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Phases of Adjustment of Couples Living with Human Immunodeficiency Virus Serodiscordance and the Role of Seronegative Partner: A Qualitative Study in Parakou, Benin

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Abstract

Introduction: HIV serodiscordance remains largely unknown to both the general public and healthcare professionals not directly involved in HIV response efforts. Three out of four infected couples are affected by this issue. This study aims to explore the adaptation process of serodiscordant couples, identifying the key stages of their journey and highlighting the central role of the seronegative partner in this dynamic. The objective of this study is to describe the adaptation process of these couples to their discordant status by outlining the stages of this adaptation and the role of the partner in this process. **Study Setting and Methods:** This study was conducted at HIV care sites in the city of Parakou, located in northeastern Benin. It was an exploratory

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qualitative study involving three target groups: people living with HIV (PLHIV) engaged in serodiscordant relationships, their seronegative partners, and resource persons involved in the care and support of serodiscordant couples. Through semi-structured face-to-face interviews, data were collected from fifteen participants (10 PLHIV and their partners, and 5 resource persons) in order to construct an adaptation model. This model was then tested on other participants (PLHIV and their partners) for refinement until saturation was reached, which occurred after 25 interviews. **Results:** The key stages of adaptation for couples in HIV serodiscordant relationships include: emotional reactions to the discovery of the couple's discordant status, questioning, redefining the terms of the union, and reaching a bilateral agreement. These stages are preceded by the sharing of respective serological statuses, which marks the entry into serodiscordance. As for the pivotal role of the seronegative partner in the adaptation process, it is crucial. The seronegative partner alone bears the responsibility for initiating and guiding the adaptation process. **Conclusion:** A successful adaptation of couples to their discordant status ensures the stability of the relationship, better adherence to antiretroviral therapy (ART) by the infected partner, and improvement in their health and well-being. This process needs to be better supported, with the systematic involvement of a psychologist, particularly emphasizing the seronegative partner, who bears almost sole responsibility for the adaptation process.

Keywords

Adaptation, Serodiscordance, HIV, Benin, Psychological Support, Adaptation Model, Marital Stability

1. Introduction

For several decades, the primary strategies addressing the HIV epidemic have concentrated on pregnant women and youth, often overlooking serodiscordant couples. Among stable and concordant seronegative couples, HIV incidence accounts for an average of 29.4% of the total annual HIV incidence. This occurs either through infections acquired by one partner from external sources, contributing 22.5% [11.1 - 39.8], or through transmissions to the uninfected partner within less than a year after the other partner acquires the infection from an external source (6.8% [3.6 - 11.6]) [1]. Stable serodiscordant couples contribute an average of 30.4% to the total HIV incidence, with the majority, 29.7% [9.1 - 47.9], resulting from HIV transmission from the infected partner to the uninfected partner within the couple [1].

The concept of a couple, defined as a union of individuals bound by shared interests, commitments, and projects, who cohabit regardless of their residential status or form of union [2], is marked by the investment partners make in acknowledging themselves as a couple and being recognized as such by their surroundings [3]. This notion plays a critical role in both the propagation of the pan-

demic and the strategies devised to combat it. In enduring relationships, the identification of an HIV-negative status in the partner of an HIV-positive individual delineates what is known as effective serodiscordance [4]. This revelation often serves as a significant shock to couples, presenting a crisis that can only be navigated through psychological efforts aimed at reconstructing the initial idealization of the romantic partner [5]. It is at this juncture that the adaptation process commences, intertwining emotions (such as sadness and fear), interests (ranging from self-protection to the desire for love, support, and protection), and resistances (like ongoing protection) within a context of tension [4]. According to Bates (2005), adaptation from an anthropological perspective is the process through which populations adjust their behaviors to enhance or ensure their survival within their environment [6]. Consequently, individuals develop adaptation strategies, comprising a series of actions designed to address the challenges they encounter, thereby enabling innate reflexes to be effectively utilized and adapted to environmental changes [7].

In the context of HIV serodiscordance, the notion of dyadic stress comes into play, as the discordant status can directly or indirectly affect both partners, who will attempt to reduce its harmful impact by using coping strategies that are both individual and dyadic [8]. Dyadic coping strategies refer to a set of conscious cognitive and behavioral mechanisms used by one partner to manage their reactions to stress caused by problematic dyadic situations that may pose a threat to them [9]. Based on various factor analyses, Lazarus and Folkman (1984) proposed a classification of these strategies into three main categories:

1) strategies focused on reappraisal, used to change one's perspective or way of viewing a problem by selectively ignoring certain frustrating or unsatisfying elements within the relationship or by making positive comparisons with other couples;

2) strategies focused on managing the negative emotions elicited;

3) problem-solving strategies, which include any adaptive behavior aimed at reducing or eliminating the stressful situation [10].

Adaptation to the risk of HIV transmission involves both technical and emotional elements. Initially, it involves technical measures such as the consistent use of condoms and pre-exposure prophylaxis. Subsequently, it requires emotional adjustments, including acceptance, consideration of the relationship's future, and a return to normalcy. Emotional adaptation is centered on fear: the HIV-negative partner fears infection, while the HIV-positive partner fears rejection or disclosure. This fear-driven adaptation can lead to either a breakup or the abandonment of reminders of the partner's status, such as condom use [4].

The process of adapting to serodiscordance within a couple is crucial for maintaining marital stability. The relationship is redefined from being centered on the infection to a partnership where the HIV-positive partner takes responsibility for managing transmission risk, supported by the HIV-negative partner. This approach yields benefits in terms of treatment adherence, health, and overall well-

being. For instance, a multi-country study conducted in Uganda, Kenya, Tanzania, and Nigeria found that individuals in serodiscordant relationships had a 2.8-fold higher adherence to antiretroviral therapy compared to those in seroconcordant relationships [11]. Additional benefits include the preservation, strengthening, and enhancement of the marital bond following the challenging circumstances [5].

This study aims to provide healthcare professionals and all stakeholders involved in the follow-up of people living with HIV (PLHIV) with tools for enhanced support, while also informing serodiscordant couples about the adaptation process, enabling them to comprehend and anticipate their experiences and adjust more harmoniously.

2. Study Framework and Methods

2.1. Study Framework

Benin, a coastal country in West Africa, is classified as a lower-middle-income country. Women outnumber men and have a higher life expectancy [12]. The monetary poverty rate stands at 38.5% [13]. Only 64% of women in unions participate in decisions regarding their own health [14]. In terms of HIV, women are more affected than men. However, men tend to be better informed than women about ways to prevent infection. HIV-positive women, often perceived as sex workers, face greater stigma than men, and when married, they risk being repudiated by their spouses and excluded from their households [14].

Benin is classified among countries with a low prevalence of the Human Immunodeficiency Virus (HIV), with this rate remaining stable at 1.2% since 2006. Regarding HIV status serodiscordance, it affects 71.70% of couples monitored at a specialized site [15]. The care and support of these couples are provided by healthcare teams, complemented by psychologists, therapeutic educators, and community mediators. This support encompasses several components: the free distribution of condoms, the prescription of Pre-exposure Prophylaxis (PrEP) for the seronegative partner during the initial months of treatment for the seropositive partner (until the latter is no longer infectious), guidance on procreation, biannual biological monitoring of the seronegative partner, and the facilitation of discussion groups addressing issues such as the future of the relationship and marriage, reproductive activities and family planning, sexual life, and the risk of transmission, among others. The active participation of seronegative partners remains limited, as they often choose to maintain anonymity in their discordant relationships.

In the Borgou department, HIV prevalence among pregnant women is low-about 0.16%, compared to the national average of 0.95% [16]. Women's decision-making autonomy is the lowest in the country. Specifically, the percentages of women who decide alone or jointly are as follows: about their own health care (20.5%), making major household purchases (19.3%), making daily purchases (28.8%), visiting family, relatives, or friends (31.2%), and deciding what food to

prepare each day (32.7%) [13]. The monetary poverty rate in the region is 53.3%, significantly higher than the national average of 38.5% [17]. Only 34% of women believe that a woman is justified in refusing to have sexual intercourse with her husband for any reason [13].

The present study was conducted in this context, at three care sites for adults living with HIV in the city of Parakou, located in the northeast of Benin. Parakou is the main city in the northern part of the country and the capital of the Borgou department. It is a cultural and economic crossroads, offering a diversity of experiences and life contexts among the individuals concerned.

2.2. Methodology

In this exploratory qualitative study, data were gathered from participants selected through purposive sampling over a seven-month period from November 2023 to June 2024. Due to challenges in recruiting both partners of serodiscordant couples simultaneously, we opted for individual recruitment, emphasizing the couple's experience. Consequently, two categories of participants were included in the study: firstly, seropositive or seronegative individuals engaged in stable serodiscordant relationships, and secondly, resource individuals involved in the care and support of these couples. In order to establish an adaptation framework, only individuals who had experienced positive adaptation-meaning good marital adjustment-were recruited. Positive adaptation is understood not merely as the continuation of the relationship, but as a good marital adjustment, the continuation or return to a harmonious situation that effectively takes into account the serodiscordant HIV status.

The criteria for inclusion in the study were as follows:

1) Individuals infected with HIV, who are 18 years or older, diagnosed for at least six months, undergoing antiretroviral therapy (ART) for at least six months, in a relationship for at least six months with a seronegative partner, and who have disclosed their HIV status to their partner for at least one month. Additional criteria included having full mental capacity, the ability to clearly and honestly answer questions, and having provided free and informed consent to participate in the study.

2) Individuals infected with HIV, who are 18 years or older, diagnosed for at least six months, undergoing antiretroviral therapy (ART) for at least six months, in a relationship for at least six months with a seronegative partner, and who have disclosed their HIV status to their partner for at least one month. Additional criteria included having full mental capacity, the ability to clearly and honestly answer questions, and having provided free and informed consent to participate in the study.

3) Presenting marital satisfaction, physical and psychological well-being, and a low level of stress

4) Individuals infected with HIV, who are 18 years or older, diagnosed for at least six months, undergoing antiretroviral therapy (ART) for at least six months,

in a relationship for at least six months with a seronegative partner, and who have disclosed their HIV status to their partner for at least one month. Additional criteria included having full mental capacity, the ability to clearly and honestly answer questions, and having provided free and informed consent to participate in the study.

The exclusion criteria are of two types. General exclusion criteria include: withdrawal of consent; patients with cognitive impairments preventing them from understanding and clearly expressing their experiences; and people living with HIV (PLHIV) whose clinical or emotional condition does not allow them to clearly express their experiences. Exclusion criteria related to negative adaptation include: marital distress, physical or psychological distress, and the presence of hostile or even violent behaviors attributable to the serodiscordant situation. Utilizing a semi-structured questionnaire, we investigated the various states and phases participants experienced up to the point of adaptation. To enhance the richness of the collected data, the selection of participants was based on criteria that could influence the variability of their experiences. Consequently, we selected PLHIV and their partners considering their age, gender, marital status, educational and income levels, religious affiliation, and the duration of their relationship. Regarding the resource persons, they were chosen based on the relevance and quality of their experience with the primary subjects, across different professional backgrounds. These include health workers, therapeutic educators, sociologists, legal professionals, and psychologists. These resource persons are both administered the questionnaire and engaged in the modeling and validation of the adaptation framework.

The primary criterion for determining the sample size is grounded in the principle of saturation. A semi-structured interview guide was employed with approximately fifteen participants (comprising 10 individuals living with HIV and their partners, and 5 resource persons) in a face-to-face interview setting. This process facilitated the development of an adaptation model, which was subsequently reviewed and enriched by the resource persons. The model was then tested on new, distinct targets to assess its applicability and further refine it as necessary until saturation was achieved. Saturation was reached following 10 additional interviews. Thus, a total of 20 PLHIV and their partners, including 13 women, were ultimately included.

Interviews were recorded using a dictaphone and through note-taking, with the consent of the participants, and were fully transcribed. The data analysis was performed using NVIVO 14 software. Once transcribed, the data were refined through proofreading and lexical correction. They were then categorized into a main code and subcodes defined based on the themes identified during data collection. Additional codes were defined during the encoding process. A thematic content analysis was conducted, focusing on the frequency of responses per individual, which allowed for the organization of information around thematic axes derived from established knowledge or key indicators emerging from the partici-

pants' discourse. This approach enabled the identification of "items" within the responses to the questions from the initial interviews; these items were aggregated into broader categories containing multiple items, facilitating the creation of a structured analysis framework from which responses were coded/classified based on their content. The concordance rate after merging the two databases was 96%.

To conduct this study, the necessary authorizations were obtained from the Research Unit and then from the relevant authorities, including the general directors of the various University Hospital Centers (CHUs), in accordance with the research guidelines in effect at the time of the study. Each participant provided informed consent after receiving an explanation of the study topic, its relevance, and its significance, ensuring sufficient knowledge and understanding of the expectations. These explanations were given in French (for literate participants) or in the participant's native language with the help of interpreters recruited from the support staff in charge of patient follow-up, who were sensitized to issues of respect and confidentiality. Participants' consent was obtained prior to registration. The principles of neutrality and anonymity were respected.

3. Results

3.1. Descriptive Characteristics of the Study Population

3.1.1. Description of Study Participants

The mean age of the participants is 36.2 years with a standard deviation of 6.79 [33.02 – 39.38], ranging from 26 to 46 years. The majority of participants are female (65%). In 65% of cases, participants are married, predominantly in monogamous relationships (95%). At the time of the survey, all participants reported practicing at least one religion, with Christian denominations being the most prevalent (75%). Indigenous ethnic groups (Baribas, Dendis, Nagot, and related) are underrepresented, constituting only 35% of the sample, while non-indigenous groups (Fon, Yoa-Lokpa, Ottamari, and related) make up 65%. The most common occupations are in liberal professions such as commerce, crafts, and self-employment (60%); 20% of respondents were unemployed at the time of the survey. A majority of the study participants have attained at least a secondary level of education (60%), and a significant majority (90%) live in urban areas. The average duration of infection among participants is 74.75 months with a standard deviation of 54.66 [49.17 – 100.33], with a range from 7 to 216 months. Screening circumstances include prenatal consultations (55%), episodes of STIs or illnesses (25%), familial screening (10%), and voluntary screening (10%).

3.1.2. Descriptive Characteristics of the Respondents' Spouses

The average age of the spouses was 37.45 years with a standard deviation of 9.20, ranging from 33.14 to 41.76, and with ages spanning from 22 to 55 years. Christian denominations were the most common, accounting for 70% of the population. Indigenous ethnic groups, including Baribas, Dendis, Nagot, and their affiliates, were underrepresented, comprising 40% of the sample, whereas non-indigenous groups, such as Fon, Yoa-Lokpa, Ottamari, and their affiliates, constituted 60%.

The majority were engaged in liberal professions, including trading, craftsmanship, and farming, making up 75% of the sample. Educational attainment at the secondary level and above was predominant, representing 60% of the population.

3.1.3. Couple Dynamics at the Time of the Study

The average length of relationships among couples was 110.05 months ± 73.95, ranging from 75.44 to 144.66 months, with a minimum of 7 months and a maximum of 288 months. Couples had an average of 3 children, with a standard deviation of 1.54, and a range from 2.33 to 3.77 children, with extremes of 0 to 5 children.

Regarding the disclosure of serological status, it was shared immediately in 50% of cases, within 1 to 12 months in 25% of cases, and after one year in the remaining 25% of cases. Concerning disclosure outside the couple, only 30% of respondents agreed to it; primarily with their mothers (20% of cases), and occasionally with children, siblings, or friends (5% in each of these instances).

3.2. Description of the Adaptation Process

The adaptation process for couples dealing with HIV serodiscordance involves both individual and mutual efforts, as each partner confronts challenges unique to their serological status. The disclosure of each partner's serostatus is essential for this adaptation, as it is impossible to effectively adapt to a condition that remains undisclosed. This section examines the stages of this adaptation process and highlights the role of the seronegative partner.

3.2.1. Sharing of Serological Status as a Prerequisite for Adaptation

General Conditions for Sharing

The sharing of serological status, which serves as a criterion for study inclusion, takes place under a wide range of conditions. These are shaped by the unique attributes of the participants, their life experiences, expectations, and concerns, as well as the couple's dynamics at the time of testing and sharing, and the guidance provided by the health professionals who conducted the testing. In the majority of instances (17 out of 20), the infected partner personally disclosed their status, with the timing of disclosure varying. (Table 1)

Table 1. Conditions for sharing serological status-Parakou, 2023.

		Men	Women
Accidental Sharing		-	1
Sharing through Health Agents	Immediate	1	-
	2 to 24 Months	-	1
Spontaneous Sharing	Immediate	-	9
	2 to 24 Months	3	5

Frequently, the disclosure of one's HIV-positive status happens after a period of personal acceptance and uncertainty regarding the status of others. Some individuals choose to be immediately open and honest, while others adopt a more cautious approach, gauging the other person's reactions and attempting to reframe the disease in a different context before revealing their own status. This sentiment is reflected in the statements of the participants that follow:

"I told him that the same day... So that he does not waste his time. Like that, if he does not want to, he can leave." **Participant 14**.

"... We were together at the hospital and when I was informed, I told him right away 'there, there, that's what they said." **Participant 7**.

"... Through conversations, I tried to gradually help her see the illness differently. I explained to her that nowadays, having this disease does not mean you are already dead—that I have friends who are living with it and doing well, that there is free treatment and follow-up available, even for the partner who is not infected. That is how I was slowly able to convince her… before finally telling her that I myself have the disease." **Participant 3**.

Madame X, a midwife with 26 years of experience, emphasizes the importance of the infected partner personally disclosing their serological status: *"The circumstances under which the status is shared are crucial. When the partner comes for their screening test, it provides an opportunity to start working with the couple on acceptance"* **Resource person 1**.

Men, in general, find it more challenging than women to disclose their status to their partners, primarily due to the fear of it being revealed.

"In our society, women are seen as the custodians of virtue and trust within relationships. Consequently, they feel compelled not to keep secrets. Meanwhile, men believe that women cannot keep secrets, hence their hesitation in sharing their status" **Resource person 4**.

The assistance of healthcare professionals can be significantly beneficial in some cases. Infected individuals often turn to them to find the appropriate words for disclosure. *"Honestly, the day my wife told me she was HIV-positive, it was a turning point for me. But when we consulted the midwife, she provided us with guidance. I accepted it as something that could happen to anyone. That's when I decided to come to terms with it"* **Partner 3**.

3.2.2. Stages in the Adaptation of Couples to Serodiscordance

The adaptation of couples to serodiscordance involves several stages, starting with the disclosure of each partner's serological status. Following this disclosure, the serodiscordant condition is established, prompting a reevaluation of certain aspects of the couple's life.

We have identified four primary stages through which couples progress (**Figure 1**):

1) Emotional responses
2) Inquiry and reflection
3) Redefining the terms of the relationship
4) Mutual agreement

The subsequent figure (Figure 2) provides a summary of these steps:

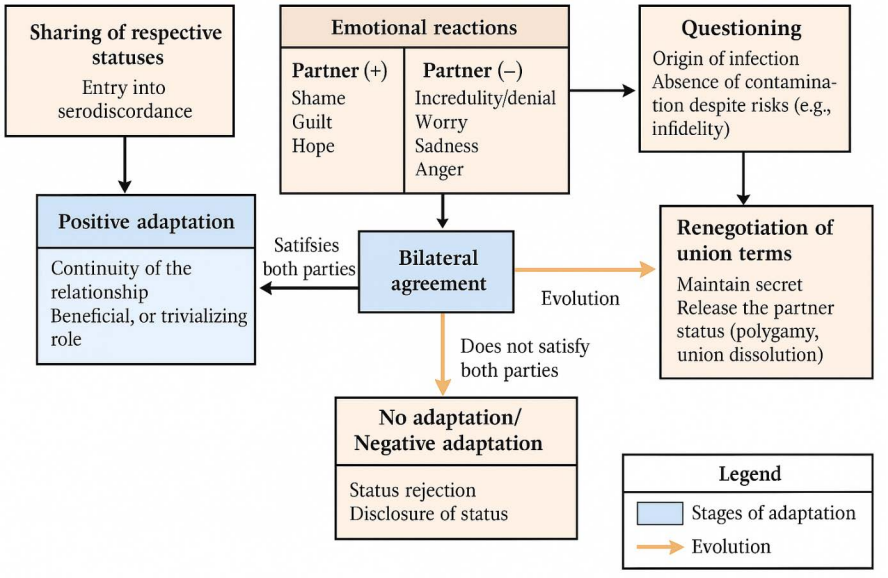

Figure 1. Stages of adaptation to serodiscordance and influencing factors based on data analysis.

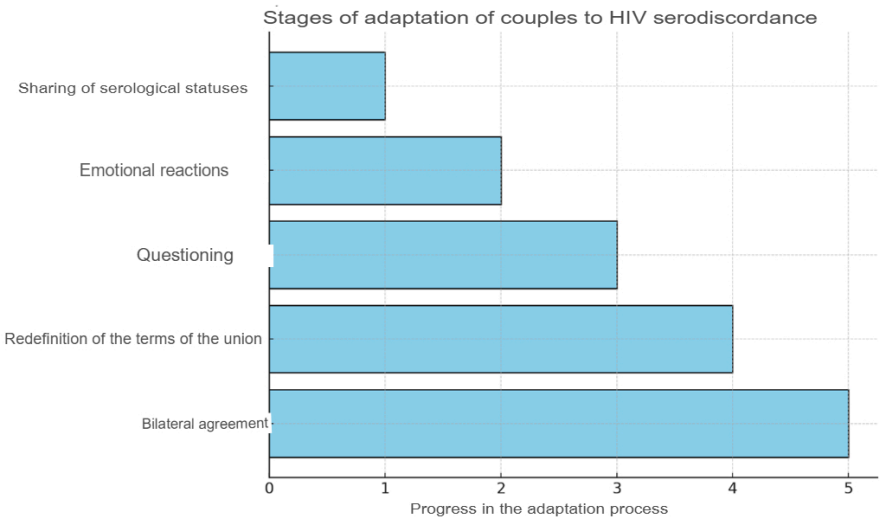

Figure 2. Stages of adaptation in serodiscordant couples.

1. Emotional Responses

The realization of serodiscordance presents an anxiety-provoking scenario, eliciting diverse emotional responses contingent on the role and status of each partner within the relationship. HIV-positive partners predominantly report feelings of guilt or shame (53.33% of the HIV-positive individuals surveyed), and sometimes hope and optimism. In contrast, HIV-negative partners exhibit emotions such as surprise, anger, sadness, or even shock. Fear is commonly reported by either one or both partners (20% of cases) (Table 2).

Table 2. Emotional responses to the disclosure of HIV-positive status by the number of coding references.

Emotional Responses to the Disclosure of HIV-Positive Status	Coding References
Guilt or Shame	8
Gradual Acceptance and Adjustment to the News Denial and Disbelief	4
Hope and Optimism about Treatment	4
Fear	4
Stigmatization	1

1) Feelings of Guilt or Shame

A total of 53.33% of individuals living with HIV reported experiencing feelings of guilt or shame. These emotions are largely influenced by the prevailing societal perception of HIV infection, which continues to be viewed as a condition linked to immoral behavior. Consequently, those infected often fear that their partner's perception of them will shift, potentially transforming from being seen as an ideal spouse to being perceived as a tainted and undesirable partner. This results in the emergence of the following narratives:

"Honestly, it's deeply shameful… But someone who has never gone through it can't truly understand what it feels like. It's really shameful, it's like—like having an alarm inside you—something that goes off at certain moments to remind you that time is no longer on your side. Even if you do not know how you got infected, you still feel ashamed. People say that those who have this disease live immoral lives—that they are promiscuous, that they are nothing more than disguised prostitutes. How can anyone hear things like that and not feel ashamed? Even someone who has not done any of those things, if they find out they are HIV positive, they feel ashamed. And honestly, that is just human" - **Participant 13.**

Through the pre- and post-test counseling offered by healthcare professionals and the psychotherapy involved in disclosing serological status, some individuals find renewed hope and optimism about the future of their relationship (26.67%). This sentiment is echoed by a 46-year-old *HIV-negative* partner: " *We give thanks to God, as contracting this illness is not a matter of personal choice. My wife did not ask for it—it was not her will. Therefore, since we have been together and I became aware of her condition, I could not simply decide to end our relationship because of it, especially since we have children together. Thank God there is treatment for it, and at the hospital, they assured me that it is possible to live a normal life with it. We stayed together, and today we have four children. None of them has the disease, and neither do I. That means the treatment works*" **Partner 2.**

The subsequent word cloud demonstrates the sentiments of guilt or shame articulated by the respondents. Prominent words include "house", "aggressive", "force", with secondary terms such as "begin", "ideas", "leave", "whims", "gets angry", "protects". This figure (**Figure 3**) effectively depicts the internal struggle experienced by participants, who are caught between seeking a protective refuge

and the desire to terminate the relationship due to feelings of guilt. This ambivalence frequently results in aggressive behaviors towards their environment.

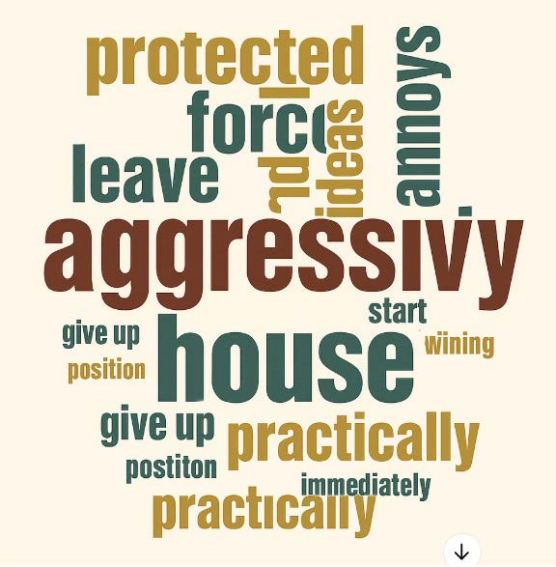

Figure 3. A word cloud depicting the emotions of guilt and shame.

2) Denial and Disbelief

Expressed by 26.67% of participants, denial or disbelief made accepting the diagnosis slower and more difficult, hampered communication, and compromised treatment adherence. This was the case for a 44-year-old female participant: "*When they told me the first time, I did not believe it. I thought to myself, 'How could I be sick?' So I let two years go by before starting treatment. During those two years, I kept falling ill, and that is when I told myself I had to take it seriously"* **(Participant 10).**

"The health workers advised me to get tested, and I discovered I was HIV positive. Right from the start, I began treatment... Initially, it was challenging to accept that I could have such a disease. Honestly, if it weren't for the guidance from the midwives and the therapeutic educator, I wouldn't have been able to come to terms with it as much as I have" **Participant 3.**

3) Fear

Fear was reported by 30% of the participants. The condition of serodiscordance generates a sense of insecurity and apprehension that couples attempt to alleviate. For the HIV-positive partner, the fear arises from concerns about abandonment or the risk of transmitting the virus to the partner. Meanwhile, the HIV-negative partner expresses anxiety about contracting the virus or facing social stigma.

"Since I found out I have this disease (HIV), I have started to be more cautious. I became afraid. I did not want to infect him—I did not want him to get it because of me. So now, I am very careful" **Participant 9.**

"Initially, I had hidden my status from him. It was not easy... When we discussed it, I admitted that I knew, but I was afraid to tell him. Since he has multiple

partners, he could have asked me to leave. It has not been easy. Even now, we are still dealing with it." **Participant 15.**

"With this illness, since the immune system is weakened, I was afraid that my partner might be unfaithful and bring home other infections. For the average person, those might be easy to recover from—but for me, I know it could be serious. I am afraid for my health... I am afraid of dying too soon" **Participant 13.**

"Sometimes, I feel discouraged, and I feel sorry for my husband. I fear that one day he might tell someone in his family, and they might advise him to expel me from his home" **Participant 5.**

4) State of Shock, Sadness, or Anger (100% of partners)

These reactions were universally expressed by all spouses. These are the responses of the infected partners upon learning of their HIV-positive status:

"At first, I did not know how to react. It was a shock—it hit me so hard I collapsed to the ground. At first, I thought it was a joke, that he just wanted to scare me. But when he explained everything, I suddenly burst into tears. A thousand thoughts rushed through my mind all at once" **Partner 5.**

The figure below (Figure 4) illustrates the reactions to the announcement of serodiscordance, highlighting the prominent words: "consequences", "disputes", "psychology", "reality", "danger", "fear". This word cloud effectively captures the emotions associated with the shock, sadness, and fear prompted by the contemplation of the couple's future.

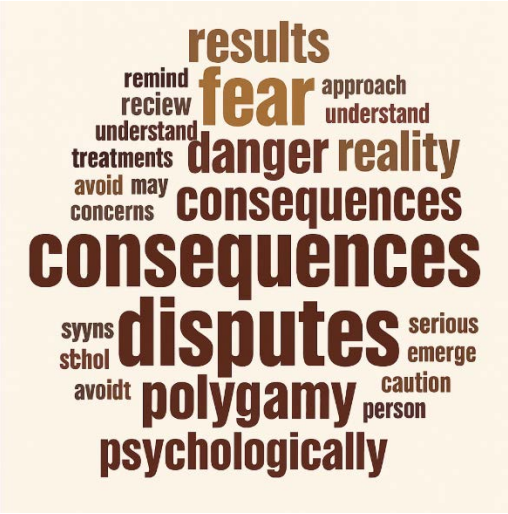

Figure 4. Word cloud depicting shock, sadness, or anger.

5) Withdrawal/Retreat

In some cases, seronegative partners require time to process the information and contemplate the implications of this new situation. This may lead to behaviors characterized by withdrawal or retreat, and occasionally a temporary pause in the relationship's progression. This response was reported by 40% of participants. A seropositive participant shared: "*Right now, she is not yet psychologically ready*

to accept her status. She is just living with it, going through the motions. Whenever we try to talk about it, she bursts into tears and goes silent. So, I have stopped bringing it up" **Partner 4.**

"After I told her the result, she asked for some time to think things over—to process it all. We did not have any contact for months. And then, she came back to me." **Participant 3.**

"Honestly, it was not easy… I did not want to make things worse, so I informed him that I needed a few days to contemplate the situation and then I would convey my thoughts. I asked him to give me a few days to think, and then we could talk about it. I secluded myself at home. I even turned off my phone, overwhelmed with tears for several days." **Partner 5.**

2. The Inquiry

The emotions conveyed by the spouses subsequently lead to a phase of inquiry: "Why is one partner infected while the other is not?" "How is it possible for the person with whom one shares a life to be infected without being aware of it?" This inquiry addresses both the source of the infection and the reasons for the spouse's lack of contamination, despite frequently engaging in risky behaviors.

To exemplify the inquiry concerning the origin of the infection, we refer to the testimonies of the subsequent participants:

"When he told me his test was negative, it was a shock for me. I thought, 'This is serious. If he does not have it, then where did I get it from? How?' A flood of questions filled my mind" **Participant 9.**

"I am personally questioning how it happened... In truth, I do not know how it occurred. Perhaps, inadvertently, my wife went to her brother's place and used a razor. I didn't inform her about any contact with another man, so as not to disturb her excessively. Because, even the most naive man, when informed that (his partner is HIV-positive), will automatically think of that first. I started imagining all kinds of possible scenarios" **Partner 3.**

My husband said to me: *'But if they told you that you have this, and we had unprotected intercourse, why don't I have it? Why am I not positive?'* **Participant 4.**

Resolving these questions is essential for the ongoing adaptation process and may be facilitated by the information exchanged, communication within the couple, the strength of the partners' relationship, and religious beliefs.

3. Renegotiating the Terms of the Union

Following the phase of questioning, the process advances to renegotiating the terms of the union. This stage is crucial for the couple's reclamation of their relationship. It facilitates the transition from being perceived as an "abnormal couple" to a stable partnership that must navigate challenges associated with illness. During this phase, negotiations focus on adopting new behaviors, particularly concerning the management of transmission risks. Discussions encompass topics such as procreation, risk management via protective measures, and the handling of information regarding the couple's status. Occasionally, this may result in the

involvement of an additional partner, particularly when a power imbalance arises between the seronegative partner, who feels blameless, and the seropositive partner, who faces significant vulnerabilities.

1) Polygamy

Polygamy, the formalization of new "legitimate" unions of a man with several women, can occur following the discovery of the couple's serodiscordant status. As one participant testified: *"It's since I was diagnosed that he sought another woman. That's what he said."* **Participant 15.**

This form of polygamy typically emerges when the uninfected partner feels compelled to "seek refuge" in what is perceived as a normal relationship, free from constraints or restrictions, and occasionally without the necessity of using protection. This sentiment is echoed by another partner: *"Truly, when I need to clear my mind, without dwelling on the risks, just being with my wife without fear or anything, that is when I visit my second wife. She is aware that this is the reason I married her."* **Partner 4.**

Polygamy primarily occurs when the seronegative spouse is the uninfected partner in the relationship, as it is culturally more acceptable for a man to take another wife to address the perceived "deficiencies" of the first wife.

2) The Liberation of the Relationship

To maintain their union, some spouses agree, in one way or another, to adopt a more flexible approach to the terms of their marriage by including occasional seronegative partners. This refers to encouraging one's partner to stray, a form of infidelity that is induced or tolerated because one of the spouses can no longer assume the marital responsibilities that they are supposed to. An infected participant recounts: *"My husband told me that it is not easy for him… That he wants what is best for me, so he would rather let me go — so I can find someone else and rebuild my life with another man. He said it is because he knows my status that he can not pretend. That if I find someone who does not know anything about it, it would be better"* **Participant 15.**

3) The Dynamics of Power

In certain instances, the condition of serodiscordance serves to either contribute to or reinforce one partner's dominance over the other. This dynamic often involves the HIV-negative partner, who possesses a "deterrent weapon" that can be brandished at any point in the relationship, especially during conflicts or to pressure the HIV-positive partner into acquiescing to their demands. *"At any moment, I can say to my wife: 'For my safety and the safety of our child, I am evicting you,' and she is powerless against me. No matter where she goes, she can do nothing... Even if I tell her own father, he would reject or even disinherit her. So, whenever she complains, I remind her that if I reveal what is happening here, she will not be accepted. Even if people accuse me of infecting her, I will simply show them my test results, and they will be pacified. She became more submissive."* **Partner 3.**

In certain situations, the HIV-positive individual asserts dominance over their HIV-negative partner by emphasizing their role within the relationship and the

mutual responsibilities that come with it. *"At home, I am the one who makes the decisions now. He (the partner) can not tell me to leave the house, like I hear some women complain about… I have been with other men before him—in fact, he was not even my first choice. Now that we are together and this situation (the serodiscordance) has come up, he is not going to control me. I told him not to talk about it to anyone, but I did tell my mother. If I do not stand my ground, he will think I am weak because of the situation—and I will end up being his slave"* **Participant 12.**

This renegotiation of the terms of the union can occur either consensually after positive communication or tacitly, through the adoption of certain behaviors or attitudes by one partner, with the acquiescence/approval of the other partner. It then leads to the principle of agreement.

4. The Principle of Agreement

After reviewing the terms of the union, both partners may reach a compromise that is mutually satisfactory, even if this satisfaction is not complete or comes at the expense of one partner. They thus achieve a bilateral agreement.

"As before, we tested him again and he is negative. I asked him what we should do next, if I should leave? He replied, 'ah! there is no problem, it is God's will, and we will continue like this. If God wills, things will improve'." **Participant 5.**

Generally, the steps identified above are not always present or sequential. At each stage, reconsiderations may occur, causing the process to restart at a more or less advanced stage. This underscores the importance of factors that sustain or reinforce the outcomes achieved.

3.2.3. The Role of the Seronegative Partner in Adaptation

The seronegative partner assumes a crucial role in the couple's adjustment to HIV serodiscordance. Frequently, the seropositive partner, who is often distressed and burdened with feelings of shame and guilt, defers the responsibility for decision-making and the initiation of the adaptation process to the seronegative partner. This may be seen as an attempt to "atone" for the perceived "transgression." This dynamic is exemplified in the following accounts: *"When I disclosed my positive status to my girlfriend, she began to cry. As the man, I took responsibility to soothe her. I asked her for forgiveness, repeatedly apologized, and admitted that I was unaware of how I contracted the disease. Ultimately, I told her that any decisions moving forward would be hers to make"* **Participant 1.**

"The last time he got tested, the result was negative. I can see that it is hard for him. Sometimes it hurts me, for his sake. He does not want to show it, but I can tell he is struggling to accept it as it is. And I pray that God helps him. In the end, whatever he decides is what we will do. I no longer have a will of my own." **Participant 5.**

The HIV-negative partner adapts by offering reassurance to their HIV-positive partner, who is beset by uncertainties regarding the relationship's future. Their role extends to guiding their partner towards acceptance of their status and fostering a positive mindset and behavior. This supportive and encouraging role is

exemplified through the following testimonies:

"When I reflect on my situation, I tend to withdraw. Initially, this occurred frequently. It is he who comes to me, advising against sadness as it would worsen my condition. He engages in lengthy conversations with me, and afterward, I genuinely regain my sense of self." **Participant 10.**

The figure (**Figure 5**) depicts the supportive role of the seronegative partner in the initiation and management of the adaptation process. The objective is to achieve "security" progressively through "knowledge". The concept of progression here conveys the perception of adaptation as a gradual and dynamic process.

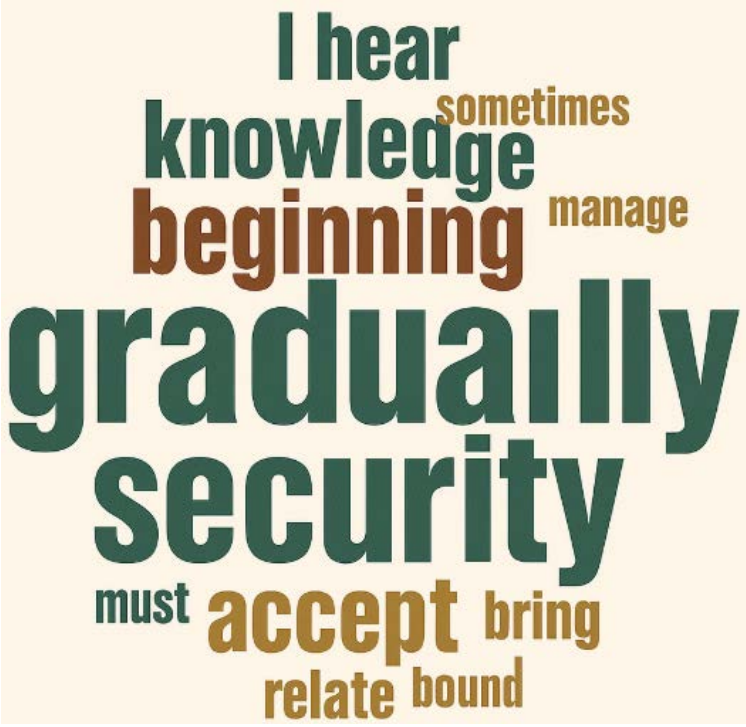

Figure 5. Word cloud illustrating the supportive role of the seronegative partner.

Nevertheless, the role of the spouses is neither supported nor facilitated: *"We ask a lot from HIV-negative partners. We expect them to support their husband or wife through treatment, to be understanding and patient. We ask them to accept the couple's status, even when it is difficult, to protect their family, and not to disclose the diagnosis unless they are certain it will not lead to a breach of confidentiality. But the truth is, we have never really stopped to ask them how we can help them cope with all this. I believe we should offer them outside support—psychological support could really help. Otherwise, they are carrying a lot of responsibility with minimal support"* **Resource person 5.**

In Summary

The adaptation process of couples experiencing HIV serodiscordance is dynamic in nature. This process encompasses psychological, emotional, and behavioral dimensions, as well as individual and relational aspects. As shown in the fig-

ure (Figure 6), the goal is to safeguard the couple, necessitating determination, positivity, and the involvement of various factors, both personal and external.

Figure 6. Word cloud summarizing how couples adapt to serodiscordance.

4. Discussion

The process of adaptation initiates when partners disclose their respective serological statuses, marking the onset of serodiscordance. Following this, the stages involve expressing feelings and emotions, engaging in questioning, renegotiating the terms of their relationship, and reaching a mutual agreement.

4.1. Stages of Adapting to HIV Discordant Status

Broadly speaking, the stages through which couples adapt to HIV serodiscordance resemble those experienced by patients adjusting to chronic illnesses, as documented in Mali [18]. In the context of chronic diseases, adaptation is a personal journey that culminates in the acceptance of one's health status and frequently receives support from close relations such as spouses, children, siblings, and the community. In the case of HIV, this adaptation process is even more intimate due to the limited number of individuals who are privy to this information.

The process of adapting to serodiscordance involves both individual and collective efforts, with each partner needing to first adjust to their own status, then to their partner's status, and ultimately to adapt together through strategies that focus on the couple and their interactions with the surrounding environment. Consequently, the stages of "questioning" and "renegotiating the terms of the union" are critical as they engage the couple's interactions as a unit or dyad within

the community. As Paterson describes in the context of the changing perspectives model, adapting to a chronic illness or situation is a continual and dynamic process [19]. For couples experiencing HIV serodiscordance, the perception of the disease in relation to both the individual and the couple shifts according to the couples' specific needs and immediate priorities. The strategies implemented here are partly those described by Lazarus [10], particularly those focused on reappraisal and emotion management; strategies aimed at modifying or eliminating the problem cannot be applied in the context of HIV serodiscordance. By comprehending the stages of the adaptation process in couples dealing with HIV serodiscordance, it becomes possible to enhance the support provided to these couples by anticipating the genuine needs of each partner at every stage. Throughout each stage of this adaptation, couples require nearly continuous psychological support.

In Benin, teams that provide care for couples are supported by psychologists; however, these psychologists are primarily engaged in handling problematic situations, such as depression, and are not involved in addressing the psychological shock associated with serodiscordance. Considering the critical nature of managing these various phases, it is recommended that psychological training be provided to all personnel involved in the follow-up process. Furthermore, the active presence and participation of psychologists in the follow-up sessions can significantly enhance the support for these couples, aiding them in adapting to the stress-inducing circumstances. This approach is particularly crucial, as evidenced by the depression index in Burkina Faso, which stands at 3.5 ± 2.1 for HIV-positive partners and 3.3 ± 1.6 for HIV-negative partners in serodiscordant relationships.

4.2. Disclosure of Serological Status

The process of disclosing discordant serological status between partners is a pivotal phase in the adaptation process and marks the genuine commencement of living with serodiscordance. Successful disclosure under favorable conditions can significantly enhance adaptation to a discordant status. These conditions should be tailored to the unique characteristics and vulnerabilities of each individual. The method of disclosure, whether face-to-face or via telephone, and the circumstances-be it spontaneous mutual disclosure, accidental revelation, or facilitated by healthcare professionals-should be strategically chosen to suit each situation. Although national guidelines exist, healthcare personnel involved in couple support often lack specific training for this task. Moreover, the discussion of respective serological statuses is greatly facilitated when HIV has already been a topic of conversation within the marital setting [20]. Consequently, healthcare professionals currently urge newly diagnosed individuals living with HIV to initiate and foster communication about HIV within their relationship prior to any status disclosure.

4.3. Emotion Management and Inquiry

The emotional responses of partners when discussing discordant HIV status dif-

fered based on their respective positions. Infected individuals predominantly conveyed emotions of shame and guilt, whereas HIV-negative partners primarily expressed feelings of doubt.

The shame and guilt experienced by infected individuals are rooted in the negative societal perception of HIV, which is often linked to infidelity, promiscuity, and impurity, particularly within stable relationships. Serodiscordance is thus viewed as evidence of infidelity on the part of one partner and reliability on the part of the other. For the HIV-negative partner, the notion of remaining uninfected despite engaging in risky behaviors, such as unprotected sexual intercourse, appears implausible.

In Uganda, individuals who tested seronegative reported experiencing confusion and disbelief [21]. This is largely due to the prevailing perception that HIV is easily transmitted through sexual contact, with even a single encounter being sufficient for transmission [22].

In Cameroon, to navigate the crisis triggered by the discovery of serodiscordance, couples engage in defense mechanisms such as intellectualization, sublimation, denial, and rationalization [5].

The questioning phase, a frequent component of the adaptation process, is likely the most critical. During this phase, couples come to understand the implications of their serostatus and the unique challenges it presents. Addressing this phase involves a combination of personal, interpersonal, and structural factors. It is essential that this phase be managed, controlled, and soothed, as there is a risk of encountering a blockage that could hinder the adaptation process. According to some scholars, the presence of HIV/AIDS in one partner can lead to psychological disarray, necessitating a reconfiguration of the marital relationship. To facilitate this, couples draw support from themselves, their partners, families, cultural backgrounds, children, healthcare providers, and peer groups [5].

Fear

Fear in serodiscordant relationships, fear is a prevalent emotion. It is typically experienced in anticipation of danger, which may involve potential harm or disadvantage [23]. While initially, the announcement of an HIV-positive status evokes a fear of AIDS-related mortality [24], there is a growing concern about the social ramifications of the disease [25]. Within couples, fear predominantly revolves around the potential failure of the relationship and/or the disclosure of the serological status. This fear is experienced by both the HIV-positive and the HIV-negative partners. The process of adapting to seropositivity [4] involves stages from denial to adaptation and integration, passing through anger, bargaining, and ultimately fear and depression [26]. Fear is the defining emotion or outcome in serodiscordant relationships. Upon learning of the HIV-positive partner's status and sharing it, fear becomes entrenched. For the person living with HIV (PLHIV), fears include concerns over their health and survival, the serostatus difference, the partner's and/or social circle's reactions, the risk of infecting their partner, children, or relatives, potential discrimination, inability to overcome this "ordeal,"

and the future of their relationship or life. For the HIV-negative partner, the primary fears are infection and being mislabeled as HIV-positive. As a couple, the fear of societal judgment is a persistent concern. Distrust may develop between partners. Consequently, the fear of stigmatization has led to reduced HIV disclosure and diminished social support for accessing HIV care [27]. Stigma and discrimination compel people living with HIV to conceal their serological status, significantly affecting their marital and social lives, particularly in serologically mixed relationships. Some authors argue that stigma is not merely a vague sociological concept but a tangible public health concern affecting both HIV-negative individuals and PLHIV. It can adversely impact infection prevention, testing, healthcare access, and health management for PLHIV [28]. According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), stigma and discrimination lead to a low perception of individual risk (as only stigmatized groups are viewed as vulnerable), reluctance to ascertain one's HIV status due to fear of negative consequences, avoidance of seeking care to prevent suspicion about serological status, and increased vulnerability of others. Organizationally, these issues manifest as inadequate counseling and support, and refusal to provide appropriate care to people living with HIV [29]. In the process of dyadic adaptation, seeking support, as well as the ability to express emotions, are associated with positive adaptation through a lower degree of marital stress [30]; a factor compromised by the stigma and discrimination faced by people living with HIV (PLHIV).

4.4. Redefining Terms of Union

In our study, the redefinition of the terms of union involved reprioritizing certain aspects, introducing new clauses not initially present in the relationship (such as polygamy), and empowering the individuals involved. Polygamy, considered here in the process of positive adaptation, represented by any legitimate union of a man with several women [31], is a polygamy that is accepted, tolerated, and lived without negative repercussions on the couple's organization. While HIV renders the carrier vulnerable to the disease, serodiscordance introduces vulnerability within the partnership. Establishing a healthy dialogue can normalize the relationship; otherwise, an imbalance may arise, potentially impacting the couple.

Marital life provides a context where decisions are formulated and subsequently implemented [32]. Serodiscordance introduces novel challenges for couples, necessitating a reconsideration of procreation, discussions on risk management strategies for transmission, and the establishment of a communication plan between partners. Sexuality management is a primary concern, particularly the recommendation to consistently use condoms during every act of sexual penetration. Many scholars argue that condom use is incompatible with marital life and may lead to its abandonment [33] [34]. The requirement to regulate one's sexual activity and use condoms can result in unsatisfactory sexual relations or even cessation with the partner, prompting some individuals to seek external partners or engage in polygamy to regain spontaneity and sensation [35]. Consequently, most cou-

ples engage in negotiations, leading some partners to make compromises [32].

In Indonesia, women developed strategies to cope with their husband's HIV-positive status, which involved establishing contractual strategies. These included learning to maintain distinct serological statuses, adapting to married life without fear, and managing daily sexual safety risks [36].

The process of redefining the terms of the union is aimed at evaluating the couple's ability to establish and maintain a semblance of normalcy. As Persson described in Papua New Guinea, this public normalcy stems from the couple's ability to adhere to social values and fulfill cultural and community obligations such as marriage, childbearing (or having more children), and providing for the family, all while concealing any signs of illness [37].

In Uganda, negotiating sexual relations posed the greatest challenge for couples, potentially leading to abstinence, separation of beds, contractual agreements for external sexual partners, or even the cessation of relations [33]. The situation in our context, however, may raise concerns. In the Borgou department, women, who represent the HIV-positive partner in most cases, have low decision-making autonomy and a normalized sense of submission to their partner's power dynamics. Negotiation therefore often occurs to their disadvantage, and the secrecy surrounding the couple's serological status does not help.

4.5. The Role of the Seronegative Partner in the Adaptation Process

In the context of adapting to serodiscordance, the seronegative partner assumes a crucial role. The seropositive partner often, due to feelings of shame and guilt, defers the decision-making and adaptation process to the seronegative partner, perhaps as a means of atonement for the perceived "fault" of their condition. The revelation of seropositivity can sometimes be tantamount to admitting or confirming infidelity, shifting the issue from a biological characteristic to a moral one, affecting the perception of the individual who was previously seen as ideal or beyond reproach [20]. The seronegative partner is thus tasked with the significant emotional responsibility of incorporating this new reality into their lives. They must first undergo their own adaptation and then lead the couple through this journey. Their role extends beyond that of a life partner and parent to include being a custodian of their partner's health and well-being. Giraud highlights that the seronegative partner provides support in battling the illness, serving as both a daily companion and caregiver during critical times, while also safeguarding the partner's secrets, all the while concealing the burden of this role and their own fears to avoid distressing the seropositive partner [20]. Without adequate support, this burden, though beneficial for managing the illness, can contribute to the deterioration of marital relationships. This underscores the importance of providing psychological support to seronegative partners.

Currently, strategies for addressing HIV do not include psychological support for the seronegative partners of individuals living with HIV (PLHIV). Typically,

their follow-up involves regular biological assessments to monitor their health and serological status. Nonetheless, the emotional and psychological burden they experience is substantial, and their well-being plays a crucial role in the adaptation and improved well-being of their HIV-positive partner. Consequently, it is essential to implement a support system for each member of the serodiscordant couple.

The significant role of the seronegative partner can be summarized as follows (Table 3):

Table 3. Summary table comparing the specific roles and responsibilities of seronegative partners based on the testimonies.

Specific Roles	Challenges Faced	Impact
Provide emotional support	Managing Fear and Uncertainty	Reduces anxiety of the HIV-positive partner
Encouraging acceptance of HIV status	Carrying the emotional charge of the couple	Improves adherence to ART
Making decisions about safeguarding practices	Dealing with social and cultural pressures	Decreases the risk of HIV transmission
Actively participate in medical follow-up	Lack of external psychological support	Strengthens the resilience of the couple
Maintaining Relationship Stability	Potential stigma related to discordant status	Promotes positive marital dynamics

5. Conclusions

The adaptation of couples with HIV serodiscordance is essential for meeting global targets in the response to the pandemic. Positive adaptation supports couple stability, enhances adherence to antiretroviral therapy (ART) by the infected partner, and improves their health and well-being. Conversely, maladaptation can lead to problematic psychological and relational functioning, with potential outcomes such as rejection, abandonment, divorce, various forms of intimate partner violence, or even death [38]. It is imperative that all individuals involved in supporting serodiscordant couples are familiar with the stages of adaptation and provide guidance to prevent the deterioration of marital relationships. Additionally, power dynamics within these couples must be balanced to ensure that both partners can flourish without compromising each other's well-being.

Psychological support for the adaptation process should be systematically integrated rather than reserved for cases of severe disorders. Nevertheless, considering the priorities and the limited availability of psychologists, contemporary solutions utilizing digital technologies could be offered to couples for remote or virtual monitoring.

6. Recommendations

The issues raised by the results of this study lead us to make the following recommendations:

1) Implement systematic psychological support: Psychologists should be inte-

grated from the discovery of serodiscordance to support couples at each stage of the adaptation process.

2) Develop adapted strategies for sharing serological status: Train healthcare professionals to support couples when sharing their serological statuses, taking into account cultural sensitivities and relational dynamics.

3) Strengthen the role of seronegative partners: Offer support programs specifically designed for seronegative partners to help them manage their emotional burden while actively involving them in the medical and psychosocial follow-up process.

4) Organize support groups for serodiscordant couples: These groups could serve as a platform for sharing experiences and best practices while providing a safe space to discuss challenges and possible solutions.

5) Facilitate access to digital tools for follow-up and support: Develop applications or online services to allow remote support, share educational information, and provide practical advice on managing serodiscordance.

6) Integrate training for healthcare professionals on managing serodiscordance: Include specific modules on the dynamics of serodiscordant couples in health training programs, particularly on managing emotions, communication, and the role of seronegative partners.

7) Strengthen community awareness campaigns on serodiscordance: Develop communication campaigns to reduce stigma and improve understanding of HIV serodiscordance within communities. These campaigns should include messages on the positive roles seronegative partners can play.

8) Promote preventive marital support mechanisms: Organize workshops for couples from the time of testing to prevent conflicts and encourage early adaptation to serodiscordance, integrating tools such as couple therapy.

9) Encourage the use of PrEP and condoms in serodiscordant couples: Strengthen access to pre-exposure prophylaxis (PrEP) and promote its regular use for seronegative partners, along with training on the correct and consistent use of condoms.

10) Adapt cultural and religious approaches to supporting couples: Collaborate with religious and cultural leaders to integrate messages on the acceptance and support of serodiscordant couples, respecting local values.

11) Evaluate the impact of interventions for serodiscordant couples: Implement a monitoring and evaluation system for support programs to identify the most effective approaches and adjust them according to the evolving needs of couples.

12) Ensure multidisciplinary care for serodiscordant couples: Integrate professionals such as sociologists, lawyers, and social workers into the support of couples to address the psychosocial and legal dimensions of their situation.

7. Study Limitations

While this study provides valuable insights into the adaptation process of couples to HIV serodiscordance, certain limitations must be considered when interpreting

the results:

1) Data collection was limited to Parakou, an urban center, which may restrict the generalization of the results to the entire population of serodiscordant couples. Although some participants came from rural backgrounds, a greater involvement of these groups could have accounted for other cultural and social dynamics.

2) By targeting couples that have already shown positive adaptation, the study does not address the issue of adaptation in its entirety, particularly the perspectives of those facing failures or major difficulties in adapting.

3) The cross-sectional nature of the study does not allow for a detailed exploration of long-term changes in marital dynamics, a gap that could be filled by a longitudinal study.

4) The study did not deeply explore community dynamics, especially the influence of the community (extended family, religious leaders, social networks) on the adaptation of couples. Although this was due to the silence surrounding the disclosure of the couple's discordant status to their entourage, such an approach would have enriched the topic further.

These limitations, while reducing the scope of the conclusions, open up opportunities for future, more inclusive, and diversified research.

8. Future Research Perspectives

1) Expand the study to rural areas or nationwide to gain a comprehensive understanding of the dynamics of couple adaptation to HIV serodiscordance based on geographic areas, living environments, and cultural contexts.

2) Study couples experiencing difficulties in adaptation to obtain a more complete view of the adaptation realities for these couples.

3) Conduct longitudinal studies with couples at the beginning of their adaptation experience (from the sharing of their respective serological statuses) to describe the circumstances and evolution of the adaptation process and identify resilience or degradation factors in marital life.

4) Integrate a community approach for couples who have shared their discordant serological status with their entourage and community to study the impact of social representations, social support, and discrimination on the adaptation dynamics of couples over time.

Propose and test psychological support programs for seronegative partners and measure their impact on the adaptation process.

Conflicts of Interest

The authors declare no conflicts of interest regarding the publication of this paper.

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