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Intersectional Impact of Religion, Gender and Health Outcomes on Health Equity in Sub-Saharan Africa

交叉视角下宗教、性别与健康结局对撒哈拉以南非洲健康公平的影响

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Abstract:

This scoping review examines the intersectional impact of religion and gender on health outcomes in sub-Saharan Africa, with particular attention to their combined implications for health equity. Despite notable improvements in healthcare systems across the region, substantial disparities persist, particularly among marginalized populations. Existing scholarship has largely analysed religion, gender, and health outcomes in isolation, overlooking the complex and mutually reinforcing dynamics that shape lived health experiences.

Drawing on intersectionality theory, this review synthesises peer-reviewed studies published between 2010 and 2023 to explore how religious beliefs, gender norms, and structural inequalities interact to influence health behaviours, access to care, and overall well-being. The findings indicate that religion plays a dual role, acting both as a facilitator and as a barrier to positive health outcomes. Religious

Keywords: Intersectionality; Health equity; Religion and health; Gender norms; Health outcomes; Sub-Saharan Africa.

关键词：交叉性；健康公平；
宗教与健康；性别规范；
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doctrines and leadership structures significantly influence health-seeking behaviour, attitudes toward medical interventions, and community perceptions of illness. At the same time, entrenched gender norms and roles continue to shape differential access to healthcare services, decision-making power, and exposure to health risks.

The review highlights how individuals experiencing compounded vulnerabilities—particularly women in socioeconomically disadvantaged or religiously conservative contexts—face distinct and amplified health challenges. It further demonstrates the influential role of religious leaders in shaping community health practices and policy acceptance.

By offering an integrated and intersectional synthesis, this study contributes to the fields of Public Health, Global Health, Health Policy, and Gender Studies. It advances current knowledge by demonstrating how sociocultural and religious structures interact with gender to sustain or mitigate health inequities in sub-Saharan Africa. The findings underscore the importance of engaging religious actors in health policy processes and designing culturally responsive, gender-sensitive interventions aimed at reducing persistent health disparities across underserved populations.

摘要：

本范围综述探讨了宗教与性别在撒哈拉以南非洲对健康结局所产生的交叉性影响，特别关注二者在促进或阻碍健康公平方面的综合作用。尽管该地区医疗卫生体系已取得显著进展，但健康不平等现象依然突出，尤其是在边缘化群体中更为明显。

现有研究多将宗教、性别与健康结局分别加以分析，忽视了塑造个体实际健康体验的复杂且相互强化的动态机制。

本研究以交叉性理论为框架，综合分析了2010年至2023年间发表的同行评议文献，探讨宗教信仰、性别规范与结构性不平等如何相互作用，从而影响健康行为、医疗服务可及性以及整体福祉。研究发现，宗教在健康结局中具有双重作用，既可能促进积极健康结果，也可能构成障碍。宗教教义及其领导结构显著影响个体的就医行为、对医疗干预的态度以及社区对疾病的认知。同时，根深蒂固的性别规范与社会角色持续塑造着医疗服务获取的不平等、决策权分配以及健康风险暴露程度。

本综述强调，处于多重脆弱境遇中的个体——尤其是社会经济地位较低或处于宗教保守环境中的女性——面临独特且被放大的健康挑战。

研究进一步表明，宗教领袖在塑造社区健康实践和推动政策接受方面发

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挥着重要影响。通过提供整合性与交叉性的综合分析，

本研究为公共卫生、全球健康、

卫生政策与性别研究领域作出贡献。研究阐明了社会文化与宗教结构如何与性

别因素相互作用，从而维持或缓解撒哈拉以南非洲的健康不平等。研究结果强

调，在卫生政策制定过程中纳入宗教行为主体的重要性，并倡导设计具有文

化回应性与性别敏感性的干预措施，以减少服务不足群体中长期存在的健康差距。

1. Introduction

Sub-Saharan Africa (SSA) faces numerous health challenges exacerbated by social determinants such as gender and religion (Ifeanyichukwu, 2020; Ichoku et al., 2013). These determinants do not act in isolation but intersect, creating complex influences on health outcomes (Weinstein et al., 2017). However, the existing literature on the relationship between religion, gender, and health outcomes often lacks an intersectional lens, overlooking the complex and dynamic ways in which these factors intersect. Understanding these intersections is crucial for addressing health inequities and achieving Sustainable Development Goal 3, which aims to ensure healthy lives and promote well-being. This scoping review explores how the intersection of religion and gender impacts health outcomes in SSA, highlighting the need for intersectional approaches in health research and policy.

2. Literature Review

2.1. Existing Research on Religion and Health

Religion plays a significant role in shaping health behaviours and outcomes in SSA. Studies have shown that religious beliefs can influence health practices, such as contraception and adherence to medical treatments (Adekola & Mothoagae, 2023; Gyimah et al., 2006). However, the impact of religion on health is not uniformly positive or negative; it varies depending on the context and the specific health problem being addressed.

2.2 Gender and Health Outcomes

Gender is a critical determinant of health in SSA. Women and girls often face significant barriers to access to healthcare, including cultural norms, economic dependence, and limited educational opportunities (Azad et al., 2020; Ogunjimi, 2012). Gender-based violence and discrimination further

exacerbate these challenges, leading to poor health outcomes for women and girls (Zinyemba & Hlongwana, 2022). Furthermore, the rigid definition of gender norms in many sub-Saharan African societies often leads to social ostracism and discrimination against those who deviate from these norms (Adekola, 2024). This creates a hostile environment for gender non-conforming individuals, contributing to stress, anxiety, and depression (Valentine & Shipherd, 2018). Moreover, discrimination within healthcare settings, as reported by Mikulak et al. (2021), can deter these individuals from seeking the necessary medical care, further exacerbating their health risks.

2.3 The Intersection of Religion and Gender

Few studies have explicitly examined the intersection of religion and gender in relation to health outcomes in SSA. Existing literature suggests that this intersection can create unique barriers to healthcare (Sundararajan et al., 2019). For example, religious doctrines may reinforce gender norms that limit women's autonomy and access to health services (Mochache et al., 2020; Agadjanian, 2013). This scoping review aims to fill this gap by systematically analysing the intersection of these factors and their collective impact on health outcomes.

2.4 Intersectionality Theory

Intersectionality theory, introduced by Kimberlé Crenshaw, provides a framework for understanding how multiple social identities intersect to create unique experiences of oppression and privilege (Crenshaw, 2018). This theory is particularly useful for examining health disparities because it acknowledges that health outcomes are influenced by multiple, interconnected social determinants (Mandelbaum, 2020). In this review, we used intersectionality theory to analyse how religion and gender intersect to impact health outcomes in SSA.

3. Scoping Review Methodology

A scoping review methodology was used to map the existing literature on the intersection of religion, gender, and health outcomes in SSA. This approach is well suited for identifying research gaps and summarising findings across diverse study designs and disciplines (Nyanchoka et al., 2019; Wong et al., 2021). A systematic search of SABINET, Google Scholar, the Directory of Open Access Journals and Scopus was performed using keywords related to religion, gender, health outcomes, and Sub-Saharan Africa, as shown in Figures 1 and 2. Studies published in peer-reviewed journals between 2010 and 2023 that used qualitative, quantitative, or mixed methods were included. Data extraction focused on study characteristics, main findings, and implications for health equity. The review followed the methodological framework outlined by Arksey and O'Malley (2005).

Figure 1: Search Protocol for the scoping review (Developed by the authors)

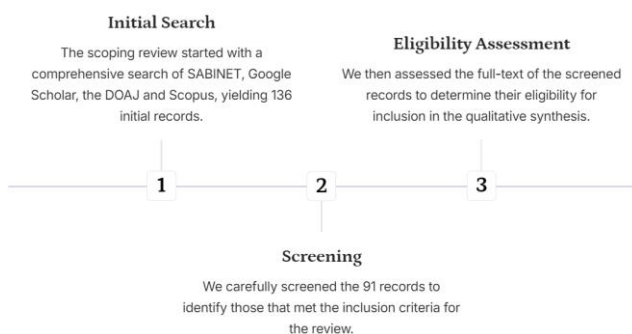
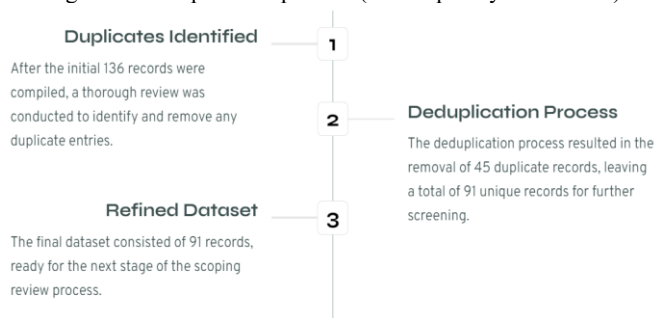


Figure 2: Deduplication process (Developed by the authors)



3.1. Data Collection

3.1.1 Inclusion and Exclusion Criteria

We included studies that investigated health outcomes in SSA, considering the effects of religion and gender, and were published in English between 2010 and 2023. Studies focused on regions outside the SSA, grey literature, such as dissertations and conference abstracts, and articles without full-text availability were excluded. Additionally, articles that did not address the intersection of religion and gender were excluded, ensuring a targeted focus on the intersectional impact of these factors on health

outcomes in SSA. Because of the high rate of health disparities and the widespread impact of gender norms and religion on influencing both individual and community health behaviours, SSA was chosen as the focus. Despite these contextual factors, the existing literature falls short of comprehensively examining the intersectional effects of gender and religion in this context. Thus, theoretical significance and empirical necessity motivated this research choice of studies.

3.2. Data Extraction

Data extracted from each included study are study characteristics such as author, year, study design, and country. We also extracted specific health outcomes investigated by each article. In addition, we extracted data on population, religious affiliations, and gender identities examined along with the key findings and implications for health equity.

3.3. Data Analysis

We performed a thematic analysis to identify key themes and patterns in the data. The findings were organised according to the health outcomes and the degree to which the studies incorporated an intersectional approach.

4. Results

Initially, our search yielded 136 publications. After removing 45 duplicates, we were left with 91 publications. We then screened these remaining publications for eligibility, and 47 of them met our study's inclusion criteria. The remaining 44 publications were excluded, as illustrated in Table 1.

Table 1 Search Results (Developed by the authors)

Total Records Identified	136
Duplicate Records Removed	45
Records Screened	91
Records Included	47
Records excluded	44

Based on the analysis of existing literature and the application of intersectionality theory, the following findings emerged.

4.1. Differential Impact of Religious Beliefs on Health Outcomes

4.1.1 Positive Influences

Religious communities often provide social support networks that can improve mental health and adherence to treatment protocols. In certain contexts, religious institutions can promote positive health behaviours, such as discouraging substance abuse and encouraging healthy lifestyles (Koenig, 2012).

4.1.2 Negative Influences

On the contrary, some religious beliefs contribute to health inequities. For example, certain religious doctrines oppose the use of modern contraceptives, leading to higher rates of unintended pregnancies and associated health risks (Agadjanian, 2013).

4.2. Gendered access to healthcare services

4.2.1 Barriers for Women

Women in many sub-Saharan African contexts face significant barriers to accessing healthcare, including religiously influenced gender norms that limit their autonomy and decision-making power (Ogunjimi, 2012). This could result in delayed or foregone medical care, particularly for reproductive health services.

4.2.2 Men's Health Neglect

Although women's health is often emphasised, men's health problems were under-addressed due to cultural expectations of masculinity and self-reliance, which discourage men from seeking medical help (Courtenay, 2000).

4.3. Intersectionality of Religion and Gender Leading to Unique Health Challenges

4.3.1 Compounded Vulnerabilities

Individuals who face discrimination or marginalisation on multiple fronts such as religious minority women may experience compounded vulnerabilities. These individuals may encounter religious and gender-based barriers, resulting in poorer health outcomes compared to those who face a single axis of disadvantage (Crenshaw, 2018).

4.3.2 Specific Health Outcomes

The intersection of religion and gender uniquely impacts specific health outcomes, such as maternal mortality rates, HIV/AIDS prevalence, and mental health conditions, as both religious beliefs and gender norms deeply influence these areas (Sekoni et al., 2020; Shabalala & Campbell, 2023). Certain religious beliefs discourage women from seeking antenatal care or utilizing modern healthcare facilities during childbirth (Aziato et al., 2016; Mutowo et al., 2021). This can lead to delays in seeking emergency obstetric care, contributing to higher maternal mortality rates. Likewise, in some cultures in SSA, gender norms can restrict women's decision-making power regarding their reproductive health. Women may be pressured to have many children or to undergo unsafe procedures such as female genital mutilation, increasing their risk of complications during childbirth (World Health Organization, 2013).

Furthermore, some religious teachings may stigmatise condom use or discourage open discussions about sexuality, making it difficult to promote safe sexual practices, which hinders HIV prevention efforts

(Ilesanmi, 2014). In the same vein, women often face unequal power dynamics in relationships, limiting their ability to negotiate condom use or refuse unwanted sex. This can increase their vulnerability to HIV infection (UNAIDS, 2021). Additionally, gender-based violence, often exacerbated by certain religious interpretations, is a significant risk factor for HIV transmission (Alemie et al., 2023).

Although religion can provide a source of comfort and social support, it can potentially buffer against mental health problems (Koenig et al., 2024). However, it can also be a source of stress, particularly for women facing discrimination or pressure to conform to rigid gender roles within religious communities (Parsitau & Aura, 2021). Similarly, societal expectations that women should be self-sacrificing and prioritise the needs of others can lead to chronic stress and depression. Men, on the other hand, may be less likely to seek help for mental health problems due to stigma associated with emotional vulnerability (World Health Organization, 2013). Therefore, we argue that understanding the unique experiences of people at the intersection of religion and gender is crucial to addressing health disparities. For example, a young Muslim woman in a rural area may face different health challenges than an older Christian woman in an urban setting. Therefore, the context matters because the influence of religion and gender on health outcomes varies depending on the specific cultural and social context.

4.4. Role of Religious Leaders in Health Promotion

Religious leaders often have a significant influence on their communities. Their support can be essential in promoting health-positive behaviours and addressing public health issues. On the contrary, their opposition can hinder health interventions (Oluduro, 2017; Adekola & Mothoagae, 2023).

The study showed that cultural and religious beliefs about gender roles, modesty, and purity influence health outcomes. For example, beliefs around female genital mutilation (FGM) or menstrual impurity could lead to harmful health practices.

4.5. Policy and programmatic implications

This review highlights the need for policies and programmes that consider the intersectional impacts of religion and gender on health outcomes. This could involve training healthcare providers on cultural competence, developing targeted interventions for marginalised groups, and addressing systemic barriers to access to healthcare.

This study revealed complex and sometimes contradictory relationships between religion, gender, and health. For example, religion offers social support that benefits health, but it also reinforces gender norms that could negatively impact women's health-seeking behaviours. The analysis revealed that religious

participation is associated with better mental health outcomes for both men and women. However, women who adhere to stricter religious practices might face higher rates of depression or anxiety due to societal pressures. In several instances across SSA, the review showed that religious leaders play a crucial role in promoting HIV prevention and treatment, but some of their messages might reinforce gender stereotypes that hinder women's access to care.

4.6. Implications for Health Equity

The findings of this study underscore the importance of an intersectional approach for promoting health equity in SSA. Understanding how religion and gender intersect helps to design more targeted and culturally sensitive interventions that address the unique needs of different populations in SSA.

5. Discussion

The findings of the scoping review underscore the complex interplay of religion, gender, and health outcomes in sub-Saharan Africa, aligning with existing literature. Notably, intersectional disparities are evident, with religious and gender minorities experiencing poorer health outcomes, including higher maternal mortality rates (Koenig et al., 2024) and reduced access to HIV treatment (Dada et al., 2024; Habib et al., 2021; UNAIDS, 2022). For example, a Nigerian study found that Muslim women faced elevated maternal mortality risks compared to their Christian counterparts (Umar, 2017). Furthermore, religious and gender-based discrimination in healthcare settings, documented in the literature (Müller, 2016; Agu et al., 2024), leads to delayed or inadequate care, as exemplified by a Kenyan study where LGBTQ+ individuals faced discrimination and delayed care-seeking (Lewis et al., 2023).

Furthermore, existing literature highlights how religious and gender factors influence healthcare access (Seidu, 2020; Mochache et al., 2020) and shape health-seeking behaviours (Bergen et al., 2020). These factors also significantly impact social determinants of health, such as education and socioeconomic status, as evidenced by a South African study linking religious beliefs to educational choices and subsequent health outcomes (Francis et al., 2019). Additionally, cultural and religious beliefs influence health practices, sometimes leading to harmful outcomes like those associated with female genital mutilation in Nigeria (Awolola & Ilupeju, 2019; Nwakama et al., 2023).

Religious beliefs and practices can significantly impact health outcomes by providing social support, promoting mental well-being, and encouraging positive health behaviours. Koenig (2012) highlights how participation in religious activities can enhance social support networks, which, in turn, improves mental health and adherence to medical treatments. For example, religious communities often offer a sense of belonging and support that mitigates the effects of stress

and mental health problems. On the contrary, some religious doctrines can hinder health outcomes. Agadjanian (2005) discusses how certain religious beliefs in sub-Saharan Africa oppose the use of modern contraceptives, leading to higher rates of unintended pregnancies and associated health complications. This opposition exacerbates health disparities, particularly in reproductive health.

In addition, gender norms influenced by religious beliefs can significantly impact women's access to healthcare. Ogunjimi (2012) notes that in many sub-Saharan African contexts, religiously influenced gender norms limit women's autonomy and decision-making power, often resulting in delayed or foregone medical care, especially in reproductive health services. Consequently, this lack of autonomy leads to poorer health outcomes for women. While much focus is placed on women's health, men's health issues might be under-addressed due to cultural and religious expectations of masculinity. Courtenay (2000) explains how traditional masculine norms, which emphasise self-reliance and toughness, can discourage men from seeking medical help, thereby neglecting their health needs. This neglect results in untreated health conditions and poorer overall health outcomes for men. Furthermore, the intersection of religion and gender can lead to compound vulnerabilities for certain populations. Crenshaw introduced the concept of intersectionality, which helps understand how overlapping social identities, such as religion and gender, contribute to unique experiences of disadvantage (Bastia et al., 2022). For example, women in religious minorities face religious and gender-based barriers, leading to poorer health outcomes compared to those facing a single axis of disadvantage. This compound vulnerability is evident in specific health outcomes, such as maternal mortality rates, HIV/AIDS prevalence, and mental health conditions. Sundararajan et al. (2019) and Embleton et al. (2022) emphasise that the intersection of religion and gender norms profoundly affects these health outcomes, as both religion and gender play critical roles in shaping health behaviours and access to healthcare.

Additionally, religious leaders have substantial influence over their communities, which can be used to promote health. Oluduro (2017) discusses how the support of religious leaders can be pivotal in promoting health-positive behaviours and addressing public health issues. For example, religious leaders advocating for HIV testing and treatment can significantly impact community acceptance and participation in these programmes. Moreover, religious leaders can play a crucial role in public health policy advocacy. Their positions of influence can be leveraged to support public health initiatives and advocate for policies that promote health equity. Engaging religious leaders in health promotion efforts can help address some of the barriers posed by religious beliefs and practices.

Therefore, the intersection of religion and gender in sub-Saharan Africa presents both challenges and opportunities to improve health outcomes. Although religious beliefs provide crucial social support and promote positive health behaviours, they can also hinder access to health services, particularly for women. The compounded vulnerabilities experienced by people facing multiple axes of disadvantage, such as women of religious minorities, highlight the need for intersectional approaches to health interventions. Engaging religious leaders in health promotion and policy advocacy can help address some of these barriers and promote health equity. The review findings showed the complex ways in which religion and gender intersect to impact health outcomes in sub-Saharan Africa. Therefore, it is essential to adopt intersectional approaches in health research and policy, considering how multiple social determinants interact and influence health outcomes. For example, health interventions should be designed to address both religious and gender-based barriers to access to healthcare. Policymakers should invest in digital health infrastructure, strengthen health information systems, promote digital health literacy, and encourage community participation to ensure that digital health innovations are used effectively to promote health equity and justice. Consequently, the need for policies and programs addressing the intersectional impacts of religion and gender on health outcomes is paramount (Mothoagae & Mavhandu-Mudzusi, 2021; Bohren et al., 2024). However, a review of healthcare policies in sub-Saharan Africa revealed a significant gap in addressing the unique needs of religious and gender minorities. This underscores the urgency of comprehensive, intersectional approaches to achieve health equity in the region.

5.1. Implications for Theory and Practice

By showing that gender identity and religious beliefs produce distinct paths to health outcomes, this study advances intersectionality theory in health research. The findings offer empirical evidence for compounded vulnerabilities rather than considering these elements in an additive manner. This extends intersectionality theory beyond its traditional focus on race, class, and gender to include religion as a critical axis of health inequality in SSA. Furthermore, the study challenges simplistic views of religion as either beneficial or harmful by showing that religious influences on health are mediated by gender positioning within religious communities. This nuanced understanding contributes to theoretical frameworks that recognise the contextual and dynamic nature of intersectional experiences.

5.2. Insights into Religion-Health and Gender-Health Relationships

The findings reveal that religious influences on

health cannot be understood without considering how gender shapes access to religious resources and exposure to religious constraints. The identification of men's health neglect within religious societies calls into question the conventional narrative that males are universally favoured, illustrating how masculine religious values can produce distinct health risks. Similarly, the documentation of women's barriers to healthcare within religious contexts provides evidence for how patriarchal religious structures compound gender-based health inequities. In addition, the critical role of religious leaders in health promotion emerges as a key theoretical insight, positioning religious authority as a determinant of community health outcomes that operates through formal healthcare access and informal health behaviours.

5.3. Health Systems and Policy Recommendations

The establishment of intersectional health policy is critical for addressing the compound vulnerabilities that individuals with religious beliefs and gender identity face. As a result, these programs must include tailored treatments targeted for specific populations. This covers both women from conservative religious groups and males whose religious beliefs prevent them from seeking medical treatment. Establishing liaison offices helps to connect healthcare services and religious communities. In clinical practice, we advocate that providers conduct intersectional health assessments and develop culturally responsive treatment plans that balance patients' religious frameworks with clinical effectiveness. Therefore, successful community engagement requires the implementation of collaborative health education initiatives and gender-differentiated outreach, emphasising the importance of collaboration with religious leaders in health advocacy and promotion.

5.4. Intervention Design and Resource Allocation

Intersectional awareness is crucial when programming health interventions in the context of intervention design and resource allocation. This involves employing multi-level approaches that simultaneously address individual, community, and structural factors and gender-responsive programming that accounts for how religious contexts shape health needs differently for men and women. Consequently, resources should be redirected toward intersectional programming that addresses compounded vulnerabilities, rather than treating religion and gender as separate issues. This approach supports community-based interventions within existing religious structures and uses intersectional indicators to monitor health outcomes across religious and gender categories.

6. Recommendations

Based on the findings of this review, we recommend that governments and health organisations

prioritise investment in digital health infrastructure to improve access to healthcare. Additionally, educational initiatives should be implemented to promote digital health literacy among underserved populations. Health interventions must involve community members in the design and implementation process to ensure cultural relevance and acceptance. Furthermore, researchers and policymakers should adopt intersectional approaches that address the multiple social determinants of health, considering how factors such as religion, gender, and other intersectional identities intersect to impact health outcomes.

Future research should explore the lived experiences of people who navigate the intersections of religion, gender, and health to provide a more in-depth and qualitative understanding of these dynamics. Furthermore, comparative studies examining other regions would explain how religion and gender interact in different cultural contexts and should develop intersectional measurement tools. Further research should also focus on developing innovative interventions that involve religious leaders in promoting health equity, particularly in communities where gender norms significantly impact healthcare access. Lastly, longitudinal studies that assess the impact of intersectional policies on health outcomes over time would be valuable to assess their effectiveness.

7. Conclusion

7.1 Summary of the Study's main findings

This scoping review revealed how the intersectionality of religion and gender influences health outcomes and equity in SSA. The study identified both the constructive and adverse roles of religious beliefs on health behaviours and shed light on how gender disparities affect healthcare accessibility. It examined the influence of religious leaders in shaping health norms and attitudes. The review emphasises the compounded vulnerabilities of marginalised populations and underscores the urgent need for intersectional and culturally responsive health policies.

7.2 Comparison with Previous Studies

While prior research has examined religion, gender, and health separately, few studies have investigated their interconnected impact on health equity. This review addresses this gap by offering a comprehensive synthesis that reveals the complex ways these social determinants intersect. It advances existing scholarship by integrating religious dynamics often overlooked in intersectional health equity frameworks within broader access, agency, and care discussions.

7.3 Theoretical and Practical Implications

Theoretically, the study contributes to intersectionality discourse by demonstrating how overlapping religious and gendered identities shape distinct health outcomes and reinforce systemic inequities in SSA. Practically, the findings call for the

integration of religious leaders in public health interventions, the design of gender-sensitive programmes, and the development of policies that are both culturally and contextually grounded. Furthermore, digital health innovations are proposed to mitigate structural and socio-cultural barriers, particularly among underserved communities in the region.

7.4 Strengths and Recommendations

This study's strength lies in its intersectional lens, which allows a deeper understanding of how religion and gender jointly influence health equity. However, its reliance on published literature and the regional focus on SSA limit the generalisability of findings. Future research should incorporate empirical studies that foreground the lived experiences of affected populations and consider emerging trends in digital health and faith-based health delivery. Policymakers and practitioners are encouraged to adopt intersectional frameworks to design inclusive, equitable health systems aligned with Sustainable Development Goal 3.

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Authors' Contributions

Ayobami Precious Adekola conceptualised the study, collected, analysed, and interpreted the data, and wrote the manuscript.

Itumeleng Daniel Mothoagae analysed and interpreted the data and critically and technically reviewed the manuscript.

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Not applicable

Informed Consent Statement

Not applicable

Data Availability Statement

Data sharing is not applicable to this article.

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Conflicts of Interest

The authors declare no conflicts of interest.

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