

**THE PROPORTION,PROCESS DRIVERS AND FACTORS
ASSOCIATED WITH DISCLOSURE OF HIV STATUS AMONG
HIV INFECTED OLDER ADOLESCENTS AND YOUNG ADULTS
IN AMPATH, ELDORET, KENYA**

BY

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**A THESIS SUBMITTED IN PARTIAL FULFILLMENT OF THE
REQUIREMENTS FOR THE AWARD OF THE DEGREE OF
MASTER OF
SCIENCE IN CLINICAL PSYCHOLOGY**

MOI UNIVERSITY

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DECLARATION

Declaration

This thesis is my original work and has not been presented for a degree in any other University. No part of this thesis may be reproduced without prior written permission of the author and/ or Moi University.

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DEDICATION

This work is dedicated to my children, larger family, fellow classmates and staff at Moi University College of Health Sciences, for their support and input in this work. Above all I am grateful to the Almighty God for the far I have come.

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I wish to express my gratitude to my supervisors, Dr Juddy Wachira and Prof Benson Gakinya, Moi University, for their guidance in the entire process of writing this thesis. I also wish to thank the staff and young adults at Rafiki Center of Excellence-Academic Model Providing Access To Healthcare for supporting me during data collection at the clinic, I also wish to express gratitude to research assistants who collected data which was used to compile and write this thesis. Their cooperation, support and positive attitude made this process easier.

ABSTRACT

Background: Disclosing HIV status to sexual partners remains a significant challenge despite being associated with positive outcomes such as reduction of transmission, strengthening relationships, and decreasing risky sexual behaviors. Kenya has progressed in fighting HIV, however, current data indicate high numbers of infections particularly among teenagers and young adults accounting for 60% of new infections. There is limited research on HIV-status disclosure to sexual partners in young adults yet rising HIV infections rates threaten Kenya's goal to combat HIV by 2030 emphasizing the need for disclosure to sexual partners to reduce transmission.

Objectives: The objective of this study was to determine rates of HIV status disclosure to sexual partners, to explore disclosure experiences, and to explore factors associated with disclosure of HIV status to sexual partners among Adolescents and Young Adults Living with HIV (AYALWH) at AMPATH-Rafiki center between August and December 2023.

Methods: The study utilized a cross-sectional mixed method approach, integrating both quantitative and qualitative data collection techniques. Male and female AYALWH, 15-24 years attending Rafiki center were interviewed. 257 participants were selected through systematic sampling methods to complete structured questionnaires. Additionally, purposive sampling was utilized to recruit participants for focus group discussions (FGDs), where interview guides were employed. Quantitative data was analyzed using descriptive statistics to determine rates Chi-square tests were used to examine associations, with findings presented in tables. Qualitative data was transcribed, translated and coded thematically to capture disclosure experiences and factors influencing disclosure of HIV status to sexual partners. The study adopted a pragmatist research philosophy for better understanding.

Results: The study determined that the rate of HIV status disclosure to sexual partners among AYALWH was low at 36.6% (95%, CI=30.1%-43. 8%). There was notable variation of HIV status disclosure between age groups. Age group 20-24 had a higher proportion (65.7%) compared to 15-19(34.3%). Females were more likely to disclose than males (p-value of 3.84¹⁰). Positive and negative disclosure experiences were noted including: reduced anxiety and acceptance, relationship termination, psychological disturbance and increased anxiety. Barriers to disclosure included, fear of rejection, discrimination and perception of partner's reaction towards disclosure. Challenges experienced included, insufficient knowledge on how to disclose, denial, and fear of negotiating for safe sex. Some factors influencing disclosure included; individual economic status, partner's temperance and AYALWH's attitude towards HIV disclosure.

Conclusion: Study findings determined low rates of HIV status disclosure to sexual partners among AYALWH. While participants acknowledge the crucial role of HIV disclosure in minimizing infections, the study reveals significant knowledge gaps of effective disclosure strategies. Additionally, it highlights key challenges and barriers and lack of guidance which hinder successful disclosure.

Recommendations: To encourage disclosure among AYALWH, tailored strategies should be developed to address key barriers. Emphasizing positive messaging and resilience-building through sharing successful disclosure experiences could help mitigate fears. Additionally, interventions should consider economic support mechanisms to reduce financial barriers linked to rejection fears. By implementing targeted support programs, young adults can be better equipped to navigate the challenges of HIV status disclosure, ultimately contributing to reduced transmission rates.

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LIST OF ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
AMPATH	Academic Model Providing Access To Healthcare
APOC	Adolescent Package of Care
ART	Anti-Retroviral Therapy
ARVS	Antiretroviral drugs
HIV	Human Immuno-deficiency Virus
ICASA	International Conference on AIDS and STI in Africa
IPV	Intimate Partner Violence
MSM	Men Having Sex with Men
NACC	National AIDS Control Council
PEPFAR	President's Emergency Plan for AIDS Relief
POC	Point of Care
SDGs	Sustainable Development Goals
STIS	Sexually Transmitted Infections
UNAIDS	United Nations Program on AIDS
USA	United States of America
WHO	World Health Organization
AYALWH	Adolescent and Young Adults Living With HIV

DEFINITION OF TERMS

Adolescent- Individuals in the 10-19 years of age (WHO) who are in the phase of life between Childhood and adulthood.

AMPATH- A comprehensive care clinic that offer care and treatment for people living with HIV mostly in western parts of Kenya.

HIV Disclosure- The process of informing another person of one's HIV- positive status

Rafiki - Swahili term meaning “friend”

Rafiki Clinic- Is a youth friendly clinic offering comprehensive care for adolescents, youth and young adults.

Relationship status- Being romantically involved with another person

Sexual activity- an intimate activity that involves any form of intercourse between individuals.

Sexual partner – Individuals who engage in sexual activity together and share intimate moments, they may or may not be in a committed relationship.

Young adults -Individuals between the ages of 15 and 24 (WHO) generally in the years following adolescence.

Young adults living with HIV - Individuals between the ages of 15 and 24 generally in the years following adolescence who are HIV positive.

CHAPTER ONE

1.0 Introduction

This chapter introduces the study, outlining the background, research problem, objectives, questions, and significance. It also defines key terms and highlights the scope and limitations. The study explores factors influencing HIV status disclosure among young adults living with HIV using a mixed-methods approach.

1.1 Background of the study

Human Immuno-Deficiency Virus (HIV) has been a global health issue since it was declared a pandemic in 1981. Despite significant progress in combating the disease, the number of persons with HIV (PLWH) worldwide increased from 30.8 million a decade ago to 38.4 million in 2021 due to an estimated 1.5 million new infections (UNAIDS, 2022). Sub-Saharan Africa remains one of the most affected region, with approximately 25.5 million individuals living with HIV, accounting for 68% of the global population (UNAIDS, 2019). In Kenya, adolescents and young adults is representation of a vulnerable group with about 60% of the country's 1.5 million HIV-positive individuals falling within this demographic (NACC, 2021).

Young adults face an increased risk of HIV infection due to issues like stigma, delayed diagnosis, and reluctance to share their status with sexual partners (NACC, 2021). They become a vulnerable group that risk getting infected with HIV because of the transitioning stage that comes with physical development and the need to fulfill their sexual and reproductive desires. Disclosure is a critical step in preventing new infections, promoting adherence to treatment, and improving social and emotional well-being (Greene et al., 2019). Young adults often face challenges with HIV disclosure, making it difficult to maintain long term sexual relationships and increasing the likelihood of casual sexual encounters and risky sexual behaviors. Understanding the

factors influencing disclosure and its impact is crucial for developing effective intervention strategies. Failure to reveal one's HIV status to intimate partners contributes to poor treatment adherence, increasing the risk of treatment failure, and heightens transmission (Enane et al., 2018). Studies have shown that disclosure of HIV status to sexual partners promotes safer sexual behaviors and significantly boosts emotional and social support systems (Greene et al., 2019). To fulfill the global objective of eradicating the HIV pandemic by 2030, initiatives have emphasized the importance of encouraging disclosure, adherence to antiretroviral therapy (ART), and promoting safe sexual practices such as condom use. Carlson-Lalloo argued that most studies done in Kenya have focused on treatment access mostly to HIV positive adults while little attention has been given to young adult's sexuality and the challenges that come with talking about their HIV status to their sexual partners (Carlsson-Lalloo et al., 2016). Kenya has made major progress in combating the HIV virus among young adults, yet recent data still indicate high rates of new HIV infections in adolescents and young adults (AYALWH). Despite existing steps such as Prevention of Mother-to-Child Transmission (PMTCT), point-of-care (POC) technology for monitoring treatment, and support programs, disclosing to one's sexual partner remain a challenge (Mahy et al., 2021). Without standardized definitions and tracking tools to assess when, how, and with what outcomes disclosure occurs, evaluating its impact remains difficult (Iwu et al., 2017).

Despite global and national efforts to promote HIV disclosure, the actual prevalence of AYALWH disclosing to their sexual partners remains unclear. Limited data makes it challenging to assess how many young adults disclose to their sexual partners and the impact this has on their mental health, treatment adherence and HIV prevention. Given the challenges and vulnerability, health care providers advise AYALWH on safe

disclosure practices to sexual partners (Greene et al., 2019), however, it's unclear whether disclosure actually happens. Establishing accurate prevalence rates is essential for evaluating the effectiveness of disclosure initiatives and identifying gaps that hinder progress. The disclosure process is deeply personal and often influenced by emotional, psychological, and social factors, this study will provide a basis to understand the motivation to disclosure and the challenges that will also determine the attributes and strategies to disclosure. While some young adults report positive outcomes such as increased partner support and relationship stability others face stigma, rejection, or even violence (Nabunya et al., 2020) exploring disclosure experiences of young adults to their sexual partners can provide insight into the emotional and relational consequences, helping to shape support systems that make disclosure safer and more manageable. AYALWH weigh multiple factors before deciding to disclose their HIV status, including anticipated stigma, trust in their partner, the seriousness of the relationship, and concerns about confidentiality (Nabunya et al., 2020). Fear of discrimination, loss of relationships, or negative reactions often deter disclosure, while supportive environments, counseling, and education encourage it. Understanding these considerations is crucial for designing interventions that address the specific concerns of young adults and empower them to make informed disclosure decisions.

1.2 Statement of the Problem

HIV is a condition that young adults manage for life and are required to make complex decisions regarding their sexual and reproductive health. Without sufficient data it will be difficult to create and implement effective strategies that could encourage AYALWH to disclose to their sexual partners in order to minimize negative disclosure outcomes. Despite global and national efforts, young adults remain disproportionately affected, particularly in Sub-Saharan Africa, where HIV prevalence is highest. In

Kenya, adolescents and young adults account for approximately 60% of new HIV infections (NACC, 2021). While interventions targeted for young adults such as antiretroviral therapy (ART), safe sexual practices, and prevention programs have been emphasized, disclosure of HIV status to sexual partners remains a critical yet complex challenge. NACC in its recent report expressed concerns that Kenya may not achieve its goal of combating HIV by 2030 and therefore not achieve its Sustainable Development Goals (SDGs) if the current wave of new infections among young adults is not contained (NACC, 2021). Non-disclosure of HIV status significantly undermines global efforts to combat the HIV epidemic by 2030 given that it is associated with increased HIV transmission, poor adherence to treatment, and heightened emotional distress. Although disclosure can promote safer sexual practices, strengthen relationships, and enhance social support, many young adults hesitate to disclose due to stigma, fear of rejection, and uncertainty about their partner's reaction. The lack of standardized guidelines and tracking mechanisms further complicates the evaluation of disclosure practices, making it difficult to assess their prevalence and impact. Addressing the issue of non-disclosure is also crucial for achieving the global target of ending the HIV epidemic by 2030.

Existing research (Mugo et al., 2021, Agot et al., 2020) in Kenya has primarily focused on HIV treatment access for adults, with limited attention to young adults' experiences and challenges in disclosing their HIV status. There is need to examine the rate of HIV disclosure among young adults, explore their experiences, and identify the factors influencing their decision to disclose. Understanding these aspects is crucial for developing targeted interventions that support young adults in making informed disclosure decisions, thereby reducing new infections and improving overall well-being.

This study sought to address these gaps by investigating the prevalence, experiences, and influencing factors of HIV disclosure among AYALWH. The findings provided valuable insights for policymakers, healthcare providers, and support programs in enhancing HIV disclosure strategies and ensuring better health outcomes for AYALWH. Additionally, addressing these disclosure gaps also played a crucial role in young adult's mental health, providing safe

1.3 Justification of the study

Ending the HIV epidemic by 2030, as set by UNAIDS, heavily relies on increased awareness, prevention, treatment adherence, and behavioral change influenced by disclosure of HIV status to sexual partners. However, the persistent challenge of non-disclosure among young adults poses a significant barrier to achieving this goal. Globally, Kenya holds the seventh-largest HIV burden and was third in ranking among the Eastern and Southern African countries in new infections according to UNAIDS in 2017 (UNAIDS, 2017). These statistics underscore the ongoing challenges Kenya faces in combating HIV/AIDS, particularly among its young adult population (NACC, 2021). Focus needs to be put to examine how AYALWH experience and think about their sexual relationships, reproduction and their quality of life in order to support them adequately. It also helps understand effective ways of revealing without having regrets and with minimal negative effects to their mental health and social life. To demonstrate this the study results will also be helpful to reduce the number of infections to sexual partners. MOH's adolescent package of care (APOC) guidelines put emphasis on disclosing HIV status to children by their parents but it is not clear how disclosure practices for sexually active young adults should be done especially to their sexual partners(NACC, 2021).

The effectiveness of disclosure needs to be thoroughly researched and documented. Disclosure of HIV status to sexual partners by AYALWH will significantly reduce the number of new infections in this population. Study done by Mkumba has shown that AYALWH suggested a need for more research on comprehensive sex education to facilitate desirable outcome and an intervention on status disclosure to sexual partners (Mkumba et al., 2021). This study is essential in shaping effective public health interventions, mental health support systems, and policy reforms aimed at increasing HIV disclosure rates. By addressing the barriers and facilitators of disclosure among young adults, the research will contribute to global and national efforts to curb HIV transmission, promote safer sexual behaviors, and improve the overall well-being of people living with HIV.

1.4 Significance of the study

This study aims to examine the prevalence of HIV disclosure among young adults, assess their experiences, and explore the factors influencing disclosure decisions. Understanding these aspects is crucial in determining whether disclosure is occurring as advised by healthcare providers during clinic visits. If disclosure rates are low, identifying the challenges and barriers young adults face will provide insights for developing targeted interventions. By addressing these determinants, policymakers and healthcare providers can establish supportive policies and strategies that promote safe and voluntary disclosure, ultimately contributing to a reduction in new infections among young adults.

The study aligns with the global goal of eliminating HIV/AIDS by 2030 by addressing the gaps that hinder effective disclosure and safe sexual practices. Given the rising number of new infections among young adults (NACC, 2021), there is reason to believe that casual unprotected sex and lack of disclosure to sexual partners contribute

significantly to the spread of HIV. Identifying the barriers and determinants of disclosure is essential in developing interventions that empower young adults living with HIV (AYALWH) to make informed decisions about disclosure, improve communication skills, and navigate partner reactions effectively (Dessie, 2022).

Beyond reducing HIV transmission, this study has mental health implications, as non-disclosure can lead to significant emotional, psychological, and social distress (Greene et al., 2019). Fear of stigma, rejection, and discrimination often prevents disclosure, leading to anxiety, depression, and social isolation. Disclosing to a trusted partner can provide emotional and psychological support, enhancing mental well-being and relationship stability. By addressing these concerns, the study will contribute to reducing the psychological burden associated with secrecy and stigma.

Additionally, this research will highlight systemic and social challenges that hinder disclosure, contributing to advocacy efforts aimed at normalizing discussions about HIV among young people. Increased awareness and openness can help combat misinformation and reduce fear surrounding disclosure. The study will also identify gaps in service delivery, helping to improve counseling, disclosure support mechanisms, and tailored interventions for AYALWH.

Finally, the findings will provide evidence-based recommendations for shaping HIV policies and interventions in Kenya, with the intention of reducing HIV transmission rates, enhancing social support systems, and improving the overall quality of life for AYALWH. Furthermore, by identifying gaps in the existing literature, this study will guide future research on disclosure practices, re-emergence of HIV stigma in young adults, and effective strategies for promoting safer sexual behaviors among AYALWH.

1.5 Scope and limitation

The study was carried out in Eldoret Kenya among AYALWH particularly those receiving HIV care and support from MTRH-Rafiki clinic. The study utilized a cross-sectional mixed method approach, integrating both quantitative and qualitative data collection techniques, focusing on the rates of HIV status disclosure to sexual partners among AYALWH, disclosure experiences and the factors influencing disclosure of HIV status to sexual partners among the young adult population. The study was carried out between August and December 2023.

Findings of this study depended on self-reporting and considering the sensitive nature of the study topic, it could be subject to social desirability and recall bias. To minimize the effects of this, participants were assured of confidentiality and were at liberty to discuss only what they felt comfortable to share.

The topic of the study is a sensitive and complex issue that impacts differently on individuals considering gender disparities. To minimize this limitation the researcher interviewed males and females separately to ensure openness and ease during discussions.

1.6 Research questions

1. What proportion of AYALWH have disclosed their HIV status to their partners?
2. What are the factors associated with disclosure of HIV status to sexual partners among AYALWH?
3. What are the experiences of AYALWH in disclosing their HIV status to their sexual partners?

1.7 Objectives

1.7.1 Broad Objective

To assess the determinants of HIV status disclosure to sexual partners among HIV-positive young adults.

1.7.2 Specific objectives

1. To determine the rate of HIV status disclosure to sexual partners among young adults living with HIV at the AMPATH-Rafiki clinic.
2. To examine factors associated with disclosure of HIV status to sexual partners among AYALWH at AMPATH-Rafiki clinic.
3. To explore the experience of AYALWH in disclosing their HIV status to their sexual partners at AMPATH-Rafiki clinic.

CHAPTER TWO

2.0 LITERATURE REVIEW

2.1 Theoretical Framework

The study applied Azjen's (1985) Theory of Planned Behaviour (TPB) which suggests that an individual's decision to perform a specific behavior can be predicted by their intention to do so. TPB often provides insights into the proportion of people involved in risky behaviors and connects beliefs to actions. This theory was deemed suitable for understanding how individuals manage the disclosure or concealment of private information, such as revealing their HIV status. Three key factors influence the theory of planned behavior:

Personal attitudes: This is individual's attitude towards a particular behaviour, it sums up knowledge perspectives and prejudices both positively and negatively that come to mind when we think of the behaviour.

Mental health plays a significant role in shaping young adults' attitudes toward disclosure. Positive attitudes, such as believing disclosure will lead to emotional relief, strengthened relationships, or improved mental well-being, may encourage disclosure. Conversely, negative attitudes driven by fears of stigma, rejection, or shame are significant barriers that can be explored through TPB

Subjective norms: This considers our view of other people towards a certain behaviour, this includes the attitude of those close to you like family, spouses, friends and workmates. It is not about what other people think but how we perceive other people's attitudes.

Perceived social expectations and support are closely linked to mental health outcomes. Young adults who feel supported by family, friends, or healthcare providers may experience reduced anxiety and greater confidence in disclosing their status. TPB

provides a lens to examine how these subjective norms influence mental health and disclosure intentions.

Perceived Behavioural control: This refers to how much we believe we can control our actions which is based on our perception of internal factors. This theory suggests that our perception of behavioral control has two key impacts: first, it influences our intentions to act in a certain way, where the more control we believe we have, and the stronger our intention to carry out the behavior. Second, it directly affects our actions, as a greater sense of control motivates us to put in more effort and persist longer to achieve success. The theory of planned behavior aligns with Bandura's concept of self-efficacy.

Mental health challenges such as depression, low self-efficacy, or fear of partner reactions can reduce perceived control over disclosure decisions. On the other hand, access to mental health support, counseling, or tools for effective communication can enhance PBC, making disclosure more likely. TPB allows for an analysis of how these factors interplay with mental health and shape disclosure behavior.

Behavioral Intentions and Mental Health:

Behavioral intention, as a mediator in TPB, is directly influenced by mental health. A young adult struggling with fear or anxiety may have lower intentions to disclose, even if they recognize its benefits. TPB helps capture how these mental health dynamics influence the intention-to-action process.

By applying TPB, this study can explore how mental health factors such as anxiety, stigma, emotional resilience, and self-efficacy influence HIV disclosure. This approach provides valuable insights into designing interventions that address both psychological

and social determinants, ultimately promoting healthier disclosure practices and improving mental health outcomes for young adults living with HIV.

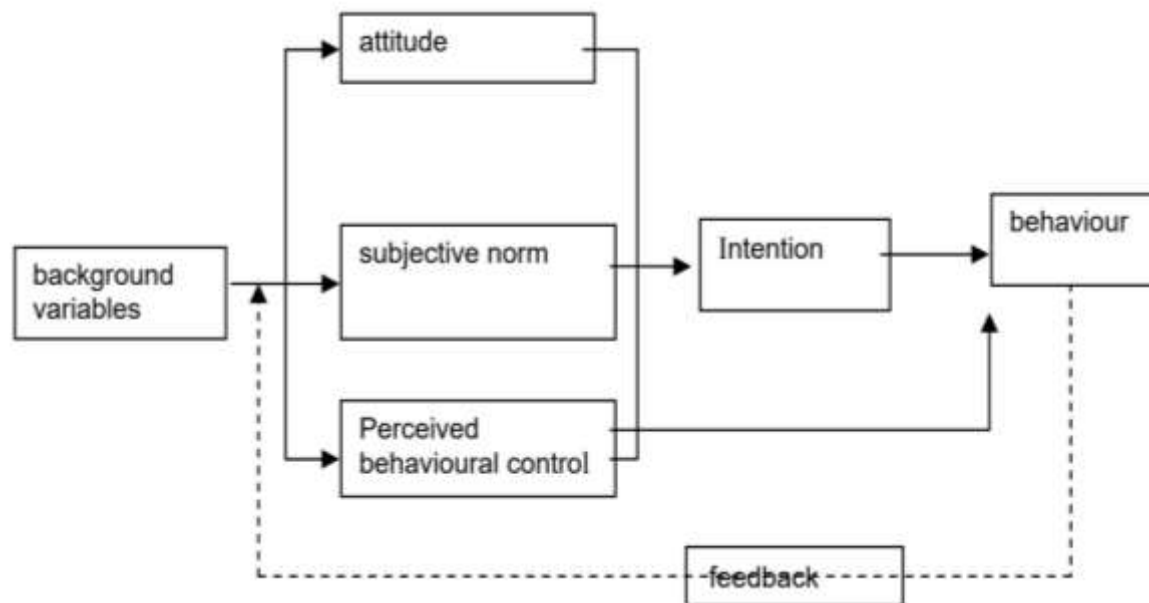


Figure 1: The Theory of Planned Behaviour

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2.2 Factors influencing Partner HIV status disclosure

To prevent new infections, sexual partners need to disclose their HIV status, adhere to treatment, and maintain HIV suppression. Knowing a partner's HIV status was mentioned in a systematic review as one of the contributing factors that motivated individuals to disclose their HIV status in 98.8 % of studies that were involved in the analysis (Yehualashet et al., 2020). Motivation to disclosure has been attributed to the belief that knowledge of partners' HIV status diffuses blame, fear and shame that result from disclosure of HIV status and makes disclosure easy for the person disclosing (Yehualashet et al., 2020).

HIV status disclosure complicates relationships with sexual partners, which makes complete disclosure or motivation to disclose low. Despite patient counseling, the fear of social isolation prevents patients from informing their partners about their HIV status

(Frimpong et al., 2022; Odiachi et al., 2018). Fear of desertion, emotional abuse, and sex deprivation were some of the obstacles to disclosing to sexual partners in a study of pregnant HIV-positive women in Nigeria (Odiachi et al., 2018). Readiness to inform sexual partners of their HIV status and disclosure rates varied between HIV-infected women and those who successfully disclosed, those who successfully disclosed had sought assistance from healthcare workers. Another systematic review among 7 countries across Africa identified partner violence especially against girls and young women as a barrier to safe sex negotiation despite higher knowledge on the importance of disclosure (Frimpong et al., 2022) in addition to these, a study in Tanzania determined disclosure experiences where individual faced negative consequences such as rejection by a sexual partner and loss of support as barriers to disclosure (Ismail et al., 2021; Iwu et al., 2017). Neelam Ismail's review concluded that because of delayed disclosure, some participants engaged in regular unprotected sex as they could not negotiate for condom use for lack of sufficient justification (Ismail et al., 2021).

2.3. Prevalence of disclosure to sexual partners

An essential part of preventing or reducing new HIV infection is disclosing one's HIV status to a sexual partner. This is one of the strategies that has been used to motivate partners' behaviour change and testing and improve social support (UNAIDS, 2018). In the United States of America (US) 1 in 5 new cases of HIV occur among adolescents and youths aged between 13 and 25. 93% of HIV diagnosis was attributed to same sex sexual contacts and 40 % among the young adult population who were also unaware of their HIV status (Agwu, 2020; Yehualashet et al., 2020). HIV disclosure has been advocated majorly by WHO, but its prevalence varies between countries (WHO, 2011). As a result of the varied disclosure rates in China, the country's overall disclosure position could not be accurately represented. The prevalence of disclosure is lowest in

developing countries according to a systematic review done by Frontiers in public Health, 2022. Infection rates is also generally high among sexual partners in South Africa and most Sub Saharan Africa countries (Iwu et al., 2019) Many high school students in Africa are engaged in sexual risk behaviours that relate to unintended pregnancies and STIs, including HIV infection (Agwu, 2020). In a study done in Siaya County, Kenya, 84% of study participants had disclosed their HIV status to their sexual partners, 10% had not disclosed and do not intend to disclose, this was attributed to participant's wish maintain their privacy (Burmen et al., 2017). While there is overwhelming evidence on potential benefits of disclosure, very few studies have given focus on the essentials and implications of disclosure of HIV status to young adult sexual partners. Additionally, there are low disclosure rates among the young adult population due to the fear associated to potential adverse outcomes and stigma (Grainger, 2017). More discussions about decision making, disclosure of HIV status to sexual partners, healthy relationships and prevention of sexually transmitted infections should be encouraged since there is a wide range of sexual behaviours and activities among young adults(Agwu, 2020). Given the high prevalence rate of non-disclosure of HIV status to sexual partners, and sex being the main transmission route, important strategies to increase the rate of disclosure to young adult sexual partners will be important in developing more detailed disclosure strategies and exploring the determinants associated with the disclosure of HIV status among AYALWH.

According to research conducted in Kayole, Nairobi County by Mugo et. al. (2021), of the 96 YLHIV, 78% were female, 33% were between the ages of 14 and 18, and 40% had contracted HIV during pregnancy. 67% of YLHIV had self-disclosed to family members and 43% to non-family people about their HIV status. Comparing YLHIV aged 14–18, they were 75% less likely to have self-disclosed. 45 (66%) of the 68 people

who were married or had ever engaged in sexual activity did not tell their spouses. The study concluded that in order to reduce psychosocial effects, YLHIV should get support during self-disclosure (Mugo et al., 2021).

In Western Kenya, Abuogi et. al. (2020) conducted research on HIV status disclosure patterns and male partner reactions in pregnant HIV-positive women receiving lifelong antiretroviral therapy. The study presents a descriptive analysis of disclosure patterns together with a multivariate analysis of characteristics linked to reactions from male partners. 95.5% of the 180 (90%) women who said they had a male relationship also said they had told him they were HIV positive. Eighty-eight percent of the women indicated that disclosure happened within a year of their diagnosis, and sixty-seven percent of them within a week. The three most common ways that information was disclosed were during couple's HIV testing and counseling (CHTC) (31.5%), during prenatal care visits (7.7%), and through self-disclosure (55.4%) (Abuogi et al., 2020).

Kenyan women's characteristics linked to their disclosure status to sexual partners were investigated by Greene et. al. (2019). A cross-sectional study involving 497 HIV-positive women aged 19–49 who had intercourse within the previous six months was carried out between May and August of 2012. 349 of the 497 women said they had told someone about their HIV status. About one-third had told a sexual partner they were HIV positive. Women who told their sexual partners were four times more likely to be the heads of their households and eleven times more likely to be married or in a common-law partnership (Greene et al., 2019).

In a study employing a case-control study design, Nyandat and van Rensburg (2017) found 180 mother-child pairs whose newborns had been exposed to HIV. To ascertain whether disclosure—or lack thereof—of one's HIV status to one's partner increased the

risk of mother-to-child transmission of HIV (MTCT), thirty-six pairs with HIV-positive babies (cases) were contrasted with 144 pairs with HIV-negative babies (controls). Four control pairings from the same facility were matched with each case pair. In general, 16.7% of moms had not told their partners they were HIV positive, with the percentage being significantly higher in cases (52.8% vs. 7.6%, $p < 0.001$). Male partner participation largely mediated the effect of non-disclosure on child HIV acquisition (indirect coefficient = 0.17, $p < 0.005$). Non-disclosure was substantially linked with infant HIV acquisition (aOR 9.8 (3.0–26.3); $p < 0.001$) (Nyandat & van Rensburg, 2017).

2.4 Relationship status and HIV disclosure status.

Couples living separately or in casual relationships have less chances of telling their sexual partners about their HIV status compared to those married and living together, the study from Central African Republic attributed the results to negligence among the unmarried whose focus was on getting married and childbearing which create fear of abandonment and as a result they keep quiet about their HIV status (Diemer et al., 2018; Tibebu et al., 2023a). A cross-sectional research conducted in South Africa, married women were more likely to disclose their HIV status but less likely to do so if they were married but lived apart (Adeniyi et al., 2021). Similar results were noted in another study conducted in Tanzania, results indicated that 34% of participants had concealed their HIV status from their sexual partners given that they were in a steady relationship but not living together. The study recruited 672 participants aged 15-49 of this, 81.6% of the married or in long-term relationships had disclosed their HIV status and 78.6% were using protection during sex with their partners following disclosure. According to the study findings, long-term partners and married people were six times more likely to reveal than short term partners. The study found that those on contraceptives and used

protection had increased odds of disclosure than those who did not (Jeremia et al., 2019). A similar study done in Uganda showed lower results of 57% disclosure rates among the married and 58.4 % Ramlagan S, (2018) of similar participants in South Africa (Ngonzi et al., 2019; Ramlagan et al., 2018). The discrepancy in these results was attributed to the study settings where studies done in the urban areas gave different results compared to those done in rural settings. It is argued that those in urban settings easily access knowledge, information and counselling resources as compared to those in rural settings resulting in greater likelihood of telling their sexual partners they are HIV-positive (Tibebu et al., 2023a). In Uganda, it is reported that in discordant couples, about 60% of the negative partners seroconvert and 30% of the married have a HIV negative partner, non-disclosure among this population fuels HIV transmission to the negative partner (Conserve et al., 2015). The findings support previous research conducted in Ethiopia, highlighting the importance of disclosure in increasing awareness and minimizing risky behaviors related to HIV-positive status. This study systematically reviews and analyzes the prevalence and determinant factors influencing disclosure in the Ethiopian context. (Yehualashet et al., 2020).

Despite high numbers of reported successful disclosure rates among married and long-term sexual partners, most of these studies focused on women mostly than men, despite significant efforts to urge and remind women to bring their spouses for HIV-related care, men's attendance at health facilities is quite low in most African contexts, including Kenya (Agot et al., 2020). Disclosing to male sex partners was a major barriers to HIV care engagement according to Nyandat's findings (Nyandat & van Rensburg, 2017). The studies also focused on adult population and little attention has been given to young adults whose sexual needs are based on their stage of physical and emotional development more than their marital status. Little focus on young adult's

sexual challenges deters the global goal of ending the pandemic by 2030 since it increases the risk of transmission given that HIV prevention and control are dependent on successfully preventing new infections.

The disparity in research results on the relationship between gender, relationship status, compared to disclosure of HIV status is explained by the possibility that other variables, such as perceptions about the consequences of disclosure, may have a higher impact on disclosure than gender.

2.5 Educational level and disclosure of HIV status.

Reduction in number of HIV infections has been successful since much efforts to create awareness on infection prevention and increase in the uptake of anti-retrovirals was emphasized. Individuals who participated in HIV associations benefit from knowledge and experiences shared by other members as evidenced by a study done in Brazil(Yehualashet et al., 2020). In a study done in Iran on women, public media was mentioned as an effective factor that aided HIV disclosure to sexual partners. This study mentioned awareness as a successful intervention that aided in reducing new infections. Studies done at that time suggested providing support to encourage individuals to safely disclose to sexual partners (Pashaei et al., 2022) However, in as much as educational level and increased knowledge increased the odds of disclosure, a study in China came to a different conclusion whereby higher levels of education were associated with lower disclosure rates among PLWHA, which was linked to elevated perceptions of stigma related to HIV

A study in Ghana associated high disclosure levels and increasing years in ART among the working class and the educated, they cited financial stability and increased social domain that enhanced a circle of enlightened friends who easily accept and integrate with the HIV positive individuals hence creating a sense of worth and importance

among them(Adam et al., 2021). The findings of this study align closely with those of a Ugandan research project. Among women lacking formal education, individuals who attained a secondary education or higher demonstrated a significantly increased likelihood of disclosing their HIV status. Specifically, the probability of disclosure was found to be 2.69 times greater for those with higher educational qualifications compared to their counterparts with lower levels of education. Awareness of disclosure, its importance and counseling services with ongoing disclosure discussions can enhance the confidence surrounding the disclosure discussion among sexual partners(Ngonzi et al., 2019). Similar results were noted by Toska in his review on adolescents and young adults' disclosure to sexual partners, he noted that knowledge of HIV and access to HIV support groups reduced sexual risk taking behaviours while increasing chances of disclosure to sexual partners (Toska et al., 2017).

In 2014, Kenyan government motivated by results from findings in the sub-Saharan Africa cited knowledge and education as social vaccine for the cure of HIV-virus on the basis that HIV is controllable, manageable and preventable. This could be realized by changing of attitudes that result to stigmatization and encouraging individuals to disclose HIV status leading to safer sexual practices hence reducing number of new infections to the sexually active sexual partners (Enane et al., 2018; Vreeman et al., 2013)

2.6 Economic status and disclosure of HIV status

In United States homelessness was linked to increased rates of STIs including HIV. In a study involving young adults 18-25 years old 29% of participants reported engaging in unprotected sex with a non-committed sexual partner and 11 % reporting exchange sex(Madden et al., 2021). The prevalence of increase in HIV infection among the homeless was between 2% and 8% Musyoki H. et al, (2015) and the African continent

has been hardly hit by high cases of HIV infection fueled by high levels of poverty (Musyoki et al., 2015). A cross-sectional analysis in South Africa determined an association between high numbers of new HIV infection and transactional sex in young women 13-24 years old fueled by high levels of poverty and unemployment (Ranganathan et al., 2016). Among the young adult population, sex for exchange of favors is prevalent, this may be in form of favors or cash. Chiang J.C et al (2022), young girls are more likely to get infected with HIV more than young men, the odds of getting infected for a young girl is 4 times more than that of a boy (Chiang et al., 2022; Ranganathan et al., 2016).

In Ethiopia, economic circumstances were found to be at the center of disclosure especially among women who depended on their spouses for financial support (Tolossa et al., 2021). Additionally, the decision to not disclose is further cemented, when social norms and family dynamics do not advocate for equality among women leading to helplessness and anxiety (Naigino et al., 2017). In Kisumu Kenya, according to an internet article sponsored by U.S President's Emergency Plan for AIDS Relief, (PEPFAR) in 2019 cited that lack of economic opportunities has made women who depend on selling fish powerless, and due to cultural issues where women are not allowed to go fishing, they rely on fishermen to provide fish and in return, they pay using sex. While being interviewed, these women disclosed that HIV infection prevention was not an idea that came to mind as long as they got fish to sell. As a result, the fishing community in Kenya has a high prevalence rate of HIV between 30% and 40% which is an enormous public health issue.

These findings were in agreement with those of a previous study, which determined that young females frequently participated in transactional intercourse and with several

partners while influenced by alcohol and drugs, which raises their risk of contracting HIV. This is likely owing to financial hardships (Ott et al., 2011; Prudden et al., 2015).

Men expressed the anxiety about ending a relationship, but women typically expressed worry of losing both social and financial assistance they received from their partner and of potential violence resulting from disclosure (Bhatia et al., 2017).

2.7 Stigma and disclosure of HIV status

Stigma and prejudice around HIV have been a significant obstacle in the battle against HIV, given that HIV disclosure among sexual partners leads to responsible healthier behaviours. Stigma is reported by researchers as a major player in HIV status disclosure across Sub-Saharan Africa (Bonnington et al., 2017). Blame, rejection, and discrimination are just a few of the various ways that HIV-positive individuals (PLWH) are subjected to stigma. Adam A., 2021 argues that internal stigma is common among PLWH and community stigma has a great impact on disclosure of HIV status and towards ending the HIV epidemic. In his study Adams concluded that internalized stigma was more prevalent among women and 79% of his participants demonstrated internalized stigma, however, levels of internalized stigma varied with high, average and minimal levels (Adam et al., 2021). Previous studies have shown that potential of stigma make PLWH to engage in risky behaviours and hinders their intention to disclose to sexual partners resulting to re-infection and the continuous spread of HIV.

According to a Ghanaian research on the link between stigma and disclosure, 21% that had withheld their HIV status information from their intimate partners did so out of fear of rejection, shame, or divorce and 57% who were the majority indicated that they wanted to maintain their private status (Arrivé et al., 2018). These findings were consistent with those done in Kenya (Colombini et al., 2016) and Cape town, South Africa (Brittain et al., 2018).

2.8 Beliefs and attitudes of HIV disclosure

The greatest numbers of HIV-positive people are found in South Africa, Nigeria, and Kenya (Tibebu et al., 2023b). Despite the great progress in approaches aimed at reducing new infections, there is still a significant number of individuals who are testing positive for HIV, this is due to the decrease in use of protective measures such as inconsistent condom use, as reported in the performance monitoring report 2020, this has been noted especially among the young adult's population. This is ascribed to a number of factors, including perceived shame, individual risk, peer pressure, and betrayal by a prior partner (NACC, 2021). The results are similar to those done in a systematic review, reviewing 35 studies on risky behaviours among young adult population by Toska, studies in sub-Saharan Africa reported increased numbers of unprotected sex and low numbers of disclosure despite increased interventions to reduce sexual risks (Toska et al., 2017). In Uganda, many had several partners while being aware of their HIV status and experienced trouble telling their significant others because they were afraid of repercussions including violence and allegations of promiscuity and adultery (Klabbers et al., 2021). As a result use of protection was compromised, there were reports that indicated that sexual partners feared disclosure after testing since it was believed that the first person to test positive was responsible of infecting the other and for fear of being falsely accused individuals resulted to keeping quiet (Klabbers et al., 2021).

According to Kassede S in 2015, further research is required to clarify how HIV status, beliefs about disclosure, and its related attitudes interact to influence sexual and reproductive outcomes. This understanding is crucial for vulnerable groups like young adults (Kassede S. 2015). It also looks into how non-pregnant women see the works of health professionals in noticing and combating Intimate Partner Violence (IPV) as well

as how they could contribute to unfavorable outcomes by not paying close attention to the dangers of disclosing their HIV status to partners. The conclusions point to the need for health practitioners to exercise greater caution by presenting substitute models for partner disclosure.

2.9 Past disclosure experiences

In 2008, Julianne M Serovich studied the consequence theory. Here, rewards and the cost of disclosure are assessed and weighed before disclosure occurs and the outcome is generated which involves disclosure or non-disclosure of HIV status(Serovich et al., 2008). The study however noted that how the process occurs is dependent on the expected outcome and the positive or negative rewards which focused more on individual's instrumental or expressive needs. Disclosure of HIV status can easily contribute to depressive symptoms. Laurie Abler assessed depression and HIV status disclosure among men who have sex with men (MSM) in New York and in this study, heightened emotional distress following disclosure was noted(Abler et al., 2015). This emotional distress greatly influences current or future relationships among these populations. The desire for social support necessitates disclosing one's HIV status, but the motivation and likelihood of disclosure can be shaped by previous experiences and the potential stigma that may follow (Fifield et al., 2018). Relationship dynamics influenced the intention to disclose, while men feared loss of relationship, women were afraid of potential violence as a result of disclosure, this happened mostly to those with previous experiences with violence and some were currently in abusive relationships (Bhatia et al., 2017). Where an individual anticipates for negative outcome after disclosure of HIV, chances of disclosure are low as explained by the theory of competing consequences.

CHAPTER THREE

3.0 METHODOLOGY

This chapter describes the research design and methodology used in this study. It entails an outline of the research design, study area, sampling procedures, data collection, data analysis and ethical issues.

3.1 Study design

The study utilized a cross-sectional mixed-method approach, integrating both qualitative and quantitative data collection techniques. Quantitative phase offered socio-demographic insights and determined the rate of disclosure of HIV status in young adults to their sexual partners. Qualitative data aimed to offer descriptive insight on influencing factors of HIV status disclosure to sexual partners and explored their experience on disclosure. Additionally, it helped explore recommendations for safe disclosure practices to young adult's sexual partners.

3.2 Study area

Academic Model Providing Access to Healthcare (AMPATH) is a program offering comprehensive care, located in the Western Part of Kenya. It is located in Uasin Gishu County with an estimated area of 3,392.2 km² within Eldoret town along Nandi Road, inside Moi Teaching and Referral Hospital and Moi University School of Medicine. AMPATH serves the health-related needs for the HIV-infected individuals and has enrolled about 150,000 people living with HIV since the year 2001. In 2016 AMPATH opened an adolescent clinic called Rafiki (Swahili word meaning “friend”) Center, with the intention to reach out to adolescents and young adults comprehensively and in a friendly manner, considering the physical, mental health, and social challenges that are unique to young adults. Being one of the largest HIV/AIDS centers in Africa, it offers services to adolescents and the youth of Eldoret town and to the western parts of Kenya with a few others from different parts of the country. AMPATH-Rafiki clinic has a total

population of approximately 780 youths, and it is required to serve a wide range of young adults from across the country and majorly from the Western parts of Kenya making it a perfect site for research-related activities, especially in the study concerning sexually active young adults an area that has not been studied systematically.

Study objective 1:

1. To determine the rate of HIV status disclosure to sexual partners among young adults living with HIV.

3.3 Study Population

The study population were 257 AYALWH between 15 -24 years both male and female receiving care from AMPATH-Rafiki clinic, Uasin Gishu County.

3.4 Eligibility Criteria

3.4.1 Inclusion criteria

- a) Young adults living with HIV
- b) AYALWH with full knowledge of their HIV diagnosis at the time of enrollment
- c) Are enrolled in care at the study site prior to study enrollment
- d) Are 15-24 years old (inclusive) on the day of enrollment

3.4.2 Exclusion criteria

- a) Those who are visibly intoxicated.
- b) Those unable to understand the consenting process. This will be assessed through the UBACC assessment tool.

3.5 Sample size determination

Cochran's formula: (Cochran, 1977), was used to calculate the sample size. Infinite formula $[n = \frac{Z^2 pq}{e^2}]$ n = the desired sample size z = the value confidence level of 1.96 (95%),

$p = 0.5$ Proportion of disclosure (Lesch et al., 2007)

$$q = 1 - p$$

$e = 0.05$ (desired level of precision) $[(1.96)^2 \times (0.5 \times 0.5)] \div [(0.05)^2]$ $n = 385$ finite
Cochran's formula. $n = [n_0] \div [1 + (\{n_0 - 1\} \div N)]$ **Where n-** reduced sample size.

n_0 - initial calculated sample size.

N- Population size.

$$n = [385] \div [1 + (\{385 - 1\} \div 780)]$$

n= 257 participants

3.6 Sampling Procedure for quantitative data

Quantitative sample was collected using systematic sampling procedure where every second patient coming to the clinic was approached and if they agreed to participate, they were consented and recruited into the study. Questionnaires were administered to every participant who consented and was willing to participate.

Study objective 2 and 3: qualitative data

2. To explore the factors associated with disclosure of HIV status among AYALWH at AMPATH-Rafiki clinic.

3. To explore the experience of AYALWH in disclosing their HIV status to their sexual partners at AMPATH-Rafiki clinic.

3.7 Sampling procedure for qualitative data

The qualitative data was collected purposively from the initial sample of 257 participants. The sample was then split into 2 clusters one for those who had disclosed their HIV status to their partners and one for those who had not. Convenience sampling was used to recruit participants for the focus group discussions (FGDs). An interview

guide was employed to facilitate the discussions, which were structured around key topics including participants' experiences with HIV status disclosure, factors influencing disclosure decisions, and their recommendations for promoting safe and supportive disclosure practices among young adults living with HIV. Because of the sensitive nature of discussions individuals who were readily accessible took part in focus group discussions. Guetterman & Guetterman, 2015 came into a consensus that the sample size in qualitative studies is smaller compared to sample size in a quantitative study. This is guided by saturation which is achieved by 12 participants where no new information can be derived (Guetterman, 2015). For this study, FGDs of between 6-12 AYALWH participated in the discussions for each cohort, a total of 4 focused group discussions were conducted, each gender (those who had disclosed and those who had not) were interviewed separately to allow ease and openness of discussion for generation of rich data.

3.8 Data Management Plan

Training of research assistants was done to ensure adherence to protocol and understanding of the study purpose, goals, and objectives was achieved. Additionally, data collection procedure and adherence to ethics were emphasized.

Data collected was stored under lock and key in well-secured cabinet and will be stored for a maximum of 5 years after which it will be shredded and disposed off. Following data collection, data entry was done in an Excel sheet in a protected password-protected file and computer. Any incomplete questionnaire with missing data or without a signed consent was not included in the analysis. The data was encrypted, and only authorized study personnel had access to the data.

3.8.1 Data collection procedure

To gather quantitative information, a semi-structured questionnaire was utilized. English questionnaires were translated into Swahili, verification was done to the translated version and back translation was done to ensure that the original intended message was not lost during translation. Participants were given the option to choose their preferred language and those who preferred to be interviewed in Swahili were accommodated. The initial part of the questionnaire gathered demographic information, including age, religion, relationship and economic status among other details. Data on disclosure (such as whether the patient reported their status, to whom, and in what sequence), was collected in the second section. Skilled research assistants with prior experience in collecting data for health research collected data using a structured survey questionnaire to assess the rate of disclosure. After obtaining informed consent, participants completed a series of questions, including demographics, some questions were adapted from WHO sexual survey questionnaires and from a prior study by Vreeman et al., (2004). The next section provided an interview guide for qualitative data collection on participant experiences with disclosure to a current or former sexual partner and information about safe disclosure practices among this population. It also helped to identify the factors associated with the disclosure of HIV status to sexual partners.

3.8.2 Data analysis for quantitative data

Version 21 of the Statistical Package for Social Sciences (SPSS) was utilized in the analysis of the quantitative data. Categorical variables were assessed for association with the categorical outcome variable (HIV status disclosure) using Pearson's Chi-square test. The results were reported using descriptive statistics, and tables were utilized to summarize the numerical data.

Variables found to be significant in bivariate analysis were further analyzed using binary logistic regression to adjust for potential confounders. The outcome variable was HIV status disclosure, coded as a binary outcome (Yes = 1, No = 0). Predictor variables included age, gender, income group, and mode of HIV transmission. Odds ratios (OR), 95% confidence intervals (CI), and p-values were reported to determine the strength and significance of associations.

3.8.3 Analysis of qualitative data

FGD's were audio recorded, translated, and transcribed qualitatively. Data verification was done to translated data to ensure accuracy by a trained and experienced research assistant.

Data was analyzed thematically according to the study objectives and coded using N-vivo 12 software. Coding was done in broad concepts and themes were marked and labelled. Coding involved sections of texts based on emerging themes, results were then summarized and presented under the main study domain.

Qualitative findings were used to complement, explain, or contrast the statistical results from the quantitative phase. This merging of data helped to strengthen the validity of the findings through triangulation and provided a more comprehensive understanding of the factors influencing disclosure among young adults living with HIV.

3.8.4 Validation of data collection tools

Supervisors and expert reviews were sought before the study commencement and amendments were made appropriately to ensure a high-quality questionnaire and interview guide. Questions were adapted from validated tools that have been in use in previous studies which were then piloted using young adults working within the AMPATH-Rafiki clinic.

3.9 Ethical considerations

Ethical approval was sought from the Moi University Ethics and Research Committee (IREC), the Chief Executive Officer (CEO)-MTRH, AMPATH Executive Research Office, and the National Commission for Science and Technology (NACOSTI).

Informed consent and assent were sought from the study participants and they provided written consent. Before their children were enrolled in the study, caregivers of adolescents under the age of 18 gave their consent, and adolescents under the age of 18 provided assent. All interactions and interviews with participants and their caregivers were conducted privately to protect the participant's privacy. Participant's privacy was observed by utilizing code numbers as the only identifier for each participant. The consent with participant's information was kept separately in a lockable locker and only accessed by the study team and the principal investigator.

Participation was entirely voluntary, individuals were allowed to withdraw from the study without facing repercussions.

CHAPTER FOUR

RESULTS

4.0 Introduction

This section covers analysis and presentation of study results. It is divided into two sections, socio-demographic data and research objectives. This chapter presents the findings of the study. The results are organized according to the study objectives and research questions. Both quantitative and qualitative data are presented to provide a comprehensive understanding of HIV status disclosure among AYALWH

4.1 Socio-Demographic Data

The study sought to find out the socio-demographic characteristics of study participants. This was key to understanding the background of participants in the study. The table below summarizes the socio-demographic characteristics.

Table 4.1: Socio-demographic characteristics

Participant characteristics	Frequency N=257	Percentage (%)
Gender		
Female	138	53.7
Male	119	46.3
Age group in years		
15-19	137	53.3
20-24	120	46.7
Relationship status		
Married	1	0.4
Not married	254	98.8
Widowed/separated	2	0.8
Religion		
Christian	245	95.3
Muslim	2	0.8
Other	10	3.9
Occupation		
Full time student	184	71.6
No income	15	5.8
Working full time	17	6.6
Working part-time	41	16.0
Household income		
<5000	198	77.0
5000+	27	10.5
Don't know	32	12.5
Level of education		
Primary	11	4.3
Secondary	161	62.7
Tertiary	85	33.1

Source: Field Data (2023)

A total of 257 young adults living with HIV (AYALWH) attending clinic at AMPATH-Rafiki comprehensive care clinic were interviewed.

The sample was predominantly female (53.7%), with a significant majority of participants aged between 15-19 years (53.3%). Most participants were unmarried (98.8%) and identified as Christians (95.3%). The majority were full-time students (71.6%), with a substantial portion (77.0%) having a household income of less than Ksh5000. In terms of education, the largest group had completed secondary education (62.7%)

4.1.1 Relationship Status

The table describes the sexual relationship status for those who have ever been in a relationship.

Table 4.2: Sexual relationship status

Statement	Frequency	Percentage (%)
In a sexual relationship with someone	n=257	
Yes	193	75.1
No	64	24.9
Relationship period	n=193	
<1 year	91	34.6
1-3 years	69	26.8
Over 3 years	33	12.5
Status of relationship at last sexual encounter	n= 193	
Steady relationship /married	16	8.3
We used to be in a steady relationship, but we are not at this time	62	32.1
We had recently met/ we had just met for the first time	36	18.7
Relationship status not defined.	79	40.9

Source: Field data (2023)

The table provides data on participants' sexual relationships, including their current status, duration, and the nature of their relationship during their last sexual encounter.

The majority of participants (75.1%) were in a sexual relationship, with most relationships being relatively short-term (less than 1 year). Among those in relationships, a significant proportion had an undefined relationship status (40.9%) at their last sexual encounter, while 16% were in a steady relationship at that time. Only a small fraction lived together as a couple or in a civil partnership (8.3%).

4.2 Proportion of AYALWH with disclosed status

The first objective of the study was to determine the rates of HIV disclosure for AYALWH to their sexual partners at the AMPATH-Rafiki clinic. The findings of the study are presented in Table 4.3

Table 4.3: Disclosure of HIV status among AYALWH

	Frequency n=193	Percentage (%)
Disclosed HIV status to any other person (not inclusive of sexual partner)		
Yes	138	71.5%
No	52	26.9%
Refused to answer	3	1.6%
Disclosed HIV status to sexual partner		
Yes	70	36.6%
No	118	61.8%
Refused to answer	5	1.6%
Aware of sexual partner HIV status		
Yes	61	32.3%
No	122	64.5%
Refused to answer	10	3.2%

Source: Field data (2023)

Table 4.3 presents data on participants' disclosure of HIV status, focusing on whether they had disclosed their status to others, including sexual partners, and their awareness of their sexual partner's HIV status. The data is based on a subset of 193 participants.

A significant majority of participants (71.5%) had disclosed to someone other than their sexual partner, but fewer (36.6%) had disclosed their status to their sexual partner.

Furthermore, most participants (64.5%) were not aware of their sexual partner's HIV status, indicating a gap in communication about HIV status within sexual relationships.

Table 4.4 Bivariate analysis of the relationship between disclosure of HIV status to sexual partners to age, gender, income and transmission status.

Variable	Category	Observed frequency n=70	Percentage (%)	Chi-square value	P-value
Age (years)	15-19	24	34.3	6.91	0.0086
	20-24	46	65.7		
Gender	Male	12	17.1	30.23	3.84x10
	Female	58	82.9		
Income status	Working Full time	18	25.0	39.36	0.0013
	Working Part time	5	7.0		
	No income	47	67.0		
Mode of transmission	Perinatally infected	28	40.0	2.8	0.094
	Non-Perinatally infected	42	60.0		

The table presents a basic bivariate analysis for participants who disclosed their HIV status. It explores how disclosure to sexual partners relates to various factors, including age, gender, income status, and the method of transmission.. These results suggested that there was a significant difference of HIV status disclosure between the two age groups, with the 20-24 age group having a higher proportion (65.7%) compared to the 15-19 age group (34.3%). The data also indicates that females and older individuals (ages 20-24) were more likely to disclose their HIV status to their sexual partners. Income status shows significant variation, with a majority (67%) having no income.

Based on P-values, the test statistic for age was approximately 6.91 with a p-value of 0.0086, which is less than the significance level of 0.05, indicating a significant

difference in HIV status disclosure between the two age groups. In terms of gender, the test statistics was 30.23 with a p-value of 3.84¹⁰, this indicates a highly significant difference in disclosure rates by gender with higher rates in females as compared to males. Employment status also showed significant variation with a test statistic of 39.36 and p-value of 0.0013, which is less than the significance level of 0.05, indicating a significant difference between those with an income and those without. The test statistic of 2.8 with a p-value of 0.094 indicates that there is no statistically significant difference between the perinatally and non-perinatally infected young adults at a significance level of 0.05.

Table 4.5 Comparison of Bivariate and Multivariate Analysis for HIV Status Disclosure

Variable	Bivariate (Chi-square)	Multivariate (Logistic Regression)	Interpretation
Age	Significant ($p < 0.05$)	Significant (OR = 1.20, $p < 0.05$)	Older participants were more likely to disclose
Gender	Significant ($p < 0.05$)	Not significant (OR = 1.25, $p > 0.05$)	Association weakened after adjustment
Income Group	Significant ($\chi^2 = 39.36$, $p = 0.0013$)	Not significant (OR = 1.11 for high income, $p = 0.705$)	Association disappeared after adjusting for other factors
Mode of Transmission	Not significant ($p > 0.05$)	Not significant (OR = 0.86, $p > 0.05$)	No association with disclosure

While bivariate analysis suggested that gender and income were associated with HIV disclosure, multivariate logistic regression showed that only age remained a significant predictor after adjusting for other factors. This suggests that some of the initial associations were likely confounded by age.

4.3 Disclosure experience

4.3.1 Experience of AYALWH with Disclosed HIV Status

The study's second and third objectives were to explore the experience and factors associated with disclosure of AYALWH in disclosing their HIV status to their sexual partners at AMPATH-Rafiki clinic. This section presents data for both those who have disclosed and those who have not disclosed their HIV status to their sexual partners.

4.3.2 Positive disclosure experiences

Two main themes emerged during the focused group discussion: acceptance and reduced anxiety.

i. Acceptance

From the quantitative data, 16% of participants reported calmness and feeling relieved after disclosure. Disclosure data collected qualitatively using focused group discussion also showed that some participants received support and acceptance by their partners after completing disclosure. For participants who were aware of their partner's health conditions, they reported finding it easy to disclose and received positive feedback from their partners.

R: For me he said its human and it's not my fault, he said we are civilized, and he understands

I: So, you are saying he took it positively?

R: Yes –Female group respondent

R: He had told me about his own health condition which is Parkinson's disease, and I thought to myself if he is open about his condition why can't I be open about mine? -Female group respondent

ii. Reduced anxiety

The study participants were asked what expectations they had before disclosing their HIV status to their sexual partner. From the study, some of the participants indicated that they had expected the relationship to end and were not certain how the relationship would be after disclosure. However as seen from the following responses, the outcome was more favorable than they expected. The anxiety that comes with fear of disclosure reduced drastically after they disclosed.

“For sure I knew was going to be rejected, I knew after disclosure the relationship will end though it happened sooner than I expected.” – Male group respondent.

“I gathered courage and started planning how to tell him, I expected 2 outcomes from him, he would either agree or refuse to agree, I had to bring in a way of telling him and make sure it doesn’t come out badly.” – Female group respondent.

The respondents were also asked to look back at a time when they were disclosing before and after disclosure, and if they think the disclosure, was a good idea. A few participants felt the disclosure was a good idea.

“Mine was ok, so I think it was a good idea to disclose.” – Male group respondent.

4.3.3 Challenges during disclosure

While some AYALWH successfully managed to disclose their HIV status to their sexual partners, the process of disclosure had its challenges. Study results indicated the challenges as follows:

a. Perceived fear of discrimination

From the quantitative data, 27.2% of the participants had disclosed their HIV status to their sexual partners. Both AYALWH with disclosed HIV status and those with no disclosed status had different expectations, they termed them as risks and benefits of disclosure. The researcher sought to find out these expectations.

The dominant theme that emerged during the focused group discussions before disclosure were fear, they expressed fear of partners' reaction, fear of rejection, fear of discrimination, fear of being blamed, Fear of their status being told to friends and relatives. They also felt that there is gap in knowledge surrounding HIV making it difficult to predict the outcome of their partner's reactions.

R: "The reason is the fear of aftermath and the stigma surrounding HIV, you know there is big knowledge gap out HIV out here."

b. Raising suspicion

During the disclosure process, after mentioning about HIV severally with the intention of creating room for discussion, their partners started getting curious and this raised suspicions by their partners who had started suspecting their HIV status, before actual disclosure was complete.

".....she reached a point and she started asking me why I am telling her all this, I told her I am telling her because I care, so incase in future we are not together or when we are not together forever I want you to have this information,....."

c. Denial

Study results also indicated that some partners did not take disclosure seriously and participants had to discuss their HIV status by putting extra efforts where some had to show proof of medication and clinic cards.

“She still did not believe me, I decided to prove to her by taking a photo of my clinic card and sent her that is when she started believing me that was a one night thing” Male group respondent

After starting the disclosure process and the curiosity of partner status raised, participants started avoiding their partners because they thought their disclosure may have triggered anger.

R: You know us ladies are usually very emotional what would you do when you disclose and someone rejects you and then you know how this men are they want to control you and when you try to disclose they put you off. They can't take you seriously, like in my previous relationship I asked my boyfriend whether he has ever had a HIV test he said he did once and he knows he is ok, if he test Positive he will know it's me, I was very scared because he doesn't like using protection during sex, I had to find a way and break up with him, up to now he doesn't know why I broke up with him.

d. Loss of control and interest in the relationship

Some participants felt that they were obligated to disclose their HIV status to their sexual partners and opted not to engage into relationships in future if it meant that they must disclose

While some participants faced difficulties in disclosing their HIV status due to the controlling nature of their partners, others felt that disclosing will make them loose the control they have in that relationship.

R: My greatest fear is that controlling, I wonder whether the relationship will be the same as it was in the beginning, will my partner keep reminding me of my condition? I don't want that completely I want us to remain locked. –Male group respondent

R: It is difficult to control disclosure after it happens because it's a lifetime thing, I have no control over it, and it's more of putting handcuffs on yourself completely.....-Male group respondent

Female group respondents expressed the domination that comes while in a relationship which happens mostly in African societies where men have more control in a relationship than women. While this might seem to have faded or reduced with the current generation, the study indicated that in some relationships men were still in control more than women. As a result, ladies expressed the fear of always being reminded about their HIV status.

R: For a lady, there is always that domination that men always want to have, "you know I am the man of the house- Female group respondent

R: They will keep reminding you are sick, remember you are sick, especially when you disagree, he knows that is your weakness - Female group respondent

Participants from the male group had this to say about the same:

R: For a lady it is difficult because a 28-year-old is dating a 32 or 35-year-old. They always shut you down by asking you to be extra careful so that it does not happen. -Male group respondents

I: From what we have discussed so far and what I am getting are you saying disclosure is easier for males than for females?

R: It is and it is real

When the same participants were asked whether they would advise their female peers dating older partners to disclose to their sexual partners, this was their response;

R: Hahaha, that one you don't disclose – Male group respondent

e. Challenges negotiating for safe sex

When it got to a time where AYALWH were to engage in sexual activities, their partners would suggest not using protection and this posed a challenge for them and some of them had to compromise and engage into unprotected sex.

Some participants were not ready to engage into unprotected sex which would leave them with guilt of transmitting the virus to their partners and as a result, decided to bluntly let their partners know about their HIV status not caring what the outcome would be.

...so after this particular meeting he was asking why I am so difficult and withholding sex from him, so I went home and he called me on phone and asked me the same question of why I was difficult on him, I just told him "I don't know how you are going to take this, but it's very difficult on me" I didn't have a plan or knowledge or education on how to disclose it, he went ahead and told me to

tell him and he kept on insisting. So I just blurted out, I am HIV positive, he asked me are you sure? I told him yeah, - Female group respondent

R: Yeah I had to do it that way because she really wanted raw sex and I didn't want to have the guilt of infecting someone else, I had to tell her and whatever will follow was ok. –Male group respondent

Others felt that they needed to disclose urgently because they were not going to be together for a while since they were going for school holidays.

“I did that from Monday to Friday, on Friday we were now closing school, and I knew if she goes I won't see her until school opens, I was forced to tell her along the way as we were walking” –Male group respondent

f. Inability to handle partner's reaction after disclosure

Some partners as indicated by the study results, did not show reaction immediately after disclosure but later and young adults were unable to handle the reactions.

R: It was like 2 days later, I don't know what evil got into him he started loading, then he started sending texts asking what will happen to him, I was not soft on him I just told him you are ok you are not infected but if you don't believe it lets go get tested. he refused and said he doesn't want to confirm he is positive, he was very childish , he pissed me off, so I told him I must commit suicide I told him fine go die and send me a pin location, I will come look for you.- Female group respondent

After disclosure some participants also noticed a change in the way they used to relate with their partners before disclosure. Some felt that their privacy was not maintained which ignited feelings of betrayal, confusion and regret.

R: The way she turned and looked at me , then all of a sudden, the way we used to relate changed, sometimes different teachers would call me and ask if I was ok, ... I could feel people were talking about me.

I: So you regret why you told her, do you think she told others?

R: Yes – male group respondent

Some participants felt threatened and taken advantage of by their partners after disclosure, this kind of threats made them feel treated indifferently which ignited anger and as a result they decide to end the relationship for their own peace of mind.

The guy started getting so much used to me, he kept threatening me that if anything happens to me it's because of you and I realized he was taking advantage of my situation. So I just asked him to leave I am ok and that is how we ended it.” – Female group respondent.

4.3.4 Types of disclosure during the disclosure process

a). Complete disclosure

This sub-theme emerged for both positive and negative disclosure outcomes. Complete disclosure refers to informing a sexual partner about their HIV status without withholding any information. While disclosure can have numerous positive outcomes, it can also lead to negative outcomes. It is important to recognize and address the potential negative outcomes.

b.) Accidental disclosure

Study results showed that some study participants experienced disclosure that was done by a third party without their knowledge and consent, as a result, their partners confronted them which left them with no option but to involuntarily confirm their HIV

status through disclosure. The fear of accidental disclosure was one of the reasons young adults expressed as the reason they felt it was necessary to disclose.

R: It's good to disclose, because if you don't disclose and there is accidental disclosure there will be a big consequence and you won't know how to handle it. - Female group respondent

R: Yes, mine he was told by someone else

I: So, yours was accidental disclosure too?

R: Naturally, he came to me and I confirmed it was true. Yes, at some point, he didn't seem to know a lot of things so when he asked I just told him it's true and I explained to him, I did not take it badly

b. Incomplete disclosure

The study sought to find out how long the participants had planned before making a full disclosure. The period taken before full disclosure was achieved influenced incomplete disclosure. While planning for disclosure some AYALWH felt that it was good to take their time before making full disclosure given that the outcome was unknown. As a result, the period of making full disclosure was different among AYALWH. However, during the preparation for disclosure, some young adults felt that the longer they prepared for disclosure the more curious their partners became, these increased the anxiety and further strained the relationship and some had to find a way of ending the HIV discussion without disclosing further.

“Yeah, that is what happened to me. I started by preparing this person and you know it doesn't take a day or a month, it's quite a long time because you tell her something and wait for her to question then you start covering yourself and you know the kind of question she will ask I have to know how to cover myself

also so that she doesn't feel like you are telling me but indirectly, you need to know how you will tell her and the question to expect so that you know how to answer the question so that she doesn't know what is going on. So with time, I came to realize that when you keep pushing questions, they now want to know more and now it reaches a point whereby, the questions she is asking start becoming difficult to answer and you don't know how to cover yourself, so you decided to keep quiet and the issue ends there.” – Male group respondent

“It took me a whole year thinking about how I was going to tell him.” – Female group respondent.

R: You know before you do it you have to think, and before you say it you have to decide I am now going to tell this person about my status. I thought about it for 2 weeks- Male group respondent

I did that from Monday to Friday, on Friday we were now closing school, and I knew if she goes I won't see her until school opens, I was forced to tell her along the way as we were walking..... I told her I was telling her because I care, so in future we are not together or when we are not together forever I want you to have this information, from there she never asked again –Male group respondent

The participants were asked to indicate whether they had prior experience with disclosure to a sexual partner. The study indicated that to some it was the first time and others it was not the first time.

“No, it was my first time.” – Female group respondent

4.3.5 Negative disclosure experiences

a. Relationship termination

As a result of disclosure some participants experienced an end to their relationship, for some it happened abruptly while for others it happened gradually which they attributed to disclosure of their status.

R: Mine was very angry and he stopped talking to me, saying that I wanted to kill him that is why I never disclosed early in the relationship. -Female group respondent

I: The fire went off, the relationship ended?

R: one or two weeks later the conversation started dropping and the guy stopped talking to me often and two months later he texted me and said he has been transferred to Egerton University and that was the end of everything we had. Yeah, it ended like that, in slow motion- Female respondent

b. Psychological disturbance and regrets

Some participants experienced emotional disturbance and trauma after disclosing their HIV status which resulted in suicidal ideations for some.

R: Yes for me also, I disclosed to my boyfriend when we were in the hostel, he jumped out of the room and ran away screaming that someone was just about to kill him with HIV, and the way our area is small, he really embarrassed me and I wouldn't want anyone to go through what I went through, I almost committed suicide - Female group respondent

The experience that the participants had on disclosure of HIV status to their sexual partners was indicated by psychological instability and disturbance characterized by panic, anxiety, fear, stress, mixed emotions and confusion.

“Anxiety, a lot of fear.” – Male group respondent.

R: Wah! So much panic- Female group respondent

R: Anxiety, a lot of fear –Female group respondent

R: Stress on how to start –Female group respondent

R: Mixed emotions- Male group respondent

R: A lot of confusion – Male group respondent

After disclosure some participants also noticed a change in the way they used to relate with their partners before disclosure. Some felt that their privacy was not maintained, which ignited feelings of betrayal, confusion and regret.

R: The way she turned and looked at me, then all of a sudden, the way we used to relate changed, sometimes different teachers would call me and ask if I was ok, ... I could feel people were talking about me.

I: So, do you regret why you told her, do you think she told others?

R: Yes – Male group respondent

Some participants felt threatened and taken advantage of by their partners after disclosure, this kind of threats made them feel treated indifferently which ignited anger and as a result they decide to end the relationship for the sake of their own peace of mind.

The guy started getting so much used to me, he kept threatening me that if anything happens to me it's because of you and I realized he was taking advantage of my situation. So, I just asked him to leave I am ok and that is how we ended it." – Female group respondent.

c. Being blamed

Participants also expressed challenges when it comes to their partners sero-converting they felt unfairly blamed for infecting their partners with HIV who may not have taken precautions to protect themselves in previous sexual engagements.

"Yes, that is very real and that is what they do, the play dirty outside get infected and come back claiming it's you because you are already HIV positive." – Male group respondent

Some were blamed for planning to ruin their partner's lives

R: So, from there she started blaming me that I have ruined her life, this is because by then we had been kissing but I knew I cannot transmit through kissing- Male group respondent

R: Mine was very angry and he stopped talking to me, saying that I wanted to kill him he said that it is the reason why I never disclosed early in the relationship. –Female group respondent

d. Increased anxiety

Participants were probed about their feelings before and after disclosing their HIV status to their sexual partner. Before disclosure, some of the participants were unsure about the outcome while others had mixed reactions in terms of how their partner would respond. After disclosure, some were relieved at first before fear kicked in, others felt confused, and some felt bad as their partners blamed them.

“At first I was relieved that at least she knows the truth, but then I suddenly remembered who is she going to tell about it? She might broadcast everywhere to both her friends and my friends. That came back in my mind and I realized eh..., but I decided to be strong wait and see what happens.” – Male group respondent

“I felt very confused, what I was expecting will happen did not happen, for me I was expecting a worse outcome, but it was a positive one.” – Female group respondent

4.4 AYALWH's with Not-disclosed Status

There were various issues that the study sought to investigate concerning the disclosure experience for those who had not disclosed their HIV status to their partners through the interviews that were conducted. The researcher sought to find out the actual reasons for not disclosing and whether there were experiences that contributed to this, this was discussed under the main theme; barriers disclosure.

4.4.1 Barriers to disclosure

a. Partner mistrust

Findings indicate that some have never attempted disclosure, some had intended to disclose but when they realized they do not trust their partners they changed their minds. They did not trust that their partners will be able to handle the knowledge of their HIV status judging on their perceptions towards HIV.

“It has come to my thoughts may be once or twice but before I said let me run a tests, but on the way I made a u-turn and I said this is not the right person so I asked her question like if you are dating someone and you realize they are HIV positive what will you do and she said I will die, I will just go I can't stay there and that was the end of that conversation with her”– Male group respondent

b. Pressure to take a HIV test from partners

Study findings also indicated participants being unsure of how their partners would respond were they to get tested together. Others indicated that they were pressured to go to the voluntary counseling and testing (VCT) center which was a difficult move for them to make. As a result, they find it difficult to start the disclosure discussion at this point as well as being evasive of going for HIV testing as suggested by their partners.

“Mine wants us to go to VCT but I am not yet ready for that.” – Female group respondent

My partners always asks me to take care of getting infected with diseases like HIV and I get scared when he suggests we go get checked together– Female group respondent

c. Fear of rejection and discrimination

In terms of emotions and feelings, the study found out that fear was one of the greatest reasons why participants could not disclose compared to their peers who managed to overcome fear, this group of AYALWH did not manage to disclose. The respondents mentioned they feared rejection, stigma, stress, being exposed, discriminated against and the relationship coming to an end.

“Stigmatization is the greatest fear, you know I have lived my whole life with HIV since I was born with it, and I have never had stigma because its only my family that knows but to this point, I get all the support I need from the family but not everybody will be like my family.” – Male group respondent.

“I fear rejection more and after you break up, he might start spreading this information to our friends.” – Female group respondent.

d. Perception of partner's reaction towards disclosure

In the study AYALWH shared severally that they could not correctly predict their partners enough to open up to them about their HIV status. They mostly feared that their partners would not keep their HIV status a secret.

R: If you love someone too much, you tell them you don't know what they will say to other people in your absence especially if he is from your area, he can tell other people, and everyone will know.

When probed further, respondents indicated that they were not sure of how their partners would receive the knowledge of their HIV status and they were uncertain of how they would react or respond. Some felt that their partners were not able to handle the knowledge of their HIV status.

R: I am against it because someone can get very emotional like I am dating some who is HIV positive, and I am going to commit suicide like she cannot handle it. This person can end up doing something that for the rest of your life you will feel you were responsible for that. - Male group respondent

R: It can lead to suicide someone can love you so much that they can't bear the thought of you being HIV positive. - Male group respondent

R: Some can become very violent and can hit you or push you- Female group respondent

e. Perceived lack of importance

Some AYALWH who did not disclose their HIV status to their sexual partners mentioned having managed their HIV virus to undetectable levels hence not able to transmit the HIV to their sexual partners. As a result, they did not see the need to disclose their HIV status to their sexual partners.

R: For me as long as I am suppressed, I don't think it's for them to know`, if I know I am suppressed I can't bring up that topic and maybe if we engage in sexual intercourse, I know I can't infect her because I am suppressed – Male group respondent

f. AYALWH'S perception towards their own HIV status

AYALWH described their perceptions towards HIV and disclosure. They feel different from their HIV-negative peers and even question why it had to be them.

R: You know most people are negative about HIV most of the time I ask God, now what is this - Female group respondent

R: According to me, those of us who are HIV positive, take HIV like it's something very bad and so you keep thinking how am I going to say something like this? - Female group respondent

I: So, you are saying it's about our attitude?

R: Yes, it's that fear- male group respondent

R: When you disclose to the wrong person then you will face the consequences I call it a mistake, the greatest mistake of your life, and you know when ladies have something that is pressing she can go and tell a friend, the friend might take it like a big deal and tells another friend at the end of the day, when you are walking home everyone is looking at you differently, that can lead to isolation, rejection, not feeling safe and maybe people don't know but when you see someone looking at you feel like they know- Male group respondent

g. Need for sexual intimacy

Study results showed that in as much as AYALWH would like to disclose, they had concerns that involved the need to fulfill their sexual desires. They reported that their

sexual life would be affected were they to disclose to their sexual partners this prompted them to postpone disclosure every time.

R: Yes, they might accept but it might also take time, you can't say that it has reached a point you have disclosed, at some point if you had already had sex before. If she reacts weirdly or unexpectedly then that is the end of the relationship, if it does not end and after a week you want to have sex that can't happen. - Male group respondents

I: So, you are saying once you disclose sex is put on hold first?

R: Yes, that will have to be put on hold and from there you have to look for help at a facility so that they can start afresh and give more knowledge to the person you disclosed to? - Male group respondents

h. Unprotected sex

Study results also indicated that it was a difficult task for AYALWH to disclose their HIV status after having unprotected sex with their partners. After being in a relationship for a while young adults reported that their sexual partners crave for unprotected sex in most cases and would often suggest sex without protection at least at some point in the relationship which often became a habit. Others pointed out that even when they don't discuss about protected sex, use of protection was not always guaranteed when the need for sexual intimacy was there.

I: So, you are saying, other youths you know of are using condoms but not consistently?

R: Yes, not consistently at all- Female respondent

R: The problem comes in where most of them do not use condom and those who use and have knowledge they don't use it for long, that is where my question comes in, you know yourself, you are telling them let's use a condom one day they agree, tomorrow

and then after a period of time they tell you can we enjoy' raw' sex today,- Female group respondent

R: You know we have HIV positive people who care and those who don't care, this only applies to those who have the knowledge and are HIV positive but for the rest (the HIV negative ones) they don't care. - Male group respondent

R: I fear telling her, she might say I infected her and maybe it's not me. - Male group respondent

i. Unwillingness to disclose

Study findings indicated that some AYALWH felt that disclosure was not an emergency, and some felt that disclosure was not a priority they felt that someone should not be in a hurry to disclose.

R: People say it's important but for me it's not that important, coz I am really praying for the injection to come in coz after injection I swear, I won't disclose- Female respondent

I cannot disclose and I am not comfortable, if it works and we move on I will tell you in the future but if it doesn't work you will go knowing I am negative- Female respondent

During the discussions AYALWH also expressed that prevention of HIV transmission should not be one person's responsibility and they felt that each person was responsible for bringing up the HIV conversation. Since their partners did not seem bothered to question their HIV status, they also did not want to bring it up as both parties were comfortable with the current status of the relationship without having to bring up the HIV discussion.

Any of us can start the conversation, we are all mature adults, he is above 18 and I am also above 18 everyone should take care of their health- Female group respondent

j. Learned experiences from peers

Observing what some of their peers went through after disclosing their HIV status to their sexual partners influenced AYALWH's decision to disclose. According to them, most of the observed experiences shared either encouraged or discouraged them to disclose their HIV status to their sexual partners.

Some of the respondents observed events that they considered traumatic through observation from their friends' disclosure experiences, this affected their intentions to disclose.

The reason why I decided I cannot disclose is because of a friend I had in school, so this guy tried to disclose and he faced full repercussions for disclosing, it was not good at all, it affected him so badly, rumors spread in school during lunch time he would either be the first and disappear or he would be last and miss his meals, food get finished before he is served. –Male group respondent

R: I also know of a lady who disclosed to her boyfriend in college, that boy told his friends, so they used to say if you date that girl it's like stepping on a livewire but the girl did not know that that is how people are talking behind her back but I think she would suspect, it was not easy for me because I was wondering what if it was me who had disclosed is this how people will say about me, for me disclosure is not an option for now I am happy I have never tried because I don't know what I would do if it had happened to me that way. –Female group respondent.

4.5 Factors considered before disclosure

The study revealed several factors that influenced participants' decisions on whether or not to disclose their HIV status to their sexual partners. These factors included the nature of their relationship and concerns about their partner's temperance, additionally, some participants considered the impact of disclosure on their own well-being by learning from their peer's disclosure experiences as well as considered the impact disclosure on their finances based on their economic status.

a. Understanding partner's temperance

After probing further, AYALWH suggested that one should not be in a hurry to disclose their HIV status to their sexual partners, they recommended that priority should be given to understanding your partner's temperance and knowing the type of person one is disclosing to be sure.

“Also look at the kind of person who you are disclosing to, like In my case I was blamed, and he was so angry, and he said that I was planning to infect him that is why I did not disclose to him for a whole year. Some can become very violent and can hit you or push you.” – Female group respondent

“Be sure you know everything about them before you disclose.” – Male group respondent

b. Participant's economic status

The study collected data related to the economic status of respondents. Findings are presented in table 4.4

The quantitative findings of the study indicate that 58.8% of the respondent's main source of income was depending on someone else's income (parents, caregiver, partner, and other relatives). 45.9% indicated that they do not receive financial support from their partners. 13.6% indicated that their financial situation now is hindering them from

disclosing their HIV status to their sexual partners, on further probing it was determined that a good number of AYALWH did not have a source of income and could not depend on relatives and family for daily upkeep making their partners their only source of financial support. Here are some of the responses.

Personally I am an orphan and my relatives have been avoiding me, only one person has accepted to support my education but he does nothing beyond paying school fees, then here I have a partner who is willing to take care of my upkeep, of course my relatives don't know about him, I am scared of telling him about my status because what will I do if he stops loving me? –Female group respondent

I see how much my parents are struggling to raise us and it's difficult to keep asking them for money, other children are also relying on them, but life must continue even if it means dating a “mbaba” (older man) hahaha- Female respondent

c. External influence and environmental factors

Response from participants indicated that information from the society to young adults makes it difficult for them to receive acceptance from their partners. Respondents felt that wrong information is still given in the society and especially in schools and new knowledge on HIV has not been spread out even to teachers at school, maintaining that the old mentality about people with HIV which is still the one being taught in schools.

R: meaning she might still be loving you but the information she has, and she has heard or learnt from school still scares them. - Male group respondent

R: Yes, because even the teachers they just follow what is in the syllabus, even if the teachers themselves are HIV positive all they do is teach what is in the

syllabus, they don't care to correct even if it's wrong information. - Male group respondent

R: Hahahahah yeah according to what she knows, she has heard from the society and has been learning and everything, she can't understand you - Male group respondent

From their conversations with their sexual partners, some AYALWH discerned their partner's attitude towards people living with HIV and as a result, they realized that they were not the right people to disclose to.

R: Not directly but when she starts saying that "that person has AIDS" and the way she says it makes me feel like she can be very dramatic when it comes to HIV issues- Male group respondent

..... because she fears it, the way she talks about it, shows that she fears so when I talk about it I will have to go through a lot of steps and stages to tell her, so someone like that when you start talking about HIV they will start asking a lot of question like why are you asking this, she talks about it a lot only when she knows of someone who is infected but the way she talks makes me feel she is not the right person to talk to about it. - Male group respondent

d. Timing and preparation for disclosure

The study sought to find out how long the participants had planned before making full disclosure. While planning for disclosure some AYALWH felt that it was good to take their time before making full disclosure given that the outcome was unknown. As a result, the period of making decision to fully disclose was different among AYALWH. However, during the preparation for disclosure some young adults felt that the longer they prepared for disclosure the more curious their partners became. This increased the

anxiety and strained the relationship as some had to find a way of ending the HIV discussion.

The study findings indicate that some had not planned the disclosure while others had planned for some period.

“Yeah, that is what happened to me. I started by preparing this person and you know it doesn’t take a day or a month, it’s quite a long time because you tell her something and wait for her to question then you start covering yourself and you know the kind of question she will ask. I have to know how to cover myself also so that she doesn’t feel like i am telling her but indirectly, you need to know how you will tell her and the questions to expect so that you know how to answer the question, so that she doesn’t know what is going on. So, with time I came to realize that when you keep pushing questions, they now want to know more and now it reaches to a point whereby, the questions she is asking start becoming difficult to answer and you don’t know how to cover yourself, so you decided to keep quiet, and the issue ends there.” – Male group respondent

“It took me a whole year thinking about how I was going to tell him.” – Female group respondent.

R: You know before you do it you have to think, and before you say it you have to decide. ‘I am now going to tell this person about my status.’ I thought about it for 2 weeks- Male group respondent

I did that from Monday to Friday, on Friday we were now closing school, and I know if she goes, I won’t see her until school opens, I was forced to tell her along the way as we were walking……. I told her I am telling her because I care, so incase in future we are not together or when we are not together

forever, I want you to have this information, from there she never asked again

–Male group respondent

The participants were asked to indicate if disclosure was their first time and experience.

The study indicated that to some it was the first time and others it was not the first time.

“No, it was my first time.” – Female group responds

CHAPTER FIVE

DISCUSSION, CONCLUSION AND RECOMMENDATIONS

5.0 Discussion

This section covers discussion, conclusion and recommendations of study results.

This chapter discusses key findings and relates them to the research questions that I set out to answer. I also relate my discussion to the theoretical framework and related research and theory. The chapter also provides a summary of the study, limitations and gives some recommendations.

5.1 HIV status Proportion of disclosure

From the study, the prevalence of AYALWH that disclosed their HIV status to their sexual partners was 36.6% (95% CI=30.1%-43.8%). On further checking for status disclosure, 71.5% of the respondents reported that they disclosed their HIV-positive status to other persons apart from their sexual partners. Researchers asked participants in sexual relationships if they were aware of their partners' HIV status, and according to the results in Table 4.3, a majority (64.6%) were not aware of their partners' HIV status. These findings were consistent with Kavuma D's study in Uganda, where only 24.4% of study participants knew their partner's HIV status (Kavuma et al., 2023), suggesting that the challenge of non-disclosure to sexual partners is a widespread issue among AYALWH across different regions.

In a study conducted in Siaya, Kenya, 84% of participants had disclosed their HIV status to their sexual partners, a higher percentage compared to the current study. Additionally, 10% of participants had not disclosed their status and did not intend to do so; this was attributed to the participant's desire for privacy (Burmen et al., 2017). These findings contrast with our study, where disclosure was more prevalent among

participants over 25 years and those in long-term relationships, particularly married individuals; however, Burmen et al. focused on a different population, potentially including older and more stable relationships where disclosure is more likely which is the reason for the disparity. Further supporting our findings, Mugo et al. in 2021. Conducted a study in Nairobi which found out that 67% of AYALWH had disclosed their HIV status to family members and 43% to non-family members majorly friends. Similar to our findings, these results indicate that AYALWH are more comfortable disclosing their HIV status to other people other than their sexual partners.

Additionally, Mugo found out that AYALWH who were not married were 75% less likely to have self-disclosed to their sexual partners, while 66% of the people who were married or were engaged in sexual activity did not tell their spouses (Mugo et al., 2021). These findings reinforce the idea that individual in sexual relationships face significant challenges when disclosing their HIV status. While there is overwhelming evidence of the potential benefits of disclosure, very few studies have focused on the outcome of disclosure of HIV status to young adults and their sexual partners. Additionally, there are low disclosure rates among the young adult population due to the fear associated with potential adverse outcomes and stigma (Grainger, 2017).

Unlike our study, other studies in Uganda and Zimbabwe had different disclosure results. In Zimbabwe, 93% of participants had disclosed their HIV status to their sexual partners, while in Uganda, 73.3 % had also disclosed to their sexual partners (Naigino et al., 2017; Shamu et al., 2014). These differences contribute to sample size variations, study populations, and methodology. Notably, compared to our study, their focus was mainly on HIV-positive women attending clinics, whereas our study focused on AYALWH attending clinics. Women attending prenatal and antenatal clinics may have

access to structured disclosure counseling and peer support, which could explain the higher rates observed in their populations.

When probed further, AYALWH expressed concerns with disclosure of HIV status to sexual partners, which included fear of judgment and rejection; the desire for acceptance and affection was so strong that the majority preferred to be silent about their HIV status to minimize the chances of rejection.

Bivariate analysis of disclosure and socio-demographics indicated that AYALWH aged between 15-24 years were more likely to disclose their HIV status, with 65% having disclosed; this was discussed further during the focused group discussions whereby AYALWH expressed that the age of their sexual partner influenced disclosure. Literature supports this observation as previous studies found that AYALWH who were in sexual relations with partners older than them by 5 years and above were less likely to disclose as opposed to those who were in sexual relations with their age mates or a less age gap (Dessalegn et al., 2019; Yonah et al., 2014). Young people are also less likely to disclose their HIV status to their sexual partners if they feel they are not in control of the relationship, which is likely when there is a considerable age gap between the sexual partners, which is also attributed to the short-lived nature of their sexual relationships (Dessalegn et al., 2019; Yonah et al., 2014). Ironically, in terms of gender, our study findings indicated that more females had disclosed their HIV status to their sexual partners compared to males. Our study findings determined that as much as more females had disclosed, female, young adults expressed having more difficulties during disclosure compared to their male peers, driven by the need to protect their partners from infection and to reduce the feelings of guilt each time they engaged in sexual activities. They expressed the age of their partner as a factor that affected successful disclosure. AYALWH and majorly young females revealed that most of them were in

relationships with male partners who were older than them. As a result, these males had more control over the relationship than them, which became even more complex when their sexual partner was the one supporting them financially. This finding aligns with the notion that women in heterosexual relationships often face more significant pressure to negotiate for safer sex (Jewkes, R., 2010), making disclosure a more complex process for them. Another possible reason why more females had disclosed more than males was attributed to a higher number of females in our sample size (53.7%). These findings indicate a need to address these differences to understand the unique challenges and pressure faced by both genders and implement targeted strategies for AYALWH to support disclosure and open communication in relationships.

Study findings also indicated that among the disclosed, a higher number of those who were non-perinatally infected had disclosed their HIV status compared to those who were perinatally infected Kavuma et al. 2023, further support these findings, indicating that non-perinatally infected participants living with their partners were more likely to disclose their HIV status to their sexual partners. Unfortunately, there are limited studies about disclosure patterns of HIV status among perinatally and non-perinatally infected individuals (Kavuma et al., 2023).

However, multivariate logistic regression analysis revealed that age was the only statistically significant predictor of HIV status disclosure among young adults living with HIV. Specifically, the odds of disclosure increased with age, suggesting that older youth may feel more confident or secure in disclosing their status, potentially due to greater maturity, life experience, or reduced dependence on others. In contrast, gender, mode of transmission, and income group, although showing significance at the bivariate level, did not remain significant in the multivariate model. This indicates that their

initial associations may have been confounded by other variables, particularly age. These findings underscore the importance of age-sensitive disclosure interventions and suggest that demographic and socioeconomic characteristics may interact in complex ways that require further qualitative exploration.

5.2 Disclosure Experiences

The findings of this study demonstrated that there were three types of disclosure outcomes. The first type of disclosure was complete disclosure, where participants openly and honestly communicated about their HIV status, including giving relevant information about their HIV status, which included communicating directly and clearly stating that one is HIV positive. The outcome of complete disclosure yielded both positive and negative disclosure experiences. This type of disclosure involves the individual personally communicating their HIV status directly to their sexual partners without the involvement of a third party. The information was effectively conveyed because the initial step in this process was to create a scenario where disclosure was the ultimate objective.

The second type of disclosure was the incomplete disclosure. This type of disclosure involved sharing some but not all information about one's HIV status. Our study findings indicated that fear of rejection based on the feedback to the already shared information and uncertainty about how to communicate the HIV status information entirely led to them retracting and ending the disclosure discussion before it was well understood. The study found that incomplete disclosure often involved providing limited information, where participants would make vague or ambiguous statements about their health status without directly mentioning HIV. Some participants preferred to discuss HIV by referencing another person without suggesting that they might be the individual in question. They would do this to pass knowledge and out of curiosity to

help them find out how much their partners knew about HIV and their attitudes toward people living with HIV. As a result, the outcome of such discussions led them to end the talks before making complete disclosure.

The findings revealed that reasons for incomplete disclosure included fear of rejection; participants were worried that fully disclosing their HIV status might result in the end of the relationship or an adverse reaction from their partners. Additionally, concerns about stigma, judgment, or discrimination from their partner or others were significant factors. Another reason cited was a lack of knowledge or confidence to communicate their HIV status and its implications effectively.

The study also indicated accidental disclosure as another type of disclosure, which refers to situations where an individual's status was revealed unintentionally or without their consent. Accidental disclosure happened when a sexual partner was informed or overheard a conversation from a mutual friend, family member, or a healthcare provider and later confronted the participant for confirmation of what they had heard. As a result, some participants confirmed the information as accurate, while others denied or terminated the relationship to avoid disclosure.

In a study done in Nairobi, Kenya, in 2013 by Moya E, non-consensual disclosure is usually carried out by well-meaning healthcare providers, but this mainly happened when the doctors discussed diagnostic tests with little regard for who else was listening or referred spouses of the HIV-positive patients for testing without telling them why (Mengwai et al., 2020; Moya & Lusk, 2013). However, in our study, accidental disclosure among AYALWH did not happen in a medical facility. Still, it happened in what they termed as betrayal from family and friends they had confided in. Accidental disclosure had significant emotional consequences and led to trust issues where the partner felt betrayed or hurt that the information was not shared directly by their sexual

partners. AYALWH experienced emotional distress, anxiety, and confusion since they were not ready nor prepared to disclose their HIV status.

Kenya's national guidelines strongly discourage non-consensual disclosure to ensure that people living with HIV have the power to decide whether to disclose or not. Unfortunately, these guidelines are not usually always adhered to (NACC, 2021).

5.2.1 Positive Disclosure Experiences

This study examined the experiences and determinants of HIV status disclosure among young adults living with HIV (AYALWH) using the Theory of Planned Behavior (TPB) as a guiding framework. According to TPB, an individual's intention to engage in a specific behavior, such as disclosing their HIV status, is influenced by attitudes, subjective norms, and perceived behavioral control (Ajzen, 1991). The findings of this study highlight how these three constructs interact to shape disclosure decisions among young adults.

Based on this theory, HIV disclosure among young adults is a planned behavior influenced by both internal and external determinants, which either facilitate or hinder disclosure decisions.

Participants revealed that disclosure of HIV status was not an easy task for them. A few participants in our study managed to successfully disclose their HIV status despite the anticipated and perceived fear of adverse outcomes AYALWH had successfully disclosed, and 16% reported receiving acceptance and support from their sexual partners. From the discussions, AYALWH gave reasons that motivated them to disclose, which included the need to build trust with their partner, which they believed would strengthen their relationship, and the need to freely take their medication as they felt tired of hiding the medicine or missing doses whenever their partners were around

them, the need to receive emotional support from their partners and the need to protect their partners from getting infected during sexual intimacy. A mixed-method study in Uganda also came up with similar findings and noted that healthcare workers emphasized adherence and proper medicine storage (Ngonzi et al., 2019). As a result, AYALWH, who were living with their partners, used to hide medication in the garden and sometimes in the kitchen, which resulted in heightened anxieties. Our study participants, however, reported that they would at times skip or delay taking their medications whenever their partners were around or would not carry their medicine whenever they went visiting their sexual partners.

Disclosure of HIV status to sexual partners with positive outcomes helps in creating awareness about HIV and reduces risky behaviors, which reduces the risk of transmission to a sexual partner. It also expands awareness to the sexual partner and encourages testing of HIV for those who are unaware of their HIV status; as a result, for discordant sexual partners, more precautions are taken to prevent transmission with an increase in PREP uptake and use of condoms. Our study findings indicated that those who successfully disclosed and had positive outcomes ended up getting more secure in their relationships, reducing anxieties and strain. These observations are similar to another quantitative study conducted in South Africa, where 7% of the study participants reported positive outcomes to HIV status disclosure among young adults 18-25 years old (Mengwai et al., 2020).

Disclosure of HIV status is an important starting point to initiate healthy discussions about HIV prevention with adequate support on care and treatment and ultimately make it easy for the HIV-positive partner to negotiate for safer sex and reduce the chances of transmission.

5.2.2 Experience in preparation for disclosure

According to our study findings, AYALWH is faced with challenges in deciding on whether to disclose or not; while most of them appreciated the importance of disclosing their HIV status to their sexual partners, the perception of possible outcomes made it harder for them to decide sometimes delaying disclosure of HIV status to sexual partners. Our study findings indicated that the period of disclosure was indefinite as it depended upon the current status of the relationship like the need for unprotected sex, the need to explain why they were not ready for sexual intimacy, and the need to create a stronger bond in the relationship by being open about their HIV status situation. As a result, some young adults decided to make a disclosure immediately. They felt pressured to have unprotected sex, while others had sex first and later thought of making a disclosure or quitting the relationship. The period taken to make or initiate disclosure discussion varied from weeks to months and even years. AYALWH engaging in casual sex are less likely to disclose, as seen in our study discussions; unprotected sex was also seen to delay the disclosure process for fear of adverse outcomes. A study done in South Africa by Mengwai K also noted patterns of delayed disclosure where 36% of study participants had stayed over a year with their partners before disclosing, which implied that HIV transmissions would continue in this kind of setting since the likelihood of safe sexual practices was minimal and chances of reinfection increases (Mengwai et al., 2020).

In Western Kenya, Abuogi et al. (2020) in their study established that eighty-eight percent of participants indicated that disclosure happened within a year of their diagnosis, and sixty-seven percent of them within a week 55.4% through self-disclosure (Abuogi et al., 2020). These results contradicted our findings, which showed that most of our participants had tried to disclose for more than a year for those in long-term

relationships, and disclosure did not happen for those in short-term relationships. These previous studies were done on participants who were in stable married relationships. In contrast, our study population consisted of AYALWH who were not married, the majority of whom were in an undefined relationship status (40.9%), suggesting casual and unstable relationship status, which is common in young adults (Carlson Laloo, 2016). Abuogi's study indicated that most participants who had disclosed, the majority being women, found it easy to disclose because they felt confident that they had contracted HIV from their current partners, and what they did was confront their partners. It was also noted that in our study, AYALWH had difficulties describing their relationship status at the last sexual encounter and could not place them in any of the options given, and as a result, 40.9% were in undefined relationship status. This could be an indication that some young adults were in casual and non-committal sexual relationships, an observation that was also noted by Abuogi and Mengwai whereby Mengwai's study determined that 42% had changed their partners after they tested HIV positive. AYALWH preferred casual sex and relationships as they did not feel obligated to make a long-term commitment, which would make them feel obligated to disclose their HIV status and, at the same time, have their sexual needs met (Abuogi et al., 2020; Mengwai et al., 2020). A similar mixed-method study in Uganda supports this narrative since their findings indicated that sexual partners living together were four times more likely to disclose their HIV status to their sexual partners compared to those who were staying alone, with their parents or relatives (Kavuma, D. et al. 2023).

Some AYALWH shared that their decision to disclose was also made out of concern for others. Those who disclosed did so to protect their sexual partners from getting infected, and those who did not disclose did so out of concern that their sexual partners were not in a position to handle the knowledge that their partners were living with HIV.

They expressed this by disclosing that every time they engage in sexual activities, they are faced with an overwhelming feeling of guilt and fear of having infected their sexual partners. The decision to disclose or not disclose was also made out of concern for self. Some disclosed to save face in situations where they felt they might be judged wrongly; others disclosed to protect themselves from situations where their partners might find out through friends or other means, which would give them a hard time explaining why they had not opened up to their partners concerning such a sensitive matter. These findings were similar to Kavuma et al.'s findings, whose study was similar to ours regarding participant's age group and study design; their sample size was slightly larger than ours (Kavuma, D. et al. 2023).

Those who had disclosed had moved a step further during the disclosure process. As a result, this marked the end of the relationship after successful disclosure; others continued with the relationship but noted that the relationship with their partner had changed negatively compared to how it was before disclosure, leading to psychological and emotional issues. A few reported calmness, and others felt blackmailed and threatened by their partners.

5.2.3 Negative Disclosure Experiences

The study findings indicated that the majority of AYALWH had psychologically prepared for adverse outcomes after the disclosure of their HIV status to their sexual partners. However, others expected support from their partners, which was not the case after disclosure. With this insight, some initiated and completed disclosures where they experienced adverse outcomes. Other negative disclosure experiences include the end of their relationships, accidental disclosure, incomplete disclosure, psychological disturbances, being blamed, and a strained relationship, which resulted in increased

anxiety. The nature of many relationships influenced disclosure among some participants, who felt confident enough to trust their partners. This trust, a significant concern before disclosure, may impact their future intentions to disclose or enter committed relationships, as highlighted during the discussion. Negative disclosure experiences have significant impacts on young adults' mental health, which may significantly affect future relationships, becoming a barrier to future intentions to disclose.

Adverse outcomes after disclosure have been noted in other studies as well; a mixed method study on women in Mbarara Hospital Uganda determined more severe adverse outcomes as compared to our study, where participants were accused of infidelity, were verbally abused, beaten and chased out of their homes by their husbands. The nature of the relationship may have occasioned the slight discrepancy in outcome from the study in Mbarara University since most participants in our study were unmarried and young as opposed to the Ugandan study, where the majority of the participants were married with a higher age group of 26-35 years of age (Ngonzi et al., 2019).

A quantitative study with participants aged 21-49 years in Addis Ababa (Dessalegn et al., 2019) also determined that HIV-positive women experienced more damaging outcomes as compared to men, which led to fewer women having disclosed, contrary to our study a significantly higher rate of disclosure was among women. However, in agreement, young women having sexual relations with older men experienced more difficulties with disclosure of their HIV status to their sexual partners compared to their male peers.

5.3 AYALWH with not disclosed status

5.3.1 Barriers to Disclosure

In our discussions, it was noted that young adults were motivated by the need to be in an intimate relationship without disclosing their HIV status with the hope that they would carefully manage intimacy through suppression of their viral loads. Barriers to HIV status disclosure, for example, partners' mistrust and pressure to take an HIV test, made it harder for young adults to initiate disclosure discussions in situations where their partners had already initiated it by asking them to get tested for HIV together. Disclosure of HIV status to sexual partners is crucial for initiating communication about safe sex to prevent new infections. Fear of rejection and perception towards their partner's reaction further increased the likelihood of them not disclosing since AYALWH revealed that they desired to continue enjoying sexual intimacy, which could be affected by disclosure of their HIV status to their sexual partners. This, combined with the challenge of not being able to negotiate for safe sex, led them to neglect the idea of disclosure completely. Another barrier noted was disclosure experiences from peers; the observed outcome of disclosure by their peers indicated the presence of stigma in their environment.

A study in Thailand with young adults 15-24 years also supported our findings, where their results determined that fear of rejection and stigma was a significant barrier to disclosure (Boon-Yasidhi et al., 2021)

In another qualitative analysis in the USA, it was revealed that young adults struggle with intimate relationships as a result of their HIV status, and similar to our findings, a majority who had disclosed to their sexual partners experienced some form of rejection, which was a significant barrier to disclosure in their current relationships (Fair & Albright, 2012).

AYALWH expressed that in their daily interactions with their peers and through the information received from their schools and colleges, there was a scarcity of the correct information regarding HIV, which creates fear that if their status were made public, then they would face challenges while interacting with the community and their peers. These findings were supported by other studies in Ethiopia in 2012 and Nigeria in 2007 (Feyissa et al., 2012; Simbayi et al., 2017); however, these findings were done on antenatal women.

Spangler et al. (2018) demonstrated how HIV stigma ignites feelings of fear, isolation, and self-censorship, which in turn limits disclosure and prevents people from fully engaging in social life (Spangler et al., 2018).

In light of this, however, the participants in our narratives demonstrated differing kinds of HIV stigma, perception towards their own HIV status, and the expression that they felt different from others was an indication of HIV self-stigma. Our study concurs with UNAIDS and Spangler's findings that stigma undermines prevention efforts by making people fearful of disclosure to reduce risk and change behavior. Greene et al. (2003) reiterated that fear of stigma contributes to setting up defensive boundaries around private information. This study's findings generally agree with other studies from Uganda and Tanzania (Naigino R, 2017), (Ngonzi J, 2019). The percentage of those who had not disclosed expressed stigma, fear of ending the sexual relationship, and fear of trauma to their sexual partner as the significant barriers to disclosure.

These findings indicate a need to tackle stigma by re-evaluating the facts about HIV and educating with information about new developments concerning HIV. This may require efforts like the ones done during the early stages of sensitization about HIV

infection and prevention through the use of media and related platforms in order to change people's attitudes and perceptions concerning HIV.

5.3.2 Need for financial support

Economic status is a facilitator and also a barrier to disclosure of HIV status, according to study findings presented in Table 4.4. During our focused group discussions, AYALWH reported that some of them had sexual partners older than them, and their economic status influenced their decision to disclose. The study determined that this seemed to be affecting more females than males. However, males involved with older sexual partners were more likely also to face similar barriers. These findings align with the study by Nyoni et al. on multidimensional poverty among adolescents living with HIV in Uganda, which highlighted that the desire of AYALWH to access basic needs served as a barrier to disclosing their HIV status to sexual partners, with poverty being the underlying factor. It contributes to risky sexual practices, especially in vulnerable populations like young adults (Nyoni et al., 2022).

Participants who told their sexual partners about their HIV status were four times more likely to be the heads of their households and eleven times more likely to be married or in a common-law partnership (Greene et al., 2019). Based on our qualitative data, these results compare to our findings in that individuals with higher economic status were more likely to disclose than individuals depending on another person's income. Additionally, our study indicated that individuals of higher economic status had more control of the relationship than those of lower economic status. Bivariate analysis (table 4.4) between disclosure and income showed a significant difference between those with an income and those without, which affected the disclosure rates. According to Klopper, Stellenberg, and Van der Merwe (2014), disclosing a sexual partner is statistically significantly correlated with fear of prejudice. The participants who had never married

(19%) were the ones who mentioned this anxiety the most. Those without money feared being blamed or discriminated against (23%) (Klopper et al., 2014).

The findings of this study indicate that economically empowering adolescents and AYALWH is essential. Additionally, initiatives aimed at promoting and strengthening support systems should be prioritized, as they play a crucial role in facilitating the disclosure of HIV status to sexual partners within this population.

5.4 Factors associated with disclosure of HIV status to sexual partners

The process of disclosing one's HIV status to a sexual partner is deeply influenced by various social, emotional, and environmental factors. The themes of understanding a partner's temperance, the participant's economic status, external influences, and the timing and preparation for disclosure provide insights into the complexities involved. Understanding a partner's temperaments and potential reactions is a significant consideration required when disclosing one's HIV status; if not done well, the anger and accusation from a partner in such instances can discourage disclosure due to fear of emotional or physical consequences; these findings are supported by Mlilo in 2020 who demonstrated that teenagers living with HIV have difficulty disclosing because it is a tough and an emotionally charged process with potentially uncontrollable consequences (Mlilo et al., 2020).

A participant's economic status can significantly shape the decision to disclose one's HIV status to a sexual partner. From the discussions, participants demonstrated the interplay between financial reliance and fear of abandonment. In such contexts, disclosure is weighed against the risk of losing financial support and emotional connection. The lack of economic independence often forces individuals to delay or avoid disclosure, even when they are aware of its ethical or health-related implications.

Social stigma and discrimination are some of the external factors related to HIV that continue to pose significant obstacles to disclosure. Fear of being ostracized by the community or labeled negatively often influences individuals' willingness to be open about their status. This highlights the critical role of public education and stigma reduction campaigns in creating an environment where disclosure is met with understanding rather than judgment. A supportive societal framework is essential to enable young adults to disclose their status without fear of adverse consequences. These study findings are generally in agreement with other studies from Uganda and Tanzania (Naigino R, 2017), (Ngonzi J, 2019). These findings indicate a need to tackle stigma by re-evaluating the facts about HIV and educating with information about new developments concerning HIV. This may require efforts like the ones done during the early stages of HIV sensitization and prevention through the use of media and related platforms in order to change people's attitudes and perceptions concerning HIV.

The disclosure process was significantly influenced by timing and preparation factors. Participants emphasized the importance of strategizing how and when to disclose. Proper preparation can mitigate risks associated with adverse reactions, such as anger or rejection. Participants emphasized the importance of seeking guidance from counselors or support groups and creating a safe, calm environment to ensure the partner's emotional readiness for disclosure.

Supporting our findings, Mlilo et al., 2020 demonstrated that teenagers living with HIV have difficulty disclosing because it is a challenging and emotionally charged process with potentially uncontrollable consequences (Mlilo et al., 2020), (Mkandawire et al., 2022), (Kiene et al., 2018).

5.5 Conclusion

Data indicates a disparity between the rates of disclosure to others versus sexual partners, as well as a significant gap in awareness of a sexual partner's HIV status.

Disclosure of HIV status to sexual partners was significantly low. AYALWH who were sexually active did not disclose their HIV-positive status to their sexual partners despite knowing the risks involved with not disclosing. A significant finding in this study determined that some AYALWH managed to disclose their HIV status either partially or entirely before engaging in sexual intercourse. However, some individuals engaged in sexual intercourse after disclosing their HIV status, while those who had not disclosed their status often demonstrated inconsistent use of protection. AYALWH reported that this was a common occurrence among their peers who faced challenges in negotiating safer sex practices. Disclosing HIV status to sexual partners has the potential to reduce new infections and contribute to the goal of achieving zero new infections by 2030.

The study findings indicated that disclosure of HIV status among AYALWH is a mentally and emotionally draining task, which indicated a gap in knowledge and decision to disclose. This is because despite the disclosure being beneficial, there are also risks that may result in psychological disturbances, stigma, isolation, and rejection by partners. As a result, AYALWH had to weigh the outcome before deciding whether to disclose it or not.

The study results also noted the existence of stigma against people living with HIV in the community. It determined that AYALWH is still struggling with a highly stigmatized condition, and they have few individuals with whom they can confidently and comfortably confide their fears and worries. This explains why AYALWH wants to maintain a low viral load, which has become a key strategy for preventing

transmission to sexual partners and to prevent opportunistic infections. However, treatment adherence becomes a challenge as soon as they start living together or when they frequent 'sleepovers,' where some prefer not to carry their medication for fear that their partners may see them. Poor adherence to HIV treatment interferes with viral loads and increases the chances of infection where protection is not consistently used. By increasing support systems, reducing stigma, and fostering open communication, it is possible to improve the management and prevention of HIV within this population.

The study results also established that socio-demographic factors such as age, gender, and income influenced disclosure. More females disclosed than males, although the number of females who disclosed was high. It emerged from the focused group discussions that females faced more challenges with disclosure than their male peers. Moreover, participants relying on their spouses for financial support significantly increased the fear of disclosing, given that disclosing their status may mean the end of their relationship, hence losing their financial support.

The decision to disclose HIV is a multifaceted personal process, influenced by factors such as the partner's temperament, economic reliance, societal stigma, and the preparation for disclosure. Interventions to support disclosure should address these themes comprehensively, offering emotional, financial, and societal support. Building an inclusive community environment, providing counseling resources, and economically empowering individuals can foster safer and more effective disclosure practices.

Based on the theory of planned behavior, which guided this study, positive and negative outcomes impact an individual's intention to disclose sensitive information like HIV status, especially to a sexual partner. Positive outcomes such as acceptance and reduced

anxiety enhance the likelihood of disclosure because they reinforce the belief that disclosure will result in beneficial outcomes. On the other hand, negative disclosure outcomes like relationship termination, psychological disturbance, being blamed, or increased anxiety reduced intentions to disclose as individuals perceive these risks as outweighing the benefits.

The perceived balance between positive and negative outcomes influenced the barriers to HIV status disclosure. Attitude towards disclosure of HIV status to a sexual partner, partner mistrust, pressure to take an HIV test, need for sexual intimacy, and unprotected sex were mentioned as some of the barriers to disclosure. Positive outcomes were expected where individuals were more likely to disclose to outweigh negative ones, but fear of adverse outcomes led to a negative attitude towards disclosure, which resulted in a lack of disclosure of HIV status to sexual partners among young adults.

Subjective norms such as fear of discrimination, raising suspicion, and losing interest in the relationship reflected societal and relational norms that influenced AYALWH's decision to disclose. This indicates that supportive social environments and positive norms around openness can encourage disclosure. Individuals may feel they lack necessary skills to manage disclosure conversations, handle adverse reactions, or advocate for their needs. Building confidence and coping mechanisms is key.

5.6 Recommendations

The study recommends the development and implementation of a disclosure support program to manage the disclosure of HIV status to sexual partners, done through training AYALWH on communication skills focusing on building confidence and reducing anxiety before and after disclosure.

There is a need to develop solutions to manage barriers and challenges to disclosure. The measures should be tailored to meet barriers like communication skills, reducing

economic dependence on relationships, and normalizing disclosure through strengthening coping skills using therapy to help AYALWH develop strategies to navigate disclosure and manage outcomes effectively.

Focus on positive messaging and fostering resilience by highlighting and sharing positive disclosure experiences to counteract fear and stigma should be emphasized by creating forums of discussions where AYALWH can share testimonials and stories of successful disclosure to encourage other peers by sharing real-life examples of favorable outcomes.

By understanding these outcomes through a mental health lens, practitioners can design interventions that encourage healthy disclosure practices while protecting individuals from the psychological risks associated with negative outcomes.

5.6.1 Recommendations for further research

Research is needed to identify effective strategies that support networks to encourage and assist AAYALWH in disclosing their HIV status to their sexual partners.

Research is needed to evaluate the effectiveness of existing disclosure support programs and current interventions in helping adolescents and AYALWH disclose their HIV status to their sexual partners.

Exploring the mental health implications of disclosure among AYALWH, including anxiety, depression, and stress levels, and how it impacts psychological well-being and quality of life is paramount.

By addressing these concerns, stakeholders, including healthcare workers, policymakers, and community organizations, can foster an environment where disclosure is safe, stigma is reduced, and AYALWH receives the support they need to lead healthier lives.

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APPENDICES

Appendix I: Consent Form

I am a student at Moi University pursuing a Master's degree of Clinical Psychology. As part of the program, I am required to research partial fulfillment of master of Clinical Psychology program.

I am therefore interested in establishing the determinants of HIV status disclosure to sexual partners among the young adults aged 15-24 years. The information will add to the pool of knowledge in improving knowledge and experience of disclosure of HIV status to young adults hence encouraging the disclosure process.

You are invited to participate in this study by answering a questionnaire. If at any point you feel uncomfortable with the questions and would like to withdraw from the interview, you are free to do so without any repercussions.

The questionnaire will be administered by a trained research assistant. The information provided will be treated as confidential and will not be used for any other purpose other than this study.

Although you may not benefit directly from participating in the study; your contribution by filling this questionnaire will make a significant contribution to the knowledge known about disclosure.

A research assistant will keep a record of all the questionnaires in a closed cabinet. Only the professional staff and the Principal Investigator will know the identity of study participants.

If you feel that you have been affected because of participating in the study directly, please contact **Ms. Tabitha Njoroge at mobile number 0722142472**.

Your signature on this form means that you understand the information presented and that you want to participate in the study. You understand that participation is voluntary, and you may withdraw from the study at any time.

.....

Name of participant Signature/thumbprint Date and Time

.....

Name of person obtaining consent Signature Date

Appendix II: Assent form

I am a student at Moi University pursuing a Master of Clinical Psychology. As part of the program, I am required to do research as part of partial fulfillment of master of Clinical Psychology course.

You are invited to participate in this study by answering this questionnaire. Some of these questions may be personal and if at any point you feel uncomfortable answering the questions and would like to withdraw from the interview. You are free to do so without any repercussions.

The questionnaire will be administered by a trained research assistant. The information provided will be treated as confidential and will not be used for any other purpose other than for this study. After this you may be invited to participate in a focused group discussion in order to discuss in depth some of the issues that affect young adults while disclosing their HIV status to their sexual partners.

Although you may not benefit directly from participating in the study, your contribution to this questionnaire will help us improve healthcare services for young adults.

A research assistant will keep a record of all the questionnaires in a closed cabinet. Only the professional staff at the pediatric clinic will know the identity of study participants.

If you feel that you have been affected as a result of participating in the study directly, please contact Ms Tabitha Njoroge, by calling or texting mobile number 0722142472.

Your signature on this form means that you understand the information presented and that you agree to participate in the study. You understand that participation is voluntary, and you may withdraw from the study at any time.

.....

Name of participant Signature/thumbprint Date

.....

Name of person obtaining consent Signature Date

Appendix IV: Questionnaire

PART A: Demographic data

1. Study Id..... RA Initials..... Date

(dd/mm/yy).....

2. Gender (*tick the appropriate*)

☐ Male ☐ Female

3. Age (years).....

4. Mode of transmission

☐ Perinatally infected

☐ Non perinatally infected

5. Relationship Status

☐ Married ☐ Single ☐ Widowed ☐ Separated

6. Religion

☐ Christian

☐ Muslim

☐ Hindu

☐ Other specify

7. Occupation:

☐ Working full time

☐ Working part time/Casual

☐ Full time student (*skip to no. 8*)

☐ No income

☐ Other (specify).....

8. Family Income range per month (including what you earn if any)

☐ Below 1000

☐ 1001-2999

☐ 3000-4999

☐ 5000-9999

☐ 10000+

☐ Don't know

9. Level of education (*tick the appropriate*)

☐ No formal education ☐ Primary ☐ Secondary

☐ Tertiary education ☐ Vocational training

PART B. Relationship status

10. Have you ever been in a relationship with someone? This may be a spouse

(husband/wife) or someone you call your partner? (e.g. Boyfriend/girlfriend)

☐ Yes

☐ No

☐ Not sure

11. How long have you been in your current or most recent sexual relationship? ---

-----period (what is the longest period that you have ever been in a relationship?)

12. How best can you describe your most recent relationship status? (*Check all that apply*)

- ☐ We were/are living together as a couple / married / in a civil partnership
- ☐ We were/are in a steady relationship at the time
- ☐ We used to be in a steady relation, but were not at that time
- ☐ We had known each other for a while, but were not in a steady relationship
- ☐ We had recently met
- ☐ We had just met for the first time
- ☐ Prefer not to answer

Experience with disclosure

13. Have you ever disclosed your HIV status to any other person apart from healthcare workers at the hospital?

- ☐ Yes
- ☐ No
- ☐ Don't know

9.1. If yes, please specify who.....

14. How long have you been in your most recent relationship?

-----period

15. Are you aware of your partner's HIV status?

☐ Yes

☐ No

☐ Refused to answer

16. Have you ever attempted to disclose your HIV status to your romantic/sexual partner?

☐ Yes

☐ No

☐ Don't know

If yes, how would you describe the outcome?

If no, what is your greatest barrier?.....

17. Did you experience any challenges before disclosure?

17.1. If yes, please describe your experience.....

.....

18. Did you experience any form of stigma or discrimination from your partner after disclosure?

☐ Yes

☐ No

☐ Don't know

19. Do you think the disclosure experience will in any way affect your future intentions to disclose your status to your partner /spouse?

☐ Yes

☐ No

☐ Don't know

If yes, how?

Individual economic status

20. What is your **main** source of financial support (money to support yourself)?

☐ I support myself (money earned as employee, self-employment, small income generation activities, loans or bursaries or welfare payments/ grants)

☐ I am dependent on someone else's income (parents, caregiver, partner, and other relatives)

☐ Don't know

☐ Prefer not to answer

21. Do you get financial support from your partner?

☐ Yes

☐ No

☐ Don't know

☐ Prefer not to answer

22. Do you think your financial situation at the moment is hindering you from disclosing your HIV status to your sexual partner?

☐ Yes

☐ No

☐ Don't know

☐ Prefer not to answer

Assessment of emotions during disclosure

23. What were your feelings before disclosure?

☐ Worried/anxious/ stressed/sad

☐ Calm

☐ Other (specify).....

21.1 What were your feelings after disclosure?

☐ Worried/anxious/ stressed

☐ Calm

☐ Other (specify).....

24. In your own opinion did you receive emotional support from your partner after disclosing your HIV status to them?

☐ Yes

☐ No

☐ Don't know

25. Do you think the disclosure experience will in any way affect your future intentions to disclose your status to your partner /spouse?

☐ Yes, encouraged

☐ Yes, discouraged

☐ No

☐ Other

If yes, how?

Thank you for your participation!

Appendix V: Young adults Interview Guide for focused group discussions
Interview guide for young adults who have disclosed their HIV status to their sexual partners. Age

Group gender

Group number

Introduction: I will ask questions about your experience while disclosing your HIV status and the determinants to disclosure of HIV status to sexual partners. Similarly, I will ask questions regarding safe disclosure practices among young adults in sexual relationships and the recommendations regarding disclosure to sexual partners. There are no right or wrong answers to the questions, and you are the expert who will decide whether this questions are appropriate or not. So, I request your honest opinion and how you came up with your answers, this will help us understand how best we can help young adults during the disclosure of HIV status to sexual partners.

I will record this discussion to help me remember what was said but your name or any identifiable information will not be connected to what was said. Please do your best not to mention your name during the interview. I will ask questions about some personal things and some questions might make you feel

uncomfortable or upsetting. You can choose not to answer any questions that you do not want to. You may also stop the interview at any time if you decide that you do not want to participate any more. Please remember that your responses will be identified by numbers only and will be confidential. Your name will not appear in this questionnaire.

HIV disclosure knowledge

1. When you first thought about disclosing your HIV status to your sexual partner, did you have any knowledge or plan on how you were going to do it?
2. Between you and your partner who do you think should initiate the HIV disclosure discussion?
3. Why do you think it is important to disclose your HIV status to your sexual partner?
4. What motivated you to disclose your HIV status to your sexual partner?
5. What would you say is the role of disclosure of HIV status in the prevention of HIV transmission?

HIV disclosure experience

6. How would you describe your experience on disclosure of HIV status to your sexual partners?
7. For how long did you plan for disclosure before finally making full
8. disclosure?
9. What expectations did you have before disclosing your HIV status to your sexual partner?

Was this your first disclosure experience?

- 9.1 Do you think your past disclosure experiences has influenced your current disclosure? Please explain how?

Assessment of emotions and feelings before and after disclosure

10. What would you say was your greatest fear while disclosing your HIV status to your sexual partner?
11. What were you feeling before disclosing your HIV status to your sexual partner?
12. What was your feeling after disclosing your HIV status to your sexual partner?
13. Looking back at a time when you were disclosing before and after disclosure, do you think disclosing your HIV status was a good idea? Why?

Barriers and Challenges during disclosure of HIV status to sexual partners?

14. What do you think hinders most young adults from disclosing their HIV status to their partners?
15. In your own opinion, what do you think can be done to encourage young adults to disclose their HIV status to their partners?
16. What challenges do you think young adults experience while disclosing their HIV status to their sexual partners?

Determinants of disclosure

17. What factors do you think young adults should consider before disclosing their HIV status to a sexual partner?
18. What recommendations would you give to young adults who are planning to disclose their HIV status to their sexual partners?

Appendix VI: Interview guide for those who have not disclosed their HIV status to their sexual partner.

Age- Group gender- Group number-

Introduction: I will ask questions about your experience while disclosing your HIV status and the determinants to disclosure of HIV status to sexual partners. Similarly, I will ask questions regarding safe disclosure practices among young adults in sexual relationships and the recommendations regarding disclosure to sexual partners. There are no right or wrong answers to the questions, and you are the expert who will decide whether this questions are appropriate or not. So, I request your honest opinion to these questions and how you came up with your answers, this will help us understand how best we can help young adults during the disclosure of HIV status to sexual partners.

I will record this discussion to help me remember what was said but your name or any identifiable information will not be connected to what was said. Please do your best not to mention your name during the interview. I will ask questions about some personal things and some questions might make you feel uncomfortable or upset. You can choose not to answer any questions that you do not want to. You may also stop the interview at any time if you decide that you do not want to participate any more. Please remember that your responses will be identified by numbers only and will be confidential. Your name will not appear in this questionnaire.

Assessing HIV disclosure Knowledge

1. What is the main reason why you have not disclosed your HIV status to your sexual partner?
2. Between you and your partner who do you think should initiate the HIV disclosure discussion?
3. What would you say is the role of disclosure of HIV status to a sexual partner in the prevention of HIV transmission?
4. Why do you think it is important to disclose your HIV status to a sexual partner?

Assessing HIV disclosure experience

5. How would you describe your experience on disclosure of HIV status to your sexual partners?
6. Do you think your past disclosure experience has hindered you from disclosing your HIV status to your sexual partner?
7. Do you have any previous experience with disclosure of HIV status to a partner?
Please describe the outcome
8. What do you think should be done to make disclosure of HIV status to a sexual partner easy?

Assessment of emotions and feelings during disclosure of HIV status to sexual partners?

9. What would you say was your greatest fear while disclosing your HIV status to your sexual partner?
10. What do you think hinders young adults from disclosing their HIV status to their partners?

11. In your own opinion, what do you think can be done to encourage young adults to disclose their HIV status to their partners?

12. What challenges do you think young adults experience while disclosing their HIV status to their sexual partners?

Determinants of disclosure

13. What factors do you think young adults should consider before disclosing their HIV status to a sexual partner?

14. What recommendations would you give to young adults who are planning to disclose their HIV status to their sexual partners?

15. In your own opinion, which is the best way to disclose your HIV status to your sexual partner?

Appendix VII: Estimated budget

Index	Equipment and stationery	Quantity	Unit cost(Kshs)	Total Cost (Kshs)
1	Printing papers	3 rims	900	2700
2	Ball point pens	1 packet	200	200
3	Pockets files	5	100	500
4	Box files	4	100	400
5	Printing(questionnaires, UBACC, consents and assents)	5 copies	800	20000
6	Audio Voice recorder	1		4500
7	Airtime	500*5		5000
8	IREC /NACOSTI approval fee	1		3000
9	Plagiarism certificate	1		5000
10	FGD Snacks and refreshments	500*24 participants	500	12000
11	RA training and refreshments	5	1000	5000
12	Miscellaneous			15000
13	Statistician			30000
Grand Total				103,300

Appendix VIII: Study work plan

	2023							
Activity	Apr-	Ma	June-	Aug-	Se	Oct	No	DEC
Obtaining necessary	x	x	x					
Participant recruitment				x	x	x	x	x
Data analysis					x	x	x	x
Thesis writing						x	x	x

Appendix: IX: Moi Teaching and Referral Hospital approval



An ISO 9001:2015 Certified Hospital

MOI TEACHING AND REFERRAL HOSPITAL

Telephone: (+254)-0532033471/2/3/4
 Fax: 0532061749
 Email: ceo@mtrh.go.ke/ceosoffice@mtrh.go.ke

NANDI ROAD
P.O. BOX 3-30100
ELDORET, KENYA

Ref: ELD/MTRH/R&F/10/2/V.2/2010 17th July, 2023

Tabitha Njoroge,
 Moi University,
 School of Medicine,
 P.O. Box 4606-30100,
 ELDORET-KENYA.

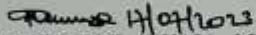
DETERMINANTS OF HIV STATUS DISCLOSURE TO SEXUAL PARTNERS AMONG YOUNG ADULTS AT ACADEMIC MODEL PROVIDING ACCESS TO HEALTH CARE-RAFIKI CENTER ELDORET-KENYA

You have been authorised to conduct research within the jurisdiction of Moi Teaching and Referral Hospital (MTRH) and its satellites sites. You are required to strictly adhere to the regulations stated below in order to safeguard the safety and well-being of staff, patients and study participants seen at MTRH.

- 1 The study shall be under Moi Teaching and Referral Hospital regulation.
- 2 A copy of MTRH/MU-IREC approval shall be a prerequisite to conducting the study.
- 3 Studies intending to export human bio-specimens must provide a permit from MOH at the recommendation of NACOSTI for each shipment.
- 4 No data collection will be allowed without an approved consent form(s) to participants unless waiver of written consent has been granted by MTRH/MU-IREC.
- 5 Take note that data collected must be treated with due confidentiality and anonymity.

The continued permission to conduct research shall only be sustained subject to fulfilling all the requirements stated above.

The approval period is 17th July, 2023 – 16th July, 2024.


DR. WILSON K. ARUASA, MBS, EBS
CHIEF EXECUTIVE OFFICER

c.c. - Senior Director, Clinical Services
 - Director, Nursing Services
 - HOD, HRISM

MOI TEACHING AND REFERRAL HOSPITAL
CEO
APPROVED

17 JUL 2023

SIGN.....
 P. O. Box 3-30100, ELDORET

All correspondences should be addressed to the Chief Executive Officer
 Visit our Website: www.mtrh.go.ke

TO BE A GLOBAL LEADER IN THE PROVISION OF EXCEPTIONAL MULTI-SPECIALTY HEALTH CARE, TRAINING AND RESEARCH

Appendix X: Institution Research and Ethics Committee approval

 MTRH/MU-INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE (IREC) MOI TEACHING AND REFERRAL HOSPITAL P.O. BOX 3 ELDORET Tel: 33471/2/3	 MOI UNIVERSITY COLLEGE OF HEALTH SCIENCES P.O. BOX 4606 ELDORET Tel: 33471/2/3 13 th July, 2023
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Reference: IREC/551/2023
Approval Number: 0004472

Tabitha Njoroge,
 Moi University,
 School of Medicine,
 P.O. Box 4606-30100,
ELDORET-KENYA.

Dear Ms. Njoroge,

DETERMINANTS OF HIV STATUS DISCLOSURE TO SEXUAL PARTNERS AMONG YOUNG ADULTS AT ACADEMIC MODEL PROVIDING ACCESS TO HEALTH CARE -RAFIKI CENTER ELDORET-KENYA

This is to inform you that **MTRH/MU-IREC** has reviewed and approved the above referenced research proposal. Your application approval number is **FAN: 0004472**. The approval period is 13th July, 2023- 12th July, 2024. This approval is subject to compliance with the following requirements;

- i. Only approved documents including (informed consents, study instruments, Material Transfer Agreements (MTA) will be used.
- ii. All changes including (amendments, deviations, and violations) are submitted for review and approval by **MTRH/MU-IREC**.
- iii. Death and life threatening problems and serious adverse events or unexpected adverse events whether related or unrelated to the study must be reported to **MTRH/MU-IREC** within 72 hours of notification.
- iv. Any changes, anticipated or otherwise that may increase the risks or affected safety or welfare of study participants and others or affect the integrity of the research must be reported to **MTRH/MU-IREC** within 72 hours.
- v. Clearance for export of biological specimens must be obtained from **MOH at the recommendation of NACOSTI** for each batch of shipment.
- vi. Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. Attach a comprehensive progress report to support the renewal.
- vii. Submission of an executive summary report within 90 days upon completion of the study to **MTRH/ MU-IREC**.

Prior to commencing your study; you will be required to obtain a research license from the National Commission for Science, Technology and Innovation (NACOSTI) <https://oris.nacosti.go.ke> and other relevant clearances from study sites including a written approval from the CEO-MTRH which is mandatory for studies to be undertaken within the jurisdiction of Moi Teaching & Referral Hospital (MTRH) and its satellites sites.

Sincerely,


PROF. E. WERE
 CHAIRMAN
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

13 JUL 2023
APPROVED
INSTITUTIONAL RESEARCH AND ETHICS COMMITTEE

cc	CEO	MTRH	Dean	SOP	Dean	SOM
	Principal	CHS	Dean	SON		SOD

Appendix Xi: NACOSTI Approval

 REPUBLIC OF KENYA	 NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION
Ref No: 316977	Date of Issue: 25/August/2023
RESEARCH LICENSE	
	
This is to Certify that Miss.. Tabitha Njeri Njoroge of Moi University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Uasin-Gishu on the topic: Determinants of HIV status disclosure to sexual partners among young adults at Academic Model Providing Access to Healthcare-Rafiki center Eldoret-Kenya for the period ending : 25/August/2024.	
License No: NACOSTI/P/23/28449	
316977	
Applicant Identification Number	Director General NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION
Verification QR Code	
	
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