

**EXPLORATION OF DISCORDANT COUPLES CHALLENGES AND
COPING MECHANISMS: A CASE OF RURAL KIAMBU COUNTY, KENYA**

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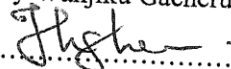
NAIROBI

AUGUST, 2018

DECLARATION

I, the undersigned affirm that this is my original work and that it has not been submitted to any other university in any form for a degree or otherwise. Where work of other scholars has been used, it has been duly acknowledged.


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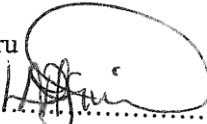
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ABSTRACT

Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) is a health challenge to many nations. Different patterns of HIV infections have emerged where there are couples living together but have different HIV status, one partner is HIV positive while the other one is negative. Discordance can cause challenges in a couple relationship. HIV discordance is poorly understood among couples and the existing literature has not sufficiently addressed the challenges and coping mechanisms in the rural Kenyan context. Therefore this study sought to establish the challenges and the coping mechanisms of discordant couples in rural Kiambu County, Kenya. A sample of 30 individuals living in a discordant relationship was purposively sampled for data collection. Focus Group Discussion (FGD) was used to collect data from the discordant couples. The study found out that the discordant couples in rural Kiambu County experience negative emotions such as fear of transmission, anxiety, stress, worry, hatred, hopelessness, stigma and discrimination, blame and guilt among others. These negative emotions affect their couple relationship in a variety of ways including sexual distancing, lack of interest in sex among others. Relationship challenges are experienced from the couple as a dyad and from outside. Challenges such as reproduction, domestic violence and separation affect the relationship. The effects are manifested in such ways as family sizes, communication and good use of preventive methods. The study also found out that couples have different ways of coping like good use of condoms, good adherence to ART and PrEP, couple counselling and good communication. Besides getting free medication and condoms from the government through health facilities, individual couples have also devised their own coping mechanisms such as assertiveness, religion and networks with other discordant couples. For discordant couples in this County to live holistically, the study recommends that the County and National governments should increase funding to address HIV/AIDS related issues. The funds channeled through National AIDS Control Council (NACC) will facilitate the hire of more counsellors and social workers so that the needs of discordant couples can be met through counselling, social support and awareness of discordance among the general population.

DEDICATION

I dedicate this work to my husband Joseph Gacheru whose unwavering support inspired me. I also dedicate it to our lovely children who, during the course of my studies, went out of their way and carried out some of my roles to ensure that everyone in the family was comfortable. Carol and Nganga, Marion and Andrew, I salute you for ensuring that Steve was comfortable in Nairobi School whenever my class-work coincided with Nairobi school visiting days. I also dedicate it to Steve who never complained whenever I would not participate, or would show up late for his school activities.

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LIST OF ACRONYMS AND ABBREVIATIONS

ART	Antiretroviral Therapy
ARV	Antiretroviral
ECASRM	Ethics Commission of the American Society for Reproductive Medicine
FN	Female Negative
FNP	Female Negative Partner
FP	Female Positive
FPP	Female Positive Partner
HIV/AIDS	Human immunodeficiency Virus/Acquired Immune Deficiency Syndrome
HTC	HIV/AIDS Testing Counsellors
KAIS	Kenya AIDS Indicator Survey
MN	Male Negative
MNP	Male Negative Partner
MP	Male Positive
MPP	Male Positive Partner
NACC	National AIDS Control Council
NACOSTI	National Commission for Science, Technology and Innovation
NASCOP	National AIDS and STIS Control Program
NGO	Non- Governmental Organization
PHC	Population and Housing Census
PrEP	Pre-exposure Prophylaxis
STIs	Sexually Transmitted Infections
UNAIDS	United Nations Agency for AIDS
USAID	United States Agency for International Development
WHO	World Health Organization
VCT	Voluntary Counselling and Testing

CHAPTER ONE

INTRODUCTION

1.1 Background Information

This section gives a general overview of the Human Immunodeficiency Virus/Acquired Immune Deficiency Syndrome (HIV/AIDS) and discordance in the general population and among couples in heterosexual relationship.

HIV/AIDS has remained a health challenge to many nations since it was discovered in 1981 (Mwakalapuka, Bali, Mwashambwa, Kibusi, & Mwansisya, 2017). It has also been termed as a world-wide pandemic that has killed over 30 million people (World Health Organization (WHO) 2015). HIV/AIDS affects men, women, children, educated and uneducated, rich and the poor. Moreover it is incurable and fatal. The best that the current drugs can do is to stabilize and prolong the lives of the affected persons. According to United Nations Agency for AIDS (UNAIDS, 2017), by July of the same year there were 36.7 million people living with HIV/AIDS globally. In 2016 alone, one million people died of AIDS related illnesses (Mmenje, Cohen, Murage, Ong'ech, Kiarie & Poel 2014; Shetty, 2013; & Sarnquist, Rahangdale & Maldonado, 2013).

According to Global HIV/AIDS, 36.7 million lived with the disease in 2017 compared to 33.2 million in 2010. This is an indication that there is continued infection. Out of the 36.7 million, 2.1 million live in North America and Europe, 7 million live in Asia and the Caribbean, 1.8 in Latin America and the rest, 25.8 live in Africa. HIV/AIDS pandemic therefore is one of the greatest challenges facing Africa (UNAIDS, 2010). Developed countries record the lowest rates of new infections

unlike the developing world (UNAIDS, 2015). Moreover Sub-Saharan Africa has the highest rates of prevalence among the young adults in stable and long-term relationships particularly among cohabiting couples. UNAIDS (2016), reported that there were 1.8 million new infections in Africa 2016.

Kenya recorded her first HIV/AIDS case in 1984 and has continuously taken bold steps to create awareness and sensitize people on the same to reduce new infections. Due to the multifaceted effects on the individual and the society, HIV/AIDS continues to receive due attention from the government. The prevalence rate of HIV in Kenya stands at 5.6% (National AIDS and STI Control Program (NASCO) 2015). A study carried out in Kenya, by the National AIDS Control Council (NACC) in 2014 shows that 65% of new infections occurred in nine out of forty seven counties in 2013 but Kiambu County was not in the category. The prevalence rate in Kiambu County is 3.8%, ranking it number 31 out of the 47 counties in Kenya (NACC, 2016).

Different patterns of HIV infections have emerged. For example, there are couples living together and both are HIV positive. There is also another pattern where one partner is HIV positive while the other one is HIV negative, often referred to as discordant couples (Wilton, 2015). According to WHO (2012), discordance in a couple relationship refers to a situation where one of the partners is HIV positive while the other one is HIV negative. According to Reis and Gir (2014), these new infection patterns have been noticed worldwide and they further impose the challenges for the prevention and care of the infected persons. Reis and Gir (2014), further indicate that although there is no cure for HIV/AIDS this to date, scientific

progress in diagnosis and medical treatment through the use of Anti-Retroviral Therapy (ART) has brought down deaths and thereby enhanced longevity of life.

In Kenya, prevalence of HIV discordance varies from County to County. A study carried out by Rispel, Cloete, and Metcalf (2009), found that about two thirds of infected heterosexual couples have been classified as discordant while another study carried out by Essien (2012), indicated that among couples that tested together, 37% had discordant results. HIV discordance is poorly understood by many communities, yet its prevalence is very high (WHO, 2012). More focus is directed to HIV prevention research because discordant couples are at a higher risk of HIV transmission (Ravikumar & Balakrishna, 2013).

Discordant couples are common in those countries where HIV epidemic is high such as the Sub Saharan Africa (WHO, 2012). The percentage of discordant couples in various African countries ranges from 5-31% (Tsuma & Wekesa, 2014). Nearly all the new infections occur in stable relationships (Reis & Gir, 2014). Discordance may be explained by early sexual debut, unfaithfulness during marriage, social-cultural practices among some ethnic groups that encourage men to engage in extra marital affairs before and during cohabitation (UNAIDS, 2013). As the discordant couples cohabit, the risk of the HIV negative partner increases because they can be infected as the need for child bearing arises (Reis & Gir, 2014).

HIV discordance among couples is on the rise but most couples are ignorant about their status (WHO, 2012). The WHO further points out that those who know their status are not willing to disclose to their partners and may not even know the status of the other partner. As such, a significant number get infected. HIV discordant couples contribute to 30% of new infections transmitted from the infected to the

uninfected partner within a couple relationship (Chemaitelly, Cremin, Shelton, Hallet, & Abd-raddad, 2012). A study carried out in India on HIV transmission among HIV discordant couples found out that there was only 1.2% of HIV per year and this was attributed to good condom use, low rates of STIs and higher CD4 count (immunity) among Indian couples (Mujugira, Baeten, Donnell, Ndase, Mugo, Barnes, & Celum, 2011). The same study further pointed out that this low prevalence rate in India is completely different from Africa, especially Sub-Saharan Africa where HIV infection rate is 10 to 100 fold higher in discordant couples.

In Kenya, prevalence of discordant couples is notable, constituting two-thirds of the infected couple population (Tsuma & Wekesa, 2014). Among the married couples living with HIV, 45% have a partner who is not infected while one in ten married couples, at least one partner is HIV positive.

HIV discordance is responsible for varied levels of emotional distress causing couples experience stress, anxiety, fear and poor emotional regulation (Atibioke & Osinowo, 2013). Partners in a discordant relationship struggle with fear and risk of transmission from the HIV positive partner. A study carried out by Sandy (2013), also pointed out that discordant couples experience a cock-tail of emotions that can lead to unbearable overwhelming emotional state. These emotions may be explained by the HIV positive partner's attempt to protect their partners from contracting the HIV virus. The emotions further point out to the HIV negative partner's attempt to maintain relationship while at the same trying to cultivate and balance the psychological and emotional well-being of their positive partner (Mudzusi, Lelaka & Sandy, 2014).

Discordance also poses relationship challenges such sexual avoidance, extra-marital relationship and inconsistent use of condoms, thereby contributing to further infection of other parties (Mujugira et al., 2011). Discordance may further contribute to marital separation or divorce (Mwakalapuka et al., 2014). To some extent, these challenges threaten the couple's coping mechanisms such as communication and couple counselling (Mudzusi, Lelaka, & Sandy, 2014). Due to emotional and relationship challenges discordant couples are more likely to adopt to such strategies as sexual abstinence and couple counselling in order to alleviate tormenting emotions (Mudzusi & Sandy, 2014). Where awareness is high, consistent and regular use of condoms serve as a good preventive measure of reducing transmission of HIV/AIDS (Amanda, 2015). Medical preventive measures such as PrEP and ART are critical in reducing transmission among discordant couples (El-Sadr, 2012).

Couple counseling is offering the best opportunity to test and receive the laboratory test results in the most conducive environment. Health workers and counselors offer support in and out of the health facilities through treatment and psycho-social support (Lelaka, 2014). Effective HIV/AIDS education through sensitization campaigns about HIV and how it is transmitted can greatly enhance individual and collective protection against infection (Omange, Bosire, & Mwenda, 2015; UNAIDS, 2010; & KAIS, 2012).

1.2 Statement of the Problem

HIV/AIDS is a condition that can affect adults as well as children. In marital relationships two trends are present whereby both partners may be HIV/AIDS, or one partner is HIV infected (positive) while the other one is HIV negative (WHO, 2012). Discordance is a major threat in a marital relationship (Mwakalapuka, et al., 2014).

Measures taken to address discordance are geared towards protection of the negative partner. Possible emotional challenges such as fear of infection, worry, blame and guilt, denial, anxiety as well as stress may arise when a couple discovers that they are discordant (Mujugira, et al., 2011). Besides emotional challenges, HIV discordance is also associated with more relationship difficulties that include sexual distancing, marital separation and disruption as well as divorce (Gitonga, Ballidawa & Ndege, 2012). Discordant couples also struggle with stigma and discrimination, reproductive issues and mistrust in their relationships (Lelaka, 2014).

Studies have been carried out in other parts of the country on the challenges and coping mechanisms of discordant couples. Most of these studies have been carried out in urban areas. However limited studies have been carried out on challenges and coping mechanisms of discordant couples in rural Kiambu County. This study therefore sought to fill the knowledge gap by exploring the challenges and the coping mechanisms of discordant couples in rural Kiambu County.

The absence of this study may imply that discordant couples are likely to develop mental disorders. It may also make their immunity go down, thus compounding their health status. This may further affect their productivity and longevity of life.

1.3 Purpose of the Study

The purpose of this study was to explore the challenges and coping mechanisms of discordant couples living in the rural Kiambu County of Kenya.

1.4 Objectives of the Study

The study was guided by the following objectives:

1.4.1 Overall Objective

The objective of this study was to explore the challenges and coping mechanisms of discordant couples living in rural Kiambu County of Kenya.

1.4.2 Specific Objectives

- 1) To identify emotional challenges among discordant couples in rural Kiambu County.
- 2) To establish the effects of emotional challenges among discordant couples in rural Kiambu County.
- 3) To explore the effects of the relationship challenges among discordant couples in rural Kiambu County.
- 4) To establish the coping mechanisms of discordant couples in rural Kiambu County.

1.5 Research Questions

The objectives were met by seeking answers to the following research questions:

- 1) What are the emotional challenges that discordant couples in rural Kiambu County experience?
- 2) What are the effects of the emotional challenges experienced by discordant couples in rural Kiambu County?
- 3) What are the effects of relationship challenges that discordant couples in rural Kiambu County experience?
- 4) What are the coping mechanisms of discordant couples in rural Kiambu County?

1.6 Significance of the Study

The findings of this study may enlighten couples on the emotional and relationship challenges that discordance brings into a marital relationship. The findings of this study may also help counseling psychologists and social workers to better understand the emotional and relationship challenges that threaten marital stability among discordant couples. The qualitative study may also give fine-tuned results to the government agents and programs dealing with HIV/AIDS because the findings are based on one-on-one approach with the respondents. The findings will also help family members, significant others and the larger society to appreciate discordant couples. Overall, general awareness of HIV discordance will be enhanced in the rural part of Kiambu County in Kenya and it may even extend to other areas where awareness is lacking.

Emotions and coping mechanisms are critical components of the well-being of a fully functioning person including the discordant couples. Therefore without this study it may be difficult for families and care-givers of discordant couples to understand that discordant couples experience emotional and relationship challenges among other challenges in their marital life.

1.7 Scope of the Study

The study was carried out in Ruiru Sub-county of Kiambu County in Kenya. Ruiru is a rural part of Kiambu County and the neighbouring counties are Nairobi, Nyandarua and Murang'a. The study limited itself to one rural sub-county health facility (Ruiru Sub-County Hospital) in Ruiru and the target population was the discordant couples aged 20-50 years in long-term relationships attending their

monthly clinics in the same health facility. The study sought to establish the challenges and coping mechanisms among these couples living in this rural set-up.

1.8 Assumptions of the Study

The study was guided by the following assumptions:

- 1) Discordant couples experience negative emotions as well as relationship challenges.
- 2) The couples gave honest responses during the research without fear of being intimidated by the nature of the investigation or their partners.
- 3) The challenges under investigation do affect marital relationships.
- 4) HIV infection has a negative impact on a marital relationship and partners' emotional balance.

1.9 Limitations of the Study

Limitations in research refer to the inherent weaknesses of the study that are beyond the researcher's control (Simon, 2011).

- 1) The study was carried out in one sub-county and therefore it did not reflect the views and experiences of other discordant couples attending clinics outside this health facility.
- 2) Due to the sensitive and personal nature of the issue, some respondents had issues with self-disclosure but the researcher reassured them of confidentiality.

1.10 Definition of Terms

The following are the operational definitions that were used in this study:

Acquired Immune Deficiency Syndrome (AIDS): It is the most sever phase of HIV which badly affects the immune system and exposes the person to opportunistic infections

Challenge: A negative demanding or stimulating situation. In the study it refers to the demands arising in the marital relationship as couples address their different HIV status.

Counselling: A helping relationship that addresses the challenges facing individuals and therefore empowers them on how to cope. In the study the term has been used to address issues of the couple as a pair/dyad.

Couple: Two persons in an on-going sexual relationship, each of the persons is referred to as a partner in the relationship (WHO, 2012).

Discordance: It refers to a situation in a marital relationship where one of the partners is HIV positive while the other one is HIV negative (WHO, 2012). In the study it has been used interchangeably with sero-discordant.

Human Immunodeficiency Virus (HIV): The virus which causes AIDS if it remains untreated. It is spread through body fluids and attacks the body's immune system and has no cure.

Sexually Transmitted Infection (STIs): Infections that are transmitted through sexual contact with an infected person.

Strategy/Mechanism: A plan, approach or process of dealing with an issue (good or bad). In this study it refers to the approach that discordant couples use in order to cope.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This chapter reflects an overview of HIV discordance, (distribution, knowledge about discordance and beliefs) and further explore on the emotional and relationship challenges that other studies have identified. The chapter also expounds on the theoretical framework as well as the conceptual framework that was used to understand the study.

2.2 Distribution of HIV Discordant Couples

Out of the estimated 33 million people living with HIV/AIDS worldwide, 60% live in Sub Saharan Africa (WHO, 2012). In Kenya, 2/3 Of the infected couples are discordant couples (Tsuma & Wekesa, 2014). This is a high prevalence rate which has called the government to shed light on HIV discordance through public communication campaigns and medical care. A study carried out by Ngilangwa et al(2015), found out that in a marital relationship, women are more likely to be the HIV positive partner as compared to the men. Besides their forms of biological susceptibility to HIV infection per sexual act, women in sub-Saharan Africa initiate sex with older men than their male counterparts (Ngilangwa et al., 2015). Other forms of transmission among women occur during care for AIDS patients and this also increases their risk of infection (Ewayo, Walque, Ford, Gakii, Lester, & Mills, 2010). Whereas caring for the sick is very necessary, there is need to sensitize young women on self-care through HIV prevention programmes. Among cohabiting couples positive prevention that ameliorates risk of infection and improves the quality of life should be

a critical intervention strategy (Sikkema, Watt, Drabkan, Meade, & Hansen, 2010). Biomedical interventions should also be enhanced through the use of Anti- Retroviral Therapy (ART) as a preventive measure (El-Sadr, 2012).

2.3 Knowledge of HIV Discordance

Couple's knowledge about their HIV status is critical in a marital relationship. HIV transmission in couple relationship may be associated with ignorance of partner or self-status. Some young women enter marriage or cohabitation when they are already HIV infected or they may be HIV uninfected but enter into marriage with an already infected man (Ravikumar & Balakrishna, 2011). Ravikumar and Balakrishna (2011), further argue that cohabiting or married couples in Kenya are more prone to HIV transmission. This is because many couples rarely go for tests together and neither do they disclose their status to their partner. There is also an assumption that there may be no HIV infection in stable marriages. This is a pointer that the couples live together and have sexual intercourse without knowledge of their partner's status.

The risk of transmission among married couples is therefore ignored and much focus and awareness is directed towards people in casual relationships or transmission through prenatal process. Tadesse (2014), posits that it is important for couples to acknowledge that being in a monogamous stable relationship does not guarantee that one is not exposed to the risk of HIV transmission. Married couples have poor knowledge about their HIV status that is further increased by lack of risk awareness which results to low condom use (Kim, 2011).

2.3.1 Peoples Beliefs/ Explanation about HIV/AIDS Discordance

Discordance is explained from different perspectives by different people and communities. However research has proved that it could be attributed to people with inherent resistance to the infection (Ravikumar & Balakrishna, 2013). The belief that an individual holds about their HIV discordance status influences a couple relationships and reduces risk behaviour among the discordant couples who are already in ART. People hold different beliefs about discordance. Some believe that there is a hidden infection not detectable by HIV tests, others believe that there is immunity, gently sex unlike rough practices against HIV transmission while others believe it is protection from God (Gitonga, Ballidawa, & Ndege, 2012). All these explanations for HIV discordance reinforce denial and ignorance of the HIV risk for the negative partner in the relationship which ultimately increase the risk of transmission (Fatene & Ayalew, 2011).

2.4 Emotional Challenges that Discordant Couples Experience

People living with HIV/AIDS experience distress which negatively impacts on the HIV care (Olagunju, Adeyemi, Adebayo, & Aina, 2012). Mental health may affect any person but individuals living with HIV/AIDS are more likely to experience psychological distress than individuals who are not living with such a condition (Mmeje et. al, 2014). Moreover when a partner in a marriage relationship is HIV negative, their psychological distress is likely to be high due to anxiety, worry and fear of transmission as well as the implications of reproduction, children and the social-economic burden associated with HIV/AIDS (Yashau, Audu, & Zuwaira, 2014).

The level of emotional distress experienced by discordant couples is determined by such factors as couple's knowledge, attachment, intimacy and self-efficacy (Atibioke & Osinowo, 2013). Rizza, Kaplan, Senn, Boemann, and Bhend (2009), point out that couples elicit different emotions following diagnosis of discordance. These emotions may range from shock, denial, anxiety, fear and panic, depression, loneliness, and even sadness (Mwakalapuka et al, 2017). These emotional challenges may pose marital difficulties and also interfere with the coping mechanisms that the discordant couples use to enable them to live with their different status.

2.4.1 Worry and tension in Discordant Couples

Upon learning their partner's status, couples have to deal with worry and tension in the relationship (Hanani, Doharty, Rubenson, Jackson, Ekstrom, & Thorson, 2013). A study carried out in South Africa and Tanzania by Rispel et al., (2011), found out that discordant couples also experience tension. Tension and worry affect the couple's sexual intimacy. Moreover studies have shown that where there is evidently high risk of HIV transmission to the uninfected partner, the marital relationship experiences difficulties related to sexual practices observed in sexual distancing which further raises the tension between worrying about the HIV negative partner being infected and maintaining an active sexual life (Reis & Gir, 2010).

Tension arises due to fear of infecting the uninfected partner, perceived or real infidelity and problems associated with continuous condom use (Ripsel et al., 2011). This study further found that condom use had negative implications such as loss of spontaneity, reduced libido and decreased frequency of sexual intercourse and reluctance by one partner to use condoms. Reluctance to consistent use of condoms

arises due to either the desire of one or both partner to have a child or the belief that the condom negatively interferes with intimacy and love-making (Bavinton et. al, 2014; Lai & Goh, 2017).

2.4.2 Panic and Fear of Infection of the HIV Negative Partner

Individuals experience fear and panic based on the assumption that such a diagnosis renders the person's life short (Rizza et al., 2012). Fear and panic may also be attributed to inadequate information and lack of counseling offered to discordant couples after receiving the diagnosis. The HIV negative partner may panic and live with fear of transmission/ infection from the HIV positive partner and as such, very few of them are likely to carry on with a functional relationship (Mujugira, Baeten, Donnell, Ndase, & Mugo, 2011; Bavinto et. al, 2014). This therefore means there is need to focus more preventive frameworks and awareness creation among married or cohabiting heterosexual couples (Mwakalapuka et al., 2017). Fear and panic then interferes with the couple's efficacy, thereby reducing ability to communicate and choose a good coping mechanism.

2.4.3 Anxiety and Stress in One or Both Partners in the Discordant Relationship

Anxiety is a negative emotion that is characterized by feelings of tension, worried thoughts and physical changes like muscle tension and increased blood pressure (APA, 2017). Strain is placed on a relationship whenever stressful circumstances affect the couple as a whole or just one partner. For example, a chronic illness (e.g. HIV/AIDS) of one partner can negatively impact on the marital relationship (Sovenic, 2013). Stress on the other hand is a biological and psychological response of an individual on encountering a threatening a situation and

they feel that they have no resources to deal with the same (Qadir, Abdi & Nisam, 2011). Stress affects cognitions and feelings as well as the physical processes. In a discordant relationship where infidelity may be the cause of the infection, and thereby the stressor, it can lead to frequent arguments as a sign of the underlying problem that may be left unaddressed (Tshoma, 2014).

Stress level of an individual who tests positive in a marital relationship depends on attachment to significant others and intimacy with the spouse. A study carried out by Cherayi (2013), pointed out that in discordant relationships, men are more stressed than women. When an individual's stress condition is persistent, it leads to increased symptomatology and also hastens disease progression and heightens levels of anxiety particularly among couples with unstable incomes (Ewayo et al., 2010). This may in the long-run impact on their coping skills.

2.4.4 Blame and Guilt in Discordant Marital Relationship

Blame is an emotional reaction that makes a partner in a discordant relationship to point an accusing finger to the other partner thus shifting responsibility of accepting their status. In a marital relationship, the HIV positive partner upon diagnosis experiences guilt and self-blame which is further perpetuated by their partner constantly blaming them (Mudzusi, & Sandy, 2014). Self-blame may breed to poor self-confidence and poor sexual activities. Lelaka (2014), further points out that blame allows the guilty partner to take responsibility of their action while acknowledging unacceptable risk behaviour. Blame works together with guilt. According to Rizza et al., (2012), HIV diagnosis reveals some aspects of a partner's behaviour that could have been kept secret and this may include infidelity resulting in feelings of guilt and blame.

2.4.5 Depression among Discordant Couples

In HIV affected relationships, women's positive status leads to greater levels of depression compared to men (Li, Liang, Lin, Ji & Xiao, 2016). This could be explained by various biological, psychological and social reasons including hormonal regulation and their low social status (Keita, 2010). Men and women respond differently to stressful situations. Whereas women develop internal symptoms such as depression, affective or anxiety disorders, men externalize their stress and develop symptoms such as aggression or substance abuse disorders (Hill & Needham, 2013).

2.4.6 Stigma and Discrimination from Family Members, Friends and Society

Stigma is the negative attitude towards people living with AIDS, manifested in prejudice, discrediting and discrimination directed to people perceived to have HIV and the individual with whom they live (Rispel, 2015). Stigma affects the couple's relationship with others, making it difficult for them to openly disclose their status and live openly with the different HIV status. Rispel et al (2015), further argues that stigma perpetuates silence surrounding HIV discordant relationships thereby impacting negatively on prevention, treatment and counselling efforts. Society always assumes that in a situation where one partner is HIV positive, the other one must always be positive (Tshoma, 2014).

The couple may be looked upon as promiscuous and a threat and risk to their families and more so to their uninfected partner (Gitonga et al., 2012). When a couple discloses their status to family members and friends, they experience stigma and discrimination. The society is also known to give labels to PLWA. In other instances, the couple may get pressure especially from the family and friends of the un-infected partner to leave the discordant relationship (Rispel, Cloete, & Metcalf, 2015). Other

forms of discrimination from the society may include gossip, name-calling, and discrimination from health care providers. Stigma and fear of discrimination may hinder people from disclosing their status to families, taking medicine and attending check-ups (UNAIDS, 2009).

2.5 Relationship Challenges among Discordant Couples

Besides emotional challenges, discordant couples also experience relationship challenges. These challenges may emanate from the couple as a dyad or from other persons and factors outside the couple relationship. These relationship challenges also have their effects on the couple relationship. The challenges include reproduction, sexual distancing, domestic violence (physical and emotional) and separation and divorce.

2.5.1 Reproduction among Discordant Couples

HIV discordant couples have reproduction desire like any other couple but they knowingly risk HIV transmission in making attempts to conceive (Brubaker, Bukusi, Odoyo, Ochando, Okumu, & Cohen, 2011). Since parenthood is personally, culturally and historically rooted, discordant couples also desire to have children (Pintye, Ngure, Curran, Vashe, Mugo, Celum, Baeten, & Heffron, 2015). As such, starting a family or having children of their own becomes a major concern among the infected couples (Brubaker et al., 2011). A study conducted by Brubaker et al., (2010), established that the discordant couple's desire to bear children is one of the motivations for higher risk behaviour. Their desire to have children therefore interferes with good condom use as well as their determination to abstain from sexual intimacy.

In the early days of the HIV epidemic, HIV women were discouraged from conceiving due to poor prognosis that was associated with HIV infection and the risk of prenatal transmission (Mmeje, Cohen, Murage, Ongech, Kiarie, & Poel, 2014). However advances in HIV interventions have allowed HIV infected persons to live longer and actualize in their reproductive goals like any other uninfected persons provided they seek care at health institutions that can provide and evaluate effective treatment and follow-up (Ethics Committee of the American Society for Reproductive Medicine, 2010).

HIV infected women report that pregnancy and child birth help them to regain their sense of womanhood and sexuality. Therefore for cultures where self-worth and identity are linked to child bearing, encouraging a woman not to conceive and bear children is unrealistic (Inhorn, 2009). The desire to have children among couples living with discordance is explained by societal expectations. Child bearing in the traditional African community is as important as marriage and the only natural way to conceive is through sexual intercourse. The individual further feels that they want to experience parenthood and that children serve as strong anchors for parents during old age. This desire to have children puts the HIV uninfected partner in a discordant relationship to higher HIV infection risks. This may affect the size of the family that the couple had intended to have before discordance was diagnosed.

Reproduction may be adversely affected by HIV infection, and fertility rates are affected by comorbidities associated with HIV (Magadi & Ogwanda, 2010). However the fertility rate can also go up due to shorter breastfeeding periods, desire to replace lost children and a couple's desire to maintain an ideal size of the family as explained by high infant mortality caused by HIV. However studies show that

discordant couples have a lesser desire to for having children as compared to those who are concordant or uninfected.

2.5.2 Domestic Violence among Discordant Couples

Gender violence adversely affects relationships among couples .Women are generally considered weak and with an inability to make decisions about their health (Gwazane, 2011). Women may be forced to have unprotected intercourse, for example, they are refused to use condoms even when they are aware that their partners are HIV positive. Moreover domestic violence coupled with threats limits a woman's ability to negotiate safe sexual behaviour, while coercive sexual intervals increases HIV transmission and gives rise psychological trauma to a woman whose male partner is HIV infected (Gwazane, 2011).

2.5.3 Sexual Distancing among Discordant Couples

Among the discordant couples, sexual distancing is imminent due to worry and fear of transmission. There is heightened risk of transmission to the uninfected partner and the relationship therefore experiences difficulties that are commonly manifested through sexual distancing (Reis & Gir, 2010). Sexual distancing may lead to emotional disconnectedness (Lai & Goh, 2017).

2.5.4 Separation /Divorce after Diagnosis

A study conducted in Kenya by Gitonga et al (2012), found out that most newly diagnosed discordant couples opted to live apart though maintaining their relationship in order to reduce instances of sexual encounters. The study also found that separation was common among couples that were not working in the same locality while others preferred living together but not sharing a bed. Where couples

are living separately due to discordance, communication is greatly inhibited. Some couple may also take divorce as an option on learning their discordant status. In Kenya separation/divorce is a strategy that discordant couples opt to take upon learning their HIV status and is common among those with low incomes where the positive partner is the woman (Mackelprang, Bosire, & Guthriel, 2014).

2.6 Coping Strategies used by Discordant Couples

Tshoma (2014), defines coping Strategies as remedial actions that an individual undertakes whenever survival or livelihood is under threat. He further adds that they are learned behaviour patterns that may be positive or negative and used as coping mechanisms. Discordant couples find ways and means to survive in their marriages despite all the challenges that they encounter. Some of the common strategies used by couples to cope with discordance include; good use of condoms, abstinence, counselling and separation where separation is used as an option by couples in shorter duration where the HIV positive partner is the woman (Gitonga et al., 2012). This study addressed the coping strategies used by discordant couples and how the strategies are affected by the emotional and relationship challenges that they experience.

2.6.1 Communication among Discordant Couples

Communication skills determine how well a relationship may survive in the midst of any storm. Effective communication is critical when matters of sex are at risk (Carney, Cuddy, & Yap, 2010). There may arise unhealthy communication between the partners combined with hurtful exchange of words that may deliberately be uttered to relieve a partner's anger (Lewaka, 2014). To address such issues in a discordant

relationship, communication should be enhanced pointing out to the meaning of discordance in the relationship, the importance of couple testing, disclosures in the relationship and the existence of HIV discordance (Tsuma & Wekesa, 2012).

Communication allows discordant couples to live happily and addresses their issues on how to get children (Rispel, et al, 2012). Both verbal and non-verbal communications enhance understanding and healthy co-existence in discordant couples. Tiffany and Gina (2015), refer to the general occurrence of communication barriers that become prevalent upon diagnosis of a terminal illness such as HIV. In this regard, they point out that communication should be an art and that there are no hard and fast rules in terms of communication and that openness in sharing in both partners should be paramount for the survival of the relationship. Negron and El-Bassel (2014), also believe that communication is key to creating and maintaining a healthy relationship by ensuring that the couples have open dialogue about such experiences as fear, un-answered questions in both partners, anxieties, confusion, shame, or even guilt. Furthermore when high levels of communication are maintained, the partners feel that their needs have been met and that a stronger commitment to the future of the relationship is created (Negron & El- Bassel, 2014).

2.6.2 Abstinence from Sexual Intercourse

Abstinence is a practice that is recommended to cope with discordance as a measure to prevent HIV transmission, re-infection and safeguard against other Sexually Transmitted Infections (STIs). It serves both as a coping strategy as well as a preventive strategy. However it has been an unsuccessful strategy since it is adopted due to unavoidable circumstances of HIV diagnosis (Tsuma & Wekesa, 2012).

Abstinence may at times not be realistic or desirable particularly in close and loving relationships (Tshoma, 2014).

2.6.3 Antiretroviral Therapy (ART) and Pre-exposure Prophylaxis (PrEP)

The WHO recommends ART for all persons with less than 350 CD4 count (Anglemyer, Rutheford, Horvrath, Baggaley, Egger, & Siegfried, 2013). ART is increasingly recognized as a preventive strategy for reducing HIV transmission among discordant couples (He et al., 2013). Furthermore, the use of ART is not only associated with decreased HIV- related morbidity and mortality and increased quality of life of people living with AIDS but also with a lower risk of transmission to the uninfected partner provided it is appropriately used (Kurth , Mayen, Beauchamp, McKinstry, Farvion, & Buchacz, 2013; Combiano, Roger, & Phillip, 2011). Moreover, a timely initiation of ART is critical for HIV discordant couples because it suppresses replication of the virus thereby reducing the risk of transmission to the negative partner (Kahn, Desmond, Roa, Max, Guthriel, Bosire, Choi, Kiarie, & Farquhar, 2013). According to the guidelines of the Doyle and Dorrington (2011), on the use of ART, mortality has dropped significantly. A study carried out in Kenya by Oduyo, Patel, Anand, Standford, Wakhungu, Bukusu, Beaten, and Brown (2016), found out that individuals appreciate ART because it prevents transmission to their partners or children, with prevention to children being stressed more commonly by female participants in the study. The same study found out that both males and females used ART to look `normal' and ` healthy' and to avoid HIV disclosures which bring stigma and discrimination from family members, thereby increasing community and social interactions without fear.

PrEP is an approach towards prevention which involves administration of anti-HIV drugs to the negative partner to reduce the risk of transmission from the HIV positive partner (Cohen, Chen & McCauley, 2011; Wilton, 2015). PrEP involves providing partners who are not HIV infected with ARVs drugs to prevent possible exposure to the virus and stop them from becoming infected (Brand, 2012). However PrEP provides only partial protection from HIV infection and should not be used to fully replace the condom (Wilton, 2015). It has been proven in a research by Young, Li, and McDaid (2013), that prescribing ARVs to HIV negative people before sexual exposure to HIV can reduce transmission.

However ART and PrEP are not without challenges. Among the discordant couples, the negative partners sometimes do not accept PrEP or if they do, they do not use them as prescribed (Ciaranello & Mathews, 2015). Others fail to adhere due to fear of stigma and discrimination. Failure to adhere increases the risk of transmission as well as unhealthy arguments between the couples.

2.6.4 Continuous Couple Counselling

Counselling is defined as a therapeutic or structured conversation whose aim is to facilitate a client's quality of life in the face of adversity (Mudusi, Lelaka, & Sandy, 2014). Velleman and Sarajane (2010), further point out that counseling is an approach that enables an individual to overcome problems, and as far as possible take control of their own lives by taking responsibility and gaining decision making in their lives for the present and the future.

Couple based counselling is a more effective approach to discordant couples because it reduces risk behavior compared to individual partner counselling. It also creates a supportive environment where both partners can agree on risk reduction

behaviour and relationship dynamics (Negron & El-Bassel, 2014). Wilton (2015), further argues that through couple-based counselling, heterosexual couples are empowered to make decisions on reproduction as they observe HIV preventive strategies. Lack of continuous couple counseling and poor understanding of discordancy points out to the higher rates of infection among the married partners (South Africa National AIDS Council, 2011).

2.6.5 Good Use of Condom

Condoms work as a barrier that prevents HIV infected body fluids from coming into contact with parts of the body that are more vulnerable to HIV infection (Wilton, 2015). Of all other preventive measures used by discordant couples, condom is the most known and commonly used strategy (Amanda, 2015). According to Smith, Herbst, Zang and Rose (2014), constant and correct condom use is a key and primary strategy recommended for prevention and transmission of HIV among heterosexual discordant couples and it reduces transmission by 70-80%. Condoms provide an excellent and impermeable barrier to HIV and STIs when used correctly (USAID, 2013). Moreover proper condom use combined with ARV enhances effectiveness and achievement of HIV prevention (Liu, Su, Zhu, Xing, Wu, & Wang, 2014). Condom use by couples on HIV treatment and among discordant couples is therefore highly recommended. Quality condoms should be accessed any time they are needed by those who need them (WHO, 2015).

It has however been noted that some partners in discordant relationships do not appreciate condoms. Some allege that condoms are tight while others complain that use of condoms reduces sexual gratification. According to Mathews and Deering

(2013), some studies have shown that some men pay prostitutes more money to have sex without condoms.

2.7 Theoretical Framework

The study was guided by two theoretical frameworks namely: The Lazarus and Folkman's (1984) Transactional Model and the Gestalt Therapy by Fritz Perls (1926). The Lazarus and Folkman's model helped the researcher to understand how a partner and / or the couple perceive their situations upon diagnosis of HIV discordance. It shed light on the cognitive appraisal of couples individually and collectively and the emotions elicited in the relationship. Gestalt Therapy on the other hand helped to understand the couple's current situation in relation to the environment, and also increase their awareness of what they are experiencing (here and now) and the required change (Corey, 2009).

2.7.1 The Lazarus and Folkman Transactional Model

The Transactional Model of stress and coping is a framework for evaluating the processes of adjusting to stressful events where stressful experiences are construed as person-environment transactions. According to this framework, stressors are demands that emanate from the environment thereby distorting the natural balance and hence affecting the physical wellbeing and requiring action to restore the balance (Lazarus & Cohen, 1977). Lazarus (1982) argues that emotions reflect a constantly changing person-environment relationship, and when the central life agendas (like biological survival, personal and social values and goals) are engaged, the relationship becomes a source of emotion.

This model explains that life is a composition of different dimensions which may be experienced internally or externally, immediate or delayed, delightful or unpleasant (Lazarus, 1991)). The framework posits that people experience their daily life in a continuum of transactions as they relate with the environment, people and institutions (Bloom, 1996). In the ordinary course of life, individuals interact with different situations such as HIV, creating demands on them and these demands may bring challenges that create stress (Mujugira et al., 2011). Stress is defined as any situation whose demands go beyond an individual's ability to cope (Lazarus & Folkman, 1984). When challenges arise in life, supplementary resources are required in form of psychological, physical or even financial to sustain livelihood and the absence of such resources causes an individual to reveal psychological or sociological symptomatology (Atibioke & Osinowo, 2013).

The severity of how one perceives such a challenge as discordancy is dependent on factors such as personal ability to handle the situation, previous experiences in dealing with similar situations, personal efficacy and the extent to which one feels overwhelmed or in control of the situation (Mwakalapuka et al., (2014). Lazarus and Folkman (1984), argue that a person copes best when they perceive the external stimuli as independent from the problem. Mwakalapuka et al., (2014), further argues that cognitive burden and difficulties determine the coping approach as well as the severity of the damage that the individual may face. It is therefore the discordant couple's perception and the evaluation of their HIV status that determines the decision-making process. According to Lazarus and Folkman (1986), an individual's appraisal as an infected couple determines their view of the severity of the problem as well as the coping strategy one needs to take and which are

specific to the challenge. Moreover individuals are unique and therefore have different perceptions, evaluations as well as perceived severity and coping strategies.

Individual differences also determine how people appraise situations. Thus, an infected couple may have different ways of managing their relationship after diagnosis and this therefore means a couple's appraisal of their discordant status defines what they make out of it, say, loss, harm or threat to their well-being (Lazarus, 1990). Lazarus and Folkman (1984), argue that an individual's appraisal is influenced by several factors such as personal morale and efficacy, motivation, values and culture, accessibility of resources and situational factors, and situational factors in this case refer to predictability, manageability, and severity of the stressful situation such as discordancy.

People develop typical coping styles to cope with challenges and the coping style may be problem focused coping or emotion focused (Lazarus and Folkman, 1984). Problem focused coping entails changes that people make to resolve a problem (for example, discordant couple may resolve to abstain from sex to prevent transmission to the uninfected partner), while emotion based coping refers to the cognitive efforts made to reduce the emotional effect of a stressful challenge (Hand, 2006). It is therefore advisable that discordant couples employ both problem- focused and emotion- focused coping styles in order for them to manage both emotional and relationship challenges.

This theory therefore informed the study that various emotions arise from the environment and that an individual needs to be flexible in order to cope with ever changing situations. Failure to adjust may render an individual a slave of the ever changing environment.

2.7.2 Gestalt Therapy

Gestalt therapy focuses on the here and now of the discordant couple situation, the what and how, and the I/ Thou of relating (Brown, 2007; Yontef & Jacobs, 2008). The goal of Gestalt therapy is to help individuals to mature and grow (Perl, 1969). Focusing on the past or future may be interpreted as avoiding the present situation of discordance, bemoaning their past mistakes and ruminating over how life would have been different if the present situation was absent (Polster & Polster, (1973).The discordant couples need to increase the awareness of what they are going through in the present and how they are handling it and awareness in this context involves insight as well as introspection.

According to Corey (2009), acceptance the self, individual's knowledge of the environment, and responsibility for choices form awareness process. Couples are therefore expected to do their own seeing, feeling sensing and interpreting as opposed to watching passively for others manifested to make decision for them. When discordant couples struggle with unfinished business, it can be in unexpressed feelings such as resentment, pain anxiety, guilt, blame and fear. According to Polster and Polster (1973), when couples have not dealt with unfinished business, the feelings linger into the present and thereby interfere with effective contact with oneself and others. Individuals however can be fully aware of themselves and their environment in different ways:

“Persons develop fuller awareness of their bodies, feelings, and environment; own their experiences instead of projecting them on to others; learn to be aware of their own needs and skills in order to satisfy themselves; rather than whining, blaming, guilt making, the individuals experience their power and

ability of self- support, thereby becoming sensitive to their surroundings to protect themselves from those parts of the environment that may be dangerous; responsibility for actions and consequences is a part of greater awareness”(Zinker, 1978, pp. 96-97).

Interruptions, disturbances and resistance to contact which may have been used as coping strategies prevent the couple from experiencing the best in the relationship. Because resistance is developed as a means of coping with discordance, it may bring up such boundary disturbances as projection, introjection, retroflection, deflection and confluence (Corey, 2009). Gestalt Therapy therefore helped the study in bringing awareness to the discordant couples, appreciating the here and now of the discordant relationship as well as develop skills to cope with discordance.

This study therefore borrowed its understanding from the Lazarus and Folkman’s Transactional model in order to relate the emotional challenges and the coping strategies adopted by couples living with different HIV status. To enhance the awareness in the couple’s relationship challenges, sense of their environment, and better their coping skills, Gestalt therapy helped to bring out the bigger picture. These two theoretical frameworks were therefore relevant in the study, as they formed a foundation upon which an exploration into the challenges and the coping strategies of discordant couples in rural Kiambu County in Kenya.

2.7.3 Conceptual Framework

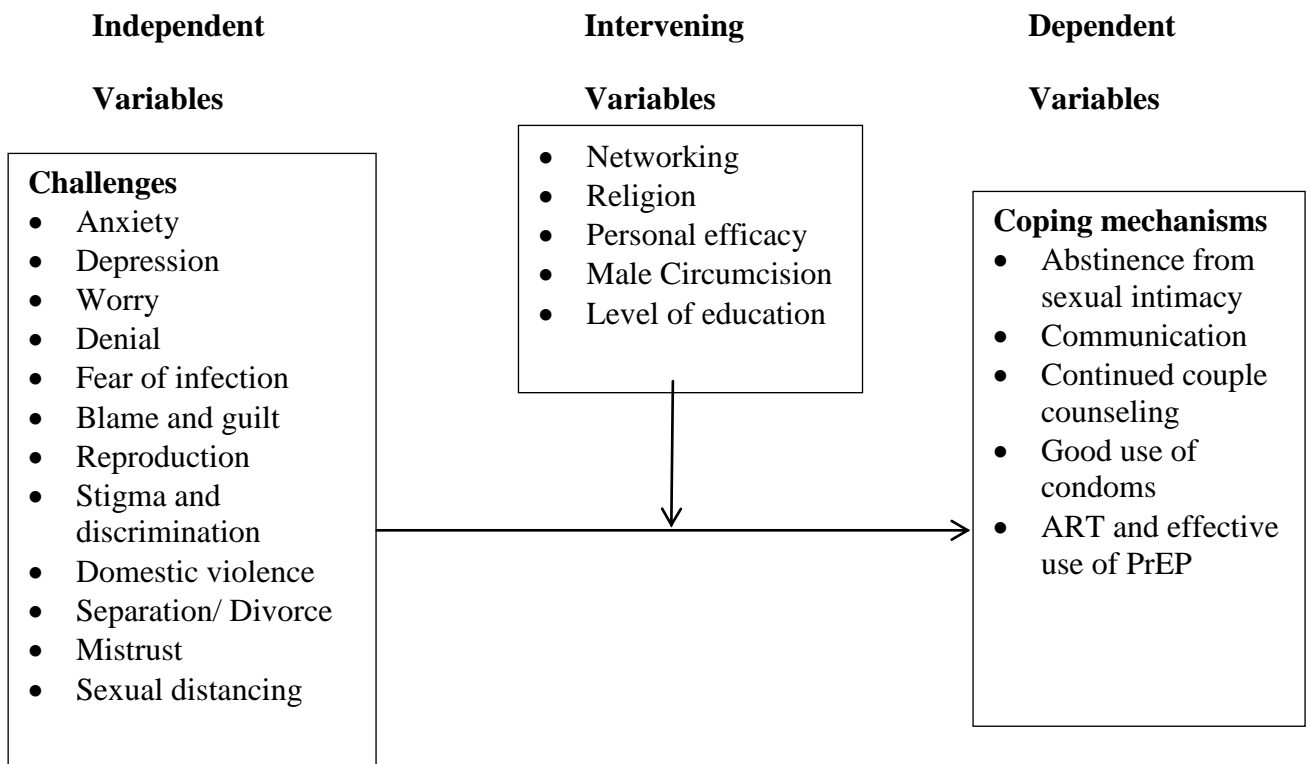


Figure 2.1: Challenges and coping mechanisms of discordant couples in rural Kiambu County, Kenya. (Source: Mary Gacheru, 2018).

In the study, the independent variables were the challenges that the discordant couples experience in their marriage. They included such factors as anxiety, stress, depression, fear and panic, blame and guilt, sexual distancing, reproduction challenges, stigma and discrimination and mistrust. Dependent variables were the coping mechanisms of discordant couples which included communication, continued couple therapy, ART, abstinence from sexual intimacy and use of PrEP, and good use of condoms. Intervening variables were those variables that mediated between challenges and the coping mechanisms used by the discordant couples as shown in the figure above. Such variables included level of education, religion, networks with other discordant couples, personal efficacy and male circumcision in communities where it

is not widely practiced. For example, networking (intervening variable) brought discordant couples together, to share their challenges (independent variable) and this greatly impacted on their appreciation for couple counselling as well as good use of condoms (dependent variable).

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter deals with the procedure that the researcher used in carrying out the study. It presents the various steps that were followed in the entire study. It includes the research design, the location of the study, the population, sampling procedure and sample size, instruments of data collection, data collection and analysis.

3.2 Research Design

Research design is the conceptual structure within which the research is conducted. It is the blue print for the collection, measurement and analysis of data in any study (Bhattacharyya, 2009). The study used an exploratory research design. It is a qualitative study that explores the challenges and the coping mechanisms of discordant couples living in rural Kiambu County in Kenya. The researcher chose a qualitative research approach because it contributes to the understanding of the perceptions, emotions and experiences of individuals. Creswell (2009), points out that a qualitative approach enables a researcher to collect data from a natural setting at the site where the participants are experiencing the issue under study.

3.3 Location of the Study

The study was conducted in Kiambu County. Kiambu is one of the 47 Counties in Kenya. It has 12 sub-counties namely, Limuru, Kikuyu, Kabete, Lari, Gatundu North, Gatundu South, Githunguri, Kiambu, Kiambaa, Ruiru, Juja and Thika

Town. The sub-counties are further sub-divided into 60 wards. It has an estimated total population of 1,766,058 (PHC, 2012). Kiambu is predominantly an agricultural zone. The county has 364 health facilities spread across the sub-counties. This study was carried out in one of the health facilities in Ruiru sub-county, Ruiru Sub-County Hospital. Ruiru Sub-County Hospital is located 22 kilometres from Nairobi Central Business District.

The Researcher chose the area because many studies on HIV discordancy have been conducted in urban settings and therefore Ruiru with its rural characteristics would give a clearer picture of the challenges and the coping mechanisms in rural places in Kenya. Besides, there is limited study that has been carried out to identify challenges and coping mechanisms of discordant couples in the rural areas in this County.

3.4 Target Population of the Study

The study was conducted among HIV discordant couples attending clinic in the Ruiru Sub- County Hospital. The healthy facility has 800 HIV patients who attend clinic. In this study the target population was the 300 registered patients who are discordant couples. The researcher formed Focus Group Discussions (FGD) with the participants. The participants were discordant couples who live in that rural area. The participants were all discordant persons in a marriage relationship although they never participated in the study as dyads. The participants were over 20 years and not more than 50 years old. The participants were married individuals attending clinic regularly and had lived together as husband and wife for at least one year since diagnosis of the discordant status. The participants were also married for more than two years because long term relationships have better coping skills in terms of communication,

interactions as a couple and the extended family; hence this data may be useful in other relevant areas in family studies. Since this study intended to get an in-depth understanding of challenges and coping mechanisms of discordance, and owing to the sensitive and personal nature of the issues, only those who offered to voluntarily participate were interviewed.

3.5 Sample Size and Sampling Procedure

The sampling frame included the 300 registered discordant patients attending HIV clinic in Ruiru Sub-County Hospital. Thirty participants (15 couples) were identified by the clinicians and the HTC. According to Mugenda and Mugenda (2013), 10% of a sampling frame forms a good representative of a sample size. The researcher used the purposive sampling method to identify the participants. Purposive sampling is a non-probability method where the researcher deliberately picks the participants to help in the exploration of the research questions in depth (Leedy & Ormrod, 2005). Maina (2012), further posits that purposive sampling enables the researcher to use only cases that have the required information with respect to the study objectives. The researcher with the help of clinicians and a HIV/AIDS and Testing Counsellor (HTC) prepared the participants earlier before the actual dates of data collection. Three groups were formed. Each group was composed of 10 participants. An ideal group of adults has between 5-8 members although it can vary slightly up-to 10 members depending on the issue under discussion (Corey, Corey, & Corey, 2016). The researcher recorded the discussions that were verbalized by the participants. Each group discussion took about 2 hours. The HTC helped the researcher to organize and prepare the participants upon giving consent. Purposive

sampling was the most appropriate method for this study since it allowed the researcher to pick participants who were open and free to discuss their HIV status.

3.6 Research Instruments

Focus Group Discussions (FGD) was used to gather the information from the participants. FGD is a qualitative approach used to gain an in-depth understanding of a social issue (Nyumba, Wilson, Derrick & Nibedila, 2018). This approach aims to collect data from a purposively selected group. An interview guide was used to guide the researcher to gather information from participants during the discussion. Probing questions and triangulation were used where need arose. Informal discussions with the respondents were also used as a tool in data collection to build rapport with the participants and also identify the mediating variables. The participants were audio-taped and their responses later transcribed verbatim, coded and analyzed to pick emerging themes. The researcher ensured that all the information collected from the participants was safely recorded and stored to ensure that accurate transcription was done.

3.7 Reliability and Validity of Instruments

According to Creswell (2013), reliability of an instrument is refers to the consistency with which a measuring instrument yields certain results when the entity being measured has not change. To enhance reliability, the researcher carried out a pilot study in a different but similar setting (VCT centre in Kiambu County Level 4 hospital) to ensure that participants in the pilot study did not take part in the final study. A pilot study is a mini-study methodological test carried out to prepare for a main study and its aim is to ensure that the methods or ideas will work in practice (Kim, 2010). The researcher formed two groups for discussion in Kiambu County

Level 4 hospital. The researcher also ensured that the same interview questions used for the pilot study were administered for all participants in the main study to further enhance reliability.

From the pilot study it was established that it was difficult to interview couples as a dyad since the positive partners were feeling intimidated as they answered some questions in the presence of their negative partners. To get good results for the final study, the researcher therefore resolved to put partners in different groups such that no one couple participated in the same group. The partners who were interviewed gave their own individual experiences as well as the couple's experiences. Some male partner did not turn up for the discussions and therefore the researcher replaced them with others provided they were living in a discordant relationship. The pilot study revealed that the couples experienced negative emotions, the negative emotions had negative effects on their marital relationships and couples were using different coping mechanisms to manage their relationships.

The validity of a measurement instrument refers to the extent to which the measurement measures what it is supposed to measure (Mugenda & Mugenda, 2013). Validity is one of the strengths of a qualitative research and it deters the accuracy of the findings from the view-point of the researcher, participant or the reader of the account (Creswell, 2013). The instrument of this study was scrutinized by the researcher's supervisors to judge its appropriateness (content validity) and determine whether the interview guide represented all the areas that need to be investigated. Validity was also enhanced by trustworthiness, authenticity and credibility that the researcher employed.

3.8 Data Collection Procedure

Data collection method is a technique used for gathering data systematically from various sources for a particular purpose, while data collection instrument refers to the device used to collect data (Mugenda & Mugenda, 2013). To undertake this study, the researcher started the process by getting approval from Tangaza University (Research Ethics Committee) to proceed to the field to collect data. The National Commission for Science, Technology and Innovation (NACOSTI) was then approached to give the researcher a permit. NACOSTI is a state corporation established under the Science, Technology and Innovation Act (2013), and its mandate is to regulate and assure quality in the science, technology and innovation section and advise the government in matters thereto. To enable the researcher to freely work within the county public health facilities (for pilot study and the actual study) the County Commissioner and the County Education offices were also consulted for authorization. The researcher then proceeded to Kiambu County Health Programmes office for authorization to interview the HIV discordant couples from the rural part of Kiambu County who regularly attend clinical check-up in the two facilities.

The researcher conducted one FGD per day to ensure that she was not overwhelmed. Three FGDs were conducted. The participants were audio-taped and data was then transcribed verbatim. The participants were assured of confidentiality before the interview was carried out to ensure that they gave information without fear. Since the information required was very personal and sensitive participants were informed about the interview in advance and they were reminded by the VCT

counselor a day before so that they were emotionally and psychologically prepared for the group discussion.

3.9 Data Analysis

The method that was employed in analyze the data was thematic analysis. Thematic analysis is an approach used in qualitative studies to extract meanings and concepts from data and may include pinpointing, examining, and even recording patterns or themes (Tjandra, Osei, Enson & Omar, 2013). According to Guest, McQueen, and Namey (2011), the data may be in any form ranging from transcription of interview, field notes video, pictures or even documents. In the present study the researcher used thematic analysis to organize the data through 3 stages namely; open coding, axial coding and thematic identification.

3.10 Ethical Considerations

The researcher observed all the key components that are required to maintain ethical considerations in research (Kumar, 2014). Prior to embarking on the data collection exercise, the researcher sought permission from the relevant authorities and institutions to carry out the research. These included Tangaza University College Research Ethics Committee, NACOSTI, Kiambu District Commissioner, Kiambu County Education Officer and Kiambu County Health Programmes Officer.

All the participants were informed beforehand to ensure that only willing HIV discordant individuals participated. The researcher ensured that due care was exercised and no respondent were exposed to harm or discomfort during the interview. To protect the participants from emotional and psychological harm, the researcher ensured that at least one of the hospital counsellors was available during and after completion of the group discussion. The participants were also informed that

there was no payment for the information they would give. They were well informed about the procedure. Consent was documented and participants therefore signed consent forms before responding to the data collection tools.

Participant's autonomy was also observed. The respondents were not coerced to give any information and they were encouraged to be real as they responded to the interview questions. Any information that they were not comfortable to give was regarded as personal and the researcher was not judgmental regarding their responses or behaviour during the group discussion.

Participants were guaranteed of total privacy and confidentiality. They were assured that all the information that they gave was to only be used for the study and not shared with any third party. Verbatim transcriptions were coded to ensure that the respondent's names remained private. Confidentiality was upheld all through and the researcher continually reminded the participants about it. All data collected was handled and stored with ultimate confidentiality before and after the research. The audio-tapes were kept in lockable drawers. After the study the information was deleted.

The researcher also promised the Ruiru Sub-district Hospital a copy of the findings of the study once it was compiled. Participants were also promised summarized notes of the findings but the relevant authorities had to be consulted. This gave them excitement to learn that they were to get firsthand information of the study. It also served as motivator to participate in this study.

CHAPTER FOUR

RESULTS AND DISCUSSION

4.1 Introduction

This chapter contains the findings of the study on exploration of discordant couples' challenges and coping mechanisms in rural Kiambu County, Kenya. The results were guided by the objectives and the research questions of the study. The objectives of the study were: to identify the emotional challenges among discordant couples in rural Kiambu County, to establish the effect of the emotional challenge in the marital relationship, to explore the effects of relationship challenges among discordant couples in rural Kiambu County and to establish the coping mechanisms of discordant couples in Kiambu County. The overriding purpose of the study was to establish the challenges and coping mechanisms of discordant couples in rural Kiambu County. After presentation of the demographic data, the rest of the findings are presented according to the study objectives.

4.2 Social-Demographic Characteristics of the Sample

This section of the study presents the characteristics of personal demographics of the individual participants. These characteristics include gender, age of the participants in years, number of the years in marriage, number of years lived since diagnosis of discordance and their level of education.

4.2.1 Gender and HIV Status of the Participants

The sample comprised of both male and female adults living in a discordant marital relationship. There were 30 participants. Out of the 30 participants, 20 were HIV positive and 10 were HIV negative, representing a percentage of 66.67% and

33.33% respectively. Majority of the participants were female (56.67%) while 43.33% of them were males. This may be a pointer that there are more HIV positive women in marital relationships than men. This may be attributed to the biological make-up of females. The distribution is shown in table 4.1.

Table 4.1 Distribution of Participants by Gender and their HIV Status

Gender	Positive	Negative	Percentage
Males	7	6	33.33
Females	13	4	56.67
Total	20	10	100.00

4.2.2 Ages of the Participants in Years

All the participants were asked to give their age in years. Majority of the respondents (46.67%) were aged between 31-40 years while 33.33% of them were aged between 21-30 years and the 20% indicating they were aged between 41-50 years. The youngest participant was 23 years old while the oldest was 48 years old. Majority of the discordant couple is shown to range between 31-40 years (46.67). This is the developmental stage when adults are in their active sexual and reproductive stage. It is also the stage at which people are making choices and life time decisions such as marriage. Those over 40 years were very few, only 6% of the sample. The result of this is shown in table 4.2.

Table 4.2 Ages Distribution of Participants in Years

Age	Frequency	Percentage
21-30	10	33.33
31-40	14	46.67
41-50	6	20.00
Total	30	100.00

4.2.3 Gender and Age Distribution of HIV Status of the Sample

The researcher asked the participants to give their HIV status and gender in order to determine the number of positive males (PM), negative males (NM), positive females (PF) and negative females (NF) in the sample. The number of the positive females was higher (43.33%) than that of males (23.33 %) in every age group. The negative males were more (20%) than females (13.33 %) in the whole sample. This may be explained by such a factor as male circumcision which is a cultural practice and a rite of passage among the people living in the area where the study was undertaken (Baeten, Dunnell, Kapiga, Ronald, Stewart, Inambao, Manoga, Vwalika & Celum, 2010; Warner, Khalil, Newsman, Macaluso, Sulvan, & Emilyu, 2009).The results are as shown in table 4.3.

Table 4.3 HIV Status Distribution by Age and Gender

Age	PM	NM	FP	FN	Total
21-30	3	2	4	1	10
31-40	2	3	6	3	14
41-50	2	1	3	0	6
Total	7	6	13	4	30

4.2.4 Number of Years Lived in Marriage and with Discordance

The researcher asked the participant to give the number of years they had lived in their marriage as well of the number of years since their discordant diagnosis status. Majority of the participants, 33.33% were in young marriages of about 5 year. The number of those who had lived with discordance for 5 years and below were quite high, 23 participants, an equivalent of 76.67%. Those who had lived with discordance for more than 5 years but not more than 15 years were 20% while those who had lived with discordance for more than 15 years were also very few, only 3.33%. This is an indication that new infections are on the rise among heterogeneous couples cohabiting together (Reis & Gir, 2010). This is the stage in marriage when couples are very active in sexual activities. Table 4.4 shows the distribution.

Table 4.4 Number of Years in Marriage and Discordance

Years	Frequency (Marriage)	Frequency (Discordance)
1-5	10	23
6-7	7	3
11-15	5	3
Above 15	8	1
Total	30	30

4.2.5 Level of Education

The participants had different levels of education varying from primary level to graduate level. Out of the 30 participants, 10 were primary school leavers, 12 had a secondary school level, and 6 had college level education while 2 were university graduates.

Table 4.5 Distribution of Education Level

Level of Education	Frequency	Percentage
Primary	10	33.33
Secondary	12	40.00
College	6	20.00
University	2	6.67
Total	30	100.00

4.3 Findings from the Study

Having presented and discussed the demographics of the data, this section consists of presentations of the 4 objectives of the study. The data is presented in the form of themes that emerged to answer the research questions. Each theme has several sub-themes derived from the participants' verbatim expressions. The verbatim expressions are written in quotes. The researcher used initials to identify the gender of the participants and to also enhance confidentiality. These initial are shown at the end of every verbatim expression.

After analyzing the data, four super-ordinate themes emerged based on the four research questions of the study. These themes are: emotional challenges among discordant couples; effects of emotional challenges among discordant couples; effects of relationship challenges among discordant couples and the coping mechanisms of discordant couples in the rural Kiambu County. These themes contained several sub-themes. The themes are further substantiated by parts of participant's verbatim narratives. The initials 'MPP' (male positive partner), 'MNP' (male negative partner), 'FPP' (female positive partner), and 'FNP' (female negative partner) have

been used to indicate the HIV status and gender of the participants. Each major theme and the sub-themes therein are identified and discussed.

4.4 Emotions Experienced by Discordant Couples

The first objective of the present study aimed to establish the emotions experienced by discordant couples in rural Kiambu County. The study found out that majority of discordant couples experience negative emotions. Some participants experienced several negative emotions at the same time. Fear, anxiety, stigma and discrimination, and worry were the feelings that most participants experienced. Denial was mostly experienced by the participants who were newly diagnosed, about one year since diagnosis, while bitterness was commonly experienced by the negative partners in the discordant relationship. Bitterness and anger loneliness were the least experienced emotions. The negative feelings are shown in table 4.6.

Table 4.6 Negative Emotions Experienced by Discordant Couple

Emotion	Frequency	Percentage (%)
Fear	15	50.0
Stress	12	40.0
Anxiety	15	50.0
Denial	10	33.33
Depression	6	20.03
Shock	10	33.33
Self-blame	12	40.0
Guilt	12	40.0
Loneliness	1	3.33
Worry	14	46.66
Bitterness	5	16.66
Anger	5	16.66
Stigma/discrimination	15	50.00
Betrayal	10	33.33
Hatred	11	36.66

Some of the expressions given by participants to point out their feelings are given as recorded verbatim. A male positive partner who said he was overwhelmed by various emotions had this to say;

“I feel stressed and hopeless whenever my wife reminds me about my disease... you see, you brought it home... Then I blame myself...Stigma is the other burden. Yes stigma is life life...yeah. My wife intimidates me whenever I mention about my health issues. She says that I am there to be seen but not to be heard and that sick people should be quiet”. (MPP, 37 years).

Other participants reported that some negative emotions were not experienced in the ordinary way they had known before. For example, hatred was depicted to

manifest in very intense and queer ways. The queer hatred and anger was commonly experienced by the negative partners in the relationships. A female positive partner indicated her experience as;

“My first husband told me many times that he hated me since I got sick. He would then calm down for a month and then start getting angry again... funny and bad anger that I have never seen... yes....I got anxious any time I saw him coming in the evening because I did not know the next thing he would do”(FPP, 33 years).

A female negative reported experiencing hatred towards the husband. She was worried about getting infected and was also in denial since she got diagnosed one year ago.

“I hate him. Yes, I hate him more when he asks for sex and sometimes I don't give him...I get very worried when we have sex... and I still don't believe that he is sick. I feel bad because all along he was pretending to be faithful.”(FNP, 28 years).

4.5 Effects of the Emotional Challenges Experienced by Discordant Couples

The second objective of the study aimed to establish the effects of the emotional challenges among discordant couples. The study established that the negative emotions adversely affect the marital relationships. The resultant effects included; sexual disconnectedness, low libido, suicidal ideations, risky nurturing practices, unhealthy secrecy, use of sex as a weapon to hurt the man and underrating the HIV positive men as the heads of the marital relationship.

“I feel stressed and guilty because my wife is always reminding me of this disease. Nshindwa (I wonder)... what do I do. Kama ilikujailikuja (since it is came, it did) yes...If she say this when we are in bed I'm not able to do sex. I

don't believe it's me who hears all these things it's bad but what do I do. Wanaume tukona shida...yeah... (Men are going through problems, yes...).God is still there". (MPP,42 years).

With regard to sexual performance, (low libido) majority of the participants verbalized how it was affected by their initial struggle with fear of infection. For them death was imminent. This is based on the village myths that being HIV positive is a one way ticket to the grave. One male negative partner reported;

"I wonder where she got it from because I know she is a faithful woman. I can't ask her but I still wonder... I can't believe... These days nashidwa na kuperform (It's hard for me to perform sexually)...mmm..., Its thirteen months since the doctor said she is that way (which way?) she is positive...eeh ... and I fear to be infected but I cannot tell her because she is good. Hii kitu inaleta mambo mengi sana kwa ndoa (this discordance brings a lot of issues in a marriage.)"(MNP, 42 years)

The HIV negative partners who are willing to engage in sex with their HIV positive partners indicated that they sometimes faced the challenge of reduced sexual urge from their partner as indicated by majority of participants in this study. Whereas male positive partners reacted to hatred and/or through abuse and neglect, female partners used sex as their weapon to position themselves in the relationship. They reported that they deliberately denied their male positive partners sex while at the same time irritatingly reminding them of their positive status. This is captured in the expression of one negative female partner.

"I hate him. Yes, I hate him more when he asks for sex and I sometimes don't give him. Because I don't enjoy it any more. Imagine hm..., I dont know...any time he comes near me, I see just AIDS on him and I get very mad... yes...and... I tell him to

take his AIDS wherever he got it from...(Clicks the tongue.)Where did he get it from? I don't know nasitaki kujua...yes sitaki kujua (I don't want to know).''(FNP, 32 years).

Women who are not HIV infected no longer respected their HIV infected male partners. This was shared by men who felt intimidated and that their roles as heads of homes had been ignored or completely dismissed. They indicated how some marital roles were undertaken in very unbecoming manners, making the man feel unappreciated. Others shared how they cannot freely talk about health issues for fear of intimidation by their partners.

“I am reminded every now and then about my mpango (illicit love affair) that made me positive. Our marriage is not the same any more. I don't have interest in sex because I have to plead with her (clicks)...kwani ni chakula? (is it food?). I keep away from sex because I don't want to beg. I also don't perform it well. I lost my power of the say that I had at home. Before the disease, she would never say no to any of my orders, eeh...mwanaume ni sauti lakini,(male authority is seen through voice) hmm...,anyway ... these days she says no to my orders and I keep quiet because there is nothing I can do. I am to blame”. (MPP, 48years).

Another male positive partner recounted how the wife's bitterness made her unmanageable after they were given the discordance diagnosis.

“Akisema la (when she says no), I just sleep..., and eeh, my sexual urge has gone down. She sings the song every other day na niyeye anatawala mimi (she rules over me) many times I eat well, but my sexual urge is just down. I have even lost weight.Those days when she is happy and wants sex, I don't feel like doing it because

eeh ...yes... so I fear because I don't want to miss to satisfy her and... and eeh... aibu (embarrassment).”(MPP, 38 years).

Both male and female partners who were ridiculed and intimidated by their negative partners cited having suicidal ideations on several occasions. They revealed that their reasoning got temporary impairment at some time. They had high anxiety levels that disrupted their optimal working level. Some cited having been treated of depression. There was evident lack of social support which made their experiences worse. One FPP stated:

“Sometimes I of think drinking poison and die because my husband diminishes me because of the disease. Kindly explain what you mean by diminishing. I mean...eeh...madharau (deaminging/contempt). I have gone to hospital and given medicine for depression but he does not care. I think of killing myself but I fear death but...Nasikia (I feel) like I am going mad.”(FPP, 34 years)

Another female positive partner, aged 32 years expressed how she nurses suicidal ideations but holds back because of her children. She imagines how they would suffer in her absence because she is the one responsible for bringing food home while the husband ensures school fees is paid.

“I feel bitter because of the way he treats me, yet he wants to sleep with me. Sometimes I don't eat well and I don't sleep well... I really think much about it.(What is it that you really think of?) Killing myself so that I don't hear his words.”(FPP,32 years).

Although participants talked of suffering from depression, only one was treated of the same. It appears that the others were just referring to depression to mean stress or anxiety.

Besides experiencing stigma and discrimination participants also reported fearing stigma. Due to this fear, some lactating mothers undertook risky nurturing practices. This included breast feeding beyond the prescribed period. (Babies born of HIV positive mothers should only be breast fed exclusively for six months. After the six months they are gradually weaned and breast feeding stops completely when they get to one year). Although one can stop breastfeeding even earlier than one year for various reasons, the researcher learnt that in this rural part of Kiambu, mothers attach a lot of importance to a two-and a- half years breast feeding period. Therefore any shorter period is usually interpreted with the suspicion that the mother could be HIV positive. Several mothers attested having breastfed their babies after one year due to fear of stigma.

“One year after I delivered, some friends came to see me. I knew they would ask me, kwanini haupei motto nyonyo? (Why are you not breastfeeding the baby?) So to avoid this and to hide my status, hm...imagine I breastfed the baby. Ngai undekere (God forgive me). By God’s grace the baby is still negative ..., I just say thank you to God, yes....” (FPP, 38 years).

The fear of stigma also makes couples exercise unhealthy secretive lives. For example some participants shared how they go for clinical check-ups very far away from the health facilities near their homes. This ensures that they do not meet anyone known to them lest their secret leaks. They further reported that they also do not talk about their status even in their matrimonial homes.

“Even at home, we don’t talk about it. Yeah, hmm... it is a secret between the two of us. Even our children do not know about it. I am from Thika mashambani (rural) but I cannot go to the nearest hospital because... I might meet people who know me. I feel safe when I am far and not my nearest hospital. Here no one knows me... yap....” (MPP, 30 years).

4.6 Effects of Relationship Challenges among Discordant Couples

The third objective sought to establish the effects of the relationship challenges that discordant couples experience as they live together as husband and wife. Such challenges included initial difficulties to disclose one’s status to their partner, poor communication, reproduction and domestic violence. These experiences also had their negative effects to the marital relationship of the discordant couples in rural Kiambu County.

Table 4.7 Distribution of the Effects of Relationship Challenges among Discordant Couples

Effect of Relationship Challenges	Frequency	Percentage (%)
Difficulties of Disclosure	27	90
Destructive Silence	12	40
Conception	15	50
Marital rape	18	60
Family Size	12	40

Majority of the participants reported the hard time and uncertainty that they went through after diagnosis. Their greatest problem was how to disclose to their partner and how they would react on receiving such news. Denial also complicated the timeliness of disclosure. A few took just a short time to disclose while majority took

longer. A longer time before disclosure had negative implication of transmission. It heightened the risk of HIV transmission and also made the positive partner avoid sex. The inability to disclose also affected the couples' communication patterns. A 39 years old female partner shared this challenge below to other participants;

“... I was very uncomfortable and I did not know what to do. It was hard. I did not tell my husband and we continued having sex although I avoided it very much hm... yeah...gosh,... I don't even want to remember this... I told him after one year and then I regretted. God... but he was negative when we went to hospital.”(FPP,34 years).

Majority of the participants pointed out that strained communication (silence) was threatening the survival of their relationship. Destructive silence was coming from the negative partners who were feeling betrayed by their positive spouses. The positive partner termed this stigma and discrimination from within the relationship. This destructive silence further brought resentment and self- blame to the positive partner. This was clearly captured in this expression;

“Since he is the one who brought the disease, eeh, I mean... I don't talk to him unless he starts talking to me. And then, my answer is yes or no or sometimes...hm... I keep quiet and I don't care. I had even thought of leaving him lakini (but) I said to myself...gosh, what will I tell people is the reason for leaving yet this whole thing isa secret?” (FPP, 37 years)

Some marital roles were undertaken in a very unbecoming manner making the positive partner feel unappreciated. Others expressed how they could hardly talk about bad health for fear of intimidation from their partners. The expression below was given by a MPP;

“Sometimes food is served without a word. Sometimes I feel like, I... I am... I can't eat it. You eat food but you can't tell where it goes because of ... it's not given well... in a good manner. I am losing weight every month. I need to hear my wife tell me good words when she is serving me... eee as she used to do before... yes. I also need to talk freely when I am not feeling well. Sickness is not only AIDS. We need to talk but I don't know how.”(MPP,36 years).

Discordance affected the couple's reproductive patterns. The participants pointed out that conception patterns as well as intended family sizes were adversely affected.. For those who learnt about discordance when they already had a child or two they were lucky. Majority of participants with such families disclosed that they opted not to bear any more children. They pointed out that there was fear of conception, lest a HIV positive baby was born. According to these participants, it would be an additional burden. Though they were very much aware that they can bear a HIV negative baby by adhering to medical instructions and drug adherence, they said there was always fear of the unknown. One participant had this to say about the dream size his family;

“Imagine now we cannot get other children and I wanted more. How many do you have? “Only two”. How many had you planned to have? “Four or five.” (takes a deep breath). (Are you aware that she can conceive and give birth to a healthy baby?)...Najua, lakini haiwezekani... halafu sitaki mashida nyingi. AIDS yenyewe tayari nishida. (I know, but it is not possible... and then I don't want more problems. AIDS alone already is a problem).”(MNP, 33 years)

Some female positive partners deliberately refused to conceive due to the bitterness that they harboured against their HIV positive partners. They deliberately

avoided conceiving because they sometimes resented their husbands who they considered promiscuous. A good number of this category of participants verbalized how they had invested heavily on trust and marital faithfulness. Initially the size of their families had been agreed through consensus. However, it was clear that after the husband tested positive, the women had an upper hand in determining conception and the size of the family. Below is an expression from one participant;

“We have two children and we had agreed to have 3 so that at least I can name after my mother or my father, yaani, upande ya familia yangu(that is my, family of origin). Now, I can’t”. What would make you not get a third child? “Ninazaa na nani...hai...Wacha nikaena wale niko nao... (With who am I conceiving... let me live with the ones I already have. Its’ very hurting... (Clicks her mouth). I think I foolishly trusted a person who was not trustworthy. Yes I trusted the wrong person.” (FNP, 32 years)

Female positive partners painfully narrated how their HIV negative partners beat and raped them. They also experienced violence whenever there was an attempt to refuse sexual advances made by their positive husbands. Both positive and negative partners pointed out that after diagnosis of discordance, and particularly during the early stages, their partners had adopted an abusive ways (physical and emotional) of handling sexual activities. The female positive participants pointed out that though the abuse waned with time, their husband’s approach was no longer the same.

“My husband sometimes beats me for not a good reason. Mostly he beats me when he wants sex and I refuse. Those first days it was very bad but these days he is better but he still forces me to do sex with him. When I ask him why...he tells me I brought AIDS home and I am no longer sweet like before, na bado analala na mimi

(but he still sleep with me). So I wonder... but I can't ask because I fear to be beaten. We don't agree. (What is it that you do not agree?) Sex. He does sex by force... (clicks) I call it rape."(FPP, 33 years).

Some women also shared of the many times they are forced into sex regardless of their feelings. Some pointed out that since they realized that sex was no longer a mutual agreement as it was before, they no longer enjoyed it. One FPP had this to say;

*"I do not enjoy sex any more but not that it is because I am positive but because my husband does it by force even when I am not prepared. To me, that is rape, yes... he rapes me many times when I refuse or I don't respond... yes it's a problem. And eee ... sometimes he abuses me with bad words, ye...."*FPP, 27 years).

Domestic violence was commonly reported among couples whose level education was low. The violence is meted much on HIV positive women who have no stable income as was narrated by one FPP;

"My husband beat me for no good reason, and many times. I eeh...eeh... yes...eeh...eeh...God. (Kindly use the language that will not give you problems to express yourself). Asante sana (thank very much)... Yes sina otherwise because, sina job na niko na watoto na... (I don't have a job and I have children and)... yes, I don't have a job, left school in form two. Namchukia sana (I hate him very much)."(FPP, 33years).

Another female partner pointed that her husband becomes violent whenever he is financially down.

"When he has no money, he complain a lot that I don't have anything except AIDS. What makes you think its lack of money? Because he says that I am only a

standard eight and he went up to college. It's true; I don't have job or my own money. When money is there he is good. I wish my own money is there..." (FPP, 37 years).

4.7 Coping Mechanisms of Discordant Couples in Kiambu County

This third objective aimed to establish the coping mechanisms that discordant couples use to enable them to address the challenges that they experience. Essentially, the objective sought to establish the different strategies the couples use to enable them to live together with different HIV status. The challenges they address may be emotional or relational, either from within the relationship or from other dimensions outside the relationship. The researcher picked the participants answers that related to help from within the relationship and outside the relationship as discussed in the verbatim quotes hereunder. Their coping mechanisms included communication, abstinence from sex, ARV and PrEP, good use of condoms and couple counselling. PrEP and ARV were strictly adhered to (100%) while condoms (50%) were not as popular. Abstinence and separation (10% and nil respectively) were the least used coping methods. Couples appreciated counselling very well (93.33). Their uses by different participants are shown in table 8 below.

Table 4.8 Distribution of the Various Coping Methods used by Discordant Couples

Method	Frequency	Percentage (%)
PrEP and ARV	30	100
Condoms	9	30
Counselling	28	93.33
Abstinence	3	10
Communication	15	30
Separation	0	0

Discordant couples reported how they rely on clinicians to chart their way forward after diagnosis. They pointed out that health care providers ensure that there is proper follow-up. Beside the clinicians, the participants pointed that the counsellors are also a great source of help. They also shared how clinicians co-work with counsellors to empower them. Continuous support is offered as and when the patients show up in the health facility. The HIV negative participants pointed out that the clinicians are very co-operative in giving them PrEP. A participant expressed his interactions with the health providers at the facility happily as quoted below;

“When I come here, I feel good because I am always told to see the right person. Okay, sometimes I may be delayed but the service I get makes me feel that even if I am positive, there is hope. The counsellors encourage us a lot. The doctors always tell us we are not sick provided we take drugs the way they tell us. This makes me feel very happy and I get hope. I also know that I am not alone.”(MPP,45 years).

A good number of participants shared how counselling had given them continued therapeutic support and new lease of life. This was commonly verbalized by the ones who had lived with discordance for less than five years. Besides counselling from the health facility, they also said that visit to the clinic served as a pressure valve that helped them to release their tension or any unknown experiences. These are days when they meet other persons living as discordant couples. They are able to share their good and bad experiences without fear. Interactions on the clinic days form their only network. The researcher learnt that clinic days provided catharsis and altruism for the participants. Outside the health facility, their situation remained a secret. One participant said

“... I like coming for counselling. When I come for medicines I talk with the others and I also listen to them. You know...eeh, we only talk about it when we come here. I wait for clinic day very much. We advise one another on what we are doing to move on. It helps us a lot, because you feel you are not alone.”(MPP, 28 years)

Counselling was found to help both the positive and negative partners alike. However it seemed to make life better for the negative participants who all along had felt that life had been unfair to them. This is the verbatim expression of one MNP about counselling;

“Counsellors here have helped me a lot through counselling. Hapa nimefika (this far) is because of them. Otherwise I was down and I was seeing life being very unfair to me.”(MNP, 46 years).

The positive participants on the other hand felt counselling was bridging the gap between them and their negative partners who were blaming them. They felt that what they could not verbalize to their partners was very well handled by counselling,

whether they came to the health facility together or individually. Communication was also used as a coping skill and it was largely learnt during counselling and networking sessions at the health facilities. One MPP said;

“Counselling has helped my wife to accept the situation and stay at home otherwise, she wanted to go... it was bad for her at first and she could not listen to me. And then...eeh yes she cooled down after counselling several times here.” She has also agreed we talk because it is the reality” What is real? “Im positive”.(MPP,46years).

Whereas networking and counselling served as psychological social support, the participants verbalized how their ‘physical take home’ interventions were helping them to cope. These included drugs for those who were positive and PrEP for the negative ones as well as condoms. These served as tools or interventions to use away from the medics, counsellors or fellow discordant couples. It was however noted that the drugs and condoms were adhered to differently by various participants

The participants receive from the hospital free condoms and drugs that are related to HIV/AIDS. These are provided as and when they are required by the HIV/AIDS patients. However a closer look at condoms use revealed that they are not strictly used. Majority of the male participants had similar complaint as verbalized by one MNP;

“We use medicine and condoms, though... eeh, condoms ... yeah... it is not very comfortable. I like using PrEP instead of condoms, kwa maana inanifinya sana(because it feels very tight).I don’t use it always when I do sex.”(MNP, 28 years).

A FPP had this to say about her husband and their use of condoms.

“I take my medicine according to what daktari (doctor) said, but my husband, hmm... yeah, my husband use condom but only sometimes. I force him to use because he say that he dislike it, si poa (it’s not good). Ana-complain (he complains) it is tight.”(FPP, 30years).

Some participants, especially those who are Catholics had negative feelings towards condoms. They felt that it was an intervention that was going against their spiritual values and beliefs. Instead of using condoms, the negative ones prefer to use PrEP and encourage their positive partners to adhere to drugs to keep the viral load low. One Catholic MNP said this;

“I hate using the condom. They make me think I am promiscuous. When I have no otherwise I use them but I know they are a sign of immorality... yes, but what do I do and she is positive”. (MNP, 37 years)

Couples have also devised their own coping mechanisms besides what they get from hospital. Majority of the participants pointed out that after struggling with disbelief immediately after diagnosis, prayers and believing in God helped them to cope. Some even recalled that after prayers, the negative emotions would wane for some reasonable time. They therefore devised prayers as their tool to fight negative emotions and also reduced their frequency of whining as was verbalized by one participant;

“I keep praying to God any time I feel bitter. I ask God to give me courage to move on and imagine... it works. In fact, since I started praying, my bitterness and stress is not much. Yes I think prayers help me to cool down even when he abuses me with bad words. Sometimes when his mood is good we pray together”. (FPP, 31 years).

Other participants have learnt to face any opposition by being assertive. They shared how assertiveness had reduced victimization and intimidation from different quotas of their life.

“My husband, when he learnt that I am positive, he ridiculed me many times. Sure I don’t know where it came from... yes I don’t know. He kept saying to me that he was only really sympathizing because I had AIDS. He was always sarcastic to me. Then one day I said enough is enough. I told him to choose between accepting me or kicking me out na nimwachie watoto (and I leave him with the children). From that day he stopped intimidating me.”(FPP, 40 years).

Resilience and time was another resource that participants pointed to have helped them. Spending quality time together was also another resource that participants pointed out to have helped them to cope. It was noted that after the initial shock, some couples decided to put aside their negative reactions and move on. This was common among couples who had children and had lived together for several years. Though it was painful, they managed to bounce back and carry on with life because of the children and societal factors such as church and community expectations. A participant had this to say;

“Time heals. Initially, I did not even want to listen to him apologizing. I felt betrayed and wondered who will take care of the children. As time went by and I continued with counselling taking medicine, PrEP, I started feeling better. Yes the bad feelings went. These days I’m not rude and I even remind him to take his medicine. I also don’t feel bad when I am taking my medicine as I used to feel before ... yeah. I have now overcome.”(FNP, 36 years).

Separation was interpreted as both a relationship challenge and a coping mechanism. However no participant reported having separated in their current marital relationship. On the other hand participants reported that abstinence was not a practical coping method.

“I tried it and never worked so I said to hell. (What is it that you tried?) Abstaining from sexual intercourse. I realized I cannot do it as long as my wife is sleeping next to me though she is positive. So I went to hospital and got PrEP”.
(MNP, 46 years).

Table 4.9 Summary of Themes and Sub-themes that emerged from the data

Objectives	Sub-themes	Themes
Identify emotional challenges experienced by discordant couples	<ul style="list-style-type: none"> • Several emotions experienced at the same time • Emotions more heightened immediately after diagnosis 	✓ Negative emotions
Effects of emotional challenges among discordant couples	<ul style="list-style-type: none"> • Sexual disconnectedness • Low libido • Suicidal ideations • Risky nurturing practices • Unhealthy secrecy • Use of sex to hurt men • Underrating HIV men as family heads 	✓ Negative emotions have negative effects on marital relationship
Explore the effects of relationship challenges among discordant couples	<ul style="list-style-type: none"> • Difficulties of disclosure • Destructive silence • Conception • Family size • Marital rape 	✓ Couples experience challenges that emanate from within the relationship and without of the relationship
Establish coping mechanisms of discordant couples	<ul style="list-style-type: none"> • Condoms • ARV and PrEP • Assertiveness • Counselling • Communication 	✓ Different couples have different coping mechanisms tailor made to suit their situations

4.8 Discussion of Results

The purpose of the present study was to explore the challenges and the coping mechanisms of discordant couples in the rural Kiambu County. More precisely it aimed to establish the challenges of discordant couples that emanate from the individual couples and or from others persons that they interact with. Data in the form of emerging themes have given very insightful contribution in answering the four research questions: What are the emotional challenges that discordant couples in rural Kiambu County experience? What is the effect of the emotional challenges experienced by discordant couples in rural Kiambu County? What is the effect of relationship challenges that discordant couples in rural Kiambu County experience? What are the coping mechanisms of discordant couples in rural Kiambu County?

All of the participants in the study attested that they experience negative emotions. The negative emotions included shock, stress, anxiety, stigma and discrimination, denial, guilt, blame and self-blame bitterness, worry and fear among others. These negative emotions are similar to the study findings of Gitonga, Ballidawa and Ndege (2012), which was carried out with discordant couples attending clinic in a large comprehensive care centre in Eldoret, Kenya. Their study has pointed out that discordant couples struggle with negative emotions. Furthermore, Mudzusi, Lelaka and Sandy (2014), in a similar study carried out in South Africa to explore the experience of discordant couples found out that the couples experienced negative emotions and the immediate emotion is shock followed by other emotions. They attributed this to lack of adequate information after diagnosis of discordancy and what ought to be done to live positively based on the different outcomes of the results. For example, panic and fear affect the HIV negative partner who struggles with

psychological burden and anger associated with betrayal if their partner got the virus from extra marital affairs.

One common challenge is stigma and discrimination. Rispel et al., (2012), offer insight into the experience of stigma and discrimination. In their study that was carried out in Tanzania and South Africa with discordant couples, they found out that stigma and discrimination cut across the African continent and was a great impediment to the couple. Discordant couples only share about their status with medics and their colleagues on clinic days. Cherayi (2013), also found out that many discordant couples did not disclose their status for fear of stigma and discrimination.

Depression is thought to be a common emotional experience among discordant couples. Consistent with previous literature in HIV relationships, HIV positive women tend to have higher levels of depression compared to their male partners (Liu et al., 2016). Moreover, Li et al (2016), in their study that was carried out in rural China to find out gender differences in depressive symptoms among discordant couples, found out that depression is higher among women in discordant relationships. In the present study depression was also linked to poor social support particularly for those females experiencing domestic violence. As was pointed out by He, Xie, Zhou, Zhong, Qin and Ding (2015), in a study carried out in rural china among the neglected old, women are more prone to depression because they are more sensitive to rejection, criticism and separation and these are key factors that contribute to depression. However the researcher found out that though depression was expressed by several female participants, they actually meant that they were sad and anxious.

Stress was found to be more common among women than men. This is in agreement with the findings of Li et al., (2016). They argued that women are more prone to stress than men because they heavily depend on their male partners for their survival and that of their children. Needman and Hill (2013), explained this phenomenon in their study which found that while women develop stress and anxiety disorders in discordant relationships, men externalize the stress through such disorder as aggression and substance abuse.

Blame and guilt emerged clearly from the themes in the presents study. It was commonly pointed out by the positive partners in the relationship. L'Akoa, Noubiap, Fang, Ntone and Kuaban (2013); Lelaka and Sandy (2014); Casale, Wild, Cluver and Kuo (2015), affirm this in their studies with discordant couples. They found out that positive partner in the relationship experience such emotions as guilt and blame than their negative partner. Besides pointing a finger to the positive partner, the participants also shared that the positive partners were also experiencing self-blame. Mudusi and Sandy (2014), affirm this in their study of discordant couples in Soweto, South Africa.

The effects of the negative emotions are quite clear in the present study. The emerging themes from the study suggest that the negative emotions experienced by discordant couples have negative effects on the marital relationships. Several participants in the study have attested that the negative emotions adversely affected their sexual intimacy. Depending on how the partners perceive discordance, it has a big impact on their sexual activities. For example where anxiety, blame, stress, worry and stigma are rampant, men experience poor sexual responses (low libido) and

ultimately lose interest in sex. Tsuma and Wekesa (2012), affirm this in their study carried out in Kenya to explore the challenges of discordant couples.

Due to fear of stigma and discrimination, couples adopt unhealthy secrecy. Mothers also resort to risky nurturing practices. HIV positive mothers confirmed having breastfed their babies after the prescribed period for fear of stigma and discrimination. Discordant couples are given labels and this becomes a major source of stress for them. Gitonga et al., (2012), found out that society and family members looked at the discordant couples as being promiscuous. To avoid stigma, couples keep their status as a secret between themselves. This study established that secrecy is highly maintained by seeking medication far away from home where they are not known (participants from Githunguri and Thika seeking medication from Ruiru yet there are similar services offered in their nearest health facilities). Besides experiencing stigma and discrimination from relatives, friends and society, the researcher established that stigma also comes from the negative partner in the relationship.

Another emerging theme presented in the results section of this study suggests that the discordant couples experience relationship challenges such as reproduction, domestic violence, marital rape and destructive silence and separation among others. These challenges affect the couples negatively. On learning that they are discordant partners' decisions on the family size and woman's the willingness to conceive becomes a challenge. Several female participants attested to their unwillingness to conceive due to risk of infection while other male participants felt that siring forth a child under discordant condition was an extra burden. This was partly due to fear of giving birth to an infected baby. Potter, Cook, Jaramillo, Santis and Jones (2016),

confirmed this perception in their study on exploration of pregnancy planning among HIV discordant couples in America. They further pointed out that conception among discordant couples was based on the couple's level of risk taking. This reasoning emerged commonly from older couples who had other children. For the younger couples they did not have a choice but to risk conception. However none of the participants pointed to having born a baby who was HIV positive. This was attributed to the advanced safe conception methods that are available. This is consistent with the findings of a study carried out in America by Ciaranello and Mathews (2015), which established that HIV risk reduction methods are available for discordant couples, provided both partners strictly adhere to preventive methods suggested by medics.

A few participants reported having contemplated leaving their partners after diagnosis. This was only common among the young discordant couples. Separation was largely reported by the HIV negative participants. Gitonga et al., (2012), working with discordant couples in Kenya also found the same phenomenon. Their study also found out that the strategy is common where the positive partner is the woman. Domestic violence precedes separation. In most cases, domestic violence was meted on the female HIV positive partners who have no income. This is consistent with findings of Hove and Gwanzane (2011), that pointed out that low income or no income was a contributing factor to domestic violence among discordant couples.

However this study found out that, though participants mentioned having contemplated to leave their marriage, none ever left. The researcher also expected to find separation as a relationship challenge as well as a coping mechanism but confirmed from the results of the study that it was neither of the two. Senyonjo and Atenu (2011), also found out that despite all the challenges encountered by discordant

couples, separation rate among them is very low considered to what people think when they compare the risk involved. This was attributed to good and new insights learnt through counselling.

The discordant couples have different coping mechanisms. Different couples have their own way of coping. Among the participants, the condom as an intervention tool was a household name. All participants acknowledged the crucial role that the condom plays in prevention of HIV transmission. A systematic literature review conducted in Greece by Giannou, Tsiara, Nikotopoulos, Talias, Benetou and Kantzonou (2015), also established that discordant couples were aware of the crucial role of the condom in HIV transmission. However it was noted that good use of condoms was only observed during the early days after diagnosis. With time male partners stopped using it complaining that it is uncomfortable, reduces sexual pleasure and others looked at it as an object of immorality. This affirms the findings of a study carried out in Nigeria by Salaudeen, Ojotule, Dorowade, Yusuf and Saka (2015), which pointed out that non-use of the condom was attributed to partner dislike, need to conceive and reduced sexual pleasure. The need to have children and women's inability to negotiate sexual behaviour in a relationship also motivated the inconsistent use of condoms. This observation fits best in the findings of Ngunjiri, Mugo, Celum, Baeten, Morris, Olunga, Olenja, Tamooh, and Bettina (2012), among discordant couples in Kenya.

The young participants used condoms as a preventive device during the early phase after diagnosis. Although condoms are supplied free by the health facilities, they are not strictly adhered to and some participants even demonize their use. Majority of HIV male negative participants who confessed having used the condom

inconsistently reported that they preferred their female partners to adhere to drugs to keep the viral load as low as possible. The low viral load served as a buffer for sex without condoms. This is quite similar to a finding by Tsuma and Wekesa (2014), pointing out that among the discordant couples in Mombasa, there were lapses in the use of condom or just unprotected sex. On a different plane, and commenting on inconsistency of the condom use, the WHO (2012), offers insight by pointing out that even though there could be large numbers of people using condoms, the impact would be limited as long as the persons are not using them consistently. Even with poor use of condoms the younger participants affirmed that there was nothing like abstinence because it hardly worked. This is consistent with the findings of Tsuma and Wekesa (2014).

Condom use was also controversial for the Catholic faithful. They argued that using condoms was a sign of immorality and being promiscuous and inconsistent with their dogma. This coincides with the argument that was put forth by Dempsey (2015), and pointed out that the practice of condom use is morally not acceptable even for married couples. This is because it prevents ejaculation into the vagina, thus depriving the act of its essential ordination to procreate (Dempsey, 2015). Catholics further argued that strict adherence to drugs and prayers would keep the viral load low.

Drug adherence was observed by all the participants. Although a few participants complained that the tablets were too big, none failed to observe the instructions given by medics. Majority of the MNP preferred taking PrEP to using the condom. They pointed out that PrEP (though the tablet is big) was user-friendly compared to the condom which needed preparation to use and then reduce sexual pleasure. This

contradicts the findings of Wilton (2015), where he argues that PrEP only provides partial protection and therefore should not be used to replace the condom.

Participants praised the contribution of counselling in positioning them in their relationships and in the society. They also pointed out that continuous counselling during the early phases after diagnosis saved very many marriages from disintegrating. Through counselling, many positive participants were convinced to disclose their status to their negative partners. This in turn encouraged them to go for testing as a duo. This affirmed the findings of Ngilangwa et al., (2015), in Tanzania which found out that couple counselling enhances good co-existence, couple testing, healthy disclosures and reduces misunderstanding among discordant couples

Networking with other discordant couples was coined in health facilities during group counselling and sensitization days during the early days after diagnosis. The clinic days discussions provided catharsis and helped them to become altruistic, but only within the hospital premises. Whereas networking serves as a pressure valve to ease fears among the participants, they said religion helps them to tone down their negative emotions. Religious practices such as prayers and regularly attending church every Sunday enables them to gain control over the discordant situation.

Good communication is the vehicle that propels most relationships. Only a few participants reported having good communication after diagnosis. A good number of participants verbalized that communication with their partners was wanting. They described silence as a salient feature of their communication patterns. Poor communication is attributed to bitterness emanating from the negative partner and poor understanding of discordance. Those with poor communication were using condoms, PrEP and ARVs without discussing about them. This is contrary to what

Rispel (2011), commented in his study that discordant couples should have dialogue involving around information, condoms, sexual risks and intimacy. However for couples who embraced an open communication policy, they were coping better. Rispel (2012), reported a similar observation in his study with discordant couples which found that good communication in Tanzania was key to their health.

Several participants pointed out that time had defined and enabled them to identify their own resources for coping with discordancy situation which they deemed as irreversible. This was a high breed of what they had learnt from the hospital and their own experiences. For example after overcoming the initial shock, those with intimidating partners developed self-efficacy and became assertive. This brought down the negative feelings and relationship challenges such as domestic violence. This study also found out that after overcoming the initial shock, denial and bitterness, women gave more support to their partners regardless of their HIV status.

The FNPs pointed out that they had learnt to negotiate sexual activities with their males whenever they refused to use condoms. FPPs also insisted on the consistent use of condom even when they were sure that the viral load is low. Those females who managed to execute the approach of assertiveness verbalized that life had become easier for them as a couple This coincides with the findings Schmid, Leonard, Amandas and Gwadz (2015), among black emerging adults in Latin America which found that couples with good assertiveness have good interpersonal skills that enable them to make good decisions in a relationship. Wilton (2014), also contributed to this approach by citing that couples' own experiences help them to make safer sex decisions and provide partner support to reduce the risk of transmission.

CHAPTER FIVE

SUMMARY, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This chapter contains a summary of the findings, conclusions and recommendations of the study on exploration of discordant couple challenges and coping mechanisms in rural Kiambu County, Kenya. The chapter begins with the presentation of the summary of the findings that were presented and discussed in the last chapter and the conclusions made there in. It ends with the presentation of the recommendations arising from the study wherein there are suggestions for further research.

5.2 Summary of the Findings

The findings of the study are summarized as follows. Under demographics, the researcher found that there were more HIV positive females than males in the discordant relationships. In terms of age, majority of the discordant couples were aged between 31-40 years (46.67%) followed by those between 21-30 (33.33%) and the rest were aged between 41-50 years (20%). This indicates that majority of the discordant couples are in their active sexual and reproductive stage (young adulthood). This is also the most productive age when adults engage in workforce and active parenting. The discordant couples who had lived together for not more than five years were many (33.33%) and they formed the larger population of discordant couples (76.67%). This is a pointer that new infections are on the rise in young marriages of heterogeneous couples cohabiting together. Discordance is higher (73.33% among those with lower levels of education (primary and secondary) than those who had higher levels (college and university) constituting 26.67%.

The various negative emotions experienced by the couples affected both partners regardless of their status. The commonest emotions reported by the couple included shock after diagnosis, fear, anxiety, stress and stigma and discrimination. Whereas men reacted to physical abuse in the relationship, women resorted to verbal and emotional abuse towards the men. Very few couples were free to disclose their status to any third party except the medics and their discordant colleagues on the days they attend clinics. Secrecy was adopted and maintained through non-disclosures and visiting health facilities that are far from home.

Discordance affects such area as reproduction and peaceful co-existence of couples in a relationship. This was clear in couples who reported to having been beaten after diagnosis. Family sizes and reproduction were also affected by the discordant status. Although HIV female partners were willing to conceive, their negative spouses considered conception to be a risky undertaking and an extra burden in the family. On the other hand the negative female partners refused to conceive because they felt betrayed by their spouses and they resented them. Couples who learnt of their discordant status some- time after having children chose not to bear any more. Domestic violence, marital rape and destructive silence are common relationship challenges among discordant couples.

Different couples have adopted different methods to cope with discordance. Counselling is the only coping mechanism that the couples appreciated without criticism. They complained about the size of condoms as well as the size of the tablets they take every day. Abstinence was dismissed as a coping mechanism that rarely works among the young couples. Although communication is a well-known strategy of coping with most marital differences, majority of the participants attested to be

poor in communication. Silence was adopted in the early days immediately after diagnosis.

After the initial shock, women supported their spouses better than men. Women take the bother to remind their partners to take drugs. However during the early stages they were more overwhelmed than men. Regardless of their status women also verbalize their feelings more than men. They also are good at devising their own coping skills than men. For example they resort to prayers and more networks, and also learn to be assertive to reduce abuse from their male partners.

5.3 Conclusions

Conclusions were drawn based on the four objectives of the present study.

- 1) The emotional challenges experienced by discordant couples include, stress, shock, fear of infection, stigma and discrimination, anxiety, denial, hatred, betrayal, depression, intimidation, self-blame, guilt, worry, emptiness, loneliness, bitterness, rejection and anger among others. Some discordant couples experience more than one negative emotion at the same time. After diagnosis, shock was found to be the most common emotion experienced followed by denial. Different individuals experience the emotions in different ways.
- 2) The negative emotions have different effects on the marital relationships. The effects include decreased interest in sex, low libido, poor communication suicidal ideations, risky nurturing behaviour, unhealthy secrecy, use of sex as a weapon to hurt men and underrating HIV positive men as heads of the marital relationship. Different negative emotions have different effects on the

couples and the ability of the individual to cope with these emotions determines the survival of the relationship.

- 3) Discordant couples experience relationship challenges which also affect their relationship. The challenges include domestic violence, reproduction and separation/ divorce. These challenges affect the marital relationship in such ways as difficulties of HIV disclosures by the positive partner, destructive silence, reproduction (family size and willingness to conceive), marital rape and domestic violence (physical or emotional).
- 4) Different couples have different coping mechanisms of addressing discordance. Majority of the couples depend coping interventions provided by the government through health facilities. They include ART, PrEP, condoms and free couple counselling. The condom is not strictly adhered to among the discordant couples. Separation is not a common coping skill. Couples who have lived together and have children rarely separate or divorce due to discordance. Couples also invent their own ways of managing their discordance through good communication, networking with other discordant couple and improving their interpersonal skills. Religion also serves as a coping mechanism through belief in supernatural power.

5.4 Recommendations

From the findings of this study, there are several recommendations made based on the research objectives and for further research.

- 1) For the negative emotions experienced by discordant couples, more couple counselling needs to be carried out to encourage them to appreciate their situation. Such interventions as psycho-education and self-awareness should

be paramount for the couples to understand themselves. Trained counsellors (including myself) need to initiate monthly or quarterly open day forums specifically for discordant couples to enable them to understand, appreciate and manage the negative emotions.

- 2) The effects of these negative emotions can be addressed through healthy disclosures with the help of counsellors and community workers. Therefore the County and National governments should increase funding in order to hire more counsellors to co-work with social workers in health facilities. The discordant couples need to enhance their communication and good networking with other discordant couples where they share their experiences.
- 3) The effects of relationship challenges like domestic violence and reproduction may be addressed through dialogue between couples. NASCOP needs train more counsellors, social workers and HTC's in order to enhance door to door campaigns to sensitize the rural residents that discordance should not affect a couple's desire to have a child. Couples should also be encouraged to learn more on discordance to avoid feeling intimidated. Non-Governmental Organizations (NGOs) are encouraged to sensitize and also help discordant couples to join or form support groups where the couples should meet and share their experiences.
- 4) The coping mechanisms which different couples use should be agreed by both partners in the relationship. Vulnerable partners may also be trained by counsellors to improve their individual coping skills such as assertiveness and self -efficacy in order to be flexible and ultimately enhance their ability to meet the unreasonable demands that arise from discordance. Apart from what is commonly provided in hospitals, couple- tailor made coping mechanisms

should be encouraged through counselling. Policy makers such as government agencies and NGOs should work closely with the discordant couples to identify their changing demands and address them accordingly.

- 5) A quantitative study on the same topic is recommended in the future. A quantitative study will involve more respondents and a wider study area and therefore the findings can form better generalization. This however does not disqualify this qualitative study and the results therein. A quantitative study will only form a comparative base for this study.

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APPENDICES

Appendix A: Interview Guide for the discordant participants

These questions formed the interview guide that the researcher used to collect data from the discordant couples.

1. How old are you?
2. How long have you been married?
3. How long have you lived with the discordant status?
4. Would you mind sharing the emotions that you experience due to your discordant status?
5. How do the emotions affect your marital relationship?
6. Would you mind sharing the relationship challenges that you experience due to your discordant status?
7. How do the relationship challenges affect your marital relationship?
8. How do you manage/cope with these feelings and relationship challenges individually and/or as a couple?

Appendix B: Sample of the transcribed verbatim narrations from participants

How old are you?

I am 36 years

How long have you been married?

Who, me... I have for 16 years there

How long have you lived with the discordant status?

Eeh...one year (clicks) yes....

Would you mind sharing the feelings that you experience due to your discordant status?

I hate myself and I am bitter to know that he is positive. Siwezi amini, I always trusted him...Im bitter... yes, now I cannot... I feel cheated and I am stressed.

How do these emotions affect your marital relationship?

I hate him. Yes, I hate him more when he asks for sex and I don't give him. Because I don't enjoy it any more. Imagine hm..., I don't know...any time he comes near me, I see just AIDS on him and I get very mad... yes...and... I tell him to take his AIDS wherever he got it from... (Clicks the tongue.)Where did he get it from? I don't know na sitaki kujua...yes sitaki kujua (I don't want to know).

Would you mind sharing the relationship challenges you experience due to your discordant status?

We have two children and we had agreed to have 3 so that at least I can name after my mother or my father, yaani, upande ya familia yangu (that is my, family of origin). Now, I can't. What would make you not get a third child? Ninazaa na nani...hai...Wacha nikaena wale niko nao... (With who am I conceiving... let melive with the ones I already have. Its' very hurting...(Clicks her mouth). I think I foolishly trusted a person who was not trustworthy. Yes I trusted the wrong person.

I had even thought of divorce but nikasema since hii ni siri yetu na hakuna mtu anajua, nitasema nimemwcha kwanini? Anyway niko na machungu because all along I could not suspect him. He pretends to be a very good Christian.

How do you manage/cope with these feelings and relationship challenges?

He uses condoms and drugs. I have also accepted to take PrEP. I have just picked them from the nurse yes... I keep praying to God to give me courage to bring up my children and eehh, ...yeah, Otherwise I don't know...

Appendix C: Participants Consent Form

RESEARCH CONSENT FORM FOR PARTICIPANTS

Title of the research project: Exploration of Discordant Couples Challenges and Coping Mechanisms: A case of Rural Kiambu County
Brief outline of project, including its purpose and the activities of the participants: To establish the challenges that discordant couples experience and the coping mechanisms adopted in the rural Kiambu County.
Name of researcher: Mary Wanjiku Gacheru
Position of the researcher: MA Student
Contact address of researcher: P. O. Box 67179-00200 Nairobi Phone: +254 722-610-162
Contact of the college: Tangaza University College, P. O. Box 15055 Langata South Rd, Nairobi, Kenya.
Signed by researcher.....
Date.....
<p style="text-align: center;">Statement to be signed by the participant:</p> <ul style="list-style-type: none">• I confirm that the organizer has explained fully the nature of the project and the range of activities which I will be asked to undertake. I confirm that I have had an adequate opportunity to ask questions about this project.• I understand that my participation is voluntary and that I may withdraw at any time during the project without having to give a reason• I agree to take part in the project. <p>Signature.....</p> <p>Date.....</p>

Appendix D: Tangaza Post Graduate Research Approval Document



TANGAZA UNIVERSITY COLLEGE

The Catholic University of Eastern Africa

DIRECTORATE OF POSTGRADUATE STUDIES & RESEARCH

E-mail: dir.pgsr@tangaza.ac.ke Website: www.tangaza.ac.ke

OUR Ref: DPGSR/ERC/No.004/06/2018

Date: 4th June 2018

Mary Wanjiku Gacheru
Reg. No. 16/00481
Institute of Youth Studies
Tangaza University College

Dear Ms. Gacheru,

RE: Exploration of discordant couples challenges and coping mechanisms: A case of rural Kiambu County, Kenya

Reference is made to your request dated 29th May 2018 for ethical approval of your thesis proposal research tools by Tangaza University Ethics Review Committee.

We are pleased to inform you that your proposal and the research tools have gone through the ethical review committee as requested and the approval has been granted. In line with Tangaza University College Research policy, you will be required to submit a copy of the final research findings to the Director of Research for records.

Before proceeding to the next stage, ensure that all the comments that were made regarding your research tool have been addressed to the satisfaction of your supervisors. Note that it is an offence to proceed without addressing the concerns of the Ethics Review Committee.

This approval is valid for one year from 4th June 2018.

This approval does not exempt you from obtaining a research permit from the National Commission for Science, Technology and Innovation (NACOSTI).

Yours sincerely,

Daniel M. Kitonga (Ph.D)
Director, Post-Graduate Studies & Research

TANGAZA COLLEGE

The Catholic University of Eastern Africa

P.O. Box 15055 - 00509 NAIROBI KENYA

Tel: 020 8067667 Fax: 8890018

E-mail: inquiries@tangaza.org

CC:

Ms. Lucy Njiru –Programme Leader, MA in Counseling Psychology

Appendix E: Tangaza Introduction Letter to NACOSTI



TANGAZA UNIVERSITY COLLEGE

The Catholic University of Eastern Africa

DIRECTORATE OF POSTGRADUATE STUDIES & RESEARCH

E-mail: dir.pgsr@tangaza.ac.ke Website: www.tangaza.ac.ke

OUR Ref: DPGSR/ERC/No.003/06/2018

Date: 4th June 2018

To The Commission Secretary,
National Council for Science, Technology and Innovation
P.O. Box 30623,
Nairobi – Kenya.

Dear Sir/Madam,

Re: Research Permit for Mary Wanjiku Gacheru

This is to confirm to you that the person named above is a student at Tangaza University College (TUC). She is registered in the Institute of Youth Studies (Reg. No 16/00481) and she is pursuing a degree in Master of Art in Counseling Psychology.

Gacheru has met all our provisional academic requirements leading to data collection. However, she cannot proceed to the field before she gets a Research Permit from the National Council of Science, Technology and Innovation (NACOSTI). Kindly assist her to process the permit for the same purpose.

Thanking you in advance for your cooperation

Yours sincerely,

TANGAZA COLLEGE

The Catholic University of Eastern Africa
P.O. Box 15055 - 00509 NAIROBI KENYA
Tel: 020 8057667 Fax: 8890018
E-mail: inquiries@tangaza.org

Daniel M. Kitonga (Ph.D)
Director, Post-Graduate Studies & Research

CC:

Ms. Lucy Njiru –Programme Leader, MA in Counseling Psychology

Appendix F: Research Authorization: NACOSTI



NATIONAL COMMISSION FOR SCIENCE,
TECHNOLOGY AND INNOVATION

Telephone: +254-20-2213471,
2241349, 3310571, 2219420
Fax: +254-20-318245, 318249
Email: dg@nacosti.go.ke
Website: www.nacosti.go.ke
When replying please quote

NACOSTI, Upper Kabete
Off Waiyaki Way
P.O. Box 30623-00100
NAIROBI-KENYA

Ref No. NACOSTI/P/18/78026/23226

COUNTY DIRECTOR OF EDUCATION
KIAMBU COUNTY
P.O. Box 2300-00900
KIAMBU

Date: 13th June, 2018

Mary Wanjiku Gacheru
Tangaza University College
P.O. Box 15055-0509
NAIROBI.

RE: RESEARCH AUTHORIZATION

Following your application for authority to carry out research on "*Exploration of discordant couples challenges and coping mechanisms: A case of Rural Kiambu County, Kenya*," I am pleased to inform you that you have been authorized to undertake research in **Kiambu County** for the period ending **11th June, 2019**.

You are advised to report to the **County Commissioner and the County Director of Education, Kiambu County** before embarking on the research project.

Kindly note that, as an applicant who has been licensed under the Science, Technology and Innovation Act, 2013 to conduct research in Kenya, you shall deposit a copy of the final research report to the Commission within **one year** of completion. The soft copy of the same should be submitted through the Online Research Information System.


DR. STEPHEN K. KIBIRU, PhD.
FOR: DIRECTOR-GENERAL/CEO

Copy to:

The County Commissioner
Kiambu County.

The County Director of Education
Kiambu County.

Appendix G: Kiambu County Research Authorization

G

OFFICE OF THE PRESIDENT
MINISTRY OF INTERIOR AND CO-ORDINATION OF NATIONAL GOVERNMENT
COUNTY COMMISSIONER, KIAMBU

Telephone: 066-2022709
Fax: 066-2022644
E-mail: countycommkiambu@yahoo.com
When replying please quote



County Commissioner
Kiambu County
P.O. Box 32-00900
KIAMBU

Ref. No: ED.12 (A)/1/VOL I/146

18th June, 2018

✓ Mary Wanjiku Gacheru
Tangaza University College
P.O. Box 15055 0509
NAIROBI

RE: RESEARCH AUTHORIZATION

Reference is made to National Commission for Science, Technology and Innovation letter Ref No. NACOSTI/P/18/78026/23226 of 13th June, 2018.

You have been authorized to conduct research on "*Exploration of discordant couples challenges and coping mechanisms: A case of Rural Kiambu County, Kenya*". The data collection will be carried out in *Kiambu County* for a period ending 11th June, 2019.

You are requested to share your findings with the County Education Office upon completion of your research.

FESTUS KIMEU
FOR: COUNTY COMMISSIONER
KIAMBU COUNTY

Cc County Director of Education
KIAMBU COUNTY

National Commission for Science, Technology and Innovation
P.O. Box 30623-00100
NAIROBI

All Deputy County Commissioner (For information and record purposes)
KIAMBU COUNTY

Appendix H: Kiambu County Health Research Authorization: (CHRDU)

KI
COUNTY GOVERNMENT OF KIAMBU
DEPARTMENT OF HEALTH SERVICES

All correspondence should be addressed to
HEAD HRDU - HEALTH DEPARTMENT
Email address: mdiritu@gmail.com
mkwasa@live.com
Mobile: 0721641516
0721974633



HEALTH RESEARCH AND DEVELOPMENT
UNIT
P. O. BOX 2344 - 00900
KIAMBU

Ref. No: KIAMBU/HRDU/AUTHO/2018/06/27/Gacheru MW
Date: 27 Jun 2018

TO WHOM IT MAY CONCERN,

RE: CLEARANCE TO CONDUCT RESEARCH IN KIAMBU COUNTY

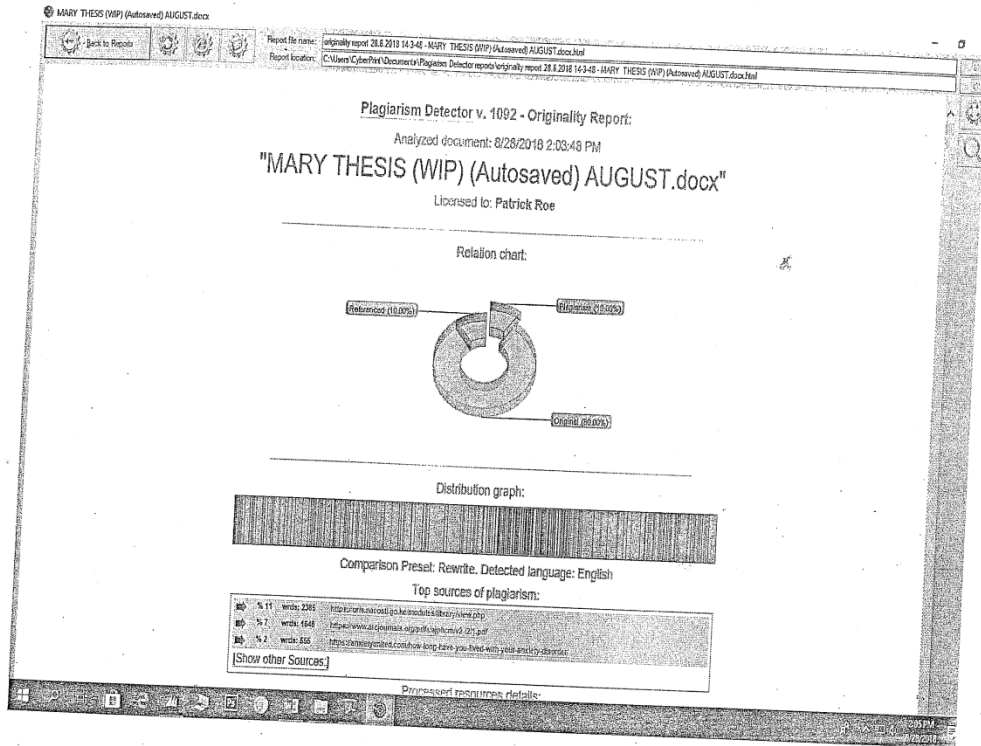
Kindly note that we have received a request by **Ms. Mary Wanjiku Gacheru** of **Tangaza University College** to carry out research in Kiambu County, the research topic being on **"Exploration Of Discordant Couples Challenges And Coping Mechanisms: A Case Of Rural Kiambu County, Kenya"**.

We have duly inspected her documents and found that she has been cleared by **National Commission Of Science And Technology** until **11 Jun 2019**. She thus does not need any further clearance with another regulatory body in order to conduct research within the county of Kiambu.

However, it is incumbent upon the facility in which the research is being carried out to ensure that they are conversant with the remit of the study and operate in line with their institutional norms on conducting research. This note also accords her the duty to provide feedback on her research to the county at the conclusion of her research.

DR. M. NDIRITU NDIRANGU
COUNTY HEALTH RESEARCH DEVELOPMENT UNIT
KIAMBU COUNTY

Appendix I: Plagiarism Check Document



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