Published in final edited form as:

Am J Mens Health. 2015 March ; 9(2): 139–149. doi:10.1177/1557988314532940.

Dating, Marriage, and Parenthood for HIV-Positive Heterosexual Puerto Rican Men: Normalizing Perspectives on Everyday Life With HIV

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Abstract

HIV-positive men are living long and healthier lives while managing HIV as a chronic illness. Although research has extensively documented the experiences of illness of people living with HIV, dating, marriage, and fatherhood among heterosexual Latino men has not been examined. To address this gap, this study used a qualitative study design to examine patterns and strategies for dating, marriage, and parenthood among 24 HIV-positive heterosexual Puerto Rican men living in Boston. The findings in our study indicate that an HIV diagnosis does not necessarily deter men from having an active sexual life, marrying, or having children. In fact, for some of the men, engaging in these social and life-changing events is part of moving on and normalizing life with HIV; these men planned for, achieved, and interpreted these events in the context of establishing normalcy with HIV. Although the HIV diagnosis discouraged some men from engaging in sexual relations, getting married, or having children, others fulfilled these desires with strategies aimed to reconciling their HIV status in their personal life, including dating or marrying HIV-positive women only. Additional important themes identified in this study include the decision to disclose HIV status to new sexual partners as well as the decision to accept the risk of HIV transmission to a child or partner in order to fulfill desires of fatherhood. Understanding the personal struggles, decision-making patterns, and needs of HIV-positive heterosexual men can aid in designing interventions that support healthy living with HIV.

Keywords

HIV/AIDS; Latinos; relationships

Introduction

Despite challenges, an HIV diagnosis does not preclude dating, marrying, or having a family. The advent of highly active antiretroviral therapy transformed the HIV experience of illness restoring individuals' ability to live normal lives managing HIV as a chronic illness.

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Declaration of Conflicting Interests

The author(s) declared no potential conflicts of interest with respect to the research, authorship, and/or publication of this article.

Research has extensively documented the experiences of illness of people living with HIV/AIDS. However, while these studies mostly document negative experiences, such as stigma and discrimination, little is known about the social adaptations to living with HIV in everyday life, particularly with regard to dating, marriage, and parenthood.

The present article reports on findings from a qualitative research study that examined the social lives of a group of HIV-positive heterosexual Puerto Rican men in Boston, Massachusetts. The overall aim of this study was to explore positive adaptations to living with HIV as a chronic illness. By examining how heterosexual men approach dating, marriage, and parenthood following an HIV diagnosis, this article aims to contribute to the scarce literature on the experience of illness of HIV-positive heterosexual men. Specifically, the authors describe the strategies of reconciling living with HIV into everyday life by examining the personal lives of this group of men. We do so by examining the men's adjustments related to dating, marriage, and fatherhood within the context of a life with HIV. Our analysis is set within a discussion of the experience of illness framework (Pierret, 2003) exploring the concept of *normalcy* to expand previous work on the incorporation of HIV into everyday life (Baumgartner, 2007).

As men continue driving the HIV epidemic (United Nations Programme on HIV/AIDS, 2012), research on dating, marriage, and parenthood among heterosexual men from groups disproportionately affected by HIV in the United States is needed. In Boston, Puerto Ricans represent 30% of the Latino population yet they account for 40% of all HIV/AIDS cases among Latinos in this city¹ (Massachusetts Department of Public Health [MDPH], 2007); men are the most affected, comprising 76% of these cases. Unlike other groups, the principal mode of HIV transmission among Puerto Rican men is injection drug use (56%); only 20% of HIV-positive Puerto Rican men identified sex with other men as the mode of infection (MDPH, 2007). Focusing on HIV-positive heterosexual men is important not only because of the potential for transmission across different populations (Volz, Frost, Rothenberg, & Meyers, 2010), but also because of the conflict between society's negative view of the reproductive intentions and sexuality of HIV-positive persons and their own desires for sexual intimacy, marriage, and parenthood (Segurado & Paiva, 2007; Sherr & Barry, 2004).

Background Literature and Guiding Concepts

The Experience of Illness

A chronic illness disrupts an individual's everyday life (Charmaz, 2000; Conrad, 1987; see also Bury, 1982). The diagnosis of a chronic illness interferes with everyday life, requiring lifestyle changes to live with a disease long-term (Lundman & Jansson, 2007; Pierret, 2000). Depending on the severity and nature of the condition, the disruption manifests with a well-defined "before" and "after" period (Nack, 2008; Pierret, 2000). A growing area of research studying people diagnosed with chronic illness has focused on how people learn to live with illness, particularly taking the viewpoint of the affected (Conrad, 1987; Lundman & Jansson, 2007; Pierret, 2003, 2007; Thorne & Paterson, 2000). The research community has posited

¹The HIV/AIDS rates among Puerto Ricans are likely much higher than the figures reported because current HIV/AIDS surveillance programs do not distinguish Puerto Ricans born in the U.S. mainland from Latinos as a whole.

important questions about how people manage life after a diagnosis: how is everyday life informed by the disease, how are individuals shaped by the social and cultural context of the illness, and how do people assign new meaning to their lives? Implied by these questions, the scope of research focuses on studying and interpreting how people move forward after receiving the diagnosis of an chronic illness, an orientation not only concerned with an individual's life with illness, but one that recognizes the diversity of experiences as well (Thorne & Paterson, 2000; see also Conrad, 1987; Pierret, 2003).

The impact of illness on everyday life has been the focus of many studies that examine the adjustments people make when facing an incurable illness (Nack, 2008; Shaul, 2012; Townsend, 2011; see also Charmaz, 2000; Larsen, 2013). An important prevailing body of research on the chronic illness experience has studied the changes people living with chronic illness make to achieve "normalcy" after being diagnosed (Joachim & Acorn, 2000; Miedema, Hamilton, & Easley, 2007; Millen & Walker, 2001). Joachim and Acorn (2000) conceive normalizing as the strategies people use to cope and feel like a part of society "rising above their chronic condition and its limitations to create a life that is normal for them and even inspirational for others" (p. 43). This body of research demonstrates that people with chronic illness follow an adjustment process that involves strategies (Royer, 1995) for redefining a *sense of normalcy* that coincides with the level of functioning determined by the condition. More precisely, Miller (2000) describes the process in terms of transformation and adaptation, that is, the adjustment involves developing the ability to see life with illness, including the accompanying changes and challenges, as normal. Although normalizing can be interpreted as a common form of illness management (Darling & Darling, 1982), critically, normalization provides a lens to study and interpret the adjustments people make as they reconcile illness into their everyday life experience.

Relationships and Family Planning in the Context of HIV

In the case of HIV, diagnosis is a life-changing event accompanied with feelings of despair and loss. The diagnosis is also often associated with receiving a death sentence (Cherry & Smith, 1993) and, for many, represents an unwelcome invitation to systematic discrimination (Herek, Capitano, & Widaman, 2002) and a future of uncertainty (Mishel, 1997). Negative experiences, including stigma, isolation, and rejection, are common among people living with HIV (Herek et al., 2002; see also Brimlow, Cook, & Seaton, 2003; Varas-Díaz, Serrano-García, & Toro-Alfonso, 2005). An HIV diagnosis involves reassessing aspects of daily life and making adjustments to one's physical, emotional, spiritual, and social life and, thus, significantly affects dating, marriage, and parenthood.

Dating and marriage after an HIV diagnosis is challenging; often, HIV-positive men face many issues when trying to reengage in sex and meeting life partners. HIV-positive men experience rejection and anxiety over the fear of being ostracized, particularly when disclosing their HIV status to a potential partner (Mason, Marks, Simoni, Ruiz, & Richardson, 1995). Much of the literature on relationships among HIV-positive men, mostly based on studies with men who have sex with men (MSM), have noted the difficulties and tension of finding a partner and disclosing the HIV status. Hatala, Baack, and Parmenter (1998) identified that even when using dating sites where anonymity is possible (e.g.,

Internet dating forums), self-identified gay and bisexual HIV-positive men were more likely to avoid disclosure of HIV status in their personal ads despite being upfront about other health issues. Similarly, other studies reported that HIV-positive men actively “make choices” regarding partner selection based on factors related to disclosure and the potential consequences of engaging in sexual behavior. These studies have identified that men either avoid sex altogether, engage in casual sex-only relationships, or become involved in committed or long-term relationships (Relf et al., 2009).

As an alternative, many HIV-positive men opt to engage with partners who are also HIV-positive (Wolitski, Flores, O’Leary, Bimbi, & Gómez, 2007; Xia et al., 2006), especially when pursuing a long-term committed relationship (Harawa, Williams, Ramamurthi, & Bingham, 2006). Seroconcordant relationships, where both partners are HIV-positive, can offer emotional and health protective benefits, along with eliminating the risks and anxiety associated with disclosure (Relf et al., 2009; Serovich, Oliver, Smith, & Mason, 2005). Consistently, the literature on partner selection noted that many HIV-positive men share concerns about not infecting others intentionally (Wolitski, Bailey, O’Leary, Gómez, & Parsons, 2003). Although a great volume of research has been conducted on relationship choices among men living with HIV, the majority of the work has focused on MSM populations.

Fatherhood is important in the lives of HIV-positive men. Parenting has been reported to have a positive impact on the overall well-being of men living with HIV, giving additional meaning to their lives after the HIV diagnosis (Paiva, Ventura Filipe, Santos, Novaes Lima, & Segurado, 2003; Sherr & Barry, 2004). Most research on parenthood in HIV populations has focused on the decision making and reproductive rights of HIV-positive women (Sherr & Barry, 2004; see also Kanniappan, Jeyapaul, & Kalyanwala, 2008; Semprini & Fiore, 2004), and in fact, few studies have examined in-depth family life and parenting desires of HIV-positive men (Paiva et al., 2003; see also Cooper et al., 2007; Myer, Morroni, & Rebe, 2007; Sherr & Barry, 2004). According to this research, being HIV-positive does not eliminate men’s expectation of having children (Chen, Philips, Kanouse, Collins, & Miu, 2001; Cooper et al., 2007; Paiva et al., 2003). The desire to father children is particularly greater among men without children in comparison with men who had fathered children prior to their diagnosis (Chen et al., 2001). Notwithstanding these desires, men tend to express hesitation to have children because of strong social prejudice and disapproval toward an HIV-positive person conceiving a child (Segurado & Paiva, 2007; Sherr & Barry, 2004). Furthermore, men often state concerns about the risk of infecting their partner or the child when asked about expectation to have children (da Silveira Rossi, Fonsechi-Carvasan, Makuch, Amaral, & Bahamondes, 2005; Paiva et al., 2003). In this regard, research has identified that although advances in medical science can reduce the risk of transmission (Cohen et al., 2011), some men consider alternative options to fulfill fatherhood expectations, such as artificial insemination or adoption (AIDS.gov, 2012).

To our knowledge, no studies have been conducted in the United States that examine dating, marriage, and parenthood among Latino HIV-positive heterosexual men as they normalize their lives within the context of HIV. To begin addressing this gap in the literature,

qualitative method was used to examine how a group of heterosexual HIV-positive Puerto Rican men engage in dating and approach marriage and family planning.

Method

The findings presented in this article are part of a larger ethnographic study investigating the positive impact of illness among a group of HIV-positive Puerto Rican men living in Boston. The qualitative study consisted of three phases of data collection: (Phase 1) exploratory research using focus groups, followed by (Phase 2) semi-structured in-depth interviews, and (Phase 3) a town-hall meeting format presentation to validate the study findings. Participants from the exploratory focus groups (Phase 1) were excluded from the in-depth interviews (Phase 2).

This article reports on findings from 24 in-depth interviews conducted during the second phase of research. A total of 31 interviews were conducted with HIV-positive Puerto Rican men during that phase of research. In efforts to focus our research on heterosexual men, 7 participants who self-identified as gay during the interview were excluded from the analysis. Interviews were semistructured and open-ended to explore key research topics. The participants were asked questions about living with HIV, including their experiences of illness, stigma, and life changes since their diagnosis. The major objective of the interviews was to explore how these men live with HIV as a chronic illness and, specifically, to document everyday living with HIV. The interviews included a short questionnaire to collect general demographic information and HIV history. The 1.5 to 2.5 hour interviews were conducted in a private setting to ensure confidentiality. Interviews were conducted in the preferred language of the respondent, the majority of which chose Spanish. Only two interviews were conducted in English.

Participants

The participants were recruited using convenience sampling at different community-based organizations that provide HIV/AIDS services to Latinos. Potential participants were informed about the study by program staff and by flyers posted at the agencies. Interested participants contacted the lead author and were then screened to determine eligibility. To participate in the study, individuals had to self-identify as Puerto Rican and be HIV-positive or diagnosed with AIDS, male, and 18 years of age or older. Additionally, individuals had to be able to give informed consent to participate. Despite the limitations of convenience sampling (Marshall, 1996), the study captured variation in the sample in terms of place of birth, mode of HIV transmission, and length of time living with HIV, in addition to other common socioeconomic indicators (see Table 1).

The study's protocol was reviewed and approved by the institutional review board of the university where the lead author is affiliated and by the institutional review board at a public health organization in the Boston area. A Certificate of Confidentiality was obtained to ensure maximum protection for study participants. The participants were asked for and gave informed consent prior to participating in the study. Each participant received \$30 for his time at the end of the interview. The names that appear throughout this article are pseudonyms to protect participant identities.

Data Analysis

To maintain the integrity of the data, the interviews were audio recorded and transcribed. All the participants agreed to be recorded and each session was transcribed using the original language. Maintaining the original language of the interview during transcription is critical for the analysis of qualitative data to safeguard the integrity of the research findings (Oliver, Serovich, & Mason, 2005). The coding of the transcripts was completed in the original language of the interview. After the analysis, selected passages from the interviews were translated into English to be included in the text of this article. Given the original language of these interviews and in an effort to maintain accuracy while reporting these results, the quotations were translated without regard to prescriptive rules of English syntax. The translations were completed by an independent translator. All the translations were checked and edited for accuracy by the lead author.

The data management, coding, and analysis were done using Atlas.ti software v.6 (Atlas.ti GmbH, n.d.). The data analysis was conducted in three stages. First, prior to initiating a systematic data analysis of the transcriptions, a precoding stage was performed. This exploratory step included listening to the recoding of each interview and reading the transcriptions to explore for themes of analysis (Corbin & Strauss, 2008), in addition to verifying the quality of the transcriptions prior to commencing coding. At this stage, particular attention was directed toward identifying patterns in the data: commonalities, discrepancies, curiosities, metaphors, and selections of words, as well as outlier events and cases. The patterns and themes observed during this exploratory stage were documented using the Memo function in Atlas.ti. Memos were then used as codes to link them directly to the text during the coding stage. The use of memos is an important component in the precoding stage of a systematic data analysis (Corbin & Strauss, 2008) and, in fact, much of the analysis of the study was driven by the ideas and themes identified during the precoding stage of analysis.

Second, once the exploratory precoding analysis was complete, the transcripts were coded to identify themes following a concurrent two-step metacoding approach (Ryan & Bernard, 2000). During the first step, the transcriptions were coded for thematic categories describing the participants' social lives and experiences with HIV using codes from a list of predetermined categories related to the primary research topics. These categories included "life changes," "coping," "community," "Puerto Ricanness," and "HIV life." These categories were derived from the literature and from the exploratory focus groups conducted during the initial phase of the research. The second step consisted of coding the text for emergent themes following an inductive approach (Thomas, 2003) to document strategies for adjusting to living long-term with HIV and for coping with the stigmatized notions attached to the illness.

Finally, to complement the systematic qualitative data analysis, additional data mining techniques were performed to explore the data for additional patterns and themes. This stage primarily included a quotation frequency analysis, a report of the number of instances that any given code was used to determine coding trends. This is a powerful technique used to visualize the data and identify unexpected themes (Corbin & Strauss, 2008). This analysis was central to uncovering the themes described in this article.

What follows is a rich, qualitative description of the experiences of 24 Puerto Rican heterosexual men as they reconcile their HIV status into their personal and social lives. The results are presented as shared by these men and interpreted from the perspective that they participate in the process of defining and constructing their own experience of illness (Charmaz, 1991, 2000; Millen & Walker, 2001; Miller, 2000; Nack, 2008). That is, despite the diagnosis and stereotypes of illness, these men exercise agency through everyday practices in normalizing their social lives to redefine what it means to live with HIV. The experiences shared by the men are organized thematically into three main categories to describe, in the context of HIV, (a) dating and sex, (b) marriage, and (c) fatherhood.

Results

Dating and Sex With HIV

Entering the dating world and, particularly, having intimate relationships was reported to be difficult after an HIV diagnosis by some of the participants in the study. Many of the interviewed men remarked that disclosing HIV status to potential partners was challenging. Often, such disclosures were received with rejection, motivating censorship from seeking romantic relationships. “Sometimes women approach me,” explains Mario, “so, a couple of women have approached me, and I ran away. I would reject them because of fear, fear of having to tell them that I’m sick. You know, perhaps for the fear of being rejected.” Aside from the fear of disclosure, some men simply accepted a “damaged goods” status, an internalized stigma of inadequacy, rejecting the possibility of having the same kind of relationships they had prior to the HIV diagnosis. Darío, for example, on learning his HIV status in prison, ended his relationship with his spouse despite her unconditional support for him.

I told her [about my HIV], but she told me she was with me 100%. That the illness was like cancer or other illness. I told her “no.” That this is a very sad case because I can’t have normal sex with her and I have to use a condom the rest of my life. “It’s sad that I have to tell you this,” I said to her, “but is better that you look for a man that can give you children because I can’t give them to you like I would like to give them to you and you have to redo your life.”

Not all men rejected relationships completely once diagnosed. One man listed his options to ease the fear of disclosure and prevent exposing others to HIV:

I know people that are healthy and are with others who are HIV, but it is a big risk. I haven’t not been able to do it. I cannot take a risk like that. I prefer ... to use my five fingers (showing his right hand to indicate masturbation) or to look for a stripper and wear a condom, or look for a person that is like me (HIV-positive).

Other participants in the study took a similar approach opting to dating exclusively HIV-positive women. Marcos explained this choice, “I don’t have to be afraid because they are like me (HIV-positive). They take the medication like I take the medication, so it doesn’t bother me.” Despite their predisposition to exclusively date HIV-positive women, the men noted that very few women attend support groups and HIV programs, making it difficult to find suitable partners. Given this scenario, one man elected relationships that perhaps would

have never been considered prior to being diagnosed with HIV. “Because I love women,” Juan confided, “do you know to what extreme I have gone? To look for a transsexual! Emotionally, I said ‘I can’t have a healthy woman.’ I met some ... there are many beautiful transsexuals, most of them are [HIV] infected.” For Juan, dating a transsexual was not ideal. However, he felt it was safe and convenient given that this person was also HIV positive.

Other men in the study did not feel an HIV diagnosis necessarily prevented or limited them from having active social lives and intimate relationships with HIV-negative women. Although open to engaging in serodiscordant relationships, some men opted to keep their HIV status secret from their partners. However, disclosure became unavoidable in a long-term relationship, as in the case of Luis:

She always asked me “listen, why every time you have relations with me you use condoms? Why, I’m not sick?” And every day that bothered me. One day I told her “look, I have to talk to you. This is what’s happening, this, this, and this (HIV).” I love you, I appreciate you, I have always protected you ...”

Not all men followed the same delayed disclosure strategy. Ramón for example was very proactive when approaching women and disclosing his HIV status to them. “Before anything happens, before anything, I tell them first. That’s my introduction: ‘I’m positive to HIV,’” explains Ramón, later adding: “With your honesty, you open doors.” Although he was aware of the potential for rejection, this had not been his experience. In fact, he believed that being honest about his HIV status was important to his success with women.

These narratives illustrate varying approaches to dating, including ending current relationships, ceasing to look for a partner, exclusively dating HIV-positive individuals, or continuing a relatively typical dating life. These strategies are shaped by the decision to disclose or not disclose HIV status to current or potential partners as well as the individual’s level of self-acceptance.

Marriage With HIV

Marriage was another aspect that men reported having to reassess after their diagnosis. At age 48, Darío, for example, had abandoned the idea of marrying and subsequently having children. While in jail, he had time to evaluate the impact of being diagnosed with HIV on his life projects.

I had a plan for my life to be married with a wife, but that has changed. Thinking in prison, all the suffering, and needing a partner because I was there for many years and I need to enjoy being with a woman and having children. HIV also destroyed that plan.

Despite the challenges motivating Darío’s decision, HIV has not prevented men in the study from getting married (see Table 2). Six men (25%) reported being married at the time of the interview; all of them wed after their HIV diagnosis. A larger portion of the participants (38%) reported being either separated or divorced, but only one participant identified his HIV diagnosis as the reason for his divorce/separation. Nine (38%) of the men in the study had never been married. The men reporting a marriage after being diagnosed, the majority married based on disease status. Sixty-seven percent of the married participants had spouses

who were also infected with HIV. Reinforcing the dating preference noted above, the men explained that being married to someone who is also HIV-positive eliminates potential problems and creates a sense of normalcy. Felix explained:

Felix: You know, in a normal day, I feel normal because my partner, we are both same ... have the same disease. But I think that if she didn't have it I think every day wouldn't be normal

Interviewer: Why do you think that?

Felix: Because of the frustration of not getting her ... not getting the person sick, you know.

Interviewer: So, it helps that your spouse is also HIV positive?

Felix: To me it does. Because I don't have to go to the explaining to another person, which I already have been through that problem.

Although marrying an HIV-positive person presents benefit, certain precautions are not eliminated and changes still take place to avoid re-infection (Crepaz & Marks, 2003). As Ivan explained, intimacy with his wife was "interrupted" when he insisted on having unprotected sex because they were both HIV-positive: "My wife already told me, 'If you don't wear [a condom] there is no [sex].'"

Marrying an HIV-negative person also presents challenges. Several men described the issues of concern when the spouse is not HIV-positive. For example, one participant noted the importance of discussing the implications of HIV on marriage before they wed. "If she doesn't want to accept me like I am, I can't do it," stated Benedicto as a requirement to his HIV-negative girlfriend for getting married. He went through great lengths to make sure she was aware of the implications and potential consequences:

I explained to her that this is an illness that is very very very severe and I told her that she can die also if she has contact with my blood. She can also get the same thing. At the end, we both went to counseling. She accepted me and we were married.

Benedicto described his strategy for a healthy relationship despite his HIV status. His approach involved speaking to his girlfriend about the challenges, discussing the potential risks, and seeking counseling. Not all men follow the same approach when laying the foundation for a marriage. For example, Orlando's case was very different.

Orlando: I got married and I hid from my wife that I was HIV positive.

Interviewer: Ah, she didn't know?

Orlando: No. And then I went and told her. After we got married.

Interviewer: And what did she say?

Orlando: We had problems, but later she started looking for information. I also gave her information and then she ... we got back together because she loves me and I love her. She is still not HIV-positive.

During the interview, Orlando commented that he did not disclose his HIV status prior to his wedding because of fear of rejection. In this case, information about HIV and acceptance were crucial to mending the relationship once he disclosed his HIV status.

Fatherhood With HIV

Fatherhood varied among the men in the study (see Table 2). More than half of the participants had children at the time of the interview ($n = 14$; 58%). Participants who were fathers had 2.2 children on average, with the majority (72%) having two children or less. One participant, Manny (42 years old), reported having five children and was expecting his sixth child at the time of the interview. In total, six men (25%) reported having a child after being diagnosed with HIV. None of the children were reported as being HIV-positive.

Several participants pointed their HIV status for the strong apprehensions to having a family. For example, Luis had not given up on the idea of one day having a family, but he realized that HIV made it more difficult to have children:

I want to have a son or a daughter. It can be done, but you have to follow a procedure, you have to find the right person. Those are long term goals. It's not like if you were a normal person that you can go, the woman gets pregnant, and that's it. My body is not the same like the body of a normal person. It's not the same.

Like Luis, the potential for HIV transmission was a major concern voiced by other men in the study. Because of their HIV status, many participants opted against having any or additional children because of the potential risk of infecting the child regardless of medical treatments available. Some men sacrificed their desire to have a family in order to ensure that another person— either the partner/spouse or child—will not be infected with HIV. Yet this was not a universal belief among the participants. For example, for Diego, having children was a calculated risk he was willing to take to please his wife.

She wanted to take a chance and have a child. I don't know, I don't know what got in me and I said "ok" (laughter)! The child is three months, thank God.... When we went to the doctor, the doctor told her that (the baby was negative) because she took the medications.

In an effort to prevent transmission, another man explored safer options available for fatherhood. Minor looked into the most advanced medical procedures available to reduce the risk of transmission. "Supposedly, in California they take the semen and extract the virus from it, they can take the virus out," he explained in detailed, "[then] they freeze the semen and they can impregnate the mom and the baby is clean." Even with the aid of advanced medical treatments to reduce prenatal transmission available today (Mofenson, 1999; see also Lindegren et al., 1999), having a child involves the potential risk of HIV transmission. This is something Benedicto and his wife experienced while having their first child:

We went to counseling. We went to counseling for medications and we were told the percentage that she could become HIV positive. So, we had our son. He is clean (HIV-negative), but she is positive (HIV).... But we didn't pass it to our son.

Discussion

Although HIV has been at the forefront of public health discourse for roughly 30 years, approaches to living with HIV only date back to the late 1990s, when advances in medical treatment altered the outcome of an HIV diagnosis. Our data support theorists and researchers in that the men in this study are *living with*, instead of *dying from* HIV, reasserting the notion of HIV as a chronic illness instead of a death sentence. The chronicity of HIV is underscored in how people manage to live after a diagnosis and work to establish a sense of normality within the context of living with the illness. The importance of normalizing life is highlighted by the qualitative findings of this study. For many of the men in this study, moving beyond the diagnosis implies moving on with life and engaging in everyday social aspects of life such as dating and sex, marriage, and parenthood. The findings in our study indicate that being HIV-positive does not necessarily deter most men from having an active sexual life, marrying, or having children. However, these participants acknowledge that they reframe these expectations as part of a new normalcy with HIV.

Our findings support the concept of a “before” and “after” to describe changes originating from the disruption caused by an HIV diagnosis and the new normalcy established by making adjustments to living with an incurable disease (Lundman & Jansson, 2007), especially one that is sexually transmitted and stigmatized (Nack, 2008). In our study, narratives of intimate relationships and marriage illustrate the everyday life established “after” an HIV diagnosis. For the men who reported having an active dating life and even getting married, an important factor was the decision to choose seropositive or seronegative partners. Most of the men in this study opted for relationships with women who were also HIV-positive as a form of risk and stigma management. Despite the known risk of retransmission or cross infection, there is less perceived risk for infection compared to serodiscordant relationships and less fear of rejection. Moreover, as these men learn to live with HIV, this decision can also underline another important factor central to the experience of illness which involves undergoing a positive identity reevaluation; a similar process is reported by people affected with other chronic illnesses (Humphreys, 2000; Nack, 2008; Ussher, Kirsten, Butow, & Sandoval, 2006). In fact, the growing body of scholarship on HIV and identity highlights that a positive adjustment to HIV involves incorporating the illness into one's identity (Baumgartner, 2007). Since the onset of the epidemic, research has consistently noted that people develop HIV identities through their association with specific HIV/AIDS networks (Roth & Nelson, 1997) and with other people living with HIV/AIDS (Dozier, 1997; Gurevich, 1996). Certainly, the anxiety and fears of disclosure are eliminated in seroconcordant relationships (Rhodes & Cusick, 2000). However, it can be argued that the need to identify and have relationships with others sharing the condition is crucial to making sense of the redefined social world in which they live (Hale, 2004), one with shared meaning, especially as it relates to engaging relationships and life-long goals.

Our data also confirm previous research findings suggesting that the desire for fatherhood is strong among HIV-positive men and being a father gives new meaning to their lives (Paiva et al., 2003; Sherr & Barry, 2004). The literature notes that although pressure to conform to social expectations of having children and a family is common, the stigma of HIV is seen as a barrier to parenthood. Despite the negative view of HIV-positive individuals' desire to become parents (Kirshenbaum et al., 2004), our study corroborates findings suggesting that HIV-status is not the only factor in family planning decision making among these men and their partners (Kirshenbaum et al., 2004). Nevertheless, when the men in the study made a decision to have children or expand their family, it took place in the context of their fear of infecting the child or partner. Often the decision to have children involved a complicated examination of the risks and benefits by both partners while bearing in mind their desire for parenthood.

A number of public health implications and recommendations can be derived from these findings, particularly with regard to the quality of life in the context of chronic illness. Quality of life is related to a satisfied personal life including a healthy sexual and dating life as well as, for some, the expectation of marriage and family. For these reasons, it is important to develop appropriate interventions that (a) assess the impact of HIV diagnosis on men's desires and expectations for dating, marriage, and fatherhood and (b) help individuals reframe these important personal expectations to make healthy adjustments and informed decisions. More concretely, the study findings support the need for interventions that provide men and couples with more information on risk of transmission and family planning, along with counseling on safe practices to enrich sexual fulfillment. Additionally, interventions should focus on couples, as the complexities of relationships in the context of HIV require the understanding and effort of both individuals to maintain health and fulfill desires. Finally, despite the fact that family planning also involves men, it is a component that has been absent from health programs targeting HIV-positive men. Very few, if any, HIV services providers discuss the topic of fatherhood with heterosexual men as part of their traditional care protocols (Sherr & Barry, 2004). Specific programs targeting men should be developed to provide information about family planning and parenting options. Reproductive counseling with a focus exclusively on HIV-positive heterosexual men can be significant in providing information on reproductive choices and alternative fatherhood options.

The results presented in this article must be interpreted within the limitations of the study. First, the methodology and size of the sample of this study place limitations on the generalizability of our findings to other people living with HIV, but nevertheless, it provides a revealing account of men's dating, marriage, and fatherhood experiences in the context of a life with HIV. Another methodological issue worth noting is that any type of language translation can misrepresent the participants' intended responses. In this regard, careful detail underwent in implementing and conducting a rigorous translation plan (see Method). Furthermore, the lead author's knowledge about the target population, derived from spending a significant time in the field, helped corroborate the quality of the translations. Also, the authors recognize that many theories and theoretical frameworks can provide additional insight into the findings of the study (e.g., theories of masculinity). In future studies, it will be important to expand the scope of analysis and consider alternative

frameworks to reflect on the wealth of factors at play in the subject at hand. In addition, although the majority of the men in our sample reported injection drug use as the mode of infection, the impact of drug abuse history on relationships was not assessed in the study. The men in the study all reported to be in recovery, which is not surprising because the study focused only on individuals who were already in care, but it is an important issue to explore in future research given the potential complications (e.g., comorbidities, relapse). Last, additional research is needed to evaluate further the impact of HIV on dating, marriage, and fatherhood. Particularly, research is needed to determine the types of interventions and social services that would be effective in providing support and improving these aspects of life for HIV-positive men.

Conclusion

HIV is no longer a death sentence. Life-saving medical treatments have set the stage for the normalization of life with HIV as a manageable chronic illness. As HIV-positive individuals are living longer and healthier lives, dating, marriage, and parenthood have a significant impact on normalizing life cultivating personal growth and fulfillment. The ability to fulfill life's desires after an HIV diagnosis makes a significant contribution to the overall well-being and allows for considerable social and psychological integration into society. Overall, individuals who are more satisfied with their social support and those who experience less depressive symptoms are more likely to adhere to treatment (Safren et al., 2001), and therefore have better health outcomes and decreased infectivity (Cohen et al., 2011). These positive outcomes have the potential to protect the public's health by decreasing the likelihood of transmission and reducing the incidence of HIV. Last, but not least, although these narratives contribute to expanding the knowledgebase on the chronicity of HIV, more important, they help highlight the continued ability of HIV-positive men to experience many, if not all, aspects of life. In the process, the same personal choices they adopt to normalize life result in processes to de-stigmatize HIV. The narratives of dating, marriage, and parenthood shared by many men in our study speak to rejecting the damaged goods status others often accept with their HIV diagnosis. These men are embracing the possibility of becoming lovers, husbands, and fathers. As one man confessed, "I did not think I could have a family, I couldn't get married, I couldn't have children. And I proved myself wrong. And then I got married, I got a family, I got a beautiful daughter ..." Not all of the men in this study rejected the damaged good status that often accompanies an HIV diagnosis, as exemplified by the narratives rejecting the possibility of intimate relationships. However, for many men in this study, dating, marriage, and parenthood become alternative normalizing spaces that can positively affect the perception others have, at least in their social networks, about people diagnosed with HIV.

Acknowledgments

Funding

The author(s) disclosed receipt of the following financial support for the research, authorship, and/or publication of this article: This work was supported by the Puerto Rican Diaspora Research Grant, Hunter College, NY; Florida International University Dissertation Year Fellowship; the Ruth L. Kirschstein National Research Service Pre-doctoral Fellowship to Promote Diversity in Health-Related (1F31MH084549-01A1); and The Center for Substance Use and HIV/AIDS Research on Latinos in the United States (NIMHD: P20MD002288).

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Table 1Demographics and HIV History of Participants ($n = 24$).

	Mean (Min, Max)	<i>n</i> (%)
Age	45 (26, 65)	
Length in the U.S. (years) ^a	22 (2, 45)	
Place of birth		
Commonwealth of Puerto Rico		20 (83%)
Mainland U.S.		4 (17%)
Education		
Less than high school		13 (54%)
High school or GED		9 (38%)
Beyond high school		2 (8%)
Employment		
Employed (PT or FT)		4 (17%)
Unemployed		3 (13%)
Does not work		17 (71%)
Length of time with HIV (years)	16 (2, 25)	
HIV transmission category		
IDU/IDU-heterosexual sex		18 (75%)
Heterosexual contact		5 (21%)
Unknown or other		1 (4%)

Note. Pt = part-time; FT = full-time; IDU = injection drug use.

^aExcludes U.S.-born Puerto Ricans.

Table 2

Martial and Family Status of Participants ($n = 24$).

Status	<i>n</i> (%)
Married	6 (25%)
Married after HIV diagnosis	6
Married (HIV-positive spouse)	4
Married (HIV-negative spouse)	2
Single (never been married)	9 (38%)
Men with children of their own	14 (58%)
One child	4
Two children	6
Three children	2
Four or more children	2
Men having children after HIV diagnosis	6 (25%)
HIV positive children	0
Men without any children (own or spouse's)	10 (42%)