
MARITAL STRATEGIES FOR REGULATING EXPOSURE TO HIV*

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In a setting where the transmission of HIV occurs primarily through heterosexual contact and where no cure or vaccine is available, behavioral change is imperative for containing the epidemic. Abstinence, faithfulness, and condom use most often receive attention in this regard. In contrast, this article treats marriage as a resource for HIV risk management via mechanisms of positive selection (partner choice) and negative selection (divorce of an adulterous spouse). Retrospective marriage histories and panel data provide the evidence for this study, and results indicate that men and women in Malawi increasingly turned to union-based risk-avoidance strategies during the period that the threat of HIV/AIDS materialized. Although both sexes strategize in a similar fashion, men are better equipped than women to deploy these strategies to their advantage. The article concludes with reflections on the long-term and population-level implications of these coping mechanisms.

Without a medical fix, controlling the HIV/AIDS epidemic in sub-Saharan Africa will remain largely contingent on behavioral change. The evidence for such change is slowly accumulating (e.g., Bloom et al. 2000; Fylkesnes et al. 2001; Gregson et al. 1998; Kamali et al. 2000; Stoneburner and Low-Beer 2004), but the tone in the literature often remains subdued with reports of fatalistic attitudes toward life and death, low or diminishing responsiveness to program interventions, and a changing sex ratio of infections that is symptomatic of the special vulnerability of women (Caldwell 2000; Caldwell et al. 1999; Eaton, Flisher, and Aaro 2003; Mwaluko et al. 2003; UNAIDS 2004). What most authors of these reports—optimists and pessimists alike—have in common is an almost exclusive focus on the constituent elements of the ABC of HIV/AIDS prevention, a set of behavioral prescriptions (Abstinence, Be faithful, and use Condoms) that has dominated the HIV/AIDS advocacy discourse for several years (Green 2003).¹ The premise of this article is that coping strategies are not confined to those outlined by the ABC, and that risk management involves behavioral responses that do not often feature in AIDS awareness campaigns or scientific inquiry. The likely motivation for men and women to look beyond the ABC for resources to contain their risk of infection is that these prescripts are not always very realistic or practical (e.g., abstinence and condom use within marriage) or are beyond individual control (e.g., faithfulness of the spouse) (see also Heise and Elias 1995; Schatz 2005). The focus of

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1. This appraisal does not apply to a tradition of critical scholars who focus on underlying or "upstream" determinants of HIV infection (Parker 2001; Schoepf 2001). In this article, too, the discussion is limited to partner selection and retainment—factors that are intimately related to what Boerma and Weir (2005) have labeled "the proximate determinants" of HIV infection—and largely ignores more fundamental causes of the spread of HIV.

this article is on marriage, and a survey of the behavioral responses in this domain reveals greater agency than we usually attribute to the men and women on the ground.

The lack of scientific attention to marital coping strategies in studies of AIDS in Africa is surprising since marriage—as well as the absence thereof—has repeatedly been invoked as a risk factor for HIV infection, particularly for women (e.g., Bongaarts 2007; Carpenter et al. 1999; Clark 2004; Glynn et al. 2003). Admittedly, the evidence for union-based strategies in HIV risk management is not entirely absent from the literature. Previous research has shown that spousal communication may be used deftly to persuade a spouse to reform and to provide information useful for evaluating one's own risk of infection (Gregson et al. 1998; Schatz 2005; Zulu and Chepngeno 2003). Strategies for selecting low-risk partners and the divorce of spouses who are believed to bring HIV into the household are other avenues for limiting risk. So far, the latter has been identified in predominantly qualitative research (Kaler 2004; Mukiza-Gapere and Ntozi 1995; Poulin 2007; Schatz 2005; Smith and Watkins 2005; Watkins 2004). Simulations suggest that (some of) these strategies could indeed be effective in regulating exposure to HIV (Bracher, Santow, and Watkins 2003). I revisit these hypotheses using marital histories and longitudinal evidence from rural Malawi.

The idea that marriage mediates health trajectories is not new (e.g., Farr 1858). Usually it is invoked in research aimed at resolving the relative importance of selection into marriage based on health characteristics versus the beneficial health outcomes of marriage itself (i.e., marriage protection) (Goldman 1993a, 1993b; Lillard and Waite 1995; Murray 2000; Umberson 1987; Waite 1995; Waldron, Hughes, and Brooks 1996; Wyke and Ford 1992). At times the debate is extended to include the effect of health status on marital quality and stability (Booth and Johnson 1994; Waldron et al. 1996). The latter has also been observed in cohort studies in Uganda, where divorce rates are higher for HIV-serodiscordant couples than for couples in which both spouses are HIV-negative (Carpenter et al. 1999; Porter et al. 2004).

Following the literature on marriage and health, I use the concept of *negative selection* to denote exit from marriage based on adverse health, and *positive selection* to refer to selection into marriage based on good health. In what follows, I investigate one hypothesis in support of each of these mechanisms: (1) behavior or characteristics associated with a relatively high risk of HIV infection (e.g., adultery) have a destabilizing effect on unions (negative selection); and (2) behavior or characteristics associated with lower risk of infection are a criterion for spouse selection (positive selection).² I am sensitive to male-female variability in the use of these strategies because of possible gender differences in the social acceptance of behavior related to initiating and terminating sexual partnerships.³ The expectation that these strategies are a response to the threat of HIV infection implies that they become increasingly important as HIV prevalence and AIDS mortality rates increase. That proposition will be formally tested as well.

This study deviates from a common practice in the literature by considering perceptions of a (potential) partner's health rather than observed health status as the driving factor behind these selection processes. This approach is justified in a setting where little is known about one's own and each others' true HIV status,⁴ but where an abundance of information

2. Not all selection into marriage needs to be driven by favorable health characteristics (Lillard and Panis 1996), but I assume it to dominate in this setting.

3. Differences in the social acceptance of "deviant" behavior by gender are not uncommon (e.g., Huselid and Cooper 1992). This is also the case for casual and/or extramarital sex that is repeatedly found to be more common for men than for women (Caraël et al. 1992). In certain African settings, a greater permissiveness of extramarital affairs for men has been associated with the practice of polygyny (which normalizes the idea of multiple sexual partners) and postpartum abstinence (which serves as justification for the practice) (Cleland, Ali, and Capo-Chichi 1999; Orubuloye, Caldwell, and Caldwell 1997).

4. In the 2004 Malawi Demographic and Health Survey (DHS), 5.6% of rural women and 12.3% of rural men reported having been tested for HIV and having received their test results (NSO and ORC Macro 2005).