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Conflict of interests

We have no conflict of interests to declare.

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Homeless young people who engage in sex work are at increased risk of HIV and other sexually transmitted infections like chlamydia, gonorrhoea, syphilis, and herpes. Semi-structured interviews were conducted with twenty-nine homeless young people between the ages of 16-25 years from Rawalpindi, Pakistan to explore how sexual practices were mediated through social and contextual conditions. Participants engaged in sex for a range of reported reasons, most commonly to generate income, but also to build intimacy and to establish intimate partnerships which could bring physical protection and social and emotional support. Although participants were aware of the sexual health risks attached to condomless sex, they engaged in it due to the social obligations of intimate partnerships, financial considerations, and to better manage potentially violent situations. Instead of condoms, participants used alternate methods like withdrawal, oral sex, post-sex douching and specific sexual positions. These were not always useful, and some methods might have inadvertently increased their risk of HIV. The study findings suggest that an integrated health promotion approach that goes beyond the health sector and a singular emphasis on risk-awareness may help reduce young people's risk of homelessness and sexual health risks.

Keywords: HIV, sexually transmitted infections, sexual behaviour, social exclusion, homelessness, young people

What is known about the topic?

- Homeless young people may exchange sex for needed resources.
- Homeless young people are at an increased risk of sexual transmission of HIV/STI due to risky sex.
- Homeless young people's risky sex has often been linked to poor knowledge regarding sexual health risks and safety.

What this paper adds?

- An explanation of homeless young people's sexual risk-taking in the context of Pakistan.
- The ways in which competing priorities of needed resources, violence avoidance, and sexual health combinedly produce contexts less conducive of safer sex.
- The identification of structural and contextual forces that may neutralise homeless young people's knowledge about sexual health risks and safety.

Introduction

Studies suggest that homeless young people (HYP) are at increased risk of HIV and other sexually transmitted infections (STI) due to practices like injecting drug use, risky sex, and a lack of access to HIV/STI prevention (Boyer et al. 2017; Melander and Tyler 2010; Milburn et al. 2006). There is also evidence of an increased prevalence of HIV among HYP compared to their stably housed counterparts (Braitstein et al. 2018; Surratt and Inciardi 2004; Beijer, Wolf, and Fazel 2012).

Nooe and Patterson (2010) suggest that social stigma attached to homelessness contributes to discrimination against HYP, decreasing their chances to secure paid work. This produces an environment in which sex work, often referred to as 'survival sex' becomes one of the few options available to HYP (Purser, Mowbray, and O'Shields 2017; Walls and Bell 2011). While sex work helps HYP to generate income, it carries a high risk of HIV/STI if there is poor access to and low use of condoms (Grangeiro et al. 2012; Skyers et al. 2018).

Often HYP's sexual risk-taking is linked to their limited knowledge regarding HIV/STI (Emmanuel, Iqbal, and Khan 2005). Sociological perspectives however highlight various intersecting social and structural forces that contribute to individuals' sexual risk-taking (Ussher et al. 2012; Tadele 2011; Chakrapani et al. 2007). Researchers like MacPhail

and Campbell (2001) and Ussher et al. (2012) emphasise how patriarchal social structures reinforce gender inequality in many societies by validating men's sexual promiscuity while suppressing women's sexual autonomy. This gender inequality may compel women to self-regulate their sexuality by not participating in sexual negotiation with husbands/partners, for them to maintain their reputation as 'good', feminine and worthy of respect (Maticka-Tyndale 1992). Therefore, women may engage in sexual risk-taking, despite knowing their husbands/partners may have concurrent sexual partnerships or be at risk of HIV/STI (Ussher et al. 2012).

Similarly, expectations of heteronormativity (a social structure reinforcing the belief that heterosexuality is constructed and performed as the 'natural' and 'normal' way of expressing and practising sexuality) have been shown to contribute to sexual risk-taking among young people with diverse sexual/gender identities (Wilkerson, Brooks, and Ross 2010). Indeed, research suggest that heteronormative policing in society can put them at risk of homelessness (Muriuki et al. 2011; Wilkerson, Brooks, and Ross 2010; Meanley, Egan, and Bauermeister 2018). Experiences of discrimination may encourage gender/sexually diverse young people to practise sex work if they are homeless, and this may not always be conducive for condom use (Skyers et al. 2018).

Engagement in paid sex also affects condom use among sex workers, particularly in developing countries where sex work is illegal, poorly paid, and where there may be little access to condoms (Chakrapani et al. 2007; Dunn et al. 2017; Rajabali et al. 2008). In settings where sex work is illegal, police can use possession of condoms as evidence of sex work and this can deter sex workers from using condoms with clients (Mayhew et al. 2009). In settings in which sex work is poorly remunerated, the offer of more money for condomless sex may be difficult to refuse (Mahapatra et al. 2013).

Social researchers like Watson (2011) and Barker (2012, 2013, 2016) have emphasised how HYP's lives are characterised by a resource-deficit, and that sex is one means by which they seek social and financial capital. Barker (2016) uses the concept of the 'habitus of instability' to explain how HYP internalise a sense of insecurity through their experiences of familial disruption, joblessness, and unstable living conditions. Through this lens, sexual practice becomes one way to obtain intimacy, physical protection, and financial resources. The desire to obtain intimacy may then take primacy over sexual safety in relationships (Watson 2011; Bujra 2000).

The aforementioned research suggests that structural factors may neutralise the role of individuals' knowledge about HIV/STI and contribute to their sexual risk-taking. In Pakistan, more attention has been paid to the relationship between HYP's knowledge about HIV/STI and sexual behaviour than it has to these social structural influences (Emmanuel, Iqbal, and Khan 2005; Sherman et al. 2005). Our study examined how HYP's sexual choices and decisions were mediated through various structural and contextual forces. Our analysis may help policymakers move beyond the conventional approach that views sexual health education for young people as the main way to achieve better outcomes and instead think of a broader range of ways to engage with and support HYP in resource-limited settings.

Methods

Data were gathered using semi-structured interviews with twenty-nine HYP (16-25 years old) from Rawalpindi, conducted in April-September 2016. Guided by recent homelessness research (Watson 2011; Beazley 2003; Barker 2012), sexually active young people (aged 16-25 years old) who were either homeless on the street or precariously homed were considered eligible to participate in the study.

Staff from a local non-governmental organisation (NGO) assisted with participant recruitment and organised interviews at the NGO's office. To allow respect to local cultural expectations, we employed a female interviewer to conduct interviews with female participants (and six were conducted by her). The remaining interviews were conducted by the lead author. The interviews were conducted in Urdu and each interview took approximately 60 minutes. We provided PKR 800/AU$10 to participants as compensation for their time and travel expenses.

The interview guide had four sections including (1) participants' demographic information, (2) their pathways to homelessness (3) street-based sexual activities, and (4) sexual beliefs and practices. Thematic analysis was performed for its flexibility, as it allowed us to identify theory-driven as well as emergent themes (Braun and Clarke 2006). The lead author (who was born and raised in Pakistan) translated and transcribed four interviews into English, so that other team members could read them and assist with coding of the initial interviews using NVivo (version 10) software. The remaining interviews were analysed in Urdu by the lead author and quotes from them were translated during the write-up phase.

The present study was approved by the Human Research Ethics Committee (HREC) of the University of New South Wales (reference: HC16261). Key ethical guidelines concerning voluntary participation, informed consent, compensation for time and expenses, and maintaining participants' confidentiality were observed throughout the research process.

Findings

Of twenty-nine participants, nine were cisgender heterosexual men, six were cisgender heterosexual women, seven were cisgender gay men, and seven were transgender heterosexual women, aged 16-25 years old. The mean education level of participants was 5.8

years of formal schooling, although some (*n = 6*) had had no formal education. Almost all of the participants reported having left their family home at least a year before the interviews took place, while a few (*n = 3*) had left home more recently.

Almost all of the participants reported being precariously homed, and one participant reported sleeping in public parks. The precariously homed talked about how peers provided them with accommodation in single rooms/flats, which they rented in Rawalpindi. However, a few had secured temporary accommodation at extended family members' homes. In terms of income generation, most (*n = 23*) of the participants reported dancing and/or sex work, whereas a minority engaged in jobs like rickshaw driving, house painting, scavenging, and labouring (construction).

Sexual partnerships

Most of the participants reported having concurrent sexual partnerships, although they were aware of sociosexual norms and the legal system that discourages and criminalises sex outside marriage and sex between men in Pakistan (Toor 2007; Qureshi 2018). Participants spoke about why they transgressed these societal norms and legal provisions. Hassan described that practising sex was necessary to fulfil, what Green (2008) calls 'erotic appetites' (29) – physical needs and pleasure from sex:

> I think sex is a natural physical need, just like food for a body. Everyone needs to have sex in some time, after a week or two. I also need it for my physical satisfaction (Hassan, Cisgender gay man, 23).

Ghalib, another gay man, described that because same-sex marriage was not permissible under Pakistani law, establishing intimate relationships with other men was an alternative arrangement he pursued:

> As far as I am concerned, it is not possible to get married to a woman. I cannot even

> think of doing it, but society, including family, cannot accept it. My parents don't even know what I do here. I lied to them that I work in a hotel in Rawalpindi. They must be concerned that now that I have grown up, I should get married, but I cannot do it. Here, I have a boyfriend I am happy with it. My parents often ask me to get married, but I haven't refused them straightaway. I told them that I will get married when I have a better job (Ghalib, Cisgender gay man, 25).

Parveen described how she obtained intimacy from her regular sexual partner like a wife could obtain from a husband. In Pakistan, women are expected to preserve their virginity until they get married and those who are unable to do so are considered unmarriageable or are likely to be divorced soon after marriage (Khan 2011). Parveen, due to her sex work, considered herself to be unmarriageable, and as an alternative to marriage, she had a boyfriend. She described how this allowed her to experience being liked and loved:

> I feel good when my boyfriend is around. He comes, we lay down on the bed, we become physical, and we do not necessarily have sex every time. That is not a 'sex' that I have with my clients. I cannot spend hours with them, I simply want them to do their work [sex] and leave because it's just my business (Parveen, Cisgender woman, 18).

Another woman, Saira, who performed *mujra* (a sexually suggestive dance, often performed at weddings to entertain men and is generally attributed to transgender women and female dancers) reported how her intimate partner provided her with physical protection. Saira described that she often felt vulnerable to verbal, physical, and sexual abuse by men at such dance events and that her intimate partner protected her from such abuse:

> People know that I am a weak person. This is obvious that no respectable woman in our society would do dance work. Men had beaten me up a few times in the past and it gave me a sense of insecurity but thanks to the man who protects me, I am sure people would

face serious consequences if they bully me now (Saira, Cisgender heterosexual woman, 25).

Consistent with research from developing countries (Logie et al. 2018; Karamouzian et al. 2016), we found that not being able to secure paid work in the formal market might lead participants to engage in sex work. Hassan believed that sex work was the most viable option to meet personal and sometimes family needs:

> Sex work has a very important role in my life which I must not deny. I feel that now I cannot imagine my life without it because I can buy everything that I need in my everyday life by doing it. I can afford to pay for important things like my room rent, food, toiletries, and my sister's school fee due to sex work. I earn as much as I can by selling sex so that I can help my family (Hassan, Cis-gender gay man, 23).

In sum, participants described the range of sexual partnerships that they engaged in their lives. These were sometimes risky and brought harms with respect to HIV/STI, violence and other risks, but also included experiences of intimacy and love. Their experiences were also shaped by the powerful and strict social expectations of heteronormativity and marriage that exist in Pakistani society. As we demonstrate later, these social relations were important in shaping participant decisions about sexual safety.

Knowledge about and strategies to prevent HIV/STI

Most of the participants, to some extent, were aware of biomedically recommended ways to reduce HIV/STI risk, including condom use. Participants described how local health promotion organisations gave them information about the nature, transmission, and prevention of HIV/STI:

> I never knew about risks related to sex because most people in my community had no

awareness regarding this, so they do not discuss it. I heard about HIV infection, hepatitis, and condom use from people from an NGO and it was quite worrisome because I had always been having sex without using condoms (Talat, Heterosexual transgender woman, 24).

NGOs and their staff acted as a source of what Wacquant (1998) calls 'formal social capital' (28) that could be used by participants to increase their safety during sex. NGOs helped participants to build 'cultural health capital' - basic biomedical knowledge about HIV/STI, their modes of transmission, prevention and treatment (Shim 2010: 2). As a result of health promotion efforts, participants had picked up some biomedical knowledge, but it was incomplete. For instance, while gonorrhoeal infection might not always show symptoms (Grosskurth et al. 1996), many participants believed that it was symptomatic and could be identified by seeing unusual urethral/vaginal discharge. Jaweria, for instance, talked about the symptoms of leucorrhoea:

There is a lot of smelly [vaginal] discharge in leucorrhoea which can also give a lot of headaches and it also sometimes causes rashes around the vaginal area (Jaweria, Cisgender woman, 23).

Many participants described methods that they used to reduce sexual health risks. The most common of these was condom use:

I think using condoms is the best way to protect yourself. We call it a penis cover. It acts as a shield against diseases. My gay friend who works for an NGO has told me about this. I also receive free condoms from him (Emad, Cisgender gay man, 25).

Hassan mentioned that mutual monogamy was another way to reduce the risk of HIV/STI, although he was not monogamous and practised sex work to generate income:

I think having sex with one partner is safe. There are fewer chances of infection in sex

between [monogamous] partners because they know each other's health status very well (Hassan, Cisgender gay man, 23).

However, many participants believed HIV infection to not be manageable and considered it a death sentence. These participants reported how they saw their friends become sick from AIDS and this led them to believe that there was no medication to manage the infection:

I have some friends who practised sex more and got AIDS. I really feel sorry for them. They have completely changed which really scares me when I look at them. They have become quite skinny and you can even see their bones and it really makes me sad (Naila, Heterosexual transwoman, 24).

One participant, Hassan, who reported to be HIV-positive knew that HIV was a chronic infection that could be managed through adherence to antiretroviral treatment (ART):

You cannot say HIV infection has no treatment. Although it remains with a person for his/her whole life, one can live a normal life by taking a pill every day. It's even safe to have sex without using condoms as far as the viral load is undetectable (Hassan, Cisgender gay man, 23).

In sum, as a result of health promotion efforts, most participants had a basic understanding of HIV/STI transmission and prevention. While many knew that using condoms could reduce the risk of acquiring HIV/STI, they did not use them. As we go on to describe, this was because of the specific and often complicated contexts in which sexual decisions were made.

Competing priorities and sexual safety

Most of the participants engaged in condomless sex with intimate partners and clients to

address immediate needs like intimacy, physical protection, social and emotional support, and money. Those who established intimate partnerships believed negotiating condoms with intimate partners would negatively affect trust: condoms signalled mistrust, and this could disrupt valued relationships:

> We do not use condoms because we do not need to. We are very close to each other. I trust that he does not have sex with anyone except me and he thinks the same about me (Saira, Cisgender heterosexual woman, 25).

Consistent with studies in other developing countries (Mahapatra et al. 2013; Dunn et al. 2017; Wojcicki and Malala 2001), participants in this study talked about the need to engage in condomless sex with clients because of the extra money offered:

> I do not really care who I have sex with because sex work is the only way by which I can earn some money. I would not be able to feed myself if I don't do it. I never send my clients back because my only concern is money. Even if there is someone sick can pay what I demand, I will happily accept it (Vaqas, Cisgender gay man, 17).

In the cases where there was a risk of violence from clients for suggesting or insisting on condoms, physical safety was preferred over protection against HIV/STI. This might also facilitate condomless sex:

> Clients who are drunk, they have a thing in their mind that they can have sex the way they want. Such clients then do not listen to me and I have no option left but to follow them (Talat, Heterosexual transgender woman, 24).

One participant, Omar, mentioned that he purposefully chose to avoid condoms because he believed that condom use might prolong sexual activity. Omar described how, in order to avoid discomfort in prolonged sexual intercourse, he did not use condoms with his clients:

> Personally, I do not like my clients using condoms because I do not want them to last longer. I think the skin to skin contact during sexual intercourse heats up a penis due to which a client can enjoy more and reach a climax earlier. Putting a condom on can prolong sexual activity which causes discomfort to me (Omar, Cisgender gay man, 24).

These results show how young people's choices and decisions about sex may not necessarily be shaped by their knowledge of HIV/STI and that there are other structural and contextual factors that shape sexual practices (Kippax et al. 2013). Social obligations in intimate relationships, the desire to maximise income, and power imbalances between participants and clients produced a context of competing priorities in which sexual safety became a secondary concern. However, because participants knew that condomless sex could expose them to sexual health risks, they used a variety of alternative strategies which they believed could reduce the risk of HIV/STI, a description of which is given in the next section.

Alternatives to reduce the risk of HIV/STI

Participants' basic knowledge meant that they were aware that they were at risk of HIV/STI when they practised sex with concurrent partners, often without condoms. As alternatives, they used cultural knowledge to devise strategies of protection which were more possible for them to use in their social contexts:

> Some clients did not want to use condoms at all. We discuss it with friends who come up with different ideas to tackle it (Ghalib, Cisgender gay man, 25).

Ghalib implies that peer groups developed 'localised' cultural health capital – a 'common sense understanding of health and illness' that participants and their peers used to make decisions about sex (Warwick, Aggleton, and Homans 1988: 213). A few participants like Rashida mentioned how they used the withdrawal method in an effort to reduce the risk

of HIV during condomless sex with clients:

> I do not let such clients cum inside me. I always caution them that if you do not want to use condoms, make sure that withdraw before you cum. This is how they remain careful (Rashida, Transgender heterosexual woman, 22).

In contrast to Rashida's experience that clients would agree to withdraw before ejaculation, Omar reported that in his experience of sex work, clients never wanted to do so, as they believed it would reduce the physical pleasure from sex; something that clients expected in paid sex. So, instead of asking clients to withdraw, Omar used post-sex douching, believing it could reduce the risk of HIV:

> I have a friend from Lahore who taught me how to clean myself from inside after having sex without using a condom. I have a shower hose in my bathroom. Each time I have sex with a client, I go to the bathroom and wash my bottom with a high-pressure water stream and try to take semen out of my body. This is how I clean myself from inside (Omar, Cisgender gay man, 24).

While Omar sees this to increase his safety, anal douching can lead to rectal tissue damage, which can potentially increase the chance of HIV transmission during condomless sex (Carballo-Dieguez et al. 2008). This cultural knowledge could be understood in terms of what Barker (2013) calls 'negative cultural capital' – cultural competence used with a positive intent to bring positive health outcomes, but could actually be destructive when evaluated from a biomedical perspective.

Emad described using a specific position during sexual intercourse as a method to protect himself if his clients did not want to use condoms. Emad said that he would sit on top of his clients while taking the receptive role, irrespective of the client's HIV status:

> In the case of condomless sex, I try to be on top of my client [while taking a receptive

role]. It is safe to have sex in this way because I think semen does not travel deeper inside if you are on top (Emad, Cisgender gay man, 25).

While this strategy may provide some degree of protection from HIV, if used consistently (Jin et al. 2010), it may increase the chances of other bacterial STI.

A few participants reported that as they had to attend to many clients daily, they tried not only to reduce the risk of HIV but also to minimise the time they spent having sex with each client. They believed oral sex was a useful method to achieve both goals. For instance, Hassan mentioned oral sex when asked if he used a different risk reduction method besides condom use:

It has become a trend among young people that they want to cum in the mouth. They mostly ask me to have oral sex and if not, I try my best to have oral sex with clients and do not give them a chance to have [penetrative] sex and I think it is safe as well. Doing oral sex makes things easier. For example, you do not have to take baths again and again; you just wash your mouth and that's it (Hassan, Cisgender gay man, 23).

While oral sex presents a negligible risk of HIV transmission (in the absence of cuts or sores), it can be an efficient way to transmit bacterial STI like chlamydia, gonorrhoea and syphilis, or viral infections like herpes (Edward and Crane 1998). Rinsing the mouth (particularly with antiseptic mouthwash) does, however, reduce the risk of STI (Chow et al. 2017).

A few participants, like Sohail reported abstaining from sex with people who looked "dirty" (unwashed or dishevelled), as they believed that such characteristics represented 'disease' or 'sickness' which could be transferred by having sex with them:

I am now very careful in deciding who I should have sex with. I completely avoid those who look dirty. I simply reject them because they can make me sick. I remember how

> I once became sick by having sex with a dirty person. I had to go to a hospital and spend four thousand rupees [almost AU$40] for the treatment of rashes I had on my whole body (Sohail, Cisgender heterosexual man, 16).

These results show that participants actively looked for and used alternative risk-reduction methods. While participants' intentions were positive, as they made efforts to protect themselves, the alternatives used were not fully protective, and some of the methods used might inadvertently increase their risk of HIV/STI (De Visser 2004; Carballo-Dieguez et al. 2008)

Discussion

This paper illuminates how conditions of ongoing "social and financial instability" and exacerbated sexual risk-taking among HYP in Pakistan (Barker 2016). The results suggest that health promotion efforts did not always help participants to protect themselves from sexual health risks. Indeed, competing risks and priorities magnified participants' risk of HIV/STI, in a context in which participants, at best, had partial knowledge of sexual health, and at worst, they relied on misconceptions about how to minimise risk.

Struggle to secure physical protection, to obtain intimacy and social support, and to generate income in marginalised conditions meant that participants had to make sexual choices and decisions that often compromised their sexual safety. For example, many participants never used condoms with intimate partners in order to maintain intimacy, love, and affection, as they believed condoms would create an atmosphere of distrust in those relationships. This finding is common internationally, particularly in similar settings like India and Iran (Karamouzian et al. 2017; Mahapatra et al. 2013). Our analysis suggests that intimate relationships were a clear example of what Warr (2005: 286) refers to as 'horizontal

social capital' – emotionally intense social ties that provided affection, companionship, and social support. Participants were aware that losing ties with intimate partners could exacerbate the adversity of their circumstances. In these circumstances, sustaining social capital took primacy over sexual safety.

Sex work, for most of the participants, was the only option available to generate the financial capital needed to meet their personal and family needs. Participants' knew that introducing condoms with clients was difficult and could lead to abuse or at least dissatisfaction from customers. This risked losing customers to other sex workers and, in turn, losing income. Hence, to maximise monetary profit, and to avoid the risk of abuse from intoxicated clients, participants often had sex without condoms during sex work.

Participants often used localised cultural health capital (Shim 2010) – a common sense of understanding of sexual risk and safety that was often shared through peer networks. Participants used lay methods of risk reduction as substitutes for condom use, like oral sex, post-sex douching, specific sexual positions, and abstaining from sex with people who looked a certain way. Participants came up with alternative ways in order to improve the convenience of their life and to maximise the number of clients, but they also attempted to minimise their risk of HIV/STI.

Similar to other studies, the present research is not without limitations. This research was a study conducted in a single location and recruited a small sample to conduct in-depth qualitative analysis. A multi-sited study with a larger sample size may have provided a broader range of insights and a greater diversity of experiences. Some lesbian women who were approached to participate refused to do so, as they felt concerned about discussing their sexuality and other matters with the study team. A study that could employ a broader range of peers as researchers could provide a safer context for lesbian women who are homeless to

participate in this type of research. The study's collaboration with a local NGO meant that we largely recruited HYP who had received some sexual health education from the NGO. Engaging participants from other, less connected networks could improve of the risks and resources of HYP in Pakistan.

Our analysis indicates the need to move beyond the conventional approach of solely increasing individuals' knowledge regarding HIV/STI. Social conditions like poverty, homelessness, and social stigma associated with sexual/gender diversity often mediated individuals' sexual behaviour and compounded their lack of knowledge or misconceptions about risks. These need to be addressed in health promotion. Interventions like peer education and vocational/technical skill-building may bring promising health outcomes among HYP in Pakistan. There is evidence of how the Sonagachi Project in India has successfully reduced HIV transmission among female sex workers by providing them sexual health education, medical care, financial incentives, and protection by the police (Jana et al. 2004). NGOs in Pakistan could review the focus adopted by the Sonagachi Project while designing the intervention for HYP. Specifically, NGOs in Pakistan might also consider educating HYP's intimate partners and clients on HIV/STI prevention. Intimate partners may need to be more careful with clients and other partners and get tested/treated more often. Since clients may not want to reveal their identity by meeting staff from NGOs, a useful way to educate them could be the use of information, education, and communication (IEC) material.

In short, HIV/STI should not be reduced to the context of brothel- or home-based sex work; rather, it is necessary to understand the social conditions shaping individuals' sexual practices that can place them at increased risk of HIV/STI. Therefore, the conventional approach of promoting health through raising awareness regarding sexual health risks may continue to bring less than promising outcomes, unless we focus on the ways in which structural and contextual forces operate to increase the chances of risky sex and HIV.

Together, policymakers, academics, and civil society organisations can help young people utilise their abilities in productive ways to further contribute to the socioeconomic development of Pakistan, a country where young people make up over half of the population.

Data availability statement

The qualitative data that support the findings of this study are available on request from the corresponding author. The data are not publicly available due to privacy or ethical restrictions.

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