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HIV Related stigma and discrimination interventions among adolescents and young people 15-24 years living with HIV in Busia HCIV.

Nekesa Gertrude[1,2*], Jane Frank Nalubega[1], Edith Akankwasa[1], Elizabeth Okello[1], David Kavuma[1]
Mildmay Institute of Health Sciences[1]
University of Manchester, UK[2]

Abstract

Introduction

The UNAIDS global estimates show that about 4400 new HIV infections occur among people aged between 15 and 24 years, of whom almost 43% are among young women.

Goal

To reduce all forms of HIV related stigma and discrimination among adolescents and young people (15-24 years) living with and affected by HIV in Busia HCIV by 70% in 12 months

Project design

The project was based on an evidence-based needs assessment that utilized the key informant approach and a root cause analysis that identified the need for a change in reducing HIV stigma and discrimination among adolescents and young people living with and affected by HIV/AIDs in Busia HCIV ART clinic. The intervention approach was based on the ADKAR theory of change, John Kotter's 8-step theory of change, incorporating the theory of reasoned action, the health belief model, adult learning theory, and the social cognitive theory. The project also examined the influence of leadership, power, culture, and policies on the change process.

Project outcomes

The project is still ongoing; however, the mid-evaluation that was done quarterly showed improving retention and disclosure of HIV status among adolescents and young people. There was also significant evidence of reduced stigma and discrimination at the facility and in the community, as seen by the social support provided by family members, and the high self-esteem and confidence among adolescents and young people, leading to improved quality of care.

Recommendation

Sensitization campaigns should be beefed up among Health workers, community leaders, and other stakeholders to address potential causes and sources of stigma among people living with and affected by HIV.

Keywords: *HIV Related stigma, Discrimination interventions, Adolescents and young people 15-24 years living with HIV, Busia HCIV.*
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Corresponding Author: Nekesa Gertrude
Mildmay Institute of Health Sciences

Introduction

The UNAIDS global estimates (2018) showed that about 4400 new HIV infections occur among people aged between 15 and 24 years, of whom almost 43% are among young women. The National HIV stigma index studies done in Uganda in 2013 & 2019 indicated that stigma is still prevalent in the community. It indicated that 1.3% of PLHIV experienced exclusion, 24% experienced internal stigma, and 34% experienced gossip. Similarly, in Busia HCIV ART clinic, 59.5% of all adolescents and young people 15-24years who had been initiated on ART in 2019. 42% had stopped taking drugs and 17% had a non-suppressed viral load as a result of stigma and discrimination (DHIS2 2019). Reducing stigma and discrimination among adolescents and young people is one of the crucial steps to removing barriers to universal access to HIV services. Eliminating stigma and

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discrimination restores dignity and respect to families and brings about equality and appreciation of differences in communities in sub-Saharan Africa. Key to note, HIV related stigma in this report is an attitude of mind founded in the tradition, culture, or belief of a community. The presidential fast track initiative on ending AIDs as a public health threat is targeting the elimination of HIV related stigma and discrimination. The road map towards zero new infections by 2030 has identified reducing stigma and social discrimination for PLWHIV as a priority. As a result, the report will discuss the rationale for change in the literature review, the project design, and the theories of change in reducing HIV related stigma and discrimination among adolescents and young people in the clinic. The report explores how power, culture, and leadership influenced the change, how resistance to change was managed, limitations, and recommendations.

Project design

The project was based on an evidence-based needs assessment that utilized the key informant approach and a root cause analysis that identified the need for a change in reducing HIV stigma and discrimination among adolescents and young people living with and affected by HIV/AIDs in Busia HCIV ART clinic. The focus of the change intervention was to promote health psychosocial adjustments and improve the quality of care of the intervention group through providing a stigma and discrimination-free environment. The intervention approach was based on the ADKAR theory of change, John Kotter's 8-step theory of change, incorporating the theory of reasoned action, the health belief model, adult learning theory, and the social cognitive theory. The project also examined the influence of leadership, power, culture, and policies on the change process. The project will give the goal, objectives, the change strategies, influence of leadership, culture, power, policy on the change intervention, how resistance to change was managed, limitations, conclusion, and recommendations.

Goal

To reduce all forms of HIV related stigma and discrimination among adolescents and young people(15-24 years) living with and affected by HIV in Busia HCIV by 70% in 12 months

Objectives

To provide an enabling environment for the elimination of all forms of HIV/AIDs related stigma and discrimination.
To provide adolescents with and affected by HIV with knowledge, skills, legal and social support, protect their rights, and empower them with options for redress.
To improve access to and utilization of health and other services by people living with and affected by HIV, especially where there are punitive laws, policies, and practices that violate human rights.
To improve on HIV positive sero status disclosure and adherence among adolescents and their sexual partners.

Strategies

A change model helps to identify areas of resistance and implement strategies designed to reduce or eliminate resistance before the change process starts. A model of change helps to create an effective communication strategy. The change was in response to the impact of HIV related stigma and discrimination among adolescents living with and affected by HIV on their quality of life. Change is complicated because it involves people, who are creatures of habit, and change upsets habits. An important factor in change being accepted is whether the change was made by us, with us, or happened to us. When change happens, there is interest, cooperation, understanding, and acceptance. It's important to recognize that organizations do not change; rather, it's people who change one person at a time. Therefore, using the ADKAR theory of change was relevant to managing internalized stigma that focused on people. John Kotter's 8-step model focused on processes in interventions to reduce enacted stigma in families, schools, and the community of adolescents and young people living and affected by HIV in the clinic.

ADKAR theory of change

Kachian et al.'s (2018) study done in Iran to assess nurses' readiness for change using the ADKAR theory of change revealed that increasing knowledge and ability of nurses to employ quality nursing, strengthens supportive factors, especially in non-teaching hospitals, and increases the participation of nurses. Similarly, Shepherd et al (2014) indicated that the ADKAR model, identification of shared governance, education of nursing leaders, and governance chairs resulted in higher nurse satisfaction, improved retention, and patient outcomes that outperformed national benchmarks. To begin with, change is any planned or unplanned transition from one state to another. However, in

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this report, a change was planned, and for the change to be successful, the project looked at starting a change with individuals who included the adolescents and young people living with HIV, and the staff who are providing the services, using the five building blocks of the ADKAR theory of change as explained below.

Awareness

Using the ADKAR theory of change, the clinic meeting was called for all the service providers to create awareness on the need for the change, in terms of why the team had to have interventions to reduce stigma and discrimination why the change was relevant but also explaining to them the risk of not reducing stigma and its effects on the young population. Equally, Bandura revealed that an increased level of awareness and knowledge of health risks is a relevant precondition for self-directed change. To achieve self-directed change, people need to be given not only reasons to alter risky habits but also the behavioral means, resources, and social support. He also emphasized that effective self-regulation of behavior is not achieved by an act of will. It requires certain skills in self-motivation and self-guidance.

Desire

During that meeting, the desire and willingness of some staff to support the stigma interventions were noticed. Desire is ultimately about personal choice, influenced by the nature of the change, an individual's situation, as well as intrinsic motivators that are unique to each person. Using the theory of reasoned action, which suggests that a person's behavior is determined by their intention to perform the behavior and that the intention is in turn a function of attitude and subjective norms. The theory helped the team leader ascertain the desire for change.

Knowledge

The theory guided, and the teams were given knowledge that represents the information, training, and education necessary to reduce stigma. It includes information about behaviors, processes, tools, systems, skills, job roles, and techniques that are needed to implement a change through empowering the adolescents /young people and the staff. Busia HIV stigma and discrimination change agents focused on empowering the young people with knowledge and information on the effects of stigma and discrimination on the quality of their lives.

Ability

Therefore, in line with the ADKAR theory of change, there was a need to assess the ability of the staff and clients to implement the stigma interventions after receiving the knowledge and information from both the clients and service providers. Where ability represents the realization or execution of the change or turning knowledge into action, and ability is achieved when a person or group has demonstrated the capability to implement the change at the required performance levels. In this case, one can have a belief that reducing stigma has positive outcomes, and a positive attitude to stigma reduction interventions will provide the ability to perform the assigned tasks. In order to assess the ability of the teams to reduce stigma among the adolescents and young people in the clinic, the members were asked if they felt that the change would improve retention in care, improve the quality of life, and if the team demonstrated a positive attitude.

Reinforcement.

Following the theory, reinforcement represents those internal and external factors that sustain a change. External reinforcements include recognition, rewards, and celebrations that are tied to the realization of the change.
Through a change readiness assessment analysis that evaluated the clinic's preparedness to change, which included the ability to initiate, follow through, and maintain lasting changes. The leader assessed individuals and working groups in terms of what motivated them, compliance with the culture, capacity, time, conditions, and resources that were available to effect the change.

John Kotter's 8-step theory of change

The theory was used to manage the processes of change that focused on creating a climate for change, engaging and enabling the health facility and the clinic to accept the change, and finally, it covered aspects of implementing and sustaining the change. Kotter's model for change emphasizes the importance of support from every level of employment. It also further prepares the employees for change, rather than surprising them with change, through the 8 steps, as explained below.

Creating a sense of urgency

According to Kotter (2012), the most important step is to identify the need for urgent change and recognize the consequences of not changing. This was relevant in that the

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formation of a powerful coalition should occur to guide the change. Using the SWOT analysis, the clinic team was able to identify the existing problems that adolescents and young people face in line with stigma and discrimination. Among others were the clinic culture, leadership, stakeholder engagements, and will to support the campaign.

Following that, the clinic staff held a meeting to openly discuss the impact of stigma and discrimination on the individual, family, and community. In the meeting, the staff discussed the challenges, threats, and possible solutions.

In line with the above, the American Holistic Nurses Association asserted that holistic care takes charge of a person fully, taking into consideration the effects of illness on the body, mind, emotions, spirit, and the person's relation with others. Also, Carson Newman University (2018) indicated that promoting the clients' emotional and psychological well-being improves retention in care of the young people, hence a good quality of care.

Form a coalition

According to the theory, forming a coalition focuses on creating a strong team with all the necessary skills, qualifications, reputations, connections, and authority to lead the change initiatives and influence the size of the team. The clinic agreed and formulated a senior guiding team of ten members that included, the clinic in charge, one adolescent, linkage facilitator, KP peer, A PLHIV representative from the community, the representative of the IP running HIV/TB programs (MJAP), representative of the CSO(UWESO) taking charge of the OVC issues, religious leaders, facility in charge, representatives of the care givers, village local councils.

Additionally, the role of the implementing partner (MJAP) was to provide technical advice on the management of the adolescents and young people in care at the clinic through roll out of Uganda HIV/AIDS consolidated clinical guidelines 2020, dissemination of the Uganda HIV/AIDs stigma and discrimination policy 2020, facilitation of stake holder evaluation meetings, resource mobilization to enable project implementation through collaboration.

The members further agreed and formed a field guiding team of eight members that aimed at promoting the vision and leading through the process and consisted of two yaps, one counsellor two care takers/guardians of some of the adolescents in care, clinician, linkage officer, and a patient safety focal person who is living with HIV and elected by the clients in care.

Also, the change teams that were formed included the above team leads, whose roles were to ensure that all the tasks were performed effectively and in time. The key stakeholders met weekly to serve as a powerful coalition and to be accountable for action items.

Aga et al.'s (2016) study demonstrated that team building partially mediates the effect of transformational leadership on project success. Key to note is that Power triggers a readiness to think, speak, and act, raising vigor and frequency of output (it energizes or activates people), it brings clarity of focus and eagerness. Therefore, the leaders here had the power and influence to think and act in a manner that directs towards managing the change. Similarly, Mburu et al (2014) indicated that group-based approaches in the delivery of HIV services are opening up new avenues for the collective participation of people living with HIV to challenge HIV stigma and act as agents of social change. Therefore, Interventions that increase the resilience and coping mechanisms of individuals to those that build the capacity of groups to collectively cope with and challenge HIV stigma were gender sensitive and respond to contextual social, economic, and structural factors that drive stigma.

According to Zajac& Westphal (2017), the study shows how social psychological and social political factors can create divergence in the preferences of an incumbent CEO and existing board regarding the desired characteristics of a new CEO, and how relative CEO/board power can predict whose preferences are realized. More powerful boards are more likely to change CEO characteristics in the direction of their demographic profile.

Likewise, the coalition team used the power of information to change staff attitudes towards intervention of HIV stigma and discrimination reduction among Adolescents and young people living with HIV/AIDs in the clinic.

Diversely, Fiske (1993) proposed that power decreases social attention because power holders are overloaded with other priorities, are not dependent on others, or have a dominant personality and do not want to pay attention.

Form a vision

The health facility's mission to improve the health and well-being of the communities that we serve guides the HIV stigma reduction. To that end, we had a clear and compelling vision. Inherent in our vision was that these best practices would ensure efficiency, optimal outcomes, and client satisfaction. The senior guiding team therefore formed a vision which stated as" having an enabling environment free from stigma and discrimination among adolescents and

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young people living with and affected by HIV in Busia HCIV clinic." The team further defined the strategies that would lead it to achieve the vision.

Communicate the vision

Guided by Kotter's (2012) recommendations on how to effectively communicate the vision to all stakeholders, leaders adopted multiple methods to articulate a simple message that was conveyed to all departments and committees. The field guiding team started their roles by communicating the vision using the facility communication channels that included health education of the clients, CMEs for the technical staff, and dialogues with stakeholders. Also noting that service providers discriminate through assumptions and judgments, and yet they are to provide appropriate services and recognition of needs. According to the WHO, health literacy is an outcome of health education; it represents the cognitive social skills that determine one's motivation and ability to gain access to understand and use information in ways that maintain and promote good health. According to Maiese (2003), dialogue is a small communication process in which participants learn of things they have never said or heard before. It enhances learning and development of shared understanding; it also seeks to inform and learn, rather than to persuade. Dialogues focused on relationships and the joint process of making sense of each other rather than winning or losing.

The dialogues held with the young people and stakeholders have enabled people to discover how hidden values and intentions control individual behaviors, and this either improves or fails the communication between service providers and young populations. By improving the accessibility of health information and the capacity to use information effectively, health literacy is critical to empowerment. According to Clarke (2007), empowerment and effective communication, the ability to reflect on work challenges, and the availability of supportive training provide a good learning environment at work; informal and formal learning are also associated with differing environments. Conversely, Cowan's (2019) study indicated that community empowerment, approaches where young populations work collaboratively to address their specific priorities and concerns, help improve structural, behavioral, and biomedical approaches. This can facilitate improved HIV outcomes by tackling barriers to uptake and retention of services as a result of HIV related stigma and discrimination.

Remove obstacles to change.

Several obstacles impeding conversion to stigma free culture were identified and included lack of awareness of the impact of stigma and discrimination, limited engagement of family members in the management of adolescents and young people in HIV care, limited engagement of stake holders in stigma reduction interventions, lack of a change agent, inadequate finances, poor leadership, lack of support by senior management, negative cultural norms and attitudes of PLWH. The clinic leads assessed factors that would limit the change and also assessed if the game changers were over-tasked with daily activities, if they felt they didn't have the skills or resources to make the change, or were overwhelmed by changes that had not worked before.

It was of great relevance to eliminate obstacles to change, and this was done through Clarification of goals and objectives, proper resource distribution.

Task analysis, non-monetary rewards, and the development of interpersonal skills through improving communication.

Create short-term wins.

After implementation of the changes staff at all levels began to see clear, tangible, and positive results, Kotter's (2012) short term wins are a crucial factor in change process, purposefully collected best practices from lived experiences of stigma among the youth, peer to peer sharing of scenarios The specific hospital context influenced staff perception and experience. Therefore, Motivation is an individual's degree of willingness to exert and maintain effort towards organizational goals. Motivation to the change agents was done in the clinic through routine appreciations like thank you during monthly feedback sessions.

Similarly, Shattuck et al (2008) findings indicated that the financial incentives alone are not enough to motivate health workers. It is clear that recognition is highly influential in health worker motivation and that adequate resources and appropriate infrastructure can improve morale significantly. Although most staff felt motivated to work, not being motivated was associated with a lack of daily supervision, a lack of awareness of the availability of HIV/AIDs counselling, using ART, stigma impacts, and working overtime.

Strengthen change

As Kotter emphasizes cultural change remains a work in progress, regression to old habits and practices will occur if sustainability is not a key focus shared by all, ensuring this

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requires a mindset of continuous performance improvement that despite successes, the welcoming of fresh ideas and looking for new change agents and leaders is imperative. to maintain the momentum HIV stigma champions continue to meet regularly to evaluate progress and set future goals.

All the change interventions and strategies were being maintained through supervision of the tasks assigned. As Dieleman et al (2007) agreed that HIV/AIDs is a crucially important contextual factor, impacting on working conditions in various ways, through opportunities that already exist, such as better use of supervision, educational sessions, and staff meetings, would strengthen the change.

Sustain the change.

Sustaining the change was done through reviewing the cultures instituted in the clinic during the change, and the leadership styles of the team managers.

(Logie et al 2018) Findings indicated that women are less likely to disclose than men for fear of the consequences, such as intimate partner violence, economic loss to unknown or discordant couples. This is well elaborated in commitments 3 and 4, which state that countries should ensure access to HIV prevention services that include PREP, VMMC, Harm reduction, and condom distribution in young women and adolescents in high-prevalence countries and key populations, as defined by the WHO and the Uganda strategic plan 2018. commitment 4 seeks to eliminate HIV related stigma and discrimination that leads to avoidance of health care among key populations because of stigma and discrimination.

Culture

HIV stigma and its diversities in different cultural settings are the primary reasons for the limited response to this pervasive phenomenon. Culture refers to the shared beliefs, practices, and ways of life that make individuals a community. Central features of culture include beliefs, practices, and systems. Furthermore, Atkinson explains organizational culture as the way work is performed, what is accepted and not accepted, and what behavior and actions are encouraged and discouraged. Other scholars define Culture as the collection of traditions, values, policies, beliefs, and attitudes that constitute a pervasive context for everything we do and think in an organization.

In Busia HCIV, Culture is reinforced through the system of rites and rituals, patterns of communication, the informal organization, expected patterns of behavior, and perceptions of the psychological contract. In line with the above, the team worked on the physical and social environment of the adolescent clinic. In terms of the physical space and social layout, deployment of stigma and discrimination change agents, provision and display of IEC materials against stigma and discrimination among adolescents.

The team developed a task culture that aided in bringing together resources and people, and this helped distribute the members in line with their expertise and interests.

Influences of culture on HIV stigma and discrimination.

According to Tarkang et al (2018), a cultural and values-based approach focusing on the ubuntu concept should be used to reduce HIV stigma and discrimination. The study revealed that the Ubuntu tradition of basic respect and compassion for others would expect positive attitudes towards PLWH. The Ubuntu tradition prescribes a rule of conduct and social ethic with values of intense humanness, caring, sharing, respect, compassion, and associated values. Therefore, ensuring a happy and quality human community life in the spirit of family.

Although Cultural heritage is made up of knowledge, experiences, meanings, and symbols, notions of time and history, roles, material objects, and possessions that are acquired through the individual and collective striving of a group, it is passed on from one generation to the next. Many of the adolescents and youth in the clinic had no experience of cultural heritage that improved their self-esteem.

Dimensions of culture that were assessed by the team included language, education, architecture, food, music, literature, Patterns of relationships, patterns of communication, patterns of handling emotions, approaches to conflict, and problem solving. In addition to that, the Values concept of time and history, concepts of origins and ancestry, and the conception of justice, where Cultural norms were accepted ways of behaving, relating, and doing things within the group or organization.

When people live outside their cultural norms, they may be temporarily cut off from their roots, or they may be completely rejected. When people are stigmatized, they become vulnerable to exploitation and abuse. People make judgments about behavior as being right or wrong without explaining the benefit or harm attached to the behavior. The concept on which stigma interventions were derived was explained to the clinic, and the adolescents were given information on how stigma and discrimination can affect their lives.

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Similarly, Airhihenbuwa et al (2014) found that public health and health behavior interventions should focus more on culture than behavior to achieve meaningful and sustainable change resulting in positive health outcomes. To change negative health behaviors, one must first identify and promote positive health behaviors within the cultural logic of its context.

Focusing on positive behavior and sustaining cultural and personal transformations requires a culturally grounded approach to public health interventions, such as the PEN 3 model that the change agents focused on. Culture played a vital role in determining the level of health of the individual, family, and community.

Studies have indicated that the behavior of the individual about family and community is one major cultural factor that has implications for sexual behavior and HIV/AIDs prevention and control efforts.

In this case, PEN 3 involved relationships and expectations, cultural empowerment, and cultural identity. The team looked at relationships at the family, school, and community levels where these adolescents and young people were coming from, and the benefits of reducing stigma and discrimination among adolescents and young people.

The empowerment messages focused on the emphasis placed on long-term survival or growth and development, and the influence of the environment on the PLHIV or those affected by HIV. Key to note is that culture helps account for variations among organizations and managers, explains why different groups of people perceive things in their own way, and perform things differently from other groups.

According to the aids health Foundation in South Africa, shifting cultural norms helps reduce stigma and discrimination, although guilt and shame kill motivation, kill hope, and kill people. However, men can change stereotypes of stigma by being engaged fathers and being sexually responsible. Reducing the number of partners and refraining from being absent fathers. Also, rejection of stigma opportunities in the cultural settings, through providing information, training, and new perspectives on the impact of stigma and discrimination among peers. And reaching more people through community dialogues and radio talk shows.

How leadership influences change

According to Karan et al (2017), the study indicated that political leadership is a critical pillar in reducing HIV related stigma and discrimination among the youth. Also, Campbell et al (2011) revealed that some churches have managed to move towards action that makes a more positive contribution to HIV/AIDs management. Through promoting various forms of social control of HIV prevention. Likewise, a study on the coping abilities of patients with HIV revealed that intense spiritual moments allowed them to better cope with pain, anxiety, despair, and impending death.

In line, with that the North American Nursing Diagnosis Association defined spiritual distress as a state of suffering related to impaired ability to experience meaning in life through connections with self, others the world and a superior being it is characterized by anxiety, crying, fear, guilt, fatigue, hopelessness, insomnia and isolated hunger and all these symptoms affect one's behavior towards health care and keeping appointments in care.

Contributing to the care and support of the AIDs affected and providing social spaces for challenging stigmatizing ideas and practices, church groups can support or hinder the creation of supportive social spaces to challenge stigma. Putting into consideration that the religious leaders could fuel discrimination through Selective quotations, myths, and silence. Although they still have potential to contribute to the change by having leaders who speak out by openly embracing diversity, challenging stigma based on religion.

Societally, laws, rules, policies, and procedures may result in the stigmatization of PLWHIV. Compulsory screening and testing of groups and individuals. Prohibition of PLHIV from certain occupations and types of employment. Infected and affected family members can still be stigmatized and discriminated against within the home.

Power influences change

Influence is the ability to change how someone else behaves or thinks based on persuasion instead of authority. The power of information is what was used with evidence-based knowledge to influence people against HIV/AIDs related stigma and discrimination.

Undoubtedly, Guinote's (2017) study demonstrated that socio-cognitive research has demonstrated that power affects how people feel, think, and act. A growing literature shows that power energizes thought, speech, and action and orients individuals towards seeking salient goals linked to power roles, predispositions, tasks, and opportunities. Power magnifies self-expression linked to active parts of the self-regulation and prioritization of their efforts towards advancing focal goals.

The effects of power on cognitive processes, goal preferences, performance, and corruption are discussed, and its potentially detrimental effects on social attention are

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discussed. "The fundamental concept in social science is power, in the same sense in which energy is the fundamental concept in physics," Bertrand Russell.

During the change interventions, the selection process of roles and responsibilities focused on assertiveness. Dominance refers to motivated behavior aiming at increasing power over others and is associated with forceful, assertive, and confident actions. Dominant individuals have strong agendas, particularly in seeking power; they deploy a great deal of effort and energy to prevail over and influence others.

Managing resistance to change

Resistance to change is the unwillingness to adapt to new circumstances or ways of doing things, and it's commonly rooted in the fear of the unknown. To be successful, the leader or change agent must use their knowledge of motivation, leadership, team building, conflict management, communication, and negotiation skills to communicate. Therefore, during the project implementation, there were a few members expected to resist the change interventions; therefore, the team lead was able to show the value in the new change by educating employees on the impact of stigma and discrimination on adolescents and young people with lived examples of testimonies in the clinic. As one of the members said, "that stigma will never end, it has been there and will always be there". By sharing experiences that touched everyone's heart, the members agreed that there was a need for the change, and then we scheduled a planning meeting with all the stakeholders to plan for the change.

According to Fernandez (2017), the successful implementation of organizational change requires lower-level participation and top management direction. Even so, the project focused on engagement of top management in terms of goal setting that motivates behavior change to the extent that they are seen as consistent with demands of reality, they are action-centered, stated in terms of everyday activities, and were associated with improved self-image linked with progress.

Monitoring and evaluation

The project had a monitoring and evaluation plan that included quarterly performance reviews that looked at retention of adolescents and young people in care and viral load suppression. The progress of the intervention was also monitored using the HIV related stigma and discrimination questionnaire, which tracked selected indicators of the level of stigma and discrimination at the community, health facility, and individual level of adolescents and young people living with HIV in the clinic.

Action plan

	Action	Evidence-based Rationale	Timescale	Evaluation
Knowledgeable adolescents and young people on the HIV/AIDs stigma and discrimination interventions (using the ADKAR theory of change and John Kotter's 8-step theory of change	Conduct health education sessions, conduct CMEs for service providers Conduct radio talk shows Conduct stakeholder dialogue meetings	To increase awareness of people on the impact of HIV /AIDs stigma and discrimination, and create a stigma-free environment	continuous	Schedule for health education Reports for CMEs Minutes for dialogue meetings
Have a stigma-free environment.	Conduct stakeholder engagement meetings.	To have full involvement of all stakeholders, both in schools and the community, to eliminate resistance to change	continuous	Participation of all stakeholders in the change processes

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Conclusions

The project is still ongoing; however, the mid-evaluation that was done quarterly showed improving retention and disclosure of HIV status among adolescents and young people. There was also significant evidence of reduced stigma and discrimination at the facility and in the community, as seen by the social support provided by the family members, and high self-esteem and confidence among adolescents and young people, leading to improved quality of care.

Limitations of the project

The project supported individuals, families, and visited schools of adolescents and children receiving care at Busia HCIV. The project was also limited to the implementing partners' activities and budget lines. The change agents were limited to only four radio talk shows on HIV related stigma and discrimination that were supported by the implementing partner.

Abbreviations

HIV: Human Immunodeficiency Virus
ART: Anti-retroviral therapy
WHO: World Health Organization.
PHDP: Positive Health Dignity Prevention
UAC: Uganda Aids Commission
PLHIV: People Living with Human Immunodeficiency Virus
GBV: Gender Based Violence
SRHS: Sexual Reproductive Health Services
UPHIA: Uganda Population-based HIV Impact Assessment
ALWHIV: Adolescents Living With HIV
YLHIV: Youth Living with HIV
PFTI: Presidential Fast Track Initiative
NSP: National Strategic Plan
UDHS: Uganda Demographic Health Survey
DREAMS: Determined, Resilient, Empowered, AIDS-Free, Mentored, and Safe

Source of funding.

The study was not funded.

Conflict of interest.

The author did not declare any conflict of interest.

Availability of data.

Data used in this study are available upon request from the corresponding author.

Author contribution

Jane Frank Nalubega supervised all the stages of the study, including manuscript drafting.
Edith Akankwasa supervised all the stages of the study, including manuscript drafting.
Elizabeth Okello supervised all the stages of the study, including manuscript drafting.
David Kavuma supervised all the stages of the study, including manuscript drafting.

Author biography

Nekesa Gertrude is a student at Mildmay Institute of Health Sciences
Jane Frank Nalubega is a tutor at Mildmay Institute of Health Sciences
Edith Akankwasa is a tutor at Mildmay Institute of Health Sciences
Elizabeth Okello is a tutor at Mildmay Institute of Health Sciences
David Kavuma is a tutor at Mildmay Institute of Health Sciences

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