

**EFFECTS OF HIV STATUS DISCLOSURE ON SAFE SEX PRACTICES  
AMONG YOUTHS LIVING WITH HIV AND AIDS IN THE LEA TOTO  
PROGRAM, NAIROBI COUNTY, KENYA**

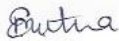
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**A THESIS SUBMITTED IN PARTIAL FULFILMENT OF THE  
REQUIREMENTS FOR THE AWARD OF THE DEGREE OF MASTER OF  
ARTS IN COUNSELLING PSYCHOLOGY IN THE DEPARTMENT OF  
COUNSELLING PSYCHOLOGY, SCHOOL OF SOCIAL SCIENCES,  
AFRICA NAZARENE UNIVERSITY**

**SEPTEMBER 2020**

## DECLARATION

I declare that this document and the research that it describes are my original work and that they have not been presented for a degree in any other university for academic work.

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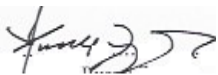
## SUPERVISORS' SIGNATURES

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## **DEDICATION**

This thesis is dedicated to all youth living with HIV for their courage and resilience. It is also dedicated to my late mother, who passed away before the completion of this work.

## ACKNOWLEDGEMENTS

I thank the Almighty God for His guidance and providence, which enabled me to undertake this research thesis, as it was very involving in terms of time and resources.

Several people, that made the undertaking and completion of this thesis possible; I am grateful to my family, and especially my husband and daughter for their support and encouragement in this long journey, they have been my constant cheering squad and my pillars.

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## TABLE OF CONTENTS

<b>DECLARATION.....</b>	<b>i</b>
<b>SUPERVISORS' SIGNATURES .....</b>	<b>i</b>
<b>DEDICATION.....</b>	<b>ii</b>
<b>ACKNOWLEDGEMENTS .....</b>	<b>iii</b>
<b>TABLE OF CONTENTS .....</b>	<b>iv</b>
<b>LIST OF TABLES .....</b>	<b>viii</b>
<b>LIST OF FIGURES .....</b>	<b>ix</b>
<b>ABSTRACT.....</b>	<b>x</b>
<b>DEFINITION OF TERMS.....</b>	<b>xi</b>
<b>ABBREVIATIONS AND ACRONYMS.....</b>	<b>xiii</b>
<b>CHAPTER ONE .....</b>	<b>1</b>
<b>INTRODUCTION.....</b>	<b>1</b>
1.1 Introduction.....	1
1.2 Background of the Study .....	1
1.3 Statement of the Problem.....	4
1.4 Purpose of the Study .....	6
1.5 Objectives of the Study.....	6
1.6 Research Hypotheses .....	6
1.7 Significance of the Study .....	7
1.8 Scope of the Study .....	8
1.9 Delimitations of the Study .....	9
1.10 Limitations of the Study.....	9
1.11 Assumptions of the Study .....	9
1.12 Theoretical Framework.....	10
1.12.1. Communication Privacy Management Theory.....	10
1.12.2 Theory of Planned Behaviour .....	12
1.13 Conceptual Framework.....	14
<b>CHAPTER TWO .....</b>	<b>17</b>

<b>LITERATURE REVIEW .....</b>	<b>17</b>
2.1 Introduction.....	17
2.2 Review of Literature .....	17
2.2.1 <i>Safe Sex Practises</i> .....	17
2.2.2 Effect of voluntary self-disclosure on safe sex practises among YLWH.....	19
2.2.3 Effect of voluntary Shared-disclosure on Safe Sex Practices among YLWH....	24
2.2.4 Effect of involuntary disclosure on safe sex practices among YLWH.....	28
2.2.5 Effect of HIV status disclosure outcomes on safe sex practices among YLWH	30
2.3 Summary and Research Gap .....	31
<b>CHAPTER THREE.....</b>	<b>33</b>
<b>RESEARCH DESIGN AND METHODOLOGY .....</b>	<b>33</b>
3.1 Introduction.....	33
3.2 Research Design.....	33
3.3 Research Site.....	33
3.4 Target Population.....	34
3.5 Study Sample .....	35
3.5.1 Study Sample Size .....	35
3.5.2 Sampling Procedure .....	35
Table 3.1 Sampling Frame for the Youth .....	<b>36</b>
Table 3.2 Key Informants Sampling Frame.....	<b>36</b>
3.6 Data Collection .....	37
3.6.1 Data Collection Instruments .....	37
3.6.2 Pilot Testing of Research Instruments .....	37
3.6.3 Instrument Reliability .....	38
Table 3.3 Reliability Test.....	<b>39</b>
Source: (Author, 2020). .....	39
3.6.4 Instrument Validity .....	39
3.6.5 Data Collection Procedure .....	39
3.7 Data Analysis .....	40
3.8 Legal and Ethical Considerations .....	41
<b>CHAPTER FOUR.....</b>	<b>42</b>

<b>DATA ANALYSIS AND FINDINGS.....</b>	<b>42</b>
4.1 Introduction.....	42
4.2 Response Rate.....	42
4.2.1 Social Demographic Characteristics of Respondents .....	43
4.2.1.1 Gender of Respondents .....	43
4.2.1.2 Age of Respondents .....	44
4.3 Presentation of Research Analysis and Findings .....	44
4.3.1 Effect of voluntary self-disclosure on safe sex practices among YLWH.....	45
4.3.1.1 <i>Safe Sex Practices</i> .....	45
4.3.1.2 Effects of Voluntary Self-Disclosure on Safe Sex Practices among YLWH ..	48
4.3.2 Effect of voluntary shared-disclosure on safe sex practices among YLWH .....	50
4.3.3 Effect of involuntary disclosure on Safe Sex Practices among YLWH .....	54
4.3.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH	58
4.4 Hypotheses Testing.....	61
4.4.1 Pearson Correlation.....	62
4.4.2 Multivariate Regression Analysis .....	63
<b>CHAPTER FIVE .....</b>	<b>66</b>
<b>DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS .....</b>	<b>66</b>
5.1 Introduction.....	66
5.2 Discussions .....	66
5.2.1 Social Demographic Characteristics of Respondents .....	66
5.2.1.1. Response rate .....	66
5.2.1.2 Gender and Age of respondents .....	67
5.2.2 Voluntary Self-Disclosure and Safe Sex Practices .....	68
5.2.3 Effect of voluntary shared-disclosure on safe sex practices among YLWH .....	73
5.2.4 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH .....	76
5.2.5 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH	79
5.3 Summary of main findings.....	81
5.3.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH.....	81

5.3.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices among YLWH ..	83
5.3.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH .....	84
5.3.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH	86
5.4 Conclusion .....	88
5.4.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH.....	88
5.4.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices .....	88
5.4.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH .....	89
5.4.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH	89
5.5 Recommendations.....	90
5.5.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH.....	90
5.5.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices among YLWH ..	91
5.5.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH .....	91
5.5.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH	91
5.6 Areas of Further Research .....	92
<b>REFERENCES.....</b>	<b>93</b>
<b>APPENDICES .....</b>	<b>105</b>
Appendix I: Informed consent form .....	105
Appendix II: Youth’s Questionnaire.....	107
Appendix III: Key Informants’ Interview (KII).....	110
Appendix IV: Focused Group Discussions for YLWH.....	111
Appendix V: Research Permit .....	112
Appendix VI: Research approval Letter .....	114
Appendix VII: Map of Study Area .....	115



**LIST OF TABLES**

Table 3.1 Sampling Frame for the Youth .....	<b>36</b>
Table 3.2 Key Informants Sampling Frame.....	<b>36</b>
Table 3.3 Reliability Test.....	<b>39</b>
Table 4.1 Response Rate.....	<b>43</b>
Table 4.2 Safe Sex Practices .....	<b>46</b>
Table 4.3 Voluntary Self-Disclosure and Safe Sex Practices .....	<b>48</b>
Table 4.4 Voluntary Shared-Disclosure and Safe Sex Practices .....	<b>51</b>
Table 4.5 Involuntary Disclosure and Safe Sex Practices .....	<b>54</b>
Table 4.6 Disclosure Outcomes and Safe Sex Practices.....	<b>59</b>
Table 4.7 Pearson Correlation.....	<b>63</b>
Table 4.8 Model Summary .....	<b>64</b>
Table 4.9 Analysis of Variance.....	<b>64</b>
Table 4.10 Regression Coefficients .....	<b>65</b>

**LIST OF FIGURES**

Figure 1.1 Conceptual Framework for Effect of HIV Status Disclosure on Safe Sex..	15
Figure 4.1 Gender of Respondents (Source: Field Data, 2020).....	43
Figure 4.2 Age of respondents (Source: Field Data, 2020). ....	44

## ABSTRACT

HIV serostatus disclosure is an immense challenge for youth living with HIV, their sexual partners, and health workers. In Kenya, however, little guidance is available to the youth on the HIV disclosure process. The purpose of this study was to examine the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS. The objectives of the study include: to examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV; to assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV; to determine the effect of involuntary disclosure on safe sex practices among youths living with HIV, and to establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV. The Communication Privacy Management theory and the theory of Planned Behaviour were used. This study adopted the correlational research design. The target population was 1573, YLWH, aged between 15-24 years, who were accessing care at the Lea Toto program, Nairobi. The sampling technique was stratified random sampling. The sample size was 157 YLWH, 14 key informants and 2 Focused Group Discussions. Pilot testing was conducted at AMREF Lang'ata with 16 respondents. 143 questionnaires were obtained from YLWH, in-depth interviews were conducted with 11 health workers, counsellors and social workers, and 2 focused group discussions with 10 participants each with YLWH. The cleaned and coded data were entered into the Statistical Package for Social Science (SPSS) statistical software version 25 for analysis. Descriptive and inferential statistical analyses were performed for the quantitative data while qualitative data from Focus Group Discussions (FGDs) and Key Information Interviews (KIIs) was subjected to thematic/content analysis. Pearson Correlation Analysis show that there was significant relationship between safe sex practices and all the independent variables (voluntary self-disclosure,  $r=0.502$ ,  $p<0.05$ ; voluntary shared-disclosure,  $r=0.392$ ,  $p<0.05$ ; involuntary/accidental disclosure,  $r=0.015$ ,  $p<0.05$  and disclosure outcomes,  $r=0.502$ ,  $p<0.05$ ) at significance level of 0.05. This was corroborated by findings from Analysis Variance that shows that all independent variables statistically significantly predict safe sex practices ( $F=26.182$ ,  $p<0.05$ ). There were also high levels of willingness to disclose their HIV status to their sexual partners. FGDs and KIIs show that disclosure was often challenged by negative effects such as stigma, marriage/relationship breakup, depression, violence, and suicide in some cases. In most cases, there were no instances of forced disclosures by health care providers. Disclosure had positive effects such as adherence to treatment and safe sex practices, especially if it was followed by support. The study recommends the need for encouraging and supporting more YLWH to disclose their statuses. The community should be educated so as to support those who disclose their statuses and avoid stigmatisation. Counselling strategies and government policies on safe sex should be strengthened. This study will form a critical auxiliary to the HIV management process through the mobilization of positive community attitudes, reduction of stigma on HIV related issues, and promotion of "courage" for HIV status disclosure.

## DEFINITION OF TERMS

**Adherence:** It refers to the whole process from choosing, starting, managing to maintain a given therapeutic medication regimen to control HIV viral replication, and improve the function of the immune system (WHO, 2018). In this study, adherence will be used to refer to specifically the act of maintaining or following a given treatment regimen consistently among young people living with HIV.

**HIV Status Disclosure:** This refers to the personal experience of communicating with another individual or group of individuals that one is HIV positive (Canadian HIV and AIDS Legal Network, 2016). In this study, HIV status disclosure is the act of a young person revealing his/her HIV status to a person with whom he/she is in a sexual relationship. It also includes disclosure to friends or family members for support.

**Involuntary Disclosure:** This is defined as coerced disclosure of a person's HIV status by another person (a health care professional), especially when the person living with HIV is a risk to others (UNAIDS, 2015). Operationally defined as the unwilling or accidental disclosure of one's serostatus, for example when the drugs (ARVs) of a person living with HIV are seen by another person, and they make the right conclusion about the purpose of the drugs.

**Safe-sex practices:** Refers to sexual activity and especially sexual intercourse in which various measures (such as the use of latex condoms or the practice of monogamy) are taken to avoid disease (such as AIDS), transmitted by sexual contact (Merriam Webster Incorporated, 2019, UNAIDS, 2020) In this study, safe sex practices include abstinence,

delaying the first sexual encounter, faithfulness to one partner, condom use and Adherence to ART.

**Sexually active:** Operationally defined as the onset of sexual intercourse with a consenting partner among youth living with HIV.

**Voluntary self-disclosure:** This refers to the act of a PLWH, telling another person of their status without being coerced (Shrestha, 2019). Operationally defined as the act of a young person who is living with HIV willingly disclosing their status to another person.

**Voluntary shared disclosure:** This is operationally used to refer to the act of a young person willingly involving another person (health care professional or family member) to disclose their HIV status.

**Youth:** The term is best understood as a period of transition from the dependence of childhood to adulthood's independence and awareness of our interdependence as members of a community (UNESCO, 2019). In this research study, a youth will be a person aged between 15 and 24 years.

**ABBREVIATIONS AND ACRONYMS**

<b>ART</b>	Antiretroviral Treatment/ Therapy
<b>AIDS</b>	Acquired Immuno-Deficiency Syndrome
<b>ARV</b>	Anti-Retroviral Drugs
<b>CCC</b>	Comprehensive Care Centres
<b>CHW</b>	Community Health Worker
<b>FGD</b>	Focused Group Discussion
<b>HIV</b>	Human Immunodeficiency Virus
<b>HIV+</b>	Human Immunodeficiency Virus- Positive
<b>HTS</b>	HIV Testing & Counselling Services
<b>KII</b>	Key Informants' Interview
<b>MHO</b>	Medical Health Officer
<b>MTCT</b>	Mother to Child Transmission
<b>PEP</b>	Post Exposure prophylaxis
<b>PrEP</b>	Pre-exposure prophylaxis
<b>PLWH</b>	People Living with HIV and AIDS
<b>PWID</b>	People Who Inject Drugs
<b>YLWH</b>	Youth Living with HIV and AIDS

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Introduction**

This chapter introduces the study. It presents an outline of HIV status disclosure, which is the independent variable and safe sex practices among youths living with HIV and AIDS, which is the dependent variable. In addition, a presentation of the statement of the problem, the purpose of the study, the research objectives, the justification, the scope, the delimitations, and the limitation of the study, and also the theoretical and conceptual frameworks of the study are included.

#### **1.2 Background of the Study**

Human Immunodeficiency Virus (HIV) is the virus, which causes Acquired Immuno-Deficiency Syndrome (AIDS), and is considered a severe global public health challenge. An estimated 38 million individuals are living with HIV in the world (World Health Organisation, 2019). There were approximately 1.8 million new HIV infections in 2019, and about 5,000 people newly infected with HIV infections each day. Research has shown that the vast majority of people with HIV are in low and middle-income countries. In 2019, there were 20.7 million people with HIV (54%) in eastern and southern Africa, 4.9 million (13%) in western and central Africa, 5.8 million (15%) in Asia and the Pacific, and 2.2 million (6%) in Western and Central Europe and North America. East and Southern Africa is the region hardest hit by HIV. It is home to 6.2% of the world's population but over half of the total number of people living with HIV in the world. In 2019, there were 790,000 new HIV infections, 43% of the global total, (UNAIDS, Global Aids Update, 2020).

From previous research, 82 percent of people living with HIV/ AIDS (approximately 25 million people) had access to antiretroviral therapy (ART) worldwide. The access to treatment of HIV is an important step towards ending the public health threat of HIV/AIDS globally (World Health Organisation, 2019). Individuals who know about their status and take ART as directed can maintain an untraceable viral load and even live prolonged healthy lives. Additionally, such people who adhere to treatments and maintain an untraceable viral load have zero risks of transmitting the virus to their uninfected sexual partners

At the end of 2019, the World Health Organization estimated that 5 million young people aged 15 to 24 years, about 13% were living with HIV and AIDS globally (UNAIDS, 2020). A healthy quality of life for these youth is important as they continue their development into adulthood. HIV-related stigma has been shown to negatively impact the quality of life for youth living with HIV (YLWH). The psychological distress that is often experienced by HIV-infected youth as the result of stigma has been associated with participation in sexual and substance use risk behaviours and decreased adherence to antiretroviral therapies (Hosek, Harper, & Domanico, 2010; Yaya, et al., 2014).

HIV prevalence in Kenya stands at 5.9%, which translates to 1,517,707 people estimated to be living with HIV and AIDS in Kenya (NACC, 2018). The same report indicates that a total of 435, 225 youth aged between 15-24 years in Kenya are HIV positive while 119,899 have HIV but been identified to be sexually active. This means that many young people are engaging in sexual relationships thus are more likely to transmit the virus to partners. Youth considerably contribute to the high HIV prevalence in Kenya, since they make up the highest percentage of persons living with the virus. Conspicuously, the young people are responsible for 51 percent of new HIV infections



among the adults, which is an upsurge from 29 percent in the year 2013. Several factors have contributed to this increase in infections. They include inadequate awareness of erotic behaviour that puts them at the risk of HIV, such as avoiding condom usage during first sexual encounters, having sex under the influence of substances, in addition to other factors. This challenge advocates for a measure that will help to overturn the pattern over time (De Cock, Rutherford, & Akhwale, 2014).

Disclosure of positive HIV status by PLWH to their sexual partners is important in reducing HIV/AIDS transmission (Dankoli, et al., 2014). This is because; it may prompt the partner of an HIV infected individual, to seek HIV testing and to take up other interventions, such as condom use (Alemayehu, Aregay, Kalayu, & Yebyo, 2014). Disclosure has been positively associated with consistent condom use among PLWH in Kenya, Namibia, and Tanzania (Bachanas, et al., 2013). Disclosure to sexual partner has been directly associated with adherence to Antiretroviral Therapy (ART) in PLWH (Yaya, et al., 2014), while among HIV positive pregnant women in Ethiopia it was a positive predictor of adherence to option B+ (Ebuy, Yebyo, & Alemayehu, 2015). Subsequent to disclosure, PLWH may experience relief from the unconditional acceptance and support from their partners (Adekanle, 2015). The positive effects of disclosure could be attributed to the ability to get support in taking one's medications and attending clinic appointments.

The number of people living with HIV and AIDS in Nairobi continues to increase each passing day with staggering statistics pointing to indiscriminate sexual behaviour among the youth. Nairobi, which was among the highest incidence counties, was ranked seventh among all counties in HIV incidence in 2017 (Omondi, 2018). 15 percent of youth between 15 and 24 years have had sex at 15 years of age (Kenya AIDS Indicator Survey, 2017). HIV prevention interventions for YLWH emphasize delaying sexual

intercourse, reducing the number of sexual partners, and using condoms. YLWH, experience unique challenges, because of the intricate relationship between sexuality, and HIV transmission (Baryamutuma, 2011). Recently, biomedical HIV prevention has shown a number of successes, including evidence of the effectiveness of male circumcision, oral and topical Pre-Exposure prophylaxis and also Post-Exposure prophylaxis for those youth who are among the Key populations; sex workers, men who have sex with men (MSM), and People who inject drugs (PWIDs) (Bekker, 2015). Therefore there is great need to focus primary and secondary prevention efforts on youth not only because they are at high risk of acquiring HIV, but also because they are at high risk of transmitting the virus to others (Bekker, 2015).

Majority of the studies reviewed focus on the prevalence of HIV among the youth (Omondi, 2018; NACC, 2018; UNAIDS, 2019), with few of them focusing on the relationship between HIV status disclosure and safe sex practices (Bachanas, et al., 2013; Yaya, et al., 2014). This study, therefore, sought to investigate the effect of HIV status disclosure on safe sex practices among the youth living with HIV.

### **1.3 Statement of the Problem**

An estimated 2 million young people aged 15–24 years are living with HIV worldwide (UNAIDS, Global Aids Update, 2020). Many of these youth are also engaging in sexual relationships thus are likely to infect their partners. In the recent past, Kenya has witnessed a rapid upsurge of new HIV infections among the youth. This is attributable mainly to the lack of HIV status disclosure and unsafe sex practices among partners. Failure by a sexual partner to disclose his/her serostatus increases the risk of transmitting the virus, thus continuing the upward trend in new infections. It is however, important to note that disclosure of HIV status, especially among the youth is

not an easy decision because they fear stigmatization and rejection by their partners (Gabbion, 2019)

Studies from Sub-Saharan Africa report inconsistent associations between knowing their own HIV-status and safe sex (Beyeza, et al., 2011). There are few known studies worldwide that have tested the effect of safe sex practices on disclosure of status to partners. One found lower, but not statistically significant, rates of condom use among adolescents who had disclosed to their partners in Uganda (Birungi, Mugisha, Obare, & Nyombi, 2009). Another study reported that disclosure of status to partners was not associated with safe sex in Canada (Dempsey, MacDonell, Naar-King, & Lau, 2012).

Previous research has shown that disclosure of HIV status is important in reducing transmission (Dankoli, et al., 2014). However, not much has been done to connect disclosure and safe sex practices, since previous studies have inclined on the increased condom use as a result of disclosure (Bachanas, et al., 2013; Alemayehu, Aregay, Kalayu, & Yebyo, 2014). This is a problem since it is important to understand whether disclosure of HIV status increases safe sex practices among the youth. This research study sought to address this problem, by checking whether HIV status disclosure affected safe sex practices and among youths.

There is a great challenge in cases where youths are engaged in sexual relationships, and some of them do not disclose their HIV status to their sexual partners; those who already know their status are in some instances afraid of stigma, discrimination, and rejection if they disclose their status. Further, there is no guideline in Kenya pointing out how youth in active sexual relationships can disclose their HIV status without victimization. Therefore, the goal of this study was to assess the effect

of voluntary self-disclosure, voluntary shared disclosure, and involuntary disclosure and HIV status disclosure outcomes on safe sex practices among the youth.

#### **1.4 Purpose of the Study**

This study sought to examine the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS in the Lea Toto Program, Nairobi County, Kenya.

#### **1.5 Objectives of the Study**

The following objectives guided the study:

- (i) To examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV and AIDS in the Lea Toto program, Nairobi County, Kenya;
- (ii) To assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV in the Lea Toto program, Nairobi County, Kenya;
- (iii) To determine the effect of involuntary disclosure on safe sex practices among youths living with HIV in the Lea Toto program, Nairobi County, Kenya;
- (iv) To establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV in the Lea Toto program, Nairobi County, Kenya.

#### **1.6 Research Hypotheses**

The following hypotheses informed this study:

- (i) Voluntary self-disclosure does not have a statistically significant effect on safe sex practices among youth living with HIV.
- (ii) There is no statistically significant effect of voluntary shared disclosure on safe sex practices among youth living with HIV.
- (iii) Involuntary/accidental disclosure does not have a statistically significant effect on safe sex practices among youth living with HIV.
- (iv) There is no statistically significant relationship between HIV status disclosure outcomes and safe sex practices among youth living with HIV.

### **1.7 Significance of the Study**

Management of HIV and AIDS has been a challenge since it touches on all spheres of humanity from a global to a national standpoint (Volberding & Deeks, 2010). National Health budgets, institutional budgets, and family budgets are affected. This study will form a critical auxiliary to the HIV management process as it will help all who are infected and affected in the mobilization of positive community attitudes, to reduce stigma on HIV related issues, and promote “courage” for HIV status disclosure. This will, in turn, help to better manage human capital. Policymakers will be able to enact policies that enable YLWH to freely disclose their status to their partners and therefore reduce new infections among the community.

In addition, this study has built on existing information and has aided government and private agencies involved in the fight against HIV and AIDS with management skills that will help reduce the high HIV prevalence rate among the youth. This in turn will provide young sexual partners living with HIV with skills on disclosing their HIV status, and knowledge of safe sex practices. Researchers and scholars stand to gain from

the research findings since the study forms a basis for identifying knowledge gaps in safe sex practices and appropriate disclosure criteria for future research.

The counsellors have more understanding of how to counsel HIV positive youth on safe sex practices and were better equipped to develop effective screening tools that help in identifying youths who are likely to disclose and those not likely to thus helping better understand how to overcome the challenges of non-disclosure. Additionally, the study helped community-based organisations like Lea Toto, among others to learn better ways of empowering youth on safe sex practices and HIV status disclosure. The study was essential to many stakeholders including the youth, existing and potential sex partners, caregivers, counsellors, public and private entities, and helping in promoting safe sex practices and embedding a caring culture in HIV and AIDS management.

### **1.8 Scope of the Study**

This study was conducted at the Lea Toto Program's eight satellites in Nairobi since the researcher was not able to reach all the sub-counties covered by the program. Many organisations deal with HIV in Nairobi but this is among the few that attend to young people living with HIV. The study sought to assess the effect of HIV status disclosure on safe sex practices among youth living with HIV and AIDS. The target population for this study was youths living with HIV aged between 15-24 years who were accessing care at the Lea Toto Program, and the number 1,503. This group makes up the highest percentage of persons living with the virus in Kenya (De Cock, Rutherford, & Akhwale, 2014). The health care workers, counsellors and social workers who deal with PLWH also form a critical part of the study as they are the frontline workers in battling this scourge, in this regard, 14 Key informants were targeted from the total 139 found in all the Lea Toto centers in Nairobi, they were randomly selected.

Two focused group discussions with ten participants per group, who were randomly selected, among the YLWH also comprised the study as part of the qualitative data so as to validate the research.

### **1.9 Delimitations of the Study**

This study was limited in scope to target youth seeking care at the Lea Toto Program. The researcher did not intend to engage other HIV and AIDS affected youth in other areas, apart from the targeted site. Additionally, it was not possible to reach out to all youths seeking care from different programs to provide information on the subject investigation due to logistical constraints and the sensitive nature of the topic.

### **1.10 Limitations of the Study**

Some of the respondents were not comfortable to provide accurate information, as they wanted to portray themselves in a positive light. The researcher however assured them that their identities would remain anonymous and that the information sought would be used purely for academic purposes. The data collection process was severely impacted by COVID 19, as many of the respondents failed to show up at the centres, prompting the researcher to venture to their homes. Most of the sites the respondents resided were informal settlements which were hard hit by the pandemic and therefore, some of the respondents refused to participate in the study since it was not economically beneficial to them many of them.

### **1.11 Assumptions of the Study**

This study was based on the assumption that the targeted respondents were willing to participate in the study. The researcher was guided by the view that the

participating respondents were youths living with HIV, who were aware of their status, and sought care from the Lea Toto Program. The researcher further assumed that in line with the study hypothesis, voluntary self-disclosure was affected by self-esteem and led to safe sex practices, voluntary shared disclosure increased social support system and led to safe sex practices, involuntary disclosure was related to stigma and hindered safe sex practices, and HIV status disclosure outcomes could be either positive or negative and would affect safe sex practices.

## **1.12 Theoretical Framework**

In this study, the following theories were used to explain the variables.

### **1.12.1. Communication Privacy Management Theory**

Sandra Petronio formulated the theory of Communication Privacy Management (CPM) in 1991. The theory stresses the significance of knowing; the proper times, individuals, and channels to disclose information. This theory is seen as a system of communication and it consists of; privacy ownership which refers to individual restrictions or borders that maintain certain information as a secret; privacy control which refers to the process of decision making where a person decides what information to disclose and whom to disclose to; and privacy turbulence that refers to situations where privacy ownership and privacy control borders are broken or do not go according to plan (Dunlop, 2015).

There are five principles of CPM, where the first four principles take care of privacy ownership and privacy control, while the fifth one handles privacy turbulence: The first is people believe they own and have a right to control their private information. The second is people control their private information through the use of personal



privacy rules. The third is when others are told or given access to a person's private information, they become co-owners of that information. The fourth is co-owners of private information need to negotiate mutually agreeable privacy rules about telling others. The fifth is when co-owners of private information do not effectively negotiate and follow mutually held privacy rules; boundary turbulence is the likely result (Griffin, Ledbetter, & Sparks, 2015).

Making decisions to disclose or protect private information often creates a tension in which individuals hesitate between sharing and concealing their private information. Within the purview of health issues, these decisions have the potential to increase or decrease risk. The choice of disclosing health matters to a friend, for example, can garner social support to cope with health problems. At the same time, the individual may have concerns that his or her friend might tell someone else about the health problem, thus causing more difficulties (Petronio & Venetis, 2017).

Disclosure of HIV-positive serostatus has been defined as a process of communicating potentially stigmatizing information that had previously been kept hidden in order to increase one's psychological well-being, and in the case of disclosure to sexual partners, to preserve the quality of relationships. Disclosure is thus not a simple act. It involves careful consideration of "to whom" and "when" and depends on preparation and a personal decision (Gabbion, 2019). This study used this theory to check whether deciding to disclose one's HIV status decreases the risk of spreading the condition by increasing safe sex practices among the youth living with HIV. This theory, however, fails to confirm whether the decision to disclose information can be foretold, or whether it is influenced by other personal factors. Therefore, the theory of planned behaviour will bridge this gap as explained below.

### **1.12.2 Theory of Planned Behaviour**

The proponents of this theory are Fishbein and Ajzei. This theory provides a framework to study attitudes toward behaviours. According to the theory, the most important determinant of a person's behaviour is behaviour intent. The individual's intention to perform behaviour is a combination of attitude toward performing the behaviour and subjective norm. The individual's attitude toward the behaviour includes; Behavioural belief, evaluations of behavioural outcome, subjective norm, normative beliefs, and the motivation to comply (Armitage & Conner, 2011).

This theory suggests that behavior is a consequence of behavioural objectives, which are a function of attitudes and individual customs. Fishbein and Ajzei created a module that incorporated both the theory of planned behaviour and the theory of reasoned action, and adopted perceived behavioral control as a supplementary element forecasting both behavioral intents and behaviour. In recent research studies, the models have been condensed into the model of Reasoned Action Approach (Ajzei & Fishbein, 2005).

The researchers noted that attitudes towards the behavior were well defined, as a collection of available or noticeable beliefs about the likely consequences of executing the target behavior. On the other hand, subjective norms were translated as the social pressure to practice or not practice the target behavior, and behavioral intentions were defined as the possibility of performing the target behaviour (Ajzei & Fishbein, 2005)

Nevertheless, one of the hindrances to the conversion of intentions to behavior is a person's ability to practice the desired behaviour. In that regard, the Theory of Planned Behaviour was critical in restructuring the Theory of Reasoned Action to contain an element of perceived behavioral control, which defines a person's perceived

ability to carry out the target behaviour. Actually, perceived behavioral control was added to the model to increase its application beyond only volitional behaviours. Before the addition was made, the model was noticeably not successful in forecasting behaviors that were not majorly under volitional control. Therefore, the Theory of Planned Behaviour suggests that the key predictors of behavior are a person's behavioral intention and perceived behavioral control (Ajzei & Fishbein, 2005).

Pikard (2009) conducted a research study on HIV voluntary counselling and testing among Kenyan male youth aged 13-15 years. Using the Theory of Planned Behaviour, the study aimed at forecasting the intentions to utilize VCT services by Kenyan students across the country. The researcher targeted students in high schools within Nairobi and Nakuru districts in 2009. The results showed no significant associations between age, school, school level, knowledge of a VCT centre, or past sexual experience with the intention to take HIV testing and counselling services. Further analysis showed a positive correlation between subjective norm and attitude, and a negative relationship between perceived risk and perceived behavioural control. Additionally, data analysis results revealed that there was an association between intention and perceived behavioural control. Further analysis using regression showed that perceived risk and perceived behavioural control significantly predicted intentions to use VCT services. From the results, the study found out that Kenyan teenagers consider the level of difficulty to practise a given behaviour as the most significant predictor of the intentions to perform the behaviour. The study recommended a theory-based intervention to reduce barriers of using VCT services (Pikard, 2009).

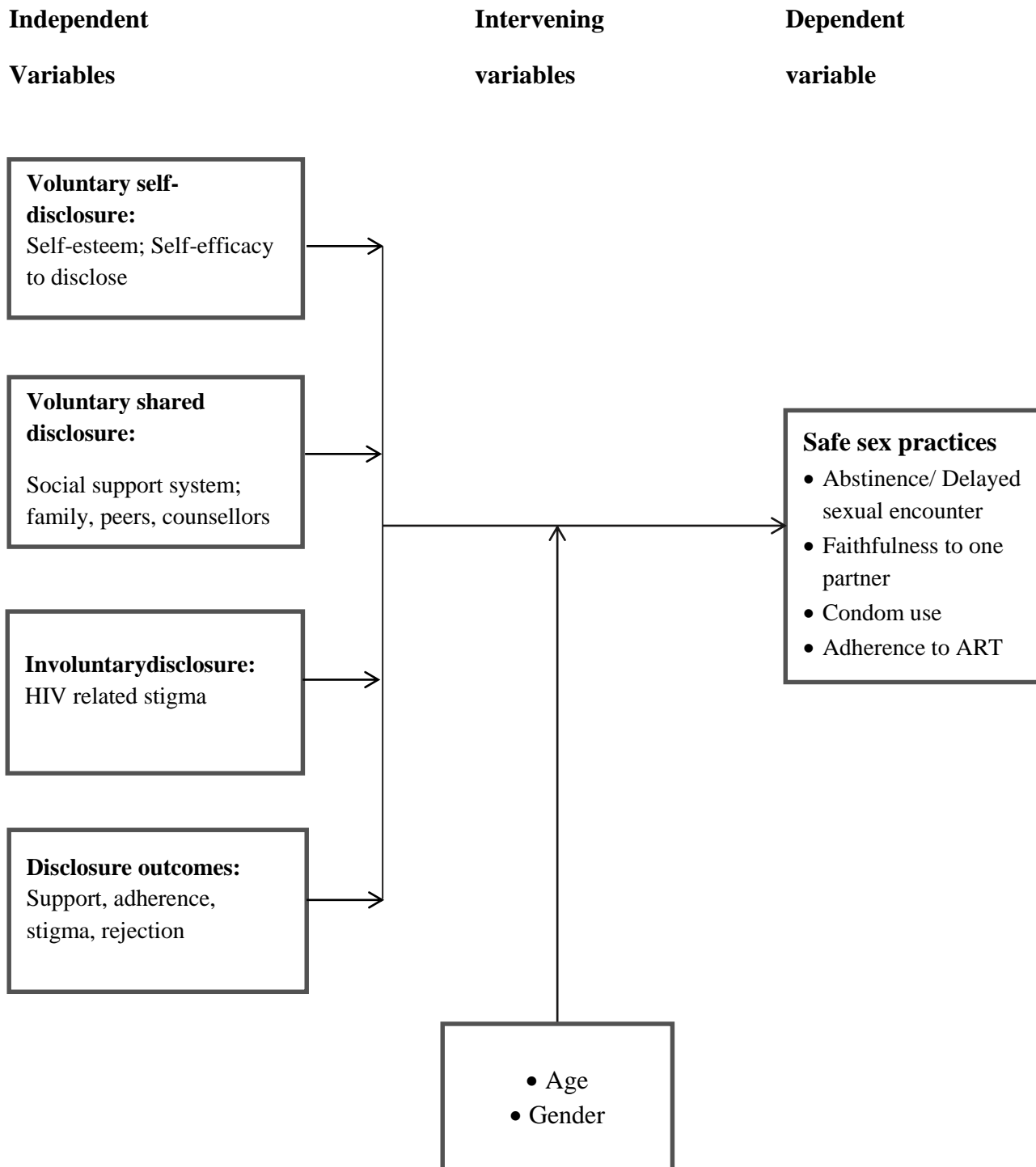
This research study seeks to find out if the action of safe sex practices will be determined by the intention of disclosing one's HIV status. It will be the researcher's aim to determine if the individual's intention and attitude towards disclosure is affected

by; Behavioural belief (what beliefs the YLHW have towards safe sex practices), and evaluations of behavioural outcome (HIV status disclosure outcomes that they have had), subjective norm (the societal beliefs on safe sex practices and HIV status disclosure), normative beliefs (the laws on HIV status disclosure and whether they are applied, and the motivation to comply (Is there any motivation among YLHW to comply to the set laws on disclosure?).

### **1.13 Conceptual Framework**

A conceptual framework is a schematic presentation which identifies the variables that when put together explain the issue of concern. It provides the link between the research title, the objectives, the study methodology and the literature review. It is an analytical tool with several variations and contexts used to make conceptual distinctions and organize ideas (Kamau, Githii, & Njau, 2014).

**Figure 1.1 Conceptual Framework for Effect of HIV Status Disclosure on Safe Sex Practices among the YLWH in Nairobi.**



(Source: Author, 2019)

This study conceptualized that safe sex practices, were used when youths who are HIV positive disclosed their status to their partners. As presented in figure 1.1 above, the independent variables that guided this study were; voluntary self-disclosure whereby the researcher looked at the effect of self-esteem and self-efficacy on disclosure; voluntary shared disclosure and effect of social support systems like family, peers and counsellors; involuntary disclosure and effect of resulting stigma; and HIV status disclosure outcomes which were either positive or negative. The dependent variable was safe sex practices (abstinence, faithfulness to one partner, condom use, and adherence to ART). The intervening variables were age and gender and these were assumed to affect both HIV status disclosure and safe sex practices.

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This chapter critically reviews the existing literature on HIV status disclosure and safe sex practices among youth living with HIV and AIDS. The independent variables are voluntary self-disclosure, voluntary shared disclosure and involuntary disclosure. Safe sex practices are the dependent variable. The objectives of the study guide the review.

#### **2.2 Review of Literature**

##### ***2.2.1 Safe Sex Practises***

Safe sex practices allude to sexual activities, specifically; sexual intercourse in which several protective actions including use of condoms or monogamy are practised to avoid sexually transmitted infections (STIs), such as HIV (The Merriam-Webster Dictionary, 2016). Promotion of safe sex practices among young people is particularly important considering the burden of HIV and other STIs in this population with reportedly 26% of new cases of HIV in the United States seen among US youth (Centers for Disease Control and Prevention (CDC), 2015), and almost half of the 20 million new STI infections each year grasped in this demographic as well (Satterwhite, et al., 2013). Besides disparities according to age, STI infections and prevalence changes according to other socio-demographic factors such as geographical location – considerably, the peak rates of STIs in the United States is seen in Southern part of the country (Aral, Fenton, & Holmes, 2007; Mississippi State Department of Health. , 2016; Centers for Disease Control and Prevention (CDC). , 2016).

Abstaining from sexual activity that involves the exchange of bodily fluids and/or genital-to-genital and/or skin to genital contact is the only sure way of avoiding the risk of pregnancy or sexually transmitted infections (STI). Safer sex practices are included in instruction for those young people who may not choose abstinence. Postponement of initial sexual activity, adherence to one sexual partner and protected sexual intercourse are sequentially offered as the next best alternatives. The programs that are most effective in helping young people to abstain involve education about abstinence, contraception and sexual health decision-making (Alberta Education, 2018).

A research study by Jenkin- Capiello was conducted to investigate university students' safe sex practises. Young people's reproductive health is a matter of serious concern. This has been evidenced by Healthy People 2010 objective of increasing the number of young people who abstain from sexual activities, or using condoms if sexually active. This research aimed at examining several factors related to sexual behaviour and reproductive health. The study used a descriptive research design, with a sample population of undergraduate students attending a public university in New England. This study used data previously collected by The Connecticut State University Profiles on Student Health Survey. Data analysis results revealed that majority of the respondents reported condom use, where men were more likely to report condom use than females. Additionally, the use of condoms reduced as class rank advanced and knowledge about the use of condoms was not related to increased condom use. Further, the majority of the respondents reported having been tested for a sexually transmitted disease (STD) and a third of them had been tested for HIV. The occurrence of STDs was notably low and there were no reported cases of HIV. From the findings, the study recommended further research to assess the factors that influence youth's protective



sexual behaviours and sexual practises (Jenkin-Cappiello, 2006; Bryan, Aiken, & West, 2014).

### **2.2.2 Effect of voluntary self-disclosure on safe sex practises among YLWH**

HIV infection is considered private and confidential information, which if revealed, can lead to rejection and stigmatization. Yet when HIV status is not disclosed to sexual partners, safer sexual practices may not be followed, and further spread of the disease may result. Thus, HIV-positive individuals often experience significant conflict and distress over what to say about their serostatus to others, particularly sexual partners. HIV-negative men may feel uncomfortable asking their partners as well (Petрак, Doyle, Smith, Skinner, & Hedge, 2010; Deribe, Ebrahim, & Bush, 2018).

Difficulties with voluntary self-disclosure have been found among both symptomatic as well as asymptomatic individuals and when disclosures were to family members and others besides sexual partners alone. Rejection does not always occur from main partners. HIV-positive individuals may not perceive or want to perceive themselves as sick, though others may view them as such, resulting in tension and conflict (Petрак, Doyle, Smith, Skinner, & Hedge, 2010; Griffin, Ledbetter, & Sparks, 2015). Flowers & Davis (2013) found in a street survey of the general public in Edinburgh, Scotland, more liberal attitudes toward HIV than persons with HIV thought existed. However, people with HIV still experience and fear rejection from potential sexual partners, and the possibility of being a sexual partner with a person with HIV was not examined in this study.

Underlying the attempt to encourage HIV-seropositive individuals to reveal their serostatus to their sexual partners is the assumption that disclosure will increase the safety of subsequent sexual activity with informed partners. Research has found that

it is sensible to assume that a couple's carefulness in using condoms constantly and properly would be improved by one partner's disclosure of HIV- positive status. Further, the findings showed that open communication is expected to encourage safer sexual practices. Actually, disclosure likely encourages the conversation of safe sex actions or the discussion about protective measures to prevent HIV. Additionally, it is likely to better the inspiration of the consenting partners to practice protection, especially if they are uninfected (Simbayi, et al., 2007; Heeren, Jemmott III, Mandeya, & Tyler, 2017).

People who actually know that they are HIV positive, and are sexually active have a legal, moral, and social responsibility to make their HIV status known to their sexual partners. Declining to disclose such information increases the chances of transmitting HIV to other people since it creates higher chances of practising unsafe sex. In case one sexual partner gets infected, he/she might infect other people unknowingly. Such a chain of events implies that declining to disclose one's HIV status to a sexual partner is totally dangerous, due to the growing HIV pandemic (Mykhalovskiy, 2011; Gabbion, 2019).

Self-efficacy is a person's confidence in their proficiency and potential to carry out goal-oriented activities in a given context. It is how assertive a person feels about undertaking certain jobs, challenges, and circumstances (Hughees, Galbraith, & White, 2015). Observed self-efficacy is a strong indication of carrying out a given task. Generally, individuals who have confidence in their abilities consider demanding responsibilities as meaningful challenges, even when others may consider similar jobs as unfavourable. Therefore, lack of self-efficacy might lead to a person having low ambitions, not putting more effort, or even giving up easily (Tsai, Chuang, Liang, &

Tsai, 2011; Hollar & Sniezek, 2016). Therefore, for one to disclose their HIV serostatus, it is assumed that they need to have a high self-efficacy to do so.

A research study was conducted to check how hope about the future and self-esteem forecast self-efficacy in condom use (Bryan, Aiken, & West, 2014). Findings from the study revealed that self-efficacy as a wide concept, which includes skills employed during condom use, interpersonal traits of talking about condom use with a person's sexual partner, in addition to the capability to use condoms while under the influence of alcohol and other substances. The researchers included communication as one of the factors influencing the self-efficacy model. Communication aspects include the ability of a person to be confident in the conversation with a sexual mate about the intention to use a condom and the ability to negotiate the use of a condom, even in cases of disappointment or opposition from the partner (Bryan, Aiken, & West, 2014). The deductions above showed an association between self-efficacy and the intention to use condoms, which has also been supported by a previously conducted study (Dilorio, Dudley, Lehr, & Soet, 2010; Hughees, Galbraith, & White, 2015).

Toska et al., (2015) stated that HIV-positive adolescents who engage in unsafe sex are at heightened risk for transmitting or re-acquiring HIV. Disclosure of HIV-status to sexual partners may impact on condom use, but no study has explored the effects of (i) adolescent knowledge of one's HIV-status, (ii) knowledge of partner status and (iii) disclosure to partners, on safer sex behaviour. The study by Toska et al., (2015) aimed to identify whether knowledge of HIV-status by HIV-positive adolescents and partners was associated with safer sex. Eighty-eight HIV-positive adolescents (10–19 years old, 52% female, 68.1% vertically infected) who had ever initiated antiretroviral treatment in 41 health facilities in the Eastern Cape, South Africa, were interviewed using standardised questionnaires. Quantitative analyses used multivariate

logistic regressions, controlling for confounders. Qualitative research included interviews, focus group discussions and observations with 43 HIV-positive teenagers and their healthcare workers.  $N = 128$  (14.9%) of the total sample had ever had sex, while  $N = 109$  (85.1%) of sexually active adolescents had boy/girlfriend. In total, 68.1% of the sample knew their status, 41.5% of those who were sexually active and in relationships knew their partner's status, and 35.5% had disclosed to their partners. For adolescents, knowing one's status was associated with safer sex (OR = 4.355, CI 1.085–17.474,  $p = .038$ ). Neither knowing their partner's status, nor disclosing one's HIV-status to a partner was associated with safer sex. HIV-positive adolescents feared rejection, stigma and public exposure if disclosing to sexual and romantic partners. Counselling by healthcare workers for HIV-positive adolescents focused on benefits of disclosure but did not address the fears and risks associated with disclosure. These findings challenge assumptions that disclosure is automatically protective in sexual and romantic relationships for HIV-positive adolescents, who may be ill-equipped to negotiate safer sex. There is a pressing need for effective interventions that mitigate the risks of disclosure and provide HIV-positive adolescents with skills to engage in safe sex.

Notably, an individual's belief in their capability to employ safe sex practices could be an important factor to consider while designing HIV prevention measures for adolescents. This is especially true since studies are confirming that self-efficacy significantly predicts safe sex behavior among sexually active people (Hendrickx, Philips, & Avonts, 2008; Heeren, Jemmott III, Mandeya, & Tyler, 2017). Additionally, the aforementioned researcher found out that self-efficacy is significantly related to safe sex intentions and behavior among Belgian adolescents in both native and ethnic minority groups. In the aforementioned research study, self-efficacy involved the

capability to suggest condom use in a sexual relationship, the ability to use a condom correctly, and the self-confidence in using a condom. Another study in the same line assessed the predictive ability of the planned behavior theory among sample university students from the United States and South Africa (Heeren, Jemmott III, Mandeya, & Tyler, 2017). The study found out that self-efficacy significantly predicts condom usage and the intent of using condoms. Moreover, it has been proved that young people with high motivation levels and high safe sex efficacy are more likely to use condoms. This confirmed earlier findings that self-efficacy was a determinant in the association between motivational readiness to change, and the use of condoms (Outlaw, Naar-King, Janisse, & Parsons, 2010; Hughees, Galbraith, & White, 2015).

A previously conducted research also found out that self-esteem, a person's belief about their own self-worth, and a person's capability to feel positive about themselves have significant impacts on healthy behaviors (De Bruijin, Kremers, Van Mechelen, & Brug, 2015). This therefore shows an association between self-esteem and healthy sexual behaviors. Specifically, another research study found out a significant relationship between individuals' self-esteem and potentially health-risk behaviors among adolescent. Findings from the study revealed that adolescents who scored poorly on self-esteem scored highly on health risk behaviors (Geckil & Dundar, 2011; Gabbion, 2019).

Research has shown that low self-esteem positions a person at an alarming risk of engaging in dangerous sexual behaviors including willingly and knowingly engaging in unprotected sex, and failing to limit sexual partners (Wild, Bhana, & Lombard, 2014). Another study in the same line found out that individuals' low self-esteem is associated with several dangerous sexual behavior such as unprotected sex among respondents who were enrolled in a drug treatment program. (Lejuez, Simmons, Aklin,

& Daughters, 2014). In addition, a research was conducted using a cross-sectional study sample of adolescents in South Africa. The findings revealed that low self-esteem had a significant relationship with several dangerous sexual behaviors such as unprotected sex. However, this and other studies have not conclusively shown that high self-esteem significantly predicts safe sex behaviors, since some research studies have shown a counter association between a person's high self-esteem and practicing dangerous sexual behaviors (Hollar & Sniezek, 2016).

In general, social norms dictate that individuals not always divulge medical problems, particularly those involving personal behaviors. Disclosing a disease may mean divulging other aspects of one's life that may potentially be embarrassing or have negative repercussions (Simoni & Pantalone, 2015). This area has been under-studied among other diseases, and clearly has additional complications about HIV. This research study will therefore, strive to examine the effect of voluntary self-disclosure on safe sex practices, among youths living with HIV in the Lea Toto Program in Nairobi County.

### **2.2.3 Effect of voluntary Shared-disclosure on Safe Sex Practices among YLWH**

Disclosing one's HIV- positive status to partners, families, and friends is a key initiative since it provides several advantages to the HIV- positive individual and the public in general (Maman & Medley, 2004; Gabbion, 2019). Disclosure makes untested sexual partners aware of the risk of HIV, therefore leading to an increase in taking HTS. Additionally, disclosing HIV status to a sexual partner informs HIV- positive couples, to make learned reproductive health decisions, that will in turn reduce the number of unplanned pregnancies, as well as decrease chances of mother to child (MTCT) transmissions (Beyeza, et al., 2011; Deribe, Ebrahim, & Bush, 2018). Disclosing HIV

status encourages individuals to lower unsafe sexual patterns, hence reducing transmission. Moreover, disclosure increases access to HIV prevention and treatment programs and leads to improved results through improvements in the adherence to ART (BC Centre for Disease Control, 2016)

Qualitative research methods have been successfully used to elucidate how individuals view and approach the meanings and complex interpersonal aspects of illness. Qualitative data and narratives of individuals' experiences can also reveal how individuals within a particular social or cultural situation or setting view a phenomenon, thus shedding light on the perspectives of these individuals themselves, as opposed to the viewpoints of researchers. One researcher presented qualitative findings examining factors affecting disclosure among respondents in East London, reporting, for example, on one focus group consisting of three infected individuals (Petрак, Doyle, Smith, Skinner, & Hedge, 2010; Gabbion, 2019).

A previously conducted research describes how individuals learn to conceptualize and manage stigmatized or "spoiled" aspects of their social or personal identities. Some individuals attempt to "conceal" symbols of stigma and to "pass," while others socialize more fully with similarly stigmatized individuals. Similarly, Parsons describes "the sick role"—a social role characterized by certain exemptions rights, and obligations, and an impaired capacity to function (Parsons, 2008). HIV-positive individuals may not perceive or want to perceive themselves as sick, though others may view them as such, resulting in tension and conflict (Petрак, Doyle, Smith, Skinner, & Hedge, 2010). Research found in a street survey of the general public in Edinburgh, Scotland, more liberal attitudes toward HIV than persons with HIV thought existed. However, people with HIV still experience and fear rejection from potential sexual

partners, and the possibility of being a sexual partner with a person with HIV was not examined in this study (Flowers & Davis, 2015).

According to Streeter & Franklin (2016), individuals living with HIV and AIDS need a complex collection of social support amenities. It is therefore important for the individuals working with this population to understand the types of support services that are most operational in assisting persons living with HIV and AIDS to support their health, safety, and well-being. Social support takes up many procedures and can incorporate a range of relations and behaviors. These can be understood as associations and connections that provide affected people with help or the feelings of attachment. Sufficient and effective social support improves the state of physical health, mental health and stress coping abilities for affected people who are a concern to many health providers (Dankoli, et al., 2014; Bekker et al., 2015).

Social support can be explained in three different forms: one is the relationships that individuals have to other people in their environments, a person's appraisal of the relationships and support from other individuals, and the actions or behaviors expressed by other people while conveying their support to an individual (Streeter & Franklin, 2016). Further research indicates that social support includes social networking, accounts of supportive behaviors, and observations of enough and meaningful support. The sources of support can be physical or emotional, and delivered by trusted friends, family, and professional social service systems (Bushi & Goodson, 2007).

Individuals living with HIV and AIDS depend on formal and informal social support systems for their HIV related issues. Nevertheless, research has proved that sources of social support are different depending on social groupings including ethnic, gender and sex-orientation groups. The research indicates that women significantly gain more from social support services compared to men (Cherin, et al., 2011). Generally,



men depend heavily on informal support systems and testify on relying on religion to handle HIV related challenges. On the other hand, the women noticeably seek help from established formal support systems, such as social services agents with reputable services. However, the women also report feelings of isolation and lack of support, lack of trust for medical providers, and report low satisfaction levels for managed care programs (Cherin, et al., 2011). Research also found out that in large social networks, women experience more stress since they see themselves as caregivers rather than recipients of social support (Walsh, 2010).

Considering ethnic differences, research has shown that African-American and Latin individuals are most likely inclined to depend on religion as a coping mechanism and depend on informal social support services such as family and friends. On the other hand, white Americans make use of a number of both formal and informal social support systems. Additionally, gay men living with HIV received very minimal support from family members and friends, as compared to heterosexual men (Kimberly & Serovich, 2009).

Previous research has shown that effective social support services assists individuals in maintaining their health and welfare even in challenging situations (Saunders & Burgoyne, 2011). Additionally, researchers have proposed that there could be a significant association between social support systems and evading highly dangerous sexual behaviors among the people living with HIV and AIDS. This is an important area for further research studies since recent studies have indicated that a statistically significant number of people living with HIV and AIDS engage in risky sexual behaviors (Reilly & Woo, 2011). More disturbing findings from a research study indicate that some individuals (both male and female) who had embraced safer sex

practices are actively re-engaging in highly dangerous sexual behaviors (Kalichman & Ostrow, 2008).

Individuals choose to voluntarily disclose their HIV status as a group for social, political or educational reasons (Massie, 2015). However, there is limited research on the impacts of voluntary shared disclosure on safe sex practices among the youth. In that regard, this research study will use data captured from the youth at Lea Toto program to examine whether voluntary shared disclosure significantly encourages or discourages safer sex practices.

#### **2.2.4 Effect of involuntary disclosure on safe sex practices among YLWH**

Involuntary HIV status disclosure takes place when an infected person accidentally discloses their status, or when another party without the person's knowledge or consent discloses the status. For public health reasons, public health officers are at times required to disclose the HIV status of individuals. This might happen in these instances: where test results of HIV positive individuals are required to be reported to public health authorities, when an infected person enters ART treatment, and when an infected person poses a public health risk but declines to disclose his/her status (Massie, 2015).

Most countries require that test results of HIV positive individuals be reported to public health authorities. This is important in preparing progress reports in the fight against HIV and AIDS. In cases where an individual carries out an anonymous test, where they fail to give out their contacts or other personal information, reporting cannot be done. Such people including the ones, who take rapid tests away from health facilities, are encouraged to report their HIV+ statuses to relevant public health facilities (Massie, 2015). This information enables governments to place informed plans in the

fight against HIV and AIDS. Additionally, when a health provider has contact details of HIV+ persons, the provider can always reach out to the individuals for follow-up treatments. In cases where an infected person enrolls into ART programs, their statuses are shared with relevant public health offices. This information enables the public officers to make proper requisitions for the required drugs to avoid shortage or wastage (Massie, 2015).

There are cases where an infected person poses a public health risk but declines to disclose his/her status. When a Medical Health Officer (MHO) is aware of such a case, he/she is bound by the public health act to disclose the status to third parties who might be affected. Before informing the third parties, the MHO should notify, or make practical efforts to inform the infected person of his or her intent to disclose the HIV status without the person's consent (Canadian Medical Association, 2018). In cases where a person is unable to disclose his or her status to potentially affected persons due to cognitive impairment, the MHO should inform the person's guardian or representative (BC Centre for Disease Control, 2016).

Involuntary disclosure could also occur in accidental situations where another person familiar with the ART drugs regimen, comes across the same from a YLWH and makes the correct conclusion that the latter may be HIV positive and divulge this information to others.

From the information above, involuntary medical disclosure could be important for public health reasons. That is, informing third parties of the potential risk from an infected person could help to encourage safe sex practises in the general public. However, there is still limited research in this area. Therefore, the researcher will use this study to shed more light on the effect of involuntary/accidental disclosure on safe sex practices.

### **2.2.5 Effect of HIV status disclosure outcomes on safe sex practices among YLWH**

A research study was conducted by Naigino et al., (2017) to check on HIV status disclosure and associated outcomes among pregnant women who were enrolled in ART in Uganda. The study employed a mixed-methods research approach and targeted 507 HIV+ pregnant women attending lifelong ART. The women were followed for a period of four months in order to examine disclosure and its outcomes. Positive outcomes (spouse support) and negative outcomes were measured using two logistic regression models. Findings from the study revealed that most of the women had disclosed their status to at least one trusted person, with a majority of them disclosing the status to their spouses. Additionally, the majority of the women reported positive outcomes of support from their spouses after disclosing their status. The support was mainly in antenatal care, and HIV related care services.

The findings further revealed that there were no significant negative outcomes after disclosure of HIV status. However, the respondents reported stigma and the fear of negative outcomes as the hindrances to HIV status disclosure (Naigino, et al., 2017). From this study, therefore, it is evident that in addition to other benefits, disclosure might increase spousal support and decrease stigma, violence, and discrimination.

Additionally, a research study was conducted to identify outcomes and factors affecting HIV status disclosure to sexual partners among women attending ART clinics. A cross-sectional institutional based research approach was used to randomly interview 191 HIV+ women attending an ART clinic in Ethiopia. Data collection was done for one month. The study findings showed that majority of the women had disclosed their HIV status to their sexual partners. Among those who disclosed the status, more than 50% were free to attend follow-up sessions, while approximately 30% of them used condoms with their sexual partners. Negative outcomes reported among those who

disclosed their status include discrimination, stigma and psychological torture. Further results revealed that women who had severed relationships with their sexual partners were less likely to disclose their HIV status, as compared to those who had good relationships. Additionally, women who had children were more likely to disclose their status, compared to those without children. Moreover, women who had received counselling were more likely to disclose their HIV+ status, as opposed to those who did not receive counselling (Deribe, Ebrahim, & Bush, 2018). From this research, HIV status disclosure could lead to either positive or negative outcomes. Disclosure might be influenced by the presence of children, the status of a relationship, and counselling (Cherin, et al., 2011).

Despite the information gathered from the studies above, there is still no meaningful link between disclosure outcomes and safe sex practises. For that reason, this research study will seek to explore the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV, a case study of the Lea Toto Program in Nairobi County.

### **2.3 Summary and Research Gap**

Promotion of safe sex practices among young people is particularly important considering the burden of HIV and other STIs in this population. Safer sex practices are included in instruction for those young people who may not choose abstinence. Postponement of initial sexual activity, adherence to one sexual partner and protected sexual intercourse are sequentially offered as the next best alternatives. HIV infection is considered private and confidential information, which if revealed, can lead to rejection and stigmatization. Yet when HIV status is not disclosed to sexual partners,

safer sexual practices may not be followed, and further spread of the disease may result (Alberta Education, 2018).

Minimal research has been done to assess the impact of HIV status disclosure and adoption of Safe Sex practice, especially among the youth or adolescents. A lot of studies are centred on adults – either married or unmarried and paediatrics (children living with HIV). In highly developed and resource-endowed countries, ample studies are available while in Africa, and especially East Africa, the studies are few. More comparative studies would help policymakers and program implementers identify the effects of HIV-Status Disclosure and adoption of safe sex practices. This body of knowledge would go a long way in addressing the challenges with the youth. For the groups where the studies are concentrated (Children and adults), this transition group, the youth, has been ignored and yet they are the critical group that informs transitions from either paediatric or to adult care. Additionally, very few research studies have been conducted to check whether attitudes towards HIV status disclosure influence safe sex practises.

## **CHAPTER THREE**

### **RESEARCH DESIGN AND METHODOLOGY**

#### **3.1 Introduction**

This chapter presents the research methodology that was used in this study. It presents the research design, study site, target population, the sample and sampling techniques, data collection instruments, pretesting, and data management procedures. It also presents data analysis and presentation. Essentially, the chapter is critical in showing the methods and tools that were used in this study.

#### **3.2 Research Design**

This study adopted a correlational research design. Correlational research designs indicate the relationships between variables. This study design examines the variables in their natural states, without including researcher- imposed treatments (Kamau, Githii, & Njau, 2014). In this study, the relationship between voluntary self-disclosure, voluntary shared disclosure, involuntary disclosure, HIV status disclosure outcomes and safe sex practises was determined. The study sought to check whether the independent variables had an effect on safe sex practices among the youth.

#### **3.3 Research Site**

This study was conducted at Lea Toto program Centres in Nairobi. Lea Toto is a community-based care program of the Children of God Relief Institute (COGRI), which extends Nyumbani children's home care of HIV+ children into the wider community. The program was established in 1998 as a Nyumbani's community outreach program and became a fully-fledged community home-based care program in September 1999.

Lea Toto Community Outreach is a home-based care program in Nairobi's informal settlements to improve the quality of life of those living with and affected by HIV and AIDS. Lea Toto, Swahili for "to raise the child", is a community-based outreach program providing services to HIV+ children and their families in the Kangemi, Kawangware, Dagoretti, Mukuru, Dandora, Zimmerman, Kibra, and Kariobangi communities of Nairobi, Kenya (children of God relief Institute, 2010). All the above research sites can be seen in the map of the study area in the document, referenced as appendix 4.

### **3.4 Target Population**

This study targeted youth aged between 15-24 years; who are accessing care at Lea Toto program, they were 1,573 in number as seen in table 3.1 on page 36 (Lea Toto Program Office, 2019). Between the strata demographics of young people (15-24 years), lies the most vulnerable group to HIV infections. The age bracket of 15-24 is a transition group of those who are in puberty (15- 19 years). Puberty is reached during adolescence, which is a major landmark in the development of sexuality. The hypothalamo-pituitary-gonadal axis function is highly essential for sexual development during puberty (De Bruijin, Kremers, Van Mechelen, & Brug, 2015). The other transition group of ( 20-24 years) are those coming to the end of their adolescence, and transitioning into adulthood, most are pursuing a college education and in some cases settling into stable relationships and even marriage (Dilorio, Dudley, Lehr, & Soet, 2010) . This population is identified to be sexually active hence is disproportionately affected by HIV.

The researcher also included Key informants who are the professionals that work with these youth daily at the centres as part of the target population. They were



139 in total and comprised of; Counsellors, Community health workers, and Social workers, this data can be seen on table 3.2 on page 36 of this document. This was vital so as to obtain a justifiable view on the research topic. Therefore, the total target population was 1712, this included the 1573 YLWH, and the 139 Key informants at Lea Toto program.

### **3.5 Study Sample**

#### **3.5.1 Study Sample Size**

The sampling formula by Kothari (2017) was employed to obtain the respondents' sample size in the study that was:

Sample size,  $n = N * 10\%$

Where:

$n$  = sample size,

$N$  = Target Population

#### **3.5.2 Sampling Procedure**

From the formula given above,

$$\text{Sample size, } n = N * 0.1 = 1712 * 0.1 = 171$$

The research study sampled 171 respondents which included, the YLWH and the professionals that work at the centres who are referred to as Key informants in the data collection tool.

The sample of the study was divided into 8 strata that are corresponding to each of the 8 Lea Toto program satellite centres. Stratified random sampling (quota

sampling) technique was used. The sampling for the youth was calculated with each of the 8 Lea Toto Sites formed a stratum out of which 10 % of each stratum was selected as seen in Table 3.1 below. The key informants from all the eight centres were combined and each of the professionals constituted a stratum and 10% was selected to constitute the sample of the study as seen in table 3.2 below:

**Table 3.1 Sampling Frame for the Youth**

<b>Stratum/ site</b>	<b>Target population</b>	<b>Sample size</b>
Kibra	280	28
Kawagware	155	15
Kangemi	250	25
Dandora	230	23
Dagoretti	210	21
Mukuru	194	19
Kariobangi	180	18
Zimmerman	74	8
<b>TOTAL</b>	<b>1573</b>	<b>157</b>

Source: (Lea Toto Program Office, 2019).

**Table 3.2 Key Informants Sampling Frame**

<b>Professionals</b>	<b>Target Population</b>	<b>Sample size</b>
Counsellors	25	3
Community Health Workers (CHW's)	88	8
Social Workers	26	3
<b>TOTAL</b>	<b>139</b>	<b>14</b>

Source: (Lea Toto Program Office, 2019).

In addition to the respondents selected and the Key informants for the interviews, the researcher conducted two focused group discussions with ten participants per group. The participants were purposefully selected from the centres' already existing support groups at the centres.

### **3.6 Data Collection**

#### **3.6.1 Data Collection Instruments**

The study used questionnaires to gather data from the YLWH, a sample of this can be seen in appendix II of the document. The questionnaire had close-ended questions with the Likert-type statements, it was divided into sections according to the study variables. Semi-structured interviews were also conducted with the Community health workers, counsellors and Social workers at the centres, the interview questions were open-ended questions, based on the objectives of the study, a sample can be found in appendix III of this document. Two focused group discussions with YLWH were conducted, the focused group discussion questions were based on the objectives of the study, a sample can be found in appendix IV of this document, each group had ten participants, who were active members of already existing support groups at the centres.

#### **3.6.2 Pilot Testing of Research Instruments**

Pilot testing of the research instruments was be done using 10% of the sample size of respondents thus 16 respondents. The sample was based on the research by Kothari (2017), which states that 10% to 30% of the study sample is adequate for pilot studies. The respondents were guided to accurately understand the research questions. The questionnaire contained demographic information of each respondent and the

issues of discussion in this study such as safe sex practices and HIV status disclosure. The pilot testing which were undertaken at AMREF Langata helped to establish the reliability and validity of research instruments, as stated by Charlotte & Hilton (Charlotte, 2015).

### 3.6.3 Instrument Reliability

The questionnaire's reliability was measured using the Cronbach alpha test. The Cronbach alpha test is used to measure the internal reliability of a data collection instrument. Basically, the test measures the internal consistency of an instrument (Bryman & Cramer, 2011).

$$\alpha = \frac{N \cdot \bar{c}}{\bar{v} + (N - 1) \cdot \bar{c}}$$

While N equals the number of items,  $\bar{c}$  is the average inter-item covariance among the items and  $\bar{v}$  equals the average variance. In this case, as the score increases, the reliability of the generated scale also increases. Kimberlin and Winterstein (2008) observed that a Cronbach's Alpha of 0.7 is an acceptable level of reliability. In this study, Cronbach alpha values ranging between 0.731 and 0.909 were obtained as presented in Table 3.3. As such, the research instrument was deemed sufficient for use in data collection.

**Table 3.3 Reliability Test**

<b>Item</b>	<b>No. of Items</b>	<b>Cronbach Alpha (<math>\alpha</math>)</b>
Safe Sex Practises	6	0.906
Voluntary Self-disclosure	6	0.902
Voluntary Shared-disclosure	6	0.909
Involuntary Disclosure	6	0.811
Disclosure Outcomes	6	0.731

**Source: (Author, 2020).**

### **3.6.4 Instrument Validity**

Pilot testing was conducted to assist in determining the accuracy, clarity, and suitability of the questionnaire. Content validity was examined to ensure the instrument answers all the research questions in line with research objectives. The main objective of this study was to determine whether HIV-Status disclosure leads to safe sex practices. In addition, the expert validation by the supervisors and other university research experts was used for validation. In this regard, their opinion was used to improve the instruments. The researcher establishes that semi-structured questionnaires, key informant interviews and Focused group discussions administered for this qualitative study were reliable and valid.

### **3.6.5 Data Collection Procedure**

The researcher visited the Lea Toto program satellite centres and asked permission to collect data. Appointments were then made with the managers for data collection in the specified times. The questionnaires were distributed to the youth during their visits to the centres on the appointed days and collected on the same day.

On days with a low turn-out at the centres, the researcher accompanied the community health workers or social workers during their home visits and distributed the questionnaires to respondents at their homes, and collected them immediately after. The key informant interviews were specially scheduled and conducted concurrently with the distribution of the questionnaires. Due to limitations related to the COVID 19 pandemic, the FGDs were conducted on two separate days within the centres. The respondents were issued with masks, they had to wash hands or sanitize, and were asked to observe social distance. The whole exercise took 10 non-consecutive days spread within a four-week period.

### **3.7 Data Analysis**

The data to be generated by questionnaires was checked, cleaned, organized and coded using numbers to specific responses. The techniques employed were mostly theming (drawing together of key responses and issues) and coding (identification of topics, issues, similarities, and differences revealed through the participants' narratives and interpreted by the researcher). The cleaned and coded data was then analysed using the Statistical Package for Social Science (SPSS) statistical software, version 25.0.0.

The study's demographic characteristics of the respondents were analyzed using descriptive data analysis. The objectives seek to check the effects of voluntary self-disclosure, voluntary shared-disclosure, involuntary/accidental disclosure and HIV status disclosure outcomes on safe sex practices among youths living with HIV. Pearson correlation and Multiple regression analyses were used to test the study objectives, by checking whether there is a relationship between the study variables. Qualitative data analysis involved the identification, examination, and interpretation of patterns and

themes in textual data to determine how these patterns and themes help to answer the research questions.

### **3.8 Legal and Ethical Considerations**

The researcher obtained a research clearance from Africa Nazarene University, this is referenced as Appendix VI in the document. The researcher also obtained a research permit from the National Commission for Science, Technology and Innovation (NACOSTI) before undertaking this study, this can be found in Appendix V.

An explanation of the study was given, and the participants chose whether to participate in the study and they did this by signing the consent form as referenced in Appendix I, for minors, consent was obtained from their parents or caregivers. All Interviews were administered Privately and Confidentially throughout the study. Respondents were assured of their anonymity (Cooper & Schindler, 2013). This means that they were assured that no identifying information would be ascribed to their responses and in this regard, even photos and videos were not obtained to protect their anonymity also considering that some of them were minors according to Kenyan law. It was hoped that this would boost their willingness to participate in the study

## **CHAPTER FOUR**

### **DATA ANALYSIS AND FINDINGS**

#### **4.1 Introduction**

The purpose of this study was to examine the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS in the Lea Toto Program, Nairobi County, Kenya. The objectives of the study were; to examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV; to assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV; to determine the effect of involuntary/accidental disclosure on safe sex practices among youths living with HIV, and to establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV. This chapter provides an analysis of the responses from the questionnaire as well as semi-structured interviews and FGDs.

#### **4.2 Response Rate**

The study targeted 171 respondents that included; 157 youth aged between 15-24 years, and 14 Key informants from the centres. Out of these, 143 YLWH and 11 key informants responded. These make a return rate of 91.1% for the youth and 78.6% for the key informants as shown in Table 4.1. below.



**Table 4.1 Response Rate**

<b>Response</b>	<b>Youth</b>		<b>Key Informants</b>	
	<b>Frequency</b>	<b>Percent</b>	<b>Frequency</b>	<b>Percent</b>
Responded	143	91.1	11	78.6
Non-Respondent	14	9.6	3	21.4
<b>Total</b>	<b>157</b>	<b>100</b>	<b>14</b>	<b>100</b>

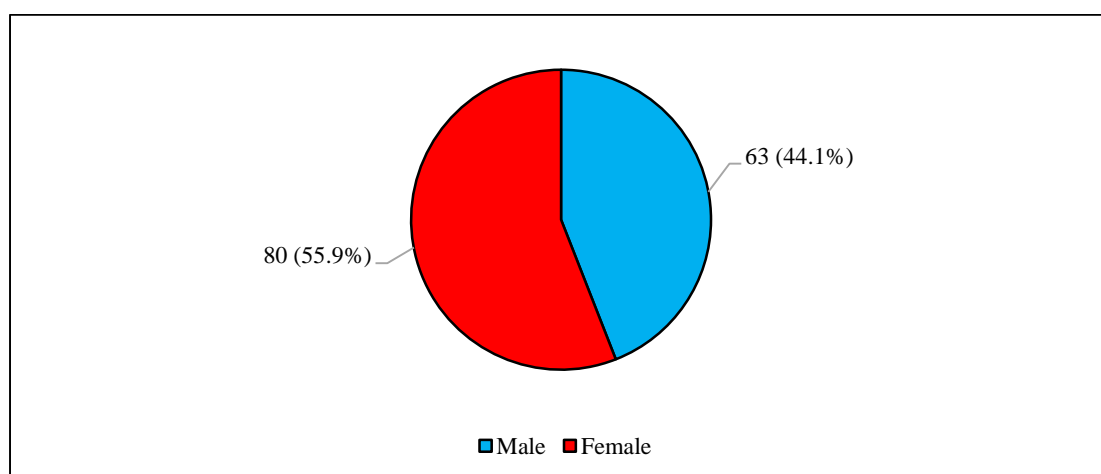
(Source: Field Data, 2020).

#### 4.2.1 Social Demographic Characteristics of Respondents

General information about the respondents that were assessed in the study included gender and age.

##### 4.2.1.1 Gender of Respondents

The study sought to find the gender of the respondents. The findings are presented in Figure 4.1.



N=143

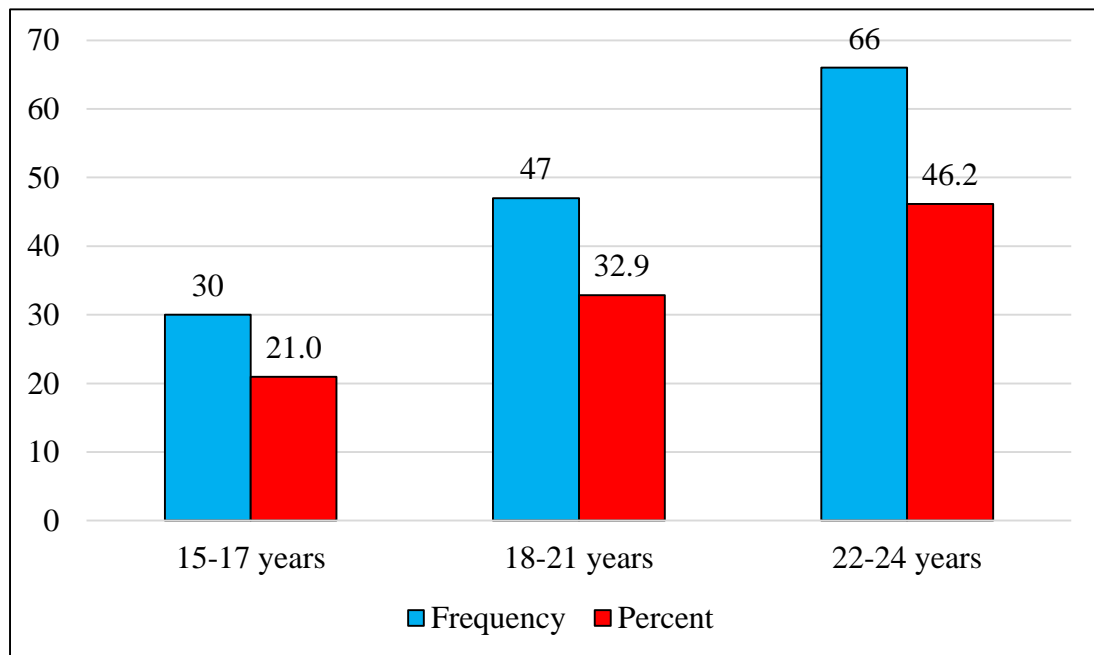
**Figure 4.1 Gender of Respondents (Source: Field Data, 2020)**

As shown in Figure 4.1, most of the respondents were female (55.9%) while males were 44.1%. This shows that both genders were well represented in the study.

#### 4.2.1.2 Age of Respondents

The study went on to investigate the age of the respondents. The findings obtained are shown in Figure 4.2.

Most of the youth, close to half at 46.2%, were 22 to 24 years. These were followed by those who were 18 to 21 years at 32.6%. The least were aged between 15 and 17 years at 21%. These findings show that the youth were drawn from numerous age groups.



N=143

**Figure 4.2 Age of respondents (Source: Field Data, 2020).**

### 4.3 Presentation of Research Analysis and Findings

This section presents the findings of the study. This is done in line with the study objectives.

### **4.3.1 Effect of voluntary self-disclosure on safe sex practices among YLWH**

The first objective of the study was to examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. The findings obtained are presented in two parts. Part one presents the study findings on safe sex practices while part two presents the study findings on the effect of self-disclosure on safe sex practices.

#### ***4.3.1.1 Safe Sex Practices***

The youth were presented with selected statements on safe sex practices. Their level of agreeability with the statements was measured on a scale of 5 to 1 where: 5- very high extent; 4- great extent; 3- moderate extent; 2- little extent and; 1- Not at all. The means (M) of the responses were used to explain the levels of agreement with each variable. The findings are presented in Table 4.2. below.

The respondents agreed to a great extent (M= 4) with five of the statements presented to them. In this regard, they agreed to a great extent that “men and women are equally responsible for buying condoms” and that “before engaging in sexual relations, I think about it carefully.” They also agreed to a great extent (M=4) that, “only two people who trust each other completely should have sexual relations,” and that “being healthy is more important than short, temporary pleasure.” Also, the respondents agreed to a great extent (M=4) with the statement, “in my opinion, faithfulness is very important in a relationship.” However, the respondents agreed to a moderate extent (M=3) with the statement, “it is possible to enjoy sex even when using a condom.” This

means that the respondents were divided about the use of condoms as protection against HIV/AIDs.

**Table 4.2 Safe Sex Practices**

	Descriptive Statistics					Mean	Std. Dev.
	5	4	3	2	1		
Men and women are equally responsible for buying condoms	57	16.2	14.8	7.7	4.3	4	1.18
It is possible to enjoy sex even when using a condom	33.1	15.5	23.2	9.9	18.3	3	1.49
Before engaging in sexual relations, I think about it carefully	50.0	16.2	20.4	9.2	4.2	4	1.23
Only two people who trust each other completely should have sexual relations	40.1	15.5	23.9	6.3	14.1	4	1.42
Being healthy is more important than short, temporary pleasure	54.2	21.1	11.3	8.5	4.9	4	1.20
In my opinion, faithfulness is very important in a relationship	64.8	16.9	9.9	3.5	4.9	4	1.11

N=143

( Source: Field Data, 2020)

The key informants were presented with the question, “do you think that Youth living With HIV practice safe sex practices/ or are aware of the safe sex practices to use when they engage in sex? If yes what is the most commonly used method? If No what can be done to make them aware of these practices?” The findings show that several methods were used. These included condoms, Depo-Provera (contraceptive injection), and other family planning methods. In this light, one of the counsellors interviewed said:

*“They use a variety of methods to practise safe sex. These include condoms and other family planning methods for purposes of protecting themselves and the unborn babies.”*

.....

(Counsellor A, February 2020)

However, some of them did not want their statuses to be known for fear of stigmatization and rejection hence they did not practice safe sex. Also, group psychology discouraged them from practising safe sex since everybody else was doing the same. In this regard, one of the interviewees said:

*“They are aware of safe practices but they go with the crowd so as not to be left out. Most youth believe that they are ‘macho’ when they have sex without protection. They are perceived to be ‘tough by their peers and even ‘invincible’ for others.”*

.....  
(Social worker D, February 2020)

The FGD participants were presented with the question, “What are some of the safe sex practices you know and how often do you practice them when engaging in sex?” The findings show that male condoms were the most used method, female condoms on the other hand were not easily accessible and not often used, even though they knew in theory how to use them. In this regard, one of the participants of FGDs said:

*“Proper use of condoms during sex is one way of safe sex practices. You must come to an agreement with your partner, discuss and agree that you want to have sex. This will help in having safe sex practices without forcing.”*

.....  
(FGD 1, 2020)

Other family planning methods were also used albeit sporadically. Other methods used included abstinence, faithfulness, and morning-after pills.

#### 4.3.1.2 Effects of Voluntary Self-Disclosure on Safe Sex Practices among YLWH

The study sought to establish the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. The respondents were presented with six Likert-scale statements as presented in Table 4.3.

**Table 4.3 Voluntary Self-Disclosure and Safe Sex Practices**

Descriptive Statistics							
	5	4	3	2	1	Mean	Std. Dev.
I would willingly disclose my HIV status to my sexual partner	45.1	11.3	14.1	7.0	22.5	4	1.63
Disclosure of status to sexual partners keeps them healthy	34.5	17.6	27.5	11.3	9.2	4	1.31
Disclosing status makes a relationship stronger	25.4	14.8	31.7	13.4	14.8	3	1.36
Disclosure of status to my sexual partner makes me feel free and happy	24.6	12.7	31.0	19.0	12.7	3	1.34
Disclosing status to a partner boosts a person's self-esteem	28.2	12.0	31.0	12.7	16.2	3	1.41
Voluntary disclosure leads to better family plans, especially on safeguarding children's health	52.8	12.7	13.4	11.3	9.9	4	1.41

N=143

( Source: Field Data, 2020).

As shown in Table 4.3, the youth agreed to a great extent (M=4) to three of the statements presented to them. In this regard, they agreed to a great extent that they would willingly disclose their HIV status to their sexual partner and that disclosure of status to sexual partners keeps them healthy. They also agreed to a great extent that voluntary disclosure leads to better family plans, especially on safeguarding children's health.

The respondents went on to agree to a moderate extent (M=3) that disclosing status makes a relationship stronger and disclosure of status to sexual partners makes

me feel free and happy. Lastly, the respondents pointed out that disclosing status to a partner boosts a person's self-esteem.

The key informants were presented with the statement, "In your working experience, do the Youth Living with HIV disclose their status to their sexual partners? If yes, out of 10 how many would disclose? If No, what do you think hinders them from disclosing? Divergent findings were obtained. To begin with, most of them, between 50 to 80% did not want their status exposed due to stigma. In this light, one of the community health workers said:

*"No, most do not want to have their statuses disclosed. This was attributed to fear of rejection/discrimination, self-stigma, lack of acceptance, and fear of unknown."*

.....  
(Community Health worker C, February 2020).

The participants of FGDs were posed with the statement, "have you ever disclosed your HIV status to anyone other than your immediate family? Who? How did you go about it?" The findings show that there was some level of disclosure to family members, relatives, friends, and lovers [sex partners]. One of the respondents said:

*"My girlfriend (lover) since I love her so much had to disclose my status to protect her from infection. I also empowered her about prep since I was told by my adherence counsellor PEP is for the negative person and she can use when at risk before engaging in sex for 21 days."*

.....  
(Respondent 5 FGD 1, February 2020)

The disclosure was also done to groups of friends but this was often challenged by the expected outcomes. In this regard, one of the respondents said:

*“Yes, once I disclosed to a close group of friends, and some just one friend. It is not always easy to start and you always have questions in your mind that you are asking yourself inside and you have no answer to any and some friends will take you in a normal way and some will reject you and go telling others your secret.”*

.....

(Respondent 4 FGD 2, February 2020)

#### **4.3.2 Effect of voluntary shared-disclosure on safe sex practices among YLWH**

The second objective of the study was to assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV. Data was collected using questionnaires, interviews, and FGDs. Table 4.4 on the next page presents the findings from Likert-scale statements from the questionnaires.

As shown by Means of 3 for all statements, the youth agreed to a moderate extent to all the statements presented to them. In this regard, the respondents agreed to a moderate extent that they would willingly disclose their HIV statuses to their families and friends and that disclosure of status to family and friends keeps them healthy. The respondents also agreed to a moderate extent that disclosing status to family and friends ensures a stronger social support system and that it makes one feel free and happy. Also disclosing status to family and friends boosts a person’s self-esteem and protected them from infection.



**Table 4.4 Voluntary Shared-Disclosure and Safe Sex Practices**

	Descriptive Statistics					Mean	Std. Dev.
	5	4	3	2	1		
I would willingly disclose my HIV status to my family and friends	57.0	16.2	14.8	7.7	4.2	3	1.68
Disclosure of status to family and friends keeps them healthy	33.1	15.5	23.2	9.9	18.3	3	1.43
Disclosing status to family and friends ensures a stronger social support system	50.0	16.2	20.4	9.2	4.2	3	1.29
Disclosure of status to family and friends makes one feel free and happy	40.1	15.5	23.9	6.3	14.1	3	1.29
Disclosing status to family and friends boosts a person's self-esteem	54.2	21.1	11.3	8.5	4.9	3	1.30
Voluntary disclosure to family and friends protects them from infection	64.8	16.9	9.9	3.5	4.9	3	1.35

N=143

(Source: Field Data, 2020).

The key informants were posed with the question, “what is the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV in your area?” The findings show that disclosure had mixed results. In this regard, a counsellor from centre F said:

*“Most of the clients prefer shared disclosure, where they seek our help as counsellors to disclose their status to their partners. Some discordant couples, where one is positive and another is negative, disclosure has often ended in a breakup, this has led to loneliness which has been aggravated by the loss of friends. In such cases, some give up on practising safe sex.”*

.....  
(Counsellor F, February 2020).

There have also been instances of stigmatization and rejection. This is exemplified in the words of one of the respondents from the FGDs who said:

*“In some cases, disclosure has led to increased blame game because each of the couple will blame the other for infecting them and as a result some face stigmatization as they get called names like; ‘prostitute’ ‘loose woman’ among others.”*

.....  
(FGD 2, February 2020).

Some of the outcomes of disclosure are not pleasant, and thus discourage others from disclosing, this is evidenced by members of FGD 1 who said:

*“Rejection and depression are some of the negative outcomes of disclosing one’s status, when one is depressed, you do not have any motivation to live, and therefore you neglect your medication( ARVs) and unless one receives counselling or help from friends, it becomes a downward spiral.”*

.....  
(FGD 2, February 2020).

Participants of FGD 1 said that: “due to the negative repercussions associated with disclosure, very few disclose.” [FGD 1, February 24, 2020, Nairobi].

However, some got support from partners, families, and friends and this led to more adherence to treatment and reduction in mother to child transmission (MTCT). In this light, a member of FGD 1 said:

*“support from partners, families and friends encouraged me to continue with my treatment and sometimes my partner is the one who reminds me to take my medication. This has enabled me to have baby who is negative”*

.....  
(FGD 1, February 2020)

The FGD participants were presented with the statement, “have you ever disclosed your HIV status to anyone other than your immediate family? Who? How did you go about it?” Some of the participants pointed out that they were not ready for it. In some though, there were instances of disclosure especially to close relatives. This can be exemplified by one FGD participant who said:

*“Yes, I have disclosed to my aunt who is our neighbour, I was able to do this with the help of my parents, this is because when my parents are not around, she is the one who takes care of me.”*

.....  
( FGD 2, February 2020).

The respondents were also presented with the question, “What are some of the skills you need to disclose your HIV status to your sexual partner?” Members of FGD 1 said:

*“There is need for those disclosing to be ready for the outcome. It could go either way, and one needs to be prepared especially for the negative reactions that may occur”*

.....  
(FGD 1, February 2020).

Furthermore, some participants of FGD said that one needed to accept his/her HIV status first before doing disclosure (FGD 2, February 2020). Members of FGD 1 pointed out that, High self-esteem, confidence, and self-love are required because without these, losing hope and getting depressed was quite easy (FGD 1, February 2020). Additionally, members of FGD 1 said that there was need to get advice from the counsellors where one obtained ARVs before disclosure. Trust with partners was also considered to be crucial before disclosure (FGD 1, February 2020). Lastly, members of

FGD 2 said that there was need for assurance of financial support before the disclosure, especially for married couples who were dependants and had children (FGD 2, February 2020).

### 4.3.3 Effect of involuntary disclosure on Safe Sex Practices among YLWH

The third objective of the study was to determine the effect of involuntary/accidental disclosure on safe sex practices among youths living with HIV. Data were collected using questionnaires, interviews, and FGDs. The findings obtained from Likert-scale statements are presented in Table 4.5 below.

**Table 4.5 Involuntary Disclosure and Safe Sex Practices**

	Descriptive Statistics					Mean	Std. Dev.
	5	4	3	2	1		
Sharing a person's HIV status without their knowledge is heart-breaking	88.0	6.3	2.8	.7	2.1	5	.73
It is unfair to use a specific person's HIV+ status as a push for safe sex without informing them	50.0	30.3	9.9	4.2	5.6	4	1.12
Health officers should be open about reporting HIV+ statuses to public health authorities	35.2	27.5	17.6	5.6	14.1	4	1.38
Public health officers should share information about infected persons who decline to disclose their status	14.1	25.4	16.2	3.5	40.8	3	1.55
It is okay to use HIV related statistics to sensitize people about safe sex practices	36.6	31.7	16.9	9.9	4.9	4	1.17
It is okay for public health authorities to use my HIV+ status outcome in ART planning	36.6	33.8	20.4	3.5	5.6	4	1.10

N=143

(Source: Field Data, 2020).

The respondents agreed to a very high extent (M=5) that sharing a person's HIV status without their knowledge is heart-breaking. They went on to agree to a great extent (M=4) that it is unfair to use a specific person's HIV+ status as a push for safe sex without informing them and that health officers should be open about reporting HIV+ statuses to public health authorities. The respondents also agreed to a great extent (M=4) that it is okay to use HIV related statistics to sensitize people about safe sex practices and that it is okay for public health authorities to use my HIV+ status outcome in ART planning. Lastly, the respondents agreed to a moderate extent (M=3) that public health officers should share information about infected persons who decline to disclose their status.

The KII participants were presented with the statement, "are there instances where you were forced to disclose patients 'statuses' without their consent to their partners and what effect did it have on safe sex practices if any?" The findings show that there were no instances of forced disclosures. In this regard, one of the counsellors interviewed said:

*"The willingness of the client is always ensured before disclosure. In most cases, the youth are advised to disclose their statuses to partners. In cases where the client is unwilling, they are educated on the effects on non-disclosure and most often, the client opts to practice safe sex. It is against my ethical code, to disclose a client's status without their consent, even if the law demands it. There's a conflict with my mandate as a counsellor because if other clients hear about it, they would never trust me."*

.....  
(Counsellor E, February 2020)

Participants of FGD 1 said:

*“Assisted disclosure is most preferred since we do not have the proper words and tactics to communicate our status to our partners. When involuntary disclosure happens, we find ourselves losing hope because friends start to treat you differently, and isolate you. One feels like there is no use in taking medication since there is nothing to look forward to”*

.....  
(FGD 1, February 2020).

The participants of FGDs were also presented with the statement, “What do you understand by the terms; voluntary self-disclosure? Involuntary disclosure?” The respondents said that voluntary disclosure was where the person decides to disclose their status without being forced. In this regard, participants of FGD 2 said:

*“ voluntary disclosure entails a situation whereby one discloses his/her status without being coerced to do so. Involuntary disclosure is when a person’s status is revealed to other people without the said person’s consent, maybe through gossip”*

.....  
(FGD 2, February 2020).

Members of FGD 1 said:

*“Voluntary disclosure is a situation where one tells his/her partner about his/her status. It is also when one goes to a health centre to know his/her status by themselves.”*

.....  
(FGD 1, February 2020).

Participants of FGD 1 When asked to describe involuntary disclosure, said:

*“In our understanding, it is when a person finds out that their status has been revealed without being involved. Like when my teacher was told my status by the school nurse and went and told other teachers in the school. ”*

.....  
(FGD 1, February, 2020).

Further, involuntary disclosure according to participants of FGD 2:

*“It is when one’s status is known through visits to comprehensive care centres like, “Lea Toto” that are known to take care of HIV positive patients. It is also a case where one was not willing to disclose his/her status, and an ex- partner finds out by getting tested themselves and if found positive, goes telling other people about your status.”*

.....  
(FGD 2, February 2020).

The Key informants were also presented with the question, “are there instances where your clients’ statuses been have involuntarily disclosed to others? What effect if any did this have on their sexual practices?” It was found that there were such instances. A social worker said:

*“Involuntary disclosure happens for some teens in schools. Examples are when a teen decides to keep drugs somewhere and a roommate sees them by mistake, or a teacher who has seen the student’s symptoms tells other teachers. It has led to a lack of adherence to medication due to self-stigma and also stigmatization by others. Such youth end up being resistant to treatment and therefore very prone to infect others.”*

.....  
(Social worker B, March 2020).

Another Social worker from centre D said:

*“There was also a case of accidental disclosure when a client was drunk; which led to a downward spiral, the spouse rejected him, he got depressed and reduced adherence to treatment was witnessed and eventually the client died.”*

.....  
( social Worker D, March 2020).

One of the community health workers in centre C said:

*“cases of involuntary disclosure also occur when drugs are seen by people who have not been disclosed to, or when one is seen going to the Comprehensive Care Clinic (CCC).”*

.....  
(CHW 5, March 2020)

Lastly, Participants of FGD 1 said:

*“It also happens when the partner tests positive and when they trace their partners, they arrive to the right conclusion. This has led to the breakup of relationships, being beaten up, depression, discrimination/losing friends and, suicide.”*

.....  
(FGD 1, February 2020).

#### **4.3.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH**

The last objective of the study was to establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV. Data were collected using questionnaires, interviews, and FGDs. The findings from Likert-type statements are presented in Table 4.6.



**Table 4.6 Disclosure Outcomes and Safe Sex Practices**

	Descriptive Statistics					Mean	Std. Dev.
	5	4	3	2	1		
Support from spouse, family, and friend after disclosure builds esteem	57.7	23.2	14.1	4.2	.7	4	.92
Acceptance from society after disclosing status encourages safe sex	43.0	26.8	19.0	4.9	6.3	4	1.18
Decreased stigma after disclosure builds a sense of responsibility	46.5	24.6	18.3	4.2	6.3	4	1.18
Discrimination from spouse, family, and friends after disclosure lowers self-esteem	62.7	14.8	16.2	2.1	4.2	4	1.08
Acts of violence and rejection from society after disclosure discourages safe sex among infected persons	34.5	32.4	22.5	6.3	4.2	4	1.09
Increased stigma after status disclosure lowers a person's sense of responsibility	56.3	16.9	16.2	4.9	5.6	4	1.19

N=143

**(Source: Field Data, 2020).**

The respondents agreed to a great extent (M=4) to all the statements presented to them. In this regard, they agreed to a great extent that that support from spouse, family, and friend after disclosure builds esteem and that acceptance from society after disclosing status encourages safe sex. They also agreed to a great extent (M=4) that decreased stigma after disclosure builds a sense of responsibility and that discrimination from spouse, family, and friends after disclosure lowers self-esteem. Lastly, the respondents agreed to a great extent (M=4) that acts of violence and rejection from society after disclosure discourages safe sex among infected persons and that increased stigma after status disclosure lowers a person's sense of responsibility.

The KII participants were presented with the statement, “what are some of the HIV status disclosure outcomes you have witnessed among YLWH? Do these outcomes

have any impact on safe sexual practices among the YLWH?” The findings show that about 70% of the outcomes were negative compared to 30% which were positive. Rejection after disclosure led to low libido, loneliness, and low self-esteem. It also led to rejection, fear, and stigmatization by relatives. It also led to non-adherence of treatment; which contributed to high viral load and HIV transmission among the youth. In some instances, disclosure led to suicide. Others stopped using protection after disclosure. In some cases, disclosure had positive effects, especially if there was support after disclosure. In this regard, disclosure led to enhanced adherence to treatment and safe sex practices. In this regard, one of the counsellors said:

*“Some disclosure outcomes are positive and their partners accept them the way they are, for others disclosures lead to breakups, depression, even suicide cases and they become reckless because after all she/she feels they will die. This when psychosocial support is crucial.”*

.....  
(Counsellor G, March 2020).

The FGD participants were presented with the question, “does HIV status disclosure have any effect on safe sex practices?” They pointed out that there were both positive and negative outcomes. Positive outcome was realized when there was support from spouses, family, and relatives. It also took place when the partners started safe practices after knowing each other’s statuses. In this regard, one of the respondents said:

*“It protects your partner because if you disclose early, you will be free of guilt of infecting another person, and if you disclose later, he/she could already be infected.”*

.....  
(FGD 2, February 2020).

Positive outcomes also took place when there was adherence to ART, psycho-education of peers, and better health statuses. In this light, one of the participants said: *“Yes, HIV status disclosure has an effect on safe sex practices, when a partner realises that they are either HIV+ or HIV- they have to go to a health centre and get more information on how to practise safe sex with HIV+ persons, or even avoid getting infected by another strain of the virus.”*

.....  
(FGD 1, February 2020).

However, disclosure could result in negative outcomes. In some instances, some would go ahead and say that one was sick. It also led to stigma, ending of relationships, and violence with some being beaten up after disclosure. If in a discordant relationship it led to negative outcome because one partner is afraid or thinks that the other partner wants to infect him/her. If the statuses of couples do not match it could lead to breakups. In this regard, some of the participants said:

*“HIV status disclosure has an effect on safe sex practices because the partner may not want to be involved with a person who is HIV+. Other outcomes include; rejection which affects self-esteem, poor adherence due to shattered confidence and gossip which leads to displacement, running away from home or school, and domestic violence .”*

.....  
(FGD 2, February 2020).

#### **4.4 Hypotheses Testing**

The following hypotheses informed this study: Voluntary self-disclosure does not have a statistically significant effect on safe sex practices among youth living with HIV; there is no statistically significant effect of voluntary shared disclosure on safe sex practices among youth living with HIV; involuntary/accidental disclosure does not

have a statistically significant effect on safe sex practices among youth living with HIV and; there is no statistically significant relationship between HIV status disclosure outcomes and safe sex practices among youth living with HIV. Pearson and regression analyses were carried to test the relationships between the study variables.

#### **4.4.1 Pearson Correlation**

Pearson correlation analysis was carried out to test the significance of the relationships between the independent and dependent study variables. The findings are presented in Table 4.7 below.

As shown in Table 4.7, there was significant relationship between safe sex practices and all the independent variables (voluntary self-disclosure,  $r=0.502$ ,  $p<0.05$ ; voluntary shared-disclosure,  $r=0.392$ ,  $p<0.05$ ; involuntary/accidental disclosure,  $r=0.015$ ,  $p<0.05$  and, disclosure outcomes,  $r=0.502$ ,  $p<0.05$ ). In this regard, all the null hypotheses were rejected since there were positive relationships between safe sex practices and all four independent study variables.

**Table 4.7 Pearson Correlation**

		Pearson Correlation				
		Safe Sex Practises	Voluntary Self-disclosure	Voluntary Shared-disclosure	Involuntary /Accidental Disclosure	Disclosure Outcomes
Safe Sex Practises	Pearson	1				
	Correlation					
	Sig. (2-tailed)					
Voluntary Self-disclosure	N	142				
	Pearson	.502**	1			
	Correlation					
Voluntary Shared-disclosure	Sig. (2-tailed)	0.000				
	N	142	142			
	Pearson	.392**	.699**	1		
Involuntary/Accidental Disclosure	Correlation					
	Sig. (2-tailed)	0.000	0.000			
	N	142	142	142		
Disclosure Outcomes	Pearson	0.066	-0.032	0.071	1	
	Correlation					
	Sig. (2-tailed)	0.432	0.707	0.399		
	N	142	142	142	142	
	Pearson	.204*	.234**	.280**	0.156	1
	Correlation					
	Sig. (2-tailed)	0.015	0.005	0.001	0.063	
	N	142	142	142	142	142

\*\* . Correlation is significant at the 0.01 level (2-tailed).

\* . Correlation is significant at the 0.05 level (2-tailed).

**(Source: Field Data, 2020)**

#### 4.4.2 Multivariate Regression Analysis

Multivariate analysis was undertaken to find out the level to which the independent variables predicted the dependent variable. The findings are presented in Tables 4.8, 4.9 and 4.10 respectively.

As shown in Table 4.8 below; the independent variables explained 26.6% of the change in safe practices among the youth ( $r^2 = 0.266$ ).

**Table 4.8 Model Summary**

<b>Model Summary</b>				
Model	R	R Square	Adjusted R Square	Std. Error of the Estimate
1	.516 <sup>a</sup>	.266	.244	.80860

a. Predictors: (Constant), Disclosure Outcomes, Involuntary/Accidental Disclosure, Voluntary Self-disclosure, Voluntary Shared-disclosure  
(Source: Field Data, 2020).

As shown in Table 4.8, Disclosure Outcomes, Involuntary/Accidental Disclosure, Voluntary Self-disclosure, Voluntary Shared-disclosure statistically significantly predict safe sex practices as shown by a significant F test ( $F= 26.182$ ,  $p < 0.05$ ).

**Table 4.9 Analysis of Variance**

<b>ANOVA<sup>b</sup></b>						
Model		Sum of Squares	df	Mean Square	F	Sig.
1	Regression	32.425	4	8.106	12.398	.000 <sup>a</sup>
	Residual	89.575	137	.654		
	Total	122.000	141			

a. Predictors: (Constant), Disclosure Outcomes, Involuntary/Accidental Disclosure, Voluntary Self-disclosure, Voluntary Shared-disclosure

b. Dependent Variable: Safe Sex Practises

(Source: Field Data, 2020).

The findings also indicated that only Voluntary Self-disclosure significantly predicted safe sex practices ( $p < 0.05$ ). Voluntary shared-disclosure, involuntary/accidental disclosure, and disclosure outcomes ( $P > 0.05$ ) did not significantly predict safe sex practices. As a result, they were not fitted into the regression model. In this regard, the fitted regression model was as follows:

$$\text{Safe sex practices} = 1.970 + (0.349 * \text{Voluntary Self-disclosure}) + 0.482.$$

**Table 4.10 Regression Coefficients**

		<b>Coefficients<sup>a</sup></b>				
		Unstandardized Coefficients		Standardized Coefficients		
Model		B	Std. Error	Beta	t	Sig.
1	(Constant)	1.970	.482		4.084	.000
	Voluntary Self-disclosure	.349	.080	.450	4.357	.000
	Voluntary Shared-disclosure	.042	.085	.052	.501	.617
	Involuntary/Accidental Disclosure	.076	.087	.066	.878	.382
	Disclosure Outcomes	.086	.091	.073	.946	.346

a. Dependent Variable: Safe Sex Practises

(Source: Field Data, 2020).

## CHAPTER FIVE

### DISCUSSIONS, CONCLUSIONS AND RECOMMENDATIONS

#### 5.1 Introduction

The purpose of this study was to examine the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS in the Lea Toto Program, Nairobi County, Kenya. The objectives of the study were to examine the effects of voluntary self-disclosure, shared-disclosure, involuntary/accidental disclosure, HIV status disclosure outcomes, upon safe sex practices among youths living with HIV. This chapter provides a discussion of the findings, a summary of key findings, conclusion, and recommendations.

#### 5.2 Discussions

In this section, a discussion of the study findings is presented. This is done in line with the study objectives. The findings are also analysed in line with findings from other studies.

##### 5.2.1 Social Demographic Characteristics of Respondents

###### 5.2.1.1. Response rate

The study had targeted 171 respondents that included 157 youth aged between 15-24 years, and 14 Key informants from the centres. In reference to Table 4.1, Out of these, 143 YLWH and 11 key informants responded; making a response rate of 91.1% for the youth and 78.6% for the key informants. Some of the youths who never responded were given forms and never returned while some never showed up for their appointments. The researcher felt that the key informants were giving similar responses for the interviews and so there was no new information to be obtained from three more



interviews. For paper-based questionnaires, a response rate of 60 is considered sufficient (Cooper & Schindler, 2013). The tools were thus deemed sufficient for use in data collection.

### **5.2.1.2 Gender and Age of respondents**

Reference is made to figure 4.1, Most of the youth were female (55.9%) while males were 44.1%. This shows that both genders were well represented in the study. It was also noted that majority of the respondents were female this was attributed to the fact that female respondents were more willing to participate in the study while some their male counterparts were hesitant or declined. Reference is made to Figure 4.2, Most of the youth, close to half at 46.2%, were 22 to 24 years, some of these youth also happened to be married, or in relationships. These were followed by those who were 18 to 21 years at 32.6%. The least were aged between 15 and 17 years at 21%. These findings show that the youth were drawn from numerous age groups. Majority of the older youths were more independent and more stable in their clinic attendance, and so would come to the appointments themselves, as opposed to some of the adolescents who were allowed in some cases to send their guardians in their place. It was also noted that the majority of the younger youth were given appointments to coincide with their school term dates which are at least three months apart, a fact that the researcher had not considered. The Corona Virus pandemic also significantly affected the attendance of the respondents at the centres as a number would avoid coming to the centres, in some cases, the researcher was forced to go to their homes together with the community health workers in order to get their responses. The researcher with the help of the centre counsellors sometimes had to make phone calls to some respondents who had not

completed the questionnaires, and in some cases use the centre WhatsApp group to get some responses from the youth.

### **5.2.2 Voluntary Self-Disclosure and Safe Sex Practices**

The first objective of the study was to examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. To begin with, levels of safe sex practices were established as seen in Table 4.2. The respondents agreed to a great extent (M= 4) with five of the statement presented to them. In this regard, they agreed to a great extent that “men and women are equally responsible for buying condoms” and that “before engaging in sexual relations, I think about it carefully.” This shows that most of the respondents endeavoured to stay safe by using condoms (Baryamutuma, 2011, Heeren, Jemmott III, Mandeya, & Tyler, 2017)

Reference is made to table 4.2, where the respondents also agreed to a great extent (M=4) that, “only two people who trust each other completely should have sexual relations,” and that “being healthy is more important than short, temporary pleasure.” This shows that there were high levels of safe sex practices and the decision to stay healthy among most of the youth (Simbayi, et al., 2007). This could check the level of HIV transmission. Also, the respondents agreed to a great extent (M=4) with the statement, “in my opinion, faithfulness is very important in a relationship.” However, the respondents agreed to a moderate extent (M=3) with the statement, “it is possible to enjoy sex even when using a condom.” Attitudes about safe sex practices are thus apparently high among the youths studied (Alemayehu, Aregay, Kalayu, & Yebyo, 2014). This could further buttress safe sex practices among the youth.

However, it's the researcher's opinion that most of the respondents only answered favourably in these questions because they knew it's the right thing to do and not because they practiced it. During the researcher's practicum at Lea Toto, she interacted with many of the youth freely, not just as a counsellor but also as a friend, and most of them would share that during the times they had sexual relations, they would act in the heat of the moment, for temporary pleasure and condom use was the last thing on their minds, this is corroborated in the study on college students in Colombia, USA by Jenkin-Cappiello, which asserts that some of the students, especially the earlier years were less likely to use condoms in a sexual encounter (Jenkin-Cappiello, 2006).

It was also noted that some of the cases handled during practicum, involved teenage girls who were pregnant and when asked why they did not use condoms, their answers varied from forgetting, to lack of access, condoms were not acceptable in their religion, or simply the fact that they did not want their boyfriends to break up with them for suggesting use of condoms. Many of the boys on the other hand, would say that some of these unprotected sexual encounters happened when they were under the influence of alcohol and other substances, therefore by the time they realized that they had done it, it was too late, and rarely did they remember using condoms, this corresponds with what Bekker reports in her article about the youth and risky behaviour (Bekker, 2015).

The theory of reasoned action states that behavioural beliefs determine evaluations of behavioural outcomes (Ajzei & Fishbein, 2005). From experience, many youths and especially, adolescents, have the behavioural belief called personal fable. The Personal Fable is a belief held by many adolescents telling them that they are special and unique, so much so that none of life's difficulties or problems will affect

them regardless of their behavior. This is where the adolescent will engage in risky sexual behavior, sometimes including substance abuse and believe that no harm will befall them (Geckil & Dundar, 2011, Gabbion, 2019).

Many of the clients dealt with during practicum, believed that they were not going to get pregnant at the first sexual encounter, or that they were not infectious to their sexual partners and as such could engage in unprotected sex without having to worry about these happening to them. It fell on the counsellor to guide them accordingly and refute these beliefs with actual facts, for some of the clients the fact that they actually became pregnant or were infectious came as a surprise. This view is also reinforced by Pikard's research on adolescents in Kenya and their likelihood of utilizing VCT services, whereby they concluded that despite having access to these services, few if any voluntarily went for the HIV test (Pikard, 2009; Kimberly & Serovich, 2009).

The Key informants show that several methods were used to enhance safe sex practices. These included condoms, Pre-Exposure prophylaxis (PrEP) for youth among the key populations, and Depo-Provera (contraceptive injection), and other family planning methods (Alemayehu, Aregay, Kalayu, & Yebyo, 2014; Gabbion, 2019). However, they felt that of YLWH did not want their statuses to be known for fear of stigmatization and rejection hence they did not practice safe sex. Consequently, this led to increases in new transmissions especially among youth (Hosek, Harper, & Domanico, 2010). As such, there was a need to put in place measures aimed at de-stigmatization. Group psychology discouraged them from practicing safe sex since everybody else was doing the same. This contributed to the increase in transmission due to social pressure (Ajzei & Fishbein, 2005). Post exposure prophylaxis (PEP) was also one of the safety precautions used to protect victims of sexual abuse, and rape. It was also administered where a survivor of sexual abuse or rape reported the crime and

also when a PLWH confessed to having sexual relations with a partner whose status was negative. Although the latter is not encouraged as it may lead to misuse of the same (Volberding & Deeks, 2010; Bekker, 2015). Most of the counsellors intimated that of the YLWH who disclosed, a large percentage were likely to have viral suppression, which indicated that they had adhered to their ART and hence had high levels of self-esteem and acceptance, on the other hand, the YLWH that were unwilling to disclose their status, in most cases, were also defaulting on their treatment and in some cases involved in drug use.

The FGD participants opined that male condoms were the most used method of safe sex practices. This agrees with Alemayehu who posits that condoms were highly used (Alemayehu, Aregay, Kalayu, & Yebyo, 2014). Other family planning methods were also used albeit sporadically. Other methods used included abstinence, faithfulness, and morning-after pills. These findings agree with Alberta Education that posits that abstinence, contraception, and sexual health decision-making (Alberta Education, 2018) were some safe sex practices employed by the youth. It was noted that most of the youth fear pregnancy more than HIV infection, as most of the females admitted to using the morning after pills but not being assertive in the use of condoms. Some the youth from disadvantaged homes admitted that they would easily engage in unprotected sex in order to get money for essential needs. This asserts the view by Volberding that, Abraham Maslow hierarchy of needs plays a major role in the prevention of transmissions as a person who cannot afford food, would not bother about their safety until this basic need is met. Lack of a proper diet for some affected their adherence, since without a proper balanced diet, the ARV's sometimes tend to have severe side effects; like vomiting, general body weakness, diarrhoea among others, (Volberding & Deeks, 2010; Flowers & Davis, 2013).

The study also sought to establish the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. As in table 4.3, the findings show that there was a significant relationship between safe sex practices and voluntary self-disclosure ( $r=0.502$ ,  $p<0.05$ ). This is in line with a study by Cherin and others that shows that disclosure enhanced safe sex practices (Cherin, et al., 2011). The youth agreed to a great extent ( $M=4$ ) to three of the Likert-type statements presented to them. In this regard, they agreed to a great extent that they would willingly disclose their HIV status to their sexual partner and that disclosure of status to sexual partners keeps them healthy. They also agreed to a great extent that voluntary disclosure leads to better family plans, especially on safeguarding children's health. These findings agree with former studies that show that disclosure enhanced the health and welfare in challenging situations (Saunders & Burgoyne, 2011; Gabbion, 2019).

The respondents went on to agree to a moderate extent ( $M=3$ ) that disclosing status makes a relationship stronger and disclosure of status to sexual partners makes me feel free and happy. Lastly, the respondents pointed out that disclosing status to a partner boosts a person's self-esteem. This was particularly so if it was followed by support (Naigino, et al., 2017).

The key informants pointed out that most of them, between 50 to 80% did not want their status exposed due to stigma. The participants of FGDs posited that there was some level of disclosure to family members, relatives, friends, and lovers [sex partners]. This shows that disclosure was often supported by expected support (physical or emotional) by trusted friends and family (Bushi & Goodson, 2007). The disclosure was also done to groups of friends but this was often challenged by the expected outcomes (Maman & Medley, 2007, Naigino, et al., 2017).

Majority of the youth who had disclosed their status or were willing to disclose their status seemed to have a high sense of self-esteem and confidence. It was also noted that these same youth had a high sense of self-acceptance and on further research, It was noted that most of the ones who had acquired the condition from their parents and had been disclosed to their status early on in life were more likely to accept themselves and their status, and more likely to disclose their status to a trusted partner. This is especially true since studies are confirming that self-efficacy significantly predicts safe sex behavior among sexually active people (Hendrickx, Philips, & Avonts, 2008). Moreover, most of the YLWH who had zero viral loads, meaning they had adhered to ART, were seen to be more willing to disclose their status and lived positive lives. Therefore, these findings further reinforce the communication privacy theory that states that in disclosing one's private information, one first needs to have confidence in themselves and in the people, they want to share with, their information (Sprecher & Hendrick, 2014; Petronio & Venetis, 2017).

### **5.2.3 Effect of voluntary shared-disclosure on safe sex practices among YLWH**

The second objective of the study was to assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV. Pearson correlation shows that there was a significant relationship between safe sex practices and voluntary shared-disclosure,  $r=0.392$ ,  $p<0.05$ ). This shows that anticipated support was pivotal in voluntary shared disclosure and safe sex practices after such disclosure (Streeter & Franklin, 2016). Means of 3 for all statements show that the youth agreed to a moderate extent to all the statements presented to them. In this regard, the respondents agreed to the moderate extent that they would willingly disclose their HIV statuses to their families and friends and that disclosure of status to family and friends keeps them

healthy. This shows that expected support from friends and close relations was key in the decision to disclose statuses (Bushi & Goodson, 2007). The respondents also agreed to a moderate extent that disclosing status to family and friends ensures a stronger social support system and that it makes one feel free and happy. Also disclosing status to family and friends boosts a person's self-esteem and protected them from infection. This, further buttresses the findings of Bushi and Goodson that shows that anticipated support from friends was pivotal in decisions to disclose statuses (Bushi & Goodson, 2007).

The key informants show that disclosure had mixed results. For discordant couples, some ended in a breakup. This led to loneliness which was aggravated by the loss of friends. There have also been instances of increased blame game and stigmatization. Rejection and depression due to negative outcomes have led to a reduction in adherence to ART (Gabbion, 2019). Due to the negative repercussions associated with disclosure, very few disclose. However, some got support from partners, families, and friends (Bushi & Goodson, 2007) and this led to more adherence to treatment and reduction in mother to child transmissions (MTCT).

Most FGD participants pointed out that they were not ready for voluntary disclosure. To undertake disclosure, some of the skills needed were being ready for the outcome (Naigino, et al., 2017). There was also a need for one to accept his/her HIV status first before doing disclosure. High self-esteem, confidence, and self-love were recommended (Bryan, Aiken, & West, 2014). There was also a need to get advice from the counsellors where one obtained ARVs before the disclosure (Toska, Cluver, Hodes, & Kidia, 2015). Trust with partners was also important before disclosure. T (Bushi & Goodson, 2007). Assurance of financial support after the disclosure was also necessary.



It was the researcher's view that most of the YLWH needed support from the counsellors or other health care workers to disclose their status, to their partners because they were concerned about their health and that of their partners, and most did not have sufficient skills and confidence to disclose on their own, this is asserted by the research done. In some cases, the counsellors had to act like they were testing both clients for the first time so as to manage the reactions of the partner. The pre-test and post-test counselling, done at HTS were pivotal in doing this as both clients, were asked of the possibility of either of them being positive and how they would react. The cases of discordant couples were noted and it is the researcher's view that not all couples ended up separated. Several cases, in particular, attest to the fact that support from the negative spouse was beneficial to some of the respondents because as a result, they minimised cross-infections and even MTCT was controlled. Majority of couples who disclosed and received support from their partners were also Adhering to ART.

On the other hand, It was noted that some of the YLWH did not want to disclose their statuses to friends, family and sexual partners because they did not want to assume the 'sick role', this is asserted in a study done in Scotland where they posited that HIV-positive individuals may not perceive or want to be perceived as sick, though others may view them as such, resulting in tension and conflict (Petрак, Doyle, Smith, Skinner, & Hedge, 2010). In the field some of the youth cited this as one of the reasons they did not want to disclose their status, they did not want to be viewed as 'helpless', or 'terminal'. They wanted to live 'normal' lives without being subjected to unwanted attention.

#### 5.2.4 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH

The third objective of the study was to determine the effect of involuntary disclosure on safe sex practices among youths living with HIV. Pearson correlation analysis showed that there was a statistically significant relationship between safe sex practices and involuntary/accidental disclosure ( $r=0.015$ ,  $p<0.05$ ). This agrees with Massie who points out that involuntary disclosures could affect safe sex practices (Massie, 2015).

The respondents agreed to a very high extent ( $M=5$ ) that sharing a person's HIV status without their knowledge is heart-breaking. They went on to agree to a great extent ( $M=4$ ) that it is unfair to use a specific person's HIV+ status as a push for safe sex without informing them and that health officers should be open about reporting HIV+ statuses to public health authorities (Canadian Medical Association, 2018). The respondents also agreed to a great extent ( $M=4$ ) that it is okay to use HIV related statistics to sensitize people about safe sex practices and that it is okay for public health authorities to use my HIV+ status outcome in ART planning. This is in line with the study by Massie who points out that in some instances, the government is obliged to report on HIV+ statuses (Massie, 2015). Lastly, the respondents agreed to a moderate extent ( $M=3$ ) that public health officers should share information about infected persons who decline to disclose their status. This also agrees with the study by Massie who was of the same opinion (Massie, 2015).

The KII participants pointed out that there were no instances of forced disclosures. In this regard, the willingness of the client was ensured. In most cases, the youth were advised to disclose their statuses to partners. Assisted disclosure was also prevalent (BC Centre for Disease Control, 2016). When accidental disclosure happened, the youth became heartbroken (Simoni & Pantalone, 2015). As a result,

adherence reduced and default levels increased. The counsellors, Community Health workers and social workers were professionally bound to maintain their client's confidentiality and so even when there was a clear disregard of the law, these professionals were caught in a dilemma, as exposing their clients would make them lose their trust and also of other clients who get to witness such. Most of the Key informants confessed that they had never been forced to disclose a client's status in a court of law, and as far as they knew very few infected people could trace the person who infected them and even when they did, it was hard to prove that it was done willingly. They agreed that they needed to be empowered on how to handle such a case if it was to occur.

When asked to point out how they understood the terms voluntary self-disclosure? Involuntary shared disclosure, the FGD participants said that voluntary disclosure was where the person decides to disclose their status without being forced. It was also a situation where one would tell his/her partner about his/her status. It was also seen as when one goes to a health centre to know his/her status by themselves. Others said that it was moderately understood. Involuntary disclosure was however seen is when a person found out that their status had been disclosed without their knowledge or being involved (BC Centre for Disease Control, 2016). It was also seen as when one went to the health clinic to know their status and that it was done by two sex partners. It was also seen as a case where one was not willing to disclose his/her status (Massie, 2015). These findings show that there was a moderate understanding of voluntary and involuntary disclosures among the respondents. This could affect their willingness to seek help.

However, the researcher noted that according to Kenyan law, HIV positive individuals who willingly infected others were liable to prosecution, however, there

was little action taken when such happened. A few of the YLWH in FCD's expressed that they were hurt and vengeful when they discovered that they had been infected and one case in particular, stated that they willingly sought others to infect until they were counselled when they fell very ill as a result, and this caused them to understand and stop the reckless path that they had undertaken.

The FGD participants also said that accidental disclosure of their status in most instances was discouraging. Accidental disclosure happened for teens in schools, where some of the students' drugs were seen by mistake. It led to a lack of adherence to medication due to self-stigma and in some cases discrimination by other students (Naigino, et al., 2017). There were also cases of disclosure when the client was drunk. Cases of involuntary disclosure also occurred when clients were seen going to the Comprehensive Care Clinics (CCC) like Lea Toto, which other residents know cater to PLWH. Accidental or involuntary disclosure also led to the breakup of relationships, depression, discrimination/losing friends and, suicide. This agrees with Deribe et al. who opined that disclosure could have negative ramifications (Deribe, Ebrahim, & Bush, 2018).

It was noted that the YLWH should be counselled and encouraged to have self-acceptance and self-esteem, this would help them in cases where disclosure happens without their consent. Counsellors and other Health care workers need to continue psychoeducation the YLWH and other Community members on the importance of destigmatizing PLWH. Training on Expected disclosure outcomes is also crucial for all PLWH since one can never determine other people's reactions and so in case the outcome is negative, Clients can be able to move on with life and achieve a sense of purpose.

### **5.2.5 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH**

The last objective of the study was to establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV. Pearson correlation analysis showed that there was a statistically significant relationship between safe sex practices and, disclosure outcomes,  $r=0.502$ ,  $p<0.05$ ). This agrees with Deribe et al. who posit that HIV status disclosure could have both positive and negative outcomes (Deribe, Ebrahim, & Bush, 2018). The respondents agreed to a great extent ( $M=4$ ) to all the statements presented to them. In this regard, they agreed to a great extent that that support from spouse, family, and friend after disclosure builds esteem and that acceptance from society after disclosing status encourages safe sex. This agrees with the study by Bushi and Goodson which find similar results (Bushi & Goodson, 2007). They also agreed to a great extent ( $M=4$ ) that decreased stigma after disclosure builds a sense of responsibility and that discrimination from spouse, family, and friends after disclosure lowers self-esteem. Lastly, the respondents agreed to a great extent ( $M=4$ ) that acts of violence and rejection from society after disclosure discourages safe sex among infected persons and that increased stigma after status disclosure lowers a person's sense of responsibility. This could lead to reduced adherence to safe sex practices (Naigino, et al., 2017).

The KIIs participants pointed out that about 70% of the outcomes were negative compared to 30% which were positive. Rejection after disclosure led to low libido, loneliness, and low self-esteem. It also led to rejection, fear, and stigmatization by relatives (Birungi, Mugisha, Obare, & Nyombi, 2009). This shows that disclosure often led to negative consequences on the youth. It also led to non-adherence of treatment; which contributed to high viral load and HIV transmission among the youth. This

agrees with the study of Hosek et al. who were of the same opinion (Hosek, Harper, & Domanico, 2010). In some instances, disclosure led to suicide. Others stopped using protection after disclosure. In some cases, disclosure had positive effects, especially if there was support after disclosure (Alemayehu, Aregay, Kalayu, & Yebyo, 2014). In this regard, disclosure led to enhanced adherence to treatment and safe sex practices.

The FGD participants pointed out that there were both positive and negative outcomes. The positive outcomes were realized when there was support from spouses, family, and relatives (Bushi & Goodson, 2007; Hendrickx, Philips, & Avonts, 2008). It also took place when the partners started safe practices after knowing each other's statuses. Positive outcomes also took place when there was adherence to ART, psycho-education of peers, and better health statuses (UNAIDS, 2019). However, disclosure could result in negative outcomes. In some instances, some would go ahead and say that one was sick. It also led to stigma, ending of the relationship, and violence with some being beaten up after disclosure. This agrees with Naigino et al. who pointed out that disclosure could result in violence in some instances (Naigino, et al., 2017). If in a discordant relationship it led to negative outcome because the partner is afraid or thinks that the infected partner wants to infect him/her. If the statuses of couples do not match it could lead to breakups. Other negative outcomes included rejection which affected self-esteem (Petрак, Doyle, Smith, Skinner, & Hedge, 2010), poor adherence due to shattered confidence and gossip which led to displacement, running away, and violence as in agreement with the findings of Naigino et al. This could affect the safe sex practices among the youth (Petрак, Doyle, Smith, Skinner, & Hedge, 2010).

It was also noted that most of the youth who were active in attending the support groups established in some of the centres, were among the youth who were assured of a stable support system and so even when they encountered negative outcomes, they

had a support system to rely on. It is the researcher's view that support groups for the YLWH should be established in all comprehensive care centres so that a support system is present for them regardless of the outcomes that come about with disclosure, this would help to curb instances where the youth resorted to suicide as a result of rejection or stigma. Support groups also provided the youth with a chance to learn from one another and also encouragement and motivation that if a certain person was able to disclose their status, so can I. The researcher also found out that some of the motivating factors that led to disclosure especially among couples included; the presence of children, the status of a relationship, and counselling, as many said that the above factors prompted them to disclose because they did not want their children to go through what they had, others claimed that the support and love experienced from a faithful spouse encouraged to trust that in turn boosted disclosure. Last but not the least, many of the respondents who had undergone counselling, came to realize that it was in their best interest to disclose their status and that none of the people around them were in charge of their health, it was a personal decision, this is further corroborated in Cherin et al. findings on satisfaction levels of services offered at HTS centres (Cherin, et al., 2011)

### **5.3 Summary of main findings**

This section presents a summary of the main study findings. The summary is presented in line with the objectives of the study.

#### **5.3.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH**

The first objective of the study was to examine the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. To begin with, levels

of safe sex practices were established and it was noted that the majority of the youth were aware of the safe sex practices. The respondents agreed to a great extent (M= 4) with five of the statement presented to them. In this regard, they agreed to a great extent that both men and women were responsible for buying condoms. It was noted that the female condom, however, was not often used. Findings further indicate, that even though most respondents agreed with the statements that they carefully thought about it before engaging in sex, and that sex should only happen between two people who trust each other, this was not the case in real life. The researcher and the key informants posited that most youths were more vulnerable to engage in risky behaviours and thus would be quick to use the morning-after pill to avoid a pregnancy but not worry too much about getting infected or infecting others. Also, the respondents agreed to a great extent (M=4) that faithfulness was important in any relationship. However, the respondents agreed to a moderate extent (M=3) with the statement, “it is possible to enjoy sex even when using a condom.” This shows that some of the YLWH believe that sex is more pleasurable without condoms, a fact that should be corrected through psychoeducation.

The Key informants show that several methods were used to enhance safe sex practices. These included condoms, Depo-Provera (contraceptive injection), and other family planning methods. However, they revealed that some of YLWH did not want their statuses to be known for fear of stigmatization and rejection hence they did not practice safe sex. Also, group psychology discouraged them from practicing safe sex since everybody else was doing the same. The FGD participants opined that male condoms were the most used methods of safe sex practices. Other family planning methods were also used albeit sporadically. Other methods used included abstinence,



faithfulness, and Post-exposure prophylaxis (PEP). It was noted that counsellors had an informal way of screening YLWH's likelihood to disclose based on adherence to ART.

The study sought to establish the effect of voluntary self-disclosure on safe sex practices among youths living with HIV. The findings show that there was a significant relationship between safe sex practices and voluntary self-disclosure ( $r=0.502$ ,  $p<0.05$ ). In this light, it is evident that voluntary disclosure could influence safe sex practices.

The key informants pointed out that most of the YLWH, between 50 to 80% did not want their status exposed due to stigma. The participants of FGDs posited that there was some level of disclosure to family members, relatives, friends, and lovers [sex partners]. Disclosure was however often challenged by low self-esteem, lack of acceptance of their serostatus, lack of emotional support, and economic challenges.

### **5.3.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices among YLWH**

The second objective of the study was to assess the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV. Pearson correlation shows that there was a significant relationship between safe sex practices and voluntary shared-disclosure,  $r=0.392$ ,  $p<0.05$ ). Means of 3 for all statements show that the youth agreed to a moderate extent to all the statements presented to them. In this regard, the respondents agreed to a moderate extent that they would willingly disclose their HIV statuses to their families and friends and that disclosure of statuses to family and friends keeps them healthy. The respondents also agreed to a moderate extent that disclosing status to family and friends ensures a stronger social support system and that it makes one feel free and happy. Also disclosing status to family and friends boosts a person's self-esteem and protected them from infection.

The key informants show that disclosure had mixed results. For discordant couples, some ended in a breakup. This led to loneliness which was aggravated by the loss of friends. There have also been instances of increased blame game and stigmatization. Rejection and depression due to negative outcomes have led to a reduction in adherence to ARVs treatments. Due to the negative repercussions associated with disclosure, very few disclose. However, some got support from partners, families, and friends and this led to more adherence to treatment and reduction in mother to child transmission (MTCT).

Most FGD participants pointed out that they were not ready for voluntary shared disclosure. To undertake disclosure, some of the skills needed were being ready for the outcome. There was also a need for one to accept his/her HIV statuses first before doing disclosure. High self-esteem, confidence, and self-love were recommended. There was also a need to get advice from the counsellors where one obtained ARVs before disclosure. Trust with partners was also important before disclosure. Assurance of financial support after the disclosure was also necessary. The researcher's findings also point to a lack of disclosure due to reluctance among YLWH to be perceived as sick by their loved ones.

### **5.3.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH**

The third objective of the study was to determine the effect of involuntary disclosure on safe sex practices among youths living with HIV. Pearson correlation analysis showed that there was a statistically significant relationship between safe sex practices and involuntary/accidental disclosure ( $r=0.015$ ,  $p<0.05$ ). The respondents agreed to a very high extent ( $M=5$ ) that sharing a person's HIV status without their knowledge is heart-breaking. They went on to agree to a great extent ( $M=4$ ) that it is

unfair to use a specific person's HIV+ status as a push for safe sex without informing them and that health officers should be open about reporting HIV+ statuses to public health authorities. The respondents also agreed to a great extent (M=4) that it is okay to use HIV related statistics to sensitize people about safe sex practices and that it is okay for public health authorities to use my HIV+ status outcome in ART planning. Lastly, the respondents agreed that the public health officers should not share the status of HIV positive individuals who refuse to disclose their status as this would be betraying their trust in them. In this regard, the researcher agrees with

The KII participants pointed out that there were no instances of forced disclosures. In this regard, the willingness of the client was ensured. In most cases, the youth were advised to disclose their statuses to partners. Assisted disclosure was also prevalent. When accidental disclosure happened, the youth became heartbroken. As a result, adherence reduced and default levels increased. It was noted that there was a disconnect between the law and Professional's code of ethics that encouraged confidentiality between the client and the therapist, therefore disclosure of a client's status against their will even when they were harming others was a paradox that they needed empowerment of how to handle.

When asked to point out how they understood the terms voluntary self-disclosure? Involuntary shared disclosure?" The FGD participants said that voluntary disclosure was where the person decides to disclose their status without being forced. It was also a situation where one would tell his/her partner about his/her status. It was also seen as when one goes to a health centre to know his/her status by themselves. Others said that it was moderately understood. Involuntary disclosure was however seen is when a person found out that their status had been disclosed without their knowledge or being involved. It was also seen as when one went to the health clinic to

know their status and that it was done by two sex partners. It was also seen as a case where one was not willing to disclose his/her status.

The FGD participants also said that accidental disclosure of their status in some instances happened for teens in schools. It led to a lack of adherence to medication due to self-stigma. There were also cases of accidental disclosure when the client was drunk. Cases of involuntary disclosure also occurred when drugs were seen or when one was seen going to the Comprehensive Care Clinic (CCC). It also happened when the partner tested positive and traced it back to their sexual partner. It also led to the breakup of relationships, depression, discrimination/losing friends and, suicide. The researcher posits that the key service needed here was counselling to boost self-esteem and follow-up to boost adherence.

#### **5.3.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH**

The last objective of the study was to establish the relationship between HIV status disclosure outcomes and safe sex practices among youths living with HIV. Pearson correlation analysis showed that there was a statistically significant relationship between safe sex practices and, disclosure outcomes,  $r=0.502$ ,  $p<0.05$ ). The respondents agreed to a great extent ( $M=4$ ) to all the statements presented to them. In this regard, they agreed to a great extent that that support from spouse, family, and friend after disclosure builds esteem and that acceptance from society after disclosing status encourages safe sex. They also agreed to a great extent ( $M=4$ ) that decreased stigma after disclosure builds a sense of responsibility and that discrimination from spouse, family, and friends after disclosure lowers self-esteem. Lastly, the respondents agreed to a great extent ( $M=4$ ) that acts of violence and rejection from society after

disclosure discourages safe sex among infected persons and that increased stigma after status disclosure lowers a person's sense of responsibility.

The KIIs participants pointed out that about 70% of the outcomes were negative compared to 30% which were positive. Rejection after disclosure led to low libido, loneliness, and low self-esteem. It also led to rejection, fear, and stigmatization by relatives. Moreover, negative outcomes led to non-adherence of treatment; which contributed to high viral load and HIV transmissions among the youth. In some cases, disclosure led to suicide. Others stopped using protection after disclosure. In some cases, disclosure had positive effects, especially if there was support after disclosure. In this regard, disclosure led to enhanced adherence to treatment and safe sex practices.

The FGD participants pointed out that there were both positive and negative outcomes. The positive outcome was realized when there was support from spouses, family, and relatives. It also took place when the partners started safe practices after knowing each other's statuses. Positive outcomes also took place when there was adherence to ART, psycho-education of peers, and better health statuses. However, disclosure could result in negative outcomes; like stigma, ending of the relationships, rejection from friends and family, and violence with some being beaten up after disclosure. If in a discordant relationship it sometimes led to negative outcome because the negative partner is afraid or thinks that positive partner would infect him/her, for some who received counselling, they ended up staying with their spouses. Most negative outcomes resulted in, poor adherence due to shattered confidence, which in some cases resulted in full-blown AIDS and eventually death, and in some cases gossip which led to displacement, running away, suicide and violence.

## **5.4 Conclusion**

This section presents the conclusions of the study findings which are based on the objectives of the study.

### **5.4.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH**

Voluntary self-disclosure had a significant relationship with safe sex practices among youths living with HIV ( $r=0.502$ ,  $p<0.05$ ). There were high levels of willingness to disclose their HIV status to their sexual partners, especially among married couples, which was seen as having an interest safeguarding the unborn children's health, where prevention of MTCT is achieved. It also strengthened relationships and boosted the self-esteem of partners. In most cases, voluntary self-disclosure was done to family members, relatives, friends, and lovers [sex partners]. There were instances of disclosure to groups of friends but this was often challenged by the expected outcomes. The higher the level of adherence by YLWH is linked to a higher likelihood disclosure.

### **5.4.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices**

There was a significant relationship between safe sex practices and voluntary shared-disclosure, ( $r=0.392$ ,  $p<0.05$ ). The youth said that they would willingly disclose their HIV statuses to their families and friends. Assisted disclosure was also prevalent. Disclosure of status to family and friends was seen as a way of keeping the youth healthy. Disclosing status to family and friends also ensured a stronger social support system and led to relief to the youth and increases in safe sex practices. It also boosted a person's self-esteem and protected them from infection. However, disclosure was often challenged by negative effects such as marriage/relationship breakup for discordant couples, perceptions of stigma or rejection, perceptions of being treated

differently as sick. It often led to rejection, depression, and reduction in adherence to ARVs treatments. Due to the negative repercussions associated with disclosure, very few disclose.

#### **5.4.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH**

There was a statistically significant relationship between safe sex practices and involuntary disclosure ( $r=0.015$ ,  $p<0.05$ ). It is evident that sharing a person's HIV status without their knowledge is heart-breaking. Though it was seen as unfair, it could be tolerated in some instances and that health officers should be open about reporting HIV+ statuses to public health authorities. It played pivotal roles in ART planning. As such, public health officers should share information about infected persons who decline to disclose their status. Mostly, there were no instances of forced disclosures. There was also accidental disclosure of their status in some instances. Accidental disclosure happened for teens in schools, when medicine was seen or when a partner tested positive. It led to a lack of adherence to medication due to self-stigma.

#### **5.4.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH**

There was a statistically significant relationship between safe sex practices and, disclosure outcomes, ( $r=0.502$ ,  $p<0.05$ ). Support from spouse, family, and friend after disclosure, built esteem and acceptance from society after disclosing status and encouraged safe sex. Decreased stigma after disclosure built a sense of responsibility. Also, discrimination from spouse, family, and friends after disclosure lowered self-esteem. Acts of violence and rejection from society after disclosure discouraged safe sex among infected persons. Increased stigma after status disclosure lowered a person's

sense of responsibility. The KIIs participants pointed out that about 70% of the outcomes were negative compared to 30% which were positive. Rejection after disclosure led to low libido, loneliness, and low self-esteem. In some instances, disclosure led to violence and suicide. In some cases, disclosure had positive effects, especially if there was support after disclosure. In this regard, disclosure led to enhanced adherence to treatment and safe sex practices.

## **5.5 Recommendations**

Based on the findings of the study, the following recommendations were made.

### **5.5.1 Effect of Voluntary Self-Disclosure on Safe Sex Practices among YLWH**

There is a need for encouraging more YLWH to disclose their statuses. The community should continue being psycho-educated on the benefits of supporting those who disclose their statuses. There is also a need to strengthen advocacy campaigns in schools so as to enhance support for youth who disclose their statuses. Sex education in schools would be beneficial for the youth as most are sexually active and have many misconceptions about sex and a majority fear pregnancy more than STI's. Counsellors should come up with counselling models to empower youth on self-esteem/ confidence, acceptance of self and anticipated disclosure outcomes so as to motivate more voluntary self-disclosures. In this regard, a proper screening tool can be developed to measure the likelihood of HIV status disclosure among PLWH, so as to assist those with a lower likelihood of disclosure, to develop self-efficacy to disclose. Female condoms to be subsidized and made readily available (like the male condom) to empower more women to be proactive about taking safe sex measures.



### **5.5.2 Effect of Voluntary Shared-Disclosure on Safe Sex Practices among YLWH**

Strategies should be put in place for checking the negative effects of voluntary shared-disclosure. Families, friends, and partners should be taught about the benefits of disclosure and encouraged to offer strong social support. There should be psychosocial support strategies, for following up on those who suffer rejection, depression, and reduction in adherence to ARVs treatments after disclosure like; more support groups for YLWH in every centre covering the different age sets.

### **5.5.3 Effect of Involuntary Disclosure on Safe Sex Practices among YLWH**

There should be strategies aimed at empowering health care workers to deal with legal issues that face them as a result of forced disclosure. Health care workers should psycho-educate the Youth about government policy on disclosure and community at large on de-stigmatization of PLWH. Assisted disclosure should be strengthened to ensure more cases of voluntary self/shared disclosure can happen. Psychosocial support interventions should be put in place for those whose statuses get accidentally disclosed to alleviate the negative consequences of this. Tough legislation and implementation of the law by Government bodies, on those found stigmatizing, discriminating, or mistreating any PLWH as a way to curb this in society.

### **5.5.4 Effect of HIV Status Disclosure Outcomes on Safe Sex Practices among YLWH**

Support from spouse, family, and friend after disclosure should be enhanced through advocacy campaigns to reign in on negative influences of the disclosure. Decisions to stop adhering to ARV treatment and safe sex practices due to negative

outcomes of HIV status disclosure should be checked through robust counselling interventions. Discrimination from spouse, family, and friends after disclosure should be checked through consistent advocacy and capacity building at community levels. Positive outcomes such as adherence to ART, psycho-education of peers, and better health statuses should be reinforced and the lessons learnt from successful cases after disclosure replicated when supporting YLWH to disclosure their statuses.

### **5.6 Areas of Further Research**

The study focused on the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS in the Lea Toto Program, Nairobi County, Kenya. There is a need for comparative studies in other related programs in Nairobi as well as other parts of Kenya. Studies focused on socio-demographic differences in HIV status disclosure among YLWH are also recommended. The issue of family planning methods came up as an issue that most youths were interested in procuring to protect themselves from pregnancy, it would be useful to conduct further research to understand the short/ long term effects of these on the youth. The researcher also noted that it was necessary to conduct more study on Pre-Exposure prophylaxis (PrEP) which was used on Key populations; Men who have sex with men (MSM), sex workers, and People who inject drugs (PWID) to avoid new HIV infection, since they are more vulnerable and Post Exposure Prophylaxis (PEP) which was used in case of possible infection in cases of sexual abuse of minors, rape, and accidents in the line of work by health care workers, these were both issues that came up as some of the preventive measures that were taken to avoid a rise in HIV infection, which the researcher had not considered as part of the sex safe practices.

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## APPENDICES

### Appendix I: Informed consent form

#### Introduction

My name is Esther Mbose Mutua. I am a graduate student at Africa Nazarene University undertaking a study on the *Effects of HIV Status Disclosure on Safe Sex Practices among Youths Living with HIV and AIDS in the Lea Toto Program, Nairobi County, Kenya.*

#### Procedure to be followed

Questions will be asked about your age, gender, HIV status disclosure, and safe sex practices. It will take approximately 15 minutes of your time, with the exception of those participating in group discussion.

#### Discomfort and Risks

The procedure to be used in this study is not associated with physical risks. However, some questions in the study maybe of a sensitive nature and you are allowed to skip answering.

#### Benefits

If there are any psychological issues that arise as a result of this study, you will be referred for counselling at the centre and assisted to overcome the challenge.

#### Confidentiality

The information you provide is only for research purposes. In the questionnaire, you do not have to write your name. Codes that are not available to any person and are stored in an enclosed space will be given to the questionnaires.

#### Participation

Your participation is entirely voluntary in this survey, but you can at any point withdraw from the study altogether. Nevertheless, it will be of great benefit to this study if you gave your truthful answers to the questions. You can ask any questions

concerning this study on what you don't understand. I would appreciate your assistance in answering the questions.

**Contact information.**

If you have any question you may ask me or call 0725-738-731

**Participant's consent ( 18yrs +)**

I have clear information about my participation in the study. I was assured of confidentiality. My participation in this research is free and I have no benefits. I have had the chance to ask questions that have all been answered to my satisfaction.

Signature or thumbprint ----- Date -----

**Consent/ Assent for minors ( below 18years)**

I have given consent for my child/ ward to participate in the study. I was assured of his/ her confidentiality. My child/ward's participation in this research is free and I have no benefits. I have had the chance to ask questions that have all been answered to my satisfaction.

Signature or thumbprint ----- Date -----

**Researcher's statement**

I, the undersigned, have explained to the participant in a language she/he understands procedures to be followed and risks and benefits involved.

Name of researcher/ research assistant-----

Researcher/ research assistant signature ----- Date-----



## Appendix II: Youth's Questionnaire

This questionnaire seeks to examine the effects of HIV status disclosure on safe sex practices among youths living with HIV and AIDS; A case of Lea Toto program, Nairobi county, Kenya. Please respond to the questions accurately. Indicate your preferred answer by ticking in a given box [, which corresponds to your choice. The responses will remain confidential and will only be used for academic purposes.

### A: Demographic Information

1. What is your gender?

Male [  ]                      Female [  ]

2. How old are you?

15- 17 years [  ]      18- 21 years [  ]      22- 24 years [  ]

### B: Safe Sex Practises

Indicate how much you agree with the following statements. Rate responses in the scale of <b>5 to 1</b> ( <b>5</b> - very high extent; <b>4</b> - great extent; <b>3</b> - moderate extent; <b>2</b> - little extent and; <b>1</b> - Not at all).					
<b>STATEMENTS</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Men and women are equally responsible for buying condoms	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
It is possible to enjoy sex even when using a condom	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Before engaging in sexual relations, I think about it carefully	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Only two people who trust each other completely should have sexual relations	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Being healthy is more important than short, temporary pleasure	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
In my opinion, faithfulness is very important in a relationship	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

**C: Voluntary Self-disclosure**

Indicate how much you agree with the following statements. Rate responses in the scale of <b>5 to 1</b> ( <b>5</b> - very high extent; <b>4</b> - great extent; <b>3</b> - moderate extent; <b>2</b> - little extent and; <b>1</b> - Not at all).					
<b>STATEMENTS</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
I would willingly disclose my HIV status to my sexual partner					
Disclosure of status to sexual partners keeps them healthy					
Disclosing status makes a relationship stronger					
Disclosure of status to my sexual partner makes me feel free and happy					
Disclosing status to a partner boosts a person's self-esteem					
Voluntary disclosure leads to better family plans, especially in safeguarding children's health					

**D: Voluntary Shared-disclosure**

Indicate how much you agree with the following statements. Rate responses in the scale of <b>5 to 1</b> ( <b>5</b> - very high extent; <b>4</b> - great extent; <b>3</b> - moderate extent; <b>2</b> - little extent and; <b>1</b> - Not at all).					
<b>STATEMENTS</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
I would willingly disclose my HIV status to my sexual partner, family and friends					
Disclosure of status to family and friends keeps them healthy					
Disclosing status to family and friends ensures a stronger social support system					
Disclosure of status to family or friends makes one feel free and happy					
Disclosing status to family and friends boosts a person's self-esteem					
Voluntary disclosure to family and friends protects them from infection					

**E: Involuntary Disclosure**

Indicate how much you agree with the following statements. Rate responses in the scale of <b>5 to 1</b> ( <b>5</b> - very high extent; <b>4</b> - great extent; <b>3</b> - moderate extent; <b>2</b> - little extent and; <b>1</b> - Not at all).					
<b>STATEMENTS</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Sharing a person's HIV status without their knowledge is heart-breaking					
It is unfair to use a specific person's HIV+ status as a push for safe sex without informing them					
Health officers should be open about reporting HIV+ statuses to public health authorities					
Public health officers should share information about infected persons who decline to disclose their status					
It is okay to use HIV related statistics to sensitize people about safe sex practices					
It is okay for public health authorities to use my HIV+ status outcome in ART planning					

**F: Disclosure Outcomes**

Indicate how much you agree with the following statements. Rate responses in the scale of <b>5 to 1</b> ( <b>5</b> - very high extent; <b>4</b> - great extent; <b>3</b> - moderate extent; <b>2</b> - little extent and; <b>1</b> - Not at all).					
<b>STATEMENTS</b>	<b>5</b>	<b>4</b>	<b>3</b>	<b>2</b>	<b>1</b>
Support from spouse, family, and friend after disclosure builds esteem					
Acceptance from society after disclosing status encourages safe sex					
Decreased stigma after disclosure builds a sense of responsibility					
Discrimination from spouse, family and friends after disclosure lowers self-esteem					
Acts of violence and rejection from society after disclosure discourages safe sex among infected persons					
Increased stigma after status disclosure lowers a person's sense of responsibility					


**Appendix III: Key Informants' Interview (KII).**


- (i) In your working experience, Do the Youth Living with HIV disclose their status to their sexual partners? If yes, out of 10 how many would disclose? If No, what do you think hinders them from disclosing?
- (ii) Do you think that Youth living With HIV practice safe sex practices/ or are aware of the safe sex practices to use when they engage in sex? If yes what is the most commonly used method? If No what can be done to make them aware of these practices?
- (iii) What is the effect of voluntary shared-disclosure on safe sex practices among youths living with HIV in your area?
- (iv) Are there instances where you were forced to disclose a patient's status without their consent to their partners and what effect did it have on safe sex practices if any?
- (v) Are there instances where your clients have accidentally disclosed their status to others either because their drugs were seen by others? What effect if any did this have on their sexual practices?
- (vi) What are some of the HIV status disclosure outcomes you have witnessed among YLWH? Do these outcomes have any impact on safe sexual practices among the YLWH?

**Appendix IV: Focused Group Discussions for YLWH**

- (i) What are some of the safe sex practices you know and how often do you practice them when engaging in sex?
- (ii) Have you ever disclosed your HIV status to anyone other than your immediate family? Who? How did you go about it?
- (iii) What are some of the skills you need in order to disclose your HIV status to your sexual partner?
- (iv) What do you understand by the words; voluntary self-disclosure? Involuntary shared disclosure?
- (v) Does HIV status disclosure have any effect on safe sex practices? Explain.


### Appendix V: Research Permit

  
**REPUBLIC OF KENYA**

  
**NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION**

Ref No: **675299** Date of Issue: **19/September/2019**

**RESEARCH LICENSE**

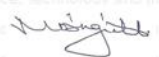


**This is to Certify that Ms.. Esther mutua of Africa Nazarene University, has been licensed to conduct research in Nairobi on the topic: Effects of HIV status disclosure upon safe sex practices among youths living with HIV and AIDs in the LEA Toto program, Nairobi County, Kenya for the period ending : 19/September/2020.**


License No: **NACOSTI/P/19/1505**

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## Appendix VI: Research approval Letter



**AFRICA NAZARENE**  
UNIVERSITY

23<sup>rd</sup> August 2019

RE: TO WHOM IT MAY CONCERN

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Mbose Esther (15503EMCP002) is a bonafide student at Africa Nazarene University. She has finished her course work Master of Arts in Counseling Psychology and has defended her thesis proposal entitled: - "*Effects of HIV Status Disclosure upon Safe Sex Practices among Youths Living with HIV and Aids in the Lea Toto Program, Nairobi County, Kenya*".

Any assistance accorded to her to facilitate data collection and finish her thesis is highly welcomed.

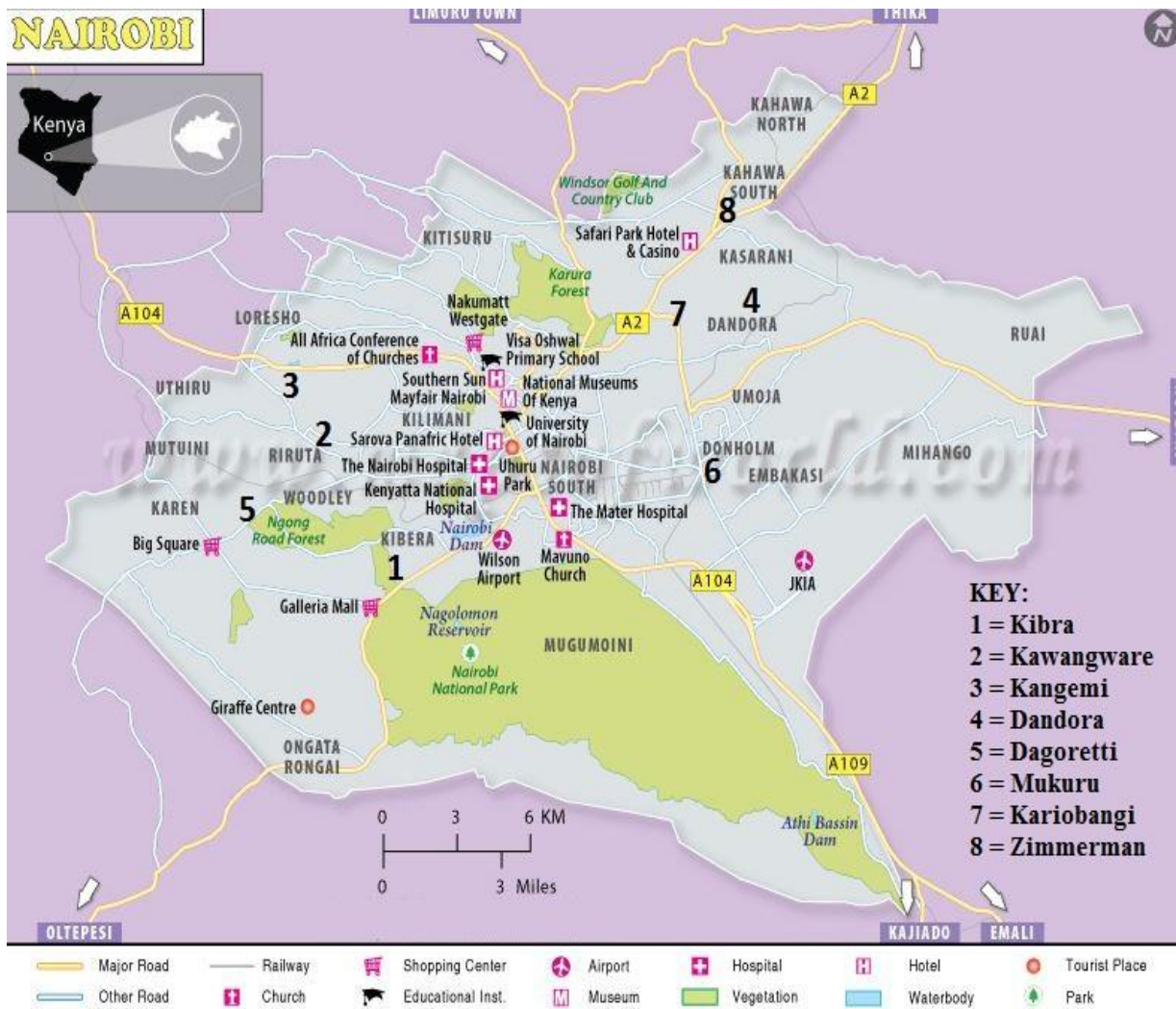
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Africa

**Prof. Orpha Ongiti**

**Ag. DVC Academic Affairs.**



Appendix VII: Map of Study Area



Source: Adapted from Maps of the World (2014).