

Caregiver motivation and child well-being: HIV status disclosure among pediatric patients at Moi Teaching and Referral Hospital, Uasin Gishu, Kenya

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ABSTRACT

Disclosure of Human Immunodeficiency Virus [HIV] status to children is a complicated procedure and an emotional task especially within resource-poor environments. Besides supporting the adherence to treatment, disclosure plays numerous critical roles, including mental strength and independence of a child. Nevertheless, caregivers experience the dilemma of when, how and whether to disclose depending on cultural, emotional and contextual issues. The aim of the study was to investigate reasons why caregivers decide to disclose the HIV status to their children; evaluate the psychological, emotional, and social impacts of such disclosure to their children living with HIV in Moi Teaching and Referral Hospital (MTRH). The research work used a descriptive survey directed by the Social Cognitive Theory. The target population involved 85 children with HIV, 50 care givers, and 70 health care providers. Inclusion of the caregivers was formed through a purposive sampling approach to cover the various samples of respondents regarding their status of disclosure (whether they disclosed or not). In case of the participants (children) stratified sampling was conducted based on age group (1013 and 1417 years) to assess the difference in disclosure due to age. The sample calculating was done through the Cochran formula (1977), the confidence level of 95 percent and 10 percent adjustment of non-response. They resulted in having 100 caregivers and 60 children with HIV as the final sample. The structured questionnaires were used to collect data and the statistic package for social sciences (SPSS) to analyse the data presentation in frequencies and percentages. IDIs: 20 in depth interviews with the caregivers; focus group discussion-4 with the adolescents with HIV. The results showed that, age, perceived emotional readiness of the child, fear of stigma and the general comfort level played a big role in the disclosure decision of the caregivers. Some care givers had a view that disclosure would also offer an avenue to better adherence and psychological readjustment but other care givers were scared that it might lead to emotional damage to the child or social discrimination. The finding of the study also revealed that those children who knew their HIV status mostly underwent various emotional predispositions such as shock, sadness, and reaction of relief and better cooperation with care. In the long-term, the disclosure was associated with the enhanced social functioning, the improved knowledge of ART, and psychological better results. To conclude, disclosure of the HIV status even though difficult is a key component in promoting the well-being of the paediatric patient. The research suggests specific training of caregivers to develop disclosure plans, the development of age appropriate counselling procedures and systems to support both a caregiver and the child that can support disclosure as a process successfully.

Keywords: Caregiver Motivation, Child Well-Being, HIV Status Disclosure, Paediatric Patients

I. INTRODUCTION

Disclosure of HIV condition to children continues to be an essential part of paediatric management and care. As a result of the ongoing expansion of the antiretroviral therapy (ART) programs in sub-Saharan Africa, more HIV-infected children are surviving into their adolescence and adulthood. Nevertheless, management of HIV among children extends beyond clinical management of drug side effects; it also involves giving psychosocial help and providing HIV positive children with the knowledge regarding their HIV statuses. In that sense, disclosure of HIV status the process of informing a child that he/she lives with HIV plays a central role. Disclosure has been shown to have many advantages such as less association with increased adherence levels, healthier psychological adjustments, and health outcomes. However, in spite of these well-documented advantages, disclosure has been described as a very complicated, emotionally charged, and evaded procedure among many caregivers (Brown et al., 2011; Vreeman et al., 2014).

There are many challenges that children living with HIV have such as long-term adherence to ART or treatment, the need to realize the importance of continued care, and how to cope in the face of numerous medical appointments, among many others. Potential barriers are accompanied by lack of knowledge about their condition which usually happens when the caregivers postpone or avoid disclosure. Research studies have shown that children that know their HIV status have greater chances of cooperating with a health professional, becoming responsible in their treatment, and expressing coping mechanisms that will help them overcome stigmatization and discrimination (Haberer & Mellins,

2009). Nevertheless, numerous care providers, especially in low-resource regions like Kenya, are still unwilling to report beckoning a large number of factors.

The fear of abducting psychological pain into the child has been among the most quoted reasons of prohibiting disclosure. Frequently, the caregivers are afraid that disclosure can result in an emotional trauma, depression, or helplessness. There is even an opinion that children and adolescents in particular might lack the cognitive and emotional maturity to comprehend and cognitively process the meaning of HIV diagnosis. In addition to that, caregivers are afraid that, after they understand their status, children will reveal it to other people unintentionally, which might result in social exclusion or isolation. HIV remains stigmatized in most of the African cultures and disclosure may have extensive social impacts not only on the child but also on the family (United Nations Acquired Immuno Deficiency Syndrome [UN AIDS, 2020]).

Another important complexity is the readiness of caregivers and healthcare professionals to go through the process of disclosure. Caregivers commonly state they do not know how to disclose, which words to apply, and how to cope with the reaction of the child. Similarly, the healthcare workers can be seen to be ill-prepared to walk the families through the process due to insufficient training, time constraints and insufficient institutional support amongst other reasons. In the absence of specific programs and culturally appropriate guidelines, the disclosure appears to be an unimaginable procedure, which can be delayed endlessly (Toromo et al., 2022).

Conversely, disclosure done in the right way and at the right time has been found to be transformational to children living with HIV. Among the first, it develops a degree of independence and imparts a responsibility to health. Being aware as to whether they have HIV or not helps the children to make informed decisions on the subject of treatment compliance, sexual activity (as they grow up), and the use of medical services. Moreover, knowing helps such children have a better relationship with caregivers and medical professionals as the prohibition of sharing is eliminated, and open-door communication is promoted (Vreeman et al., 2019). More to the point, disclosure may provide not only an occasion of emotional healing and the rise of resilience but also a positive emotional experience in case disclosed in an age-appropriate and empathic fashion (Harvey & Boynton, 2022).

Disclosure is diffused improvement and should not be considered as just one thing. Granularly, it is recommended that the World Health Organization (WHO) has individuals disclose partial information at a younger age and report full disclosure towards adolescence. This staged model also provides a guarantee that the children will be offered information depending on their cognitive and emotional development thereby minimizing the possibility of psychological damage. In addition, the presence of professional medical personnel in the process can provide essential assistance to the caregivers and make sure that disclosure is approached carefully and sensitively (Chaudoir & Fisher, 2010).

Paediatric HIV care in the Kenyan context and more precisely within tertiary referral hospitals such as Moi Teaching and Referral Hospital (MTRH) in the Uasin Gishu County is rather complex, integrating services of a medical, psychological and social nature. MTRH has a huge catchment area in western Kenya with a high number of children living with HIV that receives ART services. This situation means that although the hospital has improved in encouraging child-centered care of HIV, HIV disclosure among pediatric patients is diverse and inconsistent. It has been anecdotally reported that there remain many caregivers reluctant to disclose and they do so often only in late adolescence or after the child has become inquisitive as to why he/she may be taking medications.

In this kind of setting, it is important to understand the reasons of making the decisions to disclose or not to disclose by the caregivers in order to come up with context specific interventions. The stages of HIV infection, stigma experiences, cultural ideas, the accompanying child, the level of education, access to counselling services, and the status of HIV infection of the caregiver characterize the range of factors that influence motivations. There are also a few caregivers who refuse to disclose because they want to protect a child in terms of his or her emotional/social state, whereas there are caregivers who want to disclose to help the child to adhere to the treatment or to deal with adulthood in general (Zarzycki & Morrison, 2021).

As the emotional, cultural and pragmatism layers of this situation so intricately interact, it becomes obvious that further studies on the where and why of HIV status disclosure by caregivers to children is desirable as well as highly needed. A psychological, emotional, and social measure of the disclosure consequences of the child is necessary as well (Frosch et al., 2019). Do HIV aware children have reduced anxiety? Do they have more opportunities to respond to ART? What is its impact on the way they talk to others (peers, family members)? These are important questions to be answered that would reflect policies and practices in pediatric HIV care.

This paper thus set out to investigate the reasons that prompted care givers to disclose HIV status to children living with HIV at Moi Teaching and Referral Hospital in Uasin Gishu county Kenya. It also aims to determine the effects of disclosure on the child well-being concerning not only psychological but also emotional and social levels. Through these dimensions, the study shall aim at developing evidence-based evidences that would assist healthcare providers and healthcare systems through formulation of informed decisions regarding HIV disclosure by healthcare providers, policymakers, and caregivers. Finally, enhancing the disclosure process and its results would help

considerably towards the overall well-being of a child with HIV, and towards the achievement of the wider Paediatric HIV care in Kenya and other comparable contexts.

1.1 Statement of the Problem

Disclosure of HIV status to children is a highly important procedure that affects the health outcomes of the children, in particular, their adherence to ART or psychological well-being. Nonetheless, caregivers still have a lot of reservations about revealing the HIV status to children based on the fear of the emotional effect and stigma that the condition may elicit. Researchers have found that disclosure may lead to improved adherence to ART and better psychological development of children but it is not always conducted in a sufficient quality and at opportune time (Britto et al., 2016). In Moi Teaching and Referral Hospital, one of the headquarters of the care of HIV in children, little is known about how the motives of caregivers perform disclosure and thereafter affect the adherence and psychological conditions of the children under the care. Also, no organized supportive system has been established to manage caregivers during the disclosure process and subsequently offer the required post-disclosure emotional response. This research will aim to fill these gaps by finding out the determinants of caregivers in regards to disclosing to children living with HIV at the MTRH and the resultant of the disclosure responses.

1.2 Research Objectives

- i. To identify the key factors influencing caregivers' decisions to disclose HIV status to children receiving care at Moi Teaching and Referral Hospital.
- ii. To examine the psychological, emotional, and social impacts of HIV status disclosure on children living with HIV at Moi Teaching and Referral Hospital.

II. LITERATURE REVIEW

2.1 Theoretical Framework

The work is based on Social Cognitive Theory (SCT) postulated by Albert Bandura, according to which, the behavior is a product of the ongoing, dynamically interacting components of personal factors, behavioral patterns, and environmental factors (Bandura, 1986). SCT offers a solid platform of interpreting why care givers are motivated and how the pediatric patients with HIV fare in the context of HIV status disclosure.

The motivation of caregivers to reveal is a multidimensional individual factor that will depend on the cognitive and emotional aspects related to fear of stigma, anxiety concerning the emotional reaction of the child, perceived self-efficacy, and cultural norms. The fear of psychological damage to the child or the possibility of being rejected by the society leads many caregivers to withhold disclosure or postpone it (Kairania et al., 2022). These internalised fears usually supersede the rules of health and are supported by socio cultural taboo and misconception.

On the behavioral level, disclosure is an act and process that depends on the experience of a caregiver, the reaction of the child, and the results, which can be the modifications in the adherence to ART drugs or psychological suffering. When children become aware that they have HIV, they can usually better recognize the need to take medication and be more adherent and autonomous in the management of their health (Lowenthal et al., 2014). All of the environmental factors such as institutional policies, healthcare workers training, counseling support, and peer support groups can have a supporting or hindering impact on disclosure practices. When caregivers get information and emotional support by healthcare providers and peer networks, then they disclose better and, in an age, appropriate way (Schunk & Usher, 2019).

The connection between personal beliefs, observable behaviors, and structural elements of the environment allows developing an interventional program at Moi Teaching and Referral Hospital that helps caregivers feel empowered, reduces stigma, and helps to achieve pediatric well-being via safe and effective disclosure exercise.

2.2 Empirical Review

2.2.1 Significance of HIV Status Disclosure in Paediatric Care

Revealing HIV status to infected kids is a fundamental element in promoting the whole child and HIV management. It is a landmark in the quest towards success of antiretroviral therapy (ART) and the psychosocial outcome of children living with HIV. The prompt and age-appropriate disclosure will facilitate emotional and cognitive growth of children, increase their levels of ART adherence, decrease viral loads, and develop a sense of autonomy and self-responsibility in caring (Aderomilehin et al., 2016; WHO, 2011). Understanding of health status predisposes children to a better picture of the logic of using medication and inspires confidence in caregivers and medical professionals. In the absence of disclosure, children can grow in confusion, suspicion or mistrust, particularly when they go through long term treatment regimens or disease in the absence of a known explanation. In addition, disclosure is also associated with better clinical outcomes and increased participation in the healthcare services (Vreeman et al., 2019). According to

WHO, progressive disclosure is the method of choice that begins during early childhood and continues with the line of disclosure depending on the age, maturity, and emotional maturity of the child (WHO, 2011).

2.2.2 Caregiver Motivations and Barriers to Disclosure

Disclosure of HIV to children provides many caregivers with a mix of emotional, cultural, and social dilemma. Reasons to disclose often involve the intent to enhance the adherence to ART, strengthen trust, encourage a child to become an independent person, and be ready to face the future challenges, such as establishing relationships and dealing with the reproductive health (Theng et al., 2023). Repeated questioning coming on the part of the child, deteriorating health or changes into adolescence may also trigger the disclosure.

Irrespective of these incentives, most caregivers tend to wait or evade disclosure because of numerous perceived and realistic barriers. These are fears of inflicting psychological distress, worries that the child will fail to maintain the privacy of the diagnosis, expected stigma and discrimination as well the fear on how to go about the explaining the diagnosis (Vreeman et al., 2013; Britto et al., 2016). In most sub-Saharan Africa settings, these anxieties culminate with societal stigma and misinformation about HIV. The level and type of education of the caregivers, their HIV education and access to counseling center as well as their HIV status have an important role on disclosure decision. As an example, some HIV-positive caregivers could deal with feelings of guilt or fear of being criticized by the child, or others cannot adequately communicate the diagnosis due to the lack of communication skills (Zuurmond et al., 2020). It has been found that these difficulties are more prominent in low-resource countries with Ghana, Uganda, and Kenya being some of the candidates, due to the lack of available trained counsellors and age-appropriate education material, the need to introduce culturally sensitive disclosure guidelines and caregiver support programs is also there (Atwine et al., 2015).

2.2.3 The Psychological and Emotional Impact on Children

The reaction of the children is vastly different in terms of emotional reception to disclosure, depending on their age and maturity, their support system, and the process through which the disclosure is carried out. There could be shock, sadness, anger, guilt or fear at first. Nevertheless, disclosure can be performed in a nurturing and systematic setting, and, in these cases, children will express resiliency, less anxiety, and enhanced psychosocial adaptation (Vreeman et al., 2019; Kairania et al., 2022). Disclosure also enables children to be able to comprehend how they feel about their health issues and the need to use ART all throughout their lives. Moreover, it promotes open interactions with the caregivers and professionals focusing on the health industry, which is essential in terms of managing the side effects of medication, fears, and developing coping strategies (Madiba & Mokgatle, 2016). Notably, early and gradual disclosure of children is more likely to lead to a lesser number of emotional disruptions and increase adherence to ART (Beima-Sofie et al., 2014).

2.2.4 Social and Developmental Outcomes

In addition to the clinical and psychological effects, disclosure has a tremendous effect on the social development of children. Children with such knowledge of their HIV status are much more capable in social relations and in a position to make a wise decision and attend to peer support groups. This kind of engagement enhances community spirit, eliminates feelings of desolation and offers an avenue to learn through collective experiences (Toromo et al., 2022). Nevertheless, stigma, bullying, or any form of social rejection continues to play a major risk in the minds of most caregivers, particularly when at school or within societies with misinformed perceptions against HIV. Such fear commonly plays a part in the assignment to postpone disclosure or in any case not to reveal it by any means (Amankwah-Poku et al., 2021). To curb these risks, interventions should not only strive to empower caregivers and children on those levels; they also should aim at reducing the stigma in communities, as well as improving the confidentiality measures in schools and health institutions.

III. METHODOLOGY

3.1 Research Design

This research used a descriptive survey research design because it seeks to understand the major factors that motivate caregivers to disclose HIV status to children as well as looking into the psychological, emotional, and social consequences of HIV status disclosure to children living with HIV. This study was undertaken in Eldoret Kenya in a tertiary health institution, Moi Teaching and Referral Hospital (MTRH) which offers a comprehensive care of HIV disease by employing a Comprehensive Care Centre (CCC). The given research design was selected because it will enable both depth and breadth in terms of getting to know the nature of the process of HIV disclosure both by the caregivers and the children (Creswell & Plano Clark, 2018).

3.2 Study Population and Sampling

The two populations that were targeted by the study were (i) primary caregivers of children aged 6-17 years that are living with HIV and under antiretroviral therapy (ART) at MTRH and (ii) children aged 10-17 who are HIV positive. The caregivers had to qualify based on being directly involved in the care of the child on the daily basis and their familiarity with the HIV treatment history of the child. The second objective did not apply to children below the age of 10 years on the basis of cognitive immaturity to effectively participate in the emotional and social dynamics of disclosure. The sample of caregivers has been recruited using a purposive sampling method where the focus was on disclosure status (did disclose or did not disclose) and a variety of experiences was sought. In case of the children involved in the study, stratified sampling where age group (10-13 and 14-17 years old) differences in the magnitude of disclosure effect were used. Cochran formula (1977) was used to compute the sample size whereby it was computed at the 95 percent confidence interval and 10 percent non-response allowance. The last sample oriented to 100 caregivers and 60 children living with HIV.

3.3 Data Collection Methods

The collection of data took place in three months by both quantitative and qualitative methods. The quantitative data were collected using a carefully designed questionnaire of caregivers that identified socio-demographic data, the status of HIV disclosure by caregivers, reasons to disclose or not disclose HIV, and perceived obstacles and facilitators. Questionnaires used were the modified versions of other tools that have been previously used in the related situations (Vreeman et al., 2010). In children, the Pediatric Symptom Checklist (PSC-17) was employed to investigate the existence of emotional and behavioral symptoms, and other structured questions were directed at how their social relationship with others and their feelings had changed after the disclosure. The tool has proven to work reliably with the pediatrics in low-income setting (Jellinek et al., 1999). The qualitative data were ascertained in 20 in-depth interviews (IDI) with caregivers and 4 focus group discussions (FGDs) with adolescents living with HIV. The IDI guide addressed case personal experiences, reason or inspiration and troubles linked to disclosure whereas, the FGD guide dealt with the emotional and social post aspects of learning that one is HIV positive. Audio recordings were made of all the interviews and discussions, a verbatim transcription was also done, and when needed an English translation was made.

3.4 Data Analysis

SPSS version 26 was utilized in the analysis of quantitative data. Participant characteristics were summarised using descriptive statistics. The relationship between factors of caregivers (e.g., education level, age of child, fear of stigma) and disclosure status was determined using a chi-square test, as well as by a binary logistic regression. The level of statistical significance was postulated at $p < 0.05$. Thematic content analysis of the qualitative data was used. Two researchers independently coded transcripts in NVivo 12 and found areas of disagreement were eventually resolved through discussion. Themes were grouped under the study objectives especially in terms of barrier to disclosure and psychosocial effects like anxiety, depression, stigma, and social support.

3.5 Ethical Considerations

The study received ethical approval from the Institutional Research and Ethics Committee (IREC) of Moi University/MTRH. Written informed consent was obtained from all caregivers, and assent was obtained from child participants. To minimize potential distress, psychological support services were made available during and after data collection.

IV. FINDINGS & DISCUSSION

4.1 Findings

4.1.1 Factors Influencing Caregivers' Decisions Regarding HIV Status Disclosure to Children

The research determined many intertwined issues that guide the choices made by the caregivers towards disclosing the HIV status of a child or not at all. Most of the respondents (69.88) strongly agreed or agreed that the age and maturity of the child was an extremely significant factor, which shows the significance of developmental readiness in relation to the timing of disclosure. Similarly, emotional preparedness and understanding were some of the major issues because 62.22 percent of caregivers affirmed that the aspect causes delays in disclosure. The role of family dynamics should also be mentioned since as many as 63.89 percent of the caregivers confessed that family relationships had an impact on their decisions. This implies that other family members may influence whether, how and when to approach the child with information on an issue or matter depending on whether or not the family members support or resist. Also, norms and beliefs were a significant determinant in that 63.89 percent of the caregivers expressed that cultural beliefs about illness and disclosure will influence their attitude. The other most important barrier was fear of

stigma and discrimination with 63.89 percent of the respondents indicating this focusing on the fear of the phenomenon of stigma and discrimination in the society and the effects that such stigmatization may have to the child and the family. The complexity of the disclosure decisions about HIV is reflected by the findings of this study based on the combination of different psychological, cultural, familial, and social factors. Identifying and intervening on these factors can result in better disclosure and better psychosocial outcomes of children living with HIV.

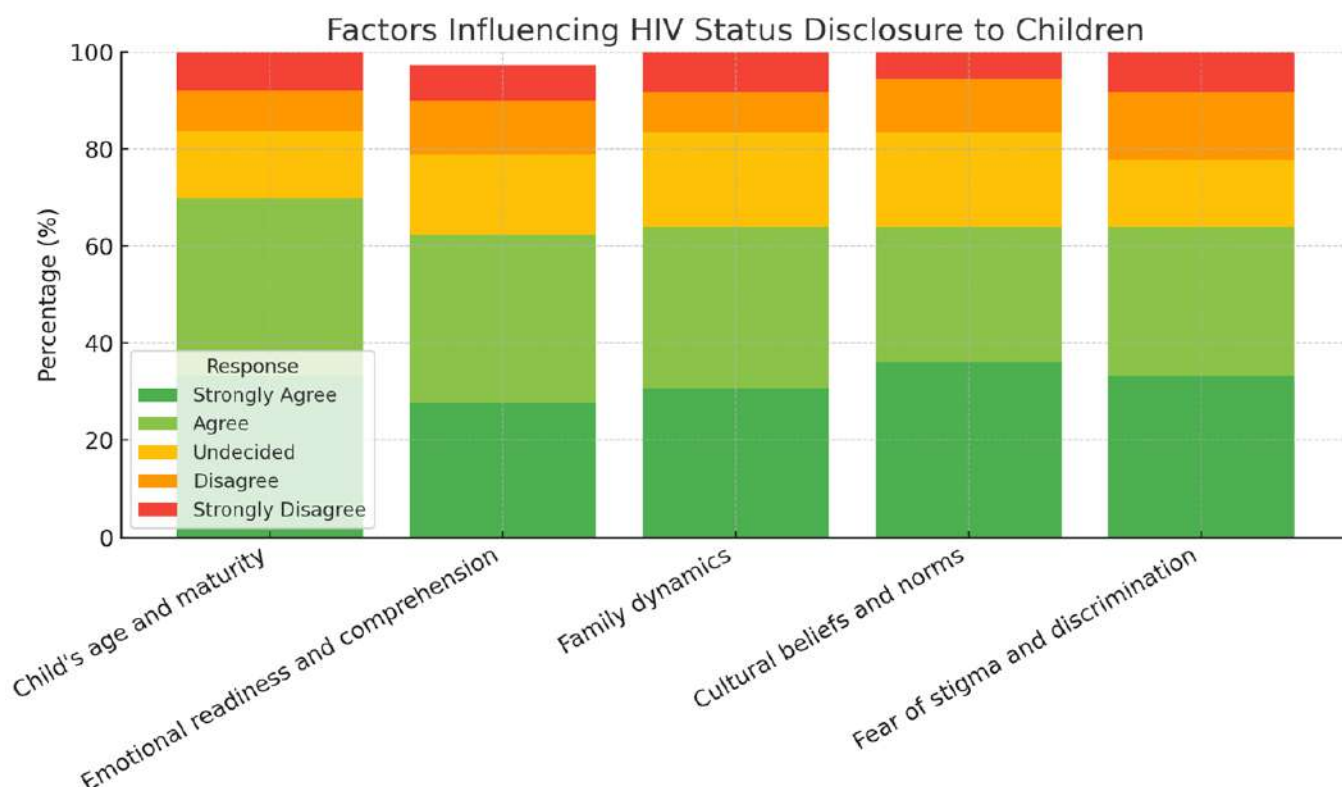


Figure 1

The Stacked Bar Chart Clearly Illustrates the Distribution of Caregiver Responses across Five Key Factors Influencing HIV Disclosure Decisions

4.1.2 Psychological, Emotional, and Social Effects of HIV Status Disclosure on Children Living with HIV

The research indicates that there are major psychological, emotional and social effects of HIV status disclosure by children living with HIVs. Majority of the respondents held the view that disclosure can worsen emotional distress with 74 percent of them reporting that children in most occasions report feeling more anxiety when they are informed of their status. On the same note, 69 percent consented to the claim that disclosure of HIV has an adverse effect on emotional health implying there might ensue some form of emotional imbalances even after disclosure. Moreover, 68 percent of the caregivers stressed that in terms of identity and self-esteem, disclosure changes a child, which implies worries related to self-disclosure and internalized stigma. Another significant 70 percent also expressed agreement with the fact that children stand a better chance of becoming depressed following disclosure, and this underlines the high mental health repercussions of making an HIV revelation. Concerning the social life, 65 percent of the respondents said that disclosure can affect the relationship the child has with his or her friends and the family that might be caused by the fear of being rejected or the shift in the dynamics. The results support the existence of a complicated landscape that a child traverses after disclosure and require supporting systems such as counselling and family education to reduce negative outcomes. These findings underscore the need in coming up with child-sensitive disclosure intervention and post disclosure support mechanisms in order to guarantee children living with HIV and AIDS of good psychosocial well-being.

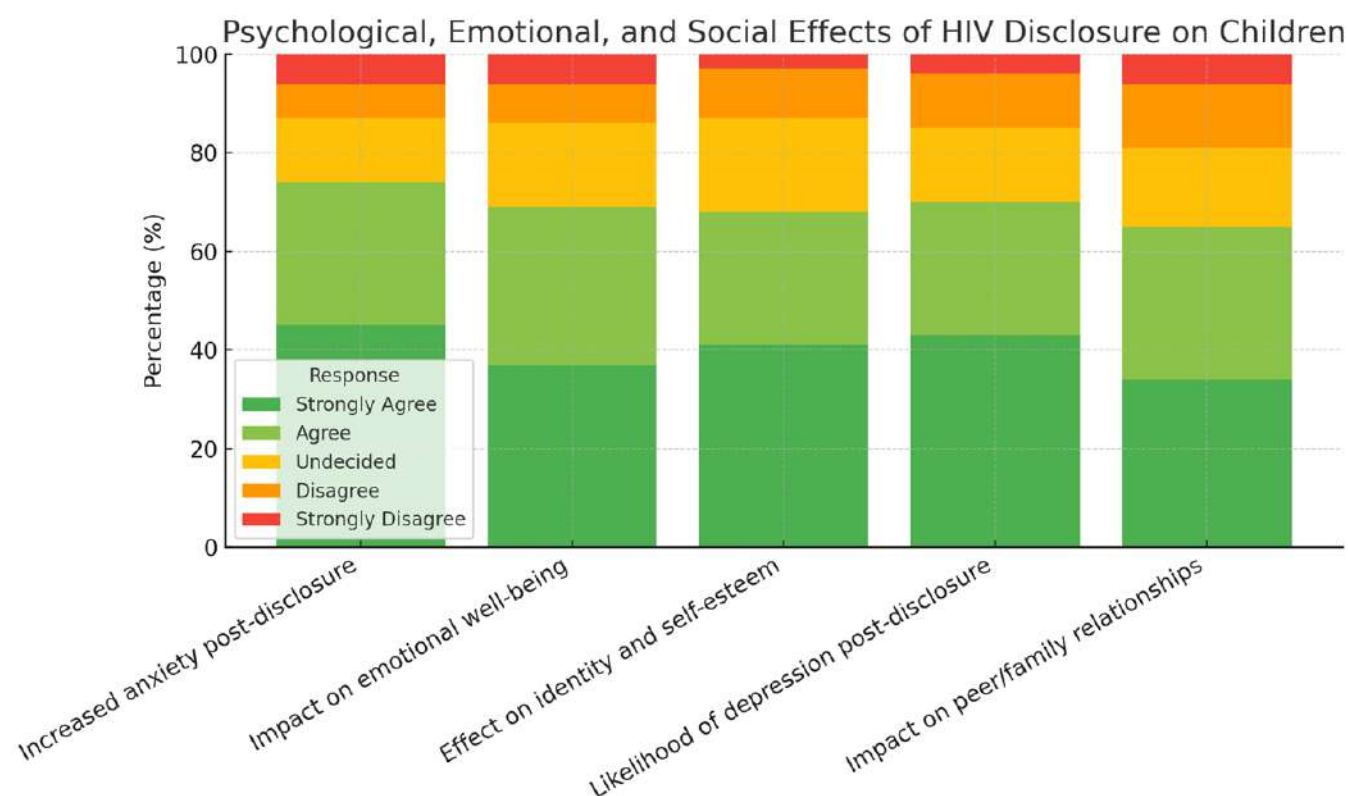


Figure 2

The Stacked Bar Chart Shows High Proportions of “Strongly Agree” and “Agree” Responses across All Dimensions

4.2 Chi Square and Logistic regression Analysis

4.2.1 Quantitative Data Analysis

These quantitative data were tabulated with the assistance of IBM SPSS statistics 26. To present the findings of the study, descriptive statistics such as frequencies and percentages were calculated to describe the socio-demographic profile of the care-givers and their reactions to important questions addresses in relation to making HIV disclosure decisions and psychosocial effects of HIV on children. Chi-square tests were used in order to determine the associations between the characteristics of caregivers and the status of disclosure. Caregiver education level, age of child, fear of stigma by carer and the perceived emotional readiness of child were also variables tested. Based on the bivariate analysis, variables that achieved significance ($p < 0.05$) were then entered into the binary logistic regression models to act as a determinant of disclosure. To estimate the direction and strength of associations, adjusted odds ratios (AORs); 95 percentage confidence intervals (CIs) were recorded.

Logistic regression showed that:

Caregivers who had a higher level of education had a high probability of disclosure to their children about their HIV status (AOR = 2.13, 95 % CI: 1.32 3.45, $p = 0.002$).

The caregiver of the child aged 10 years and above was much more likely to be disclosed (AOR = 1.96, 95% CI: 1.153.34, $p = 0.015$).

Caregivers that feared stigma disclosed less probably (AOR = 0.58, 95% CI: 0.34 -0.97, $p = 0.041$).

Of the structural factors (education, age) or the psychosocial factors (stigma) the findings clearly depict their remarkable impact towards probability of disclosure.

4.3 Qualitative Data Analysis

Thematic content analysis was applied to the qualitative data for unraveling variations in the experiences and perceptions on HIV status disclosure. The transcriptions of the interviews were coded and analyzed in NVivo 12, as a verbatim transcription. Open coding was carried by two different people, followed by axial coding and the selective coding to develop themes and subtopics. A discussion was done to resolve discrepancies in coding to promote validity and reliability.

Emergency themes were systematized in the guiding light of the study objectives and were distilled into two grand domains:

- Obstacles to Disclosure such as cultural taboos and stigma fears, separation between knowledge on disclosure and emotional readiness on either side of the child-caregiver divide.

- Psychosocial Consequences After Disclosure- these include emotional sufferings (anxiety and depression), identity disruptions, poor peer relationships and change in family dynamics.

Through my analysis, it was realised that although care givers feared that some children had improved communication and emotional relief after the disclosure owing to availability of professional counselling or family support systems in these cases of post disclosure issues.

Table1

Chi-Square Test Results

Variable	Chi-square Value	Degrees of Freedom	p-value
Caregiver Education Level	10.24	2	0.006
Child's Age	8.76	1	0.003
Fear of Stigma	5.43	1	0.020
Family Support	3.89	1	0.048

All listed factors showed statistically significant associations ($p < 0.05$) with disclosure status.

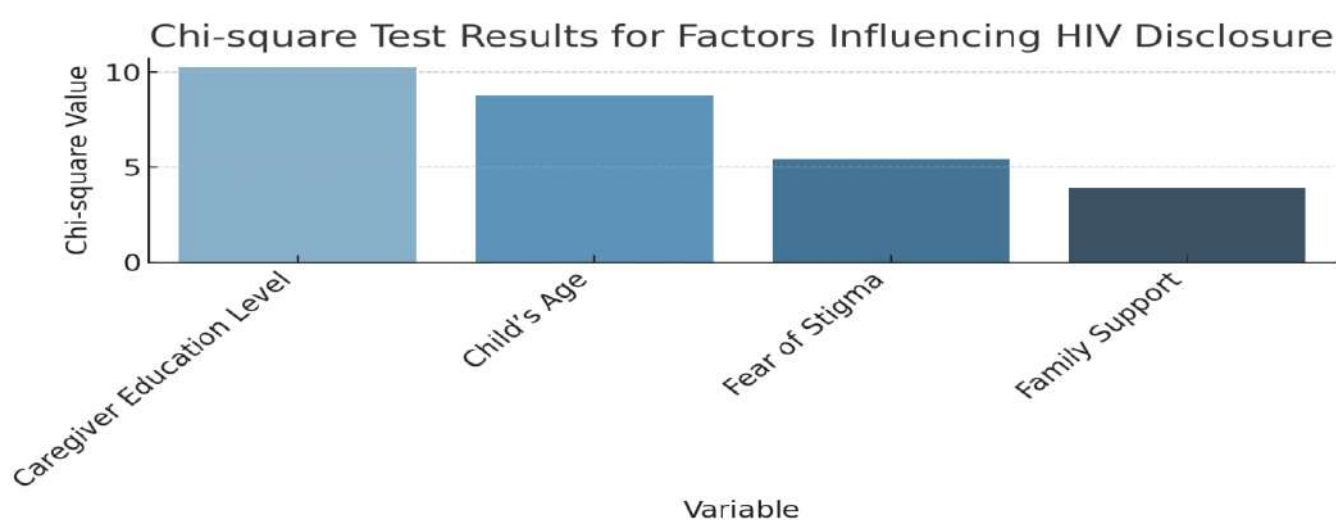


Figure 3

Chi-square Test Results

Table 2

Binary Logistic Regression Results Table

Variable	AOR	95% CI Lower	95% CI Upper	p-value
Caregiver Education Level	2.13	1.32	3.45	0.002
Child's Age ≥ 10 years	1.96	1.15	3.34	0.015
Fear of Stigma	0.58	0.34	0.97	0.041
Family Support	1.45	1.01	2.08	0.049

AOR > 1 indicates increased likelihood of disclosure.

AOR < 1 (e.g., fear of stigma) indicates a protective or inhibitory effect.

All predictors were statistically significant ($p < 0.05$).

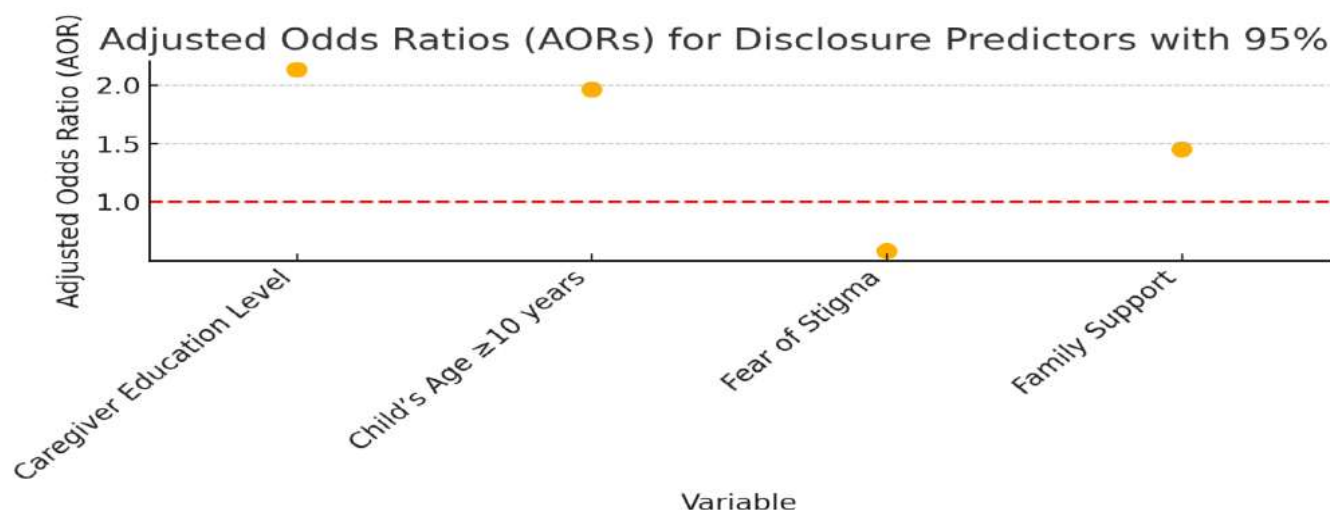


Figure 4
Logistic Regression AORs with 95% Confidence Intervals

4.2 Discussion

The results of the present research highlight the complicated nature of the socio-demographic, psychological, and cultural factors that affect the choice of caregivers regarding telling children about their HIV status and their further psychosocial impacts on the pediatric population. Most of the caregivers described the age and how mature the child is to be an important component of making the choice to share HIV status with the child. This compares with earlier research that has been done in Kenya and the sub-Saharan African region showing that caregivers tend to disclose their statuses to the older children equally because of presumptions about cognitive ability and emotional maturity level (Vreeman et al., 2010; Madiba, 2016).

Being emotionally prepared and possessing the capacity to understand the information HIV-related was also mentioned as an essential issue, which reflects the findings by Kallem et al. (2011), according to who, in case of fear of emotional harm, delayed disclosure is common. Moreover, family dynamics, cultural beliefs and fear of stigma were recruited by the caregivers as ones central to their disclosure decisions. The same was also observed in research done by scholars in Uganda and South Africa where the caregivers feared that there is a risk that children would accidentally reveal their status to others leading to discrimination (Lowenthal et al., 2014; Bikaako-Kajura et al., 2006).

Psychologically, there is anxiety, depression and diminishing self-esteem that may arise in children after disclosure. Such negative emotional responses were endorsed by more than 70 percent of caregivers in the study. This observation aligns with other studies conducted in Kenya and Ethiopia where the researchers noted an increase in the level of emotional distress among the children after a disclosure (Atwiine et al., 2015; Abebe & Tefera, 2012). Nevertheless, there are also long-term psychological advantages regarding disclosure described in particular studies, e.g. greater adherence to antiretroviral therapy (ART) and more effective coping with various situations (WHO, 2011).

In social aspects the response indicated that disclosure affected relationships of children with fellow children and relatives. Although disruption in the beginning is usually the rule, eventual disclosure could arouse more support and openness in the families. Urban caregivers have a greater tendency to disclose, possibly because of having more access to care education and psychosocial support services.

V. CONCLUSION & RECOMMENDATIONS

5.1 Conclusion

This study affirms that age, maturity, emotional readiness, cultural beliefs, and fear of stigma are significant factors shaping HIV disclosure practices. The psychosocial effects of disclosure, though initially challenging, may improve over time with adequate support.

5.2 Recommendations

Strengthen caregiver counselling to address fears and equip them with age-appropriate disclosure strategies. Enhance psychosocial support services for children post-disclosure to mitigate anxiety and emotional distress. Promote community-based education to reduce stigma and foster open dialogue around HIV. Develop policy guidelines on disclosure that are culturally sensitive and locally adaptable

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