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Community perceptions of intimate partner violence - a qualitative study from urban Tanzania

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Abstract

Background: Intimate partner violence against women is a prevailing public health problem in Tanzania, where four of ten women have a lifetime exposure to physical or sexual violence by their male partners. To be able to suggest relevant and feasible community and health care based interventions, we explored community members' understanding and their responses to intimate partner violence.

Methods: A qualitative study using focus group discussions with 75 men and women was conducted in a community setting of urban Tanzania. We analysed data using a grounded theory approach and relate our findings to the ecological framework of intimate partner violence.

Results: The analysis resulted in one core category, "Moving from frustration to questioning traditional gender norms", that denoted a community in transition where the effects of intimate partner violence had started to fuel a wish for change. At the societal level, the category "Justified as part of male prestige" illustrates how masculinity prevails to justify violence. At the community level, the category "Viewed as discreditable and unfair" indicates

partner/husband. Sexual violence was defined as being physically forced or threatened to have sex or to do something sexually degrading.

IPV against women is associated with an increased risk for health problems [8]

abused [37,38]. *The ecological model* [39] offers a comprehensive understanding of risk factors linked to IPV at different levels. The individual level indicates biological characteristics and other individual experiences related to gender norms and expectations which predict men who will perpetuate IPV towards their women partners in many settings [37,38]. Other individual IPV risk factors build on social learning theory and include witnessing violence or being abused as a child or as an adolescent [19], having partners who are excessive alcohol or drug users [7,37,39], or being financially dependent [40,41]. The relationship level refers to the immediate context in which abuse may occur, for example, male control over family resources, decision-making power, economic inequalities, and high levels of controlling behaviours [21,32,42-44]. The community level is extended to family, neighbours, work and other social networks. Risk factors include restrictive marriage norms [19], honour killings [45] and lack of social support from others due to the silence associated with violence [18,27]. The societal level includes dominant societal norms, laws and socio-economic policies that may influence sanction mechanisms. Lack of specific policies and laws to protect IPV-affected women and lack of adequate sanction mechanisms for perpetrators are risk factors for IPV [18]. Accepting and practicing polygamous relationships has also been linked with IPV against women in sub-Saharan Africa [20,46].

In a previous study, we focused on the experiences of healthcare workers who meet women clients exposed to IPV against women in Temeke District, Dar es Salaam, Tanzania. The health care workers perceived IPV against women to be linked with gender inequality, male dominancy, and poverty. They could identify substantial barriers for clients to disclose their violence experiences, but were concerned and eager to make a difference if provided with adequate skills, tools and resources [27]. However, to be able to suggest relevant and feasible community- and health care based interventions there is a need to explore further community member understanding and response towards intimate partner violence.

The specific objectives of this study were to explore how community men and women understand IPV and to capture their views regarding social, medical and legal support of IPV survivors as well as their suggestions for preventive measures.

Methods

Design

We conducted a qualitative study based on focus group discussions (FGDs) with community members. FGDs are suitable for generating information on how norms, systems and attitudes are formed and how they differ between groups in a community. The data were analysed using the steps for grounded theory [47]. The findings were summarised in a model (Figure 1) and later integrated into the existing theoretical framework for understanding IPV against women.

Setting

The study was performed in Temeke District, one of three districts in the Dar es Salaam region of Tanzania. The Temeke District population is approximately 770,000 [22] with an annual growth rate of 4%. Eighteen per cent of the population lives below the poverty line. Temeke is a semi-urban district with a mix of Tanzanian tribes including both Muslims and Christians. The district consists of 18 wards of which four are peri-urban. Each ward is divided into streets that are headed by a local government leader[48]. The basic traditional gender norm assumption in this setting, as in other parts of Tanzania, is that a woman's primary commitment is to care for her family at home and to rely on a male breadwinner who is responsible for cash and other household needs. The skills of these self-employed housewives tend to be undervalued and defined as unskilled, even when they entail complex actions and thought processes such as child care, subsistence farming, agro-processing. Customary laws and practices remain discriminatory against women on issues of property inheritance particularly for land, and in decisions on the consequences of actions such as IPV [48]. Christians have strong beliefs that marriage is a life commitment and this increases acceptance of IPV and makes it hard for women to leave violent relationships. Strict Muslim divorce procedures further increase the likelihood of Muslim women tolerating violent relationships. According to Tanzanian law, physical violence is a

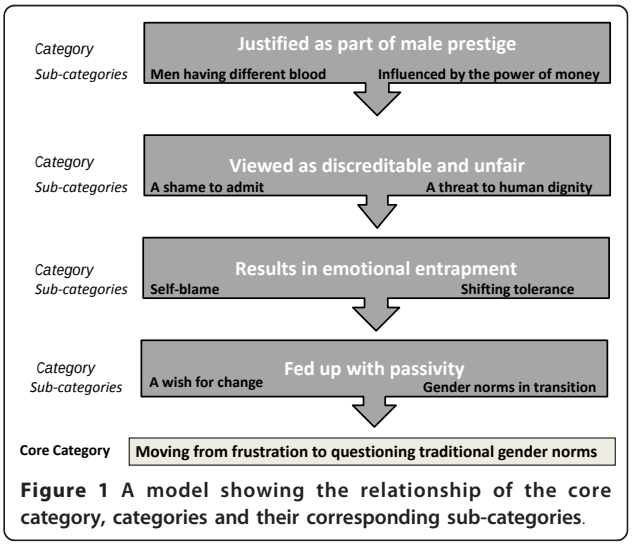


Figure 1 A model showing the relationship of the core category, categories and their corresponding sub-categories.

criminal offence. However, IPV against women is not considered separately and the law on sexual assaults does not currently include rape within marriage [24].

Selection of informants

We purposively selected our informants from the Temeke District hospital catchment area. The Temeke District management helped select four peri-urban wards of the 18 district wards. To minimize travel, we randomly selected one of the four wards since there was no socio-economic variation expected among them. Three streets within this ward were randomly picked from a list of streets given by the local government leaders. The local leaders were more familiar with the surroundings, so they assisted us in approaching community members who could capture the demographic and socio-cultural variation in the area. The specification was that community members should be between 15-59 years of age and likely to have met with people affected by IPV at work or in their community. Local leaders provided us with a list of names, indicating professions for those employed and business type for the self-employed or unemployed. A member of the research team (RL) purposively picked names to ensure variation in sex, age and profession (teachers, accountants, secretaries and agricultural officers), including religious leaders. The final sample of informants is shown in Table 1.

Data collection

Data were collected for four months and the FGDs were moderated by two researchers (a man and a woman) who were working with studies on violence. After introducing ourselves to the focus group participants, we opened the discussion by showing a drawing of a woman who looked sad. The discussants were asked to reflect on possible reasons for her state without first mentioning IPV. Later, we showed them more specific newspaper headlines, such as "What does it mean when a father beats his wife in front of the children?" to initiate a discussion on IPV and its consequences. We used a thematic guide (Additional file 1) to help us probe further.

Informed consent was obtained before each focus group and we asked for permission to record and take notes to be able to capture the interaction between participants. Each focus group had 8-12 participants. They were conducted in a quiet venue within the informants' neighbourhood and each lasted 65-90 minutes. After every FGD, we reviewed and discussed the collected information so that any new insights could guide subsequent discussions, a technique called emergent design [46]. After the seventh FGD, we felt that we had reached saturation, a state where additional information was not expected to give new insights. One of the groups was comprised of Christian leaders only since Muslim leaders were well represented in the other groups.

Table 1 Characteristics of the focus groups participants (n = 75)

Group number	Sex	Category	Number	Age (years)
1	Females	Non-professionals	12	15-40
2	Males	Non-professionals	12	30-48
3	Females	Professional and non-professionals	12	30-52
4	Females	Professionals	10	30-46
5	Males	Professionals	11	27-56
6	Females and males	Religious	10	35-52
7	Males	Professionals and non-professionals	8	32-41

Research tools

We prepared a thematic guide (Additional file 1) with four general themes. These were social cultural factors; policy environment; risks, and help-seeking behaviours in violent relationships; and future expectations of care, support and IPV prevention. The specific areas included community awareness and experiences of IPV as well as gender norms and attitudes towards marriage, IPV consequences, family, social, medical and legal support, elder and local governmental leader roles and participant suggestions for prevention. Development of the guide was based on a general understanding of IPV. During data collection and initial analyses this pre-understanding was put within brackets [47].

Analytical procedures

FGDs were transcribed verbatim in Kiswahili, which is the official language in Tanzania. Later they were translated into English to enable joint analysis by the research team. Following a grounded theory approach the text was imported into the Open Code 2007 program [49] to facilitate the coding process. After reading the transcripts, RL and ME performed open coding of the text, constantly comparing similarities and differences by going back to the original text. In the next step, RL and ME performed selective coding where relevant codes were further conceptualized and leading to the development of four main categories and eight subcategories relevant to our research focus (Figure 1). On the basis of these categories and sub-categories, a core category was constructed to capture the essence of the findings. In a last stage the analysis was integrated and compared with existing theory.

Ethical considerations

We obtained ethical clearance from Muhimbili University of Health and Allied Sciences (MUHAS) in June 2007.

Next we received permission from the local council to conduct the study in the selected wards. In accordance with the ethical guidelines of research on violence against women [50], we introduced the study as a "study on women's health and life experiences". To protect the participants from possible suffering by discussing sensitive issues, we established linkages with service providers such as Dar es Salaam Crisis Centre and Tanzania Legal Women Association (TAWLA), and appointed a psychiatric nurse to give support if needed. During the introductory part of each FGD the participants were encouraged to agree to keep the information discussed within the group. Discussants who reacted emotionally when recalling experiences of IPV were politely invited to leave the discussion and supported by one of the team members until they recovered and decided to return. None of the participants wanted to be referred to a counsellor.

Trustworthiness

Two of the research team members, RL and HL, are Tanzanians and fluently speak the local language of Kiswahili. The other research team members (LN and ME) reside abroad and have extensive experience in cross-cultural collaboration. To increase credibility, the research team made repeated visits to the study site. Prolonged engagement in the field by RL helped to build trust with the community representatives. Preliminary findings were subjected to member-checks with two Temeke district residents to confirm meanings of certain local expressions. The research team also had continuous peer-debriefing sessions as the study progressed. A flexible guide, emergent design, multidisciplinary research team, verbatim transcriptions, and predefined analytical procedures were used to promote study rigour. During the analysis, the fitness and relevance of emerging categories to the research question were tested by constant comparison and checking between the text, codes and categories and by paying specific attention to outliers or negative cases.

Results

Analysis of the focus group discussions resulted to one core category, **"Moving from frustration to questioning traditional gender norms"**, denoting a community in transition where the effects of intimate partner violence in the community had started to fuel wishes for change. The community members had started questioning the role of existing gender norms and IPV against women. The core category emanates from eight subcategories: two for each of the four categories as illustrated in Figure 1.

'Justified as part of male prestige'

The first category, '**Justified as part of male prestige**', denotes a socially constructed gender norm system where men are born to be more powerful than women, are given a superior position in decision making, and believed to have the right to a better financial status and position compared to women.

Men having different blood

The sub-category *Men having different blood* indicates ideas of masculinity seen to influence partner/husband behaviours and perceptions of IPV against women. Both women and men of all ages and professions justified a certain level of IPV against women. Men were allowed to use violence as a measure to correct women in specific situations and women accepted a certain amount of violence for discipline. Men expressed their preference for women who acted quietly, asked for permission to go out, were obedient, and had few friends. To their understanding, younger women who violated social norms were more exposed to violence. Both men and women described how men's dominance and pride made them annoyed and threatened by non-obedient women who shouted or gave men instructions. They mentioned inability to care for children, being late from work, food not ready in time, or refusal for sex as examples of situations that justified violent acts. They also indicated a clear limit for the level of acceptable violence. In the men's group, emphasis was put on presumed sex differences.

> D6: *"We men are proud. We do not want to be given instructions by women but want to instruct. That is the way we were brought up. We have different blood; unlike women who use words, we cannot wait to beat."* {FGD 5}
>
> D1: *"Men cannot just have a mere talk when they are annoyed, as head of the family, a slap or two is okay to your wife, but not bloodshed."* {FGD 5}

Discussants from a women's group justified beating in similar ways and there were often stories about how other women intentionally provoked men.

> D4: *"We annoy our husbands with our behaviours and sometimes we deserve to be beaten. I hear some women from certain tribes provoke men to beat them feeling that beating is part of love...."* {FGD 3}

Influenced by the power of money

The sub-category *Influenced by the power of money* emphasized the burden that financial power put on both men and women and expressed how dependency on men for their daily living influenced women to stay in violent relationships.

> D6: *"A man who does not have good money is not loved, while a rich husband may beat his wife at night and in the morning pledge her with offerings*

and presents. Many women continue to stay with abuse in this way." {FGD 4}

Few male discussants noted the existence of IPV perpetrated by women. Those who had low or no income were said to be at risk of both verbal and physical abuse and sometimes divorce, since they did not comply with the norm of being breadwinners or the community expectation of men being "heads of their families".

D5: *"I used to live better when I had a job. The problems started when I left the job. I suffered from abusive words and sometimes slaps from the woman I used to love. I tried to give her hope for our future but she was not ready to listen because I had no money."* {FGD 2}

D2: *"As for me, despite her abuse I tried to convince her to come back after she left me with the children, but she refused because I had no money. I suffer joblessness and abuse at the same time. I hear she lives with a shopkeeper in the next street."* {FGD 2}

'Viewed as discreditable and unfair'

The second category, '**Viewed as discreditable and unfair**', stood out when male and female informants talked about the effects of daily and long-term IPV. They mentioned the unfair situation that resulted primarily from men being violent, irresponsible, and not supporting their family's needs. There were many stories about married men arriving home late after having spent most of their earnings on other women.

D3: *"I have witnessed several men who spend their money on other women and leave their families to suffer. Most times they don't even eat at home. If a woman questions anything, she is given "presents" of slaps and verbal abuse. These women are always miserable and angry."* {FGD 3}

In men's FGDs such behaviours were noted to be unfair too for the women and they emphasized the misery, misfortune, and unhappiness resulting from long exposure to IPV.

D2: *"One of my neighbours abuses his wife after being late so that the wife does not get a chance to question him; instead she concentrates on the pain and fear. This woman is always miserable."* {FGD 6}

A shame to admit

A shame to admit emerged when women expressed their difficulties of disclosing IPV experiences that led to isolation, helplessness and limited social support from friends and the community. They also described the stigma and disgrace that abused women are believed to cause their families, friends and neighbours. Affected women were said to hide and avoid IPV disclosure to reduce pain for themselves and others.

D6: *"My friends used to laugh at me; some suspected that I was living in an unhappy marriage. Actually I did not enjoy sex and hated men. I felt embarrassed and it was shameful to pass in front of others on the streets. I looked ugly and had rough skin in those days."* {FGD 1}

D7: *"I cried several times, alone in my bed room... until we divorced. It was not easy to inform my father-in-law or anybody; the situation was too shameful."* {FGD 1}

A threat to human dignity

A threat to human dignity came up when both female and male informants mentioned the universal needs for empathy, solidarity and support. People affected by IPV were seen as being denied these basic human rights. In their discussions, women wanted men to understand that women also "have flesh" and "feel pain". Those who shared own experiences talked about being rejected, disliked and not respected by their families or society.

D6: *"But even if you are beaten once in your life you feel pain, and it is not easy to forget. My friends used*

fearful and withdrew from social life:

> *D5: "It is difficult to advise somebody who is living with violence to move out. She would always complain and blame herself because she loves the man. I wonder why a person who has problems with violence stays. Maybe she stays for the sake of the children but also for the shame, or for fear of living alone."* {FGD 4}

Shifting tolerance

Shifting tolerance describes a process where, at a certain point, women start to look for help or revenge in an effort to escape or at least receive help in their relationship. This process was said to take time since continuous stress and physical aggression alter the woman's perceptions of reality and what marriage means.

> *D2:"He threw nasty words and I packed and stayed with my friends for three days. He asked my father for help to get me back but I said that I suffered from seeing my mother being slapped and that was enough. But on the third day I felt that I had to go back to the perpetrator, I mean my husband."* {FGD 4}

Many of the coping mechanisms mentioned were emotionally focused, including decisions to fight back or to shame the abuser by revealing the violent behaviour beyond family members to co-workers or friends. Other ways to reduce the harm or end the violence were fighting back, meditation or engaging in religious activities.

'Fed up with passivity'

The last category, '**Fed up with passivity**', expresses that both men and women are tired and annoyed with IPV.

A wish for change

Both men and women expressed *A wish for change* and underscored women's role in this change.

> D2: "*We need to change, show that women don't accept violence any longer."* {FGD 4}
> D6: *"The time to be men's instruments should stop. They need us just as we need them. They continue their bad habits because we are quiet. This is not good enough."* {FGD 1}

Experiences of abusive relationships were discussed openly in the FGDs and indicate that IPV is common. However, at the individual level the informants emphasized that actions to prevent IPV are possible and that the silence surrounding it has to end.

> D6: "*After three years of suffering I decided to end the silence and shared the dangers I was living in with my brother who assisted in divorce. It was not possible to make it without his support."* {FGD 4}

Gender norms in transition

The sub-category *Gender norms in transition* emerged when men started to reflect on their current role in maintaining gender norms that justify violence.

> D1*:"IPV should stop; you know the women we beat are other people's sisters and mothers."* {FGD 5}

This statement triggered further discussion on differences and similarities between violence against intimate partners and other family members. Both men and women agreed there was a need for action at many levels and that the current harmful gender norms must be changed. They mentioned the need for consolidated efforts at different levels, governmental as well as health care.

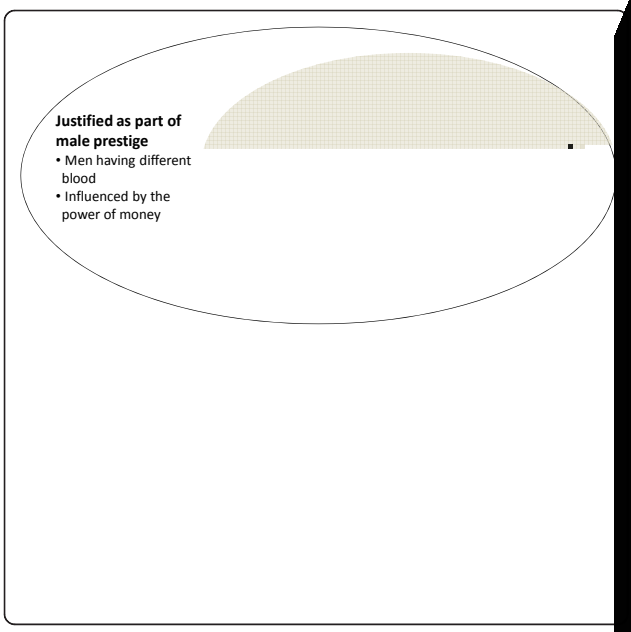
> D4: *"I think the solution to intimate partner violence problems should come from above. I mean they should be initiated by the cabinet as a higher level government organ. We may fail to solve matters individually. We witness cases of violence and they are reported in the newspaper but we are not aware of what goes on thereafter. I think we should also involve health care...."* {FGD 5}

Some informants reflected on the importance of supportive neighbours but clarified difficulties for community members to intervene in complex situations that involved violence. They saw the need for more structural changes including strong laws that could clearly indicate a normative change in attitude towards IPV against women.

> D6*: "People fight at night with the doors closed. Who will open the door for you? Can you break the door of somebody's house? It is an offense. Maybe what we need are strong laws which can strictly be followed."* {FGD 7}.

Discussion

Our findings denote a community in transition, where the effects of intimate partner violence have started to fuel a wish for change. Consistent with the ecological model developed by Heise [39], the results indicate linkages between individual, relationship, community and societal influences for both understanding and response to IPV against women. Hence, this discussion will follow the ecological model which gives a comprehensive and



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Societal level

According to the ecological model [39], factors acting a the societal level include norms of masculinity linked t male dominance, laws granting men control ove women's behaviours, and attitudes that accept men violence as a way to resolve family conflicts, and provi sion of inadequate policies and structures to addres IPV [5,27,51,52].

Our findings that IPV is '**Justified as part of mal prestige**' fits well at the societal level of the ecologica framework and indicates how the concept of masculinit is built on social norms that value men as superior an more powerful than women. These norms subordinat women in many life spheres, from economic indepen dence to lack of decision-making power [21,40,53]. Thi happens when societal norms allow the use of IPV t reprimand women and where men are expected to hav the final say in the use of family resources [5,28].

Previous studies show how patriarchal norms influ ences violence. Wife beating is more common in house holds where power is concentrated in the hands of th husband or male partner [23,54]. In these households physical violence may be used to legitimize the domi nant position of men while at the societal level, cultura norms allow men to use violence in order to maintain control.

In our study, views about masculinity and feminin y considered men to *have different blood*. This bec e part of community member explanation and justifi n for violence to a certain degree and as a way to no l-ize the situation. Gender-constructed norms were i-strated in reports that some women would n

These findings are supported by a cross-sectional study in Nordic countries [58] where less than 10% of women who experience physical violence from their partners revealed this to their gynaecologist. Many health institutions are challenged to provide medical support to women who do not disclose IPV and this makes it hard for them to give adequate care. In a previous study on experiences of IPV, healthcare workers struggled to elicit IPV information from their clients [27].

Our findings also indicate a *Human rights* concern which refers to the "basic rights and freedom to which all humans are entitled" [59]. Despite global acknowledgement that IPV is a basic human rights violation, this is not explicit in Tanzanian law [24,60]. In the study area, a woman's level of understanding about legal issues is unclear. Education and awareness of the existing legal system has not reached the majority of women. In our previous study, we found that women were discouraged from reporting IPV to the police. Unfavourable structures and legal procedures were mentioned. Informants recalled many stories from women who experienced bribe requirements and unfair treatment from the police. This led women to lose trust in the legal system when it came to IPV [27]. In the present study, informants viewed IPV as *A threat to human dignity*. This concern is important and a basic step to decrease of IPV against women in the studied community.

Relationship level

The relationship level of the ecological model includes issues of marital conflict mostly due to male control over wealth and decision-making. In the current study, discussants were concerned about the consequences of violence for women as summarized in the category '**Results in emotional entrapment**' accompanied by *Self-blame* and *Shifting tolerance*. Our study illustrates how survivors use coping mechanisms such as engaging in religious activities or attempts to fight back for temporary safety. These results can be linked to the high prevalence of controlling behaviours described in the WHO multi country study where 90% of ever-partnered women in an urban Tanzanian setting experienced one or more controlling behaviour. The likelihood of having experienced violence increased with the number of controlling behaviours by the partner [18]. Negussie et al [21] show that the risk of depression is related to level of controlling behaviour.

Individual level

The individual level of the ecological framework refers to individual risk factors such as being male or a female, alcohol and substance use, employment status, educational level and previous experience of abuse. In our study, men's alcohol abuse and lack of employment were mentioned as closely linked with violent behaviour. These findings are similar to the report of Kolawole & Uche [28] in their study of women's perceptions about domestic violence in Nigeria. Our discussants also mentioned the link between men having multiple partners and physical violence. These results are supported by Anderson et al [61] in studies from eight southern African countries, and by the study of Lawoko et al of social inequalities in IPV among Kenyan women [23].

Men's violent behaviours are associated with having witnessed abuse and IPV earlier in life [35]. The theory of learned behaviour emphasizes that violence should be seen as a learned behaviour based on the construction of gender norms. At the individual level, aggression can emerge from frustration over a man's inability to control the female partner [62], an area not frequently discussed in the FGDs. However, our findings show that men who are unable to fulfil their expected gender roles as bread winners suffered IPV from their wives/partners. The women were said to engage in relationships with other men or use violent acts towards their husbands/partners. Such gender norm sequelae are important issues to recognize and address and point to the need for engaging men in strategies to prevent gender-based violence.

Our model, shown in Figure 2, does not specifically address the individual level risk factors for violent behaviours as postulated by Heise [38] but focuses on the strong reactions against violence that were expressed in all of the focus groups. Both men and women were tired of seeing women and children suffer and were '**Fed up with passivity**'. Many community members had started to question the norms that allow violence to be accepted, and at the same time feel trapped by the power of internalised traditional gender norms. This illustrates how transition in norms at a societal level causes tension at the individual and community levels [18,39]. Some he suggested actions included that the government have a greater commitment by involving cabinet members, healthcare, judiciary systems and local governments. These recommendations are similar to those from a study in Vietnam where community members pointed out the need for the health and other governmental sectors to initiate preventive efforts [15]. Also, this is in accordance with WHO recommendations to involve the health sector, create programs for improved gender norms, provide micro credit interventions, and strengthen the use of laws and policies in order to decrease IPV prevalence [28]. A WHO report [63] points out that the elimination of violence against women is not specifically targeted in the Millennium development goals. Goal 3, "promote gender equality and empower women" needs to be expanded with a clear target of reducing lifetime IPV prevalence since

violence against women hinders progress in achieving goal 3 and all other Millennium goals. The report also underscores that the elimination of violence requires targeting the gender-based norms that exacerbate discrimination against women. Since the determinants of IPV are complex and vary between cultural settings and levels, there is a need for countries like Tanzania to be more pro-active in research that evaluates the relevancy and applicability of different preventive approaches [64]. Studies to evaluate strategies that emphasize primary prevention, target behavioural and attitudinal change at younger ages, and engage both men and women in challenging harmful gender norms are specifically called for [18,65].

Strengths and limitations of the study

Among the strengths of the study are the methodological efforts to achieve a diverse and representative sample of informants from the community and the rigour of the coding and analysis phases. The use of focus groups for data collection may have given an overly positive view of the transition in gender norms if participants avoided expression of deviant views that justify violence. We think that the discussions were open, free and reflected an increasing awareness about the seriousness of gender-based violence. We also noted the complexity of the situation with community members who are trapped within traditional expectations of masculinity and femininity and at the same time realise the harmful consequences of those expectations. While the study results cannot be generalized to all areas of Tanzania (or Africa) they are in line with many other studies from settings characterized by similar gender norm systems [18,19,21,23,53,61].

Conclusions

Prevailing gender norms still accept that women are in a subordinate position with limited possibility to control their own lives. Thus, they remain at continued risk for IPV against women. Community members have started to question these norms because of their negative effects on women's health. Hence, the Tanzanian government and other governments with similar situations need to show an increased commitment and prioritize IPV preventive efforts. This can be done by having healthier policies and resources to re-enforce legal rights as well as providing adequate medical care for IPV survivors and perpetrators. At the community level, it is necessary to raise consciousness about the human rights perspective of women's position, challenge gender norms that perpetuate IPV, and advocate for an IPV-free society. The authors acknowledge an increased interest in violence issues from the media and from government and non-governmental associations in Tanzania. However, our study reveals that these efforts need to be multiplied and focus societal-, community-, relationship, - and individual level approaches by deliberately engaging men.

Additional material

Additional file 1: Key points/issues which were considered to guide the discussions when obtaining information on community understanding and response to IPV.

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Authors' contributions

RL was involved in the design of the study, data collection, transcription, analysis and drafting of the manuscript. ME was involved in the design of the study, analysis and drafting of the manuscript. LN was involved in the design of the study and in drafting of the manuscript. HL participated in the translations of FGDs and drafting of the manuscript. RL, ME, LN and HL had access to the data and are responsible for its integrity. All authors read and approved the final manuscript.

Competing interests

The authors declare that they have no competing interests.

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