

Prevalence of HIV-Related Stigma among HIV Infected Adolescents in Samia-Sub County, Kenya

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ABSTRACT

Human Immunodeficiency Virus (HIV) is a leading cause of global burden of disease. Recently, significant progress has been made in increasing access to Anti-Retroviral Therapy (ART) for people living with HIV to suppress the replication of the virus. Suppressed viral replication facilitates restoration of the immune function and significantly reduces the risk of onward HIV transmission. Despite the increasing access to ART, compelling evidence indicate suboptimal levels of viral suppression among adolescents in many low-resource settings. This has been associated with failure of adolescents to adhere to medication due to stigma. The purpose of this study was to determine the prevalence of HIV-related stigma among adolescents living with HIV in Samia Sub County, Busia County, Kenya. The study was guided by the theory of planned behavior and the Social cognitive theory. The study adopted the mixed method research design. The study population comprised of 4 peer educators, 740 caregivers, 1580 adolescent HIV+ boys and girls, and 1 Sub County Aids and Sexually Transmitted Infections Coordinator (SCASCO). The sample size was 4 Peer educators, each drawn from the four wards, 74 caregivers for HIV+ adolescents, 158 HIV+ adolescents and the 1 SCASCO. The stratified and simple random sampling techniques was used to select the 158 HIV+ adolescents and 74 caregivers while saturated sampling was employed to select 4 peer educators and one health officer. Questionnaires, Focus Group Discussion and interview schedule were used to collect data from the respondents. All the instruments were piloted before administration in order to determine their validity and reliability. The test-retest method was used and a reliability coefficient of 0.70 was accepted. Data was analyzed using descriptive statistics such as the frequency counts and percentages. Qualitative data was organized in terms of relevant themes and sub-themes and interpreted. Data analysis was performed using the Statistical Package for the Social Sciences (SPSS) Version 23.0. The study established that there is a high prevalence of HIV-related stigma among infected adolescents in Samia Sub-County. It is recommended that the Ministry of Health, NGOs, Community Based Organization, health workers and policy makers should have an informed understanding of HIV-AIDS prevalence hence equip themselves with skills, abilities, behaviors and strategies needed to mitigate HIV-AIDS prevalence among the adolescents in Samia Sub-County. It may also help improve on programs targeting adolescents with HIV interventions for optimal viral suppression outcome among this young population.

Keywords: Prevalence; HIV-related stigma; HIV infected adolescents

INTRODUCTION

For over twenty years, Human Immunodeficiency Virus (HIV) infection and Acquired Immunodeficiency Syndrome (AIDS)

have been major public health epidemics that continue to ravage communities [1]. The World Health Organization Global Summary of AIDS shows that 33.4 million people worldwide are living with HIV/AIDS, with 2.1 million of those being children

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Received: 18-Feb-2022, Manuscript No. JPPT-22-14686; **Editor assigned:** 21-Feb-2022, PreQC No. JPPT-22-14686 (PQ); **Reviewed:** 7-Mar-2022, QC No. JPPT-22-14686; **Revised:** 14-Mar-2022, Manuscript No. JPPT-22-14686 (R); **Published:** 21-Mar-2022, DOI:10.35248/2161-0487.22.12.439

Citation: Omollo B, Opiyo RA (2022) Prevalence of HIV-Related Stigma among HIV Infected Adolescents in Samia-Sub County, Kenya. J Psychol Psychother. 12:439

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under the age of 15, and 1.8 million of these children live in the global South. The disease burden of HIV occurs within low and middle-income countries within the Global South [2].

Many of the inequalities that facilitated the spread of the AIDS pandemic are getting worse and, continue to fan the spread of HIV in many parts of the world. COVID-19 has brought these inequalities to the forefront and exposed the fragility of the gains made. The inequalities that underpin stigma, discrimination and HIV-related criminalization that enhance people's vulnerability to acquire HIV make adolescents living with HIV more likely to die of AIDS-related illnesses. Inadequate counseling opportunities and a range of social, economic, racial and gender inequalities, social and legal environments that impede rather than enable the HIV response, and the infringement of human rights are slowing progress in the HIV response and across other health and development areas.

To improve health and HIV outcomes, the Global AIDS Strategy 2021-2026 is a bold strategy that calls for all policies and future practice to be assessed to determine whether they do not further stigmatize HIV diagnosis, perpetuate discrimination and exacerbate health inequalities. It further outlines a comprehensive framework for transformative actions to confront these inequalities and, more broadly, respect, protect and fulfill human rights in the HIV response. The Strategy sets out evidence-based priority actions and bold targets to get every country and every community on-track to end AIDS as a public health threat by 2030 (Ibid). The Strategy outlines the strategic priorities and actions to be implemented by global, regional, country and community partners to get on track to ending AIDS. It leverages four decades of experience of the HIV response, supporting governments, partners and communities to "build back better", supporting systems for health to be more resilient and place people at the center. The Strategy is being adopted during the Decade of Action to accelerate progress towards the Sustainable Development Goals (SDGs), and makes explicit contributions to advance goals and targets across the SDGs.

East and Southern Africa is the region hardest hit by HIV. It is home to around 6.2% of the world's population but over half (54%) of the total number of people living with HIV in the world (20.6 million people). In 2018, there were 800,000 new HIV infections, just under half of the global total (WHO, 2019). In 2018, 25% of new HIV infections in East and Southern Africa were among adolescents and their sexual partners, despite these groups making up a fraction of the total population.

In countries of Global South like Uganda, the risk of HIV infection during adolescence is high [3]. Moreover, vertical transmissions of HIV continue to occur in these countries due to low access to perinatal health care services [4]. As a result, the prevalence of HIV in Ugandan youth is on an upward trend. Furthermore, these youth have been facilitated to live longer with HIV as a chronic infection due to Antiretroviral Therapy (ART), yet concerns about their quality of life have risen [5]. HIV-related stigma has been found to be a key stressor affecting quality of life of these youth [6]. Although several studies have elaborated how HIV-related stigma undermines the HIV

management cascade for youth little attention has been devoted to the lived experiences of adolescents with HIV-related stigma and its effects on their daily life especially in the Ugandan context [7].

In Kenya, there are approximately 190,000 HIV-infected children and adolescents, of who only 38% are on ART [8]. In 2014, the Joint United Nations Programme on HIV and AIDS (UNAIDS) launched the three 90-90-90 targets for 2020 as a major step towards eliminating the AIDS epidemic. By availing ART to HIV-infected people and expanding prevention choices to the uninfected, 21 million AIDS-related deaths and 28 million new infections can be prevented by 2030 [9]. Against this background is Agenda four in Kenya whose one of the pillars addresses quality and affordable universal health care for a healthy population.

The focus of this study was to determine the prevalence of HIV-related stigma among adolescents living with HIV in Samia Sub County, Busia County, Kenya. Now more than ever, in the fight against HIV in Kenya, the focus needs to shift to adolescents who bear the brunt of the scourge. Youth aged between 15 and 24 years now account for 40% of all new HIV infections in the country each year. In Busia County, it is estimated that about 44,326 are living with HIV. According to data, Kenya had an estimated 12,940 new HIV infections among children with Busia County ranked 21st in the country with 58 new infections in Samia Sub County. HIV prevalence among adolescence rose from 6.7 in 2017 to 7.7 in 2019 [10,11]

For the purpose of this study, prevalence refers to the percentage of adolescents living with HIV. Prevalence measures the frequency of HIV/AIDS among adolescents at a specific time. HIV-related stigma has been identified as a significant stressor affecting Quality of Life of adolescents living with HIV/AIDS. To this end, therefore there is need to contextualize an understanding of how this stigma is experienced by adolescents in Samia Sub-County.

Studies of HIV-related stigma among adolescents are of relevance since these youth are highly vulnerable to stigma and their number is on the rise [12]. Youth's vulnerability to HIV-related stigma is exacerbated by social and economic marginalization, as well as the rapid physical and psychosocial transitions [13]. Stigma often follows the fault-line of this existing social marginalization and tends to magnify and perpetuate it, [14]. This is compounded by the general lack of youth-friendly programmes to enable youth to navigate through HIV-related challenges [15].

Indeed, as in any new area of investigation, everyone has an interpretation and more than a few express their views on the HIV related stigma prevalence concept. In the current literature most of the articles vehemently decry the ranges of HIV prevalence and very few studies cite data specifically relevant to the variable under study. Therefore, the study was justified in terms of providing needed information about prevalence of HIV related stigma among infected adolescents in Samia Sub-County, Busia County, Kenya.

LITERATURE REVIEW

Nearly half of all new HIV infections in the world are prevalent among the youth aged 15–24 years [16]. Most countries in the Global South experience a very high risk of HIV infection during adolescence [3]. Specifically, vertical transmissions of HIV are frequent in these countries because of low access to perinatal health care services [4].

Enacted stigma refers to negative public attitudes or discrimination towards adolescents living with HIV. Nearly half of all new HIV infections in the world are prevalent among the youth aged 15–24 years [16]. Most countries in the Global South experience a very high risk of HIV infection during adolescence [3]. Specifically, vertical transmissions of HIV are frequent in these countries because of low access to perinatal health care services [4].

Enacted stigma and wrong notions about HIV remain widespread in West Africa. In 10 of the 18 countries it was established that, 50% or more of elderly people reported that they would not buy vegetables from a shopkeeper who is HIV positive. This discriminatory attitude was also reported by two thirds of participants in Benin, Ghana, Guinea, Mauritania and Sierra Leone.

The prevalence of HIV among the youth in Uganda for example, is increasing. Moreover, the adolescents have been facilitated to live longer with HIV as a chronic infection given the availability of Antiretroviral Therapy (ART) [5]. Despite all these, there have been increased concerns about their quality of life. HIV-related stigma remains a key stressor affecting quality of life of the adolescents [17].

In Kenya, many people born with HIV are now teenagers and young adults. A comprehensive high impact response towards stigma and discrimination against adolescents and young people is essential. Kenya has a HIV and AIDS Tribunal that forms a critical pillar for access to justice and protection against stigma and discrimination. HIV related stigma and discrimination has been identified as impacting negatively on uptake of HIV services including HIV testing and counseling, care and treatment. It affects enrollment and retention in care, therefore compromising the primary HIV outcomes for prevention and treatment. Socially excluded and vulnerable populations are more likely to experience higher levels of stigma and discrimination thus impacting more severely on efforts to promote HIV prevention and treatment in these populations. Adolescents and young people are identified as priority populations in KASF, as they are often marginalized and therefore more likely to be stigmatized in the school and community system. Stigma and discrimination is based on individual and social perceptions and attitudes. Manifestations of stigma and discrimination range from: exclusion from social events in school and communities; exclusion from participation in curriculum related activities; verbal abuse and/or threats and physical harassment. These external actions may promote self-stigma especially among adolescents and young people who also experience identity crisis and self-esteem challenges during teenage and young adult hood [18-22].

RESEARCH METHODOLOGY

The research methodology is presented in this section.

Research design

In this study the researcher adopted descriptive survey research design. It combined both quantitative and qualitative designs. Adolescents were selected for the study because they are placed more at risk of HIV through early sexual debut, multiple partners, lack of condom use, transactional or coerced sex, inter-generational sex, and sex under the influence of alcohol or drugs, and injecting drug use [23-25].

Samia Sub-County was chosen for the study because the prevalence of HIV/AIDS is at an all-time high. For example, it rose from 6.7% to 7.7% in 2019. This shows that new infections especially among adolescents and above are on the rise hence, the need to investigate the prevalence of HIV related stigma among the youth in Samia Sub-County.

Population and sample

The study population comprised of 4 peer educators, 740 caregivers, 1580 adolescent HIV+ boys and girls, and 1 health officer (SCASCO). The HIV infected adolescents participated in the study since this is the group which is assumed to have challenge in achieving the UNAIDS goal of 90% viral suppression. The peer educators were selected because they deal directly with clients, for example they monitor their drug adherence. On the other hand, the caregivers were selected as key respondents because they are the stewards of adherence at the household level and assist the adolescents with both medical and/or preventive care. The health Officer was selected because they coordinate all the HIV related activities in the Sub County. The sample size will be 4 Peer educators, 74 caregivers for HIV + adolescents, 158 HIV+ adolescents and 1 health officer.

Stratified sampling techniques was used to select the HIV infected adolescents and the caregivers. The sampling unit was gender. The respondent was classified into male and female categories. Using the simple random sampling 158 (79 Male and 79 Female) HIV+ adolescents were selected. The simple random sampling technique was used to select 74 (37 Male and 37 Female) caregivers. Saturated sampling was employed to select the 4 peer educators who are assigned to each of the four wards and the only health officer [26].

From the sampled four wards, all the 158 HIV+ adolescents, 74 caregivers, 4 peer educators and the only health officer completed the questionnaires, focus group discussion, Key informant interview and an Interview schedule respectively. The final study sample comprised 237 respondents [27].

Data collection instruments

The Adolescent Stigma Scale (ASS) adapted from Westbrook and Bauman, (1996) was used to assess stigma as perceived by infected adolescents. ASS is a self-report 43-item questionnaire with 2 subscales. The perceived stigma (self) consists of 21 items which describe feelings of negative attitudes associated with HIV

and accepted by the adolescents. The enacted stigma subscale contained 22 items that described negative public attitudes or discrimination towards adolescents living with HIV. The subscales were scored on a four-point response scale from 1 (strongly Agree) to 4 (strongly Disagree). The questionnaire was administered on individual basis and completed in 15 minutes. It was piloted to ascertain its validity and reliability in the Kenyan context [28].

Data analysis

Data analysis was mainly quantitative and less qualitative. The analysis of qualitative data involved immersion, categorization, phenomenological reduction and interpretation. To analyze quantitative data, different methods were used. First and foremost, frequency distribution tables were generated from data collected. Histograms were generated from the frequency distribution tables. These two methods of data presentation

assisted in data interpretation and analysis. After scoring the questionnaires, the data was coded and data files prepared for computer analysis. The analysis was performed using the Statistical Package for the Social Sciences (SPSS) Version 25.0. Content analysis of the written free responses of the respondents was also carried out.

RESULTS AND DISCUSSION

The study sought to determine the prevalence of HIV-related stigma among adolescents in Samia Sub County, Busia County, Kenya. Analyses were conducted for each of the naturally occurring groups namely level of education, gender and age.

Level of education

The distribution of HIV infected adolescents in terms of levels of education is presented in Table 1.

Table 1: Education Level.

Level	Frequency	Percentage (%)
KCPE	72	45.6
KCSE	67	42.4
Artisan	9	5.7
Certificate	10	6.3
Total	158	100

Data in Table 1 shows that most of the HIV infected adolescents, accounting for 45.6% were in class 8 while those with form four level of education were at 42.4%. Those with certificate and artisan qualifications accounted for 6.3 % and 5.7% respectively. This means that most of the HIV infected adolescents in Samia Sub County are within the school going age bracket

Gender

The distribution of the HIV infected adolescents by gender is presented in Table 2.

Table 2: Gender of respondents.

Gender	Frequency	Percentage (%)
Male	69	43.7
Female	89	56.3
Total	158	100

In terms of gender, results in Table 2 shows that most of HIV infected adolescents accounting for 56.3% were females while the male were at 43.7%. The results show that the girl child in Samia Sub-County is at risk of contracting HIV/AIDS. This finding corresponds with that of Gomez & Meacham (1998) who established that the girl child is more at risk of contracting HIV/AIDS compared to the boy child with respect to access to information about HIV/AIDS prevention, the ability to negotiate

negotiate safe sexual encounters and access to treatment for HIV/AIDS once infected. They further posit that throughout the world, the unequal social status of women places them at higher risk for contracting HIV/AIDS.

Age

The distribution of the HIV infected adolescents by age is presented in Figure 1.

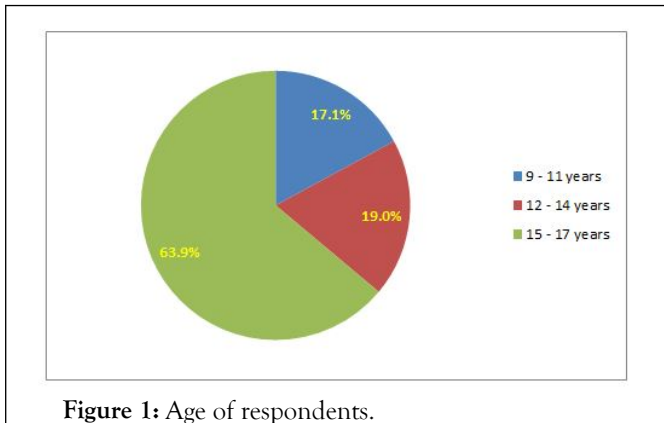


Figure 1: Age of respondents.

Results in Figure 1 shows that most of the HIV infected adolescents accounting for 63.9% were in the (15-17) age bracket while 19.0% were in the (12-14) age bracket and 17.1% were in the (9-11) age bracket. The High prevalence of HIV among adolescents between 15-17 can be attributed to early sexual debut in Samia Sub- County. This finding is similar to that of UNICEF (2020) which established that it is common for youths become sexually active by late adolescence.

The prevalence of HIV-related stigma among HIV infected adolescents in Samia - Sub County

The objective of this study was to determine the prevalence of HIV-related stigma among HIV infected adolescents in Samia Sub- County. In this study, prevalence refers to the percentage of adolescents living with HIV. Prevalence measures the frequency of HIV/AIDS among adolescents at a specific time.

Feeling uncomfortable around people

The adolescents were asked if they felt uncomfortable when people around them know they have HIV. The results are presented in Figure 2.

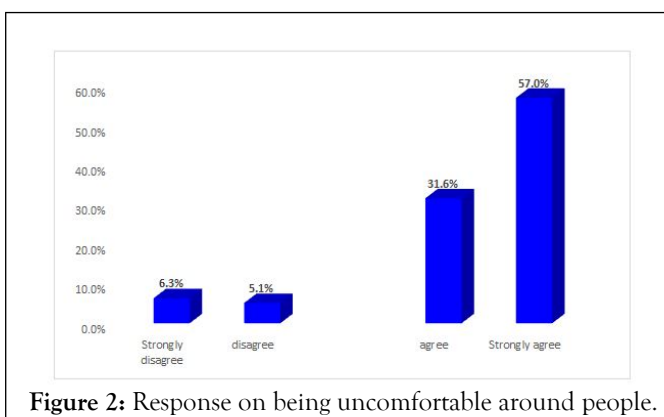


Figure 2: Response on being uncomfortable around people.

From results presented in Figure 2, most of HIV infected adolescents accounting for 88.6% (57% strongly agreed, 31.6% agreed) agreed that when people around them know they have HIV they feel uncomfortable while 11.4% (6.3% strongly disagree, 5.1% disagree) disagreed with the statement. Based on

their responses it is evident that majority of the HIV infected adolescents in Samia-Sub County has the stigma that makes them feel uncomfortable when people around them know about their HIV status.

This finding was supported by the SCASCO when she observed that to some extent, adolescent would hide and not disclose their status since they feared being perceived as sex workers which made them shy off from coming for drugs and engaging with peers. During the KII, one of the peer educators mentioned that adolescents were irregular at attending counselling sessions because of fears of how they would be perceived. This fear was mainly reported by adolescents who were within the age bracket of 16-17 years. The care givers also noted that some of the adolescents dropped out of school because of stigma from fellow peers.

HIV adolescents uncomfortable of their HIV status

The adolescents were asked if they felt uncomfortable about their HIV status.

The results are presented in Figure 3.

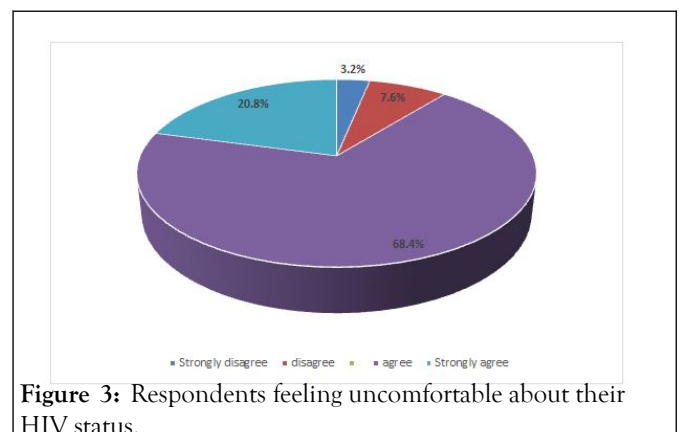


Figure 3: Respondents feeling uncomfortable about their HIV status.

Data in Figure 3 reveals that most of the HIV infected adolescents accounting for 89.2% (20.9% strongly agreed, 68.4% agreed) felt uncomfortable about their HIV status while a paltry 10.8% (3.2% strongly disagree, 7.6% disagree) did not agree with the statement. It is likely that majority of the HIV infected adolescents have the stigma of feeling uncomfortable about their status because of discrimination they face both at home and in school. During the Focus Group Discussion (FGD), this finding was confirmed by one of the caregivers who said:

The adolescents who are on medication are fond of hiding the drugs from relatives because they feared that they would be judged as being immoral.

Living with guilt of having messed

Adolescents were asked if they were living with guilt of having messed. The results are presented in a Figure 4.

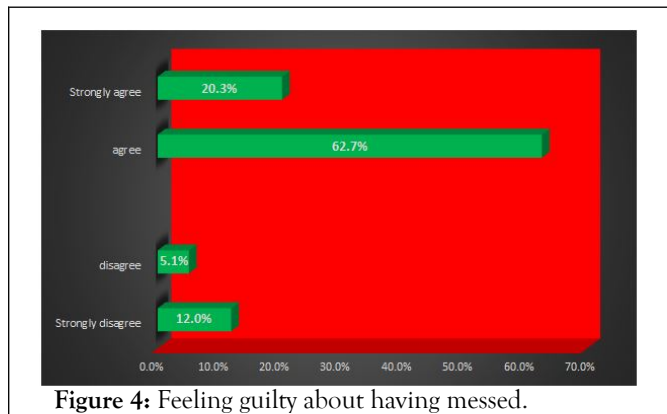


Figure 4: Feeling guilty about having messed.

As shown in Figure 4, most of HIV infected adolescents accounting for 83 % (20.3% strongly agree, 62.7% agreed) agreed with the statement that they feel guilty about having messed. This shows that most of the HIV infected adolescents in Samia Sub- County might have contracted the disease through

Table 3: Fear sharing items.

Response	Frequency	Percentage (%)
Strongly agree	18	11.4
Agree	106	67.1
Disagree	15	9.5
Strongly disagree	19	12
Total	158	100

Data in Table 3 reveals that most of the HIV infected adolescents accounting for 78.5% (11.4% strongly agreed, 67.1% agreed) agreed with the statement that they fear sharing items such as glasses and dishes with other people. Only 21.5% (12.0% strongly disagreed, 9.5% disagreed) disagreed with the statement. This shows that the level of stigma among HIV infected adolescents in Samia Sub-County is high.

The SCASCO confirmed this finding by saying that:

Having HIV makes the adolescents to be perceived as immoral people. This makes some of them shy off, develop self-stigma and poor self-esteem, denial and depression.

The finding was further supported during FGD by one of the caregivers who said that:

Having HIV makes some of the adolescents so stressed to the extent that they feel they should not share dishes and other utensils with others.

Low confidence when looking for jobs

The adolescents were asked if they had low confidence in looking for jobs. The results are presented in Figure 5.

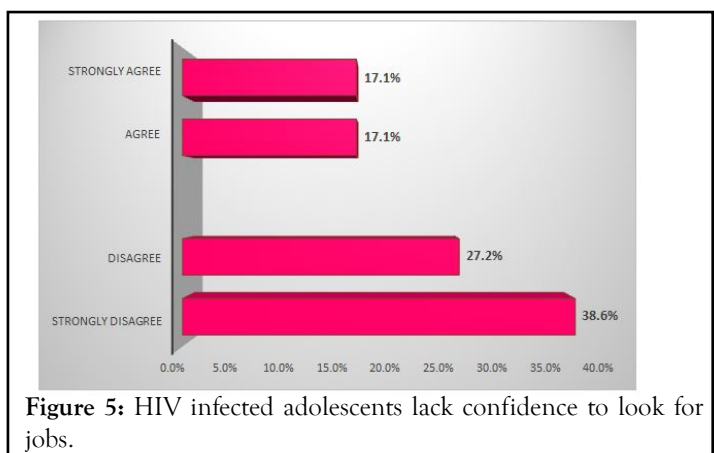


Figure 5: HIV infected adolescents lack confidence to look for jobs.

From Figure 5, results show that most of the HIV infected adolescents accounting for 65.8% (38.6% strongly disagreed, 27.2% disagreed) with the statement that, if they apply for a job, and someone else also applied who did not have HIV, the employer should hire the other person. Only 34.2% (17.1% strongly agreed, 17.1% agreed) affirmed the statement. This means that having HIV seems not to reduce the confidence of the adolescent in trying to look for employment opportunities from various organizations or firms.

Deserving respect irrespective of one’s HIV status

The adolescents were asked if they felt they are people who

deserve as much respect as anyone else in spite of their HIV status. Table 4 presents the findings.

Table 4: Responses deserving respect irrespective of one’s HIV status.

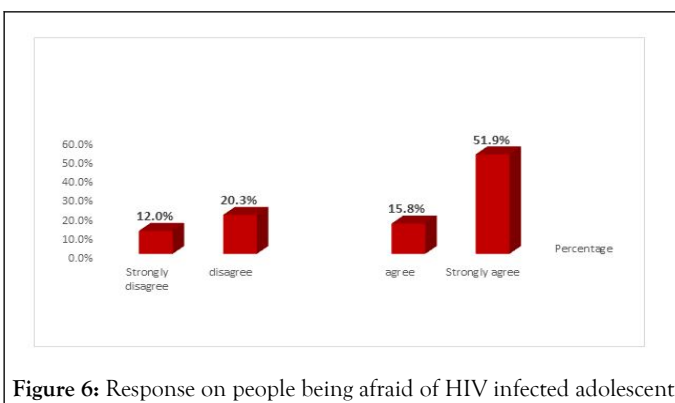
Response	Frequency	Percentage (%)
Strongly agree	58	36.7
Agree	33	20.9
Disagree	33	20.9
Strongly disagree	34	21.5
Total	158	100

Results in Table 4 reveals that most of the HIV infected adolescents accounting for 57.6% (36.7% strongly agreed, 20.9% agreed) approved the statement that although they have HIV, they are people who deserve as much respect as anyone else. On the contrary, 42.4% (21.5% strongly disagreed, 20.9% disagreed) disagreed with the statement. Inasmuch as many of them are perceived to be HIV positive and deserving respect, a good number still have the stigma.

According to the peer educators and care givers, although infected adolescents are perceived as promiscuous and therefore not deserving any respect, they aver that these youths are human beings who should be treated with dignity.

People are justified to fear coming into contact with HIV infected adolescent

The adolescents were asked if they felt that people are right to be afraid of them because they have HIV. The results are presented in Figure 6.



From the results presented in Figure 1.6, most of the HIV infected adolescents accounting for 67.7% (51.9% strongly agreed, 15.8% agreed) agreed with the statement that people are right to be afraid of them because they have HIV, while 32.3% (12% strongly disagreed, 20.3% disagreed) did not agree with the statement.

From the findings, it is evident that majority of the HIV infected adolescents in Samia Sub-County are living with the stigma that being HIV positive makes people to be afraid of them.

Accordingly, the rollout of ART was followed by reductions in HIV-related prejudicial attitudes in many African countries. However, recent studies suggest that stigma persists and continues to be a barrier to HIV treatment and care.

Low esteem about adolescents’ chances of getting people to date them

Adolescents were asked if they feel they are less attractive to those who might want to date them. Table 5 presents the findings.

Table 5: Responses about lack of people to date HIV patients.

Response	Frequency	Percentage (%)
Strongly agree	93	58.8
Agree	49	31

Disagree	8	5.1
Strongly disagree	8	5.1
Total	158	100

Data in Table 5 shows that most of the HIV infected adolescents accounting for 89.8% (58.8% strongly agreed, 31% agreed) affirmed that because of their HIV status, they feel they are less attractive to those who might want to date them. On the contrary, only 10.2% (5.1% strongly disagree, 5.1% disagree) did not agree with the statement. The findings show that majority of the HIV infected adolescents in Samia Sub-County experience low levels of self-esteem due to their condition, hence the real fear of rejection and not being able to get love from members of the opposite gender.

On the contrary, the SCASCO and the peer educators noted that although some adolescent fear disclosing their status to

Table 6: HIV adolescents fear caring for other peoples' children.

Response	Frequency	Percentage (%)
Strongly agree	14	8.8
Agree	15	9.5
Disagree	97	61.4
Strongly disagree	32	20.3
Total	158	100

Results in Table 6 shows that most of the HIV infected adolescents accounting for 81.7% (20.3% strongly disagree, 61.4% disagree) did not agree with the statement that they felt completely safe to care for other people's children even though they have HIV.

Only 18.3% (8.8% strongly agreed, 9.5% agreed) of them agreed with the statement. This means that they fear handling other people's children probably because they fear being accused of transmitting the disease to those children.

Deserving credit for coping well with HIV

Respondents were asked if they think they deserve credit for coping well with HIV. The results are presented in Figure 7.

peers, they have been equipped with skills on how to form healthy relationships with their peers and also avoid engaging in risky sexual behaviors.

Low confidence about caring for other people's children

HIV infected adolescents were asked if they felt completely safe to care for other people's children even though they have HIV. The results are presented in Table 6.

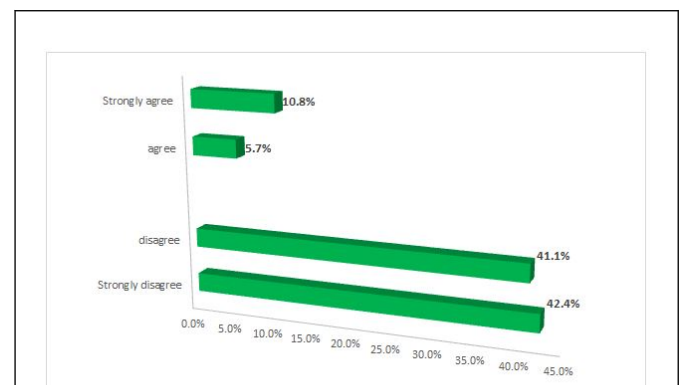


Figure 7: Responses about deserving credit for coping well with HIV.

From Figure 7 results show that most of the adolescents accounting for 83.5% (42.4% strongly disagreed, 41.1% disagreed) disapproved the statement that they deserve credit for how well they have coped with HIV, with only 16.5% (10.8% strongly agreed, 5.7% agreed) with the statement. This means that most of the HIV infested adolescents in Samia Sub- County are still not yet confident that they are able to cope with the disease.

Living with shame about how they got HIV

The respondents were asked if they feel ashamed about how they got HIV. The results are presented in Figure 8.

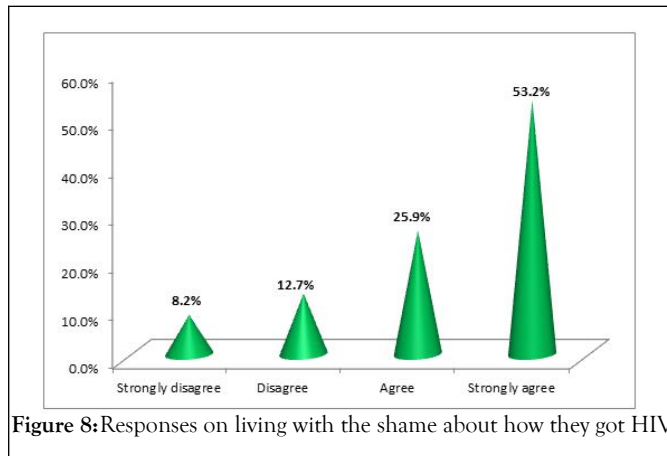


Figure 8: Responses on living with the shame about how they got HIV.

From the results presented in Figure 8, most of the HIV infected adolescents accounting for 79.1% (53.2% strongly agreed, 25.9% agreed) that, they feel ashamed about how they got HIV. A paltry 20.9% (8.2% strongly disagreed, 12.7% disagreed) did not feeling ashamed about how they got the disease.

The results reveal that majority of the HIV infected adolescents in Samia Sub-County are still stigmatized given the way in which they got infected.

Feeling of low self esteem

The respondents were asked if they feel less of themselves because they have HIV. The results are presented in Table 7.

Table 7: HIV infected adolescents feeling less about themselves.

Response	Frequency	Percentage (%)
Strongly agree	42	26.6
Agree	85	53.8
Disagree	21	13.3
Strongly disagree	10	6.3
Total	158	100

From Table 7 results show that most of the HIV infected the adolescents accounting for 80.4% (26.6% strongly agreed, 53.8% agreed) approved the statement that they think less of themselves because they have HIV. On the other hand, 19.6% (6.3% strongly disagreed, 13.3% disagreed) did not agree with the statement. The result is a further pointer to the existence of HIV stigma among the adolescents in Samia Sub-County.

Contracting HIV due to bad luck

The respondents were asked if their contracting of HIV was just a matter of bad luck. The results are presented in Figure 9.

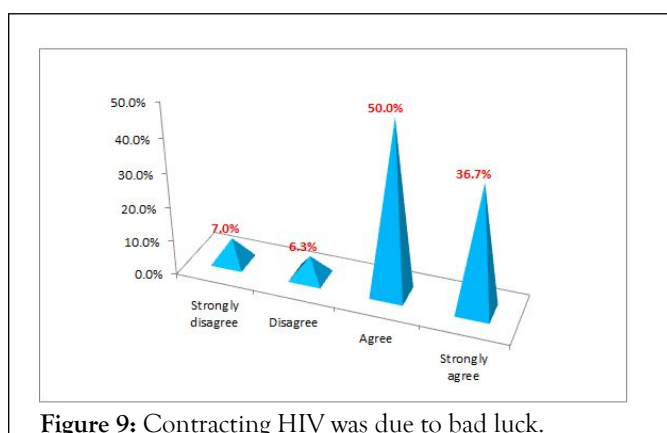


Figure 9: Contracting HIV was due to bad luck.

Results in Figure 9 show that most of the HIV infected adolescents accounting for 86.7% (36.7% strongly agreed, 50% agreed) agreed with the statement that they think that their getting HIV was just a matter of bad luck. Only 13.3% (7% strongly disagreed, 6.3% disagreed) did not agree with the statement. From the findings it is possible that due to self-denial, many adolescents in Samia Sub-County still think that bad luck could have been the reason as to why they got the disease.

Descriptive summary of HIV related stigma factors

The prevalence of HIV- related stigma among HIV infected adolescents in Samia Sub- County as one the objectives of this study, had 21 factors upon which its influence or effect on their medication adherence was evaluated. Individually or collectively, these factors to some extent contributed on the overall significance of stigma predictor in influencing or affecting medication adherence among HIV positive adolescents. A total of 21 questions in the form of statements measured on 4 point Likert scale were framed and asked to a sample of 158 adolescents living with HIV.

The descriptive statistics results presented in form of frequency tables, percentages, bar graphs, column graphs and pie charts, to a large extent, revealed high prevalence ratios for 15 HIV-stigma related factors namely: people fear dating them 89.8%, ashamed of themselves 89.3%, how they got HIV 86.7%, feeling

uncomfortable around people 86.6%, guilty about having HIV 86.1%, fear teaching about HIV 85.4%, they don't deserve praise on how they cope with HIV 83.5%, guilty of having messed 83%, living in fear 82.9%, fear caring for other people's children 81.7%, thinking less about themselves 80/4%, ashamed about how they got HIV 79.1%, fear sharing dishes and glasses 78.5%, regretting their action which contributed to them getting HIV 78.5% , and feeling that they are not of good moral characters 74%.

The other 6 factors namely: people reject being their friends because of HIV 69.6%, people are justified not to come into contact with them 67.7%, low confidence in looking for jobs 65.8%, lack of confidence to relate with their peers 62%, they do not think they deserve respect 42.4% and fear of upsetting friends because they are HIV positive 41.1%; registered a prevalence of slightly above average or below. However, collectively they could still influence medication adherence among HIV positive adolescents.

CONCLUSION

From the foregoing discourse it is reasonable to conclude that there is a high prevalence of HIV-related stigma among infected adolescents in Samia Sub-County. Who established that there is a high prevalence rate of HIV infection among adolescents in Western Kenya? The finding also corroborates that established an upsurge in HIV prevalence from 6.7% in 2017 to 7.7% in 2019 in Busia County.

RECOMMENDATIONS

The government through the Ministry of Health has a vital role to play in organizing seminars and workshops to sensitize the adolescents on how to mitigate issues of HIV related stigma. A more complete understanding on how HIV/AIDS stigma manifests and operates in a multifaceted way is integral to developing effective strategies to measure, assess the impact of, and reduce HIV/AIDS stigma. Consistent and widespread surveillance of stigma utilizing valid measures should also enable program implementers to identify and assist specific at-risk and HIV-positive subgroups who may be experiencing heightened perceived or enacted stigma when accessing prevention and treatment programs. Finally, where protective legislation on HIV/AIDS discrimination is in place, support for enforcement and targeted information campaigns for stakeholders about rights afforded by such legislation should be provided.

ACKNOWLEDGEMENT

- Masinde Muliro University of Science and Technology
- National Commission for Science, Technology and Innovation
- Samia Sub-County AIDS and Sexually Transmitted Infections Coordinator
- Respondents (HIV positive adolescents, Care givers and Peer educators from Samia Sub-County).

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