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Antiretroviral Therapy and Reproductive Life Projects: Mitigating the Stigma of AIDS in Nigeria

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Abstract

As millions of people infected with HIV in Africa are increasingly able to live longer and healthier lives because of access to antiretroviral therapy, concerns have emerged that people might eschew protective practices after their health improves. Extending beyond the notion of sexual “disinhibition,” researchers have begun to analyze the sexual behavior of people in treatment through the perspective of their marital and childbearing aspirations. This article explores the reproductive life projects of HIV-positive men and women in southeastern Nigeria, showing how actions that contradict medical advice are understandable in the context of patients’ socially normative desires for marriage and children. Based on in-depth interviews and observations (June–December 2004; June–July 2006; June–July 2007) of people enrolled in the region’s oldest treatment program, we argue that broadly held social expectations with regard to reproduction are experienced even more acutely by HIV-positive people. This is because in Nigeria the stigma associated with AIDS is closely tied to widespread perceptions of social and moral crisis, such that AIDS itself is seen as both a cause and a symptom of anxiety-producing forms of social change. Specifically, in an era of rapid societal transformation, Nigerians see sexual promiscuity and the alienation of young people from traditional obligations to kin and community as indicative of threatened social reproduction. For people who are HIV-positive, marrying and having children offer not only the opportunity to lead normal lives, but also a means to mitigate the stigma associated with the disease. Four ethnographic case studies are provided to exemplify how and why social and personal life projects can trump or complicate medical and public health priorities. These examples suggest that treatment programs must openly address and proactively support the life projects of people on antiretroviral therapy if the full benefits of expanded access to treatment are to be realized.

Keywords

Nigeria; antiretroviral therapy (ART); HIV/AIDS; life projects; marriage; reproduction; stigma

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Introduction

Over the past several years, antiretroviral therapy (ART) for HIV/AIDS has become widely available in poor countries, with millions of people benefiting from increased donor commitments, lower drug costs, and expanding governmental and non-governmental programs. This enormous increase in access is laudable for enabling people to live longer and healthier lives despite HIV infection. However, it also creates a whole range of new possibilities and problems, as those receiving treatment re-imagine and forge their larger “life projects” – that is, the socially attuned and culturally inflected aims and aspirations they have for their life course. In particular, as people realize that HIV infection is no longer a certain death sentence, they strive to actualize their most important priorities, which in Nigeria (and elsewhere) almost always include sexual relations, marriage, and childbearing. Yet even as ART enables men and women living with HIV to embark on the life projects of marriage and reproduction, they also face numerous social, ethical, and medical dilemmas as they try to live out their ambitions and live up to social norms. Although ART permits people with HIV to hope for and undertake these life projects, it also complicates them, as the medical consequences and public health implications of sex and reproduction conflict with personal priorities and social expectations. Conversely, achieving their reproductive goals frequently impinges on people’s capacity to stay on therapy, follow recommended treatment regimes, and take adequate precautions to protect others (and themselves) from further infection.

As in many parts of the world, life-saving antiretroviral drugs (ARVs) have only recently become more widely available to Nigerians. Africa’s most populous country, with more than 140 million people, has an adult HIV infection rate estimated to be 3.1 percent, translating into approximately 2.6 million people currently living with the virus (UNAIDS 2008). The Nigerian federal government launched a small-scale treatment program in 2001 that enrolled fewer than 10,000 people over four years. In late 2005, in conjunction with the increased support for antiretroviral therapy provided by international donors such as The Global Fund and the U.S. President’s Emergency Plan for AIDS Relief, Nigeria’s President Olusegun Obasanjo announced that all people in the country who need ART (defined in Nigeria as people with CD4 counts below 200 or who present with AIDS) would receive drugs free of charge. The initial goal was to reach 250,000 people by June 2006. While this ambitious target was not achieved, 2008 estimates indicate that approximately 200,000 Nigerians are receiving treatment through the scaled-up program, and enrollment continues to grow.

As ART has expanded, attention has begun to turn to the implications of treatment with regard to prevention, and specifically the sexual behavior of recipients (Cusick & Rhodes, 2000; Moore & Oppong, 2007; Lurie, Pronyk, de Moor, Heyer, de Bruyn & Struthers et al., 2008; Seeley, Russell, Khana, Ezati, King & Bunnell, 2009). Part of the motivation for studies of the sexual behavior of people on ART is a fear that successful treatment will lead to sexual “disinhibition” – that is, with the availability of successful treatment, people may eschew protective behaviors. Research in developing countries has mainly addressed behavior identified as risky by utilizing quantitative data from surveys (Loubiere, Peretti-Watel, Boyer, Blanche, Abega & Spire, 2009; Moatti, Prudhomme, Traore, Juillet-Amari, Akribi & Msellati, 2003; Bateganya, Colfax, Shafer, Kityo, Mugenyi & Serwadda et al., 2005). More recently, studies have considered the sexual behavior of people on ART from the perspective of their marital and reproductive goals (Cooper, Harries, Myer, Orner & Bracken, 2007; Myer, Morroni & Rebe, 2007; Homsy, Bunnell, Moore, King, Malamba & Nakityo et al., 2009). This trajectory of research suggests that the conduct of people in treatment for HIV must be understood through a lens that connects sexuality to gender, reproduction, and larger social contexts (Hirsch, 2007; Gruskin, Firestone, MacCarthy & Ferguson, 2008; Persson & Richards, 2008; Laher, Todd, Stibich, Phofa, Behane & Mohapi et al., 2009). But surprisingly little ethnographic research has been undertaken on the topic (for exceptions, see Castro, Khawja & González-

Núñez, 2007; Ware, Idoko, Kaaya, Biraro, Wyatt, Agbaji, Chalamilla, & Bangsberg, 2009; Watt, Maman, Earp, Eng, Setel, Golin, & Jacobson, 2009). An anthropological approach can provide the wider social perspective and the intimate details of individual lives that are necessary to make sense of behaviors that would otherwise be difficult to understand.

This paper reports on ethnographic research conducted among people on ART in southeastern Nigeria, focusing particularly on the intersection between the therapeutic itineraries of individuals on treatment and their reproductive life projects. Four emblematic case studies are presented to understand how marriage and childbearing are particularly salient in explaining why people's larger life projects can complicate and even trump medical and public health priorities in Nigeria and beyond. In an era of rapid social change, anxieties about the future of traditional kinship are widespread. Ordinary Nigerians often interpret HIV and AIDS as symptomatic of a general sense of social and moral crisis in which perceptions of unfettered promiscuous sex abound. In response to widely shared apprehensions about social reproduction, young Nigerians – regardless of their HIV status – commonly experience intense pressures to marry and have children. But for people who are HIV-positive, these expectations are even sharper, not only because ART makes possible the desire to reclaim normal life courses, but also because part of AIDS's social stigma derives from its moral association with the breakdown of pro-kinship values that are widely perceived to be essential to stable social reproduction. For people who are HIV positive, successful marriage and childbearing are inextricably tied to protecting their social reputations, hiding their HIV-positive status, and avoiding stigma. Marrying and having children offer path to normalcy, but also a way of countering the popular perception that people contract HIV because they behave in ways that flout widely accepted moral notions that connect sex and social reproduction. Marriage and fertility fulfill these obligations of social reproduction, contesting the idea that AIDS is a cause and a symptom of social and moral failures. In Nigeria – and arguably in many African settings where the situation is similar – successful expansion of treatment and continued efforts at prevention require policies and programs that more readily acknowledge and more explicitly enable people's larger life projects.

Research Setting and Methods

The findings presented in this paper are the result of several years of work and study by the authors with patients receiving ARVs from the Federal Medical Centre (FMC) in the southeastern Nigerian city of Owerri. Until recently, FMC-Owerri was the only facility in the region offering ART. The hospital initially enrolled 450 adults living with HIV, and from 2002 through 2005 these individuals received drugs at a highly subsidized rate (less than \$10 per person per month). In 2006, following the new policy of free drugs and the plans for a massive scale-up, FMC-Owerri began expanding its government-supported program with a target of 2,000 patients. By 2007 this target was achieved.

The first author has worked in southeastern Nigeria since 1989, initially as a public health advisor based in Owerri for three years, and since 1994 as an anthropologist. He has studied Nigeria's HIV epidemic since 2000, and from 2004 to 2007 conducted extended interviews with people receiving ART through the FMC-Owerri program. In 2004, he led the Nigeria component of an NIH-funded five-country comparative ethnographic research project, "Love, Marriage, and HIV," in which the marital and reproductive experiences and plans of people on ART became an important sub-theme of the larger study (Hirsch, Wardlow, Smith, Phinney, Parikh & Nathanson, 2009).

The second author founded the Owerri-based non-governmental organization, Community and Youth Development Initiatives (CYDI), in 2001, with the principal aim of addressing Nigeria's AIDS epidemic by mobilizing local people and resources to increase effective prevention, offer

counseling, and provide care and support for individuals living with the virus. CYDI has worked to organize prevention activities for hard-to-reach populations like urban non-school youths, created the most prominent and popular center for counseling and information about HIV and AIDS in the city, and helped to found the first support group in Imo State for people living with HIV, called the Association for Positive Care (AsPoCa), which is comprised of dozens of individuals receiving ART through the FMC-Owerri program. The second author has counseled scores of people who are HIV-positive.

The findings in the paper are the result of the observations, interviews, and experiences of the authors working with HIV-infected people receiving ART. Participants were recruited through information provided about the study on clinic days and at meetings of a local support group for people living with HIV. This opportunistic sample included a range of ages and marital statuses, equal numbers of men and women, and individuals who had been on treatment for as long as four years and as briefly as six months. Interviews were conducted by the authors, in mixtures of English, Pidgin English, and Igbo, with 22 people receiving treatment. Interviews were transcribed (and, where necessary, translated into English) and coded using the qualitative software data organizing program, Atlas.ti. Interviews were supplemented by observations and interactions with study subjects outside the context of formal interviews. All of the names of the individuals whose cases are described are pseudonyms, and aspects of their stories have been disguised to protect their anonymity. Each interviewee provided formal consent to participate in the study and IRB approval for the research was obtained at Brown University in the USA and at Abia State University in Nigeria.

Conceptual Framework and Analytical Approach

The interpretation of research findings is grounded in a conceptual framework that situates the reproductive and therapeutic behavior of people on ART in the context of widespread anxieties about social reproduction created by Nigeria's AIDS epidemic, together with the enduring importance of marriage and fertility – both generally, and as these values have been accentuated by the threat of AIDS. As in many African societies, in Igbo-speaking southeastern Nigeria marriage remains one of the most important individual aspirations and social duties in a person's life (Isiugo-Abanihe, 1998; Smith, 2001). It is hard to overstate the centrality of matrimony in the life course. In Igbo society, marriage is nearly universal and the failure to marry is highly stigmatizing. Marital unions are seen as a collective project in which extended families and communities are highly invested.

Yet at the same time that marriage remains a pillar of social reproduction and a pivotal rite of passage in the individual life course, the institution has not been immune to the dramatic pace of social change that characterizes contemporary Nigeria. In general, younger people are more likely than their parents to name romantic love as a significant criterion for selecting a spouse, and the notion of individual choice (as opposed to arranged marriage) is now widely accepted (though, in fact, families still exert considerable influence). Today, in addition to inflation in the amount of expected bridewealth required for marriage (bridewealth being the gifts that are transferred from the husband's family to the wife's family), the costs of wedding ceremonies are exorbitant. As a result of all these changes, although marriage is universally expected in Igbo society, elders are anxious about the types of partners that young people might choose and young people are worried about whether they can ever afford a wedding.

The AIDS epidemic intersects with these anxieties in powerful ways. The stigma attached to HIV and AIDS is inextricably intertwined with a collective sense that processes of social change are unsettling, and with the tendency to blame individual moral failures for this perception of decline. In Nigeria, as in many places in Africa, HIV is perceived as a disease of modernity, associated with social changes attributed to urbanization, globalization, and

development (Setel, 1996). A widespread sense of social crisis is expressed in the idiom of moral decline, and nowhere is this unease more powerfully articulated than with regard to concerns over sexual promiscuity. It is one of the great ironies of the African HIV epidemic that while Western societies tend to depict AIDS as the consequence of traditional African sexual and cultural practices, in African societies people explain AIDS as the result of too much change, excessive Western influence, and the bastardization of traditional culture (Setel, 1996; Rodlach, 2007). The association of modern sexualities with anxieties about growing individualism, unbridled materialism, and threatened social reproduction finds a ready medium for expression in the AIDS epidemic, a fact that reverberates in the lives of Nigerians who are HIV-positive.

Until the availability of ART, the notion that HIV was not only a medical death sentence but also a social death sentence was very much the perception in Nigeria. Understanding the nature of the social death sentence, and the restoration of life projects enabled by ART, requires recognizing that stigmatization of the disease is bound up with the fact that a life cut short by AIDS was often a life without reproduction. It is possible to hide one's HIV status, but it is not possible to hide whether or not one is married and has children, a point that will emerge repeatedly in the four case studies that follow.

With the possibility of treatment and a prolonged life, the most important goals that people receiving ART pursue are the life projects of marriage and childbearing. We argue that the high priority that people on ART attach to marriage and reproduction is explained not only by their overall value in Nigerian society, but also by the fact that HIV itself is associated with the very threats to social reproduction – by which we mean perceptions of widespread promiscuity and challenges to kinship and community posed by contemporary social change – that are so widely decried in Nigeria. Although it is possible to achieve one without the other, and although we have separated the discussions of marriage and childbearing for analytical purposes, as the cases below show, for many people the desires for marriage and children – and the effort to realize these aspirations – are mutually constituted and deeply intertwined.

The following analysis will present and explicate four separate case studies. These were chosen for the ways that they illustrate and represent more general themes in how many individuals balance their life projects with their ARV treatment. We describe each case study in detail in order to highlight the threads that were common across our larger subject population, as well as the ways in which each individual's seemingly contradictory or risky choices can best be understood in the broader context of their lives.

Therapeutic Itineraries and Pathways to Marriage

For unmarried young adults and older adults widowed by AIDS, as the shock of an HIV diagnosis is mitigated over time and as the positive effects of ART are experienced in terms of restored health and a psychological realization of a possible future, the desire for and obstacles to finding a marriage partner become the most pressing issues they face. Finding a spouse while taking ARVs creates ethical dilemmas about disclosure, poses impediments to taking the drugs, and generates possible risks to the health of both partners in such relationships. At counseling sessions offered in conjunction with ART, patients are made well aware of the medical necessity of strict observance of therapy regimens and the dangers to themselves and others if they engage in unprotected sex. It should be noted that considerable evidence exists that as ART lowers viral loads it also reduces the risk of transmission (Attia, Egger, Müller, Zwahlen, & Low, 2009). But in Nigeria the common message ART patients receive is that sex without condoms is risky. However, condom use is complicated by the fact that unprotected sex is commonly seen in southeastern Nigeria as both a marker of trust and an expression of the possibility that a relationship could evolve into marital union with children (Smith, 2004).

Public health messages about how to keep oneself and others healthy clash with social expectations and conventions about how to conduct a relationship that might lead to marriage. The challenges of navigating the landscape of sex, marriage, and reproduction are intensified by the fact that HIV itself is seen as a symbol of social crisis and moral decline.

Ifeoma's story illustrates some of the typical dynamics that unfold as a person on ARVs begins to reconstruct a life project, looking to marry but struggling with whether or how to reveal her status, and how to take her drugs while in a relationship with a man who did not know that she was HIV-positive. Ifeoma came to the FMC-Owerri in December 2002 desperately sick. She had large ulcers in her mouth. She couldn't eat and appeared severely wasted – even on the verge of death. Ifeoma tested positive for both HIV1 and HIV2 and was immediately started on ART. Over time she recovered remarkably well, to the point where the staff at CYDI said that her plump figure and smooth skin were prime examples of the astonishing effects of ARVs and evidence of the veracity of the often-cited AIDS message in Nigeria that “AIDS no dey show for face” (Pidgin English for “you cannot tell if someone has HIV by looking at them”).

A couple of years prior her illness, Ifeoma had been separated from her husband. Shortly after their first child was born, they had a serious fight that led her to return to her family and her natal community. The separation lasted several months and at one point during this estrangement she heard that both her husband and her infant son were sick. Before she could arrange to visit, she learned that they both had died. Rumors circulated that the man died of AIDS. At that time, Ifeoma's mother urged her to get an HIV test, but she refused. She felt perfectly fine and did not believe that her husband and child had died of AIDS, much less that she could feel so healthy and also be infected.

About seven months later she became ill with a fever and diarrhea and went to a local hospital. Unknown to her, the hospital conducted an HIV test. She recalled being summoned to the doctor's office, without any of the preparations of pretest counseling. The doctor began by saying things like “you know, in this world man proposes but God disposes” and “some news can appear to be too bad, but over time we realize it's not the end of the world.” He then revealed that she was HIV-positive. Ifeoma reportedly fainted and remembers waking up with water being thrown on her face and a crowd of doctors and nurses surrounding her.

After her husband's death but prior to learning of her HIV-positive status, she had begun a relationship with a man in a nearby city. When she got sick her new partner did not know of the extent of her illness or her HIV status because she had returned to her natal home. Prior to her illness, Ifeoma and her boyfriend had frequent unprotected sex and the man was encouraging her to get pregnant to “fast-forward” a marriage. He wanted evidence of her fecundity before formalizing their relationship. After learning that she was HIV-positive, Ifeoma felt she could not tell him her status without jeopardizing the relationship. She believed that once he found out he would make inquiries about her past and discover the rumors that her first husband had died of AIDS. This news, she thought, would make him suspect that she began having unprotected sex with him knowing full well that she was HIV-positive. Further, she felt it was impossible to introduce condoms into their sexual relationship given their shared desire for her to get pregnant. There would be no reasonable way to explain her sudden desire for protection.

Taking her drugs required vigilance to maintain her secret. Each of Ifeoma's three antiretroviral drugs was a separate pill and each had to be taken twice a day. Combined with the various vitamins she also took, it meant that a monthly supply was more than 200 pills. To navigate this problem, Ifeoma took advantage of one aspect of household gender inequality. She hid the pills under the sink in the kitchen – a room, she reported, her boyfriend almost never entered. Further, she would time her dishwashing – a task he never undertook – to coincide with when

she needed to take her medications. In this way she managed to keep her secret and stay on her drugs. At the time that we lost contact with Ifeoma – she moved to the city of Port Harcourt with her boyfriend and planned to try to collect her ARVs there – she was still hoping to get pregnant, marry her boyfriend, and eventually find a way to disclose her status.

For many people on ARVs like Ifeoma, issues of disclosure are central to the endeavor of navigating sexual and romantic relationships, and these issues frequently come to a head around plans for marriage. With the increasing awareness of the risks of HIV in Nigeria, many churches, including the Catholic Church, now require couples to undergo HIV tests if they wish to be married in the church. The prospect of being tested before marriage creates great anxieties for individuals who are HIV-positive. People create all kinds of ways to deal with this problem, including using premarital testing as a way to gracefully disclose their infection without revealing that they have previously kept it secret.

The case of Chinyere is illustrative. On World AIDS Day in December 2003, Chinyere came to CYDI's office in search of help. After crying until she was exhausted, she narrated her story to Benjamin, this paper's second author. Early in 2003 she had gone to the hospital very sick. Unknown to her, she was admitted at an institution notorious for its unwillingness to treat HIV cases. After a short stay at the hospital a nurse asked her to follow her to the doctor's office. Barely able to walk, Chinyere dragged herself into the doctor's consulting room. As she sat down he held up her lab result and shouted: "Look at you! The sin of fornication has finally caught up with you! Before I open my eyes I want you out of this building. We don't treat people like you here." While the willingness of health professionals in Nigeria to treat HIV has improved dramatically in recent years, some doctors still refuse to care for AIDS patients, and hospitals and clinics can be venues for the perpetuation of discrimination. Banished from that hospital, she eventually received treatment from another doctor who willingly treated HIV patients. She got well and for many months Chinyere felt perfectly fine. She put her HIV status out of her mind.

The following August, an Igbo man based in Europe whom her family wanted her to marry came home for a visit, partly with the idea of seeing whether Chinyere was the woman for him. As indicated earlier, in contemporary southeastern Nigeria, young people increasingly choose their own spouses independent of family preferences, often based on an ideal of romantic love, but the role of families in suggesting possible spouses and advocating for (or rejecting) particular unions remains prominent. Igbo men who have migrated overseas are particularly liable to look for help in finding "a good girl from home" to marry. When Obi returned to Nigeria, he and Chinyere got along well. With his migrant's wealth, they traveled around the country and Chinyere enjoyed his company. Eventually, they started having sex. Just before he was to return to Europe, she fell sick – so sick that she could not even escort him to Lagos for his departure.

When Chinyere arrived at CYDI she was frightened about her future. During Obi's visit things had gone so well that they had initiated the first steps in the traditional marriage ceremony and Chinyere had moved in with her future mother-in-law. CYDI helped her get immediate treatment, and eventually aided her in getting enrolled in the ART program. She began to get well physically, but in Chinyere's mind she had bigger problems – the possibility that her HIV infection would derail her marriage. Obi was a wealthy man. He was sending money home to build a big house in his village. Chinyere was handling the money, meaning that she always had cash. Her future mother-in-law liked her. She and Obi genuinely seemed to care for each other. There was the added enticement that she might eventually join her husband overseas. The possibility of losing it all if her HIV status was revealed was terrifying.

Not too long after Chinyere started on her ARVs Obi arranged to have the next steps of the traditional wedding ceremony undertaken in his absence. The traditional wedding, where the two extended families come together to perform the customary rituals, is often completed in the absence of one or both of the betrothed, especially in this era of far-flung migration. The plan was that they would also be married in the church when Obi next returned to Nigeria. In the week leading up to the traditional ceremony, Chinyere experienced terrible rashes all over her body, a common reaction to nevirapine, one of the first-line drugs in the ARV combination provided in Nigeria's ART program. She came to CYDI frantic about her appearance, worried that someone might guess that she had HIV, and fretting that she couldn't possibly wear a turtleneck at her traditional wedding ceremony, where the bride is expected to dress in the latest fashions. She eventually told her mother-in-law that she had an allergic reaction to an everyday medication and this was the story conveyed to the larger wedding party. Chinyere made it through the traditional wedding without her HIV status being discovered, but she still faced the fact that Obi would soon come home for the church wedding, and she had not revealed her status to him.

The impending church wedding hastened her dilemma because she and Obi were Catholics and, as mentioned above, HIV tests were required of all couples wanting to marry in the church. Chinyere came to CYDI pleading for assistance either to obtain a fake HIV lab result or find someone who was HIV-negative who could take the test in her name. It is widely known that in Nigeria fake lab results are sought and sometimes issued to enable church weddings. When she was told that CYDI would not facilitate such a scam, she discussed with her counselor other possibilities. She settled on the idea that she would go together with her fiancé for pretest counseling, pretend it was her first test, and feign horror when her result was revealed. She banked on the hope that Obi would stick by her when her status was revealed now that they were traditionally married, and that she would avoid the worse consequences of his discovering her longer-term deception.

On the appointed day, when she and Obi went for their results, Chinyere fainted dramatically. Her gamble paid off. Although Obi tested HIV-negative, he did not threaten divorce, as many Nigerian men do when they find out their wife is positive and they are negative. CYDI staff attributed Obi's seemingly enlightened response to all the time he had spent in Europe, but we can only speculate about the reasons for his tolerance because we were unable to interview him. Perhaps the most illuminating aspect of the story is that once Chinyere's status was known Obi became a co-conspirator in figuring out how to get married in the Catholic Church. He could accept his wife's HIV status, but he could not live without the social recognition of a church wedding and he personally arranged to secure a fake result for Chinyere.

Chinyere eventually became pregnant, and with the aid of treatment her child was born HIV-negative. She did not breastfeed the baby boy and again had to invent an explanation to cover her unusual behavior. Over time she lost contact with CYDI, but at last report her marriage remained amicable, her child was healthy, and only she and Obi knew her HIV status.

ART, Reproduction, and "Normal Lives"

It is hard to exaggerate the importance of childbearing in southeastern Nigeria and throughout much of Africa. As the renowned anthropologist Meyer Fortes argued long ago, "parenthood is regarded as a *sine qua non* for the attainment of the full development of the complete person to which all aspire" (1978:125). Having children is not only a means to individual personhood, but also a fulfillment of one's obligations to kin and community. Biological reproduction is part of social reproduction. Through marriage and parenthood, one not only reproduces and replaces individuals, one also creates and builds the social networks through which people survive and prosper. Every Igbo person assumes he or she will marry and have children, and

childlessness is the highest of calamities. Personal lives are devastated by it and popular culture is obsessed with it, a fact illustrated by the frequency with which infertility is a central theme in films produced by Nigeria's growing video industry.

In this context, it is no wonder that for people on ART one of the predominant aspirations once they begin to feel healthy is to have children. Many ART patients embark on or resume childbearing, but the process is fraught with social obstacles and potential health consequences. A particularly poignant case exemplifies the social and symbolic importance of children in Igbo society in general and for people living with HIV in particular.

Ukachi was a young woman who periodically attended the Monday ART clinic at FMC-Owerri to collect her drugs. But she did not join the support group and seemed to have little or no interaction with other people on ARVs. One day, she approached a CYDI staff member. She was worried that she might be infecting her boyfriend or that she was being re-infected by him. They were hoping to marry and have children and she didn't know what to do.

It turned out that Ukachi was already a single mother. She had a four-year-old son to whom she gave birth long before she discovered she was HIV-positive. Over time, we learned that as a teenager she had fallen deeply in love with her cousin. In Igbo culture they were absolutely forbidden to marry and their relationship was a secret. They fantasized about moving abroad so that they could be together but that was never possible. Although they knew they could never marry, they decided to have a child together as an enduring expression of their love. When Ukachi became pregnant her family pressured her to reveal the identity of the father, even beating her for the information, but she never exposed her cousin. Eventually, he married and had children with another woman, but he and Ukachi continued to proclaim their love to each other and he secretly supported her in raising their child.

After several years of pining for her cousin, Ukachi resolved that she too would have to marry and have a family of her own, and she set her mind to that task. She started a relationship with a man whom she thought might make a good husband. Several months into that relationship, one of her relatives was in an accident and she traveled to the hospital to donate blood. As part of that process her blood was screened and she was informed that she was HIV-positive. She had never been sick and for several months she tried to ignore the result, continuing her relationship with her boyfriend. Finally, she decided to travel to Owerri to seek a confirmatory test at the FMC. She was indeed HIV-positive. She followed up with more tests and when it was revealed that her CD4 count was low she started on ARVs.

All of the information she had learned through post-test counseling and the programs run by CDYI made her fearful that she might be infecting her boyfriend, but also apprehensive about whether he might have infected her. He had recently been sick, but claimed it was malaria. She wanted to persuade him to do an HIV test, but didn't know how without making him suspect she was infected. He wanted her to get pregnant before they set a date for marrying, so she was as worried about getting pregnant as about protecting her health. With time, the boyfriend decided they should proceed with the traditional wedding even though Ukachi was not pregnant. Shortly after they married she became pregnant. She stopped coming to Owerri for her drugs and for a long time we lost contact.

Ukachi had moved to the city of Enugu with her new husband and had indeed stopped taking her medication. We learned this because when she was seven months pregnant she went for antenatal care in Enugu and the clinic staff said they would not agree to assist her delivery unless she did an HIV test. Faced with the possibility of exposure (her husband still did not know her status), she traveled to Owerri so that she could give birth at the FMC. Once one of the most beautiful and healthy looking of all the patients in the ART program, Ukachi looked sickly and wasted. She stayed in Owerri long enough to have her baby, but returned shortly

thereafter to Enugu. When we asked why she had stopped taking her medication, she said she feared she could not hide or explain all the pills (as a patient coming from Enugu – two hours away – she could collect three months of pills, which, including vitamins, would amount to over 600 tablets). Rather than risk facing the consequences of revealing her HIV status and possibly undermining her marriage, she chose to have a child who would solidify the relationship and she stopped taking her drugs, even though these actions posed potentially disastrous health consequences for her, her baby, and others. It is impossible to understand Ukachi's therapeutic itinerary without accounting for the primacy of marriage and reproduction in the socially shared conceptions of why one would care to be alive in the first place. For people who are HIV-positive, fears of disclosure and awareness of the stigma associated with AIDS heighten the urgency of constructing a life project that looks normal to partners, family, and society.

Concerns about appearing normal extend beyond people who are infected to their spouses and families. We observed numerous cases where an uninfected spouse who knew his or her partner was HIV-positive nevertheless exerted tremendous pressure to procreate. Nnamdi was a founding member of AsPoCa, the Owerri support group. He learned he was HIV-positive after becoming extremely sick. At the time that he was diagnosed with HIV he tried numerous treatments, including various traditional doctors, without improving significantly. When the FMC-Owerri ART program began in 2002 he was one of the first to enroll. He told his wife of his problem immediately – in fact, he had no choice because when he first received his lab result several family members were with him in the hospital and the indiscreet staff revealed his HIV-positive status to him in front of the visitors. His wife stuck by him steadfastly. She tested negative for the virus. At the time of his diagnosis they had two young sons.

Nnamdi said that when he was sick he never even thought of sex, much less of having another child. But when he became better after beginning ART he and his wife resumed a sexual relationship. Nnamdi reported that he always used condoms. About a year or so after he had started on ART, he sought counseling at CYDI because his wife began putting pressure on him to have another child. As a leader of AsPoCa he was well versed in the most up-to-date information about risks, prevention, and treatment. He said he did not want to expose his wife to HIV, and he was not inclined to risk unprotected sex to produce a pregnancy when they already had two HIV-negative sons. Because of the patrilineal structure of Igbo lineages, people are greatly concerned with having sons to pass on their names, land, and property. Normally, Nnamdi would have been eager to have another child and happy to have a daughter, but under the circumstances, he said, "I am ok with two sons."

His wife, Ogechi, was, however, intensely desirous of having a third child. Nnamdi wasn't sure how to negotiate her increasing insistence so he asked if he could bring Ogechi to CYDI for counseling. At CYDI she was told about the dangers of unprotected sex for herself and about the possible risks of mother-to-child transmission. She knew the facts already and still wanted to get pregnant. She explained that her friends and relatives had been asking for some time why she had not had another child. She said, "Everyone is always asking about my next issue (offspring). I do not feel normal with only two children. I can't tell them why we are not having more issues (children)." In addition to the social pressure to have more children, she also expressed a strong desire for a daughter. Regarding the possibility of contracting HIV herself, she simply said, "My husband is healthy now that he is taking his drugs. If I become infected I will also take drugs." As with many Nigerians, the short-term desire for more children eclipsed any perspective on long-term health risks to herself.

CYDI referred Ogechi to the doctor in charge of the ART clinic at FMC-Owerri to make sure that she fully understood the medical risks. To date, Ogechi has not had another child. But the reason was not from a greater understanding of the health risks; it was due to a change in her

perception of her marriage, and particularly the behavior of her husband, who she discovered was cheating on her. Had Nnamdi not resumed a pattern of extramarital relationships that Ogechi found reprehensible, there is no reason to think that she wouldn't have continued to insist on another child.

It should be clear that marriage and reproduction are among the most important dimensions of forging a normal life in southeastern Nigeria, a fact that is accentuated for people on ART because HIV is associated with collective anxieties about social reproduction. But of course in Nigeria, as everywhere, social norms are by no means monolithic. A "normal" life is not reducible to the duties promulgated in formal social conventions. Nnamdi's resumption of habitual extramarital sex is emblematic of the multiple forms of normalcy and the kinds of resurrected life projects that must be understood in the context of the availability of antiretroviral treatment. In his public persona as an AsPoCa leader and in private conversations with friends at CYDI Nnamdi presented himself as someone who steadfastly adhered to moral and medical codes, which prohibit extramarital sex. To people who knew he was HIV-positive he spoke with great authority about all the things that one must do – and that he said he did – to protect the health of himself and others. But over time we began hearing stories from women who joined AsPoCa that Nnamdi was one of a number of men in the group who preyed upon single or newly widowed women, taking advantage of their vulnerability to entice them into sexual relationships. Nnamdi's wife, Ogechi, eventually came to CYDI to complain about her husband's behavior. She was now worried about protecting herself and no longer demanded another child. In the words of one CYDI staff member, "She no longer sees him as a loving husband for whom she will do anything in his time of need. Now she sees him as the man she's living in the same house with whose actions she cannot predict or control." In her words, "he is back to normal," with all the unhappy connotations it implied. Nnamdi's apparent sexual "disinhibition" needs to be understood in context. Rather than simply a deviation from medical advice (and from the normative life projects of marriage and reproduction), his behavior is in fact part of common pattern among married men in Nigeria, who reinforce their social status through extramarital relationships with younger women (Smith 2007). For Nnamdi, his health brought about a return to normal sexual life, both as a husband and outside his marriage.

Conclusion

For most people who are enrolled in Nigeria's expanding antiretroviral therapy program, the opportunity to resume a normal life is cherished and ardently pursued. In our experience, the most valued part of a resurrected life in Nigeria is the chance to marry (or remarry) and have children. While the vast majority of people on ARVs at the FMC-Owerri are mindful of the continued risks, and committed to keeping themselves and their loved ones safe, the physical risks to personal and public health are factored into a larger equation in which the very reasons for being alive are always paramount.

In southeastern Nigeria, marriage and parenthood, the principal tasks of biological and social reproduction, reign supreme in the hierarchy of social expectations and individual aspirations. For people who are HIV-positive, the importance of these life projects is felt even more sharply because the stigma of AIDS derives from the popular perception that infection is indicative of moral failings – like sexual promiscuity and weakening ties to kin and community – that are seen as responsible for threatened social reproduction. By pursuing normative life projects, people on ARVs mark themselves as morally legitimate despite their HIV status – in other words, they contradict the stereotype surrounding HIV. As the cases of Nnamdi and Chinyere demonstrated, when individuals pursued the pro-social life projects of childbearing and faithful marriage, many spouses dismissed the stigma of their partner's HIV and were willing to overlook the risks that their marriage posed to their own health. However, just as Nnamdi's wife began to fear for her own status only after she discovered her husband was having

extramarital affairs, so the stigma associated with HIV becomes most salient – perhaps ironically – when HIV-positive people do not commit themselves wholeheartedly to marriage and childbearing. Marrying and having children are ways of asserting one's contribution to family, community, and society, as well as deflecting the moral stigma associated with the disease.

For many people on ARVs the dilemmas of how to make families while living with HIV are resolved, or at least addressed, by seeking partners from within support groups like AsPoCa. At FMC-Owerri, AsPoCa has been a principal meeting ground for people seeking sexual partners and possible spouses. Several other support groups have been established in the region and anecdotal reports suggest that they have also become arenas for sexual networking and marriage markets (see also Rhine, 2009). Further, as in the larger society, not all of what goes on in the support group is laudable – for example, as members of support groups are sometimes subject to pressure from other members to engage in sexual relationships. But overall, the emerging communities of people living with HIV seem to be a positive development, enabling people to forge life projects, including reproduction, in ways that make it easier to address both social and medical realities.

The lives of people living with HIV remain intertwined with the wider population of people who do not know their status. Life projects, especially reproductive life projects, continue to pose social predicaments, public health risks, and existential dilemmas. Whether, when, and how to disclose one's HIV status; how to marry and have children in ways that meet social expectations and achieve personal ambitions; and how to stay healthy and on drugs while doing so – are all priority issues for people who have been provided another chance at life by ART.

As the cases described above have illustrated, the availability of drugs has restored the possibility of normal lives for people with HIV that were perceived as impossible given the social and biological death sentences associated with AIDS in Nigeria. But stigma remains powerful. As a result, people on ARVs continue to try to manage their treatment mostly in secret, while they simultaneously craft public lives that are seen as upholding the values of creating and perpetuating families, in the process securing the future of local culture through marriage and childbearing, and in so doing hopefully mitigating against potential stigma if and when their status is discovered.

Based on the findings from this ethnographic examination of a small population of people on ART in southeastern Nigeria, organizations that provide treatment and counseling face many challenges in promoting behaviors that are in the interest of both their individual patients and broader public health. The experiences at FMC-Owerri and CYDI suggest that it is crucial to acknowledge, understand, and support the restoration of reproductive life projects. Given how important sexual relationships, marriage, and reproduction are for people on ART in southeastern Nigeria – and the likelihood that these priorities will be similar in many other societies – clinicians, counselors, and other public health personnel need to be mindful that their messages and advice will be heeded much more effectively if they enable these life projects. There is probably no way to avoid the fact that the fulfillment of personal aspirations and social expectations sometimes directly conflicts with public health interests. But as the stories described here attest, people on ART are highly attuned to these issues; most of them take all of this into account to the extent that they can. The life projects of people on ARVs are complicated, contradictory, and messy. Perhaps we should not expect much different; ART allows people infected with HIV to live normal lives.

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