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DATING AND SEXUAL CHALLENGES FACED BY HIV-POSITIVE PEOPLE IN KWAZULU-NATAL, SOUTH AFRICA

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INTRODUCTION

According to the 2010 UNAIDS Report, an estimated 320 000 (or 20%) fewer people died of AIDS-related causes in 2009 when compared to figures in 2004 in sub-Saharan Africa, when antiretroviral therapy was markedly expanded (UNAIDS, 2010). This decreased mortality rate offers hope for HIV-infected people to plan a future, part of which will include dating and sexual relationships. The Report cites KwaZulu-Natal in South Africa as being at the heart of the HIV/AIDS epidemic; this article is based on research on dating and sexuality among HIV-positive people in KwaZulu-Natal.

Dating and sexuality are an integral part of living. Yet HIV-positive persons are denied intimacy at a time when this is most needed (Kasiram in Kasiram, Partab & Dano, 2006). Little is known about the full range of sexual adaptations that HIV-infected individuals choose (Schiltz & Sandfort, 2000). Kasiram, Partab, Dano and Van Greunen (2003:9) cite interaction and intimacy among HIV-positive persons as a neglected research focus, while Painter (2001) adds that insufficient attention is afforded to couple relationships for infected people.

An important reason that motivated this study on dating and sexual challenges faced by HIV-positive people was the first author's (the main researcher's) personal experience of being HIV positive and counselling and life coaching HIV-positive people. She is confronted regularly with variations of the question "Will I be normal?", which often translates to: "Will I be able to date and have sex?"

RESEARCH METHODOLOGY

The aim of the study was to understand the dating and sexual challenges faced by HIV-positive people. To this end its objectives were: exploring factors influencing and challenging the dating and sexual experiences of HIV-positive people; investigating the responses of HIV-positive persons to these challenges; and listing their recommendations on how to better manage their dating and sexual relationships.

The study employed a qualitative paradigm to provide thick descriptions of the dating and sexual challenges of HIV-positive people. This paradigm allows one to glean rich data, to uncover feelings, thoughts and meanings around the topic (Babbie, 2005), while simultaneously allowing the researcher to be "sensitive", as sex is often regarded as a "taboo" topic that takes time and sensitive attention to be uncovered comprehensively.

The target sample was HIV-positive persons over the age of 21, since at this age people would have likely accumulated some dating and sexual experiences. Other criteria for participation were race, gender and proficiency in English, since it was anticipated that data-rich and sensitive information could get contaminated and/or lost during translation. Thus criterion and purposive sampling measures were employed at the outset within a

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non-probability framework. After initial contact was made with participants (through approaching a variety of agencies known to the researcher), snowball sampling was used to secure the remainder of the sample. The final sample was 12 HIV-positive people, between 26 and 53 years of age.

The data were collected by way of semi-structured interviews, using mainly open-ended questions. The interviews were digitally recorded (with the participants' permission), transcribed and later categorised in order to assign themes and sub-themes, following content analysis procedures described by Terre Blanche, Durrheim and Painter (2006).

Ethical considerations

Since the topic was sensitive, often causing painful issues to surface, it was necessary to be responsive to participants' needs/problems. Accordingly, participants were referred to organisations, therapists and social workers for the necessary assistance. In some instances, where participants' problems needed immediate attention, the researcher (first author) offered direct assistance herself, conflating the role of researcher and therapist. Being a social worker and experiencing the problem first-hand, the researcher was able to conflate these roles, although this proved to be emotionally draining and time consuming.

Engagement and disengagement procedures were used to ensure that participants were adequately prepared for the discussion, while also not allowing them to feel "abandoned" at the conclusion of the discussion.

Anonymity and confidentiality were respected. Participants were apprised of the study purpose and how results were to be used, and assured that their identity would remain anonymous (Babbie & Mouton, 2005).

Ethical clearance from the university under whose auspices the research was conducted was also secured.

Trustworthiness

To ensure dependability of data, the researcher requested the identity documents and HIV results from each participant to authenticate details such as age and status. Credibility was achieved by transcribing the digital recordings word-for-word – this process was also made available for auditing to promote authentication. Transferability was achieved by using two data sources (written notes and tapes) and densely describing findings. Triangulation of data sources was also employed in view of the fact that 12 participants were interviewed. Honesty was stressed using social work skills, which enhanced the general trustworthiness of the data.

Limitations

Conflating the roles of researcher and therapist was time consuming and emotionally exhausting. This was exacerbated by the first author being "close" to the research topic, with the possibility that data collection and collation may have been compromised. To control for this, supervision was regularly sought and used, with debriefing included. Furthermore, the digital recordings helped ensure that all data were considered, not only

http://dx.doi.org/10.15270/49-3-51

those which made sense to the researcher, thereby lending "neutrality" to the data-collection process.

It was not possible to get an equal representation of all race groups in the final sample, despite many attempts to do so. However, this did not detract from achieving the objectives of the study, which were to glean rich data about dating and sexual experiences of HIV-positive persons.

THEORETICAL FRAMEWORK

The study was grounded in systems theory and ecosystems theory. The systems theory was relevant since it focuses on the arrangement, relations, inter-relationships and connectivity between the parts of a system (e.g. spousal system, sibling and parental dyad etc.) to explain the functioning of the individual in relation to the family (Green, 2003).

Although the study focused mainly on individual, intimate relationships, mezzo and macro factors could not be excluded. Hence it was necessary to include ecosystems theory to the theoretical framework. Mezzo and macro factors included the influence of community and community leaders, the roll-out of antiretroviral therapy and employment policies in respect of HIV in the country.

RESULTS

Results are analysed in accordance with the theory frames used on the study. Both factors affecting dating and sexual experience as well as responses to dating and sexual challenges are presented below. This interlinking produced a degree of overlap, which was unavoidable.

The final sample is briefly described in Table 1.

TABLE 1
SAMPLE DETAILS

No.	Code	Age	Relationship Status	Diagnosis	Treatment
1	CF1	26	Single – in a relationship	2010	N/A
2	WM1	26	Single	2010	N/A
3	BF1	28	Married	2009	2009
4	BF2	30	Single	2003	2004
5	CM1	30	Single	2006	N/A
6	WM2	36	Remarried	2007	2008
7	AM1	43	Married	2003	N/A
8	CM3	48	Remarried	1997	2005
9	CM2	49	Remarried	2007	2007
10	WF1	52	Divorced/in a casual relationship	2007	2009
11	BF3	52	Single – in a relationship	2011	N/A
12	WF2	53	Divorced/Single	2004	2008

Key: W= White; B= Black; C=Coloured; A= Asian; M=Male; F=Female

http://dx.doi.org/10.15270/49-3-51

All the participants were between the ages of 26 and 53 years of age: five were between 26 and 30 years. According to Louw, Van Ede and Louw (2003), these participants fit into Erikson's early adulthood stage (20 to 39 years); the remaining seven fell into the middle adulthood stage (40 to 59 years).

The sample consisted of 11 heterosexual HIV-positive people and one homosexual male. Six participants were male and six female. Initially, the sample was supposed to comprise three participants from each of the four race groups. However, the researcher encountered difficulty recruiting the required number of participants from the Indian race group despite extending the time frame allocated for acquiring research participants. It is assumed that this difficulty may be attributed to a culture of shame and silence among Indian HIV-positive people, with poor participation of Indian HIV-positive persons being similarly cited in the South African National HIV Survey (2005); hence there were four Coloured, four White, one Indian and three Black participants in the final sample.

Factors influencing and challenging dating and sexual experience

There were numerous factors cited by participants ranging from emotional and physical factors at a microsystemic level to mezzo- and macrosystemic influences such as community, media and policy that influenced and challenged HIV-positive persons with regard to their dating and sexual experiences.

Feelings of guilt, anger, fear, disconnection, denial, discrimination, stigma, rejection and poor self-esteem also influenced and challenged HIV-positive persons with regard to their dating and sexual experiences.

Guilt, anger, blame, social disconnect, negative self-esteem and self-worth and fear are common outcomes after a positive HIV diagnosis and are experienced in a complex web of interrelationships (Kasiram, 2011). These feelings and behaviours are a challenge in dating and sexual experience in a variety of ways.

Feelings of guilt at bringing a positive diagnosis into the relationship strained many relationships and this was sometimes provided as a reason for the collapse of relationships, as noted in the following comments:

> *"I was shocked, frustrated and blamed my wife for infecting me. I really believed my wife infected me and I went berserk. I fought with her and the next day I forced her to go with me to have a HIV test … she was negative." (AM1)*

> *"That relationship ended about six months later." (CF1)*

The strain also resulted in violence and abuse as cited below:

> *"I really beat my wife and she ended up divorcing me." (CM3)*

According to Maman, Mbwambo, Hogan, Kilinzo and Sweat (2001), women experience more negative reactions, such as physical abuse after a serostatus disclosure (Ramachandran, Yonas, Silvestre & Burke, 2010) and this was indicated in the above comment on the negative violent reaction.

http://dx.doi.org/10.15270/49-3-51

Alcohol abuse was also cited as straining the relationship and mentioned in the literature (Avert, HIV & AIDS in South Africa, 2007). The following participant's lament exemplifies the abuse of alcohol and how it impacted on the relationship:

> *"That relationship ended about six months later. My ex-boyfriend was drinking heavy…." (CF1)*

Negative self-esteem and self-worth were related experiences. The following responses exemplify poor self-esteem and self-worth:

> *"I was really down because I did not think any other woman would accept me with my illness." (WM2)*

> *"My self-esteem took a dip… when you've been ditched you feel worthless." (CM2)*

> *"I feel dirty…," (AM1)*

However, one participant felt supported by his partner:

> *"…good that she chooses to stay with me even though she is negative." (AM1)*

Vyavaharkar, Moneyham, Tavakoli, Phillips, Jackson and Mending (2010) also found that supportive environments improve self-esteem and self-worth, as evidenced in the comment above, where the participant was clearly happy that his partner remained with him. In this instance, this positive feeling was much appreciated given the partner's negative status.

Anger was another commonly experienced emotion. Anger was directed at the source of infection, at bringing HIV into the marriage and family. An emotion related to anger was fear, experienced in varied ways. There was, for example, fear of being blamed for infecting a partner and fearing the resultant loss of the relationship. The following comment exemplifies the anger and frustration experienced at being HIV positive and fearing termination of the relationship:

> *"I experienced stigma from a guy that ran away when I told him I was HIV-positive. When we were making out and he didn't have a problem but as soon as I told him my status, then he wanted to go and get condoms and never came back and didn't answer my calls." (CF1)*

Fear was also experienced as panic after learning of one's positive status as indicated in the following comment:

> *"It's scary because I was scared when I first found out." (CM1)*

Smith (2002:65) cites a similar fear stating that "people from groups associated with high incidences of HIV-infection – including injecting drug users, men who have sex with men, and commercial sex workers – are subject to a culture of fear and punishment when their HIV status is suspected". This fear runs deep and infiltrates functioning at many levels (systems theory) as noted in the following comment:

> *"Well, my mother she always tells people and I don't feel good… it just depresses me, I feel bad and it hurts me a lot. Well, I get depressed and I believe*

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> *that if I have to tell people I'm HIV positive, it eats me up as I always have to wait for their response and see if they are going to deny me, rape me, neglect me. That hurts me. I don't feel good about it." (WM1)*

There is also fear of rejection, associated with blame and abandonment, which in turn are related to non-disclosure as discussed by Sowell, Lowenstein, Moneyahm, Demi, Mizuno and Seals (1997), Kalichman, Dimarco, Austin, Luke and Difonzo (2003) and Dano (2007).

Anger and fear are clearly closely tied to denial and disclosure.

Disclosure, stigma, rejection and discrimination are intertwined and impact on dating and sexual experience as evidenced in the following comments:

> *"…fear of infecting someone put me off sex…." (WF2)*

> *"I decided not to have sex with my wife, for fear of infecting her... I think she was scared of being infected too." (WM2)*

Several participants chose not to disclose for fear of rejection and discrimination (Berk, 2001; Parker & Aggleton, 2003). In some cases remarriage had taken place without disclosure to new partners on the assumption that partners knew because they were "still using condoms". The relationship between non-disclosure and fear of rejection is apparent, placing the marriage and communication within it at risk, since condom use is not restricted only to preventing contraction of HIV.

Non-disclosure was also cited as protecting family members from the pain of "knowing", and is mentioned by Palmer and Bor (2001). In the present study it produced negative consequences, as mentioned below:

> *"We have not disclosed our status to my partner's family because they are negative about HIV-positive people so we just sit there and listen when they talk about HIV-positive people and think to ourselves if that's what they think about others, can you imagine what they will say and do to us…. My family knows my status and yet his family doesn't know his and we are being dishonest and secretive and that's not nice." (CF1)*

Only one participant's disclosure was well received. In this case we note that the first marital partner reacted negatively to late disclosure which resulted in divorce and learning from this experience. The new partner appreciated full and timely disclosure, and the couple subsequently married.

Disclosure is clearly a complex issue as discussed by Arnold, Rice, Flannery and Rotheram-Jones (2008) and Klitzman, Exner, Correale, Kirshenbaum, Remien, Ehrhart, Lightfoot, Catz, Weinahrdt, Johnson, Morin, Rotheram, Kelly and Charlebois (2007). In the present study disclosure had more negative than positive consequences. What was also disconcerting was the finding that counselling did not prepare participants to deal with the negative consequences of disclosure.

One participant felt stigma was an individual choice and largely self-inflicted. He referred to this along the following lines:

http://dx.doi.org/10.15270/49-3-51

> *"Stigma doesn't affect me. All those people who talk about stigma are people with a low self-esteem… I told my current wife my status when I met her in front of her friend. As time went by I told her she shouldn't clam up about it. If she wanted to be with me she had to tell her family, her friends, her children, anybody and everybody….I see the individual's confidence and self-esteem playing a greater role than stigma." (CM2)*

This meant that the person had to be strong in withstanding negative responses from others. According to this participant, self-esteem and self-worth determined dating experiences more than stigma, as these attributes influence comfort and confidence in pursuing dating and sexual relationships. The reciprocal relationships across these factors may be appreciated using systems theory.

Social disconnection was also commonly experienced and tied to several factors such as non-disclosure, fear and anger, all intertwined with reciprocity.

Serosorting (where people engage in unprotected sex with partners of a similar HIV status, according to Liu, Hu, Goparaju, Bacchetti, Weber, Correa, Nowicki & Wilson, 2011) and abstaining were other considerations that affected dating and sexual experience. Both serosorting and abstaining are responses to dating, and also factors that predict future dating or sexual experience.

Responses to dating sero-positive or sero-negative partners showed no real trend either way, as evidenced in the following comments.

Dating sero-negative people

> *"I prefer dating a HIV-negative man because if you date a HIV-positive man you've got all the risk of making yourself sick and getting different strains of the virus…." (WF1)*

> *"HIV-positive people do not want to be with HIV-positive people." (CM1)*

Palmer and Bor (2001) clarify that honesty and disclosure are reasons for sero-negative people remaining in, or choosing to be in, discordant relationships as they know their partner's status. Similarly, Dano (2007) also found that such couples were able to negotiate and sustain safer sexual practices. In the present study disclosure was not a significant finding, yet it seems to have been valued.

Dating sero-positive people

> *"I feel it is better to date a HIV-positive person because you are both going through the same thing. Because you don't need to tell a person then wait and see if they will still go out with you. I feel better in this new relationship because we understand one another. So it is good for us because we both positive." (CF1)*

Some participants clearly argued for relationships with people with whom they shared a common illness. This concurs with the study done in the United States from 2001 to 2005 (Liu *et al.*, 2011) where serosorting was practised.

http://dx.doi.org/10.15270/49-3-51

Abstaining

Some participants chose not to have sex at all as exemplified in the following comment:

> *"I'm not dating at the moment. I have no sex, not even masturbating and I'm content abstaining, quite frankly." (WF2)*

This participant temporarily suspended dating for medical reasons, explaining as follows:

> *"After that [the physical reaction – genital warts] I backed off and didn't date anyone because of the acquired disease and I had genital warts at one point as well as skin lesions on my vagina and I chose to suspend dating as it was embarrassing and would put someone off…." (WF2)*

Balfe and Brugha (2010) similarly highlight that some people suspend sexual activity because their partners' reject them or choose not to engage in sex for fear of contracting sexually transmitted infections (STIS).

Another participant's choice to abstain was communicated as follows:

> *"I'm abstaining… the Bible says no sex before marriage.. .I did make mistakes before but now I want to make things right this time." (BF2)*

This participant chose abstinence for religious reasons. She viewed her previous engagement in premarital sex as a "mistake" and her abstinence as making "things right this time"; this phenomenon of wanting to correct things is also mentioned by Keikelame, Murphy, Ringheim and Woldehanna (2010).

The decision to serosort or not, or to abstain, may be viewed as an individual (microsystemic) decision. However, the ripple effects of this decision are far reaching in the light of systems theory, influencing potential partners and the family.

Physical, medical and psychological factors included dry skin, wasting, rashes, lipodystrophy and oral thrush that negatively affected participants' self-esteem. Lipodystrophy is recognised as exacerbating the psychological distress of patients, with only a drug swop, exercise and diet being currently advocated to reduce the impact of this side effect (Heyer & Ogunbanjo, 2006). These factors were convincingly found to influence dating.

Concerns around these factors were:

> *"… my skin is dry and I've lost some weight… got like rashes on my body…. doesn't make me look good. It makes me feel ugly … if they see rashes on me they will believe they would get it too. That it's contagious." (WM1)*

> *"The fat around my stomach is just not on. It does not look nice… My lipodystrophy has made me a homebody." (WM2)*

> *"I get oral thrush a lot and I can't kiss then so my wife gets upset and I get upset." (AM1)*

http://dx.doi.org/10.15270/49-3-51

Condom breakage, STIs, inability to have a baby, awaiting blood results, unemployment and inadequate finances negatively affected participants and their dating behaviour, for example:

> *"I stress about money because I'm not working… How can you really go out and date when you don't have money." (AM1)*

> *"… if the condom breaks, the STIs that I may get? I worry about having a baby." (BF1)*

Condom usage presented a problem for the majority of the participants as it depressed spontaneity and spoilt the sexual atmosphere. Most participants were uncomfortable about using condoms for the rest of their lives. Sero-negative partners did not want to use condoms as the feeling was that they were married and that people in committed relationships did not use condoms, irrespective of their status. Fear of compromising the relationship, alongside possible non-disclosure are apparent, these being key findings in this study. One participant stated clearly that she did not use condoms with her reinstated partner, because she had not disclosed to him. Such behaviour involving fear and poor communication are common in female studies and highlight gender inequalities in relationships (Kasiram, 2011). It is therefore possible that gender inequality is a feature in dating and sexual behaviour that warrants dedicated research.

A few participants expressed low libido as compromising their sexual behaviour. One participant was even diagnosed with depression and attributed this to his low libido and erectile dysfunction, while another blamed drug usage for his decreased libido. On the other hand, one participant cited menopause for her increase in sexual desire.

A few participants on ARV treatment found that ARVs increased their sexual desire, with one participant claiming to have become a "sexaholic" because of treatment. This claim finds support in a Ugandan news report by Plus News (2008) that taking ARVs brought sex back into the marriage. However, other participants' sexuality was not affected by treatment; this variation finds support in studies by Maticka-Tyndale, Adam and Cohen (2002), Jalibert (2001) and Keegan, Lambert and Petrak (2001), which state that variation in ARVs affecting sexual experience was commonplace.

Challenges to dating

Dating options did not feature in counselling sessions; neither did participants themselves bring this up as a concern. HIV online chat rooms and blogs were hardly used, because of technological and financial limitations as indicated below:

> *"I don't have the internet or a computer so it's difficult for me to use it. If my financial status changed, then I would definitely go for online dating." (WM1)*

Singles clubs were used by only two participants, not being popular as exemplified in the following comment:

> *"From late last year I used to go out with friends to singles evenings. But they were a dead loss and I think all horrible dregs go to these singles clubs." (WF2)*

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These responses suggest that HIV-infected people themselves may be contributing to their dating and sexual frustrations by not seeking advice.

Participants reacted differently to their dating and sexual challenges. The reactions were indicated as: social disconnection, abstinence, divorce, disintegration and termination of relationships, alcohol and physical abuse, alternative dating facilities. These reactions/results have featured already as responses to a positive status. The cybernetics of converging factors as per systems theory is apparent here.

Counselling, community, media, government and religion as factors influencing and challenging in the dating and sexual experience

Participants lamented that grief, loss, sexually transmitted infections/diseases, serodiscordant relationships, disclosure, sexual changes and dysfunctions, reproduction and dating were not covered in the limited number of counselling sessions they were required to attend.

Participants unanimously agreed that communities and society played no positive role in their dating and sexual lives (mezzosystemic factors influencing dating/sexual experience). Participants seem not have considered their own role in this, since it is likely that non-disclosure on their part may have resulted in their not participating in community projects and programmes. Cultural factors that inhibit discussion about sex (Thornton, 2008) could also be attributed to the perception that society plays no meaningful role.

Participants were divided on how media influenced their dating and sexual lives. Some felt that the media had exacerbated the challenges they faced by negative and sensational portrayals of HIV-positive people. Others differed, stating that certain programmes such as *Isidingo, Siyanqoba, Intersexions* and *Generations* played a positive role, since HIV-positive people were here shown as sexual beings who dated and had sex. Examples of these mixed views are:

> *"I've watched programmes about HIV and they just talk about condoms and they don't talk about dating and sex and we are not being informed about the choices we can make." (WF1).*
>
> *"Media plays some role because there are programmes that talk about HIV and infected people being in relationships. Like 'Isidingo' is a good one but now Nandipha is no more on it. Generations had a bad one, because the guy that was positive did not want to date the lady, then when she found out she slapped him. There is a show on radio which talks about HIV." (CF1)*

Media could normalise decisions to date and have sex with an infected person and become a powerful agent in education, as discussed by Wellings and MacDowall (2000:23): "The strength of the mass media lies in helping to put issues on the public agenda, in reinforcing local efforts, in raising consciousness".

http://dx.doi.org/10.15270/49-3-51

Participants were generally pleased that government provided free testing, condoms, medication and counselling, and many participants utilised these services as exemplified in the following quote:

> *"A lot is being done by government like counselling…Counselling is for free and they also provide free condoms and ARVs." (BF3)*

However, they felt that services were not holistic and did not address their dating and sexual needs. Politics, especially that associated with AIDS denialism, was cited as clouding government's ability to offer optimal treatment in respect of AIDS as follows:

> *"Government contributed to the negative connotations of people who are HIV positive… I don't trust them whatsoever." (WF2)*

As regards religious organisations, only one participant stated that the church supported her, but not regarding dating and sexuality. All other participants complained that religious organisations emphasised prohibition of premarital sex and not using condoms. Anger at churches having double standards was discussed in that abstinence was preached, while at the same time children born out of wedlock were baptised, as referred to in the following comment:

> *"They are not playing a role because they preach abstinence from the pulpit but then they take the same child that was borne out of wedlock and baptize him. How does that make sense?" (CM2)*

CM2's response finds support in a South African study highlighting the ambiguous stance adopted by government and religious organisations, with condom and contraceptive use, abstinence, polygamy, monogamy and marriage all being jointly advocated (Zwang & Garenne, 2008).

Participants also lamented how difficult it was to discuss dating and sexuality with members from religious organisations, because guilt and shame were often experienced. They complained that the atmosphere was one of blame, as discussed by Shorter and Onyacha (1998), and of ostracism, discussed by Krakauer and Newbery (2007).

CONCLUSIONS AND RECOMMENDATIONS

HIV stigma is still largely prevalent among persons who are infected with and affected by HIV/AIDS and it contributes to fear, shame, guilt, divorce, separation, physical and alcohol abuse, non-disclosure, denial, anger, distrust, blame and poor self-esteem. Treatment, sexual (dys)function and reproduction concerns exacerbate the dating and sexual frustrations of HIV-positive people. The media, government, communities and religion were also generally found to frustrate rather than support dating and sexual experiences. HIV counselling did not cover dating and sex.

Based on the findings of the study and suggestions of participants and authors, certain recommendations are made below.

Since non-disclosure was found to be isolating and depressing for participants, counselling (microsystemic intervention) should focus on enabling disclosure. This will positively affect the relationship and will promote more active social connection and

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http://dx.doi.org/10.15270/49-3-51

involvement in community life (mezzosystemic influence). Taking responsibility for change may be empowering and help HIV-positive persons reclaim control over their sexual needs/health. It may also allow for engagement with religious bodies who may then more readily encourage discussion about sex.

Since it was apparent that counselling did not generally cover sexuality and dating, it is recommended that counsellors be trained to include these important albeit sensitive topics. These topics could be covered during individual, group and/or family services. Based on the findings, other topics to be covered during counselling include: guilt, grief, loss, blame, anger, self-esteem, discrimination, rejection, stigma, sexually transmitted diseases, death and dying, reproductive choices and abstinence.

At both a micro and mezzo level people should also be assisted with their many physical, medical, psychological and financial challenges, perhaps directly through counselling, but also through advocacy and lobbying for change.

The topic of serodiscordance was found to be confusing for many. Hence it is recommended that both partners be included in discordant couple counselling.

Government should improve and extend counselling facilities at public facilities as most of the participants in this study received counselling at public hospitals and clinics. The request was for serving the patient holistically (include sexuality, intimacy and dating) rather than focusing only on condoms, safe sex, side effects and adherence to ARV treatment. Government could also partner with the private sector to improve services and outsource counselling to private organisations as a way of addressing current service gaps and reducing workload at clinics and hospitals. In addition, the government could ensure that the **National AIDS Helpline** (www.aidshelpline.org.za**)** could have a separate section dedicated to dealing only with dating and sexual issues.

This study did not point to support groups being used as a dating option. Support groups could double as dating clubs for infected people. Support group leaders could also network with the corporate sector for supplying computers and internet access, since many participants were found to have no or limited finances and access to this resource.

HIV-dating sites should be improved and advertised so that infected people may become aware of them. They could advertise their services in clinics, hospitals and at support groups. Free sites (sponsored by the government and/or business) would be helpful, given the financial constraints expressed by most participants.

Since only a few instances of positive media portrayal of HIV-positive people dating successfully were cited, it is recommended that the media play a more active role in normalising HIV dating. A real-life documentary series on infected people who have successful dating stories could be shared. Newspapers could also provide free HIV dating columns to allow infected people to pursue dating. Both media and internet dating sites could include databases of professional service, therapeutic centres and refer members accordingly.

http://dx.doi.org/10.15270/49-3-51

Communities need to address the complexities of an HIV diagnosis by incorporating dating and sexual challenges into awareness campaigns. Political leaders, support groups, NPOs and NGOs could initiate this effort, thereby promoting holistic service.

Finally, there is a need for further research with bigger samples from different geographical areas. Expanding this study will also facilitate quantitative analysis, which in turn could influence policy change. Future research could also have specific focus areas such as gender inequality or substance use as influencing the dating and sexual experience. Dating and sexual needs of HIV-positive persons may be regarded as new, unchartered territory and needs to receive financial and other support for on-going research.

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