

The Impact of Guidance Programme in Enhancing Self-Esteem for Risk Behaviour Change among Youth Living with HIV/AIDS in Nakuru County, Kenya

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Received: November 3, 2017

Published: November 18, 2017

Abstract

This is from an experimental study, which assessed the impact of Guidance Programme in enhancing Self-Esteem among Youth Living with HIV in Nakuru county Kenya. A sample of 76 YLWHA was randomly assigned into an experimental (N=38) and control groups (N=38). Guidance programme was administered to the experimental group. Findings showed that guidance programme enhanced positive self-esteem, and hence enhanced risky behaviour change among the YLWHA. The target population was 57,800 PLWHA in the County. Quantitative and qualitative data were collected through a questionnaire and an interview schedule. Validity of the instruments was checked through expert's opinion and piloting to a similar population with similar characteristics and critically looking at the objectives. Cronbach's alpha method was used to test reliability. The corrected item total correlation for pre-test and post-test for self-esteem had a Cronbach's alpha of 0.804 for pre-test and 0.786 for post-test respectively. These values are well above the threshold for a scale which is 0.7. T-test for independent means was used to determine the difference between means of the two groups, the experimental and the control group. The percentiles and the chi-square were also used for verifications. The tests were calculated at, 0.05 level of significance. The Statistical Packages for Social Sciences (SPSS) windows version 22.0 was used to analyze quantitative data. The findings of the study revealed that the guidance programme had an impact on self-esteem. This study will hopefully be used to improve establishment and development of effective risk reduction behavior programmes for YLWHA by all stakeholders. The study recommends that the Guidance programme be incorporated in all intervention programmes for PLWHA.

Keywords: Guidance programme, Self-Esteem, Risky Behaviour Change, YLWHA

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1. INTRODUCTION

The first recognized cases of the Acquired Immune Deficiency Syndrome occurred in America in the summer of 1981 when a very rare form of pneumonia, caused by the micro-organism *Pneumocystis Carinii*, and Kaposi Sarcoma (a rare form of skin cancer), suddenly appeared simultaneously in several patients (Belin, 2012). These patients had a number of characteristics in common; they were all young homosexual men with compromised (damaged) immune systems (Cherie, 2012). Soon afterwards, a new disease, which undermined the immune system and caused diarrhea and weight loss, was identified in Central Africa in heterosexual people (Berhan & Berhan, 2015).

Initially, scientists and doctors were baffled because the causes and modes of transmission of this new disease (called 'slimming disease' in Africa) could not immediately be identified (Boafo, Dagbanu, & Oppong, 2014). It was only in 1983 that it was discovered that the disease was caused by a virus which at that stage was known as LAV (Lymphadenopathy-associated Virus) and HTLV-III (Human T cell lymphotropic virus Type III). In May 1986, the virus causing this condition was named HIV (Human Immunodeficiency Virus) (Madise, Zulu, & Ciera, 2017). At present there are two viruses associated with AIDS, namely HIV-1 and HIV-2. HIV-1 is associated with infections in Central, East and South Africa, North and South America, Europe and the rest of the world. HIV-2 was discovered in West Africa (Cape Verde Islands, Guinea-Bissau and Senegal) in 1986 and is mostly restricted to West Africa (Savaş, Bozgeyik, & Eser, 2014). All indications are that while HIV-2 is as dangerous a virus as HIV-1, it acts more slowly. This means that it takes longer for the symptoms of infection to develop in an HIV-2 infected person (Dahal, Pokharel, & Yadav, 2013).

According to Kenya AIDS Response Progress Report (2014), the HIV epidemic in Kenya has evolved, since the first case was diagnosed in 1984, to become one of the major causes of mortality and has placed tremendous demands on the health system and the economy. The epidemic has affected all sections of society; children, youths, adults, women and men. While other approaches have been used to solve the HIV pandemic problem Nationwide, for example; biomedical HIV prevention interventions, male circumcision, increased use of condoms, ensuring that all donated blood for transfusion is screened for HIV and training of health workers in adherence to recommended infection control procedures to prevent HIV transmission, the pandemic still persists. It was hypothesized that, there is no statistically significant difference in the level of self-esteem, between the YLWHA who undergo guidance programme compared to those who do not.

2. LITERATURE REVIEW

2.1 Self- Esteem and Risky Sexual Behavior Engagement

Self-esteem has been defined in a number of ways. Simoni, Huang, Goodry and Montoya (2006) regard self-esteem as a resiliency that is adopted during times of stress which can be seen as a personal and internal resource. Self-esteem is perceived as a cognitive-behavioral aspect that helps individuals to cope with their environment as well as solve problems. According to (Jensen, 2003, p. 115), self-esteem has seven components: a determination to be powerful and be able to act; the ability to think and feel, self-evaluation of character; ability to integrate feeling and thought; self-desire to seek understanding and meaning; self-evaluation of principles based on action; and ability to believe that one is not helpless. If these components are felt in a great measure, then an individual is said to have a high self-esteem, and the opposite is true.

Stereotypes that are brought about by HIV/AIDS affect the People Living with HIV/AIDS in a very negative way. The society tends to stigmatize these individuals, which may affect the self-esteem of the HIV-positive people. In many cases, when an individual has been tested positive for HIV, they may be afraid to share the results with family members and close friends this means they lack the social support that they ought to have (Kartikeyan et al., 2007). Dyk (2010) adds that low self-esteem is further heightened by the rejection either from loved ones, friends and colleagues. Stress is intensified by the lack of social support from loved ones. Society has a way of reacting to HIV/AIDS which is often negative. Kartikeyan *et al.*, (2007) declare that the fear of being a social pariah which is shown through marginalization and stigmatization is a fact that HIV infected persons does not want to live with. The assumption with HIV infection is that the infected person is deviant or immoral. Such is the thinking of the society. Social discrimination anticipation can damage the self-esteem of an individual as they are unable to cope with the situation. Low esteem can impact the adaptation of an individual to their HIV status.

Masten (2010) advances that, this can hinder the ability of an individual to socialize and they go in to a cocoon. The ripple effect here is that their self-confidence is affected, which in-turn affects their jobs and their relationships.

Exposure to HIV can lead to a low self-esteem in an individual. Pachankis (2007) notes that in cases of self-condemnation, self-loathe, guilt, and self-blame, there is bound to be low self-esteem. This can be a common case scenario in the case of stigma. HIV infection has it consequences such as physical body changes that can lead to a poor body image. Wingood, G. M., DiClemente, R. J., Mikhail, I., McCree, D. H., Davies, S. L., Hardin, J. W., Saag, M. (2007), allude that this may lead to some negative psychological tendencies such as suicide and other depressive symptoms. The loss of one's self-identity can be mirrored in their self-worth. This leads to very high risk sexual behavior by individuals who have been exposed to or have been infected to HIV (Dyk, 2010). As a reflection of passive suicidal tendencies, a person with low self-esteem may refuse to practice safe sex. Jensen (2003), introduces the concept of a false esteem as a coping mechanism but in false tendencies. False esteem causes individuals to repress their thought and their feelings. The individuals make choices based on fear. This causes them not to want to face reality. In Person's Living with HIV/AIDS, the initial shock of their HIV-positive status leads to a false esteem in which they do not want to deal with reality. Many may turn to numb repressors such alcohol abuse. Additionally, low self-esteem leads to abuse of substances and self-medication. Use of drugs and alcohol tend to mask the individuals worry about HIV and here, caution safe sex practices is thrown to the wind. Shelby, Aronstein and Thompson (2014) point out that there have been claims by some people that use of alcohol or drugs makes sex to feel better. This can be a cause factor to reinfections (Kher, 2008).

With a low self-esteem, people devalue the resources that they have at hand. Moreno (2007) elucidates that a relationship exists between HIV/AIDS and self-esteem in which HIV-positive people at first believe that they do not have a choice. This stems from the beliefs, feelings, and attitudes that are negative. In African communities, the self-esteem of a woman goes hand-in-hand with her ability to perform her specified gender roles in that community (Kher, 2008). In many instances, an HIV-infected woman is unable to perform some roles because of associated poor health that may be associated with HIV/AIDS. The woman is perceived by the society as an unfit mother if she cannot take care of her children or her inability to safely bear more children. This threatens the position of the woman in the society, affects her self-esteem and hinders her from seeking and receiving health care and services, and also disclosing her HIV status to close family and friends (Dyk, 2010). Regrettably, this can lead to lowered values. Lowered values as explained by Dyk (2010) can lead an individual to engage in high risk sexual behavior such as having unprotected sex or even having multiple partners. Interestingly, Moskowitz and Seal (2011) observe that men with a low self-esteem have a higher inclination to high risk behaviors than women. Low self-esteem can also lead to an individual seeking outside validation. The HIV-positive person is seeking approval from people who do not judge him or her. This can be a dangerous affair as there are those people that can take advantage of the situation. For instance, Glynn *et al.*, (2001) assert that young girls and women will opt to look for assurance from older men. Mabala (2006) also notes that young girls who want to feel appreciated will look for validation from older men.

High risk sexual behavior that is as a result of low self-esteem can lead to anxiety, doubt and confusion. This leads to a sense of powerlessness in an individual (Simoni *et al.*, 2006). An HIV-positive individual feels that the power to live a fruitful life has been taken away from them by the HIV/AIDS disease. This undoubtedly leads to anger and depression. The infected individual becomes cynical about everything, everyone and life in general. Guilt can lead to self-stigmatization as a result of repressed anger (Deacon, Stephney & Prosalendis, 2005). The stereotypes of HIV also result to self-stigmatization. As Deacon *et al.* (2005) note, in the absence of a societal framework that supports individuals, low self-esteem can lead to is a path for self-destruction. Individuals with low self-esteem have a negative attitude towards their own protection. In such cases, it is common to find individuals expecting their partners to less often use a condom. This also puts their partners in danger. In societal stigma, there is a sense of no belonging and this

can affect the identity of the individual and their wellness. People living with HIV are anxious and the psychological need to evade their condition leads to low self-esteem.

Children that are infected or affected by HIV/AIDS can suffer from low self-esteem (Dyk, 2010). Low self-esteem is revealed in those children who have suffered from profound loss, anxiety, fear, and grief. Parental death affects the psychological and social development of that child. Orphans show low esteem that comes from emotional status. Havighurst *et al.*, (2010) state that children with poor emotional competence often develop social and behavioral difficulties. As an emotional escape, these children are initiated into sexual activity at an early age and this can also increase that probability of contraction HIV and other sexually transmitted infections (Miller, 2010). This can be associated to the high psychological distress experienced by orphans (Nyamukapa *et al.*, 2010). Children with HIV/AIDS suffer complex feelings of loneliness, depression, guilt and low self-esteem. These children have traumatic experiences that lead to clinical anxiety and depression (Gitumu, 2011). Low self-esteem among these children is likely to result to school drop outs, isolation, and even hazardous income generating activities such as prostitution. According to Gitumu (2011), this can be viewed from a point of view of striving to survive. Children with a low self-esteem find it hard to be accepted by the peers. The peers do not understand what these children are going through. The socio-economic status of orphans puts them at high risk of HIV-infections or/and spread of the virus. Miller (2010) observes that the poor orphans may engage in transactional sex behavior so as to get money. The case is higher in orphan-headed households. In many cases, as pointed out by Gitumu (2011), poverty decreases the likelihood of access to healthcare services and this creates more anxiety and low self-esteem for the child.

Colman (2006) defines self-esteem as one's attitude towards oneself or one's opinion or evaluation of oneself, which may be favorable or high, neutral, or negative, unfavorable or low. The self-esteem of HIV-infected people is often severely threatened. Rejection by colleagues, friends and loved ones can cause one to lose confidence and a sense of one's social identity and thus to experience reduced feelings of self-worth. The inability to continue in a career to participate in social, sexual and loving relationships also diminishes the client's self-esteem. The physical consequences of HIV infection such as physical wasting and the loss of strength and bodily control contribute even more to a lowering of self-esteem (Van Dyk, 2001).

3. METHODOLOGY

3.1 Research Design

The study adopted a pure experimental research design. According to Fraenkel and Wallen (2000), an experiment usually involves two groups of subjects, an experimental group and a control. The researcher purposively selected the 76 YLWHA in the support group to participate in the study. The 76 YLWHA were divided into two equal groups that had similar representations of characteristics, which are gender and age stratification. Since the subjects were unequal on the variables gender and age, stratified sampling was used to ensure that, the strata (gender and age) in the population were fairly represented in the sample. Subjects were randomly assigned into an experimental group (N=38) and a control group (N=38). The experimental group received the treatment while the control group received no treatment. The treatment was exposure to the Guidance programme. Both the groups were tested before and after the guidance programme. The experimental group was tested on the relationship to the level of self-esteem at the end of the programme. This was to investigate whether there was a statistically significant difference in the level of self-esteem after the intervention. The two groups were also compared in terms of the level of self-esteem at the end of the programme

3.2 Participants

Participants were the 76 Youth Living with HIV /AIDS in Nakuru county Kenya, who were members of a support group. The 76 YLWHA had similar representations of characteristics, of gender and age. There were twenty two males and fifty four females in all. The Subjects were randomly assigned into an experimental group (N=38) and a control group (N=38). Each strata had eleven males and twenty seven females respectively.

3.3 Instrumentation

The self-esteem scale developed by Rosenberg (1965) was used to measure the level of self-esteem in the respondents. The scale consists of ten items measuring an individual evaluation of Self-esteem. It uses a four point response format. For items 1, 2, 4, 6, 7: Strongly Agree = 3, Agree=2, Disagree=1, and Strongly Disagree=0. For items 3, 5, 8, 9, 10 which are reversed in valence: Strongly Agree=0, Agree=1, Disagree=2 and Strongly Disagree=3. The scale ranges from 0-30 indicating the highest score possible. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

3.4 Procedures

Table 1 shows the corrected item-total correlation for pre-test and post-test for self-esteem scale.

Table 1: Corrected item-total correlation for pre-test and post-test for self-esteem scale

Item	Corrected Item-Total Correlation for pre-test	Corrected Item-Total Correlation for post-test
I feel that I'm a person of worth, at least on an equal plane with others	0.769	0.525
I feel that i have a number of good qualities	0.412	0.548
All in all, I'm inclined to feel that am a failure	0.418	0.419
I am able to do things as well as most other people	0.5	0.529
I feel i do not have much to be proud of	0.445	0.497
I take positive attitude toward myself	0.391	0.301
On the whole I'm satisfied with myself	0.535	0.376
I wish i could have more respect for myself	0.288	0.25
I certainly feel useless at times	0.435	0.541
At times i think am no good at all	0.576	0.656
Cronbach's alpha	0.804	0.786

4. RESULTS FINDINGS AND DISCUSSION

Table 2: Comparison of Control and Experimental Group Scores on Self-esteem at pre-test

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Significance	t	df	Significance
Equal variances assumed	0.437	0.511	0.348	74	0.729
Equal variances not assumed			0.348	73.302	0.729

The results show that the p-value which is 0.729 is greater than the significant level of 0.05, that is ($p > 0.05$). These results indicate that there was no statistically significant difference in the level of self-esteem between the control and the experimental group at the pre-test.

The findings of the study are in agreement with the argument of Marczyk, G. R., Deatteo, D., & Festinger, D (2005) , who state that, the main purpose of the randomized two-group design is to demonstrate causality, that is, to determine whether a specific intervention (the independent variable) causes an effect (as opposed to being merely correlated with an effect). The study sought therefore to find out if there was any impact on the variables; self-efficacy, safe sex attitude and self-esteem after the experimental group was taken through the guidance programme.

Testing of the Hypotheses: Testing the importance of the intervention; bivariate comparisons of the control group with the experimental group

A hypothesis test is a statistical test that is used to determine whether there is enough evidence in a sample of data to infer that a certain condition is true for the entire population. The hypotheses tested for this study was:-

H₀₃: There is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.

The hypotheses testing which was done before the experimental group was exposed to the guidance programme, was carried using the t statistics in order to check whether there was significant difference between pre- experimental and pre- control test groups in terms of the level of self-esteem. This was to ensure that the randomization process was effective. The two groups were also compared at the end of the intervention, so that, the researcher was able to figure out and to see how the pre- control and pre-experiment test groups changed from pretest to post- test so as to evaluate on whether one, both or neither improved over time. It was also of importance to establish whether the difference was statistically significant to be attributed to the independent variable, that is, the guidance programme. In this study, Guidance programme is defined as a systematic organized programme of activities that focuses on specific HIV/AIDS information, self-esteem and Effective risk behavior reduction. The programme was specifically offered for research purpose.

In his study, “interventions to reduce sexual risk for the HIV in adolescents”, Johnson (2003), argues that HIV/AIDS information has been found to be very important in interventions that have been successful in modifying behaviour of young people who are at risk from HIV infection. Given that one of the major modes of transmitting HIV/AIDS is hetero sex, it stimulates a strong belief that change of risk behaviour is a preventive and control measure for restricting the spread of the HIV/AIDS pandemic. The overriding hypothesis is that a training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure. Identifying common Causes of Risky behaviour; identifying sources of self-efficacy and strategies for improving self-efficacy; as well as identifying causes of low Self-esteem and how to build positive self-esteem; can increase self-efficacy to choose safe sex, change safe sex attitudes and increase self-esteem among youth people living with HIV.

This section presents results of various analyses that were carried out to statistically test for differences between the two, experimental and control groups, after the experimental group was exposed to the intervention discussed above. Paired sample t-test and a chi-square test were carried out to test out differences in the two groups so as to confirm or else refute the hypothesized importance of the training. The tests involved the checking on whether there was statistically significant difference between post-experimental and post- control group in the level of self-esteem.

4.1 Comparison of self-esteem – independent sample t-test after the intervention

H₀₃: Stated that, there is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not.

In order to test whether there was a statistically significant difference in the level of self-esteem between the control and the experimental group after the intervention, an independent t-test was carried out as shown in Table: 3

Table: 3. Independent sample t-test after the intervention to see if control and experimental group's scores are statistically different after intervention

Variances	Levene's Test for Equality of Variances		t-test for Equality of Means		
	F	Sig.	t	df	Sig. (2-tailed)
Equal variances assumed	3.879	0.053	-4.493	74	0.000
Equal variances not assumed			4.493	69.011	0.000

The results of this test show that $p=0.000$. This p-value is less than the significant level of 0.05 and therefore, there is a statistically significance difference in the level of self-esteem between the control and the experimental group after the intervention.

In order to further verify these results, a Paired samples t-test was performed to check if the self-esteem scores changed between pre and post-test for experimental group. The results for the self-esteem variable are thus shown in Table: 4.

Table: 4: Paired samples t-test to check differences in scores between pre and post-test for experimental group for the self-esteem variable

Paired Differences			t	df	Sig. (2-tailed)
Mean	Std. Deviation	Std. Error Mean			
-4.697	7.263	0.833	-5.638	75	0.000

This results show that $P=0.000$ while the $t=-6.456$.

The overriding hypothesis is that a training on the impact of HIV/AIDS and intervention measures needed, various skills on how to negotiate for safe sex and serostatus self-disclosure, among others; as well as identifying causes of low self-esteem and how to build positive self-esteem, can increase self-efficacy to choose safe sex, change safe sex attitudes and increase self-esteem among youth living with HIV. The building of positive self-esteem would hence reduce risk sex behaviour. An additional test was performed, in order to confirm the results above. The test's main objective was to compare the experimental and the control group and was categorised in to high and low self-esteem. Results are shown in Table: 5

Table: 5: Comparison of control with experimental group post-test self-esteem scores (categorised in to high and low self-esteem)

Groups	Self-esteem post-test in categories		Total	
	Low self esteem	High self esteem		
Control		60.5%	39.5%	100.0%
Experimental		23.7%	76.3%	100.0%
		42.1%	57.9%	100.0%

Pearson Chi-Square 10.581 df 1 p-value 0.001

Findings of this test show that 60.5% of the control group had low self-esteem compared to the 23.7% of the experimental group. The experimental group had a high self-esteem score of 76.3% compared to 39.5% of the control group. The p-value which was ($p=0.001$) was less than the significant level of 0.05. This results show that there was a statistically significant difference between the experimental and the control group at post- test and thus the H_03 was rejected.

5. CONCLUSION

Objective three of the study, sought to examine the impact of the guidance programme on the self-esteem of YLWHA. The self-esteem was examined using the Rosenberg self-esteem scores. This Rosenberg self-esteem score was measured using 10 metrics that is feelings of being a person of worth at least on an equal plane with others, feeling of possession of good qualities, inclination towards feeling of being a failure, and capacity to do things as well as most other people. Other aspects include feelings of not having much to be proud of, taking of positive attitude towards self, holistically satisfaction with one's self, wishing of having more respect towards one's self, feeling of being useless at times and sometimes thinking of not being good at all. The scale ranged from 0-30 indicating the highest score possible. Scores between 15 and 25 are within normal range; scores below 15 suggest low self-esteem.

Findings of this test show that 60.5% of the control group had low self-esteem compared to the 23.7% of the experimental group. The experimental group had a high self-esteem score of 76.3% compared to 39.5% of the control group. The p-value which was ($p=0.001$) was less than the significant level of 0.05. These results showed that there was a statistically significant difference between the experimental and the control group at post- test and thus the H_03 was rejected. H_03 : stated that "There is no statistically significant difference in the level of self-esteem between the YLWHA who undergo guidance programme compared to those who do not". This difference can be attributed to the impact of the guidance programme in enhancing self-esteem.

5.1 Recommendations

The study recommended that the guidance programme should be adopted in reference to the enhancing of the self-self-esteem and hence risky behaviour change in all the intervention programmes amongst the YLWHA. The guidance programme should also be incorporated in other intervention programmes used in the institutions dealing with PLWHA.

5.2 Suggestions for Further Studies

The study suggests that, for further studies, the self-esteem be given adequate time as well as practical application by learners. A study should also be done on perception on influence of culture on self-esteem.

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Cite this article

- Kariuki, R.G., Muola, J.M., and Chemwei, B. (2017). The Impact of Guidance Programme in Enhancing Self-Esteem for Risk Behaviour Change among Youth Living with HIV/AIDS in Nakuru County, Kenya. *Mara res. j. humanities soc. sci.* Vol. 2, No. 2, Pages 57 - 66, ISSN: 2519-1489