

**Factors contributing to the coping mechanisms of sero-discordant  
relationships**

by

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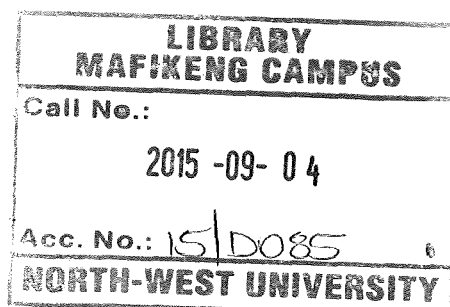
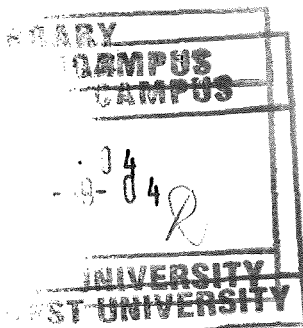
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**Supervisor: Dr. B.M.P. Setlalentoa**

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## ABSTRACT

Sero-discordant relationships are becoming popular as the scourge of HIV progresses in the country. This new trend emerges at the time HIV is still attached to stigma and discrimination despite the fact that HIV has been around for over 30 years; and nowadays many individuals are voluntarily disclosing their HIV positive status. As challenging as all relationships are, the researcher assumed that because of the presence of HIV in their lives, sero-discordant relationships must be hard hit with multiple challenges.

This study aimed at exploring coping mechanisms in sero-discordant relationships. Ecosystems theory, task centred model as well as strength based approach were used to guide the study to understand the people in their environment. The theories supported the notion that systems are interrelated and interdependent on one another. Strength based approach was useful to tap on the couples' strengths that assisted them to cope thus far by giving them tasks that assisted them to find the strength that lies within them to thrive and do well in their relationship.

The study adopted a qualitative research method; the purpose behind using this approach was to understand sero-discordancy and its challenges as well as the coping mechanisms that couples have been utilising thus far in their relationship. To achieve this, literature from different sources was reviewed and through semi-structured interviews conducted mainly at the couple's homes. An interview guide was used with key informants.

The results indicated that couples who found out their HIV sero-discordant status while in a relationship tend to struggle on adjusting to this new lifestyle. This type of relationship is fraught with many challenges one of which is stress resulting from feelings of betrayal where issues of infidelity would crop in. Then fear of transmission where the negative partner does not want to be infected and the positive partner is careful not to infect the negative partner.

Stigma and discrimination also adds as a hindrance. It makes it difficult for couples to disclose and openly live with their different HIV status because of the assumption that when a positive partner status is known it is automatically assumed that the

negative partner is also HIV positive. In spite of all the challenges faced by sero-discordant couples most of them learned to cope and thrive in their relationship.

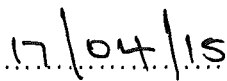
Aspects such as condom use, counselling as well as ARV's were mentioned as some resources that assisted them to cope and make their relationship a success. The negative partners also mentioned love and children as the main reasons they chose to stay in this relationship while knowing the possibilities of them getting infected are high.

Declaration

I hereby declare that this study is my original work and that it has not been submitted to any institution in any form of a degree or otherwise. Where the work of others has been used, it has been duly acknowledged.

  
.....

Ms.R.L.Tshoma

  
.....

Date

## Dedication

This study is dedicated to the following people:

My late friend Naledi Kushumane, who passed away on August 2014. May her soul rest in peace.

Most importantly to all sero-discordant couples who shared their experiences and feelings with me. May you be blessed and continue to love and support one another.

## Acknowledgements

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- Management and volunteers of life-line Vryburg for their involvement in the study.
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- My friend and former colleague, Mr D.T. Masilo, for his support.
- My loving family, my husband, Letlhogonolo Puso and daughter Refentse Puso, thank you so much...

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## CHAPTER 1

### GENERAL ORIENTATION OF THE STUDY

#### 1. INTRODUCTION

HIV and AIDS are a global health and socio-economic concern. According to the World Health Organization (WHO 2013:01) there are over 35.5 million people worldwide who were living with HIV at the end of 2012, an estimated 8% of adults aged 18-49. The number of people infected with HIV continues to rise in most parts of the world. Despite the implementations of prevention strategies, Sub-Saharan Africa is by far the most affected region. In 2010, an estimated 68% (22.9 million) of all HIV cases and 66% (1.2 million) of all deaths occurred in this region. This means that about 5% of all the adult population is infected. In this region, women compose nearly 60% of these cases. This shows that HIV infection is an epidemic in sub-Saharan Africa which is home to over 12% of the world's population (Nattrass 2012:2). In addition, Avert (2012:1) sees HIV in sub-Saharan Africa as a triple challenge with detrimental effects on healthcare; it puts a strain on the health sector when the demand for care of those living with HIV/AIDS increases. The life expectancy in this region is now estimated to be 54.4 years. It is to be acknowledged, however, that there is a significant improvement in dealing with HIV in some parts of sub-Saharan Africa. However, in 2011, there was a 25% reduction of new HIV infections in 22 countries as well as a reduced mortality rate.

South Africa is believed to have more people living with HIV and AIDS than any other country in the world, 5.7 million people living with the virus are South African. For decades, the prevailing belief amongst South Africans was that HIV and AIDS was a disease of the poor. Today HIV is found everywhere even amongst the country's richest (Van der Linde, 2013:2) Young people aged 15-24 make up the largest proportion of HIV infected people and of all the new infections in that age group, 77% are women (PEPFAR 2012:1). At a media briefing on 31st March 2014, Dr. Motsoaledi, the Minister of Health, stated that there were about 400 000 new HIV infections of females aged 25-34 in 2012 (SABC 2 News-2014).

Cichocki (2011:2) is of the view that this may be as a result of the notion that South Africa is a patriarchal society where men have the social, political and economic power. Women are not in a position to make decisions that impact their lives including the use of methods for safer sex. The Department of Health in its National Strategic Plan for HIV and AIDS and TB (2012-2016:14) states that the HIV epidemic in South Africa is largely driven by sexual transmission. It further indicates that South Africa is responding to its HIV epidemic, where life expectancy has increased by 10% since 2005. The strategic plan aims to halve the current infection rate by 2016.

In the North West Province in particular, the sexually active age group (15-49) represent 54.3% of the population of 3.1 million in the North West, and HIV prevalence amongst this age group is 18.6% (PEPFAR 2012:1). Monticelli (2009:03) on the other hand discovered that in the Dr. Ruth Segomotsi Mompoti District, the most deprived socio-economic quintile in the North West Province is also experiencing an increase in terms of HIV. HIV prevalence amongst ante-natal clients who were tested ranged from 21.8% in 2005/6 and 26.6 % in 2007/8 to 28.1% in 2008/9.

According to UNAIDS (2008:02) the most affected victims in the AIDS pandemic are the children. It is estimated that worldwide, 16 million children have been orphaned due to AIDS. 14.8 million of these live in sub-Saharan Africa, with South Africa being home to 1.9 million AIDS orphans. This means that 13% of the South African children have lost either a father or a mother or both due to an AIDS related illness (UNAIDS 2008:02). This is also explained in Ubuntu Africa NFT (2013:1) that the worst affected children are those in deeply impoverished households. They not only lose their parents, but also their livelihoods and social networks. They often relocate and are sent to stay with a relative far away. In the most extreme cases the siblings are split up and shared among the family members. A trend of child-headed households also emerges as a result of the death of the parents.

The hardship for those infected and their families begins long before people die. The death of a working member of the family, who is most often the breadwinner, has an on-going impact on the remaining family members. Death, as mentioned by Collins and Leibbrand (2007:2), poses a substantial and lingering burden from the funerals that surviving members need to finance and an on-going loss of income.

HIV is a life-threatening disease that still has stigma and discrimination attached to it. According to UNAIDS (2005:10), the stigma of HIV stems from the fear as well as the association of AIDS with sex, disease and death, and behaviours that may be illegal, forbidden or taboo such as sex work and drug use. Both individuals and couples are exposed to this disease. However, there are situations where one partner will be infected and the other continues to test negative. Such couples are referred to as sero-discordant couples,(Beckerman, 2002:35).

Canadian AIDS treatment information exchange-Catie (2011: 01) explicitly explains that a sero-discordant couple is made up of one person who is HIV negative and the other who is HIV positive. He further explains that the term 'sero-discordant' originates from the word sero-conversion, a medical term for becoming HIV positive and the word 'discordant' means 'at odds'. Instead of using the term 'sero-discordant', other authors use terms such as 'mixed status', 'magnetic' or 'positive-negative'. The challenges faced by couples in these relationships are mainly based on the fact that HIV is present Canadian AIDS treatment information exchange-Catie (2011: 02). The study conducted by Simpore,Compore,Sawadogo,Djigma, Ouerma, Martinetto, Pietra, Fa.bo, Have and Garcia (2011:186) concludes that with the increase in the number of HIV positive people in the world, it creates a high probability that one could meet an HIV positive partner.

Many people assume that when an HIV negative person dates an HIV positive person, s/he must either already be HIV positive or will eventually be HIV positive. The Department of Health gazette (2001:62) maintains that a safe sex standard for sero-discordant couples should be very stringent, with sexual activity limited to masturbation. However, there is no guarantee that couples will adhere to such advice and hence the use of condoms for vaginal or oral contact is encouraged.

Degrees andOrne-Gliemann (2008:1) believe that a "large proportion of HIV infections occur within stable relationship either because of prior infection of one of the partner or because of infidelity". Relationships are intricate social encounters, fraught with possible stresses and complexities. Add HIV to the mix and one would have what some people may see as a near impossible situation. But that does not have to be the case. According to *Siyayinqoba Beat it* (2009:1), with honesty, trust

and respect, a sero-discordant relationship can even be healthier than average relationships.

Sayler (1999:01) indicates that sero-discordant couples face similar issues regardless of sexual orientation. The couples live with fears about HIV transmission to the negative partner and concerns about maintaining a safe but satisfying sex life. A profound lack of support is encountered by some from family and friends who question why they continue a relationship full of risks such as transmission and death. Even though death can happen in any relationship, the presence of HIV makes it more likely.

It is against this background that this research study investigated the coping mechanisms of sero-discordant couples who reside in Vryburg and Ganyesa in the North-West Province.

## 2. PROBLEM STATEMENT

In marriage or courtship, sex is seen as a means to bring the couple close together. In the case where one partner is HIV positive, the researcher's concern is how knowledgeable these partners are about protection, reproductive choices (such as when they want to have children) and the prevention of HIV transmission to maintain a healthy, and mutually supportive long-term relationship. Also, whether their individual level of education, even though it may not be high, gives them the ability to make important decisions, and negotiation skills as well as the love for one's self. The level of education as far as HIV is concerned provides empowerment to prevent infection, for young people to delay sexual activities and to take appropriate measures to protect themselves (A joint report by UNAIDS, UNFPA, UNIFEM 2004:39). Therefore, emphasis is to understand their coping mechanisms in terms of protection and nurturing of a relationship

According to Kinghom as cited by Mabuza (2010:6), the impact of the HIV and AIDS epidemic on producing HIV sero-discordant couples affects primarily young and middle aged adults between the ages of 20 and 44 years. This is backed by the statistics gathered at Life-line centre in Vryburg. Life-line is a non-profitable organization that provides voluntary counselling and testing (VCT), their campaigns include testing couples together at the same time. This initiative began during its formation in 2009 as part of the funding requirements by the President's Emergency Plan for AIDS Relief (PEPFAR) in which 10% of the statistics of Life-line (Vryburg) had to reflect couples testing. In 2013 alone, they have tested 140 couples and found 80 middle-aged couples to be in a sero-discordant relationship (Life-line archives 2013:48-52). 50% of the couples in sero-discordant relationships were found in Vryburg (Naledi municipality), followed by Schweize-Reneke (Lekwa-teemane municipality). Greater Taung and Ganyesa (Kagisano-Molopo municipality) are the lowest at 10% each.

This study, therefore, sought to understand their coping mechanisms, in terms of stigma and criticisms, and discover other issues pertaining to their relationship such as issues of caretaking, future planning, sexual satisfaction, pregnancy and child rearing. Information was gathered from the couples themselves. This study answered the following research questions:

- What is the extent of sero-discordant couples in the selected area of study?
- What are the challenges that sero-discordant couples face?
- What are the coping mechanisms used by sero-discordant couples?
- What are the intervention strategies that can help strengthen sero-discordant relationships?

### **3. AIM OF THE STUDY**

This study aims at exploring the coping mechanisms of the sero-discordant relationship in Vryburg and Ganyesa area.

### **4. OBJECTIVES OF THE STUDY**

According to Brink (1996:89), objectives specify what will be done in the research process. It is stated further that the objectives should be smart, specific, measurable, attainable, realistic and achievable within a certain time-frame. The study was based on the following objectives:

- To understand the extent of the sero-discordant relationships in the selected area of study.
- To identify the challenges of couples living in a sero-discordant relationship.
- To understand the coping mechanisms used by couples in a sero-discordant relationship.
- To propose intervention strategies and programmes to help strengthen sero-discordant relationships.

## 5. SIGNIFICANCE OF THE STUDY

According to Brennen (1992:93), the significance of the study focuses on the contribution of the study to the social work profession, to policy and programme development and to the community where the study was conducted. The findings of the study would:

### **In terms of Policy:**

Assist the Department of Health and the Department of Social Development to create awareness programmes and develop pamphlets about HIV and AIDS with specific reference to sero-discordant relationships.

### **Theoretically:**

The results would contribute to existing knowledge and develop literature to understand how people in a sero-discordant relationship cope.

### **In practice:**

Assist the community to understand that people in sero-discordant relationships can cope and maintain their different status.

Highlight programmes to assist social workers to understand sero-discordant couples better.

## 6. ASSUMPTIONS

The following assumptions were made before the study:

- The negative partner compromises her chances of enjoying a fruitful HIV free life by being in an intimate relationship with someone who is HIV positive.
- The negative partner is not free to engage in sexual intercourse because of fear of being infected.
- The reasons for HIV infection in a relationship are paramount and contribute to all challenges experienced by the couple.
- The HIV positive partner is unfair to have allowed someone who is HIV negative to be in an intimate relationship with him or her.

## 7. THEORETICAL FRAMEWORK

The frameworks that shaped this research project are:

- Eco-system theory

Due to its emphasis on the person in his or her environment, this framework was used when dealing with the presence of HIV in a family as a system and on prevailing issues such as stigma.

- Task centred model

This framework guided the researcher by providing tasks that assists the participants to deal effectively with their challenges.

- The strength perspective

The strength perspective was used to tap into the couple's strengths looking at their knowledge and skills.

\*\*These frameworks are discussed in detail in Chapter 2: Literature review.

## 8. DEFINITION OF CONCEPTS

**Factors:** according to the Oxford Dictionary (2002:412), a factor is a circumstance, a fact or influence that contributes to a result. In this study, a factor can mean any circumstance or condition that can contribute to a person coping when in a sero-discordant relationship.

**Coping mechanisms:** To cope means to come to terms with or deal with a situation successfully. Therefore, a coping mechanism is a way of enabling a person to successfully deal with difficult situations or circumstances. Coping mechanisms can also be described as survival skills. They are strategies that people adopt to deal with life experiences that cause stress, pain or trauma (Hope calls, 2013. 01).

Aldwin (2007:117) describes coping as an organizational construct that describes how people regulates their own behaviour, emotion and motivational orientation under conditions of psychosocial distress. It contains people's struggle to maintain, restore, replenish and repair fulfilment of these needs.

**Sero-discordant relationship:** According to Canadian AIDS treatment information exchange-Catie (2011: 01), a sero-discordant relationship consists of one person who is HIV positive and one who is HIV negative. The term 'sero-discordant' originates from the word 'sero-conversion' which is a medical term for becoming HIV positive, and the word 'discordant' which means 'at odds'.

Instead of sero-discordant, others use words such as magnetic, sero-divergent, or mixed status to describe this relationship. For the purpose of this study, sero-discordant relationship refers to a relationship where one partner has been tested and confirmed that he/she has HIV antibodies in the blood and the other partner confirmed and tested to be HIV negative. To participate in the study, the couple should have been in a relationship for at least one year.

## **9. LIMITATIONS OF THE STUDY**

Treece and Treece (1994:104) define limitations as the criticism of the validity and reliability of the instruments, the content of data, the evidence of investigation and the respondents' honesty. The following limitations were envisaged:

The study was carried out in Vryburg and Ganyesa. This research provided some insight into the field of study and served as a general guideline for further research. The topic under study is very sensitive and some participants were hesitant to provide personal information. However, as the researcher is a registered social worker who is trained in principles such as confidentiality and individuality, the researcher confidently overcame this challenge. Ethics were also considered where the participants signed a consent form.

Since this is a relatively new area of interest, especially in the South African context, the researcher grappled with finding appropriate literature sources. Nevertheless, service providers such as the North West Provincial AIDS Council, Lifeline counselling centre and the Department of Health were contacted for information, because they work closely with HIV and AIDS issues.

## 10. ETHICAL ASPECTS OF THE RESEARCH

Ethical clearances were sought from the Department of Social Development and Life-line counselling centre as well as from the North West University ethics committee and ethical clearance number NWU-00243-14-A9 was provided. It was necessary to do so basically because human participants are involved and permission must be granted. This is supported by Morris (2006:249) who states that the process of ethical clearance assesses any potential harm to study participants and also evaluates the provisions for protection of the study participants' privacy, confidentiality and anonymity.

HIV&AIDS is a very sensitive and personal matter. When dealing with such a societal problem, it rests with the researcher to protect the subjects; hence ethics need to be considered for a successful research project. Data should not be obtained at the expense of human beings. According to De Vos *et al.*, (2005:63), ethics are a set of moral principles suggested by an individual or group. They are widely accepted and offer rules and behavioural expectations about good conduct towards research participants and other researchers. The following ethical considerations that govern this research project are found in De Vos *et al* (2005:58-67).

### 10.1 Avoidance of harm

Strydom (in De Vos, Strydom, Fouche and Delpont, 2005:160), asserts that subjects could be harmed in a physical and/or emotional manner. Discomfort may arise from being involved in this investigation. Respondents were thoroughly informed about the potential harm of this investigation before the research was conducted. The researcher arranged a debriefing session and referred those participants who needed further counselling sessions to their ward social workers to manage further.

### 10.2 Informed consent

According to Darlington and Scott (2002:25), the capacity of an individual to freely give their informed consent to research is a core principle in research ethics; it is a capacity that can be diminished by many factors.

One factor that is commonly mentioned in research ethical guidelines is that of incentives. Informed consent basically means that no subject should be forced to participate in a research project. Participation in this study was strictly voluntary and participants were made aware that they were at liberty to withdraw at any time. Consent forms were given out and signed by the participants.

### **10.3 Confidentiality/anonymity**

The right to confidentiality means that individuals decide when, where, whom and to what extent their act of behaviour or belief should be revealed. The information was gathered in such a way that it cannot be traced to a particular person. Names were not required in the questionnaire and during interviews and participants used pseudonyms (not their real names).

### **10.4 Debriefing of respondents**

Debriefing sessions were held after the session to provide participants with the opportunity to work through their feelings and experiences during the interview. Participants were briefed about the data collected to see if it is a true reflection of what they contributed and participants that need follow-up counselling were referred accordingly.

## **11. OUTLINE OF THE RESEARCH REPORT**

Chapter 1: General orientation of the study

Chapter 2: Literature review and theoretical frameworks

Chapter 3: Research methodology

Chapter 4: Data presentation, analysis and interpretation

Chapter 5: Main findings, conclusions and recommendations

## CHAPTER 2

### LITERATURE REVIEW AND THEORETICAL FRAMEWORK

#### 1. INTRODUCTION

This chapter presents an overview of the literature on HIV and AIDS as a health, social and cultural problem. Specific discussion is about the relationships involving sero-discordancy and on coping mechanisms used by couples who are in such a relationship. Intervention strategies used by social workers are unpacked to understand sero-discordancy from a professional view. Sero-discordant couples are defined by Bell (2002:1) as "couples with one HIV positive partner and one HIV negative partner". In order to investigate the coping mechanisms of sero-discordant couples, it is necessary to understand what challenges they face and then explore the mechanisms they engage in to cope with such situations.

The topic under study is relatively new and it has not been explored extensively especially in South Africa, and so there are limited sources available. It was therefore interesting to uncover the hidden issues and explore new avenues. The literature is reviewed from recent journals, articles in newspapers, pamphlets, magazines and the internet. There are no statistics currently available on sero-discordant couples as this statistic is incorporated with other statistics on HIV and AIDS. This makes it difficult to measure the contribution of sero-discordancy to new HIV infections. Through engaging in a comprehensive literature study, the researcher ensured that there is no duplication of the proposed research, or may be motivated to further address certain aspects of previously undertaken research.

In any relationship, there are challenges, but because of HIV and AIDS, sero-discordant relationships are regarded by Bunnell, Nassozi, Mubangizi, Malamba, Dillon, Kalule, Bahizi, Musoke and Mermin (2005:999) as first level high risk in terms of contracting HIV. Hence, preventative measures such as use of a condom should always be adhered to when in this relationship. The literature overview includes:

- The extent of HIV and AIDS in South Africa
- The Sociocultural aspects of HIV/AIDS in South Africa
- The impact of sero-discordancy in a relationship
- Coping mechanisms in sero-discordant relationships
- Prevention strategies available for sero-discordant couples
- Theoretical frameworks that underpin the study.

## 2. THE EXTENT OF HIV AND AIDS IN SOUTH AFRICA

HIV and AIDS continue to be one of the biggest challenges in South Africa today. Its face has changed from the initial labeling that HIV is the disease of the black heterosexual Africans, the poor and uneducated (WHO 2006:01). HIV and AIDS prevalence of 5.3% amongst whites, when compared with infection rates in Europe (0.3%), has proved that HIV and AIDS constitute a general disease also within the white community (WHO 2006:01).

It is without a doubt that the hardships for those infected and their families begin long before people die. Stigma and denial related to suspected infection cause many people to delay or refuse testing. Usually, the fear and despair which often follows a diagnosis at times is due to poor quality of counseling and lack of support. Poverty prevents many infected people from maintaining adequate nutrition to help prevent the onset of AIDS. Other compelling challenges include limited access to clinics and due to the long waiting lists for ARV treatment programmes and eligibility criteria for access to ARV's. This means that many people become seriously ill before accessing treatment. This may cause loss of income and support when a caregiver or breadwinner becomes ill, and the diversion of household resources to provide care exacerbates poverty. The challenge we still face is that people are not testing timeously. Therefore, they only realize that they are HIV positive once they are very ill at quite a late stage of the disease progression (AIDS foundation South Africa 2013:3)

HIV and AIDS pose a gender dimension. This is because women face a greater risk of HIV infection than men. According to the AIDS foundation South Africa

(2013:03), on average in South Africa there are three women infected with HIV for every two men who are infected. The difference is greatest in the 15-24 age groups, where three young women for every one young man are infected. UNICEF (2012:01) adds that women continue to be the face of HIV and AIDS in South Africa. UN AIDS says the prevalence among young women between the ages of 20-24 has peaked at an alarming 18%, fuelled by sexual violence, while the rate of prevalence among men in the same age group is at 6%. Unfortunately women's vulnerability to HIV infection is particularly heightened by their economic dependence on men, lack of access to education, poverty, sexual exploitation, coercion and rape or commercial sex work. HIV positive women face acute discrimination because they are often the first to test positive through pre-natal testing. This then brands them as HIV spreaders. They end up being physically abused and face threats of being chased from their homes (UNICEF 2012:01).

According to the AIDS foundation South Africa (2013:01), for many years the burden of care and support has fallen heavily on the shoulders of impoverished rural communities. The burden has been upon family members, particularly children and older people. Caring for terminally ill adults and orphan-hood compromises the physical and mental wellness of entire households, where 2.1 million children had been orphaned due to AIDS in South Africa by 2011. This all happens in a society where the majority of children live in poverty and 25% of the economically active population is unemployed. Whiteside and Sunter (2000:25) dismiss these statements; by contending that there are many rich communities who have HIV positive members. Therefore, it is not necessary for HIV to be associated with poverty. They further argue that there are relatively poor countries which have a low prevalence of HIV.

However, South Africa has made positive strides in managing the HIV and AIDS epidemic since the end of 2008. The number of people on ART has increased dramatically to 1 900 000 and there were 100 000 fewer AIDS related deaths in 2011 than in 2005 (WHO 2006:01). A study conducted by Eyassu (2005:01) advises that changing risky behavior and conveying the right knowledge and attitude about HIV and AIDS are essential in minimizing the spread of the disease, whereas the AIDS foundation South Africa proposes that the central focus should be to mobilize an

increased uptake in HIV testing and counseling,behaviour change communication, and a combination of prevention and treatment.

In South Africa, people with HIV have the same rights as all citizens. The Republic of South Africa (108 of 1996)protects the rights of people living with HIV. It does not allow discrimination and protects the people's rights to privacy and confidentiality.

For example Chapter 2 on the Bill of rights section 10 and section 11 on human dignity gives them the right to have their dignity respected and protected, and the right to life (RSA 1996:07).And Section 12 on Freedom and securitystates that everyone has the right to freedom, not to be deprived of their freedom and definitely not to be treated or punished in a cruel, inhuman and degrading way; also not to be subjected to scientific experiments without informed consent (RSA 1996:7-8).

### **3. The Sociocultural Aspects of HIV/AIDS in South Africa**

South Africa is considered to be one of the countries of the world most affected by HIV and AIDS(McNeil 2014:01). Complex reasons can contribute to this and the following are some socio-cultural factors towwhich the rapid spread of the disease in the country can be attributed.

#### **3.1 The political transition and the legacy of apartheid**

The National Department of Health is the steering force in the management of HIV in South Africa. HIV programs that exist are for the general South African public, not only for sero-discordant couples. McNeil (2014:01) gives a brief history of the past since the first reported incidence of HIV in 1982, under the apartheid government led by Mr. P.W Botha.The South African government has been involved starting from creating awareness about HIV up to formulating legislations on HIV. In the new democratic era under the leadership of the late President Nelson Mandela, a shift in focus emerged.The plan was to focus on prevention of HIV through public education campaigns, reducing transmission through appropriate care, treatment and support for the infected, and mobilizing resources to combat HIV and AIDS.

A plan for treatment began with a battle for the provision of anti-retroviral drugs, when AIDS activists called upon the government to distribute an ARV drug called

Zidovudine (AZT) to pregnant women. This in 1998, saw the then Minister of Health Dr. Nkosazana Zuma openly oppose, the public access to the drug and asserted that the South African government's policy was on prevention rather than treatment. The drug has since shown a tremendous prevention of HIV transmission from an HIV positive mother to her unborn baby.

Another controversial phase in the history of HIV and AIDS in South Africa was during the term of the former president Thabo Mbeki. He openly said that HIV does not cause AIDS. His statement was "Does HIV causes AIDS? How? It can't, because a syndrome is a group of diseases resulting from acquired immune deficiency"(De Vos2009:2).

The South African government has made a significant contribution in terms of preventing HIV in sero-discordant relationship. They have introduced pre-exposure prophylaxis, post-exposure prophylaxis and the normal anti-retroviral therapy (ART). According to Mugo, Heffron and Donnell(2011:2), programs aimed at reducing transmission of HIV in discordant couples are too new to evaluate their effectiveness but currently new advances that have demonstrated success in reducing HIV transmission among discordant couples are pre-exposure prophylaxis and anti-retroviral therapy (ART). Developing HIV prevention interventions that target sero-discordant couples could really assist in reducing HIV transmission.

The researcher understands that pre-exposure prophylaxis can be taken by a negative partner before unprotected sex and if it was not taken and unprotected intercourse occurred the negative partner can then take post-exposure prophylaxis.

### **3.2 Poverty and HIV**

McNeil (2014:01) believes that high levels of unemployment and an inadequate welfare system have led to widespread poverty, which renders people more vulnerable to contracting HIV because of the following factors:

- The daily struggle for survival overrides any concerns people living in poverty might have about contracting HIV.
- Strategies adopted by people are made desperate by poverty, such as migration in search of work and "survival" sex-work, are particularly conducive to the spread of HIV and Aids.

- People living in deprived communities where death through violence or disease is commonplace tend to become fatalistic; the incentive to protect oneself against infection is low when HIV is only one of many threats to health and life. Poverty may also breed low levels of respect for self and others, and thus, a lack of incentive to value and protect lives.
- Poverty is generally associated with low levels of formal education and literacy. Knowledge about HIV and how to prevent it, as well as access to information sources such as schools or clinics, is subsequently low in poor communities.

The researcher is of the opinion that, in the context of low income earners who are in sero-discordant relationships, poverty can have a detrimental effect on moulding and sustaining their relationship. Adhering to treatment by the positive partner is important, travelling to access condoms, use of ARVs and healthy eating is pivotal. Poverty may also lead to lack of formal education and limited knowledge of available resources for better coping with the relationship.

### **3.3 Migration and HIV**

Rose-Innes (2009:3) adds that the migrant labour system has been particularly important as a vehicle for HIV transmission. This to-and-fro migration has been a major factor in the spread of HIV and other STIs (which, in turn, increase the risk of HIV infection). People separated from their partner for long periods tend to seek sex outside their stable relationships, which, in the single-sex hostels accommodating migrant labourers, has often been in the form of unsafe male-to-male sex, and making use of the sex-work industry that developed in the vicinity. Men frequently become HIV-infected at their place of work, and then carry the infection back home and pass it on to their wives and unborn children(Rose-Innes 2009:3).

Research has proven that migrant labour practice has also played a part in the formation of sero-discordant relationships. As the researcher mentioned, when separated from their partner for a very long time people end up seeking sex from outside the relationship, and get infected. In some sero-discordant relationships, partners tend not to even know that they are HIV discordant.

### 3.4 Lack of knowledge and misconceptions about HIV/AIDS

It appears that the majority of South Africans have heard about AIDS, and have a fairly good level of knowledge of the basic facts i.e. that the disease is spread sexually, and that condoms reduce risk. Nevertheless, there are still many people, especially those with low levels of formal education who lack access to accurate, relevant information on HIV/Aids and sexuality, who are unaware of the risks (Rose-innes 2009:2).

Higgins, Hoffman and Dworkin 2010:05 see women in particular to have high rates of illiteracy, and many girls do not complete basic education. Also, women may be unaware of risks because their time is taken up with tending the home, and they have limited links with the outside world. Sexual violence in townships, which results partially from cultural norms regarding gender-based power dynamics and partially from psychological desperation, makes women particularly susceptible to HIV/AIDS. Female rates of HIV infection in South Africa are on average five times higher than male infection rates due to biological and social vulnerability (Higgins, Hoffman and Dworkin 2010:05).

Like other socio-cultural problems concerning HIV and AIDS, the researcher agrees that lack of knowledge about HIV is also a problem in sero-discordant relationships. One question in the researcher's mind is whether people lack means to protect themselves. Rose-innes(2009:03) alludes that people who do possess some knowledge about HIV often do not protect themselves because they lack the skills, support or incentives to adopt safe behaviours. The author further adds that high levels of awareness among the youth, a population group particularly vulnerable and significant as regards the spread of HIV/Aids, have not led, in many cases, to sufficient behavioural change. Young people may lack the skills to negotiate abstinence or condom use, or be fearful or embarrassed to talk with their partner about sex. Lack of open discussion and guidance about sexuality is often lacking in the home, and many young people pick up misinformation from their peers instead (Rose-innes 2009:03).

### 3.5 Cultural norms and practices

According to Rose-Innes (2009:3) certain prevalent cultural norms and practices related to sexuality contribute to the risk of HIV infection, for example:

- Negative attitudes towards condoms, as well as difficulties in negotiating and following through with their use. Apparently, though, men in southern African region usually do not want to use condoms, because of beliefs such that “flesh to flesh” sex is equated with masculinity and is necessary for male health. Condoms are also strongly associated with unfaithfulness, lack of trust and love, and disease.
- Urbanisation and migrant labour expose people to a variety of new cultural influences, with the result that traditional and modern values often co-exist. Certain traditional values that could serve to protect people from HIV infection, such as abstinence from sex before marriage, are being eroded by cultural modernisation.

Simbayi, Cloete and Leclerc (2005:13) highlight that the development of cultural approaches to HIV/AIDS presents a major challenge for South Africa. Shisana as cited by Simbayi *et al* (2005:13) adds that whilst all South Africans are affected by the spread of HIV, the burden of the disease lies with the majority black African population. The newly introduced method for HIV prevention is Medical Male Circumcision (MMC) which was initially called traditional male circumcision as it was mainly performed in different cultures when a boy child reached a certain age. Male circumcision involves removing the foreskin, a loose fold of skin that covers the head of the penis. The procedure can be carried out at any stage; during infancy, childhood, adolescence or adulthood. Many societies have been practicing male circumcision for hundreds of years, and circumcision is often seen as a mark of belonging to a particular tribal or religious group (Avert 2005:01).

Avert (2005:01) further believes that since the 1980s, scientists have suspected that male circumcision might reduce the rate of HIV transmission during sex. They observed that circumcised men are less likely to have HIV than uncircumcised men, and HIV is less common among populations that traditionally practice male circumcision than in communities where the procedure is rare. These findings provide

conclusive evidence that male circumcision, if performed safely in a medical environment, roughly halves the risk of a man becoming infected with HIV through heterosexual sex.

According to evidence given, circumcision can also be helpful in sero-discordant relationships. For example, if a woman is the one who is HIV positive in a sero-discordant relationship the HIV negative male partner who is circumcised has a lower chance of getting infected from the HIV positive female partner.

### **3.6 Religion and HIV**

Religious organizations have shown the effects of religious affiliation on HIV prevalence, HIV prevention and AIDS treatment and care. According to Haddad (2011:59), the leaders of religious institutions contribute in a significant manner to the public discourse on HIV and AIDS. As representatives and interpreters of religious beliefs they influence both policy making and popular attitudes. They define moral norms in matters such as condom use or pre-marital HIV test requirements and articulate a religious response to the epidemic. In other words, incidents of sero-discordancy relationships are discovered best in the churches and counseling can be provided.

However, the impact on the sexual behaviour of the members should not be overestimated. At times, the bigger a religious institution, the less likely its members are to follow its teachings, especially on sexual matters. Even though there is no specific pattern, members of 'spirit' type churches are more likely to follow their church's teachings than those of the mainstream churches (Haddad, 2011:64). In other words, when a pastor advises his followers to stop using ARV's because their God has healed them, members do so and end up dying.

According to Stroebel and Van Benthem (2012:02) the Roman Catholic Church's opposition to the use of contraceptives such as condoms has been heavily criticized. It has been argued that by reducing condom usage, the church has contributed to the spread of HIV. The Vatican on the other hand, maintains that allowing the use of condoms would be immoral and against the Catholic doctrine. In addition, it would foster promiscuity leading to an increase in risky sexual behaviour and consequently to a wider spread of the virus.

## 4 THE CHALLENGES EXPERIENCED BY SERO-DISCORDANT COUPLES

All types of relationships require work and are bound to face challenges whether large or small. Everyday stressors can strain an intimate relationship and major sources of stress can threaten the stability of a relationship. Frude (1981:170) cites typical issues in relationships as money, children, sex, chores, in-laws or extra-marital relationships.

The same may be true for sero-discordant relationships, but now, in this case, adds HIV to the mix. The reason why one partner contracted the virus may be the other stressor in the relationship. However, Sovec 2013:03 believes that most relationship problems are manageable; he adds that when challenges are left unaddressed, tension mounts, and that puts the relationship in jeopardy.

The following challenges are based on Cichocki's findings (2007:1). This research established the extent to which these challenges hold true in the Dr. Ruth SegomotsiMompoti District, North West Province, particularly in Ganyesa village and Vryburg.

### 4.1. A care giver in a sero-discordant relationship

Caregiving is also a vital concern in a sero-discordant relationship. Van Dyk (2005:323) explains that a care giver is anyone (professional, lay or family) involved in taking care of the physical, psychological, emotional and spiritual needs of a person infected by HIV or AIDS. Cichocki (2007:1) says that in a sero-discordant relationship, the positive partner is concerned about transmitting the virus to the negative partner. The negative partner commonly devotes his or her attention to the positive partner's health, becoming the caregiver in the relationship.

Johnston (1995:6-8) adds that to combat feelings of helplessness, the HIV negative partner in a sero-discordant relationship sometimes adopts a caretaker role, becoming advocates of their loved ones. They want to be involved in the entire affairs of their partners, to show their support and concern. Both Cichocki and Johnston feel that in a sero-discordant relationship, the negative partner is the one who acts as a caregiver to the positive partner. Being a caregiver to another person

who is experiencing health problems can lead to complicated feelings of guilt and depression. Helping people who cannot care for themselves can be one of the most exhausting, challenging, difficult things to do. Caregivers often get little time to care for themselves, forgetting that one must take care of oneself in order to effectively care for another (Sovec, 2013: 14)

Van Dyk (2005: 223-224) advises that it is important for the self-preservation of care givers and for their emotional survival that they should take care of themselves. Bottled up feelings almost inevitably lead to burnout and care givers need to feel confident and free to express doubts and distress, and seek help. What Van Dyk is saying is very important because a study conducted by Naran (2007) concluded that HIV negative partners in sero-discordant relationship are often neglected because they are regarded as healthy and doctors do not refer them for counselling. Naran (2007:5) further adds that when an HIV negative partner is well cared for psychologically and emotionally, they will be in a better position to care for their HIV positive partner.

On the other hand, Trisdale (2002:17) has a contradictory opinion regarding knowledge and discussions regarding health matters are other sensitive issues in a sero-discordant relationship. The writer states that "Sero-positive partners tend to not involve the sero-negative partner when coming to health matters, which makes it difficult for the sero-negative partner to help the sero-positive partner to manage their illness".

Coping with a loved one's illness can be as stressful as coping with a personal illness. In this regard, Sovec (2013: 14) believes that the couple should talk beforehand about the stress that the HIV negative partner may feel about becoming the caregiver for the HIV positive partner and also the concerns that the positive partner may have about getting sick and needing care.

#### **4.2 Guilt in sero-discordant relationship**

Collins' Dictionary (2006:344) explains guilt as "a state of doing wrong and being remorseful. Guilt can be a powerful and destructive emotion. Most often, survivor's guilt is a product of situations such as car accidents in which one partner survives while many others die. The survivor feels guilty for having lived".

However, Cichocki (2007:2) also indicates that, in a sero-discordant relationship, the negative partner can feel guilty for being negative. In extreme cases of guilt, the negative partners wish they too were infected, feeling their infection would relieve the guilt and other stressors present in the relationship. The positive partner also feels guilty for having contracted the virus.

#### **4.3 The desire to have children when in a sero-discordant relationship**

Most loving couples will consider having a family at one time or another. The research study conducted in a predominately African population by Kasim, Dano and Partab (2006:11) states that in African communities, bearing children is viewed as an essential part of being a woman. In sero-discordant relationship, this poses a challenge as falling pregnant poses the risk of one partner becoming infected.

Cichocki, (2007:2) explains the stress relating to the procedure of having children. The researcher states that while the typical stress all couples feel when deciding to start a family affects couples who are in a relationship where one is HIV positive, there are additional concerns of HIV transmission to the negative partner and to the unborn child. Sometimes even the procedures used for pregnancy and the cost attached to them heighten the stress. However, taking into consideration the findings of previous researchers, Persson (2007:5) strongly believes that HIV infection should not be considered a reason for couples to avoid getting pregnant and having children.

The couple should make decisions about family matters together. If they want to have children, they should talk about the possibility of transmission. The findings of a study conducted in Ethiopia by Hailemariam, Kassie and Sisay (2012:4) were that after the couples know their HIV status as discordant they tried different strategies to sustain their relationship and overcome some challenges that threatened their relationship. In their research, the goal that the couples had in mind in their actions and strategies towards maintaining their relationship was directed to strengthen family integrity and avoid disruptions particularly among couples who had children.

They further added that this condition put couples in a position of struggle to maintain their relationship. They further highlighted that the other causative condition

that couples found themselves in is the tension between a desire to have a child and safe sex practice (Hailemariam, *et al* 2012:4).

#### **4.3.1 Conception / reproduction as a challenge in a sero-discordant relationship**

Most couples are interested in having families, but for couples in a sero-discordant relationship, they require special and complex means before they can conceive.

Nosarka, Hoogendijk, Siebert and Kruger (2007:2) mention only two complex methods as possible scenarios at the time of conception in a relationship where one partner is HIV positive. The two methods are intrauterine insemination (IUF) and in vitro fertilisation (IVF).

On the other hand, Wilde (2002:2, volume 26), discusses the following conception methods for HIV – discordant couples. In his study, he believes that the couples should undergo counselling before they choose any of the conception alternatives available.

1. Timed ovulatory intercourse. This is when unprotected sexual intercourse is allowed at the time of ovulation.
2. Artificial insemination of the female with washed sperm from her HIV-positive partner. This involves direct injections of the sperm into the uterus after the sperm has been washed.
3. In-vitro fertilization (IVF) with prepared sperm from the HIV-positive partner. Here the sperm and egg are fertilized separately from the body and later injected into the uterus. Intrauterine insemination(IUF) is the laboratory procedure before IVF used to separate fast moving sperms from the sluggish ones or the non-moving sperms.
4. The last alternative is artificial insemination from an HIV- negative donor. This method totally eliminates risk of transmission.

Before any of these scenarios can be operationalized, Wilde (2002) believes the couple should be counselled first, because no treatment option is 100% risk free. There are also alternative options available such as adoption, or in the case an HIV

positive man, the use of donor sperm. These options should be discussed with the couple. The couple should also know the treatment's benefits and failures, their long term health outcome and the support network that should be in place.

Research conducted by the Human Sciences Research Council (2009: 2) with 26 South African couples highlights a complex set of issues related to a desire or intention to have children, including the fear of the negative partner becoming infected, reconciling conflicting desires of the two partners, the influential roles of medical doctors and the availability and affordability of alternatives to natural conception. The desire for children in a sero-discordant relationship often conflicts with the couple's desire for the HIV negative partner to remain uninfected.

#### **4.4 Stress in a sero-discordant relationship**

Although there are many different definitions of stress, it can broadly be defined by Huxley Consulting in Van Dyk(2005:324) as the perception of being unable to cope with an internal or external expectation or demand. Huxley further states that caring for people living with HIV and AIDS can be extremely stressful, and caregivers and counsellors must recognise their own stress factors and deal with them in a self-caring way to prevent burnout.

According to Sovec, (2013:12), strain can be placed on a relationship where stressful circumstances affect the couple as a whole, or even just one partner, such as a chronic illness of one partner. This can impact on the wellbeing of both partners. Such a severe stressor, often if it includes infidelity, can lead to an increase in the frequency of arguments as signs of underlying problems that have been left unaddressed. Sovec further explains that stress is experienced as thoughts and feelings as well as physical processes. Stress includes the mind and emotions as well as the body's response to the demands of life.

Stress is a fact of life. There is no escaping from stress, but there are means of coping with it. Some people cope better than others, and so they experience fewer stress related symptoms and illnesses. Stress by itself does not cause disease, but it exhausts the body's natural defences against infection, adds Powell (1987:6).

While a certain amount of stress is necessary for us to function, too much stress can have a negative impact on our lives, our work and relationships. Every person

experiences stress and anxiety in the day-to-day encounters with difficult situations at work, financial constraints, family demands, and social interactions. Moderate amounts of stress are usually not harmful and can even be stimulating, but excessive stress can be detrimental to one's health. Van Dyk (2005:223-224) further explains that psychological factors such as stress, emotional inhibition, and lack of social support have been shown to contribute to a more rapid progression from HIV infection to AIDS.

The researcher is of the opinion that stress in a sero-discordant relationship may be as a result of feelings of anger, betrayal and sadness, especially if one partner became infected while the two were already in a relationship. The first burning question for the other partner is how the virus was contracted. The stress is worsened by wondering how the other partner became infected, and then issues around infidelity can arise.

Shaw (2012:5) advises that the key to living within a sero-discordant relationship is not to become too problem-focused. HIV is only one part of the relationship and this should always be kept in perspective. Couples should discuss their different identities as HIV positive and HIV negative partners where they focus on their strengths and what they appreciate in each other. They should never forget they have an individual relationship and the love and attraction they feel for each other is what is most important.

#### **4.5 Stigma and discrimination**

Goffman (in Brown, Macintyre and Trujillo 2003, 49-59) postulates that stigma is an undesirable attribute or quality that significantly discredits an individual in the eyes of others. Moreover, stigmatization is a dynamic process that arises from the perception that there has been a violation of a set of shared attitudes, beliefs and values. In South Africa, HIV was sometimes seen as the disease of the poor. Even by 1998, when white people started 'coming out' as HIV positive, stigmatization of the condition still remained rooted in township areas (Avert, 1998:5).

According to the population council (2002, 34) the concept of stigma is often used interchangeably with that of discrimination. Manser and Thomson in Policy Project (2003: 13) argue that even though the words 'stigma' and 'discrimination' are often

used interchangeably' their meanings do differ. Discrimination focuses on observable behaviour, which means the unjustifiably different treatment given to different people or groups (Brown *et al*, 2003, 62)

There has been great stigma attached to those living with HIV and AIDS since the advent of HIV and AIDS. Stigma depends upon the social representations or the dominant discourse concerning the HIV illness. This idea is supported by Parker and Aggleton (2002; 212) who also indicate that other authors have defined stigma as social processes that are linked to societal power structures.

The history of stigma related to HIV has penetrated the country in a much deeper way. There has been much stigma and discrimination regarding HIV and AIDS in Limpopo. For example, the community decided to burn people who are HIV positive so as to end the disease. These ideas are widely shared in one's community in association with certain groups. GuguDlamini, an AIDS activist, was beaten to death by her neighbours upon her disclosure of her status on World AIDS day in Durban in 1998 (Avert, 1998:5). People have been chased from their workplaces because they are HIV positive. All this happened because people were uninformed - even 20 years after the knowledge of the existence of HIV, when a lot has been learned about the disease. It is such events that propelled the then Deputy President Thabo Mbeki in October 1998 to call for an end to discrimination against people living with HIV (Avert, 1998: 5)

The researcher agrees with Parker and Aggleton (2002), that stigma in a sero-discordant relationship could be experienced in a situation where a positive partner openly discloses that status, the other partner who is negative is assumed also to be HIV positive. Also, in the case where the partner who is HIV positive has died and the community members realized he/she died because of AIDS related illnesses, the remaining partner is also assumed to have the disease.

#### **4.6 HIV Transmission**

Sero-discordant relationships are affected by the same modes of transmission as everyone else. The common modes of transmissions as mentioned in Van Dyk(2002:19) are sexual intercourse, blood-to-blood contact as well as mother-to-

child transmission. While sexual intercourse is the number one pathway as far as transmission is concerned, the virus is not necessarily transmitted in every sexual encounter.

Common modes of transmission according to Whiteside and Sunter (2000, 11-13) includes but not restricted to the following:

#### **4.6.1 Unsafe sex**

The vast majority of HIV infections in South Africa are the results of sexual transmission.

#### **4.6.2 Mother-to-Child transmission**

After sexual transmission, the next most important cause of HIV infection is mother-to-child transmission. It is known that the child can be infected with HIV prenatally, at the time of delivery, and postnatally through breast feeding.

#### **4.6.3 Blood-to-blood infection**

Use of contaminated blood products is another way of transmitting the virus, since this route introduces the virus directly into the bloodstream. Even though there has never been a research that yielded a conclusive study as to why some persons who are exposed to HIV still remain HIV negative. The following are factors that determine whether or not someone becomes infected with HIV:

#### **4.6.4 HIV viral load**

Carter and Hughson (2014:01) define a viral load as a term used to describe the amount of HIV in a body fluid. Viral load tests measure the amount of HIV in a small sample of blood and this is one of the tests found even in public clinics to regularly monitor patients' health and assist in making informed decisions about treatment.

They believe that the results of a viral load test are described as the number of copies of HIV genetic material (RNA) per millilitre. There are a number of viral load tests in use; all tests are equally reliable at determining if the viral load is high, medium or low. However, each test has a limit at which it cannot reliably detect HIV. This is referred to as a viral load being undetectable.

Undetectable viral load is usually defined as a measure below 50 copies. This does not mean that there is no HIV in the sample, just that the number of copies is between 0 and 50. Effective HIV treatment results in a drop in viral load. The amount of virus in one's partner's blood (viral load) is very important for determining if one becomes infected or not. The higher the viral load, the greater the chance that one will become infected (Glass 2012:04).

As Glass (2012) mentioned above, Carter and Hughson (2014:01) further elaborate that there is usually a relationship between viral load and the number of CD4 cells. If the viral load is high, CD4 count will be low, making one more vulnerable to opportunistic infections. However, antiretroviral medication lowers the viral load and protects the immune system. Studies have found that having a low viral load greatly decreases the risk that HIV can be passed through sexual contact. Having a low viral load does not guarantee that HIV will not be transmitted. Even if viral load is undetectable, HIV can still be found in other parts of the body, such as semen, vaginal fluids and the breast milk.

#### **4.6.5 The type of virus**

The type of virus that infects one person maybe different from the type that infects another. Some types are more likely to spread faster than others. One's partner may be infected with a type that spreads less easily (Glass 2012:04).

Noble (2004:02) explains that there are two types of HIV: HIV-1 and HIV-2. Both types are transmitted by sexual contact, or through blood or mother-to-child. However, it seems that HIV-2 is less easily transmitted and the period between initial infection and the illness is longer in the case of HIV-2. Worldwide, the predominant virus is HIV-1 and generally when people refer to HIV without specifying the virus, they will be referring to HIV-1. The relatively uncommon HIV-2 type is rarely found anywhere except West Africa.

Whiteside and Sunter (2000:09) add that in the West people will live for at least 10 years before they began to fall ill. Nowadays, with the development of an effective anti-retroviral treatment, every infected person can expect to live a reasonable life for a longer period when they correctly adhere to treatment.

#### 4.6.6 Sexual practices

The more often you have unprotected sex with someone who is HIV positive, the more likely you are to become infected. Anal sex is a type of a sexual practice which is believed to carry the highest risk of infection. Women are more likely to become infected during sex than men. Male circumcision is believed to lower the risk in terms of HIV infection.

Male circumcision according to Avert (2009:02) involves removing the foreskin, a loose fold of the skin that covers the head of the penis. This procedure can be carried out at any stage of a male person's life, from infancy to adulthood. Circumcision has been shown to reduce a man's risk of becoming infected with HIV during heterosexual intercourse by 60% (Avert 2009:02).

The article further adds that there are several ways in which the foreskin acts as an HIV entry point during penetrative sex between an uninfected man and HIV infected partner. The inner surface of the foreskin contains a higher proportion of the cells that HIV targets such as the T-cells. The inner foreskin has less keratin, a protein found in the skin which has a protective effect.

A study of Ugandan men before and after circumcision concluded that an observed decrease in the anaerobic bacteria may play a role in reducing the risk of HIV acquisition. Circumcision can reduce the likelihood of genital ulcers which increases HIV risk. In addition, any small tear in the foreskin during sex makes it much easier for virus to enter the body.

Anal sex: receptive anal intercourse (sex where a man's penis is inserted into a person's anus) carries a higher risk of HIV transmission than receptive vaginal intercourse. The lining of the anus is more delicate than the lining of the vagina. So it is more likely to be damaged during sex, and any contact with blood during sex increases the risk of infection (Glass 2014:04).

Unprotected anal sex is linked to a high risk of HIV infection. The reason is that HIV infected semen can come into contact with fragile anal tissues that can be damaged easily. Integrated Regional Information Network, IRIN (2011:01) explains that the risk of contracting HIV through unprotected receptive anal sex is almost 20 times greater than the HIV risk associated with vaginal intercourse. The danger of unprotected

anal sex is that the lining of the rectum is more fragile and contains more susceptible cells than the lining of the vagina, making it easier to transmit HIV. In cultures where virginity is prized and regions where condoms are not easily available, women are more likely to engage in anal sex which in most cases is unprotected.

#### **4.6.7 Presence of other sexually transmitted infections**

If you have an STI other than HIV, you are more likely to become infected with HIV if you have unprotected sex with someone who is HIV positive. If your partner is HIV positive, s/he is more likely to infect you with HIV if s/he has another STI as well (Glass 2012:04). In other words, having an STI increases the risk of HIV transmission regardless of which partner has an STI, whether HIV negative or positive.

Sheth (2009:01) highlights that an HIV positive person who is co-infected with an STI has a higher chance of transmitting HIV to their partners. Most STIs cause an increase in the viral load in semen, vaginal fluid or anal fluid depending on the location of the STI. As this increase only happens in the area where the STI is located, it may have no effect on a person's blood viral load. However, it can still have a direct impact on how infectious someone is.

An HIV negative person who has an STI is more open to HIV infection mainly because STI's cause the mucous membrane (the moist tissues in the mouth, penis, vagina and rectum) to become inflamed. When these tissues are inflamed, the immune system becomes activated to fight the infection. Activated immune cells, specifically CD4 cells, are easier for HIV to pass into the bloodstream when inflammation is present. Some STI's such as herpes and syphilis can cause open sores or lesions which provide an entry point for HIV into the body. Whiteside and Sunter (2000:11) add that the presence of an STI greatly increases the odds of HIV infection. Furthermore, the very same cells that the virus is seeking to infect will now focus on the site of the STI rather than fight the HIV.

The following are common sexually transmitted infections that propel HIV transmission (Sheth2009:3-6)

1. Genital herpes- herpes is caused by the herpes simplex-3 virus, a common virus that is much higher for women, men who have sex with men and also people who are HIV positive. There is no cure for herpes. Being infected with it makes one 8 times more susceptible to HIV depending on the frequency and severity of outbreaks. A herpes outbreak causes genital ulcers or sores, making it easier for HIV to enter the body.

2. Gonorrhoea: it is caused by the bacteria Neisseria gonorrhoea. It is primarily transmitted through sexual contact involving the anus, penis, vagina, mouth or throat.

Being HIV positive and also infected with gonorrhoea, the HIV viral load in the genital and anal fluid is 10 times higher, which means the HIV positive partner is more likely to transmit HIV to another sexual partner.

The HIV negative partner with gonorrhoea is 5 times more susceptible to HIV than someone who is not infected with gonorrhoea.

3. Chlamydia: it can be transmitted through vaginal, anal or oral sex. Many people infected with chlamydia will have no symptoms. However, even people with no symptoms are still able to transmit chlamydia to their sexual partners.

Chlamydia infection causes inflammation at the site of infection. Inflammation recruits immune cells to the site of the infection. Therefore, this increases the vulnerability of an HIV negative partner and the infectiousness of an HIV positive partner.

4. Syphilis: it is transmitted primarily through sexual contact, usually when there is a sore present. It is hard to treat. Syphilis infection in people living with HIV increases the viral load in genital or vaginal fluids making a person 5 times more infectious. Genital cancers in syphilis result in inflammation and breaks in the skin providing an easy route for HIV to get into the body. So when an HIV negative partner has syphilis there are two to five higher chances of being infected with HIV.

#### **4.6.8 Genetic factors**

Everyone has a different genetic makeup. According to Glass (2012:04), an individual's genes determine how likely s/he is to become infected and how his/her immune system will deal with the infection. Some people are more likely to become infected with HIV than others. Some people have certain genetic characteristics that may make them less or more likely to become infected with HIV. An example of this is the mutation called CCR5 32.

He further continues that people who have this mutation do not become infected with HIV. Some people have a good immune response with to HIV which prevents them from becoming infected. Compared to flu, every year some people get very sick with the flu while others never seem to be ill. In a similar way, some people have immune systems that are able to fight off infection with HIV.

### **5. Coping mechanisms used in sero-discordant relationships**

Coping mechanisms are remedial actions undertaken by people whose survival and livelihood are compromised or threatened. These are the learned behavioural patterns used to cope. There are negative as well as positive survival mechanisms. It is further suggested that people are not always able to cope with difficulties they face. People experience a range of emotions throughout their lives, good or not and the behaviour has results on how the emotions are handled.

Despite challenges experienced, sero-discordant couples find ways and means to thrive. Some of the aspects that assist them to cope in their relationship are communication; antiretroviral therapy (ART) and continuous counselling.

#### **5.1 Communication within a relationship**

Johnston (1995:3-4) feels that couples in a sero-discordant relationship tend to be effective communicators. This could be because they have to keep each other abreast concerning their fears, medication and any change or challenge they may encounter.

Just as in any other relationship, when communication dies, so does the relationship. In such cases it is usually crucial to have open channels of communication as any attempt to end the relationship may affect the infected partner's health in a major way.

Trisdale (2002:16) agrees that communication and negotiation are the keys for every relationship. It is important for negative partners to remember the strain that comes with living with HIV. Just taking medication is a constant reminder of the virus. Even those who are still healthy are constantly bombarded with reminders that they are no longer like everyone else.

Cichocki (2007:2) also advises that the couple should never stop talking to one another about the relationship issues that they face. They should share their feelings, regardless of how sensitive or painful this may be. While the pain is short term, the benefits from openly discussing issues will have lasting positive effects on the relationship.

Tiffany (2011: 138) refers to the general occurrence of communication barriers that become prevalent upon diagnosis of a terminal illness such as HIV. In this regard, the author states that there can be no hard and fast rules in terms of communication, and that openness in sharing with the positive partner should remain the primary focus. As such, communication is regarded as more of an art than a science, and therefore in direct contrast with most aspects of medical life.

Persson (2007:6) is of the opinion that when couples are sharing information regarding HIV sero-discordancy, they understand each other regarding their different status and the things that they are supposed to do as a sero-discordant couple. That type of communication helps to bring support, cohesion and better understanding of the sero-discordancy. Communication has to reach the depth of the human situation and must go beyond the superficial. The individual partner and his particular disease will form a unique combination, and the illness will impinge upon the individual life of the positive partner in a manner that is different from everybody else.

Effective communication will materialize when approaching the disease against a broad background of life, including its hopes and fears. Sensitive listening creates an understanding of the effect of diagnosis upon the positive partner and negative

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Effective communication will materialize when approaching the disease against a broad background of life, including its hopes and fears. Sensitive listening creates an understanding of the effect of diagnosis upon the positive partner and negative

partner including their family members. Lack and Buckingham (1978: 222), explain that family members need to be encouraged to help these couples to express their feelings while in the environment of their home.

Gonda and Ruark (1984: 120) highlight the results of poor communication as follows:

- Mistrust will naturally arise in situations where people receive conflicting messages about important matters.
- In a situation when a positive partner is excluded from important information, feelings of powerlessness will be amplified.
- Lack of cooperation often follows where anger exists as a result of poor communication.
- As feelings of exclusion are experienced through poor communication, the positive partner will feel increasingly isolated and abandoned.
- Poor communication will result in failure to attend to important practical, emotional and spiritual matters.

Like all relationships, Shaw (2012:03) believes that communication and respect are keys to creating and maintaining a healthy body ensuring that one self and one's partner have an open dialogue about their fears, questions and anxieties as well as one's feelings. Feelings such as confusion, grief, shame or guilt are normal. They are to be expected from time to time in all relationships and particularly in sero-discordant relationships. Keep talking and listening to one another in a non-reactive manner is medicinal and healthy,

Furthermore, when these levels of communication are developed, both partners feel that their needs are being met and a stronger commitment to the future of the relationship is created. There are many sero-discordant relationships that are thriving, thanks to an ongoing commitment to open, honest communication based on attraction, respect, honesty and love (Shaw, 2012:03).

## **5.2 Antiretroviral therapy (ART) as a coping strategy**

The South African Anti-retroviral Treatment (ART) (2003: 2) indicates that since antiretroviral treatment was introduced in 1986, mortality and accompanying opportunistic infections in patients with advanced HIV infections have declined.

Likewise, according to the guidelines of the Doyle and Dorrington (2011:1), on the use of antiretroviral therapy, mortality has dropped significantly.

A research conducted at the University of Pretoria on ART by Riets (2007:4) discovered that the main obstacles with regard to the administration of antiretroviral drugs in developing countries like South Africa have been the high cost of such drugs and the lack of health care infrastructure necessary to access these. There were also concerns that the difficulties with adherence to complicated medication regimens would lead to treatment failure and the accumulation of resistant viral strains that could promote drug resistance.

In 2002 South African's high court ordered government to make nevirapine available to pregnant women to help prevent mother-to child-transmission of HIV. In November 2003, the government approved a plan to make anti-retroviral treatment widely available. Until 2003, South Africans with HIV who used the public sector health system could get treatment only for opportunistic infections but not for HIV itself (Fourie 2006:8).

Van Dyk (2004: 69) shares that in South Africa, a significant number of people use alternative, complementary and traditional medicines. The management of HIV/AIDS disease is supported by many pillars: lifestyle changes and support, treatment and prevention of opportunistic infections and antiretroviral therapy.

In discordant couples, anti-retroviral drugs play a critical role. When an HIV positive partner is on treatment, stress regarding sero- conversion and conception is easily addressed. Botes (2005, 119-124) points out that, through taking antiretroviral drugs, the viral load decreases and the immune system is boosted. When the viral load has decreased to +/- 50 copies, the virus can be undetectable. When the virus is undetectable, there are minimal chances that the HIV positive partner can infect the negative sexual partner when the two are not using a condom.

This notion does not mean that the negative partner cannot be infected, but the chances are minimal. In this regard, a couple may have a child and still be discordant. This view is supported by Dr Alexander Boon's statement that the virus is not systematically transmitted at each and every sexual encounter. It depends on how far the HIV – positive person is in the progression of his condition.

### **5.3 Continuous counselling for sero-discordant couples**

Gillis, Sikkema and Bissett (in Van Dyk 2005:175) define counselling as a facilitative process in which the counsellor, working within the framework of a special helping relationship, uses specific skills to assist clients to develop self- knowledge, emotional acceptance, emotional growth and personal resources.

Egan (2007:162) adds that the intention of counselling is not to solve everything by prescribing treatment or giving advice, but to assist the clients to review their problems and the options or choices they have for dealing with these problems. Velleman and Sarajane (2010: 19-20) add that counselling is about enabling individuals to overcome obstacles as far as possible, to take control of their own lives, to learn how to take maximum responsibility and decision-making power for themselves and their future.

As a discordant relationship is associated mainly with issues such as stress, the couple should always be encouraged to seek professional counselling through tough times. Counsellors also need to be very clear and emphasise the very high risk of the uninfected partner becoming infected, unless the couple adopts behaviours to protect the uninfected partner.

Cichocki (2007:2) is of the opinion that the couple in a discordant relationship should keep issues in perspective. The only significant difference between the couple is their HIV status and it should not define their relationship. Ninety per cent of the issues that strain a sero-discordant relationship are the same ones affecting any relationship.

### **5.4 The safety of sexual intercourse in sero-discordant relationship**

According to Trisdale (2002), sex is one of the first issues everyone thinks about with sero-discordant couples. However, many are able to find a mutually satisfying sex life. Johnston (1995:2), believes that couples in a sero-discordant relationship sometimes feel safer than a couple in the same-status relationship. Because the risk of infection is clear in positive-negative couples, it may be easier to adopt and maintain safer sex practices as the negative partner needs to maintain his/her status and the positive partner needs to reduce the risk of re-infection.

Cichocki (2007:2) adds that, for guaranteed safety, the couple should plan to discover new ways and create guidelines as ways of eroticising their love making. The couple should share their fears and feelings along the way. Shaw (2013:02) mentions that one of the major challenges specific to sero-discordant relationships is the acute risk of transmitting HIV from the HIV positive partner to the HIV negative partner. This issue can cause anxiety for the HIV positive partner which can result from a fear of rejection or abandonment and an on-going worry about infecting their partner. In addition, side effects of HIV medication and associated health issues can cause a loss of sex drive, and negatively impact energy levels and self-esteem.

Sovec (2013:05) advises that it is vital to talk about sex. It is common in sero-discordant couples for each partner to harbour fears about transmission of HIV during sexual contact. The HIV positive partner often carries concerns about potentially infecting his/her partner, while the HIV negative partner worries about being infected. These worries can create a barrier to true intimacy and leave each partner feeling unfulfilled. This is a time when each partner must risk talking about his/her needs, what forms of sexual contact feel safest, likes and dislikes, and also how as a couple they can find ways to keep their sex life active and intriguing.

The researcher is of the opinion that sex is regarded as keeping and helping the relationship and couples to bond. This may be most difficult if partners do not subscribe to any forms of satisfaction except penetrative sex. For the negative partner, it may be even more strenuous as he/she may feel the need to find other sexual partners who will provide the sexual pleasure that the husband or wife cannot provide, such as unprotected sex, penetrative sex and the like. Johnston(1995:1) supports this statement and adds that due to the fear of transmitting the disease, some couples decide not to have sex at all, as a way of prevention, whereas others use condoms each time they have sex.

For the HIV negative partner, worries can include anxiety regarding becoming infected, so both partners must make shared decisions around sexual behaviour. Clear and on-going negotiations around safe sex are extremely important, such as what precautions will both partners take to avoid the risk of transmitting HIV? What kind of play feels comfortable for both of them? What are the fears when it comes to

sex in the relationship? Are feelings around HIV causing one to hold back or emotionally withdraw from the partner?(Shaw, 2013:02).

The researcher feels that this kind of relationship is indeed risky, but on the other hand, it guarantees safety as the two researchers have indicated, because partners know from the onset that they have to use condoms in the right way to protect the sero-negative partner.

### **5.5 Social support in a sero-discordant relationship**

Ahmed (1992:111) points out that social support has been conceptualized as the emotional or tangible assistance that is provided from individuals in one's interpersonal network. This is especially salient in discussions of HIV spectrum illness because of the disabling nature of the disease as it progresses, the interpersonal nature of acquiring HIV, and the social isolation commonly seen amongst persons with HIV and AIDS, especially during the AIDS stage and nearing death.

Powell (1987:06) indicates that despite the potential for stress in close personal relationships, it is becoming increasingly clear that a long, healthy life depends on strengthening people's bonds with others. When these social supports are lost, it is felt. It seems likely that when stress levels are low, social support may have relatively little effect on health outcomes, but that during periods of high stress, the presence of adequate social support can significantly affect one's physical wellbeing. In other words, if things are going well in areas of one's life, one may not need much in the way of social support. Close relationships with others can help one to withstand the stress.

Without support, the couple may feel abandoned, angry, fearful and uncertain. Ahmed (1992:111) further adds that social support reduces the impact of adverse stress-producing events. It bolsters self-esteem because one will have people to talk to, thereby improving the positive influence in the light of stressful experiences. In this case, the social support emerges from the HIV negative partner, friends and family. In cases where one partner is discriminated against, the other partner becomes the pillar of strength for the concerned partner, and provides hope by being there, and by being positive around that partner.

The concept of the family as a unit of care is supported by Lack and Buckingham (1978:222) who found that family members who primarily carry the burden of care suffer more anxiety, depression and social malfunctioning than the patients themselves. Professional intervention is also needed and Lack and Buckingham (1978:222) explain that it is shaped by the assumption that there are intimate relationships, dependencies and supports in the family relationships of the couple, which have a direct effect on the provision of care.

For some couples, silence is seen as a positive force in that not talking about HIV reflects a feeling of oneness and a common understanding of living life in an ordinary, everyday world, shifting the focus away from HIV perceived as conducive to emotional health (Mabuza 2010:38).

## **6. PREVENTION STRATEGIES AVAILABLE FOR SERO-DISCORDANT COUPLES**

Personnel from both the Department of Health (Doctors, nurses) and Social Development (social workers) have a huge responsibility in facilitating intervention strategies, especially prevention, to curb the risk of HIV infection.

The most common means of transmitting HIV is via sexual intercourse or contact with infected blood or bodily fluids. Intercourse remains the highest risk behaviour, and methods that can be practised by a sero-discordant couple to avoid sero-conversion are abstinence and condom use.

### **6.1 Abstinence as a prevention method**

The only way to protect one another in this relationship is total abstinence from intercourse. However, in some instances, abstinence is not realistic and in a close and loving relationship, it is certainly not desirable. Plus News, Uganda (2008:14) has shown a significant number of couples who are not sharing a bed as a way of abstaining. There is also a case where an HIV positive partner has released the wife to find a negative partner who she can have sex with (Plus news, Uganda, 2008:14).

In the past, abstinence was mainly preached to young people to avoid consequences of sex, especially to prevent teenage pregnancy. At the time the

primary objective of abstinence was to delay sexual intercourse. There are programs in place that provide information such as Love-life.

Maher (2005:29) came with an abstinence based approach to sex education which focuses on teaching young people that to abstain from sex until marriage is the best means of ensuring that they avoid infection with HIV, other sexually transmitted infections and unwanted pregnancies, as well as seeing abstinence from sex as the best option for maintaining sexual health.

Until better prevention methods are available, the foundation of AIDS research-AMFAR (2007:01) believes abstinence remains the only way to ensure freedom from the risk of HIV infection. Some people with HIV have taken a conscious decision to be sexually abstinent in order not to pass on HIV. Some people appear to be practicing abstinence as an HIV prevention method; for some HIV positive people, this is because of low self-esteem or lack of confidence following an HIV diagnosis.

## **6.2 Condom use as a prevention method**

If abstinence proves difficult, in that case the couple should use a condom. According to Van Dyk (2005:131), laboratory tests have shown that the virus cannot pass through latex condoms. This means that the virus stays inside the condom after ejaculation and cannot enter the partners' body. He also reports that various researchers have reported a significantly lower incidence of HIV and other sexually transmitted infections among people who insist on using condoms. However, it should always be noted that condoms are never 100% safe because they can leak or tear.

In any sero-discordant couple, condom use is not a sufficient option taking into consideration the risk involved. Hence the introduction of condoms into a relationship when they were not previously used might pose as a huge challenge. What scientists do know is that HIV discordance is related to a combination of factors that include genetics, HI-virus type, the extent to which the infection has progressed in the HIV-positive partner, other sexually-transmitted diseases and circumcision - which Dr.ZweliMkhize, premier of Kwa-Zulu Natal indicates may reduce the risk of HIV infection. (SABC 2 News 1 December 2010).

### **6.3 Pre-exposure prophylaxis**

Wilton (2014:01) says PrEP is a new prevention method. It involves an HIV-negative individual taking anti-HIV drugs in an effort to reduce their risk of contracting HIV. They also need to commit to regular Doctor's appointments so that any side effects can be monitored and they can be tested for HIV drugs, usually tenofovir and emtricitabine (known as Truvada). It has been approved for people who are at risk of sexual transmission of HIV. However it is still possible for a person taking PrEP to become infected with HIV.

Pre-exposure prophylaxis (PrEP) can also be used as a prevention method for people who are in a sero-discordant relationship. Brand (2012:4) says that PrEP involves providing people who are not infected with HIV with antiretroviral drugs before possible exposure to the virus, to stop them from becoming infected.

PrEP is a way for an HIV negative person who is at risk of HIV infection to reduce their risk of becoming infected with HIV. It involves taking anti-HIV drugs on a regular basis. PrEP provides only partial protection from HIV infection and is not intended to replace consistent condom use (Wilton 2014:01).

In a research by Young, Li and McDaid (2013:03), it has been demonstrated that prescribing anti-retrovirals (ARV) to HIV-negative people before sexual exposure to HIV can help reduce HIV transmission. PrEP demonstrated a 44% reduction in the acquisition of HIV amongst discordant men who have sex with men (MSM) in couples when using pre exposure prophylaxis. The partner's prevention study subsequently demonstrated a reduction of up to 75% amongst sero-discordant heterosexual couples.

### **6.4 Roles of Departments in prevention**

Even though the Department of Health is the primary role player as far as the fight against HIV is concerned, the Department of Social Development through its social workers also has a significant role to play. The Department funds home-based carers to ensure that people living with HIV as well as orphans are taken care of. Social workers facilitate support groups for HIV infected and affected people.

Their knowledge of the community and its resources assist in linking their clients. Potgieter (1998:169) explains that social workers act as the brokers where they link clients with available resources through a referral system. When a client who is in a sero-discordant relationship wants to start a family and a social worker is knowledgeable about fertility clinics in that area, s/he will be able to refer the client accordingly. The social worker will also be able to offer more information on different fertility clinics. Also, more importantly, social workers provide sero-discordant couples with counseling. Sheafor, Horesji and Horesji (2000:59) define a counselor as the social worker who enhances the clients' social functioning, assisting them to uncover their own strengths and make needed changes towards their goals.

## **7 THEORETICAL FRAMEWORK**

### **7.1 Eco-system theory**

In Eco-system theory, emphasis is on the person in the environment. It is about balance between coping efforts of the individual and the demands of the environment (Miley, O'melia&DuBois, 2004:34). Hepworth, Rooney, StromGottfried and Larsen (2006:16) explain human ecosystem as being about satisfaction of human needs and mastery of tasks to acquire resources in the environment in order to achieve goodness of fit between the person and the environment.

A system is structured through the arrangement of a hierarchy, which means that in each system, there are different ranks within the system and each rank has specific tasks, roles and authority (Potgieter, 1998: 54).

Figure 1: Socio-ecological model- looking beyond the individual (Jane Moore 2003)

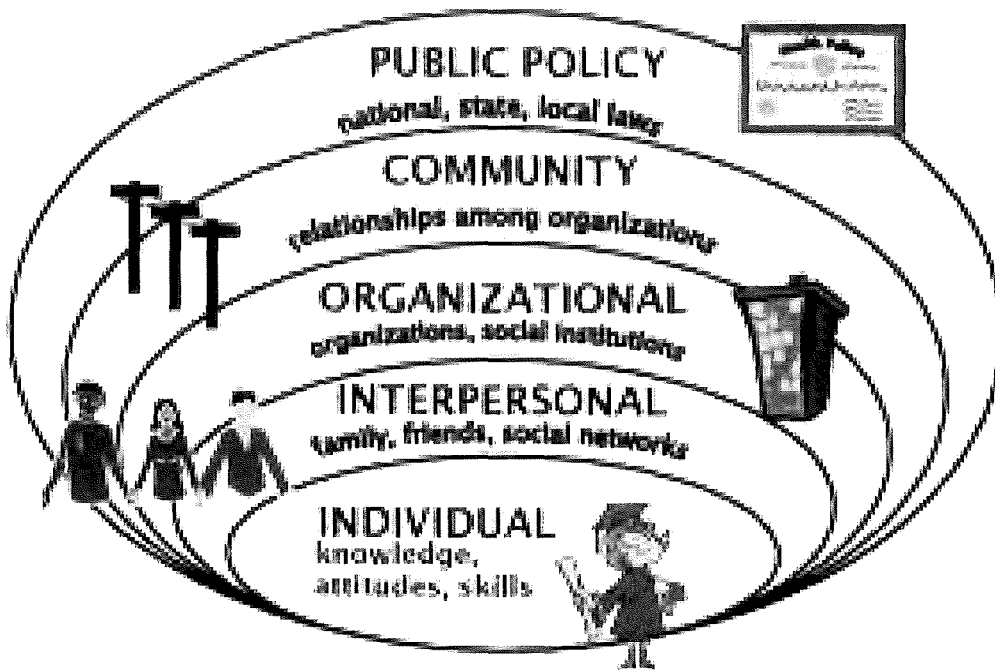


Figure 1 above indicates the different levels that people are exposed to in their everyday life.

**Individual level:** this level refers to the individual person's ability, knowledge and skills that can contribute to the betterment of self. How does one cope with the HIV positive diagnosis? Change at this level involves focus on creating an individual's functioning, adapting people to environments rather than modifying environments to better meet the needs of the people, to empower, enhance the individual self-esteem to take control of their life (DuBois and Miley 2010:70). Change may involve the individual perception on a new life, the use of a condom, issues of self- acceptance and disclosure as well as decision-making around finances and child bearing.

**Interpersonal level:** this level is about the person in the environment, the relationship with family and friends. Hawley (1986:12) believes that adaptation is a collective rather than an individual effort. It can thus be shown that systems are interdependent and interrelated. Potgieter (1998:55) adds that every single part of the system is always connected to every other part in some way and whatever happens to one part will affect the other. The researcher used eco-system theory to establish coping mechanisms used in the sero-discordant relationship, taking considerations of aspects of communication in a family environment. Both partners



in a sero-discordant relationship are a unique sub-system of the family. Communication as a baseline for any relationship needs to be respected. The couples must have a solid structure in order to ensure a goodness of fit between one another; one aspect of it is open communication. The couple has to view themselves as part of the system; the participants need to understand and read together information materials on HIV and AIDS so as to guide one another. So in order for the sero-discordant relationship to cope, both partners need one another.

**Organizations level:** This includes social institutions such as support groups where both members can feel needed and understood. South Africa's organizations in terms of employment has made a shift because people are no longer chased away from their work because they are HIV positive, and most medical aids such as the Government employee medical aid scheme (GEMS) have implemented a HIV/AIDS policy programme to assist people with HIV. The GEMS disease management programme assists members with medications (ARV's) as well as multivitamins, pathologist tests, regular monitoring to ensure that treatment is taken at the right time as well as reminders to individuals and their Doctors to do regular check-ups ([www.gems.gov.za](http://www.gems.gov.za)). This initiative assists the individual as well as the family to live without fear of financial loss hence achieving a goodness of fit in the environment.

**Community level:** It is also important that sero-discordant couples know the resources within their community where they can seek solace and assistance, such as clinics that can provide them with ARV's, or a Doctor where a positive partner can check the viral load as well as the CD4 count regularly. Where the environment is not conducive or has stigma and discrimination towards people living with HIV, community education about HIV is relevant in this regard.

**Public policy:** South Africa is indeed moving towards a better understanding on sero-discordant relationships. Many researches are underway, and currently 2.5 million South Africans are on antiretroviral treatment (Gonzalez 2013, 01). Sero-discordant relationships have been identified as one of the highest risks of HIV transmission where the negative partner is at risk of being infected. There is no law in South Africa that forces an HIV positive person to disclose their HIV positive status to their sexual partner.

## **7.2. Task centred approach**

According to Turner (1996:620), the Task centred approach was used as a starting point for Reid and Shyne's 1969 work; it is a more comprehensive, systematic and effective short term treatment. The Task centred approach utilises the time-limited structure as a way of helping clients to carry out actions or tasks to alleviate problems.

Turner (1996:620-622) further states that within the relatively few sessions and brief period of time in using the task centred approach, practitioners help clients modify the actions contributing to their difficult situation, teach them necessary skills, build within them one capacity to take constructive actions in response to their problems. He emphasises that in the task centred approach the primary agent of change is the client and not the worker. This is explicitly explained by Payne (2005:109) that the task centred approach is concerned with problems that the client acknowledges, that can be resolved through actions taken outside contact with the worker, and also work on things that the client wants to change.

Marshall and Doyle (2005:27) emphasise what Turner said above; they also agree that the Task centred approach works on time limits and it aims to leave people with more resources than they started with, to help them solve similar problems in future. In this study, the task centred approach guided the researcher on how to give clients who needed further counselling, tasks that assisted them to work on their individual self and their relationship as a whole. It assisted the clients to improve the wellbeing of their relationship because tasks given were mainly focused on the individual's positive contribution to the relationship. Especially, as Reid and Epstein (1976:112) propose, that the worker attempts to achieve an optimal balance between a responsive and a systematic style of communication with an empathetic understanding of the client's problem.

## **7.3 Strength Perspective**

According to Saleeby (2009:6), people are often doing amazingly well, the best they can at the time, given the difficulties they face when they know the resources available to them. People have survived to this point, certainly not without pain, but with ideas, will, hopes, skills and other people, all of which we need to understand

and appreciate in order to help. Change can only happen when one collaborate with client's aspirations, perceptions and strength and your family to believe them.

Hammond (2010:4) shares the same idea that embraces the belief that people have strengths, resources and the ability to recover from adversities. It encourages people to see beyond the problem. It instils an absolute belief that every person has potential and it is their unique strengths and capabilities, not their limitations that determine their evolving story as well as define who they are. He further adds that positive change occurs in the context of authentic relationships where people know that someone cares and will be unconditionally supporting them. It is a transactional and facilitating process of supporting change and capacity building, not fixing. The researcher agrees with the two authors that people in sero-discordant relationships are already coping and continuing with their lives knowing full well their different HIV status. The strength-based approach is used to tap into their inherent strengths to assist the couple to recognise the external institution in the community they live in that can assist them to cope best.

Pattoni (2012:04) believes that working to enhance an individual's awareness and understanding one's own strengths and capabilities has been shown to promote an increased sense of wellbeing. Strength based approaches value the capacity, skills, knowledge, connections and potential in individuals and communities. Hammond (2010:1) adds that the idea of focusing on the strength of people is warmly embraced and considered to be respectful and meaningful, a starting point in supporting positive change where people are taking control of their own lives in meaningful and sustainable ways.

The Strength-based practice somehow models a perception of positive thinking and belief in oneself; it assesses the inherent strengths of a person and then builds on them. Ustawi(2011: 52) feels that it is about reframing personal perception to find good in the worst situation. It does not attempt to ignore the problems and difficulties. Rather, it attempts to identify the positive basis of the person's resources (or what may need to be addressed) and strengths that will lay the basis to address the challenges resulting from the problems (Hammond, 2010: 1).

In a sero-discordant relationship, the individual partners have to understand that his/her inherent strength should surpass that of the other partner and that each and

every one of them holds the key to their own transformation and meaningful change process.

## 8. SUMMARY

In this chapter, literature from different sources was gathered. Different researchers have different opinions about HIV –discordancy. What stands out is that the high rate of HIV infection may be the cause of this new trend. What is still to be discovered is why people are not disclosing their discordancy in the relationship. Is it fear of judgement or something else? Many people feel that even if HIV discordancy is a personal choice, it is still risky and as a way of combating the pandemic, it should be discouraged.

The extent of HIV and AIDS in South Africa was looked into. Socio-cultural aspects were discussed especially their role in terms of the role of HIV status in the economy and level of education, taking into consideration that, statistically HIV prevalence is higher in women than in men in sub-Saharan Africa and South Africa. The challenges faced by couples in sero-discordant relationships are different for each partner. The HIV positive partner is more concerned about the HIV positive diagnosis, but on the other hand, the negative partner wonders what the other partner's HIV positive diagnosis means to him/her. The government, however, is doing its bit to assist a HIV negative person in a sero-discordant couple to avoid sero-conversion, (a medical term used to explain an instance where an HIV negative person becomes infected with HIV,) by providing the couple with ARV's.

ARV's help lower the viral load of the infected partner. If the infected partner is a woman, they assist to reduce the transmission of the virus to the unborn child. A negative partner in the relationship can also take pre-exposure prophylaxis before intercourse or post-exposure prophylaxis after unprotected intercourse. Counselling has a positive contribution to the relationship as far as helping the couples to cope.

Different theories also assisted the researcher in understanding the topic better. They spelt the way the theories were related to what the researchers are saying and to what this research aims to achieve. For example, Cichocki explains that sero-

discordant relationships can be stressful, while the systems theory explains that if one member of the system is affected, the entire system gets affected.

## CHAPTER 3

### RESEARCH METHODOLOGY

#### 1. Introduction

Bailey in Silverman (2000:77), explains methodology as the philosophy of the research process. It involves the assumptions and values that serve as a rationale for the research and standards, or criteria that the researcher uses for interpreting data and reaching conclusions. In this chapter, research methodology is explicitly explained and it includes the following, research approach, designs and data collection methods as well as data analysis.

#### 2. Research approach

The study adopted a qualitative method to obtain views on coping mechanisms from the couples who are in a sero-discordant relationship. Dealing with a scarce population such as the people who are in a sero-discordant relationship and in an era where HIV is still fraught with stigma and discrimination, the qualitative method with its reputation for showing sensitivity to people's feelings and experiences was relevant in exploring and describing the topic at hand. It provided rich data deduced from the participants. Maree (2007: 51) is of the view that qualitative research focuses on describing and understanding phenomena within their naturally occurring context, with the intention of developing an understanding about meanings shared by the respondents, which is, seeing through the eyes of the respondents.

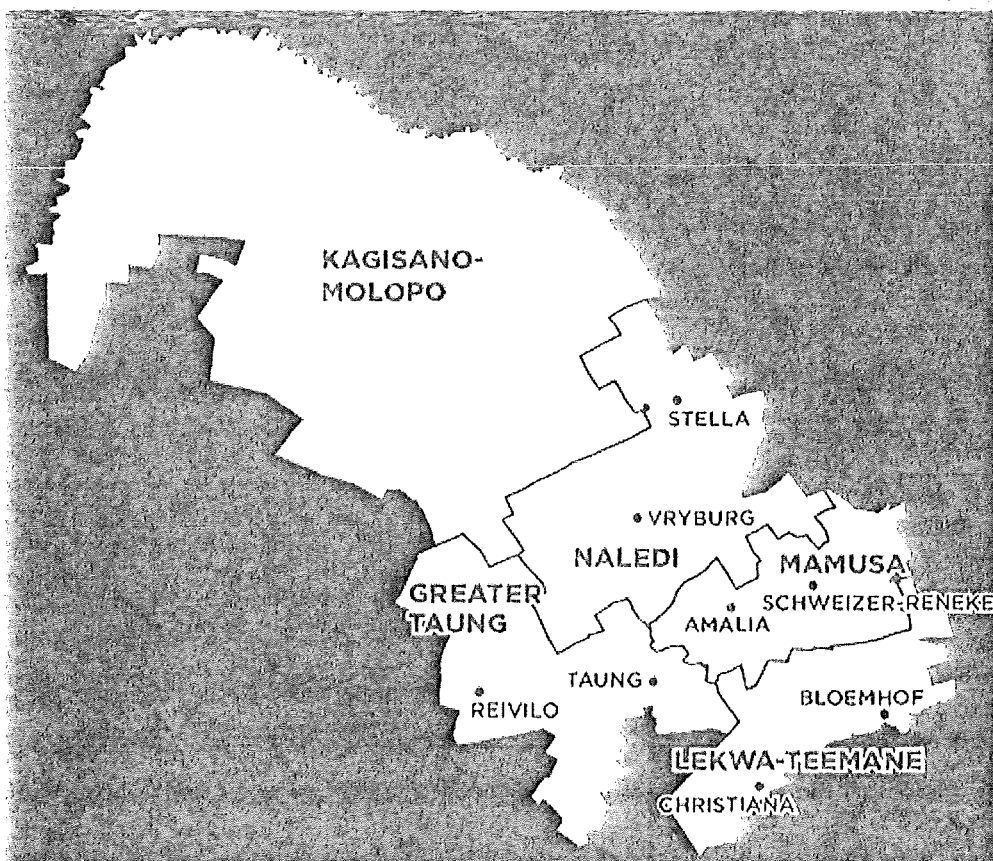
Rubin and Babbie (2010: 47) and Creswell (2007:51) further explain qualitative research methods as subjectively tapping a deeper meaning of human experiences and are intended to generate rich observations and an inquiry that begins with assumptions, worldviews and explores meaning of what individuals or groups describe as a social or human problem. Furthermore, the key informants (social workers from the Department of Social Development and counsellors from Life-line counselling centre) can provide a professional view based on their work experiences on sero-discordancy as a human and social problem.

### 3. Demarcation of the research study

The study was conducted in Dr. Ruth Segomotsi Mompoti District at Vryburg and Ganyesa areas, North West Province (see figure 2). The Province is made up of four districts, namely;NgakaModiriMolema District, Dr. Kenneth Kaunda District, Bojanala District and Dr. Ruth SegomotsiMompoti district.

The couples are from the Dr. Ruth SegomotsiMompoti District, specifically Naledi Municipality (Vryburg) and Kagisano-Molopo Municipality (Ganyesa). The study focused on their biographical profile, gender, age, marital status, socio-economic position and their level of education.

Figure 2: Map of Dr. Ruth Segomotsi Mompoti District Municipality



According to statistics from 2011 Census, Dr. Ruth SegomotsiMompoti has a population of about 463 815. Greater Taung Municipality is the largest with 182,167 41, followed by Kagisano-Molopo Municipality with 108,071 then Naledi Municipality with 58,106. Lastly are Mamusa 48 366 and Lekwa-Teemane Municipality 42,967

respectively. The majority of the people (90%) speak Setswana, with Afrikaans a poor second with only 7%.

Dr Ruth SegomotsiMompoti district is known as the largest beef producing District, with Hereford cattle being the most popular. It was sometimes called the 'Texas of South Africa.' Maize and peanuts are important crops produced in this district. The District was previously called Bophirima and is now renamed after the former Mayor of Vryburg, Dr. Ruth SegomotsiMompoti, an ANC veteran (Moncho, 2012:59).

#### **4. Research design**

This research is exploratory and descriptive in nature. The rationale for choosing these particular designs is that sero-discordant couples are a scarce population mainly because stigma is still attached to HIV, and not many people disclose their HIV positive status. Neuman (2011:21) explains that the purposes of social research may be organised into two groups based on what the researcher is trying to accomplish; either to explore a new topic, or describe a social phenomenon. Since this research has not been largely dealt with in the past, there is little information on it. HIV still remains a personal and confidential matter in society today. Few people are disclosing their status, which makes it difficult to trace or hear about sero-discordant couples.

Even though Neuman (2011:23) describes them as having many similarities, he clearly points out that exploratory research is used to explore a new topic or issue in order to learn more about it. In this regard, the researcher formulated more precise questions that future research can answer. In descriptive research, the researcher began with a well-defined subject and conducts research to describe it accurately. Engel and Shutt (2009:54) agree that qualitative research is often exploratory and that descriptive research involves the gathering of facts. The researcher is of the opinion that the findings of this study can well be used to gain a deeper understanding of the phenomenon; sero- discordant relationships.

## **5. Population**

Bless and Higson-Smith (2008:85) state that population is a set of elements that the research focuses upon. The population under study are couples in a sero-discordant relationship residing in Vryburg and Ganyesa village. The counsellors at Life-line counselling centre, the social workers at the Department of Social Development in Kagisano-Molopo (Ganyesa) and Naledi service point (Vryburg) have been selected as key informants to gain more insight into the topic.

## **6. Sampling**

A purposive sampling method was adopted because the sample consisted of people who are in a sero-discordant relationship. According to Maree (2007:178), purposive sampling is used in specific situations where sampling is done with a specific purpose in mind. Rezenti and Lee (1993:4) describe sensitive topics as those that social scientists generally regard as threatening in some way to those being studied. The stigmatization and discrimination surrounding HIV make it difficult for people to disclose their status and offer insight on the nature of their relationship.

### **6.1 Sample size**

The researcher purposively selected a sample of 40 key informants, thirty (30) registered social workers who are working with HIV positive people, because of their involvement and knowledge with regard to HIV and AIDS. Fifteen (15) from Ganyesa, Kagisano-Molopo Service Point and fifteen (15) from Vryburg, Naledi Service Point were given questionnaires to complete. Furthermore, ten (10) Life-line counsellors were purposively selected to participate in the study. The five couples were identified through the Life-line coordinator, home-based care givers and through the social workers in their various support groups.

## **7. Methods of collecting data**

Monette, Sullivan and Dejong (in De Vos, Strydom, Fouche and Delpont, 2005:160), explain that “data collection method is an important part of any research study because it does not only give the description of how data was collected, but also constitutes the basic information from which conclusions were be drawn”. For the purpose of this study, data was collected using semi-structured interviews, with open-ended questions from an interview guide; and perusing through different literature.

### **7.1 Key informant method**

Parsons (2013:01) defines a key informant as a person who is knowledgeable about a particular social problem or phenomenon. In a sense, the key informants are a proxy for that particular organization. In this study, key informants were social workers from the Department of Social Development at Naledi and Kagisano-Molopo Municipality and with counsellors from Life-line counselling centre (Vryburg). The open-ended questions on the interview guide were used to gather data from key informants. The rationale for using them was to stimulate an in-depth discussion on the question asked. Marshall (1996: 92) explains that key informant interviews provide flexibility to explore new ideas and issues not anticipated during planning. The interview can elicit new information by requesting the key informant to expand his/her answer on the initial question.

### **7.2 Literature review**

An extensive literature search on the topic was carried out to gain more knowledge and also to sharpen and deepen the theoretical framework of the research. Creswell (2009:20) states that a literature review shares with readers prior studies closely linked with the study being reported. Secondly, it relates a study to the larger on-going dialogue on the topic, as well as filling gaps and extending prior knowledge. Lastly, it provides a framework for establishing the significance of the study and a benchmark for comparing the results of a study with other findings.

De Vos, Strydom, Fouche and Delpont, (2002: 127), further explain that “a review of the literature is aimed at contributing towards a clearer understanding of the nature

and meaning of the problem that has been identified". The relevance of a literature study can be found in its provision of focus towards the specific topic. The researcher perused different journals, books and also internet (google.com, academic search engine, Ebscohost and SABINET) to search for related materials on the topic, factors contributing to the coping mechanisms of sero-discordant relationship.

### 7.3 Interviews

Semi-structured interviews were conducted with sero-discordant couples. Marshall and Rossman (2011:80) describe interviews as a conversation with a purpose. They also state that what is of most importance with interviews is that they permit probing of the reasoning behind the answers from the participant. Semi-structured interviews, according to Bless and Higson-Smith (1995:10), are useful techniques used during an exploratory research process to clarify concepts and problems as well as creating possible solutions to problems.

The researcher felt that an interview with couples where one partner is HIV positive is convenient as it involves direct interaction with participants. The interview method enabled the researcher to probe more deeply on specific issues. This is because it involves the face-to-face method of communication, and there is an advantage in being able to see the facial expression of a participant.

An audio tape recorder was used to record information in order for the researcher to acquire accurate information. The information was deleted later to protect the people's information and also to avoid the information being tampered with by others. The researcher was precise about the information she needed and asked relevant questions that enabled her to understand the coping mechanisms of the couples as well as the challenges they are faced with.

Furthermore, during the interview process, the researcher used her skills to separate the important facts from less important information. She was interested in the knowledge, skills, values and attitudes that the participants have acquired through their experience of living with different HIV statuses. Interviews were conducted with five couples, making a total of ten people who were interviewed individually on a

one-on-one basis and this was convenient as it enabled the researcher to probe more deeply without fear from one partner trying to please the other. However, the researcher made sure that the atmosphere under which the interviews were conducted was conducive to obtain the information sought.

## **8. Data analysis**

Content analysis was adopted because of its unique interpretation on qualitative interviews. According to Babbie (2010:356), content analysis is a social research method appropriate for studying recorded human communication. It is also described by Bryman (2004:542) as an “approach to people, documents that emphasizes the role of the investigator in the construction of meaning of and in text. There is an emphasis on allowing categories to emerge out of data and on recognising the significance for understanding the meaning of the context”.

Content analysis was used following the process of data analysis outlined in DeVos *et al* (2005: 334-337).

- **Planning for recording data.**

The researcher used a tape recorder to record information during interviews.

- **Data collection and preliminary analysis.**

With data collected using a tape recorder, the researcher transcribed it from tape to paper.

- **Managing and organising data**

The notes made from the tape recorder were scrutinised by the researcher highlighting the most important information for later use.

- **Reading and writing themes**

The researcher read it several times, then organised it into themes, which were interpreted to try and add meaning and significance to data collected.

- **Coding data**

From reading through data, the researcher developed categories of data where codes were used as a tool for analysis.

## CHAPTER 4

### DATA PRESENTATION, ANALYSIS AND INTERPRETATION

#### 1. INTRODUCTION

In this chapter, data is presented, analysed and interpreted. The researcher will present data gathered from couples in a sero-discordant relationship and data from key informants.

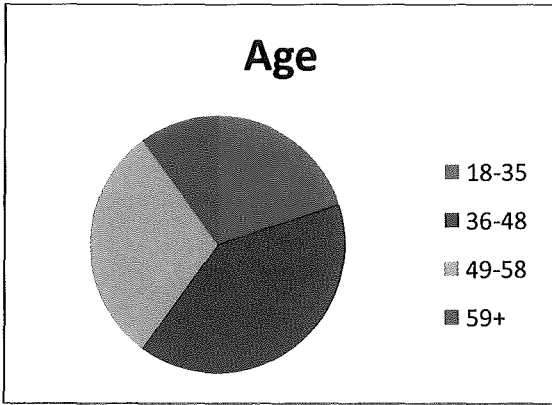
The presentation of data comprises of four sections; section A is the analysis of demographical questions which are in the form of tables and charts, and section B is the analysis of data provided by couples in a sero-discordant relationship. The first set of analysis is from data provided by HIV negative partners followed by data collected from the HIV positive partners. Then data from key informants in section C is the analysis of demographic questions in the form of tables and section D is the analysis of data provided by key informants.

#### SECTION A

##### 1. DEMOGRAPHICAL DATA

###### 1.1 Table 1. AGE

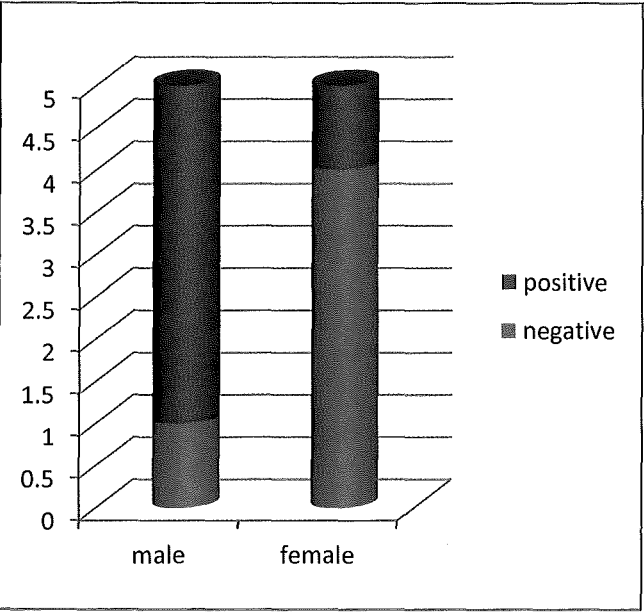
|              | Male | Female | Total |
|--------------|------|--------|-------|
| 18-35        | 1    | 1      | 2     |
| 36-48        | 1    | 3      | 4     |
| 49-58        | 2    | 1      | 3     |
| 59 AND ABOVE | 1    | 0      | 1     |



The age of the participants ranges from 18-61 years with most females being between 38-48 years of age. The males dominate in the 49-58 year old range. These percentages indicate that male and female participants are still of the childbearing age. It also indicates an increased possibility of engaging in sex.

1.2 Table 2. HIV status

|        | Negative | Positive |
|--------|----------|----------|
| Male   | 1        | 4        |
| Female | 4        | 1        |

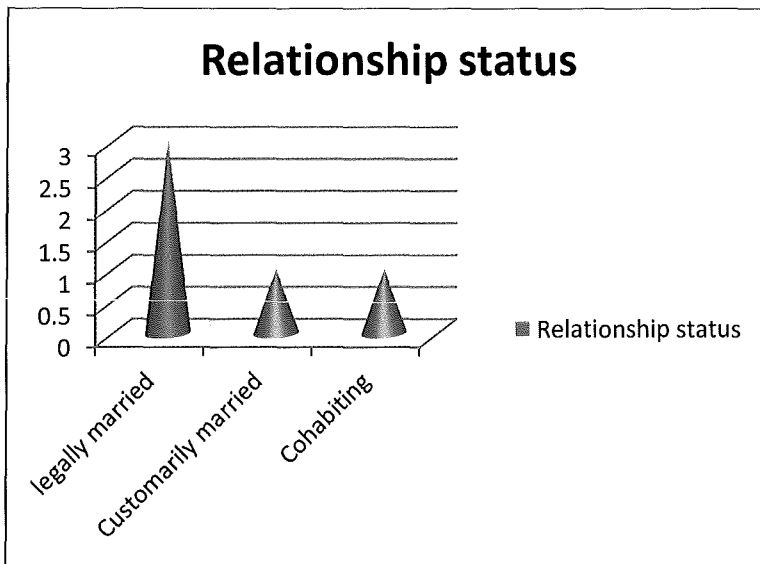


Five couples where one partner is HIV positive and the other partner is HIV positive were not chosen on gender but availability. One female participant and four male participants were HIV positive. The negative HIV participants were one male and

four females. It indicates a fair sampling with the possible effect of increased data, credibility and trustworthiness.

1.3 Table 3. MARITAL STATUS

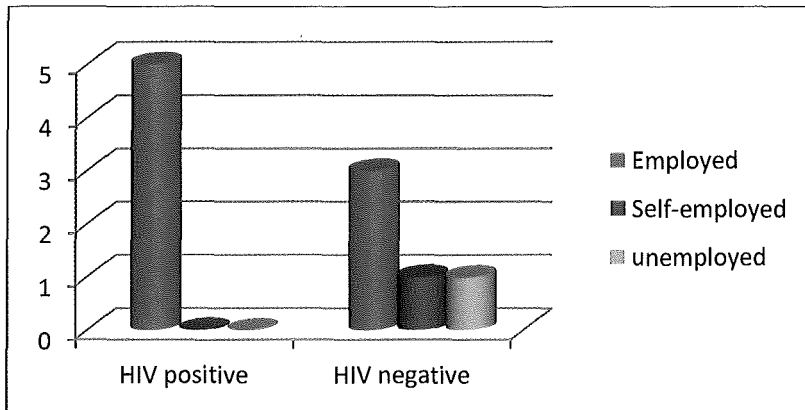
|                     |   |
|---------------------|---|
| Legally married     | 3 |
| Customarily married | 1 |
| Cohabiting          | 1 |



The participants had to be in a relationship for at least a year. Three of the participating couples were married. One couple was customarily married and the remaining couple was cohabiting. The samples met the eligibility criteria adequately, well trustworthy and credible

1.4 Table 4. SOCIO-ECONOMIC STATUS

|              | Employed | Self-employed | Unemployed | Total    |
|--------------|----------|---------------|------------|----------|
| HIV positive | 5        | <u>0</u>      | <u>0</u>   | <u>5</u> |
| HIV negative | 3        | <u>1</u>      | <u>1</u>   | <u>5</u> |



All HIV positive participants are employed. This shows that people living with HIV have the same job opportunities as everyone else. Most of the HIV negative partners are also employed; one is self-employed and one participant is unemployed.

### 1.5 Table 5. EDUCATION LEVEL

|                   |          |
|-------------------|----------|
| STD 10 (Grade 12) | <u>2</u> |
| Tertiary level    | <u>8</u> |

Most of the participants have reached tertiary level; they have better jobs, and opportunities for higher positions are not being defined by their status but qualification. Only two participants have reached only Standard 10 or Grade 12. This indicates opportunities to understand the interventions to mitigate the state of discordancy.

## SECTION B

### 2. RESULTS FROM THE NEGATIVE PARTNERS

The following themes and sub-themes emerged from the discussion with the five (5) HIV negative partners interviewed:

#### 2.1 Theme 1: Changes in the relationship due to different status

Participants were asked about changes in their relationship due to their sero-discordant status. The majority of the HIV negative participants highlighted that there have been changes in their sexual pattern due to the fear of HIV transmission. This can be summarised by a view of one participant who said 'I get scared every time we get intimate even if we use condoms.' An article on [avert.org](http://avert.org) confirms that it is very

common for people to worry about HIV infection due to many myths around HIV; no matter how many times these myths are addressed, they have already been instilled in people's minds. From the views of the participant it is clearly evident that proper education on condom use is needed.

However, it is not all participants, who share the same view. The same question elicited a different view from one HIV negative female participant who responded thus:

*"Nothing has changed"*

The fact that the other partner is HIV positive had no impact on how she viewed their relationship. There is one participant, though, who indicated that:

*"I became obsessed with testing as I doubted my negative status"*

There are however many reasons this particular participant feels this way. Nonetheless, this points back to the need for proper education on HIV, especially modes of transmission, including different tests to determine one's HIV status.

## **2.2 Theme 2: Coping mechanisms used by the couples**

The HIV negative participants definitely differed when asked about what makes their relationship survive and most of the responses were around the issues of communication, ARV and counselling.

### **2.2.1 Sub-theme 2.1: Communication within the relationship**

Research shows that couples with differing HIV status can face a number of social, sexual and relationship challenges. Communication is often emphasised as the key to cope with such challenges. Persson (2007, 4) notes that the privilege of communication as a proper therapeutic adjustment to coping with the illness assists best taking into consideration the complexities of managing HIV as a sero-discordant couple.

This notion is enhanced by the following responses on communication by the HIV negative participants:

*"We became good friends, I am the only one who knows about his status so any change he experiences, he communicates it to me and respects my input"*

*"Our communication is better than ever"*

*"I feel respected because she listens better now"*

Generally HIV negative participants feels that their communication has improved, there is a significant change in communication, except for one participant who feels that their communication has not improved:

*"There is no change, it is still the same"*

The findings have indicated that communication is a definite working process and achievement of such yields a much better and happier relationship.

### **2.2.2 Sub-theme 2.2: The use of Anti-retroviral treatment**

Taking anti-retroviral drugs in South Africa today has become much easier. In the past, an HIV positive person had to take many drugs. Now with fixed dose combination of anti-retroviral drug taken daily, it is now simpler to manage the illness.

The partners of all the HIV negative participants have already started on ARV's. The following are responses which emerged from the participants when asked how ARV's have assisted their relationship:

*"My husband's viral load is now less than 50 copies. we have overjoyed and we will work hard to maintain it that way"*

*"ARV saved my relationship, we are best buddies, I remind her to take medication and she appreciate it"*

*"ARVs gave me hope that my partner will live long"*

*“His health improved drastically and so is his attitude to life”*

The findings by a research conducted by Johnson, Mossong, Dorrington, Schomaker, Hoffmann, Keiser, Fox, Wood, Prozesky & Giddy (2013:7) contend that in South Africa, people who start treatment before their CD4 count is below 200 have a life expectancy around 80% of that of the general population. However, it still remains true that Anti-retroviral drugs do not cure HIV infection, but enable one to stay healthy for a long time.

Moreover, the HIV negative participant's knowledge about ARV's is limited to drugs known to be taken by HIV positive patients to improve their immune system. They do not seem knowledgeable about anti-retroviral drugs such as Tenofovir (disoproxil fumarate, also known as tenofovir,) which is one of the drugs used for pre-exposure prophylaxis (PrEP). According to Dr. Martin, as cited by Young (2013:2,) PrEP can potentially be a vital option for people at a very high risk of infection. He further suggests that it can lower the risk of an infected partner passing the virus to an uninfected partner in a sero-discordant couple. This, however, is an option and a personal choice when in a sero-discordant relationship.

### **2.2.3 Sub-theme 2.3: Counselling provided to couples**

A majority of the HIV negative couples feels that this kind of a relationship is difficult especially because their positive partners have not disclosed their status to other people; this becomes a burden for them and counselling assists in this regard. These are some of the responses:

*“At least I have someone to talk to”*

*“I feel better when I have spoken to a counsellor”*

*“Our Doctor has become our confidant”*

Sero-discordant couples face numerous challenges ranging from practicing safe sex to psychological stressors such as finances. Counselling, by definition, is a “helping relationship between a counsellor and a client in which the trusting relationship and the skills of the counsellor help the client understand his/her problems better and decide how best to solve those problems”.

The statement is supported by Desgrees and Orne-Gliemann(2008) who believes that a couple-centred approach to HIV counselling would help facilitate communication about the status, and adoption of preventative behaviours between the couples. This can be summarised by one HIV negative partner who feels:

*“Without counselling I will be lost”*

### **2.3 Theme 3: Future plans for the couples**

Lack of disclosure from the HIV positive partners creates a burden on some of the negative partners, but they are still eager to support their partners. Future plans are discussed looking at support systems and child bearing: it's critical that the government and HIV and AIDS organisations increase the campaign on the need to disclose, especially to an intimate friend. This is to help him or her intervene timeously.

#### **2.3.1 Sub-theme 3.1: Support systems in the relationship**

All of the HIV negative participants do not receive support from anybody else. They in turn are expected to offer support to their positive partners. Their HIV positive partners have not disclosed their status to anyone else outside their relationship. When asked about their support for their partners, these are some responses:

*“I love supporting my partner; I feel needed, kind, important to him”*

*“She knows she can count on me”*

*“Even if it's hard sometimes because he is stubborn but I will always support him”*

Even if this is the case according to the said findings, lack of disclosure from the HIV positive partner brings additional stress to the relationship. Research conducted by Naran(2007) concludes that the HIV negative partners in a sero-discordant relationship have been ignored for long and they can actually assist, even if they

themselves have their own challenges. However, counselling sessions are a source of support to the negative partners who utilise the service.

### **2.3.2 Sub-theme 3.2: The need for child bearing and child rearing**

Most of the participants already have children; only two participants out of five do not have children. The participants without children still desire to have children of their own unlike the three who have children already. One participant without a child strongly voiced the following expression:

*"I want to have children"*

Though fear of HIV transmission still prevailed, education on assistive methods to get pregnant such as IVF and UVF or surrogacy is still needed, so that the couples can make informed decisions. Some of the participants highlighted they may want more children but they have fears. Their reaction can be summarised by the following response from one participant:

*"I am afraid of getting infected"*

Childbearing has the problem of risking HIV infection or infecting the spouse. Research conducted by Beyeza-Kashesya, Kaharuza, Mirembe, Neema, Ekstroom, and Kulane (2008) in Uganda indicates that sixty per cent (60%) of new infections occur in stable relationship.

### **2.4 Participants' suggestions on sero-discordant relationships**

Despite the participants' concern about confidentiality even though it was explicitly explained, they appreciated talking to a neutral person, they felt important and cared for. They felt that they do not have a problem of forming a support group, but their partners have to be comfortable with the idea first because whatever they do they will always be associated with them. They are faced with a challenge of non-disclosure from their positive partners.

### 3. RESULTS FROM THE POSITIVE PARTNER

#### 3.1 Theme 1: The positive partner's sero-discordant status

The HIV positive participants were asked a question on what propelled or motivated them to want to know their status in the first place; 'why did you make an HIV test?' Various reasons emerged and this is one response from a participant:

*"I wanted to know my status"*

This is one participant who voluntarily went to test, whereas some participants were compelled or had a little nudge to do the HIV test. These are some of responses given:

*"I was sick"*

*"We wanted to have a baby"*

*"It was requested for any [insurance] policy to be approved"*

A little overrated motivation was from one participant who went to test because they were given incentives at work. This particular participant responded thus:

*"They were giving money at work when testing for HIV"*

This response highlights the commitment of some employers to assist their employees to know their status. This is because discovering ones status early assists with living a better life and protecting oneself either from getting infected or from re-infection. It is therefore critical that individuals, communities and organisations come up with interventions to motivate the public to know their status.

#### 3.2 Theme 2: Disclosure of their status

The HIV positive participants have not disclosed to anyone else beside their spouses, except for one HIV positive female participant who disclosed to her close friend. Even for those with children, their children did not know their status at the time of interview.

The HIV positive participants were asked about their lack of disclosure and most of the responses can be summarised by one participant response:

*"I do not see how disclosing to other people will help me"*

On the contrary, Norval (2012:1) believes that "Disclosure can help you to accept your HIV positive status and reduces the stress of coping on your own. Disclosure can help you access the medical services, care and support you need. Disclosure can help you to protect yourself and others. Openness about your HIV positive status may help to negotiate safe sex practices. Disclosure may help to reduce stigma, discrimination and denial that surround HIV and Aids."

All HIV positive participants disclosed their HIV status to their spouses. This statement is supported by Naidoo (2012:2) that people living with HIV have a moral and legal obligation to tell their sex partners that they are HIV positive. The HIV positive participants felt that it was not easy but they had to for the sake of their relationship and support. They however did not envisage the kind of response they received but they had to succumb to them as they finally led to acceptance. According to the participants, their partners' response to their disclosure ranged from anger due to betrayal, and to depression.

The participants were asked, 'how did your partner react to your disclosure?' Different responses surfaced such as the following:

*"She was shocked"*

*"She was angry"*

*"He was very understanding"*

*"We almost divorced"*

A pamphlet from the Department of Education (2011:16) has the following advice on disclosure:

"Telling others that you are living with HIV can be scary, painful and hard. When HIV positive, you do not have to tell everybody, only those you trust and you need to tell. Also, if you have kids, telling children about your HIV status can be more challenging. However, the author advises that like other touchy topics like puberty, sex, this also should be age appropriate".

All HIV + partners who have children have not disclosed to their children and most of the responses can be summarised by the following response of these participants who feel that:

*"The children will never understand"*

*"I am not ready to put them in such trauma"*

Drawing conclusions from these, it is evident that the participants avoid educating their children about HIV. Even if telling ones status is a confidential and private issue, telling ones children, according to this researcher, assists the family to unite and understand one another better.

### **3.3 Theme 3: Changes in their sexual relationship**

The participants felt that even though disclosure was difficult, it was nothing compared to their sexual relationship. According to most of them, it is difficult for them to get used to using condoms on a full time basis. When the participants were asked: 'How are you dealing with sex in your relationship?' the responses from the participants were:

*"It is very difficult to use a condom"*

*"It's not easy because I fear the condom might break"*

*"We do not have a problem enjoying sex"*

Most of the HIV positive participants were males. According to Rose-Innes (2006:11) "Men do not want to use condoms because of beliefs such as 'flesh to flesh' sex is equated to masculinity and is necessary for male health". This researcher agrees with this statement as one of the participants clearly indicated that "sex with a condom is not sex."

### **3.4 Theme 4: Coping mechanisms for the couples**

The HIV positive participants were asked what makes their relationship survive with different HIV status. The HIV positive partners indicated that even though it is hard at

times, but counselling and support groups with peers assist them to manage their illness better and improve their social functioning.

#### **3.4.1 Sub-theme 4.1: Counselling provided to couples**

Counselling definitely suffices as a support system where one is able to talk to a professional without fear that their information they provide will be disclosed. It provides a confidential space, where one is listened to, supported and encouraged to make informed decisions about their future.

Because of lack of disclosure in this case, counselling became a pivotal tool. This was highlighted when participants were asked: 'Did you seek any professional guidance in your relationship, or are you currently undergoing counselling?' Most of the participants responded that they have utilised counselling services before, and only two HIV positive participants were still undergoing counselling.

A follow-up was made on how counselling assisted them cope with their relationship and status. The following are responses that emerged:

*"I was empowered"*

*"I gained strength to continue to live positively"*

*"It feels good to talk to a neutral person"*

*"I feel understood"*

The findings indicate that the HIV positive participants find counselling helpful and it definitely improves their outlook on life as well as coping with and management of their disease.

#### **3.5 Theme 5: Feelings towards support groups**

Like counselling, finding the right support groups can help people living with HIV from getting stressed, worried or depressed. The HIV positive participants are receiving support from their HIV negative spouses. Some HIV participants are not part of a support group for they feel that the support they get from their HIV negative spouses is

sufficient. Those who are part of a support group have indicated that it is very helpful especially because as a group, you share a common problem.

When the participants were asked how the support group assisted them, the two who are part of one responded thus:

*"I could talk openly without being judged"*

*"I was happy; everybody seemed to be experiencing*

*what I was experiencing"*

In support groups, people with HIV meet others who have similar experiences. They learn that they are not alone and that they can build a new life. Carter (1994:3) feels that support groups are important because:

"They provide people with HIV a relaxed and informal place to share their experiences and build new friendships. Support groups give couples (at least one of whom is HIV positive) an opportunity to discuss relational, legal, health and other issues that concern them."

### **3.6 Theme 6: Participation in awareness campaigns**

HIV awareness campaigns have been a great success in South Africa. The people are testing, using condoms and males are getting circumcised (Dr Aaron Motsoaledi July 24, 2012). HIV positive individuals who participated in this study are not keen on disclosure due to fear of stigma, and some say they are not ready. When the participants asked if they would like to participate in the awareness campaigns, their responses can be summarised as:

*"I do not want to participate in any awareness campaigns"*

*"Maybe with time but not now"*

Awareness campaigns help break the stigma associated with HIV and can definitely encourage people to test and know their status. Participants felt that they are not ready to participate in any awareness campaign either at work or in the community. They feel that doing it will not only exacerbate stigma about them, but their partners

will also be labelled as positive and they were not ready to explain their relationship to anyone. The HIV positive participants cannot be forced to disclose, nor to participate in awareness campaigns, but it is hoped with time they can accept their status and use their experiences to help others.

### **3.7 Participants' suggestions on the interview session**

Some of the positive partners felt that even if they agreed to be part of the study, these kinds of interview only exposed them and do not assist, nor change anything about their status. On the other hand, some of them felt that they have learned a lot from this session and they hope that their family can survive whatever challenges they face.

The positive partners suggested that more awareness programmes be intensified about HIV and AIDS especially in their communities. They said that these might help them to disclose as the people they live with would now know and understand HIV, which affects all and possibly be inclined to stop discriminating against each other.

### **3.8 SUMMARY**

This section focused on semi structured interviews that were held with sero-discordant couples. Most of these interviews were held in the participant's home. The researcher requested that each partner be interviewed separately as their experiences with HIV are different and that the presence of the other should not hamper the responses of the other partner.

Information acquired from the participants was written as direct quotes, no additions made. Where necessary, the researcher integrated with literature sources. From this section's data, interviews with the HIV negative partners, five (5) themes emerged and in the interviews with HIV positive partners, six (6) themes emerged. The findings here dismissed the assumption of this study, that for a negative partner, being in a sero-discordant relationship poses a compromise. It has proven that for some it is purely because of love. The following section is on data analysis with the key informants.

## SECTION C

### 4. ANALYSIS OF DEMOGRAPHIC DATA FROM KEY INFORMANTS

#### Demographical Questions

##### 4.1 Age

|              |    |
|--------------|----|
| 25-30        | 14 |
| 31-35        | 20 |
| 36-45        | 5  |
| 46 AND ABOVE | 1  |

Table 1: Age of the respondents

A majority (50%) of the participants are in the age range of 31-35 years. Second highest are those between 25-30 years with 35%, followed by those between 36-45 years, with 12%. However the least (2.5%) are those aged 46 and above.

##### 4.2. Gender

|        |    |
|--------|----|
| Male   | 6  |
| Female | 34 |

Table 2: Gender distribution of the respondents

The above table shows that a majority, 85% of the participants were females. Males are represented by 15%, therefore mostly women participated in the study. HIV and AIDS campaign participation is gender skewed, with men not getting information as women. One to patriarchal power dynamics, the information from women does not get well to men. This constitutes a serious gap in the campaign many African countries.

##### 4.3. In which area are you working?

|  |    |
|--|----|
| Kagisano-Molopo municipality (Ganyesa) | 15 |
| Naledi municipality (Vryburg)          |    |

|  |    |
|--|----|
|  | 25 |
|--|----|

Figure 3: Area of work of respondents

The figure above shows that 62.5% of respondents are from Vryburg, Naledi municipality. This can be attributed to the fact that though they service the whole Dr. Ruth Segomotsi District, the 10 Life-line counsellors' offices are based at Vryburg. The remaining 37.5% are social workers from Kagisano-Molopo municipality at Ganyesa village.

4.4 In which department are you coordinating HIV and aids programme?

|                    |    |
|--------------------|----|
| Life-line          | 10 |
| Social Development | 30 |

Out of 100% of the participants on this study, 75% are social workers from Social Development and 25% are counsellors from Line-line. Over representation of the social workers could be a plus in that they are the ones that drives the HIV and AIDS campaigns more than other community Departments professionals.

**SECTION D**

**5. RESULTS OF THE OPINION QUESTIONS**

**5.1. Knowledge in your area of sero-discordant couples.**

83% of Social Workers who are working in this area have not come across sero-discordant relationship-related cases. 13% have come across one case of such a relationship, and 3% had come across a maximum of two cases.

The percentage of Life-line counsellors who have knowledge of sero-discordant couples is much greater than the number of social workers with this knowledge. Out of 10 counsellors who participated, all of them had seen at least out of five couples one partner tested positive during their couple testing programme.

**5.2. Discovery of existence of such relationship.**

10% said they found out during intakes, and 3% said through home-visits whereas 3% said through community awareness campaigns. Life-line counsellors have an outreach program where they encourage a person to test as a couples; that is where they discover sero-discordant couples.

### **5.3. The nature in which the problem was presented to social workers**

The one social worker said a client came to the office to report that her husband is verbally and physically abusing her since they discovered that she is HIV positive and he is not. The other intake was about a cohabiting couple where the girlfriend came to complain that the boyfriend wants them to stop using a condom and he is HIV positive whereas she is HIV negative.

Another response was that after an awareness campaign presentation, a community member approached the social worker to say that the husband is HIV positive. He is working at Rustenburg and comes home after every month end. She went to test while the husband went back to work and discovered that she is still HIV negative.

On the other hand, a social worker who discovered the existence of this relationship through a home-visit stated that she had to compile a home-circumstances report for a social relief of distress (SRD). The HIV positive client is not working and on medication (ARV's). So he needed SRD assistance to be able to eat healthily and drink his medication. At Life-line counselling centre, the couple tested together and both of them could see the other's results as soon as they appeared.

### **5.4. Rationale behind presenting the information.**

Most of the clients who presented their story to the social workers were worried and needed the social worker's intervention. The only client who had a home-visit provided the information because it was needed by the social worker.

Life-line needed not only to see how many people are in sero-discordant relationships, but also to facilitate issues of disclosure. In South Africa, there is no law that forces HIV positive people to disclose their status to their sexual partner. Through this programme, each couple is sure of the other person's status since they have witnessed the results.

### **5.5 Plan of action.**

Both individual and marital counselling was provided to the clients. The other positive client received SRD but was encouraged to look for a job. People who were at the stage of full-blown AIDS in South Africa used to be given a disability grant for a certain period while taking ARV's. De Paoli, Mills and Gronningsaete (2013:1) add that the challenge comes after their health has improved. They lose the grant; the loss of the grant and unemployment lead to food insecurity which can have serious consequences given the need for proper nutrition to ensure treatment efficacy.

HIV education was provided to clients to make them understand their condition better, and also to the negative partner especially while the positive partner is still weak. According to Macnab (2009:2), a low level of literacy is a major barrier preventing people from accessing accurate HIV/AIDS information and prevention services. It limits people's ability to make informed choices. HIV education serves as a prevention method.

Life-line counsellors are trained as lay counsellors, where they have limitations in terms of counselling services. According to the respondents, they offer post-test counselling to the couples, then refer them to the nearby social development (social workers) offices for further assistance.

### **5.6. The outcome of one's assistance.**

Even after counselling was offered, the husband still opted to leave the marriage. He believes the wife was cheating in a relationship. HIV education assisted the HIV positive boyfriend to understand his status and modes of transmission. The couple are now in a happy relationship where they use a condom each time they engage in sexual intercourse.

The wife is still staying in with the husband and they use a condom. The wife is still going for individual counselling. It is still difficult to accept the fact that her husband is HIV positive but she decided to stay in the marriage for the sake of her children.

Life-line counsellors are unable to measure the outcome of their assistance as most of the beneficiaries do not come back to their offices for feedback. Some of their offices are far away in Vryburg and in most cases, couples test in their mobile clinic.

### **5.7. Challenges experienced by sero-discordant couples.**

Most of the social workers said sero-discordant partners do not have separate challenges from those of HIV negative concordant partners. Those who said yes feel that the other partner will always be worried about the condom breaking, and they must always be on guard that the other partner does not get infected.

They deal with issues such lack of trust throughout their relationship if sero-discordancy happened while in a relationship. Like most of the social workers, even the participants from Life-line counselling centre feel that the sero-discordant couples do not have challenges separate from those in the usual concordant relationship.

### **5.8. Awareness about sero-discordant relationships.**

All of the respondents said nothing has been done to raise awareness. One of the social workers added that even if they do not raise awareness about this type of relationship particularly, they have a support group for both HIV affected and infected individuals.

Even after testing and knowing the number of sero-discordant relationships that exist in that particular area, Life-line Vryburg has not done much to raise awareness about this kind of relationship.

### **5.9. Actions to raise awareness.**

Social workers who have come across this type of relationships in their area of work believe that many people still lack information on HIV and AIDS in general. They feel that the community needs education on HIV and that on World AIDS Day, the topic of sero-discordant relationships should never be left out. People should be told about

them and make informed decisions when they find themselves in this kind of relationship.

Life-line counselling centre at the moment does not have funds to host events that can allow them to raise awareness about sero-discordant relationships. The general feeling amongst the counsellors is that if invited by the Department of Health, for example, they will gladly take the chance to tell people about sero-discordant relationships.

#### **5.10. Professional views regarding sero-discordant relationships.**

Some social workers believe that if you are educated, it is easy to understand the dynamics of such relationship. Others shared that as long as the couple love one another, taking care of themselves with love, survival of such a relationship is possible.

Some Life-line counsellors emphasised the use of condoms in a sero-discordant relationship, whereas a small number advised that couples need to know any information regarding their relationship, read magazines and browse the internet as part of empowerment.

#### **5.11. Professional advice to couples.**

- To support one another.
- Touse a condom (practice safe sex).
- Protect and respect one another.

#### **5.12. Suggestions on how HIV discordance can be handled by the Department and by the community.**

The following suggestions were provided:

- Social Workers to be educated and become aware of the existence of such relationships so that they can give relevant support.

- The Department needs to intensify awareness campaigns in the community to show that even with sero-discordancy; people can live a normal life.
- Couples should be encouraged to test together for purpose of disclosure.
- Funding of support groups should be enhanced.

### 5.13 SUMMARY

In this section, interviews with open ended questions were conducted with the social workers from the Department of Social Development at Naledi service point (Vryburg) as well as Kagisano-molopo service point (Ganyesa Village). The interviews were also conducted with counsellors at life-line, which operates from Vryburg but services the entire District of Dr. Ruth Segomotsi Mompoti. The interviews were conducted to acquire an in depth information about discordant couples.

A noticeable gap is a response from majority of social workers who said in their line of work they have not come across people who are in sero-discordant relationships. For those who did, they discovered them through their intakes, home-visits and community awareness campaigns. Life-line counselling centre, which has seen a high number of sero-discordant relationships, mentioned that as lay counsellors when they identify a need for counselling, they refer to the case social workers.

Even with the knowledge and existence of sero-discordant relationship in this area, there are still no plans on awareness solely based on sero-discordant relationships. The focus is still on the wellbeing of the positive partner. Much still needs to be done to address the psycho-social effects of the relationship to the negative partner.

## CHAPTER 5

### FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

#### 1. INTRODUCTION

The purpose of this chapter is to draw conclusions and make recommendations based on the knowledge, experience and information gained from the data reflected in the previous chapters. This chapter will indicate whether the objectives set at the beginning of the study have been met or not. It will also answer study questions previously asked.

#### 2. RESTATEMENT OF THE OBJECTIVES

- The challenges of couples living in a sero-discordant relationship.
- The extent of sero-discordant relationships in the selected study area.
- The coping mechanisms used by couples in a sero-discordant relationship.
- Intervention strategies and programmes to help strengthen sero-discordant relationships.

#### 3. MAIN FINDINGS

##### **3.1 Objective: The challenges of couples living in a sero-discordant relationship were achieved.**

The findings indicated that:

- Even if fear of transmission exists in sero-discordant relationships, the findings indicate that couples who found out their discordant status while in a relationship tend to struggle on adjusting to their new lifestyle due to fear of transmission. The positive partner is cautious not to infect the negative partner and the negative partner is cautious not to get infected.
- In the relationship, if the positive partner gets sick, it becomes a problem when the negative partner who is the care-giver ends up having to terminate employment in order to take care of the sick partner. This impact negatively on

the couple's finances. Issues of stigma and discrimination make it difficult for the couples to disclose their status to other people outside their relationship, which then exacerbates matters. Even if in the family, there can be someone available to assist the couple and take care of the positive partner, it makes it difficult when the couple is not yet ready to disclose.

- It proved to be a great challenge, when the couple does not have children at all. Most of the times partners do not know where to get help. Even after providing information on issues of fertility, the couples felt that such procedures are tiring and expensive.

### **3.2 Objective: The extent of the sero-discordant relation in the selected study area.**

- This objective was achieved in the literature review and problem statement.
- The figures show explicitly that sero-discordant relationships do exist in the area of study. Vryburg is sky rocketing high with 50% though Ganyesa is one of the lowest with 10%.
- The approach of private sector organisations such as Life-line to test couples together assists in having statistics about sero-discordant relationships. Countries such as Uganda, which is considered a success story in reducing HIV infection, have centres where they are not only dealing with HIV in isolation, but testing couples is one of their mandates. The study conducted by Beyeza-Kashesya, Kaharuza, Mirembe, Neema, Ekstroom, and Kulane(2008:2) discovered that 60% of all new infections occur in HIV sero-discordant relationships and 30% of married HIV positive people have a negative partner.
- The Strength perspective and task centred model, where the researcher tapped into the participants' strength, assisted clients to look within as they have been surviving with their different status all along. It enabled them to see beyond the problem, they saw they have potential within them to overcome their challenges. However, this achievement required minor tasks so that they were able to work on their individual self as well as their relationship.
- In South Africa, the interest is still developing. At the 6<sup>th</sup> South African AIDS conference, the HSRC mentioned that they have conducted a study on sero-

discordant relationships but on that day, the results were not presented. At this moment in South Africa, there is no program specifically for sero-discordant couples; this makes it difficult to access statistics on sero-discordant relationships.

- Sero-discordancy can be attributed to the high rate of HIV infection in South Africa. In the study area specifically, the main motivation for negative partners to continue with the relationship has been found to be because of love, and some stayed because they have children together.

### **3.3 Objective: The coping mechanisms used by couples in a sero-discordant relationship.**

- In relation to the coping mechanisms, the findings revealed that continuous counselling is very important to cope in such a relationship. Most couples felt that their relationship would not be where it is if it were not for counselling. The communities where the clients reside mainly use the free services of social workers from the Department of Health and those from the Department of Social Development. For those who need the counselling services from a psychologist, they have to travel to areas such as Mafikeng, which is 229 kilometres from Ganyesa and 155km from Vryburg.
- The ecosystem theory established coping mechanisms used by couples in sero-discordant relationships. Both the partners are unique subsystems in the family; understanding them in their own environment assisted them to establish a good structure to ensure a goodness of fit thus creating a balance. They are now empowered with skills to better themselves and understand their relationship thus working towards a common goal.
- Open communications between the couples also assists them to cope. When each has a concern, s/he knows that it is always best to be open and express this to their partners. Tiffany (2011, 138) explains that the general occurrence of communication barriers that become prevalent upon diagnosis of a terminal illness such as HIV can be detrimental to the relationship. In this regard, the author states that there can be no hard and fast rules in terms of communication, and that openness in sharing with the positive partner should remain the primary focus.

### **3.4 Objective: Intervention strategies and programmes to help strengthen sero-discordant relationships.**

Johnson (1995:369) explains the aim of intervention as enhancing social change and liberating people from dysfunction, so that people can help themselves. Intervention entails developing problem-solving capabilities and acknowledging diversity, tolerance and social justice.

- Through the South Africa Government's roll-out of anti-retroviral drugs , the couples say that it gave them hope that their partner will be around for a bit longer than before the ARV's were introduced. Nowadays with the introduction of ARV's, HIV mortality rate has been reduced.
- The Department of Health commemorates World Aids Day and invites other Departments. During such celebrations, the communities are given information on HIV and AIDS. On the interview schedule used for data collection it was found that one of the sero-discordant cases was discovered in an awareness campaign held by the Department of Social Development.
- In terms of counselling, the participants know where they can access the services as the majority of them had already utilised them. Both the Department of Health and Department of Social Development have social workers who are offering counselling services without a fee.

## **4. RECOMMENDATIONS**

Based on the findings of the study, the following recommendations are made:

- Interviews and awareness about sero-discordance have to be intensified by the different Departments especially Health and Social Development on the media, TV, radio and newspaper, so that those who are involved and want to be involved should make informed decisions.
- Social workers and care givers should be empowered by continuously arming themselves with recent information on sero-discordant relationships so that they can provide an informed assistance that does not only focus on the family orientated dysfunctional systems.

- Sero-discordant couples have to learn to communicate effectively with one another. Neither of them should feel that they were imprisoned when they decided to get involved in the relationship. The positive partner should allow the negative partner to express his/her worries without always giving an ultimatum or the negative partner always mocking the positive partner as if their views are not important because they are already involved. Each should be an equal team player for them to live a fruitful and healthy life.
- Being in a sero-discordant relationship is a health risk that a negative partner takes, hence the introduction of ART which helps reduce the viral load of the positive partner, which can lead to a lower risk of sero-conversion. Furthermore, the couple needs to learn about PrEP (pre exposure prophylaxis) and PEP (post exposure prophylaxis), its availability and how to use it. PEP will assist the negative partner to avoid sero-conversion, which is the state where the negative partner becomes positive.
- Assistive methods of conception are done in the private sector and are too expensive for most people. Motivations should be made to medical aids to cater for issues of infertility. Although this will still not help those without a medical aid, Government should also be involved and provide this service in public hospitals.

## **5. MAIN CONCLUSIONS**

Each and every relationship has problems. Whether it is a relationship between a mother and a child, or between two people who are in love, there will always be challenges. Sero-discordant relationships are no different. Some pride themselves that at least they know what they are dealing with, rather than being with someone whom you know is negative, only to be later infected because of unfaithfulness of that partner.

Eventhough all relationships have challenges, the main challenge for both partners is fear of sero-conversion. The positive partners are always careful not to infect the

negative partners with HIV. On the other hand, the negative partners have a fear of being infected with HIV from the positive partners. This seems to be creating tension and hostility especially at a time of love making.

Couples who discovered their different status while in a relationship were finding it difficult to adjust to safe sex practices such as the use of a condom at all times. They will rely on PEP as a preventative treatment. At times, this attitude was perpetuated due to a lack of assertiveness from a negative partner. They felt that they had not been using condoms in the past and they are still negative, so when the positive partner insists on not using a condom, they just agree. The couple lacked information about factors regarding HIV that may have influenced the negative partner remains negative at that time such as a low viral load.

Though disclosure of one's status is voluntary, the HIV positive partner should be encouraged to disclose. Most of the positive partners were presenting with self-stigmatization; they had disclosed to their partners but by refusing to talk to them about their status, they created a barrier that for some almost destroyed their relationship and, if not dealt with, might completely destroy the relationship.

Due to financial implications experienced by most couples, a general feeling emerged that assistive methods of conception (such as IVF and artificial insemination) when in a sero-discordant relationship are expensive. This put the sero-discordant couples who want to have a baby in a compromising situation and in an emotional turmoil. All the clinics providing these services are private; these methods are not yet adopted by government. Moreover medical aids do not pay for issues of infertility.

It was observed during this study that a high number of negative participants were women. This can be generalised to the fact that women naturally are the care givers or the fact that women outnumber men. This definitely creates a platform for more research.

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Annexure A: Letter to request permission

133 Vry Street

Vryburg

8600

13 June 2012

Department of Social Development and Life-line

Vryburg

8600

To: The Manager

**SUBJECT:REQUEST TO CONDUCT INTERVIEW AND TO IDENTIFY COUPLES  
IN SERO-DISCORDANT RELATIONSHIP**

My name is RefilweLucretiaTshoma, I am currently employed by the Department of Education as an Employee Health and Wellness practitioner specialising in trauma counselling, HIV and AIDS, Depression and Anxiety disorders amongst others. I am a social worker by profession registered with the South African Council for Social Service professions. My registration number is 10-27555. Confidentiality is a key principle in this profession and any illegal bridge of confidentiality can lead to suspension and or dismissal.

I am also a Masters' student at the University of the North West (Mafikeng Campus), student number 17097029. My research topic is the factors contributing to the coping mechanisms of sero-discordant relationship. In order to complete the dissertation one of the requirements is a field study that is to conduct interviews with key informants and sero-discordant couples.

Participation in this study is voluntary. I therefore humbly request your permission to interview the social workers and counsellors as well as sero-discordant couples who are accessing your offices to be identified by the counsellors/social workers. For sero-discordant couples, the interviews could also serve as debriefing sessions and an information session. I promise that information given will remain confidential.

Hope my request will be highly considered.

Yours in service

.....

Ms.RefilweTshoma

**053 998 3349/ 076 3396 332**

## Annexure B

**Letter to request key informants to identify sero-discordant couples**

**Department of Social Development and Life-line counselling centre**

**North West Province, Vryburg**

My name is RefilweTshoma. I am a registered Social Worker from the Department of Education. I am also a Masters student in Social Work at North West University (Mafikeng Campus). As part of my masters' research I wish to collect data regarding HIV-discordant couples. These are couples who are in a relationship where one partner is HIV positive and the other HIV negative.

I would be grateful if you could, assist me with identifying:

- Any sero-discordant couples in your area who would be willing to participate in this study.
- These participants must at least be conversant either in Setswana or English
- I will ask you to provide those who agree to participate, with my cellular phone number so that they can contact me. Alternatively you can contact me on their behalf.
- I will personally interview the participant. The interviews will be at a time and place suitable to the participants.
- After the interview, the participants can attend a debriefing session
- All participants will remain anonymous.
- An interview session may last from 30 minutes to an hour and if the participants agree, an audio tape will be used. If they do not agree, notes will be taken.

Thanking you for your cooperation.

.....

Ms.RefilweLucretiaTshoma

Contact details: **053 998 3349/ 076 3396 332**

## Annexure C

### Interview guide for the key informants

#### THE COPING MECHANISMS IN SERO-DISCORDANT RELATIONSHIP

##### SECTION A

##### DEMOGRAPHICAL QUESTIONS

###### 1. AGE

|              |  |
|--------------|--|
| 25-30        |  |
| 31-35        |  |
| 36-45        |  |
| 46 AND ABOVE |  |

###### 2. GENDER

|        |  |
|--------|--|
| Male   |  |
| Female |  |

###### 3. IN WHICH AREA ARE YOU WORKING?

|  |  |
|--|--|
| Kagisano-molopo<br>municipality<br>(Ganyesa) |  |
| Naledi municipality<br>(Vryburg)             |  |

4. IN WHICH DEPARTMENT ARE YOU COORDINATING HIV AND AIDS PROGRAMME?

|                    |  |
|--------------------|--|
| Life-line          |  |
| Social Development |  |

**SECTION B**

**OPINION QUESTIONS**

1. How many people have you come across in your area who are in a relationship where one of the two partners is HIV positive?

.....

2. How did you find out about the existence of such relationship?

.....  
 .....  
 .....  
 .....  
 .....

3. After you discovered the existence of such relationship, did you form a support group for them or encouraged them to do so?

|     |  |
|-----|--|
| Yes |  |
| No  |  |

If any of the above, please elaborate on your answer

.....  
 .....  
 .....  
 .....

4. In your opinion, are these couples experiencing challenges different from a normal relationship?

|     |  |
|-----|--|
| Yes |  |
| No  |  |

If 'yes', please mention a few of those challenges

.....  
.....  
.....  
.....

5. What has your office done to raise awareness about the existence of such relationships?

.....  
.....  
.....

6. What do you think should be done to raise awareness about the existence of this kind of relationship?

.....  
.....  
.....  
.....

7. What are your views regarding relationships where one partner is HIV positive and the other negative?

.....  
.....  
.....  
.....

8. What advice can you give to the couples who are in a relationship where one partner is HIV positive and the other is HIV negative?

.....  
.....  
.....  
.....

9. Please provide any suggestion on how HIV discordance can be handled by the Department and by the community?

.....  
.....  
.....  
.....

**Annexure D**

**Consent form for the participants**

I -----hereby agree to participate in an interview carried out by Ms.RefilweTshoma for the purpose of this research.

I declare that my participation in this study is voluntary and that I may withdraw from the project at any time if I wish to do so.

I have been informed that all attempt with be made to keep my details confidential.

I agree that the interview be recorded using an audio tape, which will be transcribed later into paper after which the tape will be destroyed.

I have been informed that my responses will only be used for this study.

Signed at -----on -----day of-----month-----  
-----year

-----

RefilweTshoma (Researcher)

## Annexure E

Questions to the participants

### SECTION A (Both HIV positive and HIV negative participants)

#### DEMOGRAPHICAL QUESTIONS

##### 1. AGE

|              |  |
|--------------|--|
| 18-35        |  |
| 36-48        |  |
| 49-58        |  |
| 59 AND ABOVE |  |

##### 2. GENDER

|        |  |
|--------|--|
| Male   |  |
| Female |  |

##### 3. MARITAL STATUS?

|                     |  |
|---------------------|--|
| Legally married     |  |
| Customarily married |  |
| Cohabiting          |  |

##### 4. SOCIO-ECONOMIC STATUS

|               |  |
|---------------|--|
| Employed      |  |
| Self-employed |  |
| Unemployed    |  |
| Pensioner     |  |

## 5. EDUCATION LEVEL

|                   |  |
|-------------------|--|
| Illiterate        |  |
| Primary level     |  |
| STD 10 (Grade 12) |  |
| Abet level        |  |
| Tertiary level    |  |

### SEMI-STRUCTURED QUESTIONS

#### Section B

#### **Questions to the negative partner ONLY**

##### **Differences in HIV status**

1. Did you know your own status before your partner disclosed his or hers?
2. How did you realise that you have a different status from that of your partner.
3. How was your relationship before discovering that you have different status?
4. Do you think people generally know about the existence of relationship such as yours, were one partner is HIV positive and the other partner HIV negative?

##### **Challenges experienced in sero-discordant relationship**

5. What are some of the challenges you encounter because of your different status?
6. Was there a stage in your relationship when you wanted to leave the relationship because of your different statuses?
7. Did your sexual pattern change upon disclosure of the HIV positive status of your partner?

##### **Mechanisms used to cope in the relationship**

8. According to you, what makes your relationship survive?
9. Is your partner on anti-retroviral treatment?

10. If yes, did they change anything in your relationship?
11. Did you seek any professional guidance in your relationship or are you currently undergoing counselling?
12. What precautionary measures do you take to ensure that you use so that you do not get infected?

### **Conception – Child bearing and child rearing**

13. Do you have children, if not, are you planning to have any?
14. What procedure did you undergo to prevent HIV transmission?
15. How did you know about this procedure?

### **Participation on support groups/ awareness campaigns and suggestions**

16. Are you part of any support group?
17. If given a chance will you participate in awareness campaigns that educate communities about the relationship were one partner is HIV positive and the other one is HIV negative?
18. Any other matter you wish to raise?

## **Section C**

### **Questions to the positive partner**

#### **Differences in HIV status**

1. How did you discover your status?
2. How does having different status from that of your partner make you feel?
3. How do you perceive your relationship with your partner?
4. Do you think your family, relatives, friends, neighbours and members of the community generally know about the existence of your relationship?

#### **Disclosure of the HIV positive status**

5. At what stage of your relationship did you disclose your HIV positive status to your partner?
6. Was it difficult for you to disclose to your partner?
7. How did your partner react to your disclosure?
8. When your partner agreed to continue with the relationship, how did that make you feel?

9. Do you prefer telling people about your status and who have you told so far apart from your sexual partner?

### **Challenges experienced in sero-discordant relationship**

10. What has changed in your relationship after you discovered your different status?
11. What are the main challenges you encounter regarding your different HIV status?
12. How are you dealing with sex in your relationship?
13. Do you ever worry about transmitting the virus to your partner?
14. How do you feel about the possibility of dying from your HIV infection?
15. Have you experienced any discrimination as an HIV positive person?
16. If yes, from whom and how?

### **Mechanisms used to cope in the relationship**

17. According to you, what makes your relationship survive?
18. Did you seek any professional guidance in your relationship?
19. Are you currently undergoing counselling?

### **Conception – Child bearing and child rearing**

20. Do you have children? If not are you planning to have any?
21. If yes, was it before the different status or afterwards?
22. If it was before, what procedures did you undergo to prevent transmission?
23. How did the whole process makes you feel?
24. If no, do you want children together with your spouse?
25. Do you know of procedures you can follow when you want children?

### **Participation on support groups/ awareness campaigns and suggestions**

26. Are you part of any support group?
27. If you are, do you benefit from it and how?
28. What awareness, if any, do you create in your community about your relationship?
29. What contribution do you wish to make in your community?
30. If given a chance, will you participate in an awareness campaign to educate your community?
31. Any other matter you wish to raise?

## **Setswana translation of the interview questions**

Batsayakarolo.....Baratani (molekani yo o tshwaeditsweng ke mogare wa lebolelamading le yo o sa tshwaetsegang)

Go molekani yo o sa tshwaediwang ke mogare wa lebolelamading (HIV) FELA:

### **Pharologanyo ya seemo sa HIV**

1. A o ne o itse ka seemo sa gago sa HIV pele molekani wa gago a tlhagisa maemo a gagwe?
2. O ne wa lemoga jang go re wena le molekani wa gago lo farologane ka seemo sa HIV?
3. A o ne o itse ka seemo sa gago sa HIV pele o ratana le molekani wag ago?
4. A o ka kgatlhegela go bolelela batho ka ga molekane wa gago. Ke mang yo o ka mmolelela?

### **Dikgwetlho tse itemogelwang ke balekani ba seemo se se farologaneng sa HIV**

1. Ke dikgwetlho dife tse dikgolo tse o kopanang le tsona mabapi le seemo sa lona sa HIV se se farologaneng?
2. A o kile ka nako nngwe wa akanya go fedisa kgolagano ya gago le molekani wa gago?
3. A mokgwa ya gago wa thobalano o ne wa fetoga morago ga fa?

### **Mekgwa ya tsepamo magareng ga kgonagano**

1. Go ya ka wena ke eng se se tsepamisang kgolagano ya gago le mokapelo wa gago?
2. A molekani wa gago o dirisa ditlhare tsa di ARV?
3. Fa karabo e le ee mo go 2, a di fetotse kgolagano ya lona?
4. A o kile wa batla kgakololo ya seporofesenale mabapile tiragalo e , kgotsa a o neelwa thotloetso go tswa golo gongwe
5. Ke dikgato itshireletso dife tse o di tsayang go netefatsa go re ga o tshwaetsege?

### **Kimo le kgodiso ya ngwana**

1. A ona le bana? Fa o se nabona, a o ikaeletse go nna le bona?
2. Fa o tshotse bana pele ga seemo se, ke dikgato dife tse o di tsereng go thibela tshwaetsano?
3. A o itse ka dikgato tse o ka di latelang fa o batla go tshola bana?

### **Go tsaya karolo mo matshelo tsibosong**

1. A o karolo ya setlhopha sengwe sa thotloetso
2. Ga o neilwe tshono, a o ka nna le seabe mo matshelo tsibosong a a rutang baagi
3. A go na le ntlha nngwe e o ratang go e tlhagisa

### **DIPOTSO GO MOLEKANE YO O TSHWAEDITSWENG KE HIV FELA**

#### **Pharologanyo ya seemo sa HIV**

1. O itsitse jang ka seemo sa gago?
2. O ikutlwa jang ka go nna le seemo se se farogologaneng le sa molekani wa gago?
3. A o ka kgatlhegela go bolelela batho ka ga molekane wa gago. Ke mang yo o ka mmolelela?
4. A o akanya gore ba lelapa la gago , losika lwa gago, baagisanyi le maloko a baagi ka kakaretso ba a itse ka tshwaetso sa gago le molekane wa gago

#### **Go bua phatlhalatsa ka seemo sa gago sa HIV**

1. A go ne go le thata go tlhagisetsa molekane wa gago ka ga seemo sa gago
2. Ke motlha ofe o ileng wa tlhagisetsa molekane wa gago ka tshwaetsego ya gago
3. Fa molekane wa gago a dumalana go tswelletsa kgolagano ya lona, o ne wa ikutlwa jang?

4. A o ka kgatlhegela go bolelela batho ka tshwaetsego ya gago. O ka bolelela mang?

### **Dikgwetlho tebang le seemo se se farologanengsa HIV**

1. Ke eng se se neng sa fetoga mo leratong la lona morago ga go lemoga seemo sa lona sa se se sa tshwaneng sa kokwanatlhoko
2. Ke dikgwetlho dife tse dikgolo tse lo di itemogelang tebang le seemo sa lona sa HIV se se sa tshwaneng
3. Maitsholo a gago a thobalano le molekane wa gago ke a a ntseng jang
4. A o tshwenngwa ke kgonagalo ya gore o ka tlhokafala?
5. A o kile wa itemogela kgethololo ka ntlha ya fa o na le kokwanatlhokoya lebolelamading?

### **Mekgwa ya tsepamo magareng ga kgonagano**

1. Go ya ka wena ke eng se se tshegetsang lerato la lona?
2. A o kile wa kopa kgakololo ya seporofesenale kgotsa a o bona thotloetso golo gongwe?

### **Kimo le kgodiso ya ngwana**

1. A ona le bana ? Fa o se na bona , a o ikaeletse go nna le bona?
2. Fa o na le bana , a ba tshotswe pele kgotsa morago ga seemo se?
3. Fa o tshotse bana pele ga seemo se, ke dikgato dife tse o di tsereng go thibela tshwaetsano?
4. O ne wa ikutlwa jang ka nako ya dikgato tse?
5. Fa o sena bana, a o batla bana le molekane wa gago?
6. A o itse ka dikgato tse o ka di latelang fa o batla go tshola bana?

## **Go tsaya karolo mo matshelo tsibosong**

1. A o karolo ya sethlopha sengwe sa thotloetso
2. A go na le mogwa mongwe o o tsibosang baagi ka ona mabapi le mogare?
3. Ke seabe sefe se o eletsang go nna le sona mo tikologong e o nnang mo go yona mabapi le kokwanatlhoko?
4. Fa o ka neelwa tshono, a o ka nna le seabe?
5. A go na le ntlha nngwe e o ratang go e tlhagisa

## Annexure F: Approval letter- Department of Social Development

29. AUG. 2013 11:25

NO. 234 P. 2/2



the dsdwcpd

Department:  
Social Development, Women, Children  
and People with Disabilities  
North West Provincial Government  
REPUBLIC OF SOUTH AFRICA

PRIVATE BAG X12  
VRYBURG  
137 VRY STREET  
VRYBURG

**DR. RUTH SEGOMOTSI MOMPATI**

Tel: +27 (053) 9281800  
Fax: +27 (053) 927 5249 / 1255  
E-mail: drmodise@nwpg.gov.za

TO : MS REFILOE TSHOMA\*


FROM : MS O.D ITUMELENG  
ACTING DISTRICT DIRECTOR COORDINATION

DATE : 14 AUGUST 2013

SUBJECT : PERMISSION TO CONDUCT RESEARCH

This communiqué serves to confirm that you have been granted permission to conduct research in Dr Ruth Segomotsi Mompoti District at the Service Point of your choice .

Yours in Service Delivery

  
MS O.D. ITUMELENG  
ACTING DISTRICT DIRECTOR



## Annexure G: Approval letter- Life-line (Vryburg)



LifeLine Community Care

LifeLine Mafikeng  
17 Connaught St.  
Golf View, Mafikeng  
PO Box 6022  
Tel: (018) 981 0976  
Fax: (018) 381 0976  
Email: [accounts@lifelinemafikeng.co.za](mailto:accounts@lifelinemafikeng.co.za)

133 Vry Street

Vryburg

9600

Date: 13 June 2012

Subject: RESEARCH APPROVAL: Ms. R.L. Tshoma

This letter informs you that your request to distribute questionnaires at our institution has been granted.

The counsellors will assist you in identifying couples who are in sero-discordant relationship for you to interview them. The couples will be those that have been discovered in our couple testing programme.

Looking forward to working with you.

Yours faithfully

Ms. M. Loeto

Life line Vryburg co-ordinator

# Annexure H: Certificate of Language Editing

1065 Hector Peterson Drive

Unit 5

Mmabatho

01/11/2014

**CERTIFICATE OF LANGUAGE EDITING**

The dissertation entitled

**FACTORS CONTRIBUTING TO THE SURVIVAL OF SERO-DISCORDANT  
RELATIONSHIPS**

Submitted by

**REFILWE LUCRETIA TSHOMA**

For the degree of

**MASTER OF SOCIAL SCIENCES  
(SOCIAL WORK)**

In the

**HUMAN AND SOCIAL SCIENCES  
MAFIKENG CAMPUS**

has been edited for language by

**Mary Helen Thomas B.Sc.(Hons) P.G.C.E**



Ms. Helen Thomas

Lecturer

School of Undergraduate Studies

Annexure I: Ethical clearance certificate



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Web: <http://www.nwu.ac.za>

**Ethics Committee**

Tel +27 18 299 4849  
Email [Ethics@nwu.ac.za](mailto:Ethics@nwu.ac.za)

**ETHICS APPROVAL OF PROJECT**

The North-West University Research Ethics Regulatory Committee (NWU-RERC) hereby approves your project as indicated below. This implies that the NWU-RERC grants its permission that provided the special conditions specified below are met and pending any other authorisation that may be necessary, the project may be initiated, using the ethics number below.

|   |                                |
|---|--------------------------------|
| <b>Project title:</b> Factors contributing to the survival of sero discordant relationships |                                |
| <b>Project Leader:</b>  | Dr BMP Setlalentoa             |
| <b>Student:</b>   | RL Tshoma                      |
| <b>Ethics number:</b>   | N W U - 0 0 2 4 3 - 1 4 - A 9  |
| <b>Approval date:</b> 2014-04-15  | <b>Expiry date:</b> 2019-04-14 |

Special conditions of the approval (if any): None

**General conditions:**

While this ethics approval is subject to all declarations, undertakings and agreements incorporated and signed in the application form, please note the following:

- The project leader (principle investigator) must report in the prescribed format to the NWU-RERC:
  - annually (or as otherwise requested) on the progress of the project,
  - without any delay in case of any adverse event (or any matter that interrupts sound ethical principles) during the course of the project.
- The approval applies strictly to the protocol as stipulated in the application form. Would any changes to the protocol be deemed necessary during the course of the project, the project leader must apply for approval of these changes at the NWU-RERC. Would there be deviated from the project protocol without the necessary approval of such changes, the ethics approval is immediately and automatically forfeited.
- The date of approval indicates the first date that the project may be started. Would the project have to continue after the expiry date, a new application must be made to the NWU-RERC and new approval received before or on the expiry date.
- In the interest of ethical responsibility the NWU-RERC retains the right to:
  - request access to any information or data at any time during the course or after completion of the project;
  - withdraw or postpone approval if:
    - any unethical principles or practices of the project are revealed or suspected,
    - it becomes apparent that any relevant information was withheld from the NWU-RERC or that information has been false or misrepresented,
    - the required annual report and reporting of adverse events was not done timely and accurately,
    - new institutional rules, national legislation or international conventions deem it necessary.

The Ethics Committee would like to remain at your service as scientist and researcher, and wishes you well with your project. Please do not hesitate to contact the Ethics Committee for any further enquiries or requests for assistance.

Yours sincerely

Prof Amanda Lourens  
Chair NWU Research Ethics Regulatory Committee (RERC)