

Medical interns' perceptions of competence and readiness for obstetrics and gynaecology practice at selected tertiary hospitals in Uganda: A qualitative study

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Abstract

Background

Medical internship is a critical transition from undergraduate education to independent clinical practice. In Uganda, intern doctors provide much of the frontline obstetric care despite shortages of specialist obstetricians. However, little is known about how interns perceive their competence and readiness to practice in obstetrics and gynaecology or the undergraduate training experiences that shape this readiness. This study explored medical interns' perceived competence and readiness to practice in obstetrics and gynaecology and the curricular factors influencing their preparedness.

Methods

An exploratory qualitative study, underpinned by an interpretivist paradigm, was conducted among medical interns at Kawempe National Referral Hospital and Naguru Regional Referral Hospital, Uganda. Data were collected through ten in-depth interviews and two focus group discussions with interns who had completed their obstetrics and gynaecology rotation. Interviews were audio-recorded, transcribed verbatim and analyzed thematically using an inductive approach. Trustworthiness was enhanced through member checking, independent coding and triangulation of data sources.

Results

Four interrelated themes emerged: undergraduate training experiences shaping competence; perceived competence in obstetrics and gynaecology; transition to internship and evolving readiness; and contextual barriers and recommendations for strengthening readiness. Interns consistently perceived themselves as well prepared in theoretical knowledge, clinical reasoning and communication, but less prepared in practical and procedural skills, particularly operative obstetrics. Readiness for practice evolved through supervised clinical exposure, repeated procedural practice and mentorship during internship. Limited theatre exposure, high student-to-patient ratios and inconsistent supervision constrained competence development, whereas simulation, structured supervision and increased opportunities for hands-on practice were perceived to enhance readiness for independent practice.

Conclusions

Medical interns perceived readiness for obstetrics and gynaecology practice as extending beyond theoretical competence to the ability to apply knowledge confidently in clinical practice. Readiness was shaped by both undergraduate training and the clinical learning environment, with supervised procedural experience emerging as a key determinant of confidence and competence. Strengthening competency-based undergraduate training through structured procedural teaching, consistent supervision and

workplace-based assessment may improve graduates' readiness for internship and enhance the quality and safety of frontline obstetric care in Uganda.

Background

Medical internship is a mandatory supervised period of clinical training undertaken after graduation from medical school and before full registration to practice medicine [1]. In Uganda, the one-year internship includes rotations in internal medicine, surgery, obstetrics and gynaecology, and paediatrics. Clinical competence, defined as the integration of knowledge, skills, and attitudes required to manage clinical situations effectively, is central to safe patient care and to interns' readiness for independent practice [1, 2]

Globally, studies have shown variability in the preparedness of newly qualified doctors for clinical practice [3–5]. In sub-Saharan Africa, similar concerns have been reported; a South African study found that many intern doctors did not feel adequately prepared to perform key obstetric and gynaecological procedures such as episiotomy, perineal repair, and assisted vaginal delivery [3]. These findings suggest that gaps in procedural confidence and readiness may affect the quality and safety of care delivered by newly qualified doctors.

In Uganda, concerns about the quality and consistency of medical graduates have been raised in the context of rapid expansion of medical training institutions, with approximately 1,000 doctors graduating annually from 12 medical schools [6]. However, there is limited documented evidence from the perspective of interns regarding their preparedness for clinical practice. Understanding interns' perceptions is important because self-perceived competence may influence confidence, help-seeking behaviour, and readiness to undertake clinical responsibilities during internship.

The need to understand intern readiness is particularly critical in obstetrics and gynaecology. Uganda continues to record a high maternal mortality ratio, estimated at 343 per 100,000 live births, with major causes including hemorrhage, puerperal sepsis, hypertensive disorders of pregnancy, complications of delivery, and unsafe abortion [7]. These conditions are largely preventable with timely and competent obstetric care. Yet Uganda has a limited number of registered obstetricians and gynaecologists nationally, meaning that intern doctors often provide substantial frontline obstetric care, frequently with varying levels of supervision. Competence in this setting includes the ability to recognize and manage common obstetric emergencies and to perform essential procedures such as normal delivery, manual removal of the placenta, vacuum extraction, and caesarean section [8, 9].

Although studies from high-income settings have explored undergraduate medical student preparedness for practice, the transferability of these findings to low-resource settings such as Uganda is limited because interns assume greater clinical responsibility earlier in training, often in environments characterized by workforce shortages and limited specialist supervision. Understanding readiness within this context is therefore essential for informing locally relevant curriculum reforms and internship support strategies.

This study therefore aimed to explore medical interns' perceived competence and readiness to practice in obstetrics and gynaecology, and to identify the undergraduate curricular factors influencing this readiness. The findings may help identify perceived strengths and gaps in undergraduate training, inform curriculum review and harmonization efforts, and guide targeted interventions to strengthen internship preparation and supervision in obstetric and gynaecological care.

Conceptual framework

This study was guided by a conceptual framework developed from literature on medical education, clinical competence, and internship preparedness [11, 12]. The conceptual framework proposes that undergraduate curricular experiences including theoretical instruction, simulation-based learning, supervised clinical exposure, feedback, and assessment shape interns' perceived competence. Perceived competence subsequently influences readiness for independent practice, while the clinical learning environment, including supervision, opportunities for hands-on practice, and workplace culture, modifies the translation of competence into readiness for practice.

2.1 CONCEPTUAL FRAME WORK:

Methods

Study design

We conducted a qualitative, exploratory study underpinned by an interpretivist paradigm, which seeks to gather in-depth accounts that build a detailed picture of how a phenomenon is understood by those with direct experience of it [10]. This approach was chosen because the study sought to understand interns' subjective perceptions of their own competence and readiness to practice, rather than to measure competence objectively.

Study setting

The study was conducted at Kawempe National Referral Hospital and Naguru Regional Referral Hospital, Uganda. Kawempe National Referral Hospital, located approximately 6.4 km from Kampala city center, is a specialized maternal and child health facility and a teaching hospital for Makerere University; it receives obstetric, gynaecological, and paediatric referrals nationally and hosts approximately 30 interns per rotation, supervised by staff from the Ministry of Health and Makerere University. Naguru Regional Referral Hospital, approximately 4.9 km from the city center, is a teaching hospital for Habib Medical School, Islamic University in Uganda; it serves the local community and referrals from neighboring Health Centre IVs, and hosts approximately 6 interns per rotation, supervised by staff from the Ministry of Health and Islamic University in Uganda.

Study population and sampling

The target population comprised medical interns within one month of completing their obstetrics and gynaecology rotation at the two study sites. Interns who were repeating the obstetrics and gynaecology rotation, or who had more than one month remaining before completion of the rotation, were excluded. Participants were recruited purposively to include medical interns who had recently completed their obstetrics and gynaecology rotation and could provide rich insights into their perceived competence and readiness for practice. Recruitment continued until thematic saturation was achieved, with no new themes emerging from successive interviews.[11].. In total, 10 in-depth interviews (IDIs) and 13 FGDs were conducted. Recruitment invitations were circulated by email, and participation followed written informed consent

Data collection

Data were collected through ten semi-structured in-depth interviews (IDIs) and two focus group discussions (FGDs) comprising six to eight participants each, consistent with recommendations for manageable FGD size [12]. IDIs lasted 30–45 minutes, while FGDs lasted 60–90 minutes. Data collection was guided by a semi-structured interview guide developed from the study objectives and relevant literature on medical education, clinical competence, and internship preparedness [3, 13]. The guide covered interns' undergraduate obstetrics and gynaecology training, perceived competence and readiness to practice, and recommendations for improving training. It was pretested with intern and registrar colleagues who were not part of the main study and refined to improve clarity, relevance, and sequencing of questions.

All IDIs and FGDs were conducted by a trained research assistant with a background in public health and substantial experience in qualitative data collection. The research assistant was selected because of their expertise in conducting semi-structured interviews and facilitating focus group discussions, as well as their ability to maintain neutrality and build rapport with participants. Using an independent research assistant, rather than the principal investigator who supervises interns clinically, helped minimize power-related bias and reduce the likelihood of participants withholding information about perceived gaps in competence or readiness.

In-depth interviews were included to provide a private setting in which participants could discuss sensitive issues related to perceived competence and readiness to practice. FGDs were included to capture a broader range of perspectives through group interaction, which can stimulate recall, generate diverse viewpoints, and reduce individual inhibition around disclosure[14].

With participants' permission, all interviews and FGDs were audio-recorded using digital voice recorders. Audio files were transferred immediately after each session to a password-protected computer accessible only to the research team, and the recordings were deleted from the recording devices after secure transfer. Data collection continued until thematic saturation was reached, defined as the point at

which no substantively new codes emerged; saturation was achieved after ten IDIs and thirteen FGDs [15].

Data management and analysis

Audio recordings from the in-depth interviews and focus group discussions were transcribed verbatim by a professional transcription service. During transcription, participant identifiers were removed and pseudonyms assigned to protect confidentiality. The transcripts were returned to participants for member checking, allowing them one week to review the content, clarify statements, and provide comments where necessary.

Data were analyzed thematically. Coding was conducted inductively from the transcripts by the principal investigator and independently reviewed by a second coder to enhance analytic reliability. Coding commenced during data collection to support ongoing assessment of thematic saturation. Codes were grouped into descriptive categories relating to; undergraduate obstetrics and gynaecology training experiences, perceived competence and readiness to practice as an intern, and challenges encountered and recommendations for improving training. These categories were subsequently organized into broader analytic themes presented in the results.

Trustworthiness was enhanced through member checking, independent co-coding, and reflexive practices throughout the analytic process. Because the principal investigator also supervises interns clinically, potential bias was minimized by using an independent research assistant to conduct all interviews and focus group discussions, and by having the principal investigator's interpretations reviewed by the study supervisor.

Ethical considerations

Ethical approval was obtained from the Uganda Cancer Institute Research and Ethics Committee (UCI-REC-06-2020). Additionally, administrative clearance was obtained from both Naguru Regional Referral Hospital and KNRH. Written informed consent was obtained from all participants before data collection. Because the study explored potentially sensitive perceptions of incompetence, interviews and focus group discussions were conducted by a trained research assistant rather than the principal investigator, who was one of the interns' clinical supervisors, to minimize the risk of coercion and protect participant anonymity. Participants in focus groups were requested to maintain the confidentiality of discussions, although absolute confidentiality among group members could not be guaranteed. Identifying information was replaced with participant codes, and all study records were stored securely.

Results

Participants represented a broad range of demographic and educational backgrounds. They were drawn from two teaching hospitals and multiple Ugandan medical schools, providing variation in undergraduate

training experiences and clinical learning environments that enriched the diversity of perspectives captured in this study (See Table 1).

Table 1
Sociodemographic and professional characteristics of study participants
(N = 23)

Characteristic	Category	n
Age (years)	< 25	1
	≥ 25	22
Sex	Male	13
	Female	10
Hospital of internship	Kawempe National Referral Hospital	17
	Naguru Regional Referral Hospital	6
Medical school attended	Makerere University	11
	Islamic University in Uganda	1
	Mbarara University	2
	Gulu University	1
	Kampala International University	6
Type of participant	In-depth interview (IDI)	10
	Focus group discussion (FGD)	13

Thematic analysis of medical interns' competence and readiness for practice

Data were derived from ten in-depth interviews and two focus group discussions involving medical interns who had recently completed their obstetrics and gynaecology rotation at Kawempe National Referral Hospital and Naguru Regional Referral Hospital. Guided by the conceptual framework, the findings were organized into four themes: (1) undergraduate training experiences shaping competence; (2) perceived competence in obstetrics and gynaecology; (3) transition to internship and evolving readiness; and (4) contextual barriers and recommendations for strengthening readiness. Together, these themes illustrate how curricular factors influenced interns' perceived competence and how this competence shaped their readiness to practice during internship. The themes and corresponding subthemes are presented in Table 2 below.

Table 2

Conceptual framework domains, themes, and subthemes describing medical interns' perceived competence and readiness to practice in obstetrics and gynaecology.

Conceptual framework domain	Theme	Subthemes
Undergraduate curricular factors	Undergraduate training experiences shaping competence	• Duration and structure of rotations • Teaching and simulation methods • Clinical exposure and supervised practice • Assessment and feedback processes
Perceived competence domains	Perceived competence in obstetrics and gynaecology	• Theoretical knowledge and clinical reasoning • Practical and procedural skills • Emergency obstetric care competence • Communication and teamwork skills
Readiness to practice	Transition to internship and evolving readiness	• Confidence at the start of internship • Dependence on supervision and guidance • Growth in confidence through repeated clinical exposure
Contextual influences on competence and readiness	Contextual barriers and recommendations for strengthening readiness	• Limited theatre and procedural exposure • High student-to-patient ratios • Inconsistent supervision and workplace culture • Recommendations for competency-based, supervised training

Theme 1: Undergraduate training experiences shaping competence

Participants consistently described competence as beginning during undergraduate training, where the organization of rotations, opportunities for supervised practice, teaching approaches, and assessment

methods collectively influenced both knowledge acquisition and confidence in clinical practice. Rather than acting independently, these educational experiences interacted to shape preparedness for internship.

Duration and structure of rotations

Participants reported variation in the duration and organization of their obstetrics and gynaecology rotations across training institutions. Longer and more structured rotations were perceived to provide greater opportunities for repeated clinical exposure and consolidation of learning.

"So, we used to have junior clerkship 12 weeks... then afterwards you would proceed to do more 10 weeks of senior clerkship. So, the time was enough." (Participant 1)

Teaching and simulation methods

Participants described a range of teaching approaches, including lectures, tutorials, ward rounds, bedside teaching, case presentations, and simulation sessions. Simulation using models was particularly valued because it allowed students to practice procedures in a low-risk environment before encountering real clinical situations.

"I think the simulations were the aspects that made me feel ready... when they bring the dolls and then they teach us how to deliver a breech, those are the things that stood out most for me." (Participant 5)

Clinical exposure and supervised practice

Interns highlighted clinical exposure as a central component of competence development. Activities such as clerking patients, participating in ward rounds, conducting normal deliveries, and assisting in theatre were considered important opportunities for translating theoretical knowledge into practice under supervision.

"In obstetrics and gynaecology, the main thing is normal delivery and caesarean section... we used to do a lot of normal deliveries and when we used to go to theatre you would do more of assist but not do." (Participant 2)

Assessment and feedback processes

Participants described assessment methods that included written examinations, oral vivas, clinical examinations, case presentations, and logbook sign-off. These processes were perceived to provide accountability for procedural exposure, although some participants noted that logbook completion did not always reflect independent procedural competence.

"Yes, we have logbooks that we are required to document the procedures that we have done, and be supervised by the seniors... in the end of the rotation, the lecturers look at what you have been doing and they assess you from there." (Participant 3)

Theme 2: Perceived competence in obstetrics and gynaecology

Participants distinguished between knowing and doing. While undergraduate education was perceived to provide a strong theoretical foundation, competence was ultimately judged by participants according to their ability to perform procedures safely and confidently in real clinical settings.

Theoretical knowledge and clinical reasoning

Many participants reported confidence in their theoretical understanding of obstetric and gynaecological conditions. They felt prepared to recognize common clinical presentations, formulate differential diagnoses, and understand management principles.

“During undergraduate training, we really covered the theory of the topics... I’m sure we covered each topic and tried to see cases of each of those topics.” (Participant 7)

Practical and procedural skills

In contrast, participants described greater uncertainty regarding practical and procedural skills. Although they had observed or assisted with procedures during training, many felt that they had insufficient opportunities to perform procedures independently under supervision.

“The preparation was there, but observing is different from the doing part of it. If they had made us do supervise caesarean sections as students, I think I would have been more prepared.” (FGD1 participant)

Emergency obstetric care competence

Participants also described varying levels of confidence in recognizing and initiating management of obstetric emergencies. Exposure to emergency cases during training and internship was perceived to strengthen their ability to identify conditions such as postpartum hemorrhage, hypertensive disorders of pregnancy, and ectopic pregnancy.

“They really wanted us to focus on the emergency management of patients... mainly emergencies in obstetrics and gynaecology and how to handle each and every thing.” (Participant 6)

Communication and teamwork skills

In addition to clinical knowledge and procedural skills, participants described developing communication and teamwork skills through patient interactions, case presentations, and collaboration with senior clinicians. These experiences were perceived to improve their ability to explain management plans and participate in multidisciplinary care.

“You clerk a patient, and you present to the consultant, and he has to sign in your logbook after presenting to them.” (Participant 4)

Theme 3: Transition to internship and evolving readiness

Participants viewed readiness as a developmental process rather than an endpoint achieved at graduation. Competence acquired during undergraduate training required consolidation through repeated supervised practice before interns felt confident managing patients independently. **Confidence at the start of internship**

At the beginning of internship, many participants felt theoretically prepared but practically uncertain. They described difficulty applying knowledge to real patient care, particularly in procedures and emergency situations.

"I wasn't competent enough in my first month... I needed guidance from my seniors." (Participant 7)

Dependence on supervision and guidance

During the early stages of internship, supervision by senior doctors and registrars was described as essential for translating knowledge into safe clinical practice. Supervision provided reassurance, facilitated decision-making, and created opportunities for guided practice.

"The goodness in the first month was that seniors were around, so in case of any challenging situations, they were all available to help." (Participant 3)

Growth in confidence through repeated clinical exposure

As interns gained repeated exposure to patients, procedures, and emergency cases, they described increasing confidence in diagnosis, management decisions, and selected procedures. This growth in confidence illustrates the progression from perceived competence to greater readiness for practice.

"By the time one month elapsed, I felt competent because I had already been to gyn annex, abortions and those emergencies; I knew how to make a diagnosis and do the MVA." (FGD1 participant)

Theme 4: Contextual barriers and recommendations for strengthening readiness

Participants consistently emphasized that competence alone was insufficient to ensure readiness for practice. Institutional factors, including supervision, clinical workload, theatre exposure, and workplace culture, either enabled or constrained the application of previously acquired knowledge and skills.

Limited theatre and procedural exposure

Insufficient opportunities for supervised theatre participation were the most consistently reported barrier. Participants felt that limited access to operative cases restricted their ability to develop confidence in surgical procedures.

"The only thing which was lacking is maybe the theatre... it wouldn't enable us to exhaust all the different areas for learning how to work on them in theatre." (Participant 8)

High student-to-patient ratios

Participants also reported that large numbers of students competing for clinical learning opportunities reduced individual opportunities for bedside learning and procedural practice.

"Sometimes the student-patient ratio would be more; the students would be more than the patients."
(Participant 7)

Inconsistent supervision and workplace culture

Some participants described inconsistent direct supervision and discouraging attitudes from senior staff. These experiences were perceived to limit participation in procedures and reduce confidence in seeking guidance.

"Some people still feel like we are still small boys; they can't even let you enter a procedure... instead of guiding you, they are discouraging you." (FGD2 participant)

Recommendations for competency-based, supervised training

Participants recommended more structured surgical-skills training, smaller learning groups, consistent direct supervision, and practical competency-based assessment of emergency obstetric skills. These recommendations were viewed as strategies for strengthening the progression from undergraduate training to readiness for independent practice.

"My recommendation is that these surgical skills should have more sessions during the training."
(Participant 1)

Discussion

This study explored medical interns' perceptions of competence and readiness to practice in obstetrics and gynaecology in Uganda. Overall, interns perceived themselves as adequately prepared in theoretical knowledge but less confident in practical and procedural skills at the transition to internship. Importantly, readiness emerged as a dynamic process that developed through supervised clinical practice rather than a competency fully attained at graduation. This finding supports previous work showing that preparedness is not solely determined by undergraduate training but evolves through workplace learning during the early stages of clinical practice [3, 4]. Taken together, these findings suggest that readiness for practice is not merely the outcome of acquiring theoretical knowledge but is an emergent process shaped by continuous interaction between undergraduate education and workplace learning during internship. This reinforces the view that competence and readiness are related but distinct constructs requiring different educational strategies.

The contrast between theoretical competence and procedural confidence was the dominant finding. While participants felt capable of recognizing obstetric conditions and planning management, many lacked confidences in independently performing essential procedures, particularly operative obstetrics. Similar findings have been reported in the United Kingdom, where newly qualified doctors consistently reported greater preparedness for clinical reasoning than procedural practice [4, 6, 13], and in South Africa, where interns expressed limited confidence in performing core obstetric procedures despite adequate theoretical preparation. This disparity suggests that undergraduate curricula may successfully impart knowledge but provide insufficient opportunities for repeated, supervised procedural practice. In Uganda, where interns often provide frontline emergency obstetric care because of specialist shortages, inadequate procedural confidence may have important implications for timely decision-making and patient safety.

The study further demonstrates that competence is shaped more by the quality of clinical exposure than by curriculum content alone. Participants consistently attributed growing confidence to repeated patient encounters, supervised practice and constructive feedback during internship. Conversely, limited theatre exposure, high student-to-patient ratios and inconsistent supervision restricted opportunities to develop procedural competence. Similar structural barriers have been reported across sub-Saharan Africa, where expansion of medical education has not been matched by growth in clinical training capacity [12]. The concerns raised by participants therefore appear to reflect health system constraints rather than deficiencies in learner ability. Addressing these institutional factors is likely to have a greater impact on graduate readiness than increasing theoretical teaching alone. These findings collectively suggest that increasing procedural opportunities alone may be insufficient unless accompanied by structured supervision, timely feedback, and graduated responsibility within authentic clinical settings.

Another important finding was the central role of supervision during the transition from student to doctor. Participants described supportive supervision as essential for building confidence, refining clinical judgement and ensuring safe practice, whereas inconsistent supervision and discouraging workplace cultures limited learning opportunities. These findings reinforce evidence that internship represents a critical period of workplace learning requiring structured mentorship and progressive responsibility rather than immediate independence [16]. Strengthening supervisory practices may therefore improve both educational outcomes and patient safety. The findings also illustrate the importance of aligning competency-based curricula with the realities of clinical learning environments. Educational reforms aimed solely at curriculum redesign may have limited impact if institutional barriers continue to restrict supervised experiential learning.

The findings have important implications for medical education, policy and clinical practice. Medical schools should strengthen competency-based training by increasing supervised procedural exposure, integrating simulation with workplace learning and adopting workplace-based assessments rather than relying primarily on theoretical examinations and logbooks [17]. At the policy level, harmonizing national standards for procedural competencies and supervision across medical schools could reduce variation in graduate preparedness, particularly in the context of Uganda's expanding medical education sector [2].

Ultimately, improving interns' procedural competence is likely to strengthen the quality of frontline obstetric care and contribute to ongoing efforts to reduce preventable maternal morbidity and mortality.

Strengths and limitations

The use of both in-depth interviews and focus group discussions, together with independent data collection, member checking and co-coding, enhanced the credibility of the findings. Including interns from two tertiary teaching hospitals and multiple undergraduate medical schools increased variation in participant experiences and enhanced the credibility of the findings. The use of both IDIs and FGDs enabled triangulation across individual and group perspectives. However, the study was conducted in only two training hospitals using a purposive sample, which may limit the transferability of the findings. Furthermore, because competence was explored through self-reported perceptions rather than direct observation of clinical performance, the findings should not be interpreted as objective measures of competence. Future research should combine self-perceived readiness with objective measures of clinical competence.

Conclusions

This study demonstrates that medical interns' perceived readiness to practice in obstetrics and gynaecology is influenced by the interaction between undergraduate curricular experiences and the clinical learning environment. Although interns reported adequate theoretical competence, they perceived important gaps in procedural and surgical skills, largely attributable to limited supervised hands-on experience, constrained clinical learning opportunities and variable supervision. These findings suggest that strengthening competency-based undergraduate training through structured procedural teaching, consistent supervision and workplace-based assessment may better prepare graduates for internship. Strengthening competency-based undergraduate training through structured procedural teaching, consistent supervision, and workplace-based assessment has the potential to enhance graduates' readiness for internship and contribute to improved frontline obstetric care in Uganda.

Declarations

Ethics approval and consent to participate

This study was approved by the Uganda Cancer Institute Research and Ethics Committee (UCI-REC-06-2020). Written informed consent was obtained from all participants before data collection. All methods were conducted in accordance with the relevant institutional guidelines and regulations and the Declaration of Helsinki.

Consent for publication

Not applicable. No identifying individual-level data, images, or videos are included in this manuscript; all quotations are anonymized and attributed to participant codes only.

Competing interests

The authors declare that they have no competing interests.

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Author Contribution

NAS conceived and designed the study, obtained ethical approval, led data collection and analysis, and drafted the manuscript. CG supervised the study design, methodology, and analysis, and critically reviewed and revised the manuscript. Both authors read and approved the final manuscript.

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Data Availability

The datasets (interview and focus group transcripts) generated and analyzed during the current study are not publicly available, as they contain potentially identifying information about a small, defined participant group and were collected under assurances of confidentiality, but de-identified excerpts are available from the corresponding author on reasonable request and with appropriate ethical approval.

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Figures

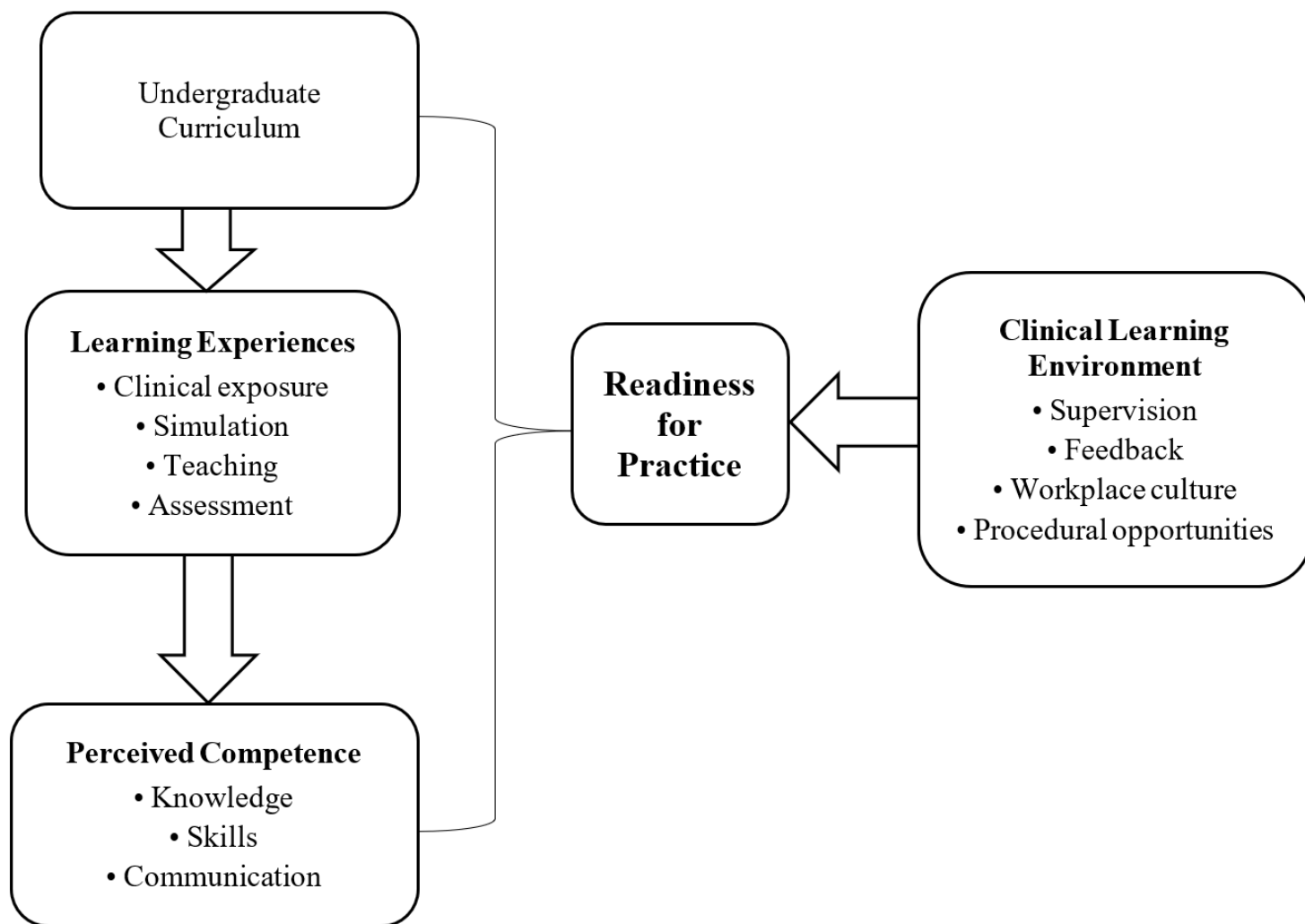


Figure 1

CONCEPTUAL FRAME WORK:

Supplementary Files

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