

Psychological Impact of HIV/Aids On Livelihood Participation of Households in VOI Sub-County, Taita Taveta County

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Abstract- Human Immunodeficiency Virus (HIV)/ Acquired Immune Deficiency Syndrome (AIDS) threatens the social fabric of the most affected countries. Sub Saharan Africa has more than two thirds of all people living with HIV/AIDS globally and is the hardest hit region in the world. Although responses to the epidemic have been successful, they have focused primarily on the prevention of new infections and the treatment of existing ones. This study however focused on the psychological impact of HIV/AIDS on the livelihood participation of households, specifically in Taita Taveta County. The theory that guided this study is the sustainable livelihood framework. The study adopted a cross sectional research design. Questionnaires were used to collect data. For the data analysis, descriptive statistics were used. Data was edited, cleaned, coded and categorized. Quantitative analysis featuring the descriptive statistics were applied in analysing data and thereafter, data presentation using graphs and tables with relevant inferences, frequencies and percentages to describe and summarize relevant findings was done. The study found that 19.7% of the respondents sometimes felt worthless and 44.8% rarely blamed themselves for the infection. The respondents always experienced inadequate hospital support services (41.8%), very often experienced limited accessibility to hospital (15.3%), and very often experienced lengthy hospital waiting times (39%). The study concluded that psychological impact of HIV/AIDS significantly influenced livelihood participation of households in Voi Sub-County, Taita Taveta County. The study recommends psychological support by family, friends and especially the community to the patients infected with HIV, as it was found that there are those who felt worthless and blamed themselves for the infection, and were tempted with thoughts of even taking their lives.

Index Terms- HIV/AIDS, psychological impact, households, livelihood participation, Taita Taveta County.

I. INTRODUCTION

In 2015, the UNAIDS global statistics reported that more than 70 countries were using the HIV Stigma Index; findings from

50 countries indicate that roughly one in every eight people living with HIV is experiencing HIV/AIDS related stigma and discrimination. "HIV/AIDS is not only a human crisis, it is a threat to sustainable global, social and economic development," says ILO Director-General Juan Somavia (UNAIDS, 2017). According to the UNAIDS global statistics, there were approximately 36.9 million people worldwide living with HIV/AIDS in 2017. Of these, 1.8 million were children less than 15 years old. The vast majority of people living with HIV are in low- and middle-income countries. In 2017, there were 19.6 million people living with HIV (53%) in eastern and southern Africa, 6.1 million (16%) in western and central Africa, 5.2 million (14%) in Asia and the Pacific, and 2.2 million (6%) in Western and Central Europe and North America.

Sub-Saharan Africa, with more than two-thirds of all people living with HIV globally, is the hardest hit region in the world, followed by Asia and the Pacific. The Caribbean as well as Eastern Europe and Central Asia are also heavily affected. HIV prevalence in East Africa is generally moderate to high and is second to Southern Africa, while showing a moderate decline in the past 20 years (UNAIDS, 2017). Although responses to the epidemic have been successful, they have focused primarily on the prevention of new infections and treatment of existing infections, and ignored or paid little attention to the implications of the disease. The presence of HIV/AIDS in a household quickly leads to depletion of household income earning capacity and of household savings and assets. The International Labour Organization report 2017, showed how HIV/ AIDS has affected the global workforce; how premature death and debilitation have removed millions of productive people from work; how the productivity of those with the most advanced symptoms has been diminished; and how these impacts have been transmitted to the families of workers living with HIV, with both immediate and long-term consequences.

Whether HIV/AIDS can cause national economies to grow slower is not particularly clear; however, many studies have projected that economic growth will be slowed down in all hard-hit countries. In the late July 2011, the World Bank released a study on the long run economic costs of AIDS to hard hit African countries that warned that previous models had greatly

underestimated the potential macro-economic impact of HIV/AIDS if nothing is done to combat the economic devastation that the epidemic is causing. The study predicted a complete economic collapse within three generations, emphasizing the importance of human capital and how it is transmitted across generations, making an overlapping generation's model more appropriate in understanding how AIDS impacts people. According to the authors, AIDS will and has retarded economic growth; by destroying human capital, particularly of young adults, by weakening and wrecking mechanisms that generate human capital and investment in people, through loss of income and death of parents, and by giving rise to a new generation with little education and knowledge, therefore less able to raise their own children and invest in their education and future. No disease in recent times has produced more ethical dilemmas, been responsible for such destructions of family life or placed greater demands on health, education and social services (World Bank, 2011).

In Kenya, The National Aids Control Council report (NACC, 2019), estimated that Kenya had as of December 2016, 1.5 million people who were living with HIV&AIDS, and that each year the country has an estimated 71,034 new HIV infections among adults, and about 6,613 new infections among children. The prevalence of the epidemic has affected the country's economy negatively by lowering the per capital output by 4.1 per cent in the last year. The high rate of HIV/AIDS infection raises enormous problems and challenges for the economic development of the country, more so because HIV/AIDS affects the most economically productive sector of the population. Food security is compromised, income is lost, assets are sold and children are orphaned and dispersed. This study looked at the psychological shocks brought about by the illness, and the impacts these shocks have on the livelihoods of affected households, specifically from Voi sub-county, Taita Taveta County. Taita Taveta county is classified as a high HIV epidemic county according to the national HIV and AIDS Estimates (NACC, 2019). With an estimated population of 323,867 persons, approximately 11,209 people were living with HIV in 2019. The county's HIV prevalence during the same period was 6.1%, higher than the national prevalence of 5.6%.

Purpose of the Study:

The aim of this paper was to determine the psychological impact of HIV/AIDS on livelihood participation of households in Voi sub-county, Taita Taveta County.

II. THEORETICAL REVIEW:

This study adopted the sustainable livelihoods framework to analyse the psychological impact of HIV/AIDS on livelihood participation of households. The British Department for International development (DFID) has developed a 'Sustainable Livelihood Framework' (SLF) which is one of the most widely used livelihoods frameworks in development practice. The SLF was integrated in its program for development cooperation in 1997. The framework highlights five key characteristics;

- i It gives attention on people's strengths and the various assets on which they can draw from to achieve their objectives.
- ii It crosses traditional divides between rural and urban areas and between various sectors (for example; between productive activities and the social sectors).
- iii It is applicable across all and any geographical area and social groups.
- iv It recognizes that there are multiple influences on people, and seeks to understand the relationships between these influences and their joint impact upon livelihoods.
- v It recognizes that there are multiple actors that influence livelihoods (from the private sector to national level ministries, or from community-based organizations to newly emerging decentralized government bodies).

The sustainable livelihood framework (SLF) enhances understanding of livelihoods in development practice. It convenes the factors that restrain or raise livelihood opportunities, and shows how they relate. In different contexts, sustainable livelihoods are achieved through access to a range of livelihood resources, (natural, economic, human and social capitals) which are basic material and social, tangible and intangible assets that people have in their possession, from which different productive streams can be generated. Livelihood strategies, (agricultural intensification or intensification, livelihood diversification and migration), the idea is, either you gain more of your livelihood from agriculture (including livestock rearing, aquaculture, forestry and others) through processes of intensification (more output per unit through capital investment or increased labour inputs) or intensification (more land under cultivation), or you diversify to a range of off-farm income earning activities, or you move away and seek a livelihood, either temporarily or permanently, elsewhere (Migration) (DFID, 2000).

The critical trends as well as shocks and seasonality, over which people have limited or no control over yet have a great influence on people's livelihoods and on the wider availability of assets. In this study, the external environment will include the impacts of HIV/AIDS related stigma, and how this stigma affects their livelihoods. As the livelihood's framework is concerned first and foremost with people, it seeks to gain an accurate and realistic understanding of people's strengths (here called "assets" or "capitals"). It is crucial to analyse how people endeavour to convert these strengths into positive livelihood outcomes. The framework is founded on the background that people require a range of assets to achieve positive livelihood outcomes. Therefore, the SLF identifies five types of assets or capitals upon which livelihoods are built, namely human capital, social capital, natural capital, physical capital and financial capital (Chambers, Pacey & Thrupp, 1989).

Institutions and organizations are how the above processes come together. Informal and formal institutions mediate access to livelihood resources thus affecting livelihood strategies and causing either negative or positive livelihood outcomes (DFID, 2000). This study used the sustainable livelihoods framework as a tool to identify how people living with HIV/AIDS operate within a vulnerability context when they have HIV/AIDS as a shock, shaped by different factors; mainly, the physical, social and

psychological effects of HIV/AIDS on livelihood participation of households in Taita Taveta county.

III. LITERATURE REVIEW:

When individuals are informed that they have test positive for HIV antibodies, they confront the realization that they have contracted what is likely to be terminal condition. This realization can be accompanied by profound feelings of shocks, disbelief, depression, loneliness, hopelessness, personal grief, guilt, anger, and the fear of dying from the disease. HIV progression is often characterized by a series of losses beginning with one's capacity to carry on with preferred daily activities, and moving through limitations in and loss of work, diminishing financial resources, declining health, which inevitably challenges psychological well-being (UNAIDS, 2017).

A study conducted by Honajie et al. (2014) in Nanning, the capital city of the Guangxi province in China examined the psychological impacts among older and younger people living with HIV/AIDS (PLWHAs). This study examined 148 participants and compared self-efficacy, depression, well-being, and quality of life among older and younger PLWHAs. Older adults were defined as age 50 and older. Compared to younger PLWHAs aged 18–49 years old, older PLWHAs reported lower levels of well-being, higher levels of depression, and poorer quality of life. Self-efficacy was similar among older and younger PLWHAs. A higher level of depression among older PLWHAs was associated with much lower levels of subjective well-being and quality of life (physical health and psychological health).

A journal article by Mahlasera (2020) showed that HIV/AIDS imposes a significant livelihood burden because PLWHIV often suffer from depression and anxiety as they adjust to the impact of the HIV diagnosis and face the difficulties of living with a chronic illness. Living with HIV causes significant challenges for livelihood participation as it is associated with a number of significant and recurrent stressors including physical pain, side effects of ART, social stigma, and discrimination. Another psychological impact of HIV is fear. After a person is diagnosed with HIV, he or she often suffers from fear of being stigmatized or fear to disclose their status in the workplace or to their family members and friends. This usually has traumatic effects and may affect one's ability to cope in their work environment and more so, their family life. Therefore, studies show that support groups and peer groups are necessary to control the effects of fear.

It is well documented that people living with HIV and AIDS experience stigma and discrimination on an ongoing basis. Studies by Skinner and Sakhumzi (2004); Deacon, Prosalendis and Stephney (2004); Douglas (1995) and Das (2014) have concluded that, not only does the continuous burden of HIV stigma cause a low rate of participation in livelihood opportunities for people living with HIV and AIDS in developing countries, but it also greatly hinders HIV stigma reduction interventions introduced in different communities, leading to psychological effects.

IV. METHODOLOGY:

This study adopted a cross sectional research design. According to the Taita Taveta County Strategic plan 2016-2020, the County is classified as a high HIV epidemic County. With approximately 11,209 persons living with HIV. These are both children, the youth and men and women, but the target population was persons between the ages of 20 to 45 from the number of persons living with HIV/AIDS. The accessible population comprised of 2683 men and women who access treatment from different VCT centres in Voi, since the centres are close to one another. The sample frame was derived from persons who are household heads, who have lived with HIV for no longer than five years and attending Moi Referral hospital, Tudor healthcare facility, St. Joseph shelter of hope, St. Joseph dispensary and Maungu model healthcare centre. Stratified random sampling technique was used to select 103 respondents based on Yamane (1967) formula. Questionnaires were used to collect data. For the data analysis, descriptive statistics were used to determine the relationship that existed between the independent and dependent variables. Data was edited, cleaned, coded and categorized. Data presentation was done using graphs and tables, frequencies and percentages to describe and summarize relevant findings.

V. FINDINGS AND DISCUSSION

Demographic Characteristics

This section presents demographic characteristics of the respondents. The demographic characteristics presented include age, gender, name of facility, whether the respondents lived alone, who they lived with if they were not alone, marital status, school attendance, years of schooling, when HIV test was undertaken, when they started treatment and use of ARVs and years lived with HIV. To present the data on these characteristics, tables are used to give a clear picture of the characteristics being reviewed.

The findings on age indicated that most respondents were aged 26-30 years forming 37.6% of the responses, followed by those aged 36-40 years at 36.6% and those aged 20-25 years at 17.4%. The findings imply that the biggest percentage of respondents are in between 20 and 30 years, and the fewest are aged 41 and above, showing that those infected with HIV and attending healthcare facility services were young individuals. Based on gender, 63.4% of the respondents were female, while 36.6% were male. This shows that those attending healthcare facility services as a result of HIV infection were female, as compared to their male counterparts. On the type of facility, the study determined that 34.7% of the responses came from St. Joseph shelter of hope, 28.6% came from Moi referral hospital, 15% came from St. Joseph dispensary while 12.7% came from Maungu model health centre. This could be attributed to the sampling framework of the study.

On whether the respondents lived alone, the study found that 87.8% of the respondents did not live alone, while 12.2% lived alone. The findings indicate that most respondents at least lived with someone else. For those who did not live alone, it was determined that most respondents lived with their parents (49.2%), 18.2% lived with their spouses, 14.4% lived with their children while 4.3% lived with their friends. The findings show that the

respondents received support from their parents, children, friends and spouses.

On marital status, the study found that most respondents were single (54.9%), 24.4% were married, 16.4% were widowed while 4.2% were divorced. The findings indicate that most HIV affected individuals attending health facilities were single, based on their young age. On whether the respondents had attended school, the study found that 92.5% had gone to school while 7.5% had not. This shows that that the majority of the respondents had at least gone to school. On the number of years schooling, the study found that 42.1% had schooled for 11-15 years, 37.6% had schooled for 6-10 years, 10.7% had schooled for 1-5 years and 8.1% had schooled for 16-20 years. The findings indicate that most respondents had schooled for less than 15 years, as indicated in Table 1.

Table 1 Demographic Information

Demographic data		Frequency	Percentage
Age	20-25years	37	17.4
	26-30 years	80	37.6
	31-35 years	3	1.4
	36-40 years	78	36.6
	41-45 years	6	2.8
	46 years and more	9	4.2
	Total	213	100.0
Gender	Female	135	63.4
	Male	78	36.6
	Total	213	100.0
	Moi referral hospital	61	28.6
Type of Facility	Tudor healthcare facility	19	8.9
	St. Joseph shelter of hope	74	34.7
	St. Joseph dispensary	32	15.0
	Maungu model health Centre	27	12.7
	Total	213	100.0
Do you live alone	Yes	26	12.2
	No	187	87.8
	Total	213	100.0
If no, with whom do you live with	Parents	92	49.2
	Spouse	34	18.2
	With friends	8	4.3
	Children	27	14.4
	Other	26	13.9
	Total	187	100.0
Marital Status	Single	117	54.9
	Widowed	35	16.4
	Married	52	24.4
	Divorced	9	4.2
	Total	213	100.0
Have you ever attended school?	Yes	197	92.5
	No	16	7.5
	Total	213	100.0

How many years of schooling have you had?	1-5years	21	10.7
	6-10 years	74	37.6
	11-15 years	83	42.1
	16-20 years	16	8.1
	More than 20 years	3	1.5
	Total	197	100.0

The study also sought to determine the year when the respondents got an HIV positive test. The responses obtained indicate that 56.8% of the respondents got their test between 2011-2016, 31.5% got their test done between 2006 and 2010 and 11.7% got their positive test between 2000 and 2005. This indicates that most respondents were diagnosed with HIV in the last ten years.

The findings on whether the respondents started their treatment immediately indicate that 70% did not start their treatment at the time they were diagnosed, while 30% started their treatment immediately. This implies that a lot of these patients because they tend to be very young go through a period of denial and thus, they do not begin treatment immediately, even after the diagnosis. This is seen from the respondents that started their treatment more than a year later (70%). The study finally sought to determine the number of years the respondents had lived with HIV, and the findings indicated that 56.8% had lived with the disease for 5-10 years, 31.5% had lived with it for 10-15 years while 11.7% had lived with HIV for more than 15 years. The findings are shown in Table 2.

Table 2 Other demographic data

Demographic data		Frequency	Percentage
Year of positive test	2000-2005	25	11.7
	2006-2010	67	31.5
	2011-2016	121	56.8
	Total	213	100.0
Did you begin your treatment immediately?	Yes	64	30.0
	No	149	70.0
	Total	213	100.0
When did you begin your Anti-retroviral treatment?	Immediately	64	30.0
	More than a year later	149	70.0
	Total	213	100.0
How many years have you lived with HIV?	More than 15 years	25	11.7
	10-15 years	67	31.5
	5-10 years	121	56.8
	Total	213	100.0

Psychological Impact of HIV/AIDS

The objective of the study was to determine the psychological impact of HIV/AIDS on livelihood participation of households in Voi sub-county, Taita Taveta County. The study first sought to determine the negative self-perception the respondents had concerning themselves. From the findings, it was found that 68.5% of the respondents rarely had lack of interest in doing things, 41.8% rarely felt they were not a good person because they have HIV, 47.4% rarely felt they deserve to be punished for getting HIV, 42.3% rarely felt that having HIV makes their body unclean, 42.3% rarely felt they should never have born, 19.7% sometimes

felt worthless and 44.8% rarely blamed themselves for the infection. Table 3 shows these findings.

Table 3 Negative self-perception

		Never	Rarely	Sometimes	Very often	Always
Lack of interest in doing things	f	22	146	0	24	21
	%	10.3%	68.5%	0.0%	11.3%	9.9%
I am not a good person because I have HIV	f	69	89	14	17	24
	%	32.4%	41.8%	6.6%	8.0%	11.3%
I feel I deserve to be punished for getting HIV	f	50	101	5	30	27
	%	23.5%	47.4%	2.3%	14.1%	12.7%
Having HIV makes my body unclean	f	69	90	19	9	26
	%	32.4%	42.3%	8.9%	4.2%	12.2%
Wishing you were never born	f	40	90	8	35	40
	%	18.8%	42.3%	3.8%	16.4%	18.8%
Feeling worthless	f	104	32	42	13	22
	%	48.8%	15.0%	19.7%	6.1%	10.3%
I blame myself for the infection	f	70	95	32	9	6
	%	33.0%	44.8%	15.1%	4.2%	2.8%

On how the respondents coped with stigma and discrimination, the study found that 11.3% of the respondent often decided to change their jobs, 14.1% sometimes decided not to seek a job/promotion, 68.5% rarely decided to stop working, 16.4%

very often isolated themselves from colleagues/ workers/friends while 13.1% sometimes felt isolated at work because of their status. The findings are shown in Table 4.

Table 4 Coping with stigma and discrimination

		Never	Rarely	Sometimes	Very often	Always
Decided to change jobs	f	74	84	18	24	13
	%	34.7%	39.4%	8.5%	11.3%	6.1%
Decided not to seek a job/promotion	f	87	39	30	29	28
	%	40.8%	18.3%	14.1%	13.6%	13.1%
Decided to stop working	f	28	146	15	12	12
	%	13.1%	68.5%	7.0%	5.6%	5.6%
Isolated myself from colleagues/workers/friends	f	86	27	35	35	30
	%	40.4%	12.7%	16.4%	16.4%	14.1%
Felt isolated at work because of my status	f	69	87	28	15	14
	%	32.4%	40.8%	13.1%	7.0%	6.6%

On the behaviors engaged, the study determined that 10.3% of the respondents very often felt hopelessness, 34.3% very often felt anxious, 27.2% very often felt like abusing alcohol and other

drugs and 11.7% sometimes feel like engaging in risky sexual behaviour. Table 5 shows these findings.

Table 5 Behaviours engaged

		Never	Rarely	Sometimes	Very often	Always
Feelings of hopelessness	f	23	148	16	22	4
	%	10.8%	69.5%	7.5%	10.3%	1.9%
Feelings of anxiety	f	33	16	53	73	38
	%	15.5%	7.5%	24.9%	34.3%	17.8%
Wanting to be alone often	f	16	93	22	59	23
	%	7.5%	43.7%	10.3%	27.7%	10.8%
Abusing alcohol or drugs	f	87	27	17	40	42
	%	40.8%	12.7%	8.0%	18.8%	19.7%
Engaging in risky sexual behavior	f	22	149	25	17	0
	%	10.3%	70.0%	11.7%	8.0%	0%

The study sought to determine if the respondents had various thoughts or feelings as a result of having HIV. From the findings, it was found that 82.6% of the respondents did not have some thought of ending their life, 14.6% thought that it would be better if they ended their life while 6.1% would end their life if they had a chance. Table 6 shows these findings.

Table 6 Thoughts or feelings as a result of having HIV

		Yes	No
I do not have any thoughts of ending my life	F	176	37
	%	82.6%	17.4%
I have thoughts of ending my life, but I would not carry them out	F	22	191
	%	10.3%	89.7%
I think it would be better if my life ended	F	31	182
	%	14.6%	85.4%
I would like to end my life if I had the chance	F	13	200
	%	6.1%	93.9%

The findings on whether when they had the negative thoughts, they engaged someone, it was found that 19.7% of the respondents engaged someone while 80.3% did not. For those who engaged someone, 28.6% found they could easily talk to family members about any of the thoughts they were having above, 23.8 found it easy to talk to the employer or the people they worked with, 23.8% sought the services of counsellors while 14.3% talked with friends. Table 7 shows the findings obtained.

Table 7 Talking to someone about the negative thoughts

		Frequency	Percent
When you have had any of the above thoughts, did you have someone you could talk to or share what you feeling with?	Yes	42	19.7
	No	171	80.3
	Total	213	100.0
Whom among the following did you engage?	Family members: Spouse or parents or relative	12	28.6
	Friends	6	14.3
	Employer or people you work with	9	21.4
	Other PLHIV	5	11.9
	Counsellor	10	23.8
	Total	42	100.0

The study findings agree with those earlier postulated in literature that when individuals are informed that they have tested positive for HIV, they confront the realization that they have contracted what is likely to be terminal condition (UNAIDS, 2017). This realization can be accompanied by profound feelings

of shocks, disbelief, depression, loneliness, hopelessness, personal grief, guilt, anger, and the fear of dying from the disease. A study conducted by Honajie et al. (2014) agrees that there was depression among HIV patients which was associated with much lower levels of subjective well-being and quality of life.

VI. CONCLUSION AND RECOMMENDATIONS

The study concluded that psychological impact of HIV/AIDS significantly influenced livelihood participation of households in Voi Sub-County, Taita Taveta County. Further, some respondents sometimes felt worthless and blamed themselves for the infection. The study recommends psychological support by family, friends and especially the community to the patients infected with HIV, as it was found that there are those who felt worthless and blamed themselves for the infection, and were tempted with thoughts of even taking their lives.

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