

**EXPERIENCES OF ATHLETES LIVING WITH HIV FOLLOWING DISCLOSURE OF
THEIR SERO-STATUS IN NDIRANDE BLANTYRE MALAWI**

Ivy Yvonne Kondowe

Student number: 3318113

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Supervisor: Dr. Lloyd Leach

Co-supervisor: Dr. Clemens Ley

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Declaration

This thesis entitled, “*Experiences of athletes living with HIV following disclosure of their sero-status in Ndirande, Blantyre Malawi*” is submitted to the University of the Western Cape in accordance with the requirement for the Master of Arts Degree in Sport, Recreation and Exercise Science in the Department of Sport, Recreation and Exercise Science has not been submitted for any other degree or diploma to any examining body. It is my work and all sources that I have quoted have been indicated and acknowledged by means of references.

Ivy Yvonne Kondowe



Signed-----

Date-----

Dedication

I dedicate this work to my husband Robert and my son Joshua for their love, tireless prayers, endless support, encouragement and patience. You have broadened my horizon, lifted me up and raised my faith to continually believe that with God all things are possible. I love you guys.



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I thank God for giving me good health and strength to move on this academic journey even when it seemed impossible. "...Is anything too hard for the Lord...?" Genesis 18 verse 14. "I can do everything through Jesus Christ who gives me strength." Philippians 4 verse 13.

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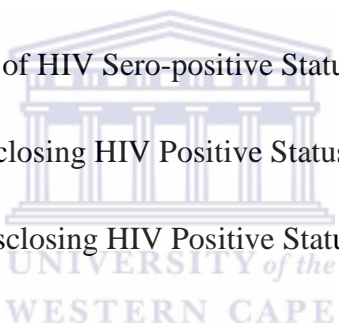
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Last but not least, my church pastors in Malawi and South Africa for their untiring prayers which have successfully made me complete this study.

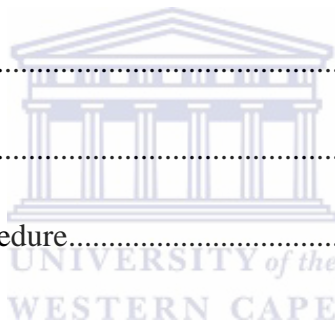
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Abstract

Athletes are at risk for HIV infection due to their celebrity status which enables them to associate with multiple concurrent sexual partnerships. Athletes with an HIV sero-positive status should be encouraged to disclose their HIV positive status to enable them access appropriate treatment, care and support. The purpose of the study was to explore the experiences of athletes living with HIV following disclosure of their sero-status. The study was conducted in Ndirande Township in the city of Blantyre, Malawi. Twelve purposively sampled athletes living with HIV, four males and eight females between the ages of 18 and 30 years, participated in this study. Data was collected using qualitative methods conducting semi-structured, face to face individual interviews and the data were analysed using thematic analysis. The consequence of disclosure model was used to explain the themes that emerged from the data. The results of the study indicated that all athletes disclosed their HIV seropositive status. The majority of the athletes disclosed their HIV positive status to spouses, family members, friends and health care providers in order to access support and treatment. However, athletes did not disclose to their clubs and sports institutions because there was no conducive environment.

After disclosure of their status, most athletes had positive experiences that included increased psychosocial support and care from their social networks. Some athletes had negative experiences such as stigma and discrimination from teammates and distant relatives. While athletes living with HIV had support from families and community support groups, there was a lack of appropriate support systems in the sport institutions. In addition, athletes living with HIV had limited access to health care services. For athletes living with HIV to remain productive, there is need for further

research and the establishment of appropriate support systems in different levels of the sport institutions.



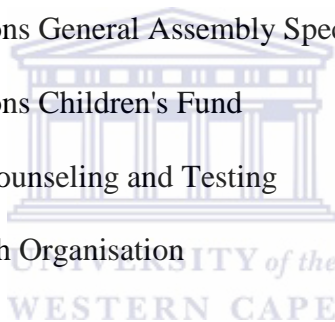
Key words:

Athletes, sero-status disclosure, experiences, HIV sero-positive, health behavior, support, HIV/AIDS, stigma, consequences, Malawi

List of Acronyms and Abbreviations

AIDS	Acquired Immunodeficiency Syndrome
ARV	Antiretroviral
AYIDO	Adolescent and Youth in Development Organization of Malawi
COWLHA	Coalition for Women Living with HIV/AIDS
DFID	Department for International Development
FEDOMA	Federation of Disability Organisations in Malawi
GBV	Gender-Based Violence
HAART	Highly Active Antiretroviral Therapy
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
HBHCT	Home-Based HIV Counseling and Testing
ILO	International Labour Organisation
IOC	International Olympic Committee
MANET+	Malawi Network of People Living with HIV/AIDS
MDHS	Malawi Demographic Health Survey
MSM	Men who have Sex with Men
NAC	National AIDS Commission
NAPHAM	National Association for People Living with HIV/AIDS in Malawi
NSO	National Statistics Office
OI	Opportunistic Infections
OPC	Office of the President and Cabinet

PEPFAR	President's Emergency Plan for AIDS Relief
PLHIV	People Living with HIV
PLWHA	People Living with HIV/AIDS
PMTCT	Prevention of Mother to Child Transmission of HIV
PwD	People with Disabilities
MACRO	Malawi AIDS Counseling and Resource Organisation
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNGASS	United Nations General Assembly Special Session
UNICEF	United Nations Children's Fund
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation



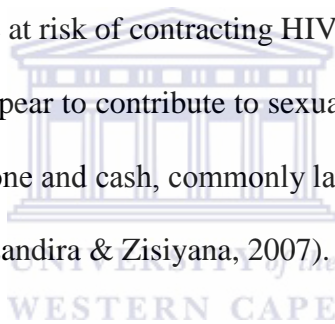
CHAPTER ONE

INTRODUCTION AND BACKGROUND OF THE STUDY

1.1 Introduction

Since the inception of the human immunodeficiency virus (HIV) and acquired immunodeficiency syndrome (AIDS) about three decades ago, the virus continues to pose a threat to the lives of many people, especially in the African sub-continent and other developing countries (UNAIDS, 2010). More than 70 million people have been infected with HIV, approximately 36 million people have died from AIDS related illnesses (AIDS, 2014). About 35 million people were living with HIV globally (WHO, 2014). In 2009, an estimated 5 million young people aged between 15 and 24 years were living with HIV globally (UNICEF, 2011). Sub-Saharan Africa (SSA) continues to have the highest reported rates of HIV infection in the world (UNAIDS, 2010; WHO, 2011). In 2009, SSA countries reported 22.5 million people living with HIV, 1.3 million AIDS-related deaths and 1.8 million new infections (UNAIDS, 2010). In 2010, an estimated 68% of people living with HIV/AIDS (PLWHA) were registered to be living in SSA, yet it's a region which has only 12% of the world's population (WHO, 2011). However, the HIV/AIDS epidemic in SSA varies considerably (UNAIDS, 2008). It is reported that in countries like Lesotho, Malawi, Namibia, South Africa and Zimbabwe, the HIV infection rates remain persistent (UNAIDS, 2008). According to Schneider (2011), life expectancy in most of the countries in SSA has decreased by 20 years or more, while the rate of population growth has fallen to almost zero. This is because death rates are almost equal to birth rates (Schneider, 2011).

A recent survey, conducted by the National Aids Commission of Malawi (NAC) in collaboration with the Department of Nutrition and HIV/AIDS in the Office of President and Cabinet (OPC), has revealed that 40 000 to 50 000 people are tested positive every year (NAC, 2013). The infection rate among adults aged 15-49 years is estimated at 10.6%, with the highest HIV/AIDS prevalence found among women. Women living in urban areas are estimated to have 22.7% infection and men in rural areas account for 7.1% of infection (NAC, 2013; Mkonda, 2013). There are more young women in urban areas infected with HIV than their rural counterparts (MDHS, 2010). The HIV prevalence rate among women with a secondary education or higher is at 16.3%, while women with a primary education or less have a lower rate estimated at 14.1% (Mkonda, 2013). It is also documented that rich men are more at risk of contracting HIV (MDHS, 2010). Among these men, there are certain qualities which appear to contribute to sexual networking and HIV transmission which include having a car, cellphone and cash, commonly labelled the “3 Cs,” and is aggravated also by alcohol consumption (Kadzandira & Zisiyana, 2007).



In spite of many people getting infected with HIV/AIDS in Malawi, HIV/AIDS is still perceived as a stigmatized disease (MDHS, 2010; MANET+, 2012). Many people associate HIV infection with illicit behaviours, such as promiscuous sexual activity, homosexuality, or intravenous drug use (Chirwa, 2009). Furthermore, disclosure of one’s HIV status often carries with it a social stigma that leads to emotional distress, depression, and isolation (Nachege, Morroni, Zuniga, Sherer, Beyrer, Solomon, et al., 2012). A review of the literature published from 2005 to 2009 on HIV stigma and discrimination revealed that stigma is still pervasive across the globe and has undesirable effects on the quality of life of PLHIV and their networks (MacQuarrie, Eckhaus, & Nyblade, 2009). Stigma discourages people from getting tested for HIV, seeking medical care and

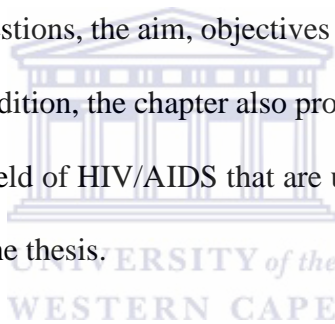
social services, disclosing to sex and drug partners and learning how to prevent further transmission (Kalichman, Simbayi, Vermaak, Cain, Jooste & Peltzer, 2007; MacQuarrie, Eckhaus, & Nyblade, 2009). Consequently, both stigma and discrimination contribute to the maintenance of risky sexual practices, which can increase the spread of HIV and frustrate efforts to reverse the pandemic and spread of the virus (Campbell, Nair, Maimane, & Nicholson, 2007; Lindsey & Banda, 2011; Visser, 2012).

In trying to reduce the HIV infection rates, Greeff, Phetlhu, Makoae, Dlamini, Holzer and Naidoo (2008) encourage the disclosure of sero-positive status among (PLHIV), as it leads to emotional and material support, and serves the goal of opening up a discussion on the HIV/AIDS epidemic. Unfortunately, many individuals with an HIV sero-positive status lack the courage to disclose their status, due to fear of stigma and discrimination (King, Katuntu, Lifshay, Packel, Batamwita, Nakayiwa et al., 2008). Stigma and discrimination affect the disclosure of one's sero-positive status, as well as access to various services (Chirwa & Kamkwamba, 2012). The consequences of stigma and discrimination are primarily a loss of employment, breaking up of relationships, denial of food, shelter or financial support, social ostracism, rejection, loss of the right to privacy and sometimes, even violence (Kohi, Makoane, Chirwa, Holzermer, Phetlhu, Uys et al., 2006; Hosek et al., 2008; Creel et al., 2011). However, traditional and psychological approaches to stigma imply that it is partly or wholly a problem of personal ignorance (Deacon, 2006). This implies that the silence can be broken around HIV/AIDS, if people are given the facts.

VCT service is an essential component of HIV prevention, treatment and care programmes (Sisay, Erku, Medhin & Woldeyohannes, 2014). In Malawi, HCT programmes emphasize the importance

of HIV status disclosure amongst those who are HIV positive (MDHS, 2010). HCT also provides important HIV-related information to individuals who may be at risk of contracting HIV (Anderson & Louw-Potgieter, 2012). In addition, HCT enables individuals with an HIV sero-negative status to remain uninfected, and those with a sero-positive status to plan their future in order to prevent HIV transmission to others (Irungu, Varkey, Cha & Patterson, 2008; Subramanian, Gupte, Mathai, Boopathi & Dorairaj, 2008). Therefore, people who have tested HIV positive are encouraged to disclose their status particularly to sexual partners, whether past, present or potential partners.

The research problem, research questions, the aim, objectives and the significance of the study are also presented in this chapter. In addition, the chapter also provides the conceptual definitions and clarifications of key terms in the field of HIV/AIDS that are used in this thesis. The chapter ends with an outline of the chapters of the thesis.



1.2 Research Problem

The HIV/AIDS epidemic is a global crisis that has affected all sectors of society in Malawi (Avert, 2012), including sport. The major risks for sportsmen and sportswomen in contracting HIV are related to off-field activities, the same as those encountered by non-athletes, and include unprotected casual sex and injecting drug use (Toriola & Brits, 2008). In the sports sector, concern is evidenced in the growing number of infections especially amongst popular celebrities and prominent athletes including Earvin “Magic” Johnson and Arthur Ashe (Leach, 2003). However, the risk of HIV infection is considerably greater in sub-Saharan Africa (SSA), where the prevalence is reported to be exceedingly high, with some people still not believing that HIV exists

(Toriola & Brits, 2008). Consequently, when these individuals are tested HIV positive, they consistently find it difficult to disclose their sero-positive status for fear of stigma that often results in social exclusion, blame, dissolution of relationships and many other unpleasant experiences (Hosek, Harper, Lemos & Martinez, 2008; Creel, Rimal, Mkandawire, Bose & Brown, 2011).

In Malawi, the specific experiences that athletes living with HIV/AIDS encounter upon disclosure of their status are not well-documented (Nyasa Times, 2013). This could be possibly due to lack of research on HIV in athletes and sport in SSA as extensively highlighted by Toriola and Brits (2008). Therefore, failure to explore the experiences that athletes living with HIV/AIDS undergo following disclosure of sero-positive status can result in improper interventions which may ironically fuel stigma and discrimination and other negative consequences. Well-designed interventions are developed based on the evidence established in research findings (Gorman-Smith, 2006).

Therefore, there is a need to explore the specific experiences of athletes living with HIV/AIDS following disclosure of their sero-positive status. This will help to develop strategies that will minimize the impact of any negative experiences. In addition, appropriate interventions can be tailored to the athletes living that HIV with focus on lessening the stigma. Furthermore the efforts aimed at encouraging disclosure can also be targeted that possibly lower the levels of negative experiences encountered after disclosure.

1.3 Research Questions

In order to gather information that would give understanding to the experiences of athletes living with HIV upon disclosure of their sero-positive status, the following research questions needed to be answered:

- What were the factors that facilitated disclosure of HIV sero-positive status among athletes?
- What were the factors that hindered disclosure of HIV sero-positive status among athletes?
- What were the experiences of athletes living with HIV following disclosure of the status?
- What were the appropriate support systems for athletes living with HIV/AIDS who disclosed their status to spouses, friends, family and community?

1.4 Aim of the Study

The research aim is a general statement that reflects on the intention or purpose of the chosen area of research which the researcher wants to achieve, while an objective is a specific statement relating to the defined goal or aim of the research and it describes how the researcher is going to achieve that aim (Collins, 2010).

The aim of the study was to explore the experiences that athletes living with HIV/AIDS encounter upon disclosure of their HIV sero-positive status in Ndirande Township in the city of Blantyre, Malawi.

1.5 Objectives of the Study

The following were the objectives of the study:

- To explore the factors that facilitated the disclosure of HIV sero-positive status.
- To explore the factors that hindered the disclosure of HIV sero-positive status.
- To explore the experiences of HIV sero-positive athletes following disclosure of their status to spouses, friends, family and community.
- To explore appropriate support systems for athletes living with HIV/AIDS upon disclosure of their status.

1.6 Significance of the Study

Athletes living with HIV in Malawi are an emerging area of research that still needs further investigation. The information generated from this study, hopefully, will help to provide planning strategies and measures that may help deal with the factors reported as barriers to HIV disclosure in sports institutions and the community. The results of this study are also intended to contribute to policy and programme development that may assist in identifying appropriate support systems for athletes living with HIV. The Information gained from this study is intended to enlighten and assist the Ministry of Sports, the Malawi National Council of Sports and the National AIDS Commissions of Malawi in their establishment, planning and implementation of HIV and AIDS programmes, specifically designed for athletes. The study is also intended to contribute to the existing literature on the experiences of HIV disclosure among athletes in Malawi. Most of the studies done on the experiences of people following disclosure have focused on the youth, and pregnant women attending antenatal clinics.

1.7 Definitions of Key Terms

This thesis used terms common in the area of HIV/AIDS. Therefore, it is necessary to elucidate such terms at the outset. These terms include acquired immune deficiency syndrome, athlete, community expert clients, discordant couples, discrimination, HIV sero-positive, HIV sero-status disclosure, human immunodeficiency virus, sero-status, stigma and virgin cleansing myth.

AIDS: Acquired Immune Deficiency Syndrome. AIDS is the most advanced stage of HIV infection. It can take from 2 to 15 years to develop depending on the individual. AIDS is defined by the development of certain cancers, infections or other severe clinical manifestations (WHO, 2013). According to Bartlett and Finkbeiner (2006), acquired means that AIDS is not inherited but acquired from some substance or microbe outside the body. Immunodeficiency means that the immune system has been weakened. A syndrome is not a disease but a collection of symptoms. In the case of AIDS, the syndrome is evidence of infections by the human immunodeficiency virus.

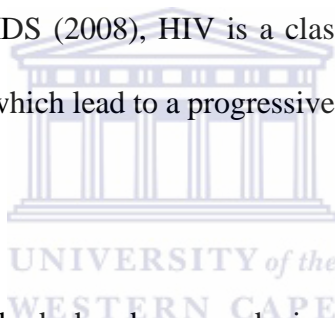
Athlete: For the purpose of this study, an athlete is a person possessing the natural or acquired traits, such as strength, agility, and endurance that are necessary for physical exercise or sports, especially those performed in competitive contexts (Collins English Dictionary, 2008).

Community Expert Clients: This refers to PLHIV who coordinate and link support groups to the medical clinic. They act as clinic focal persons for community health workers and identify patients who miss their appointments for follow-up (Ginindza & Malinga, 2013).

Discordant Couples: This refers to couples with one person who is HIV-positive and one who is HIV-negative. They are sometimes called “serodiscordant” or “mixed sero-status” (AIDS infoNet, 2014).

Discrimination: It is a negative action based on a preexisting stigma that creates isolation. In the case of HIV and AIDS, discrimination is a result of one’s positive sero-status or association with the effects of the human immunodeficiency virus (DFID, 2007).

HIV: Human Immunodeficiency Virus. It is a virus that damages the immune system (ILO, 2010; WHO, 2010). According to UNAIDS (2008), HIV is a class of viruses that infect and destroy lymphocytes or white blood cells, which lead to a progressive impairment and deterioration of the immune system (Kallings, 2008).



HIV Sero-positive: It means the body has been producing antibodies for HIV, which can be detected with an HIV antibody test, the most common type of HIV test used (Matuza, 2008).

HIV Sero-status Disclosure: Siu et al. (2012) define HIV sero-status disclosure as voluntary verbal or written passing on of private and confidential information regarding one’s HIV status and treatment to other people.

Sero-status: Is a generic term that refers to the presence or absence of antibodies in the blood (UNAIDS, 2011). The term is often used to refer to whether someone has HIV infection or not (AIDS InfoNet, 2014).

Stigma: It refers to processes of devaluing, labeling and stereotyping that are manifested in the loss of status, unfair and unjust treatment and social isolation of individuals or groups (UNAIDS, 2007). For the purpose of this study, stigma refers to the beliefs and attitudes that deeply discredit a person or group because of an association with HIV (DFID, 2007).

Virgin Cleansing Myth: This refers to the mistaken notion that if a man infected with HIV/AIDS and/ or other sexually transmitted diseases (STDs) has sex with an albino woman or virgin girl, he will be cured of the HIV disease and/or STDs (Thuku, 2011).

1.8 Thesis Outline

Chapter two provides a review of the relevant literature relating to the topic of the study. The chapter also provides a conceptual framework from which this research has been launched, logically investigating the broader debates that relate to the topic researched.

Chapter three deals with the research methods used to collect the data, including the description of the study setting, the research design, the athletes involved (population and sample), research instruments for data collection, the procedures of data collection and the methods of data analysis. The chapter concludes with a description of the ethical considerations pertaining to the study.

Chapter four is dedicated to the presentation of the results outlined in themes and sub-themes, while chapter five contains the discussion as well as the conclusion and recommendations. It also includes the strengths and limitations of the study.

1.10 Summary

This chapter has provided an overview of the background of the current study. It has also highlighted the statement of the problem, research questions, aim and objectives of the study, and the significance of the study. Further, the chapter has provided the definitions of key terms.



CHAPTER TWO LITERATURE REVIEW

2.1 Introduction

A literature review is a comprehensive examination of information that exists related to the research topic (Blankenship, 2010). The literature review is important in the sense that it gives a clearer understanding of the nature as well as the meaning of the research problem. In addition, the literature review enables the researcher to learn from previous theory on the subject, and illustrates how the subject has been studied previously. Furthermore, it helps to disclose different studies that have been conducted as well as the discrepancies of such studies. In this study, the literature review is set out using sub-titles for a more structured, logical and focused review.

Estimates of HIV prevalence at athletes in Africa are limited by the availability of data (Toriola and Brits, 2008). Major sources of HIV statistics across the region, such as the Joint United Nations Programme on HIV/AIDS (UNAIDS 2010) or the nationally representative household Demographic and Health Surveys (MDHS 2010), typically only present data for female sex workers, teachers, female cross border traders, male vendors, truck drivers, fishermen, estate workers, MSM, policemen and rich men. In this chapter, therefore, a review of the available literature on the experiences of people living with HIV (PLHIV) in the general population following disclosure of their sero-positive status is presented with focuses on Malawi, sub-Saharan Africa (SSA) and worldwide.

This chapter initially presents general information on HIV/AIDS, vulnerability and HIV, HIV and the athlete, voluntary counseling and testing necessity to disclose, the meaning of HIV sero-status disclosure, reasons for disclosing HIV positive status, reasons for non-disclosure of HIV sero-positive status, methods of disclosing HIV positive status, process of HIV sero-status disclosure,

positive experiences of disclosing HIV positive status, negative experiences of disclosing HIV positive status, stigma and discrimination, outcomes of HIV sero-positive status disclosure, risks of HIV transmission with concealment of HIV positive status, disclosure rates between developed and developing countries, condom use in relation to disclosure of HIV positive status and the outcomes of HIV sero-positive status disclosure among men who have sex with other men (MSM). The literature related to the objectives of the study is reviewed and the conceptual framework used for this study described.

2.2 HIV/AIDS

The human immunodeficiency virus (HIV) attacks the body's immune system, which is the system that would normally get rid of a virus. This virus affects the body's CD4 cells, which are the cells that coordinate the immune system's response to infections. In addition, HIV can infect many cell types, mostly lymphocytes, but also macrophages and microglia in the brain and other neurological cells, resulting in an intense asthenia, dementia and damage to the peripheral nervous system (Kallings, 2008). When HIV attacks the CD4 cells, it attaches itself to the cell's DNA and it becomes impossible to be isolated from the cells. Thereafter, it begins to replicate (make new copies of itself) and produce millions of copies. Finally, the virus damages the immune system cells until the immune system can no longer fight off other infections that it usually would be able to prevent. Then the person's body becomes vulnerable to opportunistic infections. When the person's immune system is compromised, he/she becomes sick and succumbs to various life-threatening diseases, and is said to have AIDS (Kallings, 2008).

HIV is found in the blood and the body fluids of an infected person, and in the breast milk of an infected mother. HIV transmission occurs when a sufficient quantity of these fluids get into someone else's bloodstream. The virus is mostly transmitted through unprotected sexual intercourse with an infected person, contact with an infected person's blood, use of infected blood products, injecting drugs, and a mother who is infected can pass the virus on to her baby during pregnancy, delivery or while breastfeeding (WHO, 2014).

2.3 Vulnerability and HIV

According to Morrison (2006, p. 2), vulnerability is a concept based on notions of “susceptibility to attack or to being wounded.” People become more vulnerable to infection when their civil, political, economic, social or cultural rights are not respected (Wegelin-Schuringa & Kamminga, 2006). The vulnerability to HIV/AIDS is closely intertwined with social ostracism of people most affected by the virus (Lau, Tsui, Choi & Su, 2007). The groups most at risk of and affected by HIV and AIDS include youth, women, children, orphans, men who have sex with men, prisoners, commercial sex workers, migrant labourers and drug injectors (Barnabas, Pegurri, Selassie, Naamara & Zemariam, 2014). In Malawi, the vulnerable groups most at risk include, the youth, women, children, orphans, men who have sex with men (MSM), long distance truck drivers, female sex workers, teachers, armed forces, police officers (UNGASS, 2010) and athletes (Ngolanga, 2013).

2.4 HIV and the Athlete

According to Mlilo (2013), most athletes are victims of ignorance. Many young athletes experiment with sex, alcohol and drugs during sport celebrations, where no appropriate guidance

is provided. Although they know a lot about HIV and AIDS, nevertheless, the message has not touched the important issue of their risky behaviour. Toriola & Brits (2008) points out a common belief in sport which promotes social interaction among people, consequently, creating an environment that facilitates heterosexual practice and promiscuity. Similarly, Malawian elite athletes are perceived to be at higher risk due to their celebrity status that exposes them to infection (Ngolanga, 2013). Toriola & Brits (2008) further reveal that athletes engage in casual sex more often than non-athletes, because they are more sociable. However, Nattiv and Puffer (1991) found that the physical ability and physique of many athletes make them believe that they are invincible hence, the lack of need to take the necessary precautions to minimize the risk of HIV infection. In addition, Pappas (2012) highlights the fact that elite athletes' competitive characteristics lead them into sexual behaviours with women regardless of their marital status. Consequently, female athletes involve themselves in sexual relationships with team mates, male coaches and/or sports officials and opposing athletes during national and international championships (Toriola & Brits, 2008). Some fall pregnant from their coaches and end up quitting athletics (Nyasa Times, 2012).

2.5 Voluntary Counseling and Testing Necessity to Disclose

Voluntary counseling and testing (VCT) is an approach where HCT is considered by a client who wishes for some reasons to know his or her HIV status. Successful VCT adheres to structured components which include pre-test counseling, consent and referral of HIV positive clients for ongoing treatment and care (Wanyenze, Madra & Ronald, 2008). VCT services have been used as an entry point for behavioural change and access to antiretroviral treatment (Sisay et al., 2014). It is therefore, suggested that an individual's knowledge of his or her HIV sero-positive status helps to avoid risky behaviour. People with high-risk behaviour are encouraged to know their HIV

status and to stop transmission of the HIV infection. In addition, VCT assists PLWHA to plan a better future for themselves and their children. It helps lessen the stigma attached to the disease and the discrimination they face in the community (Wanyenze et al., 2008).

VCT in Malawi was initiated in 1992 by the Malawi AIDS Counseling and Resource Organisation (MACRO) ahead of the HIV/AIDS policy development (CRHCS, 2002). VCT is offered in different settings, including health facilities, work places, free-standing sites and as outreach services. The number of sites providing HCT services has been increasing over the years. In 2011, a total of 778 mobile and 614 outreach HCT sites were providing HCT services in Malawi (MoH, 2011). The outreach facilities which are mostly home-based HIV Testing and Counseling (HBHCT) sites provide direct HCT services to all household members who express an interest (Were, Mermin, Bunnell, Ekwaru & Kaharuza, 2003). The significance of outreach services is that providers go door-to-door to offer HCT services. This completely reduces the transport costs for the clients (Matovu & Makumbi, 2007). In addition, the stigma associated with HCT is reduced, since everyone in the community is targeted regardless of risk (Wanyenze et al., 2008; Tumwesigye, Wana, Kasasa, Muganzi & Nuwaha, 2010). Consequently, Bateganya, Abdulwadud and Kiene (2010) affirm HBHCT for its increased uptake of HCT and identification of new HIV cases at earlier stages of the disease (Wachira, Kimaiyo, Ndege, Mamlin & Braitstein, 2012). Conversely, VCT/HCT was observed to be a cause of intimate partner violence, due to failure of disclosing test results to a partner, the unwillingness of men to attend counseling, and arguments over who brought HIV into the home (COWLHA, 2012).

2.6 Meaning of HIV Sero-status Disclosure

When a person is diagnosed with HIV, one of his or her most worrying decisions is with whom to share the diagnosis, a phenomenon labeled “disclosure”. The word “disclosure” could be defined as the “ability to reveal”, while HIV sero-status disclosure is the “voluntary verbal or written passing on of private and confidential information regarding one’s HIV status and treatment to other people” (Siu et al., 2012, p. 607). Disclosure is also considered a way to “open up” the HIV epidemic (UNAIDS, 2000) and, hence, is an essential step toward terminating stigma and discrimination against PLWHA (Obermeyer et al., 2011). Disclosure of HIV sero-status can occur within personal relationships such as between spouses and sex partners, within families, in the workplace and institutional settings, to healthcare personnel, and to others in the social network.

In the developing world, there are various factors that facilitate disclosure to partners, family, and friends which include length of time since diagnosis, severity of illness, a sense of ethical responsibility to partners, social support from family and friends, minimizing stress associated with non-disclosure, and disclosure as a way of HIV preventive behaviour (King, Katuntu, Lifshay, Packel, Batamwita, Nakayiwa et al., 2008). However, PLHIV have the constitutional right to control their personal information, confidentiality and privacy regarding their sero-status (Siu et al., 2012).

2.7 Process of HIV Sero-status Disclosure

Disclosure of HIV sero-positive status is a lifelong process such that an individual who wants to disclose his/her HIV sero-status, has to make decisions about what, when, to whom, and how much

to disclose (Wiener, Mellins, Marhefka & Battles, 2007). Decisions to disclose evolve over time and choice of disclosure varies, ranging from non-disclosure to partial disclosure to full disclosure and sometimes ending in forced disclosure (Wiener et al., 2007; Wekesa & Coast, 2012). More PLHIV disclose their sero-status to those who provide support (Grant, Vance, White, Keltner & Raper, 2013). In addition, Siu et al. (2012) indicate that disclosure goes beyond the act of “telling” others about one’s sero-status to a range of lived experiences. Greene, Derlega and Mathews (2006) point out that a disclosure episode often involves multiple reactions such as cognitive, emotional, and behavioural, by both the discloser and the disclosure target. This implies that disclosure of HIV sero-status is not an easy task as indicated by Sowell et al. (2003). The potential stigma, blame, shame and fear associated with HIV infection make it difficult for one to come up with a decision for disclosing his/her sero-status. This makes very few people contemplate on voluntary disclosure of their HIV sero-positive status (Paxton, 2002). Consequently, it contributes to the increase in delayed disclosure or non-disclosure among HIV-positive persons. Furthermore, Muula and Mfutso-Bengo (2005) warn that public disclosure of HIV positive status should be accompanied by appropriate individual counseling and preparation of the community to deal with stigmatization, discrimination and inappropriate healthcare services which are among the most common challenges that PLHIV face.

2.8 Methods of Disclosing HIV Positive Status

Both direct and indirect methods are commonly used for HIV disclosure in developed and developing regions. These two methods are expanded in the study by Serovich, Oliver, Smith, Tina and Mason (2005) using an inductive approach to investigate the methods which HIV positive men who have sex with men (MSM) use to disclose their sero-status to sexual partners.

The findings showed that there are five main strategies of disclosing HIV positive status from direct and indirect methods which are: point blank, indirect disclosure, stage-setting, buffering and seeking similars. The point blank method, which is referred to as direct disclosure, is where there is an open expression of one's sero-positivity. An HIV positive person reveals his or her status either in written or verbal form, "*I am HIV positive.*"

The stage-setting is another effective method of disclosure whereby one uses a variety of hints and symbols that work to clue a disclosure. This is another direct approach of disclosing one's HIV status. The different stage-setting strategies used by men living with HIV include; verbal hinting, symbolic hinting, listing one's HIV status on an online profile, asking a partner about his HIV status first and insisting on condom use.

The indirect disclosure begins with clues that one is HIV positive, however, the communication does not end in an open event where one's HIV status is disclosed. For instance, HIV positive men would ask for a glass of water to take their medications and/or expose their medicines to the sexual partner (Serovich et al., 2005; King et al., 2008). However, it is only assumed or acknowledged that the partner understands the meaning of the clue or the partner is left to figure it out on his/her own.

Buffering is an indirect method of disclosing one's HIV status which utilizes a third party (person, thing or event) because, at times, the expected costs may outweigh the benefits. As a result, a third party is used to facilitate HIV disclosure. In most cases, buffers who facilitate HIV disclosure are supportive friends who serve as a cushion between the two sexual partners (Serovich et al., 2005).

In seeking similar, athletes reported positioning themselves where they could be easily met by other men living with HIV or those compassionate and sympathetic towards them, such as AIDS walkers and support groups, as their indirect way of disclosing their HIV diagnosis (Serovich et al., 2005).

2.9 Reasons for Disclosing HIV Positive Status

From a public health perspective, disclosure of HIV sero-positive status has been advocated mostly because of its contribution to reduced risk of HIV transmission (Deribe et al., 2008). For PLHIV, the decision to disclose their sero-status to friends, family, and sexual partners may be more rewarding and pivotal in all areas of life. However, Hosek et al. (2008) as well as Dageid, Govender and Gordon (2012) observe that disclosure of HIV positive status is mostly perceived as a dilemma. On the one hand it promotes health, social support and psychological well-being while, on the other hand, it leads to stigmatization, rejection and other negative social interactions. Nonetheless, the most common influential goals of disclosing one's status are to seek emotional, psychological material and financial support and gain important information on HIV from one's social network (Law, Gogolishvili, Globerman & Rueda, 2013). Therefore, individuals who choose to disclose their sero-positive status consider the benefits more than the costs which, among others, include decreased anxiety, increased social support, increased access to PMTCT and care, treatment and support programmes, the ability to plan for the future, chances for sexual partners to be tested and opportunity to decrease risky behaviours (Medley et al., 2004). Findings from the study conducted by Dageid et al. (2012) acknowledge the benefits outlined above and also reveal disclosure to sexual partners as a means of securing support, providing the opportunity to share personal experiences and feelings with sexual partners, giving sexual partners the chance to get

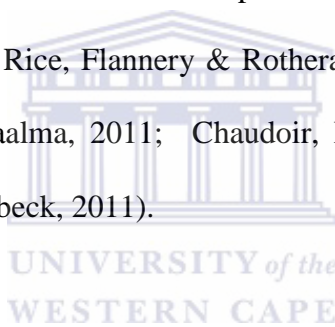
tested and to access medical care services. In the same vein, in a study conducted by Mfecane (2012), participants claimed that disclosure of sero-positive status protects sexual partners from being constantly exposed to HIV re-infection by having unprotected sex and also help to raise awareness about the gravity of the AIDS epidemic and to encourage sick people to get tested and acquire treatment.

2.10 Reasons for Non-disclosure of HIV Sero-positive Status

Remien and Bradley (2007) state that disclosure of HIV sero-positive status is an emotionally difficult task that involves communication of information about a potentially stigmatizing and transmissible illness. Study findings have indicated that disclosing HIV status, especially to one's sexual partner, encourages the partner to engage in preventive behaviours, such as condom use and HIV testing (Miller & Rubin, 2007; Deribe et al., 2008; Brown, Miller, Kamanga, Nyirenda, Mmodzi, Pettifor et al., 2011). However, PLHIV encounter significant barriers to HIV status disclosure which are fears of abuse and abandonment, disharmony in the relationship, and stigma among others (Dageid et al., 2012; Walcott, Hatcher, Kwena & Turan, 2013). In the study by Walcott et al. (2013), athletes explained that fears of abuse included being blamed for the infection, breakup of the relationship, bodily harm and being accused of infidelity or of being promiscuous that served as contributing factors to non-disclosure of one's HIV status. However, some individuals do not know how to reveal their HIV positive diagnosis due to a lack of good strategies of disclosure, and instead they choose to conceal their HIV status (Dageid et al., 2012). Nevertheless, disclosure without concern for the unique challenges could be counterproductive thereby worsening the barriers to HIV disclose rather than lessening them (Bird, Fingerhut & McKirnan, 2011).

2.11 Positive Experiences of Disclosing HIV Positive Status

Disclosure offers a number of significant benefits to PLHIV and to the general public (Seid, Wasie & Admassu, 2012). The World Health Organisation (2004) affirms that disclosure of a sero-positive status in developed and developing country settings are associated with positive outcomes, which include; access to medical care, including antiretroviral treatment, increased social support, acceptance, kindness, decreased anxiety and depression. In line with this, studies on disclosure of HIV sero-positive status have reported lower levels of emotional distress, depression and anxiety than those who have not, although this connection depends mostly on the level of social support gathered from disclosure (Arnold, Rice, Flannery & Rotheram-Borus, 2008; Stutterheim, Bos, Pryor, Brands, Liebrechts & Schaalma, 2011; Chaudoir, Fisher & Simoni, 2011; Murphy, Armistead, Marelich, Payne & Herbeck, 2011).



Findings from a study conducted by Zamudio-Haas, Mudekunyen, Mahaka, Lambdin and Dundar (2012) indicate that athletes who were in steady relationships received compassionate and understanding responses upon disclosure of their sero-positive status to their partners. The disclosee's partners were able to safeguard the health of their partners living with HIV by providing medication adherence support and taking them to clinic for medical care. However, disclosure of HIV sero-positive status to some individuals who are living with HIV is perceived as a sigh of relief after communicating difficult news (Hult, Wrubel, Branstrom, Acree & Moskowitz, 2012).

In addition, studies done by Kennedy, Cowgill, Bogart, Corona, Ryan and Murphy et al. (2011) reveal that in long-term relationships, the disclosure process is an act of honesty and integrity that improves the relationship in healthy situations. However, poor relationships which are mostly unsupportive, harassed and/or abused are hardly strengthened and often aggravated by disclosure (LeMasters, 2009). In such situations, disclosure can result in increased stress and poorer psychological wellbeing (Serovich, 2000; Fekete, Antoni, Duran, Stoelb, Kumar & Schneiderman, 2009).

2.12 Negative Experiences of Disclosing HIV Positive Status

In SSA, negative consequences resulting from HIV sero-status disclosure often occurs among adults, particularly women (Grinstead, Gregorich, Choi, & Coates, 2001; Maman et al., 2003). The disagreement between partners due to a lack of love, trust, and understanding creates a significant barrier to HIV disclosure. As a result, it promotes secrecy, tension and bitter relationships, making it difficult to initiate a peaceful conversation about HIV disclosure (Walcott et al., 2013).

Anglewicz and Chintsanya (2011) argue that women experience more negative consequences than men which make them conceal their HIV positive status. This is supported by Ntagani, Muula, Masaisa, Dusabeyezu, Siziya and Rudatsikira (2008) who reported that pregnant women after disclosure of their sero-positive status to their husbands, suffered physical abuse for being blamed for bringing the virus into their lives which included pulling of their hair, slapping, and kicking being thrown to the ground, and burning with hot liquid. In other circumstances, both men and women suffered negative consequences of a similar nature upon disclosure of their sero-positive status. For instance, in a study conducted by Mlobeli (2007), PLHIV (both men and women)

reported feeling bad and dehumanized upon being rejected and discriminated against at school and at work. Some revealed that they lost their jobs due to discrimination at work and others were denied promotion. Sadly, Mac Pherson (2002) reveals the worst experience of HIV disclosure, where one of the HIV/AIDS activists Gugu Dlamini, was beaten and stoned to death by some members of her community in Durban after she disclosed her sero-positive status. Such experiences are worrisome and provide grounds to conceal an HIV positive diagnosis and, hence, fuel the spread of HIV infections.

Despite these reports, not all HIV sero-positive individuals experience negative consequences upon disclosure of their status, as indicated by Siu et al. (2012). For instance, Medley et al. (2004) in their review of 17 studies found that the negative outcomes were fewer than initially feared and rarely led to divorce or separation. Subsequently, disclosure turned out to offer positive outcomes in most circumstances such as support, access to treatment and care services. Therefore, a more enabling environment needs to be created to increase the visibility of PLWHA as a normal part of any society (Mbonu et al., 2009).

2.13 Stigma and Discrimination

According to UNAIDS (2007), stigma refers to processes of devaluing, labeling and stereotyping that are manifested in the loss of status, unfair and unjust treatment and social isolation of individuals or groups. Simbayi, Kalichman, Strebel, Cloete, Henda and Nqeketo (2007) further describe stigma as attitudes and perceptions that deeply discredit and reduce the bearer from a whole and usual person to a tainted and discounted one. Stigma and discrimination are documented

as two main factors that need to be addressed to create an effective and continued response for HIV prevention, care, treatment, and impact mitigation (Morrison, 2006).

It is worth noting that both internal and external stigma do not only result in discrimination, but also affect the individual, spouses, family, and the community. Fear of stigma and discrimination from spouses, friends, family members, health workers and community members are identified as potential markers that prevent some individuals from going for VCT (King, et al., 2008). Consequently, it hinders individuals from seeking treatment, care and support, and, as a result, negatively affecting their quality of life and leads to increased transmission of HIV, morbidity, and mortality (Morrison, 2006). The tool available in the fight against stigma and discrimination is disclosure (Mfutso-Bengo & Muula, 2005).

Stigma and discrimination against PLWHA and AIDS is still high in Malawi (Katete, 2008). It is indicated that PLHIV are hindered access to vital information and HIV prevention efforts with reduced use of HIV/AIDS services (MANET+, 2012). Some factors identified as the basis of stigma in Malawi, include the association of HIV with promiscuous sexual behaviours, a lack of self-control of one's sexual impulses, and beliefs that HIV infection is a punishment from God, because of disobedience to parents and God (Rimal & Tapia, 2004). Unfortunately, the attitude of stigmatizing PLHIV inhibits people's willingness to have themselves tested for HIV, and socially marginalize those with known HIV diagnosis. Consequently, this leads to a failure of coping and poor general well-being (Creel et al., 2011).

The first study to document stigma and discrimination as experienced by PLHIV in Malawi was done by MANET+ (2003). The findings showed that stigma and discrimination affect disclosure of sero-positive status and access to various services. In a related study, conducted by the National AIDS Commission in 2007 (MANET+, 2012) the findings revealed that HIV-related stigma and discrimination was predominant within the home and in communities, while fear of infection and aggression towards PLHIV acted as key barriers to accessing HIV services.

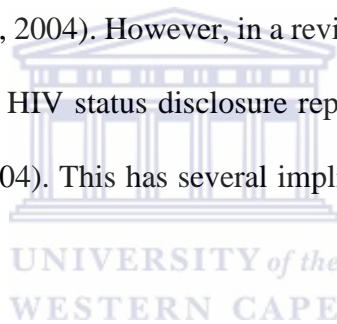
2.14 Disclosure Rates Between Developed and Developing Countries

Available literature on disclosure of sero-positive status in both developed and developing countries shows that the decision to disclose one's HIV sero-positive status is generally a difficult process (Almelech, 2004; Skogmer, Shakely, Lans, Danell, Anderson & Tshandu, 2006). Insight from Nachega et al. (2012) reveals that in both high and low HIV prevalence settings, PLHIV continue to be stigmatized, which negatively affected their quality of life and the disclosure of their status to others. Clarke et al. (2010) state that global rates of sero-positive disclosure varies from 42% to 100%, with a 49% sero-positive disclosure rate among males and a 60% among females.

The disclosure rates to sexual partners are higher among women in developed countries with an average rate of 71% (ranging from 42% to 100%,) while among women in developing countries the average rate is at 52% (with a range of 16% to 86%) (Maman & Medley, 2004). Among MSM it has been found between 77.94% and 87.31% (Serovich, Esbensen & Mason, 2007). This gender difference in disclosure could be ascribed to the high rates of stigma and discrimination and a lack of adequate healthcare and support services for those who disclose their HIV sero-positive status

(Maman & Medley, 2004). According to Qiao, Li & Stanton, (2013) HIV disclosure rates in the United States of America ranged from 20% to 67% with a median of 41%. The disclosure rate in SSA was reported to be over 74% (Obermeyer et al., 2011) Consequently, individuals who choose not to disclose their HIV test results range from 3% to 10% in the United States of America, and from 10% to 78% in the developing world (Maman & Medley, 2004).

It is argued that in many sub-Saharan countries, the rates of HIV disclosure remain low in serodiscordant couples (Medley et al., 2004; Burnnell, Mermin & De Cock, 2006). HIV disclosure to a steady serodiscordant partner was estimated on average at 49% in developing countries and 79% in developed countries (WHO, 2004). However, in a review on the rates of disclosure among serodiscordant couples, the lowest HIV status disclosure reported was among women attending antenatal clinics (Medley et al., 2004). This has several implications for PMTCT (Medley et al., 2004).



In Malawi, most women with HIV sero-positive status fail to disclose their diagnosis to their sexual partners, unlike men (Anglewicz & Chintsanya, 2011). This is possibly because many of these women are not economically and academically empowered (Nyasa Times, 2012). Consequently, they depend enormously on their husbands for support, stability and protection. Deribe et al. (2010) state that fear to disclose is particularly due to the anticipated negative consequences such as disrupted relationships, abandonment and/or marriage breakdown which result in a loss of financial and material support. On the other hand, Kadowa and Nuwaha (2009) reveal that most women fail to disclose their HIV positive status to their spouses or other sexual partners due to poor communication skills. This makes discussion of HIV and sexual issues extremely difficult

between couples. However, the literature has shown that in both developed and developing countries, disclosure of HIV sero-positive status to sexual partners is more likely to occur in long-time relationships, possibly due to the likelihood of high levels of intimacy (Duru, Collins, Ciccarone, Morton, Stall & Beckman, 2006).

2.15 Outcomes of HIV Sero-positive Status Disclosure

Fear of negative outcomes was reported as a major barrier to HIV status disclosure both in developed and developing countries. However, thirteen of fourteen studies in developing countries indicated women's fear of abandonment and loss of economic support as major barriers to disclosure of HIV status to sex partners (Maman & Medley, 2004). Interestingly, most individuals who chose to disclose their sero-positive status reported experiencing positive social outcomes as a result of their disclosure including support and understanding from partners. Similarly, Medley et al. (2004) in their review of 17 studies found that the negative outcomes were fewer than initially feared and rarely led to divorce or separation in developing countries (Maman & Medley, 2004). Interestingly, after some time, disclosure turned out to offer positive outcomes in most circumstances such as gaining support from partners, participating in treatment and support programmes (Medley et al., 2004).

In studies that looked at violence as an outcome of HIV status disclosure for women who chose to disclose, violent outcomes were reported more often by women in SSA (3.5% to 14.6%), than by women in USA studies (0.4%-4%) (Medley et al., 2004). The highest rates of disclosure-related violence were reported among women in antenatal clinics (Medley et al., 2004). HIV-infected women of sero-discordant couples or as sexual partners were the most likely to experience violence as a result of disclosure (Maman & Medley, 2004).

2.16 Outcomes of HIV Sero-positive Status Disclosure Among Men who Sleep with Men

The HIV sero-positive status of MSM is an important aspect that needs extensive discussion particularly in most of the SSA region, where same sex practices are stigmatized (Fay, Baral, Tripance, Motimedi, Umar, Ipinge et al., 2011). A report by CEDEP shows that a large number of MSM engage in unprotected sex. Sadly, they fail to access health care services due to their sexual orientation which causes them to be denied the services (Baral, Trapence, Motimedi, Umar, Ipinge et al., 2009).

However, disclosure among MSM is reported to be higher in the USA and Europe, with higher disclosure rates for steady partners, and lower rates for casual partners (Obermeyer et al., 2011). It is affirmed that partners who know their HIV sero-positive status, and have not disclosed, are more receptive to their partner's disclosure (Serovich et al., 2005). Findings from a study by Serovich et al.(2011) indicate that negative outcomes from HIV disclosure such as blame, abandonment, anger, violence, stigma and depression were not experienced due to family closeness and a loving nature of the parents and relatives disclosed to. However, it is important to note that those who chose to conceal their HIV positive status may well be those who are most likely to experience negative outcomes due to the disclosure (Gaskin et al., 2011). This is evident in a study by Grant et al. (2013) where some participants who disclosed to parents and relatives suffered rejection because of their homosexuality and HIV status.

2.17 Risks of HIV Transmission with Concealment of HIV Positive Status

In the study done by Stein, Freedberg, Sullivan, Sacvetsky, Lavenson, Hingson, and Samet (1998), they found that individuals with one partner (monogamous relationships) were 3.2 times more likely to disclose than ones with multiple partners (polygamous relationships). It was also found that individuals with high spousal support were 2.8 times more likely to disclose than individuals without support (Stein, et al., 1998). The study concluded that many individuals did not disclose their status to their sexual partner for fear of negative outcomes (Stein, et al., 1998). This therefore, suggests that sexual partners of HIV infected persons continue to be at risk for HIV infection.

In a study on the disclosure of HIV positive status in individuals on ARV preventive therapy, the findings indicated that about 20% did not disclose their status to their regular partners, and almost one third did not use a condom during their last sexual encounter with a casual partner (Gorbach, Galea, Amani, Shin, Celum, Kerndt & Golden, 2004). For MSM, it was reported that 42-48% did not disclose their HIV positive status for fear of rejection and were practicing unsafe sex (Gorbach et al., 2004). The results suggest that healthy partner communication and honest relationships may be necessary to increase disclosure of HIV status to sexual partners and reduce the prevalence of HIV transmission (Niccolai, Dorst, Myers, & Kissinger, 1999).

2.18 Condom Use in Relation to Disclosure of HIV Positive Status.

According to (UNAIDS, 2012), the global expansion of HIV prevention, care and treatment efforts has contributed to the reduction in HIV prevalence. Bachanas, Medley, Pals, Kidder, Antelman, Benech et al. (2013) also indicate that disclosure of HIV positive status to sexual partners has significant prevention and care implications. In their study Bachanas et al. (2013), found that the

majority (80%) had disclosed their HIV status to their sexual partners, 64% knew their partner's HIV status and 77% reported consistent condom use. Findings from a study by Kairania, Gray, Kiwanuka, Makumbi, Sewankambo, Serwadd et al. (2010) indicated that disclosure was marginally, but significantly higher (85.3%) among couples in which the male partner was HIV positive and had discussed the use of condoms compared to couples where the male partner was HIV positive but never discussed condom use (75.0%). In addition, Patel et al. (2012) found that increased disclosure and condom usage among married women were due to prevention of both HIV transmission and pregnancy.

Consequently, from a public health perspective, HIV disclosure has been encouraged mostly because of its contribution towards the reduction of HIV transmission including condom use and HIV testing of the sexual partner (Miller & Rubin 2007; Deribe et al. 2008). Disclosure of HIV positive status facilitates other significant behaviours which may improve the management of HIV specifically in terms of adherence to crucial treatment regimens (Deribe et al., 2008). Makoae, Portillo, Uys, Dlamini, Greeff, Chirwa, Kohi et al. (2009) state that concealment of HIV status to sexual partners or household members results in serious consequences. For example, individuals with an HIV positive status are likely to experience treatment interruptions due to the fact that tablets must be hidden and not taken in the presence of others, and they also are likely to have worse clinical outcomes due to disease progression. In addition to that, sexual partners can also persist in continued unprotected sexual practices (Seid, Wasie & Admassu, 2012). Disclosure of HIV status has become an entry criterion for many treatment programmes in resource constrained settings, as well as for gaining access to other forms of care, such as home-based care and specific social support (Ssali, et al., 2010). It is important, therefore, to create an enabling environment for

people to disclose their HIV status to families, healthcare providers, support groups and communities.

2.19 Conceptual Framework

According to Burns and Grove (2009, p.126) a “conceptual framework is an abstract, logical structure of meaning.” It guides the development of the study and enables one to link the findings to the body of knowledge. The conceptual framework chosen for this study was the ‘Consequence of HIV Disclosure Model’ illustrated in figure 2.1.

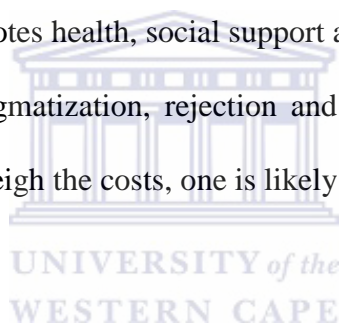
2.19.1 Consequence of HIV Disclosure Model

This model provides a framework for determining the factors that influence individuals to disclose their HIV positive status and their experienced consequences of disclosure (Serovich, 2001; Serovich et al., 2008). The model has two theories namely, disease progression and consequences of HIV disclosure. These theories try to explain how individuals reach the decision to disclose their status. In this study, the two theories were adopted and examined to ascertain whether they could be used to explain the disclosure process as experienced by athletes living with HIV in Malawi.

2.19.1.1 Disease Progression Theory

Disease Progression theory is based on the notion that, once a PLHIV becomes symptomatic, the HIV status cannot be concealed any longer (Serovich, 2001). The disease progression eventually results in hospitalizations and physical deterioration, which may result in disclosure of one’s sero-positive status to significant others, so as to gain the much-needed social support (Serovich et al.,

2008). In addition, physical manifestations accompanying disease progression, which include lesions and extreme weight loss, make concealing the diagnosis difficult. According to Serovich (2001), the theory explains that the severity of the disease, the number of infections and the time since diagnosis, can influence one to disclose to their sexual partners and significant others. Furthermore, the relationship between the theory and disclosure of HIV sero-positive status is qualified by the consequences one anticipates resulting from disclosing his or her status. For instance, PLHIV will disclose their status once he or she evaluates that the rewards of disclosing outweigh the associated costs (Serovich et al., 2008). In the same vein, Hosek et al. (2008) and Dageid et al. (2012) also observed that disclosure of HIV positive status is mostly perceived as a dilemma. On the one hand it promotes health, social support and psychological well-being while, on the other hand, it leads to stigmatization, rejection and other negative social interactions. Therefore, when the benefits outweigh the costs, one is likely to disclose one's HIV sero-positive status.



Conversely, the theory has been criticized for being outdated, since it was supported mainly during the pre-antiretroviral era when the progression of the disease was unambiguous such that once an individual got infected with HIV, the virus rapidly developed into AIDS (Serovich, 2001). It is worth noting that, nowadays with advancement of therapies, improvements in medicines and free distribution of antiretroviral therapy in most countries, people with an HIV sero-positive diagnosis live longer and stay healthy for many years and, as such, do not feel pressured into disclosing their status. Consequently, when the disease progresses to such an extent that one is hospitalized, some people even die without disclosing their HIV status. This notion is supported by one participant, a 38 years old woman in a study conducted by Zhou, Zhang, Li and Kaljee (2012, p.820) who had

this to say: *“I will not tell my child, I am afraid that he will think that his mother is a bad mother to have this kind of disease. I will never tell him about my HIV infection even when I am dying. I will never tell him.”*

The disease progression theory, consequently, fails to explain the distinctions in the disclosure process where some PLHIV may choose not to disclose even though the symptoms of HIV and AIDS can be clearly seen. In addition, some PLHIV do not disclose their sero-status regardless of their medical status, even when they are on their death beds, and this creates a gap in the theory.

2.19.1.2 Consequence of HIV Positive Status Disclosure Theory

The model postulates that PLHIV are likely to disclose their sero-positive status to significant individuals and sexual partners once the perceived benefits for disclosing outweigh the associated costs. The model advocates that as the disease progresses, it is likely that one undergoes a lot of stress which eventually makes one weigh the consequences of disclosing against the associated benefits. It is documented that disclosure of sero-positive status has potential benefits for the discloser, because it motivates sexual partners to seek testing, practice safe sex, and eventually lower the spread of the virus (Mfecane, 2012).

In addition, disclosure of sero-positive status benefits individuals from increased opportunities for social support, access to antiretroviral treatment and also increased opportunities for future planning (Greene, Carpenter, Catona, & Magsamen-Conrad, 2013). Besides these perceived benefits, disclosure of sero-positive status has a number of potential risks for an individual which include, blame, physical and emotional abuse, loss of economic support and break-up of marriages (Walcott, et al., 2013). However, this theory provides an understanding of the process once an

individual decides that the benefits of disclosing outweigh the associated risks. This ultimately leads to disclosure of sero-positive status.

The theory tries to explain how the decision to disclose an HIV positive diagnosis is reached for both men and women. However, it does not indicate the African cultural influences of disclosing an HIV diagnosis (Serovich, 2001; Serovich, et al., 2008). This could be due to the fact that the theory was not generated in the African setting. Kambarami (2009), points out that disclosure of an HIV diagnosis in the African context is not just a matter of weighing the costs or negative consequences against the benefits or rewards. In addition, the theory is unable to predict disclosure to sexual partners (Serovich, 2001).



2.19.1.3 Criticism of the Consequence of HIV Disclosure Model.

This model has been criticized due to the introduction of ARVs which serve as HIV therapies (Serovich, et al., 2008). Individuals who are living with HIV and are on ARVs hardly show a standard pattern of deteriorating health. Criticism of the model was confirmed in a study by Serovich et al. (2005) on methods that HIV positive MSM use to disclose their sero-status to casual sexual partners. In that study, there was no relationship between disease progression and disclosure to sexual partners. Therefore, the aspect of disease progression may be excluded as one of the components in the HIV positive disclosure process among individuals living with HIV. From this view point, other events which significantly influence HIV positive status disclosure among PLHIV can be implicated.

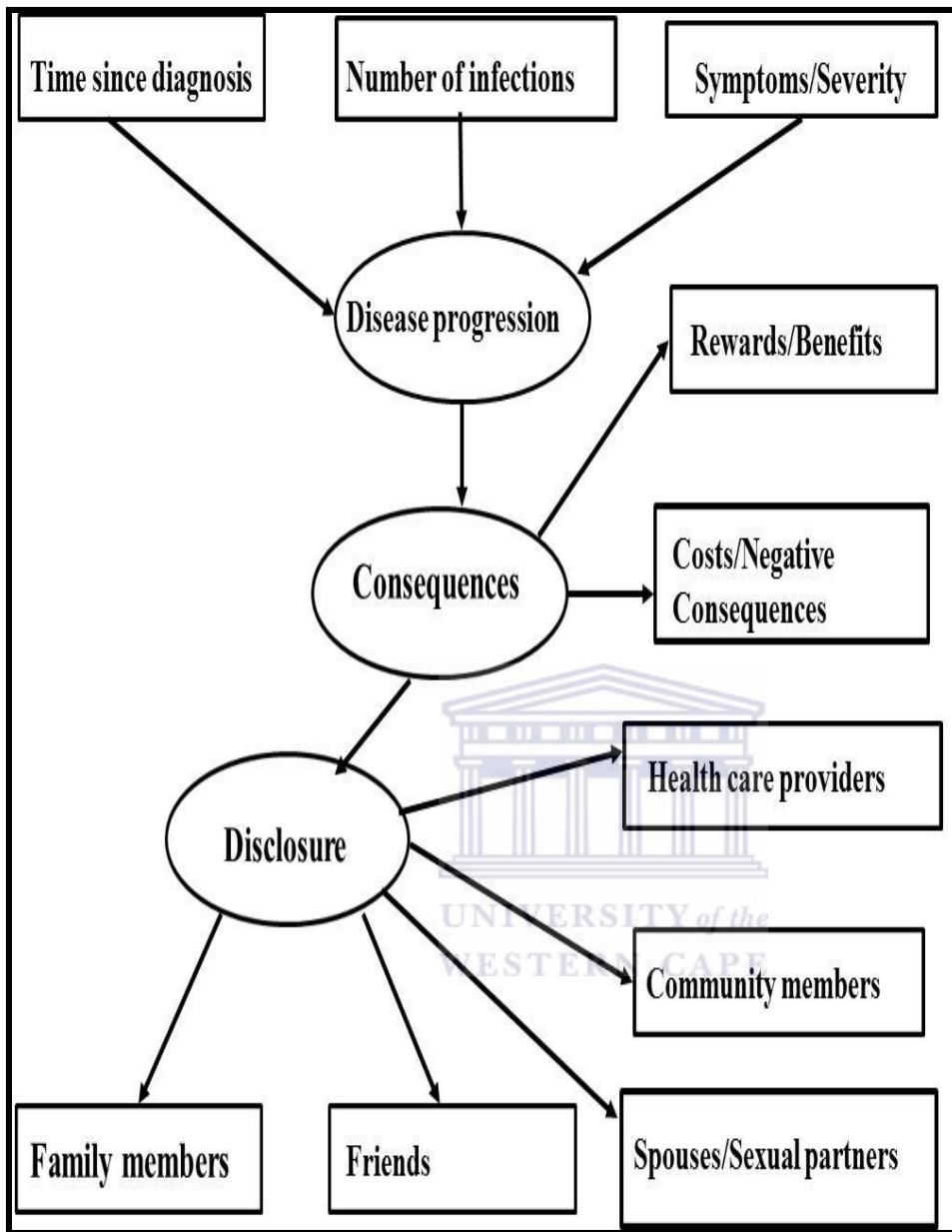


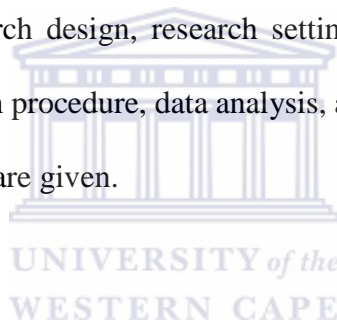
Figure 2.1. Consequence of HIV Disclosure Model by Julianne Serovich (2001).

2.20 Summary

This chapter has presented a review of literature on HIV/AIDS, vulnerability and HIV, HIV and the athlete, VCT, the meaning of HIV sero-status disclosure, the process of HIV sero-status disclosure, the methods of disclosing one's HIV positive status, the reasons for disclosure and non-

disclosure of one's HIV positive status, the positive and negative experiences of HIV positive disclosure, stigma and discrimination, disclosure rates between developed and developing countries, outcomes of HIV sero-positive status disclosure among straight individuals and among MSM, the risks of HIV transmission with concealment of HIV positive status, and condom use in relation to disclosure of HIV positive status. The chapter has also presented the conceptual framework, namely, the "Consequence of HIV disclosure model" with its two theories, the disease progression and the consequence of HIV disclosure.

The next chapter focuses on the qualitative research methodology that was used to conduct the study. A description of the research design, research setting, study population and sampling, research instrument, data collection procedure, data analysis, academic rigour and trustworthiness of the study, and ethics statement are given.



CHAPTER THREE

RESEARCH METHODS

3.1 Introduction

This chapter describes the approach which was employed to explore the experiences of athletes living with HIV following disclosure of their sero-status, in Ndirande Township, Blantyre, Malawi. A qualitative research approach with narrative design was employed. The chapter describes the research setting, sampling methods, eligibility criteria, data collection techniques and analysis. It also provides the ethics outline that guided the study.

3.2 Research Approach

The two main methods used in answering research questions are qualitative and quantitative approaches (Bergman, 2008). In this study, the qualitative approach was used to obtain data from a small group of athletes. It is argued that the qualitative approach is more suitable as it places the individuals and their perceptions of the world at the centre of attention (Barbour, 2009). The qualitative approach helps the researcher to understand the experiences, attitudes, opinions or views, and feelings of the athletes in the context in which the action takes place and gives them meaning (Brink, 2006). In addition, the qualitative approach in research uses detailed descriptions from the perspective of the athletes themselves, as a means of examining specific issues and problems under study (Brink, 2006).

In this study, the qualitative approach helped the researcher to explore the lived experiences of the athletes living with HIV and what meaning these hold for them. The advantage of using the

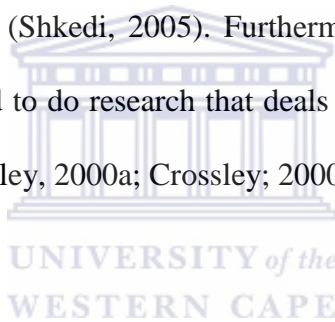
qualitative approach is that it produces more in-depth and comprehensive information, because more than one data source is used for a richer and broader understanding of the phenomenon (Pequegnat, Stover & Boyce, 2010). In addition, the qualitative approach allows an exploration of the commonalities and variations in experiences across athletes in greater depth, while minimizing the preconceived notions (Brink, 2006)

The qualitative approach is also more flexible as it allows for greater freedom and adaptation of interaction between the researcher and the participants. For example, qualitative methods use mostly open-ended questions which are not essentially worded in exactly the same way with each participant. With open-ended questions, participants are free to respond in their own words, which also tends to be more comprehensive than simply answering as “yes” or “no” (Mack, Woodsong, Macqueen, Guest & Namey, 2005). It is against this background, therefore; that the researcher adopted the qualitative approach for this study. The researcher was able to explain and record the in-depth experiences and responses of athletes living with HIV following disclosure of their sero-status.

3.3 Research Design

A research design is generally described as a plan or blueprint of how the researcher intends to conduct research (Babbie & Mouton, 2010). In addition, Parahoo (2006) describes a research design as basically a map that describes when, where and how data will be collected and analysed. The aim of a research design is to provide guidance on how the researcher obtains data about the research phenomenon from the participants (Babbie & Mouton, 2010). A good research design helps the researcher to avoid bias, while collecting data (Polit & Hungler, 1999).

In this research, a narrative research design was utilized to enable the researcher to explore, in detail, the lived experiences of athletes with HIV after disclosure of their sero-status. The narrative research design helped to describe and explain the phenomenon narrated by the athletes. According to Shkedi (2005), the narrative design also helps in the design and development of theory regarding the phenomenon. In addition, Soskolne (2003, p. 4), states that the narrative research design is a method which “doubtfully gives voice to those who have been otherwise marginalized” in order for them to significantly share their self-experience. This design enables the individual to tell his or her story about his or her experiences. Data gathered from participants focus on their stories, their explanations for the activities in which they participate, and the meaning they give to the phenomena in which they engage (Shkedi, 2005). Furthermore, the narrative design has been preferred as an appropriate method to do research that deals with people affected by HIV/AIDS and other incurable diseases (Crossley, 2000a; Crossley; 2000b; Soskolne, 2003).



3.4 Research Setting

The research setting refers to the place(s) where the study is conducted and the data collected (Burns & Groove, 2011). This study was conducted in Ndirande Township in Blantyre City in southern Malawi. Malawi is a land-locked country with a population of 15.9 million inhabitants (NAC, 2013) situated in the southern part of the equator in SSA (Malawi National Statistics Office, 2008). It shares borders with Tanzania in the north and northeast, Zambia to the north and northwest, and Mozambique to the east, south and south west (as indicated on the map below in Fig 3.1). Its land covers a total area of 118 484 square kilometres of which 94 276 square kilometres is land and 475 kilometres is water. The width of the country ranges from 80 to 161 kilometres and it is 901 kilometres long. The country is divided into three regions: the Northern, Central and Southern regions. These regions are divided into 28 districts led by district

commissioners, with six districts in the Northern region, nine in the Central and thirteen in the Southern region. The districts are subdivided into Traditional Authorities that are headed by chiefs. These Traditional Authorities are further divided into villages which are headed by village headmen/headwomen (Malawi National Statistics Office, 2008).

3. 4. 1 The City of Blantyre

The city of Blantyre is the biggest city in the country with a population of 661 444 inhabitants (Figure 3.1). It is considered the capital of the Southern region being the country's main commercial, banking and industrial centre (NSO, 2008). It is the oldest European settlement in the country founded by the Blantyre Mission 1876 and was named after a small village in Scotland where Dr. David Livingstone was born. Blantyre city has a number of townships with a varied population distribution.

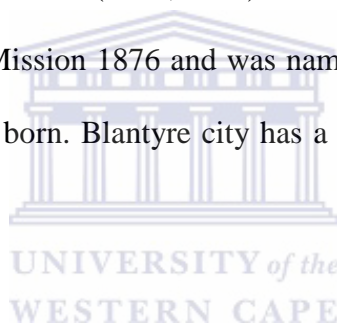




Figure 3.1. Map of Malawi showing the study setting (Blantyre).

3. 4. 2 Study Location

This study was specifically conducted in Ndirande Township, one of the townships in the city of Blantyre (Figure 3.2). This township has a low-income status and a high population density estimated at 113 000 (NSO, 2008). It is situated on the lower slopes of the Ndirande Mountain (Porter, Hampshire, Abane, Robson, Munthali, Mashiri, et al., 2010). The area has unplanned settlements which are under the jurisdiction of traditional leaders (Mkandawire & Muula, 2005), with substantial migrants and diverse ethnic groups from all districts of Malawi, mostly dominated by Yao and Ngoni tribes (Porter et al., 2010). This residential area has considerable female-headed households which are between 15% - 25% of the total population. There are a few child-headed households, and some orphans (Porter et al., 2010). Ndirande Township was chosen as the study location, because it has a sizable number of athletes, both elite and non-elite. Ndirande Township, also known as “ The Soweto of Malawi,” is also believed to be a home for criminals, drug-traffickers and prostitutes (Kachinziri (2003) as cited in Mchombo, 2006) with high rates of HIV/AIDS infection (Geubbels & Bowie, 2006) which is estimated at 17.3% among young people (AYIDO, 2008). Furthermore, the area also has a range of HIV/AIDS preventive intervention programmes and services (PEPFAR, 2009). All the activities of this study, took place in this area.

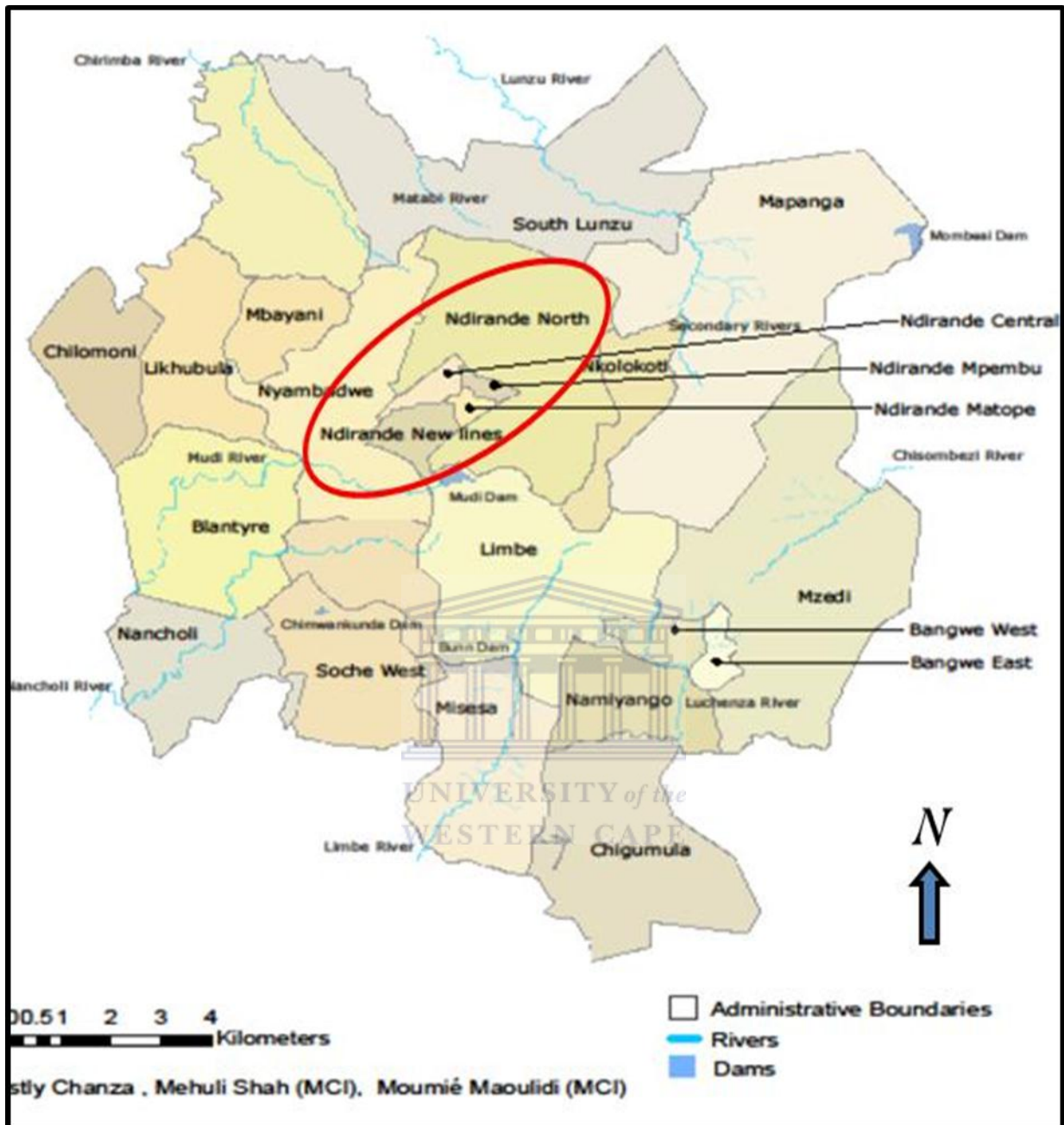


Figure 3.2. Map of Blantyre City Showing Ndirande Township (the study area).

3.5 Population and Sampling

The population of a study refers to a group of individuals who have specific characteristics and from which a sample is drawn to define the parameters or characteristics (Creswell & Plano Clark, 2007). In addition, Blankenship (2010, p. 82) further defines a population as “a group of individuals, organizations or artifacts that could be involved in the study”. A sample means “a special subset of a population observed in order to make inferences about the nature of the total population itself” (Babbie et al., 2008, p. 203). Sampling is, therefore, the process of selecting a sample of athletes.

3.5.1 Population

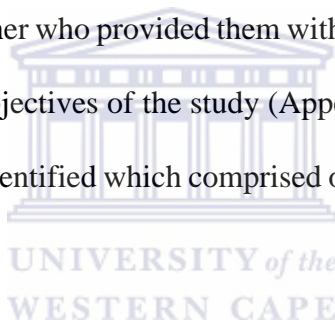
The target population of this study consisted of athletes living with HIV, both elite and non-elite, between 18 and 30 years. The athletes included both males and females drawn from two HIV support groups in Ndirande Township. However, there is lack of information in terms of the numbers on infection rates of any particular group of athletes. The Malawi Network, a support group for PLHIV (MANET+), and the National Association for People Living with HIV and AIDS in Malawi (NAPHAM) were contacted to assist in the identification and recruitment of athletes.

3.5.2 Sample and Sampling Procedure

In a research study, it is not feasible for the entire population to participate in the study. Therefore, a part of the population identified as a sample must be selected to participate in the study (Babbie & Mouton, 2010). In this study, a purposive sampling method was used to select athletes. The sampling technique was based on the researcher's judgment of the athletes who were typical of the phenomenon under study and especially knowledgeable about the imminent question (Brink, 2001;

Babbie, Mouton, Vorster & Prozesky, 2008). The researcher, therefore, sampled athletes in the support groups who she felt had first-hand experience and who had also disclosed their HIV sero-status.

The NAPHAM helped the researcher with the identification and recruitment of the athletes. This task was easy for NAPHAM, because HIV support groups are contained within their programme. The contact person from NAPHAM met the potential athletes who were drawn from two HIV support groups and asked them if they would like to participate in the study. These athletes were already identified as PLHIV and had disclosed their HIV sero-positive status. Interested athletes were then introduced to the researcher who provided them with the information regarding the study and highlighted the purpose and objectives of the study (Appendix C). A total number of twenty five athletes living with HIV was identified which comprised of fifteen males and ten females with ages ranging from 18 to 30 years.



The researcher conducted preliminary interviews in which information about the study was shared and, then, the athletes' suitability to participate in the study was evaluated. Preliminary interviews were done to allow the researcher to screen the athletes and focus mainly on the potential athletes' age, HIV status and disclosure of HIV positive status. Four potential athletes were not allowed to participate in the study, because they had not disclosed their HIV status openly and were not registered members of any HIV support groups. They had learnt about this study from friends who were interested to participate in the study. Another potential participant was turned down because he was under the age of 18 years. The process of turning them down was conducted in a gentle, sensitive and caring manner.

Among the 25 athletes identified, 15 athletes volunteered to participate in the study. The other 10 athletes, even though living “somewhat openly” with HIV, expressed fear of being stigmatized, especially if seen by friends or peers at the NAPHAM office during the study interviews. The athletes who participated in the study had been members of support groups for periods ranging between one and four years. The sporting codes which they participated in included boxing, athletics, netball and football.

In Malawi, PLHIV are easily associated with places they go to in order to receive psychological, material and medical support. The NAPHAM offices are regarded as places exclusively for PLWHA. Some fear was still present in many of the athletes, despite having disclosed their HIV status to selected individuals (partial or selective sero-status disclosure). As a result, some decided not to participate in the study. With the final sample of fifteen athletes, a convenient date and time for individual interviews was agreed upon. However, out of the fifteen athletes, three dropped out because of other personal commitments and the remaining twelve formed the sample for the study.

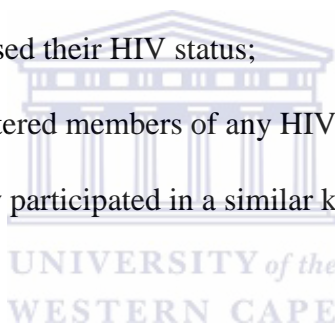
3.5.3 Eligibility Criteria

The inclusion criteria are the characteristics participants must have in order to be eligible to participate in the study, while exclusion criteria are the elements that disqualify an individual from participating in the study (Heavey, 2011). These criteria form the boundary between those individuals who were included and those who were excluded from the study (Holloway & Wheeler, 2010). In this study, the following inclusion criteria were considered for an athlete to participate, namely:

- athletes who had been diagnosed HIV positive for five years or less;
- athletes who had disclosed their status;
- athletes who were willing and capable of providing informed consent;
- athletes who were registered members of two support groups; elite and/or non-elite athletes; and
- males or females aged between 18 and 30 years.

Some athletes were excluded from this study on the following basis namely:

- athletes whose seroconversion of HIV had progressed to AIDS classification;
- athletes who had not disclosed their HIV status;
- athletes who were not registered members of any HIV support groups; and
- athletes who had previously participated in a similar kind of study.



3.6 Research Instruments

The research instrument used in this study was an interview guide with open-ended semi-structured questions combined with probes and prompts to guide the athletes in the interviewing process. An interview guide is a flexible tool that guides the conversation between an informant and an interviewer. The interview guide provides general direction and flow of the topics discussed. Open-ended questions are perceived as questions that do not restrict the athletes' answers to pre-established alternatives, i.e., either "yes" or "no" (Polit & Hungler, 1999).

The audio tape recorders were used to record the in-depth interviews, while the writing pads were used to write observation/field notes during the interviews. According to Jensen (1989),

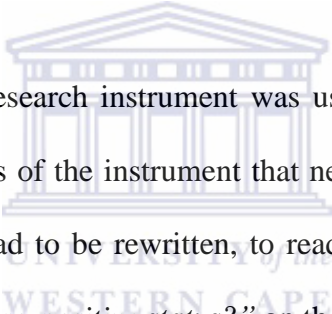
audiotaping interviews are of great help to the researcher, because they allow time to be attentive to the participant and to probe for further explanation, as necessary. In addition, using tape recorders enhance the accuracy of the interview report. Over and above this, usage of the audio tape recorder allows the researcher to capture all the information. Field notes during interviews are also important for the researcher, because he or she is able to check if all the questions have been answered (Opdenakker, 2006) and serve as a back-up in the event that the tape recorder becomes faulty or fails.

3.7 Pre-testing of the Instrument

It is advisable to test the research instrument before applying it to the actual sample of the study. The procedure of pre-testing the research instrument is done as a means of a pilot study (Welman, Kruger & Mitchell, 2005). According to Burns and Grove (2011), a pilot study is basically a smaller portrayal of the actual study done in preparation of a proposed research study. In this research study, a pilot study was conducted before proceeding with the main study. The purpose of the pilot study was to determine suitability of the research instrument prior to the main study. This was done to identify discrepancies and pitfalls in the research instrument and to investigate the accuracy and appropriateness of the instrument (Babbie & Mouton, 2010).

In this study, the research instrument (an interview guide) was discussed with the assistant researcher. This was done to ensure that all the important steps and details had been taken care of before pre-testing. The research instrument was approved by the District (Blantyre) NAPHAM coordinator and the research assistant who had extensive experience and knowledge of the construction of research instruments on HIV/AIDS. The final draft was then pre-tested on five

individuals who had similar characteristics to those who were interviewed in the main study (Polit & Hungler, 1999). These individuals who participated in the pilot study were drawn from one support group in Misesa, Blantyre. Pre-testing of the research instrument is the trial run to determine, as far as possible, the clarity, research adequacy and freedom of bias. Kvale (2007) affirms that pre-testing the research instrument through a pilot study assists the researcher to refine the questions on the interview guide. All athletes who participated in the pilot study did not participate in the main study, because they had already been exposed to the interviews and they could respond differently from those who had not previously experienced them. The data collected from the pilot study was not included in the final data analysis of the main study.



All the feedback concerning the research instrument was used to modify and rectify the final instrument. Consequently, the areas of the instrument that needed revision were addressed after pre-testing. For instance, item 8 had to be rewritten, to read as “*What were the consequences following disclosure of your HIV sero-positive status?*” on the final instrument (interview guide). This enabled the athletes to give complete responses. Thereafter, the instrument was administered to the sample of the main study.

3.8 Data Collection Procedure

Data refers to information obtained during the course of an investigation or study (Polit & Hungler 1999), while data collection is the precise, systematic gathering of information relevant to the research process, the specific objectives, questions or hypothesis of a study (Burns & Grove, 2009, p. 695). In qualitative research, data is collected from study participants through in-depth interviews or focus group discussions (Pequegnat, Stover & Boyce, 2010). Data is in the form of

quotes from interviews, documents, field notes, excerpts from video tapes and electronic communication. A combination of these is suggested to be effective in support of the research findings (Merriam, 2009). It is also argued that the method used to collect data should best suit the aim and objectives of the study (Cormack, 2005).

In this research study, individual face-to-face interviews were conducted to collect data from athletes. Probes and prompts were used to guide the athletes to provide optimal responses, so as to obtain rich data. In-depth interviews also permitted for a conversation between the athlete and the researcher to openly and honestly share information or their story (Creswell, 2007). In addition, the in-depth interviews best captured the experiences and responses of the athletes in this study. The researcher also used field notes which were taken in the presence of the athletes to record non-verbal cues that were observed during the interviews in order to balance the findings.

All individual in-depth interviews with athletes living with HIV were conducted at the recruitment site (NAPHAM offices in Ndirande Township) in the month of February 2014 for a period of three weeks. One interview was conducted each day to allow for concurrent data analysis to occur. In-depth semi-structured interviews were carried out with twelve (12) athletes, four (4) males and eight (8) females, using an interview guide. Initially, ten (10) athletes were planned for the in-depth interviews, however, the sample was increased to fifteen athletes in order to seek a point of saturation in the emerging core themes. However, Guest et al. (2006) in Pequegnat et al. (2010) suggest that twelve in-depth interviews with individuals from a social grouping are usually sufficient for most themes to emerge. Therefore, from the in-depth interviews carried out with the twelve athletes, data saturation was reached in this study. Guest et al. (2006) as cited in Pequegnat

et al. (2010) and Sargeant (2012) state that ‘data saturation’ is the point at which no new information or themes are observed in the data.

According to Tuner (2010), interviews provide information pertaining to the participants’ experiences and viewpoints of a particular topic. Precisely, ‘interviews involve unstructured and generally open-ended questions that are few in number and intended to elicit views and opinions from the athletes’ (Creswell, 2009:181). In this study, in-depth interviews were conducted in Chichewa for easy communication, since Chichewa is the commonly spoken language in Malawi. This was also done to minimize misunderstandings due to language barriers. In addition, before the interviews, the researcher was able to establish rapport with the athletes and, consequently, discovered their experiences (Jensen, 1989). Each interview took approximately 60 to 90 minutes, depending on the athlete’s mood and the extent to which they wanted to disclose their experiences. The researcher was able to maintain a climate that permitted the athletes to express their feelings and to respond freely and openly (Henning, Van Rensburg & Smith, 2004). So, athletes who wanted to share their experiences in detail were provided the opportunity to do so.

The individual interviews were tape recorded, and transcribed verbatim by the researcher, assisted by a language expert. The transcription was done in Chichewa and later translated to English. During the translation process, the original Chichewa recording was still consulted to ensure that the translation, to a great extent, carried the same meaning as the original recording. When the original word had no direct translation, that word was used in its original form and a phrase describing it was written to maintain its contextual meaning. In order to maintain confidentiality

and anonymity of all athletes during the individual in-depth interviews, the researcher created and used numbers instead of real names.

3.9 Data Analysis

Data analysis is ‘the systematic organization and synthesis of research data’ (Polit & Beck, 2010 p.552). Data analysis reduces, organizes and gives meaning to the data (Burns & Grove, 2009, p.44). In analyzing the qualitative data obtained through the interviews, the researcher followed the process described by Creswell (2009). The qualitative data was analysed using open-coding, wherein the researcher carefully reads all the transcripts to get a sense of the entire data. Then, opinions are written down as they occur, the topics are also abbreviated as codes and written on the side of the transcript. The appropriate describing words for the topics are identified and turned into categories, and data belonging to each category is grouped together to form themes.

Similarly, in this study, after all the data was collected through face-to-face individual in-depth interviews, the researcher listened to the audio recordings several times, then transcribed them verbatim and compared the transcriptions with the notes she had written down during the interviews. This allowed the researcher to identify possible emerging themes and also to get an accurate account of the data (Edwards & Skinner, 2012).

The data coding and referencing were critical aspects in this study. The process required the researcher to create a coding index of the raw data for possible themes, sub-themes and concepts (Edwards & Skinner, 2012). The coding was based upon similar words and phrases that were noticeably mentioned by different athletes during the interviews. The data collected from the

interviews was then analysed for themes, sub- themes and concepts to see if there were indeed relationships between the experiences of the athletes and the disclosure of their sero-positive status. This was done to create patterns and to construct explanations for the purposes of data interpretation.

The thematic categories that were done earlier from the athletes' narratives were then reviewed and analysed for further possible themes. These narrative themes were grouped together and further analysed according to the lived experiences of the athletes after disclosure of their sero-positive status. These were structured in the form of themes and sub-themes containing critical features of the phenomenon under study. The following were the main themes which emerged, namely: factors influencing disclosure of HIV sero-positive status, factors hindering disclosure of HIV sero-positive status, the disclosure process, consequences/experiences of HIV sero-positive disclosure, lack of appropriate support systems for athletes living with HIV and delayed HIV diagnosis.

The researcher, assisted by the assistant researcher, labelled and presented the data into identified themes and sub-themes. The data was also interpreted in a manner to give it substantive meaning. It is argued that triangulation of data helps the researcher in assessing the internal validity of the data collected (Edwards & Skinner, 2012). It also allows the researcher to confirm the validity of the findings and the identified themes. In this research study, triangulation of data involved the use of multiple sources. The researcher triangulated the data by looking at the consistency of the information obtained and the themes identified from the audio tape recordings of the in-depth interviews with the athletes, as well as the information compiled from observation notes and

information obtained from the media such as newspapers, television and radio. The researcher depended more on the multiple sources than single sources of data verification. Consequently, through the process of data triangulation, different views, opinions and experiences of the athletes were confirmed against other sources which helped the researcher bring together the athletes' ideas in order to create a comprehensive understanding of the phenomenon.

Consequently, the researcher's intention was that the collected data, when analysed and interpreted, would help in the development of guidelines to minimize the potential negative impacts of the lived experiences of athletes living with HIV following disclosure of their status.

3.10 Academic Rigour and Trustworthiness

Moule and Goodman (2009) affirm that maintaining rigour and trustworthiness is significant to the quality of the overall study. To ensure the quality of the data and the findings in this study, the researcher established rigour, trustworthiness and true value of data by ensuring the following:

3.10.1 Credibility

According to Polit and Beck (2006), credibility refers to confidence in the truthfulness of the data, and accuracy in the interpretations emanating from the data. Therefore, those reading this thesis must believe that the information is a true reflection of the athletes' views, experiences and beliefs (Moule & Goodman, 2009). In this study, credibility was obtained by member checking, triangulation and prolonged engagement in data collection and interpretation. Sufficient time was dedicated for adequate data collection activities. This helped the researcher obtain an individual

in-depth and rich understanding of the views of the athletes as they unfolded naturally. The researcher also built up trust and rapport with the athletes from the outset, and sustained it throughout the data-gathering process. This was achieved by maintaining contact with the research assistant and athletes. The athletes in this study were also provided with feedback on the emerging themes, as well as any clarifications deemed necessary in order to have a true and accurate description of their views.

3.10.2 Dependability

Polit and Beck (2006) refer to dependability of qualitative data as data stability over a period of time and over conditions. Moule and Goodman (2009) argue that dependability underscores the need for the researcher to account for the ever-changing context within which research occurs. Consequently, dependability is appreciated if findings of the research are consistent and accurate. In quantitative studies, dependability is comparable to validity. In this research study, dependability was achieved by keeping detailed records of the research process. In addition, the researcher established an audit trail which was followed in the construction and interpretation of the themes. The aspect of dependability also helps future researchers to repeat the study in the same context with the same methods and participants, and obtain similar results.

3.10.3 Transferability

This refers to the potentiality of transferring the findings to other settings (Polit & Hungler, 2006). This means that knowledge and information attained in one setting will be applicable in another (Barbour, 2008). Transferability enables another researcher to apply the findings to another setting and come up with similar results. In this study, transferability was achieved by producing a thick,

rich detailed description of the methods used in the setting where the study was conducted, as well as in the processes of data collection and analysis. In addition, the researcher included sufficient studies in the form of a literature review in order to validate transferability for this research study.

3.10.4 Conformability

This refers to the objectivity or neutrality of the data, that is, the potential for congruency between two or more independent people about the accuracy of data (Polit & Beck, 2006). Conformability is achieved when the disseminated data is the information of the study participants exclusively, and that data is not changed by the researcher (Polit & Beck, 2010). Conformability in this research was enhanced by bracketing and maintaining a flexible journal of the study. However, complete conformability is impossible in research. The researcher took every effort to make sure that her personal values and beliefs did not influence the research findings (Polit and Beck, 2006).



3.10.5 Bracketing

Bracketing refers to the process of identifying and holding in abeyance preconceived beliefs, opinions or any bias about the phenomena under study (Polit and Beck, 2006). The scope of inquiry is also limited, due to the in-depth, comprehensive data gathering approaches which concentrate on a deep understanding of the phenomenon under study, and excluding all other extraneous information (Polit & Hungler, 2000). In order to minimize bias, the researcher tried to avoid preconceived personal ideas and interest during data collection. In this research, bracketing was employed where any preconceived beliefs and opinions perceived about a phenomenon under investigation were identified and put aside (Brink, 2001). In order to explore the lived experiences of athletes living with HIV in their natural form, bracketing was maximized. At the beginning of

the study, the researcher wrote down any anticipated personal preconceived ideas, beliefs and any presumptions for self-reflection. In the process of the study, the researcher was able to recognize any of these biases and control for them. This process was intended to facilitate openness and new insight (Burn & Grove, 1997).

3.11 Ethics Statement

Prior to this study, a research proposal was developed and approved by the Community and Health Sciences Faculty of Higher Degrees and Senate Committees of the University of the Western Cape. Ethical clearance to conduct the study was obtained from the Faculty and Senate Ethics Committees of the University of the Western Cape (Appendix K). The proposal was also forwarded to the National Health Sciences Research Committee in the Ministry of Health in Malawi to obtain permission to conduct the study in Ndirande Township in the city of Blantyre, Malawi. The researcher also sought a letter of support from the Malawi National Council of Sports for the study to be conducted within the Sports Federations using the athletes living with HIV (Appendix J). Thereafter, permission was obtained from the National Health Sciences Research Committee for the researcher to conduct the study in Ndirande Township (Appendix L). Athletes were identified and invited by NAPHAM to participate in the study after being informed verbally and in writing about the aims and objectives of the study (Appendix C).

After the athletes were informed about the study, written consent was obtained voluntarily and all documents were filed securely (Appendix E). In order to ensure voluntary participation, the researcher contacted and briefed prospective athletes several days before the intended individual face-to-face in-depth interviews. This was done to help the athletes know that they were partaking

in the study on a voluntary basis and that they could withdraw at any time without penalty. As only semi-structured interviews were conducted, the athletes were never subjected to any harmful treatments or interventions. However, in the event of emotional breakdown during interviews, the assistant researcher a trained HIV/AIDS counselor was able to attend to such participants. In order to ensure privacy and autonomy during the process of data collection, athletes were informed that all individual face-to-face interviews were conducted in a private room and recorded using ~~the~~ a tape recorder subject to obtaining permission from them for the recordings.

In order to ensure athlete anonymity and confidentiality, pseudonyms were used for the athletes, and all recordings were marked accordingly. Thus, the names of the athletes were not recorded on the audio tapes or written in the researcher's journal. All the information obtained was accessible to the researcher only. The athletes were also assured that any information they provided would not be publicly reported or made accessible to parties other than those concerned with the research. The researcher kept all gathered data securely filed in locked cabinets, while the data captured on computer was subject to password coding for access. The researcher will destroy all transcripts and recordings containing raw data after a minimum period of three (3) years upon completion of the study. The athletes were also informed that they would have access to the final research report and all related documents.

3.12 Summary

This chapter discussed the research methodology that was used in this study which included the research design, the research setting, the study population and sampling, the research instrument,

data collection procedures and data analysis, academic rigour, trustworthiness and ethics statement. Chapter 4 presents the results, data illustration in the form of themes and an interpretation of the research results.

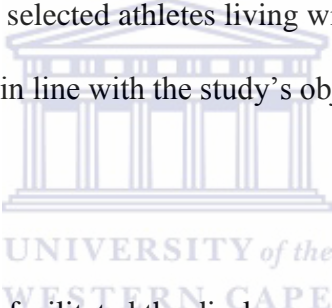


CHAPTER FOUR

RESULTS

4.1 Introduction

This chapter presents the results of this study which was conducted to explore the experiences of athletes living with HIV following disclosure of their sero-positive status, in Ndirande Township, Blantyre. In this chapter, the results have been presented in two parts. The first part covers the demographic information of the athletes. The second part presents the qualitative results of the data which included the athletes' views, thoughts, feelings and ideas that were gathered through individual in-depth interviews from selected athletes living with HIV in Ndirande Township. The results presented in this chapter are in line with the study's objectives. The objectives of the study were as follows:

- 
- To explore the factors that facilitated the disclosure of HIV sero-positive status.
 - To explore the factors that hindered the disclosure of HIV sero-positive status.
 - To explore the experiences of HIV sero-positive athletes following disclosure of their status to spouses, friends, family and community.
 - To explore appropriate support systems for athletes living with HIV/AIDS upon disclosure of their status.

4.2 Demographic Characteristics of the Athletes

This section offers a concise description of the characteristics of the athletes and their possible impact in the study. Prior to the individual in-depth interviews, the athletes were asked to give information with regard to their demographic characteristics. The demographic profile for the athletes presented in this section includes; gender, age, marital status, level of education, employment, religion and place of residence.

Table 4.1. Athletes demographic profile

Participant	Gender	Age (Year)	Marital Status	Level of Education*	Source of Income	Religion	Place of Residence
Athlete # 1	Male	30	Married	Secondary	Employed	Christian	Malaysia: Ndirande North
Athlete # 2	Female	28	Married	Primary	Spouse	Christian	Malaysia: Ndirande North
Athlete # 3	Female	25	Single	Secondary	Employed	Moslem	Ndirande Central
Athlete # 4	Female	29	Married	Primary	Spouse	Christian	Ndirande Central
Athlete # 5	Female	29	Married	Secondary	Spouse	Christian	Ndirande Central
Athlete # 6	Male	29	Married	Secondary	Employed	Moslem	Malaysia: Ndirande North
Athlete # 7	Female	26	Single	Secondary	Employed	Christian	Malaysia: Ndirande North
Athlete # 8	Female	30	Married	Secondary	Spouse	Christian	Ndirande Central
Athlete # 9	Male	18	Single	Secondary	Parents	Christian	Malaysia: Ndirande North
Athlete # 10	Female	18	Single	Secondary	Guardians	Christian	Malaysia: Ndirande North

Athlete # 11	Female	20	Married	Secondary	Casual work	Christian	Malaysia: Ndirande North
Athlete # 12	Male	30	Married	Secondary	Employed	Christian	Malaysia: Ndirande North

Key: * refers to schooling education

4.2.1 Gender

Gender representation in the study was not equal and balanced, because out of the twelve athletes only four were male whereas eight were female. This could be attributed to the fact that the HIV support group members were dominated by women, since women usually patronise such groupings more than men. Athletes for the study were drawn from PLHIV support groups in which the people who were more willing to participate were women. Men usually do not participate in activities which require voluntary participation. Another reason why the participation of men was low is that interviews were conducted during week days when the members of the groups meet which was also the time when some of the men were at work. It was also found that the members of the support groups did not meet over weekends, so it was difficult to arrange separate interviews for the men on weekends when they were more likely to be available.

4.2.2 Age

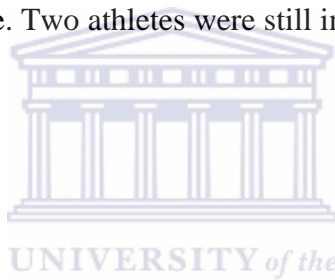
The age range of the athletes in this study was between 18 and 30 years with a mean age of 26 years. Most of the athletes were within the age range of 25-30 years, (9 participants) with the remainder falling within the age range of 18 to 24 years (3 participants).

4.2.3 Marital Status

Eight of the athletes were married, while four were not married. Ten athletes indicated that at some point in time, they had engaged in unprotected heterosexual contacts with their sex partners. This clearly indicates that the major mode of HIV transmission in this case was possibly heterosexual sex. The Malawi Demographic Health Survey (2010) documented that heterosexual sex is the common mode of HIV transmission in Malawi.

4.2.4 Level of Education

The level of education of the athletes in this study ranged from grade four at the primary school level to grade twelve at the secondary school level. Four athletes attended primary school, while six athletes completed grade twelve. Two athletes were still in secondary school, one in grade ten and the other one in grade twelve.



4.2.5 Employment

The study revealed that out of the twelve athletes, five were employed, five were unemployed, and two were still in secondary school. Studies have shown that employed PLHIV are usually discriminated against when they disclose their HIV positive status (Mlobeli, 2007: MANET+ 2012). However, that was not the case with the athletes in this study.

4.2.6 Religion

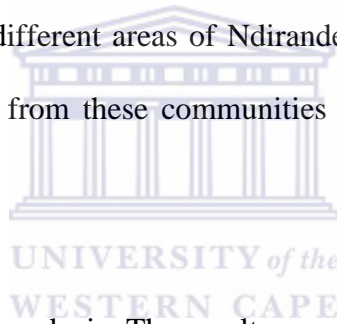
The results on religion indicated that all the athletes belonged to some religious group, the majority of whom were Christian, and two were Moslem. Most of the athletes regarded religion as an essential aspect of their lives. They indicated that religion played a significant role in their lives, especially as people who are infected and affected by HIV/AIDS, just like many people who have various personal or social problems, because it offered them a source of spiritual support.

4.2.7 Disability

Out of the twelve athletes who participated in this study, only one had a disability that was albinism.

4.2.8 Place of Residence

The athletes in this study were from two different areas of Ndirande township, four were from Ndirande central and eight were from Malaysia, a new residential site of Ndirande which is about 3 kilometres from Ndirande central. Malaysia has relatively less business activities, unlike Ndirande central which is the central commercial area of the township. The researcher decided to have the athletes from these two different areas of Ndirande township in order to compare the varied experiences of the athletes from these communities after disclosure of their HIV sero-positive status.



Data was analyzed using thematic analysis. The results were grouped into six main themes and their sub-themes aligned to the conceptual framework, the purpose and objectives of the study (Table 4.1). Some of the athletes' views are presented as direct quotations (extracts) which revealed the athletes' emotions, opinions, observations, experiences and perceptions about HIV disclosure.

The following are the six main themes and sub-themes that emerged from the qualitative data analysis:

- Factors influencing disclosure of HIV sero-positive status
- Factors hindering disclosure of HIV sero-positive status
- Disclosure Process

- Consequences/Experiences of HIV sero-positive disclosure
- Lack of appropriate support systems for athletes living with HIV.
- Delayed HIV diagnosis

The table below shows the identified themes and sub - themes:

Table 4.2. Main themes and sub-themes

No.	MAIN THEMES	SUB – THEMES
1	Factors facilitating disclosure of HIV sero-positive status	<ul style="list-style-type: none"> • Promoting HIV and AIDS awareness • Encourage sexual partner testing for HIV • Negotiating for safer sex • Benefiting from material/financial support • Accessing treatment and healthcare services • Accessing emotional and psychosocial support • Preventing Mother-to-Child Transmission of HIV
2	Factors hindering disclosure of HIV sero-positive status	<ul style="list-style-type: none"> • Fear of rejection/abandonment from spouses, family, friends and others • Fear of emotional distress for loved ones • State of denial • Fear of stigma and discrimination
3	Disclosure process	<ul style="list-style-type: none"> • Potential targeted recipients • Timing of disclosure • Strategy used to disclose

4	Consequences/experiences of HIV sero-positive disclosure	<p>Positive</p> <ul style="list-style-type: none"> • Peace of mind/sigh of relief • Getting full support • Community expert clients • Reduced stigma and discrimination • Love and acceptance • Psychosocial support • Living positively with HIV <p>Negative</p> <ul style="list-style-type: none"> • Unfriendly health care staff • Stigma and discrimination • Lack of support
5	Lack of appropriate support systems for athletes living with HIV.	<ul style="list-style-type: none"> • Poor sports facilities and equipment • Poor treatment and nutrition • Shortages of healthcare staff
6	Delayed HIV diagnosis	<ul style="list-style-type: none"> • Unknown HIV status

4.3 Factors Facilitating Disclosure of HIV Sero-positive Status

The results of the study showed that among the athletes living with HIV there were various factors which encouraged them to disclose their HIV sero-positive status. These factors depended mainly on the potential benefits of disclosure for the individual, as well as for the spouse, family and the community. They included promoting HIV and AIDS awareness, encouraging sexual partner testing for HIV, negotiating for safer sex, benefiting from material/financial support, accessing treatment and healthcare services, accessing emotional and psychosocial support, preventing mother-to-child transmission of HIV.

4.3.1 Promoting HIV Awareness

One of the main factors that facilitated disclosure was the public promotion of HIV awareness. In this study, it was found that for the PLHIV, and who had other disabilities, disclosure helped them

to fight the myths and/or misbeliefs associated with people who have disabilities. One of the athletes, a woman with a disability, had this to say:

“I have been offered money by rich men so that I should have sex with them, because they believe that when they have sex with people with disabilities, such as albinos, they will be cured and cleansed of the HIV virus.” (Athlete # 5)

The athlete was influenced to come out and disclose her status, so that men who had this belief should know that even albinos can contract HIV, and she also wanted to protect younger albino girls from being abused by men who believed that if they had sex with an albino they would be cleansed of HIV. The athlete said that she was very concerned about the misconception which people had surrounding HIV and albinism and found it very appropriate to clear this misconception. She went on to say that:

“I do tell these men that we should use their vehicle and their money to go together to the clinic for an HIV test, if they do not believe what I am telling them, [and] in so doing I help people to have correct information on HIV and AIDS.” (Athlete #5)

The results further indicated that athletes had to disclose their status in order to prevent or reduce HIV transmission. It is worth noting that most people who are living with HIV have the knowledge about reducing transmission of the virus. Athletes reported that they disclosed their status as a way of preventing further transmission of HIV to sexual partners. This was expressed by an athlete who said:

“For a person who has HIV and is still looking healthy, it is difficult for people to know the status of the individual, and if the person has not disclosed his or her status then he or she can easily infect other people.” (Athlete #3).

4.3.2 Encouraging Sexual Partner Testing for HIV

In this study, it was found that athletes living with HIV were influenced to disclose their HIV positive status to their spouses as a way of encouraging the sexual partners to test for HIV. The athletes further said that, it was unfair for people who knew their status to hide it from their sexual partners, as this would lead to transmission of HIV to the uninfected partner. They, therefore, disclosed their status, as a way of making sure that their sexual partners had a chance of getting tested and, thereafter, adopting appropriate HIV preventive measures. One athlete had this to say:

“It is unfair when you know your HIV status and you want to hide it from your sexual partner. That is “sambi” (sin), because you never know whether your partner is infected or not. Even if you know that he or she is infected, you still need to disclose it so that you avoid re-infection of HIV. Therefore, the best way is to tell them the truth.” (Athlete # 3)

In this study, some athletes reported that their sexual partners were influenced positively to get HIV tested, because they had disclosed their status to them. In all instances of testing, the partners were all found to be HIV negative, and the relationships still continued between the partners.

4.3.3 Negotiating for Safe Sex

This study also revealed that some athletes disclosed their status, because they wanted to adopt safe sexual behaviours which would prevent partner infection or further re-infection and so

promote HIV transmission between them. One of the athletes had this to say about safe sex with his partner:

“After disclosing my HIV status to my wife we decided that we should use condoms as a way of preventing further infections and prevent accelerating the progression of HIV to AIDS. I am still on bactrim (cotrimoxazole prophylaxis treatment) which means my immunity can still fight infections on its own without depending on the ARVs”.

(Athlete # 12)

The statement above affirms the importance of disclosing one’s HIV sero-positive status to sexual partners which can lead to safer sexual practices as well as encourage partners to get tested.

The study also found that the majority of the athletes were still sexually active and they all agreed that they practiced safer sex after they had disclosed their HIV status to their sexual partners. Also they now no longer felt guilty, as opposed to the situation before disclosure, when they had unprotected sex with their partner while knowing full-well that they were HIV positive. One of the athletes had this to say:

“My fiancée and I have agreed that we should be using condoms as per instructions from the hospital because, if we cannot be using condoms, it can happen that I can infect my fiancée, as it is not a guarantee that because he was not infected in the past, he can never be infected [in future]. This will also help me to stay healthy. As of now, I have not started taking the ARVs, because my immunity is still strong.” (Athlete # 3)

The study athletes reported that disclosure of their HIV sero-positive status to their sexual partners would allow them to use condoms in order to prevent HIV transmission to the uninfected partner. Disclosure of HIV sero-positive status to a partner who has a seronegative status is an effective tool in minimizing the degree of HIV infection (Bird, Fingerhut & McKirnan, 2011).

4.3.4 Benefiting from Material/Financial Support

Material support was found to have a strong and powerful bearing on HIV sero-positive disclosure. The results indicated that athletes disclosed their HIV positive status in order to get some material support from their relatives during the “lean period,” a time of financial difficulty and food scarcity. The athletes reported that whenever there was a shortage of food in their homes, their relatives would come to their aid with foodstuffs and other essential materials such as soap, salt, sugar, paraffin, and relish. They further said that if they had not disclosed their status, they would have had to starve and, thereby, become malnourished which would have further compromised their immunity. One athlete said:

“Because I disclosed my status to my relatives, and also because they know that I am financially handicapped and have problems to find the means to feed my family, they do help me with food and other necessities for the home” (Athlete # 5)

The results, therefore, suggest that PLHIV disclose their status when they perceive the need for financial and material support as significant for disclosure. Conversely, when there is a lack of support, it is possible that PLHIV may not disclose their status.

4.3.5 Accessing Treatment and Healthcare Services

Some individuals disclosed their HIV sero-positive status only when they became ill. That was the time when they wanted to access treatment and healthcare services. However, some people chose to conceal their HIV sero-positive status absolutely, regardless of their health condition. In this study, some of the athletes stated that they disclosed their status, because they were not healthy, and HIV testing was one of the remedial measures for them to have better treatment and, as such, disclosure was inevitable.

“There was a time when I was often sick and I noticed that my health was deteriorating. One day the HCT door-to-door volunteers came to our home and I decided to get tested, and the results came out positive. I decided to go to the clinic for assessment, if I could start taking ARVs. So, when I went to the clinic, the doctor checked my CD4 and told me that it was still high, so I could not start the ARVs, I was then prescribed Bactrim.”(Athlete # 7)

“When I became pregnant, I was always sick and I thought it was the pregnancy which was making me sick. I hid my pregnancy for six months and each time my aunt asked me what was the problem, I kept on telling her that I had malaria. So when my pregnancy was known, my aunt advised me to go for antenatal service. So I was tested for HIV during my first antenatal visit and this was the time that I was found HIV positive. The healthcare worker advised me to immediately start taking ARVs in order to prevent passing the virus on to my unborn baby. When I got home, I disclosed my HIV positive results to my aunt who told me that I was born with HIV which I got from my mother and have been living with it all along, and the same applied to my brother who was also HIV positive.” (Athlete # 11)

Dageid et al. (2012) state that disclosure of HIV sero-positive status increases access to PMTCT and care, treatment and support programmes. Conversely, non-disclosure of sero-positive status becomes a barrier to accessing medication and long-term adherence to treatment.

The results of the study also indicate that some of the athletes disclosed their status to their family members as a way of seeking the best treatment from them, as opposed to the situation where family members would take them to traditional healers. They said that family members who knew their HIV status would take them to hospital whenever they got sick, because that was the only solution to their problems as the athletes narrated:

“When I was very sick, my relatives took me to several traditional healers, yet my problem was not related to traditional ailments, but that I had been infected with HIV. So, when I was taken to the hospital, I was diagnosed with HIV. Since then, we do not seek any traditional medicines when I am sick, because the best treatment I can ever get is from the hospital” (Athlete # 8)

“I had to disclose my status to my mother because she is the one who is a caregiver to me, and I knew that if I don’t disclose my status to her it may happen that when I am very sick she may decide to take me to the traditional healers, when the best treatment for me is to go to the hospital.” (Athlete # 3).

4.3.6 Accessing Emotional and Psychological Support

The study revealed that athletes disclosed their status to their friends, family members, spouses so that they could get emotional and psychological support. They perceived their immediate social contacts as a true source of emotional and psychological support. The athletes said that their friendship had improved with friends (mainly childhood ones), when they disclosed their status. It

is suggested that childhood friends have been with them for some years and also in several situations, either good or bad. The study also found that, subsequent to disclosure, most of the athletes experienced great emotional and psychological support from their spouses and family members, specifically mothers and sisters. Athletes had the following to say:

“When I disclosed my status to my family, they encouraged me not to lose hope, because I am not the only one who is HIV positive in the world. They do accept me as one of them, and I see their love, care and support in the way they relate with me every day and I have always been positive on everything I do.” (Athlete # 6)

The feelings, stated above, support the notion that HIV sero-positive status disclosure is likely to be associated with emotional, psychological and physiological well-being of individuals living with HIV. However, if there is inadequate emotional and psychological support, people who disclose their HIV positive status will experience higher levels of stress which will eventually affect their health (Benotsch, Rodriguez, Hood, Lance, Green, Martin et al., 2012).

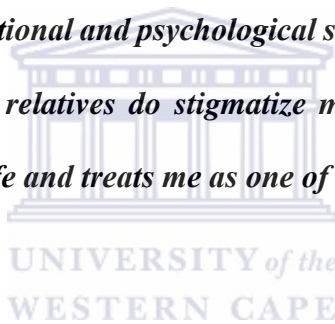
The study further found that if friends were informed about one’s HIV status, there was an improvement in the relationship, as they were more attached and offered to provide some form of support whenever there was a need to do so. This is what was expressed by some of the athletes:

“My friends supported me so much when I disclosed my status. They did not take my status as a thing which should affect our friendship. I have enjoyed their support even more now than before I disclosed my status. They have been a source of encouragement for me, and (my) life is just as normal as anybody else’s.” (Athlete # 8)

“My friends are now friendlier to me than they were before I disclosed my status, and I see this as a very good motivating factor to continue with life as normal.” (Athlete 10)

Most of the athletes reported increased emotional and psychosocial support. This was mainly the case from friendships that were from childhood friends. This meant that the friendship had been existing for a long time and this helped the friendship to be more stable and reliable. As a result, the friends found it difficult to end the friendship based on the difference in the athletes’ HIV sero-status. However, some athletes also indicated that they got more emotional and psychological support from their spouses subsequent to disclosure. As expressed below:

“My husband gives me all the emotional and psychological support such that I don’t feel lonely, despite the fact that some of my relatives do stigmatize me. But, still I have someone who encourages me to live a positive life and treats me as one of his own.” (Athlete # 11)



4.3.7 Preventing Mother-to-Child Transmission of HIV

This study revealed that some of the athletes took part in the PMTCT programme at the antenatal clinics. These athletes explained that PMTCT was a source of encouragement for disclosure of their status. One of the female athletes reported that when she got pregnant, on her first antenatal clinic visit she had a mandatory HIV test (compulsory HIV test specific to pregnant women on public health grounds). Women who tested positive were placed on the PMTCT programme. This is how she explained her experience:

“When I got pregnant, I immediately started attending antenatal care services, and on my first antenatal visit I was counseled to test for HIV, so that if I tested HIV positive, I could start taking ARVs to prevent transmission of the HIV virus to my unborn baby. I was tested HIV

positive and I disclosed it to the nurse who was attending to me. Because I was advised to take ARVs during my pregnancy, I was then lucky to give birth to an HIV negative baby.”(Athlete # 4)

Another male athlete expressed how disclosure of his HIV status to his wife prevented transmission of HIV to his children through his wife’s participation in the PMTCT programme. He said:

“Disclosure of my HIV sero-positive status to my wife has significantly benefited us. I have three children who are HIV negative, because each time my wife got pregnant, she immediately participated in the PMTCT programme. All three children were born after both I and my wife tested HIV positive.” (Athlete # 12)

Despite the positive factors facilitating HIV positive disclosure, the study found that there were also some negative factors which hindered HIV positive disclosure. These included fear of rejection, distressing loved ones, denial, stigma and discrimination.

4.4 Factors Hindering HIV Sero-positive Disclosure

There were some negative factors which hindered athletes from immediately disclosing their status. These included fear of rejection or abandonment, denial of having HIV, stigma and discrimination.

4.4.1 Fear of Rejection or Abandonment

Some athletes did not want to disclose their HIV sero-positive status for fear of rejection, blame, ostracism, and marriage break-up. However, the athletes who were in intimate relationships felt

distressed about concealing their status from their sexual partners, because they thought that if their partners found out about their status by themselves, they would be divorced or mark an end to their relationship as expressed below:

“At first, I did not want to disclose my sero-positive status to my fiancée, because I did not want to be blamed for carrying the virus, but after a second thought I decided to reveal my status. I knew that if I did not disclose my status to him and he found out on his own, he would terminate the relationship for fear of contracting the HIV.” (Athlete # 3)

4.4.2 Fear of Emotional Distress by Loved Ones

Some athletes were not able to disclose their HIV positive status, because they wanted to protect their loved ones from the stress of hearing such bad news. As a result, some of the athletes were not able to disclose their status immediately upon knowing their test results. According to one of the athletes, it took at least a week before she could build up enough courage to disclose her status to her mother, because she was afraid of disappointing her mother with the distressing information. Her statement is quoted below:

“Every time when my mother was asking what my problem was, after she saw a change in my behaviour, it was very difficult for me to tell her my status, because I was thinking about how she would react after getting the news. I knew that my mother would be worried and would also feel sorry for me, yet still I had to make a decision to tell her, because she was the one who would take care of me when I am sick.” (Athlete # 3)

4.4.3 Being in a State of Denial

Receiving an HIV positive result is stressful for many people, as well as the burden of complying with the treatment routine. Some athletes failed to disclose their status, because they were still in

denial, and there was no hope for them living much longer. During the denial period, they would not accept their HIV status and actually went for a retest to confirm whether or not they were infected. Unfortunately, the results did not change, so later they had to accept the results, and then chose to disclose their HIV status, as a way of acceptance. One male athlete had this to say:

“When I was first given my HIV positive test results, I tore the results and did not want to accept the reality of my results, and then I made a decision to go and test at another testing site and the results were the same. After further counselling, I accepted my results and it was not difficult for me to disclose my status.” (Athlete # 12)

4.4.4 Fear of Stigma and Discrimination

In this study, some athletes expressed fear of stigma and discrimination. Their fears were based on the experiences of PLHIV who are generally stigmatised and discriminated against by others in the community. They said that they chose not to disclose their HIV sero-status soon after receiving their HIV positive results, because they felt they too were going to be stigmatised and discriminated against. However, the findings of the study revealed that most of the athletes did not experience stigma and discrimination from the individuals to whom they disclosed. The study indicated that only a few of the athletes experienced some stigma and discrimination, but for a very short period of time, and later they were accepted and supported. The results also revealed that despite a few of the athletes anticipating fear of stigma and discrimination upon disclosure, they were nevertheless encouraged to disclose their HIV status to significant others, especially upon seeing the positive living of members of the HIV support groups in their community afterwards. One athlete expressed her fears as follows:

“At first, I wanted to keep my results to myself for fear of being stigmatised and discriminated against by members of the family and the community. But when I saw that the moment other

people will know that I am hiding my status, then I will be subjected to stigma and discrimination, so I opted to disclose my status after seeing that the members of the support groups were living without any problems even though people knew about their status.” (Athlete # 7)

Another athlete expressed her disappointment in the community’s reaction upon disclosure, and this is what she said:

“In this community, people with an HIV sero-positive status are treated very badly. They are given degrading names which are associated with their diagnosis, that is why I did not want to disclose my status at first, I did not want to be treated the same. However, I later decided to disclose it.” (Athlete # 2)



4.5 Disclosure Process

The results of the study established that disclosure of HIV status to sexual partners, family members, friends or other members of the social network is a stressful task, because one goes through a number of stages to achieve disclosure. This statement is affirmed by what one of the athletes, said:

“When my mother asked me ‘what is your problem? You have not been yourself the whole week. If you have a problem, please tell me.’ I could not tell her, because I did not want to disappoint my mother, so I kept my status to myself for a week.” (Athlete # 3)

Basically, disclosure of HIV sero-positive status is done by using one of two methods, either direct or indirect. In the direct method, the discloser uses either verbal or written communication, whereas in the indirect method the discloser employs cues (Serovich et al., 2006). However, when the benefits outweigh the negative consequences of disclosure, then one is more likely to disclose one's HIV status to significant others. The results of the study indicated that the disclosure process which athletes followed included the following strategies or methods of disclosure, the kind of people to whom they disclosed, and the timing of disclosure from when they knew their HIV positive status.

4.5.1 Strategies/ Methods Used for Disclosing HIV Positive Status

In this study, athletes were asked how they disclosed their sero-positive status to significant others. The study results revealed that most athletes used the direct method of HIV disclosure, in particular verbal communication. The athletes verbally explained their results to the people to whom they disclosed their status, as this was perceived to be easier and simpler. The following were sentiments expressed by some of the athletes:

“I did disclose my status to my superiors, when I was at Bible school, because I knew that it would not be proper for them to know about my status from other people. When I was doing this, my wife was very sick, and I did not want her to be worried with distressful news. But the situation forced me to disclose to her, because she insisted she wanted to know the results of my HIV test.” (Athlete # 1)

“I disclosed to my aunt immediately I came back from the antenatal clinic, where I got my HIV positive results.” (Athlete # 11)

“I disclosed my status two days after I got the results. The first person I disclosed my HIV sero-positive status to was my wife. Actually it was after contemplating between the positives and the negatives of disclosing the sero-positive status that I disclosed it. I managed to tell her because I had been advised to do so by the counsellor at NAPHAM, where I went for my second HIV test.” (Athlete # 12)

However, few athletes used the indirect method of “seeking similar”; as stated below:

“I disclosed my status to Nambewe (not real name) at the HIV support group immediately I came back from the antenatal clinic where I got tested.” (Athlete # 5)

4.5.2 Nature of People Disclosed to

The study results revealed that athletes selectively chose individuals to whom to disclose their HIV status. This was based on their personal preferences, significance and readiness. The study found that most of the athletes disclosed their HIV sero-positive status to their spouses, mothers, sisters, close relatives and friends. When athletes were asked why they chose to disclose their HIV status to these individuals, they reported that they disclosed to these individuals because they perceived more support from them. Below are some of the athletes’ responses:

“When I disclosed my status to my spouse I got all the support, and I also encouraged her to go for test and she was also found HIV positive. Since that time, we have been assisting each other, she needs my support just as much as I need her support. Disclosing my status to my wife was the most important thing I could do, because she is the only person I knew (who) would understand my situation and continue supporting me.” (Athlete # 12)

“I disclosed my status to my mother, my sisters and my cousin. These are the people I stay with, so I wanted them to know my HIV sero-positive status so that they can offer me support. Again, my mother is also living with it [HIV] so it was easy for me to tell her about my HIV status, so that she guides me on how to live positively with the virus.” (Athlete # 2)

The results of the study also showed that some athletes had first disclosed their HIV sero-positive status to their friends, then to their relatives. This suggests that their friends played very important roles in their lives as far as sharing of confidential and important information is concerned. The results also indicated that the friends to whom the athletes disclosed their status were childhood friends who were very close to them and could be trusted.

“I disclosed my status to my best friend in whom I always confided ever since we were children. I did this because I wanted her to give me emotional support, because I was still in shock.” (Athlete # 3)

“I was able to disclose my HIV status to my friends who were always concerned about my poor health before I got tested. I wanted them to know what was making me sick.” (Athlete # 9)

The study found that for young women who disclosed their status to their partners, it turned out that their partners were willing to continue with the relationship despite having a sero-discordant HIV status. This was also observed in all the athletes who were either dating or just recently married as these quotes from athletes demonstrated:

“When I disclosed my status to my fiancée he did not believe it. Then, I asked him to accompany me for another test. We both had an HIV test where the results turned out positive for me and negative for him. He told me that he was still going to marry me despite my status” (Athletes # 3)

“My husband tested negative, (and) I thank God that he does not talk that I am positive and he is negative. He loves and supports me. We live happily, and each time we have sex we use a condom” (Athlete # 4)

4.5.3 Timing of HIV Status Disclosure

This study found that time to disclosure did not really matter, whether athletes disclosed their status immediately after knowing or later. The study results indicated that time to disclosure varied among athletes, with most of the athletes not taking too long to disclose their status, while others took a little longer. Most of the athletes disclosed their HIV status the same day that they got their results, while others disclosed their status after a few days, and still others only after a week. This is what some of them said:

“When I got tested at the antenatal clinic and was told of my HIV positive status, I disclosed my results the same day to my friend, and in the evening I also disclosed to my husband, and the next day I disclosed to my mother. I realised that delaying to disclose the HIV positive results would not change my status and that was the reality of my situation.” (Athlete # 5)

“When I got tested and was told of my HIV status, I was hesitant to tell my mother, because I was afraid that she would be disappointed. I did not want her to be worried. Whenever she asked me about the change in my behaviour at home, I told her that I was okay, that there was nothing wrong. However, after a week I took courage to disclose my HIV status to her.” (Athlete # 7)

4.6 Consequences / Experiences of HIV Sero-positive Disclosure

The results of the study indicated that all athletes disclosed their HIV positive status to at least someone in their social network. The study results further established that there were different experiences of HIV positive status disclosure reported by the athletes. In this study athletes expressed that they encountered both positive and negative experiences upon disclosure, which emanated from the reactions of their spouses, family members, friends, relatives, sexual partners, healthcare providers, members of support groups and others. They further said that the positive reactions were generally reassuring, while the negative ones were demoralising and discouraging, as indicated in these quotes:

“After I had disclosed my status to my mother she told me that I should not worry so much because that was not the end of my life. She said I can still be productive as long as I accept my condition with a positive mind” (Athlete # 7)

“When I disclosed my status to my aunt she did not feel for me, instead she carelessly said that I was born with the virus which also killed my mother” (Athlete # 11)

Based on the analysis of the data, the positive experiences that athletes encountered in this study included having peace of mind and breathing a sigh of relief, unconditional support from partner, family members and community expert clients.

4.6.1 Peace of Mind and Sigh of Relief

The results of the study showed that having peace of mind and/or breathing a sigh of relief were the main positive experiences the athletes experienced after they disclosed their HIV positive status. All athletes in the study were relieved after disclosing their HIV status, especially when individuals they disclosed to reacted positively to their diagnosis. The athletes said that keeping their HIV status a secret and undisclosed was something which gave them much trouble, as they did not feel free until the burden was taken off their shoulders. The athletes also stated that the people who reacted positively were mainly close family members, close friends and HIV support group members who also offered them acceptance, reassurance and various support resources. Some athletes in this study claimed that disclosure was not so much about worrying, but was a way of feeling the relief of sharing sad news with significant others. The following were some of the responses from the athletes:

“When I disclosed my status to my mother I was relieved, because all along I felt as if I had carried a burden and I did not have the peace of mind. Now, I do not have any burden anymore, and I am free to talk to anyone about my status. I am not afraid or ashamed of anything. Disclosure really gives you peace of mind.” (Athlete # 7)

“I felt so relieved after I had disclosed my HIV sero-positive status to my mother. Since then, I have peace of mind.” (Athlete # 3)

"I felt relaxed and relieved of the worries I had about my HIV status, when I disclosed to my wife. She told me not to worry about the condition in which I was, and promised she would be there to support me." (Athlete # 12)

The study also revealed that disclosure helped people to have peace of mind, since now they were at liberty to participate in all activities in the community without fear of being the subject of gossip by other people. The athletes in the study reported that since the community already knew about their status, it was no longer any news. In contrast, people who had not disclosed became the subject of gossip.



4.6.2 Getting Full Support from Spouses, Family, Friends and Others

In the study, it was found that the athletes act of disclosure helped them to get full support in the form of food and money from spouses, relatives and friends during their times of need. Some of the athletes valued the psychosocial support they received from their family, spouses, friends and the community. In addition, some female married athletes reported that their husbands were able to provide financial support such as transport money. To support these claims the athletes had the following to say:

"My husband provides transport money for me when it is time to go and collect my medicines (ARVs) from Queen Elizabeth Central Hospital." (Athlete # 4)

"Because I disclosed my status to the village headman, he always puts my name on the list of beneficiaries for all government programmes, which are aimed at helping the vulnerable groups

in the village. I know that the village headman does this, because he knows of my status and he wants me to benefit all the time, so that I can continue to live positively.” (Athlete # 2)

“As for me, disclosing my status has helped me to have a lot of information about HIV and AIDS. It has also helped me to be enrolled in other programmes which I would not have been enrolled in, if I had not disclosed my status. It has also enabled me to benefit from the fertilizer subsidy programme and the public works programme.” (Athlete # 8)

However, when athletes were asked if they ever got support specifically from their churches or mosques some responded negatively indicating that their religious institutions were non-committal. Responses from two athletes were as follow:

“When I presented my problem to my church pastor about my HIV sero-positive status and also that I needed some support in the form of food to boost my nutritional needs, he just told me that he had heard it and that he would do something about it. Unfortunately he has never done anything up to this day.” (Athlete # 5)

“I don’t get any support from the mosque, maybe because I have not disclosed my status to the Sheik, but still other members know about my status and they have never asked what support they can give to me.” (Athlete # 3)

The results also revealed that a few athletes were able to get support from some individual members of the church. Some athletes stated that they received support in the form of encouragement through spiritual counselling, while others reported that the church and other individuals provided financial and material support whenever they were in need. One athlete who was receiving support from members of her church had this to say:

“There is one family in my church that has been supporting me financially. They have asked me to go back to school and finish my secondary education and they have also promised to pay the fees for both me and my baby who will be staying at a day-care centre when I am at school.”

(Athlete # 11)

Another athlete reported that to excel in sporting activities one needs to have complete health and well-being, and an individual must be emotionally, socially, physically and spiritually well. He further said that undisciplined athletes are not respected. As a result, they cannot be perceived as role models. Consequently, they fail to reach greater heights in their careers, since people become reluctant to give them support. This has been explained by an athlete in the extract below:

“As a church secretary, my church has always been supportive of me, and whenever I have a problem with my health they assist me, and this enables me to continue with life. As an athlete, I need to be good spiritually, because when you are spiritually well you are well-disciplined, and every sport needs athletes who are disciplined.” (Athlete # 12)

Disclosure appeared to help some individuals benefit from other programmes that target vulnerable populations in the community. Some athletes reported that they had benefitted from state-funded projects such as the farm-input subsidy programme in which farmers buy fertilizers at reduced

prices, and the public works programme and income generation project in which members work for money provided by government through donor funding and social cash transfer schemes, as explained below:

“I am among the community members who benefit from (the) farm-input subsidy programme.”

(Athlete # 2)

“My village headman registered me for (the) social cash transfer scheme and I am benefiting a lot from this project.” (Athlete # 8)

4.6.3 Community Expert Clients

This study revealed that disclosure also makes the individual have a certain advantage over their peers, as they become sources of information on issues dealing with HIV and AIDS. The athletes reported that they helped many people after disclosure than they had ever helped before. Using their personal experiences and testimonies helped other people access HCT services and, subsequently, to enrol in treatment and support services available in the community for PLWH.

This is what some of the athletes had to say:

“What I can say is that I am an expert on HIV and AIDS in the community. We are the source of information, and we also use our personal experiences and testimonies as a way of bringing many people to treatment care and support services. You can be surprised to know that other people who are more educated than we are do come to us and ask us on issues of HIV and AIDS, especially on positive living, drug adherence, side-effects and how to make disclosure.

Therefore, we help them without being selective, as we are happy to do this work.” (Athlete # 8)

“I do not take my status as a burden, but as a ministry. Wherever I go, people come to me whenever they have problems concerning HIV and AIDS. Mostly people want to know how they can publicly disclose their status and also how they can access several health services which target PLHIV like PMTCT, HAART and early infant diagnosis.” (Athlete #1)

“As someone who has lived with the HIV for quite some time, people come to me for guidance if they want to know how they can cope with HIV or when they are not sure of the signs which they have or which their relatives have which they suspect are HIV-related. What I usually tell them is that they should go for testing, and when they are ready for treatment they should adhere to treatment, and with that people are being helped and I am happy that I can assist in saving lives.”(Athlete #12)



4.6.4 Reduced Stigma and Discrimination

The study revealed that there were positive experiences which athletes experienced when they disclosed their HIV positive status to others. Despite all the fears of stigma and discrimination which they originally had before they disclosed their HIV positive status, it turned out that the moment they disclosed their HIV status they experienced very little stigma, which did not affect them very much. One athlete expressed her sentiment as follows:

“When I disclosed my HIV status to my best friend, she immediately changed her behaviour towards me and she started ignoring me and she did not want to be close to me. She continued like that for a while and later she came back to me and apologised and said she still wants to

continue being my friend. This time she is one of the people who are always on my side to support me and our friendship has been stronger than before.” (Athlete # 3)

Some athletes also reported that when they disclosed their HIV positive status to others it helped other people stop making fun of PLHIV whether jokingly or in stories, as their mere presence would not allow for such derision in a group.

“I had the courage to disclose to my friends, because I saw that my friends had a negative attitude towards PLHIV, and when they were ridiculing PLHIV I felt very bad, as if they were talking about me personally. Then I disclosed to them that I am one of them. My friends were sad that they had broken my heart unknowingly. This was a turning point for my friends as they stopped stigmatising and discriminating against PLHIV.” (Athlete # 5)

4.6.5 Love and Acceptance

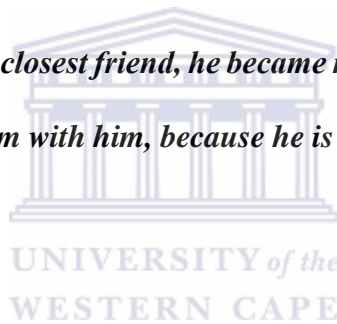
This sub-theme describes how some study athletes felt after disclosing their HIV positive status to members of their social network. The athletes reported that their spouses, sexual partners, family members, friends and others in the community demonstrated a spirit of love by accepting them. This attitude also made them become positive about PLHIV. The athletes mentioned that they saw themselves as having a purpose to fulfil in life, which motivated them to cope with their HIV positive status. These were the expressions made by some athletes:

“When I disclosed my HIV positive status to my wife, I was so surprised that she responded in a calm and loving manner. She told me not to worry because it has happened, and assured me that she would always stand by me.” (Athlete # 12)

“After my fiancée learnt about my HIV positive status, he told me that he still loved me and would marry me, despite my HIV status.” (Athlete # 3)

“My mother and all my sisters are very loving and caring, they avoid talking about my HIV status, and they treat me normally and I sometimes forget that I am living with HIV. I don’t know, but sometimes I think that maybe my mother is doing all this, because she is also living with HIV.” (Athlete # 2)

“When I disclosed my status to my closest friend, he became much friendlier than he was before. I feel loved and accepted when I am with him, because he is very encouraging and supportive.” (Athlete #9)



The athletes reported that the love which they got from their spouses, friends, family members and others in their communities was a source of strength and a reason for them to live with a positive mind-set.

4.6.6 Psychosocial Support

Most athletes reported the positive consequences of disclosure of their status, which included accessing psychosocial support from those to whom they had disclosed their status. The following were some of the responses from the athletes when they were asked about the consequences of disclosing their status:

“When I disclosed my HIV status to my employers they helped me by providing me with some special diet. They also told me that whenever I had a problem I should tell them so that they could help me.” (Athlete # 6)

“My friends have been very supportive of me. Whenever I have a problem, they come and help me; they really care about me; they encourage me to focus on my future and I have never been discouraged. This has helped me to cope very well living with HIV.” (Athlete 9)

4.6.7 Positive Living with HIV

The study findings showed that athletes who were members of PLHIV support groups were able to cope better with HIV, because they had access to group therapy where they could share their experiences and have access to material support from other well-wishers who assisted the support groups from time-to-time. PLHIV support group members were able to organise themselves into groups, where they could form teams and participate in sporting activities in order to involve those who were not athletes and did not participate in sports. A vast majority of athletes indicated that participating in sports promoted good health and wellbeing of people of all ages and of different HIV statuses. Therefore, they found it necessary that all members of the support group participated in sporting activities. They further revealed that support groups played a vital role in the sense that they provided a platform where they (PLHIV) could advocate and fight for their rights.

“I don’t care what people may say about me whenever they see me at the support group, because what I know is that I am healthy and I know how my body is. But there are some people who are busy talking about other people, yet they do not know their own status. I accepted that I am HIV positive and nothing can change that, therefore I should not stress myself but rather have peace of mind.” (Athlete # 8)

“At the support group, we share our problems freely and help each other solve these problems; we have spiritual sessions, where we dedicate our lives to God trusting that he is with us and will see us through our lives. There are health education sessions on HIV that we share at support group. At times, we are also given food stuffs like maize, soya beans, cooking oil and other things to boost our health status.” (Athlete # 4)

“I have benefitted a lot in being a member of the support group, because I know that I am not alone and also that when I have a problem, I share it with my friends who are there to help me using their personal experiences.” (Athlete # 3)

“Knowing and disclosing my status has enabled me to plan my future. I have managed to send my children to school, my siblings have attained tertiary education, I have opened a business for my wife, I am doing a course to upgrade my career, I have built two houses and I am planning to build a third house. I am doing this for the sake of my children and wife’s future.” (Athlete # 12)

Despite all the positive consequences and experiences that athletes living with HIV experienced after disclosing their HIV status, the study found out that there were also negative consequences / experiences which athletes reported. The negative consequences are outlined in the section below.

4.6.8 Unfriendly Healthcare Staff

Most of the athletes complained about the unfriendly behaviour of some nurses at the hospital where they received their ARVs. They reported that in most cases they were shouted at and

ridiculed by nurses without just cause. In some instances, they had been sent back home without getting any treatment, only to be told that they came late for treatment and could not be provided with any services. The following are some of the sentiments from the athletes:

“Some healthcare workers are not friendly to us (PLWH). They ill-treat us and talk a lot of bad things about our HIV positive status like “anthu amayunitsiwa amatopetsatu pena” (These people who come for their ARVs can be bothering sometimes). In some cases we are sent back without receiving any treatment or drugs (ARVs), and the healthcare workers claim that we have been late.” (Athlete # 8)

“When we go to the hospital to collect medicine (ARVs) we find some nurses who ill-treat patients. Sometimes we are sent back because they say we have come late and yet they are the ones who start attending to us late.” (Athlete # 2)

“We go to the health centre very early in the morning, and after a few people are served, the nurses start complaining that they are tired and cannot continue with the other remaining clients. Sadly, we are asked to go back home without receiving any treatment and the reason is that we came late. Just imagine a person who has walked all the way from home only to be told that she or he is late when she or he arrived at the health centre before the opening hours.” (Athlete # 9)

The results also indicated that sometimes the nurses would be chatting with their friends during working hours instead of attending to the clients, and this negative behaviour frustrated many athletes very much. Athletes stated that they had to wait long before they were attended to. This

kind of behaviour also raised barrier in treatment adherence, because the athletes were kept waiting the whole day for services at the health facility on empty stomachs and, therefore, failed to follow the pattern of taking their tablets (ARVs) regularly. This is what some athletes had to say:

“Some nurses arrive at the clinic late, say 08:00 am or 8:30 am, they go and chat with fellow nurses not considering that we have been there from 06:00 am in the morning, and when we ask them to start attending to us they often display their anger towards us. They lose their temper and ridicule us.” (Athlete # 11)

“I think it will be better if we were to be attended to by nurses and doctors who have passion for us PLHIV or those who are also living with HIV, because they know how it feels to be HIV positive. The other staff does not care about us, they make us wait forever to be served without eating anything and, eventually, fail to take our tablets for the day. It is worse when you are sent back home without receiving your ARVs, because the next day you have to come and stay the whole day and so how can one adhere to treatment?” (Athlete #3).

4.6.9 Stigma and Discrimination

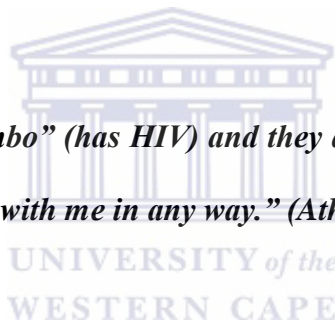
In the study it was found that some athletes experienced stigma and discrimination, though it was not consistent, and in some cases they were able to come to terms with those who had stigmatised them, as some of the athletes explained below:

“Yes, I really got ex-communicated from the church, because as someone who is living with HIV, I wanted to benefit from the church welfare fund in order to survive, since I am not working. However, I was misunderstood and the pastor and other members of the church who

thought I was using my status for some personal gains. Then I was ex-communicated and now I am with another church.” (Athlete # 1)

“Some of my teammates would not allow me to wear the jersey (sports attire) for our team. They think I can contaminate them with HIV. I still want to be playing in my team and, so I bought my own jersey, which I use. In some cases, when I am at school some of my classmates refuse to use the same writing pen I use or borrow me other pens when I want to use theirs.” (Athlete #9)

“My cousins call me “wakachilombo” (has HIV) and they also call me names and don’t want to be playing with me or associate with me in any way.” (Athlete #6)



“Most of the times, my aunt and my uncle do not give me enough food, and at times they don’t give me any food. They say giving food to me is a waste, because I am already dead. They also want me to go and be taken care of by my mother in-law.” (Athlete #11)

4.6.10 Lack of Support

This study showed that some athletes did not receive any support after disclosing their status, because other people did not see them as being of any value in the community. Some athletes also said that in some cases they were not benefitting from government social safety nets, like receiving coupons for subsidised fertilizers, the Income Generating Public Works Programmes and the

Social Cash Transfer Scheme, because they had disclosed their status and the village headman would take them as people who could not do anything meaningful. Below are statements made by some of the athletes:

“When I presented my problem to my church pastor about my HIV sero-positive status and also that I needed some support in the form of food to boost my nutritional needs, he just told me that he has heard me and that he would do something about it. Unfortunately he has never done anything up to this day.” (Athlete # 5)

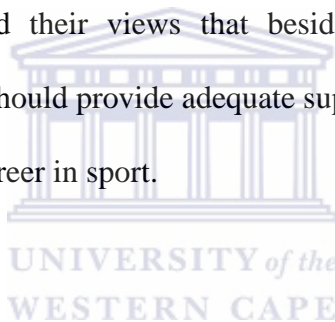
“When I asked the social welfare committee responsible for church funds to be paying me on time, so that I should be able to buy foodstuffs in good time for the sake of my health, I was told that I want to be using my status to win support from other people. They tortured me so much and this really affected my health, and for the first time my CD4 count went below 100. It really affected me.” (Athlete # 1)

“My name was removed from the list of beneficiaries in the subsidy programme because they thought I would not be able to put the fertilizer to good use as I am living with HIV.” (Athlete # 7)

“I am not benefitting from government social safety nets, like coupons for subsidised fertilizers, Income Generating Public Works Programmes and the Social Cash Transfer Scheme, because I disclosed my HIV positive status and the village headman thinks I am someone who cannot do anything meaningful.” (Athlete # 4)

4.7 Lack of Appropriate Support Systems

The study results revealed that there was lack of appropriate support systems for athletes living with HIV after disclosure of their status. The athletes reported that inadequate support from relevant individuals in the health sector, as well as a lack of support from health and sports organisations was a source of great frustration to their health and career. They reported that in most cases they failed to maintain the requisite health standards, due to poor services provided by healthcare staff. They also failed to excel in their sports performance, due to poor sports facilities and inadequate equipment coupled with a lack of instrumental support from government and the private sector. Athletes expressed their views that besides government, organisations and institutions that deal with PLHIV should provide adequate support to athletes who are living with HIV in order for them to build a career in sport.



4.7.1 Lack of support from sports insitutions

Athletes also lamented on the lack of a support mechanism from the Malawi National Council of Sports, its affiliates and clubs. Athletes had the following to say:

“The Malawi National Council of Sports should also get involved in encouraging athletes to come out in the open and disclose their HIV status, especially those who are elite in the society. This will help to come up with ways on how to support athletes living with HIV.” (Athlete # 6)

“I think (a) lack of support from sports organisations indicates that they do not have specific programmes designed for athletes living with HIV on their agenda. Because in all the sporting

events I have participated, nobody from the Ministry of Sports, Sports Council or sports clubs has ever addressed athletes on issues concerning HIV/AIDS, let alone disclosure of HIV positive status.” (Athlete # 12)

4.7.2 Lack of Good Sports Facilities and Equipment

The study revealed that all athletes indicated a lack of suitable facilities and equipment which deterred them from performing well in sport. They reported that sports facilities and equipment which they used was in poor condition and did not meet the required standards. As a result, this negatively affected their performance. The study athletes, who participated in track and field events, specifically cross-country, revealed that they encountered harsh conditions during the regional and national competitions. The running routes which they used were not user-friendly, and were mostly located in the bushes. Athletes complained that they were bruised by the shrubs, thorns and tall grasses. This is what they had to say:

“I really don’t understand why the sports officials for the Athletics Association of Malawi fail to have our welfare on their agenda. The facilities that we use are hazardous to our lives. They prepare a route in the bush for cross-country competitions and so you can imagine running on bare foot in the bush, where even snakes can bite you.” (Athlete # 3)

“What I want to see is the Malawi National Council of Sports getting involved in supporting athletes with much needed sports equipment for all sporting codes, because that will help to improve their performance and (help them) reach greater heights in the sports world.” (Athlete # 6)

“The 2014 National Cross-Country Championship held at Njamba Freedom park on the 11th January was another bad experience in my life as an athlete. We were made to run on the route which was bushy, unmarked and without officials at check points to guide us. I participated in this event, because I had prepared for it, otherwise it was better for me not to participate. Look at this wound, (points at the wound under his left foot) it is the result of that championship. Sometimes we are treated as animals not as human-beings eish!” (Athlete # 12)

“Due to a lack of sports equipment, we sometimes improvise so that we are able to do trainings in preparation for local competition.” (Athlete # 11)



4.7.3 Poor Treatment and Nutrition.

The study athletes reported that they experienced poor treatment whenever they became sick, due to shortages of medicines in many of the health facilities. Concerning nutrition and an appropriate diet, they said that they did not manage to have a well-balanced diet, because of a lack of financial resources. The following were sentiments from some athletes:

“The health centre has no malaria drugs, so we are advised to buy from private clinics. Sometimes we are given panadol for malaria treatment.” (Athlete # 11)

“We hardly manage to eat a well-balanced meal, as advised by the clinicians, because my husband does not earn enough money to buy a variety of foods. So, we eat whatever is available to fill the stomachs.” (Athlete # 4)

4.7.4 Shortage of Healthcare Staff

The study found that a majority of the athletes preferred to receive their medication and treatment at Queen Elizabeth Central Hospital in the city of Blantyre. Athletes reported that they perceived this health facility as the best in treating PLWHA. The findings also indicated that due to the increase in the number of infected people, it was difficult for the staff to satisfactorily deal with everyone. The shortage of staff was a universal call reported by all athletes. The athletes reported that they woke up at four or five in the morning for the health facility that opened at 7:30 am, and sometimes they were sent back home without being attended to, due to the large numbers of people seeking medical attention at that health facility. This is what athletes said:

“At the health centre where I receive the ARVs, there is always one nurse who checks our records on the old computer which takes time to display the information, and sometimes it freezes or fails to respond and this makes us to wait for so long, before we are referred to the treatment room or the section where we collect our medication. Now, due to inadequate health staff and a lack of proper equipment, we are disadvantaged because we have to wait for a long time before we are attended to.” (Athlete # 2)

“Imagine, we go to the clinics at four or five in the morning and queue for hours without being attended to until at about two in the afternoon and sometimes we are sent back home not being seen at all, because nurses complain that they are tired. This happens because the hospital is under staffed, and yet there are lots of people who seek the health services. My appeal to the government is to train more healthcare workers so that people can be able to access medical services.” (Athlete # 9)

4.8 Unknown HIV Status

The study found that majority of the study athletes reported that they delayed finding out about their status and that could have also contributed to contracting the virus and /or HIV re-infection, since they were sexually active. It is argued that people with unknown status are more at risk of HIV infection or re-infection through unprotected sex, needle sharing and failure to enroll for PMTCT (Medley et al., 2004).

4.8.1 Delayed HIV Diagnosis

In this study, some athletes reported that they delayed testing for HIV, because they did not suspect having contracted the virus, since they were not active sexually. It was only when they started to experience frequent sicknesses that they decided to test for HIV. These were the athletes who were born with HIV, which meant that the infection was transmitted to them from their mothers either through delivery or breastfeeding. However, some athletes said that they feared knowing their HIV status because they anticipated positive results, based on some risky behaviour which they once involved themselves in or their spouses. These are some of the narrations:

“I was born with the virus but it took me time to know my status because my care givers did not tell me that I was living with HIV. So when I was frequently getting sick, I thought of having an HIV test and the result was positive.” (Athlete # 9)

“The reason I delayed to get tested was fear of knowing my HIV positive status because I was suspecting to have been infected with HIV because of the risky behaviour of my husband. So it

was until I got pregnant that I went for HIV test at the antenatal clinic and I tested positive.”
(Athlete # 5).

4.9 Summary

This chapter presented the results of the study exploring the athletes' experiences in disclosing their HIV positive status. The results show that HIV positive status disclosure is a stressful and difficult process for HIV positive athletes. The athletes described peace of mind and feeling a sense of relief as positive experiences, while stigma and discrimination as negative experiences. The study found that while, on the one hand, disclosure of positive sero-status has positive consequences which include psychological support, reduced stigma, and living positively with HIV, on the other hand it has some negative outcomes which include stigma and discrimination. These were discovered to be the major barriers to HIV status disclosure. This chapter concluded by stating that although disclosure carries with it negative consequences, the benefits of disclosing one's HIV positive status still outweigh the negative outcomes.

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.1 Introduction

This chapter discusses the results of the qualitative study which was an exploration of the experiences of athletes living with HIV following disclosure of their sero-status. The discussion is in line with the purpose, objectives and the conceptual framework of the study. The study has revealed substantial information on the daily experiences of athletes living with HIV. The use of the qualitative approach in this study enabled the athletes to disclose real and personal information, despite it being a sensitive part of their private lives. The twelve (12) athletes in this study who were selected from two HIV support groups in Ndirande Township revealed that athletes living with HIV encounter many real and often serious challenges upon disclosure of their status. However, many athletes in this study revealed that there were factors that prompted them either to disclose immediately or to disclose at a later stage. Their decision to reveal their HIV status was based on the anticipated responses from their “significant others” and related to potential positive and negative consequences. Therefore, the athletes selectively chose to disclose to some individuals and not to others.

The chapter discusses the results that emerged from the face-to-face individual in-depth interviews. The discussion is supported by studies in the area of HIV testing, disclosure and the consequences of disclosure. Due to a lack of literature on athletes and HIV disclosure, this has impacted on the quality of the discussion, since the area is underexplored, as indicated in the statement of the problem. The chapter also presents the conclusion and recommendations based on the results of the study.

5.2 Discussion

The conceptual framework based on the consequences of HIV status disclosure model which was used in this study indicates that there is a strong relationship between disease progression and disclosure of HIV positive status. However, from the results of this study, none of the athletes disclosed their positive sero-status because of disease progression. From the results of this study, apart from HIV disclosure, knowledge of HIV status is essential for the athletes. The pattern of the athletes' behaviour leading to disclosure of their sero-positive status and its consequences is summarized in the figure below:

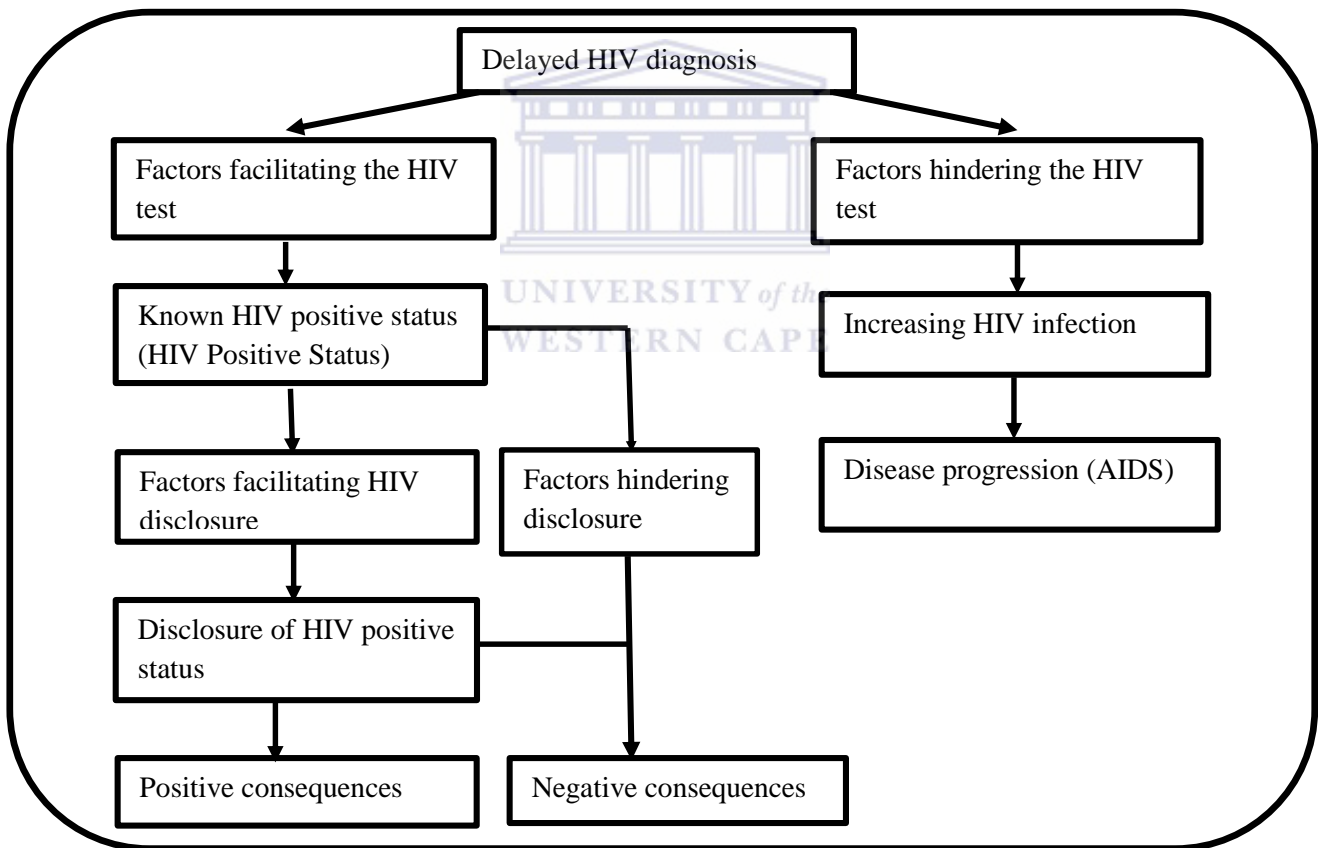


Figure 5.1. HIV Sero-positive disclosure pattern

Adapted from Consequence of Disclosure Model by Serovich (2001).

The HIV disclosure pattern for athletes, illustrated in Figure 5.1 above has the following key features: delayed HIV diagnosis, factors facilitating disclosure, factors hindering disclosure, disclosure of HIV status, and consequences and/or experiences of HIV disclosure.

5.2.1 Delayed HIV Diagnosis of Athletes

The results of this study show that some athletes went for HIV testing, because they experienced frequent sicknesses, which made them seek medical attention. It is essential that athletes go for HIV testing as part of good practice, the same way they go for anti-doping testing. This will help reduce the risk of HIV infection and re-infections and enable them to adopt healthy lifestyles (Sisay et al., 2014).

High profiled athletes are perceived to be at higher risk of HIV infection due to their public persona, thereby attracting “groupies” willing to satisfy their sexual needs (Buckley, 2012). It is argued that, for male athletes, beautiful women are often within reach while, for female sports stars, they have increased access to a variety of fashionable and “well-to-do” men in their social networks (Buckley, 2012).

Some of the female athletes in this study were obliged to go for HIV testing, as a requirement for PMTCT. This implies that HIV testing is not necessarily a common practice amongst athletes, and that some athletes delay going for HIV testing because of fear of the negative consequences. A delayed HIV diagnosis may force some athletes out of their professional sports careers, if the disease progression continues to AIDS (Keyser, 1999).

Some high profiled athletes, for instance, Magic Johnson were not influenced by poor health status to get tested. Rather, in Magic Johnson's case, he was diagnosed HIV positive during a routine health check-up, as a part of good sports practice for a high profiled athlete (Araton, 2011). According to The Daily Mail Reporter (2013), Magic Johnson had access to the best doctors who assured him that new expensive drugs would improve and prolonged his life, and millions of others. The willingness of Magic Johnson to "go public" with his HIV status set a precedent of good sports practice by high profiled athletes.

On the contrary, Greg Louganis, another high profiled, olympic athlete, took about six years to disclose his HIV status to the general public (Martinez, 2013). He felt obliged to disclose his HIV status to his coach, because of the side-effects of the medication on his rigorous physical and mental training programme (Keyser, 1999). The concealment of Greg's HIV positive status for many years portrayed an example of bad sports practice of a famous athlete as a role model for upcoming athletes. Therefore, athletes should be advised, while they are still strong and in good health, to seek voluntary counselling and HIV testing in order to access the benefits of early HIV detection and treatment (Kovacic, 2008).

The results of this study show that it is currently rare for athletes to discuss HIV and AIDS or engage in related programmes within sports clubs and institutions, especially at the onset of infection. It is argued here that a well-planned HIV/AIDS awareness programmes within sports clubs and institutions implemented during training schedules, local or regional games and competitions would help athletes to access specific information on HIV and AIDS that is relevant

to their profession and circumstances as well as play active roles in HIV and AIDS awareness (Nyasa Times, 2013).

5.2.2 Factors Facilitating Disclosure of HIV Sero-positive Status

The results of this study reveal the following factors which facilitate disclosure of HIV sero-positive status: promoting HIV and AIDS awareness, encouraging sexual partner testing for HIV, negotiating for safer sex encounters, benefiting from material and/or financial support, accessing treatment and healthcare services, accessing emotional and psychosocial support, and PMTCT of HIV.

5.2.2.1 Promoting HIV/AIDS Awareness

The athletes reported that they revealed their HIV sero-positive status to provide public awareness on HIV as part of HIV awareness interventions in their community. This was thought to be important, as some individuals in the community still believed in unfounded myths which facilitated HIV transmission, such as the virgin cleansing myth, that a man can be cured from HIV/AIDS by sleeping with a virgin girl or an albino woman. According to Thuku (2011), this myth has been propagated by some traditional healers and has left young girls vulnerable with an increase in the incidence of incest, rape and other forms of sexual abuse.

The study also found that for PLHIV who had disabilities, disclosure of their status helped them to fight misconceptions, myths and beliefs associated with people with disabilities (PwD). One of the athletes, with a disability, stated that she had been offered money by rich men to have sex with them, because they believed that sex with PwD, such as an albino, cures and cleanses one of HIV.

This is most disheartening, because they are thought not have a sex life and are therefore free of HIV infection, (Wickenden, Nixon & Yoshida, 2013). This misconception is contrary to the findings from a Malawian study which revealed that an estimated 76% of people with disabilities reported to have been sexually active (Munthali, Mvula & Ali, 2004). Therefore, PwD are equally likely to contract HIV infection through unprotected sexual intercourse, since they also have a sex life.

In the same vein, Grimes (2012) indicated that men believed that going to bed with an albino woman would cure them of the virus. Consequently, a number of albino women were reported to have been vulnerable to sex exploitation, due to this misconception (Grimes, 2012). Similarly, a study conducted by the Federation of Disability Organisations in Malawi (FEDOMA), revealed some claims and beliefs within Malawian communities that if a PLHIV had sex with PwD that the person would be cured of HIV (Munthali, Mvula & Ali, 2004).

These claims concur with what the athlete in this study reported on the virgin cleansing myth. In trying to express her concern about the misconception which people have on HIV and albinism, the athlete thought it was very appropriate to clear this misconception by disclosing her positive HIV status. She also stated that she was influenced to come out in the open and disclose her seropositive status, so that men who believed in the virgin cleansing myth would know that even women with a disability, such as albinism, can also contract HIV despite their disability. The essence of disclosing her status was also to protect younger girls with disabilities, particularly albinos, from being raped.

Due to misconceptions, many women and young girls with disabilities have become victims of sexual abuse (Hanass-Hancock, 2009). There is a need therefore, to educate people on the fallacy of virgin cleansing myth, so as to minimize HIV transmission and rape cases among PwD.

All athletes in this study reported that at some point in time they had revealed their HIV status to the members of HIV support groups and to other people in their communities, at school and at work places as a way of creating awareness for others. Most of them, however, were not able to reveal their positive HIV statuses to fellow athletes and officials in the sports arena. This was because the sports clubs and institutions did not provide conducive environments for athletes to disclose their sero-positive status. In most cases sports clubs and institutions did not provide informational and educational platforms where athletes could discuss issues related to HIV and AIDS disclosure, as well as share health messages with fellow athletes and coaches. Nevertheless, the Football Association of Malawi (FAM) in collaboration with UNAIDS Malawi launched an HIV awareness “Protect the Goal” campaign to promote major HIV prevention and treatment messages among under-17 year-old soccer players across the country (Nyasa times, 2013). This awareness campaign, however, was inadequate, as it was specifically designed for youth soccer players and soccer fans, but not for other athletes.

5.2.2.2 Encouraging Sexual Partner Testing for HIV

In this study, encouraging spouses and /or sexual partners to test for HIV was another factor that influenced disclosure of HIV sero-positive status. The athletes expressed concern that it was unfair if one knew one’s HIV positive status and still deliberately chose to hide it from one’s sexual partners. This would result in HIV infection or re-infection of the sexual partner and also delay accessing treatment, care and medical services, thus exposing oneself to the risk of opportunistic

infections resulting into disease progression. For athletes re-infections and disease progression would negatively affect their health and performance and, hence, prevent them from continued sports participation.

This corresponds with the action taken by Magic Johnson following his HIV positive result, where he disclosed his HIV status to his wife, who was pregnant then, and was obliged to go for an HIV test (Daily Mail Reporter, 2013). This suggests that there is the possibility of preventing HIV infection among sex partners, when there is early HIV diagnosis and disclosure. Similarly, Brown, Miller, Kamanga, Nyirenda, Mmodzi, Pettifor et al. (2011) indicated that sexual partners of persons with newly diagnosed HIV infection should go for HIV counselling, testing and, if necessary, access treatment. In this study, the athletes who were married or in serious relationships indicated that they had to disclose their statuses. This was done as a way of making sure that their sexual partners had the opportunity of getting an HIV test in order to avoid contracting HIV infection and as a means of accessing preventive measures, such as condom use.

The Consequence of HIV Disclosure Model of Serovich (2001) indicates that disclosure does not only happen when there is disease progression or perceived benefits or negative consequences. PLHIV can disclose their HIV positive status to those who pose little risk and avoid those who can harm them. Athletes in this study perceived it as an obligation to disclose their status to their significant others. The athletes' expressions on disclosure as a way of encouraging their sexual partners to get an HIV test show that they were undoubtedly being responsible for the lives of their spouses and sexual partners. Hult et al. (2012) argue that individuals who disclosed their HIV

status to sexual partners and spouses perceived it as a moral responsibility in protecting their partners and not only as a means of support.

5.2.2.3 Access to Emotional, Psychosocial and Material Support

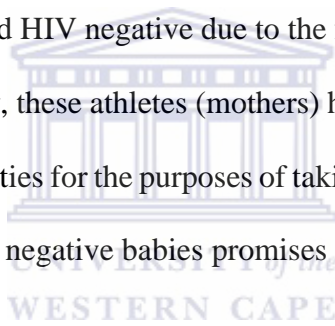
The study results indicated that most of the athletes were encouraged to disclose their HIV positive status, because they wanted to get access to emotional, psychosocial and material support services which was offered by spouses, friends, family members and support groups in their community. The emotional and psychosocial support that they obtained were in the forms of psychological counseling sessions, reassurance, health education on how to live positively with the virus, and being a part of the community of PLHIV. The material gains were humanitarian gestures, like receiving food parcels and other commodities, such as sugar, soap and paraffin. This psychosocial support highlights the role of the family in offering support and providing security, especially considering the imperfect propagation of formal social security mechanisms (Ssali, 2010). Similarly, Gonzalez (2011) reported that one of the high school athlete's living with HIV had substantial support from family members who knew her status. Moreover, her mother was more supportive and could even confront the stigmatizing attitude directed to her from people in their social network. Plaschke (2011) reported that Magic Johnson experienced great support from his wife, such that they prayed together and his wife vowed never to leave him, and that they would fight the virus together. Interestingly, they have remained a strong couple up until today, more than twenty years later. This suggests that substantial support positively impacts on the health and well-being of an athlete, no wonder Magic Johnson was able to come back on court and play impressively for two more years before finally retiring from competitive basketball (Keyser 1999). In the report by David (2013), the support services helped to empower a female athlete living with HIV in Guyana. The athlete was able to maintain her health through regular and

consistent uptake of medication and diet. Furthermore, she was able to regain her strength and won first place in a Regional Emancipation Day Championship Race. With the support she received, she was motivated to positively pursue her future in athletics, since she remained healthy (David 2013). This suggests that there is an association between the performances of athletes living with HIV and their support systems that impact on their continuation in sport as a career.

The results of this study also showed that athletes had revealed their HIV positive status to members of the HIV support groups in their community and thereafter, joined the group as members. However, these were the only support groups that athletes could join, since the sports institutions did not have support groups in place for athletes living with HIV. The significance of the support groups has been endorsed by UNAIDS (2011) as valuable approaches in moderating the psychosocial effects of an HIV positive diagnosis, providing information to PLHIV on how they can disclose to their partners, and offering therapeutic platforms of emotional and educational support for newly diagnosed HIV positive individuals (Hardon et al., 2012; Snyder, Wallace, Duby, Aquino, Stafford, Hosek, et al., 2014). Consequently, the adequate support (emotional, psychosocial and material) given to athletes living with HIV by spouses, friends, family members, community and support groups can create a platform to positively impact the promotion of HIV disclosure and curtail delays that may cause a deterioration in one's health. Sports institutions should help athletes form their own support groups so that their common experiences and problems can be easily channeled for appropriate solutions.

5.2.2.4 Prevention of Mother to Child Transmission of HIV

In the present study, gaining access to a PMTCT programme was one of the factors that facilitated disclosure of HIV positive status. The ultimate objective of the PMTCT programme is to prevent transmission of HIV from the mother to the unborn baby either during pregnancy, birth or the breast-feeding period (WHO, 2010b). Some female athletes reported that they had their HIV test done when they were pregnant. This was done at the antenatal care clinic and they immediately disclosed their HIV positive status to the nurses who were attending to them soon after getting their test results. The disclosure of their HIV status enabled them to register for the PMTCT programme in order to access the medical care services, including antiretroviral drugs for the prevention of vertical transmission of the virus to their unborn babies. Babies born from these athletes were reported to have tested HIV negative due to the fact that there was proper adherence to PMTCT practices. Consequently, these athletes (mothers) had more time for sports, as they did not have to stop their sporting activities for the purposes of taking care of their HIV positive babies. More importantly, the birth of HIV negative babies promises an HIV-free future generation.



Roxby et al. (2013) found that the decrease of infant HIV infections through PMTCT protocols on one year infant HIV transmission risk was 7% with 10 infant infections out of 143 live births. This clearly indicates that PMTCT programmes are essential in the fight to reduce HIV transmission from mother-to-child. Similarly, David (2013) reported a female athlete who became pregnant and tested HIV positive during an antenatal care appointment. The athlete believed that having HIV meant the end of her career, especially since she was also unaware of how to maintain her health and that of her child. Fortunately, she was referred to Hope for All for HIV care and support services. It is therefore, advisable that HIV testing on female athletes should not be done only when they become pregnant, but also for health reasons. This will help them get into treatment

routines as early as possible, and minimize the chances of suffering from AIDS and, possibly, help them keep their sport careers. In addition, they should also develop routine health checkups for certain diseases, such as cancer of the cervix and breasts, which are common among women.

However, there are some barriers to the PMTCT programme which may fail to achieve the core purpose of the programme. Roxby et al. (2013) found that mothers diagnosed with HIV at antenatal care clinics face challenges in disclosing to their male partners. This could possibly be due to the fear of negative reactions, especially when their husbands were violent. Njunga and Blystad (2010) provided some insight into the conflict in that the PMTCT counseling and information sessions were done mostly in the absence of men (husbands) that resulted in shock, fear and denial on the part of the men. This created a difficult situation for couples to conduct a collaborative dialogue, especially when related to infant (baby) feeding options. Njunga & Blystad (2010) and Roxby et al. (2013) provide a deeper understanding of how PMTCT programmes could be used to reach beyond expectant women, and possibly involve other parties who can be of significance in the promotion of PMTCT programmes.

Roxby et al. (2013) proposed that men should be included in the PMTCT programmes in order to allow male partners to test for HIV which could help reduce transmission of the virus in sero-discordant couples. This could eventually help decrease the rates of maternal and infant infections through prevention of HIV infection in pregnancy. In addition, this could help pregnant athletes not to shoulder the burden alone, or suffer the abuse of violence and isolation whenever they test HIV positive.

Further research on suitable approaches to support safe HIV disclosure from women to men is pivotal for the improvement of PMTCT outcomes, the reduction of HIV transmission and in the recruitment of male partners for HIV care and treatment. Healthcare services, such as STD clinics, tuberculosis services and family planning programmes should also be linked to PMTCT programmes (WHO, 2014), since they attract the target population. In addition, a well-functioning, appropriate and accessible VCT service is an explicit and significant objective which would be appealing for more HIV testing. Hence, help couples to plan for safer sex practices (Becker, Mlay, Schwandt & Lyamuya (2010).

5.2.3 Factors Hindering Disclosure of HIV Sero-positive Status

In this study, some of the factors that hindered disclosure included fear of abandonment, fear of emotional distress for loved ones, and stigma and discrimination. These factors can have a negative effect on the positive implementation of HIV prevention, care and management approaches (Legasion, 2010).

5.2.3.1 Fear of Abandonment

In this study, some athletes expressed fear of abandonment from their partners which led to non-disclosure of their status. The fear was due to the association of HIV infection with immoral behaviour and sexual promiscuity. However, after weighing the benefits against the costs they decided to reveal their status to their partners. Again, they thought that if their partners would find out by themselves, then the chances of being rejected would be too high a cost to bear, since they would be divorced or the relationship terminated. Surprisingly, all the athletes who were either dating or had just recently been married, reported being accepted and supported by their partners,

and that their partners were willing to continue with the relationship, despite having an HIV sero-negative status.

It is evident in the literature that fear of being abandoned, rejected, ridiculed and blamed for having an HIV positive status creates a strong barrier to disclosure (Greeff, 2008). Plaschke (2011) reported that when Magic Johnson revealed his HIV positive status to his wife, he cried tears of shame for his behaviour, and tears of fear that she would abandon him. Interestingly, Johnson's wife was reported to be very supportive, and they are still together as a strong couple (Plaschke, 2011).

However, this is contrary to the general view among people in most societies who believe that when PLHIV disclose their status that it would act as a barrier to their social interaction, (Mbonu et al., 2009) especially when they are looking for marriage partners. Clark, Poulin and Kohler (2009) argue that in Malawi, HIV risks dominate the marriage decision-making process, wherein unmarried individuals consider being HIV negative as the single most significant characteristic in a potential future spouse. Conversely, a meta-analysis of 17 studies in developing countries indicated that, while fear of abandonment was perceived as a major barrier to non-disclosure of HIV positive status, there was no association between the break-up of marriages and disclosure of HIV positive status (Medley et al., 2004). Instead, most of the athletes who revealed their HIV status to their partners reported receiving favourable support (Medley et al., 2004).

5.2.3.2 Fear of Emotional Distress for Loved Ones

In this study, fear of emotional distress for loved ones was reported as one of the hindering factors in the disclosure of HIV sero-positive status. The athletes feared to disclose their status

immediately they received their HIV positive test results, because they wanted to avoid the emotional distress associated with an HIV diagnosis on the part of their loved ones, including their mothers, sexual partners and friends.

Magic Johnson did not easily disclose his HIV status to his wife and his friends. According to Plaschke (2011), Magic Johnson cried when he revealed his status to his wife, and together they cried for a week. He later cried after disclosing to his teammates, because he thought he would never have the joy of playing the sport he loved again, and with men who were like a family. The cries were expressions of emotional distress to loved ones.

Miller and Rubin (2007) found that athletes were concerned that disclosure would cause their relatives difficulties, as one athlete stated that his younger relatives were not prepared to deal with the possibility that he might be dying. Another athlete was concerned that his father might collapse, due to the shocking news, and still another feared her mother might commit suicide, because of the shame (Miller and Rubin 2007). This could conceivably be due to the belief that an HIV diagnosis is literally a death sentence. It also carries connotations associated with promiscuity, infidelity and prostitution which are disgraceful to both the discloser and the people disclosed to (Stutterheim, Bos, Van Kesteren, Shiripinda, Pryor, De Bruin & Schaalma, 2011).

Deribe et al. (2010) found that male athletes were very concerned about their partners' emotional distress, due to the anger of their HIV diagnosis. As such, they opted for non-disclosure of their status to avoid worrying about their female sexual partners. Furthermore, revealing their HIV positive status would expose their unfaithfulness to sexual partners, which would make them even

more depressed at their infidelity (Deribe et al. 2010). Similarly, Patel, Patel, Baxi, Golin, Mehta, Shringarpure et al. (2012) found that some athletes were not motivated to disclose their HIV positive status to their parents who were particularly old and in poor health. They feared that the truth of the HIV diagnosis would be too stressful and painful for them, and that they would not be able to bear the reality. This, therefore, clearly indicates that non-disclosure of one's HIV seropositive status possibly stems from the desire to protect loved ones from the pain of knowing the HIV diagnosis.

However, much as one may want to conceal one's HIV status to protect loved ones from depression, non-disclosure of one's HIV positive status to sexual partners averts safer sex discussions and frustrates efforts aimed at preventing HIV transmission (Lunze, Cheng, Quinn, Krupitsky, Raj, Walley et al., 2013). Therefore, nurturing and modelling HIV disclosure skills for PLHIV to aid disclosure of their status more consistently would be a successful approach to HIV disclosure. Again interventions designed to boost self-efficacy in HIV disclosure may be significant in the promotion of HIV disclosure which in turn may reduce the negative experiences and prevent escalating infection rates.

5.2.3.3 Stigma and Discrimination

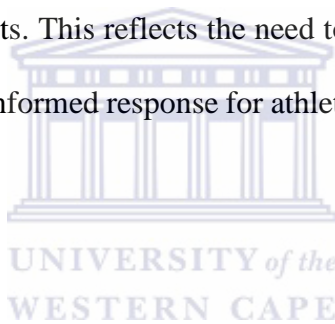
In this study, the majority of athletes did not experience stigma and discrimination, but a fear of being stigmatised and discriminated acted as initial barriers to immediate disclosure. However, a few athletes reported that HIV/AIDS related stigma was a determinant that promoted non-disclosure of their status to distant members of their social network. Fear of being discriminated against by spouses, friends, family members and community members stems from a belief that PLHIV involve themselves in promiscuous behaviours (Dageid et al., 2012; Heeren et al., 2012).

Some athletes living with HIV suffered stigma and discrimination from fellow athletes due to fear of being infected. One athlete, a boxer, reported that he was not assigned big bouts and his fellow boxers shunned him in the ring, once they had learned of his HIV status. Likewise, Magic Johnson, experienced stigma and discrimination when he decided to come back to the court. Several players did not want to play with him, due to fear of catching the virus (Araton, 2011). However, Magic Johnson's disclosure was regarded as a milestone in the fight against HIV/AIDS, being the first renowned athlete admitting to having HIV (Kovacic, 2008). In addition, his announcement helped to break the taboo of speaking openly about HIV in sport, and helped bring down the walls of stigma and discrimination surrounding HIV/AIDS (Buckley, 2012).

Some athletes in this study reported that they suffered stigma and discrimination at home, in the sports community and at school. Similarly, a high school athlete living with HIV faced enormous stigma from school mates, teammates and the coach of the school team (Gonzalez, 2011). Her school mates, when sharing refreshments, avoided drinking from the same container after her. All her friends abandoned her, and the team coach would not feature her in the team. Eventually, she was forced to withdraw from school (Gonzales, 2011).

Kovacic (2008) reaffirms that discrimination against HIV/AIDS-infected athletes is present at all levels of competition, but most alarmingly in amateur and high school sports. Most importantly, HIV awareness strategies are needed to help reduce the stigma and discrimination directed towards athletes living with HIV (Kovacic, 2008) that could also support disclosure of HIV status.

The UNAIDS (2005) toolkit for the sports community, indicated that the risk of HIV transmission in sport settings is small, and most HIV infected athletes have contracted the virus off the sports arena. However, the risk of HIV transmission may occur in some sports like wrestling, boxing, taekwondo and American football (Kordi & Wallace, 2004). Schwellnus and Derman (2005) stated that there is no epidemiological data available to calculate the risk of HIV transmission during sports participation. Therefore, athletes with known HIV infection should inform medical personnel, whenever they sustain an open injury or skin lesion during games for appropriate management of the injury. Schwellnus and Derman (2005) argued that the prevention of HIV infection in athletes should be addressed by proper guidelines for athletes, administrators and medical personnel involved in sports. This reflects the need to address stigma and discrimination in order to create an effective and informed response for athletes living with HIV so that they may continue with their careers.



5.2.4 Disclosure of HIV Sero-positive Status

Disclosure of HIV sero-positive status is a process and not a one-time even. In this study disclosure of HIV sero-positive status includes methods used to disclose, targeted disclosure recipients, timing of disclosure and reasons for disclosure.

5.2.4.1 Methods Used to Disclose HIV Sero-positive Status

Disclosure of one's HIV positive status can occur using direct and indirect methods (Serovich et al., 2005). In this study, the results indicated that the commonly used method for disclosing HIV sero-positive status was the direct method. Most of the athletes indicated using verbal

communication to reveal their HIV status to spouses, sexual partners, family members, friends and other individuals in their social network. They stated that communicating their status verbally was the easiest and most convenient method they could have used. This indicates that strong relationship ties precluded any other means of disclosure other than using the direct verbal approach.

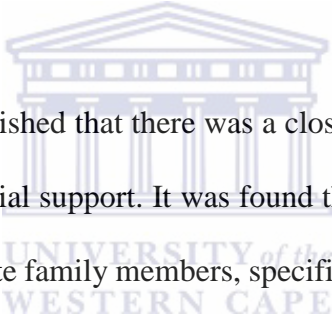
Magic Johnson disclosed his HIV sero-positive status to his wife and teammates using the direct verbal method (Plaschke, 2011). This suggests that the direct method was for him the most convenient way of communicating sad news, so as to find a solution quickly to the problem without wasting time contemplating about how to disclose. Likewise, in a previous study, one of the athletes directly disclosed her status to her best friend, while disclosure to her coach was indirect, facilitated by a third party (Gonzales, 2011).

Serovich et al. (2005) found that PLHIV used both direct and indirect methods to reveal their status to potential sexual partners. However, some athletes in this study reported using the indirect method to disclose their status by joining an HIV support group. This kind of indirect disclosure is known as “seeking similar” as indicated by Serovich et al. (2005), where PLHIV associated themselves with members of the HIV support group, so that when people saw them they would easily know that they were also living with HIV.

5.2.4.2 Targeted Disclosure Recipients

In this study, all athletes reported that they disclosed their HIV sero-positive status to people who posed less harm, including, spouses, family members, particularly mothers and sisters, close friends, sexual partners, healthcare providers and members of support groups. Most of the athletes

stated that disclosure of their status was not an easy task, bearing in mind the negative consequences that are typically associated with an HIV positive test. Siu et al. (2012) found that disclosure of an HIV positive status was perceived as a form of relationship that influenced the individual to whom to disclose or not. For instance, Magic Johnson revealed his status to his wife, because he had a good relationship with her (Plaschke, 2011). In this study, many athletes had freely disclosed their HIV sero-positive status to close family members, specifically caretakers. It could be argued that the association between intimate familial relationships and disclosure of HIV positive status could be regarded as a fundamental aspect which could provide an anchor for people living with HIV to access emotional support, treatment and care.

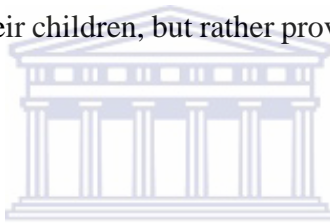


In addition, the current study established that there was a close association between disclosure of one's HIV status and perceived social support. It was found that athletes who had disclosed their HIV status to spouses and immediate family members, specifically mothers and siblings, reported more social support from those relationships. Plaschke (2011) indicated that Magic Johnson's wife vowed never to abandon him, but to fight through it with him. This kind of support was very reassuring for Magic Johnson and helped him to perceive life with a positive mind.

Conversely, some family members and individuals may not be willing to accept PLHIV, which may result in a lack of support due to stigma and discrimination. Therefore, PLHIV have the right to personally choose the individuals to whom to reveal their status who possibly can support them, and to not disclose their status to those who pose a threat (Grant et al., 2013). This is consistent with the theory of the consequences of HIV status disclosure which posits that disclosure of HIV positive status occurs when the benefits outweigh the associated costs (Serovich, 2001; Serovich

et al., 2008). It is suggested that all the benefits of disclosing an HIV diagnosis need to be expressed to both the discloser and the potential targeted recipients in order to appreciate and promote an HIV positive disclosure experience.

The majority of the athletes in this study cited that they disclosed their HIV status to their mothers. These findings were consistent with the results in the study by Iwelunmor, Zungu and Airhihenbuwa (2010) who found that mothers were first in line to learn about an HIV positive diagnosis from their children, and were the means through which their HIV status was communicated to other members of the family. This was based on an inborn belief that mothers would not chase away or disown their children, but rather provide them with the necessary support (Iwelunmor et al., 2010).



Based on the present study, none of the athletes were motivated to disclose their status to their fathers. This suggests that fathers were averse to accepting an HIV positive status from their children, because they interpret it as children with loose morals who deserve to be punished (Greeff et al., 2008). This concurs with Hult et al. (2012) that disclosure of an HIV positive status was most common to mothers, with the fathers disclosed to less frequently.

On the contrary, Zea, Reisen, Poppen, Bianchi and Echeverry (2005) found that disclosure of an HIV positive status was more frequent to closest friends and primary male partners (84.7% and 77.5%, respectively) than to mothers and fathers (37.1% and 23.2%, respectively). It is, therefore, suggested that well-designed interventions that are focused on public education, family counseling and efforts to reduce HIV-related stigma and discrimination could assist in the management of

relationships between sons and daughters living with HIV and their fathers. In addition, it could help reduce the stress and anxiety levels, and promote a better quality of life for families affected by HIV.

In the current study, athletes who were married or in steady relationships reported that they disclosed their status to spouses and fiancées to allow them to access VCT and, immediately engage treatment protocols and adopt safe sexual practices to prevent further HIV infection. In support of this, Becker, Mlay, Schwandt and Lyamuya (2010) stated that disclosure of an HIV sero-positive status to one's main sexual partner was perceived as an obligation which allowed sexual partners to make informed choices about their sexual relationship and safer sexual practices.

On the contrary, Deribe et al. (2010) found that the major reason for disclosing to a sexual partner was that it was customary to tell him or her every secret thing (62.7% of men versus 68.5% of women). The second most common reason reported was looking for support from the partner (50.8% of men v. 50.9% of women), while protecting a loved one, taking spiritual responsibility, being a prerequisite for getting married, and a fear of legal litigation were the least considered reasons for disclosure (Deribe et al. 2010). This suggests that individuals have different priorities for motivating disclosure of their HIV status to sexual partners. However, individuals with an HIV status need to be educated on the significance of safer sexual practices in order to prevent HIV transmission and foster adherence to medications, and so maintain a low viral load which can help minimize the possibility of HIV disease progression (Bartlett, Gallant, & Pham, 2009).

Athletes in this study also reported that, apart from disclosing their status to mothers and sisters, they also revealed to their friends who were concerned about their frequent illnesses. They stated that disclosure was made to childhood friends who were very close. As such, failing to reveal their status to such long-term friends would be very unfair and constitute untrustworthiness in their friendship. Athletes also wanted to let their friends know that it was the HIV infection which was making them sick, whilst at the same time providing their friends with some awareness of HIV. This concurs with Gonzalez (2011) who reported that a high school athlete living with HIV confided in her best friend to whom she disclosed her HIV positive status. Sadly, within a few days her best friend had told other people. This suggested how untrustworthy her friend was, and that she could not stand being with her in such difficult times.

In line with the results of this study, Denison et al. (2008) found that youth were more motivated to disclose their HIV status to their friends in order to alert them to the realistic danger of contracting HIV. Conversely, Leonard et al. (2010) found that youth disclosed their HIV status to trusted friends, because they wanted to feel closer to them and strengthen their relationship. It is suggested that the association of mutual disclosure of one's HIV sero-positive status to family members and close friends describes the desired reality of a great social support network (Ssali et al., 2010).

In this study, HIV disclosure to healthcare providers was associated with access to HIV medical information including treatment, care and services. This purpose was expressed by most of the athletes who reported that, due to their declining health condition, they voluntarily decided to go for an HIV test at VCT centres and, ultimately, disclosed their HIV sero-positive status in order to

access treatment, care and antiretroviral drugs. This result builds upon what was reported by Sowell, Seals, Phillips and Julious (2003) that the majority of their athletes had disclosed their status to healthcare providers in order to access needed medical care.

In another study by Thorsen, Sundby and Martinson (2008) on routine HIV testing of pregnant women, they indicated that any pregnant woman who disclosed her HIV positive result to the healthcare providers was immediately enrolled into the PMTCT programme. Consequently, the women received specific counseling on peri and neonatal nevirapine treatment and family planning methods, alongside infant feeding options (Thorsen, Sundby & Martinson 2008). From the results of the current study, the impression is that all athletes were able to disclose their HIV sero-positive status to significant others who posed little or no threat than those who appeared hostile and unsupportive. This is in line with the theory of HIV disclosure used in this study which postulates that PLHIV are likely to disclose their status to individuals who pose little risk, unlike those who could be hostile and harm them (Serovich, 2001).

All athletes in this study mentioned that they had disclosed their HIV status to members of the HIV support groups in their communities. They revealed that disclosure to the support group members was done in order to seek support and health services. Support groups supported athletes living with HIV by providing group therapy advice on living positively, and information and material support. The support provided by groups was quite reassuring and made the athletes take responsibility by encouraging other PLHIV to disclose to HIV support groups and possibly become members in order to obtain suitable support for health living. Therefore, well-structured

HIV support groups would be influential in preventing HIV transmission and addressing stigma and discrimination in order to motivate people who seek counseling and testing facilities.

5.2.4.3 Timing of HIV Sero-positive Status Disclosure

The most appropriate time for the athletes to disclose their status was not well-defined, and athletes decided to disclose their HIV status when they felt ready. The fact that HIV disclosure is a complex phenomenon entailed that athletes needed time in order to carefully contemplate the pros and cons (Driskell et al., 2008). The majority of the athletes reported that they made their HIV positive disclosure on the same day they received their HIV positive test results. None of the athletes took more than five days to disclose their HIV status.

Similarly, Magic Johnson disclosed his status to his wife immediately when he got the results (Plaschke, 2011). Also, a high school athlete knew her status when she was in grade five and disclosed to her best friend when she was in grade six (Gonzalez, 2011). Greg Louganis who knew his HIV positive status in 1988, decided to conceal it until 1995 (Martinez, 2013). From a health perspective, this was risky because he might have infected others and also re-infected himself as well (Keyser, 1999). Conversely, being an athlete, his intense training and competitive performance, most likely, could not have been maintained.

However, the results of this study suggest that there is variation in the time for disclosing one's HIV positive status. The early disclosure by athletes in the current study may suggest that they had had extensive information and knowledge about how one can live positively with HIV considering the intensive campaigns on HIV awareness in Malawi. As a result, they felt confident to disclose their status earlier than indicated in other studies (Paxton, 2002). Therefore, HIV disclosure should

be done timely in order to allow those individuals infected with the virus to access medical care and services at the right time, as well as engage in safer sexual practices and a PMTCT programme.

5.2.5 Consequences/Experiences of Athletes Disclosing their HIV Positive Status

This section discusses the experiences of the athletes following disclosure of their HIV positive status to spouses, family members, friends, sexual partners, healthcare providers and significant others in their communities. The study results show that athletes had both positive and negative experiences stemming from pleasant and unpleasant reactions from the people to whom they disclosed their status. The varied reactions of the targeted recipients were possibly because of how they perceived an HIV positive diagnosis based on the behavior and lifestyle historically associated with it, their understanding of its mode of transmission, and how the virus deteriorates one's health.

Athletes reported that after disclosure to spouses, family members, friends, sexual partners, healthcare workers and HIV support groups, they experienced positive reactions which were supportive and encouraging. The ones to whom they disclosed were able to give them psychosocial, material and financial support. These findings are similar to the findings in most of the research studies on the positive experiences of PLHIV after disclosure of their status (Miller & Rubin, 2007; Siu et al., 2012). Patel, Ratner, Gore-Felton, Kadzirange, Woelk and Katzenstein (2012) reported that in a study conducted in Zimbabwe where, for the majority (85-98%) of the athletes', disclosure occurred in a positive manner, and 72%-95% of the targeted recipients reacted positively to disclosure. Patel et al. (2012), further argued that women living with HIV in Zimbabwe disclosed their status to significant others more often. As a result, they experienced

positive reactions from people to whom they disclosed. This indicates that often HIV disclosure to potential recipients is more likely to yield positive reactions (Patel et al., 2012).

In the current study, the majority of the athletes reported that they experienced unconditional psychosocial, material and financial support from their spouses, family members, close friends and sexual partners. These results suggest a strong association between perceived unconditional support and disclosure of HIV positive status. These findings concur with those of Siu et al. (2012) where all athletes described how beneficial disclosure had been, especially receiving support, love and care from caretakers, family members and others.

In contrast, Mlobeli (2007) found that PLWHA have sometimes been chased out of their homes and communities, because of being regarded as a burden to others. This attitude indicates that some people still strongly perceive HIV as a stigmatized diagnosis (MDHS, 2010; MANET+, 2012). It is, therefore, suggested that caregivers and the community at large be sensitized about the effects of HIV-related stigma, so as to create an enabling environment that will promote love and acceptance for PLHIV. It will also enable PLHIV not to hide information about their status, which could eventually help to control the spread of the virus.

In this study, some athletes reported experiencing negative reactions upon disclosure, such as stigma and a lack of support, mainly from distant relations, friends, school mates and some members of the community. Similar negative reactions were experienced by athletes in studies done by MANET+ (2012) in Malawi on the rate of stigma and discrimination towards PLHIV in schools, workplaces, churches, mosques and marketplaces. In Indiana, a high school athlete also

experienced stigma from schoolmates, friends and her team coach (Gonzalez,2011). This shows that HIV-related stigma still exists not only in Malawi but also globally, despite the tireless efforts at eliminating it from communities (MacQuarrie et al., 2009).

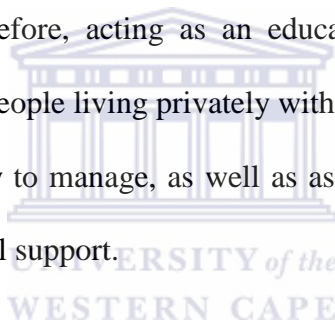
Contrary to these negative reactions, a study by Parsons et al. (2004) found that disclosure was not negatively received, but permitted HIV positive individuals to develop a deeper and more intimate connection with their sexual partners. Likewise, when Magic Johnson disclosed to his wife, he received substantial psychosocial support and there was more intimacy between them (Plaschke, 2011).

Some athletes reported that after disclosure of their status, they experienced a sense of “peace-of-mind” in such a way that disclosure came as a “sigh-of-relief”. The burden which was there before disclosure, disappeared immediately once they revealed their status to spouses, family members, friends, sexual partners and significant others. These results concur with the findings in a study by Hult et al. (2012), which revealed that some athletes disclosed their HIV positive status as a way of feeling the relief of sharing difficult news. This has a positive effect on psychosocial wellbeing, and significantly helps to promote healthy living in PLHIV (Schmidt & Goggin, 2002).

Some athletes reported that they became a source of information on issues regarding HIV and AIDS after disclosing their HIV positive sero-status. They were able to educate others using their personal experiences as testimonies, which enabled individuals to access HCT services, and enroll in treatment, care and support services for PLWHA. These findings correspond with the findings from a study by Mfecane (2012), which revealed that one of the athletes progressed into HIV

activism, where he was regarded as a local AIDS ambassador who educated people about HIV locally and internationally. HIV disclosure gave him more respect and recognition in the local and global communities.

Similarly, a study by Mwale (2006), found that some athletes and key informants were involved in counselling and educating others, due to their own suffering, illness and experiences of stigma and discrimination. Some participated in radio interviews, where they shared their life experiences of living with HIV and AIDS, and others worked as United Nations volunteers in HIV and AIDS campaigns to create awareness, and taught the public about HIV and AIDS from their own experiences (Mwale, 2006). Therefore, acting as an educational resource in the community encouraged new friendships with people living privately with HIV, thereby educating them about HIV issues, so that it became easy to manage, as well as assisted them to access medical care, treatment services and psychosocial support.



5.3 Lack of Appropriate Support Systems

The current study found that a lack of appropriate support systems by government, the private sector, sport's governing bodies and health care providers contributed to athletes' inability to cope with their HIV sero-positive status. The athletes reported the following factors which compromised their health as well as frustrated their performance, namely, poor sports facilities and equipment, poor treatment and medical care and poor nutrition.

5.3.1 Lack of Good Sports Infrastructure and Equipment

The results of the study indicated that a lack of proper infrastructure and equipment hindered optimal sports performance among athletes. The athletes reported that the playgrounds and

equipment which they used were in a sorry state making it difficult for them to achieve excellent performances. They further bemoaned that, with bare feet, they were made to run on the route which was bushy. Consequently, they ended up bruised by the scrubs and tall grass, and their wounds would not heal quickly enough, due to their compromised immunity.

According to Nyirongo (2014), Malawi suffers from poor and underdeveloped sports infrastructure, and a lack of support from government and the private sector. However, many athletes participate in sport because of a passion and interest, in spite of these difficult circumstances (Nyirongo, 2014). Orunaboka and Nwachukwu (2012) state that excellent performance involves well-equipped, good facilities for training. Standard facilities and equipment are crucial prerequisites for good and impressive performances. This suggests that standard sports infrastructure and equipment have a significant relationship with excellent sports performance. Therefore, the government of Malawi, through the Ministry of Sports and other stakeholders, should provide athletes with the much needed sports infrastructure and equipment in order to promote high level performance.

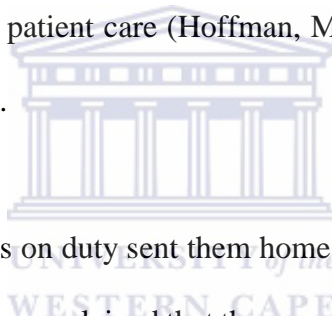
5.3.2 Poor Treatment and Medical Care

In this study, athletes reported that they experienced an inadequate supply of ARVs at health centres. They were not given enough ARVs which could last them for at least three months. They expressed worries over the situation, because ARVs are required to be taken on daily basis, and failure to adhere to recommended doses resulted in drug resistance. Parfitt (2011) states that ARVs prolonged one's life span and minimized HIV-related morbidity. Therefore, PLHIV who adhere

to adequate levels of ARV experience better treatment outcomes, unlike those who do not. Sadly, people seeking medical treatment at government-run medical facilities are unable to access adequate medication, be it ARVs, anti-malarial drugs or even painkillers (Ngozo, 2011).

The study also revealed that when the athletes suffered from malaria and other ailments, they were given painkillers instead of anti-malaria drugs. Sometimes there were no painkillers at the health centres and they were asked to buy from private clinics or pharmacies. This concurs with Kavinya (2013) who revealed that Malawi suffers ARV drug stock-outs, because of a time lag of approximately six months between ordering of ARVs and their delivery. This results in rationing of ARVs in some health centres and, possibly, resorting to substitution regimens (Ngozo, 2011). Similarly, Obua et al. (2011), revealed that recurring shortages of ARVs and OI drugs often resulted in patients borrowing and lending drugs, using substitution regimens for shorter intervals, for instance, two weeks instead of one month. Consequently, suboptimal adherence to antiretroviral therapy (ART) can lead to increased viral load, immunosuppression, drug-resistant viral strains, co-morbidities, and OI. The Ministry of Health, needs to plead with international donors to provide drugs to the health sector, since they fund up to 90 percent of Malawi's medical budget (Ngozo, 2011). In addition, a well-structured framework must be developed to ensure that ARV drugs are provided based on a public health approach. This will help individuals living with HIV achieve the full benefits of ARVs and reduce the effects of drug resistance (Obua et al., 2011). Establishment of a well-designed system to ensure regular procurement and distribution of ARVs, proper patient management and monitoring and evaluation are imperative.

In this study, most athletes reported that shortages of healthcare staff had a negative impact on their health. They said that, due to inadequate health staff, they failed to receive treatment on time. Furthermore, at times, they were sent home without treatment and/or ARV tablets. Palmer, (2006) indicated that in SSA, the health systems are fragile and staffing is totally insufficient to match the rising health needs. Malawi like most of the countries in the sub-Saharan region, faces a dire shortage of human resources in the health sector. Harries, Hargreaves, Gausi, Kwanjana and Salaniponi (2002) revealed that a shortage of healthcare professionals in Malawi is caused by foreign employment and a loss of staff, due to HIV/AIDS. The estimate is an average of one physician for every 50,000 people and a ratio of one healthcare professional to every 277 in-patient population, resulting in inadequate patient care (Hoffman, Mofolo, Salima, Hoffman, Zadrozny, Martinson & Van Der Horst, 2012).



Athletes further reported that nurses on duty sent them home after becoming tired of attending to the large number of patients. Nurses complained that there were no healthcare staff to relieve them. This concurs with Palmer (2006) that population growth and high levels of HIV and AIDS infections resulted in health sectors struggling to keep pace with the demand for services. In addition, Ivers, Jerome, Cullen, Lambert, Celletti and Samb (2011) argued that most people in need of HIV treatment and care far exceeded the capacity of the healthcare systems. Consequently, extended working hours, heavy workloads without relief or “off days” negatively affected PLHIV, especially in their medical adherence (Bradley & McAuliffe, 2009). Therefore, to address this problem, there is need for the government to come up with a comprehensive strategy, including training new healthcare professionals, and recalling retired employees who have the potential to improve the efficiency of the health systems.

5.3.3 Poor Nutrition

The majority of the athletes reported that they were not beneficiaries of nutrition supplementation and safety nets, because their sport or community leaders did not register them for the programme. This had negatively affected their health, as most of them were from poor families which could hardly provide good, well-balanced meals daily. A lack of nutritional food supplements suggests that existing programmes on the improvement of HIV treatment through food security are limited in Malawi, possibly due to the poor economy that made it difficult to purchase adequate food supplements which could be distributed in diverse settings.

In addition, people who were entrusted with the enrolment of beneficiaries and distribution of food supplements did not do their job competently. They deliberately failed to meet the targeted individuals. It is argued that nutrition supplementation and safety nets, such as food assistance and the social cash transfer scheme were significant means for the improvement of food security and nutrition outcomes in an HIV/AIDS context (Aberman, Rawal, Drimie, Claros & Kadiyala, 2014). In support of this, Miller and Tsoka (2012) found that the Malawi social cash transfer scheme had positive impacts on the health, food security and economic wellbeing of PLHIV. Consequently, athletes had an improved ability to care for their families (Miller & Tsoka, 2012). It is possible that the relationship between HIV and food insecurity significantly correlated with immune system impairment, infectious disease progression and malnutrition (Miller & Tsoka, 2012). Therefore, athletes with household food insecurity, unbalanced diets and a lack of food supplements were likely to be undernourished and prone to opportunistic diseases. Invariably, this caused them to stop participating in sport and prematurely terminated their sport careers. Therefore, interventions

and programmes on social cash transfer and nutrition supplementation should target the most vulnerable households in order to minimize the risk of developing OI and reduce conditions that can result in AIDS.

5.4 Study conclusion

The study has accomplished its aim, which was to explore the experiences of athletes living with HIV following disclosure of their HIV seropositive status in Ndirande Blantyre, Malawi. The majority of the athletes disclosed their HIV positive status to spouses, family members, friends and health care providers in order to access support and treatment. However, athletes did not disclose to their clubs and sports institutions because there was no conducive environment.

The study has established that athletes living with HIV, males and females, elite and non-elite had experienced positive and negative reactions from targeted potential recipients and other individuals in their social network after disclosure of their HIV seropositive status. The positive experiences included psychosocial support, material and financial support, love and acceptance, medical care and accredited expert clients on issues related to HIV. Stigma and discrimination which included unfriendly attitudes by health care providers, insults and degrading names from extended family members, were the most experienced negative outcomes of HIV seropositive status disclosure. In spite of the negative consequences of HIV positive disclosure, it was affirmed that the benefits and rewards of disclosing HIV positive status strongly outweighed the negative outcomes.

While athletes living with HIV had support from families and community support groups, there was a lack of appropriate support systems in the sport institutions. Sport institutions generally lacked appropriate programmes on HIV/AIDS, sport equipment and facilities were poor. In

addition, the sport institutions did not have support groups to provide psychosocial support. Furthermore, athletes living with HIV had limited access to health care services.

The results of the study have revealed that there are research gaps on athletes living HIV, particularly on disclosure of HIV positive status. The results also show a dearth of literature on policies and support systems regarding athletes living with HIV.

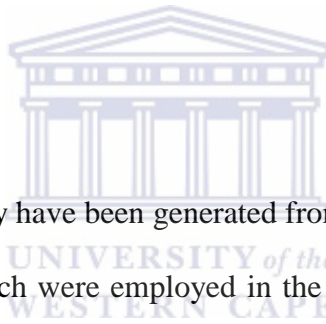
5.5 Strength of the Study

The study has explicitly examined the experiences of the athletes living with HIV following disclosure of their status. The methodology employed in the data collection process enabled the researcher to obtain more detailed and comprehensive information regarding athletes' experiences. More than one data source was used for a richer and broader understanding of the phenomenon. The sample size of twelve athletes also allowed the researcher to pay close attention to each and every individual during the in-depth interviews. This also allowed greater freedom and adaptation of interaction between the researcher and the study athlete. With twelve athletes data saturation was reached and themes suitably addressed. Thematic analysis allowed the researcher to get a sense of the entire data, create patterns in the form of themes and sub-themes containing critical features. This was for the purpose of data interpretation of the phenomenon under study.

5.6 Limitations of the Study

The findings in this research study are subject to some limitations, which may limit generalization of the results.

- The study was qualitative and comprised a small sample, therefore, generalization of the results may be difficult.
- The study involved only athletes who were registered members of support groups and not the unregistered athletes. Those outside the support group might have had different experiences.
- The results may be biased since all athletes belonged to some HIV support groups which might have an influence on the nature of the responses and views they expressed during the study.



5.7 Recommendations

The recommendations for this study have been generated from the results that have been reported and from other related studies which were employed in the discussion of the research findings. The proposed recommendations below will help to address the significance of the study that aims to address the identified gaps and suggested research areas that would promote HCT, disclosure of HIV positive status among athletes and appropriate support systems.

- Sports clubs and institutions should initiate programmes for athletes to undergo routine HIV testing as a part of good professional sport practice.
- The celebrity status that elite athletes hold gives them the potential to influence the sports community, as well as the wider society to go for HIV testing and to disclose their status, if sero-positive. This will enable many PLHIV to access treatment, care and support.

- The Malawi National Council of Sports and its affiliates should establish programmes which will help mitigate HIV/AIDS-related stigma and discrimination within sport institutions.
- The Malawi National Council of Sport and its affiliates should facilitate formation of support groups for athletes living with HIV.
- The Malawi National Council of Sports in collaboration with the Ministry of Sports-should source funding for development and rehabilitation of sport infrastructure and equipment.
- The Malawi National Council of Sports in collaboration with the Ministry of Health and Ministry of Sports should initiate special nutrition programmes for athletes living with HIV.
- The Malawi National Council of Sports in collaboration with the Ministry of Health and the Ministry of Sports should develop special guidelines for coaches and athletes in the different sport disciplines to minimize HIV infections and reinfections, especially when managing injuries.
- The Ministry of Sport, the Malawi National Council of Sport, and its affiliates such as the Athletics Association of Malawi, the Netball Association of Malawi, the Football Association of Malawi and others should put in place appropriate policies, strategies and programmes. This will enable athletes, in their celebrity capacities, to take active roles in the fight against HIV/AIDS. Interventions should include promotion of HIV testing, disclosure and initiating and facilitating dialogue on HIV/AIDS issues to dispel the myths which still surround HIV/AIDS within the sporting environment, as well as in society as a whole.

- The Ministry of Health should put in place a system that ensures sustained availability of adequate staffing, as well as adequate supplies of essential ARVs.
- There is also a need for the leadership in these facilities to put in place strategies for addressing stigma and discrimination by healthcare personnel.
- The Malawi National Council of Sports and its affiliates should develop appropriate healthcare packages for different sporting events taking into consideration the interests of athletes living with HIV.

Further Research

The study found that there was lack of literature on athletes living with HIV. Therefore, there is need to support research activities on HIV testing, disclosure and appropriate support system. The possible research studies could be:

- To further explore the possible interventions for HIV testing, promotion of HIV disclosure among athletes infected with HIV.
- To investigate sexual abuse encountered by young female athletes with disabilities in sports institutions.
- To investigate factors associated with negative outcomes of disclosing HIV positive status in order to develop better screening tools for counseling purposes.
- Exploring appropriate support systems for athletes following disclosure of HIV positive status to potential targeted individuals in their communities as well as in sports institutions.

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APPENDICES

Appendix A: Individual In-depth Interview Guide

Sections A and B.

Title of the Study: Experiences of Athletes Living with HIV/AIDS

Following Disclosure of their Sero-status in Ndirande Blantyre Malawi.

Section A: Athletes demographic information

Athlete name.....

Age.....

Sex.....

Tribe.....

Religion.....

Marital status.....

Occupation.....

Level of education.....

Location (urban, semi-urban, urban).....

Number of children

Date tested for HIV

Interview number.....

Home district.....



Section B: Interview guide for athletes

Interview no..... date.....

Time started..... Time finished.....

Introduction; welcome athlete

Introduction of the researcher

Explain the purpose of the interview and discuss issues of confidentiality

Thank athlete for deciding to take part in the study

1. Would you please tell me, how has been your life since you were diagnosed with HIV?
2. Would you explain to me what having HIV means to you.

Probe for: what do others say or think of what having HIV is? (i.e. spouses, family members, friends, community, fellow athletes/ teammates)

3. Have you experienced any social interaction changes since you disclosed your sero-positive status? If yes, would you mind share the experiences with me?

4. Please tell me what made you to disclose your HIV positive status?

5. Please explain to me how you disclosed your HIV positive status and how did you feel before, during and after disclosure of your HIV positive status?

6. How long after knowing your HIV positive status did it take to disclose?

7. What were the reactions of the people you disclosed to?

8. What were the consequences following disclosure of your sero-positive status?

9. Do you think the sero-positive status of an individual should be made public?

If yes, what are the benefits? If not, can you please give me the reasons?

10. How do people living with HIV perceive the benefits of disclosing or not disclosing their sero-positive status?

11. How can people living with HIV be encouraged to disclose their sero-positive status publicly?

12. How have the following been of assistance to you? Family members, employer, HIV/AIDS support group friends, church, community, fellow athletes, sports council, and health facility.

13. Do you know of other PLWHA who are unable to access health care, social and spiritual care? If yes, probe for situations that are hindering them access for those accessing the services find out against which obstacles and in response to which triggers.

14. What do you think are the appropriate support systems for athletes living with HIV who disclose their status to spouses, friends, family, community and sports council?

15. Is there anything you would like to tell or ask me in relation to the interviews?

Thank you so much for sharing with me this information.

Appendix B: Individual In-depth Interview Guide Chichewa Version (Mlozo wa zokambirana).

Gawo A ndi B

Mutu wa kafukufuku

Zimene amakumana nazo ochita masewera amene ali ndi kachilombo koyambitsa matenda a edzi akawulula kuti ali ndi kachilomboko.

Gawo loyamba: Kudziwa za otenga mbali mukafukufuku

Fufuzani mtundu waotenga mbali, za zaka zakubadwa, zabanja, nthawi yomwe akhala pa banja, ana amene ali nawo, kumene amakhala, zamaphunziro, zachipembezo, ntchito yomwe amagwira, tsiku limene anakayedzetsa magazi, komanso boma limene amachokera.

Gawo lachiwiri: Kukambirana mozama pakati pa otenga mbali ndi ofufuza

Nambala ya otenga mbali mukafukufuku

Tsiku la kafukufuku

Nthawi yoyambira zokambirana

Nthawi yomalizira zokambirana

Wofufuza apereke malonje kwaotenga nawo mbali

Wofufuza afotokoze cholinga cha zokambirana komanso kuthokoza otenga mbali pochita chisankho chotenga nawo mbali.

1. Chonde tandifotokozereni zamoyo wanu kuchokera nthawi imene munadziwa kuti muli ndi kachilombo koyambitsa matenda a edzi ka HIV.
2. Kodi kupezeka ndika chilomboka HIV kumatanthauza chiyani pa moyowanu?
3. Nanga enamonga akazi/amuna anu, achibale, ochitana womasewera, abwenzi ndiena onse amene akuzungulirani amati chiyani pa nkhani yakupezeka ndi kachilomboka HIV?

4. Kodi pali kusintha pa machezedwe anu ndi anzanu amene munawa wululira zoti munapezeka ndi kachilomboka HIV? Ngati zili choncho, munga ndiwuze chinkhalidwe chomwe anzanu woakhala akuku wonetserani?
5. Chonde tandifotokozereni mwatsatanetsatane chomwe chinapangitsa kutimu ulule zoti munapezeka ndi kachilombo koyambitsa matenda a edzi ka HIV.
6. Chonde tandiwuzeni mmene mudawululira zakupezeka ndi kachilombo koyambitsa matenda a edzika HIV.
7. Chonde tandiwuzeni mmene mudamvera musanawulule, mukuwulula komanso mutawulula zakupezeka ndi kachilomboka.
8. Chonde tandiwunikirana kuti padatenga nthawi yayitali bwanji kuti inuyo muwululire wina mutadziwa zoti muli ndi kachilombo koyambitsa matenda a edzi ka HIV.
9. Chonde tandiwuzeni mwatsatanetsatane zazomwe anthu amene munawawululira zoti munapezeka ndi kachilomboka anachita atamva zankhaniyi.
10. Kodi ndikoyenera kuti anthu amene anapezeka ndi kachilombo ka HIV aziwulula poyera? Ngati kulikoyenera, kodi kuli ndi ubwino wanjji? Ngati sikoyenera, mungandiwuze zifukwa zake?
11. Kodi anthu akuganiza bwanji za ubwino wowulula kapena kusawulula zoti anapezeka ndi kachilombo koyambitsa matenda a edzi ka HIV?
12. Kodi ndi chilimbikitso chanji chimene mugandiwuze kuti anthu azinena zoti anapezeka Ndi kachilombo koyambitsa matenda a edzi ka HIV komanso kunena poyera zoti ali ndi HIV?
13. Kodi anthu awa; amuna/akazi anu, achibale, abwenzi, akumpingo, ochita nawo masewera, azaumoyo, oyang'anira zamasewera ndi anthu ena okuzungulirani akhala thandizo lotani ku moyo wanu?
14. Kodi mukudzipo za ena mwa anthu omwe ali ndi kachilombo ka HIV amene amalephera kupeza thandizo kuchokera kuchipatala, ku mipingo yomwe amapemphera komanso m'midzi yomwe amakhala. Ngati alipo, chimene chimawalepherets akupeza thandizo ndi chiyani? Kwa amene amapeza thandizoli pali zovuta zimene amakumana nazo?
15. Kodi ndi thandizo kapena chilimbikitso chotani chimene chili choyera kwa anthu ochita masewera omwe adawulula kuti ali ndi kachilombo ka HIV angapeze kuchokera kwa

akazi/amuna awo, achibale, abwenzi, ochita nawo masewera, mabungwe oyang'anira zamasewera komanso amene awazungulira?

16. Kodi pali zina zowonjezera pa zomwe takambiranazi?

Zikomo kuti ndatha kukambirana nanu. Ambuye akudalitseni.



Appendix C: Information Sheet



University of the Western Cape

Private Bag X17 Bellville 7535

South Africa

Tel: +27 21-959 2350 Fax: 27 21-959 3688

E-mail: 3318113@uwc.ac.za.

INFORMATION SHEET

Project Title: Experiences of Athletes Living with HIV following Disclosure of their Sero-status in Ndirande Township Blantyre Malawi

What is this study about?

This is a qualitative research project with an exploratory design making use of narrative approach being conducted by Ivy Kondowe at the University of the Western Cape. We are inviting you to participate in this research project; you are a possible candidate to participate in the study because you are an athlete with sero-positive status who lives in Ndirande Township Blantyre. The purpose of this research project is to explore experiences of athletes living with HIV following disclosure of their status.

What will I be asked to do if I agree to participate?

You will be asked to participate in an individual face to face in-depth interview which will be recorded upon your permission. All data obtained, transcriptions and recordings will be kept confidential and you will remain anonymous. Your participation in the study will make valuable contribution in terms of developing strategies that will help to minimize negative experiences that athletes encounter after disclosing the sero-positive status in Malawi. The individual face to face in-depth interview will take approximately 60 to 90 minutes.

Would my participation in this study be kept confidential?

We will do our best to keep your personal information confidential. To help protect your confidentiality, your name will not be used in the data collection procedure. Data will be stored in locked filing cabinets and storage areas, using identification codes only on data forms, and using password-protected computer files. If we write a report or article about this research project, your identity will be protected to the maximum extent possible.

What are the risks of this research?

The study may include risks that may be better described as things that could make the athletes feel uncomfortable such as disclosing information that you don't want to share. Athletes will be provided with suitable support from the researcher or be referred to professional help.

What are the benefits of this research?

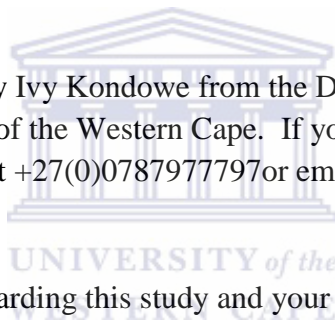
This research is not designed to help you personally, but the results may help the investigator learn more about the level and nature of experiences that athletes living with HIV encounter following disclosure of their status. It is hoped that, in future, other people might benefit from this study through improved understanding of the research topic.

Do I have to be in this research and may I stop participating at any time?

Your participation in this research is completely voluntary. You may choose not to take part at all. If you decide to participate in this research, you may withdraw from participating at any time. If you decide not to participate in this study or if you withdraw from participating at any time, you will not be penalized or lose any benefits to which you otherwise qualify.

What if I have questions?

This research is being conducted by Ivy Kondowe from the Department of Sport, Recreation and Exercise Science at the University of the Western Cape. If you have any questions about the research study, please contact me at +27(0)0787977797 or email: kondoweivy@yahoo.com. Or ivy.chinangwa@gmail.com



Should you have any questions regarding this study and your rights as a research athlete or if you wish to report any problems you have experienced related to the study, please contact:

Supervisor: Dr. Lloyd Leach
University of the Western Cape
Private Bag X17
Bellville 7535
Telephone: (021) 959 2350
E-mail: lleach@uwc.ac.za

Dean of the Faculty of Community and Health Sciences: Prof Jose Frantz
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: (021) 959-2631
Email: jfrantz@uwc.ac.za

Appendix D: Information Sheet Chichewa Version



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535,

South Africa

Tel: +27 21-959 2350 Fax: 27 21-959 3688

E-mail:3318113@uwc.ac.za.

Chidziwitso cha kafukufuku kwa otenga nawo mbali

Mutu Wa Kafukufuku: Zimene amakumana nazo ochita masewera amene ali ndi kachilombo koyambitsa matenda a edzi akawulula kuti ali ndi kachilomboko.

Cholinga cha kafukufuku ameneyu ndi chani?

Cholinga cha kafukufu ameneyu ndi kudziwa zomwe ochita masewera amene ali ndi kachilombo koyambitsa matenda a edzi amakumana nazo akawulula kuti ali ndi kachilomboko. Amene akuchita kafukufuku ameneyu ndi Ivy Kondowe amene akuchita maphunziro awukachenjede pa University ya Western Cape ku South Africa. Tikukupemphani kuti mutenge nawo mbali pa kafukufuku ameneyu chifukwa ndinu m' modzi wa ochita masewera amene anapezeka ndi kachilombo koyambitsa matenda a edzi, komanso mumakhala ku Ndirande mu mzinda wa Blantyre.

Kodi ndikavomera kutenga nawo mbali, nanga gawo langa pakafukufuku ameneyu ndi lotani?

Muzapemphedwa kutenga nawo mbali pazokambirana pakati pa inu ndi wofufuza. Zokambiranazo zizalembedwa kapena kujambulidwa inuyo mukavomera kutero. Zokambiranazo zizakhala za chinsinsi, komanso inuyo dzina lanu silidzawululidwa konse. Zokambirana za kafukufuku ameneyu zingathe kuzatenga ola limodzi kapena ola limodzi ndi theka. Kutenga nawo mbali pa kafukufuku ameneyu kuzathandiza ku peza njira zoyenera zimene zingathe kuchepetsa mavuto kwa ochita masewera amene anapezeka ndi kachilombo koyambitsa matenda a edzi akawulula kuti ali ndi kachilomboko ku Malawi kuno.

Kodi kutenga nawo mbali kwa ine mukafukufuku ameneyu kuzakhala kwa chinsinsi?

Tikulonjeza kuti zokambirana pa kafukufuku ameneyu zokhuza moyo wanu sizidzawululidwa kwa wina ali yense. Komanso poteteza chinsinsi chanu, dzina lanu silidzawululidwa ndi wofufuza pamene adzakhala akupitiriza kutolera nkhani zofunikira mu kafukufuku ameneyu. M'malo mwake, zizindikiro monga manambala ndi zilembo ndi zomwe zizagwiritsidwe ntchito. Ndipo pazakhazikitsidwa chitetezo chokwima pa nkhani zomwe zatoleredwa pa kafukufuku ameneyu. Tikamadzalembe nkhani zomwe zatoleredwa pa kafukufuku ameneyu monga tanena kale,dzina lanu silidzawululidwa konse.

Kodi pali zoopsa zotani pa kafukufuku ameneyu?

Pakafukufuku ameneyu palibe zoopsa zenizeni zimene zingakulepheretseni kutenga nawo mbali. Mwina wotenga nawo mbali akhoza kusamasuka kuti awulule mwatchutchuchu nkhani zokhuza moyo wake pa kafukufuku ameneyu. Komanso wotenga nawo mbali adzalandira uphungu woyenerera kuchokeka kwa wofufuza ngati kungafunikire kutero.

Kodi phindu la kafukufuku ameneyu ndi lotani?

Cholinga chakafukufuku ameneyu sikuti otenga nawo mbali apeze phindu lowoneka koma kuti zotsatira zake za kafukufuku ameneyu zizathandize wofufuza ndi ena onse amene angadzafune kupitiriza kudziwa mozama za zimene ochita masewera amene ali ndi kachilombo koyambitsa matenda a edzi amakumana nazo akawulula kuti ali ndi kachilomboko.

Kodi ndiri wokakamizidwa kutenga nawo mbali pa kafukufuku ameneyu?

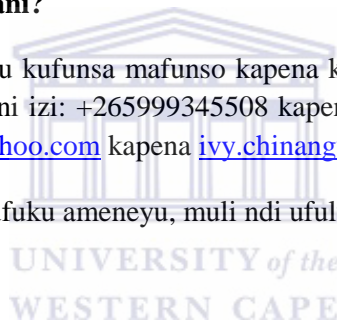
Otenga nawo mbali ndi wosawumirizidwa mu kafukufuku ameneyu. Akoza kutenga nawo mbali kapena ayi. Koma ngati wavomera kutenga nawo mbali ali ndi ufulu kusiya angakhale zokambirana zitayamba kale ndi wofufuza. Sipadzakhala chilango kapena vuto lililonse kwa iye pamene wasankha kusiya.

Kodi ndikakhala ndi mafunso nkutani?

Pakafukufuku ameneyu muli ndi ufulu kufunsa mafunso kapena kupereka ndemanga kwa Ivy Kondowe amene mungamupeze poyimba telefoni izi: +265999345508 kapena +27787977797 komanso kulembera ku email address izi: kondoweivy@yahoo.com kapena ivy.chinangwa@gmail.com

Ngati pali zovuta zina zokhuza kafukufuku ameneyu, muli ndi ufulu kuwuzana anthu awa:

Supervisor: Dr. Lloyd Leach
University of the Western Cape
Private Bag X17
Bellville 7535
Telephone: (021) 959 2350
E-mail: lleach@uwc.ac.za



Dean of the Faculty of Community and Health Sciences: Prof Jose Frantz
University of the Western Cape
Private Bag X17
Bellville
7535
Tel: (021) 959-2631
Email: jfrantz@uwc.ac.za

Appendix E: Consent Form

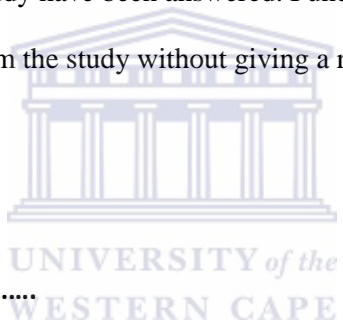


UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2350, Fax: 27 21-959 3688
E-mail: 3318113@uwc.ac.za

CONSENT FORM

Title of Research Project: Experiences of Athletes Living with HIV following Disclosure of Sero-status in Ndirande Blantyre Malawi.

The study has been described to me in a language that I understand and I freely and voluntarily agree to participate. My questions about the study have been answered. I understand that my identity will not be disclosed and that I may withdraw from the study without giving a reason at any time and this will not negatively affect me in any way.



Athlete's name.....

Athlete's signature.....

Witness.....

Date.....

Should you have any questions regarding this study or wish to report any problems you have experienced related to the study, please contact the study coordinator:

Study Coordinator's Name: Dr. Lloyd Leach

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021)959-2350

Fax: (021)959-3688

E-mail: lleach@uwc.ac.za

Appendix F: Consent Form Chichewa version



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535, South Africa
Tel: +27 21-959 2350, Fax: 27 21-959 3688
E-mail:3318113@uwc.ac.za

KALATA YOVOMEREZA

MutuWakafukufuku: Zimene amakumana nazo ochita masewera amene ali ndi kachilombo koyambitsa matenda a edzi akawulula kuti ali ndi kachilomboko.

Ine andifotokozera zakafukufuku uyu mwatsatanetsatane ndipo ndavomera mosakakamizidwa kutenga nawo mbali.Mafunso amene ndinali nawo wokhuza kafukufuku ameneyu ndisanapange chisankho chotenga nawo mbali, andiyankha moyenerera.Andifotokozera kuti dzina langa siliwululidwa mukafukufuku ameneyu ndipo ndiri ndi ufulu kusiya kutenga nawo mbali nthawi ili yonse mosakakamizidwa kupereka chifukwa chosiyira.

Dzina la otenga mbali

Saini ya otenga mbali

Mboni

Tsiku

Pakafukufuku ameneyu muli ndi ufulu kufunsa mafunso kapena kupereka ndemanga kwa oyang'anira kafukufukuyu:

Dr. Lloyd Leach

University of the Western Cape

Private Bag X17, Bellville 7535

Telephone: (021)959-2350

Fax: (021)959-3688

E-mail: leach@uwc.ac.za

Appendix G: Request for permission- National Health Science Research Committee



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535. South Africa

Tel: +27 21-959 2350, Fax: 27 21-959 3688.

13th December, 2013.

**National Health Sciences Research Committee
Ministry of Health
P.O. Box 30377
Lilongwe 3
MALAWI**

Dear Sir,

RE: PERMISSION TO CONDUCT RESEARCH STUDY AMONG ATHLETES LIVING WITH HIV IN NDIRANDE BLANTYRE, MALAWI

My name is Ivy Yvonne Kondowe, a registered student at the University of the Western Cape. I am currently pursuing a Master of Sports, Recreation and Exercise Science Degree course in Sport, Recreation and Exercise Science at the above named University.

As part of the study requirement, I am expected to conduct a research study in an area of interest. My Research Topic is: "**Experiences of athletes living with HIV following disclosure of their sero-status in Ndirande Blantyre Malawi**".

I would hereby request your kind permission to conduct the study in Ndirande, Blantyre with athletes who are athletes living with HIV. Further assistance will be sought from MANET+ and NAPHAM to assist in the identification and recruitment of athletes for this study. This is to avoid unintended disclosure of my prospective athletes living with HIV.

I will endeavor to abide by the ethical rules and regulations as laid down by the ethics committee. On completion of the study, a copy of the report findings will be submitted to your office.

Copies of the research proposal, the ethical approval from the University of the Western Cape and the information to athletes are enclosed for your attention.

Your assistance will be greatly appreciated.

Yours Faithfully,

Researcher:

Ivy Yvonne Kondowe, Cell: 0787 977 797: (265) 999 345 508

Email: kondoweivy@yahoo.com/ ivy.chinangwa@gmail.com

The Research Supervisor: Dr. Lloyd Leach, Tel: 031 260 3317

Email: lleach@uwc.ac.za

University of the Western Cape

CC: The Ethics Committee: University of the Western Cape.

Appendix H: Request for permission - Letter to NAPHAM



UNIVERSITY OF THE WESTERN CAPE
Private Bag X 17, Bellville 7535. South Africa
Tel: +27 21-959 2350, Fax: 27 21-959 3688
13th December, 2013.

NAPHAM Secretariat
Private Bag 377
Capital City
Lilongwe 3.
Malawi.

Dear Sir,

RE: PERMISSION TO CONDUCT RESEARCH STUDY AMONG ATHLETES LIVING WITH HIV IN NDIRANDE BLANTYRE, MALAWI

My name is Ivy Yvonne Kondowe, a registered student at the University of the Western Cape. I am currently pursuing a Master of Arts Degree course in Sport, Recreation and Exercise Science at the University of the Western Cape, South Africa.

As part of the study requirement, I am expected to conduct a research. My Research Topic is: "**Experiences of athletes living with HIV following disclosure of their sero-status in Ndirande Blantyre Malawi**".

I would request your good office for permission to conduct the study in Ndirande, Blantyre with athletes who are athletes living with HIV. I would also like to ask for your assistance in the identification and recruitment of athletes for this study. This is to avoid unintended disclosure of my prospective athletes (athletes) living with HIV who will participate in the study.

I will endeavor to abide by the ethical rules and regulations as laid down by the ethics committee. On completion of the study, a copy of the report findings will be submitted to your good office.

Copies of the research proposal, the ethical approval from the University of the Western Cape and the information to athletes are enclosed for your attention.

Your assistance will be greatly appreciated.

Yours faithfully,

Researcher: Ivy Yvonne Kondowe, Cell: 0787 977 797: (265) 999 345 508
Email: kondoweivy@yahoo.com/ ivy.chinangwa@gmail.com

The Research Supervisor: Dr. Lloyd Leach, Tel: 031 260 3317
Email: lleach@uwc.ac.za
University of the Western Cape

CC: The Ethics Committee: University of the Western Cape

Appendix I: Request Letter to; Malawi National Council of Sport to Support the Study



UNIVERSITY OF THE WESTERN CAPE

Private Bag X 17, Bellville 7535.

South Africa

Tel: +27 21-959 235 Fax: 27 21-959 3688

13th January, 2014.

The Executive Secretary,
Malawi National Council of Sports,
P.O. Box 452,
Blantyre.
Malawi.

Dear Sir,

RE: LETTER OF SUPPORT TO CONDUCT RESEARCH STUDY AMONG ATHLETES LIVING WITH HIV IN NDIRANDE BLANTYRE, MALAWI.

My name is Ivy Yvonne Kondowe, a registered student at the University of the Western Cape. I am currently pursuing a Master of Arts Degree course in Sport, Recreation and Exercise Science at the above named University.

As part of the study requirement, I am expected to conduct a research study in an area of interest. My Research Topic is: "**Experiences of athletes living with HIV following disclosure of their sero-status in Ndirande Blantyre Malawi**".

I would hereby request your good office to support this study by writing to the Chairman, National Health Science Research Committee, P.O. Box 30377, Lilongwe 3. This will help to facilitate approval of the study.

I will endeavor to abide by the ethical rules and regulations as laid down by the ethics committee. On completion of the study, a copy of the report findings will be submitted to your office.

Copies of the research proposal, the ethical approval from the University of the Western Cape and the information to athletes are enclosed for your attention.

Your assistance will be greatly appreciated.

Yours Faithfully,

Researcher:

Ivy Yvonne Kondowe, Cell: 0787 977 797: (265) 999 345 508
Email: kondoweivy@yahoo.com/ ivy.chinangwa@gmail.com

The Research Supervisor: Dr. Lloyd Leach, Tel: 031 260 3317
Email: lleach@uwc.ac.za
University of the Western Cape

CC: The Ethics Committee: University of the Western Cape

Appendix J: Letter of support Malawi National Council of Sports

All communications should be addressed to :

Executive Secretary

Tel : 265 (0) 1 872 204

Fax: 265 (0) 1 875 109

E-mail: sport@sportmalawi.net



MALAWI NATIONAL COUNCIL OF SPORTS

P. O. BOX 452
BLANTYRE

PHYSICAL ADDRESS:
Kamuzu Stadium Grounds
Plot no: BE 254
BLANTYRE - MALAWI

Ref No.3/1/Vol.14/72

20th January, 2014

The Chairman
National Health Science Research Committee
P. O. Box 30377
LILONGWE 3

Dear Sir,

SUPPORT FOR RESEARCH PROJECT: SOCIAL EXPERIENCES OF ATHLETES LIVING WITH HIV FOLLOWING DISCLOSURE OF THEIR SEROSTATUS IN NDIRANDE, BLANTYRE, MALAWI

As partial requirement of a Masters Course in Sport, Recreation and Exercise Science, at the University of Western Cape in South Africa, Ivy Kondowe who is one of people the Malawi National Council of Sports works with in the Athletics Association of Malawi is carrying out a research to identify social experiences of athletes living with HIV following disclosure of their serostatus.

The idea is that once the athletes' experiences are identified, programmes could be designed and implemented, that could assist both the sports sector and those institutions dealing with HIV and AIDS to benefit and improve on achievement of their core goals for an all inclusive society where people living with HIV and AIDS are able to contribute to activities of society just like their other 'healthy' partners in the community.

As you are one of the organizations in the country that deal with HIV and AIDS, Ivy has identified to have a meeting and consultation with you on her research project where she intends to obtain more in depth information about your activities and how these relate to HIV and AIDS positive athletes. With this therefore, we write to introduce Ivy to yourselves and to request your co-operation in issues and matters as she (Ivy) may wish from yourselves. Further, we request that as you discuss with Ivy, you be as honest as possible. All information that you will provide in the discussions will be treated with the strictest confidentiality and will only be used for the intended purpose.

"Developing and Promoting Sports in Malawi"

We trust that you shall provide the sought information and we thank you for your co-operation.

Yours faithfully
MALAWI NATIONAL COUNCIL OF SPORTS


G. E. Jana
EXECUTIVE SECRETARY

GEJ/csm



Appendix K: Ethics Clearance.



UNIVERSITY of the
WESTERN CAPE

OFFICE OF THE DEAN DEPARTMENT OF RESEARCH DEVELOPMENT

5 December 2013

To Whom It May Concern

I hereby certify that the Senate Research Committee of the University of the Western Cape approved the methodology and ethics of the following research project by:
Ms I Kondowe (SRES)

Research Project: Social experiences of athletes living with HIV following disclosure of their serostatus in Ndirande Blantyre Malawi

Registration no: 13/10/32

Any amendments, extension or other modifications to the protocol must be submitted to the Ethics Committee for approval.

The Committee must be informed of any serious adverse event and/or termination of the study.

*Ms Patricia Josias
Research Ethics Committee Officer
University of the Western Cape*

Private Bag X17, Bellville 7535, South Africa
+27 21 959 2988/2948 , F: +27 21 959 3170
pj Josias@uwc.ac.za
www.uwc.ac.za

A place of quality,
a place to grow, from hope
to action through knowledge

Appendix L: Letter of Permission-National Health Science Research Committee

Telephone: + 265 789 400
Facsimile: + 265 789 431

All Communications should be addressed to:
The Secretary for Health and Population



In reply please quote No. MED/4/36c
MINISTRY OF HEALTH AND POPULATION
P.O. BOX 30377
LILONGWE 3
MALAWI

17th January 2014

Ivy Kondowe
University of Western Cape

Dear Sir/Madam,

RE: Protocol # 1248: Experiences of Athletes living with HIV following disclosure of their serostatus

Thank you for the above titled proposal that you submitted to the National Health Sciences Research Committee for review.

The committee reviewed the proposal and agreed that the study may be approved through **expedited process** once the researcher addresses the following concerns;

- The appendices should have a title and numbered e.g. Appendix 1,2 etc
- Informed consent form should include NHSRC Secretariat contact details
- Should develop itemized budget and work plan
- No dissemination plan

Kind regards from the Secretariat.


.....
FOR: CHAIRMAN, NATIONAL HEALTH SCIENCES
RESEARCH COMMITTEE