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Adolescent Girls' Experiences of Shame When Diagnosed with HIV/AIDS: A Qualitative Study in Zimbabwe

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Abstract

Despite the decline in HIV incidence, two out of every seven new HIV infections globally in 2019 occurred among young people aged 15–24, with 1.7 million adolescents and 3.4 million young people living with HIV. This study explored the lived experiences of shame among adolescent girls living with HIV (AGLWHIV) in Zimbabwe, guided by the research question: What are the experiences of shame among adolescent girls following an HIV/AIDS diagnosis? The objective was to understand the sources, expressions, and impacts of shame on self-perception, relationships, and well-being. A qualitative exploratory design was employed, involving in-depth semi-structured interviews with ten adolescent girls aged 17–19 years recruited through a qualified psychologist in Harare, Zimbabwe. Data were thematically analysed and interpreted through the lens of self-psychology, which provided a framework for understanding how threats to self-esteem, empathy failures, and disruptions in self-cohesion contribute to the experience of shame. The findings indicated that shame was prevalent in the participants' lives, stemming from internalised cultural and moral biases that diminished self-esteem and aspirations. Coping mechanisms were also identified. The study highlights the need to address shame — and not only stigma — in HIV interventions and policies to enhance psychological well-being and care engagement.

Keywords: shame, HIV, adolescents and young people, Zimbabwe

Introduction

This article presents a qualitative study investigating the lived experiences of shame among adolescent girls living with HIV in Zimbabwe. By exploring how shame manifests and affects daily life, the study sought to inform targeted psychosocial interventions for this vulnerable population.

Human immunodeficiency virus (HIV) remains a major global health crisis with far-reaching implications (Duffy, 2003). As of 2023, an estimated 39.9 million individuals worldwide are living with HIV, including 2.38 million children and adolescents aged 0–19 years, with sub-Saharan Africa bearing the highest burden, with 65% of the global HIV-positive population residing in the region (UNAIDS, 2024; UNICEF, 2023). Heterosexual intercourse is the primary mode of transmission, with women disproportionately affected compared to men (Duffy, 2003; Murewanhema et al., 2022). Building on this context, it is important to consider the specific challenges faced by young women and adolescent girls within these statistics.

Young women and adolescent girls aged 15–24 are particularly vulnerable, with approximately 4,000 new HIV cases reported each week globally in 2023, 3,100 occurring in SSA (UNAIDS, 2024). This heightened risk for young women can be attributed to various factors, including age-disparate or transactional relationships, gender-based violence, patriarchal norms, limited educational opportunities, food insecurity, and practices such as genital mutilation (Dellar et al., 2015). Additionally, as of 2011, 92% of HIV-positive pregnant women were from Sub-Saharan Africa, highlighting a significant risk for mother-to-child transmission — with potential implications for shame experienced by adolescents who are either vertically or horizontally infected with the virus (Ramjee & Daniels, 2013). The Zimbabwean context reflects these broader patterns; 5.5% of people living with HIV are children aged 0–14 years, and 5.9% are adolescents aged 10–19 years (UNAIDS, 2023). Undiagnosed HIV is a leading cause of illness, hospitalisation, and mortality among adolescents in Zimbabwe, indicating similar challenges may be present in other developing countries (Lowenthal et al., 2014). Delayed diagnosis often results in severe health consequences, such as stunted growth, tuberculosis, and other opportunistic infections, exacerbated by weakened immune systems during periods of increased social interactions (Lowenthal et al., 2014).

Advances in antiretroviral (ARV) therapy have improved physical health and life expectancy for children living with HIV (Collins et al., 2010). However, as children transition into adolescence — a developmental stage characterised by identity exploration, autonomy, and the formation of peer relationships — the demands of managing a chronic, stigmatised illness intersect with these developmental tasks in ways that can create trauma. Daily ARV adherence requires strict routines that may conflict with adolescents' desire for independence and spontaneity. Regular clinic visits can disrupt school, social activities, and peer engagement and may expose adolescents to stigma or force them to disclose their status prematurely. Decisions about disclosure, coupled with uncertainty about their health and future, heighten stress and anxiety. These challenges interfere with the normal processes of identity formation, self-concept development, and social belonging, creating a compounded form of developmental trauma where adolescents ought to navigate both the psychological and social burdens of a chronic illness alongside typical developmental pressures (Lowenthal et al., 2014; Schimmenti & Caretti, 2016). Consequently, this layering of chronic illness management onto adolescence increases vulnerability to anxiety, depression, shame, and difficulties in emotional regulation, while also complicating treatment adherence and engagement with social networks (Brooks et al., 2024; Lowenthal et al., 2014).

Despite significant improvements in physical health outcomes for individuals living with HIV, the emotional and psychological challenges associated with the condition remain profound and inadequately explored (Lowenthal et al., 2014). Existing literature predominantly focuses on stigma, a pervasive factor that hinders access to medical care and discourages the disclosure of one’s HIV status (Lowenthal et al., 2014). To fully understand the psychosocial impact of HIV, it is crucial to differentiate between external stigma, internalised stigma, and shame — concepts that are often conflated (Fortenberry et al., 2002). External stigma refers to negative or discrediting attitudes and beliefs based on physical, health, or behavioural attributes (Goffman, 1963). Internalised stigma is when the negative societal beliefs about a particular identity or condition are internalised, affecting your self-worth. Enacted stigma or discrimination occurs when stigma is acted upon in any form of exclusion, restriction, or distinction (Ferguson et al., 2022).

Shame, a key component of internalised stigma, arises from societal attitudes and internal beliefs, often leading individuals to view themselves as inherently flawed (Fortenberry et al., 2002; Dolezal, 2022). Shame makes a person feel as if their whole self is flawed and unworthy, often triggered by an incident, such as a personal failure or social rejection. Shame is a self-conscious emotion that can be experienced as autonomous or heteronomous (Hutchinson & Dhairyawan, 2018). As an autonomous emotion, a person can feel ashamed about failing to meet personal standards or expectations regarding their character, morals, personality, or identity. Shame becomes a heteronomous emotion when others judge them, or fail to meet societal norms, values, and standards. Therefore, enacted, internalised, and anticipated stigma can lead to shame as they trigger heteronomous and autonomous shame in people living with HIV (Hutchinson & Dhairyawan, 2018).

Adolescent girls bear a disproportionate burden of shame. In Zimbabwe, adolescents aged 15–19 report the highest rates of feeling ashamed of their HIV status (33.3%) and blaming others for infection (30.4%) (ZNNP+, 2014). The Zimbabwe Stigma Index (2014) further highlights that HIV-positive adolescents experience social avoidance, isolation, and exclusion by peers and community members, intensifying feelings of shame. Despite this evidence, research exploring how these experiences shape daily life, self-perception, and coping strategies among adolescents living with HIV remains limited (Nabunya & Namuwonge, 2023). Although previous research highlights stigma and psychological challenges among HIV-positive adolescents, limited attention has been given to the specific experience of shame. Understanding these experiences is essential to designing effective interventions. Therefore, this study explores how shame affects the daily lives, self-perception, and coping strategies of adolescent girls living with HIV in Zimbabwe.

Research aim and objectives

The primary aim of this study was to understand the lived experiences of shame among adolescent girls living with HIV in Zimbabwe. Specifically, the study sought to answer the following research questions:

1) How do adolescent girls living with HIV describe and experience shame?
2) What are the psychosocial and emotional effects of shame on their daily lives?
3) How do societal attitudes, stigma, and family dynamics contribute to experiences of shame?

The following sections outline the study design, data collection methods, and analytical procedures used to investigate these experiences. By addressing these questions, the study contributes to a deeper understanding of the emotional and psychological challenges faced by adolescent girls living with HIV and informs interventions to support their mental health and well-being.

Methods

Study design and theoretical framework

This study employed a qualitative exploratory design to investigate the experiences of shame among adolescent girls living with HIV. The study was guided by self-psychology (Kohut, 1971), which emphasises the development and maintenance of the self through interpersonal relationships and the experience of empathy and mirroring. Self-psychology provides a lens to understand how shame can disrupt self-cohesion, self-esteem, and identity formation, particularly during adolescence, a critical stage of self-development. The framework informed the development of the semi-structured interview guide, prompting questions that explored participants' experiences of self-worth, perceived flaws, relational dynamics, and societal influences contributing to feelings of shame. This theoretical grounding ensured that the interviews not only captured participants lived experiences, but also explored how shame impacted their sense of self and social functioning.

Sampling and recruitment

A purposive sampling method was used to select ten adolescents from the AFRICAIDs Zvandiri programme in Harare, Zimbabwe. Zvandiri is a local voluntary organisation that provides large-scale support to young people living with HIV (PLHIV) through trained peers who connect with and support them to survive and thrive. Zvandiri acted as the gatekeeper, with administrators facilitating access to potential participants. Recruitment occurred during support group meetings, where the gatekeeper introduced the researcher.

The sample included low- to middle-class Zimbabwean females aged 17–19 years. Participants were included if they were living with HIV, able to provide consent or assent, and in good mental and physical health. Those unable to consent or with serious mental disorders, such as schizophrenia, were excluded. The small sample size (n=10) is consistent with qualitative research standards, allowing for in-depth exploration of participants' lived experiences. The focus was on rich, nuanced data rather than broad generalisability.

Data collection procedures and instruments

In-depth semi-structured interviews were conducted to allow participants to freely express their experiences of shame (Ritchie et al., 2013; Bernard & Ryan, 2009; Cohen & Crabtree, 2008). Individual interviews were chosen due to the sensitive nature of the topic, providing a safe and supportive environment.

The semi-structured interview guide, informed by self-psychology, included open-ended questions that explored participants' self-perceptions, experiences of relational support or rejection, and coping strategies for managing shame. Interviews lasted 60–90 minutes, were conducted in Shona at Zvandiri House, and participants were allowed to ask questions. Transport reimbursements were provided, and interviews were scheduled following participants' written expression of interest. For participants under 18, carer consent and participant assent were obtained.

Data analysis

A thematic analysis was conducted to interpret the data, capturing the complex meanings in participants' narratives. An inductive approach allowed themes to emerge naturally, while self-psychology guided the coding and interpretation process, focusing on disruptions to self-cohesion, internalisation of societal attitudes, and strategies to maintain or restore self-integrity (Denzin et al., 2006; Holloway & Jefferson, 2000). All interviews were transcribed and translated by the researcher, with personal identifiers removed to preserve confidentiality. Initial codes were developed, colour-coded, grouped, and examined for connections, and these were refined into themes and subthemes. Themes were later reviewed and validated by the study team to ensure accuracy, coherence, and alignment with the theoretical framework.

Ethical considerations

The study received ethical approval from the University of Cape Town, South Africa, and the Medical Research Council of Zimbabwe. Participants were fully informed about the study's purpose, their voluntary participation, and their right to withdraw at any time without repercussions. Confidentiality was strictly maintained; only the interviewer had access to identifiable data, and personal identifiers were removed from transcripts. Zvandiri continued to provide psychosocial support to all participants during and after the study, with additional care options available if required.

Results

Ten adolescents living with HIV participated in the study. Seven (70%) were double orphans, and three (30%) had one living parent. Participants' ages ranged from 15 to 24 years. Most were attending school, although some experienced absenteeism due to illness. Understanding these demographics provides context for their experiences of HIV-related shame.

Three overall main themes describe the participants discussion of shame: drivers of shame, reactions to HIV associated shame, and self-beliefs. Each of these main themes are discussed with the sub-themes that arose within them.

Drivers of shame

Association of HIV with sex

Participants were ashamed of their diagnosis because of the assumed mode of transmission, sexual activity and promiscuity. Worries about fault, blame and responsibility for HIV acquisition where drivers of shame:

> "I cried all the way in the bus because I was hurting. I was like, but it's not my fault – like you know the ways of transmission of HIV, mostly it's through sexual intercourse. The chances of using sharp utensils are fewer and so …" (P 3).
>
> "I did not get into the bar to look for it so where did I get it? I wasn't promiscuous so where did I get it from?" (P 7)

Participants were also worried and ashamed of HIV acquisition in relation to future sexual relationships and disclosure:

> "HIV positive people who want to indulge but especially if you are a girl, if you indulge, you lose your virginity then you want to get married, you can't disclose to your boyfriend or husband stuff…. coz they will say, "You were sleeping around … how can I marry someone who was sleeping around? I don't know where you got that disease and stuff." (P 6)

Bodily capacity

The body was seen as providing proof of HIV infection thus exposing one's status to others, leading to shame, humiliation and social out casting:

> "… my face, everywhere it was just …. skin peeling, scars, ring worms all of that was on my body… in my family, the finger pointing was already there but at school, through seeing all that, they began to point fingers at me and say I am positive" (P 7)

Being sick was seen as shameful as the body's capacity to do things was reduced. The weakness and abnormalities that the participants were experiencing induced shame:

> "… she gave me a bottle to put phlegm… I failed to do it because I was weak, and I couldn't. I was truly sick at that time." (P 7)

Weight loss and stunted growth particularly late development of secondary sex characteristics were associated with the shame of being viewed as a child when one ought to be a woman:

> "… Some other adolescents have very small bodies and yet their age does not comply with the appearance of their bodies. So, really dating can be a huge challenge because obviously a guy can't approach you seeing that you look thirteen". (P 9)

Participants were also mindful of how family members responded to them being sick with shame and humiliation being associated with ill health while acceptance was linked to health and wellbeing:

> "… I was changing, skin it was clearing… to my surprise – my family – food that I would leave they started eating it …" (P 10)

Medication

Participants struggled with the burden of taking medication for life.

> "… can you really survive like this, taking medication? … In the morning and in the evening umm it's hard". (P 2)

Taking medication both risked exposing participants' HIV status and was essential for managing the virus and related illnesses. This created internal conflict about taking it. Side effects like vomiting, weight loss, rashes, and delayed development made them worry about revealing their status. Despite these challenges, the medication also acted as a safeguard, preventing serious illness that could otherwise expose their condition and cause shame:

> "…. I could have defaulted and maybe could have fallen very ill and then people could actually realise that I have HIV … " (P10)

Participants experienced anticipatory shame of peers discovering their medication in social settings resulting in humiliation and social out casting. One participant avoided going to a camp fearing that her HIV positive status would be exposed when she takes her medication:

> "… I was afraid of taking the pill. You know how girls are, "What's in your bag? Can I see?" "Then she would start removing everything in the bag … And then suddenly the container of the pills can just fall out." (P 3)

Another participant was also uneasy about her teammates finding out about her status, thus she would device ways of taking her medication without them knowing about it:

> "… Coming from breakfast it would be time for me to take my medication ... I would walk fast and tell others that I am rushing to do something in the room so that I could take my medication before they arrived… If they got to the room before me, I would make sure that I would be the last one to get out of the room..." (P 2)

The need to conceal and come up with excuses for taking medication, also point to the shame of exposure and others discovering one's status. The medicine containers were also a cause of concern:

> "… I saw some of my friends suspecting because I did not change the containers of pills… I just took the pills without thinking about it or seeing that they were around … so there was just one friend who was like "ah that container?" … and I was like "no I couldn't find any useful container at home, so this one was more preserving than the right one" (P 6)

Family circumstances

Participants and their parents were judged and seen as being at fault or to blame for HIV acquisition, resulting in family members having little compassion for their plight:

> "…My granny when she gets upset with me would say "that's why your mother died of HIV and was in the business of bringing sickness here!" (P 4)

Seventy per cent (n=7) of the participants where double orphans while 30% (n=3) had one parent who was still alive. This meant that most of the participants were looked after by siblings and other extended family members who worried about HIV acquisition. Most participants reported facing caregiving challenges and rejection which made them prone to shame about HIV acquisition:

> ".... My sister and brother-in-law used to constantly fight, "She should leave this place" with my sister saying, "No she is not going anywhere!" (P 7)

Participants expressed not receiving good parenting as often the families they joined had other caring responsibilities. Additionally, participants felt that their caregivers where ashamed of them being HIV positive resulting in exclusion from family events. This increased participant's shame about HIV acquisition:

> "... When they are taking their children and going out … I couldn't go coz I was very thin – maybe they were ashamed of walking with me, I don't know [*crying*]" (P 10)

Furthermore, their caregivers would treat the participants' differently to their siblings or other children. This isolated them from others worsening the feelings of being flawed which caused shame:

> "… I slept by myself … My own plate, a cup that was well known that it was (Participants name)" (P 8)

Participants who were being raised by their parents mentioned that their caregivers' reactions to HIV acquisition had a bearing on their experiences of shame. A participant reflected on her mother's despair and shame about her own status which affected how she viewed herself and HIV:

> "… If someone knocks at the door, she leaves for the other room and then stays there until the visitor leaves... So, she is really in great pain because if she wasn't she could still live like she did before she knew she has HIV... "(P 3)

Reaction to HIV related shame

Resistance to testing

Most of the participants did not get tested for HIV until they were very ill, often despite their parents' death. Parents whose children tested positive for HIV avoided being tested themselves:

> "My father … I asked him a question "Are you on treatment?" … Then he said, "I have not been tested." …He is the kind of person that does not want to be tested!" (P 9)

Shame made it difficult for parents to be tested for HIV and have their children tested as well. This delayed diagnosis and treatment, a huge challenge that causes infant mortality in Zimbabwe and SSA:

> "… My mother, when my dad died …. when she started feeling sick, she went and got tested. She didn't think about taking her child to get tested because I was strong … then I started being sick as well…. they were just saying "It's just a child who is being troublesome because she is the youngest…" (P 4)

Some participants and their caregivers also tried to avoid testing by attributing sickness to evil spirits and demonic manifestations:

> "At first, they were going to white garment churches seeking help … saying, "Our daughter is sick and we do not know what is causing the sickness". So, I was being given roots, herbs, and water … but it was not helpful." (P 1)

Denying sickness/associating illness with HIV

Despite the apprehension associated with being tested and the shame of being diagnosed, participants were often tested because of sickness. All the participants reported that they were constantly unwell, but their illness was misdiagnosed or dismissed. Although the sickness was quite serious, they generally did not attribute it to HIV:

> "Well [laughing] … it was something that I couldn't believe I was going to be. Like even if – no matter how sick I was I would never think that it would like lead into being positive." (P 9)

Participants had to be seriously ill or frustrated by misdiagnosis and always being sick for them to be tested:

> ".... Aargh [Irritation]. Ah then I shouted, "Ah I want to be tested". The nurse was like "Ok, you want to be tested?" Let me put her words, ah she was like "What do you know about being tested, you?" and then I said "I want to be tested for HIV because I am always sick and each and every month I come here" … (P 6)

Some of the participants were encouraged by others to be tested. This was in response to the various symptoms that were associated with HIV:

> "… When I got herpes that is when my sisters' friend suggested that I should be tested, and I was found to be positive." (P 8)

> "My mom just said … I started developing a rash and then she said, "This rash I usually see it on others, this rash" … that was the proof". (P 2)

Secrecy, hiding and withdrawal

Participants felt they had to hide their status and do everything possible to avoid exposure. Fears of exposure were supported by the law as non-consensual disclosure of HIV is a crime:

> "… She knows that if you disclose someone's status you will be imprisoned "(P 7)

Secrecy or hiding included participants wearing clothing that covered parts of their bodies with rashes suggesting infection:

> "… Some also grew hepatitis B, and that is the actual symptom of HIV, so they cannot wear those clothes that can reveal their shoulders. If it's on the hands, they are only usually in long sleeves...." (P 5)

At school, some participants had letters explaining that they had other diseases and should be excused from certain activities thus concealing their status and averting shame:

> "… Like they wrote a letter to my school saying that I had chest problems … and the fact that I had HIV was not mentioned …" (P 6)

Those who did disclose their status at school had the misfortune of having it spread around, validating the need for secrecy:

> "That's the only one I could tell, but the teacher was not trustworthy … but told the headmaster … and then the whole school knew about it. It was … bothering me until I got transferred from the school. " (P 8)

Even in family, friendships and interpersonal relationships secrecy was valued because of fear of exposure. Living with HIV was a close family secret kept from the infected and affected:

> "Ah, it was a family secret that was just known by my grandmother and her children only." (P 1)

> “I was told that the tablets I was drinking were for a reaction to eating fish and if I were to eat fish I would have a skin reaction afterwards.” (P 9)
>
> “My brother doesn’t know… If we fight over anything he starts revealing those things he knows that I don’t want my gran and my mom to find out. So, that’s what made me keep it from him.” (P 3)

Even in cases where participants were sick and required medical attention, shame caused them to remain secretive about HIV to healthcare providers:

> “…. Like I didn’t say anything at the hospital … you know how nurses are like … well, sometimes they are just [pause] talking and they are like, “Do you know that this child is positive?” … then maybe that nurse is not a secret keeper, she goes on and tells the next person …” (P 3).

Participants expressed that public hospitals had a high likelihood of exposing HIV infection making them anticipate shame and humiliation in those settings:

> “…I go to a private clinic; I do not face challenges there. But some other peers say when you go to a local clinic or a general hospital, they will be like, “Ah, those that take HIV medication come and stand here.” What if someone in your neighbourhood is there and that person sees you going that way, what would they think?” (P 4)

Opting to go to a private clinic speaks to the fear of exposure, and the real or imagined reactions of others, and reinforces the decision to hide their status due to shame.

Blaming source of infection/Assigning blame

To defend themselves from the shame and negative personal and social labels associated with HIV infection, many of the participants wanted to know the source of infection and apportion blame for their status. Some required that their parents be tested as confirmation that they were not responsible for infection:

> “… So, getting my mother tested was just a way of knowing, “Where did I get it from?” (P 3)
>
> “I asked him, “Where did I get the virus? “…he was shocked and said, “Ah I don’t know!” … “Ah, you leave me alone!” … “If you refuse to tell me this time, I will look for a way to kill myself! “ Then he said, “My sister you were born with it, it’s not your fault, just live with what is there “. (P 7)

Many of the participants insinuated that their HIV infection was because of sexual indiscretions by their fathers. They presented their mothers as victims who were also paying for the recklessness of their fathers:

> "I wouldn't blame her as such coz she is also paying for something she did not … you know. I wouldn't know parents really, but I am sure it only came with my dad, being passed on to my mom and being passed on to me." (P 3)

> "…and I blamed my father saying that if he didn't have three wives – they are not even three, maybe there are even three more besides my mom. My mom was the last one. …. Could it be that, ah, he knew his status and wanted to spread it, or could it be that he didn't know his status and he was only doing his thing…? " (P 4)

Another participant also alluded to their father being for the source of transmission of HIV infection. This possibility of HIV infection was linked to the father's rank, income and social status as these are some of the attributes that are assumed to enable men to have multiple sex partners:

> "… Maybe my dad was the one who had it because he was a brigadier …" (P 2)

Assigning blame for HIV infection enabled participants to express their feelings towards their parents for vertical transmission and avert shame:

> "… for my parents, like I really grew with that – that bitterness in my heart, especially for my dad who passed away. He had done all he had to do with his life, and he left me with the disease, you know. So, I don't want to lie, I had been hating on my parents. It took me a while to forgive them." (P 10)

Beliefs of HIV related shame

As I am

Participants viewed themselves as being HIV and all its negative moral and social labels being a part of their identity as opposed to having a condition that does not define them:

> "My dad and grandmother called me … and they told me that that is what I am." (P 1)

> "… I just accepted, "Ah, that's just how I am." (P 5)

Statements such as "what I am" or "who I am" were used by all the participants to describe themselves in relation to HIV acquisition.

Worthlessness and low value

The belief that one is fundamentally undeserving of love or incapable of being loved was expressed and underpinned by the assumption of low inherent worth. Many of the participants felt no one would love and accept them because of their HIV infection:

> "If you say it as it is then he will tell you the absolute truth that, "He does not date people like that" and dump you." (P 1)

> "…Then it came out that he wanted to tell his parents about my HIV status, and I didn't like that. So, I was like, "God this is the reason I am breaking up with him." I don't want to mess up my life and I don't want to mess up his life …I know that parents do not want their children to get married to HIV positive people." (P 6)

The participant refused to marry a man who was accepting her HIV status because she was convinced that she was unlovable and that she would be abandoned by her partner and his family. The shame of disclosing her HIV acquisition, a blemish on the self, was seen as an attack to the self, which she defended against by ending the relationship.

Participants lived in anticipation of being shamed or rejected by others for their status:

> ".. I am thinking about telling him a story, "You know my friend had a boyfriend and she was HIV positive and then she told her boyfriend about her status and the boyfriend dumped her. If it were you in that situation, what would you do?" Then I will listen to the answer that he would have given me to see if he will accept or reject me." (P 1)

The participants were guarded about talking about their status with their boyfriends as they anticipate rejection. They tried to gauge the reactions of others by telling stories about infection hoping to ascertain the responses of others, protecting themselves from shame.

Inadequacy and low self-esteem

Participants also exhibited low self-esteem in that they evaluated themselves as lacking, inferior and not good enough in comparison to others. Therefore, to be chosen by another for interaction greatly shocked and moved them as they were shameful and unworthy in their own eyes:

> "Why not just get a real – real girl and then really…. A real – real girl who is negative and not one …… but [sic] the problem is that when you are HIV positive – it just shocked me …" (P 8)

> "I saw myself …I can say just as a person who is walking around without any value and without anything that they can try to do to be valuable." (P 9)

Perinatal HIV acquisition can cause cognitive difficulties in childhood and being ill for long periods could result in absenteeism at school. Therefore, most participants did not do well at school and felt bad about it, worsening feelings of inadequacy and incompetence:

> "Right now, I am sitting at home. I wrote 'O' Level last year. I wrote five subjects, but I passed only two." (P 5)

> "… Those that know me, if they find out that I have Ds they would say, "Are those (participant's name) results?" Yes, I really wanted to pass, and I didn't want to get

> married without passing, No! If you would be asked by your in laws “What did you bring?”, you can just bring out your certificate …”. (P 2)

Failing at school made participants feel that they had many shortcomings that they had to make up for, including HIV, making them unacceptable to others and causing shame. Feelings of incompetence often stem from the belief that "I can't do things right" or "I am incapable." This belief can become self-fulfilling as it undermines efforts to succeed or improve. Academic struggles together with living with HIV worsened the negative self-image that participants had about themselves inducing shame.

Self-loathing and hatred

Self-hatred, a belief-driven emotion, was expressed through views about being inherently bad, flawed, or unacceptable. Participants preferred dating HIV negative people because those who were positive would disclose their status. This revealed how much they disliked themselves for having HIV. They were ashamed of themselves, their status and being linked with those that were HIV positive:

> “Never! Never! … I can’t say they didn’t come. They came but I don’t want positive guys. I want a negative guy… The reason is that ah I don’t want. I want to explore the world, right? What if that person is known in their neighbourhood that they are HIV positive? That means I am also going to be known that the lady she is dating is HIV positive as well. I don’t prefer positive guys at all since I got to know my status … as for me, ah, as (participants name), I don’t want them.” (P 6)

The participants who viewed themselves as dirty and repulsive were apprehensive about being intimate with others as they feared that they would pass the infection or dirt to others:

> “Ah, the thing that I don’t like is kissing … because I am a person that is easily disgusted … diseases can be passed through saliva… I was afraid of passing the disease.” (p7)

The reactions of others in not touching them or not eating food that they touched also communicated that they were tainted or dirty, thus a consciousness was expressed about eating in a smart way or not being messy:

> “… Whatever food I might have left, even if I had not touched it or eaten in a messy way like children do, no I would eat in a smart way, just because it was eaten by someone who is positive, just to touch it, they would decide to sleep without eating …even if I have left it.” (P 5)

In addition to being regarded as dirty, participants were viewed as dangerous, reflecting beliefs such as, "I am a threat to others" or "I cannot be trusted". These feelings often stem from guilt or fear related to past actions. Participants linked this stigma to traditional caring roles women often fulfil — such as cooking and sewing — making them feel inadequate. The shame associated with these duties further exposed them to humiliation for their status and their inability to perform women's roles:

> "… Even cooking, people wouldn't allow me to cook. I don't know what they were afraid of …" (P 8)
>
> "… It was like if I sewed my dress and I didn't even prick myself; people would not even touch that needle". (P 10)

Despair and hopelessness

Despair often arises from the belief that "nothing will ever improve" or "there is no hope for me". This belief fuels feelings of helplessness and resignation. The weight of the above beliefs and the environment in which the participants lived resulted in some participants believing that nothing could be done – that HIV was a stain on the self that could not be removed:

> "It bothered me … but I tried to be strong and tried to accept it because there was nothing, I could do about it". (P 7)
>
> "Ah-ah, I just think that this is what I am and there is no one to deny it to. So, I will just survive like that." (P 4)

Discussion

Shame was a central and pervasive experience for adolescent girls living with HIV, profoundly shaping their self-concept, social interactions, and engagement with care. The drivers of shame were multifaceted, arising from internalised cultural and moral biases, societal judgments, and relational dynamics. Participants highlighted societal constructions linking HIV to moral fault, sexual deviance, or parental behaviour generating powerful feelings of inadequacy, worthlessness, and internalised blame. Cultural expectations of feminine chastity and purity further intensified these experiences, making HIV acquisition a gendered marker of shame (Bolat, 2023; Weber & Friese, 2025; ZNNP+, 2014). Shame was also reinforced by peers, community narratives, and family responses, which often framed HIV as a moral failing, compounding feelings of despair and social isolation (Jaijan & Khamphrao, 2015).

The experiences of shame reported by participants were deeply embedded in their daily lives, shaping their social interactions, personal decisions, and psychological development. Shame was not only an internal feeling but a relational and social phenomenon, mediated by community expectations and cultural norms. Adolescents described heightened self-consciousness, fear of judgment, and constant vigilance to avoid exposure or embarrassment.

These experiences are consistent with findings from other studies in sub-Saharan Africa, where HIV-related shame is intensified by pervasive moral narratives that frame the disease as the result of deviant behaviour or parental transgression (Ashaba et al., 2018; Casale et al., 2019).

Drivers and responses to HIV-associated shame

The drivers of shame identified in this study were both structural and interpersonal. Structural drivers included societal stigma, gendered expectations, and limited psychosocial support, while interpersonal drivers encompassed parental secrecy, peer ostracism, and relational dynamics that emphasized moral blame. Participants reported that community gossip, school-based discrimination, and peer judgments reinforced feelings of inferiority. In some cases, even supportive family members inadvertently contributed to shame by framing HIV in moralistic terms or expressing fear about social exposure. This combination of structural and relational pressures created a complex environment in which adolescents internalised blame and negative self-concepts.

In response to HIV-associated shame, adolescents adopted a range of coping strategies. These included secrecy, selective disclosure, social withdrawal, and externalising blame. Secrecy involved concealing one's HIV status from friends, teachers, and sometimes even close family members, reflecting a profound fear of social judgment. Selective disclosure allowed adolescents to maintain limited social connections while protecting themselves from stigma, though it often led to feelings of isolation. Social withdrawal manifested as avoiding peer gatherings, school activities, or community events, while externalising blame sometimes involved attributing infection to parental behaviour or chance rather than personal fault. These behaviours reflected an ongoing tension between the desire for social connection and the need for self-protection. Participants reported avoiding HIV testing, denying their diagnosis, inconsistently adhering to medication, and limiting engagement with care services, highlighting how shame operates as a barrier to health-seeking behaviour (Cooper et al., 2025; Marcus et al., 2025).

Understanding these responses is essential for comprehending the lived realities of adolescent girls with HIV, as these behaviours have direct implications for retention in care, treatment of adherence, and psychosocial support interventions. For example, avoidance of testing or clinic visits delays diagnosis and limits early treatment initiation, while secrecy and withdrawal reduce opportunities for social support, which is critical during adolescence. In this sense, shame is not merely an emotional experience but a significant public health concern that influences treatment outcomes and overall well-being.

Impact on identity and self-beliefs

Shame profoundly affected participants' identity formation and self-beliefs. Adolescents frequently described themselves in deficit-laden terms, including worthless, dirty, flawed, incompetent, or untrustworthy, demonstrating the internalisation of negative social labels. HIV was often perceived as an immutable flaw, conflating disease status with personal character and heightening psychological distress (Topi et al., 2025; Kane et al., 2019). This perception undermined participants' ability to form a coherent and positive self-concept during adolescence, a developmental period characterised by identity exploration, peer validation, and gender role socialisation (Erikson, 1993; Kohut, 1971).

Participants reported that shame was intensified by the perceived permanence of HIV and its associated stigma. Unlike temporary setbacks or illnesses, HIV was seen as a lifelong condition that defined who they were, rather than something they had. Adolescents often expressed hopelessness about being accepted by peers, forming romantic relationships, or fulfilling societal expectations of womanhood, such as childbearing and sexual agency. Some participants disclosed suicidal thoughts and self-harm tendencies, reflecting the extreme psychological burden of shame. These findings align with research indicating that HIV-related shame contributes to depression, suicidal ideation, and poor mental health outcomes among adolescents in sub-Saharan Africa (Ashaba et al., 2018; Casale et al., 2019; Vreeman et al., 2017).

The use of framing language further reinforced negative self-perceptions. Participants described themselves using identity-laden phrases such as "I am HIV positive" or "this is what I am". These expressions indicate that HIV status had become a core aspect of self-identity rather than a condition they lived with. This phenomenon mirrors findings in mental health literature, where individuals identify themselves by their illness— e.g., "I am a schizophrenic"— leading to internalised shame and avoidance behaviours (Topi et al., 2025). By contrast, diseases framed as external to identity, such as diabetes or hypertension, carry less psychological burden, highlighting the unique intersection of identity, stigma, and shame in HIV.

Cultural and societal contexts

Cultural and societal norms in Zimbabwe amplified experiences of shame. The use of shame as a social control mechanism, reinforced by proverbs such as "*nyadzi dzinokunda rufu*" ("shame surpasses death") and "*kushaya ganda kumeso*" ("having no shame"), emphasised the moral weight of social transgressions and the consequences of perceived deviance (Chigidi & Tembo, 2013). Adolescents experienced stigmatic shaming that labelled them as morally deficient, eroding social bonds and reinforcing negative self-beliefs (Tangney & Dearing, 2002; Hutchinson & Dhairyawan, 2018). In patriarchal societies like Zimbabwe, gendered norms intensified these effects, as societal expectations excused male sexual behaviour while severely punishing girls for similar actions, further marginalising adolescent girls living with HIV (Akatukwasa et al., 2021; Mpofu & Ganga-Limando, 2024).

Parental and familial factors contributed to shame in complex ways. Adolescents who acquired HIV perinatally often attributed infection to parental sexual behaviour, resulting in internalised blame and resentment. Family secrecy and non-disclosure practices, even when intended to protect the child, frequently reinforced perceptions of shame and inadequacy. Participants reported that parental avoidance of discussion about HIV, coupled with social and moralistic narratives, communicated that HIV was something shameful to hide rather than a manageable condition. These dynamics intersect with societal narratives that associate HIV with sexual immorality, reinforcing a dual burden of personal and social shame.

Implications for care and development

Shame operates as a significant barrier to health-seeking behaviour, adherence to treatment, and psychosocial well-being. Adolescents struggling with shame were less likely to attend clinic appointments, adhere to antiretroviral therapy, or engage in support programs. Shame also influenced disclosure decisions, limiting opportunities for social support, which is critical for resilience during adolescence. As adolescence is a key period for identity formation, peer acceptance, and social integration, shame can have long-term developmental consequences, including impaired self-esteem, hopelessness, and social withdrawal (Irani et al., 2024; Horton et al., 2025).

Interventions to address shame must operate at multiple levels. Clinical approaches should integrate trauma-informed care, structured shame-reduction strategies, and psychosocial support tailored to adolescents. Public health campaigns should employ shame-sensitive messaging, avoiding moralistic framing that reinforces blame. At a policy level, interventions should focus on reducing structural stigma, promoting adolescent-friendly services, and fostering social environments that validate adolescents' experiences without moral judgment. Implementing these strategies may improve mental health outcomes, treatment of adherence, and retention in care among adolescent girls living with HIV.

Gender-specific considerations are particularly important. Findings indicate that HIV-related shame disproportionately affects girls due to intersecting social, biological, and cultural vulnerabilities. Adolescent girls face heightened scrutiny of their sexuality, reproductive capacity, and social behaviour, making shame a gendered phenomenon that requires targeted interventions. Empowerment initiatives, mentorship, and safe spaces for disclosure and peer support may mitigate the impact of shame while fostering resilience and social integration.

Conclusion and recommendations

Shame is a powerful determinant of the lived experiences, identity development, and healthcare engagement of adolescent girls living with HIV in Zimbabwe. It emerges from a complex interplay of cultural norms, societal judgments, relational dynamics, and internalised self-perceptions. Stemming from internalised cultural and moral biases, societal attitudes, and relational dynamics, shame negatively affects self-esteem, social relationships, and engagement with care. Adolescents' coping strategies, health-seeking behaviours, and developmental trajectories are shaped by shame, with profound implications for mental health, treatment adherence, and retention in care. Recognising shame as distinct from stigma is critical to enhancing psychosocial well-being, promoting equitable healthcare access, and supporting healthy adolescent development (Shame-Sensitive Public Health; Cooper et al., 2025).

Recent studies, particularly in the post-COVID-19 context, emphasise the need to examine shame in public health interventions and policymaking, highlighting the effects of cultural norms, blaming ideologies, and long-term health consequences (Cooper et al., 2025). This study reinforces these insights, demonstrating that multi-level strategies are essential to mitigate the pervasive effects of shame and improve outcomes for adolescent girls living with HIV.

Recommendations

- **Clinical practice:** Integrate structured shame-reduction interventions into routine psychosocial support. Counselling approaches informed by self-psychology can strengthen self-cohesion, resilience, and adaptive coping strategies, helping adolescents separate their identity from their HIV status.

- **Public health messaging:** Develop campaigns that eliminate shaming language, challenge cultural narratives of blame, and promote empathy and acceptance for adolescents living with HIV. Messaging should foster supportive peer and community environments and normalise care engagement.
- **Policy:** Mandate shame-sensitive and trauma-informed training for healthcare providers to improve patient interactions, reduce heteronomous shame, and cultivate supportive care environments. Policies should prioritise adolescent-friendly services and culturally responsive interventions.
- **Research:** Investigate the long-term effects of shame, culturally specific experiences, and effective interventions to mitigate its psychosocial and health impacts, particularly among adolescents transitioning to adulthood. Future research should explore gender-specific vulnerabilities and strategies to enhance resilience and social integration (Pantelic et al., 2017).

By addressing shame across clinical, societal, and policy domains, interventions can better support adolescent girls living with HIV, promoting improved mental health, adherence to treatment, and social integration while fostering positive developmental outcomes.

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Declaration of interest statement

The authors report there are no competing interests to declare.

Data availability statement

Due to the sensitive nature of the data collected and no agreement with the participants to share their transcripts the only available data is included as quotes in the body of this article.

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