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Exploring facilitators and barriers for delivering person-centered care in a socio-economically diverse context: Perspectives of speech-language pathologists and audiologists

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ABSTRACT

Objective: The study aimed to explore facilitators and barriers in delivering person-centered care from the perspective of speech-language pathologists and audiologists in a socio- economically diverse workplace across micro, meso, and macro levels.

Method: A national cross-sectional e-survey was conducted among pooled speech-language pathologists and/or audiologists from South Africa. The e-survey included quantitative components to describe participant demographics which was analysed using descriptive and inferential statistics. The qualitative data was analyzed using metaphor and thematic analysis approaches to describe respondents' perspectives of barriers and facilitators in delivering person-centered care.

Results: The e-survey was completed by 63 clinicians (36.5% Audiologists; 36.5% Speech-Language Therapists; 27.0% dually qualified Speech-Language Therapists and Audiologists) mostly between the ages of 26 to 35 years old (33.3%). Respondents were working in various settings including the public sector (41.3%), private sector (44.4%) and in academia (14.3%). Facilitators and barriers were identified within all three systems (macro, meso and micro). The metaphor analysis resulted in six categories: uncertainty of Person centered care; its essential nature; associated challenges; relational aspect; analogies referring to animals; and food-related analogies. Thematic analysis of open-ended questions revealed five barriers, with three relating to micro systems; i) clinician factors, ii) client factors, iii) clinician and client interaction, and two related to factors within the meso system; iv) resources, and v) workplace. Only two themes were identified as facilitators towards PCC, clinician factors (mirco) and workplace factors (meso).'

Conclusions: Insights gained from exploring Speech-Language Pathologists' and Audiologists' perceptions of implementing PCC in a socio-economically diverse setting highlight the need to address contextual (meso and macro systems) and personal (micro system) factors to promote and deliver PCC effectively. Notably, for the public sector, resources emerged as a major concern and barrier on the macro system level. Despite these challenges, the investigation revealed two noteworthy facilitators: clinician factors, at the micro level, and workplace factors, at the meso level. This nuanced understanding emphasizes the necessity of tailored interventions targeting both individual and systemic aspects to enhance the successful implementation of person-centered care.

Practical Implications: Strategies should focus on enhancing clinicians' communication skills, collaboration, and teamwork, as well as addressing resource limitations through the adaptation of tools and implementation of PCC ISO standards.

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1. Introduction

Person-centered care (PCC) is a healthcare approach that has gained widespread recognition and adoption [1]. PCC has been defined as an approach that seeks to involve clients as active respondents in their own care and prioritize their individual needs, preferences, and experiences in the design and delivery of assessment and intervention services [2]. The clinical benefits of PCC are well documented in peer-reviewed scientific literature, with studies showing improved health outcomes, including increased client satisfaction and treatment adherence [3–5]. The World Health Organization further recognizes PCC as an effective way to reduce long-term healthcare costs and improve job satisfaction for clinicians [2].

Despite the associated general benefits, PCC integration in healthcare service delivery is a complex process that requires coordination and collaboration across multiple levels [6,7]. For effective and successful implementation, one needs to take careful consideration of factors within the macro system that influences policy and regulations; the meso systems that shape organizational culture and values; and the micro system that pertain to direct interactions between clients and healthcare clinicians, and their respective personal factors [8]. The International Organization for Standardization (ISO) [9] recently released ISO standards on person-centered staffing that aim to support healthcare organizations in implementing PCC consistently and effectively in practice. The guidelines promote effective communication and collaboration between clients and clinicians by fostering supportive and inclusive healthcare environments [9]. While the guidelines provide a top-down approach to fostering PCC within organizations, client-clinician interactions remain at the heart of PCC [10,11]. The benefits of PCC from clients' perspectives have been widely investigated across healthcare professions [12–16]. In speech-language pathology and audiology, clients' and their families' perspectives on PCC have been evaluated during hearing aid fitting and aural rehabilitation [17, 18], tele-audiology [19], tinnitus management [20], aphasia [21], and dysfluency [22] interventions. Clinicians, however, play a central role in initiating and ensuring all stakeholders adhere to the PCC approach.

Currently, there is no standardized measurement of the implementation of PCC in clinical settings, however, a recent literature review has recommended using the Patient-Practitioner Orientation Scale (PPOS) to determine practitioners' orientation and preferences toward PCC [23]. Research using the PPOS reveals that clinicians not only prefer PCC but also actively incorporate theapproach into their practice. [24–27]. Several observational studies have, however, revealed that clinicians may miss opportunities to address clients' psychosocial needs, build rapport, involve clients and their family members in shared decisions, and provide options for rehabilitation [17,25,28]. Clinicians may believe in the principles of PCC but struggle in its application, possibly due to the barriers they experience in implementing PCC [29, 30].

Reassuringly, research has identified a number of clinician-specific factors that facilitate the delivery of PCC services. These include training and education, access to measurement and evaluation tools, and supportive work environments for health professionals [31,32]. The majority of the studies focused on PCC have, however, originated from high-income settings where resources are generally more readily available [33,34]. Low- and middle-income settings face a myriad of additional barriers though. In South Africa, for example, the severe socio-economic disparity, and cultural and linguistic diversity complicate healthcare service delivery [35,36].

The present study aimed to explore the barriers and facilitators to delivering PCC from the perspective of speech-language pathologists and audiologists in South Africa, a socio-economically and linguistically diverse population. Understanding the underlying factors that influence speech-language pathologists' and audiologists' adoption and adherence to PCC would support progression within the fields towards inclusive, responsive healthcare.

2. Materials and method

The study received ethical approval from the relevant Institutional Research Board (HUM024/0422). In accordance with the South African Protection of Personal Information (POPI) Act, the e-survey was only accessible once respondents had clicked the link and completed the informed consent.

2.1. Study design and respondents

The study employed a cross-sectional [37] e-survey **design that** included both qualitative and quantitative components. **Prospective participants had** to **be** registered practitioners (Audiologists, Speech-Language Pathologists, Dually qualified Speech-Language Pathologists and Audiologists, Acousticians, Speech-Language Pathology assistants or Audiology assistants) **who were** providing healthcare services in South Africa. The e-survey was distributed through online social media platforms (Facebook™, LinkedIn™, WhatsApp™), professional associations (South African Speech Language and Hearing Association - SASLHA, South African Association of Audiologists- SAAA), and by forwarding to colleagues and collaborators practicing in the field of speech-language pathology and audiology in South Africa.

2.2. Instrument and procedure

The e-survey was made available to respondents using Qualtrics (Provo, UT) for three weeks between October and November 2022. It consisted of three sections, namely: 1) biographic information, 2) a Likert scale to rate ten items relating to barriers and facilitators clinicians face towards providing PCC, and 3) four open-ended questions further probing their perspectives. Results from the second section are not included in this paper due to the quantitative nature and depth of analysis, the findings are discussed in a subsequent paper.

The demographic section of the e-survey included questions relating to age, gender, current profession, number of years working in the field, employee position, work sector (public or private), and the language and culture of the clinician and clients served. The first open-ended question investigated respondents' perspectives of PCC through metaphor analysis. Respondents were asked to provide an analogy to describe their experiences of PCC, i.e. Provide an analogy to describe your experiences of PCC (for example, "getting information from you is like pulling teeth" or "he took to it like a duck to water"): Implementing PCC is like (provide one word or phrase)____. Respondents were also requested to provide a reason for y. The remaining three open-ended questions provided the opportunity to indicate their i) perceived barriers and ii) facilitators towards PCC and iii) what could facilitate PCC in their current work setting.

2.3. Data analysis

Descriptive statistics, including frequency distributions and percentages, were used to summarize the demographic data obtained. An inductive-deductive approach to the qualitative data analysis [38] was used. The qualitative data were first coded independently by two members of the research team (FMA and RE). Using a collaborative and iterative inductive approach, themes were identified. Themes were identified from the data and mapped to five consolidated priori themes (clinician, client, clinician-client, workplace, and resources factors), deduced from the ten-item Likert scale of the e-survey [39]. An in-depth discussion (between FMA and RE) took place to resolve inconsistencies until consensus was reached.

Additionally, the collected analogies that respondents provided to describe their experiences of PCC were analyzed using metaphor analysis practices [39,40,41]. The shared, salient characteristics between the respondents' experiences of PCC and the provided reasons were categorized and mapped to five consolidated themes. Analogies were

grouped into six categories including uncertainty of PCC; PCC being essential; PCC being challenging; PCC being a relationship; analogies referring to animals; and food-related analogies.

3. Results

A total of 63 clinicians (92.1% female), of which 36.5% were audiologists, participated in this study (Table 1). A few respondents (12.6%) were based in academia and were involved in either research, clinical training/supervision or teaching, with some respondents completing their postgraduate studies full-time.

Most respondents were between the ages of 26 to 35 years old (33.3%), with close to half practicing in the private sector (44.4%). Respondents indicated that their language (26.9%) and culture (26.9) did not always match those of their clients. More than half (57.1%) of the respondents indicated that they followed a PCC approach to service delivery.

Sixty-one respondents completed the metaphor analysis, and between 57 and 63 respondents completed the three additional open-ended questions (63 responses to the question on barriers, 61 responses to the question on facilitators, and 57 responses relating to needs).

In the metaphor analysis, categorized analogies, along with their reasons, were mapped to four of the five consolidated themes and relevant sub-themes deduced from the e-survey (Table 2). Respondents' experiences of PCC varied with 44.3% labeling their experiences of PCC as positive, while 27.9% respondents' experiences were negative, and 27.9% indicating that they had experienced PCC as both negative and positive.

A dominant analogy provided by respondents included the use of the proverb, "You can lead a horse to water, but you can't make it drink", meaning one can show someone how to do something, but cannot make them do it. This analogy was categorized as animal related and was mapped to the themes client and workplace factors, categorized within the micro and meso system levels, respectively. The other dominant analogy used was a quote from the movie Forrest Gump, "Life is like a box of chocolates, you never know what you're going to get," associated with the food-related analogy category and referring to the uncertainty of a situation. This analogy was mapped to the themes of client and clinician-client interaction factors, both relating to the micro system level. Both dominant analogies reference a sense of unpredictability for the clinician regarding the outcome of management, regardless of the input they provide. Reasons provided for these analogies included, "You don't know who you are going to get in your session, especially in public health" and "I can share as much as I want (information/time/resources), but I cannot force you to accept it/come for therapy/follow a plan when you don't want to".

From the open-ended questions, five themes were represented from the respondents' perceived barriers toward PCC. Three of the barriers related to micro systems include; i) clinician factors, ii) client factors, iii) clinician and client interaction, and two related to factors within the meso system; iv) resources, and v) workplace.

Within the micro system level, the most prominent barrier of a PCC approach were the respondents' personal factors. These factors included their personality as well as knowledge and experience of PCC. Some clinicians expressed uncertainty and a lack of confidence in following the PCC approach, particularly when dealing with clients' emotional needs and differences during consultations. Language and cultural differences, within the clinician and client interaction theme, was the most prominent barrier identified.

On the meso system level, workplace rules and regulations were a barrier, especially when working with colleagues from varying health professionals who are either unaware of PCC principles or have differing perspectives on the approach. The lack of resources and tools appropriate for a diverse context emerged as the greatest reported barrier to implementing PCC. Limited resources, such as interpreters, that would help overcome mismatches between clients and clinicians regarding language and culture, further impede the ability to understand and provide tailored support to clients and their families. Additionally, respondents indicated that the time-intensive nature of PCC clashed with current billing systems, leading to potential conflicts between financial interests and client-centered care.

Only two themes were identified as facilitators towards PCC, clinician and workplace factors, respectively. According to respondents, their ability to offer PCC is supported by their personality traits, knowledge, and accumulated experience over time. The most prominent sub-theme within the workplace factors was team support which included support from management and interprofessional team members. When commenting on what respondents would need to implement PCC, factors mentioned aligned with reported barriers. The identified themes relating to respondents' needs encompassed clinician-related factors and the interaction between clinicians and clients - relating to micro systems, as well as resources and workplace-related factors, which pertain to factors within meso systems (refer to Table 3).

Table 1
Participants demographics (n = 63).

Demographics	n (%)
Gender	
Female	58 (92.1)
Male	5 (7.9)
Age (years)	
< 25	20 (31.7)
26-35	21 (33.3)
36-45	10 (15.9)
46-55	8 (12.7)
>56	4 (6.3)
Current Profession	
Audiologist	23 (36.5)
Speech-Language Therapist	23 (36.5)
Dual: Speech-Language Therapist and Audiologist*	17 (27.0)
Employment and health care sector#	
Private Practice	28 (44.4)
Academia	9 (14.3)
Public Sector	26 (41.3)
Community Service[a]	14 (53.9)
Independent practitioner[a]	12 (46.2)
Other	4 (6.3)

4. Discussion and conclusions

4.1. Discussion

The present study explored the barriers and facilitators to delivering PCC from the perspective of speech-language pathologists and audiologists in South Africa, a socio-economically diverse population. The respondents were equally distributed between speech-language pathologists (36.5%) and audiologists (36.5%) with 27% being dually qualified. There was strong alignment between the professional groups in their responses to the metaphor analysis and open-ended responses. This enabled a comprehensive and cohesive discussion of the findings across the sample. These findings shed light on important factors influencing the adoption of and adherence to PCC by healthcare professionals in this context.

While more than half (57.1%) of the respondents reported following a PCC approach to service delivery, a number of them identified barriers that may hinder them from effectively utilizing a PCC approach. These barriers could potentially explain why observational studies have shown that clinicians may miss opportunities to address clients' psychosocial needs, build rapport, involve clients and their family members in decisions, and provide options for rehabilitation [17,25,28].

Table 2
Metaphor Analysis: Themes, sub-themes, analogies, reasons and categories.

Theme	Sub-Theme	Analogy	Reason	Category
Clinician factors	Knowledge and experiences	"PCC is like peanut butter and apples, you either love it or you hate it." (Audiologist) "Breathing" (Audiologist)	"Some people love applying PCC and some people don't" "It comes natural"	Food related Essential
Client factors	Personality	"Life is like a box of chocolates; you never know what you're going to get." (Audiologist)	"We work with a vast majority of different cultures and demographics. You don't know who you are going to get in your session, especially in public health."	Uncertainty
Clinician and client interaction	Language and cultural differences	"Lost in translation." (Dual qualified)	"The majority of my patients don't speak Afrikaans or English"	Challenging
	Relationship	"Sailing a boat on smooth water" (Dual qualified)	"If you have your patient on board, you are hallfway there!"	Relationship
Workplace	Team and management support	"You can take a horse to water but you can't make it drink." (Speech-language Pathologist)	"Of a poor and unmotivated work environment and multidisciplinary team"	Animal related

First three rows represent micro system elements with the last row representing meso system elements
Dually qualified refers to participants that are qualified and practicing as both speech-language therapists and audiologists

4.2. Micro system level

4.2.1. Clinician factors

On the micro system level, the most predominant facilitators towards a PCC approach identified were respondents' personal factors. Respondents indicated that their knowledge and experience of PCC played a significant facilitating role in its adoption. Personal factors have know to be linked to personality traits that are associated with one's internal locus of control, such as empathy, compassion, and client-centered attitudes [17,42]. As such clinicians who possess these qualities are more likely to embrace the principles of PCC and provide care that focuses on the needs and preferences of their clients [1,10,43,44].

Contrary to some respondents indicating that they had the knowledge and skills required to provide PCC, several respondents indicated that they felt ill-equipped or lacking the confidence to follow this approach, aligning with the category "uncertainty of PCC" identified from the metaphor analysis. Previous studies have reported similar findings with allied healthcare clinicians reporting that they lack sufficient training in "people" skills and thus have reduced confidence to handle emotional needs and differences during consultations [45–47]. It has been noted that following a PCC approach requires clinicians to facilitate and develop an alliance with their client which requires "soft" or "people" skills [32,48].

4.2.2. Client factors and clinician interaction factors

Respondents' ability to implement PCC within the existing medical model of care and the consequential impact on client and clinician interaction, were reported barriers to implementing PCC. Respondents also mentioned that some clients were not open to sharing information or lacked the support and motivation to participate in a PCC approach, making it challenging for them to engage and support their clients, as evidenced by the dominant analogies identified in the metaphor analysis. **Client motivation and involvement has** also **been acknowledged as a barrier in previous studies** [1,6,24,27,28]**.**

4.3. Meso system level

4.3.1. Workplace factors

Within the meso system level, clinicians indicated that support within the workplace from management and interprofessional teams facilitated their individual implementation of PCC. When support was lacking, respondents identified this as a dominant barrier to PCC. PCC can be fostered if there is a supportive work environment that recognizes the values of PCC and adopts a culture of PCC thus providing clinicians with the necessary resources and support to implement the approach in their practice [49].

Older respondents and respondents with less experience, however, felt that rules and regulations within workplaces were a significant barrier rather than a facilitator towards implementing a PCC approach. A change in workplace rules and regulations may be on the horizon, driven by a top-down approach from the macro system due to the increased awareness about PCC within the fields of speech-language pathology and audiology, and standardized use of the ISO standards [9].

4.3.2. Resources

The greatest reported barrier to implementing PCC was respondents' lack of access to resources and appropriate tools, on a meso system level. This was mainly reported as a significant barrier to PCC implementation by respondents based in the public sector. Considering the extent of this challenge, it is resultantly considered a barrier to PCC on a macro level. South Africa's diverse context with 11 official languages and various cultures and the identified mismatch between clinician and client culture and language [50] reflected in the current study too, impacts the implementation of a PCC approach. Resources such as interpreters in South Africa are also limited [51], further impeding the ability to find responsive, short-term solutions to the challenge. This resonates with the challenges faced in other low- and middle-income settings, where resource constraints often hinder providing quality healthcare services, particularly in government healthcare sectors [35,36].

Time was also identified as a resources that was lacking which acts as a barrier to the implementation of PCC. A PCC approach is more time intensive to allow clinicians to get to know their clients and determine specific needs and requirements. Unfortunately, current billing systems do not often cover this extended time spent with clients [1]. This leads to financial interests potentially conflicting with the client's best interest because healthcare services function as businesses rather than as people-orientated engagements [52]. The juxtaposition between PCC and finance-driven approaches can impact client and clinician interaction, particularly in the private practice sector. Changes from within workplaces, on a meso system level, would be necessary for greater shifts towards PCC to be supported.

4.4. Study limitations

PCC is widely recognized as a fundamental element of contemporary healthcare, with clinicians assuming a crucial role in its implementation [2]. The current study provides valuable insights into the barriers and facilitators to the adoption and implementation of PCC by speech-language pathologists and audiologists within the diverse socio-economic context of South Africa. This study, however, is not without limitations. Only 63 participants responded to the open-ended questions, resulting in a relatively low response rate. Over the past few years, response rates to online surveys have declined dramatically due to the rise of online survey-based studies, resulting in online fatigue. Furthermore, individuals are deterred from participating due to privacy concerns as a result of personal information (personal details including

Table 3
Identified themes, sub-themes and example quotations regarding the perceived clinician-faced barriers, facilitators and needs towards a PCC approach.

Theme	Sub-Theme	Example quotations
Barriers towards PCC		
Clinician factors	Personality	"Emotional well-being of clinicians" (Dually qualified) "Openness to patients" (Speech-Language Pathologist)
	Knowledge and experiences	"Some new territory or if I feel I don't have enough experience in that specific area of need." (Dually qualified) "Financial constraints, mental health, incorrect knowledge or understanding based off other people's experiences." (Speech-Language Pathologist)
Client factors	Personality	"In some cases the clients motivation also plays a big role" (Speech-Language Pathologist)
	Lack of resources	"Financial burden of services on clients" (Audiologist) "Patients families not being involved in the rehabilitation" (Speech-Language Pathologist)
Clinician and client interaction	Language and cultural differences	"My inability to communicate with patients in their first language, especially in the case of foreign nationals may be the greatest barrier in intervention." (Speech-Language Pathologist) "Language differences and cultural variations" (Audiologist)
Resources and tools	Time	"I am a very passionate therapist and the PCC model can be time-consuming and taxing because you always want to try harder to give the best options to the family" (Speech-Language Pathologist) "Time is a huge barrier to implement PCC" (Audiologist)
	Availability and language of the tools	"Lack of quick to use and implement resources" (Audiologist) "Staff knowledge on PCC. "Resources and Tools that assist in the other implementation of PCC. This includes appropriate language and literacy assessments that have been standardized for the South African context. Additionally, including culturally appropriate pictures." (Speech-Language Pathologist)
Workplace	Team and management support	"Not everyone in the work place believes in PCC" (Audiologist) "Staff knowledge on PCC." (Speech-Language Pathologist)
	Setting	"Dysfunctional systems in the hospital make accessing care challenging and discouraging" (Speech-Language Pathologist) "Difficult in the ICU setting, which is very protocol-driven and impersonal. For some staff, the whole notion of PCC is very foreign, and allowing even the most basic PCC such as autonomy in decision-making around care, is challenging." (Speech-Language Pathologist)
Facilitators towards PCC		
Clinician factors	Personality	"I am strongly motivated to provide PCC" (Speech-Language Pathologist) "My friendliness and my ability to connect with my patients" (Audiologist)
	Knowledge and experiences	"My clinical expertise" (Speech-Language Pathologist) "My own experience and knowledge" (Audiologist)
Workplace	Team and management support	"Professional guidance in the workplace (supervisor)' (Audiologist) "The colleagues with whom I mainly work share my interest in providing PCC" (Speech-Language Pathologist)
Expressed needs to achieve PCC		
Clinician factors	Personality	"A change in my perspective about the ways in which I can help my patients follow through with rehabilitation" (Speech-Language Pathologist) "Being person centered, not only doing person centered" (audiologist)
Clinician and client interaction	Language and cultural differences	"The ability to speak Sesotho and a deeper dive into culture" (Dually qualified) "Learning the first language of the patients" (Audiologist)
	Relationship	"Understanding patients more and listening to them and allowing them to express themselves' (Audiologist) "really listening and talking less. I need to allow my patient to talk more and not restrict their answers according to my pertinent questions" (Dually qualified)
Resources and tools	Time	"More time during consultations" (Audiologist)
	Availability and language of the tools	"Translated resources" (Dually qualified) "Resource material in different languages applicable to the South African context" (Speech-Language Pathologist)
Workplace	Team and management support	"Truly working in a multidisciplinary team where everyone prioritises PCC" (Speech-Language Pathologist) "Interdisciplinary teamwork and guidance" (Audiologist)

Dually qualified refers to participants that are qualified and practicing as both speech-language therapists and audiologists

IP address) being obtained [53]. Generalization of the findings is hampered as findings represent a young South African population with a small sample size. The gender distribution of the sample is representative, however, of the gender profile of the professions, where 95% are female [54]. A limited number of participants were involved although saturation of results was reached [55].

The responses to Likert scale questions, adapted from Danermark [39], exhibited alignment between the metaphor analysis and open-ended responses. In addition, the quantitative questions may have influenced the participants' responses to the qualitative questions, however, this facilitated the inductive-deductive thematic analysis approach. The survey questions were designed in a manner that prompted participants to provide succinct responses to reduce the time to complete the survey, to encourage participation and full data sets. It is, however, important to acknowledge that these responses, albeit concise, still held relevance and could be appropriately coded and analyzed within the context of the research question. Lastly, future research should endeavor to gather more responses from clinicians in the public sector to gain a greater understanding of the socio-economically diverse South Africa setting. Clinicians working in public healthcare facilities experience additional factors, both facilitators and barriers, that may influence the application of a PCC approach [50,56].

4.5. Conclusion

Valuable insights into the barriers and facilitators to implementing PCC among speech-language pathologists and audiologists in a socio-economically diverse context (South Africa) emphasize the importance

of addressing contextual (meso and macro systems) and personal (macro system) factors to promote the implementation of PCC. Strategies should focus on enhancing clinicians' communication skills (macro level), collaboration (meso level), and teamwork (meso level), as well as addressing resource limitations through the adaptation of tools and implementation of PCC ISO standards (meso and macro systems). By doing so, realistic and sustainable strategies can be developed to enhance the care these professionals provide and improve client outcomes.

4.6. Practical implications

The identified findings underscore the importance of addressing both contextual (meso and macro systems) and personal (micro system) factors to promote and deliver PCC effectively. To this end, as reported by clinicians in this study, strategies should prioritize enhancing clinicians' communication skills with clients and collaborative teamwork with colleagues, while also addressing resource limitations by adapting tools and increasing funding. By adopting such strategies and implementing the ISO [9] standards, it is possible to develop realistic and sustainable approaches to the implementation of PCC. Adherence to PCC approaches can significantly enhance the quality of care, ultimately leading to improved client outcomes.

Ethics statement

The studies involving human respondents were reviewed and approved by the Research and Ethics Committee, Faculty of Humanities, University of Pretoria, South Africa. The patients/respondents provided their written informed consent to participate in this study.

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CRediT authorship contribution statement

Faheema Mahomed-Asmail: Writing – review & editing, Writing – original draft, Project administration, Methodology, Funding acquisition, Formal analysis, Conceptualization. **Marien Alet Graham:** Writing – review & editing, Formal analysis. **Louise Metcalfe:** Writing – review & editing, Data curation. **Renata Eccles:** Writing – review & editing, Formal analysis.

Declaration of Competing Interest

The authors declare that they have no known competing financial interests or personal relationships that could have appeared to influence the work reported in this paper.

Data Availability

Data from this study are available from the corresponding author upon request.

Appendix A. Supporting information

Supplementary data associated with this article can be found in the online version at doi:10.1016/j.pec.2024.108250.

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