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EDITORIAL

Aims and Scope

Kampala International University (KIU) Journal of Humanities and Social Sciences (KJHSS) publishes empirical articles, critical reviews and case studies that are of interest to policy makers, scholars and practitioners in the area of humanities and social sciences. The Journal puts particular focus upon issues that are of concern to the third world. It is the goal of the Journal to advance knowledge and debate in the field of social studies by providing a platform through which scholars and practitioners can share their views, findings and experiences. Given the diverse nature of social studies, contributions are accepted from a wide range of disciplines and preference is given to articles that integrate multiple disciplinary perspectives. Contributions that examine developments at national, regional and continental level are particularly welcome. All the manuscripts received are subjected to review, by the Editor and at least two peers. The editorial policy of KJHSS aims at giving authors timely and constructive feedback and the Journal is particularly interested in assisting able researchers but who may be inexperienced in the area of publishing to develop the quality of their work to a level where it is acceptable for publication.

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Notes for Contributors

Contributors should adhere to the following requirements: Length: 4000 to 6000 words. Format: Times New Roman; size 12 and 1.5 spacing. Structure: Even though articles may have other subsections as may be thought necessary by the author(s), the following should be conspicuous: *Introduction, Methodology, Findings, Discussion, Conclusions, and Recommendations*. Tables, diagrams, figures and pictures should be in their appropriate places in the body of the article and attached, in their original, format (e.g. jpeg) as separate files. Abstract: Articles should be accompanied with an abstract of not more than 250 words. Keywords: After the abstract, the author(s) should outline the keywords in the article, on whose basis it can be classified.

Referencing: All citations must be referenced and contributors should adhere to the latest edition of the APA format. Submission: Manuscripts should be e-mailed to the editor at [kjhs@kiu.ac.ug](mailto:kjhss@kiu.ac.ug) as word attachments. Contributors may note that, although reviews may be accepted, priority will be given to scientific papers that are original and follow an interdisciplinary approach.

Peer review statement

All the manuscripts published in KJHSS have been subjected to blind review by at least two peers.

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Since its inception in 2000, Kampala International University (KIU) has steadfastly committed to its mission "to respond to societal needs by designing and delivering an education guided by the principles and values of respect for society, economy and environment and to provide and develop a supportive research environment in which scholars at every stage of their career can flourish". Indeed, it is in pursuit of this mission that the University's then School of Postgraduate Studies and Research (SPGS) launched the *KIU Research Digest* in 2007, as an in-house multidisciplinary journal. Yet, fifteen years into her existence, the University has grown phenomenally, metamorphosing into a collegiate, multi-country campus, system of organization. And as the University has evolved, so has its research and publication strategy. Now in its fourth volume, and offered as the *KIU Journal of Humanities and Social Sciences* (KJHSS), the University's journal has evolved into an international outlet of peer-reviewed research in the humanities and social sciences with an international editorial board and diverse contributions from various parts of the continent.

In this issue, contributions have been accepted from Ethiopia, Kenya, Malawi, Nigeria, Zimbabwe and Uganda. The contributions touch on issues across the broad spectrum of the humanities and social sciences including politics, economics, development, sociology, social administration, social work, education and climate change.

As drastic changes in the world system are presenting unprecedented challenges that are rendering traditional disciplinary and national boundaries futile, the management board of the KJHSS hopes that the geographical and disciplinary diversity of these contributions will promote discussion and appreciation of contemporary challenges from an internationally comparative perspective, thereby contributing to solution of the latter. In fact, the board looks forward to more submissions from scholars and practitioners on these and other areas—to develop the discussion further.

Our sincere thanks go to our anonymous reviewers for their penetrating and constructive reviews. We are grateful that they take time off their busy schedules to advise on the suitability of the many submissions received for possible publication. Our authors also work very hard—addressing suggestions for revisions and responding to editorial queries—so we thank them. Finally, we thank the management and trustees of KIU for their indispensable support towards processes of the journal.

Editor.

Contents

- 1 Editorial
- 3 Pontian G. Okoth, Geostategic Challenges of Terrorism for Integration in the African Great Lakes Region
- 19 Ngozi M. Nwakeze, The Demographic-Economic Paradox: Issues and Policies
- 33 Peter Nwadinigwe Ikechukwu, Esther Olufunmilayo Abe, Youth Unemployment in Nigeria: Implications for Counselling
- 41 Mathias Ssamula, Criminal Socialisation and Career: a Review of Social Learning Theoretical Perspectives
- 57 Hadiza Talatu Mohammed, Use of Information among Primary Healthcare Workers in Rural Areas of North Western Nigeria
- 71 F. N. Bolu-Steve, T. A. Ajiboye, Counselling Needs of Psychiatric Patients as Perceived by their Medical Personnel in Federal Neuropsychiatric Hospital, Abeokuta
- 79 Raheem Adaramaja Shehu, Isaac Opeyemi Oguntunji, Adijat Mojisola Abdulaheem, Ibraheem Ologele, Sources of Stigmatization among HIV/ AIDS Patients attending the ARV Clinic in State Hospital, Oyo, Nigeria
- 87 Livingstone Ddunga, Performance Appraisal as a Predictor of Ugandan University Lecturers' Participation in Community Service
- 97 Lester Brian Shawa, Toward Deliberative Experiences in Malawian Universities
- 107 Rakia Ahmed, Examination Malpractice in Nigeria: Incidence and Suggestions for Mitigation in Pursuit of Sustainable Development
- 113 Edith Namutebi, Employee Selection Policy and Perceived Discrimination in Universities in Central Uganda
- 127 Mukaila Ayanda Aremu, Rotimi Ayodele Gbadeyan, Abayomi Olumade Sofoluwe, Moriam Adeyemi Aremu, Influence of Homework on Students' Motivation and Performance
- 137 Adesoji A. Oni, Well Furo Adelinah, Domestic Violence and Primary School Pupils' Academic Achievement in Nigeria
- 147 Chikuvadze Pinias, Mugijima Samuel, Matswetu Vimba Sharon, Female Lecturers' Participation in Civil Engineering Research and Development Activities at one Polytechnic in Zimbabwe
- 155 Abayomi Olumade Sofoluwe, Ijeoma Charity Ogbudinkpa, Abiodun Olatoun Akinsolu, Climate Change and Sustainable Development in Nigeria
- 163 Demewoz Admasu Gebru, Academic Autonomy of Public Universities in Ethiopia



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SOURCES OF STIGMATIZATION AMONG HIV/AIDS PATIENTS ATTENDING THE ARV CLINIC IN STATE HOSPITAL, OYO, NIGERIA

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Abstract. This study investigated the sources of stigmatization among HIV/AIDS patients attending the antiretroviral clinic in State Hospital, Oyo. Data were collected from a sample of eighty-seven respondents. This was done following a descriptive cross-sectional survey design. The data collected was analysed using frequency counts, percentages and Chi-square at the .05 level of significance. The findings were that the patients did not experience stigmatization from health workers. However, they were significantly stigmatized by members of their families and communities. Recommendations made include that community members should be given education on HIV/AIDS epidemiology and consequences of HIV/AIDS stigmatization. Also, it is recommended that family and community members show love and care for HIV/AIDS patients.

Introduction

HIV/AIDS remains a pandemic public health threat and evidently fuelled by stigmatization. HIV/AIDS is capable of affecting different categories of people in the community. In 2007, an estimated 1.7 million adults and children in sub-Saharan Africa became newly infected, while 1.6 million died of AIDS (Ngozi, Bart & Nanne, 2009). Worldwide, Nigeria has the second highest number of new infections reported each year and an estimated 3.7 percent of the population is living with HIV (Federal Republic of Nigeria, 2012).

In a bid to recognize the menace of and create awareness on HIV/AIDS pandemic, since 1988 till date, December 1 of every year has been earmarked worldwide as World AIDS Day using red ribbon as a global symbol for solidarity with People Living with HIV/AIDS (PLWHA) (World Health Organization, 2014). In addition, since 2014, March 1 of every year has been earmarked as Zero Discrimination Day aimed at raising awareness about negative impacts of discrimination and the need to promote tolerance, compassion and peace towards PLWHA (United Nations Office on Drugs and Crime, 2015).

Monjok, Smesny and Essien (2009) submitted that for Nigeria to achieve her national policy on HIV/AIDS, aimed at controlling its spread and impacts, stigmatization and discrimination need to be tackled. Giddens and Duncin (2006) defined

stigma as any characteristic that set an individual or group apart from the majority of the population with the result that the individual group is treated with suspicion or hostility. Discrimination itself is a by-product of stigma. Jane (2012) asserted that discrimination occurs when people or institutions act upon stigma, and it entails unjust action or inaction towards individuals. It arbitrarily distinguishes, restricts, excludes individuals and leads to the denial of rights and services.

It is observed that HIV/AIDS patients experienced stigmatization in health sector. A stigma report of the Egyptian Health Ministry of 2011 found out that both physicians and nurses were often reluctant to provide health care services to PLWHA (Global HIV/AIDS News, 2011). The result of the study of Asuquo, Adejumo, Etowa and Adejumo (2013) among nurses in the University of Calabar Teaching Hospital revealed that 41 percent of them expressed fear of susceptibility to HIV/AIDS. Among the reasons for such include lack of knowledge about the infection, doubts to the effectiveness of prevention measures, moral stigma against illegitimate sex and fears of being stigmatized (Global HIV/AIDS News, 2011).

In hospitals, stigmatizing behaviour ranged from nuanced looks, subtle questions, actions indicating fear, awkward exchange of words and refusal to provide care. In the study of Reis, Heisler, Amowitz, Moreland, Mafeni,

Anyamele and Iacopino (2003), 50 percent of health care workers who were respondents opined that PLWHA should be confined in a separate ward. A multi-country qualitative study in Lesotho, Malawi, South Africa, Swaziland and Tanzania extensively documented verbal and physical abuses; and neglect of PLWHA by health workers in health care facilities (Thorpe, Grierson & Pitts, 2008). Feyissa, Abebe, Gurma and Woldie (2012) reported unnecessary referral of PLWHA to other health care institutions by health workers. According to Mahendra, Gilhorn, Bharat, Mudoi, Gupta, George, Samson, Daly and Pulerwitz (2007), in India hospitals, stigmatization manifests as health workers informed family members of a patient's positive HIV status without their consents, burning their beddings upon discharge, extra charge for the cost of infection control supplies and use of gloves during all interactions.

Community is personally viewed as a group of people sharing common identity and living together in a geographical location. Reactions of community members to HIV/AIDS patients can have both negative and positive effects. In the study of Johnson (2012), about two-thirds of PLWHA did not make their status known to people outside their families because of fear of stigmatization. Community level stigmatization and discrimination can manifest as ostracism, rejection, verbal and physical abuses. It has even extended to murder. In December 1998, Gugu Dhlamini was stoned and beaten to death by neighbours in her township near Durban, South Africa, after speaking openly on World AIDS Day (Agweda & Dibua, 2010).

According to Winskell, Hill and Obyerodhyambo (2011), the following stigmatized attitudes in the community towards PLWHA are outlined: gender violence, hostility which may lead to change of residence, refusal to marry daughter(s) of people who died of HIV/AIDS, rejection from neighbours, ridicule, torment against the spouse and the children of HIV positive person; and stoning to death. At times, special or a form of preferential treatment towards certain set of people in a particular community may make people think in another way.

In Yoruba culture, and virtually in all cultures, family members play significant roles in providing care and support for the sick. The study of Muoghalu and Jegede (2010) shows

that cultural practices like cultural obligations to the sick, affinity to blood relations, collective ownership of children and strong mental bond enhanced care and support for PLWHA within the family settings. However, some families provide unconditional psychological and material supports to PLWHA while some reject family members for their HIV sero-status (Lampputtong, 2013).

In some instances, some community members viewed HIV/AIDS as a disease that affect immoral people and the victims must be punished; therefore, they neglect them (Muoghalu & Jegede, 2010). As opined by Hossain and Kippax (2011), PLWHA are often turned away by their partners, family members and relatives. Keba (2011) added that in India, in the 1980s, it was reported that AIDS patients were considered outcast from families and some were given places like separate huts to sleep in and were prevented from coming in contact with anybody. The study of Sangowawa and Owosaje (2012) conducted among youths living with HIV/AIDS in Ibadan shows that upon the disclosure of their HIV positive status, 25 percent were sent out of their matrimonial homes by their husbands, 25 percent were abandoned by their spouses and 12.5 percent had experienced broken relationships.

Strebel, Cloete and Simbayi (2009) claimed that in Lesotho and Swaziland, the main source of the stigmatization was the family members manifesting in labelling, nicknaming and refusal to share cooking or eating utensils. Sometimes, family members may refuse the food cooked by PLWHA or dispose the utensils that have been used by them. In fact, some were not allowed to interact with babies or children in the family (Bogart, Landrine, Galvan, Wagner & Klein, 2013). In the report of the interview conducted within the family settings by the Centre for Policy Alternatives (2005), the following discriminatory behaviour against PLWHA were discovered namely: desertion by spouse, parental refusal, threat, assault, harassment, ridicule and excommunication.

Statement of the Problem

In Oyo State, the researcher observed that the presentation of HIV/AIDS by media houses as a killer disease is perceived to be the genesis of stigmatization. Several adverts on billboards which carry prevention messages on HIV/AIDS seriously promote stigmatization.

Some of these inscriptions include, "AIDS kills" and "HIV/AIDS gets no cure" to mention a few. By implication, HIV/AIDS is equated to a killer and everybody will try as much as possible to avoid death. Invariably, PLWHA are seeing as living corpses or ghost which await death soonest.

Joint United Nations Programme on HIV/AIDS (2010) claimed that 90 percent of governments in various countries reported that they had addressed stigmatization and discrimination in their HIV programmes. Yet, in Oyo State, it is observed that stigmatization of HIV/AIDS patients is on-going. Similarly, the United State Department of State's Country reports on human right practices for 2012 indicated that in Nigeria, there was widespread societal stigmatization against PLWHA (United States of America, 2013).

Despite increased awareness about HIV/AIDS and series of efforts put in by public officials, press, health and medical workers; and health educators inclusive, the researcher observed that stigmatization against HIV/AIDS patients still persist and possibly manifest from different sources. Upon this premise, the researcher investigated sources of stigmatization among HIV/AIDS patients attending antiretroviral clinic in State Hospital, Oyo.

Purpose of the Study

The study investigates whether HIV/AIDS patients in State Hospital, Oyo experience stigmatization from health workers, community members and family members.

Research Questions

The following research questions were answered in this study:

1. Do HIV/AIDS patients in State Hospital, Oyo experience stigmatization from their health workers?
2. Do HIV/AIDS patients in State Hospital, Oyo experience stigmatization from members of their communities?
3. Do HIV/AIDS patients in State Hospital, Oyo experience stigmatization from members of their families?

Research Hypotheses

The following null hypotheses were tested in this study:

- 1. HIV/AIDS patients in State Hospital, Oyo do not significantly experience

stigmatization from their health workers.

2. HIV/AIDS patients in State Hospital, Oyo do not significantly experience stigmatization from members of their communities.
3. HIV/AIDS patients in State Hospital, Oyo do not significantly experience stigmatization from members of their families.

Methodology

A descriptive research of cross-sectional survey type was employed for this study. It was a purely hospital-based study of HIV/AIDS patients attending antiretroviral clinic. Population for the study comprised of all registered HIV/AIDS patients attending antiretroviral clinic in State Hospital, Oyo totalling one thousand, three hundred and thirty-four (1334). HIV/AIDS patients who are below 18 years, too sick, pregnant mothers on antiretroviral prophylaxis and those on antiretroviral therapy for the purpose of post-exposure prophylaxis were excluded in the study. These categories of patients and clients amounted to 446. Therefore, the targeted population was eight hundred and eighty-eight (888).

Multi-stage sampling technique was used for the sample selection. The first stage was a stratified sampling technique which was used to put into strata all categories of HIV/AIDS patients according to inclusion criteria. The second stage was proportionate sampling technique which was used to select 10 percent from the targeted population which was eighty-seven (87) respondents; while the last stage was systematic sampling technique employed to select the sampled respondents. Researcher designed structured questionnaire which was validated by three jurors from the relevant fields with the reliability coefficient of 0.83r through split-half method using Spearman-Brown Rank Order Correlation was used.

In order to gain access to the antiretroviral clinic, the researcher obtained a letter of introduction from the Head of Department of Health Promotion and Environmental Health Education, University of Ilorin, Nigeria. The consent of each respondent was sought, privacy was provided, confidentiality pledged and ethical approval was obtained from Ministry of Health, Oyo State research ethical

review committee. The instrument was administered with the help of two (2) trained research Assistants. Data collected were sorted, edited, collated and coded. Data entry, processing and analysis were done with the use of Statistical Package for the Social Sciences (SPSS) software, version 21.0. Inferential statistics of Chi-square was used to test all the

three (3) postulated hypotheses at 0.05 alpha level of significance.

Findings

The findings of the study are summarized in Tables 1, 2 and 3.

Table 1: Stigmatization of HIV/AIDS Patients by Health Workers

Attribute	SA	A	D	SD	Total
HIV/AIDS patients suffer both verbal abuse and harassment from health workers in hospital premises	14 (16%)		34 (39%)	39 (45%)	87
Health care workers are sometimes sceptical in treating HIV positive patients	5 (5.7%)	19 (21.8%)	54 (62.1%)	9 (10.3%)	87
HIV/AIDS patients are admitted in separate hospital wards by health workers.	6 (6.9%)	43 (49.4%)	30 (34.5%)	8 (9.2%)	87
Use of and doubling of gloves while attending to HIV/AIDS patients is well practiced by health workers.	17 (19.5%)	40 (46.0%)	9 (10.3%)	21 (24.1%)	87
Health workers divulge clients' HIV status to family members and other staff without the persons' consent		14 (16.1%)	42 (48.3%)	31 (35.6%)	87
Extra fee is sometimes added to hospital bills of HIV/AIDS patients by health workers	4 (4.6%)	9 (10.3%)	56 (64.4%)	18 (20.7%)	87
HIV/AIDS patients are nicknamed and mocked among hospital staff while accessing care in hospital	4 (4.6%)	8 (9.2%)	46 (52.9%)	29 (33.3%)	87
HIV/AIDS patients are experiencing early hospital discharge by health workers while on admission	4 (4.6%)	13 (14.9%)	53 (60.9%)	17 (19.5%)	87
Total	54	146	324	172	696

Note: Cal $\chi^2 = 26.28$; Df = 21; Crit. $\chi^2 = 32.67$; Decision: Accept H_0 .

Table 1 shows the calculated chi-square (χ^2) value of 26.28 against the table value of 32.67 at 0.05 alpha level of significance with degree of freedom (df) 21. Since the calculated χ^2 value of 26.28 was less than the table value of

32.67, thus the null hypothesis was upheld. This means that health workers did not stigmatizing HIV/AIDS patients while receiving care and treatment.

Table 2: Stigmatization of HIV/AIDS Patients by Members of their Communities

Attribute	SA	A	D	SD	Total
HIV/AIDS patients often experience verbal abuse and sometimes physical abuse in the community.	47 (54.0%)	15 (17.2%)	20 (23.0%)	5 (5.7%)	87
Nicknames in the society like, immoral, dirty, walking corpse, prostitutes are given to HIV/AIDS patients by community members.	35 (40.2%)	25 (28.7%)	15 (17.2%)	12 (13.8%)	87
Community members often shun and gossip HIV/AIDS patients in their vicinities.	33 (37.9%)	32 (36.8%)	4 (4.6%)	18 (20.7%)	87
HIV/AIDS patients are often restricted by some community members from participating actively in some social events in the community.	11 (12.6%)	46 (52.9%)	22 (25.3%)	8 (9.2%)	87
Community members often treat HIV/AIDS patients as outcasts.	15 (17.2%)	42 (48.3%)	13 (14.9%)	17 (19.5%)	87
HIV/AIDS patients easily lose respect and self-esteem in the community as a result of their status.	32 (36.8%)	33 (37.9%)	11 (12.6%)	11 (12.6%)	87
Community members intentionally distance themselves from known HIV/AIDS patients	24 (27.6%)	42 (48.3%)	10 (11.5%)	11 (12.6%)	87
Community members often refuse to buy food stuffs/items from known HIV/AIDS patients.	33 (37.9%)	18 (20.7%)	14 (16.1%)	22 (25.3%)	87
Total	230	253	109	104	696

Note: Cal $\chi^2 = 49.38$; Df = 21; Crit. $\chi^2 = 32.67$; Decision: Reject H_0

Table 2 shows the calculated chi-square (χ^2) value of 49.38 against the table value of 32.67 at 0.05 alpha level of significance with degree of freedom (df) 21. Since the calculated χ^2

value of 49.38 was greater than the table value of 32.67, thus the null hypothesis was rejected. This means that community members heavily stigmatized people living with HIV/AIDS

Table 3: Stigmatization of HIV/AIDS Patients by Members of their Families

Attributes	SA	A	D	SD	Total
Family members isolate relative (s) who are HIV/AIDS patients to minimize social contact.	19 (21.8%)	25 (28.7%)	23 (26.4%)	20 (23.0%)	87
Spouses feel reluctant and occasionally reject partner who are HIV/AIDS patients.	22 (25.3%)	22 (25.3%)	33 (37.9%)	10 (11.5%)	87
Violence abuse is often experienced by female spouse in the family following disclosure of her positive HIV status.	14 (16.1%)	26 (29.9%)	36 (41.4%)	11 (12.6%)	87
Family members usually set-up strict rules and regulations for known HIV/AIDS patients in the home.	14 (16.1%)	23 (26.4%)	40 (46.0%)	10 (11.5%)	87
Members of the family sometimes refuse sharing cooking or eating utensils with HIV/AIDS patients.	18 (20.7%)	22 (25.3%)	30 (34.5%)	17 (19.5%)	87
At times, some family members exempt HIV/AIDS patients (male or female) from interacting with children within the family setting.	12 (13.8%)	19 (21.8%)	40 (46.0%)	16 (18.4%)	87
In homes, relatives sometimes give separate rooms to HIV/AIDS patients to sleep in or permanently living in due to their status.	14 (16.1%)	22 (25.3%)	38 (43.7%)	13 (14.9%)	87
Married women who are HIV/AIDS patients suffer abandonment from their immediate family members more than men.	17 (19.5%)	37 (42.5%)	14 (16.1%)	19 (21.8%)	87
Total	130	196	254	116	696

Note: Cal $\chi^2 = 65.46$; Df = 21; Crit. $\chi^2 = 32.67$; Decision: Reject H_0

Table 3 shows the calculated chi-square (χ^2) value of 65.46 against the table value of 32.67 at 0.05 alpha level of significance with degree of freedom (df) 21. Since the calculated χ^2 value of 65.46 was greater than the table value of 32.67, thus the null hypothesis was rejected. This means that family members were stigmatizing members of their families living with HIV/AIDS.

Discussion and Conclusion

This research was designed to investigate sources of stigmatization among HIV/AIDS patients attending antiretroviral clinic in State Hospital, Oyo. The result of the tested hypothesis one revealed that HIV/AIDS patients in State Hospital, Oyo did not significantly experience stigmatization from health workers. This result was contrary to the earlier report of Thorpe, Grierson and Pitts (2008) who revealed that in Lesotho, Malawi, South Africa, Swaziland and Tanzania, PLWHA experienced verbal and physical abuses; and neglect from health workers while accessing health services. The result is also at

variance with the assertion of Feyissa, Abebe, Girma and Woldie (2012) who reported unnecessary referral of PLWHA by health workers to other health care institutions.

The result obtained from the tested hypothesis two that HIV/AIDS patients in State Hospital, Oyo significantly experienced stigmatization from community members was justified by the view of a scholar that about two-thirds of PLWHA did not make their status known to people outside their families because of fear of stigmatization (Johnson, 2012). Also, the result further affirmed the assertion of Winskell, Hill and Obyerodhyambo (2011) who revealed stigmatized attitudes like gender violence, hostility, rejection from neighbours and ridicule in the community towards PLWHA.

The result of the tested hypothesis three shows that HIV/AIDS patients in State Hospital, Oyo significantly experienced stigmatization from family members corroborate with Hossain and Kippax (2011) that PLWHA were often turned away by their partners, family members and relatives. Similarly, Strebel, Cloete and Simbayi (2009)

study aligned with the result above that in Lesotho and Swaziland, family members stigmatized PLWHA which manifest in w/whoInt/bv/pub/progress_report2011/ en/. Accessed on: 15th March, 2014

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