

**FACTORS INFLUENCING MARITAL STABILITY AMONG HIV DISCORDANT  
COUPLES AT THE KENYATTA NATIONAL HOSPITAL**

**BY**

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**REG.NO: C50 / 72284 /08**

**A THESIS SUBMITTED IN PARTIAL FULFILMENT FOR THE AWARD OF A  
MASTER OF ARTS DEGREE IN SOCIOLOGY**

**NOVEMBER 2014**

## DECLARATION

This thesis is my original work and it has not been presented for award of a degree in any other university.

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## ACKNOWLEDGEMENT

Several people offered me invaluable help and advice in the development and preparation for this thesis. I would like to acknowledge my supervisors at the University of Nairobi; professor Mburugu and Dr Kiemo for their readiness to be consulted at all times. I am grateful for their intellectual guidance, critique and valuable support that gave me insight to accomplish this dissertation.

I thank Dr Margaret Makanyengo, the head of the department of Mental Health formerly (PSC) for allowing me to conduct the interviews among HIV discordant couples within the department of mental health from where they are registered for group therapy.

I thank my family, my husband Simon and my three daughters Flo, Angie and Noel for the support they accorded me as I sat down to complete my work, many are the times they sat with me late into the night.

I especially thank the senior Nursing officer of the department of Mental Health, Mrs Elizabeth Mukhisa for her support as I conducted the focus group discussions.

Special thanks go to Dr. Phillip Ayieko from KEMRI for his support in the data analysis of the study findings. Special thanks go to Charles Obange and Susan Ntinyari who helped me in taking notes during the focus group discussions. I also thank Veronica Njuguna and Grace Nafula both support staff of the department of Mental Health for arranging the rooms that we used for the focus group discussions.

More importantly I thank all HIV discordant couples who accepted to participate in this study and provided valuable information in both focus group discussions and individual interviews.

To you all I say thank you and may God bless you.

## **DEDICATION**

This thesis is dedicated to all HIV discordant couples who have endured challenges posed by their HIV discordant status and have continued to be there for each other.

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## **ABBREVIATIONS**

ART -	Anti-Retroviral Therapy
DTC -	Diagnostic counseling and testing
CD4 -	Cluster of Differentiation antigen 4
DMH-	Department of mental health
FGD -	Focus Group Discussion
HIV/ HI-Virus	Human Immunodeficiency Virus
KDHS	Kenya Demographic Health Survey
KAIS	Kenya Aids Indicator Survey
KNH -	Kenyatta National Hospital
KNHSP	Kenya National HIV Strategic Plan
NACC-	National AIDS Control Council
PITC -	Provider initiated counseling and testing
PMTCT-	Prevention of Mother to Child Transmission
PSC -	Patient Support Centre
VCT -	Voluntary counseling and testing

## ABSTRACT

The aim of this study was to establish factors that influence marital stability among HIV discordant couples. The study objectives were to determine the extent to which socio-economic status, therapeutic social interventions, demographic characteristics and culture influence marital stability among HIV discordant couples registered for group therapy at KNH. A cross-sectional study using mixed-methods approach randomly sampled 132 participants with each participants being a partner in a discordant couple marriage. Semi structured questionnaire were administered to each participant individually and four focus group discussions were conducted, two with the HIV negative and two with the HIV positives participants.

Findings showed that female respondents were more likely to report fear that marriage will not work and that their partners may desert them; this was mainly experienced by those who were HIV positive and economically dependent upon their partners.

Although most (55.8 percent) couples agreed that religion played an important role in marital stability, what came out strongly as having influenced marital stability was nature of interpersonal relationship among the couples which was indicated by 72.8 percent of the couples agreeing that their pattern of communication and openness among partners enhanced marital stability and 75.8 percent agreeing that trust and commitment to the relationship made them stay married.

Social support and therapeutic social interventions was perceived as having enhanced marital stability in both focus group discussions and individual interviews.

Based on the findings of this study, the researcher recommends that therapeutic social interventions like support groups and couple counseling be reinforced among HIV discordant couples immediately after testing. With these interventions in place; interpersonal relationship among the partners will be enhanced and hence their marriages will remain stable.

## **CHAPTER ONE INTRODUCTION**

### **1.1 Background**

As the HIV/ AIDS epidemic completes a third decade it is no longer a new and emerging disease, families have continued to be formed, children have been born in these families and survived, some marital unions have been dissolved through divorce, separation and death but many of the marital unions have survived the destructive effects of the epidemic in both HIV/AIDS discordant and positive concordant couples. With expanded access to free antiretroviral drugs (ARVs) and improved services in the health sector the life expectancy has been prolonged.

HIV / AIDS places emotional, economic, social and physical stress on the individuals and the family at large both for concordant positive and HIV discordant families, which has led to partnership disharmony and dissolution through divorce or separation. (Tangmunkongvorakul, Celentano, Burke, Boer, Wongpan & Suriyanon 1999).

Suspicion about the fidelity of the HIV positive partner and fear of being transmitted to the HI- Virus were noted to lead to relationship instability and dissolution among couples where the HIV positive partner would be accused of bringing HIV home. (Boerma, Urassa, Nniko, Ngweshemi, Isingo & Zaba 2002).

HIV/AIDS infection has been very stigmatizing, in South Africa any person who got severe illness, died or whose partner died of severe illness was interpreted as HIV infection by the close community members. (Hosegood. 2008).

The term HIV discordant couple refers to a pair of long – term cohabiting partners where only one has HIV infection while the partner does not. Since the first case of persons infected with HIV /AIDS were discovered in 1981 nothing was known of cohabiting partners having discordant HIV/AIDS status, this was probably because analysis of the determinants of HIV infection were mostly performed at individual level and also the assumption that once a spouse tested HIV positive or negative the partner assumed similar results.

However with the establishment of counseling and testing services such as the Voluntary Counseling and Testing services (VCT) and more emphasis being made on the importance of the VCT for couples, Provider Initiated Counseling and Testing (PITC) and the Diagnostic Testing and Counseling (DTC), the number of HIV discordant couples has increased and it is expected to rise as more people make use of these services. In Kenya it is estimated that about 350,000 married couples are HIV discordant. (Kenya National HIV Strategic Plan. 2006-2009/10, Kenya Aids Indicator Survey, (KAIS) 2007 & the Kenya Demographic Health Survey, (KDHS) 2008/ 2009).

VCT acceptance among couples has come with challenges too; couples who have gone ahead to have it done and were found to have the virus would often blame each other for the source of HIV / AIDS which led to violence, abandonment and marital disruption. (Machekano,

McFarland, Basset & Mandel. 2000). The situation would be challenging when only one partner is infected and worse if it is the female partner who is HIV infected; probably because men are more likely than women to be excused for the behavior that's results to their HIV infection. (Porter, Hao, Serwadda, Wawer, Lutalo, & Gray 2004)

Marriages and families of the HIV discordant couples are in no way different from other families as far the functions of a family are concerned, but with HIV / AIDS the expected functions of a family are threatened. There is evidence of changes in marriage patterns as a direct response to HIV infection, partners have stopped working in order provide comfort and care to those who become sick or to be nursed when they are the ones who are sick thus leading to loss of livelihood. (Donahue 2005 & Hosegood. 2008)

The unwillingness to take a HIV test means that more people are diagnosed late when the virus has progressed to AIDS. This has led to increase in morbidity and mortality which have disrupted family roles especially when the bread winner is the one who is affected or has died of the infection.

HIV/AIDS is not different from other chronic diseases but the fact that it is a sexually transmitted life threatening disease; which is associated with behaviors such as homosexuality and prostitution has made it very stigmatizing. It is an infection that affects the sexual relationship of the couple affected and social life of the family at large.

Marriage is associated with transmission risks in sub-Saharan Africa where more than 80 percent of the HIV transmissions are due sexual relationships among partners who are living together. (Bongaarts 2007, Mantell, Smith & Stein 2009, Stein, Nyamwatti, Ullman & Bentler 2006). Partners are therefore faced with fear of being transmitted to the HI- Virus probably because marriages involving HIV positive persons were found to end in widowhood, this fear may worsen when they are in a discordant relationship. (Floyd, Cramping, Glynn, Mwenebu, Mnkondia, & Gwira, 2008)

Prevention of Mother -to -Child Transmission (PMTCT) services and treatment programs are intended to ensure that children born to HIV positive concordant and discordant couples are born without the virus but where these services are poor, there's additional stress of risking vertical transmission of HIV to their unborn children. (Hosegood, 2008).

Contentious findings were found on the desire to have children; despite much emphasis being made on condom use, the desire to get children was found to conflict with the need for preventive measures and couples who have desired to have children or increase their number of children have gone ahead to have them, and thus exposing HIV to the negative partner. (Carpenter, Kamali, Ruberantwari, Malamba, White Worth & James, 1999). At the same time HIV epidemic has been found to exerts a downwards pressure on the desire to have children or increase the number of children a couple desires to have; couples have declined to have or increase the number of children they have due to fear of transmitting or being transmitted to the HI-Virus. (Hauveline. 2004).

However despite the devastating effects of HIV/AIDS on the family, there are some marriages which have survived and have remained intact despite one partner being HIV positive contrary to the general expectation that such marriages are doomed to fail. It is therefore evident that for marriages of couples with discordant HIV status to remain stable, there must strong reasons. This study therefore embarked on establishing the factors that influence marital stability among the couples where one partner has HIV infection while the other does not.

Cultural factors like religion and the societal values have been found to act as buffer to divorce and separation. Couples have been forced to stick together even when their marriage is not working mainly because culturally a marriage is expected to be a permanent institution suitable for the rearing of children. (Feldman & Feldman. 1985, Lamanna & Riedmann.1999).

Today most religious institutions still favor and advocate for permanence of marital unions, it was noted that divorce was highest among couples who are unaffiliated to any religious faith. Catholics, Jews and fundamentalists Christians have historically been stricture about divorce than other religious denominations. (Newman. & Graverholz. 2002). This study therefore determined the role of culture in influencing marital stability among HIV discordant couples.

Children are an important part of every marital union especially among the African communities where the process of marriage starts with the birth of the first child. (Radcliffe – Brown & Ford. 1987). Studies done in Kenya found that the main reason for a couple to get married was to have children, marriages with no children were often found unsatisfactory and a husband in such a union was expected to take another wife. (Adams and Mburugu 2001 cited in Adams and Trost, 2005).

The number of children a couple has and the duration of a marriage have also been found to enhance stability of a marriage. (Hurlock,1996). The more children a couple has can be interpreted to mean more years in marriage and more commitment in the rearing of children both emotionally and financially. Culturally when there are children in a marriage; separation or divorce is not a priority because of the expected impact of such a separation on children. (Porter et al, 2004).

Traditionally there was favor for children born within marriage as they acquired legitimate identity and a name was given by which they acquired a sense of belonging to a particular family. (Clayton, 1979, Radcliffe - Brown and Forde,1987).

A study in Thailand found that even where a discordant or positively concordant couple did not desire more children, pressure from their families and risks of disclosure of their status eventually made them bear more children. (Tangumunkongvorakul. et al 1999). By bearing more children the positive partner risks passing the virus to the negative partner and also to their children. This study therefore investigated whether presence of children would influence marital stability among HIV discordant couples.

There is a casual relationship between stress and illness. Studies have noted that stress causes decline in the CD4 count thus leading to disease progression. (Leserman. 2008, Remor, Penedo, Shen, & Schneidman. 2007).

However social support in form of family, friends and support groups has been found effective in reducing this kind of stress. Scientists have noted that people with fewer social relations are

at increased risk of diseases. (Conrad, 1993). Support groups for people who are infected with HIV/AIDS help to reduce stigma associated with HIV/AIDS and the disruptive consequences of an illness due to shared norms about the illness. (Boesten & Poku 2009, Conrad.1993).

In HIV/AIDS support groups, members learn of others who are in a similar situation like them and this motivates them to continue being there for each other. They learn that being HIV positive is not a death sentence. On the other hand, HIV discordant couples learn that there are other couples who are HIV discordant also, and their marriages have remained intact. This study established the extent to which therapeutic social interventions influence marital stability among the HIV discordant couples.

HIV/AIDS has been found to impact on a family's social economic status regardless of who gets sick in the family. HIV/AIDS is associated with loss of income and labor, cost of financing the healthcare for those who are sick as well fostering affected children. (Donahue 2005)

A family's social economic status is an important factor as far as marital stability is concerned. However there have been contentious findings on the effects of social class on marital stability. The lower social class has been related with marital instability. (Collins & Coltrane 1991) On the contrary when prosperity sets in the rates of desertion and divorce tend to go up. (Hurlock 1996)

There is a high likelihood of marital stability where livelihood factors are well catered for in a marital union common in all marriages. Most couples expect marriage to offer economic

interdependence where they rely on each other for financial support. (Newman.& Graverholz. 2002). If this expectation is not met there are possibilities that the marriage would be faced with challenges and more so if there is HIV/ AIDS in the relationship.

Studies done among the Kikuyu community found that men were expected to protect and provide for their families and the wives accepted this as the responsibility of their husbands. (Adams. & Trost. 2005).

If the family's bread winner is the one affected by HIV/AIDS this expectation is threatened and wives will be expected to provide for their families as well as performing their expected nurturing roles. This study therefore investigated if income and financial stability enhance marital stability among HIV discordant couples.

The gender of who is HIV positive has been found to enhance marital stability. Studies have highlighted women's vulnerability to social impact of HIV infection. Women who are HIV positive are more likely to experience marital dissolution than those who are HIV negative or those whose husbands are HIV positive. (Porter et, al. 2004).

This study therefore investigated whether the gender of who has the virus influences marital stability among HIV discordant couples.

## **1.2 Problem Statement**

Marital stability refers to the state in which couples in marriage continue to live together in a harmonious way that brings contentment to the party concerned and the society at large.

HIV/AIDS is a major threat to the marriage institution; it has caused changes in the marital patterns where marriages have been dissolved through separation, divorce and death in both positive concordant and discordant couple relationships. (Boerma et al 2002).

Four fifths of the global HIV transmission is due to sexual relationship. (Mantell, Smith & Stein.2009). The fact that most of its mode of transmission is sexual has made it be more stigmatizing than any other disease and this has been made worse by the fact that marriages involving HIV positive persons were found to end in widowhood. (Floyd et al 2008).

HIV/ AIDS is a chronic illness that has caused increase in morbidity and mortality in both adults and children and being a global infection it has killed more people than any other disease. Currently it is estimated that 34 million people are already living with the virus and 30 million have already died of the infection. (UNAIDS 2012)

Discordance in stable sexual relationship is a major risk factor for transmitting the virus from the infected partner to the uninfected partner. There is a possibility that this can cause fear of transmission, possibilities of death and social stigma among the couples. Among the HIV discordant couples, it is quite clear who has the virus unlike in concordant positive relationships where both partners just find themselves with the HIV virus. Therefore there is a general expectation that the HIV positive partner would be blamed for bringing the virus home.

With all these factors there is a possibility that HIV/AIDS can disrupt family life through divorce, separation and lack of harmony in the marriage; however quite a number HIV discordant couples live together. The question is how come HIV does not disrupt this commitment; what other reasons could make these couples stick together. Being a new phenomena, very little is known about the HIV discordant couples in relation to their experiences, any changes in their relationship, how they cope and what has really brought them this far. This study therefore embarked on establishing factors that influence marital stability among these couples.

### **1.3 Objectives**

The broader objective of this research was to study factors influencing marital stability among the HIV discordant couples.

#### **1.3.1 Specific Objectives of the Study**

The specific objectives include;

1. To establish the extent to which socio- economic status influences stability of marriages among HIV discordant couples.
2. To establish the extent to which therapeutic social interventions influence marital stability among HIV discordant couples.
3. To establish the extent to which demographic variables influence marital stability among HIV discordant couples.
4. To determine the role of culture in enhancing marital stability among HIV discordant couples.

#### **1.4 Justification of the Proposed Research**

HIV discordance is a new phenomenon and very little is known about the HIV discordant couples in relation to their experiences, changes in their relationship and what really makes them stick to each other. This study therefore aimed at exploring factors that influence marital stability among HIV discordant couples.

Previous research done on discordant couples is in the clinical area, while very little research has been done on the social aspects in relation to HIV discordant couples and no study has been done on factors influencing marital stability among HIV discordant couples in Kenya. Therefore this study may contribute knowledge on what influences marital stability among HIV discordant couples.

As far as policies are concerned, findings from this research may help various policy makers understand the experiences of HIV discordant couples, challenges that they face and what makes them stick together. Policy makers may understand the role played by therapeutic social interventions like counseling and support groups in enhancing marital stability among these couples and therefore emphasize on the importance of individual, couple or group counseling.

#### **1.5 Scope and Limitation of the Study**

This study examined factors that influence marital stability among HIV discordant couples. The socioeconomic status was indicated by income, occupation and the level of education. The study therefore examined how socio-economic status influenced stability of marriage among discordant couples.

This study established the extent to which cultural factors, existing social interventions influenced marital stability among the couples. The study also established if gender of the HIV positive partner, presence of children and the pattern of interaction influenced marital stability. The study experienced some limitations. Marital stability (or lack of) can be an outcome of many factors. Marital stability is about relationship and relationships are always hard to explain. One can never know all the factors that make people stay together. This study was limited to sociological issues only, there may have been medical and philosophical factors that influenced marital stability but the researcher only focused on sociological factors.

The study was done among HIV discordant couples registered for group therapy at KNH. The participants were mainly from Kibera, an informal settlement in Nairobi.

With urban dwellers, reasons for staying together cannot be assumed to be the same with rural people or people in high economic settings. Consequently the findings cannot be generalized to apply to all HIV discordant couples as it was limited to couples who had been registered as discordant couples at KNH.

## 1.6 Definition of Key Terms

**HIV discordant couple-** Refers to partners in marriage where one has HIV while the other one does not.

**Concordant Positive-** refers to partners in marriage who are both HIV positive.

**Marriage-** in this study marriage was looked at in terms of cohabitation, rather than a formally defined legal or religious status.

**Marital stability-** Marital stability refers to state in which couples in marriage continue to live in a harmonious way despite their marriage facing challenges.

**Marital disruption-** refers to breakage of a marriage through divorce or separation.

**CD4 count** - refers to a measure of the number of the T cells per cubic millimeter of blood.

**Morbidity-** refers a measure of the burden of disease in a population.

**Mortality-** refers to a measure of death due to an incident.

**Support group-** this refers to a group of people with common challenges who have come together to share and help one another.

**Fidelity-** In this study it refers to the faithfulness of the sexual partner.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 HIV Infection, Discordance and Marital Relationship**

In Sub Saharan Africa the risk HIV/AIDS remains very high with about 50 - 65 percent of the infections being found in East and Central Africa an area that accounts for only 15 percent of the sub Saharan Africa population. (KDHS 2008-2009).

The first identified case of persons infected with HIV/AIDS in Kenya was recorded in 1986 and due to its fast progression the Government of Kenya took a move to declare HIV /AIDS epidemic a national disaster in 1999 and subsequently set up the National Aids Control Council (NACC) a council which was to coordinate the multisectoral response to HIV/AIDS. In Kenya the National HIV prevalence stands at 7.1 percent and its prevalence among women has been higher than that of men at 8 percent and 4 percent respectively for those aged between 15- 49 years. (KAIS, 2007)

In the KAIS survey, most of the couples (90 percent) were HIV Negative while 10 percent had both or one partner HIV/AIDS infected. Among couples who are living together 6 percent were HIV/AIDS discordant where only one partner is infected with HIV. The survey found that about 350,000 married or cohabiting partners were HIV discordant.

The researcher looked at marriage in terms of cohabitation, rather than a formally defined legal or religious status. Marital stability refers to state in which couples in marriage continue to live in a harmonious way despite their marriage facing challenges.

HIV/AIDS ceased to be an individual problem with the declaration of the 1994 World's AIDS day theme "AIDS and the family". It was at around this time that the society started experiencing its impact on the family as well. It is a disease that occurs through family relationship and it is a major threat to the institution of marriage. Visible changes have occurred in the family patterns where families have taken the role of providing comfort and care to those who are sick. (Boerma. et. al. 2002., Bongaart. 2007, Donahue, 2005, Glynn, Caraël, Buvé, Musonda, & Kahindo. 2003. & Tangmunkongvorakul. et. al. 1999).

Fear of acquiring HIV infection was found to bring a significant reduction in the desire to get married among women who preferred single life after seeing loved ones die of the infection. (Bunnell, Nassozi, Marum, Mumbangizi, et al. 2005). For those who were married, divorce and separation were used as strategies for individuals to protect themselves against HIV risk. (Gregson, Zhuwau, Anderson. 1998 & Riners, 2008).

HIV / AIDS is not different from other chronic diseases but the fact it is a life threatening sexually transmitted disease increases fear of transmission from the sexual partner. The society views it with a lot of stigma and as a disease that is embarrassing to the family. Studies have shown that most partners enter marriage without having tested for HIV and when it is done; it is mainly prompted by illness or death of a partner or a child and that only a few insist on

knowing the HIV status of a prospective marriage partner. (Hosegood. 2008, Lugalla Emmelin, Mutembei, Sima, Kwegisabo, & Killewo, et al 2004). This is a good indicator to show that despite the fact that most people are afraid of contracting the virus, few insist on knowing the HIV status of a prospective partner and many partners engage in sexual intercourse first and there after worry after they remember that they should have protected themselves from HIV/AIDS.

Among the concordant positive couples it is not clear who infected who first because most partners just find themselves with the virus; it is common for such couples to engage in a blame game in which each partner blames the other for the source of HIV /AIDS. Among the HIV discordant couples, the source of HIV is known because only one partner is infected, there is a possibility that the positive spouse would be blamed for possible infidelity and bringing HIV home. (Boerma et al 2002).

HIV discordance in stable Sexual relationships is a major risk factor for transmitting infection from the infected partner; and a major cause of infant and childhood mortality and morbidity in Africa and which has a worldwide mortality rate of 7.7 percent. (Mantell, Smith & Stein. 2009, Tindyebwa, Kayita, Musoke, Eley, Nduati, Coovadia, Bobart, Ngacha & Kieffer. 2006).

Though great emphasis has been made on condom use for both positive concordant and discordant couples, research has found that some discordant couples hardly use them due to confirmed misconceptions about discordance. (Bunnell et al 2005, Mantell, Smith & Stein.2009). Some of the concordant positives find no harm in having unprotected sexual

intercourse because they are both HIV positive and therefore perceive no fear of transmitting the virus to each other.

According to scientists HIV discordance has been related to a combination of factors that include genetics, HI- virus type, the extent to which the HIV infection has progressed in the HIV positive partner, presence of a sexually transmitted infection and circumcision which research indicates may reduce the risks of HIV infection and possible absence of CD4 receptors in the HIV negative partner. However there are several myths and misconceptions on discordance which leaves the HIV negative partner at high risk of HIV infection. Some couples think that the HIV negative person is actually infected and it is just a matter of time before the virus shows up and that some people are totally immune to HIV infection which makes some couples dismiss the idea of condom use. Other couples have also been found to perceive that 'gentle' sex with a partner who is HIV positive buffers the negative partner from getting the virus, as only rough sex can transmit the HIV/AIDS virus. (Bunnell et al 2005).

Studies have shown that VCT services are yet to be fully accepted in marriages, and where one or both partners test HIV positive the marriage may be characterized by blame, violence, abandonment and marital disruption. The knowledge of HIV status in and of itself has been found to lead to divorce especially when a woman tests HIV positive. (Gregson, Zhuwau, Anderson, and Chandiwana, 1998, Grinstead, Gregorich, Choi, & Coates 2001, Machezano, McFarland, Basset & Mandel, 2000 & Porter, 2004).

Couples in discordant couple relationship have maintained stable marriages, despite the fact it is clear who has the virus and the general expectation that such marriages are doomed to fail. This study therefore examined factors that influence marital stability among HIV discordant couples.

## **2.2 Livelihood Factors**

### **Social economic status and marital relationship**

Studies have found that a husband's educational attainment and social economic status made him maintain a stable personal identity a factor which has been associated with marital stability. (Fiedman & Fiedman 1985). This is in line with what was found in Rakai in Uganda that formal education attainment among males reduced the possibilities of separation and divorce among HIV discordant couples. (Porter. et al, 2004).

Studies done in Kenya found a relationship between educational attainment among women and marital stability; the educated Kenyan women with a good job were less willing to tolerate an authoritarian or a dependent man who decides to live off of his wife's income. Adams & Trost ( 2005) cited in a study done by Adams and Mburugu (2001).

There are some contentious findings on the relationship between divorce and economic status; some researchers have found that when prosperity set in divorce and desertion rates go up. (Hurlock 1996); other researchers have found the opposite that it is more common to have the lower social economic class having marital conflict and subsequent marital dissolution than those in the higher social economic class. (Collins & Coltrane, 1991).

Traditionally economic security was viewed as an important reason for a woman to get and remain married because by a woman having no economic means; she was completely dependent on her husband and besides it was made clear that once she was married there was no going back to her family of origin even when she was in an abusive relationship. (Sweetman, 2003).

Divorce and separation were noted to be highest when husband and wife work but their incomes are not high, married early and when they have not been married long, (Collins & Coltrane 1991). Women who got divorced and separated were more likely to be on welfare than women from more stable families. (Hoffman 1977).

The above studies found a positive relationship between social economic status and marital stability. The question is; to what extent would income and financial stability determine marital stability? Does social economic status determine marital stability in the face of HIV/AIDS and more so when only one partner is infected?

### **2.3 Cultural aspects and marital stability**

Culturally there was a general expectation that children had to be born and brought up in a marital relationship; marriage was expected to last and this expectation made divorce very rare and every effort was made to ensure that a couple remained married. (Mwangi 1998, Radcliffe – Brown & Forde 1987). In instances where divorce or separation was likely to occur because the woman was found to be infertile, the matter was resolved by taking a second wife. (Mburugu & Adams 2001).

Research has shown that there is a positive relationship between religion and marital happiness. Couples who attend church together and participate in religious activities or are just religious have been found to be more patient with each other, more forgiving, quicker to get over anger and more supportive in their relationship. (Newman & Graverholz. 2002).

Most religions encourage people to stick together even when they are experiencing challenges in their relationship; it is commonly believed that religion acts as a buffer against divorce. This is seen in what Newman and Graverholz (2002) found that Catholics, Jews and fundamentalists Christians have historically been stricter about marital dissolution than the main stream Protestants.

They cited Heaton (1990) who found that divorce tends to be highest among couples who are unaffiliated to any religious organization and Robinson (1994) who found that among the couples he studied those who had lived for an average of 40 years said that religious faith was one of the most important factors enhancing their marriage. With such findings one is left wondering if religion would still enhance marital stability where a couple is affected by HIV/AIDS and more so when they are in a discordant relationship.

#### **2.4 Presence of children and marital stability.**

Children in Africa are highly valued as it is through them that heritage is passed from one generation to the next. Several writers have argued that part of the process of marriage is seen with the birth of the first child because it is through children that the husband and wife are

united and the two families united by having descendants in common. (Radcliffe – Brown & Forde. 1987).

Marriage has been seen as a way of giving children a legitimate identity and a sense of belonging. (Clayton 1979). A study done by Adam and Trost, (2005) reported that the key reason to why people get married is to get children as children were viewed as a source of success in marriage. They found that a marriage with no children was found unsatisfactory to a point that a husband could take a second wife if the first one failed to give him children.

Studies have found that a marriage with children has also been found harder to dissolve than one with no children due to the dependency that children create to partners who are married. Couples who have children have been encouraged to continue living together even when they are unhappy with their marriage, for the sake of the children. (Feldman & Feldman.1985, Newman & Graverholz. 2002).

Infertility in marriage is one of the factors that lead to marital problems; when a child is not born in the first year of marriage, the man and his entire family and lineage begin to get worried. This is because children are seen as a path through which there is continuity in the family. (Rukwaro. 2005)

There have been contentious findings surrounding the relationship between marital stability and the ages of children where some researchers have observed that there is more stability in marital unions when children are young than when they are older, because more time, finances

and emotional resources are devoted to the raising of children which requires the attention of both parents. (Call & Heaton 1997, Emery. 2009 & Heaton. 1990).

On the other hand studies have found that a large family size with older children deters marital disruption because having a large family means that the couple has lived together longer than when the couple has fewer and younger children. The longer a couple has lived together the more attached they are to each other and their children. (Cherlin 1977).

With a larger family there is more dependence by wives to their husband's income which makes it harder for divorce to take place for fear that financial support may cease with divorce. In the Constitution of Kenya (2010), provisions for child support and maintenance responsibility are a greater and a heavier burden to a husband who decides to divorce a wife who is dependent on him. Collins & Coltrane (1991) found the likeliness of divorce to be highest when husband and wife work but their income is not high, married early and when they have not been married long.

By HIV affecting one of the partners, the hopes of having children may be shattered for couples who discover that they are discordant after living together, this is so because having children means putting at risk the HIV negative partner who may contract the infection and also the risk of infecting the unborn baby. With the Anti Retro Viral therapy services in place, there are conception techniques which are offered to both HIV concordant and HIV discordant couples to reduce the risks of HIV transmission to the child. This has come as a relief to those

couples who may desire to have children or increase the number of children they have. (Journal on reproductive matters volume 14 Of May 2006).

A study done in Kibera by Opondo, Ekstrom, Ilako, & Indalo, (2010), found that children are viewed as prerequisites of a fulfilled happy life, a reason that makes every mother regardless of her HIV status desire have them. This was seen as one of the push factors that led women to conceive with a low CD4 count of less than 350 cells/ml. Similar findings had also been found by Dyer (2002) who argued that since women mostly bear the blame of everything negative that happens in most families, fear of being blamed for childlessness has pushed most mother who already know that they are HIV positive to conceive and bear children regardless of their CD4 count. Most families expressed increased fear of having to die childless because in most African societies children are believed to ensure a continuity of the family line.

Opondo et al (2010) cited a research done by Gerrts (1997) who found that failure to have children brought a negative repercussion in African societies. Studies have observed that most people enter marriage hoping that the mutual affection and commitment will last a lifetime, but many unhappy marriages have remained intact for the sake of the children. (Heaton. 1990, Feldman & Feldman 1985, Mwangi, 1998.)

Despite the fact that studies have found children to be important factors in buffering divorce and separation among couples, we have not been told whether they have the same effect where couples are faced with challenges of HIV/AIDS. This study therefore investigated whether presence of children in a marriage enhances marital stability even in the face of HIV infection.

## **2.5 Gender and marital stability**

Studies have found a positive relationship between gender and marital stability or instability. In the International conference on AIDs (1998), it was reported that a husband's HIV diagnosis has a profound effect on the dynamic of the relationship and the emotional wellbeing of the family. This is because men have been found to be the determinants of the outcome of a marital union depending on who has the virus. Women's care taking roles of the sick leave them disadvantaged when they are the ones who are sick as their partners may not willing to take care of them.

Women living with HIV/AIDs have often been viewed to be promiscuous or immoral and are particularly vulnerable to HIV related stigma and the situation becomes worse if it is the woman who is HIV positive while her husband is HIV negative. (Boesten & Poku. 2009). This is probably because the society has always excused men for the behavior that leads to their infection. Findings by Clark, Lindner, Armistead & Austin (2003) observed that among the HIV infected women, as levels of perceived stigma increased, the level of disclosure and psychological functioning decreased.

Mwangi (1998) found that divorce was very rare in African societies, because a woman was regarded as the foundation rock on which the home stead was built, without her the homestead would break, so it was only when efforts to keep the husband and the wife together failed that an action for divorce could be taken.

Findings have found that men are more likely to bring HIV into their marriages than women mainly due to cultural practices like polygamy or just the cultural expectation that they can have more than one woman. (Bunnell et al 2005, Porter et al 2004).

The gender of who is HIV positive was found significant in studies that reported that a female HIV positive discordant couple (M-F+) were more likely to experience divorce than the concordant HIV negative couple (M-F-) or when it is the male who is HIV positive, (M+F-). (Porter et al 2004).

A family is an important source of emotional support but when many couples discover that they are HIV/AIDS discordant; emotional support may cease to be provided. Most couples may start off well where they promise to live and care for the HIV positive partner but fear of contracting the virus and not actually knowing what to do have disrupted marital unions.

The above findings have suggested the vulnerability of the woman in a discordant couple relationship where she is the HIV positive partner; this study therefore investigated whether the gender of who is an HIV positive influences marital stability among HIV discordant couples.

## **2.6 Social support and marital stability**

Bunnell et al (2005) found that the fact that discordance is rare, it is associated with considerable emotional stress for the parties concerned. To most partners it is equated with infidelity on the part of the HIV positive partner.

Research has found a casual relationship between stress and illness. There is substantial evidence that stressful events may cause decline in the CD4 Cell count thus leading to HIV disease progression, increase in viral load and mortality. (Leserman. 2008 & Remor et al 2007). Persons who are HIV positive experience stress induced by the illness or hostile social reaction to them and such stress may impair the functioning of their immune system making them more vulnerable to infections. (Sdorow 1993).

On the other hand research has found that there is a positive relationship between sickness and social support. Social support can reduce the immunosuppressive effects of stress. Scientists have long noted that people with fewer social relationships are at increased risk of diseases. (Conrad 1993).

In Africa, marriage is a social institution that not only unites a man and woman but also creates an alliance between two families or bodies of kin that fulfills some functions without which there would be dissolution of a marriage. (Radcliffe – Brown & Ford. 1987, Rukwaro 2005). Social support can be in form of support groups, family and friends. Social support provides an opportunity for one to know that they can still live despite being HIV positive and also for discordant couples to know that other couples have been in a similar situation and have managed to stay married.

Conrad (1993) has cited Parsons (1951) who found that social support has proved to prevent the potentially disruptive consequences of an illness due to shared norms about the disease.

HIV/AIDS has been found to be one of the most stigmatizing diseases due to its mode of transmission. Stigma has been found to deny people their livelihoods and social networks. AIDS activists at community level argue that it is self stigma that inhibits people from speaking about protecting others. (Clark et al 2003)

Boesten & Poku (2009) found that in an illness like HIV/ AIDS support groups have been found to help people reduce stigma and enhance counseling done by health care workers. Such groups may help individuals to deal with their situation better and also make important contribution to the community care and prevention efforts.

Social support in terms of support groups and support from the extended family and friends has been found important especially if the marriage is experiencing challenges. However social support has also been found to impact on marriage negatively where if boundaries are not set clearly upon marriage, friends and relatives can interference sometimes leading to marital dissolution (Kephart 1977., Mc Goldrick 1999).

The same was found by Ritzer (1996) who found that people create and are threatened by social structure and its products, thus people's interactions through friendship or group relations can be both beneficial and disastrous. This means that the source of support that a couple may get can be both beneficial as well as disastrous.

When a couple learns that they have discordant HIV status, denial and confusion may set in. Such a couple may be very vulnerable especially if they rush to disclose to their respective

relatives. Extended families and friends are expected to offer social and psychological support to couples facing challenges but they can also act as push factors for such marriages to end especially in the case of couples with HIV discordant status.

The studies above have found a positive relationship between social support, the therapeutic interventions and marital stability. However studies have not told us whether social support and therapeutic interventions play role in ensuring marital stability in the face of HIV infection. This study therefore investigated whether therapeutic social interventions enhance marital stability among the HIV discordant couples.

## **2.7 Communication**

The nature and pattern of communication have been found to be important factors in enhancing marital stability. Sabatelli (2003) summarized six qualities of strong families as appreciation, spending time together, Commitment, good communication and ability to deal with crises in a positive manner.

Communication is a symbolic and a transactional process through which people create and share meaning that impacts on them as they interact; it is both verbal and non verbal. (Glavia & Gromell 1991). It is therefore necessary for the spouses to learn how to communicate and cope with many feelings and realities which include anger, grief, money problems, sexual fears, spiritual issues, doubts and parenting concerns.

Fiedman & Fiedman (1985) noted that in a good marriage, partners need to feel satisfied in what they are getting from a relationship, which is characterized by open disclosure of any feelings of dissatisfaction, ability to support each other and ability to adapt to changes that affect the relationship.

Strong marriages are found to have a good communication pattern, where couples spend time together talking and listening to each other. If the HIV discordant couples had a good communication pattern long before they learned that one of them has the HIV Virus they are likely to stick together after the diagnosis is made. A marriage is found to be successful when it makes successful adjustments in face of a stressor which is determined by the quality of the communication between the husband and wife and their appraisal of the stressor, as one that can be managed or not. (Danielson, Bissell, & Winstead, 1993).

Morgan (1985) found marital problems as problems to do with the complex pattern of emotional, interpersonal and sexual relationships that constitute a marriage. He noted that sexuality is an important component which is at the core of what makes marriage a relationship but with poor interpersonal relationship; sexual relationship may also cease among the couples. However, Bunnell et al (2005) observed that fear of HIV/AIDS transmission was noted to interfere with couples' sexual intimacy.

In a partner study conducted in northern Thailand between March 1992 and June 1996 on the sexual behavior in HIV concordant and discordant heterosexual couples, it was noted that there

were less frequent intercourse and more condom use among the discordant couples than the concordant positive couples. (American journal of epidemiology Vol.147 No.12 1998).

Disclosure of personal issues was observed to play an important role in maintaining happiness and stability of a relationship as well as increase emotional support enhance sexual intimacy and facilitate self acceptance. (Holt, Court, Vedhara, Nott, Holmes. et al 1998, Sdorow,1993).

Rolland (1993) noted that in order to maintain the family support, open communication for all family members is crucial, because living with secretes can encourage fear and guilt. He observed that since all family members are anticipating loss, it is necessary to discuss the issues of healthcare, living wills, legal matters and finances in the present. This may help the family to keep their affair in order at a time when they are under tremendous stress.

However revealing secretes has its problems also, it can cause abandonment, stigma and discrimination when people discover their discordant HIV status; this means that before disclosure a partner should understand and be ready to take its negative consequences. They should also be in a position to weigh whom to disclose to and whom they should not. This study embarked on investigating the extent to which the pattern of communication enhances marital stability among HIV discordant couples.

### **2.7.1 Trust and Commitment**

There is the general expectation that marriage can succeed if it is cultivated through the years.

Fiedman and Fiedman (1985) found that having a good model from the family of origin would be helpful in guiding a husband's efforts towards making his marriage work.

Commitment has been found to be an important factor in marital stability as it helps couples negotiate life crisis. Studies have found that during tough times romantic feelings fail, sex doesn't seem very important either and material possessions may not mean much, it is the two against the world, toughing it out, testing all their resources. Committed couples are able to learn that not all hard times lead to divorce as they are able to focus on how they have evolved past crisis. (Van Pelt 2008).

Lamanna and Riedmann (1999) argued that marriage is expected to be permanent and for permanence to occur, couples have to maintain commitment to each other. They noted that most people enter marriage hoping that mutual affection and commitment will last.

However studies do not state whether commitment plays a role as far as marital stability is concerned in the face of HIV/AIDS and more so when the couples have HIV discordant status.

Trust refers to the belief that a partner will not exploit or take unfair advantage of the other partner. (Haas & Deseran 1981).

Sabatelli (2003) has cited Burn (1993) who argues that trust is important in relationship development because it allows individuals to be less calculating and seek longer term outcomes thus allowing partners to be future oriented by increasing their confidence and a sense of security in the relationship. With HIV/ AIDS there is a possibility that trust and commitment can be eroded and especially when only one partner is HIV/AIDS infected, but to what extent

do HIV discordant couples trust and become committed to their marriage? Is the level of trust and commitment in the relationship the ingredients that have ensured marital stability among these couples?

## **2.8 Theoretical Framework**

The purpose this section was to establish a link between theory and the proposed study.

### **2.8. 1. The Social Exchange Theory**

The social exchange framework was founded by George Homans in the 1950s and 1960s and it is most dominant in family studies. This theory came from the behaviorists ideas of B.F.Skinner on the relationship between the actor and the social environment.

This perspective proposes that social behavior is as a result of an exchange process, where individuals are seen as acting out of self interest with a goal of maximizing their profits and minimizing their costs. (Homans 1958).

According to this perspective people weigh the potential benefits and risks of a social relationship; when risks outweigh the benefits, people will terminate the relationship.

In close personal relationship one's own satisfaction generally depends on the extent to which one partner is satisfied as well. Acting in the best interest of the partner becomes one way of obtaining benefits for the self.

When each behavior is reciprocated in a positive way an exchange relationship such as this fosters trust and commitment that if sustained over time can lead to the belief that the relationship has many of the special and enduring qualities that define a lifelong relationship.

When the HIV positive partner experiences acceptance from the partner she or he will be motivated to live because lack of stress will automatically boost his immunity.

**Rewards** refer to the benefits exchanged in social relationships and they are the pleasures, satisfaction and gratification that one derives from participating in a relationship. In a relationship rewards include social acceptance appreciation and approval, the provision of favors and respect. Rewards also include making positive verbal statements, listening, touching, giving gifts or spending time together. Each of these serves as reinforcement that increases the likelihood of being attracted to the relationship.

**Costs** refer to draw backs or expenses associated to a particular relationship. They can involve negative aspects of a relationship. A partner's insensitivity may be perceived negatively as might be the time and efforts required to maintain the relationship.

**Exchange** refers to the unique values and expectations individuals bring to their relationship. These are the standards by which the relationship is judged. Findings from study have found that most couples always ask themselves whether they are getting as much as they have invested in the relationship. (Lamanna & Riedmann 1999). As a general rule we tend to be more attracted to those partners who offer us the kind of rewards that we value. Individuals also tend to be more attracted to relationships whose outcomes exceed our expectations.

However this perspective experiences a major drawback in that it favors and advocates for openness in social relationships; due to stigma associated with HIV/AIDS, openness in a relationship may not be the best option, partner have to make their own independent decision to disclose their HIV status to others who are not their partner. Following this limitation, the

researcher will focus on two other theories and relate them to the study on factors that influence marital stability among HIV discordant couples.

### **2.8.2. Ethnomethodology**

Ethnomethodology is a theoretical model which was founded by Harold Garfinkel in the late 1940's but was first systemized with the publication of his studies in *Ethnomethodology* in 1967. (Garfinkel 1967).

Ethnomethodology is the study of the everyday practices used by ordinary members of the society in order to deal with their day to day lives. Through the use of commonsense the members of a society are able to understand themselves and the situation they find themselves in. Ethnomethodologists' do not focus on actors or individuals like many other approaches; their main focus is on members and membership activities. Members are viewed as people who can make their own judgment without being constrained by their institutions.

The founder of this model has discussed a variety of concepts but the researcher used concepts which are relevant in this study on marital stability among the HIV discordant couples using his key concepts, the *institution* and the *conversation analysis*.

Research has found that most couples enter marriage without the knowledge of their HIV status and that most HIV testing is prompted by sickness or death of a child or a partner. (Hosegood, 2008). Most HIV discordant couples become aware of their discordant status

within the institution of marriage and more often than not it is after they have lived with each other for some time and have had children.

HIV discordance is a challenging situation that a couple finds itself in, which is at first shocking to the couples affected. Most couples go into denial before spells of anger and bitterness begin as they embark on making sense of their situation.

As the couple comes to terms with what is happening to them they are able to make important decisions in their lives on how to proceed with their relationship, how to protect the negative partner, treatment needed, other investigations which may be required and whether to have more children or not.

This approach views couples as people who have capacity to make important decisions independently without the interference of the society. Where disclosure of their HIV discordance status is made to the society inappropriately there may be pressure for the couple to separate or live together which may be against their wishes.

In this approach, membership activities refer to what goes on in the marital relationship between the HIV discordant couples, their interaction and how they get along with each other after the awareness of their HIV discordant status, which includes; issues like sexual relationship, support they offer each other and harmony in their relationship.

Garfinkel has stressed on the importance of accounting in this model. He defines accounts as ways in which actors describe, criticize and idealize specific situations in their lives.

HIV discordant couples can make accounts of how they perceive each other in terms of their interpersonal relationship focusing on their pattern of communication and generally how they behave towards each other. The partner who has the virus can express whether he feels supported by the HIV negative partner or not.

Studies have found that if it is the female who has the virus, marital relationship is likely to end than when it is the male partner who has the virus. (Porter, 2004). So if the HIV positive partner does not feel supported emotionally or is blamed for bringing the virus home by his or her partner, the marital union may end. If it is the woman who has the virus she is likely to be sent away and her husband marries another wife. The HIV negative partner may argue that he or she offers emotional support to the HIV positive partner, but the issue is whether the person himself perceives that support or not.

Blame is common among couples where the positive partner is blamed of bringing HIV home. (Bunnell, et al 2005, Boerma, et al 2002). If this happens harmony in the marriage may be disrupted and this may lead to the dissolution of the union.

Another important principle in this model is the conversation analysis. This is basically doing an analysis of a detailed understanding of the fundamental structure of conversational interaction.

To Garfinkel, conversation analysis is based on the assumption that conversation is the bedrock of other forms of interpersonal relationship. What is said at any given time is shaped by

preceding sequential context of the conversation and what really matters is not what is said but how it has been communicated. It is the collection and analysis of highly detailed data in a conversation, in both verbal and non verbal communication and ordering the finest detail of a conversation.

In a discordant couple relationship conversation is very important and it must be made clear for both parties to understand each other. When what is intended to be said is not communicated clearly, misinterpretation and misunderstanding may follow which may lead to disharmony and instability in the marital relationship. Interaction is a two way process, one talks while the other one listens and responds appropriately.

If the recipient perceives ridicule or blame in a conversation he or she is likely to withdraw from the interaction. The tone of voice can also communicate a lot and be perceived positively or negatively.

### **2.8.3. Symbolic Interactionism**

Symbolic interactionism is a theoretical perspective that arose in Chicago at the turn of the century at a time when Chicago was booming industrially and commercially. This growth led to increase in the number of immigrants from Europe who were seeking new life, employment and social equality. The changes that occurred created new patterns in the behavior of people as they created new communities which attracted the interests of the social scientists. (Deegan & Hill 1987)

The major thinkers associated with this approach are George Herbert Mead, Charles Horton Cooley, and W. I. Thomas, Herbert Blumer and Erving Goffman. In this approach the researcher will focus on the work of George Herbert Mead and Herbert Blumer. Mead died before he published much of his work, but it was published by his predecessors. The researcher has combined his thoughts with those of Herbert Blumer in relation to the study on the factors influencing marital stability among HIV discordant couples.

The researcher focused on their concepts of reality, the self, gestures, significant symbols and language. As a pragmatist Mead argued that reality is actively created as we act, that people base their knowledge of the world on what has proven to work while they discard what does not work; people define social and physical object according to their use of them and that if we want to understand actors we must base that understanding on what they actually do in the world.

Relating the above ideas on the study on HIV discordant couples, the reality about marital relationship among such couples is that many have maintained their marital union which is against the general expectations that such marriages are doomed to fail. The reality is that it has worked for others. If it has worked for some then it has been proven to work, this is one of the reasons to why there are support groups for HIV discordant couples where emotional support is offered.

Three things are important for symbolic interactionism, the interaction between the actor and the world, the view of the actor and the world as dynamic processes and the ability of the actor to interpret the social world.

This approach conceives the individual themselves as existentially free agents who accept, reject, modify or otherwise define the community norms, rules, beliefs according to their personal interests and plans of the moment. In this approach, human beings are viewed superior to animal due to their capacity to think, interact, interpret and understand symbols, interpret situations and come up with the most appropriate course of action.

Ideally the society and major social institutions are expected to define what people ought to do under certain situation but at the same time the agents in this approach are free to make their own appropriate decision and courses of action. HIV discordant couples are free to make individual decision on whether they are to stay married or should separate after they discover their discordant HIV status.

Major social institutions like the church have always advocated for the preservation of marriage regardless of the situation that a couple finds itself in. This understanding has motivated couples to remain together, but still there are those who feel that they cannot live together even when the church recommends it and have gone ahead to separate or divorce.

Couples make individual decisions concerning their marital relationship which is mainly based upon their reasons for marriage and their expectation of each other as marital partners.

Research has found that similarity between the couples and the nature of love are some of the main reasons for people to marry. (Sdorow, 1993, Rushton & Bons, 2005).

Thus when couples possess companionate love, they are more committed to each other and are likely to stick together when problems arise in their relationship unlike those whose love is based on passion. Partners expect to get from each other affection, companionship, sex and money. The individuals in this approach make decisions concerning their relationship regardless of the pressure that comes from the society if at all they are getting what they expect to get from a relationship.

Mead views the act as the most primitive unit in his theory and he argues that in lower animals the stimulus does elicit an automatic unthinking response while human actors may think before they act although there are those who react automatically to the stimulus. Once a diagnosis of HIV discordance is made, human actors will think of the immediate situation where one partner is HIV positive while the other one is HIV negative, the actors may also consider the past experience if at all they have heard of any couples who have had HIV discordant status; for those who have heard of other couples in a similar situation, they may seek more information from health practitioners or through internet. In most situations discordant couples are hearing of discordant HIV status with their own discordant status so consideration of past experience may not be possible to most couples.

Actors may consider their reasons for and expectations from marriage. Couples may be faced with psychological problems like fear of the negative partner contracting HIV and passing HIV

to their unborn children, possibilities of stigma and discrimination from the society and the prognosis of the disease with possibilities of premature death occurring and also fear of the HIV negative partner deserting the HIV positive partner.

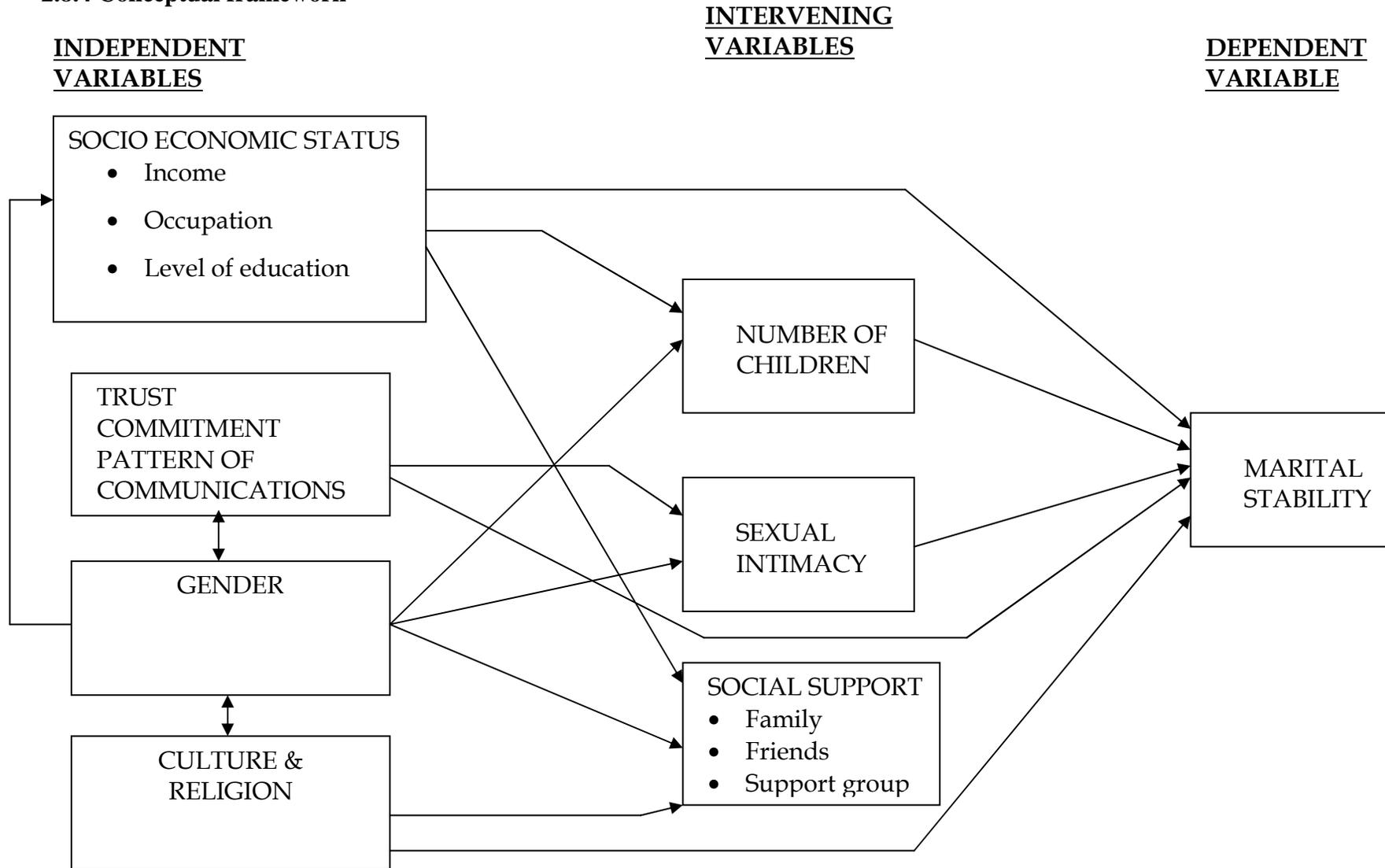
Depending on how each actor perceives the situation he or she may decide to desert or stay and support the partner. Those who decide to stay together may consider information given by the counselor or others in similar situations and may consider to join support groups.

These key contributors of this theory have discussed the importance of concepts like the conversation of gestures and significant symbols which are common to human actors and important in human interaction. They argued that action by one individual may elicit a reaction by another individual. (Blumer 1969)

Communicating love and acceptance to the HIV positive partner elicits self acceptance in the HIV positive partner and likewise non acceptance and facial expression of negative gestures communicates hatred, blame and non acceptance of the positive partner which may make him/her have a low self concept and stress which may lower his/her immunity further.

This happens because human beings have capacity to interpret symbols and understand meaning of what the partner was trying to communicate even when one does not use language. When love, appreciation, acceptance and empathy are communicated to the person with the virus there will be positive feelings which bring about stability of the marriage.

### 2.8.4 Conceptual framework



## **2.9 Hypotheses**

This study will test the following hypotheses.

**2.9.1.** There is a relationship between social-economic status and marital stability such that when HIV discordant couples have a high socio-economic status their marital stability is enhanced.

**2.9.2.** There is a relationship between gender of the HIV positive partner and marital stability such that when the male is HIV positive marital stability is enhanced than when the female is HIV positive.

**2.9.3** There is a relationship between the presence of biological children and marital stability such that when HIV discordant couples have children marital stability is enhanced.

**2.9.4.** There is a relationship between culture and marital stability such that when HIV discordant couples have strong cultural attachments their marital stability is enhanced.

## **Operationalization of variables**

### **Dependent variable**

### **Indicators**

#### **Marital stability**

Interdependence among couples for Companionship

Provision of affection

Sex

Money

Practical assistance

Emotional support

Equity among the couples

Investments' made (time, money)

Benefits from the relationship

Concern about partner

#### **Commitment to the relationship**

- Degree of dedication to the relationship

-Concern for the wellbeing of the partner

-Self sacrifice

#### **Permanence of the relationship**

- Degree of religious affiliation

-Views about divorce and separation

-Attachment to cultural values of marriage

- Expectation of sexual access/exclusivity

Behaving like a couple

-Staying together

-Thinking and planning together

-Spending time together

-Pool financial resources

**Independent variables**

**Indicators**

**Gender of the HIV positive partner**

-Husband/wife/partner HIV status

**Presence of children**

-Number of children in a marriage.

**Socio-economic status of the couple**

-Occupation, level of education, income

**Cultural attachment**

-Religious affiliation, Cultural values

**Social support**

-Attending support groups, social networks

**Pattern of communication**

-Pattern of interaction, intimacy and spending time together and level of disclosure

**Trust and commitment**

-Ability to face challenges together, experiencing a sense of security in the relationship,

## **CHAPTER THREE**

### **RESEARCH METHODOLOGY**

This section will describe the design that was used in carrying out the study. The research site, target population, sampling design as well as method of data collection will be highlighted.

#### **3.1 Study design**

This study was conducted using a cross-sectional survey design that employed both quantitative and qualitative approaches to data collection and analysis. Questionnaires were administered to HIV discordant couples at KNH to assess marital stability and FGDs were conducted to establish factors influencing marital stability. The study period was between January 2012 and July 2012.

#### **3.2 Research site**

This study was carried out at the Kenyatta National Hospital on couples who have been registered as discordant couples for group therapies at the Patient Support Centre from April 2008. Kenyatta National Hospital was founded in 1901 and it is about 4 kilometers from the city centre in the northern side of Nairobi. It is the largest referral and teaching hospital in the country with a bed capacity of 1800 and over 6000 staff members. The hospital covers an area of 46 hectares. (<http://en.wikipedia.org/wiki/KenyattaNationalHospital> 2009)

### **3.3 Study Setting and population**

The study was conducted at the Patient support Centre, a mental health unit at the Kenyatta National Hospital where group therapies targeting HIV discordant couples are held once a month. The study targeted 132 participants who were sampled from the 200 couples who had been registered for group therapy from April 2008 to March 2011. The sample comprised both HIV Positive and Negative persons, male and female.

### **3.4 Sampling method**

Simple random sampling was used to get the sample for study. The number of HIV discordant couples who had registered for group therapy as from April 2008 to March 2011 was 200. After deciding on the sample size, the researcher used a sampling frame developed from a list of the 200 couples who had registered as discordant couples. In order to give each couple an equal chance of being selected the researcher simply wrote the identifiers of each couple on a separate card put them in a box, shuffled them and then picked one at a time until the sample size was acquired. Randomly the researcher picked 132 participants who were the required sample size to participate in the study.

After the research proposal was approved by the KNH / UON ethical committee and consent given by the head of unit Patient Support Centre the researcher started recruiting participants for the study. The researcher used the attached contacts to call the 132 participants who had been sampled, introduce herself and the reason for calling. At this point the researcher booked an appointment with the participants depending on their availability. Some of the participants were interviewed on their clinic appointments.

As for the focus group discussion the researcher came up with dates for the proposed group discussions. During individual interviews the researcher was able to identify potential participants for the focus group discussions and picked those who were comfortable and were willing to share their opinions with the interviewer and others in the group. The researcher took down their contacts to inform them of the dates for the group discussion. Focus group discussions were done within duration of four consecutive Saturdays. The researcher held four group discussions, two with the HIV positive partners and two with the HIV negative partners. The groups comprised of between eight to ten participants. The group discussions were carried out at the patient support centre. The centre was conducive for both individual interviews and the focus group discussions.

### **3.5 Sample size**

The researcher used the formula by Fisher et al (1983) to calculate the sample size.

$$n = \frac{Z^2 P (1-P)}{D^2}$$

n is the desired sample size

Z is standard normal deviation at 95% confidence which is 1.96 (according to the statistical tables of percentages)

P is the estimate proportion of discordant couples with stable marriage and since the estimate is unknown we shall use 50% as recommended by Mugenda & Mugenda 1999

D<sup>2</sup> is the precision around the estimate prevalence of .05

So as illustrated by Mugenda and Mugenda (1999) the desired sample size was gotten as follows.

$$N = \frac{(1.96)^2 (.50) (.50)}{(.05)^2}$$
$$= 384$$

$$nf = 384$$

$$1 + \frac{384}{200} = 2.92$$

$$384 / 2.92 = 131.5$$

nf = 132 participants

Where:    nf = the desired sample size (when the population is less than 10,000)  
          n = the desired sample size (when the population is more than 10,000)  
          N = the estimate of the population size

### **3.6 Inclusion criteria.**

Participants who were partners in marriage.

- Partners who had tested for HIV.
- Partners who were HIV discordant.

### **3.7 Exclusion criteria**

- Partners who were not willing to give consent.
- Persons not in a marital relationship.
- Partners who were participants in another study.
- One or both couples who had not been tested for HIV

### **3.8 Method of data collection**

The study used structured close ended questionnaires which were administered to the participants individually.

Focused group discussions were held in order to get data and insights that would have been less accessible without the interaction found in groups. The researcher did four focus group discussions, two with the positive and two with the negative partners.

Before conducting the focus group discussions, the researcher asked the participants for consent to tape record and note down the interaction. When they consented, the researcher moved on to facilitate and moderate the group interactions according to questions and topics noted down. The researcher tape recorded the group interaction while an assistant noted down the interaction. Tape recording was important in order to capture what would have been missed by the assistant who were taking notes.

#### **3.8.1. Data collection and processing**

Data collection was based on administering questionnaires to respondents for quantitative data and conducting focus group discussion to obtain qualitative data. The questionnaire was administered by the researcher to a random sample of participants registered at KNH /PSC who were married and in a HIV discordant relationship. The selected clients were approached during regular visits at the Comprehensive Care Centre (CCC), and for those who don't attend clinic at KNH for example the HIV negative partner; a phone call was made using the contacts in the register. After being provided with study information consent for enrollment was sought. Clients who consented were recruited and questionnaire administration was then done.

Questionnaire administration lasted between 20 and 30 minutes. Focus group discussions were held with a subset of participants and those who were willing to participate in FDGs, who were invited for one of the four FDGs sessions conducted and facilitated by the researcher using an interview guide and lasting between 45 minutes and one hour. The data from questionnaires was inspected for completeness and coded. After coding data entry and cleaning was done using the SPSS version 17. For the focus group discussions data was coded using the NVIVO software.

### **3.8.2. Data analysis.**

All data from questionnaires were entered into the customized SPSS (version 17) database at the end of each day of data collection by a trained data entry clerk. Data cleaning and validation was conducted by the researcher. The SPSS summary procedure for data analysis was used to inspect data during data cleaning. Continuous variables for example age were summarized to look for outliers and missing or invalid entries. After cleaning these errors, measures of central tendency including mean and median were calculated along with a measure of dispersion (standard deviation or range). For categorical variables, percentages were calculated and presented as frequency distribution. Marital stability was determined and analyzed by putting the responses to nine Likert items contained in the questionnaire. These items rated participants' perception of different aspects of marital stability. The main analysis used for determining factors influencing marital stability, was done by cross-tabulating the key dependent variable with the independent variables. The chi-square statistic was computed and used to determine statistical significance with an alpha cut-off level of 0.05.

For the focus group discussions the researcher used NVIVO software for the analysis of the data. FGD data were initially transcribed verbatim using a word processor on a computer. The transcribed data were then transferred into NVIVO. Content analysis and coding was conducted in NVIVO to identify issues that underlie marital stability in discordant couple relationship.

### **3.9 Ethical Consideration**

#### **Ethical approval**

This study was approved by the KNH/UON ethical committee. The researcher also approached the head of Unit Patient Support Centre for consent to collect data at the patient support centre of those couples who have been registered as discordant couples.

After approval was given the researcher gave full information on the objectives of the study to the participants of the study for them to know that their participation is voluntary. Written informed consent was gotten from those who volunteered to participate in the study. Any information collected during the study was be used only for the purpose of the study.

To ensure confidentiality, the subject names were not used. They were assigned codes both for the individual counseling and focus group discussions and recorded information was kept safely.

This study involved participants who are above 18 years and so National identity cards were required to confirm their ages.

The participant's involvement in the study was on voluntary basis and participants were free to withdraw from the study if they wished to without any penalties or losing any benefits to which they were entitled.

## **CHAPTER FOUR**

### **DATA ANALYSIS AND INTERPRETATION**

#### **4.1 Introduction**

This chapter presents the study findings and their interpretations. For the purpose of this analysis, the frequencies of the responses of each objective were obtained and presented in numbers or in percentages for interpretation and reporting. This chapter is organized and guided by the objectives of the study.

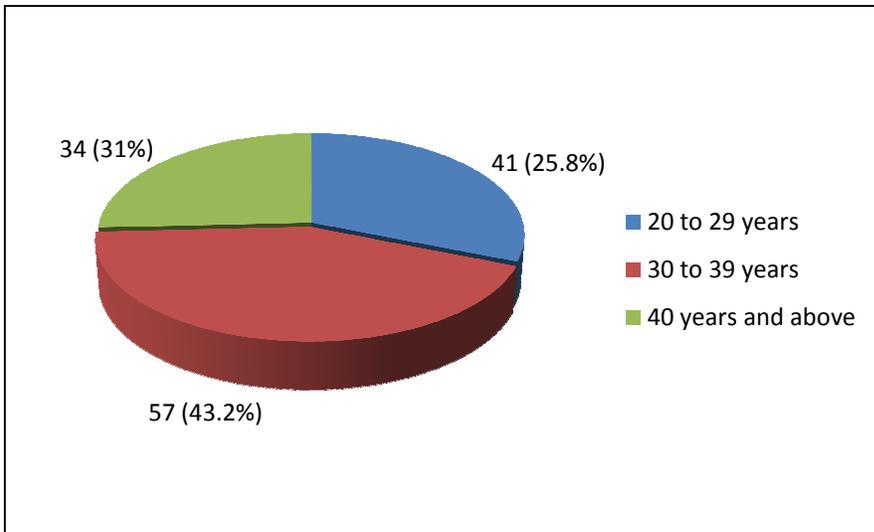
This study conducted among HIV discordant couples at KNH recruited a total of 132 respondents who completed semi structured questionnaires. Four FGDs comprising 36 respondents were also conducted; in this discussion the participants were divided according to their HIV status. The HIV positives group comprised 9 females and 9 males while the HIV negative group comprised 8males and 10 females.

#### **4.2 Socio demographic characteristics of the respondents**

The participants were men and women living as partners in marriage, each had a partner who was infected with HIV; their responses were analyzed using varying characteristics (age, gender, education, occupation, income, religion and number of children).

##### **4.2.1 Age**

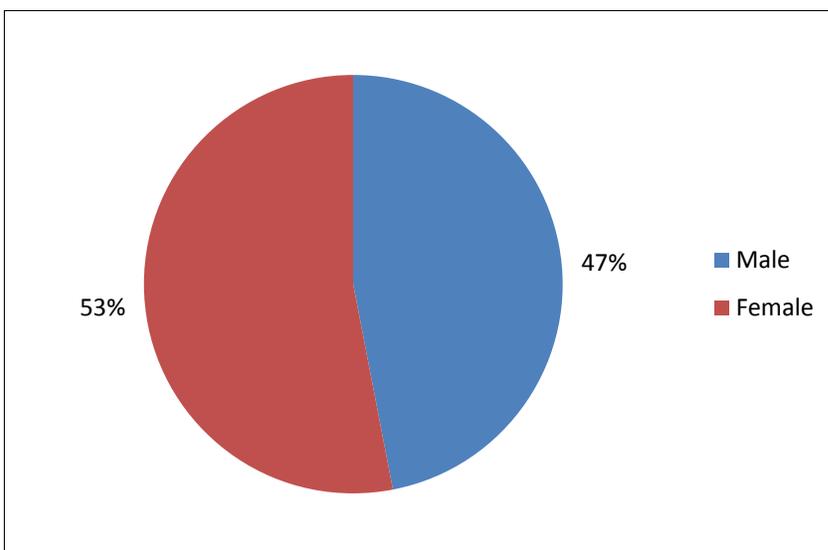
The average age of the respondent was 34.1 years ( $SD = 7.7$ ) years and the range was between 21 to 53 years. As shown in figure 1 below, most (43.2 percent) of the respondents were aged between 30 to 39 years of age.



**Figure 1: Age distribution of HIV discordant respondents at KNH**

#### 4.2.2 Gender

Females comprised 53 percent of the 132 respondents in the study giving a Male-to-Female ratio of 1:1.3 (Figure 2). Seventy percent of the participating females were HIV positive compared to 37.1 percent of the males (p value < 0.001).

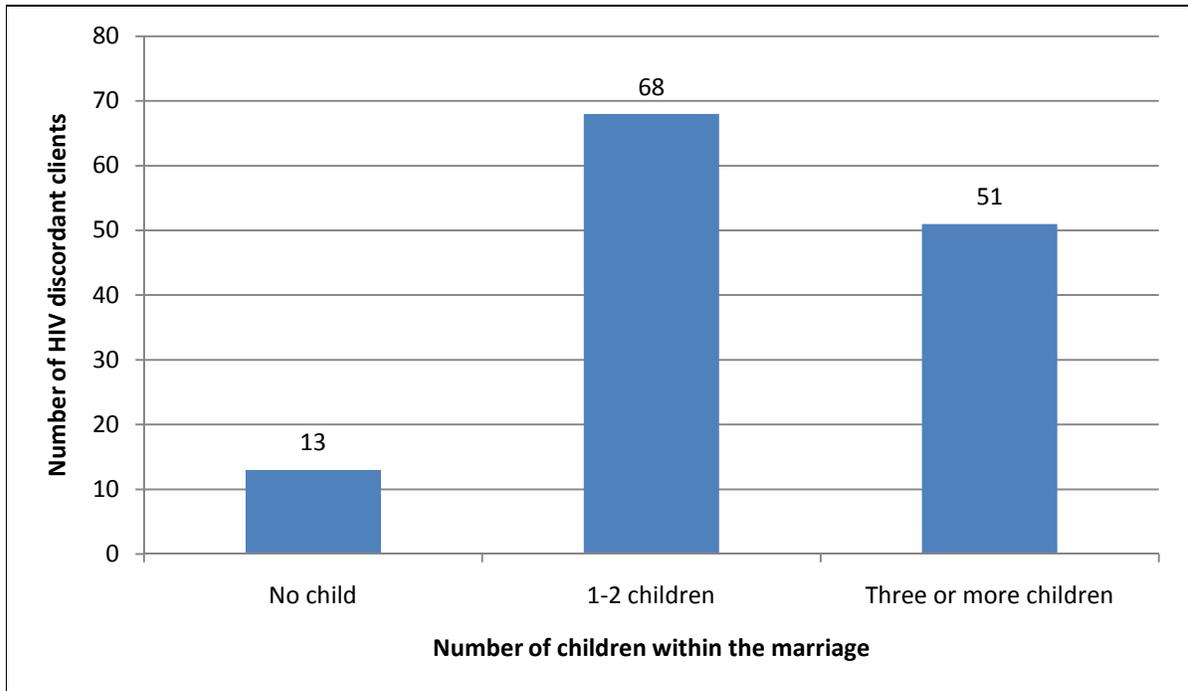


**Figure 2: Gender distribution of interviewed HIV discordant patients at KNH**

### 4.2.3 Presence of children in marriage

Figure 3 shows that 13 (9.9 percent) of the respondents reported that they did not have a child.

The majority (51.5 percent) of marriages had either one child or two children.



**Figure 3: Presence of children within marriages of HIV discordant patients at KNH**

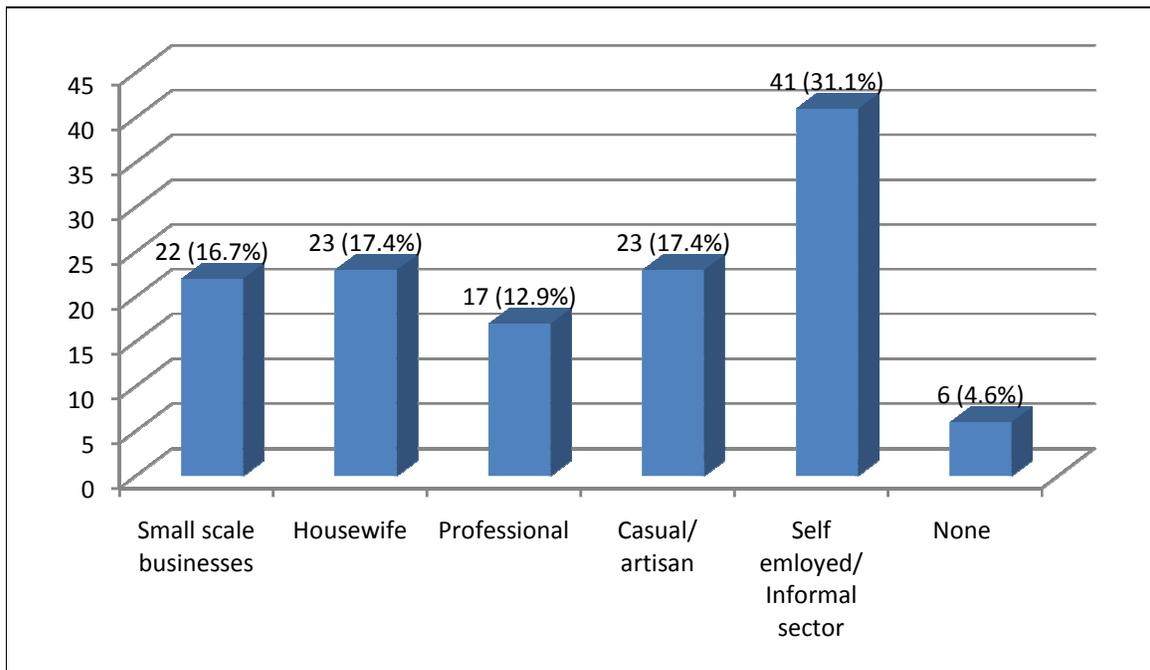
### 4.2.4 Socio-economic status of discordant couples

#### Income

The median income reported by respondents was Kshs 10,000 per month and 27(20.5percent) respondents reported that they did not have a source of income. The range of monthly income reported among the remaining respondents was Kshs 800 to 100,000. Twenty-five percent of all respondents earned up to Kshs 2500 a month while 75percent earned up to Kshs 16,000 every month.

## Occupation

Figure 4 shows that most (31.1 percent) respondents were either self employed or working in the informal sector. Examples of occupations in the informal sector included *jua kali*, hair stylists and beauticians, tailors and mechanics. Casual labourers and artisans accounted for 17.4 percent of respondents and 22 (16.7 percent) respondents were engaged in small scale businesses.



**Figure 4: Occupations of HIV discordant respondents at KNH**

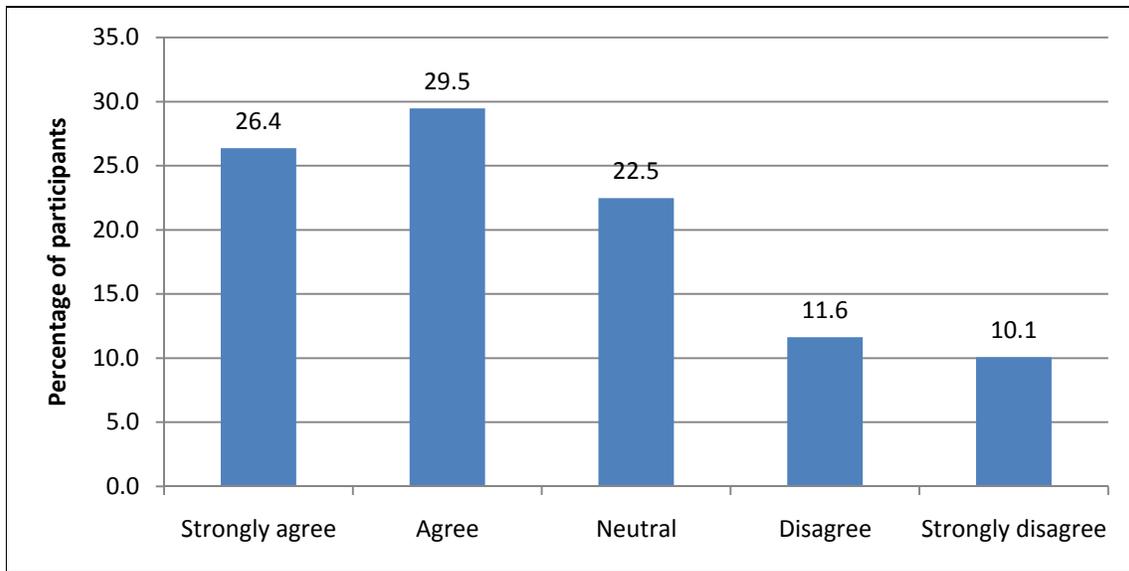
### 4.2.5 Religion

Christians comprised 97.7 percent of the participants. Table 1 shows that most (57.6 percent) respondents were Protestants and 2.3 percent of respondents professed Islamism or other religious beliefs.

**Table 1: Details of the Respondents Religion**

	Frequency	Percent
<b>Religion</b>		
Catholic	42	31.8
Protestant	76	57.6
Other Christian denominations	11	8.3
Other religion	3	2.3
Total	132	100

The views of participants on the role of religion on marital stability are presented in figure 5, with most respondents either strongly agreeing (26.3 percent) or agreeing (29.5 percent) that being committed to religion has made them stay married.



**Figure 5: Respondents' perception of the role of religion in ensuring marital stability in HIV discordance**

### 4.3 HIV testing and disclosure of discordance status

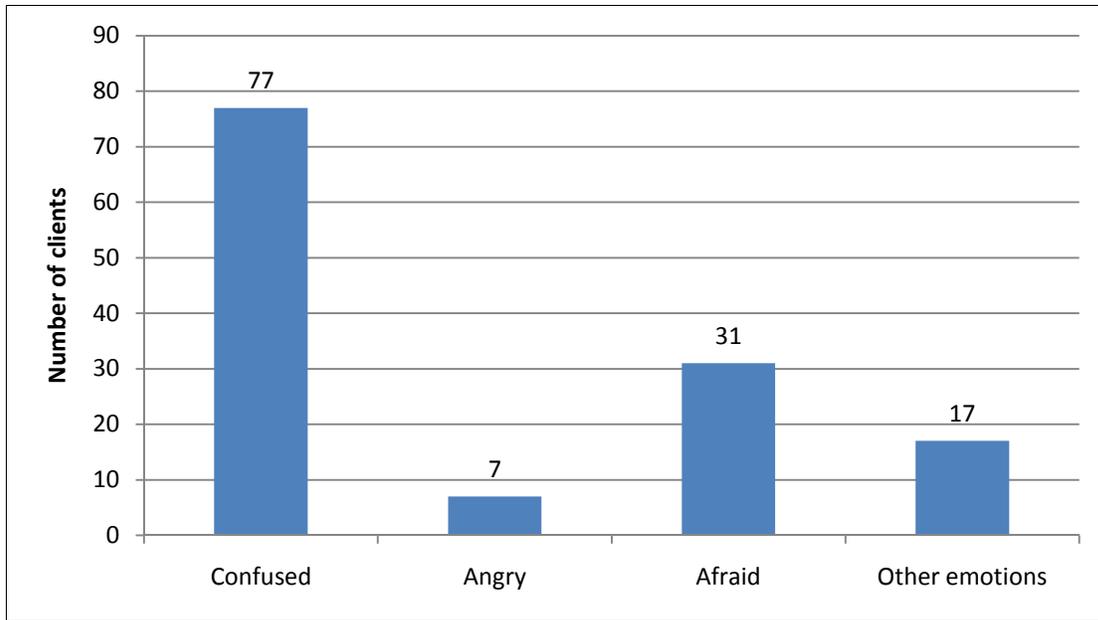
Out of the 132 respondents who completed the semi structured questionnaires 72 (54.6 percent) were HIV positive while the remaining 60 (45.4 percent) were HIV negative but had discordant partner (Table 2). Two-thirds (69.7 percent) of respondents were accompanied by their discordant partner during HIV testing and disclosure of status to partners occurred immediately after testing for 80.3 percent of the cases.

**Table 2: Details of HIV testing among discordant couples at KNH**

	Number	Percent
Respondents HIV status		
Positive	72	54.6
Negative	60	45.4
Period between testing and disclosure of discordant status		
Immediately after testing	106	80.3
Within 2 years of testing	18	13.6
2-5 years	7	5.3
> 5 years	1	0.8
Couple attended HIV testing together	92	69.7

### Initial reaction to HIV discordance status

The reaction to information about discordant HIV status varied but most respondents reported either being confused (58.3 percent) or afraid (23.5 percent) upon receiving this information (Figure 6).



**Figure 6 Individuals’ initial reaction on learning about HIV discordance status**

During the FDGs HIV negative respondents were asked about their opinion concerning their partners’ HIV positive status. Similar to the structured questionnaire responses, FDG responses reflected reactions such as shock, anger and fear which were common to both the HIV positive and the HIV negative partners and both male and female participants. The reported cause of fear and anxiety were however different for the different genders and HIV status. While HIV positive females were generally concerned about desertion by their discordant partners the FDGs among HIV negative male partners indicated that the immediate reaction was fear related to being infected by the positive partner.

Two respondents, one HIV positive and another HIV negative both expressed the shock they experienced but had divergent explanations for the cause of their emotional states which were both characterized by fear.

*“I was shocked and afraid of what would happen; I feared that he would leave me like others have done.”* (32years old female- HIV positive)

*“I was in shock; I called my relatives and informed them immediately I was afraid of being infected.”*(35 years old male-HIV negative)

#### **4.4 Marital stability**

Marital stability was assessed using nine Likert scale items (Table 3) assessing the level of interdependence among couples, equity among couples, commitment to relationship, permanence of relationship, expectation of sexual exclusivity, and behaving like a couple.

##### **4.4.1 Challenges in ensuring marital stability among HIV discordant couples**

The responses to Likert scale items on commonly reported challenges among discordant couples in the period immediately after discovering their HIV discordant status are presented in Table 3. In this study the three areas that posed the greatest challenge to marital stability after discovering HIV discordant status were: fear that marriage will work failure to attend support together and not spending leisure time together. Following disclosure of the HIV discordant status a total of 52 respondents reported that they had feared that marriage will not work much of the time 28 (21.4 percent) or most times 24 (18.3 percent). Thirty eight (29 percent) respondents were accompanied by their partners to while attending support and 26 (19.8 percent) reported rarely being accompanied by partners. Regarding leisure time 12 (9.4 percent) respondents never spent time with their partners at all while 26 (20.5 percent) spent little time with their partners.

**Table 3: Challenges faced by couples at KNH after discovering HIV discordant results**

Type of challenge	Extent of perceived challenge						
	Not at All	Little	Some	Much of the time	Most times	Total	Percent
Feared that marriage would not work after receiving HIV discordant results	16.8	25.2	18.3	21.4	18.3	131	100
Reported pressure from friends and relatives to separate	54.2	19.8	9.9	7.6	8.4	131	100
Frequency of having sex in a month	6.9	16.2	32.3	23.1	21.5	130	100
Frequency of condom used while having sex	13.8	4.6	11.5	18.5	51.5	130	100
Couple attend support together	29	19.8	17.6	18.3	15.3	131	100
Couple spend leisure time together	9.4	20.5	32.3	24.4	13.4	127	100
Couple enjoy each other's company	5.3	13	24.4	26	31.3	131	100
Thought that relationship would be better if friends and relatives left couple alone	38.9	18.3	13	12.2	17.6	131	100
Feared that partner may desert them sometimes in future	60	15.4	9.2	6.9	7.7	130	100

On the contrary, there were areas which most respondents reported did not consider to have posed significant challenges to their relationships: 60 percent of respondent were not at all worried that their partner may desert them sometimes in future, 51.5 percent used condoms most of the time and 18.5 percent much of the time. In addition, 54.2 percent of respondent did not receive any pressure at all from relatives and friends to separate from their partner after learning of HIV discordant status.

#### **4.5 Influence of socio-demographic factors on marital stability in HIV discordant couples**

##### **4.5.1 Gender of HIV positive partner**

Respondents' gender showed a significant association with responses to six of the Likert items on marital stability (Table 4). Female respondents were more likely to report that they feared marriage will not work ( $p = 0.02$ ) and they were also more concern than males about desertion by their partner ( $p = 0.04$ ). Male respondents were more likely to report spending leisure time together with their partner ( $p = 0.01$ ), enjoy partner's company ( $p = 0.04$ ), attend support group with partner ( $p = 0.02$ ), and report more frequent sexual intercourse ( $p = 0.04$ ).

**Table 4: Comparison of marital stability scores given by HIV discordant respondent of different gender**

Narrative	Female	Male	P value*
Feared that marriage will not work	2.3(1.7)	1.7(1.2)	<b>0.02</b>
Pressured to separate by friends or relatives	1.0(1.4)	0.9(1.2)	0.83
Frequency of sexual intercourse	2.2(1.3)	2.6(1.0)	<b>0.04</b>
Use of condoms during sexual intercourse	2.7(1.5)	3.1(1.3)	0.12
Attend support together	1.4(1.4)	2.0(1.5)	<b>0.02</b>
Spend leisure time together	1.9(1.2)	2.4(1.0)	<b>0.01</b>
Enjoyed each other's company	2.5(1.3)	2.9(1.0)	<b>0.04</b>
Felt relationship would be better if left alone by friends and relatives	1.6(1.7)	1.4(1.4)	0.51
Fear of desertion by partner	1.2(1.5)	0.8 (1.2)	<b>0.02</b>

\*T-test p value

#### **4.5.2 Presence of children in marriage**

Presence of biological children in a marriage was significantly associated with scores for one of the marital stability items (Table 6). Respondents with at least three children were more likely to use condoms during sexual intercourse (mean = 3.3) compared to those with one or two children (mean = 2.6) and respondents with no child (mean = 2.8), p value = 0.03. The remaining factors were not significantly associated with presence of biological children in a marriage.

**Table 5: Comparison of scores on marital stability given by HIV discordant respondents with and without children**

Item/ Narrative	Number of children			P value*
	None	1-2 children	3 or more	
Feared that marriage will not work	2.4(1.3)	2.1(1.4)	1.8(1.3)	0.33
Pressured to separate by friends or relatives	0.8(1.2)	1.1(1.4)	0.9(1.2)	0.66
Frequency of sexual intercourse	2.3(1.2)	2.3(1.3)	2.4(1.1)	0.91
Use of condoms during sexual intercourse	2.8(1.2)	2.6(1.5)	3.3(1.3)	0.03
Attend support together	1.8(1.1)	1.6(1.5)	1.8(1.5)	0.88
Spend leisure time together	2.1(1.1)	2.1(1.1)	2.2(1.3)	0.98
Enjoyed each other's company	2.8(1.2)	2.5(1.2)	2.8(1.2)	0.42
Felt relationship would be better if left alone by friends and relatives	1.2(1.4)	1.1(1.4)	0.6(1.4)	0.26
Fear of desertion by partner	1.2(1.4)	1.1(1.4)	0.6(1.2)	0.10

\*ANOVA p value

#### **4.5.3 Socio-economic status**

Table 7 shows that socio economic status was significantly associated with two Likert scale item namely fear that marriage will work ( $p = 0.049$ ) and feeling that relationship would be better if left alone by friends and relatives ( $p = 0.001$ ). Respondents with low income reported greater fear that marriage will not work (mean = 2.2) following disclosure of HIV status compared to respondents with high income (mean = 1.7).

**Table 6: Comparison of marital stability scores given by HIV discordant according to income**

Narrative	< Kshs 10,000	≥Kshs 10,000	P value*
Feared that marriage will not work	2.2(1.4)	1.7(1.2)	0.049
Pressured to separate by friends or relatives	1.0(1.4)	0.8(1.1)	0.26
Frequency of sexual intercourse	2.3(1.2)	2.6(1.2)	0.68
Use of condoms during sexual intercourse	3.0(1.4)	2.8(1.5)	0.64
Spend leisure time together	2.0 (1.2)	2.3(1.1)	0.20
Enjoyed each other's company	2.7(1.3)	2.7(1.0)	0.94
Felt relationship would be better if left alone by friends and relatives	2.0(1.7)	1.1(1.2)	0.001
Fear of desertion by partner	1.0 (1.5)	0.7(1.0)	0.25

\*t-test p value

The FGD data confirmed the findings of the semi structured interviews that economic factor was an important determinant of marital stability.

On average the female participants in this study earned less money compared to their male partners. The FDG conducted among HIV negative discordant females indicated that economic pressures partly contributed to their decision to remain in marriages.

*“I have accepted him as the head of the family and I respect him, I try very much not to blame him for the virus because he is the bread winner” (29 years old female, mother of three children- HIV negative; other 6 HIV negative females all above thirty years had similar statements)*

Fear of losing a partner through death was expressed by some of the HIV negative partner especially if the partner was the family's bread winner.

*“My partner does not accept to take ARVs and he has refused to attend the support group, I fear that he may die ...what would happen to my family in case he dies.”*(35 years old female, mother of three children-HIV negative)

Several of the items contained in the Likert scale which showed statistically significant associations with socio-demographic characteristics also emerged as important causes of marital instability among the HIV discordant couples involved in FDGs. The FGD data confirmed the findings of the semi structured interviews that the following three factors were important causes of marital instability:

#### **4.6 Factors that influenced marital instability**

1. Sexual relationships
2. Fear of HIV transmission
3. Perceived stigmatization among HIV positive partners

##### **4.6.1 Sexual relationships**

Sexual relationships are a critical factor in defining the type of marital relationships that exist between couples. HIV discordance was reported to directly impact on both the frequency and consistency of sexual intimacy among discordant couples. Condom use as a means of promoting sustained sexual relationship was reported to face significant challenges including refusal to have sexual relationships.

*“Even with condoms he does not want to have sex with me, we don’t even share a bed, he sleeps on the couch”* (32 years old female, mother of two children-HIV positive)

Apart from refusal to use condoms or have sexual relationships with infected partners, additional challenges to condom use included psychological and emotional issues impacting both on sexual drive and performance.

*“In the middle of our sexual intimacy I always remember that she is HIV positive and I am unable to proceed, this happens most of the time.”*(29 years old male, father of one child-HIV negative)

#### **4.6.2 Fear of HIV transmission**

Fear of HIV transmission is a real cause of concern among discordant couples as evidenced by the extent to which such fear had impacted on marital relations in this study. From the perspective of HIV negative couples this fear was intense during the period immediately after the disclosure of discordant status. Some couples reported that the fear of infection subsided with time.

*“We had challenges at first, especially because we had to continue using condoms but with time the challenges are not there”* (similar response reported by three HIV positive females and five HIV negative Male respondents)

On the other hand, HIV discordant status had a long term impact on sexual relationships for some participants.

*“Since we tested discordant HIV status 4 years ago, we have not had any sexual intimacy.”*( response by a thirty years old female- HIV positive) for nearly all the respondents the frequency of their sexual intimacy was affected

### 4.6.3 Perceived stigmatization among HIV positive partners

The HIV positive participants commonly reported that they sensed blame in their partner's behaviour due to the fact that the participants were HIV positive. The participants reported that this blame either manifested indirectly: *“yes with every disagreement, the issue of our status comes in”*; or openly: *“yes she has always linked my marrying a second wife as the source of HIV”* ( a specific response by a thirty three years old male, a father of two children- HIV positive)

## 4.7 Factors that influenced marital stability among HIV discordant couples

### 4.7.1 Social support and marital stability in HIV discordant couples

Most respondents either strongly agreed (37.1 percent) or agreed (25 percent) that support group attendance had made them stay together despite their discordant status (Table 8). The responses for the impact of social support from family and friends on marital stability were more varied with only 13.6% strongly agrees that social support had made them stick together.

**Table 7: Social support and marital stability**

Narrative	Percentage of respondents				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Support group attendance has made us stay together	37.1	25	7.6	13.6	14.4
Social support from friends and the family have made us stick together	13.6	21.2	22	10.7	24.2

All the respondents participating in the different FGDs felt that attending the social support groups at KNH had enhanced the stability of their marriages. The main contributions from session attendance on marital stability were related to sharing of group experiences.

*“Attending support group has made us know that there are other couples in a similar situation like us ... it has actually been a binding force to me, in the group I found others who have been living together for many years and this really encouraged me.”*

(Statement reported by nearly all respondents regardless of gender, age or HIV status)

#### **4.7.2 Pattern of communication and marital stability in HIV discordant couples**

Table 9 shows that 50.8percent of the HIV discordant respondents strongly agreed that discussing issues openly had brought stability to their marriages. A similar percentage (50.8percent) of respondents also strongly agreed that they had always had a good pattern of communication between themselves and their partner.

**Table 8: Pattern of communication and marital stability**

Narrative	Percentage of respondents				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
The pattern of communication between us has always been good	50.8	28	8.3	5.3	5.3
Discussing issues openly has brought stability to our marriage	50.8	25	9.1	7.6	3.8

### 4.7.3 Trust and commitment and marital stability in HIV discordant couples

Most respondents either agreed (34.4 percent) or strongly agreed (41.4 percent) that their partner was committed to make marriage work despite HIV diagnosis and most respondents strongly agreed (39.5 percent) that they trusted their partner not to abandon them (Table 10).

**Table 9: Trust and commitment to marriage relationship and marital stability**

Narrative	Percentage of respondents				
	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
Having lived together for many years made couple continue being married even after HIV discordant diagnosis	31.0	34.1	8.5	12.4	14.0
Partners was committed to make marriage work despite HIV diagnosis	41.4	34.4	14.8	5.5	3.9
Respondent trusted partner not to abandon him or her	39.5	17.8	21.7	6.2	14.7

#### **4.8 Discussion of study findings**

This study found a positive association between the gender of the HIV positive partner and marital stability. The study reported that Female respondents were more likely to report fear that marriage will not work ( $p= 0.02$ ) and that their partner may desert them than male respondents who were found to proceed with normal life and reported spending leisure time with their partners ( $p=0.01$ ), enjoying each other's company ( $p=0.04$ ), attending support group together ( $p=0.02$ ) and engaging in sexual intimacy more frequently ( $p= 0.04$ ).

This is in line with what was reported in an International Conference on AIDS (1998) that a husband's HIV diagnosis has a profound effect on the dynamic of the relationship. Other findings observed that divorce and separation were highest in chronic illness and mostly if it is the woman who is sick. (Porter et al 2004).

Socio economic status was significantly associated with fear that marriage will not work ( $p= 0.049$ ) and feeling that the relationship would be better if left alone by friends and relatives ( $p=0.001$ ). Respondents with low income reported greater fear that marriage will not work (mean=2.2) following disclosure of HIV status compared to respondents with high income (mean=1.7). Previous studies found contentious findings on this issue; some studies observed that divorce was more likely to occur when a husband and wife work but their incomes are not high or when the woman was on welfare. (Collins& Coltrane, 1991., Hoffman, 1977). Other studies observed that when prosperity sets in; divorce and separation rates go up. (Hurlock, 1996).

In the FGDs the female respondents reported that economic pressures forced them to remain married if the bread winner was the one who was sick. This is in with what was observed that a woman with a good income does not need to put up with an unsatisfactory marriage. (Adams & Trost, 2005, Sweetman, 2003).

This study found presence of children associated with only one of the marital stability items; where respondents with at least three children were more likely to use condom during sexual intercourse (mean= 3.3) compared to those with one or two children (mean=2.6) and respondents with no child (mean= 2.8), p value= 0.03). This is contrary to findings of previous research where children were found to be a binding factor as far as marital stability is concerned (Adam & Trost, 2005, Clayton 1979, Opondo et al, 2010 & Rukwaro, 2005).

In this study couples who were strongly affiliated to religion remained married which may be attributed to the fact that religion brings about calmness and spiritual healing and an opportunity to seek divine intervention. Most respondents either strongly agreed (26.3 percent) or agreed (29.5 percent) that being committed to religion made them stay married. This is in line with what previous studies found that religion acts as buffer against divorce and separation. (Heaton, 1990, Newman & Graverholz, 2002, & Robinson, 1994).

Most respondents either strongly agreed (37.1 percent) or agreed (25 percent) that support groups made them stay together despite their discordant status while responses from for the impact of social support from friends and family were varied with only (13.6 percent) strongly agreeing that social support made them stick together. This concurs with what Boesten & poku, (2009) found that support groups help to reduce stigma brought about by HIV /AIDS due to

shared norms about the disease. However social support from friends and family was not found to enhance marital stability which is in line with what previous findings observed about the negative impact of social support from friends and family which was found to interfere with a marital relationship leading to dissolution of marriage. (Kephart, 1977, Mc Goldrick, 1999).

In this study, partner's interpersonal relationship was considered to influence on a couple's reasons for remaining married. Most respondents either strongly agreed (50.8 percent) or agreed (28 percent) that the nature and pattern of communication, discussing issues openly enhanced their marital stability. On the other hand most respondents either strongly agreed (34.4 percent) or agreed (41.4 percent) that their partner was committed to make their marriage work despite discordant HIV /AIDS status. Likewise most respondents agreed (39.5 percent) that they trusted that their partners would not abandon them due to their HIV status.

This finding concurs with what Gravin & Brommel (1991) observed that communication is an essential feature in intimate relationship; and observation that trusting and committed couples are able to learn that not all hard times lead to divorce; couples were encouraged to focus on how they have previously evolved past crisis. (Van Pelt, 2008).

## CHAPTER FIVE

### SUMMARY, CONCLUSION AND RECOMMENDATIONS

#### 5.1 Summary

This chapter summarizes the study findings, discusses, interprets and draws conclusion and recommendations.

Research found an association between the gender of the HIV positive partner and marital stability. Female respondents were found to be more likely to report fear that marriage will not work and more concerned that their partner may desert them than male respondents who were found to proceed with normal life and reported spending leisure time with their partners and engaging in sexual intimacy more frequently. This is in line with what previous findings found that a relationship where the female was HIV positive was likely to experience dissolution unlike where both partners were concordant negative or with a male partner who was HIV positive.

Female respondents in this study earned less money than the male respondents a factor which may have placed them at a disadvantage as far the fear that their marriage would work or possible desertion by their partners; this was more likely to occur if they are the ones who had the HIV infection. In the FGDs the female respondents reported that economic pressures forced them to remain married if the bread winner was the one who was sick.

Contrary to findings of previous research where children were found to be a binding factor as far as marital stability is concerned; this study found no association between presence of children and marital stability. This finding may have been attributed to by the fact that most

couples reported challenges in sexual intimacy due to fear of being transmitted to HIV infection. In this study condom use was likely to be reported more by those couples who had three and more children. All the couples interviewed reported that it was after they had been married and lived with each other for some time that they found that they were HIV discordant. Most of these couples were already having children with this discovery. Fear of HIV transmission impacted on both frequency and consistency of sexual relationship as well as having children or increasing the number of children a couple had; condom use was reported to be a challenge to most couples, some of who reported that they had gone for years without engaging in sexual intercourse.

Couples who were affiliated to religion were found to remain marriage despite challenges in their relationship. This finding is in line to what previous research found; that religion buffers divorce and separation. In this study couples who were strongly affiliated to religion remained married which may be attributed to the fact that religion brings about calmness and spiritual healing and an opportunity to seek divine intervention.

In this study, partner's interpersonal relationship was considered to influence on a couple's reasons for remaining married. The nature and pattern of communication, open interaction, commitment in the relationship and trust that a partner will not desert were factors that were reported by most couples as having enhanced their marriage despite one partner being HIV positive.

These were factors that were agreed upon by most partners in both individual interview and focus group discussion. With a healthy interaction, blame for being the source of HIV is reduced or eliminated which makes a partner feel valued and respected. Social support and therapeutic interventions such as support groups and couple counseling services were found important in enhancing marital stability. In the FGDs most participants reported that it was in the support group that they found that they were not alone in discordance and the teaching offered helped them to understand issues surrounding discordance. With therapeutic social interventions in place; partners who discover that they are HIV discordant get an opportunity to understand their situation and be there for each other.

## **5.2 Conclusion**

This study established that therapeutic social interventions and interpersonal relationship are important factors that enhance marital stability among HIV discordant couples. Group and couple counseling services are new concepts in this country and have yet to be stretched to the rural areas. Research has reported that the actual number of HIV discordant couples is not known because VCT services for couples are yet to be accepted. Public sensitization is therefore required so that more couples can be reached and helped.

With these services HIV discordant couples will be in a position to make appropriate and informed decision about their lives and prevent discordant couples from becoming concordant positive after they infect each other with the HIV virus. Such couples will be in a position to understand how to support their partner while at the same time protecting themselves from getting the virus.

In this study sexual exclusivity was a key indicator of marital stability, but with HIV in one of the partners and challenges in the use condoms among the partners will impact this expectation. Sensitization on condom use especially among discordant couples will alleviate this challenge and couples will live together with little or no fear.

This study found women quite vulnerable due to the economic dependence that they have upon their husbands, which calls for women empowerment, like encouraging them to start some income generating activities regardless of their HIV status.

### **5.3 Recommendations**

In view of the findings of this study, the following recommendations are important.

#### **Community level**

The community should work upon adopting services which have been set up within their communities especially those services that are in relation to HIV such as counseling services and VCT services. This will ensure that people learn of their HIV status early enough and make use of various intervention methods like getting counseling and treatment.

#### **Government level**

The government of Kenya should ensure that information on HIV and the use of VCT services has reached all its citizens so that people can learn of their HIV status early in life. The government should also ensure that there are enough and widespread services for both couple and group counseling targeting all the married couples. All marriage partners should be sensitized on the prevalence of HIV among married couples and possible discordance, so that couples can go for individual testing rather than assuming each others' HIV status.

The government should avail more opportunities for women empowerment where they can be encouraged to start income generating activities in order to make them economically independent.

### **Non –governmental level**

Non-governmental organizations should work with the government to ensure that the above services have reached every one and that everyone is well sensitized.

### **Further research**

Further research should be done on HIV discordant couples in Kenya; thus addressing various gaps that have been left in this study.

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**APPENDICES**  
**APPENDIX I**

**CONSENT EXPLANATION FOR THE HEAD OF DEPARTMENT (PSC)**

I am Teresa Wambui Ngugi a Sociology student at the University of Nairobi. I am collecting data on Factors influencing marital stability among HIV discordant couples registered for group therapy at the Patient Support centre, Kenyatta National Hospital. (KNH). If consent is given the researcher will ask the participants questions on factors that have enhanced the stability of their marriages and what has brought them this far.

**Risks / Discomfort**

The only expected risk may be discomfort as the participants share about matters pertaining to their sexual life but the researcher will try to make them feel comfortable as they share.

**Benefits**

The information from this study will be used to address challenges that discordant couples face.

This information may also be used in helping newly diagnosed HIV discordant couples to enhance their marital relationship.

**Confidentiality:** Whatever information that participants will share will be treated with confidentiality. None of the information will be shared to their respective partners. Names will be substituted with codes and all recorded information will be kept safely. Participation will be voluntary and if one feels like revoking the consent they are free to do so without any victimization or loss of benefits.

**Departmental head consent statement:**

I have understood the content of this study and I agree to allow support group members to participate in the study.

Departmental head signature: .....

Researcher Name and Signature .....

## **APPENDIX II**

### **INFORMED CONSENT EXPLANATION FOR INDIVIDUAL INTERVIEW**

My name is Teresa Wambui Ngugi a student at the Department of Sociology, University of Nairobi. I am doing a research on Factors influencing marital stability among HIV discordant couples registered for group therapy at the Patient Support Centre Kenyatta National Hospital.

I will use this information for the award of a master's degree in Sociology from the University of Nairobi.

I have requested for permission from the hospital management to undertake this study and the exercise will not take more than 15 minutes per participant.

The information from this study will be treated with confidentiality and it will not be disclosed to your partner. Findings from this study will be used to look at ways of addressing challenges that HIV discordant couples face.

The study does not involve any physical tests and the only risk may be in form of discomfort as you share on matters pertaining to your sexual life and if need be you will get the services of a counselor.

My contact cell phone number is 0721728209

**APPENDIX III**

**CONSENT FORM FOR THE INDIVIDUAL INTERVIEW**

I ..... (Name) having been explained the nature of the study by the researcher Teresa Wambui Ngugi , do hereby give consent to participate in the research study on Factors influencing marital stability among HIV discordant couples registered for group therapy at the Patient support Centre, Kenyatta National Hospital.( KNH).

I have been explained the nature of the study and I understand that i am free to ask questions pertaining to the study as I participate in it. I have been explained that if at all I happen to feel that I don't want to proceed with the study, I am free to revoke my consent and withdraw from the study without any penalty or loss of benefit entitled to me.

By signing this consent form I am once again affirming that I have understood everything contained in the consent explanation.

.....(Name of participant) Signature.....Date.....

## **APPENDIX IV**

### **INFORMED CONSENT EXPLANATION FOR THE FOCUS GROUP DISCUSSION**

My name is Teresa Wambui Ngugi a student at the Department of Sociology, University of Nairobi. I am doing a research on Factors influencing marital stability among HIV discordant couples registered for group therapy at the Patient Support Centre Kenyatta National Hospital.

I will use this information for the award of a master's degree in Sociology from the University of Nairobi.

I have requested for permission from the hospital management to get individual opinions and ideas in a group concerning the topic under study.

I am therefore requesting for your consent to tape record and note down group interaction on the area under study. Instead of using your names I will use codes so that I will be able to identify who has said what without revealing the identity of the participant. Each group interview will use between one and two hours

The information from this study will be treated with confidentiality will not be disclosed to your partner and the findings from the study will be used to look at ways of addressing challenges that discordant couples face.

**APPENDIX V**

**CONSENT FORM FOR THE FOCUS GROUP DISCUSSION**

I ..... (Name) having been explained the nature of the study by the researcher Teresa Wambui Ngugi , do hereby give consent to participate in the focus group discussion in the study on Factors influencing marital stability among HIV discordant couples registered for group therapy at the Patient support Centre, Kenyatta National Hospital.( KNH).

I also consent to have my interaction with the interviewer and others to be tape recorded and noted down.

I have been explained the nature of the study and I understand that i am free to ask questions pertaining to the study as I participate in it. I have been explained that if at all I happen to feel that I don't want to proceed with the study, I am free to revoke my consent and withdraw from the study without any penalty or loss of benefit entitled to me.

By signing this consent form I am once again affirming that I have understood everything contained in the consent explanation.

.....(Name of participant) Signature.....Date.....

**APPENDIX VI.**  
**QUESTIONNAIRE**

**TO BE FILLED BY THE DISCORDANT COUPLES**

Please answer the following questions by circling in the appropriate box or by giving the necessary details on the provided spaces. The information given will be strictly confidential and only used for the purpose of this research.

1. Code Number-----
2. Age-----
3. Sex -----
4. Residential Physical Address-----
5. Place of Birth-----
6. What is your occupation? -----
7. How much do you earn? -----
8. How many children do you have? -----
9. What Religion do you belong to?
  - i. Christian ( )
  - ii. Muslim ( )
  - iii. Any other. ( )

10. What denomination do you belong to?

- i. Catholic ( )
- ii. Protestant ( )
- iii Any other ( )

11. How long did you court before marriage? -----

12. How long have you been married? -----

13. What is your HIV status?

- i. HIV. Negative ( )
- ii. HIV Positive. ( )

14. When did you learn that you are HIV discordant?

- i. Immediately after testing ( )
- ii. Within two years of testing ( )
- iii. Between two and five years ( )
- iv. After five years ( )
- v. Other (specify) ( )

15. Did you go for testing together?

- i. Yes ( )
- ii. No ( )
- iii. Any other (specify) ( )

16. If no to 15 how did you learn that you have HIV discordant status?

- i. He / She disclosed to me ( )
- ii. Through friends ( )
- iii. Through the clinic ( )
- iv. Any other ( )

17. If yes to No 15 how did you perceive your partners HIV results?

- i. Shocked ( )
- ii. Angry ( )
- ii Any other (specify) ( )

18. If positive how did your spouse react to your status.?

- i. Shocked ( )
- ii. Angry ( )
- iii. Blamed me ( )
- iv. Other (specify) ( )

19. If Negative how did you react to you partners status?

- i. shocked ( )
- ii. Angry ( )
- iii. Blamed her/him ( )
- iv. Other (specify) ( )

20. Had you heard about other couples who are HIV discordant?

- i. Yes ( )
- ii. No ( )

21. If yes to NO 20 How did you perceive HIV discordance? -----

-----  
-----

22. How did you feel upon learning that you are HIV discordant?

- i. Confused ( )
- ii. Angry ( )
- iii. Afraid ( )
- iv. Other (specify) ( )

23. If HIV positive were you afraid that that your marriage partner would desert you?

- i. Yes ( )
- ii. No ( )
- iii. Other (specify) ( )

24. If HIV negative were you afraid that your partner could transmit the virus to you?

- i. Yes ( )
- ii. No ( )

25. If yes to No 24 .how did you react to the fear?

- i. Thought of deserting him/her. ( )
- ii. Asked opinion of friends on the issue ( )
- iii. Sought medical help. ( )
- iv. Any other ( specify ) ( )

**BELOW IS A LIST OF CHALLENGES COUPLES MAY HAVE AFTER DISCOVERING THAT THEY HAVE HIV DISCORDANT RESULTS. PLEASE ANSWER ALL QUESTIONS. CIRCLE ONE OF THE NUMBERS (0,1,2,3,4.) THAT TELLS HOW OFTEN THE PROBLEM HAS OCCURRED TO YOU.**

26.	Item/ Narrative	Never	Less often/ rarely	Often/ sometimes/ fairly regularly	Much of the time	Very often/ most of the times
27.	Feared that your marriage will not work after receiving HIV discordant results	1	2	3	4	5
28.	pressure from friends and relatives to separate	1	2	3	4	5
29.	Engaging in sexual intercourse.	1	2	3	4	5
30.	Using a condom while having sex?	1	2	3	4	5
31.	Attending support together	1	2	3	4	5
32.	Spend leisure time together	1	2	3	4	5
33.	Enjoy each other's company	1	2	3	4	5
34.	Friends and relatives interfering with their relationship	1	2	3	4	5
35.	Fear that one's partner may desert him/her sometimes in future?	1	2	3	4	5

**TO WHAT EXTENT DO YOU AGREE (OR DISAGREE) THAT THE FOLLOWING FACTORS MADE YOU STICK TOGETHER EVEN AFTER DISCOVERING YOUR DISCORDANT STATUS**

NO.	ITEM/NARRATIVE	Strongly agree	Agree	Neutral	Disagree	Strongly disagree
36.	Having children together made us remain together	1	2	3	4	5
37.	Having lived together for many years.	1	2	3	4	5
38.	My partner was committed	1	2	3	4	5
39.	Commitment to religion.	1	2	3	4	5
40.	Support group attendance	1	2	3	4	5
41.	Good pattern of communication	1	2	3	4	5
42.	Discussing issues openly	1	2	3	4	5
43.	Trust that my partner will not abandon me	1	2	3	4	5
44.	Social support from friends and the family.	1	2	3	4	5

## **APPENDIX VII.**

### **FOCUS GROUP DISCUSSION GUIDE FOR THE HIV POSITIVE GROUP**

I am Teresa Wambui Ngugi a student at the University of Nairobi; I am conducting this focus group discussion for the purpose of the award Masters Degree in Sociology. I am conducting a study on Factors influencing marital stability among HIV discordant couples. This information will be used to look at ways of addressing challenges that discordant couples face in the course of their marriage.

I am requesting to tape record and note down the discussion that we shall have. Please note that whatever we discuss will be held in confidence and that I will assign you a code instead of using your name

1. What role do you think you have played in enhancing the stability of your marriage?
2. How did you react upon learning that you have the HIV virus and that your partner is HIV negative?
3. What do you think has brought you this far as a couple?
4. Do you sense blame in your partners' behavior due to the fact that he/she is negative and you are positive?
5. Do you think that the support group has enhanced the stability of you marriage?
6. How has been your sexual relationship?
7. What challenges have you had as a couple?

## **APPENDIX VIII**

### **FOCUS GROUP DISCUSSION GUIDE FOR THE HIV NEGATIVE GROUP**

I am Teresa Wambui Ngugi a student at the University of Nairobi; I am conducting this focus group discussion for the purpose of the award Masters Degree in Sociology. I am conducting a study on Factors influencing marital stability among HIV discordant couples. This information will be used to look at ways of addressing challenges that discordant couples face in the course of their marriage.

I am requesting to tape record and note down the discussion that we shall have. Please note that whatever we discuss will be held in confidence and that I will assign you a code instead of using your name

1. What role have you played to enhance the stability of your marriage?
2. How did you react upon knowing that your partner has HIV and that you do not?
3. What would you say has brought you this far?
4. How is your sexual relationship?
5. Do you sometimes fear that your partner would transmit the virus to you?
6. Do you think that the support group has been your binding factor?
7. What have been your challenges as a couple?