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## Dialectics of gender and health: the case of HIV serodiscordance

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**Abstract** The relationship between gender and health is a deeply interdependent one. Yet research in this area has focused primarily on how gender relations determine health behaviour and health outcomes. This article advocates a more holistic approach that conceptualises gender and health as fully intertwined and mutually constitutive. This interplay is explored through the case of HIV serodiscordance in which one person in a relationship is HIV positive and the other HIV negative. Drawing on in-depth research with discordant couples in urban Uganda, this study indicates that living with discordance can both reinforce and challenge normative gender power dynamics in relationships. This study, therefore, illustrates how significant health problems can influence gender relations. As such, it reveals the dialectical relationship between gender and health and also provides important insights for HIV prevention in the new era of antiretroviral treatment as prevention.

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In the last two decades our understanding of how gender relations affect health has advanced considerably. However, much less attention has been given to the ways in which health, and especially illness, can in turn affect gender relations. This study uses the case of HIV serodiscordance, where one person in a relationship is HIV positive and the other HIV negative, to examine how gender and health are intertwined. This study allows us to explore both how gender relations shape health risks, such as HIV infection, and how living with HIV then influences gender dynamics in intimate relationships. As such, it provides a way of thinking about the interrelationship of gender and health more holistically.

This focus on serodiscordant relationships also has timely implications for HIV prevention. Recent studies have indicated there are dramatic reductions in new HIV infections in serodiscordant relationships when the HIV-positive individual receives antiretroviral therapy (Anglemyer *et al.* 2011). Relationship dynamics play a key role in the success of such interventions. However, there is limited research on how discordance alters gender power relations. This article addresses these pressing empirical issues while providing a more complete conceptual understanding of what I refer to here as the dialectics of gender and health.

### The interrelationship of gender and health

Although much research on gender disparities in health remains rooted in problematic notions of gender differences as static and fixed, critical examinations of gender and health have

increasingly been informed by an understanding of gender as a dynamic social structure (Springer *et al.* 2012). Such research conceptualises gender as a multidimensional structure of embodied social relations that encompasses material, discursive and affective relations and operates on cognitive, interpersonal and institutional levels (Connell 2009, Risman 2011). Central to this framework is an emphasis on how gender identities and norms are continually reproduced in historically specific ways. Gender as a social structure is an aspect of social reproduction more generally that both shapes, and is shaped by, other social processes (Connell 2009).

A well-developed aspect of the study of gender relations and health is research examining how everyday social interaction links gender and health. Drawing on West and Zimmerman's (1987) notion of doing gender, this literature has shown that the routine ways we do gender are deeply intertwined with health behaviour, health self-perceptions and illness itself. An early contribution is Saltonstall's (1993) examination of how men and women account for their own good health. Gender played a key role in how individuals constructed their bodies as healthy and differences in health activities were strongly 'influenced by social norms related to gender' such that 'the doing of health is a form of doing gender' (Saltonstall 1993: 12).

This insight is echoed in much of the gender and health literature, from research examining how doing gender affects misperceptions of women's heart problems (Emslie *et al.* 2001), women's treatment for cosmetic surgery (Dull and West 1991) and young women's sexual health (Jewkes *et al.* 2005). There is also a growing body of research focused on how doing masculinity affects the health of men and women. This research reveals the largely, but not exclusively, deleterious health behaviour associated with enacting normative masculinity ideals (O'Brien *et al.* 2005, Oliffe 2006, Springer and Mouzon 2011, Williams 2000).

Yet Saltonstall's conceptualisation of gender and health is important in another, less well-acknowledged way. Her framework implies not a simple, one-way causal arrow from gender to health but instead presents gender and health as mutually constitutive. For Saltonstall, health actions are 'social acts' that are a form of 'practice which construct the subject in the same way that other social and cultural activities do' (1993: 12). Her research revealed that health practices were not wholly determined by gender relations but instead 'gender was emergent in health doings' and such health actions were how the self as gendered was constructed (Saltonstall 1993: 12).

There is, therefore, a dynamic interplay between doing health and doing gender. Normative gender relations shape ideas of appropriate health behaviour, and health practices play an important role in producing gendered social relations. This intertwining of gender and health is implied in other conceptualisations, including Courtenay's (2000) influential theory of masculinity and health. For Courtenay, health actions are not simply a manifestation of gender relations but are in fact a means of constructing gender, such that 'health behaviour and beliefs that people adopt simultaneously define and enact representations of gender' (Courtenay, 2000: 1388, see also Williams 2000: 395). This tight coupling of doing health and doing gender underscores a more fundamental issue raised by Connell, namely that health and gender are both about bodies and embodiment and we 'cannot logically treat gender as an independent variable and health status as a dependent variable' (2012: 1678).

While the interconnection between gender and health is suggested in these frameworks, empirical research has largely examined how doing gender determines health behaviour and outcomes. The other part of the dialectic has received relatively scant attention, even though the literature provides examples of how changes in health behaviour can challenge, undermine or subvert normative ways of doing gender. Saltonstall, for example, notes in passing how some women who adopted health behaviour perceived as masculine explicitly 'regarded their health actions as challenges to existing gender norms' (1993: 12). In their review of female-

controlled HIV/sexually transmitted disease protection methods (such as the female condom), Mantell *et al.* conclude that 'female-initiated methods could contribute to shifting the state of gender relations' (2006: 2005).

Studies of men and masculinity provide additional evidence that health crises can catalyse alternatives to dominant, hegemonic masculine ideals. Emslie *et al.* found that a minority of men coped with their depression by resisting 'culturally dominant definitions of masculinity' and 'explicitly reflected on different models of masculinity' (2006: 2246). Another study of a group of young men found that the death of a peer prompted a shift in the group's attitudes such that 'each man's thinking about what it meant to be masculine was adjusted and, eventually, served to reconfigure the group's new norms' (Creighton and Oliffe 2010: 415). Additional examples highlight the complex ways serious health issues result in reassessments of masculinity, with men rejecting certain hegemonic ideals while relying on others to cope with illness (O'Brien *et al.* 2005, Oliffe 2006).

Such findings underscore the need to examine explicitly how gender and health are intertwined and mutually constitutive. This is a crucial extension of gender relations theory in health because it foregrounds the way in which gender as a social structure continually interacts with other social forces. This perspective further undermines notions of gender (and sex) difference as a fixed binary and provides an avenue for exploring how doing health can be both doing and *undoing* gender. As Deutsch has noted, West and Zimmerman's (1987) notion of doing gender has become a theory about the persistence of gender inequality 'despite its revolutionary potential for illuminating how to dismantle the gender system' (2007: 106). Deutsch calls for greater attention to the potential of human agency to undo gender in everyday social interaction. Health practices and behaviour, I would argue, are especially rich domains in which to observe such undoings.

This study focuses on the case of HIV serodiscordance and builds on a growing literature on discordant relationships, especially research examining the interplay between gender, living with HIV and relationship power dynamics (Bunnell *et al.* 2005, Davis and Flowers 2011, Orengo-Aguayo and Perez-Jimenez 2009, Persson and Richards 2008, Stevens and Galvao 2007). Serodiscordance allows us to explore key questions related to the dialectics of gender and health. Under what conditions can an illness subvert or challenge normative gender relations? Does doing health differently have the same potential to undo both femininity and masculinity? Answering such questions allows us to grasp more fully the dialectics of gender and health and the potential that new ways of doing health have for undoing gender.

## Context and methods

Research for this article was conducted in Kampala, the capital of Uganda. As a country noted for its success in reducing HIV prevalence in the 1990s, Uganda is an important setting in which to examine the interplay between AIDS and gender relations. Current epidemiological trends in Uganda, as well as several other African countries, suggest that most new HIV infections are occurring within long-term relationships, especially serodiscordant ones (Uganda AIDS Commission and UNAIDS 2009). In addition, preliminary results from the most recent AIDS survey indicate that national HIV prevalence may have risen from 6.4 per cent in 2004 to 7.3 per cent in 2011 (Uganda Ministry of Health 2012). These trends make understanding the interpersonal dynamics of serodiscordant relationships a pressing concern for HIV prevention.

Kampala is located in the southern part of Uganda, in home of the Baganda people, and nearly all this study's participants were Baganda. Historically, the Baganda have been

primarily patrilineal and patrilineal, with polygyny associated with male status. In contrast, female monogamy was strictly enforced through social sanctions and this remains largely true today. Thus, while women's agency among the Baganda has been and remains significant, established gender relations today have strong patriarchal aspects and within intimate relationships men are largely seen as the ultimate authorities.

In contemporary urban Uganda several forces are at work reconfiguring these established gender power relations. Chronic male underemployment, women's increasing education and participation in the workforce, and the institutionalisation of women's rights have all challenged notions of innate male authority (Wyrod 2008). In addition, ideas of proper sexual behaviour for men and women are being reworked by ideas of romantic love and companionate marriage, as well as by the many HIV prevention interventions. It is in this complex and dynamic context that discordant couples cope with living with HIV.

### *Methods*

This article incorporates data collected from a broader study of changing gender power dynamics in intimate relationships in urban Uganda. In 2009 I conducted 3 months of research with cohabiting couples living in Kawempe Division of Kampala, Uganda. Because formal marriage was uncommon, couples were defined as a man and woman who described themselves as married and had cohabited for at least 6 months. Couples were recruited with the goal of creating a diverse sample based on age, relationship type (monogamous and polygynous), religion, education, income, HIV serostatus, woman's work status and partner age difference. This article focuses on couples that are in HIV serodiscordant relationships.

With the assistance of two local research assistants I identified couples appropriate for the study and continued approaching prospective participants until sufficient sample diversity was attained. Recruitment of HIV-positive participants required the additional assistance of the nurses and counsellors at the local health clinic. My prior research at this clinic facilitated this process and ensured that the HIV status of these participants had been verified within the past 6 months.

The fieldwork research combined in-depth interviews with all couples and ethnographic observation in the homes and workplaces of half the couples. The formal interview protocol began with an interview with the husband and wife together (conducted twice for polygynous couples). These interviews were deliberately short (30 minutes) and focused on basic background information to minimise the chance this initial interview would dictate what participants discussed in the individual interviews. At a later time (typically 2 days later), interviews with individuals alone were conducted. These interviews were significantly more intensive, lasting between 1.5 and 3 hours. As the findings presented below indicate, informative and insightful discrepancies between couple and individual interviews can emerge through this interview method.

The interviews were conducted with the assistance of two research assistants, one man and one woman. Both were Baganda and fluent in Luganda (the language of the Baganda) and English. I was present for all interviews with the couple together and approximately three-quarters of the individual interviews. The female research assistant often, but not always, conducted the individual interviews with women. All interviews were conducted in the homes of the participants. Approximately 80 per cent of the interviews were conducted in Luganda and the remainder in English. Prior Luganda language training allowed me to participate in the Luganda interviews. All interviews were recorded and transcribed, with transcription and translation provided by a native Luganda speaker for all interviews in Luganda.

The interviews focused on three areas: (i) the nature of intimate relationships, including notions of ideal partners, proper husbands and wives, and trust; (ii) power dynamics within

relationships, including attitudes toward women's rights and detailed descriptions of decision-making; and (iii) sexuality and HIV/AIDS, including ideas of proper sexual behaviour and challenges of living with HIV/AIDS.

Data were analysed using a thematic analysis approach. During the fieldwork an initial summary of each couple was drafted by the research team after the couple completed the entire interview protocol. After the fieldwork, a detailed couple narrative was constructed from close readings of, firstly, the interview of the couple together, then the man's interview and then the woman's interview. Close attention was paid to points of convergence and divergence in these three interviews. This narrative was supplemented by any observational data from the fieldwork and then compared to the initial couple summary created by the research team in the field. Polygynous couples required an additional round of analysis comparing the relationships between the husband and each wife.

The final stage of analysis involved grouping the serodiscordant couples based on whether the man or the woman was HIV positive. Comparisons were made both within and across these two categories. Special attention was paid to how living with discordance affected gender power dynamics in these relationships and the implications for HIV prevention.

A total of 19 couples (40 individuals) participated in the study, including two polygynous couples in which the man was cohabiting separately with two different women (all three individuals in the polygynous relationship were counted as one couple). Seven of the 19 couples were serodiscordant, including one of the polygynous couples. In five of the seven couples the man was HIV positive and in two the woman was HIV positive. These seven discordant couples are the focus of this article. This is a small, non-random sample, yet the fine-grained, experience-rich data on living with discordance generated by this study are unusual.

## Findings

In order to present the dynamics of gender and health in serodiscordant couples in some detail, this article presents data on four of the seven discordant couples who participated in the study. While all seven couples generated rich material for analysis, these four couples encompass the range of interpersonal dynamics revealed by this study.

A summary of key background characteristics for these four couples is presented in Table 1. Most of the couples were struggling financially, some quite seriously, but two were significantly better off. Unless noted otherwise, all the couples were married informally and had not had any formal introduction ceremony or wedding.

To illuminate the dialectics of gender and health, key findings are presented here in two parts. Firstly, data on how the HIV-positive person in each couple became infected is briefly outlined. The aim is illustrate how gender relations affected the ways these men and women were vulnerable to HIV infection. Secondly, a more detailed analysis of how living with HIV serodiscordance affected the gender power dynamics in these relationships is presented.

### *The effect of gender relations on vulnerability to HIV infection*

Couple A had discovered they were discordant only 1 month before they were interviewed. The husband had decided the couple should test when the wife was several months pregnant and it was then the wife discovered she was HIV positive. She suspected her infection had occurred in a prior relationship in 2005 when she was 16 and still living in her village. She described the relationship as a youthful love affair with a schoolboy her own age that lasted for about a year. The relationship ended when she moved to Kampala and she claimed she did not have another sexual relationship until she met her current husband. Thus, it was her one

Table 1: *Background characteristics of serodiscordant couples*

	<i>Age</i>	<i>Education</i>	<i>Occupation</i>	<i>Monthly income (\$)</i>
Woman HIV positive				
Couple A				
Man	23	Primary 5	Motorcycle taxi	30
Woman	21	Primary 7	Housewife	0
Couple B				
Man	26	University degree	Accountant	200
Woman	25	Studying for degree	School teacher	150
Man HIV positive				
Couple C				
Man	50	Primary 6	Casual labourer	50
Woman	42	Primary 5	Sells from home	5
Couple D				
Man	52	Primary 7	Auto parts trader	300
Woman 1	46	Secondary 4	Sells from home	20
Woman 2	45	Primary 6	Sells from home	10

prior sexual relationship that she believed was the cause of HIV infection. Her husband was adamant that he had used condoms in his prior relationships and the wife said she was inclined to believe that his recent negative HIV test was correct.

Couple B had known about their discordance for 8 months when interviewed. Again, it was the man who encouraged the couple to test after they had been together for a year. After testing positive, the woman concluded she was infected by her one and only previous sexual partner. This previous partner was a serious boyfriend in secondary school – a man she considered marriage material. She described herself as disappointed when he ended the relationship and then deeply hurt again after testing HIV positive. When her current partner tested with her, he was HIV negative and claimed this was his very first sexual relationship, which the woman believed was the case.

In contrast, the route to HIV infection for the men in couples C and D was quite different. Couple C had been together for 20 years and this man detailed the relationships he had held with other women during this time. He openly discussed how he became infected in one of these concurrent relationships, and he took responsibility for the problems he and his current wife now faced as a discordant couple. In addition, he spoke of his fear that his current wife would leave him if he disclosed his HIV status to her. It was, in fact, a serious illness that he experienced that prompted him to finally discuss the issue with his current wife, after waiting for approximately 2 years.

The route to HIV infection for the man in Couple D was similar. This was a polygynous marriage where the man had two wives living in two different houses. This man, aged 52, had little formal education but had become wealthy from trading used auto parts. He had been with his first wife (to whom he was officially married) for 25 years and with his second wife (who he had not officially married) for 18 years. In addition, this man also had two less formal long-term relationships. He described one of these women as his third wife and said they had children together. She was HIV positive and after she died of AIDS in 2005 the man tested for the first time and learned that he too was positive. He saw himself as the innocent victim and, unlike the man in Couple C, he only reluctantly took responsibility for the problems with discordance he and his wives now faced. While both wives said they were aware of the third

wife and her HIV status, neither was informed of her illness by the husband until long after she had died of AIDS.

*The effect of HIV serodiscordance on gender relations*

I now turn to a more detailed analysis of how living with discordance affected the relationship dynamics, beginning with the two couples where the woman was HIV positive. Couple A had been together for 1 year and they had no children but the woman was pregnant. They were struggling to get by on the husband's modest income as a *bodaboda* (motorcycle taxi). Both had limited education and the woman did not work. The husband said an ideal wife was one whom he could control and he described his current wife as ideal because she was submissive, not demanding, had few expectations and was an orphan with little extended family who could interfere in their relationship. While the wife seemed content with this more conventional power dynamic, she was also intimidated by her husband who, she said, could be physically abusive.

As noted above, this couple was just coming to terms with living with serodiscordance. They were very concerned about keeping this issue private and did not want anyone to know they had spoken with me about their problem. The man said 'being sick is our secret' and was particularly worried about his family discovering his wife was HIV positive. He said he feared 'my relatives will hate her because she is sick and I am not sick'. He also noted that if he disclosed his discordant relationship his male peers would pressure him to leave his wife, saying, 'they would tell me to leave her. They think like that. They cannot be faithful and they cannot use condoms regularly'.

This man did, in fact, concede that if his wife was not pregnant he would have left her. However, he chose to ignore the family and peer pressure and stay with his wife. 'I know am the one who made her pregnant', he said, 'and when you look at her situation it is not good. She doesn't have anybody to look after her, so I shouldn't just dump her'. What most preoccupied the man, therefore, was weighing his desire to maintain his relationship with his ideal wife and future child against the complications and dangers that serodiscordance presented. After learning his wife was HIV positive, he said, 'I became sad because I thought things were very good and I had found someone who doesn't have parents ... you know, someone without a parent can withstand any situation but a woman with a parent is always thinking about going back to her parents whenever some small problem [in the relationship] happens'. For the moment, marital status trumped HIV status and the man remained committed to the relationship.

This man was actively seeking information on how to continue having sex without becoming infected and how to have uninfected children (issues that largely accounted for his willingness to participate in this study). He said in the future, if he had more money, he would 'like to stay with her but I would like also to get another child with another woman'. The wife seemed resigned to this possibility, saying, 'He often says that he is going to marry a second wife and I tell him to do so because I won't lose anything if he does'. Importantly, it was clear from the interviews that it was the man's decision to either stay in this relationship or to end it. As he phrased it:

I can stay with her if it's possible to find medicine to prevent a man from getting infected after sleeping with an infected woman. [Otherwise] I will just continue taking care of her as the mother to my child.

Couple B were facing similar challenges but differed from Couple A in many important ways. Both the man and the woman had university-level education and were earning more money than other young couples in the area. They had been together for 2 years, cohabiting on and

off, and about to take the step to live together full time. They had no children and no immediate plans to have children.

What most distinguished this couple was the strong emphasis they placed on collective decision-making. More than any other couple in this study, both the man and woman stressed the importance of making decisions, both large and small, together as a team. The man was also very supportive of the woman working and finishing her university degree. In addition, he was an outspoken supporter of women's rights, more so than his fiancée. Overall, they both described their relationship as involving very little conflict and both said they were strongly committed to each other and their future together.

Having lived with discordance for 8 months when interviewed, the woman described herself as 'very happy' and lucky to be in a relationship with such a man. Both the man and woman said they were using condoms 100 per cent of the time and, while this was not ideal, both said it was not a major issue. More than anything, the man seemed preoccupied with his fiancée's health, so much so that the woman gently complained the man was overprotective now. Overall, then, this couple appeared to be coping with this issue surprisingly well and compared to other couples, their relationship seemed uncomplicated.

Yet in his interview it was clear this man was more conflicted about this relationship. He was in fact not completely committed to staying in this relationship but instead was carefully weighing all his options. When asked if he planned to marry his fiancée, he said, 'I hope. That is a question that is actually puzzling'. Unlike the man in Couple A, this man clearly articulated how much he cared for his partner and her wellbeing but, like the other man, he too was seeking information about his options, including by participating in this study.

He and his fiancée received much support from counsellors at the local health clinic and were seen as a special case that the counsellors hoped could overcome this challenge and stay together. The woman clearly appreciated her partner and suggested that staying in this discordant relationship was not something most of his male peers would do, saying:

Someone has to have courage to do that, actually. Those who do it actually have to be courageous. Not everyone can be ... [other men] have problems with dealing with such issues, but those who are courageous, yes, they can deal with them.

The man also discussed how in the eyes of some of his male peers he could legitimately leave this relationship. When he first learned his partner was positive, he said:

I thought: should I just get rid of this person? I had friends I asked and everybody was like 'Run away. Run away for your life!' And I am like, I was hesitant ... Up to now it is a question which is puzzling me.

Having children was also part of the puzzle for this man. While he was aware drugs could help them have a HIV-negative child, he did not rule out eventually taking a second wife but only for having children, saying:

If it is for sex I would say it is wrong because somehow you might conceive this HIV from this person you are with. Aren't you then spreading it to the second person? So I think it is not okay.

At the close of the interview he made his ambivalence clear, turning to me and asking:

Would you abort the whole relationship or would you continue with it? The truth is I don't know. She is not a bad person and you cannot get someone who is 100 per cent. So if someone can give you 80 per cent of what you ever desired you take it, because when you look for the 20, you have the 80 per cent at home and you are looking for the 20 outside the home. There will be implications.

Thus, couples A and B were different in many key aspects, including their socioeconomic status and relationship dynamics. Nonetheless, both men were carefully considering their options and weighing the intimacy and social status that comes through marriage with the stigma and challenges posed by their partner's HIV status. Ultimately, the decision to continue the relationship was the man's and these men remained largely in control of their own risk of HIV infection.

*Living with discordance when the man is HIV positive*

The second set of couples (C and D) indicates how different the implications of living with discordance can be when the man, not the woman, is HIV positive. Couple C had been together for 20 years and had four children together, including the youngest, who was 4-years old. The man was a casual labourer and the woman sold produce from home, and their combined income provided only the basics for this family. This couple saw the man as the leader of the home, and while they claimed they discussed issues together, both said the man was the ultimate decision maker.

The man tested positive in 2003 and, as noted above, believed he was infected by a partner in another, more informal long-term relationship. His wife had been pregnant in the meantime and had therefore been tested for HIV and knew she was negative. Although the man was slow to disclose his status, both the husband and wife stated the man did eventually take full responsibility for bringing HIV into their relationship. When discussing this, he criticised his male peers, saying, 'That is why you still see AIDS. Because a man is not able to tell a woman that he is HIV positive. Then he keeps on loving other women.'

Living with discordance proved challenging for this couple in part because the woman did not want to use condoms, fearing they could break or provide inadequate protection. Instead, the woman demanded the couple stop having sex completely. The man agreed to this arrangement under the condition he could still have sex with the woman who infected him, as well as with another woman he also saw more casually. Thus, since 2005 this couple had abstained from sex altogether. The wife described the logistics of their relationship this way:

Wife           The good thing is that I made a gap between the two of us. He sleeps here [chair] and I sleep on the other side with my children [between us] ... I think he feels good about it.

Interviewer   Has he ever demanded sex from you?

Wife           No, because we no longer have sex together. I tell him to go and have it with his second wife or maybe the other one will be interested.

When asked why he consented to this agreement, the man primarily emphasised the need to look after their children:

I am HIV positive. I got it and my wife is HIV negative. If I spread it to her, where will this leave our children? What makes most people in Africa so sick is the worry about their children ... so if you can identify a person who can remain with your children, like their

mother, then you can be hopeful that even though you may die you have left your children with someone to care for them.

Living with discordance, therefore, provided the woman in this relationship with new leverage – leverage she used to negotiate a sexual agreement that protected her from HIV infection. While this arrangement appeared successful in this regard, the agreement had also changed the nature of their relationship. The woman was now ambivalent about the relationship, saying:

I no longer trust him ... I am no longer interested [in the marriage]. I am here just for the sake of the children. I am fed up with him.

The end of the sexual relationship was a facet of her ambivalence, and she said that, 'I do love him but the other bedroom love is now gone but I still like him'.

These changes were also evident in how the man now described the relationship. When asked if their relationship was still strong without sex, he said, 'she is now my sister'. Their agreement also remained a sensitive issue for this man and he was reluctant to discuss the logistics of their relationship, saying:

Do you know what a bedroom is? It is a place where secrets are kept. If you quarrel and if she refuses to have sex with you, you leave the bed and sleep somewhere down on the floor. But it is not a matter of shouting to inform everyone that your wife has refused to have sex with you.

Clearly, not being able to have sex with his wife was stigmatising for this man, a fact that may make maintaining this agreement over the long-term difficult. Thus, the woman in this relationship negotiated some degree of protection from HIV infection but her safety remained tenuous.

Couple D was a polygynous marriage where the man had two wives living in two different houses. The interviews indicated this man was quite controlling and he believed men were innately superior to women. The wives expressed some ambivalence about such notions of men's natural superiority, with the second wife saying, 'men should remain with such rights but if it was possible it would be better for women to be with some responsibilities'. Both wives, however, were critical of aspects of the husband's domineering behaviour. In addition, it was evident that the wives were not friendly with each other and competed for favoured wife status.

Although he agreed to participate in this study, the husband did not want his HIV status widely known, saying:

It is not good to talk about it because it is not good to say, 'So and so has this type of disease' ... you keep it as a secret.

Neither wife said she cared to discuss the husband's status with him. Both said they had forgiven him and were now focused on maintaining peace in their marriages. As the first wife said:

He didn't want to get the disease but it just happened to him so you leave it and you take it as an accident ... So that is how I changed, I am no longer getting angry ... Even if I get angry, I just go somewhere so he cannot get to know.

The second wife, however, claimed when her husband disclosed his status he feared she would divorce him. This gave the second wife new leverage which she used to get an official introduction ceremony with her husband, a major step towards a formal marriage. This woman had always resented that her husband was formally married only to the first wife and now claimed she was, in fact, the favoured wife. When asked why her husband agreed to the introduction ceremony now she said:

For me I think, according to the period we have been together, and the AIDS issue also happened. OK, first you have to get angry because of the fear but I forgave him about it and secondly about those children [from the wife who died]. I am the one who has taken care of them.

Like the woman in Couple C, this woman utilised her new leverage to obtain something that would have otherwise been difficult to negotiate. Safe sex was a concern but she also used her leverage to improve her social status by having a formal introduction ceremony.

The second wife also claimed that only after her husband disclosed he was positive was she able to get him to agree to always use condoms. Everyone in Couple D claimed to be using condoms 100 per cent of the time. However, the man was adamant that he disliked condoms, saying:

Sometimes I agree to use condoms but I hate them so much ... it makes me feel bad and I think one time I will run away from my wives, that is what I think.

The safety of the women from HIV infection, therefore, was again tenuous in this discordant relationship. It is possible the husband may eventually grow tired of using condoms and one wife may acquiesce and agree to unprotected sex to secure her status as the favoured wife.

Similar relationship dynamics were evident in two of the three additional discordant couples with HIV positive-men. In one, the woman used her new leverage to get what she most wanted, namely love and greater affection from her husband. In the other couple, the wife attempted to use her leverage to make her husband use condoms and remain monogamous. Unfortunately, unlike Couple C this proved quite difficult and the woman was contemplating leaving her husband out of frustration and to safeguard her health.

## Discussion

These discordant couples reveal how deeply gender and health are intertwined. The impact of gender relations on health is evident in how all four of the positive individuals became infected with HIV. Both women described having limited sexual experiences that largely conformed to normative expectations of proper monogamous female sexual behaviour. However, both became infected by men who either did not know, or were unwilling to disclose, their own HIV status. Their monogamy, therefore, did not protect them from HIV infection and may in fact have created in them a false sense of security about their vulnerability to infection.

For the HIV-positive men, both became infected as they too pursued sexual experiences that largely conformed to normative expectations. Entrenched notions of male sexual privilege, especially having multiple sexual partners, made these men especially vulnerable to infection, probably in ways these men themselves did not fully grasp. In addition, both had trouble disclosing their status to their wives, which too can be seen as tied to dominant notions of masculinity in this context (Wyrod 2011).

Once in discordant relationships, the experience of discordance shaped the gender power dynamics in the couples. Discordance worked to either consolidate or moderate male power, and the effect of discordance on power dynamics was primarily determined by who in the relationship was HIV positive.

When the woman was positive, the men's power was largely strengthened, although this new health problem did prompt some reassessment of certain hegemonic masculine norms by both men. They both made it clear that they felt pressure, especially from male peers, to leave their HIV-positive partners. Staying in the relationship was a challenge to this simple solution to their problems, even if the men posed such challenges privately, kept their discordant relationships secret, and were ambivalent about their path forward. It is important to underscore, however, that in both relationships the men's control over decision-making was intensified by discordance, even in Couple B who, when interviewed together, stressed their collective decision-making.

In contrast, when the man was HIV positive, both men were eager to maintain their relationships for both social status and the care and support the relationships afforded them. This resulted in the women gaining new leverage in what had been largely male-dominated relationships. This is not to suggest, however, that men's power was significantly challenged but it was moderated in important ways. In addition, this new leverage did not guarantee that these women were safe from HIV infection, and both remained more vulnerable than the men in couples A and B.

These findings resonate with other research on masculinity and health, including how subtle reworkings of masculinity emerge in response to significant new health problems (Creighton and Oliffe 2010, Emslie *et al.* 2006, O'Brien *et al.* 2005, Wyrod 2011). Shifting conceptions of appropriate male sexuality were especially evident in both of the couples where the man was HIV positive. All three women in these relationships voiced criticisms of the husband's sexual behaviour and expressed anger or resentment that their partner's sexual behaviour had brought HIV into their relationships. In turn, both men had accepted aspects of this critique to varying degrees. While neither questioned that men had a right to multiple sexual partners, they both reflected on the consequences of their actions. In the process, both men abdicated some power and control in their relationships. This was especially true of the man in Couple C who agreed to stop having sex with his wife. This couple's sexual agreement was premised on the man recognising that his wife's demand to end sexual relations and her right to some degree of sexual autonomy were legitimate and should be respected.

A useful way of framing the effect of discordance on femininity is to consider the implications for women's agency. While the agency of the HIV-positive women was constrained by discordance, it had the opposite effect for the HIV-negative women. Coming to terms with this new health problem provided a rare opportunity for women to renegotiate some of the terms of their relationships. In line with gender relations theory that posits multiple and dynamic femininities (and masculinities) in any given gender order, the renegotiations advanced by women in couples C and D were quite different. The former focused on greater sexual autonomy while the latter was intent on being publicly recognised as an official second wife who dutifully accepted her husband's authority. In this sense, acknowledgement of serodiscordance was a key moment for these women to exert agency in otherwise largely unequal relationships and diverse notions of femininity animated how they directed their agency.

### **Serodiscordance and the dialectics of gender and health**

Overall, this study indicates that a serious health issue (living with HIV discordance) did prompt changes in the gender dynamics of these relationships. These changes included (i) a degree of critical engagement with dominant masculine norms on the part of the HIV-negative

men, especially whether a man should abandon an HIV-positive partner; (ii) an opportunity for some heightened agency and control for the HIV-negative women and (iii) a willingness to accede some power in the relationship by the HIV-positive men. None of these shifts was transformative of conventional gender power dynamics and, in fact, tensions were at times resolved in ways that reinforced conventional gender roles, such as the responsible husband and the dutiful wife.

Nonetheless, the way these couples responded to a serious health issue did prompt a reassessment of their relationship dynamics and destabilised certain normative aspects of gender relations. I would not suggest that living with discordance resulted in these couples fully *undoing* gender. However, their experiences do indicate that a health crisis has the potential to change relationships dynamics, and these changes have important implications for both doing and undoing gender.

These conclusions are supported by other research on serodiscordant couples. In another study in Kampala, Bunnell *et al.* (2005) found discordance could destabilise gender norms and power dynamics. This included men refusing to abandon an HIV-positive partner and an HIV-positive man agreeing to a sexual contract with his wife that allowed her to find a new male partner provided she continued to care for her husband. Beyond Africa, research on discordant heterosexual couples in Puerto Rico also found that living with HIV prompted critical reflection on gender norms, especially among men, such that 'all men in this study expressed a need to change their traditional dominant ideals ... [and] the need to incorporate some non-traditional male gender roles' (Orengo-Aguayo and Perez-Jimenez 2009: 37).

My findings on discordance and women's agency are also supported by other related research. Stevens and Galvao (2007) found that in the USA HIV-positive women struggled and largely failed to enforce safe sex with their negative partners. In this way, discordance also worked to consolidate male power in these relationships and the authors similarly conclude that the effect of discordance on power dynamics is dictated by the partner who is positive. In addition, the new leverage that HIV-negative women gained in my study finds an interesting parallel in a study of gay Scottish couples living with discordance. Davis and Flowers (2011) describe how HIV-negative men gained an upper hand in the relationship and could use this leverage to ask for unprotected sex to prove their devotion to their partner. This resonates with the complex ways the HIV-negative women in my study used their newfound agency. It also underscores a key point made by Persson and Richards (2008) in their study of discordant couples with HIV-negative women. They stress that the interrelationship of serodiscordance and gender is multifaceted and that 'analyses that hinge on generalised gender power relations may hinder rather than help our understanding of the diverse, complex ways HIV-negative women negotiate serodiscordance in their sexual lives' (Persson and Richards 2008: 800).

My study also has important implications for HIV prevention, especially given the intense new focus on antiretroviral treatment as a form of HIV prevention. Biomedical interventions cannot be focused on drug distribution alone and need to address how living with HIV shapes gender dynamics in discordant couples. These dynamics determine when a couple seeks treatment, how they adhere to a drug regimen, and how they maintain their relationship as a discordant couple. While discordance threatens relationships, my research indicates that some men with HIV-positive partners are eager to remain committed to their relationships if they receive appropriately discrete counselling. Similarly, a woman with an HIV-positive partner may be able to use her new leverage to convince her husband to adopt health practices that ensure she does not become infected. This study also makes clear, however, that women may use this leverage to buttress their relationship, thereby prioritising the social risks associated with a failed marriage over the biological risk of HIV infection.

While AIDS is in many ways a unique disease, this case study of HIV serodiscordance reveals more fundamental insights about the dialectics of gender and health. Like living with cancer, heart disease and depression, AIDS can prompt reassessments of health behaviour that may then destabilise, undermine or explicitly challenge conventional ways of doing gender. Such reworkings are complex and often entail contradictory processes that undermine certain normative aspects of gender relations while reinforcing others. Yet, as this study and others make clear, there is a potential to undo gender in doing health differently, and understanding how gender and health are intertwined requires remaining attentive to the dialectical nature of these processes.

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