



The support systems offered by the sexual partners of people living with HIV/AIDS: A qualitative study

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ARTICLE INFO

Keywords:
Condom
Disclosure
HIV/AIDS
PLWHA
Sexual partner
Support

ABSTRACT

Introduction: People living with HIV/AIDS (PLWHA) face several stressors. It is important that they get both physical, emotional, spiritual, and psychosocial support. Sexual partners are highly encouraged to offer the needed support, since, disclosure of one's HIV status to a sexual partner can have significant health implications, that are necessary to assist in reaching the goal of an AIDS-free generation. However, little is known about the support systems offered by sexual partners.

Aim: The study aimed to explore the support systems offered by the sexual partners of people living with HIV/AIDS at selected primary health care clinics in Mpumalanga.

Setting: The study was conducted in three primary health care facilities offering comprehensive HIV care in the Nkangala district, Mpumalanga province South Africa.

Methods: The study was qualitative. Purposive sampling was utilized to select 11 patients who were on antiretroviral treatment and receiving care from the selected primary health care facilities. The semi-structured individual interview was used to collect data. Data were analyzed using Tesch's method. Trustworthiness was ensured, and ethical principles were upheld.

Results: The study findings revealed three themes describing how PLWHA are supported by their sexual partners to adhere to HIV/AIDS management; The findings show that sexual partners of people living with HIV/AIDS use various support systems to encourage adherence to HIV/AIDS management.

Conclusion: The findings highlight the importance of sexual partners' support systems towards HIV/AIDS management adherence. It is therefore important for health care providers to explore ways in which sexual partners can be encouraged to provide support to their partners.

1. Introduction and background

HIV continues to be a major global public health burden. United Nations Programme on HIV/AIDS (UNAIDS) reported that at the end of 2020 an estimated 38.0 million people throughout the world were living with HIV (Global, 2021). South Africa remains a high HIV epidemic country (Avert, 2022). It is reported that in 2020, 7.8 million people were living with HIV, of whom 230,000 are new infections (Avert, 2022). World Health Organization (WHO) recommends offering testing for partners or couples and voluntary assisted HIV partner notification services as a simple and effective way to reach sexual partners, and increase maximal holistic support and associated treatment outcomes for

people living with HIV/AIDS (PLWHA) (WHO, 2020). Disclosure of HIV serostatus to a sexual partner is encouraged to receive necessary support when needed. South African national department of health support PLWHA to disclose their HIV serostatus to sexual partners in order to achieve the 95-95-95 target set by the UNAIDS. These targets means that 95% of people living with HIV should know their status, 95% of people who know their status should be on HIV treatment, and 95% of people on HIV treatment should have a suppressed viral load by 2030. In South Africa, further couple testing and counseling were adopted as one of several strategies to promote and encourage sexual partners support of any form.

HIV support is the help that PLWHA receive from his or her social

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<https://doi.org/10.1016/j.ijans.2023.100562>

Received 16 September 2022; Received in revised form 26 February 2023; Accepted 11 March 2023

Available online 15 March 2023

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networks, such as family, sexual partner, friends, community, organizations, and co-workers (Uchino, 2009). HIV support can come from family, friends, health care system and any other sources, however, it is perceived that a sexual partner HIV-related support is more valuable than support from other types of relationships (Mabachi, et al., 2020). According to Triulzi et al., (2022), sexual partner support plays an important role in retaining PLWHA taking treatment. Supportive relationships can have direct positive effects on health and mitigate the negative impact of stressors (Skakoon-Sparling, et al., 2022). In the study that investigated relationship dynamics, partner support and adherence to antiretroviral therapy among South African couples, primary partners were generally described as having a positive influence on adherence by providing instrumental, informational and emotional support (Conroy, et al., 2017). It is obvious that PLWHA get more motivated and manage well when they receive support from sexual partners compared to those without support (Dessaiegn et al., 2019). According to Burton et al. (2010), these couples are more likely to participate in motivational and educational sessions that deal with sexual interventions on risk behavior. Therefore, high levels of sexual partner support are needed to prevent the spread of HIV infection to uninfected partners and to prevent the re-infections.

Although, sexual partners are encouraged to support their HIV positive partners, Adeniyi, et al., (2021) study identified that PLWHA's are rejected, stigmatized and violated by their sexual partners instead of getting support. Waldron et al., (2021) reported that individuals living with HIV/AIDS face several stressors that affect them physically, emotionally, spiritually, and psychosocially. These stressors are experienced at the individual, family, and community levels, some of which are cross-cutting (Nyongesa et al., 2022). Hence, it is reported that patients who receive limited HIV support often experience social damage, poor adherence, increased risk-taking behaviors, poor compliance and are prone to additional psychosocial problems (Berhe, et al., 2022).

Therefore, having support from a sexual partner can make it easier for the PLWHA to manage the challenges of living with HIV.

Although substantial evidence documents sexual partner disclosure benefits, limited information exists on the support systems offered to the PLWHA by their sexual partners. We aimed to explore the support systems offered by the sexual partners of PLWHA in Ekangala district, Mpumalanga province, South Africa. Knowing the support systems offered.

2. Methods

2.1. Setting

The study was conducted in three Primary Health Clinics in Victor Khanye local municipality, Ekangala district, Mpumalanga province, South Africa. The Victor Khanye is a category B municipality. The total population is approximately 75 452 (Statistics South Africa, 2022). There are three public clinics and one hospital. These clinics render services such as maternal and child healthcare services, primary mental healthcare services, primary oral health services, chronic diseases care, allied and rehabilitation healthcare services, and youth-friendly services. HIV/AIDS. Both primary health clinics operate eight hours (08 h00 to 16 h00) per day from Monday to Friday. The majority of community members are black and have high rates of poverty and chronic diseases, including HIV infection. The clients who receive HIV and AIDS services have mostly been diagnosed by any of the three PHCs, private doctors, feeder hospitals, and other healthcare facilities, including voluntary testing campaigns within the community. The majority of the people live in Reconstruction and Development Program (RDP) houses. Reconstruction and Development Programme is a South African socio-economic policy framework, whereby housing, clean water, electricity, health care is provided free for the disadvantaged communities (Lodge, 2003). It was implemented in 1994.

2.2. Participants and sampling

The participants of this study were males and females' adults, who were 18 years and above. All of them were receiving HIV/AIDS care in either of the three primary health clinics for at least a year. We purposely recruited the patients that disclosed the HIV serostatus to their sexual partners and received a support system of any form from their sexual partners. Upon approval from the clinic manager, participants were recruited through HIV/AIDS program. A brief explanation about the study was provided to patients on an individual basis while waiting to receive their monthly care. Those interested were informed to contact the researcher who was in the clinic for the day. Thereafter, they were interviewed per appointment after completing the informed consent form. Efforts to enhance the geographical and gender presentation of potential participants were made during the recruitment period. We ensured that there are at least three participants from each clinic and one of them is a male.

2.3. Data collection

The data were collected between June and November 2019, through semi-structured individual interviews. The interviews were conducted in a private conference room of each clinic. The interviews lasted 30 to 45 min depending on the provided information and probing. The interviews were done in English or local language depending on the preference of the individual participant. Data saturation was reached with the eighth participant when no new information was shared. However, however, extra 3 participants, 1 from each facility was interviewed to ensure that any data is not missed. All the interviews were audio recorded after seeking consent from all participants and professionally transcribed. A professional translator was sought to translate the interviews conducted in the local language to English during transcription.

2.4. Data analysis

Tesch's method of data analysis was used to organize and analyze data (Tesch, 1990). Several steps were followed to finalize data analysis and develop codes, categories and sub-categories. Initially the first author transcribed data from all the participants. The transcripts were read several times to identify codes and themes by the first author and discussed it with the two co-authors. The independent coder experienced in coding qualitative data was consulted to co-code and confirm the emerging codes and themes. The discrepancies in coding were then discussed between the researchers and the independent coder until an agreement is reached. The steps followed during data analysis involved the following:

Step 1: Reading of transcripts - all the transcripts were carefully read to obtain a sense of the whole. Step 2: Use a single transcript - the researchers picked one interesting and short transcript out of the pile of those already read. He re-read the transcript and jotted down his thoughts in the margins. This was to sort out the underlying meaning of what the data were saying. Step 3: Making a list of topics - all the transcripts were read again and a list of all topics/themes that emerged during Step 2 was generated and listed. Similar topics were grouped together. Columns were developed with significant topics/themes, unique topics/themes, and leftovers. Step 4: Abbreviation of topics into codes and applying them to the data - the topics were abbreviated as codes and written next to appropriate segments of the text. This was done to see whether new categories and codes emerge. Step 5: Developing categories - the most descriptive words, sentences, and paragraphs were turned into categories, which were more abstract than the words. Each category was named and logically related to the data.

Step 6: Finalization of categories and codes - categories and codes were then arranged alphabetically. Step 7: Preliminary analysis - data material belonging to each category was assembled in one place and

performed preliminary analysis. Step 8: Re-coding existing data – the available data during recoding was used to develop sub-categories. Relevant passages and quotations were brought together and organized into codes that are relevant to one or more of the identified categories. The available data were re-coded to develop sub-categories and themes (Polit & Beck, 2017).

2.5. Trustworthiness

The researchers established trustworthiness by conducting steps as discussed by Korstjens & Moser (2018). The student was trained on how to collect data by supervisors and supervisors acted as peer reviewers every time after data collection to ensure that the collected data is rich and accurate to the study, thus ensuring credibility. Moreover, all researchers transcribed audio-recorded data verbatim.

In this study, transferability was achieved using the purposive sampling method, collecting data on only participants who met the criteria and using Atlas ti software to import transcripts for ensuring replication of the study by other researchers. Dependability was enhanced by regular peer debriefing among researchers. All original written informed consent forms are kept under lock and key so that they could be produced when necessary for an audit. This was done to ensure confirmability.

2.6. Ethical consideration

Before conducting the study, ethical clearance was obtained from the University of Pretoria, Faculty of Health Sciences Research ethics committee. Permission was also obtained from Mpumalanga department of health, Chief Director of the district, sub-district manager, the operational managers of the primary health care settings, and the participants. The participants signed informed consent form prior to the interviews. The research was conducted in accordance with the Helsinki Code of Conduct, adhering to the principles of beneficence and non-maleficence, justice, anonymity and confidentiality.

3. Results

3.1. Participants characteristics

The participants for this study were eleven in number. Three were males, while eight were females. The age range of the male participants was 26–38 years and the age range of the females was 18–48 years. All the participants have been diagnosed with HIV prior to the study and were on ART and HIV/AIDS care for more than a year. All of the participants had disclosed their HIV status to their most recent sexual partner and receiving a support from the partner. Four of the females learned of their diagnosis during pregnancy. Two females and one male knew of their positive status when receiving services related to a specific health condition, while two females and two males were diagnosed during couple and partner counselling and testing health services. All eleven participants had sexual partners and were sexually active during data collection. Two were speaking Sepedi, four Zulu, one Xhosa and four Ndebele.

The interviews with participants revealed three themes describing how PLWHA are supported by their sexual partners to adhere to HIV and AIDS management. The themes included disclosure of HIV status support, safer sexual practices support, partner support on adherence to ART.

The study followed Tesch’s method of data analysis was used to organize and analyze data. The study had 3 main themes and related sub-themes emerged during data analysis, as detailed in the table below:

Theme	Subtheme
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Theme	Subtheme
1. Support to disclose HIV serostatus to others	
2. Safer sexual practices support	- Agreed to use a condom during intimacy - Abstaining intimacy until viral load is undetectable for six months as a safe sexual activity
3. Partner support on adherence to antiretroviral therapy (ART)	

Theme 1. Support to disclose HIV serostatus to others

The participants reported to have received the support from their partners to disclose HIV serostatus to others. The disclosure of HIV status is critical in partner support as it is another way of increasing knowledge of HIV statuses to others. They reported that after knowing of their HIV serostatus, they asked the sexual partners to accompany them whenever disclosing either to family, friends and neighbors. The following was extracted from data:

Participant #4: “They told me during counselling that I can bring him with to the clinic for counselling and testing, and they will facilitate the disclosure process through couple counselling. I came with him on my next ANC visit, he went with me to the clinic and he tested negative, that did not stop him from loving me and our child. He accompanies me whenever I’m disclosing to family members or friends”.

“As soon as I got out of the hospital, I sat her down and told her I was tested at the hospital and tested HIV positive, we then went together to the nearest clinic and both tested positive”. We called a family meeting from both families and disclose to them together, it was easy because we supported each during the disclosure”. Participant #1.

This kind of support was identified as the best practice that participants preferred because it was safe and easy to inform other people if the partner has accepted the situation. The participants even indicated that people who they disclosed to empathize with them, because their sexual partners are loving and caring.

“I tested positive while pregnant and he tested negative, he supports me by accompanying me to disclose to family members. When I was ready to disclose, he accompanied me to a family gathering, he stood by my side and encouraged me to break the news to the family. Until now I did not receive any negative vibe from them, the family instead is treating us normal and remind us to take care of each other”. Participant #5.

“We are both HIV positive and live openly about our statuses, we are not judged by the community because we have each during disclosure of any form. We communicate a lot about disclosure, we are now assisting and encouraging other couples who are HIV positive to easily disclose to others”. Participant #10.

Drawing from the participants quotes, it was obvious that the presence of a sexual partner during the disclosure, motivated them to disclose the HIV serostatus without fear of been blamed and labelled for infecting the partner, victimization, stigmatized and discriminated against. Therefore, the sexual partners positive emotional presence is associated with increased disclosure of HIV status.

Theme 2. Safer sexual practices support

The second theme identified from data was safer sexual practices. The participants reported that their sexual partners suggested safe sexual practices, immediately after disclosing the positive HIV serostatus. The participants in this study received different support for safer sexual practices. Some agreed to use a condom during intimacy, while others supported by abstaining intimacy until ensuring that the viral load is tested and undetectable for at least six months.

3.2. Agreed to use a condom during intimacy

The findings show that the sexual partners suggested a condom use during intimacy. The participants indicated that by agreeing to use a condom, it means a sexual partner has accepted a situation and supportive towards reducing the risk of transmission and re-infection.

“Yes, we spoke, and we used condom from there onwards, he supported my idea of condom use”. Participant #11.

“We didn’t have much problems because they told us the benefits of condom use which made it easier for us to accept it and we are still using condom all the way, this is the support I receive”. Participant #4.

Although for some sexual partners it seems, discussing and using a condom was easy and smooth, with others it was a mission or difficult to accept and adjust to the new sexual practices. However, through discussion and considerations of supporting a sexual partner condom use was accepted.

Participant #7 mentioned that: “She [girlfriend] is the one who pushed for condom use. I had a problem of using a condom at first, to support her I accepted, but it will take me time to get used to it. I ended reducing the rate we have sex because I hate using a condom”.

“I had to adapt using a condom as a means of protecting my partner, of course just to support her ideas of re-infection, otherwise we are both positive. It is still in my mind that sex is better without a condom”. Participant #6.

Although the use of condom alone during intimacy does not provide 100% protection from HIV transmission, the participants in our study are comfortable and appreciate the practice as the best support that they receive from their sexual partners.

3.3. Abstaining intimacy until viral load is undetectable for six months as a safe sexual activity

Other participants associated safer sexual support with the abstinent from sexual activity until it safe to have sex without infecting or infecting a partner. The participants indicated that if a sexual partner endures a waiting period, is a kind of support that proves a sexual partner nonjudgmental support and commitment to the relationship. Below are some of the comments that support this subtheme.

“After disclosing to her, she went for a test and she was also positive, she suggested that we abstain intimate while concentrating to have undetectable viral load for six months, I agreed and waited”. Participant #1.

The participants were certain that since they started abstaining their viral load has improved to the extent of undetectable, which gave them opportunity to resume intimacy without fear of re-infecting each other.

“We started treatment and abstained intimacy until our viral load is undetectable. A nurse advised us, after six months of undetectable viral load, we started, we are now intimate and I’m not worried about re-infecting him, he is really supportive when it comes to re-infection”. Participant #3.

The adoption of abstinence seems to have been influenced by the fact that when a viral load is not traceable, the sexual activity can continue normally without a condom, with little chances of infecting or re-infecting one another.

Theme 3. Partner support on adherence to antiretroviral therapy (ART)

The participants in this study indicated that their partners supported them in taking the ARTs. Adherence to ART remains an important effort in improving the health status of PLWHA and preventing HIV transmission.

“She [wife] always encouraged me to take my medication, reminding me when I forget that it is time to take my medication, we both take treatment at the same time”. Participant # 1.

“Since we are both on ART, we support each other, we discussed that we are never going to default treatment and we remind each other to take treatment”. Participant # 2.

“My wife is negative, but she reminds me when it is time to take treatment, including clinic dates. She tells me to go for checkup and treatment”. Participant # 8.

Drawing from the data, it was identified that there was some support which indirectly influences the sexual partners to adhere to ART. This was evident by participants commenting that their partners finance their trips to collect medication. Participant #9 said: “My husband gives me money for a taxi when I’m due for checkup or collecting medication, this helps me, I used not to collect medication because I couldn’t walk for a long

distance, my home is seven kilometers away”.

While others indicated that their partners accompany them when going for checkups and collecting ARTs. Participant # 12 indicated that: “He always accompany me to the clinic when I go for checkup, the nurses know him and allows him to be in the room when they check me, I will not default medication because he knows exactly what I take and when to take it”.

“She supports me, she is HIV negative but accompany me to fetch medication, sometimes she collects for me, she knows my medication, I don’t hide anything, this assist in maintaining good adherence to ART”. Participant # 8.

This theme shows that sexual partners offer support towards adherence to treatment. It is, therefore, evident that sexual partner support is important because it enhances adherence to ART.

4. Discussion

Our study provides insight into the support offered by the sexual partners of PLWHA in the Steve Khanye local municipality, Nkangala district of Mpumalanga province. The findings show how sexual partners are supportive during HIV serostatus disclosure to others, safer sexual practices, and assisting their HIV-positive sexual partners to maintain good ART adherence. The participants reported having received assistance and support from sexual partners in a form of disclosure of HIV status support, safer sexual practices support, and partner support on adherence to ART.

Disclosure of the HIV status is the decision to divulge information relating to one’s HIV status. In this study, the theme relates to PLWHA getting support from their own sexual partners to disclose their HIV serostatus to family and friends without fear of being blamed. The participants in our study found it necessary to first disclose the positive HIV serostatus to their sexual partners. Similar to this finding, the participants in the study that was conducted in South Africa in the Cape Metropolitan area on Stigma and HIV disclosure, showed that PLWHA, especially males disclose to spouses and life partners first (Klopper, Stellenberg, Van Der Merwe, 2014).

According to Adeniyi et al (2021), sexual partners’ support facilitates easy disclosure of HIV serostatus to others. Evidence of sexual partner support during disclosure is critical because the one who discloses can then better access the necessary support for coping with their HIV status and illness (Atuyambe et al., 2014). While it is necessary to disclose HIV serostatus for support, there is evidence that real or/and perceived HIV stigma and discrimination make it difficult for the PLWHA to disclose their HIV serostatus, especially if there is no support from a sexual partner. Yin et al (2019), attest that PLWHA who experienced perceived HIV stigma is likely to reveal their HIV serostatus to others. Such stigma can also negatively impact couples’ relationships creating stress and depression among them. Nonetheless, those who disclose their HIV status to their sexual partners stand a 24 times better chance of knowing their partner’s HIV status and receive emotional support to disclose it to others without frustration (Bachanas et al., 2013). In our study, it was obvious that the participants experienced emotional protection from their sexual partners. A qualitative study that looked into the barriers to timely disclosure of HIV serostatus at care and treatment centers in Dar es Salaam Tanzania, revealed that PLWHA seek emotional protection, peace of mind, and freedom from significant others after disclosing to them (Ismail et al., 2021).

On the other hand, some of the participants indicated that their sexual partners support them by practicing safe sexual activity. In support of our study findings, Dessalegn et al., (2019) argue that efforts to support sexual partners living with HIV include safer sexual practices and have the potential to contribute to HIV control and prevention. In our study safer sexual practices were related to agreeing to use a condom and abstaining from sexual activities until the viral load was undetectable. The study that investigated motivations to use hormonal contraceptive methods and condoms for HIV-positive and negative women in

Malawi, revealed that most people understand that HIV is transmitted through unprotected sex and that HIV transmission can be prevented through condom use (Bula et al., 2021). The observational study conducted to monitor and evaluate the impact of Couple HIV Testing and Counseling on consistent condom use among pregnant women and their male partners revealed that the consistency in condom use improves when a sexual partner is supportive and attends HIV counseling and testing services together (Rosenberg, Graybill & Miller 2017). In Addis Ababa, Ethiopia, it was also found that greater condom use is associated with couple and partner counseling (Dessalegn et al., 2019). Likewise, in our study participants indicated that after disclosing their HIV-positive status, their sexual partners went for counseling and testing with them, and agreed to use a condom thereafter. The current study suggests the constant and correct use of condom prevents the transmission of HIV to a sexual partner. According to Ayele et al. (2021), the prevention of transmission of HIV infection is based on the greater, regular, and correct use of condoms. Condoms are a highly effective strategy to prevent the sexual transmission of HIV when used consistently and correctly. Moreover, Mengwai, Madiba, and Modjadji (2020) argue that safe sexual practices include regular condom use. More recommendations were made included promotion of condom use as one of the effective interventions in preventing HIV transmission Mengwai et al. (2020). Protecting partners by 100% condom use and other safer sex behaviors regardless of decisions on disclosure should be emphasized among people living with HIV because condoms are readily and freely available in most health establishments (Crosby et al., 2015).

This study revealed that some of the sexual partners supported the participants by abstaining from intimacy until the viral load is undetectable for at least six months. Abstaining from sex is one of the well-known methods of preventing HIV transmission. The study conducted in Nigeria on the perceptions about sexual abstinence and knowledge of HIV/AIDS prevention among school adolescents attests that abstinence remains one of the most realistic interventions for reducing the further spread of HIV infection (Oladebo & Fayemi, 2011). The idea of abstaining for at least six months of undetectable viral load might have been born from the undetectable = uninfected or untransmissible (U = U) guidelines, which support HIV-affected individuals and couples to achieve pregnancy safely (Davies et al., 2018). In addition, some studies proved that if one is established on ARTs and plasma VL confirms undetectable, that individual is considered uninfected and will not transmit HIV (untransmissible) (Lecher et al., 2021; Bavinton et al., 2017; Rodger et al., 2016). The Centers for Disease Control and Prevention (CDC) concur with scientific evidence asserting that when an individual has an undetectable HIV viral count, there's effectively no risk of them transmitting HIV to a sexual partner (UNAIDS, 2018). Therefore, faithful abstaining for at least six months of undetectable viral load is adequate to support sexual partners in preventing HIV transmission and re-infection.

Another major finding from our study was that the participants are getting sexual partner's support which facilitates the ART adherence. In the previous study conducted in South Africa, the sexual partner support was found to be a factor that better treatment outcomes for the health of PLWHA (Adeniyi et al., 2021). In addition, the study conducted in Guangxi, China showed that PLWHA in the optimal adherence group reported higher levels of support from spouse/partner, and better ART adherence was positively associated with perceived social support from spouse/partner (Mao et al., 2019). Adherence to ART is crucial to achieving a suppressed viral load, which in turn protects sexual partners from HIV infection. Adherence is the ability of the patient to follow treatment plans, take medication at prescribed times and frequencies, following restrictions regarding lifestyle, food, and other medications (Azia, Mukumang, Van Wyk, 2016).

Conroy et al., (2017) posit that primary partners are important pillars of support for ART adherence. Moreover, the same study found that more support for a positive and supportive role that partners play in helping HIV patients maintain good adherence to ART (Conroy et al.,

2017). According to Mao et al., (2019) to achieve better ART outcomes interventions to promote ART adherence should focus on strengthening PLWHA relationships with their spouse/partner. Moreover, the South African National Department of Health (2010) recommends that PLWHA identify a treatment buddy such as a sexual partner to co-attend HIV information sessions and offer support that will assist in ART adherence.

In the current study, it has also been noted that transport and accompaniment to the clinic for check-ups and collecting medication for them facilitate ART adherence. Consistent with our finding, previous studies highlighted that most of the PLWHA do not adhere to ART because of transport or money to travel to the clinic to collect medication refills and are unable to take medication freely because of mistrust, stigma, discrimination, and judgement from the sexual partners (Ahmed et al., 2017; Tabatabai et al., 2014). Our finding complements existing literature attesting that PLWHA wishes sexual partners to support with finances for transport to the clinic, collect medication on their behalf, and reminders for medication intake (Abdulai et al., 2022). In the study conducted in Dar es Salaam, Tanzania, participants mentioned that compliance to treatment and managing symptoms of HIV is easier with positive support from a significant other such as a sexual partner (Ismael et al., 2021). It was also reported that they were encouraged to disclose to others. According to Conroy et al., (2017) providing transport or accompanying a partner for follow-ups and collecting ART on the partner's behalf is done out of love, unity, trust, and commitment.

Drawing from the discussion, it is obvious that sexual partners play a role in the provision of HIV-related support. The current study, therefore, confirms that support from partners could buffer the negative effect of taking ART, and improves self-efficacy to adherence, which in turn assists PLWHA to overcome barriers to adherence, such as transportation, trust, and love commitment challenges.

5. Conclusion and recommendations

This study explored and described the support offered by sexual partners of PLWHA. Drawing from the findings it was clear that for the PLWHA to disclose their HIV status they need support, especially from their sexual partners. This support motivates them to practice safe sex and to adhere to ARTs. The significant impact of this support suggests a need to incorporate sexual partners into clinical practice and in other behavioural interventions with PLWHA. The study also taught us that the support system comes in various ways, therefore healthcare providers should develop more safe plans and strategies that encourage couples to disclose their HIV-positive status to families and friends for support. Policymakers and Sexual Reproductive Health (SRH) services should also develop strategies that are evidence-based to promote sexual partner support for PLWHA.

6. Limitations

Because our inclusion criteria were specific to PLWHA who are receiving support from their sexual partners, it is possible that the findings would have been different if we included all the PLWHA.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Acknowledgments

The authors would like to thank the Mpumalanga department of health, the Chief Director of the district, the sub-district manager, and the operational managers of the primary health care settings in Ekangala district, Mpumalanga province, South Africa who granted permission for

the authors to conduct a research study. Special thanks are also extended to all participants who participated in the study. Lastly, most gratitude to the University of Pretoria, Faculty of Health Sciences Research ethics committee for granting the ethical clearance.

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