keen interest was translated into an agentic journey for Ugo - an aspect which, to me, presents the second point of interest in this excerpt. Her desire to transcend this type of gender violence influenced aspects of her migration to Abuja, including which churches she would join. As mentioned earlier, Ugo's affiliation to both churches was an anomaly for this participant group, particularly since CWC does not encourage 'church-hopping'. Moreover, despite the use of spiritual warfare discourses amongst participants, some of the men and pastors of the church were dismissive of spiritual warfare. They argued that it was contradicted by more modern interpretations within Christianity, which centre on the principles of divine love and forgiveness. Ugo confided to me that she had kept her participation in the other church quiet and to a minimum, attending a regular prayer meeting just once a month. She also studied their literature regularly, describing it as enlightening. Therefore, in addition to transgressing the limits of her culture on gender, I interpreted her warrior-seeking ways as a means through which she transgressed the limits placed on her by CWC as well as by culture. While it was unclear whether she, like Auntie Bukky, also drew on discourses of self-worth and the ability to reconfigure gender norms and stereotypes about single women (see previous section), it was clear that she sought other means that allowed for reconfiguration and increased agency - even though these means were outside of her primary church membership.

Finally, Ugo's reference to 'seriousness' helps to illuminate why abstinence is central to her lifestyle. Seriousness involved notions of self-disciplining or policing where certain behaviours were concerned. For instance, it was not uncommon for participants to describe leaving a worldly lifestyle for one that was serious or had a 'deeper' meaning. Therefore, I interpreted seriousness for Ugo as a means through which she (and several other participants) exchanged the gender-dependent power of respectability for a more gender-neutral spiritual power. The mechanisms leading towards seriousness (abstinence from food, secular life and, namely, relationships), as it is embedded in spiritual discourses, are the same steps Mariam used as leverage to abstain from her non-Christian husband, whom she believed to be having an affair.

Mariam is a 37-year old stay-at-home mother. Before her pregnancy she had worked as a leader in the church, but left to get married and later found work within the development sector. She says she ignored warnings against marrying someone who did not share her beliefs, and felt this was to blame for her husband's infidelities which

started early on in their three years of marriage. She expressed a range of emotions, including hurt and anger, and was tired at having to put up with finding condoms, hotel bills and overhearing "*funny phone calls from strange women*" late at night. It did not help that he was frequently out of town, leaving her to feel like a single mother. In the excerpt below, she acknowledges her HIV risk and comes to a decision which she justifies using spiritual discourse.

C: *So that means that you're still intimate with your husband?*

M: *I am. It's strange, you know* [sighs]. *I know what I know even though I've not caught him red handed since the affair. He comes up with all sorts of stories... But he recently... he comes home and he tries. You know. I've told him we have to fight to save this marriage. I mean... even though I haven't really felt like making love with my husband since I had my daughter, I try. I don't want him to feel like I don't trust him, even though I don't - that won't help. I wanted to try... back then, anyway.*

C: *And now?*

M: *I'm not going to sleep with my husband...*

C: *When did you decide this? Recently?*

M: *Not really. I decided the last time he was home and I found condoms in his briefcase. Some people will tell you to be patient, but I've had enough. I don't really care what he does. I don't love him any more.*

C: *How do you think he'll take that?*

M: [Hisses]. *That's his problem. What if he gives me AIDS? Does he want to turn his daughter into an AIDS orphan? One thing I know for sure: my heavenly Father did not say that I should suffer abuse just because I'm married. He* [husband] *wants to break our marriage and break my spirit, but he doesn't know that he's dealing with the daughter of the 'Most High'* [God]. *He's in for a rude awakening, my sister. I can no longer throw my pearls to the swine!*

Mariam's frank misgivings and frustrations over her marriage were shared with me, I believe, partly due to our familiarity with one another (she was a key informant whom I had met earlier in London and helped me gain access to CWC's women's groups). However, I attributed her openness more to one of the basic lifestyle mechanisms: the 'confessional' culture. Members were encouraged to confess their faults and problems with their discipling partner, or with a member of the pastoral team, so that they could receive appropriate assistance if necessary, such as counselling in Mariam's case.

In addition to this openness, the sequence of her narrative has a number of interesting elements, because it follows the abbreviated trajectory of her decision to abstain from having sex with her husband. First, at the beginning she reveals the emotional issues that are involved in the breakdown of her marriage and her initial struggles to "*fight*" for her marriage. Again, there is a militarized response to a problem faced by many men and women. However, it seems that it is women that speak of fighting for their marriages or to save their homes. Soothill (2007) finds this same discourse utilized in Ghanaian churches, where women are also recruited and trained to wage spiritual warfare. The initial battlefront, Soothill remarks, is the home with Satan being its prime enemy (*op. cit.*:209) and women its primary defenders. Given the duplication and cross-fertilization of literature that exists in Ghanaian and Nigerian churches (Newell, 2005), the weapon of warfare is at the disposal of many women. Therefore, as a result of the growing regional influence of warfare discourses, it is unsurprising that one of Mariam's first steps to address her husband's infidelity was to "*fight*".

Her next reaction to her husband's infidelity is the second striking element of this excerpt, which is her decision not to sleep with her husband. Her prime reason for this is not simply fear of HIV transmission, but is also intertwined with the notion of romantic love, as well as a trust which she considers to have been breached. She had earlier described an initial reluctance to abstain because she wanted to "*spare his feelings*" but, as she narrates in this excerpt, she eventually "*stopped caring*". From this, I interpreted her choice to abstain as involving a decision to protect herself emotionally, as well as a decision to protect herself from possible infection.

The final interesting element about this is what could be read as a potential defence against any reaction to her decision from both her social and Christian networks. Her reference to people who said she should "*be patient*" is indicative of criticism from within a culture that places marital success (and failure) on women's shoulders, and believes infidelity to be characteristic of a 'Nigerian marriage'. However, it is unclear who those people are, but whoever they might be, they would find it difficult to argue with her more socially acceptable references to the Bible and to her very real fear of contracting HIV and leaving her child motherless. Soothill (2007:217) cites a very similar instance in Ghana, in which women drew on the spiritual and gender discourses of Pentecostal churches for their own benefit, including abstaining from marital sex to avoid contracting HIV. This suggests that, as with my participants, there is a possibility

within Christianity to find power within what is otherwise often argued to be restrictive for women.

TIME, FAMILY AND THE 'FLAIR-THING': EXPLAINING GENDERED PATTERNS OF PUBLIC PARTICIPATION IN GLOBAL JOY'S PREVENTION PROGRAMMES

Despite the leverage and confidence participants garnered from their use of ability and spiritual warfare discourses, they did not channel these aspects of identity renegotiation into HIV prevention services. Instead, they were ambivalent about their roles in Global JOY, which contrasted sharply with their very visible roles within the church and within their professional and personal lives. Male church members, however, appeared to have a much more prominent role in Global JOY, particularly in outside meetings with NACA and other NGOs working on AIDS.

While engaging in participant observation of these meetings, mostly at the invitation of informants, I often encountered William, the male coordinator of Global JOY. Chika, his female counterpart, usually remained in the office, which is where I had first met both of them. Their own professional dynamic mirrored many of the marital dynamics that were played out in CWC. She was to submit to his leadership as the male. Given this, it would have been easy to assume that William was fulfilling the gender roles prescribed to them by CWC and thereby reconstituting them. This, however, would still not account for the women's ability to negotiate safe sex, delay sex or abstain altogether. When I asked Chika why she preferred to remain in the office while William had what seemed to be the more interesting role of travelling, attending workshops and meeting new professional contacts, she confided that being in the office gave her the freedom to invest her time into a business venture she had recently embarked upon. Its success would guarantee financial independence.

This seemed to be the mantra of all the participants, apart from Geraldine who actively sought ways to enhance her skills so that she could work with Global JOY. Several participants told me that they "*would love to do more but didn't have the time*". Some told me that they participated in the short-term projects and events, such as one-day outreach campaigns. However, the more interesting narratives came from those who

had had first-hand experience with HIV/AIDS, yet resisted channelling their experience more publicly into Global JOY's programmes. In particular, these narratives entailed the notion that successful AIDS work required some sort of experience, but seemed to also require certain skills and talents, which were taken to be weightier than the experience. Participants often ascribed these talents, in particular, to men.

They've Got This 'Thing': Experience and (Mis-)identification in Lay Expertise

Esomo, a 22-year old seamstress, was one of the first people who agreed to participate in the study, because AIDS was "*very close to* [her] *heart*". I later learned that her father had recently died after a series of AIDS-related illnesses. During the interview, she told me that her family did not have enough money to send her to university, so she had tried to learn different trades until someone in the church had suggested sewing. She also relayed how her family's economic situation had changed once her father became ill and how this experience, along with the counselling and support from fellow CWC members, enabled her to resist her boyfriend's advances (who said sex would give her comfort). During her discipleship sessions, she divulged this to her mentor and her boyfriend was then duly rebuked and had repented. What did give her comfort, she said, were the television programmes in which people living with AIDS and their carers shared their experiences, as well as advice on issues including nutrition and managing symptoms.

C: *What is it about that programme that stands out for you?*

E: *Mmmm... because it's hosted by real people who have been affected by AIDS. They get through their own problems and go on to help others. My boyfriend laughs, because I'm just glued to the TV when they come on. They're so confident. It's like... it's like... they just have that 'thing', you know? I don't even think they know the impact they're having.*

C: *Could you see yourself doing something like that one day: using your experience with your dad to have that kind of impact?*

E: *Ah - I don't know if I could go and speak like that. I told you how I basically ran away when my Dad got worse. I mean I ran! I came to Abuja and the family was still in Lagos, so my brother looked after him. And now my sister has the same rashes and stooling* [diarrhoea] *that he had. It's even harder with her than it was with him, because at least our father admitted he had it* [AIDS]. *But it's my turn* [to help] *now.*

While this excerpt from Esomo's interview transcript deals with issues relating to the care and support of people living with HIV/AIDS rather than the prevention of HIV/AIDS, it is still useful in analyzing the participants' reluctance to participate in HIV/AIDS prevention services despite the power they are able to negotiate through self-worth and spiritual warfare discourses. As with the other excerpts, there are a number of compelling issues that arise with this particular one. The first factor was what I took to be her (mis-)identification with people in HIV/AIDS programmes on television. On one hand, she shows an active and involved interest which stems from her identification with "*real people*" (some of whom were positive) who provided information to people like herself and who were in the position of giving very practical hospice-type care to family members living with the condition.

On the other hand, however, Esomo could not picture herself doing the same thing. This is not to say that she had to aspire to become a media expert on HIV because of her own family's experience, but the 'lay expert' factor of the programme is precisely what had drawn her to it in the first place. It is interesting to note that she did not mention the other programmes that are on Nigerian television in which doctors, government and non-governmental staff dispense information and advice. I interpreted her (mis-)identification to be based partly on this omission, and not due to communication skills or even education, although it would have been easy to assume this. To secure an income within the competitive market of tailoring in the nation's capital requires entrepreneurial skills and confidence. Rather, I interpreted her mis-identification to be based on her identification, or rather her desire to identify, with lay experts who had "*the thing*" or the passion to live with the virus or, in her case, to live with someone living with the virus.

In other words, her reticence to be more involved was related to her feelings about her own role as a care-giver. She had expressed a lot of guilt, grief and remorse at not being able to handle her father's illness. She also expressed anxiety and fear over her sister's health, could recognize symptoms similar to those of her father's and was, therefore, preparing to share care-giving responsibilities. Where then, would she find the time to add an additional responsibility of public work, or another 'burden', at that time in her life?

Resisting the Triple Burden

Victoria is an example of participants who resist the third burden that Moser (1989) discusses and that AIDS work has become to many women. A medical doctor with a private practice and mother of two, 38-year old Victoria looked like the next generation of Nigeria's top female preachers. Well-groomed, gracious and articulate, she sat with me in a corner of the church after the last female member had elicited what seemed to be, from the look on her face, a piece of life-changing advice. As she wiped her 5-year old's nose and sent her away with a sweet, she explained that she had just negotiated a deal with the landlord of the school which housed CWC. This would free up funds to support Global JOY, as well as feed and clothe the church's "*most vulnerable*". She also explained that she often waited until after the service to speak to her women's group, because she alternated between the national hospital and her clinic, gave lectures to PLWAs, was involved with her children's parents' committee, and served on several boards in Abuja and Lagos. However, she did not mention that she had opened her home at one time or another to several of the church members, including Esomo. Regardless of all of these activities, I proceeded to ask about her involvement with Global JOY worldwide.

V: *Ah!* [Leaning back into her chair]. *I just can't afford to put my hand into anything else right now. Besides, Chidi* [husband] *is the talker. He's the head of the household but we make all the decisions together: business, family, ministry... Our first ministry is this family. Then it's our careers which help us with many expenses, both church and family. Plus as a pastor, he has a lot of practical experience and comes across all sorts of people. By the time people reach me, they're coming for treatment and to be honest between the counselling we do here* [at church] *and the clinic, I don't even think I can still be 'giving'. But he really does have a flair for these things - I mean for the type of AIDS work that we're talking about as. Especially where the youth are concerned; he's had this zeal to work with them since NYSC. That's why he has the more active role with* [Global] *JOY. We agreed* [on this].

The first striking element of Victoria's excerpt was what I interpreted to be her adamant resistance to taking on community work (a role primarily associated with women), or any other work for that matter. Given her multiple roles and responsibilities, there were a number of contradictions arising from her decision not to take on further responsibilities. It is here that the political economy of Nigeria, and especially Abuja, takes on particular relevance about how participation and non-

participation is played out. A popular perception of AIDS prevention and treatment services (or AIDS work) is that its global importance means that it attracts significant global funding, therefore affiliation with such projects (commonly referred to as 'dollar projects') is highly desirable. Like many donor funded programmes, AIDS work is characterized by a number of activities, including training and workshops that are subsidized with budgets for line items such as transportation, lunch, equipment and the highly coveted *per diem*. Furthermore, as Smith points out, in Nigeria such projects provide opportunities not only for professional advancement, but for maintaining family ties and expanding social networks (2003:709). It is, therefore, not surprising that AIDS work is perceived to be an attractive career opportunity.

Therefore, while Victoria is drawing on negotiated gender identity and norms to resist AIDS work, she is actually forfeiting a highly coveted opportunity. However, in her case it seems unlikely that working publicly with Global JOY would enhance her professionally. During the interview and the course of my fieldwork, I found that she had sat on a number of executive boards around the country, and provided lectures on health and nutrition to members of networks of people living with HIV/AIDS. She did the latter in affiliation with Global JOY. So, while it looked as if she was forgoing opportunities, I interpreted her reluctance to participate in other ways as her resistance to relinquish the power she had obtained through her profession. Moreover, despite the renegotiation of gender norms within CWC, motherhood was still central to many participants and to the church's overall ethos, perhaps due in part to its cultural significance. Therefore, her resistance to taking up further responsibilities could be interpreted as her way of drawing on renegotiated norms to suit her own purposes.

Her resistance, however, raises the second contradiction. While it was evident that Victoria had a career which afforded her certain status, it was difficult to say the same for her husband. Compared to some of the big churches in Abuja and throughout the country, CWC had around 150 members and was not a popular church. Since pastors' salaries often depend on the number and socioeconomic background of the church's members, it was unlikely that Victoria's husband commanded a high salary. In fact, many pastors of small churches in Nigeria supplement their salaries by engaging in a trade, seeking employment, or continuing in the profession they pursued prior to becoming a pastor. Moreover, he had asked me for professional advice after I had interviewed his wife. I soon learned that he also worked part-time with another pastor

and their duties involved preparing and delivering sermons, counselling church attendees, liaising with other non-profit making organizations to meet the needs of church members, fundraising, managing the accounts, overseeing the maintenance of the church's property and equipment, staff and volunteer development, etc. In other words, he was looking for further part-time employment.

Hence, I interpreted her reference to his "*flair*" to be part of the self-worth and ability discourse that reconfigured gender norms, this time addressing masculinities. By associating his flair with work and his interest in young people, she ascribes to him a passion which, for her and Esomo, is necessary in AIDS work. Furthermore, she asserts her position as equal within their relationship, albeit couched in religious gender discourse, but still refers to her husband's spiritual position over the household. In doing so, she seeks to address any perceived or felt power imbalance within their relationship, as his participation in Global JOY's activities would hopefully expand his social network and career development opportunities. His role in Global JOY would inadvertently improve his existing role of providing pastoral counselling to people at risk of contracting HIV, or who were already living with the virus. In essence, Victoria had found a socially and religiously acceptable way for her to relinquish additional responsibilities typically associated with women, despite the perceived benefits.

Nevertheless, CWC and Global JOY have similar leadership models in both the Lagos and South African programmes. These models feed into the growing perception that HIV prevention and treatment programmes in Nigeria are predominantly run by men. Informants who represented gender or women's organizations were often ambivalent about HIV/AIDS. Several cited that 'women were most affected and infected by the virus', and felt that their organizations should work to respond to the Millennium Development Goal (MDG) on Women's Empowerment (UNDP, 2002). However, the chairperson of NACA, Dr. Osotimehin, admonished women not only to "strengthen their commitment" by focusing on AIDS awareness and girls' education, but to increase men's responses to the fight against AIDS (Epia, 2007). In the language of the MDGs, this means that women's groups were charged with addressing three of the eight goals, namely achieving universal primary education, achieving gender equality and empowering women, and combating HIV/AIDS (goals 2, 3 and 6, respectively) (UNDP, 2002). However, they have been charged with the task of achieving a goal that impinges and depends on the success of several other MDGs, but have not been

endorsed with the funding and political will to support the one goal that cuts across these MDGs (including reducing poverty and hunger, reducing maternal mortality and combating child mortality or goals 1, 4 and 5, respectively). It is therefore, unsurprising that women in private and public environments are either ambivalent as to how to address these goals without adequate support, or reject the burden outright by choosing to maximise mechanisms and agency in spaces in which they already have an impact.

Although participants could renegotiate gender norms and identities, their roles in church and Global JOY were somewhat gendered. The church work that most of them preferred to do consisted of providing counselling, support and palliative care for people with a range of issues, including HIV/AIDS. The Global JOY work involved more formal and recognized processes, such as managing programmes, conducting assessments and evaluations, and administering funding. While it was true that men and women took part in both types of work, men seemed to dominate the Global JOY programme. However, these findings raise further issues about the political and economic contexts in which this work model and other work models are being developed. Furthermore, the findings beg the question as to the types of labour and income generating options that are available for men. Participants in this seemed at ease with having multiple sorts of income, especially since the secondary source usually reflected a business opportunity or personal interest. However, researchers have often narrated incidents in which men appeared to be disenfranchised, complained of the lack of employment opportunities and often sought ways in which they could track such opportunities outside of the country (Adepoju, 2000). Finally, the influx of men into the management of HIV/AIDS services has implications on the way these are delivered, and whether or not they take women's multiple roles and needs into consideration when planning and implementing prevention programmes.

SYNOPSIS

This chapter has demonstrated how abstinence, an option in HIV/AIDS prevention discourses, is understood, maintained and negotiated by participants of CWC in Abuja. Participants attributed meaning to abstinence which is otherwise ignored within empowerment literature, yet these meanings (and the mechanisms through which some of them are drawn and negotiated) are precisely what enables them to insist upon it

(and maintain it) in the face of sexual pressure. Specifically, participants drew on and negotiated a notion of spiritual power which they utilised to renegotiate gender identities through church-sanctioned discourses of self-worth, ability, bodily integrity and by becoming prayer warriors. This was achieved through their participation in basic and spiritual lifestyle mechanisms in a setting in which these gender identities were collectively negotiated with men and women.

Conversely, there are challenges and limits to doing so in the absence of a shared understanding of these meanings by sexual partners - past, present or potential (as with Timi, Mariam and Gozo, respectively). Challenges and limits also exist in the absence of laws, policies and programmes addressing sexual and gender violence (as with Geraldine). Furthermore, absence of a secular 'universal' notion of rights against violence, as well as the political will to implement and enforce those rights, increases women's vulnerability even when all of the prescribed prerequisites for safe sex negotiation are in place. This latter point is one which has been argued by agencies, activists and academics alike (for example, Baylies, 2001; Gender Health, 2004). The religious discourse of bodily integrity, while subject to contestation and misappropriation, nevertheless served as a means through which participants could articulate the demand for what is also considered to be a human right and prerequisite for safe sex and AIDS prevention.

The channel through which these discourses and mechanisms exist is not limited to the CWC, the church in this study. Researchers have argued that the rise of Pentecostalism in Africa has enabled some woman to use it to charter new spaces for themselves, particularly socioeconomic spaces. Churches (Pentecostal or otherwise) are fraught with their own conflicts and contradictions. Despite their more modern labels of 'intolerance' and 'discriminatory', they have also relied on principles and mechanisms of benevolence that predate the era of 'NGO-ism' in Nigeria to provide assistance to the poor and vulnerable. Given the broad and existing networks, and the salience these mechanisms and meanings have in many people's lives, it is little wonder that these previously self-funded efforts have attracted the support of international donors such as USAID. Nigeria received $163.6 million in 2006 and $309.4 million in 2007 for prevention, treatment, support for HIV/AIDS programmes, and antiretroviral treatment. While the Abuja branch of Global JOY funded its own AIDS programmes, its Lagos head office was one of over thirty NGOs subcontracted through the US contractor.

While I agree with researchers like Campbell (2004) and Allen (2004) who question the effectiveness of AIDS prevention programmes and policies, I must point out that there are debates in Nigeria and elsewhere on the funding disparity between treatment and prevention programmes.[80] The United States Centers for Disease Control (CDC) has argued that the current levels of prevention funding are not enough to make the desired impact, citing that there are six new infections per treated person.

Nevertheless, USAIDS's PEPFAR programme has been at the centre of the debate concerning the success of HIV prevention programmes around the world. In particular, it has been criticised as a project of Bush-led US imperialism which imposes morality and conservative views on sex through its abstinence-only programmes which, in turn, are argued to be ineffective and restrict women's sexual options. However, this criticism does not take into account the salience with which participants respond to the rhetoric that is argued to propel abstinence-only campaigns. The links between US Christianity and African Pentecostalism has been documented (Smith, 2001), and is reiterated through the media and publications from American preachers which are prevalent in countries like Nigeria (Newell, 2005). They have also documented findings that resonate with this research, namely the effect that spirituality has on AIDS prevention (Smith, 2000) and on gender relations within and outside of spiritual institutions (Hodgson, 2005).

Therefore, I would argue that in a context where women believe that they have to ensure a conjugal relationship to secure financial and social stability and power, abstinence could provide an option for women who may have previously believed that they could never choose *not* to engage in sex. In the case of participants who have already contracted HIV, it may be the primary means by which they avoid re-infection of HIV or the introduction of agents which can lead to compromised immune systems, diminishing the ability to ward off diseases (such as tuberculosis or pneumonia) - all of which could eventually lead to AIDS. In the next chapter, I analyse the mechanisms that enable women participants living with HIV/AIDS to prevent secondary infection and stay healthy ...and alive.

[80] Personal communication with Dozie Ezechukwu, Programme Coordinator for NEPWHAN, October, 2006.

CHAPTER SEVEN

Engendering AIDS Citizenship? Personal Strategies and Public Struggles

INTRODUCTION

In this chapter, I consider the ways in which participant involvement in AIDS-related activities contributes to a notion of citizenship, which empowers them to protect themselves and their families against primary and secondary infections of HIV or other STDs, and to resist stigma. One common finding amongst the participants was that stigma posed a significant challenge which they faced in their everyday lives. Some even implied that it was another type of 'death' because "*...the people around you will hate you so much that you will fall down and die*" (Yerima).[81] The term 'fall down and die' is culturally relevant because it is a local phrase popularly associated with killing evil spirits and proponents of witchcraft. Although only three women used this term specifically, their use suggests that they are aware of the way. their identity is constructed within local understandings of AIDS as 'witchcraft', 'evil' or 'immoral'. This type of identity construction is an example of the 'spoiled identity' which results from stigma (Goffman, 1973) from diseases like HIV/AIDS. However, their involvement in NEPWHAN, the umbrella organization for AIDS support groups, presents public opportunities to challenge this type of stigma. Furthermore, participants described other personal strategies through which they worked to un-spoil their identity, which included alternative prevention strategies. The combination of these actions and their public participation forge a notion of AIDS citizenship which takes shape in several strategies; personal prevention, strategic, experience-based, social and selective. I have selected the two overlapping lenses which I draw upon to analyse the findings presented in this chapter. The first is health citizenship (Epstein, 1996; Brown, 1997; Nguyen, 2005; Robins, 2004, 2005); and the second is stigma and discrimination (Joffe, 1999; Parker and Aggleton, 2003; Campbell, 2004).

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81 Some researchers and activists have documented how stigma is referred to as a 'second death' (Campbell *et al.*, 2007) and how, in South Africa, reintegration into society through drug treatment and AIDS citizenship can be interpreted as a 'resurrection' (Robbins, 2004).

AIDS citizenship refers to the combination of individual and collective responses to the material, social and discursive effects of living with HIV and its related stigma and discrimination in Nigeria. The definition used here is derived from the analyses of four separate identity-based movements. The first two took place in the USA (Epstein, 1996) and Canada (Brown, 1997) in the late 1980s and early 1990s, while the second two continue to run in Burkina Faso (Nguyen, 2005) and South Africa (Robins, 2004, 2005). Each analysis deals with the way AIDS activism contributes to a new form of expertise-based citizenship, which can be used to challenge prevailing assumptions about HIV/AIDS, albeit with different theoretical underpinnings and within different geographical and cultural contexts. Epstein's (1996) sociological analysis of the AIDS movement in the USA charts the ways in which lay experts were organically 'cultivated' from within the movement, which allowed them to contest scientific evidence which blamed homosexual men for the spread of HIV and thereby contributing to a new notion of biomedical citizenship. An ethnography of the AIDS movement in Canada reveals how AIDS-related activities that take place in spaces which are not typically associated with politics, can be opened up to issues of citizenship.

A third movement, in Burkina Faso, is examined to reveal a notion of therapeutic or biopolitical citizenship which is:

> "...based on being HIV positive (biological) together with certain claims to rights (political) and helps activists integrate being HIV positive into a moral order" (Nguyen, 2005:131).

In his sociological account of a fourth movement in South Africa, Robins (2005) suggests that AIDS activism provide benefits which go beyond claiming rights, being more related to the new identities and subjectivities forged through the shared experience of passing from death to life as a result of campaigning for and accessing drug treatment.

What these studies share in common is that they highlight the potentially empowering effects of AIDS activism, particularly in the face of stigma and discrimination. The way I have defined AIDS citizenship has parallels with the above conceptualizations, in that it is also concerned with the potentially empowering effects of AIDS citizenship which go beyond the important immediate and tangible needs of improving drug access

and anti-discrimination policies. However, my understanding differs because it is based on the ways in which participants derive and carry out prevention strategies to protect themselves, partners and children from HIV as part of the wider strategy they adopt in their everyday lives to un-spoil the identity framed by gender norms and expectations.

The various strategies deployed by participants helped to begin the process of 'proving' their citizenship or perhaps repatriation by 'un-spoiling' their identity and resisting the blame associated with (internalized) AIDS-related stigma. Spoiled identity consists of the "blemishes of individual character [which pose] a special discrepancy between virtual and actual social identity" (Goffman, 1963:12-13) for the person who is the victim of stigma, or is the stigmatised. This definition has been open to many different readings, as Parker and Aggleton (2003) point out. However, I adhere to what may be a less common reading, which views stigma and the spoiling of identity as a social process which "devalues relationships" (*Ibid.*:14). In particular, I find two concepts useful here. The first is the concept of identities, which can be used to consider multiple identities including gender as well as AIDS, which allows for a reading of Goffman's conceptualizations of stigma and identity management to include the social context of structural violence which I take as a frame for management processes. By taking this perspective of stigma and by recognizing discrimination as part of the social process which women may experience before they learn their HIV status as well as after, I lay the groundwork for examining their resistance to stigma and discrimination. This, in turn, leads my analysis to draw on the concept of social capital which, like identities, I refer to in Chapter Two and explore the negotiation of in this chapter. In essence, by highlighting experiences of women who enter the HIV/AIDS and stigma trajectory with different backgrounds, I hope to highlight the ways in which women negotiate social capital as they manage their identities in ways that may resist stigma.

This is not to say that men do not feel or experience stigma or blame. Joffe demonstrates in studies on HIV and inter-group blame amongst gay men in Britain (1999) and South Africa (1993). However, perhaps due to gender norms and expectations, it is easy to see how men in Joffe's studies trade and negotiate blame. Similar norms in Nigeria (as well as reproductive intentions and desires of women) also make it easy to comprehend how positive participants here interpret name-calling, eviction, violence and discrimination as blame for potential transmission to partners and children. Therefore, their work to un-spoil their identity would allow for their

social (and, at times, geographical) reintegration into society. However, the way in which they do so has implications for creating an environment in which people who already have HIV feel freer to discuss it and openly seek treatment.

This chapter is organized in five sections which examine five ways in which women lever social capital to un-spoil and manager identities, as well as execute strategies and practices that are salient to their AIDS citizenship or that enable them to engage in AIDS citizenship and negotiate their identities in ways that bring a sense of normalcy to their everyday lives. The first section examines *personal*[82] strategies, or the ways in which women work to un-spoil their identity in the home by engaging in the 'impetus to act' and forging alternative HIV prevention strategies that differ slightly from the traditional 'ABC' methods.

The remainder of the chapter looks at more public strategies participants used to negotiate normalcy in their everyday lives. The second section looks at how participants use *strategic participatory networking* with little or no social capital to access more essential amenities. The third section considers how *experience-based networking* allows participants to invest in social capital levered through institutional support which, in turn, can yield surprising benefits or rights normally associated with everyday citizenship. The fourth and fifth sections analyse how *social participatory networking* and *selective social networking* were deployed to negotiate participants' reintegration into 'normal' lives. The final section deals with some of the contradictions and challenges in negotiating personal and public AIDS identities.

Against this backdrop, I describe in this chapter how participants resist two major challenges - biomedical disease (HIV/AIDS) and social disease (stigma), by choosing to engage in safe sex, seek treatment (in most cases) and participate in support groups coordinated by NEPWHAN. As discussed in Chapter Three, NEPWHAN is the umbrella organization for 240 support groups across the country, with approximately 80,000 members. It was established in 1996 and has its headquarters in Abuja, where two of the interviews took place. NEPWHAN works closely with the Federal Capital Territory's Action Committee Against AIDS (FACA), who provide counselling and

[82] I use personal in the feminist sense which recognizes the personal as being political. While the strategies interpreted from participant narratives of how they prevent HIV and other infections are very rarely a private affair due to the fact that most participants give or take advice from doctors, counsellors and fellow group members, these strategies are used in the political work of proving citizenship and managing normalcy.

organize seminars on the medical management of HIV/AIDS. FACA also serves as a general meeting point and refuge for positive people, as it is located near the city centre. I conducted the remainder of my interviews in FACA's offices, as it was more convenient for people who were already there for counselling or to collect drugs or emergency 'funds' that the director dispensed to individuals (at times from his own pocket). The two-storey office building is conducive to visitors' privacy. On the upper floor are a large conference room and administrative offices (including offices for the director, consultants, counsellors and accountants). On the lower floor is a large reception area with several comfortable armchairs and sofas, air conditioning and a huge television. Many participants said that they liked to visit FACA because it was more comfortable than their own homes. They also said that it had a cheerful atmosphere and that they felt accepted here because everyone understood what the other was going through.

'I AM THE COUNSELLOR IN MY FAMILY': THE IMPETUS TO ACT AND POSITIVE PREVENTION STRATEGIES

This section discusses some of the personal strategies participants used to protect themselves from possible reinfection of HIV and the introduction or development of new infections, and to protect their partners and children from HIV. Where possible, some participants adopted these strategies alongside others to protect their overall health, including comprehensive drug therapies, nutrition management and stress management. Their ability to learn and adopt these complementary methods is more than likely a result of living in Abuja, which offers two of the country's more robust service delivery packages for people living with HIV (the other is in Jos). However, these services are not free, which means participants' access to them was varied, rendering the impetus to act and positive prevention strategies more important in managing identities in ways that reduce stigma and its internalised effects.

Impetus to Act and the Renegotiation of Spoiled Gender Identity

Participants begin what I understand to be a process of 'un-spoiling' and normalising their identity through AIDS citizenship by displaying three main characteristics of their impetus to act and adopting positive prevention strategies. These include knowing

one's status, expressing a willingness to protect their health and expressing a willingness to protect the health of those closest to them. I arrive at these interpretations by situating participants' negotiation of health and stigma within the framework of social displacement - a potential obstacle to citizenship which characterises the loss of social capital and support that each participant said they faced upon learning their HIV/AIDS status. Knowing one's status, therefore, has not only health benefits but also implications for participants' personal and social lives.

Knowing One's HIV Status

Knowing one's status involves a range of processes which would, in an ideal setting, include seeking or receiving information about HIV/AIDS, identifying a voluntary counselling and testing centre, receiving pre-test counselling, having the test, receiving post-test counselling, collecting test results, receiving follow-up counselling and negotiating and adhering to a treatment plan. Practically, however, participants described learning their status either as a result of antenatal testing (3), employment testing (1) or voluntary testing (6). Despite these different modes, the participants seemed to express ambivalent feelings towards knowing their status, as this knowledge positioned them as being knowledgeable on one hand, but ill on the other.

Donna, a 36-year old trader, expressed similar views upon learning her status in 2000, when there were very few services for people who were positive (including counselling and anti-stigma campaigns). She became the leader of one of the first women's support groups in Abuja, when she registered her group with NEPWHAN three years later. Donna eventually became a senior officer for the network of women that was coming together, partly due to her efforts. Tall and quiet, she describes how she came to learn her results and the implications this had for her.

D: *I just needed to know... for my peace of mind - my mind kept going and going. I'd look at my husband and know that he wasn't well. I'd ask him to go for testing and then he'd become angry. But I just felt that I was* [HIV positive] *in my heart. The test just confirmed it, but it's good to know one's status so that the person can plan how to conduct him or herself. When I eventually came to know my own status, I told him and he and his family called a meeting. They proceeded to abuse me* [call me names] - *that I'm ashawo,*[83] *I'm this, I'm that - then told me to pack out of the house. It was difficult time - I was now someone*

[83] A local derogatory term for a prostitute.

with AIDS (although now I know it was HIV, but then you just took it as AIDS. Most of our people don't know the difference - they just know that you just have AIDS and that you're going to die). [...] *But, somehow, knowing made me prepare my mind for it* [the separation from her husband and stigma from in-laws].

Knowing her status positions Donna in two ways that are similar to the rural women I discussed in Chapter Five, who were ambivalent yet prepared to face the challenge of being tested for HIV. First, it is interesting to observe that Donna's motive behind being tested was for a more holistic notion of health, which included her psychological health or her 'peace of mind'. It is as if having control over this would offset the psychological emotions that often accompany receiving a positive test result, such as fear, anger or denial. It also seemed to offset the marital consequences which she eventually faced. It is important to note that these consequences also had financial and social implications which would involve her exchanging her marital status for an HIV-status. This would be an understandable deterrent to being tested, as it probably is for many Nigerian women given the centrality of marital status in the quest for respectability. The fear of marital problems has been documented in other parts of the continent (Meursing and Sibindi, 1995:61). Despite this and other obstacles mentioned and referenced in Chapter Five, Donna 'overlooked' these and opted to empower herself with the knowledge of her health status.

Second, for Donna, knowing her status gave her an overall sense of control which went beyond managing her health. Phrases like 'conducting him or herself' or 'managing one's self' are used quite often in Nigeria and refer to having control over one's life by deciding and planning how to behave and what to do in the future. It goes beyond managing Donna's HIV/AIDS status, because she received her diagnosis at a time when support groups and health services did not exist on the same scale as they did at the time of our interview. However, in reference to her health and gender identity, which is stigmatised by having HIV, knowing her status paved the way towards managing her health and life, and establishing a support group to help other women to do the same.

Willingness to Protect Health

Positive participants displayed a desire to protect their health, although they went about it in different ways and had different understandings of what this meant. For all of them, this included preventing re-infection or secondary infection through safe sex. Also, for all but one participant, protecting one's health included adhering to drug treatments. Also of major concern was participants' psychological and emotional health. This was often at odds with seeking emotional support through social or intimate relationships. An excerpt from an interview with Mama Friday, a widow in her late fifties, highlights the conflicts that arise when working to protecting one's health and the implications this has on having intimate relations - a feature shared by participants who were single or widowed and wished to (re)marry. She was a trader and the mother of Friday, who facilitated the Rural Women's Association discussed in Chapter Five. She still lived in the village, but commuted to a support group in a nearby town centre, often accompanied by Friday. She had remarried ten years earlier after her first husband, Friday's father, had died. However, her second husband had died several months prior to our interview. He had three children from his previous marriage, then he and Mama Friday had had a set of twins together. All five children resided with Mama Friday, who also looked after the two children of her deceased sister.

MF: *The worst is that I feel alone; I need help. My former self - I would have married again but how can I with this thing* [HIV]*? They used to say that I was very fine* [pretty] - *some still do.* [...]. *Now my skin is sometimes full of 'nyama-nyama'* [rashes from 'disease']. *Anyway, I may still be able to marry but they told me that the AIDS can enter my body again if I'm not careful. But at least I would not die from loneliness - and I do not want these children to kill me. So I will manage what I can for now...*

From this interview excerpt, there are three main aspects which position her as being willing to protect her health despite the challenges to her social life. First, for her, her HIV status is now a barrier to securing another marriage, which may have been easier were she still HIV-negative. Referring to her "*former self*" could imply a time when she did not have HIV or a time when she was younger, more attractive with fewer skin rashes (*nyama-nyama*), or had fewer dependents, or a combination of all three. Interestingly, neither Friday nor his mother thought that her wish to remarry was particularly unique. Nor did they consider a potential barrier to remarrying in the fact

that Mama Friday had already been married twice and had seven dependents. This could be because they both realised she needed companionship (and Friday could be partially relieved from having to contribute to the children's welfare), or because they believed that her beauty would inevitably attract more possible suitors.

Second, her desire to remarry could be seen as a lay strategy towards managing her overall (mental and physical) health and protect her from other potential ills such as (depression from) loneliness or (the stress of) having primary responsibility of looking after seven children. Finally, however, she decides to counter her wish to remarry with information she has received either from her physician or from fellow support group members, and chooses to "*manage what* [she] *can*" for the time-being, which is to prioritise her health over her wish to remarry.

Willingness to Protect Family and Partners

A key aspect of un-spoiling identity and resisting blame inherent in the HIV/AIDS stigma, is to prevent others from being infected. This was of particular concern to single participants (n = 7) or those who expressed reproductive intentions (n = 5). Of these narratives, the following excerpt best reflects the range of considerations participants make on a daily basis. Rukevwe, a 32-year old artist and administrator, described how she separated from her husband when she first learned of her status, because she was afraid she would infect him. When he expressed his desire to have children with her, she continued to abstain until she found a doctor who specialised in counselling sero-positive discordant couples. Below, she explores the potential implications that her status has upon her decisions and behaviour:

R: *One thing I'll say is that my husband listens to me more now. He's the one who wants me to have a child, right? I want one too, but I am the one who has HIV. Sometimes he will want to do it* [have sex] *but I have to resist if we're not prepared. Not that I don't love my husband. The point is: I am the one who goes to meetings and is building capacity; I am the counsellor in this family; I know more about protection than him and I am learning how we can have another child without infecting either of them. After all, if my family has HIV then it will be on my head because I am the wife - positive - so I should know better. And I do... I'm trying to, anyway.*

As with the previous excerpts, knowledge takes centre stage in Rukevwe's excerpt, which she uses as one of the means to avoid infecting her husband and unborn child, as well as the blame which she would have to endure if one of them were infected. She attributes her growing 'lay-expertification' to being involved in AIDS-related activities, and in doing so is able to emerge with two unanticipated benefits: improving gender-power relations or marital relations, and reclaiming her body from the typical sites of contestation - patriarchy and biomedicine.

Positive Prevention Strategies

In order to establish how positive participants' membership of support groups helped them channel their impetus to act on HIV/AIDS prevention into actual prevention methods for themselves, I will now describe four main prevention strategies observed from participant narratives as contributing towards positive prevention, or the prevention of HIV and secondary infections amongst positive participants. They include: traditional or ABC, strategic partner selection, involuntary abstinence and medically supervised sex (particularly for participants who had had or desired to have children after learning of their status, like Rukevwe). These strategies went beyond the traditional biomedical model of ABC (Abstinence, Being faithful, and Condom use) and include practices which I interpreted as allowing them to (re)gain some semblance of control over their sexual and everyday lives, which are otherwise regimented by the management of HIV, including medical check-ups and blood tests, dietary monitoring, attending workshops, participating in advocacy meetings, peer counselling, etc.

Strategic partner selection and involuntary abstinence seemed to be the most practised amongst and informed by single participants or those separated from their partners. Favour was a 26-year old single participant who had worked as a shop attendant, but was unemployed at the time of the interview. She describes the reasons behind her strategy:

F: *I'm not in a relationship now but I wouldn't say that I planned it this way. Had I known my status in those days, I wouldn't have had a boyfriend. When you don't know* [your status], *you date one and he disappoints you, so you think 'I'll just go to another person'. Then, before you know it, you've had three boyfriends because each one breaks your heart after you thought you were 'the*

One'. [...]. *In the meantime, they look healthy and keep spreading it. But I know better now. I will either look for a fellow positive or serious Christian.*

There are two main interesting aspects of this narrative. First, there is a contradiction between her involuntary singleness and abstinence, and her strategic search for partners who meet specific criteria. This is because her involuntary singleness can be seen as a choice which would allow her the time and space to find her desired partner. Favour's strategic search for either a fellow positive or "*serious*" Christian partner further validates findings from the previous chapter, that perceptions of serious Christianity encouraged participants to engage in abstinence as a lifestyle choice. Similar could be said for positive participants, for whom safe sex is seen not as an option but is instead taken to be an imperative.

The second interesting aspect lies in the potential contradiction between her statement on how knowledge of status would have kept her from having boyfriends and her former boyfriends' roles in spreading HIV. I understood her statement to mean that, upon learning her HIV status, she would have stopped having boyfriends in order to prevent herself from transmitting the virus to anyone else. However, although she attributes the spread to her boyfriends, she does seem to implicitly 'share' the blame by tracing how she may have been infected through serial monogamy and potentially infecting "*three boyfriends*". If the latter is the case, then Favour's narrative may challenge the dominant discourse of promiscuous men who spread HIV, because it considers that potentially infected female partners may also infect their new partners.

This particular aspect of her narrative resonates with research undertaken on sexual networking and HIV/AIDS in Uganda (Epstein, 2007), which suggests that AIDS in Africa can continue to spread because of long-term serial monogamy or concurrent relationships in which a man has two or three long-term partners.[84] However, the strategies contrast with those documented in another study conducted in Uganda (Bunnell *et al.*, 2005), where people living with HIV expressed belief in the following prevention strategies: gentle sex, protection by God, immunity of the HIV-negative

[84] There may be a possibility that men in long-term concurrent relationships may spread HIV faster than women in long-term serial monogamous relationships. But this would not account for relationship models in which women have more than one partner, are abstinent, or in which men are in long-term serial monogamous relationships or are abstinent. Some of those models would match narratives found in Chapters Six and Seven, but elucidation of various relationship models and their influence on the spread of HIV would require additional research.

partner and their own HIV levels becoming undetectable by tests. However, the study does not indicate whether its participants were members of support groups or whether they participated in AIDS citizenship activities.

Nevertheless, the impetus to act and the prevention strategies elicited from Abuja participants reflect feelings of women in other parts of Africa who are faced with prejudices against positive women having sex or children (Feldman and Maposhere, 2003). They also lay the groundwork for participation in public AIDS citizenship activities. The relationships between the two are mutually reconstitutive, as participants describe how their private actions influence their public activism and *vice versa*. In the remaining sections, I analyse the ways in which participants obtain either no support or institutional, social or selective support to negotiate public forms of AIDS citizenship.

'I MUST BE THERE': ESSENTIAL PARTICIPATORY NETWORKING AND AIDS CITIZENSHIP WORK

In this section, I describe the first of four main outcomes of public AIDS citizenship: essential, recognised, repatriated and reluctant. Essential citizenship is an outcome of one of the ways in which participants use participation to build up social capital as a means to access basic amenities from either individuals or institutions. In doing so, they position themselves as resourceful agents who - despite their experiences of social displacement which are often exacerbated by stigma and discrimination - challenge the government's lack of a welfare system that should cater for the needs of people who are socially displaced or disadvantaged (including widows, orphans, the physically- or mentally-challenged). Although several states had established programmes in the areas of skills acquisition and small business enterprise, these were poorly publicised and difficult for people with little or no income to access by public transport. Consequently, this responsibility rests on the shoulders of family members, community organisations, philanthropic organisations, individual benefactors and NGOs. However, because of their socioeconomic positions at the time of diagnosis, many participants had little or no economic, cultural or social capital to build upon, which they hoped would generate access to jobs, income, treatment, etc. As a result, support groups became the primary gateway through which some participants negotiated provisions and amenities unavailable to them before their HIV diagnosis.

Specifically, essential participatory networking involved participants positioning themselves as bargainers through building social capital to help them access basic amenities, drug treatment, employment and money - which would have continued to be withheld from them had they not had HIV. Three participants (Mama Friday, Ify and Neneh) has explicitly expressed being completely alone. Mama Friday had been widowed twice and left with children to care for; Ify had been orphaned and forced to drop out of school; and Neneh had been widowed and chased away from her family home. Although Mama Friday, Ify and Neneh presented cases in which they expressed the need for help, every participant except for Yerima (see later) said they had experienced a period after diagnosis when they were either homeless, penniless or without food. However, these three cases were unique because of their positionality at the time of diagnosis which has different implications for someone who, say, loses their job several months after diagnosis.

Neneh's case was of particular interest because she seemed to have no-one to turn to, unlike Mama Friday who had an adult child who assisted her, or Ify who was constantly at FACA and was a bit more aggressive in seeking out odd jobs. When Victoria, the receptionist at FACA, introduced Neneh to me, she pulled me aside and whispered "*Please see if you can give her something*".

Neneh was 18-years old with a baby daughter and had lost her husband earlier in the year. She relayed how she had been abandoned by her family and in-laws when she was diagnosed with HIV upon the birth of her daughter, Grace. With very little education, receiving a positive diagnosis meant very little to her at the time. "*They gave me Grace and told me I was positive and I told them 'thank you'; I did not know what it meant*". When we concluded our interview she immediately (but shyly) asked if I knew of any job opportunities. She had completed Primary Six, and was skilled in hair-plaiting and cleaning, but often took up odd jobs to make ends meet. She told me that she had been advised against breastfeeding to prevent Grace from becoming infected. As a result, she said, she constantly spent "*every last kobo*" on baby formula, which cost 500-800 Naira,[85] nearly the price of a monthly supply of antiretrovirals (ARVs). When I asked whether she would be attending the upcoming ICASA conference taking

[85] The equivalent of US$2-4 at the time.

place the following week, which would open with a rally for positive people, she replied with determination:

G: *Yes, I must be there. At least they will give me a face-cap and t-shirt to wear... and I might be able to find someone to help me with my situation. I will try my best to be there.*

The first of several interesting aspects in this excerpt positioning her as a bargainer is the way in which her declaration "*I must be there*" serves as a function of her agency, despite being a young widow with a child. However, she plans to attend the conference rally to network for employment, cash or baby supplies - to meet immediate material needs rather than to achieve long-term political aims. This in itself is political, because it highlights the lack of assistance options available for her either as a widow, a single mother or a person with HIV. This point was amplified in a particularly interesting way during the conference, where many 'freebies' were on offer for people living with HIV. Throughout the five-day event, the organizers of ICASA had provided a large tent with free meals for people who were HIV positive. However, attendees complained that the offer had attracted non-positive people as well. These 'free-loading, gate-crashing opportunists' were heard to have passed comments such as "*Well, if there's free food today, then I have HIV today*". While organisers and conference attendees lamented over the 'greed' and 'craftiness', this scenario points to a) the government's lack of comprehensive and effective programmes to assist the socially-excluded, and b) the growing reputation in Abuja, especially, of HIV/AIDS being an 'industry' or business to take advantage of.

Second, not only is Neneh determined to attend, but by referring to the face-cap and t-shirt as something "*to wear*", she expands her agency a bit further in one or two possible ways. On one hand, she could be referring to the face-caps and t-shirts that are frequently given to people living with HIV/AIDS to wear during rallies, marches and outdoor events, as a badge of identification. In this case, she would wear them as her way of 'performing' her participation, which is her entry point into the rest of the conference which she hopes to network. On the other hand, she could be referring to the face-cap and t-shirt as something "*to wear*" everyday, as the very least that she could hope to obtain while attending the conference and participating in the rally. Or both meanings could apply. Either way, she is positioned as slightly 'richer' because

receiving something "*to wear*" means she has obtained something as a result of her participation.

Finally, the sequence of her comments highlights a qualification in her determination which positions her in an ambivalent light. "*I will try my best to be there*" was a qualification of her initial declaration that she "*must*" attend, perhaps because she realised that her attendance could be hindered by a number of factors, including lack of transportation fare or having to look after her daughter. Nevertheless, it was possible that she could ask a neighbour or friend (probably from the support group) for transport money, or that they would make transportation for her, but this type of provision only highlights the dependence that some positive participants described. Hence, her realisation that she was too poor to participate fully or consistently positions her has 'aware' in a way that encourages agency, but does not enhance her status materially.

The oscillation between empowerment and disempowerment interpreted from Neneh's narrative can sometimes characterise participation in AIDS-based identity politics in a way that is contradictory in several ways. First, citizenship implies participation in public institutions and a notion of personhood in the legal and bureaucratic sense (Berkovitch, 1999:10), which implies a related notion of rights. Yet, as citizens, positive participants were less likely to receive 'generic' government assistance and more likely to receive assistance as AIDS citizens.

Second, despite the possibility of receiving more assistance through HIV/AIDS citizenship than state citizenship, within the normative trope of citizenship, the rights of positive participants' citizenship would almost be questionable or even coincidental, because it was quite possible that they could not afford to attend, may be too unwell to attend or may be looking after dependents. Gouws (2005) questions the extent to which biomedical citizenship helps realise rights for women when their participation is often determined - or curtailed - due to the burden of care they experience. However, her question fails to consider the contributions of those who cannot afford to participate or are 'responsibilised' in other ways such as caring for loved ones, which limits its usefulness, thus supporting claims that citizenship is predicated on the exclusion of women (*Ibid.*:12). Therefore, for as much as there is a greater good for which people living with HIV are fighting for, there is a smaller deal of good which they feel could be done for themselves.

'BETTER THAN BEFORE': EXPERIENCE-BASED NETWORKING AND RECOGNISED CITIZENSHIP

The second theme within AIDS citizenship positions participants as their own resource of empowerment, which they negotiate through experience-based networking - or exhibiting key personal traits while working with a range of individuals and institutions and being recognised for it. Such traits include diligence, enthusiasm, genuine volunteerism, cheerfulness, relateability and resourcefulness. Although half of the participants described accessing new skills and opportunities through strategies that I interpreted as consequential participatory networking, this finding draws from two particular participants who adopted these strategies, Donna and Ramatu.

Each described how a lack of relevant services and information had led them to form support groups. As a result of their initiative and their ability to support other positive women, they were often approached by NEPWHAN or international NGOs to replicate and scale-up their efforts in other parts of the country. The success of their efforts attracted media attention, and they sometimes appeared on television or were quoted in newspapers. The findings also draw on comments about Donna and Ramatu that I heard from other informants, during meetings I observed, and during my visits to NEPWHAN. Donna and Ramatu were among the first names called upon when positive women were needed by the government or international donors for consultation. They were also called upon when NEPWHAN registered a new women's support group that needed mentoring. These comments helped me to trace some of the ways in which experience-based networking had led them to be recognised and, sometimes, rewarded.

Two of the paths that the participants' experience-based networking had opened led to knowledgeable health professionals and to organisations providing seed-money to women for small businesses. These resources were often introduced to women by Ramatu, an energetic 47-year old Muslim woman, who initiated one of the first all-women's support groups in the FCT (with Abuja as the capital). Her approach towards experience-based networking was based on her assessment and interactions with several individuals and institutions that she had approached to help manage her illness

and continue with her trade. One outcome was that her doctor became very busy with referrals from Ramatu so he, in turn, referred the excess to the slowly growing number of colleagues specialising in HIV/AIDS. Another was that Ramatu had begun helping women access seed-money for their businesses from the Ministry of Women's Affairs, who had turned down her initial requests for what she referred to as 'empowerment' or funds. Based on their feedback, she was able to identify one ministry staff member, whom she liaised with on a regular basis. Eventually, Ramatu was able to solicit five grants for 10,000 Naira each (about 450 US$ or £200) for five women in her support group and, based upon their ability to multiply the money, had been promised five more grants which would mean more women would be able to support their families and manage their illness.

Her referral to funds as 'empowerment' could easily be taken at face value as her understanding of empowerment. However, I understood her use of this term to be an example of mimicry (where she solicited the Ministry of Women's Affairs, whom she had come to understand were the providers of 'empowerment' for women) by adopting their language to ensure that her proposal would be accepted. In doing so, she reflected their understanding, which was to help provide the means for more of the basic material needs by which members of her group could sustain themselves. However, some development feminists have pointed out that empowerment through income-generating is limited if women do not have decision-making powers over the use of their money (Bhowmick and Bhattacharya, 2005).

Despite using the term empowerment to refer to seed-money for income generation, Ramatu seemed to attribute the current success to her ability to face her own negative experiences of the past. She described how she had been abandoned by both her husband and her doctor, and that both of them 'came to their senses' nearly two years later when she agreed to return to her begging husband. However, upon returning to her village with her son, she found very few people other than her (newly-repentant) doctor with whom she could discuss her health concerns. Moreover, she says she felt ashamed of her condition and eventually had to cut back on her trade until she began to feel better from her treatment and became more confident. By participating in managing their health and lives, Ramatu said, once again, that members of her support group would be empowered. Interestingly, despite having referred to empowerment in two different ways in the context of her group members, when I asked Ramatu what had

been the most empowering or beneficial aspects of belonging to a support group, she gave an unexpected answer:

R: *The best thing about the support group? It helps me, yes... but if people had told me that I would travel out of Nigeria, I wouldn't have believed them. I went to Kenya! Haha!!!* [Claps hands loudly once]. *In fact, I didn't expect that somebody could recognise me and send me to Kenya. They see that I'm hardworking, how I relate to members of my support group. So then Pathfinder said they needed PLA women to go to Kenya. I thought: "I've always been active, why not use me?"* [sits up straight and places hand on hips]. *I never even had a passport, but they got one for me. So I thank God for that. It has made me better than before.*

Ramatu's pride is what stood out throughout our interview, which seemed to coast on her enthusiasm and energy. She often leaned towards me and spoke conspiratorially where we sat in one of the offices of NEPWHAN's headquarters. Her pride and enthusiasm underlined two points in this excerpt. First, Ramatu's phrase "*Yes, it helps me, but*" was one of the factors which led me to interpret her recognition as an empowering priority, because it positions Ramatu as her own arbiter of what empowerment means to her. The "*but*" serves as a prioritizing function through which she acknowledges that there are other more 'common' benefits such as fulfilment, etc., but chooses to select owning a passport and travelling to Kenya as two related aspects of her work that are of great significance to her.

The second interesting aspect of this excerpt is, not only does Ramatu decide for herself the ways in which she is empowered through participation, but she also identifies herself (her diligence, networking skills, etc.) as the source of this empowerment. It is this set of traits that allows her to bargain for and obtain institutional social capital or support from Pathfinder, because she enters the negotiation with something to offer in exchange for the opportunity to travel.

Finally, she enhances her status further by implying a temporal analysis, which shows that her hard work preceded the institutional recognition which validated it. This could be read as further enhancing her status, by pointing out that her health status had not affected certain aspects of her personality or character. "*I've always been active*" is a function of Ramatu's intrinsic notions of empowerment, which in itself presents challenges if one tries to generalise findings, as an intrinsic notion of empowerment

could eventually be used to blame people for their 'inabilities'. Or, Ramatu's emphasis on her personal traits could also be read as a commentary that there are a number of strategies like hers that lie outside donor-funded and national level policies that could actually inform them, thus reconfiguring personal experience into 'professional' expertise - albeit on an *ad hoc* basis.

The theme of professionalism here resonates with Baylies and Bujra's (2000) research, which highlights how professionalism in Tanzania created ambivalence for workers who require credibility and legitimacy from both the populations they help and the peers with whom they work.[86] It also resonates with their findings that professionalism can create or exacerbate class tensions amongst peers. In Ramatu's case, while many informants who knew her spoke of her in favourable terms, one informant confided her displeasure at Ramatu's progress. This informant was not HIV positive, but had worked with Abuja's indigenous women since the late 1980s, some of whom I interviewed in Chapter Four. She expressed her frustration that, despite her efforts to collaborate with national and international partners on women's projects, she had never travelled abroad. What seemed most frustrating to her was that Ramatu, like her, 'no *sabi* book' or was not very literate. As a result, the informant had formed in her mind a rivalry with Ramatu, who was unaware.

Despite this interesting tension, I am also concerned with aspects of citizenship that were unavailable to positive participants when they were not HIV positive, and as a result, were only able to access them through AIDS citizenship. These are reflected in Ramatu's two perceived benefits of participation (passports and the right to freedom of travel), which are also found within discourses of citizenship and the rights and policies of people living with HIV/AIDS respectively. Some researchers on citizenship suggest that owning a passport and being permitted to travel may impart a sense of belonging to one's own country for the passport carrier. Torpey argues that "The idea of belonging that is at the root of the concept of citizenship is threatened when people cross borders, leaving those spaces where they 'belong' and entering those where they do not" (2000:12). This sense of belonging also implies that, because the traveller bears a passport, his or her affiliation with their native country would be recognised by the destination state. Furthermore, and inherent in this affiliation, is the notion of state protection were a negative incident to occur. This is often illustrated in situations where

[86] The theme of professionalism also appears in research on gay men and activism (see Epstein, 1996).

hostages have been taken and diplomats from the hostages' country are sent into the country for negotiations. Therefore, Ramatu's pride in owning a passport may reflect a deeper sense of belonging that is now officially recognised by the Nigerian government.

In essence, Ramatu's passport and travel not only function as proof of Nigerian citizenship and legitimate her work with her support group, but they also pose a challenge to countries that enforce travel policies which stigmatize travellers and aim to police their movements. Although Ramatu's destination country does not hold such policies, thirteen countries,[87] including the United States, uphold restrictions on incoming travel by positive travellers.[88] In the case of the US, a waiver is required by travellers going through or to the US, even if this only involves an aeroplane change; these waivers involve forfeiting the ability to seek treatment or to apply for a change in visa status while still in the US.[89] While this had implications on short- and long-term migration, the implications related to positive participants in Nigeria are centred on stigma, discrimination and human rights.[90] Hence, having a passport and being able to travel, particularly since there are restrictions on HIV-positive travellers, validates her health and safety as a traveller, and thus counters the unspoiled identity that comes from policy-induced discrimination and stigma.

This section highlights a number of ways by which a positive participant defined, understood and interpreted being empowered. Several positive participants referred to having active or successful lives before being diagnosed with HIV, falling ill or joining the support group, saying that joining their support groups had made them improve their lives, which they reflected on in different ways. While Ramatu was always active, Mrs. Jack said that joining the support group had made her "*more active*", forcing her to learn how to obtain a provisional licence and learn to drive a car that had been bequeathed from an affiliated church project. These findings of recognised citizenship through institutional links resonate with similar experiences of 'having a new purpose', or life acquiring new meaning found amongst people living with HIV in southern

87 The other countries banning HIV-positive travellers include Iraq, China, Saudi Arabia, Sudan, Libya, Qatar, Brunei, Oman, Moldova, Russia, Armenia and South Korea - a Deutsche AIDS Hillfe, a leading German AIDS organization and compilers of the list, point out that most of these countries have 'undemocratic regimes' (Ireland, 2007).

88 While the African Charter on Human and People's Rights 1981 states that countries can refuse entry to people they consider to be threats to national security, public health, or to the population at large or even to morality, freedom of movement for people with HIV/AIDS is unrestricted across the continent.

89 *Ibid.*

90 The International AIDS Society.

Africa (Robins, 2005; Soskolne *et al.*, 2005; Comaroff, 2007). However, it moves slightly beyond these experiences to consider participants' negotiations with recognition as a means of managing identity, in situations where the recognition and rights as everyday citizens are gained as well as lost.

SOCIAL SUPPORT NETWORKING AND ESSENTIAL REPATRIATION

The next two sections describe two dimensions of a theme interpreted from the narratives around AIDS citizenship. Some participants position themselves as having had to adopt one of two networking strategies in order to repatriate and regain lost privileges and status they say they experienced as a result of AIDS-related stigma and discrimination. These privileges and status included consumer power, professional image, family status and a more general social status. The key difference between repatriation citizenship on one hand, and essential and recognized on the other, is that the women who used discourses associated with repatriation were professional women and therefore differed in socioeconomic background with respect to education, career and income. Similar narratives existed among positive participants who had had successful trades which suffered soon after they learned their diagnosis or during HIV-related illness episodes. However, their trade also suffered from slow economic seasons, whereas the civil servants reported that due to the nature of their jobs and their negotiation of their illness with employers, their incomes remained stable and frequent and were only disrupted by occasional national-level strikes and 'administrative' delays in releasing paycheques.[91]

In this section, I describe the ways in which participants adopted social support networking to facilitate their repatriation into systems from which they felt socially displaced and to attempt to regain lost privileges and status. This finding draws on three participants in particular who, despite having had access to basic amenities and treatment, became displaced. These participants referred to how they had to 'start over' or 're-enter' society, much in the way that Nigerian sociologist Okechukwu Ibeanu

[91] Union strikes in Nigeria usually take place over increases in oil and fuel prices (see, for example, BBC (2000) about the strike in 2000, New York Times (2004b) about the strike in 2004, and Hakeem-Apanpa and Abiola (2007) about the strike in 2007). In 2006, the Nigerian Labour Congress threatened to strike, not in response to hikes in oil prices, but in response to plans to retrench 33,000 civil servants as part of a national reform to improve efficiency. They eventually reached an agreement with the government and the jobs were retained. However, informants (as well as friends and family) insist that such events usually result in 'administrative' delays in salary payments, because of greedy managers who kept entire payrolls in the bank to generate interest which they would then keep for themselves after salaries were eventually paid.

(1999) characterizes what little is documented on the causes and reintegration of internally displaced populations in Nigeria. However, internally displaced populations are not framed by stigma and discrimination (as for women living with HIV/AIDS), and are described as having a relatively swift repatriation process:

> "As a result of the effectiveness of familial and communal networks, displaced people are quickly and easily absorbed and rehabilitated. Of utmost importance are community, clan, and multi-ethnic organizations which support their members materially and provide" (Ibeanu, 1999:162).

The networks he refers to are the taken-for-granted networks which, in the case of positive participants, disintegrated when they disclosed their HIV status to their partners, friends or relatives. However, they also describe having to rebuild their own networks in order to facilitate their repatriation as women living with HIV/AIDS. Furthermore, they describe how their displacement was marked with forced or involuntary migration, which occurred when they were evicted from their marital or family homes. Some participants, like Neneh, positioned themselves as never having had control over resources, while participants create new networks to help them redress "a social relation in which a group loses control over the resources of society and the physical protection of its members" (Ibeanu, 1998:82).

One participant described the initial stages of her HIV status as the trigger for the loss of privilege and status she experienced. Sarah was a 30 year-old civil servant who worked in the Ministry of Internal Affairs. When I met Sarah, she appeared to be a content wife and mother of two, having remarried and had a child with her new husband after being diagnosed with HIV. She assured me that she had not always felt secure. When I asked what had helped achieve a sense of security, she replied "*People - God and people*". Below, she describes her experience of being tested voluntarily in 2003 and how she experienced a displacement which gradually spread from her medical and social networks. She describes how health staff failed to communicate with her after her first blood test was sent away for confirmation:

S: *All of a sudden I went from receiving advice to receiving nothing - no answers. I became lost. Then I bought a medical card, saw my doctor and they used an entirely separate clinic to conduct my test. After my result, that doctor didn't want to come near me. Then I became a taboo - to everyone around me. One*

day, I sat down and tried to think of everything I could do and I remember thinking: "Does this mean that this thing [HIV] *will finish me?" I said "No! There must be a remedy... but... where will I start? Who will I turn to?" Then I went back to befriend one very kind woman at the clinic - we attend the same church now, but they were the people who led me to the support group where I later met my* [second] *husband. Anyway, this woman helped me get my name onto the waiting list for drugs. Then I took leave from work and took my son to my mother. Then I prayed and prayed. Then they told me that I could come and collect the drugs.*

This part of the interview was quite emotional for Sarah; her voice modulated between plaintive and assertive tones, punctuated with resignation. This excerpt features several aspects which highlight Sarah's gradual displacement and the way she challenged this through social support networking, resulting in an oscillation between power and loss. First is the sequence of her comments and how this is a function of her trajectory of repatriation and her assessment of her social situation at the time, over time. She describes three different points at which her displacement deepened: after her initial blood test, after her second blood test, and after she was placed on the waiting list. This last stage displacement was almost voluntary and may reflect resignation over loss of control, and may also reflect an internalization of the stigma and discrimination she experienced. In popular terms, returning to her village is interpreted as 'going home to die' or as the 'final option', where the person may take advantage of kinship ties and receive home-based care. Even this is not always certain, as with Neneh who was forced to return to Abuja after being rejected by her family.

The second aspect that characterizes part of the oscillation is Sarah's own efforts to reflect upon and execute strategies. Due to her early strategy of seeking the test in the first place and paying for a medical card for additional tests, Sarah is positioned as a consumer. A medical card ensures membership with a hospital and can cost from 500 Naira to 2500 Naira, up to nearly a third of a civil servant's monthly salary of 7500 Naira.[92] Despite her buying power to secure a confirmation of her blood test, it is undermined by her diagnosis which positions her as a "*taboo*" or social outcast.

Her response to this is the third aspect which makes her somewhat less ambivalent and more agentic - her initiating and building new social networks as a person living with

[92] The cards cost from the equivalent of £2 or 4 US$, while the minimum salary of a civil servant is equivalent to £30 or 65 US$ per month.

HIV/AIDS. Her social support networking positions her as being empowered, because despite stigma and lack of institutionalized support from her AIDS support group, or a local or international NGO, she draws on these networks to enable her to access treatment which keeps her healthy enough to participate in other social memberships, which eventually lead her to identifying a support group that caters specifically for the needs of people living with HIV. She does this by utilising kinship ties (with her mother) as well as building new ties with strangers (the kind woman) and organizations (churches), whom she told me often provided her with home-based care when she was unable to look after herself. Perhaps most interesting is that the support group, rather than providing Sarah with basic amenities or access to drug treatment, provided her with a setting in which she could meet other people living with HIV - one of whom she married. Her marriage performs the double work of achieving normalcy by avoiding a gender taboo of being 'un-marriable', but also by providing her with the desired companionship and intimacy found within social support.

Social support can be a source of empowerment in the absence of more formal institutions, because they deal with psychosocial aspects of living with HIV that are not dealt with in the same way by membership groups. Gaede *et al.* (2006:366) include affection, tangible support (such as food preparation, assisted hospital visits) and emotional support (such as someone who will listen). While this could take place in membership groups, it is can come from family, or from friends or members of religious groups who do not act as purveyors of stigma and discrimination. While each participant reported experiencing stigma and discrimination, six of the participants said that they received social support from members of their church or families. Interestingly, social support does not necessarily involve disclosing one's AIDS status (*op. cit.*:367). The following section describes how one participant was able to draw on social support (to a much lesser degree than Sarah) without disclosing her HIV status.

MANAGING DISCLOSURE AND SECRECY: SELECTIVE SOCIAL NETWORKING AND RELUCTANT REPATRIATION

Selective social networking is the fourth and final theme interpreted from participant narratives on prevention and public participation. This involves selectively identifying and eliciting certain types of support, such as treatment-related support from health professionals. This selection depended on HIV status disclosure and was 'cemented' through secrecy. Participants who adopted this form of networking did so as a means of simultaneously managing their health and their identities, particularly as they were perceived by family members and colleagues. So while participants who elicited either institutional support (such as Ramatu) or social support (such as Sarah), which they described as involving disclosure of their status, as other (n =3) participants did not always or consistently do so. Their selectivity and secrecy, however, did not affect their public participation when they were amongst other people with HIV/AIDS, and in one case, it did not prevent one participant, Ify, from using condoms.

This finding draws on participants who, at the time of their interview, employed selective networking or had done so in the past. The fact that all of the single positive participants, as well as those with professional jobs, worked in an office on a full-time basis, led me to interpret their selective networking as a strategy used mainly to manage their identity in a way that upheld gender norms and expectations around singleness, professionalism and respectability. As a result, by networking selectively and employing secrecy, participants position themselves as ambivalent yet skilful negotiators in the management of their health and identity within their immediate public environments, which they perceived as having more personal implications.

Yerima is a determined 28-year old police officer who was diagnosed with HIV in 1999 shortly after receiving a blood transfusion for injuries sustained in a motor accident. She had approached our interview with a stern demeanour, which broke when I noted that she had had a birthday two days earlier. When I asked her how she celebrated, she took out photographs of her in her flat with one male friend, two female friends and a cake. She told me that this birthday was particularly special, because when she was diagnosed, she had been told that she had eight years to live and that she was just a year away from disproving the doctor who tested her. She was also very

proud of the fact that she looked "*robust and plumpy*" and not "*kpankele*" (slim and sickly) "*like a broom*" or the popular depictions of people living with HIV. Later in the interview when I asked about sources of social support, she commented that she had had one friend who was positive but had died two years earlier. When I asked if she had confided in her family since then, or the friends in the picture, she replied:

Y: *Why would I want to impose that* [knowledge of her health status] *on anyone? I have one senior brother but he doesn't live here. How do you start: "Hello, I have AIDS?". I guess I've always said nothing then because after the test they told me that I have 8 years to live. So I for a long time I was just there... waiting to die... but I didn't. And now that I'm ok, I haven't told my family because I have that* [death sentence] *at the back of my mind and it hasn't been 8 years yet. Why should I worry my mother? What can anyone do for me? Besides, they will ask me how it happened and not even believe it. One of them* [the girls in the pictures] *knows but I haven't yet told my colleagues.*

C: *Why?*

Y: *Exactly - why? Why should I tell them? They can't do anything for me, anyway. If you ask any of them, they knew me as one of the gallant girls. Everyone knows me like that. I don't want that to change* [in their minds]. *It's only my boss who knows, and he's private and supportive. Very private! He didn't even tell me that there were other people in our section who have it, but I've seen them at the big meetings* [held by FACA on treatment management].

C: *So what did you say when you came here* [to the FACA office]*?*

Y: *If I have to leave the office, like now, or go to my doctor, I just tell them that I have to go and collect a form from somewhere.*

Yerima's experiences are at odds with the body of AIDS research which suggests that people living with HIV/AIDS face considerable stress due to having nobody to share their disclosure and experiences with (Visser *et al.*, 2005; Bell *et al.*, 2007). However, Yerima's excerpt positions her as the authority of what she considers to be stressful. She does this by considering two sites of negotiation where stress may be felt most acutely (for her). The first site of negotiation is one in which she has chosen not to disclose her status, which underlines her ambivalence or reluctance to be fully repatriated as a woman living with HIV/AIDS. From her excerpt, I interpret three arguments which are functions of her role as arbiter of her affairs; the first and second are concerned with the biomedical aspects of her diagnosis, which she suggests may have emotional implications for herself and her family, particularly her mother.

Yerima's strategy of selective disclosure and secrecy can be interpreted as a means of protecting her family's emotional well-being, as well as her own. Her decision not to disclose her diagnosis may actually reflect a broader resistance, not to anticipated or feared rejection alone, but to the biomedical advice that accompanied her HIV test results. Perhaps one of the more striking factors influencing this protection is that, depending on timing and circumstances surrounding their HIV test, there are still people who live with a death sentence that was handed to them along with their test results. Her statement that she did not die as expected along with her phrase "*and now that I'm okay*" suggests that somewhere in her trajectory she learned that the sentence was false. It is unclear how long Yerima lived with the sentence before learning that she could possibly live for more than eight years. What is clear from the exchange I had with her (with which I introduce the excerpt) is that she still marked off the dates, suggesting an internalised race against time. Given the very real possibility of death, it is also possible that she needed to beat the eight-year death sentence before she felt she could share her experience with her family in a way that might lead them to think that her death was inevitably imminent.

The second component concerned protecting her family, and is meant to uphold her status as a 'good daughter' as well as to privilege the health of her family over hers. However, it underscores a potential resistance to stigma may which revolve around her source of infection. Although Yerima cites that she received a blood transfusion as a result of a motor accident, she also admits to having a boyfriend at the time with whom she had lost contact. Her fears around her family's potential doubt may also reflect her own admitted confusion over how she was actually infected, which may be why she could be interpreted as policing even her non-sexual actions to avoid stigma and judgment against her sexual ones.

Her confusion is understandable, because it emphasizes the extent to which heterosexual intercourse is used to explain HIV/AIDS transmission in the face of confusing evidence of other transmission modes.[93] A national blood transfusion service was established in Abuja in 2005, where blood was to be sent, screened and dispatched out again. Despite this and the introduction of a safe blood policy the same year, cases

[93] Studies reveal conflicting data with one, for example, showing how three out of four different screening kits used in a Lagos hospital failed to accurately detect HIV antibodies in 87% of blood samples collected from adult donors (Odunukwe *et al.*, 2004). However, another study (Ogunkolo *et al.*, 2006) shows that 0.87% of men screened as donors tested HIV positive.

of infected blood transfusions have been reported in the press.[94] Nevertheless, prevention methods focus on mitigating sexual transmission, thereby policing sex itself and women especially (Campbell *et al.*, 2006). Therefore, while Yerima's decision not to disclose her HIV status or its source could be interpreted as policing past sexual behaviour as a means by which she manages her identity and maintains respectability, it could also be interpreted as her effort to manage her own health and her stress levels by protecting her mother's. This is yet another repatriation strategy which moves her away from her displaced status.

In the context of her workplace, Yerima uses her networking strategies to achieve similar aims of identity management, only in this case it is to uphold an image that she believes her male colleagues have of her, one which she doesn't want "*to change*". Yerima's understanding of stigma is one in which people do not normally envisage people with HIV/AIDS as being "*gallant*". It would be easy to assume that she might also be protecting her image as a capable female police officer, but earlier in the interview Yerima insisted that she was treated with the same respect as her male colleagues who, like herself, were in the police force to serve "*the National Coat of Arms*".[95] Therefore, the interpretation of her identity management is based on her desire to be seen in certain ways by both her family and her colleagues.

There may seem to be a contradiction between Yerima's choice not to disclose to her colleagues, despite her boss's knowledge of her status. However, this decision is based on Yerima's second argument - one which spans both sides of negotiation: she refuses to disclose her status to people who cannot "*do anything*" for her. While I do not wish to diminish the emotional and difficult aspects of disclosure, for Yerima these aspects seem so intense that she requires something in return to help minimise the intensity and normalise her life, which is done by staying healthy through positive prevention, including drug treatment, stress reduction and preventing sexual and non-sexual infection. Moreover, her boss's knowledge of her status was not volunteered by Yerima herself, but was imposed through the police force's mandatory testing policy for

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94 One high profile case involved 'Baby Eniola' who was found HIV-positive shortly after her birth despite both of her parents being HIV-negative. It was eventually revealed that she had been infected through a blood transfusion. Five of the hospital's administrators were fired, while several others were demoted (Punch, 2006).

95 The National Coat of Arms is a nationally recognized symbol of authority and state power.

applicants, which is how Yerima learned of her status.[96] However, she used his knowledge to her benefit when she needed to visit her doctor (who knew her status and could offer treatment and advice) or attend meetings and lectures organized by FACA, which were often held during lunchtimes but could last an entire afternoon. She also relied on his sense of privacy to help her maintain her own privacy in the workplace, thus maximising his knowledge to manage or un-spoil her identity.

Finally, leaving the office to collect a form is just one of the ways in which participants use secrecy to manage their identity, in spite of their otherwise public identification with other people living with HIV/AIDS. In Yerima's case, she used to her benefit another factor that would deter any suspicion - the notorious and frustratingly slow bureaucratic business of collecting, filling in and filing simple administrative forms within many parts of the national civil service.[97] Three participants informed me that they were able to secretly take time from work to attend meetings, by offering an excuse related to processing some form of paperwork in another branch of the civil service, such as a ministry office. Some also hid medication from family members and friends. Both professionals and non-professionals gave different reasons for this, citing their behaviour as being easier, or as a means to avoid pity or being thought of as 'used goods'.

In Sarah's case, discussed in the previous section, secrecy and selective disclosure did not deter her from accepting help affiliated with social support from church members. "*At first, I didn't tell them that I was sick because I didn't know how they would respond*". Her statement suggests that the strategy may have a phasic element. Such strategies can be interpreted as steps in negotiating repatriation. These are just a few examples in which participants used formal settings and processes to normalize the more visible aspects of living with HIV, such as "*being down*" (being ill or broke}, attending doctors' appointments or other meetings, or participating in rallies and marches.

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96 The fact that Yerima was employed despite her status suggests that there is an anti-discrimination policy in the police force. However, it is more likely that the police force wanted to avoid an incident similar to one which I later learned of. In 2003, a policewoman was demoted after a media-house leaked her HIV status, and the police force was attacked mainly by the Center for Human Rights, a local NGO working on human rights. However, it was unclear whether the woman was restored to her former position or not.

97 Abuja was popularly regarded as being exempt in this regard. I had several experiences in which administrative processes were carried out quickly. However, my experience with the Abuja Police revealed that the majority of the police stations still remain uncomputerised, which meant that officers, plaintiffs, lawyers, etc. physically transported files and communication by hand, making the logging, pulling and transfer of police reports and related documents, extremely slow.

While disclosure helps reduce the burden of keeping HIV a secret, and helps to reduce stigma in the long run, in the context of repatriation and citizenship, the choice not to disclose (even if it is just for the time being) may foster a sense of normalcy for those who work in a professional setting (like Yerima and Sarah) and do not have the flexibility that may come with running one's own business (like Ramatu) or working independently, albeit with a team at times (like Donna). Despite this, the selectiveness and secrecy described here did not hinder participants' involvement in public demonstrations and rallies, particularly in those organised around ICASA.

AIDS CITIZENSHIP AND EMPOWERMENT: CONTRADICTIONS AND CHALLENGES

The last three sections have focused on how positive participants responded to some of the challenges and complexities they faced while working to regain a sense of normalcy in their everyday lives by adopting various strategies to build personal networks and resist stigma. In this section, I discuss some of the contradictions which emerge from participants' own involvement in and analysis of the collective and public side of AIDS citizenship activities. The first extends the concept of disclosure while the second focuses on problems with treatment programmes.

Participants who adopted selective disclosure strategies (choosing not to tell family or colleagues about their HIV status) nonetheless participated in public rallies, marches, meetings and conferences. Despite the anxieties involved in disclosure, participants stated their belief in their power as a collective group of people living with HIV/AIDS. Participants' public action, despite personal fears, positioned them as powerful social actors who were able to influence their social and political environment. The record of NEPWHAN and its support groups is quite strong in popular opinion. They are frequently mentioned in newspapers or seen on television. In particular, they are recognized as a pressure group which challenges institutions that discriminate against people on the grounds of being HIV-positive. For example, in 2004, NEPWHAN was credited with challenging a school to reinstate a HIV-positive student whom they had expelled upon learning of his status (Chikwe & Anaele, 2007). In addition, NEPWHAN has forged partnerships with nearly every national and international

agency working on HIV/AIDS in Nigeria and tried to ensure that AIDS-related policies and programmes are developed with their input.

However, it is the participants' involvement in AIDS citizenship, and particularly NEPWHAN's efforts to access drug treatment, that suggest contradictions are arising, which are being raised by NEPWHAN itself and its stakeholders. NEPWHAN's programme coordinator, Chidozie Ezechukwu, informed me:

CE: *The problem we're seeing now is that despite the fact that we're making progress with treatment access and availability to treatment, we're also noticing low uptake and compliance with ARV* [antiretroviral] *treatment – which means that positive prevention and health are compromised.*[98]

He remarked further that both international and national stakeholders were surprised by the preliminary observations and had no way of explaining them, particularly given high levels of participation from people living with HIV and increased government support, especially during the Obasanjo administration. His comments were confirmed by external evaluations of Nigeria's ARV programme, which revealed that one in five people living with HIV had access to drug treatment.

While it is beyond the limits of this research to offer a comprehensive analysis of ARV programmes in Nigeria, instances of non-adherence which were indicated in this research have little to do with accessibility. By emphasizing issues other than access, I do not mean to mitigate the circumstances contributing to poor access outside of Abuja, which serves as one of the country's main service delivery points and a logistical distribution centre for ARVs. Before the report was made public in September 2007, official and local speculations over reasons for low access had already been circulating for some time. Officials cited logistic and decentralization issues, while activists pointed to NACA's alleged misuse and misappropriation of funds.[99] In addition, there

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98 Personal Communication.

99 The reasons given involve discourses which have currency in different local contexts. Decentralisation and logistics management seemed to be accepted as an 'official' discourse which was used during other national health programmes, such as the Expanded Program on Immunization, which relies of the distribution of vaccines via cold chains throughout the country. The less official discourse (and the one which is excluded from official public reports) was centred on NACA's "questionable management" of international and government funds totalling 201 million US$, of which 6.5 million (eleven billion Naira) disappeared (Mayah, 2006). While addressing an audience at a local event commemorating World AIDS Day, a reverend appealed to NACA's representatives by saying "Remember, it is not all about money; it is about service to God and humanity" (All-Africa, 2006). At an international level, the Global Fund suspended grants of 50 million US$ to NACA in 2005, but reinstated them the following year (Okekearu, 2006).

were debates about where drugs should come from. Local drug manufactures complained of the government's prioritization of international suppliers of ARVs (some of whom donate drugs) over those manufactured locally, while the government felt obliged to accept donated drugs and said they could not reject assistance from international donors who insist on specific brand-name drugs.

More lay-level explanations for the low take-up of drug treatments exist, including preference for traditional remedies, patient fear of taking fake drugs and patient fear of 'biowarfare' or becoming sicker or even dying from the drugs. While the first two are dilemmas around compliance and are experienced by people treating diseases other than HIV, the third marks a type of resistance against biomedicine in general, which one positive participant seemed to share. Yerima, discussed in the previous section, had disclosed that she had never taken ARVs, despite participating in public demands to the government for increased access to them. Instead, she reported that she focused on her nutritional health, prayer life and friendships to stay "*stress-free and healthy*" - all under the monitor of her doctor. While it is difficult to say how this positions her, other than interpreting it as ambivalence, the narrative in which her revelation is embedded positions her as a 'normal' person empowered by knowing. Knowing is part of the impetus to act on *personal* strategies. However, in this case, she suggests that knowing can lead to the decision to act publicly in different ways, or not to act publicly at all.

Y: *If all Nigerians knew their status then there would be no more HIV. Look at me... you can have it and look ok. Everybody should know their status, including the government. Most of them* [politicians] *have it and they know it. That's why they're so interested in us. If you talk to them, you see them listening with full attention because they're actually gaining information that they can use for themselves. Yes, it's the masses that come out and mobilise for ARVs... and now it's free even though they* [the government] *want to charge for it. But they* [government] *keep quiet while we come out in the hot sun and rally at ICASA and the like. Then they will make speeches and say that AIDS is about poverty. If they all come forward now the way the judge in South Africa did, then they'd see the truth. We got access to drugs, we made it free! And everybody is benefiting from it.*

Yerima leaned back in her chair after this last sentence in a statement she rendered with what can only be described as restrained resentment. What seemed of particular salience was the way in which her selectivity is based on, and positions her, as both a consumer and provider, and therefore a lay expert who is conscious of the contribution

her participation makes towards securing rights and treatment for people living with HIV/AIDS in Nigeria. Moreover, she is conscious of how she engages with those rights and treatments, even if it seems to conflict with her public activism. There are three ways in which I interpreted her as doing this.

First, for Yerima, knowledge is the primary weapon against HIV, thus highlighting her position as a consumer of HIV/AIDS services and information. She suggests that this knowledge enables a transition into more knowledge (or a 'truth') which is only based on the experience of being HIV-positive. Robins (2004) cites that living with HIV/AIDS provides a rite of passage from victim to expert citizen. This suggests that AIDS-related information is validated and more readily taken into consideration when it is based on the experiences of those living with HIV. Hence, Yerima is a consumer, not only of biomedical AIDS information, but of experience-based information which she accesses by participating in her support group and in AIDS citizenship activities.

Her consumption of experience-based information is evident by her reference to "*the judge in South Africa*" whom she cites as an example of an educated and affluent professional living with HIV/AIDS publicly.[100] Yerima's charge against politicians supports a popular speculation around wealthy Nigerian politicians and public figures who may be living silently with HIV/AIDS. Their argued reluctance and refusal to reveal their HIV test results is popularly interpreted as a means by which they avoid the shame and stigma associated with HIV/AIDS. This avoidance may also protect the family. Professor Olikoye Ransome-Kuti, a former health minister and brother to Fela Anikulapo-Kuti, the popular musician who died of AIDS in 1997, spoke of his family's struggle with this stigma after Fela's death:

> "We quarrelled at length. The rest of the family wanted to hide it but I told them that it was better not to conceal it – he had so many fans whom this could affect in a positive way. They only agreed when I pointed out that the hospital staff knew that it was AIDS, which might be revealed in the long run".[101]

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100 Judge Edwin Cameron is a high-profile South African judge who declared his HIV status in 1999 and is recognised as being a key proponent in developing legislation that protects people living with HIV/AIDS and for making drug treatment accessible in South Africa. He is also noted for challenging the notion (to a certain extent) that AIDS affects only poor black South Africans (Cameron, 2005).

101 Personal communication.

Second, it is the experience-based information of people like Judge Cameron that consequently transform Yerima into being a provider of information. Despite being a public health issue, the physiology of AIDS takes on very personal and individual characteristics, resulting in different responses to treatments or different symptoms revealed.[102] Yerima's example of herself as proof of successful living without treatment has implications for her 'audience', who may or may not be HIV-positive. This, in itself, may be attributed to the example of NEPWHAN's national coordinator, Dr. Pat Matemilola, who has been instrumental in obtaining wide access to drug treatment, despite refusing to take drugs for over fourteen years. For positive audiences (whether they choose to identify publicly or privately), Yerima and Dr. Pat (as he is popularly referred to) provide an alternative for those who may prefer to avoid entering a drug regime, or cannot handle the possible side-effects and wish to seek natural or nutritional therapies.

For audiences living without the virus, Yerima may provide realistic prevention information, particularly to those who engage in selective prevention or choose sexual partners based on whether they look healthy or not. In doing so, she once again confronts and dispels the picture of emaciated Africans with AIDS, by presenting evidence of an alternative picture of HIV/AIDS - herself as a healthy and active citizen.

Third and finally, her selectivity, coupled with consumer-provider or lay expert role, also positions her as a political observer of AIDS. Positive people participate on behalf of themselves but also (perhaps unwittingly to some) on behalf of AIDS 'anti-citizens'. Those willing to separate themselves from the movement most likely do so because they fear losing their status or livelihood. Hence, this identity-politics is benefited not only by those who cannot identify, but also by those who appear to be taking advantage of the passion, conviction and altruism of collective AIDS citizenship. For Yerima, positive participation is taken to be an exploitation by those who can afford not to rally and can afford to reveal their status, but cannot afford to be activists because of what they stand to lose socially.

SYNOPSIS

[102] Personal observations whilst working in Nigeria.

This chapter has focused on the ways participants endeavour to resist stigma. The analysis began by exploring the way positive prevention allowed participants to work their way out of spoiled identity, the identity understood as being a desired one to achieve. The import of this is that the desired identity deals with respectability and normalcy, but does not necessarily or explicitly reject the newer AIDS identity which, in itself, lends itself to opening up hybridized spaces in which participants negotiate empowerment on their terms, given the very real constraints they face. In effect, the negotiation of normalcy which participants pursue is one that maximizes the benefits that are possible through AIDS citizenship, such as treatment or a life that was 'better than before' without having to endure the negative sequelae of stigma and discrimination.

The realization of an unspoiled gender identity is dependent on participants' efforts at 'responsibilisation' in the face of further infection, thus resisting any potential blame from others should they or their family members fall ill. Also, this important tactic reflects individual desires to stay healthy. As I described at the beginning, participants internalize stigma as blame ascribed by derogatory terms. As a result, their resistance is both collectively and individually managed. This can be difficult to manage as the prevention assumes an HIV-free status. Furthermore, failure to document non-sexual modes of transmission, such as blood transfusions or needle pricks, facilitate blame on individuals and groups, and involve absolving the government of its responsibility to maintain health care quality and blood safety. This in itself causes an additional conundrum by proposing a re-ascription of blame and responsibility, transferring 'the biomedical gaze' elsewhere within HIV/AIDS. But it also points to the need for frank and accurate transmission rates which, as I write, UNAIDS has released with a statement suggesting that HIV/AIDS rates are not as high as initially assessed. In their statement, UNAIDS (2006) attribute the statistical change to a review of monitoring systems but, despite these changes, they acknowledge that "there is a need to improve the representativeness of the underlying data". For countries like Nigeria, these new statistics not only have funding implications, but there are also implications of what this might mean in the wider social context within which AIDS stigma and discrimination are experienced and given meaning, and which may be contested.

Outside of stigma, participants are faced with having to forge satisfactory futures for themselves in which their engagement in prevention and related activities are not just

seen as resistance, but as part of an acceptable lifestyle, as it was for the Christian group discussed in the previous chapter. In doing so, they uncover elements (such as being active, gallant or having someone to turn to) that help to construct normalcy, but do so in a way that reconfigures those elements. For example, Yerima was able to maintain a responsibilised gallant identity, which she separated from her AIDS identity through selective disclosure and secrecy but, in doing so, she actually reconfigured both. These reconfigurations take a paradoxical turn, as pursuing normativity becomes their form of resistance. It is within the hybridized spaces of AIDS citizenship that the notion of empowerment is raised, which cannot be overstated due to the very real isolation and trauma that participants also experience.

Finally, on a theoretical note, drawing on Bourdieu's (1986) conceptualization of social capital allows for a consideration of the participants' different socioeconomic positions, which also helps to understand how they constructed empowerment within these spaces. Moreover, it allows for a reflection of various dimensions of power which relate to the "material and economic; expertise, knowledge and strategic position; psychological; political awareness, mobilization and organization" (Parpart *et al.*, 2002:240). Finally, it was also useful in highlighting differences in participant experiences with HIV/AIDS, thus distinguishing the analysis from being based solely on accounts from the 'poorest of the poor'. However, the convergence of implicit participant constructions of an un-spoiled gender identity based on respectability and responsibilisation, points to the narrow hegemonic gender norms and expectations that pervade Nigerian society.

CHAPTER EIGHT

Concluding Discussion

INTRODUCTION

This thesis began with the assertion that women's empowerment towards HIV/AIDS prevention is framed within a wider context of power relations between experts and lay people. Where the dominant discourse of HIV/AIDS is one which takes its cue from development discourses, which seek to rescue Third World women from the ravages of their patriarchal societies, there is very little space for representations of African women other than those which depict them as poor, vulnerable, promiscuous, prostituting, pregnant, passive yet hypersexual, and heterosexual. However, these representations do not diminish their capacity to facilitate social transformation. The preceding chapters have endeavoured to contextualise the experiences of participants which, I have argued, occupy hybrid locations in which they negotiate dominant discourses of gender, sexuality and identity. As a result, their accounts can be considered not only as situated knowledge which constitute new ways of seeing empowerment and prevention, but also as the power relations inherent in the international and local politics of AIDS which reify and privilege dominant representations over others.

The remainder of this concluding discussion consists of four sections: an overview of the key findings; implications of the research for policy and programmes; suggestions for further research; and final reflections on the research and thesis.

OVERVIEW OF KEY RESEARCH FINDINGS

The comparative element of the analysis allowed for an exploration of differences and similarities between the different groups. This began with an analysis of the rural and urban Guides, who responded minimally to HIV/AIDS prevention messages, and ended with an analysis of positive participants, who were mostly engaged with prevention in their personal lives. The different responses of the groups highlight the significance of

location and identity to the women's sexual lives and experiences, as well as what empowers them or gives them strength. Comparing the five groups has not been the only reason for this study. A comparative consideration has placed participant accounts at the centre of this analysis. By emphasising gender inequality alone, previous research has largely held women's experiences with HIV to implicit norms of poverty and heterosexuality. Then, by examining participant accounts across groups, these norms were displaced by other power relations. A primary example is the way in which the underground network of women in same-sex relationships feared the new anti-gay legislation, which posed a genuine threat to their ability to organise for sexual rights and appropriate health services. Members' fear of homophobic violence and discrimination also challenged their ability to organise around identity-based politics, due to some members' reluctance to openly identify with the network through nomenclature. Rather, some took advantage of their hybrid location and deployed discursive tactics to deflect any suspicions. Hence, this aspect of the research demonstrates the relevance of sociopolitical and historical influences on individual and collective participation and empowerment.

However, in these and in many other instances, participants' perceived notions of gender norms and expectations greatly influenced their individual sexual decisions and the ways in which they chose to participate collectively. In particular, participants' discursive approaches to negotiating normalcy, as discussed in Chapter Seven, constitutes a key finding of the analysis presented in this thesis. This stands in contrast to the dominant representations of HIV/AIDS prevention as benign and benevolent, where a biomedical notion of health is dominant. In participant accounts, it was not just the achievement of health that was desirable but the desire to appear responsible, thereby achieving normalcy even though this seems to be dictated by gender expectations. Nevertheless, it differs from the notion of passive victims 'waiting to be empowered', as well as the idea of simply resisting blame in and of itself. Rather, discursive work is identified in participants' accounts which disrupt dominant discourses of gender, sexuality and identity, and reconfigures them based on participants' attempts to favourably locate themselves within these reconfigurations. In other words, participants' discursive strategies in themselves begin the work of dislodging hegemonic and dominant discourses.

In this study, dominant discourses are shown to be those aspects of expert knowledge that are incorporated into policy guidelines and prevention programmes, and are deployed as technologies of AIDS biopower which police women. Hence, the assumptions implicit within the dominant discourse (such as hyper-passive sexuality or heterosexuality) are managed by participants during the interviews in order to establish ways in which they are positioned or located in relation to these assumptions. Bhabha's (1996) notion of hybridity, as a way of understanding research interviews as liminal or 'in-between' spaces in which translation and negotiation take place, points to a number of key findings in terms of empowerment. Negotiating normalcy, as an attempt to achieve perceived gender norms and expectations, is in itself an act of resistance to gender expectations, because participants are negotiating from an outside position, thereby redefining the boundaries of normalcy. The best examples are of this are the positive participants, discussed in Chapter Seven, who wish to be seen as having a 'normal' illness (like malaria for example), but whose very demand for normalcy constitutes its changing parameters. Their negotiation process is productive, yielding alternative prevention practices that have implications on prevention as a whole.

The implications of various power relationships, other than gender relationships, were highlighted through the discourse analysis of participants' everyday empowerment within different social locations. The accounts of participants who belong to different groups suggest that an intersectional approach is more useful than previous research which utilised singular (or no) theoretical approach at all. In particular, social identity is most useful as part of an intersectional theoretical approach that includes post-colonial concepts of hybridity, because the combination allows for a notion of agency in the context of multiple power dynamics which may not have been possible using social identity on its own, or as part of a psychosocial framework alone. Furthermore, the intersectional analysis of empowerment and prevention provided new understandings of the social identity of 'quasi-experts', challenging the notion of the disembodied expert as being predominantly Western and male. Finally, an intersectional approach challenges assumptions made on the basis of social identity alone (which is that social identity is a predictor of sexual behaviour). For example, an important finding was how both the speech and silence of participants was read as social identity protection which led to low self-risk perceptions in ways that actually placed them at risk, in spite of their identities as teachers and quasi-experts to the 'young and the rural'. The chasm between lay and expert is narrowed in the context of

HIV/AIDS, in which lay people become experts, but it is also narrowed when experts (through text or speech) are positioned in the context of knowledge production.

The implications of the findings arise from the theoretical framework for analysing power described in Chapter Two. Such a notion requires interrogation of power dynamics which are inherent and implicit in funding prevention programs and in conducting research more generally. Following the mandate of critical and discursive social psychology, the framework discussed in Chapter Two forms a critique of programmes either informed solely by behaviourist theories but also critique the power of these theories and their failings without analysing power in and of itself; in the case of this study mainly through an interrogation of the concepts of governmentality, hybridity, power and empowerment.

Specifically, this framework allows for the contestation (through discursive empowerment) of different types of power (governmentality and biopower) which, taken together, call for the naming of expert power. In this respect the research differs from other studies of empowerment that do not explicitly define power or limit the definition to gender equality or power between men and women only. The definition of power as a network of apparatuses institutions and actors is demonstrated by HIV prevention in Nigeria with the donors, Nigerian governmental agencies and participants. While it was beyond of the scope/remit of this research to focus on the dynamics within international donors and expert agencies such as UNAIDS or USAID, the focus on the documents and the messages that are agreed upon by donors and government agencies as an aspect or form of governmentality, in turn allows for an analysis of participant responses to this type of power (as well as their response to the type of power imbalance between men and women).

It is only through the interpretive and theoretical framework outlined in Chapter Two that certain tensions could be found in participant narratives. For example, the type of resistance towards governmentality as experienced or defined in the research was at first difficult to observe through answers to the question about the Nigerian government's performance on managing HIV and AIDS. The responses to this question usually began "Well, the government is trying but..." which was interpreted as an ambivalence or even hybrid space in which participants - like Lolo Faith in Chapter 4 - were simultaneously appreciative of the government's efforts yet critical about certain

aspects its activities or policies. This ambivalence in itself marks a difference from mainstream descriptions of women who are entirely divorced from the political process or are fully and collectively involved in advocacy around HIV. This research shows a range between these extremes and how some participants try to navigate them to achieve their own desired objectives, including blaming and othering with the protecting their social identity.

Hybridity as a concept was drawn upon to fray the binary between experts and lay people and is pivotal in recognising empowerment as a discursive activity that occurs everyday. As talk- in-interaction (Tate, 2005), it also characterises the space within which people can say what they want to say and create alternative world or the world they want to portray to others. Examples of this occurred in the interviews themselves but also in the space described by Fola (Chapter Five) in which she and her friends spoke in code thereby creating confusion about their sexuality (they functioned as heterosexual but their code language discursively concealed their identity as women in same-sex relationships). Another pertinent example of hybridity is the way in which positive participants occupy both lay and expert positions, the ways in which the relationship between the two positions influences women's everyday approaches to prevention, and how this influenced their collective participation in advocacy activities which only punctuated their lives.

One of the results of drawing on a Foucauldian notion of power is that a subsequent reading of the findings suggest the need to look at different modes of power that operate within women's lives in order to understand the different ways in which resistance manifests and highlights women's empowerment, even if this mode of women's empowerment is at odds with explicit formal associational or health objectives. For example, the concept of social capital as a 'tool' for enhancing collective participating for women's empowerment in the face of HIV seemed inappropriate for the rural women in Chapter Five because the notion takes for granted the existence of solidarity, trust and common goals, which were disrupted or even non-existent due to factors such as belief in witchcraft, and fear of gossip. Yet in Chapter Seven, positive participants relied on social networks to meet both personal and associational goals, including economic assistance and advocacy, respectively.

The findings support Parpart's (2002) argument for a rethinking of empowerment and lead to the suggestion that researchers and practitioners need to allow empowerment to be conceptualised explicitly as discursive, silent, subaltern, subjective and spiritual or ontological. The fear is that it could lead to victim-blaming or that "silence = disempowerment". But this does not allow for the notion of everyday empowerment – only organised visible and audible empowerment that usually takes the form of collective participatory activities like advocacy events. However, the analysis in Chapter 5 reveals the dangers in this yet also highlights safer alternatives that can still be leveraged in HIV prevention.

One of the key findings of this study rests in the different types of opportunities that exists for empowering women which differ from many of the mainstream perspectives currently underpinning "women's empowerment". As described in Chapter One, these perspectives fall loosely in the following three categories: health and HIV prevention, academic, development policy standards of empowerment. First, the health and HIV prevention notions of empowerment include behavioural concepts which are often used within HIV as indicators of empowerment (i.e., to negotiate condom use). The findings demonstrate that participants drew on social, spiritual, emotional and economic reasons to explain why they were able to protect themselves from infection or re-infection, bearing in mind that Mrs. Nwolisa and several other participants in Chapter Four refused - in their own way, mainly through silence - to comment on whether prevention was possible or not.

From mainstream perspective of empowerment within academia/debates on gender, such participants in this study might again be considered to be disempowered. For example, Kabeer's (1999) definition of empowerment as *"as a process by which those who have been denied the ability to make strategic life choices acquire such an ability"*. For her, one of the ways in which this is achieved is through advocacy which implies a vocal and open challenge to the status quo which differs significantly from the types of empowerment demonstrated by participants who used silence and other discursive and subversive tactics to access their choices.

These more material perspectives are mirrored in gender and development policy, which is increasingly informing HIV prevention amongst women in countries around the world. For example, at the time of concluding the thesis, the United Nations

documents identify women's empowerment as a key development goal which is in turn equated and used interchangeably with gender equality. Again, according to this particular definition - "the equality between men and women" (UNDP, 2008:5) - most participants, such as Sadatu in Chapter Five or Yerima in Chapter Seven, would be considered disempowered. Adding to the dominant notion of disempowerment are the other social, geographic and biological aspects of inequality which leave many women vulnerable to HIV.

However, the findings in this research, particularly by focusing on *both* discursive and material/behavioural factors, demonstrate that participants' empowerment was indeed possible and evident in the face of these real and seemingly immovable constraints. Namely, the types of empowerment among participants includes: HIV and health empowerment, social empowerment, emotional empowerment, economic empowerment and spiritual empowerment. These can occur in either discursive or non-discursive forms (see Table 8. 1 on p. 274).

Notwithstanding these other forms of empowerment for women, the findings demonstrate that women's empowerment was not limited to addressing gender equality by reducing gaps in education and income alone. But it also included discursive strategies of silence (for social protection as in Mrs Nwolisa's case or for survival or to avoid discrimination as was the case for many participants who were HIV-positive or in both heterosexual and same-sex relationships). These strategies are considered to be empowering for several reasons.

First, empowerment amongst participants helped prevent HIV in ways that have both immediate and potential long-term impact. An example of immediate impact on prevention is Mariam, who used spiritual discourse and beliefs in order to justify her reasons for refusing to have sex with her husband. Harnessing existing traditional vehicles in which sex is discussed and sex-related paraphernalia (including sex toys and condoms) is sold amongst women in Northern Nigerian, serves as an example of an empowerment strategy with potential long-term impact because of the difficulty of to determining how widely accessible and acceptable different types of gadgets will be, and whether they will be used consistently among women in same-sex relationships.

Second, empowerment amongst participants helped overcome problems and challenges that they prioritised for themselves. For example, the findings show social insulation as a form of empowerment against threats which participants perceived to be real and salient to their everyday lives versus threats identified by either internal or external experts regardless of how pertinent these threats are on a societal and even global level, which HIV and AIDS very much is. This raises the issue of how to penetrate what could understandably be interpreted as denial amongst participants who sought ways to maintain social and professional credibility. One answer has already been mentioned by some of the participants themselves, which is to have more high-level people openly disclose their HIV status, thereby changing the notion that to be presumed HIV-negative is the only way to demonstrate credible expertise and maintain social respectability.

Finally, some of the strategies for empowerment demonstrated by the participants challenged negative stereotypes which they faced locally and which were "put upon" them by some of the mainstream AIDS literature and policy that positioned them as disempowered, such as the USAID material mentioned in Chapter Two. This is most effectively demonstrated by the findings in Chapter Eight that highlight the ways positive participants challenged stigma and discrimination. Another example of this is the rural women who exhibited health seeking behaviour and – again – diverted any potential 'gaze' from me as a researcher. This example of power and empowerment through discursive modes of resistance raises ethical issues within research and health concerning the types and depth of personal information experts are entitled to find out in the name of HIV prevention, which was addressed in Chapter Three.

Table 8.1 Types of Empowerment Amongst Participants

	HIV and Health Empowerment	Social Empowerment	Emotional Empowerment	Economic Empowerment	Spiritual Empowerment
Non-discursive/ Action (Objective)	• Outward Channelling, teaching – Gabi, p. 154-6 • Inward Channelling, info seeking – Mrs Mitti, p. 158-159 • Inward Channelling, HIV testing – Evangelina, p. 162 • Impetus to Act /knowing one's status – Donna, p. 235-236 • Willingess to protect health – Mama Friday, p. 237-8 • Willingness to protect family and partners, Rukevwe, p. 238	• Support and Acceptance – Rose, p. 186- 7 • Willingness to protect family and partners, Rukevwe, p. 238-9 • Experienced-based Networking – Ramatu, p.245 • Essential Participatory Networking – Neneh, p. 242 • Social Support Networking – Sarah/MOIA, p. 251 • Selective Social Networking – Yerima, p. 254	• Impetus to Act /knowing one's status – Donna, p. 235-236 •	• Support and Acceptance – Rose, p. 186- 7 • Essential Participatory Networking – Neneh, p. 242 • Social Support Networking – Sarah/MOIA, p. 251	• Lifestyle mechanisms – Temi, p. 199
Discursive/ Language (Subjective)	• Assessing risks – Sadatu, p. 181-183 • Bodily Integrity – p. Geraldine, p. 210-11 • Prayer warrior – Mariam, p. 218-220 • Gendered Public Participation – Victoria, p. 224	• Silence –Mrs Anali, p. 138 • Silence – Mrs Mitti (social) • Blame, resists dominant discourse but reinforces them by "othering" – Lolo Faith p. 133-7 • Social insulation – Moriamo, p. 146-148 • Social insulation – Rhiela, p. 150 • Outward Channelling – Christy p. 151-153 • Pragmatic Identity Alignment – Etoro, p. 179-180 • Balancing – Rose, p. 185 • Support and Acceptance – Fola, p. 187-189 • Bodily Integrity – Geraldine, p. 210-11 • Gendered Public Participation – Esomo, p. 222 • Gendered Public Participation – Victoria, p. 224	• Silence –Mrs Anali, p. 138 • Silence – Mrs Mitti (vulnerable) • Discourses of ability and self-worth – Auntie Bukky, p. 207-9 • Bodily Integrity – p. Geraldine, p. 210-11	• Social insulation – Moriamo, p. 146-148	• Bodily Integrity – p. Geraldine, p. 210-11 • Prayer Warriors – Ugo p. 216 – 217 • Prayer warrior – Mariam, p. 218-220

Another key research finding arises from the implications that donor funding has on policy development and service delivery in a post-military state. The research project aimed to explore the way in which experts frame HIV/AIDS prevention within the context of gender inequality and women's empowerment. However, it found that based on their own professional disciplinary standpoint (whether HIV/AIDS, gender or women's empowerment, activist-researcher, policy-maker or practitioner), expert notions of women's empowerment and gender equality proved to be slippery concepts which were largely dependent upon donor imperatives. The attempt of women's organisations to articulate a collective view on gender inequality and empowerment was *ad hoc* and became influenced by donor relationships, which led to a lack of pressure on the Nigerian government to address gender inequality. Hence, this research traces the effects that global governance of HIV/AIDS and gender issues have on the institutions' implementation of programmes and women's responses to prevention messages.

Perhaps the most important research finding lies within the participants' different configurations of empowerment as they related to identity and location. The concept of power outlined in Chapter Two allowed for an exploration of new and less-visible space in which heteronormativity was challenged. This highlighted participants' task of negotiating normalcy in ways that challenged multiple power dynamics which, in turn, allowed for common aspects of femininity to be interpreted across the five associations. These include health, respectability and responsibility which are inextricably linked and exacerbated by AIDS biopower. Implicit in the negotiations is an articulation of how women construct empowerment as a way of resisting biopower's inscription upon them through 'technologies of self', and managed to avoid reifying gender norms and expectations but challenged them instead.

New research questions have been posed with regard to dominant discourses of morality, and with regard to HIV/AIDS and religion, or Christian Pentecostalism, in particular. Previous authors have questioned the role of Christianity in HIV/AIDS with regards to gender relations. This research has facilitated a critical interrogation of the relationship between gender, power and Pentecostalism within the context of HIV/AIDS. Perhaps one of the more striking findings in regard to the comparative element of this research are the similar discourses of spirituality among all of the

groups. Clearly, the emphasis on spiritual power among the CWC participants reflects alternative understandings of gender and power that are prevalent among Christians in Nigeria generally, which is beginning to achieve hegemony within the society. Yet, this aspect of Christianity as it intersects with HIV/AIDS prevention remains hidden, possibly amongst an assumption that Christianity, as it is practised in Nigeria, mirrors the evangelical Christianity that is said to propel the contested abstinence-only rhetoric in US policies on HIV/AIDS. This highlights further points of dissonance between lay people and HIV/AIDS experts; although again, the presence of lay experts who work in 'faith-based' groups is increasing in Nigeria (reflecting the impetus of US donors). Nevertheless, this further obscures the binary between lay people and experts, not as a way of subjugating women, but as a way of transcending social and spiritual malevolencies, taken to be real with real material implications. HIV/AIDS prevention needs to engage with those aspects of identity or lives from which women draw their power.

SUGGESTIONS FOR FURTHER RESEARCH

This study has investigated a wide scope of issues pertaining to women's empowerment and HIV/AIDS prevention, and opens up possible areas for future research. The thesis work, based on interview transcripts, fieldnotes, media and policy texts, represents just a small part of the rich data material, which is not possible to adequately encapsulate within the restricted space of a Ph.D. thesis. In particular, there are several themes in this work which warrant further explanation in future analyses, particularly in relation to African femininities. This thesis has contributed to the knowledge of femininities within the context of HIV/AIDS by challenging dominant discourses in prevention research. Nevertheless, opportunities for further research remain in the thesis, including the lack of a more nuanced attention to Islam and other axes of difference.

This is somewhat related to another area which could be examined further, which is that of masculinities. Although there are a number of studies containing young men's masculinities, less attention has been paid to the theoretical and epistemological implications of their experiences. For example, what are the implications of the dominant discourses around African male sexuality as being 'hyper-sexualised'? In this

research, a number of participants were in heterosexual relationships. It would have been interesting to explore their accounts, alongside those of their partners, from a feminist post-colonial perspective. However, doing so might raise ethical considerations around safety, particularly where multiple relationships exist, as in the case of married women who are in same-sex relationships or heterosexual women with more than one partner.

Given the need for effective policy provision and service design, sexual violence forms another key area of research, although attention has been paid to heterosexual gender-based violence (Watts and Mayhew, 2004; Jewkes, 2007). The possibilities of HIV/AIDS being transmitted through sexual violence, based on sexual or religious identity, remains an area for further research.

IMPLICATIONS FOR POLICY, PROGRAMMING AND SERVICE DELIVERY

The findings from this research have a number of implications for policy, programming and delivery of HIV/AIDS prevention services. Evidently, an egalitarian standpoint calls for prevention and treatment options to be equally available to citizens regardless of their social, ethnic, religious, sexual or gender identity. While targeting prevention messages and services to 15 to 24-year old heterosexual women and men may reflect an imperative to maximise funding made available, doing so implicitly discriminates against and alienates women who do not fall within this category. This research has explored some of the implications of targeting for participants in various groups. In particular, the attitudes of health workers had placed emotional strains on many of the groups, which compounded the financial and practical strains it took to access the services in the first place. The discrimination that some of the women faced while accessing services reflects a wide range of stigmas attached to either having sex, or being poor, a single mother, widowed, in a same-sex relationship, separated, too young or too old to have sex, unemployed, too educated or too illiterate to access services. These stigmas are further reinforced by the absence of policies addressing the issues of women who may fall outside the target group of 15 to 24 years old.

Some of the effects of targeting have implications for international and national AIDS research and policy. While research on empowerment and gender-based violence has elicited recommendations for female-controlled prevention measures such as microbicides, problems still exist in barrier methods for women in same-sex relationships. The issue of microbicides, while extremely pertinent, assume heterosexual and vaginal intercourse. Yet, as this research suggests, women in same-sex relationships appear to have a need for both vaginal and non-vaginal barrier methods as well as female-controlled methods. Interestingly, another female-controlled method, the female condom, is slowly becoming more available, although it is still relatively unknown and more expensive than the male condom.

The lack of availability and low awareness of the female condom and non-penetrative safe sex methods could be reflective of the Nigerian government's lack of engagement with issues of sexuality in the context of HIV/AIDS prevention. However, as this research suggests, alternative service delivery routes can be found in traditional or even faith-based mechanisms for discussing sex-related issues. A more inclusive proposal for delivery would enable recognition of women who prefer to (or are only permitted to) access these alternative routes without rendering them disempowered.

The policy framework of medicalising issues of HIV/AIDS allows women who can afford service fees to secure information and services. However, there remains a situation where appropriate information and services are unavailable to many women who may be able to access treatment, but are denied it due to their sexuality. Furthermore, women who are socially marginalised due to their sexuality may find it even more difficult to access services in the absence of family (financial) support or employment. Similarly, appropriate services (particularly testing) are more difficult to access for women who are outside of reproduction. These situations reflect a hetero-normative discriminatory bias which is backed not only by Nigeria's legal framework on homosexuality, but also by their policy framework informed by patriarchal gender norms and reinforced by donor imperatives. Participants in each group were aware of their legal vulnerabilities from the standpoint of ethnicity, sexuality, gender and age. This highlights the necessity of policies that address the diverse needs of women - many of whom are sexually active, exposed to non-sexual risks and fall outside the ages of 15 to 24.

The stigma, prejudice and discrimination that participants experienced point to the need for improved awareness and training among service delivery staff. Participants in both the underground network of women in same-sex relationships and in the HIV/AIDS support groups experienced high levels of stigma which affected their ability and willingness to access services. This was also true of young women in general, some of whom fell within the target group age of 15 to 24.

CONCLUDING REMARKS

In the first chapter, I explored the implications that a notion of empowerment such as gender equality has on HIV/AIDS prevention. I will conclude by exploring the implications of this approach regarding prevention amongst women, taking into account the findings of the current research. Previous research has been either discursive or has focused on the implications of participation only. This study has extended these debates by exploring the implications of participation framed by the governmentality of mainstream HIV/AIDS prevention and the effects of its dominant discourses on women's engagement with HIV/AIDS prevention programmes and services, coming from a number of different cultural and socioeconomic contexts.

The prospect of (empowering women through) collective participation as a means of rebalancing gender inequality is an important one. The focus on HIV/AIDS prevention as a biopower often highlights (hetero-)normative barriers. Hence, for example, women are empowered to negotiate ABCs on the basis of gender, rather than on sexuality, spirituality or identity. Nevertheless, I would argue that the remedies proposed require observing broader conceptions of power. Women's associations and HIV/AIDS activists groups have not only to challenge cultural and gender inequality, but must also be critically engaged with government and international donor funding mechanisms and policy directives which have implications on how sexuality and other aspects of identity are addressed in prevention programmes. Despite previous discursive analyses of HIV/AIDS in Africa, the reality is that different scenarios remain whereby women of various backgrounds find it difficult to adopt the conventional prevention measures of the ABCs - even when they do not describe themselves as disempowered or vulnerable. This is not to deny the financial and manpower challenges involved in addressing the needs of women who have different socioeconomic backgrounds, whereby the concerns

of women who fall outside of the target range are silenced or not even articulated for fear of being associated with the hegemonic notion of vulnerability. The strategies to manage identity and, in particular, normalcy in the face of silence form a repeated theme in participant accounts. Notwithstanding this, the recognition of broader gender inequalities also influences identities.

It seems almost inevitable that international development aid will continue to alleviate pressures on governments and citizens to provide facilities in the absence of necessary programmes and services, while at the same time perpetuating less than helpful representations on gender, sexuality and identity. As a result, future work is needed to explore the various power relations and how they inform international development and local policy. As this research study demonstrates, the focus on spirituality requires the need for development policy to factor in alternative service delivery vehicles and messages that go beyond moral pleadings and address alternate core lifestyles and beliefs. Ethnic minority and political contexts influenced participation options for rural participants. Recognition of similar contextual dynamics informing participation will enable priorities and identity perceptions to be amplified, challenging hegemonic gender and sexuality discourses in HIV/AIDS. There is a need to consider power dynamics that go beyond those grounded in sexual relationships. A critical and reflexive consideration of HIV/AIDS prevention calls for more knowledge about contemporary gender and sexuality realities. This study serves as an advancement towards that objective.

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APPENDIX 1

SAMPLE INTERVIEW QUESTIONS

Introductions
Where are you from?
Tell me about yourself?
Your family? Background?
Education? Early experiences?

What brings you to Abuja?
How do you find it?
How often do you go to your hometown?
What are some of the differences or similarities between Abuja and home?

When did you join your organization?
Why?
What are the highlights of working there?
What are the challenges?
How has working there helped or hindered you in life?
What other things help or hinder you in life?
Which people have helped or hindered you in life?

How did you first hear about HIV/AIDS?
When was that?
What were some of the things you heard?
What were your feelings about it?
How does it spread here in Nigeria?
What is being done to prevent HIV?
Who is working on prevention?
How would you describe the success or failure of these programmes?
Is there anything that could be done differently?

Who is most affected by HIV in Nigeria? Describe them.
How are they affected?
Who is at risk of getting HIV?
Do you think you're at risk of infection?
Do you know your status?
(How do/would you feel about having HIV?)
(Do you know how you contracted HIV?)
What do you do to keep yourself healthy?
What sorts of things do you do to prevent infection?
Is it easy or difficult?
What makes it easy or difficult?
How do you feel about people with HIV?
Do you know anyone (else) with it?
(Where do you /they get support from?)