

HIV Stigma among the Kenyan Adolescents: A Barrier to Tests and Medications

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Abstract: HIV testing and counselling remains to be the primary doorway to accessing treatment and prevention. Stigma associated with HIV creates negative mindset and convictions about HIV positive individuals. The partiality involves labelling a person as socially inadequate and excluding them from societal activities. While stigma refers to an attitude or belief, discrimination is the behaviour that results from those attitudes or beliefs. In Kenya, stigma level is highest in school settings where adolescent spend most of their time. The mind-set people have regarding the infection creates perceived fear which acts as a barrier for the adolescents to go for HIV test. The Same stigma creates challenge for adherence to treatment which suppresses the viral load for those who have tested positive given the unfriendly environment. The scenario does not provide room for this age group to go for counselling, to take HIV test, enlist on and adhere to treatment. Most of the available innovations and programs are not contextualized to fit the adolescents in boarding school set up, particularly self testing kits. Albeit the effectiveness of the innovation, stigma and school schedules remain to be a barrier that hinder adolescents from relying on such technology. This paper argues that HIV stigma is not an issue of the past but also the present, and should be prevented from being a future agenda.

Keywords: HIV stigma, Adolescents, Treatment, Testing, Counselling.

1. INTRODUCTION

1.1 HIV Stigma among the Kenyan Adolescents: A Barrier to Tests and Medication

The society has lived in dark ages regarding teenage health information and statistics. HIV and AIDs was the proverbial gun that deterred adolescent from engagement in early sexual activities. HIV threat became monotonous the moment society presumed that adolescent age group involves young and innocent population that does not count in the HIV and AIDs statistics. Coupled with inadequate data on teenagers, Kenya has cloned the medieval comportment that bases its reputations on archaic rituals and superstitions. HIV stigma is non-discriminative, yet scholars evade the adolescent population in HIV and AIDs discussions. Victimization is the modern-day textbook that prevents young adults and teenagers from taking HIV test or adhere ARVs once they test positive. School environment where teenagers spend most of their time neither provides an atmosphere that may cater for HIV positive adolescents to take ARV drugs without risking humiliation.

Health practitioners recommend annual testing for risk-prone populations across the globe. The risk-prone groups include adolescents, teenagers, and people living within urban settlements (Gwadz et al., 2018). In particular, adolescents face the most significant risk. The same group is also the largest group that avoid counselling and keep away from HIV testing like a plague. HIV Global statistics showed that thirty six point nine million (36.9M) people were already infected with HIV by the year 2017. The same statistics also showed that 25% of the world population is unaware of its status (AVERT, 2018). The following figure illustrates the data of (PLHIVA) people living with HIV and AIDs and those who are unaware of their status globally.

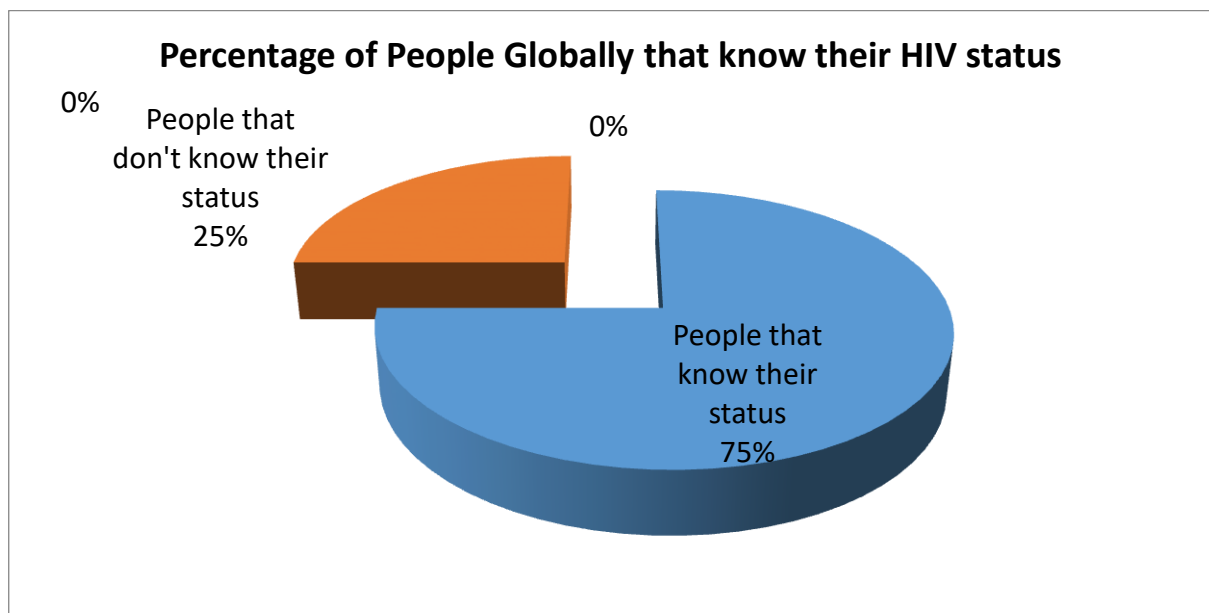


Figure 1: Showing 2017 global HIV statistics retrieved from avert.org

Twenty-five percent of the world's population is a significant percentage, especially given the development of technology in HIV tests. Given that a quarter of world population lives without the knowledge of their status, the chances are high that the world is slowly ignoring the importance of HIV and AIDS test. Mioro (2013) argues that stigma associated with HIV infection is the primary barrier to more voluntary testing, more so because of continuous interactions with defamed social identities. The records suggest that the world has a large number of individuals living with the virus without their knowledge.

Other than those that do not know their status, a massive percentage of PLHIVA do not receive ARV medications. The figure below (retrieved from avert.org) illustrates that an enormous portion of the PLHIVA avoid treatment (ARVs) despite knowledge of their positive status. According to UNAIDS (2016), the number of people receiving HIV treatment from 2010 to 2015 is increasing progressively. However, the rate at which the PLHA community rely on ARV and other therapeutic drugs is way below the 90/90/90 expectations. The expectation envisions a scenario where ninety percent of the world population test and know their status; ninety percent of the positive population is placed on ARV care; and the same percentage of people on ARVs have an HIV viral load that is suppressed (AVERT, 2018). Combined with the information that a large part of the world population has not been tested, it is likely that stigma levels are still high, more so given that ARV drugs are provided for free.

Table1: Showing the population of PLHIVA who are currently accessing treatment worldwide

Year	No. of PLHIVA In Millions	No. of people receiving treatment In Millions	
1	2000	28.9	0.77
2	2005	31.8	2.2
3	2010	33.3	7.5
4	2013	35.2	13
5	2014	35.9	15
6	2015	36.7	17
7	2016	36.7	19.5
8	2017	36.9	21.7

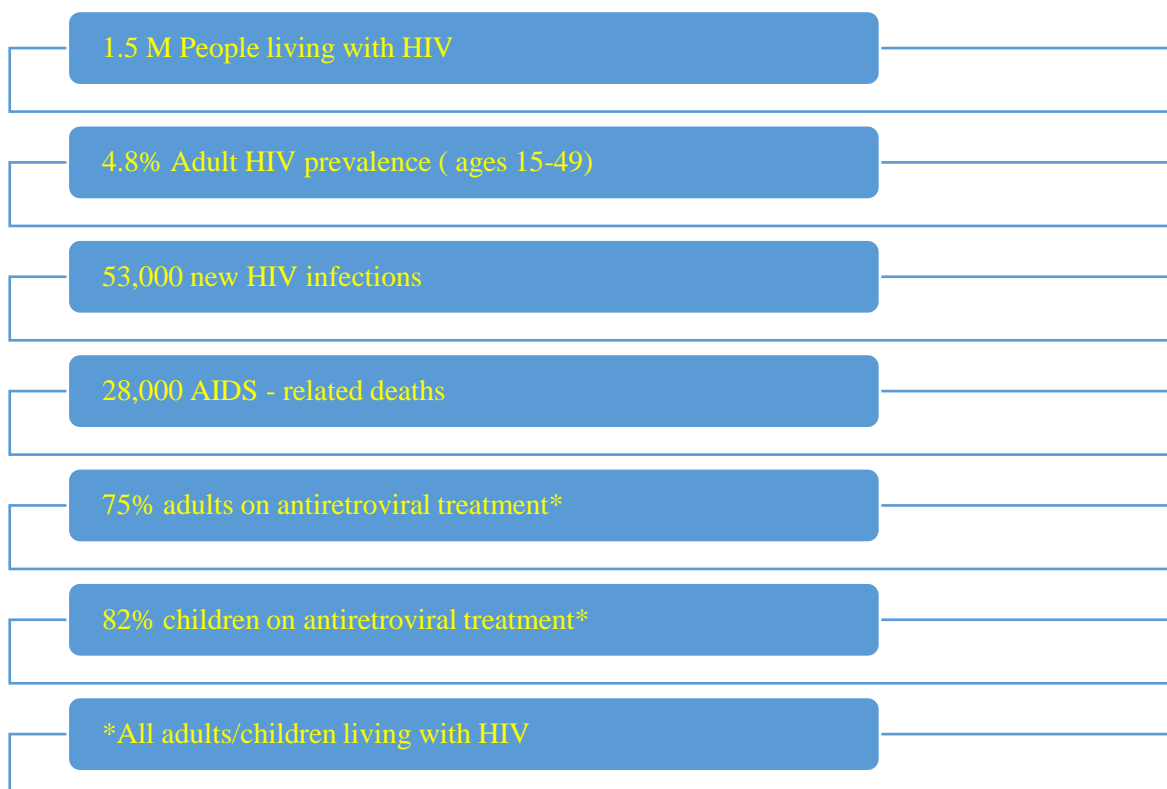
Source: UNAIDS Data 2018

Kenya records a successful HIV prevention story in the East African region. It was one of the first to approve the use of Pre-exposure prophylaxis (PrEP) and has led the way in providing Voluntary Medical Male Circumcision (VMMC) (AVERT, 2018). As a result, new infections have fallen dramatically in recent years.

Kenya list fourth among the worst hit countries with HIV epidemic globally, in conjunction with Mozambique and Uganda (UNICEF, 2014; Kyaddondo, Wanyenze, Kinsman, & Hardon, 2013). The most vulnerable groups in Kenya have been highlighted to include the gay community, female sex workers, street children, and people who inject drugs (UNICEF, 2014). This group (the vulnerable population) also has an adolescent population, but the data and the statistical report does not capture this information because in most cases, the teenage group is covered among children of 0-14 years and adults of 15 to 49 years.

Statistic coverage from significant research organizations suggests that the HIV threat in adolescents is much lower at approximately twenty-four percent (24%). However, this data is inconclusive because the statistic does not provide independent data for adolescents. Albeit the resources at their disposal, large organizations like UN, UNICEF, UNAIDS, and AVERT still lack disaggregated HIV data on adolescents. The chart below is a snapshot of the United Nations (UN) data regarding HIV statistics in Kenya.

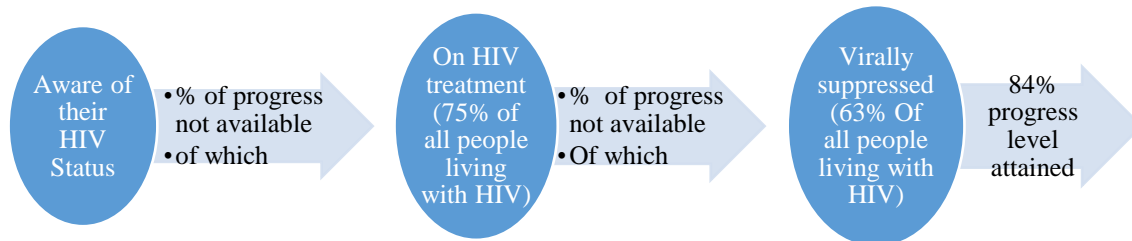
2. UN DATA REGARDING HIV STATISTICS IN KENYA



3. RETRIEVED FROM UNAIDS 2019 REPORT

While the data has information regarding the age group, there is a deliberate assumption that teenage details are less important. Note that the statistics groups teenagers with children below fifteen years and also fix in the category of adults of fifteen to forty-nine years. The order in which data is presented fails to capture the actual status of adolescents (mainly those in high school stage). Be that as it may, these figures may misrepresent teenager (between 13 and 19 years); another factor that exacerbates vulnerability to HIV infections among adolescents. The following chart shows Kenyan progress towards 90/90/90 target in all ages.

4. KENYAN PROGRESS TOWARDS 90/90/90 TARGET



Source: AVERT 2018

Studies also posit that a significant proportion of the Kenyan population is still reluctant to take HIV test and treatment. In 2016, only sixty-four percent of people living with HIV in Kenya were accessing treatment (AVERT 2018). Despite the widespread of information regarding HIV and AIDS, many PLHIVA in Kenya face high levels of stigma and discrimination that prevents them from accessing HIV services (Bonnington, et al., 2016). A study conducted in Kisumu revealed stigma is a massive barrier to HIV testing, making women circumvent delivering babies in health centres to avoid HIV test (Turan, Miller, Bukusi, & Sande, 2008). The findings are daunting given that HIV stigma was also revealed in adults. Hypothetically, if parents also experience stigma, then they are not in a position to protect the adolescents from stigmatization. At the point adults suffer stigma predicament, then it is; likely that the situation is worse in teenagers and young adults. The primary issue with stigma is that it becomes a barrier for the HIV positive population to access critical medical care that enables them to live a healthy life.

5. HIGH PREVALENCE COUNTIES IN KENYA

A report from Kenya Aids Strategic Framework showed that the lake region of Kenya has been leading the pack of top ten counties with the highest HIV and AIDS prevalence among then adult population. Homa Bay tops the 2018 list at 25%; Siaya County follows closely at 23.7% and Kisumu taking the third position with 19.3%. Following in the same directory are Migori with 14.7%; Kisii at 8%; Turkana at 7.6%; Mombasa 7.4%; Nairobi and Busia tied with 6.8; and Nyamira closed the top ten lists with a 6.4% (Kenya AIDS Strategic framework, 2019). There seems to be a consistency in top three counties more because, in 2013 alone, Homa Bay had 12,279 new records for HIV infections; Kisumu followed in the list with 10,349 new cases in the same year; Siaya County also registered 9,869 new cases in 2013 (Kenya National AIDS Control Council, 2019). The consistency rate in the most prevalent counties is a manifestation that the worst-hit counties are ignorant of the safety precautions. Ideally, registering high prevalence should form an alert to the surrounding population to take care.

High HIV AND AIDS prevalence in the lake region is partly attributed to traditional ethnic practices surrounding sexuality and gender relations (Juma, Askew, Alaii, Bartholomew, & Borne, 2014). Though on the decline, some of the traditions contributing to a high percentage of the population contracting HIV include; the non-circumcision rite of passage in the Luo community, disco manages the practice in the villages and, widow inheritance among men.

Disco matanga is a traditional occasion that seals mourning after the death of a loved one and offers a platform for the affected family to raise funds to cater for funeral expenses. Furthermore, the practices as mentioned earlier are popular in remote villages. Juma et al., (2014) explain that the events take place mostly in the night, and teenagers are encouraged to help in fundraising alongside music and dance. The scene explained is nothing but a sanitized night club that looks appealing for teenagers. The events associated with disco matanga create an atmosphere that provides opportunities for

youth to engage in risky sex that promotes HIV/STI transmission (Juma, Askew, Alaii, & Bartholomew, 2014). Furthermore, most of the attendees of the funeral discos are teenagers who are ignorant of ways to protect themselves from STIs. Therefore, HIV is spread in the events at an alarming rate as the teenagers are vulnerable to rape incidents and voluntary engagement in unsafe sex. Such an environment propagates risky teenage commitments that are sexual and such exposes them to a higher risk of infection. The problem will continue to affect adolescents because adult population presumes that this age group is still innocent beside the perceived stigma related to testing positive.

HIV prevalence is declining in Kenya; however, cases in Kenya are still leading in East Africa. Most recent studies show that the number of PLHIVA is declining. Ideally, research bodies derive these conclusions only from the number of people that have tested positive. The latest study by UNICEF, UNAIDS, and AVERT shows that HIV incidence has declined in Kenya from 8.9% as recorded in 2000 to 5.6% (Andae, 2019). Scholars attribute the difference to reliance on antiretroviral therapy (ART). This perception of improved medication could be the case. However, the same study also concluded that more than a third of the infected population is not on ART (Andae, 2019). Posting lower records in levels of people being infected and living with HIV could point out that a few people were going for tests. Note that the most significant population that does not consent to test could be the adolescents who shy away from HIV test.

Kenyan societies stigmatized vulnerable population through gossips and despising narratives. A study by Pennington et al. (2016) assessed the forms of HIV stigma in sub-Saharan Africa, including Counties with highest HIV records in Kenya. In the study, the researchers found that “Africa, stigma was evidenced by gossips and the relative absence of supportive interpersonal discourse, which fuelled judicious disclosure” (Bonnington, et al., 2016, p4). The case shows that stigma level is too high and given that those who do not know their status are aware of the situation. It is unlikely that no one would take the test within these areas. Furthermore, the situation also makes it hard for those that test positive to get help in the medical facilities. Adolescents have the majority of the population that is profoundly affected by esteem issues. Scenarios, where gossips are shared, will there escalate stigma in teenagers like a plague.

AIDS Strategic Framework also shocked Kenyans with their findings that the majority of the HIV positive population were married. Surprisingly, the worst-hit population is the adult population in marriages (Kenya National AIDS Control Council, 2019). The married community is the most affected, as Kenya AIDS Strategic framework puts it; 83.6% of HIV positive couples are married couples and are unaware of the partners status (Kenya AIDS Strategic framework, 2019). The point of living with positive partners without taking a test is an alert that a large population has not tested. The thinking may be farfetched but given the disaggregated data; the chances are that the community were exposed at the adolescent stage and proceed into marriage still hiding from the stigma of exposures.

The Anthropological Theory to Clinical Practice states that many PLHIVA are confronted with stigma because of the society they live in regarding HIV positive individuals as lesser human beings (Castro & Farmer, 2005). Once they live with the humiliation, it will be hard to eradicate the downgrading sentiments since many of the victims feel neglected by society. This theory postulates that different forces hinder the HIV positive teenagers from participating in community activities and from being acknowledged as regular human beings with challenges but also who have the right to belong. Such inhibitors include poverty and lack of medical attention by the government. They are discriminated and treated as outcasts.

Human rights and particularly the rights of the child stand out as aspects that if looked into, may not only lead to enhancement in the uptake of HIV and AIDS services but also increased rate of adherence to treatment by adolescents. Idele (2014) argues that respecting the rights of people living with the virus escalates their uptake of HIV services. Therefore, society must respect, shield, and advance the rights of adolescents and young people to ensure that they access HIV and AIDS-related information, its supplementary services, and treatment (UNAIDS, 2015). There is need to create an environment that gives school-going adolescents the power to test for HIV and AIDS, the capacity to protect themselves from infection/re-infection and, the capability for adherence to HIV treatment in school situation without stigma or any form of discrimination. Those who are affected have the right to a supportive environment that enables continuity of their education.

6. RESEARCH INSTITUTIONS ON HIV AND AIDS

Currently, different institutions invest time and resources in fighting the HIV and AIDS pandemic to bring it to a halt. All this would be futile if precise, and practical strategies are not put in place to fight the scourge. As alluded to by UNAIDS (2016), it will take the specific age-specific approach to address HIV and AIDS among certain age groups like the

adolescents; specially designed programs for different populations and cultures; and well thought out ideas to fit different geographic locations and countries. Diverse communities need different approaches, strategies, and programs that they can identify with, and that provide the group. Plans that fit the gay community, female sex workers, and people who inject drugs may not fit school situations where most adolescents belong.

7. STIGMA IN SCHOOLS

Discrimination on PLHIVA scares and prevents them from actively pursuing important HIV and AIDS services, including counselling, testing, prevention, and treatment. Research indicates that adolescents who are in school face the inhibiting stigma that scares them from HIV testing, the disclosure of their HIV status and the much-needed treatment adherence (NACC, 2015; Arnold, 2014). Strategies that have been put in place to curb stigma in schools tend not to make much impact on learners.

High levels of stigma are not healthy in an HIV and AIDS prone society and are a significant threat to the overall fight against the menace. As NACC (2015) puts it, Stigma and intolerance associated with HIV and AIDS, limited access to information and poor access to HIV and AIDS services are just some of the hindrances that keep young people in Kenya on the high HIV risk list (Juma, Askew, Alaii, & Bartholomew, 2014). Unless such limitations are forcefully, tactfully, and successfully tackled and overcome, the country can as well bid farewell to the HIV free generation by 2030, which could only remain a pipe dream.

High level of stigma impedes the fight against HIV and aids. Furthermore, stigma and discrimination related to HIV and AIDS have continuously been cited as having a negative bearing on the fight against HIV and AIDS among adolescents and youths in Kenya (NAC, 2015). Stigma hinders young people from testing, joining, and adhering to treatment and seeking counselling services. Despite constituting an active HIV and AIDS tribunal to ensure attainment of justice regarding stigma and biases stemming from HIV and AIDS-related conditions, the stigma remains a disturbing menace to the youth and adolescents in Kenya (CNACC, 2015). Stigma is high in educational institutions where most adolescents spend a significant portion of their time and life each year. The set-up makes it very difficult if not impossible for young people to seek HIV related services. Schools, therefore, need proper preparation to deal with stigma issues to free the mind and psychology of young people and empower them to seek healthcare services such as counselling, test, prevention, and treatment in a stigma-free environment.

Attitudes and perceptions held by the individual members of the society informed, feed, and fuel stigma in any traditional or modern community. Where there is a lack of knowledge, limited availability of information or misrepresentation of the same, negative attitude towards those who are suffering and those who are affected quickly arise (Kenya AIDS Strategic framework, 2019). It is therefore imperative that attitude change is pursued by individuals, groups, communities, and systems of a nation like Kenya that has a passion for minimizing HIV and AIDS pandemic by the year 2030.

Stigma is present in varied forms in schools and society at large. Some of them include verbal abuse by peers and care providers, suspicion, exclusion from performing activities such as music or sports, threats, and segregation in dormitories or cubicles to mention a few (Turan, Miller, Bukusi, & Sande, 2008). Such an experience may create deficient levels of self-esteem thereby leading to an unspecified identity crisis for the young and rapidly developing group in this critical developmental stage where a lot of physical, psychological, mental development occurs.

8. SELF-TESTING KITS

VCT (Voluntary counselling and Testing) is the primary entrance to accessing treatment and prevention (Mugo, et al., 2017). Albeit the available testing services including self-testing kits, the adolescents in Kenya do not test. According to Little & Rosenberg (2018), the adolescent makes up the highest proportion of PLHIV in the Kenyan population who are unaware of their status. As such, though positive, they are not on treatment.

The introduction of self-testing kits in Kenya has enabled people to test themselves in the comfort and seclusion at their homes. Arguably, self-testing kits provide the users with the privacy and secrecy they need when taking HIV test and should, therefore, encourage young people to know their HIV status. However, given the characteristics of adolescents and the environment from which most of them operate, self-testing remains a pipe dream for them. It is questionable whether stigma-related issues would allow adolescents to go for the kits, let alone accepting HIV positive results.

The school situation entails strict timelines, an occasional change of routine coupled with stigma and discrimination. Sometimes it encompasses conditions that bar testing and disclosure of one's HIV status. The young population prefers postponing everything to a later stage when they have the freedom to consent, are in a more favourable environment and, where time is more available, and they have more control over their health issues (Juma, Askew, Alaii, & Bartholomew, 2014). It is a dangerous time for the adolescents since for some, stigma means postponement of HIV testing and treatment; for others, it connotes non-adherence to treatment; and to still others, it is living under stigma and discrimination-allowing viral load to increase to levels they can easily infect other HIV cynical peers.

Adolescents cannot fully benefit from self-testing technology because it entails the absence of counselling before and after testing. The idea brings to mind situations in the early 1980s when persons having their status disclosed to them without proper advice headed straight to the rope and committed suicide (Firestone, 2017). Young individuals cannot be allowed to test in such conditions. Given the above psychological predicament, knowledge of status does not guarantee that teenagers would seek medical attention. In the absence of proper guidance, self-test kits could be another cause of death. They must be accompanied by guidance and counselling to enable them to accept their health and be placed on ART. Such conditions are rarely available in school set up, especially in boarding facilities. Therefore, beneficial innovations for the fight against HIV should be contextualized appropriately to fit within the school environment and accommodate adolescents.

Antiretroviral treatment (ARV's) helps in reducing HIV and AIDS-related deaths a great deal. When adhered to, the ARVs help suppress an individual's viral load to a point they cannot possibly infect a partner and does not suffer from AIDS. However, the privilege of adherence to ARVs eludes in-school adolescents. Those who are already on ARV may not find it easy to continue with treatment. Those who are not yet tested may shy off due to the fear of being stigmatized by the community. This situation hampers testing, the disclosure of status, starting on treatment, and adherence to treatment. The other issue is the ease of access to therapeutic drugs by students in active sessions. Some of these learners exhaust their prescribed medication early and cannot access them until the school permits visitation, a school mid-term, or school closure.

Compared to other counties in Kenya, Kisumu has the third-largest number of people living with HIV with an estimated percentage of 22 to 25 percent. The county is reported to be having at least 10,000 new cases annually (Juma, Askew, Alaii, & Bartholomew, 2014). Out of this proportion, 12 percent of them are youths (Ministry of Health, 2014). The discrimination has led to poor management and treatment of the victims. Over the years, Kisumu County has experienced other forms of stigmatization of HIV patients more so to the youths. According to the study done by the International Centre for Alleviation of Poverty, the children have lost dignity within the society, many of them being tagged as unfortunate, inferior people.

Stigma among adolescents in the country is categorized into three; namely experienced, internalized and perceived (Bonnington, et al., 2016) Perceived stigma refers to the victim's belief that they will be discriminated against because of their state of life. Victims isolate themselves from the community to avoid experiencing negative thoughts about themselves and on how they will be seen in the community. The experienced stigma occurs after the victim is enacted to what is happening in the society to the PLHIVA. The victims have experienced real events in the community.

Many youths in the county fall in this group. Their families abandon some of them. Both the categories of the HIV stigma can affect the youths differently; for instance, it may lead to delayed diagnosis (Katieno, 2016). The declaration will further distant people from the victim instead of receiving the much-needed help and support that is urgently needed. It is recommendable for the victims, with the backing from an immediate available societal structure such as friends, family, teachers to know their status early, start their medication first so that their immunity does not deteriorate. For the adolescents in high schools who are positive; they need encouragement, being treated with dignity like other people in society. Unfortunately, this is yet to be the norm in Kisumu County as stigma is still prevalent against People Living with HIV (PLHIV).

9. STIGMA ISOLATES HIV PATIENTS

HIV Stigma isolates affected individuals from the rest of the population. In the case of high school teenagers in the worst hit Counties in Kenya, (especially Kisumu and Homa Bay) the situation is further worsened by poverty, religious beliefs, and the culture of gossip (Bonnington, et al., 2016). In many parts of the world, programmes have already been

implemented that are directed specifically towards supporting HIV positive adolescents. The goal is to enable such individuals, and those who have already been victims of stigmatization accept their HIV status and live positively. As Macleki (2019) puts it, accepting ones way of life makes an individual not to bother about what people say. For such positivism, the individual can develop inner self drive and willpower necessary in taking responsibility for adhering to medication and interacting with the community freely.

REFERENCES

- [1] Andae, G. (2019, May 23). Kenya's HIV incidence falls but remains highest in East Africa. Retrieved July 17, 2019, from Business Daily: Daily Nation online: <https://www.businessdailyafrica.com/datahub/HIV-incidence-falls-but-remains-highest/3815418-5128116-eoqtjsz/index.html>
- [2] Arnold, E. A., Rebchook, G. M., & Kegeles, S. M. (2014). 'Triply cursed': racism, homophobia and HIV-related stigma are barriers to regular HIV testing, treatment adherence and disclosure among young Black gay men. *Culture, health & sexuality*, 16(6), 710-22.
- [3] AVERT. (2018, Oct 2018). Global information and education on HIV and AIDS. Retrieved from AVERT: <https://www.avert.org/global-hiv-and-aids-statistics>
- [4] Bonnington, O., Wamoyi, J., Ddaaki, W., Bukonya, D., Ondenge, k., Skovdal, M., et al. (2016). Changing forms of HIV-related stigma along the HIV care and treatment continuum in sub-Saharan Africa. *MBJ Journals*.
- [5] Castro, A., & Farmer, P. (2005). Understanding and Addressing AIDS-Related Stigma: From Anthropological Theory to Clinical Practice in Haiti. *American Journal of Public Health*, 95(1), 53. <https://doi.org/10.2105/AJPH.2003.028563>
- [6] Firestone, L. (2017). SUICIDE: WHAT THERAPISTS NEED TO KNOW? American Psychological Association Education Directorate, 2.
- [7] Gwadz, M., Leonard, N. R., Honig, S., Freeman, R., Kutnick, A., & Ritchie, A. S. (2018). Doing battle with "the monster:" how high-risk heterosexuals experience and successfully manage HIV stigma as a barrier to HIV testing. *International journal for equity in health*, 17(1), 46. doi:10.1186/s12939-018-0761-9
- [8] Idele et al (2014). Epidemiology of HIV and AIDS among adolescents: current status, inequities, and data gaps. *Journal of Acquired Immune Deficiency Syndrome*; Vol. 66(12):144–53.
- [9] Juma, M., Askew, I., Alaii, J., & Bartholomew, K. L. (2014, January 27). Cultural practices and sexual risk behaviour among adolescent orphans and non-orphans: a qualitative study on perceptions from a community in Western Kenya. *BMC Public Health*, 14(84).
- [10] Katieno. (2016). Effects of Stigma on Uptake of Antiretroviral Therapy among Women Attending Prevention of Mother-To-Child Transmission Clinics in Rachuonyo North Sub-County, Kenya
- [11] Kenya National AIDS Control Council. (2019, April). Kenya AIDS strategic framework 2014/2015-2018/2019. Retrieved June 30, 2019, from UNESCO HIV and Health Education Clearinghouse: <https://hivhealthclearinghouse.unesco.org/library/documents/kenya-aids-strategic-framework-20142015-20182019>
- [12] Kyaddondo, D., Wanyenze, R. K., Kinsman, J., & Hardon, a. (2013). Disclosure of HIV status between parents and children in Uganda in the context of greater access to treatment. 2-18.
- [13] Little, K., & Rosenberg, S. (2018). Update on Kenya HIVST. *PSI*.
- [14] Maleki. (2019). the HIV AND AIDS Pandemic in Kisumu County – Macleki. Retrieved March 16, 2019, from <https://macleki.org/stories/the-hiv-aids-pandemic-in-kisumu-county/>
- [15] Ministry of Health. (2014). the national HIV AND AIDS stigma and discrimination index report
- [16] Mioro, J. (2013). Stigma and discrimination against people living with HIV (PLHIV) in the Methodists church a case of Njia Circuit, Igembe South Sub County, and Meru County

- [17] Mugo, P. M., Micheni, M., Shangala, J., Hussein, M. H., Graham, S. M., Rinke de Wit, T. F., et al. (2017). Uptake and Acceptability of Oral HIV SelfTesting among Community Pharmacy Clients in Kenya: A Feasibility Study. *PLoS ONE* , 12 (1).
- [18] National AIDS/STI Control Program (NASCO) (2015). 'Epidemiologic and Programmatic Profile of HIV among Key Populations in Kenya. Final Report'
- [19] Turan, J. M., Miller, S., Bukusi, E. A., & Sande, J. (2008). J.M. Turan, S. Miller, E.A.ow fears of stigma and discrimination affect uptake and provision of labour and delivery services. HIV and Maternity care in Kenya.
- [20] UNAIDS. (2016). Global AIDS update 2016. *HIV global Estimates* .
- [21] UNICEF. (2014). 2014 Annual Results Reports for HIV and AIDS. HIV and AIDS/ UNICEF, 8-74.