

---

## THE INFLUENCE OF GENDER-RELATED FACTORS ON ACCESS TO ANTIRETROVIRAL THERAPY IN NAIROBI, KENYA

---

\*Richard T. Kamau<sup>1</sup>, Isaac O. Mwanzo<sup>1</sup>, Nicholas K. Gikonyo<sup>2</sup>

<sup>1</sup> Department of Public Health, Kenyatta University, Nairobi, Kenya.

<sup>2</sup> Department of Pharmacy and Complementary/Alternative Medicine, Kenyatta University, Nairobi, Kenya.

---

### ABSTRACT

This is a research report of a study set out to investigate the influence of gender related factors on access to antiretroviral therapy. The results showed that the number of females visiting ART clinics was twice that of males, and in the 18-26 years age bracket, females were 3 times more affected by HIV/AIDS than males. The marital status carried a 5-fold risk of carrying the AIDS virus while women were twice as likely to be infected by their husbands as compared to men getting the virus from their wives. The findings indicate that the lower the formal education, the higher the chances of carrying the virus. The findings suggest men had a significant advantage over women on access to ARVs. The clinic schedules precluded about 10% of the patients from access. Social stigma was low (approx. 10%) within spouses, and very high (approx. 90%) outside the institution of marriage. Women bore the larger burden of the stigma. In addition, the results suggest that gender segregated clinics would have no influence on the number of patients attending the clinics.

**Key words:** Gender, access, antiretroviral therapy, HIV/AIDS.

### INTRODUCTION

Kenya's national gender based HIV/AIDS prevalence is 3.5 percent for males and 6.7 percent for females. Nairobi has a gender based prevalence of 8.0 percent for males and 12.3 percent for females [1]. With this background in mind, there is little published information disaggregated by gender, age or socio-economic status to indicate who is accessing ART services in resource poor contexts. However, data available elsewhere suggests that access to ART services is often most common amongst educated men living in urban areas. Literature suggests that poor women appear to be at a disadvantage in accessing HIV/AIDS treatment. Furthermore, there are some groups of women who appear excluded from mainstream HIV/AIDS services, such as commercial sex workers, intravenous drug abusers, HIV positive women who are pregnant or have children [2].

Addressing the role of gender in HIV/AIDS and education, Palomo [3] identifies the unequal gender relations as a factor that is influencing the spread of the epidemic. He argues that women and girls are at higher risk of contracting the virus because of their vulnerability occasioned by biological, economical, and social-cultural factors. Where there are direct costs for ART services, both poor women and men have limited ability to access the services. Where a household has only sufficient resources for one member to receive ART services, it will usually be the male head who takes priority. Where women have some independent access to financial resources, they may forgo food or other essentials to pay for health care, or alternatively not seek health care. Where women care for children, they will often put providing for the child before their own health care needs. Even if treatment is free, other indirect costs that are incurred can prevent women's access to treatment. Besides these financial constraints, many women's domestic responsibilities mean they find it difficult to leave their homes and families to travel to a clinic.

In finding out the influence of gender related factors (GRFs) on access to ART amongst PLWHA's in Nairobi, this study had the following specific objectives: To determine the role of patients' socio-demographic characteristics in access to ART, to establish the influence imposed by socio-economic status of a patient on access to ART and to reveal the influence of socio-cultural factors on access to ART.

## **METHODOLOGY**

**Research design.** This study employed a descriptive cross-sectional design and was conducted in selected resource constrained sites in Nairobi, in the period October–December 2007. The study population comprised of male and female patients living with HIV/AIDS, who were accessing treatment and care within the boundaries of City of Nairobi as per the zoning pattern of NASCOP's ART program. To qualify for inclusion in this study, patients had to be over 18 years of age, HIV-positive and enrolled in a formal health program within Nairobi.

**Variables.** The gender related factors that constituted the independent variables in this study were classified into three broad categories. The categories were socio-demographic, socio-economic and socio-cultural factors. These are factors known to take different values within the same gender, and also vary across the gender. The factors that were considered in this study were: Sex, age, marital status, patient on ARVs, level of education, residence, method by which the virus was contracted, physical access, nature of marriage, awareness of social support groups, decision making, social stigma, and preference for gender segregated clinics.

**Sampling and Sample Size determination.** By end of 2006, Nairobi’s overall population, extrapolated from the 1999 census was approximately 3 million, with a HIV/AIDS population of 197,000 [4] The sample size was determined using the sample size determination formula [5] as follows:

$$n = \frac{Z^2 pq}{d^2}$$

Where: n = the desired sample size (if target population is >10,000), Z = the standard normal deviate at the required standard level, p = the proportion estimated to have the characteristics being measured, q=1-P, and d=the level of statistical significance set. The proportion estimated to possess the characteristic being measured was 197,000/3,000,000 =0.07. Hence, p = 0.07 and q =0.93. At 95% confidence level, the sample size for this study was worked out as follows:

$$n = \frac{(1.96)^2 (0.07) (0.93)}{(0.05)^2} = 99.8 \quad (100 \text{ patients})$$

Hence, a minimum of 100 PLWHA’s were to be selected for inclusion into the study through a multistage sampling approach which involved random, proportionate to size sampling technique. In the actual research, 255 PLWHA’s were studied. The number of patients interviewed by site and gender is shown in Table 1.

**Table 1 Patients interviewed by site and gender**

<b>Name of ART Centre</b>	<b>Male</b>	<b>female</b>	<b>Total</b>
1) Mathare North Health Centre	9	26	35
2) Dandora Health Centre	13	40	53
3) STC Casino	8	11	19
4) Westlands Health Centre	4	11	15
5) Lang'ata/Kibera	18	31	49
6) Kangemi health centre	19	47	66
7) Kariobangi	2	3	5
8) Jamaa Maternity Hospital	4	9	13
<b>Total</b>	<b>77</b>	<b>178</b>	<b>255</b>

Clearance for this study was sought from department of Public Health, Kenyatta University, Nairobi City Council, (Public Health Department) and Nairobi’s Provincial Medical Officer. A structured questionnaire was formulated intended to measure the various gender related factors. Completed questionnaires were subjected to data cleaning, coding, computer entry and analysis using SPSS software (Version 10).

## RESULTS AND DISCUSSIONS

**Distribution of study population by Sex.** Out of the 255 patients who took part in the study, 77 (30.2%) were men and 178 (69.8%) were women (ratio 1:2.3). Health workers in the health centres attributed the higher number of women attending clinic to the fact that men attend to paid work and often don't get permission from their workplace to visit the clinic. Whereas this finding is not conclusive, such a trend in a Southern African study was associated to routine screening of women as part of their antenatal care. Equivalent services do not exist for men [6]. This suggests that more women are diagnosed earlier than men and making their numbers in ART clinics high.

**Age profile of the study population:** The study sought to establish out the age profile of the sample population. From the results, the 26-33 years age group had the highest number overall followed by the 34-41 years age group with 80 (31.3%) and 77 (30.2%) of the respondents respectively (Table 2). The two age groups constituted of respondents whose ages ranged 26-41, N=157 (61.5%). The finding closely agrees with the UNAIDS report that shows the 25-39 years age group as the most affected by the HIV/AIDS globally. It will be noted that there were very few patients (only 2) older than 50 years and none of them was a woman. This finding is consistent with that of Muula, [4], where it was noted that older women tend to be less likely to access care and treatment services as a result of greater social stigma and neglect.

**Table 2. Age profile of the study population**

Age group	male	%	female	%	Total	%
18-25	10	13.0	34	19.1	44	17.3
26-33	20	25.9	60	33.7	80	31.3
34-41	21	27.3	56	31.5	77	30.2
42-49	24	31.2	28	15.7	52	20.4
Older than 50	2	2.6	0	0	2	0.8
<b>Total</b>	<b>77</b>		<b>178</b>		<b>255</b>	<b>100</b>

**Distribution of study population by marital status.** This study sought to find out how HIV/AIDS patients are distributed around the marital status. There were 161 (63.2%) people who were married and this constituted the largest state of marital status. The widowed/separated/divorced status was composed of persons who were once married. Hence, if current and past states of marriage are put together, then the state of being in marriage or had been once married had 213 people (83.5%) overall. The overall number of the unmarried was 42 (16.4%). This suggests that the state of marriage makes one about five times likely to access ART which in turn implies higher likelihood to contract the AIDS virus compared to

being single. This finding agrees closely with a Thailand study [7] which noted that marriage and long term relationships do not protect women from infection with HIV/AIDS.

**Table 3. Distribution of study population by marital status**

<b>Marital status</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Single	11	4,3	31	12.1	42	16.4
Married	50	19.6	111	43.5	161	63.2
Divorced/separated	7	2.7	14	5.4	21	8.2
Widowed	9	3.5	22	8.6	31	12.2
<b>Total</b>	<b>77</b>		<b>178</b>		<b>255</b>	<b>100</b>

**Number of patients on ARVs.** The relative numbers of the patients who were already on ARVs was assessed. A total of 174 patients were on ARVs. This number comprised of 54 men and 120 women (ratio 1:2.2). These findings were consistent with a study conducted in South Africa. The study found that male:female ratios on ARVs in that region was about 1:2.3 [6]. The study concluded by stating that overall, there were more females on ARVs than there were males and this was not solely explained by the higher HIV prevalence among females compared to males in the Southern Africa situation. However, the results of the current study suggest that the ratio of men to women attending ART clinics is replicated in the ratio of those on ARVs. The National ART Guidelines [8] indicate that a patient must have a CD<sub>4</sub> count of 200 and below to qualify for the ARVs. If the patient has a CD<sub>4</sub> count above 200, they are managed for opportunistic infections and related complications. For this reason some of the patients interviewed were not on ARVs. Nevertheless, all the patients were asked to state whether they were taking ARVs. The findings are consistent with those of (Muula *et al.*, 2007) who reported that there were more women on ARVs than men in a South African study, a fact easily explained by the larger numbers of PLWHA's who are women. However, viewed from within the genders, the findings suggest men have an advantage over women on access to ARVs. Among the men, 70.1% were on ARVs compared to 67.4% among the women. But a few of the ones not taking ARVs, did not know why the drugs were not prescribed to them, an indication that they were not well informed on their condition and how it is managed.

**Education profile of the patients:** The study sought to establish how the education level was distributed amongst the respondents. Overall, 125 (49.0%) respondents had at least high school education. However it is noted that this educational achievement was not equally distributed within the genders. Among the men, this attribute was possessed by 40 (51.9%) of the men, while amongst the women, it was possessed by 85 (48.0%) women (Table 4). This implies that the lower the education level, the higher the chances

of being infected, which will be reflected in the higher numbers seeking ART services. Hence, education becomes a gender related factor that influences access to ART differently amongst men and women. Education and adequate knowledge on contemporary health issues is generally accepted as crucial in preventing contracting infectious diseases.

**Table 4. Distribution of study population by education level**

<b>Highest Level of Education achieved</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>
Never went to school	1	0.4	10	3.9	11
Primary school	36	14.1	83	32.5	119
High school (O Level)	34	13.3	70	27.5	104
Middle level college education	4	1.5	10	3.9	14
University education	2	0.7	5	1.9	7
<b>Total</b>	<b>77</b>	<b>30.2</b>	<b>178</b>	<b>69.8</b>	<b>255</b>

**Residential profile of the patients.** The results show that almost a quarter of the clients came from outside the area (20.2%). In fact some patients revealed that they preferred distant ART centres to reduce chances of being spotted by somebody known to them. Thus, the problem of stigma and denial are still rampant among the patients. Nevertheless, the findings underscore the importance of bringing services close to where people live. The results also suggest that men are more fearful of stigma than women.

**Contracting the AIDS virus.** With respect to transmission, a huge proportion of the PLWHA's (80.9%) said that they had contracted the virus sexually. More specifically, 45.5% had contracted through sex with their spouses, 35.4% with friends (Table 5). However, it will be noted that, within men the number who got it from their wives was 17 (22%) and within women, the number who got it from their husbands was 99 (55.2%). The findings suggest that there is more than double likelihood for men to infect their wives with the virus as do women to their husbands. This is further supported by the fact that men engage in casual sex more often than women, as within men, 45 (58.4%) got it through casual sex compared to 45 women (25.2%) who got it through sex with a friend other than a spouse. A Cambodian study [7] showed that 13% of urban men and 10% of rural men engaged in extramarital sex, and a study by the same body in Thailand showed that about 75 % of HIV-positive women were likely to have been infected by their husbands. The findings of this study are in close agreement with the UNAIDS report.

**Table 5. Method by which the AIDS virus was contracted**

<b>Method by which the AIDS virus was contracted</b>	<b>Male</b>	<b>%</b>	<b>Female</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Sex with spouse	17	6.7	99	38.8	116	45.5
Sex with a friend	45	17.6	45	17.6	90	35.4
Sexual assault/rape	0	0	2	0.8	2	0.8
Blood Transfusion	2	0.8	4	1.7	6	2.4
Don't Know	13	5.0	28	11	41	15.9
<b>Total</b>	<b>77</b>		<b>178</b>		<b>255</b>	<b>100</b>

**Scale-up of access to ARVs.** It is noted that about 32.9% felt that there is not enough awareness on the existence of ART clinics (Table 6). Another 23% were of the opinion that the ARVs should be brought close to where they live: in private clinics, pharmacies and through a mobile ART service as well as through more intensified home visits by health personnel. About 10.9 percent of the patients suggested that ARVs should be made accessible from any where, any time, and that HIV/AIDS clinics should be abolished and HIV/AIDS treated like any other disease.

**Table 6. How to make ARVs more accessible**

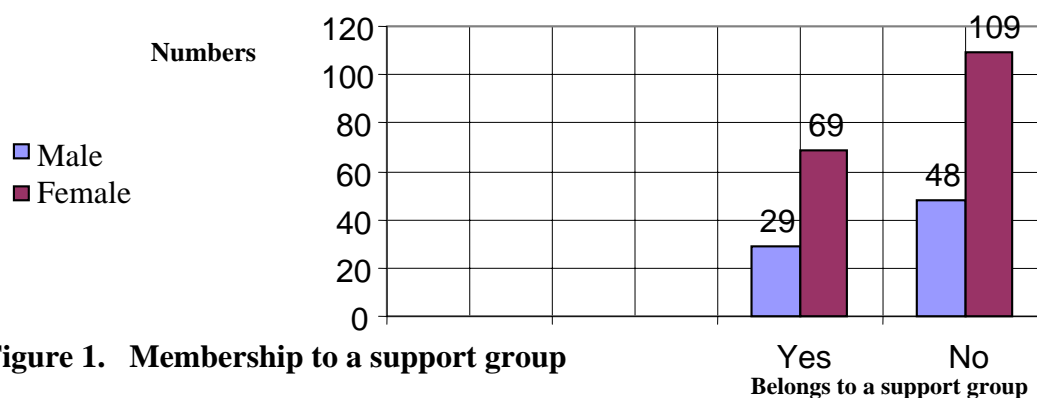
<b>How to make ARVs more accessible</b>	<b>M</b>	<b>%</b>	<b>F</b>	<b>%</b>	<b>Total</b>	<b>%</b>
Raise awareness of the ART services and where they are located; educate patients on the benefits of ARVs.	25	32.5	59	33.1	84	32.9
Bring them to public and private clinics and pharmacies nearest to where people live, set up mobile clinics, and intensify home visits by health personnel.	18	23.4	42	23.6	60	23.5
The current arrangement is satisfactory so maintain it.	14	18.2	33	18.5	47	18.4
The ARVs should be made accessible from any where, any time, abolish clinic days and treat HIV/AIDS like any other disease.	8	10.3	20	11.2	28	10.9
HIV/AIDS patients should not be discriminated against	4	5.2	8	4.5	12	4.7
Make them absolutely free and accessible even from the private clinics, pharmacies and hospitals.	3	3.9	7	3.9	10	3.9
Improve existing ART facilities, provide food and a round the clock helpline on ARVs.	3	3.9	5	2.8	8	3.1
Provide a whole year supply instead of the current 3 monthly supplies.	2	2.6	4	2.3	6	2.6
<b>Total</b>	<b>77</b>		<b>178</b>		<b>255</b>	<b>100</b>

**Nature of marriage.** The state of marriage poses a considerable risk of contracting the AIDS virus. The study sought to seek the pattern and nature of marriage within the sample population. The states of marriage were categorised as monogamy, polygamy, widowed/separated and unmarried. More than half of the respondents 142 (55.6%) were in monogamous relationships (Table 7). The unmarried within the study group were 89 (34.9%), but the proportion of unmarried within the women was higher, 66 (37.0%) than within men 23 (29.8%). The findings suggest a higher risk of contracting the virus in marriage, than being single. The results are also in agreement with the well established fact that women are more vulnerable to the virus compared to men, whether married or not. The findings also agree with UNAIDS (2004) which noted that 75% of women were likely to have been infected by their husbands, and that the state of marriage offers no protection against the virus. This suggests that women are affected to a greater extent meaning a bigger number of them will troop to the ART clinics than men.

**Table 7. Nature of marriage**

Nature of marriage	Male	%	Female	%	Total	%
Monogamy	47	18.4	95	37.2	142	55.6
Polygamy/Inherited spouse	3	1.2	6	2.4	9	3.6
Widowed/Separated	4	1.6	11	4.3	15	5.9
Unmarried	23	9.0	66	25.9	89	34.9
<b>Total</b>	<b>77</b>		<b>178</b>		<b>255</b>	<b>100</b>

**PLWHA’s awareness of where to get social support.** HIV/AIDS infection devastates not only the body and its functions, but also disorients the psychological constitution of a victim. For this reason, PLWHA’s are normally advised to seek and belong to at least one social support group. The study set out to measure the extent PLWHA’s are aware of existence of support groups.



**Figure 1. Membership to a support group**



Out of the 255 respondents, 157 (61.6%) PLWHA's did not belong to any support group. Only 98 (38.4%) belonged to such a group (Figure 1). Within men 29 (37.6%) belonged to a support group compared to women with 69 (38.7%). This suggests that women's representation in social groups is slightly more than that of men. Commenting on social groups, one male respondent remarked that most of the social groups are full of women and very few men. This suggests that a substantial number of PLWHA's are not comfortable mixing with the opposite sex in the support groups. This problem could be addressed by trying out men only, and women only social groups, with a view of raising the number of participants in each gender.

**Decision Making on Visiting the ART Centre.** Decision making is an important aspect of access to health services especially for women. The study investigated the extent to which opportunity and freedom to make own decisions exists and how it is distributed among the genders. The patients were asked to state how they arrived at the decision to visit the clinic. Viewed from within the genders, the results suggest that own decision making in this regard is strong within women 109 (61.2%), than within men 24 (31.2%) (Table 8). In a study done in Uganda on decision making for ART, Bitangoro, (2005), found out that men once infected stay longer in denial than women. A possible reason for this is that many women are forced to open up to discussions on HIV//AIDS with their partners particularly because of the need to get not only financial assistance, but also permission to leave the home. The study underlined gender differences as a denominator in access to ART by noting that patriarchal norms that emphasize male supremacy and control over women mean that women's access to ART does not only require sanctioning by their partners, but also restricts women's control over money, other assets, skills and even their own sexuality. While this is the widely held view by many, the results of current study did not support this view, possibly because a sizeable number of the women respondents were not married. However, in general decision-making power enabled greater access to ART services

**Table 8. Decision making within the genders**

<b>Decision making</b>	<b>Male</b>	<b>%</b>	<b>female</b>	<b>%</b>
Own decision	24	31.2	109	61.2
Prevailed upon by spouse	24	31.2	4	2.2
Advised by the doctor	8	10.4	22	12.5
Advised by relatives	12	15.6	24	13.5
Prevailed by friends	4	5.2	4	2.2
No Response	5	6.4	15	8.4
<b>Total</b>	<b>77</b>	<b>100</b>	<b>178</b>	<b>100</b>

**Impact of Stigma.** Stigma is a major social obstacle against access to health services for certain chronic diseases and conditions like HIV/AIDS. To measure the degree of stigma in HIV/AIDS in the sampled

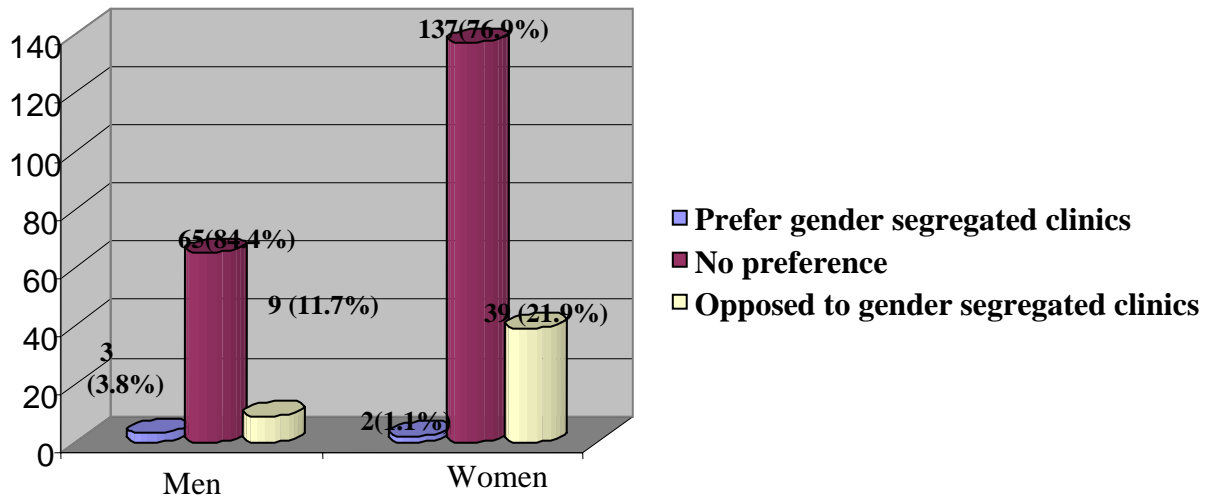
population, respondents were asked to state whom they have discussed their status with. In particular, patients were asked whether they have discussed their status with employer, neighbour, work mates, fellow worshippers, spouse, children (where applicable), parents (where applicable) and siblings. Among the married men, 47 (94%) had shared their HIV status with their spouses. Among the married women, 95 (94%) had also shared their status with their husbands. The findings show that there is little secrecy and high level sharing of information amongst married people.

With regard to Siblings, all the 77 men and 178 women responded to this question. Amongst the men, 18 (23.4%) of them had discussed their HIV status with their brother and/or sister. The proportion within the women was 54 (30.3%). However, these results may not be conclusive because some of the respondents may not have had sisters or brothers. Within the men, 6 (7.7%) had discussed the status with fellow worshippers while in the women group; it was 4 (2.2%). This suggests that both genders do not have much trust with fellow worshippers on matters that carry stigma. The number of men who discussed their status with colleagues/workmates was 2 (2.3%) and for women the number was 8 (4.5%). Again, workmates and colleagues came out as an unpopular group to discuss confidential matters that carry stigma. Four men (5.2%) had discussed the issue with a neighbor while in women they were 16 (8.9%). These are low figures and indicate the unwillingness to discuss the issue widely with other persons.

**Table 9. Person with whom the status has been discussed**

<b>Person with whom the status has been discussed</b>	<b>Within men</b>	<b>Within women</b>	<b>Totals</b>
Spouse	47 (94%)	95 (94%)	142
Siblings	18 (23.4%)	54 (30.3%)	72
Fellow worshippers	6 (7.7%)	5 (2.8%)	11
Workmates/colleagues	2 (2.3%)	8 (4.5%)	10
Neighbors	4 (5.2%)	16 (18.9%)	20
<b>Totals</b>	<b>77</b>	<b>178</b>	<b>255</b>

**Preference for a Gender Segregated ART Clinic.** Overall, a higher proportion (79.2%) of the respondents did not have gender preference for clinic attendance (Figure 2). Only 5 (1.9%) had strong preference for gender segregated clinics, while strong dislike was reported by 48 (18.8%) of the respondents. Within the genders, the pattern of preferences was similar as with the overall majority. The results suggest that there will be no gain for greater access to the services for either gender by setting up gender segregated ART clinics.



**Figure 2. Preference for gender segregated clinics**

## CONCLUSIONS

The overall objective of this study was to find out the influence of gender related factors (GRFs) on access to ART amongst PLWHA's in Nairobi, and specifically, to determine the role of patients' socio-demographic, socio-economic and socio-cultural factors in access to ART. From the findings, the study makes the following key conclusions.

The social demographic profile indicates that women are disproportionately affected by the scourge more than men. There is need, therefore, to mount gender specific program targeting women because of their unique vulnerability (biologically, economically and culturally) to the scourge. Some patients are not able to visit the clinics because they have to attend to paid work. It is recommended that the ministry of health makes adjustments to its ART service planning so as to offer evening, weekend and public holiday clinics, with a view of serving PLWHA's who work during the weekdays. In addition, the government should put up spirited campaign and create incentives for more employers to start workplace HIV/AIDS programs, so that employees do not have to seek for permission to visit ART clinics elsewhere for their ARVs supplies.

Stigma is still high amongst the PLWHA's. More intensive and sustainable campaigns are still needed to reduce the stigma. Given that abstinence, faithfulness and use of condoms (the ABC message) has been widely disseminated, people require to be educated more on HIV/AIDS. They need to know of the minor methods of the virus transmission to reduce the number of people who have no idea how they contracted

the disease. While the most common method of the virus transmission is now well known by the public, (sexual method) focus should now shift to the minor and less known methods of transmission.

Within the genders, there are a bigger proportion of men on ARVs than amongst the women. This situation requires to be monitored closely, to avoid a situation where a large proportion of men are on ARVs and a small one among women.

The results of this study indicate that GRF's have an influence on access to ART. It is therefore suggested that gender mainstreaming continue to be a paramount consideration in planning ART service delivery, with a view of making up for disadvantages in either of the genders.

### **ACKNOWLEDGEMENTS**

The authors wish to thank the following persons who in one way or another, made this research possible: Dr. Lawrence Oteba for assistance in the development of the concept and Mr. Oguya from Kenyatta University for the advice on the statistical approach to data gathering and analysis. Ms. Janet Ouma, the data collection assistant, the Provincial Medical Officer of Nairobi, the Medical Officer in charge of Public Health Department of the City of Nairobi and the respective Medical Officers in charge of the various health centres where data was collected.

### **REFERENCES**

- [1] National Aids Control Council and United Nations general assembly special session on HIV/AIDS, Country report for Kenya. 2008.
- [2] S.Lorelei, and J.Raven, Analysis of the gender dimension in the scale-up of ART and the extent to which free treatment at point of delivery ensures equitable access for women. Liverpool Associates in Tropical Health; Gender and Health Group, LSTM. 2005.
- [3] F. B. Palomo, The role of gender in HIV/AIDS education. Centre for community based health strategies, Academy for Educational Development. 2003.
- [4] UNAIDS and WHO AIDS epidemic update. United Nations, Geneva. Switzerland. 2007.
- [5] O.M. Mugenda and A.G. Mugenda, Data Analysis. Research Methods, Quantitative and Qualitative Approaches. African Centre for Technology Studies (ACTS) Nairobi, Kenya. Pages 115-144. 2003.

- [6] A. S. Muula, J.N. Thabale, S. Seter, M.M. Cecilia, U. Eric, W.P. Hans, S.W. Charles, and H.M.Ronald, Gender distribution of adult patients on highly active antiretroviral therapy (HAART) in Southern Africa: a systematic review. Department of Community Health, University of Malawi, College of Medicine, Chichiri, Blantyre, Malawi.2007.
- [7] UNAIDS, Report on the global HIV/AIDS epidemic/UNAIDS/04.16E. Geneva. 2004.
- [8] MOH-Kenya, Guidelines for antiretroviral drug therapy in Kenya. National AIDS & STI Control Program, P. O Box 19361, Nairobi, Kenya. 2005.