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ORIGINAL ARTICLE

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Community perspectives on tuberculosis care in rural South Africa

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Abstract

Patient nonadherence to tuberculosis (TB) treatment is an ongoing challenge, particularly since the advent of drug-resistant TB and complications posed by HIV/AIDS. Some solutions may lie in understanding patient and community perspectives about barriers to TB care and treatment adherence. Using a qualitative framework, we explored community perceptions and beliefs about TB and perceived facilitators and barriers to care in a rural South African community affected by TB. We were particularly interested in capturing cross-cutting themes and the "merged voices" of participants. Interviews were conducted in 2013 and 2014 with 43 participants, including home-based care workers, clinic staff, patients living with TB and community members in and around a primary healthcare clinic. The data were analysed using principles of thematic analysis. The study reveals the complex interplay between contextual factors and community understandings of the disease. Cultural beliefs about causality and treatment-seeking paths were often mentioned in conjunction with biomedical views. There was a strong interface between TB and HIV in this community, and knowledge of TB was often confused with HIV. HIV-related stigma has been extended to those living with TB. The impact of poverty on treatment adherence was a particularly important theme. Other themes related to the role of the clinic in the community. Our study highlights the socioeconomic vulnerability of this community and the fragility of existing care systems. The findings reinforce the need for a community-centred approach to TB care that takes cognisance of lifeworld issues. We discuss some implications of this study for practice and policy.

KEYWORDS
community, cultural beliefs, medication adherence, qualitative research, South Africa, tuberculosis

1 | INTRODUCTION

Tuberculosis (TB) is a major global health concern, especially in developing countries. It is a leading cause of death, with 1.4 million estimated deaths in 2015. Sub-Saharan Africa has seen a dramatic increase in recent years in the number of TB cases and a disproportionately high number of people living with TB in this region (World Health Organization, 2016).

South Africa has the highest incidence of TB worldwide: in 2005, extremely drug-resistant TB was first detected in Tugela Ferry and since then there has been a countrywide surge in the number of cases of drug-resistant TB, exacerbated by the HIV burden (Saidi, Salie, & Douglas, 2017; Shah et al., 2017; Singh, Upshur, & Padayatchi, 2007). In addition, limited resources and infrastructure as well as social and economic difficulties have made the identification, treatment, and cure of TB a challenging task in this context.

Adherence to TB treatment is complex and nonadherence is a worldwide challenge (van den Boogaard, Boeree, Kibiki, &

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Aarnoutse, 2011). Patients must adhere to treatment for long periods, but many stop taking treatment for various reasons. Although new drugs are being developed, DR-TB treatment regimens in particular have a high pill burden and patients must also receive regular injections (Daftary et al., 2014). Some estimates indicate that a typical DR-TB regimen over 2 years includes 14,600 pills plus 6 months' worth of daily injections. There are a number of possible reasons why patients may abandon or not adhere to treatment: for example, side effects can be debilitating; treatment may be abandoned early when patients start to feel better; or stigma may prevent patients from seeking treatment (Cramm, Finkenflugel, Moller, & Nieboer, 2010). The disproportionately high rate of HIV and TB coinfection also poses challenges: many patients seek treatment late and present with clinically significant TB; drug regimens are often more complex in cases of comorbidity (Venkatesh, Swaminathan, Andrews, & Mayer, 2011); and patient monitoring and tracking is difficult particularly in rural and impoverished areas (Heunis et al., 2011).

While there may be numerous reasons for nonadherence to treatment, some solutions to this issue may lie in understanding community perspectives, experiences, and beliefs about the disease, as well as barriers to accessing care (Brunello et al., 2009; Govender & Mash, 2009). Patients and community members are experts of their own lifeworlds—their everyday experiences, lives, and problems (Mishler, 1984)—and their beliefs about illness and treatment may have a significant impact on adherence (Moshabela, Pronyk, Williams, Schneider, & Lurie, 2011). Germond and Cochrane (2010) describe the concept of "healthworlds," an extension of the concept of lifeworld which incorporates traditional or cultural notions of health and illness and considers the complex influence of contextual factors on patients' engagement with healthcare and treatment seeking.

Our work in the HIV/AIDS context has highlighted some unique barriers to care experienced by patients, and confirms the complex interplay between illness, sociocultural, economic, context, and systemic issues which may impact adherence behaviours. The work also reinforces the critical role of communication factors in promoting adherence and the need to explore challenges to care using qualitative methods from the social sciences (Penn, Watermeyer, & Evans, 2011; Penn & Watermeyer, 2018). The voices of medicine and healthworld do not always align, which can lead to frustration and conflict (Barry, Stevenson, Britten, Barber, & Bradley, 2001; Campbell, Scott, Madanhire, Nyamukapa, & Gregson, 2011). When healthcare workers engage with and show awareness of the voice of the lifeworld (or healthworld), there may be significant positive implications for medical interactions and health outcomes (Penn & Watermeyer, 2018).

In this paper, we focus on some of the challenges to TB care and treatment adherence as described by a number of different stakeholders in a particular community. Taking into account a "healthworld" perspective, we were particularly interested in the "merged voices" of the participants and in common themes identified across the data sets, something which previous studies have not typically focused on but which we have found a particularly powerful approach to research in community contexts (Penn & Watermeyer, 2018).

What is known about this topic

- Maintaining patient adherence to complex TB treatment regimens is challenging.
- Patients may stop taking treatment for various reasons.
- Understanding barriers to care and community challenges may provide insight into nonadherence.

What this paper adds

- Cultural beliefs and community perspectives continue to play a role.
- Care systems are fragile and vulnerable to change.
- Care systems need to take cognisance of lifeworld and communication issues.

2 | METHODS

This qualitative study forms part of a larger project on communication issues in HIV and TB care in a rural community in Mpumalanga Province, South Africa. We aimed to explore and understand illness and treatment experiences, cultural beliefs, as well as facilitators and barriers to care in a rural South African community affected by TB. Our research question was: "What are some of the challenges to TB care and treatment adherence experienced in this community?"

2.1 | The research setting

Mpumalanga is an area characterised by extreme poverty, high unemployment levels, a high incidence of HIV/AIDS, and a lack of basic infrastructure. Barriers to healthcare provision and access in this context include the high burden of disease, language and cultural differences, emigration of healthcare workers, social and geographical isolation in rural areas, staff shortages, staff attitudes, lack of medical equipment, high levels of poverty, and violent crimes (Barratt & Penn, 2009). The district in which this study was conducted has one of the lowest rates of educational attainment and one of the highest rates of illiteracy in the country (12% of people aged 25–64 years have not received any schooling, only 65% have completed secondary schooling, and 32% are illiterate; more women than men have not received any schooling) (Statistics South Africa, 2017). Male involvement in healthcare in this region is hampered by stigma and cultural stereotypes linked to community perceptions of male identity (Mlambo, 2014).

The clinic at which we conducted this research is run privately through the assistance of international funding. It provides treatment

TABLE 1 Demographic details of participants

	Number of participants	Gender	Age range	Average years of experience of working with TB
Patients	9	6 females 3 males	30–70 years	—
Community members	15	11 females 4 males	18–45 years	—
Home-based care workers	11	11 females	20–65 years	—
Healthcare workers	8	5 females 3 males	20–55 years	3.8 (range 1–7)

and support to people living with HIV/AIDS in a catchment area of over 250,000 people.

2.2 | Data collection

Ethical clearance was obtained from the University IRB (clearance number: M120211). Permission to conduct the study was also obtained from the Mpumalanga Department of Health. A trained research assistant familiar with the local community approached potential participants and explained the study in their language of choice. A written participant information sheet was also provided in the language of choice. Written consent was obtained from all participants except in the case of those who were illiterate, in which case verbal consent was obtained. The research assistant stressed that participation was voluntary and there would be no negative consequences for nonparticipation or withdrawal from the study. Participants were assured of confidentiality and anonymity.

Data collection involved semistructured interviews with 43 participants, conducted in 2013 and 2014. We aimed to interview between 10 and 15 participants in each participant category, although there were fewer patients and healthcare workers available who met the inclusion criteria. Healthcare workers, home-based care workers, and patient participants were selected via purposive sampling and invited to participate in the study. Potential participants included: all healthcare workers involved with TB care at the clinic; all home-based care workers associated with the clinic; patients who had been diagnosed with TB and who were attending the clinic during the data collection period. Patients who were too ill or not able to engage in an interview were not included. Community informants were selected via convenience sampling; specific inclusion criteria in terms of age and gender were not employed. Minors were not included in the study.

The interviews explored illness experiences, explanation of causation, treatment-seeking paths, communication issues and perceived challenges to TB care and adherence in the community. Interviews were conducted in SiSwati (or in English where appropriate) by a trained research assistant familiar with the community. The interview guideline was based on similar studies we have conducted in this context (as described in Penn & Watermeyer, 2018) and questions were modified slightly after a pilot study conducted by the research assistant with a community member. Interviews were audio recorded. The average length of interviews was as follows: community members—4 min; home-based care workers—7 min 46 s; healthcare workers—13 min 23 s; patients—9 min 10 s.

In addition, the authors conducted ethnographic observations of the TB unit at the clinic and accompanied an injection team on home-based care visits in the community. The authors also held informal discussions with clinic staff prior to collecting the interview data.

2.3 | Data analysis

Following transcription and translation of the recorded interviews by the research assistant into English, the data were analysed using principles of thematic analysis (Braun & Clarke, 2013). The first author read through each transcript in order to identify potential themes, and then identified and categorised major themes and subthemes across interviews within the same participant group (e.g., all interviews with patients). A process of revisiting the data allowed for fine-tuning of themes identified across each participant data set (as per suggestions by Rapley, 2011). Finally, a list of cross-cutting themes which seemed common to the entire data set was compiled. Data saturation was reached.

During this process of data analysis, the first author discussed emerging themes with the research assistant and clarified any translated phrases and cultural terms which were unclear. The second author and an independent researcher then verified the themes that had been identified. Thus, peer debrief and careful scrutiny and discussion of the translated transcripts ensured a rigorous research process (Long & Johnson, 2000).

3 | RESULTS

Participants across the data set were predominantly female, reflecting a general trend of females dominating care and more female patients attending clinics in this area (Mlambo, 2014). The age range across the participant groups was 18–70 years (see Table 1 for demographic details of participants).

TABLE 2 Common themes and subthemes identified across the data set

Major theme	Subthemes
Knowledge and understanding	• Causes of TB • Contagion; how TB is spread • Prevention of TB • Uncertainty about cause and exposure • Personal experience of the disease
Traditional beliefs	• Causality • Dual consultation and beliefs • Intergenerational differences
HIV-TB link	• Strong link; diseases work together • Confusion about cause • Stigma, segregation
Challenges to treatment adherence and access to care	• Notion of cure • Adherence linked to access issues • Role of poverty • Acceptance (life and death) • Power of example • Clinic and community • Communication and relationship

Analysis revealed a number of common themes across the data set which enhances our understanding about TB-related issues in communities (see Table 2). Four major themes related to issues around knowledge and understanding of the disease; the role of traditional beliefs; links between HIV and TB; and challenges to treatment adherence and accessing care. The themes presented in this section were mentioned across all four participant groups, although some participants gave more detail about certain themes which were more relevant to their particular experiences. The majority of perspectives shared during the interviews were well aligned. We end the section with a reflective piece on a follow-up visit to the clinic.

3.1 | Knowledge and understanding

Participants made reference to a range of causes of TB, including smoking, working in a dusty environment, inhaling the air, being in a dirty house, flies in houses, and eating dirty food. The concept of contagion was also mentioned: contact with bacteria, sitting near somebody who coughs, being in a house with someone who has TB, sharing cups, inhaling vapours from saliva containing TB, and having sex with someone who has TB. For example, one participant indicated that:

> This one breathes, this one breathes and you find that this one has it, you get it. (C9)

Some participants were able to correctly describe ways in which TB might be prevented, for example, opening windows in a house and covering one's mouth when you cough.

While some community members and patients had a good understanding of TB and how it is spread, others only partially understood the disease and the concept of contagion. Importantly, some of the home-based care workers demonstrated confusion in this regard. Staff indicated that they feel the community members "are dying because of lacking information about TB" (S2) and that although they had some awareness of TB, they did not always know how to protect themselves from the disease. This occurred in spite of the fact that the clinic staff have actively attempted to provide education for the community.

It seemed that knowledge and understanding was heavily dependent on personal experiences of the disease, and those who had contracted TB themselves or knew someone who had TB seemed to have a greater level of knowledge and a better understanding of the disease. Intergenerational differences in understanding were also highlighted—for example:

> Old people do not understand. (C1)

> Us young people at least we are a little informed, they have taught us at the clinics. (C6)

While most of the patient participants had some knowledge of how TB is transmitted, almost all of them indicated uncertainty about how they might have been exposed to TB:

> I really do not understand, maybe it is the TB or the [HIV] virus. (P2)

> I wish to know where does it come from (P7) (this patient went on to surmise that perhaps it came as a result of working with a vacuum machine and dust at his place of work, or perhaps via second hand smoke).

3.2 | The role of traditional beliefs

Traditional beliefs about illness and treatment appeared to have a significant influence on knowledge and understanding of TB. This was confirmed in interviews with community members and patients, who often spoke about "tindzaga" or "mafulatsa" (a cultural disease manifesting in

TB symptoms as a result of not following cultural rituals correctly especially when there is a death in the family). The disease was also spoken about as a cultural disease, described by one participant as:

> Illness that has been there long and people say it is like flu that came from outside the world. (C14)

The cure for this cultural disease involves smoking herbs provided by a sangoma. Occasional references were made to bewitchment or a curse on the family as the cause of TB.

Dual consultation and dual beliefs appeared to be the norm in terms of treatment-seeking paths, with hesitant acknowledgement from some participants that the community is accessing both approaches to healing:

> I believe that TB can be cured by taking tablets in the hospital but people believe that TB is cured by traditional medicine. (C13)

Staff also spoke about the importance of acknowledging and engaging with the fact that patients are accessing biomedical and traditional treatments. In some instances there may be a need to encourage patients to take TB medications first and then traditional treatments:

> You tell them that you only take the TB treatment for a certain period and when you are finished taking them then you can try the [traditional remedies] or whatever it is. That way we usually use to convince them…until they finished their TB medication. But if you just ignore that she/he will be mixing, the person now will be drinking traditional muthi [remedies], now drinking the TB tablets, now drinking [traditional remedies] and will not be cured. (S5)

3.3 | HIV and TB

The link between HIV and TB in the data appeared to be a strong one, described by one staff member as the "diseases that work together" (S2). This is to be expected in a disease context such as South Africa where TB and HIV are strongly linked.

What was apparent, however, was some degree of confusion about TB and HIV causation, as alluded to in some of the following statements:

> They say TB is caused by us who are sick, us who are HIV positive…those of us who are sick always have TB. (C4)

> When they see that one has TB they say haayi it is not TB, that one is HIV positive. (C1)

> It comes from sexual intercourse. (HBC8)

> They think the AIDS is killing them. (S1)

Although participants indicated that TB appeared to be more acceptable in the community and patients described experiencing less perceived stigma than that directed towards people living with HIV, stigma and segregation are still experienced by patients living with TB. Home-based care workers in particular spoke about how the community does not like to talk about TB and several participants related stories about being chased away from houses because of the fear that many community members have about TB.

> TB [means] that you are HIV positive and you are sick and you are dying. (C1)

> It is the thing that is making many people die [not accessing treatment] by saying "they will laugh at me." (P3)

> You will hear a person saying "I will never eat where a person who has TB ate. They will infect me with TB." They segregate us. (P9)

> You will find others being locked in [their houses]. (HBC5)

> There are many people who are sick, you see they hide themselves and do not go to the clinic. (HBC10)

> They do not speak a lot about TB… they are afraid… TB is found everywhere. (C12)

3.4 | Challenges to treatment adherence and accessing care

Adherence and barriers to care were discussed at length by some participants and a strong link between the two was noted. Related to discussions about traditional beliefs, there were different opinions about the issue of cure with some noting that TB can be cured "by taking tablets in the hospital" (C13) and "others say it cannot be cured" (C8). Some community members mentioned that if people do not believe in a cure, they will not adhere to the tablets:

> Many believe that TB treatment does not work. (HBC7)

Other challenges to adherence included a lack of access to the clinic and lack of transport; the slow process involved in diagnosing TB (although this may have improved since the recent widespread rollout of GeneXpert in the South African public healthcare system); patients getting "tired" of taking tablets due to treatment fatigue; the large size of the tablets; side effects of treatment, including vomiting; people feeling healthy so they stop taking the tablets.

Poverty was mentioned as a specific obstacle to adherence. Participants talked about how one should not take TB treatment without food as this can damage the body or cause dizziness, and a lack of food seemed to pose a significant obstacle to adherence in this community:

> They don't drink the tablets, they say there is no food. (HBC6)

Poverty was also seen by some as a cause of TB:

> Our people are not working, they do not have money to buy food, some they don't even have money to make a garden, to buy the seed…which means it's poverty which causes TB. (HBC4)

What was apparent during our visits to the community was the way in which poverty dictates, for example, the size of houses in the community, whether they have windows or not, how many people live in close proximity within the house, how accessible the house is by the injection teams and home-based care workers, etc. Patients in particular spoke about the importance of social grants to alleviate poverty and enable them to adhere to treatment. While temporary social grants have been made available to some patients living with HIV/AIDS, they are technically only available to those with DR-TB under specific circumstances.

Patients spoke particularly about the concepts of "life" and "death" in relation to living with TB, and how by focusing on living, they have been able to maintain adherence to the TB treatment:

> I accepted and said I am going to live…take the treatment and finish the treatment and life will go on. (P1)

Acceptance of the disease and trust in the treatment were also described as important facilitators of adherence. One patient referred to the fact that they realised that when they were ill with TB, they were "walking but really dead" (P3) until they started taking treatment. Also, they were compelled to adhere after seeing how the treatment had produced noticeable differences in their health:

> The tablets took you out of death…I suddenly feel and see a difference. (P4)

> When you stop them [tablets] there are many I have seen and they died. (P9)

Home-based care workers described the way in which those in the community who had been successfully treated for TB provided powerful examples to others and acted as facilitators of adherence:

> I have seen who is taking the medication and was healed; I am also going to drink and live. (HBC3)

> When [the patient] is being difficult, the cured one will explain [the importance of adherence]. (HBC9)

Staff in particular highlighted the importance of communication in patient and community understanding of TB, its treatment, and adherence. Staff felt strongly that in cases where patients default on treatment, this is often directly attributable to ignorance, poor counselling, or a lack of understanding of the need for adherence to avoid the development of drug resistance. Community members had a fairly good understanding of the need for adherence to a course of TB treatment, but some of the patient participants did not seem to understand, instead asking questions such as:

> I want to ask…because we are drinking [tablets] will it be cured? (P3)

> How long? When am I going to finish [the treatment]? (P5)

Importantly, some staff also talked about the importance of building a relationship of trust and respect, which encourages adherence, as well as seeking to understand the patient's point of view:

> You have to look for the things that made [the patient] to miss the doses…then you will be winning the rapport of the patient…it's gonna be like winning compliance. (S1)

The issue of communication and its multilayered complexity in TB care is one which we have explored in more detail elsewhere (AUTHORS, 2018).

3.5 | A follow-up visit

In early 2014, we visited the clinic in order to provide feedback on this project. We had been made aware of the withdrawal of international funding some months before, but this visit allowed us to see the extent of the impact of this occurrence on the clinic and community. The funding withdrawal had placed the future of the clinic into jeopardy. The clinic had to negotiate with other funders (including government) for continued existence. Many of the staff had left and the region and the clinic had been affected by strikes and protests—some of them violent—by patients and healthcare workers who recognised that they would be left stranded should the clinic close down. Some staff at the clinic carried on valiantly and were of the opinion that should the clinic close, there would be renewed numbers of children in the community being born with HIV/AIDS, a resurgence in nonadherence, and increased cases of MDR-TB.

On a positive note, the staff had started an MDR-TB DOTS-based outreach programme into the community, which involved home visits to provide treatment to patients and monitor adherence rather than admitting patients into the small inpatient unit at the clinic. This programme was perceived to have had a direct positive impact on decreasing stigma

levels in the community. We accompanied a group of staff from the clinic on one such visit and were made keenly aware of the resource-intensive nature of this programme: the clinic had purchased a van suitable for travel on badly corrugated dirt roads; the clinic had paid for driving lessons so that one of their staff members could get her driving license in order to drive the van; three staff members were required for each home visit; a thorough knowledge of unmarked roads and villages in the area was required and so on. While the interviews had provided important insights into community perceptions about TB, seeing the realities and challenges for ourselves reinforced the reliance of TB community care models on resources, manpower, and funding. These realities were reflected in informal interviews with staff, in which they articulated the lack of support from department of health structures, promises not materialising, and outreach programmes not being implemented.

4 | DISCUSSION

The phrase, "walking but really dead" (P3) refers not only to the need for TB treatment and care as experienced by this patient but it also seems a suitable metaphor to describe the current state of TB care in this community. Such care seems overly reliant on efficiency of the system, adequate human resources, and support from the Department of Health. The changes in TB care in this community brought on by the withdrawal of funding, lack of governmental support, and attempts to decentralise services highlight the fragility of the system and the vulnerability of patients, communities, and healthcare workers.

In a study conducted 20 years ago in rural Mpumalanga, Edginton, Sekatane, and Goldstein (2002) describe patient beliefs about TB. They note the presence of cultural beliefs and causal attributions that delayed diagnosis and treatment seeking, stigma in the community towards people living with TB, and challenges in accessing healthcare services. There are strong similarities between their results and ours, suggesting that traditional beliefs continue to influence TB care and adherence in a significant way. The consistently poor rates of educational attainment and literacy in this district cannot be ruled out as contributing factors to some of the issues identified around community knowledge and understanding of the disease. Poverty is another significant challenge, which at times seems horribly insurmountable.

While there is currently a strong international focus on developing new TB drugs and vaccines, there is also a need to focus on issues of context and community. Efficiency of TB care seems to depend not just on the availability of adequate resources. This study shows the importance of understanding community issues and the lifeworld or healthworld of the patient. Because of the mechanisms of contagion and the need for prevention, TB presents a particularly important case for focusing on common themes and exploring merged voices within communities. In this study, we have shown that these issues are cross-cutting and relevant for patients, communities, and healthcare workers, thus revealing a meeting point between the voice of the lifeworld (or healthworld) and the voice of medicine.

This study points to a number of implications for TB care. Communication processes between patients, communities, and healthcare workers are essential to focus on if one wants to achieve a situation where all voices are considered and there is mutual trust and a sense of working together in TB care. Studies have demonstrated the potential for change in the TB epidemic if there are sustained relationships built between clinics and communities (Brust et al., 2012; Loveday et al., 2015).

Although some participants did have a reasonable understanding of biomedical explanations of TB, and healthcare workers were aware of the multiplicity of beliefs, we would argue that introducing communication skills training for healthcare teams may empower them to communicate information more effectively to patients and communities—important points such as the need with adhere to TB treatment; how TB is spread and how it can be prevented; and what is DR-TB. In addition, there are ways of checking patient understanding which apply here too (Watermeyer & Penn, 2009).

Cultural constructions and experiences of illness and treatment are complex and dynamic, as reflected through the participants' voices in this study and echoing what others have described (Fried, Harris, Eyles, & Moshabela, 2015; Manderson & Smith-Morris, 2010; Steen & Mazonde, 1999; Waldron, 2010). This study confirms the existence of intergenerational differences and divergent beliefs about causality and care among patients and communities, which may differ from biomedical views.

We have written previously about the important role of cultural brokers in enabling a successful negotiation of different worldviews and an effective integration of the voices of medicine and the lifeworld using ecologically valid approaches within the clinic space (Penn et al., 2011; Penn & Watermeyer, 2014; Penn & Watermeyer, 2018). Here lies the potential for expert patients to play a role as both cultural brokers and community educators who can strengthen links between healthcare workers and communities. Similarly, home-based care workers could provide these links, but there needs to be a greater focus on their role in the healthcare team and on improving their knowledge and understanding of the disease.

If we compare this work to previous similar studies that we have conducted in HIV/AIDS (e.g., Penn et al., 2011), it is clear that TB care requires an approach that is tailored to the particular challenges of individual communities and to TB-specific issues. The fact that TB seems to be strongly linked to and even confused with HIV by community members implies that community education programmes need to focus on separating the two diseases. Long-term engagement at a site enables an up close and personal insight into its participants and the challenges experienced by the people at that site.

5 | CONCLUSION

If we are to respond effectively to the call for "transforming the health sector a well-functioning health system capable of producing improved health outcomes" (Dr Aaron Motsoaledi, 2010), then the role of communication should be foregrounded. Although based on a small group of participants at select sites across two provinces, the results of our study have implications for other contexts and

communities where TB care models are implemented. Although exploratory, this study confirms the need to understand the perspectives of different role players in community TB care as a starting point for developing locally attuned solutions. It demonstrates the value of qualitative methods in highlighting the voices of the participants.

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