Winter March 3, 2022

# The People-Centred Approach to Policymaking.pdf

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Global Implementation Research and Applications
https://doi.org/10.1007/s43477-022-00040-9

COMMENTARY

# The People-Centred Approach to Policymaking: Re-Imagining Evidence-Based Policy in Nigeria

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Received: 11 August 2021 / Accepted: 9 February 2022


## Abstract

The discourse on evidence-based policymaking in healthcare continues to explore sustainable solutions to current and emerging challenges. However, what constitutes evidence in health policymaking needs to be defined and agreed upon, especially in places with several forms of knowledge and ways of knowing. Researchers, policymakers, and other stakeholders must understand the value of people-centred approaches to health policies, given the increased focus on equitable distribution of power and resources for sustained health outcomes. This paper argues that people's values, lived experiences, and opinions are not always adequately considered when formulating health policies, especially in countries with diverse cultural and social norms. A country, like Nigeria, with many health challenges requires health policies based on contextual knowledge, given the country's diverse lived experiences and values. Implementation researchers note that to ensure the adoption of evidence-based policies, researchers and implementers must intentionally incorporate elements for successful implementation into the planning and formulation of policies. Evidence shows that the policy development process in public health does not always adequately capture informal knowledge in the policy formulation process. With the lack of data on the role of informal knowledge in policymaking, Nigerian researchers could begin to examine the potential benefits these types of knowledge could have on policies. Future research could explore, and document experiences and lessons learned from other fields to apply these to public health.

**Keywords** Health policies · Health equity · Informal knowledge · Lived experiences · Nigeria · Policymaking · Implementation science · Community participatory action research

## Introduction

Nigeria's public and health policymaking are fraught with many challenges due to its size and the presence of over 450 ethnic groups and languages that represent Christianity, Islam, and traditional religions. As a result, health outcomes in the country's six regions are very diverse (National Population Commission, 2013, 2019). Under Nigeria's federal system, the three levels of government, federal, state, and local have different healthcare responsibilities, each with its own management and financing. State governments may adopt, accentuate, or build on national policies and laws. Many states adopt or assent to federal laws or policies by applying state-specific knowledge or information. Often, policymakers and industry stakeholders take a top-down approach to formulating and developing health policies (Head, 2007).

Over the years, policy implementation researchers have focused on contextual implementation, advocating for consideration of new knowledge within existing practices and the importance of values and norms (Johansson, 2010; Nilsen et al., 2013). Although, it appears that Nigeria's process of formulating policies in public health does not adequately consider informal knowledge, which consists of experiences, opinions, and emotions of beneficiaries of health policies (Bowen & Zwi, 2005; Chapman et al., 2020; Mirzoev et al., 2013). Consequently, we continue to see the benefits of public health programs often obscured or ignored because of distrust and fear. Our intention is not to separate

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Published online: 03 March 2022

formal and informal knowledge but rather argue for the integration of informal knowledge due to its unique role in policymaking alongside formal knowledge.

Often research on patient values, experiences, and opinions is not disseminated effectively as actionable items for policymaking (Cairney & Oliver, 2017; Kitson & Straus, 2010; Oxman et al., 2009). As public policy shifts its focus to ensuring equitable distribution of power and resources to sustain health outcomes (WHO, 2008), researchers must examine other forms of knowledge to inform and enrich the policymaking process and its implementation (Greenhalgh & Wieringa, 2011). Policymakers must access these new data sources to make timely, informed decisions. Researchers must ensure that evidence from informal knowledge is available and easily accessible to policymakers who may lack data analysis skills. As Kitson and Straus (2010) explain, a lack of skills to synthesize and apply the volume of health knowledge available is a common challenge shared by patients, researchers, and policymakers. We recognize that researchers and policymakers all have roles to play in using evidence for decision-making. Although there may sometimes be a misalignment of priorities between researchers and policymakers, valid, credible, and timely evidence that supports the development of effective policies and programs is essential. As researchers continue to explore options to bridge the gap between evidence and evidence use, the other side of that conversation should include the types of evidence required for policymaking and its implementation. As Bucknall and Rycroft-Malone (2010) note, it is essential to consider the characteristics of all types of evidence in policy designs and implementation.

We align our view in this commentary with scholars who have previously called for integrating knowledge translation, policy, and implementation science. Taking an inclusive view that integrates all forms of knowledge into policies, we assert that it is critical to re-evaluate what constitutes informal evidence in policymaking from an inclusive perspective. We advocate that promoting knowledge use must be complemented with great effort to include communities and individuals who are the direct beneficiaries of policies from the beginning of the policy process. Could citizen engagement in health policy formulation begin the much-needed transparency in policy formulation and, inadvertently, improve public health outcomes and sustained development?

## Understanding Evidence-Based Policymaking

Health policy researchers recommend that evidence-based policy addressing health inequities and population health should focus on contextual evidence, country-specific policy landscape, and human factors (Freudenberg & Tsui, 2014; Oliver et al., 2012). Research has shown that implementation science is crucial for addressing health inequalities (Bauer & Kirchner, 2020; Goldstein & Olswang, 2017). Using an implementation framework would enhance the uptake of evidence in health interventions and increase impact. However, with the common discourse focusing on empirical evidence from descriptive information and facts about service trends and program performance, we potentially renounce the role people's values and experiences could have on policymaking (Oliver & Pearce, 2017; Shroff et al., 2015). When evidence discourse includes experience, researchers seem to present it as the need to understand the power dynamics of policymaking, politicians' needs, and the political landscape. Some implementation researchers note that to ensure the adoption of evidence-based policies, researchers and implementers must intentionally incorporate elements for successful implementation into the planning and formulation of policies (Bullock et al., 2021; Ojo et al., 2021; Proctor et al., 2011).

In Nigeria, we opine that the term evidence-based has become so focused on research evidence that patients' values and preferences, which are essential components for optimal evidence-based practice, are neglected. Bombard et al. (2018) note in their study of implementation strategy and contextual factors affecting patient satisfaction that there has been a shift in the last two decades from assessing patients as passive users of health to engaging patients as integral, experienced-based co-design partners. They argue that a balanced input on evidence that recognizes the diverse groups involved in policymaking require policymakers to decide on the voices, interests, and needs that should be prioritized in policies.

Other researchers argue for a more inclusive categorization that is consistent with existing forms of knowledge: formal evidence consisting of scientific research and informal evidence consisting of the experiences, opinions, wisdom and perceptions of policymakers and users of policies (Bowen & Zwi, 2005; Mirzoev et al., 2013; Oliver & Pearce, 2017; Rand et al., 2019). Both views are valid depending on the context or sector seeking, generating, or using the evidence. For example, in the health sector, quality improvement policies that translate evidence into practice could explore both forms of evidence. In contrast, policymakers in a minor specialist field might only explore one form of evidence.

## Importance of Evidence-Based Policymaking

Globally, there is a dire need for evidence-based policies. Studies show that evidence-based policies have the most impact and deliver the most outcome (Bauer & Kirchner, 2020; Leuz, 2018; Uneke et al., 2015). Several studies find that evidence-based health policies are in high demand in

low- and middle-income countries (LMICs) like Nigeria (Gonzalez Block & Mills, 2003; Shroff et al., 2015). Poorly formulated policies and implementation are critical reasons some researchers have given for the failure of health systems and the low quality of services provided in health facilities (Hudson et al., 2019; Lavis et al., 2004, 2009; Mueller, 2020). For health policies to successfully achieve their target of improving health outcomes, there must be a clear definition of priorities and targets those policies should focus on achieving. Some of these priorities and targets require inputs from those who are the beneficiaries of the policies. Therefore, asserting that policies are only viable if beneficiaries perceive them as such appears to be a valid notion in every policymaking context. Therefore, having reliable information is the first step in ensuring evidence-based policies.

Additionally, it is essential to distinguish between people-centred policy formulation and people-centred policy implementation. While both terms are often treated as separate terms, policy implementation is a component of the policy development process focusing on actualizing a formulated policy (Ajulor, 2018; Gold, 2014). Policy implementation is not a separate process and must be considered during the formulation process. The people-centred policy recognizes the impact of beneficiaries in implementing policies. We opine that participating in the formulation process as members of committees could allow beneficiaries to help define the problem and reveal solutions outside of expert knowledge. As such, people-centred policy implementation as the epicentre of policy process emphasizes the roles of stakeholders in policy uptake, including beneficiaries of policies, coordinating required resources, and identifying activities and plans to ensure the success of policies (Maduabum, 2008; Mbieli, 2017).

Many implementation issues are due to poor policy formulation that fails to consider implementation success. Gold (2014) explains that while a good policy can be implemented poorly, it is challenging to implement a bad policy. For instance, evidence on Nigeria's millennium development goals performance illustrates a significant gap in social and public policies that have only reinforced persistent health, economic, and social gaps between rich and poor households (Durokifa & Abdul-Wasi, 2017; Paul et al., 2017). According to some researchers, Nigeria's policy problem is implementation. However, they contend that Nigeria's poor policy performance begins with an ambitious policy design that is vague, unrealistic, and lacking in understanding of people's priorities (Agbazuere, 2020; Makinde, 2017; Okoli & Onah, 2002). We believe a poorly formulated policy can result inadvertently in implementation issues. With the current focus on sustainable development goals, countries like Nigeria are eager to find meaningful and appropriate strategies to engage citizens for sustainable outcomes. Policymakers and researchers must begin to advance policy research into non-traditional focal areas to determine other factors that could ensure the effectiveness and sustainability of policies. One may even posit that the people-centered approach is a practical implementation strategy and provides evidence to enhance policies. Until researchers explore alternative means of engaging citizens as health owners, achieving the sustainable development goals may go the way of the millennium development goals.

This focus on context plays a critical role in promoting a culture of evidence-based policy and practice created to sustain the demand for context-specific evidence-based decisions (Chen et al., 2021; Onwujekwe et al., 2015; Uneke et al., 2015). One critical importance of informal evidence could be the realignment of contextual factors to specific policies that provide local solutions using local resources. Context-specific evidence can enrich policies that address contextual issues rather than having generic content drawn from international policies under the guise of best practices.

## Generating and Translating People-Centered Evidence for Policymaking

Generating evidence for policymaking is a complex process. Studies have shown that involving critical stakeholders in the process ensures the adoption and use of evidence for policy (Cairney & Oliver, 2017). The timeliness of data, resources available, and the type of evidence needed for policy formulation determine the evidence required for policymaking.

Studies have shown that traditional research methods designed to return desired queries to hypotheses have a way of silencing the voices of those who use healthcare (Hammell, 2001; Lhachimi et al., 2016; Montori et al., 2013). In Nigeria, sourcing for data would require creating a space for beneficiaries to drive research outcome experiences instead of researchers. The success of every policy has a dependency on human factors, which in health means the best treatments or interventions depend on a person's goal, values, needs and preferences, all of which differ among people. These factors can provide insight into potential solutions and outcomes derived from experiences (Montori et al., 2013).

Given that policies are meant for the people, we argue that these people's opinions, voices, and values should be considered in the policy process. Researchers recommend using participatory research, a qualitative method, as the appropriate method for sourcing people-centred evidence (Freudenberg & Tsui, 2014; Gollust et al., 2005; Salimi et al., 2012). According to Salimi et al. (2012), participatory research reduces the challenge of engaging people in policymaking. It can create social transformation in designing, implementing, and evaluating policies, especially in explicating health disparities and health determinants. Specifically, it makes sourcing evidence from the community

accessible. They explain that community participatory research's success depends on the researchers' understanding and recognition of the role of community knowledge, culture, and effective communication.

Appollonio & Bero (2017), Levkoe and Sheedy (2019), and Kapiriri et al. (2003) seem to have successfully generated informal evidence from the community using participatory research and translated it into policy. For instance, Levkoe and Sheedy (2019), in their evaluation of a food program in Canada, outlined the process, which included community members as food insecurity experts. In their exploration of public participation in Uganda district-level health planning, Kapiriri et al. (2003) proved that it is possible and vital to engage the public in developing health policy despite resource limitations. Findings from other health systems, South Africa, Tanzania, Zimbabwe, and Kenya that have explored community engagement in health policy planning and formulation provide data on the importance of health policies responsive to community needs and preferences (Maluka et al., 2011; Masuku & Macheka, 2021; Meier et al., 2012; O'Meara et al., 2011). These findings present Nigeria's public health system with opportunities to apply lessons learned, and devise strategies for incorporating similar processes into Nigerian health policy development.

Evidence may be used in every stage of the policy process. Strategically, the agenda setting and policy formulation stages present an excellent opportunity for researchers and policymakers to brainstorm on the kind of data and evidence that should inform policies. Having a pre-agenda setting meeting with the community to determine their needs and preferences may lead to a quickly adopted policy at the community level. This way, engaging with the community may create a sense of having control over their governance and may be the beginning of a self-aware community that readily proposes health policies. As a heterogeneous society, perspectives, values, beliefs, expectations, and goals for health and life differ across Nigerians. In the same way, people engage differently with processes in considering the potential benefits, harms, costs, and inconveniences of various options. Understanding such specific factors and how each region, state, and group interact and behave could strengthen policy formulation and implementation.

Although, a crucial challenge in the country's policy process is that donors and funders are primary determinants of policy in developing countries (Ajulor, 2018; Khan et al., 2018). According to some researchers, donors influence the policy process in countries like Nigeria through financial and political incentives (Khan et al., 2018; Unsworth, 2015; Uzochukwu et al., 2016). Often, countries perceive donors as exerting strong influence around the policy process, dictating priorities and agendas, sometimes to the detriment of their health systems once foreign assistance ends (Ajulor, 2018; Brownson et al., 2009; Khan et al., 2018; Unsworth, 2015; Uzochukwu et al., 2016). One may argue that the Nigerian government cannot decide how and what policies to formulate in the face of subtle donor influence. However, other researchers such as Gautier and Ridde (2017) and Lauber (2021) note that donors' influence on a country's policy process was minimal. Instead, other actors like the private sector exert more influence. While we recognize the substantive influence of donors in Nigeria, we argue that the donor-recipient relationship does not negate who sits on the driving seat of policymaking in Nigeria. We opine that development aid is negotiable. When governments are intentional about the wellbeing of their citizens, there is an opportunity to balance priorities. As Gautier and Ridde (2017) state, governments and donors' interests can coexist. However, there remains the question of what should constitute evidence? Therefore, as Khan et al. (2018) note, there is a need to understand evidence-based policymaking in Nigeria, where the health system is donor-driven.

## Applying Consolidated Framework for Implementation Research (CFIR) Framework to a People-Centered Approach

A growing interest in incorporating patient experiences into practice has led to a body of literature on how implementation science and evidence-based practices can effectively reduce health inequity (Balas & Boren, 2000; Fisher et al., 2016). Implementation science emerged to investigate and address the gap between the availability of evidence-based practices and the degree to which such practices are actually used with sufficient fidelity to benefit patients (Damschroder, 2020). The interest in integrating evidence-based practice and implementation science strategies designed to promote evidence for decision-making has led to implementation research to increase uptake of evidence in health programming (Johansson, 2010; Nilsen et al., 2013; Waltz et al., 2019). However, some researchers believe there is minimal guidance on deploying these strategies in different contexts (Baker et al., 2015; Waltz et al., 2019). Such researchers argue that strategies need to be context-specific as contextual determinants differ (Baker et al., 2015; Waltz et al., 2019). Other researchers note that developing an appropriate implementation strategy to address these challenges requires understanding the context, identifying an appropriate theoretical framework and developing a method that uses the framework (Jo & Bucknall, 2010; O'Toole, 2004; Waltz et al., 2019).

According to Nilsen (2013), these implementation frameworks aim to guide translation of findings into practice, understand factors influencing the implementation and evaluate the success or failure of implementation. Among the frameworks we believe can explain the importance of

context in policies in low- and middle-income countries is the Consolidated Framework for Implementation Research (CFIR). This determinant framework incorporates contextual and determinant factors influencing the success or failure of policy implementations. Although other existing frameworks might adequately reveal and explain contextual issues, the CFIR appears to be the most common among LMICs (Means et al., 2020; Ojo et al., 2021). There are five CFIR domains: Intervention Characteristics, Characteristics of Individuals, Outer Setting, Inner Setting, and Process. An Innovation Characteristics domain includes factors like relative advantage, complexity, evidence strength and quality that influence an intervention or policy.

As noted earlier, policy formulation is a critical phase in the policy process, and implementation depends on a sound policy. Using the CFIR framework, policymakers and researchers can identify strategies to develop policies that can result in effective and sustainable interventions. Applying concepts related to the characteristics of individuals and interventions, researchers can identify priority areas, multiple stakeholders, and quality and valid evidence to inform the development and implementation process. The framework is applicable at any stage of implementation, beginning, mid and end. Despite finding limited use of this framework in LMICs, studies have shown that applying it before implementing can expose Nigeria's policymaking readiness and potential barriers. For instance, a systematic review by Means et al. (2020) and Nnaji et al. (2021) found that some researchers in LMICs applied the framework before implementing evidence-based interventions to identify barriers. Other researchers like Ojo et al. (2021) and Gimbel et al. (2016) applied CFIR to existing health services to map contextual factors influencing the implementation.

## Re-defining People-centred Evidence-Based Policymaking in a Public Health Context

The concept of a people-centred approach requires that Nigeria organizes its health systems around people and communities' health needs and expectations rather than diseases (Freudenberg & Tsui, 2014; Sinai et al., 2020). The term people-centred approach is commonly used in patient care to explain how patients' interactions with health services and people in the community shape health policy and services. The approach leverages qualitative research methods—such as ethnography, contextual inquiry, and targeted observations and interviews—to better understand people and their interactions with social structures (Sinai et al., 2020). This approach means policies start and end with the people who are using the health system. The approach focuses on understanding those the health system is trying to reach and designing policies from their perspective. When people are involved in the design process, there is a strong likelihood that new and innovative solutions to problems could emerge. Studies show that involving people in policy formulation could potentially increase the quality of design, implementation, and evaluation of policy outcomes (Levkoe & Sheedy, 2019; Salimi et al., 2012).

The health sector achieves a people-centred approach when the system integrates and prioritizes all actors' diverse roles, needs, and preferences, including community groups and individuals (Abimbola et al., 2014). Some authors opine that the people-centred approach as a force for social change seeks to change social inequities and disparity (Korten, 1987; Samuel, 2007). The approach assumes that people know best, so they work with field experts to ensure the best outcome. The approach, grounded in equity and sustainability, requires engaging diverse stakeholders who make up the health system. Invariably, the approach takes an equity lens to address social determinants of health which, is at the core of every health policy. When applied to health policies, it becomes a tool for transforming health behaviour and empowering people to consciously position themselves as health experts and re-define their health choices.

The people-centred approach's philosophy requires understanding the health system as complex with varying attributes. People would determine its form and dynamically influence it. Therefore, it is crucial to understand how people function and influence the health system's quality and policies through lived experiences interacting with the system (Sheikh et al., 2011, 2014). Sheikh et al. (2014) argue that understanding the health system means appreciating power relations and recognizing people as active participants in health instead of passive recipients.

Several studies have recommended changing the definition of evidence to make it more inclusive of the variety of types of knowledge that should inform policymaking in public health (Lavis, 2006; Lavis et al., 2004; Sinai et al., 2020). Researchers note that the question of what constitutes these pieces of evidence is emerging from the need to include other forms of knowledge into policymaking (Apollonio & Bero, 2017; Greenhalgh & Russell, 2009; Greenhalgh & Wieringa, 2011). In contrast to other fields, the public health space has been slow in defining evidence that is more inclusive of diverse types of knowledge that can inform both practice and policy (Kothari et al., 2015; Oliver & de Vocht, 2017).

Using women's health as an example, we know the data about women's disadvantaged position in society. However, these disadvantages are complex regarding the health space. We opine that the common discourse on equitable distribution of services does not account for the unequal use of health services in different contexts. There seems to be an assumption that women's health interventions are one size fits all endeavor, such that a successful program in

Bangladesh can be replicated in Nigeria (Hodgins & Saad, 2020; Jensen et al., 2021; Kaehne, 2018; Mehtar et al., 2020). In our view, this approach relies on a decontextualized approach that assumes similar needs and common experiences of all women related to their health services. This assumption can ignore, or minimize the differences, needs, and preferences of women in other societies, such as Nigeria. Policymakers must engage with Nigerian women to learn and understand their specific experiences with existing health structures, services, and policies.

One approach proposed for inclusivity that ensures people's involvement in policy formulation is the people-centred approach derived from the product design approach, human-centred design (Sinai et al., 2020). This approach requires customer feedback and opinion on products before manufacturing to users' specifications. This principle drives the "people-centered approach." The people-centred approach in policy consciously adopts the perspectives of individuals, families, and communities, both as participants and beneficiaries of health systems, in developing policies (Sinai et al., 2020; Strehlenert et al., 2015). In contrast, typical policy development involves formal feedback loops favouring lobbyists and industries, with little or no information from lived experiences (Bowen & Zwi, 2005; Sinai et al., 2020; Strehlenert et al., 2015).

Consequently, Nigerian researchers must examine health from the people's perspectives to truly understand their experiences and diverse definitions of health and wellness. From this perspective, we may discover several factors that explain why multiple investments to improve the country's health indices have been only marginally successful. We believe that the lived experiences of people cannot be represented adequately nor solely by standardized policies or guidelines, nor solely by measuring outcomes using predetermined indicators. Instead, the people-centred approach requires a participatory appraisal of the range of experiences of the people who use health services, so that researchers and policy makers can align their strategies to react to, integrate, and interpret these experiences. The people-centred approach balances health policymakers' ambitious plans with the interests of the multiple stakeholders. It provides a framework for sustainable development and meaningful improvement in the health status of people. It is essential to clarify that the people-centred approach goes beyond community participatory action research, which involves communities' participation in processes. This participation, often criticized for seeming coerced, does not allow for sharing unique experiences that could be important for any policy development effort (Baum et al., 2006; Holland et al., 2010). Some researchers argue that participatory action research does not include all voices (Baum et al., 2006; Holland et al., 2010; Nilsen et al., 2013). Specifically, they argue that focusing only on marginalized voices suggests that oppressed people are the only ones who can contribute to solving the problem. This ideology negates the value that other community members can bring to the process. Therefore, we recommend involving a representative sample of the population, inclusive of a broad range of experience and diverse socio-economic conditions.

For a policy to successfully deliver on its goal of providing quality health care to the people most in need, policymakers must move beyond developing and implementing generic policies that are decontextualized. Instead, policymakers should formulate policies based on the opinions and lived experiences of individuals and the community as a whole—people-centred policies—that are not solely disease burden driven or based solely on quantitative outcomes. Apollonios and Bero (2017) provide evidence that engaging communities in developing policies would translate to effective policies. As such, researchers and policymakers should formulate policies that recognize that lived experiences and statistical data, together, can improve policy outcomes and begin to address the inequitable distribution of resources and health.

## Conclusion

Nigeria needs to reorient its policymaking process to focus on people rather than developing policies that focus on problems. Until we recognize lived experience as evidence, promising programs may continue to be under-resourced, perpetuating persistent inequities in health services and society. Given the lack of data on the role of informal knowledge in policymaking, Nigerian researchers should begin to examine the potential benefits these types of knowledge could have on policy development and implementation. This commentary joins many others to advance the discourse on using implementation science to plan, formulate, implement, and evaluate health policies and interventions.

Future research could explore, and document experiences and lessons learned from other fields that have incorporated the lived experience of the people being served and apply these to public health. It would be valuable to track the challenges and constraints other fields may have documented in generating and translating informal knowledge from the community. Furthermore, it would be particularly interesting to know if and how these fields successfully translated these data into policy. Another focus for future research could be to explore the impact or effect of these person-centred policies on the community, given their role in formulating and developing such policies. Also, it would provide an opportunity for policymakers to understand how the community is interacting with the policies and if the implementation and impact is sustainable.

An additional area for future research also could be a comparative analysis of prior policies with the current policies developed using the people-centred approach. These studies would provide empirical data on the efficacy and efficiency of the policies and whether the people-centred approach does make a difference in health systems' efforts to narrow health inequities. There is a shortage of research in this area, especially research using local data (Lee et al., 2018). Head (2007) warns us that the term, community, is an innocuous description that connotes a unified, equal, peaceful existence which politicians have continued to use to minimize the extent of inequity in societies. As a result, policymakers and researchers need to be aware of the dynamics of the society when applying the people-centred approach to policy to avoid silencing voices or excluding a marginalized group while also including the voices of the broader community.

**Author contributions** MN: conceived the paper's idea and drafted and redrafted the manuscript. OA and AO: Contributed with reviewing.

**Funding** No funding was received.

**Availability of data and material** All data and material are publicly available.

**Code availability** Not available.

## Declarations

**Conflict of interest** The authors declare no conflict of interest or competing interests in this article.

**Consent to participate** Not available.

**Consent for publication** Not available.

**Ethical approval** Not available.

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