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Renegotiating intimate relationships with men: how HIV shapes attitudes and experiences of marriage for South African women living with HIV: ‘Now in my life, everything I do, looking at my health’[★]

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Abstract

This paper explores marriage attitudes and practices among Xhosa-speaking women living with HIV (WLHIV) in Cape Town, South Africa. It reports on a study that assessed the fertility intentions of a cohort of people living with HIV, aimed at informing an HIV care intervention. It draws on qualitative data generated from 30 successive interviews with WLHIV in wave 1, 23 interviews in wave 2 and 20 follow-up interviews in wave 3.

Gender inequality, marriage and HIV are strongly intertwined. Broader layers of South Africa's history, politics and socio-economic and cultural contexts have consequences for the fluidity in intimate relations, marriage and motherhood for WLHIV. Key and conflicting themes emerge that impact on marriage and motherhood. Firstly, marriage is the ‘last on a list of priorities’ for WLHIV, who wish to further their children's education, to work, to earn money, and to achieve this rapidly because of their HIV-positive status. We demonstrate that the pressure women face in marriage to bear children creates a different attitude to and experience of marriage for WLHIV. Some WLHIV wish to avoid marriage due to its accompanying pressure to have children. Other WLHIV experience difficulties securing intimacy. WLHIV may find it easier to seek partners who are also living with HIV. A partner living with HIV is perceived as sharing similar fertility goals. In this study, HIV accentuates existing issues and highlights new ones for WLHIV negotiating intimacy. The findings contribute to the existing knowledge base regarding the fluidity of

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marriage and fertility intentions within the dynamic context of living with HIV. These are likely to have broader relevance in currently rapidly urbanising and economically developing countries with high HIV prevalence in southern Africa.

I. Introduction

South Africa has one of the most severe HIV epidemics in the world, with 11 percent of the general population infected with HIV.¹ Approximately twice as many young women between the ages of 15 and 24 years are infected with HIV compared with young men in this age group.² Among pregnant South African women, the prevalence of HIV is 29.5 percent.³ Living with HIV affects many people's attitudes and experiences of social relationships. When women or mothers are sick, not only do they re-assess their residential,⁴ economic⁵ and health care arrangements for themselves, their children and households, they also re-negotiate their intimate relationships and their attitudes towards such relationships. While research has investigated certain aspects of how individuals negotiate intimate partnership matters such as sexual behaviours,⁶ experiences of disclosing HIV diagnosis⁷ and men's involvement in caring for HIV-positive members in households,⁸ little is known about how HIV impacts on attitudes and experiences of marriage more directly.

In this paper we explore the experiences and attitudes towards marriage and motherhood for a group of women living with HIV in an urban-based community. We focus in particular on how women make connections between living with HIV and attitudes and decision-making around marriage and childbearing. The paper aims to make an important contribution to the research on marriage, cohabitation and HIV in South Africa by considering the relationship between attitudes to marriage and experiences of marriage for women living with HIV (WLHIV). Given the high HIV prevalence rate amongst young women in South Africa, more women face marriage and intimate partnerships as well as reproductive decision-making. At a time when the nature of marriage and coupling has changed dramatically, this research pays specific attention to how WLHIV experience union formation and reproductive decisions.

(1). HIV and coupledness

Rising unemployment and social inequalities have left youth, and poor young women in particular, vulnerable to relationships that put them at risk for HIV infection. This is coupled with reduced marriage rates and rising levels of women's circular migration, a longstanding feature of men's migration.⁹ As described elsewhere in this journal, for centuries, marriage and family formation in southern Africa have been profoundly influenced by labour migration from rural to urban areas.¹⁰ A history of marital instability – with women becoming more independent and separated spaces being formed for couples impacting on changed gendered domestic roles – is underpinned in part by the historical context of colonialism and apartheid in South Africa. Patterns of marriage and residential arrangements amongst black South African women continue to be dynamic and currently most black South African women are living in non-marital arrangements.¹¹ Greater urbanisation has occurred more rapidly in South Africa than elsewhere in southern Africa and is also linked to reduced marriage rates.¹² Given the high rates of marriage amongst (young) women in

Lesotho, Harrison et al¹³ argue that marriages were ‘near universal experiences’ in Lesotho.¹⁴ The context in which women living with HIV negotiate marriage and reproductive decisions in Lesotho provides an interesting contrast to the experiences of marriage for WLHIV in South Africa who marry much later, if at all. Coupledness in the context of HIV may be especially fragile. Many people living with HIV (PLHIV) experience anxiety and contradiction in seeking to strike a balance between obtaining sexual intimacy and safety from HIV reinfection to self or transmission to a partner. However in real-life contexts, the forging of intimate relationships for PLHIV is filled too with emotions rather than only calculated decision-making.¹⁵ We explore how this intersection plays out in the attitudes towards and practices adopted in the forging of intimate coupledness within the context of living with HIV in an urban setting in South Africa.

This paper examines the intersection of the experiences of marriage, intimate partnerships, fertility decisions and living with HIV among a sample of WLHIV in South Africa. We examine whether there is a double disadvantage for WLHIV related to marriage and the obligation for childbearing and difficulties in forging intimate relationships. Conversely, living with HIV may promote greater resilience and independence in intimate relations in WLHIV. Perhaps WLHIV negotiate or avoid gendered social norms around childbearing and marriage because of their HIV status? In this paper we focus on how WLHIV balance the intersecting influence of social norms, their HIV status, marriage and having children.

II. Methods

(1) Study setting

This study was conducted with women and men living with HIV prior to initiating antiretroviral (ARV) treatment. The sample was recruited from four public sector primary health care centres in Cape Town, South Africa. These clinics provide free health care, including HIV care services. Participants were interviewed at these facilities or at a venue of their choice at follow-up. Only the findings from women participants are reported on in this paper.

(2) Study design and sample selection

Following approval from the Health Sciences Faculty Human Research Ethics Committee at the University of Cape Town and the Institutional Review Board at the New York State Psychiatric Institute and Columbia University, qualitative data were collected. This was part of a broader structural intervention study integrating sexual and reproductive health into HIV care. Three consecutive interviews were conducted with an initial cohort of 30 women (wave 1). We aimed to ultimately have 20 women in the third interview, so recruited 30 for the first interview, estimating that ten would leave, mostly due to being too sick, having died or moving out of the area. Twenty was considered a sufficient number for the purposes of gathering qualitative in-depth insights on the key domains of interest (see below). Twenty-three women were followed up for a second interview at nine months (wave 2), and 20 women for a third interview (wave 3) at 18 months. The 23 women interviewed in the second wave had all been interviewed in the first wave and all 20 women interviewed in the third wave had been interviewed in both the first and second waves. The study was

conducted between September 2007 and August 2009. Loss to follow-up over the 18 months was due to subsequent refusal for further interviews (2), moving out of Cape Town (4), being too sick to be interviewed or deaths (3), and untraceable (1). Inclusion criteria were: (a) being HIV-positive; (b) being 18 years or older; (c) having the cognitive ability to consent and participate unencumbered in an interview; and (d) willingness to have the interview audio-recorded. Being married or having children were not criteria for recruitment, nor was being in a heterosexual intimate relationship. However, no women acknowledged being in a same-sex relationship. The study sample consists of only black women participants as these were the female clients presenting in study health centres in areas where there was a high HIV prevalence. Some participants were initiated onto ARV treatment by the third interview.

We systematically approached every third woman client in the waiting area, explained the study objectives and procedures, screened for eligibility, and initiated the informed consent process with interested eligible women.

(3) Data collection

We conducted three interviews so as to develop a rapport with participants on sensitive issues and track changes in fertility intentions over 18 months. The focus of this paper is not primarily on changes in fertility intentions. Fertility changes become relevant mostly in relation to how some changes occurred in marriage intentions and why they occur. The interviews included detailed conversations about several key areas, including the impact of HIV on their lives; disclosure of HIV status; and intimate partner relations, including marriage, life goals, desire for parenthood and reproductive decision-making. In addition, background demographic data were collected. Table 1 (below) shows key demographic background details of the participant sample in the baseline interviews, including how many were married, how many were in other forms of intimate partnerships or were single and whether they had children or not. Data were collected using semi-structured interview guides by two skilled female researchers. Interviews took place in participants' preferred language. In all cases, this was Xhosa. Interviews lasted between one-and-a half and two hours. Interviews were audio-recorded, transcribed into Xhosa and translated into English.

(4) Data analysis

Data management was conducted with NVivo 7 using a systematic coding process. Primary coding categories were identified and themes within each category delineated. Codes relating to themes of marriage, children and HIV were developed. The first author synthesised the coding list, which was then reviewed and commented on by the other two authors. Thematic analysis was conducted and illustrative quotes relevant to each theme were extracted. The quotations chosen from the raw data are typical of women interviewed and therefore dominant themes, unless otherwise specified. Some minor but important issues emerged and are indicated. While themes that emerged did not primarily centre on changes across time, where these occurred and were reflective of changed marriage and fertility intentions and their reasons, illustrative quotations were selected. The narratives and themes were compared to assess similarities and differences between participants. All names used in this paper are pseudonyms.

III Findings

(1) Socio-demographic characteristics of sample

Participants ranged in age from 19 to 61 years. At the first interview, over three-quarters of the respondents were in an intimate partner relationship; less than one-third were married. The average number of children women had was three. Three women had no children. Nine women lived in a household with only their children and six lived with another close family member (mother or sister) and their children; four and two, respectively, lived with their boyfriends or their husbands only (see Figure 1). Their average initial CD4 count (this is the measure that reflects their immune status) was 339. Normal is a CD4 count of between 600 and 1200 CD4 cells/mm³. For fuller details of participant characteristics, see Table 1. Medical eligibility for initiating ARV treatment (ARVs) for PLHIV at the time of the study was a CD4 count of below 200 cells/mm³.

The attitudes towards marriage and experiences of marriage and childbearing for married and unmarried women were centred on three main themes. In order of prevalence, these themes are the following: (a) intensified desire for their own financial support prior to marriage; (b) negotiating normative links between marriage and motherhood; and (c) securing and maintaining intimate relationships. Some of these themes confirm research findings from other studies on WLHIV's attitudes and experiences of marriage.

(2) Increased desire for own financial support prior to marriage – the need for 'quick success'

Many women, particularly those who were younger, had important life goals related to children's education, their own securing of work, and the need to support themselves and their children or families that superseded their interest in marriage. When asked whether HIV had changed her life goals, a common response was that of Phumeza, who saw her life goals of working and earning an income as important to maintain: 'I had hoped that I can work and have my own money ...'.¹⁶

A key theme that emerged in WLHIV was an increased, intense desire to study, work and earn money. There seemed to be a greater impetus to do this quickly. Their HIV-positive status drove an urgency to achieve many things in their lives because of the tenuousness of their health status. For example, Xoliswa noted the importance of more focused planning for her child's future and earning a livelihood. Perceptions of shortened life spans are likely to exacerbate this drive in the context of HIV:

Yes, I do have a lot of plans. I want to save money for my child, to work ... I wish I can get a brick house to stay because it is very cold in that shack very cold ... I am more focused [after knowing that I have HIV] on working now.¹⁷

Life goals of children's education, and their own work and income were extensively discussed. Fundiswa echoed the views of others, in saying:

... like now in my life, everything I do, I do looking at my health ... This is so that everything must quickly be successful because when the time comes for me to die, I must at least know that I have the right plans for my child ... That it [her child]

can grow up at least, and go to school. I must have put aside money for her so that if I die, she will be able to continue with her studies ...¹⁸

Some WLHIV who were newly diagnosed with HIV in the first interview, if they remained well at later interviews and came to terms with living with HIV, grew more optimistic about the chances of realising their life goals. For example, by her third interview, Fundiswa was even more resolved about not being held back by living with HIV:

... all the plans I had before I was HIV+, I am still doing them. ... Like now I have just passed my driver's licence ... there is nothing that is holding me because of being HIV+ ... I wanted to have it [driver's licence] so that I can get a job.¹⁹

However, others, who either became sicker or perceived ill health to be their future, became more pessimistic about being able to achieve their life goals 'in time'. Phumeza, in her third interview and Khetiwe, in her second interview, were typical of this group of women in speaking about the detrimental effects of HIV on their life goals. Phumeza's inability to work because of poor health impeded her in achieving her life goals:

[The problem is] ... not to have money and to think that I am not able to work ... because I won't be able to do everything. I might get a job where you must work hard and I won't be able to.²⁰

Marriage was perceived as the 'last' on a list of potential priorities. Some WLHIV only mentioned marriage in their follow-up interviews, concentrating on their experiences of living with HIV in the first interview. For Khetiwe, who had only completed grade 8 and was working part-time, this included passing on a message from one generation (particularly those affected or infected with HIV) to a younger generation:

I had HIV that is why I could not go further with school so I would encourage them ... [my child] that they must finish school and work ... and they can have their own family ... the first one is to finish school and work [and then] marriage comes last.²¹

Sibonisile, who was unmarried, emphasised women's desire to be economically independent. She described her economic support for her family. She did not see the need to marry in order to have a child:

No, it's not caused by the fact that I'm HIV+. From the very beginning, I told myself that I wouldn't ... I mean at home they were dependent on me so there is nothing that would make me go into marriage for the purpose of getting a child again.²²

Delinking motherhood from marriage in younger women surfaced as a strong theme. Ntombi, living with her boyfriend, spoke of the 'normalcy' of having a child before marriage: 'That is why I'm saying ... it is right to even have one child [before marriage], ... and then if you get married, you would know even if it's one, you do have one.'²³

(3) Negotiating normative links of marriage and motherhood

Zodwa expressed the views of many other participants in indicating that she perceived it as socially normative as well as her personal desire to have children: 'I would say it is

important to have children because you need to have them. Like it is part of life to bring up children and these children like you are making yourself a family.'²⁴

Where women did not have any children they expressed strong desires to have at least one child. A dominant theme that emerged spontaneously even before this was probed was the anguish surrounding the possible decision not to have children. Agnes, aged 55 years, said:

It is very important to have children ... I see people who have no children are very hurting in their hearts ... But if you know how is your condition [that you have HIV] and you have one or two, then do not think of continuing.²⁵

Others did not wish to have a child or more children. Where women had no children, this was due to fears of HIV impacting negatively on their health. Where they did not wish to have more children, this could be due to having reached a desired family size or to the impact of HIV. For example, Thembisile said:

No, we [she and her partner] no longer talk about children, it's just love, making each other happy. There's no one who has thoughts about children, each person [already] has children.²⁶

Gloria said: '... we had two children [with her husband, who had passed away]. So I am still bringing up my young children.'²⁷ Bongiwe adopted a practical approach:

... anyway I already had children ... not knowing that I am HIV+ ... I kept giving birth. As the life goes on ... now my children are enough. I do not want children anymore ... I am not married – nothing I am going to do with lots of children ... that fill up the house.²⁸

Ntombi echoed the earlier sentiments of some others. She did not see HIV as relevant to her desire not to have more children, but saw it as something that prompted her to pass on a message to her children to achieve an education:

I could not say it [not having children] is because of HIV status ... but because I know that I must look after my children now. I would like them to get education as much as they can and I will relate my life to them, why am I not educated, telling them that I do not wish them to become like me. I would like them to focus.²⁹

Some older respondents, in particular, expressed ambivalence about not having more children. This emerged when they reflected on this some way into their first interview. Initially, in her first interview, Thandeka said she did not want more children. But later in the same interview she stated: '... Yes, I do [wish to] have more children'.³⁰

By the second interview, Khetiwe, who had said in her first interview that she did not want to have children, had changed her position. Newly diagnosed at her first interview, she now reflected on the possibility of becoming ill due to HIV and needing assistance: 'It is very important to have children in the sense that when you are sick, your children can help you ...'³¹

While many of the participants presented marriage as part of an 'ideal life package' or as a future possibility, many also saw it as practically unfeasible. For WLHIV, the pressure to

have a child or more children in marriage was the strongest deterrent to getting married. Lungiswa said: 'When you are married, there's no way of not having children. You must have other children.'³² Fundiswa feared being obliged to have children in marriage:

... if I get married, a person would want me to have his children [an additional child to the one she already has that is not his child] ... So I am not prepared to do that... So I told myself I don't want to get married.³³

Given the patrilineal nature of the communities in which these women lived, apart from husbands, extended families frequently pressurised women to bear their sons' or son-in-laws' biological children. Xoliswa and Nomphumelo explained this in a way typical of respondents:

... After getting married ... we waited a shorter period then while I was looking for a baby, eish, we find that we do not get it ... Now I hate the fact that I have been married for a long time, and the family ... yes, this one [the one she already has but not from her husband] is also their baby but ... in marriage ... they need that we must have [more] children [indicates that it should be her husband's child]³⁴

... in marriage a wife is a wife by having a child, children, so at my home [her own family] they would be stressed if I didn't have children and ask how can I go into marriage and don't have children³⁵

Women felt that married women would be strongly stigmatised if they did not bear children: 'If you are married, it is important to have children with your husband. If you got married, one of the reasons of marrying is to bear children for this family.'³⁶

Fears of having children or feeling compelled to have more children in marriage, and thus compromising their health, was a key reason for WLHIV not wanting to marry and have children. They perceived this as a chain of events: Marriage would lead to pressure to have more children and this could be detrimental to their health in the context of HIV. Nomonde and Fundiswa echoed the fears of other participants in saying: '... I know that when you are HIV+, the more you give birth, the more you deteriorate.'³⁷ Fundiswa said:

I don't see that as an option ... once you have married, the person you have married will want another child – the thing of marrying and then having to risk my life because if I have to have another child, it will put my life at risk³⁸

Zandile, who was not in a relationship at the time of the interview, related her experience that living with HIV could cause conflict between partners about having children. This may be exacerbated when women are married:

... it was the main thing that used to cause a misunderstanding between us. He would be abusive and say 'you don't even want to give me children' ... No, what I would like to encourage is that women who are HIV-infected ... I wish she wouldn't even start having a child, it's even worse with ... those who are married.³⁹

Another reason given for avoiding having more children was the fear these women felt that they would die early as a result of HIV, thus leaving behind young children for whom they

would be unable to care. Fundiswa echoed the views of others in explaining this further, linking it to marriage:

I don't want to get married [because of HIV] ... I told myself that as I am having this one child, ... I don't wish to die leaving my young child, I wish at least to die when my child is old ... So if I could have another child, she/he would be too young⁴⁰

WLHIV, therefore, balance whether to marry – with its accompanying pressure to have children – with the perceived negative impact of childbearing on their health.

Economic self-reliance for women, whether married or not, is likely to increase women's decision-making power with respect to making choices. In some circumstances this may override married women's obligations to have children. As Nomsa explained:

... I buy enough food ... He [her partner] gets work and then again he doesn't get any ... I told him that I don't want too many children ... Two children are right ... he has agreed ... using contraception ... I made the decision myself ... I just told him⁴¹

(4) Securing and retaining intimate relationships

Securing intimacy in relationships for unmarried WLHIV is complicated by their HIV status. Some WLHIV sought to marry. In some cases they indicated that this would give them a sense of normalcy in the context of living with a life-threatening illness. Phumeza's statement was typical of this view: 'I also wish to get married because I used to see people talking on TV saying that she got married [even though she is] living with HIV.'⁴²

Philiswa initially thought she would not marry but changed her mind by the third interview. She became more knowledgeable about preventing vertical HIV transmission to an infant, which had been one of her earlier concerns.

When I first learned that I was HIV+, I told myself that I don't want to have children, you see ... I didn't have enough information about how can I have a child being HIV+ ... So that changed after I had full information. So I told myself that I can ... get married and have a family.⁴³

The social stigma attached to persons living with HIV may play a role in dissuading WLHIV from marrying, the fear being that, once married, her partner may reject her because of her HIV-positive status. At her third interview Andiswa confided in the interviewer, stating her dilemma that she wished to marry, but rejection by her previous partner based on her HIV status had prevented her from doing so. As a result, community members questioned why the intention to marry had been abruptly terminated. She feared this could lead to inadvertent disclosure of her HIV-positive status within her community. She had not disclosed that she was living with HIV to her current boyfriend, with whom she had been in a relationship for four years. She explained:

... I wish I can get a husband ... I have started taking ARVs ... [I am] still having this problem of being deserted ... That person broke up with me after I have disclosed that I am HIV+ ... because he was going to marry me so he got married

with someone else ... yes, and people obviously want to know why didn't he marry me.⁴⁴

However, personal and social situations are not homogeneous and some HIV uninfected male partners showed acceptance of a prospective wife's HIV status, as was the case with Zodwa. Zodwa clearly sees HIV as 'part of herself' and something that her husband therefore had to accept when going into marriage, when saying:

... when I got to marriage ... I knew that I am HIV-positive ... if my husband did not accept me with my HIV, he was going to withdraw from marriage, although we were engaged, so I would say HIV is part and parcel of this [our being able to get married].⁴⁵

WLHIV frequently found intimate relationships or marriage easier if they were already in or sought an HIV-concordant relationship – with a partner who is also living with HIV. A partner living with HIV is perceived as sharing many of the same goals and hence some of the problems mentioned could be circumvented. Married partners, where both are living with HIV, may have greater synergy in fertility goals and in seeking health care to maximise safety and health, as illustrated in Boniswa's case:

Me and my husband, we went to see the doctor to find out what can we do to have children ... the doctor said we must come back when my husband's CD4 count has increased ... then we came back to the doctor and he said we are having a problem [in becoming pregnant] between us [indicated infertility problem].⁴⁶

Favouring HIV-concordant intimate relationships was described both within and outside of marriage. Princess, when interviewed, did not have a current intimate partner, as she did not wish to have to disclose her HIV-positive status continually to partners. However, she explained that if she had an intimate partner in the future, she would want him to be HIV-positive. She felt that a partner living with HIV would be more understanding about her not wanting to have another child:

I don't want a partner ... I cannot keep on telling all of them that I am HIV+ ... I might want someone who has ... HIV ... they say they [those living with HIV] differ ... I don't want to have a child ... I won't be able to take care of that child.⁴⁷

Some women saw marriage as mutually supportive, in the context of HIV. Lungiswa and Boniswa expressed this as follows:

It's my husband who gives me support ... support for perhaps when there is something that I've heard and he will say 'you mustn't worry yourself, relax' and he would talk with me and that thing will come to an end and we become happy.⁴⁸

I gave him my support as much as I can ... so we just united, in so much that I was the first woman to come to the clinic with her husband.⁴⁹

This support was given, but not exclusively so, when a husband was HIV-concordant. Xoliswa explained: 'My husband supported me more when I told him about my HIV.'⁵⁰

However, women also reported receiving support from a boyfriend in the context of HIV:

He [her partner] cares for me because I always go [to him] for holidays ... [since knowing I am HIV+] ... he phones all the time, and if he doesn't phone, he says sorry. Before if he didn't phone and ... and if I asked why are you no longer phoning ... no ... now he doesn't speak like that ... he always gives a reason, like I didn't have money, and says sorry.⁵¹

Some women reported the burden of financial support for both partners in the couple falling on families. For Boniswa, in an HIV-concordant relationship, it was unclear whether her own and her partner's inability to work for a period was due to HIV or to general unemployment:

My husband was not working so it was not nice in my soul by then because I could not get everything and I was also not working ... so I ended up being helped by my family ... At home we used to meet half way with my husband but after that my husband is working again so things are back to normal.⁵²

The strong support bond between migrating daughters and parents, particularly between daughters and mothers, was a salient theme that emerged in some interviews. Fundiswa expressed this view – common to others – in saying:

Like you see, now that I am studying, when I have finished studying I am going to get a job ... I am not yet working ... and it is my mother who is supporting me ... it upsets me when I see that she also doesn't have any ... It would be better if I had my own money so that I could also help her ... If I die because I am here in Cape Town and she is far away in the Eastern Cape, I don't want my mother to have to be the one to struggle⁵³

(5) Involved fathers

A number of participants mentioned that their partners wished to be involved in parenting. Zodwa, recently married, indicated that her husband wanted to have more children with her, so as to be more involved as a father the second time around:

... he has children outside [marriage] already, but he did not have a chance to bring up those children because they were outside [marriage] ... We decided that we can have a baby by next year.⁵⁴

Other young women also spoke of men enjoying more involved father-hood roles. Phumla, who was in an HIV-concordant relationship with her boyfriend, said:

It is important ... he [her boyfriend] is so interested to have children because he never had children, but now I can see he is enjoying to be a parent though he knows our health condition.⁵⁵

Among our participants, younger women living with HIV in their 20s and 30s reported that some men expected, as fathers, to be in caring beyond providing financial support. This was articulated by Ntombi who was in an HIV-concordant relationship. While it was unclear what her own view on this issue was, she said that her boyfriend felt that they should not have a child if he was not fit to work and play a caring role for their child:

... at least, so that we are able to help each other in bringing the child up ... he wants [children] too, but the problem is that he is not working ... so he ended up saying, I must not have a child whom he should be able to care for ... he doesn't have the energy to do so⁵⁶

IV Discussion

How does living with HIV shape women's attitudes towards experiences of marriage in relation to having children? In what ways does living with HIV impact on conceptions of mothering and in what ways does living with HIV influence the types of intimate relationships WLHIV engage in? These were the questions that were posed at the beginning of this paper.

Our interviews with WLHIV provide important insights into how HIV diagnosis affects attitudes towards and experiences of marriage and intimate relationships. We found that women's need for securing their financial self-reliance is intensified. Similar to previous studies,⁵⁷ we found that WLHIV prioritise attaining their own sources of financial support before getting married. However, the need and desire to secure such self-reliance was intensified by the tenuousness of their health status. In particular WLHIV initiated plans to make sure their children would be supported even after they passed away. Supporting a child appeared to be seen as primarily a woman's responsibility both before and after their illness.

As changes in the political, economic and social terrain occurred, the fertility rate for women has decreased. The average number of children decreased from 6.8 in the 1950s to around 3.0 for black South African women by 2000.⁵⁸ This reduction in family size is underpinned by rapid social and economic development, increased life opportunities, and the accessibility and acceptability of contraception in South Africa.⁵⁹ It is also influenced by HIV.⁶⁰ Consistent with other studies, our findings show that, depending on their health status, WLHIV may either acquire greater or lesser fertility intentions.⁶¹ We found that some WLHIV were opting out of marriage as a way of managing their (reproductive) health. Given the normative expectation of childbearing in marriage, some WLHIV believed it may be easier to remain unmarried. Women's marriage and fertility decision-making is mediated by individual, family and social situations. It is also mediated by the length of time they have been living with HIV. Most women and men disclose their HIV-positive status to stable intimate partners over time. Elapsing time after an initial HIV-positive diagnosis allows for a greater likelihood that women would have disclosed their HIV status to their male partners.⁶² It also allows for greater reconciliation with their condition and the ability to make life choices.⁶³ WLHIV's state of health is critical in either promoting or hindering childbearing desires⁶⁴ and marriage intentions in complex ways.

Like culture, tradition and social norms, household formation evolves and transforms through 'lived experience'. This is illustrated in the family-formation profiles of the women living with HIV in our study. Some of the formations may indeed be impacted on by the presence of HIV, where biological mothers and fathers living with HIV died over time, in the pre-antiretroviral extended roll-out period, prior to 2010. This has promoted family structures in which older relatives or sisters or brothers caring for siblings and their children

– although common in the whole of southern Africa – has occurred on an unprecedented scale in the context of widespread HIV prevalence.⁶⁵

Historically, changes have occurred in the conceptions and practices of motherhood. Our findings extend our knowledge of the ‘uncoupling’ of marriage and having children in South African WLHIV. While the focus of this paper is not on fertility intentions of WLHIV per se – as this has been reported on elsewhere; our findings reiterate that some women living with HIV retained a strong desire to have at least one biological child.⁶⁶ Some WLHIV felt urgency either to have children while they remained well or later when they had been on ARVs. The latter may be due to treatment optimism, that ARVs would make them well, as has been reported in other studies.⁶⁷

Balancing conflicting pressures of feeling obligated to have children in marriage with their own concern about the potential negative effects of childbearing on their health appears to diminish the desire to marry in WLHIV. Like other women, WLHIV continued to hold marriage as the ‘ideal’ to strive for, but frequently viewed it as impractical. WLHIV's key reason to eschew marriage was because they wanted to avoid having more children. HIV seems to intensify the desire to realise other life goals, such as prioritising children's education, their own work and economic well-being.⁶⁸ Women in our study strongly highlighted that, due to the possibility of untimely mortality, they rapidly wanted to achieve success through ensuring their children acquire an education, through their own work and by earning money.

HIV has had specific consequences for fluidity in intimate relationships and motherhood in WLHIV. More generally, by the 1970s, women migrated not only to join partners and receive financial support, but to escape rural poverty and patriarchy. Several studies show that black women began to opt out of marriage in the interests of economic empowerment and independence, casting off the constraints of traditionalism.⁶⁹ Our findings underscore that WLHIV may either seek to escape marriage altogether or renegotiate it in a way that suits their life goals. A number of WLHIV in our study were in relationships with HIV-positive partners. This may have resulted from one partner having infected the other. However, our data also indicate that some women living with HIV intentionally pursue relationships or marriage with men living with HIV. Seeking a partner who is also living with HIV has been reported in a number of studies elsewhere.⁷⁰ In our study this emerges particularly in terms of WLHIV's desires and ability to negotiate intimate relationships with men living with HIV. They perceive them to be ‘different’ to other men and more likely to have life goals compatible with their own. This is particularly the case with respect to having children.

WLHIV sometimes found marriage to be very supportive. However, this support was not confined to marriage only. Our findings support other research evidence⁷¹ that some women cohabiting or who had boyfriends receive crucial support from male partners and that men may desire involvement in the caring aspects of parenting. In addition, household members, and particularly mothers, were key sources of financial and social support for WLHIV. Supporting this finding, Seekings⁷² argued that co-residence rather than marriage is important in patterns of support for poor women.

Most study participants were not medically eligible for ARV treatment until the third interview, when their CD4 count fell below 200. They had minimal knowledge of ARV treatment's widespread positive effects. The dramatic expansion of ARV treatment in South Africa since 2010 – covering nearly two million people living with HIV⁷³ – may have led to further changes in WLHIV's attitudes about marriage, life chances and having children since our study was conducted. The medical eligibility criteria for initiating ARV treatment, currently a CD4 count of below 350, may further create changed expectations in life for WLHIV.

At a personal and social level, gender inequality exists both outside and inside formal marriage relations in South Africa.⁷⁴ However, despite constraints, over the past three generations, black South African women have carved out opportunities to create greater fluidity in intimate sexual relations to their own advantage. WLHIV may start out at a potentially double disadvantage. Conventional practices in marriage, which support biological childbearing of a husband's offspring, may be at odds with concerns of WLHIV that childbearing may be detrimental to their health. However, it appears that in the face of this, WLHIV may initiate greater independence in the types of intimate relationships they form and in fertility decision-making. There is some evidence from our data that WLHIV either avoid intimate partner relationships or renegotiate gender norms around marriage and intimate relationships. Some may do so especially if they find they are in an HIV-concordant relationship or they specifically seek out HIV-concordant partners.

This study has a number of limitations. It was conducted among black WLHIV in the urban area of Cape Town. We are therefore unable to draw conclusions about how HIV affects attitudes and patterns of marriage and childbearing among rural WLHIV and other groups of South African WLHIV. As this study was a qualitative one, it was intended to explore a range of views in depth, and the study design does not intend for the results to be generalised.

V Conclusion

Historical, political, social, cultural and economic factors have had significant consequences for fluidity in intimate relationships, marriage and motherhood among black South Africans. These intersect with women's evolving kinship and family responsibilities and their health status in the context of HIV. Our findings underscore the paradoxical nature of living with HIV. WLHIV, in common with other women, balance caring roles, serving as the linchpin in family formation and survival, with their own and others' desires for childbearing, but with the specific challenges of engaging in intimate relationships and having biological children, while living with HIV.

The findings contribute to the existing knowledge base regarding the fluidity of marriage and fertility intentions within the dynamic context of living with HIV. Moreover, our study revealed themes about how WLHIV balance different options in marriage, family formation, caregiving, and other life goals. These are likely to have broader relevance in currently rapidly urbanising and economically developing countries with high HIV prevalence in southern Africa.

Our study findings support those of other studies⁷⁵ that younger women, in this case those living with HIV, increasingly adopt a discourse of economic self-reliance in striving to achieve more equitable gender relations. The lives of these young WLHIV are embedded in history and society. Whether reported changes in some women and men's intimate interpersonal relations, given the generalised HIV epidemic in the country, will translate to deeper and enduring transformation of gender relations will only become clearer over time. Nonetheless, these changes and renegotiations in intimate relations among women and men living with HIV highlight vulnerability in intimate relations, while at the same time provide small windows of opportunity for advancing greater equality in intimate gender relations.

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18. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, 1st interview.
19. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, interview.
20. Phumeza, 24 years, live-in boyfriend, boyfriend HIV positive, one child, 3rd interview.
21. Khetiwé, 27 years, boyfriend – living together, boyfriend HIV positive, one child, 2nd interview.
22. Sibonisile, 28 years, has boyfriend for eight months, boyfriend HIV negative, one child, lives with child, 1st interview.
23. Ntombi, 27 years, living with her boyfriend, boyfriend HIV positive, two children, 1st interview.
24. Zodwa, 31 years, stable relationship at 1st interview, married by 2nd interview, husband HIV negative, one child, lives with her husband and child, 2nd interview.
25. Agnes, 55 years, lives with her children, no current sexual partner, 1st interview.
26. Thembisile, 31 years, lives with husband – unknown HIV status, two children, 2nd interview.
27. Gloria, 37 years, boyfriend for six months, stable relationship but not live-in, boyfriend HIV positive, two children, 1st interview.
28. Bongiwé, 38 years, husband lives in rural area apart from her, boyfriend HIV positive, lives with her and her three children (her husband's), 1st interview.
29. Ntombi, 27 years, boyfriend, living together, boyfriend HIV positive, two children, 2nd interview.
30. Thandeka, 46 years, lives with her sister and her sister's children and her own two children, has boyfriend, stable but not live-in, boyfriend HIV negative, two children, 1st interview.
31. Khetiwé, 27 years, boyfriend – living together, boyfriend HIV positive, one child, 2nd interview.
32. Lungiswa, 34 years, husband, husband HIV positive, lives with husband and children, two children, 1st interview.
33. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, 3rd interview.
34. Xoliswa, 39 years, husband HIV-negative, lives with husband, one child (not her husband's), 3rd interview.
35. Nomphumelelo, 42 years, married, husband's HIV status unknown, lives with husband and extended family member, three children, 1st interview.
36. Patience, 61 years, no current sexual partner, has four children, 1st interview.
37. Nomonde, 27 years, boyfriend (not live-in), boyfriend unknown HIV status, one child, 1st interview.
38. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, 2nd interview.
39. Zandile, 33 years, no current partner, two children, 1st interview.
40. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, 2nd interview.
41. Nomsa, 39 years, partner – cohabiting for 18 years, partner HIV positive, one child, 3rd interview.
42. Phumeza, 24 years, live in boyfriend of 6 months, boyfriend HIV positive, 1 child, 1st interview.
43. Philiswa, 25 years, boyfriend, not live-in, boyfriend HIV positive, no children, 2nd interview.
44. Andiswa, 35 years, currently boyfriend for four years, has not disclosed her HIV status to him, boyfriend of unknown HIV status, one child, 3rd interview.
45. Zodwa, 31 years, stable relationship at 1st interview, married by 2nd interview, husband HIV negative, partner aware she was living with HIV, one child, lives with her husband and child, during 2nd interview.
46. Boniswa, 31 years, at first interview live-in boyfriend, had married him by 2nd interview, now husband, HIV-positive, one child, 3rd interview.
47. Princess, 36 years, employed, lives alone, no current sexual partner, one child, 1st interview.
48. Lungiswa, 34 years, husband, husband HIV positive, lives with husband and children, two children, 1st interview.

49. Boniswa, 31 years, boyfriend at 1st interview, now husband, husband HIV-positive, 3rd interview.
50. Xoliswa, 37 years, lives with husband, husband HIV negative, one child (not her husband's child), 1st interview.
51. Fundiswa, 25 years, boyfriend for three years, stable, but not live-in, partner's HIV status unknown, 1st interview.
52. Boniswa, 31 years, boyfriend at 1st interview, by third interview had married him, partner HIV-positive, 1st interview.
53. Fundiswa, 25 years, lives with her mother and her child, boyfriend of three years, stable but not live-in, boyfriend's HIV status unknown, one child, 1st interview.
54. Zodwa, 31 years, stable relationship at 1st interview, married by 2nd interview, husband HIV negative, one child, lives with her husband and child, 2nd interview.
55. Phumla, 27 years, boyfriend, living together, boyfriend HIV positive, one child, 2nd interview.
56. Ntombi, 27 years, living with boyfriend, boyfriend HIV positive, two children, 1st interview.
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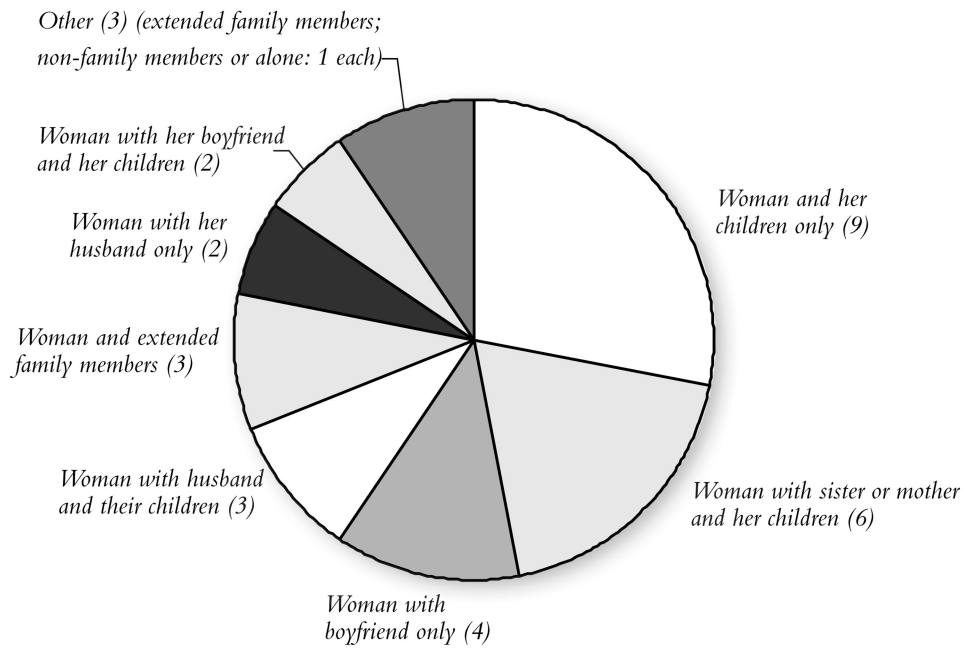


Figure 1. Living arrangements

Table 1
Socio-demographic characteristics of study respondents (N = 30)

Average age (range)	33 years (19–61 years)
Average number of years of education (range)	10.3 years (8–12 years)
Employment status	Employed (9) Unemployed (21)
Type of main sexual partner	Husband (9) Boyfriend (live in or not) (14) Missing (includes those without a main sexual partner) (7)
HIV status of main partner	Living with HIV (11) HIV negative (3) Of unknown HIV status (12) Missing (4)
Average time HIV+ diagnosis	3.0 years (range: 1 month–9 years)
Mean number of children	2.0 (3 women had no children. range: 0–6; Missing = 3)
Mean CD4 at baseline	339 (range 7–858); Missing = 5
Follow-up interview 1	293 (range: 170–547)
Follow-up interview 2	284 (range: 170–547)