

Sociodemographic Factors Affecting the Practices of Exclusive Breastfeeding Among Mothers Attending Brikama District Hospital, West Coast Region, The Gambia

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Abstract: World Health Assembly resolution emphasized on countries to ensure that maternal and child nutrition especially the six global targets are met by 2025, and it was all clamored for more efforts to be put on increasing the rate of exclusive breastfeeding by 50%. To support a child's best growth and development, exclusive breastfeeding should be observed for the first six months after birth followed by supplemental feeding for two years or longer. This study investigates the sociodemographic factors influencing the practice of exclusive breastfeeding among mothers with children who are two years or less attending antenatal care in Brikama Health Center, The Gambia. Structured and pretested interviews and questionnaires were used to obtain data from study participants respectively. Face-to-face interviews with mothers on their clinic days were used to collect data during the one-month study period and descriptive statistics were carried out using SPSS for Windows version 20.0. A total of 384 women participated in this study, out of which, the majority, 240 (62.5%) of participants had exclusively breastfed their babies. Above half 168 (44%) of the mothers had breastfed their babies on demand, majority of them 49 (21%) reported that they had given their babies lactating milk or formulae food before the sixth month. The results show a significant relationship between Type of family ($p=0.002$), Religion ($p=0.035$), Ethnicity ($p=0.005$), Type of deliveries ($p=0.023$), and Place of birth ($p=0.001$) and practice of exclusive breastfeeding (EBF). Concerning the frequency of EBF, Educational status and Occupation showed a significant relationship ($p=0.032$ and 0.051) respectively. Type of family, religion, ethnicity, type of delivery, place of birth, educational status, mother's occupation, and child's sex were the socio-demographic characteristics that influenced exclusive breastfeeding in this study. In planning exclusive breastfeeding intervention programs, these factors need to be considered.

Keywords: Exclusive Breastfeeding, Brikama, Practice, Socio-Demographic, Mothers

1. Introduction

Exclusive breastfeeding (EBF) is one of the best feeding regimens for newborns and young children [1]. Breastfeeding

is when a mother feeds her baby with her breast milk, while exclusive breastfeeding refers to a six-month period during which a newborn is fed only breast milk (including expressed breast milk) and no other liquids or solids other than vitamins,

minerals supplements, or medicine [2]. To support a child's best growth and development, exclusive breastfeeding should be observed for six months after birth followed by supplemental feeding for two years or longer [3]. Every infant has the right to good nourishment, according to the Convention on the Rights of the Child [4]. The nutritional well-being of a population is both an outcome and an indicator of national development. Nutrition is, therefore, an issue of survival, health, and development of current and succeeding generations [5]. Breast milk is a highly nutritious food that has been reported to be the natural and best nutrition for babies and infants who obtain this through breastfeeding. According to the World Health Organization (WHO), exclusive breastfeeding for the first six months of life is the best approach to feeding a newborn, after which complementary foods should be taken simultaneously with breast milk for another two years or longer [4]. This is because breastfeeding has so many advantages for both infants and mothers. Breastfeeding reduces the occurrence of several children's ailments, including but not limited to chest infections, pneumonia, sudden infant death syndrome, diabetes mellitus, malocclusion, and diarrhea, let alone the benefits it offers to the mother-child bond [6, 7]. Breastfeeding also promotes healthy brain development and is linked to improved cognitive scores in children and adolescents [8, 9].

The merits of exclusive breastfeeding to the mothers are; the promotion of faster involution of the uterus, reduction of post-partum bleeding, enhancement of faster return to pre-pregnancy weight, decreased risk of breast and ovarian cancer, increased bonding with the infant, enhancement of self-esteem in the maternal role as well as delays the menstrual cycle. [5]. A 2011 study found that inadequate breastfeeding practices contributed to 804,000 infant deaths or 11.6% of all under-five mortality worldwide [10]. In 2012, World Health Assembly Resolution 65.6 emphasized on countries ensure that maternal and child nutrition especially the six global targets are met by 2025, and it all clamored for more efforts to be put into increasing the rate of exclusive breastfeeding by 50% [4].

Global EBF trends are expected to be 42%, with 34% in West and Central Africa [11]. Despite all of the evidence-based health benefits of EBF, global targets have yet to be fulfilled, with just 41% of children under the age of 6 months being exclusively breastfed, compared to a global target of 70% by 2030 [2]. Despite these efforts, EBF remains a concern in The Gambia with just 48% of children aged 0 to 6 months being exclusively breastfed as revealed by the Demographic Health Survey 2013 [12]. Another recent report from the Multiple Indicator Cluster Surveys (MICS) (2018) revealed that 55.2% of infants under 6 months are exclusively breastfed [13]. These numbers remain below the WHO's 2018 global objective of 70% for 2030 as well as the 90% national target [14].

Socio-demographic factors have been reported to affect exclusive breastfeeding. A study conducted in Markudi, Nigeria, showed that the socio-demographic factors affecting

exclusive breastfeeding in this study were maternal age, maternal education level, maternal employment type, maternal residence, maternal monthly income, and maternal spouses' occupation [15]. Another study in Kenya revealed that four socio-demographic factors were found to be influencing the practice of exclusive breastfeeding which include child gender, level of education, marital status, and parity [16]. Jawo *et al.* revealed that socio-demographic characteristics of the mothers such as ethnicity and place of birth were significantly associated with the knowledge of mothers on EBF [17].

The Gambia Demographic and Health Survey (GDHS) 2013 also suggests a low prevalence of exclusive breastfeeding may be due to cultural, economic, and social factors. Mensah *et al.* found that there was a significant association between socio-demographic characteristics of mothers such as age, religion, type of employment, and the practice of exclusive breastfeeding [18]. Compared to mothers working in both the public and private sectors, self-employed mothers are more likely to practice EBF. This is because mothers who work for themselves have more time with their children than mothers who work for the government.

According to Onah *et al.*, socioeconomic status had an inverse relationship with EBF practice [19]. A lower rate of EBF practice was linked to a higher socioeconomic status. This study also revealed that maternal education, socioeconomic class, mode of delivery, and infants' first feed were retained as important maternal predictors of EBF practice.

According to a study conducted in Ghana, numerous factors influence the practice of EBF, including sociodemographic and maternal education, with schooling for 8 years or less having a 34 percent increased risk of ceasing exclusive breastfeeding [20]. Another study in Nigeria discovered that mothers who visited antenatal clinics were more likely to practice exclusive breastfeeding, while mothers who lived in rural regions were less likely to do so [21]. In Ethiopia findings from a research study also observed that mothers with less income status are positively associated with the practice of exclusive breastfeeding [22]. Socioeconomic status (SES) is already acknowledged as a variable influencing breastfeeding, with mothers in a higher income bracket breastfeeding longer, regardless of race [23]. The Gambia, like many other nations, has implemented policies and strategies to promote and support EBF, including the creation of the National Nutrition Agency (NaNA), whose mission is to coordinate all nutrition activities and formulate policies aimed at promoting optimal health and nutrition [24]. The establishment of the Baby Friend and Community Initiatives (BFICI) and Baby Friendly Hospital Initiatives (BFHI) programs, as well as high-level stakeholder involvement in promoting EBF, the enactment of a nutrition policy (2018-2025), and the enforcement of breastfeeding regulations from 2006, are among the strategies to promote EBF [14]. Despite all the efforts, EBF remains a concern, as the Demographic Health Survey (DHS) 2013

revealed that only 48% of children aged 0 to 6 months are exclusively breastfed [12].

As a result of the continuously low level of exclusive breastfeeding among mothers in The Gambia, there is a need to find out those socioeconomic factors that influence the practice of exclusive breastfeeding, hence the purpose of this study.

2. Materials and Methods

2.1. Study Area

The study was conducted in Brikama District Hospital. Brikama District Hospital is located in Kombo Central District, West Coast Region (WCR) of The Gambia in West Africa. It is the regional capital of the Western Region, the base for the headquarters of the Brikama Area Council (BAC), and it is the most populated Local Government area in the country. The main urban settlement is approximately 35km (22 miles) southwest of the capital city, Banjul, and has a population of 699,704 people [25]. Brikama District Hospital provides basic health care needs for the people living in Brikama and its surrounding villages.

2.2. Participants

Participants were mothers with children under the age of two who were receiving antenatal care in Brikama District Hospital whose children are two years or less during the one-month data collection exercise. Their consent was sought for participation in the study and mothers whose children are more than two years old were excluded from the study.

2.3. Sample Size Determination

A cross-sectional study was conducted in June 2021 for a period of 30 days. Participants were randomly selected from mothers attending antenatal clinics in Brikama District Hospital and also consented to participate in this study. The sample size for this study was determined using the formula described by Thrusfield based on a 95% confidence interval [26].

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

Where N= sample size

Z= appropriate value for the standard normal deviation for the desired confidence interval (1.96) Using a prevalence of 48% of children aged 0 to 6 months are being exclusively breastfed as revealed by the Demographic Health Survey 2013 and adding a non-response rate of 8%, we have 384 as our final sample size. [12]

2.4. Data Collection Methods

Structured and pretested interviews and questionnaires were administered to obtain data from study participants respectively. In-person interviews with mothers on their clinic days were used to collect data during the one-month

study period. Every mother visited once a month, and our researchers collected data from each mother once to avoid collecting from the same mother again. The mothers who attended Brikama District Hospital were approached by the researchers, and those who agreed to participate in the study were interviewed until the final sample size was attained. The interviews were conducted utilizing questionnaires in the hospital's waiting rooms. In addition, the interviews lasted an average of 8 minutes per individual, and confidentiality was maintained throughout the process. This was done to maximize the chances of the participants feeling comfortable and able to answer the questionnaires. The researchers informed the participants prior to the interview that the process would be completely anonymous, that the information gathered would be kept private, and that written informed consent would be obtained. They also gave them a brief overview of the survey topic and the questionnaire's format. The research team also let the women know that participation in the study was optional and that there would be no financial incentive, so they could withdraw from the interview at any time if they were uncomfortable with it.

2.5. Ethical Considerations

The Regional Health Directorate (RHD), Western Region 2 granted ethical approval. The Regional Health Directorate (RHD) approved letter was delivered to Brikama District Hospital. The purpose of the study was thoroughly explained to the study participants, and their written agreement was obtained.

2.6. Data Analysis

In order to ensure that the data was accurate and consistent, it was first entered into Microsoft Excel. Then later exported to STATA Version 13 for analysis [27]. Statistical relationships were sought between the practice of child exclusively breastfeeding and the selected socio-demographic conditions of the respondents. Results were recorded as frequencies, chi-square, and *p*-values. For all purposes, a *p*-value of 0.05 was considered as the level of significance.

3. Results

3.1. Sociodemographic Characteristics of the Study Participants

Table 1. Shows the Socio-demographic characteristics of the study participants. A total of 384 women participated in this study. The mean age (standard deviation (SD) of the women was 26.69 (±5.67) years and ranged from 16 to 49 years. The majority of the women were married 92.19% (354) and lived in an extended family of 67.19% (258). Most of them were Muslims 90.10% (346) while Christianity followers were just 9.9% (38). The majority of respondents were Mandinka by ethnicity 44.01% (169). 16.15% (47) of respondents were not able to read and write, and only 41.41% (159) of them completed secondary school. 72.66% (279)

were housewives and 10.42% (40) were government employees. The majority 90.63% (348) had a normal delivery and 90.36% (347) were delivered in the hospital.

Table 1. Socio-demographic characteristics of the study participant (n=384).

Characteristics	Frequency (n)	Percentage (%)
Marital Status		
Married	354	92.19
Single	30	7.81
Type of Family		
Nuclear	126	32.81
Extended	258	67.19
Religion		
Muslim	346	90.10
Christian	38	9.9
Ethnicity		
Mandinka	169	44.01
Wolof	27	7.03
Fula	94	24.48
Jola	37	9.64
Others	57	14.84
Educational Status		
Primary	75	19.53
Secondary	159	41.41
Tertiary	41	10.68
Arabic	62	16.15
Non-Formal Education	47	12.24
Occupational Status		
Housewife	279	72.66
Government Employed	40	10.42
Self-employed	46	11.98
Others	19	4.95
Monthly Income in Gambia Dalasi		
<1500	49	12.76
1600-2500	36	9.38
2600-3500	30	7.81
>3600	269	70.05
Mode of deliveries		
Normal	348	90.63
Cesarean Section (CS)	36	9.38
Place of Birth		
Home	3	9.64
Hospital	347	90.36
Child AGE (in months)	Mean (26.69)	SD (5.67)
Child Sex		
Male	200	52.08
Female	184	47.92

3.2. The Practice of Exclusive Breastfeeding Habit Among Respondents

In this study all the mothers interviewed have reported having breastfed their babies, 89% (342) of the mothers reported that their babies were still been breastfed at the time of this study and 11% (42) of them said that, their babies were no longer breastfed. The majority 62.5% (240) of participants had EBF for their babies, while 37.5% (144) of mothers indicated that, they had given their babies water or food at some point during the first six months after birth. Above half 44% (168) of mothers had breastfed their babies on demand, and majority of them 21% (49) reported that they had given their babies lactating milk or baby formulae food before the sixth month. A good number of the mothers 40%

(116) reported that they had given their babies plain water before six months. The majority 87% (335) of the respondents reported that they had planned to exclusively breastfeed their babies before delivery and 70% (268) had sought the advice of health workers about practicing exclusive breastfeeding (Table 2).

Table 2. Study participants' practice toward EBF (n=384).

Characteristics	Frequency (n)	Percentage (%)
Child Currently breastfeeding		
Yes	342	89
No	42	11
Was your child EBF?		
Yes	240	62.5
No	38	37.5
How often do you breastfeed your child?		
On-Demand	168	44
Regularly	122	32
Randomly	94	24
Does your child drink water or any other liquid?		
Yes	276	72
No	108	28
If Yes, at what Age		
At 6 months	167	57
Less than 6 Months	116	40
Can't remember	9	3
Does your child eat any food other than breast milk?		
Yes	194	51
No	190	49
If Yes, at what Age		
At 6 months	169	73.80
Less than 6 Months	49	21.40
Can't remember	11	4.80
Did you plan to EBF before delivery?		
Didn't plan to breastfeed	49	13
Plan to breastfeed	335	87
Did you take the advice of any health worker?		
Yes	268	70
No	116	30

3.3. Exclusive Breastfeeding Practices and Their Correlation with the Socio-Demographic Characteristics of Mothers

Table 3 shows the comparison of the socio-demographic features of the respondents and the practice of EBF. The results show a significant relationship between Type of family ($p=0.002$), Religion ($p=0.035$), Ethnicity ($p=0.005$), Type of deliveries ($p=0.023$), and Place of birth ($p=0.001$) and practice of EBF. Concerning the frequency of EBF, Educational status and Occupation showed a significant relationship ($p=0.032$ and 0.051) respectively. There was a significant relationship between the consumption of any other food apart from breast milk with ethnicity and sex of the child ($p=0.001$ and 0.040) respectively. Also planning for exclusive breastfeeding before delivery was significant with Religion ($p<0.001$), Occupational status ($p<0.001$), and Ethnicity ($p<0.001$).

Table 3. Cross-tabulation of sociodemographic features and practice of EBF.

Item	Factors	X ² Value	P-Value
Is your child exclusively breastfed?	MS	1.097	0.219
	TF	9.351	0.002*
	R	4.430	0.035*
	E	15.094	0.005*
	ES	4.993	0.288
	O	6.693	0.153
	FI	1.093	0.779
	MD	5.193	0.023*
	PB	10.888	0.001*
	SC	0.377	0.624
How often do you breastfeed your child?	MS	0.974	0.615
	TF	2.741	0.254
	R	4.011	0.135
	E	9.523	0.300
	ES	16.797	0.032*
	O	12.468	0.051*
	FI	5.722	0.455
	MD	2.603	0.272
	PD	0.974	0.615
	SC	1.234	0.540
Does your child eat any food other than breastmilk?	MS	0.103	0.850
	TF	0.917	0.216
	R	0.632	0.246
	E	18.041	0.001*
	ES	4.440	0.350
	O	4.829	0.305
	FI	4.963	0.175
	MD	14.466	0.070
	PD	6.39	0.266
	SC	3.413	0.040*
Does your child drink water or any other liquid?	MS	3.347	1.880
	TF	4.129	1.270
	R	4.085	1.130
	E	4.439	0.816
	ES	6.556	0.585
	O	3.085	0.929
	FI	6.919	0.338
	MD	3.199	0.202
	PD	0.802	0.670
	SC	0.620	0.970
Did you plan to exclusively breastfeed before the delivery/birth of your baby?	MS	3.928	0.269
	TF	1.801	0.615
	R	23.616	<0.001*
	E	43.385	<0.001*
	ES	18.939	0.090
	O	36.001	<0.001*
	FI	10.983	0.277
	MD	5.993	0.112
	PB	4.961	0.175
	SC	3.005	0.391

Note: MS (Marital Status), TF (Type of Family), R (Religion), E (Ethnicity), ES (Education Status), O (Occupation), FI (Family Income), MD (Mode of Delivery), PB (Place of Birth) and SC (Sex of Child)

4. Discussion

This study investigated the socioeconomic factors

influencing the practice of exclusive breastfeeding among mothers with children who are two years old or less. The mean age of the mothers was 26.7 with a standard deviation of 5.7. The majority (72.7%) are housewives. Habibi *et al.* revealed that of the surveyed mothers, 87.2% of them were housewives, with more than half (59.6%) having attained secondary education level [28]. This is similar to those in the study conducted by Onah *et al.* where most of the mothers surveyed had secondary school education as their highest educational attainment [19].

However, 284 (71.0%) of the surveyed mothers believed that EBF is the most ideal infant feeding option and agreed that they would practice EBF if given the time and opportunity to do so. A study in Bedele, Ethiopia, found that the majority (91.8%) of mothers knew the importance of EBF [29, 30] which would have been the motivating factor for exclusive breastfeeding. On the contrary, a study in Vietnam showed that mothers were less aware of the advantages of EBF in helping contraception [3]. In contrast, 87 (21.8%) disagreed and said that they would not practice EBF even if the conditions were ideal. Twelve (13.8%) of the 87 mothers were concerned about becoming overweight as they asserted that EBF makes them eat too much. Twenty-two (25.3%) of the mothers said that EBF's demand was excessive, 13 (15.0%) feared the baby would refuse other foodstuffs hence EBF makes weaning difficult, and 12 (13.8%) believed that water is essential for life and that giving it to babies earlier is the right thing to do contrary to those who are not adherent to this belief.

Out of the 89% of the respondents who were breastfeeding their babies, 62.5% of them were practicing exclusive breastfeeding. This study was in contrast to the findings of Debre Birhan in Ethiopia in which 83.4% of mothers were practicing EBF [31]. Onah *et al.* in their study reported that exclusive breastfeeding has been practiced by 33.5% of the surveyed mothers, out of which 27.85% practiced predominant breastfeeding while 38.8% practiced complementary breastfeeding ($p=0.002$) [19]. This figure remains below the 2030 global target of 70% (WHO, 2018) and also below the national target of 90% [14].

From this study, 70% of mothers got information on EBF from health workers. This is in contrast with the findings of Habibi *et al.* where only 41.1% of the participants were provided with information on exclusive breastfeeding and useful steps for its successful management by health professionals [28]. Also, Mensah *et al.* reported that a significant proportion of mothers (97.1%) had information on exclusive breastfeeding from health facilities [18]. The findings also revealed that only 44% of mothers feed their babies on demand. Contrary, Habibi *et al.* reported that a significant proportion (72.7%) of women breastfeed their babies on demand.

Concerning the sociodemographic factors affecting the practice of EBF, the results show a significant relationship between Type of family ($p=0.002$), Religion ($p=0.035$), Ethnicity, ($p=0.005$), Mode of delivery ($p=0.023$), and Place of birth ($p=0.001$) with regard to the practice of EBF. This is

in consonant with the findings by Jawo *et al.* which revealed that socio-demographic characteristics of the mothers such as ethnicity and place of birth were significantly associated with the knowledge of mothers on EBF [17]. Mensah *et al.* also found a significant association between religion ($p = 0.035$) and the practice of exclusive breastfeeding [18].

Onah *et al.* revealed the mode of delivery as one of the predictors of exclusive breastfeeding as there is decreased practice of EBF among mothers who delivered through cesarean section as compared to those that delivered vaginally [19]. Most of the respondents had normal vaginal deliveries and this would have led to most of them practicing EBF. Some mothers who delivered through a cesarean section usually take some time to recover from the anesthetic effects coupled with the increased stress after a cesarean section and this could delay the onset of breast milk.

The study also revealed a significant relationship between the educational status of mothers and the frequency of EBF. Similarly, Egwuda *et al.* revealed maternal education level as one of the factors influencing EBF [15]. Mothers with primary education and those with secondary education are less likely to practice EBF as compared to mothers with tertiary education. Mothers who had no formal education were more unlikely to practice exclusive breastfeeding than their peers with higher education as mothers with no education tend not to be well informed about the benefits of exclusive breastfeeding as compared to their counterparts with higher education [32].

Concerning the occupational status of the respondents and the frequency of EBF, the study shows a significant relationship. This is similar to the study conducted by Mensah *et al.* [18] and Egwuda *et al.* [15] which found a significant association between the type of employment ($p = 0.005$) and the practice of exclusive breastfeeding. A study in Singapore shows that although work status did not affect the initiation of breastfeeding, it did affect the duration of breastfeeding. Working mothers were more likely to stop breastfeeding earlier as compared to none working ones [33, 34]. When one compares mothers working in both the public and private sectors with self-employed mothers, it is likely that self-employed mothers practice EBF more often. This is because mothers who work for themselves have more time with their children than mothers who work for the government. Hence the majority of the mothers in this study are housewives and that makes them more inclined to practice EBF, especially on demand.

There was a significant relationship between the consumption of any other food apart from breast milk with ethnicity and sex of the child ($p=0.001$ and 0.040) respectively. It is culturally believed that male children eat more than female children and that breast milk alone will not be enough for them and this would have led to the consumption of any other food apart from breast milk. A study in Kenya revealed that child gender is one of the factors influencing the practice of exclusive breastfeeding [16].

In this study, 87% of mothers interviewed planned before delivery to exclusively breastfeed their babies. Similarly, Habibi *et al.* reported that the majority (76.43%) of mothers in their study planned to breastfeed their infants exclusively until the age of 12 months [28]. Also planning for exclusive breastfeeding before delivery was significant with Religion ($p<0.001$), Occupational status ($p<0.001$), and Ethnicity ($p<0.001$).

However, some of the respondents 144 (37.5%) who do not practice EBF reported that feeding their babies with water or formula food was more satisfying to the child than only breast milk. Others reported that household chores or work are the reason why they do feed their babies with water or formula food. Similarly, Onah *et al.* stated that those mothers who did not practice EBF gave various reasons such as the baby crying too much, not gaining weight, pressure from relatives, work/business demands, feeling that the baby is thirsty and needed water, and baby eating too much [19]. Additionally, the wrong perceptions bearded in this study regarding exclusive breastfeeding is consistent with Habibi *et al.* who reported that 227 (76.43%) of mothers had planned to exclusively breastfeed their babies until the age of 12 months [28]. Among these mothers, 66% of them did not reach their intended breastfeeding duration for numerous reasons such as difficulties related to maternal health problems and the widespread belief among mothers that food and other liquids were more nutritious than exclusive breast milk.

5. Conclusion

Nursing mothers must be aware of the many influences on their breastfeeding decisions as well as the various resources available to encourage them to choose exclusive breastfeeding. From this study, exclusive breastfeeding practice is poor as the figure still remains below the 2030 global target of 70%. Also, many factors such as type of family, religion, ethnicity, mode of delivery, place of birth, educational status, mother's occupation, and child's sex have been found to be predictors of exclusive breastfeeding. In order to increase maternal awareness of the health advantages of exclusive breastfeeding, public health programs should take socio-demographic aspects into consideration. Health initiatives must be created in order to enhance breastfeeding habits among mothers in the Gambia. Families, authorities, and the larger community must be among them. Health professionals must rise to the occasion by providing mothers of children under five and the broader public with nutritional advice and well-being education. The topic must be raised as early as possible by maternity and healthcare facilities, and these services must encourage nursing mothers to make wise decisions about breastfeeding. Further multi-level analysis should be done to understand the influence of these factors on EBF in order to guide policymakers and public health organizations in planning appropriate and adequate interventions to improve EBF practice.

Authors Contributions Statement

Conceptualization, EJ, AK, EAU; methodology, PAM, MK, IM; validation, PAM, AK, EM; formal analysis, EJ, PAM, EM; data duration, AK, MK, IM, EJ; writing—original draft preparation, AK, EJ, EAU, PAM. All authors read, corrected, and approved the final manuscript.

Conflicts of Interest Statement

The authors have declared that there is no conflict of interest in this study.

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