

**THE EFFECTS OF PERCEIVED STIGMA ON PSYCHOLOGICAL  
WELLNESS AND INTERPERSONAL RELATIONSHIPS OF ADOLESCENTS  
WITH HIV/AIDS IN RUIRU, KIAMBU COUNTY, KENYA**

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**DECLARATION**

This thesis is my original work to the best of my knowledge and has not been presented for the award of an academic degree in any other university.

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## **DEDICATION**

I dedicate this work to my dearly loved parents Mr. Fredrick Gutu Mathenge and Mrs. Esther Muthithi Gutu for their unending support, my son Mr. Malachi Mutirithia Wanjiru who was my muse of academic inspiration and to all the children and adolescents of the world living with HIV/AIDS in whose life this research will make a difference.

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## **LIST OF ABBREVIATIONS**

ART-	Anti-Retroviral Therapy
CCC-	Comprehensive Care Centre
DSM-IV-	Diagnostic and Statistical Manual of Mental Disorders Fourth Edition
KAIS-	Kenya AIDs Indicators Survey
KASF-	Kenya AIDS Strategic Framework
KDHS-	Kenya Demographic Health Survey

## ABSTRACT

There are an approximated 2.1 million HIV-positive adolescents in the world and 15% of the HIV-infected females are young women 15 to 24 years old; of these, 80% live in sub-Saharan Africa, hence, HIV predominance among juvenile females of ages 15 to 19 years is very elevated. The UNAIDS Gap Report concluded that there is a gap in provision of psychological services addressing stigma among other reproductive health needs among adolescent girls as they prepare for adulthood. The study used a cross-sectional research design. Three questionnaires were adopted to assess the three variables. Study participants were recruited from adolescents in long-term follow-up in the five HIV Comprehensive Care Centres in Ruiru Sub-County, Kiambu County, Kenya. The sample included 75 adolescents in the age of 12-19 years. Regression analysis was used to check the effect of perceived stigma on psychological wellness and interpersonal relationships. The results revealed that perceived stigma was a significant predictor of psychological wellness,  $t = -3.293$ ,  $p = 0.020$ . The results further showed that perceived stigma was indeed a significant predictor of interpersonal relationships,  $t = -3.505$ ,  $p = 0.001$ . Correlation analysis revealed that psychological wellness and quality of interpersonal relationships are positively related,  $r = 0.340$ . Regression analysis results also showed that disclosure, family awareness, friends' awareness, friends' emotional support, type of hospital support were significant predictors of psychological wellness and interpersonal relationships. According to the results however, gender was not a significant predictor of psychological wellness and interpersonal relationships.

## **CHAPTER ONE**

### **INTRODUCTION**

#### **1.1 Background of the Study**

Stigma and division due to HIV/AIDS are increasingly causing worry globally. Stigma, particularly, self-stigmatization is a major contributor to low self-esteem and a sense of social unfitness among HIV/AIDS positive individuals. There are 2.1 million HIV infected adolescents globally with an annual increment of approximately 380,000 new HIV infections (UNAIDS, 2014). Of the females infected with HIV/AIDS globally, 15% are aged between 15 and 24 years. Further, 80% of this population live in sub-Saharan Africa, where females get HIV infection approximately 5 to 7 years before their male counterparts (UNAIDS, 2014).

HIV/AIDS remains a major cause of death in Sub-Saharan Africa where nearly 25 million live with HIV/AIDS (Demmer, 2010; Julia et al. 2012). Although several factors have been implicated as a driving force of the pandemic, HIV/AIDS-related stigma is the single most important barrier to controlling the HIV/AIDS pandemic in Sub-Saharan Africa (Mall et al., 2013; Boyes et al., 2013; Haber et al., 2011). On the same vein, the United Nations Secretary-General Ban Ki-moon argues that HIV/AIDS continues to devastate most communities mainly because of stigma (*The Washington Times*, 2008).

In the course of socialization, individuals develop understanding of being labeled either as 'alcoholics', 'mentally ill' or even 'HIV infected' among others. The treatment of those labeled when then be treated in accordance to shared values. These cognitive processes are to some extent independent of others actual behavior. In the process profiling individuals in stigmatizing conditions, those profiled live with a sense of worthlessness. The feeling of unworthiness emergence once individuals internalize/own the labels (Scheff, 1966). Studies reveal association between medically related issues and stigma. HIV/AIDS stigma stems from its association with misbehavior and as such blames the victim (Fife & Wright, 2000). Siegel and Krauss (1991) affirms these findings by highlighting Goffman's (1963) stigma statuses including physical defect, character blemishes, and enrollment in a poorly respected social class.

Available HIV/AIDS stigma literature has not explicitly defined the concept, instead, the concept has just been blankly referred to as "a mark of disgrace" (Mahajan et al., 2008). Stigma is associated with disabling the abilities of PLHIV and key populations including sex workers, injecting drug users and men having sex with men among others who constitute a big

proportion of HIV Infection (UNAIDS, 2014). While there has been an overall increase in the acceptance of PLHIV, it is not enough for the creation of an enabling environment for an effective response to HIV. Further, studies have also revealed that there is a higher HIV stigma among men than women with a smaller percentage increase in the acceptance levels among men compared to women.

A 2005 ICRW report indicated that HIV/AIDS stigma is exacerbated by the public treatment of victims where they tend to lose respect, hope, income, marriage and childbearing choices, sense of worthlessness, and poor social support system among others. Many social structures reinforce stigma and discrimination, for example, gays and lesbians in the society are likely to be discriminated upon. HIV stigma is pegged on the method of transmission as believed by the majority, for example, in sub-Saharan Africa, heterosexuality is the essential technique for disease, which implies that HIV-related stigma in this region, is premised on sexual misconduct.

The UNAIDS Gap Report approximates that there are 24.7 million individuals living with HIV in sub-Saharan Africa, almost 71% of the world's average. Nearly 81% of individuals living with HIV in this region (sub-Saharan Africa) are spread across ten countries; Ethiopia, Kenya, Malawi, Mozambique, Nigeria, South Africa, Uganda, the United Republic of Tanzania, Zambia and Zimbabwe. The prevalence of HIV/AIDS among young girls aged between 15–24 years is significantly high with nearly four out of ten new transmissions being among young ladies. A study by Baugher and his colleagues revealed that 82% of individuals with disguised stigma are aged between 18-29 years (Baugher et al. 2017). Such findings imply poor administration of psychosomatic tending to stigma among other regenerative wellbeing needs as young people transit to adulthood (UNAIDS, 2014). HIV stigma is not only an issue in Africa, about 8 out of 10 HIV patients in the United States report experiences of HIV-related stigma.

The Kiambu County Health Sector Strategic and Investment Plan (KHSSIP) 2014 – 2019 (2014) singles out HIV and AIDS as the leading cause of morbidity and mortality in the county hence a priority intervention area. The County has a population of 42,400 adults (over 15 years old) and 4,256 children (below 14 years old) living with HIV/AIDS (KENERELA+ Kenya, 2016). According to "Stigma Index" (2016), the Kenya AIDS Indicators Survey (2007) revealed that women remain at an elevated dominance rate contrasted to their male counterparts; females at 8.4% compared to 5.4% males and KDHS (2008-09) ladies at 8%

compared to 4.3% males. Gender parity is elevated in girls aged 15-24 years, where HIV frequency rate is a four multiple contrasted to juvenile males of similar ages (5.6% versus 1.4%) respectively (KAIS 2007), in addition to 4.5% and 1.1% respectively (KDHS 2008-09). Young women at the age of 15-24 years are considered a vulnerable group in HIV infection risk (KAIS, 2012). The young women contribute up to 21% of all new infections nationally and are heterogeneous; found among key populations, discordant couples, and people living with HIV, in and out of school and across all geographic areas. Stigma and fear of stigma discourage people from getting tested for HIV, disclosing their HIV status, seeking care, and adhering to treatment (Global, 2017).

## **1.2 Statement of the Problem**

Kiambu County is considered to be among the 18 high weight districts and contributes 3% of all the HIV positive people in Kenya, yet, early sexual introduction remains a key HIV challenge, with females aged 15– 24 years representing 21% of new HIV infections (Kiambu County HIV and AIDS Strategic Plan, 2014). Stigma hinders individuals from seeking health services.

Social exclusion and stigma affects a number of elements of individuals' well-being. The profiled individuals may be included by family and friends and may sometimes get unfair treatment while seeking health services and in school settings leading to mental harm and disintegration of their human rights. All these experiences hinders access to HIV testing, treatment, and other HIV administrations. Social exclusion and stigma makes it difficult for individuals to watch over themselves and even offer consolation and support to individuals affected, thus obstructing endeavors to manage HIV/AIDS. At the point when individuals can't act supportively, it confounds choices about HIV testing, the revelation of status, and capacity to arrange disease counteractive action conduct, including the utilization of contraceptive measures (ICRW, 2005).

The labeling of persons with HIV and the general perception of the society towards these people make the victims fear revealing their status. In Ruiru, there are 2,620 active clients who are the Known Positives (KP). This study assumed that there are possibility of the number to more than the official number considering HIV/AIDS stigma. The numbers could even be higher for persons aged between 15-24 years if the national trends is anything to go by. Perceived stigma and other forms of stigma have made the parents prevent the children from being tested or live in denial that their adolescents might not have been infected during birth.

It is also due to perceived stigma and other existent forms of stigma that adolescents may be afraid to get a HIV test. HIV-related stigma and discrimination stand in the way of HIV prevention efforts- they lead people to be afraid to seek out information about how to reduce their exposure to HIV, and to adopt safer behavior in case this raises suspicion about their HIV status (UNAIDS, 2010).

### **1.3 Purpose of the Study**

The purpose of the study was to determine the effects of perceived stigma on the psychological wellness and interpersonal relationships of adolescents living with HIV/AIDS.

### **1.4 Objectives of the Study**

The objectives of the research were:

1. Determine the effects of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS
2. Establish the effects of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS
3. Examine the relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

### **1.5 Research Questions**

The study sought to solve the following:

1. What are the effects of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS?
2. What are the effects of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS?
3. What is the relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS?

### **1.6 Research Hypotheses**

The following were the hypotheses of the study:

**H<sub>01</sub>:** There is no significant effect of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS.

**H<sub>a1</sub>:** There is a significant effect of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS.



**H<sub>02</sub>:** There is no significant effect of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS.

**H<sub>a2</sub>:** There is a significant effect of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS.

**H<sub>03</sub>:** There is no significant relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

**H<sub>a3</sub>:** There is a significant relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

### **1.7 Justification of the Study**

While HIV/AIDS stigma has attracted a number of studies (Berger, Ferrans & Lashley, 2001), not much has focused on perceived stigma. Perceived stigma has been found to affect the adherence to prescription regimens and HIV risk conduct (Odhiambo, 2013). Despite a number of studies (Kamau, 2012; Colombini, Mutemwa, Kivunaga, Stackpool Moore and Mayhew, 2014) examining stigma in Kenya, perceived stigma remains variously unexplored due to lack of standardized estimation instruments to measure the degree and effect of the stigma. There have been challenges in isolating stigma from discrimination and measuring the viability of stigma-diminishment endeavors.

A study by Bunn et al., (2007) revealed that stigma related with HIV/AIDS can adversely affect the lives and conduct of individuals living with HIV/AIDS. There is therefore a need for a closer examination of the effect of on young people, who are more vulnerable to mental problems and interpersonal relationship challenges because of stigmatization. Puberty is the period of life changes between adolescence and adulthood which envelops components of natural development and real social changes (Sawyer, Azzopardi, Wickremarathne and Patton, 2018).

It is the time for identity development and urges of being involved with individuals of the opposite sex that could or could not possibly lead to marriage. This age has not been comprehensively investigated, concerning the impacts of HIV related stigma particularly to their emotional well-being status and furthermore to the associations with their companions and other individuals in the general public. The researcher therefore, noted that there was need to research more on the psychological and interpersonal challenges that adolescents face as they are living with HIV/AIDS, regarding how they perceive stigma from their significant others and community as a whole.

### **1.8 Significance of the Study**

The findings of the study are of significance to the academia as it contributes knowledge on the prevalence of stigma among adolescents. Additionally, the findings inform the research fraternity in the classification of forms of stigma and a guide to refining measurement tools to quantify the extent and impact of the stigma. The study is also of significance to practitioners as it illuminates the understanding and perceptions of adolescents on the effects of their social life on their adherence to medication and how to mitigate the influence of stigma on disease progression. Further, the findings are of significance to policy makers as it highlights the potential intervention options relevant in addressing HIV stigma.

### **1.9 Scope of the Study**

This study focused on adolescents between 12-19 years old, whereby a total of 75 adolescents was sampled. The independent variable is perceived stigma experienced by teenagers living with HIV/AIDS. In this case, perceived stigma is subjective rather than an aspect that the researcher can pinpoint. Perceived stigma is viewed as being engrained in an individual's mind where an individual believes that other people are treating them differently because they are HIV positive. The dependent variables are psychological wellness and interpersonal relationships which also formulate the research. For this research, psychological wellness is viewed and measured as six sentimental conditions, gauging six scales: unease, dejected mood, affirmative health, self-discipline, overall healthiness, and also vigor. Quality of interpersonal relationships in this study is understood as affection-linked anxiety which is degree of how people are uncertain vs. confident of the degree of their significant others' accessibility and openness, and affection-linked evasion which is degree of how much individuals are uneasy of the closeness to other people versus feeling safe dependent on other people.

### **1.10 Limitations of the Study**

This study focused on adolescents, 12-18 years old, in Ruiru Sub-County Comprehensive Care Centres. Although most of the available data captures prevalence of HIV/AIDS among adults aged 15-24 years and children aged 14 years and less (KENERELA+Kenya, 2016); the researcher overcame the challenge by using available data on the number of registered youths living with HIV/AIDS in the hospitals in Ruiru. Respondents were drawn from this locality as well as other adolescents transferred from other health facilities, receiving care and treatment in Ruiru CCCs including: Ruiru Sub-County Hospital, Nazareth Hospital, St. Joseph Medical

Centre, Githurai-Lang'ata Health Centre and Githunguri Health Centre. Respondents may be from Ruiru and other neighbouring counties as long as they attend the said facilities. Results of the study will be generalized to other hospitals since the study used a highly representative sample.

### **1.11 Assumptions of the Study**

The study assumes that adolescents with HIV/AIDS experience self-stigmatizing perceptions which affect their perception of themselves and relationships with others.

### **1.12 Definitions of Operational Terms**

#### **Disclosure:**

Disclosure refers to the action of making new or secret information known (Hielscher & Waghorn, 2015).

#### **Interpersonal relationships:**

Interpersonal relationships refer to relationships where individuals are interdependent to each other and their behavior towards each other affects their outcomes (iResearchNet 2016).

#### **Marital Status:**

Marital status refers to the state of an individual's situation with regard to whether one is single, married, separated, divorced, or widowed (Oxford Dictionaries, 2018).

#### **Perceived stigma:**

It is the awareness by an individual of public stigma, or belief by a person that others have passed judgment and hold stigmatizing thoughts or stereotypes about a condition in this case HIV (Barney, Griffiths, Jorm, & Christensen, 2006).

#### **Psychological wellness:**

According to WHO (2016), psychological wellness is a state of well-being in which every individual realizes his or her potential, can manage the everyday pressures of life, can work productively and fruitfully, and can deliver a contribution to her or his community.

**Religion:**

Religion is the belief in and worship of a god or gods, or any such system of belief and worship (Dictionary, 2018).

**Social Support:**

Social support is the type of support or help that an individual receives from others ("MacArthur SES & Health Network Research", 2018).

## **CHAPTER TWO**

### **LITERATURE REVIEW**

#### **2.1 Introduction**

This section covers literature around the three variables: perceived stigma, psychological wellness and interpersonal relationships. Disclosure and social support as components of stigma and discrimination are covered. Confounding variables including gender, marital status and religion are also discussed. The independent variable in the study is perceived stigma experienced by adolescents living with HIV/AIDS, while the dependent variables are psychological wellness and interpersonal relationships.

#### **2.2 Stigma and Discrimination**

In an ethnographic qualitative research by Kamau (2012), it was discovered that there was general accord that stigma and segregation had adversely affected Children Living with HIV/AIDSCLWHA's mental state. Some CLWHA communicated an aching for companions. Underlining the significance of friendships, Murray and Greenberg (2006) showed that "peer companionships and peer rejection decides youngsters' social, enthusiastic and scholarly wellbeing." (p.222). All CLWHA stressed the importance of keeping one's HIV infection a secret, which helped them adapt to stigma and separation. It was revealed that in a bid to disguise their status; some CLWHA kept just a few friends. Findings revealed that all the children had encountered no less than one sort of stigma and they explained how these were experienced. Every one of the kids had encountered both inner stigma and felt stigma. Thus, stigma and separation had effects for the CLWHA's prosperity or deficiency, including social segregation, avoidance and suicide thoughts.

A study was carried out in Kenya to investigate the encounters of stigma of HIV-positive customers going to family arranging and post-natal administrations and suggestions for benefit utilize and antiretroviral treatment (ART) adherence (Colombini, Mutemwa, Kivunaga, Stackpool Moore and Mayhew, 2014). The investigation was qualitative and utilized interviews with a target sample of 48 ladies living with HIV. The findings revealed that numerous ladies living with HIV report abnormal amounts of foreseen stigma, bringing about a longing to conceal their status from family and companions inspired by a paranoid fear of being oppressed. Numerous ladies dreaded being left alone following revelation of their positive status to accomplices. Thus, a few ladies chose to conceal their status and follow HIV treatment in hiding. Just a couple of ladies in the investigation revealed encounters of endorsed stigma,

mainly having been left by spouses. The most pronounced sort of stigma obvious among the respondents was foreseen stigma from networks and relatives, especially spouses or accomplices. This fear can potentially cause behavioral changes, for example, poor exposure, hazardous breastfeeding approaches, and diminished ART adherence or making it more unpleasant. The findings of the study revealed that the desire to adhere to medication for the good of the infected youth far outweighs the stigma associated with HIV among majority of the respondents.

## **2.3 The Effects of Perceived Stigma on Psychological Wellness of Adolescents Living With HIV/AIDS**

### **2.3.1 Disclosure of HIV Status**

Perceived stigma hinders individuals' willingness to disclose their HIV status. A study by Poindexter, Henrickson, Fouché, Brown and Scott (2013) exploring the experiences of HIV-positive African immigrants in Aotearoa/New Zealand with regard to encounters of stigma and discrimination. Using a qualitative approach, the study sampled 13 participants that interviewed at their convenience. The findings revealed that the participants were reluctant to reveal their HIV status citing fear of judgment by others. The participants' description of their experiences implied social exclusion by both self and from the society. The study further revealed that most of the participants only disclosed their status to those they trust and in situations where their revelations was aimed at offering assistance to those disclosed to. It was noted that even in the event that they revealed their status, they did not give their full experiences. The study concluded that individual non-disclosure was driven by personal factors including anxiety, concerns about privacy, or fear of blame or ridicule.

Gillard and Roark (2012) conducted a research in Springfield Massachusetts, USA to comprehend youthful grown-ups' inspirations to disclose their HIV status. Study data was gathered at a program carried out by the AIDS Foundation and 41 youthful grown-ups of age 16– 19 years were chosen. Member perceptions and semi-organized one-on-one interviews with nine youth members of ages 17– 19 years, and interviews with two leaders were collected as study data. Findings showed that controlled inspiration to share HIV status happened when members were inspired to share as a result of reasons identified by other individuals, instead of interior or individual reasons. Taking everything into account, unveiling one's HIV status for individual fulfillment reasons reflected self-sufficient inspiration. In this research, disclosure was important in light of its connection to individual character. Individual thought processes explaining youths' character styles have been seen to emphatically identify with duty

and individual prosperity, while controlled reasons contrarily identify with psychosocial changing results (Smits et al. 2010). Being more seasoned was a critical indicator of social self-exposure, given the expanding psychological and intelligent aptitudes, which are associated with the development process. Youths who are more established may not just have had more opportunities to unveil as they grew up (Wiener and Battles, 2006). These youths can likewise be relied upon to be more prepared in expecting both positive and unfavorable impacts of divulgence decisions than other youthful young people. They may likewise make choices more freely, while looking for their self-sufficiency (Michaud et al., 2009). The drawback of this study is that the study sample was little and subsequently results may not be general.

Nöstlinger, Bakeera-Kitaka, Buyze, Loos and Buvé (2015) conducted a research in Kampala, Uganda and Western Kenya to research the mental and social reasons impacting revealing HIV status to peers. A group of 582 Adolescents Living with HIV (ALHIV), with ages 13– 17 years was considered. Interviews using questionnaires were used to collect data. Findings of the study revealed that one out of five members revealed having shared their HIV status with their associates. Recorded levels of individually-perceived stigma were in the normal range, with the most elevated rates for personal disgrace. Teenagers from Uganda reported more disclosure than respondents from Kenya. Having a frail self-adequacy to reveal was fundamentally and adversely related with the result variable. Having more years of age was a noteworthy indicator of social self-divulgence. Social help from peers was more identified with social self-revelation than help through the family. By and large, respondents assessed responses on unveiling issues to peers as positive and supportive. Social exposure among ALHIV in the sample was associated with singular variables like self-adequacy yet a more critical degree to the social setting and psychosocial assets. The drawback was that members were chosen at picked pediatric and other health centers as a baseline for a programme intervention, which may reduce the validity of the results.

### **2.3.2 Social Support towards the HIV Infected**

Social help is the kind of help that an individual gets from others. It is grouped into emotional, instrumental and informational help. Emotional help relates to the things that individual's do that influence us to feel cherished and tended to, that advance our feeling of self-esteem (MacArthur SES and Wellbeing System Exploration, 2018). Instrumental help relates to the different sorts of substantial help that others may give, such as cash. Informational help is the help that others may offer through giving information (MacArthur SES and Wellbeing System Exploration, 2018). In this research, the impression of help is seen as originating from 2

sources: Family and Companions. Jadhav (2015) looked into in Maharashtra, India to inspect the relationship between age, sexual orientation, social help and the mental prosperity of individuals living with HIV. Using a cross-sectional approach, respondents were purposively examined from the health center where PLWHAs get help. A sample of 60 people living with HIV/AIDS was chosen. The effect of social help on the psychology state of patients with HIV was studied by choosing 30 male members who were HIV positive who received social help and 30 with HIV who had no social help. The outcome demonstrated that the men with the social help had a moderate level of dejection, uneasiness, and worry when contrasted with the HIV positive men without social help. The conclusion was that social help significantly affected psychological well-being of patients with HIV. The investigation found that social help has positive influences and diminishes sorrow, uneasiness, and stress. The constraint of the examination is that it had a little sample size of just 60 out of the entire populace. This study corrected this shortcoming by using a highly representative sample of adolescents living with HIV/AIDS.

Folasire, Akinyemi and Owoaje (2014) conducted a study in Ibadan, Nigeria, looking into the perceived social help of PLWHA with HIV-antagonistic people and checked on possible issues possibly associating to influence their apparent social assistance from family, companions and other noteworthy people. The cross-sectional research approach was utilized. The two sets of respondents were randomly selected from a populace of 1.3 million individuals with a HIV predominance of 3%. The HIV seropositive patients were enlisted from the Aids Prevention Initiative of Nigeria (APIN-plus) antiretroviral clinic, University College Hospital (UCH), Ibadan, Nigeria. Each set comprised of 150 members. Questionnaires were utilized to gather information on socio-demographic information and satisfaction with social help was evaluated with the multidimensional scale of perceived social support (MPSSS). The conclusion was that the HIV positive and negative sets of respondents got the most deficient help from their families. HIV-positive respondents had the least help scores from their family, trailed by other noteworthy people, and the most significant help was from their companions. Considering that the study was only conducted in one hospital, the findings are not generalizable.

A study by Forouzan, Jorjoran, Sajjadi, Salimi and Dejman (2011) examining the interpersonal communications as significant help for people living with HIV/AIDS in Iran, Tehran. A cross-sectional approach was targeted on 224 members who were randomly chosen among all individuals with HIV/AIDS from social counselling centers. The mean age of the subjects was 35 (SD = 8.5) years, 68.3% were female and 31.7% male. Social help was estimated through



the Norbeck Social Support Questionnaire (NSSQ) which surveys the steady connection between the members and the individuals from their community networks. The research revealed 72% relative and 28% non-relative as a source of social help. The research found that relative individuals were the most compelling individuals in the life of PLWHA. Due to the high and stable nature of ties between families, it is impossible that accessible help and relations to relatives can be supplanted by other individuals in the society. The study concluded that relatives need to comprehend the requirements of HIV/AIDS patients and help them to deal with the new states of existence with HIV/AIDS to enhance their mental states. The restriction of the research is that the data gathering process through questionnaires controlled surveys may have supported misrepresentations or omission of data by the interviewees.

Dalmida, Koenig, Holstad and Wirani (2013) led a research study in the South-Eastern United States to analyze social help as a potential go between of the recommended association between profound adapting and depressive signs. The cross-sectional approach was utilized. Respondents were enrolled through pamphlets that were posted at convenient sites and shared to patients by hospital staff at enlistment which included 292 male and female outpatients on different phases of HIV/AIDS. Respondents' mean age was 45.1 years. Personal fulfillment with social help was evaluated through the Social Support Questionnaire-6 (SSQ-6). Analysis using the quantitative approach revealed that PLWHA who were disappointed with their social help had relatively low mean positive religious adapting, higher mean negative religious adapting and altogether higher mean depressive signs. The conclusion was that there were relationship between social help fulfillment, religious adapting, stress, and depressive signs. The study therefore alluded that profound methods of adaptation impact PLWHA's view of or reactions to pressure and social help in both great and terrible ways. This at that point influences their psychological state, implying that individuals who have depression indications have mental states that yield less sense of fulfillment from social help and negative types of religious adaptations. The constraint of the research is that the random approach to sampling may cause prejudice while choosing a sample that should be considered representative.

Yadav (2010) in Nepal explored the relationship between perceived fulfillment from social help, expectation, and QOL of PLWHA. The research depended on an intentionally chose test. An illustrative and cross-sectional plan was connected to a sample of 160 HIV-positive people getting treatment, care, and support from eight network based NGOs. QOL was surveyed utilizing the WHO (QOL) - 26 instrument. Social help was controlled by the help of an improved Sarason's Social Support Questionnaire. The sample chosen was PLWHA getting

assistance from a network based NGO. A Hope Assessment Scale was additionally created. In general, fulfillment from social help and hope had a significant association with QOL. A considerably positive association was also found between the perceived aggregate fulfillment from the social help and psychological wellness. LaMarca (2011) argues that a Likert scale survey is restricted in light of the fact that it is uni-dimensional as it just offers 5-7 options for the respondent to look into, yet attitudes of the populace for one specific thing, in actuality, exist on an immense, multi-dimensional continuum. Additionally, regularly individuals fear utilizing the extraordinary choices of the question, as a result of unfriendly ramifications of radicalism, regardless of whether the outrageous alternative is to be the most exact LaMarca (2011).

In conclusion, as per the researches above, sharing one status may influence mental wellbeing. However, there is still a gap in linking the overall effects of perceived stigma on the psychological wellness of individuals living with HIV/AIDS. This research study aimed at filling this research gap.

## **2.4 The Effects of Perceived Stigma on Interpersonal Relationships of Adolescents Living With HIV/AIDS**

### **2.4.1 Disclosure of HIV Status**

Perceived stigma has an association with interpersonal relationships among adolescents living with HIV/AIDS. A study by Poindexter et al. (2013) examining the experiences of young immigrants in New Zealand revealed that community perception on HIV influenced the interpersonal relationships of young adults living with HIV. The young adults cited the fear of community judgment as a reason for non-disclosure of their HIV status. Studies by Opdenakker (2006) revealed that young adults living with HIV/AIDS expressed unwillingness to reveal their status because they wanted to save their families and friends from the shame associated with a positive HIV status. In yet another study in the USA by Gillard and Roark (2012) examining the factors influencing young adults' to reveal their status. The findings revealed that participants in the study felt demotivated when others uncovered their status to them, without their authorization.

Despite the fact that individuals wished to keep their status private, they regularly had no apparent or genuine control over others' activities. Associates and guardians or parental figures once in a while uncovered respondents' statuses without their assent, leaving the respondents to deal with whatever things happened after, and regularly cracked the connections. From opinions of dialogs about revelation, it gave the idea that there were somewhat more cases of

exposure without member assent from guardians and close relatives than by companions or associates. The unfriendly reactions to revelation obstructed the respondents' social-relevant condition that could have upheld self-governing inspiration. Controlled inspiration to uncover HIV status incorporated the explanations behind craving to achieve a closer relationship, responding to a common mystery for mental or passionate help, and for consideration. Revealing one's HIV status for fundamental individual fulfillment reasons reflected independent inspiration. In this research, revelation was important in light of the fact that it was utilized as a way to teach others about HIV/AIDS. All in all, the helping mentality reflected in the self-governing inspiration to unveil as a method for training about HIV/AIDS can advance sentiments of closeness with others, which can be vital to empower youth feeling disconnected on account of their HIV status. A potential drawback of the investigation is that respondents' perception strategy has researcher's favoritism (Kawulich, 2005).

Similar findings were revealed in a study conducted by Nöstlinger et al. (2015) in Kampala, Uganda, and Western Kenya, seeking to explore how mental and social components influence self-revelation of HIV status to peers. The study sampled 582 Adolescents Living with HIV of ages 13–17 years and not in marriage/cohabitation. Using a cross-sectional approach, the study revealed that social factors including family background, being an orphan among others influenced adolescents living with HIV willingness to disclose their status (Menon et al., 2007; Sherman et al., 2000).

A qualitative study by Muparamoto and Chiweshe (2015) in Zimbabwe on the factors influencing parents living with HIV/AIDS willingness to reveal their status to their children. The findings revealed that participants were unwilling to reveal their HIV-positive status to their children for fear of the potential reaction from their children. Guardians were worried about keeping up their pride which they feared discoloring on off chance that they revealed their status to their kids. A section of the respondents in this investigation were of the feeling that revelation of HIV status may conflict with the guardians' social status and expected personality from their youngsters who view them as good examples. With regards to this research, the parental good example depends on the requirement for parents to give moral direction to their kids by advancing things, for example, ethical quality. Along these lines, revealing their status would disintegrate the guardians' apparent 'fairness' and 'respectability,' ruining their personality, as being HIV-infected has been related with being of poor morals in different media portrayals in Zimbabwe (Vambe, 2003). Such impression geared by disguising one's status from his/her youngsters proposes that guardians introduce the possibility of them

trying to control how their kids see them. Goffman's work features how people can plan and control interactional movement (Smith, 2006). Conclusively, divulgence can possibly shape basic socio-logical results and make open doors for discussions which may have been restrained. The drawback of this research is that they utilized a little samples estimate, thus the research has low outer legitimacy.

Lugalla, Yoder, Sigalla and Madihi (2012), conducted a research study in Dar es Salaam and Iringa districts, Tanzania. A sample of 57 respondents was utilized, and interviews were utilized to gather information. Findings of the research revealed that the social setting of people and the idea of their social relations regularly encouraged testing for HIV. The quality of social connections to family and colleagues impacted exposure designs. Additionally, the sorts of conjugal relations (single, wedded, isolated or separated) and sexual associations (monogamous, various, simultaneous) that people kept up altogether influenced exposure. Individuals took HIV tests and uncovered the outcomes to individuals with whom they shared a high state of trust. These are mostly relatives, for example, guardians (particularly a mother), a sibling, sister, uncle, auntie and at times dear companions. Additional research revealed that a person's social gathering, the social connections in which they take an interest and the sort of response they foresee from others upon revelation impact how people choose to share the findings of HIV tests with others.

Findings from Tanzania revealed that disclosure of HIV test by a lady to a spouse can potentially harm or even end their relationship. Due to gender imbalance, women have to be cautious in revealing their HIV-status particularly if they were HIV-positive. Upon disclosure, some ladies were beaten for a number of reasons including bringing disgrace to the family. Because of the potential consequences, women were found to be unwilling to disclose their status unless their husbands were the first to disclose their status to them. In this stud, husbands were found to be more willing to reveal their HIV status particularly when their illness became intense. Their study concluded that there is a significant association between social/mental factors and willingness to disclose ones HIV status.

#### **2.4.2 Social Support towards the HIV Infected**

An examination of the effect of social, monetary, mental and ecological factors on wellbeing and prosperity among PLWAHAs by (Adedimeji, Alawode and Odutolu, 2010) in Nigeria in which a cross-sectional approach, qualitative participation approach was used to sample 50

HIV-positive individuals eight health officers and 32 medical providers found that the desire for support and care influenced individuals choice to disclose their HIV status. Thus individuals cannot foresee help, the tendency to reveal their status will be low. Moreover, the need to support persons living with HIV is influenced by prevailing social standards and view of sickness. Since HIV/AIDS is still broadly seen as something associated with an indecent way of life and being strongly contagious, just close relatives are willing to administer and support PLWHAs on the grounds that they think of it as a commitment to look after their own. With the utilization of flow diagrams and pairwise rankings, PLWHAs respondents could distinguish and rank issues they thought important to their health. The point that scored highly in uplifting PLWHAs was the accessibility of care and social help from relatives and dear companions (93%). The study concluded that social support significantly affected how patients balanced their social life. The shortcoming of this study was it was not representative, the challenge is addressed by using a big sample size of PLWHAs.

Ingram et al., (1999) sought to explore the experiences of persons with HIV/AIDS in unsupportive environments. Using a cross-sectional approach the study sampled 271 constituting 96 from Ohio State University and the Virginia Commonwealth University and 75 from Virginia Commonwealth University. Their study revealed that people who revealed more HIV-related unsupportive social collaborations additionally were more exposed to depression. Unsupportive social relations explained the fluctuations in depressed state of individuals past the distinctions accounted for by physical functionality and social help. The conclusion was that results underscore the significance of both social help and unsupportive social associations in the relational sectors of individuals living with HIV.

Li, Lee, Thammawijaya, Jiraphongsa and Rotheram-Borus (2009) led a research in Thailand to investigate connections among demographics, HIV-related stigma, and social help and their effect on PLWHAs. Utilizing the cross-sectional approach, a sample of 408 people intentionally partook in the interview. Multiple-item scales were utilized in measuring dejection, stigma, and social help. Findings of the investigation showed huge negative connections were seen among enthusiastic, social help and disguised disgrace and perceived stigma. The research additionally found that levels of misery were essentially connected with levels of disguised disgrace, perceived stigma, and social help. Relationships were likewise found among PLWHA's demographics, and perceived stigma, disguised disgrace, social help, and sorrow. Elevated amounts of perceived stigma were altogether connected with low levels of social help. Likewise, low levels of social help were essentially connected with more

elevated amounts of sorrow. There was a huge effect of both disguised disgrace and social help on despondency. The conclusion is that there was a noteworthy relationship between perceived stigma and social help; that PLWHAs who experienced antagonistic network response were essentially more inclined to report a decrease in their social help after some time. The study additionally demonstrated that lower passionate help was essentially related with higher pain. Discouraged individuals frequently neglect to fulfill their craving for having a place seeing someone, with potentially cruel results (Leary, 2000). Discouraged individuals report less private relations and bring out less positive, mindful reactions and various negative, dismissing responses from others (Gotlib, 2002; Joiner and Coyne, 2006; Segrin & Abramson, 2004). Discouraged individuals additionally appear to actuate negative feelings in others, which brings out dismissal and the loss of socially satisfying openings (Coyne, 2006; Joiner and Katz, 2009).

A study by Walstrom et al. (2013) examining the influence of average cooperation on ladies well-being and HIV treatment. The cross-sectional approach was utilized, and a sample of 4 targeted groups, where 18 ladies were arbitrarily chosen from 10 bolster gatherings of HIV-infected injury survivors. FGDs took approximately 120 minutes. The deliberations were recorded and deciphered into English in 72 hours. Findings of the research demonstrated that respondents depicted changes that at first came about because of involving in care groups, setting up an establishment for mental recuperating where sentiments of security, strength, and trust started to rise. Respondents noted that care group inclusion gave chances to uncover their own stories in a protected setting free from manhandle or disgrace. Members depicted that being heard by their HIV-positive companions were center needs that were fulfilled by help gatherings. They announced encountering less depression and expanded association and solidarity with other colleagues following their inclusion in the care groups. Examining each other's encounters enabled members to recapture a feeling of sympathy for others.

Respondents portrayed disengaging themselves as methods for self-assurance from stigmatization. In this manner, re-developing sentiments of solidarity and association with others gave an opening to enhanced social working and the start of mental recuperating from injury. Respondents depicted care group discussions as 'groundbreaking.' Narratives regularly uncovered encounters of 'resurrection' among respondents, with the view that before aggregate participation, misery and dread were high to the point that they much of the time scrutinized their capacity and readiness to survive. Through the guidance got from help gatherings, numerous ladies experienced revived reasons to continue with their lives. Subsequent to interacting with other ladies in the care group and recuperating inspiration and an importance

to life, members portrayed inclination better prepared to associate and connect outside the groups, incorporating with accomplices, youngsters, and network. Ladies related an enhanced feeling of social working, starting with the security of care groups and out to their families and in the end other networks.

Brashers, Neidig, and Goldsmith (2004) conducted a research in the Midwestern United States to investigate how social help can advance or interfere with the administration of vulnerability about connections, wellbeing, and personality. Utilizing the cross-sectional approach, a sample of six targeted groups of 33 grown-ups confirmed to have HIV or AIDS was utilized, where 29 (88%) were men and 4 (12%) were ladies. Enlistment was led by a nurse at an Adult AIDS Clinical Trials Unit (ACTU) at college health center. Findings of the research demonstrated that strong others could encourage vulnerability control by empowering the individual with HIV to create adapting aptitudes. Improvement of capabilities might be important for people new to medicinal services settings (e.g., recently analyzed individuals) or the individuals who need required social aptitudes. Respondents detailed that having someone else with whom to talk was a method for overseeing vulnerability by diminishing pressure or by influencing issues to appear to be more concrete. Respondents esteemed the attestation that others could give through social help. The craving to control chance emerges from a need to decide, to take care of issues, to keep up a rational character, and to create and manage connections. The conclusion was that social help is indispensable in the experience of vulnerability and that strong correspondence is fundamental in relational connections. The defect of the research is that the kind of the target groups may have presented social-attractive favoritism in answering the narrative questions directed to the group members. In this research, the researcher stressed on the importance of answering the questions honestly to the respondents.

## **2.5 Confounding variables**

### **2.5.1 Gender**

Cederfjäll, Langius-Eklöf, Lidman, and Wredling (1997) directed a research in Stockholm, Sweden to examine the sexual orientation contrasts in personal satisfaction among patients with the HIV disease. The examination utilized the cross-sectional approach. The sample utilized was 55 ladies and 134 men getting outpatient therapeutic care in a clinic. Solid reference groups of two stratified, arbitrarily chosen samples comprising of 75 females and 70 men; and 90 females and 90 men from the number of inhabitants in Stockholm County. Self-report polls were utilized to gather information from the respondents. Findings of the research

demonstrated that females scored altogether more negative health, weaker SOC, and less social contact than the men. Women who decided not to inform anybody regarding their HIV status announced impressively more encounters of positive health. The HIV-positive patients of the two sexual orientations scored fundamentally more awful on general wellbeing and had significantly weaker SOC than in the two arbitrarily chose reference groups. Results of the research also showed that the men more regularly experienced prosperity, more social help and a more grounded SOC than the ladies. All in all, the investigation demonstrated that ladies with HIV had less welfare and social help than men, regardless of that they were in a prior phase of their ailment. SOC was the most powerful indicator of health-related quality of life (HRQOL) in the two sexual orientations in spite of the fact that ladies had weaker SOC than men. The impediment is that the analyst utilized a low number of ladies when contrasted with men and this could have influenced how generalizable the investigation is to different populaces. In this current research, more girls than boys were interviewed.

Benjet & Hernández-Guzmán, (2002) in Mexico City conducted a study. The research sample included 951 members where 512 were females and 439 men of which 208 were fifth-grade understudies, 287 6th grade student, and 456 seventh grade students. Information accumulation was through polls which were regulated to the students amid the start and the finish of the year. Findings of the research demonstrate that sexual orientation affected the likelihood of having depression indications where females recorded higher side effects than guys. The young ladies additionally announced lower confidence than the young men. Ladies announced less externalizing manifestations than young men; henceforth young ladies had less lead influences and forcefulness. The key finding of the research is that the intense experience of menarche, yet not the planning of development unfavorably influenced Mexican youthful young ladies' mental prosperity, most particularly with respect to depression indications. Conclusively, antagonism is experienced by young ladies as they experience pubertal changes, not like young men whose progressions seem to have a beneficial outcome. This research was constrained in that the cross-sectional approach was utilized yet a few members changed their pubertal status consequently directing factors were not considered.

Marks (2006) led a research to analyze sexual orientation and conjugal status contrasts in mental prosperity. The investigation utilized the longitudinal approach from 1992 to 1993. The research sample was (N = 6,876). Wisconsin Longitudinal Study to be particular is what was utilized for examinations. Computer-supported phone interviews (averaging around 60



minutes) led via prepared questioners utilized by the Letters and Science Survey Laboratory at the University of Wisconsin-Madison were finished with 90% of living respondents (n= 8,496). Mental trouble was estimated with a somewhat adjusted variant of the 20-items Center for Epidemiological Studies Depression (CES-D) file (Radloff, 1977). Being hostile was estimated with a three-item record that requested respondents to demonstrate how long in the most recent week they felt irritated or prone to altercations, had a craving for berating somebody, and felt irate or antagonistic for a few hours. Cronbach's alpha for this record is .79. Constructive mental health was estimated utilizing six self-controlled scales created and approved by (Ryff 1989; Ryff & Keyes, 1995). The research findings propose that among wedded people, ladies report more mental misery; at the same time, more self-acknowledgment, more reason throughout everyday life, and more self-awareness. Curiously, wedded men report more self-governance than wedded ladies. Isolated or separated ladies, widowed ladies, and every single man are, to be sure, essentially more troubled than their wedded partners.

As to wellness results, all groupings of single women performed poorly compared to their married colleagues with respect to self-acknowledgment, natural dominance and reason throughout everyday life. Isolated or separated and never-wedded men display consistently less self-acknowledgment, natural capacity, and reason throughout everyday life. The little minority of widowed men are the same in this sample from wedded men on any of the results of positive prosperity. These outcomes imply that, by and large, singles at midlife fared more ineffectively on a wide cluster of measures of mental prosperity than wedded individuals. In spite of standard way of thinking, as a rule, there are no distinctions in mental prosperity between wedded individuals and singles. Both isolated or separated and never-wedded people score higher than their wedded associates on self-sufficiency. Isolated or separated from ladies additionally show larger amounts of self-awareness. Isolated or separated from men and never-wedded men give off an impression of being doing to some degree, more inadequately than their ladies partners. Widowed ladies in a couple of cases are observed to do somewhat more badly than widowed men (a minor gathering at midlife). The restriction of the research is that amid computer-supported phone interview, if a subject needs to make an improvement to a past answer after the session, it is more challenging to return and make adjustments than is the situation with paper surveys. Along these lines some important views of the interviewee might be lost. For this study, paper surveys were used, therefore it was easy to go back and make changes in case a respondent changed his/her mind.

A study by Logie et al., (2011) using simple random sampling exploring encounters of stigma and separation and adapting techniques among HIV-positive ladies from underestimated networks. The examination utilized the subjective approach. Information gathering was done among fifteen target groupings (twelve English, two French, and one-Spanish) with HIV-infected ladies in five towns in Ontario. Findings of the research found out that disguised HIV-related stigma may render it hard to leave damaging relational connections, because of dread of not discovering another person to love them. Females living with HIV revealed reliant and commonly constitutive relationship inside social characters and basic imbalances, for example, HIV-related prejudice, stigma, sexual orientation segregation, homophobia, sexism, and transphobia. Conclusively, different sorts of stigma, for example emblematic, disguised, and authorized, are connected with underestimated characters: HIV-positive status, females, sex laborer, sexual minority, transgender, and ethnic minorities. The shortcoming of this research is that it utilized a non-randomized method of gathering samples, which utilizes the subjective judgment of the scientist.

Calmes and Roberts in 2008 set to check how co-rumination clarifies sex contrasts in passionate pain and relationship fulfillment among undergrads in New York at the University at Buffalo. This research utilized a quantitative approach in a cross-sectional outline. The sample comprised of 345 students of which 125 were male, and 220 were female. The sample individuals' ages run from 18 to 45 years of age. Three sorts of polls were utilized to gather information from the respondents. The three measures included Beck Anxiety Inventory, Beck Depression Inventory-II, Co-rumination Questionnaire, Ruminative Response Scale, and the Quality of Relationships Inventory. Findings of the research demonstrate that females had higher rates of sorrow and nervousness contrasted with guys. On the opposite, females announced more noteworthy fulfillment in kinships, fulfillment in parental connections and fulfillment in sentimental connections when contrasted with guys. Females likewise announced fundamentally more elevated amounts of co-rumination in companionships with men. Interestingly, there were no sexual orientation contrasts in co-rumination with guardians, sentimental accomplices, or house mates. The conclusion is that females were more probable than guys to co-ruminate with companions, and this kind of co-rumination raised depressive symptoms and more prominent companions' fulfillment. Conversely, guys and females did not contrast in their level of co-rumination with guardians, sentimental accomplices, and same-sex house mates.

### **2.5.2 Marital Status**

Reneflot, and Mamelund (2005) in Norway led a study to examine whether people in sexual relationships display poor levels of mental prosperity than their wedded partners. The investigation utilized national representing information from Statistics Norway's the Health and Level of Living Survey' led in 2005. The sample constituted of 10,000 people over the age of 15 years. The data on psychological well-being was acquired by a postal survey, after an underlying meeting by home visit or phone. Depressive and misery symptoms were estimated by the Hopkins Symptom Checklist which comprises of 25 questions (HSCL-25). Liquor issues were estimated by CAGE (Craving, Annoying, Guilt, and Eye-opener) (Ewing, 1984). Life Time History of Major Depression (MDE) depended on the DSM-IV criteria (Kendler et al., 1993). Results of the research revealed that only the single and the separated have a higher danger of showing despondency than the general population that is wedded. The research likewise found that there was an essentially higher danger of having MDE among the separated than among the wedded. There was no distinction in the exposedness of MDE when looking at companions who had never wedded, with the wedded. The reason that already wedded companions will probably report a past filled with significant wretchedness (MDE) might be connected to the separation encounters. Additionally, the two groupings of singles and widower(s) are more inclined to report a background marked by real misery than the wedded.

Kim and McKenry (2002) examined the relationship between marriage and mental prosperity. The research utilized the longitudinal approach. The present research utilized information from two periods (1987-1988 and 1992-1993) of the National Survey of Families and Households (NSFH) (Sweet, Bumpass, and Call, 1993). The baseline data was made up from interviewing a national sample of 13,008 respondents, including a principle sample of 9,637 respondents of ages 19 or more and a twofold sample of minority families and single-parent families, stepfamilies, newly wedded couples, and couples living together. One grown-up per family unit was chosen to be the essential respondent. The measures utilized as a part of the T2 informational collection are relatively indistinguishable to the ones used in the review at T1.

By controlling for age, educational level, number of kids in the family, and beginning level of depressive manifestations, the change from wedded to separated/isolated not-living together, remaining separated/isolated not-living together, and remaining never wedded non-living together were identified with higher levels of depressive side effects at T2 in contrast with the remaining wedded. The change from never wedded not-living together to wedded was conversely identified with depressive manifestations at T2. It is fascinating to realize that

change from separated/isolated to remarried was not fundamentally identified with lessened depressive manifestations at T2 in logical inconsistency to the individuals who were recently hitched, inferring that constructive outcomes of conjugal connections on mental prosperity would be diverse for second or consequent marriage. Research findings reveal that the progress from wedded to unmarried and remaining unwedded are solid indicators of depressive side effects.

Conclusively, the level of mental wellness varies as indicated by various conjugal status classes, wedded people have a more elevated amount of mental prosperity than individuals from some other relationship status, and above all else relationship status is related with individual mental prosperity. Additionally, remarriage was identified with a noteworthy reduction in depressive indications contrasted with separated/isolated people who did not remarry. In any case, dwelling together was not identified with a reduction in depressive side effects. Companions have poorer mental prosperity in contrast with wedded people, recommending that the insurance impacts of marriage are not as appropriate to living together. The individuals who ended up separated/isolated, the persistently separated/isolated, and the ones that were never wedded were found to have more elevated amounts of depressive effects contrasted with people who stayed wedded. The individuals who were first-time couples showed less levels of depressive effects contrasted with the individuals who stayed wedded (Fitzpatrick & Wampler, 2000). The confinement of this research is that the data-set used was secondary, thus it constrained the capacity to test hypothetically centered ideas. For this current study, the data captured was primary, thus hypothesis testing was effective.

A study by Loughlin (2014) examining the relationship status and the impacts it had on relational connections, self-personality and life-fulfillment. The study utilized a cross-sectional relationship approach. The sample size of the study was 208 sampled by the snowball approach. Self-detailed surveys were utilized to assemble the information. The outcomes found that no huge contrasts were found between the individuals who were single and the individuals who were in a relationship as far as personal connections. Accordingly, it can be inferred that relationship status does not affect the nature of a person's personal connections. However, significant findings were noted for single people, who showed dreadful and engrossed connections. The impediment of this research is that more people in relationships took part in the research than single people. A significantly number of members from every classification would give clearer and more attractive outcomes.

### **2.5.3 Religion**

A study by Chamberlain and Zika (1988) examining religiosity as an indicator of various parts of prosperity, with regards to a few measures of importance throughout everyday life. The research utilized the longitudinal examination approach. A sample of one hundred and eighty eight (188) ladies was utilized. Qualification to take part in the research was for the ladies to have no less than one kid with less than five years and to have no paid work outside the home. All of the respondents were wedded (N = 178, 95%), with 4 (2%) being separated, and 6 (3%) unwedded. Seventy-three ladies (39%) had one kid, 69 (37%) had two youngsters, 31 (17%) three kids, and 15 (8%) had at least four. All except 4 ladies were of Caucasian roots, and most (73%) portrayed themselves as white collar class. Life meaning was evaluated using three unique measures, the Life Regard Scale (Battista and Almond, 1973), the Purpose in Life Test (Crumbaugh and Maholick, 1964), and the Sense of Coherence Scale (Antonovsky, 1985). Religiosity was evaluated by two of the King and Hunt (1975) sub-scales, Orientation to Growth and Striving, and Salience: Cognition. Three parts of health were incorporated into the research.

Andrews and Withey's (1976) worldwide measure, Life-3, was utilized to survey life's sense of fulfillment. Affectometer 2 (Kammann and Flett, 1983) was utilized to evaluate positive and negative effect. Findings of the research revealed that among the health measures, just life fulfillment is fundamentally related with religiosity. Introductory contact with respondents included an individual meeting amid which the LRI and SOC were filled. After three months (mean = 102 days, SD = 12.5 days), respondents finished a mail poll which included PIL, the religiosity measures and the prosperity measures. Findings of the research proposed that the importance of life may relate with religiosity in forecasting health. The connection between life fulfillment and religiosity may well be interceded by significance. Conclusively, the connection between religiosity and subjective prosperity, where it occurs, is certain however little. Religiosity additionally, had an alternate relationship to various segments of health. The confinement of this research is that the sample just contained ladies, while it may have been imperative to consider the perspectives of the men.

Julie J Park and Melissa Millora at the University of California Los Angeles led a research in 2004 and 2007. The motivation behind the research was to investigate how psychological well-being (PWB) connections to the religious and otherworldly commitments of undergrads. The investigation utilized the longitudinal approach. Information for this examination were from the College Students' Beliefs and Values (CSBV) Survey led by the Spirituality in Higher

Education Project, which is housed at the UCLA Higher Education Research Institute (HERI). In 2004, undergraduates finished the CSBV as a component of a supplement to HERI's Freshman Survey. Subsequent to taking out foundations where the reaction rate was too low, the task group requested that 207 colleges take part in the 2007 follow-up study. An aggregate of 148 colleges consented to take an interest, however 12 got expelled on account of unfeasible reaction degrees.

The sample incorporated an aggregate of 14,527 undergraduates who finished both the 2004 and 2007 studies, mirroring a reaction rate of 40% for the last 136 organizations. The findings of the research demonstrated that recognizing oneself as a Catholic was the strongest indicator of 2007 PWB for Latino undergraduates, much more grounded than an undergraduate's level of PWB in 2004. For White undergraduates, recognizing as Jewish religion less was an undesirable indicator of PWB. Religious stress negatively affected PWB, though an undergraduate's feeling of practicality had a beneficial outcome. The huge reexamination of convictions spoke to in religious battle and otherworldly missions could bring about pressure and even discouragement, particularly if such battles drove them to disengage from the network. The negative impact of the profound mission on PWB could be translated from multiple points of view. Be that as it may, an undergraduate's level of the profound mission as an approaching undergraduate appeared to have a uniquely extraordinary association with PWB than his or her level of the otherworldly voyage as a third-year undergraduate. Results of the research demonstrate the pertinence of issues of religion and otherworldliness to mental and enthusiastic wellbeing. The interior battles, interests, and discussions that understudies are preparing concerning religion and otherworldliness have generous ramifications for their emotional wellness. The restriction of the research is that the studies should have been done yearly, to incorporate the patterns and individual contrasts because of changes in scholarly levels.

Frankel and Hewitt (1992) explored the connection between internal religion and mental/physical prosperity among Canadian undergraduates. A sample of 299 was drawn from a population of 26,000 undergraduates. The sample was in two groupings. The main group comprised of individuals from some Christian clubs or confidence gatherings ("partnered gathering"). The second gathering comprised of understudies enlisted in initial 3 and second-year human science courses ("non-subsidiary gathering"). The data-set was gotten from the individuals in each sample subgroup amid normal club gatherings or class periods. The research instrument utilized was a self-controlled survey. The survey contained inquiries on

fundamental statistic qualities, push, authority, confidence, mental and physical wellbeing, utilization of social insurance assets, kinship examples, convictions and qualities, and religious practice.

An examination of the two groups reveals that over the previous year, realism and individual achievement have turned out to be more essential to individuals from the nonaffiliated group than to the subsidiary undergraduates. Then again, the relationship-introduction esteems - family life, coexisting with others, church life, companionship, guardians, and God - have turned out to be more basic to the subsidiary group. Accordingly, the associated undergraduates reflect in their esteem frameworks the basic lessons of Christianity. The examination additionally found that those partnered with on-grounds religious gatherings seem more joyful than their unaffiliated partners. The partnered aggregate reports a fundamentally higher by and large score in a few features of their lives of passionate fulfillment, including fellowships, interests, family life, confidence, physical wellbeing, instructive accomplishment, and monetary conditions. There are no noteworthy contrasts between the subsidiary and nonaffiliated understudies with respect to either dominance or confidence as measurements of mental or enthusiastic prosperity. Conclusively, the associated undergraduates appear to be happier with their lives and to express more positive mental states than their non-subsidary partners. The restriction of this research is the self-regulated polls can't totally record passionate reactions of the respondents. Consequently, important information may go unnoticed.

A study by Barkan and Greenwood (1994) in the United States investigating religious participation and subjective prosperity among more established Americans. Information was gathered from the General Social Survey (GSS), a national likelihood of the grown-up, non-systematized populace since 1988 to 1994 aside from 1992 when the GSS was not controlled. The database had 10,505 respondents. The sample utilized comprised of 1,994 respondents 65 years of age or more. Findings of the research demonstrated that religious participation is decidedly identified with prosperity in both life fulfillment subsets and the joy subset. The religious get-together has a direct, non-misleading, healthy impact on both life fulfillment and satisfaction. Barkan and Greenwood findings suggests that the helpful impact of religious support for more established grown-ups is vigorous crosswise over two measures of subjective prosperity and intervened by general social assets. The impediment of the research is that, it ought to have considered other age sets to think about contrasts in individual prosperity after religious participation among individuals of different ages.

Wilcox and Wolfinger (2008) reviewed the Fragile Families and Child Wellbeing Study, a national review intended to ponder new unwed guardians, their connections, and their youngsters in substantial U.S. urban communities. The overview takes about 3,700 youngsters who are unmarried and 1,200 kids living with wedded guardians in 20 urban communities with populaces over 200,000. The pattern control interviews were directed between February 1998 and September 2000. New moms were met in the clinic inside 48 long stretches of birth, and new dads were met at the healing facility or somewhere else around a similar time. A subsequent meeting with guardians and youngsters around a year after birth; extra meetings were led following 36 and 60 months.

The examination yielded a sample size of 2,034 male-female couples and in this manner 4,068 information focuses. Findings of the research demonstrated that couples who go to chapel consistently have more great demeanors about personal connections, a more grounded adherence to values that ought to encourage upbeat connections (i.e., the code of respectability), and a higher occurrence of steady practices inside associations, contrasted with couples where neither one of the partners goes to on a successive premise. Religious interest may impact bliss in sentimental connections by influencing how individuals view such connections when all is said in done. Conclusively, religious accomplices will probably convey specific aptitudes to their connections, maybe on the grounds that the standards they experience in their holy places urge them to approach others with deference and fondness. The restriction of the examination is that the scientists contemplated new urban guardians. Thus their outcomes don't really sum up to childless couples, or to couples living in rural and country America.

A study by van der Lans, et al., (2000) using a cross-sectional research approach and with a sample of second-age Muslim refugees aged 17 to 25 years old and had gone to class in the Netherlands for no less than 5 years. The testing procedure had the sample drawn from records with addresses, provided by the civil organization of the examination areas (two medium-sized urban communities and two commonplace towns). An equivalent level of male and female respondents was utilized. Information was gathered utilizing structured interviews which included points among others: religious practices and subjective prosperity. Findings of the research demonstrated that the 27 respondents with high responsibility appraised their prosperity on the Cantril scale higher (mean score 6.9) than the 26 individuals with few duties (mean score 5.6). In the solid religious-duty gathering, less respondents griped about sentiments of sloth than in the classification of less religiously dedicated subjects.



Conclusively, there was a relationship between religious contribution and subjective prosperity, however it is to some degree feeble. Then again, non-support in otherworldly practice does not really build the occurrence of psycho-social issues. The impediment of the research is that cross-sectional outline couldn't represent psychosocial designs over a period which may have been fundamental to demonstrate the distinction precisely between religious association and subjective prosperity.

## **2.6 Theoretical Framework: Erving Goffman's Theory of Social Stigma**

This research study has been based on the theory of social stigma by Erving Goffman (1963). Goffman argued that an individual assumes their contrasts are recognized and clear. Goffman claims that there are flaws of individual character where characteristics are gathered from a record of having a psychological issue, habit, homosexuality, and for this situation being HIV infected. An individual can neglect to satisfy what others request of him but be generally immaculate by his disappointment, protected by his estrangement, and ensured by personality convictions of his own. A person may feel that he/she is an undeniable levelheaded person and that others are the ones who are not by any stretch of the imagination human. An individual endures a disgrace, however does not appear to be awed or humbled by it (Drew, Wootton, & Berger, 2003).

A mentally ill individual seems to have similar convictions which other people have towards them. The person may perceive that whatever other people profess, they do not acknowledge him and are not ready to interact with him on the same level. Additionally, the principles he adopted from the community enabled him to be completely careful of how individuals consider as his weakness; definitely making the individual agree that he doesn't make the grade regarding what he should be. Disgrace turns into a focal probability emerging from the person's view of one of his own characteristics similar to a debasing thing to have, and one he can promptly consider himself to be not having (Drew, Wootton, & Berger, 2003).

Individuals learn and incorporate the standing point of the 'normal' people through the socialization process, hence acquiring the personality convictions of the extensive society and a general thought of what it resembles to have a specific disgrace. There are designs in the socialization procedure: one includes people with an inherent disgrace, who wind up associated into their unfavorable circumstance while learning and consolidating the benchmarks against which they miss the mark (Lindesmith and Strauss, 1956).

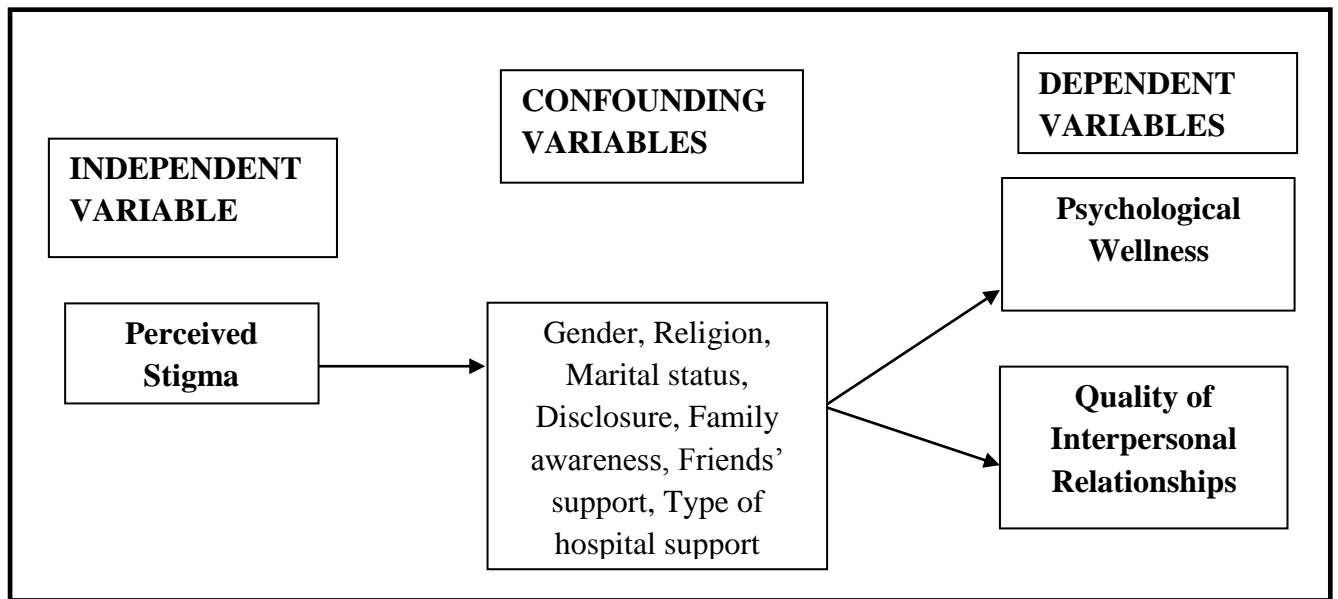
Another arrangement is at the limit of a family or nearby neighborhood to constitute itself a defensive manner for its young. A naturally vilified kid can be precisely maintained utilizing info regulation. Self-belittling depictions of him are ceased from infiltrating the enchanted circle. Wide section is given to different impressions held in the more extensive network that guide the secured kid to see themselves as a completely common person of normal personality. The third example of socialization is the point at which one ends up labeled at an older age or realizes at an older age that he has been shameful. Such an individual has found out about the 'ordinary' and the demonized, well before he should consider himself to be insufficient. This person may have an exceptional issue in re- classifying himself, and a unique probability of creating dissatisfaction with self.

## **2.7 Conceptual Framework**

Disclosure may affect psychological well-being through feelings of betrayal of privacy and isolation. Individuals may also be afraid to disclose their HIV status due to the effects it may have on their families, decency and their respectability in the community. On the other hand, other people may disclose their status for purposes of educating others about accepting themselves and about appreciating people who are HIV positive. From the literature, it is evident that low social support or the lack of it from family, significant others and friends may lead to mild levels of depression, anxiety and stress. Social support has been found to be an important pillar of mental wellness among the HIV infected patients while stigma and discrimination are barriers. Low social support may lead to a reduced adjustment in social life may lead to depression. Individuals with stable support systems have an improved sense of social functioning.

Controlling for gender, it was found that women experienced less positive well-being as there are higher depressive symptoms in females than males. Internalized HIV stigma was responsible for making females reluctant in leaving abusive interpersonal relationships for fear of being unloved. Females, however, showed significant satisfaction in relationships. Marital status as confounding variable is seen as influencing the relationship of the variables and it is evident that married people had lower depressive symptoms. Cohabiting couples exhibited lower psychological wellness, unlike the married couples. On the other hand, relationship status seemed to have no impact on individual, interpersonal relationships, although single people exhibited fearful and preoccupied attachments around people. Religion appeared to have a positive relationship with subjective well-being though small. Affiliation to religious groups leads to more satisfying and positive psychological states as well as more validating and

nurturing interactions. On the contrary, non-participation in religious practice does not increase the incidence of psychosocial problems. Reevaluation of beliefs in religious struggle and spiritual quest could result in stress and even depression. Religious participation helps to develop skills such as respect and affection, promoting happiness in romantic relationships.



**Figure 2.1: Conceptual Framework**

## **CHAPTER THREE**

### **METHODOLOGY**

#### **3.0 Introduction**

This chapter presents the research methodology was used in this study. The chapter highlights the research design, study area, target population, the sample size and sampling procedure, inclusion and exclusion criteria, data collection instruments, data collection procedures, data analysis, and ethical obligations. It also presents data analysis and presentation.

#### **3.1 Research Design**

This study used a cross-sectional research design. In social science, a cross-sectional study is a type of observational study that analyzes data from a population, or a representative subset, at a specific point in time (Malhotra, 2007). Cross-sectional designs focus on analyzing and drawing inferences from existing differences between people, subjects, or phenomena. The cross-sectional investigation is centered on finding relationships between variables at one moment in time (USC, 2016). This study employed the survey method. This is the method where respondents answer questions through filling questionnaires.

#### **3.2 Study Area**

The study was conducted in five hospitals which have Comprehensive Care Centres for HIV in Kiambu County. Among the hospitals, Ruiru Sub-County Level Four Hospital and Nazareth Private Hospital are based in Ruiru Town. Githurai-Lang'ata Health Centre is based in Githurai 45. St. Joseph Medical Centre is private and located in Kahawa Wendani along Thika Super-Highway. Githunguri Health Centre is located in Githunguri near Kenya Prison in Ruiru.

Kiambu County is located in the Central highlands of Kenya in the former Central Province, close to Kenya's capital, Nairobi. Ruiru Sub-County was preferred by the researcher due to its proximity to Nairobi City County, which has a HIV prevalence of 6.8% (ranked 8th nationally), and falls in the high incidence counties. Therefore, Nairobi City County has influence over Ruiru. This is because it offers access to affordable housing thus attracting members of key populations. According to Kiambu County HIV & AIDS Strategic Plan (2014), Kiambu County hosts many institutions of higher learning, thus making it a host to a large population vulnerable to HIV/AIDS. According to the Kenya Information Guide Website (2018), Ruiru town is located along the Thika superhighway between Kenyatta University and Juja, and is one of the fastest growing towns in the county. It is a busy commercial hub with a heavy

presence of industries. Economic activities and the industrial nature of the town brought by the good road networks in the county have brought about high rates of settlements in the county. The vast plantations of coffee, tea and horticulture also attract immigrant workers who normally don't live with their families. The study targets Ruiru because the high rates of urbanization and settlement following the construction of Thika Superhighway in the sub-county has greatly contributed to the increase in new infections. This population pressure in the sub-county has brought about a mushrooming of informal settlements (slums) where the living conditions predispose women and children to rampant sexual and gender based violence (Kiambu County HIV & AIDS Strategic Plan).

### **3.3 Target Population**

The target population of this study was the adolescents living with HIV in Ruiru Sub-County that were to be found in five hospitals. The five hospitals with Comprehensive Care Centres in Ruiru Sub-County were Ruiru Sub-County Hospital which has 35 enrolled adolescents, Githunguri Health Centre which has 10 enrolled adolescents, Githurai-Lang'ata Health Centre which has 6 enrolled adolescents, Nazareth Hospital with 14 registered adolescents, and St. Joseph Medical Centre which has 10 adolescents enrolled on HAART.

### **3.4 Sample Size**

Adolescents living with HIV/AIDS in Ruiru Sub-County were accessed through the five Comprehensive Care Centres. The sample in this study was adolescents from 12-19 years living with HIV in Ruiru Sub-County, who were at the time of data collection, 75 in total as enrolled in the CCCs registers. The sample size which was the population was deemed small because over the years there have been interventions to reduce and hopefully eradicate mother to child transmission of HIV. Launched in 2011, The Global Plan's target was to reduce new infections among children by 90% by 2015. In 2013, 1.3 million women living with HIV gave birth—a figure which is unchanged from 2009. However, the number of children newly infected fell from 350 000 in 2009 to 199 000 in 2013. The 75 subjects were found at the hospitals because HIV-positive adolescents are a sensitive group to engage in research within the community, due to issues of stigma and discrimination, hence they are not easily accessible in their communities of residence. Hospitals were the “safest” place, therefore, to conduct this research without placing the lives of adolescents at risk of stigma and discrimination by identification in their communities, since the use of snow-balling would elicit opportunities for

discrimination and even a sense of betrayal on the part of the parents that someone has disclosed to a stranger their child's status.

### **3.5 Sampling Procedure**

Purposive sampling was used to identify both the hospitals with CCCs and the study respondents. The respondents were selected purposively, since they are a small group of adolescents. This is an advantage over the probability sampling technique, which would reduce the sample significantly and would therefore not be enough to answer the study questions. Subjects were considered through total sampling by use of the hospital registers at the CCCs; hence all the registered patients shall become the subjects of the research. To ensure that the sample did not reduce, the researcher conducted social mobilization with the help of the peer mentors attached to each CCC. A peer mentor is an adolescent living with HIV and who lives positively and has gone public and is a long-term survivor who follows treatment responsibly. The peer counselors made phone calls to all the adolescents' parents to ensure that they attended the clinic on the date of clinic appointment and they accompanied their children to the clinic.

#### **3.5.1 Inclusion and Exclusion Criteria**

This study included adolescents at the age of 12 to 19 years who had their HIV statuses disclosed to them; hence this way, the researcher avoided accidental disclosure and hence social harm. Adolescents in day schools as well as boarding schools were included in the study. Those who had been transferred to these specific CCCs from other hospitals as well as those who had reached the age of 12 by the day of data collection were included for participation in this study. Adolescents who declined to assent/ consent were excluded from participating in the study, as well as those whose parents declined to consent. This study was excluded to adolescents whose mental capability was limited, as well as those too unwell, that they could not be reasonably consulted.

### **3.6 Research Instruments**

The researcher employed a semi-structured questionnaire as the tool of data collection. Specifically, the Perceived Stigma Scale and the Experiences in Close Relationships Revised Questionnaire was used to collect data. Responses were measured using the Likert scale. Jackson (2009) agreed that the Likert scale is most preferred by researchers as it is easy to analyze statistically. Sections include: Section (A) - demographic information sheet and the

content section (B) in three parts measuring perceived stigma, psychological wellbeing and interpersonal relationships.

The Perceived Stigma Scale (PSS) is a 10 item questionnaire that assesses the construct of perceived stigma. The PSS was adapted for use with participants living with HIV/AIDS from a measure of perceived stigma in mental health patients (Link, 1987). The term "mental health patient" was changed to fit individuals living with HIV/AIDS, and items were scored on a seven-point Likert-type scale numbered 1–7 with 7= "Very Strongly Disagree", 6=" Strongly Disagree", 5="Disagree", 4="Neutral", 3="Agree", 2="Strongly Agree", and 1="Very Strongly Agree". The scoring is done by summing the items, and dividing by 12, thus higher scores indicate more perceived stigma. The original mental health measure by Link (1987) showed adequate reliability (alphas=.73–.82). This scale was used by (Luoma et al., 2007) in their study on stigma in individuals receiving treatment for substance abuse and the instrument obtained coefficient alpha=.89.

Dupoy's scale, originally called the General Well-Being Schedule, and revised to the Psychological General Well-Being Index (PGWBI), has been widely used as such across many medical specialties and in many countries. The scale comprises 22 polytomous items where a high score is indicative of high levels of psychological well-being. Six affective states are assessed within six subscales: anxiety, depressed mood, positive well-being, self-control, general health and vitality. A reliability index (Person Separation Index - PSI) is also reported. The PGWBI was evaluated with Rasch- and factor analysis by Lundgren-Nilsson, Jonsdottir, Ahlborg, & Tennant, (2013). They registered that where data are usually distributed this can be interpreted as alike to Cronbach's alpha, and thus values of 0.7 and 0.85 are indicative of reliability sufficient for group and individual use respectively.

The Experiences in Close Relationships-Revised (ECR-R) questionnaire by Fraley, Waller, and Brennan (2000), is a revised version of Brennan, Clark, and Shaver's (1998) Experiences in Close Relationships (ECR) questionnaire. Both the ECR and the ECR-R are designed to assess individual differences in respect to attachment-related anxiety (i.e., the extent to which people are insecure vs. secure about the degree to which their significant others' availability and responsiveness) and attachment-related avoidance (i.e., the extent to which people are uncomfortable being close to others vs. secure depending on others).

The first 18 items comprise the attachment-related anxiety scale. Items 17 – 34 contain the attachment-related avoidance measure. Each item is rated on a 7-point scale where 7= Very Strongly Disagree, and 1= Very Strongly Agree. To get a score for attachment-related anxiety, please average a person's responses to items 1 – 16. However, because items 7 and 9 are "reverse keyed" (i.e., high numbers represent low anxiety rather than high stress), the answers were reversed in those questions before averaging the responses. For example, where choice 6 to 9 it was rekeyed as a 2 before equating. To get a score for attachment-related avoidance, please average an individual's responses to items 17 – 34. Items 18, 20, 24, 25, 26, 27, 28, 29, 31, 32, 33, and 34 were reverse-keyed before one calculates this aggregate. In this study, we have modified the items to refer to "others" rather than "romantic partners." A high score in this scale was indicative of low attachment related avoidance and anxiety.

The reliability of the data collection instrument was measured using the Cronbach's alpha, which is a measure of the internal reliability of a measuring instrument. Analysis results returned a Cronbach's alpha of 0.73, which is an acceptable reliability (Kimberlin & Winterstein, 2008). Validity was measured through content validity, where the instrument was examined to ensure that it answers all the research questions in line with research objectives.

### **3.7 Data Collection Procedures**

Permission was obtained by the researcher, from the University of Nairobi, Kenyatta National Hospital-University of Nairobi Ethics Research Committee, and the hospital administrators to undertake the research. The researcher then consulted with the peer counselors and mentors on the adolescents with disclosure issues so as to prevent accidental disclosure. These ones were instructed by the peer mentor to go home and come during the next appointed date. During adolescents' consultations with the clinical officers and drug collection, the researcher briefed each parent about the research and sought informed written consent after which the parent/guardian was free to go home. After the child left the consultation room, the researcher also briefed the child about the research and informed assent sought from those less than 18 years and consent from those who were 18 years and above.

The adolescents without disclosure problems who assented and consented, and whose parents/guardians gave consent, were directed to the tent pitched near the CCC to uphold the privacy of the subjects, after every one of them had consulted with the clinical officers on site to ensure hospital activities were not interrupted. The study was explained to the adolescents



by the researcher, as a team in the most understandable terms. The researcher also responded to the questions raised by the adolescent participants. After ensuring that they had understood all the information provided, the researcher obtained the adolescent participants' voluntary agreement to participate. Each subject then had a consent form given to them for signing then collected by the researcher. Those who withheld consent shall were escorted back to the CCC by the researcher.

Data captured using the questionnaires was checked, edited organized and coded using numbers to specific responses. This was done in order to data entry easier. Additionally, this step ensured that data used for analysis was 'clean', that is, it had no errors such as missing values, repetitions and duplications. The cleaned data was then entered into SPSS for data analysis.

### **3.8 Data Analysis**

Data was analyzed using the Statistical Package for Social Scientists. Data was analyzed through the use of descriptive statistics including measures of central tendency and measures of variation then represented in the form of frequency distribution tables, percentages and pie/bar charts. The independent and dependent variables in this study were qualitative, and they employed the ordinal scale of measurement in the form of Likert scale. The use of Spearman-Rho statistic was used to measure the hypotheses comparing the relationship between the independent and dependent variables. The third alternative hypothesis comparing the two dependent variables was tested using bivariate correlation in specific the Spearman-Rho statistic. Correlation ( $r$ ) was used to measure the strength of association between two variables and ranges between -1 (perfect negative correlation) to 1 (perfect positive correlation). Cohen (1992) outlined the interpretation of the absolute value of the correlation: -0.3 to +0.3 is weak, -0.5 to -0.3 or 0.3 to 0.5 is moderate -0.9 to -0.5 or 0.5 to 0.9 is strong and -1.0 to -0.9 or 0.9 to 1.0 is very strong. These data was then represented using a scatter plot. The interaction of the three variables was tested using multivariate analysis; multiple regression. The regression analysis test produced three important results that assisted in checking the relationships. That is: a model summary, ANOVA (analysis of variance) and model coefficients.

### **3.9 Ethical Obligations**

Permission was obtained from the University of Nairobi's Department of Psychology through an authorization letter to conduct the study. A research permit was also requested by the researcher from the National Commission for Science and Technology and Innovation. The researcher explained to the participants that participation was voluntary. The researcher sought informed written consent from the respondents' parents/guardians to ensure that children had permission to engage in research. The adolescents were issued with an assent form for those under 18 and a consent form for those 18 and 19 so as to seek written informed consent.

The researcher's central tenet was to uphold individuals' rights to confidentiality and privacy. However, in case of a subject/s having answered that they felt like ending their lives, as observed by the researcher during data collection and handing in of questionnaires, the researcher promptly recommend to the Ruiru Sub-County Hospital peer counselor, individual counseling to the specific subjects with immediate effect. This is because suicidal intention or ideation is a psychiatric emergency.

Privacy and confidentiality of information was upheld to minimize the risk to subjects involved. The researcher determined and controlled access rights to research data. With a view to uphold respondents' access rights to questionnaire was strictly confined only to those who had been granted access: the researcher and the supervisor. Paper records related to the subjects' participation in research were securely stored in the University supervisor's office.

Signed informed consents and assents were neither used as the identifying link to the research data and did not contain participant ID numbers, nor were they filed with other research data files. Digital records containing respondents' research data were stored in password protected files with regular and secured back-up in a location separate from the original. Once the period of retention has expired, five (5) years after the age of majority of the children, research data shall be disposed of for questionnaires, assent and consent form; and digital/computerized data deleted securely and confidentially in a manner appropriate to its format. The researcher then will retain de-identified data for future analysis in the context of this project for which data were collected. Data shall be de-identified when all links between individual identity and the data are destroyed.

## **CHAPTER FOUR**

### **DATA ANALYSIS**

#### **4.0 Introduction**

This chapter presents the results and interpretation of data analysis, to determine the effects of perceived stigma of perceived stigma on psychological wellness and interpersonal relationships of teenagers with HIV/AIDS in Ruiru sub- County. Regression analysis was performed using SPSS to answer the research objectives.

#### **4.1 Demographic Characteristics**

Analysis of the demographic characteristics revealed that majority of the teenagers that is, 51%, were girls, while 49% of the teenagers were boys. Majority of the respondents (24%) were aged 16 years, 23% were 15 years, 14% were 17 years, 13% were 13 years, 11% were 14 years, 7% were 19 years, while another 7% were 18 years. Additionally, all the respondents were Christian. Further, 99% of the respondents attended school, while only 1% had not attended school. 99% of the respondents lived with family, while only 1% of them lived alone. Analysis also showed that none of the teenagers were married, and that all the teenagers were unemployed. Further analysis revealed that all the interviewed teenagers had been tested for HIV/AIDS before the study was carried out, and 84% of the respondents have disclosed their HIV status before, while 16% of them had never disclosed their status. Additionally, 96% of the respondents stated that their families were aware of the teenagers' positive HIV status, while 4% stated that their families did not know about their positive HIV status. 9% of the respondents said that their families gave them emotional support on their HIV status, while only 1% stated that they do not receive emotional support from the family. 74% of the teenagers stated that their friends are aware of their HIV positive status, while 26% noted that their friends did not know about their positive HIV status. 79% of the respondents believed that their friends gave them emotional support of their positive HIV status, while 21% stated that their friends do not give them emotional support. 96% of the interviewed teenagers visited a hospital monthly, 3% of them visited the hospital twice a week, while 1% of the teenagers visited the hospital after two months. Lastly, 96% of the respondents received medication from the hospital, 3% received counseling and medication, while 1% of the teenagers received treatment and adherence support.

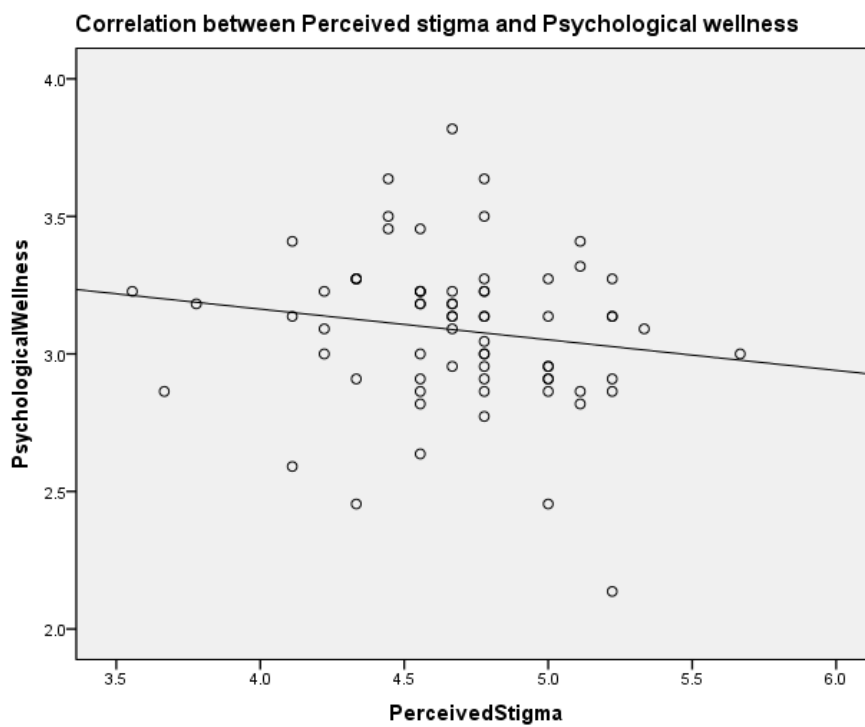
## 4.2 Correlation of Variables

### 4.2.1 Correlation of Main Variables

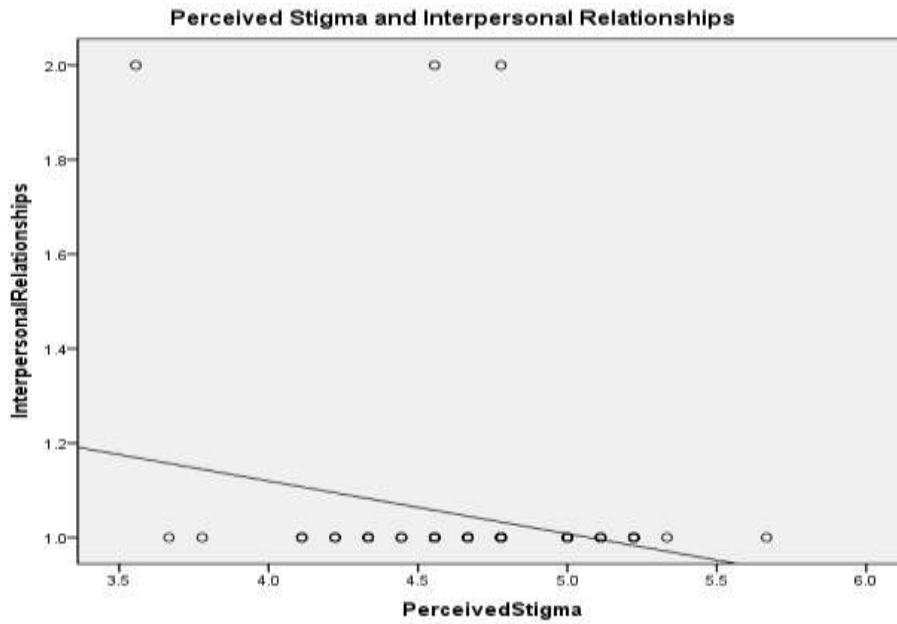
This section reports on the correlation between the main study variables. That is, correlation between perceived stigma, psychological wellness, and interpersonal relationships. The results are as given in table 4.1 and figures 4.1, 4.2 and 4.3

**Table 4.1: Correlation of Variables**

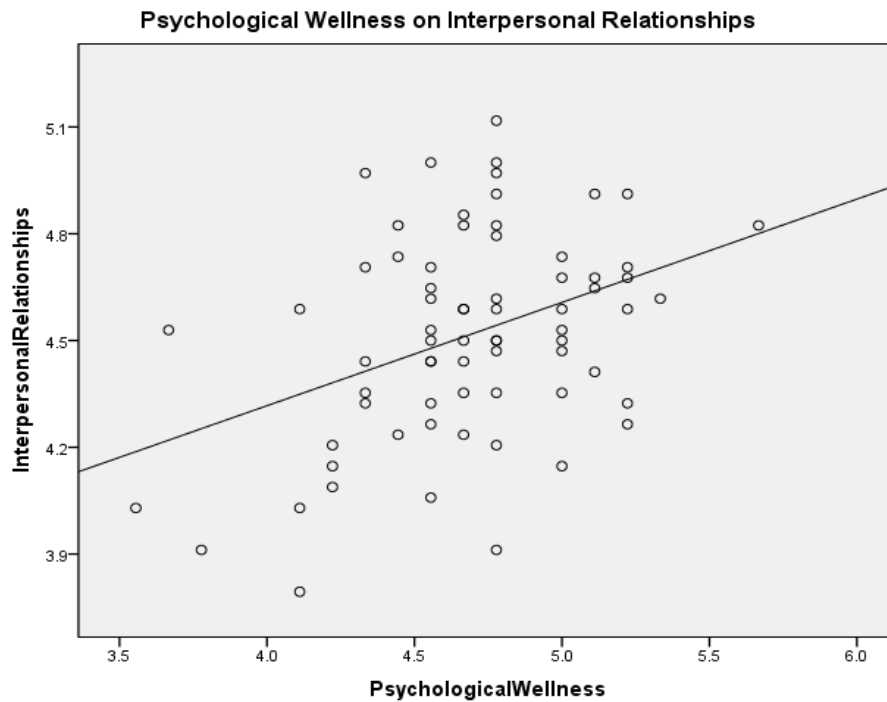
	Perceived Stigma	Psychological Wellness	Interpersonal Relationships
Perceived Stigma	1	-.255	-.391
Psychological Wellness	-.255	1	.340
Interpersonal Relationships	-.391	.340	1



**Figure 4.1: Correlation between psychological wellness and interpersonal relationships**



**Figure 4.2: Correlation of perceived stigma and interpersonal relationships**



**Figure 4.3: Correlation between psychological wellness and interpersonal relationships**

Table 4.1 and figures 4.1 to 4.3 show correlations of the main variables used in inferential analysis. From the results, perceived stigma and psychological wellness both have a correlation of - 0.255 (-25.5%). This implies a unit increase in perceived stigma reduces psychological wellness by 25.5%. Perceived stigma and interpersonal relationships have a correlation of –

0.391 (-39.1%). Thus, when perceived stigma increases by a unit, interpersonal relationships reduce by 39.1%. Lastly, psychological wellness and interpersonal relationships have a correlation of 0.340 (34%). Therefore, when psychological wellness increases by a unit, interpersonal relationships increase by 34%.

#### 4.2.2 Correlation of Study Variables

**Table 4.2: Correlation of study variables**

	Disclosure	Family awareness	Friends' awareness	Friends' support	Type of hospital support	Perceived Stigma	Psychological Wellness	Interpersonal Relationships
Disclosure	1	.102	.644	.731	.024	-.034	.122	-.133
Family awareness	.102	1	.198	.233	-.043	-.214	.061	.060
Friends' awareness	.644	.198	1	.888	-.027	-.013	.084	-.037
Friends' support	.731	.233	.888	1	-.007	-.008	.082	.006
Type of hospital support	.024	-.043	-.027	-.007	1	.001	-.136	.180
Perceived Stigma	-.034	-.214	-.013	-.008	.001	1	-.255	-.391
Psychological Wellness	.122	.061	.084	.082	-.136	-.255	1	.340
Interpersonal Relationships	-.133	.060	-.037	.006	.180	-.391	.340	1

Table 4.2 shows the correlations between confounding and main variables. As explained in table 4.2, a positive correlation indicates that a unit increase in one variable causes an increase in the other variable. On the other hand, a negative correlation indicates a unit increase in one variable causes a decrease in the other variable. For instance, disclosure and friends' support have a correlation of 73.1%, meaning that a unit change in disclosure causes an increase of 73.1% in friends' support. Additionally, family awareness and perceived stigma have a correlation of -21.4%, implying a unit increase in family awareness reduces perceived stigma by 21.4%.

### 4.3 Perceived Stigma on Psychological Wellness among Adolescents Living with HIV/AIDS

Regression analysis was conducted to test the effect of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS. Results showed that perceived stigma and psychological wellness have a negative correlation of correlation of – 25.5%. Secondly, the results revealed that perceived stigma explain 9.4% of the total variation in psychological wellness. Further, the results as shown in table 4.3 indicated the model was significant and that perceived stigma had a statistically significant effect on psychological wellness of adults living with HIV/AIDS,  $F = 4.672$ ,  $p = 0.02$ . The p value is less than 0.05, thus perceived stigma had an effect on psychological wellness of adults living with HIV/AIDS.

**Table 4.3: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.364	1	.364	4.672	.020
Residual	5.304	68	.078		
Total	5.435	69			

a. Predictors: (Constant), Perceived Stigma

b. Dependent Variable: Psychological Wellness

Further analysis revealed that perceived stigma was indeed a significant predictor of psychological wellness,  $t = -3.293$ ,  $p = 0.020$ . The table also gives the model coefficients, hence the model as given below:

$$\text{Psychological wellness} = 3.609 - 0.211 (\text{Perceived stigma})$$



From the results above, there is sufficient evidence to reject the null hypothesis and conclude that perceived stigma has a significant effect on psychological wellness among adolescents living with HIV/AIDS.

#### 4.4 Perceived Stigma on Quality of Interpersonal Relationships among Adolescents Living with HIV/AIDS

Regression analysis was conducted to test the effect of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS. Results indicated the variables have a correlation of  $-0.391$ . Moreover, the results reveal that perceived stigma explain  $15.3\%$  of the total variation in interpersonal relationships. Analysis of Variance results as in table 4.4 below indicated the model was significant and that perceived stigma had a statistically significant effect on interpersonal relationships of adults living with HIV/AIDS,  $F = 12.284, p = 0.001$ . The p-value is less than  $0.05$ , therefore perceived stigma had an effect on interpersonal relationships of adults living with HIV/AIDS.

**Table 4.4: The Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.885	1	.885	12.284	.001 <sup>a</sup>
Residual	4.898	68	.072		
Total	5.783	69			

a. Predictors: (Constant), Perceived Stigma

b. Dependent Variable: Interpersonal Relationships

Further analysis indicated that perceived stigma was indeed a significant predictor of interpersonal relationships,  $t = -3.505, p = 0.001$ . The table also gives the model coefficients, hence the model as given below:

$$\text{Interpersonal relationships} = 3.156 - 0.29 (\text{perceived stigma})$$

From the results above, there is sufficient evidence to reject the null hypothesis and conclude that perceived stigma has a significant effect on interpersonal relationships among adolescents living with HIV/AIDS.

#### 4.5 Relationship between Psychological Wellness and Quality of Interpersonal Relationships among Adolescents Living with HIV/AIDS

Regression analysis was conducted to test the relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS. Results showed the variables have a correlation of 34%. Additionally, the results reveal that psychological wellness explains 11.2% of the total variation in interpersonal relationships. Analysis of variance test results as in table 4.5 indicated the model was significant and that psychological wellness had a statistically significant effect on interpersonal relationships of adults living with HIV/AIDS,  $F = 12.284$ ,  $p = 0.018$ . The  $p$ -value is less than 0.05, thus psychological wellness had an effect on interpersonal relationships of adults living with HIV/AIDS.

**Table 4.5: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.351	1	.351	4.131	.018 <sup>a</sup>
Residual	5.772	68	.085		
Total	5.783	69			

a. Predictors: (Constant), Psychological Wellness

b. Dependent Variable: Interpersonal Relationships

Further analysis indicated that psychological wellness was indeed a significant predictor of interpersonal relationships,  $t = 3.362$ ,  $p = 0.018$ . The table also gives the model coefficients, hence the model as given below:

$$\text{Interpersonal relationships} = 4.377 + 0.305 (\text{psychological wellness})$$

From the results above, there is sufficient evidence to reject the null hypothesis and conclude that psychological wellness has a significant effect on interpersonal relationships among adolescents living with HIV/AIDS.

#### 4.6 The Interaction of Perceived Stigma and Psychological Wellness on Interpersonal Relationships.

Regression analysis was conducted to examine the relationship between perceived stigma and psychological wellness. Results showed that the variables have a combined correlation of 0.405 (40.5%) with interpersonal relationships. Secondly the results also revealed that perceived stigma and psychological wellness explain 26.4% of the total variation in interpersonal relationships. Analysis of variance test results as in table 4.6 indicated the model was

significant and that perceived stigma and psychological wellness had a statistically significant effect on interpersonal relationships of adults living with HIV/AIDS,  $F = 6.580$ ,  $p = 0.002$ . Therefore, perceived stigma and psychological wellness had an effect on interpersonal relationships of adults living with HIV/AIDS.

**Table 4.6: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.949	2	.475	6.580	.002 <sup>a</sup>
Residual	4.834	67	.072		
Total	5.783	69			

a. Predictors: (Constant), Psychological Wellness, Perceived Stigma

b. Dependent Variable: Interpersonal Relationships

Further analysis revealed that perceived stigma and psychological wellness were significant predictors of interpersonal relationships,  $t = -3.606$ ,  $p = 0.001$  and  $t = 3.947$ ,  $p = 0.018$  respectively. The table also gives the model coefficients, hence the model as given below:

Interpersonal relationships =  $4.377 - 0.255$  (perceived stigma) +  $0.305$  (psychological wellness)

#### **4.7 The Interaction of Perceived Stigma and Interpersonal Relationships on Psychological Wellness.**

Regression analysis was conducted to assess the relationship between perceived stigma and interpersonal relationships have a combined correlation with psychological wellness of 19.2%. Additionally, perceived stigma and interpersonal relationships explain 13.7% of the total variation in psychological wellness. Analysis of variance as in table 4.7 indicated the model was significant and that perceived stigma and interpersonal relationships had a statistically significant effect on psychological wellness of adolescents living with HIV/AIDS,  $F = 4.283$ ,  $p = 0.024$ . Therefore, perceived stigma and interpersonal relationships had an effect on psychological wellness of adolescents living with HIV/AIDS.

**Table 4.7: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.668	2	.334	4.283	.024 <sup>a</sup>
Residual	5.234	67	.078		
Total	5.435	69			

a. Predictors: (Constant), Interpersonal Relationships, Perceived Stigma

b. Dependent Variable: Psychological Wellness

Further analysis indicated that perceived stigma and interpersonal relationships were significant predictors of psychological wellness,  $t = -3.293$ ,  $p = 0.020$  and  $t = 3.947$ ,  $p = 0.037$  respectively. The table also gives the model coefficients, hence the model as given below:

Psychological wellness = 3.231 – 0.211 (perceived stigma) + 0.120 (interpersonal relationships)

#### 4.8 Effect of Disclosure on Psychological Wellness and Interpersonal Relationships

##### 4.8.1 Effect of Disclosure on Psychological Wellness

Regression analysis was conducted to assess the relationship between disclosure and psychological wellness. Results revealed the variables have a correlation of 12.2%. Additionally, the results indicate that disclosure explains 4.5% of the total variation in psychological wellness. The Analysis of Variance results revealed that disclosure was a significant predictor of psychological wellness,  $F = 5.038$ ,  $p = 0.013$ . The p- value was less than 0.05, indicating disclosure had a significant effect on psychological wellness.

**Table 4. 8: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.398	1	.398	5.038	.013 <sup>a</sup>
Residual	5.353	68	.079		
Total	5.435	69			

a. Predictors: (Constant), If yes, have you ever told someone about your HIV status?

b. Dependent Variable: Psychological Wellness

From further analysis, it is evident that disclosure was actually a significant predictor of psychological wellness. From the results  $t = 3.016$ ,  $p = 0.013 < 0.05$ . The regression equation is as given below:

$$\text{Psychological wellness} = 2.978 + 0.094 (\text{disclosure})$$

#### 4.8.2 Effect of Disclosure on Interpersonal Relationship

Regression analysis was conducted to assess the relationship between disclosure and interpersonal relationship. From the results, the r-square value is 0.048, implying that disclosure explains 4.8% of the total variation in interpersonal relationships. The analysis of variance results revealed that disclosure was a significant predictor of interpersonal relationships,  $F = 4.266$ ,  $p = 0.032$ . The p-value is less than 0.05, confirming disclosure had an effect on interpersonal relationships.

**Table 4.9: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.355	1	.355	4.226	.032 <sup>a</sup>
Residual	5.681	68	.084		
Total	5.783	69			

a. Predictors: (Constant), If yes, have you ever told someone about your HIV status?

b. Dependent Variable: Interpersonal Relationships

Further analysis revealed that disclosure had a significant effect on interpersonal relationships. The  $t$  value =  $-3.107$ ,  $p = 0.032 < 0.05$ . Regression model:

$$\text{Interpersonal relationships} = 4.638 - 0.105 (\text{disclosure})$$

From the results above, it is evident that disclosure had an effect on both psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

## 4.9 Effect of Family Awareness on Psychological Wellness and Interpersonal Relationships

### 4.9.1 Effect of Family Awareness on Psychological Wellness

Regression analysis was conducted to assess the relationship between family awareness and psychological wellness. Results showed that the variables have a correlation of 21.4%. Additionally, family awareness explains 4.6% of the total variation in psychological awareness. The Analysis of Variance results revealed that family awareness was a significant predictor of psychological wellness,  $F = 4.125$ ,  $p = 0.036$ . The p-value was less than 0.05, indicating disclosure had a significant effect on psychological wellness.

**Table 4.10: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.606	1	.606	4.125	.036 <sup>a</sup>
Residual	10.022	68	.147		
Total	10.501	69			

a. Predictors: (Constant), Is your family aware of your positive status?

b. Dependent Variable: Psychological Wellness

Further analysis confirmed that family awareness is a significant predictor of psychological wellness. The  $t$  value = -3.803,  $p$  value =  $0.036 < 0.05$ . The regression model is as given below:

$$\text{Psychological wellness} = 5.113 - 0.409 (\text{family awareness})$$

### 4.9.2 Effect of Family Awareness on Interpersonal Relationships

Regression analysis was conducted to assess the relationship between family awareness and interpersonal relationships. The results revealed the variables have a correlation of 16%. Additionally, family awareness explains 2.4% of the total variation in interpersonal relationships. The analysis of variance results revealed that family was a significant predictor of interpersonal relationships,  $F = 4.247$ ,  $p = 0.021$ . The p-value is less than 0.05, confirming family awareness had an effect on interpersonal relationships.

**Table 4.11: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.361	1	.361	4.247	.021 <sup>a</sup>
Residual	5.762	68	.085		
Total	5.783	69			

a. Predictors: (Constant), Is your family aware of your positive status?

b. Dependent Variable: Interpersonal Relationships

Additional analysis revealed that family awareness is indeed a significant predictor of interpersonal relationships. The  $t$  value = 3.497,  $p$  value = 0.021 < 0.05. Regression model is as given below:

$$\text{Interpersonal relationships} = 4.427 + 0.085 (\text{family awareness})$$

From the results above, it is evident that family awareness had an effect on both psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

#### **4.10 Effect of Friends' Awareness on Psychological Wellness and Interpersonal Relationships**

##### **4.10.1 Effect of Friends' Awareness on Psychological Wellness**

Regression analysis was conducted to assess the relationship between friends' awareness and psychological awareness. A correlation test revealed the variables have a correlation of 18.4%. Additionally, friends' awareness explains 5.7% of the total variation in psychological wellness. The Analysis of Variance results revealed that friends' awareness was a significant predictor of psychological wellness,  $F = 4.086$ ,  $p = 0.048$ . The  $p$ -value was less than 0.05, indicating friends' had a significant effect on psychological wellness.

**Table 4.22: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.323	1	.323	4.086	.048 <sup>a</sup>
Residual	5.396	68	.079		
Total	5.435	69			

a. Predictors: (Constant), Do your friends know your positive HIV status?

b. Dependent Variable: Psychological Wellness

Further analysis revealed that friends' awareness is indeed a significant predictor of psychological awareness. The  $t$  value = 3.097,  $p$  value = 0.048 < 0.05.

The regression model is as given below:

$$\text{Psychological awareness} = 3.019 + 0.054 (\text{friends' awareness})$$

#### 4.10.2 Effect of Friends' Awareness on Interpersonal Relationships

Regression analysis was conducted to assess the relationship between friends' awareness and interpersonal relationships. Results revealed that friends' awareness has a correlation of 13.7% with interpersonal relationships. Additionally, friends' awareness explains 1.1% of the total variation in interpersonal relationships. The analysis of variance results revealed that friends' was a significant predictor of interpersonal relationships,  $F = 4.123$ ,  $p = 0.042$ . The  $p$ -value is less than 0.05, confirming friends' awareness had an effect on interpersonal relationships.

**Table 4.33: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.008	1	.008	4.123	.042 <sup>a</sup>
Residual	5.775	68	.085		
Total	5.783	69			

a. Predictors: (Constant), Do your friends know your positive HIV status?

b. Dependent Variable: Interpersonal Relationships

Additional analysis revealed that friends' awareness is indeed a significant predictor of interpersonal relationships. The  $t$  value = -3.304,  $p$  value = 0.042 < 0.05. Regression model is as given below:



$$\text{Interpersonal relationships} = 4.547 - 0.024 (\text{friends' awareness})$$

From the results above, it is evident that friends' awareness had an effect on both psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

#### 4.11 Effect of Friends' Emotional Support on Psychological Wellness and Interpersonal Relationships

##### 4.11.1 Effect of Friends' Emotional Support on Psychological Wellness

Regression analysis was conducted to assess the relationship between friends' emotional support and psychological wellness. The variables have a correlation of 18.2% according to the results. Additionally, the results revealed that friends' emotional support explains 4.7 % of the total variation in psychological awareness. The Analysis of Variance results revealed that friends' emotional support was a significant predictor of psychological wellness,  $F = 4.464$ ,  $p = 0.028$ . The  $p$ - value was less than 0.05, indicating friends' emotional support had a significant effect on psychological wellness.

**Table 4.44: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.353	1	.353	4.464	.028 <sup>a</sup>
Residual	5.398	68	.079		
Total	5.435	69			

a. Predictors: (Constant), If yes, do your friends give you emotional support?

b. Dependent Variable: Psychological Wellness

Further analysis revealed that friends' emotional support is indeed a significant predictor of psychological awareness. The  $t$  value = 3.681,  $p$  value = 0.028 < 0.05.

The regression model is as given below:

$$\text{Psychological awareness} = 3.018 + 0.056 (\text{friends' emotional support})$$

#### 4.11.2 Effect of Friends' Emotional Support on Interpersonal Relationships

Regression analysis was conducted to assess the relationship between emotional support and interpersonal relationships. According to results, the variables have a correlation of 10.6%. Additionally, friends' emotional support explains 5.8% of the total variation in interpersonal relationships. The analysis of variance results revealed that friends' emotional support was a significant predictor of interpersonal relationships,  $F = 4.502$ ,  $p = 0.032$ . The p-value is less than 0.05, confirming friends' emotional support had an effect on interpersonal relationships.

**Table 4.55: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.383	1	.383	4.502	.032 <sup>a</sup>
Residual	5.783	68	.085		
Total	5.783	69			

a. Predictors: (Constant), If yes, do your friends give you emotional support?

b. Dependent Variable: Interpersonal Relationships

Further analysis revealed that friends' emotional support is indeed a significant predictor of interpersonal relationships. The  $t$  value =  $-3.048$ ,  $p$  value =  $0.032 < 0.05$ . Regression model is as given below:

$$\text{Interpersonal relationships} = 4.511 - 0.004 (\text{friends' emotional support})$$

From the results above, it is evident that friends' emotional support had an effect on both psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

#### 4.12 Effect of Type of Hospital Support on Psychological Wellness and Interpersonal Relationships

##### 4.12.1 Effect of Type of Hospital Support on Psychological Wellness

Regression analysis was conducted to assess the relationship between type of hospital support and psychological wellness. Results revealed that the variables have a correlation of 13.6%. Additionally, the results revealed that type of hospital support explains 2.8 % of the total variation in psychological awareness. The Analysis of Variance results revealed that type of hospital support was a significant predictor of psychological wellness,  $F = 4.281$ ,  $p = 0.022$ .

The p- value was less than 0.05, indicating type of hospital support had a significant effect on psychological wellness.

**Table 4.66: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.334	1	.334	4.281	.022 <sup>a</sup>
Residual	5.334	68	.078		
Total	5.435	69			

a. Predictors: (Constant), What type of support do you receive from hospital?

b. Dependent Variable: Psychological Wellness

Further analysis revealed that type of hospital support is indeed a significant predictor of psychological awareness. The *t* value = -3.132, *p* value = 0.022 < 0.05.

The regression model is as given below:

$$\text{Psychological awareness} = 3.202 - 0.108 (\text{type of hospital support})$$

#### 4.12.2 Effect of Type of Hospital Support on Interpersonal Relationships

Regression analysis was conducted to assess the relationship between type of hospital support and interpersonal relationships. Results revealed the variables have a correlation of 18%. Additionally, type of hospital support explains 3.2% of the total variation in interpersonal relationships. The analysis of variance results revealed that type of hospital support was a significant predictor of interpersonal relationships, *F* = 4.271, *p* = 0.036. The p-value is less than 0.05, confirming type of hospital support had an effect on interpersonal relationships.

**Table 4.77: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.350	1	.350	4.271	.036 <sup>a</sup>
Residual	5.596	68	.082		
Total	5.783	69			

a. Predictors: (Constant), What type of support do you receive from hospital?

b. Dependent Variable: Interpersonal Relationships

Results further revealed that type of hospital support is indeed a significant predictor of interpersonal relationships. The  $t$  value = -3.048,  $p$  value = 0.032 < 0.05. Regression model is as given below:

$$\text{Interpersonal relationships} = 4.359 + 0.147 (\text{type of hospital support})$$

From the results above, it is evident that type of hospital support had an effect on both psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS.

### 4.13 Effect of Gender on Psychological Wellness and Interpersonal Relationships

#### 4.13.1 Effect of Gender on Psychological Wellness

Regression analysis was conducted to assess the relationship between gender and psychological wellness. Correlation test results showed that the variables have a correlation of 2.6%. Additionally, the results revealed that gender explains only 0.1% of the total variation in psychological awareness.

**Table 4.88: Analysis of Variance (ANOVA)**

Model	Sum of Squares	Df	Mean Square	F	Sig.
Regression	.004	1	.004	.046	.830 <sup>a</sup>
Residual	5.431	68	.080		
Total	5.435	69			

a. Predictors: (Constant), I am a...

b. Dependent Variable: Psychological Wellness

The Analysis of Variance results as shown in table 4.18 revealed that gender was not a significant predictor of psychological wellness,  $F = 0.046$ ,  $p = 0.830$ . The  $p$ -value was greater than 0.05, indicating gender did not have a significant effect on psychological wellness.

#### 4.13.2 Effect of Gender on Interpersonal Relationships

Regression analysis was conducted to assess the relationship between gender and interpersonal relationships. Results showed that the variables have a correlation of 6.7%. Additionally, gender explains only 0.5% of the total variation in interpersonal relationships.

**Table 4.19: Analysis of Variance (ANOVA)**

Model	Sum of Squares	df	Mean Square	F	Sig.
Regression	.026	1	.026	.311	.579 <sup>a</sup>
Residual	5.757	68	.085		
Total	5.783	69			

a. Predictors: (Constant), I am a...

b. Dependent Variable: Interpersonal Relationships

The analysis of variance results as shown in table 4.19 above revealed that gender was not a significant predictor of interpersonal relationships,  $F = 0.311$ ,  $p = 0.579$ . The p-value is less than 0.05, confirming that gender had no significant effect on interpersonal relationships.

## **CHAPTER FIVE**

### **SUMMARY OF FINDINGS, CONCLUSIONS AND RECOMMENDATIONS**

#### **5.0 Introduction**

The study was carried out with several objectives: to assess the effects of perceived stigma on psychological wellness among adolescents living with HIV/AIDS, to find out the effects of perceived stigma on quality of interpersonal relationships among adolescents living with HIV/AIDS, to determine the relationship between psychological wellness and quality of interpersonal relationships among adolescents living with HIV/AIDS and lastly to assess the interaction of perceived stigma and psychological wellness on interpersonal relationships.

#### **5.1 Summary of the Study's Major Findings**

##### **5.1.1 Effects of Perceived Stigma on Psychological Wellness among Adolescents Living with HIV/AIDS**

The first objective of the study sought to establish the effects of perceived stigma towards HIV on psychological wellness among adolescents living with HIV/AIDS. The study revealed that there is a weak relationship between perceived stigma and psychological wellness. However, it was noted that perceived stigma and psychological wellness had a negative correlation. The study further examined the significance of the association of perceived stigma and psychological wellness, the result revealed that the relationship between the two variables was significant, in which case, perceived stigma was thus found to be a great predictor to the psychological wellness of adolescents with HIV/AIDS.

##### **5.1.2 Effects of Perceived Stigma on Quality of Interpersonal Relationships among Adolescents Living with HIV/AIDS**

The second objective sought to establish how perceived stigma influences the quality of interpersonal relationships among adolescents living with HIV/AIDS. The result revealed a moderate negative association between perceived stigma and interpersonal relationships among adolescents living with HIV/AIDS. On testing the significance of the association, the study revealed that perceived stigma had a statistically significant effect on interpersonal relationships among adolescents with HIV/AIDS, with a p-value of 0.001. The study thus found that perceived stigma can predict the interpersonal relationships of adolescents with HIV/AIDS.

### **5.1.3 Relationship between Psychological Wellness and Quality of Interpersonal Relationships among Adolescents Living with HIV/AIDS**

The third objective sought to examine the relationship between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS. The findings revealed that there was a weak association between psychological wellness and interpersonal relationships among adolescents living with HIV/AIDS. While the association was weak, the relationship was found to be statistically significant represented with a p-value of 0.018.

## **5.2 Conclusions**

From the findings, perceived stigma towards HIV affects the psychological well-being of adolescents with HIV. The effect of perceived stigma towards HIV impairs the psychological wellness of adolescents with HIV/AIDS. These findings are corroborated by the findings of Markowitz (1998) that examined the effects of stigma on the psychological wellbeing and life satisfaction of individuals, and revealed that stigma had adverse effects on psychological wellbeing and life satisfaction of individuals.

On the effects of perceived stigma towards HIV on interpersonal relationships among adolescents living with HIV/AIDS, the study concludes that perceived stigma was a significant predictor of the quality of interpersonal relationships among adults living with HIV/AIDS. The findings concur with those of Lloyd and colleagues (2005), who examined the perceptions of social stigma and its effects on interpersonal relationships of young males, their findings revealed that there is a significant effect of labelling and stigma on interpersonal relationships of the young men. The findings further showed that labelling and stigma cause significant changes in self-perception among the young people.

The study further concludes that psychological wellness enhances adolescents' with HIV/AIDS quality of interpersonal relationships. With psychological wellness, individuals tend to have better relationships with themselves and others regardless of their HIV status. The positive effect of psychological wellbeing on the quality of interpersonal relationships was confirmed by Zea et al., (2005) whose study examined the effect revealing HIV status on the psychological well-being of individuals. In their findings, HIV status disclosure yielded greater social support, which in turn had positive effects on psychological well-being and also improved relationships with other people. Similar findings were revealed in the Gordillo et al., (2009)

whose finding revealed a positive association between emotional support received from friends and family and the overall psychological well-being of young adults living with HIV.

### **5.3 Recommendations**

Based on the findings, the study makes the following recommendations:

- i) There is a need for public sensitization towards change of perception about those living with HIV/AIDS, such social changes promises more social support towards persons living with HIV/AIDS.
- ii) Schools and social society groups should avail more social activities targeting teenagers to enable them interact better with their peers-educating them about HIV to create an awareness that it is a condition like any other that empowered and appreciated adolescents can live with. This will be useful in enabling the HIV infected adolescents improve their interpersonal relationships.
- iii) It would also be important for researchers to explore various other forms of internal and external stigma, define their measurement clearly and how they influence the quality of life of adolescents living with HIV/AIDS.
- iv) The study also recommends a need for initiation of group and individual counselling sessions to help enhance their psychological wellbeing.
- v) The government should offer trainings to frontline health workers (community based and religious communities based) to help expand care options to the adolescents living with HIV/AIDS.



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## APPENDICES

### **Appendix I: Parental/Guardian Permission Form for Child's Research Participation**

**Study Title:** The Effects of Perceived Stigma on Psychological Wellness and Interpersonal Relationships of Adolescents with HIV/AIDS in Ruiru Sub-County, Kiambu County, Kenya

**Principal Investigator:** Brenda Wanjiru Gutu

**IRB Study Number:** P55/02/2018

**Supervisor:** Prof. Michael Ndurumo, Psychology Department, University of Nairobi

This study seeks to have your child as one of the respondents. In this section, the purpose for this research has been clearly stated and what the minor will be asked to answer. Lastly, the form also explains how the captured data will be used, should you decide to consent for the participation of your kid.

#### **What is the reason for carrying out this research?**

The research is about perceived stigma surrounding living with HIV. The purpose of the study is to investigate how perceived stigma affects how your child views him/herself and how it affects their interaction with others.

#### **How will my child be involved in this study?**

The kid will be requested to fill a questionnaire about how they feel about their life and other people. Some questions may be personal or sensitive. Participation should take about 30 minutes.

The researcher will keep these questionnaires in the researcher's personal file and they will only be used by the researcher.

#### **What are the possible risks or discomforts to my child?**

Your child's participation in this study may involve some emotional risk to your child; but, not beyond that of everyday life. For example:

#### **What are the possible benefits for my child or others?**

There are no proceeds to be gained from this work. The research aims at checking on effects of perceived stigma on psychological wellness and interpersonal relationships of adolescents

with HIV/AIDS in Ruiru Sub-County, Kiambu County, Kenya. The findings might be of help to the society.

**How will you protect the information you collect about my child, and how will that information be shared?**

Results of this study may be used in publications and presentations. Your child's name shall not appear anywhere in the questionnaire. All the data collected shall be kept safe in the researcher's database.

Should we project that your child has an aim of hurting themselves or even some other children, the relevant authorities will be alerted.

**Financial Info**

Involvement in this study requires no payment from children or guardians. The respondents will also not be remunerated.

**What are my child's rights as a research participant?**

Participation in this study is voluntary. Your child may withdraw from this study at any time -- you and your child will not be penalized in any way or lose any sort of benefits for deciding to stop participation. If your child decides to withdraw from this study, the researchers will ask if the information already collected from your child can be used.

If your child is deemed to require further psychological care he/she shall be referred to the peer counselor:

Mr. Johnson Mutuku, +254716276882, [mutukujohnson@yahoo.com](mailto:mutukujohnson@yahoo.com)

**Who can I contact if I have questions or concerns about this research study?**

If you or your child have any questions, you may contact the researchers at:

Brenda Wanjiru Gutu, +254707154099, [brendagutu@students.uonbi.ac.ke](mailto:brendagutu@students.uonbi.ac.ke)

Should you have any inquiries about your kid's privileges as a respondent in this study, please reach:

KNH-UoN Ethics Review Committee

Kenyatta National Hospital

P.O. Box 20723 (00202)

Nairobi, Kenya

Phone: +254 (020) 2726300 - 44355

Email: uonknh\_erc@uonbi.ac.ke

**Parental/Guardian Consent for the kidas a Respondent**

I agree to have gone through the consent, making enquiries and satisfactory responses given to me. For additional enquires, a person (s) to reach has been identified. Therefore, I consent for my child to be a participant in this study and agree to receive a copy of the consent.

\_\_\_\_\_

Name and Signature \_\_\_\_\_  
Date

\_\_\_\_\_

Individual Receiving Parental Permission \_\_\_\_\_  
Date

## **Appendix II: Mzazi Au Mlezi Ruhusa Fomu Ya Ushiriki Wa Utafiti Wa Mtoto**

**Kichwa cha Utafiti:** Athari za Udanganyifu Unaojulikana juu ya Ustawi wa Kisaikolojia na Uhusiano wa Mahusiano ya Vijana wenye VVU / UKIMWI katika Kata ya Ruiru, Kata ya Kiambu, Kenya

**Mtafiti Mkuu:** Brenda Wanjiru Gutu

**Nambari ya Utafiti** wa KNH-UoN ERC: P55 / 02/2018

**Msimamizi:** Prof. Michael Ndurumo, Idara ya Saikolojia, Chuo Kikuu cha Nairobi

Mtoto wako anaombwa kuhusika katika utafiti wa utafiti. Fomu hii ina taarifa muhimu kuhusu sababu ya kufanya utafiti huu, nini tutamwomba mtoto wako afanye, na njia tunayotaka kutumia habari kuhusu mtoto wako ikiwa unachagua kuruhusu mtoto wako awe katika utafiti.

### **Kwa nini unafanya utafiti huu?**

Mtoto wako anaombwa kushiriki katika utafiti wa utafiti kuhusu unyanyapaa unaojulikana unaoishi na VVU. Kusudi la utafiti ni kuchunguza jinsi unyanyapaa unaoathiri unavyoathiri jinsi mtoto wako anavyojiona mwenyewe na jinsi inavyoathiri ushirikiano wao na wengine.

### **Je, mtoto wangu ataulizwa kufanya nini ikiwa mtoto wangu ni katika utafiti huu?**

Mtoto wako ataulizwa kujaza maswali kuhusu jinsi wanavyojisikia kuhusu maisha yao na watu wengine. Maswali mengine yanaweza kuwa ya kibinafsi au yenye uwazi. Ushiriki unapaswa kuchukua muda wa dakika 30.

Mtafiti ataweka maswali haya katika faili ya kibinadamu na atatumiwa tu na mtafiti.

### **Je! Ni hatari gani au kutoweka kwa mtoto wangu?**

Ushiriki wa mtoto wako katika utafiti huu unaweza kuhusisha hatari ya kihisia kwa mtoto wako; lakini, si zaidi ya ile ya maisha ya kila siku. Kwa mfano:

- Mtoto wako anaweza kujisikia kihisia au kuvuruga wakati akijibu baadhi ya maswali. Mtoto wako anaweza kumwambia mhojiwa wakati wowote ikiwa yeye anataka kuchukua pumziko au kuacha mahojiano.
- Mtoto wako anaweza kuwa na wasiwasi na baadhi ya maswali na mada tutakayouliza kuhusu. Ikiwa mtoto wako hajali wasiwasi, ni huru ya kujibu au kuruka kwenye swali linalofuata.

Kama na utafiti wote, kuna nafasi ya kuwa siri ya habari tunayokusanya kuhusu mtoto wako inaweza kuvunjwa - tutachukua hatua za kupunguza hatari hii, kama ilivyojadiliwa kwa undani zaidi hapa chini katika fomu hii.

### **Je! Ni faida gani kwa mtoto wangu au wengine?**

Mtoto wako havezi kuwa na manufaa ya moja kwa moja kutokana na kuwa katika utafiti huu wa utafiti. Utafiti huu umeundwa kujifunza zaidi juu ya [weka lengo / mada ya utafiti].

Matokeo ya utafiti yanaweza kutumiwa kusaidia watu wengine baadaye.

### **Je, utalindaje habari unayokusanya kuhusu mtoto wangu, na taarifa hiyo itashirikiwaje?**

Matokeo ya utafiti huu inaweza kutumika katika machapisho na mawasilisho. Jina la mtoto wako halitaonekana mahali popote katika maswali. Takwimu zote zilizokusanywa zitahifadhiwa salama katika databana ya uchunguzi.

Ikiwa tunadhani kuwa mtoto wako anatarajia kujidhuru yeye mwenyewe au wengine, tutawajulisha watu / mashirika sahihi kwa taarifa hii.

### **Maelezo ya Fedha**

Kushiriki katika utafiti huu hakutakuhusisha gharama au mtoto wako. Mtoto wako hatalipwa kwa kushiriki katika utafiti huu.

### **Je! Haki za mtoto wangu ni mshiriki wa utafiti?**

Kushiriki katika utafiti huu ni kwa hiari. Mtoto wako anaweza kujiondoa kwenye utafiti huu wakati wowote - wewe na mtoto wako hautaadhibiwa kwa njia yoyote au kupoteza manufaa yoyote kwa kuamua kuacha kushiriki.

Ikiwa mtoto wako anaamua kujiondoa kwenye utafiti huu, watafiti watauliza ikiwa habari tayari zilizokusanywa kutoka kwa mtoto wako zinaweza kutumika.

### **Ikiwa mtoto wako anadhaniwa kuwa anahitaji huduma ya kisaikologia, atatumwa kwa mshauri wa rika:**

Mheshimiwa Johnson Mutuku, +254716276882, [mutukujohnson@yahoo.com](mailto:mutukujohnson@yahoo.com)

### **Nani ninaweza kuwasiliana ikiwa nina maswali au wasiwasi kuhusu utafiti huu wa utafiti?**

Ikiwa wewe au mtoto wako una maswali yoyote, unaweza kuwasiliana na watafiti wa:

Brenda Wanjiru Gutu, +254707154099, [brendagutu@students.uonbi.ac.ke](mailto:brendagutu@students.uonbi.ac.ke)

Ikiwa una maswali yoyote kuhusu haki za mtoto wako kama mshiriki katika utafiti huu, unaweza kuwasiliana na ofisi inayofuata:

Kamati ya Uchunguzi wa Maadili ya KNH-UoN  
Hospitali ya Taifa ya Kenyatta

Sanduku La Posta 20723 (00202)

Nairobi, Kenya

Simu: +254 (020) 2726300 - 44355

Barua pepe: uonknh\_erc@uonbi.ac.ke

**Mzazi / Mlinzi Ruhusa ya Kushiriki kwa Watoto katika Utafiti**

Nimesoma fomu hii na utafiti wa utafiti umeelezewa kwangu. Nimepewa nafasi ya kuuliza maswali na maswali yangu yamejibu. Ikiwa nina maswali ya ziada, nimeambiwa ni nani anayewasiliana. Ninapa ruhusa kwa mtoto wangu kushiriki katika utafiti wa utafiti ulioelezwa hapo juu na atapokea nakala ya fomu hii ya Ruhusa ya Wazazi baada ya kusaini.

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Jina la Mzazi / Mlezi wa Kisheria

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Tarehe ya Saini

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Jina la Mtu Kupata Ruhusa ya Wazazi

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Tarehe ya Saini



## **Appendix III: Written Assent for Adolescents 12-17 Years**

### **Title of Research Study:**

Effects of Perceived Stigma on Psychological Wellness and Interpersonal Relationships of Adolescents with HIV/AIDS in Ruiru Sub-County Hospital

**Investigator:** Brenda Wanjiru Gutu

### **Why should I participate?**

This study is important since it will help to find a better way to treat people and understand the society in a better perspective. You are eligible for participation since you are aged between 12 & 19 years and have come to the clinic today.

### **Anything I need to be aware of in a research study?**

The researcher cannot force you to participate in the study. The decision to be a respondent is solely yours. Should you want to disengage from it even after agreeing, you are free to do so and nothing will happen to you. You are free to enquire about anything that is not clear to you.

### **What is the motive behind this study?**

I would like to understand how people, like you for instance, consider about how other people view you and how it makes you feel about yourself and how you relate with others.

### **How much time will it take?**

Your involvement in this research study will last 30 minutes.

### **What if I say “Yes, I want to be in this research”?**

If you are comfortable and consent to join this study, you will be asked to fill the questions that you shall be given.

### **What might be the disadvantage of this study to me?**

The research study might make you feel like your privacy is being affected

### **Any measures to secure the information collected for the study?**

We will be careful to ensure that nobody accesses your personal information, including research study records. However, I encourage you to allow us to share it with other health care professionals who are treating you. They also may not release any information about you without your written permission. If you require further psychological care, you shall be referred to the peer counselor:

Mr. Johnson Mutuku, +254716276882, [mutukujohnson@yahoo.com](mailto:mutukujohnson@yahoo.com)

**Person to reach?**

If you have enquiries, concerns, or complaints, regarding the study, talk to the researcher at **07071540999**.

**Signature for Child Assent/ Consent**

---

Signature of child \_\_\_\_\_ Date \_\_\_\_\_

**BRENDA WANJIRU GUTU**

---

Printed name of person obtaining assent \_\_\_\_\_ Date \_\_\_\_\_

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Signature of person obtaining assent \_\_\_\_\_

## **Appendix IV: Written Consent for Adolescents 18-19 Years**

### **Title of Research Study:**

Effects of Perceived Stigma on Psychological Wellness and Interpersonal Relationships of Adolescents with HIV/AIDS in Ruiru Sub-County Hospital

**Investigator:** Brenda Wanjiru Gutu

### **Why am I being asked to take part in this research study?**

A research study is usually done to find a better way to treat people or to understand how things work. You are being asked to take part in this research study because you are between 12 and 19 years old and have come to the clinic today.

### **What should I know about a research study?**

You do not have to be in this study if you do not want to do so. It is up to you if you want to participate. You can choose not to take part now and change your mind later if you want. Your decision will not be held against you. You can ask all the questions you want before you decide.

### **Why is this research being done?**

In this study, I want to find out more about how you think other people view you and how it makes you feel about yourself and how you relate with others.

### **How long will the research last?**

Your participation in this research will last 30 minutes.

### **What happens if I say “Yes, I want to be in this research”?**

If it is okay with you and you agree to join this study, you will be asked to fill the questions that you shall be given.

### **Is there any way being in this study could be bad for me?**

This study might make you feel like your privacy is being affected

### **What happens to the information collected for the research?**

Efforts will be made to ensure nobody accesses your personal information, including research study records. However, I encourage you to allow us to share it with other health care professionals who are treating you. They also may not release any information about you without your written permission. If you require further psychological care, you shall be referred to the peer counselor:

Mr. Johnson Mutuku, +254716276882, [mutukujohnson@yahoo.com](mailto:mutukujohnson@yahoo.com)

**Who can I talk to?**

If you have questions, concerns, or complaints, about the research, talk to the researcher at **07071540999**.

**Signature for Child Assent/ Consent**

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Signature of child \_\_\_\_\_ Date \_\_\_\_\_

**BRENDA WANJIRU GUTU**

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Printed name of person obtaining assent \_\_\_\_\_ Date \_\_\_\_\_

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Signature of person obtaining assent \_\_\_\_\_

## **Appendix V: Ridhaa Imeandikwa**

### **Kichwa cha Utafiti:**

Athari za Udanganyifu Unaojulikana juu ya Ustawi wa Kisaikolojia na Uhusiano wa Mahusiano ya Vijana wenye VVU / UKIMWI katika Hospitali ya Ruiru Sub-County

**Mtafiti:** Brenda Wanjiru Gutu

### **Kwa nini ninaombwa kuingilia katika utafiti huu wa utafiti?**

Utafiti wa utafiti unafanywa kwa kawaida ili kupata njia bora ya kutibu watu au kuelewa jinsi mambo yanavyofanya kazi. Unastahili kushiriki katika utafiti huu wa utafiti kwa sababu uko kati ya umri wa miaka 12 na 19 na umekuja kliniki leo.

### **Ninajua nini kuhusu utafiti wa utafiti?**

Huna budi kuwa katika utafiti huu ikiwa hutaki kufanya hivyo. Ni juu yako ikiwa unataka kushiriki. Unaweza kuchagua kutoshiriki sasa na kubadili mawazo yako baadaye ikiwa unataka. Uamuzi wako hautafanyika dhidi yako. Unaweza kuuliza maswali yote unayotaka kabla ya kuamua.

### **Kwa nini utafiti huu unafanyika?**

Katika utafiti huu, nataka kujua zaidi kuhusu jinsi unavyofikiri watu wengine wanakuona na jinsi inakufanya ujisikie juu yako mwenyewe na jinsi unavyohusiana na wengine.

### **Utafiti utaendelea muda gani?**

Ushiriki wako katika utafiti huu utaendelea dakika 30.

### **Ni nini kinachotokea ikiwa nikisema "Ndiyo, nataka kuwa katika utafiti huu"?**

Ikiwa ni sawa na wewe na unakubali kujiunga na utafiti huu, utaulizwa kujaza maswali ambayo utapewa.

### **Je, kuna njia yoyote kuwa katika utafiti huu inaweza kuwa mbaya kwangu?**

Utafiti huu unaweza kukufanya uhisi kama faragha yako imeathirika

### **Je, kinachotokea kwa taarifa zilizokusanywa kwa utafiti?**

Jitihada zitafanywa ili kuhakikisha hakuna mtu anayepata maelezo yako ya kibinafsi, ikiwa ni pamoja na kumbukumbu za utafiti. Hata hivyo, mimi kukuhimiza kuruhusu sisi kushiriki na wataalamu wengine wa afya wanaokutenda. Pia hawawezi kutoa taarifa yoyote kuhusu wewe bila ruhusa yako binafsi.

Ikiwa unadhaniwa kuwa unahitaji huduma ya kisaikolojia, utatumwa kwa mshauri wa rika:

Mheshimiwa Johnson Mutuku

+254716276882

[mutukujohnson@yahoo.com](mailto:mutukujohnson@yahoo.com)

**Nani ninayeweza kuzungumza naye?**

Ikiwa una maswali, wasiwasi, au malalamiko, kuhusu utafiti, jadiliana na mtafiti kwa:  
**07071540999.**

**Saini ya Kuthibitisha Kibali**

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Saini ya mtoto

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Tarehe

BRENDA WANJIRU GUTU

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Jina la kuchapishwa la mtu anayepata  
kukubali

---

Tarehe ya

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Saini ya mtu kupata kibali

## Appendix VI: Questionnaire

### A QUESTIONNAIRE CONSISTING: PERCEIVED STIGMA SCALE, PSYCHOLOGICAL GENERAL WELL-BEING INDEX (PGWBI) AND THE EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED (ECR-R) QUESTIONNAIRE

Date: \_\_\_\_\_

Participant ID \_\_\_\_\_

#### INSTRUCTIONS

1. Some of the questions will seem quite personal; but it is important that you answer them honestly because the information is strictly confidential/ secret.
2. DO NOT write your name.

#### SECTION A: BASIC INFORMATION

Please tick one answer.

1. I am  Male  Female
2. How old are you? .....
3. I am a.....  Christian  Muslim  Hindu
4. Do you attend school?  Yes  No
5. If not, which class did you reach in school? Standard ..... Form .....
6. With whom do you live with?  Alone  Family
7. Are you married ?  Yes  No
8. Are you employed?  Yes  No
9. If not employed, what do you do?.....
10. Have you ever been tested for HIV/AIDS?  Yes  No
11. If yes, have you ever told someone about your HIV status?  Yes  No
12. Is your family aware of your positive status?  Yes  No
13. If yes, does your family give you emotional support?  Yes  No
14. Do your friends know your positive HIV status?  Yes  No
15. If yes, do your friends give you emotional support?  Yes  No
16. How often do you attend hospital ?  Once a week  Two times a week  Other.....
17. What type of support do you receive from hospital ?.....

**SECTION B (I) : PSYCHOLOGICAL GENERAL WELL-BEING INDEX (PGWBI)**

READ: This section of the questionnaire contains questions about how you feel and how things have been going for you over the past month. For each question tick  the answer which best applies to you.

**1. How have you been feeling in general during the past month?**

- In excellent spirits     In very good spirits     In good spirits mostly  
 I have been up and down in spirits a lot     In low spirits mostly In very low spirits

**2. How often were you bothered by any illness, infirmity, aches or pains during the past month?**

- Every day     Almost every day     About half of the time  
 Now and then, but less than half the time     Rarely     None of the time

**3. Did you feel depressed during the past month?**

- Yes - to the point where I felt like killing myself  
 Yes - to the point where I did not care about anything  
 Yes - very depressed almost every day  
 Yes - quite depressed several times  
 Yes - a little depressed now and again  
 No - never felt depressed at all

**4. Have you been in firm control of your behaviour, thoughts, emotions or feelings during the past month?**

- Yes, definitely so     Yes, for the most part     Generally so  
 Not too well     No, and I am somewhat disturbed     No, and I am very disturbed

**5. Have you been bothered by nervousness or your "nerves" during the past month?**

- Extremely so - to the point where I could not work or take care of things     Very much so  
 Quite a bit     Somewhat - enough to bother me     A little     Not at all

**6. How much energy or vitality did you have or feel during the past month?**

- Very full of energy - lots of vitality     Fairly energetic most of the time  
 My energy level varied quite a bit     Generally low in energy or vitality



- Very low in energy or vitality most of the time
- No energy or vitality at all - I felt drained, sapped

**7. I felt downhearted and low during the past month**

- None of the time                       A little of the time                       Some of the time
- A good bit of the time                       Most of the time                       All of the time

**8. Were you generally tense or did you feel any tension during the past month?**

- Yes - extremely tense most or all of the time                       Yes - very tense most of the time
- Not generally tense, but did feel fairly tense several times
- I felt a little tense a few times                       My general tension level was quite low
- I never felt tense or any tension at all

**9. How happy, satisfied or pleased have you been with your personal life during the past month?**

- Extremely happy - could not have been more satisfied or pleased
- Very happy most of the time                       Generally satisfied - pleased
- Sometimes fairly happy, sometimes fairly unhappy                       Generally dissatisfied or unhappy
- Very dissatisfied or unhappy most or all the time

**10. Did you feel healthy enough to carry out things you like to do or had to do during the past month?**

- Yes - definitely so
- For the most part
- Health problems limited me in some important ways
- I was only healthy enough to take care of myself
- I needed some help in taking care of myself
- I needed someone to help me with most or all of the things I had to do

**11. Have you felt so low, discouraged or hopeless, or had so many problems that you wondered if anything was worthwhile during the past month?**

- Extremely so - to the point where I have just about given up                       Very much so
- Quite a bit                       Somewhat - enough to bother me                       A little bit                       Not at all

**12. I woke up feeling fresh and rested during the past month.**

- None of the time                       A little of the time                       Some of the time
- A good bit of the time                       Most of the time                       All of the time

**13. Have you been concerned or worried, or had any fears about your health during the past month?**

- Extremely so                                       Very much so                                       Quite a bit  
 Some, but not a lot                                       Practically never                                       Not at all

**14. Have you had any reason to wonder if you were losing your mind or your memory or losing control over the way you act, talk, think or feel during the past month?**

- Not at all       Only a little       Some - but not enough to be concerned or worried about  
 Some - and I have been a little concerned                       Some - and I am quite concerned  
 Yes, very much so and I am very concerned

**15. My daily life was full of things that were interesting to me during the past month.**

- None of the time                                       A little of the time                                       Some of the time  
 A good bit of the time                                       Most of the time                                       All of the time

**16. Did you feel active, vigorous, or dull, sluggish during the past month?**

- Very active, vigorous every day  
 Mostly active, vigorous - never really dull, sluggish  
 Fairly active, vigorous - seldom dull, sluggish  
 Fairly dull, sluggish - seldom active, vigorous  
 Mostly dull, sluggish - never really active, vigorous  
 Very dull, sluggish every day

**17. Have you been anxious, worried or upset during the past month?**

- Extremely so - to the point of being sick or almost sick       Very much so  
 Quite a bit       Somewhat - enough to bother me       A little bit       Not at all

**18. I was emotionally stable and sure of myself during the past month.**

- None of the time                                       A little of the time                                       Some of the time  
 A good bit of the time                                       Most of the time                                       All of the time

**19. Did you feel relaxed, at ease or tense, on edge or wound up during the past month?**

- Felt relaxed, at ease the whole month  
 Felt relaxed, at ease most of the time  
 Generally felt relaxed but at times felt fairly on edge  
 Generally felt tense but at times felt fairly relaxed

Felt tense, on edge or wound up most of the time

Felt tense, on edge or wound up the whole month

**20. I felt cheerful, light-hearted during the past month.**

None of the time

A little of the time

Some of the time

A good bit of the time

Most of the time

All of the time

**21. I felt tired, worn out, used up or exhausted during the past month.**

None of the time

A little of the time

Some of the time

A good bit of the time

Most of the time

All of the time

**22. Have you been under or felt you were under any strain, stress or pressure during the past month?**

Yes - almost more than I could bear or stand

Yes - quite a bit of pressure

Yes, some - more than usual

Yes, some - but about usual

Yes - a little

Not at all

**SECTION B (II): THE EXPERIENCES IN CLOSE RELATIONSHIPS-REVISED (ECR-R) QUESTIONNAIRE**

This questionnaire measures how you feel about others. Please tick one answer.

Are the following statements like what you feel?	Very Strongly Agree	Strongly Agree	Agree	Not Sure	Disagree	Strongly Disagree	Very Strongly Disagree
I'm afraid that I will lose the love of the people close to me							
I often worry that people close to me will not want to stay with me							
I often worry that people close to me don't really love me							
I worry that people close to me won't care about me as much as I care about them.							
I worry a lot about my relationships							
When I show my feelings for people close to me, I'm afraid they will not feel the same about me							
I rarely worry about people close to me leaving me							

People close to me make me doubt myself							
I do not often worry about being abandoned							
I find that people close to me don't want to get as close as I would like							
Sometimes people close to me change their feelings about me for no apparent reason							
My desire to be very close sometimes scares people away							
I'm afraid that once people get to know me, he or she won't like who I really am							
It makes me mad that I don't get the affection and support I need from people close to me							
I worry that I won't measure up to other people							

	<b>Very Strongly Agree</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>Very Strongly Disagree</b>
People close to me only seem to notice me when I'm angry							
I prefer not to show people close to me how I feel deep down							
I feel comfortable sharing my private thoughts and feelings with people close to me							
I find it difficult to allow myself to depend on people close to me							
I am very comfortable being close to people around me							

I don't feel comfortable opening up to people close to me							
I prefer not to be too close to people around me							
I get uncomfortable when people close to me want to be very close							
I find it relatively easy to get close to people around me							
It's not difficult for me to get close to people around me							
I usually discuss my problems and concerns with people close to me							
It helps to turn to people close to me in times of need							
I tell people close to me just about everything							
I talk things over with people close to me							
I am nervous when people around me get too close to me							
I feel comfortable depending on people close to me							
I find it easy to depend on people close to me							
It's easy for me to be affectionate with people close to me							
People close to me really understand me and my needs							

**SECTION B (III): PERCEIVED STIGMA SCALE**

This scale is to examine about perceived stigma or how people view those who are different from them. Please tick one box.

<b>Are the following statements like what you feel?</b>	<b>Very Strongly Agree</b>	<b>Strongly Agree</b>	<b>Agree</b>	<b>Not Sure</b>	<b>Disagree</b>	<b>Strongly Disagree</b>	<b>Very Strongly Disagree</b>
Most people would willingly accept someone living with HIV/AIDS as a close friend							

Most people believe that a person living with HIV/AIDS is just as intelligent as the average person							
Most people believe that someone living with HIV/AIDS is just as trustworthy as the average citizen							
Most people would accept someone living with HIV/AIDS as a teacher of young children in a school							
Most people feel that being diagnosed with HIV/AIDS is NOT a sign of personal failure							
Most people do not think less of a person living with HIV/AIDS							
Most people in the community would treat someone living with HIV/AIDS just as they would treat anyone else							
Most people would be willing to date someone living with HIV/AIDS							
Once they know a person has HIV/AIDS most people will still value his or her opinions							

Any other comments

.....

.....

.....

.....

.....

**Thank you for taking part in this study**

**Appendix VII: National Commission for Science, Technology and Innovation Research Clearance Permit**

**THIS IS TO CERTIFY THAT:**  
**MS. BRENDA WANJIRU GUTU**  
of UNIVERSITY OF NAIROBI, 0-20303  
OLKALOU, has been permitted to  
conduct research in *Kiambu County*

on the topic: **EFFECTS OF PERCEIVED  
STIGMA ON THE PSYCHOLOGICAL  
WELLNESS AND INTERPERSONAL  
RELATIONSHIPS OF ADOLESCENTS  
LIVING WITH HIV/AIDS IN RUIRU,  
KIAMBU COUNTY**

for the period ending:  
**25th January, 2019**

  
.....  
**Applicant's  
Signature**


Permit No : NACOSTI/P/18/41623/20921  
Date Of Issue : 25th January, 2018  
Fee Received : Ksh 1000




  
.....  
**Director General  
National Commission for Science,  
Technology & Innovation**

**CONDITIONS**

1. The License is valid for the proposed research, research site specified period.
2. Both the Licence and any rights thereunder are non-transferable.
3. Upon request of the Commission, the Licensee shall submit a progress report.
4. The Licensee shall report to the County Director of Education and County Governor in the area of research before commencement of the research.
5. Excavation, filming and collection of specimens are subject to further permissions from relevant Government agencies.
6. This Licence does not give authority to transfer research materials.
7. The Licensee shall submit two (2) hard copies and upload a soft copy of their final report.
8. The Commission reserves the right to modify the conditions of this Licence including its cancellation without prior notice.

  
**REPUBLIC OF KENYA**

  
**National Commission for Science,  
Technology and Innovation**

**RESEARCH CLEARANCE  
PERMIT**

Serial No.A **17252**  
CONDITIONS: see back page



**Appendix VIII: Home Institution Research Authorization**



**UNIVERSITY OF NAIROBI**

FACULTY OF ARTS  
DEPARTMENT OF PSYCHOLOGY

Telegrams: Varsity Nairobi  
Telephone: 3318262 ext.28439  
Telex: 22095

P.O. BOX 30197  
NAIROBI  
KENYA

September 18, 2017


TO WHOM IT MAY CONCERN

**RE: BRENDA W. GUTU- C50/82658/2015**

The above named is a student in the Department of Psychology undertaking a Masters degree in Community Psychology at the University of Nairobi. She is doing a project on "***Relationship among perceived stigma, Psychological wellness and quality of interpersonal relationships among teenagers living with HIV/AIDS***". The requirement of this course is that the student must conduct research thesis in the field and write a Project.

In order to fulfill this requirement, I am introducing to you the above named student for you to kindly grant her permission to collect data for her Masters Degree Project.

Yours Sincerely,

  
Date: \_\_\_\_\_  
**Dr. Luke Odieno**  
Chairman,  
Department of Psychology

## Appendix VIII: KNH-UoN Ethics Research Approval



UNIVERSITY OF NAIROBI  
COLLEGE OF HEALTH SCIENCES  
P O BOX 19676 Code 00202  
Telegrams: varsity  
Tel: (254-020) 2726300 Ext 44355

### KNH-UON ERC

Email: [uonknh\\_erc@uonbi.ac.ke](mailto:uonknh_erc@uonbi.ac.ke)  
Website: <http://www.erc.uonbi.ac.ke>  
Facebook: <https://www.facebook.com/uonknh.erc>  
Twitter: @UONKNH\_ERC [https://twitter.com/UONKNH\\_ERC](https://twitter.com/UONKNH_ERC)



KENYATTA NATIONAL HOSPITAL  
P O BOX 20723 Code 00202  
Tel: 726300-9  
Fax: 725272  
Telegrams: MEDSUP, Nairobi

Ref: KNH-ERC/A/265

July 11 2018

Brenda W. Gutu  
Reg. No. C50/82658/2015  
Dept. of Psychology-Faculty of Arts  
College of Humanities and Social Sciences  
University of Nairobi

Dear Brenda

### RESEARCH PROPOSAL – THE EFFECTS OF PERCEIVED STIGMA ON PSYCHOLOGICAL WELLNESS AND INTERPERSONAL RELATIONSHIPS OF ADOLESCENTS WITH HIV/AIDS IN RUIRU SUB-COUNTY, KIAMBU COUNTY, KENYA (P55/02/2018)

This is to inform you that the KNH- UoN Ethics & Research Committee (KNH- UoN ERC) has reviewed and **approved** your above research proposal. The approval period is from 11<sup>th</sup> July 2018 – 10<sup>th</sup> July 2019.

This approval is subject to compliance with the following requirements:

- a) Only approved documents (informed consents, study instruments, advertising materials etc) will be used.
- b) All changes (amendments, deviations, violations etc) are submitted for review and approval by KNH-UoN ERC before implementation.
- c) Death and life threatening problems and serious adverse events (SAEs) or unexpected adverse events whether related or unrelated to the study must be reported to the KNH-UoN ERC within 72 hours of notification.
- d) Any changes, anticipated or otherwise that may increase the risks or affect safety or welfare of study participants and others or affect the integrity of the research must be reported to KNH- UoN ERC within 72 hours.
- e) Clearance for export of biological specimens must be obtained from KNH- UoN ERC for each batch of shipment.
- f) Submission of a request for renewal of approval at least 60 days prior to expiry of the approval period. (*Attach a comprehensive progress report to support the renewal*).
- g) Submission of an *executive summary* report within 90 days upon completion of the study. This information will form part of the data base that will be consulted in future when processing related research studies so as to minimize chances of study duplication and/ or plagiarism.

Protect to discover

## Appendix VIII: KNH-UoN Ethics Research Approval

### COUNTY GOVERNMENT OF KIAMBU DEPARTMENT OF HEALTH SERVICES

All correspondence should be addressed to  
HEAD HRDU - HEALTH DEPARTMENT  
Email address: [mdiritu@gmail.com](mailto:mdiritu@gmail.com)  
[mkwasa@five.com](mailto:mkwasa@five.com)  
Mobile: 0721641516  
0721974633



HEALTH RESEARCH AND DEVELOPMENT  
UNIT  
P. O. BOX 2344 - 00900  
KIAMBU

Ref. No: KIAMBU/HRDU/AUTHO/2018/08/13/Gutu BW

Date: 13 Aug 2018

TO WHOM IT MAY CONCERN,

**RE: CLEARANCE TO CONDUCT RESEARCH IN KIAMBU COUNTY**

Kindly note that we have received a request by **Ms. Brenda W Gutu** of **University Of Nairobi** to carry out research in Kiambu County, the research topic being on *"The Effects Of Perceived Stigma On Psychological Wellness And Interpersonal Relationships Of Adolescents With HIV/AIDS In Ruiru Sub-County, Kiambu County, Kenya"*

We have duly inspected her documents and found that she has been cleared by **Kenya National Hospital - University Of Nairobi Ethical Review Committee** until **10 Jul 2019**. She thus does not need any further clearance with another regulatory body in order to conduct research within the county of Kiambu.

However, it is incumbent upon the facility in which the research is being carried out to ensure that they are conversant with the remit of the study and operate in line with their institutional norms on conducting research. This note also accords her the duty to provide feedback on her research to the county at the conclusion of her research.

A handwritten signature in black ink, appearing to read 'M. Ndiritu Ndirangu'.

**DR. M. NDIRITU NDIRANGU**  
**COUNTY HEALTH RESEARCH DEVELOPMENT UNIT**  
**KIAMBU COUNTY**