

HIV Related Stigma Among People Living with HIV and AIDS in Limbe Health District, Cameroon

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Abstract: The background to the article is that, the Human Immuno-deficiency Virus (HIV) - related stigma tends to create a vicious cycle of fear, ignorance, mistrust, misinformation, denial and self-isolation, which tend to further spread the virus because stigma affects the way people will take their treatment. The objective of this study was to assess the forms of stigma, and determine the role of stigma and other factors among HIV and the Acquired Immuno-Deficiency Syndrome (AIDS) patients on Anti- Retroviral Therapy (ART) in Limbe Health District. For the method, a cross-sectional design with a sample size of 389 was used. Interviewer- administered questionnaire was used to collect data from HIV and AIDS patients belonging to HIV support groups in Limbe Health District found at the treatment centre of the Limbe Regional Hospital. Data was collected on socio-demographic characteristics of respondents, forms of stigma and factors in association. Data was analyzed using STATA version 7.0. Results have shown that in all, stigma was experienced by 76.7% respondents. Among this group, self-stigma was experienced by 95% of the respondents while 28% experienced external stigma. Majority of respondents (92.8%) admitted it was not easy to disclose their status, 7.2% felt dirty while 20.05% felt guilty of contracting HIV. Association of overall stigma with adherence to treatment showed no statistical significance, however respondents who did not experience self-stigma were more adherent (76.9%) than those who experienced overall stigma (71.01%). It can thus be concluded that people living with HIV/AIDS (PLWHA) belonging to HIV support groups in LHD experienced both internalized and external stigma, with the former experienced by almost all the respondents. Although stigma was not significantly associated with adherence to treatment, the very high level of internalized stigma warrants the implementation of stigma reduction measures.

Keywords: HIV/AIDS, Stigma Experiences, Effects

1. Introduction

The stigmatization of people living with HIV and AIDS (PLWHA) tends to create a vicious cycle of “socially shared ignorance, fear, mistrust, misinformation, denial which further spread the disease” [1]. This study was out to determine the forms of HIV-related stigma experienced by HIV patients taking treatment at a health district.

The National AIDS Control Committee (NACC) estimates that 141 HIV new infections are diagnosed daily in Cameroon, giving an average of six infections per hour. As

concerns the mode of transmission, 90% of transmission is through sexual contact, 6% by mother-to-child transmission and 4% by blood and other means [2].

According to the Joint United Nations Programme on HIV/AIDS (UNAIDS), continued stigmatization and the resulting discrimination of PLWHA has created numerous barriers in preventing further infections, providing further care, support and treatment of PLWHA [3]. HIV-related stigma and discrimination is defined as “a process of devaluation of people either living with or associated with HIV and AIDS. While discrimination follows stigma and is the unfair and unjust treatment of an individual based on his

or her real or perceived HIV status [4]”. Furthermore, Goffman defines stigma as “an attribute that is deeply discrediting and that reduces the bearer from a whole and usual person to a tainted, discounted one [5]”.

HIV-related stigma is due to many factors including; lack of understanding of the disease, believe that it is transmitted through irresponsible life styles, lack of access to treatment and the believe that it leads to death [6]. Stigma is generally associated to sexuality, gender, race and ethnicity and class. Sexual stigma is very common because HIV is mainly transmitted sexually, and in most parts of the world, the disease first affected people whose life style was questionable. This included homosexuals, prostitutes, intravenous drug users etc. Thus HIV is seen as a disease of the people who are promiscuous, or living a sexual deviant life style [7]. This probably explains why HIV and AIDS is seen “as death, as horror, as punishment, as guilt, or as shame”, AIDS metaphors which “have exacerbated these fears thereby reinforcing and legalizing stigmatization and discrimination [7].

In Cameroon, both external and self-stigma is very common. Due to this, some HIV positive individuals isolate themselves from others, denying themselves the right to health care and even life because of fear of prejudice of others. Some even conceal taking the ART from their family members thereby leading to non-adherence and eventually leading to drug resistance [8]. A study carried out by Jacobi *et al* (2013) in Buea revealed that about half of the PLWHA interviewed suffered from stigmatization and discrimination mainly in the form of gossiping and verbal insult. Meanwhile about 50% felt ashamed and guilty of being HIV positive [9].

Equally important is the fact that the shame of living with HIV referred to as internalized or self-stigma may prevent PLWHA from seeking counseling, treatment, support services and even from exercising their rights such as going to work or attending school. This may often result to serious psychological influence on them leading to self-denial, blame, depression and self-imposed isolation [10].

Furthermore it is documented that HIV-related stigma has a negative impact on life satisfaction and the quality of life. It is associated with poorer mental outcomes, reduced self-esteem, reduced self-efficacy and decrease adherence to therapy [11]. In Vietnam for instance, stigmatizing community attitude towards PLWHA has profound consequences on them as it leads to internal stigma, self-isolation, lower self-esteem, and non-disclosure of HIV status. This has acted as a major barrier to seeking health care, adherence to therapy thereby leading to further transmission of the virus [12].

1.1. Statement of Problem

HIV stigma and discrimination in the health facilities may result to PLWHA not being able to access adequate prevention, care and treatment services [24]. According to UNAIDS, stigmatizing and discriminatory actions directed at PLWHA violates their fundamental human right to freedom from discrimination. It also lead to the violation of their other

rights such as “rights to health, dignity, privacy, equality before the law, and freedom from inhuman, degrading treatment or punishment” [25]. Evidence also shows that stigma can become internalized by the patient and this can seriously affect physical and mental health. Internalized AIDS stigma can play a crucial role in the wellbeing as well as the distress suffered by AIDS patients [26]. Based on these, this study on experiences of internalized or self stigmatized among PLWHA at the study site.

1.2. Objectives

1. Assess the common forms of stigma experienced by PLWHA who were members of HIV support groups in Limbe Health District.
2. Determine the association between stigma and people accepting to take treatment among PLWHA who were members of HIV support groups in Limbe Health District.
3. Identify who and what are the main causes of stigma among PLWHA who were members of HIV support groups in Limbe Health District.

2. Materials and Methods

A descriptive cross-sectional and analytical study was conducted. The study setting was in an urban health facility. Eligible participants were HIV and AIDS patients who were initiated on antiretroviral therapy and were members of HIV support groups. The target population was made up of PLWHA, aged 21 years and above, who were HIV/AIDS positive and were on treatment.

A non-probability convenient sampling technique was used to recruit participants. The eligible participants who were available and accepted to take part in the study by signing the consent form were interviewed. This process continued until the sample size was reached. A standard structured interviewer administered questionnaire was used to collect data.

A sample size calculation formula that was used considered the estimation a single population proportion for a cross-sectional study of an infinite population.

$$n = \frac{z^2 p(1 - p)}{d^2}$$

- Where n = sample size
- z = is the standard deviation in normal life which becomes 1.96, using a 95% confidence interval
- p = assumed proportion of non stigmatized 50% = 0.5
- d = margin of error tolerated at 5% = 0.05
- Computing in the formula gave:

$$n = \frac{1.96^2 * 0.5(1-0.5)}{0.05^2} = 384$$

A standard structured questionnaire designed to meet the objectives was used in data collection. It assessed whether respondents experienced stigma, and the forms of stigma. Internalized or self-stigma was assessed using the Internalized

AIDS-Related Stigma Scale adapted and validated by Kalishman from the World Health Organization (WHO) Generic Tools for operational research [13], The Internalized AIDS-Related Stigma Scale is a structured screening tool with 6 items for the assessment of HIV related self-stigma and concealment of HIV status. To simplify administration, the questions were responded to dichotomously as 1= "Agree", and 0= "Disagree". This gave a stigma score ranging from 0-6 and if the respondent accepted that she had feelings of shame or worthlessness for example, she was considered as experiencing self-stigma [14, 15]. Enacted or external stigma was also measured using the WHO generic Tools for Operational Research [14]. It consists of 15 items focusing on physical assault, verbal abuse and abandonment of the HIV victim. Data was collected on a face-to-face administration of the questionnaire. Data collection was health facility and support group based. HIV support groups were visited during their meeting days for those who could be met at the health facility. After explaining the study and its purpose, informed consent was sought individually from members before administering the questionnaire. Data was analyzed using the statistical software programme STATA version 7. Administrative and ethical clearances were obtained from the Institutional Review Board of the Faculty of Health Sciences of the University of Buea and the health administrative structures of the region.

3. Results

Three hundred and eighty nine (389) correctly filled questionnaires were received and used for Out of a total of 389 participants who took part in this study the majority (69.41%) were female. One hundred and three (26.48%) respondents were unmarried, 61.7% were married, 8.23% were divorced and 3.6% were widows or widowers. Twenty-one (5.4%) of the participants had no formal education, 32.39% attended primary education, the majority (53.98%) attended secondary education, while 8.23% had been to the university. The participants' age ranged from 21 years to more than 50 years, with the age bracket 31- 40 years being the modal age range. Table 1 also describes the religious, residential, occupational status, food sufficiency and transport means of study participants to HIV treatment centre to receive their ARVs. A large majority of participants (96.66%, n =376) were Christians, only 4 (1.03%) were Muslims, while 9 (2.31%) had no religion. Residential distribution of participants shows that as many as 324 (83.29%) lived in Limbe Health District (LHD -Urban) and 65 (16.71%) live out of Limbe Health District (rural) and only came to attend HIV support group meetings and refill their ARVs. As concerns participant's occupational status, 38.8% were unemployed while 61.18% were employed or had something doing which raises them income. Respondents were also assessed on food sufficiency. More than half (63.24%) reported that they had food sufficiency in the one month prior to the interview, 33.16% sometimes had food insufficiency, 2.31% participants often had difficulty feeding themselves while 1.29% always had food shortage.

The participants were also assessed on the transport means,

length of time spent to treatment centre, transport cost to treatment centre and the length of time on ART. These were assessed because they might have implications on ART adherence in the long run.

The study participants used various transport means to the HIV Treatment Centre at the Limbe Regional Hospital where all of them receive their ARVs. More than half (60.41%, n=235) went there by car, 34.7% (n=135) by motor cycle and only 4.9% (n=19) went there on foot. The mean time spent to reach the treatment centre was 31 minutes, with standard deviation (SD) of 38.71. The lowest and highest time spent was two minutes and three hours 10 minutes respectively.

Also the mean transport cost spent by the participants to and fro the HIV Treatment Centre was 1,197FCFA with SD of 1,583. The least transport cost was 0 FCFA (those who trekked); while some participants spent as much as 10,000 FCFA just to refill their ART each month.

As concerns length of time on ART, the least time was 6 months and the highest time was 15 years, giving a mean time of 4.9 with a SD of 3.11. Table 1 below shows the socio-demographic characteristics of the study participant.

Table 1. Distribution of participants according to socio-demographic variables.

Variable	Freq. (N = 389)	Percent
Gender		
Female	270	69.41
Male	119	30.59
Marital status		
Unmarried	103	26.48
Married	240	61.7
Divorced	32	8.23
Widow	14	3.6
Educational level		
None	21	5.4
Primary	126	32.39
Secondary	210	53.98
University	32	8.23
Age		
21-30	45	11.57
31-40	164	42.16
41-50	128	32.9
>50	52	13.37
Religion		
None	9	2.31
Christianity	376	96.66
Islam	4	1.03
Residence		
Out of LHD	65	16.71
LHD	324	83.29
Occupation		
Unemployed	151	38.8
Employed	238	61.18
Food need		
Never lack	246	63.24
Sometimes	129	33.16
Often	9	2.31
Always	5	1.29
Transport means		
On foot	19	4.88
Motorcycle	135	34.7
Car/vehicle	235	60.41

For forms of stigma, overall stigma was experienced by 76.7% of the respondents. The respondents experienced both internalized and external stigma.

For experiences of internalized or self-stigma, self-stigma was experienced by a large majority of the respondents. Three hundred and seventy-one (95%) experienced self-stigma as shown on Figure 1.

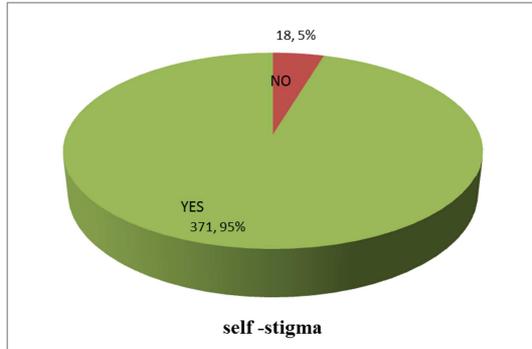


Figure 1. Distribution of participants according to self-stigma.

With regards to aspects of experiences of self-stigma, an overall, 92.8% of respondents agreed that it was not easy to disclose their HIV status, 7.2% agreed that being HIV positive made them feel dirty, 20.05% had feelings of guilt, 19.79% felt ashamed, 21.59% felt worthless while 83.8% actually hide their HIV positive status. Different question items represented issues on internalized stigma (Table 2).

Table 2. Distribution of participants according to various items of internalized stigma.

Items	Frequency (N)	Percentage
It is easy to tell people you are HIV positive		
Disagree	361	92.80
Agree	28	7.20
Being HIV positive makes you feel dirty		
Disagree	361	92.80
Agree	28	7.20
You feel guilty that you are HIV positive		
Disagree	311	79.95
Agree	78	20.05
You are ashamed that you are HIV positive		
Disagree	312	80.21
Agree	77	19.79
You sometimes feel worthless because you are HIV positive		
Disagree	305	78.41
Agree	84	21.59
You hide your HIV status from others		
Disagree	63	16.20
Agree	326	83.80

The association of self-stigma with socio-demographic variables was analyzed and summarized as on table 3 below. Results shows that 94.81% female and 96.64% male respondents felt stigmatized by being HIV seropositive.

Regarding marital status, 94.17% of unmarried, 96.67% married, 93.75% divorced and 85.71% widowed were stigmatized by their HIV status. This association was however not statistically significant. The relationship between self-stigma and age of respondents also show no statistical significant. However, those above 50 years felt lesser self-stigma (90.38%), compared to 93.33% for the age group 21-30 years; 95.73% for those aged 41-50 years; and 97.66% for those aged 41-50. With regards to educational level, all with non-formal education (100%), 94.44% of those with primary education, 95.71% with secondary education and 93.75% of those with tertiary education experienced self-stigma. Also relationship between self-stigma and religious affiliation show no statistical significance. All Muslims (100%) and all those who reported having no religion (100%) experienced self-stigma as against 95.21% of Christians. Likewise the association of stigma with occupational status shows that 96.03% of unemployed and 94.96% employed respondents experienced self-stigma. Place of residence had, 95.38% (n= 62) of respondents who lived out of Limbe Health District (rural) and 95.37% (n= 309) of those within Limbe Health District (Urban) felt stigmatized. As realized, the association between HIV self-stigma and the socio-demographic characteristics of respondents show no statistical significance (Table 3).

Table 3. Association of HIV self-stigma with participant's socio-demographic variables.

variable	stigmatized		p-value
	NO	YES	
Gender (N,%)			
Female	14 (5.19)	256 (94.81)	0.430
Male	4 (3.36)	115 (96.64)	
Marital status (N,%)			
Unmarried	6 (5.83)	97 (94.17)	0.222
Married	8 (3.33)	232 (96.67)	
Divorced	2 (6.25)	30 (93.75)	
Widowed	2 (14.29)	12 (85.71)	
Age bracket			
21-30 YRS	3 (6.67)	42 (93.33)	0.179
31-40 YRS	7 (4.27)	157 (95.73)	
41-50 YRS	3 (2.34)	125 (97.66)	
>50 YRS	5 (9.62)	47 (90.38)	
Level of education			
None	0 (0.00)	21 (100.00)	0.660
Primary	7 (5.56)	119 (94.44)	
2 nd /high	9 (4.29)	201 (95.71)	
University	2 (6.25)	30 (93.75)	
Religion			
None	0 (0.00)	9 (100.00)	0.760
Christian	18 (4.79)	358 (95.21)	
Muslim	0 (0.00)	4 (100.00)	
Occupation			
Unemployed	6 (3.97)	145 (96.03)	0.625
Employed	12 (5.04)	226 (94.96)	
Residence			
Out of LHD	3 (4.62)	62 (95.38)	0.996
LHD	15 (4.63)	309 (95.37)	

Looking at data on external or enacted stigma, there was a minimal existence of 109 (28%) (Figure 2).

From the above figure, unlike self-stigma, fewer respondents experienced external stigma. Detailed result of various aspects of who and what showed stigma perpetuated by spouse or sex to be 15.94% while most respondents did not suffer stigma caused by their partner (84.06%).

The response per item of external stigma caused by spouse or sexual partner is shown on Figure 3 below. Five point four percent (5.4%) of the participants experienced physical assault from their partner after disclosing their HIV status, 10.54% were blamed for contracting HIV, 8.25% were verbally abused, while 5.93%, 6.43% and 5.4% experienced

divorce, were ignored and abandoned respectively by spouse.

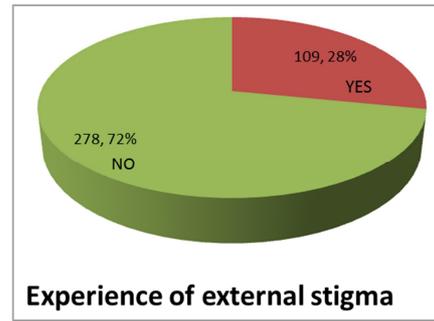


Figure 2. Distribution of respondents according to external stigma.

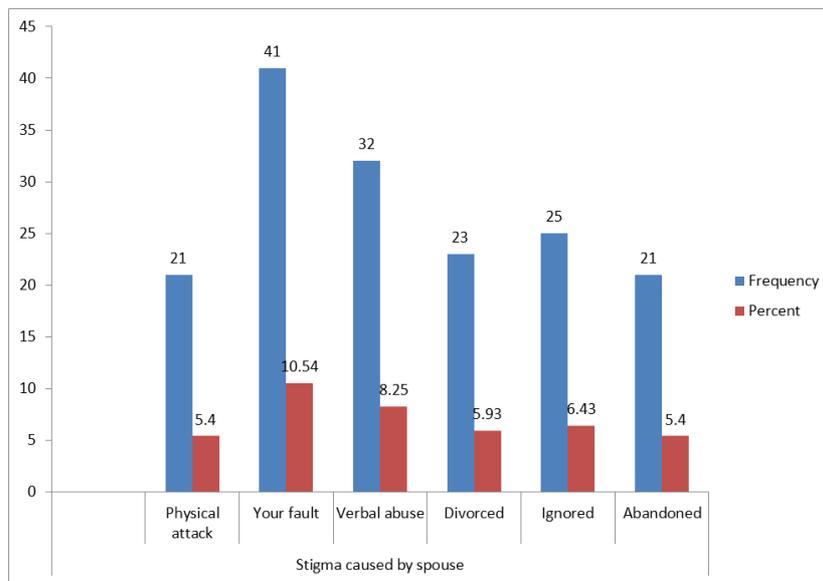


Figure 3. Distribution of participants per item of external stigma caused by spouse or sex partner.

The experiences of external stigma caused by community and other family members and the results: that less than a quarter of the participants 22.62% experienced stigma from the community and other family members. Figure 4 depicts the response per item of external stigma caused by the

community and other family members. The three aspects of external stigma suffered mostly by respondents from community and other family members were being gossiped about (19.02%), blamed as being one's fault for contracting HIV (5.14%) and verbal abuse (3.36%).

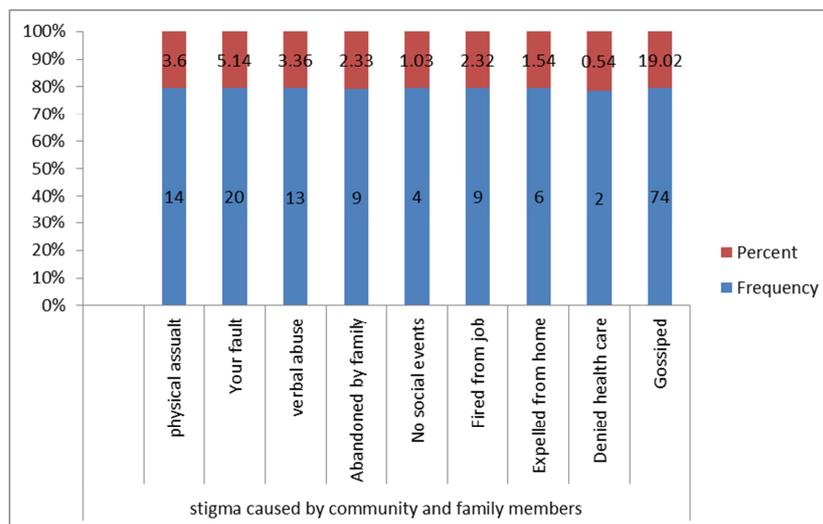


Figure 4. Distribution of participants according to stigma caused by community and other family members.

An association between external stigma by spouse and socio-demographic data was established as below.

Gender: Result reveals that 26.05% of male respondents as compared to 11.48% of females were stigmatized by their spouse because of their HIV positive status. This difference was statistically significant (P-value <0.01). Comparing males to females, males were 2.72 times as likely as females to be stigmatized by their spouse. After adjusting for confounders (religion and residence), males were 2.94 times as likely as females to be stigmatized by their spouse.

Marital status: Also, 13.59% of unmarried respondents and 13.33% of married respondents were stigmatized by their spouse, meanwhile 50% of the divorced reported being stigmatized by their former spouse or sexual partner. 100% of widows/widowers reported no spousal stigmatization. This difference was not statistically significant.

Educational level: Concerning educational level, majority of respondents who felt stigmatized by spouse or partner were those with secondary education (17.14%), followed by primary school leavers (15.08%), while respondents with tertiary education (12.50%) were the least stigmatized by their spouse or partner.

Religion: Concerning religion, 75% of Muslims, 15.16% of Christians and 22.22% of respondents without a religion reported stigmatization by spouse or sexual partner. This difference was statistically significant with a P-value of 0.0043.

Comparing Christians to respondents without religion, Christians were 0.63 times as likely as those without a religion to be stigmatized by their spouse. After adjusting for confounders, Christians were 0.88 times as likely as those without a religion to be stigmatized by their spouse.

Comparing Muslims to respondents without a religion, Muslims were 10.5 times as likely to be stigmatized by their spouse. After adjusting for confounders, Muslims were 16.71 times as likely to be stigmatized by their spouse as respondents without a religion.

Residence: 24.62% of respondents living out of Limbe Health District and 14.20% of those living in Limbe Health District were stigmatized by their spouse or sexual partner. This difference was statistically significant (P-value 0.036).

Logistic regression gave an OR of 0.51 while multiple logistic regressions gave an aOR of 0.40. This means that participants in LHD were 0.04 times as likely as participants out of LHD to be stigmatized by their spouse. The OR is less than one (1) which means that those living out of LHD experienced more stigma from their spouse.

Occupation: Association of internalized spousal stigma with participant’s occupation was not statistically significant. Overall, 13.91% of unemployed and 17.23% of employed participants were stigmatized because of their HIV status. Table 4 below summarizes the association of external stigma by spouse/sexual partner with participant’s socio-demographic characteristics.

Table 4. Association between external stigma by spouse and socio-demographic data.

Variable	Yes (N,%)	No (N,%)	P-value	OR	aOR	P-value	95% CI
Gender			0.000				
Females	31 (11.48)	239 (88.52)		ref			
Males	31 (26.05)	88 (73.95)		2.72	2.94	0.000	1.65-5.26
Marital status			0.0767				
Unmarried	14 (13.59)	89 (86.41)					
Married	32 (13.33)	208 (86.67)					
Divorced	16 (50.00)	16 (50.00)					
Widow/widower	0 (0.000)	14 (100.00)					
Level of education			0.8926				
None	3 (14.29)	18 (85.71)					
Primary	19 (15.08)	107 (84.92)					
Secondary	36 (17.14)	174 (82.86)					
Tertiary	4 (12.50)	28 (87.50)					
Age bracket			0.6720				
21- 30 years	9 (20.00)	36 (80.00)					
31- 40 years	22 (13.41)	142 (86.59)					
41- 50 years	22 (17.19)	106 (82.81)					
>50 years	9 (17.31)	43 (82.69)					
Religion			0.0043				
None	2 (22.22)	7 (77.78)		ref			
Christians	57 (15.16)	319 (84.84)		0.63	0.88	0.881	0.17-4.65
Muslims	3 (75.00)	1 (25.00)		10.5	16.71	0.053	1.0-288.9
Residence			0.036				
Out of LHD	16 (24.62)	49 (75.38)		ref			
Within LHD	46 (14.20)	278 (85.80)		0.51	0.40	0.008	0.20-0.79
Occupation			0.383				
Unemployed	21 (13.91)	130 (86.09)					
Employed	41 (17.23)	197 (82.77)					

4. Discussion

In this study, the proportion of respondents who experienced internalized and enacted stigma, and the relationship between stigma and participants' socio-demographic variables was assessed.

Overall stigma was 76.7%. This finding is in contrast with the findings from South East Nigeria [16] where overall stigma was only 31.7%. Between the two forms of stigma experienced, internalized or self-stigma was very high (95%), while enacted stigma was experienced only by 28% of the respondents. This means that stigma is felt more internally than externally. This high level of internalized and low external stigma corroborates with a study carried out in Los Angeles in 2007 [17] which shows that internalized stigma was 89% and external stigma was 31%. It differs from a study carried out in Nigeria in 2012 [1] which portray that only 37.1% of the respondents experienced self-stigma and up to 98% suffered from external stigma. Although the association of internalized stigma with socio-demographic variables was not statistically significant, this study reveals that increase in education was directly related to reduce self-stigma. Respondents with the highest level of education (tertiary education) experienced the least self-stigma (93.75%) compared to 100% self-stigma among those without formal education. This could be as a result of better living and working conditions among people with higher education. This result is in consistent with a study carried out by Sekoni et al [ibid] which reveals that increase in level of education was associated with a reduction in self-stigma.

Only 28% of respondents experienced external stigma in this study. This low level of stigma is probably because majority of respondents (83.80%) hide their HIV status from other people and 14.91% of them even admitted that their spouses were not aware of the fact that they were on ARV treatment. Result of external stigma also reveal that many of the respondents suffered from gossip, verbal abuse, were blamed for contracting HIV, physically assaulted, ignored and abandoned by their spouse. This is in conformity with a study carried out in Buea Cameroon by Jacobi et al [9] which shows that the major problem faced by PLWHA regarding stigmatization was gossiping, verbal abuse and abandonment. A statistically significant association was observed between external stigma caused by spouse with socio-demographic variables (gender, religion and place of residence) of respondents. Women (11.48%) were less likely to be stigmatized by their spouse, while men (26.05%) were more likely to be stigmatized by their spouse. This is evident as women are quick at accusing their spouse of infidelity and infecting them with the virus when their HIV result shows positive. Also Muslim respondents (75%) experienced more stigma by spouse compared to only 15.16% Christians and 22.22% respondents without a religion. However no studies were found which separately related external stigma caused by spouse and that caused by community with socio-demographic variables. Most studies on internalized and

external stigma [1, 18, 19] only assessed the association between self-stigma and/or external stigma with socio-demographic variables.

Likewise the association of external stigma caused by spouse and by other community members with residence shows a statistical significant association (P-value 0.036 and 0.003 respectively). Respondents living out of LHD (rural) experienced more stigma from their spouse than those living in LHD (urban). Respondents out of LHD (rural) also experienced more stigma from community members compared to those living in LHD (urban). This may explain why some respondents travelled over three hours, spending as much as 10,000FCFA every month just to go to the HIV treatment centre at Limbe Regional Hospital for treatment refill, meanwhile there are other HIV treatment centres not very far from their residence. This finding corroborates with the finding of Nyblade L [7] which shows how people have tried to distant themselves from HIV by "not seeking care until extremely ill, grinding pills into powder to conceal medications from others and travelling far from home and local gossip to visit health providers". The public health implication is that despite the dramatic progress in HIV interventions, the social aspect of the disease such as stigma continues to threaten the emotional, psychological and physical welfare of PLWHA thereby reducing adherence level and affecting other areas of their life. As PLWHA are stigmatized upon by family and community members, this may encourage them to take their treatments in hiding and may skip some doses thereby leading to sub-optimal treatment with the resulting consequences on their health and to society as a whole.

5. Conclusions

PLWHA in Limbe Health District experience enormous self-stigma. Self and enacted stigma exist in the study population and affects the taking of treatment. Spouses and sex partners are also agents of stigma; and worse of all community and other family members have been found to be a source of stigma.

6. Recommendations

Self-stigma reduction interventions should be a priority among PLWHA and they should be educated on stigma reduction strategies during counseling sessions and HIV support group meetings.

General community sensitization is still required to reduce stigma by spouses, family and community members.

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