

RESEARCH ARTICLE

The prevalence of burnout, depression, anxiety and stress in the Lithuanian midwifery workforce and correlation with sociodemographic factors

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Abstract

Aim: To investigate the prevalence of burnout, depression, anxiety and stress of Lithuanian midwives.

Design: A descriptive, cross-sectional survey design.

Methods: The Work Health and Emotional Wellbeing of Midwives (WHELM) survey instrument developed within the Australian maternity context was adapted and used in this research. The survey collects country-specific demographic data and incorporates several validated measures including the Copenhagen Burnout Inventory (CBI), Depression, Anxiety and Stress Scale (DASS-21).

Results: Three hundred and thirty-eight completed surveys were received. Results obtained using a CBI subscale showed that 84.9% experienced personal burnout, 70.1% reported work-related burnout and 41.1% had client-related burnout. The results indicate that the midwives reported moderate to extreme levels of depression (16.3%), anxiety (28.4%) and stress (13.9%) symptoms.

KEYWORDS

anxiety, burnout, depression, midwives, stress

1 | INTRODUCTION

Maternity care is one of the most essential healthcare system sectors vitally contributing to the present and future health of society (Kruk et al., 2018). There is increasing evidence of the positive impact midwifery care has on the health outcomes of mothers and babies (Renfrew et al., 2014). Attracting and retaining a competent midwifery workforce is, therefore, a key goal in the development of sustainable maternity services (Tracy et al., 2013). There is an increasing awareness of the pressures faced by workers within the healthcare sector, and the potential impact this has on long-term workforce planning (Kabene et al., 2006). The work of midwives is emotionally

demanding since they provide care to women experiencing various symptoms including anxiety, pain, fear, grief and trauma (Hunter & Warren, 2014; Fenwick, Sidebotham, et al., 2018; Jepsen et al., 2017; Yoshida & Sandall, 2013). Working closely with distressed women may cause emotional tension in midwives. Professional burnout results from chronic stress experienced by healthcare professionals and its major symptoms include emotional and physical fatigue (Chiara et al., 2019).

Large-scale collaborative studies using reliable psychometric measures have identified that burnout within the midwifery profession is a factor that needs to be closely monitored and addressed. The Work Health and Emotional Lives of Midwives

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(WHELM) study, initially developed in the Australian context (Jordan et al., 2013), has been repeated in other countries including New Zealand, Sweden, Norway, The United Kingdom and Canada, leading to an increased awareness of the impact that the working environment has on midwives' emotional health and well-being (Creedy et al., 2017; Dixon et al., 2017; Hildingsson et al., 2013; Henriksen & Lukasse, 2016; Hunter et al., 2019; Stoll and Gallagher, 2019). The levels of burnout reported in each country cover a wide range with the highest level of burnout recorded by midwives in the United Kingdom (Hunter et al., 2019). High levels of burnout among midwives are associated with dissatisfaction with their role, leading to increased risk of workforce attrition (Cull et al., 2020; Harvie et al., 2019). While there is emerging data on the impact on well-being related to the model of care midwives work in, (Dixon et al., 2017; Fenwick, Lubomski, et al., 2018; Fenwick, Sidebotham, et al., 2018; Stoll and Gallagher, 2019) more collaborative work is needed to identify the underlying factors contributing to burnout in the midwifery profession to develop prevention strategies.

2 | BACKGROUND AND CONTEXT TO THE STUDY

During the Soviet times, the role of midwives in Lithuania was diminished to the position of a doctor's assistant without any possibility to make individual clinical decisions and with minimal responsibility. Lithuania had an obstetrician-led maternity care system in which midwives provided a significant amount of care but had minimal opportunity to be autonomous in their practice (Bartuseviciene et al., 2018; Riklikienė et al., 2012).

After Lithuania (1990 years) became independent, changes in the health system began, as a result of which the role and functions of the midwife began to change. While these changes represent some movement to midwives providing care as the lead carer for birthing women, the wide-scale introduction of midwifery-led care for low-risk women and their babies remains a challenge (Bartuseviciene et al., 2018). For continued progress towards an autonomous midwifery profession, able to provide evidence-based midwifery care in Lithuania, we need to understand the professional and emotional needs of midwives as they work through this transition. Little is currently known about the emotional well-being of the midwifery workforce in Lithuania. As midwives become more involved in the care of pregnant and birthing women, they are more likely to be exposed to previously described psychological, emotional and social problems existing in a dynamic workplace environment. To optimize the quality of Lithuanian maternity services, measures should be in place to ensure the professional requirements and individual needs of Lithuanian midwives are met within the workplace. It is important, therefore, to understand the impact of this changing role on their health and well-being by measuring current levels of stress, depression, anxiety and burnout within the profession.

2.1 | Research question

This paper aims to measure the prevalence of burnout, depression, anxiety and stress in the Lithuanian midwifery workforce and identify demographic factors associated with elevated levels of burnout, depression, anxiety and stress.

3 | METHODS

3.1 | Research design

A descriptive, cross-sectional design was applied in this study.

3.2 | Sample and recruitment

In 2016, there were 912 licensed midwives in Lithuania. According to sample calculation formula, we had to interview 271 midwives (912 midwives in Lithuania, 95% probability and 0.05 error percentage). Since we expected not all would voluntarily consent to participation, we chose a higher sample size to be adequately powered. Approximately 450 midwives were members of the national Lithuanian Midwives Association (LMA). The LMA agreed to let the primary researcher (VV) recruit midwives to study during the annual conference in 2017. All midwives attending the Lithuanian Midwives Association national conference ($n = 450$) in November 2017 were invited to take part in the research by one of the primary researchers (VV). The purpose of the study was described and the order of filling in the questionnaires was explained. Information about the study was provided in written form along with copies of the questionnaire to all midwives who attended the conference. Consent was implied by return of the completed questionnaire.

3.3 | Measures

We adapted the Work Health and Emotional Well Being of Midwives (WHELM) survey tool used in previous studies to undertake this study (Creedy et al., 2017; Dixon et al., 2017; Pallant et al., 2015; Pallant et al., 2016). These studies use validated tools to measure rates of anxiety, stress, depression and burnout within the midwifery workforce. Therefore, it is designed to identify factors that promote well-being and improve the working lives of midwives. The final WHELM questionnaire package consisted of a number of sections.

Firstly, midwives were asked a number of demographic questions (e.g. age, marital status and education). Secondly, midwives were asked about work-related characteristics such as employee status, principal role and model of care. Third, we are measure to Burnout with the Copenhagen Burnout Inventory (CBI) (Kristensen et al., 2005) and evaluating prevalence of the depression, anxiety and stress with Depression, Anxiety and Stress Scale (DASS-21). Key questions pertaining to participant's intention, or otherwise, to leave

the profession were also included. This questionnaire was translated into Lithuanian and back into English. Compared versions and minor adjustments were made. In this paper, we will report on the outcomes measured by the CBI and DASS.

3.4 | Instruments

The CBI is a 19-item three-factor scale that assesses burnout in the personal (6 items), work (7 items) and client domains (6 items). Personal burnout is a state of prolonged physical and psychological exhaustion; work-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work and client-related burnout is a state of prolonged physical and psychological exhaustion, which is perceived as related to the person's work with clients. Each item is scored on a '0–25–50–75–100' 5-point Likert scale, with higher scores denoting higher levels of burnout. Burnout Scores were 50–74 moderate, 75–99 high and 100 > severe. (Kristensen et al., 2005). In this study, the CBI reliability was supported with a Cronbach α of 0.86 for midwifery. The Copenhagen Burnout Inventory (CBI) was validated in the other Lithuanian researcher's studies (Mikalauskas et al., 2016).

The Depression, Anxiety and Stress Scale-21 items (DASS-21) have three subscales assessing anxiety (7 items), depression (7 items) and stress (7 items). DASS-21 was validated by psychologist, public health specialist Rasa Kuodyte-Kazieliene (2015). The anxiety scale assesses autonomic arousal, skeletal muscle effects, situational anxiety and subjective experience of anxious affect. The depression scale assesses dysphoria, hopelessness, devaluation of life, self-deprecation, lack of interest/involvement, anhedonia and inertia. The stress scale assesses difficulty relaxing, nervous arousal, and being easily upset/agitated, irritable/over-reactive and impatient. In the current study, Cronbach alpha reliability coefficients for each subscale were as follows: for anxiety—0.81; for depression—0.88 and for stress—0.89.

3.5 | Data collection

Paper-based questionnaires were distributed to all midwives who attended the LMA conference in 2017. Midwives were encouraged to complete them while attending the conference and return them to a designated collection point at the conference in a plain envelope. No identifying information was collected. In total, 338 completed questionnaires were returned (response rate of 84.5 per cent). The 338 midwives who participated in the study from 912 midwives in the country represent 37 per cent of the midwifery workforce in the country.

3.6 | Data analysis

All data from the paper-based survey forms were manually entered into the statistical software package SPSS for Windows 20.0. Descriptive statistics for the sample, CBI and DASS subscales were

generated. As DASS scores were skewed, non-parametric Spearman's rho was used to identify correlations between CBI and DASS subscales. DASS subscale scores were used as continuous variables and also collapsed into two groups (normal/mild versus moderate to extremely severe) using cut-points provided in the DASS User's Manual (Crawford & Henry, 2003; Lovibond & Lovibond, 1995).

3.7 | Ethical considerations

The Bioethics Committee approved the study at the Lithuanian University of Health Sciences (BEC-KS (M)-566).

Confidentiality of respondents was assured, and anonymity was maintained since respondents were never asked for any personal identifiers such as their names, surnames or addresses. Data were summarized and reported only in the aggregate.

4 | RESULTS

4.1 | Sample characteristics

Table 1 describes the sample characteristics in total and per hospital. The average age of midwives participating in the study was 45.8 ± 9.852 years, and the average length of service was 25.00 ± 10.75 years. 34.9% of midwives had university higher education, and 40.2% of midwives rotated between different clinical areas within the hospital and all midwives worked full-time in the hospital. (Table 1).

4.2 | Prevalence of burnout, depression, anxiety and stress

Research data reveal that the mean score is 61.33 for the personal burnout subscale, 49.08 for the work-related burnout subscale and 33.88 for the client-related burnout subscale. However, it is important to establish the strength of distribution of burnout across all subscales. In the personal burnout subscale, 64.8% midwives indicated moderate to severe levels of burnout.

In the work-related burnout subscale, 42.6% of midwives had moderate and high levels of burnout. An analysis of the client-related burnout scale shows that 85.8% of midwives had no or low level of burnout while 14.2% of respondents reported moderate to high levels of burnout.

An analysis of depression prevalence among midwives revealed the mean score of 6.24 for the anxiety subscale, 6.44 for the depression subscale and 10.95 for the stress subscale. The majority of midwives (71.6 to 86.1%) indicated the normal to mild range on the DASS subscales. The proportion of midwives recording CBI and DASS scores are shown in Table 2.

Of all midwives who participated in the study, 27.5 per cent had only personal burnout, 3.8 per cent of midwives had only

TABLE 1 Socio-demographics characteristics of midwives (*n* = 338)

Variable	n/%
Age	
23–35	69 (20.4)
36–45	89 (26.3)
>45	180 (53.3)
Marital status	
Single	26 (7.7)
Married	228 (67.5)
Living with a partner	31 (9.2)
Divorced	40 (11.8)
Widowed	13 (3.8)
Has children	
Yes	271 (80.2)
No	67 (19.8)
Education	
College degree	220 (65.1)
University degree	118 (34.9)
Place of employment	
Public sector	274 (81.1)
Private sector	16 (4.7)
Public and private sector	34 (10.1)
Academic sector	3 (0.9)
Academic and public and/or private sector	11 (3.2)
Length of time qualified as a midwife	
≤10 years	70 (20.7)
>10 years	268 (79.3)
Shift duration	
12 hr	101 (29.8)
<12 hr	58 (17.2)
>12 hr	102 (30.2)
Mixed shifts	77 (22.8)
Principle area of service	
Rotation across all clinical areas in a hospital including antenatal clinic birthing suite, antenatal/postnatal ward and the special care nursery	150 (44.3)
Antenatal clinic only	55 (16.3)
Birth suite only	63 (18.7)
Postnatal ward only	70 (20.7)

work-related burnout and 1.8 per cent had only client-related burnout. The remaining midwives had several types of burnout. We analysed how a particular type of burnout is related to socio-demographic characteristics. An analysis of personal, work-related and client-related burnout, depending on various sociodemographic factors, shows that the personal burnout group was dominated by midwives who are young, single, have no children, are university educated and employed in academic, public and/or the private sector and are working longer than 12-hr shifts. Midwives,

who had work-related burnout, are younger, living with a partner and have children (Table 3).

Multivariate logistic regression analysis revealed that depression, anxiety and stress increased opportunity for respondents to have personal burnout one more time (if depression score evaluation increased by one point, opportunity to have personal burnout increased more than one time).

Depression, anxiety and stress also increased the opportunity to have work burnout. Stress had the main impact for work burnout—when stress evaluation increased by one point, the opportunity for work burnout increased 1.21 time.

The factors influencing client-related burnout could not be assessed, because only 14.2% of respondents have this type of burnout (theoretical assumptions should be at least 20%) (Table 4).

5 | DISCUSSION

5.1 | Burnout

The World Health Organization Burnout is defined as follows: “Burn-out is a syndrome conceptualised as resulting from chronic workplace stress that has not been successfully managed” (World Health Organization, 2019). Burnout is associated with loss of motivation, job withdrawal, increased job dissatisfaction and feelings of cynicism. In addition, self-esteem and productivity are decreased (Maslach & Leiter, 2016).

Our research data reveal that 64.8% midwives indicated moderate-to-severe levels of personal burnout; 42.6% of midwives had moderate and high levels of work-related burnout and 14.2% of respondents reported moderate to high levels of client-related burnout.

A study conducted by British researchers focusing on burnout among midwives found that midwives who were over 40 years of age, were single, and had less than ten years of work experience, were experiencing high levels of professional burnout. Midwives, who had smaller workloads or worked in shifts, had lower levels of burnout (Hunter et al., 2019). A Swedish study that used CBI reported higher client-related burnout—15% of respondents (Hildingsson et al., 2013). Australian researchers obtained similar data to ours using the CBI. Participating midwives who were younger than 35 and had less than ten years of work experience more frequently reported higher personal and work-related levels of burnout (Fenwick, Lubomski, et al., 2018; Fenwick, Sidebotham, et al., 2018).

Our data show that midwives who had work-related burnout were also younger, living with a partner, and have children. Summarizing the data from all the researchers (Sidhu et al., 2020), we can assume that younger midwives are more likely to experience work-related burnout because they do not feel knowledgeable in their field due to a lack of experience. Midwives with children are more likely to experience work-related burnout due to difficulty in balancing responsibilities at work and home; they have too many roles and responsibilities.

TABLE 2 Mean and prevalence for burnout, depression, anxiety and stress

Measure	M (SD)	Prevalence cut-off	N (%)
CBI			
Personal burnout (N = 338)	61.33 (23.02)	No/low (<50)	119 (35.2)
		Moderate (50–74)	87 (25.7)
		High (75–99)	129 (38.2)
		Severe (100)	3 (0.9)
Work burnout (N = 338)	49.08 (17.85)	No/low (<50)	194 (57.4)
		Moderate (50–74)	106 (31.4)
		High (75–99)	38 (11.2)
		Severe (100)	0
Client-related (N = 338)	33.88 (15.65)	No/low (<50)	290 (85.8)
		Moderate (50–74)	44 (13.0)
		High (75–99)	4 (1.2)
		Severe (100)	0
DASS			
Depression (N = 338)	6.44 (7.5)	Normal/mild	283 (83.7)
		Mod/severe/extreme	55 (16.3)
Anxiety (N = 338)	6.24 (6.2)	Normal/mild	242 (71.6)
		Mod/severe/extreme	96 (28.4)
Stress (N = 338)	10.95 (8.3)	Normal/mild	291 (86.1)
		Mod/severe/extreme	47 (13.90)

Data from our study also revealed that midwives who worked 12-hr shifts and were single had statistically a significantly higher incidence of personal burnout. Therefore, we can assume that the changed role of the midwife in the healthcare system, patients' expectations and workloads lead to more significant personal burnout.

From the analysis of work-related burnout, it can be seen that Lithuania is in the middle position compared with Australia, New Zealand, Sweden and England. Lithuanian midwives who participated in the research had a mean score of 49.08 of work-related burnout (respectively 48.44, 44.63, 33.86 and 56.15) (Hildingsson et al., 2013; Hunter et al., 2019). We can assume that workloads cause a high work-related burnout score (all midwives in our study are working full time, work the 12-hr or longer shift and half of them are older than 45 years). In contrast, the mean score of the client-related burnout was the smallest in all types of burnout, but highest in WHELM collaborating countries (Australia, New Zealand, Sweden and the UK) (Hildingsson et al., 2016; Hunter et al., 2019) (see Table 5).

5.2 | Depression, anxiety and stress

Other factors in the work environment that were analysed in our study were depression, anxiety and stress. Based on research, we found that midwives consider the following to be major causes of stress: high workloads, conflict situations at work and home and insufficient knowledge in managing change (Birch, 2001; Mollart et al., 2013). The inability to say no to excess work and the lack of support from colleagues and administration also proves to be stressful (Birch, 2001).

Analysis of our data shows that 86.1% of midwives participating in this study reported average to mild levels of stress; 16.3% of the midwives who participated in the study reported moderate to extreme depression and 13.9 per cent reported moderate to extreme stress. When we compared our data with UK data (Hunter et al., 2019), we found that our midwives have a low mean score of CBI subscale (see Table 5). Based on this data, we can deduce two facts. One is that despite the high CBI scale mean score, midwives can manage tension and stress at work. We can assume that professional experience and education help to cope with stress. Also, the changed role of midwives includes extended professional autonomy, recognition and a relatively new opportunity to individually handle cases of normal birth.

This would explain the low client-related burnout score. On the other hand, we may think that personal and work-related burnout is so profound that daily activities cannot cause more stress. Although, a more in-depth research is needed to confirm these assumptions. The results of our study are partly explained by the transitions in the midwifery profession. The Lithuanian national project on the analysis of the healthcare workforce focuses on professional rights, duties, responsibilities, competence, functions and workload of midwives in practice. A multi-professional (professional associations and higher educational institutions, healthcare funding, midwives and obstetricians/gynaecologists) focus group discussion was conducted on this study. The results of the study revealed the main elements that still hinder the development and recognition of the midwifery profession. Participants mentioned that midwives still have insufficient decision-making freedom, a lack of opportunity to practice across

TABLE 3 Burnout type dependency on sociodemographic characteristics

Variables	Personal burnout, n = 93 (27.5%)		Work-related burnout, n = 13 (3.8%)		Client- related burnout, n = 6 (1.8%)	
	n (%)	p	n (%)	p	n (%)	p
Age						
23–35	25 (36.2)		3 (4.3)		0	
36–45	24 (27.0)		3 (3.4)		0	
>45	44 (24.4)	.174	7 (3.9)	-	6 (3.3)	-
Marital status						
Single	9 (34.6)		0		0	
Married	75 (32.9)		9 (3.9)		6 (2.6)	
Living with a partner	5 (16.1)		2 (6.5)		0	
Divorced	3 (7.5)		2 (5.0)		0	
Widowed	1 (7.7)	.002	0	-	0	-
Has children						
Yes	72 (26.6)		11 (4.1)		6 (2.2)	
No	21 (31.3)	.528	2 (3.0)	.506	0	-
Education						
College degree	58 (26.4)		7 (3.2)		4 (1.8)	
University degree	35 (29.7)	.604	6 (5.1)	.388	2 (1.7)	-
Place of employment						
Public sector	73 (26.6)		11 (4.0)		6 (2.2)	
Private sector	3 (18.8)		2 (12.5)		0	
Public and private sector	9 (26.5)		0		0	
Academic sector	0		0		0	
Academic and public and/or private sector	8 (72.7)	.011	0	-	0	-
Length of time qualified as a midwife						
≤10 years	25 (35.7)		5 (7.1)		0	
>10 years	68 (25.4)	.115	8 (3.0)	.154	6 (2.2)	-
Shift duration						
12 hr	43 (42.6)		0		0	
<12 hr	9 (15.5)		3 (5.2)		0	
>12 hr	18 (17.6)		3 (2.9)		6 (5.9)	

TABLE 3 (Continued)

Variables	Personal burnout, n = 93 (27.5%)		Work-related burnout, n = 13 (3.8%)		Client- related burnout, n = 6 (1.8%)	
	n (%)	p	n (%)	p	n (%)	p
Mixed shifts	23 (29.9)	<.001	7 (9.1)	-	0	-
Principle area of service						
Rotation across all clinical areas in a hospital including antenatal clinic birthing suite, antenatal/ postnatal ward and the special care nursery	33 (37.1)		7 (18.0)		2 (1.5)	
Antenatal clinic only	19 (34.5)		4 (7.3)		0	
Birth suite only	23 (36.5)		2 (3.2)		0	
Postnatal ward only	18 (25.7)	.148	0	-	4 (1.8)	-

the full spectrum of maternity care at all levels of healthcare and the profession remains inconspicuous in terms of remuneration and science. There is a lack of understanding and vision of what a midwife could do in the community and low motivation of midwives themselves to function according to their competence and the full potential of their role (Riklikienė et al., 2012).

5.3 | Strengths and limitations

Strength of this study is the large sample size with adequate representation of midwives working in Lithuania. Furthermore, this is the first national study aiming to assess the emotional well-being of midwives. Since the midwifery profession in Lithuania is still establishing its autonomy, the study results may therefore be context specific and need to be interpreted with caution. There are importance messages in the Lithuanian context on how to better support midwives and improve their working conditions to minimize personal and work-related burnout. Understanding the factors contributing to burnout will enable healthcare organizations to reduce costs associated with staff attrition, reduce human costs regarding the

TABLE 4 Multiple logistic regression for Personal and Work burnout

Variable	B	S.E.	Odds ratio	95% CI lower upper	p value
Personal burnout*					
Depression scores	0.188	0.06	1.21	1.08-1.35	<.001
Anxiety scores	0.099	0.05	1.11	1.01-1.21	.030
Stress	0.103	0.04	1.11	1.03-1.19	.007
Constant	-1.480	0.26			<.001
Work burnout**					
Depression scores	0.011	0.03	1.01	1.01-1.08	.048
Anxiety scores	0.003	0.04	1.01	1.01-1.06	.050
Stress	0.186	0.03	1.21	1.12-1.30	<.001
Constant	-2.417	0.29			<.001

*Personal burnout model: $\chi^2(3) = 146.67, p < .001$, Nagelkerke $R^2 = .48$, overall classification 75.42% (for the categories "Personal Burnout = Yes" 85.7 and "Personal Burnout = No" 63.9).
 **Work burnout model: $\chi^2(3) = 118.21, p < .001$, Nagelkerke $R^2 = .39$, overall classification 73.4% (for the categories "Work Burnout = Yes" 58.3 and "Work Burnout = No" 84.5).

TABLE 5 Comparison of CBI and DASS Scores from WHELM collaborating countries

	Lithuania	UK	Sweden	Australia	New Zealand
	Mean	Mean	Mean	Mean	Mean
Copenhagen burnout inventory (CBI)					
Personal burnout	61.33	65.54	42.95	55.90	52.67
Work-related burnout	49.08	56.15	33.86	48.44	44.63
Client-related burnout	33.88	25.36	30.42	25.59	29.64
Depression, anxiety and stress scale (DASS)					
Depression	6.44	10.81	5.64	6.66	5.99
Anxiety	6.24	9.22	2.83	5.35	4.51
Stress	10.95	15.03	8.33	11.13	9.63

health and well-being of midwives. These issues must be addressed and embraced if the midwives in Lithuania are willing to fulfil their role in practice according to their education and legally regulated scope of practice.

A limitation is that the sample of midwives was selected only from members of the national organization who were attending a conference. As such, they are demonstrating a level of commitment to professional growth that may not be representative of all midwives in Lithuania. Another limitation is that it does not extend over a period of time, but was done at a single point in time.

6 | CONCLUSIONS

Prevalence of personal and work-related burnout in Lithuanian midwives was high. The physical and psychological exhaustion associated with the different types of burnout were reflected in symptoms of depression, anxiety and stress. These levels of burnout and their influence on stress, depression and anxiety are serious concerns for the profession. Depression, anxiety and stress the main factor which influencing personal and work burnout for midwives.

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CONFLICT OF INTEREST

The authors have no conflicts of interest concerning this study.

DATA AVAILABILITY STATEMENT

The authors confirm that the data supporting the findings of this study are available in the article.

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