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"*First was to sit down and bring our minds together*". A qualitative study on safer conception decision-making among HIV sero-different couples in Zimbabwe

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Abstract: *Decision-making on childbearing and safer conception use in HIV sero-different couples involves an intricate balance of individual desires and perceived HIV acquisition risk. This paper addresses an important knowledge gap regarding HIV sero-different couples' considerations and the relationship and power dynamics involved when deciding to use a safer conception method. Between February and June 2019, we conducted semi-structured in-depth interviews among 14 men and 17 women, representing 17 couples, who exited the SAFER study – a pilot study assessing the feasibility, acceptability and cost-effectiveness of a safer conception programme for HIV sero-different couples in Zimbabwe. All couples in SAFER were provided with a choice of safer conception methods and were followed for up to 12 months of pregnancy attempts and 3 months following pregnancy. While couples generally perceived their safer conception discussions to be easy and consensus-driven, the decision-making process also involved complex gender dynamics and trade-offs in relationship power, which resulted in differing interpretations of what constituted a joint or shared couple decision. Participants regarded effective couple communication as an essential component of and precursor to good safer conception conversations and requested additional training in couple communication. Couples relied on information from healthcare providers to kickstart their safer conception discussions. Safer conception programmes should address relationship power imbalances, promote effective couple communication and offer healthcare provider support to enable HIV sero-different couples to make informed choices about conception in a manner that upholds their safety and reproductive autonomy.* DOI: 10.1080/26410397.2024.2366587

Plain language summary: *Our study explored how HIV sero-different couples in Zimbabwe made decisions on the use of safer conception methods. We interviewed 14 men and 17 women who participated in the SAFER study – a pilot study looking at how feasible, acceptable and cost-effective a safer conception programme for HIV sero-different couples is in Zimbabwe. We sought to understand the relationship dynamics, considerations and power trade-offs involved in choosing a safer conception method. Couples reported that their conversations about safer conception were easy and agreeable. At the same time, we found that both gender norms and HIV status shaped the couples' decision-making process, with male gender and partners with an HIV-negative status often having more influence in the final decision of which method to use. Effective couple communication was deemed crucial to support safer conception conversations, with participants requesting additional training in this area. The findings emphasise the importance of providing safer conception methods in a context that addresses power disparities, fosters good communication and includes healthcare providers' support to uphold HIV sero-different couples' reproductive rights and help them achieve their reproductive goals.* DOI: 10.1080/26410397.2024.2366587

Keywords: decision-making, safer conception, HIV sero-different, sero-discordant, Zimbabwe, couples, child-bearing, PrEP, vaginal insemination, semen washing

Introduction

Decision-making around child-bearing and safer conception use is complex for HIV sero-different couples and involves balancing individual desires and self-perceived vulnerability to HIV acquisition.[1,2] Effective safer conception methods reduce the chance of HIV transmission during pregnancy attempts and support the reproductive rights of HIV sero-different couples – where one partner is living with HIV and the other partner is not.[3] Safer conception methods include antiretroviral therapy with viral load suppression (ART/VL) for partners living with HIV, pre-exposure prophylaxis (PrEP) for partners with an HIV-negative status, vaginal insemination (VI) for sero-different couples with a woman living with HIV and semen washing and intra-uterine insemination (SW/IUI) for sero-different couples with a man living with HIV.[4–6]

Despite high fertility desires and demand for safer conception services among couples with an HIV sero-different status, there is low availability and utilisation of these services in resource-limited settings.[3,7,8] This results in many sero-different couples attempting pregnancy without adequate mitigation of the heightened HIV transmission vulnerability, which undermines their reproductive rights and safety.[1,2,8–12] A systematic review of the availability of safer conception services in sub-Saharan Africa (SSA) found that

while individual safer conception methods (e.g. ART, PrEP, VI, SW/IUI) are available in a number of settings, they are generally not provided in the context of safer conception programmes and the implementation of safer conception services has largely been limited to research projects.[4] For example, while ART has been scaled up in SSA, it is not generally provided in the context of safer conception counselling and services and viral load suppression may not be routinely assessed.[13] Access to oral PrEP is increasing, but its availability continues to remain limited in many settings throughout SSA.[14,15] The availability of SW/IUI is limited due to expense, though efforts to make semen washing more accessible and at a lower cost are underway.[16] Vaginal insemination, while low-cost, is infrequently discussed with patients outside of safer conception research projects.[4,17]

To date, most studies on safer conception among HIV sero-different couples have focused on factors that influence decisions to conceive or use safer conception services in general and many of these have been based on hypothetical use of safer conception.[8–10,18–20] These studies have found that several factors influence couples' decisions to use safer conception, including individual-level factors (awareness of HIV status, knowledge and acceptability of safer conception methods), couple-level factors (partner-specific preferences, relationship dynamics, family expectations) and structural factors (HIV-related healthcare access constraints, societal and gender norms, HIV-related stigma).[21–24] To date, very few studies have explored clients' experiences when using safer conception under real-world implementation[1,19,25,26] and none have described the decision-making processes that couples go through when choosing specific safer conception methods. These real-world data are critical for the development and roll-out of interventions and support services tailored to the specific needs of couples in safer conception programmes.

We piloted SAFER, a safer conception programme, in Zimbabwe, where an estimated 25,000 new HIV infections occur annually and approximately 1.3 million people are living with HIV.[27] In Zimbabwe, most new HIV infections stem from heterosexual transmission, with HIV sero-difference being a key factor in transmission among stable couples, and 9% of cohabiting couples have differing HIV statuses.[28–30] Despite successful ART roll-out and improved access to viral load testing, a significant portion of reproductive-aged individuals on ART are not virally suppressed.[31] As in most countries in SSA, there is no safer conception policy or programme in Zimbabwe, leaving providers unprepared to counsel women and men in need of safer conception services. During SAFER, we offered various methods such as ART/VL, PrEP, VI and SW/IUI for HIV sero-different couples attempting pregnancy, all of which exist in either the public or private sector but are not widely available or being provided in the context of safer conception.[6,32] SAFER was found to be feasible and acceptable and allowed sero-different couples to achieve pregnancy, with no cases of HIV transmission to partners or newborns.[6] We conducted a qualitative study among a subset of SAFER study couples to explore their experiences and decision-making processes with safer conception methods. This paper addresses a vital knowledge gap regarding the considerations, and the relationship and power dynamics involved in choosing a safer conception method among HIV sero-different couples wishing to conceive a child.

Methods

Study design, population and setting

Between February and June 2019, we invited all 46 participants (representing 23 couples) who had exited the SAFER pilot study to participate in qualitative semi-structured in-depth interviews (IDIs) to explore patient attitudes, experiences, preferences for safer conception strategies and the decision-making process related to selecting and adhering to these strategies. The study coordinator, a nurse by profession, recruited participants by approaching couple dyads either together or individually, during or after their participation in the follow-up phase of the SAFER study, to invite them for IDIs. Although we invited both members of each couple dyad for an IDI, participation as a couple was not required. Thus, a participant was eligible even if their partner did not agree to participate in the IDI.

Detailed study methods and clinical findings from the SAFER study are presented in Brown *et al.*[6] In brief, the SAFER study was an open-label, prospective, non-randomised pilot study to measure the impact, feasibility, acceptability and cost-effectiveness of safer conception strategies among 23 HIV sero-different couples in Chitungwiza and Harare, Zimbabwe between March

2017 and June 2019. Individuals were eligible to enrol in the SAFER study if they were part of a heterosexual HIV sero-different relationship (men, 18 + years and women, 18–35 years), sexually active, seeking to get pregnant in the next 6 months, and willing to use at least one safer conception method. SAFER was implemented by the University of Zimbabwe Clinical Trials Research Centre (UZ-CTRC), at the Zengeza Clinical Research Site (CRS) located on the grounds of the Zengeza Municipality Clinic in Chitungwiza, Zimbabwe. All couples enrolled in the SAFER study received HIV prevention counselling and were counselled on the use of safer conception methods, guided by a safer conception counselling toolkit specifically developed for healthcare providers offering safer conception to HIV sero-different couples.[33] Prior to conception attempts, all enrolled couples underwent a two-month run-in period during which they returned to the clinic each month to receive additional counselling on methods, as needed. Upon completion of the run-in period, couples were counselled to begin conception attempts with their chosen safer conception method(s) and returned to the study clinic monthly for pregnancy testing, HIV antibody and viral load testing, and targeted counselling on adherence to their selected safer conception methods. Following pregnancy, couples were followed up quarterly until three months after delivery.

Qualitative data collection and analysis

We developed a semi-structured IDI guide (see Supplemental data) to provide guidance along relevant themes but sufficient flexibility to allow for unexpected discoveries of social processes and cultural meanings. The first section of the IDI guide collected information on prior knowledge of safer conception, perception of methods, decision-making and choice of methods, and experiences with using safer conception strategies/services. These questions were developed to ensure study aims were achieved and refined after pilot testing. Socio-demographic data on SAFER participants were collected during the SAFER study. This paper analyses IDI data that relate to couples' decision-making processes when choosing a safer conception method.

Three experienced social scientists (PrM, THC and KS) with Master's degrees and over two years of interviewing experience, who were trained on the protocol but not involved in the SAFER study, conducted semi-structured face-to-face IDIs. The interviewers and participants were gender-matched, meaning that men were interviewed by a male interviewer while women were interviewed by female interviewers. For quality control, each interviewer conducted 1–2 supervised, mock interviews and received feedback and approval from the study's senior social scientist (PeM) prior to collecting actual data. Members of couples were interviewed separately but at the same time. All interviews were conducted in a private room within the UZ-CTRC study site located in the Zengeza Municipality Clinic grounds in Chitungwiza, Zimbabwe. Interviews were conducted in the participant's preferred language, either Shona or English and each lasted 1–2 hours. IDIs were audio-recorded with consent from the participants; the audio files were transcribed and, if needed, translated into English by MC, a Master's degree holder and FK, a Bachelor's degree holder.

All IDI transcripts were independently reviewed and coded by two investigators (PeM, MC) using a codebook that was developed after the interviews, reviewed and tested by study investigators and research team members using the first completed transcripts. During the analysis period, two coders (PeM, MC) met weekly to discuss codes applied to emerging themes. Additionally, emerging themes from the transcript of an individual were compared to that of their partner for consistency or variance and subsequently grouped into categories for research team discussion to ensure validity. To check for the consistency of text interpretation, coding was compared across the coders using an agreed-upon codebook and discrepancies were discussed by the research team (PeM, MC, JMB, SG, FM) until resolution. After all the interviews were coded, code reports were generated and summarised into memos, the dominant themes were organised, and representative quotes were chosen to illustrate these themes in the words of the participants. DEDOOSE Software Version 9 (Sociocultural Research Consultants, LLC, Los Angeles, California) was used for data management and organisation. Four of the 31 IDI transcripts (13%) were double-coded and the level of intercoder-reliability was established at approximately 80%. The COREQ checklist was used for reporting study findings.[34]

Statement of positionality

To minimise bias, IDIs were conducted by three social scientists who were engaged as qualitative

interviewers and trained on the study protocol but not involved in the clinical aspects of the SAFER study. PrM, a female with a Master's degree in Development Studies and over a decade's experience conducting IDIs, THC, also a female holding a Master's degree in Social Work with two years of IDI experience, and KS, a male with a Master of Philosophy degree in Social Sciences and over 10 years of IDI experience, served as the interviewers. IDI participants were informed about the broader objectives of the research when being consented for the SAFER study as well as the IDIs; however, the participants did not have a prior relationship with the lead researchers or the interviewers and were unaware of their individual interests in safer conception work. To enhance comprehension and encourage authentic responses, participants were interviewed in their preferred language, either English or Shona, with most participants choosing Shona.

Ethics and consent

The study protocol, consent forms, interview guides, and all participant-related materials were approved by the Medical Research Council of Zimbabwe (MRCZ/A/2117), the Medicines Control Authority of Zimbabwe (CT143/2016), the Joint Research Ethics Committee for Zimbabwe (JREC/220/16), the Research Council of Zimbabwe (RCZ/02930) and the University of California, San Francisco Institutional Review Board (UCSF CHR #15-16936) from January 2016 through (i) December 2019 (JREC, MRCZ, RCZ); (ii) Jan 2020 (MCAZ); (iii) and ongoing at UCSF. Each couple member was consented individually, in their preferred language (English or Shona), to minimise coercion, and provided written informed consent prior to study participation. All IDI study participants were reimbursed US$10 for their time and transport expenses.

Results

We conducted IDIs among 31 participants (17 women (7 living with HIV) and 14 men (8 living with HIV)) who exited the SAFER study. These 31 participants represented 17 couples; 14 couples with both dyad members interviewed and three couples with only one member interviewed. Fifteen participants declined to participate in IDIs because they were unavailable due to work commitments ($n = 3$) or uninterested in further participation due to relationship dissolution ($n = 4$) or other unspecified reasons ($n = 8$). The median age was 32 years (range: 21–35) for women and 34 years for men (range: 24–54) (Table 1). Approximately three-quarters of men and two-thirds of women had completed secondary education. All the participants interviewed had opted for a combination of two or more safer conception methods during the SAFER study. ART/VL was selected by all couples (100%), with each couple also choosing at least one additional method. PrEP was selected by 12 out of 17 couples (76.5%); seven women and five men without HIV. Among seven couples with a woman living with HIV, two (28.6%) opted for VI, while 3 out of 10 (30.0%) couples with a man living with HIV chose SW/IUI. Of the 17 women interviewed, 12 (71%) achieved pregnancy. Five participants with HIV who were taking ART were not virally suppressed at enrolment into SAFER, and two of these participants continued to have detectable viral load at the end of the two-month run-in period (viral load: 19,000 and 34,000 copies/mL) despite reports of high adherence. These two participants had drug resistance

Table 1. Characteristics of male and female participants interviewed

	Men	Women
	($n = 14$)	($n = 17$)
	Median (IQR) or *n* (%)	
Age in years (range)	34 (32–49)	32 (28–33)
Completed secondary education (%)	11 (78.6)	11 (64.7)
Married to and living with study partner (%)	14 (100)	17 (100)
Employed (%)	13 (92.9)	8 (47.1)
Living with HIV (%)	8 (57.1)	7 (41.2)
Months on ART if living with HIV (range)	36 (8–70)	15 (3–33)
Parity (range)	–	2 (0–3)
One or more living children with current partner (%)	9 (64.3)	10 (59.9)
Number of living children, total (range)	2 (0–4)	2 (0–4)

testing and were switched to second-line therapy (time to viral suppression was 4 and 6 months, respectively). Once virally suppressed, all but two participants with HIV maintained viral suppression throughout follow-up. The socio-demographic and method use characteristics of the six couples who did not participate in IDIs were similar to the 17 who did participate, but three of them withdrew due to relationship dissolution and none achieved pregnancy. Notably, no HIV-negative partners or infants tested positive for HIV during SAFER.[6]

This study revealed three primary themes associated with decision-making within couples: (1) couples perceived their conversations on safer conception method choice to be easy, harmonious and consensus-driven; (2) the decision-making process was nuanced and involved complex gender dynamics and trade-offs in relationship power; (3) couples relied on information from healthcare providers to kickstart their safer conception discussions. Below we discuss these main themes and their sub-themes in greater detail and provide illustrative quotes.

Couples perceived their conversations on method choice as easy, harmonious and consensus-driven

Couples started with a common mindset

When deciding on the safer conception strategies to use, most couples described conversations that started with coming together physically and mentally as depicted by a 39-year-old male participant without HIV who stated "*… first was to sit down and bring our minds together*". They then discussed various safer conception methods based on the counselling they had received from the study staff, talked about method applicability and individual preferences, and chose the method that best suited them as a couple. In some instances, the couple would initially have different opinions or preferences and would reach an agreement after discussing with each other.

Interviewer: *When you say they [conversations] were 'fine' what do you mean?*

Respondent: *Alright, we started the discussion while on our way home and I asked her which method she saw best from the options we had, and she said PrEP could work. I told her I was not comfortable with PrEP because of some reasons plus we were not sure if the PrEP pill would work and were afraid that she might contract the virus if the PrEP pill was not compatible with her system. I then suggested semen washing when she asked for my opinion and we both agreed on it and that was that.*

(Male, living with HIV, age 34, couple used ART/VL + SW/IUI)

Safer conception strategy conversations were "easy"

Most of the couples reported that the conversations were "easy" for various reasons. Some couples reported that understanding and accepting their sero-different status and regularly discussing matters to do with HIV infection made it easy to discuss conception strategies.

Couples were equally motivated and agreeable to having a baby and felt that they were ready to do what was required thus making the safer conception decision easier. A culture of consulting each other, doing things together as a couple and respecting gender roles where ultimate decisions fall on men all facilitated easier conversations and decision-making.

"*It was easy for me because at first when my husband was telling me about his status, I didn't really care about what was happening because it's not that person's fault to get that disease. And we cannot put that person on the side to say just because he is HIV-positive we can't talk or we can't be together. So, I think in choosing the [safer conception method] first, once you can accept that [HIV status] then you won't have any problems accepting the other thing. Just knowing that we both want the kid so we have to do what is needed to be done.*" (Female, HIV-negative, age 21, couple used ART/VL + PREP + SW/IUI)

In addition, being well informed about the safer conception methods on offer and how they work, which was provided through counselling from the SAFER team, helped to simplify decisions.

"*The use and the explanation and to then know how it is like, that is what made it [conversation] easy and also following what will be said, what will be required. That is what made it easy.*" (Female, living with HIV, age 31, couple used ART/VL + PREP)

Couples strived for consensus when views differed

There were a few instances where the decision on a safer conception method was not easy as couples initially disagreed because their

preferences for or understanding of different methods differed. However, they later reached an agreement after discussion. Some of the things that helped reach consensus on choice of methods were consideration for the other partner's preferences or understanding their potential fears regarding a particular method. One partner often served as a source of information to clarify certain aspects of the method under discussion and this helped bring consensus.

"*Huh it was right, I don't want to lie, huh. But the first days he was the one who was a bit concerned because we tried – we first were asked to go and discuss. We went home and discussed and I said it will work but he once refused. So, I said 'alright if you don't want then take what, the (PrEP) pills' and he said 'no it can't, to take (PrEP) pills when I don't have the disease'. But as time went by … .I then said OK so let's choose this other one, explaining to him as we were given the strategies and I said 'how about this one [referring to vaginal insemination]' and he said 'huh yah this one it can do because it seems simple'.*" (Female, living with HIV, age 33, couple used ART/VL + VI)

Open partner communication regarding HIV status disclosure was essential for safer conception discussions

Participants reported that with open communication, one could freely convey their desire to have children, invite their partner to visit the clinic with them and seek guidance on how to have a baby while protecting the partner without HIV. Though the couples mentioned that safer conception conversations were easy during the study, some had previously encountered communication challenges that they were able to overcome before joining the study. For instance, some individuals living with HIV reported that they did not initially know how to convey their HIV status to their partners and this resulted in delayed disclosure.

"*Yah, I think that [partner communication] is very critical. Because what I, from my own experience … When it comes to testing. During that time, we never had that knowledge as a couple. I just thought of going alone. I didn't know what was going to happen if I go with my wife. I just went there and was found positive [HIV-positive]. And it is something that took me time after I got tested and received my results, to disclose them to my wife. I didn't know what I was going to say to her … .Aah, I think it took about a month. Because I didn't even know how to … How to tell her.*" (Male, living with HIV, age 42, couple used ART/VL + PrEP)

Some women talked about how women living with HIV may find it difficult to disclose their HIV status to their partners for fear of being asked how they contracted the virus. Fear of negative repercussions such as dissolution of the marriage or being blamed for bringing the disease to the relationship was seen as a deterrent for women living with HIV to disclose their status.

"*I can accept that I am [HIV-]positive but to tell my husband he will say it is you who brought the disease in here. So, if I know that it will be hard for me to disclose, I would just think 'ah what if I just keep quiet' or 'ah if I disclose he would say that I am the one who brought the disease so what will I do'.*" (Female, living with HIV, age 33, couple used ART/VL + VI)

Many participants mentioned that training on how to communicate one's HIV status to their partner was an essential component of and precursor to initiating safer conception.

"*I think for you to get into SAFER [study], first thing is to be open about your [HIV-] status to your partner. Then you protect each other, so that the person who is [HIV-] negative will remain negative.*" (Female, living with HIV, age 32, couple used ART/VL + PrEP)

Participants acknowledged that communication with their partners was crucial for discussing safer conception decisions, and they believed that training in couple communication would enhance their relationships and facilitate sharing their fertility desires, ultimately aiding in selecting and adhering to a safer conception method.

"*Because some people would want to speak but they do not know how to start that conversation [safer conception], how to do it. … so, people need to be taught.*" (Male, living with HIV, age 34, couple used ART/VL + SW/IUI)

Safer conception decision-making involved complex gender dynamics and trade-offs in relationship power based on HIV status

Male partners had an upper hand in decision-making

Gender roles and dynamics strongly influenced the decision-making process and this played out

differently for different couples. For many couples, the decision about which methods to use rested with the male partner while the woman simply went along with the methods that the male partner decided they should use. Part of the reason why a woman played a subservient role was because she perceived the man as the head of the family and final decision-maker and hence felt that she had to listen to him. In such cases the woman went along with the male partner's decision regardless of her preferences.

"*For me I hadn't an option to select and say, 'this is the best'. I had to listen to him and that is what he said that 'this is not my girlfriend but my wife, so I don't want anything to be different' and so he just said this is not OK*." (Female, living with HIV, age 24, couple used ART/VL + PrEP)

Joint decision-making was complex and open to individual interpretation

Some participants mentioned that they made the final decision as a couple either because they had a tradition of "*meeting in the middle*" when making decisions about anything or because they felt the information that they had received during safer conception counselling enabled them to act jointly. However, on closer examination of the data, we found that many of the partners in such couples yielded discrepant information with one partner viewing the decision as a joint one while the other one felt that it was a single person's decision. In the majority of these couples where one partner mentioned that they had shared the decision as a couple, the other partner stated that the male partner had made the final decision on which safer conception method to use, pointing to a nuanced interpretation of shared decision-making when gender dynamics are at play. Below are representative quotes from a female and male member of a couple dyad:

"*We both made the decision, because the study nurse, once came in and we asked her about the [PrEP] pill, and she explained in detail about the pill, so she left again, because when she came in she had asked if we had decided yet, so she left. When she came back the second time we then told her that we had made the decision. We want the pill*." (Female, living with HIV, age 28, couple used ART/VL + PrEP)

"*I would say we made the decision together, but because it was selected by me (the husband) we might say the decision was made more by the husband. Because it was I who had chosen it, but we had to agree. … Then I would say it was more of the decision of the husband because it was a method I had chosen*." (Male, HIV-negative, age 34, couple used ART/VL + PrEP)

Living with HIV curtailed decision-making power

Many partners living with HIV, especially women, preferred or felt obliged to allow the partner with a HIV-negative status to decide which safer conception method to use. Some partners living with HIV felt that they could not make the final decision regarding the method because they wanted their partner to protect themselves with a method they felt safe to use.

"*I did not have any option because it is difficult to choose for someone, yet you are the one who is [HIV-] positive. I am the one who is HIV-positive, so it is difficult for you to say 'ahh no, the [PrEP] pill strategy is okay' because for me I will be safe but it may not be safe for him. So, I could not say anything because I thought otherwise, he might say [vaginal] insemination is the one he prefers. I didn't know what was on his mind. So, I gave him the opportunity to select what was easy for us, when he chose it was still fine for us*." (Female, living with HIV, age 24, couple used ART/VL + PrEP)

For others living with HIV, deferring the decision was a sign of respect or gratitude to the partner without HIV for staying in the relationship despite the sero-difference status. They appreciated their partner for being understanding, as illustrated by the quote below from a man living with HIV:

"*She is the [HIV-]negative one and should remain uninfected. Some partners after knowing that the other partner is HIV-positive they would opt out of the relationship but she understood as a married woman that this scenario was possible*." (Male, living with HIV, age 44, couple used ART/VL + PrEP)

Thus, partners living with HIV tended to entrust safer conception decision-making to their partner with a HIV-negative status, whose choices they embraced. In two cases where the man living with HIV made the final decision, they did so because they wanted to protect their partners from HIV.

"*It is unfortunate that I then got infected but I had told myself that I do not want to put her in a situation where she becomes vulnerable to contract*

HIV. That is why I chose semen washing because I know they will wash the semen before injecting it into her body." (Male, living with HIV, age 34, couple used ART/VL + SW/IUI)

Couples relied on information from healthcare providers to kickstart their safer conception discussions

Couples knew little about safer conception prior to the study and felt that they received comprehensive safer conception information from the SAFER providers which enabled them to extensively discuss the method attributes as a couple and how these fitted in with their preferences and goals. The couples appreciated being given time after the counselling session to discuss their options either at home or during the waiting period prior to them choosing a safer conception strategy.

"*I would say since we were diagnosed, when my wife was diagnosed with HIV, we had never heard that we could have a baby safely. What we were being encouraged to do was that throughout life we should use condoms. That we do protected sex*." (Male, HIV-negative, age 34, couple used ART/VL + PrEP)

"*The doctor that we spoke to that day gave us a rundown of all the methods and explained to us and then left us to decide which method we wanted, and we had enough time to decide what would work best for us*." (Female, HIV-negative, age 21, couple used ART/VL + PREP + SW/IUI)

Discussion

This study provides valuable insights into the decision-making processes of HIV sero-different couples regarding safer conception strategies in Zimbabwe. Overall, we found that couples' conversations to choose a safer conception method were largely agreeable owing to the couples' common goal and desire to have a child. We also found that gender dynamics and individual partners' HIV statuses played an important role in the couples' decision-making. Prior to the study, couples had limited knowledge about safer conception and relied on the information provided by healthcare providers during counselling sessions to kickstart their decision-making process. The counselling provided by SAFER study staff, method applicability, and individual preferences were considered during the conversations within couples, ultimately leading to the selection of a method that best suited each couple.

Most couples found it easy to discuss safer conception strategies due to understanding their sero-different status and shared motivation for having a baby. They actively discussed and reached agreements, even when opinions differed, considering each other's preferences and concerns about specific methods. To our knowledge, there are no published studies to date that describe the nature of safer conception conversations that HIV sero-different couples have in real-world settings; instead, most published manuscripts have focused on knowledge, attitudes, acceptability, choice and adherence to safer conception methods.[1,25,26,35,36] Our focus on safer conception decision-making with a partner is unique as it brings out the behind-the-scenes tensions, negotiations and considerations that happen within a couple and lead to adoption of a safer conception method(s). Couples' comprehensive knowledge of the available methods through counselling, their culture of consultation and shared decision-making, and respect for gender roles also played a part in facilitating discussions. In contrast to our findings that couples found safer conception conversations easy and harmonious, Matthews *et al.* found that Ugandan couple dyads enrolled in a hypothetical study of safer conception preferences struggled with conversations around HIV status disclosure, child bearing intentions and commitment to one another as relationship partners.[9] Many couples in the Matthews *et al.* study had not yet disclosed their HIV status to their partner, most couples had divergent childbearing intentions, and couples were not being offered safer conception services, which may account for the difficulties expressed. In contrast, all couples participating in SAFER had previously disclosed their HIV status, both members of the couple desired pregnancy, and all were offered safer conception, which may account for the differences in findings between these two studies.

It is crucial to acknowledge, however, that some couples faced communication challenges prior to joining the SAFER study, particularly related to disclosing HIV status. Our findings align with other studies in SSA that indicate that women living with HIV find it more challenging than men to disclose their status due to fear of negative consequences such as marital dissolution

and being blamed for the disease.[9,37,38] Other studies indicate that men living with HIV also struggle with disclosure due to stigma, fear of losing the relationship and lack of the skills necessary for effective disclosure leading to a low interest in safer conception services.[11,24,39] These challenges highlight the need for interventions aimed at improving communication skills within couples, especially concerning sensitive topics like HIV status disclosure, sexual matters and fertility desires in order to improve uptake and adherence to safer conception regimens.[9,40] Women living with HIV who seek to disclose their HIV status to their partners can benefit from communication training and facilitated disclosure to mitigate against the potential for intimate partner violence.[38] On the other hand, imparting men with communication skills and a safe environment to express their fears regarding HIV disclosure can help reduce internalised and community stigma, thus enabling them to engage with safer conception services.[39] Thus, training on effective couple communication should be an essential component of safer conception programmes as it helps to improve relationship dynamics, strengthens relationships, facilitates conveying fertility desires and promotes couples' engagement with safer conception services.[9,41]

Gender dynamics and HIV status were identified as influential factors in safer conception decision-making. The dominance of male partners in decision-making was evident in many couples, where the final decision on the method rested with the male partner, and the female partner willingly complied. This subservient role assumed by women stemmed from perceiving the man as the head of the family and the ultimate decision-maker. As previous studies have shown, gender dynamics and power imbalances within HIV sero-different relationships significantly influence reproductive decision-making processes, with traditional gender roles favouring the male partners to have the final say.[8,18] Women in HIV sero-different relationships may feel compelled to defer decision-making to their male partners due to societal expectations and perceived gender roles.[8,42] This power imbalance can impact the choice of safer conception methods and the extent of women's involvement in decision-making processes. In addition, male dominance in reproductive decision-making, coupled with their female partner's low agency, makes women vulnerable to HIV acquisition and unwanted pregnancy, suggesting the need for gender-informed safer conception programmes that address gender power dynamics.[42] Further investigation is necessary to explore how additional support and counselling can enhance women's agency in the decision-making process and care related to safer conception.

Despite some couples claiming to have made joint decisions, closer examination revealed varied perceptions, indicating complexities in joint decision-making, especially when gender and relationship dynamics were at play. Studies show that couples' values and preferences as a unit tend to dominate partners' individual wishes in fertility and decision-making but that male preferences prevail when individual desires differ, which may influence individuals' HIV vulnerability during conception attempts.[8,18,22] Additionally, we found that the partners living with HIV, women in particular, frequently deferred to the method choice of the partner without HIV. Reasons for deferring included wanting to protect the negative partner and expressing gratitude or respect for their understanding. These findings underscore the need to address power imbalances resulting from differing gender roles and HIV statuses and promote shared decision-making in safer conception.[41,43]

The study also highlighted the important role of healthcare providers in initiating safer conception discussions. The counselling facilitated extensive discussions at home and during the waiting period, enabling couples to align their preferences and goals with the attributes of different methods. Healthcare providers are a critical and often trusted source of information on safer conception and can play an important role in lowering the barriers to decision-making that couples face.[18,44] Effective counselling that involves both the partner living with HIV and the partner without HIV empowers couples to make informed decisions, addresses their concerns, and helps foster shared decision-making processes.[45,46] Furthermore, clients seeking safer conception services perceive high value from their safer conception visits and prefer regular attendance until conception.[25] Thus, it would be important to situate a safer conception programme in a healthcare setting where HIV sero-different couples can seek information and support to help them make decisions regarding the safer conception strategy to use.

The strengths of this study include interviewing both couple members simultaneously, though separately, enabling us to analyse and compare individual couple members' views on how decisions were made. To the best of our knowledge, no previous research in Zimbabwe or among other African populations has analysed how couples make decisions on safer conception method use in real-world settings where couples are offered multiple safer conception options; this study, therefore, expands our knowledge, and we hope further research in the region will be conducted. This study also has limitations. The generalisability of the findings may be limited as the study was conducted at one research site in an urban setting and participant experiences may not be representative of those of the larger population, including those who were unable to overcome barriers to participate in a couples-based safer conception programme. In addition, the SAFER study offered safer conception counselling and a choice of methods, which were provided for free. Thus, decision-making processes for couples in our study may be different from those of couples who do not receive safer conception counselling, have fewer safer conception choices, or have to pay for safer conception methods. Despite these limitations, results from this study are supported by previous studies and hold practical implications for delivery of safer conception services in Zimbabwe and similar settings.

Conclusion

In conclusion, we found that safer conception decision-making in Zimbabwe is primarily characterised by consensus-driven conversations within couples, and that both gender dynamics and HIV status influence the decision-making process. Effective couple communication and interventions aimed at addressing power imbalances and promoting shared decision-making are essential pillars of a safer conception programme to ensure that couples can make informed method choices free of coercion. By doing so, safer conception programmes can support the basic right of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children. Healthcare providers play a critical role in providing comprehensive information and initiating discussions, thereby empowering couples to make decisions that align with their preferences and goals.

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Contributor roles

Conceptualisation of the study: JMB, EB, CRC, SS, LD, GWR, FM. Data curation: PeM, MC, SG, PrM, JMB, FM. Formal analysis: PeM, MC. Funding acquisition: JMB, EB, CRC, SS, LD, GWR. Investigation: PrM, Kenny Sithole, Tinei H. Chitowa. Methodology: JMB, SG, BM, AM, GC, CC, TM, CRC, SS, LD, GWR, FM. Project administration: BM, TC, AM, GC, CC, NM, CM, PeM, TM, CSR, ZMC, FM. Supervision: JMB, FM, PM. Transcription/translation: MC, Faith Kowo. Writing - original draft: SG, JMB, PM, MC. Writing - review and editing: JMB, SG, PeM, MC, PrM, BM, TC, AM, GC, CC, NM, CM, TM, CS-H EB, CRC, SS, LD, GWR, ZMC, FM.

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Résumé

La décision d'avoir un enfant et d'utiliser une méthode de conception plus sûre chez les couples sérodifférents pour le VIH suppose un équilibre complexe entre les désirs individuels et le risque perçu de contracter le VIH. Cet article aborde une lacune importante dans les connaissances sur les considérations des couples sérodifférents, ainsi que les relations et la dynamique de pouvoir en jeu lorsqu'ils décident d'utiliser une méthode de conception plus sûre. Entre février et juin 2019, nous avons mené des entretiens approfondis semi-structurés avec 14 hommes et 17 femmes, représentant 17 couples, qui avaient abandonné l'étude SAFER – une étude pilote évaluant la faisabilité, l'acceptabilité et la rentabilité d'un programme de conception plus sûre pour les couples sérodifférents au Zimbabwe. Tous les couples de l'étude SAFER avaient eu le choix entre des méthodes de conception plus sûre et ont été suivis sur une période pouvant aller jusqu'à 12 mois de tentatives de grossesse et trois

Resumen

La toma de decisiones sobre la capacidad de tener hijos y el uso de métodos de concepción más segura en parejas serodiscordantes con relación al VIH implica un delicado equilibrio entre los deseos individuales y el riesgo percibido de adquisición del VIH. Este artículo aborda una importante brecha de conocimiento sobre las consideraciones de las parejas serodiscordantes y las relaciones y dinámica de poder implicadas en la decisión de utilizar un método de concepción más segura. Entre febrero y junio de 2019, realizamos entrevistas semiestructuradas con 14 hombres y 17 mujeres, que representaban 17 parejas, quienes concluyeron el estudio SAFER, un estudio piloto para evaluar la factibilidad, aceptabilidad y rentabilidad de un programa de concepción más segura para parejas serodiscordantes en Zimbabue. A todas las parejas en SAFER se les ofreció una variedad de métodos de concepción más segura y se les dio seguimiento durante hasta 12 meses de intentos de embarazo

mois après la grossesse. Si les couples estimaient en général que leurs discussions sur une conception plus sûre étaient faciles et fondées sur le consensus, le processus de prise de décision impliquait aussi une dynamique de genre complexe et des compromis en matière de pouvoir dans la relation, ce qui aboutissait à des interprétations différentes de ce qui constituait une décision de couple commune ou partagée. Les participants considéraient une communication de couple efficace comme un élément essentiel et préalable de bonnes conversations sur une conception plus sûre, et ont demandé une formation supplémentaire sur la communication de couple. Les couples s'appuyaient sur les informations données par les prestataires de soins de santé pour lancer leurs discussions sur une conception plus sûre. Les programmes de conception plus sûre devraient corriger les déséquilibres de pouvoir dans les relations, promouvoir une communication de couple efficace et offrir le soutien des prestataires de soins de santé pour permettre aux couples sérodifférents de faire des choix éclairés sur la conception d'une manière qui protège leur sécurité et leur autonomie procréatrice.

y 3 meses después del embarazo. Aunque las parejas generalmente percibieron que sus conversaciones sobre concepción más segura eran fáciles e impulsadas por consenso, el proceso de toma de decisiones también implicó complejas dinámicas de género y compensaciones de poder en las relaciones, que produjeron diferentes interpretaciones de lo que constituía una decisión conjunta o compartida de la pareja. Las personas participantes consideraban la comunicación eficaz de pareja como un componente esencial y precursor de buenas conversaciones sobre la concepción más segura, y solicitaron capacitación adicional sobre la comunicación de pareja. Las parejas dependieron de la información que recibieron de profesionales de salud para iniciar sus conversaciones sobre concepción más segura. Los programas de concepción más segura deberían abordar los desequilibrios de poder en las relaciones, promover la comunicación eficaz de pareja y ofrecer el apoyo de profesionales de salud para habilitar a las parejas serodiscordantes con relación al VIH para que tomen decisiones informadas sobre la concepción de una manera que preserve su seguridad y autonomía reproductiva.