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Reproductive Desires and Considerations of HIV-Positive Men in Heterosexual Relationships in New York City

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Abstract

The reproductive desires of HIV-positive men have been investigated far less than those of HIV-positive women, especially in the US. This qualitative study of a sample of 94 HIV-positive men in New York City who were in a relationship with a woman of reproductive age examined their reasons for wanting a child as well as the conditions under which they would feel ready to attempt conception. Participants felt a child would make them feel normal, give meaning to their lives, or make others in their life happy. Although they reported HIV-related concerns (i.e., horizontal or vertical transmission, reinfection, or shortened life expectancy), participants mostly discussed factors unrelated to HIV (e.g., finances, housing, incarceration, substance abuse, or relationships) as deterrents to acting on their desire to having a child. When providing information on safer conception, healthcare providers should be aware of the broad desires and factors informing HIV-positive men's reproductive goals.

Keywords

HIV-positive men; reproductive desires; heterosexual/bisexual men; United States

Introduction

With access to care and early treatment, the life expectancy of people living with HIV is approaching that of their uninfected peers [1–4]. HIV treatment and prophylaxis as well as assisted reproductive technologies have become very effective in preventing horizontal

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Conflict of Interest

The authors declare that they have no conflict of interest.

Compliance with Ethical Standards

All procedures performed in this study involving human subjects were in accordance with the ethical standards of the institutional and/or national research committee and with the 1964 Helsinki declaration and its latter amendments or comparable ethical standards.

Informed Consent

Informed consent was obtained from all individual participants included in the study.

transmission to an uninfected partner when conceiving [5,6] and antiretroviral regimens have been available since 1997 to prevent vertical transmission from an infected mother to a child during pregnancy [7]. As a result, HIV-positive men and women may increasingly desire a child, and feel confident both that it can be born uninfected and that they will survive long enough to raise that child. Greater knowledge about the reasons why HIV-positive adults may want children can help tailor information about safer conception to those who need it.

Despite the important role men can play in heterosexual couples' decision making about childbearing, researchers have paid much less attention to the reproductive desires of HIV-positive men than those of HIV-positive women [8,9]. The few surveys that have included HIV-positive men found that they, like HIV-positive women, were not deterred from wanting to conceive children because of their illness [for a review, see 10,11]. In the US, two surveys found that about the same proportion of HIV-positive individuals of both genders expressed a desire to have children: 28% of the men and 29% of the women in a 1998 survey of 1,421 HIV-positive adults [12], and 39% of men and 38% of women in a 2010 survey of 93 respondents [13]. Proportions are higher among men in relationships as, in a study of 143 HIV-positive men in serodiscordant heterosexual relationships recruited from a reproductive health center in the US between 2002 and 2009, 72% indicated that they desired to conceive a child with their partner in the future [14]. Internationally, surveys have found that HIV-positive men of younger age [12–18], with no prior children [14,15,17–19], and in a heterosexual relationship [15,19] were more likely to desire children.

In qualitative studies, HIV-positive men have often conveyed that concerns for horizontal and vertical transmission do not deter them from desiring a biological child [20–24]. Many appear to perceive a cultural imperative to father children and to do so through procreation [20,21,25]. HIV-positive men in a qualitative study of 12 serodiscordant couples in Canada felt it was a man's responsibility to father a child by impregnating their partner and that if being HIV-positive meant they could not conceive children, then they had failed in meeting an important relationship expectation [24]. In a small qualitative study in Ireland of six female and four male HIV-positive participants, men expressed that procreating was an essential part of their societal role as adult males that HIV prevented them to fulfill [26].

When asked why they desired to conceive children, HIV-positive men (and women) in qualitative studies often talked about a desire for normalcy; that is, a wish to feel like they can live a normal life despite being infected with HIV [20,21,24,26–30]. In a sample of 24 HIV-positive Puerto Rican men in Boston, participants saw dating, having an active sex life, and planning on settling down with a partner and having children as ways to begin normalizing their lives [20]. In studies outside the US, men also cited wanting to pass down family traditions [22], to leave something behind after they died [21], or to bring purpose to their lives [27] as motivations for wanting children. Men have also reported desiring to have children because of pressure from parents who want grandchildren [24], to strengthen a relationship with a partner with whom they did not have previous children [28], or to satisfy their female partner's wish [31].

These studies often allude to the fact that the reproductive desires of HIV-positive people are influenced by an array of factors not directly related to HIV. For example, a qualitative study

of 17 HIV-positive men who have sex with women in San Francisco found that their concerns about having children included financial insecurity, relationship instability, or their own or their partner's older age [32]. A qualitative study of HIV-positive men and women in Tanzania [33] concluded that reproductive decision making was influenced by factors at multiple levels, from individual ones (like attitudes toward safer conception strategies or HIV and individual health status) to structural ones (like poverty and gender norms).

Most of the qualitative data on HIV-positive men's reproductive desires comes from Africa [21–23,25,28,29,33–35]. Because the social characteristics of people living with HIV and the medical resources and care available to them vary greatly across countries, research on the reproductive desires and behavior of men from other countries may not be generalizable to men in the US. In the US, where the majority of HIV-positive men have become infected through male-to-male sexual contact [36], qualitative data about the reproductive desires of HIV-positive men in heterosexual relationships are especially scarce and often come from small convenience samples [20,32,37]. This paper thus seeks to provide a fuller understanding of the reproductive desires of U.S. HIV-positive men in heterosexual relationships, how these desires are influenced by the broader context of their lives, and what factors may limit their willingness to act on them. We answer these questions using qualitative data collected from 94 HIV-positive men living in metropolitan New York City who had been in a main relationship for at least six months with a woman of reproductive age who, in some cases, was also HIV positive.

Methods

Sample

The sample for this paper is taken from a larger study of the reproductive desires of HIV seroconcordant and serodiscordant heterosexual couples. To be eligible for that study, individuals had to be in an ongoing primary sexual relationship for at least six months in which one or both partners were HIV positive. Both members of the couple had to be aware of their own and their partner's serostatus (which was self-reported), be fluent in English, and live in the New York City (NYC) metropolitan area. The female member of the couple had to be between 18 to 45 years of age and the male 18 or older. Seropositive participants had to identify as Black/African American or non-Hispanic White and have been born in the US, or identify as Latino/Hispanic (of any race) and have lived in the US for 10 years or longer. Both members of the couple had to be willing to participate in the research.

Recruitment and Screening

A variety of recruitment strategies were used to ensure representation from diverse segments of the population. In addition to placing advertisements in free newspapers widely distributed in NYC, we also made use of our ties with several community-based organizations that provide HIV-related services and other types of services (e.g., organizations serving substance users, homeless or unstably housed individuals, and low socioeconomic-status individuals in need of social services). Advertisements were also placed in a variety of settings including HIV-testing sites, HIV clinics and specialized physicians' offices (e.g., reproductive care), family planning clinics, drug treatment clinics,

needle exchange services, and at AIDS-related events (e.g., AIDS Walk, HIV-specific women's conferences, and health fairs). Agencies were asked to include advertisement for our study in their email newsletter (if they had one), have staff give flyers to potentially eligible clients, or leave the material in their waiting rooms. The study advertisements included a phone number and a link to the study webpage that provided a brief description of the research. Interested individuals were asked to call the study line and were screened on the phone. Purposive sampling aimed at recruiting a heterogeneous sample of approximately equal numbers of seroconcordant couples and of each type of serodiscordant couples. In total, 150 couples (300 individuals) were enrolled. This included 56 couples with a female seropositive partner, 44 couples with a male seropositive partner, and 50 seroconcordant couples. Interviews were conducted between mid-2009 and early 2012.

Data Collection

Both members of a couple were interviewed separately but required to schedule their interview for the same date and time for two reasons: a) to prevent one member of the couple from discussing their interview with the other and thereby influencing the answers of the partner who was interviewed later and b) to avoid incomplete couple cases (i.e., one individual completing an interview without her or his partner subsequently also participating). After signing an informed consent form, participants completed an interviewer-administered questionnaire that elicited sociodemographic and background data, followed by a small battery of standardized measures administered through Audio Computer-Assisted Self-Interview software (ACASI). The remainder of the meeting was used to conduct the interview, which was audio-recorded and took on average 1 hour and 42 minutes. Each participant received a $50 honorarium and reimbursement for all reasonable transportation costs. The Institutional Review Board at Columbia University Medical Center approved study procedures.

Data were gathered through qualitative interviews that relied on a non-directive approach to interviewing and on unstructured questions [38,39]. The interviewer uses an interview guide, which serves as a conceptual roadmap of topics to be covered during the interview in no predefined order rather than as a formal interview schedule in which there is a fixed set of questions always asked in the same order. A nondirective approach is one in which the interviewer asks broad, neutrally worded questions that allow interviewees to largely determine the course of the interview, what will be discussed within different topic areas, and the order in which topics are covered. It also allows the interviewer to ask unique questions that may be provoked by what the interviewee has said about a topic and seem likely to contribute to answering the research aims. By following the natural flow of participants' thoughts and remarks, the connections and linkages they make between topics or issues are illuminated. An unstructured question does not fix attention on any specific aspect of the situation or of the response [40] (e.g., "What have you found most challenging about being HIV positive?"). Unstructured questions increase the likelihood that unanticipated issues related to the topics of interest will have an opportunity to emerge [41]. The interview guide covered (among other topics such as contraceptive behavior and sexual risk behavior) the participants' desires, motives, and deterrents for having a child with their current partners.

Data Analysis

After interviews were transcribed verbatim, the interviewers prepared an analytic profile for each participant they interviewed. Such profiles are effective ways to condense and organize data [42], especially when interviews are long and topics are not always covered in the same order with each participant. For each participant, interviewers wrote a detailed summary of how their interview data related to each of the study aims and substantiated their write-up with relevant quotes. A senior investigator supervised the quality of these analytic profiles throughout the data collection. Although a more common analysis method is to code transcripts, we have found, in prior studies [43], that the use of analytic profiles leads to comprehensive synthesis of findings more quickly and efficiently. A very similar strategy has also been used by others [44].

For the present paper, we focused on why HIV-positive men in a stable heterosexual relationship desired to have a child. This decision was made because it seems likely that the desire for a child in this population will grow, considering treatment advances that result in longer survival and a growing number of ways to prevent horizontal or vertical transmission. To address this question, we reviewed the section of the analytic profiles of the 94 HIV-positive male participants that related to one principal aim of the study—to investigate participants' reproductive desires with their partner and the reasons why they were currently willing or not willing to have a child. Through a first reading of the interviews, provisional codes were created that produced an inventory of all the different motives, deterrents, and influences related to participants' reproductive desires. The authors then distinguished between two main categories of codes. The first category referred to the meanings and emotions participants associated with childbearing and parenting that, in most cases, underpinned their desires and motives for wanting to conceive a child or become a parent. The second set of codes referred to different conditions they felt should exist or issues that needed to be resolved prior to acting on their desire to have a child. These conditions typically were deterrents to attempting conception at the present time, which they hoped to resolve in time. The desires in the first set of codes were thus also sometimes the motivation to attain the conditions or overcome the obstacles enumerated in the second set of codes. After these two groupings of codes were created, we then reviewed the analytic profiles again to edit and refine the factors and desires outlined in each category of codes. We report the final categorization of the types of desires and motivations in Table 2 and the factors informing the decision to have a child in Table 3.

Results

Sample Characteristics

Table 1 outlines characteristics of the 94 HIV-positive male participants collected with the questionnaires. Participants' ages ranged from 18–68 (mean=43). The distribution on education, income, and housing categories reflect the sample's low socioeconomic status. About 72% of these men had no more than a high school degree and only 18% reported employment as their main source of income. Conversely, 76% of participants indicated their main source of income was either public assistance or HIV-related benefits. About 61% of men made less than $10,000 in personal income per year. One-quarter of participants (24%)

lived in a SRO or hotel room paid for by welfare, specialized AIDS housing, or some form of temporary housing. Seventy percent reported that they had known of their HIV-positive status for more than 10 years. Most (62%) participants were married or engaged to their partners; only 18% had been with their partners for only 6 to 12 months, while almost half (47%) had been with their partner for more than four years. Only 32% of men had no biological children and, among the 64 participants who previously fathered children, the average number of children was 2.7.

Desires and motivations for having a child

When asked, in the questionnaire, if they wanted to have a biological child with their current partner, the majority (62%) of men said "Yes." In interviews, these participants further described the motives underlying their desires, which we grouped into three broad categories: normalization (having a child as a way to live a normal life and feel normal despite one's illness or to meet societal expectations of fatherhood); existential (finding meaning in life with a child or parenting as a way to redeem oneself and/or become the kind of person one wants to be); and altruistic (having a child to meet someone else's needs and desires, rather than one's own). Many felt unready to act on their desire until they achieved some conditions that they felt would enable them to be good parents (e.g., attaining financial stability or becoming drug free) or had some concerns alleviated (i.e., risk of HIV transmission to their partner or child). In some cases, the desire to have a child was in fact a motivation to surmount these problems or was often strong enough to overcome fears of horizontal or vertical transmission, as discussed below. Table 2 outlines the different types of desires and motivations to have children under each category with representative participant quotes.

Normalization—Many participants who wanted to have a child thought doing so was normative and socially expected of them or that it would demonstrate their virility and physical normality as adult males despite their HIV infection. Their understanding of normalcy reflected cultural ideals about adulthood, maleness, and heterosexual relationships.

Fatherhood as a social obligation and legacy: Participants' desires for children reflected a societal expectation that men should father children and leave a legacy. They conveyed that fathering a child was culturally expected of them and that the experience of being a parent should be an important part of an adult's life. They perceived it to be normative for men to desire offspring and produce children in their own image who would be their legacy. Some men also perceived a responsibility to further their family lines or "bloodlines" and to pass down their names. This desire to fulfill their role as adult men and to leave a legacy was, in some cases, felt with greater urgency because of their awareness that HIV could cut their lifespan short.

Procreation as a demonstration of virility and able-bodiedness: Becoming a parent was not only, as described above, a way to fulfill their expected social role as men, but also a demonstration of their virility. For some of these men, fathering a child was a way to feel like an able-bodied person whose sexual potency and manhood were intact despite being HIV positive. Notwithstanding concerns about transmission to their partner or child or

reinfection, the vast majority of the men who wanted children desired a biological child that they would "naturally" conceive by impregnating their partner through sexual intercourse. Many men felt that a child would not really be theirs if they turned to adoption or sperm donation. Men who never had children before also wanted to procreate in order to confirm their fertility.

Normal progression of a relationship: Participants saw having a child as an expected logical stage in the progression of their relationship. Some men said they wanted a child because they had found a partner they loved and who loved them. They believed that having a child would solidify their commitment to one another and reflect their confidence that the relationship would endure. Many men also felt that having a child with their partner would be a way to spend more time with that person, to dedicate themselves more to their relationship, and to keep improving different aspects of it. For instance, the project of raising a child together would be a motivation to resolve any conflict that could arise in the relationship. Parenting was a shared goal between partners that could make the relationship stronger and more meaningful.

Existential—Closely related to a desire for normality, many participants wanted to have a child to fill an existential void in their lives. They believed having a child would give meaning to their lives and commit them to certain life goals that would give them purpose and direction. For many, this motivation also involved either a desire to redeem themselves from past poor life choices or to prove their ability to overcome unfavorable life circumstances.

Give meaning and direction to one's life: Some men expressed wanting a child in order to find purpose in their lives. Many of them had spent their early adult lives struggling with drug addiction and/or being in and out of jail. They felt that they had finally reached a point in their lives where they were looking for more meaningful goals and felt that raising a child would provide that meaning. A few participants also said that planning to have a child would motivate them to commit to making better life choices such as remaining sober, avoiding criminal activity, being more responsible financially, and finding and maintaining employment. Having a child was viewed as arriving at a point of no return, where they would feel compelled to remain healthy, sober, employed, and generally responsible in order to take care of their family.

Redemption: As mentioned above, many participants had previously fathered children, but had not been there to raise them because of issues with substance abuse, incarceration, mental health, poverty, or homelessness. Some of these children were raised by their former partners, by relatives, or had been put into foster care. These experiences were the source of considerable guilt and regret for these men. The possibility of having a new child and raising it responsibly was perceived as a way to redeem themselves and proved they were now responsible adults. These men dreaded the idea of having another child taken away from them and wanted to do whatever was necessary to ensure that would not happen again if they had another child.

Overcome difficult family circumstances: A few participants had themselves been raised by parents who had been absent, neglectful, dysfunctional, or abusive. They wanted to have a child to show they could do better by their child than their parents had done by them and to prove that it was possible to be a good parent despite being poorly cared for or supervised as a child. Having a child would also be a way to demonstrate they had successfully overcome difficult and damaging childhood experiences, which gave them a goal to strive for in life. Many participants came from very socioeconomically disadvantaged groups and desired to elevate themselves to a lifestyle more characteristic of the working class, if not the middle class. They felt that being able to have a family and properly care for their children emotionally and financially would represent, to some extent, such an achievement.

Altruistic—Some men said that, while they themselves did not have a strong desire to have a child, they were willing to do so because other people in their lives, whom they cared about, wanted them to or would benefit from it. Some who were already fathers wanted to provide siblings for existing children. Some participants even said they wanted to oblige their children's request for a sibling. A few men said they had parents, especially mothers, who wanted the participant to give them a grandchild. Finally, a few men said that, although they themselves did not necessarily want to have a child, they were willing to do so because their female partners strongly desired a baby. Some of these men felt like they were too old to father a child or already had enough children from previous relationships; however, they were in relationships with women who were younger or had not had children and were willing to put their female partner's reproductive desires before their own. Some participants in a serodiscordant relationship said they would prefer not to have a child to avoid the risk of infecting their partner, but were with an HIV-negative woman whose desire to have a child with them was greater than her fear of becoming HIV positive.

Factors influencing willingness to act on reproductive desires

Men in our sample considered several factors when discussing their desire to have a child with their current partners. Some of these were directly related to HIV, including concerns about: horizontal transmission to an HIV-negative partner, reinfection between HIV-positive partners, vertical transmission of the virus to the child, or HIV-related health concerns limiting their ability to care for children or their longevity to raise them. Participants also considered socioeconomic and lifestyle factors (e.g., financial and housing concerns, alcohol and drug use, or history of incarceration) as well as personal and interpersonal ones (e.g., age, personal life goals, relationship status and duration, or parenting history). The factors outlined below are practical considerations that interacted with participants' desire for having children in different ways. Many factors were practical obstacles that deterred participants from having children until they were resolved; however, wanting to have a child could also be a motivation for working to surmount some obstacles. Table 3 outlines the factors discussed below with relevant quotes.

HIV-related factors

Horizontal transmission or reinfection: Some men were worried that conceiving a child would require them to have condomless intercourse. Men in serodiscordant couples knew this could result in their female partner becoming infected and then transmitting the virus to

the baby, while those in seroconcordant couples worried that either partner could be reinfected with a different strain of HIV. Some men in serodiscordant relationships did not want their partner to take the risk of becoming infected with HIV for fear that, if she did, as the illness progressed, she might become debilitated and unable to raise a child. Most participants who had heard of sperm washing or in-vitro fertilization did not consider them viable options as they were cost prohibitive. Some of these men also feared that reinfection of themselves or their partners could hasten the progression of the disease and compromise their ability to care for a child.

Vertical transmission: The vast majority of the men expressed concerns that a child they conceived could be born with HIV. Relating to their own experience of being HIV positive, participants did not wish for their children to have to go to doctors' appointments and take medications, which were particularly salient concerns among some participants who had been infected perinatally. Concerns about vertical transmission were, of course, more salient among men in a relationship with HIV-positive women while those in serodiscordant relationships were most concerned about horizontal transmission. As with horizontal transmission, there was a range of perspectives on preventing vertical transmission. A few presumed there were no ways to prevent their child being born with HIV and, as a result, felt discouraged from having a child. Most participants had heard that a pregnant woman could take medication to prevent transmission to an unborn child, but there was considerable variation in how much they believed in this method's efficacy. Many participants believed no method to prevent transmission could be foolproof and, despite doctor's reassurances, thought that there could always be a chance, albeit a very slim one, that the child would be born with HIV. Finally, some participants were confident, based on their own experiences or those of people around them, that they could conceive a child who would be uninfected. Since they came from populations with a high prevalence of HIV, many participants knew other HIV-positive people who had had children born without the virus, or had themselves had a child born uninfected despite their (and sometimes their partner) being infected when they conceived that child.

HIV illness and longevity: Being HIV positive raised concerns in some men that they might not live long enough to raise their children. Men described different milestones in the lives of their children that they wanted to witness (e.g., high school or college graduation, getting married, etc.), but feared they might not live long enough to do so. Some also worried that being sick might restrict them from engaging in activities that they felt fathers should do with their kids (e.g., outdoors activities or playing sports). Some men also said they would find it daunting to explain their HIV disease to a child, including explaining how they had acquired it and having to warn them that they could pass away suddenly. In the case of men in seroconcordant couples, these concerns were more pressing considering that their children could potentially lose both parents to HIV-related complications.

Viral suppression and overall health: Some men felt they were not currently healthy enough or did not have their HIV under sufficient control to be ready to attempt conception. In many cases, desiring to have a child was motivating these men to make health-promoting changes in their behavior, for example, getting on antiretroviral medication and/or adhering

to it. In the case of serodiscordant couples, attaining and maintaining an undetectable viral load would reduce the risk of transmitting HIV to their partner, which would then also protect the child they wanted to conceive. Treatment adherence would also improve their CD4 cell count, which, in combination with other behavioral changes such as refraining from drug use, would improve their overall health. Before conceiving, these participants thus wanted to make sure that they would be healthy and well-functioning parents who could be active with their children and who would live long enough to raise them.

Factors other than HIV

Finances and housing: As noted above, most participants in our sample were very socioeconomically disadvantaged. When asked why they would want to have a child or not, worries about financial and housing stability often seemed to be more prominent deterrents than concerns directly related to their illness. Many of the men expressed that they would want to have a child in the future, but only after they had improved the material conditions of their life. Some participants lived in the shelter system while those who had their own apartments often found them unsuitable to raising a child because they were too small or shared with other people. Some men felt it was essential to have their own place with enough space to raise a family before conceiving a child. Many also had very little income that often came from their own or their partners' HIV-related or other public-assistance benefits, which they felt was insufficient to provide adequately for a child. Finding stable employment was often a condition they had set for themselves before considering conceiving a child.

Drug and alcohol problems: Factors related to their past lifestyle choices and low socioeconomic status also influenced men's willingness to have a child. Many participants and/or their partners had dealt with alcohol and drug abuse at different points in their lives and they understood that an ongoing addiction would hinder their ability to be good parents. Many had been in and out of recovery programs and, although not currently using drugs, wanted a longer period of abstinence for themselves and/or their partners before attempting to have children. A few participants indicated they did not currently desire children because working on their alcoholism or addiction problem was presently their priority. Some who wanted children said their partner refused to conceive with them until they stopped using drugs or alcohol and committed to staying off them.

Issues with criminal justice system: Many participants and their partners also had a history of incarceration and had been in jail a number of times, in some cases until quite recently. In many instances, the acts that had led to their arrest had been part of an attempt to provide for themselves and survive on the streets (e.g., shoplifting, petty theft, prostitution, selling drugs). Some participants and their partners had outstanding issues with the criminal justice system that they felt needed to be resolved before planning to have a child. Many participants had previously conceived children that they had not been able to raise because they had been incarcerated or dealing with substance abuse problems. In quite a few cases, their children had been lost "to the system" (i.e., foster care) or custodial family members. It was thus particularly important to them to resolve these issues before planning to have another child so that they could be present and responsible parents.

Life course and relationship: Participants' willingness to have a child was in some cases influenced by where they were in their life course. Some of the younger ones simply felt like it was too early for them to have children and needed more time to settle into adulthood before doing so. Some participants had only been with their partners for a short time and wanted to wait until they felt confident that their relationship was stable and would endure before having children. A few men and/or their partners did not want to conceive a child until they had been formally married either because marriage symbolized to them a commitment to a lasting relationship or because they held religious or moral values against having children out of wedlock. Some men said that it was ultimately a woman's decision to have a child or not because she would be the one carrying it and, in the case of men in a relationship with an HIV-negative woman, the one putting herself at risk. Other men said they really wanted a child, but cited their partner's current unwillingness to have one as the reason why they were not currently trying to conceive.

Discussion

This study sought to provide a thorough understanding of the reproductive desires of HIV-positive men in the US. Prior research on the topic has largely focused on women while the studies that looked at men mostly originated from resource-poor countries and/or used small convenience samples. Collecting data from a relatively large (n=94) sample of HIV-positive men in metropolitan NYC allowed us to portray a broader and more nuanced picture of these men's reproductive desires while providing knowledge that is specific to the social conditions of HIV-positive people in the US. Restricting eligibility to men who had been in a relationship for at least six months with a woman of reproductive age allowed us to explore reproductive desires among participants who often had discussed the possibility of having children with their partner. Thus, men's discussions of their reproductive desires and considerations were not merely hypothetical or aspirational, as they might have been in studies that included single men.

We found that the majority of our participants wanted to have a child with their current partner and that HIV transmission, although a concern, did not deter most of them, which is consistent with prior studies with HIV-positive men in heterosexual relationships [14]. Our non-directive approach to interviewing allowed men to describe their reasons for wanting children in their own way, and we found that their reproductive desires could be grouped in three categories: a desire for normalization (based on societal expectations and cultural ideals about what a "normal," HIV-free life should be); an existential desire (to give meaning to their life or elevate themselves above prior life conditions); and an altruistic desire (to fulfill the desires of other people in their lives). When discussing reproductive desires, participants also mentioned conditions or circumstances they wanted to be in place before trying to conceive. Because of our use of unstructured questions, participants could bring up the concerns that were most salient to them, and we found that many did not directly relate to HIV but instead to factors associated with their socioeconomic conditions. In some cases, these factors deterred participants from acting on their reproductive desires, at least at the moment, while, in other cases, their desire for a child could motivate participants to surmount these deterrents.

For some participants, being able to conceive and parent a child was grounded in a desire to live a “normal” life, as if uninfected with HIV. Several studies in diverse sociocultural contexts [20,21,24,26–28] also found that HIV-positive people wanted children because it would make them feel normal. Participants in our study did not want HIV to prevent them from fulfilling the societal expectation of becoming a parent or to hamper what they thought was the normal progression of a relationship. Similarly, recent studies with serodiscordant couples found they wanted to try to live their relationship as they believed they would if both partners were seronegative [30], and that the HIV-positive partners felt they would not adequately fulfill their role in the relationship if they could not conceive with their partner [24,45]. Although our participants had some concerns about horizontal or vertical transmission of the virus, the desire for normality seemed to support a strong preference for having children through procreative intercourse. Our participants felt that a biological child would be more “theirs” or “in their image” than one obtained through adoption or sperm donation, sentiments other studies with HIV-positive adults have also found [22–24]. Some participants also felt that conceiving through intercourse would confirm their virility and “normal” sexual functioning, which made some uninterested in safer conception methods like sperm washing with in-vitro fertilization.

Although a few prior studies had mentioned that HIV-positive people might be deterred from having children by factors unrelated to HIV [32,33], our study allows for a more thorough understanding of the interplay between desires and other factors. Most participants desired to have children and almost all could potentially do so with their current partners; however, they enumerated various conditions or circumstances that they felt should be in place before they would act on those desires. They wanted to improve their financial and housing situation, to get off alcohol and/or drugs, or to resolve outstanding issues with the criminal justice system to ensure they would be able to care for a child properly. These conditions were important to participants, as the vast majority of them had experienced the negative effects of poverty, addiction, and criminal activity. That is, many men had been unable to raise prior children or had themselves had unstable childhood because of these issues. Such life histories were the basis for reproductive desires in the existential category, in which men wanted to raise a child properly to either redeem themselves for prior parenting issues or elevate themselves above the unfavorable circumstances of their past life. The desire for children was thus also a motivator to better one’s life by committing to stable employment and housing, by staying off alcohol and drugs, and keeping away from criminal activity.

The non–HIV-related factors we outlined here are still somewhat related to the disease as they reflect the unequal distribution of HIV/AIDS in the US across specific socioeconomic groups. For instance, HIV/AIDS prevalence is higher in the US in urban poverty areas and among people of lower socioeconomic status [46] and roughly one in five Black and Hispanic HIV-positive men in the country has been in a correctional facility [47]. As Singer argued in 1993, health and social problems are intertwined among the urban poor and “*AIDS itself emerges as an opportunistic disease*, a disease of compromised health and social conditions, a disease of poverty” (p. 937; emphasis in original) [48]. The non–illness-related considerations about childbearing mentioned by participants (i.e., poverty, drug problems, and criminal history) were not unique to people living with HIV, but they were pronounced given that they were often also the conditions that had made participants

vulnerable to exposure to HIV or hindered their ability to attend medical appointments and adhere to medications. This reiterates the importance, as argued by Singer earlier in the epidemic [48], to understand HIV-related issues in the broader context of the socioeconomic circumstances associated with them.

It is thus important for healthcare providers and other professionals working with HIV-positive men to be aware of the multiple components underlying their reproductive desires. Our participants often related their desire for having a child to meeting other goals like improving their overall health, adhering to HIV treatment, staying off alcohol and drugs, and improving their finances, which were sometimes part of broader desires for normality or redemption. Thus, when HIV-positive men mention their reproductive goals to healthcare providers, there could be an auspicious opportunity to discuss how making other behavioral changes might support that goal and protect the health of their partner and future child. Providing these men with information about safer conception methods could still be useful, but our findings suggest that many men are likely to prefer to conceive through intercourse rather than assisted reproductive methods. For these men, emphasizing the importance of treatment as prevention and/or pre-exposure prophylaxis for preventing horizontal transmission during intercourse is thus more likely to be well received. Our study also shows that U.S. HIV-positive men in relationships with women have strong desires for having children but also significant concerns about pursuing their desires. Our findings thus support the development of programs offering information or assistance for HIV-positive men in heterosexual relationships who want children.

There are limitations to this study that should be noted. Participants self-selected into the study and were willing to come to our institution to talk about their HIV status and reproductive goals in the context of their relationship. The study required that both partners be each other primary sexual partner for at least six months and be aware of their own and their partner’s serostatus. Thus, the sample may be biased toward couples who were in a stable relationship in which both partners were open with each other about their serostatus and willing to share information about their relationship with researchers. Another limitation is that the sample was limited to individuals from the NYC metropolitan area, where HIV is prevalent and resources for infected individuals are accessible. Nevertheless, to our knowledge, our study collected the largest sample of HIV-positive men in the US for a qualitative study about their reproductive desires. Further, the characteristics of HIV-positive men who have sex with women in NYC are similar to that of other major HIV/AIDS epicenters in the US. Our findings also reveal the interconnection of multiple factors in shaping HIV-positive men’s reproductive desires, which can inform further research in other locales. Finally, as viral load suppression rates are increasing in the US [49] and as PrEP has become more available, it is possible that HIV-positive men in serodiscordant relationships today are less worried about transmitting the virus to their partners during conception. Nevertheless, our study showed that participants’ reproductive desires were mostly influenced by factors unrelated to HIV, which would not be different with the advances of PrEP and HIV treatment.

In conclusion, this study provided a thorough account of the reproductive desires of U.S. HIV-positive men in stable heterosexual relationships and the different factors influencing

their decision to act on these desires or not. Findings show that HIV-related concerns are not always the most salient ones to HIV-positive people thinking about conceiving, and that a broad range of concerns related to socioeconomic conditions and lifestyle are sometimes more important. Interestingly, participants did not raise lack of support from family for their desire to conceive as a deterrent to having a child. Further research should examine to what extent HIV-infected men share their desires with family and how the reaction of relatives may influence their decision making. Future research could also look at HIV-positive people's experiences or anticipation of support or discouragement from healthcare providers regarding their reproductive goals. Longitudinal studies could also investigate how reproductive desires change at different stages of the illness and its treatment. Reproductive desires may also fluctuate with changes in health status or as relationships progress or end, which longitudinal studies would be able to demonstrate. This study shows the importance, when doing research with HIV-positive populations, of considering the broader aspect of their lives. Future research should thus cast the same broad perspective to study the reproductive desires of other specific groups affected by HIV.

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Table 1

Sample Characteristics.

Characteristics	*n* = 94	%
Age (in year; mean ± SD)	43	± 11
Race/ethnicity		
Black/non-Hispanic	53	56%
Hispanic (of any race)	38	40%
White/non-Hispanic	3	3%
Highest education level		
Less than High School	24	26%
High School/GED	44	47%
Technical degree/some college/Associate's degree	21	22%
Bachelor's degree	5	5%
Main source of income		
Job	17	18%
Public assistance	38	40%
HIV-related public benefits	34	36%
Other	5	5%
Personal income		
<$5,000	23	24%
$5,000–$9,999	34	36%
$10,000–$14,999	16	17%
$15,000–$19,999	8	9%
$20,000–$24,999	5	5%
$35,000–$49,999	5	5%
$50,000–$74,999	3	3%
Living situation		
Apartment/house	71	76%
SRO/hotel paid by welfare	11	12%
Specialized AIDS housing	8	9%
Other temporary housing	4	4%
Type of relationship with main partner (n=85)		
Wife	32	38%
Fiancée	21	25%
Girlfriend	25	29%
Other	7	8%
Duration of sexual involvement (n=85)		
6–11 months	15	18%
1–3 years	30	35%
4–6 years	21	25%
7–10 years	11	13%
>10 years	8	9%

Characteristics	*n* = 94	%
Years since HIV diagnosis (n=93)		
<1 year	3	3%
1–3 years	6	6%
4–6 years	8	9%
7–10 years	11	12%
11–15 years	16	17%
>15 years	49	53%
Most recent T-cell count		
<250	11	12%
250–500	34	36%
>500	38	40%
Does not know/does not recall	11	12%
Most recent viral load count		
<50	29	31%
50–1000	11	12%
>1000	14	15%
Does not know/does not recall	40	43%
Previously fathered children		
No	30	32%
Yes	64	68%
Mean number of biological children among 64 participants who previously had children ± SD	2.7	± 2.2
Not counting adoption, would you like to have a child with your main partner in the future? (Yes) (n=87)	54	62%

Table 2

Categories of HIV-positive men's desires for children

Normalization

Fatherhood as a social obligation and legacy.

Any man wants to leave a legacy. . . . I guess that's just a man thing, you know? Yeah that's my offspring, that's me, you know? (144: age 42, Black, seroconcordant)

I'd like to have my bloodline. . . . You know, seeing somebody in your image. . . . I could just picture myself in the future, old, watching something that I helped raise. You know? . . . It'll make me feel comfortable knowing that if I die that, you know, I left the world something—my reflection. (182: age 36, Black, seroconcordant)

Procreation as a demonstration of virility and able-bodiedness.

I want my baby inside my wife, not somebody else's. It's somebody else's sperm: it's not my baby. I want to be the biological father 100%. . . . Regardless of my HIV status, I wanted a family. I got married to have a family. You understand? Reproduce. (102: age 46, White, serodiscordant) I had wanted to get a sperm count, because I was wondering why over the past 18 years . . . nobody was coming up to me and telling me, "Yo, I'm pregnant and it's yours." (103: age 52, Black, serodiscordant)

Normal progression of a relationship.

Because I know she'd be a great mother, and, it's just the love that I, you know, that I have for her, and I believe, you know, this is what I deserve, and this is what I want, and this is what she wants. . . . And, you know, I would be a good father with our kids, and I believe she just wants to because she loves me. (163: age 49, Black, seroconcordant)

The reason I wanna have a child with her is because she would be a good mother. And it would give us an opportunity for the both of us to raise a child. Our child. (178: age 47, Hispanic, seroconcordant)

Existential

Give meaning and direction to one's life.

I'm at the age now, I feel something's missing. I feel I shortchanged myself enough. I believe in . . . a God. . . . I just feel that that's . . . the missing piece of the puzzle. I don't have any children of my own. . . . I don't know, you know, what my — really my purpose is, and if I did have a child, I would try to just be a better person for that child. (151: age 48, Black, seroconcordant)

At my age now. [Having a child] would be something to stop a whole lot of things and, you know, make my life complete. At this age I am now, it would make me real happy to see a little lady in my world. . . . It would give me something more to really live for, to care for. You know? It would make me more stronger. I think it would make me more stronger. (106: age 55, Black, serodiscordant)

Redemption.

I wouldn't mind having another child if I was able to keep that child home with me and not . . . have something go wrong and my kids be taken away. . . . My kids from my second relationship, the city took. . . . I always wanted to just, you know, have my kids or, you know, that shows the world, you know, I'm not a bad father. (101: age 27, Black, serodiscordant)

Well actually it [not having raised his daughter] makes me want to have more. . . . Because it's something that I missed out on and I wanted to see what it was, you know, I want to have that experience. . . . I'm a good person, you know, and I'm good with kids, even. (119: age 45, Hispanic, serodiscordant)

Overcome difficult family circumstances.

Because I wanted to give love that I don't think I received from my mother and — or definitely didn't get from my father and still don't get from my father. (140: age 45, Black, seroconcordant)

It's like I don't wanna be like my father. My father made kids everywhere and he doesn't care. . . . Being there. What my father didn't do for me, I would wanna do it for him, you know? I mean taking care of his, you know, schooling and future, you know. Planning for his future and everything. (169: age 50, Hispanic, seroconcordant)

Altruistic

Give a sibling to another child

My daughter—I only got one, one daughter. . . . We trying for the boy. You know, for my daughter could have a brother. (105: age 30, Hispanic, serodiscordant)

Her [his partner's] daughter said she can't wait to have a little sister or little brother. So I guess that's sign that they [his partner's family] gonna receive the baby with open arms also. (178: age 47, Hispanic, seroconcordant)

For the partner who wants a child.

Sometimes things are done because of the partner. Sometimes you, in reality, for you, you don't want it but, you know what, you accept it because your partner wants it. So, you know, it's about pleasing your partner. (120: age 49, Hispanic, serodiscordant)

She's enthusiastic about it. She's the one that's always, unlike me, . . . she wants to be a mother. She wants to be a mother. I mean, she never got a chance really to raise her other two boys, you know, and it's like, you know, she missed that. . . . And then, she starts to get sad 'cause, you know, she wants a child of her own. (151: age 48, Black, seroconcordant)

For family (parents)

Because my mom get on my case about having a child every day, “I want a grandson! I want a grandson! . . . You can have — I want a grandson!” . . . Like, it’s taking too long or something. . . . I know it’s her right to want a grandchild. (182: age 36, Black, seroconcordant)

My mother is harping on me already about “I’m not gonna have no grandchildren!” (136: age 31, White, serodiscordant)

Table 3

Factors influencing HIV-positive men's willingness to have a child

HIV-related factors

Horizontal transmission or reinfection.

They give it [medication] to the mother . . . so when the baby come out it won't have the virus. . . . [But] I am worried about it [horizontal transmission] because I know she's taking a big risk for me [by getting pregnant]. . . . It's messed up. The mother still got the virus but the baby don't have it. You understand what I'm saying? Come on, it's still her health. (106: age 55, Black, serodiscordant)

Most important that she can become sick and then not even be able to take care of the child, you know? So, I mean, if you have the child and you can't take care it 'cause you're sick, and then, what are you going to do with the child? You know, then what we going to do? See, then that becomes a problem and that's a stress and that's something that, you know, I'm really, really trying to prevent. (119: age 45, Hispanic, serodiscordant)

We've been . . . trying to know what our options will be when the time comes as far as, like, the sperm washing we've been reading into. . . . Every now and then we'll just go online real quick and just, like, look who does them and how much it is and cost is probably gonna be a big factor. . . . I mean just trying to figure out you, like, how much it's gonna cost essentially just to get pregnant first of all. (121: age 24, Black, serodiscordant)

Like I might give her a strain where the medication she's taking might stop working. . . . She might get resistant, too, you know? I've heard of the strain− The double strain. (138: age 41, Hispanic, seroconcordant)

Vertical transmission.

The doctors give — make me feel there's a 50/50 chance these days. . . . Now it's proven that—if you give a woman that medication during the pregnancy—that the baby will not come out infected. But there's always a chance. . . . There's always that chance. (169: age 50, Hispanic, seroconcordant)

I wouldn't want my son or daughter to have to go through the process of taking medicine, and the process of when they actually get older and they have relationships, they have to tell their partners. 'Cause all that stuff, I went through, and I know it's not easy, so I wouldn't want them to go through the same thing. (192: age 20, Hispanic, perinatally infected, serodiscordant) From what I read and what I learned from being HIV positive, there have been some women that have slept with HIV-positive men and have gotten pregnant where their children came out with no virus. . . . So them scenarios and stuff like that always gives me a positive outlook on things because I believe, if it can happen for them, it's a possibility that it can happen for us. (112: age 38, Hispanic, serodiscordant)

HIV illness and longevity.

One day you have to say, "look, I'm this and that." That'd be hard to tell. . . . The fear of not being there for your kid. . . . You wanna see your kid go to high school. Grow, graduate. So but my being the virus, it's like you count on the days. (138: age 41, Hispanic, seroconcordant) 'Cause you're gonna have to explain to him that one day you're not gonna be around and he's not gonna really understand. . . . It's usually a little young for him, but you gotta try to get him to understand that, you know, "one day you might wake up and I'll – I seriously might not be here." Not because of old age, it's because of something totally different so. (154: age 32, Black, seroconcordant)

Viral suppression and overall health.

'Cause it's gonna be certain things that we gonna have to do in order for her to get impregnated. And there's certain things that I'm gonna have to start doing myself, which is, I'm gonna have to start taking medication. She's gonna have to start taking medications during and after the pregnancy. . . . That's because being that my sperm is going inside her I have to make sure that I'm healthy enough and my T-cell count is healthy enough and my viral's undetectable where so she won't get re-infected. And the baby doesn't get infected. (178: age 47, Hispanic, seroconcordant)

It came on a conversation [with] a female doctor and, like, she thought it would be a nice idea but she was talking about . . . we gotta get off the [illicit] drugs, we got to get healthy, you know? . . . She's seen the improvement that I went through so that's why she's for it now. She said, "I can see that you really wanna do this," you know. "So, I wanna try to help you." (146: age 42, Hispanic, seroconcordant)

Factors other than HIV

Financial stability.

Yeah, I would like to have a child with her. Yeah. . . . I have to have a job to support. That's most important. To support the child. I wouldn't mind if it's sick or not, but mostly it's support. . . . Give it everything it needs. (156: age 40, Black, seroconcordant)

Well, first of all, um, I gotta really, really look for a good job to support these kids, okay? Right with the little bit of money that I got, it's just enough to feed 'em. When she eats, the babies eat, you know, um, plus, it's too much hassle. Too much work, you know? Taking care of them, buying them clothes when they need it, buying 'em shoes, buying food, you know, taking 'em out. That's a lot of money. (173: age 48, Hispanic, seroconcordant)

Housing stability.

But we just ain't ready yet. . . . I need an apartment. I want to get all my family back together, you understand? . . . Until I get situated again, you know, be able to set up the baby's room, paint the room, get the crib ready, it's a lot of work, clothing, you know. . . . Because we're not ready. See, I'm living in one room. Me, her, and two cats. (102: age 46, White, serodiscordant) Make sure that we have a place. I mean actual number one have your own place you know. I mean havin' a kid livin' with family or someplace else, it's just not right for me. I want to have my own, you know, a house or bedroom, condominium anything you know. Not no shelter, you know, not no shelter. You know 'cuz you know I want my baby to have their own room, you know? (144: age 42, Black, seroconcordant)

Drug and alcohol problems.

I always told her I wanted another one [child]. . . . My drug use, my running around in the streets, . . . since my drug use, my wife was like, "Well, you, get yourself together before we have a baby." Yeah, she wants to have my baby, but I need to get myself situated. (118: age 30, Hispanic, serodiscordant)

We have housing. We have food. We have clothing . . . Just a little drug problem, but apart from that, . . . everything's in order, basically. Just that one thing that's in the way, . . . drugs. When you have a child you can't be getting high. (123: age 39, Black, serodiscordant)

Issues with criminal justice system.

We've talked about it [adoption] but that's about it. . . . Because of our history, . . . she had her kids taken away from her and, you know what I mean, and I've been to prison. . . . It wouldn't be realistic for us. (165: age 52, Black, seroconcordant)

I wish I could change our situation. . . . We can build a bigger foundation for us; us and the kids. . . . In my case, . . . I know for a fact I just have to stop smoking cigarettes and, you know, going to jail man. (175: age 46, Black, seroconcordant)

Life course and relationship.

I mean just I'm not ready for kids yet. You know, I'm young. . . . So, I'm not ready for kids yet. . . . I'll wait 'til the time. (135: age 20, Hispanic, serodiscordant)

I think we would have to work harder on our communication skills, 'cause we're gonna need good communication skills with the baby too. . . . We're a little stressed all the time, so. (192: age 20, Black Hispanic, perinatally infected, serodiscordant)

Of course, if I want a kid, . . . but there's a right time and a place for it. . . . She watches all these baby shows. . . . But, you know, later. . . . I wanna be settled down together and then think about it, but I'm open to, you know, sperm washing or whatever techniques. (190: age 27, Hispanic, perinatally infected, serodiscordant)

I would like to, but that decision is hers. . . . We can discuss it, but the final decision is hers. . . . I can't really tell her to have the baby. . . . I can ask, but then I have to take into consideration her age, and the fact that she's going to be HIV-positive, we're going to raise a baby that's, you know, after 18 months is going to be negative. But the thing is that it's her decision whether or not she wants to have that child. . . . I can't tell her to have that baby. (103: age 52, Black, serodiscordant)

I want another one. . . . She don't think it's the time. . . . We had a little disagreement on it. . . . She was like, "Look Baby. Look where we at." . . . You know, we're in a nursing home. . . . I wasn't even thinking. . . . She's more stronger and open minded than I am. . . . And thinks more clearly than me. . . . The possibility of, you know, the baby might be infected, you know, she thought about all of it. (144: age 42, Black, seroconcordant)