

ORIGINAL ARTICLE DILEMMAS, RISKS AND FAMILIAL IMPLICATIONS OF LIVING IN HIV SERODISCORDANT RELATIONSHIPS, JIMMA TOWN/OROMIA

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Abstract

Till recently, serodiscordant couples were ignored though HIV negative sexual partners and children born in the relationship are at high risk of infection. Difficulty of making decision with respect to divorce, child bearing, and managing sexual patterns characterize serodiscordants. In Ethiopia, most infected married people are serodiscordant and do not mutually know their HIV status. Lack of adequate studies on serodiscordance necessitates this study to identify people's perceptions and practices concerning serodiscordance. In-depth interview with serodiscordant couples and key-informant interviews with health care providers, and thematic analysis were employed to gather and analyze the information respectively. Serodiscordant couples know their HIV status lately after they have developed health complications; practice unsafe sex and give birth to infected child. Confusions are observed among discordant couples and health care providers on the possibility of future infection of the negative partner and the etiology of serodiscordance in general. The explanations are inconsistent and some are erroneous. Difficulty of managing familial relationships, the dilemma of child bearing, risk of child infection, forced changes in patterns of sexuality, lack of social support, and unreliable livelihood are among the challenges they face. Negative HIV partners and children born to serodiscordant couples are at risk of infection. Yet serodiscordance is not given adequate attention in HIV/AIDS care and prevention public programs. Programs targeting married people and serodiscordant couples are necessary to curb Mother to Child Transmission.

Keywords: Serodiscordance, discordant couples, Risky group, Mother to Child Transmission

Operational Definition of Terms

Sero-conversion - refers to the development of antibodies to a particular antigen such as HIV in which people ‘seroconvert’ from antibody-negative to antibody-positive taking from as little as one week to several months or more after infection with HIV for antibodies to the virus to develop.

Window Period - Time from infection with HIV until detectable sero-conversion.

Serodiscordant Couple - A married or cohabitating couple in which one partner is HIV positive and the other is HIV negative. The term serodiscordant originates from the word "seroconversion", which is the medical term for becoming HIV positive, and the word "discordant", which means "at odds".

Concordant Negative: A couple is described as concordant negative when both partners are HIV negative.

Concordant positive: A couple is described as concordant positive when both are HIV positive.

Discordant Male: A “discordant male” is a couple in which the male is HIV positive and the female is HIV negative and

Discordant female: A “discordant female” a couple in which the man is negative and the woman positive

Background

Preventing new HIV infections through identification of groups at high risk supplemented by provision of care and support for infected people have been widely accepted intervention approach in fighting HIV and AIDS (De Walque, 2007; Bishop, M., and K. Foreit. 2010: 1). Till recently, however, the long list of HIV risky groups missed [serodiscordant couples]¹ even though the relationship involves vulnerable partners to infection. As a result, serodiscordance is not adequately studied and intervened in Sub-Saharan Africa at program level (Futures Group, 2008; Colvin et al., 2008).

Differential emphasis given to the three prevention modes (ABC) is an important factor for overlooking serodiscordant couples as vulnerable category. While abstinence (A) and using condom (C) are duly regarded, “Be Faithful” (B) mode of prevention is accorded lower attention given married partners are mistakenly assumed to be less vulnerable to HIV infection (Bishop & Foreit 2010). As a result, serodiscordant couples were left aside in the campaign of fighting against HIV/AIDS. Lately, however, serodiscordance started to attract increasing attention in Sub-Saharan Africa

¹ Serodiscordant couples are married or cohabiting couples in which one partner is HIV positive and the other is HIV negative.

since its significant contribution to new infections has become recognized (UNAIDS, 2010: vi; Beyeza-Kashesya et, al, 2009).

A number of dilemmatic conditions accompany serodiscordant marital life. Difficulty of making decision on whether to stay in the relationship or to get divorced, whether to have child or not, and managing sexual pattern are just a few. Unless serodiscordant couples are identified as one of HIV risky population and programmatically responded, serodiscordance may lead to familial crisis in case all family members (father, mother and child/ren) are infected. Accordingly, serodiscordance involves double risky families of HIV infection: HIV negative sexual partners and children born in the relationship. Hence, integrated intervention program targeting married or cohabited partners as well as their children is quite important.

Statement of Problem

In Ethiopia research revealed that most infected marital relations are serodiscordant and most of these couples do not mutually know their HIV status (DHS 2005). In the general public alike most partners do not know Voluntary Counseling and Testing VCT evidence based HIV status of their partners. Positive news of declining incidence of HIV infection in Ethiopia for the last few years, which is counter checked by unresolved Mother to Child Transmission (MTCT), is a current signal for necessity of programmatic intervention of serodiscordance in the country. Yet enriched literature is lacking in Ethiopia because of very limited clinical and theoretical findings on serodiscordance.

Hence, the present study attempted to explore the experiences of serodiscordant couples in Jimma town, South West Oromia. The researchers believe that this study bridges the knowledge gap about HIV serodiscordant couples in the study area. The study specifically focused on exploring explanations for discordance, challenges of living in discordant relationship, and coping strategies as well as public responses to the problem.

With an intention to investigate the psycho-social aspects of serodiscordant couples in Ethiopia and particularly, in South West Oromia, this study, using qualitative approach investigated the experiences of serodiscordant couples to understand their own and key informants' (health care providers) explanation for discordance, challenges, coping strategies and responses given to the dilemmatic conditions of living in serodiscordant relationships. The general objective of the study was to assess the dilemmatic conditions of living in HIV serodiscordance relationship in Jimma town, South West Oromia. The specific objectives include:

1. To understand people's response to HIV serodiscordance

2. To examine possible explanations for the occurrence of serodiscordance and future infection
3. To identify perceived causes for infection of the HIV positive partner and
4. To describe discordants' life course experiences

Methods

This study was conducted in Jimma town, South West Oromia in 2012. The research involved qualitative approach to derive meanings from observations, feeling and experiences of serodiscordant couples and health care providers who participated as key-informant in interviews. We undertook twenty (20) in-depth interviews with key informants from health care facilities and HIV sero-discordant couples. The key informants were purposively selected based on their perceived knowledge and experiences of working with the discordant couples. This is because it is assumed that experienced professionals can provide relatively more detailed information about the issue at hand. Sixteen HIV serodiscordants out of sixty tested and registered serodiscordants at Organization of Social Services for AIDS (OSSA), Jimma branch, were requested for participation through the program coordinator. Availability, ability and willingness to participate were criteria of selection. All informants were above 18 years and able to speak Amharic or Afan Oromo.

Information from informants (discordant couples) and key informants (health care providers) were collected only by the researchers for ethical reasons. Informants were contacted when they come to the service centers for treatment or follow ups. The interviews with key informants, that is, with the health care providers were held at their offices. Interviews with health care providers were conducted in Amharic whereas both Afan Oromo and Amharic were used to interview HIV serodiscordant couples based on their ability. Notes were taken in the same language of interview as the researchers are able to use both languages. Later, the information was translated into English by researchers themselves for confidentiality purpose.

Thematic analysis of qualitative data was made. Thematic analysis of the qualitative data is important to reveal core aspects of living in discordant relationships like feelings, experiences, life decisions, changes in patterns of lifestyles, challenges and coping strategies. Specifically, *successive approximation* techniques were used in this study through three steps of coding: open coding, axial coding, and selective coding.

Permission was secured to carry out the study from the office Research and Post Graduate Studies of Jimma University where also the funding is obtained from. The purpose of the study was explained to the potential participants (informants and key informants) and their written

consent was obtained to participate in the study. Participants were assured the confidentiality of the information they provided.

Findings

Delayed Identification of HIV Serodiscordance Statuses among Couples

Serodiscordance couples know their HIV status lately mainly after they have developed health complications related to HIV infection and AIDS; sometimes very late at stage when Antiretroviral Therapy (ART) is needed. External pressure from partners, friends and health practitioners during medical visit are necessary to seek HIV test.

M² (+ve male partner) has known his HIV status three before years during this study in 2012. He was informed for the need of getting tested by his ex-marital partner. According to him, she convinced him that he has to get tested and consequently took him to (VCT) service center. Then he was found HIV +ve and then he started bacterium and soon after ART. Another example, D (male –ve partner) and A (female +ve partner) became to know their HIV serodiscordance statuses after five years of their marriage when they went to Jimma Hospital because of her sickness whereby first TB was diagnosed and treated. Because the sickness became more serious and she was physically weaker, volunteers working for OSSA came to visit her at home and advised her to be tested for HIV. The test showed +ve result. She immediately told her husband the result of her HIV status and based on CD4 test, she began ART.

A male HIV –ve partner also expressed similar condition as, *“When we met, she felt normal but she did not know her HIV status until the TB diagnosis and consequent sickness resulted into doubt which in turn led to HIV test.”* Another informant forwarded the condition as, *“We came to Jimma searching for job. Then she became sick and I took her to hospital for VCT and the result was HIV +ve. I and our two children were also tested three times and we all are found HIV –ve.”*

These pair of couples lived in unsafe sexual contact for relatively longer period of time as it could be estimated from the stage of HIV and AIDS they have developed at the time of testing. Early identification of HIV status for married people is very important both to effectively treat the infected partner and to reduce the likely infection of the HIV negative partner and children born to the union. Although conclusive statements should wait for a representative and robust survey research, the experience of serodiscordant couples included in this study signals that infected children are being born in such relationship.

² Initial letters in their names are used to represent the personal names of discordant couples throughout the analysis for confidentiality purpose.

The issue of MTCT also regards untested concordant +ve couples so long as they are not aware of their status. In one way or another, it is between married people (whether +ve concordant or discordant couples) most of infected children are born. The only difference is that early diagnosis in serodiscordant couples has double advantage than in +ve concordant couples because the latter also saves the negative partner from possible infection with the virus. Therefore, special program/strategy that initiates married people's to undertake co-test for HIV can reduce the rate of MTCT as many couples may not aware of their or their partners' HIV status.

Couple's Response to Serodiscordant Results

Serodiscordant couples differently respond to serodiscordant results. While some were shocked, others took it normal. Some disclosed the result to their spouses or sexual partners, children, friends, relatives and even to the wider community; some selectively inform their husband and only few friends. The variation mainly emanates from the extent of personal fear of being discriminated in case they disclose their HIV status. Paraphrased from interview words, one of our interviewee reported that she informed her HIV +ve status to her husband, family, relatives, and her son; all have positively reacted to her condition. She did not feel fear of the HIV result because of information she got from counselors during the test whereby she was advised to accept the result. The pre-VCT counseling service eased her reaction towards HIV result. Experiences of other serodiscordants who were shocked or even failed to accept the result particularly when it is +ve, however, shows that pre-VCT does not similarly affect different people. A female HIV positive partner told that both of them (husband and wife) were advised to be tested at mobile VCT together, the virus was found in her blood. She made the test twice and it was proved +ve. She was shocked when she knew the result. Before the result, she had no feeling of pain, no sickness. But she developed sickness soon after she knew her status which was about two years when the interview was conducted. Hence she started ART. The immediate development of illness just after the result may not be a simple coincidence rather it shows the effects of psychological experiences on the development of disease or physical experiences.

Serodiscordance and Possibility of Future Infection: Discordants' Perception

There are disagreements among health practitioners and discordants as per to the etiology of serodiscordance and the possibility of future infection of the negative partner. In addition to explanations given by the discordants, their actual practices related to these matters also vary.

Generally, there are mixed findings on the explanation of the occurrence of serodiscordance and the likely of possible infection for the currently HIV negative partners. Some are erroneous and others seem correct against the existing literature. While some of the confusions emanated from personal problems, others from the way the features of discordance are communicated to them by the health workers including the physicians. The erroneous in understanding the probability of future infection for the currently negative partners in particular is very dangerous. Further elaborations are given in the following paragraphs.

Explanation of the Occurrence of Serodiscordance: Implications and Risks

Some discordant couples believe that they are naturally immunized against the infection forever because of their unique nature; some others think their discordance is only temporary; and still others convinced themselves they are HIV +ve even though it is not detected by blood examination hence they deny the existence of serodiscordance itself. Let us look at these multiple realities from people's experiences in the condition at hand.

D (male HIV –ve partner) believes that the cause of his non-infection so far is having “different blood” as he was told by a physician; according to D, the physician told him it was proved by a study conducted in Kenya that serodiscordance occur because of blood variation between the couples. It seems there was distorted communication between patient and the doctor as this explanation somehow deviates from what is commonly explained as a likely cause of serodiscordance. Such notion of serodiscordance is also likely lead to reluctance in regularly and properly using condom thereby increases the chance of infection. This idea seems more relevant when you hear his response for the question do you think that you can be infected if you do not use condom? His response was, *“I think I may not be infected because we have different blood types. But I do not avoid using condom though I believe this way; the virus may be transmitted.”* From the quotation, one can easily understand that D is more comfortable with the idea that he may not be infected than the other way round. In the presence of other risk factors, he is more likely to be exposed to unsafe sex with his own wife or with other women.

A (+ve female partner) is not sure whether her husband can be infected if condom is not used as she reacted she does not know if he can be infected or not. These points show that people do not know the exact cause of their or their partner's infection and have no clear understanding of whether HIV is transmitted from the HIV +ve partner to the –ve one. This in turn results from lack of clarity along the health care providers as to the

cause of serodiscordance and misunderstanding occurs in communication between the health workers and the clients.

A (male +ve partner) replied to a question “Why does serodiscordance occur?” stating that,

I asked the same question and a nurse said that ‘her (his HIV -ve partner) blood does not receive the virus; your blood types are different’ and she advised her that she should follow VCT quarterly in case the virus is hidden. I think that is true (he meant blood variation). If she will give birth normally because she is currently pregnant, I will stop sexual relationship with her at all because I do not know what will happen in the future. She is 19 years old; I am older; I should not expose her to the virus.

A is found in a number of dilemmatic conditions. Obviously, they were practicing unsafe sexual relations so far. This could be inferred from her pregnancy and from his future plan of stopping such relationship. On the other hand, he was not sure whether she would accept the offer and he claimed the decision will be hers. Not only A has doubt about the probability of future infection of his wife and her decision about what he suggested but also about the appropriateness of his plan of total termination of sex with her instead of using condom. If the plan is to come to effect, another dilemma will automatically occur on their interpersonal relationships. He claimed that he told her that practicing unsafe sex is wrong and she should take her own decision yet he wants her to serve him by cooking food and helping him in adhering to the drugs.

C (male –ve partner) pointed out how they practice sex as, “*She told me that she was HIV positive. But I insisted that my blood does not hold (receive) HIV and I forced her to have unsafe sex with me. My blood type is O; it does not take unless her blood type is similar; if that was the case I might be infected.*” It seems that C misunderstood information communicated to him about CD4 receptor with blood type and he thinks that he naturally cannot be infected by HIV if her blood type is not O. Whatever the case, he is practically at risk of being infected because he admits that he is practicing sex without using condom. This implies that absence of clear communication between health workers and their HIV clients or failure to communicate in a way messages are easily understood by their clients will lead to risky wrong practices.

As we mentioned earlier, there is difference in the understanding level and counseling practice among the health workers themselves. Here is the witness in line with popular literature.

We make test many times when she takes ART. The health care providers ask me about my marital status and pattern of sexuality. They told me that we have to stop unsafe sex practice. Before the

advice, we used to have sex without condom. Currently, we practice both unsafe sex and using condom in different conditions. When I have interest to have sex but she does not, I request to use condom. As she argues that repeated sex harms her, I use condom because she assumes using condom reduces the level of harm. And when both of us have the interest of practicing sex, it will be without condom.

This implies that the choice of condom use or its avoidance does not depend on factors of transmission of the virus from her to him. Their preference of sexual pattern is fully determined whether she is initiated to have sexual relationship at that moment or not. This, therefore, increases his probability of being infected.

Many of discordant couples are in a state of confusion about how discordance occurs. For instance, T (male –ve partner) has no clear idea about how serodiscordance can occur. He mentioned it as, *“I do not know how it occurs. I made blood test twice and I was found HIV–ve. Then after, I have been taking care.”* In some, the confusion is accompanied with tendency of externalizing the origin of the problems. For instance, Z (female +ve partner) reacted as,

First, females are more vulnerable to any disease and HIV in particular. It is said in case of HIV that white blood cell (O blood cell) has the power to attack and defeat the virus. But I have information that the virus can be found in his sperm (i.e her husband) even though it is missed in his blood. In the long term, however, it can be found in his blood too. I always ask this question and the responses are like these.

Z seems to be confused from inconsistent information about serodiscordance. On the one hand, she thought that there is natural immunity against the HIV because of having ‘O’ blood type. This idea has no scientific support so far in relation to HIV infection. Even if this is taken as to mean lack of CD4 receptor, it is rare occurrence and does not well represent the issue of serodiscordance because serodiscordant negative couples are more likely to be infected by the virus as times have passed.

In other case, the level of suspicion and confusion is raised to the level of denial of the negative result as it happened in a negative male partner but seriously sick with similar symptoms of AIDS patients. He responded to the question why and how serodiscordance occurs as, *“I am confused. Even I don’t believe that I am HIV –ve. I could not be confident in my HIV status because my friends tell me that it will be detected in the future. I doubt that the current health problems I am suffering from can be because of HIV/AIDS itself.”*

This person is in dilemma of accepting the advices given to him by the physician or by his friends because of the symptoms of disease he is

experiencing. The confusion resulted from different sources regarding the HIV status result lead him to believe that he is likely to be positive. More visible indicators that shade doubt on the reliability of HIV test result amongst the discordants and health workers can be learned from B's (male – ve partner) living experience as follows.

“I asked how I can be HIV negative. And the Doctor (in Jimma University Hospital) replied that ‘it occurs’ and informed that ‘We have 600 clients of discordant cases; there are planned tools/materials that will come by next year (2013).’ Other health care providers in coffee ceremony told us that there are some people whose white blood cells can defend the virus. I do not believe in the result. How can I be different while my wife is HIV positive? The result is false for me. Rather, I believe the virus exists in my body. I had been with her (he meant in unsafe sexual relation) for long before she knew her HIV status. It is impossible.”

There is shared confusion among the health care providers and discordants. One of the confusion is viewing the rarity case of naturally immunized people as universal for all discordant couples. Acceptance of such rarely occurring events as common thing may in turn lead to reluctance in practicing safe sexual intercourse. It seems the same thing occurred in the life of the above interviewee.

As implied earlier, there are mixed findings regarding people's perception about the possibility of infection of the negative partner in discordant affiliation. Variation about whether future infection a HIV negative partner is likely or not also emanates from multiple and uncertain sources of information about how and why discordance may occur. Accordingly, informants either think that they are likely to be infected or it is less likely or unlikely at all. Yet, some may remain in a state of confusion about it.

It seems that C (HIV –ve male partner) believes that he is less likely to be infected by the virus. His response to a more direct question about whether he will be likely infected or not in the future if he does not properly and regularly use condom implies this position.

“I lived for three years (implicitly to mean having unsafe sexual practice). I have not seen any health problem even a cough. Therefore, I do not think it will infect me in the future. As she is properly taking ART, it saves me from infection. What matters more is helping her to adhere to the drug for both of us. Hygiene and adherence avoid her hurt. The absence of these can change the situation. She may have wounds. To avoid this, if I give care for her hygiene and provide food, I am sure that I will not be infected.”

C has replaced safe sexual practice by other pretexts such as keeping her hygiene; helping to adhere to ART; properly feeding her; generally giving her care. Although the contribution of such practices should not be undermined in reducing HIV infection in one way or another, they cannot be guarantee to avoid infection in the absence of condom use. In other words, such practices may reduce the likelihood of infection but they cannot replace condom use in serodiscordance.

F (+ ve female partner) held another pessimistic position as she thought that her husband might be infected and she wants to take him to VCT services. She also revealed that he did not like to use condom in the past. Only after the birth of a child, she told him to use condom. She believes in the importance of using condom not only to prevent him from infection but unsafe sex can have other negative consequences. Among these is she believes that frequent sexual relation results in aggravated health conditions. She reported that he claimed that he is not infected for long time and questioned how he could be infected now or in the future. The last point indicates that the husband is not in a position to end unsafe sexual intercourse.

Perceived Causes of HIV Positive Partner's Infection/ Attribution of Causes of Infection

As per to the attribution or blaming regarding the cause of discordance, discordant couples have experienced complex circumstances. Some specifically attribute the cause to God, others to the other partner, some to themselves yet others to no one or nothing. In this regard, it was common to hear the phrase “God knows” from the HIV +ve and the HIV–ve partners when it comes to questions “Who/what is the cause for the infection?” or “Who should be blamed for the infection?” The HIV negative partners in particular want to escape from such discussions because they do not, even cannot, know the exact cause. They attempt to view their HIV positive partners as innocent as much as possible and it seems that this escaping mechanism is a key not to blame each other and retain smooth companionship.

M (male HIV +ve partner) responded for the question “Whom do you blame for the infection?” as, “*I do not judge anybody about the infection and I cannot suspect its source; it must be from God*”. As it is mentioned earlier, he does not want to blame his former marital partner in any way. B (HIV –ve male partner) responded to same question stating that, “*I cannot know that; no way.*”

But in case of personal disagreement between the two, the HIV negative partners use it as a ‘weapon’ for counter attacking in verbal dispute. In some cases, however, the HIV negative partners have developed suspicion

against their HIV +ve partners thinking that the latter might have committed adultery or extramarital sexual affair. An informant was constantly blameful against his HIV +ve wife (she also confirmed during interview) to be the sole cause of infection because of her extramarital sexual affairs when he was away for long period of time (sometimes for six months) being a heavy truck driver. But this person does not want to divorce her not to leave her alone and he is not quite sure to make her fully responsible. He knows that she had sexual affair with someone who was HIV positive (now died) and his wife revealed that she had extramarital relationships (very likely multiple) although she alleged that she was consistently using condom. Another interviewee stated similar condition as, *“He blames me and insulted People Living With HIV AIDS (PLWHA). He insulted all of us.”*

However, T (HIV –ve male partner) carefully explained his doubt whether his wife could be held responsible because of extramarital sex which he tends to normalize for its occurrence. He put it as, *“It is common to both males and females to make mistake (he meant extramarital sex). Therefore, it might be because of sexual affair she had with someone.”*

Self-blaming/guilty feeling or at least viewing the HIV negative partner as a “saint”, although at different levels, characterizes the HIV positive partners in serodiscordant relationships. They are particularly grateful and surprised for why their partners decide to live with them while they can lead a decent life with someone else who is HIV negative.

A different case was that an HIV +ve female partner, S, doubted that her HIV –ve husband could be the cause for her infection referring to her trustfulness for her marriage and his past multiple sexual partners during he was in military service. He also fully trusts her not to commit adultery hence he does not blame her by any means for the infection and he confessed his past dangerous sexual experiences with potential exposure to the virus but the result showed the opposite; their three children are also HIV negative. Her argument is quoted below.

“I was wondering that how I could be HIV +ve. I did not know anything how it could be. I always cried because of the unexpected result. I left my relatives and parents for the sake of this marriage. I saw many females’ photographs in his photo album. In the earlier, I accused him as if he brought the virus to me. Latter, I cancelled the accusation when I understood that it is common nature of the disease.”

Her husband forwarded similar statements declaring that,

“I do not know. After we left the military service, we made checkup frequently. We trust each other; I trust her more. We lived together for ten years. I have not seen anything in her life

(he meant sexual related misbehavior). *She is my wife; we live together. Yet the issue of discordance is also my question.*”

This circumstance in addition to the experiences of some serodiscordant –ve partners (diagnostically) who complain to have similar disease symptoms (practically) that characterize AIDS creates doubt on how much the test results are dependable for all people.

A (wife of D) tends to externalize the cause of her infection to other events. Regarding the cause of her infection, she does not know but she suspects that she was giving care for her daughter in law who died of AIDS with no proper self-care. Yet she admitted to have sexual affair with other people. She put it as, *“Although I had sexual affair with other people before and after the current marriage, I consistently used condom.”* She also blames both herself and her husband for her infection.

It is generally understood that people have strong fear of potential HIV infection if they become aware that the person towards which they are sexually attracted is HIV positive. The transmission of television dramas with such contents have been commonly used in Ethiopia as a prevention strategy in promoting proper and consistent use of condom. Importance of such strategy is undeniable in bringing behavioral changes among those who are responsive to the message communicated. However, one important challenge towards our common perception of the consequences of knowing +ve HIV status of one’s potential sexual partner is that knowing the status alone is not a guarantee to refrain from having sexual relationship at all or practicing safe sexual intercourse with him or her. During the interview, M repeatedly acknowledged that his ex-partner told him her HIV +ve status before starting sexual relationship with her but he could not avoid the risk as he mentioned as, *“I do not know what forced me to have unsafe relationship with her”*. They had lived together for five years before he got tested and he alleged they had been using condom regularly. Yet the result showed HIV status while he was tested being in the same marriage before they got divorced and he married to the current woman.

Here is a more pressing experience of a couple from an interview with a +ve female partner concerning the start of her current marital relationship and patterns of relationship. She expressed that their relationship was established when she was in a hotel working as a prostitute whereby he regularly visited her as a customer. She put the scenario as, *“I told him that I was HIV +ve; I showed him ART drugs I was using and finally the certificate. But he did not believe until he saw the certificate. Then, he convinced me to stop prostituting and we rented home to live together as husband and wife.”* Her husband confirmed his strong unwillingness to use condom till the interview was conducted because of his belief that he cannot be infected with HIV.

Conclusion and recommendations

Conclusion

There is very poor couple based (VCT) among married people till one of the two has developed suspicion of HIV infection because of certain health complications. Discordant couples came to know their discordance relationship when they have developed AIDS symptoms. Making VCT before marriage is nearly absent among discordant couples even if they married to someone who divorced or separated or lost former partner by death. Hence there is no practice of avoiding risk of HIV infection through the strategy of pre-marriage VCT. A prevention strategy called “Be Faithful” seems replaced by “Get Married” because there is no sufficient programmatic effort targeting couples and lack of couples’ tradition that support timely and regular practice of VCT.

Ignoring serodiscordants in particular and married people as important risk population is indirectly allowing Mother to Child Transmission (MTCT) to grow unchecked. Serodiscordance is both the result of complicated prior life experiences such as abandonment, migration, divorce, occupational hardship and poverty. Moreover, it creates interrelated psychosocial and economic dilemmatic and challenging conditions in the lives of the serodiscordants. Serodiscordants are not a homogeneous group yet they have many overlapping feelings, experiences, challenges, and coping strategies that could be addressed through public programs. The mere existence of pregnancy among the serodiscordant couples and strong desire to have children as well as hatred against condom use proves that they practice unsafe sex hence the negative partner is at higher risk of HIV infection. A popular notion that people take proper care if they are aware of the +ve HIV status of a sexual partner is an old fashion among discordant couples.

The repeated exposure to HIV for longer years but remain uninfected by the virus among discordant couples shade certain doubts either on the reliability of the test or whether sexual intercourse is the primary means of HIV transmission. Serodiscordant couples encounter a number of personal, interpersonal, socio-cultural, and structural challenges which are strongly interrelated in a complex web. Serodiscordance is, therefore, not a mere health problem.

Recommendations

The reluctance of getting tested for HIV and consequently late diagnosis of the infection by married people needs special attention because of its significant implications on HIV transmission and effective treatment of the infected partner. An important question we must raise here is that “How many such (discordant) couples we have in Ethiopia?” This question needs

national survey to know the prevalence and then to design responsive program for its solution.

The popular assumption of viewing married people as if they are less vulnerable to HIV infection than their unmarried counterparts needs to be empirically checked through national based surveys and couple-targeted VCT strategy.

The most appropriate level of intervention to tackle MCTC is married people although possibility of pregnancy outside marriage should not be undermined by HIV/AIDS program so long as most children are born in marital relationship. Yet all personal, interpersonal, and structural challenges should be addressed in integrated and participatory approaches.

The extent to which marriage through its prevention strategy called “Be Faithful” can be a dependable insulator against HIV infection also needs attention along with this question. The rough assumption that there is fidelity between husband and wife seems diverted HIV intervention away from married people to unmarried ones. Although the assumption of marital faithfulness should be positively regarded as it is a shared value which tends to encourage trustworthiness, possible deviation from this normative yardstick necessitates certain suspicion.

Another concern of these researchers which is quite related to the above question that does not deserve less programmatic attention is Mother to Child Transmission (MTCT). Compared to other HIV components, failure in effectively reducing the rate of MTCT might be strongly related to the gap of knowledge about the prevalence of HIV serodiscordance and the consequent lack of intervention.

Family responsive programs could be designed with two purposes. First, preventive strategies such as joint voluntary counseling and testing that target uninfected families to tackle HIV infection in the general population. Second, preventive and rehabilitative interventions for already infected family of serodiscordant couples will have a double advantage of securing the family and the general population.

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