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Research Article

Unmet Needs of Patients with Prostate Cancer Attending Cancer Centers in Eastern Kenya

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Abstract

Introduction: Prostate cancer (PCa) is the leading cancer among males globally. Patients with PCa experience a wide range of unmet needs including emotional, psychological, spiritual informational among others. However, resource constrained settings are unable to holistically address these needs. In Kenya, most studies assessing the unmet needs of cancer patients have been general or have focused on those already in palliative care. As a result, there is a gap in specifically addressing the unmet needs of patients with PCa across all stages of their disease and treatment, particularly those undergoing active treatment. Therefore, this study sought to explore the unmet needs of patients with PCa in Eastern Kenya. *Methods:* This was a qualitative descriptive study which was carried out in two cancer centers. A total of 32 males with histologically confirmed PCa participated in the study. Four focus group discussions (FGDs) were carried out, two per cancer center. Comprehensive Needs Assessment Tool (CNAT) was adopted as the interview schedule guide in the FGDs. Data was analyzed thematically. Ethical clearance and research permit were obtained from relevant authorities and the participants signed an informed consent. *Results:* The mean age of study participants was 71.94 years. Majority were married (81.3%, n=26) and over half were unemployed (53.1%, n=17) with a mean monthly income of about KES 5,078 (39$). All the participants had a medical cover mainly Social Health Authority (SHA) (78.1%, n=25). Most had been diagnosed at stage III (40.6%, n=13) and were on chemotherapy (75%, n=24). Only less than half reported to have comorbidity (31.25%, n=10) and all the participants did not belong to any support group (100%, n=32). Three main themes emerged: Hospital Environment, Psychosocial needs and Holistic distress. *Conclusion and recommendation:* These findings underscore a critical need for a more holistic approach that addressed these comprehensive needs to truly improve patient well-being. Therefore, healthcare providers should assess the unmet needs as they offer services to patients with PCa. The government should extend the scope of PCa management to include comprehensive support to the patients.

Keywords

Prostate Cancer, Unmet Needs, CNAT, Focus Group Discussion, Kenya

1. Introduction

Prostate cancer (PCa) was ranked among the leading cancers in morbidity and mortality globally in 2024 [1]. Recently, the incidence of PCa has shown an increasing trend in South Korea, Singapore, Vietnam, China, and Japan [2]. Similarly,

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in Sub-Saharan Africa, PCa is the most frequently reported cancer among males and it is the third among all the cancers in incidence and also in causing cancer-related deaths [3]. In 2022, PCa was the leading cancer among males in Kenya with 3, 582 new cases and 2,029 deaths [4]. PCa has further been reported as the most prevalent cancer among males in Meru County, Kenya [5].

Patients with PCa experience a wide spectrum of unmet needs spanning from emotional, informational, social, sexual, spiritual, and practical domains. Globally, mental distress is common among patients with cancer, with many patients with PCa reporting anxiety, depression, and reduced quality of life due to cancer diagnosis, treatment side effects, and fear of recurrence [6, 7]. In Germany, it was observed that approximately one-third of patients with cancer have unmet needs for psychosocial support [6], highlighting the necessity of integrating mental health services into oncology care. Similarly, a systematic review showed that survivors' post-treatment experiences are often shaped by emotional vulnerability, altered self-identity, and a need for reassurance [8]. Sexual health and intimacy concerns remain among the major concern yet usually under-addressed unmet needs. Erectile dysfunction, loss of libido, and fears about masculinity profoundly affect the patient's self-esteem and relationships [9]. These issues are compounded by limited communication with healthcare providers on sexual well-being [10]. From a coping and support perspective, patients with PCa employ strategies such as seeking peer support, spirituality, and focusing on positive lifestyle adjustments to manage the illness [11]. Nevertheless, coping success is strongly influenced by access to structured psychosocial interventions [12].

Routine assessment of patient-reported outcomes can help identify evolving psychosocial needs [13]. In Sub-Saharan Africa, however, research on systematic screening of unmet needs remains scarce [14] and stigma often limits help-seeking [15]. Moreover, cultural beliefs, marital status, and societal perceptions of masculinity shape patient's willingness to disclose distress, particularly among unmarried patients [16, 17]. Stigma and isolation among cancer patients has also been documented in African settings, where cultural silence around cancer and sexual health leads to delayed care and emotional withdrawal [15, 18]. Practical needs such as financial support for transport and treatment intersect with psychosocial well-being, especially in low-resource settings [18-20]. In Kenya and Tanzania, qualitative studies reveal concerns over health system support- including long waiting times, lack of continuity of care, and inadequate counseling services which in turn exacerbates psychological strain [18-20]. Patients with cancer, including PCa also report feeling isolated and inadequately informed about treatment options and side effects [18, 19, 21].

While several studies in Kenya [12, 15, 18, 20, 21] have examined unmet needs among cancer patients, most have been conducted among other patients with other cancers and not those with PCa and also on cancer patients already engaged in palliative care or support programs. There is limited research specifically addressing patients with PCa across different stages of the disease and treatment, particularly those undergoing active treatment rather than survivors or those in end-of-life- treatment. Hence, this study sought to determine the unmet needs of patients with prostate cancer.

2. Methods

2.1. Study Design and Setting

This was a qualitative descriptive design and was carried out in two government/public cancer centers in Eastern Kenya. The qualitative descriptive design was suitable to describe the unmet needs of patients with PCa [22]. The study targeted patients with a histologically confirmed PCa attending the two cancer centers in Eastern Kenya. The very sick patients and those who declined to give consent were excluded from the study.

2.2. Sampling Method and Sampling

This study was part of a larger study [23] where quantitative data was collected among 58 PCa patients and 32 were later purposively selected to participate a qualitative study; 17 and 15 participants from Embu and Meru cancer centers respectively. This qualitative study was conducted to explore quantitative findings.

2.3. Data Collection

The comprehensive needs assessment tool (CNAT), which had been used to collect the quantitative data was adopted as the interview schedule guide for the FGDs. The CNAT has a comprehensive structure with eight components that enables the researcher or healthcare provider to systematically identify and respond to the multiple, interrelated needs of people living with cancer [24].

Four FGDs were conducted two per cancer centre with seven to nine participants each. The FDGS were audio recorded and the researchers as well took notes of the general content of the discussion. The group discussions were conducted in English. However, some participants gave their responses in Kiswahili, since they were not very fluent in English.

2.4. Data Analysis

Data was analyzed manually. The researchers began with a verbatim transcription of recordings triangulating them with the notes taken. All the notes were combined with the tape-recorded discussions and retrieved verbatim and formed comprehensive notes, which provided qualitative data on the unmet needs of patients with PCa. The transcripts in Kiswahili were later translated into English. Six steps of qualitative data

analysis were used to analyze qualitative data [25]. The researchers read through the transcripts to familiarize themselves with the data before generating the initial codes. This was followed by the researchers searching for existing themes by collating similar codes in line with the eight components of CNAT. After that, a review of the themes and subthemes was done to test them for adequacy by comparing them with the raw data. Finally, the data were generated and presented in narrative form under three main themes: (a) Hospital Environment (b) Psychosocial needs (c) Holistic distress.

2.5. Ethical Considerations

We sought ethical approval from Chuka University Institutional Research Ethics and Review Committee (CUIERC/NACOSTI/586) and a research permit from National Commission for Science, Technology and Innovation (NACOSTI/P/24/39/242) for the study. All the participants provided informed consent at the beginning of the study.

3. Results

3.1. Characteristics of Study Participants

As shown in Table 1, the participants were older and had a mean age of 71.94 (±7.65) where the majority were aged between 60 and 74 years (62.5%, n=20). Majority were married (81.3%, n=26), had at least secondary school education and above (59.4%, n=19), were protestants (59.4%, n=12) and unemployed (53.1%, n=17). The mean household income was approximately KES 5,078 (US$39). All participants (100%, n=32) had a medical cover mainly the Social Health Authority (SHA) plan (78.1%, n=25). In terms of clinical characteristics, majority of the participants had been ill for more than 24 months (53.1%, n=17), had been diagnosed at Stage III (40.6%, n=13) and were undergoing chemotherapy (75%, n=24) as part of their disease management. A majority of the participants did not have a comorbid (68.75%, n=22) and none was part of a cancer support group though they all expressed a willingness to join one.

Table 1. *Characteristics of participants.*

Socioeconomic Characteristic (n = 32)		
Age		
	Mean (±SD)	71.94 (7.65)
	Median	71
	Range	60 – 90
Age group		n (%)
	60 - 74	20 (62.5)
	75 years and above	12 (37.5)
Marital status		
	Married	26 (81.3)
	Widowed	6 (18.8)
Highest level of education		
	Primary and below	13 (40.6)
	Secondary and above	19 (59.4)
Religion		
	Catholic	13 (40.6)
	Protestant	19 (59.4)
Source of income		
	Unemployed	17 (53.1)
	Formally employed	6 (18.8)
	Self-employed	9 (28.1)
Estimated family monthly income		

Socioeconomic Characteristic (n = 32)		
	Mean (±SD)	5078.13 (3820.80)
	Median	4500.00
	Range	500 – 15000
	500 – 4,999 (US$3.87 - 38.7)	16 (50.0)
	5,000 and above (aboveUS$38.7)	16 (50.0)
Had a medical cover		
	Yes	32 (100)
Type of medical cover		
	SHA	25 (78.1)
	SHA and a private cover	7 (21.9)
County of Residence		
	Tharaka Nithi	8 (25.0)
	Embu	7 (21.9)
	Kirinyaga	5 (15.6)
	Meru	12 (37.5)
Clinical characteristics		
Duration of illness		
	1 – 24 months	15 (46.9)
	More than 24 months	17 (53.1)
Disease stage		
	Stage II	9 (28.1)
	Stage III	13 (40.6)
	Stage IV	10 (31.3)
Disease management		
	Radiotherapy	11 (34.4)
	Hormone therapy	17 (53.1)
	Chemotherapy	24 (75.0)
Presence of comorbidity		
	No	22 (68.75)
	Yes	10 (31.25)
Type of comorbidity		
	Diabetes	4 (40)
	Hypertension	6 (60)
Belonged to a cancer support group		
	No	32 (100)
Would like to join a support group		
	Yes	32 (100)

Bold - majority

3.2. Unmet Needs of Patients with PCa

Table 2 shows a summary of themes and issues that were identified using the CNAT components before the themes were merged into three themes.

Table 2. *Key Emerging Issues.*

Unmet need	Key issue
Health care staff needs	Desire for respectful communication, and empathetic interactions Lack of involvement in treatment decisions Poor explanation of medical procedures
Psychological needs	Depression, fear, anxiety, and hopelessness Lack of routine emotional support or counselling Emotional suppression and loneliness
Family/social support needs	Relationship strain and role changes, insufficient emotional support, feelings of being a burden Loss of sexual intimacy and identity
Practical needs	Long travel distances and high cost of transport Loss of income and financial strain Lack of caregiving at home
Information needs	Poor guidance on diet, exercise and side-effects Confusing or conflicting medical information Lack of education on symptom recognition
Hospital facilities and services needs	Long delays for services Fragmented care and lack of coordination No dedicated staff to walk patients through care
Physical needs	Chronic pain, fatigue, nausea, treatment side effects, sexual dysfunction and cognitive decline, struggle with body image
Religious/spiritual needs	Mixed spiritual experiences and faith struggles Desire for trained emotional and spiritual support

Related areas were merged into three broad areas; hospital environment (needs related to healthcare staff, information, and hospital facilities and services), psychosocial needs (psychological and family/social support needs) holistic distress (physical, religious/spiritual, and practical needs).

3.2.1. Hospital Environment

Participants emphasized the need for empathy, respect, and clear communication. Warm, considerate care made them feel valued, while cold attitudes dehumanized them: "*Some nurses are warm… others are too cold… it breaks my heart when I am ignored"* (participant 1, FGD2). They also expressed their need for clear explanations to build trust and cope better: "*Doctors should not assume we don't need to know… a simple explanation goes a long way"* (participant 6, FGD4). They also demanded for active involvement in decision making saying this made them feel empowered while exclusion frustrated them: "*I appreciate it when doctors ask for my opinion… I feel empowered. It's my body"* (participant 2, FGD3). Unmet information needs left many confused and anxious. Some were discharged without guidance: "*I was sent home with little advice… I needed clear instructions"* (participant 5, FGD4). Others only learned of the side effects of the treatment from their peers: "…w*hen they recommended hormone therapy, they didn't tell me how long I'd be on it or what side effects to expect, I had to learn from other patients in the waiting room…."* (participant 7, FGD4*).* Others wanted clarity about their prognosis, warning signs, and evidence-based advice on diet and therapies to avoid misinformation. There was a strong interest in alternative and complementary therapies. One participant reported; *"…I heard about acupuncture helping with pain, but my doctor dismissed it. I wanted to know, is there evidence? Is it safe to try it alongside my treatment?"* (participant 6, FGD1).

Hospital systems also contributed to the participants' distress. Participants felt abandoned when passed between specialists without guidance and called for dedicated counselors. A participant said: *"When I got conflicting advice from different doctors, there was no one to help…. A dedicated counsellor would have saved me so much stress."* (participant 1, FGD 2). Delays in results and treatment scheduling, described as "*torture*" (participant 1, FGD4), heightened anxiety. Timely services were critical, especially for pain relief: *"There were times I waited a long time for pain medication, and it made me feel neglected"* (participant 2, FGD4). Emotional needs were often ignored, with doctors focusing on medical progress and overlooking mental health: *"The doctor asked me about my PSA levels but never how I was coping mentally,"* (participant 6 FGD1). Participants urged routine screening, counselling, privacy, comfortable spaces, and home-based follow-up as they felt forgotten after hospital discharge; *"…When you're recovering from major surgery, even basic wound care feels overwhelming. We need better transition support from hospital to home..."* (participant 3, FGD 3). One participant noted that rehabilitation and workplace reintegration were also important: *"I needed someone to explain reasonable accommodations for fatigue and bathroom breaks"* (participant 3, FGD1).

3.2.2. Psychosocial Burden

Participants described PCa as emotionally devastating, with depression and anxiety as dominant issues. Many felt their world had collapsed, with one saying he was "*…slowly disappearing inside myself"* (participant 6, FGD3), while another admitted to hiding his pain behind smiles (participant 4 FGD2). Anger and irritability were also common, often directed at loved ones: "*There are days I snap at my wife for no reason'* (participant 1, FGD4). Loneliness and fear of being a burden compounded these struggles, even within supportive families. One participant explained, *"Even in a room full of people, I feel distant"* (participant 2, FGD3), while another lamented "*I think my family is tired, even though they never say it"* (participant 6, FGD2).

Physical and treatment-related changes further strained the participants' self-esteem and social life. Incontinence, sexual dysfunction and weight loss left the participants struggling with their identity. "*…the scars and the weight loss… it's hard to look in the mirror"* (participant 5, FGD1). Although a few reframed these changes as *"…signs of survival*" (participant 5, FGD2), most saw them as daily reminders of loss. Friendships also suffered, as peers withdrew or excluded them from activities "*…some friends just disappeared…when I couldn't go out, they moved on" (*participant 1 and 6, FDG1). Illness also reshaped family roles and intimacy. Spouses often became caregivers, creating distance: "*My wife became my nurse, not my partner"* (participant 5, FGD4). Some participants felt fragile in their children's eyes or forgotten altogether: *"…my kids treat me like I'm brittle. I just want to feel like their dad again..."* (participant 3, FGD1). Another one added: *"…my sons don't visit as often as they used to… this disease makes you feel forgotten. I need help reconnecting with my family…"* (participant 5, FGD 4). Intimacy was strained as couples struggled to communicate about changes in sexuality and emotions. Despite this, acts of genuine support, such as a brother driving a participant to every chemotherapy session, were deeply appreciated. Yet others lamented empty gestures: "*People say, 'Let me know if you need anything,' but they don't mean it"* (participant 5, FGD 2).

3.2.3. Holistic Distress

PCa was described as not only a medical condition but profound disruption to daily life with pain, fatigue, and treatment side effects severely affecting physical and emotional well-being. Eating difficulties were particularly distressing, with one participant lamenting, *"I used to love food, but now even the smell of it makes me sick"* (participant 1, FGD 1), while another admitted, *"Some days, I force myself to take a few bites, but it's a battle just to keep it down"* (participant 8, FGD 4). These changes led to weight loss and weakness, compounded by fatigue and limited activity: *"Just walking to the local church feels like running a marathon"* (participant 3, FGD2). Visible physical changes, such as hair loss, reinforced feelings of vulnerability, and sexual dysfunction deeply affected identity and relationships. One participant confessed that: *"It's the hardest part for me, losing that connection with my wife. I feel less of a man"* (participant 2, FGD2).

Practical and financial struggles were also central to participants' experiences. They described it as being drained of savings, with one stating; *"Cancer has finished me financially… all the money I had saved is gone for hospital bills"* (participant 4, FGD4). Long, costly journeys to specialized care added to the burden: *"… if the treatment could be brought closer, it would save me time, money and pain"* (participant 7, FGD1). Lack of support for basic needs in hospitals and at home left the patients vulnerable, as one participant explained, *"Sometimes in the hospital, you need someone to help you even to go to the toilet, but there is no one"* (participants 8, FGD3). Caregiving demands were mostly experienced by the elderly spouses or young families, with younger parents stressing, "*Parenting through chemo is impossible… we desperately need affordable childcare help"* (participant 7, FGD2).

Spirituality was both a source of comfort and struggle. Some participants found reassurance in their faith: *"Knowing God hadn't abandoned me after diagnosis meant everything"* (participant 6, FGD3). Yet others wrestled with doubt and fear of mortality, with one participant admitting, *"I've always believed in heaven, but now that death feels closer, I'm scared* (participant 5, FGD 4). Empty promises, such as being told to *"…just have faith,"* were described as unhelpful (participant 3, FGD2), underscoring the need for more tailored, supportive spiritual care.

4. Discussion

The hospital environment and the quality of engagement with the healthcare providers play a central role in shaping the experiences of patients with PCa. Beyond medical treatment, patients' well-being is strongly determined by the empathy, communication, and responsiveness of staff, as well as the adequacy of hospital infrastructure and support systems. The following discussion highlights patients' perspectives on these issues.

4.1. Hospital Environment

The study participants of the current study wanted empathy, respect, and clear communication from healthcare professionals. They described feeling dehumanized when staff were cold or indifferent, but valued when treated with warmth and openness. They also stressed the importance of timely service delivery, especially for pain relief, and emphasized involvement in healthcare decision making. Similar findings are echoed in global research where Irish men with PCa felt more supported when clinicians showed compassion and explained treatment options clearly, enhancing trust and patient-provider relationship [26] as poor communication and lack of transparency in care left patients feeling excluded [27]. In Tanzania, PCa patients were reported to have perceived gaps in provider attitudes and responsiveness, which undermined their confidence in care [19]. These findings reinforce that provider empathy, timely care, and shared decision-making should be adopted while providing care to the patients.

Frustrations over limited, unclear, and inconsistent information from providers were issues that were identified by the participants. They often learned about side effects or treatment options informally from peers, and many desired clear instructions on symptom management, prognosis, dietary guidelines and use of alternative and complementary medicines. In Europe, patients with PCa emphasized the need for tailored, transparent communication to reduce uncertainty and enhance coping [27]. Moreover, both patients and stakeholders recognize informational support as a critical unmet need after discharge [28]. In Tanzania, patients felt neglected when information was incomplete or not delivered in a timely way [19]. The need for more information on alternative and complementary medicine is crucial since some patients with cancer including PCa, tend to use them with a majority not disclosing to their healthcare providers [29, 30].

Poor hospital infrastructure, delays in diagnostics, and lack of follow-up, and inadequate psychological and social support as major service gaps identified by the participants. They desired mental health screening, peer support, privacy, rehabilitation, and dedicated staff to guide their care journey. These findings mirror those reported among Chinese cancer patients who felt dissatisfied with fragmented hospital services and lack of coordination [31]. In Kenya, similar concerns about inadequate support and poor continuity of care have been documented [18, 21] findings that have also been reported in other nations across the globe [32, 33] These studies emphasize the importance of patient-centered hospital systems that integrate medical, psychological, and supportive services.

4.2. Psychosocial Burden

There was profound psychological distress following diagnosis, characterized by depression, anger, irritability and a sense of isolation. Altered body image from treatment side effects, such as incontinence and sexual dysfunction, further compounded emotional suffering. These findings are supported by a previous study that found that adjustment to PCa is often accompanied by loss of control, emotional turmoil, and identity struggles [34]. Another study reported that patients with advanced disease described uncertainty and psychological vulnerability as part of living with PCa [32]. In SSA, heightened psychological distress among patients with cancer, including those with PCa has been observed [18]. These findings are consistent with our participants' reports of depression and emotional breakdown. Collectively, these studies confirm that psychological distress is central to the PCa experience.

Participants of the current study felt abandoned by friends, were socially isolated, and emotionally distant from family members. Shifts in family dynamics, such as spouses assuming caregiver roles, strained relationships and reduced intimacy. Nevertheless, small acts of loyalty from family or peers were deeply appreciated. PCa has been reported to disrupt social roles and relationships, with patients struggling to maintain connections and intimacy [11], struggles that were also reported among our participants. Patients with PCa have highlighted the stigma and isolation they feel in relation to their diagnosis [35]. In Ghana, unmarried patients with PCa were reported to face even more acute challenges of loneliness and lack of social support [17]. These findings affirm that family and social networks can be both protective and strained, hence there is need for interventions that foster open communication and reduce stigma. In addition, there is need to train family members on caregiving as this may ease the patient's anxiety and enhance patient-caregiver quality of life.

4.3. Holistic Distress

Pain, fatigue, nausea, and sexual dysfunction emerged as dominant physical concerns in our study. These symptoms were described not only as clinical burdens but also as sources of emotional distress, undermining daily functioning, self-esteem and intimate relationships. This aligns with reports from across Europe where patients with PCa reported the need for support of treatment side effects such as fatigue and incontinence, which threatened their independence [29]. Similarly, patients with advanced PCa in China reported that they struggled with symptom burden and functional decline [36]. In

Kenya patients with cancer, including PCa, attending palliative clinic reported similar physical challenges, underscoring the need for holistic care [20]. This convergence of findings highlights that physical symptoms of PCa are inseparable from emotional and psychological well-being requiring targeted care approaches.

Spiritualty was a source of both comfort and struggle for this study's participants. Many found strength in prayer and belief in God's presence, while others wrestled with questions of mortality or felt dismissed by simplistic religious reassurances. Comparable issues were found among Irish patients with PCA who reported drawing resilience from faith but also grappling with existential uncertainty [26]. In SSA, it was observed that spirituality plays a central role in cancer coping though patients often lack structured spiritual support in healthcare system [16]. The findings of the current study echo this gap, highlighting that spiritual needs remain disregarded/overlooked despite their importance to coping and meaning making.

Financial strain, transport challenges, and loss of income were among the most pressing practical challenges identified by participants. Many described depleted savings, missed appointments, and reliance on untrained spouses for basic caregiving at home. Similar challenges had been reported in Tanzania where financial hardships and long travel distances were cited as barriers to care [19]. In addition, the feasibility challenges in regularly assessing patient-reported outcomes, as patients with PCa often faced resource constrains that hindered consistent engagement [13]. Palliative care patients in Meru, Kenya have highlighted financial and caregiving burden as major practical needs [20]. This consistent finding confirm that financial and caregiving strain are universal but particularly acute in African context where systemic support such as insurance and home-based care remain limited [37]. As a result, the participants are likely to experience poor health outcomes since they are unable to take care of all healthcare costs [38].

5. Strengths and Limitations

The strength of this qualitative study is that it enabled the researchers to uncover the details, context and extent of the unmet needs of the study participants, as a result, provide holistic view of the participants lived experiences and the meaning they attach to them. However, one limitation of this study is that the participants of the study were from only four counties hence the results of the study may not be generalizable to the entire country as well as regionally and globally.

6. Conclusion and Recommendations

This study reveals that the experience of living with PCa is multifaceted, extending far beyond the clinical symptoms. Participants of this study faced psychological distress, feeling abandoned, isolated, and overwhelmed by a loss of independence and identity. Their struggles were compounded by a lack of empathetic and timely care, insufficient information, and major practical barriers like financial strain and transportation challenges. These findings highlight a critical need for more holistic, patient-centered approach to cancer care. Moving forward, interventions must address not just the physical illness but also the profound emotional, social, and practical needs of these participants to truly improve their quality of life.

Abbreviations

CNAT	Comprehensive Needs Assessment Tool
FGD	Focus Group Discussion
HCP	Health Care Provider
Ksh	Kenya Shilling
PCa	Prostate Cancer
SSA	Sub-Saharan Africa
US$	US Dollar

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Author Contributions

Monicah Kiraki: Conceptualization, Formal Analysis, Methodology, Resources, Writing – original draft

Catherine Gichunge: Supervision, Writing – review & editing

Domisiano Impwii: Supervision, Writing – review & editing

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Data Availability Statement

The data supporting the outcome of this research work has been reported in this manuscript.

Conflicts of Interest

The authors declare no conflicts of interest.

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