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Lived experiences of gynaecological cancer survivors in Oman: a qualitative study

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ABSTRACT

Objective A significant number of patients with gynaecological cancers survive their disease and are considered cured. However, the diagnosis of cancer and its treatment can affect quality of life adversely. We sought to explore the lived experiences of women surviving gynaecological cancers in Oman.

Methods Omani patients with gynaecological cancers who had completed their treatment more than 1 year ago and were following up in the medical oncology clinic at a major cancer centre in Oman were interviewed. A qualitative study design was employed using face-to-face semistructured individual interviews. To prevent recall bias, women diagnosed with cancer within the past 5 years only were included. The sample size was determined using data saturation, where data collection revealed no new information. All interviews were tape recorded and transcribed verbatim. Transcripts were analysed using a standardised thematic analysis approach.

Results Four main themes emerged: 'Beliefs and attitudes'; 'Living with Treatment Complications'; 'Living with cancer' and 'Coping with the Cancer Journey'.

Conclusions The diagnosis of cancer had a profound effect on the lives of women with gynaecological cancer. The diagnosis negatively affected their lives throughout their cancer journey due to social role changes, fertility and sexual problems. Religion and social support played major roles in coping with the disease. This is the first study describing the lived experiences of Muslim and Omani survivors of gynaecological cancers and may help to determine their survivorship needs.

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ This is the first qualitative study that provides an in-depth understanding of the lived experiences of Omani survivors diagnosed with gynaecological cancers.

⇒ The experiences described in this manuscript might not reflect the experiences of all Omani women with gynaecological cancers.

⇒ Being a qualitative study with small sample size conducted in a single cancer centre in Oman affects the generalisability of the findings.

BACKGROUND

Over the years, significant improvements in screening, early detection, diagnostics, surgical expertise, radiation techniques, combination chemotherapy and supportive care have changed the landscape of cancer outcomes. As the incidence of cancer increases, and more patients are cured, the number of cancer survivors continues to increase.[1]

Gynaecological cancers constitute the fifth most common form of cancer worldwide.[2] Many successful efforts have increased the life expectancy of patients with gynaecological cancer and an increased number of 'cured' patients. On the other hand, diagnosis and treatment of gynaecological cancers lead to health problems that may have a negative effect on the quality of life (QoL) of survivors and their families.[1 3] Women with gynaecological cancers struggle through different stages of illness, and changes in their roles, responsibilities and social functioning have been reported.[4] Furthermore, cancer negatively impacts a woman's sexuality, sexual functioning and sense of self.[4–8]

Despite the disruption the cancers bring to the lives of women and their families, the growing number of studies focusing on their QoL, there are limited studies which provide in-depth understanding of women's experience living with gynaecological cancers. In addition, there are only a few reports of the impact of cancer diagnosis on Muslim women. Experiences of Turkish women with gynaecological cancer included physical and psychosocial difficulties, effect on family and daily life and the meaning of illness, especially as a woman.[4] In Iran, women used coping behaviours, such as worshipping and believing that illness and healing come from God during the process.[9] Gynaecological cancers are the seventh most common form of cancer in Oman; between 130 and 150 new cases are diagnosed annually.[10] This study aimed to explore the lived experiences of Omani women surviving gynaecological cancers.

METHODOLOGY

This study was conducted at a tertiary referral hospital in Oman between September 2019 and June 2020. Oman is situated on the eastern side of the Arabian Peninsula. The population is predominantly Muslim and Arab. For an in-depth exploration of the experience of living with gynaecological cancers, a qualitative study design was implemented using face-to-face semistructured individual interviews.

The study design allows for in-depth understanding of participants' experience.[11] Interviews were conducted using a topic guide designed on relevant literature and the main objectives of the study. To prevent recall bias, women diagnosed with cancer within the past 5 years were included. Furthermore, the participants had to have received treatment in a curative setting and should have received their last treatment 1 year or prior to the interview.

A purposive sampling method was employed. The sample size was determined by data saturation, and the interviews were stopped when there were no new issues or emerging themes and participants repeated the same issues/concerns. Also, data saturation was established as the researchers had captured in-depth experiences of women living with gynaecological cancers in Oman.[12]

All interviews were tape recorded and transcribed verbatim. Each interview took 30–45 min, and the transcript was validated by the research team. The interviews were conducted by one of the research team members (HA), who is a healthcare professional but had no direct contact with patients in the clinical setting. She is an Omani woman who speaks Arabic as her first language and identifies herself as a researcher.

For the analysis of this study data, the researchers embraced a pragmatic approach of thematic analysis by adapting the method of Clarke and Braun. Clarke and Braun's approach is a systematic approach consisting of six main steps.[13] The researchers started the analysis by familiarising themselves with the data by reading the interview transcripts. Two members of the research team (HA and AM) reviewed the transcripts and generated initial codes independently. Both are healthcare professionals who speak Arabic as their first language. Then both researchers met and reviewed the codes and agreed on the main codes that are relevant to the study aims and objectives. This was time-consuming, resulting in several discussions until consensus was reached. Then, meetings were held with other members of the research team, and each code was validated and grouped with other similar codes to create common themes. The themes were then reviewed and compared with ensure they reflected the participants' experiences as they told their stories. The final step was inserting the themes into the manuscript, supporting them with the participants' accounts of their experiences.

Selected quotes representing themes were translated by HA into English. The translated quotes were reviewed by another bilingual member of the team and translated back to Arabic. The original quotes and the back-translated versions were examined by an independent member of the team for inconsistencies.

The study was approved by the Medical Research Ethics Committee, College of Medicine & Health Sciences, Sultan Qaboos University. All patients signed an informed consent. In accordance with the journal's guidelines, we will provide data for independent analysis to a selected team suggested by the Editorial Team for the purposes of additional data analysis or for the reproducibility of this study in other centres if such is requested.

Table 1 Sociodemographic profile of the study participants

Variable	Category	Number
Age	18–30 years	2
	40–50 years	4
Marital status / education	Married/illiterate	1
	Married/primary-secondary school	1
	Married/university level and above	2
	Single/university level and above	2
Children	Having children	3
	No children	3
Employment	Employed	2
	Not employed	4
Diagnosis	Vaginal sarcoma	1
	Cervical	1
	Uterine/endometrial	2
	Ovarian	2
Years since diagnosis	2–4	6
Cancer staging	Stage 1A	2
	Stage 1B	2
	Stage 4	2
Family history for cancer	Positive	2
	Negative	4
Treatment received	Chemotherapy	1
	Chemotherapy+surgery	3
	Chemotherapy+surgery +radiotherapy	2

Patient and public involvement

Patients and the public were not involved in the design, conduct, reporting or dissemination plans of this research.

RESULTS

Six survivors were interviewed. Information about sociodemographic and clinical profiles was extracted from clinical records and is illustrated in table 1. Four themes were extracted: 'Beliefs and attitudes'; 'Living with Treatment Complications'; 'Living with cancer' and 'Coping

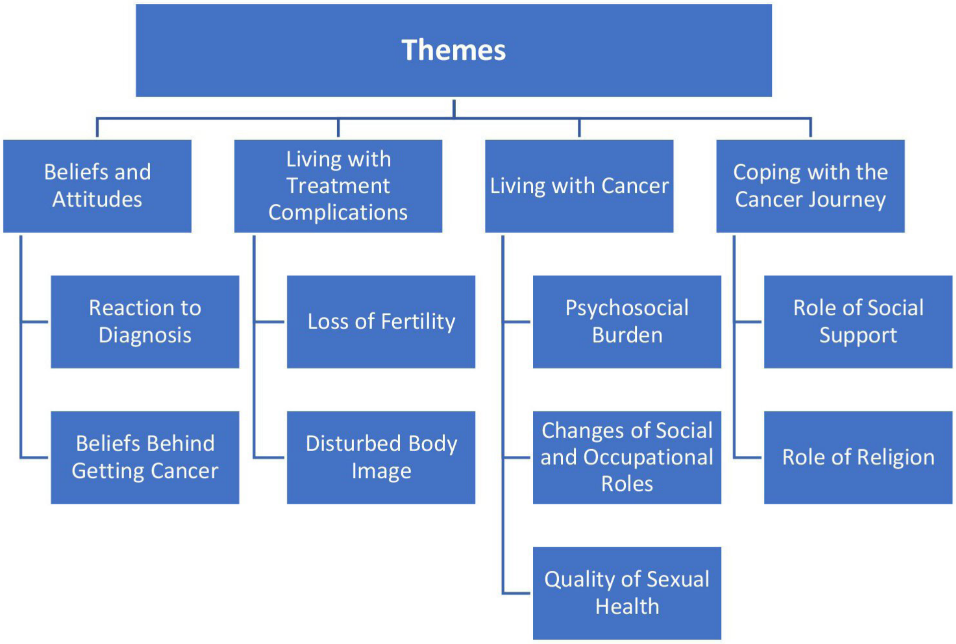

Figure 1 Four main themes have been identified based on the experiences of Omani women with gynaecological cancers. Many of the main themes have subthemes that are highlighted mainly by the experience of the study participants.

with the Cancer Journey'. Themes and subthemes are shown in figure 1.

Beliefs and attitudes

For an in-depth exploration of the women's experiences living with cancer, we had to understand how they reacted to the diagnosis of cancer. Participants had different attitudes, beliefs and reactions when they received the cancer diagnosis. Being diagnosed with cancer was shocking for many participants. Hiding the diagnosis was a common reaction, mainly to avoid family distress. There was better acceptance of the disease when the diagnosis was analysed in a religious context. Two subthemes were identified:

Reaction to diagnosis

Women who participated in this study were able to clearly recall their day of diagnosis and its profound effect on them and their families. Their cancer journey started mainly with shock and disbelief. All participants linked 'death'" to the diagnosis of cancer. Despite having some cancer signs and symptoms, some participants did not accept the diagnosis and were in denial and sought a second opinion overseas.

> Participant 2: Up till now I feel I don't have it (cancer), although all the investigations showed that I have cancer, and I removed the uterus but till now I ask myself 'is it cancer? do I have cancer disease, or I have been misdiagnosed? I don't know!!' Till now still I feel it is not (cancer).

Half of the participants preferred to hide the diagnosis mainly to avoid family distress. COVID-related social restrictions made it easier to hide the diagnosis from others. Participants tried to 'be strong' and hide their feelings to avoid family distress related to their cancer diagnosis. To them, acting as 'strong' was a mechanism to comfort their loved ones.

> Participant 5: I must be strong for my family. Also, for my husband, I feel when I am weak, they all become weak, I used to hide my feelings.

Some participants were expecting the diagnosis because they interpreted having a related symptom with the background of having a previous cancer or being at high risk of developing cancer. They felt there was a delay in diagnosis, which led to frustration and mistrust in the healthcare system, causing them to seek second opinions, and had an impact on their coping. Some participants thought that the delay in diagnosis affected their prognosis.

> Participant 5: At first when I went to the hospital (one of the tertiary hospitals), they informed me that I have nothing!! without even examination!!! I think the problem here is medical negligence, they always neglect patient's small complaints. When the doctors informed me later (in the same hospital) that I need to do the surgery, I decided to travel abroad to do it, how can I trust them after they missed my diagnosis earlier.

Beliefs behind getting cancer

Participants had different thoughts about why they have got cancer. Four participants believed that the disease was sent from God, maybe as a sign that God loves the person, or that it could be a test from God. These interpretations made some of them accept the diagnosis as it concurred.

> Participant 1: I have nothing to do with that, no one has given it to me, it is sent from God and thanks God.

One participant who was educated and not married linked the cancer diagnosis with Blackmagic. To her, the diagnosis and disease progression were difficult to explain and were linked to many events. This participant had two different cancers.

> Participant 4: I thought about magic. Before it was envy!! when I used to work, many young men proposed to marry me and I rejected them, also I got marriage proposals from my relatives. I linked my disease to magic, because I got the disease in a body part that is vital for women. But in the end, I had to accept my faith.

Living with treatment complications

One of the main concerns was the treatment-related complications and their effect on the participants' lives. For the participants, cancer treatments had a profound effect on their lives as they affected them in different aspects. They had many side effects such as hair loss, generalised fatigue, fever, infection and long hospital stay, infertility, losing virginity, skin changes and mood symptoms. The side effects of the treatment, whether it is chemotherapy, radiotherapy or surgery, did cause distress to all the participants.

There are two main subthemes highlighted by the participants' experience:

Loss of fertility

Half of the participants had one or more children. For most participants, losing fertility was a major loss in their cancer journeys. Many of them wished for the preservation of fertility, whether they did or did not have children. Loss of fertility affected how the women perceived themselves as women and wives. For married participants, childbearing, with more than one child, was also important. Loss of fertility did disturb some women's marriage lives as they were unable to have children, which resulted in husbands taking second wives. For unmarried participants, this has affected their future of getting married and having families.

> Participant 5: It is a negative thing when someone is not able to have children. Sometimes I get some ideas about why I did not get married earlier before getting this problem and I cannot have any more children.

Disturbed body image

All participants were concerned about the change in their body image. Participants were very concerned about how treatment had changed their bodies and stated they felt ugly, defeminised, had decreased self-esteem, and disturbed body image. For one participant in particular, the period when she got chemotherapy was a very distressing time that she had struggled to cope with. For this participant, she not only lost her look and attractiveness but also linked her change in appearance to loss of marriage life and feeling of loneliness.

> Participant 2: For the first time in my life I felt I was ugly, not beautiful, no eye lashes, no eyebrows, no hair, no skin fairness, no body weight, no child and no husband around! That's a difficult thing to feel, when you feel that your attraction as a female is not only less, but it also disappeared.

As mentioned earlier, the COVID pandemic lockdowns helped the women to hide their diagnosis by hiding the changes on their bodies, especially losing their eyebrows. COVID-related social restrictions made it easier for them to hide the diagnosis and treatment side effects, as there were limited social interactions during that time. For them, less social interaction made them feel better as a limited number of people had seen the changes on their bodies due to treatment side effects. So, they do not have to explain to people the reason for those changes.

> Participant 1: For months I did not meet anyone outside the house, we meet for short time only, I used not to go to any events. When I lost my eyebrows already COVID-19 started and everyone stayed home, I did not meet my sisters.

Living with cancer

This led to changes in women and their families' lives affecting them psychologically, altering their social roles as mothers, wives, daughters, etc. For married women, it also affected the quality of the women's sexual life. Three subthemes emerged as the participants in this study lived with cancer as cancer survivors. These include:

Psychosocial burden

The diagnosis of cancer caused anxiety, and some participants preferred to seek a second opinion. All participants expressed 'fear of death', 'fear of disease recurrence'"; '"distress caused by being treated as a sick person'"; "'feeling lonely'"; "'deep understanding of human nature, weakness and vulnerability'" and "'the need for psychological support from the healthcare team'".

> Participant 1: I really was scared, I was thinking about my children if I died, initially I became suspicious that this disease will kill me

It is very important to highlight the important role families played in all the participants' cancer journeys. Participants' families were either very supportive or anxious and overprotective. For this study, participants' families included parents, siblings, spouses as well as children. They all played different roles and shaped the participants' experiences. To reduce their families' psychological burdens and worries, some participants tried to avoid allowing family members to accompany them to their hospital appointments.

> Participant 4: From the start (of diagnosis) they were caring about me and thanks God they are not that type of family that may mistreat or abuse their daughter, but they started to be more afraid about me and seeing me as a sick (person), so I was coming to the hospital alone so they don't become afraid about what the doctors will say.

Changes in social and occupational roles

Participants went through changes in their social and occupational roles after being diagnosed with cancer. One-third of the participants felt that they did not have the energy, felt exhausted and had no drive to carry on doing their usual work.

> Participant 1: Now I don't feel like doing any household work, now I don't have the will to do anything. I just want to go out, I get depressed if I don't go out for 1 day.

The diagnosis of cancer has also disturbed married women's lives. The disease and its treatment affected women's appearance, fertility and their level of energy, resulting in unstable marriage lives. Some participants felt guilty as they were not able to satisfy their husband's needs. One participant was disappointed as her husband married a second wife after she was diagnosed with cancer; two believed that their husbands had the right to marry a second wife to reduce their guilt feelings.

> Participant 2: Once I talked to my husband, I said till now I didn't count my losses because of the disease, I don't have children, and I have my uterus removed. Shortly after radiation my husband did marry, I felt it like a slap on my face, I had to deal with all these together.

Some felt that their role as a mother was affected; one became overprotective of her only child. Furthermore, having children made some participants more psychologically distressed with the diagnosis of cancer as they were worried, they would die and leave their children alone. Others realised they cannot contribute to the care of their children. They felt that there was a gap between them and children because of the effect of disease and its treatment.

> Participant 5: During the treatment, I did not look after my daughter, she was 5 years old. There was a gap in our relationship, she was very young when I got the disease. I had to leave her and go abroad.

Some women found that their workplace did not provide them with career development chances. Some were uncertain about being fit physically to resume work. The cancer and its treatment affected working participants' career development.

> Participant 4: I feel I am oppressed at work; I did not get the promotion I deserve. I wanted to continue studying, but I was not able to do so because I got cancer and then my family did not allow me to complete my study because of study stress, they were worried that this stress may affect my health.

Quality of sexual health

Sexual health is perceived to be a sensitive, private and confidential issue, not frequently discussed. It was not easy to discuss sexuality and sexual desire with all the participants except one of them who is a highly educated woman with no children. Fatigue and low mood were found to affect the participants' intimate lives. Despite having no sexual complaints, some participants found it difficult to have the same premorbid level of intimacy because of the chemotherapy side effects and fatigue. Some participants used to get pain with sexual activity and linked the sexual relationship to pain, which was distressing for them. Even after the pain disappeared, they had decreased interest in sexual activity. It is interesting that one husband was worried about getting negatively affected, through sexual relationship, by chemotherapy and radiotherapy.

> Participant 2: He (husband) was worried that he gets affected with the chemotherapy and radiotherapy I received, but our sexual relationship was normal. But you know I had no energy when I was on chemotherapy and I was not in the mood and I didn't want to talk to anyone, and I was always nervous and silent not joyful!!! He asks me where my smile is, where my joy and jokes are, I say I am sick and tired, I am exhausted, he wants me to act as before, but we are going through difficult times.

Coping with the cancer journey

Coping with a cancer diagnosis was positively affected by two factors: social support and religious beliefs. Circumstances related to late diagnosis negatively affected the coping and treatment journey of some participants. One participant found the disease a financial burden. Several participants travelled abroad to seek a second medical opinion or even started treatment while still overseas, which added to their financial strains. Two main subthemes were identified:

Role of social support

Most of the participants emphasised the supportive role of their close family, husband, children and husband's families, which had a great impact on accepting the diagnosis and treatment. Despite the marriage strains, some of the participants' husbands played an integral role in supporting them by making them feel accepted and desired. Husbands' support made a difference in how the participants accepted the disease and their body changes.

> Participant 5: Every time I move away from my husband, he tries to come closer, so I don't feel there is a problem. Even when I lost my hair, he used to say: 'it is fine, you don't have to cover your head or wear a wig, I accept your look', this made me feel positive.

On the other hand, as mentioned earlier, sometimes family members were over-protective, making patients more anxious and emotionally disturbed. This made some participants avoid informing their families about their disease status.

Role of religion

For all participants, the word ‘God’ was prominent during the whole interview. They all praised God all through their disease journey. Many participants practised religious rituals more frequently after the diagnosis of cancer, for example, reading the Quran and praying, which made them feel relaxed and affected their coping positively. It was evident that faith in God and religion were the main factors in adaptive coping with the illness. They were convinced that the disease was sent from God, a test from God, and hoped for reward from God.

> Participant 3: Maybe something good for me, God test people if he loves them.

DISCUSSION

Summary of main results

Lived experiences of Omani women with gynaecological cancers who participated in this study consisted of four major themes (figure 1).

Results in the context of published literature

We chose a qualitative study design to have an in-depth exploration of the experiences of women with gynaecological cancers, including the balance between treatment and the sexual, psychosocial and financial effects of treatment. The diagnosis of cancer was shocking for Omani women with gynaecological cancers; some of them doubted the diagnosis even after starting the treatment and living with the disease and treatment complications. All participants linked the cancer diagnosis to death. Despite advances in cancer care and the increased number of cancer survivors, perceiving a cancer diagnosis as a death sentence is a worldwide phenomenon and has been widely reported in the literature.[14 15]

Many participants explained their diagnosis of cancer to Gods’ will, and another participant linked it to ‘Black Magic’. A qualitative study exploring the coping strategies of Omani women with breast cancer showed that Omani breast cancer survivors struggled to find a meaning or reason for their illness, and they related their illness to ‘super-power’, rather than physiological/anatomical changes.[16]

Based on the participants’ accounts, cancer treatments had a profound effect on their lives. Two main complications affected them the most: ‘how they looked’ and ‘losing their fertility’. Changes in body image due to treatment complications have been widely reported in the literature.[17 18] A recent survey from Canada reported that participants reported feeling ‘ugly’ and ‘disfigured’. This made many of them to experience emotional distress, which affected their daily lives and their relationships.[18]

All gynaecological cancers pose a potential threat to loss of fertility due to treatment complications. Surgical intervention, chemotherapy and radiotherapy all have the potential to damage or alter the women’s reproductive organs.[19] All women included in this study were less than 50 years of age; therefore, loss of fertility was a major concern for both married and unmarried women. Studies showed that infertility is a concern for women with gynaecological cancers and influences their cancer treatment plans, as parenthood is perceived by many as the most important in life. Infertility affects the QoL due to side effects of treatment, self-perception, depression and unstable relationships. Several studies report infertility as a concern, second only to the chances of recurrence in survivors of gynaecological cancers.[20]

In many countries, women are offered fertility preservation services, which were not the case for the participants in this study.[19] None of the participants mentioned anything about fertility preservation, which raises a question of whether to offer such services and their importance for young women with cancer.

The participants expressed carrying a lot of psychological burden through their cancer journey. Studies report the prevalence of cancer-related distress in the gynaecological cancer survivors to be as high as 85%.[21] Multimodal treatment, a history of psychological distress and a high body mass index predict a higher rate of distress.[22 23] Lived experiences of patients with gynaecological cancer reveal the role of social support—or its absence, selective withholding of information and existential loneliness in women as the major factors for the distress.[24]

Several participants experienced disturbance of their roles as daughters, wives and mothers due to low energy levels. This observation is consistent with earlier studies.[25] Treatment can be debilitating, limiting activities of daily living. Patients may feel depressed, emotionally labile and develop guilt that they bring disgrace to their families and may stay indoors because of perceived altered body image.[26]

Another important theme was the quality of sexual health. Participants reported decreased sexual desire, reduced interest and satisfaction, feelings of guilt, fatigue and low mood. Survivors experience a broad range of sexual concerns.[6] Common concerns are dyspareunia, decreased sexual activity, decreased libido, alterations in body image, anxiety related to sexual performance, difficulty maintaining previous sexual roles, emotional distancing from the partner and perceived change in the partner’s level of sexual interest. The treatment of gynaecological cancers can have varying impacts on sexuality across different cultures and populations. For example, one study reported women experienced a change in their sexual functioning after treatment; however, not all women experienced a negative sexuality change, and many reported both pleasurable and difficult sexual experiences.[27] Half of the participants reported a significant disruption in their sexual lives prior to treatment due to severe symptoms.

The authors challenge the argument that treatment for gynaecological cancer has a greater negative effect on women's sexual functioning than the symptoms of the disease themselves. The symptoms prior to diagnosis may be worse compared with treatment side effects. Several women described a process of re-embodiment after treatment, where they came to accept and celebrate their sexual identity. Higher rates of sexual dysfunction and distress were observed in patients with ovarian cancer compared with the general population, mainly due to gaps in communication with healthcare providers and using different strategies for coping.[28]

Most participants in the current study reported religion and social support as positive and supportive coping factors. Significant positive correlations between social support and hope scores in women with newly diagnosed or recurring gynaecological cancer have been reported previously.[21] The burden of physical symptoms may worsen the emotional well-being of gynaecological cancer survivors who have fewer social support resources.[29]

The participants in our study used religious beliefs to cope in a positive way. They believed in the will of God and accepted the diagnosis as beyond their control. They were convinced that they would receive a reward from God later. Having a positive relationship with God made them gain the sense of self-acceptance and emotional comfort. Practising rituals and prayers served as a soothing mechanism and reduction of negative emotions. A strong relation between patients' reliance on religious beliefs and practices has been reported previously.[30 31] Among Tunisian women newly diagnosed with breast cancer, who had a moderate to high level of religiosity, a weak correlation was found between religious coping scores and depression, as well as anxiety scores. High levels of affective religiosity were the main predictive factor of positive religious coping.[25] Religious beliefs and practices helped Arab–Palestinian women with breast cancer to handle psychological distress.[32] Among American Indian women, 93% used a variety of spiritual or religious coping.[33] Duman reported a positive correlation between religious attitudes of Muslim women with gynaecological cancer and mental adjustment.[34] Coping and spiritual well-being were positively affected by spiritual intervention carried out by oncology nurses with spiritual training in Indonesia.[35]

Strengths and limitations

This is the first qualitative study of Omani gynaecological cancer survivors that provides an in-depth understanding of their lived experiences. There are some limitations. First, the sample size was small; however, since the data were analysed simultaneously with ongoing interviews, we were able to identify the saturation point and concluded the study. Second, since this study was conducted in one cancer centre in Oman, the findings may not be generalisable. However, this study sets a benchmark for future work.

Implications for practice and future research

Healthcare professionals need to design and implement new interventions to support women with gynaecological cancers and consider their social, psychological, religious/spiritual and sexual needs. There is a need to develop tools to assess the effectiveness of different interventions and continue to assess the QoL of women throughout their cancer journey and survivorship.

Conclusion

We report the lived experiences of Muslim, Omani survivors of gynaecological cancers from Oman. Religion and social support were used as the major coping mechanisms. Change of occupational and social roles, loss of fertility and quality of sexual health affected the QoL of survivors. Healthcare providers can provide effective and comprehensive care to survivors and their families if they fully understand their physical, emotional, social and spiritual experiences. Follow-up programmes should be integrated to include individual women's needs regarding psychosocial aspects, providing person-specific information, and if needed, intervention.

Contributors HA-A, IB and MAB conceived the presented idea. They worked together for the study proposal. HA-A and MAB collected the data. HA-A conducted the interviews and transcribed them verbatim. HA-A and AM did the thematic analysis. IB did the themes validation. HA-A, IB and AM prepared the manuscript. All authors have read and approved the final draft of the manuscript. HA-A is the guarantor, HA-A accepts full responsibility for the finished work and the conduct of the study, has access to the data, and controlled the decision to publish.

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Patient consent for publication Not applicable.

Ethics approval This study involves human participants and was approved by the Medical Research Ethics Committee (MREC), College of Medicine & Health Science, Sultan Qaboos University. REF.NO.SQ-EC/030/19. MERC APPROVAL# 1854. Participants gave informed consent to participate in the study before taking part.

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Data availability statement Data are available upon reasonable request. All data relevant to the study are included in the article or uploaded as supplementary information. This is a qualitative study. The study transcripts and analysis are available for sharing.

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