Available online at www.sciencedirect.com

ScienceDirect

journal homepage: www.elsevier.com/locate/cegh

Student's Section

Determinants of delay in the health care seeking behaviour of STD patients

Sabeena Jayapalan*

Department of Dermatology and Venereology, Government Medical College, Thiruvananthapuram, Kerala, India

ARTICLE INFO

Article history:

Received 30 August 2015

Accepted 26 October 2015

Available online 14 November 2015

Keywords:

Health care seeking behaviour

STDs

Delay

ABSTRACT

Background: Prevention of STDs is a strategic common element in the control of HIV, prevention of infertility and improving maternal and child health. Health care seeking behaviour is a central issue in the prevention and control of STDs. Timely and appropriate treatment is secondary prevention for the patient and primary prevention for the community. Knowledge about the proportion of patients, who delay in seeking appropriate treatment, and the factors affecting the delay can contribute in implementing preventive strategies.

Methods: The study design was a hospital-based cross sectional study for a period of 6 months in a tertiary care centre in South Kerala. After informed consent, 93 symptomatic STD patients were studied. The data were collected using a structured questionnaire. The outcome variable was delay. The independent variables were socio-demographic characteristics, clinical characteristics, behavioural characteristics, cognitive factors, and geographical access to health care. Data were analysed using appropriate soft ware. For univariate analysis chi-square statistics was used. All the variables with a p value <0.05 in univariate analysis were entered into logistic regression model.

Results: Out of the 93 patients, delay of 8 or more days in seeking appropriate treatment was observed in 54 (58.1%) patients. Among the 54 patients who had delay, 27 (52.9%) were males and 27 (64.3%) were females. After logistic regression modelling, the determinants of delay in males were lowered self efficacy (OR – 17.32, 95% CI – 1.48–207.3, $p = 0.023$), presence of growth in the genitalia (OR – 8.56, 95% CI – 0.619–118.3, $p = 0.10$) and symptoms other than urethral discharge (OR – 3.6, 95% CI – 0.59–22.4, $p = 0.16$). The determinants of delay in females were having non-ulcerative STDs (OR – 22.3, 95% CI – 3.4–152.9, $p = 0.0012$) and having a nuclear family (OR – 6.69, 95% CI – 1.08–44.02, $p = 0.04$).

Conclusion: Both males and females delayed in seeking treatment if their disease was not associated with severe symptoms such as pain and ulcer. Many patients in spite of having adequate knowledge of STDs continued to have sexual contact while being symptomatic, and did not adopt preventive measures. Future preventive strategies should incorporate in the health education messages different aspects of STDs such as the modes of transmission, symptoms, importance of timely and appropriate treatment and the importance of preventive measures. Periodic training should be given to primary health care providers regarding adequate management of STDs.

© 2015 INDIACLEN. Published by Elsevier, a division of Reed Elsevier India, Pvt. Ltd. All rights reserved.

* Tel.: +91 9846097771/94476366595.

E-mail addresses: sabinajayapalan@gmail.com, vsbijoy@rediffmail.com

<http://dx.doi.org/10.1016/j.cegh.2015.10.006>

2213-3984/© 2015 INDIACLEN. Published by Elsevier, a division of Reed Elsevier India, Pvt. Ltd. All rights reserved.

Sexually transmitted diseases (STDs) have a profound impact on sexual and reproductive health, and rank among the top five disease categories, for which adults seek health care.¹ More than 1 million people acquire a sexually transmitted infection every day.¹ Beyond the immediate impact of the infection, STDs can have serious consequences such as pelvic inflammatory disease, adverse pregnancy outcomes, infertility and cervical cancer.¹ Some STDs can increase the risk of acquisition of Human immunodeficiency virus (HIV).² Many countries have taken up STD control as the top priority issue. The control programmes address many aspects of prevention. Most of the preventive efforts, both in developing and developed countries, are targeted towards tackling high risk sexual behaviour. This was met with only partial success. Failure to understand the health care behaviour was one of the reasons for the partial success. Health care behaviour includes health care seeking behaviour of the patient and behaviour of the health care provider.³ Delay in health care seeking is one of the important factors in the transmission dynamics of STDs. Timely and appropriate treatment is secondary prevention for that particular patient and primary prevention for the members of the community.³ If there is a delay in treating STD patient, there could be sexual activity during this period giving opportunity for transmission of infection and development of complications. The delay in seeking treatment can be due to many factors such as socio-demographic factors, behavioural factors, factors related to the disease, support and cognitive factors. Knowledge of the factors affecting the delay in seeking treatment will be useful for planning and implementation of preventive strategies. The delay in treatment seeking behaviour of STD patients and the factors affecting the delay has not been studied in our part of the state. Hence this study was conducted to estimate the proportion of patients, who wait for eight days or more before seeking appropriate treatment after the onset of symptoms and the determinants of delay in those patients.

1. Methods

STD patients attending the department of Dermatology and Venereology of a tertiary care centre in South Kerala were studied after getting informed consent. Partner of the index patient, asymptomatic STDs diagnosed by laboratory investigations and non-consenting patients were excluded. Hospital based, cross sectional descriptive type of study design was used. Using the sample size formula, $n = pq(z_{\alpha})^2/d^2$, where, p being the proportion of patients with delay was set at 34 based on a pilot study in the same institution, q being the proportion without delay as 66, precision as 10 and z_{α} as 1.96, and the minimum sample size was calculated to be 87. Structured questionnaire was used to collect data under the broad domains of socio-demographic characteristics, clinical characteristics, behavioural characteristics, support, cognitive factors and geographical access. After consultations with experts in the field of STDs, the outcome variable, delay, was defined as waiting for eight days or more in seeking appropriate treatment after the onset of symptoms. Treatment was considered appropriate, if it was in accordance with National AIDS Control Organization (NACO)/World Health

Organization (WHO) guidelines. The independent variables were socio-demographic variables (age, gender, education, occupation, marital status, family income and housing), diseases characteristics (symptoms and previous history of STDs), behavioural characteristics (information seeking, discussing the problem with others, treatment seeking behaviour and sexual behaviour), cognitive measures (knowledge, perceived seriousness, self efficacy and shame and guilt), support (family support and friend support) and geographical access to a health facility. Each cognitive measure was assessed by a set of questions and median score of each was used to categorise patients into two groups, those with and without that particular cognitive measure. Social support was divided into family support and friend support, and each was assessed under three headings namely physical support, emotional support and monetary support. Data were entered in Excel, and statistical analysis was done by using appropriate software. The distribution of each independent variable was looked into. Univariate analysis was done with the outcome variable delay and each independent variable separately for both males and females. Non-parametric tests were used. Continuous variables were categorised into two for univariate analysis. Age was categorised based on the median age of 30 (≤ 30 and > 30) for both males and females, duration of marriage into ≤ 9 and > 9 based on the median duration of 9 for both males and females, education into $10+$ and ≤ 10 based on the assumption that those who had college level education will have less chance for delay, income into > 2000 and ≤ 2000 in males and > 1200 and ≤ 1200 in females based on the median values of 2000 and 1200 respectively. In the family type, extended and joint family was clubbed together; unmarried, divorced and others were clubbed together in the marital status; and occupation was categorised to unskilled and skilled in males and working women and home maker in females. Odds ratio (OR) with 95% confidence interval (CI) and the level of significance were computed for each variable. Logistic regression was used for the multivariate analysis. All the independent variables with a significance level < 0.25 in the univariate analysis were considered for logistic regression analysis. Forward stepwise likelihood ratio method was used to select the model. Criterion for the elimination of the variable, that is the default, was set at a p value ≥ 0.1 .

2. Results

Ninety-three patients with STDs who attended a tertiary care centre were studied for a period of six months. Delay in seeking appropriate treatment was observed in 54 (58.1%) patients. Among the 93 patients, 51 (54.8%) were males and 42 (45.2%) were females. Out of the 54 patients who had delay, 27 (52.9%) were males and 27 (64.3%) were females.

Majority of the males and females were from rural areas, belonged to 20–29 age group, were married, with high school level of education and belonged to the lower income group (Table 1).

Ulcer (33.3%) was the most common symptom in males followed by dysuria (21.6%), discharge per urethra (19.6%), growth (15.7%) and increased frequency of micturition (2%). In females, the major symptoms were ulcers (50%), vaginal

Table 1 – Socio-demographic characteristics.

Variables		Males (51)		Females (42)	
		N	%	N	%
Residence	Rural	47	92.2	41	97.6
	Urban	4	7.8	1	2.4
Age	<20	3	5.9	1	2.4
	20–29	24	47.1	19	45.2
	30–39	19	37.3	14	33.3
	≥40	5	9.8	8	19
Marital status	Unmarried	24	47.1	2	4.8
	Married	26	51	33	78.6
	Others	1	2	7	16.7
Duration of marriage	0–5	7	26.9	15	45.5
	5–10	8	30.6	6	18.2
	10–15	5	19.2	3	9.1
	15–20	5	19.2	3	9.1
	>20	1	3.8	6	18.2
Education	≤4	5	9.8	6	14.3
	5–7	14	27.5	10	10
	8–10	21	41.2	20	47.6
	>10	11	21.6	6	14.3
Occupation	House hold and others	4	7.8	31	73.8
	Unskilled	17	33.3	9	21.4
	Skilled	20	39.2	0	0
	Office going	10	19.6	2	3.9
Income	<1000	8	15.7	7	16.7
	1000–1999	17	33.3	21	50
	2000–2999	14	27.5	8	19.1
	≥3000	12	23.5	6	14.3
Housing	Kutcha	17	33.3	16	38.1
	Pucca Kutcha	29	56.9	24	57.1
	Pucca	5	9.8	2	4.8
Family type	Nuclear	37	72.5	16	38.1
	Extended	11	21.6	21	50
	Joint	3	5.9	5	11.9

discharge (28.6%), growth (16.7%), pain (11.9%), dysuria (2.4%), and increased frequency of micturition (2.4%). Past history of STD was present in 37.3% males and 19% of females.

The distribution of the behavioural, cognitive and social support characteristics is shown in Table 2. After the onset of symptoms, 15.7% of males and 4.8% of females sought information about their symptoms from magazines and newspaper. Among the males who discussed their problem,

58.6% discussed with their partner, 24.1% discussed with family members and 48.3% discussed their problem with friends. Females also discussed their problem with partner (63.9%), family members (63.9%) and friends (13.9%). Inappropriate treatment seeking behaviour was seen in 27.5% males and 33.3% of females. The sources of inappropriate treatment were traditional healers, ayurvedic doctors, homoeopathic doctors, left over medicines, reuse of old script, self prescribed

Table 2 – Behavioural, cognitive and social support.

Independent variables		Males (51)		Females (42)	
		N	%	N	%
Information seeking	Present	8	15.7	2	4.8
Discussion of the problem	Yes	29	56.9	36	85.7
Inappropriate treatment seeking	Present	14	27.5	14	33.3
Sexual activity during symptoms	Yes	14	27.45	18	42.86
Knowledge	No knowledge			23	54.8
	Some	26	51	12	28.5
	Satisfactory	25	49	7	16.7
Perceived seriousness	High	13	25.5	15	35.7
Self efficacy	High	10	19.6%	2	4.8%
Shame and guilt	Present	20	39.2	18	42.9
Social support	Family support	10	19.6	33	78.6
	Friend support	14	27.5	5	11.9
Geographical access	Yes	34	66.7	36	85.7

Table 3 – Univariate analysis of determinants of delay – males.**

		Males (No: 51)			
Variables		Delay		Odds ratio (95% CI)	p value
		Yes (27)	No (24)		
Self efficacy	Yes	1	9	1	0.0035 [*]
	No	26	15	15.6 (1–362.1)	
Discharge urethra	Yes	2	8	1	0.032 [*]
	No	25	16	6.25 (1–49.3)	
Discussing problem	Yes	19	10	1	0.038
	No	8	14	0.3 (0.09–0.95)	
Growth	Yes	7	1	1	0.052 [*]
	No	20	23	0.12 (0.014–1.09)	
Geographical access	No	6	11	1	0.07
	Yes	21	13	2.96 (0.76–11.95)	
Family support	Yes	8	2	1	0.08 [*]
	No	19	22	0.2 (0.03–1.33)	
Dysuria	Yes	3	8	1	0.113 [*]
	No	24	16	4 (0.92–17.4)	
Shame	Yes	8	12	1	0.136
	No	19	12	2.37 (0.75–7.5)	
Knowledge of STD	Yes	11	14	1	0.209
	No	16	10	2.04 (0.667–6.2)	
Ulcers	Yes	7	10	1	0.233
	No	20	14	2.04 (0.625–6.66)	

^{*} Fisher exact test done.

^{**} Only those variables with $p < 0.25$ shown.

* Fisher exact test done.

** Only those variables with $p < 0.25$ shown.

medicines etc. Majority of patients, 58.8% males and 78.6% females sought treatment from a modern medicine facility, and among them only 10% of males and 3% of females received appropriate treatment at the first point of contact. Sexual activity after the onset of symptoms was seen in 27.5% males and 42.9% females. The sexual contact was with marital partner, casual partner and sex workers in the case of males and marital partner and casual partner in the case of females. The sources of pre-existing knowledge among males were from friends and newspaper, whereas for females the major sources were television and news paper. Support from family was more for females (78.6%) and support from friends was more for males (27.5%). Access to health care facility was there for 66.7% males and 85.7% females.

Each independent variable was cross tabulated with the dependant variable delay and the OR with 95% CI, chi square statistics and p value with 5% significance level was analysed separately for both males and females. The independent variables cross tabulated with delay for univariate analysis were socio-demographic characteristics (age, residence, marital status, duration of marriage, occupation, education, income and type of family), clinical characteristics (symptoms of dysuria, discharge, ulcers, growth, pain and past history of STD), behavioural characteristics (seeking information, discussing the problem with others, and inappropriate treatment), cognitive factors (knowledge of STDs, perceived seriousness, self efficacy and shame), support (friend and family) and geographical access. The variables with p value < 0.05 among males were the symptom of urethral discharge ($p = 0.0035$), discussing the problem with others ($p = 0.032$) and self efficacy ($p = 0.038$) and among females, the duration of marriage ($p = 0.0012$), symptoms of vaginal discharge ($p = 0.03$), ulcer ($p = 0.03$) and growth ($p = 0.038$) (Tables 3 and 4).

Logistic regression was used for the multivariate analysis of the determinants of delay. All independent variables having a p value < 0.25 was used as the entry criteria for variables into the model. The variables entered for males were self efficacy, discussion of the problem, urethral discharge, growth, geographical access, family support, shame and guilt, knowledge of STDs and ulcers (Table 3). Even though the variable dysuria satisfied the entry criteria, it was not entered into the model. Symptoms of dysuria and discharge usually go together and the problem of co-linearity would have occurred. Variables selected for logistic regression in females were ulcers, vaginal discharge, duration of marriage, perceived seriousness, age, family type and education (Table 4). Two variables, i.e., growth and self efficacy, with significant p value were not entered into the model, as the OR in univariate analysis was 0. Tables 5 and 6 show the results of logistic regression analysis in males and females respectively.

3. Discussion

The transmission of STD in the community depends on the duration of infectiousness of the infected individuals, probability of exposure of susceptible to infectious persons and the efficiency of sexual transmission when such exposure occurs.³ As the treatment is delayed the duration of infectiousness is increased, and the chance of spread in the community is high. A delay in seeking appropriate treatment of 58.1% is a matter of grave concern from the point of secondary prevention. Like in many studies females outnumbered males though the difference was not significant statistically ($p = 0.26$).^{4,5}

The socio-demographic factors such as age, residence, education, income, and marital status did not influence the

Table 4 – Univariate analysis of determinants of delay – females.**

		Females (N – 42)			
Variables		Delay		OR (95% CI)	p value
		Yes (27)	No (15)		
Ulcer	Yes	8	13	1	0.0012
	No	19	2	15.3 (2.3–128.9)	
Duration of marriage	≤9 years	16	14	1	0.03 [*]
	>9 years	11	1	9.63 (1.02–225.1)	
Vaginal discharge	Yes	11	1	9.63 (1.02–225.1)	0.03 [*]
	No	16	14	1	
Growth	Yes	7	0	1	0.038 [*]
	No	20	15	0 (0–1.25)	
Perceived seriousness	Yes	7	8	1	0.07
	No	20	7	3.27 (0.86–12.35)	
Self efficacy	Yes	0	2	1	0.12 [*]
	No	27	13	Undefined	
Family type	Others	14	12	1	0.14 [*]
	Nuclear	13	3	3.7 (0.72–21.41)	
Education	10+	2	4	1	0.164 [*]
	≤10	25	11	4.55 (0.58–43.07)	
Age	≥30	14	4	1	0.209 [*]
	<30	13	11	0.29 (0.06–1.32)	
Income	>1200	11	9	1	0.231
	≤1200	16	6	2.18 (0.72–5.16)	

* Fisher exact test done.

** Only those variables with $p < 0.25$ shown.

timely treatment of the disease in both sexes. Unlike in males, women who were married for nine years or more had nine-fold delay (OR 9.63, CI 1.02–225.12, p 0.03) in seeking appropriate treatment. A population based study from Kenya, though has not taken into consideration the duration of marriage, states that older women waits longer than younger women in visiting a health care facility.⁶

Symptoms associated with the disease were the major determinants in both sexes. Similar to other studies men with urethral discharge did not delay treatment, but the delay was six-fold in those without discharge (OR – 6.25, CI – 1.17–33.2, p – 0.04).^{4,5} As far as males are concerned, urethral discharge is abnormal and is often associated with dysuria forcing the patient to seek medical care. Contrary to males, the females with vaginal discharge had nine-fold delay in seeking

treatment (OR – 9.63, CI – 1.02–225.12, p – 0.03). This may be due to the inability of women to distinguish pathological from physiological discharge. Women with ulcers sought treatment early, whereas women without ulcers had a 15-fold delay (OR – 15.43, CI – 2.81–84.7, p – 0.0004). This may be due to the fact that ulcers in the genitalia are painful and are considered as abnormal.^{6–8} Growth in the genitalia was associated with delay in both sexes. Males with symptoms of growth in the genitalia had an eight-fold delay than those without growth (OR – 8.3, CI – 0.71–71.4, p – 0.052). All the female patients with growth had delayed treatment. This is alarming, because the clinical diagnosis of all the patients with growth was condyloma acuminata, an infection caused by human papilloma virus, which can later undergo malignant transformation.

Table 5 – Logistic regression analysis – males.

Variable	B	S.E.	Wald	df	Sig	R	Exp(B)	95% CI
No self efficacy	2.8521	1.2596	5.1268	1	0.023	0.2106	17.3243	1.5–207.3
Growth	–2.1482	1.3354	2.5876	1	0.1077	–0.0913	0.1167	0.1167–118.3
No discharge urethra	1.2917	0.9271	1.9415	1	0.1635	0.0000	3.6391	0.59–22.4
Constant	–0.5197	0.3863	1.8099	1	0.1785			

–2 log likelihood – 53.166, goodness of fit – 50.316, model Chi square – 17.359, df – 3, significance – 0.0006.

Table 6 – Logistic regression analysis – females.

Variable	B	S.E.	Wald	df	Sig	R	Exp(B)	95% CI
No ulcer	3.1087	0.9620	10.4416	1	0.0012	0.3927	22.391	3.4–152.9
Nuclear family	1.9007	0.9274	4.2002	1	0.0404	0.2005	6.6905	1.1–44
Constant	–3.7216	1.1231	10.9814	1	0.0009			

–2 log likelihood – 36.233, goodness of fit – 66.847, model Chi square – 18.515, df – 2, significance – 0.0001.

The male patients, who discussed their problem had three-fold delay (OR = 3.33, CI = 1.05–11.1, $p = 0.038$) in seeking treatment. Majority discussed with their marital partners. This is contradictory to a report where women exerted an important influence on the decision of men to seek health care.⁹ None of the behavioural determinants in females achieved statistical significance, though studies from elsewhere have shown significance.^{5–10} Inappropriate treatment seeking did not achieve statistical significance, unlike report from Kenya.^{4,11} Among the cognitive factors, men with lowered self efficacy had 15-fold delay (OR = 15.6, CI = 1.69–362.1, $p = 0.0035$) similar to a study by Hooks.^{12,13} Cognitive factors did not affect the timely treatment seeking in women like in other studies. Geographical access was not a predictor of delay as in many other studies.^{11,14} The fact that only a small proportion of the patients, who sought treatment from a modern medicine facility received appropriate treatment is a matter of great concern. Sexual activity after the onset of symptoms can increase the efficiency of transmission. This was more in females compared to males like in many studies, though the difference was not significant statistically. Married females may find it difficult to deny sex even while symptomatic like the study from Zambia.⁸

In the logistic regression model, the determinants of delay for males were lowered self efficacy, urethral discharge and growth in genitalia. Though the p value (0.16) for urethral discharge was not significant it was very near to the default cut off value of 0.1, and can be considered as a determinant. In the logistic regression model for females, the determinants were non-ulcerative diseases and having a nuclear family. Women from extended and joint family did not delay treatment due to the better support from joint family.

The basic limitation of the study was the inadequate sample size. Though the sample size was adequate for cross sectional study, when the whole patients were divided into two groups based on delay and gender, the sample size was low and could explain the reason for the wide CI for the important determinants and some important variables not achieving significance level. The results cannot be generalised, as the study setting was a tertiary care centre. Both males and females do not seek treatment if their disease was not associated with severe symptoms. Many patients in spite of having adequate knowledge of STDs continued to have sexual contact, while being symptomatic and did not adopt preventive measures increasing the transmission dynamics. Timely and appropriate treatment decreases the duration of infectiousness and prevents transmission to others. It is also alarming that many patients did not receive appropriate treatment at the first point of contact. STD preventive strategies should take into consideration education of the public regarding the modes of transmission, symptoms, importance of timely and appropriate treatment and the importance of adopting preventive measures. Periodic training should be given to health care providers regarding adequate management of STDs.

Conflicts of interest

The author has none to declare.

Acknowledgements

Dr. T.V. Gopalakrishnan Nair M.D., Dr. K.T. Shenoy M.D., D.M. and all faculty, RCERTC, Thiruvananthapuram are acknowledged for their useful contribution towards this study.

REFERENCES

1. World Health Organization: Sexually Transmitted Infections (STIs): Fact Sheet No: 110 (Updated November 2013). Available from: <http://www.who.int/mediacentre/factsheets/fs110/en>.
2. Rottingen JA, Cameron DW, Garnett GP. A systematic review of the epidemiology in interactions between classic sexually transmitted diseases and HIV: how much really is known? *Sex Transm Dis.* 2001;28(10):579–597.
3. Aral OS, Holmes KK. Social and behavioural determinants of the epidemiology of STDs: industrialized and developing countries. In: Holmes KK, Mardh PA, Sparling FP, eds. et al. *In: Sexually transmitted diseases*. New York: McGraw-Hill; 1998 :39–75.
4. Mulder DW. Disease perception and health seeking behaviour of STDs. In: *Prevention and Management of STDs in Eastern and Southern Africa: Current Approaches and Future Directions*, NARESA. Nairobi, Kenya: NARESA; 1994:83–89.
5. Moses S, Ngugi NE, Brandley EJ, et al. Health care seeking behaviour related to the transmission of STDs in Kenya. *Am J Public Health.* 1994;84:1947–1952.
6. Voeten MCA, O'Hara BH, Kusimba J, et al. Gender differences in health care seeking behaviour for sexually transmitted diseases – a population based study in Nairobi, Kenya. *Sex Transm Dis.* 2004;31(5):265–272.
7. Leenaars PEM, Rombouts R, Kok G. Seeking medical care for a sexually transmitted disease: determinants of delay behaviour. *Psychol Health.* 1993;8:17–32.
8. Makasa M, Fylkesnes K, Sandoy FI. Risk factors, health care-seeking and sexual behaviour among patients with genital ulcers in Zambia. *BMC Public Health.* 2012;12:407.
9. Norcross WA, Ramirez C, Palinkas LA. The influence of women in the health care seeking behaviour of men. *J Fam Pract.* 1996;43(5):475–480.
10. Harrison RM. Women's treatment decisions for genital symptoms. *J R Soc Med.* 1982;75:23–26.
11. Irwin DE. Self treatment patterns and medical care seeking behaviour in STD patients. *Sex Transm Dis.* 1997;24(July (6)):372–377.
12. Hook 3rd EW, Richey CM, Leone P, et al. Delayed presentation to clinics for STDs by symptomatic patients: a potential contributor to continuing STD morbidity. *Sex Transm Dis.* 1997;24(September (8)):443–448.
13. Fortenbury JD. Health care seeking behaviours related STDs among adolescents. *Am J Public Health.* 1997;87:417–420.
14. Celum CL, Bolan G, Krone M, et al. Patients attending STD clinics in an evolving health care environment: demographic, insurance coverage, preferences for STD services, and STD morbidity. *Sex Transm Dis.* 1997;24 (November (10)):599–605.