GREAT JOURNS

Journal of Public Health

Vol.1 No.2, October 2024

The Attitude of Adults Living with HIV/AIDS attending Hospitals towards HIV Status Disclosure in Slum Areas Nairobi County, Kenya.

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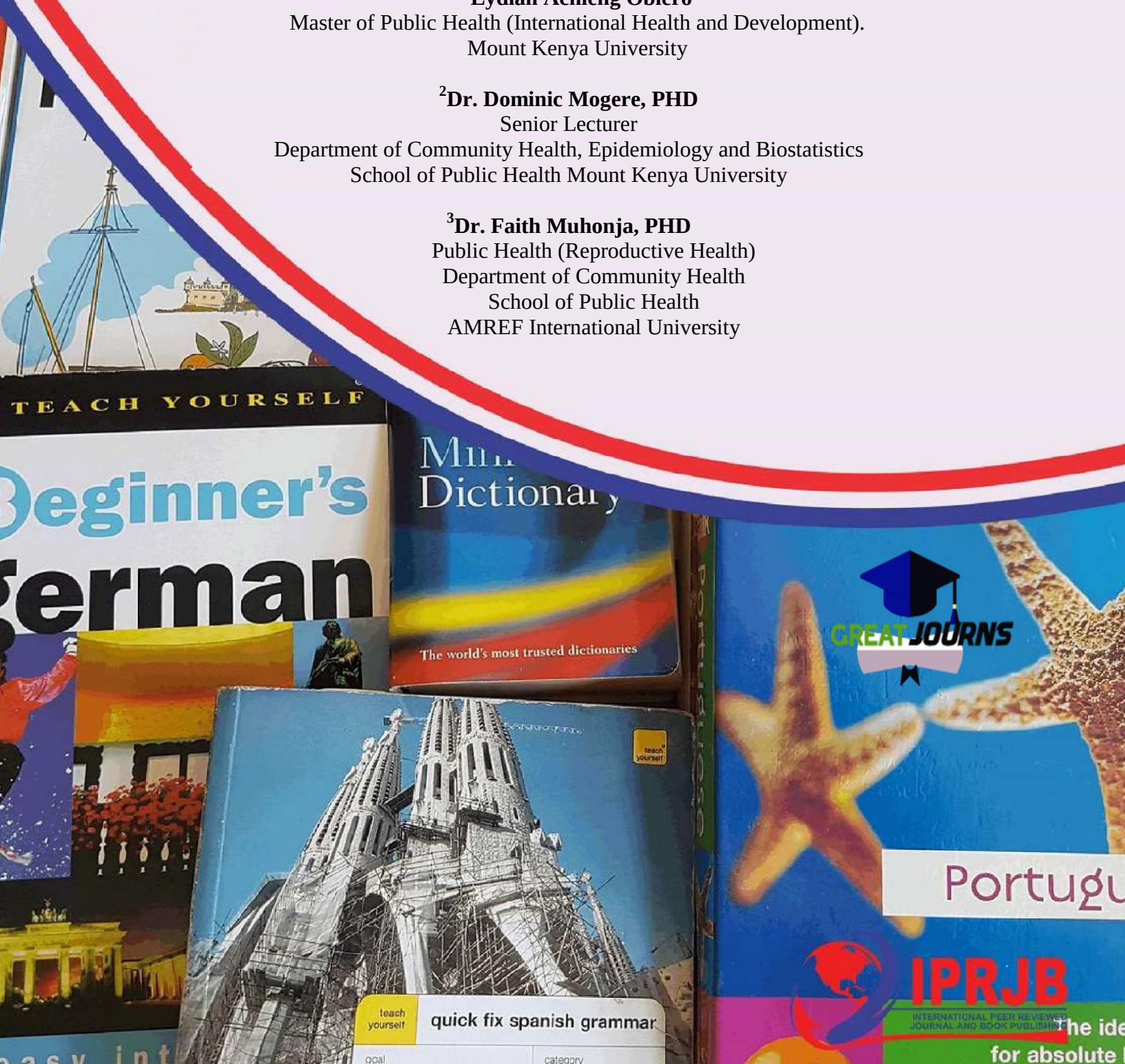

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024

Journal homepage: www.greatjourns.com

ABSTRACT

HIV status disclosure among adults living with HIV/AIDS (ALWHA) is a crucial aspect of managing the disease, yet it remains a sensitive and challenging issue. In slum areas, where social, economic, and healthcare disparities are prominent, the attitudes towards disclosure may be influenced by multiple factors, including fear of stigma, discrimination, and social rejection.The purpose of the study was to investigate the Attitude of Adults Living with HIV/AIDS attending Slum Hospitals towards HIV Status Disclosure in Slum Areas Nairobi County, Kenya. According to a research done on HIV disclosure at Mama Lucy Kibaki Hospital in Nairobi, 54% of adults had done status revelation to loved ones, 46% had not. Hence, the urgent need to conduct the study to assess factors influencing disclosure of HIV status among adults living with HIV /AIDS (ALWHA) attending comprehensive care clinics (CCC) in hospitals in slum areas. Nairobi County, Kenya; with the focus of solving the niche of non-disclosure among Kenyans and slum hospitals in Nairobi in turn containing the spread of HIV virus.Respondents were: ALWHA and CCC healthcare workers in the six level 4 hospitals in Nairobi slums areas namely: Mathare North, Mukuru MMM, Kariobangi North, Kasarani, Dandora II and Makadara H/C. The study population was 10071 ALWHA; Yamane's 1967 sampling formulae of $n = N/1+ N (e)^2$ deriving 400 participants; sampling technique used was simple random sampling method. Reliability and validity was checked by checking the questionnaires for completeness, peer reviews and by getting vast guidance from the university supervisors. Close-ended questionnaires and FGDs were administered to ALWHA whereas KII was given to 24 CCC healthcare workers to gather the research data. Pre-testing of research instruments was done at Korogocho health Centre. The following gave permission to gather data: MKU/ERC, NACOSTI, Nairobi County, sub-county MOH, facility in charges, and respondents signed consent form. Ethical considerations: confidentiality, informed consent, integrity and right to leave the study were upheld. Quantitative data was examined using SPPS version 26; qualitative information evaluated by content and theme. By putting the data into the computer, data cleaning and analysis were completed. Level of significance was assessed at p value 0.05 at 95% CI. The researcher concluded that women were the most affected gender by HIV virus since they accounted for close to 73.35 percent of HIV infection among Nairobi slum areas and they had positive health seeking behaviour than their male counterparts. In addition married couples were also the most affected group among respondents attending CCC in slum areas, due to married couples' 57.5 percent empowerment HIV status disclosure to sexual partners, has improved from 13 to 33.6 percent.Sensitization and health campaign to be done to young adults between 18-24 and known HIV positive who have not commenced ARVs and those who have stopped HIV care, since they are ones leading in HIV infection and in this study they were few yet they are the leading age in HIV infection more so females.

Key Words: ***Attitude, Adults, HIV/AIDS, HIV Status Disclosure***

1.0 INTRODUCTION

Urban slums is defined to as one that has absence of any of the five components that is accessto improved water , can obtain clean water, can obtain appropriate cleanliness , guaranteed safety, durable shelter and adequate residential areas (UN Habitat ,2010) . Other scholars have reframed this definition as lacking two or more of features of UN Habitat list. Hence, all the health

facilities in this study meet all the criterion of slum areas (Zulu et al., 2002; Fotso et al., 2007).In existence, there are more than 100 areas categorized as slums areas, Nairobi city which is the headquarters of Kenya, house 1.5 million slum dwellers (Mitullah, 2003). Slum areas have been in existence within and around, since the origin of the city in 1899 (United Nations Environment Programme 2011).

Attitude on the other hand can be perceived as an acquired tendencies to behave in good or bad manner towards a specific notion, individual or circumstance such as ALWHA
disclosing HIV seropositive results to loved ones. (Fishbein, 1967; Hogg, 2000). Rosenberg further analyses attitude based on three major components: cognitive (knowledge), emotions (affective) and behavioral (Rosenberg, 1960). This objective has been discussed per the following sub- themes:

II: RESEARCH METHODOLOGY

2.1 Introduction

A systematic process that researchers employ to describe and forecast events is known as research methodology (Rajasekar et al., 2013).Target and study population, sample population, designs, location of the study ,research instruments, sampling procedures & techniques, test for validity and reliability, data collection methods and procedures, ,data analysis technique & procedures , ethical considerations, ethical clearance are expounded in this chapter.

2.2 Research Design

The intermittent organization that connects experimental data with the investigative questions to arrive at a conclusion is termed as research design (Yin, 2008). In order to characterize the situation as it is, the study employed a descriptive analytic research approach (Kombo & Tromp, 2006). This inquiry used blended tactics and a pragmatic approach to completely address the research questions, combining qualitative and quantitative techniques to a unified report. 70% quantitative and 30% qualitative research design were both used in this study (Creswell, 2009).

2.3 Location of the study

The capital of Kenya, which is located on the African continent, is Nairobi. In addition to being Kenya's capital, Nairobi is also its most populous town. Nairobi, which got its start in 1899 as the location of the Uganda Railway headquarters, is known as the "Green City in the Sun" because it attracts many visitors of all races looking for employment opportunities. Nairobi has a population of 4,397,073 as per the Kenya population and housing census (Moseley & Otiso, 2022). Nairobi is projected to have a population of 5,541,172, people;the county is home to about 6.5 million people. Nairobi is located on a 696 km^2 piece of land. English and Swahili are the primary languages spoken by Nairobi residents (World Population Review, 2024). Nairobi was listed as having 17 constituencies including Westlands, Mathare, Kibra, Kasarani, Langat, Roysambu, Embakasi: South, Central, East & West, Makadara, Starehe, Dagoretti North, Dagoretti South, Kamukunji and Ruaraka. As a result, the subject of this study was only the health facilities that were specifically chosen in the constituencies of Ruaraka, Makadara, Embakasi North, Kasarani, Embakasi East, and Embakasi West (County Trak Index, 2020).

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024

2.4 Target Population

A thorough assessment of all items in a particular area of interest in a research can be defined as target population (Kothari, 2009). The target population can alternatively be described as being made up of a variety of different components from which the sample population is drawn. All ALWHA in Nairobi County were the target group of this study (Cooper and Schindler, 2014).

2.3.1 Study population

Participants in the research were adults who are HIV-positive and healthcare professionals recruited from six hospitals: Mathare North Health Centre, Mukuru MMM Health Centre, Kariobangi North Health Centre, Kasarani Health Centre, Dandora II Health Centre, and Makadara Health Centre, these health care facilities are located in Nairobi's slums.

2.4 Sampling Procedures and Techniques

Sampling is a means of arraying a set of items for a study to guarantee correctness reflective of the entire group, where items have been obtained.

(Mugenda & Mugenda, 2003). Healthcare facilities on east side (Eastlands) of Nairobi, slum areas were mapped out which met the required inclusion criterion. Seven hospitals were single out using lottery method where folded paper written Yes were picked for the study.

2.5 Sample Population

The population of the six hospitals in the study by end of December 2022 was 10071 patients who are currently active on care and linked to HIV treatment. The population of comprehensive care clinics healthcare workers who were issued KII guides were 24 that is 4 per health centre (Source: Researcher, 2023).

2.5.1 Formula for determining sample size

To arrive at the desired ALWHA sample size, Yamane's Formula was used in this study.
Where:
$n= N/ 1+N (e)^2$
Whereas,
n = required sample size
N = Total population
e^2 = margin error (0.05 or 5%)Source: (Yamane, 1967).

2.5.2 Application of Yamane's sample Formulae
N= 10071
$e^2 = 0.05$
Therefore, $10071/1+10071(0.05)^2=10072/10272*0.0025$

= 400 participants

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024

Journal homepage: www.greatjourns.com

2.5.3 ALWHA sample distribution and sample size determination

Table 1 : ALWHA sample distribution and sample size determination

Health facilities	ALWHA distribution	Sample size
Dandora II	1984	79
Kariobangi North	1330	52
Mukuru MMM	1476	59
Makadara	1754	70
Mathare North	2240	89
Kasarani	1287	51
Totals	10071	N/population*400 =400

Source: Researcher (2023)

2.6 Research Instruments

A data tool should be able to collect enormous information in a reasonable amount of time. (Orodho, 2005). Hence, questionnaires with close ended questions and with instructions were administered to 324 ALWHA and focus discussion group's questions were used to collect data from adults living with HIV/AIDS; the FGDs consisted of 8-10 participants. According to USAID, key informant interviews (KII) are qualitative, detailed inquiry for people chosen for being primarily endowed with immense knowledge in an area of study (USAID, 1996). Hence, this study employed KII to gather information from 24 healthcare providers namely: clinical officers, PMTCT nurses, Counselors and peer educators within the six hospitals where the study was conducted, their prowess and experience in dealing with HIV seropositive adults as well as helping them in the disclosure process of seropositive status to significant others in order to receive psychosocial support and in turn enhancing adherence to ARVs treatment. In addition to attain reliability the research tools used were similar in all the six study sites (Gidron, 2013).

Research instrument administered that is FGDs questions, KII questions and close-ended questionnaires were same to attain similar and consistent results. Likert scale was used in rating statement by the study participants during response. The scale consisted of statements like disagree, strongly disagree, agree and strongly agree. The researcher encountered a number of challenges in the process of administering research instrument: emotional outburst among ALWHA, since the study topic is very sensitive and had psychological impact, eye impairment among two ALWHA who were very willing to participate in filling of questionnaires, hence, the researcher could help in reading aloud questionnaires questions then ALWHA choose his/her response then the researcher would help in ticking the response (Field, 2024).

Another challenge was researcher coming across ALWHA with hearing impairment explaining what the research entailed was so hard, hence, the researcher was forced not to administer any research instrument to the participants. Finding a place where researcher could sit with the respondents and answer ALWHA'S concerns was a challenge in four H/C except Mathare north and Mukuru MMM health facilities in that HIV treatment and care needed great level of confidentiality to avoid accidental disclosure resulting to Stigma (Field, 2024).

Administration of FGDs to ALWHA was a challenge in Makadara ,Mukuru MMM and Mathare North health centers , hence, the researcher only administered questionnaires to ALWHA due to reasons such as finding an organized PSSG (Psychosocial support group) was a challenge or patients not coming on the schedule dates for PSSG that is

ALWHA coming for TCA early or late. For instance, a researcher encountered a scenario where there was FGD for new ALWHA on treatment was scheduled the researcher had planned and informed the persons concerned to be part of it, but, on the day of the PSSG, researcher was not permitted to participate since ALWHA were new on HIV treatment and had not disclosed and involving a third party (researcher) will make ALWHA

uncomfortable (Field, 2024).

2.7 Validity and Reliability

2.7.1 Piloting of research instrument

The pragmatism, reliability, feasibility and the validity of the research instrument was achieved through pre-testing of close-ended questionnaires, FGDs and KII (Charlotte, Emma & Hilton, 2017). Pilot studies are very essential in that many kind of these studies make it possible to get feedback from the research respondents and other people that leads to crucial improvements in the main study. Therefore five ALWHA from the Korogocho health centre were administered close- ended questionnaires & FGDs questions prior to the study, and five healthcare workers were administered KII questions to check fr ambiguous questions in order to rephrase questions for easy understanding and accurate responses to questions (Borg &Gall, 1979).

2.7.2 Validity

A research tool's validity refers to how well it assesses what is tailored to evaluate. Again, Gay makes the claim that a researcher can adopt the position of an expert and decide whether the instrument is appropriate for his or her study, necessitating the need for a pilot study to enhance study outcomes (Gay, 1976). Other studies on the subject put forward that views, literature searches, and pre-testing of FGDs, KII questions and closed-ended questionnaires, can increase the validity of a research instrument. To strengthen the validity of the research tools peer reviews and advice from university supervisors were used by the study conductor. For validation of language to remove further ambiguities the researcher gave the research instruments to a linguist who is an English Literature teacher at Rusinga Girls Secondary school who screened the research tools pinpointed grammatical mistakes, ambiguous statements and recommendations on how to correct the gaps, which the researcher implemented accordingly to improve efficacy of research instruments of the data acquired from each study site. To guarantee the correctness of the data collected at each study site, research instrument responses were provided while the researcher was there (Wilkinson, 1991).

2.7.3 Reliability

The rate to which study findings produces corresponding outcomes or data over several attempts is known as reliability. Study subjects were questioned alike by researcher during interviews, FGDs & questionnaires to ensure dependability. The investigator collected the data, took notes on the focus group discussion questions and key informant interview responses, and verify for responses completeness (Allan, 2013).

Constant comparison of the information acquired from the six chosen healthcare facilities ensured reliability, as well extensive use of tables in research. The researcher was able to get comparable results in all of the study health facilities by comparing the data gathered from the six health facilities (Eliane, 2015).

2.8 Data Collection Methods and Procedures

Gathering of information intermittently for research purposes is known as data collection (Kothari, 2004). By giving the study participants questionnaires, focus group discussion prompts, and interviews, the data was gathered. Further, the respondents were given instructions on the questionnaires on how to fill in, before the questionnaires are admitted for data collection for instance, on this questionnaire kindly write not your name and research respondents signed consent form before taking part in the research, after being enlighten what the research entailed.

2.9 Data Analysis Techniques and Procedures

Intermittently was data analyzed per the four research questions or objectives. Main themes and subtopics captured from qualitative and quantitative data was analyzed in accordance with the research aims.

2.9.1 Statistical Package for Social Sciences

Tables, bar graphs, and pie charts, were produced after data was loaded into a computer and analyzed using SPSS version 26 which made it easier to compare and contrast the information obtained from research instruments distributed to the six study health facilities. Percentages and frequency examples of descriptive statistics were applied for quantitative data. Using inferential statistics, such as chi-square hypothesis was tested at a level of significance p value 0.05 & 95% confidence interval and logistic regression to assess the association between independent and dependent variables.

2.9.2 Thematic analysis

Refers to the procedure of finding similar patterns, or topics within qualitative data relevant to the study objectives (Clarke & Braun, 2006). Thematic analysis for qualitative data helps in sorting and segregating crucial data for study aim and research questions. Therefore, the researcher analyzed and determined themes, sub-topics or ideas that appear more frequently in the data garnered from the field. The variables in conceptual framework for easy interpretation of qualitative data collected were further divided into sub-themes (Bala, 2019).

2.9.3 Content analysis

Content analysis refers to any method of drawing inferences by intermittently and objectively recognizing outstanding features of text. Qualitative data collected from
research instruments such as FGD, close ended questionnaires and key informant interviews was condensed into manageable headings, sub-headings to allow easy comparison of qualitative and quantitative data (Holti, 1968).

2.10 Ethical Considerations

Undisputable measure and parcel of the study planning and consolidation process, standard code of conduct and the defined societal norm of behavior are paramount elements as the research is being conducted are ethical considerations (Gakuu,2018).This study also was grounded on certain ethical principles. In research maintaining the highest level on integrity in handling data collection and analysis is of prime importance (Welma & Kruger, 2001).

The respondents to the questionnaires, FGDs and KII questions were assured of utmost confidentiality about any personal details disclosed in the FGDs, questionnaires or interviews. Respondents were given right of informed consent, right to seek clarity regarding research and freedom to leave at any juncture of the study. Author whose work was used in this research was properly cited in order to prevent plagiarism issues.

2.11 Ethical Clearance

Researcher was given an introduction letter by MKU Directorate of Graduate Studies to present to the NACOSTI in addition the researcher acquired authorization from MKU ERC referenced MKU/ISERC/3057.The researcher further was bestowed a letter of approval by NACOSTI – NACOSTI /P /23/29595 and the researcher attained authorization from Nairobi County – NCCG/HWN/REC/436 to collect data.

The researcher further presented approval to collect data given by Nairobi County to the sub-county medical officers of health who gave their approval on data collection and gave permission to proceed and inform the health facility in charges of motive to collect data in the hospitals they headed and facility in charges introduced the researcher to CCC in charges and the healthcare providers who were among the study respondents; before commencing research, in order to get accurate responses, the researcher thoroughly briefed the ALWHA and CCC healthcare personnel on the study's specifics.

Letter of authorization to collect data from University of Nairobi /Fahari ya Jamii offices was not necessary, since permission from Nairobi County was adequate. .For health centers such as Mukuru MMM, the researcher needed other documents such as to sign a Safe- guarding Policies & Code of Conduct and Student/Interns Personal Accident Cover as a paramount requirements prior to be permitted to collect data.

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024

Journal homepage: www.greatjourns.com

IIII: RESULTS

3.1 Attitude of adults living with HIV/AIDS attending slum hospitals towards Disclosure

This section handles the attitude of the slum areas towards the disclosure of their HIV status.

Table 1: Knowledge of ALWHA in slum hospitals on HIV/AIDS

Question	Strongly Agree Frequency (%)	Agree Frequency (%)	Disagree Frequency (%)	Strongly Disagree Frequency (%)
I feel it is important for one to be tested for HIV	262 (81.6)	55 (17.1)	1 (0.3)	3 (0.9)
My loved ones have business in knowing my HIV status	208 (64.8)	83 (25.9)	17 (5.3)	13 (4)
I feel is necessary to tell my sexual partner my HIV status or use condoms or encourage them to take Prep to protect them	221 (68.8)	88 (27.4)	3 (0.9)	9 (2.8)

Source: (Field, 2024)

Table 4 shows that, 1.2 percent (4) of the total respondents feel it is not necessary for one to be tested for HIV. The majority of the total respondents 98.7 percent (317) feel it is important for one to be tested for HIV. In addition, majority of the respondents 96.2 percent (309) feel it is vital to tell their partner their HIV status and protect them using PREP and condom, and 3.7 percent (12) of the total respondent feel it is not necessary to their partners of their HIV status and to protect them using condom or PREP (Field, 2024). Statistically there was no significant association between being tested for HIV and disclosure(X^2 = df 3 critical value 5.883 p value 0.117) .There was significant association between ALWHA knowing it is business of their loved ones to know their HIV status (X^2 = df 3 critical value 13.586 p 0.004). There was statistical relationship between ALWHA finding it necessary to disclose to sexual partner, use condoms or encourage them to use PREPs and disclosure, since p value is less than 0.05 (X^2 = df 3 critical value =10.681 p =0. 014).

The average percentage of responses from the three questions is 95.2 percent the research on HIV knowledge amongst the respondents was considerably high average rate for the three questions 95.2 percent. The FGD provided evidence of the participants' understanding of the various ways in which HIV can spread, including through breastfeeding and childbirth,

unprotected sex with an infected individual, sharing sharp objects like syringes, razorblades, and barber machines, coming into contact with blood from wound to wound, sharing a deep kiss when both partners have sore lips, accidents, poor adherence to ARVs among HIV positive breastfeeding mothers, and blood transfusions. Additionally, to protect sexual partners they showed that they understood how crucial it was to confess their HIV positive condition. (Field, 2024).

According to findings from table 4 average 95.2 percent of the total ALWHA and from FGD were endowed with adequate and right knowledge regarding HIV/AIDS. In addition, the figure 10 on disclosure status 92.52 percent of ALWHA had disclosed to their loved ones against 7.48 percent who had not disclosed to anyone, this high disclosure status depicts high knowledge level on the importance of disclosure as an essential arsenal in HIV/AIDS management (Field,2024).These findings further concurs with Murwira perspective that states that due to absence of vaccination for HIV/AIDS correct and adequate knowledge of HIV/AIDS in terms of available therapy , mode of transmission and its overall management such as disclosure was paramount for its effective control (Murwira., et al,2021).

In addition, the knowledge level of total respondents 95.2 percent, surpassed the knowledge level threshold of 60 percent mentioned by Wairimu; which means the respondents understanding of HIV/AIDS was 35.2 percent more than the expected (Wairimu, 2014). Furthermore, these findings from table 4 and FGD about knowledge of HIV/AIDS among slum dwellers that they disclosed to protect sexual partner from getting HIV virus, supports BMC perspective that purports that if partners are aware of each other HIV status through disclosure this will encourage knowledge of HIV status through testing and if it's a case of discordant couples the HIV negative partner can be protected through use of PEP, condoms and PREPS. These findings depict that slum dwellers are enormously aware of benefits of disclosure such as combating the transmission of HIV virus to a loved one (BMC, 2014).

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024

Journal homepage: www.greatjourns.com

Table *2*: Behavioral risk factors for ALWHA in slum hospitals

Question	Strongly Agree Frequency (%)	Agree Frequency (%)	Disagree Frequency (%)	Strongly Disgree Frequency (%)
I find it so hard to convince my partner to visit a hospital or accompany me to the health facility	73 (22.8)	42 (13.1)	22 (6.9)	183 (57.2)
I have several partners and they do not know my HIV status	44 (13.8)	25 (7.8)	18 (5.6)	233 (72.8)

Source: (Field, 2024)

As indicated in table 5, 35.9 percent (115) of the total ALWHA admitted they had challenge in persuading their partners to accompany them to health facility. On the contrary 64.1(205) percent dismissed having hard time in convincing partner to go with them to the health facility. (X^2 = df 3 critical value 6.431 p value 0.92 is greater than 0.05, hence no statistical relationship between convincing partner to visit a hospital or accompany to the health facility and disclosure. In addition, 21.6 percent (69) concurred that their HIV seropositive status was unconfessed to their several intimate partners, this further shows that these respondent were unfaithful hence, sticking to a single sexual partner is likely to be impossible. Whereas, 78.4 percent (251) refuted having several partners and not disclosing. In addition, these respondent could maintain fidelity in their sexual relationship, therefore not dreading disclosure (Field, 2024). There was statistical significant between having several partners and disclosure, since p is less than 0.05 (X^2 = df 3 critical value 11.351 p 0.010).

The findings from table 5 depicted that 64.1 of the total respondents faced difficulty when they tried to convince their partner to go with them to the hospital when going for clinic appointment and only 35.9 percent had ease of being accompanied for clinic appointment .In addition, from these findings going to clinic regularly for checkups even when not sick seems to be a taboo among majority of slums respondents based on these findings, hence even going for HIV test may be a huge load to carry. This finding matches, other studies that slum areas had poor health seeking behaviors resulting to low usage of health facility leading to high mortality and loved ones contracting HIV virus due to non-disclosure (Zhen et al., 2016).

The research shows that 78.4 percent of ALWHA were faithful to their sexual partner and they had disclosed protected them from HIV virus. The research also indicated that 21.6 percent of ALWHA had the propensity of HIV status masked from their many partners, which means as much the fight against HIV/AIDS is vigorous, reducing the rates of new infection becomes a difficult task, since sexual partners would not know what risk they are in to use preventive

Great Journs
ISSN: 2328-4870
Vol.1 No.2, October, 2024
Journal homepage: www.greatjourns.com

measures available. Furthermore, according to figure 10 about age at first sexual encounter denotes that more than half of ALWHA slum dwellers 62.9 percent engage in sexual activity between the ages of 10-19 this early engagement in sexual may be due to early exposure social media and pornographic materials ,peer pressure idolizing involvement in sex early as sign of victory or qualification to fit in the group , (Field, 2024).These findings echoes quite a number of scholars who posited slum areas respondents to, have large number of intimate partners and starting sexual activity at a very tender age making negotiation for condom use unlikely (Mo & Coulson,2010).

Additionally, respondents engage in risky sexual behaviors to survive in that they engage in sex at tender age, hence negotiating for condom use not to talk of HIV status disclosure with the partner is unlikely and the popular education among them is primary level meaning they cannot procure a good job 35.6 percent were either hustling or unemployed making them more prone to, engaging in sexual activity to get income to cater for basic needs. (Mbirimtengerenji, 2007; Greif et al., 2011; Zulu et al., 2003). Since, the slum areas respondents were knowledgeable about benefits of disclosure hence, they had positive attitude towards disclosure. P= 0.086, p= 0.016, p= 0.773, p= 0.007 & p= 0.47, logistic regression for question 1-5. Only variables 2&4 significantly add to predicting the attitude of adults living HIV/AIDS in slum hospitals and HIV status disclosure. The model explained R^2 18.5 percent of the variance of HIV status disclosure and correctly classified 92.2 cases. (X^2 (6) =14.6 P 0.182 > 0.05) is bigger than 0.05; therefore no statistical relationship between attitude of ALWHA attending slum hospitals and disclosure.

IV SUMMARY

4.1 Attitude of adults living with HIV/AIDS attending slum hospitals towards disclosure

95.2 percent of respondents were knowledgeable about HIV/AIDS in terms of mode transmission, prevention and management such as taking ARVs and disclosing to make adherence to medications smooth, hence they had little challenge in disclosing. Knowledge level of HIV/AIDS had increased from 60 percent to 95.2 percent (Wairimu, 2014).

Even though 92.52 disclosure rates have been achieved, certain behavioural factors still made respondents attending CCC in slum areas at risk of new HIV infection, 62.9 percent of respondents admitted their commenced their sexual behaviours between 10- 19 years, 35.6 percent admitted to have difficulties in convincing sexual partner to accompany then to hospital and 21.6 percent had several partners whom they had not disclosed, these behaviours Still make slum dwellers at risk of new HIV infections, translating to high prevalence rates of HIV virus in Nairobi county. Positive attitude towards unveiling HIV positive status to loved ones was depicted among the respondents from slum areas hospitals.

V: CONCLUSION AND RECOMMENDATIONS

5.1 Conclusion

The researcher concluded that women were the most affected gender by HIV virus since they accounted for close to 73.35 percent of HIV infection among Nairobi slum areas and they had

positive health seeking behaviour than their male counterparts. In addition married couples were also the most affected group among respondents attending CCC in slum areas, due to married couples' 57.5 percent empowerment HIV status disclosure to sexual partners, has improved from 13 to 33.6 percent.

5.2 Recommendations for practice

Sensitization and health campaign to be done to young adults between 18-24 and known HIV positive who have not commenced ARVs and those who have stopped HIV care, since they are ones leading in HIV infection and in this study they were few yet they are the leading age in HIV infection more so females.

Encourage consistent and correct condom use among sexually active individuals through education and provision of free or subsidized condoms at healthcare facilities. Ensure that pregnant women living with HIV are provided with appropriate counseling, treatment, and support to prevent transmission during pregnancy, childbirth, and breastfeeding.Address misconceptions about HIV transmission, such as the mistaken belief that HIV is transmitted through casual contact, which can lead to risky sexual behaviors.

Offer counseling services that address mental health issues, including depression, anxiety, and substance abuse, which can increase risky behaviors such as inconsistent condom use, multiple sexual partners, and substance use. Support groups for adults living with HIV can help to reduce the psychological burden and stigma of living with the condition. These groups can provide a space for individuals to share experiences, offer emotional support, and discuss coping strategies.

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