

**THE IMPACT OF HIV SERODISCORDANCY ON MARRIED
COUPLES ATTENDING THE INFECTIOUS DISEASE CLINIC
AT 1 MILITARY HOSPITAL**

BY

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Declaration

I, the undersigned, hereby declare that this is my original work and that it has not been submitted previously in its entirety or in part to any other university for a degree

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ABSTRACT

THE IMPACT OF HIV SERODISCORDANCY ON MARRIED COUPLES ATTENDING THE INFECTIOUS DISEASES CLINIC AT 1 MILITARY HOSPITAL

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HIV/AIDS is severely affecting the armed forces in South Africa. Combating HIV/AIDS demands a high level of commitment from the Ministry of Defence and all the Divisions and Services at all levels in the Department of Defence. Prevention practice for HIV/AIDS is a challenge because the nature and full extent of the impact on the forces, and in particular on serodiscordant couples, are not known.

This research study explored the experiences of serodiscordant couples regarding the impact of serodiscordancy on their marriages. The Infectious Disease Clinic engages serodiscordant couples as active participants in dealing with their HIV status. The researcher explored the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital with the intended outcome of informing intervention and prevention strategies and programmes for serodiscordant couples.

The study utilised a qualitative research approach and the research design was an instrumental case study. The population for the study was all the married serodiscordant

couples in the Infectious Disease Clinic at 1 Military Hospital. The sample consisted of 20 serodiscordant couples attending the Infectious Disease Clinic for at least the past two years. The data was collected through semi-structured interviews.

The study concluded that empowerment programmes on HIV/AIDS should include knowledge of, as well as coping skills and guidance for couples dealing with serodiscordancy, including disclosure and discrimination; marital and parenting roles; health management, building of trust; facilitating open and positive communication; and financial management.

Based on the conclusions of the study, the main recommendation is that prevention strategies and empowerment programmes for serodiscordant couples should be based on a holistic, well-integrated intervention plan which contextualises strategies and programmes for prevention, treatment, counselling, empowerment and continuous support of the employee, their spouse and their family, including home visits, as required by the serodiscordant couple. Furthermore, it should clearly conceptualise the role of each team member at both the Infectious Disease Clinic and the relevant units of the SANDF, in particular the role of the social worker.

Key concepts:

- Serodiscordancy
- Serodiscordant couples
- Infectious Disease Clinic
- 1 Military Hospital
- HIV/AIDS
- Marriage
- South African National Defence Force (SANDF)

- Impact
- Antiretroviral (ARV)
- South African Military Health Services (SAMHS)
- Condom

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CHAPTER 1

GENERAL INTRODUCTION AND ORIENTATION TO THE RESEARCH STUDY

1.1 INTRODUCTION

HIV/AIDS is severely affecting the armed forces in South Africa. However, the full extent of the impact of the pandemic on the forces is still not clear. Any research initiative on HIV/AIDS inevitably has to deal with constraints and suspicions, as well as reluctance to provide data on the part of those in the position to do so. This scenario allows for conclusions to be drawn, suggesting that the prevalence of HIV/AIDS amongst the armed forces is twice as high as amongst the population as a whole, possibly as much as five times higher. This applies even when such conclusions are not based on empirical studies (Rupiya, 2006: 9).

In essence, HIV/AIDS is like a corrosive acid undermining the combat-readiness of the military forces, eroding their capability to deliver on their mandate and impacting directly on the very fibre of human security (Rupiya, 2006: 9). This has limited the national recruitment pool, resulting in high recruitment costs for military and other organisations, because human resources have to be replaced more frequently than before. Combating HIV/AIDS demands a high level of commitment from the Ministry of Defence and all the Divisions and Services at all levels in the Department of Defence (DoD). Measures to ensure the containment of the epidemic should be the priority of everyone in the DoD, while the care and support of members and their dependents infected and affected by HIV is the domain of the South African Military Health Services (SAMHS), according to its mandate (RSA, *Department of Defence Instruction: Surgeon General no.01/99*, 2001).

Because of the stigma attached to the illness, participants in an HIV/AIDS project may feel unable to discuss their diagnosis with their families, spouses and friends. In such cases, participants depend on social workers to intervene on their behalf.

In South Africa, there is no law compelling spouses to disclose their HIV status to their husbands or wives (Maelane, 2001/2002: 26).

Couples are referred to as being serodiscordant when one spouse is HIV-positive and the other is HIV-negative (Sayler, 1999: 1; Chu, 2004: 131; Beckerman, 2002: 35). Many people assume that when an HIV-negative person dates an HIV-positive person he or she must either already be HIV-positive or will eventually become HIV-positive (Sayler, 1999: 1; Chu, 2004: 131; Beckerman, 2002: 35). Saucer (2006: 375) states that HIV serodiscordant couples are sexually active because of their young age and are therefore at risk of transmitting the virus because of improper condom use or unprotected intercourse.

In a study conducted by Peltzer (2003: 258), most of the sexually active participants indicated that they did not use condoms. The main reasons for this were that they did not like using condoms, they encountered inconveniences during condom use, or they experienced negative psychological feelings when using condoms. There is clearly a need to change the attitudes of sexually active people towards the use of condoms. The majority of the young, married and infected participants in Peltzer's study indicated that they only occasionally used condoms because their families expected them to have children, and also that the couple would be reluctant to disclose their status to their families because they feared stigmatisation, discrimination and victimisation (2003: 58).

The principle behind the successful prevention of HIV infection is ensuring that people are not exposed to the virus and, if they are, that they are not susceptible to infection. Vaccines provide protection against infections. However, vaccines are not yet available to people infected with HIV. According to Ferris and Kabaabetswe (2003: 4) and to Whiteside and Sunter (2001:17-19), precautionary measures are threefold:

- Firstly, it is necessary to stop transmission through behaviour change. This can be achieved when people gain knowledge, then change their attitudes and finally alter their behaviour. Transmission can also be prevented if people adhere to one sexual partner and if they delay their first experience of sexual intercourse. This is the classic ABC message: A – abstain, B – be faithful, C – use a condom if necessary.
- Secondly, those infected with HIV ought to be identified at an early stage so that treatment, counselling and health education can commence.
- Thirdly, precautionary measures to prevent HIV transmission in the care delivery setting, i.e. HIV and AIDS clinics and hospitals, should be maintained.

To prevent HIV transmission, those at risk of HIV infection and their sexual partners should be tested. Completing voluntary HIV testing forms is part of healthcare for suspected HIV-related illnesses. These forms may also be provided in conjunction with information, education, counselling and other support services to help promote sustained behavioural change. The Department of Health (RSA, 2001: 62) maintains that a safe sex standard for serodiscordant couples should be very stringent, with sexual activity limited to masturbation. However, the Department acknowledges that the reality is different. There is no guarantee that married couples will adhere to such advice and hence the use of condoms for every vaginal or oral contact should be advocated (RSA, The Department of Health, 2001: 62).

Prevention practice for serodiscordant couples is challenged because the nature and full extent of the vulnerability of the HIV-negative spouse are not known. Peltzer (2003: 255) found that people are not willing to take an HIV test for fear of being stigmatised by the community. The author explains that HIV-infected people do not go for the test because there is no cure for the disease should their results reveal infection (Peltzer, 2003: 255-256). The researcher concludes that the

general population's attitudes, misconceptions and myths surrounding HIV/AIDS also apply to serodiscordant couples.

This research explored the experiences of HIV serodiscordant couples regarding the impact of serodiscordancy on their marriages. The researcher has endeavoured to highlight the needs and rights of seronegative spouses and determine the knowledge and coping skills required to deal with this situation in their families. This knowledge, in turn, may inform intervention and prevention strategies for serodiscordant couples.

The Infectious Disease Clinic, located at 1 Military Hospital, was launched for all uniformed SANDF members and their dependents. Participants, who include: HIV-negative and HIV-positive participants with the T-helper lymphocytes (CD4 count) above two hundred, take part in the Clinic voluntarily, and are referred by their own clinics, which are situated in different units where they work. Members visit the clinic after being diagnosed as HIV-positive, and thereafter their follow-up visits are determined by their HIV status (CD4 count). Participants whose CD4 count is below 200 are assessed by doctors, a social worker and the pharmacist before antiretrovirals (ARVs) can be dispensed. The monthly visits include the following tests:

- an HIV test for seronegative spouses;
- a pregnancy test for all female spouses, negative and positive;
- a test for sexually transmitted diseases (STDs) for all participants, male and female; and
- an HIV viral load test for all HIV-positive participants.

The HIV viral load test is taken to check how diligently a participant is taking the medication. Participants who are not yet on medication undergo medical examination to check whether their CD4 count is decreasing or increasing.

The social worker at the Infectious Disease Clinic is responsible for post-counselling of serodiscordant couples and for the assessment of the treatment-readiness of infected spouses when their immune systems are low (CD4 count is below 200).

The researcher has been engaged in the Infectious Disease Clinic for five years and at Phidisa clinic for three years. During counselling sessions with the participants/ patients in the clinic, the researcher has observed that HIV-positive spouses continue to deny their status when their spouse is HIV-negative. The SANDF members find out first about their HIV status because they are expected to undergo all the medical tests in preparation for international deployments. The members are supposed to inform their partners of their status or bring them to the multi-disciplinary team to disclose. If this does not happen, SANDF spouses find out when they are ill or pregnant (in the case of a female spouse), or when they have to sign the HIV test consent form on behalf of their ill or disoriented spouses who cannot give consent for treatment.

During a personal interview with the section head of the Infectious Disease Clinic, Dr Ratsela (2008), he indicated that the intended study will not only benefit the Infectious Disease Clinic, but will also be in the interest of the whole SANDF and its members. He voiced his concern about the increasing number of serodiscordant couples, indicating that these couples are faced with enormous challenges in their marriages, families and other relationships. In support, the sister in charge of the Infectious Disease Clinic, Sister Butjie, indicated that the study will enable medical doctors to better understand the family circumstances of serodiscordant couples, and that the research findings will encourage publication of similar or related studies (Butjie, 2008). According to Dr Ratsela (2008), it is expected of professionals engaged in the Infectious Disease Clinic to do studies that will help with the further handling of the patients.

1.2 PROBLEM FORMULATION

Bless and Higson-Smith (1995: 29) indicate that a well-formulated problem is already a half-solved problem. Several authors (Babbie, 1990: 61; Bailey, 1996: 28; Mouton, 2001: 320) agree that problem formulation is the process of reducing and sharpening a problem until it is clearly formulated.

According to Kinghorn (2000: 23), the impact of the HIV/AIDS epidemic on HIV serodiscordant couples principally affects young and middle-aged adults between 20 and 44 years of age. These years are the most sexually active for these target groups, as well as being their prime productive and reproductive years. Since most HIV serodiscordant couples are between the ages indicated above, their serodiscordant status becomes a formidable challenge when they want to start a family (Walker, Reids & Cornell, 2004: 15). Walker *et al.* (2004: 15) indicate that in South Africa in 2000 there were estimated to be 2.5 million HIV-positive women aged between 15 and 49, and 2.2 million HIV-positive men aged 15 to 49.

When people know their HIV status and continue engaging in sex with more than one partner without the use of condoms, the further spread of HIV/AIDS cannot be prevented (Peltzer, 2003: 258). The SANDF has HIV/AIDS programmes that aim to change members' attitudes to the scourge of this virus and empower them to prevent their contracting HIV. Despite these programmes, there are still newly-infected members discovered on a daily basis. A contributing factor to this increase is that the programmes initially targeted only the main members of the SANDF. Since HIV serodiscordant couples are particularly at risk in the category of newly-infected members, it is crucial that the HIV/AIDS programmes are extended to SANDF members' spouses and dependents. Since the beginning of 2005 when the Infectious Disease Clinic national roll-out for ARVs was launched, programmes such as 'Care for the Caregiver' and 'Support Group for HIV-negative and HIV-positive Participants' have been established.

The stigma attached to HIV/AIDS discourages SANDF members from coming forward for help when they are affected or infected. This implies that the number of newly-infected people increases rapidly and renders fruitless the precautions for preventing the spread of the infection. Within this context, the SANDF is still far from effectively combating the spread of HIV/AIDS. As indicated above, people have different beliefs and attitudes that affect their views on and responses to HIV/AIDS. The fact that members of the SANDF are from diverse cultural backgrounds poses a considerable challenge to the design of HIV/AIDS educational and prevention programmes aimed at reaching all members.

Despite these difficulties, however, the SANDF could have a significant impact on preventing the spread of HIV/AIDS among SANDF members and their families, as well as the South African community in general. Such an impact would show understanding of serodiscordant couples' willingness to share their experiences and fears about revealing and dealing with their serodiscordancy, and its effect on their marital relationships. Such knowledge would be of advantage to social work, inter-disciplinary intervention and prevention strategies in effectively addressing the impact of serodiscordancy on married couples. Furthermore, it would identify the gaps in the SANDF's education and prevention programmes that are geared towards preventing the spread of HIV/AIDS among serodiscordant couples, and those that are intended for SANDF members in general.

In summary, the rate of HIV infection in the SANDF remains high. Because they fear stigmatisation, some HIV-positive serodiscordant spouses are unwilling to reveal their status to their HIV-negative serodiscordant spouses as indicated above. In many instances, the social worker has to intervene and facilitate the counseling after disclosure of the serodiscordant spouses' HIV/AIDS status. The effect of serodiscordant status of married couples is not known, which in turn affect the intervention and prevention strategies and programmes required in effectively addressing the problem of serodiscordancy in the SANDF.

The Infectious Disease Clinic engages serodiscordant couples as active participants in dealing with their HIV status. The researcher explored the impact of HIV serodiscordancy on married couples in the Infectious Disease Clinic in order to review and inform both intervention and prevention strategies and programmes that could be used in the Infectious Disease Clinic.

1.3 GOALS AND OBJECTIVES OF THE STUDY

According to de Vos, Schurink and Strydom (1998: 7), a goal is a broader, more abstract conception of the end towards which effort or ambition is directed, while an objective denotes the more concrete, measurable and more speedily attainable conception of such ends towards which effort and ambition are directed. Fouché (2002a: 107) further defines a goal, purpose or aim as a “dream”, while objectives are the steps to be taken, one-by-one, realistically, at grass-roots level and within a certain time-span, in order to attain the dream.

The goal and objectives of this study were as follows:

1.3.1 Goal of the study

The goal of the study was to explore the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital, with the intended outcome of informing intervention and prevention strategies and programmes for serodiscordant couples.

1.3.2 Objectives

The objectives of the study were the following:

- To contextualise and conceptualise HIV serodiscordancy within the SANDF.

- To explore the impact of HIV serodiscordancy among married couples attending the Infectious Disease Clinic with regard to their experiences, attitudes, behaviour, interaction and skills in dealing with HIV serodiscordancy in their marital relationship.
- To explore the role of the social worker in service delivery to HIV serodiscordant couples within the SANDF.
- To set forth recommendations on intervention and prevention strategies and programmes for HIV serodiscordant couples based on the research findings and conclusions.

1.4 RESEARCH QUESTION

Since this research was qualitative, an exploratory study and a research question were employed to uncover the unexpected and new avenues of the study (Marshall & Rossman, 1995: 34).

1.4.1 Research question

According to Babbie and Mouton (2001: 75), an empirical study question addresses a real-life problem. To resolve this question, researchers have to either collect new data or analyse existing data. For the purpose of this study, new data was collected because little is known about the topic.

The research question that directed the research study was as follows:

What is the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital?

1.5 RESEARCH METHODOLOGY

In this chapter, the research methodology will be briefly described, to be followed by a more in-depth discussion in Chapter 3.

A qualitative research approach was used for this study. According to Streubert and Carpenter (1999: 21-22), qualitative research attempts to capitalise on the subjective as a means of understanding and interpreting human experiences. The researcher engaged serodiscordant married couples participating in the Infectious Disease Clinic at 1 Military Hospital to obtain their experiences of the impact of serodiscordancy on their marital relationship.

This study was applied because the findings imply a practical application to the observed concern, in other words serodiscordancy in the SANDF. According to Durrheim (1999:41), applied research aims to contribute to practical issues of problem-solving, decision-making, policy analysis and community development.

The research design that was used in this study was the instrumental case study. According to Fouché (2005: 272) the instrumental case study is used to elaborate on a theory or gain a better understanding of a social issue. In the case of this study, the social issue focused upon was the impact of HIV serodiscordancy on married couples.

The population for this study comprised all the married HIV serodiscordant couples in the Infectious Disease Clinic at 1 Military Hospital. McBurney (2001: 248) refers to the population as the sampling frame. In line with the qualitative nature of this study, the purposive sample method was used to draw the sample for the study. Strydom and Venter (2002: 207) state that this type of sample is based entirely on the judgment of the researcher. The sample consisted of 20 HIV serodiscordant couples attending the Infectious Disease Clinic for at least the past two years.

The method used to collect data was semi-structured interviews. Greeff (2002: 302) emphasises that semi-structured interviews are especially suitable when the issue is controversial and personal, as is the case with serodiscordancy. The interview schedule was piloted with two couples. Data was analysed manually using the Thematic Analysis Method, where themes are generated from the interpretation and from exploration of various statements and situations (McMillan and Schumacher, 1993).

The researcher obtained consent to conduct the study from the Section Head of the Infections Disease Clinic of 1 Military Hospital.

The study adhered to the ethical aspects of research, which are discussed in Chapter 3.

1.6 DEFINITION OF CONCEPTS

Babbie (2004: 118) indicates that conceptualisation is the process by which researchers specify what they mean when they use particular terms. Although it is a continuing process, it is vital for the researcher to describe what the terms and concepts are at the beginning of the study. The key concepts in this study are as follows:

1.6.1 Human Immunodeficiency Virus (HIV) and Acquired Immune Deficiency Syndrome (AIDS)

The Human Immunodeficiency Virus (HIV) is a virus that attacks and hijacks the body's most important defensive cells – CD4 – and the macrophage of the human immune system, while AIDS is a collection of many different conditions that manifest in the body because HIV has weakened the immune system (Van Dyk, 2001:4-7). Rupiya (2006: 11) emphasises that HIV enters human bodies and

affects the immune system, making it a member of a special class of retroviruses. The HI virus can only replicate inside living organs, affecting the cells and the surface of the special protein called CD4 Lymphocytes. This process makes HIV dangerous as it attacks the immune system, which is the group of cells and organs designed to protect the body by fighting viruses and infections.

The HI virus continually changes its replicating formula. Scientists are still trying to develop a cure, but the virus has been killing infected people aggressively, without recognition of race, financial status or age, and knowing no boundaries.

1.6.2 Married couples

A married couple is linked by a relationship and marriage. The *Blackwell Encyclopedia of Social Psychology* (Manstael & Hewstone, 1995: 471) defines a relationship as an enduring association between two persons. Jose (2001: 1) defines marriage as a civil contract between a man and woman to become husband and wife. The moment they marry, their relationship acquires a legal status. Married couples have financial and personal duties both during a marriage and after separation or divorce. Marriage is a private bond between two persons, but it is also an important social institution. Societies therefore recognise marriage as “a way to expressing commitment, strengthening intimate bonds and the provision of mutual emotional support” (Jose, 2001: 1). The most commonly recognised form of marriage is between one man and one woman, known as husband and wife, respectively. However, other forms of marriages are also recognised. Although the forms and rules differ, marriages always involve some form of legally legitimised sexual relationship.

For the purposes of this study, the researcher defines marriage as a signed contract between a man and a woman embedded in the formal legal system, including marriage according to customary law, and which binds the couple within a particular relationship.

1.6.3 Serodiscordant couples

Abdool-Karim and Abdool-Karim (2005: 133) mention that a rare number of individuals exist who appear to have a natural resistance to HIV-1 infection. Cases have emerged of individuals who report exposure to HIV-1 but who appear not to be susceptible to infection and who are persistently seronegative. Persson (2007: 1) state that the word 'discordant' in itself suggests disharmony and tension.

In this study, the term 'serodiscordant couples' refers to married couples with differing HIV statuses. That means that one spouse's blood (sero) is infected with HIV, while the other spouse's blood shows no sign of the virus. This serodiscordant status creates anxiety and challenges for the marital relationship.

1.6.4 Impact

The *Cambridge Advanced Learners' Dictionary* (2003: 626) defines impact as a powerful effect that something, especially something new, has on a situation.

For the purposes of this study, impact is defined as the effect, whether positive or negative, that serodiscordancy has on the marital relationship and the embedded challenges for the couple who are dealing with serodiscordancy in their families.

1.6.5 Infectious Disease Clinic

The Infectious Disease Clinic, situated within 1 Military Hospital, is the clinic that specialises in all the sexual transmitted diseases (STDs) in the SANDF. 1 Military Hospital is an academic hospital treating SANDF members and their dependents, as well as politicians and their dependents. The clinic started in 2000, and is also currently focusing on dispensing ARVs and Tuberculosis (TB) medication.

1.7 LIMITATIONS OF THE STUDY

The findings of the research cannot be generalised, as generalisation is not intended in a qualitative research study (Streubert & Carpenter 1999: 22). The 2010 FIFA World Cup had an impact on the study, as some of the participants were deployed to the borders of South Africa and could not honour their appointments. The researcher anticipated that SANDF members would partake in the World Cup and extended the sample according to the criteria in order to find 20 couples to participate in the study. The researcher did not extend the sample to the initially planned 25 couples when the data became saturated.

The research participants might have known that the researcher is the social worker working in the Infectious Disease Clinic because of her presence as part of the team. They were, however, counselled and seen by the psychologist not the researcher. There is a slight possibility that this could have influenced the responses of the participants. The research findings, however, do not indicate that the researcher's position as social worker had an impact on the outcomes of the study.

1.8 CONTENT OF THE RESEARCH REPORT

Chapter 1 presents the general introduction and orientation to the study, including the context and rationale, the problem statement, the research goal and objectives, the research question, a brief overview of the research methodology, the key concepts relevant to the study, and the limitations of the study.

Chapter 2 discusses the theoretical framework for serodiscordancy within the SANDF context.

Chapter 3 provides the research methodology for this study and presents and discusses the empirical results and research findings.

Chapter 4 presents the conclusions and recommendations of the study.

CHAPTER 2

THEORETICAL OVERVIEW OF HIV SERODISCORDANCY WITHIN THE CONTEXT OF THE SOUTH AFRICAN NATIONAL DEFENCE FORCE (SANDF)

2.1 INTRODUCTION

As defined in Chapter 1, HIV serodiscordancy refers to a trend of HIV/AIDS where one spouse is HIV-positive and the other is HIV-negative. Serodiscordancy is not purely a medical phenomenon; it also has social, psychological, economic, legal and political implications. This trend (of serodiscordancy) is also manifesting in serodiscordant couples in the South African National Defence Force (SANDF).

Adetunji (2007) indicates that the proportion of heterosexual couples that are HIV serodiscordant is higher than the proportion where both couples are HIV-positive. The only exception is in Lesotho. In Kenya, the proportion of serodiscordant couples with female infected partner is 60% high than the proportion with male infected partner (Adetunji, 2007).

Deo (2009) and Cichoki (2007) indicate that there are many challenges that need to be explored around HIV serodiscordant couples. They further state that the multidisciplinary team needs to work together in order to treat serodiscordant couples holistically. Persson (2007) agrees and adds that the concept 'discordancy' suggests disharmony and tension resulting in social, sexual and relationship challenges. Within this context, serodiscordant couples in the SANDF are faced with many challenges, which range from social and economic/ financial, to marital and other relationships, including sexual practices.

In this chapter the researcher will provide an overview of the literature on HIV/AIDS in relation to serodiscordancy. Reference will be made to the SANDF context where applicable. The literature overview includes the prevalence of HIV/AIDS in

South Africa; conceptualising serodiscordancy and the factors that impact on serodiscordant couples.

In the final section of the chapter, the SANDF specifically will be discussed, with the emphasis on the profile of HIV/AIDS of its members; contributing factors to infection rates of members with HIV/AIDS; and its particular responsibility with regard to HIV/AIDS. The discussion will include an overview of the SANDF, the clinic and its services with regard to serodiscordancy, and in particular the role of the social worker and the professional team. The chapter will conclude with the findings and challenges derived from the literature within the context of the SANDF.

2.2 HIV/AIDS IN SOUTH AFRICA

HIV/AIDS is one of the most dangerous viruses worldwide, and also one of the most destructive to society. Sayson and Meya (2001: 542) compare the global impact of the pandemic with a stone being dropped into a pool and “... ripples from AIDS move to the very edge of society, affecting first just one person in a family, then the entire family, then the community, and finally the nation”. The ripples of HIV/AIDS have affected all nations worldwide, including South Africa.

HIV/AIDS affects all racial groups; it knows no boundary of gender or age group, and all people are equal before it. Seigle (2000: 8) mentions that “no nation is immune, including South Africa”. Cameroon (2005: 103) stresses that the epidemic is becoming more and more visible every day, its “deadly reaping” noticeable in almost every family, workplace, township, farm, suburb, church and organisation. Only the ignorant and careless think that they are immune to the virus.

According to the *Magazine for Medical Professionals* (2009: 8), the third national prevalence survey of HIV/AIDS conducted by the Human Sciences Research Council in 2008 showed that infection rates were stabilising in South Africa and

even decreasing among children. However, young women continue to be at a higher risk of infection compared to their male counterparts. The *Magazine for Medical Professionals* (2009:8) sketches the following scenario on HIV/AIDS infection:

- About 5,2 million (10,6%), of South Africa's total population is HIV-positive.
- HIV prevalence peaks in women aged 25-29 years (32,7%) and in men aged 30-35 years (25,8%). This is a new peak for men compared to the two previous surveys.
- The level of infection among young women is very high. For example, among the 15-19 year age group, the prevalence is 2.7% times higher than that of their male counterparts. HIV prevalence among women increases even more dramatically in comparison to men in subsequent age groups: to 21,1 percent among those aged 20 to 24 , and seven percent in the 25-29 year age group. In the age category 30-34, the disproportion is much smaller.
- In adults aged 25+ years, HIV prevalence increased by 1,3 percent from 2002 to 2008. A similar trend exists in the 15-49 years age group.
- In children aged 2-14 years, the prevalence of HIV decreased by 3,1 percent from 2002 to 2008. Among young people aged 15-24, a decline in HIV prevalence was observed from 2005 to 2008.

Although the last two points indicates a stabilisation and decrease in the prevalence of HIV/AIDS, the researcher is of the opinion that these figures remain disturbing and that South Africa has not yet made HIV/AIDS a national priority. This was confirmed by the State President, Mr Jacob Zuma, in his announcement on 1 December 2009 that the South African nation is perishing and that we should take bold steps to save the nation from HIV/AIDS (Bryson, 2009). He highlighted the devastating effects of HIV/AIDS on the country:

They [statistics] show that nearly six out of 10 deaths in our country in 2006 were deaths of people younger than 50 years. More and more people are dying young, threatening even to outnumber in proportional terms those who die in old age. The number of deaths registered in 2008 jumped to 756 000, up from 573 000 the year before. At this rate there is a real danger that the number of deaths will soon overtake the number of births. The births register during this period were 1 205 111. *Mail & Guardian* (Bryson, 2009: 9)

The view of the South African government is in sharp contrast with the former president of South Africa, Mr Mbeki, who on Thursday 28 October 1999 addressed Parliament revealing his concern regarding the toxicity of the antiretroviral (ARV) drugs and the endangering of a user's health (Cameroon, 2005: 103-107). Mbeki's statement had a negative impact on the whole country in that there are still, today, people who refuse to take ARVs because they are scared of the drugs' toxicity and side-effects. These people would rather die than endure the pain that will be inflicted on them if they take the ARVs

Motsoaledi (2009: 13) compared the life expectancy of South Africans, which has fallen to about 47 years, with war-torn Afghanistan where life expectancy is only marginally better at 44 years. In further positioning South Africa, Zuma emphasised that in Algeria life expectancy was 70 years and in Senegal it is 60 years (Motsoaledi, 2009: 13).

The South African government needs to learn from countries like Nigeria and Uganda where HIV/AIDS is well controlled and managed and where there are many researchers conducting research regarding the new trend of serodiscordant couples and the spread of HIV/AIDS.

2.3 CONCEPTUALISING HIV SERODISCORDANCY

There have been various theories as to why some couples are serodiscordant, but none has yet yielded conclusive answers regarding the causes of serodiscordancy. According to Karim and Karim (2005: 133) a rare number of individuals exist who

appear to have a natural resistance to HIV-1 infection. Cases have emerged of individuals reporting multiple exposures to HIV-1 but who appear not to be susceptible to infection and who are persistently seronegative (Karim & Karim, 2005: 133). Serodiscordancy thus implies that despite uninfected partners having unprotected sexual relationships with infected spouses, they remain HIV-negative. There are no statistics currently available on serodiscordant couples, as these statistics are incorporated into other HIV/AIDS statistics. There is thus no certainty regarding how serodiscordancy is impacting HIV/AIDS infections.

Serodiscordant couples are affected by the various modes of HIV transmission as any other people. The main ways in which HIV/AIDS can be transmitted are as follows (van Dyk, 2002: 19; RSA, Department of Health, 2004: 15):

- A fluid like blood is in contact with the broken skin.
- Mother-to-child transmission (unborn baby or baby infected through breastfeeding).
- Drugs by using the same needle
- Using the same razor blade during circumcision.

According to the researcher, however, there are other ways in which HIV can be transmitted. These include traditional cultural and religious practices and belief systems such as:

- Traditional doctors using the same razor blade to cut family members to put muti into the skin (*ukugcaba/ go phatsa*).
- ZCC church members using the same needle to poke members' legs and only rinsing it in water (*go pula*).
- Men entering their partner(s) without a condom and ejaculating outside the body.
- Sleeping with elderly people. The myth that engaging in sexual intercourse with elderly people will cure an infected person.

Poku (2001:195-196) adds that the poor health of Africans coexists with undiagnosed and untreated sexually transmitted diseases (STDs), which are now recognised as a significant co-factor in the transmission of HIV.

There is thus no distinction between the modes for discordant or concordant HIV transmission. Whilst the HIV-positive serodiscordant partner will contract HIV in one of the abovementioned ways, similar exposure of the other partner will result in an HIV-negative status. No research has yet yielded a conclusive answer as to why a person exposed to HIV remains negative. Although serodiscordant couples represent a critical risk group, it is not yet clear why the number of serodiscordant couples is increasing (Okware, 2006). A rare number of individuals exist who appear to have natural resistance to HIV-1 infection; cases have emerged of individuals reporting multiple exposures to HIV-1 but who appear not to be susceptible to infection and who are persistently seronegative (Karim & Karim, 2005: 133). The authors further indicate that there are multiple factors, involving host factors and viral fitness, that are likely to contribute to possible protection from HIV-1 infection. Polymorphisms in host chemokine receptor/ ligand genes have been shown to play a role in protection (Karim & Karim, 2005: 133). Associations between highly exposed persistently HIV-seronegative (human leukocyte antigen, or HLA) and protection have also been described as playing a role in directing the type of immune responses that can result in protection the negative spouses (Karim & Karim, 2005: 133). According to Okware (2006) “discordant couples represent a critical risk group but [it is] not yet clear why the number of discordant couples [is] increasing”. He states that there is an increasing number of people with a negative HIV status despite multiple exposure, but that this does not mean that the HIV-negative serodiscordant partner is not at risk of contracting HIV. The increasing HIV infection rate in South Africa is evidence of the high risk of any person who is exposed to the virus. Jackson (2002: 87) highlights that gender inequality is a critical factor in the spread of HIV/AIDS in Africa. It is scientifically proven that women are more vulnerable because they have more mucosal surface

exposed during sexual intercourse (Jackson, 2002: 87). Mazibuko (2002:7) adds that it is easier for women to contract HIV/AIDS during sex because their reproductive organs expose more tender skin to infection, making them more receptive partners during sex.

There are, however, also other factors contributing to women's vulnerability to infection, including human rights abuses and socio-economic factors such as poverty and migration.

2.3.1 Women's human rights and HIV/AIDS

Jackson (2002: 93) reveals that all over the world women's human rights are violated every day. In many societies women do not have control over their sex lives as they must do what their male partner tells them to do, and they will not ask their male partners to use condoms even if they are aware that their partners are practising unprotected sex with other women. Buve, Bishkwabo-Nsarhaza and Mutangadura (2002) state that in many parts of sub-Saharan Africa women are still subordinate to men. Women are expected to have little or no sexual knowledge before marriage and are expected to stay faithful to their husbands. Men, on the other hand, are expected to have pre-marital sex and extramarital affairs are condoned. As a result, women are financially dependent on their husbands; have little to say; and have no sexual power or influence.

The researcher has observed in working with HIV/AIDS patients in the SANDF that many men expect their partners to be submissive. However, the researcher concurs with Jackson (2002) and Buve *et al.* (2002) that not all men are autocrats in their families. There are, for example, women who refuse to use condoms, alleging that they develop "rash" in their "private parts". This emphasises the importance of knowledge and education to ensure that women make wise decisions to protect themselves from infection.

2.3.2 Poverty and HIV/AIDS

Van Niekerk (2001: 146) argues that poverty, with its accompanying side-effects such as prostitution (the need to sell sex for survival), poor living conditions, poor education and poor health care, are major contributing factors to the current spread of HIV/AIDS.

Some of the medication is expected to be taken after meals. Food is thus essential for the effectiveness of anti-viral medications; in the words of a patient: “The pill only works if there’s food” (*City Press*, 2008: 25). It is thus difficult for a patient who does not have any source of income to adhere to the medication (*City Press*, 2008: 25).

The economic effects of HIV/AIDS are first and foremost felt by the family. Almost all families with relatives dying of HIV experience a decrease in income because the infected person may no longer be able to work, whilst another person in the family may have to leave employment to become a caregiver. There is also an increase in expenses for the family because of the need for medication and care. The medical cost of managing AIDS depletes households’ resources and has been shown to lead to indebtedness and loss of property in developing countries (RSA, Department of Education 2001a: 11; Marcus 2002: 56). In addition, the high cost of funerals contributes to the burden.

2.3.3 Migrant labour

Mark *et al.* (2002) state that migration continues to play an important role in the spread of HIV-1 in South Africa. The direction of the spread of the epidemic is not only from migrant men returning to their rural partners, but also from women joining their migrant partners. Poku (2001: 195-196) attributes poverty in rural areas and lack of access to sustainable livelihoods to labour mobility. The mobile population, which often consists of the majority of young men and women, is isolated from

traditional cultural and social networks, and will often engage in risky sexual behaviour with obvious consequences in terms of HIV infection (Poku, 2001: 195-196).

Against the above background, it is evident that the HIV/AIDS pandemic has to be addressed not only in medical terms, but also in a broader structural context. Addressing HIV/AIDS, however, is influenced by knowing one's HIV status, as this knowledge can not only prevent further spread, but can also ensure that infected people start with early treatment. On the other hand, knowing one's status can also link to the enormous burden on HIV-positive people of deciding whether or not to disclose their HIV status.

2.4 DISCLOSURE VERSUS NON DISCLOSURE OF HIV STATUS

The relationships of serodiscordant couples are fraught with many challenges, which include the following:

2.4.1 Disclosure

Wright (2000) indicates that the term 'psychosocial' refers to a combination of aspects of every person's life – the psychological and social. The psychosocial impact of HIV/AIDS disclosure thus refers to the psychological and social effects upon the HIV-positive person of disclosing their health status to others.

Collini and Obasi (2006: 5) posit that in the case where one spouse has been tested first, the process of encouraging their spouse to be tested can entail a variety of partner notification strategies, including patient referral (disclosure by the patient themselves) or various types of third-party notification strategies. This is important for the HIV-seropositive index partner who wishes not to transmit the virus and for the non-index partner who want to know their status and how best to manage and respond to their illness (Collini & Obasi, 2006: 5).

HIV/AIDS disclosure may provide both psychological and tangible benefits and costs to infected people (Derlega, Winstead & Folk-Baron, 2000). There are reasons for and against disclosure. According to Weiner, Battles and Heileman (1998), disclosing an HIV/AIDS diagnosis is an emotionally charged and taxing experience for the infected person in the same way as initially learning about the diagnosis itself was. Derlega *et al.* (2000) assume that the reasons for and against self-disclosure among HIV-positive people could be divided into three categories based on benefits and risks faced by those infected in terms of self, others, and relationships. According to Derlega *et al.* (2000), self-focused reasons for and against self-disclosure deal with the psychological or tangible benefits and costs to self, based on disclosing one's HIV diagnosis. An example of a motivation for disclosure in this case would be to gain social support, while fear of rejection would be an example of a reason for not disclosing. Other-focused reasons for and against self-disclosure deal with the benefits and risks for others resulting from divulging ones HIV-positive status. Relationship-focused reasons for and against self-disclosure deal with the costs and benefits associated with relationships between the HIV-positive person and their partner after disclosure. For example, partners may disclose to one another if they have a close and satisfying emotional relationship.

Weiner *et al.* (1998: 116) provide a list of reasons why people disclose their status, in descending order from most important to least important:

- A desire for emotional closeness with or support from others
- A forewarning for significant others.
- Health transmission concerns.
- A desire to be honest with others.
- A need for tangible assistance like information material about HIV/AIDS.

Where the infected person was accompanied by a friend to get their HIV test results, the following situational factors play a role (Weiner *et al.*, 1998:116):

- A desire to educate others.
- Feelings of loyalty to significant others.
- Ease of disclosure to someone with a similar background.
- Catharsis or self-expression.
- Testing of others' reactions.

The infected spouses react differently when handling the issue of disclosure; some disclose within a day of knowing their status, while others take months or even years. Disclosure, however, brings its own benefits and challenges. The earlier participants disclose their status to their spouse, the sooner they can prevent their spouse being infected. On the other hand, disclosure creates tension in the marital relationship and uncertainty with regard to further disclosure within and external to the family. The infected thus have to decide if they want full disclosure (i.e. publicly revealing their HIV status) or partial disclosure (i.e. telling only certain people, such as relatives or friends) (Van Dyk, 2001: 271).

Disclosure can be accompanied by the following benefits (Southern African AIDS Training [SAT] Programme, 2000):

- Helping people to accept their HIV-positive status and reduce the stress of coping on their own.
- Helping people to access the medical services, care and support that they need.
- Helping people to protect themselves and others. Openness about their HIV-positive status may help women to negotiate safer sex practices.
- Helping to reduce the stigma, discrimination and denial that surround HIV/AIDS.

- Promoting responsibility. It may encourage the person's loved ones to plan for the future.

Whether or not to disclose their HIV-positive status is a difficult decision for HIV-infected individuals because both options hold major, life-changing consequences. Disclosure is a personal and individual decision and hence all relevant personal circumstances should be taken into account. Counsellors should help their clients to carefully consider the benefits as well as the negative consequences that disclosure may have for them as individuals and for their spouses.

2.4.2 Non-disclosure

Weiner *et al.* (1998: 116) lists seven reasons for non-disclosure of HIV health status, namely:

- A fear of rejection or ostracism.
- A desire to protect the feelings of significant others.
- A fear that others will gossip.
- An act of ignorance.
- Uncertainty about how to disclose.
- A desire to keep others from making sacrifices or fear of disrupting relationships.
- Geographical separation, such as when an infected person does not want to disclose over the telephone.

As an alternative to the dichotomy between disclosure and non-disclosure, Weiner *et al.* (1998: 116) argue that the concepts of sero-sharing and sero-silence describe ways of living with HIV that either put HIV in the foreground or the background in different ways. According to these authors, disclosure and non-disclosure are “an attempt to capture the layers and trajectories of communication and silence, and what they achieve in a relationship” (Weiner *et al.*, 1998: 116).

Sero-silence allows patients to consider silence as a potential medium of both support and denial, as both skilled and unskilled practice, and as having both positive and troubling effects on couples' health happiness and sexual decisions (Weiner *et al.*, 1998: 116).

The core motivation of many of the reasons for disclosing an HIV diagnosis involves the desire to sustain a close and good relationship with significant others (Weiner *et al.*, 1998). In the same way, most of the reasons for non-disclosure centre on the desire to protect or avoid negative feedback from significant others (Weiner *et al.*, 1998). These authors argue that the HIV positive person would sometimes have a feeling that the other person would have little to offer or nothing that would be beneficial and thus use non disclosure for emotional self protection (Weiner *et al.*, 1998).

Collini and Obasi (2006) mention that there are higher rates of disclosure among women with lower socioeconomic status. They give the following reasons for nondisclosure amongst women:

- Fear of accusations of infidelity;
- Abandonment (and loss of economic support); and
- Discrimination.

In alignment with the views of Weiner *et al.* (1998) and Collin and Obasi (2006), the researcher has experienced the following reasons in the SANDF with regard to HIV-infected partners' non-disclosure to their spouses:

- Fear of discrimination or stigmatisation from spouses/siblings.
- Fear of being neglected by their family.
- Affect on their sexual relationship.
- Fear of being blamed by their spouse.
- Not knowing how to disclose to their partners.

- Bewitched by their spouse, especially if the HIV-positive person is ill.

The legal and ethical obligations and considerations of the infected persons further complicate HIV disclosure.

2.4.2.1 Legal aspects of non-disclosure

The right to privacy is enshrined in section 14 of the Constitution of the Republic of South Africa (Act 108 of 1996). However, neither the concept of 'privacy' nor the scope of the right to privacy is defined in the Constitution, and it has fallen to the courts, on a case-by-case basis, to attempt to define both the concept of 'privacy' and the scope of the right.

The law is now clear that the right to privacy includes protection from disclosure of an individual's private and confidential medical information, including their HIV status. Put differently, there exists no general duty on an individual to disclose their HIV status; in other words, no one can be compelled to disclose their HIV status (*Southern African Journal of HIV Medicine* 2008: 46).

HIV-positive people have the right to keep their seropositive health status confidential, and it is also the health worker's duty and obligation to keep the infected person's health status confidential. Conversely, health workers or physicians have an obligation to warn third-parties or significant others of an infected person where there is a risk of transmission and, as such, they have to breach confidentiality (Sauka & Lie, 2000).

The South African Constitution (RSA, Act No. 108 of 1996) is the supreme law of the country and all other laws must comply with its provisions. The Bill of Rights (RSA, 1996) enumerates a number of basic human rights that apply to all citizens and that therefore also protect people living with HIV/AIDS. Van Wyk (2000: 404) captures the rights of people enshrined in the Constitution as follows:

- The right not to be unfairly discriminated against, either by the state or by another person
- The right to bodily and psychological integrity, which includes the right to security and control over the body
- The right not to be subjected to medical or scientific experiments without the person's own informed consent
- The right not to be refused emergency medical treatment
- The right to information and basic education
- The right to privacy

Healthcare professionals are ethically and legally required to keep all information about clients or patients confidential. Information about a person's HIV status may not be disclosed to anybody without that person's fully-informed consent. Doctors must also request consent from the patient before disclosing their HIV status to other healthcare professionals. If the patient refuses to consent to such information being given out to other healthcare professionals, the doctor must respect this decision (Van Dyk, 2002: 409).

On the other hand, Collini and Obasi (2006: 3) point out that disclosure is recognised as an important prevention goal, and counselling is one measure to encourage disclosure to sexual partners at risk of HIV.

HIV-positive women who are economically disadvantaged can experience additional strain when it comes to deciding whether to disclose their health status or keep it confidential. Withholding information about poor HIV-positive women's health status may jeopardise their opportunity to be eligible for social services and/or social assistance. As such, disclosure is a very difficult decision for economically disadvantaged HIV-positive women because they lack money to buy medical and social services (Brown, 1993).

In the SANDF the non-disclosure policy is not available anywhere and the national HIV/AIDS policy from national Department of health is relied upon. This is very unfair to both the professionals working at the SANDF and the family or spouse of the infected patient. In the SANDF there is no policy that guides the professional in what to do when faced with such patients. Patients are told to disclose their status to their partners within two weeks, after which time, if they do have not disclosed their status, the professional who saw the patient is obliged to do so. Uniform members have no choice but to comply with this verbal warning, but there are no written documents that can protect them when they are to be taken to court. This unwritten instruction contradicts the view of the Legal Aid Board (University of the Witwatersrand, 2009) that the infected person can sue the professional if permission for disclosure is not given by the patient. The infected spouse must give the professional permission, which should preferably be written down in case they change their mind.

In view of the obligatory disclosure in the SANDF, professionals should be aware of, understand, and be prepared to assist positive serodiscordant people in dealing with the consequences of disclosure. One of the most difficult aspects of disclosure to deal with is the fear of being isolated, discriminated against and stigmatised by family and/or the community, as will be discussed in the next section.

2.5 HIV/AIDS STIGMA

Discrimination against people living with HIV/AIDS and their partners, families, friends and caregivers, is a worldwide tendency. Stigmatisation is defined as negative thoughts about a person or group based on a prejudiced position (Advocacy for Action on Stigma and HIV/AIDS in Africa, 2001: 1).

Goffman's description of stigma (cited in Green, 2000: 123) defines stigma as "a deeply discrediting attribute deviating from a prototype". Green (2000) further indicates that stigma is not mere prejudice, but that it denotes a preference for

avoidance and carries a mark of shame and discredit, and its disclosure may possibly arouse negative reactions from other people, as well as the infected person. In serodiscordancy the stigma will be there since the majority of people do not know about serodiscordancy and members can be rejected and labelled as denying their HIV status.

HIV-related stigma can manifest itself in many ways, especially in serodiscordant couples, as couples typically find it difficult to explain the cause of serodiscordancy. The media does not talk about or report on serodiscordancy. According to the report of the Siyam'kela Project (2003), because of the internal stigma, people living with HIV/AIDS often fear disclosure, withdraw socially in a negative manner and exclude themselves from certain services and opportunities. Persson (2007) indicates that studies dealing with serodiscordant couples differentiate between stigma and silence on the external and internal levels. In some cases, the seropositive partners internalise their status and make it their responsibility not to share it with their negative partners (Persson, 2007; Siyam'kela Project, 2003). On the other hand this makes the seronegative partner feel excluded from any engagement with HIV/AIDS (Persson, 2007; Siyam'kela Project, 2003). The Siyam'kela Project's report (2003) further explains that an internal or external level reaction includes avoidance, rejection and moral judgments that are experienced by most people living with HIV/AIDS. Avoidance is related to the fear of transmission of the virus and take the form of others not being willing to touch objects touched by those living with HIV/AIDS, as well as the tendency to gossip, which, in turn, results in the isolation of people living with the virus (Siyam'kela Project, 2003).

Stigmatisation and rejection are practised openly in other countries (Skhosana, 2009). According to a 2009 interview with Dr Skhosana, a general physician specialising in neurosurgery, in Cuba there is a small, separate community where HIV-positive people are kept and isolated from society, while in South Africa, there is still confidentiality regarding a patient's status and a person can be taken to court

for disclosing someone's status without their consent. In the SANDF there are unwritten laws that are followed and obeyed by members.

Because of the stigma associated with HIV/AIDS, seropositive spouses in particular can be rejected by their partners because of their status. In other countries where serodiscordance is observed, such as Nigeria for example, the HIV-negative partners in serodiscordant couples are advised to divorce their partners (Ole Oyedeji, 2008).

Rejection is often based on moral judgments because HIV/AIDS is often linked to at-risk sexual behaviour, resulting in people being judged or labelled as immoral (Siyam'kela project, 2003). Stigmatisation can also occur by association, where people assume that when you lose weight, or when the cause of death is not known, a person has HIV/AIDS. Relatives or children might also be stigmatised due to their infected family member or parent who promotes non-disclosure to children and other siblings (Siyam'kela Project 2003, Clacherty & Associate, 2002, Strode, Grant, Clacherty & Associates, 2001).

According to De Vos (2001: 273), HIV/AIDS continues to generate fear, misunderstanding, misinformation and discrimination. Because it is obligatory in the SANDF for seropositive spouses to disclose their status, the fear of stigmatisation is even greater. It is therefore important that counsellors and other healthcare professionals facilitate interventions that will counteract these negative attitudes. On the one hand, people infected and affected need support, and on the other hand, awareness programmes must continue to educate and empower communities with regard to HIV/AIDS (De Vos, 2001). An example of discrimination is the case of Gugu Dhlamini who was killed in December 1999 by members of her community after she disclosed her HIV status (Jackson, 2002:347). The fear of stigma can only be successfully addressed in the SANDF if it is dealt with on a community and broader society level. Stigma, however, is not

only attached to the fear of being rejected. It is also deeply rooted in peoples' belief systems, which also influence people's behaviour.

2.6 BELIEF SYSTEM AND HIV/AIDS

People's believe systems play a vital role in their day-to-day living. There are many cultural belief systems in South Africa, with traditional cultural beliefs and religious and spiritual beliefs being at the forefront in determining people's behaviour.

2.6.1 Traditional cultural beliefs

According to Van Dyk (2001) traditional cultural beliefs play a vital role in people's explanations and definitions of the origin of HIV/AIDS. In seeking the cause of their illness, some patients, especially black South Africans, have turned to traditional medicine for answers and for a cure. It is a trend that a patient would consult a traditional healer to understand their illness.

Traditional and spiritual healers function as psychologists, physicians, priests, tribal historians, legal advisors, and marriage and family counsellors in their communities (Van Dyk, 2001). From practical experience in the SANDF, the researcher agrees with Van Dyk (2001) that traditional cultural beliefs play a vital role in black South Africans' interpretation of the cause of their illness, and in influencing and empowering them with knowledge regarding HIV/AIDS and behavioural change. It is therefore important that traditional and spiritual healers be trained in order to fully understand HIV/AIDS and that they form part of the multi-disciplinary team. In that way, they can be effectively monitored and educated with regard to their contribution to making a positive impact on HIV/AIDS. In the SANDF there are no traditional healers in the multi-disciplinary team.

The traditional cultural model imposes a big challenge on Africans who believe anything a traditional healer tells them. This, in many instances, contradicts the

medical facts. When an HIV serodiscordant couple in the SANDF resorts to visiting a traditional healer, they will, for example, be told that they are bewitched and that they must stop the western medication and drink herbs. The traditional healer knows very little about HIV serodiscordancy because of its rarity and due to the little information on it in the media.

2.6.2 Religious and spiritual beliefs

Religion to most people means comfort, being closer to their Creator and seeking answers from God. Religion also gives HIV-infected people hope to accept their status. Clark (2003) describes hope as giving inspiration and vitality to people. Faith in a higher power may help patients to make sense of their world and provide a foundation for daily decision making. Parsons, Cruise, Davenport and Jonas (2006) state that church attendance, religious practices and spiritual belief contribute to an individual's health in general and thus may benefit the patient. They also suggest, however, that strong religious beliefs concerning sin and morality may also affect the individuals negatively by playing into the stigma attached to HIV/AIDS.

From a religious or spiritual perspective, the HIV-positive patient will easily fall prey to religious people who claim that they can cure HIV/AIDS. Although there is always room for miraculous healing, the researcher has not come across one HIV-positive patient who will come back from a visit to a traditional healer or a western or African Christian religious healer and then test HIV-negative. These patients are easy targets for a person who wants to make money quickly. This is despite the awareness campaigns conducted in the SANDF by members of the multi-disciplinary team warning people that there is no cure for HIV/AIDS.

Traditional cultural and religious or spiritual beliefs underpin responses to disclosure of serodiscordancy and also influence the psychosocial impact of serodiscordancy on married couples.

2.7 THE PSYCHOSOCIAL IMPACT OF SERODISCORDANCY ON MARRIED COUPLES

The psychosocial dimension is a combination of two aspects of every person's life: the psychological and social (Wright, 2000). The psychosocial impact of HIV on serodiscordant couples refers to the psychological and social effect on the couples of the challenges they face with their different HIV status.

Serodiscordancy is a challenge both for the couple themselves, and their counsellors and significant others. Serodiscordant relationships often are riddled with stress, anxiety, fear and concern (Cichoki, 2007).

The impact of serodiscordancy on married couples will be discussed with regard to coping challenges, engagement with the HIV-negative spouse, stress in the relationship, childbearing, intervention plans, effects of condoms on transmission, male circumcision, gender issues, ARVs, and counselling and support.

2.7.1 Coping challenges for HIV serodiscordant couples

Matthews and Zeidner (2003) identify two main factors influencing individuals' ways of coping with challenges. Firstly, the attributes of people facing challenges influence and determine their ways of coping with the challenges they face (Matthews & Zeidner, 2003). Attributes in this case includes things like available resources, the individuals' sense of efficacy, and their commitment, beliefs and values. Secondly, knowledge relating to possible ways of coping and personal beliefs concerning the efficiency of the available options, determines the ways in which people deal with challenges (Mathews & Zeider, 2003).

Aldwin (1994: 107) regards coping as "the use of strategies for dealing with actual or anticipated problems and their attendant negative emotions'. He mentions four

factors that might influence the way in which individuals cope, namely their appraisal of stress, the coping resources available, the resources provided by their culture, and the reactions of other people (Aldwin 1994: 107). Culture, in turn, might influence the kind of stress experienced by individuals, as well as individuals' evaluation of challenging situations and the possible coping strategies that they might employ when coping with difficult situations (Aldwin, 1994: 107).

Although social and cultural factors influence the way serodiscordant couples encounter stress, they cope and respond differently to the many challenges that face them not only as a couple, but also as individuals. Coping, according to the researcher, refers to adjustment in order to address demands in the relationships of the serodiscordant couples, which includes the engagement of both partners. Leserman, Perkins and Evans (1992) assert that coping is generally described as the cognitive and behavioural efforts to adjust to or manage a specific external and or internal demand or perceive threat or stressor.

2.7.2 Engagements of the HIV-negative partner

Persson (2007) states that in the sero-silent mode HIV was very much in the background and was seen by either partner, or by both, as the domain of the seropositive partner, rather than as a shared experience. Persson (2007) alludes to the fact that negative partners rarely got involved in the medical or emotional management of the HIV-positive partners. They tended not to be well informed and HIV was hardly ever talked about. For some HIV-positive partners the sero-silent mode meant that they were forced to carry the responsibility alone, or it was seen as a sign of their partner's denial, their refusal to engage with HIV (Persson, 2007). Persson (2007: 5) summarises the consequences as follows:

Conversely, some HIV-negative partners felt excluded from any engagement with HIV. Thus, for some couples, silence was a source of tension, raising difficult issues around trust, intimacy and acceptance and at times, it had a troubling effect on the sexual

practice as silence negated the possibility of mutual decision-making around safe sex.

Naran (2007) indicated that HIV-negative partners in serodiscordant couples have been ignored for too long. The author indicates that although HIV-negative partners face many challenges and problems, they can also assist in the management of their partners' illness.

However, embedded in silence lies the evidence that relationships often are riddled with stress, anxiety, fear and concern (Cichocki, 2007: 1). Relationship stress increases dramatically after one partner becomes HIV-positive (Cichocki, 2007: 1).

2.7.3 Stress in the serodiscordant relationship

Persson (2007) explains that, for some couples, silence is seen as a positive force in that not talking about HIV was a way to reflect a feeling of "otherness" and to claim their place in an ordinary, everyday world. There are spouses who welcomed the fact that their partners did not make an issue of HIV or treat them differently from anyone else. They spoke of this as being liberating and supportive, and as a sign of unconditional acceptance. Shifting the focus away from HIV was perceived as conducive to emotional health and allowed them to get on with their lives (Persson, 2007).

Cichoki (2007) further states that in couples where one partner is HIV-negative and one is HIV-positive, different issues impact on their coping with stress. The seropositive partner is concerned about transmitting the HIV virus to the seronegative partner, while the seronegative partner commonly devotes their attention to the seropositive partner's health and becomes the caregiver in the relationship. This ultimately causes emotional conflict and increasing stress within the relationship (Cichoki, 2007: 1).

A study conducted at the University of Medicine and Dentistry of the University of New Jersey found that psychological distress, along with drugs and alcohol abuse, were commonly found in serodiscordant relationships (Cichocki, 2007: 1).

When one partner becomes HIV-positive while in a relationship, the first burning question for the other partner is how the virus was contracted. The stress is underpinned by hearing that/ wondering whether the infection is the result of unprotected sex outside the relationship or a consequence of sharing needles while injecting drugs in the case that the negative partner had no idea that they were using drugs. The stress in this relationship consists of the feelings of anger, betrayal and sadness, as the reality of their partner's infidelity and/or use of drugs sets in. The HIV-negative partner can feel guilty for being negative, which can increase if the seropositive partner becomes sick due to their HIV status (Cichoki 2007). Naran (2007) argues that most negative partners are not well cared for by the members of the multi-disciplinary team because they are regarded as healthy.

The researcher concurs with Naran (2007) that the stress of the HIV-negative partner should be very deliberately addressed. They are often neglected because they are regarded as healthy and very few doctors refer them for counselling or screening for depression. Reaching out to the HIV-negative partner is thus a huge challenge for the multi-disciplinary team working with HIV-positive patients. When the HIV-negative partner is well cared for psychologically and emotionally, they will be in a better position to care for their HIV-positive partner.

2.7.4 Childbearing in serodiscordancy

For those in a serodiscordant relationship, the decision to have children is more stressful than for non-infected couples (Cichoki, 2007: 2) due to additional concerns of HIV transmission to both the negative partner and unborn child.

Cichoki (2007) asserts that most loving couples will consider having a family at one time or another. Thaczuk (2006, in Persson, 2007) states that HIV infection in itself is not considered a reason to avoid pregnancy, especially when effective antiretroviral treatment is available, as it is in the developed world. Current treatment guidelines can reduce the risk of passing HIV from an HIV-positive mother to her child to the range of one to two percent, and that artificial insemination or assisted methods are the safest for pregnancy (Thaczuk, 2006 in Persson, 2007). However, there are serodiscordant couples that want to conceive naturally.

In a study of HIV-negative women with HIV-positive spouses, Lancet Laboratory (1997) found that four percent of the women became HIV-positive after a natural pregnancy. However, not all of their partners were on antiretroviral therapy, and there was thus no information available about viral load levels.

There is no written document on how to prevent HIV transmission in serodiscordant couples. Moreover, they are taught that there are people who are fortunate to have core-receptors (CCR5) that have no binding for HIV/AIDS. The cause of this deformity is not known (Ledwaba, 2009). SANDF members are more vulnerable to HIV infection because of the nature of their work. They are deployed and detach across provinces and outside the country.

It is difficult for an African woman to deny her husband children, irrespective of their different HIV status. In most African families, childbearing is the pride of the family and the husband feels proud and honoured to see his offspring. Bearing a child also ensures that the wife will be accepted and not mocked by other family members. Kasiram, Dano and Partab (2006) state that, in African communities, bearing children is viewed as an essential part of being a woman and of being successful. Women who are HIV-positive and decide not to have children are viewed as unsuccessful, unfulfilled and incomplete (Kasiram et al., 2006). African serodiscordant couples will thus always strive to be accepted in an African

community. To avoid questions about why women in serodiscordant marriages are not falling pregnant, they will risk their lives to bear children with or without a doctor's consent. This poses a big challenge to their HIV status because the HIV-negative spouse might be infected during the process of falling pregnant.

Within the context of the above discussion, contraceptives, prevention and ARV treatment of HIV/AIDS cannot be seen in isolation. They are key elements of an integrated intervention plan for serodiscordant couples.

2.7.5 Intervention plan for serodiscordancy

Both medical and social service professionals, such as social workers, have a huge responsibility in planning and facilitating interventions with serodiscordant couples to alert them to the infection risk and encourage protection at all times. These interventions cover prevention, including contraceptives and ARV treatment, counselling and support.

2.7.5.1 Prevention of HIV infection

Prevention plays an important role in addressing the spread of HIV/AIDS.

Collini and Obasi (2006) and Okware (2006) recommend the following ways to protect or reduce the risk of infection of the HIV-negative spouse:

- Abstaining from sex.
- Behaviour intervention by advocating public education campaigns and encouraging voluntary counselling and testing.
- Faithfulness to partners.
- Avoiding contact with blood.
- Male circumcision.
- Cessation of the relationship.

- Condom use.
- Using sterile needles.

The following are prevention methods practised in South Africa and worldwide (Rossouw, 2007; Evian, 2002; Van Dyk, 2004)

- Post-exposure prevention with antiretroviral.
- Microbicides, which come in many forms: gel, cream, suppositories, rings that release the active ingredient over time, films and sponges. It is used to prevent STDs.
- Vaccines, which are currently undergoing trials in South Africa, Thailand and the USA.

Although condoms prevent conception/ pregnancy in addition to protecting against sexual transmitted diseases, including HIV infection, their use can be seen as negatively affecting women's self-esteem because they (the women) will not bear children as is expected by their in-laws and the community. By the same token, if a man insists on using a condom, his behaviour can be construed as an attempt to use the women by removing the possibility for her fulfilling her cultural role of motherhood. The introduction of condoms into a long-term relationship where they have not previously been used threatens the trust that is implied in the relationship.

2.7.5.2 Effects of condoms on transmission of HIV in serodiscordant couples

The first record of condom use comes from Egypt, where hieroglyphics from before 1000BC show men wearing sheaths over their erect penises. Condoms were also used during the Roman Empire, and the word condom probably derived from the Latin word "condon", meaning receptacle. In Europe during the seventeenth and eighteenth centuries condoms made from linen or animal intestines were available for the prevention of pregnancy as well as prophylaxis against STDs. The rubber

condom as is known today was first widely produced after the vulcanisation of rubber, which was patented in 1844 (Abdool Karim & Abdool Karim, 2005: 172).

All men and women need to know how to have safer sex. Condoms provide protection from HIV and other STDs (Soul City, 2009).

Correct, consistent use of condoms remains an essential pillar of any HIV prevention programme. Water-based lubricant is essential to minimise condom tearing. Condoms and water-based lubricant should therefore be widely available in all detection facilities (*South African Journal of HIV Medicine*, 2008: 27).

The use of condoms is but one strategy in preventing or reducing the risk of HIV infection. The use of ARVs is essential to the treatment plan of HIV/AIDS. ARV treatment links with prevention on a tertiary level in that it reduces the risks of the spread of HIV/AIDS through a low viral load. The use of antiretroviral therapy reflects a commitment of serodiscordant couples to manage and control the spread of HIV.

2.7.5.3 ARVs and serodiscordancy

Antiretroviral therapy, more than before, has a multitude of treatment options for HIV-infected people. The medication targets HIV in the replication cycle, including reverse transcription of viral RNA, the assembly of new viral particles and the binding of HIV to the cell-membranes (Kalichman & Malow, 2004 in Uldall, Palmer, Whetten & Mellin, 2004). Combinations of antiretroviral medication, commonly referred to as highly active antiretroviral therapy (HAART), have brought about more simplified dosing schedules, multi-drug pills that combine two or three medications in one pill, and the lowering of toxicities to the patient (Kalichman & Malow, in Uldall *et al.*, 2004).

It is well known that the government of former president Mbeki created huge confusion about the use of ARVs, as pointed out in section 2.2. The current government is taking a very bold stance again HIV/AIDS. On World Aids Day, 1 December 2009, President Zuma indicated that HIV/AIDS and ARV dispensing must be taken very seriously by the government. The current government realises that many people died due to the negligence of not giving them ARVs to prolong their lives (Bryson, 2009: 02).

ARV treatment plays a vital role, especially for the HIV-positive spouse, keeping their viral load below 50ml. A low viral load is not only important when a serodiscordant couple wants to have a baby; it also prevents the development of AIDS and the infection of the HIV-negative spouse. ARVs will thus not only save more lives, they will also reduce the number of orphans in South Africa. ARVs are thus important for the treatment and prevention of HIV/AIDS and hence a priority in managing HIV/AIDS (Ammann, 2006).

2.7.5.4 Gender of the infected partner in serodiscordant couples

The infected partner can bring about a change in the family circumstances, for example, in their eating patterns, how they make love, and drinking the antiretroviral or immune booster when they are not yet on ARVs.

The HIV epidemic in sub-Saharan Africa is believed to be male-led, which means that the proportion of couples where the man is the HIV-infected partner is expected to be higher than in the case where the woman is the infected partner (Adetunji, 2007). The only exception is likely to be in countries with a mature or generalised epidemic where most of the first-generation HIV-infected men have died and where the proportion of women who are HIV-positive is higher among the younger generation because they are more likely to bring infection into their marriages (Adetunji, 2007).

Adetunji (2007) further states that he expects the level of male-infected serodiscordant couples to be higher in rural areas than in urban areas, because of the male-female imbalances in education distribution, economic opportunities and the higher prevalence of polygyny (Adetunji, 2007).

In the SANDF there are no statistics of the dominating gender in serodiscordant couples. The only statistics on record are of the ARV treatment of the seropositive partner and the indication is that more males are infected.

2.7.5.5 Counselling and support of serodiscordant couples

Counselling and support of serodiscordant couples play a major role in their coping with their status.

2.7.5.5.1 Counselling

Counselling starts when a person reports to the clinic to determine his/her HIV status. The multi-disciplinary team will see the patient individually, according to their scope of practice. During the individual testing, it is recommended that people make use of the voluntary counselling and testing (VCT) service that is available. Internationally, much emphasis is placed on the process of counselling a person when they are undergoing an HIV test and the South African Department of Health, similarly makes special provision for counselling and counsellors in its regulations (RSA, Department of Health, 2003).

The World Health Organisation (WHO) (2006:) defines HIV counselling as a confidential dialogue between a client (patient) and a care-provider, aimed at enabling the client to cope with the stress of a positive diagnosis and to assist the client in taking personal decisions related to HIV/AIDS, for instance, when and to whom to disclose the diagnosis according to the Global Programme on AIDS.

VCT for screening is done as one component of the health assessment of all SANDF uniform members. HIV-positive results of initial screening using rapid test kits are confirmed with laboratory tests (RSA, *Department of Defence Directive DODD/SG/00006/2009*, 2009: 8).

It is important that pre-counselling and post-counselling be conducted when doing a HIV test. Counselling before doing a HIV test is a requirement, according to HIV policy and WHO policy on treating HIV patients with ARVs. The counselling aims to prepare an individual for both good and bad news results (RSA, *Department of Defence Directive DODD/SG/00006/2009*, 2009: 8).

2.7.5.5.2 Support for HIV serodiscordant couples and their families

Relatives of those living with HIV/AIDS face many challenges themselves, as the pandemic impacts the whole family and requires them to cope with a relative becoming ill and ultimately dying. The feelings and psychosocial experiences of significant others (both family members and loved ones) corresponds with those of a person with HIV/AIDS (Mokwelo, 1997). Mokwelo (1997) further explains that family members typically display reactions of disbelief, confusion and shock. Other feelings that are commonly experienced include uncertainty, anger, emotional numbness, despair, stress and depression (Mokwela, 1997). Relatives may further fear the infection themselves or even be angry with the family member for bringing the stigma onto the family (Richter, Manegold & Partner, 2004; Van Dyk, 2001; Mokwelo, 1997).

Rolland (1994) asserts that sensitive, open, direct communication about a range of issues is essential to living well with chronic disorders. Persson (2007: 1) concurs with Rolland's opinion that where couples are sharing information regarding HIV serodiscordancy, they understand each other regarding their different status and the things they are supposed to do as serodiscordant couples. The communication helps to bring support, cohesion and better understanding of the serodiscordancy.

The SANDF follows up on HIV-negative partners after six months and the HIV-positive partners every three months. However, most serodiscordant couples come to the clinic together to provide moral support for the HIV-positive spouse. In most instances, when they are requested to be seen by the doctor, nurse or social worker for non-compliance with their medication regime, the HIV-negative spouse acts as 'treatment buddy' to their spouse.

The researcher's experience in the SANDF is similar to the research findings of Richter *et al.* (2004), Van Dyk (2001) and Mokwela (1997) with regard to the HIV-negative spouse supporting the HIV-positive spouse. The SANDF serodiscordant couples are faced with many challenges since very few of these couples are comfortable with disclosing their status to their family because of the fear of stigmatisation and discrimination, and hence they end up supporting each other as a couple. In this regard, in the South African Military Health Service (SAMHS), the social worker plays a vital role in providing support, counselling and facilitating multi-disciplinary team work.

2.8 THE ROLE OF SOCIAL WORK IN THE SOUTH AFRICAN MILITARY HEALTHCARE SERVICE (SAMHS)

Dhooper (1997: 3) is of the opinion that in all healthcare settings, the social worker provides a holistic perspective on problems and situations, highlighting the social antecedents and consequences of illness and the need to deal with the larger picture along with the immediate concern. Dhooper (1997: 3) further points out that at the level of the individual's acute or chronic illness, a social worker's focus is on the patient's physical, psychological and environmental health needs. Cowles (2000: 12) adds that social workers in the healthcare setting are concerned with the interaction of the physical, psychological, and social conditions of the client, both as causes and effects. Cowles (2000: 12) posit that the social situation of life-changing events (such as marital dysfunction, social isolation, loss of job or death

of loved ones) can produce emotional distress that can lead to changes in physical health functioning, which in turn increase one's vulnerability to diseases. Cowles (2000: 12) further explains that a physical health problem can erode self-confidence. Interference with the ability to perform customary activities can affect marriage, other social roles and relationships, which can lead to emotional distress.

With regard to serodiscordancy, it can be concluded that the patient must be treated holistically, as the patient's family circumstances and social environment play a vital role in the healing process. Rehr and Rosenberg (1991: 20) posit that the patient can no longer be fragmented in the delivery of services and that they are best served within a holistic approach. This requires a health setting that accommodates team work in healthcare, education and prevention.

Cowles (2002: 10) highlights the importance of team work as follows:

- Shared assessment of patient problems and needs;
- Exchange of relevant information;
- Team teaching of clients/ patient;
- Ethical decision making;
- Development of intervention plans;
- Delegation of tasks and responsibilities;
- Modification of plans as needed; and
- Evaluations of outcomes.

In the military setting the multi-disciplinary team plays a vital role both in the hospital and in the clinics, with the social worker taking a central position.

In the SANDF, patients are discussed in panels/ conference calls by all multi-disciplinary members with the purpose of planning and implementing holistic interventions. This helps team members to render a comprehensive and effective service to the patient.

The particular challenges and response of the SANDF to HIV/AIDS and serodiscordancy are discussed in the next section.

2.9 THE SANDF: RESPONSE TO HIV/AIDS AND SERODISCORDANCY

The SANDF is the arm force which constitutes one of the most important sectors in the country. The SANDF provides both national security and deployment, and is also the symbol of a country's military institutions and therefore has far reaching implications which go beyond the men and women in uniform. The South African Constitution, Act No. 108 of 1996 (RSA, 1996: 113) states that "the defence force must be structured and managed as a disciplined military force. The primary objective of the defence force is to defend and protect the Republic of South Africa, its territorial integrity and its people in accordance with the constitution and the principles of the international law regulating the use of force".

As indicated in section 1.1 the threat posed by HIV/AIDS has the potential to undermine all that the SANDF represents. It is "like a corrosive acid that undermines the combat readiness of the military forces, eroding their capabilities to deliver on their mandate and impacting, directly on the very fibre of human security" (Rupiya, 2006: 21).

There are currently no statistics available on the origin and thus the duration of HIV/AIDS in the SANDF. A contributing factor to the lack of accurate HIV statistics is that in the past researchers were not allowed to conduct research in the SANDF for security reasons. In the absence of structured planning and attendance to the slow-growing time bomb of HIV/AIDS in the SANDF, the majority of the members who were diagnosed in the 1980s and could not afford to buy the medication privately have already died. There are, however, some members who have been infected with HIV for more than two decades and who sought private medical treatment that are still alive.

The available statistics for HIV/AIDS in the Infectious Disease Clinic indicate a dramatic increase in HIV/AIDS in the SANDF workforce over the past decade. This does not pose an inherent threat to the SANDF and society because there are now extensive treatment and intervention programmes in place to address the impact of this life threatening disease. However, the opening of the Infectious Disease Clinic in 1998 was the evidence of the SANDF's commitment to combating the impact of HIV/AIDS within its ranks.

In the next section, the particular factors that make SANDF members vulnerable to HIV/AIDS are discussed.

2.9.1 Factors that increase vulnerability of SANDF members to HIV/AIDS

In conceptualising the vulnerability of soldiers with regard to HIV/AIDS, the point of departure lies within the nature of SANDF members' migrant labour: they are deployed from one province to another and from South Africa to other countries. This makes them vulnerable because they do not travel with their spouses and as they travel from province to province and outside the borders of South Africa, some engage with sex workers. It is also observed when a group of young women and men are deployed that some women fall pregnant in the deployment areas, which puts them at risk of contracting HIV.

The deployment of soldiers for long periods such as a year not only increases their risk of being infected, but also the risk of, on their return, transmitting the virus to their spouses. The broader community is also at risk because the spouses who stay home are also tempted to engage in risky sexual behaviour in the absence of their soldier spouses. The direction of spread of the HIV/AIDS epidemic is thus not only from returning migrant men/ women to their partners/ spouses, but also from women/ men to their migrant partners/ spouses. Mark *et al.* (2002) affirms that migration continues to play an important role in the spread of HIV-1 in South Africa.

The deployment factor is central to the nature of the SANDF and hence not an easy one to address. The length of the deployment period has, in many instances, forced some members to have families in other countries (Poku, 2001). It is expected of SANDF members to protect and defend their country and its neighbouring states. In addition, SANDF members want to increase their salaries through deployment.

In the work setting, the researcher has observed that SANDF members are more vulnerable in the case of external deployment (e.g. for nine months or more) and detachments to other provinces where the member only goes home once per month.

Deployment, however, is only one factor that plays a role in the infection rate in the SANDF. The researcher has observed the following additional factors that increase HIV/AIDS vulnerability and serodiscordancy in the SANDF:

- Attending courses far from home (e.g. sent to Angola for a whole year).
- Cultural norms that accept men having more than one partner or wife, even encouraging it.
- Gender inequality, with the status of women in some communities making them more vulnerable.
- The fear of talking about HIV in most communities.
- Men marrying traditional women with no education, which makes the wives vulnerable because they cannot read or understand a document if they came across it about their husband's HIV status.
- Unemployed women who are married to soldiers rely on the partner as their sole bread-winner and hence cannot challenge their husband, even when he is not maintaining them financially. They are particularly vulnerable because they do not know their rights and depend on their husbands financially.

The researcher's observation is echoed by Jackson (2002: 8), who lists general vulnerability factors as follows:

- Population movements, military movements.
- Gender inequalities and equity.
- Lack of social cohesion in some areas.
- Broad sexual mixing patterns and multiple partnerships, including commercial sex.
- Various cultural factors (e.g. low rates of male circumcision).
- High levels of untreated sexually transmitted infection and reproductive organs infection, and
- Relatively low condom use.

The abovementioned factors emphasise the tremendous threat of HIV/AIDS amongst SANDF members, their partners/ spouses and the larger society to which they belong. The Infectious Disease Clinic plays a huge role in addressing the HIV/AIDS threat in the SANDF.

2.9.2 The Infectious Disease Clinic

The Infectious Disease Clinic – initially called AIDS Clinic – was established in 1999 under section head Dr Stutler with the purpose of focusing on the increasing number of HIV-positive patients that were not qualifying to be deployed internationally.

In 2002 Dr Stutler mentioned (2009) that patients were not willing to come to the clinic because of its name and the stigma surrounding HIV in the military. The name of the clinic was then changed to the Infectious Disease Clinic. At the time, newly-diagnosed HIV cases were given only multi-vitamins because there was no ARV treatment available at 1 Military Hospital.

In 2003 a number of serodiscordant couples were observed at the clinic. This led some members to stop attending the clinic because they did not believe that one partner could be HIV-negative and the other one HIV-positive. Dealing with this situation required thorough counselling with the couples, and some couples went elsewhere to get confirmation of one spouse's negative HIV status. Poor understanding of serodiscordancy is based on various misconceptions that were noted in a study from Uganda (Collini & Obasi, 2006), namely:

- The belief that both people in the couple were infected but that tests had failed to detect this;
- The belief that the HIV-negative partner was somehow immune to HIV;
- The belief that God was protecting the HIV-negative partner; and
- The belief that “gentle” sex offered protection to the HIV-negative partner.

The researcher observed similar myths on serodiscordancy amongst the SANDF members in serodiscordant couples, including:

- The HIV-positive spouse is bewitched;
- God is punishing the HIV-positive spouse;
- The HIV-negative spouse is “positive” but it does not show when tested;
- The couple must stop using condoms to see if the negative spouse is really negative;
- The HIV-negative spouse refuses to use condoms because they want to die with their spouse;
- The couples have “quick” sex in the belief that this will not transmit the virus, as it is “sleeping”; and
- Having “gentle” sex will prevent transmission of the virus to the HIV-negative spouse.

The Infections Disease Clinic is currently saving soldiers' lives by giving them ARVs, along with their dependants who are also infected. There are more than 100 serodiscordant couples at 1 Military Hospital's Infectious Disease Clinic.

In November 2004 the Phidisa clinical trial was introduced in the SANDF to provide ARVs for members who are at the AIDS stage; that is, who have a CD4 count of below 200. The South African government, however, was very reluctant to roll-out the ARVs. The large proportion of funding for ARV roll-out was obtained from the American President's Emergency Plan for AIDS Relief (PEPFAR), which reached out when the SANDF discovered that more soldiers and their spouses were dying of AIDS.

The researcher has observed that some of the seropositive partners who are on ARV treatment improved a lot after taking their medication as prescribed by the doctors. The ARV treatment thus prolongs the life of the SANDF members and minimises orphans in the SANDF community.

Serodiscordant couples are presenting more often to their doctors as the HIV/AIDS epidemic continues to spread. In the SANDF serodiscordant couples are counselled by doctors and then referred to a social worker for further counselling. The counselling includes encouragement and motivation to use condoms. Females in particular are encouraged to take female condoms and to not always expect their male partners to use condoms, but to make it a joint effort. The HIV-negative partners/ spouses are supported and motivated to maintain their negative status to be able to care for their children and support their HIV-positive partners.

In the context of this study disclosure of HIV status in the SANDF is a huge challenge. Most male patients indicated that it is difficult for them to tell their spouses because they fear they will judge them on their behaviour. Non-disclosure, on the other hand, impacts on patients' progress and their taking their medication. In most instances compliance is compromised when they take ARVs because

infected partners/ spouses need the reminders and support from their loved ones when taking the treatment.

The HIV-positive patient in the SANDF does not always view disclosure of their status as helping them and their families. The fear of unknown responses overrules everything in their thoughts and behaviour. This makes it difficult for the counsellor who conducts the counselling sessions. The chances of them infecting their partners can be reduced if they disclose their status as soon as it becomes known. To counteract this fear, the patient is encouraged to bring a treatment buddy along when they start attending the clinic prior to their treatment being dispensed.

In view of the many myths and challenges of disclosure and embarking on the full programme available to manage the HIV infection, the SANDF has to continue with its HIV/AIDS awareness programmes.

2.9.3 Awareness programmes in the SANDF

The SANDF has HIV/AIDS awareness programmes that started in 2000 for all uniform members. The programmes are called *Masibambisane* (Let's hold hands against HIV/AIDS) and Gender Equity Programmes (GEP). These are programmes that are compulsory for all uniform members to attend. The programmes empower members with detailed information regarding the origin of HIV/AIDS, prevention, replication and treatment, as well as encouraging infected members to get treatment and HIV-negative members to care for themselves.

Despite well-structured campaigns, newly-infected patients arrive at the clinic on a weekly basis. In view of the fact that HIV infection could have occurred long before the infected started to suspect infection and got tested, it is not yet possible to predict the success rate of the awareness campaigns in preventing new infections.

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Serodiscordancy is growing in the SANDF and in South African society. The literature study points out that there are numerous factors that cause psychosocial challenges among serodiscordant couples. Knowing their status requires a change of lifestyle for serodiscordant couples, which includes adopting a healthy diet, engaging in safe sex and waiting for the doctors to tell them when they can have children, among others. Serodiscordant couples require a well-structured, holistic intervention plan, which implies that the social worker and team members need extensive knowledge of the physiological and psychosocial implications of serodiscordancy to enable the social worker to do a thorough assessment and come up with effective intervention plans.

The seronegative spouse's HIV status does not mean that they are not at risk of contracting HIV. There are various factors that contribute to the danger of infection and reinfection during international or internal deployment, or detachments to other units. These movements pose a tremendous threat of HIV/AIDS among SANDF members and their spouses, putting both at risk to be infected. There are, however, factors that contribute more specifically to women's vulnerability to infection, including human rights abuses and socio-economic factors such as poverty and unemployment.

Disclosure of HIV status in the SANDF is still very challenging because the HIV/AIDS policy does not force the HIV-positive spouse to disclose their status to their spouse unless the spouse is at risk. Wilson *et al.* (2002: 439) indicate that counselling in this regard should continue throughout the entire therapeutic relationship. This call for a much closer and more personal relationship between the health professionals and patients. Patients should be encouraged to disclose their status and the health professional should offer to assist in the process of disclosure (Wilson *et al.* 2002: 439).

The issue of disclosure must be formalised to force the infected spouses to disclose their status, as this could save those spouses that have not yet been infected. It will also protect professionals at the Infectious Disease Clinic if they disclose a member's status to his/her spouse. This will increase the number of serodiscordant couples, and ensure that the seronegative spouse is prepared to take care of their HIV-positive spouse where necessary because HIV/AIDS illnesses are unpredictable. This will also help to minimise the number of orphans of HIV/AIDS. In the Infectious Disease Clinic married patients are encouraged to bring their spouses in to be their treatment buddies, and also to motivate their spouses to know their status, which is another way of motivating the HIV-positive spouses to disclose.

In the SANDF treatment of serodiscordancy is approached holistically and intervention plans are embedded in a multi-disciplinary team. The Infectious Disease Clinic plays a huge role in the treatment process by issuing and ensuring that ARVs are taken as prescribed, and offering counselling services on how to comply with ARV treatment. In addition, awareness campaigns and programmes form part of prevention intervention strategies and not only impact on the SANDF, but on the larger South African society.

The next chapter will focus on data analysis and empirical findings.

CHAPTER 3

RESEARCH METHODOLOGY, EMPIRICAL STUDY AND RESEARCH FINDINGS

3.1 INTRODUCTION

This chapter firstly outlines the research methodology of the study, and follows with a discussion on the ethical issues relevant to the study. The research findings are then presented and discussed. The empirical study was guided by the following research question: What is the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital?

3.2 RESEARCH METHODOLOGY

The discussion on research methodology includes the research approach, the type of research, the research design and methods, and the feasibility of the study.

3.2.1 Research approach

The researcher used a qualitative research approach for this study. According to De Vos, Schurink and Strydom (1998: 15), a qualitative approach is research in which the procedure is not strictly formalised, while the scope is more likely to be undefined, and a more philosophical mode of operation is adopted. A qualitative research approach involves fieldwork in which the researcher physically goes to the people to interview informants or observe behaviour in a natural setting (Streubert & Carpenter, 1999: 21-22). A qualitative research paradigm was chosen because of its systematic approach to capturing people's experiences and interpretation of events and circumstances. Streubert and Carpenter (1999: 21-22) state that qualitative research attempts to capitalise on the subjective as a means of understanding and interpreting human experiences. The researcher engaged

serodiscordant married couples participating in the Infectious Disease Clinic at 1 Military Hospital.

3.2.2 Type of research

This study was applied research because the findings imply a practical application to the observed concern. According to Durrheim (1999: 41), applied research aims to contribute to practical issues of problem solving, decision making, policy analysis and community development. Bailey (1996: 24) adds that applied research is interested in whether or not the results of the study can be applied to limiting certain problems. The goal of applied research is thus to develop solutions for problems in practice or to change troublesome situations (Fouché & De Vos, 2005: 105). Neuman (1994: 21) states that the application of the results of applied research may be beyond the researcher's control. As a result, the researcher has an obligation to translate findings from scientific technical language into the language of those who are going to make use of the findings (Neuman, 1994: 21).

In this study, applied research was used to explore the impact of serodiscordancy on couples among the married participants attending the Infectious Disease Clinic at 1 Military Hospital with the intended outcome to improve and/or develop new intervention and prevention strategies and programmes to address HIV serodiscordancy in the SANDF.

3.2.3 Research design and methods

This section will focus on the research design and methods, including the research population, sample and sampling methods, data collection methods and data analysis.

3.2.3.1 Research design

According to Durrheim (1999: 29), a research design is a framework for action that serves as a bridge between the research questions and the execution or implementation of the research. The research design also provides a plan that specifies how the research is going to be executed in such a way that it answers the research question.

The research design that was used in this study is the instrumental case study. According to Fouché (2005: 272) the instrumental case study is used to elaborate on a theory or gain a better understanding of a social issue. The interest is “in the process rather than outcomes, in context rather than a specific variable, in discovering rather than confirmation” (Henning, Van Rensburg & Smith, 2004: 41). The instrumental case study not only serves the purpose of gaining knowledge about the social issue, but can also help to understand the impact of serodiscordancy on married couples.

3.2.3.2 Research population, sample and sampling methods

A population is the total number of persons, events, organisation units, case records or any other sampling units with which the research problem is concerned (McBurney, 2001: 248). According to Babbie and Mouton (2001: 100), the population for a study is that group from which researchers want to draw conclusions, while McBurney (2001: 248) refers to the population as the sampling frame. The population for this study was all the married serodiscordant couples being treated at the Infectious Disease Clinic at 1 Military Hospital. The clinic has 2000 participants, 854 of whom are undergoing ARV treatment or therapy. Among these 2000 participants there are 100 serodiscordant married couples.

Sampling is a process during which decisions are made on what and how to sample (Kuru, in Talbot, 1995: 468). This involves selecting a group of people with whom to conduct a study. A non-probability sampling approach using the purposive

sampling method was employed to obtain a sample of informants (Polit & Hungler, 1999: 235).

Bless and Higson-Smith (1995: 86) define a sample as a subset of the whole population that is actually being investigated by the researcher. The sample is thus the group of individuals selected for research purposes who will represent the population. Of the population of 100 serodiscordant married couples, 20 couples were included in the sample.

In line with the qualitative nature of this study, the purposive sample method was used to draw the sample for the study. Strydom and Venter (2002: 207) state that this type of sample is based entirely on the judgment of the researcher.

To be eligible for inclusion in the study, spouses had to comply with the following criteria. They had to:

- be accessible to the researcher
- have been a serodiscordant couple for at least two years
- be within the age group 25-45
- speak of at least one of the following languages: English, Zulu, Northern Sotho, Tswana, Southern Sotho or Afrikaans. (The researcher can speak and read these languages.)

3.2.3.3 Data collection methods

Intuiting requires a researcher to become totally immersed in the phenomenon under investigation (Streubert & Carpenter, 1999: 49). It is the process whereby the researcher begins to know about the phenomenon as described by the informants, by being involved in the data collection and data management process (Streubert & Carpenter, 1999: 49).

Intuiting occurs when the researcher remains open to the meaning that informants attribute to a phenomenon and views it from an emic perspective (Polit & Hungler, 1999: 272). Streubert and Carpenter (1999: 49) argue that it is through imagination that new knowledge is discovered, and that data collection involves the researcher as instrument for data collection.

The data was collected by the researcher in face-to-face interviews. Borgan and Biklen (2003: 94) define an interview as a purposeful conversation, usually between two people but sometimes involving more that is directed by one person in order to get information. The researcher conducted semi-structured interviews to collect data. These interviews were guided by a semi-structured interview schedule (see Annexure A, attached). Greeff (2002: 302) emphasises that semi-structured interviews are especially suitable when the issue is controversial and personal. Serodiscordancy is controversial, complicated and personal.

It is important that the researcher collect valid and reliable data. Validity refers to the extent to which the information collected is true and represents an accurate picture of what is being studied. As stated by McMillan and Schumacher (1993:392): “Internal validity refers to the degree to which the explanation of phenomena matches the realities of the world.” This refers to the extent to which the findings of a given study are accurately described. In this study the research question, the aim of the study and its theoretical-conceptual perspective guided the research process for validity.

Reliability refers to the extent to which different researchers discover the same phenomena and how far the researcher and participants agree about the description of the phenomena (Merriam, 1991: 206). According to McMillan and Schumacher (1993: 386), reliability refers to “the consistence of the researcher’s interactive style, data recording, data analysis and interpretation of participants’ meaning from the data”. These writers further explain that, in qualitative research, the role of the researcher in the study should be identified and the researcher

should provide clear explanations to the participants (McMillan & Schumacher, 1993: 386).

In this regard the researcher's interaction with participants did not influence reliability, as she clearly identified her role and status. She did not offer personal opinions because that would have influenced participants towards a particular position, which in turn may limit reliability (Merriam, 1998: 206). Reliability of data was enhanced through the number of respondents used for this study, which was evident in the saturation of data.

The pilot study was conducted with two couples who were not included in the main study. There were no changes made after the pilot study as questions were clear and understandable to the couples.

3.2.3.4 Data analysis

Analysing data involves identifying the essence of the phenomenon under investigation, based on both the data obtained and how data is presented (Streubert & Carpenter, 1999: 52). Qualitative analysis is a process of fitting data together, of making the invisible obvious, and of linking and attributing consequences to antecedents (Polit & Hungler, 1999: 576). In qualitative analysis several simultaneous activities are performed, namely collecting information from the field, sorting the information into categories, formatting the information into a story or picture, and writing a narrative description of the results (Polit & Hungler, 1999: 576).

In analysing data, the researcher applied Wolcott's model or approach, which views data analysis as a tri-phased process, involving description, analysis and interpretation (Wolcott, 1994: 84). Wolcott (1994: 84) explains that analysis addresses the identification of essential features and systematic description of interrelationships among them, in short, how things work.

Data was analysed manually by the researcher using the Thematic Analysis Method, where themes are generated from the interpretation and from exploration of various statements and situations (McMillan & Schumacher, 1993). The researcher analysed and interpreted the data by deeply immersing herself in the interview transcripts, field notes and other collected materials (Rossman & Rallis, 2003: 270). This entailed fully knowing the data (immersion), organising the data into chunks (analysis), and bringing meaning to those chunks (interpretation) (Rossman & Rallis, 2003: 270).

The recorded interviews were transcribed. Greeff (2002: 304) maintains that a tape recorder allows for a much fuller record than notes taken during interviews. Greeff (2002: 304) further explains that using a tape recorder allows the researcher to concentrate on how the interview is proceeding and where to go next.

As the study in the Infectious Disease Clinic was conducted in different languages, the transcripts of all participant interviews were translated into English before data analysis. The guidelines provided by Creswell (1998) (in De Vos, 2005: 334) were used in the data analysis process.

Planning for recording

The researcher explained to the participants why she was using the tape recorder. The participants chose nicknames for anonymity when recording. The members loved the idea of nicknames and they gave nicknames from when they were young. It was easy for the researcher to use the chosen nicknames.

Data collection and preliminary analysis

The data was transcribed by following the themes and sub-themes identified during the data collection and the transcripts were kept in hardcopy.

Management and organisation of data

The hardcopies were filed according to the numbers they were labelled with during the interview. This made it easier to go back to any specific participant's data during the study and also for future references.

Reading and writing memos

The researcher read transcripts and notes repeatedly to familiarise herself with the content of the scripts.

Generating categories, themes and patterns

The researcher identified recurring themes and patterns that emerged from the data. From the themes, the researcher was able to identify subthemes.

Coding data

The researcher coded themes and subthemes.

Testing emergent understandings and searching for alternative explanations

The data was analysed through emerging information using themes and responses of the participants.

3.2.4 Feasibility of the study

According to Grinnell (1997: 58) a problem is researchable if it lends itself to solution by the research method (qualitative) in obtaining knowledge. In simple terms, feasibility of the study means how possible it is to conduct a study on the chosen research subject. Fouché (2002b: 121) indicates that all proposals should address the resources that are available and necessary for carrying out the study. She further indicates that all studies must develop an organisational plan, a work plan, a timetable schedule and a financial plan (Fouché, 2002b: 121).

The participants' contact numbers are available in their files at the Infectious Disease Clinic, so it was not difficult to contact them. The travelling cost was manageable because most of the Infectious Disease Clinic participants attend monthly follow-up visits to the doctors or the pharmacist. Those who do not attend monthly, especially the spouses who are not SANDF members and the spouses who visit the clinic only after six months, were interviewed at home on weekends. The researcher personally accepted responsibility for the costs of these visits. The majority of the participants, however, were interviewed in the hospital.

The researcher obtained permission to conduct the study from the following person/ bodies (see the following annexures attached):

- Annexure B: Section head of Infectious Disease Clinic
- Annexure C: Ethics Committee of the Faculty of Humanities, University of Pretoria
- Annexure D: Ethics committee of 1 Military Hospital

3.2.5 Ethical Aspects

Social research is about using human beings as the subjects of study. Durrheim (1999: 65) indicates that researchers need to protect the rights and welfare of such respondents. For the purpose of this study, the researcher took the following ethical issues into consideration.

3.2.5.1 Informed consent

According to Kumar, Mwamwenda and Dye (1999: 192), it is considered unethical to collect information without participants' knowledge. Their involvement and willingness to express consent are essential. The researcher requested that the respondents sign the informed consent form (see Annexure E, attached) before they participated in the study. This enabled the participants to make a voluntary decision on whether to take part or not.

Before the participants join the Infectious Disease Clinic, they have to sign a consent form giving their personal permission to have a full medical check-up conducted. Information about the purpose of the treatment is given on the consent form, and the advantages and disadvantages must be discussed prior to their signing the forms. Over and above this consent, the SANDF HIV/AIDS policy emphasises that informed consent must be obtained from the participant, whose medical condition is confidential, especially their HIV/AIDS status.

3.2.5.2 Deception regarding subject and respondents

According to Strydom (2002: 66), no form of deception should ever be practiced on respondents. In other words, withholding information to ensure subjects' participation is unethical. Neuman (2000: 229) states that deception occurs when the researcher intentionally misleads subjects by way of written or verbal instruction, through the action of other people, or through certain aspects of the setting. McMillan and Schumacher (1997: 194) state that "deception should be used only in cases where (1) the significance of potential results is greater than the detrimental effects of lying; (2) deception is the only valid way to carry out the study; and (3) appropriate debriefing, in which the researcher informs the participants of the nature of and the reason for the deception following the completion of the study, is used".

It would have been unethical for the researcher to hide the truth from participants. The researcher did not violate the protocol of the project by misrepresenting information crucial to voluntary participants. All the information the respondents should know before participating in this study was made available to and clarified for them. The participants knew the real purpose of the study, and the significance of the study, as well as its advantages and disadvantages. Serodiscordancy is a very sensitive topic to investigate. The participants were not forced to participate in this study or deceived into doing so. This was explained in detail to them by means of a letter of informed consent.

3.2.5.3 Violation of privacy, confidentiality and anonymity

The participants were guaranteed confidentiality and privacy so that they could participate in this study without fear. Strydom (2002:67) indicates that confidentiality, anonymity and privacy are synonymous.

Privacy is defined as that which is not normally intended for others to observe or analyse (Strydom, 2002: 67). According to Kumar *et al.* (1999: 193), certain types of information can be regarded as sensitive or confidential by certain people and revealing such information is thus an invasion of privacy. The researcher should tell the respondents the type of information that will be needed from them and give them enough time to decide whether they want to participate, without any major inducement. During this study, the researcher kept all the data interviews in a safe place to which access was restricted.

The issue of confidentiality was thoroughly addressed in the consent forms, which were signed by both the respondents and the researcher. During the interview, the respondents were verbally assured that the information gathered would be treated as strictly confidential. The researcher marked the data from respondents only for her own use in case she needed to have follow-up interviews with participants.

3.2.5.4 Harm to respondents

Strydom (2002: 64) indicates that emotional harm to subjects is often more difficult to predict and determine than physical discomfort, but often has more far-reaching consequences for participants. Kumar *et al.* (1999: 193) explain that harm includes not only hazardous medical experiments, but also social research that might involve emotions like anxiety, harassment and invasion of privacy, or demeaning or dehumanising procedures. Babbie and Mouton (2001: 471) mention that there could be concrete harm to the respondents' family life, relationships or employment situation. The fact that past negative behaviour may be called to mind during the investigation could be the beginning of renewed personal harassment or

embarrassment. For this reason, the researcher should have the firmest of scientific grounds if they extract sensitive and personal information from subjects (Babbie, 2004: 147).

The topic under investigation is very sensitive and the researcher is aware of the stigma associated with HIV/AIDS. This indicates that she made sure to avoid emotional harm. All the couples were engaged in a de-briefing session directly after the interview. The one couple who mentioned that they desire to have more children were referred to a gynaecologist and obstetrician. The researcher made sure that the relevant contact numbers of the psychologist at the Infectious Disease Clinic were accessible to the participants in case they needed counselling.

3.2.5.5 Publication of findings

Strydom (2002: 72) says that the researcher should inform subjects of the findings in an objective manner, without offering too many details or impairing the principles of confidentiality.

The researcher is expected to write a dissertation that will be available in the library of the University of Pretoria. In writing up the research findings, the researcher adhered to the principles of anonymity, confidentiality and objectivity so as to not compromise the participants' identities. A manuscript based on the findings of the study will be compiled for publication in an accredited journal. The disclosure of the publication details of the research findings formed part of the informed consent required from the participants.

3.3 RESEARCH FINDINGS

In this section the research findings will be presented and discussed. In the first section the biographical data of the respondents will be presented and discussed. The following section will present and discuss the themes and sub-themes that emerged from the data. Where applicable, the research findings will be

substantiated by literature. Twenty (20) couples were interviewed; thus 40 respondents (n) participated in the study.

3.3.1 Biographical data

The study focused on married couples. Nineteen couples were legally married and one couple was married according to customary law. The couple married according to customary law did not know that their marriage is regarded as legal. There is clearly a need to educate and empower society, especially in rural areas, regarding the fact that customary marriage is regarded as a legal marriage in South Africa.

The biographical data in this section includes the age of the respondents; their HIV status; the race profile of the respondents; their education levels; the number of their children; the position and age of their children; and finally their home language.

3.3.1.1 Age of respondents

The ages of the respondents ranged from 25 to 48. The majority of the respondents were between the ages of 31 and 48.

The respective age categories for males and females are captured in Table 1.

Table 1: Age of respondents (n=40)

| Age | Female | Male |
|-------|--------|------|
| 25-30 | 2 | |
| 31-36 | 8 | 8 |
| 37-42 | 8 | 8 |
| 43-48 | 2 | 4 |
| Total | 20 | 20 |

The respective percentages for the male and female respondents are depicted in the following figure.

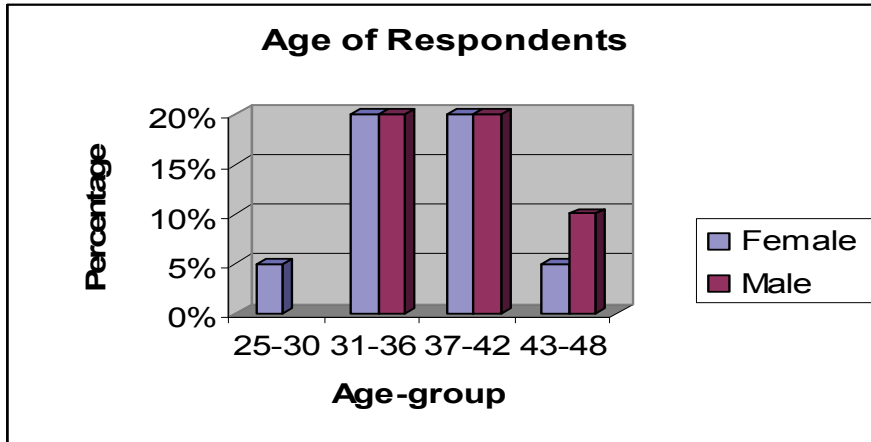


Figure 1: Age of respondents

Figure 1 indicates that many of the couples ($\pm 45\%$) are still of childbearing age, which could be a stressor in their marriage. There were no members above the age of 40 who said that they wanted children.

3.3.1.2 HIV status of couples

The distribution of the HIV status between the females and males of the couples is summarised in Table 2.

Table 2: HIV status of couples

| COUPLES HIV STATUS (n=20) | | | |
|---------------------------|------|--------------|------|
| HIV Positive | | HIV Negative | |
| Female | Male | Female | Male |
| 6 | 14 | 14 | 6 |

This table shows that six female respondents (30%) interviewed in this study were HIV-positive whilst 14 (70%) were HIV-negative. The opposite scenario applied to the male respondents, where 14 (70%) were HIV-positive and six (30%) were HIV-negative. There were thus more male HIV-positive partners in the study sample than females.

3.3.1.3 Race profile

HIV/AIDS knows no boundary nor gender or age group, and people are all equal before its eyes (cf. Seigile, 2000: 8), which is also evident at the SANDF Infectious Disease Clinic. However, the majority of the attendees of the Clinic are Africans. It should be taken into account that because of the change in the employment policy following affirmative action, more black people were recruited and employed in the SANDF post-1994. Indian, 'coloured' and white couples were approached to participate in the study, but they were either not interested or had work commitments. It needs to be acknowledged that some couples are financially more independent and can afford to go to a private doctor for treatment and management of HIV/AIDS. Being well informed about HIV/AIDS also plays a vital role in accepting and managing the virus, especially by not fearing the stigma and labelling of being seen at the Clinic.

3.3.1.4 Educational levels of couples

In Table 3 below, findings indicate that the majority of the respondents – 28, or 70% have standard 10 (grade 12), while two (5%) have N4 which is equivalent to a high school qualification and only 6 (15%) had tertiary qualifications. Only one respondent (2,5%) had standard 8 (grade 10) and three (7,5%) standard 9 (grade 11).

Table 3: Educational levels of couples

| Educational level | Male | Female |
|--------------------------|-------------|---------------|
| Standard 8 | 1 | |
| STD 9 | 1 | 2 |
| STD10 | 14 | 14 |
| N4 | 1 | 1 |
| N6 | 1 | 1 |
| Diploma | 1 | 1 |
| Degree | 1 | 1 |
| Total | 20 | 20 |

In the SANDF after 1994, the qualification did not matter as long as you were fit to be a soldier, so people never took furthering their studies seriously. The level of

education influences the income levels of SANDF members, which, in turn, makes them more dependent on resources within the working context.

3.3.1.5 Number of children per couple

With the exception of two couples, all couples had children. Half of the couples (50%) have three children, while one couple has four. The total number of children amongst the 20 couples is thus 38. Table 4 shows the number of children per couple.

Table 4: Number of children per couple

| Number of children per couple | |
|-------------------------------|----------------|
| Number of children (n=46) | Couples (n=20) |
| None | 2 |
| 1 | 2 |
| 2 | 5 |
| 3 | 10 |
| 4 | 1 |

3.3.1.6 Position and age of children

The age of the couples' children ranged from under five to over 21. Table 5 below shows that most of the children (34) are 18 or younger, which implies school-going age. The position of the children ranges from preschool or crèche, to studying at university and working. The profile of the position and age of the children correlates with the age categories of the respondents as indicated above (see 3.3.1.1.).

Table 5: Position and age of children

| Schooling/non schooling | Age group | Number | Percentage |
|-------------------------|-----------|--------|------------|
| Preschool/crèche | <5 | 11 | 55% |
| Primary | 6-14 | 14 | 70% |
| High school | 14-18 | 9 | 45% |
| University | >21 | 1 | 5% |
| Working | >21 | 2 | 10% |
| Unemployed | >21 | 1 | 5% |
| Total | | 38 | |

The majority of the couples were of childbearing age when they discovered their status. That is why their serodiscordancy poses a challenge to those who wanted

children and those who still want to increase the number of children they have. There were couples who indicated that they are planning to have children despite their serodiscordancy.

The study did not include a question on whether children have been tested for the HIV virus due to a risk of the HIV-positive mother transferring the virus to the child. Given the young age of more than half of the couples' children, it is a concern that children may be infected with HIV without knowing it if their parents, after conceiving, chose not to take an HIV test. Pregnant women attending the Antenatal clinic at 1 Military Hospital are advised, not forced, to test for HIV. It is thus possible that some of the children may have HIV, but neither they nor their parents will know this until the child becomes ill and is tested. In the case where the couple discovered their status when they conceived, females are given antiretroviral therapy that protects the baby from contracting the virus. The couples who had small children when they discovered their status were advised to test them; however, it is not known whether they tested their children. If they have not tested their children, it is even more of a concern because many couples' children do not know about their parents' serodiscordancy and would not suspect that they are infected if they are not well.

3.3.1.7 Home language

The most spoken languages amongst the respondents were Northern Sotho and Zulu, spoken by five couples (25%). Setswana and Xhosa were the second most popular languages, spoken by four couples (20%). Only one couple (5%) spoke Ndebele and one couple (5%) Southern Sotho.

Figure 2 (below) captures the language spread of the respondents

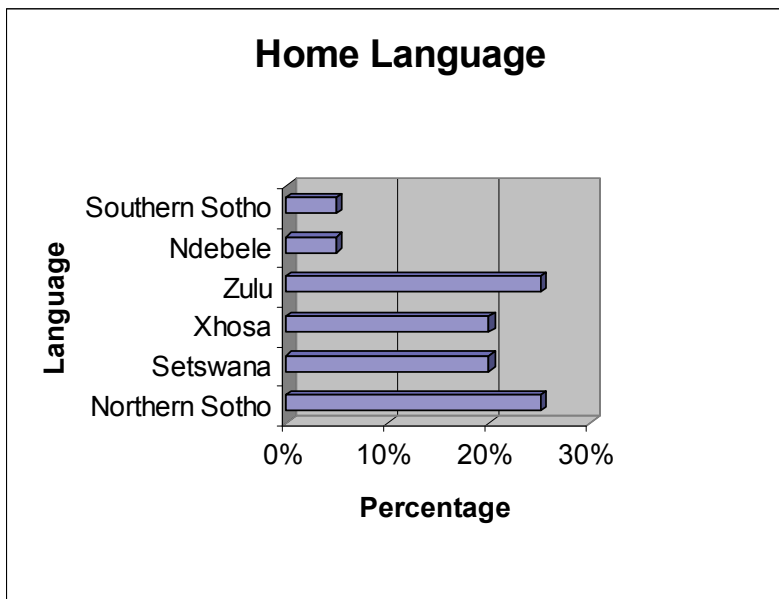


Figure 2: Home languages

All participants could understand English, as the questions were written in English. There were some who mixed English with their mother tongue when answering questions. The participants interviewed were allowed to speak a language that they felt comfortable expressing themselves with. The researcher could understand the languages because she is familiar with the languages spoken by the participants.

3.4 KEY THEMES

In the data analysis phase, there were recurring themes and sub-themes that emerged from the data. The themes and sub-themes were as follows:

Theme 1: Serodiscordant status

- Reasons for testing
- Disclosure and response

Theme 2: Marital relationship

- Intimate relationships

- Communication pattern
- Trust in relationship
- Blaming, guilt, anger and fear

Theme 3: Support systems

- Support system from spouse/ family/ supervisor/ friend
- Professional support

Theme 4: Coping strategies

- Family and parenting roles
- Health
- Discrimination
- Finances

Theme 5: Social services

- Accessibility and availability of the social worker in the SANDF
- Support groups
- Awareness programmes

Theme 6: Future planning

- Autonomy

3.4.1 Theme 1: Serodiscordant status

The findings show that couples discovered their serodiscordant status differently. Although the majority knew that they had a different status to their spouse, very few knew that they were called 'serodiscordant' couples. There was one couple who knew what the possibilities of them being serodiscordant couples meant, but the rest of the couples did not know why they are referred to as serodiscordant couples. The term 'serodiscordancy' was thus new to some of them. This shows the importance of awareness campaigns regarding serodiscordant couples. All the

couples knew about the modes of HIV transmission, which shows that awareness campaigns on this subject are known to most people in the SANDF and their dependents.

The sub-themes underpinning knowing their serodiscordant status are the following

3.4.1.1 Sub-theme 1.1: Reasons for testing

The couples had different reasons for testing their status. Some were forced to test because of the Concurrent Health Assessment (CHA) where all members of the SANDF are supposed to know their health status. Other couples discovered their status through other means. The following quotes indicate the way in which respondents discovered their status, or what prompted them to find out their status:

“I was doing CHA.”

“I wanted to know my status.”

“I had a rash.”

“I was pregnant.”

“I had gum problems.”

“I was told at Phidisa Clinic.”

“I became blind.”

“I took a policy.”

“I was renewing my contract.”

“I was ill.”

It is evident from the findings that SANDF members test for their HIV status for different reasons. According to the *Department of Defence Directives* (RSA, 2009: 2), it is policy that the health classification and management of SANDF members presenting with certain chronic medical conditions, including HIV/AIDS, are conducted in an efficient, simple and structured manner consistent with the principles set out in the General Regulations and the Department of Defence policy on the Management of HIV/AIDS.

3.4.1.2 Sub-theme 1.2: Disclosure and response

Aside from disclosure to their partners, five couples have not told anyone else of their status. Most of the infected members have disclosed their status to family members, including parents, siblings, nephews and nieces. Only one couple informed their entire family, including their children. The majority of the couples chose not to disclose their status to their children. Only one member informed his supervisor and one member his friends.

Upon disclosure, infected members received various responses. Three couples, who have not disclosed their status to anyone indicated that they were not yet ready, one couple said that they were far from relatives, and one couple did not trust their family enough to make their status known.

The one couple who informed the member's supervisor indicated that he was fully accepted and supported and was, despite his status, promoted. The couples who disclosed their status to family members all indicated that they were fully accepted and supported by their families. Not one couple who disclosed their status was rejected by those to whom they disclosed their status. However, acceptance by the partner did not come without a response of mixed feelings.

3.4.1.3 Response of partners on disclosure

Couples responded in a variety of ways when they heard their own and their spouses' status, ranging from acceptance, to anger, to blame, to questioning. Infected spouses, in the case of both male and female, were relieved about their spouse's seronegative status. The following responses reflect the views and feelings of the infected member and their spouse:

"I have accepted my status because there is nothing I [can] do about it."

"I was angry with myself."

"From whom did I get it."

“Why did it happen to me?”

“I think my husband deserves HIV/AIDS because he had many partners.”

“I think God gave my wife the virus to make us closer together because GOD gave me diabetes, [it] is the same as HIV/AIDS.”

“GOD gave me the illness to give me [a] second chance in life.”

“I was happy for my negative spouse.”

All the couples stated that they were initially affected when they heard about the diagnoses of their spouse, but that after they got counselling they were fine. All the spouses with a negative status indicated that they will always support their spouses. This includes the partner who felt her husband deserves to be HIV-positive because of his promiscuity. Most spouses provide emotional support by accompanying partners to their scheduled visits at the Infectious Disease Clinic. The general response of the seronegative partners can be captured in the words of one respondent:

“We live our life as [if] nothing is wrong, I never bring it up, we just continue in life as [if] nothing happened. I mean we don’t make an issue in our house.”

The fact that five couples have not yet disclosed their status to anyone, and that all but one have not revealed their status to their children, indicates the fear and stigma that is attached to disclosure. For those who only rely on one another for support, it is more difficult to cope when either or both of them suffer from burnout. Fesko (2001: 236) states that individuals who have begun to accept their diagnosis may disclose their HIV status as a coping mechanism to regain control over their lives and relieve the stress of not disclosing. Some couples have thus chosen not to carry their full burden alone by hiding the infected partner’s status. The findings indicate that disclosure is not only important for the infected individual, but also for the family to accept and motivate the couple, because it is not only the infected spouse who needs support, but also the affected spouse.

3.4.2 Theme 2: Marital relationships

All the couples indicated that their relationship has not had any negative impact on their family with regard to how they take care of the children and function as a family. This is contrary to the findings of Persson (2007) that the word ‘discordant’ suggests disharmony and tension. This, however, does not mean that the participants did not face a number of social, sexual and relationship challenges as the literature indicates (cf. Rolland 1994). The findings indicate that the couples have adapted their behaviour and functioning according to their serodiscordancy status as will be discussed under the following sub-themes.

3.4.2.1 Sub-theme 2.1: Intimate relationships

Rolland (1994) asserts that sensitive, open, direct communication about a range of issues is essential to living well with chronic disorders especially in HIV serodiscordant couples.

The couples indicated that the only time they were reminded that they are serodiscordant couples was when they wanted to make love and had to use condoms. Most couples indicated that condoms must be used until a cure is found for the virus. They indicated that female partners also take responsibility to use condoms. There were two couples who do not use condoms because they believe that God will protect them. Both couples indicated that the risks in this regard were pointed out to them by doctors and a social worker.

“Previously I was scared to make love to my husband but [now I] know I am fine.”

“I fear that the condom must not bust.”

“No changes”.

“Protect my negative spouse from getting the virus”.

“I am scared when making love”.

“My libido is low”.

“Not condomising. God will protect me from getting infected”

“When using condoms it takes long to get an erection”.

“We are active and I have no problems using condoms”.

“We are very careful”.

“I don’t use [a] condom with my wife because I don’t like [using] a condom.”

“I don’t love my husband because his behaviour destroyed the love I felt for him”.

“There is no sex, we are abstaining due to his ill health”.

3.4.2.2 Sub-theme 2.2: Communication pattern

Most couples indicated that their communication is better now as compared to before they knew their status, or that it has stayed the same. However, two couples indicated that their communication had been good but has now become bad, or that it had been bad and has now become worse. Some couples indicated that there were no changes in the communication patterns in their families. The couples who had improved their communication indicated that they discuss issues around HIV and healthy eating habits and that the infected spouse is reminded to take their ARVs, especially when they are on boosters. Most of the couples who have children who are 14 years and above indicated that they do talk about HIV/AIDS in their family even though they have not disclosed their status to their children. The couples voiced their views on their communication as follows:

“There [is] no changes in their communication.”

“Communicate the support to each other.”

“Better than before.”

“Did [not] change anything.”

“Communicate more now.”

“Good” / “Fine.”

“Was good, now [it] is bad.”

“Communication is not good.”

“No difference.” / “Same, no changes.”

“Nice now after discovering his status.”

The findings thus indicate that HIV serodiscordancy either has no influence on communication (meaning that the communication stayed as it was before their status became known – whether good or bad), that it negatively impacts their communication, or that it improves their communication. Persson (2007) confirms the importance of communication in terms of keeping the couple and family functional and healthy, and regards it as an imperative that should be encouraged.

3.4.2.3 Sub-theme 2.3: Trust in relationship

There were a few partners who either doubted their spouse or did not trust them at all. However, most of the participating couples indicated that they trust each other, as indicated in the following responses of the participants:

“I trusted my husband [for] 2 years of our marriage. After discovering his status I still do trust him.”

“I strongly trust my husband.”

“We trust each other.”

“[We are o]pen to each other.”

“I trust him 100%.” / YES.”

“Before knowing our status it [trust] was less now [it] is higher.”

The reasons for one spouse not trusting the other revolved around the sexual behaviour of the partner. An HIV-negative spouse indicated that she does not trust her HIV-positive husband because he continues to be promiscuous even after knowing his status. She was concerned that if he is not using condoms when having sex with his girlfriends and does not use condoms when making love with her, he will infect her. This particular partner refuses to use a condom when he has sex with his partner because he argues that he is not supposed to use a condom with his wife. She fears that he will end up being infected with HIV-2 (currently he is

infected with HIV-1) and that eventually he will infect her if he does not use condoms. During the interview the perceived promiscuous husband denied that he is promiscuous.

The finding indicates that trust is essential for couples to communicate and support each other and talk about their feelings. By sharing information, both partners engage in the emotional and practical management of HIV. Participants were of the opinion that there was a sense of a shared experience and a shared identity as an 'HIV couple'. Persson (2007: 4) says that HIV was often described as a bond: "It is something that locks us together... We understand each other".

3.4.2.4 Sub-theme 2.4: Blame, guilt, anger and fear

Couples and partners within a couple responded differently with regard to feelings of blame, guilt, anger and fear.

- **Blame and guilt**

Most of the seronegative partners indicated that they did not blame their partners for having contracted the virus because they claimed not to know how it was transferred to their partner. Only one spouse blamed her husband because of his bad sexual behaviour. The majority of the HIV-positive and HIV-negative spouses do not feel guilty about their status. They indicated that feeling guilty will not help them, but will put them back and cause stress in their family, which they do not want because of the HIV-positive spouse. There were, however, two couples who indicated that they do feel guilty and one spouse that sometimes feels guilty. The respondents mixed views are evident in the following responses:

"Do blame myself".

"Never feel guilty".

"Don't blame myself".

"Do feel guilty when my wife is angry with me".

“Husband does feel guilty”.

“Sometimes”.

Cichoki (2007) states that in serodiscordant couples the non-infected partner can sometimes feel guilty for being HIV-negative. The guilt increases if the HIV-positive partner becomes sick. Cichoki (2007) adds that in extreme cases the HIV-negative partner wishes they were infected, feeling that their infection would relieve the guilt and other stressors present in their relationship.

- **Anger**

The majority of HIV-negative partners indicated that they are not angry about the virus or with their HIV-positive spouse. As one respondent expressed it:

“Husband does not feel angry with me because of my ill health and drinking pills.”

With regard to how the HIV-positive spouses felt about themselves, only one indicated that he was very angry with himself for having the virus and for having to drink pills because his ill health deprives him of many opportunities. Clearly this respondent is projecting his anger more towards himself as opposed to focusing on the impact on his partner and family.

Cichoki (2007) argues that the level of anger is related to how the infection happened. Partners are angrier if the infection was due to unprotected sex or using intravenous drugs. The HIV-negative partner will feel angry, betrayed and sad due to the behaviour of their partner and the HIV-positive partner, in turn, feels angry with themselves that it happened (Cichoki, 2007).

- **Fear**

The fear of infecting the HIV-negative spouse was mentioned by all the HIV-positive females and males. The seropositive spouses fear that they will infect

their seronegative spouse if they do not use condoms correctly. As indicated earlier, there are couples who risk spreading the virus by not using condoms because of their belief that God will protect them:

“I don’t use condoms to my wife because I believe that God will protect me, as He did for [the] many years that we [have been an] HIV serodiscordant couple.”

Participants had a general fear that their infected partners would develop AIDS because they are too afraid to take ARVs. Other fears relate to the stress of coping with uncertainty about one’s future health, and loss of control over the future. These fears are in accordance with specific fears mentioned by Van der Walt and McKay (1991: 46-47), including that of becoming ill, anticipation of pain and disfigurement, and concern about the possibility of loss of supportive relationships, whether personal or social.

In the worst-case scenario, the couple may become overly cautious and avoid any intimate contact in fear of spreading the virus. Some couples indicated how lack of intimacy and fear of infecting the HIV-negative partner impacts on their intimate relationships. While it is not the most important part of a relationship, sexual intimacy is a key component of any loving relationship. Without intimacy, feelings of frustration, longing and resentment surface, and the relationship suffers (Cichoki, 2007: 4). Motang (1990: 16) asserts that all individuals with HIV/AIDS, and many of those closely associated with them, are experiencing extreme rejection and isolation due to the public’s fear of contamination.

3.4.3 Theme 3: Support systems

Most of the participating couples receive support from their partners, from their family and, in the case of one couple, from the infected spouse’s supervisor. The

participants that do not get support from their family because they have not disclosed their status to them, rely on professional support.

Xudu and Karstaed (2001: 8) state that HIV can exert a social, mental and physical impact on an individual and their environment. Levels of psychosocial distress are highest in the early stages of diagnosis of HIV infection. This is caused by anxiety about the repercussions of being HIV-positive (Xudu & Karstaed, 2001: 8). In this study, the infected partners received support from all levels where their status had been disclosed.

3.4.3.1 Sub-theme 3.1: Support from spouse/ family/ supervisor/ friend

The serodiscordant couples indicated that they get the most support from their partners. In addition, they experience the support of their family and, where disclosed, in the working environment. The level of support is thus directed at the infected partner, their spouse and larger family, as is indicated in the following responses:

“My wife is supporting me all the time”.

“When I am stress[ed] my wife is supporting me”.

“My whole family and husband, they are supportive always”.

“My family has not change[d], they are supportive and my wife accompanies me to the clinic”.

“My brother, wife and nephew are supportive, [and] never judge me”.

“My brother, cousins, wife and my in-laws [are] supportive to me”

“My wife, brother, mother in-law, sisters and some friends all know and [are] supportive”.

“Mother, father, wife and have not change[d], they [are] still the same towards me”.

“My whole family knows and they are supportive”.

“My parents and my supervisor they [help me] to function well at work and before disclosing to them I was always absent at work”.

“My sister and my wife they are normal did not change”.

The positive experience of being supported by loved ones prompted many of the infected partners in the study to feel loved and cared for and thus to be happy. The following responses are evidence to this effect:

“I am always happy”.

“Always taking care of me”

“Everybody loves me”.

“I am happy and I am promoted at work due to the support they gave me”.

The couples that have not disclosed their status to anyone outside their relationship only rely on each other for support. This brings additional stress into the relationship as they cope with their status.

3.4.3.2 Sub-theme 3.2: Professional support

The majority of couples, especially those that did not disclose their status to their families, rely on professional support from social workers, nurses, a psychologist, a dietician and doctors. The Infection Disease Clinic plays a huge role in providing this professional support, as summarised by one respondent:

“I feel better because I get help from the clinic”.

The serodiscordant couples see the multi-disciplinary team members when they come for their monthly visits to the Infectious Diseases Clinic at 1 Military Hospital. There is one social worker, one dietician and many doctors and pharmacists in the clinic. When they do not have enough medication, they report to the sister in charge to inform the pharmacist about their problem. For example, they might have lost the medication, or may need more medication due to their immediate deployment or their attendance of courses in another province. When they are not well or they have side-effects caused by the medication, they will ask to see the

doctor. It is compulsory for the social worker to see them for two to three sessions to prepare them for their medication if they qualify. Other than this they can show up at the clinic because they want to see the social worker due to their family circumstances or if a spouse is refusing to use a condom, for example. During their monthly scheduled visit they see the doctor and the pharmacist. Even when their partners and/or family provide support, infected partners still require professional services. However, they do not always make use of this, either because they are not aware of the support or because they do not want to use it for specific reasons. See Theme 5 for further discussion of social services.

Studies into social support and emotional well-being have shown that people with HIV/AIDS report low levels of depression and hopelessness if they have enough social support to discuss emotional and illness-related problems (Bor & Elford, 1994). Friedland, Renwick and McColl (1996) state that it is clear that coping and social support are potentially powerful sources that would help to alleviate the stressors associated with HIV/AIDS and influence infected people's quality of life.

3.4.4 Theme 4: Coping strategies

The couples were asked how they are coping on a daily basis with their serodiscordancy. The majority indicated that, given the circumstances, they are coping the best they can. With regard to their role in the family and as parents, most respondents indicated that not much has changed. The stressors that they have to cope with relate to their health, discrimination and finances. Leserman, et al (1992) describe 'coping' as the cognitive and behavioural efforts to adjust to or manage a specific external and or internal demand or perceived threat or stressor. The responses below indicate different ways participants respond to their stressors.

3.4.4.1 Sub-theme 4.1: Family and parenting roles

Most respondents and couples indicated that they were still committed to their family and parenting roles and responsibilities. They regarded themselves as the same parents they were before their serodiscordancy status became known. Some couples, however, were even more committed to promoting their family life. The following responses reflect respondents' views:

"I am still the wife [and] he is the husband."

"Loose family before [but] now we are a solid family."

"We are serious about our health as a family."

"We are a positive family focusing on life."

"Nothing had changed."

"Still guide and encourage our children like [we did] before knowing our status."

"Negative spouse took [out] insurances for our children to prepare [for] their future."

"Give our children more attention than before we knew our status."

3.4.4.2 Sub-theme 4.2: Health

The most pressing stressor for serodiscordant couples is the fear that the HIV-positive partner will develop complicated illnesses because their health status affects their work and impacts their finances. All the participants were aware that there is no cure for HIV/AIDS, but that there is medication to manage it so that they can prolong their lives. The following responses reflect how they cope with the fear of illness:

"I do not think about it".

"Gives me problem I cannot sleep at night sometimes".

"Sometimes I become angry".

"Have accepted my status"

“Managing it, I don’t think about it”.

“We support each other”.

“Subconsciously [it] is haunting me”.

“Sometimes when [I] am alone yes, I do think about my status”.

The above responses indicate that despite the support they get from their partners, family, at work and from professionals, and their perceived acceptance of their status (see theme 4), coping is a lonely and difficult process.

3.4.4.3 Sub-theme 4.3: Discrimination

Most participants indicated that they fear being discriminated against at work and that is why many participants did not disclose their status to their supervisor. The serodiscordant couples both experience discrimination because when people see them at the Infectious Disease Clinic, they assume that both are positive and that hurts the HIV-negative spouse. Deployment is another concern for discrimination because they have to provide their CD4 cell count before they are deployed. It is expected that SANDF members’ medical and health status are declared and recorded on the data base. This is perceived by the serodiscordant couples as discriminatory because it forces the employee’s – and, in effect, the couple’s – status to be known. The captured information is meant to enable the multi-disciplinary team members to access the information for further management, handling and counselling of patients. However, the expectation is that this information is confidential and that it should not be communicated beyond the purpose for which it is required. However, being refused deployment automatically exposes an employee to the risk that their supervisor will become aware of their status and as a result being discriminated against.

“I was not deploying because of my HIV status”.

“I am not attending courses because of my HIV status”.

“I [was] not promoted because of my positive HIV status”.

“I am negative but some of my colleague who sees me at the clinic with my positive wife they think I am positive too”.

“All people who are HIV-positive and those who have [incurable] illness are grouped in one company, [and it] is known that when you work in [that] company ... you have [either] HIV or [a] bad illness”.

3.4.4.4 Sub-theme 4.4: Finances

In the case of most couples, both partners are working and can afford to buy food and care for their families. One couple indicated that they are in debt because they live beyond their means. From the following responses, it can be concluded that couples cope in different ways with their finances, ranging from well to reasonably well. Some respondents are proactive by earning an extra income which helps them to be financially stable. Respondents' voices regarding their finances were as follows:

“Coping well”

“We are balance”.

“We are ok”.

“Good”.

“Better since we had [an] increase in March 2010”.

“Have a small business to help my husband”.

“Praying and God provides”.

“Struggling like any other person but we always have enough for living”.

“We are struggl[ing] bad[ly and] we don't sleep without proper food”.

“Battling and we are surviving”.

“We don't cope like I wish to be”.

“Not coping so well”.

“We are fluctuating”.

The findings indicate that all couples have money to survive. No couple indicated that they did not have food or that their children cannot go to school. Neither did

they indicate that they cannot afford it to come to the clinic for their follow-up visits. The financial position of the participants has not yet been seriously threatened by ill health.

A family's expenses increase when a family member becomes ill, resulting in food insecurity and ultimately the weakening of the nutritional status of the people involved. As such, HIV/AIDS intensifies poverty and negatively impacts family life and family relationships, as well as a family's access to school and economic resources (cf. Ramsden, 2002; Kelly, 2001; and Mokwelo, 1997).

3.4.5 Theme 5: Social services

The SANDF Phidisa Clinic (treating patients with HIV/AIDS) and the Infectious Diseases Clinic are key role-players in providing social and medical services, including those of the following professions: social workers, psychologists, doctors, nurses, community healthcare workers, pharmacists and dieticians. These professionals form the multi-disciplinary team that becomes directly involved with the patients. Within the social work context of this study, the question focused specifically on social services and the role of social work.

3.4.5.1 Sub-theme 5.1: Accessibility and availability of the social worker in the SANDF

Most participants indicated that they never consulted the social worker in their work units regarding their serodiscordancy or with their social problems. This, however, has to be seen in perspective. Some units do not have social workers, whilst in some cases the participants preferred not to go to the unit's social worker, but rather to consult the social worker at the Infectious Disease Clinic when they discovered their status.

The serodiscordant couple needs to consult a social worker after they discover their status for psychosocial preparation to face their family and cope with life.

Cowles (2000) affirms that serodiscordancy means a life change to the couple, and they need empowerment and motivation to be able to support each other.

From the below responses, it is clear that most participants do not see a social worker in their units for a variety of reasons, as indicated above. This is a concern because of the shortage of social workers, not only at the Infections Disease Clinic, but also in the units. Many couples indicated that their emotional distress, which can negatively impact on their relationship, was handled by the multi-disciplinary team members at the Infectious Disease Clinic. There are certain issues that specifically need a social worker to handle them, for example, the impact of marital problems on serodiscordant couples, with specific reference to assisting them with coping with the psychosocial aspects of the diagnosis. Cowles (2000: 12) explains that social workers in healthcare settings are concerned with the interaction of physical, psychological and social conditions of the client, both as causes and effects. The limited contact with social workers is observed from the following responses of participants:

“I don’t know the social worker in my unit”.

“Social work[er] is easily accessible but [I] did not consult with her”.

“Not available, his unit is far from home”.

“Yes is easy in the sickbays”.

“No social work in his unit”.

“Social work[er] did visit him when he was ill”.

“Use 1 Military Hospital Infectious Disease Clinic social workers”.

For those units where there are no social workers or the service of the social worker is not used or accessible, professional support will be compromised for serodiscordant couples. This is of great concern for the couples because, as Cowles (2000: 12) points out, a physical health problem can erode self-confidence or interfere with the ability to perform customary activities, which can affect marriage or other social roles and relationships. Social situations that imply life-

changing events, such as contracting HIV, produce emotional distress that can lead to changes in physical health functioning, which increases the couple's vulnerability to further illness (Cowles, 2000: 12).

3.4.5.2 Sub-theme 5.2: Support groups

Although the majority of respondents perceived a support group as an important tool to gain information by interacting with other participants who are in the same situation, not all indicated that they would like to be a member of a support group for serodiscordant couples.

Some of the respondents indicated that they were interested in having a support group exclusively for serodiscordant couples. Respondents who are in favour of a support group indicated the value of such a group lay in assisting them with disclosing their HIV status, whilst others regarded it as a platform where they can collectively share ideas and opinions on how to grow and cope with their illness. On the other hand, some respondents indicated that they would not like to become involved in a support group because it will reveal their HIV status, whilst others saw no purpose for a support group at all. The respondents' views on a support group for serodiscordant couples are reflected in the following responses:

“Yes we can get information [from each other]”.

“Will help but I don't want to attend because people will know my status.”

“Yes, [speak] the truth and share ideas with other couples who are in the same situation as us.”

“Never thought about it, I don't think there is anything to gain.”

“I don't think so”.

“It will not support me, I get support from my wife.”

“It will encourage us and motivate us.”

“I have no interest; I support my husbands' decision.”

3.4.5.3 Sub-theme 5.3: Awareness programmes

The respondents indicated that they did attend awareness programmes for uniform members or SANDF employees, but that these programmes do not include their spouses. These programmes discuss HIV/AIDS in detail, but serodiscordancy as a course is not discussed in detail, especially for non-medical employees. The spouses indicated that they want to participate in the HIV/AIDS programmes conducted by SANDF. The respondents indicated that awareness campaigns should also cover when and how parents can disclose their status to their children, and which professional can be consulted when they find it difficult to disclose. The participants mentioned the following programmes that they attended in the SANDF:

- *Masibambisane* programme (Let's hold hands against HIV/AIDS)
- Gender Equity Programme (GEP)

These programmes are compulsory for all SANDF uniform members to attend, and they empower members by providing detailed information regarding the origin of HIV/AIDS, prevention, replication and treatment. The programmes encourage infected members to get treatment, while HIV-negative members are encouraged to take care of themselves to avoid infection.

All the couples interviewed indicated that HIV/AIDS is undoubtedly a major problem facing the SANDF. They suggested that the SANDF's HIV awareness programmes should be extended to members' spouses, as it was only presented to the main members. They feel that this is not only going to help them; it will also help them to educate their children and their families regarding the virus.

3.4.6 Theme 6: Future planning

All the couples indicated that they were planning for their future. The couples wanted to see their children growing up and becoming independent and able to

care for themselves. Despite their serodiscordant status, they all see their future as bright. Those who did not have children and are trying to conceive through the assisted reproduction unit, wish to see their children grow and become parents.

3.4.6.1 Sub-theme 6.1: Autonomy

Respondents all agreed that persons with HIV/AIDS have the same rights to do and achieve what they want to achieve. Their serodiscordancy is not preventing them to achieve their dream and visions in their life. The majority of the serodiscordant couples said they can strive for and have a normal and healthy relationship.

Autonomy enshrines the right to self-governance and personal freedom, and the freedom to express one's own will in a community or society, (cf. Achmat *et al.*, 1997: 275; Pera & Van Tonder, 1996: 145; Spencer 2003: 15). Pera and van Tonder (1996: 145) further define autonomy as the individual's freedom to determine their own objectives and act accordingly. This implies that a person should be free to decide for themselves, on condition that their autonomy does not encroach upon the autonomy of others. Autonomy expresses respect for the unconditional worth of an individual and also respect for individual thought and action. Persons with HIV/AIDS are entitled to autonomy in decisions regarding marriage and childbearing, although counselling regarding their decision should be provided (Achmat ., 1997: 275).

3.5 CONCLUSION

This chapter was guided by the research methodology herein discussed. From the research data, six themes emerged, namely: serodiscordant status, marital relationship, support systems, coping strategies, social services and future planning. Findings were substantiated by the voices of the participants through direct quotes and, where applicable, integrated with literature. The next chapter will present the conclusions and recommendations of the study.

CHAPTER 4

CONCLUSIONS AND RECOMMENDATIONS

4.1 INTRODUCTION

The main aim of this chapter is to explain how the researcher achieved the goal and objectives of the study. The chapter will explain how the objectives were achieved by highlighting the main findings of the study. Conclusions will be drawn and final recommendations put forward based on the key findings of the study.

4.2 GOAL AND OBJECTIVES OF THE STUDY

The goal of the study was to explore the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital, with the intended outcome of informing intervention and prevention strategies and programmes for serodiscordant couples.

The research question that directed the research study was as follows:

What is the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at 1 Military Hospital?

The goal of the study was achieved through the following objectives:

Objective1: To contextualise and conceptualise HIV serodiscordancy within the SANDF.

Objective 1 was discussed in-depth in Chapter 2 (section 2.3) as part of the literature study, and in Chapter 3 (theme 1, sub-theme 2) as part of the empirical study. Key findings included the following:

- The HIV-negative partner in a serodiscordant couple is affected by the various modes of HIV transmission in the same way as any other person, including through contact with blood; mother-to-child; sharing needles or blades; and engaging in unprotected sex. The nature of work at the SANDF promotes exposure to HIV due to the deployment of members without their partners. The availability of alcohol in the deployment workplace is a further factor causing irresponsible behaviour leading to HIV infection.
- Women are more vulnerable to HIV infection due to the violation of women's rights, including their HIV-positive husband's choice not to use condoms, poverty and the nature of the migrant labour of the SANDF. Knowing their status does not only enable serodiscordant couples to prevent infection of the HIV-negative partner, but also ensures that infected partners start with early treatment. As in the case of HIV-positive people in general, serodiscordant couples struggle with the decision of whether or not to disclose their HIV status. Reasons common in the SANDF with regard to members finding it difficult to disclose their HIV status to their partners include discrimination and stigmatisation; fear of being rejected; the impact on their sexual relationship; blaming of the spouse; and ignorance as to how to disclose.
- SANDF members test their HIV status for different reasons, which include voluntary testing; testing during pregnancy; testing for deployment as the Concurrent Health Assessment (CHA), testing for contracts that require a health record; and testing at the renewal of employment contracts.
- The majority of serodiscordant couples were of childbearing age, and some still wanted children. Most of the couples who have children of 14 years and above indicated that they do talk about HIV/AIDS in their family, even though they have not disclosed their status to them.

Objective 2: To explore the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic with regard to their experiences, attitudes, behaviour, interaction and skills in dealing with serodiscordancy in their marital relationship.

Objective 2 was achieved through the review of the literature study in Chapter 2 (sections 3 to 6) and the empirical study in Chapter 3 (themes 1 to 4). Key findings included the following:

- Although the couples knew about their serodiscordant status, most of them did not know what serodiscordancy meant. The diagnosis of their status initially affected the serodiscordant couples very negatively; however, counselling played a major role in helping them come to terms with their status and start to support one another.
- Serodiscordant couples' experiences, attitudes and behaviour are influenced by stressors and factors such as cultural beliefs, blame, guilt, anger, fear and trust in the relationship. Anger and blame are linked to how the infection was contracted. Fear is attached to stigmatisation and discrimination, the possibility of infecting the HIV-negative spouse, and developing AIDS. Disclosure remains very difficult for serodiscordant partners and they mostly disclosed their status to close family members. Due to fear of discrimination, couples find it most difficult to disclose to their children, friends and supervisors at work.
- Cultural belief systems, of which traditional cultural beliefs and religious and spiritual beliefs are at the forefront, play an important role in determining serodiscordant couples' behaviour with regard to aspects such as protective sex and treatment.
- Trust is essential for couples to be able to communicate with and support each other. Communication is important for discussing issues surrounding HIV, healthy eating habits, and the taking of ARVs.
- Serodiscordant couples need coping skills on various levels, including dealing with their serodiscordant status; family and parenting roles; health management; discrimination, especially in the working environment; and increased expenses when health deteriorates and impacts on income and livelihoods.

- Coping skills are attached to the type of support systems serodiscordant couples have. Couples receive the most support from their partners and family because they mostly disclose to them. Although some discordant couples or spouses make use of professional support from social workers, nurses, psychologists, dieticians and doctors, it appears that social work services are not always available or not used due to specific reasons, including fear of discrimination.

Objective 3: To explore the role of the social worker in service delivery to serodiscordant couples within the SANDF.

This objective was achieved through the literature study in Chapter 1 (section 1.7) and theme 5 of the empirical study (Chapter 3). The key findings derived at were:

- At the SANDF Infectious Diseases Clinic, the social work is one of the role-players in the inter-disciplinary team, which also includes social workers, psychologists, doctors, nurses, community healthcare workers, pharmacists and a dietician. The social worker is the key role-player in providing social services and takes a central position in the multi-disciplinary team in providing a holistic perspective on problems and situations affecting serodiscordant couples. The social worker plays an important role in highlighting the social antecedents and consequences of illness and the need to deal with the larger picture in terms of the patient's family circumstances and social environment, which plays a vital role in the healing process.
- The social worker is part of the team that conducts awareness campaigns and educational programmes in the SANDF for all the uniformed members. The social worker plays a major facilitation role in organising the programmes and ensuring that these programmes empower members, providing them with detailed information regarding the origin of HIV/AIDS, infection prevention, replication and treatment. However, despite well-structured campaigns, there are newly-infected patients at the clinic on a weekly basis. Social workers are

not always available at the various SANDF units to provide professional support and/or social services due to their deployment or attending courses, or to the many vacant posts.

Objective 4: To set forth recommendations on intervention and prevention strategies and programmes for serodiscordant couples, based on the research findings and conclusions.

This objective is achieved in Chapter 4 and discussed below in sections 4.3 and 4.4.

4.3 CONCLUSIONS

The continuous infections rates reported by the Infectious Disease Clinic can either be attributed to the success of the Clinic's awareness campaigns and empowerment programmes where members come to the fore to be tested and assisted, or it can be seen as an indication of the prevalence of unprotected sex and exposure to HIV/AIDS and as a sign that more needs to be done in terms of prevention in the SANDF. Due to the ignorance displayed in the research findings regarding the meaning of serodiscordancy, awareness campaigns and empowerment programmes should include a section that focuses on this.

Whilst the cultural and religious belief systems must be understood and respected when assessing and implementing intervention plans with serodiscordant couples, professional team members, especially the social worker, are immensely challenged to contextualise the use of condoms in protection against infection and the use of treatment. Clark (2003) describes hope as giving inspiration and vitality to people. Faith in a higher power may help patients to make sense of their world and provide a foundation for daily decision making. Parsons *et al.* (2006) state that church attendance and religious practices and spiritual belief contributes to the individual's health in general and may hence benefit the patient. They also

suggest, however, that strong religious beliefs concerning sin and morality may also affect the individuals negatively by playing into the stigma attached to HIV/AIDS.

The fear of discrimination is no different in the SANDF than in the rest of the country. In fact, it is more severe because the SANDF is a working environment where employees' health, including HIV status, has to be recorded for deployment purposes. This not only impacts on disclosure, but it is also directly linked to the level of support that an HIV-positive partner and the serodiscordant couple will receive. In most instances the lack of disclosure limits the level of support of significant others, as well as from professional people, including social workers. However, it is still positive in terms of prevention if couples that do not disclose their serodiscordancy status to their children do at least talk about HIV/AIDS in their family. Rolland (1994) asserts that sensitive, open, direct communication about a range of issues is essential to living well with chronic disorders. Persson (2007: 1) concurs with Rolland's view that where couples are sharing information regarding serodiscordancy, they understand each other with regard to their different statuses and the things they are supposed to do as a serodiscordant couple. The communication helps to bring support, cohesion and better understanding of the serodiscordancy.

Empowerment programmes focusing on HIV/AIDS should impart knowledge, coping skills and guidance for couples to help them deal with their serodiscordant status, including disclosure and discrimination; marital and parenting roles; health management; building of trust; facilitating open and positive communication; and financial management.

Serodiscordant couples need empowerment programmes that will facilitate their learning of coping skills to deal with their HIV status and the related challenges impacting on their marriage; on other relationships in various contexts, and on their health and finances.

Counselling and other professional services have a positive impact on couples dealing with serodiscordancy. However, much more needs to be done to provide social services and support, especially with regard to access to a social worker in all units of the SANDF.

Treatment for serodiscordant couples at the Infectious Disease Clinic is accessible in terms of the relatively short waiting period to see a team member and having access to treatment. This prolongs the life of the infected partner, protect the HIV negative partner and prevent orphans in the family and community.

4.4. RECOMMENDATIONS

The following recommendations can be made from the study:

- Prevention strategies and empowerment programmes for serodiscordant couples should be based on a holistic, well-integrated intervention plan that contextualises strategies and programmes for prevention, treatment, counselling, empowerment and ongoing support of the employee, their spouse and their family, including home visits as required by the serodiscordant couple. Furthermore, the intervention plan should clearly conceptualise the role of each team member at both the Infectious Disease Clinic and the respective units of the SANDF, and the role of the social worker in particular.
- In view of the central position within the multi-disciplinary team taken by the social worker in the Military setting – both in the hospital and specifically in clinics such as the Infectious Disease Clinic – the social worker can coordinate the development of the proposed integrated intervention plan and facilitate the implementation, monitoring and evaluation of the plan under the auspices of the Infectious Disease Clinic.

- In addition to the social workers in the Infectious Disease Clinic and other clinics, social workers should also be permanently based in the different units of the SANDF to implement the proposed integrated plan. For this role, social workers need additional training in the physiological and psychosocial implications of serodiscordancy, as well as knowledge and skills in counselling and establishing support groups for serodiscordant couples.
- Finally, additional research should be done on the following themes:
 - The success of the awareness campaigns and empowerment programmes in preventing new infections and facilitating testing for HIV infection which is important for the development and implementation of an integrated intervention plan of counselling, treatment and developing coping strategies.
 - The SANDF policy which oblige members who want to attend courses or want to be deployed internationally to reveal their HIV status. This policy should be challenged in relation to the impact of disclosure on discrimination and stigmatisation; members' right to confidentiality and access to extra money when deployed, and to promotion when they attend courses.

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ANNEXURE A :

SEMI-STRUCTURE INTERVIEW SCHEDULE



SEMI-STRUCTURED INTERVIEW SCHEDULE Serodiscordancy couples

Research topic

The impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic in the 1 Military Hospital.

Goal of the study

The goal of the study is to explore the impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at the 1 Military Hospital, with the intended outcome of informing intervention and prevention strategies and programmes for serodiscordant couples.

BIOGRAPHICAL DATA

1. Age

| | | | |
|-------|-------|-------|-------|
| 25-30 | 31-36 | 37-42 | 43-48 |
|-------|-------|-------|-------|

2. Ethnicity (for equity purposes)

| | | | |
|---------|-------|----------|-------|
| African | Asian | Coloured | White |
|---------|-------|----------|-------|

3. Marital Status

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

4. How many dependents do you have?

| Number | | Ages |
|--------------|--|------|
| None | | |
| 1-2 children | | |
| 3-4 children | | |
| 5-6 children | | |
| 7+ children | | |

5. Formal educational level

| | |
|--------------------------|--|
| Illiterate | |
| Sub A-B (Grades 1-2) | |
| Standard 1-2 (Grade 3-4) | |



| | |
|-----------------------------|--|
| Standard 3-4 (Grade 5-6) | |
| Standard 5-6 (Grade 7-8) | |
| Standard 7-8 (Grade 9-10) | |
| Standard 9-10 (Grade 11-12) | |
| N1-N2 | |
| N3-N4 | |
| N5-N6 | |
| ABET level 1-2 | |
| ABET Level 3-4 | |
| ABET Level 5-6 | |
| Diploma/certificate/ degree | |
| Others, specify | |

6. Home language

| | |
|-----------------|--|
| Ndebele | |
| Zulu | |
| Swati | |
| Xhosa | |
| Setswana | |
| Northern Sotho | |
| Southern Sotho | |
| Tsonga | |
| Venda | |
| English | |
| Afrikaans | |
| Others, specify | |

THE IMPACT OF HIV SERODISCORDANCY

Serodiscordant status

- Why did you decide to test for HIV/AIDS?
- How did you feel when you discovered your status?
- How long after getting to know your status did you tell your spouse?
- When your spouse disclosed her / his status, what was your first response?
- What do you think the reasons for your HIV serodiscordancy status are?
- How informed are you about HIV/AIDS and its modes of transmission?



- Have you told your children about your status? If yes, how did they respond?
- If you have not told them yet, when do you intend to do so?
- What have you decided about disclosing your status to close/important people in your lives?

Marital relationship

- How is serodiscordancy affecting your marriage?
- How would you describe your communication with each other before knowing your serodiscordancy status and afterwards?
- How does your serodiscordancy status influence your sexual practice and intimate relationship?
- How would you describe the level of trust in your relationship before and after knowing your serodiscordancy status?
- To what extent is your relationship influenced by blame; feelings of guilt and anger towards your spouse or yourself?
- To what extent do you manage and support each other in maintaining a healthy life-style?
- Has your marital relationship been influenced in any way by the reaction of friends or loved ones to your serodiscordancy status?

Family relationships

- How would you describe your family relationships before and after knowing your serodiscordancy status?
- How has your serodiscordancy status influenced your/ your children's family roles and responsibilities?

Coping strategies

- How do you cope with your serodiscordancy status on a daily basis?
- What or whom do you regard as your support systems? To what extent do they meet your expectations?



- Have you sought professional assistance since you heard about your serodiscordancy status? If so, what are the nature, expectations and experience of this help?
- What kind of support or assistance do you get from your husband's/wife's employment unit?
- How do you feel about the availability, accessibility and services of the social workers in the SANDF?
- How do you cope as a family financially, emotionally and socially?
- Do you think the Support Group for HIV Serodiscordancy can help you? If so, in what way?
- How familiar are you with the HIV and AIDS programmes conducted in the SANDF?
Do you think HIV and AIDS awareness programmes should be extended to the uniformed member's spouse?

General

- What are the key things that have changed in your life from before to after your serodiscordancy status? How do you see your future?

THANK YOU FOR YOUR PARTICIPATION

ANNEXURE B:

CONSENT: SECTION HEAD OF INFECTIOUS DISEASE CLINIC
AT 1 MILITARY HOSPITAL

Tel No: (012) 314 0999
Enq: Capt P. Mabuza



1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143

September 2008

AUTHORIZATION OF CAPT POPPY MAHLANGU-MABUZA TO CONDUCT A STUDY ON PATIENTS AT 1 MILITARY HOSPITAL

1. Capt P. Mabuza would like to conduct a study on HIV positive members at 1 Military Hospital.
2. The study is entitled: "The impact of HIV sero discordancy among married couples attending the infections disease clinic at 1 Military Hospital".
3. After reading the protocol a conclusion was reached that the subject was quite important to our understanding of this subject of discordancy, in HIV positive patients.
4. It is therefore strongly recommended that this member be allowed to conduct this study.
5. It is also advised that this member contact the ethical committee of 1 Military Hospital about this proposal.


(A. RATSELA)

CHIEF SPECIALIST PHYSICIAN 1 MILITARY HOSPITAL: COL

For Action

ETHICAL COMMITTEE MILITARY HOSPITAL: (Attention: Lt Col M. Baker)

For Info

GOC 1 Military Hospital



ANNEXURE C:

CONSENT: ETHICS COMMITTEE OF THE FACULTY OF HUMANITIES,
UNIVERSITY OF PRETORIA



Our Ref: Ms P Woest / 9381295
Tel: 012 420 2736
Fax: 012 420 2698
Email: petru.woest@up.ac.za



Pretoria 0002 Republic of South Africa
Tel: 012 420 3111 Fax: 012 420 2698
<http://www.up.ac.za>

Faculty of Humanities

12 November 2009

Ms PL Mahlangu
PO Box 1171
Silverton
0127

Dear Ms Mahlangu

TITLE REGISTRATION: FIELD OF STUDY – MSW: HEALTH CARE

I have pleasure in informing you that the following has been approved:

TITLE: The impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at the 1 Military Hospital

SUPERVISOR: Prof A Lombard

CO-SUPERVISOR:

I would like to draw your attention to the following:

1. **ENROLMENT PERIOD**

- (a) You must be enrolled as a student for at least one academic year before submission of your dissertation/essay.
- (b) Your enrolment as a student must be renewed annually before 31 March, until you have complied with all the requirements for the degree. You will only be able to have supervision if you provide a proof of registration to your supervisor.

2. **APPROVAL FOR SUBMISSION**

On completion of your dissertation/essay enough copies for each examiner as well as the prescribed examination enrolment form which includes a statement by your director of studies that he/she approves of the submission of your dissertation/essay, as well as a statement, signed by you in the presence of a Commissioner of Oaths, must be submitted to Student Administration.

3. **NOTIFICATION BEFORE SUBMISSION**

You are required to notify me at least three months in advance of your intention to submit your dissertation/essay.

4. **INSTRUCTIONS REGARDING THE PREPARATION OF THE DISSERTATION/ESSAY AND THE SUMMARY APPEAR ON THE REVERSE SIDE OF THIS LETTER.**

Yours sincerely

for DEAN: FACULTY OF HUMANITIES

ANNEXURE D:

CONSENT: ETHICS COMMITTEE OF 1 MILITARY HOSPITAL



Tel: 012 314 0487
Facsimile: 012 314-0013
Enquiries: Lt Col MK Baker



1 Military Hospital
Private Bag X1026
Thaba Tshwane
0143
September 2009

CLINICAL TRIAL APPROVAL, PROTOCOL TITLE: “THE IMPACT OF HIV SERODISCORDANCY ON MARRIED COUPLES ATTENDING THE INFECTIOUS DISEASE CLINIC AT 1 MILITARY HOSPITAL”

1. The 1 Military Hospital Research Ethics Committee (1MHREC), comprised of the following members, and adhering to GCP/ICH and SA Clinical Trial guidelines, evaluated the above-mentioned protocol and additional documents:

- a. Lt Col M.K. Baker: Neurologist, male, chairman 1MHREC.
- b. Col H. du Plessis: Surgeon, male, member 1MHREC.
- c. Col H. Ingram: Anaesthetist, male, member 1MHREC.
- d. Lt. Col. D. Mahapa: Dermatologist, female, member 1MHREC
- e. Lt Col L. Hofmeyr: Otorhinolaryngologist, male, member 1MHREC.
- f. Ms C. Jackson: Layperson, independent of the organization, female, member 1 MHREC.

2. The following study protocol was evaluated “The Impact of HIV Serodiscordancy on Married Couples Attending the Infectious Disease Clinic at 1 Military Hospital”, including Appendices labelled “Semi-Structured Interview Schedule Serodiscordancy Couples” and “Informed Consent”.



3. The recommendations are:

The study was ethically approved on 04 September 2009. The principal investigator will be Capt P.L.Mabuza. Report backs are to be made to the 1MHREC six monthly, in the event of any serious adverse event and on completion or termination of the study. Any study protocol amendments will need to be separately approved. A copy of any eventual publication arising from the study must be submitted to the 1 MHREC. Capt P.L. Mabuza is to submit a current curriculum vitae of herself to the 1 MHREC. *

(M.K BAKER)
CHAIRMAN 1 MILITARY HOSPITAL RESEARCH ETHICS COMMITTEE: LT
COL/ PROF

DIST

For Action/Info

Capt P.L. Mabuza

Curriculum vitae received 11/09/2009.
MKB

ANNEXURE E:

PARTICIPANTS' INFORMED CONSENT FORM

25/11/2010

Our Ref:
Researcher: Poppy L Mahlangu
Tel: 083 412 3286
E-mail: pmahlangu@phidisa.org

RESEARCH PARTICIPANTS: INFORMED CONSENT

1. **Study title**

The impact of HIV serodiscordancy on married couples attending the Infectious Disease Clinic at the 1 Military Hospital.

2. **Purpose of the study**

The goal of the study is to explore the impact of HIV on married couples attending the Infectious Diseases Clinic at 1 Military Hospital with the intended outcome to inform intervention and prevention strategies and programmes for serodiscordant couples.

3. **Procedures**

I understand that the semi structured interview will be scheduled based on the availability of the researcher and myself. I also understand that the interview conducted by the researcher will take about one hour of my time. I am aware that the interview involves my views regarding the impact of HIV serodiscordancy on marriage. I am aware that I may be approached for a follow-up interview should the researcher want to clarify any data. I understand that the research will be written up in a research report for the University of Pretoria and that the research findings will be made known to the Infectious Diseases Clinic in order to improve their services delivery.

4. **Risks and discomforts**

As a participant I understand that the interview conducted will not be used against me as was confirmed by the researcher. I also understand that I can request to be referred to a therapist should the interview evoke feelings and emotions which I have to work through.

5. **Benefits**

I was informed by the researcher that there are no direct benefits to myself or other participants in the research and I also understand that the research findings and recommendations may be considered in order to improve the service rendered by the Infectious Disease Clinic to HIV serodiscordant couples.



6. Confidentiality

I understand that information collected during the interview will be treated as confidential since no names will be disclosed in the research findings. I further understand that only the supervisor and the researcher will have access to the data. I further understand that information collected will only be used for data analysis and that it will be kept by the University of Pretoria for a period of 15 years, where after it will be destroyed. I understand that my informed consent will be obtained if the data is to be used for further research during this period.

7. Participants' rights

I understand that my participation is voluntary and that I may withdraw from participating in the study at any time and without negative consequences. I understand my rights as a participant and I therefore voluntarily agree to participate in the study. According to my understanding, the researcher will provide me with a copy of this informed consent letter as soon as both of us have signed it. I understand that I will be informed of the time and the venue of the interview. I understand that that interview will be audiotape. I take note that the cassette and transcripts will be kept in a secure place by the University Of Pretoria for a period of fifteen years and will only be used by the researcher for research purposes. My understanding is that the data will not be used for further research without my consent.

Signed on (date) at(place)

.....

Signature of the participant

Signed on (date) at(place)

.....

Signature of the researcher