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Forms and Emerging Responses to Dementia Stigma in Southern Africa: A Scoping Review

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Abstract

Introduction: Dementia is an escalating public health concern in Southern Africa, where stigma, cultural misconceptions, and witchcraft accusations hinder timely diagnosis and care. Despite growing recognition of dementia-related challenges, the region remains underrepresented in stigma research compared to other parts of Africa.

Method: Guided by Arksey and O'Malley's scoping framework and PRISMA 2020 reporting standards, we searched peer-reviewed and grey literature published since 2010 across PubMed, Scopus, Web of Science, AJOL, and Google Scholar. Eligible studies addressed dementia stigma, cultural beliefs, caregiving practices, or health system challenges in Southern Africa. Data were extracted and thematically analyzed to identify forms of stigma, drivers of vulnerability, and emerging responses.

Results: Evidence from South Africa, Zambia, and Tanzania highlights widespread public stigma, supernatural attributions, linguistic marginalization, caregiver strain, and health system deficiencies. Three intersecting drivers including witchcraft accusations, caregiving burden, and weak diagnostic/referral pathways were consistently reported. Interventions remain largely at pilot or recommendation stage, with community health worker engagement, outreach to traditional/religious leaders, and culturally tailored education showing early promise but lacking rigorous evaluation.

Conclusion: Dementia stigma in Southern Africa is shaped by cultural beliefs and systemic gaps, with interventions still in formative stages. Addressing these challenges requires culturally sensitive messaging, caregiver support, and strengthened health systems. Future research should prioritize standardized stigma metrics, larger controlled trials, and expanded geographic coverage to inform sustainable policy and practice.

Keywords: Dementia, Stigma, Southern Africa, Witchcraft, Caregiving, Scoping Review

Introduction

Dementia is increasingly recognized as a global public health priority due to its profound physical, psychological, social, and economic impacts on individuals, families, and societies. As of 2021, the World Health Organization (WHO) estimated that 55 million people were living with dementia globally, with projections indicating 78 million by 2030 and 139 million by 2050 (WHO, 2021). These figures remain consistent with more recent forecasts [1,2]. Each year, approximately 7.7 million new cases are diagnosed [3], with projections estimating nearly 14 million affected individuals by 2060 [4]. Fossey [5] similarly forecasted a tripling

of cases by mid-century. The global economic burden of dementia was estimated at US$1.3 trillion in 2019 and is projected to rise to US$1.7 trillion by 2030, with informal caregiving by families contributing significantly to these costs [6,7]. These figures underscore the urgency of coordinated global action to address dementia across diverse populations.

Despite growing research interest, dementia remains underrepresented in studies involving marginalized populations, including younger individuals, those with limited education, and communities in low- and middle-income countries (LMICs) [8-13]. These groups often face heightened stigma, delayed diagnosis, and limited access to care, despite being critical to early detection and prevention efforts [6]. In LMICs, the lack of awareness campaigns, inadequate health infrastructure, and limited training of healthcare professionals further exacerbate the challenges of dementia care. This underrepresentation in research not only limits understanding of the lived experiences of these populations but also hinders the development of culturally appropriate interventions.

Stigma and discrimination associated with dementia have far-reaching implications for individuals and their families, affecting help-seeking behavior, quality of life, and social inclusion [14-16]. In Southern Africa, these challenges are compounded by cultural misconceptions that frame dementia as a normal part of aging or as evidence of supernatural affliction. In Southern Africa, particularly Zambia, South Africa, and Tanzania, dementia symptoms are often misattributed to witchcraft or supernatural affliction leading to social ostracization, abuse, and even physical violence, particularly against older women [17-19]. While similar beliefs exist elsewhere in Sub-Saharan Africa, this review focuses specifically on the Southern African sociocultural landscape, where stigma is compounded by weak health systems and rapid urbanization. Unlike East Africa, where community stigma reduction programs have begun, or West Africa, where youth awareness gaps dominate, Southern Africa's stigma is uniquely shaped by witchcraft accusations against older women, linguistic marginalization, and fragile health infrastructure.

Symptoms such as forgetfulness, confusion, and disorientation are often misinterpreted as signs of possession or malevolent spiritual activity [18,19]. These interpretations are exacerbated by weak health systems, where diagnostic tools and specialist services are scarce [20,21,16]. The erosion of traditional family-based care systems due to urbanization and social change further increases the vulnerability of people living with dementia [17]. Younger generations migrating to urban centers often leave older relatives without adequate support, intensifying caregiving strain for those who remain. Moreover, the region faces a severe shortage of skilled medical professionals and diagnostic tools, delaying diagnosis and treatment initiation [21,23]. This gap in healthcare provision perpetuates cycles of stigma, as families and communities rely on cultural explanations rather than biomedical ones [20].

This review therefore sought to consolidate available evidence on dementia stigma in Southern Africa, focusing on cultural, structural, and institutional factors that shape perceptions and caregiving experiences. By synthesizing peer-reviewed and grey literature published since 2010, the review aimed to provide a comprehensive understanding of the unique challenges faced in the region. The findings underscore the importance of culturally tailored messaging, caregiver support, and strengthened health systems to reduce stigma, improve diagnosis and referral pathways, and protect the rights and dignity of affected individuals [20,21]. Given the scarcity of evaluated interventions in Southern Africa, this scoping review consolidates existing evidence to map stigma forms, cultural drivers, and emerging responses. The aim is to identify gaps and inform culturally tailored strategies for stigma reduction.

Method

A literature search on studies reporting the forms of dementia stigma published from 2010 to 2024 was conducted. Databases including PubMed, Scopus, Web of Science, African Journals Online (AJOL), Google Scholar as well as grey literature including NGO reports, were sought. A comprehensive search using keywords such as "dementia," "Southern Africa," "stigma," "witchcraft," "aging," "caregiving," and "health systems" was employed relying on Boolean operators and MeSH terms. The was a scoping review guided Arksey and O'Malley [22], refined by Levac et al. [23], and guided by the PRISMA-ScR 2020 guidelines. This review did not aim to assess intervention effectiveness but to map the forms of stigma, cultural drivers, and emerging responses in Southern Africa.

We included peer-reviewed and grey literature published in English between 2010–2024 that addressed dementia stigma, cultural beliefs, caregiving practices, or health system challenges in Southern Africa. Studies outside the region, not focused on dementia, or non-human were excluded.

Titles and abstracts of studies identified by the literature search were reviewed by two researchers independently to determine suitability for inclusion based on established criteria. After reviewing records based on title and abstract and the two researchers agreeing on disputed studies with involvement of a third independent researcher, a full reading of the text of the studies that were potentially relevant was done, in order to ascertain their compliance with the inclusion/exclusion criteria. Studies were selected by researchers working separately; any doubts were settled by mutual agreement. A purpose-designed Excel data extraction sheet including Author(s), year of publication, study country, study design, sample size, the forms of dementia stigma, three interconnected drivers of dementia-related vulnerability: witchcraft accusations, caregiving strain, and health system deficiencies as well as stigma reduction interventions identified and their effectiveness. Extracted data were tabulated (Tables 1–3) to summarize study characteristics, stigma forms, and intervention approaches. Methodologically, qualitative approaches dominate, with interviews and focus groups capturing

lived experiences. While cross-sectional surveys and mixed-methods studies are emerging, they remain few and limited in scope. Participant groups typically include older adults, caregivers, community members, and health workers, with youth appearing in a handful of awareness-focused studies.

The PRISMA flowchart for the selection of studies is shown in the Figure 1.

Although scoping reviews do not typically exclude studies based on quality, we conducted a descriptive appraisal using the Mixed Methods Appraisal Tool (MMAT, 2018) to highlight methodological strengths and weaknesses. This appraisal informed interpretation but did not serve as exclusion criteria.

Extracted data were analyzed using a thematic synthesis approach. Following Braun and Clarke's framework for thematic analysis, we coded study findings inductively to identify recurring forms of stigma, cultural drivers, and intervention strategies. Codes were then grouped into three overarching domains: cultural stigma (e.g., witchcraft accusations, supernatural attributions), structural stigma (e.g., weak diagnostic systems, poor referral pathways), and institutional stigma (e.g., exclusionary practices in health and non-health settings). To enhance rigor, coding was conducted independently by two reviewers, with discrepancies resolved through discussion. Patterns across studies were compared to highlight commonalities and divergences within Southern Africa, while noting contrasts with East and West African contexts only where they provided explanatory value. The analysis emphasized mapping stigma forms and emerging responses rather than evaluating intervention effectiveness, consistent with the scoping review design.

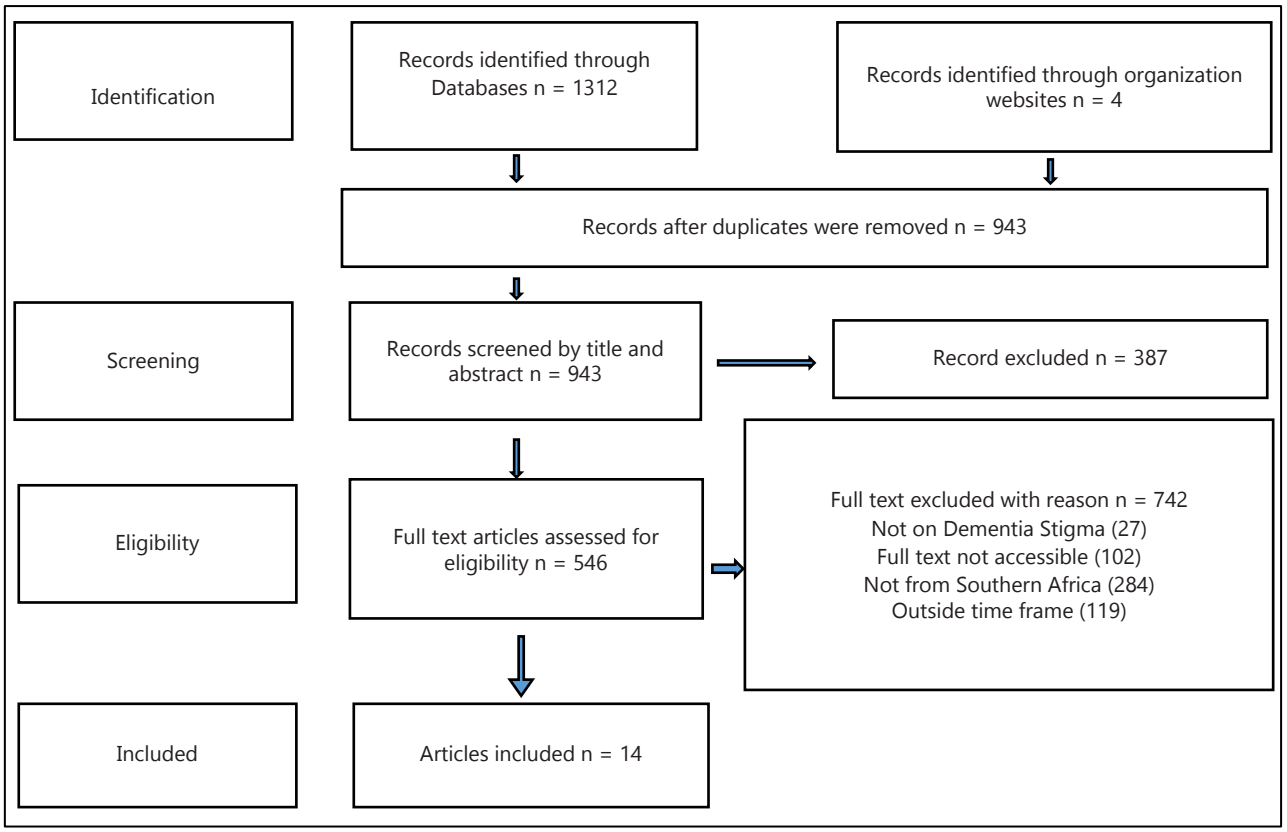


Figure 1. Flowchart of the article selection process and sources of evidence.

Results

Table 1 shows that empirical literature on dementia stigma in Southern Africa remains limited in both scale and geographic coverage, with most studies concentrated in South Africa, Zambia, and Tanzania. Fourteen studies met inclusion criteria (Figure 1). As summarized in Table 1, most were qualitative, small-scale, and concentrated in South Africa and Zambia, with limited coverage of other Southern African countries. Research is predominantly single-country and small-scale, offering valuable local insights but lacking the breadth needed for region-wide policy or program development across the Southern African Development Community.

Across studies, public and community stigma marked by negative attitudes, stereotyping, and social distancing is widespread. Cultural and spiritual beliefs, including witchcraft accusations, are especially prevalent in rural and peri-urban areas, contributing to secrecy and delayed care. Of the 14 included studies, nine reported witchcraft accusations as a driver of stigma, primarily in rural and peri-urban settings (Table 2). Linguistic stigma and caregiver burden characterized by isolation, shame, and limited support are recurring themes. Structural and institutional stigma, reflected in weak diagnostic systems, poor referrals, and exclusionary practices in non-health settings like prayer camps, further compound vulnerability.

Table 1. Characteristics of Dementia Stigma Studies by Author (year), Title, Design & Population, Country, Identified forms of Stigma

Author (Year)	Study title	Study design & population	Country	Main forms of stigma identified
Jacobs et al. [21]	Dementia in South Africa: A Situational Analysis	Situational analysis using policy/service documents and stakeholder inputs (multi‐sectoral)	South Africa	Structural stigma: policy and service gaps, limited diagnosis pathways, resource barriers leading to exclusion
Jacobs et al.[16]	Stigma and its implications for dementia in South Africa: a multi‐stakeholder exploratory study	Qualitative multi‐stakeholder study (people living with dementia, care givers, health workers, public, policymakers)	South Africa	Public stigma, internalized stigma, affiliate (caregiver) stigma, structural stigma, language/terminology stigma
de Jager et al. [23]	Dementia Prevalence in a Rural Region of South Africa: A Cross‐Sectional Community Study	Community cross‐sectional survey of older adults (rural sample, cognitive screening and case ascertainment)	South Africa	Implicit/observed stigma via under recognition, normalization as ageing, barriers to diagnosis (contributes to enacted and structural stigma)
Mfene & Pillay [27]	Dementia‐Friendly Communities: Exploring Terms used to Describe Dementia, Attitudes and Reactions Towards People with Dementia in Ilembe District	Cross‐sectional/qualitative survey of community members (attitudes, language use)	South Africa	Linguistic stigma (derogatory terms), public stigma, social exclusion, discrimination
Mfene & Pillay [32]	Knowledge of dementia and dementia care in rural and urban KwaZulu‐Natal	Cross‐sectional survey comparing rural and urban residents (knowledge, attitudes)	South Africa	Knowledge gaps underpin public stigma; stigma manifested as avoidance, blame, low help‐seeking
Khonje et al. [28]	Knowledge, attitudes and beliefs about dementia in an urban Xhosa‐speaking community	Descriptive cross‐sectional / qualitative study in Xhosa urban community	South Africa	Cultural stigma; dementia conflated with "madness", spiritual explanations, social distancing and fear
Simushi et al. [23]	Unmet Care Needs for Patients with Dementia and Their Caregivers in Zambia	Mixed methods / cross‐sectional assessment of patients and caregivers (health system and needs focus)	Zambia	Structural stigma (service gaps, unmet needs), caregiver burden, social marginalization
Mataa et al. [34]	Using community health workers to assess prevalence of dementia in older Zambians	Community prevalence study using CHWs (community‐based older adult sample)	Zambia	Community-level stigma: witchcraft attributions, neglect, fear of disclosure, barriers to participation in care
Walker et al. [37]	Patient and caregiver experiences of living with dementia in Tanzania	Qualitative semi‐structured interviews with people with dementia and caregivers	Tanzania	Public and cultural stigma, social isolation, misattribution to ageing or spiritual causes, barriers to help‐seeking
Kehoua et al. / EPIDEMCA group [29]	People with dementia in sub‐Saharan Africa: From support to abuse by caregivers (Congo)	Longitudinal / program data from EPIDEMCA‐FU (people with dementia and caregiver reports)	Republic of Congo	Caregiver‐perpetrated abuse and neglect, stigma within households, dehumanizing treatment linked to beliefs and caregiver burden
Adebisi & Salawu [25]	Misconception of dementia‐related disorders in Sub‐Saharan Africa	Cross‐sectional / empirical case studies across SSA settings (focus on misconceptions)	Multiple SSA countries	Widespread misconceptions (dementia as punishment/witchcraft), resulting in social rejection, delayed care and abuse
Fisher et al., [44]	Implementing Cognitive Stimulation Therapy (case study, Tanzania)	Stakeholder engagement and stakeholder interviews plus pilot CST groups (people with dementia, caregivers, health staff)	Tanzania	Identified stigma as barrier to implementation: community beliefs, fear of labelling, low uptake due to shame and service mistrust
Roe et al., [45]	Dementia prevalence and risk factors (hospital/community samples)	Cross‐sectional screening and assessment in older outpatient and community samples	Tanzania	Stigma expressed as underdiagnosis, preference for non‐pharmacological/ traditional options driven by cultural beliefs

Table 2 highlights three interconnected drivers of dementia-related vulnerability: witchcraft accusations, caregiving strain, and health system deficiencies. Supernatural attributions especially in rural and peri-urban areas fuel stigma, social exclusion, and delayed help-seeking. Caregiving strain was documented in 7 studies, characterized by isolation, secrecy, and affiliate stigma, with some reports of neglect or abuse. Health system deficiencies were noted in 6 studies, including poor diagnostic access, weak referral pathways, and limited community support (Table 2).

These domains often co-occur, with cultural beliefs intensifying caregiver stress and weak systems reinforcing misinformation and exclusion. Policy responses should prioritize culturally sensitive education, strengthen dementia recognition and referral in primary care, and expand caregiver support. Research should focus on rigorous mixed-methods evaluations of stigma reduction, tracking affiliate and internalized stigma over time, and testing integrated models that combine community engagement, CHW involvement, and health system strengthening.

Table 3 outlines emerging responses, including community health worker engagement, outreach to religious and traditional leaders, and culturally tailored education. All interventions were at pilot or recommendation stage, with no large-scale evaluations or standardized outcome measures. Where implemented, interventions were typically small-scale feasibility studies showing early signs of acceptability and attitude shifts, but lacking rigorous outcome measurement. Commonly proposed approaches include community engagement through CHWs, outreach to religious and traditional leaders, and culturally tailored education. However, structural and health system barriers though frequently documented are rarely addressed in evaluated programs.

Caregiver support is widely recommended and endorsed in qualitative studies, yet formal evaluations, especially randomized trials, are notably absent. Despite the recurring role of supernatural beliefs like witchcraft in driving stigma, few interventions have systematically tackled these with culturally sensitive messaging. Key priorities moving forward include developing standardized stigma metrics, conducting larger controlled trials of multi-level interventions, and evaluating strategies that engage traditional and religious leaders to directly address harmful beliefs.

Table 2. Study Indicators: Witchcraft Accusations, Caregiving Challenges, Health System Gaps

Author (Year)	Study Title	Accusations of witchcraft	Caregiving challenges	Health system gaps
Jacobs et al. [21]	Dementia in South Africa: A Situational Analysis			✓
Jacobs et al. [16]	Stigma and its implications for dementia in South Africa: a multi‐stakeholder exploratory study		✓	✓
de Jager et al. [23]	Dementia Prevalence in a Rural Region of South Africa: A Cross‐Sectional Community Study			✓
Mfene & Pillay [28]	Dementia‐Friendly Communities: Exploring Terms used to Describe Dementia, Attitudes and Reactions Towards People with Dementia in Ilembe District		✓	
Mfene & Pillay [32]	Knowledge of dementia and dementia care in rural and urban KwaZulu‐Natal		✓	✓
Khonje et al. [30]	Knowledge, attitudes and beliefs about dementia in an urban Xhosa‐speaking community		✓	
Simushi et al. [24]	Unmet Care Needs for Patients with Dementia and Their Caregivers in Zambia	✓	✓	✓
Mataa et al. [35]	Using community health workers to assess prevalence of dementia in older Zambians	✓	✓	✓
Walker et al. [38]	Patient and caregiver experiences of living with dementia in Tanzania	✓	✓	✓
Kehoua et al., [31]	People with dementia in sub‐Saharan Africa: From support to abuse by caregivers (Congo)		✓	
Adebisi & Salawu [26]	Misconception of dementia‐related disorders in Sub‐Saharan Africa	✓		✓
Fisher et al., [44]	Implementing Cognitive Stimulation Therapy (Tanzania)		✓	✓
Roe et al. [46]	Dementia prevalence and risk factors (hospital/community samples)			✓

Note: ✓study identified this issue.

Table 3. Stigma Reduction Interventions Reported or Identified and their Effectiveness

Author (Year)	Stigma reduction intervention identified	Effectiveness (tested / observed outcome)
Jacobs et al. [21]	Recommended multi‐level strategy (policy strengthening, public awareness, workforce training)	Not tested; recommended in situational analysis (no primary intervention evaluation)
Jacobs et al. [16]	Community and stakeholder engagement, language‐sensitive awareness activities (recommended)	Not tested within study; formative qualitative support for acceptability only
de Jager et al. [23]	None (prevalence study)	Not applicable
Mfene & Pillay [27]	Community language and terminology work (recommendation to change derogatory labels)	Not tested; evidence limited to documented community attitudes
Mfene & Pillay [32]	Public education and caregiver training recommended	Not tested in study; associations reported between knowledge and attitudes
Khonje et al. [28]	Community education and culturally framed health messaging (suggested)	Not tested; descriptive evidence supports need for interventions
Simushi et al. [24]	Service‐level recommendations: caregiver support, referral pathways, training	Not tested; identified unmet needs but no intervention trial
Mataa et al. [34]	Use of community health workers (CHWs) for case finding and community engagement	Feasibility demonstrated for CHW assessment; impact on stigma not yet measured (prevalence/feasibility focus)
Walker et al. [38]	Recommendations for culturally appropriate support, caregiver groups, training for primary care	Not tested; qualitative evidence indicates acceptability but no outcome evaluation
Kehoua et al. / EPIDEMCA group [31]	Community awareness campaigns and caregiver support programs implemented in parts of EPIDEMCA	Some program data show improved recognition and reduced abuse reports in local program follow‐up, but evidence is heterogeneous and not from randomized evaluation
Adebisi & Salawu [25]	Public education campaigns, integration into primary care, community outreach (recommended)	Not tested empirically in this paper; recommendations synthesize case reports and regional data
Fisher et al.,[44]	Cognitive Stimulation Therapy (CST) adaptation and stakeholder engagement to reduce barriers	Implementation work identified stigma as barrier; small‐scale pilots indicated feasibility and potential benefit for engagement but no definitive stigma outcome data
Roe et al.[45]	Health‐system strengthening recommendations (screening, referral, awareness)	Not tested within the prevalence/risk study

Discussion

Reviewed evidence on dementia stigma in Southern Africa reveals a complex interplay of cultural, structural, and institutional factors that shape public perceptions and caregiving experiences. This synthesis highlights that stigma in Southern Africa is not only a cultural phenomenon but also reinforced by systemic health gaps and caregiving strain. Unlike in regions with stronger health infrastructure, stigma here is sustained by limited diagnostic access and weak referral pathways, which perpetuate reliance on supernatural explanations. Studies in the region consistently show public stigma, spiritual attributions such as witchcraft, and linguistic marginalization as dominant themes [25-27]. These findings reflect broader Sub-Saharan African patterns, where misconceptions and spiritual beliefs often drive delayed help-seeking and social exclusion [28,29]. However, Southern Africa remains underrepresented compared to East African countries like Kenya and Uganda, which had begun piloting community-based stigma reduction programs and documenting caregiver burden in more detail [30,31]. In contrast, West African studies, such as those from Ghana and Nigeria, emphasize youth awareness gaps and caregiver abuse, suggesting regional variations in stigma expression and intervention priorities [32,33]. On the contrary, research from Europe, Australia, and North America highlights more structured approaches to stigma reduction, including dementia-friendly communities, arts-based interventions, and targeted public education campaigns [34,35]. Studies in Australia emphasize age-related differences in stigma perception, with older adults expressing more negative stereotypes and social distancing behaviors [36]. European and North American initiatives often focus on cultural inclusivity within dementia care, particularly for minority and immigrant populations, where stigma is compounded by language barriers and limited awareness [37]. These regions benefit from more robust health systems and policy frameworks, enabling broader implementation of anti-stigma interventions. The contrast underscores the need for Southern African strategies to integrate culturally sensitive, community-driven models while leveraging global best practices.

The three intersecting drivers of dementia-related vulnerability identified in Southern Africa including witchcraft accusations, caregiving strain, and health system deficiencies. These reflect a complex interplay of cultural beliefs and systemic limitations. Supernatural attributions particularly common in rural and peri-urban areas research, continue to fuel stigma and delay help-seeking [17,18]. The persistence of witchcraft accusations reflects the deep entrenchment of traditional cosmologies

and the absence of sustained public health education campaigns. Addressing these beliefs requires culturally sensitive messaging that engages traditional and religious leaders, rather than relying solely on biomedical framing. In contrast, stigma in developed countries of Europe, and North America, is more often linked to fear of cognitive decline, ageism, and misunderstanding of dementia symptoms rather than spiritual or supernatural beliefs [2,5]. This divergence across regions highlights the need for culturally tailored messaging in Southern Africa that directly addresses witchcraft-related misconceptions while promoting biomedical understanding of dementia as equally advanced by Nyirongo [20].

Caregiving strain is a global concern, but its manifestations differ across regions. In Southern Africa, caregiver burden is compounded by limited formal support, affiliate stigma, and social isolation. Unlike in high-income settings where structured respite care exists, Southern African caregivers often face isolation without formal support. This highlights the urgent need for community-based caregiver protection policies and integration of dementia into primary health care. While caregivers in high-income countries also report emotional stress, they often benefit from structured support systems, respite care, and public health initiatives that recognize their role [7,11]. Health system gaps in Southern Africa such as poor diagnostic access and weak referral pathways further exacerbate stigma and exclusion. These systemic deficiencies not only delay diagnosis but also reinforce stigma, as families default to cultural explanations. Strengthening primary care recognition of dementia and building referral networks are therefore critical anti-stigma strategies. By contrast, countries with stronger health infrastructure have begun integrating dementia into national public health strategies, emphasizing early detection, community-based care, and inclusive research practices [1,38]. These global models offer valuable lessons for Southern Africa, where future interventions should combine culturally sensitive education, caregiver support, and health system strengthening to address stigma holistically.

The highlighted critical gap between recommended dementia stigma reduction strategies and their formal evaluation in Southern Africa while most interventions remain at the pilot or feasibility stage, showing promise in shifting attitudes but lacking robust outcome data. In Southern Africa, interventions remain at pilot stage, with promising but untested approaches such as community health worker engagement and outreach to traditional leaders. The absence of standardized stigma metrics and controlled evaluations limits scalability and policy uptake. While community engagement through CHWs and outreach to religious and traditional leaders are commonly proposed in Southern Africa, structural barriers such as weak diagnostic systems and limited care infrastructure, are rarely targeted in implemented programs. Moreover, despite the well-documented role of supernatural beliefs like witchcraft in perpetuating stigma, few interventions have directly addressed these with culturally sensitive messaging, a gap not seen in high-income settings where stigma is more often linked to ageism and cognitive decline [2,5]. Future research should prioritize longitudinal designs and validated stigma measures, while governments must integrate dementia stigma reduction into national health strategies. Without this dual focus on evidence and policy, stigma will continue to undermine timely diagnosis and care.

Conclusion

We observed a vivid shortage of large, representative epidemiological studies and an absence of randomized or controlled evaluations of stigma‐reduction interventions in the region. Measurement of stigma is inconsistent across studies, with few using validated scales or longitudinal designs, which limits comparability and evidence synthesis. Interventions that directly address supernatural attributions, caregiver protection, and health‐system strengthening are rarely tested despite repeatedly being identified as priorities. Research priorities should therefore include the development and use of standardized stigma outcome measures, larger controlled trials of culturally adapted community and health‐system interventions, and expanded geographic coverage across Southern Africa.

Conflict of Interest

The authors declare that they have no conflicts of interest related to this work.

Ethical Approval

As all data in review will be extracted from previously published studies, the study does not meet the requirements of human subjects' research and, as such, was exempted from Institutional Review Board (IRB) review.

Declaration of Generative AI and AI-Assisted Technologies

During the preparation of this work the authors used Microsoft Copilot in order to assist with structuring the manuscript, refining section organization, and improving clarity of arguments. The authors also used QuillBot in order to check grammar, spelling, and sentence flow. After using these tools, the authors reviewed and edited the content as needed and take full responsibility for the accuracy and integrity of the publication.

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