INTRODUCTION

Sub-Saharan Africa is the center of the global HIV epidemic with nearly two-thirds of those living with HIV/AIDS residing in this region. Sixty percent of people infected with HIV in sub-Saharan Africa are women in their reproductive years, accounting for over 12 million women (UNAIDS, 2008). About three-quarters of the estimated 3.28 million pregnant women infected with HIV who give birth each year live in this region; where most of the annual 700,000 new infections of HIV in children occur (UNAIDS, 2008).

There is a growing recognition of the reproductive decisions faced by HIV-infected women and men worldwide. Previous research existing on fertility intentions of HIV-infected couples in sub-Saharan Africa shows considerable diversity in perspectives on future fertility intentions. However, due to the increased emphasis on highly-active antiretroviral therapy (HAART), the prevention of vertical HIV transmission and other health care services for HIV-infected women and men in sub-Saharan Africa, the major influences on reproductive decisions among HIV-infected couples are not well-understood and studies on this topic have demonstrated inconsistent, often contradictory, results (Myer et al., 2005; Harries et al., 2007; Kaida et al., 2011).

METHODS

This paper reports on the results of a qualitative investigation among HIV positive, married couples in Nyanza Province, Kenya. The Nyanza Province has among the highest HIV prevalence in Kenya; it is estimated that between 15-21% of the population is HIV positive, the highest in the country (Kenya's national HIV prevalence is 6.7%) (Kenya Ministry of Health, 2005) The study's overall objective was to investigate perspectives of couple decision-making and relationship power around fertility and family planning among HIV-infected and affected men and women. Individual, semi-structured, in-depth interviews were conducted among 25 married, HIV sero-concordant heterosexual couples from June-September 2010. Each male and female partner was interviewed separately but simultaneously by local, trained interviewers matched to the sex of the respondent. The main objective of this paper was to learn more about the impact of HIV on infected couples' fertility intentions and the main factors influencing fertility decision-making following an HIV diagnosis.

RESULTS

SMALLER FAMILY PREFERENCES

After learning that they were infected with HIV, many couples reported they had altered their fertility plans and had decided to have fewer children than they would have preferred. One 20 year old mother of one child who was HIV-positive desired one more child now although she had not intended to limit her family size before learning of her HIV status: *"before I realized that I am infected with the Virus, I was thinking that we should just have children, if God allows we should just have children."* One 47 year old father of six children said that he said he previously had never considered contraception because he hoped to have as

many children as possible, *"before she had the Virus, she would just give birth until one day God willed that she would stop giving birth. I just wanted children….those days I desired to have many of them and it is God who did not put them the way I wanted them… but my desire was to have many of them ."*

Large family size preferences were common but HIV appeared to change the landscape of fertility norms. In the context of HIV, having at least one child, especially a son who could carry on the family name and inherit the family land, was paramount. One 36 year old father of three said *"I see that we can have a future if we have children, given that we will die later on since both of us are already HIV positive. Yes, our children will go on with our family name even after we have died so that is one of the things that can make me have the desire to talk with my wife about having children."* Another 37 year old mother of four seemed to struggle with her desire to have a male heir with her belief she should stop childbearing: *"As for me, in my heart I wanted to stop giving birth but another part of my heart was telling me that I still don't have a male child. I recently gave birth to a child who died. Now I am seeing that I should just try and if God accepts, I give birth again and then I can stop…. I feel that I should just give birth to only that one…"*

CONCERNS OF DEATH & CHILD WELFARE

Many participants explained that they had contemplated the likelihood of their own early deaths, as well as the possible death of their currently living children and any future children. While they might not have given much thought to fertility before HIV became a factor, decisions about preferred family size, contraceptive use and overall fertility goals were now given careful consideration and reflection. For some, the fear of child death, due to HIV or other factors, led them to decide to stop childbearing all together. However, the possibility of child death compelled others to desire more children to compensate for the likelihood of child loss. For example, one 35 year old father of four who had two wives and two children that had died said *"…in this world you cannot be certain because sometimes God, the bad luck of death may fall on you and you remain without any…having many of them is good you can remain with some."*

Concerns of the future welfare of children also influenced fertility decisions. Couples worried they would not be able to take care of an HIV-infected child, especially given their own poor health status. For example, a 35 year old father of four said *"given my current status I feel that having a child may cause me a lot of problems…..I may have that child but then the child turns out to be positive so this will come with the problem of caring for the baby."* Another 35 year old father of four living children, who had two children that had died, described how his uncertain future compelled him to use family planning: *"… I am still young and I don't know what is in store for me in the future. But with my current condition, I have to plan my family because I can have a child who is infected and I may die leaving the child with the infection. That is very bad because there may be very few people who are willing to take care of that child.*"

Some participants also specifically discussed how HAART influenced them to consider having more children because they were more likely to believe they would survive to see their children grow up. For

example, one 24 year old mother of one girl said that she was planning to have at least two more children. When asked about how HIV had changed her fertility plans, she spoke of her hopes for the future: *"this medicine has helped my life and it has made me to feel free… I am happy because the medication has given me a better life. It has changed my mind that I can give birth and that my child can be without the Virus if I take the baby to the clinic."*

MOTHER-TO-CHILD TRANSMISSION

Another major concern for many participants was the fear of vertical HIV transmission; the possibility of having an infected baby was enough to convince some couples to stop having children. There was a considerable lack of awareness about how to prevent mother-to-child transmission (MTCT). Even among those who were aware of the measures to prevent MTCT, they were not confident that they would be successful and many felt that the risk was too great. One 25 year old mother of two said that she was not planning to have additional children. "*I know that when one is infected with the HIV Virus, …there are certain processes that one should go through and it should be at an early age, but it also fifty-fifty. You can go though all those processes but the baby ends up being born with the Virus."*

Couples receiving MTCT prevention counselling were more likely to believe it was possible to have healthy children. One 45 year old father of ten said they had decided to have another child after receiving counselling at the clinic: *"This has changed my mind greatly…I think I have the knowledge, that even if my wife gives birth, it's not a must that she give birth to an infected baby. The baby could be born negative."* In contrast, some couples who had a baby that was HIV-negative planned to stop childbearing because they feared that if they had another child, they might not be as fortunate next time. They did not want to tempt fate. One 24 year old mother of four children said: "*Well, once I had known and was told that I have it, I felt that there was no need of adding more children because God had protected these ones and they escaped without getting the infection, I feel that if I add another, he or she can be infected…"*

COMMUNITY STIGMA

Many participants discussed the stigma associated with HIV positive couples having children. They talked about how people in their communities did not believe that HIV positive women should have children because it was assumed that the baby would be born infected. A 32 year old father of one son explained: *"…the community members think that when they give birth to children, these women will die; when they die they will leave their family members with the hard work of feeding the orphans. So they feel that when one is infected with the HIV Virus, life ends like that, that one should just rest with the disease and die when her dying time is due."*

WIFE DEFERENCE TO HUSBAND

The threat of infidelity, divorce, and potential lack of financial support plagued many women. Disagreement about fertility intentions created considerable anxiety for the wives, who often felt obligated to comply with the wishes of their husbands, whether or not they personally agreed. One 28 year old mother of three explained that although she was afraid of having a baby who would be HIV positive, she would accept the final decision of her husband, who wanted more children: *"I am thinking that the three children I have are enough… If he [my husband] wants then I can just add because I cannot deny him. He is the one who is taking care of me."*

DISCUSSION & CONCLUSIONS

The fertility intentions of HIV-positive individuals are driven by both individual preferences, and societal and cultural expectations. HIV influenced couples' fertility decisions in several ways. As found in other studies, HIV both promoted childbearing in some couples while reduced the desire and intention to have children in most others (Cooper et al., 2007).While most couples planned to have fewer children than they had originally hoped for, many were conflicted because of their own personal desires for children, and the cultural norms which placed a high value on large families. Although it is common for African women to defer to their husbands in reproductive decision-making, HIV has amplified male power and authority (Ezeh 1993; Dodoo et al. 1997; Wolff et al., 2000; Shattuck et al., 2011). Decisions to stop childbearing were influenced by the potential of early death, fears of future child welfare, vertical HIV transmission, gender roles, and economic instability. In addition, stigma and discrimination associated with HIV and childbearing deterred some couples from future childbearing. However, counselling programs in the prevention of MTCT convinced others that they could have healthy babies. Furthermore, the availability of HAART gave some couples hope that they could have more children because of the possibility of living longer, healthier lives, which also influenced childbearing intentions.

The recognition of the reproductive rights of all couples, regardless of HIV status, should be emphasized. While HIV contributes to some couples' intentions to stop childbearing, many others express the desire to continue childbearing. However, the universal promotion of contraception is unlikely to meet the varying needs of HIV-infected couples. Information regarding the prevention of MTCT can help allay couples' fears of vertical transmission. Additionally, the findings suggest that these couples did not have sufficient information to make informed fertility decisions. A more supportive environment is required to assist all HIV-infected couples in achieving their fertility goals, especially among HIV sero-discordant couples. Providers could play a crucial role in relaying accurate health information. Finally, the findings underscore the need to de-stigmatize HIV and childbearing. Community-level programs are needed to dispel myths that a large proportion of HIV-positive women will give birth to infected babies, and reduce widespread stigma associated with childbearing among HIV-positive women. One approach would be to engage community leaders to help bring awareness and education around these issues to their communities.

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