Partners' Perceptions and Attitudes Towards Antenatal Care Services in the Denkyembour District in the Eastern Region of Ghana

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ABSTRACT

Male partner involvement in antenatal care (ANC) remains limited in many rural settings, yet men's perceptions and attitudes shape women's access to care, household decision-making, and maternal health support. This study aimed to explore male partners' perceptions and attitudes towards antenatal care services in the Denkyembour District of Ghana. This study reports the male-partner analytic strand of a larger qualitative case study on low male involvement in ANC in the Denkyembour District of Ghana. The study recruited 57 participants through purposive and snowball sampling. Fifteen male partners participated in individual semi-structured interviews, while 42 participants took part in focus group discussions, comprising 16 expectant mothers, six community leaders, and 20 healthcare providers. Data were generated over six weeks, audio-recorded with consent, transcribed verbatim, coded inductively, and analysed thematically with support from NVivo version 14. The findings showed uneven knowledge and awareness of ANC. Some male partners had no clear understanding of ANC, while others associated it only with routine activities such as weighing, injections, and general advice. A smaller group demonstrated rudimentary but accurate knowledge, while fewer participants understood ANC as a preventive service that supports early detection, monitoring, and protection of maternal and fetal health. Men with direct exposure to ANC services were the most informed and expressed more supportive attitudes towards participation. The study concludes that low male involvement in ANC in the Denkyembour District is closely linked to limited knowledge, weak exposure, and insufficient male-directed engagement. Targeted health education, community outreach, and male-inclusive ANC services are necessary for strengthening men's support for pregnant women and improving maternal and neonatal health outcomes.

Keywords: antenatal care, attitudes, male partners' involvement, maternal health education, perceptions

Introduction and Background Context

Antenatal care is a central part of maternal health because it helps prevent complications, supports early detection of risk, and improves the chances of safe pregnancy and childbirth. World Health Organisation guidance presents antenatal care as person-centred care that protects the health of the mother and baby while also providing women with a positive pregnancy experience. This places antenatal care beyond routine clinic attendance. It serves as a major entry point for health education, monitoring, counselling, and timely referral during pregnancy (World Health Organisation [WHO], 2016).

Within this broader maternal health agenda, male partner involvement has become an important issue. In many low- and middle-income settings, men still shape household decisions about money, transport, care-seeking, and facility use during pregnancy. For that reason, their perceptions and attitudes towards antenatal care can either support or weaken women's access to services. Recent reviews from sub-Saharan Africa show that men's involvement in maternal healthcare is influenced by social, cultural, economic, health-system, and policy factors. These reviews also show that men's participation has been linked with better birth preparedness, stronger couple communication, improved use of skilled care, and better maternal and newborn outcomes, even though involvement remains uneven across settings (Moyo et al., 2024; Musiwa et al., 2025).

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The Ghanaian context makes this issue especially important. Ghana has made progress in maternal health, but the maternal mortality burden remains above the Sustainable Development Goal target. The World Bank Gender Data Portal reports a maternal mortality ratio of 234 deaths per 100,000 live births in Ghana in 2023, which remains above the global target of fewer than 70 deaths per 100,000 live births. Ghana's reproductive health policy also explicitly recognises pregnant women, their spouses, and families as beneficiaries of antenatal care and states that support person involvement should be encouraged. This policy direction places male participation within the logic of maternal healthcare delivery, even where practice lags behind policy (Republic of Ghana, 2014; World Bank, 2025).

Studies from Ghana show that male involvement in antenatal and related maternal health services remains mixed and often limited. In Anomabo, only 35% of men reportedly accompanied their partners to antenatal care, and the study linked low involvement to education, distance, provider attitudes, gender roles, and cultural norms (Craymah et al., 2017). In the Upper West Region, Ganle and Dery (2015) found that fewer than one quarter of male participants had ever accompanied their wives to antenatal or postnatal care, with barriers rooted in provider behaviour, cost, and the belief that pregnancy care is mainly a woman's responsibility. In Bosomtwe District, Morgan et al. (2022) similarly identified work demands, financial pressure, cultural expectations, and the absence of services targeted at husbands as key barriers. Even where participation appears higher, as reported in Sekondi, socio-cultural beliefs and health-facility factors still shape how men engage with antenatal care (Annoon et al., 2020). Urban qualitative work in Ghana further shows that men often enter antenatal spaces as outsiders who must negotiate care environments already marked as feminine (Ampim et al., 2021).

This literature is useful, but three gaps remain. First, much of the Ghanaian evidence has focused on barriers and facilitators in general rather than on male partners' own perceptions and attitudes as a distinct analytical concern. Second, some studies rely on women's reports or cross-sectional survey measures, which provide valuable evidence but offer limited access to how men themselves interpret antenatal care. Third, district-level rural contexts remain unevenly represented. Recent work from Ghana and wider sub-Saharan Africa shows that local meanings of fatherhood, masculinity, marriage, service design, and community expectations strongly shape men's participation. Place-specific qualitative evidence is therefore important, especially in rural districts where social norms are entrenched and health-system access is fragile (Morgan et al., 2022; Moyo et al., 2024; Musiwa et al., 2025).

It is within this gap that the present study is located. The parent thesis in Denkyembour District was a qualitative case study designed to examine low male involvement in antenatal care from the perspectives of male partners, pregnant women, healthcare providers, and community actors. For the present article, the focus is narrowed to the first research objective, namely, to explore the perceptions and attitudes of male partners towards antenatal care services in the Denkyembour District. The thesis shows that men's understanding of antenatal care varied from complete lack of knowledge to informed and comprehensive views, with direct exposure to antenatal services improving understanding and supporting more positive attitudes. Perceptions and attitudes therefore provide a strong entry point for explaining why some men remain distant from antenatal care while others recognise its relevance and benefit.

Against this background, this article examines how male partners in the Denkyembour District understand antenatal care and how those understandings shape their attitudes towards participation. By focusing directly on men's own voices in a rural Ghanaian setting, the study adds local evidence to a national and regional debate that still needs more context-sensitive qualitative work. It also offers practical insight for designing health education, community engagement, and service delivery strategies that can bring men into maternal healthcare in ways that support, rather than overshadow, women's care.

Therefore, this study aims to explore male partners' perceptions and attitudes towards antenatal care services in the Denkyembour District of Ghana. Specifically, it addresses the question: How do male partners in the Denkyembour District perceive antenatal care services, and in what ways do these perceptions and attitudes shape their involvement in antenatal care?

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MATERIALS AND METHODS

Study design

This study employed a qualitative case study design within a social constructivist paradigm to explore male partners' perceptions and attitudes towards antenatal care services in the Denkyembour District of Ghana. The qualitative approach was appropriate because the study sought to understand meanings, experiences, and socially shaped interpretations of antenatal care within a specific rural context. A case study design was considered suitable because it allowed an in-depth examination of a real-life phenomenon shaped by social, cultural, and institutional influences in its natural setting. The design also supported the collection of rich, contextual data that could illuminate how male partners understood antenatal care and how these understandings influenced their engagement with maternal health services.

Study setting

The study was conducted in the Denkyembour District in the Eastern Region of Ghana. Akwatia serves as the district capital. The district is largely rural, with dispersed settlements and communities whose livelihoods are based mainly on agriculture and small-scale mining. Health care delivery in the district is organised through one government district hospital, several health centres, Community-based Health Planning and Services compounds, and private clinics that provide antenatal and other maternal health services. The district was considered an appropriate setting because local reports and preliminary information from health workers indicated persistently low male involvement in antenatal care, making it a relevant site for examining men's views and attitudes in relation to antenatal services.

Study population and sampling

The article draws from a wider qualitative case study whose population comprised male partners of expectant mothers, pregnant women, community opinion leaders, and healthcare professionals who provide maternal health services in the Denkyembour District. The parent study recruited 57 participants: 15 male partners, 16 expectant mothers, six community leaders, and 20 healthcare providers. The 15 male partners participated in individual semi-structured interviews and formed the main analytic sample for this article. The remaining 42 participants took part in focus group discussions and supplied contextual perspectives on women's experiences, community norms, and health system practices. Men who were unmarried or whose partners had no recent pregnancy experience were excluded. Purposive sampling was used to identify participants who met the inclusion criteria and had direct or indirect experience of pregnancy-related care. Snowball sampling was subsequently used because some eligible participants were difficult to reach through health facility contact alone. Initial contacts were made through health workers, community entry points, and referrals from participants who knew other eligible participants in the district.

Table 1: Participant distribution by data collection method

Participant group	Data collection method	Frequency	Analytic role in this article
Male partners	Individual semi-structured interviews	15	Main analytic corpus
Expectant mothers	Focus group discussions	16	Contextual and triangulating data
Community leaders	Focus group discussions	6	Community-level contextual data
Healthcare providers	Focus group discussions	20	Health system contextual data
Total	Interviews and focus group discussions	57	Full parent-study sample

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Participant recruitment and saturation

Recruitment continued alongside data collection and preliminary analysis. The study used the principle of data saturation to determine the adequacy of the qualitative sample. Saturation was judged to have been reached when subsequent accounts repeated existing meanings around ANC knowledge, direct exposure, perceived benefits, sociocultural expectations, economic pressures, and reasons for low participation without adding a new theme. This process supported the inclusion of a range of sociocultural and demographic perspectives across the 15 individual interviews and the 42 focus group discussion participants.

Data collection instrument

Data were collected using a semi-structured interview guide developed from the literature on male involvement in maternal health and antenatal care. The guide was designed to generate detailed information on participants' understanding of antenatal care, their views about male participation during pregnancy, and their attitudes towards accompanying partners to antenatal services. The instrument also included a short demographic section to capture participants' age, marital status, education, occupation, religion, and ethnicity. To improve content relevance and clarity, the guide was reviewed by the study supervisor and other experts with knowledge in maternal health and social research. A pilot test was conducted in the Birim Central District, which shares similar social characteristics with the study area. Minor revisions were made to improve the wording and flow of the questions before the main fieldwork began.

Data collection procedure

Data were collected over six weeks through 15 semi-structured individual interviews and focus group discussions involving 42 participants. The individual interviews were conducted with male partners and generated the principal data for this article. The focus group discussion participants comprised 16 expectant mothers, six community leaders, and 20 healthcare providers. Two trained research assistants who were fluent in Twi and English supported the fieldwork after a three-day training session on qualitative interviewing, ethical conduct, confidentiality, and consistency in field procedures. Interviews and focus group discussions were conducted in community centres, health facilities, and private residences, depending on participant convenience and privacy. Each session lasted between 25 and 30 minutes. All sessions were audio-recorded with participants' consent, and field notes were taken to document environmental contexts and non-verbal cues. Individual interviews were used to obtain personal accounts of men's understanding, attitudes, and experiences with ANC, while focus group discussions elicited shared community meanings, collective views, and interactional responses on male participation.

The two data collection methods were integrated at the analysis stage. Interview transcripts and focus group discussion transcripts were first treated as distinct qualitative sources in NVivo. The research team then compared codes across both sources to identify convergent meanings, method-specific emphases, and divergent interpretations. The individual interviews produced direct accounts of male partners' knowledge, perceptions, and attitudes towards ANC. The focus group discussions provided contextual evidence on pregnant women's experiences, community expectations, and health system factors that shaped or limited male involvement. The comparison showed broad convergence across the two methods: both data sources linked low male participation to limited knowledge, gendered expectations, economic constraints, and unwelcoming service environments. Themes were retained when they were analytically coherent and supported by relevant evidence from one or both methods.

Data management and analysis

Audio recordings were checked against field notes and then transcribed verbatim. Transcripts generated in Twi were translated into English and checked for meaning accuracy before analysis. The data were analysed thematically with support from NVivo version 14. Analysis followed an inductive process. First, the transcripts were read several times to promote familiarity with the data. Initial codes were then generated from meaningful segments of the data through line-by-line reading. Interview and focus group discussion data were coded separately at the early stage and subsequently compared in a common codebook. Related codes were grouped

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into categories, and the categories were reviewed and refined into themes and sub-themes. Every transcription was double-checked against the audio recording to ensure accuracy and completeness. The researcher and the two trained research assistants held cooperative coding sessions, during which coding disagreements were discussed, checked against the raw transcript excerpts, and resolved by consensus. An audit trail was maintained to record coding choices, category development, and theme refinement.

Trustworthiness

Several measures were used to strengthen the trustworthiness of the findings. Credibility was supported through triangulation of individual interviews, focus group discussions, audio recordings, and field notes. Member checking was used to confirm the accuracy of selected participants' views during field engagement. Dependability was strengthened through a transparent audit trail consisting of field notes, transcription checks, coding decisions, category development, and the NVivo project file. Coding quality was strengthened through cooperative coding sessions involving the researcher and the two trained research assistants. Coding disagreements were resolved through discussion, comparison with raw transcript excerpts, and consensus-based refinement of the codebook. Confirmability was supported through reflexive journaling, which helped the researcher examine assumptions during data collection and interpretation. Transferability was supported by a detailed description of the study setting, sampling approach, participant characteristics, and data collection procedures.

RESULTS AND DISCUSSION

The results reported in this article are based on the 15 male partners who participated in individual interviews. The broader parent study included 42 focus group discussion participants whose views supplied contextual and triangulating evidence. Among the male partners, six participants were aged 18-30 years, five were aged 31-40 years, and four were aged 41-50 years. Most participants were married (n = 12, 80%), while three were cohabiting (n = 3, 20%). Their educational backgrounds ranged from basic to tertiary level, with secondary education being the most common level reported. The participants also represented varied occupational, religious, family, and ethnic backgrounds. Table 2 presents the demographic characteristics of the male partners.

Table 2: Demographic characteristics of male partners

Characteristic	**Category**	**Frequency**	**Percentage**
Gender	Male	15	100
Age	18-30	6	40
Age	31-40	5	33
Age	41-50	4	27
Marital status	Married	12	80
Marital status	Cohabiting	3	20
Level of education	Tertiary	4	27
Level of education	Secondary	8	53
Level of education	Basic	3	20
Occupation	Butcher	1	7
Occupation	Electrician	3	20

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Occupation	Farmer	2	14
Occupation	Teacher	3	20
Occupation	Taxi driver	1	7
Occupation	Mason	1	7
Occupation	Carpenter	1	7
Occupation	Trader	3	20
Religion	Christianity	14	93
Religion	Islam	1	7
Number of children	1-2	7	46
Number of children	3-4	6	40
Number of children	5+	2	14
Ethnicity	Akan	7	46
Ethnicity	Ewe	3	20
Ethnicity	Krobo	2	14
Ethnicity	Akyem	2	14
Ethnicity	Ga	1	7
Ethnicity	Fante	1	7

Theme and Sub-themes

Table 3: Theme and its sub-themes

Theme	**Sub-theme**
Knowledge and Awareness of Antenatal Care	Complete Lack of Knowledge
	Superficial and Limited Understanding
	Rudimentary but Accurate Understanding
	Informed and Comprehensive Understanding
	Knowledge Through Direct Experience

Knowledge and Awareness of Antenatal Care

This theme examines the varying levels of knowledge and awareness regarding antenatal care (ANC) among participants, spanning a continuum from complete unawareness to a comprehensive and well-informed understanding. The responses highlight differences in participants' familiarity with ANC services, their purposes, and the health benefits associated with them. This variability in understanding can be attributed to the differing

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degrees of exposure to or involvement in ANC, as well as the diversity in educational backgrounds and health literacy among the participants.

Complete Lack of Knowledge. A segment of participants displayed a fundamental lack of awareness regarding ANC, demonstrating little to no understanding of its purpose or significance. These individuals expressed a complete absence of knowledge, indicating that they were not familiar with the term or its associated healthcare practices. This lack of awareness could be attributed to limited exposure to health education or a general lack of access to information about ANC. These responses suggest a concerning gap in the public's understanding of basic health services like ANC, which could be indicative of insufficient community outreach or education on maternal health services. Some of the participants were of the view that:

"I have no idea what they do at antenatal care. I don't know what antenatal care is about. I just heard the name" (Male partner, 21 years).

Superficial and Limited Understanding. Participants in this sub-theme displayed a superficial understanding of ANC, often associating it only with visible or basic activities such as weight monitoring or general advice. While they were aware of some procedures, their understanding was limited and lacked depth regarding the comprehensive health purposes of ANC. These responses illustrate that while these participants had some knowledge of ANC, their awareness was restricted to a narrow range of procedures and did not encompass the broader, preventive health benefits that ANC provides for both the mother and the fetus. The majority of the participants said that:

"I only know my wife goes to weigh herself. That's it. It's a place where they weigh the woman and give advice. They give injections and medicine to the woman" (Male partner, 25 years).

Rudimentary but Accurate Understanding. In this sub-theme, participants exhibited a more accurate but still rudimentary understanding of ANC. While they recognised the fundamental purpose of ANC, monitoring the health of the mother and the baby, their understanding remained general and lacked detail regarding the full scope of services provided, such as early detection of complications or preventive care. These participants correctly identified key aspects of ANC but did not fully appreciate the range of services involved. Their understanding was based largely on second-hand information rather than personal experience or comprehensive education. Some participants claimed:

"I haven't gone there, but I hear it's for checking the woman and the baby. I don't know much, but I hear they check the baby's position and growth. They check the woman, give medicine and advice" (Male partner, 23 years).

Informed and Comprehensive Understanding. Participants in this sub-theme demonstrated a thorough and nuanced understanding of ANC, recognising not only its fundamental purpose but also its critical role in preventing complications and ensuring the health of both mother and child. They acknowledged the proactive nature of ANC, emphasising its importance in early detection, monitoring, and prevention.

"Especially for monitoring the baby's health and the woman's condition. Antenatal care helps in detecting complications early. It's a very important service. I see antenatal as a way to protect the mother and baby. Antenatal care helps to detect problems early. It is good" (Male partner, 26 years).

These participants reflected a sophisticated understanding of ANC, recognising its importance as a vital service for identifying and addressing potential health risks early. This awareness suggests a deeper understanding of ANC's preventive and protective roles, which can encourage more positive attitudes towards male participation.

Knowledge Through Direct Experience. The final sub-theme highlights the role of direct experience in shaping participants' knowledge and attitudes towards ANC. Participants who had firsthand exposure to ANC services were able to articulate more detailed and informed perspectives, indicating that personal involvement significantly enhances understanding. This firsthand experience allowed participants to gain practical insights

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into the purpose and procedures of ANC, underscoring the value of direct engagement in fostering a deeper appreciation for maternal health services. Some of the participants said that:

"It is informative. I went once with my girlfriend and learned a lot" (Male partner, 19 years).

The analysis of knowledge and awareness of antenatal care among participants reveals significant variation in understanding, with some individuals showing a complete lack of knowledge and others possessing a well-rounded comprehension of the importance of ANC. This diversity in awareness suggests a need for targeted educational interventions to increase public knowledge of ANC and its critical role in maternal and fetal health. Specifically, efforts to engage those with limited or no knowledge of ANC, as well as those with superficial understandings, could lead to improved participation and better health outcomes. Furthermore, enhancing knowledge through firsthand exposure to ANC services can help bridge gaps in understanding and foster more positive attitudes towards maternal healthcare.

DISCUSSION

This study shows that male partners in the Denkyembour District have uneven levels of knowledge and awareness of antenatal care (ANC) services. Many participants reported either no clear understanding of ANC or only a superficial awareness of it, often limited to visible activities such as weight checks, injections, and general advice. Only a smaller number of participants showed a fuller understanding of ANC as a preventive service that supports early detection of complications and protects the health of both mother and child. The most informed views came from men who had direct exposure to ANC services, suggesting that familiarity with the service may shape more positive attitudes towards involvement.

The variation in knowledge levels points to a wider problem of poor male awareness of ANC in the district. This finding is consistent with broader evidence from sub-Saharan Africa, where male involvement in maternal health remains constrained by low knowledge, weak engagement, and poor understanding of reproductive care processes (Moyo et al., 2024). Male involvement matters because men often influence household decisions, including financial support, transport, and care-seeking during pregnancy, and their participation has been associated with improved maternal health outcomes and service use (Yargawa & Leonardi-Bee, 2015). In this study, men with limited knowledge of ANC appeared less likely to appreciate its preventive value. This may partly explain their low engagement. The finding also agrees with previous studies showing that many men continue to view pregnancy care as a woman's responsibility, which reduces their willingness to participate in ANC (Ganle & Dery, 2015; Nesane et al., 2016).

The more informed male partners in this study recognised that ANC is important for monitoring pregnancy, identifying potential risks early, and preventing poor maternal and neonatal outcomes. This suggests that direct exposure and education can play a major role in shaping supportive attitudes. Similar evidence has shown that interventions which bring men closer to maternal health services, including direct participation, targeted counselling, and structured engagement activities, can improve care-seeking, couple communication, and practical support during pregnancy (August et al., 2016; Tokhi et al., 2018). Yet the present findings also show that many men remain uninvolved until complications arise. This points to the need for earlier and more proactive forms of education that explain ANC before pregnancy-related risks become urgent.

The findings further support the view that knowledge and awareness are central to male involvement in ANC. Reviews of the field have shown that male involvement includes physical attendance at clinics, communication, decision-making, emotional support, and practical support, all of which depend partly on what men know and how they understand maternal health services (Galle et al., 2021). Where knowledge is weak, meaningful involvement becomes limited. This study, therefore, adds to the growing evidence that male-targeted education is necessary if men are to move from passive observers to informed and supportive partners in maternal healthcare (Moyo et al., 2024).

These findings have practical implications for policy and service delivery. There is a clear need for targeted health education campaigns that explain ANC as more than routine weighing, advice, or medication. Education efforts should stress the preventive and protective functions of ANC and should present male involvement as a

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shared family responsibility rather than an intrusion into women's care. Evidence from intervention studies suggests that engaging men through community-based education, structured facility support, and inclusive maternal health strategies can improve male participation and strengthen support for women during pregnancy (Okwako et al., 2023; Tokhi et al., 2018). Health facilities in the district could therefore organise community sessions for couples, create more welcoming environments for male partners, and encourage joint attendance at selected ANC visits.

Improving access to information for men who are not already involved in the pregnancy process is also important. Public health campaigns can use accessible community channels, especially radio and other mass media platforms, to reach men with clear messages about the value of ANC. Evidence from Malawi shows that mass media campaigns can improve men's participation in antenatal, delivery, and postnatal care (Zamawe et al., 2015). In the Denkyembour District, such strategies could be combined with community meetings and local outreach to widen men's exposure to maternal health information. Overall, the findings suggest that closing knowledge gaps among men is a necessary step in building stronger shared responsibility for maternal health.

Practical Implications

The findings have clear practical implications for maternal health programming in the Denkyembour District. Since men's knowledge of antenatal care ranged from very limited to well-informed, male involvement is unlikely to improve unless health education targets men directly and explains ANC as a preventive service that supports early detection, monitoring, and protection of both mother and child. The thesis also points to male-focused education, community outreach, and service restructuring as key responses to this gap. Health facilities should therefore make ANC more male-inclusive by inviting partners to selected visits, providing brief education for couples, and creating a more welcoming environment for men. Wider evidence shows that male engagement improves when services are inclusive and when men are given structured opportunities to participate. Community-based channels such as radio, local meetings, and engagement through traditional and religious leaders may also help normalise male participation and extend information to men who do not attend clinics.

CONCLUSION

This study shows that male partners in the Denkyembour District do not share a common view of antenatal care. Their perceptions and attitudes range from a complete lack of awareness to informed understanding of ANC as an important preventive service. Many men knew little about ANC beyond visible routine activities, while a smaller group, especially those with direct exposure to ANC services, understood its role in monitoring pregnancy, detecting complications early, and protecting maternal and child health. The findings therefore suggest that low male involvement is closely tied to weak knowledge and limited engagement with antenatal services.

The study concludes that improving male involvement in ANC in the Denkyembour District will require more than encouraging attendance alone. It will require deliberate efforts to improve men's awareness, reshape community perceptions, and make maternal health services more inclusive of male partners. Male-focused health education, community and mass media outreach, and more welcoming health facility practices are likely to be important steps in closing the knowledge gap and strengthening shared responsibility for maternal health. In this way, greater male understanding of ANC may help improve support for pregnant women and contribute to better maternal and neonatal health outcomes in rural Ghana.

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Ethics Approval and Consent to Participants

This study adhered to ethical principles for research involving human participants. Ethical clearance was obtained from the Ethical Review Committee of Klintaps University College of Health and Allied Sciences before data collection. Official letters were sent to the participating health facilities in the district. All participants were informed about the purpose and procedures of the study, and written informed consent was obtained before participation. Participation was voluntary, and participants retained the right to withdraw from the study at any time. Personal identifiers were removed from the data, participant labels were used in the reporting of quotations, and all information was stored securely in password-protected files accessible only to the research team. The rights, dignity, anonymity, confidentiality, and well-being of all participants were respected throughout the study.

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Data Availability Statement: The completed dissertation report has been archived in the University of Cape Coast Institutional Online Repository. The raw qualitative interview and focus group discussion transcripts are restricted because they contain potentially identifying accounts from a small rural participant group. De-identified excerpts that support the findings are included in this article. Additional de-identified data may be made available by the corresponding author upon reasonable request and subject to the conditions of the approving ethics committee.

Declaration: We declare that this study is the result of our original research.

Consent for publication: Not applicable

Competing interests: The authors declare no competing interests.

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