

**AN INVESTIGATION INTO THE INFLUENCE OF SOCIO-CULTURAL FACTORS ON
HIV PREVENTION STRATEGIES: A CASE STUDY OF HIV SERO-DISCORDANT
COUPLES IN HARARE-ZIMBABWE**

by

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DECLARATION

I, Elizabeth Shambadza Magada, declare that this dissertation entitled: *An Investigation into the Influence of Socio-Cultural Factors on HIV Prevention Strategies: A Case Study of HIV Sero-Discordant Couples in Harare-Zimbabwe* is my own work and that all sources I have used or quoted have been acknowledged by means of complete references.

Signature

A handwritten signature in black ink, appearing to read 'E. Shambadza Magada', is centered within a light blue rectangular box.

30 January 2014

Elizabeth Shambadza Magada

Date

ABSTRACT

This study was an attempt to investigate the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples in Harare, Zimbabwe. HIV sero-discordance is a scenario whereby one partner is HIV-positive and the other is HIV-negative. HIV sero-discordant couples are a unique and vulnerable population that encounters many peculiar challenges. When dealing with this population, researchers have to deal with contradictory ideas and perceptions presented by each partner making up the couples and also understand the relationship in the context of cultural values, norms and the dynamic of power and oppression. In addition to this, the concept of HIV sero-discordance and the frequency of its occurrence are poorly understood in most African communities. Despite the growing evidence of HIV discordance, HIV prevention strategies have largely focused on clinical aspects at the expense of socio-cultural issues that impact on HIV prevention strategies targeted at HIV sero-discordant couples. The study seeks to contribute to the conceptualization and design of intervention programs dealing with sero-discordance. The study is underpinned by the symbolic interactionism theory and was qualitative in design involving 13 HIV discordant couples in heterosexual relationships enrolled in the HIV Preventions Trials Network 052 Study (HPTN 052 Study) being undertaken by the University of Zimbabwe's department of medicine. The study utilized 2 Focus Group Discussions (FGD) and 10 in-depth interviews (IDI) to collect data. The study's findings indicate that discordant couples are in fact critical stakeholders in the uptake of all the available HIV prevention strategies. Failure to acknowledge this tenet is self-defeating as evidenced by the perception of viewing condom use within a marriage as humiliating for a woman. The study further noted that practitioners in the HIV prevention domain must guard against over-relying on the scientifically demonstrated efficacy of the strategies. The study recommends that HIV prevention strategies must be socially and culturally acceptable and embedded for them to be more efficacious.

KEY TERMS:

Influence, Socio-cultural factors, HIV prevention strategies, HIV sero-discordant couples, Zimbabwe

DEDICATION

I dedicate this dissertation to my three beautiful and intelligent daughters, Kudzaiishe, Tafadzwa and Tinashe. This write up is about you, your being and your life as women-to-be in the Zimbabwean marriage and culture setting. I also dedicate this work to my dear parents Gerald Mwazha and Margaret Mwazha who did not live long to witness my advancement in education. I also dedicate it to my caring and God fearing husband, Wyclif, who empowered me throughout the process and encouraged me to call upon the Lord Jesus Christ for guidance.

LIST OF ACRONYMS

- AIDS**- Acquired Immuno Deficiency Syndrome
- ACTG**- AIDS Clinical Trials Group
- ART**- Antiretroviral Therapy
- CDC**- Centers for Diseases Control
- CD4 Count**- The number of T-helper Lymphocytes per cubic millimeter of blood
- DNA**- Deoxy Ribo Nucleic Acid
- FGD**- Focus Group Discussion
- HIV**- Human Immuno Deficiency Virus
- HIV+ve**- Human Immuno Deficiency Virus present in the blood.
- HIV-ve**- Human Immuno Deficiency Virus not present in the blood
- HPTN**- HIV Preventions Trials Network
- IDI**- In-depth Interview
- IDU**- Injecting Drug Users
- IMPAACT**- International Maternal Pediatric Adolescents AIDS Clinical Trials
- MSM**- Men who have Sex with Men
- NAC**- National Aids Council of Zimbabwe
- NIH**-National Institute of Health (USA)
- PrEP**- Pre Exposure Prophylaxis
- SI**- Symbolic Interactionism
- STI**- Sexual Transmitted Infection

TA- Thematic Approach

USAID- United States Agency for International Development

VMMC- Voluntary Medical Male Circumcision

WHO-World Health Organization

ZAPP-UZ- Zimbabwe Aids Prevention Program in conjunction with University of Zimbabwe

ZDHS- Zimbabwe Demographic Health Survey

ZIMSTAT- Zimbabwe Statistical Agency

UZCRC- University of Zimbabwe Clinical Research Centre

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CHAPTER 1

INTRODUCING THE STUDY

1.1 INTRODUCTION

HIV sero-discordant partnerships, which are the central focus of this study, are common in areas where the HIV prevalence burden is high such as the sub-Saharan African region (Rispel, Metcalf, Mooddy and Cloete, 2009:9). HIV Preventions Trials Network 052 study protocol (2006:16) defines HIV sero-discordance as a situation whereby one partner is HIV-positive and the other is HIV-negative. HIV sero-discordant couples are increasingly recognized as a priority for HIV prevention due to the risk of transmitting the virus to the HIV-negative partner. This study sought to investigate into the influence of socio-cultural factors on Human Immuno Deficiency Virus (HIV) prevention strategies among HIV sero-discordant married couples. Socio-cultural factors referred to in this study are social, cultural and behavioral factors that describe and define relationships amongst HIV sero-discordant couples. Solomon (2011:7) contends that the ability to manage these socio-cultural issues is crucial to the couples' decisions on HIV prevention strategies hence the control of HIV transmission among sero-discordant couples. Reference to a 'married couple' in this study does not consider the technicalities of the form of marriage but is only concerned about whether or not the participants perceive their living arrangement as a 'marriage'. The broader aim of this study was to contribute to the conceptualization and design of intervention programs dealing with sero-discordance. The researcher's interest in studying this population is centered on the fact that HIV sero-discordance poses a significant risk of transmission to the negative partner thereby contributing significantly to the transmission of HIV. There are, however several underlying socio-cultural factors that influence the couple's decisions on HIV prevention strategies which require investigation. Farquhar (2007:16) asserts that, despite the growing evidence of HIV discordance, HIV prevention strategies have largely focused on clinical aspects and ignored the socio-cultural issues that impact on HIV prevention strategies targeted at HIV discordant couples. Cohen and MacCauley (2011:493) argue that HIV sero-discordance is a high risk relation for HIV transmission. Therefore, in order for partners to remain HIV sero-discordant, active prevention strategies have to be maintained. In concurrence with this, Farquhar (2007:16) contends that,

HIV prevention efforts amongst HIV discordant couples are essential and their effectiveness comes as a result of paying attention to existing socio-cultural factors. This qualitative interpretative study targeted couples enrolled in the HIV Preventions Trials Network 052 Study. HPTN 052 is a treatment and prevention study, which seeks to evaluate the effectiveness of antiretroviral therapy plus HIV primary care versus HIV primary care alone, to prevent the sexual transmission of HIV-1 in sero-discordant couples. Guided by Symbolic interactionism the findings of this study noted that the HIV negative partner's risk of contracting HIV within the discordant partnership is determined by numerous social and cultural factors that shape gender and sexuality perceptions, attitudes and behaviors among discordant couples. Consequently, HIV discordant couples are key stakeholders in relation to the effective uptake and use of available HIV prevention strategies.

1.2. Background and motivation

HIV/AIDS is a major health and social issue, usually described in horrifying words such as 'pandemic' or 'crisis' in Zimbabwe, due to its negative impact on the well being of individuals, families and the society at large. In 2008, Zimbabwe became one of the most affected countries in the sub-Saharan region, with 1,3 million people living with HIV/AIDS and one million children having lost one or both parents to the disease (UNAIDS/WHO, working group on global HIV/AIDS and STI, 2008:23). The National policy on HIV/AIDS and STI (2008:31; cf UNAIDS/WHO, working group on Global HIV/AIDS and STI, 2008:31) asserts that during the period around 2008, Zimbabwe was experiencing political and economic crises which resulted in hyperinflation and the economy shrinking by 40% as epitomized by the shortage of basic commodities. Natrass (2003:12) argues that political commitment remains a limited factor in tackling HIV in most parts of Africa. As a result, AIDS impacted on labor production, undermined human capital, reduced productivity and affected class relations and social structures (Dickson, 2006:5). However, during the period around 2009 Zimbabwe also witnessed an increase in civil society interventions and this assisted in abating the 'crises levels'. Part of this intervention matrix saw the expansion of such institutions as the University of Zimbabwe Clinical Research Center (UZCRC) in Harare. The UZCRC directed its research efforts on

various aspects of HIV including HIV discordance, in order to improve medical knowledge about HIV and also influence policy on how to manage the scourge.

According to the National AIDS Council of Zimbabwe (NAC) (2013:2), Harare, Zimbabwe's capital has the highest population of people living with HIV in the country. Basing on the National prevalence of HIV infection of 13, 6% and greater Harare's population of 1,559,502 residents, it is estimated that greater Harare has nearly 212,100 people living with HIV (Zimbabwe Demographic Health Survey, 2012:13). Basing on these statistics, it is reported that 42,420 people, (20%) are in urgent need of antiretroviral treatment (Zimbabwe Statistical Agency, 2012:13).

Worldwide, 20-50% of couples may be in an HIV sero-discordant relationship (ZDHS, 2011:17). De Bryn (2007:15) argues that the percentage of HIV sero-discordant relationships is estimated to range from 5-31% in various African countries. On the same note, USAID (2012:32; cf ZDHS 2011:25) notes that in Zimbabwe HIV sero-discordance ranges from 12-13, 2 % of the country's total population. Although many of these couples remain in socially stable relationships, they go through many challenges and sero-discordance remains the epicenter of HIV transmission (Katherine, Shannon, and Khanhakwa, 2011:934). Stable sero-discordant relationships and sexual concurrency have been seen to be contributory factors to the HIV epidemic in Zimbabwe and sub-Saharan Africa at large (Katherine et al. 2011:933).

This study is one of the many efforts to influence the fight against HIV and was conducted at the University of Zimbabwe Clinical Research Centre (UZCRC), a University of Zimbabwe Medical School owned international research centre. The centre conducts HIV/AIDS treatment and prevention clinical trials under the auspices of the Ministry of Health and Child Care. UZCRC is situated 1, 5 kilometers from the city centre near Parirenyatwa Teaching Hospital in Harare. Currently, the centre conducts expanded HIV/AIDS treatment and prevention clinical trials initiated by the HIV Preventions Trials Network (HPTN), World Health Organization (WHO), National Institute of Health (NIH), AIDS Clinical Trials Group (ACTG), International Maternal Pediatric Adolescence AIDS Clinical Trials (IMPAACT) and other observational studies. Participants in this study were recruited from the ongoing HPTN 052 study for HIV discordant couples and reside in greater Harare and areas 40 kilometers outside Harare City.

The researcher's interest in this study came as a result of the apparent lack of attention on investigating the socio-cultural factors that influence HIV prevention among sero-discordant couples in the HPTN 052 study. The HPTN 052 is largely a medical intervention yet Ngozi (2009:63) argues that it is now widely acknowledged that effective treatment and prevention strategies require an understanding of the socio-cultural context.

The researcher's choice to undertake research at this site was motivated by the following factors:

1. UZCRC is currently the only site in Zimbabwe where a cohort of HIV discordant couples is being followed up.
2. The researcher is quite familiar with the research setting, the population and its cultural values.
3. The researcher's anxiety which emanated from her own professional experience in working with HIV sero-discordant couples during the last decade.
4. The researcher's professional engagement in the study, which enabled her to gain the trust of both the participants and the responsible authority in undertaking the study.

1.3. Problem Statement

HIV sero-discordant couples are a population that has received limited attention in human and social sciences research. As a result, knowledge of the causes and factors behind sero-discordance is still ambiguous and confusing. HIV prevention strategies particularly their uptake by HIV discordant couples is to ensure that the HIV negative partner maintains their status by not contracting HIV from the HIV positive partner. The degree to which married couples in an HIV sero-discordant relationship make decisions and choices pertaining to their uptake of HIV prevention strategies is influenced by various socio-cultural issues (Solomon, 2011:7). However, in the mainstream of HIV prevention strategies, particularly those focusing on sero-discordance, little attention has been given to the importance of socio-cultural dynamics. Instead, interventions have largely given preference to the clinical aspects of interventions (Farquhar, 2007:16). Inadequate focus on the socio-cultural challenges associated with the uptake of HIV prevention strategies by HIV discordant couples has a bearing on the sustained ability of the HIV negative partner maintaining their status. This study's intention was to influence programming

and policy formulation that focuses on increasing the efficacy of the prevention strategies among sero-discordant couples. The findings of the study are significant in the formulation of strategies and policies aimed at improving the health situation of sero-discordant couples. In addition, this study meant to contribute to the academia particularly the sociology and public health research.

1.4. Purpose of the study

This study's intention was to investigate into the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples. An understanding of these issues would help to inform programming that seeks to implement HIV prevention strategies with an uptake level high enough to ensure that the HIV negative partner maintains their status.

1.5. Research methodology and design

This study applied the qualitative research methodology in a domain that is generally influenced by positivist quantitative thinking. The research used a total of 13 married heterosexual HIV discordant couples currently enrolled in the HPTN 052 study. Data was collected using a semi-structured in-depth interview guide and a focus group discussion guide was used to collect data from the FGD participants. Data analysis and interpretation for this study was done using the content thematic approach, which is defined by Neumann (2008:61) as the categorization of data into meaningful themes.

1.6. Research questions

- (a) What are the factors that contribute to the acceptance of the sero-discordant status by the concerned couples?
- (b) What are the factors that contribute to the rejection of the sero-discordant status by the concerned couples?
- (c) What are the main socio-cultural factors that influence HIV prevention decisions among HIV sero-discordant couples?

1.7. Study objectives

This study hopes to contribute to the scholarship on sero-discordance broadly, through achieving the following objectives.

- (a) To investigate factors that contribute to the acceptance of HIV sero-discordance among HIV discordant couples.
- (b) To investigate factors that contribute to the rejection of HIV sero-discordance among HIV discordant couples
- (c) To explore socio-cultural factors that influence HIV prevention decisions among HIV sero-discordant couples.

1.8. Propositions

The following propositions are the underlying assumptions that the study made in approaching the issue under investigation.

- (a) It is difficult for married hetero-sexual couples to accept HIV sero-discordance.
- (b) Socio-cultural factors have an influence on the way sero-discordant couples make sexual and HIV transmission prevention choices.
- (c) HIV discordance does not constitute sufficient enough grounds to break the sexual relationship component in married hetero-sexual couples.

1.9. Operational definitions of key terms

The following main concepts were used in the study and are understood to take the meanings defined below.

Hetero-sexual HIV discordant couples: Sexual partners of opposite sex whereby one partner is HIV-positive and the other is HIV-negative (HPTN 052 protocol, 2006:16).

HIV infected partner: A member of the couple who is HIV-positive (HPTN 052 Protocol, 2006: 7).

HIV–negative partner: A member of the couple who is not infected with HIV (HPTN 052 Protocol, 2006:7).

HIV-positive partner: A member of the couple who is infected with HIV (HPTN 052 Protocol, 2006:7).

HIV prevention strategies: Interventions or ways that have been proven to minimize or prevent the transmission of HIV to the HIV-negative partner (Zimbabwe National strategic Plan, 2012-2015:22).

HIV sero-discordant couple: A couple whereby one partner is HIV infected and the other is not infected (HPTN 052 protocol, 2006:43).

Human Immuno Deficiency Virus: A social disease that requires proper identification and evaluation of the socio-cultural norms that are likely to expose the individual member of the couple to the condition (Dibua, 2010:37).

Influence: A determining factor believed to affect an individual’s tendencies and characteristics (Oxford dictionary, 2009: 232). The Influence can either be a positive or negative.

Married couple: Two persons in an ongoing sexual relationship, each of these persons is referred to as a ‘partner’ in the relationship (Allen, 2012:5).

Socio-cultural factor: The cultural practices, values and norms that interact with the HIV discordant couples’ capacity to make choices regarding HIV prevention (Dibua, 2001:37).

Symbolic interactionism: A sociological humanistic theory which is anchored on the belief that human beings (in this case, HIV discordant couples) are active participants in the construction of social reality and the meaning of events comes from the interaction of the individuals (Blumer, 1969:2).

1.10. Chapter outline

Chapter 1

This chapter provides the context within which to introduce the study and briefly describe the background of the phenomenon. It is in this chapter that the problem statement, significance of the study, methodology and research design, research questions, study objectives, propositions and operational definition of key terms are discussed.

Chapter 2

This chapter presents a review of literature on the socio-cultural factors that influence HIV prevention strategies among HIV sero-discordant couples. The chapter outlines the definitions and arguments around the phenomena of HIV sero-discordance. It further presents the global, African regional and Zimbabwean perspectives, myths/misconceptions on sero-discordance and the extent of the phenomena. The socio-cultural factors that influence HIV prevention amongst HIV discordant couples are discussed and illustrated. This chapter also presents and explains symbolic interactionism, a sociological humanistic theory that underpinned the study.

Chapter 3

This chapter outlines the research methodology, design and justification why those research methodological techniques were used. The sampling design and procedures, data gathering techniques and tools are discussed and justified. Ethical considerations in conducting research with human participants are also discussed in this chapter.

Chapter 4

The chapter presents the demographic characteristics of the study participants and the findings of the study. It also discusses the qualitative data obtained from in-depth interviews (IDIs) and focus group discussions (FGDs). The socio-cultural factors that influence HIV prevention among HIV discordant couples in Harare, Zimbabwe are also presented and discussed. The symbolic interactionism theory was applied in the analysis of findings.

Chapter 5

The chapter presents the limitations of the study, summary of findings and the study conclusions. It further proposes areas for further research and makes recommendations for policy formulation.

CHAPTER 2

LITERATURE REVIEW

2.1. INTRODUCTION

The previous chapter among other aspects highlighted the purpose of the study and gave a brief background on the context of the study. This chapter will present the context within which to view the influence of socio-cultural factors on HIV prevention strategies among sero-discordant couples in Harare, Zimbabwe. Key issues that include the phenomenon of HIV sero-discordance and scientific arguments around it will be reviewed. The global, regional and local perspectives and the extent of the phenomenon will also be discussed.

2.2. Definition and arguments around the phenomena of HIV sero-discordance

With reference to the early times of the HIV epidemic, HIV prevention efforts in sub-Saharan Africa indicate that they have been focused on populations regarded to be at risk of HIV transmission. These populations include HIV-negative individuals, commercial sex workers, individuals with multiple sexual partners and vulnerable groups such as women and young people (Desgrees-du-lou and Orne-Gliemann, 2008). However, the prevention efforts have expanded to include positive prevention strategies that involve people living with HIV and married or cohabiting HIV discordant couples. HIV discordant couples have been considered as one of the most important groups to target within the broader prevention framework because of the continued risk of transmission to the HIV-negative partner (Bishop and Foreit, 2010, USAID, 2010).

HIV sero-discordance as highlighted in the previous chapter is a situation whereby one partner is HIV-positive while the other is not. This situation emanates from a situation where one sexual partner either comes into the sexual relationship already infected or becomes infected later in life (Bishop and Foreit, 2010:3). The evolution of HIV sero-discordance occurred from the beginning of the epidemic and the majority of HIV transmissions were from an HIV infected partner to one that is uninfected (Celum, 2013:1519). Johwa (2010:1) asserts that transmission amongst

partners goes through discordance, which implies that HIV transmission between partners does not occur simultaneously. It was initially argued by Alexander (2009:4) that the virus is not systematically transmitted at each and every sexual encounter and that transmission depends on how far the HIV-positive person is in the progression of his condition. The increasing rate of HIV discordance among couples worldwide brings new challenges to HIV prevention and treatment. The need to pay more attention to the influence of socio-cultural factors on discordant couples' decisions and efficacy to prevent HIV transmission to the HIV negative partner becomes more critical (Medellin and Robert, 2004:1).

Moreover, HIV sero-discordance creates a puzzle among researchers and scholars. Gisselquist (2003: 162), for example, argues that HIV sero-discordance is caused by unsterilized medical equipment. However, McCook (2005:1) disagrees with Gisselquist by asserting that HIV-negative partners in HIV sero-discordant relationships may owe their status to extremely high levels of antibodies that fight HIV infection. The National Institute of Health (2011: 62) explores a different angle by suggesting variables influencing discordance such as circumcision, length of relationship, frequency of sexual encounters and the presence of sexually transmitted diseases. On the same note, Centers for Disease Control (2011:3) lists factors that influence the transmission of HIV among couples to include the frequency of sexual exposures, levels of viral load, and injury of genital tract. Zakumumpa (2011:1) notes that scientists also suggest that some people have unique cells that do not allow the virus to mutate in them. However, such findings are not conclusive and there are several research efforts to understand the causes of discordance. The research efforts include the one being funded by the Bill and Melinda Gates Foundation in South Africa, Botswana, Kenya, Uganda, and Rwanda.

Recent literature such as Beyeza-Kashesya, Ekstrom, Kaharuza, Miramba, Neema and Kulane (2010:223) postulate that there is still little information that exists in order to give reasons why some people become infected with HIV and others remain uninfected. Based on the research work discussed above, there is substantial evidence that there is still no conclusive biological evidence which can be used to explain reasons for an HIV discordant result.

2.3. Global extent of HIV sero-discordance

Globally, HIV sero-discordance is a major public health problem due to the increased risk of HIV transmission to the HIV-negative partner (Osinde, and Kakaire 2011: 436). Currently, more than 34 million people live with HIV globally and approximately 50% of them are aware of their HIV status (UNAIDS, 2012:6).

Basing on these statistics, WHO (2011:26) asserts that up to 50% of people living with HIV who are in relationships are estimated to be HIV discordant couples and yet the needs of such discordant couples are not fully addressed. In regions other than Africa, HIV basically affects populations that include men who have sex with men (MSM), injecting drug users (IDU) and sex workers. In this respect, WHO (2012:5) asserts that high levels of sero-discordance among stable couples are largely from sub-Saharan Africa and other regions provide little data. Eyawo, Walque, Ford, Gaku, Lester, and Mills (2010:2) argue that in the African region, HIV discordance is more prevalent in Swaziland (16, 4%), Lesotho (13, 6%), Zimbabwe (13, 2%) and Zambia (11, 2%). A significant portion of these partnerships are affected by HIV and half are HIV discordant (Fishel, Bradley, Mbofana and Botao 2011).

USAID (2010:1) emphasizes the fact that intra-couple transmission between individuals in long term stable partnerships causes a high percentage of HIV transmission and should therefore receive attention in terms of HIV prevention funding. The fact that transmission from one partner to the other results in a high percentage of HIV transmission within stable partnerships has been proved by a study conducted in Zambia. In the Zambian study, Deoxy ribo Nucleic ACID (DNA) sequencing showed that 87% of new HIV infection of the negative partner in a sero-discordant relationship was transmitted from the HIV-positive partner (WHO 2012:5). On the other hand, a study conducted in Southern Africa at 14 clinical sites established that 64% of sero-conversions could be linked by viral sequencing to the HIV-positive partner in long term relationships (WHO 2012:5). In response to these findings, the HPTN 052 study for discordant couples provided evidence that early treatment of an HIV positive individual in a sero-discordant relationship reduces transmission of HIV to the negative partner by 96,3% (Cohen, Chen, MacCauley:493). In this respect, WHO (2012:5) recommends that all HIV-positive individuals in a discordant relationship should receive treatment and care. However, WHO

(2012:2) acknowledges that identifying HIV discordant couples through various interventions gives room to explore socio-cultural factors that influence prevention strategies among HIV discordant couples and reduce the spread of HIV. However, investigations into socio-cultural factors have received insufficient attention to date (Farquhar, 2007:16).

2.4. African regional perspective, extent of sero-discordance and myths/misconceptions

Were, Wool, Balidawa, Ayuo, Sidle and Fife (2008:328) argue that in the African region, HIV transmission in couples has mostly been linked to high viral load, lack of male circumcision, extra marital sex, low literacy, ignorance of self or partner's HIV status and limited understanding that HIV discordance can occur within couples. However, Gitonga, Ballidawa and Ndege (2012:20) argue that people in the African region have limited knowledge of HIV. The limited knowledge makes them believe that HIV discordance is a rare case and despite couples being educated on HIV discordance they still display ignorance about this phenomenon. In this instance, Gitonga et al. (2012:21) note that the African society perceives the HIV discordant couples as resulting from promiscuous individuals who bring risk to their families.

WHO (2012:2) argues that HIV sero-discordance is a phenomenon that is poorly understood by lay people and even some health personnel. In this context, Were et al. (2008:328) highlight some of the African perceptions on sero-discordance, stating that many individuals assume that if one partner in a sexual relationship is HIV infected then the other partner is also HIV infected and that stable couples are likely to have the same HIV sero-status. Beckerman (2000:20) notes that because people have limited knowledge of HIV discordance they think that if partners stay together for a long time and have children together, chances of infecting each are slim, and also think that infection might have occurred through other modes. Some African cultures hold the view that if a woman in an HIV discordant relationship is HIV-positive, she can be disinherited, leading to her children being disowned by the HIV-negative partner (Were et al. 2008:329). Owing to these misconceptions and misperceptions, WHO (2012:2) and Allen (2012:5) argue that despite growing evidence of its importance, the concept of sero-discordance and the frequency of its occurrence are poorly understood in most African communities resulting in insufficient focus on socio-cultural issues that impact on prevention strategies.

UNAIDS (2011) observes that the sub-Saharan Africa region has the highest prevalence and incidence of HIV infection in the world, mostly attributable to heterosexual transmission and accounting for 68% of the world's population living with HIV, 69% of new infections and 72% of AIDS cases (WHO 2012:5). Kaiser, Bunnell and Kim (2011:2) argue that there is increasing evidence that a large proportion of new HIV infections in Africa occur in cohabitating couples, many of whom are unaware of each other's sero-status. WHO (2012:10) notes that in sub-Saharan African countries with HIV prevalence of 10%, about 75% of partnerships affected by HIV are discordant. Given that discordant couples account for a large proportion of HIV transmission in sub-Saharan Africa greater attention is required to investigate into the socio-cultural factors that influence the HIV prevention strategies (Chemaitelly, Cremin, Shelton, Timothy, Hallet, and Raddad, 2012:57). The HIV/AIDS pandemic constitutes a sustained and complex severe socio-economic crisis in sub-Saharan Africa. The HIV/AIDS pandemic in the sub-Saharan Africa region is mainly attributable to intricate socio-cultural factors (Ogunbodede 2004: 352). There is a complex interaction of material, social, cultural and behavioral factors that shape the nature and outcome of using HIV prevention strategies in sub-Saharan Africa. These include the subordinate position of the African woman, religious beliefs, and traditional beliefs in relation to HIV prevention. As a consequence, greater focus on the influence of socio-cultural factors on HIV prevention strategies among peculiar populations such as HIV discordant couples is paramount.

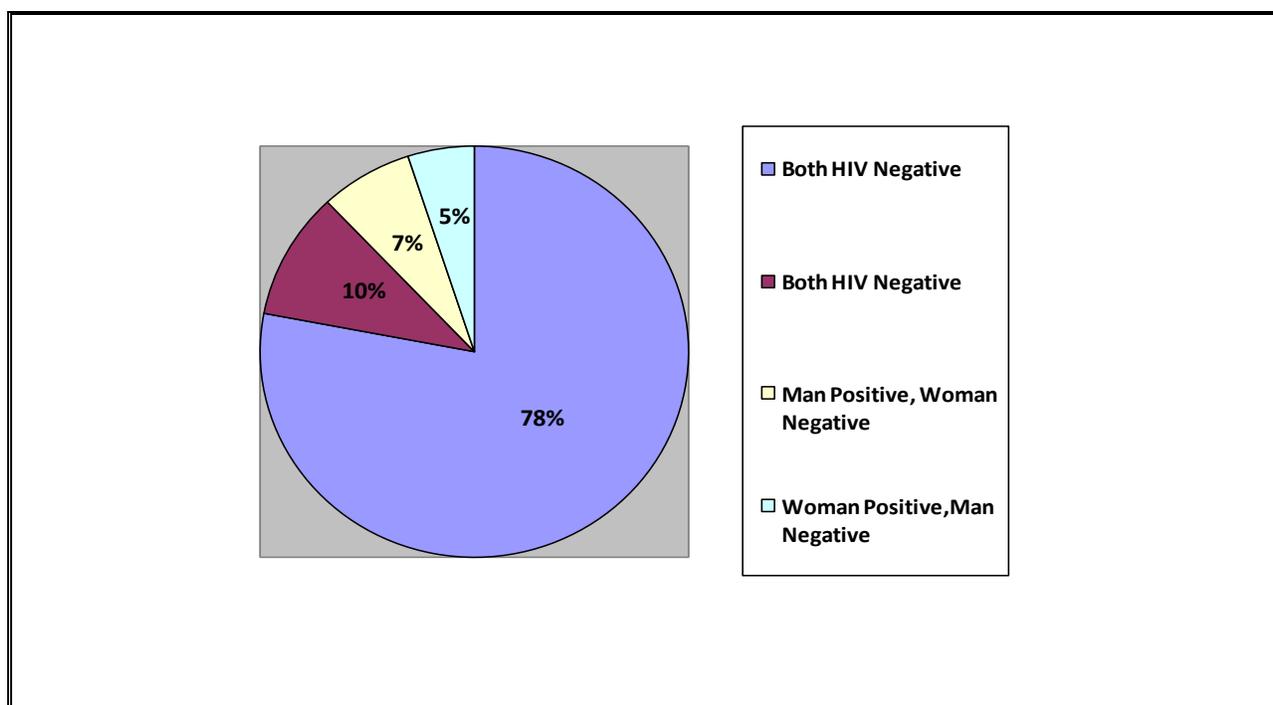
2.5. Zimbabwean perspective, extent of sero-discordance and myths/misconceptions

Zimbabwe has a population of 12, 8 million and is amongst the countries of sub-Saharan Africa worst affected by the HIV/AIDS epidemic (UNAIDS 2012:15). HIV prevalence in Zimbabwe was estimated to be 23, 7% in 2001 and 18, 4% in 2005 and further declined to 13, 1% in 2011 (ZDHS 2012: 13). According to the USAID (2012:20) the decline was projected to have started in the late 1990s and is attributed to successful implementation of prevention strategies, especially behavior change, condom use and reduction in multiple sexual partners. National Aids Council of Zimbabwe (2011:17) argues that despite the decline, HIV transmission in Zimbabwe remains predominantly sexually driven and also accounting for more than 90%. This shows a significant gap in HIV prevention and the need to address socio-cultural factors in all circles. A

recent rigorously conducted study in Rwanda and Zambia estimates that 55-93% of all HIV transmissions in those countries occur between married couples or in cohabitating relationships and that reducing transmission within these couples could avert 36-60% of new infections. The HIV Prevention Trials Network Study 052 clinical trial released study findings which showed that initiating a sero-positive partner on ARV treatment (ART) with a CD4 count of 350-550 reduces the chances of infecting their HIV negative partner by 96,3% (Lancet 2011:1). In 2002, Zimbabwe’s HIV sero-discordance prevalence rate was placed at 20-25 % of the country’s total population (USAID, 2012, ZDHS, 2011). According to the ZDHS (2011: 25), 12% of people in marriages or cohabiting relationships in Zimbabwe are sero-discordant.

2.6. Table 1

2.6.1. HIV prevalence in Zimbabwean Couples



Source (USAID 2012:20)

With reference to the diagram above, 78% of the couples in Zimbabwe are HIV-negative. In 10% of the couples, both partners are HIV-positive. However, 12% of the couples are HIV discordant. Of the 12%, 7% are cases where the male partner is HIV-positive while the female

partner is negative and 5% are cases where female partners are positive and the male partners negative (USAID, 2012:20).

There are several misconceptions and misperceptions about the causes of discordance hence medical and social researchers continue to try to better understand the causes of discordance among couples. Zimukumpa (2011:1) also argues that there is need to explore more on the biological and socio-cultural factors that may help researchers and the communities to understand the mystery of HIV discordance among sexual partners

In the middle of the puzzle concerning HIV discordance, people, including some in Zimbabwe, have come up with myths that some people are 'immune' to HIV. Consequently, the Global AIDS Program (2008:220) has tried to dispel this by outlining that the HIV window period does not explain discordance because it is a temporary state. The Global AIDS Program (2008:220) further argued that the biological make up of a woman's vagina or men's penis does not cause discordance and that the HIV uninfected partner is not immune to HIV. However, recent publications show that early treatment of an HIV-positive member of a couple with antiretroviral therapy reduces the transmission of HIV-1 to the HIV-negative partner by 96, 3% (Lancet, 2011:4). In this respect, Cohen et al. (2011:495) further argue that despite the 96.3% reduction rate, transmission of the virus is still possible. Therefore, without risk reduction and constant exposure to the virus, ultimately all discordant couples will become concordant positive. This is the most recent explanation being proffered by most studies, including the HPTN 052 study in Zimbabwe.

Fetene and Ayalew (2012:11) observe that in most African countries HIV sero-discordance is perceived as a hidden infection which cannot be identified by HIV tests. The same authors further note that people believe that HIV discordance means that the negative partner has a strong immune system and also that gentle sex protects the HIV negative partner from getting infected. On the same note, the Global AIDS Program (2008:220) asserts that people in several African countries including Zimbabwe perceive the HIV window period as an explanation for discordance despite it being a temporary state. Zimbabwe being a multi-religious society, religion has brought in multi-faceted perceptions on sero-discordance thereby denouncing

discordance as a punishment against a sexual sin committed by the HIV infected member of the couple (Dibua 2010:27).

According to Muchini, Benedict, Gregson, Gomo, Mate, and Mugurungi (2012:487), Zimbabwean married couples and people in stable partnerships are at greater risk of HIV infection when compared to those who have never been married. This is because culturally defined values and norms control the interaction process. In this case, the extent to which married couples in an HIV discordant relationship make sexual decisions pertaining to HIV prevention is controlled by masculinity and femininity issues (Solomon, 2011:7). Lack of condom use is a pattern replicated across married couples in Zimbabwe and is attributable to various socio-cultural factors (Nyatsvimbo, 2011:1). These factors may include couples' perceiving themselves to be of low risk or no risk at all because they are in stable unions. ZAPP-UZ (2012:2) argues that due to lack of couple engagement, couples' HIV counseling and testing services more than 50% of people in stable partnerships are not aware of their partner's HIV status. This leaves them vulnerable to HIV infection.

2.7. Factors that contribute to the acceptance of an HIV sero-discordant result

HIV testing for couples has become common in Zimbabwe and an increased number of couples are discovering that one partner is HIV-positive while the other is not (ZDHS, 2012: 14). Such couples bare the thorniest set of issues hence individuals react differently to the discordant result (Fetene and Ayalew, 2012:11).

Allen, Kautzman, Zulu, Musonda and Haworth (2012:5) contend that despite growing evidence of its importance, the concept of sero-discordance and the frequency of its occurrence are poorly understood in most African communities. In explaining his state of affairs, Nirembe (2010:1) argues that discordant results are often difficult to accept among couples probably because it is difficult for health care providers to explain discordance in simple terms. The Global AIDS Program (2008:220) observes that increased understanding and acceptance of HIV discordance requires intensive training of health workers, proper referral to treatment, care and support organizations. This training will give health workers the ability to handle discordant results and enable health workers to give accurate information on sero-discordance (Nirembe, 2010:1). This

in turn will help HIV discordant couples to accept the results and commit themselves to better decision-making in relation to transmission and prevention strategies (Global AIDS Program, 2008: 220).

The National Institute of Health (2011:17) argues that when an individual is faced with a life threatening condition such as heart and cancer diseases, they experience psycho-social stress. Similarly, the HIV infected individual in a discordant relationship may experience unique stressors such as fear of transmission, societal pressure, shame, guilt, anger, regret and lack of support (Katherine et al. 2011:940). If these factors are not effectively addressed they may affect the degree to which an individual or a couple accepts their sero-discordant status. The Global AIDS program (2008:222) further notes that in order to increase acceptance of the HIV discordant status, there is great need to relay the HIV discordant results to the couple in a way that the couple can easily understand.

In order to enhance understanding of sero-discordance and acceptance of the sero-discordant status as well as minimizing the confusion created by such a puzzle, the Global AIDS program (2008:226) suggests the following points as essential.

- The counselor should emphasize that the results are accurate and indicate that one partner is infected and the other is not.
- It is common for one partner to be infected even if the couple has been together for a long time and had children; this implies that transmission of the virus has simply not occurred.
- Immunity to HIV is exceedingly rare and only occurs in very unusual circumstances and this should not be considered an explanation for discordance.
- There is only an exceptionally small possibility that the uninfected partner was infected by a recent exposure that was not detected by the infection within a few weeks.
- The uninfected partner remains at a very high risk of becoming infected through exposure to the infected partner.

- The longer the infected partner lives with the virus and the more exposure to the uninfected partner the more likely the uninfected partner will become infected. This implies that without risk-reduction all the discordant couples will ultimately become concordant positive.

Nirembe (2010:1) further argues that HIV discordance should therefore be taken as a standard procedure in HIV and AIDS testing facilities. Upon learning of their discordance, couples often feel traumatized and experience feelings of guilt, fear, stigma, gender inequality and rejection. All these aspects contribute to the degree to which the couple will accept the result. The Global AIDS Program (2008:227) asserts that this ability will help the counselor give accurate information on discordance and as a result the discordant couple will understand and accept the result and commit to positive living. Counselors need to pay attention to their choice of words and should choose appropriate information for explaining discordance to concerned couples. The Global AIDS Program (2008:230) argues that by addressing this gap one helps the couple to understand their HIV discordance better and make decisions in relation to mutual disclosure of results, prevention of HIV, child bearing, adherence to antiretroviral therapy, and maintenance of the discordant relationship.

2.8. Socio-cultural issues that influence HIV prevention among sero-discordant couples

(a) Gender based violence and patriarchy

The degree to which married couples in an HIV sero-discordant relationship make decisions and choices pertaining to HIV prevention is controlled and shaped by gender-related values and norms defining masculinity and femininity (Solomon, 2011:7). The cultural practices, values and norms and traditions have strong influences on the individual's sexual behavior and are important determinants of couples' vulnerability to HIV (Dibua, 2010:37). Beyeza-Kashesya et al. (2010:145) note that there are various socio-cultural issues that are common to people living with HIV/AIDS but sero-discordant couples are confronted with multifaceted socio-cultural challenges. In this instance, socio-cultural factors have a strong relationship with the prevention of HIV because the personal risk of contracting HIV is determined by numerous social and

cultural factors that shape gender and sexuality, perception, attitudes and behaviors. Ogunbodede (2004) asserts that there is great need for cooperation between medical research and the socio-cultural arena of HIV discordant couples in order to achieve maximum prevention of HIV transmission.

Gender norms are deeply rooted in the socio-cultural context of each society and are enforced by practices in that society. Socio-cultural norms generate aspects of masculinity and femininity which in turn create inequality of power relations between men and women (Beyeza-Kashesya et al. 2010:145). The power imbalance controls women's and men's access to key resources, information and their sexual decisions regarding HIV prevention strategies. It negatively affects the HIV-negative woman's sexual autonomy and expands the HIV-positive partner's freedom and control over sexuality by indulging in unprotected sex (Fishel et al. 2011:6). The gender role prescribed to women or feminism leads them to be submissive and passive on making decisions regarding HIV prevention (Wendell, 2009:46).

Socio-cultural issues such as a marriage's cultural context, child bearing and rearing, disclosure of the HIV status, religion and traditional beliefs have been found to inhibit decision making in relation to preventing the contracting of HIV. The result is to expose the HIV-negative partner to the ills of HIV/AIDS (Dibua, 2010:37). Therefore, socio-cultural beliefs and values about sex and HIV prevention are of great importance in discordant couples' ability to determine HIV prevention strategies (Beyeza-Kashesya et al. 2010:156).

Fishel et al. (2011:6) emphasize the fact that the HIV-negative members of the couple are a population at increased risk of infection and are in need of specially designed services to reduce their susceptibility (Dibua, 2010:37). Beyeza-Kashesya et al. (2010:166) argues that there is great need to address socio-cultural issues that influence couples' sexual practices and decisions on preventing HIV. Dibua (2010:37) asserts that HIV/AIDS is a social disease and efforts in controlling the pandemic meaningfully and adequately require a proper identification and evaluation of the socio-cultural norms and practices that are likely to expose the individual members of the couple to the condition. The United Nations Program (2012:16) concurs that addressing the socio-cultural behaviors and values of the communities that expose couples to HIV risky behaviors can lead to effective HIV/AIDS interventions for sero-discordant couples.

(b) Gender dynamics among HIV discordant couples

HIV prevention trials with heterosexual HIV discordant couples have focused mainly on the treatment and prevention of the epidemic, at the same time overlooking the relationship and gender dynamics in HIV sero-discordant relationships (UNAIDS, 2010:16). To this effect, Reiners (2012:418) argues that the central role of the dynamics that take place within such relationships and the role played by socio-cultural constructs of the feminine and masculine have not been fairly addressed in Zimbabwe (cf UNAIDS, 2012:26). In concurrence, Wendell (2009:46) argues that most societies have predominant ideologies that indicate the control men and women have on certain resources. This difference in roles and behavior sometimes gives rise to gender inequalities (Katherine et al. 2011:940).

(i) Sexual decision making:

The Zimbabwe Ministry of Health and Child Welfare (2000:7) note that the Zimbabwean society is by and large a patriarchal and traditional society emanating from the socialization process. Consequently, decision making is mainly in the hands of the male partner thereby putting the female partner in a suppressed position. Chitando (2008:277) argues that the gendered structure of sexual decision making is informed by Christianity as well as traditional religious sexual socialization. However, the National Arts Council of Zimbabwe (2012:5) argues that today some of the country's traditional values and beliefs seem to be disappearing because of various factors such as colonialism, urbanization, globalization and acculturation, and hence not all men have power over women.

Zalewski (2010:60) captures the feeling among African men by noting that African men seem to be concerned with the ideas of equality between men and women in terms of marriage. Under this setting, HIV-negative women's worth in a discordant relationship is devalued and her subservient role heightened as they are considered to be perpetual minors who are not supposed to have a say within a marriage.

To this effect, gender inequality in marital relations, especially in sexual decision making, increases women's vulnerability to HIV transmission. Current data on a nationally representative study in Kenya, Uganda and Malawi proved that over 80% of new HIV infections suggest that

the incidence of HIV is rising among married and cohabitating HIV discordant couples. In spite of them having knowledge of their spouse's HIV-positive status, HIV-negative women are unable to protect themselves due to an imbalance of power within relationships created by economic and emotional dependence (United Nations program, 2009:11).

Recent studies have shown that ideologies and social constructions of gender frequently lead to high risk sexual practices and eventually result in HIV infection among married women (Pierotti, 2013:2). Wendell (2009:15) further viewed these ideologies as also being cognitive rather than restricting them to the social and political perspectives. These social constructs affect the day to day operations of these couples including fear of transmission, condom use and safer sex practices, child bearing issues, ability to disclose and even ability to adhere to antiretroviral therapy as an HIV prevention strategy. In her critical analysis, Collins (2008:2) focuses on various groups of people in different situations, whose lives were characterized by injustice emanating from the social and cultural forces surrounding those individuals.

Wendell (2009:17) argues that in order for women to act with hope in opposing oppression, they need to view themselves as human beings capable of instilling change and power to direct their own lives. However, radical feminists like Butler (1990:72) argue that the distinction between sex and gender turns out to be of no consequence at all. Hence to be a woman is a social construction which is then used by patriarchy to oppress the subject of that construction. Lippa (2010: 982) observes that among HIV discordant couples, some women are perpetrators and some men become victims of sexual abuse due to various factors, some of which include loss of a job, sexual incompetence and age gap as the husband maybe too old to sexually satisfy the young female partner. However, Lippa (2010:1137) argues that 'not all men have power and not all of those who have power are men.' On the other hand, Wendell (2009:17) views man as an individual who has increased levels of aggression and a woman as an individual who looks for someone to depend on. This state of affairs compromises the efforts of HIV prevention amongst HIV discordant couples. Radical feminists like Butler (1990:7), and as supported by Wendell (2009:18), concur that being a woman is a good thing but the good attributes of a woman are not recognized in a patriarchal society where women are oppressed. However, Cornwall (2009:61) argues that masculinity is not always linked to men because women can also display masculine

attributes and masculine and feminine attributes are not constant throughout cultures, but can be seen in men or women. Wendell (2009:20) concurs that the gender oppression theory further suggests that women are unequal to men and exist under subordination, oppression and abuse by men. Zalewski (2010:61) posits that women's behaviors are culturally constructed and nurtured.

Gender based violence has become a common practice in almost all societies. Acts of violence greatly increase vulnerability to HIV especially for women and marginalized groups such as discordant couples. Various social, cultural and religious norms are responsible for gender inequality that characterizes gender based violence. The Musasa Project (2010:16) argues that gender based violence is a key factor in increasing fear and the risk of contracting HIV. It further notes that sexual encounters characterized by coercion and violence overweigh negotiation. The Musasa Project (2010:17) further argues that women can face forced sexual intercourse because culturally men demand submission and respect; hence the HIV-negative partner faces a challenge in terms of HIV transmission and prevention. Gomez (1993:742) notes that fear of partner has been cited by a significant group of Latin American women as the reason why they do not raise the issue of condom use with their partners. In their qualitative research study, Sandy, Jorworsky, Newmeyer, Hough, Rachlis, and Martin (2011:37) note that fear of transmission has an adverse effect on couples' relationships as it results in sex partners feeling discomfort and experiencing difficulty in communicating about HIV issues.

Mugurungi (2012:28) notes that the level of dependence of women on men or vice versa given the economic melt-down in Zimbabwe remains a high contributing factor. Duflo (2012:1054) concludes that it is an established fact that women tend to depend more on men for money and economic welfare and this dependence obviously increases the vulnerability of a woman in negotiating for safer sex. The Population Action International (2008:2) buttresses the argument by stating that in sub-Saharan Africa and many other parts of the world women have lower educational, hence they have fewer economic opportunities than men.

Smith (2006:10) concurs when he notes that the standpoint of men is consistently privileged and that of women devalued. In respect of this, gender dynamics negatively impact women worldwide, hence Population Action (2008:18) asserts that gender based violence plays an overlooked but significant role in women's vulnerability to HIV. Butler (1993:224) emphasizes

the point that gender performances are culturally sustained, for example, the authoritative speech by male partners and statements that exercise a binding power make women vulnerable. This is supported by Harding (2009:206) stand point theory which posits the idea that what an individual knows is controlled by where he or she stands in society. This reflects the specific attitudes, emotions and values that partners in an HIV discordant relationship have in relation to prevention of HIV.

(ii) Lack of condom use

Nyatsvimbo (2011:1) argues that condom use is not expected in a marital bed in most African countries. Sandy et al. (2011:37) also argue that condom resistance among African cultures is a challenge. On the same note, Kigozi (2008:74) argues that condom resistance among HIV discordant couples still remains an issue and despite them being confirmed discordant, the couples continue to practice unprotected sex. Therefore, lack of or inconsistent use of condoms is a pattern replicated across African marriages and can be attributed to a number of socio-cultural factors which include the idea that couples perceive themselves to be at low risk or no risk at all because they are in stable unions, diverse cultural beliefs, norms and values and also lack of knowledge concerning the issues of sero-discordance (Magure, 2012:13). Cultural stigma and taboos around condom use increase men's and women's vulnerability to HIV. Mugurungi (2013: 32) argues that besides being regarded as taboo, most husbands will not agree to use a condom. A common belief amongst married people seems to prevail that the use of condoms is not for married people and that married women have little or no choice on condom use (Nyatsvimbo, 2011:1).

(iii) Desire for children

Solomon (2011:8) argues that marriage is socially and culturally influenced. Therefore, marriage is the accepted norm in most African countries and couples are expected to have children (Masuku, 2005:81). To this effect, Mbiti (1980:330; cf Tichagwa 1998:50) posits that an individual who does not participate in marriage and procreation does not gain status and is regarded as sub-human and a curse to the community. The HIV-negative woman in a discordant relationship will be under pressure to give her husband children, hence issues of barrier

prevention methods are not considered in such relationships (Ackermann and Klerk, 2002). Motherhood is regarded as a key symbol of femininity, so the use of contraceptives such as barrier methods in preventing pregnancy and HIV present difficulty in such relationships. As a result of this, Beyeza-Kashesya et al. (2010:145) argues that the desire to have children is quite common in the African culture and HIV discordant couples experience pressure from in-laws and the society who will be ignorant of the couple's HIV status.

(iv) The Quest for sexual satisfaction/fulfilling sexual gratification

Sexual partners strive to fulfill sexual gratification by suppressing their own sexual desires and taking the risks that militate against their own health. Sexual partners do this to stop the other partner from seeking sexual intercourse outside marriage. In Zimbabwe, one in eight married men have casual sex with more than one sexual partner while only one in a hundred married women have sex outside marriage (DeWalque, 2007:523). This inhibits discordant couples from engaging in safe sexual acts, thereby exposing the HIV-negative partner to the risk of HIV transmission. Sexual partners are paralyzed from perceiving the real risk of being discordant and taking preventive measures against the spread of HIV to the negative partner. DeWalque (2007:513) argues that high levels of quest for sexual gratification remove the need for precautionary measures. From a relationship point of view in Zimbabwe, women have to live to please men; they have been conditioned to prevent men from feeling uncomfortable and as a result indulge in sexual intercourse without using a condom.

(v) Religion

It should be noted that from an African point of view, for one to be considered human and to gain recognition the individual needs to belong to the whole community. This implies taking part in festivals, ceremonies, religious beliefs and rituals of that community (Mbiti, 1980:2). Zimbabwe is a multi-religious society since in it one finds African traditional religions, Christianity and Islam. These religions dominate the religious culture in the country. To a certain extent, they may expose the HIV-negative partners to HIV infection through the misconceptions and misperceptions that are rife in their religious set up (Global AIDS program, 2008:222).

Religion and religious beliefs are the cornerstones of life in a majority of marriages and these provide ethical guidelines for different aspects of life, including sexual beliefs and HIV prevention. Mbiti (1980:2) argues that religion is the major force in the construction of masculinity across Africa and other parts of the world. Some of the religiously tailored belief systems such as the apostolic sect of Johanne Marange and Johanne Masowe discourage condom use, as well as treatment for prevention under the guise of religion. Muchena and Tapfumaneyi (2011:6) argue that such beliefs and practices place the HIV-negative partner at a disproportionate risk of contracting HIV. On the same note, Kathryn (2012:1) notes that the Catholic Church showed resistance towards condom use and other different forms of contraception and promoted abstinence. However, a historic change to the church's longstanding ban for contraceptives took a new turn when Pope Benedict XVI approved condom use (Kathryn, 2012:2). It is, however important to note that from the time condom use was allowed, fear and embarrassment still characterizes condom use among the Catholics and the change has not yet had enough impact on the ground (Kathryn, 2012:2). Such religions which advocate against condom use create a challenge against the prevention of HIV among discordant couples; hence they expose the negative partners to the wrath of HIV/AIDS. To this effect, Solomon (2011:5) asserts that while HIV prevention strategies such as antiretroviral therapy, treatment for the HIV uninfected partners, condom use and male circumcision have shown substantial benefits, the uptake of these strategies is hindered by socio-cultural factors.

Chitando (2008:2) argues that some religions advocate for women to be submissive to their husbands, thereby encouraging gender inequality and promoting gender stereotypes. On the same note, Chitando (2008:55) asserts that religion is the major force in the construction of masculinities in most African countries in which women have been made to believe that it is not ideal for them to negotiate safe sex. This increases the vulnerability of the HIV-negative partner to HIV infection. Religious belief systems and practices, that perceive HIV discordance as a curse and as an unacceptable practice among married couples further compound the situation. Solomon (2011:7) argues that denouncing HIV discordance tends to fuel stigma against HIV discordant couples. This has the effect of indirectly increasing the negative partner's vulnerability to HIV. HIV related stigma is also triggered by many forces such as lack of

understanding of HIV sero-discordance, fears relating to transmission of HIV, illness and death (Nirembe, 2010:2).

Besides being social determinants of vulnerability, religions have great potential for preventing HIV and reducing stigma among discordant couples (Lindsey and Beach 2000:433). Mbiti (1980:1) argues that religion is the strongest element in the traditional background and exerts probably the greatest influence upon the thinking and living of the people concerned. Lindsey (2000:433) asserts that religion has been known to be a significant source of social coercion. This is as a result of the influence that religious leaders exert on the community, including issues of behavior change interventions, including condom promotion among HIV discordant couples in order to reduce HIV transmission to the negative partner.

(vi). Alcohol /substance use and non adherence to ART

Alcohol and substance use has been associated with non adherence to ART in HIV-positive patients who are taking ART (Braithwaite and Bryant, 2008:280). In this respect, Cook, Dereika and Hunt (2001:83) assert that although HIV related deaths have since declined, they are still common among patients who do not take their medication as prescribed, resulting in reduced treatment effectiveness.

Cook, Dereika and Hunt (2001:83) argue that alcohol consumption is a strong and consistent risk factor for poor ART adherence across a wide spectrum of patient cohorts and care settings. Braithwaite and Bryant (2008:283) concur that the use of alcohol and substances affect the survival chances in HIV infected people through various pathways and the most crucial pathway being through effects on ART adherence. Alcohol and substance use is a socio-cultural factor that requires attention among HIV-positive individuals as it impacts on the treatment benefits as well as on the prevention of HIV from the HIV-negative partner.

2.9. Theoretical framework

Sexual decision making among sero-discordant couples is a central variable for analysis in this study as it contributes to HIV prevention. The following theoretical construct is proposed as the analytical framework for this study:

2.9.1. Symbolic interactionism

Symbolic interactionism is a sociological humanistic theory proposed by Mead (1863-1993) and popularized by Blumer (1969). The theory is anchored on the belief that human beings are active participants in the construction of social reality and the meaning of events comes from interaction of the individuals (Blumer, 1969:2). The major tenet of symbolic interactionism is that meanings are derived from social processes. It seeks to understand how the inter-subjective world is constituted on everyday basis and how individuals learn to interpret the world (Oliver, 2011:411). The theory aims to uncover, describe and understand the meaning of human experiences in a particular situation (Wolf, 2011:36). Therefore the primary objective of symbolic interactionism is to interpret and describe the creation of a person's self and socialization into a larger community through such ways as meaning, language and thought (Charon, 2007:87). Symbolic interactionism suggests that human beings are best understood in relation to their environment and their associations and also how they are affected by the same (Blumer, 1969:2, Reynolds and Kinney, 2003:19).

Symbolic interactionism is proposed for this study since it gives room to understand in-depth events, activities and processes in a person's social life (Oliver, 2011:412). This framework provides a mechanism to understand the establishment of meaning through interacting with the participants and through that, clarification of values is achieved (Blumer, 1998:3). The way the HIV discordant couples interact and create meaning given their otherwise diverse situations, will help this study to isolate the significant variables that go into decision making. It is this decision making that makes people adapt and/or accept or find it difficult to cope with their situation.

Symbolic interactionism, however, has its own limitations especially on the prominence of subjectivity in the interpretive process and meaning formation. Arguments have been raised that people do not necessarily create new meanings in given situations but they recall previously held

meanings upon a situation because meaning is already established in a person's psychological make-up (Blumer, 1969:2). This creates a conundrum which this study benefits from as it directly compares individual decision making as influenced by culture and society.

Symbolic interactionism helped the researcher to step into the world of HIV discordant couples and to examine how these couples view themselves and how they are viewed by others, thereby investigating into the influences of socio-cultural factors on their decisions to prevent HIV transmission. The theory helps the researcher to see how HIV discordant couples construct their sexual realities, from which they follow their sexual beliefs and practices. Symbolic interactionism helps the researcher to answer questions usually asked when studying HIV discordant couples. Some of the questions include (a) what are the main socio-cultural factors that influence HIV prevention decisions in HIV sero-discordance couples? (b) what are the factors that contribute to the acceptance of the sero-discordant status by the concerned couples? (c) what are the factors that contribute to the rejection of the sero-discordant status by the concerned couples? These types of questions will help the researcher investigate how the HIV discordant couples are viewed by others and thus create the 'looking glass.' The researcher will investigate the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples using the three core principles of symbolic interactionism as outlined by Blumer (1996:2). This will help the researcher evaluate human interaction. While this is fairly significant, it will be easy to see how HIV prevention among sero-discordant couples can be a challenge if the lines of socio-cultural factors are not dealt with and assumptions are made.

2.10. Conclusion

This chapter provided the context within which to examine HIV sero-discordance and the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples enrolled in the HPTN 052 study. This review of literature gave a brief overview on HIV sero-discordance and its evolution, the global perspective and extent of HIV sero-discordance, the African /regional perspective of the phenomena and the Zimbabwean perspective. Scholarly views that were reviewed indicated that acceptance of HIV sero-discordance is influenced by the couple's level of understanding of discordance, among other factors. Uptake of prevention strategies is dependent on socio-cultural factors and underlying gender dynamics. The chapter

also presented the symbolic interactionism humanistic theory which will underpin the study. The study's methodology and research design will constitute the central discussion in the next chapter.

CHAPTER 3

RESEARCH METHODOLOGY AND DESIGN

3.1. INTRODUCTION

The previous chapter focused on reviewing existing literature on socio-cultural factors that influence the uptake of HIV prevention strategies among HIV discordant couples and factors that contribute to the acceptance of an HIV sero-discordant result. This chapter intends to present the research methodology that the researcher utilized. Methodology encompasses aspects of the research design, study population, data collection techniques and instruments, sampling design and the ethical considerations involved in carrying out the study.

3.2. Research methodology/design

Cohen, Manon, and Morrison (2000:44) argue that methodology in research involves a systematic process of collecting data from a given population in order to understand a phenomenon. The researcher used a qualitative approach because it provides a deep insight into ‘the complex world of lived experiences from the point of view of those who live it’ (Schwandt, 1994:118). The qualitative approach assumes that reality is socially constructed and the researcher becomes the vehicle by which the reality is revealed (Cavana, Delahayee and Sekaran, 2001:112). The chosen approach is consistent with the construction of the social world characterized by the interaction between the researcher and the HIV discordant couples. Garcia and Quek (1997:459) argue that the researchers’ interpretation plays a major role in this kind of study because it brings subjectivity to the forefront, supported by substantial arguments instead of statistical exactness. The approach enabled the researcher to establish meaning, thought and language around the socio-cultural issues that influence HIV prevention amongst HIV discordant couples (Cresswell, 2003:23).

The purpose of this study was to investigate the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples currently enrolled in the HPTN 052 study in Harare, Zimbabwe. The study is premised on understanding the sociology and psychology of culture, norms and values in influencing HIV prevention decisions of couples in a sero-discordant relationship.

The interpretative design paved way for the researcher to understand in-depth events, activities and processes involved in the couples' sexual decisions regarding HIV prevention strategies (Oliver, 2011:411). Researchers using qualitative interpretive design tend to lay considerable emphasis on situational and often structural contexts (Oliver, 2011:412). Focus is mainly on the subjective experience of the individuals and their perceptions of reality. This was achieved by the researcher's ability to explain the socio-cultural factors on HIV prevention strategies among HIV discordant couples using the three core principles of meaning, thought and language as outlined by Blumer (1969:2). In this regard, the interpretative design was used to understand the couples and to clarify values related to their sexual decisions pertaining to HIV prevention strategies.

The interpretative design was used in this study to evaluate the interaction between HIV discordant couples in terms of HIV prevention strategies. While this is fairly significant, the use of this design made it easy to see how HIV prevention among discordant couples can be a challenge if the socio-cultural aspects are not properly interrogated and addressed.

3.3. Sampling technique and procedure

3.3.1. Availability/ convenience sampling

A sample is a special subset of a population observed for purposes of making inferences about the nature of the total population itself (Polit and Hungler, 1995:279). The researcher used availability/convenience sampling which is a non-probability sampling technique.

Streubert and Carpenter (2011:102) argue that availability sampling or convenience sampling is a non-probability sampling technique whereby participants are selected because of their convenient accessibility and proximity to the researcher. Patton (2002:137) asserts that availability sampling is often appropriate in social research in instances where the researcher cannot access all the elements in the target population. In this case, the sample was drawn from a population of HIV discordant couples currently enrolled in the HPTN 052 study in Harare, who were readily accessible to the researcher and willing to participate in the study. The target participants for this study had to be aged 18 years and above, should have participated in the HPTN 052 study for at least 2 years and residing within a radius of 40km of greater Harare.

The researcher opted for availability sampling because it was cost effective for a student dissertation and capable of enabling an in-depth study of a social phenomenon using fewer targeted cases (Streubert and Carpenter, 2011:117). The sampling method allowed the researcher to gain information without having to travel extensively to reach out to the whole target population, hence saving both time and money. Patton (2002:137) notes that when using this sampling method the researcher is assured that the selected sample has the appropriate characteristics. The researcher settled for 26 participants only because a much larger sample for a qualitative study of this nature would generate too much data which would be too cumbersome for analysis (Streubert and Carpenter, 2011:127)

However, the biggest risk with availability sampling is that the selected cases may not have been the best cases to represent the phenomenon hence biasing the results probably because only similar cases could have been selected erroneously by sheer coincidence (Guion, Diehl and MacDonald, 2011:13). The researcher minimized this limitation by collecting data through FGDs and in-depth interviews as a way of triangulating findings.

3.4. Procedure for selecting participants

Couples were informed of the study and those who expressed willingness to participate were recruited for IDIs and FGDs. A participant daily log book was used to identify couples who would have reported for clinic procedures on that day. Some of the targeted couples opted out of the study right at the beginning for different reasons such as; (a) not having time to attend interviews due to work commitments, (b) a single member of the couple would agree to participate and the other declines, and (c) regarded the process as tedious because the interviews were to be conducted after the HPTN 052 study procedures.

Despite these 'opt-outs' the researcher managed to recruit an adequate target sample. Five couples were selected and interviewed individually. Eight couples were recruited and separated by sex into different focus groups to accommodate marriage related sensitivities. The participants for the focus group discussions were different from those selected for IDIs in order to triangulate both the methods and data obtained (Guion et al. 2011:3). The total sample for the study was 26 individuals.

3.5. Reliability and validity of data

Hofstee (2006:116) argues that it is quite critical to pretest instruments to see whether they are measuring what they are supposed to measure. Reliability and validity in this study were ascertained by pre-testing the research tools and assessing whether the question had the same meaning to different people and validity was ascertained on whether the tool had the ability to obtain the data that the researcher intended to get. The IDI guide was pre-tested using 3 couples who were interviewed separately. The FGD guide was also pre-tested using 8 couples who had attended a quarterly support group meeting. The FGD guide was pre-tested using 2 homogenous FGDs. Mavhu, Langhaug and Manyonga (2008:564) assert that pre-testing the instruments is a crucial stage of the study, yet its importance is underrated and often limited to piloting questions to check their understandability. Effective pre-testing of instruments in this study was done through cognitive interviewing, defined by Mavhu et al. (2008:7) as a well validated technique for pre-testing instruments that brings out those aspects that play a part in providing a given response. It affords the participants an opportunity to come up with solutions on restructuring the interview question and interpret the cultural context within which responses are given. Cognitive interviewing in this study was done through the verbal probing technique which allowed the researcher to have control of the interview and motivate the participants to say more (Caspar, Lester and Gordon, 1999:6). This method of pre-testing instruments was used in order to help the participant to comprehend the question in a way he or she believes the question demands to be answered. It also gave the researcher a clue on what relevant information did the participant need to recall in order to respond to the question. Through the use of cognitive interviewing, the researcher was provided with an insight into how to word sensitive questions in the interview guides (Mavhu et al. 2008:570).

3.6. Data collection techniques and data collection tools

The study used the qualitative data collection techniques of in-depth interviews and focus group discussions (FGDs) to collect data. The concurrent use of two data collection methods helped the researcher triangulate data obtained through the two methods. Triangulation of data increases the validity of research undertakings (Guion et al. 2011:1). In addition, notes and observations made

during interviews were used as additional sources in the study. For further elaboration, secondary sources such as existing literature on sero-discordance were used.

(a). In-depth interviews (IDIs)

In-depth interviews (IDI) were conducted when couples came for their scheduled clinic visits for the HPTN 052 study. Guion et al. (2011:1) regards an IDI as a discussion where a participant is prompted to say more regarding the topic under discussion. To cater for sensitivity and privacy, participants were interviewed individually in a private room and interviews were audio taped and transcribed verbatim. All interviews were conducted in Shona unless the participant preferred to use English. Shona is the researcher's first language and is the predominant language in the geographical area of the study. The study proposed in-depth interviews because they are based on open ended questions, which allowed for an open and trustful discussion, made possible exploration of sensitive issues and stimulated natural conversation (Harrell and Bradley, 2009:6). Verbal and non-verbal cues were observed in order to add value to the data collected (Burns and Grove, 2008:114). This helped to unveil hidden feelings or unspoken communication. However, Guion et al. (2011:12) argues that self-reports of sensitive data are often unreliable especially when asking questions about behaviors that are culturally or socially censured. Since the researcher is professionally attached to the HPTN 052 project, some of the participants' responses were subjective in nature. To overcome this limitation, the researcher conducted IDIs with couples as individuals in order to thoroughly explore sensitive issues.

A semi-structured interview guide was used to collect data, which according to Cresswell (2009:13) is a good alternative since it helps in direct observation, collecting past data. The questions in this tool led to more specific answers by keeping the discussion on track (Streubert and Carpenter, 2011:115). However, the interview guide had its own limitations. As argued by Guoin et al. (2011:3), opinions of the participants may vary from actual events, out of natural environment and some interviewees may not be able to effectively communicate their experiences.

(b) Focus group discussions (FGDs)

Morgan and Margaret (1999:253) describe a focus group discussion as a qualitative data gathering method where participants are purposively selected to discuss issues on a specific phenomenon of mutual interest to them and the researcher. FGDs were conducted in a private room when participants attended their scheduled support group meetings. The FGDs were constituted based on one's sex to cater for husband-wife sensitivity. On the same note, Burns and Grove (2008:116) observes that FGDs bring several participants together, obtain divergent views and an increase in balanced views is achieved. This technique provided a convenient way to interact and learn from the target audience by getting multiple responses from a single question. Streubert and Carpenter (2011:163; cf Harrell and Bradley 2009:82) argue that in this set up, participants may tend to withhold sensitive information or behavior they may think is socially unacceptable. To overcome this limitation, the researcher allocated less sensitive questions to the FGDs in order to put participants at ease (Cook, 2012:44).

A focus group discussion guide was used to collect data during focus group discussions. According to the Centers for Disease Control and Prevention (2008:1), the FGD guide is composed of a series of questions that serve as a road map and memory for the facilitator. Similarly, the Office of Quality Improvement (2007:4) views an FGD guide as an important data collection tool that produces valuable information not likely to come from personal interviews. However, Morgan and Margaret (1999:254) argue that the FGD guide is limited in that the information required by this tool does not represent any other groups and the exploration of questions is controlled in order to cater for sensitivity among members of the group.

3.7. Limitations of data collection techniques

The limitations of the study's data collection techniques included the inherent internal conflict between the individual's subjectivity and the socio-cultural dynamics which are group defined. In an attempt to address this limitation, the researcher mixed data collection methods that privileged the individual's perspective with group generated perspectives using in-depth interviews and Focus Group Discussions.

Another limitation with the data collection techniques came from the role of the researcher herself. The influence of the researcher in the study cannot be underestimated as she works as some form of a filter and in the process influences the study. In the same way, there was a dilemma on how the researcher would 'exit' after the completion of the study considering the intimate information given during data collection. This is especially considering that the participants were fully aware that the researcher is a staff member of the HPTN 052 study. However, the researcher made an effort to be reflexive and approached the study with an open mind and not with pre-conceived ideas to the greatest extent possible.

3.8. Data analysis and interpretation:

Streubert and Carpenter (2008:60) define data analysis as a mechanism for reducing and organizing data to produce findings that require interpretation by the researcher. In this qualitative study thematic analysis (TA) was used to analyze data. Neumann (2008: 61) defines thematic analysis as the categorization of data into meaningful themes. It is a data analysis approach which focuses attention on identifying patterned meaning across a data set (Frost, 2008:2). It is used widely in various disciplines like the behavioral, social, clinical, health and educational sciences.

During the process of collecting data, the researcher was also involved in the data analysis process. In this respect, all recorded data, including non-verbal communication and emotional responses were initially transcribed by the researcher. Grinnell (1997:263) argues that data transcription provides an opportunity to 'review and connect' with data.

Thematic analysis can be approached in various ways, some of which include inductive, deductive, realist and constructionist ways of analyzing data. However, in this instance the researcher used the inductive way whereby coding and development of themes were directed by the content of the data collected (Thomas, 2003: 2). The researcher familiarized herself with the data collected by means of reading and re-reading it in order to be acquainted with the content of the interviews. This was done through the researcher writing notes and capturing the key ideas and the meanings from the data. Interview responses were coded manually and grouped into themes. Themes were searched to examine the codes and organized in order to identify

significant themes. Each individual case was described thoroughly and themes were identified with special reference to the research questions. Themes were later reviewed and a detailed analysis of each theme was developed through defining and naming the themes and finally producing a write up.

3.9. Ethical considerations

According to Fouka (2011: 4) research ethics demand an individual to make choices and actions in relation to participation. The Office of Human Research Participants (2012:62) argues that research with human participants raises a wide range of ethical issues which researchers need to address in order to effectively prevent harm. As rooted in the Nazi experiments conducted on large numbers of prisoners by Germans, research with human participants is expected to involve three fundamental principles of respect, beneficence and justice (UNAIDS, 2003:3).

(a) Permission to conduct research

Permission to conduct the study was sought from the Principal Investigator and Director for the University of Zimbabwe Clinical Research Centre, the Medical Research Council of Zimbabwe (Ethics Committee) and the Higher Degrees Committee (UNISA Department of Sociology).

(b) Informed consent

Informed consent is a critical ethical component when conducting research with human participants. Martha, Rumay, McBride, Smith, and Ruiz (2010:192) state that informed consent implies that a person knowingly, voluntarily, intelligently and in a clear and manifest way gives his consent. On the same note, Sercombe (2010:9) argues that an informed consent is a process whereby a participant is expected to understand the research procedures, risks and benefits of the study. In this respect, a participant's signature only is not considered adequate for an informed consent because an informed consent is a process with four key considerations which are: information exchange, comprehension, voluntarism as well as documentation of the whole process (Royal College of Nursing Research Society, 2011:3). The goal of informed consent in this study was to respect the participants' dignity by means of obtaining written informed consent prior to any study procedures. This was done in a language easily understood by the participants. In line with the guidelines by the National Institute of Health (2011:31), the

researcher informed each participant about his or her right to participate, clarified the purpose of the study, described and explained what would be done and specified duration of the study and time spent in IDIs and FGDs. The risks and benefits were also outlined without deception to ensure a non-coercive process (Laura, 2010:1186)). Participants were informed that their participation would be voluntary hence they were free to withdraw from the study at any given time without losing any benefits and services offered to them by the University of Zimbabwe Clinical Research Center.

(c) Confidentiality

Sercombe (2010:10; cf UNAIDS 2003:3) asserts that confidentiality is a cornerstone of most professions and is central to the maintenance of trust between the researcher and the participant. Individuals are free to give or withhold as much information as they want. Therefore, in this study the researcher protected participants to the extent that information in their records and what they said was not at any point linked to the participant's identity or disclosed without the participant's consent. Limitations of confidentiality were discussed, for example, disclosure of information if necessary, in order to protect the participant from risk of death or serious harm. McCormick (2012:10; cf Sercombe 2010:10) also argues that there are ethical problems in maintaining confidence. Therefore, there can be a breach of confidentiality in order to protect the society or the participant from engaging in harmful acts. To ensure confidentiality of participants' information, each participant was identified by a code allocated to them by the researcher as they enrolled for the study. This was supported by Frank (2013:1) who emphasizes that the use of pseudonyms or codes helps in distorting details of interviews when transcription takes place. Since confidentiality cannot be guaranteed in focus group interviews; participants were advised that the researcher will take all precautions to ensure confidentiality of data.

(d) Anonymity

Considering the sensitivity of the subject under discussion, it was important for the researcher to observe the anonymity of the participants. To observe this anonymity, the researcher did not request participants' real names. Participants were allocated codes which were used to identify the individual during the data collection processes.

3.10. Conclusion

The purpose of this chapter was to present the methodology that was used in the study. The chapter focused on procedural aspects of the study which included the research design, study setting, data collection techniques and tools, sampling technique, data analysis and interpretation, as well as the ethical considerations in conducting research with human participants. The next chapter will present and discuss the study's findings.

CHAPTER 4

RESEARCH FINDINGS AND DISCUSSION

4.1. INTRODUCTION

The previous chapter detailed how the research was conducted. This included a description of the research design, study setting, data collection techniques as well as ethical considerations involved in conducting the study. This chapter uses thematic analysis to present and discuss the research findings from in-depth interviews and focus group discussions. Significant data in the form of statements obtained through in-depth interviews and focus group discussions will be presented and discussed according to identified themes, while retaining individual and peculiar differences regarding the participants' experience. Each theme will be identified with special link to the research questions. The study sought to investigate the influence of socio-cultural issues on sexual choices and the resultant implications on HIV prevention strategies among HIV discordant couples. In this chapter, an attempt will be made to answer the following research questions.

- (a) What are the factors that contribute to the acceptance of the sero-discordant status by concerned couples?
- (b) What are the factors that contribute to the rejection of the sero-discordant status by concerned couples?
- (c) What are the main socio-cultural factors that influence HIV prevention decisions in HIV sero-discordant couples?

4.2. Table 2

4.2.1. Demographic characteristics of the study participants

Participant Code	Sex	Age	HIV Status	Work	Children	Education	Religion	No. of Years in Discordant R/Ship
IDI-01M	M	48	HIV+	Plumber	4	Diploma	Protestant	7
IDI-02F	F	42	HIV-	Vendor		Form 2	Protestant	
IDI-03M	M	47	HIV-	Welder	6	Form 4	Orthodox	10
IDI-04F	F	45	HIV+	cross-boarder		Grade 7	Orthodox	
IDI-05M	M	47	HIV-	Shop Assistant	3	Diploma	Protestant	9
IDI-06F	F	38	HIV+	Vendor		Form 2	Protestant	
IDI-07M	M	41	HIV-	Driver	4	Certificate	Orthodox	7
IDI-08F	F	35	HIV+	Dress-marker		Diploma	Orthodox	
IDI-09M	M	54	HIV+	Insurance Manager	6	Degree	Protestant	10
IDI-10F	F	50	HIV-	House wife		Diploma	Protestant	
FGD-11M	M	44	HIV+	Vendor	2	Grade 7	Orthodox	10
FGD-12F	F	40	HIV-	Dressmaker		Diploma	Orthodox	
FGD-13M	M	36	HIV+	Farmer	3	Diploma	Orthodox	7
FGD-14F	F	30	HIV-	Vendor		Form 2	Protestant	
FGD-15M	M	42	HIV+	Farmer	3	Certificate	Protestant	8
FGD-16F	F	30	HIV-	Vendor		Grade 7	Protestant	
FGD-17M	M	40	HIV-	Driver	4	Certificate	Orthodox	6
FGD-18F	F	38	HIV+	Pre-school Teacher		Certificate	Orthodox	
FGD-19M	M	47	HIV-	Plumber	6	Diploma	Orthodox	6
FGD-20F	F	40	HIV+	House wife		Form 4	Orthodox	
FGD-21M	M	38	HIV-	Petrol Attended	3	Form 4	Protestant	7
FGD-22F	F	34	HIV+	Security Guard		Certificate	Protestant	
FGD-23M	M	41	HIV+	University Lecturer	3	Degree	Orthodox	7
FGD-24F	F	38	HIV-	Primary School		Diploma	Protestant	

Participant Code	Sex	Age	HIV Status	Work	Children	Education	Religion	No. of Years in Discordant R/Ship
				teacher	2			7
FGD-25M	M	35	HIV+	Security Guard		Form 4	Orthodox	
FGD-26F	F	30	HIV-	Shop Assistant		Certificate	Orthodox	

Source: Obtained from HPTN 052 participant source documents, however participants were also asked these questions during IDIs and FGDs.

The sample comprised 6 HIV-positive women and 7 HIV-negative women, 6 HIV- positive men and 7 HIV-negative men. The couples have been diagnosed HIV discordant for 6 to 10 years. Their opinions on specific themes are weighed towards their sex and HIV status. All the quotations used have markers which show the aspects of sex and HIV status by an annotation in brackets showing (HIV-F) meaning an HIV-negative female or (HIV+F) meaning an HIV positive female. The code IDI or FGD indicates whether the participant was involved in in-depth interviews or focus group discussions. The couples who participated in IDIs and FGDs have their ages, sex, HIV status, and years of marriage in a discordant relationship, educational levels, religion and other relevant information tabulated above.

4.3. Research findings

The ensuing discussion shows the opinions of individuals whose lives are directly affected by not only the presence of HIV but also having to navigate the dynamics that come with the reality of HIV discordance. The analysis follows the views of participants around seven *a priori codes* decided upon in the best judgment of the researcher as representing the contours around HIV prevention strategies. This study is premised on a qualitative interpretive research design. A decision was therefore made to refrain from the usual methods of tabulation and frequencies. The analysis of the data involved coding of quotations according to pre-decided themes otherwise known as *a priori codes*.

Around these themes are analytically identified sub-themes defined by the direction by which respondents preferred to answer the questions. Of significance to the analysis is the direction of thought regarding the specific issue which worked as a prompt and the researcher's task is to then try and understand a particular direction of thought.

The main *a priori codes* used to guide analysis for objective 1 and 2 are as follows:

1. Meaning of being in an HIV discordant relationship
2. Acceptance and rejection of HIV discordant status

The main *a priori codes* used to guide analysis for objective 3 are as follows:

3. A condom as an HIV prevention strategy and efficacy of its use
4. Antiretroviral therapy as a prevention strategy
5. Voluntary medical male circumcision as an HIV prevention strategy
6. Pre-exposure prophylaxis as an HIV prevention strategy
7. Power dynamics in handling HIV prevention

4.4. Research findings objective 1 and 2

4.4.1. Theme 1: Meaning of being in an HIV sero-discordant relationship

As noted in Nirembe (2010:1), it is difficult for health care providers to explain discordance in simple terms and this makes it difficult for couples to accept them. The understanding of the meaning of HIV discordance therefore has a bearing on acceptance and rejection of HIV sero-discordance among HIV discordant couples. Participants were asked to explain what being in a HIV discordant relationship meant to them. Some of the HIV-positive participants argued that in their view being the positive partner in a discordant couple was a clear indication that they were going to succumb to AIDS related illnesses and eventually die. This view was aptly expressed by two participants who were quoted as saying: "Eeh, for me it means though my wife does not have the disease...., I have it and it is just stressful and traumatizing because I consider it the end

of my life” (IDI -01/ M). The fatalistic perception portrayed by the participants may be attributed to the prior knowledge in their social environment that being HIV-positive means one’s death is imminent. The view that people’s views and belief systems are influenced by their environment is consistent with the tenets of symbolic interactionism that human beings are best understood in relation to their environment and their associations (Blumer, 1969:2, Reynolds and Kinney, 2003:19).

4.4.2. Theme 2: Acceptance and rejection of an HIV sero- discordant status

The finding that the association of an HIV-positive status with an inevitable and imminent death leads to psychosocial trauma and stress concurs with the assertion by the National Institute of Health (2011:17) which notes that when an individual is faced with a life threatening condition s/he experience psycho-social stress.

The discovery of discordance by a couple demands many changes in their lives to enable them to cope with their new situation. The HIV-positive partner finds him/herself with an obligation of preventing the transmission of the virus to his/her HIV-negative partner. Commencement and adherence to the ART regimen is in itself life changing because it brings with it demands which affect both the HIV-positive and HIV-negative partners’ usual life routine. One participant expressed the ultimate obligation that is placed upon the HIV-positive partner and the expectation that the HIV-negative partner has by saying: “It means my husband has to take antiretroviral drugs so that I do not contract HIV as well” (FGD-12HIV- /F). This finding of heightened expectation of obligation as evidenced by the use of compelling phrases such as ‘my husband has to’ concurs with Katherine et al.’s (2011:940) view that the HIV infected individual in a discordant relationship may experience stressors such as fear of transmission of HIV to the HIV-negative partner. It was however noted that although some of the participants were of the view that discordance necessitated some life changes there was emphasis that this change did not include aspects of affection. One participant was quoted as saying: ‘That is what my wife is, but it does not change the love that we had for each other before she got the virus’ (IDI-03HIV-/M). This finding that the HIV-negative partner is capable of accepting and continue to be affectionate to his HIV-positive partner is interesting to note. Scholars such as Nirembe (2010:1) postulate a contrary view that HIV-positive partners may feel rejected by the HIV-negative partner. The

finding that the HIV-negative partner was showing acceptance and affection to their HIV-positive partner seems to be influenced by the former's appreciation of the realities of the concept of HIV discordance. This view is consistent with the theory of symbolic interactionism propounded by Mead (1863-1993), which is underpinned by the belief that human beings are not passive participants in the construction of social reality.

Acceptance of discordance may be more difficult in instances where the female partner is the one who is HIV-positive. One participant was quoted as saying:

Aaa, it was difficult to understand how I contracted HIV as a woman when my husband is HIV-negative. It troubled me and I felt ashamed because we know men are the ones who are promiscuous. However, I accepted it and told myself that it is God who knows. (IDI-04HIV+ /F).

The view expressed by this participant clearly brings to the fore the gender stereotypes and generalizations associated with the contraction of HIV in a heterosexual relationship. The participant's sentiments are however paradoxical in the sense that she is the one who is HIV-positive yet she stereotypes men as the ones who are more susceptible to HIV contraction because they are known to be promiscuous. The participant went further to explain the interrogation that she was subjected to by her HIV-negative husband whom she quoted as saying:

Are you sure of the results that you are HIV-positive and I am negative..... How come you contracted HIV when I am negative? It means you are promiscuous, how did you contract the disease? (IDI-04 HIV+/ F).

The symbolic interactionism theory assists in explaining and appreciating the social meaning attached to a married woman being HIV-positive. The woman's HIV status is mired in social stereotypes that seem to make it more socially acceptable for a man to be HIV-positive.

An FGD participant also expressed similar sentiments that a female HIV-positive status in a discordant marriage is associated with promiscuity and poses a challenging dynamic in the relationship that even extends to the extended family. Sentiments from some of the FGD

participants are quoted here: “I am HIV-positive but ummm, for a woman I think it is difficult and it means people will consider you a prostitute” (FGD-22HIV+/F).

While literature from such sources as the Global AIDS Program (2008:220) acknowledges that understanding and acceptance of HIV discordance requires intensive training of health workers to ensure better service delivery, it seems there has not been adequate focus on the complex gender intricacies associated with the acceptance of the female partner’s positive status as elaborately indicated in the quotations above.

The findings indicate that faith and religious affiliation of a couple play a significant role in the levels of acceptance. Faith and religious affiliation seem to influence some partners in discordant partnerships to rationalize their situation and the associated challenges as expressed below.

“Assh, I thank the Lord. The day that I heard about it I just said, “He had always been cheating so I told God that I will not contract HIV. It is going to be him. With my faith from our church I told myself I will not contract HIV” (IDI-10 HIV-/F). The views of the cited participant concur with the argument by Mbiti (1980:1) that religion plays a major role in influencing the thinking and living of the people concerned. The symbolic interactionism theory can be instrumental in explaining and understanding the role played by faith and religion as a socio-cultural determinant in one’s perception regarding their susceptibility to HIV infection.

The study participants were engaged in a discussion on what has motivated them to remain in a discordant relationship. The motivating factors alluded to include more knowledge on HIV discordance, the conundrum of sero-discordance in a marriage, concerns on the well being of children, life history, unconditional love, acceptance of the HIV discordance by the HIV-negative partner as key and couple counseling as an effective approach to resolve issues. Some of the motivating factors will be discussed in greater detail below.

Participants acknowledged that HIV education and knowledge on HIV discordance played an important role in helping them accept the discordant HIV status as conveyed in the following quotation from a participant.

The most important was the help and knowledge about discordance that we were given by the counselors and all the other people on the program. My partner also understood that we could live together without transmitting the virus to each other through correct and consistent condom use (IDI-09HIV+/M).

This finding that counseling plays an important role in the acceptance of HIV discordance by couples concurs with the assertion by the Global AIDS program (2008:226) that to enhance understanding of sero-discordance and acceptance of the sero-discordant status counseling has to be comprehensive by encompassing critical explanations about discordance.

The participants acknowledged that staying in a discordant relationship is difficult and pointed out that the existence of children in the family plays a significant role in helping them accept and stay in the relationship. They argued that children bring the couple together and help them restrain their thoughts precipitated by the challenges brought about by an HIV discordant status. One participant was quoted as saying:

Haa, my first born gave me strength because he asked, Now that my father is HIV-positive, what will happen if you divorce? This is because when the elephants fight it is the grass that suffers; it is us the children that you would have put into trouble (FGD-25HIV+/M).

As presented above, children are important considerations that work as the glue when the relationship between parents is under threat from HIV discordance. The finding that children are generally considered important concurs with the view proffered by Solomon (2008:8) who argues that marriage is socially and culturally influenced and is the accepted norm in most African countries and it is a wide expectation that couples should have children.

The participants perceived a couple's life history as having an influence on the acceptance of an HIV discordant status. The individual's life history is valued and plays a pivotal role in influencing acceptance of sero-discordance. The decisions surrounding the acceptance of an HIV

sero-discordant result and whether to continue to be in the relationship seems to be influenced by how far the couple has come together and even the material accumulation that has taken place over the years. One of the participants was quoted as saying: “The most important thing is that I thought about where we have come from and the properties that we acquired as a family. Aaa, these made me re-consider my thoughts” (IDI-03 HIV-/M). The participants also alluded to the fact that affection for each other regardless of adverse circumstances also helped them in accepting an HIV discordant result and sticking to each other. This was summed up by a participant who was quoted as saying; “What also brought us together is the fact that we just love each other. Even if he is promiscuous, when he is around we understand each other and our children” (IDI-09HIV-/F).

The finding that, acceptance of an HIV sero-discordant result and the decision whether or not to continue in the relationship is influenced by the couple’s history, levels of affection and material accumulation concurs with a finding by Fetene and Ayalew (2012:11) who argue that the reaction to an HIV discordant result is dependent upon various factors.

The study noted that the attitude of the HIV-negative partner appears to play a key role in the acceptance of the discordance and the continuation of the relationship. The participants observed that usually the HIV-positive partner feels disempowered, an assertion that concurs with Katherine et al. (2011:940) who postulate that the HIV-positive partner experiences negative feelings and lack of support. A positive attitude from the HIVnegative partner as revealed in the following quotation empowers and strengthens the HIV-positive partner. “For me, it was easy because my wife accepted it and she gives me social support” (FGD-23 HIV+/M).

The participants indicated that counseling services played a critical role in accepting an HIV sero-discordant result and ultimately the decision whether to continue or leave the relationship. This was clearly articulated by a participant who was quoted as saying:

There were problems until we were taken back for counseling, which is the thing that helped us because she would say, you transmitted it to me, and then I would argue, “How can I transmit it to you when I am negative?” (Kkkkkk, everybody laughs) (IDI-07HIV-/M).

Access to correct facts about HIV discordance is important for acceptance of the result and for partners to make informed decisions on whether or not they should stay in the relationship. The indication in the quote that there is a deficit of knowledge about HIV discordance resonates with the view by Allen et al (2012:5) who postulate that despite growing evidence of the importance of the concept of sero-discordance and the frequency of its occurrence it largely remains misconstrued in most African communities. This finding on the importance of counseling concurs with an assertion by the Global AIDS Program (2008:222) which stresses that in order to increase the acceptance of the HIV discordant status, it is important to relay the discordant results in a manner comprehensible to the couple.

From the foregoing analysis it can be argued that for an HIV sero-discordant couple to accept their condition and decide whether or not to continue in the relationship there are intrinsic and extrinsic variables that come into play. These variables include the history of the couple, affection for each other, concern for the children, increased knowledge and education about the concept and access to counseling services.

4.5. Research findings objective 3

4.5.1. Theme 3: Acceptance of condoms within a marriage and their efficacy

The condom has been touted as the option of choice for HIV prevention. However, Kigozi (2008:74) argues that the use of condoms among HIV discordant couples still faces resistance despite the confirmation of their discordant status. It is with this background that the use of the condom was specifically discussed with the participants in a bid to understand the extent of its acceptance by partners in a discordant relationship.

The participants' views and perceptions can be classified into broad categories which include perceived reduced sexual pleasure. One participant was quoted as saying:

The very first days were very difficult for me because I was used to my husband. They say a sweet is sweet when it is not covered, not when it is covered in paper. That is why I did not like a condom. I was really concerned because I had little knowledge. I could not believe that he was wearing a plastic thing when I had gotten used to getting it as it is, kkkkk

(laughter). The one that is not covered is enjoyable; I had a difficult time with my husband because I did not like it. My husband remained firm, insisting that we would not have unprotected sex, but would use a condom. But I did not like it; I wanted unprotected sex (IDI-08 HIV+/F).

The participant's negative perception of protected sex may be understood within the theoretical framework of symbolic interactionism theory that underpins this study. The theory interrogates the way in which a person interprets situations and events to create meaning (Charon, 2007:87).

The participants indicated that the use of condoms in a marriage setting regardless of HIV discordance is largely undesirable and unacceptable. According to the participants, the use of condoms is not morally right to the extent that some of the female participants revealed that they sometimes engaged in unprotected sexual intercourse with their spouses regardless of the full knowledge of their discordant HIV status. The perception that condom use is not considered important in situations of discordance resonates well with the observation by Kigozi (2008:74) that condom resistance among HIV discordant couples still remains an issue with couples continuing to practice unprotected sex. Nyatsvimbo (2011:1) further notes that condom use is not expected on the marital bed in most African countries. The negative perception of the condom as a critical HIV transmission and contraction method among HIV discordant couples is an indictment on the condom itself as an HIV prevention strategy.

There was also a finding that the use of the condom among HIV discordant couples was characterized by complex contestations of power and authority surrounding the subject of conjugal rights in a marriage. The marriage institution is portrayed as one steeped in gendered roles that permeate decisions about sexuality. The contestations were put across by one participant who shared her own experience by saying:

He resisted saying "I do not want to use a condom; I did not marry a plastic". I would also refuse and suggest that if that is the case then the marriage could collapse. I would tell him saying, "I am going because I cannot wait to contract HIV. I no longer want sex, so let us use different rooms". At some point he forced me and we had it without a condom. I

stood firm because I knew that if I gave in I would contract HIV (FGD-24HIV-/F).

The UN (2009:11) makes a similar observation when it notes that despite their knowledge of their spouses' HIV positive status; HIV-negative women are unable to protect themselves due to an imbalance of power within relationships, created by economic and emotional dependence. The helplessness of the HIV-negative women may be best understood from the symbolic interactionism perspective that human beings are best understood in relation to their environment and their associations and how they are affected by these factors (Blumer, 1969:2, Reynolds and Kinney, 2003:19).

This study noted that the use of condoms in general and in a marriage setting in particular is influenced by religious beliefs as indicated by one participant who said:

Aaa, the most important is the church issue that I have alluded to. At the end of the day I felt as if the HIV could not be prevented using the condom but to start by casting out the demon (IDI-04 HIV+/M).

This finding is supported by Chitando (2008:69) who argues that religion tailors belief systems. For instance, the Johanne Marange sect discourages condom use. Kathryn (2012:1) also notes that the Catholic Church showed resistance towards condom use.

The participants pointed out that the societal expectations that every couple must have children during the subsistence of the marriage makes the use of HIV barrier prevention methods such as the condom very difficult. Upon further probing the participants elaborated that HIV is still viewed with a lot of stigma hence many people keep their HIV-positive status confidential and it is even worse for a couple with a discordant HIV status because it prompts the others to demand elusive answers. As a result of the secrecy surrounding an HIV-positive status and discordance in general couples in such settings bear a lot of pressure from the society that expects them to reproduce just like all the couples around. One participant acknowledged this wide view by saying:

Yes, it is true. HIV prevention can be disturbed by a lot of things that happen in our life. Firstly, there is the problem of my family members whom you hear saying, “My son, you got married a long time ago but why are you not having more children? This gives me a lot of pressure (IDI-07HIV-/M).

The finding that HIV discordant couples may find it difficult to use condoms because of the pressure to have children exerted upon them by the society concurs with an assertion by Beyeza-Kashesya et al. (2010:145) who postulate that the desire to have children is common in the African culture where HIV discordant couples experience pressure to bear children from in-laws and society who will be ignorant of the couple’s HIV status.

4.5.2. Theme 4: Antiretroviral therapy (ART) as an HIV prevention strategy

Antiretroviral therapy (ART) is one of the strategies in HIV prevention and management and has been shown to help in reducing the viral load and suppressing the rate of multiplication of the virus. The participants in the study cited possible reasons that may inhibit adherence to the uptake of ART as a prevention strategy among HIV discordant couples. These reasons include the belief in traditional and herbal treatments. One participant was quoted as saying the following about her HIV-positive husband:

Alovera and Tianshi; because they say these drugs treat and heal HIV. So, at some point my husband stopped taking his drugs, when we bought Alovera and Tianshi. However, we later discovered that he was actually hurting himself; actually he once became sick (IDI-10 HIV- /F).

The participants went further to explain that allegiance to the beliefs of certain religious sects could also have an adverse effect on the levels of adherence to ART. Mbiti (1980:1) argues that religion is the strongest element in the traditional background and influences the life decisions that people make. This argument was buttressed by a participant who was quoted as saying:

It is true because we go to the Masowe church. We can be advised not to take tablets because the virus will be treated by the Holy Spirit.... Aaa, as

you know, if you contract this disease you try everything. Going to Masowe church is actually a way of trying to survive. Eee, at times it gets into me and I follow what they say but I notice that I am getting sick again. It is difficult but I like the medication (IDI-08/F).

The use of alcohol and other intoxicating substances also came up in the FGDs as a possible cause of lack of adherence to ART. One participant acknowledged that alcohol and substance abuse was a challenge in his effort to achieve optimal adherence. He was quoted as saying: “The problem that we had was beer and marijuana, but I have since reduced on these. The problem was that I did not think or behave normally. At times I forgot to take my drugs as prescribed” (IDI 01/M). The finding that alcohol can be detrimental to ART adherence concurs with the assertion by Cook et al. (2001:83) that alcohol consumption is a strong and consistent risk factor for poor ART adherence across a wide spectrum of patient cohorts and care settings. Braithwaite and Bryant (2008) also note that the use of alcohol and substances affects the survival of HIV-positive individuals through various pathways and the most crucial pathway is through its effects on ART Adherence.

The participants also argued that more positive discoveries in relation to the efficacy of some of the HIV prevention strategies such as ART result in HIV discordant couples drifting into a comfort zone where they even consider it unnecessary to have protected sex.

Haaaa! I think at times my husband has a lot of belief in the 96% that you alluded to and he thinks we are alright. He would suggest that we have sex without a condom and that is why you see the prevalence of pregnancies in the 052 study ... what do you attribute this to? (IDI-08 HIV+/Female).

The reference to the high efficacy of ART in reducing the chances of transmission of HIV to the HIVnegative partner in discordant couples is in line with the submission by Cohen et al. (2011: 493) who put the efficacy level at 96.3%.

The participants also expressed the view that while it is clear that many people in HIV discordant couples appreciate the importance of adhering to ART as an HIV prevention strategy, fear of disclosure and stigmatization may hinder this goal. One participant was quoted as saying:

The stigma issue is the one that troubles me; I am especially afraid that my in-laws may know that their son-in-law is taking anti-retroviral drugs. They will say if their daughter is HIV-negative and the son-in-law is positive ... these things kill. The influence that they will give her may affect our relationship. They will ask her why she is staying with a person like this. For that reason, I try my best not to be discovered that I am taking anti-retroviral drugs. The problem related to this is that I cannot take them in public or when I visit them, especially when my wife is absent. At times it makes me skip taking some doses (FGD-15 HIV+/Male).

Dibua (2001:37) also shared the same view when he argued that decision making in relation to preventing the transmission of HIV is depended on many variables that include disclosure of the HIV status, religion and traditional beliefs.

4.5.3. Theme 5: Voluntary Medical Male Circumcision as an HIV prevention strategy

WHO (2010:7) postulates that voluntary medical male circumcision (VMMC) has gathered momentum as an HIV prevention strategy. It is suggested that male circumcision reduces chances of HIV contraction by males by as much as 60% in addition to prevention of cervical cancer in women and penile cancer in men (Gray, 2007:657). In the discussion focusing on VMMC, the participants raised varied opinions which included the view that many of the HIV male participants had somewhat missed the boat since HIV-positive males are not encouraged to take up VMMC as an HIV prevention strategy due to the heightened risk of complications.

There was also the view that VMMC can lead to irrational sexual exuberance where a circumcised male can actually perceive themselves to be invincible and immune to the contraction of HIV. This view was expressed by one participant who was quoted as saying: “Yes, I am circumcised but I am HIV-positive.....For me, if I look at the time before contracting

HIV I was very confident that nothing was going to befall me just because I was circumcised” (IDI-09 /M). This notion that VMMC can result in a false sense of total protection and invincibility to HIV which can however turn out to be detrimental concurs with an assertion by WHO (2010:26; cf Gray 2007: 660).

The HIV-negative male participants pointed out that even though they could still consider the uptake of VMMC there were a couple of reasons that would discourage them from seeing through this choice. These reasons included perceived decreased sexual performance, the pain associated with the procedure which many of the eligible participants described as unbearable and the general misconception that if a married man gets circumcised it is a clear sign that they want to be promiscuous. There was also a view that VMMC is alien to many people and is better left to the rightful cultures and tribes who have always practiced it. The quote below shows how male circumcision is embedded in specific cultures to the extent that ‘othering’ is frequent in discussions related to the subject as one participant was quoted as saying: “I am HIV-negative but from the way I was brought up, I know that this is something that is done by the Chewa people. For that reason, I did not take it as a method that is permissible for use” (FGD-17 HIV-/M). This finding highlights the difficulties of implementing culturally embedded practices at a large enough scale to achieve the necessary impact as noted by the WHO (2010:3 cf Rizvi, 1999: 16).

4.5.4. Theme 6: Pre-Exposure Prophylaxis as an HIV prevention strategy

Pre-exposure prophylaxis is another form of ART meant to prevent HIV-negative partners and those at risk of HIV infection from contracting the virus. PrEP is a new HIV prevention strategy which has proved to prevent HIV by 67-75% (CDC, 2012:2). The participants cited possible factors that can affect the uptake of this particular strategy. These factors included the fear of perceived side effects such as resistance to ART drugs if the HIV-negative partner gets HIV-positive at some point. The participants attributed this fear to lack of adequate knowledge about the strategy and the perceived burden of commencing on ART when someone is HIV-negative giving the false impression that they are not different from those who are HIV-positive. They went on to argue that the uptake of this strategy is better suited to those who feel more prone to contracting HIV either because they are prostitutes or because they have multiple sexual

partners.

4.5.5. Theme 7: Gender dynamics in HIV prevention

An important factor that was noted to have an effect on the uptake of HIV prevention strategies in this study is gender. The aspect of gender has always been of interest to HIV prevention practitioners and researchers as it underpins the bargaining power in decisions related to sexual choices and prevention strategies among sexual partners. Participants alluded to the social constructs of the female partner as subservient to the male partner regardless of their respective HIV status. A female participant was quoted as saying:

When we are at home I respect him regardless of his condition. I also understand what he says because the Bible says you should be subservient to your husband, I don't take advantage of my husband's condition, no!! (FGD 26 HIV-/F).

This finding concurs with a view by Smith (2006:10) that the standpoint of men is consistently privileged and that of women devalued. Wendell (2009:20) asserts that the gender oppression theory suggests that women are unequal to men and exist under subordination and oppression by men. Duflo (2012:1054) asserts that it is an established fact that women tend to depend more on men for money and economic welfare and this dependence increases the vulnerability of a woman in negotiating for safer sex.

4.6. Conclusion

This chapter presented and discussed the findings of the study, under the following broad themes for the study's first objective: meaning and understanding HIV discordance, acceptance of the HIV discordant result, and power dynamics in handling HIV prevention. In order to address the second objective, this chapter further presented and discussed the different HIV prevention strategies such as condom use, ART, VMMC and PrEp. The feasibility and efficacy of these prevention strategies was interrogated in the context of an HIV discordant couple. It was noted that the use and choice of the various prevention strategies was influenced by intricate socio-cultural factors such as gender and the societal pressure exerted on couples to reproduce.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

In the previous chapter, qualitative data from the study was presented and discussed. In line with the study's first objective, the study revealed that factors that contribute to the acceptance and/or rejection of HIV sero-discordance among HIV discordant couples are both intrinsic and extrinsic. In line with its second objective, the study indicated that the uptake of HIV prevention strategies by HIV discordant couples is influenced by various intricate socio-cultural factors. This chapter presents the study's key findings, limitations, suggestions for further research and recommendations for policy and practice.

5.2. Key findings of the study

The study concluded that the decisions surrounding the uptake of the various HIV prevention strategies among HIV sero-discordant couples are influenced by many complex factors. The factors include cultural expectations which for instance make it difficult for discordant couples to use a barrier method such as the condom contrary to the extended family's expectation for them to have children. Socialization also plays a role in influencing these decisions and choices where the study found that most of the time men seem to have the prerogative to take the lead in decision making while women are subservient. The finding that discordant couples' decisions are influenced by many factors concurs with proponents of the symbolic interactionism theory who suggest that human beings are best understood in relation to their environment and their associations and also how they are affected by the same (Blumer, 1969:2, Reynolds and Kinney, 2003:19). The study further concluded that the efficacy of the various HIV prevention strategies available to discordant couples is inter-mediated on the socio-cultural factors more than on the scientifically proven efficacy level. The study unraveled the nuances that exist in people's lived lives regarding negotiations for safe sex, negotiations for HIV prevention strategies adopted and adhered to by the couple and even acceptance of their state of being HIV discordant. This study concluded that people living with HIV are themselves critical stakeholders in the uptake of all the available HIV prevention strategies. Failure to acknowledge this tenet is self-defeating as

evidenced by a perception of viewing condom use within a marriage as humiliating for a woman. Symbolic interactionism theory buttresses this finding on the view that human beings are active participants in the construction of social reality and the meaning of events comes from interaction of the individuals (Blumer, 1969:2).

5.3. Limitations of the study

The limitations of this study included the inherent internal conflict between the individual's subjectivity and the socio-cultural dynamics which are group defined. The debate about the conflict between an individual and society is bigger and has a long history (Lug, 1997:16). Symbolic interactionism privileges individual subjectivity and meaning as already established in a person's psychological make-up (Blumer, 1969:2), whereas issues of culture are embedded in group dynamics. To try and manage this paradox, the researcher mixed data collection methods that privileged the individual's perspective with group generated perspectives using in-depth interviews and Focus Group Discussions.

Another limitation in this study came from the role of the researcher herself. The influence of the researcher in any study cannot be underestimated as s/he works as some form of a filter and in the process influence the study. In the same way, there was a dilemma on how the researcher would 'exit' after the completion of the study considering the intimate information given during data collection. This is especially considering that the participants were fully aware that the researcher is an active member of the HPTN 052 study. Questions may be asked on the extent to which the answers the researcher got were not influenced by the participation of the respondents in the HPTN 052 study. However, the researcher attempted to be reflexive and approached the study with an open mind and not with pre-conceived ideas to the greatest extent possible (Guoin et al. 2011:12)

Another inherent puzzle in this study pertains to the interface between time and projection of opinions. At times it was difficult to establish whether or not participants were talking about historical opinions and myths or their current beliefs. In some cases participants would talk about an issue in third person as in 'some men', 'some people', while this is one advantage of FGDs that they allow a high level of anonymity. The study could have gone further to probe whether or

not participants were projecting their personal opinions. During the course of the study, there was reference to the analogy of equating condom use to eating sweets in their wrappers that has been in existence for a very long time. This makes it difficult to determine whether or not the opinions or perceptions are current or just regurgitation of common opinions. This methodological limitation to place opinions or perceptions within a well-defined time frame gives credence to the argument raised by proponents of the symbolic interactionism theory that people do not necessarily create new meanings in given situations but they recall previously held meanings upon a situation because meaning is already established in a person's psychological make-up (Blumer, 1969:2).

5.4. Suggestions for Further Research

There are four areas this researcher wants to highlight as possible trajectories for further research emanating from this micro study of sero-discordant relationships:

- The extent to which people are driven to divinity/ heightened spirituality upon learning of their HIV positive status.
- The extent to which the acceptance of an HIV-positive status is externally triggered.
- To what extent do HIV prevention strategies such as ART, the condom and VMMC and PrEP contribute towards the surge of the HIV prevalence rate in Zimbabwe?

The current study was qualitative in its design. It is however important for further research to consider a quantitative design or a mixed methodology to also get an insight into the quantitative extent of the findings of this study and others similar to it.

5.5. Recommendations for policy and practice

The following are the recommendations from this study:

1. The findings of the study show that the concept of HIV sero-discordance presents various intricate socio-cultural challenges to the concerned couples. However, current interventions such as the HPTN 052 study seem to be too preoccupied with the biomedical mystery aspect of the phenomena. This focus on the biological and medical aspects has been at the expense

of the socio-cultural dimensions which, as this study has shown, have far reaching implications for HIV prevention strategies for instance. It is therefore recommended that medical research bodies such as the Zimbabwe Medical Research Council should work on ensuring that research protocols are comprehensive enough to encompass socio-cultural issues as there is a latent risk to harm participants in pursuit of biomedical research.

2. The researcher recommends that deliberate efforts be made at country and international level to direct financial and human resources to research that focuses on the HIV ‘special populations.’ These populations include sero-discordant couples, which as this study noted, have intricate challenges that impact on their choices and uptake of HIV prevention strategies. Ultimately, this affects efforts to curb the further spread of HIV particularly in stable relationships.

Practitioners in the HIV prevention sector need to be cognizant of the fact that they must not be driven or guided by the scientific evidence on the efficacy of a particular strategy only. This study showed that participants have a propensity towards critically interrogating the various strategies in their particular socio-cultural and economic settings. There are perceptions of socio-cultural fear and disaffection with many of the available options. It is therefore recommended that practitioners, in their promotion of prevention strategies, need to consider the socio-cultural acceptability and embedment of these strategies for them to be effective.

The researcher recommends the further interrogation of the suitability and adaptability of the available HIV prevention methods to peculiar socio-cultural settings. As noted in this study sero-discordant couples make particular considerations regarding the uptake of the various HIV prevention strategies; further research may also reveal that other populations such as teenagers and those in transactional relationships may also have their own considerations dictated by their circumstances.

The area of choices surrounding sex among HIV sero-discordant couples remains a frontier for power struggles. This study, however, shows that it might not be necessarily correct that men are always the villains and winners in the struggle. There is therefore need for HIV

advocates and by extension those in the gender equality frontline to be cognizant of these subtle nuances that exist within people and take due care in guarding against incorrect generalizations and stereotypes. The study found out that the area of sexual choices and HIV prevention strategies among HIV discordant couples is a contested battle for power frontier in which there are no clear winners.

There is need for policy makers to generate interest and to provide an enabling framework to stimulate those with interest in public health to commission studies to try and understand the extent to which current HIV prevention strategies such as ART, condoms; VMMC and PrEP may be contributing to a surge in HIV prevalence in Zimbabwe. Current interventions and policy guidelines may be underestimating the moral hazard of these strategies which appears to be far greater than known.

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APPENDICES

Appendix A: Request for permission to conduct research

Stand 9559 Chipukutu Park

Ruwa

Harare

Zimbabwe

The Director/Principal investigator

UZCRC

Corner Josiah Tongogara and Mazoe Street

Harare

15 April 2013

RE: APPLICATION TO CONDUCT RESEARCH

Dear Sir

I hereby apply for permission to conduct In-depth Interviews and Focus group Discussions at the University of Zimbabwe Clinical Research Centre.

I am a student at UNISA studying Master of Arts in Social behavior studies (HIV/AIDS).

I am looking forward to conduct 10 in-depth Interviews and 2 focus group discussions. 5 Couples will participate in IDIs and 8 couples will participate in FGDs.

Your response is greatly appreciated

Yours Faithfully

Elizabeth Shambadza Magada (Student number: 5078645)

Appendix B: Permission to conduct research



University Zimbabwe Clinical Research Centre
Box A1578, Avondale, Harare
Tel: 263-4-701717/701356/705995
Fax: 263-4-705986
J. Tongogara/ Mazowe St.
Parirenyatwa Annex, Harare

24th April 2013

The Chairperson
The Medical Research Council of Zimbabwe
P.O Box CY 573
Harare

Dear Madam

RE-Permission to Carry out Research at the University of Zimbabwe Clinical Research Centre

Mrs Elizabeth Shambadza Magada is a Senior Research Counsellor at the UZCRC. She is pursuing a Masters of Arts degree in Social Behaviour studies in HIV/AIDS by distance education with the University of South Africa (UNISA). Her research focus is on HIV sero-discordant couples. She will be under the supervision of Mr Leon Roets of UNISA.

As part of her degree programme she will be performing research work leading to a dissertation. She would like to conduct interviews as follows: 5 HIV sero-discordant couples to be interviewed as individuals (10 in-depth interviews); 8 couples to be separated by gender into 2 focus group discussions (2 focus group discussions). The total number of individuals who will be involved in the study will, therefore, be 26 individuals. She has made a request to me to access the HPTN052 study sero-discordant couples at the UZCRC for this purpose.

If the Council grants her permission, I have no objection in allowing her to interview these couples for the purpose of fulfilling her academic requirements. I shall monitor her interaction with the couples and will ensure that she treats them with respect and maintain confidentiality.

Yours sincerely

Prof JG Hakim
Principal Investigator HPTN 052

Appendix C: UNISA- Ethical clearance letter

UNISA 
University of South Africa

Department of Sociology
College of Human Sciences
12 August 2013

Proposed Title: An investigation into the influence of socio-cultural factors on HIV prevention strategies. A case study of HIV sero-discordant couples Harare-Zimbabwe

Principle investigator: Ms ES Magada (Student number 50786458)

Reviewed and processed as: Class approval (see paragraph 10.7 of the Unisa Guidelines for Ethics Review).

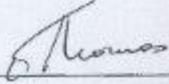
Approval status recommended by reviewers: Approved

The Higher Degrees Committee of the Department of Sociology in the College of Human Sciences at the University of South Africa has reviewed the proposal and considers the methodological, technical and ethical aspects of the proposal to be appropriate to the tasks proposed. Approval is hereby granted for the candidate to proceed with the study in strict accordance with the approved proposal and the ethics policy of the University of South Africa.

In addition, the candidate should heed the following guidelines,

- To complete and sign a Supervisor-Student Agreement form, which is a code of conduct guiding the research process,
- To start the research study only after obtaining the necessary Informed Consent,
- To carry out your research according to good research practices and in an ethical manner,
- To maintain the confidentiality of all data collected from or about research participants, and maintain safe procedures for the protection of privacy and when storing such data,
- To work in close collaboration with the assigned Supervisor and to ensure the way in which the ethical guidelines as suggested in the reviewed proposal has been implemented in your research,
- To notify the Committee immediately in writing if any change/s is proposed to the study and await approval before proceeding with the proposed change,
- To immediately notify the Committee in writing if any adverse event occurs.

Regards,


Dr. Chris Thomas
Chair: Department of Sociology
Tel: 0027 (0)12 429 6301

supported

21/08/2013



University of South Africa
Pretorius Street, Huddersville Ridge, City of Pretoria
PO Box 892, UNISA 0001 South Africa
Telephone: +27 12 429 5111 Facsimile: +27 12 429 4150
www.unisa.ac.za

Open Rubric |

Appendix D: MRCZ- Approval Letter

Telephone: 791792/791193/792747
Telefax: (263) - 4 - 790715
E-mail: mrcz@mrcz.org.zw
Website: www.mrcz.org.zw



Medical Research Council of Zimbabwe
Josiah Tongogara / Muzoe Street
P. O. Box CY 573
Causeway
Harare

APPROVAL

Ref: MRCZ/B/570

23 September, 2013

Elizabeth Shambadza Magada
UZ College of Health Sciences
P.O Box A178
Avondale
Harare
Zimbabwe

RE: An investigation into the influence of socio-cultural factors on HIV prevention strategies. A case study of HIV sero-discordant couples, Harare-Zimbabwe.

Thank you for the above titled proposal that you submitted to the Medical Research Council of Zimbabwe (MRCZ) for review. Please be advised that the Medical Research Council of Zimbabwe has **reviewed** and **approved** your application to conduct the above titled study. This is based on the following documents that were submitted to the MRCZ for review.

- a) Research proposal and summary
- **APPROVAL NUMBER** : MRCZ/B/570
 - This number should be used on all correspondence, consent forms and documents as appropriate.
 - **APPROVAL DATE** : 23 September 2013
 - **TYPE OF MEETING** : Expedited
 - **EXPIRATION DATE** : 22 September 2014

After this date, this project may only continue upon renewal. For purposes of renewal, a progress report on a standard form obtainable from the MRCZ website or our website should be submitted three months before the expiration date for continuing review.

- **SERIOUS ADVERSE EVENT REPORTING:** All serious problems having to do with subject safety must be reported to the Institutional Ethical Review Committee (IERC) as well as the MRCZ within 3 working days using standard forms obtainable from the MRCZ website: www.mrcz.org.zw
- **MODIFICATIONS:** Prior MRCZ and IERC approval using standard forms obtainable from the MRCZ website is required before implementing any changes in the Protocol (including changes in the consent documents).
- **TERMINATION OF STUDY:** On termination of a study, a report has to be submitted to the MRCZ using standard forms obtainable from the MRCZ website.
- **QUESTIONS:** Please contact the MRCZ on Telephone No. (04) 791792, 791193 or by e-mail on mrc.zimbabwe@yahoo.com or mrcz@mrcz.org.zw

Other:

- Please be reminded to send in copies of your final research results for our records as well as for the Health Research Database
- You are also encouraged to submit electronic copies of your publications in peer-reviewed journals that may emanate from this study.

Yours Faithfully


MRCZ SECRETARIAT
FOR CHAIRPERSON
MEDICAL RESEARCH COUNCIL OF ZIMBABWE



PROMOTING THE ETHICAL CONDUCT OF HEALTH RESEARCH

Appendix E: Request to participate in a research

9559 CHIPUKUTU PARK,
RUWA,
HARARE, ZIMBABWE

Dear Mr. /Miss.....

REQUEST TO PARTICIPATE IN A RESEARCH PROJECT FOR AN MA IN SOCIAL BEHAVIOUR (HIV/AIDS).

You are hereby requested to participate in a research project that is undertaken as a requirement of an MA in Social Behavior (HIV/AIDS) degree with the University of South Africa (UNISA).

The title of the research project is: AN INVESTIGATION INTO THE INFLUENCE OF SOCIO-CULTURAL FACTORS ON HIV PREVENTION STRATEGIES. A CASE STUDY OF HIV SERO-DISCORDANT COUPLES IN HARARE-ZIMBABWE.

Empirical Research will be primarily done by:

1. In-depth interviews (IDIs)
2. Focus group discussions (FGDs)
3. Observations

You are therefore requested to participate in the first two parts. The objective of the study is to explore the socio-cultural influences on HIV prevention among couples in a clinical trial, Harare, Zimbabwe

The duration of the interview and focus group discussions is estimated to be between 30 to 45 minutes. The participation and input obtained during the research will be treated with extreme care to maintain confidentiality. Real names will not be divulged in the final report to ensure anonymity. The results of the interviews will be shared with the researcher’s supervisor only and they will be kept in a locked safe place. The final product of the research will be published and will be on the library shelves at UNISA and other libraries around the world will access it

through the UNISA library. Participation in this research is voluntary, should the participant wish to withdraw at any time they will be free to do so. The researcher will ensure that all ethical obligations and considerations will be adhered to.

If permission is granted, may I request that you sign the attached consent form.

Kind Regards,

Ms Elizabeth Shambadza Magada

Cell: +263-772 241 699 and email lizmag@uzcrc.co.zw

7.6. Appendix F: Informed consent form for participants (English)

I, Mr. /Ms (Full name and surname in capital letters)

.....
do accept to participate in the research process with Elizabeth Shambadza Magada, an MA student in Social Behavior (HIV/AIDS) at UNISA.

1. I am aware that my participation in this project is entirely voluntary.
2. I am aware that I am free to withdraw from the project at any time without any problem.
3. I understand that my personal information including recordings and narratives will be kept confidential.
4. I understand that my true identity will not be divulged in the final project to ensure anonymity.
5. I understand that I will receive no payment or compensation in the study;

Date.....

Signature of applicant.....

Signature of witness.....

7.7. Appendix G: Informed consent form for participants (Shona)

Ini, Va/Mai/Muzvare (Zita renyu rakazara nezita remhuri mumavara makuru)

.....Ndinobvuma
kupinda muurongwa hwetsvakurudzo yaElizabeth Shambadza Magada, mudzidzi wekuUNISA
anoita dhigirii reunhu nemagariro padanho reMA.

Check numbering on this form!

- 1.Ndinoziva kuti kupinda kwangu mutsvakurudzo iyi hakumanikidzwi zvachose.
- 2.Ndinoziva kuti ndakasununguka kubuda mutsvakurudzo chero nguva ipi zvayo uye pasina dambudziko chero ripi zvaro.
- 3.Ndinonzwisisa kuti ruzivo ruri maererano neni, kusanganisira zvinenge zvatapwa uye nhoroondo zvichachengetedzwa pakavanzika.
- 4.Ndinonzwisisa kuti zita rangu chairo harizoburitswi muripoti yekupedzisira kuitira kuti zvisazikanwa kuti ruzivo rwakabva kunani.
- 5.Ndinonzwisisa kuti hapana chandinobhadharwa mutsvakurudzo iyi.

Zuva.....

Sainecha yeari mutsvakurudzo.....

Sainecha yechapupu

Appendix H: Focus group discussion guide (English)

AN INVESTIGATION INTO THE INFLUENCE OF SOCIO-CULTURAL FACTORS ON HIV PREVENTION STRATEGIES. A CASE STUDY OF HIV SERO-DISCORDANT COUPLES IN HARARE-ZIMBABWE

Principal Investigator: Mrs. Elizabeth Shambadza Magada

Focus group discussion guide – HIV Discordant Couples in the HIV Preventions Trials

Network 052 study- Zimbabwe-Harare

- Introduce self and explain study
- Review consent issues
- Explain main purpose of the study

This study seeks to investigate the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples in Harare, Zimbabwe with a view to inform both policy discourse and interventions.

- Set ground rules

Notes to interviewer:

- *Questions in italics are meant to be probes. They do not have to be asked as they appear here. Rather, phrase and order questions according to the flow of the discussion).*
- *Depending on the level of rapport with participants the FGD Facilitator may ask/record the participants' demographic characteristics (age, sex, marital status, source of income, religion educational level etc) right at the beginning or at the end of the FGD and record on a separate sheet of paper for reference and analysis.*
- *Exploration of FGD questions should be limited to cater for sensitivity.*

Attitudes/perceptions around HIV sero-discordance

Q No	Question	Probes
1	What does being HIV sero-discordant mean to you?	<i>a. What is it?</i> <i>b. What is its meaning?</i> <i>c. How do you feel about it?</i> <i>d. Why do you feel this way?</i>
I	What is it like to be a female/male partner of an HIV infected/uninfected person?	<i>a. Probe for participants' views</i> <i>b. Why do you perceive it this way?</i>
Ii	Are there any advantages of being in an HIV discordant relationship?	<i>a...Explore basing on response given</i>
Ii	Are there any disadvantages of being in an HIV discordant relationship?	<i>b. Explore basing on responses given</i>

Sexual Choices, HIV Prevention and Gender issues

Q. No	Question	Probes
3	How easy is it to negotiate for HIV prevention methods	Probe: <i>a. Condoms</i> <i>b. ART</i> <i>c. Male circumcision</i> <i>d. Pre Exposure prophylaxes (PrEp)</i> <i>e. Couple counselling</i>
Ii	What encourages/ discourages you about taking	

	up prevention methods?	
--	------------------------	--

iii	Does gender affect the HIV prevention decisions among HIV discordant couples?	<ul style="list-style-type: none"> a. <i>If no. Why?</i> b. <i>If yes, How? Which gender dominates the other?</i> c. <i>What are your impressions about this gender imbalance?</i> d. <i>How does this compare to a concordant positive and a concordant negative relationship?</i>
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7.9. Appendix I: Focus Group Discussion guide (Shona)

DZIDZO YEKUTSVAKURUDZA ZVINOKONZERWA NAMAGARIRO
NAMARARAMIRO PAKUSHANDISA NZIRA DZOKUDZIVIRIRA UTACHIONA
HWEHIV. CHIDZIDZO PANE VAVIRI VANODANANA VANOTI UMWE ANE
UTACHIONA HWEHIV UMWE ASINA, MUHARARE, ZIMBABWE

Mukuru WeChidzidzo: Mrs Elizabeth Shambadza Magada

Hurukuro yeboka (FGD Shona)

Instructions to the interviewer

- *Introduce self and explain study*
- *Revisit Consent issues*
- *Explain main purpose of the study*

CHINANGWA CHEDZIDZO

Chidzidzo ichi chinoda kutsvakurudza zvinokonzerwa namagariro namararamiro pakushandisa nzira dzokudzivirira utachiona hweHIV pakati pevane utachiona nevasina, vari muchirongwa cheHIV *Preventions Trials Network*, muHarare, Zimbabwe. Izvi zvichaitirwa kuzopa umboo kune vanoona nezveHIV zvingava zvingabetsera pakudzivirirwa kweHIV pane mumwe ane HIV umwe asina.

- *(Note to interviewer: Questions in italics are meant to be probes. They do not have to be asked as they appear here. Rather, phrase and order questions according to the flow of the discussion). FGD questioning should be non-sensitive.*
- *(Depending on the level of rapport with participants the FGD Facilitator may ask/record the participants' demographic characteristics (age, sex, marital status, source of income, religion educational level etc) right at the beginning or at the end of the FGD and record on a separate sheet of paper for reference and analysis).*

Views around HIV sero-discordance.

Q No	Question	Probes
1	Zvinorevei kuve neutachiona hweHIV umwe anahwo umwe asina	<p><i>d. Zvinorevei?</i></p> <p><i>e. Munonzwa sei nezvazvo</i></p> <p><i>f. Sei muchinzwa zvakadai?</i></p>
ii	<p>Munozvitora sei kuva umwe wouyo ane utachiona kana asina</p> <p>Zvakanakirei?</p> <p>Zvakaipirei?</p> <p>Inyore zvakadii kutambira/kana kusatambira umboo hwekuti umwe ane utachion umwe haana</p>	<p><i>Bvunzurudza</i> maonero evari kubvunzwa</p> <p><i>c. Sei muchizviona saizvozvi?</i></p>

Sexual choices, HIV prevention and Gender issues

Q No	Question	Probes
2		
ii	Zviri nyore zvakadii kukurukura nezvekushandisa nzira dzekudzivirira HIV	<p><i>Bvunzurudza pakushandiswa kwezvinotevera:</i></p> <p><i>a. Makondomu echirume kana echikadzi</i></p> <p><i>b. Mishonga yekurwisa utachiona hweHIV</i></p> <p><i>c. Kuchecheudzwa</i></p> <p><i>d. Kudzivirirwa kweasina utachiona hweHIV nemishonga inorwisa utachiona hweHIV</i></p>
iii	Chii chinokukurudzirayi kana kusakukurudzirayi pakushandisa nzira dzekudzivirira utachiona hweHIV	<p><i>Bvunzurudza pane zvinotevera:</i></p> <p><i>a. Magariro namararamiro evanhu vane chekuita nekusarudza nzira dzekudzivirira HIV</i></p>
Iv	Kuve munhurume kana munhukadzi muushamwari hwenyu kunokubatsirayi zvakadii pane zvekudzivirira HIV?	<p><i>Bvunzurudza</i> zvingakonzerwa nekuva munhurume kana munhukadzi pane zvekudzivirira HIV</p>

Appendix J: In-depth interview guide (English)

AN INVESTIGATION INTO THE INFLUENCE OF SOCIO-CULTURAL FACTORS ON HIV PREVENTION STRATEGIES. A CASE STUDY OF HIV SERO-DISCORDANT COUPLES IN HARARE- ZIMBABWE

Principal Investigator: Mrs Elizabeth Shambadza Magada

In-depth Interview guide – (IDI English)

- Introduce self and explain study
- Review Consent Issues
- Explain main purpose of the study

This study seeks to investigate the influence of socio-cultural factors on HIV prevention strategies among HIV discordant couples in Harare, Zimbabwe with a view to inform both policy discourse and interventions.

Notes to interviewer:

- *Questions in italics are meant to be probes.*
- *Depending on the level of rapport with participants the interviewer may ask/record the respondents' demographic characteristics (age, sex, marital status, source of income, educational level etc) right at the beginning or at the end of the interview and record responses on a separate sheet of paper for reference and analysis.*

Individual/Personal issues around HIV sero-discordance

Q No	Question	Probes
1	What does being HIV sero-discordant mean to you?	<i>g. What is it?</i> <i>h. What is its meaning?</i> <i>i. How do you feel about it?</i>

		<i>j. Why do you feel this way?</i>
2	What is it like to be a partner of an HIV infected/uninfected person?	<i>d. Probe for participant's views e. Why do you perceive it in this way?</i>
3	Has being HIV discordant affected your relationship in any way?	<i>a. How? b. Why not?</i>
4	Why are you still in this relationship? What has helped you? What is it that has made your relationship to discontinue/ continue?	<i>a. Probe to get participant's views</i>

Sexual choices and HIV prevention

Q No	Question	Probes
1	How easy is it to accept HIV discordance (ii) What prompts rejection of sero-discordant status?	<i>a. If easy (How?) b. If not easy (Why?) c. Probe on those factors that lead participants not to accept sero-</i>

		<i>discordance</i>
2	How easy is it to negotiate or use HIV prevention methods	<p><i>Probe on use of:</i></p> <p><i>a. Condoms</i></p> <p><i>b. ART</i></p> <p><i>c. Male circumcision</i></p> <p><i>d. Pre-exposure prophylaxes (PrEp)</i></p>
3	What encourages/ discourages you about taking up prevention methods?	<i>Explore on the socio-cultural issues that influence HIV prevention choices</i>
4	What role is played by gender in influencing your HIV prevention decisions?	<i>Probe on masculine and feminine issues influencing HIV prevention efforts within the relationship</i>

Appendix K: In-depth interview guide (Shona)

DZIDZO YEKUTSVAKURUDZA ZVINOKONZERWA NAMAGARIRO
NAMARARAMIRO PAKUSHANDISA NZIRA DZOKUDZIVIRIRA UTACHIONA
HWEHIV, CHIDZIDZO PANE VAVIRIVANOTI UMWE ANE UTACHIONA HWEHIV
UMWE ASINA, MUHARARE, ZIMBABWE

Mukuru WeChidzidzo: Mrs Elizabeth Shambadza Magada

Hurukuro youmwe-neumwe (IDI Shona)

Instructions to the interviewer

- *Introduce self and explain study*
- *Revisit Consent issues*
- *Explain main purpose of the study*

CHINANGWA CHECHIDZIDZO

Chidzidzo ichi chinoda kutsvakurudza zvinokonzerwa namagariro namararamiro pakushandisa nzira dzokudzivirira utachiona hweHIV pakati pevane utachiona nevasina, vari muchirongwa cheHIV Preventions Trials Network, muHarare, Zimbabwe. Izvi zvichaitirwa kuzopa umboo kune vanoona nezveHIV zvingava zvingabetsera pakudzivirira kweHIV pane ane HIV umwe asina.

- *(Note to interviewer: Questions in italics are meant to be probes. They do not have to be asked as they appear here. Rather, phrase and order questions according to the flow of the discussion).*
- *(Depending on the level of rapport with participants the FGD Facilitator may ask/record the participants' demographic characteristics (age, sex, marital status, source of income, religion educational level etc) right at the beginning or at the end of the FGD and record on a separate sheet of paper for reference and analysis).*

Individual/Personal issues around HIV sero-discordance

Q No	Question	Probes
1	Zvinorevei kuve neutachiona hweHIV umwe anahwo umwe asina	<p><i>k. Zvinorevei?</i></p> <p><i>l. Munonzwa sei nezvazvo</i></p> <p><i>m. Sei muchinzwa zvakadai?</i></p>
2	Munozvitora sei kuva umwe wouyo ane utachion kana asina	<p><i>f. Bvunzurudza maonero eari kubvunzwa</i></p> <p><i>g. Sei muchizviona saizvozvi?</i></p>
3	Kuve umwe weane utachiona kana asina kwakanganisa hushamwari hwenyu zvakadii?	<p><i>Sei?</i></p> <p><i>B Sei zvisina kukanganisika?</i></p>
4	<p>Sei muchiri muhushamwari uhwu?</p> <p>Chii chakakubatsirayi?</p> <p>Chii chakaita kuti ushamwari hwenyu hugume/kana kuenderera mberi?</p>	<p><i>a. Bvunzurudza maonero eari kubvunzwa</i></p>

Sexual choices and HIV prevention

Q No	Question	Probes
1	<p>Inyore zvakadzi kugamuchira umboo hwekuti umwe ane utachiona umwe haana?</p> <p>Chii chinoita kuti vanhu vatambire kana kusatambira umboo hwekuva neutachiona hweHIV umwe asina?</p>	<p><i>a. Kana zviri nyore, sei?</i></p> <p><i>Kana zvisiri nyore, sei?</i></p> <p><i>b. Bvunzurudza pazvinhu izvozvo zvinoita kuti vasatambire humboo hwokuva neutachiona hweHIV umwe asina</i></p>
2	<p>Zviri nyore zvakadzi kukurukura nezvekushandisa nzira dzekudzivirira HIV?</p>	<p><i>Bvunzurudza pakushandiswa kwezvinevera:</i></p> <p><i>a. Makondomu echirume kana echikadzi</i></p> <p><i>b. Mishonga yekurwisa utachiona hweHIV</i></p> <p><i>c. Kuchecheudzwa</i></p> <p><i>d. Kudzivirirwa kweasina utachiona hweHIV nemishonga inorwisa utachiona hweHIV</i></p>
3	<p>Chii chinokukurudzirayi kana kusakukurudzirayi pakushandisa nzira dzekudzivirira utachiona hweHIV?</p>	<p><i>. Bvunzurudza pane zvinevera:</i></p> <p><i>a. Magariro namararamiro avanhu vane chekuita nekusarudza nzira dzekudzivirira HIV</i></p>

Q No	Question	Probes
4	Kuve munhurume kana munhukadzi muushamwari hwenyu kunokubatsirayi zvakadii pane zvekudzivirira HIV?	Bvunzurudza zvingakonzerwa nekuva munhurume kana munhukadzi pane zvekudzivirira HIV

Appendix L: Declaration letter from the Editor



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31 January 2014

Department of Sociology
University of South Africa
Republic of South Africa

TO WHOM IT MAY CONCERN

**RE: EDITORIAL DECLARATION FOR ELIZABETH SHAMBADZA
MAGADA (STUDENT NUMBER 50786458)**

This letter serves to confirm that I, Emmanuel Chabata, of the African Languages Research Institute, University of Zimbabwe edited Elizabeth S. Magada's dissertation titled '*An Investigation into the Influence of Socio-Cultural Factors on HIV Prevention Strategies. A Case Study of HIV Discordant Couple in Harare – Zimbabwe.*'

My editorial task mainly focussed on correcting grammatical and typographical errors.

Yours faithfully

Dr. Emmanuel Chabata (PhD Linguistics, University of Oslo, Norway)
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Dada nomutauro wako. Ziqhene ngolimi lwakho. Be proud of your language.