Policy Analysis of Family Planning: Enhancing Coverage through Community Participation

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Abstract

Introduction: Family planning is a cornerstone of public health and sustainable development. In Oman, modern contraceptive prevalence remains substantially below the OECD average despite free provision through a well-established public health system. Persistent cultural, social, and structural barriers continue to limit uptake. This study analysed demand-side determinants of low utilisation and evaluated additional policy options using a structured framework.

Methods: A policy analysis was conducted using Weimer and Vining's five-step framework. The status quo and three demand-side alternatives were assessed: (a) multisectoral reproductive health education for youth, (b) a national reproductive health campaign, and (c) community participation in family planning. Each option was evaluated against predefined criteria of financial sustainability, equity, political feasibility, and externalities, based on a structured synthesis of peer-reviewed and grey literature applied consistently across all four options.

Results: Ministry of Health records document modern contraceptive prevalence at 15.3%, any-method prevalence at 24.4%, and unmet need at 55.9% among married women aged 15-49, confirming a utilisation rather than availability gap. The status quo scored low on equity despite universal service access. Alternative 1 (youth education) offered strong equity benefits but faces cultural and inter-sectoral feasibility constraints. Alternative 2 (national campaign) achieved high reach but evidence suggests limited sustained behavioural impact without community reinforcement. Alternative 3 (community participation) performed best overall, scoring high on equity, political feasibility, and long-term sustainability.

Conclusion: Community participation is the most appropriate additional policy option for Oman, addressing cultural sensitivities, enhancing equity, and supporting sustainable improvements in family planning coverage, aligned with commitments to Universal Health Coverage and the Sustainable Development Goals.

Keywords: Family planning; policy analysis; health systems; GCC countries; reproductive health; contraceptive utilisation; Oman

Introduction

Family planning is a globally recognised cornerstone of public health and sustainable development [1,2]. Approximately 121 million pregnancies are unintended annually, with over 60% ending in abortion [3], carrying wide-ranging implications for maternal health, poverty, and women's economic participation [4]. Within the Sustainable Development Goals, family planning is consistently identified as a development best buy [4,5].

Oman provides free contraceptive services through its public health system, with the Birth Spacing Programme now in its fourth edition [6]. Uptake nonetheless remains limited. The most recent nationally representative survey estimated any-method prevalence among married women at approximately 38% [7], while Ministry of Health programme records report modern contraceptive prevalence at 15.3% and any-method prevalence at 24.4% [8,9], substantially below the OECD average exceeding 80% [10]. Cultural and religious norms,

information asymmetries, and limited spousal involvement continue to constrain uptake [7,11]. Although Oman's Vision 2040 health agenda prioritises governance, non-communicable disease prevention, and digital transformation, family planning coverage is not identified as a distinct strategic target within its implementation framework [12]. Similarly, GCC health reform initiatives such as Saudi Arabia's Vision 2030 and Qatar's National Health Strategy 2018-2022 address preventive health primarily through non-communicable diseases (NCD) and service quality lens, without identifying contraceptive utilisation as a measurable outcome [13,14]. Globally, a multi-country synthesis of 52 primary healthcare case studies across 42 countries identified family planning consistently among the most prioritised health service areas, with persistent demand-side challenges, including evolving social norms, spousal refusal, and restricted adolescent access, that closely parallel those documented in Oman and the Gulf Cooperation Council (GCC) countries [15]. The 30th anniversary of the 1994 International Conference on Population and Development has reinforced a global call for person-centred, rights-based approaches foregrounding women's agency [5,16], while the WHO health systems framework affirms that weaknesses in governance, financing, or community engagement can each independently constrain outcomes [17,18].

No structured policy analysis has systematically evaluated alternative strategies for improving family planning coverage within Oman's cultural and governance context. This study addresses that gap by: (i) examining current family planning policy and utilisation in Oman; (ii) applying Weimer and Vining's five-step framework to evaluate the status quo and three demand-side alternatives against criteria of financial sustainability, equity, political feasibility, and externalities; and (iii) recommending the most appropriate policy option aligned with national development goals.

Methods

Study Design

This study employed a policy analysis design guided by Weimer and Vining's five-step framework: problem definition, identification of evaluative criteria, generation of alternatives, systematic assessment, and recommendation [19]. The analysis was conducted in 2025, drawing on published systematic reviews, official national policy documents, and WHO and World Bank secondary data rather than primary data collection.

Contraceptive Prevalence and the Policy Problem

Contraceptive prevalence data were compiled from the UN Population Division Family Planning Indicators 2024, World Bank World Development Indicators, Ministry of Health Annual Health Reports 2023 and 2024, and country-level Demographic and Health Surveys [8,9,20,21], organised by World Bank income classification to enable comparison across GCC countries, OECD benchmarks, and Muslim-majority comparators. This comparison is presented in Table 1 and provides empirical grounding for the central argument that demand-side barriers, not income level or religious context, are the primary determinants of low contraceptive utilisation across the GCC.

Policy Options

The status quo and three additional demand-side policy alternatives were evaluated: multisectoral reproductive health education for youth (Alternative 1), a national reproductive health media and communication campaign (Alternative 2), and community participation in family planning (Alternative 3). These represent the principal demand-side intervention approaches documented in the global family planning literature [22,23,24,25]. All three are evaluated as demand-side complements to existing free contraceptive provision, not as replacements for it.

Evaluative Criteria

Each option was assessed against four predefined criteria [19,26]: financial sustainability, defined as cost to the health system, cost-effectiveness, and long-term efficiency; equity, encompassing fair access across demographic, geographic, and socioeconomic groups including youth and rural women; political feasibility, including cultural acceptability, alignment with Islamic values, and institutional complexity; and externalities and trade-offs, comprising unintended effects on gender norms, stigma, and social cohesion.

Data Sources

The analysis drew on a structured synthesis of secondary data and published literature, including WHO and World Bank global monitoring reports, UN Population Division Family Planning Indicators, Ministry of Health Oman annual health reports and programme guidelines, and peer-reviewed studies on contraceptive use and reproductive health policy in Oman, the GCC, and comparable settings. Literature was identified through targeted searches of PubMed and Google Scholar, supplemented by reference tracking and review of WHO, World Bank, and UN repository documents. Where Oman-specific evidence was unavailable, comparable GCC or MENA settings were used as proxies. Health system readiness scores from the Global Contraception Policy Atlas-MENA 2023 and Europe 2026 editions-were incorporated to complement utilisation data, measuring institutional commitment to family planning, contraceptive supply access, and public health information availability [27,28].

Analytical Approach

Policy options were evaluated through an a priori matrix structured around the four criteria above. Impact ratings of Low, Medium, or High were assigned based on the weight and consistency of the evidence. The use of predefined criteria and a standardised rating scale imposes analytical discipline, reducing the risk of arbitrary judgement and providing a transparent, reproducible basis for comparison. This process is inherently interpretive, and rating subjectivity is acknowledged as a study limitation. Results are presented in Table 2. Health system readiness scores from the Global Contraception Policy Atlas are reported separately in Table 3. Financial sustainability ratings are directional, inferred from international cost-effectiveness evidence rather than Oman-specific or GCC-specific cost data, which do not currently exist; this criterion therefore carries lower discriminatory power than the other three.

Results

Problem Analysis

Family planning in Oman demonstrates a persistent mismatch between awareness and utilisation. Over 90% of women report knowledge of family planning methods; however, fewer than 40% adopt modern contraceptives [7]. Ministry of Health Annual Health Reports document that total family planning use among currently married women aged 15-49 stands at 24.4%, disaggregated into modern methods (15.3%) and traditional methods (9.1%), with withdrawal alone accounting for 5.1% of all use [8,9]. Unmet need for family planning was documented at 55.9%, comprising 31.8% for spacing and 24.1% for limiting [8,9]. The substantial share of traditional method use and the high unmet need confirm that barriers are demand-side rather than access-related.

Three primary causes were identified. First, cultural sensitivities, provider biases, and misconceptions reduce uptake despite financial access [7]. Second, adolescents and unmarried youth often lack accurate reproductive health information due to stigma and restrictive norms [29]; birth spacing services are available to unmarried women under the 2025 guidelines, with guardian approval required for minors [6]. Third, information asymmetry between couples undermines shared decision-making. In Oman, patient rights frameworks emphasise privacy, dignity, and respect for cultural values, while healthcare facility regulations support environments that protect these principles, which may contribute to gender-sensitive care arrangements and, particularly in obstetric and gynaecological outpatient clinics and hospital visits, limited access of male companions during clinical consultations [30,31,32]. In the context of family planning, this structural arrangement may constrain opportunities for combined spousal consultation, contributing to the information asymmetry between partners that the literature identifies as a key driver of low contraceptive uptake [7,11]. This structural feature has not been formally documented in the published literature and warrants systematic investigation. These factors confirm that Oman's challenge is a policy implementation gap, not a service availability gap.

The prevalence estimate of approximately 38% any-method use derives from the most recent nationally representative survey [7], with Ministry of Health Annual Health Reports 2023 and 2024 providing the most current official programme figures [8,9]. The absence of a more recent national survey is itself a governance gap that this study recommends addressing as part of the monitoring phase of the proposed roadmap.

Table 1 places Oman and the GCC countries within a broader global context by comparing contraceptive prevalence across World Bank income groups and Muslim-majority comparators. The data

demonstrate that GCC countries High Income countries perform less than at the level of Lower-Middle Income Muslim-majority countries in contraceptive uptake, an income-uptake paradox that cannot be explained by financial constraints or religious context, and that points to GCC-specific demand-side governance and structural barriers as the primary drivers of low utilisation.

Table 1: Any method and modern method contraceptive prevalence rates (CPR) among married women aged 15-49, with traditional method gap, grouped by region and World Bank income classification. Source: UN Population Division Data Portal, population.un.org (accessed March 2026). 2026 figures are modelled projections (proj).

Country	WB Income Group	Any Method CPR (%)	Modern Method CPR (%)	Gap (pp)	Year	Primary Source
Bahrain	High Income	63.4	45.1	18.3	2026 proj.	UN Population Division 2026
Kuwait	High Income	60.5	50.0	10.5	2026 proj.	UN Population Division 2026
UAE	High Income	53.7	42.8	10.9	2026 proj.	UN Population Division 2026
Qatar	High Income	51.0	42.7	8.3	2026 proj.	UN Population Division 2026
Saudi Arabia	High Income	42.0	34.6	7.4	2026 proj.	UN Population Division 2026
Oman	High Income	39.5	27.5	12.0	2026 proj.	UN Population Division 2026
Morocco	Lower-Middle Income	71.2	62.0	9.2	2026 proj.	UN Population Division 2026
Egypt	Lower-Middle Income	62.6	60.6	2.0	2026 proj.	UN Population Division 2026
France	High Income	78.4	75.3	3.1	2026 proj.	UN Population Division 2026
United Kingdom	High Income	76.1	69.3	6.8	2026 proj.	UN Population Division 2026

CPR = Contraceptive Prevalence Rate. Gap (pp) = any method CPR minus modern method CPR, representing the proportion of contraceptive use attributable to traditional methods. WB = World Bank. proj. = UN modelled projection. All figures are for married or in-union women, female sex, age 15-49.

Policy Options Evaluated

Free contraceptive provision through the public health system is a permanent structural commitment that will continue regardless of which additional policy is adopted. The three alternatives evaluated below are not substitutes for this provision; they are complementary demand-side strategies designed to enhance utilisation of services that already exist. This additive logic is reflected in the study's title and is consistent with the Weimer and Vining analytical framework, which evaluates policy alternatives against a defined status quo baseline rather than treating them as mutually exclusive choices.

Status Quo: Free Contraceptive Provision

The current policy guarantees free contraceptive access through primary healthcare centres [7,33]. Its political stability and financial sustainability are strengths. However, it does not address demand-side barriers including stigma, limited health literacy, and information asymmetry [34]. Internationally, youth and rural women remain disproportionately underserved despite universal availability [35,36].

Alternative 1: Multisectoral Youth Reproductive Health Education

Integrating reproductive health education into schools and universities could improve equity and informed decision-making across socioeconomic groups [22,23,37]. However, implementation requires coordination across the Ministries of Health and Education, with cultural and religious sensitivities increasing complexity [29,36]. Long-term benefit through reduced unintended pregnancies are anticipated [38].

Alternative 2: National Reproductive Health Campaign

A national campaign could correct misconceptions and reach urban and rural populations [39]. However, such campaigns require substantial upfront investment [24] and evidence consistently shows they improve short-term awareness without sustaining behavioural change unless reinforced by community-based interventions [22,37]. Risk of sociopolitical backlash in culturally conservative settings is a further concern [36].

Alternative 3: Community Participation in Family Planning

Engaging communities, religious leaders, and civil society organisations in the co-design and delivery of family planning initiatives enhances cultural tailoring, trust, and acceptability [25]. This approach improves equity and political feasibility by aligning services with local values [35]. Community ownership supports long-term sustainability [24,25]. Oman's primary care system and national birth spacing guidelines already recognise the importance of spousal and community involvement in reproductive health counselling, providing an institutional foundation for formalising this approach [6,7]. Effective implementation requires four enabling conditions: (i) policy formalisation, roles, functions, and authority must be codified in legislation rather than left to informal arrangements that lack legitimacy and are vulnerable to dissolution; (ii) transparent community representation, standardised selection processes are essential to ensure representatives genuinely reflect community needs; (iii) institutional capacity support the health system must actively invest in building community structures rather than relying on organic development; and (iv) administrative training of community representatives require substantive, ongoing training in health system functions, participatory governance, and community engagement. Without these four conditions, participatory structures risk becoming informal bodies without defined authority, a pattern documented across diverse health system contexts [40,41].

Evaluation framework: Weimer & Vining policy analysis criteria. Alternatives 1-3 are assessed as demand-side interventions complementary to the status quo (free contraceptive provision), not as replacements. Rating scale - High: strong, convergent evidence supporting effectiveness; Medium: mixed or context-dependent evidence; Low: limited effectiveness or significant implementation barriers. RH = Reproductive Health.

Table 2. Comparative Assessment of Family Planning Policy Options in Oman.

Criterion	**Sub-criterion**	**Status Quo** **Existing free provision**	**Alt. 1** **Youth Education**	**Alt. 2** **Awareness Campaign**	**Alt. 3** **Community Participation**
A. Financial Sustainability					
	Cost to health system	Medium free access sustained by public funding 21,26	Medium multisectoral collaboration may optimise costs 22,23	Medium upfront investment; potential long-term savings 15,24	Medium co-design improves resource efficiency 15,25

	Efficiency of resource allocation	Low persistent underutilisation; supply-focused 7,34	High early education reduces unplanned pregnancies 22,23	High awareness reduces associated downstream costs 15,24	High community-led initiatives improve adherence and uptake 15,25,35
B. Equity					
	Universal access	Low youth and rural women persistently underserved 7,35,36	High school programmes reach diverse socioeconomic groups 22,23	High campaigns reach marginalised and geographically dispersed populations 15,36,39	High co-design addresses group-specific barriers to access 15,25,35,40
	Addressing all demographics	Low utilisation disparities across age, geography, and parity remain unresolved 35,36	High curricula tailored to diverse youth needs and development stages 22,29	High messaging designed for inclusive demographic reach 36,39	High participatory design; established precedent in Oman context 15,25,40
C. Political Feasibility					
	Political acceptability	High entrenched model; politically stable and institutionally embedded 6,33	Medium cultural and religious sensitivities require careful stakeholder navigation 29,36	Medium requires sustained cross-sector endorsement; risk of policy fatigue 15,36,39	High promotes cultural alignment; prior community health precedent in Oman 25,36,40
	Implementation complexity	Medium existing infrastructure may be insufficient to support demand-generation functions 33	Medium requires new inter-ministry partnerships and cross-sectoral coordination 22,29	Medium demands comprehensive planning, phased rollout, and systematic evaluation 24,39	Medium builds on existing community structures; lower institutional burden 25,40
D. Externalities and Trade-offs					

	Gender equity and stigma effects	Low may reinforce paternalistic norms; limited demand-side engagement [34,40]	High normalises reproductive health discourse; risk of sociocultural backlash if content is not contextually sensitive [5,29,36]	Medium broad reach may reduce stigma; sociopolitical risk if messaging misaligned with cultural norms [15,36]	High strengthens gender equity and male involvement; risk of norm reinforcement if participatory processes are not sufficiently inclusive [15,25,36,40]

Source: Author compilation. Evidence ratings reflect synthesis of peer-reviewed literature and policy documents cited. All alternatives presuppose retention of universal free access to contraception as the supply-side foundation.

Comparison of Options

Community participation (Alternative 3) was rated highest overall, scoring High on equity, political feasibility, and long-term sustainability across all four evaluative criteria, consistent with evidence from multi-country primary healthcare syntheses and community-based programmes in comparable settings [15,25,42]. It is the only option capable of addressing demand-side barriers simultaneously across multiple health system dimensions [17,18]. Evidence from comparable settings further indicates that every USD $1 invested in family planning yields approximately USD $23 in cross-sector savings [38], strengthening the economic case for this approach.

Across all four criteria, financial sustainability showed the least discriminatory power, with all options rated Medium on direct cost to the health system. This uniformity reflects the absence of Oman-specific or GCC-specific costing data rather than genuine equivalence; the recommendation therefore rests principally on equity, political feasibility, and externalities, where the evidence is stronger and more contextually grounded.

Table 3 provides a complementary policy environment perspective. Oman's health system readiness score of 18.6% is the lowest among GCC countries and falls substantially below Egypt (53.1%) and Morocco (51.3%), both Lower-Middle Income countries, confirming that the utilisation gap reflects not only demand-side cultural and structural barriers but also opportunities to strengthen the governance infrastructure supporting contraceptive access [27,28].

Policy environment scores measure health system readiness across institutional commitment to family planning, contraceptive supply access, and public health information availability. Scores are composite indices and do not measure contraceptive prevalence or actual utilisation rates.

Table 3: Contraception Policy Environment and Health System Readiness Scores: Selected Countries (2023 and 2026).

Rank	**Country**	**Region**	**Score (%)**	**WB Income Group**	**Source**
OECD Countries - High Income					
1	France	OECD	97.9%	High Income	EPF Europe Atlas, 2026
2	United Kingdom	OECD	95.8%	High Income	EPF Europe Atlas, 2026
Arab Region - Lower-Middle Income					

3	Egypt	MENA	53.1%	Lower-Middle Income	EPF MENA Atlas, 2023
4	Morocco	MENA	51.3%	Lower-Middle Income	EPF MENA Atlas, 2023
GCC Countries - High Income					
5	Qatar	GCC	44.2%	High Income	EPF MENA Atlas, 2023
6	United Arab Emirates	GCC	34.2%	High Income	EPF MENA Atlas, 2023
7	Saudi Arabia	GCC	32.5%	High Income	EPF MENA Atlas, 2023
8	Bahrain	GCC	32.2%	High Income	EPF MENA Atlas, 2023
9	Kuwait	GCC	20.3%	High Income	EPF MENA Atlas, 2023
10	Oman	GCC	18.6%	High Income	EPF MENA Atlas, 2023

Score interpretation: ≥80% - strong policy environment; 50-79% - moderate; 30-49% limited; <30% - weak.

Note: MENA scores from EPF Global Contraception Policy Atlas: Middle East and North Africa 2023 (data collected 2022, validated by the Arab Institute for Women). Europe scores from EPF Global Contraception Policy Atlas: Europe 2026. The two editions have different reference years and scores are not directly time comparable. GCC countries are all classified as World Bank High Income; Egypt and Morocco are Lower-Middle Income comparators.

Discussion

The structured analysis confirms that Oman's family planning utilisation gap is primarily demand-side in nature and requires policy interventions that go beyond supply-side provision. Among the options evaluated, community participation demonstrated the strongest and most consistent evidence base across all four criteria, and its alignment with Oman's cultural, governance, and institutional context distinguishes it from the alternatives.

Community Participation as a Health Systems Strategy

The conditions necessary for effective community participation in family planning, accountability in recruitment, engagement of existing community structures, trust-building through credible intermediaries, and facilitative strategies addressing the feminisation of services, have been empirically validated across diverse settings [25]. Community health worker models in comparable culturally conservative contexts have demonstrated measurable increases in contraceptive prevalence by addressing stigma through trusted community figures [42]. Case-study evidence from Indonesia, the world's largest Muslim-majority country, further demonstrates that participatory communication involving healthcare workers, community leaders, and religious organisations was pivotal in overcoming cultural and religious barriers to family planning uptake [43]. The convergence of this evidence across culturally comparable settings strengthens the transferability of Alternative 3 to Oman's context.

Framed through the WHO health systems building blocks [17], community participation is not a single-point intervention but a systemic one. It simultaneously strengthens service delivery through cultural co-design, extends workforce reach through community advocates and religious leaders, improves health information systems through real-time community feedback, enhances financing efficiency by targeting demand rather than supply, and builds governance legitimacy by grounding services in local priorities. This

multi-building-block impact is what distinguishes Alternative 3 from Alternatives 1 and 2, both of which address individual demand-side levers without producing the same systemic effect.

Regional Policy Lessons

The GCC pattern, high income, universal service access, persistently low contraceptive utilisation, confirms that financial and infrastructural investment alone is insufficient to close the utilisation gap. Saudi Arabia's community health volunteer programmes under Vision 2030 have been deployed for non-communicable disease prevention but not formally evaluated for reproductive health [13], representing a regional evidence gap that Oman could address by rigorously evaluating Alternative 3 implementation. Qatar's experience similarly demonstrates the challenge of translating health equity frameworks into culturally responsive reproductive health practice [14,36]. Within Oman, Vision 2040 prioritises governance, digital transformation, and non-communicable disease prevention without identifying family planning coverage as a distinct strategic target [12], creating a specific policy space that the recommendation of this study is designed to fill.

OECD benchmarks consistently attribute high contraceptive uptake to sexuality education, male engagement, and community participation rather than to service availability alone [10,35,39]. This reinforces the conclusion that the demand-side strategy represented by Alternative 3 is the appropriate policy direction for Oman and potentially for GCC health system reform more broadly [15,40].

Policy Implications: A Strategic Roadmap

Phase 1- Community Co-Design (0–12 months): Engage community and religious leaders in participatory needs assessment and programme co-design, with formal codification of roles and authority in line with the National Health Policy [12,40]. Align messaging with Islamic family values and the objectives of the Birth Spacing Programme [6].

Phase 2- Capacity Building and Service Redesign (12-36 months): Train community health advocates to extend counselling beyond clinical settings [5,40]. Review structural arrangements governing male companion access in outpatient clinics and hospital visits to identify barriers to combined spousal consultation and develop evidence-based recommendations to facilitate joint attendance where clinically appropriate and culturally acceptable [30,31,32]. Establish adolescent-sensitive reproductive health services with guardian-inclusive pathways consistent with national legal requirements [6].

Phase 3- Monitoring, Evaluation, and Iteration (36+ months): Deploy disaggregated health information systems to monitor contraceptive uptake by age, sex, region, and method. Conduct mixed-methods evaluation to assess impact and inform iterative improvement. Economic evaluations should quantify cross-sector benefits from averted unintended pregnancies [38].

Limitations

This study has four principal limitations. First, the analysis relies on secondary data and published literature; demand-side nuance may be underestimated, and the proposed model requires formative qualitative research with women, men, youth, religious leaders, and policymakers prior to implementation. Second, feasibility ratings were based on literature and contextual knowledge rather than direct stakeholder interviews, which is an inherent limitation of the policy analysis method; assessments were grounded in a structured evidence synthesis applied consistently across all options using predefined criteria, though the interpretive nature of this process is acknowledged. Third, the most recent nationally representative prevalence survey dates from 2019 [7]; a dedicated national reproductive health survey should be prioritised as a governance imperative. Fourth, generalisability to other GCC settings requires contextual adaptation given differences in governance structures, health system maturity, and social norms. Additionally, financial sustainability ratings are based on transferable international cost-effectiveness evidence rather than Oman-specific or GCC-specific cost data, which do not currently exist in the published literature; prospective costing studies for demand-side family planning interventions in Gulf health systems represent an important evidence gap.

Conclusion

The evidence base supports community participation as the most appropriate policy direction for improving family planning coverage in Oman. It addresses the demand-side determinants of underutilisation that supply-side approaches have demonstrably not resolved, it is feasible within Oman's cultural and institutional context, and it generates the kind of systemic health system strengthening that aligns with both Vision 2040 objectives and global reproductive health commitments. Prospective implementation with rigorous mixed-methods evaluation would generate evidence of direct value to Oman and of wider relevance to GCC health system reform.

Adopting this approach would strengthen Oman's commitments to Universal Health Coverage and directly support SDG 3 (good health and well-being), SDG 5 (gender equality), SDG 10 (reduced inequalities), and SDG 17 (partnerships for the goals) [4,5].

Ethics Statement

This study is a policy analysis based exclusively on publicly available documents, secondary data, and published literature. It did not involve human participants or identifiable personal data. Ethical approval and informed consent were not required.

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Author Contributions

JA: Conceptualisation, Methodology, Formal Analysis, Writing - Original Draft, Writing - Review and Editing. SA: Conceptualisation, Writing - Review and Editing. Both authors approved the final version.

Conflicts of Interest

The authors declare no conflicts of interest.

Data Availability Statement

Data will be provided upon reasonable request from the corresponding author.

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