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Patients' perceptions on reluctance to undergo cataract surgery in Sedibeng district hospital, Gauteng province

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Background: Over 50 million people are blind, and 135 million people suffer from severe visual impairments, with cataracts contributing to 51% of global blindness cases. Despite efforts to promote cataract surgery (CS), many patients remain hesitant, underscoring the importance of understanding their perspectives.

Aim: This study aimed to explore and describe patients' perceptions regarding reluctance to undergo CS to improve awareness and increase surgery uptake.

Setting: The research was conducted in the Sedibeng District, Gauteng province, South Africa.

Methods: A qualitative descriptive phenomenological design was employed to capture the lived experiences of patients through face-to-face, individual semi-structured interviews with 15 patients aged 38 – 72 years prior to their CS. Purposive sampling was used to select participants, and Colaizzi's seven-step analysis was used for data analysis.

Results: The findings highlight several barriers perceived by participants, including long waiting times; fear; lack of knowledge; limited financial, material and human resources; power outages; uncontrolled blood sugar levels; and coronavirus disease 2019 (COVID-19) pandemic restrictions. Nevertheless, some view it positively as a means to avert blindness and enhance vision.

Conclusion: To address the challenges, the study recommends boosting the number of eye health care professionals, prioritising budget allocation, addressing electricity interruptions and conducting community outreach educational programmes to improve access to CS in the district.

Contribution: The insights gained from this study can help health care providers and policymakers optimise care and support for CS patients through policy formulation and education. Addressing these knowledge gaps will likely increase surgery uptake and improve patients' quality of life.

Keywords: cataract surgery; patients; perceptions; reluctance; public hospital.

Introduction

Globally, cataracts are a leading cause of blindness, affecting over 50 million people and contributing to severe visual impairments in at least 135 million people, with cataracts responsible for 51% of blindness cases.[1] According to the World Health Organization (WHO), there are at least 2.2 billion visually impaired people worldwide,[2,3] with approximately 1 billion of these cases being avoidable.[2] Refractive errors and cataracts are the predominant causes of vision impairment and blindness globally.[2]

Approximately 95% of cataract-related blindness occurs in low- and middle-income countries (LMICs).[4] In sub-Saharan Africa, the prevalence of blindness among individuals aged 50 has been estimated to range from 1% to 9% over the past decade.[2] South Africa alone has about 330 000 blind individuals, with the majority (80%) residing in rural areas.[5]

Cataract surgery (CS), which involves removing a cloudy lens from the eye and replacing it with an artificial intraocular lens,[6] aims to enhance visual function, thus enabling individuals with visual impairments to engage in daily activities with improved capacity.[7] Despite the effectiveness of this procedure, many individuals affected by cataracts are hesitant or reluctant to undergo the necessary surgery.[5]

To address this issue, the WHO and the International Agency for the Prevention of Blindness (IAPB) launched the 'Right to Sight' Global Vision 2020 campaign, which prioritises the elimination

of avoidable blindness, with cataracts as a major target disease.[8] Despite these efforts, persistent barriers remain, including financial constraints, limited access to services, inadequate awareness of available resources and insufficient knowledge about CS.[5]

Research conducted in Cape Town, South Africa, revealed significant backlogs in CS at the province's two biggest hospitals, Tygerberg and Groote Schuur, with 1200 and 2500 cases pending, respectively.[9] This is of particular concern given that the recommended CS rate in South Africa is 2000 per million population annually.[9] These challenges hinder progress towards achieving the United Nations (UN) Sustainable Development Goals (SDGs), particularly target 3.8, which aims to 'achieve universal health coverage (UHC), including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all',[6] whereby access to essential health care services includes those related to eye health and vision care.[6]

The advent of the coronavirus disease 2019 (COVID-19) pandemic and the subsequent restrictions imposed have shifted focus away from priority programmes such as cataract prevention and management[10] towards preventing and managing infectious diseases,[10] exacerbating the backlog of patients awaiting surgeries.[10] Sedibeng District Hospital is among the hardest hit, with a waiting list of approximately 3000 patients for CS, 2250 of whom must wait up to 9 months for surgery.[11,12] The leadership from provincial, district and hospital has expressed concerns regarding the low rate of cataract surgeries, particularly at Sebokeng Regional Hospital.[11,12]

Many of the patients diagnosed with cataracts who have been scheduled for surgery often exhibit reluctance to undergo the procedure. This reluctance raises concerns and has prompted an investigation into the patients' perceptions regarding CS. The reasons behind this reluctance remain largely unknown. Therefore, the primary aim of this study was to explore and describe the patients' perceptions regarding reluctance to undergo CS at a public hospital in Sedibeng District, Gauteng province, South Africa. The study ultimately seeks to provide evidence-based recommendations to policymakers on strategies to enhance the acceptance and increase the uptake of CS.

Research methods and design

Study design

To capture the lived experiences and perceptions of patients regarding reluctance to undergo CS, a qualitative descriptive phenomenological study design was employed. This design is particularly relevant in qualitative research within the social and health sciences as it provides a comprehensive account of how individuals experience a specific phenomenon under investigation. Descriptive phenomenology allows for an in-depth understanding of participants' perspectives, thereby offering valuable insights into their subjective experiences.[13,14,15]

Study setting

The study was conducted at a public regional hospital in Sedibeng District, Gauteng province (GP), South Africa. The district is predominantly semi-rural and characterised by a diverse population of mixed races who attend the Sedibeng District Hospital Ophthalmology Unit. This hospital serves as a referral institution for 15 primary health care clinics and 4 community health centres. Participants were recruited during clinical reviews and treatment prior to their CS.

Sampling methods and population

The population of this study included all patients booked for CS in Sedibeng District Public Hospital. The study included patients aged 18 years and older who had failed to attend their CS appointments for more than 6 months. Patients under 18 years of age and those who had missed appointments for less than 6 months were not considered for inclusion. A purposive sampling technique was employed to select participants who could articulate their ideas and reasons for not attending their scheduled CS and who were willing to participate. This approach ensured the collection of rich, detailed data on patients' perceptions regarding CS.[15]

A total of $n = 15$ participants were included in the study, and data saturation was achieved with this sample size. Saturation refers to the point at which no information or themes are observed in the data, indicating that further data collection is unnecessary.[16,17]

Data collection

A face-to-face individual semi-structured approach was used to collect first-hand information from participants reluctant to attend CS.[18,19] A list of all booked patients, including contact numbers, was retrieved from the patient system with the assistance of an administrative clerk, following approval from the hospital's chief executive officer (CEO). The researcher then contacted the participants to schedule appointments, determining a date, time and venue that were convenient for the interviews. Most participants had chronic diseases and agreed to come for an interview on their clinical review or treatment collection dates.

To assess the feasibility of the interview guide, the researcher conducted a pilot interview with five participants to ensure the questions were understandable and elicited clear responses. These participants' results were not included in the main study. No modifications to the research instruments were necessary, and data collection proceeded from 24 March until 16 May 2023.

Participants received comprehensive information regarding the purpose and methodology of the research before providing their informed consent. Those who could read and write provided written informed consent, while those unable to do so gave verbal informed consent, which was recorded.

Interviews were conducted in both English and Sesotho, the predominant local language, and responses were later translated into English by the researcher.

Interviews took place in a private room within the hospital to ensure privacy and provide a conducive environment for participants to share their thoughts, feelings and perceptions. Each interview lasted between 45 min and 1 h. Fifteen patients who had missed their CS appointments were interviewed using a semi-structured interview guide. The interviews were recorded, and supplementary field notes were taken to capture the emotional and nonverbal expressions of the participants. The researcher maintained a respectful and non-judgemental attitude throughout.

The interview process began with a main open-ended question: 'In your opinion, how do you perceive the cataract surgery'? This was followed by further discussion to help participants clarify their responses if needed.

Data analysis

In qualitative studies, data collection and analysis are closely intertwined.[16] Following each interview, the researcher utilised Colaizzi's steps for phenomenological analysis to manually process the data.[20,21] The first step involved transcribing the data verbatim, including field notes, followed by reading all transcribed and written material to comprehend the data fully and identify similar data.

Similar data were arranged and categorised based on their familiarity or connotations, grouping those with related meanings together. Through this, categories were classified into themes. Additionally, themes were presented for critical review by other second researchers to compare and contrast the study's findings and conclusions, thereby developing robust arguments and discussions. Objectionable statements were emphasised or supported using codes and excerpts from the interview transcripts. To validate the study's findings, a member check was conducted where the researcher revisited the participants through telephone calls, as previously arranged during data collection. Furthermore, audit trials and results were presented to two experienced researchers in qualitative studies to confirm the appropriateness of the analysis.

The researcher engaged in active reflexivity, thoughtfully and consciously separating personal assumptions, beliefs, behaviours and viewpoints that could potentially affect the research process and outcomes. Reflexivity enhanced the reliability, accuracy and transparency of qualitative research serving as a vehicle for self-awareness.[22]

Trustworthiness in qualitative studies

The researcher employed the trustworthiness criteria proposed by Lincoln and Guba[20,21] to ensure the validity and reliability of the study. These criteria include credibility, dependability, confirmability and transferability.[22] Credibility was strengthened by supporting themes with actual quotes from participants, thereby enhancing the believability of the findings. Interviews were recorded, and an audit trail of raw data, consent forms and field notes was maintained for scrutiny throughout the enquiry process ensuring dependability. Additionally, the researcher sought validation from the participants to confirm the accurate capture of their perceptions and views. To increase transferability, field notes and direct quotes from participants were documented. Conformability was achieved by presenting audio-recorded data, raw data, field notes and research reports to an experienced researcher for critical examination of the process and results. Overall, the research methodologies were described thoroughly and in a contextualised manner, allowing readers to make informed judgements about the findings.[23,24]

Ethical considerations

The study adhered to the principles of the Helsinki Declaration to ensure ethical research practices.[13] Ethical approval was granted by the University of South Africa's College of Human Science Research Ethics Committee (CREC), with clearance reference number: *62037676_CREC_CHS-2023*. Additionally, permission to conduct the study was obtained from the CEO reference number: *GP_202302-034* granted. Participants were provided with detailed information about the research purpose and methodology before consenting to participate. They gave written and verbal consent and were assured that their participation was voluntary, with the right to withdraw at any stage without facing any negative consequences. Prior permission was also obtained to record the interviews. To ensure confidentiality and anonymity, the interview content was treated as strictly confidential. Participant names were replaced with codes, and the data were securely stored on a password-protected laptop, accessible only to the researcher.[16]

Results

Participant demographics

The sample consisted of a total of n = 15 participants as summarised in Table 1. Participants ranged in age from 38 to 72 years and were all scheduled for CS. The majority of participants were married, identified as Christians and resided in semi-urban areas, with four participants from urban areas. Educational attainment varied among the participants: only 1 participant had attained tertiary education, while 11 participants attended school up to the secondary level, and 3 participants had dropped out of school at the primary level. Employment status also varied: two participants were employed, five participants were unemployed, and the remainder were retired. Most participants had chronic illnesses such as hypertension and diabetes mellitus, which might have contributed to their poor vision. Only two participants did not have any chronic diseases. Three themes emerged from the data analysis.

TABLE 1: Participant demographics.

Demographics	Frequency	Percentage
Gender		
Male	8	53.3
Female	7	46.6
Age (years)		
38–49	3	20.0
52–62	4	26.6
64–72	8	53.3
Residence		
Urban	4	26.6
Semi-urban	11	73.3
Chronic conditions		
Diabetes and hypertension	12	80.0
None	3	20.0
Employment		
Unemployed	5	33.3
Employed	2	13.3
Retired	8	53.3
Education level		
Tertiary	1	6.7
Secondary	12	80.0
Primary	2	13.3
Religion		
Christian	13	86.6
None	2	13.3
Marital status		
Married	11	73.3
Single	2	13.3
Divorced	1	6.7

TABLE 2: Different themes and sub-themes that emerged from the study.

Themes	Sub-themes
1. Positive attitude and perceptions towards cataract surgery	1.1 Protection from blindness 1.2 Improved eyesight
2. Knowledge related to cataract surgery	2.1 Limited knowledge 2.2 Fear
3. Perceived barriers to undergo cataract surgery	3.1 Waiting time 3.2 Lack of human, material and financial resources 3.3 Load shedding 3.4 Public sector strike 3.5 Uncontrolled blood sugar 3.6 COVID-19 pandemic lockdown restrictions

COVID-19, coronavirus disease 2019.

Study themes and findings

The study revealed three themes and sub-themes, as summarised in Table 2.

Theme 1: Positive attitude and perceptions towards cataract surgery

This theme surfaced from participants' discussions about their health-related beliefs with respect to CS, despite not having undergone the procedure. This study revealed the following perceptions on health beliefs about CS: Protection from blindness and improved eyesight.

1.1. Protection from blindness: Most participants viewed CS positively, seeing it as a way to improve their eyesight and protect against blindness. However, they emphasised the need for health care providers to educate the community about cataracts and the benefits of surgery to encourage more individuals to undergo the procedure.

The below quotation supports this:

> 'Removing cataracts will allow me to see better again.' (P2, Male, 28 March 2023)

> 'I believe that after cataract surgery my eyesight will be improved.' (P8, Female, 08 May 2023)

1.2. Improved eyesight: Several participants considered CS not only as a protection from blindness but also as a means to enhance their eyesight. They noted that, according to their surgeons, spectacles were no longer an efficient means of improving vision and that surgery was the only viable option. The following statements from participants illustrate this perception:

> 'My eyesight will undoubtedly improve after cataract surgery and being able to assist my child with homework.' (P8, Female, 08 May 2023)

> 'It would be great if they could remove this grey thing inside my eyes as it is difficult for me to see, even when I write.' (P10, Male, 10 May 2023)

Theme 2: Knowledge related to cataract surgery

The study participants expressed a lack of knowledge, fear and concerns regarding CS. These factors negatively impacted the uptake of surgeries in the selected hospital. Each subtheme is presented below, accompanied by paraphrased quotations that support these sub-themes.

2.1. Limited knowledge: Despite the majority of participants recognising the advantages of CS, some participants in this phenomenological study still lacked an understanding of the causes of cataracts. The following statements are from three participants:

> 'My understanding is that my filthy eyes are going to be cleaned and sprayed to remove this white thing called cataracts [*bolepu*].' (P1, Male, 24 March 2023)

> 'I have no idea what cataracts are and what caused them.' (P11, Male, 10 May 2023)

> 'I think I cried a lot when I found out that my husband is cheating, and that might cause my eyes to weaken and cause cataracts.' (P10, Female, 08 May 2023)

2.2. Fear: Several participants expressed trepidation over CS because of their lack of knowledge about what to expect. The fear of going blind contributed to unfavourable attitudes towards the procedure. One participant mentioned her apprehension stemming from it being her first operation and the prospect of being awake during the surgery.

The following quotations support this subtheme:

> 'Since this is my first-time having surgery, I'm afraid of what will happen, especially when they said I will be awake during the operation [*Laughter*].' (P8, Female, 08 May 2023)

> 'I was afraid of going blind following cataract surgery.' (P2, Female, 28 March 2023)

Theme 3: Perceived barriers to undergo cataract surgery

Participants identified several barriers that impeded the full realisation of the potential benefits of CS, despite their recognition of these benefits. The study identified six sub-themes that substantiate this issue, each supported by participants' quotes.

3.1. Waiting time: Despite the provision of public health care services at no cost, most participants reported dissatisfaction with the long waiting lists following diagnosis, often having to wait for 2–3 years before undergoing surgery. Participants expressed concerns that they might not survive this extended waiting period alive. The following quotations illustrate this sub-theme:

> 'I've been going to the clinic since 2018, and they keep telling me to come every six months, but the waiting list has been excessively long.' (P11, Male, 10 May 2023)

> 'Since 2019, they have consistently promised to call, but they haven't, and is very painful [*Angry*].' (P10, Male, 10 May 2023)

3.2. Lack of human, material and financial resources: Based on the responses of the majority of participants, delays in surgical care delivery within public health care institutions were primarily attributed to limitations in resources, including financial, material and human resources. Participants also acknowledged that while private health care provides prompt and high-quality treatments, the associated costs make it inaccessible to many individuals. The dissatisfaction expressed by participants centred on prolonged waiting periods, inadequate staffing and the frustration of excessive waiting to see a single doctor. The following concerns were raised by participants:

> 'Government is free, the lack of linen, which they said was being washed somewhere else, was the reason for the cancellation.' (P5, Female, 04 April 2023)

> 'You might wonder how much linen is available, considering there are only four of us, but they say they can't operate on us because there's not enough linen [*Disappointed*].' (P5, Female, 04 April 2023)

> 'I think there should be more doctors performing cataract surgery because we are many.' (P14, Female, 16 May 2023)

3.3. Load shedding: Some participants recognised that power outages hindered their ability to access CS and suggested implementing backup systems in hospitals. The participants reported the following concerns:

> 'In 2021, load shedding caused us to be cancelled, they told us that they could not operate us with torches. I think the hospital should have backup electricity to enable them to continue operating.' (P5, Female, 04 April 2023)

> 'They usually cancel us and say there is load shedding.' (P13, Female, 10 May 2023)

3.4. Public sector strike: Participants expressed concerns about not receiving treatment for their cataracts or not obtaining care on arrival for their review appointments, as they were unaware that the facility was closed because of a strike:

> 'The doctors and nurses were not available when we came for our appointments because of a public strike.' (P5, Female, 04 April 2023)

> 'When I arrived the other day, the gates were closed due to a public strike.' (P11, Male, 10 May 2023)

3.5. Uncontrolled blood sugar: Two participants voiced unfavourable views regarding the impact of inadequate blood sugar control, which leads to cancellations and postponements of CS. The following quotes support this concern:

> 'They sometimes reschedule cataract surgery if your blood sugar is high.' (P5, Female, 04 April 2023)

> 'My blood sugar was high, so they told me they couldn't do an operation.' (P7, Male, 17 April 2023)

3.6. COVID-19 pandemic lockdown restrictions: Participants highlighted that the COVID-19 pandemic restrictions and regulations served as obstacles, resulting in delays in receiving timely CS. Two participants made the following statements:

> 'I have now decided to visit to inquire as to why I was not contacted since COVID-19 because they said we must stay at home.' (P10, Male, 10 May 2023)

> 'COVID-19 causes a delay since I've been here for four years because they stopped doing operations.' (P7, Male, 17 April 2023)

Discussion

The study has revealed significant insights into the patients' perceptions regarding CS at a public hospital in Sedibeng District, GP, South Africa. These perceptions have been systematically examined and categorised into three main themes, namely, positive attitude, knowledge and barriers to receiving surgery. While these findings highlight notable distinctions, they also show a degree of consistency with previous research conducted in other countries.

Positive attitude towards cataract surgery

Given that the majority of research participants held favourable views and were well informed about the advantages and benefits of CS, these positive attitudes could serve as incentives, encouraging individuals to undergo the procedure. This, in turn, could potentially lead to an increased uptake of cataract surgeries within public hospital services. The conclusions drawn from this study are supported by findings from Ibanga et al.,[25,26] who noted that individuals' knowledge and beliefs greatly influence their behaviour and that the adoption of health-related interventions is more likely when the perceived benefits outweigh the perceived risks. Similarly, research by Mahakud and Hellem et al.[27,28] suggests that an individual's knowledge and beliefs can influence their behaviour if they are aware of and believe in the benefits of a particular action. This is further supported by a study conducted by Jain et al.,[6] which found that CS is the only treatment for cataracts and is highly successful in

restoring vision. Studies by the WHO and various other researchers have highlighted that cataracts, which cause visual impairment, increase the risk of accidents and reduce overall quality of life.[2,29,30.]

Contradictory findings from other studies conducted in Cape Town suggest that meeting CS targets can be impacted by inaccuracies in target calculations, particularly prevalent in regions with specific diseases like trachoma and onchocerciasis, which may not be relevant to other districts in South Africa.[9]

Knowledge and understanding regarding cataract surgery

The study findings reveal that patients with cataracts had a limited understanding of the causes of the condition, despite some awareness of the benefits of surgery. This lack of knowledge, coupled with fears and concerns about the procedure, contributed to hesitancy in pursuing CS. This is consistent with a study by Du et al.,[31] which found that approximately 52.24% of participants believed cataracts could be treated with medication, indicating a misunderstanding of the most effective course of treatment. Individuals who believe that eye drops or other medications can substitute for CS may choose not to undergo the procedure.

Similarly, Hall et al.[32] reported that 40% of participants viewed cataracts as an unavoidable part of ageing, with no available treatment. Kurniyawan et al.[33,34,35,36] emphasised the role of nurses in educating patients about CS to help them prepare for the procedure and adapt to the associated health challenges. Winarni et al.[37] further highlighted the importance of family support in encouraging patients to undergo CS, suggesting that such support can act as a motivating factor.

However, Konjevoda et al.[38,39] found that anxiety is prevalent prior to CS, with 44.7% of patients experiencing significant fear, often driven by concerns about losing their vision. This fear is exacerbated by incorrect assumptions shared by friends and family, which can lead to misinformation about the procedure. Additionally, Das et al.[40,41,42] reported a different concern, where individuals who develop cataracts may fear losing their job and income during their hospital stay, leading to reluctance in seeking medical attention.

Barriers to receiving cataract surgery

The results of this study revealed that patients with cataracts face significant challenges in accessing health care services. These challenges include long waiting time, insufficient human resources, one ophthalmologist and two medical officers, material and financial resources, power outages because of load shedding, public sector strikes, uncontrolled blood sugar levels and restrictions related to the COVID-19 pandemic. As a result, patients felt that their expectations for the quality of care were not met. This is consistent with findings from a study conducted in Malaysia by Ngah et al.,[4] which reported that patients with cataracts may have to wait up to a year for surgery because of space constraints and high patient volume. Similarly, Goel et al.[43,44] identified socioeconomic status, a shortage of human resources, direct and indirect costs, and cultural concerns as major barriers to accessing eye care services.

Sengo et al.[12,45] emphasised that proper facilities, equipment, supplies and technology are essential for providing high-quality care. In contrast, a study by Vedachalam et al.[46,47] found that hospitals delayed cataract surgeries during the initial lockdown because they were uncertain about the procedures necessary to ensure the safety of the surgical team and the patients undergoing surgery. Additionally, Mahyuvi[1] noted that in individuals with a history of high blood sugar, the lens of the eye may adhere to the posterior capsule, complicating cataract removal and requiring specialised care, thereby delaying surgery.

Furthermore, Bloom[12,48,49] provided evidence of the obstacles surrounding CS highlighting that the public health care system in the country is plagued by frequent power outages. Inadequate lighting during surgery, associated with these outages, leads to higher rates of surgical error and postoperative complications, resulting in postponed surgeries. The negative impact of public strikes on patient outcomes and health care delivery was also corroborated by Essex et al.[50,51]

Recommendations

Based on the findings of this study, researchers suggest that policymakers consider implementing mass media awareness campaigns to bridge the knowledge gap among individuals who may have limited understanding of the importance of CS. This would enable open and transparent discussions between individuals with cataracts and health care providers, facilitating conversations about self-care interventions to manage glucose levels, as well as addressing their challenges, and exploring potential treatment options. These efforts are expected to reduce delays, alleviate fears and address concerns related to CS. To improve access to services and minimise waiting times in the Sedibeng District, policymakers are advised to address the challenges posed by limited resources. This can be achieved through initiatives such as procuring reliable electricity backup systems to mitigate the impact of power outages and addressing labour-related issues to prevent interruptions in service delivery. Additionally, it is recommended that content related to CS be integrated into the nursing education and training programme curriculum. Specifically, this should include information on the benefits and importance of CS, as well as emphasising the appropriate management and control of glucose levels among patients with diabetes in both the medical and surgical modules.

Strength and limitations

The researcher identified several limitations, including the small sample size and the use of a qualitative design. Qualitative research is intended to provide a contextual

understanding rather than generalising findings to a larger population. Consequently, the results of this study are specific to the participants at a particular public hospital in the Sedibeng District and may not be generalisable across the entire district. Despite this limitation, the study offers valuable insights into the factors influencing CS uptake among patients who are hesitant about undergoing the procedure. For future research, it is recommended to use a quantitative survey methodology to gather data from a larger and more diverse sample of patients and health care professionals within the Sedibeng District. Such an approach would enable a more comprehensive understanding of the issues at hand and provide actionable insights for improving CS uptake and service delivery.

Conclusion

This study aimed to explore and describe patients' perceptions regarding CS. The study revealed that patients have limited opportunities to undergo surgery because of inadequate knowledge and understanding of CS and highlighted barriers to undergo surgery such as extended waiting times and resource shortages. The challenges underscore the need for policy interventions, education and awareness including appropriate resource distribution to cater for the population's needs.

Conversely, some participants expressed positive attitude regarding surgery, viewing it as a means to improve their eyesight and overall quality of life, which would enable them to engage more fully in self-care and daily activities.

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Competing interests

The authors declare that they have no financial or personal relationships that may have inappropriately influenced them in writing this article.

Authors' contributions

H.M.M. conceptualised the study, and collected and analysed the data. S.H.M. contributed to the verification of data analysis, and writing and editing of the article.

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Data availability

Data that support the findings of the study can be made available upon request to the corresponding author, S.H.M.

Disclaimer

The views and opinions expressed in this article are those of the authors and are the product of professional research. They do not necessarily reflect the official policy or position of any affiliated institution, funder, agency or that of the publisher. The authors are responsible for this study's results, findings and content.

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