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Male Involvement in Family Planning in Some Selected Rural Communities in the Enugu East Local Government Area of Enugu State, Nigeria

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Abstract

Background: Men's involvement in family planning has the potential to enhance its recognition, acceptance, and uptake, particularly in rural Nigerian communities like Enugu, where men dominate household decisions, including family planning choices. Many men may determine whether their wives use family planning and which methods are adopted.

Objectives: To determine the percentage of men who practice family planning in the studied communities, identify factors affecting men's involvement in these communities, define the nature of men's participation in family planning, and identify the family planning methods most commonly adopted by men in these communities.

Methodology: A cross-sectional study descriptive survey of 360 married men using a structured questionnaire to assess their family planning participation, influencing factors, and preferred methods. Data were analyzed descriptively (frequencies, percentages) and inferentially (chi-square test) to examine links between sociodemographic variables (age, education, occupation, religion) and family planning engagement. A four-point Likert scale measured involvement levels, with item means compared to a criterion mean.

Results: Only 46% of men practiced family planning. Key barriers included limited knowledge, few male contraceptive options, poor education, and cultural/religious influences. Common methods were withdrawal, condoms, and vasectomy. Socioeconomic factors significantly affected participation, with 24.7% regularly using contraceptives and 35.3% supporting family planning decisions. The findings highlight the need for male-inclusive family planning programs to improve uptake by addressing knowledge gaps and sociocultural barriers.

Conclusion: Male family planning participation is limited, necessitating targeted education, expanded contraceptive options, and strategies addressing socio-demographic influences.

Keywords: Male involvement, family planning, Rural communities



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INTRODUCTION

Family planning is a voluntary process that enables individuals and couples to choose how many children to have and when while making sure they have the necessary resources to care for them. It's essential for promoting health, welfare, and social development ¹. However, in rural areas, men often hold significant decision-making power within households and society, which affects family planning choices. Some men decide whether their wives use family planning and which methods to choose.²

Reports from the United Nations Population Fund ³ indicate that male involvement in family planning remains low in Africa, at around 30-40%, compared to Western countries, where it is 60-70%. It was also observed that in developed countries, male participation in family planning is relatively high, at 65% in Europe and 70% in the U.S., whereas African countries show significantly lower involvement. For example, only 35% of attendees at family planning clinics in South Africa are male, and in Togo, the male-to-female participation ratio is 1:3⁴. In many traditional African societies, including Nigeria, men control decisions about childbearing, contraception, and reproductive health. However, it is also noted that men's perceived power, shaped by cultural norms and societal expectations, influences their willingness to discuss family planning with their partners, their choices regarding contraceptive use, and their participation in family planning programs overall, especially in rural communities.

Male involvement in family planning is crucial for increasing awareness, acceptance, and participation, especially in rural areas where men are the primary decision-makers. Engaging men in family planning can help lower population growth, reduce sexually transmitted infections, and decrease maternal and infant mortality by improving access to family planning.²

Despite worldwide efforts to include men in family planning, Nigeria has not fully integrated them into such programs. In Nigeria, male involvement in family planning remains low; for example, a study in Ilorin found only 20% contraceptive use ⁵, while national surveys show rural participation rates of 45% ⁶. This disparity reflects broader Sub-Saharan trends where men's engagement is limited by patriarchal norms ² and a lack of services aimed at men ^{3,6}. Pregnancy and delivery issues are still viewed as women's concerns, but although men do not carry pregnancies, they initiate this process and should be involved in family planning to improve outcomes. ⁷.

Most family planning initiatives mainly target women, leaving men unaware of their benefits ⁸. This is especially concerning in rural areas like Enugu East LGA, where traditional beliefs and resistance to change make it hard for women to adopt family planning without their husbands' approval.

Documented evidence shows that three hundred million pregnancies occur in sub-Saharan Africa, and eleven million Nigerian women become pregnant each year, while half a million women die from pregnancy-related complications and childbirth, with 99% of these deaths happening in developing countries ⁹. It is estimated that about 200 million couples worldwide want to delay or stop having children, but lack access to contraception ¹⁰. Even though they try to control family size, many men see pregnancy and childbirth as women's responsibilities, leaving women to face the risks of unwanted pregnancies and sexually transmitted infections alone.

Records from ESUT Teaching Hospital, Parklane Enugu (2023) ¹¹ revealed that 60% of high-parity referrals from rural communities in Enugu East LGA were due to husbands' decisions and cultural values. Additionally, male attendance at family planning clinics between 2018 and 2022 was only 10%. Given the influence men have in decision-making, their participation in family planning programs is essential for improving maternal and child health outcomes.

METHODOLOGY

Study design: A cross-sectional descriptive survey design was employed for this study.

Study area: This research was conducted in Enugu East Local Government Area (LGA), Enugu State, with its headquarters located at Nkwo Nike. The local government area is bordered to the north by Isi-Uzo LGA, to the south by Enugu North, to the east by Nkanu East LGA, and to the west by Udi LGA. Currently, the LGA consists of four development centers: Enugu East Central, Mbulujodo, Mbulu Iyiukwu, and Mbulu Owelle. Out of the nine communities in the LGA, Ugwuomu, Nkwubo, and Obinagu-Onuogba were selected. The residents are predominantly Igbo, with a few Fulani settlers. The majority of residents in communities practice Christianity; others are traditional worshippers, and a few are Muslims.

Population of study: The study population included all married males in the three selected communities.

Married males aged 20 to 70 years numbered approximately 3320¹².

Inclusion Criteria: All married men aged 20-70 years whose wives were of reproductive age (15-49 years), who were willing to participate, and available at the time of the study were included.

Exclusion Criteria: The exclusion criteria included married men who met the inclusion criteria but were either severely ill, had cognitive/communication impairments that hindered their ability to provide informed consent, or who voluntarily withdrew their consent during the course of the study.

Sample size determination: The sample size of three hundred and sixty males (360) from Ugwuomu, Nkwubo, and Obinagu-Onuogba communities was used for the study. The sample size was statistically determined using the Taro Yamane formula for a finite population.¹³

Determination of sample size with the total population Taro Yamane's formula for a finite population. The formula is given as:

$$n = \frac{N}{1 + N(e)^2}$$

Where

$$\begin{aligned} n &= \text{the sample size} \\ N &= \text{the finite population} \\ e &= \text{level of significance or (limit of tolerable error)} \\ I &= \text{unit (a constant),} \\ n &= \frac{3320}{1 + 3320(0.05)^2} \\ &= 359.5 \end{aligned}$$

Sample size = 360

Sampling techniques: A multistage sampling technique was used to select the respondents for the study.

Stage 1: The study utilized a simple random sampling method involving balloting to determine the specific location within the Enugu East Local Government Area where the research would be conducted. Ultimately, one out of the available four development centers was chosen for the study.

Stage 2: In the selected development center, 3 communities each were selected using a simple random sampling technique.

The sample size for each of the three communities studied was determined proportionately.

To statistically determine the number to be selected from each of the three communities: - To get the

Community proportion, community size, and sample size were utilized.

By using a total of 3320 representing the population, we divided the community size, then multiplied it by the sample size. Thus, Nkwubo 156, Obinagu Onuogba 126, and Ugwuomu 78.

Stage 3: In the three selected communities, systematic random sampling was employed. Houses were enumerated and numbered, then selection began at a randomly chosen starting point (number 10). Every 10th house was approached, with eligible respondents selected from each. Locked houses and dwellings with unwilling/ineligible respondents were skipped until reaching the required sample size.

Method of Data Collection: Data collection was conducted using a semi-structured questionnaire specifically designed for this study to gather information on male involvement in family planning in selected rural communities within the East Local Government Area. The researcher developed this questionnaire, which also served as an interview guide for illiterate respondents, to collect data. It was divided into two sections: Section A (4 items) covered respondents' socio-demographic details, while Section B (17 questions) addressed the study's objectives. Section B included structured questions related to the research focus. Question 5 examined the percentage of men practicing family planning. Questions 6–11, utilizing a 4-point Likert scale, evaluated the extent of men's involvement. Question 12 focused on commonly used methods, and Questions 13–22 investigated factors influencing men's participation in family planning. The questionnaire was administered by trained research assistants who were briefed on the study's purpose, sampling procedures, and informed consent processes. Community awareness was raised through traditional rulers, village heads, age-grade leaders, and town criers. Data collection sites included streams and village squares, with data gathered in a clockwise manner from each location. Houses were numbered, and assistants collected data only from eligible respondents, assisting illiterate participants as needed. Data collection took place in the evenings over eight weeks, excluding market days when residents were usually engaged in farming or trading activities during the day.

Validity and Reliability of Instrument: Validation was done by the researcher's Supervisor, a Community Health Specialist, and two others who were experts in the field of measurement and evaluation for face

validation. Their observations were used to make necessary modifications before final approval by the supervisor.

The reliability of the instrument was checked using the test-retest method. This was done by administering the same questionnaire to 30 respondents in a similar rural community in Nkanu West Local Government Area in Enugu State. After two weeks, the same test was administered again to the same group who had taken it previously. The two sets of scores obtained were used to compute a correlation coefficient using the Cronbach Alpha formula or coefficient alpha (α), which resulted in a value of 0.845, indicating that the instrument was reliable.

Data analysis: The data analysis utilized descriptive statistics such as means, standard deviations, frequencies, and percentages, and was carried out with the help of Statistical Package for the Social Sciences (SPSS) version 17. For the four-point Likert-type scale, the item means were computed and compared with the criterion mean to show the level of involvement.

The significant association between male involvement in family planning and socio-demographic variables such as education level, age, occupation, and religion was investigated using the Chi-square values for testing the hypothesis at a 0.05 level of significance.

Ethical Approval: Ethical clearance was sought and obtained from the Research and Ethical Committee of the Ministry of Health, Enugu, with reference number (MH/MSD/EC/0124). Following a thorough explanation of the study's goals and the participants' responsibilities, written informed consent was obtained from the participants. The study was voluntary, and confidentiality and anonymity were maintained throughout. Permission to carry out the study in the rural communities was also obtained from the Enugu East Local Government Area Chairman and the Traditional Rulers of the three selected communities.

RESULTS

The total number of questionnaires distributed was 360, but only 348 (97%) were returned. Eight were lost, and four were not completed.

Socio-demographic characteristics of respondents

According to Table 1, the mean age of the study participants was 45.2 ± 10.5 years. However, the majority of the participants, 306 (87.9%), were Christians; 159 (45.7%) had tertiary education; and 247

(78.7%) were gainfully employed, including public servants (196, 56.3%) and farmers (78, 22.4%). [Table 1]

Table I: Socio-demographic characteristics of the respondents (n = 348)

Demography	Frequency	Percentages
Age range (Mean=45.2 years)		
30 – 39	84	24.1
40 – 49	75	21.6
50 & above	189	54.3
Level of education		
No formal education	54	15.5
Primary education	42	12.1
Secondary education	93	26.7
Tertiary education	159	45.7
Occupation		
Farming	78	22.4
Trading	62	17.8
Public servant	196	56.3
Artisan (plumber, electrician)	12	3.4
Religion		
Christianity	306	87.9
Muslim	18	5.2
Traditional religion	24	6.9
Total	348	100

160 (46%) of the participants are currently involved in practicing family planning, while 188 (54%) are not. Therefore, less than 50% of the men in the communities practice family planning. [Table 2].

Table II: Respondents' responses to the percentage of men who get involved in practicing Family Planning (n=348)

Currently involved in FP	Freq	Percent
Yes	160	46
No	188	54
Total	348	100

Most respondents, 266 (76.4%), agreed that inadequate knowledge impacts men's participation in family planning (Mean = 3.10). Similarly, 267 (76.3%) agreed that limited male contraceptive options are a barrier (Mean = 3.03). About 207 (59.5%) identified poor IEC as a factor (Mean = 2.61), and 220 (63.2%) acknowledged the influence of religious beliefs (Mean = 2.61). Meanwhile, 218 (62.7%) believed culture affects involvement (Mean = 2.77), and 221 (63.5%) agreed on spousal influence (Mean = 2.67). Conversely, 212 (60.9%) disagreed that the lack of male-only facilities is

a factor (Mean = 2.24), 219 (63.0%) dismissed provider availability issues (Mean = 2.23), and 168 (48.3%) disagreed on economic concerns (Mean = 2.49). An overall mean of 2.64 suggests these factors significantly influence men's participation. [Table 3]

Table 3. Factors influencing man's participation in FP-

Factors influencing men's participation in Family Planning	SA (4) F	%	A (3) F	%	D (2) F	%	SD (1) F	%	Mean ± SD
Inadequate knowledge	148	42.5	118	33.9	50	14.4	32	9.2	3.10 ± 1.26
Lack of many contraceptive options for men	126	36.2	141	40.1	46	13.2	35	10.1	3.03 ± 1.27
Lack of exclusive family planning facilities for males	55	15.8	81	23.3	103	29.6	109	31.3	2.24 ± 1.45
Poor IEC	79	22.7	128	36.8	67	19.3	74	21.3	2.61 ± 1.33
Religious beliefs	87	25.0	119	34.2	62	17.8	80	23.0	2.61 ± 1.32
Culture	112	32.2	106	30.5	68	19.5	62	17.8	2.77 ± 1.52
Economic concern	71	20.4	109	31.3	87	25.0	81	23.3	2.49 ± 1.49
Spousal influence	101	29.0	120	34.5	39	11.2	88	25.3	2.67 ± 1.45
Provider availability	56	16.1	73	21.0	114	32.8	105	30.2	2.23 ± 1.37

SA – Strongly agree, A – Agree, D – Disagree, SD – Strongly disagree

Most respondents, 226 (64.9%), reported using contraceptives to a moderate or high degree, supported by a high mean value of 2.83. However, 214 (61.5%) showed low or very low support for their spouse's contraceptive use (Mean = 2.21). About 244 (70.1%) made contraceptive-related decisions to a moderate or great extent (Mean = 2.89), but 223 (64.1%) discussed family planning with their spouse only minimally (Mean = 2.21). Similarly, 247 (71.0%) rarely accompanied their spouse to family planning services (Mean = 2.11), and 218 (62.7%) provided financial support for family planning to a low or very low extent (Mean = 2.25). An overall mean of 2.42 indicates generally low male involvement in family planning. [Table 4].

Table 4: Respondents' responses to the nature of men's involvement in family planning

Items	High extent (4)		Moderate extent (3)		Low extent (2)		Very low extent (1)		Mean ± SD
	F	%	F	%	F	%	F	%	
I use a contraceptive method	134	38.5	92	26.4	54	15.4	68	19.2	2.83 ± 1.53
I support my wife in using a family planning method	64	18.4	70	20.1	88	25.3	126	36.2	2.21 ± 1.55
I decide in favour of contraceptive use and continuity within the family	115	33.0	129	37.1	54	15.5	50	14.4	2.89 ± 1.38
I discuss family planning freely with my wife	59	17.0	66	19.0	113	32.5	110	31.6	2.21 ± 1.52
I accompany my Wife to the facilities to obtain family planning services	68	19.5	33	9.5	117	33.6	130	37.4	2.11 ± 1.52
I give my wife money for the family Planning	62	17.8	68	19.5	114	32.8	104	29.9	2.25 ± 1.46
Overall mean									2.42

Out of 160 men who are currently involved in family planning, 38 (23.8%) use only condoms, 21 (13.1%) use only vasectomy, 111 (31.9%) use only withdrawal, while 44 (27.5%) use both condom and withdrawal methods of family planning. [Table 5].

Table 5: Methods of family planning adopted mostly by men in these communities. (n = 160)

Which of the following family planning methods do you use	Frequency	Percent
Condom only	38	23.8
Vasectomy only	21	13.1
Withdrawal method	57	35.6
Both condom & withdrawal	44	27.5
Total currently using	160	100

Hypothesis Testing

H₀: The null hypothesis was rejected, indicating a statistically significant association between these socio-demographic variables and male involvement in family planning."

Table 6: Association between socio-demographic variables and male involvement in family planning

Variables	Male involvement Yes (%)	Male involvement No (%)	Chi-square	P-value
Age	(n=160)	(n=188)	13.706	< 0.001
30 - 39	24 (15.0)	60 (31.9)		
40 – 49	37 (23.1)	38 (20.2)		
50 & above	99 (61.9)	90 (47.9)		
Level of education			41.615	< 0.001
No formal	12 (7.5)	42 (22.3)		
Primary	6 (3.8)	36 (19.1)		
Secondary	57 (35.6)	36 (19.1)		
Tertiary	85 (53.1)	74 (39.4)		
Occupation			21.300	< 0.001
Farming	18 (11.3)	60 (31.9)		
Trading	32 (20.0)	30 (16.0)		
Public servant	104 (65.0)	92 (48.9)		
Artisan	6 (3.8)	6 (3.2)		
Religion			24.231	< 0.001
Christianity	148 (92.5)	158 (84.0)		
Moslem	12 (7.5)	6 (3.2)		
Traditional	0 (0.0)	24 (12.8)		
Total	160 (100.0)	188 (100.0)		

Table 6 presents the association between socio-demographic variables and male involvement in family planning. The findings reveal a statistically significant association across all the socio-demographic factors examined, as all p-values were less than 0.05.

Regarding **age** ($\chi^2 = 13.706$, $p < 0.001$), male involvement in family planning increased with age, with the highest participation observed among men aged 50 years and above (99, 61.9%). Similarly, a significant association was found with the **level of education** ($\chi^2 = 41.615$, $p < 0.001$). Involvement increased progressively with higher educational attainment, peaking among those with tertiary education (85, 53.1%).

Occupation was also significantly associated with male involvement ($\chi^2 = 21.300$, $p < 0.001$). The majority of the men involved were public servants (104, 65.0%), followed by traders (32, 20.0%), with farmers and artisans showing much lower involvement. Finally, there was a significant association between male involvement and **religion** ($\chi^2 = 24.231$, $p < 0.001$), with the vast majority of involved men identifying as Christians (148, 92.5%).

In summary, higher age, advanced education, formal employment (public service), and Christian affiliation are positively and significantly associated with greater male participation in family planning in the studied communities. Consequently, the null hypothesis is rejected.

DISCUSSION

The percentage of men who get involved in practicing family planning

The results showed that 46% of men were involved in practicing family planning. This implies that less than half of the respondents practice family planning in the communities. The findings agree with those of studies on male involvement in family planning⁶ in Southwest Nigeria, where it was found that the rate of male participation in family planning is 45%. However, this varies with the study in India¹⁴, where 62% of males practiced family planning, higher than African but lower than Western rates. Additionally, in the U.S./Europe, 65% of men shared Family Planning responsibility¹⁵.

The factors affecting men's involvement in the family

Results also revealed that men believed the following factors influence men's involvement in family planning: inadequate knowledge, limited contraceptive options for men, poor information, education, and communication, religious beliefs, cultural norms, economic concerns, and spousal influence. In line with¹⁶, who found in Ethiopia that spousal influence is a significant factor, it was noted that men who practice family planning are twice as likely to have discussed contraception with their wives compared to those who have not¹⁷. Similarly, study in rural Rwanda found that communication between spouses is associated with contraceptive use. The difference in family planning practices between men in urban and rural areas suggests that some contraceptive options are more readily available in urban settings^{18,19}. The study aligns with research conducted in Kenya²⁰, where economic hardship was the most common reason for vasectomy acceptance among men. Likewise, in Ghana,²¹ economic considerations were among the primary motivations for using family planning methods. The findings from a study in Saudi Arabia, where 72% of men avoided Family Planning due to beliefs that it conflicts with Islamic teachings, support that men's involvement in family planning can be influenced by religious beliefs.²² The findings also align with recent studies in Nigeria and Tanzania, where religious denomination significantly predicts male participation^{23,24}. For instance, it was found that Islamic communities in Northern Nigeria exhibit stronger resistance to vasectomy compared to Christian-majority regions, mirroring our results.²⁴

Nature of men's involvement in family planning

The results showed that 24.7% of males use contraceptives to a high degree, while 35.3% make decisions supportive of contraceptive use and continuity within the family. However, only a few support their spouse in using family planning methods, discuss family planning openly with their spouse, accompany their spouse to facilities to access family planning services, or give their spouse money for family planning. This indicates a low level of contraceptive use among males in the communities. The finding agrees with studies in Ghana²⁵, where 29% of men discussed Family Planning with their partners.

The finding does not align with¹⁴, who reported a 62% prevalence rate of contraceptive use among males in India, but it aligns with⁸, who found that in Kenya and Uganda, males decide on family planning adoption in their households. Similar results were found in a study in Kenya². This also concurs with the findings of²⁶, who observed that males show little or no support to their wives regarding family planning matters.

The methods of family planning that are mostly adopted by men in these communities. Results showed that the most common family planning methods used were withdrawal, condoms, and vasectomy among men in the communities. The findings align with studies conducted in India by¹⁴, where 62% of men practicing family planning used condoms or vasectomies; similarly,²⁷ supported the findings on low vasectomy uptake. As found by²⁴ in Bangladesh, the withdrawal method was the most popular, but its use was low (26.2%). Similar results were also found in a study in Ilorin, which showed that vasectomy and withdrawal are among the least known or used family planning methods²⁴. It was also found in a global review that less than 5% of family planning research focuses on male methods (such as vasectomy and male pills), which contributes to the ongoing low uptake.^{19,29}

Socio-demographic variables such as age, educational level, occupation, and religion are significantly linked to male involvement in family planning. The findings showed that their involvement increased with age and educational attainment. More men reached a tertiary education level, which explains why a higher number of public servants were more engaged in the practice. Also, most of those involved are Christians. This aligns with the finding that religious beliefs, social norms, and denominations are significantly associated with men's use of family planning methods in Saudi Arabia²². It was

discovered by ^{30,31} that 78% of men in Ethiopia lacked basic knowledge of male contraceptives due to weak public health campaigns and noted a 70% increase in contraceptive use after educational efforts, highlighting their importance. Additionally, in Southwest Nigeria observed that education level and occupation significantly influence men's participation in family planning⁶.

Strengths and limitations of the study

A major strength of this study lies in its focus on men within rural, traditional settings. This demographic is frequently overlooked in family planning literature despite its role as primary household decision-makers. Furthermore, the study employed a rigorous systematic random sampling technique, which achieved an exceptionally high response rate of 97%. The methodology was also inclusive; administering the questionnaire as an interview guide for illiterate respondents ensured that the data genuinely reflected the broader rural population, regardless of educational background.

However, the study has certain limitations that must be acknowledged. First, the cross-sectional design of the research allows for the identification of associations between socio-demographic variables and family planning involvement, but it cannot establish causal relationships. Second, the data relies on self-reporting regarding sensitive topics like contraceptive use and spousal support, which may introduce social desirability bias. Additionally, because the study relied solely on the perspectives of men, the actual spousal dynamics were not cross-validated with their wives. Finally, the study was localized to three selected rural communities in Enugu East Local Government Area, meaning the findings should be generalized with caution to urban populations or other regions in Nigeria. Future research could benefit from a mixed-methods approach that includes couples (dyadic data) to provide a more holistic view of male involvement in family planning.

Implications of the Findings of The Study

The result of this study found that less than half of the respondents in the rural communities get involved in practicing family planning. Therefore, to improve men's involvement in family planning, adequate information, education, and communication through health education sessions on family planning methods and benefits must be employed by nurses to increase awareness, acceptance, and practice among men at various men's forum such as Igwe's cabinet/age grade

meetings and men's religious organization. This is to enable them to have correct information and knowledge about family planning because they are the major decision makers who control power and authority at the household level, especially within the rural communities. While among women, at various immunization and postnatal clinics, spousal influence has been found as one of the determining factors for male involvement.

Also, more male options should be promoted as well as made available by the nurses as service providers. There should also be improved nurses' availability and reputation, as this positively affects involvement in family planning. Nurses as service providers should be available and accessible to clients to avoid confusion as to when providers can be seen at service areas, especially in rural communities. The nurses should be permanently stationed or have scheduled days and times that will suit the men provided services.

CONCLUSION

Generally, men's participation in family planning is poor, especially in rural areas. Methods of family planning, such as withdrawal, use of condoms, and vasectomy, were mostly adopted by men who are involved in family planning. However, the majority of them do not support their spouses in getting involved in any family planning method. Various factors such as Inadequate knowledge, lack of many contraceptive options for men, poor IEC, religious beliefs, culture, economic concern, and spousal influence were found to be determinants of men's participation in family planning. Therefore, to improve men's involvement, adequate IEC must be employed to increase awareness, and more male options should be promoted as well as made available. This study has also confirmed the fact that socio-demographic variables such as age, educational level, occupation, and religion are significantly associated with men's involvement in family planning.

Declarations

Authors' contribution

The formulation, design, data collection, analysis, and interpretation for this work were all carried out by the authors with the help of research assistants.

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