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RESEARCH ARTICLE

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Contemporary perspectives regarding domestic violence and abuse in primary care: Cross-sectional NHS patients survey

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KEY MESSAGES

- Most patients are aware of domestic violence and abuse (DVA), but many are unclear about its signs, highlighting the need for public education.
- NHS patients trust healthcare providers to conduct sensitive screenings with standardised tools like WAST-short.
- Incorporating these tools into routine practice could strengthen DVA interventions and support efforts.

ABSTRACT

Background: Primary care plays a key role in addressing domestic violence and abuse (DVA) globally. However, DVA remains underdiagnosed and inadequately addressed in primary care, necessitating a deeper understanding of patients' perspectives in the UK.
Objectives: To explore patients' perceptions of their awareness of DVA signs and their attitudes towards using the Woman Abuse Screening Tool (WAST)-short during routine primary care encounters.
Methods: An anonymous 29-item e-Survey, available in 18 languages and including information about DVA support services, was administered via the Qualtrics XM Platform™ from March to October 2022. Eligible UK National Health Service patients aged 18+ were identified by GP practices in Northwest London and invited via SMS to participate.
Results: Data were collected from 6,967 NHS patients. The majority (78.0%) claimed awareness of the signs of DVA in adults and children, while about 22% were unaware or unsure of the signs of DVA. Nearly 85% reported insufficient public awareness about DVA. Around 70% recommended implementing the WAST-short screening tool during primary care encounters to raise awareness and support survivors. Over 50% viewed general practice as the optimal setting for identifying and referring survivors.
Conclusion: Improved public education on DVA is needed, as a significant proportion of patients remain unaware or unsure of its signs, with the majority deeming public knowledge insufficient. Patients' strong support for using standardised screening tools like the WAST-short reflects their trust in healthcare providers to conduct sensitive assessments. Integrating these tools into routine practice could enhance DVA interventions.

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Domestic violence; primary care; public health; primary prevention

Introduction

Domestic violence and abuse (DVA) is a global public health concern, characterised by abusive, coercive, or controlling behaviour between intimate partners or family members [1]. Research shows violence is often learned and transmitted across generations, frequently accompanied by psychological and, in many cases, sexual abuse [2]. DVA remains hidden due to fear and stigma, significantly impacting mental health and perpetuating cycles of abuse, particularly among children [3]. The NHS faces significant challenges from DVA, as survivors frequently endure it for years before seeking help, often attending multiple GP visits, which creates crucial opportunities for intervention and support.

In the year ending March 2023, 20% of UK adults had experienced DVA since age 16 [4]. DVA incurs

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profound socio-economic costs, affecting survivors, perpetrators, and dependents [5]. The World Health Organisation advocates for early identification and intervention, emphasising the role of primary care, which is well-positioned to initiate discussions on DVA. However, these opportunities are often missed due to the sensitive nature of the issue [6]. Clinicians report barriers such as inadequate training, fear of offending patients, and uncertainty about effective interventions [7]. Cultural biases, scepticism and high workloads further complicate addressing DVA in general practice.

Survivors' generally desire healthcare providers to enquire about DVA [8], with most open to such discussions [9]. Yet, studies indicate under-identification, with a survey showing nearly two-fifths of women in general practice experienced DVA, but few were asked about it [10]. Time constraints and discomfort hinder clinicians from addressing DVA [11], but identifying and treating survivors in primary care, even without visible injuries, is crucial for achieving 'health for all'. Effective DVA identification in primary care requires risk assessments, survivor safety considerations and appropriate referrals [12], but reluctance persists despite training [13], which can lead to hypermedicalisation, overuse of healthcare systems, misdiagnosis, and, in extreme cases, death.

Screening for DVA is accepted in various healthcare settings [14, 15] improving early survivor identification and health outcomes [16]. In countries like the United States, routine screening is recommended for women in primary and prenatal care [17], enabling early detection and intervention. However, the evidence on screening versus clinical enquiry is conflicting [14], with no clear indication of which is more effective [17], resulting in variance with WHO [18] and NICE guidelines [19]. Screening programs are similar to targeted enquiry approaches [17], but require validated tools, standardised algorithms, and the removal of provider barriers [15].

Several brief screening tools such as HITS (Hurt/Insult/Threaten/Scream) [20] and HARK (Humiliation/Afraid/Rape/Kick) [21] are effective in primary care. Broad labelling questions are ineffective, while short screening tools better identify DVA [22]. The Woman Abuse Screening Tool (WAST) has shown high reliability and sensitivity [23, 24]. A shorter version, WAST-Short, has been validated [25] for use in busy clinics, offering a feasible option for early DVA detection. Clinicians and patients report comfort using these tools [25], highlighting their potential for broader implementation in primary care settings.

Our study explored patients' perceptions of DVA, their awareness of signs, and attitudes towards using the WAST-short tool in routine primary care. We also analysed the association between reported history of abuse and awareness of DVA signs, and evaluated comfort levels with the WAST-short tool.

Methods

Study design

This cross-sectional survey targeted NHS patients, using an anonymous 29-item electronic questionnaire (see Supplementary Material) created by the research team, piloted, and refined for study goals. Conducted on the Qualtrics platform (Version XM) from 3 March to 7 October 2022, it gathered data from patients across GP practices in Northwest London (NWL). Practices identified participants and sent SMS links to the survey and the Participant Information Sheet (PIS), which detailed available domestic violence and abuse (DVA) support services. Participation was voluntary and anonymous, with support information accessible throughout the survey. Reporting followed the Checklist for Reporting Results of Internet E-Surveys.

Participant recruitment

The survey included UK residents aged 18 and above, with NWL selected for its diverse demographics, allowing participants to share perspectives on this sensitive issue anonymously.

Electronic survey

The Qualtics survey contained 29 questions available in 18 languages (English, Arabic, Bengali, Chinese (simplified), Chinese (traditional), French, German, Hindi, Italian, Persian, Polish, Portuguese, Sinhalese, Somali, Spanish, Tamil, Turkish and Urdu). It explored experiences with DVA, public opinions on routine screening, and support for abuse survivors in general practice. The validated Woman Abuse Screening Tool (WAST)-short [23], assessed relationship tension and argument difficulty, accurately identifying 100% of non-abused women and 91.7% of abused women (both English-speaking and Non-English speaking) [25]. We chose this non-threatening, gender-neutral screening tool to analyse its suitability in our society. The two-item tool minimised survey length, helping prevent participant fatigue. The WAST-Short score was calculated by the addition of the points allocated to the answers to the two questions: (i) Tension in a relationship (no tension =1, some tension = 2, a lot of tension = 3) and (ii) difficulty in working out arguments (no difficulty = 1, some difficulty = 2, great difficulty = 3). For example, a respondent answering 'a lot of tension' to the relationship question and 'some difficulty' to the working out arguments question would get a score of 5.

Statistical analysis

Data were analysed using Chi-squared tests to assess DVA awareness and history of abuse associations. The WAST-Short scores' link to screening recommendations and respondent comfort levels was analysed with the Kruskal-Wallis test, followed by Mann-Whitney U tests with Bonferroni adjustments for pairwise differences. Statistical significance was set at $p < 0.05$, and analysis was performed with IBM SPSS version 27.0.

More details on materials and methods used are described in Supplementary File 1.

Ethics

This study was given ethical approval by the Imperial College London Research Ethics Committee (ICREC #21IC6721).

Results

Demographic profile of respondents

Seventeen general practices across Northwest London (NWL) participated in our study with 75,094 NHS patients identified as eligible to receive the e-Survey link via SMS. In total 6,967 patients clicked on the e-Survey link (response rate of 9.3%), of which 4,253 (61.0%) consented and completed the questionnaire (see Table 1). Exclusions included individuals who did not provide consent ($n = 4$) and those who clicked on the survey link, consented, but did not answer any questions 38.9% (2,710/6,967). The average age was 41.7 years, ranging from 18 to 99. Nearly half (46.4%) were aged 26–45, with a majority being female (73.2%). More than half of the respondents were of white ethnic background (52.4%), and a quarter were Asian (21.3%). Over half were partnered (32.8% married and 17.8% in a domestic relationship), and more than a third (35.7%) were single. Finally, more than two-thirds of the respondents (67.6%) held a university degree or higher and were in full-time employment (65.7%).

Table 1. Characteristics of respondents.

	N	(%)
Age		
18–25	678	(15.9)
26–35	1092	(25.7)
36–45	882	(20.7)
46–55	676	(15.9)
56–65	580	(13.6)
66 and Older	345	(8.1)
Gender		
Female	3114	(73.2)
Male	1061	(24.9)
Other	42	(1.0)
Ethnicity		
White	2227	(52.4)
Mixed/Multiple ethnic groups	257	(6.0)
Asian/Asian British	908	(21.3)
British Black/African/ Caribbean	415	(9.8)
Other	268	(6.3)
Education		
Secondary School	453	(10.8)
A levels/College	908	(21.6)
University Degree or higher	2845	(67.6)
Employment		
Employed (full or part-time)	2784	(65.7)
Retired	380	(9.0)
Unemployed	398	(9.4)
Unable to work	254	(6.0)
Other	424	(10.0)
Marital Status		
Married	1384	(32.8)
In a domestic relationship	750	(17.8)
Single	1506	(35.7)
Divorced/Separated	517	(12.2)
Widowed	64	(1.5)

Survey findings

Awareness and understanding of DVA. The majority (78.0%) of participants claimed awareness of the signs of DVA, while 22.0% expressed uncertainty or lack of awareness (Table 2). Most participants recognised signs of DVA in adults, including withdrawal/isolation (95.4%), physical injuries (93.8%), pressured into sex (91.2%), belittling (91.1%), financial control (90.3%), and other indicators. Similarly, they recognised signs in children, such as aggression (93.5%), mental illness (93.2%), school problems (91.2%), and various behavioural changes.

Perceptions about DVA. Most (84.9%) noted insufficient public awareness and a shortage of support services (46.1%), while nearly all (94.1%) believed HCPs should be trained in identifying and supporting DVA survivors (Table 2). Although more than half (51.8%) considered general practice as an ideal place to identify survivors, only 38.8% stated they would turn to it for help. Instead, they preferred seeking support from friends (63.5%), family (52.7%), police (48.3%), or helpline services (46.9%). About half (45.7%) were open to receiving additional information about DVA support services. Barriers to seeking help included fear (90.1%), stigma (85.7%), and a fear of not being believed (82.2%), among others.

History of DVA. Almost half (49.0%) of respondents confirmed experiencing DVA, with 6.1% choosing not

Table 2. Survey findings.

	N	(%)
Are you aware of the signs of domestic violence and abuse?		
Yes	3289	(78.0)
No	128	(3.0)
Unsure	797	(18.9)
Which of the following do you think are signs of domestic violence and abuse (DVA)? (Please select all that apply)		
Emotional abuse	4128	(97.5)
Controlling behaviour	4040	(95.4)
Financial abuse	3828	(90.4)
Sexual abuse	4038	(95.4)
Physical abuse	4121	(97.3)
Stalking and harassment	3732	(88.1)
Online or digital abuse (social media, SMS threats)	3608	(85.2)
Do you know if DVA is a criminal offence in UK?		
Yes	4013	(95.2)
No	201	(4.8)
Which of the following groups do you think are at an increased risk of DVA? (Please select all that apply)		
Teenagers	3492	(82.6)
Pregnant/A new mother	3494	(82.7)
Elderly	3489	(82.6)
LGBT	3306	(78.2)
Substance abuse problems	3588	(84.9)
Chronic illness or disability	3509	(83.0)
Mental illness	3803	(90.0)
Those isolated	3719	(88.0)
Language barrier	3473	(82.2)
In deprived conditions	3703	(87.6)
Ethnic minority	3352	(79.3)
Past violent relationship	3686	(87.2)
Which of the following do you think are signs of DVA in adults? (Please select all that apply)		
Being withdrawn or isolated	4015	(95.4)
Personality changes	3730	(88.6)
Finances controlled	3800	(90.3)
Often being unavailable	3423	(81.3)
Internet monitored	3668	(87.1)
Physical injuries	3949	(93.8)
Being belittled	3835	(91.1)
Pressured into sex	3841	(91.2)
Told being overreacting	3664	(87.0)
Worried about pleasing their partner	3757	(89.2)
Wearing clothes that do not fit the season	3281	(77.9)
Which of the following do you think are signs of DVA in children? (Please select all that apply)		
Being aggressive	3914	(93.5)
Anti-social behaviour	3794	(90.7)
Mental illness	3899	(93.2)
Attention-seeking	3613	(86.3)
Bed-wetting, nightmares or insomnia	3766	(90.0)
Regularly feeling sick	3518	(84.1)
Substance abuse	3610	(86.3)
Eating disorders	3719	(88.9)
Problems in school	3816	(91.2)
Being withdrawn	3769	(90.1)
Animal cruelty	3539	(84.6)
The following questions will ask you about your personal experiences or opinions about DVA. Have you experienced domestic violence and abuse?		
Yes	2074	(49.0)
No	1898	(44.9)
Would rather not say	257	(6.1)
What was/is your relationship with the abuser?		
Husband/ Wife	558	(27.1)
Partner	385	(18.7)
Ex-partner	731	(35.5)
Parent	595	(28.9)
Child	114	(5.5)
Friend	131	(6.4)
Colleague/Manager	128	(6.2)
Carer	35	(1.7)
Other	251	(12.2)
Would rather not say	76	(3.7)
This question relates to any relationship that has, or is currently causing you concern (e.g. partner, ex-partner, family member, close friend or carer). In general, how would you describe your relationship?		
No tension	1930	(46.4)
Some tension	1114	(26.8)

(*Continued*)

Table 2. Continued.

	N	(%)
A lot of tension	1116	(26.8)
Do you work out arguments with		
No difficulty	1549	(37.4)
Some difficulty	1436	(34.6)
Great difficulty	1162	(28.0)
How comfortable did you feel answering these questions? Level of tension in the relationship question		
Very comfortable	1802	(43.2)
Comfortable	1599	(38.3)
Uncomfortable	773	(18.5)
How comfortable did you feel answering these questions? Working out arguments in relationship question		
Very comfortable	1490	(37.8)
Comfortable	1558	(39.5)
Uncomfortable	894	(22.7)
Who would you approach for support/advice if you or someone you know experiences abuse? (Please select all that apply)		
General Practice	1637	(38.8)
Healthcare professional	1079	(25.6)
Pharmacist	255	(6.0)
Emergency services	1205	(28.6)
Police	2036	(48.3)
Helpline services	1978	(46.9)
Social media/online support groups	830	(19.7)
In-person support groups	988	(23.4)
Religious leader	471	(11.2)
Friends	2678	(63.5)
Family	2220	(52.7)
Marriage counsellor	556	(13.2)
No-one	542	(12.9)
Other	1414	(33.5)
To what extent do you agree with the following statements		
There is not enough awareness about DVA in the general public		
Agree	3584	(84.9)
Neither agree nor disagree	383	(9.1)
Disagree	254	(6.0)
General practice is the best setting to help identify & refer victims of DVA		
Agree	2142	(51.6)
Neither agree nor disagree	1181	(28.4)
Disagree	830	(20.0)
Healthcare providers should have adequate training to identify and support victims of DVA		
Agree	3899	(94.1)
Neither agree nor disagree	169	(4.1)
Disagree	77	(1.9)
Children should learn about DVA in schools		
Agree	3829	(92.7)
Neither agree nor disagree	221	(5.3)
Disagree	81	(2.0)
There are sufficient support services available for victims of abuse		
Agree	1060	(25.8)
Neither agree nor disagree	1154	(28.1)
Disagree	1897	(46.1)
There needs to be more funding, research & interventions to tackle DVA		
Agree	3669	(90.1)
Neither agree nor disagree	314	(7.7)
Disagree	89	(2.2)
Why do you think some victims of abuse don't get help/support? (Please select all that apply)		
Stigma	3624	(85.7)
Fear	3809	(90.1)
Mental illness	2917	(69.0)
Fear of not being believed	3476	(82.2)
Mistrust for the judicial system	3015	(71.3)
Lack of support	2823	(66.8)
Financial difficulties	2774	(65.6)
Do not want to trouble anyone	3069	(72.6)
Private matter	2790	(66.0)
Unaware they are experiencing abuse	3338	(78.9)
Other	606	(14.3)
Would you recommend that your GP/nurse do a short (1 min) screening questionnaire on ALL patients during routine visits to increase awareness, identify and support those experiencing abuse?		
Yes	2953	(69.7)
No	366	(8.6)
Unsure	917	(21.6)

Table 3. Association between history of abuse and awareness of the signs of domestic violence and abuse.

	History of abuse				
	Yes n (%)	No n (%)	WRNS n (%)	Total n (%)	*p*-value
Awareness of the signs of domestic violence and abuse					<0.001
Yes	1752 (85.0)	1350 (71.9)	171 (67.1)	3273 (78.0)	
No	35 (1.7)	84 (4.5)	7 (2.7)	126 (3.0)	
Unsure	274 (13.3)	444 (23.6)	77 (30.2)	795 (19.0)	

to disclose it. Those who reported DVA indicated as a source of abuse their current spouse or partner (45.8%), their ex-partner (35.5%), or a parent (28.9%).

The relationship between reported history of abuse and awareness of DVA signs was also examined (Table 3). A statistically significant difference was obtained between reported history of abuse and awareness of the signs of DVA ($p < 0.001$). Awareness of the signs of DVA is notably high among individuals with a reported history of abuse, at 85.0%. This awareness is slightly lower in those without a history of abuse, at 71.9%, and declined further to 67.1% among individuals with an unknown history of abuse, labelled WRNS. Uncertainty about the signs of DVA is highest in individuals without a history of abuse (23.6%) and those with an unknown history (30.2%), while only 13.3% of those with a history of abuse reported uncertainty.

Screening

The majority (69.7%) of respondents advocated for GPs/nurses to conduct short screening questionnaires during routine visits to enhance awareness and assist those facing DVA. However, 21.6% were uncertain, and only 8.6% disagreed with the routine screening (Table 2).

WAST-short tool

Nearly all (97.0%) respondents completed the WAST-short questionnaire. A significant proportion reported relationship tension (26.8%) and difficulty in resolving arguments (28.0% with great difficulty, 34.6% with some difficulty); Table 2. Most felt comfortable answering these questions (81.5% for tension, 77.3% for arguments).

We also explored the association between the WAST-short score and the recommendation for its use in general practice, and the respondents' comfort levels (Table 4). Those feeling uncomfortable with the 'tension' question and the 'working out arguments' question had significantly higher WAST-short scores compared to those who felt comfortable ($p < 0.001$) or very comfortable ($p < 0.001$), suggesting a dose-response relationship between the level of comfort and the WAST-short. When examining whether to recommend a GP/nurse for screening, we found no significant difference in WAST-short scores among the groups (*p*-value = 0.43).

Table 4. Association between WAST-short score, recommendation of using a short screening tool in general practice, and respondent comfort levels in answering the WAST-short questions.

	WAST-short score		
	Median (IQR)	*p*-value (Kruskal-Wallis test)	Post-hoc MWU *p*-value (Bonferroni Adjusted)
Recommend GP/nurse do a short screening		0.43	
Yes	4.0 (2.0, 5.0)		N/A
No	3.0 (2.0, 5.0)		N/A
Unsure	4.0 (2.0, 5.0)		N/A
Comfortable answering Level of tension in the relationship question		<0.001	
Very comfortable	2.0 (2.0, 4.0)		VC vs C: <0.001
Comfortable	4.0 (3.0, 5.0)		VC vs U: <0.001
Uncomfortable	5.0 (4.0, 6.0)		C vs U: <0.001
Comfortable answering Working out arguments in relationship question		<0.001	
Very comfortable	2.0 (2.0, 3.0)		VC vs C: <0.001
Comfortable	4.0 (3.0, 5.0)		VC vs U: <0.001
Uncomfortable	5.0 (4.0, 6.0)		C vs U: <0.001

Post-hoc MWU *p*-value adjusted using Bonferroni correction; statistically significant if $p < 0.0167$.
VC: Very Comfortable; C: Comfortable; U: Uncomfortable.
N/A: Not applicable.

Discussion

Main findings

Our study surveyed NHS patients in Northwest London (NWL) to assess awareness of domestic violence and abuse (DVA). While 78% of respondents recognised DVA signs, especially those with prior abuse experience, 22% were unsure or unaware of them. Nearly 85% highlighted a lack of public awareness. Although many viewed general practice as a potential setting for identifying DVA, there was reluctance to seek professional help due to stigma and reliance on informal support. Almost half reported personal abuse experiences, and nearly 70% supported using the WAST-short screening tool in primary care to raise awareness and aid survivors.

Strengths and limitations

The study's strengths include its large and diverse respondent pool, offering generalisable insights into DVA awareness and perceptions in primary care. The use of the WAST-short tool and statistical analysis provided valuable data on the association between abuse history and DVA awareness. However, the reliance on self-reported data presents limitations, such as response bias, social desirability, and recall issues. Additionally, the survey's online format may have excluded certain demographics, limiting its representativeness. The 61% completion rate is encouraging given the topic's sensitivity and typical online response rates [26]. Future studies should aim for broader demographic inclusivity, considering variables like age, socioeconomic status, and location to reduce bias.

One notable limitation is the sample's gender skew, as most respondents were female, potentially limiting the findings' applicability across genders. Furthermore, most respondents held university degrees and full-time employment, potentially underrepresenting those from lower educational and employment backgrounds. The cross-sectional design also precludes establishing causal relationships, and the study did not explore healthcare providers' perspectives. Future research should investigate the complexities of DVA screening across diverse settings, and assess the social, health, and economic benefits of different identification strategies.

Comparison with existing literature

This study is one of the first large-scale efforts to explore patients' knowledge, perceptions and attitudes regarding DVA screening in a primary care context. While most respondents understood DVA, 22% were unsure of the signs highlighting a need for increased public education. This aligns with research highlighting education's role in shaping attitudes towards DVA, as seen in studies with Chinese university students [27] and Australia's National Community Attitudes survey [28]. Despite government campaigns many individuals still lack awareness of support services, revealing gaps in outreach efforts.

Among non-disclosers, two-thirds recognised DVA signs, yet a third remained unsure, suggesting confusion or uncertainty about their own experiences. This supports findings from recent UK studies that, while people may understand the general impacts of DVA, they often fail to recognise specific behaviours contributing to abuse [3]. Community-based interventions could help reduce stigma and encourage disclosures, potentially improving recognition and reporting.

Nearly half of respondents reported experiencing DVA in our anonymous survey, consistent with previous research indicating underreporting due to a lack of awareness about what constitutes abusive behaviour [29]. Identifying DVA can be challenging due to its subtle presentation and survivor denial. Despite general practice being seen as a potential place for DVA support, fewer than 40% of respondents expressed willingness to seek help from GPs, contrasting with past surveys where 83% sought medical assistance [30]. This disparity may reflect ongoing discomfort or barriers to disclosure in clinical settings.

Most participants supported routine screening using tools like WAST-short, emphasising its acceptability and potential effectiveness in general practice [31]. Research from other countries, such as France [32] and Malaysia [33], has demonstrated the validity of screening tools like WAST for routine DVA detection. The WAST-short tool is particularly promising due to its brevity and self-administration format, making it feasible for use in busy primary care settings. Studies [34] also suggest that it is more reliable than standard clinical interviews in detecting DVA. A review on DVA screening highlighted the need for continuous provider training, a measure supported by nearly all study respondents [35].

Implications for research and/or practice

A preventive approach to domestic violence and abuse (DVA) is crucial for patient care and the healthcare system. Primary care providers should treat DVA as a preventable public health issue, utilising public awareness, education, and routine screening to support survivors.

Our study found strong patient support for screening tools like WAST-short, highlighting the need for standardised screenings to detect abuse early and provide essential support. Future research should refine these tools and assess their real-world application. Effective DVA screening requires provider training, clear protocols, and sufficient resources. While resource-intensive, these programs can reduce long-term healthcare costs by preventing ongoing abuse.

Conclusion

This study offers insights into patients' perceptions of domestic violence and abuse (DVA) and the WAST-short tool in primary care. Patients support the use of standardised screening tools like WAST-short in primary care, reflecting trust in healthcare providers. Integrating such tools into routine practice could enhance the identification and referral of DVA survivors, improving intervention efforts.

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Authors contributions

All authors provided substantial contributions to the conception (VS, AEO), design (VS, AEO, EB, MK), acquisition (MK, AEO), and interpretation (VS, AEO, MK, EB) of the study data and approved the final version of the paper. VS took the lead in planning the study with support from co-authors. MK and EB carried out the data analysis. AEO is the guarantor.

Consent to participate

Participation in the survey was voluntary. Participants consented prior to completing the survey.

Disclaimer

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Disclosure statement

No potential conflict of interest was reported by the author(s).

Ethics statement

This study was given ethical approval by the Imperial College London Research Ethics Committee (ICREC #21IC6721).

Data availability statement

All data generated or analysed during this study are included in this published article and its supplementary materials.

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