ORIGINAL ARTICLE SOCIOECONOMIC CHALLENGES AND COPING MECHANISMS OF HIV SERODISCORDANT COUPLES IN JIMMA TOWN, OROMIA/ETHIOPIA

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Abstract

This study on socioeconomic challenges faced and coping strategies used by HIV serodiscordant couples[1] was conducted in Jimma Town in 2012/13. Research objectives are to identify socioeconomic challenges of living in HIV discordant relationship; to describe coping strategies of the discordant couples, and to examine public responses toward HIV discordance. Purely a qualitative research approach was employed. Given different personal and structural factors, serodiscordant couples practice unsafe sex hence there is higher probability of infection for the negative partner and a child born to the union if the mother is HIV positive. Challenges of living in HIV discordant relationships include difficulty of managing marital and family relationships, the dilemma of child bearing, risk of child infection and lack of their wellbeing, forced changes in patterns of sexuality, stigma and discrimination, lack of social support, lack or absence of dependable livelihood and income related problems. Externalization of responsibility, blaming and non-blaming attitude, hope, secrecy, intimacy and cooperation, avoidance, naturalization/normalization, sharing, denial, self praising, tolerance, and adherence are among the coping mechanisms used by discordants in managing the serodiscordant relationships. Finally, the issue of serodiscordance is not adequately programmatically intervened in Ethiopia towards which these researchers call the commitment of all stakeholders.

Keywords: Challenges, Coping Mechanisms, Serodiscordant couples

[1] Refers to couples in which one is HIV positive and the other is HIV negative

Introduction

HIV serodiscordance was not adequately addressed till recently (Bishop & Foreit 2010) when it started to attract increasing attention in Sub-Saharan Africa as its significant contribution to new infections has become recognized (Beyeza-Kashesya et., al 2009). As a result, serodiscordance is not adequately studied and intervened in Sub-Saharan Africa at program level (Futures Group, 2008; Colvin et al., 2008).). A very broad list of HIV risky groups had been omitting HIV-negative cohabiting partners of HIV-positive individuals (De Walque, 2007). This omission was later realized as misperceptions about the extent of serodiscordancy. Serodiscordance marital life is accompanied by a number of dilemmatic conditions to the partners. Among these, the desire to have children has its own implications for HIV transmission among discordant couples (Chomba et al., 2008).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 it is duly responded at different levels, serodiscordance may lead to familial crisis by infecting parents and children altogether. Accordingly, serodiscordance involves multiple risky families of HIV infection.

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). A study conducted in South West Ethiopia found that a considerable proportion of the study participants did not know their partner's HIV status. In the general public alike most partners do not know Voluntary Counseling and Testing (VCT) evidence based HIV status of their partners (Kebede, et., al, 2008 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 study specifically focused on exploring challenges of living in discordant relationship and coping strategies as well as public responses to the problem.

This study was conducted using qualitative approach. The general objective of the study was to assess conditions of living in HIV serodiscordance relationship in the study area. The specific objectives include: to identify socioeconomic challenges of living in HIV discordant relationship; to describe coping strategies of the discordant couples, and to examine public responses toward HIV discordance.

Methods and Sources

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 (informants) and health care providers through interview. Sixteen interviews and four key informant interviews were conducted with HIV discordant couples and health care providers respectively. 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. The discordant couples were selected mainly based on their availability around the service centers. Willingness to participate was another factor of sample selection in all interview procedures. 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 respective offices or work settings.

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. Participants were assured the confidentiality of the information they provided. The translation and transcription of the interview were carried out by the researchers alone to avoid other parties' access to the informants' personal details.

Results

Sociological Challenges of Living in HIV Discordant Relationship

Marital Conditions

This section is devoted to problems related to marital relationships that discordant couples have been encountered. Marital experience, marital dispute, changes in patterns of interpersonal relationship or communication, tendency of divorce, children related problems and sexuality are presented.

Marital and Family Experiences

Many discordant couples have "unconventional" marital experiences such as cohabitation, prior divorce, and becoming step-parents. These are the cases because they have engaged in sort of socially disapproved sexual partnership (no formal or legal marriage), have experienced divorce and remarriage, and brought children to the present marriage from earlier

dissolved marriage or from which they abandoned. M[2] (male HIV +ve partner) had engaged in an irregular union with his ex-partner (she was HIV +ve) whom he easily left and started to live with his current partner (she is HIV -ve) after he was back from his short abandonment to Agaro as migrant laborer. The point is, the former marriage was not legally terminated to begin the second one yet the ex-partner knew his engagement into another relationship. Two risky conditions are clearly observed in the marital life of Mr. M: switching from one sexual partner to another and seasonal migration. The third indicator of family problem is that both his ex-and-current partners have children from another marriage which implies that he was married to divorcee and assumed a step-fatherhood role. More similar experiences related with the familial or marital relationship of the serodiscordant couples are presented as follows.

Both D (male HIV –ve partner) and A (female HIV +ve partner) were divorced from another marriage before the current marriage and each has one child from the previous marriage. Similarly, both C (HIV –ve male partner) and his current wife were divorcee. She has two children (11 and 10 years old) from the previous marriage. Both of them are HIV –ve. He also has a child from the previous marriage. He stated the divorce scenario as, "*Once when I was back to home at 10:00 PM in the night, the child (of 3 years) was left alone at home. I mean she abandoned to her family. Soon I went to her parent's home and they told me that she was away with her friends but I found her with another man. Then I stopped the relationship*." While D and A do not have common child in the new marriage because of unwillingness of D, C and his wife have a son of one year whose blood examination repeatedly showed –ve result but is seriously sick since his birth.

F's (female +ve partner) first marriage was in rural area. She came from Toba divorcing her ex-husband. Then she joined a hotel where she served for 7 years at the time. In the meantime, when she developed serious sickness, the hotel owners suggested her to be tested for the virus which was found +ve. Soon she stated Anti Retrieval Therapy (ART). Here, F has experienced complex and interrelated life difficulties: divorce and remarriage, migration, commercial sex work (prostitution), and finally HIV/AIDS. Similarly, T and his wife A T (she is called through her husband's name) have been in marriage for the last eight years. This is the second marriage for both T and A because he was separated from the first marriage as a result of military service in which he had two children and she abandoned from her earlier marriage, her child (a daughter) and relatives. In the current marriage, however, they have no child. The couples are elders

[2]M refers to the initial letter of his name. All names of serodiscordants in this study are represented likewise.

living in difficult socioeconomic conditions because they do not have house, are daily laborers, hence no dependable income, no relatives around and even have no any means of contact with relatives at distance. It is understood that multiple problems are intertwined in the lives of T and A. Both had divorce experience; both have separated from their children and relatives at all/abandoned; and both are elders with no reliable source of income or social support. It is on top of these all problems they became serodiscordant couples. T and A are 54 and 42 years old respectively but both of them are physically weakened; they are not in a position to engage in any income earning activities. Here is another story we have to here from another HIV +ve female partner, namely Z.

> *Before this marriage, I had a husband for whom I had two children. It was because of interpersonal disagreement that we divorced. We used to live in Agaro from where I came to Jimma. Then, I married to the current husband without making blood test. I married this one after four years of divorce from the earlier marriage. I and his sister were living in a compound where we met. I had no idea of marriage (even to live with males) after I divorced because I suffered a lot in previous marriage as well as I had complicated health problems (diabetes, pressure, and chronic headache). In this marriage, I gave birth to two children (twins); one alive and the other died.*

For her husband, B, this is his first marriage. Both came to Jimma from rural areas.

The recurrence of divorce and remarriage or cohabitation, abandonment, economic hardships such as lack on dependable income and social detachment among the discordant couples tend to imply that discordance in particular and HIV infection in general can be considered as an extension and function of these problems. While this can be true, precaution is necessary not to conclude that married people with no such problems are insulated from HIV infection. It appears that discordant couples who disclose themselves to service organizations are the ones who want to get material benefits for survival. In contrast, those who can survive on their own resources or income less likely visit service organizations hence they are technically excluded from interviews for studies.

Child Related Challenges

Dilemma of child bearing, rearing step children, HIV infection of children, and poverty are among the major problems related to children. Below we will focus on couple's desire to have child/ren.

The Dilemma of Child Bearing – this child related challenge seems to be the most sensitive issue because it involves the possibility of HIV infection on the HIV negative partner and the potential child to be born. Child's infection during delivery and through breasting can occur only when the mother is HIV positive. Discordants have taken various positions upon whether they have to give birth to child/ren. Discordant couples may have similar positions or they may have different positions and they have different reasons for their positions. Among others, need of child, family or friends or community's pressure, fear of the negative partner and child's infection, having child/ren from previous marriage, economic difficulties, and maintaining intact relationship. Both M's (HIV +ve male partner) current and earlier wives have children before they got married to him but he does not. He has no plan to have child because he is told that the child will not grow. On the contrary, his current wife wants to have child from him but he refused her request because he thought she might be harmed as she had surgical operation experience during earlier delivery.

A (HIV +ve male partner) has a daughter from the current wife and she was seven months pregnant for the second time. Being the mother is HIV negative, there is little risk for the child so long as she is not infected during pregnancy or breast feeding. Therefore, they have greater chance to give birth to a healthy child. In addition, he claimed that she is attending prenatal care at hospital which is also better chance of having uninfected child. He also mentioned that she made VCT for the sixth time when this interview was conducted. And until that day, her HIV status was –ve. They agreed to use condom when they decided to marry each other. But latter she refused the use of condom and started to practice unsafe sex.

It is straight forward to understand that these couples have agreed on the need to have children and they have been practicing unsafe sex so far and it also tends to continue in the future because the wife who is at risk of infection has refused using condom. This shows that it is very difficult to say people have brought behavioral change even when they are at most likely risk.

The risk of giving birth to a healthy child is very doubtful when the mother has HIV positive status because it is proved that child infection may occur during delivery or breasting feeding. The latter is more risky for the child infection because the former can be minimized if prenatal and neonatal care is given. The issue of breast feeding remains unresolved challenge because two conflicting values crosscut over it. The first is the importance of exclusive breast feeding till six months which is suggested to be helpful for the child's mental and physical health. The other is avoiding (if possible) or minimizing breast feeding in case an HIV infected mother gives birth to a child. Both are equally challenging for the child in such situation because

both can adversely affect its survival. Avoiding breast feeding would be better evil yet it needs replacing breast milk by equivalent food which in turn is challenging in itself for most African women.

C is an uninfected father of a child from an infected mother. There was prenatal follow up and she gave birth for the child at hospital. However, the child is repeatedly sick and his disease is not identified yet. According to information he got from physicians, it is not readily known whether the child is HIV +ve or –ve. As a result, he is dissatisfied with the long process of blood examination of his son for HIV status and he has great doubt that he might be infected. He complained that he was told that blood of the child was sent to Hawassa for test before four months but no response about what is going on while the sickness has become more serious. The child was repeatedly admitted to hospital as inpatient for longer period of times (15 days, 25 days, or more). He also condemned the medical malpractice and maltreatment by nurses and avoidance of doctors not to properly follow up his child. He is anger at them because they shortly change the type of drugs administered even without noticing the effects of the earlier drug. And they ruthlessly stop any type of food provided by the parents. Now C and his wife have no plan to have another child in the future because of fear of child infection and not to suffer again with another child.

People's decision and desire to have more child/ren is also significantly affected by cultural values even if the couples can avoid new pregnancy. Here is an argument from an uninfected male discordant. He complained both of them are young and should not remain with only two children. He also argued that it is impossible to avoid need of child so long as they (i.e couples) are human beings. He gave the clue for plan of new birth as, "*We have information that giving birth for a healthy child is possible. Therefore, we will consult health workers about how we can give birth for a healthy child. I want to have offspring because when I die they carry my name. Two children are not enough; they may die. My wife also agrees with this idea.*" What is clearly observed from discordant couples is they have some doubt about the possibility of child's infection but it seems they ignored the possible infection of the HIV negative partner.

Conflicting interests may arise between husband and wife regarding the number of children they have to have. S (an infected mother) put the case as, "*We have two children. If they will be HIV +ve, I want to have more. He does not know whether I am using contraceptive. Now I do not want to have more if the existing ones are infected but he does. "* You can imagine how much the desire to have child is strong among the serodiscordants even if they are in a hardship conditions.

Tendency of Divorce

Another challenging and dilemmatic condition among discordant couples is whether they have to decide either to maintain the marital relationship or quit it. In contrast to the would be common assumptions in general public as to what follows serodiscordant relationship, that is likely divorce, most of them including the HIV –ve partners have decided to stay in the union. It seems that they are emotionally attached to the extent they fail to plan to divorce in the future. Yet there are some who tend to divorce under certain conditions. In this regard, M has no plan to divorce his uninfected wife and more importantly he is thankful for his wife's rejection against strong pressure from her relatives to divorce him. The more many close relatives uninfected partner has around him/her, it is more likely to receive stronger pressure. One of our interviewee replied that, *"I want to live with him forever even after death."*

A conditionally wants to get divorce only when she is getting angry at disagreements occur mainly related to economic hardship. She explained her past experience as, *"Once I decided to divorce when we quarreled. I attempted but I could not reject him when he came back later. The primary cause of our disagreement was not related with HIV status but with the general living conditions such as housing problems. Our pressing problem is lack of home."*

A female discordant explicated the difficulty of getting divorce even when some forcing conditions necessitate it. She mentioned her experience and feelings related to divorce attempts as follows.

"Living with people is both bad and good. If one does not smoke, drink, chew, he can be improved. But he is not one to be changed. Sometimes I hope he might be changed. Once I was in serious health problem in hospital and someone gave me some money. Unfortunately, my husband took away it from me recklessly and I became hopeless. As a result, we separated for sometimes and when I saw him one day in the morning sleeping in a veranda, I felt sorry and took him back to home. I am happy if we get divorced if he can lead better life but I do not want to see him deteriorated; I do not let him sleep in a veranda."

It seems she strongly believes in the need of divorce because she does not benefit from him yet she could not decide. She is disturbed because of the condition of their four years child as he is being emotionally affected when they quarrel (and beat) each other. She said the child leaves the home even at night when they fight. She strives to raise the child properly; send him to school; and expects he will become her future hope. As a result, she gives him greater care at any cost.

It seems she is very challenged by the life she is leading with her sero-negative partner. She fears for his future life as he has sexual affairs

with other women. Her fear is that if he will be infected from a woman who is using or stopped using ART, he may not get proper drugs for treatment. She also fears that he can bring another type of virus to her.

Another uninfected partner, B, declared his unconditional commitment to stay in the union stating that "*I never think divorce. We pray to God; the lord can deliver her. We wait for his word. Sometimes she gets angry because of the disease then I tolerate it; I advise her how to live with HIV because it is possible to live with it.*"

In some cases, a positive partner may urge the other to get divorced to lead a better life when they develop a guilty feeling and view their HIV – ve partner as "holy" and innocent. Although it is difficult to know how much it is genuine offering, one of our interviewee told us that **"***Once I asked him for divorce so that he could be married to another healthy woman and secure better life for himself and his child.*" However, her offering to divorce was rejected by her husband (B) as mentioned in the preceding paragraph.

Patterns of Sexuality

In this sub-section, we have attempted to examine whether discordance can have influences on the patterns of sexuality. Whether they consistently use condom was our primary concern because unsafe sex practice implies that the negative partner is more likely to be infected in the future as time passes. Evidence obtained from health care providers tell us that the longer the unsafe sex continues to be practiced, the more likely the other partner will be infected. The frequency of sexual contact was also roughly explored. Generally, serodiscordance has changed the patterns of sexuality in one way or another although the experience varies from couples to couples. Unfortunately, it could not increase people's care against infection of the HIV negative partners. There is no consistent use of condom among them which can be partly witnessed by the occurrences of pregnancies. Some alleged the desire of child, others complained the unwillingness of the spouse, some believed they are naturally immunized or thought they are already infected even though not detected so far. We came across only two couples (four spouses) that fully and confidently declared that they have discontinued unsafe sex. They have consistently used condom for 4 years. They did not give birth to a new child since they knew their status.

There are couples who have reduced the frequency of sexual intercourse but have not accompanied it by avoiding unsafe sex as A stated as, "*We practice sex only once per week but we do not use condom.*" C, who is HIV –ve partner, confessed that they do not consistently use condom to avoid emotional harm but reduced the frequency of sexual relations. C told us like, "*After birth of the child, sexual relation is practiced per two weeks.*"

But he has no commitment or plan to regularly use condom even in the future primarily not to harm her emotionally. He put it as, "*If I suggest and request her to consistently use condom by totally avoiding bare sex, it will hurt her emotions. However, if we discuss and agree to regularly use condom, it is possible; what matters is our agreement.*" From C's argument, we can understand that he tries to please her to maintain smooth interpersonal relationship at the expense of exposing himself to the virus.

Similar reason for the total rejection of condom use by her uninfected husband is reflected in S's subsequent argument. "*We have not used condom except at the beginning until he was tested. I want to use condom but he refused. I think his refusal is for me (emotional support). But I want him to live for my children. But we stop using condom though I am using contraceptive to prevent pregnancy without his knowledge.*"

Z gave birth after she knew her HIV result and even started ART. Her husband was very much advised (by her and health care providers) to avoid unsafe sex but he refused the advice. He has not been using condom when he gets drunk. Now he has multiple relationships with other women because Z does not have interest and ability to practice sexual intercourse which got worsen (lack of interest of sexual relationships) after diabetes was diagnosed in her and her CD4 became lower. Moreover, she does not have anything to eat whereas she believes that sexual relationships need mind peace and energy but he has sexual interest because of alcohol initiation or other addictions.

B and his wife continued unsafe sex practice for long as he mentioned it as, "*We continued for sometimes until the child was born thinking that it happened once. After the birth of child, we consistently use condom. The sickness and life situation changed the manner of sexuality. Because of the weakness, sexual interest has reduced.*"

In some cases, discordants are found in dilemma of its future continuity because of the desire of child although they are currently using condom consistently. B (different from above) told that they consistently use condom. Regarding plan of giving birth he stated his dilemma as, "*It is God's will. We do not know how we can give birth for a child. But we need to have child. It is now about a year since she knew her status. Sexual satisfaction before and after the HIV infection of a partner varies. Now we are restricted to frequent condom use. However, it didn't change the frequency of sexual relationship.*" It seems that B is not comfortable with using condom for two reasons and he views using condom as imposition. The first reason is they want to have child which necessitates naked sex and the other, sexual satisfaction reduced.

Disclosure to Community, Social Support, Stigma and Discrimination

The discordant couples do not afraid of their HIV statuses as we observed them during the interview sessions which imply that their allegation to have exposed themselves to their spouses, friends, relatives and even to the wider community seems true. Yet some are selective in to whom they should disclose the status. Family members and close relatives are not well informed except in certain conditions. There are occasions in which they keep it secret when it comes to relatives. Such experiences were observed along the following interviewees.

C mentioned that the neighbor knows that they are discordant but not his relatives (in rural and urban areas) including his parents except one of his brother. Regarding the social support, he put as, "*My relatives are here in Jimma but I do not go to them mainly for work but they come to my home. I am busy because if I do not work hard, we do not have any to eat. My relatives do not know the discordance case, only a brother knows. If he wants me to divorce, I refuse. However, her relatives are not around*." His wife, F, reports that the community knows the serodiscordance case but, as she claims, they live in love and they do not know what others think about them. But relatives do not know (I doubt whether she even knows that one of his brother knows the scenario). She did not experience discrimination so far. She believes she has no anybody else in her life except her husband.

All of them were voluntary to tell their names for the sake of identification. M and his wife were known in the community for their HIV statuses and both were members of the same Idir, a local self help membership association. M has told his current partner his HIV status and other people in the compound knew the case. But it is still doubtful to speak for significant decline in stigma and discrimination against people living with HIV/AIDS at least proportional to increment in disclosure by the infected people.

It seems that there are mixed findings concerning discrimination and people's level of awareness about HIV and AIDS in general and about serodiscordance in particular. In this line, D reported that the community members and his relatives know the discordant statuses. Both his and her relatives have blaming attitude towards her. Hence, they discriminate their co-living. He stated that the reaction of relatives from both sides as, "*There is pressure from my relatives to separate me from her. They even think as if I am living with the virus merely because of living with her. There is feeling of hatred towards her. People do not understand or believe me. However, they later started to understand that I am free from the virus. From the other side, her relatives appreciate my commitment to live with her.*" According to him, some people appreciate and encourage serodiscordant couples to continue living together yet others advise the –ve partner to get divorced. He also

recognized important changes in some regards. D stated people's current response to HIV related concerns as follows. "*When bleeding occurs because of certain accident, people do not come close to her. In such situation, I am the only person to treat her; I do not leave her alone but I use glove for protection from contamination. When people ignore her during bleeding I feel bad. In the earlier, neighbors made her to have a separate coffee cup; now such things become unusual.*"

This clearly indicates that people know that the major way of HIV transmission is blood contact than physical one or via sharing utensils. However, serodiscordance is nearly a new phenomenon to the general public that many people could not easily understand it. According to reports from serodiscordant couples and key informants working in the community, community members have difficulty of believing that husband and wife of different HIV status can exist. This is mainly because of gap of not only intervention but also information on serodicordance as an important element of campaign against HIV/AIDS. Even if some people know their serodiscordance relationships and are admired how such things can happen, they do not believe HIV–ve status of a partner; they suspect that they hide. They came to believe only when they see the result certificate.

Similar condition was reflected by B as,

"*The community members know. We do not keep our serodiscordance relationship secret because we believe that God made it; we want to be open to the community. Some people consider both of us as HIV patients but they do not discriminate except some of them. I believe in God as the cause of the problem; God brought the disease. We advise people to save generation.*"

He complained that there are discrimination against her but he gives more attention to encouraging/advising her because she feels bad when some people label them as patients and aid recipients. B (not the above one) also mentioned all know. According to him, some tend to discriminate by not allowing their children to play with his child. Some refuse coffee cup though not explicitly. But many people do not discriminate. S's neighbors know but her relatives do not and she found their neighbors' reaction positive. But she mentioned one of her discriminatory experience as,

"*I used to use washing vessel; when she heard that I am HIV positive, she ordered me to properly clean the vessel with boiled water after using it. Then after, I stopped to use her material and we separated. The relatives do not know. I want to tell my mother when she comes to Jimma to visit me but she didn't hear so far.*"

Livelihood and Income Related Challenges

The life course of many serodiscordants resulted from a combination of many interrelated personal/psychological, interpersonal, and structural

problems. As a consequent, they are characterized by low income and unreliable working conditions. Prior life experiences such as divorce, migration from rural to urban centers, military services, occupational risks and other life hardships have implications not only on their exposure to HIV but also to earn insignificant income. And most of the serodicordant couples interviewed for this study had such experiences.

A (male +ve partner) has been with his current HIV -ve wife for the last two years. His earlier wife died in 2005 for which the suspected cause was AIDS or TB. After her death, he was healthy for longer time. He was going to work in rural areas for 2 to 3 months as he was carpenter until he became blind that forced him to shift his earning to begging. A confirmed that his current wife knew his HIV +ve status and as he was using ART when she married to him. This woman who is very young (under 20) compared to his (in 60s) deserted her families because of some disagreements and she came to Jimma. Many informants had divorced or separated from another marriage before they married to the current one. For example, A was separated from his late wife who gave birth for five children, two dead; three alive.

As per to their sources of income M is a daily laborer and his wife is domestic servant for other people. This condition is shared by many other discordants. A's regular earning is 100 Birr per month from assistance given by Mekane Iyesus, one of Protestant religion denominations. In addition, he begs to supplement this minimal income. His wife had no any source of income; she totally depends on what he earned. Both have no relatives around them. He has been separated from his relatives and he does not know where they are. Originally, he came from Kaffa since long time during the Derge Regime and she is from Dawuro.

He had been working on vehicle. His wife does not have any occupation. C lately revealed that she was commercial sex worker and she was tested while she was engaging in the activity whereby found to be HIV +ve. And their relationship was established as customer-prostitute relationship which latter changed into marital relationship. Some do not have any source of income at all. One of the interviewees mentioned it **as, "***When I get better I engage in daily laborer; otherwise we have no source of income*." Therefore, the issue of income and livelihood of discordant couples should not be ignored in activities and strategies of interventions of serodicordant groups.

The Coping Strategies of Discordant Couples

Serodiscordant couples are not uniform not only in their perceptions of serodiscordance and challenges they face but also in their coping strategies to overcome challenges of living in serodiscordant relationships.

Serodiscordant couples use different coping mechanisms. Among these the major ones include: externalization of responsibility, non-blaming attitude, blaming attitude, hope, secrecy, intimacy and cooperation, avoidance, naturalization/normalization, sharing, spouse deceiving, allegations/pretexts, denial, self praising, tolerance, and adherence. Let's briefly look at how some of the coping strategies work among the serodiscordant couples. While some of the coping strategies are applicable in many cases, others are less common.

Externalization of responsibility **-** There is a tendency of attributing responsibility to external bodies, be it human or not, rather than condemning oneself. God is widely perceived as a causing agent and/or as a knowing entity of HIV infection. While this notion is commonly shared among the majority, some still associate to the HIV positive partner except in few cases whereby the HIV negative partners are suspected of introducing the virus to the HIV positive one.

Blaming, self praising and non-blaming attitudes- Blaming self or others including one's partner as responsible agent for HIV infection of the positive partner is a coping strategy among serodiscordants. Either the positive partner blames oneself for committing adultery or the negative one feels guilty of causing it. A typical example is what a lorry driver who worked as long distance to Djibouti leaving his wife behind for a period of six months or more witnessed. On the other hand, some HIV negative discordant to praise themselves as innocent particularly when disagreement arise between them. In most cases, however, non-blaming attitude is a popular strategy used by negative serodiscordants not to offend the positive one.

Hope - Serodiscordant couples hope something new may happen in the future that may change fate of their lives. Yet the sources of an expected positive change vary; some hope inventions in medical technology others believe in deliverance from supernatural powers.

Secrecy – Some serodiscordant couples keep the status secret away from the general public to reduce discrimination. While some make it known the wider community, others inform only to selected people they think very important in their lives. However, hiding from one's marriage partner is uncommon except immediately after the blood test; all participants in this study know the HIV status of their husband or wife.

Sharing, intimacy and cooperation - Sharing burdens and feelings, developing and maintain strong intimate relationship and cooperation among serodiscordant couples is another fruitful coping strategy that keeps them intact. Divorce is not common among the group given these factors.

Avoidance - Discordant copules also use intentionally avoiding discussions on HIV related topics between themselves as well as with other people so as to be free from such concern.

Naturalization/normalization - Discordants also attempt to take their serodiscordance status normal or natural as something usually happens to many people.

Denial - Some also deny their HIV status whether it is positive or negative. An HIV negative spouse, for example, totally denies his status and believes he is also infected. Listing, common symptoms he developed which are similar with those of HIV positive people, he convinced himself he a carrier. On the contrary, some have difficulty of fully accepting the examination report till they start to see some symptoms.

Tolerance and adherence - Serodiscordant couples also use tolerance in their social interactions with each other or with community members so as to withstand negative consequences of quarrel and discrimination. The tolerance is also extended to consistently use ART for those who have begun it. The contribution of the HIV negative partners in supporting adherence of the infected partners is paramount as reported by many of them.

Public Responses toward Serodiscordance

Serodiscordance needs interventions that should be made at different levels. But programmatic response tends to take the central place among all because national recognition and response to serodiscordance is a guiding force to bring change at different levels. As information obtained from both discordants and health workers shows, there is no special program that targets serodiscordants in particualr. Instead, the issue is being treated as part of the general HIV targets. Hence, it seems that this risky population is not given a due attention. This population has its own unique character that cannot be addressed within the general efforts of HIV prevention and control programs by which the general population is thought to be addressed. The interviewees complain that no one has even communicated them by the name “serodiscordance” for discussion, experience sharing, awareness raising training, seminar or workshop, and other support. Some expressed that this individual interview can be considered as the first communication targeting the issue at hand. It is only when they go to hospital or service provider organizations like Organization of Social Services for AIDS (OSSA), Jimma branch, that they get information about the matter.

The primarily service they have been receiving in relation to serodiscordance is counseling which targets how to avoid infection of the HIV negative partner and manage desire of child bearing. They have been also visited home to home by volunteers working with OSSA and who follow up their conditions and report their cases to the agency. Many

discordant couples could know their HIV statuses by the effort and support of these volunteers who encouraged them through the strategy of home to home visiting preventive, care and support services. Health care providers advise them to maintain their own and children's health better by following certain living standards. They also get regular checkup. They are also advised how to smoothly stay in the relationship.

D mentioned that the major services they get is advice related to mode of transmission (MOT) mainly sexuality (its pattern, frequency, persistent and careful use of condom), and avoiding sharing sharp materials. At the center of the advice is saving the negative partner from infection. As preventive effort to save the negative partner is overemphasized, there is a possibility of ignoring the HIV +ve partner particularly for males. His wife, A, also recognized the function of the counseling service as, "*I have been receiving counseling services on ART usage, education about healthy life styles, persistent condom use, avoidance of child bearing if possible because child bearing is not recommended for a discordant female or the need of follow up only if insisted.*" It is apparent that A has better understanding of counseling and educational services provided by the health workers where as others are a little bit confused of the messages communicated to them. S has also captured the knowledge and put in to practice in her life as she argued, "*they advised us not to get pregnant, give us emotional support, how to give care for children, importance of keeping our hygiene, and I apply all what they tell us.*"

Yet similar problems are likely to exist among the workers given different and inconsistent explanations about the cause of discordance and the possibility of future infection of the HIV negative partner.

A (HIV +ve partner) told that his wife is receiving counseling services from health care providers which focuses on taking care and possibility of her future infection or the appearance of hidden signs of AIDS (which implies that she might have been infected but the symptoms are not revealed or diagnosed). He goes only to hospital to get counseling services and to the Mekane Yesus where he had got 100 Birr per month. However, no one dealt with them as serodiscordance in the hospital. He has never come across when serodiscordance was considered as issue or discussed about or trainings given about. This interview was his first time to hear and to be asked about the issue of discordant relationship. This implies that serodicordance lacked attention of those working on HIV/AIDS; no program or project is designed for it; no workshop or training is organized for this most vulnerable group. B (HIV negative male partner) expressed his discomfort on the counseling services particularly regarding sexuality as, "*They do not clearly tell me except that I am negative and I should not worry*

about. They always tell us to use condom without clearly explaining its causes."

Conclusion and Recommendations

Serodiscordants are not a homogeneous group yet they have many overlapping feelings, experiences, challenges, and coping strategies that could be addressed through public programs. 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. Serodiscordance among these study participants results into socioeconomic challenges but proceeded by social pathologies such as abandonment or divorce from previous spouse, risky occupational behavior and poor socioeconomic backgrounds. The most appropriate level of intervention to tackle MTCT is married people so long as most children are born in marital relationship although the possibility of pregnancy outside marriage should not be undermined by HIV/AIDS program. Yet all personal, interpersonal, and structural challenges should be addressed in integrated and participatory approaches. Participation of program owners, funders, implementers and beneficiaries (i.e serodiscordant couples) should be given due attention in designing and implementing appropriate strategies.

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