

Lived experiences of adolescents living with human immunodeficiency virus in Namibia

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ABSTRACT

Adolescents living with human immunodeficiency virus (HIV) experience stigma, ill-treatment, and many other challenges due to their health condition. Their experience with HIV is highly overlooked, yet, it shapes their decisions and influences their health outcomes. The objective of this study was to explore and describe the lived experiences of adolescents living with HIV in the Namibian context. We conducted a qualitative study of adolescents (aged 10-19 years) at five different anti-retroviral treatment (ART) clinics in Rundu district, Kavango region Namibia. We used purposive sampling and collected data through in-depth interviews with 21 adolescents from October 2020 to December 2020. We analyzed the data with content analysis. The mean age of participants was 16 years, and the age ranged between 12-19 years. Most participants (62%) have never been in a relationship or engaged in sexual activities. All the participants were in school at the time of the study. The content analysis yielded five broad categories: i) experience with HIV care and treatment, ii) finding out about HIV Status, iii) the interplay between HIV and social relationships, iv) the need for information on HIV and the treatment, v) multiple fears, worries, and means to cope. Adolescents living with HIV (ALWH) experience many challenges due to their health condition. Learning about their HIV status is one of the most challenging experiences. There is a need for continued HIV care and support for adolescents living with HIV, which is adolescent-friendly and focused.

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1. INTRODUCTION

The Joint United Nations Program on human immunodeficiency virus HIV/AIDS (UNAIDS) estimated that about 38.4 million people live with HIV globally, and about 54% of these people live in Eastern and Southern Africa. HIV infections in Sub-Saharan Africa (SSA) remain high, with 1.5 million people infected with HIV in the year 2020 alone. Adolescents account for 25% of these new infections. Namibia is one of the countries in SSA hard hit by the HIV pandemic, with 210,000 people living with HIV and a prevalence rate of 11.6% [1]. HIV infection among adolescents in Namibia seems to increase, adding to the emerging survivors of the HIV epidemic since the onset of Antiretroviral treatment. The viral load suppression rates among the adolescent population in Namibia are currently standing at 80% below the national target of 95% [2]. Additionally, the mortality rate among adolescents living with HIV is higher at 31% compared to that of adults and children [3]. Adolescents living with HIV represent a vulnerable population among people living with HIV, in whom a distinctly lower level of adherence to anti-retroviral treatment (ART) treatment is noted. Studies done elsewhere in Africa have reported challenges faced by

adolescents ranging from stigma, poor adherence to treatment; lack of knowledge on HIV; challenges understanding ART treatment; poor disease management skills; challenges with disclosure, and psycho-social issues, among others [4]–[6]. Conversely, in SSA, adolescents living with HIV have suboptimal adherence to antiretroviral therapy (ART) with consequent lower viral load suppression rates and higher mortality risk than other populations [7]. The HIV care for adolescents living with HIV in this part of the world lacks effectiveness, as evidenced by increased mortality rates and poor health outcomes.

Adolescents living with HIV experience stigma due to their diagnosis. HIV-associated stigma and secrecy emotionally burden adolescents and push them into isolation [8], [9]. Experiences of an individual with the phenomenon are said to shape their thought process and behaviors. Various experiences of adolescent living with HIV has been documented in other places. However, it has mainly focused on either older or vertically infected adolescents. There is not much evidence of the experiences of adolescents living with HIV in all phases of adolescence. HIV services rendered to adolescents need to meet their specific needs and expectations; hence their voices need to be heard. This study explores and describes lived experiences of adolescents (aged 10-19 years) living with HIV in Namibia, regardless of how they acquired the virus.

2. RESEARCH METHOD

2.1. Study setting and participants

This study was a qualitative descriptive design using individual in-depth interviews. The study population was adolescents living with HIV (N=428) and receiving ART treatment at five Rundu district, Namibia clinics. Rundu district is in Kavango East region, in the country's northeastern part. The region borders Angola on the north and Botswana on the south and southeastern side. Although the region boasts agriculture, agroforestry, and tourism as the main economic activities, it is considered one of the poorest regions in the country. The selected clinics were Rundu, Nkarapamwe, Sauyemwa, Ndama, and Kaisosi ART clinics. They are urban and peri-urban ART clinics that serve adolescents living with HIV. The region has adopted the integration of the health services model; however, ART services at these five facilities still need to be fully integrated. These facilities' direct ART service providers include physicians, pharmacists, pharmacist assistants, nurse-initiated management of ART (NIMART) nurses (enrolled and registered), health assistants, and data clerks. They see adolescents monthly or every two months and offer all due services (consultation, laboratory monitoring, and dispensing) in one visit.

The researchers used the purposive sampling method based on their characteristics to provide broader information and experience about the phenomenon under investigation [10]. The criteria of “information redundancy” guided the sample size. The sample size for the current study was 21 participants who met the inclusion criteria, namely: adolescents living with HIV aged 10-19 years, on ART and receiving treatment at one of the five facilities under study; adolescents whose HIV status is disclosed to them; available and willing to participate; able to communicate in English. We excluded adolescents who were too ill or unable to participate meaningfully due to cognitive or physical challenges.

2.2. Study procedures

The researchers obtained ethical clearance, and the pilot study commenced at the end of September 2020 using an interview guide. We conducted two pilot interviews with two adolescents from Nkarapamwe clinic, and the results were not included in the final data analysis. The pilot aimed to evaluate the clarity and comprehensibility of the interview questions. The main data collection was done between October 2020 and December 2020. Although it was an individual interview, participants were informed that they could bring a trusted adult to be with them during the interview. The ART nurses were the gatekeepers and informed the adolescents and their parents/legal guardians about the study during regular consultations. Those willing to participate were referred to the researcher, who explained the purpose of the study.

Participants aged 18 years and above were offered participant information sheets and consent to sign. Parents or legal guardians of adolescents under 18 years were either approached in person (if they accompanied the adolescent) or were contacted telephonically, and the study purpose was explained. Adolescents under 18 years old who came to the clinic alone and wished to participate were given assent before participation. They were also given a legal guardian/parent information sheet and consent form to take home to their parent/legal guardian. The researcher also asked for the adolescent's permission to contact their parent or legal guardian, given that the parent/legal guardian was aware of their HIV status. Again, assent was obtained from adolescents under the age of 18 years before participating.

The researcher conducted in-depth interviews using an interview guide in the clinic board/rooms. The interviews were conducted in English, and the local language (Rukwangali) was used to clarify some points. The information elicited during the interview focused on the experience of adolescents living with HIV and various aspects of their lives concerning the diagnosis of HIV. Interviews began with an unstructured question that evolved as the phenomenon deepened, such as; i) ‘can you share with me your

experience, being an adolescent living with HIV'? ii) 'can you tell me how it feels like being on HIV treatment at this clinic? The interviews were tape-recorded using a recorder with the participant's permission and took field notes. We interviewed each participant once, and the interviews lasted between 30 to 60 minutes. Older adolescents had a more extended interview duration compared to younger adolescents. The difference could be attributed to older adolescents' more developed cognitive ability than younger adolescents. Data were collected until no new information was emerging, and recruitment was discontinued by the 21st interview when data saturation was achieved.

2.3. Data analysis

Content analysis was used to analyse the data following the framework of preparation, organization, and presentation, as suggested in the inductive content analysis [10]. Analysis of the interview data began during data collection. First, the data was transcribed verbatim; then, the researcher began organizing and sorting the data. The researcher then moved to get an overview of the data by reading the full text and reviewing the scripts of all the data sources. Next, two researchers coded the data to eliminate the risk of bias. Next, we identified patterns and grouped them into meaning units. Significant statements, phrases, and paragraphs shared the same meaning were clustered and labelled with a term. They were then synthesized further into subcategories and categories. Four strategies were used to ensure the trustworthiness of the data, namely: credibility; this was ensured through prolonged engagement, where the researcher spent about six months in the field, preparing the field and collecting data. Member checking was also employed by sharing data with the participants it was solicited from to determine accuracy. Transferability was ensured by providing rich and detailed accounts related to the context, sampling, participants, and data collection process. We ensured dependability by keeping a dependability audit trail. This provided a detailed chronology of research activities and processes that influenced the data collection, analysis, and emerging categories. Finally, conformability was ensured through inductive reasoning, flexibility, and re-evaluation of self-bias and minimizing their influence on the research process.

2.4. Ethical consideration

The Human Research and Ethics Committee of the University of Witwatersrand approved the study. The permission was granted by the Ministry of Health and Social Services, the Directorate of Health in Kavango East region, the Primary health care District office for Rundu district and the ART clinics. The study conformed to the principles of the Helsinki Declaration. Before data collection, the participants and the parents or legal guardians obtained written consent and assent.

3. RESULTS AND DISCUSSION

3.1. Results

3.1.1. Characteristics of participants

We conducted 21 interviews with adolescents living with HIV at five selected ART clinics. Participants ranged from 12 to 19 years, with a mean age of 16. Twelve (n=12) participants (57%) were male, and nine (43%) were females. Only 29% (n=6) of the participants lived with both parents at the time of the interview. The majority (79%) lived with one parent or other relatives. Eight (38%) participants have been on ART treatment for less than five years, and 13 (62%) have been on ART for more than five years. All the participants were enrolled in school at the time of the study. Three (14%) participants indicated that they have been in a romantic relationship and are sexually active, and five (24%) have only been in a relationship. However, they have never engaged in sexual activities, and 13 (62%) have never been in a relationship or engaged in sexual activities.

3.1.2. Study themes

We grouped the findings grouped into five main categories: i) experience with HIV care and treatment, ii) finding out about HIV Status, iii) the interplay between HIV and social relationships, iv) need for Information on HIV and the treatment, v) multiple fears, worries, and means to cope.

3.1.3. Experience with HIV care and treatment

– Clinic service

Participants identified attending the clinic as a central feature of their experience. They reported attending the clinic from a very young age and could not remember how they started coming.

"I cannot remember when I started coming to the clinic. I was two years old when I started HIV treatment." (RUT, 15-year-old female)

Participants expressed satisfaction with the service they received at the clinic. They described it as excellent and timely. However, adolescents at one of the clinics expressed that nurses do not always prioritize

the adolescents to be seen earlier than adults. They further reported the clinic to be overcrowded, and they had to wait in long queues to be seen by the service provider.

“The service at the clinic is fine. But sometimes the waiting time is too long because of long queues.” (RUU, 18-year-old male)

– *Clinic attendance and interaction with healthcare workers*

Participants expressed feeling shame and were uncomfortable attending the clinic.

“I am ashamed to come here because I could meet with people that know me, and they will know I have HIV.” (RUV, 15 years-old male)

The attitude of the staff could be an obstacle to a meaningful relationship between the service providers and the adolescents. Therefore, participants narrated the staff attitude both positively and negatively.

“I am free to talk to specific people at the clinic, like Mr X who leads our teen club.” (RUU 18-years-old male)

“The nurse took my blood that day. He did not say much to me apart from if there is a problem with my medicine.” (SX, 14-year-old male)

– *Taking the medicine*

Participants reported not having side effects or problems with their medication. These medications are essential to prolong life and give them hope to live everyday life and hope for the future.

“I feel better because I will drink medicine to help me keep the virus down and get cured so that I do not die soon. My medicine does not give me anything bad.” (RUT, 15 years old female)

On the other hand, participants felt that the treatment schedules for HIV are somehow rigid and need a certain degree of flexibility.

“When I look at my siblings, I mean they are all fine they can go to play or without worrying about tablets or to think that I might miss my pills.” (RUV, 15 years-old male)

3.1.4. Finding out about the HIV status

– *The emotional effect of living with HIV*

Some participants were diagnosed with HIV while they were still young. They expressed several negative emotions upon finding out about their HIV status. These emotions ranged from shock, anger, disappointment, denial/disbelief, and numbness. Some participants even contemplated suicide.

“When they told me that day, I was shocked. I was feeling bad, I wanted to commit suicide and then I received counselling.” (NX, 17-years-old male)

“I thought I was the only one in the family that had it and I thought like my whole world was crashing down so I went a little bit mad. I wanted to end my life.” (RUW, 18-year-old female)

3.1.5. The interplay between HIV and social relationships

– *Peer and family dynamics*

Respondents in the current study said they have lost one or both parents and consequently are living with relatives or other family members. Losing a biological parent was a shared experience that emerged. Nonetheless, they reported feeling supported and having a good relationship with the people they are living with at home:

“My mother passed away when I was one-year-old. I have not seen my mother. I live with my aunt, and my relationship with her is fine. My aunt treats me like her daughter.” (NV, 15-year-old female)

Some adolescents mentioned that other family members they live with were aware of their HIV status but preferred otherwise.

“They know about my HIV; I think my aunt told them. I feel bad that they know my status. I prefer they did not know.” (NKY, 12-year-old male)

Participants cited that in their households, they do not discuss anything related to HIV. To a certain extent, their relationships with the people they live with are marked with secrecy.

"I noticed, we do not discuss anything related to HIV in our house, I do not know why." (NV, 18-year-old female)

Some participants reported having a good relationship with their friends even after sharing information on their illnesses.

"My friends know that I have HIV and they encourage me sometimes. This make me feel ok when they encourage me, I think to myself if I drink maybe everything will truly become possible." (SV 19-year-old male)

Contrary, some have mentioned not having friends and preferring to avoid friendship, although they could not explain the reasons for their preference.

"I do not have a friend. I just have my brother whom I live with, and I talk to. I used to stay home always because I do not like friends. I do not want friends." (VK, 16-year-old male)

"I do not have friends. I do not want friends." (RY, 13-year-old female)

– *The decision not to tell*

Participants were concerned about disclosing their status to a friend or sexual partner for fear of the consequences of such disclosure. They emphasized not trusting them enough to warranty revealing their secret. Some avoid engaging with people who are hostile toward HIV.

"I do not really like talking about that or even being with people that are so negative about HIV and AIDS. I know even if I tell them, they will go and spread it and I will have low self-esteem." (RUW 18-year-old female)

"I did not tell my girlfriend about my status because I do not know how she will take it. I am afraid maybe she will dump me." (SV, 18-year-old male)

Participants felt different from their peers who do not have to take treatment like them. They strongly emphasized the issue of trust and mistrust. It is difficult for them to identify themselves with their peers they refer to as 'different'. They anticipate that they could be teased or hated.

"I do not trust a friend because they are different. When I tell him or her, and he will tell other friends. I may end up leaving the school and just staying home." (RUU, 18-year-old male)

"It is not good to tell a boyfriend about it. He will end up hating you, telling the friends, and breaking up with you". (RUT, 15-year-old female)

Other participants also expressed feeling shame. They are not 'free' and are ashamed of the fact that they are living with HIV.

"I do not tell my friends or people about it because it is kind of shameful, I hid it and I keep it like a secret of mine." (NY 18-year-old male)

Some participants also reported receiving instructions from their parents not to share information on their HIV status with anyone, including other family members and friends.

"Because my mother said I must not tell my friends or anyone. She does not like me to discuss about my medicine with other people in our house around." (RUS, 14-year-old female)

– *Decision to Tell*

However, some participants feel differently about sharing information about their illness with a sexual partner and assuming that in a sexual relationship or marriage, there should be a certain level of trust that qualify transparency and honesty.

"I can only tell someone if I start dating or if I marry." (RUU, 18-year-old male)

“First, I observe if the person is trustworthy, most of the time, I do not tell just anybody my status most especially boyfriend.” (RUW, 18-year-old, female)

3.1.6. Need for information on HIV and the treatment

– Understanding HIV

Participants' worries were around realizing the dreams of finding a life partner, getting married, and having a family. They are questioning if they will be able to study, have a career or get a job.

*“I want to know how I can live with HIV and date and get married (RUU 18-years-old male)
How it is transmitted and how I can avoid transmitting it to other people during sexual intercourse.” (RY, 15-year-old female)*

– Living healthy

They also want to know how to manage the signs and symptoms and live a healthy lifestyle. Finally, they expressed their need for encouragement to believe all these are possible despite their situation.

“I want to know how the virus can kill the people. If someone can finish school and work even if they have HIV.” (NKY, 12-year-old male)

“How people that are infected are going to take care of the symptoms, how they will take care of themselves?” (RUS, 14-year-old female)

– Understanding the treatment

Some adolescents have expressed their desire to know how ART treatment works so that they can better understand their medicine.

“I want the adolescent to know how ART work and what happens in the body when you drink or do not drink ART.” (NX, 17-year-old male)

They strongly feel they need a platform to discuss topics related to their condition and treatment with their peers who are living with HIV as well.

“I think we need to find a day with people at the clinic and other adolescents who are living with HIV so that they can teach us about how to live better with HIV. How we can take care of ourselves and prevent getting sick.” (NY 18-year-old male)

3.1.7. Multiple fears, worries, and means to cope

– Being afraid

Adolescents believe they will not live long and are afraid of dying. They reported feeling anxious about dying. However, they believe there is a future for them that could alleviate such feelings. Some adolescents have spoken about the deaths of significant people like a parent, siblings, or friends. Expressing that such an event reminds them of their own death frightens them. They also mentioned feeling sad and lonely because of the death of a loved one. It is not clear if these significant people were living with HIV before they passed on or not.

“The death of my father left me feeling sad and lonely, we were close with him. Sometimes it makes me think of my own death. When I think of dying, I get scared.” (RUT, 15-year-old female)

“I know a friend that was taking medicine, but she died. I am scared of one day the medicine I am taking to fail, and I die.” (RUS, 14-year-old female)

– Constant worrying

Some participants expressed constant worries. Stating that they are worried about the future and their ability to excel in school is important because they feel that their family members look up to them to provide for them as they grow old or retire.

“Because sometimes I stress a lot about my viral load and imagining how I will be in the future, maybe if I do not finish school who will take care of my family someday?” (RUV, 15 years old male)

Additionally, others communicated feeling bad and angry about their condition and highlighted that they take it one day at a time, and some days are better than others. They question their situation, why it has to happen, and so on. Others think that perhaps they are being punished or they are just bad luck.

“Sometimes I feel bad, voices come to me saying why me? Why am I hated? Why does it have to happen to me? Why am I so bad luck? I was very angry. Honestly if my children were not here, I seriously do not know where I would be by now.” (XK, 18 years old female)

There is a desire to be utterly free from HIV. One participant expressed the longing for ‘freedom’: wanting to be free from HIV and the treatment. It appears they are not free to do what they want, or their freedom is limited. They also cited wanting to be like a ‘normal person’. Being ‘normal’ in the context of not having a disease

“I want to know about how HIV and when will it be completely out of my body. When will I be cured? When will HIV be out of me so that I can be free? I also want to feel like a normal person.” (KY, 16 years old male)

– *Help and support from home, clinic and peers*

Participants placed a major emphasis on suggestions that could help them cope better or can help them cope with their condition. They have highlighted the need for support from their family members, the clinic staff, and from their peers.

“Sometimes I feel that my parents do not care about me that they just send me to the clinic alone without support. I do not feel free coming here alone.” (XK, 18 years old female)

With regards to support at the clinic, participants mentioned that they would like to see clinics being more adolescent friendly. One of the adolescent friendliness approaches that were brought forward was the issue of seeing adolescents on specific days only.

“I have always thought of an idea whereby the elders are separated from the teens. Whereby they are all allocated their days, just them alone. (RUW 18-year-old female)

“I think adolescents can be supported by being seen early and quickly. Not to stand in long queues because this discourages them from coming to the clinic.” (NX 17-year-old male)

Participants indicated that being in the same space with their peers is something they enjoy. These are the people they recognize themselves with, and they share similar experiences and challenges.

“When I come to the clinic for the teen club, I feel at peace because my friends are all here to talk about HIV.” (RUV 15-years-old male)

“Seeing how other teenagers are drinking their medicines very well. It also gives me that power to be like, if he can do it, then I also can. I am still a normal person.” (RUW 18-year-old female)

– *Strong religious believes*

Adolescents believe God has put this upon them, they have accepted it, and he will give them complete healing according to his will if they pray. They also believe that they can only die and go to heaven if God decides to take their lives, indicating that they pray daily and find comfort in the word of God.

“Because God is the best, and he helps me when I pray, he heals me in every way that I want. I wake up like a normal person, like I don't have HIV, and I feel strong because I believe in God.” (RUV, 14-year-old male)

However, some adolescents felt the contrary. They are questioning the motives of God for sending this upon them and would like to know when all this would end.

“Why God gave us this disease, and why is he not taking it away? Nevertheless, he is the only one who knows when all this will go away...when he decided himself that now he is going to cure people of HIV and find solutions to it?.” (RUT, 15-year-old female)

3.2. Discussion

There is a lack of evidence on the experiences of adolescents living with HIV in sub-Saharan Africa, particularly Namibia. To our knowledge, this is the first published study in Namibia that has investigated this phenomenon. We explored the lived experiences of adolescents living with HIV in the Namibian context through individual in-depth interviews. Adolescents described attending the clinic as a central feature of their experience living with HIV. Although some had positive experiences at the clinic, some encountered negative experiences too either with the actual service or with service providers. The findings of this study

suggest that adolescents consider the services not meeting their expectations. They alluded to overcrowding, long waiting periods, and lack of privacy as negative experiences at the clinic. The findings support the evidence from prior research [11], [12] where adolescents described revisiting the clinic as a cumbersome process sometimes due to long waiting periods and so much time spent at the clinic.

Results further indicate that adolescents are constantly concerned about being recognized, especially by adults, in a place that offers services to people living with HIV because it could only mean they are in HIV care. Similar studies in Africa [11], [13], [14] indicated that both anticipated and experienced stigma affect retention and adherence behaviors. Adolescents in that study cited avoiding attending the clinic for fear of being seen and being labeled as living with HIV, as this condition is linked to multiple sexual partners and other risky sexual behaviors.

The current study's findings further suggest that clinics and health facilities that offer services to adolescents need an adolescent-friendly approach to their services to make them appealing. Many adolescents lack the agency and confidence to navigate adult settings. Adolescents could be more comfortable receiving care within their peer group. Healthcare providers in adolescent clinics tend to understand adolescent needs better. Moreover, they respond appropriately to adolescent health and developmental needs. This situation is considered to directly influence improved adolescent health access and outcome altogether [11].

Results of the current study indicate that some services aimed at adolescents are offered at inconvenient times, and they need full access or utilization. This is because they attend school and have to be absent from school sometimes to attend the clinic. Clinic staff attitude was narrated in both positive and negative ways. It was noted that most adolescents have a good relationship with the staff at their clinics. However, despite this, they need to be more confident to engage them in discussions when they have concerns or queries regarding their condition. The attitude of the staff could be an obstacle to a meaningful relationship between the service providers and the adolescents [15], [16]. Their study argues that in such circumstances, adolescents tend to have reservations about asking questions about their care when they lack trust and confidence in the healthcare worker. They found that one of the barriers adolescents experience when revisiting the clinic is the changing of health care providers and negative attitudes from health care providers.

Adolescents in the current study highlighted experiencing several negative emotions upon finding out about their HIV status. These emotions ranged from shock, anger, disappointment, denial/disbelief, numbness, and relief. Participants further articulated their struggle to discuss with their parents and caregivers how they acquired the illness, especially those infected vertically. Similarly, prior research documented that parents are uncomfortable disclosing or discussing their status openly with adolescents [4], [17], [18]. Adolescents must understand that the medications will not cure them but will help them prolong their lives and live healthier. The experience of taking medication is described differently by participants. Medications are viewed as a good thing, citing that it brings them hope and enable them to live a longer and healthier life like anyone else. Some participants do not seem to believe that this treatment is lifelong; they are hopeful that they will eventually be cured if they adhere to it. It is not clear what influenced such belief. In 2017, Mackworth-Young *et al.* [19], [20] noted that stigma is a significant issue around HIV disclosure and is closely related to non-adherent behaviors. Likewise, lack of privacy at home and at the clinic influences medication-taking behaviors. Fear of anticipated stigma is further associated with the adolescent decision to avoid taking medications in the presence of their siblings, friends, or schoolmates. A situation that results in them skipping doses when they cannot escape the company of these people.

The findings revealed several factors contributing to poor adherence, such as treatment schedules, which were somewhat rigid and somewhat less flexible. The treatment schedules interfere with their normal daily activities like going to school or going out to play. Pill burden and treatment fatigue was identified as unpleasant experience and could be another contributing factor to non-adherence as it has a marked impact on the desire to attend the clinic appointment. Nonetheless, participants in the current study were aware of the need for complete adherence to achieve viral suppression. These results support the findings of [21] that maintaining adherence is a complex matter, and knowing the importance of adherence does not guarantee adherent behaviors. Some participants have expressed their desire to know how ART treatment works so that they can better understand their medicine. They also identified the need to be aware of side effects and how to manage them when experienced. In 2019, Kacanek *et al.* [22], [23] noted that there is a lacuna in interventional research which addresses ART treatment literacy among this population, especially when switching ART regimens.

Adolescents are reluctant to share information about their condition; this is attributed to fear of multiple factors like mistrust, fear of judgment and reprisal, and anticipated stigma. These results are not unique to this study and context. Research shows that generally, there is secrecy surrounding an HIV diagnosis; hence people who are infected with HIV find it difficult to share their status with others due to the fear of being seen differently, judged, and losing friendships [4], [20], [24], [25]. Earlier research demonstrated the need for sexual health information for adolescents living with HIV exist. Adolescent prefers to get this information from healthcare workers and peers because the vertical acquisition of HIV

exacerbates discomfort with discussing sexual issues between an adolescent and the parent [19], [20]. The findings of the current study revealed a lack of age-appropriate information, particularly on sexual reproductive options resulting in adolescents feeling unprepared concerning the sexual experience. This is evidenced by the adolescent's concern about realizing the dream of having a family for fear of infecting the partner or child. Separate studies [26], [27] showed similar results: adolescents are confident in a promising future ahead of them and desire to pursue professional careers. They also aspire to have families and children of their own but are concerned about the risk of HIV transmission to the partner and the baby.

Adolescents in the current study reported having a good relationship with the people they live with at home. With the out-of-family ties, some adolescents engage in meaningful conversation with their peers and friends at and outside school. However, some have indicated that they do not have a friend and do not desire to form such ties because they find them intruding and unnecessary. Despite that, they highlighted the need for support from their family members, the clinic staff, and peers. Amplifying that meeting with peers to share experiences and information could be a learning opportunity.

Additionally, knowing that they are not alone and that others share the same burden as them could be comforting or lessen their burden. These findings align with those of earlier studies, which suggest that adolescents recognize the value of peers whom they associate themselves with and consider them crucial in providing authentic support around shared issues [13], [24], [28]. Results show that some participants believe they will not live long and are afraid of dying. Their lives are marked by constant worries and multiple fears, including, feeling trapped. This suggests the conundrums adolescent experience in their lives and the burden of their condition. These findings coincide with the results of other studies, which emphasized that adolescents with HIV have doubts and worries that they may not live long to pursue future careers or even have children [29], [30]. These findings underscore the need for and importance of assertive communication and problem-solving strategies, which could buffer the effects of such feelings. Religion and faith play a dominant role in the lives of adolescents. Believing in God is an essential element as a means to cope with a lifelong condition. Similar beliefs were reported in a study conducted in Rwanda, where adolescents believed that God would cure them of HIV one day because they believed in sacred healing and cure [11].

4. CONCLUSION

Adolescents living with HIV experience many challenges due to their health condition. Learning about their HIV status is a challenging experience considering that an HIV diagnosis impacts many facets lives. Their experiences need to be acknowledged and engaged in the therapeutic process to assist them in coping with their condition and move beyond it. This study provides additional supportive evidence of the challenges that adolescent living with HIV have to overcome daily as a result of their condition. There is a need for continued HIV care and support for adolescents living with HIV, which is adolescent-friendly and focused. They could also benefit from peer support and comprehensive information on HIV and ART treatment to promote their well-being and health outcome. Interventions targeting this population have to be prioritized, designed, and upscale to address their needs and improve their health outcome.




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