A Grounded Theory Study of How Muslim Wives Adapt to Their Relationships with Husbands Who Are HIV-Positive

Agnes Yeni L.N., Praneed Songwathana, Pajongsil Perngmark

Abstract: Staying in marital relationships with husbands who are HIV-positive is a challenge for wives, especially in the Muslim context. The purpose of this study was to explore how Muslim wives managed to maintain their HIV-negative status and marital life with their husbands being HIV-positive. A grounded theory approach was conducted using in-depth interviews of 15 married women who were known to be HIV-negative and were recruited from voluntary counselling and testing clinics, local non-governmental organizations and peer group leaders from five towns in East Java Province, Indonesia. Each interview was conducted in places that were mutually chosen by both participants and the researcher. Transcription of interviews, analysis and interpretation were undertaken simultaneously using a constant comparative analysis.

The findings revealed that "Sharing control in maintaining marital relationship and HIV sero-negative status" was the core category. Three themes were identified as Muslim wives' strategies to be with their husbands who were HIV-positive: 1) Learning to maintain the difference of their HIV status, 2) Adjusting to married life without fear, and 3) Managing daily risk for sexual safety under contract. These findings point to the importance of married life relationship and the choice-making skill to be safe from HIV infection when facing dilemmas. The findings can promote the understanding of the wives' protective and safe ways of living with husbands who are HIV-positive. They can be used to guide nurses at clinics and family nurse practitioners in the counseling of married Muslim wives under the context of HIV prevention in married life.

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Introduction

The current data evidences that around 36.7 million people are living with HIV/AIDS throughout the world.[1] There is an increasing proportion of women among new HIV infections among the group 15 years and older; currently almost 43% are women.[1] In Indonesia, the Ministry of Health (MoH) reports that new HIV infections have been increasing since 2011, and the proportion of women living with HIV/AIDS in particular, has escalated to 63.5% in 2017, up from 9,265 cases in 2011.[2] In addition, 40.5% of the total cases of HIV positive women are married women in a monogamous relationship.[2] The data provide

evidence that HIV has spread to women through sexual transmission in the general population.

Since 2008, the Indonesian National AIDS Commission has launched a comprehensive program called Pencegahan Melalui Transmisi Seksual (PMTS) or HIV-AIDS prevention program through sexual transmission in order to prevent HIV transmission through sexual intercourse.[3] The program has emphasized condom promotion and provision of STI treatment services for members of the key population. In the general population, the ABC propaganda – Abstinence, Be faithful, Condoms use – has become the famed AIDS prevention strategy. This method focuses on the route of HIV transmission through sexual intercourse and has proven to be successful in generalized epidemics. Uganda, for example, provides the perfect case study of a successful ABC approach which showed the decline of HIV transmission to women.[4] In addition, couples-based intervention is recommended to reduce transmission risk among serodiscordant couples[5], particularly for married women.

Several studies show that sexual negotiation takes on another important part of condom use.[6,7] A woman's ability to engage in sexual negotiation within marriage or a long-term partnership should be enhanced by social structural factors, such as education, self-efficacy, and knowing their HIV status; also the length of marital relationship has a significant influence on sexual negotiation.[6,7] The ability of sexual negotiation lets married women communicate about safe sex, initiate safe sex, offer methods of barrier and refuse unprotected sex with their husband.[8] Further, sexual negotiation may also describe how women in serodiscordant relationships play an active role in managing their HIV-negative status.[9] However, there are some barriers of HIV/AIDS prevention behavior in people living with HIV serodiscordant couples. Ridwan et al.[10] define that resistant serodiscordant couples using condoms use fear being labeled as mandul (infertile) couples, desire to have children, and feel that real sex without barrier (condom) is more convenient than using a condom. There is a lack of studies about how women with HIV-negative status manage their sexual life within marital relationships in a Muslim context.

Literature review

In the area of HIV/AIDS, the term serodiscordant relationship usually refers to a couple who engages in a relationship in which one partner is HIV-positive and the other HIV-negative.[11] Although HIV testing is available, the majority of serodiscordant couple in long-term relationships are unaware either of their own HIV status or their partners.[11] In addition, HIV prevention among serodiscordant couples is different from the prevention needs of individual or people in casual relationships since condom use may not exist or not be practical.

Condom use often poses a challenge in sexual life of serodiscordant couples as they feel the use of condoms during any sexual intimacy with their spouses as overburdening and alien. In addition, sexual negotiation plays an important part among serodiscordant couples. Some potential factors related to sexual negotiation and condom use within non-Muslim community include education, length of marital relationship, economic dependency, gender roles and reproductive desire[8,9]. However, the method seems to lie in the needs and rights of the uninfected women, which has not been explored in Muslim married women.

After living with discordance over a considerable period, couples reported having come to a compromise in regard to sexual matters, and felt that something was amiss.[12] Islamic and Javanese values might also play a role in their decisions. In Islam, marriage is a religious task and is consequently a moral safeguard because families are established through marriage.[13] Therefore, while divorce is allowed in Islam, it is most hated by Allah.[13] Furthermore, there is a stigma attached to being a widow (*janda mati*) or divorcee (*janda cerai*) in Indonesia society. Society has

stigmatized a *janda* (a widow or divorcee) as an immoral woman, and it is hard for such a person to hold herself as a respectable woman.[14] Religious values and the stigma of being a *janda* along with other conditions make Muslim wives stay in their marriage.

Indonesian married women have been influenced by Islam as the majority religion and local culture to perform their role as a good housewife.[15] They are expected to be polite and trust their partner, and in this context, can be interpreted as not using condoms in their sexual activities.[15,16] These barriers are challenges for Muslim wives, particularly for those who want to keep their HIV-negative status and continue sexual life after the husband's HIV-positive diagnosis. Yet, some Muslim wives who overcome barriers can successfully maintain their HIV-negative status and their marital relationship and sexual life. Since most literature has focused more on the barriers and influencing factors of condom use for HIV prevention, the process of becoming successful in HIV prevention among Muslim wives is necessary.

Study Aim

This study aimed to describe managing process of Muslim wives to maintain their HIV-negative status and married life after knowing husband's HIV-positive status.

Methods

In this study, grounded theory method was used to generate theory related to the managing process in the perception, action, and interaction of Muslim wives to be safe from HIV infection. Grounded theory offers a practical means for scholars and participants to create a new and emic perspective.[17] A constructivist approach to grounded theory inquiry provides guidance to explore basic social process of Muslim wives who manage their sexual life with an HIV-positive husband. Applying the constructivist grounded theory method also allows the researcher concentrate attention on the core of social process that may happen in a certain background[17,18], which might not be instantly noticeable, yet appears later as the data is analyzed and theorizing takes place. The Muslim wives' responses to HIV prevention in marriage life were collected within their social context, interpretation was derived from the data, and concepts, categories and theory were formulated and refined based on analysis of data.

Setting

The study was conducted in East Java Province, Indonesia, where Islam is the predominant religion and Javanese are the largest ethnic group. In 2017, East Java Province had the second highest concentration of HIV/AIDS cases in Indonesia with 50,057 cases.[19] Of the 38,102 HIV/AIDS cases involved in the CST (Care, Support and Treatment) program, 38.3% were women.[19] Housewives are the highest group of women who got HIV/AIDS from their husbands. However, the low number of records of women who were HIV-negative was partly due to less monitoring. The field research was conducted in four towns where the CST program was available and the locations were near to each other and had similar characteristics in terms of ethnicity, types of women's social activities, and socio-economic condition.

Study Participants

Muslim women were the prime focus of this study, due to the fear that if men were included the women would lose their voices. Learning from the women was also expected about any successful HIV prevention. The study initially used purposive and snowball sampling approaches to recruit 15 married Muslim wives with known HIV-negative status. Snowball sampling is a form of purposive sampling that is applied with isolated or hidden populations whose members are not likely to be located and cooperate without referral from others.[17] All eligible participants were selected from those who met the inclusion criteria: being a wife of a husband with HIV-positive status (based on the non-government

(NGO)/ voluntary counselling and testing (VCT) clinic reports), having been married at least one year, and having known of HIV-negative status by a history of their two most recent HIV tests. Muslim wives who participated in the study were both difficult to find and somewhat of a hidden population in the community. The researcher relied on the VCT clinic staff and NGO leaders/members who introduced the potential eligible participants. A further five participants were recruited later by convenience sampling to allow for data saturation. This study took over 15 months between April 2016 and July 2017.

Ethical Considerations

Permission to conduct the study was obtained from the Institutional Review Board Committee, Faculty of Nursing, Prince of Songkla University, #MOE 0521.1.05/2148. Official permission also was obtained from all four health authorities in located towns. The participants were informed about the purpose and nature of the study, their rights and potential risks of the study. All information was delivered orally and through information sheets. Oral information was provided in two languages, Javanese (local language in the study setting) and Bahasa Indonesia (national language), while an information sheet was provided in Bahasa Indonesian to ensure that the participants clearly understood the study. In addition, a crucial issue arose in the context of joining the study was that participants must be allowed by husbands to join. At this point, it was accepted by the Muslim culture that wives must seek permission from husbands when they wish to participate in any activities outside their home. They were assured that their personal data would be kept confidential and their anonymity strictly protected with pseudonyms throughout this study.

Data collection

Data were collected via in-depth interview, observation and field notes. An inteview guideline with open-ended questions in the local language was used. Each participant was interviewed at least twice, mostly at home. A few were interviewed at the VCT clinics invited by the NGO leaders/staff. Examples of questions included: "Could you tell me about how you perceive or learn to live with your husband after knowing his HIV status?" and "Please share your strategies to be safe from HIV, what, when and how you do for HIV prevention?". The questions were not necessarily asked in the same sequence with each participant. Probing questions were used to explore in depth and to link with sexual life and marital relations. Each interview was about 60 minutes in duration and recorded using a digital recorder. Each participant was interviewed at least twice to clarify and validate some points from the previous interview. All interactions and behaviors observed during interview were also recorded in the field notes. Data were transcribed verbatim in Indonesian language. Data collection and data analysis proceeded simultaneously until data was saturated and no new information emerged with the last question "Do you have any information or story to share but remains untold or forgotten, please?"

Data analysis

Data were analyzed following the guideline of constructivist grounded theory[17,18] which advocates an eight-stage process of initial coding, focusing coding, theoretical coding, early memo writing, advance memo writing, theoretical sampling, saturation and ordering memos. In the initial coding, line-by-line coding was applied for all the transcripts. All of the codes were written down in a separate electronic worksheet to develop preliminary categories. Throughout focus coding, the researcher examined overall words that were used by the participants to explain their feelings and experiences, perceptions and meanings. In this process, memo writing was performed and all codes from the initial coding were reviewed and grouped with similar codes, and put together into preliminary sub-categories. To unite the grounded theory, one core category was determined that integrated and linked all categories.

Trustworthiness

Trustworthiness and rigor in this study was established by using the criteria of Lincoln and Guba.[20] For increasing confirmability, data audits from the personal interviews and observations, member checking and peer review were used. The participants' words and phrases were used as quotes to confirm the findings. Credibility in grounded theory research is important; peer debriefing among researchers during data collection and analysis was used. Dependability was also assured by providing a detailed memo prior to the beginning, during the planning stages, during the discussion sessions, after each session. A thick description related to audit trail was presented as well as the rich narratives and thick descriptions of context and participants and clearly stating the purpose of the study to ensure transferability. In addition, the researchers confirmed and captured rich descriptions from different sources at various times. To ensure trustworthiness, all processes of data analysis were discussed throughout the study with thesis advisors, and the dissertation committee provided their expertise as auditors.

Findings

Fifteen Muslim wives with HIV-positive husbands participated in the study and were aged 26-48 years. Every participant had been living in their marital relationship at least a year after knowing their husband's HIV diagnosis. All of them had taken HIV tests and knew their own HIV-negative status, while their husbands received antiretroviral therapy. The educational background of the participants was mostly at secondary level (n=9). Javanese was the most common ethnicity of the participants (n=14) and one was Sundanese. Most (n=10) were housewives, and five were employed in a village. Most were living in nuclear families (n=9) and had been married for more than five years (n =12) and had lived with current husband with HIV-positive for more than 1 year (n=11). The participants reported having two children (n=9) or one child (n=3), and two participants were childless. Most participants (n=9) knew about their husbands' HIV-positive status for at least one year from the health care providers (n=10) and the rest (n=5) were told by their husbands. Almost all of them did not want more children after knowing their husbands' HIV-positive status; one desired to have children.

The core category that emerged was *Sharing control in maintaining marital relationship and HIV-negative status*. It refers to the participants' efforts to manage many events or difficulties to maintain their married relationship and their sexual safety from contracting HIV. The participants had to make a lot of effort to overcome these difficult situations. The difficulty started after learning of their husbands' HIV-positive status by coincidence during hospital admission due to HIV related disease/symptoms including lung TB, loss of consciousness, a mass on certain body area, or digestive and skin problems. Sharing control in maintaining the marital relationship and HIV-negative status was carried out through some important actions in the certain circumstances. Three major themes emerged: *Learning to maintain the difference of HIV status*, *Adjusting to married life after HIV*, and *Managing daily risk for sexual safety under contract*. (**Figure 1**)

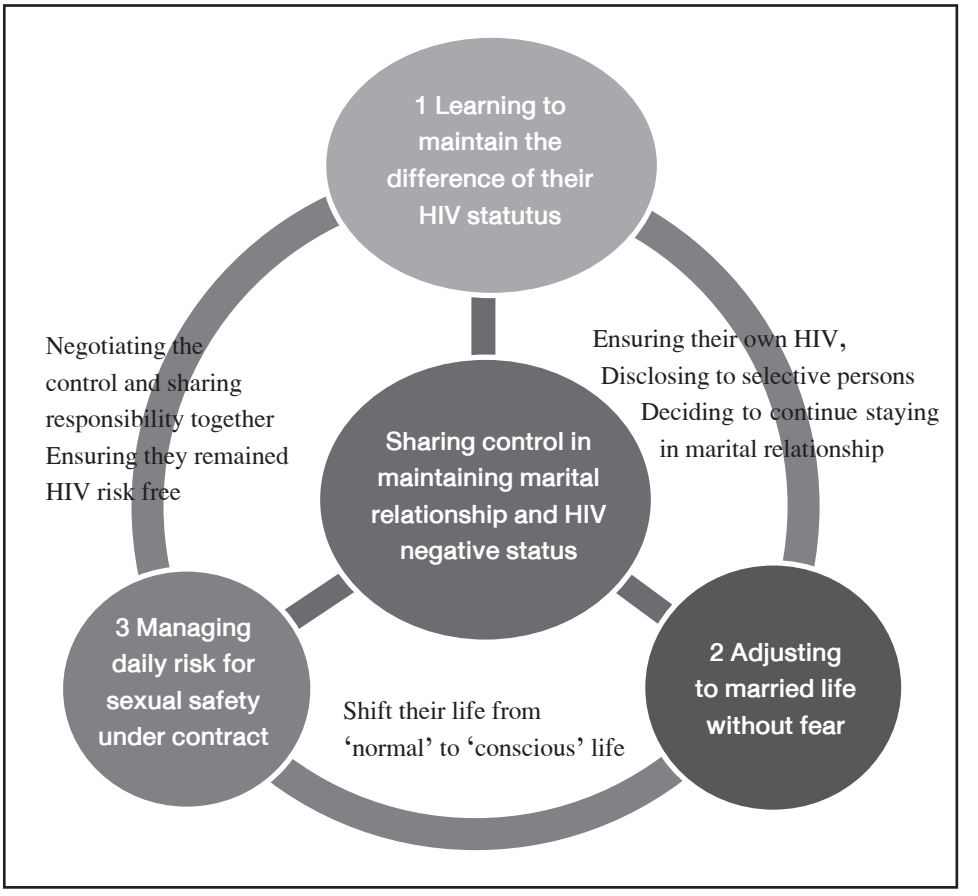

Figure 1. Muslim's wives' strategies to be with their husbands having HIV-Positive

Theme 1: Learning to maintain the difference of HIV status

This condition began after the participants knew the result of their husband's HIV test. It was a state when the participants viewed their life shift from 'normal' to a 'conscious' life after living with their husbands who were HIV-positive, and had become infected through misconduct, by having extra-marital sex with other women, particularly with commercial sex workers. The participants defined 'normal' as a life before knowing their husbands' and their own HIV status with fear, but "conscious" life was a new condition they learned to accept without fear of HIV transmission, a life with their husbands being seen as an honest person, a life without fear of negative judgment from people. The time taken to realize the meaning and consequences of living with a husband who was HIV-positive varied greatly from a moment, to hours and days. Some strategies were used, starting from ensuring their own HIV, or disclosing to selected people about whether to continue staying in marital relationship.

Ensuring own HIV status

The participants realized that they had to take an HIV test to ensure their position; either they shared the disease or were free from it. Six participants were sure they did not share the disease as they had a regular testing. For instance, Mrs. Ma believed that she was free from HIV although she used to work as a migrant worker because she always has medical check-ups every six months and took the test as she said:

I went to the VCT clinic to take the test. I felt sure that I didn't get the disease. I was a migrant worker in Hong Kong for 10 years. I did medical (check-up) *every six months. I would also notice if there was any change in my body. Alhamdulillah* (Thanks to Allah), *the result was negative* (Mrs. Ma, age 46).

Disclosing to selected person

Disclosing to selected person referred to an action of telling about their husband's HIV-positive status to a certain person whom they believed could be trusted to keep their secret and also to get the support they needed. Most participants disclosed their husbands' HIV-positive status to selected family members for some reason, such as disclosing to their sisters/brothers- in law as they need assistance in caring for their husband, or to their parents and children to prepare the family if something were to happen to their husband, as in the following example:

I told my husband I couldn't bear the news alone, I asked him who should we tell about his illness. There were two choices, his mother and his older sister. Then he decided to tell his older sister. So, we told her when his sister came to visit (Mrs. S, age 41).

Deciding to stay in marital relationship

The participants decided to continue their marriage after knowing their husbands' HIV status. They believed that to stay married to their husbands when he was HIV-positive was their destiny and also referred to what they did as worship:

He asked if I already knew about his illness. I told him that I was told by another doctor. I don't mind about his illness. He was afraid I couldn't accept it. I supported and told him that the disease might be Allah's trial for us. I assured him that I would always be by his side. He cried and apologized for his past before he married me (Mrs. SUN, age 41).

In addition, a reason to continue their marriage was to accept their husband's HIV-positive status and illness rather than reject it. It was like a turning point for the participants to pull themselves together to accept their new situation. A religious value described by the Arabic term '*ikhlas*' is important. Commonly, *ikhlas* is perceived as whatever people did in their life was the form of worship to Allah; the participants accepted their husbands' illness because they believed it was a trial from Allah and they had to accept this to get Allah's blessing. So, accepting the illness with *ikhlas* referred to a set of actions that the participants took to accept their husband's' illness in an attempt to worship Allah. Mrs. Sun, a kindergarten teacher, explained her situation:

It (husband's HIV-positive status) *might be a berkah* (blessing) *from Allah. At first, he was hospitalized to remove a mass in his butt. In the end, he just needed to take medicine to remove it. I told him it* (husband's HIV-positive status) *didn't matter to me. I accepted his condition. It was Allah's will. Allah gives trials to every human being. The important thing is we have to face it with ikhlas. Allah gives a solution to every problem* (Mrs. Sun, age 41).

Moreover, the participants' faith and culture had a strong influence on their decision to accept their husbands' illness. They believed what happened to them was a part of their destiny. Saying the marriage vows meant they were bound to each other in every way. They could not just leave their spouses because something happened in their marriage. They should face and fight every problem together and believe that every problem has its solutions. Having problems was a part of human life. Living with HIV was not solely their husbands' problem; it was a family problem. They were looking for ways to solve problems through their beliefs. A participant described her beliefs as follows:

> *At that time, I didn't know yet what was the cause of his HIV. I told him that I would stay married for our children, he was like a victim. He got HIV because he worked hard to find food for us. Another thought, if a sick person came to me and I rejected to take care of him, it would make me very cruel. I would be so heartless if I leave my sick husband. Allah is the most forgiving, He forgives all sins. I imagined if it had happened to me. I tried to put myself in his shoes* (Mrs. N, age 45).

Women used several conditions/factors to provide strategies for learning to stay with the difference of their HIV status by ensuring their own status and deciding to continue staying in the marital status. Some factors are concerned with staying in the marital relationship such as staying for her children and staying for mutual benefit.

Staying for my children

In general, parents are likely to be more concerned for their children's future rather for than their own. Most participants and their husbands put their children's wellbeing over their needs. Some reflected the tension between their own feelings and the children's future regarding the risk of their children. They had to remain negative when taking care of their husbands and their children. This could be seen from the following quotations:

> *My children were the main reason why I had been staying in my marriage, otherwise I would leave him.* (Mrs. Y, age 35).

Staying for mutual benefit

Most of the participants decided to stay in their relationship for mutual benefit based on different roles and family status such as demanding financial dependence, expecting the social negative impact, feeling obligated to take care of husband since they were married.

Demanding financial dependence

Although a few used to plan for leaving, they did not know where to go and were unable to return to their parents as it may put more burden on them. Being a fulltime housewife and taking care of family caused them to lack skills and experience in employment. In addition, being afraid of financial loss and being more concerned for their children's as well as their extended family's wellbeing led them to stay rather than leave. A participant explained her situation as follows:

> *I thought about my situation. I need to depend on him. What would I do if I left my husband? I don't have any job. What would happen to my children and family? There was no guarantee he will pay the child support if we are divorced.* (Mrs. N, age 45).

Expecting social negative impact

In the study community, HIV/AIDS is viewed as a horrible disease, a disease for amoral people such as female sex workers, and a highly contiguous disease. It was also depicted as a lunatic disease which affected the negative image of persons with HIV/AIDS. Persons who were HIV-positive and their families including members of the family were HIV-negative seem to be rejected and avoided. The participants reflected their expectation of the negative impact of HIV from people's reactions on HIV-positive persons and their family as follows:

> *There is a neighbor who doesn't talk to me since she knew that my husband got HIV. She also doesn't come to my home anymore after my husband got sick. ...It was a common thing in my neighborhood, if we asked our neighbors' help in our rice fields; we should send them some food and beverages. However, after they found out about my husband's illness, they didn't want us to send food and beverages. They would provide for themselves. Even though they didn't say it literally, I knew they were worried the food would transmit the disease* (Mrs. NUR, age 41).

Feeling obligated to take care of the husband

All of the participants considered that taking care of their HIV-positive husband was their major role. They felt sorry for their husband when he was sick. Taking care of their husband was a commitment with some assistance from family member or their extended family. As one participant expressed their concerns about taking care of her husband:

> *Actually, I wanted to find a job. Yet, I couldn't leave him in that condition. Who would take care of him if I had to go to work? Sometimes, I felt miserable as he used to spend money with someone else. At the end, I took care of him when he had no one or nothing left. I just felt sorry for him and considered him as my brother* (Mrs. I, age 45).

Theme 2: Adjusting to married life without fear

Adjusting to married life without fear while living with a husband with HIV was a state when the participants viewed their life shift from 'normal' to 'conscious' life after HIV. The conscious life at this stage was viewed as life with caution, playing safe without fear of HIV transmission. It was reflected when they trusted their husband as an honest person, and they learned to adapt their life without fear of negative judgment from people, or worries for their children's wellbeing and future.

The participants defined having a conscious life by hiding HIV status from others and that avoiding risk to children would help them learn to maintain their married life. Some of the participants limited physical contact with their husbands to prevent the HIV transmission. They tried to keep their distance from their husband because they were worried about contacting through the husband's wound. Some of the participants separated their sleeping arrangements to sleep with their children. As one participant, stated she made her sleeping arrangement as a reason to limit contact with her husband by sleeping with her children.

> *After he was diagnosed with HIV, I went to bed with my kids in another room. I told him I felt really sorry for my children since he was admitted to hospital; I was always at his side and left my children at home. So, I wanted to make it up. In fact, the real reason I didn't accompany him when he went to bed because I was frightened of the wound he had* (Mrs. A, age 35).

Hiding their husband's HIV-positive status was a main concern for the participants. In their married life, they could not leave their husband by revealing their husband's HIV to their family and friends. Commitment to stay with their husband to maintain marital and family relationships was stated, for example, as:

> *I told my daughter and neighbors that my husband gets chronic gastritis. I didn't want my daughter know about her father's illness. It would make her upset. I am worried if my neighbors know about my husband's illness, they absolutely will avoid my family. Whenever they come to visit my husband, they always asked about his illness. I just told them that he has chronic gastritis. They seem to believe it and this makes everyone happy. It helps all to stay in good relationship* (Mrs. M. age 47).

Theme 3: Managing daily risk for sexual safety under contract

Managing daily risk for sexual safety under contract was a stage in which the participants worked together with their husbands to overcome many events or difficulties to attain their purposes of living and maintain their sexual life after HIV. The participants reflected one of the most difficult events was using condoms when they had sex. They learnt about condom use and sexual health education when they joined the NGO activities, some of them receiving information during their husband's hospitalization. So, they used

some strategies in facing the conditions including negotiating the control and sharing responsibility together and ensuring they remained HIV risk free.

Negotiating the control and sharing responsibility together

The ability to share their control in sexual life was one strategy women used. Nine participants used their HIV-negative status to negotiate with their husbands. They felt free to communicate their sexual needs to their husband. They put their safety over their sexual desire. A few of them came to the HIV consultants (nurses, NGO) to get more knowledge about their situation. They wanted to ensure their safety while fulfilling their sexual needs. In addressing their sexual needs without forgetting the existence of HIV, one participant explained about her sexual life after HIV as follows:

> *I would refuse if he asked to have sex without condoms. I don't want get HIV. He also realized that, so he always has condoms with him whenever he comes to me* (Mrs. N, age 45).

In addition, participants addressed the need to be safe from HIV while maintaining their sexual life with their husband by sharing information they learned from health care workers. The participants who followed the instructions from the health care providers ensured they remained HIV free through regular testing, for example:

> *I requested him to use a condom whenever we had sex, otherwise I didn't want to have sex. I consulted the counselor at the hospital about sexual intimacy with my husband. She suggested that to maintain our safe condition* (stay negative), *we always have to use condoms... I asked him* (husband) *to always prepare it* (condom) *whenever we have sex. If he didn't want to use condom, I would absolutely refuse to have sex with him* (Mrs. Y, age 35).

Another one felt free to reject her husband and also insist that he used a condom whenever they had sex:

> *I always asked him to use a condom; otherwise I didn't have sex with him. He supported me. He didn't want me get the disease. Alhamdulillah* (thanks to Allah), *he was aware of the difference* (HIV status) (Mrs. L, age 36)..

Sharing responsibility was also performed using an ARV (or ART) reminder. They understood that taking ARV on time would keep their husband in a healthy state and protect them from contracting the disease, for example:

> *"I am always careful and remind him about taking ARV on time. He sometimes delays to take and I nag and nag him"* (Mrs A, age 38).

Ensuring they remained HIV risk free

Apart from this commitment in condom use, participants shared the responsibility together by supporting women to take HIV testing regularly to ensure safety from HIV transmission. The participants were accustomed to their routine activities, particularly related to HIV prevention. Most participants had taken the test more than twice to confirm that they were still negative.

> *Since he was diagnosed HIV-positive, I have taken an HIV test three times. I had the first two tests in the first year and took the third test in the second year* (Mrs. W, age 43).

> *Whenever I took the test, I always asked the staff when I should take the next test. I put reminder in my cellphone. I did it on my own initiative. I did everything by myself* (Mrs. S, age 41).

In summary, Muslim married women could share their control by using various strategies after learning of their HIV serodiscordant status. The participants were able to protect themselves to be safe from HIV as well as simultaneously maintain a marital relationship that was a dynamic process and concurrently performed as a journey of sharing control.

Discussion

The core category *Sharing control in keeping marital relationship and HIV-negative status* emerged through the participants' perceptions and actions. The findings were congruent with the principle of *musvawarah* (the wives concurring with the husbands' opinion, and the husbands agreeing with the wives' position) when the family faced some certain issue that needed an agreement between husband and wife.[21]

After knowing the difference of HIV status, the Muslim married women learned to live and stay with their HIV-positive husband and maintain the marital relationship as well as HIV safety. Taking an HIV test helped participants to increase their knowledge of HIV status. The World Health Organization states that serodiscordant couples who know each other's HIV status are more able to give each other emotional support, and to support access and adherence to treatment.[9]

Participants' disclosure about their husband's HIV-positive status was a challenge. The majority expressed the support from family members after disclosure, which is similar to a previous study where family support provided multiple levels of positive impact on people after they disclosed their HIV-positive status to the family.[22] The participants reflected that their children's future was one of their concerns to continue their marital relationship. This finding was supported by a previous study which showed that the serodiscordant couples who had children and frequent communication were better equipped to overcome their problems and continue their marriage.[23]

In addition, Islamic and Javanese values might also play a role in the participants' decisions. In Islam, marriage is a religious task and is consequently a moral safeguard because families are established through marriage.[13] Although a divorce is allowed in Islam, it is most hated by Allah.[12] Furthermore, there is a stigma attached to being a widow (*janda mati*) or divorcee (*janda cerai*) in Indonesia society. Society has stigmatized a *janda* (a widow or divorcee) as an immoral woman, and it is hard for such a person to hold herself as a respectable woman.[14] In addition, the participants' commitments to their marriages might have been influenced by the length of their marriage. The findings showed that 12 of the participants had been married for more than five years. The length of marriage could be interpreted as showing that the couples have strong marital commitment and good communication. In Javanese society, their commitment to each other for a length of time reflected the Javanese proverb *'witing tresno jalaran soko kulino'* which means that love itself would grow with familiarity to one another.[24]

In Islam, sexual intimacy is a holy feature; it is an act of worship to Allah *(ibadah)* in addition to its biological and social functions.[21,24] A wife has also a right to do things as needed in some conditions. The findings revealed that both the wives and husbands expressed their sexual needs by taking control for having protected sex. They achieved the ability to share their control in sexual life as a process in which the participants and their husbands gave encouragement to each other to have sexual intimacy with condom use. They sought support and wanted to be ensured that it was safe to have sex with proper condom use. This process showed the stability in their marital relationship that led them to have good communications on sexual matters. This is congruent with a previous finding in a non-Muslim country which showed that love, respect, honesty, trust, communication, sexual satisfaction, and sexual faithfulness were the most salient characteristics of good marital relationships[25]. In addition, it was helpful for the participants as women to request condoms early, often and firmly in safer sex negotiation.[7-8,26]

Information from the nurses and other health care providers about HIV status after their testing and safe sex education helped them realize the importance of using a condom. Information during their husband's hospitalization and attending NGO activities helped the participants gain a new perspective about their future sexual life. The participants acquired a voice to

talk with their husbands about the condom use and the need to maintain their HIV-negative status. A wife also received support from her husband because it was perceived as his responsibility and desire to keep her safe from HIV. The participants also shared their thoughts with their husband and decided together who should be told about their HIV status. This finding is supported by a previous qualitative study that safe sex/sexual abstinence among serodiscordant couples might be influenced by some factors, such as a wife's assertiveness, the fear of a wife's contracting HIV, mutual understanding, positive communication regarding sex, and the husband's desire to protect his wife.[26-28]

In this study, several factors seemed to help women to achieve successful sexual negotiation. First, nurse/health care providers at the VCT and NGO clinics emphasized the importance of condom use at all times as a means to prevent HIV transmission.[3] They provided informational support for the poor and low educated Muslim wives who were HIV-negative and could facilitate some strategies for them to initiate safe sex negotiation with their husbands who were HIV-infected. Most participants learned of their HIV-negative status after hearing about the HIV blood test discordance (of themselves and of their husband) and receiving VCT. Most participants initially did not dare to speak with their husband about this issue partly due to their low power in the household, as they are used to being submissive in their culture. Starting discussion with husbands was difficult and they did not know how to open up the talk. However, the support by nurse/health care providers, accompanied with the reassuring climate at VCT clinic, served to empower these Muslim HIV-negative wives to assume strength and move on for safe sex, always use a condom, negotiate with their husband and use other protective methods for their children.

Second, knowing the HIV serodiscordant status could shift the wives to yield greater power over their husbands who were HIV-positive, who got sick and also had signs and symptoms of HIV-infection during hospitalization. The flipped situation could thus back up the wives to perform strategies to protect themselves and others and stay HIV negative. Moreover, Islamic beliefs and teaching played an additional role in these processes. Islam emphasizes the prohibition of sexual intercourse outside of the marriage.[13,21] In this study, women reflected on their husbands feeling guilty since they got HIV-infection by their misconduct, having extra-marital sex with other women, particularly with commercial sex workers. Due to a strong Islamic belief (It is Allah's will, as a test in our family),[21] most of the wives forgave their husbands. They then decided to stay in a marital relationship rather than leave their husband alone.

Limitations

This study only focused on Javanese Muslim women with a HIV-positive husband. Though this study begins to illuminate some of the ethnic specific realities that can lead to safe or risky behavior, more empirical studies are needed to have a full understanding of sexual negotiation of Muslim married women.

Conclusion and Implications for Nursing Practice

A holistic understanding of the combined factors in this study contributes to the way in which women learn about serodiscordant status and how to be safe from HIV. Learning the difference in HIV status and lessening the impact on family life as part of mutual benefit made it possible to adjust marital relationship after the husband's HIV diagnosis. Although their serodiscordant status may cause both the wife and husband to worry, condom use and sexual negotiation are viewed as their shared responsibility, especially for the wives. As a consequence, it helped them to negotiate and manage their risk in daily life, to maintain the marital relationship as well as to ensure safety from HIV as essential. So, in the Islamic context of marital relationship, more protective methods beyond

condom use, may be used. It may be concluded that HIV prevention research on serodiscordant Muslim wives has to focus on marital and family relationships. Understanding the heterogeneous composition of married Muslim women will aid nurses in the development of culture-specific strategies to reduce the transmission of HIV/AIDS.

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การศึกษาทฤษฎีฐานรากของภรรยามุสลิมที่มีการปรับตัวด้านสัมพันธภาพกับสามีที่ติดเชื้อเอชไอวีอย่างไร

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บทคัดย่อ: การคงไว้ซึ่งสัมพันธภาพระหว่างคู่สมรสกับสามีที่ติดเชื้อเอชไอวีเป็นเรื่องที่ท้าทายสำหรับภรรยา โดยเฉพาะในบริบทสังคมมุสลิม การศึกษานี้มีวัตถุประสงค์ เพื่อค้นหาว่าภรรยามีการจัดการอย่างไรให้ตนเองยังคงปลอดจากการติดเชื้อเอชไอวีและมีชีวิตคู่กับสามีติดเชื้อเอชไอวี ใช้การศึกษาแบบทฤษฎีฐานรากโดยการสัมภาษณ์เจาะลึกกับสตรีที่สมรสแล้วและทราบว่าตนเองยังคงมีผลตรวจเชื้อเอชไอวีเป็นลบ ซึ่งคัดเลือกจากคลีนิกการตรวจเลือดแบบสมัครใจและให้คำปรึกษา รวมทั้งองค์กรเอกชนในพื้นที่ และผู้นำกลุ่มจากห้าเมืองในจังหวัดจาวาตะวันออก ของอินโดนีเซีย การสัมภาษณ์แต่ละครั้งเกิดขึ้นตามข้อตกลงร่วมกันระหว่างผู้วิจัยและผู้ให้ข้อมูล มีการถอดเทป วิเคราะห์และตีความอย่างต่อเนื่อง และใช้วิธีการวิเคราะห์เปรียบเทียบ

ผลการศึกษาพบประเด็นหลักคือ “การร่วมกันควบคุมให้คงไว้ซึ่งสัมพันธภาพระหว่างคู่สมรสและผลเลือดเอชไอวีเป็นลบ” โดยภรรยามุสลิมมีกลยุทธ์ในการอยู่ร่วมกับสามีที่ติดเชื้อเอชไอวี 3 วิธี 1) เรียนรู้ความแตกต่างของสถานะการติดเชื้อ 2) ปรับชีวิตสมรสให้อยู่อย่างไม่กลัว 3) จัดการความเสี่ยงในแต่ละวันให้เกิดความปลอดภัยทางเพศภายใต้สัญญา ผลการศึกษานี้ได้ชี้ประเด็นความสำคัญของสัมพันธภาพระหว่างคู่สมรสและทักษะการจัดการแบบมีทางเลือกที่นำสู่ความปลอดภัยจากการติดเชื้อเอชไอวีเมื่อมีสถานการณ์ลำบาก รวมทั้งการส่งเสริมความเข้าใจในการปกป้องตนเองของภรรยาและการอยู่ร่วมอย่างปลอดภัยกับสามีที่ติดเชื้อเอชไอวี จึงช่วยให้พยาบาลที่ปฏิบัติงานคลีนิกและพยาบาลครอบครัว มีแนวทางการให้คำปรึกษาภรรยามุสลิมที่สมรสแล้ว ภายใต้บริบทของการป้องกันการติดเชื้อเอชไอวีในชีวิตสมรส

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