www.idosr.org Kirua, 2024

©IDOSR PUBLICATIONS

ISSN: 2550-7931

International Digital Organization for Scientific Research IDOSRJAS9.2.546200
IDOSR JOURNAL OF APPLIED SCIENCES 9(2):54-62, 2024.
https://doi.org/10.59298/IDOSRJAS/2024/9.2.546200

Examining the Influence of Stigma and Discrimination on the Retention of Pupils Affected By HIV/AIDS in Emarti Zone, Kirindon Division, Transmara District of Kenya

Samwel Oshulai Kirua

Institute of Open and Distance Learning, Kampala International University, Uganda

ABSTRACT

This study examines the impact of stigma and discrimination on the retention of HIV/AIDS students in Kirindon, Emarti Zone, and Transmara District. The findings revealed that culture is the primary contributing factor to stigma. However, some researchers have reported that we can change culture for the better. We can achieve this by first sensitizing the masses about stigma and discrimination. This could be a starting point for a change of attitude. The people who need to change their attitude include the educators, the parents, and their children. Once completed, the remainder of the intervention will proceed seamlessly. Schools should review the HIV/AIDS interventions they've adopted and start implementing them, taking into account children's right to education. Those in charge of counseling must also carefully observe the children who lose interest in learning or begin to withdraw from school. This behavior may be stigmatizing, necessitating the need for related counseling. Schools must intensify their advocacy for children's rights. For instance, we must intensify communication-based approaches and collaborate with the local community. Peer educators and volunteers should travel from village to village, meeting families and encouraging them not to isolate those who are HIV/AIDS positive and not to misinform their children.

Keywords: Discrimination, HIV/ AIDS, Interventions, Stigma, Teachers

INTRODUCTION

Studies conducted in Kenya about HIV/AIDS reveal that an estimated 34% of pupils sampled had lost at least one parent, and at least 10% lost both parents to HIV/AIDS [1]. Widespread HIV/AIDS-related stigma and discrimination have persisted, despite the fact that they increase people's vulnerability. Isolating people and depriving them of care and support worsens the infection's impact. Indeed, it impedes every step in an effective response, from prevention to treatment care and support, and even extends into the next generation, placing an emotional burden on children who may be trying to cope with the death of their parents due to AIDS/HIV [2]. But stigma did not just emerge from a vacuum; rather, it emerged from other stereotypes, prejudices, and social inequalities, including those relating to culture, gender, nationality, ethnicity, and sexuality. However, this is primarily related to the SDS force in schools, which is influencing children to drop out of school. Some individuals dread attending school, fearing rejection and accusations [3]. The 2002-2003 World AIDS Campaign aimed to inspire leaders across all levels and backgrounds to confront HIV/AIDS-related discrimination, drive public action, and combat the discrimination individuals encounter due to the epidemic. Principles of non-discrimination, equality, and participation are central to an effective HIV/AIDS strategy that integrates human rights [4]. Despite the governments' efforts to educate the community and society about HIV/AIDS, encouraging them to avoid risky behaviors and seek treatment for those infected, the issue of discrimination and stigma has emerged as a new

challenge [5]. Teachers and fellow pupils have isolated children affected by AIDS in schools. Some have chosen to stay at home due to their disapproval of the comments and actions directed towards them. If the government truly aims to integrate all children into the mainstream, regardless of their diverse needs, then its strategy is failing, as many children have already left school due to stigma [6]. This necessitated the present study, which examines the impact of stigma and discrimination on the retention of HIV/AIDS students in Emarti Zone, Kirindon Division, Transmara District, Kenya.

THE CONCEPT OF DISCRIMINATION AND STIGMA

Discrimination against persons living with HIV (PLHIV), as defined by the UNAIDS protocol for the identification of discrimination against people living with HIV, refers to any measure entailing an arbitrary distinction among persons depending on their confirmed or suspected HIV stereotyping status or state of health [7]. Discrimination against PL HIV may lead to intolerance and exacerbate the stigma PL HIV faces regularly. Discrimination based on infectious disease is just as inequitable as discrimination based on race, gender, or disability [8]. HIV-positive people do not pose a health threat, and discrimination based on HIV or health status may compound the marginalization of groups already facing stigma and societal oppression, such as gay men, injecting drug users, and sex workers [9]. Discrimination also undermines public health efforts to identify HIV-positive people in order to prevent transmission and provide care and treatment. If individuals fear the personal, social, and economic consequences of being diagnosed with HIV/AIDS, they may forego testing, fail to discuss their health and risk behaviours with counsellors, health care professionals, and their partners, and refrain from entering the health care system for treatment [10]. Finally, by placing the focus on HIV infection on specific groups in the community, discrimination may breed complacency in other groups who wrongly assume that they are not at risk of HIV infection. Alleviating discrimination is consistent with efforts to respect, protect, and fulfil human rights to prevent HIV and AIDS through public health initiatives [7]. Discrimination against people living with HIV/AIDS is a common experience in Kenya. Caretakers of HIV/AIDS patients have actually tried to conceal them from the public to avoid ridicule. Even those who are HIV positive have attempted not to go public for fear of losing their jobs, being isolated by their friends, or being rejected by family members. Remember, these individuals require comprehensive emotional and health care support. By denying them the two, they are increasing their chances of deteriorating to death [11]. Repeatedly, experts at the international level and service providers at the local level have described the powerful force of SDS. Jonathan Mann, then Director of the WHO Global Programme on AIDS/HIV, warned about SDS in regards to HIV/AIDS. Speaking to the UN General Assembly in 1987, he cited three phases of the HIV/AIDS epidemic: the epidemic of HIV, the epidemic of segregation, and the epidemic of stigma, discrimination, and denial. He further noted that the third phase is as central to the global AIDS challenge as the disease itself [12]. Rubaihayo [13] lamented that each year more and more people die from HIV disease, and that it is the misinformation about the disease (HIV) that is killing people, and that people faced death rather than the consequences of social stigma such as losing a business and even families.

HIV AIDS Stigma and Discrimination in the Education Sector

Education is essential for an individual's full development. Furthermore, education reduces the likelihood of sexual exploitation, unwanted pregnancy, and the acquisition of sexually transmitted infections in children. Studies have shown that an additional year of schooling reduces the risk of HIV infection in children. Schools may provide nutrition assistance to the most needy and may be the only forum for a discussion of safe sex practices and HIV/AIDS geared to the child's level of development and maturity [14]. However, stigma and uncertainty about HIV/AIDS often lead to discrimination in the education sector. Due to their perceived or actual HIV status or that of their parents, schools may refuse access to children or require them to leave after admission. Within the education system, they may face discrimination in the form of segregation, isolation, or differential and prejudicial treatment [15].

Causes of Stigma

Despite the insistent voices warning about stigma and discrimination, little research has been undertaken in this specific area. Some scholars have proposed that stigma and discrimination are a result of misconceptions about the cause and spread of HIV/AIDS [16]. Also, among young people, there is still a significant gap in specific knowledge about modes of transmission, prevention, strategies, and levels of risk. LQAS conducted research in 2002–2004 to assess young people's knowledge about

HIV/AIDS. Researchers established that mosquito bites, sharing utensils or toilets, and witchcraft spread HIV/AIDS [17]. However, similar research in Kenya revealed that most young people were aware of the transmission mechanism of HIV/AIDS [18]. If indeed they knew much about the mode of transmission, then why should they ostracise their peers who are carrying the AIDS virus? Roeder [19] also commented that each year, more and more people die from the HIV disease, and it is the misinformation around HIV/AIDS that is killing people. Hawkins et al. [20] also highlighted the possibility of psychological, social, or attitudinal causes, which are difficult to quantify in laboratory settings and involve numerous cultural complexities. He went on to ask whether the constructs of shame, discrimination, and shame have a commonality across cultures. We have yet to establish whether stigma and discrimination in Kenya are products of culture. Are there psychosocial bases for stigmatisation and discrimination in various cultures in Kenya?

Interventions for HIV/AIDS stigma and discrimination

We can take action against stigma and discrimination in schools. On this note, Chen et al. [21al. [21] advised that interventions such as information counselling, coping skills, and contact can be used. Alinaitwe et al. [22al. [22] advised that it is important that we understand in order to diminish shame, stigma, and discrimination so that people are willing to access available and effective biomedical and psychosocial interventions. UNAIDSUNAIDS [23[23] advised that human rights that relate critically to reducing vulnerability to HIV/AIDS and mitigating the impact of the epidemic are found in existing human rights instruments, such as the Universal Declaration on Human and Cultural Rights, the Convention on the Elimination of All Forms of Discrimination Against Women, and the Convention on the Rights of the Child. According to UNESCO [24], education is a basic right under the International Covenant on Economic, Social, and Cultural Rights (Article 13) and the Convention on the Rights of the Child (Article 28). The general anti-discrimination clause prescribing discrimination on the basis of other "status" in both of these international agreements has been interpreted by the treaty monitoring bodies as forbidding discrimination on the basis of HIV status. UNAIDS [23] also highlighted that principles of non-discrimination, equality, and participation are central to an effective HIV/AIDS strategy that integrates human rights. There are many, but specifically in this study, we are more concerned about protecting the dignity of people infected and affected by HIV/AIDS as well as preventing the spread of the infection. They include non-discrimination, the right to health, equality between men and women, the rights of children, the right to privacy, the right to education and information, the right to work, the right to marry and start a family, the right to social security, assistance, and welfare, the right to liberty, and the right to freedom of movement. HIV/AIDS-related action taken by the government of Kenya has been to provide information and education relating to sexual health and HIV/AIDS prevention. The 2002-2003 World AIDS Campaign aimed at encouraging leaders at all levels and in all walks of life to visibly challenge HIV-related discrimination and stigma, spearhead public action, and act against the many other forms of discrimination that people face in relation to HIV/AIDS [4]. In the same vein, UNAIDS [23] advised that the government should actively involve people living with HIV/AIDS in response to the epidemic, monitor human rights violations, ensure that people are able to challenge discrimination and stigma, and receive redress through national administrative, judicial, and human rights institutions designed to safeguard rights, create an enabling legal environment for fighting discrimination, and ensure that prevention, treatment, care, and support services are accessible to all.

METHODOLOGY

Research Design

The research took a descriptive approach to investigate the problem. Quantitative techniques had to be employed to help analyze the data that were collected from the field.

Study Area

This study was undertaken in the selected primary schools of Emarti zone, Kirindon division, Transmara district of Kenya. The following schools participated in the study: Emarti primary school, Oloonkolin primary school, Enkipai primary school, Kmintet primary school, and Esoit Naibor primary school.

Target Population

The population for this study comprised of the primary teaching staff from ten schools of Emarti zone, Kirindon division, Transmara district in Kenya. It was felt that primary schools constitute a fairly large enough sample to be the representative of all Kenyan primary schools and to a large extent tend to provide a large number of teacher representation of the range and diversity found in primary schools.

Sample Size and Selection Techniques

Because every teacher was a potential respondent, a simple random sampling technique was employed to pick 4 teachers from each primary school. Together 40 teachers were chosen for this study.

RESULTS

Table 1: Respondents' responses on the teachers' levels of experience

Professional qualification	Frequency	Percentage
Over five years	18	**35.2**
Two-five years	25	**49.0**
Under two years	8	**15.6**
Total	51	99.8

Source: Primary data 2010

According to table 1 above, 18 teachers had an experience in the teaching field of five years and a half. Twenty-five teachers on the other hand had just completed their probation, and eight teachers were still new in the field. When the percentage is considered, a tool percentage of 84 of the teachers have enough experience to identify the problem of stigma and they themselves avoid discriminating learners who have been affected by HIV/AIDS.

Table 2: Respondents' responses on how HIV/AIDS spreads

Knowledge of teachers about HIV/AIDS	Agree	Disagree	Don't know	Total
HIV/AIDS can spread by shaking hands with the infected child	08	36	07	**51**
HIV/AIDS children can infect teachers when they touch their teaching materials	08	35	08	**51**
A teacher can get HIV/ AIDS by inhaling the same air with the infected children	11	31	09	**51**
HIV/AIDS affected children should sit separately from the normal children	27	10	14	**51**
HIV/AIDS children can easily infect the rest of the children when they play together	18	19	14	**51**
Total	**72**	**132**	**52**	255
Total percentage	**28.02**		**20.3**	100.2
Source: Primary data 2010				

From table 2, 28% of the teachers agreed that HIV/ AIDS can spread from those children infected by the virus, by shaking their hands, by touching their study or them touching the teaching materials, by inhaling the same air with these children. And because of this, they must sit separately from those who are normal and could infect other children when they play together. More than half of the teachers believed that these children should sit separately a sure indication of ostracism in schools. From the same analysis 51. 7% the teachers disagreed to the statements and 20.3% of the teachers did not know what to believe. These findings are in line with the findings of Nabunya and Namuwonge[25] who had talked of shame, discrimination and stigma (SDS force) as a result of cultural beliefs and values. According to this group of researchers they assumed it was the psycho-social base in various cultures that influenced the peoples' attitude towards the victims of HIV/AIDS. Table 2 equally highlights that up to now a large percentage teachers have wrong information about how HIV/AIDS spreads from one person to another. Despite of what has been taught to them during their teacher training course. It also shows that the curriculum does not adequately prepare the teachers to meet the needs of learners. More so the analysis also highlights the role of culture m influencing stigma and discrimination[26].

Table 3: Respondents' responses on cultural influences of the respondents about people who are affected by HIV/AIDS

What children know about HIV/AIDS	Agree	Disagree	Don't know	Total
When I shake hands with my friend who has HIV/AIDS I can get it	17	28	27	**70**
When I play with a child suffering from HIV/AIDS I get it	10	34	26	**70**
When I sit with a child who has HIV/AIDS I can also get it.	17	28	27	**70**
When I share books or a pen with an HIV/AIDS child I can get it	15	30	25	**70**
HIV/AIDS is an airborne disease which can easily be caught	08	33	29	
Total number of responses	**67**	**153**	**134**	350
Total percentage	**19.1**		**38.2**	100.0
Source: Primary data 2010				

Table 4 shows that 19% of the learners knew that when they shake hands, with their peers who have been affected by HIV/ AIDS, sit together, share their books, with them, or play and inhale the same air, they would also catch the virus and fall sick. But 44% of the children disagreed with the statements and 38% of them didn't know.

Table 4: Respondents' responses on what children in schools have been told by parents about AIDS/HIV

Knowledge of teachers about HIV/AIDS	Agree	Disagree	Don't know	Total
Children who have HIV/AIDS and their parents got it through adultery	17		**09**	**70**
HIV/AIDS was due to witchcraft	**24**	**35**	**11**	**70**
No to associate with HIV/AIDS because they are a shame	17	38	15	**70**
Do not share anything with HIV/AIDS learners	20	45	05	**70**
Do not play with them because their bad luck will infect you	14	32	24	**70**
Total	**92**	**194**	**64**	350
Total percentage	**26.2**	**54.4**	**18.2**	98.8

Source: Primary data 2010

In Table 4, 26.2% of the children had negative beliefs about HIV/ AIDS affected children because their parents had told them. Their parents committed adultery; it is a shame to associate with them; that they should not share anything with them or play with them due to fear of infection.54.4% however did not agree that the parents had taught them to disassociate with the HIV/AIDS children and 18.2% did not know.

DISCUSSION OF FINDINGS

The analysis of the professional qualifications and experiences of teachers revealed that while most of them had an education degree, only a small number possessed additional professional skills such as guidance and counselling, and special needs education. The absence of pertinent professional skills led to the confirmation that the teachers were among those who discriminated against children believed to have HIV/AIDS. Inadequate comprehension of the impact of HIV/AIDS on children. As for teaching experience, the majority of the teachers had enough experience to identify, protect, and help HIV/AIDS perceived or suspected to educate the rest, not to ostracise them [27]. Teachers estimated that an average of five children had left each of the seven schools under study due to HIV/AIDS. This also highlighted the problem of HIV/AIDS and school dropouts. It is possible that some of these children quit school because of stigma at home and in school [28]. The analysis revealed that a number of teachers had conflicting knowledge about HIV/AIDS. Some teachers concurred that they can contract AIDS and HIV by shaking hands with infected children or those affected in any other way. It is easy to get the infection when you touch these children's study materials or inhale the same air as you. In other words, it was airborne. Therefore, these children should not be seated with other children who are considered normal. This finding shows that if indeed teachers believe that HIV/AIDS could spread like this, then it is possible that they discriminate against, isolate, and ostracise the victims of HIV/AIDS at school. This finding revealed the teachers' misconceptions about HIV/AIDS [29]. Research also revealed that 31% of children held conflicting beliefs about AIDS and HIV. Similar to their teachers, some children concurred that engaging in play or sharing items with individuals afflicted by the disease increases the risk of contracting it. As a result, many of them have been forced to avoid interacting with those affected by HIV/AIDS. Therefore, the learners were also

contributing to the stigma that their peers were facing because of misinformation about HIV/AIDS. These findings are in line with the findings of Nabunya and Namuwonge [25], who talked of shame, discrimination, and stigma (SDS force) as a result of cultural beliefs and values. According to this group of researchers, they assumed it was the psychosocial base in various cultures that influenced people's attitudes towards HIV/AIDS victims. Cultural beliefs, according to the teachers and children, led many of them to believe that HIV/AIDS was a result of witchcraft. They believed that anyone with the disease was either an adulterer or a person with bad luck, and anyone associated with them was susceptible to contracting the disease. Rigid cultural beliefs therefore proved to be the root of discrimination, isolation, and stigma. Teachers and children avoided their peers, who really needed their help and support during this trying time of their lives. Researchers established that cultural beliefs influenced people's attitudes towards learners with HIV/AIDS. This concurs with the findings of Sileo et al. [30], who observed that stigma did not evolve from a vacuum but rather from stereotypes relating to culture, gender, and sexuality.

CONCLUSION

HIV/AIDS stigma is indeed present in Kenya's primary schools. Regrettably, people's attitude towards HIV/AIDS sufferers has deteriorated due to rigid cultural beliefs, leading to an increase in stigma and discrimination. Researchers have observed that culture is the dominant contributing factor to stigma. However, some researchers have reported that we can change culture for the better. We can achieve this by first sensitizing the masses about stigma and discrimination. This could be a starting point for a change of attitude. The people who need to change their attitude include the educators, the parents, and their children. Once completed, the remainder of the intervention will proceed seamlessly. Schools should review their HIV/AIDS intervention implementations and start implementing them with consideration for children's right to education. Those in charge of counseling must also carefully observe the children who lose interest in learning or begin to withdraw from school. This behavior may be stigmatizing, necessitating the need for related counseling. Schools must intensify their advocacy for children's rights. For instance, we must intensify communication-based approaches and collaborate with the local community. Peer educators and volunteers should travel from village to village, meeting families and encouraging them not to isolate those who are HIV/AIDS positive and not to misinform their children.

REFERENCES

1. Mwangi, J., Miruka, F., Mugambi, M., Fidhow, A., Chepkwony, B., Kitheka, F., Ngugi, E., Aoko, A., Ngugi, C., Waruru, A.: Characteristics of users of HIV self-testing in Kenya, outcomes, and factors associated with use: results from a population-based HIV impact assessment, 2018. BMC Public Health. 22,643(2022). https://doi.org/10.1186/s12889-022-12928-0
2. Mahajan, A.P., Sayles, J.N., Patel, V.A., Remien, R.H., Ortiz, D., Szekeres, G., Coates, T.J.: Stigma in the HIV/AIDS epidemic: A review of the literature and recommendations for the way forward. AIDS. 22, S67–S79 (2008). https://doi.org/10.1097/01.aids.0000327438.13291.62
3. Andersen, M.M., Varga, S., Folker, A.P.: On the definition of stigma. J Eval Clin Pract. 28, 847–853(2022). https://doi.org/10.1111/jep.13684
4. The Fight for an AIDS-Free World: Confronting the Stigma, Reaching the Marginalized | Annals of Global Health, https://annalsofglobalhealth.org/articles/10.5334/aogh.4414
5. Kitara, D.L., Aloyo, J.: HIV/AIDS Stigmatization, the Reason for Poor Access to HIV Counseling and Testing (HCT) Among the Youths in Gulu (Uganda). Afr J Infect Dis. 6, 12–20 (2012)
6. Njuguna, I., Moraa, H., Mugo, C., Mbwayo, A., Nyapara, F., Aballa, C., Wagner, A.D., Wamalwa, D., John-Stewart, G., Inwani, I., O'Malley, G.: "They should show them love even if their status of being HIV positive is known": Youth and caregiver stigma experience and strategies to end HIV stigma in schools. Trop Med Int Health. 28, 466–475 (2023). https://doi.org/10.1111/tmi.13878
7. Barr, D., Amon, J.J., Clayton, M.: Articulating A Rights-Based Approach to HIV Treatment and Prevention Interventions. Curr HIV Res. 9,396–404(2011). https://doi.org/10.2174/157016211798038588
8. Ojukwu, E., Hirani, S., Sotindjo, T., McKay, E., Okedo-Alex, I., Magagula, P., Pashaei, A., Agudosi, G.M.: The Impact of Intersectional Discrimination and Stigma on HIV Care for

African, Caribbean, and Black Women Living With HIV During the COVID-19 Pandemic in British Columbia: A Descriptive Study. J Assoc Nurses AIDS Care. 35, 175–188 (2024). https://doi.org/10.1097/JNC.0000000000000457

9. Arrington-Sanders, R., Hailey-Fair, K., Wirtz, A.L., Morgan, A., Brooks, D., Castillo, M., Trexler, C., Kwait, J., Dowshen, N., Galai, N., Beyrer, C., Celentano, D.: Role of Structural Marginalization, HIV Stigma, and Mistrust on HIV Prevention and Treatment Among Young Black Latinx Men Who Have Sex with Men and Transgender Women: Perspectives from Youth Service Providers. AIDS Patient Care STDS. 34, 7–15 (2020). https://doi.org/10.1089/apc.2019.0165
10. Nyblade, L., Stangl, A., Weiss, E., Ashburn, K.: Combating HIV stigma in health care settings: what works? J Int AIDS Soc. 12, 15 (2009). https://doi.org/10.1186/1758-2652-12-15
11. McHenry, M.S., Nyandiko, W.M., Scanlon, M.L., Fischer, L.J., McAteer, C.I., Aluoch, J., Naanyu, V., Vreeman, R.C.: HIV Stigma: Perspectives from Kenyan Child Caregivers and Adolescents Living with HIV. J Int Assoc Provid AIDS Care. 16, 215–225 (2017). https://doi.org/10.1177/2325957416668995
12. Kavanagh, M.M., Gostin, L.O.: The World Health Organization's Momentous Struggle to Respond to the AIDS Pandemic. Am J Public Health. 108, 1272–1273 (2018). https://doi.org/10.2105/AJPH.2018.304653
13. Rubaihayo, J., Tumwesigye, N.M., Konde-Lule, J., Makumbi, F., Nakku, E.J., Wamani, H., Etukoit, M.B.: Trends and Predictors of Mortality Among HIV Positive Patients in the Era of Highly Active Antiretroviral Therapy in Uganda. Infect Dis Rep. 7, 5967 (2015). https://doi.org/10.4081/idr.2015.5967
14. Duflo, E., Dupas, P., Kremer, M.: Education, HIV, and Early Fertility: Experimental Evidence from Kenya. Am Econ Rev. 105, 2757–2797(2015). https://doi.org/10.1257/aer.20121607
15. Failing Our Children: Barriers to the Right to Education: III. The Impact of HIV/AIDS, https://www.hrw.org/reports/2005/education0905/5.htm
16. Stangl, A.L., Grossman, C.I.: Global Action to reduce HIV stigma and discrimination. J Int AIDS Soc. 16, 18934 (2013). https://doi.org/10.7448/IAS.16.3.18934
17. Nabisubi, P., Kanyerezi, S., Kebirungi, G., Mboowa, G.: Knowledge and attitude of secondary school students in Nakaseke, Uganda towards HIV transmission and treatment. AAS Open Res. 4, 23 (2021). https://doi.org/10.12688/aasopenres.13210.2
18. Young, P.W., Musingila, P., Kingwara, L., Voetsch, A.C., Zielinski-Gutierrez, E., Bulterys, M., Kim, A.A., Bronson, M.A., Parekh, B.S., Dobbs, T., Patel, H., Reid, G., Achia, T., Keter, A., Mwalili, S., Ogollah, F.M., Ondondo, R., Longwe, H., Chege, D., Bowen, N., Umuro, M., Ngugi, C., Justman, J., Cherutich, P., De Cock, K.M.: HIV Incidence, Recent HIV Infection, and Associated Factors, Kenya, 2007–2018. AIDS Res Hum Retroviruses. 39, 57–67 (2023). https://doi.org/10.1089/aid.2022.0054
19. The cost of South Africa's misguided AIDS policies | News | Harvard T.H. Chan School of Public Health, https://www.hsph.harvard.edu/news/magazine/spr09aids/
20. Socio-economic factors associated with mental health disorders in Fort Portal, western Uganda | Hawkins | South African Journal of Psychiatry, https://sajp.org.za/index.php/sajp/article/view/1391/1693
21. Chen, J.A., Gilmore, A.K., Wilson, N.L., Smith, R.E., Quinn, K., Peterson, A.P., Fearey, E., Shoda, Y.: Enhancing Stress Management Coping Skills Using Induced Affect and Collaborative Daily Assessment. Cognitive and behavioral practice. 24, 226 (2017). https://doi.org/10.1016/j.cbpra.2016.04.001
22. Alinaitwe, R., Seggane, M., Turiho, A., Bird, V., Priebe, S., Sewankambo, N.: Family Psycho-Social Involvement Intervention for severe mental illness in Uganda. S Afr J Psychiatr. 30, 2138 (2024). https://doi.org/10.4102/sajpsychiatry.v30i0.2138
23. Human rights-based approach to ending AIDS as a public health threat | UNAIDS, https://www.unaids.org/en/topic/rights
24. Right to education handbook - UNESCO DigitalLibrary, https://unesdoc.unesco.org/ark:/48223/pf0000366556
25. HIV-Related Shame, Stigma and the Mental Health Functioning of Adolescents Living with HIV: Findings from a Pilot Study in Uganda-PMC, https://www.ncbi.nlm.nih.gov/pmc/articles/PMC9170548/

26. (15) (PDF) What we're teaching teachers: An analysis of multicultural teacher education coursework syllabi, https://www.researchgate.net/publication/222705479_What_we're_teaching_teachers_An_analysis_of_multicultural_teacher_education_coursework_syllabi
27. Bakar, R.: The influence of professional teachers on Padang vocational school students' achievement. Kasetsart Journal of Social Sciences. 39, 67–72 (2018). https://doi.org/10.1016/j.kjss.2017.12.017
28. Wiggins, L., O'Malley, G., Wagner, A.D., Mutisya, I., Wilson, K.S., Lawrence, S., Moraa, H., Kinuthia, J., Itindi, J., Muhenje, O., Chen, T.-H., Singa, B., Mcgrath, C.J., Ngugi, E., Katana, A., Ng'ang'a, L., John-Stewart, G., Kholer, P., Beima-Sofie, K.: 'They can stigmatize you': a qualitative assessment of the influence of school factors on engagement in care and medication adherence among adolescents with HIV in Western Kenya. Health Educ Res. 37, 355–363 (2022). https://doi.org/10.1093/her/cyac018
29. Moyo, Z., Perumal, J.: STIGMA AND DISCRIMINATION AMONGST TEACHERS LIVING WITH HIV/AIDS. (2019)
30. Sileo, K.M., Baldwin, A., Huynh, T.A., Olfers, A., Woo, C.J., Greene, S.L., Casillas, G.L., Taylor, B.S.: Assessing LGBTQ+ stigma among healthcare professionals: An application of the Health Stigma and Discrimination Framework in a qualitative, community-based participatory research study. J Health Psychol. 27, 2181–2196 (2022).https://doi.org/10.1177/13591053211027652

CITE AS: Samwel Oshulai Kirua (2024). Examining the Influence of Stigma and Discrimination on the Retention of Pupils Affected By HIV/AIDS in Emarti Zone, Kirindon Division, Transmara District of Kenya. IDOSR JOURNAL OF APPLIED SCIENCES 9(2):54-62. https://doi.org/10.59298/IDOSRJAS/2024/9.2.546200