

A cross-sectional study of primary care physicians' knowledge, attitudes, and practices toward the treatment of depression and anxiety at primary care facilities in Eastern and North-Central Trinidad

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received: 13. 12. 2024;

revised: 19. 12. 2024;

accepted: 18. 7. 2025

Summary

Background: Primary care physicians are often the first point of contacts for patients and therefore play a critical role in identifying and managing depression and anxiety.

Aims: To determine the knowledge, attitudes and practices of Primary care physicians (PCPs) towards the treatment of depression and anxiety at primary health care facilities in Eastern and North Central Trinidad.

Subjects and methods: A validated questionnaire derived from previous studies- (Haddad et al., 2015; Zada et al., 2020; Meredith et al., 2000) with similar study populations was utilised. The questionnaire was uploaded to Google forms and disseminated to eligible PCPs via email and WhatsApp.

Results: Most respondents were between 25-35 years (54%) and practiced medicine for 11-13 years (23%). PCPs strongly agreed on the use of screening tools during patient consultations, referrals to specialists, appropriate prescriptions and follow up care. 76.9% of PCPs felt confident in recognizing depression and anxiety and acknowledged the importance of mental health. However, knowledge gaps were identified for pharmacological treatments and psychotherapy.

Conclusion: PCPs should be trained and updated on evidence-based guidelines for the effective management of common mental health conditions presenting in primary care.

Keywords: Mental Health, Primary Care, Depression, Anxiety

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INTRODUCTION

According to Kupcova et al. (2023), depression and anxiety have increased by 25% globally since the COVID-19 pandemic. A recently published systematic review investigated the prevalence of depression and anxiety amongst the general population during the COVID-19 pandemic. The studies included in the review were mostly cross-sectional in design and were conducted in eight countries, including New Zealand, Saudi Arabia, Iraq, Nepal, Turkey, Iran, China and Italy. Anxiety prevalence ranged from 8.3%-47%, and depression prevalence from 14.65% to 45%. The prevalence rate varied between studies, as some reported the degree of severity of the disease and others reported the overall prevalence (Alqahtani et al., 2023). These disorders are also of concern in Trinidad and Tobago (T&T). Nayak et al. (2021) found that the prevalence of depression among healthcare workers in Trinidad and Tobago during the COVID-19 pandemic was

42.28%, while anxiety disorders affected 56.2% of this group. Post COVID-19 the prevalence of depression in the adult population was 13.6% (PAHO/WHO 2024)

Similarly, a Russian study by Syunyakov et al. (2023) found that the proportion of healthcare workers with higher-than-normal anxiety levels rose from 16.09% in 2020 to 39.08% in 2023. It can be seen that the high prevalence of these conditions is not localized and imposes public health burdens across the globe.

A cross-sectional study (Maharaj et al., 2007) conducted at a family practice in Trinidad found that 65 respondents (12.8%) were depressed, with no significant association between age, marital status, employment, education level, or ethnicity. Single patients had a higher likelihood of depression, and the likelihood decreased with age and education level (Maharaj et al., 2007). This emphasizes the need for more effective mental health care strategies. Primary care physicians (PCPs) often serve as the first point of contact for patients and, therefore, play a critical

role in managing depression and anxiety. According to Abed et al. (2010), up to 70% of mental health patients may receive treatment in a primary care setting, and between 66% and 75% of depression cases are managed by primary care providers rather than specialist mental health care providers. Funk et al. (2008), in a study conducted in the United States, found that while primary care providers recognized the importance of addressing mental health issues, many felt inadequately trained to manage them effectively. In Trinidad and Tobago, PCPs are tasked with the initial assessment, treatment and referral to specialists when needed, however, their ability to adequately manage conditions such as depression and anxiety can be affected by their knowledge, attitudes and perceptions towards these common mental health issues.

SUBJECTS AND METHODS

Study Setting

This data collection process was conducted virtually to enhance accessibility and availability of the survey instrument. This method was also advantageous as it was viewed as less time-consuming for the physicians, more cost-effective, and more appealing to the participants as it allowed anonymity. The study setting included Primary Health Care Facilities under the jurisdictions of the Eastern Regional Health Authority and the North Central Regional Health Authority.

Study Design

This study investigated the Knowledge, attitudes and practices of PCPs towards the Treatment of Depression and Anxiety at Primary Care Facilities in Eastern and North Central Trinidad via a cross-sectional research format. The questionnaire was adapted from previous studies conducted in similar study populations (Haddad et al., 2015; Meredith et al., 2000; Zada et al., 2020) and was used as the survey instrument for data collection. Permission to use and adapt these questionnaires was obtained from the respective authors.

Study Population

This study population consisted of PCPs who were currently employed at the Eastern Regional Health Authority (ERHA) and North Central Regional Health

Authority (NCRHA) in Trinidad with at least 1 year of experience in diagnosing and treating patients in primary care. The ERHA and NCRHA are the agencies that govern the provision of clinical services in Eastern and North Central Trinidad. The educational background of the PCPs consists of an undergraduate medical degree-Bachelor of Medicine & Bachelor of Surgery (MBBS) and Post-graduate qualifications in one of the following specialities: Family Medicine, General Practice or Public Health with full unrestricted specialist registration with the Medical Board of Trinidad and Tobago. Responses were collected through convenience sampling via a Google form that was disseminated to eligible PCPs employed by the ERHA and NCRHA using email and WhatsApp.

Study Sample

The sample population consisted of PCPs from both the NCRHA and ERHA comprising 84 PCPs (77 full-time and 3 part-time) employed by the NCRHA and 74 PCPs (all full-time) employed by the ERHA.

Sample Size

The sample size was computed by first determining the requires sample for an infinite population. Using the standard formula for sample size calculation, with a 95%

Table 1: Demographic features of participants

Variable	Category	Frequency (%)
Sex	Male	51 (36.7)
	Female	88 (63.3)
Age	25-35 years	54 (38.8)
	36-44 years	49 (35.3)
	45-55 years	31 (22.3)
	56-64 years	4 (2.9)
	65-70 years	1 (0.7)
Duration of Practice	2-4 years	29 (20.9)
	5-7 years	19 (13.7)
	8-10 years	14 (10.1)
	11-13 years	32 (23.0)
	14-16 years	22 (15.8)
	17-20 years	20 (14.4)
> 20 years	3 (2.2)	

confidence level, 5% margin of error, and 50% proportion, this was found to be 384 participants. This initial value assumes no constraints on the population size, providing a conservative estimate for large or infinite populations. However, since the study is conducted on a finite population of 158 PCPs an adjustment for the finite population is necessary. After applying this adjustment, the required minimum sample size was reduced to 113 participants

Inclusion and Exclusion Criteria

Inclusion criteria:

Full-time or part-time PCPs who were currently employed at Public Health Facilities in Eastern and North-Central Trinidad for a minimum period of 1 year.

Exclusion criteria

- 1 PCPs who were on a leave of absence at the time of the study.
2. Newly qualified PCPS with less than 1-year experience were excluded Aziz et al.(2025) as they were deemed not to have sufficient experience to form opinions regarding knowledge, attitudes and practices towards the treatment of depression and anxiety.

Ethical Considerations

Ethical approvals were granted by the University of the West Indies, the NCRHA and the ERHA Research Ethics committees to conduct the study. The University's Ethics Committee reference number is "SA.2376/11/2023". Also, all participants have given consent via agreeing to a statement within the questionnaire confirming that they voluntarily agree to participate in the study, they have not been persuaded or forced to answer any questions, and they agreed to let the researchers use their data for research purposes.

Data Collection

The method of data collection was done via an online questionnaire using Google Forms. Participants were provided with a consent form at the start of the questionnaire. This consent form assured the confidentiality and security of the data shared after completing the questionnaire. The information collected from the questionnaire was anonymous as no personal information was asked. Moreover, participants were made aware that they have

the right to withdraw if they do not feel comfortable during any stage of answering the questions. The questionnaires were done via Google Forms and disseminated via WhatsApp and email to PCPs to allow the physicians to complete the questionnaire on their own time.

Data Analysis

Data was analyzed after the completion and collection of questionnaires using Microsoft Excel and SPSS version 29. Likert scale components of the questionnaire were checked for internal consistency using Cronbach's alpha and Exploratory Factor Analysis (EFA). The data was analyzed using descriptive statistics and presented in the form of bar charts and comparative tables. Inferential statistics such as chi-square, were utilized to analyze categorical variables, while responses that provide continuous variables were analyzed through means and standard deviations.

Patient and Public Involvement

This study did not involve the public or patients as it was limited to the views of consenting Primary Care Physicians only.

RESULTS

A total of 139 primary care physicians (PCPs) participated in the study. The most common age group was 25-35 years (38.8%), while the most common duration of practice was 11-13 years (23.0%). The descriptive statistics for the Revised Depression Attitude Questionnaire items revealed no missing data or entries as well as most of the items having an average score of less than 2. The Kaiser-Meyer-Olkin measure of sampling adequacy was 0.863, above the commonly recommended value of 0.6. and Bartlett's test of sphericity was significant ($\chi^2 \chi^2 = 1466.576, p < 0.001$).

As seen in Table 2, there was no significant difference ($p = 0.342$) in the mean Physician's view for treating anxiety and depression subscale score for sex. However, there were significant differences in the subscale scores for both Age categories and Years of Practice. The post hoc Bonferroni and LSD tests for Age indicated that the means for all categories were significantly different from each other, except for the age groups 45-55 and > 55 years. However, for Years of Practice, all means were

Table 2: Physician's view for treating anxiety and depression subscale

Variable	Category	Physician's Confidence Mean (SD)	P-value	Physicians view for treating anxiety and depression Mean (SD)	P-value	Physicians view on recognizing anxiety and depression Mean (SD)	P-value
Sex	Male	1.684 (0.679)	0.016*	1.588 (0.672)	0.342*	1.451 (0.596)	0.240*
	Female	1.960 (0.974)		1.636 (0.670)		1.523 (0.537)	
Age	25-35 years	2.331 (0.602)	< 0.001**	1.907 (0.668)	< 0.001**	1.722 (0.496)	< 0.001**
	36-44 years	1.703 (0.801)		1.517 (0.624)		1.463 (0.600)	
	45-55 years	1.410 (0.507)		1.323 (0.599)		1.226 (0.599)	
	>55 Years	1.057 (0.078)		1.333 (0.333)		1.067 (0.333)	
Duration of Practice	2-4 years	2.522 (0.795)	< 0.001**	2.069 (0.692)	< 0.001**	1.690 (0.570)	< 0.001**
	5-7 years	2.271 (0.384)		1.737 (0.813)		1.860 (0.420)	
	8-10 years	1.959 (0.586)		1.762 (0.546)		1.643 (0.577)	
	11-13 years	1.848 (0.715)		1.604 (0.636)		1.500 (0.580)	
	14-16 years	1.130 (0.245)		1.227 (0.429)		1.197 (0.541)	
	17-20 years	1.371 (0.457)		1.283 (0.409)		1.167 (0.229)	
	> 20 years	1.04 (0.082)		1.11 (0.192)		1.00 (0.000)	

All significant differences are in bold.

* Independent samples t-test

** ANOVA

significantly different from each other except for the 5-7- and 8-10-year categories.

While there was no significant difference ($p = 0.240$) in the mean scores on recognizing anxiety and depression as health conditions for sex, significant differences are recognized in the subscale scores for both Age category and Years of Practice. Moreover, the post hoc Bonferroni and LSD tests for Age indicated that the mean score for the age group 25-35 was the only category significantly different from the rest. However, for Years of Practice, all means were significantly different from each other except for the 2-4-, 5-7- and 8-10-year categories.

With regard to knowledge, 81% ($n=112$) of the PCPs were aware of Cognitive Behavioural Therapy as the most evidence-based psychotherapy used for Depression and Generalized Anxiety Disorder (GAD). Additionally, the majority (74.1%) of physicians knew that a patient must have anxiety symptoms for a minimum duration of 6 months before they can be diagnosed with clinical GAD. Furthermore, most physicians (58.2%) were aware that anxiolytics and sedatives (minor tranquillizer) do not have equivalent efficacy in major depression as antidepressant medications.

The proportion of correct responses varied across the questions. However, the correct response rate was extremely low for Q8, "In order to diagnose a patient with

clinical Generalized Anxiety Disorder) (GAD), he or she must have anxiety symptoms for a minimum duration of: 72 hours, 2 weeks, 1 month, 2 months, 6 months, there is no time limit," (0.7%) and Q9, "Which medication would you consider as your first choice for the treatment of Generalized Anxiety Disorder (considering there are no contraindications) in PHCC: Citalopram, Paroxetine, Fluoxetine, Amitriptyline, Venlafaxine,"(10.8%), while the highest correct response rate was for Q10, "The following psychological therapy has the most evidence based role in the management of common mental health problems like anxiety or depression: Counseling, Debriefing, Cognitive Behavioral Therapy, Hypnotherapy, EMDR (Eye Movement Desensitization and Reprocessing), All of the above are equally effective," (80.6%).

There were significant associations between the duration of practice and identifying the need for pharmacological interventions and follow-up assessment for patients with depression and anxiety. This was illustrated in questions Q2 (p -value 0.008): "Identify the need for pharmacological interventions and the prescription of these pharmacological interventions for patients with depression and anxiety." and Q3 (p -value 0.029): "Perform a follow-up assessment for patients with depression or/and anxiety, determining management dependent on the progress of the patient's depression or/and anxiety."

DISCUSSION

The patient population of Eastern and North-Central Trinidad is ethnically diverse, with African and East Indian ethnicities predominating. The population spans all socio-economic strata, with the majority belonging to the low/middle-income bracket. All physician practices are regulated by law under the Medical Board and Mental Health Acts of the Republic. Currently, 5,925 physicians are registered with the Medical Board of Trinidad and Tobago (MBTT), serving a population of approximately 1.4 million.

Regarding the first-choice medication for the treatment of Generalized Anxiety Disorder (GAD), 11% ($n = 15$) of physicians selected paroxetine, while the majority selected fluoxetine. Stahl et al. (1998) noted that first-line treatments for GAD include selective serotonin reuptake inhibitors (SSRIs), such as paroxetine, citalopram, and fluoxetine. However, paroxetine is often preferred due to its potency and fast-acting nature, allowing for quicker management of the patient's symptoms, and because it is the only SSRI specifically indicated for the treatment of GAD. Only 29% ($n = 40$) of physicians were aware of evidence suggesting that primary care clinicians prescribe appropriate doses. However, this information was removed from the original study by Meredith et al. (2000), as it was deemed not an accurate measure of the physicians' knowledge.

A similar study conducted by Gibson and Walcott (2013) in Kingston, Jamaica, evaluated the knowledge, attitudes, and practices of primary care physicians (PCPs) toward depression. The results revealed that the surveyed PCPs had low knowledge regarding the pharmacological management of depression, with knowledge scores ranging from 0–9, and a median score of 6. In contrast, knowledge about the diagnosis of depression ranged from 0–15, with a median score of 11.

Regarding the attitudes of PCPs, the increased prevalence of mental health disorders in primary care highlights the importance of PCPs being proficient and willing to provide effective treatment for anxiety and depression. Haddad et al. (2015) concluded that an important aspect of proper mental health management is a physician's optimistic perspective on mental illness, as this attitude can greatly influence treatment success rates. Mental illnesses such as anxiety and depression continue to be highly stigmatized within Caribbean communities (Gallimore et al., 2023). Stigmatization of mental illness can have detrimental effects on patients and their families. Adams et al. (2010) reported that healthcare professionals are often reluctant to seek help or disclose mental health issues, leading to an overreliance on self-medication, reduced support from others, and an increased risk of suicide.

A study conducted in Saudi Arabia sought to understand discriminatory views held by PCPs in tertiary hospitals toward individuals with mental health conditions. Using the Mental Illness Clinical Attitudes (MICA-4) scale, Saad et al. (2019) found similar correlations regarding gender differences in attitudes, with female physicians demonstrating fewer stigmatizing views toward mental illness compared to their male counterparts. Similarly, a recent study in Russia discussed the social stigmatization of mental illness by healthcare professionals. Yashikhina et al. (2022) indicated that, while non-psychiatrist health professionals exhibited lower levels of stigma toward mental illness compared to substance abuse, there remains a need for physicians to adopt more positive attitudes toward depression to further reduce the stigma surrounding mental illness, thus enabling more effective mental health treatment.

By & Kosteniuk (2024) reported conflicting observations in their Canadian study, which yielded different results. In terms of gender, female physicians were less likely to have positive attitudes and were, therefore, less effective in treating mental disorders such as anxiety and depression. It is important to note that the Canadian study also examined factors such as patient workload and the location of undergraduate training, which were not included in this study.

Regarding physician practices, there was a high total aggregate score (31.39) for physicians who take a detailed history, including asking about physical risk factors. Physicians who conduct assessments through history taking, which includes a history of depression and anxiety, family history, and psychosocial history, achieved a high aggregate score (31.38). Similarly, physicians who strongly support referring patients to mental health specialists when necessary obtained a high total aggregate score (32.14), as did physicians who identify the need for pharmacological interventions and prescriptions (29.83). The aggregate score for physicians who perform follow-up was high (30.07) and statistically significant ($p < 0.05$).

These high aggregate scores suggest that PCPs generally agree on the utility of screening tools during patient consultations, referrals to mental health specialists, when necessary, prescription of appropriate medications, and follow-up care. Physicians with 14-16 years of practice experience were more likely to prescribe pharmacological interventions and provide follow-up.

Although most PCPs reported effective practices, there was some evidence of substandard practices. For example, when responding to the statement, "As a physician, I create an environment that facilitates open communication for patients with anxiety and depression," the aggregate score was 31.5, indicating strong agreement. However, 2.8% of respondents disagreed. Facilitating an

environment conducive to communication is essential for treating patients. Another deviation from evidence-based guidelines occurred when responding to question number 2. While the aggregate score was 29.83, indicating majority agreement, 3.6% of respondents disagreed. According to evidence-based guidelines, pharmaceutical interventions are recommended only after a psychological assessment. Substandard practices were also observed with follow-up care, with some physicians not adhering to systematic follow-up protocols. Infrequent use of evidence-based guidelines was seen among PCPs of varying practice durations, with no correlation between the number of years in practice and infrequent use of these guidelines. Non-recommended practices were also evident in the lack of systemic follow-ups with patients. In response to question 3, three physicians reported not performing follow-ups with patients presenting with anxiety or depression.

Several barriers to effective management were identified. Yang et al. (2021) expressed that depression and GAD are significant public health challenges globally, and Trinidad and Tobago (T&T) are no exception. Despite growing recognition of the importance of mental health, the detection and management of these conditions in primary care settings remain challenging. Primary care centres face limited resources, including a shortage of mental health professionals and inadequate mental health training for PCPs. These factors contribute to the underdiagnosis and undertreatment of depression and GAD.

A non-systematic qualitative literature review by Lepièce et al. (2023) identified six main themes that facilitate or hinder collaboration between general practitioners and clinical psychologists. These themes include barriers to interprofessional collaboration, lack of mutual trust, dissatisfaction with information exchanged, the paradox of professional secrecy, the necessity of a paradigm shift, and conceptual frameworks of collaboration. This is supported by the WHO-AIMS (2007) report for T&T, which cited a "lack of resources for the efficient and effective running of the mental health system." Additionally, the report highlighted that only 2.6% of medical school training is dedicated to mental health, and 0.3% of PCPs receive at least two days of refresher training in mental health. This lack of training is particularly concerning, as PCPs are often the first point of contact for patients with symptoms of depression and GAD. These physicians must receive specialized training to stay informed about changes in the treatment and management of mental health conditions. Ali et al. (2017) reported that doctors with post-graduate diplomas in family medicine receive, on average, only 20 weeks of mental health training over eight years of their education. The study also found

alarmingly low depression screening and detection rates in the Regional Health Authority being studied, though it was unable to determine whether there was a correlation between physicians' levels of training and screening rates. Locally, Ali et al. (2017) reported that "3% of the Gross Domestic Product (GDP) is allocated to health, with 4% directed to mental health, of which 85% is spent on staff salaries at the psychiatric hospital, leaving a mere 0.02% for all other mental health expenditures," highlighting the severe resource constraints.

Another obstacle for local primary care facilities is managing a high patient load while being relatively understaffed. Singh et al. (1999) found that the average waiting time for patients at primary care clinics is 2 hours and 40 minutes, with consultations lasting on average only 3 minutes. This leads to a more symptom-centered approach to treatment, rather than a patient-centered one, and results in physicians prioritizing the management of physical symptoms, screening for mental conditions only when time allows or when a patient's history indicates a need. This approach can lead to the missed identification of conditions such as depression and GAD, which may contribute to non-communicable diseases (NCDs). Bădescu et al. (2016) concluded that the prevalence of depression is markedly increased in diabetic patients and suggested a relationship between depression and the risk of developing diabetes. This underscores the need for comprehensive management of mental health conditions within primary care to ensure that all aspects of patient care are assessed and the best care is provided.

PERSONAL BARRIERS

The results of our study indicate that physicians have limited knowledge regarding the diagnosis and treatment of depression and GAD. This lack of knowledge can significantly impact their ability and willingness to properly treat and diagnose patients, leading to misdiagnosis or underdiagnosis. Kosteniuk et al. (2009) and Ravello et al. (2014) emphasized that in T&T, negative cultural perceptions of mental health present a barrier to diagnosis and treatment. Many locals view individuals with mental health disorders as "crazy," which deters patients from seeking help. Such attitudes are also reflected among many PCPs, despite exposure to mental health teachings. Culture plays a vital role in belief systems, ultimately affecting the quality of service provided to patients with mental health conditions. Contrastingly, our study found that the majority of physicians had a positive attitude toward treating patients with depression and anxiety and

were confident in their ability to diagnose and treat these conditions. Stuber et al. (2014) reported that, while physicians generally had more positive perceptions of mental illness than the general public, many still maintained unfavourable attitudes toward individuals with mental illness and sought to socially distance themselves, both in professional and personal contexts. These negative perceptions are often deeply ingrained due to societal and cultural influences.

The study reveals that while PCPs can recognize depression and anxiety and generally demonstrate a positive attitude toward treating these conditions, there are gaps in their knowledge about pharmacological treatment options and psychotherapy. This suggests a need for expanded clinical mental health training at both the undergraduate and postgraduate levels to improve the proficiency of PCPs and mental health outcomes for patients treated in primary care.

CONCLUSION

The study reveals that primary care physicians (PCPs) are able to recognize depression and anxiety but lack comprehensive knowledge regarding pharmacological treatment options and psychotherapy. This underscores the need for clinical training to be incorporated into medical school curricula. While physicians generally exhibit a positive attitude toward treating depression and anxiety, the research emphasizes the importance of integrating mental health care into primary care settings. It also advocates for informing regional health authorities (RHAs) of these findings and expanding the study population to include other healthcare workers.

To address these ineffective practices, several recommendations can be made. First, for physicians to create an environment conducive to open communication, they must be adequately educated on the tools required to do so. Therefore, the study stresses the necessity of incorporating and strengthening clinical training in mental health during both the preclinical and paraclinical years of medical education. Currently, undergraduate medical training includes only one clinical clerkship in Psychiatry, delivered over eight weeks. Physicians pursuing careers in primary care should be well-equipped to diagnose and effectively treat mental health conditions. Efforts should be made to ensure that post-graduate education includes mandatory professional development in mental health topics. These requirements should be linked to the renewal of medical practice licenses and should be evidence-based, accredited by appropriate bodies, and

designed to promote a comprehensive and holistic approach to treating mental health conditions.

Additionally, while physicians displayed a generally positive attitude toward treating patients with depression and anxiety, and expressed confidence in their ability to do so effectively, these findings further suggest the need for the integration of mental health services into primary care. This integration would allow mental health to be routinely addressed alongside physical health. As most physicians are already willing to treat these conditions, effective integration into primary care would further promote positive attitudes and improve the diagnosis and treatment of patients with mental health disorders. Furthermore, the study shows that the majority of physicians employed effective practices, such as taking detailed patient histories and referring patients to specialists when necessary. This highlights the importance of a collaborative approach to care and underscores the need to strengthen relationships between PCPs and mental health specialists. Such improvements can be achieved by streamlining referral processes and enhancing communication channels.

The results of this study support the adoption of nationwide strategies to screen for depression and anxiety in primary care, thereby benefiting the general population, as PCPs are well-equipped to reliably identify and diagnose these conditions. At the community level, existing services, such as mental health, stress, and wellness clinics, can be bolstered by building capacity within the PCP workforce through targeted training, increased access to pharmacological agents and psychotherapeutic options, and improved awareness of mental illnesses.

Declaration of Interest Statement: The authors declare no conflict of interest and this study was self-funded.

Ethical Considerations: Does this study include human subjects? YES

Authors confirmed the compliance with all relevant ethical regulations.

Conflict of interest: No conflict of interest.

Funding sources: The authors received no funding from an external source.

Authors Contributions: Dr. Raveed Khan – Designed study, acquired data, analysed data, drafted manuscript, revised manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Mr. Rameez Baksh – Designed study, acquired data, analysed data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Ms. Ashley De Leon – Designed study, acquired data, drafted manuscript, approved final ver-

sion for submission, agreed to be accountable for all aspects of work. Ms. Gabrielle-Christina Gour – Designed study, acquired data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Ms. Renata John – Designed study, acquired data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Mr. Varenyam Maharaj – Designed study, acquired data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Mr. Mykel Rahim – Designed study, acquired data, an-

alysed data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Mr. Suren Ramoutar – Acquired data, analysed data, revised manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Mr. Travis Ramroop – Designed study, acquired data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work. Ms. Jordanne Questel – Designed study, acquired data, analysed data, drafted manuscript, approved final version for submission, agreed to be accountable for all aspects of work.

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