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Looking to the future: South African men and women negotiating HIV risk and relationship intimacy

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Abstract

This paper examines the approaches heterosexual men and women in South Africa use to engage their partners in discussions of HIV and risk factors in their relationships. These strategies entail balancing the risks of infection while managing the challenges of maintaining a relationship. In a context in which there is a great deal of insecurity in relationships it is especially challenging to discuss HIV risks with partners. Our findings reveal that concerns about children or the desire to have children provided a legitimate basis for discussing HIV risk with partners. The focus of these discussions is on the future for their children. Research in South Africa should attend to men's and women's desires to have and to raise children. HIV prevention and treatment programs can capitalise on concerns regarding children, and the future of the family, to engage men and women in discussing mutually acceptable strategies for preventing infection and ensuring safe conception.

Keywords

South Africa; HIV/AIDS; gender; relationships; risk

Introduction

High rates of HIV infection in South Africa, together with the rollout of antiretroviral treatment, mean that increasingly men and women (and their families) are grappling with long term infection, illness, and the fear of HIV transmission. International research on couples and families has highlighted the struggle to balance disease risks and illness while maintaining healthy relationships (van Campenhoudt 1999; Cusick and Rhodes 2000). In South Africa, the challenges of living with HIV, or the threat of HIV, are further exacerbated by insecurity in relationships. Researchers have documented decreasing rates of marriage and cohabitation in South Africa since the 1950s (van der Vliet 1991; Preston-Whyte 1993; Budlender, Chobokoane, Simelane 2004; Hunter 2007; Hosegood, McGrath, Moultrie 2009). The challenges of securing and maintaining long term relationships complicates individual's efforts to address HIV risk and testing with their partners. Here we are concerned with investigating how individuals attempt to discuss HIV risk and testing with their partners.

We have drawn from qualitative interviews with men and women between the ages of 18 and 32 who lived in control and intervention communities in two South African settings that participated in a randomised, controlled HIV prevention trial. The NIMH Project Accept (HPTN 043) study is testing a multifaceted, community based voluntary counseling and testing (CBVCT) model. Our analysis for this paper focused on participants' reported efforts to discuss HIV risk and testing with their partners. We were interested in individual's approaches to discussing these issues. Our coding identified four main approaches used by men and women to engage partners in these discussions. We found that both men and women usually reported that it was the female partner who was expected to initiate discussions. In a few instances the male partner reported (or was reported) as initiating the discussions of HIV risk and/or testing.

Our analysis of participants' narratives revealed that the most frequently used approach was to discuss HIV in the context of their own, or their partner's, desire to have children or their concerns regarding raising their children. Participant narratives suggest that this approach was the least threatening and most successfully used to engage partners in discussions of HIV testing and risk avoidance. These discussions focused on their concerns for the future wellbeing of their families and their desires to raise their child/ren in a family environment. Here we examine the four approaches we identified and provide illustrations of how men and women in different social locations articulated their concerns. We argue that the qualitative data from this study suggests that addressing desires to have children or parent's desires to raise their own children is vitally important in HIV prevention and care programs.

Gender, heterosexual relationships and HIV risk

Researchers have drawn our attention to the gender specific risks of heterosexual transmission of HIV in sub-Saharan Africa. As has been well documented, the disproportionately higher infection rates among women have been fuelled by the complex intersections of biological, social, and economic factors. This research has documented the role poverty and unemployment plays in women's dependence on men. Researchers have argued that women's economic dependence coupled with male abuse of women compromises women's ability to insist on safer sexual practices in heterosexual relationships (Kim and Watts 2005). To a lesser extent, researchers have documented ways in which economic factors have compromised men's ability to adequately achieve the ideals of marriage and family support (Hunter 2005; Mkhize 2006; Sangeetha, Townsend, Garey 2008). These gendered economic factors intersect with sociocultural norms that emphasise women's submission to male authority and that sanction men having multiple sexual partners (Hunter 2007). What is less well understood is how relationship dynamics shape men's and women's efforts to negotiate these risks.

Couples in South Africa navigate a fraught and often insecure landscape with regard to maintaining relationships. The legacies of the colonial and apartheid labour system together with increased unemployment and greater socioeconomic inequalities contribute to high rates of separation from partners and low rates of marriage. Marriage rates in South Africa have consistently declined since the 1950s. In a KwaZulu-Natal study, Hosegood, McGrath, Moultrie (2009) found that in 2000, 35 percent of women had ever been married declining to 31 percent in 2006, while in 2000, 25 percent of men, and in 2006, 23 percent of men, reported ever being married. Not only did they find low marital rates but it also takes a long time to secure a marriage. They found that in 2005, the median age of marriage for women was 25 years and 31 years for men. In 2000, nationally the mean age at first marriage was 30 years for women and 34 years for men (2009:292).

In his research in Mandeni, Hunter (2007) notes recent economic changes (particularly higher unemployment) have rendered men less capable of meeting *ilobolo*/bridewealth

payments so that fewer couples are able to realise marriage. Furthermore, ever since the 1950s women are more socially and economically independent and less inclined toward marriage (van der Vliet 1991; Preston-Whyte 1993). These changes have shifted the gendered terrain such that men are no longer consistently able to provide for families and women no longer consider marriage a favourable means of securing support. Hunter concludes that marriage in South Africa has increasingly become a middle-class phenomenon.

These changes in marriage and relationship security are compounded by the HIV epidemic in the region. In the era of HIV and AIDS, there is a heightened discourse on sexuality and modernity along with changes in legal codes and policies that have fundamentally altered the political landscape of sex and sexuality in South Africa (Posel 2005). In the context of changing gender norms and relations, men are struggling to come to terms with what it means to be a man engaged in “modern styles of relating” (Sideris 2004:47), while women have struggled with men who hold fast to conceptions of “tradition” (van der Vliet 1991; Preston-Whyte 1993). In our efforts to improve HIV prevention and care it is essential that we consider the challenges men and women face as they balance the risks of disease, illness and changing gender relations while they attempt to secure and maintain relationships.

Methodology

This paper is based on qualitative data from the NIMH Project Accept (HPTN 043) study (see Genberg et al. 2008; Khumalo-Sakutukwa et al. 2008; Maman et al. 2009 for further details of this study). Forty-eight communities in four countries (South Africa, Zimbabwe, Tanzania, and Thailand) were enrolled in the study. Communities were randomly assigned to the community based voluntary counselling and testing (CBVCT) intervention or to standard, clinic-based VCT. One aspect of the study entailed conducting in-depth qualitative interviews with a stratified random sample of 656 individuals who participated in the baseline behavioural survey in both intervention and control communities. Interviews with these participants were conducted at four points during the study (baseline, 6 months, 15 months and 30 months). The study procedures were reviewed and approved by ethical review boards at the University of California, Los Angeles and the University of the Witwatersrand, South Africa.

To select participants for interviews, we stratified the baseline survey sample into a combination of eight demographic categories according to gender, age (18–24 years and 25–32 years), partner status (single or coupled¹), and control or intervention sites. Participants were randomly selected in both control and intervention communities at baseline and may or may not have participated in the CBVCT programs available in their community. The in-depth interviews were semi-structured based on a standard field guide that was used across all sites (for details see Maman et al. 2009). Questions focused on issues concerning HIV-related attitudes, norms, and behaviours of the individual as well as their perceptions of partners', family members', friends' and community members' attitudes and behaviour. Trained local interviewers conducted 30–60 minute interviews in the local language in the individual's home. The interviews were audiotaped, transcribed and translated into English. They were then computerised and coded in Atlas.ti. Thematic data analysis included indexing the data by topics through the application of topical codes, also called descriptive codes (Miles and Huberman 1994). These topical codes included contextual information, HIV risk behaviours, stigma, testing behaviours and HIV related discussions.

¹“Single” designates individuals who at the time of the interview were not married and were not in a relationship lasting longer than 3 months, while “coupled” designates individuals who were married or in a primary relationship for 3 months or longer.

In this paper, we focus exclusively on data collected in the South African sites: 8 communities in Vulindlela, a rural area NW of Pietermaritzburg, KwaZulu-Natal; and 8 urban communities in and around Soweto, Johannesburg. The analysis is based on the available complete coded data sets including the baseline, 6 month and 15 month follow-up interviews. These interviews were conducted between July 2005 and March 2009. Since we are most interested in how individuals reported negotiating HIV risk with their partners, our analysis drew on the data topically coded as “HIV discussions with partner” and “partner attitude toward testing.” These topical codes highlighted discussions the interviewee had with his/her partner regarding HIV as well as discussions regarding their partner’s attitudes to HIV and testing. We were specifically interested in how individuals reported their efforts to address HIV, risk and testing with their partners. We compared these topical issues by site (Vulindlela or Soweto including both intervention and control communities), by gender, by partner status (coupled or single), and by age (under 25 and 25 or older) to ascertain whether there were any significant differences between these groups (see Table 1). We did not investigate changes over time or differences between control and intervention sites since we were primarily interested in the approaches to these discussions (these variables will be the subject of future analyses). The most notable differences in approach that we found were related to gender. There were no notable differences based on partner status, site and age.

Approaches to Discussing HIV Risk and Testing

Recent research examining negotiations of HIV risk in heterosexual relationships in African settings has drawn attention to the indirect strategies that are often used. Miller et al. (2009) found that Akamba couples in Kenya sought to address sensitive issues with caution using intermediaries (such as church members, friends or family) or a circuitous approach “until the bull’s eye at the centre of their own relationship was reached” (2009: 56). Like Miller et al.’s study participants, our participants used caution in addressing HIV risk in their relationships and deployed indirect strategies to draw their partners into the core issues that concerned them. We identified four primary approaches.

First, though our interviews did not directly explore the extent to which family members or friends mediated discussions, interviewees reported initiating a discussion by expressing concerns regarding the HIV status of a family member or friend in the community. Kabelo (a pseudonym)ⁱⁱ, a 22 year old man in Soweto, told an interviewer that he had decided to discuss HIV with his partner after a friend with HIV/AIDS died.

As I was telling you, when my friend passed away that’s the only time we talked about how careful we must be, because you know girls are more careful than our guys, you see. Like maybe when someone has HIV and we know it, maybe the person is bleeding, she will tell me I must become aware of that. All of that is safety.

(2 July 2007, 22 y.o., coupled, male, Soweto).

After a clinic visit Lerato, a single woman in Soweto, initiated a discussion with her partner who was afraid to talk about HIV. She explained that her aunts had HIV.

We spoke just as I have said this thing kills, it exists, you understand? I told him about my aunts. So I’m scared I have children that I need to look after, I don’t want to die. And he said that I am speaking the truth, he also experienced such things with his family and 2 friends. So (...) it’s important for a person to know whether he’s dying or not and that he’s dying from this disease. Dying is for us all, but you have to know what is killing you.

ⁱⁱAll names used here are pseudonyms.

(11 September 2005, 25 y.o., single, female, Soweto).

Takalani, a single man in Soweto, noted that his partner had raised the issue of HIV with regard to a friend who had died of AIDS.

I think it was yesterday, I can't remember because I was drunk, but I think it was yesterday, we were talking about it. She said, there is someone I know who died because of this disease, who passed away. I think it was her friend from Sakkies. We were talking about her and then she told me that she died because she has AIDS. She said she met her child. And then she told me that she doesn't trust me. She wishes that I can always be around because my phone is always off when she is not around. She thinks I am going to infect her with AIDS. Then she said she will go test.

(10 August 2007, 31 y.o., single, male, Soweto).

This was a relatively safe approach for initiating a discussion of HIV to test out a partner's reaction in a manner that would not implicate either partner directly. The person initiates the discussion with reference to HIV outside his/her relationship but uses this to hone in on his/her specific concerns regarding HIV risk in their own relationship. These discussions did not usually result in more specific discussions of HIV risk and HIV testing.

Media (both radio or television broadcasts) was a second, relatively safe, approach to initiating discussions of HIV. Xolani in Vulindlela noted that he discussed HIV with his partner.

Sometimes when we are watching TV (...) we discuss about the rate at which people are dying. For an example we compare the time frame and the number of deaths that have occurred, do you get what I'm saying?

(2 December 2005, 22 y.o., coupled, male, Vulindlela).

Gugu, in Soweto mentioned the television program "Siyanqoba." She noted that her partner told her that while she was at church on Sundays,

"I was watching that program Siyanqoba, I heard them talking but was scared to even listen to what they were saying. But I know AIDS rules, but I'm still scared to listen to it" [reporting partner's discourse].

(8 May 2007, 30 y.o., coupled, female, Soweto).

She noted that their discussions of HIV focused a great deal on the fear of contracting HIV. Similarly, in Soweto Kabelo said he discussed HIV with his girlfriend when they were watching television:

We just ask each other some questions. Sometimes there's something on TV then we sommer (just) talk about that. That's how the whole topic starts. But both of us we don't actually know too much about HIV and AIDS.

(2 July 2007, 22 y.o., coupled male, Soweto).

Television was a fairly neutral way to discuss HIV and a means through which individuals that were fearful of HIV/AIDS could more safely enter the realm of HIV. But again, this approach did not usually lead to more specific discussions of HIV risk and testing.

A third approach entailed joking to "test" a partner's reactions. This approach was used with caution since it could invoke an angry response. Managing potential violence or rejection was critical in the decision-making entailed in using this approach. In Vulindlela, Nkosinathi reported,

P: We have not discussed it [HIV], except that I sometimes say she must go and test her blood, saying it in a joking manner, you see? That is what I usually tease her about and say, hey lady go and test your blood here.

...

I: Okay, okay how does she feel when you tell her?

P: I think that she gets really worried because she sometimes takes it as if I do not trust her, you see? Yes, she does feel sad indeed. (...) I end up being frightened; I then apologise and say no I was just joking.

(26 July 2006, 18 y.o., coupled, male, Vulindlela).

For a woman this joking strategy could be more risky. Nomusa in Vulindlela reported that her partner did not like to discuss HIV, so she used joking to raise the issue.

I: He does not like if you talk about it [HIV]. If you are starting that topic he just talks about another topic

(...)

P: I once tested him and said, ei, I need to go and get my treatment. Do you know that we are..., we are both going to die? Ei, I saw that his face changed. He said what are you saying? I said; please stop joking I am serious. Let's go and get the treatment at Mafakathini (clinic).

(...)

I was just testing him. I wanted to see where he really is.

But this strategy could be dangerous. She went on to say,

P: (...) He had that [look] that he wants to hit me. Hhayi, I could see that I am about to be beaten. I then said, hhayibo, I am joking I wanted to see how you take things. I see that on the day I am told that I have AIDS you will hit me." He said, "Actually I definitely will." (...) He will indeed hit me when I am diagnosed with AIDS.

I: How would he know if you are the one who came with it, or if it's him?

P: It means that he is relying on me; ..., he will say I am the one who brought it.

(28 May 2006, 22 y.o., coupled, female, Vulindlela).

Such an approach is open to misinterpretations. Nomusa had to be prepared to back pedal very quickly to lower the risk of an angry partner. She used joking as a strategy for testing the potential level of her partner's anger should she test HIV positive. This approach was used less often.

A final, more common approach emerged in the context of pregnancy or the desire to have children. Children provided a means of initiating discussions of HIV testing and/or condom use. Women usually raised this issue with respect to concerns about their child/ren's future: What would happen if we die? Who would care for the children? Hence, we need to keep ourselves safe and know our status. Men could be more receptive to these discussions and were less likely to immediately discount these concerns. Planning for the future was an

important and often productive theme in discussions of HIV with a partner that could lead to discussions of risk and testing. It could be a less volatile context for HIV discussions that enabled men and women to hone in on their concerns regarding the risks of infection in their relationships without directly accusing their partner of risky behaviour. Women, in particular, could more easily appeal to concerns about the health and future of children as a means of negotiating testing or safer sexual practices. Thobile, a 26 year old woman in Vulindlela revealed that she and her partner were no longer together and he was living with another woman. However, she felt that if he should return she would have to take him back:

Eh, the reason that I am not able to leave him is my child. (...) It's just that I am unable to help her [my child] further at school, as she will be starting school very soon, and I will be unable to pay for her schooling years. But if I could I would leave him.

This economic dependence is what often resulted in women maintaining relationships with the father/s of their child/ren. Earlier in the interview Thobile described discussions with friends about HIV noting that:

We just talk about looking after ourselves. We must (use protection) since we have children. Our children need us. Eh, it is difficult to leave behind [she is talking about death] a small child at home.

(25 October 2005, 26 y.o., coupled, female, Vulindlela).

She noted that women were generally concerned about the risks of HIV to their children, in particular, the risk that they would die before their children were grown. In her discussion of HIV with her partner Nomonde raised concerns for her children's future as a means of insisting that he avoid having other sexual partners.

He's also afraid of the disease and he promised he never can go around or cheat on me or sleep with someone else, because I told him I can die of this disease. I have children, and I don't want to leave my children behind. I want to see them grow. I want to see them finish school, go work and... I want a life with my children. I don't want to [unclear] the disease. So we talk openly not to go around, mess around because it's not nice even if you use protection. (...) So we talk openly about it. And I'm afraid of the disease, I'm very afraid. (13 July 2006, 28 y.o., single, female, Soweto).

Nomonde was able to use her concerns about staying alive to raise her children to lead her partner into a more frank discussion of the necessity of using protection to prevent HIV transmission. Similarly, after attending an uncle's funeral, Thato told his regular girlfriend that he wanted his child to have the experience of growing up in a family.

I told her that if we are not careful we will end up lying in that [death] bed with no one crying for us, and I still have a lot of things I want to achieve, and also want to do some things for my mother. (...) You see, I still have to be on my own and go fetch my child so that she can grow up in my family, so that she can have her family culture.

(June 2007, 27 y.o., coupled, male, Soweto).

In Vulindlela, Busi reported using the desire for children to initiate a discussion with her partner on HIV testing:

The time when he first talked about being pregnant, he said he wants a boy. I said if you want a boy you should go for a checkup, and when I am pregnant I will go to the clinic.

(8 April 2006, 32 y.o., coupled, female, Vulindlela).

These discussions regarding children provided opportunities not only to express fears of HIV but enabled men and women to address avoiding risky sexual behavior and HIV testing. In South Africa, in the absence of marriage children often become a marker of a committed relationship. As noted in some of the reported instances here, even if the relationship dissolved, if the couple had a child together children often resulted in the maintenance of the relationship in some form. This could include ongoing sexual relations. In these instances it was difficult to negotiate safer sexual practices (particularly condom use) since couples who already had a child tended to assume that they had either already been exposed to HIV or were negative. We found it was much more common for individuals to report using a condom in casual relationships (whether single or coupled) than in longer term relationships. The danger is that condom use, or rather the cessation of condom use, seems to be implicated in committed relationships especially those with children.

Gendered patterns in discussions of HIV with partners

We found that trust is a critical issue that individuals invoked in their reported discussions of HIV with partners. Managing trust in relationships meant that men and women had to be cautious in addressing their concerns regarding HIV risks with their partners. These discussions revealed differing gendered expectations of partners. There was greater expectation and acceptance of men having multiple partners. While men were often expected to initiate sexual relationships, women were generally expected to initiate discussions of HIV (cf. Miller et al. 2009). As Sibongile in Vulindlela asserted,

It is not easy for a male person to think that they need to test because commonly males do not really care that much about [testing]. The problem [of testing] is with us females.

(11 January 2006, 25 y.o., coupled, female, Vulindlela).

Women were proactive in addressing the risks of infection in their relationships. When asked whether she had discussed HIV with her partner, Ntombi, a 20 year old in rural Vulindlela said,

Before I met him he had a girlfriend and they broke up and we became involved. Now he is no longer involved with me only, he has another girlfriend. I normally tell him that since you are involved with both of us, *how can you trust us?* I asked him, “Your girlfriend has another boyfriend, how do you know what the boy is doing, where he is? The girl might get AIDS and she will come and infect you and you will infect me. What if we use a condom, both of us?” And he will say “No, because you are the mother of my child.” I asked if he uses a condom with the other one, and he said, “Yes, I use it.” That is all, and it is I who spoke to him about AIDS. As a couple, he has not initiated an AIDS discussion.

(14 October 2005, 20 y.o., coupled, female, Vulindlela).

Like Ntombi, we found that men and women expressed concerns about their partner’s sexual networks and often acknowledged the risk factors in their own sexual history. However, men largely depended upon women to initiate discussions about HIV risk and testing before seeking out healthcare services themselves (if they did so at all). Mpho in Soweto described the process she went through with her partner in addressing the risks of HIV and seeking appropriate healthcare services.

P: I wanted to know [my HIV status] because I had just broken up with someone I was sleeping with and I thought that I can’t go into another relationship not knowing [my status]. (...) So I wanted to test. And then I postponed it, and you know, each time you just don’t make time for it. You’ll think about it until eventually you’re sleeping with this person. Now

that's like one extra person you're counting. Like there are so many people and now it's him as well. But if it happens that you are [positive] you have to tell so many people that it is like this you know.

I: Did you voice those concerns to him?

P: Yes, he knew, he knew I wanted to get tested.

I: Ok, what did he say? What was his reaction?

P: He said I was very brave! He said, he is not going to go get tested. He only went after I got my results. (...) But he didn't just go get tested. He got sick (...), and he got bronchitis and he was very sick all the time so they just did a routine test. They checked everything with him. So, they did the HIV test as well. It was better because it was after my results. I think he was a bit more relaxed than I was, waiting for his results you know.

(28 June 2006, 25 y.o., coupled, female, Soweto).

Here it is clear that Mpho not only initiated the discussion of HIV, and the risks of infection to herself and her partner, but she laid the ground for him to seek healthcare services and to agree to HIV testing. Although women usually initiated HIV discussions, they generally reported an inability to persuade a reluctant or defiant partner to test.

Men frequently told interviewers they relied on female partners to test as a means of determining their own HIV status. Nompumelelo explained her discussion with her partner regarding this issue. She told the interviewer,

No, we have never discussed [HIV] as such but I tell him that he should go and test. We are taught about these things that I can test negative (and my partner test positive). He might not be negative. (...) He must go to test. He then says no, if I tested negative it means that he is also negative.

(13 July 2006, 23 y.o., coupled, female, Vulindlela).

This phenomenon of men testing by proxy was not uncommon (Levack 2005; cf. Morrill and Noland 2006). Men entrusted testing to their partners assuming that their status would be the same as their partner's. In Vulindlela, Nomusa reported that her partner also insisted that his HIV status would be the same as her own after she was tested.

... all that he [my boyfriend] is saying is that, hhayi, because you [tested], if you went and you were told that you are negative, you should know that I am also negative.

(28 May 2006, 22 y.o., coupled, female, Vulindlela).

Similarly Nkosinathi talked about his efforts to initiate a discussion of HIV with his partner in which he encouraged her to test insisting that their status would be the same. In this discussion he raised the issue of trust in their relationship.

Just, sometimes I will say to her she must go and test her blood sometime. She tells me that she is scared, at least I must go, you see. (...) No, I want her to be the one who will tell me that you see. This is the way it is. Besides she is the person that I *trust*, you see. (...) If things are bad in her, things will also be bad with me [if she is infected I will also be infected].

(26 July 2006, 18 y.o., coupled, male, Vulindlela).

On occasion participants viewed the discussion of HIV and risk as entailing mutual responsibilities. Here we saw some differences between urban and rural participants in the study. Discussions invoking mutual responsibility in addressing HIV risks in their relationships though not common were more likely in urban Soweto than in rural Vulindlela. Thapelo, a single man in Soweto, explained that he and his partner discussed HIV and condom use. He related a discussion he had with a partner about their mutual risk:

We talk about it's after effects and the importance of using a condom. What if you were sleeping with the person you were dating before me without using a condom? We talk about such things because you wouldn't know where that person is from, and it's impossible to start dating someone immediately they are born, so rather be safe than assume that this person is like this...

(20 June 2007, 21 y.o., single, male, Soweto).

Raising the issue of trust, Banele described her discussion with her boyfriend regarding HIV testing, insisting that they both needed to test:

Because right now he always tells me that he trusts me, "I won't cheat on you". But I told him that I want to test first because it's risky. I don't know where he's been and he doesn't know where I've been. (10 November 2005, 20 y.o., single, female, Soweto).

When men initiated the discussion of HIV and testing with their female partners they usually insisted on couples testing. In Vulindlela, Mlungisi spoke with his partner about the need to test:

I once talked about it [HIV] with my partner [saying] that, eh, no my friend we should go for a checkup. ... I want to see what is going on.

He went on to say,

But we do not have time because of our work, you see. (...), going together it is impossible (...), we cannot because her job and mine is different. There is no chance of going together for checkup.

(28 August 2006, 27 y.o., coupled, male, Vulindlela).

Wandile, in Vulindlela noted similar issues in a discussion of HIV testing that her partner initiated. She and her partner had agreed to test together but they had difficulty doing so since "he is busy and is working far" (22 August 2006, 21 y.o., coupled, female, Vulindlela). Tumelo, a single man in Soweto, noted that he and his partner had been able to successfully test as a couple. After much discussion (which he had initiated),

Then she agreed [to test]. We then went to the doctor and not the clinic. (...) So, the doctor explained everything to us and told us about counseling and all those things as to what happens when you are positive and when you are negative. And then he took our blood sample and told us to come back in three days. (...) So we went back and before he could give us the results he told us about counseling and all that and it scared the hell out of me (...) And he told us that we are both negative.

(19 April 2007, 20 y.o., single, male, Soweto).

These gendered patterns in negotiating HIV risk in relationships placed the burden primarily on women to initiate discussions and to test. Men most often relied on their female partners to determine their HIV risk through proxy testing. Some couples discussed HIV risk and testing as entailing mutual responsibilities. On occasion men would initiate this discussion.

The challenge for both men and women was trying to address HIV risk in ways that facilitated the maintenance of trust in the relationship.

Balancing HIV risk and maintaining healthy relationships

Participants had to carefully negotiate HIV discussions in their relationships, managing how, when and what information or concerns to share. Men and women were engaged in processes of weighing viral risk and relationship risk (Cusick and Rhodes 2000: 480). Buhle explained her relative risk of HIV with her partner in relation to her assessment of his character and their relationship. She told the interviewer:

You cannot predict a person, but he [my partner] is a person who is careful. (...) Even if something is going to happen he explains that thing you see. ... he is not a person who fails quite often. If he does something, he does it and means it. You can end up guaranteeing [trusting] him. When he says he loves me, he loves me, ... he is by nature like that. ... So when it comes to HIV and AIDS I think I can give him sixty percent, you see, yes we can give him [that].

(24 August 2006, 24 y.o., single, female, Vulindlela).

Buhle exhibits an awareness of uncertainty in her relationship. She considers her partner's personality but expresses an awareness of the unpredictable nature of people. She acknowledges the risk of HIV and even attempts to quantify the risk of infection that her partner represents. Another single female in Vulindlela, Jabulile, spoke about her efforts to manage HIV risk in her relationship. She tested HIV positive after her partner died. Jabulile noted the importance of the support she received from her current partner (also HIV positive) but said she could not compromise her own or his health. She chose to disclose her status.

P: I told him about my status. That, no my brother, I cannot now [unclear] because my life is now here where it is. I now do not want to fool around with you. I think that my love will not fit because I now have principles which I am going to follow, which are now compulsory to me, that I will not do this and that.

...

I have now met someone and explained my problem. He also explained his. He promised that he is someone who is going to take care of me because he is also in this situation which I am in. So ... there is no way he is going to ill-treat me because there is nothing he does not know [regarding my HIV status] now.

I: Okay. What did you do when he told you his status?

P: You know I was sad in spirit seeing that life was over with me. (...) When he told me he said, "When you see me walking you cannot say that there is a problem I am having. I am just like other people. The only thing I now have to look after myself. There is nothing I can [do] without a condom. And I also do not forget that I am someone for the tablets [ARVs]." We live on tablets. (...) I felt comforted.

(3 April 2006, 30 y.o., single, female, Vulindlela).

Here both partners disclosed their HIV positive status. Despite her sadness, their honest discussion of the challenges of living with HIV left Jabulile feeling comforted in having a partner who would support and care for her. Similarly, Vusi, a single man in Soweto saw managing HIV risk in relationships as vital to sustaining a relationship. He told an interviewer:

I guarantee it's safe. It is better that we talk about it. If you talk about these things that's when you are able to see the relationship itself can be sustainable.

(17 August 2007, 24 y.o., single, male, Soweto).

Self-disclosure in a cultural context that generally preferences indirect communication strategies can be risky but, as the above two individual's experiences reveal, self-disclosure can also have positive outcomes for sustaining a relationship. Men and women used various strategies to feel their partner's out regarding their attitudes to HIV risk. They negotiated HIV risk in ways that enabled them to develop and maintain their relationships.

Conclusions

As men and women negotiated HIV in their relationships, they navigated the terrain of intimacy in varied ways. Sometimes they sought to openly reveal their HIV status, at other times they cautiously approached HIV discussions, and many reported their partner's or their own fear of discussing it. Their approaches entailed a careful management of the risks of addressing HIV in their relationships. As Cusick and Rhodes observe, "relationship risk management in the time of AIDS is as much an effort to protect relationships as intimate, loving and secure, as it is an effort to ensure viral safety" (2000:482). They argue, "HIV should be recognised as a risk factor threatening relationships as well as individual and partnership health." (2000: 484). Understanding the stressors on relationships in South Africa is vital to helping couples face the challenges of HIV.

Understanding the specifics regarding how men and women attempt to negotiate the risks of HIV in relationships is critical to the development of effective interventions that can better enable individuals to protect themselves against HIV. The qualitative data gathered in the course of Project Accept suggests that concerns about children or desires to have children can be a less threatening and perhaps more effective means for men and women to discuss HIV risk. In a context in which many men and women have children long before marriage, children become a proxy for relationship commitment.

Furthermore, in South Africa children are critically important to both men's and women's social status. They can be a marker of adulthood. African women are able to achieve social status as mothers whether or not they are married (Preston-Whyte 1993). However, as Mkhize (2006) and Morrell (2006) note, for men achieving fatherhood can be more challenging since they are unable to attain recognition as fathers if they are not married to the mother of their child/ren. Doing so requires paying what are often unaffordable bridewealth/*ilobolo* transactions. Unless as Hunter (2005) found, they negotiate to pay "damages" (a less costly transaction) to the woman's family which then entitles them to limited fatherhood claims. Smith (2007) in his research with men in Nigeria argues that appealing to men's existing sense of responsibility to their families is a potentially successful strategy for engaging men in HIV prevention.

The challenge in the South African context is to address men's efforts to secure their status as fathers and their relationships with the mother/s of their children. One arena in which this can be addressed by the medical community is to follow the recommendations of Varga (2003) and Maharaj (2001) who have noted that men's lack of involvement in family planning results in a lack of perceived responsibility for controlling reproduction and STDs. HIV prevention programmes in South Africa would do well to address the mutual interests and investments of men and women in children by drawing partners into systems of care. Men and women can more effectively negotiate HIV risk in their relationships as they look to the futures of their children and invest in the future of their relationships.

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Table 1

Descriptors of qualitative study participants by site and interview period

	Vulindlela Baseline	Vulindlela 6 months	Vulindlela 15 month	Soweto Baseline	Soweto 6 months	Soweto 15 month
# of participants	126	85	80	100	72	62
Male/female	65/62	44/41	43/37	45/55	36/37	33/29
Coupled/single	64/61	45/36	46/33	42/58	29/45	22/40
<25/>25	63/63	41/43	42/38	42/57	26/47	19/43