

**A STUDY OF THE DATING AND SEXUAL
CHALLENGES FACED BY HIV POSITIVE
PEOPLE**

BY

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**Submitted in partial fulfillment of the academic
requirements for the degree of MASTER OF SOCIAL WORK
in the School of Social Work and Community Development,
Faculty of Humanities, Development and Social Sciences
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ABSTRACT

Dating and sexual relations are basic processes in the lives of most human beings. However, dating and sexual relationships in HIV positive peoples' lives are fraught with challenges. Limited knowledge of these challenges is recorded. Studies focusing on the challenges of serodiscordance, ARVS, adherence, side effects of ARVS, condoms, reproduction, disclosure and stigma are plentiful, however studies addressing dating and sexual challenges of HIV positive people are sadly lacking.


The study described and explored the dating and sexual challenges faced by HIV infected people. The systems and ecosystems approach provided the theoretical framework for the study. A descriptive and exploratory design was chosen for this study. Purposive and snowball sampling was utilised to access respondents for this study. Data was collected qualitatively, using semi-structured interviews with 12 HIV positive respondents. The interviewed lasted between 1 to 2 hours.

This study found that People living with HIV (PLHIV) experience many challenges in their dating and sexual lives. The challenges varied amongst the respondents. The challenges were divided into the following themes: disclosure; stigma; rejection and discrimination; dating options to pursue; serosorting or abstaining; guilt; anger; blame; social disconnection; negative self esteem and fear; physical, medical and psychological factors; impact of ARVS; sexual changes/sexual dysfunction; reproduction; community/society; the media; counselling, awareness and education about dating and sexual relationships; government and the consequences of relationships ending.

The study encouraged further research on the topic.

DECLARATION OF ORIGINALITY

I declare that this short dissertation is my original work. All references to the work of others has been appropriately acknowledged and referenced in accordance with university requirements.

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DECLARATION BY SUPERVISOR

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November 2011

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ACKNOWLEDGEMENTS

I would like to thank and express my gratitude to:

All the HIV positive respondents who participated in this study.

To my mom who was by my side throughout, offering me all the support and encouragement I needed during this process.

To my brother, Dean Mulqueeny and sister, Tasnim Gangat, for their unconditional support.

To my friends, colleagues and relatives who encouraged and supported me through thick and thin.

My supervisor, Prof Madhu Kasiram, for her expertise and assistance.

DEDICATION

This study is dedicated to:

My late father, Lyle Mulqueeny, for his unconditional belief in me and for constantly telling me to wear my HIV status with dignity.

and

All HIV positive people around the world: May your HIV journey be filled with love, happiness and joy.

ABBREVIATIONS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
ARVS	Antiretrovirals
CBOS	Community Based Organisations
Ddl	Didnosine
D4T	Stavudine
DOH	Department of Health
FBOS	Faith Based Organisations
HAART	Highly Active Antiretroviral Treatment
HCP	Health Care Professional
HCW	Health Care Worker
HIV	Human Immunodeficiency Virus
HIV & AIDS & STI	HIV & AIDS and Sexually Transmitted Infections National Strategic Plan (2007 – 2011)
HPV	Human Papilloma Virus
HSV	Herpes Simplex Virus
IPV	Intimate Partner Violence
KZN	KwaZulu Natal Province
MDG	Millennium Development Goals
MTCT	Mother-to-child transmission
NGO	Non Governmental Organisation
NPO	Non Profit Organisation
NSP	National Strategic Plan for South Africa
PLHIV	People living with HIV
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of Mother-To-Child Transmission
PWA	People with Aids
SABC	South African Broadcasting Corporation
SI	Self Insemination
STI	Sexually Transmitted Infection

STD	Sexually Transmitted Disease
UN	United Nations
UNAIDS	United Nations – AIDS
UNGASS	United Nations General Assembly Special Session on HIV/AIDS
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VL	Viral Load
WHO	World Health Organization

CHAPTER 1

INTRODUCTION

1.1 INTRODUCTION

According to the 2010 UNAIDS Report on the global AIDS pandemic, an estimated 5.6 million people were living with HIV/AIDS in South Africa in 2009. The results in the report suggested that KwaZulu Natal, Mpumalanga and the Free State have the highest HIV/AIDS prevalence (UNAIDS, 2010).

It is now 30 years since HIV/AIDS was first discussed. There have been significant advances in HIV/AIDS prevention and treatment even though an effective vaccine eludes scientists.

Advancements in antiretroviral (ARV) treatment have created a great degree of hope and improved the life expectancy of people living with HIV/AIDS, which begs the question: does ARVS “promote safer sexual practices by reducing the social marginalization and stigmatization of people living with AIDS, thereby making it more likely that HIV positive people will try not to pass on the disease?” (Nattrass 2004:132)

Stigma and discrimination have been negative consequences of many HIV/AIDS diagnoses and disclosures. Van Dyk (2008:319) shows a close relationship between sexuality and stigma as follows “Closely related to negative attitudes towards sexuality are the issues of stigma and stereotyping”. This suggests that stigma and sexuality are closely related and stigma could negatively impact on the dating and sexual life of the infected person.

Van Dyk (2008:293) states some of the challenges facing HIV infected people as being “fear of infection and re-infection; discordant HIV status, disclosure to partner or others; feelings of guilt for bringing HIV/AIDS into the relationship; survivor guilt, blaming and punishing each other; fear of relationship failure; sexual difficulties;

pregnancy; relationship issues with the extended family; caring when illness comes; financial problems and communication difficulties around issues such as sex, death, dying and loss". The myriad of challenges that infected people face play an important role in their dating and sexual life.

Government, non-governmental organisations and community based organisations, interventions and awareness programs have attempted to assist in destigmatising the disease. This study seeks to explore what impact these interventions have made in the infected person's life specifically with regards to dating and sexuality.

Coleman (1998:111) states that "the AIDS epidemic is having repercussions throughout our society in terms of dating, marriage and other intimate relationships in which sex plays a role" and this challenge "may help to foster a better understanding of intimate relationships and have a positive, rather than a negative effect on our thinking in this area". This means that a study focusing on the dating and sexual challenges facing HIV positive people is relevant today in order to ascertain what changes have occurred to date.

Dating and sexual relationships are an integral part of human living. These relationships have existed from the start of time, have posed challenges for individuals and are topical issues. Given that sex is the primary mode of HIV/AIDS transmission, it is important to have an understanding of the challenges faced by HIV infected people when pursuing dating and sexual arenas.

The prevalence of HIV/AIDS in South Africa begs the topics of dating and sexuality to be explored as thirty years down the line, all people irrespective of their HIV/AIDS status deserve to be loved, dated and allowed to engage in sexual relationships.

According to Bergh and Theron (2003) Maslow identified air, water, food and sex as the most basic needs of human beings. The first level in his 'Hierarchy of Needs' sees sex as a physiological need. As sex is an integral part of a person's life it is important to understand the challenges that the infected person faces as a result of his/her positive status.

The third level focuses on the need for love and affiliation whereby the individual feels the need for friends, dating (affectionate relationships), children and a sense of community. It is important for humans to feel a sense of belonging and acceptance. They need to love and be loved (sexually and non sexually) by others.

Campbell's (2003:1) views are similar as sexuality is seen to be shaped and constrained by factors ranging from "the deepest psychological needs for intimacy and pleasure, to the complex and unequal relationships between men and women and rich and poor".

An absence or inadequacy of this could make the individual susceptible to loneliness, social anxiety and depression. Shernoff in Kasiram et al. (2003:9) state that when People with AIDS (PWA's) learn of exposure to HIV/AIDS "their sexual life is seriously affected", straining relationships. Dano in Kasiram et al. (2006) reports that HIV positive people are denied intimacy when they most need it, namely at the face of rejection upon learning of their positive diagnosis.

Sue et al. (2003:305) state that "because sexual behaviour is such an important part of our lives and because so many taboos and myths surround it, people have great difficulty dealing with the topic in an open and direct manner. To some extent Freud made the discussion of sexual topics more acceptable when he made sex (libido) an important part of psychoanalytic theory".

Human beings are social by nature and any threat to their social system impacts on the way they feel and behave. Humans are social beings from the day they are born as they form part of relationships e.g. belonging to a family, school, sport associations, form intimate relationships, partake in sexual relationships, form part of a community, right until their death. Therefore a study of this nature is important to understand what impact/threat an HIV diagnosis plays in the infected person's social, dating and sexual life.

Argyle et al. in Bergh and Theron (2003:197) see "social and interpersonal behaviours and personal relationships, such as attachment styles and loneliness,

social support and social competencies, as related to psychological adjustment and health". This study examines the multiple challenges experienced by HIV positive persons as influenced by the relational nature of human beings (Van Dyk, 2008).

Conducting a study on this topic poses ethical challenges as a result of the stigma and human rights surrounding HIV/AIDS. The researcher is aware that researching dating and sexual practices will pose a challenge as topics involving sex cause people great embarrassment and because sexual relationships and practices always involve a degree of privacy. However, the need for the study prevails despite its potential to be difficult to access participants who will honestly share their sexual and dating experiences.

Dating and sexual challenges are universal and therefore necessitate research as information on this topic is not easily and readily available.

1.2 STATEMENT OF THE PROBLEM

The formulation of a problem involves clearly defining concepts and determining all the variables used as well as their relationships (Bless et al., 2000). To my knowledge there has not been any research dedicated solely to dating and sexual challenges faced by HIV infected people.

The appearance of several online HIV/AIDS dating sites with most of the criteria for becoming a member, being an HIV positive status resulted in a question: are there challenges attached to dating if one has an HIV positive status as there are dedicated HIV/AIDS dating sites? This question offered an avenue to pursue this research.

The purpose of this study is to explore the challenges that affect the dating and sexual relationships of HIV positive people.

1.3 JUSTIFICATION OF THE STUDY

According to the 2010 UNAIDS Report on the global AIDS epidemic, KwaZulu Natal is the epicentre of the South African HIV/AIDS epidemic. The report goes further to state that “The effects of antiretroviral therapy are especially evident in sub-Saharan Africa, where an estimated 320 000 (or 20%) fewer people died of AIDS-related causes in 2009 than in 2004, when antiretroviral therapy began to be dramatically expanded” (UNAIDS, 2010).

This decrease in mortality rate could provide a positive aspect for HIV infected people as there is hope for PWA’s who may be able to plan for their future and live longer lives as a result of longer life expectancy. It is for this reason that the researcher wanted to explore the challenges of dating and sexuality for HIV positive people.

Given the strong focus on sexual risk behaviours, little is known about the full range of sexual adaptations HIV-infected individuals choose (Schiltz & Sandfort, 2000). Kasiram et al. (2003:9) highlight interaction and intimacy “as a neglected area, needing much attention”. Painter (2001) felt insufficient emphasis has been directed towards couple relationships for infected people.

Dano in Kasiram et al. (2006) reported that inadequate information relating to couple related issues is a means of understanding the gaps in the understanding of how infected people deal with HIV/AIDS in developing countries. This study aims to fill the gap in knowledge related to the topic.

In summary the researcher’s interests in this topic and rationale for conducting this research are that:

- Dating and sexuality are an integral part of society.
- Dating and sexuality is a universal challenge therefore the researcher’s interest in how a HIV diagnosis challenges the infected person’s dating and sexual life.

- The research is relevant to South Africa today and for the future as it is a universal challenge and will not disappear anytime soon.
- The USAID report cites KwaZulu Natal as having a high HIV infection rate and South Africa has one of the highest HIV infection rates in the world so it was befitting that the research be conducted in KwaZulu Natal.
- There is insufficient literature on the specific topic of dating and sexual challenges faced by HIV positive people conducted in KwaZulu Natal.
- The research could assist with awareness and intervention programs relating to the topic.

Another reason which motivated this study was the researcher's personal experience. The researcher herself is HIV positive and has been involved with counseling and life coaching of HIV positive people for the past ten years and has consistently been confronted with the question "Will I be normal?" and after probing, has discovered that "normal" is a euphemism for "will I be able to date and have sex?"

1.4 SIGNIFICANCE OF THE STUDY

The study of HIV/AIDS and related fields such as sexuality are topical and have been the focal point of much research across disciplines (Manderson, Bennett & Sheldrake, 1999). Quite familiar to the HIV/AIDS discourse is the term "research". "Research" not only intercedes between the life and death of HIV/AIDS discourses, but is itself a discursive context with much variability. For example, research carried out has either considered the "social dimensions" of HIV/AIDS (prevalence of male homosexuals, intravenous drug users, sex workers, women and orphans) or its "bio-medical dimensions" (cause, progression of virus and treatments) (Strebel & Lindegger, 1998:4-20).

Within HIV/AIDS research, sexual desire has been taken for granted and assumed to be universal, and even though a degree of "lip-service" has been paid to the importance or potential role of social and cultural factors in shaping sexual experience, such factors have been neglected or perhaps not taken seriously. This

study will provide insights into sexual behaviour and experiences of HIV positive people. There is no study solely addressing the dating and sexual challenges faced by HIV positive people in KwaZulu Natal, South Africa. This is a gap which this study can address.

Sexual intercourse is an important part of our lives, regardless of HIV/AIDS status. It is a basic need and HIV positive people require this basic need to be met; hence this research seeks to explore how this need is addressed. An HIV diagnosis should not be the end of living, loving, dating and sex. Pre and post test counseling is afforded to every South African but the means by which HIV positive people should negotiate the dating game and their sexuality is not forthcoming.

The study has the following potential value if results are disseminated to different target audiences:

- Benefit counselors, researchers, families and communities infected and affected by HIV/AIDS.
- Assist counselors in evaluating the effectiveness of current counseling services.
- Contribute to the limited, existing information and knowledge that exists within professional and social science arenas.
- Attract and encourage funding for further research.
- Encourage awareness and expose more challenges as well as revealing gaps that require further research.
- Sensitise the public at large about the dating and sexual challenges faced by HIV positive people.
- Encourage an improved approach to the dating and sexual needs of HIV positive people.
- Increase and improve public information and education about the needs of infected people.
- Be relevant to infected people.
- Assist infected people understand and cope with their experiences.

- Empower relevant stakeholders to understand the importance of dating and sexuality in the lives of infected people.

Thus, the value of this study is that it could guide service provision, equipping medical and para medical staff as well as helping professionals such as social workers with the necessary understanding of dating and sexual needs/challenges of HIV positive persons.

1.5 RESEARCH AIMS AND OBJECTIVES

The researcher has to achieve something at the end of the research; therefore it is prudent that the researcher states the aims and objectives of the research at the onset.

Bless et al. (2000) reflect the aims and objectives of research as establishing whether the researcher has sufficient information to establish a relationship between variables and whether or not it is beneficial to establish causal relationships. It also dictates and assists the researcher in establishing the nature of data to be collected.

The overall aim of this research is to gain a better understanding of the dating and sexual challenges faced by HIV positive people.

The main objectives of this study are to:

- Describe and explore factors that influence and challenge the dating and sexual lives of HIV positive people.
- explore responses of HIV positive persons to dating challenges.
- explore opportunities and factors that ease dating and sexual relations.

1.6 RESEARCH QUESTIONS

Babbie (2005) sees all research commencing with the identification and clear formulation of a research problem which is either in the form of a research hypothesis or a research question. Choosing a research question is core for qualitative research.

Puttergill in Collins et al. (2007) views the research question as a means of allowing the researcher to identify the essence of his/her research. It also provides a structure for the research. The research question is in essence the gist of what the research is all about.

Cresswell (2007:17) states that “in a qualitative study, the research question/s often start with a ‘how’ or ‘what’ so that initial forays into the topic describe what is going on” and “are open-ended, evolving, nondirectional and restate the purpose of the study in more specific terms”.

The following questions will assist the researcher address the objectives of the research:

1. What are the influential factors and challenges affecting the dating and sexual lives of HIV positive people?
2. How do HIV positive persons respond to dating and sexual challenges?
3. What are the frustrations and opportunities that affect dating and sexual relationships?

1.7 THEORETICAL FRAMEWORK

The research is grounded in systems theory and the ecosystems theory to explore and describe the various challenges faced by HIV positive people.

Green (2003:37) sees the systems theory as focusing on the arrangement, relations and inter-relationships between the parts of the system to explain the functioning of the family. The primary theme of systems theory is “families (systems) organize themselves to carry out the daily challenges and tasks of life, as well as to adjust to the developmental needs of the members” (www.family.jrank.org) and itself as a whole.

Systems theory focuses on a whole consisting of several parts which are all interrelated. Any change to one part results in change to the whole (Stamps, 1980). Systems theory focuses on multiple levels of phenomena simultaneously and how the interaction between the levels affects and impacts on behaviour. The connectivity between systems as well as availability and sources of support and stress.

Taking the above into consideration, a systems perspective is applicable as HIV/AIDS affects several systemic levels of influence such as relationships with spouses, children, relatives, friends and colleagues and therefore this approach assists to provide an understanding of behaviour in context.

The study also considers larger systems as per ecosystems theory namely the micro system, the mezzo system and the macro systems.

The micro system comprises of HIV positive men and women, their partners, spouses as well as potential partners and spouses. The impact of a HIV positive diagnosis on the individual’s dating and sexual life will be explored and described. At the individual level a positive diagnosis can have a positive, negative or neutral outcome which can enhance or devastate the infected person’s dating and sexual life.

The mezzo system refers to the community in which the infected person lives, works and socializes. The community can play a negative or positive influence on an infected person’s dating and sexual life.

At the macro level, reference is to government, policy makers and the laws and policies which impact on the dating and sexual life of the infected person.

This study largely focuses on the individual and intimate relationships with partner/s. Therefore systems theory was mainly used as the grounding framework, with due recognition to larger systems impacting the individual and partner/s. Systems theory assists in understanding the range of dating and sexual challenges faced by infected persons.

1.8 RESEARCH DESIGN AND RESEARCH METHODOLOGY

The research design and methodology is fully discussed in chapter 3. This section summarizes the research approach as follows:

In this study the researcher used the qualitative research method to describe and explore the dating and sexual challenges of HIV positive people as this method assists in understanding feelings, thoughts and meanings (Babbie, 2005). The sensitivity of the study necessitated a qualitative research method.

1.8.1 Population and Sample

The researcher's target population was HIV positive people over the age of 21. The sample comprised twelve participants from four race groups namely Black, Asian, Coloured and White. The sample also comprised equally of males and females. All respondents were proficient in English as interviews were conducted in English only.

Non probability sampling was used, specifically purposive and snowball sampling were used. HIV positive men and women were interviewed utilizing semi-structured face-to face interviews. These interviews were tape recorded in order to maintain accuracy. The questions were open-ended and circular to get as much information on the question and topic at hand.

1.8.2 Ethical Obligation

According to Babbie and Mouton (2005) participation should be voluntary, should not cause any harm to the respondents and ensure confidentiality of the respondents. The researcher understands the ethical considerations of research and ensured that the respondents fully understood the research process, were comfortable with the process, understood that they were free to leave the project at any time and were assured of their confidentiality. Any painful issues that emerged during the interview were referred to organisations, therapists and social workers to deal with to ensure the participants were appropriately assisted after the interview.

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

1.8.3 Data Collection

Data collection techniques allow researchers to systematically collect information about their objects of study (people, objects, phenomena) and about the setting in which they occur (Alston & Bowles, 2003). This study utilised face-to-face interviews to gather information about the dating and sexual challenges faced by HIV positive people.

Kadushin (1990:12) states that the purpose of information gathering interviews “is to obtain a focused account of the individual, group or community, in terms of social functioning”.

1.8.4 Data Analysis

“Describing, classifying and interpreting are at the heart of qualitative data analysis and entail salient themes, recurring ideas or language and patterns of belief”, is how De Vos et al. (2002:352) summarises the data analysis process. The recorded interviews were transcribed by the researcher and data was categorized and assigned to themes and sub-themes which arose from the data.

1.8.5 Definitions of Key Terms

Dating

According to the South African pocket Oxford dictionary (1994:230) “dating” is defined as “a social appointment with the opposite sex”.

Sexuality

The term “sexuality” refers to “the ways in which we experience and express ourselves as sexual beings”, that is, in the awareness of being fe/male, as well as in the capacity one has for erotic experiences and responses (Rathus et al.1997:5).

1.9 OUTLINE OF THE RESEARCH REPORT

The research report will consists of five chapters. An expose of the chapters are:

In Chapter 1

Introduction and orientation to the study.

Chapter 2 : Literature Review

Consists of the literature review which explores theoretical frameworks for understanding the dating and sexual challenges faced by HIV positive people. The literature review encompasses national and international research.

Chapter 3 : Research Methodology

The research design and method/s utilised in this study are herein highlighted.

Chapter 4 : Research Findings

Provides data, analysis as well as interpretation of the results of the research.

Chapter 5 : Conclusions and recommendations

Provides the overall findings, conclusions and recommendations from the study.

CHAPTER 2

LITERATURE REVIEW

2.1 INTRODUCTION

This chapter is dedicated to reviewing literature pertaining to the dating and sexual challenges faced by HIV positive people in order to provide a foundation for this study.

This literature focuses on past and current literature about the HIV/AIDS pandemic and the various factors and challenges influencing the dating and sexual life of infected people.

2.2 THE HIV/AIDS PANDEMIC

A major challenge facing South Africa today is the HIV/AIDS pandemic. HIV/AIDS was discussed thirty years ago and even then, as it is now, the outcome of the pandemic is catastrophic. Medical improvements, research, roll out of antiretrovirals (ARVS), government and community awareness programs have increased and yet we still have new infections daily. Prevalence rates have decreased according to the World Health Organisation WHO (2009) but the decrease is not a significant one.

In 2009, South Africa had one of the highest HIV/AIDS statistics globally, namely 5.6 million. This constitutes over two thirds of the infected people worldwide (UNAIDS, 2009; WHO, 2009; UNGASS RSA, 2010). Statistics reflected in Table 1 overleaf are taken from the Department of Health's 'National Antenatal Sentinel HIV and Syphilis Prevalence Survey in South Africa, 2009', published in 2010. The table

includes data from antenatal clinics which were used to estimate pregnant women's HIV prevalence. Data from the 'South African National HIV Prevalence, HIV Incidence, Behaviour and Communication Survey, 2008' is also used in the table (<http://www.avert.org/safricastats.htm>).

Table 1: Estimated HIV prevalence (%) among antenatal clinic attendees, by province.

Province	2001	2002	2003	2004	2005	2006	2007	2008	2009
KwaZulu Natal	33.5	36.5	37.5	40.7	39.1	39.1	38.7	38.7	39.5
Mpumalanga	29.2	28.6	32.6	30.8	34.8	32.1	34.6	35.5	34.7
Free State	30.1	28.8	30.1	29.5	30.3	31.1	31.5	32.9	30.1
Gauteng	29.8	31.6	29.6	33.1	32.4	30.8	30.5	29.9	29.8
North West	25.2	26.2	29.9	26.7	31.8	29.0	30.6	31.0	30.0
Eastern Cape	21.7	23.6	27.1	28.0	29.5	28.6	28.8	27.6	28.1
Limpopo	14.5	15.6	17.5	19.3	21.5	20.6	20.4	20.7	21.4
Northern Cape	15.9	15.1	16.7	17.6	18.5	15.6	16.5	16.2	17.2
Western Cape	8.6	12.4	13.1	15.4	15.7	15.1	15.3	16.1	16.9
National	24.8	26.5	27.9	29.5	30.2	29.1	29.4	29.3	29.4

Provinces that recorded the **highest HIV prevalence were KwaZulu Natal (39.5%)**, Mpumalanga (34.7%), Free State (30.1%) and the North-west (30%). The Northern Cape and Western Cape recorded the lowest prevalence at 17.2% and 16.9% respectively. (<http://www.avert.org/safricastats.htm>).

Table 2: Estimated HIV prevalence among South Africans, by age and sex, 2008

Age	Male prevalence %	Female prevalence %
2-14	3.0	2.0
15-19	2.5	6.7
20-24	5.1	21.1
25-29	15.7	32.7
30-34	25.8	29.1
35-39	18.5	24.8
40-44	19.2	16.3
45-49	6.4	14.1
50-54	10.4	10.2
55-59	6.2	7.7
60+	3.5	1.8
Total	7.9	13.6

Among females, HIV prevalence statistics are highest in those between 25 and 29 years old; among males, the peak is in the group aged 30-34 years (<http://www.avert.org/safricastats.htm>).

Table 3: HIV prevalence (%) by province 2002-2008

Province	2002	2005	2008
KwaZulu Natal	11.7	16.5	15.8
Mpumalanga	14.1	15.2	15.4
Free State	14.9	12.6	12.6
North West	10.3	10.9	11.3
Gauteng	14.7	10.8	10.3
Eastern Cape	6.6	8.9	9.0
Limpopo	9.8	8.0	8.8
Northern Cape	8.4	5.4	5.9
Western Cape	10.7	1.9	3.8
National	11.4	10.8	10.9

The above prevalence rates show that KwaZulu Natal, Mpumalanga and Free State have the highest HIV prevalence. However, the relatively small sample sizes may limit precision, and in several cases the ranges of uncertainty overlap (<http://www.avert.org/safricastats.htm>).

Table 4: HIV prevalence by population group, 2008

Population group	Prevalence (%)
African	13.6
White	0.3
Coloured	1.7
Indian	0.3

(Unauthorised: <http://www.avert.org/safricastats.htm>).

Clearly, prevalence rates are highest amongst African people. The HIV & AIDS and STI Strategic Plan for South Africa 2007 – 2011 key priority areas 1, 2, and 4 focus on prevention, treatment care and support as well as human rights and access to justice. The impact of this plan provides background information to the study on dating and sexual challenges faced by HIV positive people.

2.3 FACTORS AND CHALLENGES INFLUENCING DATING AND SEXUALITY OF HIV POSITIVE PEOPLE

2.3.1 GRIEF AND LOSS

Corr et al. (2000) define grief as the individual's experience of loss, sorrow, pain and sadness especially when it involves the death of a partner. Allan et al. (2003) see grief and loss as part of all human beings as everyone experiences grief and loss at some time irrespective of their social status, race, creed or religious background. The degree to which they experience grief and loss differs according to the relationship they had with their partner, their developmental stage and the individual's coping and grieving system/process.

2.3.1.1 Grief

Corr et al. (2000) explain grief as consisting of three components, namely a somatic, a behavioural and emotional component and mourning as the coping mechanism for loss. Leick and Davidsen-Nielsen's (1991) model of grief work highlights four tasks:

- Accepting that the loss is a reality;
- Entering into the emotions of grief;
- Acquiring new skills; and
- Reinvesting energy in new ways.

If the abovementioned tasks are not pursued and completed the grieving process is incomplete and could affect the individual pathologically through delayed grief, avoided grief and chronic grief.

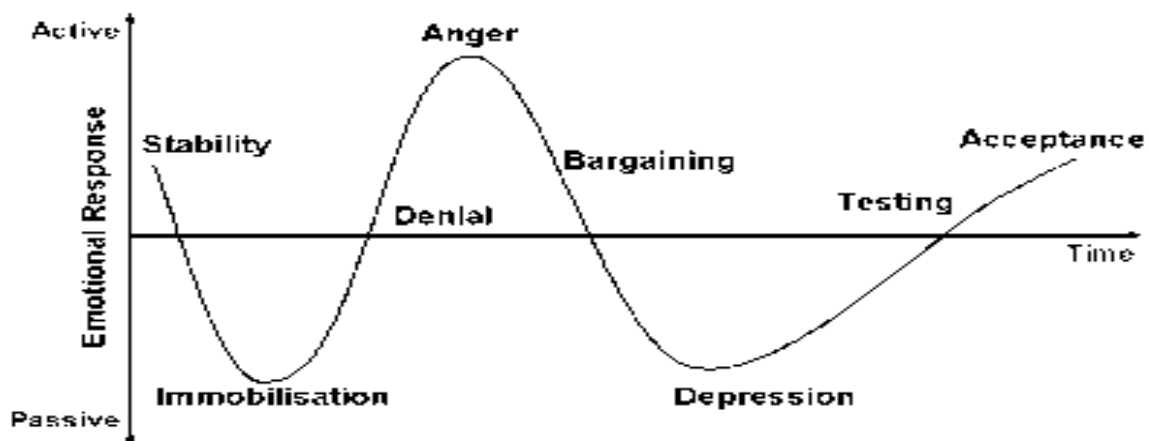
There are differences between HIV/AIDS related bereavement and traditional grieving models as many infected people die at a young age, death may have been anticipated, there is stigma attached to HIV/AIDS which may challenge the surviving spouse's grieving process, living spouses/partners may experience survivor guilt or

be too concerned with his/her own HIV status to fully grieve his/her partner (Kain, 1997; Walker, 1991). The manner in which the surviving partner grieves may affect his/her dating and sexual life.

Elizabeth Kübler-Ross's grief cycle depicts the coping mechanism of an individual coping with a terminal or chronic illness (Kübler-Ross, 1969). This cycle can be applied to an HIV positive diagnosis as it embodies change namely from a HIV negative to HIV positive status as well as the myriad of emotions infected people experience. Counseling and support can play a pivotal role in reducing and/or eliminating these emotions (www.ekrfoundation.org)

The Extended Grief Cycle

The Extended Grief Cycle is shown in the graphic depiction below. This shows the roller-coaster ride of activity and passivity as the person squirms and resists changes in their status quo (www.changingminds.org).



Unauthorised, undated,

http://changingminds.org/disciplines/change_management/kubler_ross/kubler_ross.htm).

The initial state before the news (HIV diagnosis) is received is stable and can progress to denial, anger, bargaining, depression and acceptance thereafter. The

stages of Elizabeth Kübler-Ross's grief cycle (www.saap.za.net) are discussed hereunder as they adequately capture the emotional turmoil of a HIV journey:

Denial stage

This is an emotional stage characterised by denial of one's HIV status. Denial acts as a protective mechanism and allows a time delay before having to deal with the diagnosis. An individual may become stuck in the denial stage not accepting the inevitable outcome (www.changingminds.org). When individuals choose not to move on, they continue to deny their status (Antelman et al., 2001). An example is a person who knows their positive HIV status and still continues to practise unsafe/unprotected sex because of associating condom usage with acceptance of a positive HIV status.

Wringe et al.'s (2009) north-west Tanzania study highlighted the use of traditional healers to deny an individual's HIV positive status. Hendriks (2004) attributes cultural differences as a reason for denial and non disclosure of one's HIV positive status. This author clarifies that western cultures are seen to be open cultures whereas African cultures are viewed as closed; therefore non disclosure will be more prominent in these cultures. It is for this reason that the present study comprised of 12 respondents, from all four race groups to be representative of different cultures and races in South Africa to get some understanding of how different cultural groups respond to their dating and sexual needs.

This stage is dangerous and therefore it is important for counselors, psychologists and health care professionals to focus on this stage to reduce infection and reinfection rates. This is in keeping with the HIV & AIDS and STI Strategic Plan for South Africa 2007- 2011.

Anger stage

Anger and revenge are potential factors that challenge HIV positive people's dating and sexual lives (Kasiram & Khoza, 2008). Anger is the individual's response to frustration and pent-up emotions. Reasons for the anger and revenge could be

that they feel they are being punished for their past, they did not consciously go out and get infected, they do not want HIV and feel infecting others will make them feel better (Milgram et al., 2006). Den Hollander (2006) refers to the latter as revenge infecting.

Anger could be directed at God, at HIV negative people, at the person/s that infected the individual and at the individual as well. This anger could physically and emotionally harm the infected person if it is not handled appropriately. The person may be angry and choose to repress it or just bottle it up inside. An individual may be stuck in permanent anger as an escape from reality or as a way of repeated bargaining (Unauthored, undated, www.livestrong.com).

Bargaining stage

This stage provides a bargaining component whereby the infected person bargains with GOD or a higher power to make the diagnosis disappear. This stage is characterized by looking for an exit from their status by offering conditions to GOD/higher power for a different outcome. An example is “If this diagnosis is wrong, I will take better care of myself” (www.livestrong.com). The danger is, if the higher or supreme power does not entertain this bargain, the bargainer may react negatively to their life.

Depression stage

According to Womenshealth.gov. “Depression is twice as common in those who have been diagnosed with the virus that causes AIDS than in the general population. Symptoms include a lack of interest in recreational activities or outings with friends, sadness, loss of appetite and difficulty sleeping or sleeping too much” (www.womenshealth.gov/HIV/livingwith/depression.cfm). It is more difficult to get stuck in active states than in passive ones, and getting stuck in depression is perhaps a more common ailment (<http://www.livestrong.com/article/181712-emotional-stages-of-people-with-AIDS/#ixzz1ThzFOK9g>).

Lee et al's., American study (2002) found that individuals with HIV can internalize stigma which could contribute to depression and impact on the wellbeing of the individual. Vyavakarkar et al. (2010) discussed a correlation between HIV stigma, social support and depression.

The researcher feels that depression could negatively impact on their dating and sexual life as individuals may not feel confident to continue in their current relationship or pursue alternate relationships because they do not see any positive aspects of their life at that time or in the future. This forms part of the subject of the study.

Acceptance stage

“It is during this stage that the infected person decides to accept his/her status by choosing to continue with his/her life or allowing him/herself to be consumed with the diagnosis and lose interest in life as well as relinquishing feelings of anger” (Unauthored, undated, <http://www.livestrong.com/article/181712-emotional-stages-of-people-with-AIDS/#ixzz1ThzFOK9g>). The infected person looks for the way forward to continue with his/her life with HIV.

Individuals may move on to the next phase whilst not completing an earlier phase and then move backwards in cyclic loops (pendulum movements) by repeating previous emotions and actions. Thus, for example, a person that finds bargaining ineffective may go back to anger or denial (Unauthored, undated, <http://www.livestrong.com/article/181712-emotional-stages-of-people-with-AIDS/#ixzz1ThzFOK9g>).

It is the opinion of the researcher that from the denial stage, anger stage, bargaining stage, depression stage to the acceptance stage, the infected person has a decision to make of either accepting, denying or skipping a stage. The degree to which the individual inhabits each stage is determined by what he/she is feeling, going through or willing to face at the time. The study explores emotions

and feelings that give birth to the manner in which the infected person inhabits the various stages and the impact thereof on their dating and sexual lives.

2.3.1.2 Loss

HIV positive people can experience various types of loss (Anderson et al., 2010; Dageid, 2008; Hult et al., 2009) as a consequence of their HIV positive status namely loss of:

- their HIV negative status
- a partner as a result of separation and/or divorce due to denial or non acceptance of their HIV status by themselves and/or their partner/s
- physical and sexual appeal (Grierson et al., 2000)
- family and friends due to stigma and discrimination
- unprotected sexual relationships as condom use is highly advocated in PLHIV's sexual activity (De Matteo et al., 2002; Maharaj & Cleland, 2004; Shernoff, 1991; van der Straten et al., 1998).
- loss of identity in the case of a serodiscordant status as their partner now has a different serostatus to them
- sexual intimacy due to their partner/s being afraid of being infected as well as their concern with infecting others
- their partner/s and the fact that they are still living whereas their partner/s died as a result of the illness
- their old life as they now have to adapt to their HIV positive status, physical, emotional and psychological changes, people's perceptions of them, their perceptions of themselves and their new life, being on medication for life and the fact that there is no cure for their illness.

Baum's (2007) Israeli study explored the separation guilt in women who initiate divorce and found that "Divorce is a loss for initiators, just as it is for non-initiators. Initiators too lose their spouse, their intact family and their familiar routines; and they too must struggle to build a new life for themselves and new relationships". Non initiators of divorce can maintain a victim role as the divorce was not what they

wanted; they were not in control of the process and may experience feelings of rejection and ultimately not accept the divorce (Gray, 1996; Hagestad & Smyer, 1982; Kincaid & Caldwell, 1995). Initiators of divorce on the other hand fare much better both emotionally and psychologically and experience relief after it takes place (Amato, 2000; Gray, 1996).

Loss as a result of separation and divorce could result in the infected person experiencing guilt which could interfere with their ability to build and maintain new intimate and sexual relationships. The abovementioned study and findings expose the consequences of divorce as a challenge to an infected person's dating and sexual life as the divorced person may be emotionally and psychologically affected by the divorce.

Feelings of loss of physical and sexual appeal as well as anxiety and confusion were also reported by 89 respondents with HIV/AIDS in Australia (Grierson et al., 2000). This can negatively impact on the dating and sexual life of a person living with HIV (PLHIV) as they may feel unattractive to their partners or potential partners.

The social and political impact of AIDS denialism (those who denied that HIV causes AIDS) under Thabo Mbeki's presidency in South Africa is still felt today as it discouraged HIV positive people from utilising ARVS (Boseley, 2005; Watson, 2006). As a result of the government's AIDS denialism stance, many human lives were lost in South Africa (Chigwedere, 2008; Nattrass, 2008).

Loss can affect the dating and sexual lives of HIV positive people as many have lost loved ones and fear moving on with their lives as the guilt of having infected their partner/s is enormous. There are also feelings of betrayal and therefore they opt not to enjoy intimate relationships as their deceased partner/s were not afforded such opportunities.

2.3.2 DISCLOSURE

Disclosure is a complex process as it places emphasis on knowledge and information as having power since the infected person decides when, how, to whom and why they will disclose information about their HIV status (Arnold et al., 2008; Klitzman et al., 2007).

According to Arnold et al. (2008) infected people pursue three choices for disclosure namely to disclose to all and sundry, not to disclose at all or to disclose to some. Their choice is dependent on the person's frame of reference and their life world. Makin et al. (2008) and Medley et al. (2004) stress the 'when', 'how' and 'who' infected people choose to disclose to. Exposure of how disclosure fits into one's social identity is seen as an avenue that can be pursued by researchers in the future.

There are several reasons for non disclosure of one's HIV status such as fear of rejection, shame, guilt, relationship changes, divorce, relationship breakups, and intent to maintain secrecy as well as engaging in protected sex as justification for non disclosure (Klitzman et al., 2007; Klitzman & Bayer, 2003; Simoni et al., 1995).

Ware et al. (2006:904) expose stigma as a social process contributing to marginalization and exclusion in their qualitative study of "52 HIV positive, active illegal drug users". The study highlights a correlation between disclosure, safe sex, stigma and drug abuse. Stigma is a deterrent for infected people negotiating protective sex and disclosing their status to their partner and/or potential partners (Bouillon et al., 2007; Elford et al., 2008; Skogmar et al., 2006; UNAIDS, 2009).

Some respondents in a Canadian study declined to disclose their positive status as they viewed utilizing condoms as a precautionary measure to prevent the transmission of HIV while others were concerned about the response to their disclosure and therefore undertook to be sexually inactive rather than deal with the reaction to their disclosure (Maticka-Tyndale et al., 2002). This aspect of sexual

inactivity and denial relates to this study as they contributed to the dating and sexual challenges faced by HIV positive people.

A study conducted with HIV infected African American women living in the rural Southeastern United States showed stigma as being a major reason for non disclosure of their HIV status which resulted in isolation and contributed to psychological outcomes like depression (Kalichman et al., 2003; Sowell et al., 1997; Vyavaharkar et al., 2010).

The reaction of family members to a positive HIV diagnosis impacts on the individual and his/her relationship/s. This was highlighted in the study conducted by Serovich et al. (1998:19) where respondents chose not to disclose their status due to family members' reactions which focused on factors such as "the nature of the relationship, having known others with HIV/AIDS, lack of knowledge about HIV/AIDS transmission or prejudice". Family member reactions could lead to infected people choosing not to disclose to their families.

De Wit and Lessing (2010) highlight the correlation between silence and non disclosure. Clearly many HIV positive people choose to remain silent about their HIV positive status because of the social and personal backlashes and this results in many infected people living lonely lives.

2.3.3 DATING OPTIONS

Dating has been taking place since the beginning of time. HIV positive people are not excluded from this process.

This study describes and explores the challenges and experiences of PLHIV in pursuing dating and sexual relationships.

PLHIV are confronted with the following options:

- to pursue a dating and sexual relationship
- to leave their current dating and sexual relationship

- to continue in their existing relationship
- to date a seropositive or seronegative person
- to abstain from dating and sexual relationships
- to pursue casual dating and sexual relationships.

Elisabeth Pernicone (2009) published an article about the choices HIV positive people confront when deciding to date. She documented two options namely to date a HIV positive person or a HIV negative person. Stigma and discrimination of infected people are contributing to serosorting (which is the process whereby people engage in unprotected sex with partners of a similar HIV status) being a dating and sexual choice (Liu et al., 2011). However, this option is not without risk of becoming infected because contraceptives are not used.

Below are excerpts from two internet blogs that suggest that dating a HIV positive is still a concern to infected people and affected people:

(<http://answers.yahoo.com/question/index?qid=20081113064857AApTQ6o> and <http://www.frihost.com/forums/vt49603.html> : April 16, 2011)

WOULD YOU DATE SOMEONE WHO IS HIV/AIDS POSITIVE? IF YES WOULD YOU MARRY HIM/HER IF NO WHY NOT?

“Yes I would date someone HIV/AIDS positive and marry that person. Simple fact is that in my eyes, love is love. Just they have a disease doesn’t change the person they are.”

“No, because I want to have a child...and not HAVE to adopt. Then I would have to worry about that person not being there for the kid as they grow up or worse giving our child or myself HIV/AIDS accidentally. Too risky...I understand love knows no bounds but this is talking about someone else's life”

“No, I want to have children some day, and I couldn't have sex with someone who was potentially going to be responsible for my child's untimely death”

<http://www.frihost.com/forums/vt49603.html> : April 16, 2011

“AM I UNDATABLE BECAUSE I’M HIV/AIDS+” By Accidental Bear

Would You Marry A HIV/AIDS Positive Partner?

Yes	29%	[16]
No	45%	[25]
Undecided	25%	[14]

Total Votes : 55

A friend who is HIV/AIDS negative is dating his HIV/AIDS positive girlfriend. What are the odds if he should want to marry her?

Can this really be a test of real love?”

“Man, that is a bad decision to have to make. Love, disease, blame, guilt. Man, I don’t even know how to think about it all. Those two just need to be really sure about what they do.”

”I think it’s all right, if they really love each other. Though it would impose great danger for the other and for the child, I do not think it should be a hindrance for their love. They can live together, marry and have a happy life by accepting the situation as it is and accept death as it comes. It would hurt, but turning away from the love because of the virus would hurt too anyway. About having a child, they should think carefully about it.

“but doesn’t HIV/AIDS kill you, like really slowly so wouldn’t their marriage end sooner than they would want?”

“If you love him/her too much and that you could overcome the courage of transmitted the HIV/AIDS virus, go ahead.”

“But in my opinion, this risk is too much, too much as it will potentially, or rather surely, take away your life. Would you do that far to secure your love?”

“To me, I’d rather be in close friends with her. Though this might be discrimination, but your life is at stake. Value your life! Otherwise, you have to resist the urge of having sex with him/her, something that completes the marriage I believe”.

Blogs allow people to remain anonymous. They are interactive and focus on a specific topic. They allow for sharing and exchanging of information. The above blogs focused on dating and marriage of HIV positive people.

Online dating is also discussed later in this chapter under the media (Section 2.3.15).

People have met casual and permanent sexual partners in informal as well as formal places such as parks, on the street, at parties, dance clubs, through newspaper adverts, in the workplace, on the internet, at dating clubs, at social events as well as through family and friends. The researcher has not come across any research on the dating options that HIV positive people pursue and therefore this study will expose some of these options.

The internet is increasingly impacting on the interpersonal relationships of people today and reasons cited are “anonymity, accessibility, affordability” (Cooper et al., 1999; Goldenberg et al., 2008 & Wallace, 1999). Online dating allows individuals to use the internet through computers and cell phones to pursue romantic and/or sexual relationships. Some sites use pay dating while others are free (Bishop, 2008b).

The use of the internet for cybersex and dating could have a systemic impact on an infected person’s partner/s, friends, family and work.. This is in accord with the systems and ecosystems frameworks. Changes in couple intimacy and less involvement with friends and family are results cited in an American study (Goldberg et al., 2008).

2.3.4 FINANCIAL IMPLICATION

HIV/AIDS has been with us for thirty years and even though there have been marginal decreases in the prevalence rate of HIV/AIDS recently, it still has an economic and financial implication. A HIV diagnosis has a direct impact on households through loss of income of one or both partners or the family

breadwinners who succumb to HIV/AIDS as most infections take place during economically productive ages. Unemployment, funeral costs, absenteeism and high medical expenses result in economic challenges which could lead to poverty (www.treasury.fs.gov.za). The loss of economically active people in their most productive years has an overall negative impact on the South African economy.

According to www.tradingeconomics.com/south-africa/unemployment-rate (unauthored, undated), a statistical website, the South African unemployment rate for the first quarter of 2011 was 25%. The unemployment rate is defined as “the number of people employed plus the number unemployed but seeking work. The non labour force includes those who are not looking for work, those who are institutionalised and those serving in the military” (www.tradingeconomics.com).

Vulnerability of the unemployed makes decision making challenging. If the infected person is solely dependent on his/her spouse for survival it is difficult for them to negotiate and insist on condom usage if the breadwinner refuses to use condoms (Smith, 2002). HIV/AIDS in South Africa is linked to the increase in household economic and social vulnerability (Kooijman & Avis, 2011). Balaile et al. (2007) concluded from their study of Tanzanian women that they had become poorer and more vulnerable as a consequence of their infection which had resulted in them pursuing casual sex for their survival.

A descriptive study in the Eastern Cape highlighted that questions regarding disability grants were the most frequent questions asked by HIV positive people as they had food and income challenges and discontinuance of a disability grant, which negatively impacted on the infected person’s quality of life (Ruud et al., 2010).

Some studies conclude that the pandemic has little impact on the economy while others conclude that it does. There is no consensus on the impact of HIV/AIDS on the economy according to Kooijman and Avis (2011).

In as much as government has made positive strides in providing free voluntary testing and counseling, free antiretrovirals, tuberculosis testing and treatment, the pandemic still puts economic pressure on the health care system and health budget. A healthy South African population could assist economic growth.

However, government cannot achieve economic growth alone, so it is imperative that the private and community sector all play a role. A financially healthy, infected person may have a head start in pursuing a dating and sexually active life.

The researcher believes that a HIV positive status reinforces existing inequalities in South Africa as the unemployment rate and poverty rates are high and the chance of the infected person being self sufficient and financially independent are low given the unemployment statistics discussed previously. An unemployed, HIV positive person is financially and socially vulnerable and could experience great difficulty in negotiating condom use and relationships.

This vulnerability could result in reduced self esteem and self worth as they may be compelled to engage in risky sexual behaviour, stay in abusive or alcoholic relationships which may be against their better judgment (Smith, 2002).

2.3.5 GUILT, SHAME, SELF BLAME AND SELF ESTEEM

HIV positive people experience feelings of guilt, shame and self blame and reduced self esteem when confronting trauma resulting from a HIV diagnosis. Allport explains self esteem as part of one's self concept which is important to the functioning of the individual (Louw, 2003:283). A HIV positive person with a negative self esteem as a marketing tool for a dating and sexual relationship would be exposed to further challenges which could compromise the quality of their life.

Feelings of guilt, shame, low self esteem and self blame could erode the dating and sexual life of HIV positive people as they may believe they brought HIV into the current relationship and/or take it into future dating and sexual relationships (Kasiram & Khoza, 2008).

Sue et al.'s (2003:211) exposé of Taylor et al.'s (2000) study of the psychosocial predictors "of the course of illness in men with AIDS" revealed a correlation between acceptance of death and longevity. Respondents in that study with "a high realistic acceptance died an average of nine months earlier than those with a low realistic acceptance". This shows that "a positive sense of self, a sense of personal control and an optimistic, even unrealistic optimistic, view of the future..." may provide a coping strategy for the infected person to manage challenging, life altering events (Taylor et al., 2000:106).

The International Centre for Reproductive Health and Sexual Rights' (INCREASE) findings from a survey conducted on the sexual pleasure among women in Nigeria revealed that fear, anxiety, guilt, grief can hinder sexual pleasure as well as contribute to sexual dysfunction (www.increase-increase.org). By addressing poor self esteem, choice of sexual of partners, STDs, pregnancy, alcohol and domestic violence couples would be able to achieve the dating and sexual relationship they required.

An infected person may develop stress or anxiety due to a fear of dying, rejection, stigma from disclosure or while awaiting blood results that could indicate a decline in their physical condition and/or their ability to take care of themselves, their spouse and their offspring.

Van Dyk (2008) stresses the importance of women exercising their assertiveness in sexual matters for example insistence on condom usage and the ability to say no and mean no. Sy in Van Dyk (2008) emphasizes the need for partners to effectively communicate with their sexual partners.

A study conducted on 420 HIV positive men and 643 HIV women in Cape Town, South Africa revealed that one in three participants indicated "feeling dirty, ashamed or guilty" as a result of their HIV status (Simbayi et al., 2007:1829). These feelings affect their self esteem which impacts on their dating and sexual life.

A destigmatised environment could assist in building the self esteem of infected people as well as reducing depression (Vyavaharkar et al., 2010). Stigma plays an important part in choice of dating and/or sexual partner.

An American study conducted on 56 HIV positive people cited a correlation between Intimate partner violence (IPV) and HIV as infected people may use physical violence as a coping mechanism for their guilt and fear (Ramachandran et al. 2010). The study showed IPV following disclosure and was mainly reported by heterosexual men.

Alcohol is also a coping mechanism for infected people dealing with their seropositive status (Avert, HIV & AIDS in South Africa, undated). Stigma and discrimination are some of the reasons for alcohol abuse in HIV positive people (Bonepwa, 2008; Kang'ethe, 2010).

2.3.6 A SERODISCORDANT STATUS

Individuals who have been involved in unprotected sexual relationships and where one partner tested HIV negative while the other tested HIV positive are known as serodiscordant couples or partners ([www.cpa.ca/PHASE/families, friends & partners](http://www.cpa.ca/PHASE/families_friends_and_partners)).

There are a high number of serodiscordant couples in sub-Saharan Africa and this number is increasing (Bunnell et al., 2005; Palmer & Bor, 2001). It is therefore important to have an understanding of these results to understand how they affect the dating and sexual lives of PLHIV's.

2.3.7 DEVELOPMENTAL STAGE

Adulthood comprises early adulthood (20-39 years), middle adulthood (40-59) and late adulthood (60 onwards) (Berk 2001; Louw et al., 2003). The respondents in

this study fall into early and middle adulthood. Louw states the tasks relating to interpersonal relationships in both stages as follows:

“Early adulthood

- To choose a partner
- To establish a satisfying and meaningful relationship with your partner
- To become a parent and raise children

Middle adulthood

- To learn to live with one’s partner’s physical changes
- To share common interests with one’s partner
- To help children become independent and being supportive to them in their new roles
- To adjust to and accept responsibility for ageing parents” (Louw et al., 2003 : 474)

Erikson’s psychological conflict of intimacy versus isolation in the individual during early adulthood focuses on their thoughts and feelings about intimacy (Berk, 2001). If intimacy is lacking it may result in isolation which could be a challenge in the early adult’s dating and sexual life. The early adult also seeks to be a parent and a HIV diagnosis could prevent attainment of reproductive goals. This study seeks to describe and explore the impact that the two development stages have on the dating and sexual lives of infected people.

2.3.8 STIGMA AND DISCRIMINATION

Stigma has been linked to and existed from the onset of HIV/AIDS. Dreyer (2002:87) acknowledges that “...that people with HIV/AIDS form one of the most oppressed groups in our country, especially since they are both stigmatised and marginalised”.

The availability of ARVS together with community programs can lead to more awareness about AIDS which would ultimately reduce stigma and discrimination (WHO, 2003). In 2011, stigma and discrimination still prevail and one questions the impact that ARV roll out programs and community projects have on stigma and

discrimination or whether they have resulted in new challenges such as increased unprotected and reckless sex (UNAIDS, 2005). Several authors agree that although much research has been conducted about stigma, it still exists (Morrison et al., 2002; Prachakul et al., 2007; Vyavaharkar et al., 2010).

Stigma, discrimination and gender inequality are key factors contributing to HIV risk and vulnerability in many countries today (UNAIDS, 2008). HIV positive people may fear stigma and in so doing steer clear of playing positive roles in prevention programs (UNAIDS, 2005).

Stigma can contribute to HIV positive people experiencing psychological, physical and social health challenges which can lead to loneliness, social isolation and withdrawal and depression (Prachakul et al., 2007; Sayles et al., 2007; Vyavaharkar et al., 2010).

Sandelowski, Lambe and Barroso (2004: 124) reflect stigma as being “virtually synonymous with the experience of HIV infection in women” and issues associated with stigma being “the ability to bear children, sexuality and presumed promiscuity, sex, work and drug use”. These issues associated with stigma inhibit social interaction and social support.

Colbert et al. (2010) highlight the different perceptions of stigma between men and women and the manner in which social support and health status are affected by stigma. The Colbert et al. study reflected women having “higher levels of stigma than men after controlling for race, history of injection drug use and exposure category” (Colbert et al., 2010:304).

Aggelton and Parker (2003) too reflect a close correlation between inequalities of class, gender, race and sexuality as well as how stigma fuels those inequalities. Emler (2007) found HIV related stigma to be lower amongst Whites than African Americans. This study comprised of all four race groups and the degree to which stigma played a role will be discussed in the findings.

2.3.9 SEXUAL DYSFUNCTION AND SEXUALLY TRANSMITTED INFECTIONS (STIS)

2.3.9.1 Sexual Dysfunction

Sexual dysfunction assumes an abnormality in sexual functioning. Sue et al. (2003:311), define sexual dysfunction as “a disruption of any part of the normal sexual response cycle”. Vaginismus occurs when the vaginal muscles contract and go into spasm when penetration takes place or is attempted. Impotence in men can be attributed to psychological reasons when a male is unable to have or sustain an erection (Bennion, 1991; Sue et al., 2003). Studies focusing on sexual intimacy revealed a decline in sexual activities and in some infected people experiencing a turnoff about sex after their HIV diagnosis. This was especially prevalent in infected people who were part of a couple at the time of their diagnosis. Sexual desire and intimacy, however did return after some time (Adam & Sears, 1996; Maticka-Tyndale et al., 2002).

Sexual dysfunction can present in HIV negative as well as HIV positive people and loss of libido or sexual drive can significantly affect the quality of life of the HIV positive person and partner as well as their self worth (Maticka-Tyndale et al., 2002). This type of dysfunction can arise in times of trauma and stress when a person receives a positive HIV diagnosis as the infected person could experience shock, worry, disbelief and loss of sexual desire as a result. Concerns about infecting one’s partners could also cause sexual problems (Maticka-Tyndale et al., 2002).

Many infected people experience sexual decline and repulsive feelings towards sex as they fear infecting their partners (Adam & Sears, 1996). From the Canadian study it is noted that the decline in sexual intimacy and/or libido was attributed to psychological fears of infecting partners and the side effects of ARVS. Some respondents who experienced sexual decline avoided situations which could lead to sexual contact. The study exposed differences in HIV positive peoples’ sexual experiences (Maticka-Tyndale et al., 2002).

According to an unauthored, undated article (www.aboutdepression.com) some drugs used to treat depression such as fluoxetine (Prozac) or paroxetine (Seroxat) can negatively affect sexual functioning. HIV positive men with low testosterone levels, caused by the direct effects of HIV or chronic ill health, can present as sexual dysfunction (Dobs & Brown, 2002).

Antiretroviral drugs such as ddI (didanosine, Videx) and d4T (stavudine, Zerit) may cause numbness in the genital area which affects the ability to maintain an erection. Protease inhibitors containing ritonavir (Norvir) are also likely to cause sexual dysfunction. The inability to maintain an erection and other types of sexual dysfunction caused by ARVS could impact on the dating and sexual life of the infected person (Unauthored article: www.namlife.org). Unmarried infected people may experience sexual dysfunction (erectile dysfunction) as they feel guilty about partaking in premarital sex and guilty about their status being a form of punishment. Religious beliefs can also play a role in sexual dysfunction (Bennion, 1991) and result in some becoming celibate.

The researcher found that there is insufficient scientific research on sexual dysfunction in women with the exception of arousal and lubrication difficulties and that sexual dysfunction can arise as a result of the decision to be sexually active, resistance to practicing safer sex, disclosing one's status and on whether or not to have children. Sexual topics are sensitive topics and sexual dysfunction can be a result of medical and psychological factors that challenge PLHIV and vary from person to person.

2.3.9.2 Sexually Transmitted Infections (STIS)

Sexually transmitted infections/diseases are common in HIV positive as well as HIV negative people. The disclosure of STIS are low as they are seen as stigmatised diseases (Goldenberg et al., 2008; Nack, 2000; Pavlin et al., 2008). Guilt and shame cloud the disclosure of STIs (Newton & McCabe, 2008). Some STIS such as Human Papilloma Viruses, Chlamydia, Gonorrhoea, Herpes Simplex Virus (HSV) and Syphilis will now be discussed.

Human Papilloma Viruses (HPV)

“Human papilloma viruses are DNA-based viruses that infect the skin and mucous membranes...HPV is transmitted sexually, and some of them can cause genital warts...the pap smear will show cellular abnormalities. Pre-cancerous lesions will then be targeted and removed surgically, prior to the development of invasive cervical cancer” (Van Dyk, 2008:73). Genital warts do not automatically disappear but need to be treated. The appearance of genital warts can affect the sexual life of an infected person as they can be painful and uncomfortable during sex and also disclosing STI's can be an embarrassing process.

Chlamydia

“Chlamydia is one of the most commonly reported bacterial sexually transmitted diseases (STDs)...Chlamydia can be transmitted by having unprotected vaginal, anal or oral sex with someone who is infected; from a mother to her baby during vaginal childbirth and by transferring the infection on fingers from the genitals to the eyes...” (www.avert.org).

Knowledge of having Chlamydia can cause anxiety amongst infected people especially if they do not have adequate knowledge of the progression of it as well as proper treatment. The chance of transferring it to an unborn baby can cause stress to infected people who want to have children and could result in partners not wanting to engage in sexual relations, thereby affecting their dating and sexual life.

Gonorrhoea

“Gonorrhoea is a curable STD that affects both men and women and can infect the cervix, urethra, rectum, anus and throat...which can lead to abdominal pain, ectopic pregnancy in women and infertility, meningitis and septicaemia. Gonorrhoea is transferred through penetrative sex. Pregnant women with gonorrhoea may pass

the infection on to her child and the baby could be born with a gonococcal eye infection...” (www.avert.org). Inflammation of the testicles and prostate glands which can cause infertility are some of the results of gonorrhoea. “Once gonorrhoea has been successfully treated it will not come back unless the person becomes reinfected” Unauthored article (www.avert.org).

The researcher sees the impact of gonorrhoea as affecting the dating and sexual lives of infected people as it could cause sexual discomfort and dysfunction as well as impacting on the couple's plans to have a baby. A couple who has gonorrhoea and has not had adequate counseling may avoid having a baby or avoid sexual activities.

Herpes Simplex Virus (HSV)

“Genital herpes is...acquired from sexual contact and affects the genital area” (www.avert.org). HSV can also impact the dating and sexual life of an infected person as it is incurable and reoccurs. HSV can also be transmitted to a sexual partner therefore it is understandable then that the person with HSV would not want to be sexually active. Disclosure of this STI can also be embarrassing.

Syphilis

“Syphilis is a sexually transmitted disease (STD) caused by the bacterium *Treponema pallidum*” and congenital syphilis is when the disease is passed from an infected mother to her unborn child (www.avert.org). Use of condoms can reduce syphilis however; it does not reduce the incidence of becoming infected with syphilis. As condoms do not cover the whole affected area, direct skin contact could result in transmission. A pregnant woman with syphilis can be given treatment whilst she is pregnant at no risk to her unborn baby (www.avert.org).

HIV positive people may experience dual stigma due to their HIV positive status and their sexually transmitted infection as both are stigmatised infections (Balfe & Brugha, 2010; Nack, 2000). The researcher feels the stigma from both infections can negatively impact the dating and sexual life of infected people as it may promote denial, deception and secrecy as they may choose not to disclose these infections to avoid rejection, shame, blame, embarrassment and stigma.

This could also result in guilt which could negatively impact on current or future relationships (Coleman & Lohan, 2009; Newton & McCabe, 2008) as their partner/s could accuse them of being unfaithful or refuse them sex. Duncan et al. (2001) cite violence as a reason for non disclosure of STIS.

Counseling about various STIs as well as the means to manage sexually transmitted infections should be forthcoming and infected people should be encouraged to disclose STIs to their partners in order for them to be adequately treated (Van Dyk, 2008). Such disclosure and treatment could positively influence current and future sexual relationships.

2.3.10 DATING AND SEXUAL COUNSELING

Sexuality is one of the most ancient and perplexing occurrences today. It is complex in human experience and core to life and takes many forms through identity, behaviour, fantasy, drive, passion, physical sensation and ways of relating to others (Chodorow, 1978).

Van Dyk (2008) discusses the dual discomfort in both counselors and HIV positive people when discussing intimacy and sex. She stresses the importance of counselors, counseling couples together about HIV-related concerns and challenges which impact their relationship. One's sexual experiences, relationships and functioning are important to well being, yet many people do not communicate adequately about their sexuality and sexual functioning. This inability to adequately communicate about sensitive issues creates stress for the PLHIV.

Chronic illnesses such as HIV/AIDS affect one's sexual functioning and it is therefore important for health care professionals and counselors to be comfortable and well informed to pass on the relevant information to patients. However, many health care professionals are uncomfortable discussing sexuality and therefore do not offer the relevant informational support and care required by patients (Byers, 2011). Some healthcare professionals do not fulfill this responsibility; because they have not received adequate or suitable training to assist clients and patients with sexual issues while others are uncomfortable discussing sexual issues in general (Arrington, 2004; Byers, 2011).

In some societies, policy makers may be reluctant to expand the capacity of health care professionals by allowing them to adequately address sexual and reproductive issues of HIV positive people as they do not want to be identified as promoting sexual activity. This contradicts the 2006 UN General Assembly (UNGASS) High Level Meeting on AIDS where governments were obligated to initiate laws and policies that protected the rights of HIV positive people in order that they are able to make responsible choices regarding their sexual and reproductive health.

Sexual issues that clients/patients may need information about are sexual orientation, gender identity, safe/r sex, sexual side effects of medication, pregnancy and adjustment of partners' sexual changes due to medication (Byers, 2011). Sex and sexuality are not topics that many clients are comfortable initiating, so a proactive measure would be for counselors, psychologists and healthcare professionals (HCP's) to initiate such conversations in order for the client to feel comfortable to discuss them.

A study conducted with 31 men and 4 women in Canada 1999 – 2000 provided insight for clinicians and counselors alike by highlighting the importance of sexual desire and intimacy in counseling sessions (Maticka-Tyndale et al., 2002). Sexual satisfaction is a topic deserving much needed attention in the infected person's life as it contributes to their quality of life.

Prior medical and/or professional background or standardized training are not prerequisites for auxiliary health workers such as lay counselors and community health workers (CHW's). They are trained through in-service training (Ruud et al., 2010). Added to this, is the fact that HIV has added to the workload of healthcare professionals. The limited amount of time and resources allocated to counseling contributes to the limitation and insufficiency of information and care.

The researcher therefore asks the questions: Are lay counselors and community health workers competent to assist HIV positive people with dating and sexual challenges that they may encounter in their lifetime if they do not have proper medical, professional education and training? Further can they effectively offer such assistance given their time constraints and workloads?

2.3.11 REPRODUCTIVE HEALTH AND FAMILY PLANNING

“Advances in treatment with antiretroviral medication have dramatically improved the prognosis for those infected with HIV, transforming it into a manageable chronic illness and allowing many infected individuals to have long, active and productive lives” (Cibulka, 2007:3). Antiretrovirals have given infected women a positive outlook to having babies, given the reduced infection in mother-to-child transmission (MTCT). Family planning can be a positive process in the infected person's life.

Berk (2001) emphasized how individuals in the early adulthood (20 to 39 years) phase need to have children. An HIV diagnosis should not end people's dream to be parents. Mother-to-child-prevention strategies allow infected women to give birth to healthy babies. Some respondents in this study fell in this stage.

A purposive study was conducted on 3 White and 12 African American HIV positive women to uncover the reproductive health concerns of infected women (Cejtin, 2008).

The study covered the following reproduction options namely:

- Self insemination (SI) : identifying a woman's fertility period and self insemination with her partner's freshly ejaculated semen,
- Minimising risk before conception: Reducing viral load with antiretroviral medication (decrease viral load through use of antiretroviral therapy) and
- The default option (no plan for future conception).

The study revealed that some respondents were uninformed about self insemination as a reproductive option. Some respondents utilizing minimizing risk had difficulty identifying their fertility period and ran the risk of infecting their partners while the default option was the process chosen by most of the respondents.

The birth of a child in some communities is important to legitimize relationships so a female's inability to have a child could have negative consequences in their intimate relationships (Matheka & Sekudu, 2006).

Taking into account the economic impact of HIV/AIDS, the impact of HIV/AIDS on the South African economy and services in the public health system available to the majority of South Africans, the researcher feels that self insemination would be an expensive option to the majority of HIV positive females. The second and third options would be easier as antiretrovirals are freely available to the majority of infected people.

Many infected women choose not to discuss their reproductive intentions with counselors and health care professionals to avoid negative reactions. A reason volunteered for their unwillingness to discuss their reproductive plans was that they viewed discussing reproduction plans as a reminder of their HIV infection.

Discussion of reproduction options is important in counseling so that infected women are aware of the options available to them in order to make informed decisions (Cibulka, 2007).

2.3.12 GENDER INEQUALITY

According to WHO (2008) HIV positive women in sub-Saharan Africa constitute 60% of the region's infected people. The pandemic is driven and fuelled by gender inequalities. Only 38% of young women have accurate, comprehensive knowledge of HIV/AIDS according to the 2008 UNAIDS global figures (UNAIDS, 2008). The Millennium Development Goals 3 and 6 (MDG 3 & 6) focus on the promotion and reduction of gender inequality and elimination and reduction of HIV/AIDS, TB and malaria (www.un.org).

Culture and tradition encourage men to have more sexual partners as well as encouraging older males to have younger female partners which contributes to the high female infection rate especially amongst women (15-24 years) compared to young males. Further homophobia results in stigmatisation of homosexuals thereby making them and their partners more vulnerable to HIV (WHO, 2008).

Many studies and HIV literature reflect gender inequality exposing male dominance in sexual relationships whereby males exert this inequality and control over women by their refusal to use condoms. This threatens women's rights and fuels HIV infections and re-infections (UNAIDS, 2004). Males exert male dominance by putting their sexual pleasure first as they see protected sex as reducing sexual pleasure and the risk of infecting their partners with HIV and/or sexually transmitted diseases (STDS) (Flood, 2003; Moeliono, 2004; Oriel, 2005).

Foreman (2002:42) give reasons for soldiers' refusal for condom usage as they are a "restriction of masculinity [and] they reduce sensation". This indicates that men's pleasure is superior to women's. This implies that women have the responsibility for safe, protective sex and have to be an equal partner in sexual activities by negotiating protective sex. Khan et al. (2003) advise that men should be encouraged to use condoms in order to prolong sexual performance and pleasure.

The researcher feels that inequality in gender roles in the dating and sexual relationship impacts on the self worth of the parties involved in the sexual relationship.

2.3.13 ARVS AND THEIR SIDE EFFECTS

ARVS are not a cure for HIV/AIDS but can reduce one's viral load (VL) to enable stability and restoration of the immune system. This improved, stabilized immune system can be threatened when treatment failure occurs which could necessitate regimen changes (Noë et al., 2005). An Ethiopian cross sectional study on the quality of life of patients on highly active antiretroviral therapy (HAART) revealed that masculinity, youth, education and employment resulted in positive quality of life of PLHIV on HAART. This study also highlighted the increased life expectancy of people on HAART.

The apartheid government's failure to address HIV/AIDS adequately as well as the denialism era of Thabo Mbeki are key reasons for high HIV/AIDS rates today (Keikelame et al., 2010). According to UNAIDS (2009) the mortality rate has since decreased since the ARV roll out in 2004 and quality of life of infected people has improved since the availability of ARVS in South Africa.

ARVS are lifelong medication and can cause side effects. Long term, irreversible side effects of infected people on regimen one include lipodystrophy, peripheral neuropathy and lactic acidosis (WHO Press release, 30 Nov 2009). Some are mild whereas others are debilitating and affect the quality of life of PLHIV's (Jalibert, 2001; Keegan et al. 2001). "Often there are several ways to lessen the harm, either by treating the side effects or by switching to alternative antiretroviral drugs" (www.avert.org).

The notable side effects of ARV drugs are described below (www.avert.org). This is not a complete list.

Diarrhoea

Diarrhoea is a common side effect of many antiretroviral drugs. The diarrhoea can last for only the first few weeks or for the duration that they are taken. Although it

may not be enough to solve the problem, changing the diet may reduce the severity of diarrhoea (www.avert.org).

Occasional diarrhoea can be embarrassing and ongoing diarrhoea can “lead to dehydration, poor absorption of nutrients and drugs, weight loss and fatigue” (www.avert.org). Both occasional and persistent diarrhoea can be uncomfortable in a dating and sexual relationship and may result in the infected person being embarrassed by continuous visits to the toilet. The other party in the relationship could become frustrated by the impact diarrhoea has on the relationship.

Nausea and vomiting

Nausea and vomiting are some of the side effects of antiretroviral drugs. They can cause reduced appetite during the first few weeks of treatment. A well balanced and managed diet, with the assistance of a dietician, can reduce these effects. “Some antiretroviral drugs can be taken with food, and doing so may lessen their harmful effects. It may also be possible to alter drug dosage or frequency” (www.avert.org). Nausea and vomiting could temporarily or permanently dissuade the infected person from pursuing a dating and/or sexual relationship.

Rash

“Rashes often appear as a side effect of antiretroviral treatment. These may be itchy but are usually harmless and short-lived. Antihistamine tablets can sooth rashes and are generally available without a prescription. However, because these may interact with antiretroviral medications, patients should check with their doctors before using them” (www.avert.org).

Potential partners in a dating and/or sexual relationship may be put off by rashes as they may seem contagious. The rashes could also impact on the self esteem and confidence of the PLHIV as they may feel physically unattractive to their partners.

Lipodystrophy

“Lipodystrophy involves losing or gaining body fat, often in ways that can be disfiguring and stigmatising (www.avert.org) Lipodystrophy manifests in the following ways:

- “Loss of fat on the face, arms, legs and buttocks, resulting in sunken cheeks, prominent veins on the limbs, and shrunken buttocks.
- Gaining fat deep within the abdomen, between the shoulder blades, or on the breasts.
- A mixture of fat gain and fat loss” (www.avert.org).

Diet does not make a significant difference, however changing ARV regimes and exercise may improve physical appearance (Heyer & Ogunbanjo, 2006). “Aerobic exercise (such as running or swimming) tends to have more effect on the fat just below the skin than on the deep fat gained through lipodystrophy...Switching antiretroviral treatment should stop the symptoms getting worse, but is unlikely to lead to much improvement once the condition has advanced” (www.avert.org).

Psychological Impacts of Lipodystrophy on Women

A common area of concern for HIV positive women and homosexuals is lipodystrophy as it impacts image and self esteem. Both parties feel pressured to look good and be seductive and desirable. Infected women are concerned with the impact these bodily changes have on their partners as these bodily changes make them look unattractive and reduce their chances of finding partners. They may be able to hide their medication but will be unable to hide the visible signs of the disease. The increase in breast size could be a positive aspect if their partners are breast inclined and this could positively influence the relationship (Unauthored, undated, www.cwhn.ca).

The researcher feels that a HIV diagnosis, and body changes/distortions caused by lipodystrophy negatively influence the self esteem and confidence of the infected person. Body image is important to women and they are more prone to lipodystrophy which creates thoughts of shame, ugliness and being unattractive to a potential partner and could result in PLHIV resorting to abstinence and celibacy (Donnelly, 2001).

2.3.14 COMMUNITY/SOCIETY

Most human beings are born into a family and community. As human beings are social beings HIV positive people are no different and rely on interaction between friends, family and community members. The manner in which communities treat HIV positive people impacts their dating and sexual lives. Stigma from community members can result in the breakdown of relationships and psychologically affect the PLHIV (Sayles et al., 2007).

Families and communities can play a role in the infected person's choice of partner, which to a large extent is fueled by stigma, awareness and educational programs about HIV/AIDS. The present study seeks to uncover how such factors impact on the dating and sexual lives of PLHIV's.

2.3.15 THE MEDIA

The media encompasses electronic media, print audio and visual media. A qualitative study (Retief, 2002) discussed the important role the media plays in responsibly and consistently reporting about the pandemic. Parker and Shepperson et al. (2000) agree that the media plays a major role in assisting the public and health care workers understand key elements of the epidemic. Dating and sexuality are elements of the epidemic; therefore the importance of the media's impact is relevant to this study.

The Panos Institute research report (2004:12) highlighted “the public’s reliance on the media for HIV/AIDS information is unquestionable...We only have the media to inform us. They are the bridge between the individual and the outside world. If there is anything we need to know about AIDS, it is through the media”.

Lovelife is a HIV/AIDS media outlet aimed at a core target market of youth aged between 12-19 years to “measurably contribute to behaviour change ... achieve the Lovelife strategic imperative of a 50% reduction in new HIV infection in the period 2010-2014” as well as “sustain awareness of the organisation’s numerous support and outreach programs through print, radio, TV and mobile platforms” (www.lovelife.org). The Department of Health (DOH) is Lovelife’s primary funder.

South African Broadcasting Corporation (SABC) provides HIV programs on an ongoing basis. Soapies contribute to HIV/AIDS via story lines such as in ‘Isidingo’ wherein an HIV positive female, Nandipha finds love, gets married, gets divorced and partakes in intimate relationships.

Electronic media has a wealth of information on HIV/AIDS through search engines such as Yahoo and Google. E-dating and blogs address the dating and sexual challenges faced by HIV positive people. Solely dedicated HIV internet dating sites are found on the internet. However, there are few South African HIV dating sites namely www.positive.datingbuzz.com. and www.HIVpositivedating.co.za. Profiles are uploaded at no cost; however corresponding with other members entails a subscription fee, which is indicated as follows:

“You can create your profile, search for matches, and even receive messages from subscribers while you're a free member, but you will need to purchase a PositiveBuzz subscription if you want to take full advantage of all that the site can offer you. Here's a summary of the benefits you'll receive as a subscriber.

As a free member you can:

- *Create your profile and upload up to ten photos*
- *Let other members know you're interested by adding them to your favourites*
- *Find out your top 100 matches*
- *Receive emails and respond with one of our quick "**one-liners**"*

Subscribers have access to the full range of features:

- Set up a private, invitation only, photo gallery
- Email other members using our safe and private email service messages.
- Receive up to 1000 matches
- Subscribing to PositiveBuzz is quick, easy and affordable.

Check out our rates below:

Normal Subscription Rates		
12 months	R719.95	Equivalent to just R60.00 per month Billed in one payment of R719.95 , then after 12 months: R60.00 per month until <u>cancelled</u> TOTAL SAVING: R1079.45
6 months	R449.95	Equivalent to just R74.99 per month Billed in one payment of R449.95 , then after 6 months: R74.99 per month until <u>cancelled</u> TOTAL SAVING: R449.75
3 months	R299.95	Equivalent to just R99.98 per month Billed in one payment of R299.95 , then after 3 months: R99.98 per month until <u>cancelled</u> TOTAL SAVING: R149.90
1 month	R149.95	
3 days*	R59.95	

- * **3 day** subscriptions are only available as gifts for other members.
- If you've received a voucher or promotional code, you may be entitled to further discounts off the normal rates. Simply enter your voucher number below to access your special rates." www.positive.datingbuzz.com

Users of the "positive.datingbuzz.com" website have been assured that their personal details will not be sold. This assurance is not entirely reliable as hackers are able to penetrate most websites (www.ramonthomas.com). Online dating is an option that PLHIV can pursue.

Sassman's website (www.positive.datingbuzz.com) provides members with an option to use technology at their convenience to find partners who meet their expectation. Online dating reduces costs as members are assisted in sorting through many potential suitors at a fraction of the cost of taking a partner out for dinner, buying gifts and the frustration of going on many unsuccessful dates. Anonymity is an attractive key to online HIV daters as well as the challenge of disclosing their status.

Most international HIV dating sites are free. A Google search exposed the following HIV dating sites (www.google.com):

www.HIVpassions.com	www.positivesdating.com	www.personals.poz.com
www.livingpositive.com	www.afropoz.com	www.HIVandsingle.com
www.HIVpoz.net	www.HIVmatch.co.uk	www.positivesingles.com
www.lovepositive.co.uk	www.gayHIVpoz.com	www.pozcircle.com
www.HIVpositivedating.co.za	www.positivelove.com	www.pozvibrations.com
www.HIVnet.com	www.datepositive.net	www.HIVpositivedating.net

The dating industry was also affected by the economic downturn as stated on Unauthored source: www.onlineprnews.com

“HIV Dating Site Slashes Upgrade Fee In Response to Tough Economic Times

HIV dating and herpes dating site www.datepositive.net reduces fees to help more people join in current tough economic climate.

Online PR News – 08-July-2011 –An HIV dating and herpes dating website has cut membership fees to help more people join in the current economic climate. www.datepositive.net made the move after some members emailed to say they had lost their jobs and couldn't afford to upgrade”

The economic impact of HIV, computer literacy and the cost of owning a computer and accessing internet make online HIV dating inaccessible to the majority of infected people hence internet dating in South Africa is not an easy option to explore.

2.3.16 RELIGIOUS, CULTURAL AND FAITH BASED ORGANISATIONS (FBOS)

According to Bennion (1991:30-32) “A powerful reason why the world holds that SEX IS BAD is that it is unspiritual. It is of the flesh, and its delights are carnal. We are taught to mistrust the flesh....As the Bible says: it is the spirit that quickeneth; the flesh profiteth nothing....Sex is bad because God hates it...and they were both naked, the man and his wife, and were not ashamed”.

Bennion continues as follows:

“The only reason allowed by Jesus for divorce was sexual intercourse with a person other than the spouse, sex being the one thing so bad that it could burst the divine marriage bond...It is bad because it is dirty, animal, bad and unseemly. Submission to it is weakening, and wears out the body. It produces unwanted children or unpleasant abortions. It spreads disease. It endangers relationships...It is unspiritual “The only reason allowed by Jesus for divorce was sexual intercourse with a person other than the spouse, sex being the one thing so bad that it could burst the divine marriage bond...It is bad because it is dirty, animal, bad and unseemly. Submission to it is weakening, and wears out the body. It produces unwanted children or unpleasant abortions. It spreads disease. It endangers relationships...It is unspiritual” (Bennion,1991:31).

A HIV diagnosis could impact on the self image and self esteem of individuals as they could perceive their status as punishment for contravening biblical laws.

Christianity places emphasis on marriage which requires sexual intercourse to be delayed until marriage, focusing on procreation and eliminating the use of contraceptives and contraception techniques (Bennion, 1991). Christianity advocates marriage and monogamy (Shorter & Onyacha, 1998) whilst the government promotes condoms and contraception. These differing stances can cause confusion for a PLHIV exploring dating and sexual options (Zwang & Garenne, 2008).

Holtsman and McLeroy (2007) highlight marriage being the risk contributing to many HIV positive women's lives. They were infected subsequent to their marriage, so marriage was not a preventative measure for their contraction of HIV (Bunnell et al, 2005). Van den Berg (2006) does not see marriage as a deterrent against HIV. “The burden of HIV in stable relationships places emotional, economic and physical stresses on families” (Tangmunkongvorakul et al.,1999:1). This quote aptly summarises that a HIV diagnosis in a stable relationship results in many challenges and it is those challenges that impact on infected peoples' dating and sexual lives.

Some infected people are consumed by sex-negativism which contributes to a great sense of guilt about their sexuality (Bennion, 1991). The guilt felt by infected people can lead to anxiety and stress which compromises the immune system and their well being and socialisation of the person. Celibacy is a form of sexual abstinence which many religious people pursue in bringing themselves closer to God (Bennion, 1991). Celibacy can also be an alternative to sexual intimacy as a result of the religious guilt that infected people may feel, an issue that will be explored in this study.

Infected people are told when they are initially counseled by lay counselors to practice safe/r sex, yet Thornton (2008:199) states many traditional healers do not advocate condoms as they see their traditional medicine as being effective in HIV prevention and transmission of STI's and see condoms as presenting significant dangers such as 'back-up' of semen in the male.

The researcher understands that religious organisations and faith based organisations (FBOS) are visible and prevalent in most communities and therefore play a pivotal role in peoples' lives. This is enforced by an African American study highlighting the psychological and physical roles that religion plays in HIV positive women's lives (Morse et al., 2000). Given their positioning in the communities they serve, they have an important role to play in HIV positive peoples' lives in terms of counseling, care and support and should be able to assist with the dating and sexual challenges faced by infected people.

Faith based organisations are seen to engage communities at grass roots level in terms of offering direct and indirect HIV/AIDS services which would include counseling, prevention programs, care and support. However, according to Keikelame et al. (2010), the degree to which research reflects this, is rather limited. This reflects the need for research on how FBOs serve those who are infected and affected by HIV/AIDS.

Tiendrebeogo and Buykx (2004:53) state that "more research is needed to document the influence of religion on behaviour change and to assess the effects

and processes of FBO work". Dreyer (2002:105) sees HIV/AIDS as "... one of the problems most neglected by theologians and religious communities in South Africa".

A closer relationship between communities, theologians and infected people would assist people to confront the challenges of dating and sexuality in their lives and communities.

In this regard a key informant study in South Africa offered the following findings about the role of FBOS:

- "Both the secular and faith based respondents perceived difficulty among FBOs in dealing with and speaking openly about sex and sexuality.
- However, when members of the congregation or community fear moral blame for having HIV infection; this fear is thought to act as a strong deterrent to disclose... Fear may be especially potent among clerics and other religious leaders who are themselves HIV-positive.
- Faith based informants also discussed the self-stigmatisation that prevents some PLHIV from accessing critical health services offered by FBOs...
- The respondents also noted the importance of leaders in the reduction of stigma associated with being tested for HIV, by means of their own public participation voluntary counseling and testing (VCT) programmes..." (Keikelame et al., 2010:66-67).

Faith based organizations play a pivotal role in reducing and/or eliminating stigma and discrimination and in so doing can reverse the impact of the pandemic by speaking to their members to find out what types of support they want and need.

The researcher believes that religious, cultural and faith based organisations' members are their clients/ customers and in order to meet their clients'/customers' needs they need to find out what these are and endeavour to meet them.

2.3.17 GOVERNMENT

In 2004, the South African government rolled out antiretroviral treatment to HIV positive people. Free condoms and counseling are also offered by government at clinics and hospital.

Keikelame et al. (2010) see the South African government's original response to the origins and treatment of HIV/AIDS as a contributory factor to the stigmatization and misunderstanding of HIV/AIDS by many communities. They go further to reflect stigma as presenting in many negative forms such as exclusion, rejection, blame or devaluation which impacts on the way the individual views him/herself.

Frederickson and Kanabus (2000:1) endorse this by stating that "From the moment scientists identified HIV and AIDS, social responses of fear, denial, stigma and discrimination have accompanied the epidemic". This viewpoint can pose a challenge to the dating and sexual experiences of HIV positive people.

The role that government plays in an infected person's dating and sexual life will be explored in this study.

2.4. CONCLUSION

The HIV positive person forms part of a system/whole. The interlocking roles of all subsystems and parts of the whole are imperative to the functioning of the whole. All the factors and challenges influencing the dating and sexual life of the infected person are all parts of the whole.

Dating and sexuality of the HIV positive person has not been given the attention it deserves. Research studies solely dedicated to dating and sexuality have not been forthcoming even though there is a need for such research. Dating and sex are normative components of human beings lives. However, in an infected person it results in many challenges such as rejection, depression, sexual dysfunction,

abstinence, sexual promiscuity, violence, deception, unsafe sex, isolation, separation and divorce.

Clearly socio-economic issues such as sexual taboos, gender inequalities, unemployment, stigma and discrimination; medical issues such as ARV side effects, and sexual dysfunction; psychological issues such as self esteem, guilt, blame, grief, all provide challenges to meeting HIV positive people's dating, sexual and reproductive health needs. This study seeks to explore the effect of these challenges.

CHAPTER 3

RESEARCH METHODOLOGY

3.1 INTRODUCTION

The first chapter provided an introduction to the study; statement of the problem; justification for the study; significance of the study; research aims; goals and objectives; research questions; theoretical framework; research design and methodology and an outline of the research report. The previous chapter reviewed literature applicable to this research study. This chapter describes the research approach, procedures, processes and methodology used in this study.

3.2 RESEARCH APPROACH

As the purpose of this study was to explore and describe the dating and sexual challenges and experiences from an inside perspective (Babbie, 2005) qualitative research was chosen. A qualitative approach to research according to Mouton and Marais (1989:157) is "...that approach in which the procedures are formalized and explicated in a not so strict a manner, but in which the scope is less defined in nature and in which the researcher does his or her investigation in a more philosophical manner".

The researcher has pursued a qualitative approach to study human action in this case the dating and sexual challenges and experiences from the perspective of the social actors themselves (HIV positive people) according to Babbie (2005).

A research study based upon a qualitative process of inquiry may have the goal of understanding a social or human problem from multiple perspectives. Qualitative research is conducted in a natural setting and involves a process of building a complex and holistic picture of the phenomenon of interest. In order to expose what

challenges HIV positive people are confronted with, the researcher chose to source this information from HIV positive people themselves.

A qualitative approach promotes trust and empathy between the researcher and respondents (Collins et al., 2007). The choice of this approach allowed the researcher, who is HIV positive herself, to conduct the study in a trusting and empathetic manner, as the respondents felt comfortable discussing their circumstances with a researcher who had the same diagnosis as them. The researcher disclosed her status to respondents but adopted an outsider's reality in this study as she viewed her role as describing and exploring the insider's (respondents') reality.

3.3 RESEARCH DESIGN

Babbie (2005) views a research design as a blueprint of how the researcher intends conducting the research. It focuses on the research being planned and the kind of results aimed for. Grinnell (2001) views a research design as a plan which includes all aspects of a proposed research study from identifying the problem through to the dissemination of findings.

The research design employed by the researcher was explorative and descriptive. The researcher's reason for this choice was to have an exposé of the feelings and emotions of HIV positive people towards the challenges/experiences they have encountered and/or are still encountering. The researcher needed to fully explore and describe the various challenges and experiences of infected people.

Exploratory research focuses on the 'what' of a problem in this research namely the dating and sexual challenges faced by HIV positive people. This type of research provides the impetus for future and further research on the topic. An exploratory design was used because there is insufficient information available on the dating and sexual challenges of HIV positive people in South Africa.

Neuman (2003) adds that an exploratory design seeks to enable the researcher to become familiar with people's views (on dating and sexual challenges, in this case).

Neuman (1997:19-20) states the aims of descriptive research as follows:

- “To describe a process, mechanism or relationship
- To generate information that will stimulate new possible explanations
- To provide basic background information or context
- To compile a series of categories or to classify types
- To explain specific sequences, phases or steps
- To document information disproving previous findings about a particular topic”.

While exploratory research focuses on the ‘what’ of a problem, descriptive research focuses on the ‘how’ and ‘why’ of the problem and the relevant stakeholders concerned in the problem (Green & Thorogood, 2004). This study also attempted to answer how and why questions in relation to the research problem. Both go hand in hand as any topic has to be explored before it can be described.

3.4 THE RESEARCH POPULATION, SAMPLING AND SAMPLING TECHNIQUES

The research population should focus on demographic characteristics, attitudes, experiences, behaviours according to Babbie (2005). It can also be defined as the entire group of persons or set of objectives and events the researcher wants to study. A population “is a group of individuals, persons, objects, or items from which samples are taken for measurement.” (Bless et al., 2006:98). The research population for this research project is men and women over the age 21 years of age, who are HIV positive and living in KwaZulu Natal.

Sampling

De Vos et al. (2002:198) describe sampling as “the act, process, or technique of selecting a suitable sample, or a representative part of a population for the purpose

of determining parameters or characteristics of the whole population. A sample is conducted rather than a complete enumeration (a census of the population for many reasons)". The researcher's reason for utilising a sample (twelve respondents) was to learn something about the population (HIV positive people). Utilising a sample is cheaper in relation to time and effort and more effective to observe a part rather than the whole and could result in a quality research outcome.

Sampling Techniques

Purposive sampling according to Babbie (1990:97) is when a researcher selects the sample on the basis of his/her own knowledge of the population, its elements and the nature of the research aims.

The researcher used a non-probability sampling technique known as snowball sampling as HIV/AIDS is a sensitive subject and anticipated challenges in locating respondents from all the race groups. The researcher asked respondents to recommend potential participants for the study from people they had met at clinics and at support groups. Alston and Bowles (2007:75) view qualitative researchers as more focused on understanding social reality and it is for this reason that non-probability based or purposive sampling techniques were used as respondents were chosen for a purpose. The research is purposive and therefore this sampling technique was suitable.

Researcher's Sampling

According to Alston and Bowles (2003:81) "for a sample to be representative, it must be chosen in such a way that subjects or cases have beliefs, attitudes or experiences which are similar to the population being investigated". The respondents came from various areas in Durban, KwaZulu Natal. The researcher's reasoning was KwaZulu Natal has high infection and prevalence rates (UNAIDS, 2009).

However, as will be noted later the final sample was not representative of all cultural groups.

The researcher's sampling criteria were:

- HIV positive persons (male/female) over the age of 21 years and up, who had experienced dating and sexual challenges.
- Person over the age of 21 who were willing to participate and had consented freely to participate.

The researcher's sample comprised of twelve participants. They were six females and six males, who were all over 21 years of age as the researcher wanted respondents who were able to consent of their own will rather than seeking custodians' and/or guardians' permission. All respondents were English speaking to avoid translation.

The twelve respondents were from the four main racial groups in South Africa:

- Four White respondents
- Four Coloured respondents
- Three Black respondents
- One Indian respondent

3.5 PREPARATION FOR DATA COLLECTION AND THE METHOD OF DATA COLLECTION

Researcher's Preparation

A checklist was drawn up by the researcher to ensure she kept to a procedure. A lockup drawer was allocated for all research information. Three files were allocated for the research project in order for all relevant information to be in one place and to live up to security and confidentiality requirements. Books were sourced from the library and articles and papers from the internet. Information on data collection was read in order to be prepared for the task ahead. The researcher liaised with ex-

research students for tips on research and for research reference books to assist in the research project. Finally, the research process was supervised at the university and research protocol followed.

The researcher used a voice recorder. Stationary such as tapes, memory sticks, writing pads, pens, pencils, printing paper and printing cartridges were used for the research project. A laptop was already in the possession of the researcher to transcribe the twelve interviews.

Participant's preparation prior to data collection

The researcher had individual meetings with all twelve respondents prior to the actual interviews to address what the research was about and the researcher's role, what the role of the respondents was, as well as to serve as a preparatory forum to address concerns that the respondents may have had, for example, how long the interview sessions would take, the interview procedure and request for use of a tape recorder in the interview process. On the day of the interviews, the researcher phoned each respondent on their landline and/or cell phone to confirm the interview and to discover if they were ready for the interview.

3.6 DATA COLLECTION TECHNIQUES

Data collection techniques allow researchers to systematically collect information about their objects of study (people, objects, phenomena) and about the settings in which they occur (Alston & Bowles, 2003). If data is collected haphazardly, it will be difficult to answer the research questions in a conclusive way.

Alston and Bowles (2003:66-73) state various data collection techniques can be used such as:

- “Using available information
- Observing
- Interviewing (face-to-face) ... “

Face-to-face interviews were utilized by the researcher to gather information regarding the types of challenges experienced and the people involved in the challenges. A semi-structured questionnaire which served as an interview guide was formulated from which the researcher asked the respondents questions which were mostly open-ended.

Kovac (1987) views an interview guide as a set of written questions used in a face-to-face interview in which the researcher asks the questions of the subjects and records their answers either during the interview or as soon as possible thereafter.

The advantages of using an interview guide, according to Kovac (1987:70) are:

- “That it can be used when the questionnaire cannot - that is, with persons who cannot read.
- Answers are immediately available. The researcher does not have to wait for the return of responses.
- Use of the interview guide provides greater flexibility in interpreting questions.
- Interview provides an opportunity to observe and assess the validity of the response”.

Kovac’s (1987) views the interview guide as placing much emphasis on the respondent’s verbal response or written response. The researcher can take those responses at face value or interpret the response in light of what the researcher knows about the subject, as well as the response may be used to draw inferences about some aspects of the subject’s behavior or personality which have not been reported.

Kadushin (1990:12) states that the purpose of information gathering interviews “is to obtain a focussed account of the individual, group, or community, in terms of social functioning”. An interview is a data collection technique that involves oral questioning of respondents, either individually or as a group and all questions should relate to the research problem (Bless et al., 2006:116).

Answers to the questions posed during an interview can be recorded by writing them down (either during the interview itself or immediately after the interview) or by voice-recording the responses, or by a combination of both. In this study the researcher used both as some of the participants did not speak loud enough and the researcher wanted to ensure she had their responses as they stated them.

Researchers often use a combination of flexible and less flexible research techniques. Flexible techniques, such as loosely structured interviews using open-ended questions, focus group discussions and participant observation are also called qualitative research techniques. They produce qualitative data that is often recorded in narrative form. The researcher used questioning and observation in this study.

Babbie (1990) regards open-ended questions as those questions in which respondents are asked to provide their own answers to the questions.

The open-ended questions chosen by the researcher were as follows:

- When were you diagnosed HIV positive?
- What was the state of your dating relationship when you were diagnosed HIV positive?
- What impact did your positive status have on your dating and sexual life?
- Have you explored dating and sexual relationships since your diagnosis?
- What is your current state of dating and sexual life?
- What positive or negative experiences have you had in your dating and sexual life?

- How do you feel about these experiences?
- Has stigma and/or discrimination played any role in your dating and sexual life?
- What types of stigma and/or discrimination have you experienced in your dating and sexual life?
- What dating facilities do you know of, that are available to HIV positive people?
- Have you pursued any of them and what has been the outcome?
- How has ARV treatment affected your dating and sexual life?
- What medical factors affect your dating and sexual life?
- What psychological factors affect your dating and sexual life?
- What physical factors affect your dating and sexual life?
- What role does community/society play in your dating and sexual life?
- What role has stigma played in your dating and sexual life?
- What role did pre/ post test and/or ongoing counseling play in your dating and sexual life?
- What role has awareness programs from the media played in your dating and sexual life?
- What role has community awareness programs played in your dating and sexual life?
- What role has government awareness programs played in your dating and sexual life?
- What support and/or assistance would you embrace in your dating and sexual life?
- From whom would you require such support and assistance?
- What dating and sexual advice/recommendations would you give to another HIV positive person?

All twelve interviews were recorded and transcribed. All interviews were held at the respondent's place of choice e.g. office, home. The researcher wanted the participants to be comfortable and therefore the interviews were held in their appointed surroundings. Another reason for conducting the interviews at their

convenience was that the researcher felt it was cost effective to have one person, namely the researcher go to the various venues than twelve people being transported to a venue. The researcher's reason for using face-to-face interviews was also to ensure a high response rate and to obtain clarity to questions that may have needed clarification.

Interviewing skills

The researcher took the following interviewing techniques and tips into account from Seidman (1998):

- The researcher listened more and spoke less and allowed the participants to do most of the talking.
- Questions asked were brief and clear as they were already predetermined as part of the research.
- Asked one question at a time and only continued when the first question was completed successfully.
- The researcher ensured that she understood the questions before asking the respondents to answer.
- Allowed for pauses in conversation as the researcher took into account language differences and attention span of the respondents.
- Explored emotions when they were identified.
- Constantly enquired from the respondents if they were okay with the questions.
- Ended the interviews within the pre-arranged times to avoid boredom and irritation on the part of the participants.
- Researcher kept water next to her in case the respondents required same.

Babbie (2005:73) distinguishes between “two main data sources, namely, numeric data (numbers, statistics, psychological test scores, and physiological measures) and textual data (documents, texts, conversations, and interview transcripts”). For the purpose of this study the researcher utilized textual data in the form of interview transcripts.

3.7 METHOD OF DATA ANALYSIS

Data analysis takes place “once data collection and checking have been completed. This analysis is conducted so that the researcher can detect consistent patterns with the data” Bless et al. (2006:163). “Describing, classifying and interpreting are at the heart of qualitative data analysis and entail salient themes, recurring ideas or language and patterns of belief”, is how De Vos et al. (2002:352) summarise the data analysis process. The researcher categorized all the data that was received and identified themes and sub-themes emerging from the data, which were written up.

Analysis was concluded as follows:

- The interviews were tape recorded and the researcher transcribed the tape recorded interviews word for word.
- The researcher engaged in preliminary reading of the interviews and extracted all information relevant to the dating and sexual challenges faced by HIV positive people.
- The researcher selected one interview transcript namely participant CM1 as it was the shortest interview. The researcher’s underlying meanings and substance was written in the margin of the transcript.
- The researcher then completed the above task for all eleven of the remaining transcripts.
- All data was categorized.
- The researcher listed all the relevant topics identified and grouped them together.
- Topics were assigned codes and the codes were assigned abbreviations (Punch, 2005; Rubin & Babbie, 2008).
- Topics were assigned themes to describe them.
- Data was divided into themes and grouped accordingly.

Alston and Bowles (2003:207) document the aspects of qualitative data analysis which was completed by the researcher (see above) as follows:

- “It aims to capture the richness and complexity of lived experience
- Includes the experiences of the researcher, both before and during the research (experiential data)
- Consists of three general stages which follow one another in a continuous cycle: data reduction, data organization and interpretation”.

The qualitative nature of sampling and analysis and the semi structured interviews resulted in differing content and time devoted to questions dependent on the respondent’s particular concerns. An example was that not all the respondents were on ARVS so therefore different amounts of time was devoted to that question.

3.8 RELIABILITY, VALIDITY AND TRUSTWORTHINESS

Researchers differ about the definition and criteria for reliability and validity as they are not all applicable to qualitative research. The area where there is a lack of consensus is the difference and importance between reliability and validity. Reliability focuses on measuring an instrument’s consistency whereas validity focuses on the measurement accuracy (Babbie & Mouton, 2005; Rubin & Babbie, 2008).

The concern in this study was qualitative studies focus on multiple perspectives and meanings and do not always totally focus on measurement. The researcher understood this and therefore sought opinions from researchers who had prior knowledge of conducting research about HIV/AIDS. The interview questions were viewed by selected scholars in the field to ensure that they adhered to reliability and validity standards.

To ensure trustworthiness the researcher requested the identity documents and HIV results from each respondent. This activity authenticated respondents’ status and promoted dependability of data. Credibility was achieved by transcribing the tapes word for word to ensure the data utilised was authentic. Transferability was

achieved by ensuring a dense description of data, using both written and audio recording of the interview. The importance of honesty when answering questions was stressed by the researcher if the study was to have value and be an impetus for further research.

3.9 ETHICAL CONSIDERATIONS

“Social work ethics are those principles that are intended to define rights and responsibilities of the researchers and practitioners of social work in their relationship with one another and with other parties, including employers, research subjects, clients and students” (Grasso & Epstein, 1992:118). The research project must be planned so that the chance for misleading results is minimized. Secondly, the project must be planned so that it meets ethical acceptability.

Ethics is “a set of widely accepted moral principles that offer rules for, and behavioural expectations of, the most correct conduct towards experimental subjects and respondents, employers, sponsors, other researchers, assistants and students” (Strydom in De Vos, Strydom, Fouché & Delport, 2002:75).

In order to adhere to ethical principles the researcher:

- utilised letters inviting participants to participate in the research (Addendum 1). This was utilized to give the participants a formal written background about the research to be carried out. The researcher read out the invitation letter as well as the consent letters to ensure that the respondents fully understood what they were going to be part of.
- asked the respondents to read, understand and sign informed consent letters in order not to coerce the participants to participate against their will and for the research process to be a voluntary one. (Appendix 1).

- maintained confidentiality- The researcher explained to the respondents that there would be no identifying personal details in the research. Confidentiality according to Babbie (2005) reflects that only a few relevant stakeholders would be aware of the respondents' identifying details but these people have made a commitment to confidentiality and have had prior experience with research and therefore have a thorough understanding of confidentiality.
- engaged in consultation with participants prior to the actual interview in order to make the participants comfortable. The researcher provided an explicit, detailed account of the whole research and interview process and allowed the respondents to ask questions in order to be comfortable with the process prior to signing up to participate. Questions addressed during this process were the frequency and number of the interviews, the time frame of the interviews, the time, venue and date of the interview/s, the aims and the goals of the research.
- treated all the participants with respect to maintain their human dignity and rights (Neuman, 1997) by greeting them on arrival, acknowledging them, constantly asking them if they were okay with the proceedings at hand and seeing them at their convenience.
- ensured no harm came to the participants as she met them at places of their choice and enquired whether they were comfortable with the process several times prior to commencement as well as during and after the interview took place. The researcher explained from the onset that if at any stage the respondent felt uncomfortable during the interview he/she should let the researcher know. Research that poses potential harm, risk, or danger to the participant is not allowed, unless the benefit of the research outweighs the risks and full informed consent is given.
- took notice that the respondents were all over 21 years of age and all respondents were comfortable with the interviews taking place in English.

- explained to the participants that the information they gave could assist other HIV positive people improve their dating and sexual lives in order to reduce and/or eliminate challenges in the future. Creswell (2007:39) states that “in the entire qualitative research process, the researchers keep a focus on learning the meaning that the participants hold about the problem or issue, not the meaning that the researchers bring to the research or writers from the literature”.
- management of information was adhered to by keeping a filing system in a lockable cupboard and by saving her work on a laptop with a password to ensure no accessibility by others. The researcher explained the management of their information to all twelve respondents for example, tapes, notes and transcripts would all be in the keep of the researcher in a lockable drawer in a secure cupboard and a password guarded laptop.

Debriefing

Judd et al. (1991:517) describe debriefing sessions “as the time after the research session/s when the respondents get the opportunity to work through the experiences and its consequences as a means to assist respondents and to minimize any harm”.

A summary of the debriefing process followed in the study was:

- The researcher offered assistance to respondents, after the research interview/s, to work through their experiences and the impact thereof. This served to minimize possible harm that may have occurred during the process.
- Where assistance was offered during the interview, the researcher handled termination and withdrawal of such assistance professionally.

The researcher held a debriefing session with each respondent to address any concerns and/or challenges they may have had. The researcher asked each respondent how he/she felt about the process. All felt that if the information would

help others, they were happy to share their experiences. The researcher referred respondents to counseling centres and thanked all the respondents for participating.

3.10 LIMITATIONS OF THE STUDY

Most research studies have limitations which impact on the outcome (Cooper & Schindler, 2003). HIV is still a highly stigmatised disease and many HIV positive people are not comfortable discussing their stigma let alone their dating and sexual challenges. HIV positive people can be described as a 'vulnerable population'.

Finding infected persons willing to share their experiences was challenging because of the nature of the stigma and discrimination associated with HIV disclosure. The researcher took this into account by approaching infected people who were willing and available to share their stories and be part of the study. Her pre-existing relationship with service providers facilitated access to some participants and resulted in honest responses. However, this relationship also posed a danger of data contamination which was addressed in the ethics form.

The greatest mode of HIV transmission in sub-Saharan Africa is sex and such discussions are not comfortable. The correlation between HIV transmission and promiscuity is high which could be attributed to many infected peoples' discomfort discussing their sexual lives.

The sample comprised of twelve people which is not representative of all HIV positive people. The researcher experienced great difficulty recruiting Indian HIV positive people. This maybe as a result of many of those race group members being more uncomfortable than the other groups in disclosing their status let alone discussing their sexual and dating challenges.

Respondents were restricted to KwaZulu Natal and therefore the data is limited. It is possible that respondents from all provinces would have yielded different results, themes and challenges.

The interviews were conducted in English. The Black respondents did not object, even though their mother tongue was IsiZulu. This may have resulted in only some information being shared due to language difficulties. However, it is also possible that because many respondents were known to the researcher, they were more forthcoming than the ones that were not.

The researcher felt there was a need for ongoing assistance for the respondents as some were emotional although many put on a brave face. Ongoing counseling and therapy was very important, and although referral was offered, the researcher is uncertain if this actually occurred.

Finally, because the researcher is HIV positive herself, maintaining neutrality was a challenge although her training as a social worker and family therapist was helpful in ensuring objectivity. Indeed, her status helped respondents to be open and honest.

3.11 CONCLUSION

This chapter explored the research design and methodology and provided an explanation for the qualitative research approach.

Chapter four will explore and describe themes which emerged from the interviews with the twelve respondents in the context of the literature review.

CHAPTER 4

RESEARCH FINDINGS, ANALYSIS AND DISCUSSION

4.1 INTRODUCTION

This chapter presents the research data, an analysis thereof as well as an interpretation of the results of this study.

The study was qualitative in nature in order to best describe and explore the dating and sexual challenges faced by HIV positive people. The presentation of findings will be discussed in accordance with systems and ecosystems theory as change to one part of the system usually results in change/s in other parts of the system as well as larger systems to which smaller systems are linked.

This chapter is divided into two sections. The first section focuses on the demographic profiles of the respondents such as gender, age, date of HIV diagnosis, HIV treatment, marital status and race. The second section discusses the various dating and sexual challenges and/or experiences of the respondents according to the ecosystems theory.

Respondents were drawn from clinics, lay counselors, HIV positive people and purposive and snowball sampling was used. Demographical information was collected from all the respondents during in-depth interviews. Semi-structured questions were asked from an interview guide. The interview questions were aimed at exploring and describing the dating and sexual challenges and experiences faced by the respondents. The interviews were tape recorded and transcribed by the researcher. On completion of the transcription, data was analysed and then divided into themes. The themes will be discussed after an exposé of the respondents'

profiles. Full profiles of all the respondents have purposefully been eliminated to preserve confidentiality and anonymity.

The reader will be exposed to 12 respondents of all four race groups from KwaZulu Natal, South Africa. Six of the respondents are female and 6 are male. The reason for this distribution by race and gender is that the researcher did not want to limit options by focusing on one gender or race group alone but instead opted for a broader participant categorisation.

The next section will provide the reader with demographical profiles of the respondents in order for the reader to understand the conclusions reached by the researcher in the next chapter.

4.2 DEMOGRAPHICAL PROFILES

The researcher conducted one semi-structured interview, using an interview guide with each of the twelve respondents. Respondents were all HIV positive between 26 and 53 years old. Four respondents were married at the time of their HIV diagnosis and 3 respondents had subsequently divorced and have remarried. Two of the remarried respondents have married HIV negative women, one respondent married a HIV positive woman and one respondent remained married to his partner from the time of his diagnosis.

Codes were assigned to the various race and gender groups as well as the number of respondents per gender and per race. The respondents were coded per number, race group and gender. The study was supposed to comprise 3 respondents per race group, therefore the numbering 1, 2 and 3. Coding begins and continues throughout the analysis. Coding plays an integral part of analysing qualitative social research data (Punch, 2005; Rubin & Babbie, 2008).

The codes for this study are:

RACIAL CODES	GENDER CODES
A : INDIAN	F : FEMALE
B : BLACK AFRICAN	M : MALE
C : COLOURED	
W : WHITE	

Table 5: DEMOGRAPHIC INFORMATION

The table below contains the demographics of all the respondents. Limited identifying details are provided.

NO.	CODE	RACE	GENDER	AGE	CURRENT MARITAL STATUS	YEAR DIAG	BEGAN TX
1	CF1	COLOURED	FEMALE	26	SINGLE- IN A RELATIONSHIP	2010	N/A
2	WM1	WHITE	MALE	26	SINGLE	2010	N/A
3	BF1	BLACK	FEMALE	28	MARRIED	2009	2009
4	BF2	BLACK	FEMALE	30	SINGLE	2003	2004
5	CM1	COLOURED	MALE	30	SINGLE	2006	N/A
6	WM2	WHITE	MALE	36	REMARRIED	2007	2008
7	AM1	INDIAN	MALE	43	MARRIED	2003	N/A
8	CM3	COLOURED	MALE	48	REMARRIED	1997	2005
9	CM2	COLOURED	MALE	49	REMARRIED	2007	2007
10	WF1	WHITE	FEMALE	52	DIVORCED/IN CASUAL RELATIONSHIP	2007	2009
11	BF3	BLACK	FEMALE	52	SINGLE- IN 2 RELATIONSHIP	2011	N/A
12	WF2	WHITE	FEMALE	53	DIVORCED/ SINGLE	2004	2008

All the respondents were between the ages of 26 and 53 years of age. One respondent had discovered her status under one year ago (2011) while the rest had been diagnosed over one year ago. One of the 12 respondents was not in a committed relationship and another respondent had just lost his partner to an opportunistic illness at the time of their diagnosis. The sample consisted of 11

heterosexual HIV positive people and one homosexual male. The fifty percent gender representation was achieved in the sample. Initially, the sample was supposed to comprise 3 respondents from each of the 4 race groups. However, the researcher encountered challenges recruiting the required number of respondents from the Indian race group, hence there were 4 Coloured, 4 White, 1 Indian and 3 Black respondents in the final sample.

Five of the 12 respondents are between 26 and 30. According to Louw et al. (2003) these respondents fall into Erikson's early adulthood stage (20 to 39 years) and the other 7 fall into the middle adulthood stage (40 to 59 years). Information about these respondents' work lives and financial status was not obtained and may be viewed as a limitation in the study since such variables could have had an influence on how these respondents dated or addressed challenges to dating.

4.3 PRESENTATION OF THE THEMES: DATING AND SEXUAL CHALLENGES

According to O'Sullivan et al., (2008:40) "...the researcher looks for themes and concepts in the analysis of qualitative data". The researcher grouped similar themes together in this section. The themes identified are consequences of respondents' HIV diagnosis; disclosure, stigma, rejection and discrimination; dating options respondents pursued; serosorting or abstaining; guilt, anger, blame, social disconnection, negative self esteem and self worth and fear; physical, medical, psychological and financial factors; impact of ARVS on respondents; sexual changes/sexual dysfunction that challenge respondents; reproductive challenges of respondents; community's/society's role; the media's role; counseling, awareness and education about dating and sexual relationships; government's role; religious organisations' role and respondents' choice to date again. The PLHIV does not exist in isolation but interacts on different levels therefore the themes identified will be grouped according to the impact on the micro level, the mezzo level and the macro level. Themes identified under the micro level refer to the general impact of the positive diagnosis on the individual.

4.3.1 CHALLENGES ON THE MICRO LEVEL

Theme 1: Consequences Of Respondents' HIV Diagnosis

The table below reflects the consequences of a HIV diagnosis on respondents' dating and sexual relationships:

Table 6: CONSEQUENCES OF RESPONDENTS' HIV DIAGNOSIS

CODE	MARITAL STATUS AT TIME OF DIAGNOSIS	YEAR DIAG	RELATIONSHIP LENGTH POST DISCLOSURE	CONSEQUENCE OF HIV DIAGNOSIS AND/OR DISCLOSURE	CURRENT RELATIONSHIP STATUS
CF1	SINGLE - IN A RELATIONSHIP	2010	6 MONTHS	TERMINATED RELATIONSHIP - PARTNER IN DENIAL ABOUT HIS HIV STATUS AND ALCOHOL ABUSE	SINGLE - IN NEW RELATIONSHIP
BF2	SINGLE - IN A RELATIONSHIP	2003	2 YEARS	TERMINATED RELATIONSHIP - PARTNER IN DENIAL ABOUT HIS HIV STATUS	SINGLE - NOT IN A RELATIONSHIP - ABSTAINING
CM1	SINGLE	2006	N/A	NONE	SINGLE - IN CASUAL SEXUAL RELATIONSHIPS
WM1	SINGLE	2010	N/A	NONE	SINGLE - IN CASUAL SEXUAL RELATIONSHIP
BF1	MARRIED	2009	N/A	NONE	MARRIED
AM1	MARRIED	2003	N/A	NONE	MARRIED
WM2	MARRIED	2007	1 YEAR	DIVORCED	REARRIED
CM3	MARRIED	1997	2 YEARS	DIVORCED	REARRIED
CM2	MARRIED	2007	2008	DIVORCED	REARRIED
WF1	DIVORCED - IN RELATIONSHIP WITH 2 MEN	2007	24 HOURS	BOTH MEN ENDED RELATIONSHIPS WITH WF1	SINGLE - IN A NEW CASUAL RELATIONSHIP
BF3	SINGLE - BROKEN UP WITH BOYFRIEND AND IN A CASUAL RELATIONSHIP	2011	N/A	NONE	RESUMED RELATIONSHIP WITH EXBOYFRIEND - STILL IN CASUAL RELATIONSHIP
WF2	DIVORCED - IN A RELATIONSHIP	2004	N/A	TERMINATED RELATIONSHIP - PARTNER'S ABUSE OF ALCOHOL	SINGLE - ABSTAINING

As noted from the above table only respondents AM1 and BF1 remained in their original relationships post disclosure. Later the researcher will qualify that both AM1 and BF1 were dissatisfied in their relationships, for different reasons as discussed under theme 3 (dating options) and theme 8 (sexual changes).

This demonstrates the findings of Bunnell et al. (2005:1009) that being in a relationship is not a “safe haven” nor a prevention strategy for a HIV diagnosis; it only adds to the fragility of the relationship. Indeed a HIV diagnosis puts strain on some of the respondents’ lives and relationships as noted in the following words:

“I’m still with my wife. 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. The next day we went to the hospital for her to get tested. She was negative. I felt relieved that she never gave it to me but I was worried where I got it from”. (AM1)

The above response clearly reflects that the respondent experienced many feelings and emotions on receipt of his diagnosis and his initial reaction was to apportion blame for his positive status, to his partner. This blame quickly turned to uncertainty and concern about the source of his infection when his partner received a negative diagnosis. These concerns show a great deal of uncertainty and pain that impacted the relationship negatively. This concurs with the findings of various studies which show a correlation between a positive diagnosis, disclosure blame and rejection (Bouillon et al., 2007; Elford et al., 2008; Skogmar et al., 2006).

No impact of their positive diagnosis was felt by the 2 participants in casual relationships as one was a sex worker and the other had previously lost a partner as a result of the disease. This shows that a positive diagnosis has varying impact on individuals’ lives and is dependent on the type of relationship they are in, as reflected in the following response:

“Well, I was prostituting. It didn’t change because I was not in a relationship... My sex life carried on as normal and I still dated casually”. (WM1)

The above response by WM1 highlights that an HIV diagnosis did not have a significant impact on HIV positive persons who are in casual relationships. As noted in Table 6 the majority of respondents remained in their relationships for between six months to two years. All these respondents reported strain within their relationships post disclosure, which ultimately resulted in separation and divorce. This was explained as follows:

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

"The relationship with my wife was strained". (CM2)

"Our relationship did not last as it was very hard for me... we separated." (BF2)

"I'm divorced. My wife divorced me in 2008". (WM2)

"...she ended up divorcing me. So yes, I'm divorced". (CM3)

"It ended in 2006 after a 2 year relationship..." (WF2)

Reasons that were cited by respondents and/or their partners for leaving their relationships were alcohol abuse, physical abuse, denial and negative reactions to a HIV positive diagnosis. Systems theory focuses on the importance of relationships and highlights that change in one part of the system impacts on the other parts as well as the whole. From the respondents' comments, their diagnosis had a negative impact on them as individuals as well as on their partners and their relationship as a whole. The following quotation refers to physical abuse encountered in the relationship:

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

According to Maman et al., (2001) women experienced more negative reactions after a serostatus disclosure in the form of physical violence and this was noted in the above respondent's comment. In respondent CM3's instance, the abuser was HIV positive and projected his guilty feelings on his negative wife through physical violence (Ramachandran et al., 2010). From a systems perspective, a positive diagnosis has far reaching consequences resulting in physical abuse as noted in the above quote.

Alcohol abuse was also highlighted as a challenge to the following respondents' relationships as follows:

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

"It ended in 2006 after a 2 year relationship it was mainly due to alcohol abuse". (WF2)

"...I just drank..." (CM3)

Alcohol is one of the coping mechanisms that infected people use (Avert, HIV & AIDS in South Africa, undated). CF1 and WF2 did not drink alcohol but their partners drank excessively after their diagnosis whereas CM3's partner did not drink but he drank excessively after his diagnosis. Not only does a positive diagnosis impact on partners but on the infected person as well. The excessive use of alcohol in the above respondents' relationships impacted negatively on their relationship, to the extent that all three relationships ended.

Denial

The following quotes refer ...

"...did not want to face up to his status ... He was in denial." (CF1)

"...because he was in denial. He suggested I go to a traditional healer to get rid of this disease." (BF2)

Denial is a reaction of a HIV diagnosis. However, the length of time the denial lasts can pose a challenge for the infected person and their loved ones (Antelman et al., 2001).

This was clearly the case in the above quoted comments as the positive diagnosis impacted on the respondents' relationships and ultimately resulted in the termination of these relationships. Denial is also associated with the use of traditional healers which was highlighted in the study conducted in north-west

Tanzania (Wringe et al., 2009). BF2's partner suggested she see a 'traditional healer' to 'get rid of' both their HIV illnesses. He resorted to pursuing his cultural beliefs to deny and eliminate their diagnosis. This denialism of BF2's partner resulted in her terminating their relationship. The current study findings together with those by Wringe et al. (2009) indicate the need for socio cultural interventions in relation to HIV/AIDS management.

Negative reaction to a discordant diagnosis

Some of the respondents in the current study mentioned the negative reactions of their partners to their HIV positive status as follows:

"...I think she was uncomfortable being married to an infected man..."
(WM2)

"I don't think my wife could handle it. I don't think she was honest about how she felt about being negative and me being positive." (CM2)

The above responses suggest how HIV infected individuals perceive a negative reaction even when it is not verbally communicated. These findings concur with a study by Dano (2007) where four respondents described being afraid and feared being rejected by partners. Although the above mentioned respondents' partners did not directly state their discomfort at being in relationships with positive men, the respondents blamed these negative reactions for the deterioration and ultimate disintegration of their marriages.

Relationships form one part of the individual's whole as well as influence the manner in which one lives. So if there is discordance in one part of the whole (their relationship) it impacts on the other parts of their living as per the systems approach, which allows therapists to understand the impact of a HIV diagnosis on a relationship or loss thereof on the infected person's life, as noted in the aforementioned findings.

The next theme focuses on disclosure, stigma, rejection and discrimination.

Theme 2: Disclosure, Stigma, Rejection and Discrimination

The early adulthood stage emphasises the young adult establishing intimate ties with others by finding a partner to share sex, work and friendship with. Rejection plays an important role during this stage as the young adult dislikes being turned down by a partner or potential partner and significant others (Berk, 2011). This was clearly noted in the lives of several respondents.

Concerns about the consequences of disclosure are evidenced in the following statement:

“Well, I would be afraid to tell people my status because I don’t know how they would take it. It will hurt me if they came to know and they didn’t want anything to do with me”. (WM1)

These sentiments clearly demonstrate the fear of rejection, stigma and discrimination that results in some infected people choosing not to disclose their status. The above statement highlights the complexity of disclosure (Arnold et al., 2008; Klitzman et al., 2002).

The following respondent (CF1) disclosed to a potential sexual partner who made an excuse to leave the relationship which left the respondent feeling upset and angry about being honest. This anger is depicted in the following quote:

“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 from that day until today.” (CF1)

Rejection, stigma and discrimination are not only common to the respondents in the early adulthood stage but also affected respondents in the middle adulthood stage.

This is evident from the following excerpts:

“I am so guilty about not disclosing especially to my partners because to me it’s a bit early to disclose maybe there will come a time when I will disclose to them”. (BF3, 52 years)

“Anger from two ex partners because they were afraid of being infected. I phoned him and he asked me “what have you done to me?” (WF1, 52 years)

“Well as far as the negative boyfriend is concerned he thought he was being horrible and nasty by telling my daughter about my status” (WF2, 53 years)

The aforementioned responses show that developmental stages and age do not exclude anyone from stigma.

Two respondents communicated that their reasons for non disclosure to their family members were due to fear that their respective families may discriminate against them as follows:

“Our family challenges our dating relationship... So we just keep it to ourselves and we not going to tell our parents because they still have a thing about HIV. ..They don’t know we are HIV positive and they live with us and we go and visit them and everything. Like if they find out or we tell them that so and so is HIV positive. They say ooh they going to die...” (BF1)

“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)

The abovementioned quotes reflect reasons for non disclosure of status to family members as protecting them from any pain and keeping the family together and is also discussed by Palmer and Bor (2001). As noted from CF1, the respondents in this study were uncomfortable about disclosure and therefore chose to be ‘dishonest and secretive’.

The respondent quoted below is remarried and has chosen not to disclose to his new wife.

“I have not disclosed to my wife. She asked why we were still using condoms after our marriage. I don’t feel comfortable disclosing my status to my wife...” (CM3)

The above response clearly demonstrates the discomfort that some PLHIV experience about disclosing. This new marriage has begun with deception. The consequences of this deception was not highlighted in this study but could prove important in studies regarding disclosure.

Only one respondent did not see stigma as a dating and sexual challenge but rather related it to low self esteem, which is discussed under theme 5 separately. The following quote explains the respondent’s view:

“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)

Full disclosure in this case helped this relationship to thrive. The respondent saw it necessary to confidently disclose rather than suffer under the weight of secrets and stigma. From a systems perspective the relationship between honesty and a positive marital relationship is clearly evident. However, disclosure must be carefully undertaken with a need to consider the ‘when’, ‘how’ and ‘who’ to disclose to, as discussed by Makin et al. (2008) and Medley et al. (2004).

Disclosure, stigma and discrimination affect the individual at different systemic levels. They could affect relationships with partners, friends and family as well as how the individual is viewed in the community. Partners, friends and family play a valuable, supportive role in the individual’s life without which there could be isolation and the individual system will remain undernourished.

Theme 3: Dating Options Pursued

The respondents considered and pursued various dating options such as online dating sites, social media, bars, singles clubs, dance clubs, casual sexual relationships, support groups, newspaper adverts, friends and family, HIV clinics; while some chose to abstain from seeking dating and another did not entertain any other dating options as she was still in her original relationship.

Some respondents were successful in their dating and sexual endeavors while others were not. This is reflected in the table below:

Table 7: DATING OPTIONS

CODE	AGE	DATING OPTION	DATING RESULT
CF1	26	Friends	In a new committed relationship with a HIV positive male
WM1	26	Online dating	Unsuccessful
BF1	28	Has not pursued dating options as she is still in same relationship from time of diagnosis	
BF2	30	Friends	Unsuccessful Abstaining
CM1	30	Bars	Successful – casual relationships
WM2	36	Singles Clubs Family and friends	Unsuccessful Successful Remarried to a HIV positive woman
AM1	43	Attended HIV clinics to find HIV positive women	Unsuccessful Still in a marriage with HIV negative woman
CM3	48	Bars and clubs	Successful Remarried to a HIV negative woman
CM2	49	Dance clubs	Successful Remarried to a HIV negative woman
WF1	52	Online dating Newspaper adverts	Unsuccessful Successful in a casual relationship with a HIV negative man
BF3	52	Bars	Resumed relationship with ex partner and is still in a casual relationship as well
WF2	53	Singles clubs Online Dating	Unsuccessful Successful with meeting someone online however nothing tangible materialized. Has since chosen to abstain

Human beings seek partnerships and interactions of an intimate nature to fulfill their need for social connection, intimacy and to have children. If this need is not met then their functioning as individuals with multiple relationships and responsibilities, is affected, this being understood from a systems perspective.

Online Dating

It was interesting to note that all the White respondents had pursued online dating unlike any of the other race groups. Perhaps the reason for this lies in the other respondents not having access to the internet or fear that confidentiality may be compromised if they used this dating option. The other possibility is that respondent' from other race groups were better connected socially and could rely on friends and family to set them up with potential partners.

Reasons for suspending or stopping this option were financial, geographical distance and no success rate. One White respondent's reasons for stopping internet dating was narrated as follows:

"... 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)

This clearly reflects that online dating is an option he was comfortable with and would pursue in the future as his financial status impedes him pursuing it at this point in time.

"I tried some online dating sites but most of them are overseas, so I didn't continue with them." (WM2)

WM2 did not totally rule out online dating but highlighted that the sites he pursued had foreign suitors. The researcher is of the opinion that he was not well informed of various national dating sites or foreign dating sites which have South African suitors as well. This respondent has since remarried a woman he met through friends and family.

Success in pursuing online dating is not always possible which was the experience of the following respondent:

“I’ve tried online dating but I’ve had no success.” (WF1)

WF2 did pursue HIV online dating sites and met someone online and communicated for some time; however it did not amount to a dating or sexual relationship:

“I did meet someone on the site...he was keen to meet up with me and paid a subscription for 3 days for me so we could communicate and subsequently he went on a holiday for 40 days and never contacted me again.” (WF2)

None of the respondents in this study achieved success in their pursuit of online dating.

Singles Clubs

Singles clubs were pursued by two of the White respondents and their experiences were as follows:

“I went to a single club but that was not my scene I was afraid to tell any woman there about my status because I was afraid of their reactions and singles clubs are public. I was not prepared to have rejection because of my status in front of strangers. So eventually I stopped going to the singles clubs.” (WM2)

“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)

The two respondents who pursued single clubs were unsuccessful for different reasons as WM2 had difficulty disclosing his status to women and WF2 did not find any suitable males. This highlights the plight that HIV infected individuals are confronted with when it comes to disclosure of HIV positive status. Similar findings were found by Maticka-Tyndale et al. (2002) in a study conducted in Canada.

The researcher could not draw any conclusions about whether or not dating sites and singles clubs were suitable for dating and sexual relationships as the respondents had pursued them for a short period. The responses may have differed, had they continued utilizing these sites. However, this being a qualitative study with a small select sample, makes such generalization unnecessary.

Casual sexual relationships and bars:

One respondent pursued casual sexual relationships to cope with his grief as he was mourning the loss of his partner. This is demonstrated below:

"I had just lost my girlfriend days before I found out I was also positive... The last thing on my mind was looking for another steady relationship so I just find takeaways in bars. It's easier I don't need to disclose my status and they also want casual sex, they not looking for serious affairs". (CM1)

"I meet men in bars and if we like each other we go for it". (BF3)

Family and friends:

"I met dates and this boyfriend through my friends after my first relationship ended". (CF1)

I met my current wife the old fashioned way through my family and friends". (WM2)

Dance Club:

"I met my second wife in a dance club, Dance Café and we still together". (CM2)

HIV Clinic:

"I go to the HIV clinic to find a woman who is HIV positive as well but I have not found one yet..." (AM1)

Respondent, AM1 was uncomfortable being in a relationship with his HIV negative wife (discordant relationship) and chose to pursue finding an infected woman at HIV

clinics. However, he had been unsuccessful in his pursuit and remains in the relationship with his wife.

Respondents who pursued dance clubs, bars, family and friends were more successful than those who pursued online dating and singles clubs.

Theme 4 Serosorting or Abstaining

After their diagnosis and subsequent disclosure, some respondents were confronted with the decision to date seronegative or seropositive people or to abstain. The decision to date a person with a similar serostatus is known as serosorting. Decisions similar to this were well documented in an article by Pernicone (2009). This decision was based on information they had at hand, personal choice, previous situations and relationships and not on the counseling they received. This study rendered no consensus on which options HIV positive people pursued.

The following quotes indicate the respondents' decisions:

To date seronegative 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)

"My wife is HIV negative..." (CM3)

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

"I don't want to go out of my way to find a HIV positive partner. The reason being she may come with her own problems of adjusting and then we both end up with a problems because I grow stronger on a daily and I don't know if I would be strong enough to carry someone else's weaknesses". (CM2)

The above responses are in line with findings by Palmer and Bor (2001), who attribute honesty and disclosure of one's status as reasons for seronegative 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.

To date seropositive 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)

"I'm happy I found a HIV positive woman because I saw the problem having a HIV negative wife. I think she didn't understand HIV and was afraid and thought divorce was the answer. I feel good about my new relationship because we going through our illness together. I think the insecurity of being married to a HIV negative person psychologically messes with your head. I won't date a HIV negative person, it's too much drama". (WM2)

"I think it is easier to date someone who is sick too, so we can understand each other. But I haven't met one". (AM1)

"...at the same time I don't know if I am closing myself in this shell because I want a person who is HIV positive..." (BF2)

The above excerpts suggest that some HIV positive individuals prefer engaging in relationships with those whom they share a common illness. This concurs with the study done in the United States from 2001 to 2005 where serosorting was observed as respondents selectively engaged in sexual relationships with partners of the same HIV status (Liu et al., 2011).

Abstaining

Abstaining was one of the options chosen by the HIV infected participants in the study. The responses were as follows:

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

That same respondent temporarily suspended dating due to medical reasons.

“...After that I backed off and didn’t date anyone because of the acquired disease and I had genitals 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)

The researcher wondered how respondent WF2’s decision to abstain could have been different had she not experienced ‘embarrassing’ genital warts and skin lesions. Similarly Balfe and Brugha (2010) highlight that some people suspend sexual activity due to their partners’ rejecting them or choosing not to partake in sex with them due to sexually transmitted infections (STIS).

Another respondent’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)

The above respondent has chosen to abstain due to religious reasons. Abstinence is a HIV prevention method. However, the respondent is HIV positive and views her prior engagement in premarital sex as making ‘mistakes’ and her abstinence as making ‘things right this time’, which relates to the findings of a study conducted in South Africa that revealed that some respondents “fear moral blame for having HIV infection...” (Keikelame et al., 2010). The above response by BF2 is in agreement with Bennion’s (1991) belief that sexual relations should be delayed until marriage which differs from van den Berg et al’s (2006) study which does not see marriage as a HIV prevention strategy as many married people get infected.

The decision to serosort or not or to abstain operates according to the micro systems level as this decision is based on the individual’s need to feel comfortable and able to function to his or her optimum in his/her life world. This decision affects all aspects of the person’s functioning. This decision also assists the infected person to realise his/her goals and dreams with a person who appreciates him/her and creates a synergetic outcome in respect of dating and sexual challenges.

Theme 5: Guilt, Anger, Blame, Social Disconnection, Negative Self Esteem and Fear

Guilt, anger, blame, social disconnect, negative self esteem and self worth and fear are potential outcomes of a HIV positive diagnosis. These feelings pose challenges to an infected person's dating and sexual life as they form part of the current relationship and can be transferred into a new relationship (Kasiram & Khoza, 2008; Milgram et al., 2006). The following quotes exemplify these sentiments:

Guilt:

"...I felt too guilty about my status..." (WM2)

Guilt was communicated by most participants in the present study.

Anger:

"... I guess I'm angry at myself and my past". (AM1)

Some participants expressed anger towards themselves, while others blamed the people who had infected them with the disease.

Blame:

*"Maybe he can leave me if he can have an idea that I infected him".
(BF3)*

Although participant BF3 was unsure of who infected her, her biggest fear was that her partner would reject her when he found out about it and blame her for infecting him.

Social disconnection:

*"Friends invite me to go out with them. I just don't bother to go out".
(WM1)*

The above respondent had only disclosed to his immediate family and did not disclose to others. This non disclosure of his positive HIV status can be attributed to him isolating himself (Kalichman et al., 2003; Sowell et al., 1997).

Human beings are by nature social beings which builds on the systems and ecosystems approach as it places emphasis on individuals existing in relation to their surroundings and environment. If the environment is uncomfortable and unpleasant it poses a challenge to their life.

Negative Self Esteem and self worth:

The following responses expose the negative self esteem and self worth these respondents experienced due to their HIV diagnosis:

“...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)

“What worries me is what I think about myself” (CM1)

“I feel dirty...” (AM1)

“It’s understandable I don’t like to tell people that I’m HIV positive because it makes you sound like you not normal, like you dirty...” (CM1)

“They have pitied themselves and they only have themselves to blame. (CM2)

“Many of us have problems with our self esteem and then to be about this illness, it just makes you feel worse and you lose confidence.” (CM3)

One respondent felt:

“...good that she chooses to stay with me even though she is negative” (AM1)

and another was:

“...pretty shocked that he accepted my status the way he did” (WF2)

Both the abovementioned responses by AM1 and WF2 seemed to indicate that they were perturbed that their negative partners chose to be in relationships with them after disclosing their status. Vyavaharkar et al. (2010) found that supportive environments improve the self esteem and self worth and reduce depression levels of women. Negative self worth and self esteem was found in both men and women in this study.

A respondent volunteered the following information for the relationship not lasting:

“I think I was more apprehensive than he was...Because of a lack of information I wouldn't deep kiss at all, ...was expecting him to be fearful of the disease because of the stigma, discrimination that he would think I was a dirty bitch and having told him all this...If I had more information I would probably have had a far better relationship”. (WF2)

This response by WF2 refers to the negative self worth that some HIV positive people have about themselves as well as the lack of information about HIV that challenges their dating and sexual lives. Adequate knowledge is important in the dating relationship. This is echoed in the following quote:

*“...had I known better, the relationship would have been even better...”
(WF2)*

Fear:

“...It's scary because I was scared when I first found out”. (CM1)

Research has shown 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” (Smith, 2002:65). This is applicable to respondent WM1 in the following quote:

“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 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)

Fear of partner/s leaving:

“Sometimes I worry about my partner finding someone else”. (BF1)

“...I worry that my partner would leave me...” (AM1)

“...maybe he can leave me because he has an idea that I infected him.” (BF3)

All the above responses reflect fear of rejection, blame and abandonment which are factors that contribute to non disclosure (Kalichman et al., 2003; Sowell et al., 1997).

Fear of infecting the other partner:

“...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)

“...I was unsure if I had infected her and my son...” (CM3)

The above quoted feelings of fear, undermine the confidence and self esteem of the respondents and affect their dating and sexual lives.

The systems framework assists one to understand that changes in the HIV infected individuals’ feelings, emotions and being, affect the individual holistically. Knowledge of these changes can offer impetus for improving the status quo and understanding what interventions will work for different outcomes.

Theme 6: Physical, Medical and Psychological Factors

The respondents' dating and sexual lives were affected and challenged by various physical, medical and psychological factors which are expressed in the following quotes:

Physical and medical factors included:

"... my skin is dry and I've lost some weight. I've got like rashes on my body. So I believe it doesn't make me look good. It makes me feel ugly because of all these things and the way my appearance is... if they see rashes on me they will believe they would get it too. That it's contagious or it can affect them as well". (WM1)

"I would have to say lipodystrophy. The fat around my stomach is just not on. It does not look nice... My lipodystrophy has made me a homebody. It affects my dating and sexual life indirectly because I am conscious of it". (WM2)

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

"My body shape has changed and clothes don't fit me properly and I don't look good when I'm dressed up". (WF1)

WM2 and WF1 disclosed the impact that lipodystrophy had on their dating and sexual lives but did not volunteer that it has resulted in them pursuing a celibate life unlike respondents in a study of involuntary celibate adults who cited a negative body image as a reason for being celibate (Donnelly, 2001).

According to Visser et al. (2006) disclosure can inhibit and reduce the debilitating effects of a HIV diagnosis. The above quotes did not reveal that disclosure reduces the debilitating effects of their illness as they had chosen to selectively disclose their status rather than opting for full disclosure and these factors negatively affected them and their dating and sexual lives.

Psychological factors included:

“Another challenge I have is, if the condom breaks, the STIs that I may get? I worry about having a baby.” (BF1)

“I get a bit depressed when I’m waiting for my blood results ... to tell you whether you ok or not. So that does affect my relationship and at times my sex life because I’m preoccupied with results instead of giving my partner attention”. (WM2)

“I have a grudge against women because a woman did this to me. I worry that my partner would leave me and tell people I’m sick. ..I feel dirty like I’ve done something wrong... I think about the person that infected me, why they infected me, they must have known they were infected and then infected me”. (AM1)

Physical and medical factors such as dry skin, rashes, lipodystrophy and oral thrush all affect the dating and sexual lives of the respondents. To date there is no available treatment for lipodystrophy however; a drug swop, exercise and diet could reduce the impact of this side effect (Heyer & Ogunbanjo, 2006).

Psychological factors such as condom breakage, STI’S, reproduction, depression, reduced libido and anger also affected the respondent’s dating and sexual lives. A study conducted in Australia by Grierson et al. (2000) concurs with these psychological reactions which also exacerbated feelings of physical and sexual loss experienced by the respondents in their study.

Two respondents cited finance as a challenge to their dating and sexual lives as follows:

“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 my financial status changed,...” (WM1)

AM1 was unemployed and received a disability grant while WM1 was a sex worker who experienced the brunt of the economic downturn on the sex industry. Finance played a role in their dating and sexual lives as WM1 wanted to pursue online

dating but did not have the technological equipment and finance to do so while AM1 felt that money was an important factor to pursue dating. From an ecosystems perspective, financial concerns emanating from a depressed economy are herein seen to affect the individual's sexual and dating life.

Physical, medical and psychological aspects of respondents played a role in the respondents' dating and sexual lives. These aspects form significant parts of the whole (existence) and therefore it is important to understand their impact on the respondents' lives.

Theme 7: Impact of Arvs

Few respondents in this study were not on ARVS while the majority who were on ARVS, did not identify treatment as a challenge to their dating and sexual lives.

This was evident in the following comments:

"None because I have not started taking them". (WM1)

"I'm not on ARVS so it does not affect my life". (CM1)

"I am not on ARVS as my cd4 count is over 200. But now government has changed that I am going on Monday to see if I can go on them." (AM1)

"Not as yet. I'm not on ARVS because my cd4 count is a little high it was 470 two months ago". (BF3)

It is uncertain if the above respondents fully understood the side effects of ARVS as none of them indicated any impact that side effects of treatment could have on their dating and sexual lives.

There were mixed responses about ARVS from the other respondents as follows:

"I started ARVS after my wife divorced me. I must admit I didn't feel like having sex at that time. It could be because I was still dealing with my HIV news. When I felt I was ready to have sex, the ARVS did not seem to be a problem. I have a normal sex life with my girlfriend". WM2)

"Initially stocrin was bad and another guy told me about it. I couldn't put my finger on it. The stocrin was like Viagra. You up all the time. That's changed now and with my new wife I sleep the whole week and do not even touch her". (CM2)

"I'm on ARVS since 12 January 2009. No it hasn't." (WF1)

One respondent attributed ARVS for her being a "sexaholic" whereas her partner who is also on ARVS "is just that person who does not want to have sex. We only have sex once a week whereas I always want to have sex..." ARVS affect people differently and this is evident from the above quotes which is in agreement with a Canadian studies (Jalibert, 2001; Maticka-Tyndale, 2002) and a United Kingdom study (Keegan et al., 2001) where respondents experienced varying sexual reactions/experiences while on HIV medication.

Theme 8: Sexual Changes/Sexual Dysfunction

Fear, anxiety, guilt and grief are also factors which could hinder the infected person's dating and sex life and could also lead to sexual dysfunction (www.increase-increase.org).

"Added to the pressure on couples is the need to practice 'safer sex' at a time when intimacy and closeness is most needed but often difficult to achieve" (De Matteo et al., 2002:273). Safe sex poses a challenge to the dating and sexual lives of respondents as condom usage is advocated during counseling and many are uncomfortable with this and some partners refuse to use condoms.

Condom usage requires adjustment and leads to conflict in relationships as it can be a reminder of the disease, reduces spontaneity and limits enjoyment. This is confirmed in a study which explored the extent and determinants of condom use within marital and cohabiting partnerships in KwaZulu Natal, South Africa (Maharaj & Cleland, 2004) that condom use was attributed to interrupting sexual activity and producing discomfort whilst also denying sexual gratification.

Although there is much awareness and emphasis on using condoms this information does not result in individuals actually using them. Many problems associated with condoms have limited the method's acceptability and use. People of both sexes worry that condoms inhibit sexual enjoyment (Maharaj & Cleland, 2004). This is evidenced through the following responses:

“What happens is most of the time before we have sex you have to think of using a condom whereas before we never used to use a condom so wherever we were, we used to have sex and never think about a condom...Sometimes having sex with a condom is not the same as having sex without a condom.” (BF1)

“...and he insisted and pursued it with a condom...I had sex with him with great in trepidation and panic. I was very worried about the condom breaking or falling off and I would infect him. I had a huge fear of that. The fear of infecting someone put me off sex at that time...He was very concerned initially that it wouldn't be spontaneous” (WF2)

“We always have to have condoms with us which hinders our sex life because we can't have it when and wherever so it must be planned all the time. Sex is natural, condoms are not, so yes using condoms does affect our sex life”. (WM2)

Maharaj and Cleland (2004) concluded in their study that the type of relationship has an influence on whether a condom will be used or not and condom usage is less practiced in marital relationships. This is in line with a response from this study.

“In the beginning my new wife wanted sex bareback because she said you are my husband now so how can we be using condoms. We had tons of fights...” (CM2)

This finding is also similar to the findings of Palmer and Bor (2001) who found that seronegative partners insisted on unsafe sex to become infected in order to be on an equal footing with their positive partners. The above comment is also consistent with a KwaZulu Natal study about condom use within marriages and committed relationships (Maharaj & Cleland, 2004).

A study conducted by Smith (2002) revealed that older women are not as assertive regarding the use of condoms. This was also found in the present study with one older woman reporting as follows:

“No, no he doesn’t use condoms and I don’t insist because we were not condomising before. .. I feel guilty about not using condoms with the one I resumed a relationship with”. (BF3)

Smith (2002) states that the shortage of information and research regarding sexual needs of older women in communities could be attributed to them being past the reproductive stage. This poses a challenge in older women’s dating and sexual lives, as limited research is conducted on the topic which may leave some older women feeling isolated and alone in their dating and sexual challenges.

Maharaj and Cleland (2004:122) concluded that even though there is widespread disagreement on the use of condoms in marriages and cohabiting relationships, couples have been ‘adapting’ to the epidemic in KwaZulu Natal. Their study was done almost seven years ago and yet this research study which was conducted in 2011, found similar condom disapproval. This is evident by:

“...should ask where’s the condom. Women they don’t ask, so that means they are HIV positive themselves. I don’t feel guilty about not using a condom. Women should insist on condoms. People who don’t have condoms on them and don’t insist on using them, they know why. They are positive. I think it is better if a woman wears a condom.” (CM1)

The abovementioned respondent insinuated that if women did not insist on condoms, then they were probably infected themselves. He justified his non insistence of condom use to their non assertiveness and therefore assumed they were infected as well.

Some respondents in this study engaged in safe sex as evident in the following quotes:

“I strictly have to use a condom. There will definitely be no sex without a condom. I value my life. I have children to see to, so I can’t have other diseases like sexually transmitted ones”. (BF2)

“I did not use condoms and was not fussy about who I slept with. When I got sick I came to my senses. I met my wife and we use condoms and eventually we got married”. (CM3)

“The casual one we use condoms... we always use a condom but still I have not disclosed to him either...” (BF3)

Respondents in a study conducted by Dano (2007) highlighted positive and negative changes in the sexual lives of serodiscordant couples. Bunnell et al., (2005) highlighted that sexual relations pose a challenge for couples, especially women. Infection, utilising safer sexual practices, health status of partners, transmission concerns are factors that challenge sexual and dating relationships (Palmer & Bor, 2001; Shernoff, 1991; van der Straten et al., 1998).

This study revealed similar results even though respondents were all seropositive and their partners both seropositive and seronegative. Respondents had experienced sexual changes and dysfunctions since their HIV diagnosis which impacted on their sexual and dating lives. Some of these changes were temporary while others persisted.

Drug abuse, increase and decrease in sexual needs, erectile dysfunction and low libido, menopause, religious beliefs and seronegative partner’s disinterest in sex will now be discussed as challenges to dating and having a sexual life.

One respondent who was addicted to “sugars” attributed this drug addiction for his loss of libido as follows:

Drug abuse:

“Drugs have affected me a lot because its affected my libido I don’t get turned on very easily. I’m not really in a mood for sex and making love, so drugs have taken my sexuality away from me . I’m just not in the mood for it at times. Most of the time I do it for the money not because I want to have sex”. (WM1)

WM1 was a sex worker who has a drug addiction problem. His drugs contributed to his low libido. The researcher did not ascertain whether his drugs were a coping mechanism for dealing with his status.

Increase and decrease in sexual needs:

“Since we have been on ARVS I always want to have sex whereas my partner is just that person who does not want to have sex. We only have it once a week whereas I always want to have sex. ...I tell him I’m going to get another boyfriend that is going to be eager to have sex with me because you don’t want to have sex with me...” (BF1)

BF1 is still in the same marital relationship she was in at the time of her diagnosis, however her increased sexual needs since being on ARVS is threatening that relationship. This observation has been made in several studies in Canada and the United Kingdom (Jalibert, 2001; Keegan et al., 2001; Maticka-Tyndale et al., 2002).

Erectile Dysfunction and low libido:

“It’s not easy for me to get an erection and my wife always orgasms before me. I feel down and depressed about this disease and when I feel down I don’t want to have sex”. (AM1)

Respondent AM1 had experienced erectile dysfunction and a low libido for eight years since his diagnosis. Erectile dysfunction can be caused by various challenges such as stress, finance, anger, health and family. This respondent discussed the following stresses that affected his libido:

“...we had been having unprotected sex for about three years...When I found out I went off sex and my wife has to force me to have sex with her. I always make excuses that I have a headache. I really don't want to do sex...I worry that my partner would leave me and tell people I'm sick...I feel down and depressed about this disease and when I feel down I don't want to have sex...I stress about money because I'm not working...You feel guilty because you did not follow the rules of your religion.” (AM1)

Erectile dysfunction and a low libido was found to strain his dating and sexual relationship. This respondent was in a serodiscordant relationship which could be contributing to the abovementioned challenges to his sexual and intimate life which is in agreement with a study conducted in Durban, KwaZulu Natal, South Africa which highlighted changes in sexual desire after a HIV diagnosis (Dano, 2007).

One respondent who was not on ARVS was keen to embrace ARVS as she believed they will positively contribute to her dating and sex life.

“I see going on ARVS really improving my sexual and dating life because it's happening to my friends.” (BF3)

Menopause:

“I got a shock that since I'm menopausal I never thought that I would be having sex again. To my surprise I'm hyper active sexually. I want sex quiet often.” (BF3)

The above respondent was concerned about her 'hyper active' sexuality. She was particularly worried that her sex drive may threaten her relationship/s as her partner/s may not be as sexual and become unhappy in the relationship or leave the relationship.

Religious Beliefs:

“I think it is the church. I'm abstaining. I'm trying to find a husband.... When it comes to the church, the bible says no sex before marriage.” (BF2)

Seronegative partner's disinterest in sex:

"My partner lost interest in sex. Before we knew my status, she was highly sexed but after we found out I was positive she was not interested in sex." (CM2)

Sexual changes and dysfunction occur for various reasons that the respondents have given. These include drug abuse, ARVS, religious beliefs, menopause, depression, increase and decrease in sexual frequency, erectile dysfunction and loss of libido.

Theme 9: Reproductive Challenges

The respondents who were concerned about difficulty in having children and who wanted to have children were all heterosexual and between the age of 26 and 30 which falls in the early adulthood stage. Berk (2001:372) attests "to cultural and generational influences on adult development: the social clock – age-graded expectations for major life events, such as beginning a first job, getting married birth of the first child... researchers determined how closely participants followed a "feminine" social clock (marriage and parenthood in the early or mid-twenties)..."

The following quotes reflect the respondents' feelings regarding reproduction:

"I worry about having a baby because I'm young and want to have a baby. I know the doctors told me to wait until I'm on ARV and my viral load goes down but how long will that take?" (CF1)

"I do want a baby but I'm afraid if my baby is HIV positive so I have to be very careful... If I couldn't have a baby that would threaten my dating life because at my age, 28 years old, I'm supposed to have a baby. I worry he may leave me if there's no baby". (BF1)

"...and have kids". (BF2)

"...and I want kids". (CM1)

The 'social clock' can be a reason for all these respondents in early adulthood having concerns about producing children. Respondent BF1 cited an inability to

reproduce as a challenge to her relationship given her age which reinforces the 'social clock' concept. Four of the 5 respondents in early adulthood stage wanted to have children. These findings suggest that HIV infected individuals aspired to have children in spite of their HIV diagnosis.

However WM1, who also falls in the early adulthood stage, was the only respondent who did not have these aspirations. A reason could be his homosexual status and being concerned about raising children within such a relationship.

In some African communities, relationships and marriages are not legitimized and recognised until the female produces a child. This signifies the woman's integration into the male's family according to Mbiti (as cited in Matheka & Sekudu, 2006). This has been highlighted in respondent BF1's comment above.

These findings highlighted that reproductive health of HIV infected people is fundamental to their wellbeing and those of their partners. It is therefore important for infected people to discuss their reproduction aspirations with their health care professional to get a holistic overview of the challenges and opportunities of reproduction (WHO, 2006a).

Challenges such as condom usage, financial implications, dating options, reproduction, disclosure, medical and psychological factors affect the individual's whole system. These challenges and changes affect the micro level of the individual and their effects radiate outwards as per systems and ecosystems theory.

Theme 10: Dating Again If Their Current Relationships Ended

Only one respondent expressed negativity with dating and sexual relationships if her current relationship ended. This is reflected below:

"No, because it would really be hard to start again. I couldn't deal with having to disclose again, be rejected again and then starting over again"
(CF1)

Several respondents expressed their positivity with pursuing new dating and sexual relationships.

“Yes, I would. I know I’m much more comfortable than when my ex-wife left. I have confidence now to handle rejection because I know not every woman is comfortable with dating and having a sexual relationship with an infected man. I have hope and know I will be able to find another partner if this one ends”. (WM2)

“Yes. I would look for a HIV positive person.” (AM1)

“Yes, I would. I still won’t disclose my status but I will date and have sex”. (CM3)

“Yes, I’m confident to get back on the horse if I fall off it”. (CM2)

“Yes” (BF3)

“Yes I would, if I could find a man”. (WF2)

Respondents who were in casual relationships did not comment about dating again. Another respondent (BF2) who was abstaining until marriage, also did not respond to this question. It was clear from these responses that interventions and support currently used by respondents were inadequate to equip them to pursue new relationships.

The community’s/ society’s, religious organisations’ and the media’s role will be discussed in the next theme according to the mezzo level.

4.3.2 CHALLENGES ON THE MEZZO LEVEL

Theme 11: Community’s/Society’s Role

Communities at large had not played any positive role in the dating and sexual lives of the respondents in this study. However, family and friends did contribute somewhat according to the responses below:

“Not much exactly because they afraid to assist people because they are not coming out and talking to people”. (BF1)

“My friends and family did because they introduced me to females and set up blind dates to encourage me to go on with my life. They saw the potential in women before I did.” (WM2)

“No, community plays no role. As I said I don’t disclose”. (CM3)
“I’m not sure if community can do anything. The person themselves has to do something about their dating and sexual life. The community at large has played no role in my dating and sex life”. (CM1)

“They don’t play a good role. Nothing really”. (AM1)

Communities operate within the mezzo systems level. The community interacts with the individual and family systems. The findings suggests that at the mezzo level, the community was not meeting and satisfying the individual’s dating and sexual needs. The greatest mode of transmission of HIV is sex. Cultural differences in discussing sex could be attributed to respondents’ dissatisfaction in the community’s response in addressing their dating and sexual needs (Thornton, 2008). Factors for this occurring were noted as stigma and community’s non commitment to servicing the needs of their individuals and families holistically.

Theme 12: The Media’s Role

Respondents stated that the media had both a negative and positive impact on their dating and sexual lives according to the following quotes:

The negative responses were:

“Media plays no role. Because most people meet a woman in a bar. They are not going to want to have sex after watching Bold and the Beautiful”. (CM1)

“I’ve watched programs 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).

“... I don't think they play any role because they portrayed it as a death sentence. Many people may still think that... They make it glamorous to swop, to be in numerous relationships but maybe they going from one extreme to the other... the ads are stupid like the animation one, it's silly ... I know what I am about, so media has not had a positive impact on my dating and sexual life.” (CM2)

“A seriously negative role because they have caused negative publicity, TV and printed media pictures ... have showed pictures of people that are thin, skin and bone. People have found us dirty, poor and untouchable ... This has definitely contributed to the dating and sexual challenges that we face... They've not only done it to people who may want to date HIV positive people but they have actually done it to the HIV patients themselves.” (WF2)

These comments show that media had not assisted HIV positive people in their dating and sexual lives but was an active hindrance due to the negative images they portray about infected people. WF2 was outspoken about the media's contribution to the dating and sexual challenges experienced by infected people.

The positive comments by respondents were as follows:

“Media plays some role because there are programs 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)

“You need to do things and for instance there was a drama, Intersexions, that was playing on SABC but it's finished now. There it showed how you don't have to have sex 3 or 5 times, it's just the minute you are together without protection that's how you get infected ” (BF1)

“In SABC there are some programs in TV. Take for instance these programs, soapies, Generations, Isidingo. There are some scenes in them that show that it's never that you HIV that you can't live a normal life. You can still get married. You can still live your life as usual. There's another program which is always on Sundays on TV 1, Siyanqoba”. (BF3)

“The media, here I'm talking about books and magazines helped me gain confidence and learn about HIV. When I felt I knew enough about HIV then I had the courage and confidence to see myself as capable of

finding a partner. Television didn't really play any role because none of the programs I watch, had infected people in them. Newspaper articles about HIV positive people's lives did help understand that you can live a somewhat normal life". (WM2)

With the exception of "soapies" like 'Generations', 'Isidingo' and programs like 'Intersexions' and 'Siyanoqoba', respondents felt the media did not address dating and sexuality in depth. Only one respondent (WM2) used print media as a source of information for his dating and sexual life. Respondents who highlighted the negative impact that the media had on infected people's dating and sexual lives stated that the media portrayed negative images and information about infected people to the public.

All respondents did not pursue the media as an option for dating and sexual advice and solutions (e.g. advertising) therefore the researcher is unable to fully discuss the impact of the media on their dating and sexual lives.

The media has the ability to play a pivotal role in the lives of HIV infected and affected people which is in accordance with the fact that "education is the best available protection against HIV infection" (van Demoorlele & Delamonica, 2000:1). This pivotal role should include awareness about HIV/AIDS and also educate readers, viewers and listeners holistically about the pandemic in order for all human beings to fully understand all the components of a HIV positive person's journey which includes dating and sexuality.

This is confirmed by Wellings and Macdowall (2000:23) that: "The strength of the mass media . . . lies in helping to put issues on the public agenda, in reinforcing local efforts, in raising consciousness about . . . issues and in conveying simple information . . . The limitations of the mass media are that they are less effective in conveying complex information, in teaching skills, in shifting attitudes and beliefs, and in changing behaviour in the absence of other enabling factors".

The influence of media as a large and influential system (ecosystems theory) cannot be overlooked.

Theme 13: Religious Organisations' Role

One respondent reported a positive impact that religious organisations had on her life but not necessarily on her dating and sexual life.

"Umh, they have been supportive" (WF1)

A study conducted among 104 HIV infected women on the use of religion among HIV infected African American women highlighted "...the regular practice of religiosity may serve as a protective factor for HIV infected women, keeping them both psychologically and physically healthy..." (Morse et al., 2000:275). One respondent (BF2) highlighted how her religious beliefs guided her in abstaining as she saw this as assisting her to get her life 'in order'.

Respondents reported that religious organisations placed more emphasis on religiosity than on the dating and sexual needs of their members. The church did not appear to understand and support the sexual and relationship needs of their members which is the subject of this study. This is indicated in the responses below:

"You feel guilty because you did not follow the rules of your religion" (AM1)

"I don't think my church would have been able to help me finding a date because they don't believe in condoms and will not encourage me anyway because I'm not married". (CF1)

"They don't play a positive role because they have this thing that you are not supposed to have sex before you get married you must first get married and then have sex, so...can't go up to them and be calm and tell a pastor in the church that I'm HIV positive because the pastor is going to discriminate against you and say you HIV positive, how did it happen and you have to say why. The first thing that's going to come to their mind, is that you had a lot of partners". (BF1)

"They play no part, especially the Anglican church. They mostly dealing with people with problems in the home. Like problems like unemployment and all that. Like HIV I don't think they know anything

about this disease. They refer you to a counselor or someone who has this disease". (CM1)

"I'm not a religious person. My girlfriend is, so her church members and cell group people are always forcing her into marriage. So that irritates me because we will get married if and when we see fit. If they continue to nag her we could break up or she could leave the church which will impact on our relationship". (WM2)

"They 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 baptise him. How does that make sense. I think from personal experience that when I spoke to the Anglican priest and he said "no, no, don't let anyone know". (CM2)

CM2's response concurs with a study conducted in South Africa which highlighted the contradictory stance adopted by government and religious organisations in advocating condom and contraceptive use and in advocating marriage and monogamy (Zwang & Garenne, 2008). Such contradictions imposed by larger systems in the ecology have a profound effect in complicating existing sexuality and dating challenges.

Some religious organisations' resistance to condom use dissuaded infected people from discussing their dating and sexual needs with religious elders. Shorter and Onyacha (1998) too highlighted abstinence as strong Christian disciplines.

The above responses clearly suggest that religious organisations in the respondents' lives imposed guilt and shame on them for having had premarital sex, and were not equipped to deal with dating and sexual challenges. Indeed, they were found to have double standards in the manner in which they dealt with children borne out of wedlock. Whereas their parents were ostracised for having premarital sex, the children were still baptized and accepted into the church.

Religious organisation in the context of this study (which may not be representative of the general trend adopted by such organizations) were not seen to provide positive assistance to infected persons' dating and sexual lives and were not considered as an option worth pursuing for such assistance.

Religious organisations are part of communities and therefore play a role on the mezzo system level. The inability to fully understand and support these needs of their members creates conflict within the individual and the organization as well as creates a service gap that remains unaddressed. It would seem that respondents were upset by the reactions of poor support they received, as they had expected a different, more understanding response. Although such reactions were specific to this sample of respondents, and may not reflect general trends in the country, they warrant challenging as such support is key to healthy living and survival.

4.3.3 CHALLENGES ON THE MACRO LEVEL

Theme 14: Government's Role

Respondents had both positive and negative feedback regarding the government's role in their dating and sexual lives as detailed below:

Positive impact that government makes on HIV positive peoples dating and sexual lives

“Government does provide free testing and condoms so it does play a role”. (CF1)

“They play a good part... they have these programs like Lovelife. They always talking about abstaining and If you aren't, then you should be using condoms”. (CM1)

“A lot is being done by government like counseling...“Counseling is for free and they also provide free condoms and ARVS” (BF3)

It is clear from the above that testing, condoms and ARVS are offered by government but this did not prepare infected and affected people for the challenges they may face in their sexual and dating lives. Government focuses on community awareness through programs focusing on monogamy, abstinence, the use of condoms, and provision of affordable treatment (Smith, 2002).

Negative impact that government makes on HIV positive peoples dating and sexual lives

Dating and sexual relationships form part of infected people's lives and yet it this area is sadly neglected. This is confirmed by the following responses:

"... they not putting much effort into it...The only help I can talk about is you get tested for free, you get condoms for free and some type of counseling for free. But even the counseling, it is not professional by really qualified people". (WM1)

"None. I found out my status through my GP so I did not deal with government. I buy my condoms because I don't trust government's condoms". (CM3)

"Government doesn't really focus on HIV positive people's dating lives or relationships. I think counseling is not done by really qualified people, it's like they have a script and ask you questions from there. They don't seem to tailor the counseling to suit your needs. Government counseling is like mass production one size fits all". (WM1)

"Before we get to the media this whole this has a ripple effect, the government in Thabo Mbeki era as far as I'm concerned caused the biggest, biggest problem for HIV/AIDS. They have made people into moles: you must hide, duck, dive don't open up about your status, it must be a secret. How many people can live with this secret." (CM2)

"They play a negative role because of the government's initial stand of the disease. Government contributed to the negative connotations of people who are HIV positive... I don't trust them whatsoever." (WF2)

These comments show that the respondents did not hold the government in high esteem to assist them with the dating and sexual lives. Trust was highlighted by respondents due to the manner in which the government introduced HIV/AIDS in South Africa. Government is seen to play a peripheral role in the HIV positive person's life and not a holistic role offering a wide range of services to comprehensively support and help the infected person.

Government operates on a macro system level and changes to the macro system could assist infected people with various challenges. Counseling and public health

policies could be changed/introduced so that the dating and sexual plight of infected people could be positively impacted.

Counseling will be discussed under government's role as most of the respondents attended governmental clinics and hospital for counseling.

Theme 15: Dating and Sexual Counseling

Most of the respondents stated that their counseling sessions focused predominantly on condoms and safe sex and did not volunteer information on dating and relationships.

Bunnell et al.'s study (2005:4) stated "very few clients and counselors provided accurate information about why HIV discordance existed". The reason for this, is that there is no universal explanation for a discordant result. Bunnell et al. (2005) found participants in their study to display confusion by their discordant result, suggesting that they were not adequately counseled about this outcome.

None of the respondents in this study volunteered that they had received discordant couple counseling. Both partners were not afforded the opportunity to deal with issues of dating and sex despite this being an integral part of a discordant relationship. This inadequate form of counseling challenges the dating and sexual lives of HIV positive people. One can do better only when one knows better. Respondents in this study were not presented with adequate information about their discordant results thus feelings of fear, confusion and guilt arose.

Counseling did not prepare respondents to deal with discordant relationships. Some respondents in this study stated that being told that one partner is HIV positive comes as a 'shock' and leaves them unable to think about relationships and dating. However, dating and sexual relationships form an integral part of their lives and this is not afforded much attention in counseling sessions, as evident in the findings.

A discordant result did not come out directly as the reason for the respondents' partners leaving and requesting a divorce. However, respondents highlighted their partners' vague reasons for not wanting to be in the marriages:

"I don't think my ex could handle it. I don't think she was honest...Before we knew my status she was highly sexed and after we found out I was positive she was not interested in sex." (CM2)

"My wife didn't seem to mind me not wanting sex...She eventually said she wanted a divorce." (WM2)

"No, it didn't cover anything about dating only about condoms..." (WM1)

"Maybe have better counseling because that seems to be an issue. Counselors are not properly trained to really help an infected person. If you think about it they really only tell you about using condoms and they don't spend enough time with you if there are queues of people". (CF1)

"I went once and it only covered me and using condoms but it didn't cover dating and all of that, so I believe counseling should give more advice than awareness campaigns and all of that" (WM1)

"Dating was not covered with the psychologist... Dating as an HIV positive person is not talked about in your sessions. So maybe counselors or psychologists should deal with that. Dating is hard and as an HIV positive person, it is even harder". (CF1)

Counseling is an important part of the HIV positive person's journey and without this being responsibly undertaken, it can negatively affect both the individual and all the systems with which he/she is linked. Many respondents were not afforded appropriate counseling to fully equip them to handle this aspect of their lives as the focus of the counseling was restricted to condoms, ARVS, side effects and diet whereas dating and relationship changes were just as important. The need to have more post test counseling sessions is clearly required as some respondents were shocked and unable to focus on relationship issues at that stage.

Dating, sexuality, sexual desire, sexual changes and dysfunction are important to HIV positive people's quality of life and therefore deserve appropriate attention in the counseling process.

4.4 CONCLUSION

The sample chosen were from all 4 race groups in South Africa. The types of challenges differed amongst the respondents. The positive aspect of this research study was that the data were received from HIV positive people themselves using in depth interviewing and not from a third source. This helped authenticate the data as discussed in the section on trustworthiness of data in chapter 3.

Findings showed that dating and sexuality have not adequately been explored in HIV training and awareness and counseling. HIV stigma is still prevalent and contributes to many challenges for the individual such as fear, shame, guilt, divorce, separation, physical and alcohol abuse, non disclosure, denial, anger, distrust, blame, negative self esteem, poor confidence. ARVS, sexual change and dysfunction as well as reproduction all add to the above mentioned and influence the dating and sexual options for the infected and affected person. The media, government, counseling, communities and societies all have a valuable role to play in the dating and sexual challenges faced by HIV positive people.

CHAPTER 5

CONCLUSIONS AND RECOMMENDATIONS

5.1 INTRODUCTION

This is the final chapter in the researchers report and will focus on conclusions reached from the findings in the previous chapter and on recommendations. Due to limited research dedicated solely to this topic the researcher will also make recommendations and suggestions for future research around the topic.

The aim of this study was to describe and explore the dating and sexual challenges and experiences of HIV positive people. This research study pursued a qualitative research design. The systems and ecosystems theoretical framework was used to explore and describe the dating and sexual challenges faced by HIV positive people.

The sample for the study comprised of 12 HIV positive people, aged between 26 and 53 years of age. Purposive and snowball sampling was utilised in the study. In depth interviews conducted with all 12 respondents provided the data which exposed the dating and sexual challenges they face.

None of the respondents had received counseling or therapy that included dating. Most of the respondents highlighted that their counseling placed emphasis on condom use in their sexual lives. With the exception of one respondent, the rest had explored dating and sexual relationships from the time of their diagnosis.

The value of this study is its likely contribution to understanding the lives of HIV positive people holistically, with dating and sexuality being important components of their life, in line with a systems and ecosystems perspective.

The aims and objectives of the study form the basis for the conclusions and recommendations in this chapter. The first objective was to explore factors that influence the dating and sexual lives of HIV positive people. The second objective was to explore and describe the dating and sexual challenges confronted by HIV positive people. The third objective was to explore responses of HIV positive person to dating challenges. The fourth objective was to explore opportunities and factors that ease dating and sexual relations.

5.2 CONCLUSIONS BASED ON THE RESEARCH PROCESS AND THE RESEARCH FINDINGS

In as much as the conclusions are reflective of the aims and objectives of the study, the researcher merged the objectives as they overlapped. The conclusions are divided into two categories namely factors that influence and challenge the dating and sexual lives of HIV positive people and the responses of HIV positive persons to dating challenges and discussed hereunder:

5.2.1 FACTORS THAT INFLUENCE AND CHALLENGE THE DATING AND SEXUAL LIVES OF HIV POSITIVE PEOPLE

5.2.1.1 Guilt, anger, blame, fear, denial, discrimination, stigma, rejection and negative self esteem

Guilt at bringing a positive diagnosis into the relationship caused strain in the relationships. Guilt also contributed to negative self esteem and was cited as a reason for searching in HIV clinics to find an infected person to be in an intimate relationship with. Guilt at being positive was also cited as a reason for the collapse of relationships.

Anger was another commonly experienced emotion. Anger was directed at the source of infection, at bringing HIV into the marriage as well as the potential infection of loved ones in the family.

Fear was a further emotional response, specifically fear of being blamed for infecting a partner as respondents feared their partner leaving the relationship as a result.

Disclosure of most of the respondents' HIV status was not well received which highlighted society's ignorance or denial of the disease. Some respondents chose not to disclose for fear of rejection, discrimination and self blame.

Only one respondent's disclosure was well received. But cognizance has to be taken that his first marital partner had a negative reaction to his disclosure which resulted in divorce. What was obvious from this case was the respondent had learnt from the first negative reaction and ensured that his second partner fully understood his illness as well the challenges associated with being in a serodiscordant relationship. The partner was comfortable with all the information given by the respondent. This comfort level allowed for full disclosure of his status to her children, family and friends and resulted in them getting married.

Few respondents had not disclosed to their partners. In some cases remarriage had taken place without disclosure to new partners on the assumption that partners knew because they were still using condoms. This raises questions about trust and honesty in relationships.

Respondents still in their original relationships since their diagnosis had not cited love and commitment as reasons for staying in those relationships. Thus, these may have been temporary or 'in the meantime relationships' as some respondents pursue serosorting to meet their needs and threaten to leave their relationships due to unmet sexual needs and to ARV side effects.

Disclosure is a complex process with many factors hindering and contributing to the complexity thereof. Disclosure in this study had more negative reactions than positive ones given the strain it put on the relationships. It is important that respondents and their partners are adequately prepared for marital and relationship

changes after their diagnosis. Counseling did not prepare any of them to deal with such challenges.

In as much as countries and communities have been discussing HIV/AIDS for 30 years now, stigma is still alive and well in KwaZulu Natal. This was evident in the majority of the respondents' comments. Some respondents chose not to disclose to their partners' families for fear of stigma from them. They saw their family's reaction to their status as challenging their dating and sexual relationships. Therefore there was deception on respondents' part when visiting and staying over at family homes. Reasons given for their non disclosure were fear of their family's reaction and protecting them so they will not worry unnecessarily.

Most of the respondents feared stigma and the ramifications thereof in the form of rejection and discrimination from their partners, potential partners, family members and community members. The fear of the backlash of disclosure contributed to many of the challenges they felt in their relationships.

One respondent felt stigma was an individual choice in that it was largely self inflicted and related to how the individual saw him/herself. This meant that the person had to be strong in withstanding negative responses from others. Self esteem and self worth controlled the way respondents chose their partners and their dating options. It played a major role in firstly the way the respondents' viewed themselves and secondly how comfortable and confident they were in pursuing dating and sexual relationships.

Respondents experienced varying consequences to their HIV diagnosis. With the exception of respondents that were not in committed relationships, all other respondents experienced emotional tension and strain. This emotion and tension challenged the respondents' dating and sexual relationship. Being in a relationship did not provide any safety for most of the respondents; in fact it helped end their relationships. The challenges of their HIV diagnosis resulted in most respondents' still not being in their original relationships. Physical and alcohol abuse, denial and

a negative reaction to a discordant diagnosis were some of the stressors imposed on the relationships as a result of the diagnosis.

The majority of the married male respondents were under the impression that their wives had negative reactions to their discordant HIV results which ultimately resulted in the breakdown of their marriages. This was not communicated by their partners, however they noted their negative partners' attitudinal changes towards sex.

Disclosure, stigma, rejection and discrimination are quadruplets as they are intertwined and impact on the dating and sexual lives of infected people. These factors have an impact on other parts of the infected person's life. Disclosure can result in stigma which presents as rejection and/or stigma.

5.2.1.2 Dating Options

Dating did not play any part in the counseling session/s of all the respondents. This was evident from all the respondents which exposes inadequate counseling in the private and public sector and suggests a counseling gap in both sectors.

Most of the respondents did not know of the various dating options that individuals could pursue in finding intimate and sexual partners. It was a case of 'swim or sink' as there was no prior knowledge of dating options to pursue. Many pursued options through word of mouth and through trial and error. HIV infected people themselves could have contributed to their dating and sexual challenges to some extent as many expressed initial shock at their diagnosis and did not think of dating and/or sex at the time of counseling.

Pursuance of HIV online chat rooms and blogs to confront the dating and sexual challenges was absent. Technological and financial constraints could have contributed to these options being pursued as this was reflected in the study.

5.2.1.3 Physical, medical and psychological factors

Dry skin, wasting, rashes, lipodystrophy, oral thrush were physical and medical factors that negatively affected respondents lives. This further eroded their self esteem and confidence as they did not feel good about themselves. No evidence was forthcoming in the study about what they did about these reactions.

Condom breakage, STIS, ability to have a baby and awaiting blood results, unemployment and poor financial situations were psychological challenges that respondents felt affected their dating and sexual lives.

5.2.1.4 Sexual changes/sexual dysfunction

Condom usage presented a problem for the majority of the respondents as it halted spontaneity and spoilt their sexual atmosphere. Most respondents were uncomfortable using condoms for the rest of their lives. Seronegative partners did not want to use condoms as the feeling was they were married and that people in committed relationships did not use condoms, irrespective of their status. Only one respondent did not use condoms with her reinstated partner because she had not disclosed to him and did not want to draw attention to her status by insisting on condom use. Such reactions are common in female studies and highlight gender inequalities in relationships.

Few respondents expressed low libido as a challenge to their sexual lives. Only one respondent suffered depression about his status and attributed this to his low libido and erectile dysfunction while another attributed drug usage for his decrease in libido. One respondent attributed menopause for her increase in sexual desire.

A serodiscordant status was attributed for the decline in sexual relationships with respondents' previous wives.

Few respondents on ARV treatment acknowledged that ARVS increased their sexual desires. Some of the respondents were not on treatment and therefore did not provide any input on the impact of ARVS on their sexual lives.

5.2.1.5 Reproductive challenges

Most of the respondents under the age of 35 wanted to have children. The inability to reproduce was seen to impact negatively on their relationship.

5.2.1.6 Community's and society's role

Respondents unanimously agreed that communities and society played no positive role in their dating and sexual lives. A reason for these results could have been the fact that most of the respondents did not fully disclose their HIV status and many did not participate in community projects and programs. Therefore they might have not been aware of what their various communities were doing. A study focusing on other geographical areas could yield different results as this study focused on infected people in KwaZulu Natal only.

5.2.1.7 The Media's role

Respondents were divided on the role of the media in their dating and sexual lives. Some respondents felt that the media had contributed to the challenges that HIV positive people face in their dating and sexual lives as a result of the images, pictures and programs they had initially broadcast when HIV/AIDS was first discussed. They believed society held on to those negative images and this has promoted stigma which prevails today.

Other respondents highlighted certain programs like Isidingo, Siyanqoba, Intersexions and Generations playing a positive role as HIV positive people were shown dating and being involved in sexual relationships. These programs could

assist in normalizing the decision to date an infected person and reducing the challenges infected people face.

Television was the main media source of HIV information and hence respondents commented on it.

5.2.1.8 Counseling, awareness and education about dating and sexuality

Counseling was definitely an area of weakness for all respondents. They lamented that dating, grief, loss, sexually transmitted infections/diseases, serodiscordant relationships, the impact of disclosure, sexual changes and dysfunctions, reproduction and dating options available were not covered in their counseling sessions. Some respondents expressed displeasure with the limited number of sessions they were allowed to attend as this did not adequately address all the challenges they experience. They also complained that counseling offered at government hospitals and clinics was grossly inadequate, sometimes unprofessional and time consuming.

Intimacy and sex are important components of human lives yet these aspects are not given much exposure. Informative, holistic counseling could have better prepared respondents for the challenges they could encounter.

5.2.1.9 Government's role

Respondents were pleased that government provided free testing, condoms, medication and counseling and many respondents utilised these services. However, they felt this contribution was good but did not adequately equip them for their dating and sexual lives. Most of the respondents who utilised government services felt that government was not fully committed to holistically servicing infected people needs. Politics was cited as clouding government's ability to change the way infected people were treated.

5.2.1.10 Religious, cultural and faith based organisations' role

Only one respondent shared that the church had played a supportive role but did not assist her with her dating and sexual life. All the other respondents did not find that religious organisations played any part in their dating and sexual lives. Some respondents viewed the church as negatively impacting their relationships because it constantly emphasized prohibition of premarital sex.

Churches' stance on non condom use was also not appreciated. Church counseling did not encompass dating and sexual issues and referred infected people to other infected people to counsel them. Double standards by some churches were highlighted in the study as they preached abstinence and yet baptized children out of wedlock. The study exposed the discomfort of respondents to discuss dating and sexuality with religious members because guilt and shame was often imposed upon them.

5.2.2 RESPONSES OF HIV POSITIVE PERSONS TO DATING CHALLENGES

Respondents reacted differently to the dating and sexual challenges. The reactions were social disconnection, denial, abstinence, divorce, termination of relationships, alcohol and physical abuse, pursuance of alternate dating facilities. These reactions will be discussed below:

5.2.2.1 Social Disconnection

Social disconnection was a reaction to feelings of guilt and fear about a seropositive status and the resultant behaviour was to vegetate and avoid social interactions as the fear of exposure of one's status and the reaction to the disclosure was stressful.

5.2.2.2 Denial

Denial of one's HIV status was a coping mechanism which resulted in the disintegration of relationships as it was stressful being in a relationship where one partner did not acknowledge their HIV status. Respondents felt it was better to end their relationships than continue in dishonest relationships.

5.2.2.3 Abstinence and change in sexual behaviour

The reasons for abstinence varied from comfort to religious reasons. Fear of infecting partners resulted in some respondents avoiding having sex with their uninfected partners after their diagnosis. Some resumed sexual relations later.

5.2.2.4 Divorce and termination of relationships

Some respondents terminated their relationships due to denial by their partners of their own status. Non acceptance of a serodiscordant status resulted in the divorce of partners as well. Alcohol and physical abuse were responses to denial of a HIV status in some respondents' relationships.. They were also used as a coping mechanism for the guilt of bringing the virus into the marriage and resulted in one respondent's marriage ending in divorce.

5.2.2.5 Non disclosure

Various reasons were given for non disclosure of a HIV status such as a means of dealing with the challenges of disclosure, rejection and discrimination. Some saw practicing safe sex as negating the need to disclose while others saw non disclosure as a response to 'asking no questions and hearing no lies'. One respondent felt that if the potential partner did not bring up HIV or disclosure there was no need to do so. This fuels a perspective that people need to take responsibility for their own wellbeing by being assertive and insisting on condoms.

5.2.2.6 Pursuing alternative relationships and dating options

Respondents pursued various dating options to address their dating and sexual challenges. Eurocentrism and afrocentrism was obvious in the respondents' choice of dating options. White respondents pursued online dating, social networking, newspaper adverts and singles clubs whereas the non white respondents pursued dancing clubs, bars and family and friends.

Lack of technology and financial constraints played a role in some respondents dating options as they were unemployed and received disability grants. Dancing clubs, bars and family friends as dating options yielded the highest success amongst the respondents.

Respondents had not been exposed to the various dating options that PLHIV can pursue in their counseling sessions. Serosorting and abstinence were also not discussed and could be reasons for respondents not acknowledging them as challenges.

5.2.2.7 Serosorting or abstaining

The process of choosing a partner based on respondents' serostatus was obvious in this study as some respondents chose to only date HIV positive people, some chose to date HIV negative people while others chose to abstain. This decision was based on past experiences and comfort levels, with respondents wanting to be with partners who were comfortable with them and their status and vice versa.

None of the respondents made an informed decision about who to date, based on information they gleaned during counseling regarding the pros and cons of serosorting as it was not discussed in the sessions. The absence of this information could have left respondents without relevant information to make life altering decisions.

5.2.2.8 Conclusion

Given all the challenges that this study explored and described only one respondent was uncomfortable with pursuing dating if her current relationship ended as she was afraid of the outcome while the rest were positive about pursuing new dating and sexual experiences; however, it was unclear which dating options they would pursue in the future.

With the exception of the various dating options pursued all the dating and sexual challenges were experienced by all race groups which leads to a conclusion that they affect anyone regardless of race, religion, creed, gender or age.

5.3 RECOMMENDATIONS

Recommendations will be made from an individual, community, counseling, governmental, media, faith based and religious organisations perspective as they are all components of systems and ecosystems theory and play an interrelated role in the infected person's life. The recommendations are based on the respondents' comments to which the researcher has added her own suggestions.

5.3.1 Micro level Recommendations

The Individual

HIV positive people should play more meaningful roles in society, their community, in the media and in faith based and religious organisations by being intrinsically motivated to make a difference to the challenges that HIV positive people face. They must not create a subculture where they only mix with each other and keep their status and challenges a secret as this is isolating and unhelpful and can promote stigma. This will produce an 'us and them' scenario, alcohol, drug and physical abuse, termination of relationships, divorce, psychological stress and depression.

Such mixing could be achieved by adequate, professional counseling and aggressive community awareness programs and training which embrace infected people in their entirety.

HIV positive people should utilise accredited counseling facilities where possible to ensure they are informed of all aspects of their journey.

Counseling

Counselors, therapists and health care professionals should fully understand the impact an HIV diagnosis has on individuals. Dating and sexual relationships are part of the individual's whole system. Holistic counseling should therefore include dating, sexual and intimacy issues in order that the whole person and his/her related concerns are addressed.

Topics such as guilt, grief, loss, blame, anger, self esteem, self worth, disclosure, discrimination, rejection, stigma, sexually transmitted diseases, death and dying, reproductive choices, abstinence, dating options, fear, physical, medical, psychological and financial challenges should all be included in counseling sessions.

Clients and patients should both be aware of the various topics that can be addressed during counseling, in order that they could request such assistance, should they require it. In order to explore and understand the various topics, more sessions should be afforded to infected people to feel comfortable to take advantage of addressing potential challenges by being proactive.

Counselors and therapists could assist the infected person deal with pathological grief and survivor guilt in order for them to feel comfortable to pursue dating and sexual relationships.

Discordant couple counseling should be in depth for both parties to fully understand the complexity of such relationships. The serodiscordant partner should be

included in the counseling sessions to eliminate confusion in relationships and provide relevant information for future dating endeavors. It would also equip the infected person to deal with their status and provide fundamental information for them should their relationship status change.

Sexual challenges like STIS, sexual changes and sexual dysfunction are sensitive topics and therefore necessitate sensitivity and professionalism when they arise; therefore creation of a warm, nurturing counseling environment is imperative for the infected person to feel comfortable to initiate these conversations which challenge their lives.

Private practitioners should refer their patients to therapists, psychologists and social workers for in depth counseling of dating and sexual challenges that they may feel uncomfortable discussing.

Government should improve the counseling facilities at public outlets as most of the respondents in this study attended counseling sessions at public hospitals and clinics in order to meet all the needs of their infected patients rather than just focus on condoms, safe sex, side effects and adherence to ARV treatment.

Counselors should upgrade and improve their counseling skills in order to address dating and sexual challenges of their clients, thereby fully addressing their counseling needs and improving patient service.

Individual, couple, group and family counseling should be advocated to address potential challenges holistically and involve all stakeholders who play a role in the dating and sexual challenges of infected people.

Government should make a concerted effort to spend more money and resources to address dating and sexuality holistically.

5.3.2 Mezzo level Recommendations

Support Groups

This study did not yield any evidence of support groups being used as a dating option. Support groups should double as dating clubs so infected people would know who is available and not spend time and money unwisely pursuing people who do not want to date HIV positive people. Support group leaders should network with corporates for supply of computers and internet access so PLHIV's could feel comfortable to access dating sites.

HIV Dating Sites

HIV dating sites should be improved and advertised so infected people are aware of them. They could advertise their services in clinics, hospitals and at support groups. Free sites would be a good option as overseas sites are mostly free compared to the South African sites. To improve client service they could supply computers to some clinics so PLHIV can access them easily and avoid internet café costs and assist reduce many infected people's financial burden.

Community

Communities need to address the complexities of an HIV diagnosis by incorporating dating and sexual challenges of their community members into their awareness campaigns. In order to understand and address these challenges they need to be educated on the relevance of these components in the lives of infected people in their communities.

Political leaders, support groups, NPO's and NGO's could be initiators of this process to better serve their people. Dating groups could be started in the community so that HIV positive people feel served by their community.

Media

The media should normalize HIV dating by having more HIV positive people engaging in intimate relationships so society does not stigmatise the dating of HIV positive people. A South African equivalent of 'The Bachelor' and 'The Bachelorette' for HIV positive people could assist by showing PLHIV as also seeking love, relationships and marriage.

Infected people who have successful dating stories should share them in community and provincial newspapers and books.

Newspapers should provide free HIV dating columns to allow infected people to pursue dating.

ARVS have improved the quality of life of PLHIV. This should be communicated by all stakeholders in infected peoples' lives in order to address the many challenges that infected people experience.

Religious, Cultural and Faith based Organisations

Religious organisation should include dating and sexuality in their lay ministry and counseling. They need to assess the needs of their members and improve the services they offer. They could put together databases for professionals and counseling and therapeutic centres to refer their members to in order to show they care about their wellbeing.

Psychologists, therapists, medical practitioners, facilitators and social workers

Private practitioners and GP's should be adequately trained to advise infected people on their dating and sexual lives. Therapy and counseling should be conducted in an empathetic and non judgmental manner.

Therapeutic practitioners should counsel infected people about all the factors that could impact on their current as well as future dating and sexual lives. These factors and challenges could be changes in the current relationship, divorce and separation, impact of a serodiscordant result, improvement or worsening of their relationships, rejection by partners and family members, physical violence, alcohol abuse, sexual changes, impact of ARVS, withdrawal of financial, sexual and emotional support.

These challenges should be adequately pursued to highlight the potential of these taking place in the client's life. Support strategies and support systems should be identified at this stage so clients would have a plan when confronted with these challenges.

Therapists could probe to ascertain whether their clients knew anyone who was diagnosed HIV positive and had been in a relationship or pursued relationships. They could discuss how that person dealt with their dating and/or sexual relationship, what experiences they had and what their client had learnt or could learn from others' experiences. Role plays and in depth discussions could ready the client for potential outcomes in their HIV journey. This would entail several sessions which could be time consuming and costly, however the results could be beneficial.

There is a dire need for a database of therapists, counselors, psychologists and lay counselors who specialize in HIV counseling to be set up, so medical practitioners, faith based, religious and community organisations are able to refer people to them to get much needed assistance. It is valuable for therapists to understand how clients react to challenges in their dating and sexual lives.

Conclusion

All stakeholders including PLHIV's have a role to play in reducing and/or eliminating the challenges faced by HIV positive people. South Africa has made positive strides with HIV testing, ARVS, condom supply, limited counseling. It is time to take

another step by addressing all the needs of infected people of which dating and sexuality is important.

5.3.3 Macro level Recommendations

Government

Government can utilise provincial and national policies to improve the counseling services provided to infected people to be all encompassing of their dating and sexual needs. These challenges need to be addressed in order to destigmatise HIV/AIDS.

Government can link up with the private sector to improve counseling facilities to better serve infected people. Outsourcing counseling to private organisations would be a source of strengthening counseling and reducing workload on clinics and hospitals.

A joint venture between private internet companies and government could provide free internet access at government hospitals and clinics.

Financial assistance for HIV positive unemployed people should be available to aid people in their dating endeavors.

The National AIDS Helpline (0800-012-322) could have a separate section assigned to dealing with dating and sexual issues.

HIV pamphlets and booklets discussing dating and sexual issues and challenges should be distributed and left in all healthcare facilities so they are easily available.

Government can improve their customer service by having counselor mentors to assess their services regularly to ensure they are servicing patients professionally and providing services that are client focused.

5.4 FURTHER RESEARCH ON THE TOPIC

This study comprised a sample of 12 respondents. There is a need for further research with bigger samples conducted in different geographical areas to get richer data for quantitative analysis. The topic of this research necessitates further research and discussion in order to address the various challenges HIV positive peoples' are confronted with and improve their quality of life holistically.

Further research could broaden scientific knowledge of an important aspect of HIV positive people lives which would improve counseling and the community's and government's perspective of these challenges. Quantitative research could be used to examine the correlation between employment, financial status, family commitments and dating and sexual experiences of infected persons. Further, qualitative and quantitative research relating to the topic could explore other locations in South Africa to establish how commonality of these experiences affects the dating and sexual lives of infected people. In addition, the role of religion and spirituality could be a specific focus of a future study.

5.5 CONCLUSION OF THE CHAPTER

The aims and objectives of the study were achieved. The study highlighted the various dating and sexual challenges that HIV positive people face.

Respondents' challenges varied from their personal feelings about their status, their self worth or lack thereof, the impact of family, friends, society and community, reproductive challenges, condom use, fear of the unknown, limited awareness of dating options available to infected people, the decision to date an infected person or a negative person, to engage in casual relationships or to abstain, physical, medical, psychological and financial concerns, fear of infecting others and contraction of STDS and STIS. A major conclusion was that counseling was inadequate as many questions that could have been addressed and resolved in counseling sessions remained problematic and unaddressed.

A major drive is required to give the dating and sexual needs of HIV positive people more attention as it is evident from the study that these are important components of infected peoples' lives. They should not be dismissed and ignored as infected people deserve sex, love and relationships as all human beings do.

***“You do better when you know better “ “ Action is a doing word “
(Author's own belief)***

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APPENDICES

Appendix 1: INFORMED CONSENT

Dear _____

RE: RESEARCH PROJECT ON DATING AND SEXUAL CHALLENGES FACED BY HIV POSITIVE PEOPLE

My name is Delarise Mulqueeny and I am a Masters student at the Department of Social Work and Community Development at the University of KwaZulu Natal (UKZN). As part of my studies I have to undertake a research project which focuses on the dating and sexual challenges faced by HIV positive people.

The reasons for undertaking this research project is little is known about this topic. Since you have personal experience about this subject, I regard you as an expert who can provide me with valuable information about this topic.

In this letter, I would like to explain to you what your participation in this research project will involve (if you agree to participate). Should you agree to participate in this research project, I would like to have one (1) interview with you at a time and place that would best suit you. This interview would not exceed two (2) hours.

Given that I would like to give you my full attention during the interview and given that I might forget some of the valuable information that you share, I would like (with your permission) to record the interview on tape. After the interview, this tape recording will be typed out word-for-word.

When typing out the interview, all information that might identify you personally will be removed so that no one will be able to link you to any of the information that you have shared will be documented in a research report and nowhere will your name or any personal information be shared, this will make it impossible for anybody to identify you.

Please note that participation in the research is completely voluntary (you are free to participate or not participate). You are not forced in any way to take part in this research project. Your decision to participate, or not to participate, will not affect you in any way now or in the future.

If you agree to take part, you still have the right to change your mind at any time during the study and to withdraw from the study.

There is no financial reward that you will receive for participating in this study.

You have the right to ask question concerning the study at any time. Should you have any questions or concerns about the study please feel free to ask or contact me on 031-3072209/0839556755.

If you agree to participate in this study, I would like you to sign the consent form that follows.

Delarise Mulqueeny
Researcher

Appendix 2 : INTERVIEW SCHEDULE

SECTION A

DEMOGRAPHIC INFORMATION

1. Age
2. Gender: Male or Female
3. Race
4. Marital Status

MARITAL STATUS	TICK	DURATION
Married		
Single		
Divorced		
Separated		
Casual relationship		

5. HIV status of respondent? Tick relevant box

HIV Positive		HIV Negative	
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SECTION B

During the interview the following questions will be directed to you:

1. When were you diagnosed HIV positive?
2. What was the state of your dating relationship when you were diagnosed HIV positive?
3. What impact did your positive status have on your dating and sexual life?
4. Have you explored dating and sexual relationships since your diagnosis?
5. What is your current state of dating and sexual life?
6. What positive or negative experiences have you had in your dating and sexual relationship?
7. How do you feel about these experiences?
8. Has stigma and/or discrimination played any role in your dating and sexual life?
9. What types of stigma and/or discrimination have you experienced in your dating and sexual life?
10. What dating facilities do you know of, that are available to HIV positive people?
11. Have you pursued any of them and what has been the outcome?
12. How has ARV treatment affected your dating and sexual life?
13. What medical factors affect your dating and sexual life?
14. What psychological factors affect your dating and sexual life?
15. What physical factors affect your dating and sexual life?
16. What role does community/society play in your dating and sexual life?
17. What role has stigma played in your dating and sexual life?
18. What role did pre/ post test and/or ongoing counseling play in your dating and sexual life?
19. What role has awareness programs from the media played in your dating and sexual life?
20. What role has community awareness programs played in your dating and sexual life?
21. What role has government awareness programs played in your dating and sexual life?

22. What support and/or assistance would you embrace in your dating and sexual life?
23. From whom would you require such support and assistance?
24. What dating and sexual advice/recommendations would you give to another HIV positive person?
25. If your current relationship ended what dating and sexual options would you explore?



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20 July 2011

Ms D Mulqueeny (211558239)
School of Social Work & Community Development
Faculty of Humanities, Development and
Social Sciences
Howard College Campus

Dear Ms Mulqueeny

PROTOCOL REFERENCE NUMBER: HSS/0573/011M
PROJECT TITLE: Dating and sexual challenges faced by HIV positive people

In response to your application dated 15 July 2011, the Humanities & Social Sciences Research Ethics Committee has considered the abovementioned application and the protocol has been granted **FULL APPROVAL**.

Any alteration/s to the approved research protocol i.e. Questionnaire/Interview Schedule, Informed Consent Form, Title of the Project, Location of the Study, Research Approach and Methods must be reviewed and approved through the amendment /modification prior to its implementation. In case you have further queries, please quote the above reference number.

PLEASE NOTE: Research data should be securely stored in the school/department for a period of 5 years.

I take this opportunity of wishing you everything of the best with your study.

Yours faithfully

.....
Professor Steven Collings (Chair)
HUMANITIES & SOCIAL SCIENCES RESEARCH ETHICS COMMITTEE

cc. Supervisor: Prof M Kasiram
cc. Mrs S van der Westhuizen, Post-Graduate Office

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