**UNIVERSITY OF EDUCATION, WINNEBA**

# EXPLORING THE CAUSES, EFFECTS AND COPING STRATEGIES AMONG ADOLESCENTS LIVING WITH HIV/AIDS IN THE NEW JUABEN SOUTH MUNICIPALITY, GHANA.

**BISMARK BUABENG**

**MASTER OF PHILOSOPHY**

**2025**

**UNIVERSITY OF EDUCATION, WINNEBA**

# EXPLORING THE CAUSES, EFFECTS AND COPING STRATEGIES AMONG ADOLESCENTS LIVING WITH HIV/AIDS IN THE NEW JUABEN SOUTH MUNICIPALITY, GHANA

**BISMARK BUABENG**
**(202142783)**

**MASTER OF PHILOSOPHY**

**A dissertation in the Department of Counselling Psychology, Faculty of Educational Studies, submitted to the School of Graduate Studies in the partial fulfilment of the requirements for the award of Master of Philosophy (Counselling Psychology) in the University of Education, Winneba**

**FEBRUARY, 2025**

## DECLARATION

### Students' Declaration

I, **Bismark Buabeng**, declare that this dissertation, except for quotations and references contained in published works which have all been identified and dully acknowledged, is entirely my original work, and it has not been submitted, either in part or whole, for another degree elsewhere.

**Signature:……**

**Date**:……

### Supervisor's Declaration

I hereby declare that the preparation and presentation of this work were supervised under the guidelines for supervision as laid down by the University of Education, Winneba.

Name of Supervisor: Prof Mathew Kojo Namale

Signature:…….

Date: ……

## DEDICATION

I dedicate this work to the Almighty God and my lovely children; Ivan Barimah-Buabeng and Othniel Yeboah Barimah-Buabeng.

**ACKNOWLEDGEMENTS**

**I am highly appreciative and indebted to my supervisor, Prof Mathew Kojo Namale, Department of Counselling Psychology for his endless encouragement, patience, wisdom, support and mentorship.**

**I am also grateful to all staff in the Counselling Unit (Voluntary Counselling and Testing Unit) of Koforidua Regional Hospital for allowing me to collect data from their clients in the unit.**

**I would like to acknowledge my wife and children for the love and support you have shown and continue to show me.**

**Another heartfelt gratitude goes to Mr Prince K. Asante for his meticulous proofreading and intellectual assistance.**

**Finally, warm gratitude goes to Mrs Alice Ofosu Obeng for her immense support in making this work a success, God richly blesses you.**

## TABLE OF CONTENT

## LIST OF TABLES

**ABSTRACT**

The study sought to explore the causes, effects and coping strategies among adolescents living with HIV/AIDS in the New Juaben South Municipality. A qualitative research design was adopted for the study. A purposive sampling method was used to select a sample of 13 participants for the study. A self-developed interview guide was used to collect data for the study. Thematic analysis was used after verbatim responses were transcribed and themes were used for the data analysis. The study found that misinformation about HIV transmission fuels stigma among adolescents, leading to confusion, judgment, and emotional distress due to their . HIV/AIDS status. Many wrongly associate HIV with promiscuity or unsafe behavior, even when infections occur through birth. Also, it was realised that participants experienced emotional stress. The study revealed that victims of HIV/AIDS sought counselling services as a coping strategy. It was, therefore, recommended that to prevent perinatal transmission of HIV/AIDS, lactating mothers who are HIV positive should stop breastfeeding their babies and resort to the use of complementary foods.

# CHAPTER ONE

# INTRODUCTION

## 1.0 Background of the Study

About 1.5 million of the 1.8 million adolescents with HIV predicted to be geographically widespread in 2020 reside in sub-Saharan Africa (Kaunda-Khangamwa et al., 2020). Evidence suggests that they have the worst undetectable viral load and medication compliance, as well as greater fatality rates (Kemigisha et al., 2019; Foster et al., 2021). More so, this population is still among those most at risk for HIV infections (Schuyler et al., 2017). This has compelled world authorities, including the United Nations, World Health Organization, and local and other international organizations, to bring the rate of infection to a declining trend. However, Okumu et al. (2020) maintain that the progress toward eradicating AIDS as a public health issue by 2030 is jeopardized by the rising number of adolescents living with HIV/AIDS worldwide and their poor virologic results.

The literature on HIV/AIDS in Africa and Ghana highlights its causes, effects, and coping mechanisms. HIV/AIDS remains a significant health challenge in Africa, with two-thirds of new infections occurring on the continent, primarily through heterosexual transmission (Huynh et al., 2024). In Ghana, an estimated 150,000 people were infected in 2014, with the highest prevalence in the Eastern Region (Avornyo, 2013). The epidemic negatively impacts economic growth, contributing to GDP declines and increasing healthcare costs (Haacker, 2009; Over, 2004). At the household level, HIV/AIDS leads to financial instability, food insecurity, and deepening poverty, particularly in female-headed and asset-poor households (Laar, 2015). Coping strategies often include reducing food intake, begging, or adopting cognitive restructuring strategies influenced by education and family support (Dake,

2023). The epidemic also exacerbates poverty, as seen in South Africa and Botswana, where HIV/AIDS-related income shocks push households into chronic poverty (Booysen, 2004; Greener, 2004). Furthermore, it strains extended families, reduces labour supply, and disrupts intergenerational knowledge transfer, affecting long-term development (Commission on HIV/AIDS and Governance in Africa, 2008). The impact on food security is particularly severe in agriculture-dependent households, leading to declines in production and shifts in land-use patterns (de Waal & Whiteside, 2003; Nguthi & Niehof, 2008). While some argue that the effects are household-specific, others emphasize the broader socio-political and economic structures that perpetuate inequality and hunger, intensifying the impact of HIV/AIDS beyond the immediate household level (Ansell et al., 2009). Addressing these challenges requires a multifaceted approach that combines healthcare, economic support, and policy interventions to mitigate the epidemic's far-reaching consequences.

HIV care, especially adherence to antiretroviral medication (ART) and retention in care is negatively impacted by stigma connected to the virus (Gesesew et al., 2017). Consistently, Feyissa et al. (2020) note that although there have been advances in the global response to the pandemic, increased access to antiretroviral therapy or medication (ART), and a decline in infection rates worldwide, HIV stigma and discrimination remain major issues on a global scale. The effects of stigmatization on an individual's identity can occur on both an intrapersonal and an interpersonal level. Families, communities, and healthcare facilities stigmatize and discriminate against persons living with HIV in resource-constrained environments like Vietnam, Indonesia, and Thailand (Mathew et al., 2020; Mahamboro et al., 2020; Fauk et al., 2021). In a countrywide study of over 10,000 South Africans, 36% said they had

experienced discrimination and 43% said they had internalized HIV stigma in the previous year (Pantelic et al., 2020).

According to the UNAIDS factsheet, "HIV-related stigma" refers to any stigma and discrimination, including those based on sex, gender identity, sexual orientation, drug use, sex work, and HIV status, that affects the HIV response. Numerous stigmatizing behaviours, such as avoidance behaviours, rumours, verbal abuse, and social rejection, are associated with HIV stigma" (UNAIDS, 2021). Adolescents with HIV experience several forms of stigma, including "enacted, expected, and internalized" stigma, as well as discrimination in their households, neighbourhoods, and schools (Shenderovich et al., 2021; Levy et al., 2021). Adolescents living with HIV/ AIDS (ALWHIV) may individually encounter enacted stigma in the form of prejudice, exclusion, or discrimination because of their HIV condition (Kip et al., 2022).

According to Pantelic et al. (2015), internalized stigma can cause emotions of guilt, humiliation, hopelessness, and, in rare instances, suicidal thoughts. Internalized stigma, which causes people to feel that the negative preconceptions about their identity are true of them, has been linked to psychological suffering in persons with HIV/AIDS, including poor self-esteem, sadness, and helplessness (Williams et al., 2020). These are a consequence of their cognitive processing based on the understanding that they are social outcasts who could have transgressed social norms and are exposed to discrimination from other individuals (Kimera et al., 2020). Further, HIV/AIDS stigma is "the prejudicial feelings, stereotypical perceptions, discriminatory behaviours and actions, or social devaluation of HIV infection, HIV/AIDS-related illnesses, the activities associated with HIV infection, and people with HIV" (Vorasane et al., 2017, p, 45). There have been reports that the major

causes of HIV stigma and discrimination in these contexts include the fear of catching HIV through physical, social, and healthcare-related encounters and interactions, as well as ignorance regarding how HIV is spread (Mahamboro et al., 2020).

According to Nöstlinger et al. (2014), discrimination differs from stigma in that it is more common for other individuals to engage in discriminating behaviour than the stigmatized individual. Discrimination occurs when someone is openly treated differently from others because of their HIV status (Earnshaw and Chaudoir, 2016). "Discrimination can take many different forms, such as physical abuse, denial of social or health assistance, loss of work or educational prospects, incarceration, and the aforementioned stigmatizing behaviours when they interfere with the exercise of rights. Additionally, it may be codified in criminal laws, travel limits, testing requirements, and job limitations. People may encounter intersectional prejudice or stigma based on a variety of factors, such as race, infirmity, and social class" (UNAIDS, 2021) In a joint United Nations Programme on HIV/AIDs study published in 2017, one in eight persons living with HIV are refused access to health care due to stigma and discrimination.

As cited by Levy et al. (2021), African states pledged to fight all kinds of discrimination against PLWHA during the United Nations (UN) General Assembly Special Session on HIV/AIDS in 2001. The UN then unveiled the "Getting to Zero" campaign in 2011. The initiative's objectives were to eradicate new HIV infections, stigma, and AIDS-related fatalities by the year 2030, acknowledging the critical role that stigma reductions and infection rates must play in achieving this ambitious goal. While there has been progress, it is doubtful that zero targets will be attained since

HIV/AIDS-related stigma and discrimination are difficult to eradicate purely through top-down measures and messaging campaigns (Parkhurst 2014).

Due to the complexity of navigating these issues in the context of a highly stigmatized and potentially fatal illness, adolescents living with HIV/AIDS confront severe psychological obstacles as a result of the aforementioned. Therefore, most adolescents may use a variety of techniques to cope with the effects of stigma and discrimination as they experience it. Coping is the process of being ready to identify and respond in ways that support survival to environmental demands (Berardi, 2019). Skinner and Zimmer-Gembeck (2016) argue that physiological, psychological, and social factors all play a significant role in coping. They went on to say that coping is influenced by several aspects of psychological functioning, including emotions, motivation, attention, volition, cognition, and communication. Coping requires immediate action, whereas meeting requests entail a drawn-out succession of precise real-time transactions. How people cope, as well as the social and personal resources they draw upon to do so, alters significantly during development (Skinner et al., 2016).

One of the most important decisions is frequently whether to reveal one's HIV status. As a frequent strategy, non-disclosure restricts YLHIV's access to social support, which may harm Antiretroviral therapy (ART) adherence and care participation (Evangeli &Wroe, et al., 2017). Reviews have demonstrated that disclosure increased trust in a marriage, access to treatment, financial assistance, psychological well-being, and emotional relief to promote ART adherence. Thoughtful self-disclosure, according to Evangeli and Wroe (2017), could help individuals cope with stigma by enabling them to address responses personally and on their conditions and may also lead to social support. Nevertheless, research also discovered that disclosure was linked to reporting internalized stigma, enacted stigma, isolation, anxiety, and depressive symptoms (Gabbidon et al., 2020). Health outcomes for PLHIV may be

harmed by avoiding seeking medical attention and by fearing social stigma when HIV status is revealed (Tran et al., 2022). Despite the perceived threat still existing, avoidance as a coping mechanism may be beneficial in the short term (Tran et al., 2022).

The Disclosure Processes Model (DPM) paradigm explains the decision-making processes that lead to disclosure or non-disclosure as well as the mediating processes that reduce inhibition, foster social support, and alter social information (Chaudoir and Fisher, 2019). According to this concept, those who choose an avoidance attitude may decide not to inform others they are HIV positive (Tran, Vu, Susa, and DeSilva, 2022). Pinho et al. (2017), suggest that adolescents living with AIDS must learn coping mechanisms to lessen the psychological discomfort caused by all the challenges associated with this condition. Coping mechanisms are ideas and actions that people employ to arrange the internal and external demands of a certain stressful event or situation (Silva, Moura and Pereir, 2017). They are affected by sociodemographic, personal, social, and environmental factors (Murray et al., 2017).

HIV disclosure statistics differ from low to high depending on the nation, customs, and sociodemographic characteristics. For example, studies in Cape Coast, Ghana, discovered that 78.6% of 510 respondents revealed their HIV status to at least one person (Obiri-Yeboah et al., 2015). In Cape Town, South Africa, 995 women recorded a 95% disclosure rate (Brittain et al., 2018), whereas 507 PLWHA in Kenya reported an 83.7% rate (Colombini, James, Ndwiga, Team & Mayhew, 2016). Conversely, lower levels of HIV status disclosures (33.3%) were observed in the Lower Manya Krobo district (Gyamfi, Okyere, Appiah-Brempong, Adjei, &Mensah,

2015); in the Eastern Region of Ghana, with both Accra and Kumasi (16.2%) among quasi group participants (Paintsil, Kyriakides, & Antwi, 2016).

## 1.1 Statement of the Problem

**Problem Statement**

**HIV/AIDS remains a significant public health concern in Ghana, with adolescents facing unique challenges due to stigma and discrimination. By the end of 2018, approximately 334,713 individuals in Ghana were living with HIV, with 19,931 new infections recorded that year, resulting in an overall HIV prevalence of 1.69% (GAC, 2019). In 2020, over 19,000 new cases were reported, with 28% of infections occurring among individuals aged 15 to 24 (GAC, 2020). While the prevalence among this age group declined from 1.5% in 2017 and 2018 to 0.7% in 2020, the persistence of new infections remains a major concern. Adolescents, particularly those living with HIV (ALHIV), are among the most vulnerable to the social consequences of their condition, including stigma, discrimination, and psychological distress.**

**The stigma associated with HIV/AIDS is deeply entrenched in Ghanaian society, often fuelled by misconceptions, cultural beliefs, and fear of contagion (Anafi et al., 2014; Armstrong-Mensah et al., 2023). Individuals living with HIV frequently experience social isolation, rejection by family and friends, discrimination in educational and employment settings, and emotional distress (Ayieko, 2020; SeyedAlinaghi et al., 2023). A study by Armstrong-Mensah et al. (2023) found that stigma in Ghana is primarily driven by ignorance (70.5%),**

**fear of contracting HIV (30%), and negative societal attitudes, with 70% of respondents stating that derogatory comments about HIV testing contribute to stigma. Moreover, 24.3% of participants even believed that individuals with HIV "deserve" their condition due to their choices.**

**The consequences of stigma are profound. Dake et al. (2023) reported that 81.8% of adolescents in Accra admitted to experiencing stigma and discrimination, aligning with findings from Armstrong-Mensah et al. (2023) in Kumasi, where 90.6% of adolescents reported stigma-related challenges. Such experiences contribute to feelings of depression, shame, emotional distress, and reluctance to seek healthcare services. Stigma also negatively affects treatment adherence, with 92.8% of participants in Armstrong-Mensah et al. (2023) acknowledging that stigma-related challenges impact their willingness to seek HIV treatment and care.**

**Despite various interventions aimed at reducing stigma, their effectiveness has been limited. Public health campaigns, including awareness programmes and anti-stigma initiatives, have been launched by the Ghana AIDS Commission (GAC) and non-governmental organizations (NGOs) to promote inclusivity and acceptance of people living with HIV (PLHIV). However, these efforts have yielded minimal results, as deep-seated cultural beliefs and societal biases persist. The National HIV and AIDS Strategic Plan (2016–2020) aimed to reduce stigma through educational outreach, yet reports indicate that stigma remains a major barrier to HIV prevention and treatment efforts (GAC, 2020). Furthermore, the implementation of counselling services and peer-support programs has been inconsistent due to resource constraints, limiting their reach and impact on adolescents living with HIV.**

**Moreover, the role of institutional support systems in addressing stigma remains inadequate. The National AIDS Control Programme (NACP) faces challenges in meeting its goals due to resource constraints, while the Ministry of Health lacks a** clearly defined budget for addressing HIV/AIDS-related psychosocial challenges. As a result, adolescents living with HIV often have limited access to counselling and support systems that could help them cope effectively with stigma and discrimination. The Ghana Demographic and Health Survey (2014) highlighted the extent of negative societal attitudes toward people living with HIV/AIDS (PLWHA), with only 14% of men and 8% of women expressing positive attitudes toward PLWHA (GSS-GHS, 2015). Such findings underscore the persistent stigma that adolescents must navigate daily, exacerbating their psychological and social vulnerabilities. UNICEF (2017) has emphasized that adolescents living with HIV share the same aspirations as their peers but face significant psycho-social obstacles. Without targeted interventions that address stigma, enhance coping mechanisms, and improve support systems, ALHIV will continue to face severe barriers to well-being and personal development.

The aforementioned challenges illustrate the circumstances of seropositive adolescents in Koforidua, particularly in the New Juaben Municipality, where HIV-related stigma remains a pressing issue. Many of these adolescents struggle with social rejection, lack of emotional support, and limited access to effective coping mechanisms. Despite awareness campaigns and stigma-reduction programs, the entrenched biases within communities continue to affect their daily lives, mental health, and treatment adherence. Therefore, this study, conducted in the New Juaben Municipality, Koforidua, seeks to explore the causes of stigma, the coping strategies adopted by adolescents living with HIV, and the demographic and social factors influencing these strategies. By addressing this knowledge gap, the research aims to

provide insights that can inform the design of stigma-reduction preprogrammed psychosocial interventions tailored to the unique needs of ALHIV in Ghana. A deeper understanding of coping mechanisms can contribute to policies and interventions that empower adolescents to navigate stigma more effectively while improving their mental health and overall well-being.

### 1.2 Purpose of the Study

This study explores the causes, effects, and coping strategies adopted by adolescents living with HIV/sAIDS in New Juaben South Municipality.

### 1.3 Research of Objectives

The objectives of the study are to:

1. **Examine the causes of HIV/AIDS on Adolescents Living With HIV (ALWHIV) in the New Juaben South Municipality.**
2. **Explore the coping strategies adopted by adolescents living with HIV/AIDS in the New Juaben South Municipality**
3. **Identify the effects of HIV related-stigma on Adolescents living With HIV/AIDS.**
4. **Explore the counselling intervention for Adolescents Living With HIV/AIDS in New Juaben South Municipality.**

### 1.4 Research Questions

**The study is guided by the following questions:**

1. **What are the causes of HIV/AIDS on adolescents living with HIV/AIDS in the New Juaben South Municipality?**

2. **What coping strategies are adopted by adolescents living with HIV/AIDS in the New Juaben South Municipality?**

**3.What are the effects of HIV/AIDS- related stigmaa on adolescents living With HIV/AIDS?**

**4.What are the counselling interventions for Adolescent Living With HIV/AIDS in New Juaben South Municipality.**

## 1.5 Significance of the Study

**The high prevalence of HIV/AIDS among adolescents has significant social and economic implications for national development. This study is important for several reasons:**

**Firstly, it will contribute to the development of targeted psychosocial and community-based interventions aimed at reducing the effects of HIV/AIDS related- stigma and improving the well-being of adolescents living with HIV/AIDS. These interventions may include peer support programs, stigma-reduction campaigns, mental health counselling, and community sensitization efforts to foster social acceptance and inclusion. Secondly, the study's findings will provide healthcare practitioners and public health officials with insights to design more effective stigma-reduction initiatives for newly diagnosed adolescents. Addressing internalized stigma could help reduce risky sexual behaviours, improve access to HIV-related healthcare services, and enhance adherence to antiretroviral therapy (ART), ultimately reducing HIV transmission in high-risk populations. Thirdly, policymakers can use the study's findings to formulate evidence-based policies and frameworks that address adolescent HIV/AIDS stigmatization and improve healthcare support systems.**

**Finally, the findings will be incorporated into training manuals and used by civil society organizations and NGOs engaged in HIV/AIDS advocacy. These insights will strengthen health promotion campaigns, community education, and interventions aimed at reducing stigma and improving the quality of life for adolescents living with HIV/AIDS. Additionally, this study contributes to the growing body of research on HIV/AIDS stigmatization and adolescent health in Ghana.**

### 1.6 Delimitation of the Study

**Geographically, the study was organized in the New Juaben South Municipality. There were so many issues about HIV/AIDS but contextually, the researcher explored the causes, effects of HIV –related on adolescents living with HIV and coping strategies adopted by adolescents living with HIV/AIDS in the New Juaben South Municipality.**

### 1.7 Limitations of the study.

The study used a smaller sample size due to the characteristics of qualitative research methodology. The bureaucracy the researcher had to go through concerning the request of an introductory letter from the university as well as an ethical approval letter before embarking on the data collection. Most of the respondents were reluctant to give detailed information about their HIV status.

### 1.8 Operational Definition of Terms

**Adolescence: Adolescenc**e is defined by the World Health Organization as the period in human growth and development that occurs after childhood and before adulthood from the ages of 10 to 19. Adolescence is also the period of transition from childhood

to adulthood, that is between the ages of 10 – 19 years). But in the case of this research, adolescence is people between the ages of 10 – 24 years of age.

**Stigma:**Stigma can be defined as a mark of shame or discredit. People who are stigmatized are often devalued and viewed as unworthy in the society in which they live. As a result, someone with a stigma may be perceived as having no worth as a human being. It's also a kind of tag or label or tattoo imprinted or pasted on people.

**Coping strategies**: Coping is a mental process of dealing with distress in different ways, with different approaches to the stressful situation, based on the individual's resources

**HIV/AIDS:** HIV (human immunodeficiency virus) is a virus that attacks cells that help the body fight infection, making a person more susceptible to other infections and diseases, according to WHO

ALWHIV: These are people within the ages of 12 -24 years that have contracted HIV infections confirmed and diagnosed at the laboratory.

### 1.9 Organization of the Study

The study was made up of five chapters. Chapter one focused on the introduction/ background of the study, the research problem, the purpose of the study, research objectives, research questions, the significance of the study, the definition of terms and the organisation of the study. Chapter two concentrated on the literature review. Chapter there indicated the methodology used for the study. Chapter four presented results from data collection as well as a discussion of the results. Finally, Chapter Five focused on the summary of the study, key findings, the conclusion of the study and recommendations and areas for future research.

# CHAPTER TWO

# REVIEW OF RELATED LITERATURE

## 2.0 Introduction

This chapter took into consideration the ideas, opinions and findings of researchers and educationists that were found relevant to the study. The following topics were reviewed in the study.

- Theoretical foundations of the study
- Empirical review
- The concept of HIV/AIDS
- Causes of HIV/AIDS
- Effects of HIV/AIDS
- Dimensions of HIV/AIDS stigmatization
- Experiences of HIV/AIDS stigmatization and discrimination
- Coping strategies

## 2.1 Theoretical Foundations of the Study

### 2.1.1 Existential Theory

**The existential theory is the dogmatic position that individuals have free will and may construct purpose and meaning in their lives (More, 2022). Also, Adams (2014) views existential theory as an inquiry into personal meaning, and everything people do has a philosophical underpinning. According to him, the theory concentrates on the individual, but it goes beyond that to analyze the human condition in a broader philosophical and social framework. He argues that the theory considers a person's capacity to face life's problems instead of function and dysfunction.**

The underlying premise of the theory is that “individuals have the freedom and courage to transcend existential givens and environmental influences to create their future. Secondly, they emphasize the phenomenological reality of the experiencing person. Thirdly, they are holistic in their focus on the lived experience and future aspirations of the whole person in action and context. Finally, they attempt to capture the high drama of human existence the striving for survival and fulfilment despite the human vulnerability to dread and despair. (Wong, et al 2021). The authors believe that the existential theory was conceived by Kierkegaard, who is often regarded as the founder of existentialism. In Martin Heidegger's "Being and Time," (1962), the phrase "being-in-the-world" refers to how humans are inextricably linked to the world and learn about it by engaging with it, harmonizing it with counselling psychology.

Wong et al. (2021) proposed that existential positive psychology holds the assumption that suffering is necessary for flourishing, enduring happiness and well-being. They also supported the thesis that suffering triggers the search for meaning, or self-transcendence, which in turn functions as a buffer against the adverse effects of suffering. Sustainable well-being is achieved through learning how to make the best use of the dynamic and dialectic interplay between positive and negative life experiences in each context. Wong et al proposed that the most promising strategy to accomplish the mission of positive psychology is to confront the dark side of human existence and understand the unique experience and expression of well-being in different cultures.

The Existential theory introduces principles and practices such as accepting and confronting with courage the reality that life is full of evil and suffering, recognizing

that everything in life comes in polarities and learning from Indigenous psychology such as the ancient wisdom of finding deep joy in bad situations.

According to Existentialism, persons suffering from HIV/AIDS can choose how to respond to their condition since they may identify themselves as both subject and object (May 1967). This enables individuals to find meaning in their pain, which is vital to their humanity (Fabry, 1968). HIV/AIDS is an existential crisis that impacts people's lives, causing feelings of alienation, resistance, identity, conflict, human hope, and despair (Gould, 1993). HIV/AIDS patients are motivated to find purpose and importance in their lives, which can lead to feelings of meaninglessness and pessimism. Making desired life changes, beginning a relationship, exercising control over medical decisions, becoming politically engaged, or having a spiritual practice may all help people create and retain a sense of hope. Participating in support groups may also assist people in initiating, mobilizing, and achieving personal and family goals. According to Frankel (1967), in fulfilling purpose, one is responsible not only to oneself and others but also to a Higher Being. According to Wood and Aull (1990), spirituality, beliefs, and the ability to keep hope have all been proven to be positively connected with the ability to live effectively with HIV/AIDS. According to Gould (1993), the existential investigation into HIV/AIDS analyzes what it means to be alive and a search for the feeling of completeness. Bland (2020, p. 712), suggests that this healthy state is best attained when persons are “constructively confronting, creatively responding to, and transcending the challenge by embracing its non-duality,” thereby neither overemphasizing its positive nor its negative aspects.

This theory aligns with this study by explaining how seropositive adolescents in Koforidua navigate identity, meaning, and resilience amid adversity. The theory emphasizes free will, meaning-making, and coping with suffering (More, 2022).

Adolescents living with HIV/AIDS face stigma, alienation, and an existential crisis (Gould, 1993), yet they can define their identity beyond the illness (May 1967).

By finding purpose through spirituality, social support, or advocacy**,** they transcend despair and develop resilience (Wong et al., 2021). Hope and meaning-making play a crucial role in their well-being (Frankel, 1967; Wood & Aull, 1990). Understanding their lived experiences through this lens sheds light on coping strategies and empowerment in the face of HIV/AIDS.

### 2.1.2 Transactional Model of Stress and Coping (TSC)

The transactional model of stress and coping, introduced by Lazarus and Folkman in 1987, classified coping as a process including both cognitive and behavioural reactions that people use to cope with internal or external pressures thought to exceed their abilities. However, Lazarus and Folkman suggested that Coping is closely related to the concept of cognitive appraisal. They further stated that "psychological stress is a specific interaction between the individual and the environment that is judged by the person as exhausting or surpassing his or her resources and harming his or her well-being" (Lazarus and Folkman, 1984, p. 19). The stress and coping paradigm has served as the de facto approach for comprehending stress and coping mechanisms for more than 40 years (Revenson et al., 2022). Both the cognitive appraisal phase and the coping phase are significant stages in this relationship.

#### 2.1.2.1 Cognitive Appraisal Phase

According to this concept, the way a person experiences their illness—more particularly, their cognitive assessments of stress—is a key determinant of the coping

strategies they employ, which in turn influence their ability to change psychologically (Revenson et al., 2022)

Cognitive appraisal is the “process of categorizing an encounter, and its various facets, concerning its significance for well-being” (Lazarus and Folkman, 1984, p. 31). Primary and secondary evaluation are the first two stages of cognitive appraisal (CA), which defines how people understand and react to stress (Korbmacher and Wright, 2020).

#### 2.1.2.2 Primary phase

In the primary phase, Dixon (2021) indicates that a person's initial assessment of a source of stress is whether it is (a) unimportant, (b) innocuous, (c) hurtful, (d) worrisome, or (e) difficult. He argues that it won't be stressful if it's unimportant or harmless. When anything is deemed to be dangerous, dangerously threatening, or difficult, it is stressful. If injury or loss is anticipated, a threat assessment is necessary. A challenge evaluation indicates that the subject believes the stressor may provide benefits (Dixon, 2021). Further, when people appraise whether or not an undesirable occurrence is a stressor—that is if it constitutes a danger to or harms their well-being—they are engaging in cognitive evaluations

#### 2.1.2.3 Secondary phase

Secondary appraisal happens when there are meaningful connections between a person and their surroundings (Lazarus, 2012). The person determines the possibilities accessible for managing the circumstance during secondary appraising. This might be material, social, or psychological (friends and family support, health, energy and money). A person will experience stress if something is first and foremost evaluated as stressful (damaging, challenging or scary), and secondarily evaluated as being too tough to cope with. Because of this, Lazarus's complete definition of stress is "...a

relationship between the person and the environment that is judged as personally relevant (primary appraisal) and as demanding or surpassing resources for coping (secondary appraisal)."

Secondary appraising, according to Smith and Lazarus (1993), comprises accountability, problem-focused coping potential, emotion-focused coping potential, and future anticipation. Assigning blame or credit for results is known as accountability (Smith & Lazarus, 1993). People evaluate their coping self-efficacy, or their confidence in their capacity to control a circumstance, during secondary appraisal (Chesney et al., 2006).

When environmental demands surpass a person's capacity, both personally and socially, people see those circumstances as stressful. Although there are other aspects involved, stress evaluations affect how people choose to deal with stress (e.g., experience). Approach and avoidance tactics are both a part of caring. To make informed treatment options, approach tactics may include researching the ailment. Avoidance tactics might include avoiding communicating with others to make it seem less real or downplaying the significance of a diagnosis to cope with it in more manageable chunks.

According to research, avoidance tactics may be beneficial in the short term when people are overcome by emotion and overwhelmed by what the future holds, but they can be destructive over the long term. Both methods of coping are needed to manage a chronic condition. While certain stresses or adaptive tasks may offer a solution, others may only demand acceptance. Persons with better social skills can likely handle the problem-focused actions needed to treat their sickness. There may be a connection

between poor psychological adjustment and low self-care activity involvement, according to some research (Cheval et al., 2021).

Demands, restrictions, and possibilities in the environment are related to CA on both a personal and a societal level (Devonport & Lane, 2006). The process of interpreting stress and coping with it is not linear since various outputs of the appraisal and coping processes may re-start earlier processes (Carver et al., 1989).

**2.1.2. 4 Coping phase**

According to Litwic-Kaminska (2022), the concept of coping with stress is somewhat unclear. Stress management may be viewed as a method, strategy, or way of life. This phrase refers to distinctive behaviours and responses that individuals exhibit in highly stressful circumstances. They defined Coping as "the cognitive and behavioural efforts made to master, tolerate, or reduce external and internal demands and conflicts among them" (Folkman and Lazarus, 1980, p. 223). This concept emphasizes the effort involved in a person's response while also addressing the cognitive, emotive, and behavioural parts of the coping process. Lazarus and Folkman (1984) add that in addition to the more conventional understanding of coping as control over one's surroundings, managing stress also includes accepting, tolerating, avoiding, or minimizing the stressors. Furthermore, coping encompasses all deliberate efforts to control stress, regardless of whether they are successful or not (Frydenberg, 2020). That is a stressful experience that is personally relevant and drains or surpasses a person's resources, triggering a coping reaction (Frydenberg, 2020). The conceptualization of Lazarus & Folkman (1984) has multiple important components, including the idea that coping is a transaction between the person and their environment and that assessment is a component of the coping process. Coping is an ongoing concept that evolves in response to demands and the wake of both absolute

and relative evaluations (Frydenberg, 2020). According to Aldwin and Yancura (2004), coping is responsive to both environmental demands and personal factors such as values and beliefs. They argue that coping strategies are flexible and unfold over time, either in response to changing appraisals or as a function of developmental processes. There are many different conceptualizations of coping strategies, but the five general types include problem-focused coping, emotion-focused coping, social support, religious coping, and meaning-making (Aldwin and Yancura, 2004). Factors including sociodemographic, personal, sociocultural, and environmental elements all have an impact on coping mechanisms (Silva et al., 2018). They also rely on resources that may be both personal and societal, such as familial traits, social networks, economic circumstances, romantic relationships, and so on. Personal resources include health status, morality, religiosity, intelligence, and individual uniqueness (Mohanraj et al., 2015).

Emotion-focused coping, which at one point encompassed techniques including distracting oneself from the stressor, venting frustration at family members, engaging in delusional thoughts about one's condition, and blaming others, is now thought of more widely as emotion management (Scheier et al., 2012). According to longitudinal studies, higher emotion regulation, as demonstrated by emotional processing and expression, has been linked to decreased depression symptoms in older people when perceived stress is high. But over time, more depression symptoms were connected to higher emotional processing (Hoyt et al., 2020). Therefore, it is evident that emotions play an adaptive function in the coping process.

There is strong evidence that psychological stress has a negative influence on health (Hemmerle et al., 2012; Gradus, 2017; Sgoifo et al., 2017). Individuals with HIV/AIDS frequently see their physical health worsen and levels of psychological

stress rise because of stigmatization and discrimination (Sun, Wu, Qu, Lu, & Wang, 2013). These individuals may also have concomitant conditions or secondary infections such as extrapulmonary TB as a consequence of immunodeficiency. (Naing, Mak, Maung, Wong, & Kassim, 2013), Oral human papillomavirus infection (Beachler & D'Souza, 2013), hepatitis B and/or C viruses (Zhang et al., 2017). Long-term health, psychological well-being, and social functioning are all impacted by coping, in addition to the immediate stress reaction. According to the concept, which places a strong emphasis on the person-environment interaction, an individual's assessment processes have a significant impact on how they react under stress.

The Transactional Model of Stress and Coping (TSC) is appropriate for this study because it provides a comprehensive framework for understanding how individuals assess and respond to stressors within their environment. Given that this study examines how individuals experience, interpret, and manage stress, the TSC model is instrumental in explaining the cognitive and behavioural processes that influence their coping mechanisms and decision-making.

First, the cognitive appraisal phase of the TSC model justifies its relevance to this study, as it emphasizes how individuals assess the significance of stressors. The primary appraisal stage helps determine whether a situation is perceived as a challenge, threat, or insignificant, while the secondary appraisal phase evaluates available coping resources. This aligns with the study's focus on how individuals perceive stressors and the extent to which these perceptions shape their responses.

Second, the coping phase of the model supports this study by highlighting the various strategies individuals adopt to manage stress. Whether through problem-focused coping (directly addressing the stressor) or emotion-focused coping (managing

emotional responses), the model helps explain how stress and coping strategies influence well-being, performance, and decision-making.

By applying the TSC model, this study is better positioned to analyze the interaction between stress perception, coping mechanisms, and their overall impact on individuals. The model's emphasis on the dynamic person-environment interaction makes it a suitable theoretical foundation for understanding the stressors under investigation and the coping responses employed.

## 2.2 Empirical Review

### 2.2.1 Understanding HIV/AIDS

Based on the virus's development to the final stage of infection and the symptoms' increased severity, the Human Immunodeficiency Virus (HIV) can cause AIDS (CDC, 2019). HIV particularly targets CD4 cells, also known as helper T-cells, which are immune system defences. An individual is vulnerable to AIDS if their CD4 count falls to a certain level (Vijayan et al, 2017; Nall, 2020). The average lifespan of an AIDS patient without treatment is three years, albeit this depends on how long it takes the virus to develop to its most advanced level (CDC, 2019). Antiretroviral therapy (ART) and treatment have allowed more people to survive longer than they would have otherwise, changing the stigma associated with HIV infection (Frieden et al., 2015). If used as directed, drugs for HIV can help a person with the virus maintain good health and pose little or no risk of HIV transmission to HIV-negative partners.

Hayes (2021) asserts that individuals with HIV may anticipate living as long as their non-HIV peers. According to her, having access to high-quality medical care and successful HIV treatment are two variables that determine life expectancy. She also

asserts that chances of surviving HIV are greater if individuals start therapy and receive a diagnosis quickly. It is anticipated that those who have just received a diagnosis will live longer (Hayes, 2021).

Access to HIV care is crucial to the global campaign to eliminate AIDS as a public health hazard (Gallant, 2017). Globally, 28.7 million persons with HIV have access to antiretroviral medication (ART) as of the end of 2021, or 75% of them. HIV-positive individuals who are aware of their condition and use ART as directed can live long and healthy lives (Global Statistics, 2022). Pre-exposure prophylaxis (PrEP) is a successful preventive measure that can be used to reduce the incidence of HIV, particularly in those who are at higher risk (Nicol et al., 2022)

There is currently no cure for HIV and many people who have it or are at risk of getting it do not have access to prevention, care, or treatment (Fauk et al., 2021). In addition to having an impact on people, the HIV epidemic also has a negative influence on families, communities, and the growth of nations' economies (Lamontagne et al., 2019; Zinyemba et al., 2020). However difficult the situation may be, there have been achievements and encouraging indicators.

Over time, there have been fewer cases of newly acquired HIV (UNAIDS, 2022). UNAIDS warns that progress in lowering new HIV infections, expanding access to care, and putting an end to AIDS-related fatalities has been uneven (UNAIDS, 2020). The effectiveness of our global response to HIV/AIDS may be in jeopardy as stigma and discrimination continue to emerge as major obstacles (Kimera et al., 2020).

### 2.2.2 Adolescents' HIV patterns

Slogrove and Sohn (2018) provided a summary of current research on the worldwide epidemiology of young people (aged 10 to 19) living with HIV (ALHIV), the impact of HIV on young people's health, and HIV-related mortality. According to their results, a total of 1.03 million older (age 15–19) and 770,000 younger (age 10–14) people with HIV were projected to be living in sub-Saharan Africa in 2016, with an uncertainty range of 1.4–2.7 million. In 2015, HIV-associated mortality was the ninth most common cause of teenage deaths worldwide and the fourth most common cause in low- and middle-income African nations. More peri/postnatally infected ALHIV is surviving into older ages, which leads to an increase in the ALHIV population. It is estimated that 35% of older female ALHIV were peri/postnatally infected, compared to 57% of older male ALHIV. While the number of younger ALHIV deaths is decreasing, the number of older ALHIV deaths has stayed constant since peaking in 2012.

Using data from the national HIV population-based household surveys performed in 2008, 2012, and 2017, Mabaso et al., (2021) examined trends and variables related to HIV prevalence among teenagers in South Africa. The variables influencing the prevalence of HIV were identified using both univariate and multivariate logistic regression models.

According to the study's findings, HIV prevalence among adolescents aged 12 to 19 increased significantly overall, rising from 3.0% in 2008 to 3.2% in 2012 and 4.1% in 2017. The likelihood of being HIV positive among 12- to 19-year-olds was noticeably greater in females than in men, in the province of KwaZulu-Natal than in the Northern Cape, and in those who did not attend a school or who were jobless compared to those

who did. Compared to Black Africans, the risks were much lower among Whites and Indian/Asian demographic groupings.

Mbarani et al., (2022) performed secondary analyses utilizing information culled from the national HIV prevalence surveys done in South Africa (2005–2017). The analysis presented weighted descriptive statistics, realized totals, and age- and sex-specific stratification (10–14 and 15–19 years, respectively). Results indicate that there were 360 582 teenagers who tested positive for HIV in 2017, up from 3.0% in 2012 and 3.7% in 2017. Compared to male adolescents, female adolescents have a disproportionately high prevalence of HIV (5.6% vs. 0.7%). The prevalence of HIV remained largely unchanged.

Regarding the UNAIDS 90-90-90 objectives, around 62.3% of teenagers were aware of their HIV status; 65.4% of these were receiving antiretroviral medication, and of those, 78.1% had achieved viral load suppression. There are gaps in our understanding of the prevalence of prenatal and postnatal infections, as well as the socio-behavioural risk factors for the spread of HIV among adolescents in South Africa.

### 2.2.3 Determinants of HIV/AIDS among adolescents

To lessen the spread and effects of the pandemic, Belle and Gamedze (2019) looked into the behavioural factors that contributed to the transmission of HIV and AIDS among female youth in Mbabane, Swaziland. They also made recommendations for policies that could encourage positive female youth behaviour change. To acquire a thorough understanding of the experiences of female teenagers in Mabane, the study adopted a qualitative research methodology. A questionnaire was used to gather data, and it was given to 210 randomly selected female students at the Mbabane Public

Health Unit who were between the ages of 16 and 24. The study's background was provided by the Behaviour Change Communication (BCC) theoretical framework.

According to the results, the majority of respondents (64%) were young unmarried women; 45% had a high school degree; and 57% had no or little other sources of income in addition to being unemployed. Most of them (88%) engaged in sexual activity, and sex was the primary method of HIV/AIDS transmission. Many (52%) people got their knowledge about HIV and AIDS from health services. The majority of people (97%) were aware of HIV and AIDS, yet despite this, casual sex, irregular condom use, and early sexual debuts were nevertheless common, showing resistance to behaviour change.

In South Africa, Mabaso et al. (2018) examined the socio-demographic and behavioural factors that influence the risk of HIV infection among AGYW. Using the multi-stage stratified cluster random home sample from the 2012 population, a secondary data analysis was done. The parameters that were independently related to the incidence of HIV were identified using multivariate stepwise backward and forward regression modelling. In the 3092 AGYW that were tested and questioned, 11.4% had HIV. In comparison to teenage girls (5.6%), young women had a much higher overall HIV prevalence rate (17.4%).

In the AGYW model, being a young woman between the ages of 20 and 24 and using a condom during the most recent sex were associated with an increased risk of HIV infection, while in other racial groups, having a partner who is under the age of five, obtaining a higher education, using low-risk alcohol, and having only one sexual partner were associated with a decreased risk. In the teenage girl's model, a lower chance of contracting HIV was linked to belonging to other racial groups, being

married, and living in less deprived circumstances. In the models for young women, condom usage during the most recent intercourse was correlated with a higher risk of HIV infection, while in other racial groups, one sexual partner, low-risk alcohol consumption, having a partner under the age of five, and university education were linked to a lower risk.

Saffier et al. (2017) conducted a comprehensive assessment of all available research on HIV prevalence and risk factors for HIV infection among Brazilian youth aged 10 to 25.

Reference lists of pertinent studies from any time during the HIV epidemic that provided estimates specifically for Brazilians aged 10 to 25 (or some subset of this age range) on either: (a) HIV prevalence or incidence; (b) the association between HIV and sociodemographic or behavioural risk factors were searched and analysed. According to the findings, 48 publications—44 cross-sectional, 2 case-control, and 2 cohort—met the criteria for inclusion. Data from four investigations were analysed nationally. Estimates of HIV prevalence were supplied by 47 research, mostly for six demographic subgroups: blood donors, pregnant women, institutionalized people, men who have sex with men (MSM), and female sex workers (FSW). Estimates of HIV incidence were provided by 4 studies. Twelve research revealed a wide variety of risk variables, such as age, sexual and reproductive history, infection history, drug use, location, marital status, mental health, and socioeconomic position, to be related to HIV status.

Hadish et al. (2017) looked at the characteristics that predict high-risk sexual practices in young people from Gabon and Cameroon, aged 15 to 24. Demographic and Health Surveys (DHS) from Cameroon (2011) and Gabon (2012) were utilized to collect nationally representative data for the study. 14,880 adolescents were recruited overall,

with probability proportionate to size selecting 9511 (63.91%) from Cameroon and 5369 (36.08%) from Gabon.

A binary multivariate logistic regression was conducted using SPSS version 22. Of all the respondents, 81.0% of Gabonese and 67.9% of Cameroonian youth reported having had sexual relations before the study. Despite the gender differences, 17.4% of Cameroonian and 21.3% of Gabonese young people reported having several relationships. Similarly, non-spousal sex was reported by 57.3% of Gabonese adolescents and 33.9% of Cameroonian youth. Age, location of residence, educational level, religion, marital status, wealth index, employment, general knowledge, and attitude of respondents were substantially linked with numerous relationships, paid sex, and non-spousal sex on multivariate analysis. Males in both nations were more likely than females to engage in high-risk sexual practices when comparing the two groups by gender.

Malga et al. (2018) investigated risky sexual behaviour and variables related to HIV/AIDS among students at Vuyolwethu High School between the ages of 12 and 18. The study used a mixed method of investigation. While the qualitative phase concentrated on life-orientation teachers, the quantitative phase was only focused on students. There are 150 participants in the research sample overall, and both males and females make up 50% of the sample. Ages 17 to 18 and grade 11 are most prevalent among responses.

Descriptive analyses were performed on the quantitative data, and theme analysis was done on the qualitative data. Results of the study showed that a total of 51.3% of respondents strongly agreed that having sex without protection is harmful and that it can result in unwanted sex, teen pregnancy, HIV/AIDS, and other sexually

transmitted diseases. Other findings indicate that drug misuse has a significant role in influencing teenagers' hazardous sexual behaviour, which can lead to unintended pregnancies and HIV/AIDS infection.

To identify the factors that raise the risk of HIV infection, Awotidebe et al. (2014) undertook cross-sectional research of 430 secondary school students (47.4% males and 52.6% girls) from two rural schools in South Africa. Data on demographics, sources of HIV/AIDS information, HIV awareness, sexual habits, communication and negotiating skills, self-efficacy to reject sex, peer influence, and time perspective were gathered using a self-administered questionnaire. Results of the study showed that out of the 113 individuals (27.2%) who said they were sexually active, over 48% said they had sex before turning 15 and 42.2% said they had penetrating sex with more than one person. Only 44.8% of them reported using condoms consistently and frequently before each intercourse.

Peer pressure, gender differences, and a lack of knowledge about HIV all had an impact on teenagers' sexual risk behaviours. Teenagers who are in school in rural locations tend to be more sexually active. Teenagers are more likely to engage in dangerous sexual behaviours because of peer pressure, especially guys. Positively, teenagers are more likely to use condoms throughout every sexual encounter if they have a high level of understanding about HIV infection.

Using a descriptive qualitative study methodology, Qanche et al. (2021) investigated the causes of the high HIV prevalence in the Majang zone in the Gambella area, Southwest Ethiopia. The findings indicate that many variables may be responsible for the persistently high incidence of HIV. Some of the reasons that led to the high prevalence of HIV in the Majang zone included poor government attention to HIV

prevention and control measures, low perceived severity of HIV, drug use, sociocultural factors, and rapid migration of persons into and out of the research region. The usage of "Tifo Bet" by teenagers and young adults for risky sexual behaviour, adulterous sexual behaviour, and societal support for polygamy are examples of sociocultural variables. These variables either make it more likely that unprotected sexual activity may increase susceptibility to the virus or impair efforts by governmental and non-governmental groups to prevent HIV.

### 2.2.4 The Concept of HIV/AIDS in Ghana

HIV is a global health epidemic that killed over 39 million people worldwide, according to the World Health Organization. As of 2013, WHO estimates that over 35 million people living with HIV worldwide. Most of these people live in low-income and developing countries. Sub-Saharan Africa accounts for almost 70 per cent of new HIV infections.

HIV, the Human Immunodeficiency Virus, is the virus that causes AIDS. This disease suppresses the body's ability to fight infections and weakens the immune system by killing vital T-cells, according to WebMD. After a person is infected, there is an incubation period in which there are no symptoms present. This period can last from a few months to 10 years, according to WebMD.

Although there is no cure for HIV/AIDS, the combination of antiretroviral drugs or therapy (ART) controls viral replication and helps the immune system regain strength. These drugs drastically improve life expectancy and quality of life for people living with HIV, according to WHO.

HIV (Human Immunodeficiency Virus) is a viral disease that attacks the body's immune system. If HIV is not treated, it can lead to AIDS (acquired immunodeficiency syndrome). There is currently no effective cure. Once people get

HIV, they have it for life. However, with proper medical care, HIV can be controlled. People with HIV who get effective HIV treatment can live long, healthy lives and protect their partners.

### 2.2.5 Historical Perspective of HIV/AIDS

HIV infection in humans came from a type of chimpanzee in Central Africa. Studies show that HIV may have jumped from chimpanzees to humans as far back as the late 1800s. The chimpanzee version of the virus is called the *simian immunodeficiency virus*. It was probably passed to humans when humans hunted these chimpanzees for meat and came in contact with their infected blood. Over decades, HIV slowly spread across Africa and later into other parts of the world. The virus has existed in the United States since at least the mid to late 1970s. The only way to know if you have HIV is to get tested. Knowing your HIV status helps you make healthy decisions to prevent getting or transmitting HIV. Many HIV tests are quick, free, and painless.

### 2.2.6 Causes of HIV/AIDS

HIV can be transmitted from a mother to her baby during pregnancy, birth, or breastfeeding. However, it is less common because of advances in HIV prevention and treatment. This is called perinatal transmission or mother-to-child transmission. Mother-to-child transmission is the most common way that children get HIV. Recommendations to test all pregnant women for HIV and start HIV treatment immediately have lowered the number of babies who are born with HIV. If a woman with HIV takes HIV medicine as prescribed throughout pregnancy and childbirth, and gives HIV medicine to her baby for 4 to 6 weeks after birth, the risk of transmission can be less than 1%.

**Usage of Sharp Objects**

You are at high risk for getting HIV if you share needles, syringes, or other drug injection equipment (for example, cookers) with someone who has HIV. Never share needles or other equipment to inject drugs, hormones, steroids, or silicone. Used needles, syringes, and other injection equipment may have someone else's blood on them, and blood can carry HIV. People who inject drugs are also at risk for getting HIV (and other sexually transmitted diseases) if they engage in risky sexual behaviours like having sex without protection (such as condoms or medicine to prevent or treat HIV).

**Oral Sex**

Oral sex involves putting the mouth on the penis (fellatio), vagina or vulva (cunnilingus), or anus (rimming). Ejaculation in the mouth with oral ulcers, bleeding gums, or genital sores.

**Biting and Spitting**

The small number of documented cases have involved severe trauma with extensive tissue damage and the presence of blood. This rare transmission can occur through contact between broken skin, wounds, or mucous membranes and blood or body fluids from a person who has HIV. There is no risk of transmission through unbroken skin.

**Blood transfusion with unscreened blood**

Blood transfusion is one of the means through which HIV can be transmitted from one person to the other. Individuals due to their health conditions and need blood can be infected if health providers do not take due diligence to screen the blood before being transfused to the sick person.

**Causes of HIV/ Stigma**

HIV stigma is rooted in a fear of HIV. Many of our Ideas about HIV come from the HIV images that first appeared in the early 1980s. There are still misconceptions about how HIV is transmitted and what it means to live with HIV today. The lack of information and awareness combined with outdated beliefs leads people to fear getting HIV. Additionally, many people think of HIV as a disease that only certain groups get. This leads to negative value judgments about people who are living with HIV.

### 2.2.7 HIV/ AIDS stigmatization

HIV/AIDS stigma refers to unfavourable perceptions of those who have the virus (CDC, 2022). According to Lu et al. (2020), stigmatization is the act of labelling a person, identifiable group of people, place, or country with a stereotype or treating them differently in a negative way because they had or were linked to something that people did not want to have or be associated with, especially health conditions. Those who are thought to be infected by the virus may be subjected to name-calling, branding, and finger-pointing (Dapaa, 2020). The term "biosocial phenomena" is used to describe stigma when it results from an epidemic. Despite being a harmful social construct, the stigma has a detrimental impact on health (Nylander, 2020). Also, HIV discrimination is the practice of treating HIV-positive persons and those who are not different (Stringer et. al., 2016).

Stigma is an attitude, whereas discrimination is a set of actions brought on by such attitudes or beliefs (Alexandra et al., 2019). Stigma and discrimination affect people living with HIV/AIDS through social exclusion, anxiety and emotional coping, and deprivation of social and financial resources, in addition to fuelling the development

of infections (Turan et al., 2013). Numerous research indicates that stigma connected to HIV may have reduced access to HIV treatment (Fekete et al., 2018). Additionally, this can result in lower antiretroviral medication (ART) adherence and hence worse treatment success rates (Katz et al., 2019). Stigma and discrimination pose substantial health risks (American Psychological Association, 2020). It is unjust and unproductive, undermining any initiatives made to combat the condition (Dapaa, 2020). Further, the most significant impediment to public action continues to be stigma. It's one of the key causes why a lot of individuals are reluctant to be tested for HIV or to seek treatment if they do. Because of this, many individuals are afraid to talk about AIDS or take simple actions that can help prevent it. The AIDS epidemic still decimates civilizations all over the world in large part due to stigma. (Ban Ki-Moon, United Nations Secretary General, 2008).

According to the poll, 82% (909) of persons with HIV have encountered HIV stigma related to their status in the past year. Additionally, one in five partners of HIV-positive individuals cited stigma as one of the greatest obstacles they encountered, and almost two-thirds (59%) of HIV-negative participants admitted to concealing their partners' status out of concern for self-discrimination (ViiV Healthcare, 2022).

### 2.2.8 Experiences of Stigma HIV/AIDS and Discrimination

In Vietnam, Tran (2016) examined the stigmatization and discrimination faced by persons living with HIV (PLWH) in a variety of social contexts, including the home, neighbourhood, and healthcare institutions. In three towns in Vietnam where the HIV pandemic is concentrated, cross-sectional research utilizing a culturally customized HIV stigma measure included a total of 1,016 patients (63.8% men, mean age = 35.4).

To investigate the variables connected to the type of stigmatization that patients experienced, zero-inflated Poisson models were utilized. The findings showed that 66.2% of PLWH experienced stigma related to HIV/AIDS, with stigma coming more commonly from their community (62.8%) and family (30.2%) than from healthcare institutions (8%). The degree of stigma experienced by PLWH in the community is correlated with socioeconomic class (e.g., income, occupation). Patients who were unemployed and members of the lower and middle classes reported experiencing more prejudice and stigma from the community. For ART, PLWH experienced less stigmatization in all contexts, demonstrating the advantages of quickly expanding ART programs. At the provincial level of the health administration, PLWH reported experiencing higher stigma and prejudice. Those who had previously injected drugs claimed to have experienced substantially less stigma in the hospital context.

In Zomba, Malawi, the psychological difficulties experienced by ALHIV patients enrolled in an ART program tailored to adolescents were evaluated by Kip et al. in 2022. Between April and May 2019, we held eight focus groups with a sample of 80 ALHIV adolescents aged 12 to 18 (n = 80). The participants came from four Teen Clubs that were connected to a program for young people with ART. Inductive and deductive data analysis were used to find themes about ALHIV's psychosocial experiences. The study reveals a complex patterning of HIV-related stigma, particularly experiences of internalized and enacted stigma among ALHIV. Participants acknowledged that taking their ARVs in some situations, such as in boarding schools or with other persons present, presented some difficulties.

HIV-related stigma has also been linked to an increase in dangerous health habits such as concealing prescription drugs and failing to take ART as prescribed. ALHIV

expressed displeasure that HCPs disseminated information regarding their HIV status. The participants in this study faced several difficulties, including sadness, loneliness, and a sense of rejection, as well as physical, emotional, and verbal abuse. Because of their HIV status, ALHIV has personally encountered enacted stigma in the form of prejudice, exclusion, or discrimination.

### 2.2.9Triggers of Stigma

A qualitative study by Fauket et al. (2021) was conducted in Yogyakarta and Belu, Indonesia, using in-depth interviews with 92 PLWHA (52 women and 40 men) and 20 healthcare professionals. The paper discusses the perspectives and individual experiences of the 20 healthcare professionals with HIV stigma and discrimination toward PLWHA in both study settings. Utilizing a snowball sampling method, the healthcare professionals were chosen from hospitals that offered HIV-related medical treatment. Data analysis was guided by an examination of a qualitative framework. According to the findings, ignorance of HIV, concern about acquiring HIV, personal values, religious beliefs, and social values and norms were identified as the causes or enablers of HIV-related discrimination and stigma.

Teshale et al. (2022) examined adult populations in 15 sub-Saharan African countries for their attitudes toward persons living with HIV/AIDS and its related variables. Data from the 15 Demographic and Health Surveys that were carried out in sub-Saharan Africa between 2015 and 2019/20 were utilized in the study. The data from each nation were combined, and the final study employed a weighted sample of 318,186 adults (unweighted sample: 315,448) who had ever heard of AIDS. The result variable was obtained using the two questions about discriminatory attitudes. The results showed that there was an average of 47.08% discriminatory attitudes toward HIV/AIDS in the 15 sub-Saharan African countries, ranging from 17.64% in Malawi

to 79.75% in Guinea. Both person-level and community-level factors were substantially linked with discriminatory attitudes toward people living with HIV/AIDS in the multivariable analysis. Younger age, lack of formal education, never getting married, low socioeconomic status, households headed by men, non-use of contraceptives, lack of exposure to the media, and incomplete knowledge of HIV/AIDS were among the individual-level factors linked to higher odds of discriminatory attitudes toward those living with the disease. Being an urban resident and residing in the western SSA area were two community-level characteristics that were strongly linked to an increased likelihood of having a discriminating attitude toward persons who are HIV/AIDS positive.

The UNAIDS (2021) fact sheet highlights several factors contributing to stigmatization among adolescents, particularly in relation to their sexual and reproductive health and HIV status. Adolescents around the world face challenges accessing health services due to stigma, discrimination, and judgment from communities, families, and even healthcare providers.

Adolescent girls are particularly affected by stigma related to sexual activity and pregnancy. The report shows that nearly half of adolescent girls aged 15 to 19 in Eastern and Southern Africa have had sex, and 26% have been pregnant. However, stigma and social norms around adolescent sexuality hinder access to sexual and reproductive health services, including contraception. Many young people avoid seeking these services because they fear being judged, blamed, or mistreated. As a result, only 24% of sexually active adolescent girls are using modern contraception, despite their vulnerability to unintended pregnancies and sexually transmitted infections.

Stigmatization also affects adolescents' mental health. The UNAIDS (2021) report indicates that mental health among adolescents is an emerging area of concern, with many adolescents experiencing depression, anxiety, and other mental health conditions. However, stigma and lack of understanding often prevent them from seeking help. Health systems in many countries do not have adequate resources or trained personnel to support adolescent mental health needs, which reinforces feelings of isolation and shame among affected youth.

HIV-related stigma is another major barrier. Adolescents are often afraid to get tested, disclose their HIV status, or seek treatment because of fear of being stigmatized or discriminated against. The report notes that stigma can come from family, peers, schools, and healthcare workers. This anticipated stigma discourages adolescents from accessing the services they need to live healthy lives. Even when services are available, the attitudes of service providers can be a deterrent, as many adolescents report feeling judged or unwelcome in clinical settings.

Furthermore, legal and policy environments in some countries criminalize certain behaviours associated with HIV risk, such as same-sex relationships, drug use, or sex work. This legal stigma reinforces social exclusion and discourages adolescents from seeking health information or support. Adolescents from key populations are particularly affected by these laws, as they face both legal and social barriers to accessing care.

Armstrong-Mensah et al. (2023) carried out a study to determine the causes of HIV-related stigma in Ghana, the obstacles it presents to care and treatment, and the suggestions made by PLWH regarding the ways in which different groups, such as community members, healthcare professionals, and teenagers, should endeavour to lessen stigma. A mixed methods cross-sectional methodology was used to collect

data from 404 PLWH at the Suntreso Government Hospital in Ghana's Kumasi Metropolis. The findings revealed that 90% of participants experienced stigma because of having HIV, and the majority (70.5%) thought that ignorance was the cause of HIV-related stigma in Ghana. The stigma-related difficulties influenced how they were treated and how they sought assistance. The recommendations for HIV destigmatization included avoiding prejudice against PLWH, teaching teenagers about HIV and transmission, detecting stigmatising behaviours, educating community members about HIV, and not disclosing one's HIV status.

Kabunga et al. (2024) conducted a qualitative research of HIV stigma among pregnant teenagers in southern Uganda. The study revealed five overarching themes from one-on-one narrative interviews with 28 teenagers aged 14 to 19: experiences of double stigma, societal and cultural elements driving stigma, healthcare system problems, stigma's psychological implications, and resilience and coping techniques. The study discovered that double stigma, caused by social preconceptions about HIV status and underage pregnancy, produced a complicated situation for participants. Despite these obstacles, they demonstrated tenacity via external assistance and personal strength.

Research on family communication and social support variables associated with HIV disclosure and stigma among children and adolescents living with HIV in Uganda was carried out by Nabunya et al. (2020). 702 adolescents between the ages of 10 and 16 who were HIV +, knew they had the virus, were prescribed antiretroviral medication, lived with family, and were enrolled in one of the 39 health centres in the research region were included in the study. The findings demonstrated a substantial relationship between children's degree of comfort with HIV disclosure and how frequently they talked to others about their status. HIV disclosure and HIV-related

stigma were specifically linked to support from educators and peers. The study emphasises how crucial it is to comprehend and deal with these elements in HIV prevention and therapy.

### 2.2.10 Types of Stigmatizations

HIV-related stigma encompasses negative attitudes and perceptions toward individuals living with HIV (Odibo et al., 2018). The Health Stigma Framework (HSF) developed by Earnshaw and Chaudoir identifies three key mechanisms of HIV-related stigma: enacted stigma, anticipated stigma, and internalized stigma, each shaping the social experiences of people living with HIV (PLWH) (Earnshaw et al., 2013). According to Schönnesson et al. (2024, p. 2):

> *Enacted stigma refers to the prejudice and discrimination that PLWH perceive they have experienced, often manifested in social rejection, avoidance, and exclusion.*
>
> *Anticipated stigma involves the expectation of negative treatment due to one's HIV-positive status.*
>
> *Internalized stigma occurs when PLWH adopt societal negative attitudes toward themselves, leading to feelings of shame, self-blame, embarrassment, and diminished self-worth.*

Internalized stigma can have profound social and psychological effects, prompting individuals to delay marriage, avoid intimacy, withdraw from family and friends, or even refuse medical care (Simbayi et al., 2007; Kingori et al., 2012). Akatukwasa et al. (2021) highlight that narratives of internalized stigma frequently reveal deep feelings of worthlessness and humiliation, often resulting in self-isolation and, in

extreme cases, suicidal ideation. Cultural and religious norms, as well as the persistent association of HIV with promiscuity, further reinforce internalized stigma.

Perceived stigma particularly the expectation of discrimination has been linked to higher levels of depression, social exclusion, reluctance to disclose HIV status, and poor adherence to medical care and treatment (Ayiga et al., 2013). However, the likelihood of experiencing stigma varies with age and engagement in HIV care. Research suggests that older individuals (40 years and above) and those who are stable on antiretroviral therapy (ART) are less likely to anticipate stigmatizing attitudes (Bonnington et al., 2017).

Discrimination, a form of enacted stigma, manifests in actions intended to diminish the rights and opportunities of PLWH. Such discriminatory practices may result in denial of employment, education, and healthcare (USAID, 2005). A notable legal case illustrating this is Georgina Ahamefule v. Imperial Medical Centre (Suit No. ID/1627/2000) in Nigeria. Ahamefule, diagnosed with an AIDS-related opportunistic infection, was tested for HIV without her consent and subsequently dismissed from her job after testing positive. She suffered severe emotional distress and pregnancy loss due to the discriminatory treatment. The Lagos High Court ruled that her dismissal was unlawful and motivated by malice and bad faith (AU, 2004).

### 2.2.11Dimensions of Stigmatization

A conceptual model was developed by Holzemer et al. (2007) to describe the settings and dynamics of HIV/AIDS stigma as experienced by African nurses and people living with the disease. It is a component of a wider investigation to better comprehend the HIV/AIDS stigma. According to their conclusions, there are two parts to the data: the stigma process itself, and contextual elements including the

environment, healthcare system, and agents that impact and affect stigma. The stigma process has four components: triggers of stigma, stigmatizing behaviours, types of stigmatization and its outcomes.

HIV stigma is a complex social phenomenon in which people are frequently treated unfairly and socially undervalued because of their HIV status (Henny et al., 2022). Internalized HIV stigma is linked to detrimental effects on a person's social support, mental health, and support from others (Chambers LA, et al., 2015). For many populations, HIV stigma overlaps with other societal problems (such as racism and homophobia) that further marginalize people who are already living with HIV (Burnham et al., 2016). However, the dimensions found by Holzemer et al. (2007), are discussed in the following section. To minimize HIV/AIDS stigma, individuals need to raise awareness that we all have a role to play in stopping HIV stigma. When we support people with HIV, we make it easier for them to live healthy lives. HIV stigma is negative attitudes and beliefs about people with HIV. It is the prejudice that comes with labelling an individual as part of a group that is believed to be socially unacceptable. Here are a few examples:

1. Believing that only certain groups of people can get HIV
2. Making moral judgments about people who take steps to prevent HIV transmission
3. Feeling that people deserve to get HIV because of their choices.

While stigma refers to an attitude or belief, discrimination is the behaviours that result from those attitudes or beliefs.

HIV discrimination is the act of treating people with HIV differently than those without HIV. Here are a few examples:

1. A healthcare professional refusing to provide care or services to a person living with HIV
2. Refusing casual contact with someone living with HIV
3. Socially isolating a member of a community because they are HIV positive

### 2.2.12 Effects of HIV/AIDS -Related Stigma on Adolescents Living With HIV.

Mhode and Nyamhanga (2016) examined how stigma and discrimination affect adherence to antiretroviral therapy (ART) among persons living with HIV (PLHIV). Information on the actual lived experiences of stigma and prejudice was gathered using a phenomenological technique. The saturation concept was used to calculate the sample size. The findings showed that respondents have encountered many types of HIV-related stigma, including verbal, social, and perceived stigma. Relational discrimination, poor treatment by healthcare professionals, blame and rejection from spouses, and employment discrimination are just a few of the several types of discrimination that were faced.

By encouraging HIV status concealment and reducing social support, HIV-related stigma and prejudice hampered adherence to antiretroviral therapy (ART).

Madiba and Josiah (2019) evaluated the self-reported medication adherence of ALPHIV and investigated structural variables that either encourage or inhibit adherence. In-depth interviews with ALPHIV were conducted for this qualitative study at a teaching hospital's infectious disease control centre in Botswana.

Thirty young people between the ages of 12 and 19 who were aware of their HIV status were specifically sought out. Thematic analysis and NVivo data analysis tools were used to examine transcribed interviews. The findings showed that non-adherence was a concern in both genders and all age groups. A significant obstacle to adherence

to ART was perceived stigma. The fear of embarrassment and unintentional revelation was particularly prevalent in boarding school students. The teenagers refused to take their medication in front of their housemates and strangers.

They chose to conceal themselves and take their prescription in secret, which resulted in missed dosages. Having trouble making appointments for clinic visits was caused by the increased anxiety of being seen collecting ART drugs. When there was a conflict between school activities, dose times, and scheduled clinic appointments for ART refills, fear of stigma also affected the decision-making process. The primary supportive factor for adherence was the home environment. The main factor that encouraged teenagers to attend and maintain clinic appointments was support. On a personal level, wanting to be well and live a long time was a big incentive to stick with it.

George (2019) researched to ascertain the many circumstances in which PLHA experience stigma and prejudice and its effects on their health. At the Network for Positives' office, PLHA were the subject of qualitative research. To find out the circumstances under which PLHA and peer counsellors experienced stigma and prejudice, informal interviews with them were performed. Focus group discussions for both male and female PLHA were conducted independently. A semi-structured interview guide was used to gather the data, and the interviews were audio recorded.

They were then manually coded, thematically assessed, and triangulated after transcription. According to the study's findings, PLHA frequently faced stigma and/or prejudice in five distinct contexts, including the media, the person, family, community, and the healthcare system. It was discovered that stigma and prejudice had an adverse effect on people's health conditions since they discouraged them from using the available healthcare services, which caused their health to get worse.

According to Turan, Hatcher, Weiser, Johnson, Rice, and Turan (2017), PLHA may be reluctant to disclose their sexual orientation to family, friends, and romantic partners out of fear of discrimination, stigma, and possible violence. This can worsen their isolation, make it harder for them to get to and stay in treatment, and undercut measures at prevention like sharing drug equipment and using condoms. In addition to other negative effects, stigma can include family rejection, poor treatment in medical institutions, and the loss of home and work.

### 2.2.13 Coping Strategies

Coping mechanisms are ideas and actions people use to organize the internal and external demands of a certain stressful event or situation (Silva et al., 2013). According to Kumar et al. (2015), PLHA used many proactive strategies, such as clear awareness and comprehension of HIV, social support and family well-being, selective disclosure, job confidence development, and involvement in proactive networks.

Healthy coping strategies were impeded by inadequate knowledge about HIV and apprehensions about being branded immoral, whereas increased knowledge, membership in support groups, family support, the presence of children, and financial independence increased PLHA confidence. Positive coping techniques like these might be used to guide culturally appropriate therapies.

According to Makoae et al. (2008), the usage of disclosure as a coping mechanism varied depending on whether it was believed to make things better or worse. When the PLWHA thought that reporting may elicit support from spouses and family

members, disclosure was primarily employed as a coping mechanism. After disclosing, especially to a spouse or family member, participants said they felt lighter thereafter as if a burden had been lifted off their shoulders. A strong desire to live in the face of disease can be seen in coping by believing oneself to be ok. This was indicated through participating in social activities and going to social and community functions. Speaking with others establishes social networks, whether they are official or informal, and these networks offer a forum for everyone to express themselves, share their suffering, communicate with others, and make friends.

To better understand the association between coping strategies used by the rural HIV/AIDS population and the stigma connected to the disease, Anima-Korang, Gere, and Salimi (2018) undertook a mixed-method study. The results showed that self-isolation was the most widely employed kind of coping technique among respondents. The results of the study also showed that coping mechanisms might be either emotional or problem-focused. The person's personality traits are likely to influence how often one strategy is employed in contrast to the other. For instance, while many respondents were prepared to seek social support in some way or participate in destructive or hazardous behaviours, few respondents were willing to seek religious assistance.

Mukherjee et al. (2017) examined the stigmatizing pattern in HIV/AIDS (PLWHA) patients and evaluated the coping mechanisms used for quality of life (QOL) assessment. Through "snowball sampling," PLWHA visiting the HIV (human immunodeficiency virus) clinic at Medical College, Kolkata (n = 120) were included in a descriptive, cross-sectional research design. Data on socio-demographics were gathered using a quick semi-structured interview schedule. The WHO-BREF (World

Health Organization Quality-of-Life) scale was used to measure the quality of life (26-item). According to the findings, 96.7% of people said they were stressed. Most stigma encounters took place in a socio-family setting. Compared to individuals who had experienced stigma, fear of stigma was far more prevalent.

In the psychological realm, there is a negative correlation between the quality of life and internalizing stigma. Those who encountered stigma had a higher-than-average quality of life. There were several different defensive systems found. The most popular defensive tactics were "Altruism," "Anticipation," and "Humour." Such coping mechanisms, however, appeared to be self-taught and were only marginally effective in reducing perceived stigma.

Research by Ekstrand et al., (2018) was carried out in South India to examine the impact of stigma on the health and quality of life of rural women living with HIV. The adoption of avoidant coping mechanisms, such as lying to family members about the cause of doctor visits or medication use, has been connected to stigma. It seems that the ladies were unable to acquire much-needed social support and felt lonely as a result since such tactics are meant to limit disclosure.

Laar et al. (2015) examined, among other things, how families in Ghana afflicted by HIV employed negative coping mechanisms to maintain their way of life. The results showed that households impacted by HIV engaged in a variety of degrading coping mechanisms, including missing a whole day's worth of meals, cutting portion sizes, gathering immature crops, and begging.

Mbonye et al. (2013) performed longitudinal qualitative in-depth interviews with 41 members of The AIDS Support Organization (TASO) from 2005 to 2008 in Jinja,

Uganda, to explain the stigma trajectories of PLHIV across 5 years from the time they began ART. Interview topics included stigma and ART usage.

The findings indicate that stigma was quite high before beginning ART, which can be explained by outward symptoms of chronic diseases as well as personal accounts of prejudice and maltreatment. Early coping mechanisms included withdrawing from society, quitting one's job owing to illness, and relocating with family.

The individuals were able to take charge of their condition and manage their social lives after beginning ART, which resulted in a continuous drop in stigma. Better health allowed people to resume working and engaging in sexual activity, but less information was shared with employers, co-workers, and new romantic partners.

Sero-sorting was cited by a few individuals as a way to avoid discussions about their HIV serostatus. During the 18- and 30-month interviews, there may have been an increase in stigma levels that was associated with less sharing.

By 2011, the stigma associated with ART was even more pervasive, especially among people who had begun new sexual relationships, found work, and shown physical symptoms of its adverse effects.

## 2.5 Conceptual framework

This study's conceptual model is based on the Transactional Model of Stress and Coping (TSC), Adlerian Theory (Existential Perspective), and insights from the reviewed literature. Miles and Huberman (1994) define a conceptual framework as a "visual or written product that explains, either graphically or in narrative form, the main things to be studied the key factors, concepts, or variables and the presumed relationships among them" (p. 18). The central premise of this study is that adolescents who are aware of their HIV-positive status experience significant stigma and discrimination, which serve as stressors requiring appraisal. Their responses to these stressors shape their coping mechanisms, which, in turn, influence health outcomes that benefit both the adolescents themselves and society at large. The conceptual model, illustrated in Figure 1, is connected to the literature on adolescent stressors and coping strategies for stress management.

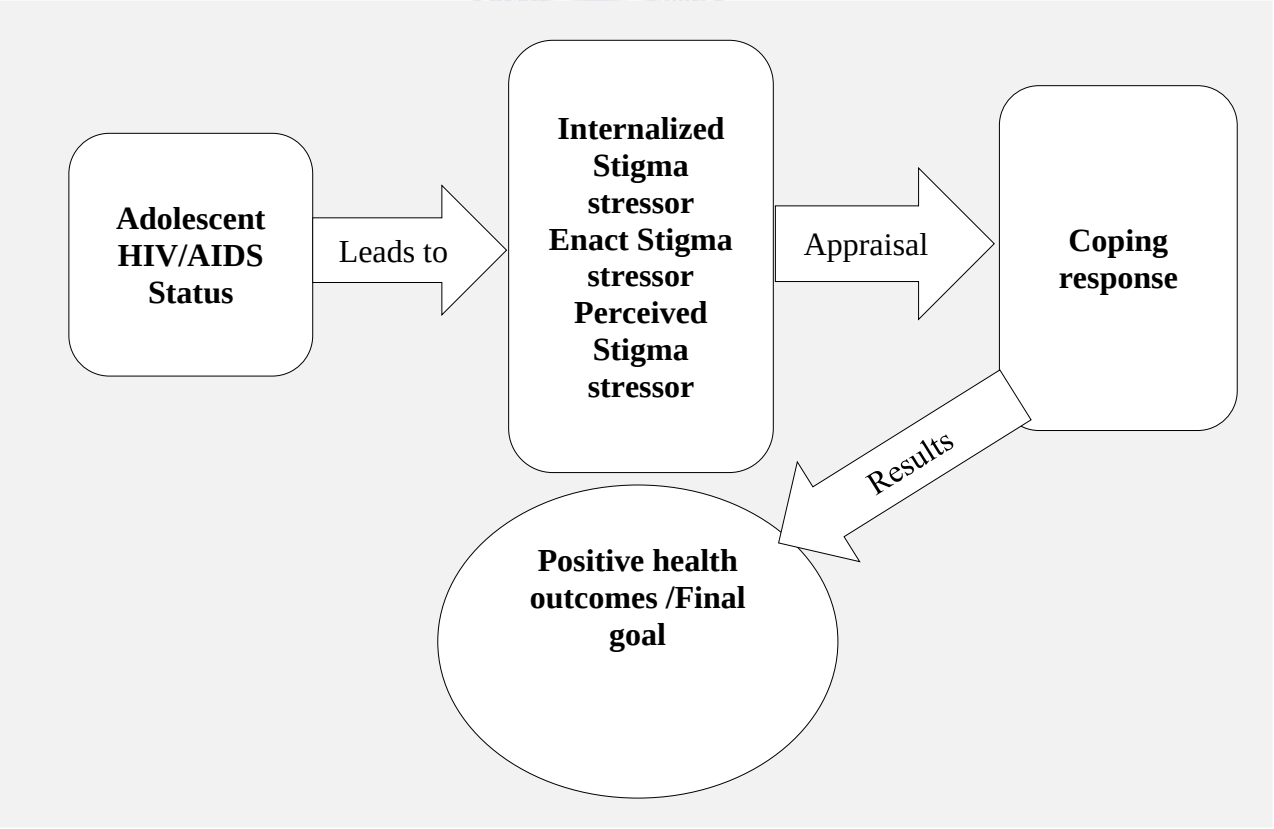
The Transactional Model of Stress and Coping (TSC), developed by Lazarus and Folkman, provides a framework for understanding how individuals perceive and respond to stress. Within this context, internalized, enacted, and perceived stigma act as primary stressors for adolescents living with HIV/AIDS. The model posits that individuals appraise these stressors and adopt coping strategies that are either problem-focused (e.g., seeking social support) or emotion-focused (e.g., avoidance or denial). The effectiveness of these coping mechanisms ultimately determines their health outcomes, reinforcing the relevance of TSC in explaining how stigma influences adolescent well-being.

From an Adlerian (Existential) perspective, stigma represents not only a psychological burden but also an existential challenge that affects adolescents' sense of belonging, self-worth, and purpose. Adlerian theory suggests that individuals are

driven by an innate need for personal growth and social connection, which influences how they interpret and respond to adversity. Adolescents' perceptions of stigma, shaped by their social environment and personal beliefs, influence their coping responses and long-term psychological adjustment. Those who find meaning in their experiences and develop resilient coping mechanisms are more likely to achieve positive health outcomes despite the challenges of living with HIV/AIDS.

By integrating these two theoretical perspectives, the conceptual framework offers a comprehensive understanding of how adolescents manage stigma-related stress. While TSC emphasizes the cognitive and behavioural aspects of stress appraisal and coping, Adlerian theory provides deeper insights into the emotional and existential dimensions of resilience. Together, these models provide a holistic view of the coping mechanisms that contribute to improved health and well-being among HIV-positive adolescents.

**Figure 1. Conceptual framework**



## 2.6 Chapter Summary

Chapter Two presents a comprehensive literature review, providing a theoretical and empirical foundation for the study. It begins by outlining relevant theoretical frameworks and explaining key models and concepts that underpin the research. These theories help in understanding the relationship between the study variables and provide a basis for the research hypotheses. By integrating insights from multiple theoretical perspectives, the study establishes a structured approach to examining the research problem.

The chapter then delves into an empirical review, analyzing existing research findings on the topic. This section highlights significant trends, patterns, and relationships observed in prior studies. It also identifies gaps in the literature, pointing out areas where further research is needed. This review ensures that the study builds on established knowledge while addressing critical issues that have not been fully explored.

A conceptual framework is also presented, visually illustrating the connections between key variables and explaining how they interact within the research context. This framework serves as a guide for data collection and analysis, ensuring that the study remains focused on its core objectives.

Finally, the chapter concludes with a summary, synthesizing the key insights from the literature review. It emphasizes the theoretical and empirical gaps identified, reinforcing the significance of the research. By highlighting these gaps, the chapter justifies the need for the study and sets the stage for the subsequent methodology and analysis.

# CHAPTER THREE

# METHODOLOGY

## 3.0 Introduction

This chapter discusses the study setting, design, and procedures utilized to carry out the current study. It includes the population of the study, selection of participants, development of research instrument, collection of data, analysis of data, rigour and ethical considerations. Essentially, it shows the progression of the researcher's knowledge, understanding, and data acquisition to respond to the research questions and advance knowledge.

## 3.1 Research Approach

This study is a qualitative exploratory study employing a phenomenological approach. One major feature of well-collected qualitative data is that they focus on naturally occurring, ordinary events in natural settings, so that, we have a strong handle on what is ‘real life’ is like. Given Jonker and Penning (2010), qualitative research is rooted in natural science which postulates that ‘knowledge about reality can only be obtained “through the eyes of the researcher”.

It is mainly grounded on the assumptions of positivism and represents a view of social reality as an external objective reality ( Bryman & Bell, 2011). Similarly, Weinreich (2009) stated that qualitative research employs methods from natural science that are designed to guarantee generalizability, objectivity and reliability.

In quantitative research, some of the techniques employed include the random selection of research informants from the study population in an unbiased way. Shields and Twycross (2003) suggested that at the most basic level, qualitative

research methods are used when a question needs to be described and investigated in some depth.

Moreover, qualitative research involves an interpretive, naturalistic approach to the world, thus, qualitative researchers study phenomena in terms of the meanings people bring to them. Qualitative research implies an emphasis on the qualities of entities and on processes and meanings that are not experimentally examined or measured (Denzin & Lincoln, 2005).

According to Patton (2001), qualitative research is defined as the kind of research that produces findings derived from real-world settings where the phenomena of interest unfold naturally. That is to say, is any kind of research that produces findings not arrived at employing statistical procedures or other means of quantification. Unlike quantitative research which has its objective, of collecting facts about human behaviour that will lead to the verification and extension of theories, qualitative research emphasises the improved understanding of human behaviour and experiences.

Qualitative research usually involves the use of multiple data-gathering methods, particularly engaging respondents in an interview and uses an inductive research approach to data analysis, extracting its concepts from the mass of particular detail which constitutes the database. This approach was used to allow respondents to share their lived experiences to enable the researcher to understand the various ways in which adolescents acquired HIV/AIDS, their experiences of stigmatization and their coping strategies.

### 3.2 Research Design

A research design is a blueprint or model for how the researcher plans to carry out the study and respond to the research question(s) (Griffee, 2012). The study design is conceived of in terms of the aim, tactics used, and decisions taken about data collecting and analysis, including processes and procedures, as well as time horizon and ethical issues (Saunders, 2009). A qualitative research design was adopted for the study. A qualitative research approach seeks to comprehend people's perceptions after they have experienced the phenomena. (HIV) (Patton, 2002). According to Saldaa (2015, p.3), the term "qualitative research is an inclusive term for a wide variety of approaches and methods for the study of natural social life." The goal of qualitative research is to fully express people's lived experiences in contrast to quantitative research, which examines dependent and independent variables, qualitative research investigates social events in a natural context using words rather than numbers (Marshall & Rossman, 2011).

In essence, the qualitative research study design research is the best method to employ for this study since it allows young people living with HIV to independently explain how they experience stigma and discrimination as well as how they are coping with their condition. Having a thorough understanding of their experiences from many angles would make it easier to understand their situation.

### 3.3 The Study Area

The study was conducted in the New Juaben Municipality of the Eastern Region, Ghana. The municipality has a total population of over 183,700, with 30.8% of the population being youthful (below 15 years old). The population is composed of 51.7%

females and 48.3% males, with 93.3% residing in urban localities (Ghana Statistical Service, 2010).

Data for the study were collected at the Koforidua Regional Hospital, a major referral facility that serves over 180,000 inhabitants of the municipality and surrounding towns, including Nkurankan, Asesewa, Odumase, Somanya, Huhunya, Oterkpolu, Akim Tafo, and others in the Eastern Region. The hospital provides a wide range of healthcare services, including antiretroviral therapy (ART), obstetrics and gynecology, and primary healthcare. The facility serves over 3,000 people living with HIV (PLHIV) and operates three major clinic days per week (Tuesdays, Wednesdays, and Thursdays), with an average daily attendance of 120 patients. ART services are provided at both the main hospital and an associated Polyclinic, which primarily serves prevention of mother-to-child transmission (PMTCT) services for antenatal clinic attendees.

The Eastern Region of Ghana has been identified as one of the most affected areas in the national HIV epidemic, making it a critical focal point for this study. According to the Ghana AIDS Commission (GAC, 2018), the region recorded the highest HIV prevalence rate at 2.3%, surpassing the national prevalence of 1.7%. This high prevalence rate underscores the urgent need for targeted research and intervention strategies, particularly among vulnerable populations such as adolescents.

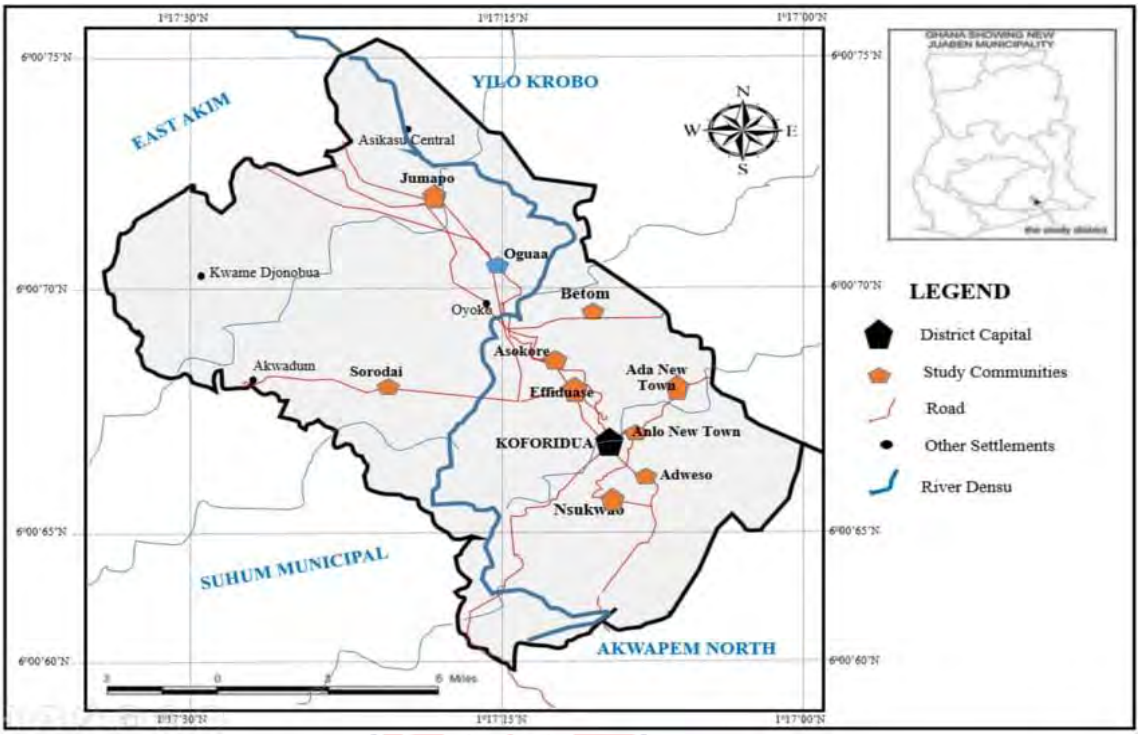
The burden of HIV among adolescents in the Eastern Region aligns with national trends, where young people aged 15–24 years account for 28% of new HIV infections (GAC, 2019). Specifically, adolescents aged 15–19 years have an estimated prevalence of 0.7%, placing them at significant risk of HIV-related stigma, discrimination, and barriers to accessing healthcare. These challenges can negatively

impact their psychosocial well-being, adherence to treatment, and overall health outcomes.

Furthermore, the Eastern Region is among the four regions in Ghana that collectively account for 75% of all people living with HIV, despite representing only 58% of the national population (CCM Ghana, 2018). The region has also been identified as a hotspot for key populations, including female sex workers and men who have sex with men, further contributing to the complexity of HIV transmission dynamics, stigma, and health disparities.

Given these factors, this study is crucial in understanding how adolescents in the Eastern Region experience HIV-related stigma, develop coping mechanisms and access healthcare services. The findings will help shape evidence-based interventions aimed at improving treatment adherence, mental health support, and overall well-being of adolescents living with HIV/AIDS in this Region.

### 3.3.1 MAP OF NEW JUABEN MUNICIPALITY




### 3.4 Population of the Study

A population is the group of people, events, things, or other phenomena that a researcher is most interested in; it is frequently "who" or "what" the researcher wants to be able to say something about after the study (Sheppard, 2020). Seropositive men and women who seek medical care at the Eastern Regional Hospital-Koforidua are thus eligible to participate in the research. The research is targeting adolescents whose ages range from 10 to 24.

### 3.5 Sample Size and Sampling Procedures

Purposive sampling was used to select those living with HIV/AIDS who offered in-depth and extensive information on the phenomena being studied. Following this plan, all adolescents who had ever started HIV treatment at the Regional Hospital, Koforidua were found through clinic patient records and tracked down to nearby

communities like Srodae, Betom, Effiduase Asokore, Agavenya, Old Estate, Trom, etc. to make sure those who weren't receiving care were not included. The concept of information power, which states that fewer participants are required for research if the sample has more information that is important to it, was utilized to determine the sample size (Malterud et al, 2016).

The sample size of the study was thirteen (13). They were given codes to make the analysis easy. The codes were R1- R13, where R1 represent the (1st) respondent (1), R2 for respondent (2), R3 for respondent (3), R4 for respondent (4), R5 for respondent (5), R6 for respondent (6), R7 for respondent (7), R8 for respondent (8), R9 for respondent (9), R10 for respondent (10), R11for respondent (11), R12 for the (12th) respondent and R13 representing the (13th) respondent)

The table below presents information on the location of participants and the number selected from the community suburb.

**Table 1: Demographic Location of Participants**

| No | Name of suburb | Number |
|---|---|---|
| **1** | Srodae | 1 |
| **2** | Cantudu | 1 |
| **3** | Zongo | 2 |
| **4** | Effiduase | 2 |
| **5** | Highways | 1 |
| **6** | Adweso | 2 |
| **7** | Trom/Two streams | 2 |
| **8** | Mile 50 | 2 |
| | **Total** | **13** |

### 3.5.1 Justification for the Sample Size

The selection of a sample size of thirteen (13) participants was guided by the principle of information power as proposed by Malterud et al. (2016). According to this concept, the adequacy of a sample in qualitative research is determined by the richness and relevance of the information obtained rather than the sheer number of participants. When the sample consists of individuals who provide in-depth and substantial insights into the phenomenon being studied, a smaller sample size is sufficient.

Given that the study focuses on adolescents living with HIV/AIDS who have initiated treatment at the Regional Hospital in Koforidua, purposive sampling was employed to ensure that only individuals with relevant lived experiences were included. This approach ensured that the selected participants could offer detailed and context-specific information regarding their treatment experiences, adherence challenges, and the social factors affecting their health and well-being.

Furthermore, the sample was drawn from multiple suburbs, including Srodae, Cantudu, Zongo, Effiduase, Highways, Adweso, Trom/Two Streams, and Mile 50, to ensure a diverse representation of adolescent experiences across different socio-environmental contexts. The geographical spread of participants also helped capture a broad spectrum of factors influencing treatment adherence and HIV-related stigma.

Thus, the decision to limit the sample to thirteen participants was based on the depth and specificity of the data required for the study. This aligns with qualitative research principles, where achieving data saturation the point at which no new themes or insights emerge validates the sufficiency of the sample size.

### 3.6 Sources of Data

The study employs both primary and secondary sources of data for this research. Specifically, the primary source of data would be gathered through in-depth interviews whereas secondary sources would include books, personal sources, journals, newspapers, websites, government records (Eastern Regional Government Hospital-Koforidua, publications of Ministry of Health, Ghana AIDS Commission and National AIDS Control Program) etc.

### 3.7 Research Instrument

An interview guide is a list of questions or topics that the interviewer hopes to cover during an interview. Based on the study's goals and questions, an interview guide was developed. The interview guide was divided into three sections: sociodemographic factors (age, education level, marital status, number of children, occupation, and duration with HIV), experiences with HIV-related stigma, and coping mechanisms. Open-ended questions were asked on coping mechanisms and HIV-related stigma, whereas closed-ended questions were asked about sociodemographic factors.

The interview guide helped interviewers to know what to ask about and in what order and it ensures a candidate experience that is the same for all applicants.

An interview guides outline issues that a researcher feels are likely to be important. Participants are asked to provide answers in their own words and to raise points they believe are important, so each interview is likely to flow a little differently.

The benefits of using an interview guide include:

- it creates a structured process
- it provides all applicants with the same candidate experience
- it makes it easier to assess every candidate in the same way, hence reducing the risk of bias in the interview process.
- The interview guide serves as a reference for the researcher throughout the study.
- It also provides context to anyone who may examine your data after analysis so they can better understand your coding decisions.

### 3.8 Ethical Considerations and Approval

In conducting this study, the researcher adhered to strict ethical protocols to ensure that data collection and analysis upheld the highest ethical standards. The four pillars of medical ethics autonomy, non-maleficence, beneficence, and justice were carefully considered, especially given the sensitive nature of HIV/AIDS-related research. Special attention was given to confidentiality and the potential risks associated with partner notification. The study followed the National AIDS Control Organization (NACO) policy, which mandates that no individual should be tested for HIV without voluntary consent. Ethical concerns related to stigma, discrimination, and possible psychological, social, and economic harm were thoroughly addressed to protect participants' rights and well-being.

#### 3.8.1 Consent Issues

Consent was a critical component of the study. Each participant was fully informed about the purpose of the research, the procedures involved, and their right to withdraw at any time without consequences. They were given ample time to ask questions

before providing their voluntary consent. Since the study involved minors, additional consent was sought from hospital authorities acting in loco parentis, ensuring compliance with ethical research guidelines. During the interviews, confidentiality was strictly maintained. Participants were identified using coded labels (R1–R13) instead of their real names, and all recordings and transcripts were securely stored to prevent unauthorized access.

### 3.8.2 Gatekeepers and Access to Participants

To gain access to participants, the researcher sought formal permission from the relevant gatekeepers. Approval was obtained from the head of the Department of Counselling Psychology at the University of Education, Winneba, as well as from the Regional Hospital's HIV/AIDS Focal Person. Before engaging with participants, the researcher personally contacted the in-charge of the hospital's HIV/AIDS unit to discuss the study's objectives and ethical considerations. The hospital authorities then scheduled a convenient time for data collection during one of the quarterly peer interactive meetings at the Koforidua Regional Hospital, where adolescents living with HIV/AIDS were already gathered. This arrangement provided a safe and familiar environment for participants while ensuring that ethical standards were maintained.

### 3.8.3 Access to Documents

The researcher also required access to specific documents related to the care and management of adolescents living with HIV/AIDS. Permission was sought from hospital authorities to review anonymized reports, policy documents, and counselling guidelines that informed the provision of healthcare services to these individuals. These documents provided valuable context for understanding the institutional

support systems available to participants. To maintain confidentiality, no personally identifiable information was accessed, and all data obtained from documents were used solely for research purposes.

### 4.0 Sample Size

The researcher adopted a purposive sampling approach, selecting adolescents who had received HIV treatment at the Regional Hospital. The sample size of thirteen (13) was determined based on the concept of information power, which suggests that a smaller sample is sufficient when participants provide rich and detailed information relevant to the research objectives. Data saturation was achieved when additional interviews no longer yielded new insights, confirming that the collected data were comprehensive. To enhance credibility and ensure the accuracy of responses, each participant was interviewed on three separate occasions. These repeated interviews allowed for cross-verification of responses, ensuring that information remained consistent over time. Any discrepancies in participants' narratives were addressed through follow-up discussions, strengthening the reliability of the findings.

### 4.1 Data Collection Procedures

The researcher conducted face-to-face and in-depth interviews with participants to obtain rich qualitative data. Interviews were recorded using smartphones after participants had given their consent. The sessions were conducted in a private consulting room allocated by the in-charge of the counselling unit, ensuring confidentiality and minimizing disruptions. The researcher took handwritten notes, especially when participants discussed the effects of HIV/AIDS on their lives. Each participant was interviewed three times to allow for deeper exploration of their

experiences and to confirm the consistency of their responses. These follow-up interviews enabled the researcher to cross-check previous statements, ensuring accuracy and reliability. Interviews lasted approximately 45 minutes each, and data collection took place in November 2022.

### 5.0 Trustworthiness of the Interviews

To enhance the credibility, dependability, transferability, and confirmability of the study, several strategies were employed.

### 5.1 Credibility

Credibility was established through member checking, where participants were allowed to review and verify their statements. This allowed them to clarify their intentions, correct errors, and provide additional details where necessary. This process ensured that the findings accurately represented their experiences.

### 5.2 Dependability

Dependability was achieved by providing detailed descriptions of the data collection process, ensuring transparency. The researcher documented each step of data collection, analysis, and reporting, allowing for reproducibility and verification by other researchers.

### 5.3 Transferability

To enhance transferability, a purposive sampling technique was used to select adolescents living with HIV/AIDS, ensuring that the sample reflected diverse experiences. A thick description of the findings was provided, making the results

applicable to similar contexts beyond the study area. This was particularly relevant for stakeholders such as educationists, healthcare professionals, and policymakers.

### 5.4 Confirmability

To ensure confirmability, the researcher maintained a rigorous data-checking process. Transcripts were reviewed multiple times, and a data audit was conducted to document any modifications. The open-coding technique was employed to minimize bias, and peer debriefing was conducted with a fellow researcher pursuing an MPhil in Counselling Psychology at the University of Education, Winneba. Additionally, discussions with a colleague who had completed a similar study helped validate the themes and findings.

### 6.0 Data Management and Analytic Procedure

Thematic analysis was employed for data analysis, following the inductive approach outlined by Braun and Clarke (2006). Audio recordings were transcribed verbatim, and where necessary, translations into English were conducted. The correctness of the transcripts was cross-checked against the audio recordings before coding was performed. Codes were developed based on the frequency and significance of data extracts, leading to the identification of key themes. Discrepancies between codes and themes were carefully addressed through a rigorous review process. To provide depth to the analysis, direct quotes from participants were included to illustrate their lived experiences, particularly about HIV-related stigma and coping strategies.

Throughout the data management process, ethical considerations were upheld to ensure that participant information remained secure. Transcripts and recordings were stored in password-protected files, and access was restricted to authorized personnel

only. The study adhered to strict confidentiality protocols, ensuring that participants' identities remained protected. The combination of rigorous ethical standards, robust data analysis techniques, and trustworthiness measures contributed to the reliability and validity of the study's findings.

## 7.0 Summary of the Chapter

Chapter Three presents the research methodology used in the study, outlining the research design, population, sampling techniques, data collection methods, instruments used, and data analysis procedures. The chapter begins by explaining the research design and providing justification for its selection based on the objectives of the study. The chosen design serves as the framework that guides the entire research process, ensuring that the study remains structured and systematic.

The chapter further discusses the target population and the sampling techniques employed in selecting participants. The criteria for selecting participants are outlined, ensuring that the sample is representative of the population being studied. The sampling method is explained, along with the rationale for determining the sample size. This ensures that the study includes an adequate number of participants to allow for meaningful analysis and conclusions.

Data collection methods are also elaborated upon, detailing the techniques used to gather relevant information. Whether through surveys, interviews, or observations, the study ensures that the data collection process is rigorous and reliable. Additionally, the instruments used for data collection are described, with a focus on their validity and reliability. Measures taken to ensure the accuracy and consistency of the data are also highlighted.

The data analysis procedures are then presented, explaining the methods used to interpret the collected data. Depending on whether the study follows a qualitative or quantitative approach, the relevant analytical tools and techniques are described. The analysis ensures that the data is systematically examined to draw meaningful insights that address the research questions and objectives.

Lastly, the chapter discusses the ethical considerations that were adhered to throughout the research process. Issues such as confidentiality, informed consent, and voluntary participation are emphasized to protect the rights and well-being of the participants. The study follows ethical guidelines to ensure that the research is conducted responsibly and respectfully, particularly given the sensitivity of the topic.

Overall, Chapter Three provides a comprehensive overview of the research methodology, ensuring transparency and rigour in the study. It lays the foundation for the data collection and analysis process, ensuring that the findings are credible, valid, and ethically obtained.

# CHAPTER FOUR

# DATA ANALYSIS AND DISCUSSION OF RESULTS

## 4.0 Introduction

This chapter provides a comprehensive presentation of findings from fieldwork on the dimensions of stigmatization and coping strategies among adolescents living with HIV/AIDS in New Juaben Municipality together with data analysis and discussion. This study employed inductive thematic analysis suggested by Braun and Clarke (2006) to analyse data collected from the respondents. To guarantee comprehensive reporting, the chapter is divided into two parts. In the first part, respondents' demographic data is presented. The second part of the study, which includes major themes and sub-themes, addresses the study's goals, objectives, and research questions.

Specifically, the first research question measured the extent of stigma experienced by adolescents living with HIV/AIDS. It explored different forms of stigma, including internalized stigma, perceived stigma, and enacted stigma, and how these affect their daily lives. The study also identified the causes of stigma, such as misconceptions about HIV transmission, cultural and religious beliefs, fear of contagion, and negative societal attitudes towards people living with HIV/AIDS. These factors contribute to widespread discrimination and marginalization of affected adolescents.

The second research question examined the psychological, emotional, social, and economic consequences of stigma. The findings revealed that stigmatization leads to emotional distress, social isolation, school dropout, discrimination in healthcare and employment, and reduced adherence to medication. Many adolescents struggle with low self-esteem, anxiety, and depression due to the negative perceptions and

treatment they receive from society. Additionally, the study highlighted how stigma discourages some adolescents from seeking medical care or support services, further worsening their health outcomes.

The third research question assessed the different mechanisms adolescents use to navigate stigma and its impact. The findings showed that many rely on support from family, peers, and counselling services to cope with the emotional burden of stigma. Others turn to religious or spiritual practices for strength, while some choose to selectively disclose their HIV status to avoid discrimination. Participation in support groups was also identified as an effective coping strategy, providing a safe space for sharing experiences and receiving encouragement. However, the study also noted that some adolescents resort to avoidance behaviours, such as withdrawing from social interactions, as a means of self-protection.

**Table 2: Coding and Interpretations**

| CODES | INTERPRETATION |
|---|---|
| R1 | 1st Respondent |
| R2 | 2nd Respondent |
| R3 | 3rd Respondent |
| R4 | 4th Respondent |
| R5 | 5th Respondent |
| R6 | 6th Respondent |
| R7 | 7th Respondent |
| R8 | 8th Respondent |
| R9 | 9th Respondent |
| R10 | 10th Respondent |
| R11 | 11th Respondent |
| R12 | 12th Respondent |
| R13 | 13TH Respondent |

## 4.1 Results

13 in-depth interviews were performed to the point of saturation in all and were examined. The 13 interviews provided enough data, however, to justify deeper analysis without returning to the field to gather additional data.

The respondent's characteristics are described in Table 1.

**Table 3: Demographic characteristics of respondents**

| Respondents | Gender | Age | Level of education | Occupation | Duration with HIV |
|---|---|---|---|---|---|
| R1 | Male | 17 | Primary | Apprentice | 5 |
| R2 | Male | 16 | JHS | Student | 16 |
| R3 | Male | 24 | SHS | Unemployed | 2 |
| R4 | Female | 23 | SHS | Unemployed | 9 |
| R5 | Female | 16 | SHS | Unemployed | 3 |
| R6 | Male | 19 | SHS | Student | 3 |
| R7 | Female | 22 | JHS | Student | 8 |
| R8 | Female | 18 | Tertiary | Student | 3 |
| R9 | Female | 20 | SHS | Student | 4 |
| R10 | Male | 24 | Tertiary | Unemployed | 1 |
| R11 | Male | 19 | JHS | Student | 10 |
| R12 | Male | 14 | JHS | Student | 14 |
| R13 | Female | 24 | Tertiary | Student | 5 |

Table 3 presents the demographic characteristics of the respondents, including gender, age, level of education, occupation, and duration of living with HIV. The data provides valuable insights into the diversity of the participants and helps contextualize their experiences.

In terms of gender distribution, the table shows a fairly balanced representation, with seven males and six females participating in the study. This balance allows for a comparative analysis of experiences across gender lines, particularly in how males and females perceive and cope with HIV. The age of respondents ranges from 14 to

24 years, indicating that the study focuses on adolescents and young adults living with HIV. This age range is significant, as young people face unique challenges related to stigma, social acceptance, and access to healthcare services.

The level of education among respondents varies, with some having attained only primary or junior high school (JHS) education, while others have reached senior high school (SHS) or tertiary education. Notably, four participants have tertiary education, while the majority have either JHS or SHS education. This variation in educational levels suggests potential differences in awareness, access to health information, and coping mechanisms among the respondents.

Regarding occupation, the table shows that most of the participants are students, while a few are unemployed or apprentices. Specifically, seven respondents are students at different educational levels, reflecting the challenges of managing HIV while pursuing education. Three respondents are unemployed, highlighting the economic vulnerabilities that some young people living with HIV may face. One respondent is an apprentice, suggesting an effort to acquire vocational skills for future self-sufficiency.

The duration of living with HIV varies significantly among the respondents, ranging from 1 to 16 years. Some participants have been living with the condition since early childhood, while others acquired it more recently. Notably, the longest duration recorded is 16 years, which suggests that some respondents may have been born with the virus or diagnosed at a very young age. The variation in duration implies differences in adaptation and coping strategies, with those living with HIV for longer periods possibly having developed better resilience and mechanisms for managing the condition.

**4.2 Organisation of Research Questions and Sub-themes**.

The findings of the study have been organized around the three main research questions, with each question generating specific sub-themes that capture the causes, effects, and coping mechanisms related to HIV/AIDS stigmatization among adolescents in the New Juaben South Municipality. These are clearly presented in Table 4

**Table 4: Research Questions and Sub-themes**

| **Research Questions** | **SUB-THEME** |
|---|---|
| RQ1 Causes of HIV/AIDS n | Misinformation about HIV transmission<br>Moral judgment and social discrimination<br>Fear of contagion and social exclusion |
| RQ2 Effects of HIV/AIDS | Emotional stress<br>Cognitive stress<br>Internalised stigma<br>Perceived stigma<br>Enacted stigma<br>Loss of job<br>School drops out<br>Loss of hope in life<br>Shunning |
| RQ3 Coping Strategies | Family support<br>Counselling<br>Prayer<br>Selective disclosure<br>Involvement in proactive networks<br>Avoidance |

| | |
|---|---|
| **RQ 4: Counselling interventions** | |

### 4.2.1 What are its causes of HIV/AIDS among adolescents in the New Juaben South Municipality?

The first research question examined the level and causes of HIV/AIDS stigmatization among adolescents in the New Juaben South Municipality. The findings revealed that adolescents experience internalized, perceived, and enacted stigma, largely driven by misinformation about HIV transmission, such as beliefs that HIV is only spread through promiscuity or the use of sharp objects. Moral judgment also played a role, especially against females, with cultural and religious norms fueling blame and shame. Additionally, fear of contagion led to social exclusion and isolation, even among family and peers. These factors collectively contribute to the psychological and emotional stress experienced by adolescents living with HIV/AIDS.

***Misinformation About HIV Transmission***

Lack of accurate knowledge about HIV transmission fuels stigma, as many people assume the disease is only linked to certain behaviours such as sexual promiscuity or drug use. This misinformation leads to fear, discrimination, and isolation of adolescents living with HIV. Here are a few excerpts shared by respondents:

> *"For that, I don't know yet, and it is very strange to me because I have never had sex before… Some people say you can get HIV from using sharp objects, but I don't know if that is true." (R3)*

> *"I was young when I had it. I was told that my mother died of HIV/AIDS, but I have four siblings, and I am the only one with HIV. It confuses me." (R8)*

*"I fell ill in school and was admitted to the hospital. A series of tests confirmed I was HIV positive. What surprises me is that I have never had unprotected sex." (R5*

***Moral Judgment and Social Discrimination***

HIV/AIDS is often linked to behaviors that are socially condemned, such as premarital sex or multiple sexual partners. Adolescents, especially females, experience greater stigma due to cultural norms that place a heavier burden of morality on them. The following remarks were given by a respondent:

*"I got pregnant and went to the hospital for a check-up. I was diagnosed as HIV positive. The young man who impregnated me refused to be tested, and the nurses advised me to reconsider my relationship with him." (R6)*

*"I am sure I had HIV through sex because I have dated multiple men. I wasn't into prostitution, but I was seeing more than two guys just to survive financially." (R10)*

***Fear of Contagion and Social Exclusion***

Many people still fear that HIV can be transmitted through casual contact, leading to the isolation of those living with the disease. This fear is particularly damaging to adolescents, who may be rejected by peers, teachers, and even family members.

*"Please, it is through birth. My parents didn't tell me the exact age I was infected… One day, I asked my mum why I had been on medication for so long, and she told me that I had been infected with HIV." (R2)*

*"According to my father, I had it through birth. My mother was living with HIV/AIDS and passed it on to me. When she found out I was also HIV positive, she left me and ran away." (R7)*

In sum, the stigma surrounding HIV/AIDS among adolescents is driven by misinformation about its transmission, societal attitudes toward morality, and fear of contagion. These factors contribute to discrimination, isolation, and psychological distress for affected adolescents. Addressing these causes of stigma requires increased education, open discussions on HIV transmission, and support systems to help adolescents cope with their diagnosis without fear of rejection or discrimination.

### 4.2.2 What are the effects of HIV/AIDS related stigma on adolescents living with HIV/AIDS?

The second research question, "What are the effects of HIV/AIDS related stigma on adolescents living with HIV/AIDS?", examined the psychological, emotional, social, and economic consequences of stigma. The findings revealed that stigmatization leads to emotional distress, social isolation, school dropout, discrimination in healthcare and employment, and reduced adherence to medication. Many adolescents struggle with low self-esteem, anxiety, and depression due to the negative perceptions and treatment they receive from society. Additionally, the study highlighted how stigma discourages some adolescents from seeking medical care or support services, further worsening their health outcomes

**Emotional stress**

Some respondents expressed sadness, anger, grief etc. when they got to know about their seropositive status. Here are some of their comments:

> *"Hmmm, I felt bad and frustrated, because I was wondering why I wasn't dead by now. My mum cried and told me how she contracted it and said she was very sorry…. I think she thought I should know my HIV status so I would take my medication very well*" (R3).

> *"When they told me that I was HIV positive, I didn't do anything but I was hurt and felt so bad because I was too young to be infected by this deadly disease. Hmmm… it wasn't easy for me, I thought they were trying to prank me…Later I got to know that my parents were also HIV positive and they gave it to me at birth. I was disappointed that my parents hid this information from me all this while"* (R6).

> *"Hmmm, I felt very bad and it saddens me for more than a month. The only thought that came to my mind was that I was going to die one day. I cried and wondered what I had done wrong to have been infected with this shameful disease. What will people say about me? A lot was running through my mind"* (R8).

**Cognitive stress**

Other respondents expressed anxiety, self-criticism and shame when they came to know of their status. Here are some of their comments

> *"I felt very sad and sorry for myself, I realized it was because of the life I lived"* (R4).
>
> *"Hmmm" it wasn't easy for me, I felt very bad and thought my world had come to an end. I couldn't sleep for some days. I was always crying and thinking about my status.* (R2).
>
> *It was shocking and it was the darkest moment in my life. I thought I was dreaming. (R3*).
>
> *"Hmmm, it's very horrible and unbelievable. It was like my world had come to an end. I held the neck of that nurse who broke the news that I*

*was HIV positive. This young man who infected me is the number one womanizer but he is very handsome"* (R4).

**Discrimination**

Evidence of internalized stigma ( Discrimination was revealed from the stories of respondents' sentiments of unworthiness, humiliation, and embarrassment revealed. Most of the respondents felt saddened, occasionally when others who they thought would lift them instead made remarks that made them feel down. One respondent shared the following:

> *"…Yes, I did, I went to her room one morning, and I knelt, crying softly to touch her heart to forgive me but she didn't even look at me and left, saying instead of learning a skill in Koforidua, I engaged in prostitution and brought disgrace to the whole family. I felt very ashamed by the comments made by my mother whom I thought would encourage me to be hopeful … Sometimes I cry and feel so bad to be in this state. Sometimes too I pray for a miracle. I also fast on my day of birth, which is Tuesday, that God should not allow this sickness to send me to my early grave but the purpose of God in my life should be fulfilled. I am a singer in church and I sing very well every Sunday. However, ... Hmmm I feel so bad because they don't encourage and assure those who are living with HIV but rather, they condemn us that we will soon die, during the sermon at church and it adds up to my sorrows. I sometimes leave the church before the service comes to an end..."* (R4)

Another respondent said:

> *"Hmmm because of what I have heard about HIV both in school and church, I was depressed and was wondering if was going to die soon. I thought my life had come to an end...I always want to be left alone. My only mother who would have comforted me is nowhere to be found. Sometimes I feel worthless and I think I will die soon and always become so sad"* (R7).

One respondent highlighted her mother's behaviour toward her HIV status as justification for continuing to feel guilty about disclosing her status.

> *"Personally, after the first test, though I didn't believe it, I always thought about whether what had happened was true. Psychologically I was down and didn't want to meet any of my boyfriends…When I started going out with them again after some months, I was very strong initially but was falling sick intermittently …When I got pregnant and was confirmed of being HIV positive, I went back to my hometown at Somanya and lived with my parents. I told my dad of my ill health; that I had been diagnosed of having HIV. Later when my dad told my mum about it, my mum insulted me and asked me to leave the house but my dad did not agree…Life with my mother in the house was very bad. She does not give me food, she doesn't allow me to touch her buckets, utensils and other belongings in the house... I don't know what other people in the neighbourhood will say should they get to know I am HIV positive. I have so much guilt now … maybe I should have kept things to myself"* ( R4).

Another completely lost interest in school because of the cold behaviour schoolmates exhibited towards him. He indicated that:

> *"Some of my mates at school got to know that I was HIV positive and started dissociating themselves from me. None of them plays with me at school. I always feel bad when I go to school. I stopped developing an interest in going to school……I complained to my mum about what I had been going through in school, so she withdrew me from that school and enrolled me in a new school''* (R1).

Another respondent sought refuge at the orphanage as a result of internalized stigma.

> *"…. My auntie told all the children in the house about my HIV status so none of the children wanted to interact with me, let alone play with me, I felt lonely and neglected because of these behaviours meted on me. I finally ran away to the orphanage"* (R2).

In a similar vein, another respondent stated;

> *"I felt betrayed, rejected and ashamed. I was praying we write the WASSCE fast so I could run away from this shame.*

> *…hmmm, in the house, everything is normal, we do everything together but when I was in school my close friends rejected and dissociated themselves from me just because they might have heard that I was HIV positive. This affected the results of my final examination"* (R6).

**Perceived stigma**

In addition to internalised stigma, perceived stigma was one of the challenges faced by HIV/AIDS victims. They suffer from this type of stigma sometimes directly or indirectly from peers within the neighbourhood, school and even siblings in the house. One participant gave a narration of the perception his siblings have about persons living with HIV;

> *"Well, I can say things are not the same after they got to know I was HIV positive. Though we share the same room, none of them sleeps with me again on the same bed. They don't eat with me from my bowl or plate. They don't touch my belongings. It's as if they are being cautious in the house because they think I can infect them. … Their interaction with mum is normal, but I ask myself why they are treating me like this… Before they got to know of my HIV status, we used to play together and chat for a long time but now, they don't spend much time with me. I feel rejected and alienated. I wish one day; I will leave the house and live as an independent person"* (R 12).

Another respondent who learned of his seropositive status after becoming unwell and being accompanied to the hospital by his Housemaster shared the following comment.

> *"After I was discharged from the hospital back to the boarding house, my close friends began acting quite weird to me. It seemed the housemaster had told them something about my ill health…They no longer shared my food with me. They only talked to me but I didn't feel their closeness. At first, some of them would come and sleep with me on the bed but after I was admitted to the hospital, all of them stopped doing that"* (R 6).

**Enacted Stigma**

Enacted stigma was manifested as verbal discrimination, humiliation, rejection, and explicit acts of segregation, and was primarily driven by fear of infection. Respondents indicated that they were rejected, marginalized, ejected and received different treatment compared to other siblings in the same household. For the majority of adolescents living with HIV, circumstances like these are sources of stress since they might not have someone they can turn to for support. This, however, is dependent on personal experiences. One respondent described a terrifying incident in which her landlord kicked her out of her home, informed the other tenants of her HIV status, and further stated that if she continued to live there, it would endanger the lives of the other co-tenants.

> *"My landlord ejected me from the house just when he got to know I was HIV positive. My co-tenants went to inform him that, they couldn't share the same bathroom and toilet with me and that they didn't feel comfortable and safe being in the house with someone living with HIV/AIDS. … The landlord gave me my balance and told me he doesn't need me in the house again because I posed a danger to other innocent tenants".* (R4).

Similarly, another respondent said:

> *"When my auntie heard that I was living with HIV, she told her children not to come closer to me, not to use my cup, plates and other belongings of mine. She doesn't even want to shake hands with me. At a point in time, she wasn't even responding to my greetings. She told me to keep my belongings such as cups, plates, spoons etc. at a place that her kids would find difficult to access. Sometimes I feel very bad but life must still go on"* (R7).

Another respondent remarked:

> *"I was sacked from the house so painfully; no one wanted to associate with me in the house. I was rejected outright and they threw all my utensils and other belongings away. I was pushed to sleep on the porch for some days before calling on my grandma to come for me..."* (R13).

### 4.2.3 What coping strategies are adopted by adolescents living with HIV/AIDS?

The third research question explored the coping strategies adopted by adolescents living with HIV/AIDS. The findings, as summarized in Table 4, revealed a range of approaches. Family support emerged as a crucial source of emotional and practical help. Counselling services, where available, helped some adolescents manage stress and stigma. Others turned to prayer and spiritual activities for comfort. Selective disclosure choosing carefully whom to confide in—was a common tactic to avoid judgment. Participation in support groups and proactive networks also provided solidarity and encouragement. In some cases, adolescents resorted to avoidance, deliberately distancing themselves from people or environments where they felt stigmatized.

**Psychosocial support**

This was described as the encouragement, good treatment, show of love and guidance on how to deal with overt behaviours from others provided by parents, siblings, and immediate and extended family members. One respondent indicated the good treatment and support he had received from his parents, especially from his grandma who goes for his ART drugs for him.

> *"My father, grandma and brother have been very supportive and keep on encouraging me that everything will be fine. They always assure me that, all I need to do is to take my medication and I will be fine…. I am now learning a trade i.e., Fixing sliding glass and I pray no one gets to know about my HIV status in the workplace… My grandma has been coming for my medication at the hospital for me every month... Currently, everyone in my family treats me well"* (R10).

Another respondent also said this:

> *"The support I receive from my family keeps me going. I used to think I would be dying soon but now I don't think much of that again"*

(R10).

Psychosocial support in terms of love received from parents enables adolescents to live a normal life as they can make new friends without any fear. A respondent had this to say:

> *"My parents have been guiding me on how to manage people's behaviour towards me. They care and show me much love…I also made new friends in my new school so I don't think much of my status"* (R11).

#### 4.2.2.3.2 Acceptance of the situation

Many respondents who had in-depth knowledge of HIV did not find the overt remarks from other individuals to be bothersome. This was made feasible by the counselling provided by medical professionals, who explained that HIV was like any other sickness and that so long as they take their ART medications, they could live normal lives and participate in all activities in their respective society. The following remarks were given by respondents;

> *"I take my medication very well so that I won't grow lean for people to see that I have contracted HIV…When I go to the hospital, the workers also talk to me about the sickness and they say that it's just like any other disease and so we should not think about it… I also play with some of the people around my house just to help me forget about the sickness"* (R9).
>
> *"When I came to the hospital, the doctors and other health workers told me that, I shouldn't worry too much about it because it is just like any other sickness and I will be fine when I take my medication. This brought some happiness into my life. …. The most exciting moment was when the counsellors at the hospital told me that when you are on medication, you can marry and give birth without infecting the baby…. I have been on medication since childhood"* (R9).
>
> *"I was told that when you take your medication, you will be like every normal human being and you won't die early. The counselling I have been receiving keeps me going"* (R3).

One respondent reported that they try to keep away from people whose behaviour makes them feel unwanted.

> *"What I am doing now is…. I need ideas to be able to manage the situation…. I don't mingle with them again but we only speak. I don't want to feel unwanted among my peers in school and the community ... Also, I think not mingling with my schoolmates and friends in the community will help, considering how they make me feel unwanted …when I grow up and start working, I will leave the house and live in a different town or place where nobody knows me"* (R6).

**Prayer**

Respondents indicated that God is the only one who forgives and that the days of mankind were in his hands therefore seeking his intervention through prayer was something that has become an integral part of them. Most indicated that once they prayed, long life and good health were guaranteed and therefore they were not bothered about what one would say about their status.

At best, moving to a different location or environment where no one knows their positive status will take away the stigma and discrimination and foster peace of mind. Here are excerpts from some respondents;

> *"My father is the only person who has been showing me love and care. He is not too bothered about my situation and keeps encouraging me to pray and take my medication so that I'll be fine… I often ask my father if my mother is my true mother because she doesn't like me. But I know when I pray to God and seek his intervention for good health and long life, I have nothing to worry about. Prayer keeps me going"* (R4).
>
> *"… relying on God through prayer has been my number one source of hope and comfort. I always pray to God for forgiveness and a touch in my life so I live long. I don't miss out on church activities…I see this disease as shameful because of the negative comments from people. I see this has*

*rather brought me closer to God and I have nothing to worry about since He is in control. I am part of my church prayer warriors"* (R 9).

*"... I always pray to God to give me more days. I love to pray. I am a catholic that is where I pray. I normally ask God to forgive me because it was not my intention to contract HIV. Of course, sometimes I feel down but when I talk to my God to give me strength to overcome what people are doing to me, I feel much better and in control"* (R12).

*"God's destiny has been outlined, but it depends on our behaviour. Prayer brings peace and fasting equally has an effect in that direction... I fast on Mondays and Thursdays; moreover, praying brings me closer to God... If you do a lot of worship, your sins will be melted away; it helps to dissolve your sins, right? I hope so too… Getting closer to God in prayer reduces guilt, and sins, makes you feel calmer, and makes you have a high spirit in life…"* (R 6).

**Selective disclosure**

One significant theme that respondents used to avoid stigma and discrimination was selective disclosure. Some reported that they were encouraged to make disclosures about their positive status when they were fully convinced that they would receive acceptance and emotional support from those who got to know about their status. For instance, one respondent said

*"When I came to the Koforidua Central Hospital and was told that I was HIV positive, I didn't tell anyone but as time went on and I went to Sefwi, where my parents were living to deliver, I visited another hospital for antenatal care. There, I was screened again and it was confirmed that I was HIV /AIDS positive. Hmmm, I had no option but to let my parents know about it because I needed support from them. I have never regretted telling them because of the encouragement I receive from them"* (R4).

Another also said;

> *"My siblings did not know about my status ……my younger siblings don't have HIV. My mother sat us down and talked to them about my HIV status as well as hers. She told them that they could do everything with me except the usage of my blade stick and other sharp objects. Our status is only known within the nuclear family and this keeps us going… nobody knows about it"* (R 6).

However, it was shocking for one respondent when he disclosed his status. This was what he said;

> *"... hmm, it is very bad. After my mother got to know that I was HIV positive, she didn't allow me to touch anything of hers, especially her cooking utensils…When she comes from the farm and I have prepared food for them, she won't eat and will go and prepare another meal for herself. She doesn't talk to me anymore… I wouldn't have gone ahead to disclose if I knew this was going to happen"* (R4).

Many ALHIV patients who had told their families about their condition described the support they got favourably. Family members provided patients with both emotional and practical support, such as by supporting them and increasing their self-esteem by picking up their meds when they were unable to get to the clinic or by reminding them to take their ART as *prescribed.*

> *"If your parent cares about you, your status cannot hinder that love at all. She will encourage you to finish the medicine, and you will be okay. She will give you the medicine and encourage you; with example, teachings and education."* (R 6).

**Involvement in proactive networks**

Adolescents had a supportive group of contemporaries with whom they could trust and have a sense of identity by engaging in multiple things and joining good networks. Some participated in these networks as outreach workers, which required them to counsel and assist other positive peers and educate them about living with HIV. They also encouraged them to seek early medical attention. They felt tremendously fulfilled by the sense of purpose and usefulness this gave them. Most adolescents developed life management skills with time, as a result of frequent encounters with medical professionals and others, in supportive networks. As one respondent said;

> *"Once diagnosed with HIV, people will need help. At the time I was angry at my partner, and felt like committing suicide. The counsellors told me how to practice safer sex and deal with my condition emotionally. It didn't help because I was very shocked. What helped was when I came to the network and saw that there were many others like me"* (R13).

Another respondent remarked:

> *"Though I do think about my predicament and mum's attitude towards me, I take solace in God because I am a Christian and the word of God says "In all things, we should give thanks to God". This is reinforced by the testimonies shared by other people when I come to adherence meeting at the Regional Hospital... So, I would say, this comforts me a lot"* (R4).

Another said

> *"Yes, on the other side it is bad, but joining the adherence support group helps me a lot. I don't miss meetings because anytime I come, I leave here with hope in life… my parents and siblings are also keen on what takes place at our meetings. I brief them anytime they ask and through that, they give me support. My sister too is a medical doctor and she gives me all adherence counselling but psychologically, I think of it. I have been asking*

*myself if I will be able to get a lady who will accept my condition and marry me in future. Apart from this, I am ok… I have been told I can marry and have children who would not be reactive*" (R10).

**RQ4;**

## 4.2 DISCUSSIONS

This study aimed to explore stigmatization coping strategies among adolescents living with HIV/AIDS in the New Juaben Municipality and analyse such strategies in light of their consequences on their health outcomes. The discussion begins with the demographic characteristics of respondents, and then the primary themes and sub-themes are covered following the objectives of the study.

### 4.2.1 Demographic characteristics of respondents

Out of the thirteen respondents, 7 males represented 54% with 6 females representing 46 % participated in the study. This finding contradicts the findings of Fauket et al. (2021) and Awotidebe et al. (2014) where a greater number of females dominated those studies conducted in Yogyakarta and Belu, Indonesia and two rural schools in South Africa respectively. This finding may be that at the adolescent level, males have a soft stand in going for voluntary counselling and testing than their female counterparts.

Regarding the ages of the respondent, those between ages 11 -21 (54%) constituted the majority of the respondents followed by those between the ages of 22 – 31(46%). These findings are congruent with research done by Mabaso et al. (2021) in South Africa, where HIV prevalence among adolescents aged 12 to 19 increased dramatically, going from 3.0% in 2008 to 3.2% in 2012 and 4.1% in 2017. This could be that adolescents at that younger age may have heard a lot about sex from their parents and the media, and because they are adventurous and may want to explore sex at that time without having the courage to walk to over-the-counter drug stores, they may engage in raw sex, which could explain the high prevalence of the age group found in the current study. Further, this confirms the studies of Awotidebe et al. (2014) where results showed that out of the 113 adolescents, 27.2% said they were sexually active, over 48% said they had sex before turning 15 and 42.2% said they had penetrating sex with more than one person. Only 44.8% of them reported using condoms consistently and frequently before each intercourse.

Findings from the analysis of the results show that four (31%) of the thirteen respondents said their highest level of education was Junior High School, while five (39%) others had graduated from Senior High School, and just three (23%) and one (7%) were university students and a primary school graduate respectively. It was therefore not surprising that respondents had a better comprehension of what HIV/AIDS was, including how it was transmitted. This result is consistent with research from Trinidad and Tobago, where adolescents reported learning about HIV/AIDS through the radio, local and international television broadcasts, posters and brochures, public health/social workers, newspapers and magazines, and in schools (Jones et a., 2015)

Concerning the number of years they had lived with HIV/AIDS, 6 (46%) indicated that they had lived with the disease for 3-5 years. Moreover, two of the respondents (15%) indicated they had lived with the disease between 0-2 years and 9 - 11 years respectively. All the remaining respondents indicated they had lived with the disease between 7 – 8 years, 12 – 15 years and 16 years and above respectively, representing (8%). Similar to this conclusion, Owusu (2020) discovered that adolescents had been HIV-positive for an average of 6 years (range = 6 months to 13 years). Additionally, 15% of the respondents had been diagnosed between one and five years.

### 4.2.2 Causes of HIV/AIDS Stigmatisation Amongst Adolescents

The first research question sought to understand the level of HIV/AIDS stigmatization and its underlying causes among adolescents in the New Juaben South Municipality. One of the central findings was that misinformation about HIV transmission significantly contributes to various forms of stigma including internalized, perceived, and enacted stigma experienced by adolescents.

The study found that adolescents hold various misconceptions about how HIV is transmitted. These misconceptions fuel fear, confusion, and unjustified moral judgments. Many adolescents believed HIV is only contracted through promiscuity or the use of sharp objects, and some were puzzled about how they had become infected despite not engaging in high-risk behaviour. This misunderstanding led to confusion, emotional distress, and self-stigmatization. These findings are consistent with global research. According to the UNAIDS (2021) fact sheet, misinformation and lack of comprehensive knowledge about HIV/AIDS significantly contribute to the stigmatization of adolescents. It emphasizes that stigma is often linked to societal misconceptions that HIV is a result of immoral behaviour, which leads to discrimination and exclusion. This misinformation becomes a barrier, discouraging

adolescents from accessing sexual and reproductive health services due to fear of being judged or mistreated. Further reinforcing this, Armstrong-Mensah et al. (2023) found that 70.5% of people living with HIV (PLWH) in Ghana attributed HIV-related stigma to ignorance. Their study underlines the need for widespread education to correct these misconceptions and reduce stigma, especially among young people. Kabunga et al. (2024) also echoed similar themes in their study on pregnant adolescents in Uganda, revealing that stigma was frequently tied to misinformation and social prejudices, particularly regarding sexual activity and pregnancy.

The findings from this study align well with existing literature, affirming the role misinformation plays in perpetuating HIV-related stigma globally. However, this research adds a micro-level lens by focusing specifically on adolescents, who face unique social and emotional challenges due to their developmental stage. It thus fills a crucial gap in understanding how stigma manifests at this age and how it is exacerbated by misinformation and silence surrounding HIV in families and schools.

While most literature supports the notion that misinformation leads to stigma, some studies suggest that even in contexts where correct knowledge about HIV is widespread, stigma persists. Teshale et al. (2022), for example, found that even among adults who had heard of AIDS, discriminatory attitudes were still prevalent. This contradiction suggests that beyond knowledge, deep-seated cultural norms, fear, and moral judgment may continue to drive stigmatization, even in well-informed populations. It underscores the need to complement information campaigns with culturally sensitive and emotionally engaging interventions.

An unexpected aspect of the findings was the extent of confusion among adolescents who had contracted HIV at birth. Despite not engaging in any risky behaviours, these individuals were still subjected to moral judgment and internalized

guilt. This raises concerns about how health communication strategies have failed to differentiate between transmission modes clearly. The use of qualitative methods, including in-depth interviews, was critical to uncovering these nuanced experiences. However, reliance on self-reporting may have introduced social desirability bias, potentially underreporting more stigmatizing encounters or internalized emotions.

Like most studies, this one is not without limitations. The sample may not be representative of all adolescents in the municipality, particularly those not engaged with health services or schools. The study also focused on self-perception and reported experiences, which can be subjective. Furthermore, cultural and religious biases of respondents could shape how they interpret or report stigma. These limitations may affect the generalizability and validity of the findings, though the depth of insight they offer remains valuable.

In summary, misinformation about HIV transmission remains a fundamental driver of stigmatization among adolescents. It aligns with global patterns documented in the UNAIDS (2021) report and academic literature, but it also reveals gaps in local health education strategies that need addressing to dismantle stigma at its roots.

### 4.2.3 Effects of HIV/AIDS Sitgmatization On Adolescents

The study found that adolescents encounter stigma and discrimination to various degrees, which leads to numerous types of psychological stress, including emotional and cognitive stress. The forms of stigma identified were internalised stigma, perceived stigma and enacted stigma. These are unpacked in the following discussion:

**Internalized Stigma**

The study discovered subtle correlations in the descriptions to show internalized stigma. Specifically, some felt devastated by remarks made by people they looked up

to for support regarding their seropositive predicament. This finding is supported by the claims of Pantelic et al., (2017) and Turan et al., (2017) who assert that internalized stigma triggers emotions of guilt, humiliation, despair and occasionally severe depression. This finding is in line with (Mugo et al., (2021), where thirty-one (50%) ALHIV who had self-disclosed had experienced internalized stigma, as opposed to seven (21%) who had not. An additional countrywide survey of more than 10,000 HIV-positive adults in South Africa indicated that 36% had experienced discrimination and 43% had encountered internalized HIV stigma in the previous year (Simbayi et al., 2015).

Additionally, internalized stigma elevated from 17.8% of adolescents who did not experience discrimination to 32.5% and 54.5% of adolescents who did experience one or more types of discrimination, respectively, according to cross-tabulation results from the studies of Pantelic et al. (2020) that also showed a graded, positive association between discrimination multiplicity and internalized stigma. This finding adds to the growing body of qualitative evidence, which has suggested that multi-faceted discrimination that young people face results in profound feelings of shame that make it difficult to engage in life-saving services (Mavhu et al., 2013)

Additionally, respondents in this study experienced difficulties with internalized stigma, and the descriptions they provided in their narrative attempted to imply acceptance of unpleasant views about HIV and, thus, self-stigmatization.

This backs up the assertions made by Williams et al. in 2020, who contended that this sort of stigma causes persons with HIV/AIDS to experience psychological distress since it causes them to feel shame, remorse, and a bad self-image because of their condition. Kimera et al. (2020) state that despair, powerlessness, and low self-esteem are some potential effects of internalized stigma. Internalized stigma compromises

treatment compliance and care retention. This circumstance may lead to ALHIV having worse mental health, less social support, and more HIV-related symptoms. Their treatment adherence may also be hampered by HIV stigma from classmates or other members of their community (Foster et al, 2020).

According to studies conducted in South Africa, Tanzania, Uganda, Zambia, and Kenya, HIV-related stigma has a detrimental impact on the psychological, behavioural, and health outcomes of those living with the virus (Dow et al., 2020; Shenderovich et al., 2021; Willis et al., 2018)

Findings show that internalized stigma is usually characterised by cognitive stigma as respondents expressed anxiety, self-criticism, and shame, out of control when they came to know of their seropositive status. Most adolescents continued to experience poor self-perceptions, internalized stigma, anger, grief, despair, and denial long after disclosure. They grew to fear self-disclosure and lived in continual terror of having their serostatus found out. Their sadness weakened their commitment to their treatment.

The adolescents who viewed disclosure as a pleasant experience, on the other hand, accepted their HIV diagnosis and led normal adolescent lives. The protracted negative responses highlight the significance of continuous post-disclosure treatments for adolescents in remote areas where psychosocial support resources are insufficient to address their emotional wellness (Maseko and Madiba, 2020)

**Perceived Stigma**

Findings show that respondents' fear of being stigmatization based on experiences with anti-HIV stigma often makes them directly or indirectly retain information from peers within the neighbourhood, school and siblings in the house. It was observed that their stigmatizing statements and discriminatory beliefs inform participant perceptions

of the prevalence of stigma among this group and lead to very specific fears of vengeful disclosure and social isolation (Chory et al., 2021).

These findings are consistent with previous literature addressing the concerns of adults living with HIV, as well as parent-child dyads (McHenry et. al., 2017). Further, in qualitative research, Karamouzian et al. (2015) attempted to comprehend how ALWH viewed stigma. The majority of subjects expressed internalized stigma in the form of silence, humiliation, and feeling unpleasant. Respondents also encountered discrimination from their relatives and medical professionals. This finding may be a result of poor knowledge about HIV which play an important role in determining the level of stigmatization.

According to Youssef et al. (2020), people who are less educated and are from a family with a lower income have less exposure to diverse groups of people. In contrast, Coleman et al. (2016) report that those with higher incomes and education levels are better able to understand and support those who have HIV because they are more familiar with the mechanisms of transmission and treatment options. People's opinions regarding ALHIV are impacted by their lack of information about the methods of HIV transmission.

As a result, when people are influenced by the misjudgement of elderly or less-educated community members, unfavourable sentiments are sparked (Farouq, 2016). This emphasizes the need for informational initiatives that increase knowledge about HIV and teach people to embrace ALHIV.

Many of the respondents stated experiencing sadness or having suicidal thoughts due to the perception that their lives were dismal and worthless. This caused mental anguish, which negatively impacted how well people followed their anti-retroviral regimens. The respondents decided to stop taking their medicine when they felt their lives were no longer valuable or when they were afraid of being harshly judged. Without treatment, the responders' viral counts rose, which made them extremely underweight and more susceptible to AIDS-related diseases (Bae et al., 2011).

These beliefs also significantly hindered their capacity to readily interact with friends or family, preventing them from having a support system.

**Enacted Stigma**

In the current study, a variety of respondents described their encounters with HIV-related stigma and discrimination in various settings. Respondents reported having personally encountered enacted stigma in the form of discrimination, exclusion, or

stereotypes because of their HIV status. Respondents reported experiencing discrimination and stigma both at school and in the larger community. ALHIV are marginalized or subjected to discrimination and mistreatment. The results support earlier research in South Africa, Zambia, Tanzania, Ethiopia, Uganda, and Kenya that revealed stigma, discrimination, and bullying in both the home and school settings (Lwidiko et al., 2018; Pantelic et al., 2018).

In this current study, the emotional stress caused by verbal abuse, despair, loneliness, and a sense of rejection was recognized as a drawback of having HIV. These results are consistent with other research from Zambia, Tanzania, and Uganda that also revealed cases of emotional, physical, and domestic abuse against ALHIV (Kaunda-Khangamwa et al., 2020; Kalembo et al., 2019). Further studies have revealed that ALHIV were occasionally humiliated, physically abused, subjected to discrimination, and called "walking dead" (Lwidiko et al., 2018), and those who had lost their original parents had to endure stepmother harassment (Mutumba et al., 2013).

Research conducted in Zambia revealed that young individuals, especially, described psychological abuse as having affected their ability to control their HIV (Merrill et al., 2022). Furthermore, the researchers in the Zambian study noted that young people in this study identified various types of abuse as a frequent occurrence with negative impacts on their HIV self-management practices and their mental health (Merrill et al., 2022).

Emotional stress has been linked to poor adherence to treatment and management continuity in ALHIV (10–24 years old) and has been associated with high levels of anxiety, loneliness, sadness, and suicidal thoughts (Pantelic et al., 2018). Additionally, there is evidence linking these mental health concerns to an increase in

sexual risk behaviour (Kalembo et al., 2019). The pressures that ALHIV experience, including stigma and discrimination, are multifaceted and interconnected, and may worsen their vulnerability to mental health problems. When considered collectively, these data lend a compelling argument in support of recent literature demands for more focus on the negative consequences of psychological and emotional abuse on health (Beres et al., 2020).

### 4.2.4 Coping with Stigma and Discrimination

Findings show that respondents employed a variety of coping mechanisms, including family support, clear awareness, prayer, selective disclosure, and participation in proactive networks to deal with stigma and discrimination.

#### 4.2.4.1 Psychosocial support

Findings from the narratives indicated that respondents' support in the form of good treatment shown from parents, siblings, and immediate and extended family members enabled them to live a normal life and make new friends. Social support is an important modulator in this. Parents provide emotional support and also help educate their adolescents on how to deal with stressors that they may face. Daily hassles, poor coping and limited social support can adversely affect the psychological well-being of HIV-affected adolescents (Kimera et al 2021). Studies among HIV-affected adolescents in Zambia and Nigeria help to buttress this important point (Dhanalakshmi, et al 2013). These findings are also in line with those found in previous research on HIV-positive pregnant and postpartum women in Uganda (Mutumba et al., 2017). Furthermore, the association between perceived social support and quality of life, according to research by Sabina and colleagues (2020) done in Nepal, was strong and was somewhat mediated by psychosocial coping techniques. The stigma that ALHIV individuals have internalized considerably

reduces the mediating effect of coping mechanisms on the association between perceived social support and quality of life. The efficacy of mediation in resolving issues that centre on the relationship between social support and quality of life was shown to be moderated by internal stigma.

In addition, results from the anecdotes showed that respondents had affection and support from their family, friends, lovers, and/or peers. This result is consistent with research by Tran et al. (2022), who reported that adolescents in their survey who willingly or inadvertently disclosed their HIV status to family, friends, partners, and/or peers had positive emotional support and treatment support.

Many respondents in the research reported feeling pleased to be out of hiding. However, as health professionals have remarked, adolescents living with HIV require time to psychologically and emotionally prepare before disclosing to family so that they can be trusted, have a solid understanding of HIV and demonstrate that they are living well despite having HIV. The ALHIV who assisted his mother in learning how to deal with his HIV status displayed the same strategy. Less depressed symptoms and improved ART adherence in PLHIV have been linked to coping self-efficacy (Andrinopoulos et al., 2010; Rodkjaer et al., 2014). Psychological wellness significantly improved, according to a feasibility study of an intervention combining mental health and coping self-efficacy methods (Rodkjaer et al., 2017).

The best coping technique employed by adolescents living with HIV, under a thorough assessment by Beres and Narasimhan (2017), is unquestionably informal social support from family, friends, and relatives.

Psychosocial assistance has legitimately been proven to encourage antiretroviral medication adherence in patients who test positive for HIV (Atukunda et al. 2017). For ALHIV who experience significant stigma, increasing psychosocial coping and

the provision of social support may help enhance their quality of life (Subramanian et al., 2020).

These results imply that social support is crucial for HIV-positive adolescents in reducing HIV-related stigma experiences. Therefore, establishing a supportive environment with reduced stigma among adolescents is critically important to reduce the felt stigma experienced by PLHIV and encourage more positive coping strategies toward HIV-related stigma (Youchun et al., 2013)

**Acceptance of the HIV situation**

The study demonstrated that the respondents dealt with problems in a variety of ways; one of which was adaptability. In line with the results of the present study, adolescents were able to deal with their conditions by accepting who they were, to the point, where they were unconcerned about what others thought of them. Instead of concentrating on what other people thought of them, they focused on making the best of their status so that they could grow into responsible adults. According to Columbian research on Latino adolescents, despite difficulties, they developed a sense of what was important in life by setting attainable objectives (Martinez et al., 2012).

These findings are significant because rational coping is linked to improved illness management, more disease adaption, and higher levels of well-being for patients. However, avoidance coping or emotional coping strategies lead to poorer psychological outcomes, lower treatment compliance, and worse disease adaption, which raises stress and anxiety levels (Garrido-Hernansaiz et al., 2017).

In contrast, HIV-positive individuals could be coping with their condition ineffectively. Due to the significant emotional effect of receiving an HIV diagnosis, these findings may be warranted (Lessa et al., 2014). Because of this, these patients

lack the confidence to adopt coping mechanisms based on negative auto-focused coping to actively confront the effects of the condition. The lower levels of resilience and psychological well-being in this group of patients may also be explained by the increased usage of emotional coping mechanisms.

Makoae and colleagues (2008) showed how some respondents (21%) were outspoken regarding their diagnoses and acted as ambassadors for others in the study of coping mechanisms for HIV stigma in five African nations (Lesotho, Malawi, South Africa, Swaziland, and Tanzania).

Many revealed their HIV status to win the support of friends, family, and neighbours, while some did so to stop rumours and gossip. In the same study, it was also revealed that a small percentage of individuals (18%) refused to isolate themselves from social interactions when they encountered stigma because they perceived themselves as brave and normal in the face of their sickness and stigma.

They sought assistance from peers, counsellors, or health professionals instead. Given that the majority living with HIV experience severe stigma and have a great fear of exposure. This sort of care is desperately needed in Ghana.

**Prayer**

According to our findings, prayer was a popular strategy used by research respondents to deal with HIV-related situations. Prayers have a profound impact on how someone views living with HIV-related stigma. Prayers appear to bring forth a sense of calm and optimism and assist individuals in accepting any circumstance (Genrich et al., 2005).

In Uganda and other African nations, prayers and trust in God have been named as two of the most effective coping mechanisms for dealing with HIV-related stigma

(Mao et al., 2019). Therefore, it is crucial to connect HIV-positive adolescents to spiritual support networks as a means of coping with experiences of HIV-related stigma. Another method that adolescents with HIV utilise to manage their health is spiritual assistance. The study's conclusions demonstrated that adolescents who were HIV-positive looked to God for strength to cope with their circumstances. They poured out their emotions in prayer to God because they felt that only God could provide them strength beyond what was expected of them, enabling them to deal with their circumstances. Abrahams and Jewkes came to the same conclusions, finding that people frequently turn to spiritual and religious pursuits as a means of coping (Abrahams et al., 2012).

They were able to appeal to their God for guidance and were given support to bear their predicament thanks to spiritual intervention. Conner and others agree with Abraham and Jewkes' theories of how spirituality and religion help Columbian adolescents living with HIV cope. Attribution and religious beliefs of individuals affected their long-term survival, mental health, and illness development (Conner et al., 2006).

According to Dalmida et al. (2015), ALWH frequently resorts to prayer to cope with the stressful impacts of the virus. Ironson et al. (2006) also found that individuals who increased their prayer after receiving a diagnosis had slower viral growth over four years. In a different study, Ironson et al. (2016) found that the use of spirituality as a coping mechanism predicted longer survival across 17 years in HIV-positive individuals. In their 12- to 18-month longitudinal research, Trevino et al. (2010) discovered that spiritual struggle, or feeling angry with God, was linked to decreasing CD4 counts over time in ALWH and baseline viral load.

While Trevino et al. (2010) found that neither a change in VL nor a CD4 count was predicted by positive religious coping, another study found that a positive view of God was associated with a slower rate of HIV progression for four years (Ironson et al., 2011). On the other hand, a disbelief in God indicated a quicker spread of the infection. Although a lot of research has focused on how increased religiosity involvement may enhance health-related quality of life in PLWH (Dalmida et al., 2015), long-term studies that consider viral progression are incredibly uncommon.

These findings require reflection on the lack of effectiveness of existing mass education programs for reducing stigma. Identifying better programs to strengthen effective coping strategies for ALHIV in Ghana could serve to enhance their physical and psychological well-being, as is effective in other settings. The affected individual perceives religious coping as providing a pleasant and peaceful situation that can quiet an uneasy spirit or heart (Mar'ati and Chair, 2017), and can also develop hope and trust, which can relieve stress (Husnar et al., 2017).

The importance of prayer as a crucial coping mechanism for overcoming trauma and adversity is highlighted in the literature on HIV-positive clients (Hamader et al., 2013). People frequently turn to religion for solace and security (Carlucci et al., 2015) As a result, stress may lead HIV-positive people to seek spiritual guidance (Cotton et al., 2006) For the betterment of HIV-positive clients, prayer or spirituality fosters acceptance and optimism (Liboro and Walsh, 2016).

Based on the supposition that spirituality is the basis of regaining a sense of purpose in life, social support, and coping mechanisms, a positive relationship between spirituality and well-being in HIV-positive clients is assumed to exist (Liboro and Walsh, 2016). According to surveys, being prayerful affects well-being and helps

people digest traumatic events more effectively so they can deal with stress-related symptoms (Hamader et al., 2013).

In agreement with our findings, research shows that spiritual aspects help HIV-positive individuals have high levels of life satisfaction (Liboro and Walsh, 2016). Life satisfaction and lessened stress were both substantially correlated with spiritual coping in HIV-positive patients (Brownley et al., 2015) Other research, which contradicts the findings, has demonstrated that HIV-positive clients seldom resort to spirituality as a means of coping with HIV-related stress (Wanyama et al., 2017).

**Selective Disclosure**

It was observed that the majority of respondents had little choice but to reveal their information to persons they trusted to receive the necessary help. This conclusion is reinforced by a prior study that found that HIV-positive individuals received support when they told their loved ones, acquaintances, and colleagues about their condition (Agnes and Songwathana, 2021). Selective disclosure to their household, mates, HIV activists, and caregivers was employed as a constructive coping mechanism, which is also in keeping with the findings of Kumar et al. (2015) and Mendelsohn et al. (2015). According to an exploratory study, HIV-negative spouses who wanted to prevent unfavourable reactions from their husbands' relatives, friends, and medical professionals, only told a small number of people about their husbands' HIV status (Larki, 2020).

This is significant since adolescents frequently prefer to talk about symptoms with unofficial sources like peers (Camara et al., 2017).

The use of disclosure as a coping strategy differed depending on whether Makoae et al. (2008) felt it would make things better or worse. The disclosure was largely used as a coping method when the PLWHA believed that reporting may generate

encouragement from partners and relatives. Respondents described feeling lightened after confessing, particularly to a spouse or family member, as if a load had been lifted off their shoulders.

The ability to cope with illness by convincing oneself that everything is OK might be interpreted as a strong want to live. Engagement in social events and attending social and community events provided evidence of this. Whether they are formal or informal, communicating with others creates networks, and these networks provide a platform for everyone to express themselves, share their pain, interact with others, and build friendships.

However as seen in earlier research (Kimera et al., 2020; Gabbidon et al., 2020) Thoth et al., 2014), young people with HIV chose non-disclosure strategies to deal with internalized and perceived stigma. These strategies included hiding drugs and dosages taken, keeping to themselves, and negotiating condom use in casual relationships.

To avoid getting angry looks from others, they thereby forfeited chances to receive social assistance. Low social support may also negatively impact their mental health, ARV adherence, and willingness to participate in treatment. According to studies, non-disclosure is stressful and can damage mental health, which is already adversely impacted by internalized and perceived stigma (Larsen et al., 2020). These findings are in line with this study (Rueda et al., 2016).

**Participation in Proactive Networks**

Concerning the support network, it was revealed that everyone surveyed who belonged to it, irrespective of gender, valued having conversations with other HIV-positive people. The exchange of information gave the adolescents awareness about their situation, which was a source of solace and inspiration in their lives.

They no longer experienced loneliness and instead gained knowledge from the experiences and coping mechanisms of their peers. Seeing friends who have experienced comparable difficulties allows adolescents to cope and acquire strength.

This is comparable to prior research that showed that knowing someone who has HIV helps individuals who are affected accept their HIV status because they sense inner comfort knowing that someone understands what they're going through (Kotzé et al., 2013). This result supports research demonstrating the critical role peer support groups play in assisting women living with HIV to comprehend HIV and PMTCT programs, resulting in retention in care and ART adherence (Murithi et al., 2015).

In line with past research, respondents said they felt at ease talking about their condition with others in a similar predicament (Agnes and Songwathana 2021). According to different research, HIV-negative partners in discordant relationships who fear being rejected by their family or friends may decide to seek assistance from their HIV-positive spouses' peer group or HIV community groups (Talley & Bettencourt, 2010).

Though the severity might vary, emotional discomfort affects the majority of People Living with HIV/AIDS (PLHA) at some time. When they first learn they are positive, some PLHAs could feel upset, while others might be blatantly suicidal. Anti-retroviral therapy may be simple for some people to start and maintain, but it may be challenging for others.

All of these individuals may benefit from joining groups, sometimes mostly as supporters or primarily as supporters. The social network formed in support groups may aid in lessening these feelings of loneliness and fostering a sense of social solidarity with others who are dealing with comparable difficulties. Being part of a group, itself might help to reduce psychological and emotional stress. Support groups

may not be the ideal solution for everyone, but they do give many people a cheap way to enhance their well-being.

For instance, some individuals with mental discomfort or condition may require medicine, whilst others may choose individual counselling or treatment. For everyone who is HIV-positive, joining a support group is a crucial first step. It may imply a total reversal of how they are now living. Support groups have been cited by ALHIV as safe places, a viable form of intervention, and a means of facilitating access to psychological support (Hall et al., 2012; Mupambireyi et al, 2014).

**ART Adherence**

Selective disclosure was found as a basis for respondents to take their medication. This finding supports the claims of Amadi et al., (2020) who assert that the thoughtful of adolescents to disclose to people they trust increases their adherence to HIV medication. The finding is also consistent with the studies of Madiba et al. (2016) and Jemmott et al. (2019) who found that adolescents who make disclosures about their status were four times more likely to adhere to ART than those who did not. As a result, non-disclosure by adolescents with HIV has been identified as a hurdle to adherence to antiretroviral therapy (ART) in both developing and developed nations (Arage et al., 2014).

Another observation made was that adolescents contemplate the effects of non-adherence on their health and well-being to make an educated decision about taking medicine. The results of this study corroborate Madiba et al. 2016's findings, which showed that revealing HIV reduces hazardous behaviours while also increasing awareness and comprehension of the illness. Adolescents often participate in dangerous behaviours including unprotected sexual activity and unintended partner infection. People may take action to safeguard their health and lower the danger of

spreading the virus to others when they are aware of their HIV status (Biressaw et al., 2015).

The ability of respondents to boost adherence to ART treatment in exchange for joining support groups was an intriguing discovery. In a similar fashion Njuguna et al., (2020) report on how clinics in Kenyans increased ALHIV adherence and retention in a random sample of 102 HIV clinics in Kenya. According to the survey, typical tactics include providing adolescent support groups (97%), designating particular clinic days for adolescents (91%), and holding clinic days on the weekends (57%). Additionally, there have been increased efforts to employ personnel that adolescents may feel more at ease getting treatment and counselling from, as seen by the overwhelming majority (89%) of clinics that now make use of peer leaders (Njuguna et al., 2020).

The role of peer support in connection to care following an HIV diagnosis is rarely described in cases, although peers are frequently employed to facilitate linkage (Fox and Rosen, 2013). The majority of examples emphasise adherence to ART and/or retention in care as outcomes, both of which may be improved. Researchers in South Africa discovered that joining a three-session peer support group increased youths' connection to care as compared to adolescents who opted out (Snyder et al., 2014). According to recent research presenting the Zvandiri model in Zimbabwe, ART connection was strengthened by adding a peer support strategy. The Community Adolescent Treatment Supporters (CATS), a group of HIV-positive youth aged 18 to 24, are enlisted by the model to provide adherence and psychological support via weekly home visits, monthly peer support meetings, and connections to other resources (Willis et al., 2019). That is, the results of this study show that peer support

is a successful strategy for bringing and keeping persons living with HIV in HIV care, for enhancing ART adherence, which leads to viral suppression, and for preventing virology failure (Berg et al., 2021)

A thorough psychosocial intervention is required to encourage ART adherence and retention in care among ALWH. These psychological support strategies should encourage HIV disclosure and communication, support medication compliance, treat loneliness and other emotional discomfort, and address needs to be linked to developing sexuality (Schotanus-Dijkstra et al, 2017). These findings are significant because rational coping is linked to improved illness management, more disease adaption, and higher levels of well-being for patients.

Furthermore, low adherence to ART is frequently attributed to the complexity of the treatment schedule, the numerous dosages and tablets, and the existence of depressive symptoms. Successful therapy adherence requires strategies that address physical, emotional, cultural, and behavioural factors. These strategies call for shared responsibility and decision-making among PLWHA, their healthcare team, and their social network. Different cognitive-behavioural response patterns are related to mental health. People may use coping mechanisms like avoidance or adaptive coping, which can affect how well they adhere to their treatment plans.

**Summary of Chapter**

Chapter Four of the study presents the data analysis and discussion of results regarding the dimensions of stigmatization and coping strategies among adolescents living with HIV/AIDS in New Juaben Municipality. The chapter is structured into two

main sections: the demographic characteristics of respondents and the thematic analysis of key findings based on the study's research objectives.

The study employed inductive thematic analysis following Braun and Clarke's (2006) framework to analyze qualitative data gathered through in-depth interviews. A total of 15 interviews were conducted, but only 13 were analyzed due to data corruption issues affecting two interviews. Respondents varied in gender, age, educational level, occupation, and duration of living with HIV.

Three primary research questions guided the study, focusing on (1) the causes of HIV/AIDS among adolescents, (2) the effects of HIV/AIDS-related stigmatization, and (3) the coping strategies adopted by adolescents. From the data, three major themes emerged: knowledge of HIV transmission, effects of HIV/AIDS on adolescents, and coping strategies. Each theme was further categorized into sub-themes to highlight specific aspects of the findings.

Regarding the causes of HIV/AIDS, the study identified perinatal transmission, sexual transmission, blood transfusion, and the use of sharp objects as the main routes of infection. Some respondents were uncertain about how they contracted the virus. The effects of HIV/AIDS-related stigma were categorized into emotional stress, cognitive stress, internalized stigma, perceived stigma, enacted stigma, social exclusion, school dropout, and loss of job opportunities. Coping strategies identified included family support, counselling, prayer, selective disclosure, involvement in proactive networks, and avoidance mechanisms.

The findings provide an in-depth understanding of the lived experiences of adolescents with HIV/AIDS, revealing significant psychological, social, and economic challenges. The chapter concludes with insights into the importance of

institutional support, community awareness, and stigma reduction efforts to improve the well-being of affected adolescents.

# CHAPTER FIVE

# SUMMARY OF FINDINGS, LIMITATIONS, CONCLUSION AND RECOMMENDATIONS

## 5.0 Introduction

This chapter presents the summary of key findings, limitations, conclusion and recommendation of the study

## 5.1 Summary of the Study

The study sought to explore the causes, effects and coping strategies among adolescents living with HIV/AIDS in New Juaben South Municipality and analyse such strategies in light of their consequences on their health outcomes.

Ethical approval was obtained through the Head of the Department of Counselling Psychology, University of Education, the Medical Director and the HIV/AIDS Focal Person of the Regional Hospital in Koforidua (RHK), for the study protocols for data collection. A face-to-face in-depth interview lasting approximately 45 minutes was used to collect data from 13 respondents in November 2022 after their consent was sought.

The objectives of the study were; to examine the causes of HIV/AIDS Stimatization among adolescents in the New Juaben South Municipality, to identify the effects of HIV/AIDS on adolescents living with HIV/AIDS, and finally, to explore the coping strategies adopted by adolescents living with HIV/AIDS in the New Juaben South Municipality.

A qualitative research design was adopted for the study which sought to comprehend people's perceptions after they have experienced the HIV/AIDS phenomena.

A purposive sampling technique was also employed in the study with a sample size of 13 HIV/AIDS respondents. The use of an interview guide was adopted in collecting data from the respondents after which the data were analysed under the instructions for the inductive thematic analysis provided by Braun and Clarke (2006).

Here are the key findings of the study, organized according to the research questions:

1. What is the level of HIV/AIDS stigmatization, and what are its causes among adolescents in the New Juaben South Municipality?

- Adolescents experienced high levels of HIV/AIDS stigmatization in three forms: internalized, perceived, and enacted stigma.
- Misinformation about HIV transmission (e.g., linking it solely to promiscuity or sharp objects) was a major cause of stigma.
- Moral judgment, especially against females, fuelled by cultural and religious norms, contributed to shame and blame.
- Fear of contagion led to social exclusion, even from family, peers, and teachers.

2. What are the effects of HIV/AIDS stigmatization on adolescents living with HIV/AIDS?

- Internalized stigma led to sadness, shame, and self-isolation.
- Perceived stigma created fear and anxiety about being judged or mistreated.
- Enacted stigma resulted in discrimination and exclusion in schools and communities.
- These experiences caused emotional and psychological distress, affecting mental well-being and self-worth.

3. What coping strategies are adopted by adolescents living with HIV/AIDS in the New Juaben South Municipality?

- Adolescents relied on psychosocial support from parents and caregivers.
- They practiced self-acceptance, prayer, and sought counselling.
- Selective disclosure of HIV status to trusted individuals helped reduce emotional burden.
- Participation in support groups and outreach programs fostered resilience and social connection.

## 5.2 Conclusion

This study makes a valuable contribution to our understanding of how adolescents cope with stressful situations spurred on by HIV discrimination and stigma. The following conclusions are therefore drawn based on the results of the current investigation concerning the study's goals. Adolescents contracted HIV by prenatal transmission, sexual contact with infected persons, and other unknown routes. They were forced to disclose their situation through frequent medical trips and incidences of illness. Adolescents encounter stigma and discrimination to varying degrees, which causes a wide range of psychological stress, such as emotional and cognitive stress.

The three types of stigmatisations that were found were internalised, perceived, and enacted. The majority of respondents said they felt hurt or ashamed when people whom they believed would encourage them instead made negative comments.

Reducing stress has a significant effect on many health indicators. The key conclusion regarding coping mechanisms was that adherence to ART medicine led to an improvement. Accessing ART medications proved to be a significant barrier for the majority of responders. Nevertheless, the psychological support they got from friends, family, and peers encouraged them to adhere to their ART.

## 5.3 Recommendations

Based on the findings, the following recommendations are proposed:

Firstly**,** the Ghana Health Service should enhance medication regimens and remove barriers that hinder adolescents from accessing antiretroviral therapy (ART). Additionally, establishing community adolescent treatment supporters (CATS) can provide psychological support through home visits and peer support meetings.

Secondly**,** the Ghana Education Service should strengthen sex education and reproductive health programs in schools by adequately resourcing counselling units. Awareness programs should emphasize the importance of condom use and other preventive measures to reduce the risk of HIV transmission among adolescents.

Future studies should use a larger sample to get findings that are more generalizable and to better understand the lived experiences and coping mechanisms in different contexts.

## 5.4 Areas for Further Studies

Future researchers can consider the following areas:

1. Impacts of HIV/AIDS stigma on children's academic performance, a case of selected schools in the New Juaben South Municipality.
2. HIV /AIDS awareness among adolescents in the Eastern Region of Ghana.
3. Exploring the trends and infections of HIV/AIDS among males and females in the Eastern Region of Ghana.
4. Exploring the relationship between stigmatization and longevity among HIV patients in Ghana.

## REFERENCES


Abrahams, N., & Jewkes, R. (2012). Managing and resisting stigma: a qualitative study among people living with HIV in South Africa. *Journal of the International AIDS Society, 15(2), 10-7448.*

Abramson, Z. (2015). The meaning of neurosis according to Adler. *The Journal of Individual Psychology, 71(4), 426-439.*

Adams, M. (2014). Human development and existential counselling psychology. *Counselling Psychology Review, 29*(2), 34-42.

Adler, A. (1956). *The individual psychology of Alfred Adler (HL Ansbacher & RR Ansbacher, Eds.)*. New York, NY: Basic.

Adolescent HIV prevention. UNICEF DATA. (2022, September 6). Retrieved November 13, 2022, from https://data.unicef.org/topic/hivaids/adolescents-young-people/

Africa, S. S. (n.d.). *Improving lives through data ecosystems*. Statistics South Africa. Retrieved November 18, 2022, from https://www.statssa.gov.za/?page_id=6634

Aggleton, P. (2004). Sexuality, HIV prevention, vulnerability and risk. *Journal of Psychology & Human Sexuality, 16*(1), 1-11.

Aggleton, P., Parker, R., & Maluwa, M. (2003). Stigma, discrimination, and HIV/AIDS in Latin America and the Caribbean.

Agnes, Y. L. N., & Songwathana, P. (2021). Understanding stigma and coping strategies among HIV-negative Muslim wives in serodiscordant relationships in a Javanese community, Indonesia. *Belitung Nursing Journal, 7(5), 409-417.*

Akatukwasa, C., Getahun, M., El Ayadi, A. M., Namanya, J., Maeri, I., Itiakorit, H., ... & Camlin, C. S. (2021). *Dimensions of HIV-related stigma in rural communities in Kenya and Uganda at the start of a large HIV 'test and treatment trial*. PloS one, 16(5), e0249462.

Aldwin, C. M., & Yancura, L. A. (2004). *Coping and health: A comparison of the stress and trauma literature*.

Alexandra Marshall, S., Brewington, K. M., Kathryn Allison, M., Haynes, T. F., & Zaller, N. D. (2017). Measuring HIV-related stigma among healthcare providers: a systematic review. *AIDS care, 29(11), 1337-1345*.

Amadi, K. U., Nduanya, U. C., Odinka, J. I., Onu, J. U., Muomah, C. R., Odinka, P. C., ... & Igwe, M. N. (2005). *Religion and adherence to antiretroviral medication: is there a link?*

Andrinopoulos, K., Clum, G., Murphy, D. A., Harper, G., Perez, L., Xu, J., ... & Adolescent Medicine Trials Network for HIV/AIDS Interventions. (2011). Health-related quality of life and psychosocial correlates among HIV-infected adolescent and young adult women in the US. *AIDS Education and Prevention, 23(4), 367.*

Anima-Korang, A., Gere, B. O., & Salimi, N. (2018). *Stigma and discrimination: coping strategies for persons living with HIV/AIDS in rural America*. IAFOR J Psychol BehavlSci, 4(1), 33-44.

Atukunda, E. C., Mugyenyi, G. R., Oloro, J., & Hughes, S. (2015). Tackling sexually transmitted infection burden in Ugandan communities living in the United Kingdom: a qualitative analysis of the socio-cultural interpretation of disease and condom use. *African Health Sciences, 15(3), 878-887.*

Avert. (n.d.). *Home*. Avert. Retrieved November 13, 2022, from https://avert.info/

AVERT. Young people, HIV and AIDS | Avert. (2020). Retrieved November 13, 2022, from https://www.avert.org/professionals/hiv-social-issues/key-affected-populations/young-people.

Awotidebe, A., Phillips, J., & Lens, W. (2014). Factors contributing to the risk of HIV infection in rural school-going adolescents. *International journal of environmental research and public health, 11(11), 11805-11821*.

Ayieko, J. (2018). *Optimization of the HIV care cascade in rural Uganda and Kenya* (Doctoral dissertation, University of Antwerp).

Ayieko, S., Nguku, A., & Kidula, N. (2021). It's not just about pads! Adolescent reproductive health views in Kenya: A qualitative secondary analysis. *PLOS Global Public Health*, *3*(5), e0001285.

Ayiga, N., Nambooze, H., Nalugo, S., Kaye, D., & Katamba, A. (2013). The impact of HIV/AIDS stigma on HIV counselling and testing in a high HIV prevalence population in Uganda. *African Health Sciences, 13(2), 278-286.*

Bae, J. W., Guyer, W., Grimm, K., & Altice, F. L. (2011). Medication persistence in the treatment of HIV infection: a review of the literature and implications for future clinical care and research. *Aids*, *25*(3), 279-290.

Baxter, P., & Jack, S. (2008). Qualitative case study methodology: Study design and implementation for novice researchers. *The qualitative report, 13(4), 544-559*.

Belle, J. A., & Gamedze, N. N. (2019). Behavioural factors contributing to the transmission of HIV and AIDS amongst young women of Mbabane in Swaziland. *African Health Sciences, 19(3), 2302-2311*.

Beres, L. K., Narasimhan, M., Robinson, J., Welbourn, A., & Kennedy, C. E. (2017). Non-specialist psychosocial support interventions for women living with HIV: a systematic review. *AIDS care, 29(9), 1079-1087*.

Berg, R. C., Page, S., & Øgård-Repål, A. (2021). *The effectiveness of peer-support for people living with HIV*: A systematic review and meta-analysis. PLoS One, 16(6), e0252623.

Biressaw, S., Abegaz, W. E., Abebe, M., Taye, W. A., & Belay, M. (2013). *Adherence to Antiretroviral Therapy and associated factors among HIV infected children in Ethiopia*: unannounced home-based pill count versus caregivers' report. BMC paediatrics, 13(1), 1-9.

Bland, A. M. (2020). Existential givens in the COVID-19 crisis. *Journal of Humanistic Psychology*, *60*(5), 710-724.

Block, B. L., Mehta, T., Ortiz, G. M., Ferris, S. P., Vu, T. H., Huang, L., & Cattamanchi, A. (2017). *Unusual radiographic presentation of Pneumocystis pneumonia in a patient with AIDS*. Case Reports in Infectious Diseases, 2017.

Bonnington, O., Wamoyi, J., Ddaaki, W., Bukenya, D., Ondenge, K., Skovdal, M., ... & Wringe, A. (2017). *Changing forms of HIV-related stigma along the HIV care and treatment continuum in sub-Saharan Africa*: a temporal analysis. Sexually transmitted infections, 93(Suppl 3).

Braun, V., & Clarke, V. (2006). Using thematic analysis in psychology. *Qualitative research in psychology*, *3*(2), 77-101.

Brittain, E. L., Duncan, M. S., Chang, J., Patterson, O. V., DuVall, S. L., Brandt, C. A., ... & Freiberg, M. (2018). Increased echocardiographic pulmonary pressure in HIV-infected and uninfected individuals in the Veterans Aging Cohort Study. *American journal of respiratory and critical care medicine, 197(7), 923-932*.

Brownley, J. R., Fallot, R. D., Wolfson Berley, R., & Himelhoch, S. S. (2015). Trauma history in African-American women living with HIV: *effects on psychiatric symptom severity and religious coping. AIDS care, 27(8), 964-971.*

Bryman, A. and Bell, E. (2011). Business research methods 3rd Oxford: Oxford University Press.

Burnham, K. E., Cruess, D. G., Kalichman, M. O., Grebler, T., Cherry, C., & Kalichman, S. C. (2016). Trauma symptoms, internalized stigma, social support, and sexual risk behaviour among HIV-positive gay and bisexual MSM who have sought sex partners online. *AIDS care, 28(3), 347-353.*

Calvete, E., & Connor-Smith, J. K. (2006). *Perceived social support, coping, and symptoms of distress in American and Spanish students*. Anxiety, Stress, and Coping, 19(1), 47-65.

Carlson, J., Watts, R., & Maniacci, M. (2006). *Adlerian therapy*. Washington, DC.

Carlucci, L., Tommasi, M., Balsamo, M., Furnham, A., & Saggino, A. (2015). Religious fundamentalism and psychological well-being: an Italian study. *Journal of Psychology and Theology, 43(1), 23-33.*

Carver, C. S., & Scheier, M. F. (1994). Situational coping and coping dispositions in a stressful transaction. *Journal of personality and social psychology*, *66*(1), 184.

Carver, C. S., Scheier, M. F., & Weintraub, J. K. (1989). Assessing coping strategies: a theoretically based approach. *Journal of personality and social psychology, 56(2), 267.*

CDC. (2019). Understanding the HIV care continuum. In *https://stacks.cdc.gov/view/cdc/81315*. Centres for Disease Control and Prevention (CDC). Retrieved March 26, 2025, from https://www.cdc.gov/mmwr/volumes/70/wr/mm7022a1.htm#:~:text=The%20number%20of%20infections%20among,1984%E2%80%931985%20(25%25).

Chambers, L. A., Rueda, S., Baker, D. N., Wilson, M. G., Deutsch, R., Raeifar, E., & Rourke, S. B. (2015). *Stigma, HIV and health: a qualitative synthesis*. BMC Public Health, 15(1), 1-17.

Chaudoir, S. R., & Fisher, J. D. (2010). The disclosure processes model: understanding disclosure decision making and post-disclosure outcomes among people living with a concealable stigmatized identity. *Psychological bulletin, 136(2), 236.*

Cherry, K. (2021). *What to Know About Adlerian Theory*. Verywell Mind. Retrieved 8 March 2022, from https://www.verywellmind.com/alderian-theory-definition-techniques- and-efficacy-5213796#toc-what-is-adlerian-theory

Chesney, M. A., Neilands, T. B., Chambers, D. B., Taylor, J. M., & Folkman, S. (2006). A validity and reliability study of the coping self-efficacy scale. *British journal of health psychology, 11(3), 421-437.*

Cheval, B., Mongin, D., Cullati, S., Uribe, A., Pihl-Thingvad, J., Chopard, P., & Courvoisier, D. S. (2021). Associations of emotional burden and coping strategies with sick leave among healthcare professionals: A longitudinal observational study. *International Journal of Nursing Studies, 115, 103869.*

Chory, A., Nyandiko, W., Beigon, W., Aluoch, J., Ashimosi, C., Munyoro, D., ... & Vreeman, R. (2021). *Perspectives of education sector stakeholders on a teacher training module to reduce HIV/AIDS stigma in Western Kenya*. BMC Public Health, 21(1), 1-10.

Clissold, E., Nylander, D., Watson, C., & Ventriglio, A. (2020). Pandemics and prejudice. *International Journal of Social Psychiatry, 66(5), 421-423.*

Coleman, J. D., Tate, A. D., Gaddist, B., & White, J. (2016). Social determinants of HIV-related stigma in faith-based organizations. *American Journal of Public Health, 106(3), 492-496.*

Colombini, M., James, C., & Ndwiga, C. (2016). The team I, Mayhew S. *The risks of partner violence following HIV status disclosure, and health service responses*: narratives of women attending reproductive health services in Kenya. J Int AIDS Soc, 19(1).

Cotton, S., Puchalski, C. M., Sherman, S. N., Mrus, J. M., Peterman, A. H., Feinberg, J., ... & Tsevat, J. (2006). Spirituality and religion in patients with HIV/AIDS. Journal of General Internal Medicine, 21(S5), S5-S13

da Silva, J., Bunn, K., Bertoni, R. F., Neves, O. A., & Traebert, J. (2013). Quality of life of people living with HIV. *AIDS care*, *25*(1), 71-76.

Dalmida, S. G., Koenig, H. G., Holstad, M. M., & Thomas, T. L. (2015). Religious and psychosocial covariates of health-related quality of life in people living with HIV/AIDS. HIV/AIDS research and treatment: *open journal, 1(1).*

Dapaah, C. (2020). *Ghana Aids Commission Regulations, 2020 LI 2403*.

Davids, E. L., Zembe, Y., de Vries, P. J., Mathews, C., & Swartz, A. (2021). Exploring condom use decision-making among adolescents: the synergistic role of affective and rational processes. *BMC Public Health*, *21*, 1-11.

Davids, E. L., Zembe, Y., de Vries, P. J., Mathews, C., & Swartz, A. (2021). *Exploring condom use decision-making among adolescents: the synergistic role of affective and rational processes.* BMC Public Health, 21(1), 1-11.

De Cock, K. M., Fowler, M. G., Mercier, E., de Vincenzi, I., Saba, J., Hoff, E., Alnwick, D. J., Rogers, M., & Shaffer, N. (2000). *Prevention of mother-to-child HIV transmission in resource-poor countries*. JAMA, 283(9), 1175. https://doi.org/10.1001/jama.283.9.1175

Denzin, N. K., & Lincoln, Y. S. (2005). Introduction: The discipline and practice of qualitative research. In N. K. Denzin & Y. S. Lincoln (Eds.), The Sage handbook of qualitative research (pp. 1-32). Thousand Oaks, CA: Sage.

DeSilva, M. B., Penwill, N., Sabin, L., Gifford, A. L., Li, Z., Fujie, Z., Weiwei, M., Yongzhen, L., Hongyan, L., Xuemei, Z., Barnoon, Y., Gill, C. J., & Bonawitz, R. (2018). We don't dare to tell her … we don't know where to begin: Disclosure experiences and challenges among adolescents living with HIV and their caregivers in China. *International Journal of Pediatrics and Adolescent Medicine, 5(1), 5–12. https://doi.org/10.1016/j.ijpam.2017.11.001*

Devonport, T. J., & Lane, A. M. (2006). Cognitive appraisal of dissertation stress among undergraduate students. *The Psychological Record, 56(2), 259-266.*

Dixon, S. M. (2021). *The Stress Coping Skills Middle Managers Need for Century Life: An Interpretive Phenomenological Analysis (Doctoral dissertation, Colorado Technical University).*

Dong, X., Yang, J., Peng, L., Pang, M., Zhang, J., Zhang, Z., ... & Chen, X. (2018). *HIV-related stigma and discrimination amongst healthcare providers in Guangzhou, China*. BMC Public Health, 18(1), 1-10.

Dow, D. E., Mmbaga, B. T., Gallis, J. A., Turner, E. L., Gandhi, M., Cunningham, C. K., & O'Donnell, K. E. (2020). *A group-based mental health intervention for young people living with HIV in Tanzania: results of a pilot individually randomized group treatment trial.* BMC Public Health, 20(1), 1-13.

Earnshaw, V. A., Rosenthal, L., & Lang, S. M. (2016). *Stigma, activism, and well-being among people living with HIV*. AIDS care, 28(6), 717-721.

Ebrahimi, M., Karami, G., Barazandeh Choghaee, S., & Bagiyan Kulehmarz, M. J. (2015). An intervention in social adjustment and reducing impulsive behaviours of male students with mathematical learning disabilities: Efficiency and effectiveness of parents with Adlerian approach. *Journal of Learning Disabilities, 5(1), 7-31.*

Ekstrand, M. L., Heylen, E., Mazur, A., Steward, W. T., Carpenter, C., Yadav, K., ... & Nyamathi, A. (2018). *The role of HIV stigma in ART adherence and quality of life among rural women living with HIV in India*. AIDS and Behavior, 22(12), 3859-3868.

Evangeli, M., & Wroe, A. L. (2017). HIV disclosure anxiety: A systematic review and theoretical synthesis. *AIDS and Behavior, 21(1), 1-11*.

Fabry, J. B. (1974). Application of logotherapy in small sharing groups. *Journal of religion and health*, 128-136.

Fakhry, C., & D'Souza, G. (2013). *Discussing the diagnosis of HPV-OSCC: Common questions and answers*. Oral oncology, 49(9), 863-871.

Farouq, A. (2016). An Exploratory Case Study of HIV/AIDS Related Stigma in Rural Ghana (Doctoral dissertation, University of Guelph).

Fauk, N. K., Gesesew, H. A., Mwanri, L., Hawke, K., & Ward, P. R. (2022). HIV-related challenges and women's self-response: A qualitative study with women living with HIV in Indonesia. *Plos one*, *17*(10), e0275390.

Fauk, N. K., Ward, P. R., Hawke, K., & Mwanri, L. (2021). Cultural and religious determinants of HIV transmission: A qualitative study with people living with HIV in Belu and Yogyakarta, Indonesia. *PLoS One*, *16*(11), e0257906.

Fazlıoğulları, O. (2012). Scientific research paradigms in social sciences. International *Journal of Educational Policies, 6(1), 41-55.*

Fekete, E. M., Williams, S. L., & Skinta, M. D. (2018). *Internalised HIV-stigma, loneliness, depressive symptoms and sleep quality in people living with HIV*. Psychology & Health, 33(3), 398-415.

Ferguson, E.D. (2020). Adler's Motivational Theory: A Historical Perspective on Belonging and the Fundamental Human Striving. *The Journal of Individual Psychology 76(1), 51-58. doi:10.1353/jip.2020.0016.*

Ferrand, R. A., Bandason, T., Musvaire, P., Larke, N., Nathoo, K., Mujuru, H., ... & Corbett, E. L. (2009). Causes of acute hospitalization in adolescence: burden and spectrum of HIV-related morbidity in a country with an early-onset and severe HIV epidemic: a prospective survey. *PLoS medicine*, *7*(2), e1000178.

Ferris France, N., Macdonald, S. H. F., Conroy, R. R., Chiroro, P., Ni Cheallaigh, D., Nyamucheta, M., ... & Byrne, E. (2017). 'We are the change'-An innovative community-based response to address self-stigma: A pilot study focusing on people living with HIV in Zimbabwe. *PloS one*, *14*(2), e0210152.

Feyissa, T. R., Harris, M. L., Forder, P. M., & Loxton, D. (2020). *Contraceptive use among sexually active women living with HIV in western Ethiopia*. Plos one, 15(8), e0237212.

Foster, C., Ayers, S., & Fidler, S. (2020). *Antiretroviral adherence for adolescents growing up with HIV:* understanding real life, drug delivery and forgiveness. Therapeutic Advances in Infectious Disease, 7, 2049936120920177.

Foster, C., Domínguez-Rodríguez, S., Tagarro, A., Gkouleli, T., Heaney, J., Watters, S., ... & Rojo, P. (2021). The CARMA Study: early infant antiretroviral therapy—timing impacts on total HIV-1 DNA quantitation 12 years later. *Journal of the Pediatric Infectious Diseases Society, 10(3), 295-301.*

Fox, M. P., & Rosen, S. (2015). Retention of adult patients on antiretroviral therapy in low-and middle-income countries: systematic review and meta-analysis 2008–2013. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 69(1), 98-108.*

Frankel, C. (1976). The rights of nature. *When Values Conflict: Essays on Environmental Analysis, Discourse, and Decision". Ballinger Co*.

Frankl, V. E. (2000) *Man's Search for ultimate meaning*. Perseus (review)

Frieden, T. R., Foti, K. E., & Mermin, J. (2015). Applying public health principles to the HIV epidemic—how are we doing? *New England Journal of Medicine, 373(23), 2281-2287.*

Frydenberg, E. (2020). *My journey in coping research and practice: The impetus and the relevance*. The Educational and Developmental Psychologist, 37(1), 83-90.

Gabbidon, K., Chenneville, T., Peless, T., & Sheared-Evans, S. (2020). *Self-disclosure of HIV status among youth living with HIV*: a global systematic review. AIDS and Behavior, 24(1), 114-141.

Gallant, J., Hsue, P. Y., Shreay, S., & Meyer, N. (2017). Comorbidities among US patients with prevalent HIV infection—a trend analysis. *The Journal of Infectious Diseases, 216(12), 1525-1533.*

Garrido-Hernansaiz, H., Martín-Fernández, M., Castaño-Torrijos, A., & Cuevas, I. (2018). Development and Validation of the ADAS Scale and Prediction of Attitudes Toward Affective-Sexual Diversity Among Spanish Secondary Students. *Journal of Homosexuality, 65(8), 1032-1050.*

Genrich, G. L., & Brathwaite, B. A. (2005*). Response of religious groups to HIV/AIDS as a sexually transmitted infection in Trinidad.* BMC Public Health, 5(1), 1-12.

George L. S. (2019). *HIV Related Stigma and Discrimination among People Living with HIV/AIDS in Ernakulam District: A Qualitative Study. Indian Journal of Community Medicine*: official publication of Indian Association of Preventive & Social Medicine, 44(Suppl 1), S34–S37. https://doi.org/10.4103/ijcm.IJCM_30_19

George, G., Chetty, T., Strauss, M., Inoti, S., Kinyanjui, S., Mwai, E., ... & Kelvin, E. A. (2018). Costing analysis of an SMS-based intervention to promote HIV self-testing amongst truckers and sex workers in Kenya. *PloS one*, *13*(7), e0197305.

Gesesew, H. A., Tesfay Gebremedhin, A., Demissie, T. D., Kerie, M. W., Sudhakar, M., & Mwanri, L. (2017). The significant association between perceived HIV related stigma and late presentation for HIV/AIDS care in low and middle-income countries: *a systematic review and meta-analysis. PLoS One, 12(3), e0173928.*

Ghana AIDS Commission (GAC). (2015). Country AIDS progress report. https://www.ghanaids.gov.gh/GHA_narrative_report_2015.pdf

Ghana AIDS Commission (GAC). (2020). National and sub-national estimates and projections dissemination. Retrieved from from https://www.ghanaids.gov.gh/pages/fact-sheets-reports

Ghana AIDS Commission. (n.d.). Retrieved November 13, 2022, from https://www.ghanaids.gov.gh/pages/fact-sheets-reports

Goffman, E. (1963) Stigma. Notes on the Management of Spoiled Identity. Englewood Cliffs: Prentice-Hall

Goffman, E. (2009). *Stigma*: Notes on the management of spoiled identity. Simon and Schuster.

Golub, A., Gorr, W. L., & Gould, P. R. (1993). Spatial diffusion of the HIV/AIDS epidemic: modeling implications and case study of AIDS incidence in Ohio. *Geographical analysis*, *25*(2), 85-100.

Griffee, D. T. (2012). *An introduction to second language research methods*. TESL-EJ Publications.

Gringeri, C., Barusch, A., & Cambron, C. (2013). Examining foundations of qualitative research: A review of social work dissertations, 2008–2010. *Journal of Social Work Education, 49(4), 760-773.*

Guideline on HIV disclosure counselling for children up to 12 ... - who. (n.d.). Retrieved October 20, 2022, from https://apps.who.int/iris/bitstream/handle/10665/44777/9789241502863_eng.pdf?sequence=1

Gyamfi, E., Okyere, P., Appiah-Brempong, E., Adjei, R. O., & Mensah, K. A. (2015). Benefits of disclosure of HIV status to infected children and adolescents: perceptions of caregivers and health care providers. *Journal of the Association of Nurses in AIDS Care, 26(6), 770-780.*

Hadish, M. T., Mao, J., Gong, G., Hadish, B., & Tesfamariam, E. (2017). *Predictors of high HIV/AIDS risk sexual behaviours*: Comparison study among Cameroonian and Gabonese Youth Aged 15-24 years. J HIV Retrovirus, 3, 1.

Hall, H. I., Gray, K. M., Tang, T., Li, J., Shouse, L., & Mermin, J. (2012). Retention in care of adults and adolescents living with HIV in 13 US areas. *JAIDS Journal of Acquired Immune Deficiency Syndromes, 60(1), 77-82.*

Hayes, (2021). MMWR Supplement on National HIV Behavioral Surveillance Among Transgender Women—Seven Urban Areas, United States, 2019-2020. *Public Health Reports*, *139*(3), 269-270.

Hemmerle, A. M., Herman, J. P., & Seroogy, K. B. (2012). *Stress, depression and Parkinson's disease*. Experimental neurology, 233(1), 79-86.

Hendriks, T., Schotanus-Dijkstra, M., Hassankhan, A., Graafsma, T., & de Jong, J. E. T. (2018). *The efficacy of multi-component positive psychology interventions: A systematic review and meta-analysis*. Positive psychology interventions in a multi-ethnic and cross-cultural context.

Henny, K. D., McCree, D. H., & Mermin, J. (2022). *Opening Editorial AIDS and Behavior Special Issue on Stigma*. AIDS and Behavior, 26(1), 1-4.

Holubova, M., Prasko, J., Ociskova, M., Grambal, A., Slepecky, M., Marackova, M., ... & Zatkova, M. (2018). *Quality of life and coping strategies of outpatients with a depressive disorder in maintenance therapy–A cross-sectional study. Neuropsychiatric disease and treatment, 14, 73*.

Holzemer, W. L., Uys, L., Makoae, L., Stewart, A., Phetlhu, R., Dlamini, P. S., ... & Naidoo, J. (2007). A conceptual model of HIV/AIDS stigma from five African countries. *Journal of Advanced Nursing, 58(6), 541-551.*

Hoyt, M. A., Wang, A. W. T., Boggero, I. A., Eisenlohr-Moul, T. A., Stanton, A. L., & Segerstrom, S. C. (2020). *Emotional approach coping in older adults as a predictor of physical and mental health. Psychology and ageing, 35(4), 591*.

Ironson, G., Kremer, H., & Lucette, A. (2016). Relationship between spiritual coping and survival in patients with HIV. *Journal of General Internal Medicine, 31(9), 1068-1076.*

Jalilian, K., Amiri, H., Arefi, M., & Afsharnia, K. (2020). The effectiveness of Adlerian group counselling on mental health and social adjustment of parents. *Archives of Pharmacy Practice, 1, 143-151.*

Jemmott III, J. B., Zhang, J., Croom, M., Icard, L. D., Rutledge, S. E., & O'Leary, A. (2019). Barriers and facilitators to engaging African American men who have sex with men in the HIV care continuum: a theory-based qualitative study. *Journal of the Association of Nurses in AIDS Care, 30(3), 352-361*.

Joint United Nations Programme on HIV/AIDS (UNAIDS), Global HIV. & AIDS statistics — Fact sheet (2021)]. Available from: https://www.unaids.org/en/resources/fact-sheet

Joint United Nations Programme on HIV/AIDS (UNAIDS). Botswana leads the way for high HIV burden country certification on the path to eliminate vertical HIV transmission [Internet]. 2022 [cited 2022 Nov 3]. Available from: https://www.unaids.org/en/keywords/botswana

Jolle, J., Kabunga, A., Okello, T. O., Kadito, E. O., Aloka, J., Otiti, G., ... & Udho, S. (2022). *HIV-related stigma experiences and coping strategies among pregnant women in rural Uganda: A qualitative descriptive study*. Plos one, 17(10), e0272931.

Jones, A., Cremin, I., Abdullah, F., Idoko, J., Cherutich, P., Kilonzo, N., ... & Dybul, M. (2014). Transformation of HIV from pandemic to low-endemic levels: a public health approach to combination prevention. *The Lancet*, *384*(9939), 272-279.

Jonker, Jan and Pennink, Bartjan (2010), The Essence of Research Methodology: A concise Guide for Master and PhD Students in Management Science. Berlin: Springer.

Jordan, K. (2010). Vicarious trauma: Proposed factors that impact clinicians. *Journal of Family Psychotherapy, 21(4), 225-237*.

Junça-Silva, A., Caetano, A., & Lopes, R. R. (2018). Activated or deactivated? Understanding how cognitive appraisals can drive emotional activation in the aftermath of daily work events. *European Review of Applied Psychology*, *68*(4-5), 189-198.

Kalembo, F. W., Kendall, G. E., Ali, M., & Chimwaza, A. F. (2019). *Socio-demographic, clinical, and psychosocial factors associated with primary caregivers' decisions regarding HIV disclosure to their child aged between 6 and 12 years living with HIV in Malawi*. Plos one, 14(1), e0210781.

Kamya, M. R. (2017). *Belief in divine healing can be a barrier to antiretroviral therapy adherence in Uganda.* Aids, 21(11), 1486-1487.

Katz, I. T., Bogart, L. M., Dietrich, J. J., Leslie, H. H., Iyer, H. S., Leone, D., ... & Bangsberg, D. R. (2019). *Understanding the role of resilience resources, antiretroviral therapy initiation, and HIV-1 RNA suppression among people living with HIV in South Africa*: a prospective cohort study. AIDS (London, England), 33(Suppl 1), S71.

Kaunda-Khangamwa, B. N., Kapwata, P., Malisita, K., Munthali, A., Chipeta, E., Phiri, S., & Manderson, L. (2020). *Adolescents living with HIV, complex needs and resilience in Blantyre, Malawi*. AIDS Research and Therapy, 17(1), 1-13.

Kaunda-Khangamwa, B. N., Maposa, I., Dambe, R., Malisita, K., Mtagalume, E., Chigaru, L., ... & Manderson, L. (2020). *Validating a child youth resilience measurement (CYRM-28) for adolescents living with HIV (ALHIV) in urban Malawi*. Frontiers in Psychology, 11, 1896.

Kemigisha, E., Zanoni, B., Bruce, K., Menjivar, R., Kadengye, D., Atwine, D., & Rukundo, G. Z. (2019). *Prevalence of depressive symptoms and associated factors among adolescents living with HIV/AIDS in South Western Uganda. AIDS care.*

Kenu, E., Obo-Akwa, A., Nuamah, G. B., Brefo, A., Sam, M., & Lartey, M. (2014). *Knowledge and disclosure of HIV status among adolescents and young adults attending an adolescent HIV Clinic in Accra, Ghana.* BMC Research Notes, 7(1), 844. https://doi.org/10.1186/1756-0500-7-844

Khan, M., Ilcisin, M., & Saxton, K. (2017). Multifactorial discrimination is a fundamental cause of mental health inequities. *International Journal for Equity in Health, 16(1), 1-12.*

Kimera, E., Vindevogel, S., Engelen, A. M., De Maeyer, J., Reynaert, D., Kintu, M. J., ... & Bilsen, J. (2021). *HIV-Related Stigma Among Youth Living With HIV in Western Uganda*. Qualitative Health Research, 31(10), 1937-1950.

Kingori, C., Reece, M., Obeng, S., Murray, M., Shacham, E., Dodge, B., ... & Ojakaa, D. (2012). *Impact of internalized stigma on HIV prevention behaviours among HIV-infected individuals seeking HIV care in Kenya*. AIDS Patient Care and STDs, 26(12), 761-768.

Kip, E. C., Udedi, M., Kulisewa, K., Go, V. F., & Gaynes, B. N. (2022). *Stigma and mental health challenges among adolescents living with HIV in selected adolescent-specific antiretroviral therapy clinics in Zomba District*, Malawi. BMC paediatrics, 22(1), 1-12.

Kivunja, C., & Kuyini, A. B. (2017). Understanding and applying research paradigms in educational contexts. *International Journal of Higher Education, 6(5), 26-41*.

Korbmacher, M., & Wright, L. (2020). *What Can We Learn from Exploring Cognitive Appraisal, Coping Styles and Perceived Stress in UK Undergraduate Dissertation Students?* Psychology Teaching Review, 26(1), 48-62.

Kotzé, M., Visser, M., Makin, J., Sikkema, K., & Forsyth, B. (2013). *Psychosocial variables associated with coping of HIV-positive women diagnosed during pregnancy*. AIDS and Behavior, 17(2), 498-507.

Krauss, S. E. (2005). *Research paradigms and meaning making*: A primer. The qualitative report, 10(4), 758-770.

Kumar, S., Mohanraj, R., Rao, D., Murray, K. R., & Manhart, L. E. (2015). *Positive coping strategies and HIV-related stigma in south India*. AIDS patient care and STDs, 29(3), 157-163.

Laar, A., Manu, A., Laar, M., El-Adas, A., Amenyah, R., Atuahene, K., ... & Quakyi, I. (2015). *Coping strategies of HIV-affected households in Ghana*. BMC Public Health, 15(1), 1-9.

Lamontagne, E., Over, M., & Stover, J. (2019). *The economic returns of ending the AIDS epidemic as a public health threat.* Health Policy, 123(1), 104-108.

Larki, M. (2020). Living with discordance: A qualitative description of the challenges faced by HIV-negative married women. *International Journal of Community Based Nursing and Midwifery, 8(2), 103.*

Lazarus, R. S. (1993). *From psychological stress to the emotions*: a history of changing outlooks.

Lazarus, R. S., & Folkman, S. (1984). *Stress, appraisal, and coping*. Springer Publishing Company.

Lazarus, R. S., & Folkman, S. (1986). Cognitive theories of stress and the issue of circularity. In *Dynamics of stress: Physiological, psychological and social perspectives* (pp. 63-80). Boston, MA: Springer US.

Levy, I., Wieder-Finesod, A., Litchevsky, V., Biber, A., Indenbaum, V., Olmer, L., ... & Rahav, G. (2021). Immunogenicity and safety of the BNT162b2 mRNA

COVID-19 vaccine in people living with HIV-1. *Clinical Microbiology and Infection, 27(12), 1851-1855.*

Levy, M. E., Waters, A., Sen, S., Castel, A. D., Plankey, M., Molock, S., ... & Kassaye, S. (2021). *Psychosocial stress and neuroendocrine biomarker concentrations among women living with or without HIV*. PloS one, 16(12), e0261746.

Liboro, R. M., & Walsh, R. T. (2016). *Understanding the irony*: Canadian gay men living with HIV/AIDS, their Catholic devotion, and greater well-being. *Journal of religion and health, 55(2), 650-670.*

Lincoln, Y. S., & Guba, E. G. (1985). *Naturalistic inquiry*. Sage.

Litwic-Kaminska, K., Kotyśko, M., Pracki, T., Wiłkość-Dębczyńska, M., & Stankiewicz, B. (2022). The Effect of Autogenic Training in a Form of Audio Recording on Sleep Quality and Physiological Stress Reactions of University Athletes—Pilot Study. *International Journal of Environmental Research and Public Health, 19(23), 16043*.

Liu, L., Pang, R., Sun, W., Wu, M., Qu, P., Lu, C., & Wang, L. (2013). *Functional social support, psychological capital, and depressive and anxiety symptoms among people living with HIV/AIDS employed full-time*. BMC Psychiatry, 13(1), 1-10.

Lu, Y., Tang, S., Qin, Y., Harypursat, V., Wu, H., & Chen, Y. (2022). Changes of human immunodeficiency virus (HIV) burden globally and in China over three decades: a secondary analysis of global HIV statistics. *Chinese Medical Journal, 135*(22), 2690-2698.

Lwidiko, A., Kibusi, S. M., Nyundo, A., & Mpondo, B. C. (2018). *Association between HIV status and depressive symptoms among children and adolescents in the Southern Highlands Zone, Tanzania*: A case-control study. PLoS One, 13(2), e0193145.

Mabaso, M., Maseko, G., Sewpaul, R., Naidoo, I., Jooste, S., Takatshana, S., ... & Zungu, N. (2021). *Trends and correlates of HIV prevalence among adolescents in South Africa:* evidence from the 2008, 2012 and 2017 South African National HIV Prevalence, Incidence and Behaviour surveys. AIDS Research and Therapy, 18(1), 1-8.

Mabaso, M., Sokhela, Z., Mohlabane, N., Chibi, B., Zuma, K., & Simbayi, L. (2018). *Determinants of HIV infection among adolescent girls and young women aged 15–24 years in South Africa*: a 2012 population-based national household survey. BMC Public Health, 18(1), 1-7.

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research, 16(2), 193-205.*

Mackenzie, N., & Knipe, S. (2006). Research dilemmas: Paradigms, methods and methodology. *Issues in educational research, 16(2), 193-205.*

Madiba, S. (2016). *Caregivers' lack of disclosure skills delays disclosure to children with perinatal HIV in resource-limited communities*: multicenter qualitative data from South Africa and Botswana. Nursing Research and Practice, 2016.

Madiba, S., & Josiah, U. (2019). *Perceived stigma and fear of unintended disclosure are barriers in medication adherence in adolescents with perinatal HIV in Botswana*: a qualitative study. BioMed Research International, 2019.

Mahamboro, D. B., Fauk, N. K., Ward, P. R., Merry, M. S., Siri, T. A., & Mwanri, L. (2020). HIV stigma and moral judgement: a qualitative exploration of the experiences of HIV stigma and discrimination among married men living with

HIV in Yogyakarta. *International Journal of Environmental Research and Public Health, 17(2), 636.*

Mahamboro, D. B., Fauk, N. K., Ward, P. R., Merry, M. S., Siri, T. A., & Mwanri, L. (2020). HIV stigma and moral judgement: a qualitative exploration of the experiences of HIV stigma and discrimination among married men living with HIV in Yogyakarta. *International Journal of Environmental Research and Public Health, 17(2), 636.*

Makoae, L. N., Greeff, M., Phetlhu, R. D., Uys, L. R., Naidoo, J. R., Kohi, T. W., ... & Holzemer, W. L. (2008). Coping with HIV-related stigma in five African countries. *Journal of the Association of Nurses in AIDS Care, 19(2), 137-146.*

Makoae, L. N., Greeff, M., Phetlhu, R. D., Uys, L. R., Naidoo, J. R., Kohi, T. W., ... & Holzemer, W. L. (2008). Coping with HIV-related stigma in five African countries. *Journal of the Association of Nurses in AIDS Care, 19(2), 137-146.*

Makoae, M., & Mokomane, Z. (2008). *Examining women's vulnerability to HIV transmission and the impact of AIDS*: the role of peer education/peer support in Lesotho's garment industry

Makombe, G. (2017). An expose of the relationship between paradigm, method and design in research. *The qualitative report, 22(12), 3363-3383.*

Malga, P. F., Setlalentoa, B. M., Oduaran, C., & Maforah, N. (2018). *Factors influencing HIV/AIDS and risky sexual behaviour among learners in South Africa*. Glob J Health Sci, 10(5), 197.

Malterud, K. (2019). *Qualitative meta-synthesis*: A research method for medicine and health sciences. Routledge.

Maniacci, M.P., Carlson, J., & Sackett-Maniacci, L. (2017). Neo-Adlerian Approaches to Psychotherapy. *The Journal of Individual Psychology, 73, 109 - 95.*

Marín-Chollom, A. M., & Revenson, T. A. (2022). Cultural values as a resilience resource for Latino/ adolescents and young adults coping with parental cancer. *Journal of Psychosocial Oncology, 40(1), 26-44.*

Marshall, C., & Rossman, G. B. (2014). *Designing qualitative research*. Sage publications.

Mathew, R. S., Boonsuk, P., Dandu, M., & Sohn, A. H. (2020). Experiences with stigma and discrimination among adolescents and young adults living with HIV in Bangkok, Thailand. *AIDS care, 32*(4), 530-535.

Mavhu, W., Berwick, J., Chirawu, P., Makamba, M., Copas, A., Dirawo, J., ... & Cowan, F. M. (2013). *Enhancing psychosocial support for HIV-positive adolescents in Harare, Zimbabwe*. PloS one, 8(7), e70254.

Mbonye, M., Nakamanya, S., Birungi, J., King, R., Seeley, J., & Jaffar, S. (2013). *Stigma trajectories among people living with HIV (PLHIV) embarking on a lifetime journey with antiretroviral drugs in Jinja, Uganda*. BMC Public Health, 13(1), 1-11.

McCluskey, M. C. (2022). *Revitalizing Alfred Adler*: An Echo for Equality. Clinical Social Work Journal, 50(4), 387-399.

McGregor, S. L., & Murnane, J. A. (2010). *Paradigm, methodology and method*: Intellectual integrity in consumer scholarship. International journal of consumer studies, 34(4), 419-427.

McHenry, M. S., Apondi, E., McAteer, C. I., Nyandiko, W. M., Fischer, L. J., Ombitsa, A. R., ... & Vreeman, R. C. (2018). Tablet-based disclosure counselling for HIV-infected children, adolescents, and their caregivers: a pilot study. African *Journal of AIDS Research, 17(3), 249-258.*

Melemis, S. M. (2015). Focus: addiction: relapse prevention and the five rules of recovery. *The Yale journal of biology and medicine, 88(3), 325.*

Mendelsohn, J. B., Calzavara, L., Daftary, A., Mitra, S., Pidutti, J., Allman, D., ... & Myers, T. (2015). *A scoping review and thematic analysis of social and behavioural research among HIV-serodiscordant couples in high-income settings*. BMC Public Health, 15(1), 1-18.

Mengwai, K., Madiba, S., & Modjadji, P. (2020). *Low disclosure rates to sexual partners and unsafe sexual practices of youth recently diagnosed with HIV*; implications for HIV prevention interventions in South Africa. In Healthcare (Vol. 8, No. 3, p. 253). MDPI.

Merrill, K. G., Campbell, J. C., Kennedy, C. E., Burke, V. M., Miti, S., Frimpong, C., ... & Denison, J. A. (2022). '*So hurt and broken'*: A qualitative study of experiences of violence and HIV outcomes among Zambian youth living with HIV. Global public health, 17(3), 444-456.

Mhode, M., & Nyamhanga, T. (2016). *Experiences and impact of stigma and discrimination among people on antiretroviral therapy in Dar es Salaam: A qualitative perspective*. AIDS research and treatment, 2016.

Miller, R. J. (1973). *Cross-cultural research in the perception of pictorial materials*. Psychological Bulletin, 80(2), 135.

Miller, R. L., Boyer, C. B., Chiaramonte, D., Lindeman, P., Chutuape, K., Cooper-Walker, B., ... & Fortenberry, J. D. (2017). Evaluating testing strategies for identifying youths with HIV infection and linking youths to biomedical and other prevention services. *JAMA pediatrics, 171(6), 532-537.*

Mkansi, M., & Acheampong, E. A. (2012). Research philosophy debates and classifications: *students' dilemma. Electronic journal of business research methods, 10(2), pp132-140.*

Mohanraj, R., Jeyaseelan, V., Kumar, S., Mani, T., Rao, D., Murray, K. R., & Manhart, L. E. (2015). *Cultural adaptation of the Brief COPE for persons living with HIV/AIDS in southern India*. AIDS and Behavior, 19(2), 341-351.

Muchiri, E., Odimegwu, C., & De Wet, N. (2017). HIV risk perception and consistency in condom use among adolescents and young adults in urban Cape Town, South Africa: a cumulative risk analysis. *Southern African Journal of Infectious Diseases*, *32*(3), 105-110.

Mugo, C., Seeh, D., Guthrie, B., Moreno, M., Kumar, M., John-Stewart, G., ... & Ronen, K. (2021). *Association of experienced and internalized stigma with self-disclosure of HIV status by youth living with HIV*. AIDS and Behavior, 25(7), 2084-2093.

Mukherjee, A., Lahiri, S., Mukherjee, A., Choudhury, S., & Sinha, R. (2017). Study on defence mechanisms to cope with stress due to stigma among people living with HIV/AIDS reported in Eastern India: a single centre experience. *Indian Journal of Clinical Medicine, 8, 1179916117742919.*

Murithi, L. K., Masho, S. W., & Vanderbilt, A. A. (2015). Factors enhancing utilization of and adherence to the prevention of mother-to-child transmission (PMTCT) service in an urban setting in Kenya. AIDS and behaviour, 19(4), 645-654.

Murray, K. R., Dulli, L. S., Ridgeway, K., Dal Santo, L., Darrow de Mora, D., Olsen, P., ... & McCarraher, D. R. (2017). Improving retention in HIV care among adolescents and adults in low-and middle-income countries: a systematic review of the literature. *PloS one, 12*(9), e0184879.

Murray, K. R., Dulli, L. S., Ridgeway, K., Dal Santo, L., Darrow de Mora, D., Olsen, P., ... & McCarraher, D. R. (2017). *Improving retention in HIV care among adolescents and adults in low-and middle-income countries*: a systematic review of the literature. PloS one, 12(9), e0184879.

Mutumba, M., Bauermeister, J. A., Musiime, V., Byaruhanga, J., Francis, K., Snow, R. C., & Tsai, A. C. (2015). *Psychosocial challenges and strategies for coping with HIV among adolescents in Uganda:* a qualitative study. AIDS patient care and STDs, 29(2), 86-94.

Mwangwa, F. (2022). *Integrated Health Care Delivery for Adolescents Living with and at Risk of HIV Infection:* A Review of Models and Actions for Implementation. AIDS and Behavior, 1-14.

Nabunya, P., Ssewamala, F. M., Mukasa, M. N., Byansi, W., & Nattabi, J. (2015). Peer mentorship program on HIV/AIDS knowledge, beliefs, and prevention attitudes among orphaned adolescents: *an evidence-based practice. Vulnerable Children and Youth Studies, 10(4), 345-356.*

Naidoo, I., Reddy, T., Ndlovu, P., Sewpaul, R., Mokhele, T., Mabaso, M., ... & Zungu, N. (2022). *Pregnancy and HIV risk behaviours: Evidence from four national surveys in South Africa. Southern African Journal of Demography, 22, 1.*

Naing, C., Mak, J. W., Maung, M., Wong, S. F., & Kassim, A. I. (2013). *Meta-analysis: the association between HIV infection and extrapulmonary tuberculosis*. Lung, 191(1), 27–34. https://doi.org/10.1007/s00408-012-9440-6

National AIDS/STI Control Programme, Ghana Health Service and Ministry of Health. (2016). *HIV Sentinel Survey Report 2015. ASHA Lead, 21(5), 20.*

Nguyen, T. T. M. (2019). *Data collection methods in L2 pragmatics research: An overview*. The Routledge handbook of second language acquisition and pragmatics, 195-211.

Nicol, E., Basera, W., Mukumbang, F. C., Cheyip, M., Mthethwa, S., Lombard, C., … & Bradshaw, D. (2022). *Linkage to HIV care and early retention in care rates in the Universal Test-and-Treat era*: a population-based prospective study in KwaZulu-Natal, South Africa.

Noro Filho, G. A., Salgado, D. M. R. D. A., Casarin, R. C. V., Casati, M. Z., Costa, C., & Giovani, E. M. (2013). Anti-infective periodontal therapy promoting improvement in systemic markers of HIV infection. *AIDS Research and Human Retroviruses*, *29*(7), 1040-1044.

Oduro, G. (2017). *Perceptions and Attitudes Towards Vaginal Candidiasis Infection a Survey Among Female Students in Selected Senior High Schools in the Lower Manya Municipality in the Eastern Region of Ghana* (Doctoral dissertation, Ensign Global College).

Ohemeng, F. N. (2016). The Meaning of AIDS-Related Deaths in an Urban Town in Ghana. *Illness, Crisis & Loss*, *24*(4), 261-278.

Okumu, M., Nyoni, T., & Byansi, W. (2020). Alleviating psychological distress and promoting mental wellbeing among adolescents living with HIV in sub-Saharan Africa, during and after COVID-19. *Global Public Health*, *16*(6), 964-973.

Onyebuchi, O. B. (2015). Tuberculosis and Leprosy Control Policy in Nigeria, 1985-2015. *Elixir Pharmacy*, *88*(2015), 36313-36315.

Owusu, K. F., Doungmo Goufo, E. F., & Mugisha, S. (2020). Modelling intracellular delay and therapy interruptions within Ghanaian HIV population. *Advances in Difference Equations*, *2020*(1), 401.

P. Zinyemba, T., Pavlova, M., & Groot, W. (2020). Effects of HIV/AIDS on children's educational attainment: a systematic literature review. *Journal of Economic Surveys*, *34*(1), 35-84.

Paintsil, E., Kyriakides, T. C., Antwi, S., Renner, L., Nichols, J. S., Amissah, K., ... & Sankofa Study Team. (2020). Clinic-based pediatric disclosure intervention trial improves pediatric HIV status disclosure in Ghana. *JAIDS Journal of Acquired Immune Deficiency Syndromes*, *84*(1), 122-131.

Pantelic, M., Casale, M., Cluver, L., Toska, E., & Moshabela, M. (2020). Multiple forms of discrimination and internalized stigma compromise retention in HIV care among adolescents: findings from a South African cohort. *Journal of the International AIDS Society*, *23*(5), e25488.

Parkhurst, J. O. (2014). Structural approaches for prevention of sexually transmitted HIV in general populations: definitions and an operational approach. *Journal of the International AIDS Society*, *17*(1), 19052.

Patton, M. Q. (2002). *Qualitative research & evaluation methods*. sage.

Pinto, R. M., Witte, S. S., Filippone, P. - L., Baird, K. L. & Whitman, W. R. R. (2017)... Factors that influence linkages to HIV continuum of care services: implications for multi-level interventions. *International journal of environmental research and public health*, *14*(11), 1355.

Qanche, Q., Wondimu, W., Asefa, A., Yosef, T., Midaksa, G., & Nigussie, T. (2021). Factors contributing to high HIV prevalence in Majang zone, Southwest Ethiopia: what lies beneath the tip of the iceberg?. *Journal of Multidisciplinary Healthcare*, 3273-3283.

Saffier, I. P., Kawa, H., & Harling, G. (2017). A scoping review of prevalence, incidence and risk factors for HIV infection amongst young people in Brazil. *BMC infectious diseases*, *17*, 1-13.

Saunders, M., Lewis, P., & Thornhill, A. (2009). *Research methods for business students*. Pearson education.

Sgoifo, A., Bignamini, A., La Mantia, L., Celani, M. G., Parietti, P., Ceriani, M. A., ... & Agostoni, E. C. (2017). Integrated imaginative distention therapy to cope with fatigue. DIMMI SI study: the first randomized controlled trial in multiple sclerosis. *Neurology and Therapy*, *6*, 213-223.

Shenderovich, Y., Boyes, M., Esposti, M. D., Casale, M., Toska, E., Roberts, K. J., & Cluver, L. (2021). Relationships with caregivers and mental health outcomes among adolescents living with HIV: a prospective cohort study in South Africa. *BMC Public Health*, *21*, 1-11.

Shenderovich, Y., Boyes, M., Esposti, M. D., Casale, M., Toska, E., Roberts, K. J., & Cluver, L. (2021). Relationships with caregivers and mental health outcomes among adolescents living with HIV: a prospective cohort study in South Africa. *BMC Public Health*, *21*, 1-11.

Sheppard, M. J. (2020). A case study of a radical constructivist approach to teaching innovation. *Journal of Education for Business*, *95*(8), 559-566.

Shields, L., & Twycross, A. (2003). The difference between quantitative and qualitative research: this paper is one of a series of short papers on aspects of research by Linda Shields and Alison Twycross. *Paediatric nursing*, *15*(9), 24-25.

Silva, T. D., Pereira, J. M., & Miranda, G. J. (2017). O estresse em graduandos de Ciências Contábeis e Administração. *Advances in Scientific and Apllied Accounting*, *11*(2), 330-350.

Simbayi, L. C., Zungu, N., Evans, M., Mehlomakulu, V., Kupamupindi, T., Mafoko, G., & Zuma, K. (2015). HIV serostatus disclosure to sexual partners among sexually active people living with HIV in South Africa: Results from the 2012 National Population-Based Household Survey. *AIDS and Behavior*, *21*, 82-92.

Simbayi, L.C., Kalichman, S.C., Strobel, A., Cloete, A., Henda, N. & Mgeketo, A., (2007), 'Internalized AIDS stigma, AIDS discrimination and depression among men and women living with HIV/AIDS in Cape Town, South Africa', Social Science and Medicine 64(9), 1823–1831. http://dx.doi.org/10.1016/j.socscimed.2007.01.006

Slogrove, A. L., & Sohn, A. H. (2018). The global epidemiology of adolescents living with HIV. *Current Opinion in HIV and AIDS*, *13*(3), 170–178. https://doi.org/10.1097/coh.0000000000000449

Slogrove, A. L., Schomaker, M., Davies, M. A., Williams, P., Balkan, S., ... & Leroy, V. (2018). *The epidemiology of adolescents living with perinatally acquired HIV*: a cross-region global cohort analysis. PLoS medicine, 15(3), e1002514.

Smith, C. A., & Lazarus, R. S. (1993). Appraisal components, core relational themes, and the emotions. *Cognition & emotion*, *7*(3-4), 233-269.

Teshale, A. B., & Tesema, G. A. (2022). Discriminatory attitude towards people living with HIV/AIDS and its associated factors among adult population in 15 sub-Saharan African nations. *PLoS One*, *17*(2), e0261978.

Toska, E., Pantelic, M., Meinck, F., Keck, K., Haghighat, R., & Cluver, L. (2017). Sex in the shadow of HIV: A systematic review of prevalence, risk factors, and interventions to reduce sexual risk-taking among HIV-positive adolescents and youth in sub-Saharan Africa. *PloS one*, *12*(6), e0178106.

Tran, B. X., Vu, P. B., Nguyen, L. H., Latkin, S. K., Nguyen, C. T., Phan, H. T. T., & Latkin, C. A. (2016). Drug addiction stigma in relation to methadone maintenance treatment by different service delivery models in Vietnam. *BMC public health*, *16*, 1-9.

Tran, H. V., Filipowicz, T. R., Landrum, K. R., Nong, H. T., Tran, T. T., Pence, B. W., ... & Gaynes, B. N. (2022). Stigma experienced by people living with HIV who are on methadone maintenance treatment and have symptoms of common mental disorders in Hanoi, Vietnam: a qualitative study. *AIDS Research and Therapy*, *19*(1), 63.

Turan, B., Hatcher, A. M., Weiser, S. D., Johnson, M. O., Rice, W. S., & Turan, J. M. (2017). Framing mechanisms linking HIV-related stigma, adherence to treatment, and health outcomes. *American journal of public health*, *107*(6), 863-869.

Turan, J. M., & Nyblade, L. (2013). HIV-related stigma as a barrier to achievement of global PMTCT and maternal health goals: a review of the evidence. *AIDS and Behavior*, *17*, 2528-2539.

UNAIDS . 2022. Danger: UNAIDS Global AIDS Update 2022.https://www.unaids.org/en/resources/documents/2022/in-danger-global-aids-update Available from. Accessed 3 August 2022.

UNAIDS. (2023). UNAIDS Data 2022. In *unaids.org*. Retrieved March 26, 2025, from https://www.unaids.org/en/resources/documents/2023/2022_unaids_data

Van Denrzen, E. (2016). *Skills in existential counselling and psychotherapy*

Vidya Vijayan, K. K., Karthigeyan, K. P., Tripathi, S. P., & Hanna, L. E. (2017). Pathophysiology of CD4+ T-cell depletion in HIV-1 and HIV-2 infections. *Frontiers in immunology*, *8*, 580.

Vorasane, S., Jimba, M., Kikuchi, K., Yasuoka, J., Nanishi, K., Durham, J., & Sychareun, V. (2017). An investigation of stigmatizing attitudes towards people living with HIV/AIDS by doctors and nurses in Vientiane, Lao PDR. *BMC health services research*, *17*, 1-13.

Vreeman, R. C., McCoy, B. M., & Lee, S. (2017). Mental health challenges among adolescents living with HIV. *Journal of the International AIDS Society*, *20*, 21497.

Wariri, O., Ajani, A., Raymond, M. P., Iliya, A., Lukman, O., Okpo, E., & Isaac, E. (2020). "What will my child think of me if he hears I gave him HIV?": a sequential, explanatory, mixed-methods approach on the predictors and experience of caregivers on disclosure of HIV status to infected children in Gombe, Northeast Nigeria. *BMC public health*, *20*, 1-13.

Weinreich, N. K. (2009). A more perfect union: integrating quantitative and qualitative methods in social marketing research. *Social Marketing Quarterly*, *3*(1), 53–58. https://doi.org/10.1177/152450049600300106

Williams, M. E., Zulu, S. S., Stein, D. J., Joska, J. A., & Naudé, P. J. (2020). Signatures of HIV-1 subtype B and C Tat proteins and their effects in the neuropathogenesis of HIV-associated neurocognitive impairments. *Neurobiology of Disease*, *136*, 104701.

Willis, N., Mavhu, W., Wogrin, C., Mutsinze, A., & Kagee, A. (2018). Understanding the experience and manifestation of depression in adolescents living with HIV in Harare, Zimbabwe. *PloS one*, *13*(1), e0190423.

Wong, P. T. (2016). Integrative meaning therapy: From logotherapy to existential positive interventions. *Clinical perspectives on meaning: Positive and existential psychotherapy*, 323-342.

Wood, W., & Aull, M. R. (1991). Women and AIDS: Implications for Occupational Therapist. *Occupational Therapy in Health Care*, *7*(2-4), 151-160.

World Health Organization (WHO). Africa cuts HIV infections, deaths but key targets still elusive [Internet]. WHO | Regional Office for Africa. {2022)]. Available from: https://www.afro.who.int/news/ africa-cuts-hiv-infections-deaths-key-targets-still-elusive

World Health Organization. (2018). mHealth, use of appropriate digital technologies for public health: Report by the Director-General. https://apps.who.int/iris/handle/10665/274134

World Health Organization. (2021). HIV [fact sheet]. https://www.who. int/news-room/fact-sheets/detail/hiv-aids

Yousuf, A., Musa, R., Isa, M. L. M., & Arifin, S. R. M. (2020). Anxiety and depression among women living with HIV: prevalence and correlations. *Clinical practice and epidemiology in mental health: CP & EMH*, *16*, 59.

Zhan, J., Wu, X., Fan, J., Guo, J., Zhou, J., Ren, J., ... & Luo, J. (2017). Regulating anger under stress via cognitive reappraisal and sadness. *Frontiers in psychology*, *8*, 1372.

# APPENDICES

## APPENDIX A

## UNIVERSITY OF EDUCATION, WINNEBA

## FACULTY OF EDUCATIONAL STUDIES

## DEPARTMENT OF COUNSELLING PSYCHOLOGY

## INTERVIEW GUIDE FOR PEOPLE LIVING WITH HIV/AIDS

I am **Bismark Buabeng**, a Master of Philosophy student at the University of Education, Winneba,

Faculty of Educational Studies and Department of Counselling Psychology. I am researching "Exploring Causes, Stigmatization and Coping Strategies among Adolescents Living with HIV/AIDS in the New Juaben Municipality. The study is purely for academic purposes; therefore, the information and identity of respondents will be treated as confidential if respondents' consent is given.

Date: ……

**SECTION A. DEMOGRAPHIC CHARACTERISTICS OF RESPONDENTS**

1. Sex of respondent

a. Male [ ]

b. Female [ ]

2. Age ……

3. Academic status

a. Still in school [ ]

b. Out of school [ ]

c. Never attended school [ ]

4. Highest level of education

a. Primary [ ]

b. Secondary/Technical [ ]

c. Diploma [ ]

d. Degree [ ]

f. None [ ]

**SECTION B. STATUS DISCLOSURE IN SOCIETY**

**5. Please how long have been living with the HIV/AIDS**

6. Please how did you contract HIV/AIDS?

7. Explain the ways through which you contracted HIV/AIDS.

8. What types of stigmatizations do you encounter in your community?

9. which types of stigmatizations do you experience more often in your community?

10. Why do think you are being stigmatized in your community?

11. What psychological challenges do you encounter most often?

12. How do you cope with stigmatization as a result of your HIV/AIDS status?

13. How effective are the coping strategies you adopted?

## APPENDIX B

## INTRODUCTORY LETTER TO RESEARCH SETTING CENTER

UNIVERSITY OF EDUCATION, WINNEBA
FACULTY OF EDUCATIONAL STUDIES
DEPARTMENT OF COUNSELLING PSYCHOLOGY
P O Box 25, Winneba, Ghana psychology@uew.edu.gh
030 298 0904

31st October, 2022.

**TO WHOM IT MAY CONCERN**

Dear Sir/Madam,

**LETTER OF INTRODUCTION**

I write to introduce to you, BISMARK BUABENG, the bearer of this letter who is a student in the Department of Counselling Psychology of the University of Education, Winneba. He is reading Master of Philosophy in Counselling Psychology with index number 202142783.

He is conducting a research on the topic: EXPLORING THE DIMENSIONS OF STIGMATIZATION AND COPING STRATEGIES AMONG ADOLESCENTS LIVING WITH HIV/AIDS IN THE NEW JUABEN MUNICIPALITY. This is in partial fulfillment of the requirements for the award of the above mentioned degree.

He is required to gather information through interview guide to help him on the said research and he has chosen to do so in your outfit.

I will be grateful if he is given permission to carry out this exercise.

Thank you.

Yours faithfully,

**DR. PAUL KOBINA A. BEDU-ADDO**
**AG. HEAD OF DEPARTMENT**