

Full Length Research Paper

Re-marriage decisions among people living with HIV in rural Southern Malawi

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This study explores re-marriage decisions of people living with human immunodeficiency virus (HIV) in matrilineal Chiradzulu and patrilineal Chikhwawa communities in Malawi. Specifically, it analyzes reasons and circumstances that come into play as they re-consider marriage relationships. Data were collected from July to December, 2010 using in-depth interviews from eighteen informants purposively sampled and was analyzed using content analysis method. Findings show four main issues; irrespective of kinship organization and despite resistance from kin, women decide to re-marry for financial support while men for physical care and emotional support. In the absence of widow inheritance, widows from patrilineal communities are not receiving the expected support from the deceased husband's relatives leading them to seek support through re-marriage. New marriages in patrilineal communities are supported through traditional marriage formalities. Suggesting that decisions to re-marry are influenced by socio-economic factors. Therefore, we recommend cultural sensitive health programmes embedded in these local realities that accept people living with HIV to re-marry and continue to access prevention of mother to child transmission of HIV and antiretroviral therapy services without reprisal.

Key words: Malawi, decisions, human immunodeficiency virus (HIV), reproductive health, kinship, marriage.

INTRODUCTION

In the early years of the human immunodeficiency virus (HIV) epidemic, little attention was given to the reproductive decisions among people living with HIV (PLWH), because of the risk of mortality and a few options to reduce mother to child transmission. Recently, however, HIV-related morbidity, mortality, and mother to child transmission of HIV during pregnancy, delivery and in the newborn are declining, because of antiretroviral therapy (ARV/ART) (Chasela et al., 2010; Kredo et al., 2009). HIV infection may now be considered a chronic illness because the ARVs suppress HIV replication resulting in

resulting in increased CD4 cell count, delayed clinical progression of acquired immune deficiency syndrome (AIDS) and prolonged survival (Volberding and Deeks, 2010). Consequently, evidence emerging from research in developing countries indicates that ART may encourage PLWH receiving treatment to reconsider their reproductive decisions including getting married and having children (Nattabi et al., 2009).

Earlier studies in Malawi (Chirwa and Chizimba, 2009) and Uganda (Mukiza-Gapere and Ntozi, 1995) indicate that marriage practices have changed due to factors not

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not limited to HIV and AIDS only. Social-economic changes such as high cost of living, high unemployment rates, intermarriages, education and modern religion have also affected marriage practices. Similarly, studies on the impact of the AIDS epidemic on marriages (Boerma et al., 2002; Caldwell, 1997; Floyd et al., 2008; Mukiza-Gapere and Ntozi, 1995; Kaler, 2004; Reniers, 2008; Schatz, 2005; Oleke et al., 2005) indicate that the epidemic has exerted a downward pressure on probabilities of re-marriages after either widowhood or divorce. In addition, HIV-infection has created fear of marriage as such some people refuse to marry for fear of finding 'death in marriage', possibility of spreading HIV to new spouses, re-infecting each other or transmitting HIV to a child in case they decide to have children. Stigmatization due to AIDS or suspicion of infidelity in case of widowhood, separation and divorce is high because the primary means of HIV transmission in sub-Saharan Africa remains heterosexual intercourse. Finally, HIV and AIDS reduce the attractability of widows of all ages (Oleke et al., 2005).

However, recently, de Walque and Kline (2012), indicate that re-married PLWH are likely to engage in behaviour typically associated with married couples, such as regular intercourse and infrequent condom use. Furthermore, since there is increased likelihood of one or both partners being HIV-positive, the re-married are a significant conduit for spreading HIV. Therefore, with the wide access of ART in developing countries and recent change of behaviour among PLWH, there is need for current information on the impact of HIV on re-marriages.

Nevertheless, there is a surprising paucity of literature on the reasons and circumstances for re-marriage (refers to couples that were married at some point in the past and decide to marry again) of PLWH. Existing studies focus mainly on: women (Agot et al., 2010; Boileau et al., 2009; Edwards et al., 2011); HIV-risk and separation, divorced or widowed (Lopman et al., 2009; Mermin et al., 2008; Boileau et al., 2009; Reniers, 2008); and re-marriage relating to religion and traditions (Muula, 2010; Trinitapoli and Regnerus, 2006). However, they did not consider the influence that the variation in kinship organisation (patrilineal and matrilineal) and gender might have on re-marriage decisions.

This paper therefore explores re-marriage decisions among PLWH who decided to marry when they were HIV positive in matrilineal and patrilineal communities. Specifically, it analyses reasons and circumstances that come into play as they re-consider marriage relationships. This paper extends research on impact of HIV and AIDS on reproductive decisions. However, it is limited to people who are living in rural Malawi where marital roles are distinct and limited to homemaking and subsistence farming.

METHODOLOGY

A qualitative approach was opted because the focus area has little

existing research based knowledge. In addition, the area has sensitive, emotive and personal topics that could be captured fully through careful probing which lies at the core of the qualitative in-depth interview (Morse and Richards, 2007). The research questions required a greater depth of response capturing the meaning attached to re-marriage decisions in rural matrilineal and patrilineal communities.

Study setting

Informants were recruited from antiretroviral therapy clinics involved in the treatment and care of PLWH at two health centres in Southern Malawi. In Chikhwawa, informants were recruited from the Ngabu Rural Hospital and in Chiradzulu, from the Ndunde Health Centre. The two centres offer inpatient and outpatient HIV and AIDS treatment using multidisciplinary teams, and serve primarily low-income individuals from diverse backgrounds (National Statistical Office [NSO], 2010).

In Chikhwawa, kinship, marriage is organised according to patrilineal descent and virilocal residence, so that the transfer of traditionally cattle, but nowadays money (*lobola*) from the husband to the bride's family legitimizes marriage leading to the move of the woman from her natal household to her husband's compound after marriage. In these compounds, men are related by patrilineal descent and the children become members of the father's descent group. This practice places a married woman in a position of dependence on her affinal kin, especially her mother-in-law. In Chiradzulu, on the other hand, the pattern is matrilineal descent and uxorilocal residence, that is, men leave their natal household to live in their wives' compound after marriage (Chimbiri, 2007), hence creating compounds where children become members of the mother's descent group. The man depends on his wife's kin for land and residence (Peters, 1997).

The interviews were conducted in the clinics from July to December, 2010. The sites were opted for because they receive patients from more remote villages, and are located away from trading centres and main roads that attract people whose origins are elsewhere. The informants came from areas surrounding these health facilities and the average time to and from their villages to the hospital ranged from one hour to three hours on foot.

Data collection

Data for this study was from a larger qualitative study that explored reproductive decisions of twenty couples living with HIV in two rural settings of matrilineal Chiradzulu and patrilineal Chikhwawa in Southern Malawi. Informants were recruited upon receipt of permission to conduct the study following ethical approval in Malawi (Kamuzu College of Nursing College Research Publications Committee and University of Malawi College of Medicine Research Ethics Committee (COMREC)) and Norway (Regional Committees for Medical Research Ethics (REK)). From the twenty couples in the main study, nine concordant couples living with HIV (CLWH) were recruited using purposive sampling, which implies a selection of participants due to their characteristics and knowledge of the research topic (Morse and Richards, 2007). The strategy used for purposefully selecting the informants was 'Maximum variation sampling', which implies conscious selection of informants with emphasis on variation of characteristics within the agreed upon inclusion criteria. Patton (2002) indicates that 'maximum variation sampling' aims at capturing and describing the central themes that cut across a great deal of participants. In the main study, variation was achieved through age, level of education, occupation, years living with HIV, number of children and length in a marriage union. This sampling technique enabled the researcher to select informants with diversity regarding socioeconomic status, education,

length of marriage and number of years living with HIV. In this study, the selection criteria was HIV-positive (concordant couples) in monogamous marriage relationship, had re-married when they were living with HIV, aware of their own HIV status and their current spouses' before they got married, had information about each other's HIV status as a couple and were in the reproductive age group of 18 to 49 years (NSO, 2010).

Three months were spent in each of the two study settings. This prolonged engagement, in addition to the researcher's fluency in Chichewa, enabled an in-depth understanding of expressed beliefs, fears, expectations, dominant ideas, and values of the informants related to re-marriage (Emerson et al., 1995). Practical access to the antiretroviral therapy clinics was gained through collaboration with the clinic co-ordinators. In both sites, the antiretroviral therapy clinic co-ordinators identified a contact person with whom the researcher discussed the study thoroughly.

A pilot study to test the data collection tool was done at Chiradzulu and Chikhwawa district hospitals during the researcher's orientation period to the study sites. Through piloting, we discovered that when the informants were being interviewed as a couple, one spouse did most of the talking. In Chiradzulu the men were dominating discussions about general issues, that is, support in the family, decisions to seek help while the women were dominating on issues of cultural practices pertaining to reproductive health. In Chikhwawa, the males were dominating the entire discussion, and assumed an heir of authority. In both study sites, the only areas that the women were discussing freely were issues that dealt with hospital antenatal care. As a result, the selection of informants was couples as units but the empirical analysis was at an individual-level.

People living with HIV were approached while waiting for their monthly check-up at the two study sites. Information about the research was given to the patients at the antiretroviral therapy clinic in two phases. First as part of the general briefing (health talk) that all clients received in an open area before the check-up begins and secondly as a private conversation with the contact person. Couples living with HIV, who indicated willingness to take part in the study, met the researcher who then asked them a few questions to determine eligibility. Those eligible were accorded an appointment for an interview. Informants gave an oral consent, which was tape-recorded. The informants that consented were assured of confidentiality, and were informed that they were free to quit if they wished. During the research activity, all the informants were given transport reimbursements of \$2 and snacks were provided.

In-depths interviews were conducted in vernacular language. In-depth interviews were opted for because they allowed room to explore issues deeper, and are interactive in nature thereby enabling clarification of issues during the interview. In addition, they allowed further probing and modification of interview guides in the course of the study (Morse and Richards, 2007). The guide comprised a section on demographic characteristics. It also had an outline of topics with open-ended questions covering reasons, challenges and sources of information for their decisions among other areas.

The guide was carefully translated from English to Chichewa. An independent translator verified the quality of translation: who translated it back into the original language. Original and back-translated documents were then compared for consistency by the interviewer. Informants were interviewed independently from their partners, but on the same day to enable free expression of feelings and views. After one spouse was interviewed, he/she had to wait until the other spouse was interviewed in order to correct discrepant information. Most of the discrepancies were on the areas of number of pregnancies and children and use of family planning method. The in-depth interviews were carried out within the area of the ART clinic in offices or outside under trees where comfort and confidentiality was guaranteed. The interviews lasted between 50 minutes to 2½ hours.

Data analysis

The general principles and procedures for qualitative data content analysis as summarized by Graneheim and Lundman (2004), were used. The content of the interview text was from a larger study that was exploring reproductive decisions of CLWH. The interviews were read through several times to obtain a sense of the whole. Then the texts about re-marriages were extracted which constituted the unit of analysis. The texts were then divided into condensed meaning units, which were later labelled with a code. In this study, we consider a meaning unit as words, sentences or paragraphs containing aspects related to each other through their content and context. In order to ensure inter-rater consistency, once the coding team independently analysed each transcript, tentative categories of the codes were discussed between the researchers who initially did the coding independently. When the coding was compared, a few differences were observed. These were discussed and the transcripts were re-analysed resulting into fine-tuning of the coding and interpretations. Once the codes were agreed upon, the underlying meaning of the different categories of the codes was formulated into sub themes and the main theme. All the data from digitally-recorded in-depths interviews that was transcribed verbatim were typed. NVIVO version 9 was used to analyze and organize the data.

The interviews revealed several themes, which were highly inter-related, thus could naturally be located under any of the themes. Subsequently, the presentation was nonetheless chosen as the best way to guide the reader through the informants' elicitation. The results that follow present the most common themes expressed by the informants.

RESULTS

Characteristics of the informants

The participants for the study comprised 18 informants who re-married after death of their spouse or divorce and their ages ranged from 29 to 46 years with a mean age of 36 years. Ten informants (three from the matrilineal and eight from the patrilineal communities) had been living with HIV for less than five years. Five informants from matrilineal and two from patrilineal communities had been living with HIV for more than five years. All informants reported that they were in a monogamous relationship. They were living in either the wives or husbands' natal compounds depending on kinship organisation. Two female informants (one from each community) had no formal education at all. Sixteen informants had some schooling; 12 (four from the matrilineal and eight from the patrilineal community) had completed primary education while the other four (three from the matrilineal and one from the patrilineal community) had completed secondary school education (Form 4). Fourteen informants were subsistence farmers with small gardens and were without any other source of income. Only four male informants had formal jobs. All of the informants reported that they were Christians.

Further attributes on marriage status of the informants are summarised in Table 1. The results show that most of the informants' earlier marriage(s) ended because of either divorce or widowhood.

Table 1. Information on marriage.

| Characteristic | Matrilineal | Patrilineal |
|---|--------------------|--------------------|
| Number of informants in | | |
| 2 nd marriage | 8 | 9 |
| 3 rd marriage | 0 | 1 |
| Marital status before current marriage | | |
| Divorced women | 3 | 3 |
| Divorced men | 3 | 2 |
| Widow | 1 | 2 |
| Widower | 1 | 3 |
| Mean time (year) lapse for re-marriage following | | |
| Divorce | 1 | 2 |
| Death of spouse | 2 | 1 |

Reasons for re-marrying and challenges

The purpose of the study was to explore re-marriage decisions among PLWH who re-married when they were HIV-positive in matrilineal and patrilineal communities. Despite negative reactions, on their re-marriage decisions after divorce or death of spouse, from their kin and health workers, they ended up re-marrying. Reasons for re-marriages varied according to gender and kinship organisation.

Financial/material support

Irrespective of kinship organisations, female informants reported that they re-married because they could not support their children from their previous marriages as single mothers following divorce or the death of their spouses. They were all unemployed and relied on their local gardens for produce. One female informant from the matrilineal community eloquently captured this theme by stating the following:

“My former husband had a chain of girlfriends. It reached a point that he never would give me money for household necessities. We discussed over it with our counsellors and I made my mind that I was ready for divorce, which I did against his wishes. Following the divorce, I continued staying here with my four children and took the responsibility of caring for all my four siblings because by then our parents had passed away and I was the oldest child. I kept on farming and I started a business, selling samosas in order to buy soap, and other necessities. It was tough and was determined to re-marry to ease the burden off me.”

Confirming the wife's narrations, the husband in his separate interview indicated:

“We used to stay close to each other and I was staying by myself following divorce. I could see that she was struggling and was leading a very miserable life. She was shouldering all the responsibility on her own; none of her late husband's relatives was helping her. Furthermore, she lost both parents and she was married to a certain man who was mistreating her. They divorced and still struggled although she was doing some small scale business.”

Another couple from the patrilineal community in their separate interviews shared this view regarding a similar experience:

“To be honest I needed financial assistance with my children and my late sister's children who passed away and left behind 4 children, 1 of the children stays with my parents and I stay with 3 because their father also passed away. Unfortunately, my late sister's husband only has an old mother and her husband died some time back. My husband and I provide all the support to them. At least my husband has animals that are a source of income from the family.”

The husband had this to say:

“She used to suffer with the children before I re-married her. Her children [from a previous marriage] stay with her at my home village including her sisters' children. I do not think she can let them go because of some hardships (poverty) at her home village. I have goats, cattle and chickens which are my main source of income.”

In addition, the female informants from the patrilineal community explained that following the death of their spouse or divorce, they were unable to stay at their marital home and were forced to go back to live with their parents and brothers. They explained that despite the

expected norm for the children to remain at their late husband's home compound, the residence depend on availability of resources [human, financial and material] from the parents-in-law. Some women stated that they were asked to take their children along, thus placing them in a difficult economic situation. A 35 year-old woman from a patrilineal community who was now in her second marriage with no child, but currently staying with her three children from her previous marriage narrated:

"When my husband died, they [her late husband's parents] told me that they could not afford to take care of neither me nor my children. Knowing that I could not stay alone like that with the children, I decided to accept their marriage proposal."

Another woman from the same community echoed similar experience:

"My late husband passed away after suffering for a long time with leg sores and I had 2 children with him who currently stay with me because when my husband passed away, I was informed by his [late husband] relatives that I should go back to my home village but I left the children behind. However, after some months my in-laws complained that they could not take care of the children because they were very young and one of them used to be ill frequently. Therefore, I have been staying with the children with no support [financial / material] from their fathers relatives."

The socio-economic situation comes over as crucial. Regardless of the women living in a patrilineal or matrilineal community, their families were unable to support them due to poverty. This necessitated for a male partner who could offer financial and material support and they re-married outside of the family and not a relative of their deceased spouse.

Physical care

The male informants said that although their current health status was fine they dreaded their future needs for care from a spouse once they develop AIDS. Informants who had once been sick after divorce or death of their spouse expressed how their female relatives had to take care of them. They further explained that even though cultural norms indicate that female relatives are responsible for the bulk of the caring responsibility, in situations where a man is sick, the wife is supposed to take up this responsibility. A man from a matrilineal community said:

"But I told her [his mother] that I know the consequences of the problem [HIV] that I have but I needed someone to be taking care of me."

A man from a patrilineal community also expressed

similar sentiments:

"Since the death of my first wife, I never re-married so throughout the time that I was sick, it was my mother and sisters who were taking care of me. When I recovered I decided to get married to avoid a similar situation."

Independent of kinship organisation, the burden of care is expressed to be too heavy to be placed on female relatives. Hence, re-marriage is found to be the best solution.

Emotional support

The male informants explained further that they established new marriage relationships following death of a spouse or divorce in order to have a bond with someone. They narrated that when they were alone they felt that the absence of a spouse was the worst experience they ever had. Men in the matrilineal communities expressed how they were lacking emotional support after both their children and wife left.

Man from matrilineal community:

"I went to explain to my uncle and told him that; 'Since my first wife died I am lonely. Although I stay with my parents, I still need a wife. Moreover, all my children are at my late wife's relatives. I stay alone in my house. I have found a woman in Chiradzulu whom I feel I can be staying with."

While the men in the patrilineal communities indicated that although they had their children and relatives around, they needed someone to intimately share their life. They indicated in their separate interviews that their wives were their confidantes in issues related to HIV and AIDS.

Man from patrilineal community:

"Yes all my children from my previous marriage were still with me but I needed someone to be taking care of me. Apart from that, it will be easy for us to follow the counseling advice that they give us and we can live longer. It is only your wife that you can share intimately your concerns about our situation [HIV-positive status]."

Childbearing

In addition to financial and economic reasons for re-marrying, a matrilineal couple and two patrilineal informants explained that they had re-married in order to have children after divorce due to inability to conceive.

Woman from patrilineal community:

"I am not his first wife, they divorced and afterwards we

married. He told me that he divorced because they could not have a gift [child].’ I was also divorced in my first marriage because I never had a child. When I came to him, luck was with me and I finally had a child. At least I have one child.”

Man from patrilineal community:

“We were not able to have a child with my first wife so my relatives insisted that; ‘May be both of you have been bewitched.’ I Divorce her and re-marry another woman.’ I used to say to myself, ‘If only I had a chance to have just one child, my heart would have been at peace. I divorced her and re-married and I have 4 children.”

Societal expectation

The male informants, regardless of their kinship backgrounds, indicated societal expectation as a reason for re-marrying. They explained that independent of HIV status, an adult but unmarried man is viewed as irresponsible and selfish in their societies as the following narratives demonstrate (Men from a matrilineal community):

“It is because of our traditions.it is a big problem to the extent that others will not look at me as a person. They will be pointing fingers at me. I did not want to be living as a bachelor, as a young boy, no I had to re-marry”

“I was demeaned by some people that I was not a man; others said I was a selfish man who does not want to share his resources with others. As such, I decided that I should not be staying alone, yes I had relatives but they could not look after my day to day needs because they were all married.”

Nevertheless, some informants from the matrilineal community, who decided to re-marry, never had a formal engagement. This group’s views can be summed up by a male informant who said:

“The problem is that they just leave us on our own and they say, ‘Just leave them, they will know what to do themselves this is not their first marriage.”

Unlike their counterparts from the matrilineal community, PLWH who decided to remarry in patrilineal community were accorded all the marriage formalities. *Luphato*, a gift, a wrapper and money, given to a girl/woman from her boyfriend as a sign of marriage proposal, which is shown to parents. *Chifunukura mulomo* which is money given to girl by her boyfriend to initiate discussion of marriage proposal. *Maonano* also money, but given to a girl’s parents from the boy’s parent but for initiating the

first marriage discussions and *lobola*, bride price. It was during these marriage ceremonies that parents and kin from both sides discussed issues of HIV-positive status. However, all the informants from the patrilineal community indicated that they married outside of the family and not a relative of their deceased spouse.

When asked about their experiences with the community and hospital pertaining to their re-marriage decisions, majority of informants reported negative experiences. Several informants explained how re-marriage in PLWH would induce talk in the community. For example, one female informant said,

“They [community] talk behind your back and ridicule you. They say we are just fast tracking AIDS by re-marrying.”

The hospital was not even a safe net as they were cited as their harshest critics especially during health talks. Many informants spoke about the common jokes that health workers would make about re-marrying: ‘bomb’, *‘kuika nankafumbwe mu chimanga’* [placing weevils in dry shelled maize]. They explained that the jokes are hurtful and prevent them from asking for guidance and seeking information about re-marrying.

DISCUSSION

Floyd et al. (2008) and Schatz (2005), argue that the presence of high HIV prevalence was creating a general fear of marriage, often expressed as a fear of finding ‘death in marriage’ (Desgrées and Coleman, 2005). Similarly, Reneirs (2008), in Malawi, and Oleke et al. (2005), in Uganda, show that HIV has reduced the re-marriage of widows because of the suspicion that their former husbands might have died from AIDS. However, with wide access of ARV’s in developing countries PLWH continue to establish new marriage relationships (Kredo et al., 2009; Nattabi et al., 2009). Consequently, there is need for current information on the impact of HIV on re-marriages. The purpose of the paper is therefore to explore re-marriage decisions among PLWH in matrilineal and patrilineal communities focusing on those who re-married when they were HIV positive. This study extends research on impacts of HIV on reproduction decisions by exploring factors that drive PLWH to re-marry after divorce or deaths of their spouse. It is also an individual-level analysis of the decision of re-marrying, reflecting gender differences.

Firstly, the findings revealed that informants decide to re-marry mainly for economic, physical and emotional support. Specifically, women irrespective of kinship organisation, re-married for economic support. Consistent with results of previous studies that showed that women, whose main gender role in a marriage is house making have a greater economic incentive to re-marry than men because they have lower earnings power in the labour

market and their economic status often deteriorates following marital dissolution (Holden and Smock, 1991). Consequently, the findings suggest that women understand the effects of their financial constraints and lack of access to resources on them and their children and decide to re-marry consistent with findings reported in Kenya (Sarna et al., 2009) and Uganda (Seeley et al., 2009).

On the other hand, men re-marry for physical and emotional support irrespective of kinship organisation. This finding supports earlier work by Bernard (1972), who argued that men and women experience marriage in different ways. "His" marriage is thought to provide men with practical and emotional support, whereas "Her" marriage has been described as burdening women with homemaking and care giving responsibilities. This suggests that care remains a burden placed on women. Furthermore, the findings suggest that that even though ARV's are available, men are still concerned about the potential risks for deteriorating health and the possibility of not living long enough to raise the children.

The foregoing means that men depend on their spouses for care and homemaking tasks consistent with observations made by Carr (2004) and Hirsh et al. (2009), and that they tend to rely exclusively on their wives for emotional intimacy and have few other sources of emotional support consistent with findings reported by Dykstra and de Jong Gierveld (2001). The main reason is that men tend to have few confidantes other than their spouses, whereas women tend to have larger and more emotionally intimate friendship networks than men (Antonucci and Akiyama, 2004).

Secondly, the findings revealed that the widows were not welcome to remain in their deceased husband's compound due to economic reasons. This comes despite expectations that widows in patrilineal kinship communities would remain in their deceased husband's compound, where one of the relatives, either a brother or a cousin, is expected to inherit the widow and take care of her and the children. In addition, the in-laws were unable to take care of the children and the widow. This may suggest that interventions against widow inheritance in the presence of HIV and AIDS are modifying society behaviour consistent with Agot et al. (2010), Ambasa-Shisanya (2007), in Kenya and Ntozi (1997), in Uganda. On the other hand, widows in matrilineal kinship communities stay with their children, kin, and access farmland belonging to their natal compound. However, they still face economic hardships without a husband, because his contribution with work on the farm and income generating is essential to the proper upbringing of the children and other household activities (Peters, 1997). Irrespective of kinship organisation, widows were unable to provide basic necessities for their children leading them to re-marry with a view to surviving now rather than leaving their children to die of hunger (Ambasa-Shisanya, 2007).

Thirdly, the findings suggest that informants from patrilineal communities received social support through traditional marriage formalities that the community organized probably driven by the fact that a bride price had to be paid even in a second marriage. On the other hand, there were no formal marriage formalities arranged for informants re-marrying in matrilineal communities. Although, social support from friends and kin demonstrated in this paper among the patrilineal community may influence the establishment of the re-marriage relationship, the close relationships may obstruct the formation of a romantic relationship. Older children may disapprove or try to monitor the behaviour of a bereaved parent who is starting to date (Moore and Stratton, 2001). However, such a comprehensive discussion is beyond the remit of the present discussion since all the informants that re-married had children below 18 years of age.

Finally, the findings suggest that expectations from the society influenced informant's decisions to re-marry. Some decided to re-marry because they were unable to conceive children in their previous marriage. Since childless is stigmatized in most societies (Runganga et al., 2001), some decided to re-marry in search for a child. Additionally, it was perceived to be socially unacceptable, economically unviable and emotionally constraining for an adult male to remain unmarried irrespective of kinship organization. The reason is that marriage is a normative social status in sub-Sahara Africa and that the societies are what could be called 'totally a married society' (Rhine, 2009) with the unmarried adults, being ridiculed as barren, prostitutes, or selfish. Hence, following separation or death of a spouse, people are likely to re-marry regardless of their HIV status (Gregory et al., 2007; Reneirs, 2008).

The analysis of the four reasons governing re-marrying decisions among PLWH might be framed in the Sallis and Owen (2002) socio-ecological model, which emphasizes the dynamic interaction between an individual and the environment. The model recognizes that, where individuals are responsible for instituting and maintaining life style changes necessary to reduce risk and improve health, individual behaviour is influenced by factors at different levels (Elder et al., 2007). In this paper, we have shown that informants gave various reasons for re-marrying which could fall under three levels: individual for support (economic, physical and emotional), community because of established norms values and societal.

This empirical work has a limitation because informants were not interviewed when they were considering to get married but some time after they re-married. As a result, they might have rationalized the reasons for their behaviour. However, despite the limitation, this study highlights important public health issues pertaining to re-marriage decisions of PLWH that warrant attention. In addition, it gives rich in depth insights into the lives and experiences of a growing segment of the population of

Malawi PLWH.

Conclusion

This study explored re-marriage decisions among CLWH in matrilineal and patrilineal communities focusing on CLWH who re-married when they were HIV positive. Specifically, it analyzed reasons and circumstances that come into play as CLWH re-consider marriage relationships. Stories of hardship after divorce or death of a spouse were common in the narratives of the informants. However, the problems and hardships differed, reflecting the different values and benefits brought to a relationship by men and women. The findings suggest that women decide to re-marry for financial support while men re-marry for physical care and emotional support irrespective of kinship organization. Furthermore, in the absence of widow inheritance, the findings suggest that widows from patrilineal communities are not receiving the expected support from the deceased husband relatives leading them to seek support from elsewhere through re-marriage. Nevertheless, the new marriages of PLWH in patrilineal communities were supported through traditional marriage formalities. Finally, the results suggest that decisions to re-marry were influenced by social expectations: individuals failing to conceive re-married in search of children while men re-married because it was expected that an adult male should be in a marriage. This study extends research on impacts of HIV/AIDS on reproductive decisions by exploring factors that drive PLWH to re-marry after divorce or deaths of their spouse. However, this study was limited to individuals who re-married while HIV-positive and living in rural areas where marital roles are distinct and limited to homemaking and subsistence farming.

RECOMMENDATIONS

The study shows that the informants re-marry after divorce or death of a spouse for financial, physical and emotional support. The reasons depend on gender, economical status and kinship organisation. Furthermore, we are aware that re-married individuals may be faithful, but they are certainly not going to abstain, and they are unlikely to use condoms (de Walque and Kline, 2012), thereby raising biomedical concerns about the risk of HIV super-infection, viral recombination and transmission of drug-resistant virus in cases where unprotected sex is practised. If no intervention is put in place, Malawi's maternal and infant mortality due to HIV will continue to be high; at the same time derailing the current achievements in HIV and AIDS. Therefore, in addition to HIV prevention information, we recommend a cultural sensitive health programme embedded in these local realities that accept PLWH to re-marry and continue to access prevention of mother to child transmission of HIV (PMTCT) and ART

services without reprisal.

In order to improve the quality of life and the health of PLWH, we cannot solely focus on the individual, but must also focus on the local community and society as a whole. Therefore, policy makers, programme designers and implementers should not just focus on the individual but take into account the family and community in which the individual exist and do everything possible to help PLWH achieve their sexual and reproductive aspirations. Such interventions can only be done through collaborative partnerships that involve community leaders, health providers, and PLWH.

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