EFFECT OF YOUTH HIV AND AIDS DISCLOSURE ON FAMILY AT THE COMPREHENSIVE CARE CLINIC IN KENYATTA NATIONAL HOSPITAL, NAIROBI KENYA

BY

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Declaration

This thesis is my original work and has not been presented for a degree or any other award at any other University.

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Table of Contents

Dedication

I dedicate this work to my mother Milca Mbula, and father Cornelius Kinyili for their unwavering support throughout my academic journey, and life in general. I dedicate this research to all the HIV and AIDS positive youths in our society and their families.

Acknowledgement

My gratitude first goes to God for the blessings, favour, grace, and endurance to complete my thesis. I would like to appreciate my supervisors Dr. Esther Marima, and Dr. Jane Ngure for their patience, wisdom, and support in my research writing process. I acknowledge and thank the Psychology Department of Pan Africa Christian University for their guidance and encouragement during my studies.

Abstract

Opening up about one's HIV and AIDS status to friends and family has proven to be beneficial in the overall health of an individual. However, the process of disclosure brings an unbalance in the family as they try to adjust to this new reality. The purpose of this study was to investigate the effect of youth HIV and AIDS disclosure on the family in the Comprehensive Care Clinic in Kenyatta National Hospital. The objectives focused on: the reasons for youth disclosure or non-disclosure to the family, to identify the family status disclosure outcomes to the youth's HIV and AIDS status disclosure, the coping strategies implemented when status disclosure occurs, and the counselling needs that arise in the family post-disclosure. The communication privacy movement theory was used to explore how the family navigates youth's HIV and AIDS status disclosure. The descriptive design was used in exploring the disclosure indicators, the family status disclosure outcomes, the coping strategies, and counselling needs that arose in the family post-disclosure. Both qualitative and quantitative data collection methods were used for the descriptive research design. For the purpose of the study, the target population consisted of 9,500 youths, with a sample size of 384 respondents. The sample was determined using Cochran's formula and purposive non-probability sampling technique was used, where data from the youth was collected using in-depth interviews and a questionnaires. The data was analysed and presented using frequency distributions, tables and charts using the SPSS version 28.1. The Spearman's coefficient correlation was used to assess the monotonic relationship between the youth HIV and AIDS status disclosure, and the effect it had on the family variables of the study, which was calculated using SPSS 28.1. The study found that the youth were more inclined to disclosure, if they are aware that the family will love them unconditionally despite finding out their HIV and AIDS status. The study concluded that fear of rejection due to the societal worldview, and the kind of relationship the youth has with their family influenced the youth HIV and AIDS status disclosure decision. The youth emphasized that the way their family receives the news of their HIV and AIDS positive status determines how they navigate and find ways to live with this new reality. The study demonstrated that family members can play an important role in helping the youth make appropriate life decisions to make room for their positive HIV and AIDS status. It was recommended by the study that the disclosing youth and their families need to have the appropriate resources, to help address the relational issues that presented post-disclosure. The study is significant to health care providers and also to the families to holistically equip them with the necessary tools to develop healthy coping strategies post-disclosure.

List of Tables

List of Figures

Abbreviations and Acronyms

AIDS: Acquired Immunodeficiency Syndrome

ART: Antiretroviral Treatment

ARV: Antiretroviral.

CCC: Comprehensive Care Clinic.

HIV: Human Immune Virus

KENPHIA: Kenya Population-based HIV Impact Assessment

KNH: Kenyatta National Hospital.

KNHIV: Kenya's national HIV survey.

MOH: Ministry of Health

WHO: World Health Organisation.

Definitions of Terms

Disclosure: The process of making unknown information known (Gahanna et al., 2018).In the study, disclosure will be used to assess the process of how the positive youth makes their disclosure decision of their HIV and AIDS status to their family, using it to investigate the family's reaction to the youth's status, coping strategies, and counselling needs that arise post-disclosure.

Coping strategies: Can be described as the ways in which people adjust in an attempt to reduce concerns and issues that emerge (Casey et al., 2020).Coping strategies in the study will be explored to investigate how the youth and their family finds ways to adjust either positively or negatively when the youth discloses their positive HIV and AIDS status.

Counselling needs: These are described as the physical, emotional and psychological concerns that arise in therapy like the family's reactions to the youth's HIV and AIDS positive status and youth coping strategies (Casey et al., 2020). Counselling needs are issues that come up in the family with regards to knowing the youth's HIV and AIDS positive status, which if not properly addressed can result in negative implication on how the family members interact with each other and the disclosure outcome.

Family: This is described as the basic unit in our societies (Gahanna et al., 2018). The family is seen as a unit, and when one person is affected, the whole unit is affected as the youth is navigating their positive HIV and AIDS status. The influence of the gender and age is also highlighted in the study as the youth navigates HIV and AIDS status disclosure to their family.

Chapter One: Introduction and Background to the Study

Introduction

This chapter serves as an introduction, encompassing the background of the study. It furnishes information on the statement of the problem, research objectives, and the research questions addressed in the study. Additionally, it covers the significance, justification, and the scope and limitations that manifested within the study.

Background of the Study

Throughout the world, Human Immune Virus and Acquired Immunodeficiency Virus (HIV and AIDS) has been a global epidemic that has been actively affecting the human population and Kenya is no exception. HIV can be defined as a virus that attacks the white blood cells that fight infections in the body, leaving an individual assailable to other diseases and infections (World Health Organisation, 2020). AIDS on the other hands is described as a more advanced stage of HIV which occurs in the individual where the body's immune system has been greatly damaged by the virus (WHO, 2020).

In an attempt to address what comes with a positive HIV and AIDS diagnosis for the youth, it is important to understand how the process of disclosing their status will affect their families. There are different ways in which an individual can contract the HIV and AIDS virus which according to UNAIDS (2017) include: blood, which can happen during blood or organ transfusion process, or in the process of those who use drugs sharing needles. Another means is through bodily fluids like vaginal fluids, semen and pre-seminal fluids during unprotected sex. The other way is through mother to child transmission that happens through breastfeeding, childbirth and pregnancy of a mother with a high viral load (Kazanjian, 2017).

WHO (2020), states that there are different symptoms to indicate that an individual has HIV and AIDS which include, swollen lymph nodes, fever, sore throat, endless fatigue, rashes and night sweats. However, these symptoms are not conclusive and to be sure, individuals are encouraged to go for a test which gives the conclusive diagnosis. There are different ways of getting tested for the virus including pricking on the finger or blood being drawn from the veins, and in the recent day, oral swabs that can be done at home (Weinreich & Benn, 2019).

Over the years, a lot of research has covered the individual needs presented by the individual diagnosed with HIV and AIDS (UNAIDS, 2017), providing coping and ways of how they can lead healthy and long lives by taking their medication, eating healthy and working out to keep healthy. After going through the pre-test counselling and receiving a positive diagnosis, individuals go through post-test counselling as stipulated by WHO. Weinreich and Benn (2019), argue that when one tests positive, there are counselling needs that arise and need to be discussed such as developing a healthy lifestyle.

Hospitals provide counselling services giving social support and helping the individual address issues like shock, feeling depressed, being angry that they were infected, or suicide ideation for others. Kazanjian (2017), argues that psycho-education given on status disclosure encourages individuals to open up in order to get more social support from their family and friends. In the past years, most energy and resources have been pushed towards mitigating the spread of HIV and AIDS, and ensuring that the affected population is on the ARVs medication (Kazanjian, 2017).

The World AIDS Day Report (2022), states that there are 37.7 million people who are HIV and AIDS positive globally, and only 84% of the total population is on ARVs. Despite the efforts put in place, the vision of having 100% of the HIV and AIDS positive

population on ART is not yet a reality. Studies conducted report that most of the positive population still experience discrimination and stigma from their families, and also the society by people avoiding physical contact, like greeting them for fear of being infected (UNAIDS, 2017).

In Africa, the WHO (2020) reports that of the 25.7 million people who are HIV and AIDS positive, only 64% of them are on ARVs. The World AIDS Day Report (2022), confirms that the youth population is still largely affected by HIV and AIDS, with young women between the ages of fifteen to twenty-four years being highly affected. Despite the efforts put in place in an effort to mitigate the spread of HIV and AIDS a prevalence of 25% is seen among young adults in East Africa.

In Kenya, the epidemic has significantly been a public health problem since the year 1984 affecting individuals' physically, psychologically, socially and economically (United Nations Programme on HIV/AIDS,2017). HIV and AIDS has proven to be a serious public health issue that cuts through all genders, socio-economic status, ethnicity and age in both rural and urban centres (Hatcher et al., 2020). In Kenya statistics by World AIDS Day Report (2022), states that there are 1.5 million positive individuals, and of this population 63% are on ARVs. The Ministry of Health (MOH) through the Kenya Population-based HIV Impact Assessment (KENPHIV) conducted a survey in 2018 with the findings indicating a prevalence of 4.9% in the youth population (KNHIV, 2020). Assessment of findings revealed that the prevalence of infection in women is 6.6% and 3.1% in men, with the prevalence being thrice between the ages of 20-34 years in both genders (WHO, 2020).

A lot of other research on the counselling needs for positive patients has been done, however, this begs the question of what happens when the youth born negative is infected

and needs to disclose their positive status to the family. The process of disclosure is critical and is psychologically and emotionally taxing to the youth, which can result to either a reaction of support and love, or stigmatization and discrimination (Martins et al., 2019). Despite the physical health of the positive individual, there are other factors that come into the picture like the psychological health of the youth, and the role the social support plays in their overall health with regard to disclosure (Qiao et al., 2018).

It can be argued that there is need for understanding how the relationship of the youth to those around them affects the result of their disclosure (Smith, et al., 2017). Attention needs to be paid to the family of the infected youth according to Pequegnat and Bell (2021), with regards to the counselling needs that arise and the coping experiences of their families, investigating whether disclosing will bring a negative consequence or it will be among the positive factors that promotes resilience as the family interacts. KNHIV (2020) argues that once the youth's HIV and AIDS status disclosure is done to their family members, it directly affects them as they are now directly included in the process of living, and maintaining a healthy lifestyle that comes with unique physical, emotional and psychosocial aspects.

When the youth receives a positive diagnosis Kazanjian (2017), states that some of the individuals suffer grief for loss of physical health, anxiety, fear of death, and some abuse drugs due to relational difficulties among other effects. Focusing on the youth's reactions to a positive diagnosis, the counselling needs and coping strategies are vital, but it is also important to understand what happens in the family when the youth discloses their HIV and AIDS status. Gahanna et al., (2018), argue that there is need for extensive literature conveying the counselling needs that root from disclosure in the family post-disclosure. This is resulting to an increase in the attention given to the family members'

reactions to youth's HIV and AIDS status disclosure, the counselling needs and coping strategies of affected families according to Pequegnat and Bell (2021).

Studies done seem to suggest that the psychological consequences of disclosure evidently show that besides the infected individual, the family is also directly affected (Dimbuene, 2019). The World AIDS Day Report (2022), reports that apart from the counselling given to the positive individual, it is evident that integrating the family in the process of therapy is very beneficial to them. This ensures that both the youth and the family members are holistically empowered with appropriate tools that will help them navigate the youth's HIV/AIDS status disclosure process.

According to the WHO (2020), HIV/AIDS status disclosure occurs in different ways, first disclosure is between sexually active partners, where the HIV positive individual is expected to reveal their status to their partner. The second way disclosure occurs is between a mother and their child, where the HIV/AIDS positive mother reveals to the child about their positive HIV/AIDS status. Finally, HIV/AIDS status disclosure occurs when an individual born negative tests HIV/AIDS positive, and they reveal their status to their friends or family members (KNHIV, 2020).

When the youth tests positive for HIV and AIDS they are often encouraged by medical professionals who conduct the testing and counselling process to disclose their status to their families (WHO, 2020). When not carefully handled, disclosure can leave room for a lot of maladaptive coping mechanisms, issues rooting from family members' reactions to youth's HIV and AIDS status, and counselling needs going unaddressed for the youth and their family (Joe et al., 2017). In Kenya, the youth is expected to disclose but they lack guidance on how to navigate status disclosure to their families, and the post-disclosure reactions that result from opening up about their HIV and AIDS status.

Most people in Kenya view HIV and AIDS as a death sentence in the case of a positive diagnosis, leaving the individual with psychological stresses and feeling of helplessness (Dimbuene, 2019). The history of HIV and AIDS in Kenya paints a picture of if an individual is positive they are either men sleeping with men, or are just promiscuous individuals (Pequegnat & Bell, 2021). Our societies' and cultural world views have great influence on our views regarding HIV and AIDS, which leaves families where the youth who was born negative, and has now disclosed that they are HIV and AIDS positive in a place of distress (Joe et al., 2017). This then would result to the family being like a ticking bomb awaiting to explode because of all the issues simmering within the family as a result of youth HIV and AIDS status disclosure (Scanlon et al., 2018).

Buki, Kogan, Keen and Uman (2017), argue that in the new light of disclosure, there are changes in how the family will perceive the positive youth, and how they interact hence dysfunctional patterns may crop up in the family. In Kenyatta National Hospital, programs have been implemented to help curb the issue of HIV and AIDS, where they offer both physical and psychological help to positive patients (KNHIV, 2020). Such programmes are established to encumber the epidemic of HIV and AIDS, they are health care systems for the population in order to ease the process of delivering health care and treatment (Scanlon et al., 2018).

Statement of the Problem

With the increase of cases where youths are testing positive for HIV and AIDS, this means that most of this population is encouraged to disclose their status which is a complex process. The Comprehensive Care Clinic (CCC) offers medical and psychological support through focus group discussions to offer social support (Kenya's national HIV survey, 2020). Okorie et al. (2023), report that the global rate at which infected youths are disclosing their status to their family is estimated to be 79% of the positive population.

On the other hand, the rate of youth HIV and AIDS disclosure to family members range from 9% to 72% varying from country to country, due to influences from different factors that affect HIV and AIDS disclosure (Okorie et al., 2023). Research according to Okorie et al. (2023), reveals that there is a rate of 70-80% when it comes to HIV and AIDS status disclosure among the youth in Kenya. This then poses the question of the effect of youth HIV and AIDS disclosure has on the family. It also poses the question why 30-20% of the positive youth population decide to keep their HIV and AIDS status a secret from their families.

It is important that the youth who desires to disclose their positive status to the family is fully equipped to deal with the reactions and consequences of this process (Martins et al., 2019). Scanlon et al. (2018), argues that understanding how the youth and the family navigate the process of HIV and AIDS disclosure and its consequences is critical for the overall health of both the youth and their family. Literature on the physical and psychological effects of HIV and AIDS and treatment of the youth is vast throughout the world, but there is inadequate literature on the detrimental psychological, physical and emotional effects HIV and AIDS disclosure can have on the family as a unit (Hatcher et al., 2020). The research therefore contributed to knowledge production in investigating the effects of youth HIV and AIDS status disclosure on the family members at the CCC, Nairobi Kenya.

Purpose of the study

When disclosure is done there are consequences that result from this including; psychiatric illnesses like depression and anxiety, while the family also experiences a reorganisation of their structure, functioning, and the way they relate (Weinreich & Benn, 2019). On the other hand, some youths opt to keep their positive status to themselves for

fears of being looked at differently (Gahanna et al., 2018). American Psychological Association, (2017), states that with the event of disclosure, there is the possibility of the occurrence of harassment, secondary stigma and social rejection for the family and in turn this directly affects the family psychologically.

The social rejection can be within the family towards the positive patient, or from outside the family when the society or community they live in get wind of the positive diagnosis of the youth (Dessie et al., 2019). At the same time, Gahanna et al. (2018), indicates that there are financial and medical challenges experienced by the family as a result of when disclosure by the youth happens in Kenya. Most young people are not yet established financially, or are in the process of establishing themselves and still depend on their family's support when they disclose their status (Dimbuene, 2019).

While focusing on the reactions from the family Buki et al. (2017), highlights that the rejection and isolation is a common theme seen globally when positive individuals disclose their status to their family, hence some opt not to disclose their status. Qiao et al. (2018), argues that HIV and AIDS is still a sensitive subject among different nationalities and cultures globally, where despite public knowledge, some individuals still face discrimination which discourages disclosure and testing. This study therefore seeks to investigate the effect of the youth's positive HIV and AIDS status disclosure on the family.

Objectives of the Study

The following are the objectives of this study:

1. To investigate the reasons for disclosure of youth HIV and AIDS status to the family members.

2. To identify the youth's HIV and AIDS outcomes from status disclosure to the family members.

3. To assess the youth coping strategies resulting from HIV and AIDS status disclosure in the family.

4. To investigate the youth counselling needs resulting from HIV and AIDS status disclosure in the family.

Research Questions

1. What are the reasons for youth HIV and AIDS status disclosure to the family members?

2. How does the disclosure outcomes of youth HIV and AIDS status disclosure present in the family?

3. To what extent does the youth find coping strategies as a result of HIV and AIDS status disclosure in the family?

4. What are the youth counselling needs that arise as a result of HIV and AIDS status disclosure in the family?

Assumptions of the Study

This study worked on the assumption that when the youth received a positive diagnosis, there are reasons that encouraged or discouraged them from disclosing their HIV and AIDS status to their family. At the same time, as a result of youth HIV and AIDS status disclosure, there were outcomes that occurred in the family as a result of finding out the youth's status which can be beneficial or not to the youth. As a result the youth disclosing their HIV and AIDS status to their family, experienced a variety of reaction and feedback which varied from family to family based on different aspect like family perspective on HIV and AIDS.

From this, there were significant counselling needs that developed in the family, which affected the overall treatment process of the youth and the family. At the same time, the study assumed that the youth's reason for disclosure, outcomes of status disclosure, disclosure experience, and counselling needs were common to everyone that received a positive diagnosis, but when they were neither properly diagnosed nor treated in relation to how disclosure affects the family this led to maladaptive coping.

Justification of the Study

HIV and AIDS and its management in the Kenyan setting mainly focuses on the patient, and barely any attention is paid to the family, with regard to the reactions experienced on finding that the youth is positive, and how they cope with their new reality once disclosure is done by the positive youth. Most of the research done focuses on the process before testing and results being given to the patient, and how the patient is affected psychologically when they find out that they are HIV and AIDS positive (Casey et al., 2020). However, literature on the devastating psychosocial effects of disclosure of youth HIV and AIDS status in the family has been greatly overlooked even though in the recent years the need of this research has been put into consideration (Hatcher et al., 2020).

This study focused on the effect disclosure of the youth's positive HIV and AIDS status has on their family, bearing in mind that the burden of physical, financial and psychosocial needs falls on the family which results to stress reactions (Dimbuene, 2019). It is important to consider that even with the health practitioner's trained to deal with HIV and AIDS individual, the factors encouraging youth status disclosure, the youth's status disclosure outcome, experience and counselling needs resulting from disclosing their HIV and AIDS status to family members are greatly overlooked (Joe et al., 2017). This then indicates the need for family interventions that help in the event disclosure is done.

Significance of the study

From a marriage and family therapist's point of view, there is a gap that is yet to be tapped into with regards to the reasons for disclosure of youth HIV and AIDS status to the family, outcomes from status disclosure to the family members, the youth's disclosure coping strategies resulting from status disclosure, and the counselling needs resulting from the youth HIV and AIDS status disclosure in the family. It is important however, to understand the reasons that fuel a decision of whether one wants to disclose their status or not.

Hereof, the findings of the study are a doorway to determine and come up with a structured framework for dealing with the outcomes, coping strategies, and counselling needs resulting from the youth's HIV and AIDS status disclosure to their family members. The study will enable health care practitioners like nurses, counsellors, psychologists and other mental health practitioners to address the specific counselling needs and the outcomes resulting from the youth's positive HIV and AIDS status disclosure. At the same time, the family members can benefit from this research through psycho-education, and therapy, they are able to process the psychological and emotional reactions that stem from disclosure.

Having a family oriented intervention also helps the youth and family reduce social stigma, isolation and also curb HIV-risk behaviours in the youth. Above all, the youth is the greatest beneficiary from this research as they are sufficiently helped to understand and navigate the process of disclosure appropriately with their families, which ensures their overall health physically and psychologically.

Scope of the Study

The study was conducted on the HIV and AIDS positive youths who seek medical attention in the Kenyatta National hospital where over 9,500 individuals seek medical attention (KNHIV, 2020). The 384 youths purposively sampled from the Comprehensive Care Clinic were used in the study, with support groups that have thirty individuals each. The descriptive research aimed at using both qualitative and quantitative methods to obtain data. The study used in-depth interviews and questionnaires to collect data from the Comprehensive Care Clinic. The study focused on the youth in the clinic whose ages range from 18 years-24 years, for individuals who have received a positive HIV and AIDS diagnosis in the last five years, with regard to the effect of youth HIV and AIDS status disclosure at the clinic.

Limitation of the Study

Despite the youth being encouraged to disclose their HIV and AIDS status to their families, there are different factors that affect the success or failure of the process. Considering that the research is generalised for the youth population in KNH, conducting the study in a different population like rural areas has a possibility of giving different results due to factors like geographic and socio-economic factors. To avoid this bias, the population used in the study was selected specifically from the Comprehensive Care Clinic.

Some of the respondents at the Comprehensive Care Clinic were reluctant to participate in the study as a result of being apprehensive about disclosing their status to their own family members. This was mitigated by giving a detailed consent form with details on the objectives of the study, and the risks and benefits of participating in the study as a HIV/AIDS positive youth.

At the same time, the research greatly depended on the willingness of the youth to participate in the study, as some have disclosed their status while some prefer to keep their HIV and AIDS status private. To avoid these biases in the study, the respondents were limited to those who have already undergone counselling prior and after receiving a positive diagnosis, those who have already disclosed their status to their family, and those willing to consider disclosing their status.

Chapter Summary

Finding out one has tested HIV and AIDS positive is not easy to take in. The youth being encouraged to disclose their HIV and AIDS status will experience the aftermath of their disclosure in the family which the study is aimed at exploring. This chapter introduces the phenomenon of youth HIV and AIDS status disclosure, the research problem, the statement problem, study objectives, and research questions were stated. The significance of the study, the purpose, the scope, and study limitations were explained. In the next chapter relevant literature about what is already known in the field was reviewed.

Chapter Two: Literature Review

Introduction

This chapter gives an introduction of the literature that was reviewed in the study. It includes the empirical review, the theoretical framework and conceptual framework. The chapter also includes the research gap that the study investigated, with regards to the effect of youth HIV and AIDS status disclosure in the family. Over the years, most individuals all over the world who are given a positive diagnosis of HIV and AIDS are always encouraged to disclose their status to their family and loved ones (Joe et al., 2017). This is done because it is intended to provide social support and make the process of living with this new reality easier for the individual (Ullery & Carney, 2020). In Kenya, statistics show that the youth have the highest percentage of HIV infections according to a survey conducted by the Ministry of Health (2020).

However, disclosure can result to negative responses towards the youth who have decided to open up to their family about their health status because most health workers encourage disclosure. Attention is not paid to factors like if it is safe for the youth to disclose, how their disclosure will play out and affect their family, and what will be the way forward for the youth and the family in light of this new reality (Martins et al., 2019).

Empirical literature

The Communication Privacy Management (CPM) theory has been applied to various contexts, including health and risk communication, to understand how individuals manage private information and make decisions about disclosure. This section reviews the empirical literature on CPM and its application to HIV/AIDS disclosure, focusing on the objectives of investigating reasons for disclosure, identifying disclosure outcomes, assessing coping strategies, and investigating counselling needs.

Reasons for Disclosure

Disclosure of private information is a sensitive process that is not easy to navigate for different individuals. There are different aspects that influence the decision for disclosure, and it can be argued according to Smith et al., (2019), that the relationship the youth has with the family will determine if the youth will come to the decision of disclosing their status. The youth can have motivation to either disclose their HIV and AIDS status to their family, or keep it to themselves.

Zhiwen et al. (2017), examined young partners who were newly diagnosed as being HIV and AIDS positive and were in the process of navigating status disclosure. The study was conducted in 2 cities and 10 counties in Guangxi Autonomous Region in China. The aim of the study was to investigate factors influencing HIV and AIDS status disclosure among spouses and parents living positively. The quantitative study used survey to collect data from 2,987 participants. The respondents were at least 18 years old, and children ranging between the ages of 5-16 years.

The study was built on the Communication Privacy Management theory to investigate aspects that motivate status disclosure for individuals who have received a positive HIV and AIDS status. Findings of the study indicated that there are different factors that influenced the ability of an individual to disclose or not disclose their positive HIV and AIDS status. Key factors like motivation and gender were looked at, and gender was used to compare the difference in experience of HIV and AIDS status disclosure decision between men and women (Zhiwen et al., 2017).

Pequegnat and Bell (2021), argued that the gender of an individual caries a lot of weight in the process of HIV and AIDS status disclosure, the youth is seen as either promiscuous or regarded as men who sleep with men. The study revealed that respondents

weighed the risk or benefit of disclosing their status, and decided to disclose because they did not want to keep secrets from their family, and wanted to have someone who will be there to support them in those tough times making their family members co-owners of their health status (Smith et al., 2019).

The study found that the logic to make the status disclosure decision varied between men and women, where men made their decision based on the logic behind if it will benefit them to disclose or not, while women made the decision based on how secure they feel in their relationship (Zhiwen et al., 2017). The study also found there was a lot of fear of stigma and discrimination that was a stumbling block for HIV and AIDS status disclosure.

The study also revealed that sometimes individuals find it hard to disclose their status for the fear of being stigmatised because culture and society view HIV and AIDS as a death sentence (Gahanna et al., 2018), which can discourage one from open up. On the other hand the study also established that in an attempts to manage stress and depression, other respondents decided to disclose their status. The study suggested that before the youth disclose their status, it is important to evaluate these different aspects before sharing information on their positive HIV and AIDS status.

Disclosure Outcomes

Disclosure outcomes have been a crucial aspect in understanding the effect youth HIV and AIDS status disclosure has on the family (Lee et al., 2019). Research on the experience on the disclosure outcomes was explored in 15 clinics of the Adolescent Medical Trial Network clinics across the United States and Puerto Rico (Lee et al., 2019). The qualitative study was conducted using interview on the 402 respondents between the ages of 12-24 year.

The study revealed that due to the fear of receiving negative reactions from family members, the youth are mostly opposed to HIV and AIDS status disclosure. Lee at al. (2019), emphasized the importance of understanding the critical aspects like support seeking that can lead to status disclosure, and how this is received in the family post-disclosure. The study reported that post-disclosure, there was a difference in interaction where some respondents experience a distancing of physical proximity, and withdrawal of emotional connections with those they disclosed their HIV and AIDS status to (Lee et al., 2019).

The study by Lee et al. (2019), highlighted the important role youth sexual orientation, race and ethnicity has on the perceptions on HIV and AIDS, played on the reactions family and friends had when they come to the realisation that the youth is HIV and AIDS positive. The study however had its limitation where the data collected was only limited to social and family networks, highlighting the need for expansion in the research field in order to investigate the quality of the disclosing youth, focusing on the coping strategies and counselling needs that crop up post disclosure (Lee et al., 2019).

Coping Strategies

In the instance that the youth's viral load is too high to the point they are admitted in hospital for AIDS, the caregiver has to be brought into the process of treatment as stipulated by the WHO (2020). Looking at this to explore disclosure using context, it is important to understand that the health status is still private information even after the youth has disclosed their HIV and AIDS status. However, because disclosure has to happen, the youth and the family have to find a way to navigate the effects this will have in the relational issues that will crop up post-disclosure (Frain et al., 2018).

A qualitative study was conducted by Aurpibul et al. (2023), with an attempt to investigate the challenges that presented themselves in the family as a result of youth HIV and AIDS status disclosure. The study was conducted in Botswana, where in-depth semi-structured interviews were conducted to explore different themes like the lifestyle adjustments required post-disclosure. The study emphasised on the ability of the youth who had disclosed their positive HIV and AIDS status access to emotional security and unconditional love, or otherwise to those they had disclosed to (Aurpibul et al., 2023).

Martins et al. (2019), argued that the information shared involved how long the youth had been on ART medication, how they were infected, and how they had been coping since they found out about their positive HIV and AIDS status. However, the study respondents faced multiple challenges which included poor adherence on antiretroviral therapy, and financial burdens and stressors that came with being HIV and AIDS positive. The study highlighted that in some families navigating problem solving was a big challenge, while in some families knowing the youth was HIV and AIDS positive was a source of resilience for both the disclosing youth and their family (Aurpibul et al., 2023).

When disclosure occurred, the impact was evident in the family which then left the question; is there a right time and place for one to disclose? At the same time, the study insisted that it was important to understand that the nature of disclosure is complicated, and it has influence on what kind of private information is shared (Braithwaite et al., 2018). The study recommended the need for healthcare providers and support systems like family, to give priority to providence of counselling services to ensure development of positive coping strategies post HIV and AIDS status disclosure (Aurpibul et al., 2023).

Counselling Needs

As the youth and their family navigate news of the positive HIV and AIDS status, the reactions include the emotional experience of the family who can express disappointment, or reassure their unconditional love to the youth (Qiao et al., 2018). Lockwood et al. (2019), conducted a qualitative study in Kibera, Kenya using focus groups to investigate the counselling needs presented by the youth who had received a positive HIV and AIDS status diagnosis. The semi-structured focus group discussions were conducted on the 52 respondents whose ages ranged between 18-27 years old.

It is important to understand that the ability of families to navigate the youth's positive HIV and AIDS diagnosis greatly varied from one family to another, and the counselling needs reflected in the families were unique. This was explored by Lockwood et al. (2019), focusing on aspects like the quality of life, the increase of risk-behaviour, and social impairment that resulted from HIV and AIDS status disclosure or non-disclosure. The study highlighted the need for families being empowered with the appropriate resources they needed to navigate the issues that presented, like the psychological and financial constrain post-disclosure.

The study insisted on the need for interventions that addressed aspects like the ability for family to positively contribute to the quality of life of the disclosing youth like accompanying them for doctor's appointments. Lockwood et al. (2019), study recommended the need for family focused interventions to help newly diagnosed youth navigate HIV and AIDS status disclosure across different socio-ecological levels in Kenya. The study insisted that health care providers should equip the disclosing youth with problem solving, and conflict resolution skills before encouraging them to disclose their HIV and AIDS status to their families.

In summary, the empirical literature on CPM and HIV/AIDS disclosure highlighted the importance of understanding the reasons for disclosure, the outcomes of disclosure, the coping strategies used, and the counselling needs of individuals living with HIV. These findings presented significant implications for the development of effective interventions and support systems, to promote the health and well-being of individuals and families affected by HIV/AIDS (Lockwood et al., 2019).

Theoretical Framework

There are different models and theories that have been developed in attempt to investigate the effect disclosure has on the family, and what comes during and after disclosure. The Communication Privacy Management theory was developed by Sandra Petronio in 2002, which explored disclosure of private information. The theory is built on the foundations of communication, with its research systemically designed to help understand how the individual and family navigate disclosure.

The theory can be used in family communication to explore different aspects of life, and the process the family has to go through as they try to adjust to accommodate this new information (Petronio, 2002). The theory has proven to be helpful in facilitating sensitive conversations as people open up on topics like having a miscarriage, getting divorced, matters of sexual abuse, or their HIV and AIDS status.

The theory looks at disclosure as a process and not a one-time thing, it analyses the state of tension that happens in the process of an individual trying to disclose private information or not to their family (Petronio, 2002). It can be argued that when looking at the relationship between an individual's privacy and their decision to disclose or not, is important to understand that these two factors cannot be looked at separately because they are intertwined in nature, which is referred to as privacy dialectics. Privacy dialectics argue

that there are different factors that come into play and affect the process of an individual's privacy, and their decision to disclose private information or not (Braithwaite et al., 2018). It is important to understand that interacting with people every day does not necessarily mean we know them entirely, as everyone has something they keep to themselves.

Braithwaite et al. (2018), argue that as an individual is going through the tough time as they try to navigate the disclosure process to their families, it is important to understand that disclosure is a complex process. The fact that an individual is avoiding disclosure does not mean they will entirely decide against disclosing private information (Petronio, 2002). The theory therefore looks at the process of disclosure through the lenses of the motions the individual and family have to go through as they try to navigate the new private information.

Petronio (2002), argues that privacy boundaries are used to map out what information is referred to as private or public information. Privacy boundaries are used to demonstrate how much or little of the private information is revealed, Braithwaite e al., (2018), argue that these boundaries can be permeable or impermeable in nature. Boundary permeability is defined as how much or little access, or closeness is present in the privacy boundaries (Petronio, 2002). The easier it is for the private information to be shared the thinner and permeable the boundaries, while impermeable boundaries mean that private information is kept private by any means necessary (Braithwaite et al., 2018).

Boundary linkage is a term in the theory that dictates that there are rules that dictate how information will navigate through the privacy boundary from the individual to their family (Petronio, 2002). As people try to navigate the collective boundaries of private information as co-owners of the new information, Petronio (2002), states that boundary

linkage dictates what kind of information is disclosed, the depth of the information given to another and, how privacy will be maintained.

It is important to understand that privacy boundaries are guided by principles according to Braithwaite et al., (2018), which include the right for a person to have the power to disclose what they are comfortable opening up about as owners of the information. Secondly, people control the kind of information that they have creating privacy boundaries. The third principle argues that once disclosure occurs, those who have been told are now also co-owners of the private information. In the fourth principle, both parties agree on whether to open up to other people or keep it to themselves as dictated by the privacy rules. Petronio (2002), argues that if the co-owners cannot successfully agree on which boundaries to keep in preserving the private information, the disagreement causes boundary turbulence which is the fifth principle.

Petronio (2002), states that whoever has the private information is also considered to be part of the co-owners of the information. Opening up can leave individuals feeling susceptible to the reaction that follows whether negative or positive, and to prevent this feeling there are privacy rules that dictate how the owners interact with the private information. Before people disclose, they tend to weigh the risks and benefits that come with sharing private information (Petronio, 2002). When private information is shared, the private boundaries become collective boundaries as there are other people who own the information, and there are privacy rules that guide the process (Braithwaite et al., 2018).

Braithwaite et al (2018), argues that the privacy rules are classified in categories which dictate how disclosure will occur. It is important to understand that the privacy rules are not used as absolute truths that cannot be adjusted, for them to work appropriately they have to be flexible to accommodate change (Petronio, 2002). The first category is core,

which entails culture that sets the norms of which topics to open up about and which to keep private.

Gender is also a core category, where the socialization process in our different societies dictates how information will be given and received based on one's gender. Petronio (2002), argues gender weighs on the process of disclosure where men mostly use logic to make the disclosure decision by assessing the factors in play. Women on the other hand, need to feel secure with the person they intend to disclose to their private information.

The other category of private rules is catalyst which entails context where the environment has influence of an individual's decision to disclose or not. Motivation is another catalyst category which Petronio (2002), argues that closeness in relationships can promote sharing of private information on the basis of feeling comfortable to open up, or even open up after the other party has disclosed something about themselves. The last catalyst category is where people asses the risks or benefits that come from sharing private information and make a decision to disclose or not based on this (Braithwaite et al., 2018).

Despite disclosure being verbal or written, Weinreich and Benn (2019), argue that there are different ways in which disclosure can happen. The first way is direct disclosure where the individual opens up to family and friends about their status, The second way is indirect disclosure where the individual has someone who comes in to help them disclose like a doctor or a therapist. Finally the other ways disclosure can happen is by family members or friends finding the ARV medication forcing the individual to disclose, or in the instance where the individual's health is so bad to the point they are admitted in hospital forcing the doctor to disclose to the family (Dessie et al., 2019).

It can therefore be argued that the Communication Privacy Management theory makes the stance that once disclosure happens, one cannot take back the private information shared, regardless of whether the new co-owner embraces or rejects them. Petronio (2002), argues that when people are unable to successfully navigate the privacy boundaries as dictated by the privacy rules, this results to boundary turbulence. When people open up about new information, they are still trying to navigate the boundaries of interacting with the private information (Braithwaite et al., 2018). After sharing and receiving private information, the co-owners have expectations which when not met accordingly can lead to conflict.

Petronion (2002), argues that sometimes the new co-owners can violate the privacy boundaries, giving no regard to the privacy rule, by telling other people about the private information revealed resulting to strife in the relationship between the co-owners. It is important to understand that boundary turbulence is not entirely always negative, as the co-owners of the private information try to navigate and form new boundaries this can lead to an improvement in their relationship. Privacy recalibration therefore comes in to help the individual and the family as new co-owners of private information, find a way to maintain the private information private which protect both the youth and the family as a unit.

Receiving a positive HIV and AIDS diagnosis as a youth is not a simple thing to navigate, let alone coming to the decision of disclosing one's status to their family. When disclosure occurs there is a period of distress that goes on in the family when they are dealing with the sensitive issue of the youth's positive HIV and AIDS status disclosure. As a marriage and family therapist, the family is seen as a unit and when one person is affected so is the whole family (Frain, Berven, Chan, & Tschopp, 2018). Being a youth

who was born HIV and AIDS negative, but has now tested positive puts their family in a different position when disclosure occurs (Hatcher et al., 2020).

In some families, knowing what the youth is going through can be a great source of support which is good, but in some cases it can result to negative response from the family like stigmatization (Dessie et al., 2019). Sometimes to avoid the negative response from the family or friends, an individual can opt to keep their positive diagnosis to avoid being discriminated against (Frain et al., 2018). The Communication Privacy Management theory is significant in the study as it explores the different factors that determine whether the youth will disclose their HIV and AIDS status or keep it to themselves (Braithwaite et al., 2018).

At the same time as required by the study, the theory is significant in exploring boundary turbulence of how the youth HIV and AIDS status disclosure affects the family, focusing on the issues that come up and how the family finds ways to navigate them, whether positively or negatively. Statistics over the years in Kenya, report that there is a high prevalence of infections in young people, a lot of resources is being channelled to ensure everyone is receiving their medication and social support (Ullery and Carney, 2020). However, efforts to expand research that examines the distress and the emotional experience the family has to go through when the youth discloses their HIV and AIDS status is inadequate.

Reasons for youth HIV and AIDS Status Disclosure

Navigating privacy boundaries is not an easy task for either the youth or the family which can cause distress when youth HIV and AIDS status is disclosed to the family (Braithwaite et al., 2018). Knowing that privacy boundaries from family to family is important because in some families the boundaries are thin making the process of

disclosure easier, or impermeable making the youth keep the private information to themselves (Qiao et al., 2018).

Understanding that as the youth and their family try to navigate boundary linkage that dictates what kind of information is disclosed, to what depth the information is given to another, and how privacy will be maintained in the family in the process of disclosure is important. Smith et al (2017), argues that the kind of relationship the youth has with their family will contribute to how easy or hard it will be for them to navigate the privacy boundaries and the post-disclosure reactions in the family. This means that if the youth has a close relationship with their family, it will be easy for them to open up about their positive HIV and AIDS status.

APA (2017), states that most studies conducted globally argue that how the family relates with each other, and their ability to address hard situations and navigate them successfully can encourage the youth to either decide to disclose their HIV and AIDS status or not. Casey et al., (2020), argues that in most cases in Africa and in Kenya, the youth have assurance that they can depend on their family members for support in difficult and complicated situations, can encourage status disclosure.

It is important to understand that there are factors that determine how the process of disclosure plays out uniquely from family to family, and the consequences that are an aftermath of when youth HIV and AIDS status disclosure occurs. With this in mind, if the youth comes from a family where they are able to talk and address hard topics, they successfully navigate them together, and are more inclined to open up about their HIV and AIDS status. Weinreich and Benn (2019), argue that factors like the gender of the youth and their family's culture also have an impact on how the youth will decide to disclose their HIV and AIDS status or keep the private information private.

Youth HIV and AIDS Status Disclosure Outcomes

When looking at the disclosing youth and their family, being added as co-owners of the youth's HIV and AIDS status causes an unbalance in their homeostasis physically, emotionally and psychologically causing stress (Casey et al., 2020). It can be argued that family works as a unit, and when a person is affected, the whole family is also affected. Using this grounds when looking at the positive HIV and AIDS youth, it is important to understand how their status disclosure plays out as they try to navigate the outcomes resulting from this new information as a unit. APA (2017), argues that on a global level, regionally in Africa and also in Kenya, every family will have different outcomes whether positively or negatively, with regards to the HIV and AIDS status.

As the family tries to come to terms with the new private information revealed, they present reactions that can either be negative or positive as they try to change to accommodate the youth's HIV and AIDS status (Weinreich & Benn, 2019). It can therefore be argued that the youth's HIV and AIDS status disclosure outcomes in the family can be reflected by how the family members behave, and carry themselves around the youth who has decided to disclose their HIV and AIDS status. As a result of knowing the youth's HIV and AIDS status, the family members can respond by openly discriminating the youth or become emotionally distant from them.

On the other end of the spectrum, other family members can respond by offering unconditional positive acceptance, and offer social support to the youth. As the youth and their family try to make meaning of their new reality, feelings of disappointment, anxiety, fear, disgust, or anger can present themselves in the family, and sometimes conflict can be experienced, hence presenting as family disclosure outcomes in the study.

The youth's and their family's worldview of HIV and AIDS, and the privacy rules like gender or culture, highly influence the magnitude of outcomes resulting from the youth disclosing their HIV and AIDS status (Petronio, 2002). This then means if a girl for instance comes from a culture where openly talking about their sexual encounters is a taboo, this will make her feel insecure discussing her HIV and AIDS status. From her decision to disclose her HIV and AIDS status to her family despite the unconducive dynamic, the outcome of her disclosure will definitely be negative.

Sometimes the outcome in the family that present themselves were looked at as a chance for the family to change and discover the potential they have as a unit, and they can use them to learn and grow. The youth revealing their HIV and AIDS status is a unique situation which causes unrest in the family, and seeing the reactions the family members have in relation to the youth's status disclosure is an occurrence to be expected. At the same time, if the youth and their family are able to identify available resources at their disposal, they can use them to help them navigate the effect of youth HIV and AIDS status disclosure. These resources can include the youth and their family freely communicating their opinions and concerns as they try to navigate their new reality.

HIV and AIDS Status Disclosure Coping Strategies

As stated by Braithwaite et al (2018), privacy turbulence is not always a bad thing, because if well navigated using privacy recalibration, the family can benefit from it. In an attempt to adjust to this new information, privacy turbulence can result to the family growing closer, and finding ways to openly talk about sensitive topics in an attempt to ease stigmatization (Hatcher et al., 2020). It is therefore important to understand that despite the fact that navigating the new privacy boundaries can be challenging, as the family goes through the boundary turbulence, they can adopt healthy ways of accommodating the youth's positive status.

Smith et al (2019) states that some families come in as co-owners who help the youth live a healthy lifestyle by involving a nutritionist, others accompany the youth to hospital when they go for ARV medication. Family members who decide to be part of the youth's support system by accompanying them to hospital, or being part of the people who actively help the youth make lifestyle decisions has proven to be beneficial in Kenya (KNHIV, 2020). APA (2017), argues that some families globally, in Africa and in Kenya offer support and unconditional love, but this is not the case in every family. This means that every youth and their family, process of navigating disclosure should be given special attention, because each family will experience the youth's HIV and AIDS status disclosure differently.

Frain et al (2018), state that by finding ways to cope, the family and the youth both explore the new unmarked privacy boundaries together using the privacy rules, and develop resilience to navigate the boundary turbulences they experience. They find ways to ensure that the youth feels accepted and loved unconditionally. When disclosure happens successfully, the youth and their family find ways to cope accordingly. Their experience as a family has a ripple effect to the society as more people are equipped with healthy coping skills, and are able to address their needs in a healthy way within the family.

However, in some families, youth HIV and AIDS status disclosure is experienced negatively where they are taken aback, and secretly or openly reject the youth leading to discrimination. In attempt to make room for the youth's HIV and AIDS status the youth and their family can develop maladaptive coping strategies according to Hatcher et al (2020), where for example, they attack the positive youth, and distance themselves by either giving them specific utensils to use in the house, or chasing them away.

HIV and AIDS Counselling Needs

The youth's HIV and AIDS status is sensitive information which when disclosed, causes the family to experience privacy turbulence as they try to navigate and stipulate new privacy boundaries (Braithwaite et al., 2018). As the new co-owners of the youth's private status, the family can infringe on the privacy of the youth, by telling other extended family members or friends resulting to problems that can be presented as counselling needs in therapy (Martins et al., 2019). With this in mind, incorporating the youth and their family can be beneficial to them as a unit, in their process of trying to navigate these uncharted waters of the youth's HIV and AIDS status.

In the incident where the youth is sick with AIDS and the family has to be brought into the process of treatment as stipulated by WHO (2020), factors like these in the family if not properly addressed can be detrimental to the overall health of the family. The family is expected to come into the medical emergency scenario for the youth admitted for AIDS, but they are inadequately prepared (KNHIV, 2020). It is important for the youth and the family to be prepared and equipped psychologically, so that they can respond effectively to the outcome of disclosure. Looking at the statistics globally, in Africa and in Kenya, not many youths and their families have access to, knowledge of Marriage and family therapist who can help them navigate HIV and AIDS disclosure (APA, 2017).

Dessie et al (2019), argues that as new co-owners of the youth's status, the youth and their family might go through turbulences of fearing that the youth who is positive may die, or anger that the youth is promiscuous and now they are infected. The family needs to be assessed with regards to their emotional experience in light of the new information, and also get help addressing some of the concerns that arise (Frain et al., 2018). The family may be concerned as this new information demands that they evaluate

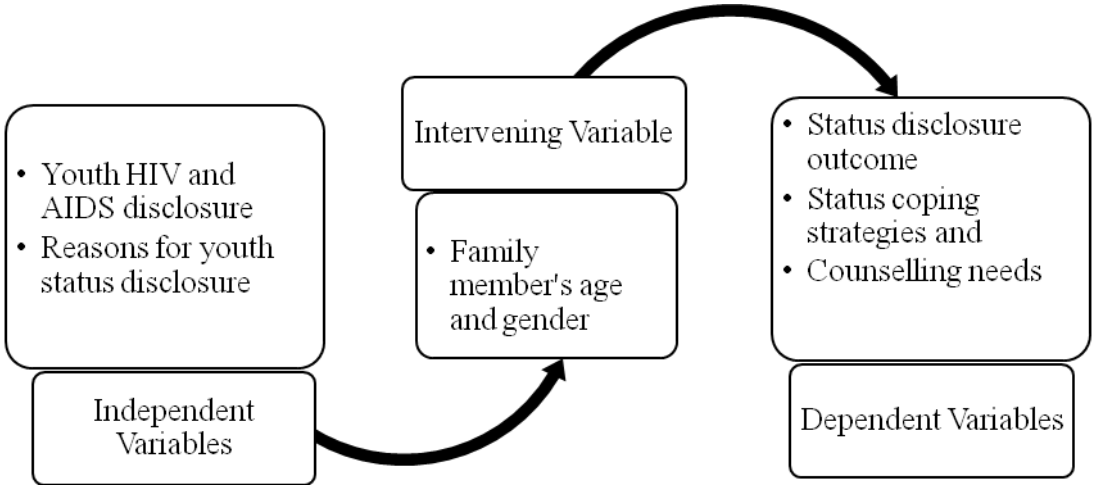
the roles they play in financially supporting the youth, providing caregiving, and their concerns for the lifespan and quality of life of the youth (Dimbuene, 2019).

As they navigate the privacy turbulence, other concerns can be the sexual activities that the youth involves themselves in, and how equipped the youth is to face this new reality they are now sharing with their family. At the same time the lifestyle changes needed to make room for a healthy transition needed the youth and the family should be addressed (Ullery & Carney, 2020). This is not only important for the physical health of the youth but also ensures the wholesome health of the family including their emotional and psychological health.

Conceptual Framework

Figure 1

Illustration of the effect of youth HIV and AIDS disclosure on the family using Communication Privacy Management model.



Variables.

1. Youth HIV and AIDS disclosure and reasons for youth disclosure represent the independent variables.

2. Family member's age and gender are intervening variables.

3. Status disclosure outcome, Status coping strategies, and counselling needs are the dependent variables.

In the research the goal was to investigate the reason for status disclosure of the youth who is HIV and AIDS positive, the outcomes of youth HIV and AIDS status disclosure in the family, the youth HIV and AIDS status coping strategies, and the counselling needs that present themselves in the family. The indicators of the study were explored using both themes and by exploring data collected in categories in a questionnaire to help understand the relationship the youth's HIV and AIDS status disclosure had in the family at the CCC in KNH. The youth HIV and AIDS status indicators were based on the number of youth participating in the study who have already disclosed their status and those who have not.

Indicators on the reasons for youth status were based on responses given in the theme based interviews which guided the study. Indicators like the type of relationship the youth has with their family, their gender, and the usefulness of their family in times of stress. Responses given in the questionnaire were significant in the study. Indicators of family member's age and gender were explored and analysed based on the feedback received from the youth, with regard to which family member they have disclosed their HIV and AIDS status to.

The status disclosure outcomes indicators included aspects like the physical, emotional and psychological reactions that resulted from the HIV and AIDS positive youth

disclosing their status to their family. The status coping strategies were based on how the youth and their family adjusted to the youth's HIV and AIDS positive status, like if the youth will receive emotional, physical, financial and psychological support from their family. Indicators also brought attention to the role perspectives and believes on HIV and AIDS on HIV and AID plays on the interactions the youth had with their family once they disclosed their status.

Counselling needs indicators were based on how the youth and their family addressed concerns and the needs that come with the youth living life being HIV and AIDS positive, and the role they need to play in the youth's life moving forward. Indicators also brought attention to the need for policy makers' involvement in ensuring the youth is fully prepared and equipped to navigate the concerns that will arise in the family after HIV and AIDS status disclosure.

Research Gap

Over the years, research has been conducted to view the consequences that come when an individual receives a positive HIV and AIDS diagnosis and the factors that motivates one to disclose or not (Qiao et al., 2018). Despite the development of models to help guide the process of disclosure, focus needs to be paid on the relationship between a positive youth disclosing their status, its effects on the family in terms of youth status disclosure outcome, youth's coping strategies, and the counselling needs that arise in the family.

Chapter Summary

Every individual comes from a different family, and the youth who finds out they are HIV and AIDS positive have a hard decision to make on whether they will disclose their status or not. Focus in the chapter was given to literature and theoretical review on

existing research on the effect of youth HIV and AIDS status disclosure on family members, using the Communication Privacy Management Theory, which was used to create the conceptual framework. The next chapter contains a detailed discussion of the research methodology used is presented.

Chapter Three: Research Methodology

Introduction

Focus in this chapter has been given to the research design and methods of data collection used in the study. It gives information on the research design, the population targeted, the sample size, and the procedures used to choose the study samples. The chapter explains the data collection instruments, the instruments pre-testing, its reliability and validity, the data analysis plan and finally the ethical consideration in the study.

Research design

The study used descriptive research design to focus on the effect of youth HIV and AIDS disclosure had on family members at the comprehensive care clinic in Kenyatta National Hospital. The descriptive research contributed in the process of collecting and analysing the collected data on the opinions and experiences with disclosure, which was significant for the study. The design was appropriate for addressing the study's research questions, and using both quantitative and qualitative methods ensured inclusivity in study, in an attempt to create a picture of how disclosure influences the youth's family. (Joe et al., 2017).

Population to be studied

The study was carried out at the Kenyatta National Hospital located in Nairobi Kenya. The study site was the Comprehensive Care Clinic located in the hospital where programmes for HIV and AIDS positive youth have been established where the youth are enrolled in different support groups.

There are over 9,500 individuals who seek treatment for HIV and AIDS from the Kenyatta National Hospital, with both men and women seeking services from the CCC. The Comprehensive Care Clinic is set up to accommodate youths between the ages of 10

years to 24 years, with subgroups of about thirty people each to ensure the content discussed is age appropriate. The groups are named Tumaini group which accommodates ages ten to fourteen, Amani group ages range from fifteen to nineteen, and Hodari group has ages twenty to twenty four.

Inclusion criteria

Samples were collected from Amani and Hodari groups who accommodate youth who are already enrolled in the CCC programme, are actively receiving medical care from the Kenyatta National Hospital, and are between the ages of 18-24 years as required by the study. The youths who participated in the study were also people who have already received their positive diagnosis in the last five years, and have already disclosed their status, or are in the process of considering disclosure of their HIV and AIDS status to their family.

Exclusion criteria

Youth who are HIV and AIDS positive who are not enrolled at the programmes in the CCC at the Kenyatta National Hospital were excluded from in the study. Other patients seeking medical attention at KNH were excluded from the study. The study was only conducted on voluntary basis, and the youth who were unwilling to participate in the study were excluded. The study also excluded individuals below 18 years, and those above 24 years old.

Sampling Technique

Non-probability sampling technique was used for the study, as the samples selected at Comprehensive Care Clinic did not include everyone in the target population at the Kenyatta National Hospital, and everyone did not have an equal chance to be included in

the study (Creswell, 2017). Purposeful sampling was used to pick the study site as the CCC in KNH, where the samples were picked.

Homogenous sampling method was effective and appropriate for samples that were for the study, as they were based on the youth's age ranging between 18-24 years as guided by the study, including individuals who had received a positive HIV/AIDS status in the last five years, and individuals who had disclosed their positive HIV/AIDS status or are considering status disclosure. The researcher chose samples to be included in the study based on daily appointments according to the Comprehensive Care Clinic hospital records, and used the study's guidelines of the population, choosing the samples based on the HIV/AIDS positive youth willingness to participate in the study.

Sample Size Determination

As recommended for a population under ten thousand, the Cochran's formula with a 95% confidence and a 5% margin error was most appropriate (Creswell, 2017). The Cochran's formula used for the study is $Ss= (t)^2\times (p)\times(1-p)\div(d)^2$. Where Ss is the Sample size, t is the reliability coefficient of 1.96 at 95% confidence interval, p is the desired level of precision, and d is the maximum likely error of 5% for the study. The sample size= $(1.96)^2\times (0.49) \times(1-0.49)\div(0,05)^2$ which gave a sample of 384 according to Etikan and Bala (2017).

Table 1

Population Distribution

	Frequency	Percent
Male	175	45.6%
Female	209	54.4%
Total	384	100.0%

Source: Comprehensive Care Clinic (2024)

Types of data

The principle investigator collected primary data for this study which entailed both quantitative data and qualitative data. Quantitative data aided in measuring the study variables using numeric and computational techniques using SPSS version 28.1. This enabled the researcher to perform inferential analysis to test the statistical significance between scores. Qualitative data comprised of the respondents' experiences which were significant in exploring the effect of youth HIV and AIDS status disclosure in the family. Secondary data was also included in the study via literature and empirical review.

Data Collection methods

Semi-structured interviews

The study used semi-structured interviews that were asked using open ended questions, to ensure that the respondents explored wholesomely in the in-depth interviews using the ODK Collect App and stored in Google drive. Themes explored in the interviews covered issues like reasons for youth HIV and AIDS status disclosure, the outcomes of youth HIV and AIDS status disclosure in the family, the youth coping strategies resulting from their HIV and AIDS status disclosure, and the counselling needs that arise as a result of the youth disclosing their HIV and AIDS status in the family.

The interview schedule were also translated to Kiswahili to ensure inclusivity of patients who may not understand English. The in-depth interviews guided by the research themes were semi-structured in nature, and were conducted using open-ended questions to probe respondents. With help from the hospital's social workers, the in-depth interviews that were conducted lasted between forty five minutes to one hour. The qualitative data was transcribed, analysed, and included in the study as thematic narratives.

Self-administered questionnaire

A four point Likert scale questionnaire ranging from one to four was developed and used, where 1 is strongly disagree while 4 is strongly agree. The self-administered questionnaires investigated reasons for youth HIV and AIDS status disclosure, the outcomes of youth HIV and AIDS status disclosure in the family, the youth coping strategies resulting from their HIV and AIDS status disclosure, and the counselling needs that arise as a result of the youth disclosing their HIV and AIDS status in the family.

The questionnaire comprised of both open ended and closed ended questions to help in exploring the research objectives of the study, and were arranged in terms of sub-themes to investigate the effect youth HIV and AIDS status disclosure has on the family members. Item one to four were used to measure for reasons for youth HIV and AIDS status disclosure, item five to eight were used to explore the outcomes of youth HIV and AIDS status disclosure in the family. Item nine to twelve measured the youth coping strategies resulting from their HIV and AIDS status disclosure, and item thirteen to fifteen measured the counselling needs that arise as a result of the youth disclosing their HIV and AIDS status in the family.

Instrument pre-testing

In conducting the study, Creswell (2017) argues that it is important to pre-test questionnaires and interview schedule before using it in any study. This ensures that the materials used in the study connect with the target population, and is answering the relevant questions raised in the research questions.

The pre-test was done at Mama Lucy Kibaki Hospital in Nairobi Kenya who also have a Comprehensive Care Clinic, using thirty eight youths who were recruited as a 10% representation of the study population. This was done with the aim of reducing ambiguity,

and ensure the questions were clear and could be understood. Although the results have not been included in the final data compiled, pre-testing ensured that the methods chosen for the study were appropriate and understandable.

Reliability of Instruments

When a questionnaire is reliable, it gives the same results when used over a period of time severally (Creswell, 2017). When the questionnaire is reliable after doing the test retest, the results will be similar. The 15 items on the four point Likert scale questionnaire were given values in order of ranking. The ability of the questionnaire's items to give similar results was established by using the Spearman's coefficient correlation to assess the monotonic relationship between youth HIV and AIDS status disclosure, and the effect it has on the family.

The correlations fall between +1 and -1, where if both the independent and dependent variables increase there is a positive correlation. However, if the dependent variable decreases and the independent variable increases the correlation is said to be negative, this was done with the use of Statistical Package for the Science software (SPSS) version 28.1.

Validity of Instruments

Validity is the ability of the questionnaire used to test the relationships between the variables in the study through the data that it collects. Content validity of the questionnaire that was used in the study was fine-tuned with the help of allocated supervisors' input. The interview schedule also went through content testing to ensure that the language used was easy to understand, and that the questions were applicable and clear.

Data analysis

Qualitative Processing and Analysis of Data

The information obtained from the transcribed in-depth interviews from Kiswahili to English, were reviewed to check if there are similarities in experiences with regards to the discussed themes. Thematic analysis was done to evaluate if the in-depth interviews gave information on the study's objectives of assessing the reasons for youth HIV and AIDS status disclosure, the outcomes of youth HIV and AIDS status disclosure in the family, the youth coping strategies resulting from their HIV and AIDS status disclosure, and the counselling needs that arise as a result of the youth disclosing their HIV and AIDS status in the family.

Quantitative Processing and Analysis of Data

The data obtained through the questionnaires was evaluated and presented in form of figures, frequency tables and charts. To get the frequencies and percentages in presenting the data that was collected, the SPSS 28.1 was applicable in the descriptive research. The presentation of the analysed data was used to describe the bivariate analysis to understand the relationship the youth's HIV and AIDS status disclosure has on the family.

SPSS 28.1 was used to calculate the Spearman's coefficient correlation which informed the kind of monotonic relationship between youth HIV and AIDS status disclosure, and the effect it has on the family. This informed the kind of correlation relationship that exists between youth HIV and AIDS status disclosure and the effects it has on the family members, whether the correlation was positive or negative in the study.

Ethical considerations

Approval and an introduction letter was provided from Pan Africa Christian University. The study was reviewed by the Ethical Review Clearance board at the Pan Africa University, where an ethical review certificate was given. A prerequisite license was obtained from the National Commission of Science, Technology and Innovation (NACOSTI), which is a licensing body that provides authority to conduct research in Kenya. Clearance was also sought out from the KNHUoN-ERC who assessed that all ethical standards had been attained before the researcher began conducting the study at the CCC. A social worker assigned to the Comprehensive Care Clinic assisted with distributing the questionnaires, and helped in the facilitation of the 384 respondents in the interviewing process.

Before the questionnaire and interviews were administered, the youth gave consent by signing a consent form, where the positive and negative risks of participating in the study had been explained to them. At the same time, it was made clear that the respondents had the freedom to discontinue their participation in the study at any time if they wanted to. The respondents were allocated pseudo names to ensure confidentiality was maintained.

Extra precaution to protect the identity of the HIV and AIDS positive youth population at the CCC in Kenyatta National Hospital participated in the study were taken, hence the researcher was the principal investigator of the study. The respondents were given re-assurance of confidentiality throughout the research process. As the study was under the hospital's administration, the respondents were allocated pseudo names in order to protect their identity. In case of any questions or need for further clarifications, the researcher's contact information was provided to ensure transparency in the process. Due to the sensitive nature of the research, risk of participating in the study was minimized by

the researcher to ensure all respondents and materials used followed all procedures that needed to be observed.

The study is greatly beneficial to the youth who will be equipped with the appropriate information to help them navigate HIV and AIDS status disclosure. At the same time the study is significant to policy makers like the USAID, the Ministry of Health in Kenya and the Kenyatta National Hospital who come up with policies, the study will help them make wholesome policies and guidelines for the youth population and their empowerment when it comes to HIV and AIDS status disclosure in their family.

Chapter Summary

The chapter detailed the research design that would achieve the study objectives. The population and study samples, including the sampling techniques were explained. Information on the data collection methods, instrument pre-test, data analysis plan and ethical consideration were included. The results of the study were analysed and interpreted in the next chapter.

Chapter Four: Results and Discussions

Introduction

This chapter focuses on the findings of the study that are analysed and presented. The chapter examines the response rates on different items as guided by the study data collection tools, to give descriptive data on the study variables. Information on the quantitative analysis is included to explore the effect of youth HIV and AIDS status disclosure on family members. The chapter contains information presenting the data collected, and its interpretation for the study including the thematic analysis conducted.

Demographic analysis and Response rates

The results show that majority of the study respondents were women as compared to men. These results show that among the youths diagnosed with HIV and AIDS at the CCC in Kenyatta National Hospital in the last five years are mainly women. This is in line with the statistics on new youth HIV and AIDS diagnosis that claims that women have a higher prevalence of infection than men (WHO, 2020).

Table 2

Gender Rates of respondents

The study targeted 384 respondents at the Comprehensive Care Clinic in KNH. The gender of respondents is presented in table 2 below.

	Frequency	Percent
Male	175	45.6%
Female	209	54.4%
Total	384	100.0%

The study conducted at Kenyatta National Hospital, Comprehensive Care Clinic included 384 respondents where 54.4% were women who were 209, and men who were 175 were 45.6% of the population.

Table 3

Age of respondents

The research sought to establish how respondents were distributed by age. The distribution is presented in Table 3 below.

	Frequency	Percent
18	21	5.5%
19	42	10.9%
20	44	11.5%
21	41	10.7%
22	31	8.1%
23	78	20.3%
24	127	33.0%
Total	384	100.0%

From Table 3, 5% of the respondents were aged 18 years, 10.9% of the respondents were 19 years old, 11.5% of the respondents were 20 years old, and 10.7% of the respondents were 21 years old. 8.1% of the respondents were 22 years, while 20.3% were 23 years and the majority of the respondents were of age 24 years translating to 33.1% of the total study population.

Table 4

Marital status of respondents

The research sought to establish how respondents were distributed based on marital status. The distribution is presented in table 4 below.

Frequency	Percent	Valid Percent
Single	277	72.1%

Married	38	9.9%
Engaged	46	12.0%
Divorced	19	4.9%
Widowed	4	1.0%
Total	384	100.0%

Table 4 shows that the majority of respondents are single youths, comprising 72.1% of the sample. A smaller proportion is married 9.9%, engaged youths 12.0%, divorced 4.9%, and widowed youths is 1.0%.

Table 5

Employment status of respondents

The study conducted an analysis on the respondent's employment status. The results of the analysis are presented in Table 5.

	Frequency	Percent
Employed	102	26.6%
Self employed	133	34.6%
Unemployed	149	38.8%
Total	384	100.0%

From table 5, 26.6% of the respondents are employed, while 34.6% are self-employed, and a further 38.8% who are the majority, are unemployed. This is in line with Dimbuene (2019), who indicates that most young people are not yet established financially, or are in the process of establishing themselves and still depend on their family's support when they are considering status disclosure.

Table 6

Education status of respondents

The study performed a descriptive analysis of the respondent's level of education. Table 6 below represents the results.

	Frequency	Percent
High school	101	26.3%
College	95	24.7%
University	188	49.0%
Total	384	100.0%

Table 6 shows that a significant portion of the respondents, 49.0%, reported having completed university education, making it the most prevalent category. College education was reported by 24.7% of the respondents, while 26.3% indicated having completed high school.

Table 7

Year of respondent's diagnosis

The respondents were asked to indicate which year they received a positive HIV and AIDS status diagnosis. The results of the study are indicated in table 7 below.

	Frequency	Percent
2019	92	24.0%
2020	70	18.2%
2021	52	13.5%
2022	61	15.9%
2023	99	25.8%
2024	10	2.6%
Total	384	100.0%

From table 7, the majority of diagnoses occurred in the years 2019 and 2023, accounting for 24.0% and 25.8% of the cases, respectively. The year 2020 follows with 18.2%, while 2022 and 2021 contribute 15.9% and 13.5%, respectively. A smaller proportion of diagnoses, 2.6%, occurred in the most recent year, 2024. This is in line with the survey conducted by the MOH that indicated a prevalence of HIV and AIDS infections among the youth population (KNHIV, 2020).

Table 8

Respondents' mode of testing

The respondents were asked to indicate which mode of testing revealed their positive HIV and AIDS status. The results of the study are indicated in Table 8 below.

	Frequency	Percent
Sickness	91	23.7%
Self-test kit	149	38.8%
Hospital visit for other reasons	144	37.5%
Total	384	100.0%

Table 8 depicts that the most common method of testing reported is through the use of self-test kits, accounting for 38.8% of the sample. Another substantial portion, 37.5%, found out their HIV status during a hospital visit for reasons other than HIV testing. Additionally, 23.7% of respondents discovered their status when experiencing sickness.

Figure 2

The study sought to establish the personal reactions the youth had to a positive HIV and AIDS diagnosis. Figure 2 below displays the results.

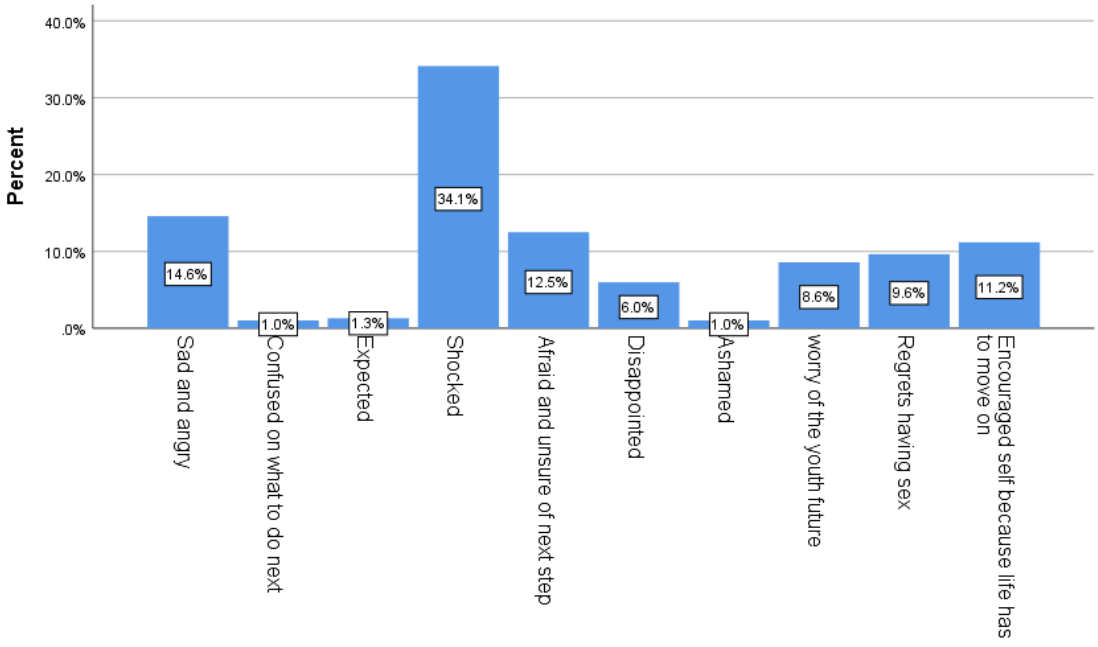


Figure 2 provides an insightful overview of individuals' personal reactions upon receiving the news of being diagnosed as HIV and AIDS positive. The most prevalent emotional response appears to be shocked, representing 34.1% of the respondents, followed by regrets of having sex, and encouraged self because life has to move on with percentages of 9.6% and 11.2%, respectively.

Other notable reactions include I'm afraid and unsure of next step at 12.5%, worry of the youth's future at 8.6%, and disappointed with self at 6.0%. The cumulative percentages highlight the diverse range of emotional reactions expressed by individuals, with some experiencing negative emotions such as sadness, anger, and fear, while others adopt more positive perspectives, emphasizing resilience and forward-looking attitudes.

Table 9

Status disclosure rates to family members

The study sought to establish the number of respondents who had disclosed and not disclosed their status. Table 9 displays the results.

	Frequency	Percent
Yes	259	67.4%
No	125	32.6%
Total	384	100.0%

Table 9 shows that majority of the respondents, accounting for 67.4%, reported having disclosed their positive HIV and AIDS status to their families. Conversely, 32.6% of the respondents indicated that they had not disclosed their HIV and AIDS status to their families. This is in line with Martins et al. (2019), who argues that the newly diagnosed youth decide to keep their HIV and AIDS status a secret from their families because they are not fully equipped to deal with the reactions and consequences of this process.

Table 10

Persons disclosed to in the family

Respondents were asked to indicate the family members they had disclosed their status to. Table 10 displays the results.

	Frequency	Percent
Father	27	10.5%
Mother	160	62.0%
Brother	19	7.5%
Sister	25	9.7%
Grandmother	9	3.5%
Uncle	3	5.8%
Aunt	14	3.9%
Total	258	67.2%

Among the 258 respondents who have disclosed their status, the most common recipients were mothers, with 62.0% of respondents disclosing to them. Other common recipients included sisters 9.7%, brothers 7.5%, and aunts 5.8%. Fathers 10.5%, grandmothers 3.5%, and uncles 1.2% were also mentioned as recipients of youth HIV and AIDS status disclosure.

Table 11

Descriptive statistic of persons disclosed to in the family

The study sought to establish the ages of person's disclosed to in the family. Table 11 displays the results.

	N	Minimum	Maximum	Mean	Std. Deviation

Age of family member disclosed status to	259	18	81	47.08	10.277
Valid N	259				

Table 11 provides descriptive statistics for the age of family members to whom respondents disclosed their HIV and AIDS status. Among those who disclosed 259 respondents, the age of family members ranged from 18 to 81 years. The mean age was 47.08, with a standard deviation of 10.277.

Table 12

Duration of disclosure after HIV and AIDS status confirmation

The study sought to establish the duration after which the respondents disclosed their positive status. Table 12 below displays the results.

	Frequency	Percent
After a month	24	6.2%
After a week	113	29.4%
Same day	122	31.8%
Any other	125	32.6%
Total	384	100.0%

Table 12 presents the duration of time individuals took to disclose their confirmed positive HIV and AIDS status after receiving the news. Notably, the majority of respondents, 31.8%, chose to disclose their status on the same day as confirmation, indicating a swift and immediate decision to share the information. Additionally, 29.4%

opted for disclosure after a week, suggesting a relatively prompt acknowledgment of their situation. Another 6.2% disclosed after a month, highlighting a smaller but still significant portion with a slightly delayed timing for sharing their status. The category any other encompasses 32.6%, representing the youths who are yet to disclose their HIV and AIDS status.

Figure 3

Figure 3 presents the duration after which the respondents disclosed their HIV and AIDS status.

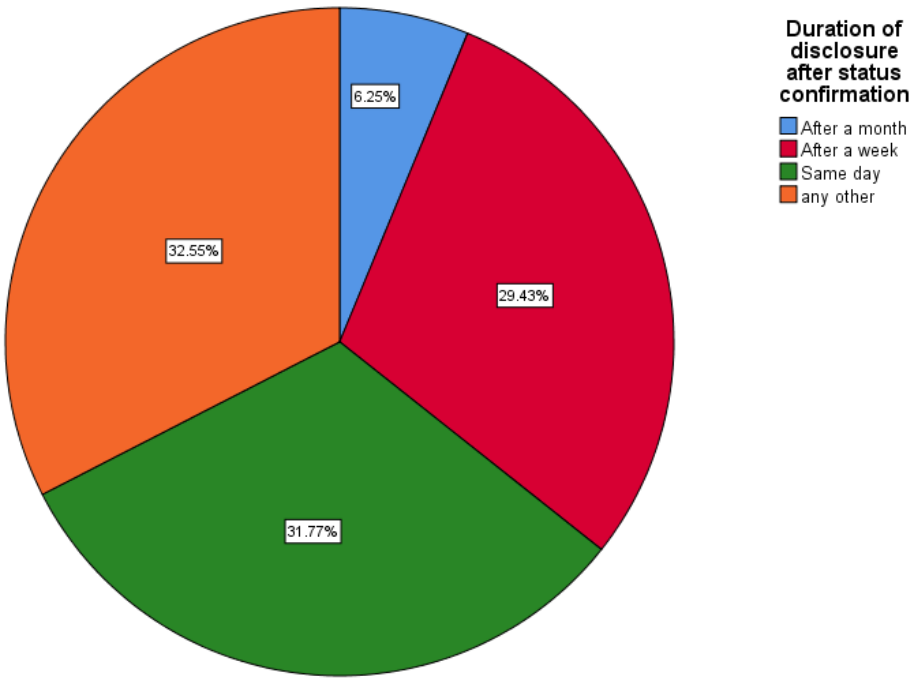


Figure 3 gives information on the duration of disclosure after the youth HIV and AIDS Status Confirmation. 29.43% disclosed after a week, 6.25% disclosed after a month, 32.55% disclosed any other, while 31.77% disclosed their status the same day

Table 13

Reasons for disclosure to the above named family member

The respondents were asked to indicate the reasons that encouraged status disclosure to the above stated family member. The reasons given are presented in table 13.

	Frequency	Percent
Needed family support	139	37.8%
I'm close to my family and trust them to be there regardless of my status	30	7.9%
Not yet disclosed	125	29.4%
I live with them	21	5.8%
Family member is in the medicine field	39	10.6%
I wanted my family to know in case something happens to me	30	8.5%
Total	384	100.0%

Table 13 above provides insights into the reasons respondents disclosed their HIV status to specific family members. The most frequently cited reason is the need for family support, with 37.8% of respondents expressing the importance of seeking emotional and practical assistance from their family during challenging times.

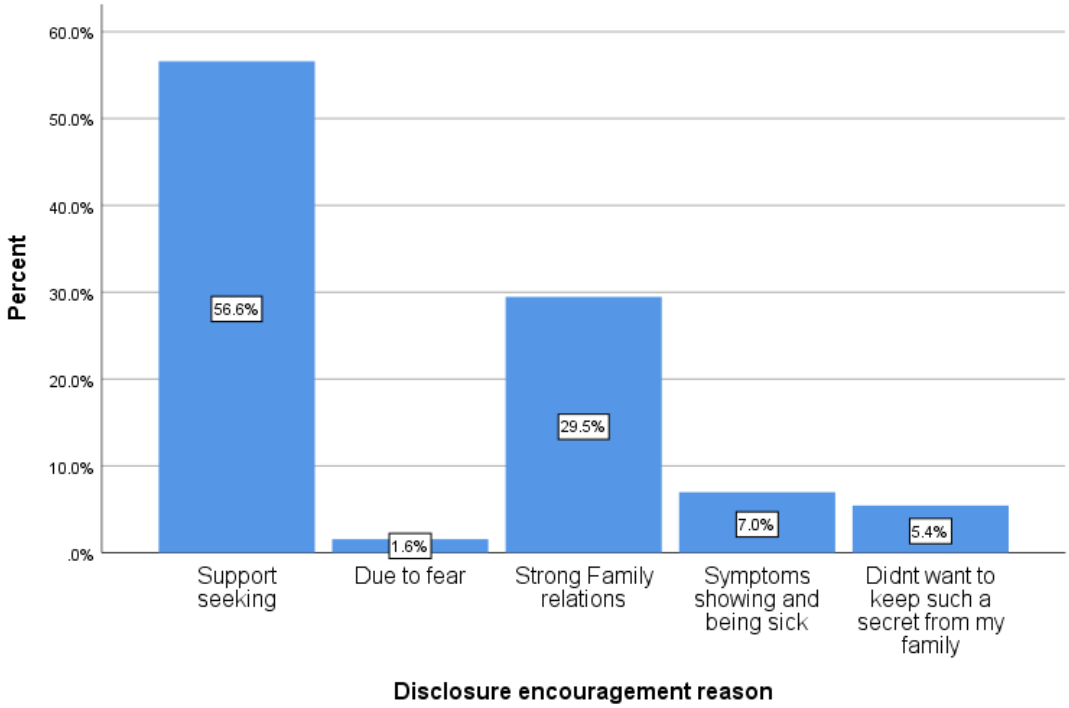
Additionally, 7.9% mention being close to their family and trusting them to offer support regardless of their status, emphasizing the significance of trust and emotional bonds. A notable portion, 29.4%, indicates that disclosure has not yet occurred, suggesting ongoing considerations or hesitations. Other reasons include living with family members 5.8%, having a family member in the medical field 10.6%, and wanting family to be informed in case of future health complications 8.5%.

Descriptive Statistics

Objective 1: *Reasons for disclosure of youth HIV and AIDS status to the family members.*

Figure 4

Figure 4 presents respondent's reasons for HIV and AIDS status disclosure.



The first objective of the study was to investigate the reasons for disclosure of youth HIV and AIDS status to the family members at the CCC, Nairobi Kenya. This section gives descriptive analysis of reasons for youth status disclosure items on the questionnaire, giving scores of testing the relationship between youth status disclosure and reasons for status disclosure to the family members.

There are different reasons behind individuals' decisions to disclose the positive HIV and AIDS diagnosis. Figure 4 shows that among those who disclosed reasons, given by the youth were: Support seeking by youth emerges as the most prevalent, representing 38.0% of respondents, highlighting the importance of seeking assistance and understanding during challenging times. Other significant factors include strong family relations at 19.8%, emphasizing the role of familial connections in the decision-making process.

The youth reported the reason of symptoms showing and being sick at 4.7%, reflecting instances where the physical manifestations of the condition may prompt

disclosure. Additionally, due to fear of family members finding out and the youth did not want to keep such a secret from my family contribute to 1.0% and 3.6%, respectively? The factor of being very sick leading to disclosure is in line with Dessie et al (2019), who argue that in the instance where the individual's health is so bad, the hospital administration requires the doctor to disclose the youth's HIV and AIDS status to the family.

Table 14

Disclosure discouragement reasons

Respondents were asked to indicate their disclosure discouragement reasons. Table 14 presents the reason given.

	Frequency	Percent
Fear of rejection	88	22.9%
Religion and culture will make family think I'm promiscuous	10	2.6%
Unsure of their reaction	10	2.6%
Fear of discrimination	6	1.6%
Fear of being negatively judged	4	1.0%
Uninterested in disclosing	7	1.8%
Total	125	32.6%

Table 14 provides insights into the reasons why respondents chose not to disclose their HIV and AIDS status to their family members. The predominant reason for non-disclosure is fear of rejection, accounting for 22.9% of respondents, underscoring the apprehension individuals feel about potential negative reactions from others. This is in line with Frain et al. (2018) who argues that sometimes to avoid the negative response from the family or friends, an individual can opt to keep their positive diagnosis to avoid being discriminated against.

Figure 5

Figure 5 presents the respondents' reasons that discouraged disclosure.

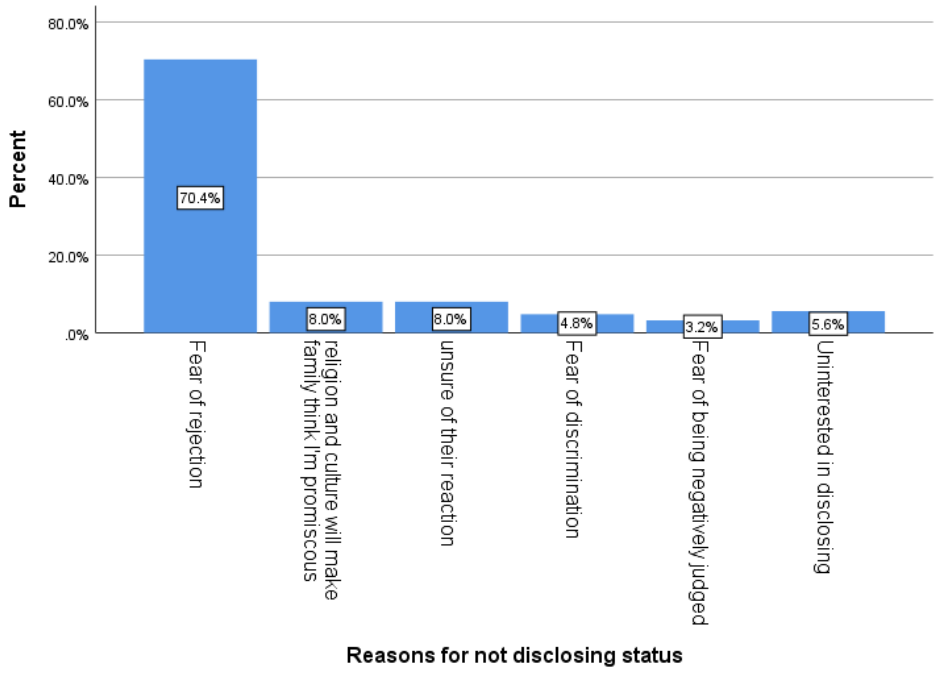


Figure 5 gives additional factors contributing to non-disclosure include concerns related to religious and cultural perceptions, with religion and culture will make family think I'm promiscuous at 2.6%, and uncertainties about others' reactions with unsure of their reaction at 2.6%. Fear of discrimination and fear of being negatively judged constitute smaller percentages at 1.6% and 1.0%, respectively, reflecting worries about potential stigmatization.

Notably, a subset of individuals, 1.8%, cite uninterested in disclosing because it will cause more problems as their reason for not sharing their status. This is in line with Weinreich and Benn (2019), who argue that factors like the gender of the youth and their family's culture also have an impact on how the youth will decide to disclose their HIV and AIDS status or keep the private information private.

The table below presents item statistics measuring for youth disclosure on a four point scale from 0.99-1.0 means strongly disagree, from 1.0-1.99 means disagree, from 2.0-2.99 means agree, and 3.0-4.0 means strongly agree.

Table 15

Reasons for disclosure of youth HIV and AIDS status to the family

The first objective was to determine the reasons for disclosure of youth HIV and AIDS status to the family members at the CCC. Table 15 presents the descriptive analysis of the respondents' scores.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Family members dependency for support in stress times	384	1	4	3.21	.889	-1.020	.125	.331	.248
Societal view affecting youth status disclosure	384	1	4	3.18	1.112	-1.007	.125	-.505	.248
Family relationships making it easy to open up and give details	384	1	4	2.62	1.275	-.148	.125	-1.662	.248

Youth gender influencing family member reception	384	1	4	2.60	1.305	-.097	.125	-1.727	.248
Valid N	384								

From the table above, on average, respondents indicate a relatively high level of agreement mean of 3.21 that family members are dependent for support during stress times. The low standard deviation of 0.889 suggests that there is less variability in responses, indicating a more consistent agreement among respondents. On average, respondents express a moderate agreement mean of 3.18 that societal views affect youth status disclosure. The standard deviation of 1.112 indicates some variability in responses, suggesting that opinions on this item are not uniform.

On average, the respondents show a moderate level of agreement mean of 2.62 that family relationships make it easy to open up and give details. The higher standard deviation of 1.275 indicates a greater variability in responses, suggesting diverse opinions on this item. On average, respondents tend to agree with a mean of 2.60 that youth gender influences family member reception. The standard deviation of 1.305 is relatively high, indicating a wide range of responses and less consensus among respondents.

The skewness and kurtosis values provide insights into the distribution characteristics of the variables in the table. For the items family members dependency for support in stress times, societal view affecting youth status disclosure, family relationships making it easy to open up and give details, and youth gender influencing family member reception, the negative skewness values -1.020, -1.007, -0.148, -0.097, respectively indicate a slight asymmetry with more responses leaning towards higher values on the Likert scale.

The kurtosis values -0.331, -0.505, -1.662, -1.727, respectively suggest that the distributions are less peaked and have slightly heavier tails compared to a normal distribution. Overall, these skewness and kurtosis patterns suggest that the respondents tend to provide ratings on the higher end of the Likert scale for these variables, indicating a prevalence of positive perceptions, or agreements regarding family dynamics, and youth status disclosure in the studied population.

Thematic analysis yielded themes of role of gender in youth status disclosure, motivation for disclosure, fear of rejection, and the need for unconditional support were the experiences of youth seeking medical attention at the CCC in KNH, Nairobi Kenya. In terms of the theme the role gender plays in disclosure, respondents observed that their greatest motivation to open up to family members was the kind of relationship they have with their family.

As for fear of rejection, most of the respondents noted that the kind of perspective and believes in their families informed their status disclosure decision. Respondents described that knowing the family will be there for them and love them unconditionally despite them being HIV and AIDS positive, which is in line Ullery and Carney (2020). Most of the respondents reported that the age of the family member being disclosed to determine if the youth will disclose their HIV and AIDS status.

For instance, some of the respondents reported that: ‘My relationship with my parents is bad at the moment because I have been failing in school because of stress, they cannot handle knowing I have HIV and AIDS’ (Respondent KNH/241).While Respondent KNH/38 reported that, ‘I disclosed my status to my sister though I was scared, I could trust her to keep my secret between us so I told her’. This is in line with Smith et al. (2017), observing that the kind of relationship the youth has with their family plays a role in either encouraging them to disclose or not.

‘I hear how my family usually talks about people who have HIV and AIDS as being as good as dead, I cannot tell them I have HIV and AIDS’ (Respondent KNH/22). On the other hand Respondent KNH/7, reported that ‘My uncle is usually open minded on current topics like HIV and AIDS, because we were once talking about people living with HIV and AIDS live long lives as long as they take medicine well, I know he will accept me’. This statement affirms Dessie et al (2019) argument that the fear of rejection influences the youth’s status disclosure decision.

‘My mum and I have really been through a lot since she is a single mum, I know she will be there for me in this journey now that I found out I’m HIV and AIDS positive’ (Respondent KNH/78).Respondent KNH/45 reported, ‘ I moved out of home when I finished form four, I have a job so I take care of myself because my family is struggling financially, there is no need for me to add to the problems at home, because them knowing about my HIV and AIDS status will not add anything positive to my life’. This is in line with Ullery and Carney (2020), who found out that knowing the family will be of support to the youth, can encourage or discourage the youth HIV and AIDS status disclosure decision.

Respondent KNH/270 reported, ‘When I found out I was HIV and AIDS positive, I knew immediately I cannot tell my family because they will say that I came to have sex with everyone and became a prostitute when I came to University because I’m a girl’. While Respondent KNH/106 reported that,‘ Being a young man sometimes I find it hard to talk to my parents about my personal life struggles, but my older brother is understanding as he is more open minded about things like HIV and AIDS so it was easy to tell him when I found out I have HIV and AIDS’. This is in line with Braithwaite et al (2018), who examines how gender influences how differently men and women make their disclosure decisions.

Objective 2: *Youth HIV and AIDS outcomes from status disclosure to the family members*

The second objective of the study was to identify the youth's HIV and AIDS outcomes from status disclosure at the CCC, Nairobi Kenya. This section gives descriptive analysis of youth HIV and AIDS outcomes from status disclosure to the family member's items on the questionnaire, giving scores of testing the relationship between youth status disclosure and HIV and AIDS status disclosure to the family members.

The table below presents item statistics measuring for youth disclosure on a four point scale from 0.99-1.0 means strongly disagree, from 1.0-1.99 means disagree, from 2.0-2.99 means agree, and 3.0-4.0 means strongly agree.

From the table below, on average, respondents tend to disagree with a mean of 2.01 that there is physical avoidance by family members after status disclosure. The higher standard deviation of 1.209 suggests more variability in responses, indicating that opinions on this item are diverse.

Table 16

Youth HIV and AIDS status disclosure outcomes in the family

The second objective was to determine the youth HIV and AIDS status disclosure outcomes to the Family Members at the CCC. Table 16 presents the descriptive analysis of the respondents' scores.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Physical avoidance by family after status disclosure	384	1	4	2.01	1.209	.639	.125	-1.250	.248

Emotional disconnection by family members after status disclosure	384	1	4	2.09	1.278	.537	.125	-1.464	.248
Family's opinion affecting their reaction towards my disclosure	384	1	4	3.18	.899	-.953	.125	.133	.248
Family successfully finding a way to express their feelings about my status	384	1	4	2.92	1.036	-.512	.125	-.953	.248
Valid N	384								

For physical avoidance by family after status disclosure, emotional disconnection by family members after status disclosure, family's opinion affecting their reaction towards my disclosure, and family successfully finding a way to express their feelings about my status, positive skewness values 0.639, 0.537, -0.953, -0.512, respectively indicate a slight asymmetry with more responses leaning towards lower values on the Likert scale. The kurtosis values -1.250, -1.464, 0.133, -0.953, respectively suggest that the distributions are less peaked and have slightly heavier tails compared to a normal distribution.

The findings in Table 16 were supported by thematic analysis of the responses which revealed that there are different aspects that result immediately after the youth discloses their positive HIV and AIDS status at CCC, Nairobi Kenya. Some of the respondents addressed the following themes: ‘My sister no longer likes sharing my clothes

like we used to do in the past, life is no longer the same for all of us' (Respondent KNH/209).

This is supported by Buki et al. (2017), who highlights that the rejection and isolation is a common theme seen globally when positive individuals disclose their status to their family. On the other hand, in some families the news of the youth's positive HIV and AIDS status is received by family members well, and they do not discriminate against the disclosing youth. Respondent KNH/177 reported, 'I'm surprised my family took the news of my positive HIV and AIDS status, they keep asking me if I am okay, which makes me feel good that they care to check up on me.'

'I was very sick in hospital when I decided to tell my cousin that I am actually HIV and AIDS positive, and he was really concerned and kept reassuring me that he will always be there for me and he will keep my status a secret between us because I haven't told anyone else' (Respondent KNH/84). This is in line with Ullery and Carney (2020), who say that when the youth disclose their status, the one who has been told will want to find out more with the intent to provide social support and make the process of living with this new reality easier for the individual or reject the youth.

'My aunt told me that being HIV and AIDS positive is not a death sentence, and that she will help me as I begin with my journey of taking ARVs because she is a nurse' (Respondent KNH/380). On the other hand Respondent KNH/86 reported, 'Ever since I found out I'm HIV and AIDS positive, it has been hard to talk about it and I find myself keeping to myself, but my mum keeps asking me if I am okay because she feels I have been distant of late'.

Braithwaite et al. (2018), supports this theme by arguing that when people consider disclosure, they are still trying to navigate receiving the news of the youth's positive HIV and AIDS status. Respondent KNH/27 reported, ' When I told my sister on the phone that

I found out I'm HIV and AIDS positive, she told me to go meet her at her home so that we can talk in depth because she was at work when I called her'.

'Ever since I told my mum I'm HIV and AIDS positive, she doesn't usually want me in the kitchen cooking to avoid cutting myself as I cook (Respondent KNH/12). While Respondent KNH/ 93 reported, 'I'm so grateful my cousin who I live with has not changed after knowing I'm HIV and AIDS positive, our physical interactions are still the same which means he has accepted me as I am and he does not hate me'. This is in line with Weinreich & Benn (2019) who argued that the youth's HIV and AIDS status disclosure outcomes in the family can be reflected by how the family members behave, and carry themselves around the youth who has decided to disclose their HIV and AIDS status.

Objective 3: *Coping strategies resulting from youth HIV and AIDS status disclosure in the family*

The third objective of the study was to assess the coping strategies resulting from youth HIV and AIDS status disclosure in the family at the CCC, Nairobi Kenya. This section will give descriptive analysis on the coping strategies resulting from youth HIV and AIDS status disclosure in the family items on the questionnaire, giving scores of testing the relationship between youth status disclosure and coping strategies resulting from youth HIV and AIDS status disclosure in the family.

The table below presents item statistics measuring for youth disclosure on a four point scale from 0.99-1.0 means strongly disagree, from 1.0-1.99 means disagree, from 2.0-2.99 means agree, and 3.0-4.0 means strongly agree.

Table 17

Youth coping strategies resulting from HIV and AIDS status disclosure in the family

The third objective was to examine the coping strategies resulting from youth HIV and AIDs status disclosure in the family at the CCC. Table 17 presents the descriptive analysis of the respondents' scores.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Family actively helping to implement my lifestyle changes	384	1	4	2.99	1.200	.275	.125	3.697	.248
Family members providing emotional security and support	384	1	4	2.98	1.163	-.620	.125	-1.176	.248
Family members constantly bashing due to my status	384	1	4	2.03	1.226	.608	.125	-1.318	.248
Family being depended to be present during emergencies	384	1	4	2.92	.927	-.564	.125	-.494	.248
Valid N	384								

Table 17 shows that on average, respondents indicate a moderate level of agreement mean of 2.99 that their family actively helps in implementing lifestyle changes. The standard deviation of 1.200 suggests some variability in responses, indicating that opinions on this item are not entirely uniform.

On average, respondents express a moderate level of agreement mean of 2.98 that their family members provide emotional security and support. The standard deviation of 1.163 indicates some variability in responses, suggesting diverse opinions on this item. On average, respondents tend to disagree with a mean of 2.03 that their family members constantly bash them due to their status.

The higher standard deviation of 1.226 suggests more variability in responses, indicating diverse opinions on this item. On average, respondents indicate a moderate level of agreement mean of 2.92 that their family is dependent on being present during emergencies. The low standard deviation of 0.927 suggests more consistency in responses, indicating a more uniform agreement among respondents.

For family actively helping to implement my lifestyle changes, the positive skewness 0.275 suggests a slightly skewed distribution to the right, indicating more responses on the higher end of the Likert scale. The high kurtosis 3.697 indicates a distribution with heavier tails and a more peaked shape compared to a normal distribution.

For family members providing emotional security and support, the negative skewness -0.620, suggests a slightly skewed distribution to the left, with more responses on the higher end of the scale. The negative kurtosis -1.176 indicates a distribution with less peaked tails compared to a normal distribution.

Regarding family members constantly bashing due to my status, the positive skewness 0.608 suggests a slightly skewed distribution to the right, while the negative kurtosis -1.318 indicates a distribution with less peaked tails. For family being dependent to be present during emergencies, the negative skewness -0.564 suggests a slightly skewed distribution to the left, while the negative kurtosis -0.494 indicates a distribution with tails and a shape relatively close to a normal distribution.

Thematic analysis of the interviews revealed the following themes: ‘Sometimes when I’m struggling with feelings that my life is over, mum encouraged me by telling me of other people she knows who are happy with their lives even if they are HIV and AIDS positive’ (Respondent KNH/219). This is in line with Frain et al. (2018), findings that argues that some families find ways to ensure that the youth feels accepted and loved unconditionally.

‘I regret ever telling my mum that I’m HIV and AIDS positive as she uses it to rebuke me every time I do something wrong, where she tells me that as a first born I have set a very bad example for my siblings’ (Respondent KNH/3). As the youth and their family tries to find ways to cope knowing the youth’s HIV and AIDS status, the youth and their family can develop maladaptive coping strategies as argued by Qiao et al. (2018). Respondent KNH/361 reported, ‘Because I have not told my family about my HIV and AIDS status, I have been hiding my medicine, and sneaking around to take it which makes it harder for me to keep up with medicine because I am hiding my status from my family’.

‘Sometimes my mum gets angry at me and shouts at me telling me that I joined university, but I went to be loose sexually and started sleeping with everyone instead of taking my education seriously’ (Respondent KNH/125). This is in line with Hatcher et al. (2020), who argues that some families find healthy ways to openly talk about sensitive topics in an attempt to ease stigmatization, while some families are unsuccessful at finding ways to adopt healthy ways of accommodating the youth’s positive status. While Respondent KNH/87 reported, ‘When I told my mother I’m HIV and AIDS positive, every time I am stressed my mum usually knows and she takes me out for lunch where she usually encourages me to talk to her about the struggles I am going through now that I’m HIV and AIDS positive’.

‘My sister has really been of great support since I told her I have HIV and AIDS, she makes sure to send me weekly allowances to eat well since I live on campus as a student, which is really helpful because the medicine I was given is very strong, eating a heavy meal helps reduce the feeling of nausea I feel when I take the ARVs. She also sets time to come visit me when I get sick or when I call her to send me money with no prior notice, she always comes through for me’ (Respondent KNH/58). Smith et al. (2019), findings state that some families come to help the youth by facilitating their treatment journey like financially supporting them.

Objective 4: *Counselling needs resulting from youth HIV and AIDS status disclosure in the family*

The fourth objective of the study was to investigate the counselling needs resulting from youth HIV and AIDS status disclosure in the family at the CCC, Nairobi Kenya. This section will give descriptive analysis on the coping strategies resulting from youth HIV and AIDS status disclosure in the family items on the questionnaire, giving scores of testing the relationship between youth status disclosure and coping strategies resulting from youth HIV and AIDS status disclosure in the family.

Table 18

Youth counselling needs resulting from HIV and AIDS status disclosure in the family

The third objective was to examine the counselling needs resulting from youth HIV and AIDs status disclosure to family at the CCC. Table 18 presents the descriptive analysis of the respondents’ scores.

Table 18 presents item statistics measuring for youth disclosure on a four point scale from 0.99-1.0 means strongly disagree, from 1.0-1.99 means disagree, from 2.0-2.99 means agree, and 3.0-4.0 means strongly agree.

	N	Minimum	Maximum	Mean	Std. Deviation	Skewness		Kurtosis	
	Statistic	Statistic	Statistic	Statistic	Statistic	Statistic	Std. Error	Statistic	Std. Error
Family being involved in my life decision making process	384	1	4	2.79	1.146	-.449	.125	-1.234	.248
Status disclosure increasing family interactions	384	1	4	2.62	1.233	-.219	.125	-1.557	.248
Status disclosure triggered longevity concerns that family help in navigation	384	1	4	2.99	1.024	-.668	.125	-.726	.248
Valid N	384								

From the table above, on average, respondents indicate a moderate level of agreement mean of 2.79 that their family is involved in their life decision-making process. The standard deviation of 1.146 suggests some variability in responses, indicating that opinions on this item are not entirely uniform. On average, respondents express a moderate level of agreement mean of 2.62 that status disclosure increases family interactions. The higher standard deviation of 1.233 indicates more variability in responses, suggesting diverse opinions on this item.

On average, respondents indicate a moderate level of agreement mean of 2.99 that their status disclosure triggered longevity concerns, and their family helps in navigation.

The relatively low standard deviation of 1.024 suggests more consistency in responses, indicating a more uniform agreement among respondents. For family being involved in my life decision-making process, the negative skewness -0.449 suggests a slightly skewed distribution to the left, indicating more responses on the higher end of the Likert scale. The negative kurtosis -1.234 indicates a distribution with less peaked tails compared to a normal distribution.

For status disclosure increasing family interactions, the negative skewness -0.219 suggests a slightly skewed distribution to the left, with more responses on the higher end of the scale. The negative kurtosis -1.557 indicates a distribution with less peaked tails. Regarding status disclosure triggered longevity concerns that family help in navigation, the negative skewness -0.668 suggests a slightly skewed distribution to the left, while the negative kurtosis -0.726 indicates a distribution with tails and a shape relatively close to a normal distribution.

Thematic analysis of the interviews revealed the following themes: ‘When I disclosed to my Uncle that I’m HIV and AIDS positive he has really been involved in my treatment process and even helped me make the decision to transit to Kenyatta National Hospital, as opposed to the village hospital in Homabay, for easier access to ART as I’m currently in Nairobi’ (Respondent KNH/52). This is in line with the KNHIV (2020) that emphasizes impactful role of having family members as part of the people who actively help the youth make lifestyle decisions which has proven to be beneficial in Kenya.

‘All the arguments I have with my mother due to how she started treating me after knowing I’m HIV and AIDS positive has totally spoiled our interaction’ (Respondent KNH/350).This is in line with Pequegnat & Bell (2021) statistics which highlight the need for disclosing youth and their families to have the appropriate resources to help address the relational issues that present as counselling needs by different families.

‘Since I’m still undergoing dialysis, there were issues of going to different hospitals for my dialysis and my ART treatment, my family decided it would be better if I would move to Kenyatta National Hospital which accommodates all these different clinics that offer these special services at a cheaper charge that they can afford’ (Respondent KNH/15). On Respondent KNH/164 reported, ‘ Since I have not told my family about my positive HIV and AIDS positive status, I constantly feel so sad and alone which leads to me being sick all the time, because I’m not even taking my medicine well and I have no one I can tell in our family’. This is in line with KNHIV (2020) report which emphasizes on the important role family members can play in helping the youth make appropriate life decisions to make room for their positive HIV and AIDS status diagnosis.

Correlation Analysis of Study Variables

The study correlation analysis was performed to investigate the effect of the youth’s positive HIV and AIDS status disclosure has on the family at CCC, Nairobi Kenya. The table below represents the correlation between youth HIV and AIDS status disclosure, and the variables reasons for status disclosure, family disclosure outcomes, coping strategies and counselling needs.

Table 19

Correlation coefficient analysis

Correlation analysis was performed on the study objectives to measure for the effect of youth HIV and AIDS status disclosure in the family at the CCC in KNH. Table 19 presents the Correlation Coefficient Analysis.

	Reasons for disclosure or not	Status Disclosure Outcome	Coping Strategies	Counselling Needs

Spearman's rho	Reasons for disclosure or not	Correlation Coefficient	1.000	-.310**	.480**	.465**
		Sig. (2-tailed)	.	.000	.000	.000
		N	384	384	384	384
	Status Disclosure Outcome	Correlation Coefficient	-.310**	1.000	-.528**	-.612**
		Sig. (2-tailed)	.000	.	.000	.000
		N	384	384	384	384
	Coping Strategies	Correlation Coefficient	.480**	-.528**	1.000	.833**
		Sig. (2-tailed)	.000	.000	.	.000
		N	384	384	384	384
	Counselling Needs	Correlation Coefficient	.465**	-.612**	.833**	1.000
		Sig. (2-tailed)	.000	.000	.000	.
		N	384	384	384	384

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

The correlation between reasons for disclosure or not with family disclosure outcome has a Correlation Coefficient of -0.310**. There is a significant negative correlation between reasons for disclosure or not and family status disclosure outcomes. This suggests that the reasons for disclosing or not disclosing are negatively related to how the family reacts to the disclosure.

The correlation between reasons for disclosure or not with coping strategies has a Correlation Coefficient of 0.480**. There is a significant positive correlation between reasons for disclosure or not and coping strategies. This implies that the reasons for disclosure or non-disclosure are associated with the coping strategies adopted by the HIV and AIDS positive youth and their family.

The correlation between reasons for disclosure or not with counselling needs has a Correlation Coefficient of 0.465**. There is a significant positive correlation between reasons for disclosure or not and counselling needs resulting from youth HIV and AIDS status disclosure. This indicates an association between the reasons for disclosure or non-disclosure and the utilization of counselling needs that present themselves post-disclosure.

The correlation between status disclosure outcomes with coping strategies has a Correlation Coefficient of -0.528**. There is a significant negative correlation between status disclosure outcomes and coping strategies applied in the family. This suggests that the way the family reacts to disclosure is related negatively to the coping strategies employed by the youth and their family at CCC, Nairobi Kenya.

The correlation between status disclosure outcomes and counselling needs has a Correlation Coefficient of -0.612**. There is a significant negative correlation between the status disclosure outcomes and the counselling needs that arise. This implies that the status disclosure outcomes is negatively associated with the counselling needs that arise in the family after the HIV and AIDS positive youth has disclosed their positive status.

The correlation between coping strategies with counselling needs has a Correlation Coefficient of 0.833**. There is a significant positive correlation between coping strategies and counselling needs. This indicates a strong positive association between coping strategies and the counselling needs that arise after youth HIV and AIDS status disclosure.

Chapter Summary

In this chapter, the findings of the study have been presented, interpreted, and discussed. The chapter begun by providing a descriptive analysis of the demographic profile of the study respondents which shows that women were the majority of the new

positive HIV and AIDS infections at CCC, Nairobi Kenya. The chapter has presented both quantitative analysis in terms of descriptive statistics and inferential analysis, which also included thematic analysis of the study qualitative data. The data has been presented using appropriate figures, tables and charts.

Chapter Five: Summary of Findings, Conclusions, Recommendations, Areas for Further Research and Conclusions

Introduction

The main objective of this study was to investigate the effect of youth HIV and AIDS status disclosure on family members at the CCC in KNH, Nairobi Kenya as a case study. This chapter described the findings discussion, including an overview of the main findings for each study objective. The sections gives a conclusion that summarised the study results discussed, reflecting the theoretical and practical implications of the study results. From this, conclusions have been included, and used for recommendations for further research.

Socio-Demographic population description

The study involved a total of 384 HIV and AIDS positive youth at the CCC, where 54.4% were female and 45.6% were male. The study involved youth between the ages of 18-24 which has proven to be among the highest newly HIV and AIDS diagnosed population as reflected by WHO (2020), and it is evident that most of the youth are single as 72.1% of the population.

Most of the youth who participated in the study were unemployed comprising of 38.8% of the sample population, because most of them were in school comprising of 49.0% of the population. This is supported by Dimbuene (2019), who argues that most of the youth are afraid to consider status disclosure because they depend on their families.

The youth were people who have been diagnosed as HIV and AIDS positive in the last five years, and most people found out in 2023 being 25.8% of the study population, with most of them being 38.8% found out through self-test kits. The data collected showed

that when the youth received a positive HIV and AIDS diagnosis, they had different personal reactions to this news which is in line with Weinreich and Benn (2019) statistics.

The data showed that the most prevalent emotional response appeared to be shocked, representing 34.1% of the respondents, followed by regrets having sex and encouraged self because life has to move on with percentages of 9.6% and 11.2%, respectively. Other notable personal reactions included afraid and unsure of next step at 12.5%, worry of the youth future at 8.6%, and disappointed at 6.0%.

Of all the 384 youths at CCC, 67.4% of them had disclosed their positive status to their families and 32.6% of them were yet to disclose their status. The largest number of people disclosed to were mothers at 62.0% of the 258 people the youth disclosed their HIV and AIDS status to. Of the 67.4% youth who disclosed their status, there are reasons that encouraged them to tell their families of their HIV and AIDS status as argued by Dessie et al., (2019).

Among the disclosure reasons given, support seeking emerged as the most prevalent, representing 38.0% of respondents, highlighting the importance of seeking assistance and understanding during challenging times. Other significant factors included strong family relations at 19.8%, emphasizing the role of familial connections in the decision-making process, and symptoms showing and being sick at 4.7%, reflecting instances where the physical manifestations of the condition prompted disclosure. Additionally, due to fear and did not want to keep such a secret from my family contributed to 1.0% and 3.6%, respectively.

Of all the 384 youths at CCC, the 32.6% youth who had not disclosed their status, had reasons that discouraged them from telling their families of their HIV and AIDS status as supported by Weinreich and Benn (2019).The predominant reason for non-disclosure

was fear of rejection, accounting for 22.9% of respondents, underscoring the apprehension individuals feel about potential negative reactions from their family members. Additional factors contributing to non-disclosure included concerns related to religious and cultural perceptions, with religion and culture will make family think I'm promiscuous at 2.6%, and uncertainties about others' reactions with unsure of their reaction at 2.6%. Fear of discrimination and fear of being negatively judged constituted a smaller percentages at 1.6% and 1.0%, respectively, reflecting worries about potential stigmatization. Notably, a subset of individuals, 1.8%, cited uninterested in disclosing as their reason for not sharing their status.

Youth Status Disclosure

The second section of the questionnaire was a four point Likert scale that was developed ranging from one to four was used, where 1 was strongly disagree while 4 was strongly agree. Item one to four were used to measure for reasons for youth HIV and AIDS status disclosure, item five to eight were used to explore the outcomes of youth HIV and AIDS status disclosure in the family. Item nine to twelve measured for the youth coping strategies resulting from their HIV and AIDS status disclosure, and item thirteen to fifteen measured the counselling needs that arise as a result of the youth disclosing their HIV and AIDS status in the family.

Reasons for disclosure of youth HIV and AIDS status to the family

According to this study, there are different reasons that encourage or discourage the youth from disclosing their HIV and AIDS status to their family members. The items ‘Need for support from family has an influence on my HIV/AIDS status disclosure decision’, ‘Status disclosure to my family members is greatly influenced by societal view on HIV/AIDS’, ‘Closeness in relationship with family members determines my ability to

open up and give detail', and 'Gender influences family members reception of my HIV/AIDS status disclosure' results were represented in the study (Table 15), and relevant themes reflected.

The respondents indicated a relatively high level of agreement $\bar{x}$ of 3.21 that family members are dependent for support during stress times. The lowσ of 0.889 shows that there is less variability in responses, indicating a more consistent agreement among respondents. Respondent's thematic analysis described that they were more inclined to disclosure, if they know the family will be there for them and love them unconditionally despite them being HIV and AIDS positive, which is in line Ullery and Carney (2020).

The respondents expressed a moderate agreement $\bar{x}$ of 3.18 that societal views affect youth status disclosure. The σ of 1.112 indicated some variability in responses, suggesting that opinions on this item are not uniform. Thematic analysis was affirmed by Dessie et al. (2019), who argues that the fear of rejection due to the societal worldview of people who are HIV and AIDS positive influences the youth's status disclosure decision.

Respondents show a moderate level of agreement $\bar{x}$ of 2.62 that family relationships make it easy to open up and give details. The higher σ of 1.275 indicated a greater variability in responses, suggesting diverse opinions on this item. In line with Smith et al. (2017), who observed that the kind of relationship the youth has with their family plays a role in either encouraging them to disclose or not, from the respondent's interview thematic analysis.

Respondents tend to agree with a $\bar{x}$ of 2.60 that youth's gender influences family member's reception of HIV and AIDS status disclosure. The highσ of 1.305, indicated a wide range of responses and less consensus among respondents. This is in line with

Braithwaite et al (2018), who argues that gender influences how differently men and women make their status disclosure decisions which was addressed through thematic analysis.

Youth HIV and AIDS outcomes from status disclosure to the family

The study explored the youth HIV and AIDS status disclosure outcomes at the CCC, Nairobi Kenya. The items 'Family members start physically avoiding me after HIV/AIDS status disclosure', 'Emotional disconnection follows after my HIV/AIDS status disclosure to family members', 'Different family member's opinions on HIV/AIDS affect how they receive news of my status disclosure', and 'Family members successfully find ways to express their strong feelings on my HIV/AIDS status disclosure' results were represented in the study (Table 16), and relevant themes reflected.

Respondents disagreed with a $\bar{x}$ of 2.01 that there is physical avoidance by family members after status disclosure. The higher σ of 1.209 indicated more variability in responses, indicating that opinions on this item were diverse. Results of thematic analysis were supported by Buki et al. (2017), who highlighted that the physical rejection and isolation is a common theme seen globally, which varies when positive individuals disclose their status to their family.

Respondents disagreed with a $\bar{x}$ of 2.09 that there is emotional disconnection by family members after status disclosure. The higher σ of 1.278 argues variability in responses, indicating diverse opinions on this item. Thematic analysis presented were supported by Ullery and Carney (2020), who argue that in different situations families react differently emotionally, either pulling back or being emotionally close to the disclosing youth.

Respondents showed a relatively high level of agreement $\bar{x}$ of 3.18 that their family's opinion affects their reaction towards the respondent's disclosure. The lower σ of 0.899 shows that there is more consistency in responses, indicating a more uniform agreement among respondents. Braithwaite et al. (2018), supported the evidence of theme by arguing that when people open up about new information, they are still trying to navigate receiving the news of the youth's positive HIV and AIDS status and sometimes their opinion on the subject influences their reaction as guided by the Communication Privacy Management Model.

Respondents agreed with a $\bar{x}$ of 2.92 that their family successfully finds a way to express their feelings about the respondent's status. The σ of 1.036 indicated some variability in responses, that opinions on this item are not entirely uniform. Evidence of thematic analysis were supported by Weinreich and Benn (2019), who argued that the youth's HIV and AIDS status disclosure outcomes in the family can be reflected by how the family members behave, and carry themselves around the youth who has decided to disclose their HIV and AIDS status, as family members tried to express themselves differently in different families.

Coping strategies resulting from youth HIV and AIDS status disclosure in the family

The study investigated the coping strategies resulting from youth HIV and AIDS status disclosure in the family at the CCC, Nairobi Kenya. The items 'I seek help implement necessary lifestyle changes by disclosing my HIV/AIDS status to family members', 'I disclose my HIV/AIDS status to receive emotional security and unconditional acceptance from family members', 'I disclose my HIV/AIDS status to avoid being attacked and discriminated against by family members', and 'I seek problem solving help from family members by HIV/AIDS status disclosure' results were represented in the study (Table 17), and relevant themes reflected.

Respondents indicated a moderate level of agreement $\bar{x}$ of 2.99 that their family actively helps in implementing lifestyle changes. The σ of 1.200 shows some variability in responses, indicating that opinions on this item are not entirely uniform in the study. Thematic analysis results were in line with Frain et al. (2018) findings that argue that families successfully or unsuccessfully find ways to ensure that the youth feels accepted and loved unconditionally as they try to figure out their new lifestyle.

Respondents expressed a moderate level of agreement $\bar{x}$ of 2.98 that their family members provide emotional security and support. The σ of 1.163 indicated some variability in responses, which showed diverse opinions on this item. Thematic analysis results were supported by Qiao et al. (2018), who argues that different families try to find ways to cope knowing the youth's HIV and AIDS status, the family can either develop maladaptive or healthy coping mechanisms.

Respondents disagreed with a $\bar{x}$ of 2.03 that their family members constantly bash them due to their status. The higher$\sigma$of 1.226 indicated more variability in responses, indicating diverse opinions on this item. Thematic analysis results were in line with Hatcher et al (2020), who argued that some families find healthy ways to openly talk about sensitive topics in an attempt to ease stigmatization, while some families are unsuccessful at finding ways to adopt healthy ways of accommodating the youth's positive HIV and AIDS status.

Respondents indicated a moderate level of agreement $\bar{x}$ of 2.92 that their family is dependent on being present during emergencies. The low σ of 0.927 shows more consistency in responses, indicating a more uniform agreement among respondents. Smith et al (2019), findings support the thematic analysis results by arguing that some families

come to help the youth by facilitating their treatment journey like financially supporting them, as opposed to some families who do not show up in times of emergencies.

Counselling needs resulting from youth HIV and AIDS status disclosure to family

The study investigated the coping strategies resulting from youth HIV and AIDS status disclosure in the family at the CCC, Nairobi Kenya. The items 'Family members are actively involved in life decision making process after my HIV/AIDS status disclosure', 'My HIV/AIDS status caregiving and financial needs are addressed in the family', and 'My HIV/AIDS status disclosure will lead to quality of life concerns in the family' results were represented in the study (Table 18), and relevant themes reflected.

Respondents indicated a moderate level of agreement $\bar{x}$ of 2.79 that their family is involved in their life decision-making process. The standard deviationσ of 1.146 shows variability in responses, indicating that opinions on this item are not entirely uniform. Thematic analysis results were in line with the KNHIV (2020) report, which emphasized the impactful role of having family members as part of the people who actively help the youth make lifestyle decisions which has proven to be beneficial in Kenya and should be addressed specially for each family.

Respondents expressed a moderate level of agreement $\bar{x}$ of 2.62 that status disclosure increases family interactions. The higher standard deviation σ of 1.233 indicated more variability in responses, showing diverse opinions on this item. Thematic analysis results were in line with Pequegnat and Bell (2021) statistics which highlight the need for the disclosing youth and their families to have the appropriate resources, to help address the relational issues that present as counselling needs by different families.

Respondents indicate a moderate level of agreement $\bar{x}$ of 2.99 that their status disclosure triggered longevity concerns, and their family helps in navigation. The relatively lowσ of 1.024 indicated more consistency in responses, indicating a more uniform agreement among respondents. Thematic analysis results were in line with KNHIV (2020), report which emphasizes on the important role family members can play in helping the youth make appropriate life decisions to make room for their positive HIV and AIDS status diagnosis which presents differently for families.

Conclusions

The focus of this study was to investigate the effect of youth HIV and AIDS status disclosure on family members at the CCC in KNH, Nairobi Kenya as a case study. The objectives of the study were to investigate the reasons for disclosure of youth HIV and AIDS status to the family members at the CCC, Nairobi Kenya, to identify the youth's HIV and AIDS outcomes from status disclosure to the family members, to assess the coping strategies resulting from youth HIV and AIDS status disclosure in the family, and to investigate the counselling needs resulting from youth HIV and AIDS status disclosure in the family.

Conclusion was drawn that reasons for youth HIV and AIDS status disclosure and youth status disclosure outcome was negatively correlated at ρ of -0.310. This shows that the reasons for disclosing or not disclosing are negatively related to how the family reacts to the youth HIV and AIDS status disclosure. The youth described that they were more inclined to disclosure, if they know the family will be there for them, to love them unconditionally, and receive the news of their status well despite knowing the youth is HIV and AIDS positive, which is in line Ullery and Carney (2020).

The descriptive findings indicated that reasons for youth HIV and AIDS status disclosure and youth coping strategies was positively correlated at ρ of 0.480. This shows that the reasons for disclosure or non-disclosure are associated with the coping strategies adopted by the youth and their families once they have disclosed their HIV and AIDS status. The youth's responses were affirmed by Dessie et al. (2019), who argued that the fear of rejection due to the societal worldview of people who are HIV and AIDS positive influences the youth's status disclosure decision.

The correlation revealed that reasons for youth HIV and AIDS status disclosure and youth counselling needs was positively correlated at ρ of 0.465. This indicates an association between the reasons for disclosure or non-disclosure, and the reflection of counselling needs that need to be addressed in therapy after the youth disclosed their positive HIV and AIDS status to family members. This is in line with Smith et al. (2017), who observed that the kind of relationship the youth has with their family plays a role in either encouraging them to disclose their HIV and AIDS status or not. This is because once the youth disclosed their HIV and AIDS status to their family members, the dynamics in relationships can change positively or negatively, which need to be addressed in the therapy room.

Statistics indicated that youth status disclosure outcomes and coping strategies was negatively correlated at ρ of -0.528. This shows that the way the youth HIV and AIDS status disclosure outcomes is related to the coping strategies employed by the youth and their family now that they know the youth is HIV and AIDS positive. Braithwaite et al. (2018), supported the study findings that when people open up about new information, they are still trying to navigate receiving the news of the youth's positive HIV and AIDS status and sometimes their opinion on the subject influences their reaction as guided by the Communication Privacy Management Model. This then means that how the family

receives the news of the youth being HIV and AIDS positive, will determine how they will find either positive or negative ways to live with new reality.

Analysis revealed that youth status disclosure outcomes and counselling needs was negatively correlated at ρ of -0.612. This indicated that the family's reaction to disclosure is associated with the counselling needs that arise in the family post youth HIV and AIDS disclosure. The study findings are supported by Pequegnat and Bell (2021) statistics which highlight the need for the disclosing youth and their families to have the appropriate resources, to help address the relational issues that present as counselling needs by different families.

Conclusions was drawn that coping strategies and counselling needs are positively correlated at ρ of 0.833. This indicated a strong association between coping strategies and the counselling needs that presented in the family after the youth discloses their positive HIV and AIDS status. Results were in line with the KNHIV (2020), report which emphasizes on the important role family members can play in helping the youth make appropriate life decisions to make room for their positive HIV and AIDS status diagnosis which presents differently for families.

Pequegnat and Bell (2021), also argued that attention needs to be paid to the family of the HIV and AIDS infected youth, with regards to the counselling needs that arise and the coping experiences of their families, investigating whether disclosing will bring a negative consequence, or it will be among the positive factors that promotes resilience as the family interacts. This shows that each family should be given special attention to help them address the unique coping strategies, and counselling needs that present themselves once the youth discloses their positive HIV and AIDS status.

Study Recommendations

Based on the study findings, the researcher has the following recommendations: Youth HIV and AIDS status disclosure is quite a sensitive and complex process. Therefore, it is important that medical practitioners, like counsellors, social workers and doctors, are involved in the process of helping the youth navigate their positive diagnosis and status disclosure. The study recommended that the hospital comes up with special programmes that facilitate the unique population who are newly diagnosed as HIV and AIDS positive, to help the youth navigate the different pieces in the process of disclosure, like having a treatment buddy to walk with them when they are newly diagnosed.

There is clear need for families to receive sensitization and psycho-education on how to navigate the youth's positive HIV and AIDS status disclosure. The study recommends that it is important for governmental and non-governmental policy makers to involve Family therapist who treat the family as a unit. Seminars and campaigns can be facilitated in the Comprehensive Care Clinics and public forums, to create awareness on disclosure and its impact on the youth and their family. Aspects like the different ways they have to adjust to make room for this new reality, and resources available to help them navigate the impact of youth HIV and AIDS status disclosure should also be addressed to reduce stigma and discrimination.

Further Research Recommendations

The current study examined the effect of youth HIV and AIDS status disclosure on family members at the CCC in KNH, Nairobi Kenya which looked at the different variables involved in the youth disclosure process. Another study can be carried out focusing on the intervening variables like family member's gender and age, and how they influence youth HIV and AIDS status disclosure. At the same time, the study was conducted in Nairobi, a similar research should be conducted in the rural settings, to

compare with the results given in the urban set up to establish the difference in youth HIV and AIDS status disclosure experience.

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Appendices

Appendix I: Informed Consent

DEAR (SIR/MADAM);

Greetings, I am Winnie M. Kyalo, a student from Pan Africa Christian University working to complete my Masters of Arts in Marriage and Family Therapy. As part of the process, I am conducting a research on effect of youth HIV and AIDS status disclosure on family members at the Comprehensive Care Clinic in Kenyatta National Hospital, Nairobi Kenya.

The Aim of the study

The study is aimed at working with HIV and AIDS positive youth who have received a positive diagnosis in the last five years and have disclosed their status, or are considering disclosing their status to their family. The findings of the study contribute to the available knowledge to empower, and come up with interventions to help the HIV and AIDS positive youth navigate their status disclosure to their families.

Procedure

After proper information about the study being given to those willing to participate in the study, they will be required to sign a written informed consent. The investigator will ask questions in a face to face interview that will take 45 minutes to one hour, and also use a self-administered questionnaire.

Questions asked will be guided by the study and will revolve around: reasons for disclosure of youth HIV and AIDS status to the family, the youth's HIV and AIDS outcomes from status disclosure to the family member, the youth's disclosure experience resulting from HIV and AIDS status disclosure in the family and the counselling needs resulting from the youth HIV and AIDS status disclosure in the family.

Confidentiality

Due to the sensitive nature of data collected through the interviews and questionnaire, the researcher will be the principle investigator of the study. All information collected will be kept private and confidentiality will be upheld, and the information will only be used for the purpose of the research only. All respondents will be given pseudo names to protect their private information, and all information collected will be stored in a password protected device.

Right to withdraw and refuse

The youth has the right to refuse to participate in the study, as participation is purely on voluntary basis. At the same time, after giving consent, if the youth at any point feels uncomfortable they have the right to withdraw from the study, without any negative consequences to the medical services received at the Kenyatta National Hospital.

Benefit of participation

The youth will greatly benefit from the participating in the study as they will be psycho-educated and concerns surrounding HIV and AIDS status disclosure addressed appropriately, and all necessary counselling services offered. Participation in the study is purely based on voluntary terms, hence no monetary benefits will occur from participating in the study.

Risk of participation

There is no anticipated harm that will come from the respondents engaging in the study. However, it is important for the youth willing to participate in the research to understand that by engaging in the study, they at risk of their privacy being invaded, and experiencing emotional and psychological triggers as a result. However, in the case where the

respondents gets triggered by themes explore during the study, the researcher will offer counselling and psychological help as needed.

Whom to contact

In case of any inquiry of follow up questions, feel free to contact the principal investigator Miss Winnie Kyalo 0791272244, or Dr. Esther Marima 0721563110 the principle investigator's supervisor. The research participant may also contact the Secretary/Chairperson, Kenyatta National Hospital-University of Nairobi Ethics and Research Committee, Telephone No. 2726300 Ext. 44102 email uonknh_erc@uonbi.ac.ke. This study has approval by The KNHUoN-ERC protocol No. P422/04/2023.

CONSENT FORM (STATEMENT OF CONSENT)

Participant's statement

I have read this consent form or had the information read to me. I have had the chance to discuss this research study with a study counsellor. I have had my questions answered in a language that I understand. The risks and benefits have been explained to me. I understand that my participation in this study is voluntary, and that I may choose to withdraw any time. I freely agree to participate in this research study. By signing this consent form, I have not given up any of the legal rights that I have as a participant in a research study.

Name: Date:

Signature:

Researcher's statement

I, the undersigned, have fully explained the relevant details of this research study to the participant named above, and believe that the participant has understood and has willingly and freely given his/her consent.

Sincerely,

Winnie Kyalo. Signature: Date:

Nyongeza I: Idhini ya Taarifa

MPENDWA (BWANA/MADAM);

Salamu, mimi ni Winnie M. Kyalo, mwanafunzi kutoka Chuo Kikuu cha Pan Africa Christian ninafanya kazi kukamilisha Shahada yangu ya Uzamili ya Sanaa katika Ndoa na matibabu ya familia. Kama sehemu ya mchakato huo, ninafanya utafiti kuhusu athari za ufichuzi wa vijana wa VVU na UKIMWI kwa wanafamilia katika Clinic ya Kina ya Huduma katika hospitali ya taifa ya Kenyatta, Nairobi Kenya.

Lengo la utafiti

Utafiti huo unalenga kufanya kazi na vijana wenye VVU na UKIMWI ambao wamepata utambuzi chanya katika miaka mitano iliyopita na wamefichua hali zao, au wanafikiria kufichua hali zao kwa familia zao. Matokeo ya utafiti yatachangia maarifa yanayopatikana ili kuwawezesha, na kuja na afua za kuwasaidia vijana walio na VVU na UKIMWI kukabiliana na hali yao ya ufichuzi kwa familia zao.

Utaratibu

Baada ya taarifa sahihi kuhusu utafiti kutolewa kwa wale walio tayari kushiriki katika utafiti, watahitajika kutia sahihi kibali kilichoandikwa. Mpelelezi atauliza maswali katika mahojiano ya ana kwa ana, ambayo yatachukua dakika 45 hadi saa moja, na pia kutumia dodoso la kujisimamia mwenyewe.

Maswali yatakayoulizwa yataongozwa na utafiti na yatahusu malengo yafuatayo: sababu za kufichua hali ya vijana ya VVU na UKIMWI kwa familia, matokeo ya vijana kuhusu VVU na UKIMWI kutokana na kufichuliwa hadhi kwa mwanafamilia, uzoefu wa ufichuzi wa vijana kutokana na hali ya VVU na UKIMWI, na kufichua katika familia na mahitaji ya ushauri nasaha yanayotokana na ufichuzi wa hali ya VVU na UKIMWI kwa vijana katika familia.

Usiri

Kutokana na hali nyeti ya data zilizokusanywa kupitia mahojiano na dodoso, mtafiti ndiye atakuwa mpelelezi mkuu wa utafiti. Taarifa zote zitakazokusanywa zitawekwa faragha na usiri utadumishwa, na taarifa hiyo itatumika kwa madhumuni ya utafiti pekee. Washiriki wote watapewa majina ya uwongo ili kulinda taarifa zao za faragha, na taarifa zote zitakazokusanywa zikihifadhiwa zitalindwa kwa nenosiri.

Haki ya kujiondoa na kukataa

Vijana wana haki ya kukataa kushiriki katika utafiti, kwani ushiriki ni kwa hiari tu. Wakati huo huo, hata baada ya kutoa idhini, ikiwa vijana wakati wowote wanajisikia vibaya wana haki ya kujiondoa kwenye utafiti, bila matokeo yoyote mabaya kwa huduma za matibabu zinazopokelewa katika Hospitali ya Kitaifa ya Kenyatta.

Faida ya ushiriki

Vijana watafaidika kwa kiasi kikubwa kutokana na kushiriki katika utafiti kwani watakuwa wameelimishwa kisaikolojia na wasiwasi unaohusu ufichuzi wa hali ya VVU na UKIMWI kushughulikiwa ipasavyo, na huduma zote muhimu za unasihi zinazotolewa. Kushiriki katika utafiti kunategemea tu masharti ya hiari, kwa hivyo hakuna faida za kifedha zitakazopatikana kutokana na kushiriki katika utafiti.

Hatari ya ushiriki

Hakuna madhara yanayotarajiwa ambayo yatatoka kwa washiriki wanaoshiriki katika utafiti. Hata hivyo, ni muhimu kwa vijana walio tayari kushiriki katika utafiti kuelewa kwamba kwa kushiriki katika utafiti, wana hatari ya ufaragha wao kuvamiwa, na kupata vichochezi vya kihisia na kisaikolojia kama matokeo. Hata hivyo, katika hali ambapo washiriki huchochewa na mada zinazochunguzwa wakati wa utafiti, mtafiti atatoa ushauri nasaha na usaidizi wa kisaikolojia inapohitajika.

Nani wa kuwasiliana naye

Iwapo kuna swali lolote la maswali ya ufuatiliaji, jisikie huru kuwasiliana na mpelelezi mkuu Bi Winnie Kyalo 0791272244, au Bi. Esther Marima 0787650606 msimamizi wa mpelelezi mkuu. Mshiriki wa utafiti pia anaweza kuwasiliana na Katibu/Mwenyekiti, Hospitali ya Kitaifa ya Kenyatta-Kamati ya Maadili na Utafiti ya Chuo Kikuu cha Nairobi, Nambari ya simu 2726300 Ext. 44102 barua pepe uonknh_erc@uonbi.ac.ke. Utafiti huu umeidhinishwa na Itifaki ya KNHUoN-ERC Na. P422/04/2023.

FOMU YA RIDHAA (TAARIFA YA RIDHAA)

Kauli ya mshiriki

Nimesoma fomu hii ya idhini au nimesomewa maelezo. Nimepata nafasi ya kujadili utafiti huu na mshauri wa utafiti. Nimejibiwa maswali yangu kwa lugha ninayoielewa. Hatari na faida zimeelezewa kwangu. Ninaelewa kuwa ushiriki wangu katika utafiti huu ni wa hiari, na kwamba ninaweza kuchagua kujiondoa wakati wowote. Ninakubali kwa uhuru kushiriki katika utafiti huu. Kwa kutia saini fomu hii ya idhini, sijaacha haki zozote za kisheria nilizo nazo kama mshiriki katika utafiti wa utafiti.

Jina: Tarehe:

Sahihi:

Kauli ya mtafiti

Mimi, aliyetia sahihi hapa chini, nimeeleza kikamilifu maelezo muhimu ya utafiti huu kwa mshiriki aliyetajwa hapo juu, na ninaamini kuwa mshiriki ameelewa na ametoa ridhaa yake kwa hiari na kwa uhuru.

Kwa dhati,

Winnie Kyalo. Sahihi: Tarehe:

Appendix II: Youth Questionnaire

This tool will be used to investigate the effect of youth HIV and AIDS disclosure on the family members, with special focus being given to disclosure indicators, family member's reaction to youth's HIV and AIDS status, coping strategies, and counselling needs that present post-disclosure. On a scale of 1 to 4, where 1 is strongly disagree and 4 is highly agree, the tool will also be used to obtain respondents bio-data kindly fill the spaces with a tick, and answer the questions where applicable.

Age: ( )18 ( )19 ( )20 ( )21 ( )22 ( )23 ( )24

Gender: ( ) Male ( ) Female

Marital status: ( ) Single ( ) Engaged ( )Married ( ) Divorced () Widowed

Employment status: ( ) Unemployed ( ) Employed ( ) Self-employed

Education status: ( ) High-school ( ) College ( )University

1. When did you receive your positive HIV and AIDS diagnosis?( ) 2019 ( ) 2020 ( ) 2021 ( ) 2022 ( ) 2023

2. What made you get tested for HIV? ( ) Sickness ( ) Self initiative through self-test kit ( ) Hospital visit for another reason

3. What was your reaction to being HIV and AIDS positive?

4. Have you disclosed your HIV and AIDS status to your family?

If yes, give reasons for disclosure-

If no, give reasons for non-disclosure-

5. To whom have you disclosed your positive HIV and AIDS status? ( ) Mother ( ) Father ( ) Brother ( ) Sister ( ) Aunt ( ) Uncle ( ) Cousin ( ) Grandmother

( ) Grandfather

6. How old is the family member you disclosed your HIV and AIDS status to?

7. Give reasons as to why you chose to disclose to the person you have indicated above in question 6

8. After how long did you decide to disclose your HIV and AIDS status to your family?

( ) Same day ( ) After a week ( ) After a month ( ) Any other

9. On a scale of 1 to 4, where 1 is strongly disagree and 4 is strongly agree, rate your experience with disclosure. Please indicate the extent to which you agree or disagree with each statement by using ticks in the rating scale as indicated.

Statement	Strongly Disagree 1	Disagree 2	Agree 3	Strongly Agree 4
Need for support from family has an influence on my HIV/AIDS status disclosure decision				
Status disclosure to my family members is greatly influenced by Societal view on HIV/AIDS				
Closeness in relationship with family members determines my ability to open up and give detail				
Gender influences family members reception of my HIV/AIDS status disclosure				
Family members start physically avoiding me after HIV/AIDS status disclosure				
Emotional disconnection follows after my HIV/AIDS status disclosure to family members				
Different family member's opinions on HIV/AIDS affect how they receive news of my status disclosure				

Family members successfully find ways to express their strong feelings on my HIV/AIDS status disclosure				
I seek help implement necessary lifestyle changes by disclosing my HIV/AIDS status to family members				
I disclose my HIV/AIDS status to receive emotional security and unconditional acceptance from family members				
I disclose my HIV/AIDS status to avoid being attacked and discriminated against by family members				
I seek problem solving help from family members by HIV/AIDS status disclosure				
Family members are actively involved in life decision making process after my HIV/AIDS status disclosure				
My HIV/AIDS status caregiving and financial needs are addressed in the family				
My HIV/AIDS status disclosure will lead to quality of life concerns in the family				

Nyongeza II: Dodoso la Vijana

Chombo hiki kitatumika kuchunguza athari za ufichuzi wa VVU na UKIMWI kwa vijana kwa wanafamilia, huku mkazo maalum ukitolewa kwa viashirio vya ufichuzi, mwitikio wa wanafamilia kwa hali ya vijana ya VVU na UKIMWI, njia za kukabiliana na mahitaji ya ushauri nasaha ambayo yanawasilishwa baada ya kufichuliwa. Kwa kipimo cha 1 hadi 4, ambapo 1 hakubaliani kabisa na 4 anakubali sana, zana hiyo pia itatumika kupata washiriki data ya kibaolojia kujaza nafasi kwa tiki na kujibu maswali inapohitajika.

Umri: ( )18 ( )19 ( )20 ( )21 ( )22 ( )23 ( )24

Jinsia:( ) Kiume ( ) Kike

Hali ya ndoa: ( ) Pekee ( ) Kushirikiwa kwa kuolewa ( )Nimeolewa ( )Talaka ( ) Mjane

Hali ya ajira:( ) Bila ajira ( ) Kuajiriwa ( ) Kujiajiri

Hali ya elimu: ( ) Secondari ( ) Chuo cha elimu ( ) Chuo Kikuu

1. Je, ni lini ulipokea utambuzi wa VVU na UKIMWI? ( ) 2019 ( ) 2020 ( ) 2021 ( ) 2022 ( ) 2023

2. Ni nini kilikufanya upime VVU? ( ) Ugonjwa ( ) Kujitolea kupitia kifaa cha kujipima ( ) Tembelea hospitali kwa sababu nyingine

3. Je, uliitikiaje kwa kuwa na VVU na UKIMWI?

4. Je, umeeleza hali yako ya VVU na UKIMWI kwa familia yako?

Ikiwa ndio, ni nini kilihimiza uamuzi wako wa kufichua?

Ikiwa hapana, ni nini kilikatisha tamaa uamuzi wako wa kufichua?

5. Je, umemweleza nani kuhusu hali yako ya VVU na UKIMWI? ( ) Mama ( ) Baba ( ) Kaka ( ) Dada ( ) Shangazi ( ) Mjomba ( ) Binamu ( ) Bibi ( ) Babu

6. Je, mwanafamilia uliyemjulisha kuhusu VVU na UKIMWI ana umri gani?

7. Toa sababu kwa nini ulichagua kufichua kwa mtu uliyetaja hapo juu katika swali la 6

8. Baada ya muda gani uliamua kufichua hali yako ya VVU na UKIMWI kwa familia yako?

( ) Siku hiyo hiyo ( ) Baada ya wiki ( ) Baada ya mwezi ( ) Nyingine yoyote

9. Katika mizani ya 1 hadi 4, ambapo 1 hakubaliani kabisa na 4 anakubali sana, kadiria uzoefu wako kwa kufichua. Tafadhali onyesha kiwango ambacho unakubali au hukubaliani na kila kauli kwa kutumia tiki katika mizani ya ukadiriaji kama ilivyoonyeshwa.

Kauli	Kwa Nguvu Usikubali 1	Usikubali 2	Kubali 3	Kubali sana 4
Kuhitaji msaada kutoka kwa familia kunaathiri uamuzi wangu wa kufichua hali ya VVU/UKIMWI				
Ufichuaji wa hali kwa wanafamilia yangu unachangiwa pakubwa na mtazamo wa Jamii kuhusu VVU/UKIMWI				
Ukaribu katika uhusiano na wanafamilia huamua uwezo wangu wa kufunguka na kutoa maelezo				
Jinsia huathiri wanafamilia kupokea ufichuzi wangu wa hali ya VVU/UKIMWI				
Wanafamilia wanaanza kuniepuka baada ya kufichua hali ya VVU/UKIMWI				
Kukataliwa kihisia kunafuata baada ya kufichua hali yangu ya VVU/UKIMWI kwa wanafamilia				
Maoni tofauti ya wanafamilia kuhusu VVU/UKIMWI huathiri jinsi wanavyopokea habari za ufichuzi wa hali yangu				
Wanafamilia walifanikiwa kutafuta njia za kuelezea hisia zao kali juu ya ufichuaji wangu wa hali ya VVU/UKIMWI				

Ninatafuta usaidizi wa kutekeleza mabadiliko muhimu ya mtindo wa maisha kwa kufichua hali yangu ya VVU/UKIMWI kwa wanafamilia				
Ninafichua hali yangu ya VVU/UKIMWI ili kupokea usalama wa kihisia na kukubalika bila masharti kutoka kwa wanafamilia				
Ninafichua hali yangu ya VVU/UKIMWI ili kuepuka kushambuliwa na kubaguliwa na wanafamilia				
Ninatafuta usaidizi wa kutatua matatizo kutoka kwa wanafamilia kwa kufichua hali ya VVU/UKIMWI				
Wanafamilia wanashiriki kikamilifu katika mchakato wa kufanya maamuzi ya maisha baada ya kufichua hali yangu ya VVU/UKIMWI				
Mahitaji yangu ya hali ya VVU/UKIMWI na mahitaji ya kifedha yanashughulikiwa katika familia				
Ufichuaji wangu wa hali ya VVU/UKIMWI utasababisha wasiwasi wa maisha katika familia				

Appendix II: Semi-structured In-depth group interview guide

The purpose of the study is to investigate effect of youth HIV and AIDS disclosure on family members at Comprehensive Care Clinic in Kenyatta National Hospital, Nairobi Kenya. The information obtained will be used for academic purposes only and confidentiality will be maintained.

1. What factors encouraged or discouraged your decision for HIV and AIDS status disclosure as a youth to your family?

2. What role does HIV and AIDS status disclosure play in you and your family member's lives?

3. How does HIV and AIDS status disclosure affect the youth and their family either positively or negatively?

4. What role does youth and family perception and believes on HIV and AIDS play in the process of disclosure and disclosure outcome?

5. How different does the youth and family interact after HIV and AIDS status disclosure happens?

6. How does the youth and their family find ways to cope and make room for this new reality revealed through HIV and AIDS status disclosure?

7. How different can the youth be prepared and equipped appropriately for the process of HIV and AIDS status disclosure to their family and the post disclosure consequences?

8. How does the youth and their family address concerns that result from HIV and AIDS status disclosure?

Thank you for participating.

Nyongeza II: Mwongozo wa usaili wa kina wa kikundi wenye muundo nusu

Madhumuni ya utafiti huu ni kuchunguza athari za ufichuzi wa VVU na UKIMWI kwa vijana kwa wanafamilia katika Kliniki ya Utunzaji Kamili katika Hospitali ya Kitaifa ya Kenyatta, Nairobi Kenya. Taarifa zitakazopatikana zitatumika kwa madhumuni ya kitaaluma pekee na usiri utadumishwa.

1. Ni mambo gani yalihimiza au kukatisha tamaa uamuzi wako wa kufichua hali ya VVU na UKIMWI kama kijana kwa familia yako?
2. Je, ufichuzi wa hali ya VVU na UKIMWI una nafasi gani katika maisha yako na ya wanafamilia wako?
3. Je, ufichuzi wa hali ya VVU na UKIMWI unaathiri vipi vijana na familia zao iwe chanya au hasi?
4. Je, mtazamo wa vijana na familia na kuamini juu ya VVU na UKIMWI una jukumu gani katika mchakato wa kufichua na kufichua matokeo?
5. Je, vijana na familia huingiliana kwa namna gani baada ya kufichuliwa kwa hali ya VVU na UKIMWI?
6. Je, vijana na familia zao wanapataje njia za kukabiliana na kutoa nafasi kwa ukweli huu mpya uliofichuliwa kupitia ufichuzi wa hali ya VVU na UKIMWI?
7. Je! ni tofauti gani kati ya vijana wanaweza kutayarishwa na kuwezeshwa ipasavyo kwa ajili ya mchakato wa kufichua hali ya VVU na UKIMWI kwa familia zao na matokeo ya baada ya kufichua?
8. Je, vijana na familia zao hushughulikia vipi wasiwasi unaotokana na kufichuliwa kwa hali ya VVU na UKIMWI?

Asante kwa kushiriki.

Appendix III: Ethical Clearance Certificate

Certificate of Ethical Clearance

Pan Africa Christian University
Thika Road Campus | Valley Road Campus
P.O. Box 56875-00200 | +254 730955000 | +254 730955501/2
enquiries@pacuniversity.ac.ke | www.pacuniversity.ac.ke

INSTITUTIONAL SCIENTIFIC ETHICSREVIEW COMMITTEE

(IS E R C)

This Certificate is awarded to

Winnie Mwikali Kyalo

For the research titled

Effect of youth HIV/AIDS disclosure on family members at the Comprehensive Care Clinic in Kenyatta National Hospital, Nairobi Kenya.

Ref/PAC/ISERC/003/2/23

having complied with PAC University Institutional Scientific Ethics Review Committee's guidelines and Standard Operating Procedures for ethical clearance.

This Certificate is issued subject to compliance with the following requirements:

i. Before commencing the study, you are required to obtain a Research License from the NationalCommission for Science, Technology and Innovation (NACOSTI) as well as other institutional clearances as and where needed.
ii. Only approved documents including research instruments and informed consent forms will beused.
iii. All changes including amendments and/or deviations are to be submitted for review andclearance by PAC University Institutional Scientific Ethics Review Committee before use.
iv. Any expected or unexpected changes that may increase the risks to study participants or affectthe integrity of the study must be reported in writing to PAC University Institutional Scientific Ethics Review Committee within two days.
v. Any request for renewal or approval must be submitted to PAC University Institutional ScientificEthics Review Committee at least four weeks prior to the expiry of this Certificate and must be accompanied by a comprehensive progress report to support the renewal.

Date of issue	27/2/2023	**Expiry date**	27/2/2024

DR.JANE KINUTHIA

Secretary PAC_ISERC

Appendix IV: Pac University Research Authorization Letter

PAN AFRICA CHRISTIAN
PAC UNIVERSITY

P.O. Box 56875 - 00200
Nairobi, Kenya
Lumumba Drive, Roysambu
off Kamiti Rd, off Thika Rd
Tel: 0734 400694/0721 932050
Email: enquiries@pacuniversity.ac.ke
website: www.pacuniversity.ac.ke

1ST MARCH, 2023

TO WHOM IT MAY CONCERN

Dear Sir/Madam,

RE: RESEARCH AUTHORIZATION & ETHICS CLEARANCE LETTER FOR WINNIE MWIKALI KYALO REG. NO: MMFT/15628/0/19

Greetings! This is an introductory letter for the above named person a final year student at Pan Africa Christian University (PAC University), pursuing the degree of Master of Arts in Marriage and Family Therapy.

She is at the final stage of the programme and is preparing to collect data to enable her finalise on the Thesis. The Thesis title is ***"Effect of youth HIV/AIDS disclosure on family members at the Comprehensive Care Clinic in Kenyatta National Hospital, Nairobi, Kenya".***

We kindly request that you allow her obtain a research permit so as to proceed and conduct research at the Comprehensive Care Clinic in Kenyatta National Hospital, Nairobi, Kenya.

Warm Regards,

PAN AFRICA CHRISTIAN UNIVERSITY
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Appendix V: Nacosti Permit

REPUBLIC OF KENYA

Ref No: **986373**

NATIONAL COMMISSION FOR SCIENCE, TECHNOLOGY & INNOVATION

Date of Issue:**16/March/2023**

RESEARCH LICENSE

This is to Certify that Miss.. Winnie Mwikali Kyalo of Pan Africa Christian University, has been licensed to conduct research as per the provision of the Science, Technology and Innovation Act, 2013 (Rev.2014) in Nairobi on the topic: EFFECT OF YOUTH HIV AND AIDS DISCLOSURE ON FAMILY MEMBERS AT THE COMPREHENSIVE CARE CLINIC IN KENYATTA NATIONAL HOSPITAL, NAIROBI KENYA for the period ending: 16/March/2024.

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