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GENDER AND REPRODUCTIVE  
DECISION-MAKING AMONG  
COUPLES WITH HIV/AIDS IN  
BULAWAYO, ZIMBABWE

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# Gender and Reproductive Decision-Making among Couples with HIV/AIDS in Bulawayo, Zimbabwe

## Abstract

*Gender, the culturally constructed social relations between men and women, plays an important role in determining not only the role and place of both sexes in society but also impacts the distribution of power between the sexes. Men, especially in patriarchal settings, have been observed to dominate women economically, politically and even sexually. Thus men generally exercise power over women. This article explores the impact of gender on reproductive and sexual decision-making among couples with HIV/AIDS. It discusses the decision-making process itself and then examines how gender and the exercise of power influence the decisions or choices made by these couples. Based on a sample of HIV-positive couples from Bulawayo (Zimbabwe), an important observation that this paper makes concerns the lack of male dominance in decision-making among these couples. This is explained in terms of high level of HIV/AIDS awareness among the study sample, the high cost of parental investment to women as well as the behavioural change necessitated by an HIV-positive diagnosis.*

## Introduction

Decision-making in whatever context is a complex issue. Among HIV-positive couples in Zimbabwe, it encompasses personal desires, medical, moral, ethical, gender and other socio-cultural issues. Individuals approach decision-making processes from different social, cultural, interpersonal, and historical contexts. As Plous (1993) argues, there is no such thing as context free decision-making. But how does an individual or in this case a couple arrive at a particular decision and how does gender impact this process? The following discussion focuses on decision-making among HIV-positive couples and the impact of gender on this process.

In the patriarchal setting where men arguably dominate social and economic relations, gender relations are expected to play an important role in influencing reproductive behaviours and decisions. Gender in this article was not used to refer specifically to the situation of women but rather to culturally constructed social relations between men and women that have resulted in gender inequalities. As Hawkes and Hart (2000) note, whereas sex refers to biological differences between men and women; gender refers to culturally determined notions of masculinity and femininity which differ from culture to culture. Though a number of studies encompass the influence of gender on reproductive decision-making in Zimbabwe (Grieser *et al.*, 2001; Feldman & Maposhere 2003), little attention has so far been paid to the role of gender power relations in decision-making among couples with HIV/AIDS. In the analysis of how gender influences the decision-making process among those infected with HIV/AIDS, this paper defined the concept of gender-based power relationship as the ability of one partner to act independently, to dominate decision-making, to engage in behaviour against the other partners' wishes, or to control a partner's actions (Pulerwitz, Gortmaker & De Jong, 2000).

This paper proceeds by first describing the decision-making process among HIV-positive couples. It then explores the role of gender in this process by examining the power dynamics between men and women during the decision-making process.

## **Study Sample**

The research that forms the basis of this paper was undertaken as part of my PhD field research. Using the in-depth interview method, fifteen couples were interviewed. Of these only two were sero-discordant. At an individual level the couples were interviewed about their sexual and reproductive lives as well as their fertility intentions both prior and post diagnosis. Of the fifteen couples only two couples and five other individuals expressed an intention to have children. It is notable however that none of these couples or individuals has had a child or pregnancy post diagnosis. Further sample characteristics are presented in Appendix Table 1.

This discussion is based on a small and unique sample of HIV-positive people, only those HIV-positive persons who were couples and who had disclosed their status to each other and were willing to participate in the study, were selected. Thus the sample is not representative of HIV-positive people in Bulawayo let alone in Zimbabwe. UNICEF (2005) estimated that the population of Zimbabwe stood at 12.9 million by the end of 2004. Of these people nearly 800 000 lived in the city of Bulawayo and 24.6% of the total population were living with

HIV/AIDS (UNICEF, 2005). Using these figures it can be estimated that over 150 000 people lived with HIV/AIDS by the end of 2004 in Bulawayo. The atypical nature of the respondents also has to be noted. Due to the nature of the method used to recruit willing participants most respondents display a high level of knowledge and understanding of HIV/AIDS and related issues. Some of the respondents interviewed in this study are involved in HIV/AIDS activism and work, with some being peer counsellors in Opportunistic Infections (OI) clinics. Most are on ARVs and some on the waiting list and most have gone through intensive counselling and education through support groups organised by the OI clinics, NGOs and people living with HIV/AIDS themselves. Thus most of the respondents are exposed to information on HIV/AIDS. Apart from this, those couples/individuals who intend and some who still desire to have children indicated that they searched for information regarding HIV and reproduction from a number of different sources, including the internet. As a result of this proactiveness in seeking information some of the respondents displayed a high level of understanding of issues relating to their condition and reproduction. As such these characteristics probably render the sample quite unrepresentative of the general population of Bulawayo.

## **A description of the decision-making process among HIV-positive couples**

To put the decision-making process of HIV-positive couples into context it is important to briefly look at reproductive decision-making among the general population. HIV-negative couples' decisions to have a child are not usually as involved and intense as is the case among HIV-positive couples studied. As the results from this study and from an earlier study on fertility and child death in Zimbabwe (2000) indicate, in non-infected couples the decision to have a child might or might not be approached rationally or consciously. Among married and unmarried couples many if not most pregnancies "just happen" as it is an expectation that they should happen. The couple may decide to have a child but they do not set about having one deliberately at a specific moment as it seems to be the case among HIV-positive couples. HIV-negative people, it seems, do not go to the same lengths as HIV-positive people in considering the decision to have or not to have a child. In contrast to HIV negative couples (Grieser *et al.* 2001), HIV-positive couples gather information, weigh risks and benefits and discuss whether to have a child or not relatively more intensively.

The lack of meticulous planning and consideration of risks and benefits of having a child seems to be a familiar trend among the HIV-negative couples. Grieser *et al.* (2001) in their analysis of reproductive decision-making in Zimbabwe indicate that;

“...when asked about reasons to have children some of the older respondents had difficulties answering because it seems that they had never before questioned their desire for children. Adult life was taken to be synonymous with child bearing, and many respondents referred to the societal and marital expectations that contribute to the view of child bearing as a duty...”

Among many HIV-negative couples in Zimbabwe, except perhaps the well educated, it seems there is no conscious or rational approach to child bearing that is evident among HIV-positive couples who were studied. Child bearing seems to be an expected result of marriage or partnership. HIV-positive couples usually weigh the potential risks and benefits of child bearing before they make a decision to either have a child or not. Their decision-making process also seems to be more involved in that both couples are seen to be involved in the discussion and they gather and process much more information before making a pregnancy decision.

Unlike HIV-negative couples, those who are HIV-positive are usually in no position to expect pregnancies “just to happen” or to be nonchalant about being pregnant. First, because of their ill health they have to consider the impact that pregnancy may have on their health and plan accordingly. They also have to guard against re-infection and its possible impact on their health hence they have to minimise unprotected sexual encounters. Unprotected sex has to coincide with the fertile period of the woman if pregnancy is the desired result. Thus having a chronic illness introduces a different context in terms of reproductive decision-making among couples with HIV. To them it becomes paramount to make rational and conscious decisions to have or not to have a child at a particular moment as this has implications for their overall health and well being.

Fifteen couples in the study were confronting or had confronted reproductive decision-making since knowing their HIV-positive status. The couples were at different stages of decision-making. While some had decided not to have children now or in the near future, others were still mulling over the idea while others had decided that they will definitely try for a child in the near future. This paper focuses on those couples and individuals who still intend to have children and who have discussed their intentions as a couple. As such the discussion will centre on couples 1, 5, 9, 12 and 14.<sup>1</sup> It will attempt to reconstruct the decision-making process from the time one partner conceived the idea to have a child up to the time they made a choice or decision as a couple. The process of decision-making among HIV-positive couples can be characterised as occurring in a number of stages: from when the idea first enters into consciousness to discussion and decision-making between partners to searching for information

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<sup>1</sup> Henceforth, C1, C5, C9, C12, C14 etc (refer to appendix table 1).

and to weighing the risks and benefits of having children. These stages by no means represent a linear progression of reasoning or action in the process of decision-making. They do not necessarily occur one after the other. Any of the suggested stages may follow after the idea is first conceived and they may occur simultaneously. The attempt here is to describe what goes on from the time the idea of having a child enters one's consciousness to the time a decision is made.

## **Formulating the idea of conceiving a child**

It is not easy to determine exactly when the idea to have a child enters into a person's mind but a number of factors that trigger the idea were identified. These are different from individual to individual or couple to couple but they all seem to stem from the deep seated need to have a child or a child of a certain sex for those who already have a child or children. There are factors that may be said to offer fertile ground on which the seed to have a child is sown. These act as common denominators to all individuals who intend to have a child. They include the availability of HAART and the confidence they have in it, their newly found health and social comparison, i.e., the fact that others who are HIV-positive and in a worse health state than them have negative children. These factors and the need to have a child are the wood with which to make a fire but the spark that sets the fire alight seems to differ from individual to individual or couple to couple.

For C1M the fear of dying without a child after recovering from a serious illness seems to have been the trigger. While this fear is also detectable from C5F, she indicates that the information she received during counselling sessions made her decide to try for a child in the near future. This was her response when asked:

Interviewer: when did you decide that you will have a child?

Respondent: I decided- - when was it? I think 2004 when I used to go to counselling sessions and they'd tell us about it (possibility of having a child), so I thought okay – I'll just have one, just try for one.

She however pointed out that she had always wanted to have her own child and that her improved health as a result of ARVs had played a significant role in motivating her to have a child. She said, “actually (the availability of ARVs) helped. I think that is what made me decide to have a child”. In this instance the availability of information on HAART, MTCT and reproduction through counselling acted as a trigger in the decision-making process. However, for the male partner in C5 the trigger was different. The idea only came into his mind when his partner informed him about her need to have a child. Before she had raised the issue of having a child he had not thought about it and this may be

because he already has a child. Describing how he came to decide to have a child with his partner he said; “A-a-h!, XXX wants a baby and she says she wants my baby you know and she is so beautiful I think I also want a baby with her, I would love to have a child with her...”.

For C12 the triggering factor to try for a child at that particular time in their life was similar and it was the need to eliminate negative family involvement in their relationship. At the time they decided that it was best to try for a child, they were under immense pressure from the woman’s parents to end their relationship. Her parents did not approve of her sexual relationship with a man in her current state of health. She indicates that to them it was a worthless and dangerous endeavour in terms of health for her to have a male partner when she was already sick. Commenting on this she said, for them “...someone with HIV should not have sex. My mother, wherever I meet her, she always says ‘my child, never do it. When you have sex you will die quicker’. They say an HIV-positive person should not have sex because that is believed to worsen the disease. Plus the old people believe that condoms are the ones that cause the disease”. Due to this conceptualisation of HIV by her parents they had arguments and quarrels as they insisted that she ends her relationship. Her relationship with her parents became strained to such an extent that she broke all communication with them and went to stay with her partner against their will.

It was this family resistance to their relationship that triggered the idea of trying for a baby at that particular time. C12F said, “there is a time last year (2004) in December when I missed my period for 3 months, I was happy because I thought I was pregnant because I want a child and I also saw it as a way of stopping my parents from interfering in my relationship because if I was pregnant and with a child they would give up and say let her stay”. C12M also concurs that the family resistance to their relationship triggered the idea of having a child as a way of securing their relationship. So the reasoning behind their attempt to have a child was that if the woman became pregnant her parents will be forced to accept her relationship and as such leave them alone.

Thus although there are common factors in wanting a child what actually triggers the idea at a particular time actually differs from individual to individual or couple to couple. With the idea of having a child having been conceived, how then do couples or individuals proceed in fulfilling their quest?

## **Discussion and decisions between partners**

With the idea having entered their consciousness, the next step taken by most of those who conceived the idea of having a baby was to discuss it with their partners. As indicated earlier, most couples said decisions in their relationships

are made through open discussion and communication with each other. C5F said that having conceived the idea she approached her partner and informed him about her desires. They discussed the issue, considered the obstacles and conditions favouring their desire. Having considered their health, the implications of HAART on reproduction and their financial standing they agreed to have a child in the near future. They however decided to wait until their health and financial situation improved. Commenting on how they came to this decision and what issues they considered C5M said,

“...we have discussed this thing thoroughly and I have said no XXX your CD4 count, her CD4 was 44 by then while mine was 158, and I was saying with your CD4 at 44 now, at least for us to be able to have a child it should be around eight hundred to over a thousand. So we discussed it ...until we are satisfied that our CD4 cell count is alright we will not have a child because we have also enquired, talked to people in the field of medicine, trying to find out what the odds are, now we are quite aware of what we are supposed to do”.

While C5M emphasised their health concerns C5F focussed on the financial aspect. She pointed out that she intends to have a child in the near future but “I am waiting until I am financially stable”.

In their discussions the couples raised a number of key issues some of which are their concern about health, MTCT, the role of ARVs in reproduction, their parenting abilities and the issue of financial resources. Health concern is the main reason that made C1F, C9F and C14F decide not to accede to their partner’s suggestions of having a child. C1F indicates that her partner did express his desire to have a child but she turned him down because of concern about her health. She said, “ya-a; he talked about it but I do not see any way forward for now. You see this other partner will be safe but when I become pregnant my immune system will go down you see”. She also indicates that they discussed the issue of child bearing and made a mutual decision. She said;

“we do not force each other, we discuss and agree...as long as we live together I think we must always try that whatever we do together should be agreed upon...so in most cases we discuss things, we have not had any difficulties so far, I know in life there are difficulties but we have not had any so far”.

Having discussed the issue based on the information that they had they decided as a couple that “...we will live as we are, we will live even without a kid...” (C1M). The male partner however indicated that he still intends to have a child and C1F did indicate that if her health situation changed she may consider having a child. She said, “I have the desire that maybe one child but here is HIV...in the future maybe and I will also be doing it for his sake because he has no child”.

For C9, the male partners' intentions on the childbearing front have also been discussed but the female partner, despite her desire to have a child, has decided not to have one in the near future. Responding to the question of whether they had discussed the issue of having children as a couple she said,

“we were talking about it in this past month, he was saying he now wants a child. I told him that if he was serious we should go for counselling but I know he will not do that”.

She also said,

“...he says he wants to have a child with me but I can see that he is afraid. If he has a child with me he will become infected. So that means the child will have to come outside this relationship. It will have to be from outside this relationship because I also do not want him to say I am the one who infected him”.

The woman does not want to have a child because she does not want to shoulder the burden of blame and a guilty conscience should her currently HIV-negative partner becomes infected.

In the case of C12 the initial decision was to have a child immediately so as to get rid of family interference in their relationship. However having had a false alarm (the woman missed her period for three months and thought she was pregnant) and with the family pressure having subsided over time, the couple decided to delay trying for a child. They still intend to have a child soon, “maybe early next year (2006)”, as indicated by C12F. It seems the consideration of their financial position convinced them to delay trying for a child by a year. C12F indicates that they sat down and discussed their new position and decided to firstly try to be financially stable so that they would be able to care for their child effectively. Narrating how they came to this new decision she said,

“we sat down and I told him that my friend, in the near future I would want a child but for now because of our condition which we know, let us first of all prepare for our child, so that if it happens that my health deteriorates after having the child you would have the resources to hire a maid to help you take care of the child, rather than having a child who will give us financial problems tomorrow.”

Among the couples where both or one partner intends to have a child, it seems the decisions that were made were a result of discussions and consultations. The discussion involved the consideration of factors that the couples regarded as critical in deciding whether to have or not to have a child. These included their readiness to be parents, their financial standing, and the impact of pregnancy on their health as well as the health risks to the child. The evaluation of these factors determined the standpoint of each individual during the negotiating stage. It can also be noted that the decision-making process among HIV-positive

couples is in no way dominated by men. Both sexes play a significant role in determining the path they will take with regard to sexual and conception issues.

## **Searching for information**

Information gathering emerged as a continuous process from the time the respondents first conceived the idea of having a child through the decision-making stage and beyond. Those who intend to have children reported that they sought information about the effects of pregnancy on their health, the effectiveness of ARVs and nevirapine on MTCT and their possible impact on their health as well as that of the child. They also sought information about the possible delivery options. The concern about the possible negative health impact of pregnancy on their health and the concern about the health of the child seem to have been the main factors among those who decided not to accede to their partners' desires to have a child, i.e. C14F, C9F and C1F. On the other hand the need to have a child and the optimism about the effectiveness of HAART and nevirapine seem to have been the main factors among those whose joint decision was to have a child in the near future, i.e. C5 and C12. The couples and individuals who intend to have children indicated that they gathered or searched for information mainly from the print and electronic media, the pamphlets from health and OI clinics, counselling sessions, support groups as well as direct communication with HPs.

C5, C12 and C1M all said they had direct discussion with HPs on the issue of having children. They pointed out that they got worthwhile information from these discussions though most did indicate that the information they got was neither balanced nor unprejudiced. They had to take what they wanted from the information and discard what they did not want. The sample results indicate that men were more proactive in searching for information. This may be because in the cases in point, that is, C1, C9 and C14 the male partners do not have any surviving children while the women already have children except for C14F. Thus men may be motivated by their burning desire to have a child and, by gathering more up-to-date information on HIV and reproduction, they hope to strengthen their stance and bargaining power and in the process try to convince their reluctant and critical partners of the possibility of having HIV-negative children without undue risk to their health or that of the child.

It is important to note that when the reproductive decisions/choices were made they were based on the information available to the couple at that particular time and on their understanding of HIV and reproductive issues at that time. Since the situation in the frontline against HIV is continuously evolving the men may have felt that by continuously searching for more relevant and up-to-date information

and learning more about HIV they may in the future be able to convince their partners to accede to their intentions of having children. It is notable that the women who turned down their partners' proposals to have a child indicated that they may change their minds in future depending on developments in the field of HIV/AIDS treatment. Thus decision-making in this instance is not static but is a process in a state of flux which responds to changing conditions.

## **Risk-benefit analysis**

The process of reproductive decision-making also entails the risk-benefit analysis of having children hence the justification by couples/individuals of why they decided for or against having children. For the two couples (C5 and C12) who decided to have a child in the near future, the benefit of having a child outweighed the risks involved, while for the women who refused to have children, the risks posed by pregnancy far outweighed the joy of having a child. Among the couples who considered the issue of having children, it seems their decision involved the assessment of the following factors: their own psychosocial readiness to have a child, the risk estimation to their health and the risk estimation of MTCT. In the case of C1, C9 and C14 while the men were psychologically ready to try for a child the women were not. They also felt the risk to their health was high and they were not willing to take any chances with the risk of vertical transmission as they were not ready to take care of an HIV-positive child.

The possibility of perinatal transmission of HIV was also a critical concern for the women in determining whether to have or not to have a child. C14F pointed out that she was afraid "to have a positive child" and that she was also concerned about her health. She said "...and I am also concerned about my health you see. It is said that if you give birth your health deteriorates and so on. That is what I do not want. I still want to live". Similar sentiments were expressed by C1F and C9F which points to the fact that they are not yet psychologically ready to have a child unlike C12F and C5F whose outlook on having a child is generally positive. The couple's psychosocial readiness to have a child involved a number of considerations including their satisfaction with the number of children living with them (C12 also decided to have a child because none of their children lived with them), the stability of their health condition and their financial standing. C5 and C12 decided to delay having a child because of the consideration of some of these issues. They wanted to be in a better state of health (C5) as well as being financially stable (C5 and C12) in order to be able to discharge their parenting duties effectively.

Results indicate that in assessing risk, women showed more concern and apprehension than men. Women were more worried about the effects of pregnancy on their health, about MTCT as well as the general health and welfare of the child. Men on the other hand seemed to have a more positive outlook about the possibility of having an HIV-negative child as well as about the impact of pregnancy on the health of their partners. This may be because men were more informed than their partners on the issue of HIV and reproduction as a result of their pro-activeness in searching for information. Their optimism may also stem from their intentions to have children and the fact that they are not the ones who would carry the pregnancy. However, even after considering the possibility of having an HIV-positive child, men seemed to generally have a more positive outlook on the issue of reproduction than did women.

Thus the process of reproductive decision-making can be characterised as involving a number of stages which are not necessarily linear in progression. These include the conception of the idea, searching for information and encounters with HPs, risk-benefit analysis and discussion and decision-making. In making their decisions the couples also evaluated a number of factors some of which are the effects of pregnancy on their health, the impact and effectiveness of ARVs and nevirapine, perinatal transmission of HIV, the health of the child, their parenting abilities as well as the status of their finances.

## **Who is who in Reproductive Decision-making? The politics of gender among HIV-positive couples**

The gender imbalance in favour of men in the socioeconomic-political setup of today's society need not be emphasised since it has been the subject of many studies and debates over the years (Baylies & Bujra, 1995; Wilton, 1997). This dominance of men over women, it has been argued, also extends to reproductive and sexual issues. Men are generally regarded as formidable barriers to women's decision-making about fertility and contraceptive use (Greene 2000). Drennan (1998), Francis-Chizororo (1999) and Caldwell (1987) have characterised the power of men in reproductive issues as overarching. They argue that men determine when and how many children to have. Bassett and Mhloyi (1991), see women in Zimbabwean society as generally having limited control to determine their own lives. This, they argue, partly stems from the patriarchal nature of the society where men are the main decision makers.

The social, cultural, political and economic structure of the Zimbabwean society is such that women are below men in status both in the public and private arena.

Though a number of gender laws have been passed over the years, most women remain economically dependent on men and this has greatly limited their power in relationships. Thus, to a large extent, women's lack of voice in reproductive decision-making, it has been argued, derives from their low status in society, and usually their dependency on men which renders them powerless to firmly assert their views in the relationship (Baylies & Bujra, 1995; Wilton, 1997). Thus it seems "a regime of gender in which women are dependent on men has been profoundly naturalised within and by whichever paradigm is hegemonic in various cultures of the world" (Wilton, 1997).

Studies carried out between 1998 and 2001 in Zimbabwe do indicate that indeed men seem to have a dominant role not only in household issues but also in issues pertaining to reproduction and sexuality (Grieser *et al.*, 2001; Feldman & Maposhere, 2003). In a study carried out in 1998-1999 in Matabeleland, of which I was part, (see, Grieser *et al.* 2001), men and women concurred that men dominated reproductive decisions especially regarding how many children to have. One issue which is usually absent in gender literature, the 'fight back' strategies used by women to counter male dominance in reproductive issues, needs to be highlighted. Women pointed out that they used traditional as well as modern forms of contraception secretly, or they sometimes claimed they were sick or on their monthly period to avoid pregnancy or sex. In the study of HIV-positive couples, women also did point out that they used these strategies and others to further their reproductive desires, if these conflicted with those of the male partner. Thus though men, through their dominant position in the patriarchal Ndebele family setting may be said to have 'power over' women, they do not always have the 'power to' control women's sexuality. As Greene & Biddlecom (2000) point out, men may not prevent women from covertly using or not using contraception. The portrayal of women as victims of patriarchy, powerless and voiceless beings in the area of reproduction fails to take into cognisance the strategies that women have devised to counter male dominance.

Gender power relations within the context of decision-making among HIV-positive couples has not been given much attention in the literature. Studies that look at reproductive decision-making among HIV-positive people focus mainly on women and how they make their pregnancy choices (Thornton *et al.*, 2004; Chen *et al.*, 2001; Kirshenbaum *et al.*, 2004; Mitchell *et al.*, 2004; de Bruyn, 2002). The absence of male voices in this process is intriguing considering that it is claimed they dominate this process. It seems gender relations among infected couples and HIV-positive people in general have been largely ignored or assumed to follow general social trends where men are said to dominate decision-making (Feldman & Maposhere, 2003). What emerged from the study of HIV-positive couples however paints a different picture. Men do not seem to dominate reproductive decision-making in these relationships. HIV-positive

women seem to have a stronger voice and to be more assertive in determining the nature of their sexual and reproductive engagement with their partners. Among all the couples interviewed there was no case where decisions pertaining to reproductive issues post diagnosis can be said to have been dominated by men. In the few occasions where men suggested non condom use, claiming among other reasons that they were not used to it, the women stood their ground and refused sex. This was observed both in married and unmarried couples. In such a scenario, given the ‘dominance of men’ and women’s ‘lack of bedroom power’, one would expect the sexual preferences of the man to prevail.

Among HIV-positive couples women seem to be able to determine the nature of their sexual interaction with their partners. In C3, C13, and C15 (all married couples), it is the women who introduced the use of the condom in their relationships. In instances like C14 and C15, where male partners did try to protest against condom use women stuck to the ‘no condom no sex’ policy. Commenting on this C14F said,

“no, we never did it that way (without a condom). We told ourselves that no condom no sex. So when he wanted to do it without a condom I would refuse. I would tell him that if you do not want go and look for other women outside, it’s your life. I would tell him that it’s his life”.

C15F indicated that she was ready to fight with her husband over the issue of condom use. She said “at the beginning he did not want to but he ended up agreeing because I ended up being harsh with him since I knew what they had said. They had told me at the hospital that when we were having sex we should use condoms. I would tell him that it is better to abstain if you do not want (to use condoms) or else look for others not me”. Given the characterisation of women’s lack of voice in marriage in the literature (Baylies & Bujra, 1995; Wilton, 1997; Grieser *et al.*, 2001; Feldman & Maposhere, 2003) one would not expect such a bold stance from a married woman. However such assertiveness by women seemed to be a trend among HIV-positive couples who were studied. Couples indicated that they consulted each other on reproductive as well as sexual decisions and that they made mutually agreed decisions. The importance of communication was stressed by these couples. Thus contrary to other studies on gender power relations within relationships this study found that there was no evident manifestation of power by men over women. Ampofo (2004) characterises the manifestation of power in a relationship as being evidenced by “the ability to influence decision-making and behaviour according to one’s wishes (advance one’s objective position) even when this may be detrimental to the other partner”. Such kind of dominance was not observed among the study sample. What was observed however was the proactiveness of men in gathering reproductive information and their more positive outlook regarding child bearing compared to women. This however did not translate into dominating the

decision-making process, which points to the complex nature of the decision-making process. The decision-making process among HIV-positive couples revealed that decision-making is not harmonious but a process fraught with conflict as people do not always have similar needs or methods with which to attain those desires. The decisions made by these couples were a result of negotiation, bargaining and compromise seldom dominated by one sex or gender. Thus, although there were differences of opinion and disagreements the couples were able to make mutually inclusive decisions without one dominating the other.

## **The rise of voiceless women**

Important questions that arose from the study are: if the assertion that women lack power to determine their reproductive and sexual lives is assumed to be true why do women all of a sudden seem to have found their voices; what has changed in their relationships that now gives them power to assert their views and stand by them? This paper offers a number of interrelated explanations to account for this.

It can be argued that this is because most of these couples (n=9) are in 'loose' relationships, they are not tied down by the restrictions, and expectations of marriage. They are in much freer unions where they can assert their rights; stand up for their desires and needs and where, if one partner feels they can not accept those terms, they have the freedom to leave. This freedom to opt out of the relationship if one was in disagreement with their terms of 'no condom, no sex' was expressed by C14F who indicated that she told her partner that if he did not want to use a condom then he was free to leave the relationship. However this postulation that women assert themselves strongly because they are in unmarried relationships is countered by the fact that a similar scenario is observed among those who are married. As indicated above, C3F, C13F and C15F initiated condom use in their marriages. When the male partner tried to object in C15, the women insisted on condom use and gave her husband the right to look for other women willing to go without a condom outside the matrimonial home. Faced by such a challenge the man decided that it was better to use a condom than attempt other given options.

With HIV, women seem to gain some power in their relationships. Their concerns in sexual interactions with men seem to gain prominence and they seem to stand up for their needs and desires, not through covert strategies but by directly confronting men and getting their way. Is this because by becoming HIV-positive, men lose some of their masculine power or is it that when HIV-positive they become more inclined to safeguard their health than their claimed

authority and power over women? Does the threat to their life posed by HIV/AIDS make both men and women realise that it is best for them to work in tandem to safeguard their health than play the dangerous game of sustaining social norms detrimental to their health?

This observed reproductive behaviour between men and women may be explained from two perspectives: the socio-biological and the health belief or behavioural change perspectives. From a socio-biology perspective it can be argued that naturally men and women adopt different strategies of reproduction to maximise their fitness and the biological differences between them may thus explain their behavioural differences regarding reproduction. Taking the socio-biological view point it may be argued that women have always been significantly involved in the reproductive process than currently assumed as a result of their greater parental investment in the offspring. Trivers (1972) defined parental investment as any investment by a parent in an individual offspring that increases the offspring's chance of surviving at the cost of the parent's ability to invest in other offspring. Biologically and physically women invest more time and effort in any single offspring and as a result of this high cost of offspring they are limited in how many they can produce (Campbell, 2002; Barash, 1979). The costs of reproduction are greater in women than in men as it is the woman who produces the egg that sustains the zygote before implantation, she carries the pregnancy through and bears its risks and usually she carries the greater burden of caring for the child until it matures. Thus typically each child entails a greater investment of time, effort and energy for the mother than the father.

As a result of their larger parental investment it is understandable that women show more concern about reproduction than men and hence it can be expected that they play a significant role in decisions concerning reproduction. The findings from the research seem to support the socio-biological view that women have more at stake in reproduction than men. Women in this study were assertive and choosy when it came to the issue of whether to have or not to have a child; a behaviour that is biologically expected from the parent who invests more in the offspring. With HIV parental investment and the biological costs of reproduction have significantly increased for HIV-positive women. The process of conception poses more risks to their health as a result of re-infection. There is also the possibility of caring for an HIV-positive and perennially sick child with its attendant stress and financial and physical commitment to a doomed reproductive cause. Thus the more visible voice of women among HIV-positive couples is a reflection of this increased biological cost to women. To minimise these biological costs of reproduction and hence minimise their reproductive loss they had to be more assertive with regard to reproduction. Thus the concern, apprehension and reluctance displayed by most HIV-positive women towards

reproduction has to be understood within the context of their increased parental investment in reproduction as a result of being HIV-positive.

It can also be argued that the assertiveness shown by HIV-positive women in decision-making and their greater concern about reproduction than men is not a determinant of biological or evolutionary mechanisms but a result of their state of health. Their state of health demands that they modify their behaviour if they are to survive. Thus women are more vocal in decision-making because of the need to survive. The health belief model which posits that the likelihood of a person adopting a given health related behaviour is a function of that individuals' perception of a threat to their personal health. This theory of behavioural change offers plausible explanations for the observed behaviour change among HIV-positive couples. According to this theory, individuals are more likely to change a given behaviour if they believe that such behaviour increases their risk for a certain condition and if they believe that this condition will form a serious threat to their health or well being. They are also more likely to make behavioural adjustments if they believe that behavioural change will reduce susceptibility to the condition or its severity and that the perceived benefits of changing behaviour outweigh potential negative effects (Rietmeijer, 2005).

However to make drastic behavioural adjustments the couples had to have a high level of information and awareness of HIV/AIDS. Though the study sample was a mixed bag in terms of education levels, ranging from primary education to tertiary educated respondents, they all displayed a profound understanding of HIV/AIDS. This may be because of their exposure to HIV/AIDS information and education at OI clinics and in their support groups. The lack of dominance by men in decision-making and the presence of women's voices in the process of decision-making may also be a result of the information and education given to HIV-positive people which promotes unity of purpose among partners.

The reproductive and sexual advice and information that HIV-positive people are given at OI clinic's, and in their support groups seem to invoke a reaction described by the health belief model. When their health and life is threatened, people react by taking all the possible necessary steps to safeguard it. In the study, HIV-positive people pointed out that HPs stressed the point of safer sex and avoidance and most of the HPs concurred with this assessment. It was stressed that the condom had to be used anywhere, anytime and every time that HIV-positive people had sex and as C14F quipped, 'the condom now rules the house'. No couple in the study indicated that they did not use the condom. Most (n=13) indicated that they used the condom all of the time. All couples used the condom primarily for the prevention of re-infection which, they were informed

by the HPs, may be detrimental to their recovery process and future health and some also used it as a contraceptive.

Thus it can be argued that HIV-positive people were more willing to discard their social constructed negative views about condoms as a tool for prostitutes and promiscuous people (Feldman & Maposhere, 2003; Usdin, 2003) and to embrace it because its non use would increase their risk of getting a higher viral load, different strains of the virus and ultimately developing drug resistant strains. This could impact negatively on their health ultimately leading to a quicker descent into AIDS and death. The conviction that adherence to safer sex would enable them to live longer convinced many couples to accept condom use even in marriage. Women were forced to assert their demands in sexual encounters with their partners, sometimes forcefully (C15), because they felt their life was at stake not only through re-infection but also through the risks of pregnancy. Addressing this felt threat to her life by becoming pregnant C14F said; “Ah! me risking my own life? It’s me and the child who are going to die and he will remain alive. He will be able to look for another woman but I will be dead...and me, I still want to live. Ha-a! to be alive, I really still want to live”.

It is not surprising therefore that people who still have such a passion for life will not tolerate risky behaviour that can endanger their health and cut short their life. It seems women’s voices become more prominent among HIV-positive couples because they feel it is their life that will be being threatened if their sexual partners fail to understand their concerns, be they sexual or reproductive oriented. It may also be postulated that threatened by certain death through AIDS, men also feel obliged to discard certain norms and beliefs that go with masculinity and manhood in favour of behaviour and practices that will safeguard their health and life. Thus the benefit of changing behaviour by both sexes in the light of a life threatening disease has been seen to outweigh potential negative effects of a premature death. It will seem that with the threat of death women have decided to be more vocal on issues of reproduction and sexuality while men seem to also have recognised the lack of wisdom of sticking to ‘traditions’ while sacrificing their health and lives.

## **Concluding remarks**

The health belief model, the high costs of parental investment in the age of HIV/AIDS and the high level of awareness shown by HIV-positive couples all seem to explain the absence of male dominance on reproductive and sexual decision-making among these couples. There seems to be a levelling of the playing field maybe because both partners are aware of their life debilitating condition and are concerned with safeguarding each other’s health. Thus being

HIV-positive seems to have played a 'positive role' in balancing the gender power scale among HIV-positive couples. However a broader study is needed to examine this issue in more detail since this study was based on a small urban sample which is not representative of the HIV-positive population in Bulawayo.

Appendix Table 1 – Main Characteristics of the HIV-positive sample

		Age	Relationship status	Level of education (years in educ)	No. of children	No. of pregnancies	Children in current relationship	HIV status: Year known	On ARVs?	Desires to have children	Intends to have children	employment
C1	F	36	Single; in a relationship	Secondary (11 yrs)	1	1	0	HIV-positive: May 2004	Yes: Nov.2004	yes	no	Unemployed
	M	33	Single; in a relationship	Secondary (11 yrs)	0	NA	0	HIV-positive Dec. 2004	Yes: Feb.2005	yes	yes	Self employed
C2	F	42	married	tertiary	1	2	0	HIV-positive 1986	Yes	no	no	Peer counsellor
	M	45	married	Secondary (9 yrs)	4	NA	0	HIV-negative	NA	no	no	Musician
C3	F	42	married	Primary (7 yrs)	3	3	2	HIV-positive 2004	no	no	no	Unemployed
	M	43	married	Secondary (11 yrs)	2	NA	2	HIV-positive: 2002	No	No	no	Pensioner
C4	F	39	Widowed; in a relationship	Secondary (11 yrs)	3	3	0	HIV-positive Aug.2004	no	yes	yes	Unemployed
	M	40	Widowed; in a relationship	Secondary (11 yrs)	3	NA	0	HIV-positive Sept.2004	No	no	no	Self employed
C5	F	26	Single; in a relationship	tertiary (did not complete degree studies)	0	1	0	HIV-positive 2003	yes	yes	Yes	Unemployed
	M	36	married	Secondary (11 yrs)	1	NA	0	HIV-positive 1996	yes	yes	yes	Self employed
C6	F	43	Widowed; in a relationship	Primary (7 yrs)	4		0	HIV-positive Mar. 2001	Yes Aug.2004	no	No	Self employed
	M	38	Widowed; in a relationship	Secondary (11 yrs)	3	NA	0	HIV-positive 2001	yes	no	no	Security guard
C7	F	36	Widowed; in a relationship	Secondary (11 yrs)	2	-	0	HIV-positive 2003	no	yes	no	Unemployed
	M	42	Widowed; in a relationship	Secondary (9 yrs)	3	NA	0	HIV-positive 2001	yes	yes	no	Security guard
C8	F	30	married	Secondary (11 yrs)	4	4	4	HIV-positive 2002	Yes 2004	no	No	Unemployed
	M	36	married	Secondary (11 yrs)	4	NA	4	HIV-positive 2003	yes	no	no	Self employed
C9	F	28	Single; in a relationship	Secondary (10 yrs)	1	1	0	HIV-positive 2000	yes	yes	no	Unemployed
	M	30	Single; in a relationship	Secondary (11 yrs)	0	NA	0	HIV-negative	NA	yes	yes	Factory worker

<b>C10</b>	<b>F</b>	43	married	Primary (7 yrs)	4	4	4	HIV-positive 2001	yes	no	no	Community worker
	<b>M</b>	48	married	Primary (7 yrs)	4	NA	4	HIV-positive 2005	no	no	no	Tailor
<b>C11</b>	<b>F</b>	32	Widowed; in a relationship	Secondary (11 yrs)	3	5	0	HIV-positive 1999	Yes 2004	yes	no	Self employed
	<b>M</b>	39	Widowed; in a relationship	Secondary (9 yrs)	4	NA	0	HIV-positive Aug.2004	Yes Nov.2004	yes	no	Self employed
<b>C12</b>	<b>F</b>	36	Single; in a relationship	Secondary (11 yrs)	1	1	0	HIV-positive Dec2002	Yes Apr.2004	yes	yes	Peer counsellor
	<b>M</b>	38	divorced; in a relationship	Secondary (11 yrs)	3	NA	0	HIV-positive 2003	Yes May2004	yes	yes	Security guard, part time peer counsellor
<b>C13</b>	<b>F</b>	34	married	Primary (7 yrs)	3	-	2	HIV-positive Jan.2004	yes	yes	No	unemployed
	<b>M</b>	30	married	Secondary (11 yrs)	2	NA	2	HIV-positive Oct.2003	Yes Jul.2004	yes	no	Security guard
<b>C14</b>	<b>F</b>	24	Single; in a relationship	Secondary (11 yrs)	0	0	0	HIV-positive Jan.2004	no	yes	No	Self employed
	<b>M</b>	29	Single; in a relationship	Secondary (11 yrs)	0	NA	0	HIV-positive Dec.2003	no	yes	Yes	unemployed
<b>C15</b>	<b>F</b>	35	married	Primary (7 yrs)	1	2	0	HIV-positive Feb.2005	no	yes	no	Self employed
	<b>M</b>	30	married	Secondary (9 yrs)	1	NA	0	HIV-positive Mar.2005	no	yes	no	Self employed

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