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Sexual myths and sexual health attitudes among health profession students in Turkey

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Abstract

This study was conducted to compare health care students' beliefs about sexual myths and their attitudes towards addressing This study compared health profession students' beliefs in sexual myths and their attitudes toward sexual health in their future profession. Data were collected online from 420 students between January and April 2023. The Sexual Myths Scale and Sexual Health Attitudes Questionnaire were used. Results showed that students generally had moderate belief levels in sexual myths and positive attitudes toward sexual health, with significant differences based on gender and education level. Findings highlight the need for integrating sexual health education into health curricula to promote evidence-based and inclusive professional practice. *(Afr J Reprod Health 2026; 30 [1]: 54-63).*

Keywords: Sexual health, sexual myth, midwifery, nursing, sexual counseling, student

Résumé

Cette étude compare les croyances des étudiants en professions de santé concernant les mythes sexuels et leurs attitudes envers la santé sexuelle dans le cadre de leur future profession. Les données ont été recueillies en ligne auprès de 420 étudiants entre janvier et avril 2023. L'échelle des mythes sexuels et le questionnaire sur les attitudes face à la santé sexuelle ont été utilisés. Les résultats montrent que les étudiants ont généralement des niveaux de croyance modérés concernant les mythes sexuels et des attitudes positives envers la santé sexuelle, avec des différences significatives selon le sexe et le niveau d'études. Ces résultats soulignent la nécessité d'intégrer l'éducation à la santé sexuelle dans les cursus de santé afin de promouvoir une pratique professionnelle inclusive et fondée sur des données probantes. *(Afr J Reprod Health 2026; 30 [1]: 54-63).*

Mots-clés: Santé sexuelle, mythes sexuels, sage-femme, soins infirmiers, conseil sexuel, étudiant

Introduction

Sexuality encompasses sex, gender, sexual identity and orientation, eroticism, attachment, fantasies, beliefs, attitudes, values, practices, roles, and thoughts related to reproduction. It represents a fundamental aspect of human life and overall well-being.[1] According to WHO, sexuality is an integral part of being human, and sexual health reflects a positive and respectful approach to sexuality that promotes lifelong physical, emotional, mental, and social well-being.[2,3]

Sexual health encompasses more than the absence of disease; it involves a positive and respectful approach to sexuality and relationships that ensures pleasurable and safe experiences free from coercion, discrimination, and violence. The World Health Organization emphasizes that protecting and fulfilling sexual rights is essential for maintaining sexual health [1]. Recent research further highlights that sexual health contributes significantly to individuals' quality of life, autonomy, and social well-being.[2,4] Therefore, promoting sexual health through education and open dialogue is vital for both personal and public health. Strengthening sexual health education can also help individuals communicate about sexual issues more comfortably and confidently.

Sexual health education encompasses a wide range of activities designed to provide individuals with knowledge, skills, and attitudes that promote healthy sexual behaviors and relationships.[5] However, most educational programs still emphasize the prevention of sexually transmitted and reproductive diseases rather than fostering healthy sexual functioning,

communication, and satisfaction.[6,7] Sexual development is a lifelong process that begins in childhood, and comprehensive sexuality education introduced during these formative years plays a critical role in fostering awareness, positive attitudes, and behavioral competencies that support healthy sexual well-being throughout life.[8]

Sexual health education should ideally be provided by trained health professionals, as it requires both professional knowledge and experiential competence.[9] Health professionals play key roles in assessing sexual health, identifying and addressing problems, and determining individuals' needs for information and counseling on sexuality.[1] However, their effectiveness in these roles is strongly influenced by their personal beliefs, sexual myths, and attitudes toward sexuality.[10,11] Therefore, addressing these misconceptions and providing targeted education are essential for improving communication about sexuality-related issues in clinical practice. Importantly, instilling this awareness and competency during professional education is crucial, as students who internalize a holistic view of sexual health are more likely to integrate sexual health assessment into patient care in their future professional roles.[8]

Despite the recognized importance of integrating sexual health education into health professional training, studies indicate that cultural values, personal beliefs, and prevailing sexual myths continue to shape students' attitudes and confidence in this area.[6,11,12] This issue may be particularly pronounced in societies where discussing sexuality remains sensitive due to cultural and religious norms, potentially affecting students' readiness to address sexual health in their future professional roles. Recognizing this gap, it becomes crucial to investigate how these factors influence students' competencies and comfort levels in sexual health communication. Therefore, the present study aims to examine sexual myths, knowledge, and attitudes toward sexual health among Muslim students studying in health-related fields, and to contribute to the literature by providing data on their perceived competence and readiness to engage in sexual health assessment and counseling.

Methods

This study was conducted to compare health students' beliefs in sexual myths and attitudes toward addressing sexual health issues in their future professions. This is a descriptive and cross-sectional study, which was conducted online between January and April 2023 by contacting health students via their social media accounts, WhatsApp groups, etc. The population for the study consisted of students who lived in Türkiye, studied in the health field at universities, and used digital media. Before the data collection process was initiated, the researchers sent the invitation to the study first to each other and then to a field expert who was not involved in the study for testing purposes. Questions that were not understood or expressed incorrectly were revised.

The questionnaire was created using Google Forms and was made available from January 2023 to April 2023. Participants were first contacted online via social media accounts and WhatsApp groups.

A text about the study was sent to the administrators of the social media and WhatsApp groups, which included the research population, and the link to the online questionnaire, and brief information about the research was shared by the administrators in the groups. During the data collection process, reminder messages about the survey were sent to WhatsApp groups and social media accounts three times. Participation in the research was completely voluntary and no incentives were given to the participants. Participants' personal information was not requested during data collection.

The answers of the participants who completed the survey were transferred to the Statistical Package for the Social Sciences (SPSS) software.

Sample size

The sample size was calculated using Raosoft software (Raosoft Inc., Seattle, WA, USA) based on the sampling method for an unknown population. A power value of 95% and a margin of error of 5%

Wereadopted(http://www.raosoft.com/samplesize.html). Considering possible attrition during the study, a pattern effect of 1.3 was applied, resulting in a minimum required sample of 351 participants. The study was completed with 420 participants, exceeding the required number.

Inclusion criteria:

Being aged >18 years old, literacy in the Turkish language, approving the voluntary consent form, living in Türkiye, attending education in the health-related departments of Turkish universities, completing the questionnaire, having access to the Internet.

Exclusion criteria:

Not taking a sexual and reproductive health course

Survey instruments

The questionnaire included a descriptive information form, the Sexual Health Scale, and the Sexual Myths Scale. The details of these scales are given below.

The descriptive information form*:* Developed by the researchers in line with the literature,[6,9,12–14] this form contains seven questions about participants' socio-demographic characteristics.

The sexual health scale*:* This scale was developed by Areskoug-Josefsson *et al*,[6] and its Turkish validity and reliability study was conducted by Çay and Kırlıoğlu (2021).[15] It consists of 21 items and four sub-dimensions evaluating health sciences students' attitudes toward addressing sexual health in their professional roles. The scale uses a five-point Likert structure, with total scores ranging from 22 to 110. In the original study, the overall Cronbach's α was 0.90. In this study, the overall α was 0.90, and the sub-dimension coefficients were as follows: Comfort in future client relationships (α=0.94), Fear of negatively affecting future client relationships (α=0.79), Future work environment (α=0.78), and Need for education (α=0.47). Written permission was obtained for the use of the scale.

The sexual myths scale*:* Developed by Gölbaşı *et al*. [16] this five-point Likert-type scale consists of 28 items and eight sub-dimensions that measure individuals' beliefs about sexual myths. Higher scores indicate stronger belief in sexual myths. In the original study, the overall Cronbach's α was 0.91. In this study, the overall α was 0.91, and the sub-dimension coefficients were as follows: Sexual orientation (α=0.85), Gender roles (α=0.81), Age and sexuality (α=0.83), Sexual behavior (α=0.83), Masturbation (α=0.88), Sexual violence (α=0.68), Sexual intercourse (α=0.68), and Sexual satisfaction (α=0.55). Written permission was obtained for the use of the scale.

Data analysis

Study data were analyzed on the SPSS version 23 (SPSS, Inc., Chicago, IL, USA). The normality of the data was examined with the Kolmogorov-Smirnov test. Spearman's Correlation, Mann-Whitney U, Kruskal-Wallis H, and Linear Regression tests were used for comparisons. $p<0.05$ was accepted as statistically significant.

Ethical Statement

Prior to the study, the approval of the Research Ethics Committee of Kirklareli University was obtained (protocol number: PR0431R0/date: 12/29/2022). All the procedures were performed in accordance with the rules regarding studies involving human participants by considering the ethical standards of the institutional and/or national research committee and the 1964 Declaration of Helsinki and its later amendments or comparable ethical standards.

Results

The mean age of the participants was 20.71±2.12 (18-40) years. The distribution of the participants by departments was as follows: 50% (n=210), midwifery; 33.3% (n=140), nursing; 6.7% (n= 28), social services; 5.7% (n=24), emergency medical technician education; 4.3% (n=18), anesthesia department.

The distribution by school year was as follows: 54.5% (n=229), 2nd-year students; 29.5% (n=124), 3rd-year students; 16% (n=67), 4th-year students. Additionally, 90.7% (n=381) were female, and 99% (n=416) were single (Table 1).

Table 1: Students' descriptive characteristics (n=420)

Characteristics	**Mean±Sd**	**Min.-Max.**
Age	20,71±2,12	18-40
	n	**%**
Department		
Midwifery	210	50.0
Nursing	140	33.3
Social services	28	6.7
Emergency medical technician education	24	5.7
Anesthesia	18	4.3
Gender		
Female	381	90.7
Male	39	9.3
Marital status		
Single	416	99.0
Married	4	1.0
School-year		
2	229	54.5
3	124	29.5
4	67	16.0

Table 2: Relationships between participants' age and the Sexual Myths Scale and the Sexual Health Scale (n=420)

Variables		**Sexual Myths Scale**	**Sexual Health Scale**	**Age**
Sexual Myths Scale	***r***	1.000	-0.291	0.046
	p	-	**<0.001****	0.351
Sexual Health Scale	***r***	-0.291	1.000	0.079
	p	**<0.001****	-	0.105
Age	***r***	0.046	0.079	1.000
	p	0.351	0.105	-

**significant at $p<0.001$; *r*: Spearman rho correlation coefficient

The relationships between the age variable of the participants and the Sexual Myths Scale (SMS) and Sexual Health Scale (SHS) were examined with the Spearman correlation test because the normality assumptions were not meet (Table 2). A statistically significant negative correlation was detected between the Sexual Myths Scale (CMS) and the Sexual Health Scale (SHS) ($p<0.001$). However, no relationship was found between the age variable and these two scales ($p>0.05$). As seen in Table 3, some categorical data of the participants were compared with the total and subscale scores of SMS (Sexual Myths Scale). A significant difference was observed between the department variable and the mean scores of the subscales (except SMS total and SMS-F5), with EMT students showing higher mean scores than other departments ($p<0.05$, $p<0.001$). A significant difference was detected between gender and the total and subscale scores of the SMS ($p<0.001$), with male participants scoring higher than females. A significant difference was observed between school year and the SMS-F3 (age and sexuality) and SMS-F7 (sexual relationship) subscale scores ($p<0.05$), with 4th-year students showing lower mean scores than others.

Table 4 presents the comparison of some variables of the participants and the scores on the Sexual Health Scale and its subscales (n=420). As seen in Table 4, some categorical data of the participants were compared with their mean scores on the SHS (sexual health scale) and its subscales, namely SHS-F1 (the feeling of comfort regarding future client relationships), SHS-F2 (fear of negatively affecting future client relationships), SHS-F3 (future working environment), and SHS-F4 (need for education).

Table 3: Comparison of some variables of the participants with the mean scores on the total and subscales of the Sexual Myths Scale (n=420).

	n	SMS Mean±SD	SMS-F1 Mean±SD	SMS-F2 Mean±SD	SMS-F3 Mean±SD	SMS-F4 Mean±SD	SMS-F5 Mean±SD	SMS-F6 Mean±SD	SMS-F7 Mean±SD	SMS-F8 Mean±Sd
Department										
Midwifery	210	47.80±13.51	12.47±5.30	7.93±2.94	5.94±2.77	3.93±1.79	3.85±2.15	5.27±2.08	4.21±1.88	4.16±1.77
Nursing	140	54.84±17.69	13.00±5.34	9.35±4.42	7.35±3.44	4.73±2.52	4.59±2.43	6.04±2.76	5.02±2.07	4.72±2.00
Social services	28	41.07±11.12	8.82±3.33	6.71±1.82	6.21±3.09	3.57±1.19	3.78±1.96	4.46±1.13	3.89±1.83	3.60±1.54
EMT	24	63.79±22.16	17.16±5.95	10.70±6.19	7.79±4.18	5.50±3.74	4.45±2.57	7.12±3.56	5.87±2.78	5.16±2.23
Anesthesia	18	56.22±20.68	15.05±6.15	8.38±2.91	7.16±3.39	5.00±3.51	4.55±2.85	6.44±3.09	5.27±2.46	4.33±2.22
X^2		38.048	31.268	22.447	23.325	15.260	8.993	24.494	22.055	13.729
P		**<0.001**	**<0.001**	**<0.001**	**<0.001**	**0.004**	0.061	**<0.001**	**<0.001**	**0.008**
Gender										
Female	381	49.09±14.93	12.42±5.35	7.99±3.10	6.37±3.08	4.14±2.10	4.04±2.28	5.42±2.27	4.47±2.01	4.24±1.83
Male	39	69.33±20.41	16.38±5.61	13.54±5.77	8.72±3.71	6.00±3.43	5.36±2.31	7.67±3.52	5.95±2.42	5.72±2.24
Z		-6.126	-3.940	-7.451	-4.800	-3.860	-3.550	-4.780	-3.666	-4.121
P		**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**	**<0.001**
School year										
2	229	50.91±16.82	12.52±5.76	8.33±3.81	6.69±3.09	4.38±2.29	4.15±2.23	5.72±2.54	4.82±2.11	4.30±1.95
3	124	51.96±16.73	13.06±4.99	8.88±4.02	6.66±3.23	4.40±2.44	4.30±2.42	5.67±2.56	4.49±2.00	4.50±1.99
4	67	49.37±15.49	13.22±5.47	8.39±3.25	6.10±3.59	3.93±2.13	3.94±2.44	5.27±2.22	4.09±2.10	4.43±1.65
X^2		0.968	1.938	1.401	6.183	3.193	1.667	2.387	8.459	0.939
P		0.616	0.379	0.496	**0.045**	0.203	0.434	0.303	**0.015**	0.625

**significant at $p<0.001$; X^2: Kruskal-Wallis H test; *Z*: Mann-Whitney U test; EMT: Emergency medical technician education; SMS: Sexual Myths Scale; SMS-Factor1: Sexual orientation; SMS-Factor2: Gender; SMS-Factor3: Age and sexuality; SMS-Factor4: Sexual behavior; SMS-Factor5: Masturbation; SMS-Factor6: Sexual violence; SMS-Factor7: Sexual intercourse; SMS-Factor8: Sexual Satisfaction.

Table 4: Comparison of some variables of the participants and the scores on the Sexual Health Scale and its sub-scales (n=420)

	n	SHS Mean±Sd	SHS -F1 Mean±Sd	SHS-F2 Mean±Sd	SHS-F3 Mean±Sd	SHS-F4 Mean±Sd
Department						
Midwifery	210	80.73±11.78	32.23±6.21	26.39±4.96	10.13±2.80	11.98±2.14
Nursing	140	71.86±14.01	27.55±7.37	23.71±5.21	9.31±2.80	11.29±2.16
Social services	28	75.61±11.00	31.43±5.31	23.46±4.95	9.14±2.41	11.57±1.79
EMT	24	74.42±13.32	29.88±8.14	25.17±7.03	9.17±3.07	10.21±2.50
Anesthesia	18	79.94±10.81	32.06±6.38	26.50±3.97	9.89±3.05	11.50±1.58
X^2		38.071	38.128	25.861	9.969	18.555
p		**<0.001**	**<0.001**	**<0.001**	**0.041**	**0.001**
Gender						
Female	381	77.40±13.20	30.60±7.03	25.40±5.29	9.75±2.82	11.66±2.13
Male	39	73.48±12.36	29.23±6.60	23.67±5.02	9.56±2.91	11.03±2.43
Z		-1.821	-1.448	-1.889	-0.103	-1.619
p		0.069	0.148	0.059	0.918	0.106
School year						
2	229	76.22±13.23	29.93±6.91	25.20±5.43	9.77±2.89	11.31±2.14
3	124	76.47±13.20	29.96±7.06	24.95±5.00	9.74±2.73	11.81±1.85
4	67	80.90±12.35	33.28±6.60	25.88±5.30	9.55±2.79	12.18±2.62
X^2		6.458	14.913	1.449	0.408	12.232
P		**0.040**	**0.001**	0.485	0.815	**0.002**

**significant at $p<0.001$ and $p<0.05$; X^2: Kruskal-Wallis H test; *Z*: Mann-Whitney U test; EMT: Emergency medical technician education; SHS: Sexual Health Scale; SHS-Factor1:The feeling of comfort regarding future client relationships; SHS-Factor2: Fear of negatively affecting future client relationships; SHS-Factor3: Future working environment; SHS-Factor4: Need for education

Table 5: Regression analyses of participants' perceptions of sexual myths and sexual health (n=420)

Model 1[a]		B	Std. Error	Beta	95% confidence interval Lower	Upper	*p*
	Department	1.536	0.701	0.099	0.158	2.914	0.029*
	Gender	18.396	2.593	0.323	13.299	23.493	**<0.001****
	SHS	-0.247	0.057	-0.196	-0.358	-0.135	**<0.001****
Model 2[b]							
	Department	-1.265	0.595	-0.103	-2.435	-0.096	0.034*
	Gender	1.053	2.330	0.023	-3.526	5.633	0.651
	SMS	-0.178	0.041	-0.223	-0.258	-0.097	**<0.001****

*significant at $p<0.05$, **$p<0.001$, Linear Regression Test
[a]Model 1: Sexual Myths Scale, $R=0.436$, $R^2=0.190$, Model 1 $F=19.417$, $p<0.001$.
[b]Model 2: Sexual Health Scale, $R=0.275$, $R^2=0.076$, Model 2 $F=6.780$, $p<0.001$.
SHS: Sexual Health Scale, SMS: Sexual Myths Scale

A significant difference was found between the department variable and the mean scores on the total and subscales of the SHS (p<0.05), with midwifery students

showing higher mean scores than students from other departments. A significant difference was found between school year and the mean scores on the SHS total, SHS-F1, and SHS-F4 subscales (p<0.05), with 4th-year students having higher mean scores than other students.

As seen in Table 5, participants' perceptions of sexual myths and sexual health were examined with multiple regression analysis by establishing two models, namely Model 1 and Model 2. These two models were found to be significant (p <0.001). When the R^2 value was examined, it was found that

department, gender, and sexual health scale variables explained 20% of the sexual myths scale in Model 1 and that department, gender, and sexual myths scale variables explained 8% of the sexual health scale in Model 2. In Model 1, it was determined that department (β:0.099, p=0.029), gender (β:0.025, p<0.001), and sexual health scale (β:-0.196, p<0.001) significantly predicted the sexual myths scale. In Model 2, the sexual myths scale (β:-0.223, p<0.001) significantly predicted the sexual health scale, while the department variable (β:-0.103, p=0.34) was not a significant predictor.

Discussion

Although sexual health is an integral component of holistic well-being, many health professionals continue to experience discomfort in addressing sexuality-related topics.[17] Negative attitudes and false beliefs, or sexual myths, may hinder the development of the open and non-judgmental perspective required for effective sexual health counseling.[2] The findings of this study revealed an inverse relationship between belief in sexual myths and attitudes toward addressing sexual health, suggesting that individuals who hold stronger myths may be less willing or less confident to discuss sexual issues in clinical practice. Similar associations have been reported in previous research, indicating that personal attitudes and cultural values strongly shape professional readiness for sexual health communication. [6,18]

Previous research has shown that health sciences students—future healthcare professionals—tend to report relatively high levels of sexual myths, often reflecting broader social and cultural attitudes toward sexuality.[6,12,13,19] In the present study, sexual myth scores were lower than those reported in earlier Turkish studies[10,20] but consistent with findings from research conducted in more urbanized regions.[21] This may suggest that cultural modernization and greater exposure to Western norms contribute to more liberal attitudes toward sexuality in certain regions of Turkey.

The relatively higher sexual myth scores among Emergency Medical Technician (EMT) students may be linked to curriculum structure. Associate degree programs generally include sexual health content only in a limited or elective form, which restricts opportunities for comprehensive sexual health education. Similar curriculum limitations have been identified internationally, where insufficient training leads to lower competence and confidence in addressing sexuality-related issues.[22,23] These findings underscore the importance of systematically integrating sexual health topics into all health education programs to foster competence and reduce misconceptions among future professionals.

Most students in health-related fields perceive their knowledge and skills to address patients' sexual health concerns as inadequate, and only a small proportion feel confident in providing sexual counseling.[18,19] Previous research from Turkey similarly revealed that the sexual health education provided to nursing students was insufficient, and that students influenced by cultural and religious beliefs were less likely to deliver sexual health services.[24] Personal values also play a critical role, as nursing students' comfort in discussing sexuality with patients has been shown to depend largely on their individual attitudes and belief systems.[12] These findings highlight the ongoing need to strengthen sexual health education and to address the impact of cultural and moral values in shaping students' readiness to engage in sexual health communication.

Gender roles, sexual beliefs, religiosity, and cultural background are among the key factors shaping individuals' sexual attitudes.[19,25] These variables interact in complex ways, influencing how individuals perceive and respond to sexual issues. In this study, male students exhibited higher sexual myth scores compared to female students, a finding consistent with previous research indicating that men tend to hold stronger sexual myths and experience greater discomfort in addressing sexuality within professional contexts.[6,13,14,26] This pattern may reflect broader gender norms in which male students internalize more traditional beliefs and face additional barriers to discussing sexuality openly. Previous research supports this interpretation, indicating that gender differences constitute a significant barrier in addressing patients' sexual health. For example, Bdair and Constantino (2017) found that male nurses experience greater discomfort when providing sexual healthcare, particularly when caring for

patients of the opposite sex.[27] These findings highlight the importance of fostering self-awareness among health professional students regarding their sexual myths and gendered beliefs, as well as integrating reflective and gender-sensitive training approaches to enhance competence in sexual health communication.

In this study, second-year students demonstrated higher sexual myth scores than fourth-year students. This finding aligns with previous research showing that sexual myths and negative attitudes tend to decrease as students progress through their education, gain experience, and receive more exposure to sexuality-related topics.[6,12,28–30] The decline in sexual myths with advancing education may be attributed to the cumulative effects of theoretical learning, professional socialization, and clinical practice, which promote greater awareness and comfort in addressing sexuality. Although the overall sexual health scores in this study were relatively low[15,31] fourth-year students reported greater ease in communicating with future patients, likely reflecting the impact of internship experience. Consistent with prior studies, this suggests that increasing knowledge alone is not sufficient for competence in sexual counseling; attitudinal change and experiential learning are also essential components.[6,12,13,17,32] Although the regression models in this study were statistically significant, their explanatory power was relatively low (R^2 = 8%, 20%). This indicates that while the variables examined provide valuable insight into sexual myths and sexual health attitudes, other unmeasured factors—such as personal values, social norms, and educational climate—may also contribute to these relationships. Future studies should explore these additional determinants to build a more comprehensive understanding of the factors influencing sexual health competence.

Strengths and limitations

Although the sample size of this study allowed for robust data analysis, the fact that the majority of participants were female limits the generalizability of the findings. Since most of the participants were from midwifery and nursing departments, the results may not fully represent students from other health disciplines. In addition, participants were recruited through social media and WhatsApp groups using convenience sampling, which may have introduced selection bias and further limited representativeness.

Conclusion and recommendations

In this study, a negative relationship was determined between Muslim health students' belief in sexual myths and their attitudes toward addressing sexual health in their future professions. Muslim students' sexual myth levels and sexual health scale scores were at moderate levels. It was observed that department, school year, and gender variables affected sexual myth levels and sexual health scale scores. These findings highlight the need for structured and comprehensive sexual health education within health curricula to help students develop positive, evidence-based attitudes toward sexuality. Integrating sexual health topics into undergraduate programs, with particular emphasis on reflective, gender-sensitive, and culturally aware approaches, may improve future healthcare professionals' competence and confidence in addressing sexual health issues. Furthermore, continuing education and training opportunities focusing on sexual health communication should be encouraged to ensure that future practitioners can provide holistic and inclusive care.

Authors contributions

RO: Conceptualization, Data curation, Literature Review, Funding acquisition, Investigation, Project administration, Resources, Supervision, Writing - original draft, Writing - review & editing.
SDA: Conceptualization, Data curation, Formal analysis, Investigation, Methodology, Software, Validation, Visualization, Writing - original draft, Writing - review & editing.
ND: Conceptualization, Data curation, Investigation, Writing - original draft, Writing - review & editing.
ASK: Conceptualization, Data curation, Investigation, Writing - review & editing.

Competing interests

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