

**FACTORS INFLUENCING YOUTH LIVING WITH HIV/AIDS PARTICIPATING IN
SUPPORT PROGRAMS IN KAYOLE SUB COUNTY LEVEL II HOSPITAL**

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**A Research Project Submitted in Partial Fulfilment of the Requirement for the Award
of the Degree of Master of Arts in Project Planning and Management of The University
of Nairobi.**

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DECLARATION

I therefore confirm that this study is my original work for submission of the award of a degree in my University education.

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I confirm that this research project has been submitted for examination with my approval as a university supervisor.

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Date

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DEDICATION

This work is dedicated to my husband..... for his continuous motivation, encouragement and financial support towards the study of this degree and to my children for understanding that their mother also needed time to study and the moral support they gave me towards my study.

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ABBREVIATIONS AND ACRONYMS

AIDs	Acquired Immune Deficiency Syndrome
ART	Adherence to Antiretroviral Therapy
HIV	Human Immunodeficiency Virus
KAIS	Kenya AIDS Indicator Survey
MAXFACTA	Maximizing facts on HIV and AIDS
NACC	National AIDS Control Council
NACOSTI	National Commission for Science, Technology and Innovation
NASCOP	National Aids and STI control program
PLWHA	People Living with HIV/AIDS
SPSS	Statistical Package for Social Science

ABSTRACT

The fast widespread of HIV/AIDS internationally is a challenge to the healthcare system for the affected people and their families. As a response, the HIV/ AIDS support groups have found solutions to supporting and caring the PLWHA through non-governmental officials, governmental, surrounding society, and the PLWHA. The primary goal of this study was investigating different factors that influence youth living with HIV to join social support programs in Kayole Sub County level II hospital. The study was set to assess the influence of stigmatization on HIV positive youth joining social support programs; to examine the influence of adherence to antiretroviral therapy on HIV positive youth joining social support programs as well as examining the influence of the desire to achieve positive mental health outcomes on HIV positive youth joining social support programs. The study will be significant to youths living with HIV since they will be able to know the importance of social support programs and therefore makes efforts to join the support groups. At the community and national level, the findings will inform the improvement of support programs in health centers. The study was based on Ecological systems theory. The research employed a cross-section survey design where the targeted research groups consisted of 220 respondents. The interview guide and questionnaires will be used in data collection. The researcher will pre-test the instruments through piloting to familiarize with data collection process and improve their validity. Reliability was tested through Cronbach's Alpha Coefficient method. The analysis of the quantitative data will be through the usage of both descriptive and inferential statistics using SPSS version 21. The presentation of data was in tables. The informed consents were taken from all the interviewees to ensure all respondents participate voluntarily and the data was used for the purpose of the study and assured confidentiality. Findings established that HIV positive youths were stigmatized against in one way or another, which to some extent affected their family members; although majority of the sampled youth were currently on ARVs, the adherence was low whereby some youths living with HIV did not take the ARVs constantly and positive HIV status affected HIV positive youths' physical and mental health whereby poor adherence rate contributed to health deterioration. The study concludes that HIV positive youths in Kayole are still afraid of disclosing their HIV status for fear of stigmatization, ARV adherence rate amongst HIV positive youths in Kayole is low and support group members share ideas which help to reduce stress and live a healthy life. The researcher recommends that the Government should network with people living with HIV/AIDS to help them increase self-confidence and enhance the self-esteem of people living with HIV/AIDS.

CHAPTER ONE

INTRODUCTION

1.1 Background of the Study

The fast spread of HIV and AIDS globally has greatly burdened the public's health care system and for PLWH and their families. To respond to this, the groups supporting HIV/ AIDS victims are established as an alternate supportive health care for PLWHA by NON-governmental, local communities, governmental officials, PLWHA themselves (Lyttleton, 2004). Apparently, the victims of HIV/AIDS are less likely to get support and care because of discrimination and stigma. "HIV and AIDS is usually related to specific cultural practices and behaviors which are prostitution, homosexuality, and vein drug use, which are against the societal values, religious morals, and cultural norms of the societies. The connection of HIV/AIDS with similar cultural practices has contributed to the rejection or discrimination of PLWHA or assumed to be by their communities. Therefore discrimination and stigmatization encountered by victims of HIV/AIDS is "multifaceted and complex" (WHO, 2002).

The support for better incorporation of reproductive health services into HIV prevention programs or vice versa, started in the 1994 United Nations ICPD which articulated a more inclusive, client-centered method to reproductive and sexual health, such as HIV prevention and services that were traditionally under family planning (ICPD, 1994). Building on the ICPD outcomes, the UN Millennium Development Goals (MDG) to be attained by 2015 reaffirmed the goals of reducing poverty, education for all, gender balance, improving reproductive/maternal health, minimizing child mortality, restricting the spread of HIV/AIDS and strengthened partnerships. A systematic review of HIV/AIDS and social support programs linkages literature

conducted by IPPF, UCSF, UNAIDS, UNFPA & WHO (2008) revealed that linking social support programs and HIV was considered helpful and achievable, particularly in Family Planning (FP) clinics, testing centers, and HIV counseling, as well as HIV clinics towards addressing the unattained individual needs for contraception in both general epidemics and concentrated among HIV clients.

Acquired Immune Deficiency syndrome (AIDS) is a worldwide epidemic which is among the extreme challenges facing humanity. The spread of the disease is alarming over the world. Genrich (2007) notes that since the first incident of Human Immunodeficiency Virus (HIV) was known in 1981, over 30 million people have succumbed to diseases linked to AIDS. UNAIDS (2013) evidenced that the infected people of HIV and AIDS, rose from about 8 million, in the year 1990 to 35.3 million in the year 2012. Worldwide, there are approximately 36.7 million people currently infected with HIV, with youth representing half (50%) of all adults living with HIV worldwide (UNAIDS, 2016).

According to UNAIDS (2013), Sub Saharan Africa has a population of 25 million PLWHA. The report indicates that there are 1.6 million estimated new infection and 1.2 million estimated AIDS deaths in 2012. Eastern and Southern Africa, the most hit region consists of 17.1 million people with HIV where youth aged 18-29 years accounting for 60% of this population. Kenya AIDS Indicator Survey (KAIS) (2012) indicates that Kenya as a nation has close to 1.6 million PLWHA and a national prevalence rate of over 6% of its population. KAIS (2012) report indicates that HIV endemic in Kenya is mainly spread by heterosexual transmission. The report adds that controlling HIV and AIDS is much prioritized in Kenya. According to KAIS (2012) the

Government of Kenya (GOK) formulated the Kenya National HIV/AIDS Strategic Plan (KNASP 111) for the 2009/10-2012/13 implementation period, ongoing all-inclusive national response to the endemic in partnership with civil society, the private sector and development partners. From a gender perspective, Kenya AIDS Indicator Survey (KAIS) records show HIV prevalence among young people of up to 29 years. This prevalence is higher among women at about 8% percent and 4 % Percent among men (KAIS, 2012).

Kayole Sub-County is in Nairobi County and comprises of five villages namely: MohraMoldada, Kyang'ombe, Sokoni, Soweto and Matopeni village; with a population of about 51,000 people, (inventory on Nairobi Slums, 2009). The researcher's selection of Kayole Sub County is informed by a series of Social Support Programmes in these villages to reduce the effect of HIV on those affected. Kayole has benefited from the services of a wide range of HIV social support Programmes to respond to challenges of HIV. Kayole has benefited from the services of a wide range of HIV social support Programmes to respond to challenges of HIV. The Maxfacta, a youth group organisation and Kayole II Sub County hospital exists to implement programmes that implement projects that empower young people living with HIV specific information (UNICEF, 2015). The organisation also promotes exchange visits between its members and members from other organizations to build individual capacity, share information, ideas and cultural experiences. It also applies sustained behaviour change and positive living strategies to ensure youths living with HIV are adequately supported to make informed decisions in different aspects of their lives. This study therefore seeks to analyse the factors influencing youths living with HIV to join social support programs in Kayole Sub County level II hospital.

1.2 Statement of the Problem

Looking for social support is among the strategies applied to manage HIV-related stress amongst the youth. Coping with HIV treatment might be improved by social support that might be influential such as offering monetary and transportation as well as emotional support such as providing positive feedback or advising. The challenge of HIV-positivity calls for informal and formal assistance both for the infected people and their partners (Folkman, Chesney, & Christopher, 2012). Social support is related to health wellbeing and positive emotional for individuals living with HIV (Kalichman et al. 2013).

Consequently, the increased HIV pervasiveness and increased number of people aged between 18-35 years living with HIV/ AIDS, approximately 400,000 victims are presently on ART diagnosis (NASCO, 2014). Home and Community-based HIV service delivery is becoming very vital in reaching and placing nearly all PLWHA on diagnosis (Farmer, 2010). The non-adherence leads to both tangible and intangible results such as death, frustrations, low quality of life, resentment, and hopelessness.

There are many studies conducted on the relationship between social support programs and the lives of people living with HIV; Kalichman & Simbayi (2014) in a study carried out in South Africa reported that PLWHA who were members of support groups were less affected with stigmatization and discrimination as compared to those who were not in any support groups; Muthiani (2010) in Nyeri Provincial General Hospital in Kenya reported established that PLWHA who participated in support group meetings had higher ART adherence rate. For Kayole Sub-county the HIV positive youths experience challenges of living positively with HIV/AIDs.

The major factors influencing this trend have not been clearly understood. It was against this background that it became necessary to examine the influence of stigmatization, adherence to antiretroviral therapy and positive mental health outcomes of youths living with HIV/AIDs in support groups in Kayole sub-county of youths living with HIV in Kayole sub county, Nairobi County, Kenya.

1.3 Purpose of the Study

This study is purposed to assess the factors influencing youth living with HIV/AIDs in joining social support programs in Kayole Sub County level II hospital.

1.4 Objectives of the Study

The study objectives were:

- i. To find out how the influence of stigmatization on HIV positive youth joining social support programs in Kayole Sub County level II hospital.
- ii. To determine the influence of adherence to antiretroviral therapy on HIV positive youth joining social support programs in Kayole Sub County level II hospital.
- iii. To examine the influence of the desire to achieve positive health outcomes on HIV positive youth joining social support programs in Kayole Sub County level II hospital.

1.5 Research Questions

The research questions were:

- i. To what extent does stigmatization influence HIV positive youth joining social support programs in Kayole Sub County level II hospital?
- ii. How does adherence to antiretroviral therapy influence HIV positive youth joining social support programs in Kayole Sub County level II hospital?

- iii. To what extent does the desire to achieve positive health outcomes influence HIV positive youth joining social support programs in Kayole Sub County level II hospital?

1.6 Significance of the Study

The study findings might benefit the youths living with HIV since they will know the importance of social support programs and therefore makes efforts to join the support groups. At the community and national level, the findings will inform the improvement of support programs in health centers. The study findings also add to the knowledge base of many interventions and effort that are geared towards the scaling up of support programs for HIV positive youths. Once the social support needs of HIV positive youths are met because of improved service delivery, this may help in reducing the number of HIV positive births and HIV–interrelated infant and child deaths. Maternal and child morbidity rates may reduce significantly in view of helping to meet the sustainable development goals. Recommendations for the study may aid young people living with HIV in Kenya in taking charge and controlling their maturity by embracing accountability for themselves and others, building their confidence, being educated, career focused and starting families.

1.7 Limitations of the Study

Some PLWHA were not comfortable to take part publicly in the study and some of them were not willing to fill the questionnaires. However, the researcher ensured that the questionnaires were not administered publicly since data was collected from them using a single technique. The respondents at first concealed crucial data fearing that their status might be disclosed. Getting the caregivers was difficult due to their busy schedules but the researcher booked appointments and adjustment time for data collection where necessary.

1.8 Delimitation of the Study

The research study was delimited to youths living with HIV who access health services from Kayole Sub County Level 11 Hospital. The study covered factors influencing youths living with HIV/AIDs to joining Social Support Programs in Kayole Sub County Level 11 Hospital.

1.9 Basic Assumptions of the Study

The assumption was that the target population would be available. The respondents would understand the questions and truthfully and accurately answer the questionnaire without being subjective. All the questionnaires would be answered and returned within the target time frame.

1.10 Definition of Significant Terms

Adherence to ART- refers to following the practitioner's prescriptions by consuming all pills in the doses in time and in the right ways. Such drug that are prescribed includes taking ARV combinations in the correct time and quantity following all procedures given by the clinicians.

Barriers- refers to the issues preventing HIV positive youths from joining social support groups.

People living with HIV/AIDs- refers to anybody who is infected with the HIV virus.

Positive health outcomes- refers to individuals living with HIV who are in good physical and mental health.

Social support – refers to support systems available to HIV positive people to cope. These include treatment, family members, friends, peers, work colleagues, support groups and clinical staff.

Youth- refers to people aged between 18-35 years.

1.11 Organization of the study

The study is structured into five broad sections or chapters. Chapter one focus on introduction, which comprises of problem statement, background to the study, purpose, objectives of the study, research questions, delimitations of the study, significance, basic assumptions, study limitations, definition of significant key terms, and organization of the study. The second Chapter consists of Literature Review which comprises of Introduction, stigmatization and discrimination, adherence to antiretroviral therapy, health outcomes, barriers, concept of social support programs summary of similar literature reviewed, conceptual and theoretical framework.

Moreover, Chapter three focus on methodology with subheadings; introduction, research design, sample size and procedure, research instruments, target population, validity and reliability of instruments, procedure of data collection, analysis of data, as well as ethical considerations. The fourth chapter covers presentation, data analysis, and interpretation. Fifth chapter presents summary, and conclusions, as well as the recommendations.

CHAPTER TWO

LITERATURE REVIEW

2.1 Introduction

This Literature Review chapter covers concept of social support programs, stigmatization and social support programs, adherence to antiretroviral therapy, health outcomes and barriers preventing participation of HIV. It will also cover summary of theoretical framework, literature review, and conceptual frame-work.

2.2 Social Support Groups

HIV psychosocial support comprise of PLWHAs with a common objective, the key objective of these support groups is improving the health of the members as well as the important objectives such as the improvement the standard of living of members by establishing the activities that generate income (Oyeledun, 2012). Majority of support groups are initiated by patients registered at the HIV care centers at times with the assistance of the health practitioners as well as the community health workers. Social Support works to improve physical and mental health by conferring some form of help or assistance to an individual. This help could come be emotional (e.g. esteem, affiliation with others), informational support (e.g. advice/information on social issues, health, employment), and instrumental support (e.g. finances, housing assistance), that an individual can acquire from relationships (Hough et al.2011).

Social support have a shielding effect from the negative psychological effects of stress, enabling individuals to cope better with life (Lakey&Orehek, 2011). This is especially essential for those living with a chronic illness such as HIV, where better coping mechanisms can manifest in such

ways as better quality of life, less morbidity, and reduced transmission risk behaviors (Leserman et al. 1999). WHO (2010) notes that HIV support groups have been a phenomenon in countries across the income spectrum from the United States of America, Britain, Germany, India, South Africa and Brazil, principally to fight against discrimination to which people infected with HIV are subjected.

In Uganda, the Ministry of Health noted that psycho-social support attempts to address stigma, discrimination and denial of infection, and known causes of delays in diagnosis, treatment and care for both people in pre- and post-HIV test groups (MOH Uganda, 2014). Uganda also showed that by serving as role models and offering encouragement, Network Support Agents (NSAs) enabled information sharing on how to cope with issues of denial, stigma, and discrimination and fear arising from the uncertainty of living with the virus (Kim & Kalibala, 2012). The Kenya, NASCOP (2012) reported that persons living with HIV/AIDS participated in activities that included counseling, HIV/AIDS awareness and prevention, a demonstration of positive living, networking, advocacy, stigma reduction, voluntary counseling and testing, home-based care, succession planning and life skills training

2.3 HIV/AIDS Related Stigma and Participation in Social Support Groups

Worldwide people with AIDS are stigmatized and are subjected to discrimination. According to Nowell and Van der Merwe (2009), the stigma is described as ridiculous response that is directed towards HIV positive individuals. Such responses are being avoided when family members are being discriminated at workplaces, prejudiced medical treatment, and rejection by funeral homes of HIV victims or violence. HIV/AIDS related stigma is conceptualized and defined as an actual

or supposed undesirable feedback to individuals by the communities, societies, or other people. It is characterized by denial, rejection, predisposition, discrediting, discounting, and discrimination that are directed at individuals assumed to be infected with HIV (Herek, 1999).

HIV stigma is related to fear and shame: shame because drug injecting and the sex that transmit HIV are against the morals and cultures, and fear because people consider AIDS as a deadly disease (Piot&Seck, 2001). Reacting to AIDS by abusing the victims solely forces the endemic concealment, thus causing suitable circumstances for spreading HIV/AIDS. HIV/AIDS related stigma results from relating the disease with irresponsible sexual behavior, humiliation, blame and lack of respect (De Cock, 2012). Associating HIV with a specific class in the society created a deceitful delusion of safety because everyone was susceptible to infection, more so with the prevailing false impression about the method HIV virus transmission (UNAIDS, 2012).

There are some qualities to which the stigma follows (the color of the skin, how a person speaks and their work) might be relatively random. In a specific, the setting of the culture has certain characteristics that are considered and defined by others as dishonorable or worthless. Stigmatization happens when a distinction is created between people which lead to an individual of a group of individuals being treated unreasonably and discriminatorily based on where they belong or assumed to be part of a specific group. Discrimination happens when bad thoughts make people or organizations to take, or not to take, actions which treats an individual unreasonably and discriminatorily based on the assumed or real HIV/AIDS status. The discriminatory actions, on the basis on assumed or real HIV status, are violations of human rights (UNAIDS, 2012).

2.4 Antiretroviral Therapy Adherence and Social Support Programs

The spiritual and emotional support for PLWHA, care partners, and their families is an essential feature of living positively (Ankrah, 2006). The establishment of clinical-care models should therefore recognize the importance for non-clinical approaches of care and make sure that HIV care is offered through all-inclusive community and family centered method. Medical innovations in both nature and accessing HIV related diagnosis methods have contributed to the establishment of all-inclusive HIV care programs in various nations with approximately one million people that are actively on antiretroviral medications especially in sub-Saharan Africa(WHO,2013).

American Psychological Association data (2008) asserted that psychosocial effects of being infected with HIV differ in the progression of HIV disease and might be as different as the HIV disease range. In addition, the people facing psychological stress after HIV diagnosis, including general anxiety disorder, depression, drug abuse, and panic disorders, have less chances of engaging in prevention and care behaviors and might hence challenge their health as well as that of their partners (Friedland,2011). HIV positive people on ART but with unsolved psychosocial concerns in most cases have poor response rates to medication. Amongst HIV positive people, it is estimated that the rate of non-adherence to medication routinesvaries from either the 35 percent to 95 percent (Murphy, 2002).

The success of offering ART in a developing countrysuch as Kenya will be determined by the potentialities and abilities of patients and care providers in sustaining and accessing proper

adherence to the diagnosis programs. Exceptional adherence to ART is important for medication success (Patterson, 2014). Failure to comply with combination therapy might contribute to high HIV transmission and the development of viral mutations, which might contribute to medication resistance (Bangsberg, 2000). Among the main issues in providing and increasing ART in poor environments is the emergence of drug-resistant virus because of suboptimal ART adherence (Palella, 2004). There are many factors related with reduced levels of adherence to antiretroviral medications which are: depression, harshness of side effects, negativity about HIV, perceived stress and insufficient coping mechanisms. The failures of adhering to drug prescriptions results to medication failure because of the formation of drug-resilient virus that leads to poor clinical results and high likelihood of causing death (Chesney, 2011).

Factors related to adherence are not the same in progression of the disease. Pre-ART interventions might, for instance, address various methods as compared to interventions equivalent with ART commencement and maintenance. Very varying issues are likely to be of importance to people who have taken ART for long. To majority of them, HIV disease is regarded as more of a chronic condition and other lifestyle issues, which might be more instant and important such as job, daily stressors, medical care, sexual and dyadic relationships, drug and alcohol use, and contentment about infectivity. Moreover, poor adherence can also affect the response of medication and lead to high healthcare and morbidity expenses (Panos Global AIDS Program, 2006). Increased adherence to the antiretroviral therapy is the main predictor of progressiveness of HIV disease, the survival rate, and reduced health care expenses (Hopkins, 2010). The impacts of adhering to antiretroviral therapy on direct health care expenses were

evaluated with the result found to be enhanced health results for infected individuals, which saves an overall monthly health care expense of approximately \$85 for every patient (Jean, 2009).

Mills (2014) carried out a study on challenges and enablers of ART adherence in 72 developed and 12 developing countries. Barriers to adherence were established as; disclosure, lack of memory, health illiteracy, drug and alcohol abuse, complex treatments, financial constraints, disruption in access and few health centres especially in rural areas. Yuan (2012) carried out a study in China on Antiretroviral Medication. The target population was 113 patients and 98 respondents agreed to participate in the study. The average adherence level was about 91 percent, 89 percent, and 88 percent at baseline and at 3 and 6 months, respectively. Approximately 58 percent of the respondents indicated that they took all doses and were categorized as regular adherers who had better physical function had a higher CD4 cell count. They also were also admitted in hospitals less often, they stayed in hospital for fewer days and less hospital costs. Constant adherence is related to improved health outcomes, improved living standards, higher CD4 counts, and less health care expenses. This revealed same results amongst those infected group who were members of social support groups had good adherence to ART medication, which led to better clinical results.

Oyeledun *et al* (2012) carried out a study in Nigeria and established that partnering with locally-based community organization to support the delivery of ARV to patients via support groups improved connections between community and facilities. Majority of these community-based partners offered psychosocial services through clinics companions and education, among others. Wouters (2013) study in South Africa established that community support groups focusing on

HIV victims notably improved adherence to ART. The results of the study showed that taking ART late minimized the effectiveness of ART and support from community health workers, treatment friends, and support group considerably improving the outcomes of treatment as shown from systematic review of PLWHA's retention rates in antiretroviral therapy Programmes in South Africa.

Psychosocial support groups have an incredible duty of moving HIV services providers that are busy to the patients living with the community. These have proved to be an effective strategy particularly in developing countries where health workers are not enough. A report by Rwandese Ministry of Health (2010) showed that 1,076 patients who adhered to observed changes in CD4 cell count after taking ART. These results show that HIV support group leaders and community health workers can efficiently offer support to the patients on ART as a way of adhering well and referring the ones who require advanced medical attention if they have sufficient support, mentoring, and training.

NASCOP (2014) survey revealed that a poor adherence forecasts and low Baseline CD4 cell count premature mortality in Kenya. There is very little information with regards to the achievable level of antiretroviral adherence in resource-limited settings. Steegen et al. (2009) carried out a study among PLWHA enrolled on ART in the Coast regional hospital in Kenya which established that 85.6% of PLWHA who had been on ART for more than six months had not succeeded in suppressing HIV viral loads in their bodies to undetectable levels. Nine out of the 14 PLWHA enrolled in the study recorded high-level resistance of ARV. A study conducted by Muthiani (2010) in Nyeri Provincial General Hospital in Kenya reported a PLWHA's ART

adherence rate of 65% and patients who were in participated in support group meetings had higher adherence rate.

2.5 Health Outcomes and Social Support Programs

Various literal sources have assessed the relationship between health outcomes and social support among the people infected with the HIV. Many of them focus on the connection between assumed or received psychological stress, social support, life standards and HIV disease outcomes like CD4 count and death (Burgoyne & Renwick, 2004). In addition to curbing stress, people living with HIV might encounter more stress as a result of discrimination because of HIV status, losing people they love to HIV/AIDS, losing relationships, uncooperative relationships, decisions about revelation of HIV status, and for those on ARV therapy, the stress of sustaining a very high level of ARV adherence (Friedland et al. 2011).

High levels of poverty and lack of employment, poor general health, and high HIV stigma, especially in rural might also increase stress. Social support may assist to reduce the adverse impact of stress on health amongst HIV positive individuals (Geonnottiet al.2006). Nevertheless social conflict and social separation, which might be worsened by HIV infection, might rise stress levels (Cohen, 2004).Psychosocial factors like social support is believed to influence HIV results through biological and behavioral mechanisms.

Patterson and London (2014) established that more extensive informal community measure was emphatically related with more survival time. In any case, arrange estimate was not associated

with CD4 tallies. Greater system estimate was connected to a shorter side effect free period for individuals who were asymptomatic at pattern. Ironson (2008) established a positive relationship between's social help and HIV results. An investigation of negative psychosocial factors established no connection between poor social help and HIV illness movement (Chida and Vedhara, 2009). Jiaet al. (2004) revealed that social help was not significantly connected to physical working, job constraints, or torment. Social help and fulfillment with social help is identified with physical working. Increment in social help was identified with higher physical working levels while fulfillment with social help was identified with better physical working and decreased physical torment (Swindells et al. 1999).

2.6 Theoretical framework

The current research study is framed or follows the theoretical approach of the Ecological Systems Theory that was developed by Bronfenbrenner (1979). The theorist's framework locates individuals at the center of successfulness to represent a broad environment. Bronfenbrenner developed four categories of environmental system including the mesosystem, macrosystem, microsystem, and exosystem. On microsystem, the theorist referred to the environmental levels where people experienced face-to-face contacts that are influential to other people. Among the examples of microsystem setting include school, families, church, peer group, and workplace. Such levels of relationship are known to be bi-directional, which means the traits of the HIV positive youths is influenced by the people around them in a similar way they affect other people. The behavioral implications affected at this level is perceived, accepted, exposed, and reinforced by others to the diversity roles (Berk, 2000).

Despite the fact that bi-directional impacts occur in all levels of the earth, Bronfenbrenner clarified that these effects are most grounded and have the best impact on the adult at the microsystem level. The mesosystem is the ecological level that incorporates connections between microsystems, or associations between circumstances. Precedents of mesosystem associations are home-companion connections, working environment family, and school-neighborhood connections. Issues like consistency and essential regard among and between frameworks have suggestions for individual improvement and conduct (Bronfenbrenner, 1979). It look like irregularities that occur inside mesosystem collaborations could represent a huge worry for the adolescent at the focal point of the framework as a result of the clashing messages they may get. The exosystem is the level of the earth in which an individual does not straightforwardly take an interest, but rather in which choices are made that generously influence the person. The structures in this level effect advancement by collaborating with some structure in the microsystem. Models incorporate a companion's place of business, nearby school sheets and neighborhood government. The individual might be affected by how choices at this level influence her/his very own best advantages and by the social emotionally supportive networks made accessible at this level.

Bronfenbrenner depicts the macrosystem as the level of the condition that incorporates methods for sorting out the institutional existence of society. Precedents incorporate belief system, social arrangement, shared suspicions about social contracts, and human instinct. Basic issues affecting the person at this level incorporate states of mind towards ladies and minorities and a collectivist versus individualistic mindset. For instance, if a culture puts a disgrace on HIV/AIDS, that culture might be more averse to offer help to those tainted or influenced. This thus influences the

help that the relatives will give a tainted individual. Bronfenbrenner (1979) noticed that to completely comprehend bolster from social contacts, the formal and casual connection units must be broke down inside the more extensive social frameworks they are installed in. As proof of the transformative idea of this structure, a fifth component was added to address advancement after some time.

Bronfenbrenner utilized the term chronosystem to depict the intelligent idea of people, situations, and formative procedures after some time. Bronfenbrenner's (1999) formulated theoretical model that gives considerable consideration regarding the effect of proximal procedures on human improvement after some time. He characterizes proximal procedures as "persevering types of collaboration that happen inside the setting of a person's quick condition that have the ability to shape improvement" (p.5). Models of proximal procedures incorporate mother-tyke connection, accomplice or associate collaboration, gathering or individual treatment, perusing or considering. Bronfenbrenner (1999) demonstrates that the power proximal procedures need to shape improvement changes with attributes of people and the situations. These proximal procedures work as compelling drivers of advancement just when an individual takes part reasonably routinely in an action that turns out to be progressively unpredictable. For instance, proceeded with investment in a HIV bolster gathering may improve both confidence and communication abilities. As indicated by Bronfenbrenner, collaborations with the two individuals and things work as proximal procedures. The current investigation will utilize this hypothesis to manage the examination of the connections between different levels of the biological framework. Environmental frameworks hypothesis gives clarification for the manners in which that gatherings inside the informal organization may furnish assets to adolescents living with HIV.

The connections between those system individuals that tend to bunch together with others may clarify a great part of the vulnerability in how arrange attributes affect slander and separation, ART adherence and psychological wellness. Irregularities between bunches may prompt lessened help seen by the lady, subsequently influencing her psychological well-being.

2.7 Conceptual framework

The conceptual framework looked at how the various factors under the study that influences youths living with HIV to join Social Support Programs in Kayole Sub County Level 11 Hospital. The conceptual framework shows that there is relationship between social support programs (dependent variable) and curbing stigmatization, high adherence to ARV and health results of HIV positive youths (independent variable). Youth and caregivers support attitudes as well as government policies on HIV stigmatization are the intervening variable. This shows that the services offered by care givers at the social support programs could help HIV positive youths to adhere to counseling, recommended nutrition to keep healthy as well as improve their lifestyle.

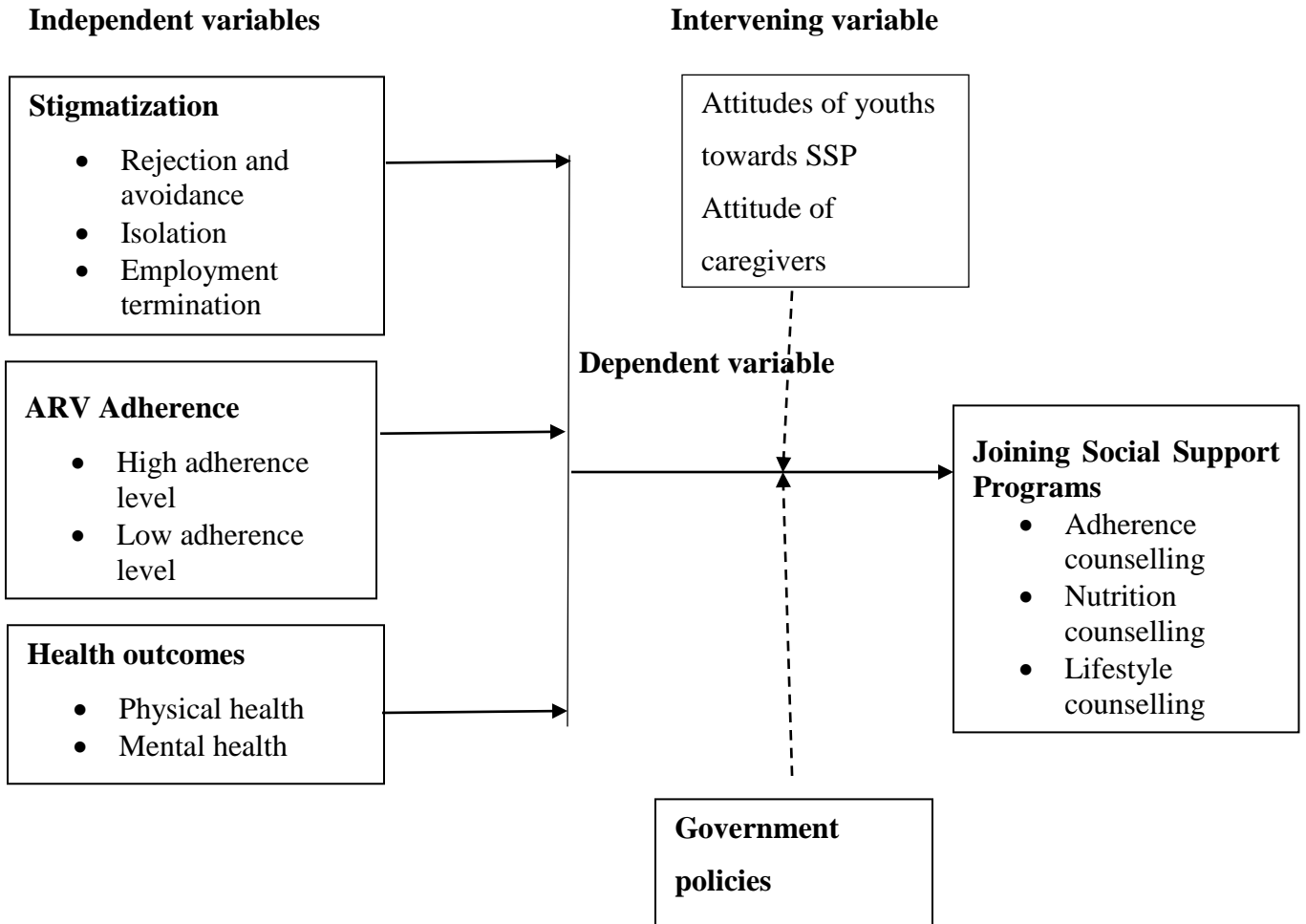


Figure 2.1: Conceptual Framework

Table 2.1 Knowledge Gap

Variable	Author &Year	Study Title	Findings	Knowledge Gap
Stigmatization	Simbayi, Kalichman &Simbayi (2014)	Factors contributing to stigmatization of PLWHA	Misconception about AIDS continues, but PLWHA who were members of support groups were less affected with stigmatization	This study focused on factors contributing to stigmatization hence the need to carry out to assess whether stigmatization influence youths to participate in social support groups.
Stigmatization	Herek, Capitanio, &Widaman, (2012).	HIV-Related stigma and knowledge in the United States	AIDS stigma was expressed form of anger and other negative feelings towards PLWHA	This study targeted all age groups living with HIV but the current researcher focus only on people aged 18-35 years.
ARV adherence	Yuan (2012)	Antiretroviral Medication among PLWHA	Regular ARV adherers had better physical function, strength, general health, social functioning and mental health and had a higher CD4 cell count	This study was carried out in a developed country and adherence rate could differ in developing countries like Kenya.
ARV adherence	Wouters (2013)	Effect of support groups focusing on HIV victims	community support groups focusing on HIV victims notably improved adherence to ART	There is no similar study conducted in Kenya and this study aims at carrying out a similar study in Kenya.
Health Outcomes	Chida & Vedhara, 2009)	Psychosocial effect of positive HIV status	There is found no connection between poor social help and HIV illness movement	This study focused only on psychosocial effect but the current researcher focus on both physical and mental health
Health Outcomes	Swindells, Mohr, Berman, &Squier (1999).	Impact of social support on quality of life in patients with HIV	Satisfaction with social support was associated with better physical functioning and reduced physical pain	The study focused generally on the quality of life of PLWH. This study will focus on whether the urge to maintain positive health outcomes influence participation in Social support programs.

Source (Researcher, 2018). Source (Researcher, 2018).

2.7 Summary of Literature Review

Literature review has indicated the relationship between social support groups and people living with HIV. Studies by Kalichman and Simbayi (2014) showed that even though knowledge about HIV transmission has improved, there was prove that delusion about AIDS continues, especially myths associated to HIV transmission and PLWHA who were members of support groups were less affected with stigmatization as compared to those who were not in any support groups. Muthiani (2010) established that patients who took part in support group meetings had higher adherence rate. Geonnotti and Whetten (2006) reported that social support might assist reduce the adverse impacts of stress on health amongst HIV positive people. Swindells et al. (1999) established that fulfillment with social support was related with better health and reduced physical pain. However, these studies were carried out in other parts of the world and a systematic research is being carried out in Kenya on factors influencing youths living with HIV to participate in social support programs.

CHAPTER THREE

RESEARCH METHODOLOGY

3.1 Introduction

This chapter focus on the overall methodology that was employed in the study. It covers the target population, research design, sampling procedures, sample size and research instruments such as reliability and validity of instruments, data analysis approaches, data collection procedures, and ethical considerations.

3.2 Research Design

This researcher employed the cross-sectional study design, which aims at examining the factors influencing HIV positive youths to join social support groups. Cross-sectional design involves using different groups of people with different interest but share other characteristics. The study focuses on youths who are HIV positive and are members of focus groups and those youths who are HIV infected and are not members of any group. The exposure is defined by relation to mental support groups. Using routinely collected data allows wide cross-sectional studies to be made at less or no costs. This is the main benefit as compared to other types of epidemiological study.

3.3 Target Population

The researcher focuses on all youths who are registered at the centre for HIV care at Kayole sub-county level II hospital. The youth were selected according to their age and the researcher targeted only those aged between 18-35 years. This age was considered for the study since young people in this age group are sexually active. Total target population was 220 respondents (Kayole sub-county level II hospital, 2018).

Table 3.1: Target population

Target group	Target population
HIV caregivers	10
Youths	210
Total	220

Source (Kayole sub-county level II hospital, 2018)

3.4 Sampling Frame

Sampling frame is the complete listing of all objects of the population that the researcher desires to study (Saunders *et al.*, 2014). The sampling frame for the study was 10 care givers and 220 HIV/AIDS positive youths.

3.4.1 Sample Size and Sampling Procedure

Simple Random sampling methodology was applied to choose the size of the sample. According to Mugenda and Mugenda (2008), 10-20% of the target population is enough for sampling. The researcher therefore sampled 30% of the youths hence 63 youths participated in the study. The whole population of the caregivers was sampled to make a total of 73 respondents.

Table 3.2: Sample Size

Target Group	Target population	Sample size	Percentage
HIV caregivers	10	10	100%
Youths	210	63	30%
Total	220	73	-

3.5 Research Instruments

The questionnaire was used as a tool for data collection. A questionnaire enables the researcher to obtain a large quantity of data inexpensively from a wide range of participants sometimes spread extensively in a geographic space.

The research instrument that was used in this study included the youths' questionnaire. The questionnaire included Likert scale questions which included responses ranging from a 1 to 5 rating with a response of *1-Strongly agree, 2-Agree, 3-Neutral, 4-Disagree, 5-Strongly disagree*.

The questionnaire was divided into six sections. Section A covered the background information of the respondents, section B covered influence of curbing stigmatization on youth joining social support programs, section C covered influence of ART adherence on joining social support programs, section D covered influence of the desire to achieve positive mental health outcomes on joining social support programs and section E covered respondents perceptions on social support programs. The researcher also administered an interview guide on caregivers which was based on the research questions.

3.6 Validity of the Instruments

The researcher pre-tested the instruments through piloting in order to improve their validity and get familiar with data collection process. Content validity for checking the representation of research questions was used whereby some items were discarded while others were modified. Content validity was tested through examination of the related literature, discussions with the experts during the questionnaire designing stage to ensure enough representation set of questions. The researcher sought an expert judgment to determine whether the set of items accurately represents the concept under study and sought supervisors' assistance to improve the content validity of the instrument. The pilot test was carried out with 10 HIV positive youths

representing 5% of the 210 youths. The individuals in the pilot study did not take part in the actual data collection.

3.7 Reliability of the Instruments

Reliability was tested through Cronbach's Alpha Coefficient method. This technique involved administering the questionnaires twice within a period of two weeks after which the scores in the two sets were correlated. Cronbach's Alpha Coefficient was used because it examines the consistence of the variables of research instruments. The alpha coefficient is measured from the value of zero to one. The nearer the Cronbach's alpha coefficient is to 1 is relatively greater to the internal consistency of the variables in the scale (Zikmund et al. 2013). Cronbach's Alpha Coefficient value of 0.7 was the cutoff and all items whose value was less than 0.7 was considered weak, therefore adjusted or left out of the final questionnaire.

3.8 Data Collection Procedures

The researcher obtained the authorization from National Commission of Sciences, Technology and Innovation (NACOSTI) and introduction letter from the Department of Open, Distance and eLearning University of Nairobi before visiting the field. The researcher paid a visit to the hospital to alert the management on the collection of data. The researcher administered questionnaires in person and assure the respondents confidentiality. Questionnaires were collected immediately they were filled.

3.9 Data Analysis Technique

Quantitative data was examined using the descriptive statistics using the descriptive statistics measurements utilizing the SPSS version 21 that introduced the use of means, percentages, and frequencies. The findings were presented using the charts, bar diagrams, and tables. This was achieved by adding up reactions, processing rates of varieties as per depicting and translating of

data in regards with the investigation presumptions and targets through the use of SPSS. Inferential statistics were important in establishing the relationship between the variables which was tested using the Pearson Correlation Coefficient.

3.10 Ethical Considerations

Ethical considerations are essential for any research. They include proper conduct of the researcher when collecting data, avoiding plagiarism and deception, discretion and secrecy of the data gathered from the respondents, avoiding physical and psychological harm to the respondents, getting voluntary and informed consent from the respondents and giving out of the findings, these values were strictly observed. Earlier plans were likewise made with the healing facility and parental figures to affirm the dates for information accumulation. An educated assent was looked for from every one of the respondents so the respondents partake deliberately. The data which was gathered was treated with privately and utilized with the end goal of the investigation as it were.

Table 3.3: Operationalization of Variables

Objectives	Variables	Indicators	Measurement scale	Analysis Tool
To establish the influence of stigmatization and discrimination on HIV positive youths joining social support programs	Independent variable Stigma and Discrimination	Rejection and avoidance Isolation Employment termination	Nominal Ordinal	Descriptive statistics Inferential statistics
To determine the influence of adherence to antiretroviral therapy on HIV positive youths joining social support programs	Independent variable ARV Adherence	High adherence level Low adherence level	Nominal Ordinal	Descriptive statistics Inferential statistics
To examine the influence of the desire to achieve positive mental health outcomes on HIV positive youths joining social support programs	Independent variable Health outcomes	Physical health Mental health	Nominal Ordinal	Descriptive statistics Inferential statistics
Social Support programs	Dependent variable Social Support programs	Adherence counselling Nutrition counselling Lifestyle counselling	Nominal Ordinal	Descriptive statistics Inferential statistics

CHAPTER FOUR

DATA ANALYSIS, INTERPRETATION, PRESENTATION, AND DISCUSSION

4.1 Introduction

The chapter focuses on presentation interpretation, analysis of data, and discussion. The aim of the research was to examine factors that influence youth living with HIV/AIDs in participating social support programs in Kayole Sub County level II hospital. The study was organized based on the objectives of the study including influence of HIV/AIDs related stigma, antiretroviral therapy adherence as well as influence of desire to attain health outcomes among HIV-Positive. The responses were analyzed into frequencies, percentages and mean and presented in tables.

4.2 Response Rate

The respondents who participate in the study were HIV positive youths and care givers. They returned the questionnaires as presented in Table 4.1.

Table 4.1: Instrument Response Rate

Respondents	Sampled size	No. collected	Return rate (%)
HIV/AIDs positive youths	63	45	71.1
Care givers	10	6	60.0
Total	73	51	-

Table 4.1 indicates that the average questionnaire return rate was well above 70 percent which according to Mugenda (2008) is adequate for analysis.

4.3 Reliability Test

Through the Cronbach's alpha, the reliability of the questionnaire was tested to measure its internal consistency. Stigmatization, ARV adherence and positive health outcomes had alpha

values of 0.786, 0.710 and 0.782 respectively. Social support had an alpha value of 0.829 which is a sound and reliable measure as presented in the Table 4.2.

Table 4.2: Reliability Statistics

Variables	Cronbach's alpha	Items
Social support	0.829	11
Stigmatization	0.786	5
Antiretroviral Therapy Adherence	0.710	5
Positive health outcomes	0.782	5
Scale Combination	0.746	26

Source: Survey data

4.4 Descriptive Statistics

The demographic information of respondents concentrated on their gender, age, period of living with HIV/AIDs and the care givers period of working at the centre. Table 4.3 presents the respondents demographic information.

Table 4.3: Demographic Information

Variable	Frequency (F)	Percentage (%)
Gender		
Male	12	26.7
Female	33	73.3
Total	45	100.0
Age		
18-23 years	13	28.9
24-29 years	25	55.5
30-35years	7	15.5
Total	45	100.0
Education level		
Secondary	19	42.2
College	17	37.8
University	9	20.0
Total	45	100.0
Period of living with HIV/AIDs		
1-5 years	26	57.8
6-10 years	17	37.8
More than 10 years	2	4.4
Total	45	100.0
Period of working at the Centre		
5-10 years	4	66.7
More than 10 years	6	33.3
Total	10	100.0

Results in Table 4.3 show that; majority of the HIV/AIDs positive youths 73.3% (33) were female while 26.7% (12) were male. This shows that the rate at which females accepted their HIV status and took a step to visit health centres was higher as compared to that of male. With respect to age, findings show that 55.5% (25) of the youths were aged between 24-29 years, 28.9% (13) were aged between 18-23 years and 15.5% (7) were aged between 30-35 years. This

shows that all ages of the youth group. With respect to education level, 42.2% (19) of the HIV/AIDS positive youths had attained secondary education, 37.8% (17) had attained college education and 20% (9) of the HIV/AIDS positive youths had attained university education. This shows that the youths were well educated and therefore had the capability to understand concept of the study easily. Further findings show 66.7% (4) of the care givers had worked at the centre for 5-10 years while 33.3% (2) had worked at the centre for more than 10 years. This shows that the caregivers had worked the centre for a considerable number of years hence in a position to understand the activities of support groups.

4.3.1 HIV/AIDS Related Stigma and Participating Social Support Program

The first objective established how the influence of stigmatization on HIV positive youth participating social support programs in Kayole Sub County level II hospital. The youths were requested to show the extent to which HIV/AIDS related stigma influence HIV positive youths to join social support groups as presented in the Table 4.4.

Table 4.4: Extent to Which Stigma Influence Participating Social Support Groups

Extent	Frequency	Percentage	Mean
Very great extent	10	22.2	1.27
Great extent	30	66.7	
Moderate extent	5	11.1	
Total	45	100.0	

The results in Table 4.4 show that majority of the respondents 66.7% (30) pointed out that HIV/AIDS related stigma influence participating in social support groups to a great extent, 22.2% (10) indicated to a very great extent and 11.1% (5) indicated that HIV/AIDS related stigma influence participating in social support groups to a moderate extent. This implies that HIV/AIDS

positive youths join social support groups so as to cope stigmatization. The findings are in agreement with Sihlangu (2013), who revealed that with sufficient knowledge which is mostly acquired in the support groups, the levels of stigma related to the disease might reduce.

The researcher asked the youths to respond to some questions related to stigmatization as presented in the in Table 4.5.

Table 4.5: Responses on HIV/AIDS Stigmatization

Statements	Yes		No		Mean
	F	%	F	%	
Have you in any way been stigmatized against by virtue of your HIV/AIDS status?	33	73.3	12	26.7	1.22
Have you in any way been affected by stigma due to your HIV/AIDS status?	35	77.8	10	22.2	1.22
Have any of your family members experienced stigma as a result of your status?	33	73.3	12	26.7	1.27
Can HIV related stigma prevent people from testing and disclosing and why	42	93.3	3	6.7	1.07

N=45

Findings in Table 4.5 show that 73.3% (33) of the youths had been stigmatized against by virtue of their HIV/AIDS status while 26.7% (12) had not been stigmatized. The youths further indicated that as a result of revealing their HIV status, their partners left them, they were being pointed out in social places where people knew them, some lost their jobs or were transferred to positions they were not comfortable. Furthermore, 77.8%(35) have been affected by stigma due to HIV/AIDS status while 22.2%(10) have not been affected by affected by stigma due to HIV/AIDS status. The youths said that their personal life was affected as a result of stigmatization whereby some were chased away from home, others lost their jobs and were also

banned from taking part in family meetings. The youths also said that as a result of stigma, they stopped taking part in family meetings and other social meetings. In addition, 73.3% (33) of the youths family members were stigmatized whereby the family members were humiliated in public, they were verbally assaulted, physically assaulted and their family members were labeled as promiscuous. While responding to the question on whether HIV related stigma prevent people from testing and disclosing, 93.3% of the youths said yes while 6.7% said no. The youths further explained that the society perceptions of HIV positive people prevent them from disclosing their status. The respondents view on PLWHA being stigmatized and maltreated due to HIV status was that HIV positive people are not supposed to be stigmatized since anyone can either be affected or infected. They thought that the common mode of transmission according to many is through irresponsible sexual behavior and the thought that one can get infected through physical contact. With regards to influence of stigmatization on HIV positive youths joining social support groups, one of the care givers said and I quote:

“Youths who join social support programs have better chances of dealing with stigmatization. Once they join the support groups they are able to share their experiences and encourage one another . This helps them to relate with other people and also stop hiding from people. The support group members are less affected with stigmatization as compared to those who are not in any support groups”

This shows that stigmatization against HIV/AIDs positive youths is still in existence even after years of constant awareness against PLWHA discrimination. The finding is in agreement with Kalichman & Simbayi (2014) that PLWHA who were members of support groups were less affected with stigmatization as compared to those who were not in any support groups.

4.3.2 Antiretroviral Therapy and Participating Social Support Program

The second objective was to determine the influence of adherence to antiretroviral therapy on HIV positive youth participating on social support programs in Kayole Sub County level II hospital. The researcher sought to find out whether the HIV positive youths sample were currently using ARV drugs as presented in the Table 4.6.

Table 4.6: Responses on Using ARVs

Extent	Frequency	Percentage	Mean
Yes	39	86.7	1.11
No	6	13.3	
Total	45	100.0	

Findings in the Table 4.6 show that most of the youths 86.7% (39) were currently using ARV drugs while 13.3% (6) were not using ARVs. The researcher also found out that not all HIV positive youths started using ARV immediately they were diagnosed with HIV. According to the youths, their spouse, friends, support group members and relatives were the most important people who can help them achieve maximum ARV adherence. For instance, there were some youth who have been living with HIV for more than 10 years and had used ARVs for less than 10 years. This implies there are HIV positive youths who are ARV defaulters and others have taken time before accepting the ARV therapy. The finding concurs with Steegen et al. (2009) who established that high-level resistance the ARV drugs and Wouters (2013) who established that taking ART late minimized the effectiveness of ART.

Respondents were further asked to tick on their level of agreement with regards to influence of ARV adherence on HIV positive youths joining social support groups as presented in the Table 4.7.

1- Strongly disagree, 2-disagree, 3-Not sure, 4-agree, 5-strongly agree

Table 4.7: Influence of ARV Adherence on Joining Social Support Groups

Statements	1		2		3		4		5		Mean
	F	%	F	%	F	%	F	%	F	%	
Support for care partners is an important aspect of ARV adherence	31	68.9	12	26.7	2	4.4	0	0	0	0	1.40
Patients on ART but with unresolved psychosocial issues have poor adherence rates	5	11.1	37	82.2	1	2.2	2	4.4	0	0	2.00
Excellent adherence to ART is critical for treatment success	7	15.6	16	35.6	22	48.9	0	0	0	0	2.33
Fear of HIV status disclosure affects adherence to ARVs	3	6.7	18	40.0	16	55.6	8	17.8	0	0	2.64
Community HIV support groups initiatives positively improved responses to ART amongst patients	10	22.2	27	60.0	4	8.9	4	8.9	0	0	2.04

N=45

The results in Table 4.7 show that; 68.9% (31) of the HIV positive youths strongly agreed that support for care partners is an important aspect of ARV adherence, 82.2% (37) agreed that patients on ART but with unresolved psychosocial issues have poor adherence rates, 48.9% (9) were not sure whether excellent adherence to ART is critical for treatment success, 40%(18) agreed that fear of HIV status disclosure affects adherence to ARVs and 60%(27) of the HIV positive youths agreed that the

community groups supporting HIV victims positively improved responses to ART amongst the patients. In addition, the care givers said that:

“Members of social support groups advise each other on the importance of adhering to ARV. While some members give testimonies of how their live have improved, others are encouraged to adhere to the therapy. Members also design specified time schedules which helps them to remember when to take the ARVs.

This has greatly helped to improve the adherence rate.”

This shows that HIV positive youths might join social support programs in order to help them adhere to ARV hence improving their health. The finding concurs with Muthiani (2010) who established a high ART adherence rate among patients who participated in support group meetings.

4.3.3 Positive Health Outcomes and Joining Social Support Program

The third objective was to examine the influence of the desire to achieve positive health outcomes on HIV positive youth joining social support programs in Kayole Sub County level II hospital. The youths indicated the extent to which the desire to achieve positive health outcome influence HIV positive youths to join social support programs as presented in the Table 4.8.

Table 4.8: Extent to which Health Outcomes Influence Joining Social Support Program

Extent	Frequency	Percentage	Mean
Very great extent	4	8.9	2.56
Great extent	21	46.7	
Moderate extent	11	24.4	
Total	45	100.0	

Findings in Table 4.8 show that 46.7% (21) of the HIV positive youths indicated that the desire to achieve positive health outcome influence HIV positive youths to join social support programs to a great extent, 24.4%(11) indicated to a moderate extent, 20%(9) indicated to a little extent and 8.9%(4) of the HIV positive youths indicated that the desire to achieve positive health outcome influence HIV positive youths to join social support programs to a very great extent. This shows that social support groups help HIV positive youths to attain and maintain positive health outcomes. The finding is in agreement with Geonnotti et al., (2006) that social support may assist to reduce the adverse effects of stress on health amongst people living with HIV.

The researcher established whether the HIV status of the youth affected their physical or mental health as presented in the Table 4.9.

Table 4.9: Responses on Whether HIV Status Affect Youths Physical or Mental Health

Extent	Frequency	Percentage	Mean
Yes	40	88.8	1.10
No	5	11.2	
Total	45	100.0	

The findings in Table 4.9 shows that most of the youngsters 88.8%(40) indicated that their HIV status affected their health while the physical and mental health of 11.2%(5) of the youths was not affected. The youths further explained that their bodies have become weak and are unable to work effectively and some youths also suffered from depression since it was hard to accept their status. The finding concurs with Friedland et al. (2011) that HIV-positive people may face more stress as a result of discrimination because of HIV status, losing relationships, uncooperative relationships, and the stress of sustaining a very high level of drug adherence.

Respondents indicated the level of agreement on the listed statements on influence of desire to achieve positive health outcomes as presented in the Table 4.10.

1- Strongly disagree, 2-disagree, 3-Not sure, 4-agree, 5-strongly agree

Table 4.10: Influence of Desire to Achieve Positive Health Outcomes

Statements	1		2		3		4		5		Mean
	F	%	F	%	F	%	F	%	F	%	
Stress of a chronic illness affects my mental health	18	40.0	22	48.9	3	6.7	2	4.4	0	0	1.87
I suffer from stress of maintaining an extremely high level of medication adherence	5	11.1	32	71.1	3	6.7	5	11.1	0	0	2.18
I am stressed by discrimination due to my HIV status	14	31.1	18	40.0	11	24.4	2	4.4	0	0	2.02
Unsupportive relationships from family and friends affect my physical health	4	8.9	21	46.7	13	28.9	6	13.3	1	2.2	2.53
I am frequently stressed by social conflict and social isolation	14	31.1	20	44.4	7	15.6	4	8.9	0	0	1.96

N=45

Results in Table 4.10 show that; 48.9%(22) of the HIV positive youths agreed that stress of a chronic illness affects their mental health, 71.1%(32) agreed that they suffer from stress of keeping a very high level of drug adherence, 40%(18) agreed that they were stressed by discrimination due to their HIV status, 46.7%(21) agreed that unsupportive relationships from family and friends affect their physical health and 44.4%(20) of the HIV positive youths agreed that they are frequently stressed by social conflict and social isolation. Furthermore, the givers said that:

“Some youths suffer mentally and physically after getting HIV positive results. Some do not accept their status and refuse to take the medication which makes them vulnerable to many diseases hence they grow weak. Some even go mad as a

result of depression. However, social support groups helps the youths to manage their stress and accept their status hence are able to check on their health and eventually achieve and maintain good mental and physical health.”

This implies that HIV positive youths suffer both physically and mentally hence some consider joining social support to share their experiences and be able to manage the stress associated with HIV positive status. This finding concurs with Swindells et al.,(1999) social help is linked with higher physical working levels and fulfillment with social help is identified with better physical working and decreased physical torment.

In order to assess whether the HIV positive youths at the centre attended social support groups, the researchers asked the youths whether they had ever attended a support group as presented in the Table 4.11.

Table 4.11: Responses on Support Group Attendance

Extent	Frequency	Percentage	Mean
Yes	31	82.2	1.18
No	8	17.8	
Total	45	100.0	

Findings in Table 4.11 show that 82.2%(31) of the HIV positive youths attended social support groups while 17.8%(8) had never attended social support groups. The youths who had attended support groups further indicated that they had attended an HIV support group for 1-2 meetings but did not continue, others had attended an HIV support group once a while and some of the youths attended social support groups regularly for several months. This shows that although majority of the youths attended social support groups, they did not actively participate in the social support groups.

The researcher further sought the youths' opinion on how support would help manage their HIV.

The findings are shown in the Table 4.12.

Table 4.12 HIV Management Support

Statements	Yes		No		Not sure		Mean
	F	%	F	%	F	%	
An addictions treatment Programme	37	82.1	7	15.6	1	2.2	1.20
Someone to help me understand what the doctors are saying	20	44.4	25	55.6	0	0	1.56
Help me find or keep housing	19	42.2	16	35.6	10	22.2	1.80
More information on how to stay healthy	35	77.8	7	15.6	3	6.7	1.29
Nutrition classes	33	73.3	11	24.4	1	2.2	1.29
HIV support group	30	66.7	9	20.0	6	13.3	1.47
Counselling	32	71.7	9	20.0	4	8.9	1.38
Peer/ buddy support	24	53.3	11	24.4	10	22.2	1.69
Help getting nutritious food	29	64.4	13	28.9	3	6.7	1.42
More awareness to reduce stigma	37	82.2	2	4.4	6	13.3	1.31

N=45

The findings are in the Table 4.12 show that most of the HIV positive youths responded in affirmative whereby 82.1%(37) thought that support would help an addictions treatment Programme, 44.4%(20) thought that support would help someone to understand what the doctors are saying, 42.2%(19) thought that that support would help them find or keep housing, 77.8%(35) thought that support would help them get informed on how to stay healthy, 73.3%(33) thought support would help in nutrition classes, 66.7%(30) thought that HIV support group would help them manage their HIV status, 71.7%(32) thought that counselling would help them manage their HIV status, 53.3%(24) thought that peer/ buddy support would help them manage their HIV status, 64.4% (29) thought that support would help them get nutritious food

and 82.2%(37) of the HIV positive youths thought that would help them get more awareness to reduce stigma. This shows that social support groups are essential in the lives of youths living with HIV.

CHAPTER FIVE

SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS

5.1 Introduction

This section provides a summary, discussion, conclusion, and recommendation of the findings while finding the possible suggestions and actions for future research.

5.2 Summary of Findings

The researcher found out that the HIV positive youths were stigmatized against in one way or another which to some extent affected their family members. Stigmatization resulted to family and relationship breakages and some of the HIV positive youth lost their jobs. The youths also lost their self-esteem especially when isolated by people close to them. In addition stigma prevent people from testing and disclosing their HIV status. This finding is in agreement with Kalichman&Simbayi(2014) thatPLWHA who were members of support groups were less affected with stigmatization as compared to those who were not in any support groups.

The findings revealed that although majority of the sampled youth were currently on ARVs, the adherence was low whereby some youths living with HIV did not take the ARVs constantly. However, the researcher established that support for care partners is an important aspect of ARV adherence, fear of HIV status disclosure affects adherence to ARVs. The finding is in agreement with Wouters(2013) who established that community support groups focusing on HIV victims notably improved adherence to ART.

The researcher found out that positive HIV status affected HIV positive youths' physical and mental health whereby poor adherence rate contributed to health deterioration and depression as

a result of stress and isolation by family, work colleagues and friends. The finding concurs with Jia et al. (2004) who established that social help was not positively connected to physical working, job constraints, or torment.

5.3 Conclusion

The researcher concludes HIV youths positive youths in Kayole are still afraid of revealing their HIV status for fear of stigmatization. This could be attributed to the fact that other HIV positive people have had suffered from revealing their status by losing their partners especially the married people and to extreme extent losing their sources of income. However, the social support group helps PLWHA to deal with stigmatization and this answers the research question that stigmatization influence HIV positive youth joining social support programs in Kayole Sub County level II hospital to a great extent.

It is also concluded that ARV adherence rate amongst HIV positive youths in Kayole is low since not all HIV positive youths were willing to take the medication from the health centre. This was because they felt ashamed and thought that other people would see them and defame them. There are also some youths who default the therapy and it takes the efforts of support groups and care givers to keep following them and reminding them to take their medication.

The researcher further concludes that the desire to achieve and maintain positive health outcomes influences the HIV positive youths to join social support groups. This is because the support group members share similar experiences and through the forum they share ideas which help to reduce stress and live a healthy life.

5.4 Recommendations

- The Government should network with HIV/AIDS positive people to help them increase self-confidence and enhance the self-esteem of HIV/AIDS positive people. People at the community level should stop believing that being HIV positive is shameful and that stop stigmatizing family members and they should therefore change perceptions for blaming HIV/AIDS positive people.
- The government should ensure that all public health centres provide ARVs at no cost and also recruit community health workers to make follow up of ART adherence amongst PLWH. This will in return increase their adherence rate.
- The government should come up with measures to ensure that all patients are intensively counseled before breaking the news of their HIV status. This would help to reduce stress related to disclosure of HIV positive status as well as maintain positive health outcomes for the patients.
- Findings have established that patients who were members of social support groups had better understanding of HIV/AIDS and were in a better position to manage their health. Therefore, all patients should be encouraged to actively participate in support groups.

5.5 Suggestions for Further Study

The research paper thus suggests the same study in other developing countries for comparison purposes and study on ARV adherence rate among all age groups.

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APPENDICES

APPENDIX 1: Letter of Introduction

Doreen Bosire,

Department of Open, Distance and eLearning,

P.O.BOX _____.

Date.....

The Hospital Superintendent

Kayole sub-county level II hospital

Dear Sir,

RE: PERMISSION TO CONDUCT A RESEARCH IN THE HOSPITAL.

I am a university student pursuing a master’s degree in Open, Distance and eLearning at University of Nairobi. I am carrying out a research on the “Factors influencing youths living with HIV to join Social Support Programs in Kayole Sub County level II hospital” I would be grateful if you allow me to involve caregivers and HIV positive youths. The information obtained will be used for the study only and the identities of the respondents will be kept confidential. I will appreciate your support and cooperation.

Thank You.

Yours faithfully,

DOREEN BOSIRE

APPENDIX II: Questionnaire for HIV Positive Youths

This questionnaire is for research only. Please tick (✓) in appropriate bracket or write your response to all questions. Do not write your name anywhere.

SECTION A: Demographic information

1. Gender

Male [] Female []

2. Age in years _____

3. What is your highest education level?

Primary [] Secondary []

College [] University []

4. For how long have you lived with HIV?

Less than 1 year [] 1-5 years []

6-10 years [] More than 10 years []

SECTION B: HIV/AIDS Related Stigmatization

5. To what extent does stigmatization influence joining of social support programs?

Very great extent [] great extent [] moderate extent [] little extent [] no extent []

6. Have you in any way been stigmatized and/or discriminated against by virtue of your HIV/AIDS status?

Yes [] No []

If yes, kindly share some of your experiences

1.

2.

3.

4.

5.

7. Have you in anyway been affected by stigma due to your HIV/AIDS status?

Yes [] No []

If yes, how has this affected your Personal life?

8. Have any of your family members experienced stigma as a result of your status?

Yes [] No []

9. Can HIV related stigma prevent people from testing and disclosing and why?

Yes [] No []

10. What is your view on PLWHA being stigmatized and maltreated due to their HIV status?

11. Why do you think people stigmatize and discriminate against PLWHAs?

SECTION C: Antiretroviral Therapy Adherence

12. Are you currently using ARV drugs?

Yes []

No []

If yes, for how long have you been on ARV drugs?

a)years.

b)months

13. According to you who are the most important people who can help you achieve maximum adherence

14. Kindly indicate your level of agreement on the listed statements on influence of ARV adherence.

Key: 5 Strongly, 4 Disagree, 3 Neutral disagree 2 Agree, 1-Strongly agree

STATEMENTS	1	2	3	4	5
Support for care partners is an important aspect of ARV adherence					
Patients on ART but with unresolved psychosocial issues have poor adherence rates					
Excellent adherence to ART is critical for treatment success					
Fear of HIV status disclosure affects adherence to ARVs					
Community HIV support groups initiatives significantly improved responses to ART among patients					

SECTION D: Health Outcomes among HIV-Positive Youths

15. To what extent does the desire to achieve positive health outcome influence HIV positive youths to join social support programs?

Very great extent [] great extent [] moderate extent [] little extent [] no extent []

16 Have your status affected your physical or mental health?

Yes [] No []

Kindly explain your answer?

17. Kindly indicate your level of agreement on the listed statements on influence of desire to achieve positive health outcomes.

Key: 1-Strongly agree, 2-Agree,3-Neutral, 4-Disagree, 5-Strongly disagree

STATEMENTS	1	2	3	4	5
Stress of a chronic illness affects my mental health					
I suffer from stress of maintaining an extremely high level of medication adherence					
I am stressed by discrimination due to my HIV status					
Unsupportive relationships from family and friends affect my physical health					
I am frequently stressed by social conflict and social isolation					

SECTION E: Social Support Groups

18. Have you ever attended a support group?

Yes () No ()

If yes, how often?

19. Do you think the following supports would help you manage your HIV?

- | | |
|---|----------------------------|
| An addictions treatment Programme | Yes () No() Not Sure () |
| Someone to help me understand what the doctors are saying | Yes () No() Not Sure () |
| Help me find or keep housing | Yes () No() Not Sure () |
| More information on how to stay healthy | Yes () No() Not Sure () |
| Nutrition classes | Yes () No() Not Sure () |
| HIV support group | Yes () No() Not Sure () |
| Counselling | Yes () No() Not Sure () |
| Peer/ buddy support | Yes () No() Not Sure () |
| Help getting nutritious food | Yes () No() Not Sure () |
| More awareness to reduce stigma | Yes () No() Not Sure () |

THANK YOU FOR YOUR COOPERATION.

APPENDIX III: Interview Schedule for Care Givers

1. How long have you worked at this center?
2. What is your view on influence of stigmatization and discrimination on HIV positive youths joining social support groups?
3. Do you think the urge to adhere to ARV therapy influence HIVpositive youths to join social support groups?
4. What is the adherence rate of youths who get the ARVs from this centre?
5. Do you think that some youth suffer mentally and physically after getting HIV positive results?
6. How does the support groups help the youths with regards to stress do associated with their status?

APPENDIX IV:Time plan

Activity	Period						
	May- Jun 2018	July-Sept 2018	1 st -15 th Oct 2018	16 th -31 st Oct 2018	Nov 2018	Nov 2018	Dec 2018
Identification Of research Title							
Proposal writing and literature review							
Submission of the proposal							
Data collection							
Data analysis and project writing							
Submission of the project							
Graduation							

APPENDIX V: Budget

Item	Description	Quantity	Unit Price	Total Cost
Transport				15,000/=
Stationary	Books, Pencils, felt pens and manila papers	Assorted		8,000/=
Photocopy and printing	Purchase of rims of plain papers and printing of questionnaires and letters	Assorted		18,000/=
Project preparation and binding				13,000/=
Miscellaneous				10,000/=
Total cost				64,000/=