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HIV Prevention, Infertility and Concordance in Partner Selection among Couples Living with HIV and AIDS in Rural and Peri-Urban Contexts in Botswana

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Abstract

This paper examines marital partner selection and the significance of fertility status among couples living with HIV using qualitative research methods. This study was conducted in the Maun and Gaborone areas in Botswana in southern Africa where patrilineal marriage traditions are normative and both civil as well as traditional marriage practices remain prevalent. Data were collected from 32 respondents using in-depth interviews after new civil marriages and where HIV status was positive for both partners. Results from the research demonstrate that HIV status is socially significant in the decisions that the couples living with HIV make in terms of selecting marriage partners. Yet once new marital relationships are established based on concordant HIV status, the cultural importance of fertility and child-bearing remains paramount and rates of unprotected sex remain high. HIV positive and concordant couples engaged in unprotected sex in order to reinforce positive social status through reproductive success even when knowledge about mother to child transmission and increased viral loads in their own bodies was evident. This paper demonstrates the value of understanding cultural norms that surround fertility desires and fears of infertility in crafting efficacious HIV prevention programmes. HIV concordant couples still seek fertility success with partners in a context where HIV infection rates have remained high and this paper contributes to literature on both partner selection with respect to HIV status as well as the value of qualitative investigation to elucidate cultural challenges to HIV prevention. The paper concludes with further recommendations for understanding of the often overlooked cultural significance of infertility in areas with high HIV infection in order to better inform policies in the formulation of evidence based prevention strategies in Botswana with respect to people living with HIV and AIDS.

Keywords: HIV and AIDS; Botswana; Marriage; Concordance; Infertility

Introduction

Infertility can affect anywhere between 8 - 12% of a population worldwide. In cross-cultural contexts and in the African continent, these estimates can vary widely although evidence suggests a notable central and southern African infertility belt stretching from Namibia to Mozambique. Mogobe [1] notes that health seeking behaviours that are related to fertility can account for as much as one third of all medical care worldwide and that reproductive failures are distributed equally in men and women [2]. While infertility is socially significant in many cross-cultural contexts such as Botswana, it remains less visible in the face of the HIV and AIDS epidemic and hardly considered in the literature on partner selection in those contexts. In this southern African nation, there is some evidence to suggest that patients do voice concerns over fertility and positive status but there remains a dearth of information on how those fears or decisions are ameliorated.

In Botswana, the HIV and AIDS epidemic has changed the reproductive landscape of the country. For the past two decades, the epidemic has had a tremendous impact; overall incidence remains greatest for women and youth ages 15-29 and while both incidence and prevalence vary according to rural versus urban contexts, the overall incidence rate in the country is just under 18%. As a result of an aggressive and subsidized ARV (anti-retroviral program) in the country, HIV and AIDS are arguably more chronic than acute conditions at this point [3]. The cultural perception of health [4], actual increases in longevity and participation in unsafe sexual practices as a result of ARV therapy [5-7]; including multiple concurrent partnerships, unprotected sex in order to facilitate pregnancy and negate infertility, all contribute to any further reduction in incidence or prevalence rates in Botswana.

While a stereotype persists that African fertility is “naturally” high, making the study of infertility irrelevant or unimportant, it is clear that potential fertility remains a culturally and socially significant factor in seeking a marital partner in this part of southern Africa. Literature on partner-seeking behaviours rarely focuses on cultural factors such as fecundity and potential parenting [8,9] nor does it necessarily include an investigation of how stigma and social identity intersect with respect to these issues.

The focus of this research was to gather ethnographically grounded data on perceptions of infertility and health in Botswana and how those perceptions play an important role in long-term partner selection. The study was conducted in both rural and peri-urban settings in order to compare the experiences and narratives of HIV positive individuals with respect to their fertility desires and concerns over concordant (or non-concordant) marital partners in two settings with differing access to health clinics and reproductive care. This study illustrates the significance of cultural factors such as infertility-related stigma and suggests reasons why HIV positive persons may still engage in high risk behaviours while on ARV treatment and with high levels of knowledge

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about the disease. This article suggests that the study of infertility can help provide better explanation for social behaviours of people living with HIV and AIDS (PLWHA) who are in concordant marriages in Botswana and to better understand the sexual lives of PLWHA more generally in global contexts.

Social Context

It is well documented that among the sub-Saharan and southern African countries, Botswana has the highest HIV/AIDS incidence and prevalence rates, with prevalence overall estimated at 17.6 per cent [2,10]. These rates are highest among those living in urban and more developed areas of the country and among those with the greatest access to health care resources, higher standards of living and more economic resources in general. The latest data show that HIV prevalence rates for both sexes were highest among the 40-44 age group (an increase of five years overall since the last BAIS survey) at 40.6 per cent. Women in general have a higher HIV prevalence rate across the board than men (the exception is among those between 50-64 who are slightly lower than their male counterparts, 22.9 and 21.7 per cent) [10].

In the past decade, the government of Botswana and numerous NGO's, co-ordinated through the National AIDS Coordinating Agency (NACA) has addressed the increasing AIDS epidemic. Educational and informational media have blanketed the country with radio and television programmes and messages about safe sex, use of condoms, abstinence, the need to protect oneself against vulnerability in multiple concurrent partnerships, voluntary adult male circumcision as a preventative measure against the spread of HIV for men and even a reconsideration of the ABCs and prior prevention strategies [11,12]. Increasingly to a focus on partner selection in conjunction with discussion over sexual networks has become a necessary part of HIV prevention strategies.

Customary marriages are common types of marriage in the rural areas of Botswana. The actual marriage union involves the familial social networks of individuals and the exchange of *lobola* or bride price/dowry, a process that can take many years [13]. While a traditionally patrilineal kinship system, challenges to marriage laws [14] and shifts in practices as a result of HIV and AIDS, unemployment rates, out-migration by men, education and intersections with religion have meant that attention to gender and marital patterns have changed. Common law marriage has increased in more urban settings but all marital partnerships have been subject to socio-cultural factors such as the fear and stigma associated with people living with HIV and AIDS.

Since 2002, the Botswana government has been proactive and implemented an effective anti-retroviral (ARV) policy that provides access for all infected individuals with a CD4 count of less than 200. Many businesses will support ARV treatment for employees as well as one dependent spouse. This policy has had wide reaching effects, most notably a decrease in attention to the role of care-givers in communities (primarily rural communities) and an increase in observations that the population is once again "healthier" and with a great quality of life and longevity. ARV's have been so successful in fact that the availability of such therapy has influenced the need to voluntarily disclose one's HIV status and has mediated stigma of being HIV positive [15]. ARVs do also have the effect of "restoring" health, increasing caloric intake and essentially bringing individuals back to a healthy or even greater weight and potentially changing beliefs about what is "safe" sex [16,17]. In Botswana too it is important to note that there are several different serotypes of HIV in circulation and this may have an impact upon ARV efficacy and drug resistance in the future [18,19]. While this study was not designed to closely examine those in Botswana who are HIV concordant but serotypically discordant, it will be important to continue this research and delve more deeply into those complexities. In addition, study participants did not always know or acknowledge these differences and this information would be extremely relevant as part of future qualitative research in similar contexts.

One of the greatest impediments to successful HIV and AIDS prevention programmes has been the lack of attention paid to gender complexities and partner selection with respect to HIV and AIDS and fertility desires in Tswana culture. As Phaladze and Tlou [20] have recently suggested, a focus on male involvement in HIV and AIDS prevention has been gradually increased yet for a variety of social and biological reasons, women remain at greater risk of infection. They have less accessibility to resources and are situated within a context of tensions between traditional and more modern gender roles and expectations [20]. Throughout much of the country, individuals have begun to discuss the potential impact of some of these approaches to the pandemic and in particular, the focus on partner selection as a significant contributor to the ongoing epidemic.

As Phaladze and Tlou suggest [20], the primary aim of the government and NGO approaches to stemming the spread of HIV and assessing outcomes of awareness has been to "empower men and women in all aspects of HIV and AIDS prevention and care" (p. 24). In this article however, I suggest that there are several cultural factors that influence the extent to which prevention and care of HIV and AIDS is accessible or even desirable among men and women in Botswana such as marriage, whether customary or civil and in rural as well as urban contexts and that these center on the significance of fertility imperatives [21]. While awareness of HIV and AIDS and prevention programmes is high in Botswana, AIDS "fatigue" is simultaneously high [22] given the longevity of the epidemic. The advent of ARVs has meant that many people can live longer, healthier lives and simultaneously fulfill cultural imperatives related to childbearing that may have been inaccessible in early years of the epidemic. Stigma associated with HIV status is ameliorated through knowledge of sero-concordance and drives increased testing and potentially lessened stigma to PLWHA.

Methodology

A qualitative approach was utilized in order to complement existing demographic and more quantitative information about Botswana. While research on HIV and AIDS and concordance is relatively abundant in this region, there is a dearth of qualitative and research driven evidence about infertility and issues that surround partner selection such as HIV and concordance. In addition, this research is driven by inquiry into potentially sensitive topics and qualitative methods, such as in-depth interviews and participant observation.

Study setting

The respondents in the study were recruited through snowball sampling methods. The author has worked extensively in Maun and Gaborone, Botswana on issues of infertility and the socio-cultural and physiological connections between fertility and HIV and AIDS. Many research participants volunteered independently upon hearing about the research project. In addition respondents were recruited from two clinics, one in the village of Maun in the northern part of the country with a population of approximately 49,945 (from worldpopulationreview.com) and one in the capital city of Gaborone in the southern part with a reported population of 208, 411. These clinics were chosen because the northern clinic received patients from remote

areas throughout Ngamiland where people live removed from larger communities or access to public health. By comparison, the southern clinic catered to more urban and educated patients. As with all clinics in Botswana at present, both offer government sponsored ARV therapy to all BaTswana (citizens of Botswana) free of charge.

Data Collection

Respondents were recruited after permission to conduct research in Botswana was granted and following ethical Institutional Review Board examination in the U.S. and Botswana as part of a larger research project on the outcomes of HIV and AIDS and shifts in community life, migration and economic stability as a result of the epidemic. Twenty-five couples living with HIV were recruited in the study using a combination of both purposive recruitment (via snowball sampling) as well as participants who had volunteered for the study after hearing about the project. Participants were included who could provide information on decisions about reproductive decision-making, fertility status, HIV status. Inclusion criteria for study participants were: currently married (either customary or common), HIV positive (concordant), had shared information on HIV status and fertility status with current marital partner, were from villages and communities that utilized clinics in the Maun and Gaborone areas. Ultimately a total of 32 respondents who were in HIV positive and concordant marriages were included in the analysis. Participants were between 18 and 49 years of age.

Data were collected between January and May of 2010. Immersion, previous and ongoing research experience of the researcher facilitated contacts within the two communities. Experience working in the local language (*SeTswana*) and with interpreters allowed the researcher to develop a more in depth analysis drawing upon holistic participant-observation and ethnographically rich data collection via interviews. All interviews were between 45 minutes and 3 hours in length and were transcribed verbatim. In order to promote confidentiality in interviews privacy was maintained as interviews were conducted one on one in areas around clinics, in homes and in places outside where participants felt comfortable.

Data Analysis

Standard ethnographic and qualitative methodology was utilized in the analysis of these data. General principles and best practices as outlined by Patton were followed [23]. All interviews were transcribed and then read through completely in order to get a holistic sense of any immediate themes. The texts with respect to marriage and infertility were extracted and formed the basis for more in depth analysis and coding. Preliminary codes were discussed between the researcher and field assistants who coded the transcripts independently. A codebook with meaningful codes, descriptions and usage was created. The four most significant codes that emerged based upon these transcript data and supported through participant observation and ethnographic fieldnotes were; reasons for partner selection, infertility fears, risk perception of marriage, kin/community responses to marital and fertility outcomes. All the data were transcribed and then typed and MAXQDA (a product of VERBI GmbH software company, maxqda.com) software was used to organize the data.

Results

Characteristics of research respondents

All of the respondents in this study reported that they were in a long-term relationship – either married or in the process of becoming married in civil ceremonies. All respondents identified as Christian (the predominant religion in the country and a significant source of information on sexual decision making and HIV education in the past several years). All were between the ages of 18 and 49. At least seven individuals had been married previously and 14 had children prior to their current relationship. Six participants had no education beyond primary school, eight had some secondary school education and at least twelve had completed or begun tertiary education at the national university or accredited teacher's colleges in the country.

Not all who have children prior to their current relationship were married to the previous partner although some relationships did end in divorce. The high rate of HIV and death due to TB, pneumonia and associated illness account (at least anecdotally from interview data) for the dissolution of earlier partnerships. In addition, it is culturally not uncommon for individuals to have children early during childbearing years but not necessarily to end up marrying those particular sexual partners.

Partner selection

The intent of this paper is to highlight some of the reasons and responses given to marital partner selection in Botswana given the context of HIV, knowledge of HIV status and the significance of cultural and gender norms that place reproductive status above all. A key component in the data was the responses from familial and community members to marital partner selection in the context of HIV and AIDS awareness. In the sections that follow these particular issues are explored in more depth and illustrated with the use of qualitative, ethnographic narratives that are representative of the significant themes that emerged in the data.

Reasons and motivation for partner selection

People living with HIV and AIDS (PLWHA) in Botswana often expressed the desire for marriage even given the risks associated with lack of concordance, stigma and fears of reproductive outcomes. For those who were concordant, the idea that their partners would "understand" or be able to "know the experience" of HIV positive status was of paramount importance. This may be particularly important to women living in more rural areas. As several women pointed out:

"I was very alone when I was first tested, my husband was working in the south [in one of the mines in South Africa] which was not unusual for our village, many men traveled far for work. The problem has been that they get a girlfriend or what my parents would call a 'little wife' or a woman who would live in the 'little house', when he was away it was as if I was not his wife, he had many girlfriends or little wives. So when I tested HIV positive I was sure that it was because of this and it created a strain. He became very ill but his family thought I was to blame. I was fortunate that my family, those who know me in this village could tell them it was not me, but it was my husband who made us both sick. We took this before the *kgotla* [customary court] and I was able to be divorced. My husband now knows of my status and is also the same but neither of us is to blame, we support each other, we do not blame each other." ~married HIV positive woman in a rural area

Another echoed this story with the following:

"I think we will live together much longer and healthier...we know what it is like to be sick and we are both now taking ARV pills, we can remind each other to take the pills and there is no hiding. We both have children but we also are not afraid if we 'share blankets' and there

is another child, we know what we can do to keep that child healthy." ~married mother of two in urban area

Others commented that stigma associated with HIV positive status did remain a significant part of the partner selection process and commented that:

"I did not have a child and people in my home village had been talking about that, it was very strange to them that I did not have a child yet and I went off to the city, I wanted to finish my education. Many girls, they will tell you that they had a child and will leave it with their parents, with their mother or grandmother, but I didn't want that. I kept myself safe but when I was at school, at university I slept with a boy and later found out that he had given me an infection. It was not HIV, not then, not with him, but I remember thinking about the shame and the talk that would happen if my family found out that this had happened." ~ married woman in rural area

Another woman talked about how having a concordant partner helped ameliorate potential stigma:

"We talked a lot about HIV at school, growing up and especially at university but to tell you the truth, it was not until later, when my husband and I both found out that we were HIV positive that it was something I could really discuss. It is better to marry someone who you can have a child with and then also who has the same status, you are not worrying so much then about what people will say. I was very careful and very serious about getting married and having a child so the reactions to us having HIV and being together was not as difficult. For some people, people will say they hate them and they stay away from them if they are HIV positive, but my husband and I both knew our status and talked about it from when we were together early on. These days it is not like the old days, today you know many people, you see them on ARVs and you know they have this disease but they will also live to be very old." ~ married woman in urban area

Infertility and Stigma

The most significant form of stigma, even for those living with HIV, remained the potential stigma associated with the lack of childbearing. For both male and female respondents in this study, it was clear that the cultural importance of fertility both hindered and helped the negotiation of the stigma associated with HIV positive status. Specifically, as one man put it,

"It is well known that people who are HIV positive should be careful, use condoms, take pills and not play around, spreading the disease. But if you listen too much to those messages, you will not get married, you would not be able to be happy, to have children. You have to find someone who is able to be with you, maybe you are both taking pills and you can support each other, but what is most important is to have a child, maybe before you meet that person, but it is better if you can have one together and you will know how to answer any questions. I would rather be with a woman who was HIV positive and we could talk about that and talk about having children then worrying that I was going to pass along an infection. People are educated about HIV, it is better to be with someone who knows that life and who is aware." ~ married man in rural area

Awareness and education were themes that were evident in all narratives but it was clear that individuals thought regularly about HIV awareness and how that affected fertility outcomes. As another woman suggested,

"Everyone is aware of HIV and AIDS, when we were small children, this was part of schooling and now you see it everywhere, billboards, part of any campaign, even football adverts have some kind of HIV awareness message. But it is fine, we are aware and educated and that is much better for everyone...people used to just have sex and not think about the health outcomes, they were more interested in having a child, now people understand that they can have a child and still be healthy. Even if you are with someone who is HIV positive and you are not that might be possible, but more often you see HIV positive people together and nobody is worried about the children they have, at least not in the same ways that we used to. People are cautious but you do not hear people saying it is about discouraging sex anymore, it is about being safe with sex and having children." ~married woman in urban area

Another man, a teacher and HIV educator noted,

"For most people, they have HIV knowledge, but it is still important, even here in the city, to say you have children. Maybe you wait a while and maybe you find a wife or a husband who is like you and positive, but it is still important [to have children] that is what our families would have told us years ago, before HIV and even today, now that we have lived with it in this country for so long it is still the same message." ~ married man in urban area

Responses to Partner Selection

Given the traditional role in selecting partners for kin and the cultural significance of childbearing, it was perhaps surprising to see that a shift in kin involvement has occurred with the advent of more public awareness and acknowledgement of individual HIV status. Some interviewees were not surprised at the lessened kin involvement in the selection of their marital partner but did note that community perceptions still played a role in individual choices. As this unmarried man living in Gaborone suggested:

"It is very difficult to know if you are making the right choice. I had a long time girlfriend, we were to be married soon and she passed [away] before we could be married. We both knew our status [as HIV positive] and it was fine because we were always open and talked with each other about it, we did not ask our families the way that our grandparents did or what is traditional for the Tswana people. We made this choice on our own but when she died, many members of my family came to talk to me, to tell me how they feared for me. They wanted to see me happy but they were also worried that this would hurt my future and they wanted to be involved. Many wanted to be involved before and now they could tell me that I should have listened to them." ~unmarried man in urban area

Similarly a woman from the same peri-urban area talked about how her parents and family were supportive but would have preferred her to be single instead of "risking" additional sickness. Her response and many others illustrate how the advent of widely available and effective drug therapies has shifted the notion of risk itself.

"I think for my parents they just wanted to be sure that the HIV was controlled...when they were growing up it was early in the epidemic, not so many drugs were available and it was a death sentence...my father used to say he could point out people at the university who were sick, you could count them, the people with slimming disease. But now as I try to tell them, it is different and it is not difficult for people who are both HIV positive to get tested, to get treated, to have children, my husband and I are together and the drugs are working, we both feel good and it is difficult now for my parents and those in my home village to say that we should not have been married. In some ways we are keeping the HIV for ourselves, we are faithful and we are not spreading any sickness." ~married woman from urban area

Perceived Risks of Partner Selection

The risks that participants discussed when it came to partner selection and HIV status and concordance largely focused on the acknowledgement that viral load and positive status would likely increase. HIV and AIDS education has been ubiquitous throughout Botswana over the past several decades and Tswana are well aware of HIV transmission via the radio, billboards and aggressive national and internationally sponsored campaigns across the country. Most participants talked about the need to utilize condoms but all discussed at some point the conflict posed if they did not fulfill or conform to socio-cultural norms regarding fertility. Many men too discussed the risk of being perceived of as "playing around" or having additional extra-marital relationships if he utilized or had a condom. For many women, asking their partner to utilize a condom could be perceived as a lack of trust. For all participants the risks of selecting a partner who was HIV positive were relevant topics of discussion.

"I know that there are dangers of HIV and my status but this is the last partner for me...I do not think that we will be apart from each other, we are committed and we have children already so we are trying to be careful, to be safe. It is difficult to know what God's plan might be for us....before, with my daughter's father, he had lots of girlfriends and I knew that but if I asked him to wear a condom as I was told, he would be very upset, he accused me of not trusting him. Now, I see my husband and I think that even though we are sick, we are happy and we are the same. With the pills (ARVs) today, it is not even a problem." ~ married woman from a rural area

Indeed for many in the study, the awareness of HIV and of one's status has been greatly ameliorated by the advent of ARVs (anti-retroviral drug therapies) in Botswana and many reflected on how their availability changed the stigma and perceived risks of infection.

"I know it is a not a cure, we are told this all of the time, but the government provides the drugs, we know they work and people are getting better...you do not see the slimming, the people who are dying just because they have positive status. Today you see people and you would never know, there is no gossip about them, nobody knows their status except maybe their families and sex partners, the risks of marrying someone with HIV?....they are not there as they were when we were growing up, today you can live and be healthy with HIV, it doesn't mean that nobody will marry you." ~ married man living in an urban area and volunteer at an HIV counseling clinic

Another woman, a small business owner who had recently moved from the more urban context to the more rural voiced sentiments that several study participants had when it came to thinking about the future implications of childbearing and HIV status and said,

"Do I want to have more children now that I know my status and have the pills?...my husband, he does, he wants to have more kids and my family does, they want us to be happy but they also know that times are different now, more children are left behind as a result of the epidemic, too many of their parents were late [had died] and so who knows what will happen if the drugs stop working, we do not want our children to be left alone."

Such statements reflect both a more traditional or cultural imperative and aspiration to have children but simultaneously the recognition that PLWHA are in a precarious position and are unsure as to whether continued or increased childbearing is a desired outcome. This study population is small and did not include questions about these changes specifically but based upon the above, it is clear that while the stereotype of high African sexuality has been ubiquitous in literature and the minds of many in public health, it will be important to examine whether PLWHA choose to have more children, fewer children or whether there has been any significant change in total fertility rates as a result of HIV status and concordance in future studies.

Discussion

Ethnographic evidence from this study suggests that not only are PLWHA living well with HIV in their communities, whether rural or peri-urban, they are marrying and the importance of having children remains paramount. Even in a context with high, accepted and long-term HIV and AIDS education and prevention programming, this study suggests that cultural values and mores must be taken into consideration when designing the most efficacious and potentially stigma-free testing and treatment plans.

The study indicates that despite potential regional differences (peri-urban versus rural) two important conclusions can be drawn from these data. One is that cultural imperatives with respect to childbearing, fertility and fecundity remain important aspects in the creation of Tswana identity. Previous studies have suggested that despite migration, burdens associated with caregiving, educational attainment and in the context of the HIV and AIDS epidemic, stigma associated with sterility and the lack of children can far outweigh the risks associated with HIV infection. Positive status does not automatically confer negative stigma and respondents in this study often observed that simply having HIV did not mean that one stopped living. Secondly however, with the advent of HIV and AIDS and the nationally supported program of ARV therapy in Botswana, strategies that HIV positive individuals utilize to find a marital partner are novel and individually driven in ways that differ from more culturally embedded traditions. Specifically, as numerous respondents pointed out, it is still far "more important to have a child so that you can get married, even if that person knows you are HIV positive because you tell them, today you still worry more about the person without a child than the person with HIV." Using the lens of reproductive status, it is easy to see that sero-condordance has shifted the patterns of marriage and childbearing to a slight degree, allowing individuals more autonomy and reducing stigma of HIV positive partners. In addition however, it is perhaps also clear that some of the same health risks remain in an era where despite high levels of awareness and education, HIV and AIDS incidence and prevalence rates remains high and fertility desires persist [24].

As some have argued [25,26], for those on ARVs and PLWHA in general, finding a marital partner with the same HIV status is the best strategy for social, familial and community status amelioration. Clinics and social networks through which PLWHA are connected have become the means through which marriage and reproductive status can be attained. Historically, marriage partners and childbearing might have been more regulated by kin or community members, particularly in more rural settings. As this study demonstrates however, whether rural or urban, both men and women who are living with HIV positive status, seek and feel most comfortable and accepted with other PLWHA. In addition to the positive status conferred, the lowered stigma and acceptance that individuals reported, it was also clear that the role of condoms remained a central point of debate. In early decades, at the advent of the HIV and AIDS epidemic, the ABCs were a common trope (Abstain, Be faithful and Condomise) and an oft-cited strategy for reducing risk and exposure to HIV. As this study suggests however, it may be that the use of condoms remains a sticking point in contemporary HIV and AIDS prevention programming [11]. Condom use is still seen as problematic in intimate relationships [27], even and

perhaps particularly seen as ineffectual in HIV concordant couples. As Gombachika et. al [6] and others [28,7] have suggested in studies across the continent [29], while some risky behaviors may be reduced with the use of ARVs, a larger proportion of individuals continue to have unsafe sex despite viral loads, the risks of mother to child transmission and increased risks for STIs.

This study demonstrates the cultural significance of fertility and childbearing in a context where both HIV and HIV awareness and education programming is high. PLWHA are getting married in Botswana and continue to pursue positive fertility outcomes even and at times particularly with partners who are HIV concordant. Concordant partnerships and marriage should not be discouraged but any future prevention programming and counseling should necessarily take into account the recognition of the importance of fertility and childbearing.

Methodological limitations

The study acknowledges that the relatively high median age of study participants limits the applicability of the findings and recommendations to the Tswana population writ large. The majority of PLWHA in Botswana with the highest prevalence are those under 25, many of whom have had a child but who have not been married in either customary or civil ceremonies previously. The findings do suggest that fertility desires and partner selection after knowledge of HIV status and fecundity may play a significant role in marital partner selection. Apart from age then, the other demographic characteristics reflect a snapshot of the Botswana population on the whole as indicated in the BAIS III.

In reporting conclusions from this study it is important to recognize that these data are from qualitative research with a relatively small population in Botswana, a context with high access to ARVs and treatment for PLWHA. It may not accurately reflect partner selection and cultural considerations of fertility in larger populations; those without access to ARVs or with less education about HIV and AIDS or those in contexts without the differing HIV serotypes as found in Botswana. The cultural diversity and varying attitudes and practices with respect to fertility and childbearing throughout sub-Saharan and southern Africa mean that this study has certain methodological limitations and additional similar research should be conducted in this region for effective comparison and policy planning with regards to managing fertility outcomes and desires among PLWHA.

Conclusion

HIV status is important in the decisions that couples living with HIV make in terms of who they will marry and with whom they will have children. However two conclusions are clear, one that once a marriage is established, HIV status becomes less important and two, the primacy of childbearing the amelioration of infertile status takes precedence over dis-concordance or prior marriage. It is also clear that Tswana individuals have high levels of awareness and education as to HIV and AIDS as a result of the past several decades and concerted, organized, national and international efforts to address the epidemic. As a result, informed sexual decision- making occurs but also highlights the relative and sustained importance of fertility despite knowledge about sexual risk and HIV infection. While it is unclear as to how and whether knowledge of differing serotype status has limited or affected partner selection in the context of Botswana in this particular study, this information will be salient in future work.

Despite location, couples in this study were making decisions about marital partners and ranking potential, perceived and proven fertility above actual or potential HIV status. This indicates a level of continued significance in socio-cultural factors that bear continued investigation as Botswana endures steady HIV incidence and prevalence rates. This paper is neither an attempt to undermine marriage or sexual partnerships among those living with HIV, nor is it aimed at suggesting that the HIV and AIDS efforts within the country have not been successful. Rather it contributes to the discussion on the necessity for careful consideration of socio-cultural factors, including but not limited to kinship structure, gendered decision making, the importance of fertility in the lives of PLWHA. It offers insight and suggests potential barriers to successful HIV prevention and testing programmes throughout southern Africa and other contexts.

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