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The Relationship Between Spiritual Health and the Provision of Spiritual Care to Patients Among Iranian Nurses

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Abstract

Background

Considering the importance of the spiritual dimension of human health, the provision of spiritual care is increasingly recognized as an essential responsibility of healthcare providers, particularly nurses. Spiritual care competence is required for nurses to deliver effective spiritual care, and this competence is associated with other variables, including nurses' own spiritual health. This study aimed to investigate the relationship between nurses' spiritual health and their spiritual care competence.

Methods

A descriptive cross-sectional study was conducted in 2024 with the participation of 151 nurses working in three selected hospitals affiliated with Shahid Sadoughi University of Medical Sciences in Yazd (Shahid Sadoughi, Afshar, and Fatemeh Al-Zahra), selected through convenience sampling. Data were collected using questionnaires measuring spiritual health and spiritual care competence. Descriptive statistics, independent t-test, one-way ANOVA, and Spearman's correlation coefficient were used for data analysis. The data were analyzed using SPSS version 21, and the significance level was set at 0.05.

Results

The participants showed a mean (SD) score of 87.64 (15.09) on spiritual health (out of a maximum of 120) and 88.80 (18.20) on spiritual care competence (out of a maximum of 135). A significant positive correlation was found between spiritual health and spiritual care competence ($r = 0.331$, $P < 0.001$). Spiritual health scores differed significantly according to gender and hospital, while the total score of spiritual care competence showed no significant relationship with any of the demographic variables.

Conclusions

The study revealed a positive and significant relationship between nurses' spiritual health and their spiritual care competence. Therefore, strengthening nurses' spiritual health can be considered an important factor in enhancing their ability to provide spiritual care and meet patients' spiritual needs.

Keywords
Spiritual health, Spiritual care competence, Nurses, Correlation, Iran.

Introduction

Human health is a multidimensional concept that goes beyond the absence of physical illness and also encompasses psychological, social, and spiritual dimensions. In recent decades, increasing attention has been directed toward the spiritual dimension of health, as this dimension plays a central role in shaping meaning, purpose in life, hope, and individuals' ability to cope with suffering, illness, and existential crises [1]. Spirituality, as an inseparable part of the human experience, not only influences overall individual health but can also provide powerful inner resources for confronting life's challenges.

In the field of health and treatment, this multidimensional understanding of the human being has led to the development of the holistic care approach. Holistic care is based on the principle that achieving true recovery requires attention to all existential dimensions of the patient [2]. Among healthcare professions, nursing, due to its continuous and relational nature with patients, holds a unique position for realizing this approach. Nurses are not only responsible for physical care but can also play an important role in identifying and responding to patients' deeper spiritual needs [3].

Spiritual care refers to a set of actions aimed at identifying, respecting, and responding to patients' spiritual needs. This care may include empathetic listening, supporting the patient's religious or non-religious beliefs, facilitating connection with spiritual resources, creating a safe space for expressing existential concerns, and helping to find meaning in the experience of illness [4]. Numerous studies have shown that the provision of spiritual care is associated with improved quality of life, reduced anxiety and depression, increased sense of calm, and enhanced patient resilience [5, 6].

Nurses' spiritual health has also been proposed as an important prerequisite for providing spiritual care. Spiritual health is defined as a dynamic state in which an individual experiences a sense of meaning, purpose, inner harmony, and positive connection with self, others, and the transcendent [7]. Nurses with higher levels of spiritual health typically demonstrate greater sensitivity to patients' spiritual needs and greater ability to establish spiritual communication and provide empathetic care [8].

The reciprocal relationship between nurses' spiritual health and the spiritual care provided to patients has received attention in recent research. Findings indicate that the higher a nurse's spiritual health, the greater their competence and willingness to provide spiritual care, ultimately leading to better clinical outcomes for the patient [9, 10]. In other words, a nurse's spiritual health is not only a resource for better patient care but is itself strengthened through the experience of providing spiritual care.

To scientifically explain this relationship, multiple theoretical frameworks have been presented in the nursing literature. Jean Watson's Theory of Human Caring regards spirituality as the central core of care and maintains that true care occurs when the nurse is able to connect with the transcendent dimension of the patient's existence. In this theory, the caring relationship is an interactive and spiritual process in which both the nurse and the patient have the opportunity for spiritual growth [11]. The Crescent of Care model [1], with a focus on the Islamic context, introduces spirituality as an inseparable part of care and emphasizes the alignment of care with the patient's cultural and religious values [12].

Neuman's Systems Theory considers the spiritual dimension as one of the main lines of defense against stressors, and the Theory of Spiritual Nursing Care states that patients' spiritual needs are well met when the nurse's spiritual competence, the environment, and the care provided interact with one another [13]. Van Leeuwen's Spiritual Care Competence framework also defines six main domains, and studies have shown that nurses' level of spiritual health has a significant relationship with scores in these domains [14].

Despite the broad consensus on the importance of spiritual care, a notable gap exists between recognizing the importance of this dimension and its practical implementation in clinical settings. Many nurses acknowledge the importance of spiritual care, yet in practice, due to time constraints, lack of training, work pressure, and absence of organizational support, they are unable to provide it regularly [15]. This situation is particularly evident in under-pressure healthcare systems, including Iran.

In the cultural and religious context of Iran, spirituality and religion hold a special place in people's lives, and patients often have specific spiritual expectations from the treatment team. However, Iranian studies indicate that nurses' spiritual health is mostly at a moderate level and that spiritual care competence also requires strengthening [16, 17]. These findings highlight the necessity of a more precise examination of the relationship between nurses' spiritual health and their ability to provide spiritual care to patients.

Therefore, a deeper understanding of the concept of spiritual health, the nature of spiritual care, the relationship between the two, and their impact on the experiences of both patients and nurses is an essential foundation for designing effective educational and organizational interventions. The present study was designed to examine the relationship between spiritual health and the provision of spiritual care to patients among Iranian nurses, with the aim of complementing existing knowledge in this field and providing a scientific basis for improving the quality of spiritual care in the healthcare system.

Materials and Methods

Study Design

The present study is a descriptive-cross-sectional study conducted in 2024. This research, using a

quantitative approach and a questionnaire, examined the relationship between nurses' spiritual health and the provision of spiritual care to patients in three selected hospitals affiliated with Shahid Sadoughi University of Medical Sciences in Yazd. The findings of this study can provide strategies for promoting the spiritual health of nurses and patients, as well as improving the quality of spiritual care, to hospital managers, relevant officials, and the educational staff of medical sciences universities.

Study Setting

This study was conducted in three selected hospitals affiliated with Shahid Sadoughi University of Medical Sciences in Yazd, including Afshar, Shahid Sadoughi, and Fatemeh Al-Zahra Mehriz hospitals. The selection of these hospitals was based on their accessibility. These centers, as educational-therapeutic hospitals, provide a diverse range of medical services and are considered suitable representatives of the educational hospital environments in Yazd Province.

Study Population

The study population consisted of nurses working in the three hospitals of Afshar, Shahid Sadoughi, and Fatemeh Al-Zahra Mehriz. Sampling was performed using the convenience sampling method, and the sample size was calculated as 162 individuals, considering $\alpha = 0.05$, $\beta = 0.2$, and according to Formula 1. The proportional distribution of the samples was as follows: Shahid Sadoughi Hospital 74 individuals, Afshar Hospital 44 individuals, and Fatemeh Al-Zahra Mehriz Hospital 44 individuals. Formula 1:

$$n = \frac{z^2 S^2}{d^2}$$

Instruments of Data Collection

Data were collected using two validated questionnaires: the Spiritual Health Questionnaire (SHQ) and the Spiritual Care Competence Scale (SCCS).

The Spiritual Health Questionnaire was originally developed by Paloutzian and Ellison [18] and consists of 20 items measuring two dimensions: religious health (10 items) and existential health (10 items). Each item is rated on a 6-point Likert scale ranging from 1 (strongly disagree) to 6 (strongly agree). The score for each dimension ranges from 10 to 60, and the total spiritual health score ranges from 20 to 120, with higher scores indicating higher levels of spiritual health.

The Spiritual Care Competence Scale (SCCS) was developed by van Leeuwen et al. [19] and consists of 27 items across six dimensions: (1) assessment and implementation of spiritual care (items 1–6), (2) professionalization and improving the quality of spiritual care (items 7–12), (3) personal support and patient counseling (items 13–18), (4) referral to specialists (items 19–21), (5) attitude toward the patient's spirituality (items 22–25), and (6) communication (items 26–27). Each item is rated on a 5-point Likert scale ranging from 1 (strongly disagree) to 5 (strongly agree). Total scores range from 27 to 135, with higher scores indicating greater spiritual care competence.

Questionnaires were distributed in person to 162 eligible nurses working in three selected hospitals (Shahid Sadoughi, Afshar, and Fatemeh Al-Zahra Mehriz). Participants were given one hour to complete the questionnaires. Incomplete or unreturned questionnaires were considered as exclusion criteria. Of the 162 distributed questionnaires, 151 were returned fully completed (response rate: 93.2%).

Scoring System

For the Spiritual Health Questionnaire, scores for each dimension (religious health and existential health) were calculated separately, and the total spiritual health score was derived by summing both dimensions. Higher scores represented higher spiritual health. No specific cut-off points were defined for categorizing levels; instead, scores were interpreted based on their numerical value.

For the Spiritual Care Competence Scale, mean scores for each of the six dimensions were calculated, as well as a total competence score. All items were positively worded, and higher scores indicated higher perceived competence in providing spiritual care.

Validity and Reliability

The validity and reliability of both instruments have been previously established in the Iranian context. The content validity of the Spiritual Health Questionnaire was confirmed by Seyedfatemi et al. [20], and its reliability was assessed using Cronbach's alpha, yielding a coefficient of 0.82, indicating good internal consistency.

The construct validity of the Spiritual Care Competence Scale was evaluated by Khalaj et al. [21] k using exploratory and confirmatory factor analysis. Reliability was assessed using Cronbach's alpha for each dimension, with coefficients ranging from 0.65 to 0.85: assessment and implementation of spiritual care (0.85), professionalization and improving quality (0.82), personal support and patient counseling (0.76), referral to specialists (0.83), attitude toward the patient's spirituality (0.72), and communication (0.65). These values indicate acceptable to good reliability for the scale.

Statistical Analysis

After collection, the data were entered into SPSS software version 21. Then, using descriptive indices (frequency, percentage, mean, and standard deviation) and statistical tests appropriate to the type of variables, including the t-test, ANOVA, Kruskal-Wallis, Mann-Whitney, and

Spearman's correlation coefficient, the data were described and analyzed at a 95% confidence level.

Results

In total, 151 nurses participated in this study. The participants were working in three hospitals: Shahid Sadoughi, Afshar, and Fatemeh Al-Zahra. Most participants held a bachelor's degree (92.1%) and were female (64.9%). About 70% were married, and nearly half of them had less than 10 years of work experience. The age distribution was mainly in the 25–35 years group. The demographic characteristics of the participants are summarized in **Table 1**.

Table 1: Frequency distribution of demographic variables and hospitals of the participants

Qualitative variables	Frequency	Frequency percentage
Education		
Bachelor's	139	92.1
Master's	12	7.9
Gender		
Male	53	35.1
Female	98	64.9
Marital status		
Single	45	29.8
Married	106	70.2
Hospital		
Shahid Sadoughi	70	46.4
Afshar	42	27.8
Fatemeh Al-Zahra	39	25.8
Age		
25–35 years	76	50.3

Qualitative variables	Frequency	Frequency percentage
35–45 years	59	39.1
Over 45 years	16	10.6
Work experience		
Less than 10 years	73	48.3
10–15 years	44	29.1
15–20 years	19	12.6
Over 20 years	15	9.9

The status of the scores of spiritual health and spiritual care competence, as well as the dimensions of these two variables, is presented in **Table 2**. Accordingly, the mean total score of spiritual health was 87.64 (out of a maximum of 120) and the mean total score of spiritual care competence was 88.80 (out of a maximum of 135).

Table 2: Mean and standard deviation of spiritual health and spiritual care competence scores and their dimensions (n=151)

Questionnaire	Dimensions / Level	Mean / Frequency	Standard deviation / Percentage
Spiritual health	Religious health	47.82	8.43
	Existential health	39.82	8.34
	Total score	87.64	15.09
Spiritual care competence	Assessment and implementation of spiritual care	18.21	5.31
	Professionalization and improving the quality of spiritual care	19.66	5.24
	Personal support and patient counseling	19.61	4.68
	Referral to specialists	9.60	2.78

Questionnaire	Dimensions / Level	Mean / Frequency	Standard deviation / Percentage
	Attitude toward the patient's spirituality	14.72	3.05
	Communication	7.01	1.94
	Total score	88.80	18.20

Based on the results of **Table 3**, there was a significant relationship between religious health and gender (P=0.036) and marital status (P=0.040), between existential health and gender (P=0.044), hospital (P<0.001), work experience (P=0.045), and age range (P=0.037), and also between the total score of spiritual health and gender (P=0.025) and hospital (P=0.011). In contrast, educational level showed no significant difference in any of the spiritual health indices. Overall, the spiritual health score differed significantly based on gender and hospital (P-value < 0.05).

Table 3: Comparison of mean spiritual health scores according to demographic variables

Variable	Religious health Mean (SD)	Existential health Mean (SD)	Total spiritual health score Mean (SD)
Gender			
Male	45.87 (8.49)	37.96 (8.26)	83.83 (15.40)
Female	48.88 (8.25)	40.83 (8.24)	89.70 (14.58)
p-value	0.036*	0.044*	0.025*
Marital status			
Single	45.67 (9.23)	39.38 (8.30)	85.04 (15.08)
Married	48.74 (7.93)	40.01 (8.38)	88.75 (15.02)
p-value	0.040*	0.672	0.169
Education			
Bachelor's	47.60 (8.45)	39.68 (8.44)	87.28 (15.32)
Master's	50.42 (7.99)	41.42 (7.13)	91.83 (11.70)

Variable	Religious health Mean (SD)	Existential health Mean (SD)	Total spiritual health score Mean (SD)
p-value	0.26	0.49	0.31
Hospital			
Shahid Sadoughi	48.60 (8.74)	40.56 (8.35)	89.16 (15.34)
Afshar	46.05 (4.43)	35.83 (5.44)	81.88 (7.78)
Fatemeh Al-Zahra	48.33 (10.76)	42.79 (9.38)	91.13 (18.78)
p-value	0.274	<0.001*	0.011*
Work experience			
Less than 10 years	46.63 (9.57)	39.93 (9.35)	86.56 (17.32)
10-15 years	49.16 (7.35)	40.68 (6.18)	89.84 (12.12)
15-20 years	48.95 (7.37)	41.74 (8.03)	90.68 (14.17)
Over 20 years	48.27 (6.22)	34.33 (7.44)	82.60 (11.16)
p-value	0.403	0.045*	0.291
Age range			
25-35 years	46.74 (9.63)	39.92 (9.27)	86.66 (17.29)
35-45 years	49.42 (7.24)	41.00 (6.69)	90.42 (12.48)
Over 45 years	47.06 (5.17)	35.00 (7.86)	82.06 (10.52)
p-value	0.172	0.037*	0.104

*The significance level was considered as 0.05.

- Comparison of means was performed using the independent t-test (for gender and marital status) and one-way ANOVA (for hospital, work experience, and age range).

The data in Table 4 show the relationship of spiritual care competence and its dimensions with demographic characteristics. Accordingly, a significant relationship was observed between the dimension of personal support and patient counseling and marital status (P=0.031) and hospital (P=0.045), between the dimension of assessment and implementation of spiritual care and hospital (P=0.023), and also between the dimensions of personal support and counseling, attitude toward

the patient's spirituality, and communication with work experience (P=0.001, P=0.015, and P=0.017, respectively). Age range was significantly related only to the communication dimension (P=0.038). However, the total score of spiritual care competence showed no significant difference based on any of the demographic variables (P-value > 0.05).

Additionally, a positive and significant correlation existed between spiritual health and spiritual care competence (r = 0.331, P-value < 0.001).

Table 4: Mean scores of spiritual care competence according to demographic variables

Variable	Assessment and implementation of spiritual care Mean (SD)	Professionalization and improving quality Mean (SD)	Personal support and patient counseling Mean (SD)	Referral to specialists Mean (SD)	Attitude toward the patient's spirituality Mean (SD)	Communication Mean (SD)	Total competence score Mean (SD)
Gender							
Male	18.45 (5.10)	19.94 (5.50)	18.70 (4.44)	9.34 (2.79)	14.49 (3.10)	6.66 (2.14)	87.58 (19.31)
Female	18.07 (5.43)	19.51 (5.12)	20.10 (4.75)	9.74 (2.77)	14.84 (3.03)	7.19 (1.81)	89.46 (17.63)
p-value	0.675	0.630	0.078	0.394	0.508	0.108	0.548
Marital status							
Single	18.00 (4.29)	18.78 (4.97)	18.36 (4.10)	9.16 (2.58)	14.11 (3.19)	7.04 (1.77)	85.44 (16.94)
Married	18.29 (5.70)	20.04 (5.33)	20.14 (4.82)	9.79 (2.85)	14.97 (2.97)	6.99 (2.02)	90.23 (18.60)
p-value	0.712	0.168	0.031*	0.189	0.112	0.879	0.142
Education							
Bachelor's	18.18 (5.38)	19.73 (5.32)	19.54 (4.61)	9.59 (2.79)	14.76 (3.03)	6.99 (1.96)	88.79 (18.49)

Variable	Assessment and implementation of spiritual care Mean (SD)	Professionalization and improving quality Mean (SD)	Personal support and patient counseling Mean (SD)	Referral to specialists Mean (SD)	Attitude toward the patient's spirituality Mean (SD)	Communication Mean (SD)	Total competence score Mean (SD)
Master's	18.50 (4.50)	18.83 (4.34)	20.42 (5.58)	9.75 (2.77)	14.17 (3.35)	7.25 (1.82)	88.92 (15.07)
p-value	0.821	0.512	0.534	0.847	0.521	0.643	0.981
Hospital							
Shahid Sadoughi	17.05 (5.81)	19.55 (5.29)	19.00 (4.95)	9.48 (2.92)	14.55 (3.19)	6.96 (2.04)	87.58 (19.31)
Afshar	19.85 (3.35)	20.10 (4.67)	20.50 (3.71)	9.57 (2.73)	14.81 (2.80)	6.90 (1.85)	91.73 (15.41)
Fatemeh Al-Zahra	18.48 (5.68)	19.23 (5.59)	19.74 (4.72)	9.69 (2.77)	14.64 (2.99)	7.33 (1.70)	89.11 (18.35)
p-value	0.023*	0.712	0.045*	0.921	0.894	0.512	0.981
Work experience							
Less than 10 years	18.29 (5.41)	19.71 (5.42)	18.96 (4.89)	9.67 (2.85)	14.62 (3.11)	7.05 (1.84)	88.30 (18.79)
10-15 years	18.23 (5.00)	19.55 (4.94)	19.73 (4.75)	9.68 (2.73)	14.55 (3.07)	6.98 (1.97)	88.73 (17.59)
15-20 years	17.89 (5.19)	19.21 (5.47)	20.05 (4.33)	9.58 (2.74)	15.11 (2.80)	7.63 (1.61)	90.47 (17.12)
Over 20 years	17.60 (6.16)	18.80 (6.13)	18.73 (5.41)	9.20 (2.82)	13.47 (3.52)	7.33 (1.88)	85.13 (18.00)
p-value	0.891	0.874	0.001*	0.912	0.015*	0.017*	0.712
Age range							

Variable	Assessment and implementation of spiritual care Mean (SD)	Professionalization and improving quality Mean (SD)	Personal support and patient counseling Mean (SD)	Referral to specialists Mean (SD)	Attitude toward the patient's spirituality Mean (SD)	Communication Mean (SD)	Total competence score Mean (SD)
25-35 years	18.08 (5.38)	19.58 (5.42)	19.28 (4.89)	9.64 (2.84)	14.51 (3.12)	6.82 (1.85)	88.00 (18.26)
35-45 years	18.29 (5.24)	19.69 (5.16)	19.73 (4.71)	9.63 (2.79)	14.89 (2.95)	7.25 (1.83)	89.46 (18.19)
Over 45 years	17.44 (5.79)	18.56 (5.00)	18.44 (4.43)	9.44 (2.67)	14.56 (3.41)	7.75 (2.13)	86.19 (17.53)
p-value	0.812	0.721	0.085	0.934	0.077	0.038*	0.684

*The significance level was considered as 0.05.

- Comparison of means was performed using the independent t-test (for gender and marital status) and one-way ANOVA (for hospital, work experience, and age range).

Discussion

The findings of the present study showed that the mean total score of nurses' spiritual health was 87.64 (out of a maximum of 120) and the mean total score of spiritual care competence was 88.80 (out of a maximum of 135). These results indicate a relatively favorable level of spiritual health and spiritual care competence among the studied nurses. Recent studies in Iran have also reported similar or slightly higher levels. Heidari et al. reported a mean spiritual care competence of 108.93 and an acceptable level of spiritual health [7]. In another study in Yazd, the mean spiritual care competence was reported as 83.9, which is consistent with the present findings [22].

The most important finding of the present study was the positive and significant correlation between spiritual health and spiritual care competence ($r = 0.331$, $P < 0.001$). Although this relationship is weak to moderate, it is statistically significant and aligns with the results of previous studies. Heidari et al. also reported a positive and significant relationship between these two variables and demonstrated that spiritual health can be a predictor of spiritual care competence [7]. More recent studies in Iran and other countries have also confirmed this association [23, 24]. This finding supports Watson's theoretical framework and Van Leeuwen's spiritual care competence model, which regard the nurse's spiritual health as a prerequisite for providing effective spiritual care [11, 25].

In examining the relationship with demographic variables, the spiritual health score was significantly higher in women than in men. This finding is consistent with the results of some Iranian studies that have reported higher levels of spiritual health among female nurses [7]. In addition, hospital was significantly associated with the total spiritual health score and existential health. This difference may be due to variations in organizational climate, workload, and care culture across hospitals, which has also been emphasized in recent studies [26].

In contrast, the total score of spiritual care competence showed no significant relationship with any of the demographic variables. This finding is consistent with the results of Heidari et al., who observed no significant relationship between spiritual care competence and demographic characteristics [7]. However, some dimensions of spiritual care competence (such as personal support and counseling, assessment and implementation, attitude, and communication) showed significant associations with marital status, hospital, work experience, and age. Recent studies have also shown that work experience and the hospital environment can influence certain dimensions of spiritual care competence [1, 27].

The present findings can be interpreted within the cultural-religious context of Iran. In a society where spirituality and religion hold a central place, nurses are expected to possess an acceptable level of spiritual health. Nevertheless, a gap still exists between recognizing the importance of spiritual care and its practical implementation. Recent reviews indicate that the main challenges include lack of structured training, work pressure, absence of organizational support, and time constraints [10, 16]. These barriers may explain why, despite a relatively favorable level of spiritual health, spiritual care competence still requires strengthening in some dimensions.

Overall, the results of the present study emphasize the importance of strengthening nurses' spiritual health as an effective factor in enhancing spiritual care competence. Designing targeted educational programs, creating a supportive environment in healthcare organizations, and integrating spiritual care into the nursing curriculum can contribute to improving the quality of holistic care.

Limitations

The main limitation of this study was the reluctance of some nurses to participate in the research. Efforts were made to increase participation motivation through in-person encouragement. In addition, the cross-sectional nature of the study does not allow causal inferences, and the use of self-report instruments may have been influenced by social desirability bias.

Future Research

It is suggested that future studies be conducted with longitudinal or interventional designs to examine the effect of spiritual health training on spiritual care competence. Furthermore, qualitative studies for a deeper understanding of nurses' experiences in providing spiritual care, as well as multicenter studies with larger samples, are recommended.

Conclusion

Maintaining and promoting nurses' spiritual health is not only a professional necessity but also an effective step toward improving the quality of spiritual care provided to patients. The findings of this study showed a positive and significant relationship between spiritual health and spiritual care competence. Therefore, it is essential to design and implement targeted educational programs to strengthen nurses' spiritual health, while simultaneously addressing practical spiritual care skills in clinical settings. Additionally, creating a supportive environment in healthcare organizations and integrating the concepts of spiritual care into the nursing curriculum can contribute to the sustainable enhancement of holistic care quality and better responsiveness to patients' spiritual needs.

Declarations

Abbreviations.

SCCS: Spiritual Care Competence Scale

SH: Spiritual Health

Ethics approval and consent to participate

This study was approved by the Ethics Committee of the School of Public Health, Shahid Sadoughi University of Medical Sciences, Yazd, Iran (Ethics Code: IR.SSU.SPH.REC.1403.130). All procedures were performed in accordance with the relevant guidelines and regulations, including the Declaration of Helsinki. Written informed consent to participate was obtained from all participants prior to data collection.

Consent for publication

Not applicable.

Availability of data and materials

The datasets used and/or analyzed during the current study are available from the corresponding author on reasonable request.

Competing interests

The authors declare that they have no competing interests.

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Authors' contributions

R.M. and M.A.Z.B. contributed to the study conception and design. E.R. contributed to data collection, data analysis, and drafting of the manuscript. All authors reviewed and approved the final manuscript.

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