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Urban, low-income, African American Parents' experiences and expectations of well-child care

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ABSTRACT

Purpose: Well-child care is the foundation of pediatric health promotion and disease prevention. Primary care quality is lower for low-income and African American children compared to white children, and social determinants have an increasingly acknowledged impact on child health. Ensuring that high-quality well-child care fulfills its potential to mitigate the negative effects of social determinants on African American children is imperative. This study provides an understanding of urban, low-income, African American well-child care experiences and expectations.

Design and methods: A qualitative, focus group method was used. A purposive, volunteer sample of low-income, African American parents with children birth to age five was recruited from St. Louis and Milwaukee. Focus groups were held in convenient, community sites. Data was audio-digitally recorded. Transcribed data were coded and analyzed through inductive content analysis.

Results: Thirty-five caregivers, 86% females, participated in four focus groups. Categories (and sub-categories) identified include: Community factors (We want better schools, It's getting more rough where I live); Sources of parenting advice (Google it, Call your parent, Older remedies); System challenges (Cost, Frequent new faces, Politics); Challenges with providers (Couldn't help me, Missed something important, Treated differently, Are you really listening?); Anticipatory guidance (Breastfeeding, Discipline, Vaccines, Development); and What parents desire (Know them, trust).

Conclusions: This study reveals the contexts that give rise to health care disparities and provides insight into parent's healthcare behaviors.

Practice implications: Results offer providers guidance in providing well-child care for this population to improve pediatric care quality and child health.

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The first priority for the pediatric primary care provider (e.g., pediatrician, nurse practitioner, or physician's assistant) at every well-child visit is to address parents' concerns (Hagan et al., 2017, p. 265). Without understanding urban, low-income African American's parenting and health care experiences and perspectives, providers have little basis for approaching the visit and providing effective, culturally appropriate, anticipatory guidance that addresses parents' concerns. Parents' experiences and expectations contribute to their perception of the provider and his/her guidance, which ultimately impacts the outcomes of well-child care (WCC).

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Well-child care that takes place in the context of a high-quality parent-provider relationship has the potential to improve child health outcomes (Hagan et al., 2017). African American parents report lower overall quality of pediatric primary care compared to White parents ($\beta = -0.9154$) (quality includes first contact utilization, longitudinality, and coordination of care) independent of socioeconomic status and health systems factors (Stevens & Shi, 2002b). African American parents are more likely than White parents to report that their child's provider never, or only sometimes, understands their child's needs (OR = 1.45) and how the parents wish to raise their child (OR = 1.56) (Flores, 2010). Factors including trust, lack of parent self-efficacy, and family-centeredness of care all contribute to challenges in the parent-provider relationship (Koschmann & Hooke, 2019b).

Purpose

Eliminating health disparities and attaining health equity are foundational principles of Healthy People 2030 (U.S. Department of Health and Human Services, 2018). High-quality WCC is particularly important for children who are at increased risk for poor health and development due to negative social determinants of health (Children's Defense Fund, 2017). Decreased access to care, increased risks for poor health outcomes, and increased rates of developmental concerns further highlights the need for improved WCC for this population (Diao et al., 2017; Flores, 2010; Zuckerman et al., 2014). Additionally, current literature on WCC for this population is limited. A clear first step in improving health for urban, low-income, African American children is to ensure that WCC is fulfilling its potential to mitigate social determinant factors that negatively impact child health and well-being. The purpose of this study was to develop an understanding of parents' experiences and expectations of WCC to serve as a basis for improving primary care quality and strengthening provider relationships with urban, low-income, African American parents.

Design and methods

This qualitative focus group study provides a greater understanding of the expectations and experiences that urban, low-income, African American parents have of WCC. Focus groups offer a form of interviewing that elevates the participants' voices and provide a helpful way to understand nuanced information about a cultural group (Casey & Krueger, 2014). The study took place from May to August 2019 in St. Louis, Missouri, and Milwaukee, Wisconsin and was part of a larger qualitative study that also included healthcare provider interviews. These cities have similar demographics with respect to their African American populations (U.S. Census Bureau, 2018). Both cities are often reported among the most racially segregated metropolitan areas in the United States (Comen, 2019).

Participants

A purposive, volunteer sample of parents was recruited in the neighborhoods proximal to the event sites the week before each focus group. Recruitment strategies included partnering with communities (Koschmann & Hooke, 2019a). Inclusion criteria included parents or caregivers of at least one child aged birth through five years who self-identified as African American, lived in an urban community, and qualified for either Medicaid, The Special Supplemental Nutrition Program for Women, Infants, and Children (WIC), or Head Start (a proxy for income status). Exclusion criteria included parents of children who were premature, had physical or developmental disabilities, or identified as African immigrants, as these parents likely have different experiences of WCC. Consent was obtained at the start of each focus group. Participants received a \$40 gift card in gratitude for their time.

Data collection

Focus groups were conducted in the communities by the principal investigator who was trained in focus group methodology. Sites included an apartment complex community room, an elementary school, and a community center. Focus groups lasted approximately 90 min and childcare and food were provided. Using the focus group question route methodology, broad introduction questions were asked to quickly break the ice and build rapport before going more in-depth with key questions about the overall experiences of WCC (Table 1) (Casey & Krueger, 2014). Focus group questions encouraged conversation around general parenting experiences as they would relate to the types of concerns that WCC visits could address through anticipatory guidance (e.g. sleep, nutrition, discipline), as well as parents WCC expectations and experiences. Data were

Table 1
Sample focus group questions.

Questions
<ul style="list-style-type: none">• What is the easiest/most difficult part of being a parent?• What are your biggest struggles, worries, or concerns about your child's health, growth, and/or development?• Who (or what) do you turn to for advice about parenting?• Think back to your most recent well-child visit with your child's health care provider. What was your experience like? What did you like? What didn't you like?• Could you share more about what made you say you either would, or would not, ask your child's healthcare provider for advice?• How do you think your child's healthcare provider can help you be a better parent and deal with the difficult parts of parenting?• Have you ever changed how you parented or cared for your child based on advice from your child's provider? If so, how?• How does your race, as African Americans, impact your child's healthcare and well-child checkups?

audio-digitally recorded. This study was approved by the University of Minnesota Institutional Review Board.

Analysis

To ensure study rigor, the primary investigator practiced reflexivity, journaling, and debriefing during data collection (Polit & Beck, 2008). Data were then professionally transcribed and analyzed using conventional content analysis (Elo & Kyngäs, 2008; Hsieh & Shannon, 2005). Phrases and sentences of data were indexed by topic and noted as emerging codes. Codes were then analyzed for similarities and collapsed into categories and sub-categories. Dedoose, a cloud-based qualitative analysis platform, was used to assist with coding ("Dedoose Version 8.0.35," 2018). The principal investigator performed the initial coding and analysis, and two co-investigators reviewed and verified the coding.

Results

Thirty-five parents participated in four focus groups, two groups in each city (Table 2). While the categories and subcategories that emerged through analysis provide specific, concrete examples of challenges and actions, it is also important to highlight the general consensus of parent participants to give a clear picture of the importance they place on the task of parenting. Throughout the focus groups, participants shared the joys and the struggles of parenting. Parents were passionate about the easiest task of parenting – loving their children. As one parent said: "No matter what they do or what's going on in life, you keep going. It's like, this is my child, I love them, and I'm going to protect them no matter what. And that's the easiest thing... if you can care for them, love them, and protect them."

While loving comes easily, there was also a sense that the stressors parents face, particularly African American parents, are more difficult today. The challenges of parenting included providing for their children, not just financially, but also childcare, food, and a safe home. One participant shared his experience of food insecurity: "My kid...she says 'num-num' anytime she wants a snack. And when she wants to eat, like, food, for real, she'll say 'eat-eat.' But she'll come to me, 'Daddy, eat-eat.' There's no excuse good enough I can give my baby; I can't feed you today." Parents struggled to provide basic necessities for their children, but hoped to somehow provide a better life for them than their own.

Results emerged through analysis across all four focus groups. Six categories were identified from the transcribed data with thirty-eight sub-categories (Figure). The categories include community factors impacting parenting, sources of support and advice, health care system challenges, challenges with providers, anticipatory guidance topics, and

Table 2
Participant characteristics.

Characteristic	FG 1	FG 2	FG 3	FG 4	% (n = 35)
Participants	9	6	9	11	
Sex					
Female	7	6	8	9	86%
Male	2	0	1	2	14%
Age, y					
18–24	0	2	0	1	9%
25–34	7	2	4	6	54%
35–44	2	1	3	2	23%
45–54	0	1	0	2	9%
55 y +	0	0	2	0	6%
Relationship					
Mother	7	6	5	8	74%
Father	2	0	0	2	11%
Grandmother	0	0	2	1	9%
Other relative	0	0	2	0	6%
Benefits utilized					
WIC	3	2	1	8	40%
Head Start	2	0	4	2	23%
Medicaid	8	6	9	9	91%
Age of children ^a					(n = 49)
0–12 months	3	1	0	2	12%
1–2 years	4	2	0	3	18%
3–5 years	13	3	10	8	69%

Note. FG = focus group; WIC = Special Supplemental Nutrition Program for Women, Infants, and Children.

^a Age of children represents all children five and under represented by the parent participants.

what parents desire in WCC and their provider. The most common relevant subcategories with example quotes are reported (Table 3).

Community factors impacting parenting

Parents expressed frustration over their inability to control the environment where they raise their children. Inferior schools, the influence of media on their children, and limited access to parenting resources in the community were all concerns (Table 3). Many parents shared safety fears. One mother said, “It’s getting more rough where I live... now I’m looking to move... Just to save my son’s life.” Safer neighborhoods, better schools, and visible, accessible providers and support organizations in the neighborhood were priorities.

Sources of parenting advice and support

Parents reported a variety of sources of support with maternal grandmothers consistently referenced as the first source of advice. One parent remarked, “my grandma teaches me more than a doctor can for my child.” Older family members shared cultural remedies for diaper rashes, potty training, and other common childhood complaints. Praying and depending on God was also important. While the majority of parents felt comfortable using the internet for advice, several parents raised caution about trusting information from social media. Past experiences with health care, their own or others’, was the source for many

Table 3
Categories and select sub-categories with example quotes.

Category/sub-category	Example quote
Community factors impacting parenting	
Sometimes it ain't even the parents	<i>“And then sometimes it ain't even the parents. You can raise your kid, or try to raise your kid, to the best of your ability, but now it's this Internet, it's the YouTube, it's the outside, the kids at school.”</i>
Sources of parenting advice and support	
Just Google it	<i>“I normally Google stuff... And Google is just the smartest technology. Even when it comes to my car I'm going to Google.”</i>
Previous experiences inform healthcare decisions	<i>“When you lose a child and have a child it put so much on you. Like when I had my son... my baby eyes would just be pink... My mama's like... 'Where are you going girl?' The ambulance be on the way mama, his eyes red and he's coughing and I don't know what's going ... I'm talking about for anything and everything we was at the emergency room... But it was a habit because I was so scared... Especially of SIDS itself. I was so scared to have it happen again. So anything that I felt out of place I would call 911.”</i>
Health care system challenges	
A lot of politics and money to healthcare	<i>“Nowadays it's all about the money. So if you got a doctor's office, if they got 200 patients, you could see this patient for two seconds, you gonna get paid the same as if you was with that child two hours. It's all in the billing. It's all about money...”</i>
Challenges with providers	
Providers do stereotype	<i>“But I feel like with African Americans they always try to say the kid got ADHD, like always putting them on Ritalin and stuff... Label us... They just push that too much... Some kids just got a little more energy.”</i>
Providers don't really care, they come for the paycheck	<i>“If your child been going to see this doctor since they was an infant, you should know. We telling you how they eatin', how they feelin', what they doin'. So, yeah, you typin' all the stuff in the computer, but where's your note that input to me where 'I see [your child's] growing... I see [your child's] teeth is coming in.' Stuff like that. They don't give me that feedback to the point where you're just doing your job. You actually are not concerned about my child. You're just getting this paycheck.”</i>
You see a new face every two weeks.	<i>“But it makes me wary... So it makes you feel uncomfortable.... Like, what's going on, and why I see somebody new every week?... You know, you know something's wrong from the inside out... They're just like where I live. When I see a new maintenance man every two days, something wrong. So I'm going out... And you not coming up in here. Don't come in here. Ain't nothing broke, no...”</i>
Anticipatory guidance topics	
I like to know where they are (growth and development)	<i>“I will say that I didn't like the fact that the doctor switched the milk, saying that the child was at an upper percentage, as far as weight, and I was like compared to who, because he was kind of thin to me. Like who was they comparing it to, as far as different races? You know what I'm saying? So that was a concern.”</i>
Discipline is hard	<i>“Honestly, it might not be a good conversation with that. I'd probably be like, 'I whoop him,' and the doctor be like, 'You whoop his ass?' You got to discipline. They might not take it how I'm saying it. I'm taking it as structure and they taking it as abuse.”</i>
What parents desire in well-child care and their provider	
Know them like the back of your hand	<i>“My kids been with their pediatrician for a long time... and I love my pediatrician. She's really good. Like if I bring my oldest in, she knows my kids so well. If I don't see anything, she'll see something with their growth. Not even just their growth; it's just that she knows them like the back of her hand. I have no concern when I'm talking to her because I trust her. My kids have a special bond with her and me and her talk. Like she has my cell phone number; I have hers. We just have a great relationship. I think that's very important.”</i>
It's all in who you trust	<i>“I would say trust comes with defining whether the doctor really cares about your child, if you're showing me that you really care and that you are concerned about his health. Because that's your position; that's who you are; you're a doctor. I think that's where the trust comes in. Like, OK, I can trust you. I really genuinely think you care about my child's life or you care about his health and it goes from there. My kids... They don't have it like that.”</i>

parents' health knowledge and opinions, and often their lack of trust in the health care system.

Health care system challenges

Health care systems can create barriers between parents and providers. Parents shared that having Medicaid, while helpful, does not take away the financial burden of hidden health costs and expenses such as parents' own insurance. Parents reported long appointment waiting times and indicated that there were not enough providers in their neighborhood. There was also a sense that health care was about money and not about their children. This mindset went so far as parents expressing belief that public-insurance-covered care, including generic prescriptions, was lower-quality than private-insurance care. One example of this perception was a parent who shared, "Private insurance gonna treat you better than Medicaid and Medicare. Period...Much, much better...In fact, the medicine is different."

Challenges with providers

Parents described many frustrations with their child's provider. Parents were troubled by the instances where they would seek care, but not receive a clear plan. At other times, parents felt the provider missed a diagnosis or failed to examine the child thoroughly. Parents suspected that providers' stereotypes of them and their children impacted care. One parent shared: "I feel like with African Americans they always try to say the kid got ADHD...Label us... They just push that too much." Parents shared a concern that providers appear to be doing the job only to earn a paycheck. Communication challenges included providers not prioritizing parents' concerns, parents receiving misinformation, provider contradictions, and a general lack of clarity around health knowledge. These negatively impacted parents' evaluation of their care. As a result of many of these concerns, parents reported going elsewhere for a second opinion.

Anticipatory guidance topics

Parents reported that they had prior parenting knowledge and practices but still wanted additional guidance and advice from providers. Parents reported that they would often consider the provider's advice and weigh it against other sources, modify it, or choose to go with another option. Parents shared that sometimes they did not follow the advice because they did not feel it was culturally relevant. Parents endorsed breastfeeding while acknowledging their struggles and the desire for better support. They also shared concerns that the growth curve was not designed for African Americans, and felt that providers misdiagnosed their children as overweight. Parents also conveyed a fear of vaccines. One parent shared, "My kids get most of them, but they're not getting nothing new, because a lot of this stuff... they don't even know if it's working, they practicing on us. You know, they got to practice on somebody."

What parents desire in well-child care and their provider

Beyond the challenges, parents also shared what they desired from WCC and providers. Parents in both cities shared the names of prominent African American providers who practiced in urban areas for generations, were a part of their community, and well-loved. Parents desired more health information. Having providers show passion for their work and knowing their child was important for building trust. Trust, which undergirds many of the identified categories, was described in terms of both how to build trust, and how trust impacts the outcome of the care. As one parent said, "I trust my kids' doctor... If she says 'do it,' let's do it."

While we have much to learn from the experiences and expectations that were discouraging, parents also expressed satisfaction and

gratitude for their provider: "She's got a good interaction with my kids...she's always got activities and stuff for them to do just so me and her can have that conversation because I be having like a whole bunch of questions... yeah, I like my doctor a lot."

Discussion

When it comes to parenting, providers are often reminded of the equalizing maxim, that all parents want the best for their children. This is no different for vulnerable children and their parents. Nevertheless, factors related to culture, race, and socioeconomic status impact the ability of parents to give their child the best. These factors lead to a challenging intersection of parenting and WCC. By providing high-quality parent education and health services, providers can help parents to provide their best and counter the toxic stress of racism and poverty (Hagan et al., 2017; Halfon et al., 2014).

Results from this study support findings from the quantitative literature and offer additional contextual understanding. African American parents are more likely to say that providers do not understand their parenting needs (Flores et al., 2005). Quantitative data also identified parent-provider relationship challenges such as longitudinality, trust, and family-centeredness of care (Koschmann and Hooke, 2019b). Results from this study identified similar challenges with longitudinality, trust, and family-centeredness of care, as well as other experiences and perceptions that existing literature also endorse (Fig. 1). The qualitative data offer more depth of understanding.

Community factors impacting parenting

Providers should be aware of the influences outside of the home on urban, low-income, African American children. While parents are doing the best they can, other ecological factors such as schools, safety, and lack of resources impact child health as lifecourse science has shown (Shonkoff et al., 2012). Providers must actively invest in neighborhoods through public policy and through grassroots involvement in communities to promote neighborhood safety, school support and reform, and access to local, high-quality, patient-centered medical homes.

Sources of parenting advice and support

Most parents have a support network for raising children. Urban, low-income, African American parents are no different and turn toward many of the same sources as others: family, the internet, natural remedies, and providers. What stands out in the data from this study was the role that past experiences have on informing health behaviors. While providers may judge the parent, who used the ER inappropriately (see Table 3), the mother's legitimate fear after the loss of a child influenced her behavior, not lack of knowledge, as is often assumed. The role of parents' own Adverse Childhood Events (ACEs) is an additional factor to consider in how parenting decisions are made (American Academy of Pediatrics, 2014). Creating a space where those past experiences can be unpacked and reframed, rather than judged, is the most promising approach for ultimately changing the behavior.

Health care system challenges

The complexity of systemic racism impacts the rate of poverty and public insurance among African Americans. Fifty-five percent of African American children are on public insurance, compared to 32% of white children (U.S. Census Bureau, 2017). With public insurance being so prevalent in these communities, it is understandable that parents might view the care covered by public insurance as sub-standard. Moreover, for those with an already poor perception of care, something as small as waiting too long for an appointment can signal disrespect or decreased value and further reduce the perception of the care.

Six Identified Categories and Related Sub-Categories

Fig. 1. Six identified categories and related sub-categories

Challenges with providers

One's perceptions can become one's reality. When parents report perceiving that providers did not answer questions, missed something, were not thorough, stereotyped, and failed to listen, these experiences are real. Changing perceptions requires making consistent, concerted efforts to change practice behaviors. The trust between parents and providers reported by participants was very tenuous. Something as benign

as looking hastily in a child's ears, coupled with the parent's misunderstanding about the way ear tubes work, led one parent to mistrust the provider completely. Providers need to consider how their actions are perceived by populations where trust has repeatedly been violated in health care. The response of parents to these challenges was often to seek care elsewhere. This finding is consistent with African American parents having only a 6–11 month average length of relationship with a provider (Stevens & Shi, 2002a). Trust, which depends in part on

continuity of care, may improve child health outcomes (Horn et al., 2012). Provider trust increases with partnership building communication, which is one piece of quality care (Horn et al., 2011).

Anticipatory guidance topics

Cultural influences on health behaviors were evident in parents' discussions about parenting preferences and practices. Providers should accept cultural health behaviors that are not harmful and seek to understand the genesis of those practices that are harmful in order to provide culturally sensitive anticipatory guidance.

One example of this was discipline. Parents felt that discipline was one of the most challenging parts of parenting, yet they were reticent to discuss discipline with their provider for fear of being reported for abuse. In early childhood, discussions of discipline are a high priority at well-child visits and providers watch carefully for signs of corporal punishment and abuse (Hagan et al., 2017). While African American parents are 50% more likely to use corporal punishment than white and Latino parents (Pew Research Center, 2015) they often do so out of the real fears for their child's safety and see it as part of their cultural tradition (Patton, 2017). Providers should recognize that corporal punishment was not a part of pre-colonial West African culture (Patton, 2017). The use of corporal punishment by African Americans has its origins in slavery when young parents were beaten as slaves and were also under pressure to control their children for fear of them being sold, severely whipped, or killed (Patton, 2017). Still today, parents may feel that the use of corporal punishment in the home will help to prevent their child from misbehaving in a threatening environment and suffering a greater consequence (Patton, 2019). With that knowledge, providers can help parents understand that when we ask them to part ways with what they consider a cultural practice and instead use more effective, evidence-based disciplinary approaches (Sege & Siegel, 2018), we are actually helping them remove the ongoing trauma of slavery (Patton, 2019).

Parents also raised topics that were on target with standard practices. Parents viewed breastfeeding as the preferred infant feeding method. Their children's nutrition and sleep were significant parent concerns, and they desired to reduce screen time. Given the lower rates of breastfeeding (Anstey et al., 2017) and higher rates of pediatric obesity (Hales et al., 2017; Ogden et al., 2018) among low-income African Americans, providers may assume that parents lack the knowledge or motivation to change these health behaviors. However, the results from this study align with those which point to the systemic barriers that inhibit health changes such as lack of adequate breastfeeding support, and food deserts (Ganter et al., 2015; Jones et al., 2015).

What parents desire in well-child care and their provider

The passion and clarity with which parent participants shared their experiences and expectations for WCC underscore the importance they place on the task of raising healthy children. All parents want reassurance and a chance to discuss their priorities with their child's provider (Radecki et al., 2009). All parents would like a continuous relationship with one provider who values the child and seeks parent input (Radecki et al., 2009). Parent participants highlighted just how impactful these expectations are for their population: providers knowing their child "like the back of their hand," and "I want you to talk to me...include me in everything." Nevertheless, we know African American parents are less likely to have a medical home (Diao et al., 2017) and less likely to be involved in decision making (Cox et al., 2012).

Having providers, particularly African American providers, embedded in the communities where parents live, work, play, and raise their children was seen as an important way to build trust. These findings contradict other study results, which showed that parent-provider racial concordance did not improve health care quality (Godoy et al.,

2014; Horn et al., 2011; Stevens et al., 2003) but warrants more exploration as the results are mixed in the adult health literature (Meghani et al., 2009). Regardless, increasing the diversity of providers in the United States is necessary and requires creative and collaborative solutions such as internships and pipeline programs (Bouye et al., 2016).

Practice implications

These results can inform best practices for providers working with this population. Providers must develop and enhance skills for increasing trust, avoiding stereotypes, and using clear communication. Changing scheduling practices to increase the consistency in providers will improve the provider knowledge of the patient and family. Creating bridges for providers between the community and clinic setting is another strategy that parents valued. Developing culturally acceptable anticipatory guidance education around topics such as discipline and vaccinations is also needed. These changes can be accomplished individually and through careful formation and education of future providers. Continuous quality improvement projects will enhance the depth and rigor of these practice changes at individual clinic settings to meet the specific community and population needs.

Limitations

Results of this study are transferable to like contexts but may not apply to all African American parents seeking care in different settings. Careful selection of two similar cities for conducting the research increases transferability. Parents might have held back in sharing due to worry that their opinions would be shared with their provider. However, focus groups were held outside the clinic setting, limited identifiers were collected, and the principal investigator was not associated with any clinic in the area. Additionally, results do not allow for any comparison to other patient populations. Methods to ensure study rigor minimized limitations (Polit & Beck, 2008). A key strength of the study was that using qualitative methods produced results that reveal rich contextual data and offer support and clarity to the existing quantitative literature.

Conclusion

While parent expectations for WCC are not that different between races and income levels, the experiences of urban, low-income, African American parents report ongoing disparities in their experiences and perceptions of care. Additionally, the history of racial injustices carried out against African Americans continues to plague the parent-provider relationship and impact trust. The idea that vaccines are being tested "on us" is just one example voiced in this study that reveals the ongoing belief that health care is using African American parents and children for research or revenue. Changing that perception to one of health care helping parents and children requires the continued commitment of all providers. What is evident from this study is that improving WCC quality for urban, low-income African American children is only one part of building a health care environment that promotes a healthy life course. As the impact of negative social determinants on child health is increasingly becoming the priority for child health promotion, the limitations of WCC to address these complex, systemic issues become apparent. Providers must wrestle with these issues not only in the exam room, but also through advocacy, political action, and community engagement.

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Author' statement page

Dr. Koschmann conceptualized and designed the study, carried out the data collection and initial analysis, drafted the initial manuscript, and reviewed and revised the manuscript.

Dr. Peden-McAlpine assisted with study design, verified the qualitative analysis, and reviewed and revised the manuscript.

Dr. Chesney critically reviewed the manuscript for important intellectual content and professional practice implications.

Dr. Mason critically reviewed the manuscript for important intellectual content and public health implications.

Dr. Hooke assisted with study design, supervised data collection, verified the qualitative analysis, and reviewed and revised the manuscript.

All authors approved the final manuscript as submitted and agree to be accountable for all aspects of the work.

Declaration of Competing Interest

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