Author’s response to reviews

Title: Awareness, knowledge, attitude and practice of adverse drug reaction reporting among health workers and patients in selected primary healthcare centres in Ibadan, southwestern Nigeria

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Author’s response to reviews:

POINT-BY-POINT RESPONSE TO EDITOR’S AND REVIEWERS’ COMMENTS IN RESPECT OF OUR MANUSCRIPT CODED: BHSR-D-19-01703

Dear Editor,

BMC Health Services Research

We are very grateful for the comments and suggestions received in respect of our Manuscript coded: BHSR-D-19-01703 and titled “Awareness, knowledge, attitude and practice of adverse drug reaction reporting among health workers and patients in selected primary healthcare centres in Ibadan, southwest Nigeria” We have found the comments quite useful.

Kindly find below the point-by-point response to editor’s and reviewers’ comments and suggestions in respect of our manuscript. Details of clarifications and modifications made to the original manuscript are highlighted in YELLOW in appropriate sections of this revised version. The appropriate locations where modifications, clarifications and inclusions were made in the revised manuscript are highlighted in this response letter.
Technical Comments:

Please do the English editing.

RESPONSE

The revised manuscript has been comprehensively revised and edited by a native English speaker and all the typographical and grammatical errors pointed out have been appropriately effected in the revised manuscript. See the entire revised manuscript for the edited corrections.

Editor Comments:

Methods

1. The total number of PHCs in Ibadan should be stated so that we could justify the representativeness of the PHCs from Ibadan

RESPONSE

The total number of PHCs in the 11 Local Government Areas (LGAs) in Ibadan was found to be 234 which were scattered across the nooks and crannies of the LGAs, while the number of PHCs in the five LGAs selected for our study was found to be about 114 PHCs with different coverage and population size. However, each LGA typically has a model PHC, which is usually the prototype, located within or in close proximity to the Local Government headquarters. Though, it may be deduced that the number of PHCs used in our study, i.e. ten (10) may not be considered as a representative sample of the entire PHCs in the LGAs selected, however, the choice of using the model PHC in each LGA and another one selected based on relatively high patients’ patronage may still provide a suitable and useful basic information that may be necessary to guide policy decision on the way forward or approach that may be useful in enhancing adverse drug reaction reporting among the general populace. This is largely because the model PHC used in the study is a replica for other PHCs in every LGA. Nevertheless, the possible non-representativeness of the number of PHCs used in our study has been appropriately captured as one of the limitations. See the method section, page 4/5, lines 103-116 in the revised manuscript for the details on inclusion of the number of PHCs in Ibadan, with appropriate justification for the 10 PHCs selected for our study; also the discussion section, page 17/18, lines 428 -435 in the revised manuscript contained the inclusion of the non-representativeness of the selected PHCs as one of the limitations of our study.
2. How did the researchers select the PHCs? Were there the inclusion criteria?

RESPONSE

We quite appreciate the editor’s comment in this regard. We have found it useful. In our study, the 11 LGAs in Ibadan were stratified into urban and semi-urban LGAs, of this, five LGAs comprising three urban and two semi-urban LGAs were selected using a systematic random sampling of every other LGA. Subsequently, 10 PHCs were purposively selected from the five LGAs consisting of the model PHC for each LGA and another PHC chosen based on relatively high patients’ patronage. The explanations in this regard have been appropriately included in the revised manuscript. See the method section, page 5, lines 128 -130; page 6, lines 131 – 133, and under the inclusion/exclusion criteria, page 6, lines 135 -139 in the revised manuscript for these clarifications.

3. How did the researchers justify content validation from the five PHC workers and 15 patients?

RESPONSE

We are quite grateful for the editor’s observation in this regard. As a form of clarification to the comment, it was the face validity/pretest of the questionnaires that was done among five health workers and 15 patients, while content validation of the questionnaires was done by two academic scholars in our department of Clinical Pharmacy who were expertise in the field of pharmacovigilance. In essence, these are the two major forms of validation checks that were carried out on the questionnaires. Although, reliability test for some subsections of the questionnaires especially the attitude questions was done with the Cronbach alpha value of 0.7, though not reported in the manuscript, it was done merely to at least verify the internal consistency of the question-item in the subscale before the main study commenced. For a survey study of this nature which does measure patients reported health-related clinical outcomes, various validation checks as stipulated in the COSMIN guidelines may not be strictly essential, thus, the reason why we deemed it fit to report largely the content and face validity checks which are mostly germane.
Generally, the pretest/face validity was done among the potential participants from one of the excluded PHC in order to ascertain the ease of comprehension of the question-items in the questionnaires. Content validation with the academic scholars was done so as to ensure the comprehensiveness of the question-items vis-à-vis the study objectives, as well as to ensure that there are no ambiguous statements or questions. In the revised manuscript, the subsection of “pretest and content validation of the instrument” has been appropriately rephrased as pretest and validation of the instruments, while the explanation of the content has been made clearer to reflect on each of the two validation checks ascertained. See the method section, page 7, lines 165 -174 in the revised manuscript for these clarifications and explanation.

Results

4. The analyses should be enhanced to explore any staff’s and patients’ characteristics related to the knowledge and awareness of pharmacovigilance and ADR reporting.

RESPONSE

We quite appreciate the editor’s comment and suggestion in this regard. It has enabled us to revisit our raw data to explore the possible association between health workers and patients characteristics and the overall knowledge about ADRs, attitude towards ADR reporting, as well as pharmacovigilance awareness. This has greatly enrich our study findings and the analysis has enabled us to see some patients’ and health workers characteristics that may significantly or otherwise influence the core variables of interest in our study in terms of ADR knowledge, attitude towards ADR reporting and pharmacovigilance awareness. See Table 4, page 28 and Table 7, page 31 in the revised manuscript for the results in these regards. Also, the results section, page 10, lines 249 -254; page 11, line 255-262, and page 12, lines 287-293 of the revised manuscript for these inclusions and clarifications.
5. Since the authors took a sample, hence the analysis should include 95% of the estimated proportion

RESPONSE

Editor’s comment in this regard is well appreciated. Yes, we took a sample of the population of interest since we cannot sample the whole population. This is usually the norm in many research studies. Thus, the most important reason for the calculation of a representative sample size for a study. For our study, we used the Raosoft® sample size calculator to guide us on the representative target sample size to use for our study. In actual fact, the Raosoft® sample size determination for our study incorporates 95% confidence level, 5% margin of error, with 50% population proportion which are usually the basic assumptions when using the sample size calculator, while inputting the estimated population for the period of our study gave us a sample size value of approximately 345 for the patients and 67 for health workers. However, with 10% adjustment for attrition rate, a minimum target sample size of approximately 380 and 74 (which was rounded off to 80) was obtained for patients and health workers, respectively. This was used to guide enrolment of participants in our study. Precisely, in our study, all the valid response to variables of interest were considered in the data analysis, which in most cases was 360 for the patients representing those who consented and completed the study out of the 380 patients who were approached for participation based on the minimum target sample size obtained. Incidentally, approximately 95% of the patients approached for participation consented and completed the study. However, for the health workers, all the 80 health workers who were approached in accordance with the target sample size obtained, consented and completed the study. Therefore, with the basic assumptions considered in the calculation of representative sample size by the calculator, i.e. 95% confidence level and 5% margin of errors, which may largely indicates that one is at least 95% confident/sure that the response provided by participants to a statement may likely be a representation of the larger population. Thus, this might have possibly taken care of the concern in this regard. See the method section, page 6, lines 141-150 of the revised manuscript for these clarifications and inclusions that may clear the details of sample size calculation in our study.
Reviewer reports:

Reviewer 1:

METHODS:

1) I suggest including the coverage of each center considered in the study, as well as the number of health professionals and patient who were potential to be recruited.

RESPONSE

As rightly pointed out by the reviewer, the coverage of each PHC, as well as the number of potential patients and health workers in the PHC have been appropriately included in the revised manuscript. Precisely, between 120 and 200 adult patients above 18 years typically patronize each model PHC per month. Though, other category of patients below the age of 18 years also attend the PHCs for treatment and care. For the health workers, between 6 and 10 health workers are on full-time employment in each PHC facility. These were the estimated numbers that guided the determination of estimated population used in the calculation of representative sample size for our study. See the method section, page 5, lines 116-120 in the revised manuscript for the details on coverage of each PHC, also page 5, method section, lines 112-114 for details on the number of potential patients and health workers.

2) It is important to explain better the criteria of exclusion, as well as the staff team (reading the results, I observed that there is no pharmacist).

RESPONSE

Clarifications on the exclusion criteria has been fully made in the revised manuscript. In our study, all the full-time PHC workers employed as healthcare practitioners and whose job description in the facility involve day-to-day treatment and care of patients in the facility, as well as adult patients above 18 years, attending the PHC for health-related complaints and who gave consent for participation were included. Workers in the PHCs who were solely employed for administrative duties, health workers on in-service or pre-qualification training as well as patients who declined participation were those excluded. Details of these clarifications can be seen in the method section, page 6, lines 134-139 of the revised manuscript.
Generally in Nigeria, pharmacists’ employment/recruitment into the PHCs system is very rare, except only in a very few states where pharmacists have been primarily employed to practice in the PHC, for instance in Osun state, every LGA has at least a pharmacist as employee. However, in Oyo state where our study was carried out, no such recruitment of pharmacists into the PHCs has happened, thus, the non-reflection of pharmacists among the professional cadres captured in the selected PHCs in our study might have been a confirmation of the trends of non-recruitment of pharmacists into the PHCs work force in many states in Nigeria. Though, we did not strongly emphasize or reported the lack of pharmacists in the PHCs as a finding in our study because it is not really the major focus of our study, though in Table 6, page 30 in the revised manuscript, one of the results indicate where pharmacists was largely cited by participants as the second most contacted source for obtaining information about ADRs. This may therefore be an aspect that concerned stakeholders in each state may have to consider, especially considering the value added role that the inclusion of pharmacists into the PHCs work force may have on the entire PHC system, such as medication therapy management and as well as drug-related issues, of which ADRs is a key component. Future study may however need to consider a comprehensively look at this area.

In addition, we have rightly observed that Primary healthcare workers (i.e. PHC workers) may not only include the healthcare practitioner, but also the non-healthcare practitioners who are employed in the PHCs solely for administrative duties. We have therefore make appropriate amendments to reflect this all through the entire revised manuscript.

3) The process of validation is complex and include several phases. I suggest changing the word validation to adaptation of the instrument. For example: transcultural validation was not performed.
We really appreciate the reviewer’s comment in seeking clarification on the extent of validation done with our study instrument. In response to the reviewer’s comment in this regard, the questionnaire which is the main instrument used for our study, was subjected to two major phases of validation checks, specifically, the content validity and face validity checks/pretest. The content validity check of the questionnaire was done by two academic scholars from our department of Clinical Pharmacy who are expertise in the field of pharmacovigilance, this is to ascertain the comprehensiveness of the question-items in the questionnaire vis-a-vis the study objectives, as well as to ensure that there are no ambiguous questions or statements. The face validity check/pretest on the other hand was done among five health workers and 15 patients, this is to ensure the ease of comprehension of the question-items by the would-be participants, as well as the intended recruitment procedure. The feedback from the validity assessments helped to modified and rephrased some questions/statements before the final version of the questionnaires were made available for the main study. Though, not reported in our study, a reliability test, especially for the attitude subscale was done with Cronbach alpha value of approximately 0.7 obtained. Generally, in carrying out the validation checks for our study questionnaire, due consideration was given to content and pretest/face validity checks which are mostly germane to the nature of our study, that does not measure patients reported health-related clinical outcome. See the method section, page 7, lines 165-174 in the revised manuscript for some further clarifications to ensure better understanding of the context and reason for performing these two major validation checks.

As rightly pointed out by the reviewer, we did not subject the questionnaire to some other validation checks that may be mostly require for studies that may measure patients’ reported health-related clinical outcomes as indicated in COSMIN guideline/checklist. Also, the transcultural validation as pointed out by the reviewer was not considered to be totally deemed necessary largely because majority of the participants in our study belong to the Yoruba descendant with the same culture, thus we were of the opinion that such transcultural validation check may not be absolutely necessary, however, the questionnaire for the patients was translated into Yoruba language for ease of comprehension by those who may not understand English, with subsequent back translation done to ensure response consistency, Moreover, translation to Yoruba is a mandatory ethical requirement for any study to be conducted among patients’ population before ethics approval is given, which is also the case with our study. Nevertheless, the reviewer’s observation in this regard is well noted in the future study.
Also, in response to the reviewer’s suggestion that it may be preferred to change the subsection heading to “adaptation of the instrument” instead of validation. Having closely look at that possibility, we discovered that what we did in respect of the questionnaire as clearly reflected in the content of the subsection may largely fit into “validation” as stipulated in the COSMIN guideline or checklist, rather than “adaptation of the instrument” which may be more appropriate for what we did during the general design of some aspects of the questionnaire, as well as in the determination of scoring criteria for our study. Thus, the possible choice of staying with the rephrase of the subsection titled as “pretest and validation of the instrument” while making the explanation of the content to be clearer by removing any form of ambiguity in the statement that may be preventing appropriate understanding of the reason for performing these two phases of validation checks. See the method section, page 7, lines 165-174 in the revised manuscript for modifications to reflect these clarification.

RESULTS:

1) Owing to rate of return of questionnaire is generally low, I suggest to the authors to describe the strategies applied which contributed to 100% of adherence of health professionals.

RESPONSE

The observation of the reviewer in this regard is quite useful and it has help us to be able to share some of the strategies and approach that were employed during the enrolment and distribution of questionnaire to the participants, especially the health workers, which then made possible the achievement of maximum cooperation and participation in our study. Generally, when we conducted the pretest/face validity check, we realized the need to embark on some necessary approach or strategies that will help us during the main study. One of these strategies or approach include the identification of the need to adjust or come down to the supposed level of these health workers being the practitioners at the so-called lowest level of the three tiers of the healthcare delivery system in Nigeria, thus, the need to approach the workers in a very courteous manner. Also, we observed the need to approach the health workers during the respective duty shift period which is largely morning and afternoon, and when there are less patients’ workload. More importantly, the need to make available the writing material, specifically pen, for those who may not have it handy at the time of filling the questionnaire. In addition, the question-items in the questionnaire were designed in a less tasking and simpler way to fill, with mostly non-judgmental question items. All these approach or strategies were consistently applied all through the period of the study in the respective PHC visited, and the approach has really helped to obtain maximum cooperation and sustained interest of the health workers, and even patients in responding to our questionnaires. Thus, the resulting 100% response rate among the health workers and 95% response rate among the patients were largely achieved following the aforementioned strategies. See the method section, page 7/8, lines 175-181, page 8, lines 188-185 in the revised manuscript for the inclusions and description of some of the strategies employed in our study.
Regarding attitudes, I suggest calculating the prevalence of ADR reporting before and after the questionnaire, in order to compare with data obtained from the instrument.

RESPONSE

We quite appreciate the reviewer’s suggestion in this regard. Even though, our study did not precisely design to assess the prevalence of ADR reporting before and after the questionnaire administration, rather it explores the attitude towards ADR reporting as well as ADR reporting practices among the health workers and patients in selected PHCs. However, previous studies had reported that between 6 and 10% of healthcare professionals reported all the ADRs (ref 11, 12), with the professionals in this context, who may largely comprised the healthcare professionals in secondary and tertiary care settings, since most of these previous studies on ADR reporting were carried out in the two tiers of healthcare system. In our study, as earlier mentioned, we did not directly calculate the prevalence of ADR reporting, but we were able to concisely explore health workers’ attitude towards ADR reporting, which largely showed moderately positive attitude towards ADR reporting among the health workers, using the overall responses of the workers, However, perusing the response of the health workers to individual attitude statement, we noted an encouraging and relatively high proportion of the health workers (nearly 99%) who expressed willingness to report all the ADRs encountered among others attitude-related statements explored in our study. See Table 2, page 26 in the revised manuscript. This may perhaps suggests that if such impressive positive attitude towards ADR reporting can be further reinforced and pursued, there may be improvement in ADR reporting rate among the PHC health workers. Though, the perceived attitude of the health workers may not necessarily be a direct reflection of what may actually happen in clinical practice. Nevertheless, the finding still point into a good direction that may be harnessed to ensure improved ADR reporting among this category of healthcare practitioners who are the closest to the people of the grassroot.

In addition, in responding to one of the reviewers’ comments, we were able to found out that about 19% of the patients reported the previously experienced ADRs, while the relationship of patients’ characteristics with this specific finding was also compared. The results for some of these clarifications and explanation in this respect can be seen in Table 7, page 31; Table 2, page 26 in the revised manuscript. Nonetheless, as rightly suggested by the reviewer, future study may need to comprehensively and precisely explore this aspect in order to ensure far reaching conclusion in this regard.
See the results section, page 9/10, lines 228-233, the discussion section, page 14/15, lines 343-358 and Table 7, page 31 in the revised manuscript for some of the clarifications and explanations in these regards.

3) There are many tables. I suggest joining those that demonstrate the attitude and knowledge data of health professionals with years of experience.

RESPONSE

The reviewer’s observation in this regard is well noted and appreciated. However, in as much we may really appreciate the need to possibly reduce the number of Tables for our study, we are equally constrained by the fact that in responding to one of the comments of the editor and even one of your (i.e. Reviewer 1) suggestions, which are vital comments/suggestions, we have found it extremely important to bring out some tables that will show the relationship of patients’ and health workers’ with the overall ADR knowledge, attitude towards ADR reporting as well as pharmacovigilance awareness. These tables were found out to be very germane to our study, as well as further enriching our study findings. Thus, the necessary emergence of new Table 4 and Table 7 which clearly depict the information on the relationships among these core variables of interest. Also, it is realized that the results in these tables would be better presented in a table format rather than in a text form in order to ensure better appreciation, replication and understanding by the reader. However, we have been able to remove the original Table 4 which was eventually found out to capture less information on the core variables of interest in term of combining the ADR knowledge, attitude and awareness with health workers’ demographic characteristics.

See the results section, page 10/11, lines 249-262; page 12, lines 287-293; Table 4 page 28 and Table 7 page 31 in the revised manuscript for the details explanation and clarification in these regards. The findings in these tables have also enrich the discussion, see the discussion section, page 13, lines 311-312; lines 319-330 and page 17, lines 404-405 in revised manuscript for the inclusions.

4) An interesting result is the comparison of knowledge, awareness and attitudes among the health professionals, in order to observe possible differences in the practice of pharmacovigilance.
RESPONSE

This suggestion is quite useful and we have totally comply with the suggestion by revisiting the raw data with reanalysis of the concerned variables. See Table 4, page 28 in the revised manuscript for the included results and clarifications.

DISCUSSION:

1) Attitudes were measured with aid of a questionnaire. There is a bias, since the answers may not represent the behavior developed in the clinical practice. This should be included in the limitations.

RESPONSE

The observation and concern of the reviewer in this regard is appropriate and we have concisely capture the possible bias that may result from self-reported behaviour or attitude of participants as one of the limitations of our study. See the discussion section, page 17, lines 422-427 in the revised manuscript for the inclusions.

Reviewer 2: TITLE: Awareness, knowledge, attitude and practice of adverse drug reaction reporting among health workers and patients in selected primary healthcare centres in Ibadan, southwest Nigeria

GENERAL COMMENTS: This manuscript addresses a very important issue of adverse drug reaction and its reporting among healthcare workers and patients in a primary care setting in Ibadan, South-West Nigeria. It is well conceptualized with good methodology which can easily be replicated.

There are some few grammatical /syntax errors that are highlighted in the manuscript along with other queries/clarifications.

RESPONSE

We quite appreciate the commendation of the reviewer. The revised manuscript has been concisely revised and edited by a native English speaker, the few typographical and grammatical errors pointed out have been appropriately effected in the revised manuscript. See the entire revised version for the effected corrections.
SPECIFIC COMMENTS:

ABSTRACT: Kindly revise the "conclusion". There is no need to repeat the study findings here verbatim. Try and summarize and comment on the steps to be taken vis implication for practice.

RESPONSE

We have found this comment quite useful. The abstract conclusion in the revised manuscript has been concisely revised, while repeated words/statements have been pointedly rephrased or removed as may be appropriate. See the conclusion section of the abstract, page 3, lines 56-63 in the revised manuscript for the modifications.

BACKGROUND:

Page 4, Line 81 - this has pose a great challenge - this poses

RESPONSE

Corrections in response to this comment can be seen in the background section, page 4, line 83 in the revised manuscript

METHODS:

Page 6, Line 108 - "Primary healthcare workers, as well as regular patients' attendee in the selected PHCs" - Why not consider "patients attending the selected PHCs"

RESPONSE

Corrections and the rephrase of the statement in respect of the comment have been appropriately effected. See the method section, page 5, lines 125-126 in the revised manuscript for the corrections

Page 6, Line 127 - "All consented healthcare workers": Why not consider using this phrase "all healthcare workers who gave consent"
RESPONSE

The appropriate corrections in this regard have been effected in the method section, page 6, lines 135-137 in the revised manuscript.

Page 7, Lines 131-135: Kindly revise this sentence to make shorter with better clarity. You may want to just summarize and attach the questionnaire as an appendix.

RESPONSE

We have really found this comment very useful, and the entire subsection under data collection instrument has been concisely summarised and revised with better flow and understanding. See the method section, page 6/7, lines 151-158 in the revised manuscript for these modifications. Actually, the questionnaires for our study have been originally attached as an additional or supplementary during the online submission.

Page 7, Line 146: "there is no ambiguous". Please change to "are no ambiguous questions or statements"

RESPONSE

The grammatical error pointed out in this regard has been appropriately effected in the revised manuscript. See the method section, page 7, line 168 in the revised manuscript for the effected correction.

RESULTS

Page 9, Line 106: Please re-phrase the second half of the sentence.
Though the line stated here was found to be incorrect (it should be line 186 instead of 106), however, the sentence has been appropriately rephrased. See the results section, page 9, lines 215 and 217 in the revised manuscript for the effected correction.

Page 9, Line 198: "Primary health workers" - Please maintain PHC workers for consistency.

Page 9, Line 198: 

**RESPONSE**

Appropriate correction has been effected in the results section, page 9, line 227 in the revised manuscript.

Page 9, Lines 201-202: There seems to be some ambiguity about this statement. Kindly clarify.

**RESPONSE**

The reviewer’s observation in this regard has been appropriately clarified, and the whole sentence has been concisely rephrased. See the results section, page 9/10, lines 228-233 in the revised manuscript for the clarification.

Page 10, Line 207: Kindly delete the highlighted segment and change include to "included".

**RESPONSE**

The corrections in this regard have been appropriately effected in the revised manuscript. See the results section, page 10, lines 238-239 for the appropriate corrections.

Page 10, Line 211: Add respondents after "Thirty".
RESPONSE

See the revised manuscript under the results section, page 10, lines 242-243 for the correction

Page 10, Lines 216-217: Please re-phrase the sentence for sake of clarity. The message being passed across is not very clear

RESPONSE

The concerned sentence has been appropriately rephrased and clarified. See the results section, page 10, lines 246-247 in the revised manuscript for the clarification.

Page 10, Line 224: Please re-phrase the sentence especially the latter half. You may want to use "patients" only. Participants to be deleted.

The corrections have been appropriately effected, and can be seen under the results section, page 11, lines 263-265 in the revised manuscript for the effected correction.

Page 10, Line 225: Females or female patients

RESPONSE

The correction has been appropriately effected in the results section, page 11, line 266 in the revised manuscript

Page 12, Line 257: Kindly explain what is meant by "sub-medical cadre". This is not a standard way of describing these sub-set of healthcare workers
The reviewer’s suggestion in this regard is quite appreciated and we have found it useful. The ideal word to use for the professional cadres in the PHCs which we initially referred to as “sub-medical cadres” should have been “paramedical” which are usually use to refer to other group of healthcare professionals’ aside the physician/medical doctor. The statement has been appropriately rephrased in the revised manuscript. See the discussion section, page 13, line 305 in the revised manuscript for the effected correction.

Page 12, Lines 271-274: “This may probably…..” This is not a good explanation for the observed finding. Can the authors think about some other reasons why this may happen?

We quite appreciate the constructive observation of the reviewer in this regard. As rightly suggested by the reviewer, we have been able to reflect on our results in this respect again, and we have concisely provide a suitable explanation and justifiable reasons to support our finding in this regard. See the discussion section, page 13, lines 318-329 in the revised manuscript for the modifications and clarifications.

Page 14, Line 305: Change "constitutes" to constitute

We quite appreciate the constructive observation of the reviewer in this regard. As rightly suggested by the reviewer, we have been able to reflect on our results in this respect again, and we have concisely provide a suitable explanation and justifiable reasons to support our finding in this regard. See the discussion section, page 13, lines 318-329 in the revised manuscript for the modifications and clarifications.

Page 15, Line 334: Change "on" to one
Page 15, Line 346: Change "underscore" to underscores

RESPONSE
See the discussion section, page 17, line 416 in the revised manuscript for the effected correction

Page 16, Line 360: Kindly revise the "conclusion". There is no need to repeat the study findings here verbatim. Try and summarize and comment on the steps to be taken vis implication for practice

RESPONSE
We have found this comment very useful. The conclusion in the revised manuscript has been concisely revised and summarised, while the repeated words/statements have been pointedly rephrased or removed as may be appropriate. See the conclusion section, page 18, lines 439-446 in the revised manuscript for the modifications.

REFERENCES

Page 19, Lines 437-439: Please check this reference. There seems to be a mistake with names. Kindly check and revise

RESPONSE
The correction in one of the authors’ name has been appropriately effected in the revised manuscript. See the reference section, specifically reference 14, page 21, lines 515-517 in the revised manuscript for the correction.

Thank you