NIGERIAN JOURNAL OF HEALTH, EDUCATION AND WELFARE OF SPECIAL PEOPLE

Vol. 2 No. 2 AUG. '98

CONTENTS

COMMONLY REPORTED GYNECOLOGICAL MORBIDITIES AND HEALTH-SEEKING BEHAVIOURS AMONG REPRODUCTIVE AGE WOMEN IN URBAN NIGERIA

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ABSTRACT

The present study investigated the commonly reported gynecological morbidities by reproductive age women in some/urban areas of south western Nigeria. Specifically the study attempted to determine the proportion of the reproductive age women surveyed reported the symptoms associated with obstetrics and gynecological morbidity, the perceived causes of such obstetrics and gynecological morbidity in the women, whether such women sought treatment or consultation for specific symptoms, and in what kind of health facilities. , The Ex post facto research design was adopted in the study. The subjects used for the study were randomly selected from four health facilities located in the Ibadan metropolis, south western Nigeria. The findings from the study revealed that 91% of the respondents have had cause to report their problem to either government hospital, primary health center, private hospital, a sub-center or traditional hospital. Also,

55% of the respondents had their medium of information about health programmes through the radio, while the remaining 45% had been adequately informed about health programmes through the other media like television, video, magazines, workshops or seminars. About 80% claimed that they have menstrual disorders of heavy or light irregular bleeding, painful menstruation or spotting between periods, while 79.6% claimed to have anaemia indicated by feeling excessively weak, tired or breathless during household activities. Some 60.4% of the respondents claimed to have lower reproductive tract infections while 30.7% stated that tney have acute pelvic inflammatory disease, which is the lower abdomen pain or vagina discharge with fever. Also, about 58.4% was the percentage of women who sought treatment or consultation for specific symptoms in the private hospital while the rest used the network of health centers and sub-centers available in their areas under the primary health care system. The implications of these findings were highlighted and discussed.

INTROD JCTION

As in most areas of medic ne, a careful history and physical exam ination form the basis for patient evaluation and clinical management in obstetrics and gynec ology A complete history must be recorded at the time of pre-pregnancy evaluation or at the initial antenatal visit. Several detailed standardized forms are available for recording the pertinent aspects of antenatal history, but this does not negate the need for a detailed chronologic history taken personally by the physician who will be caring for the patient. While taking the history, major opportunities arise to provide counselling and explanations that serve to establish close rapport and to allay apprehensions. Generally, there is paucity of information about obstetric and gynecological morbidity in Nigeria. Most studies are based on information from clinics or hospitals, but because a large proportion of women typically do not visit such facilities, results do not reflect the true magnitude of the problem. In addition, the statistics provide information only on biomedical causes, investigations of social, economic, demographic, and behavioural determinants. Perhaps, the only dimension of women's reproductive health that has been thoroughly investigated by means of large representative surveys is fertility regulation and the avoidance of unplanned pregnancy (Fortney and Kiragu, 1995, Moronkola, 1996). Whereas women are the main respondents in surveys on fertility and family planning, effective ways of gathering information about their health have not, until recently been explored.

In fact, one can posit that our ignorance of the causes and exténd of reproductive health problems in the contemporary world is abysmal.

These include not just pregnancy-related morbidity and mortality. but also the psychological and emotional problems of marginalized and exploited teenagers and battered wives as well as the consequences of economic deprivation and harmful cultural practices (Sai and Nassim, 1989) Deaths from illegal abortion are particularly under reported (Akingba, and Gbajumo, 1970, Onemokpe, 1994). Maternal mortality is estimated to e the first or second most important cause of death among women of reproductive age in the least developed countries. It accounts for 25 per cent of their deaths (Rosenfeild and Maine, 1985, The Alan Guttmacher Institute, 1998). Many women survive pregnancy and childbirth but with serious physical impairments or infections that may lead to long term health problems and frequently to infertility (Schulz, Schulte and Berman, 1992, The Alan Guttmacher Institute, 1998). It was reported at a time that some three hundred young women in a month were treated for repair of vesico-vaginal fistulae in one gynecology clinic in the northern part of Nigeria, while those on the waiting list were said to be as many as one thousand (Sai and Nassim, 1989). The majority of the women so disabled are cast out by their husbands, with no support and often turn to prostitution or eventually die a slow, difficult but certain death.

Apart from chronic morbidity caused by badly managed pregnancy itself, pre-existing morbidity is often exacerbated by pregnancy or leads to severe consequences that otherwise might not have occurred. For instance anemia could lead to hemorrhagic complications in pregnancy. Most infectious diseases are more common or more serious in pregnancy. Malaria, typhoid and infectious hepatitis are more harmful for pregnant women than for the general population (Sai and Nassim, 1989). In the same vein the effects of diabetes and cardiovascular, kidney and Lung diseases are usually exacerbated by pregnancy. Even with such sobering data, indicators of maternal morbidity have yet to be articulated and no systematic attempt at classification has been made. Concerted efforts are therefore needed to provide such useful information to health planners and care providers so that appropriate strategies can be designed to bring about an improvement and ultimately enhance optimum maternal health From this premise therefore, the present study investigated the commonly reported gynecological morbidities by reproductive age women in some urban areas of south western Nigeria. Patterns of the health-seeking behaviors with relation to reproductive health-related morbidities of the respondents were also investigated. It is anticipated that such data would provide ample baseline data for systematized health intervention.

RESEARCH QUESTIONS

On the premise of the rationale and significance of the study as well as the information base derived from the literature, the following research questions were posed to guide the conduct of the study:

1. What percentage of the reproductive age women surveyed reported the symptoms associated with obstetrics and gynecological morbidity?
2. What are the perceived causes/symptoms of obstetrics and gynecological morbidity in the women sampled for the study?
3. What percentage of the reproductive age women surveyed sought treatment or consultation for specific symptoms?
4. What proportion of the respondents sought treatment in convectional hospitals/clinics compared with unorthodox medicare facilities?

RESEARCH METHODOLOGY

Research Design

The Ex post facto research design was adopted in the present study. With this design, a systematic inquiry on the commonly reported gynecological morbidities by reproductive age women in some urban areas of south western Nigeria was implemented without any direct intervention on the outcome variables.

Subjects

The purposive sampling technique was adopted in this study, with sample drawn from the following four locations in the Ibadan area, southwestern Nigeria:

1. State Hospital Adeoyo, Ibadan;
2. University College Teaching Hospital, Ibadan;
3. Association for Reproductive and Family Health Agodi G.R.A. Ibadan,
4. Ibadan North East Health Center Iwo Road Ibadan.

A total of 182 female subjects of reproductive age randomly selected from the above health facilities was recruited for the study. Demographic characteristics reflect that the age range of the cohort was between 18-35 years and equal proportion of Christians and Muslims with varying levels of educational attainment.

Instrumentation

The Ibadan Gynecological Morbidity Inventory was used for the generation of data. This instrument which was developed by the research team was adapted from that of Zurayk et al (1995).
The instrument consisted of 53 items eliciting demographic data, (locale of domicile, age and highest educational qualification), as well as

experienced and reported symptoms of gynecological morbidities as well as health-seeking behaviors for such problems.

In-depth interviews were also conducted. An interview schedule was developed in which items were generated for the reproductive health issues surrounding gynecological morbidity.

RESULTS

Table 1: Age of Respondents

ITEM	QUESTION	BELOW 20YRS	20-25 YRS	26-30 YRS	31-35	35 YRS	TOTAL
1	AGE	5	55	100	15	7	182

Table 1, shows that 5 of the respondents representing 2.7% were below age of 20 years, 55 representing 30% were 20-25 years of age, 100 representing 54.95 were aged 26-30 years, 15 representing 8.2% were aged 31-25 while 7 representing 3.8% were above 35 years of age.

Table 2 Medium of Information about Health Education

ITEM	QUESTION	TELEVISION	VIDEO	RADIO	MAGAZINE	WORKSHOP	TOTAL
1	Are you adequately informed about health programmes through the following media	50	15	100	10	7	182

From Table 2, out of the total respondents of 182, 50 representing 27.5% were aware of health programmes on television while 15 representing 8.2% out of respondents had their level of awareness of health programmes by watching video tapes. 10 respondents representing 55% had their medium of information about health programmes through radio relayed programmes, 10 respondents representing 5.49% read about health programmes in magazines while the remaining 7 respondents representing 3.84% get information through workshop and seminar held on health programmes.

Table 3: Symptoms of Gynecological Morbidity Reported by Subjects

ITEM	STATEMENT	YES	NO	TOTAL
1.	Do you have complaints on the following symptoms associated with menstrual disorders? heavy or light irregular bleeding, painful menstruation or spotting between periods	146 (80%)	36 (19.8%)	182
2.	Lower reproductive tract infections, White or coloured discharge from the vagina with bad odour, itching or irritation	110 (60.4%)	72 (39.6%)	182
3.	Acute pelvic inflammatory disease: lower abdomen pain or vaginal discharge with fever	56 (30.7%)	126 (69.3%)	182
4.	Anaemia: Feeling excessively weak tired or breathless during normal household activities	145 (79.6)	37 (20.4%)	182
5.	Hemorrhoids: Pain of bleeding while passing stools	34 (18.6%)	148 (81.4%)	182
6.	Urinary tract infections during the months prior to the interview, abnormal frequency of irritation burning sensation while passing urine	35 (19.2%)	147 (80.8%)	182
7.	Prolapse: Feeling of something mass swelling coming from the vagina or leakage of urine when coughing or sneezing	27 (14.8%)	155 (85.2%)	182
8.	Fistula: Constant leaking of faeces or urine from the vagina	15 (8.2%)	167 (91.8%)	182
9.	Infertility: Inability to become pregnant despite attempts	25 (13.7%)	157 (86.3%)	182
10.	Dyspareunia: Pain during intercourse	4 (2.1%)	178 (97.9%)	182
	TOTAL	597 (32.8%)	1223(67.2%)	1820

As observed in table 3, item 1, 146 out of the 182 respondents presenting 80.2% claimed that they have menstrual disorders, characterized by heavy or light irregular bleeding, painful menstruation or spotting between periods. While 36 representing 19.8% indicated that they do not usually have menstrual disorders. In item 2, 110 out of 182 respondents representing 60.4% claimed to have lower reproductive tract infections while 72 representing 39.6% claimed not to have any such ailment. Item 3 of table 3 showed that 56 out of 182 respondents representing 30.7% claimed they have acute pelvic inflammatory disease that is lower abdomen pain or vaginal discharge with fever, but 126 representing 69.3% claimed not to have the disease.

Table 3 item 4 shows that 145 out of 182 respondents representing 79.6% claimed to have anaemia that is, feeling excessively

weak tired or breathless during household activities, while only 37 of the respondents representing 20.4% claimed not to have anaemia. Out of the 182 respondents in table 3 item 5, only 34 representing 18.7% claimed to have hemorrhoid, that is pain or bleeding while passing stool, while 148 out of 182 respondents representing 81.3% claimed not to have any such health problem. Item 7 of table 3 shows that 155 of the respondents representing 85.2% claimed to have the problem of prolapse that is, having feeling a of something (a mass swelling) coming from the vagina or leakage of urine when coughing or sneezing while 27 representing 14.8% claimed not to have such complaint. Item 8 on the table shows that 15 out of 182 respondents representing 8.2% have the problem of leaking faeces or urine from the vagina which is medically called fistula while 167 representing 91.8% indicated that they have not had anything of such. Item 9 on the same table shows that out of 182 respondents who were aware of the existence of infertility, only 25 representing 13.7% claimed to be infertile since marriage while 157 respondents representing 86.3% claimed to be fertile. Surprisingly, only an insignificant 2.1% revealed experiencing dyspareun a which is painful intercourse. A relatively prevalent reproductive health morbidity among women in sub-Saharan Africa, the sensitive nature of the issue may have accounted for the rather low reporting documented here.

Table 4: Type and place of medical consultation

Symptoms Associated with	Percentage of Women Who Sought Treatment or Consultation for Specific Symptoms and the Type and Place of Treatment or Consultation					
	Government hospitals	Primary Health Centers	Health Sub-Centers	Private hospitals	Traditional and Other	Total
Menstrual Disorders	29.2	3.5	6.2	58.4	2.7	100
Lower reproductive tract infections	29.0	3.8	2.5	62.8	1.9	100
Acute pelvic inflammatory disease	36.2	2.1	0.0	58.5	3.2	100
Anaemia	27.6	3.7	2.7	64.5	1.5	100
Hemorrhoids	14.3	3.6	0.0	75.0	1.1	100
Urinary tract infections	26.1	8.7	0.0	56.5	8.7	100
Prolapse	37.5	0.0	0.0	62.5	0.0	100
Fistula	0.0	0.0	0.0	80.00	20.0	100
Infertility	0.0	0.0	0.0	100.00	0.0	100

As shown in table 4 approximately one third of the women surveyed in this study reported current symptoms suggestive of at least one type of reproductive morbidity. With the exception of infertility, the proportions who had sought treatment or medical consultation are surprisingly constant, ranging only from 43 percent to 55 percent for all other conditions. Again, interpretation may not be wholly representative here because successfully treated episodes will not be represented as the abnormality or severity of their symptoms. Nevertheless the findings indicate that a large proportion of women consider their symptoms to the sufficiently serious to warrant medical treatment. A clear majority of those women who had sought treatment used private sources of medical care, while typically about 30% had used the services available at government hospitals. A lower proportion used the network of heath centers and sub-centers available in their areas under the primary health care system. Further analysis of the determinants of reported symptoms and their consultant or treatment is limited to the four main symptoms categories, those associated with menstrual disorders, lower reproductive tract infection, acute pelvic inflammatory disease and anaemia.

RESEARCH QUESTIONS ANSWERED

The data generated and analyzed in this study was designed to permit the successful appraisal of the research questions postulated in this research. The confirmation or refutal of the research questions would assist in drawing inferences and deductions the basis on which vital conclusions about the research objectives could be reached.

Research Question I: What percentage of reproductive age women surveyed reported the symptoms associated with obstetrics and gynecological morbidity? The results show that the sample across the different health care facilities surveyed reported divergent range of symptoms of morbidity. Reference to Table 4 shows that 97% response was received from government hospital reporting the symptoms the such morbidity, while 90% response was received from patients attending primary health centers so also 90% response came from private medical practitioners. The above findings were adequate to affirmatively answer the first research question.

Research Question II: The second research question posits that what are the perceived causes/symptoms of obstetrics and gynecological morbidity in the women sampled for the study? As observed from table 3, the symptoms of gynecological morbidity and the percentage of women reporting each symptom is shown, also the percentage of each symptom as indicated by the women is also presented; (menstrual disorders: 80%, reproductive tract infections: 60.4%, acute pelvic inflammatory disease 30.7%, anemia: 79%, hemorrhoids: 18.6%, urinary

tract infections 19%, prolapse: 14.8%, fistula: 8.2%, infertility: 13.7%, dyspareunia: 2.1%. The associated symptoms of the condition seem to be common among the women with a cumulative 31.8% of the respondents indicating having one form of genealogical morbidity or the other, as compared with 67.2% who claim not to have any such problems. This is indicative of the fact that the prevalence is quite considerable among the cohort.

Research Question III: This research question inquires on what percentage of the reproductive age women surveyed sought treatment or consultation for specific symptoms? Table 4 shows the percentage of women who sought treatment and the place where such health-seeking behaviour was made. It was observed that 58.4% reported the symptoms of menstrual disorder to private doctors while only 3.5% reported same to primary health centers. It does seem that the women were more favourably disposed to seeking treatment in the private hospitals perhaps for the promptness, the personalized service and possibly the privacy that is characteristic of such health facilities irrespective of the prohibitive cost. The result also shows that a good proportion of the respondents sought treatment in government hospitals probably because such infirmaries strike a balance between relatively good quality service and cost effectiveness.

Research Question IV: The fourth research question attempted to ascertain what proportion of the respondents sought treatment in conventional hospitals/clinics compared with unorthodox or traditional medicare facilities? Reference to table 4 shows the pattern of health-seeking behaviours among the subjects. The findings show that most of the respondents prefer conventional/orthodox medical facilities vis a vis traditional or quasi modern medical centers like chemists or pharmacists (97.3% of menstrual disorder patients, 98.1% of lower reproductive tract infection patients and 98.5% of anemia patients among others). It is encouraging that such health-seeking behaviours are prevalent among the cohort.

DISCUSSION OF THE FINDINGS

This study revealed that there is a considerable high prevalence of gynecological morbidity among reproductive age women surveyed in urban Nigeria. Menstrual disorders seem to be a dominant problem in this cohort. In most cultural contexts, women due to a wide range of attitudinal reasons, are generally reluctant to subject themselves to gynecological examination, particularly when they have no apparent symptoms of disease. Evidence from research on reproductive morbidity indicates that refusal rate is considerably high, even when examination is limited to symptomatic women (Trebouk et al, 1994, Adler al 1996).

Most women refused to declare the true nature of the problems they have. This high refusal rate introduces severe research sample selection bias, and in such circumstances, comparisons of the responses from the questionnaires with the results of clinical examination and medical tests are difficult to synchronize and interpret. Traditionally doctors have depended to a large extent on a patient's history for reaching appropriate diagnosis. But presently reliance is essentially dependent on sophisticated laboratory tests requiring expensive instruments that can only be performed in clinical settings. Until simple, inexpensive and accurate screening procedures are developed that can be used in field situations, the contribution of clinical examination and laboratory tests for detecting reproductive morbidity among representative samples will remain limited.

Health care facility records are valuable because they indicate what services are being sought and by whom. However, they are much less suitable for estimating the magnitude of reproductive health problems because a large proportion of women having such problems do not visit these facilities, even though, the correspondence between self reports and clinical diagnosis is far from exact. The relevance of symptoms reported by women is in no doubt because the recognition of a disorder, its perceived causes, and feared outcome, rather than a sophisticated medical diagnosis, determines a patient's reaction and treatment seeking behaviour. Certainly some conditions and infections are symptomatic or exist in so early a stage that the patients do not recognize them. Equally conditions arise that are psychosomatic in origin or that medical professionals do not recognize But if women seek care for imaginary illnesses and are willing to pay for it, medical justification is found for such care. As a measure of potential demand for services, self-reported symptoms of morbidity are, therefore more applicable than clinical diagnosis. Health education may increase in the long run the consistency between an individually determined and medically determined need.

Approximately two third of the women in this study reported the symptoms suggestive of at least one kind of gynecological morbidity. The exclusion of other women without young children may have acted to depress this estimate. Nevertheless, the results indicate a high prevalence of perceived illness or disorder. While no information was collected on the severity of the report problems, the finding that about half of those reporting symptoms had sought treatment clearly suggests that the majority of symptoms were not regarded as minor or inconsequential. Approximately eighty percent of young women reported menstrual problems. Menstruation is, of course a normal occurrence and an integral part of women's lives. Presumably women would report

menstrual problems only if they perceived them to be severe. The incidence of reproductive tract infection in women has been found to be remarkably high, owing to a combination of biomedical, behavioural and societal factors. These infections, if not diagnosed early and treated promptly may represent a serious long term threat to women's health, fertility and productivity. The survival and health of infants born in these conditions may be seriously compromised and such infections may adversely affect the overall health of the subjects.

In the present study, a significant proportion of the sample reported white or coloured vagina discharge, which is often associated with lower reproductive tract infections as well as with no diagnosable problems. Half of the women reporting symptoms sought consultation or treatment for these problems. Majority of such consultants were with private medical practitioners. This may be due to extreme privacy women desire especially on such matters. Even with the prevailing economic hardship in Nigeria, it was pleasantly surprising to discover that a good proportion of the respondents preferred private health care to public ones. It does seem that subjects in this cohort are striking a balance between proper health care and prohibitive cost that is characteristic of private medical practice in Nigeria. Most public predominantly government owned health centers, except a few teaching hospitals are ill-equipped and badly run representative of what Adekunle and Ladipo (1992) referred to as fragile infrastructure. It is obvious that such conditions are aversive enough to discourage most patients with the high preponderance of preference for private health facilities.

RECOMMENDATIONS AND IMPLICATIONS FOR REPRODUCTIVE HEALTH CARE

A number of recommendations emerge from the present study, and these have far reaching implications for reproductive health care in Nigeria and other developing nations. There is need for increased sensitization for women to be more assertive in terms of their health-seeking behaviours obtainable through exposure to the media and to informal adult and health education programmes especially at the community level. By availing themselves of such health enlightenment programmes or reading from periodicals and ladies' magazines, women cultivate better health-seeking behaviours and promptly report any symptoms if undetected and treated, would otherwise degenerate into more serious health problems.

Cultivation of the habits of personal hygiene, self- care and monitoring have relevance to the present study. Consistent maintenance of personal hygiene is capable of reducing the problem of opportunistic infections that are prevalent in the poorer nations of the world. The

indices of personal hygiene should include bathing, wearing neat underwear, using good sanitary pads, washing and combing the hair, washing and changing clothes frequently, clipping the nails, and washing the hands after defecation before meals.

In addition to regular checkups at health facilities, women can also monitor their own health. Health education that teaches women how to care for themselves and how to recognize danger signs is critical especially in places where access to good medical care is limited.

Furthermore, occasional laboratory testing should be encouraged especially if the women are resident in places where health facilities have the necessary equipment and supplies. Laboratory testing may include blood tests for sexually transmitted disease infections including HIV. It may also include a complete blood count to look for early detection of anaemia. Any problems found during the history, physical examination or laboratory testing should be followed up as soon as possible in a proper medical center.

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