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System disconnects in first food environments: Mothers' lived experiences in two vulnerable urban communities, Western Cape Province, South Africa

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Background. The context in which mothers and caregivers make decisions about feeding during the critical first 1 000 days plays a crucial role in optimal infant and young child feeding (IYCF).
Objectives. To describe mothers' lived experiences of IYCF and the system disconnects affecting first food environments.
Methods. In this qualitative phenomenological study, mothers aged ≥18 years with children <5 years who were receiving a child support grant were purposively sampled from two vulnerable communities in the Western Cape Province, South Africa: Zweletemba (*n*=15) and Masiphumelele (*n*=17). In-depth interviews were conducted by mobile phone between February and April 2021, audio-recorded with permission, transcribed and thematically analysed.
Results. Mothers who breastfed described breastfeeding as affordable and enjoyable and reported that it was preferred by their babies. Reasons for suboptimal practices included perceived insufficient breastmilk supply, the baby appearing hungry or refusing the breast, returning to or seeking work and fathers purchasing commercial milk formula (CMF) rather than contributing to the child's general support. The high cost of CMF, particularly in the context of income pressures during the COVID-19 lockdown, together with mothers spending more time at home, encouraged breastfeeding. IYCF advice in healthcare settings focused on promoting breastfeeding rather than providing detailed guidance on how to breastfeed or prepare CMF feeds safely. Specific brands of baby food, often encountered through advertising, were viewed as aspirational because of their convenience, palatability and cost. These included ultra-processed products, such as cereals or porridges, and 'snacks', including two-minute noodles.
Conclusions. This study highlights the urgent need for health, food, education, urban, social and economic systems to align in support of improved IYCF within child-centred first food environments, thereby ensuring access to nutritious, safe and affordable diets and essential services that support children's healthy growth and development.

Keywords: Infant and young child feeding, first food environments, system disconnects

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Global health authorities recommend initiating breastfeeding soon after birth and exclusive breastfeeding (EBF) for the first six months of an infant's life. Nutritionally adequate complementary foods should then be introduced from six months of age, while breastfeeding continues until two years of age and beyond.[1] Despite the strong evidence supporting these recommendations,[2] the 2021 United Nations Children's Fund (UNICEF) global report, 'Fed to Fail?', highlights their poor implementation and draws attention to the crisis in children's diets during the critical developmental period from birth to two years of age.[3]

The contexts in which mothers and caregivers make feeding decisions during this period, including healthcare settings, shops, workplaces, communities and homes, play a crucial role in encouraging, supporting or hindering optimal infant and young child feeding (IYCF).[4] These settings, collectively referred to as 'first food environments', influence the availability, cost, convenience, safety and quality of infant foods, as well as exposure to their marketing.[4] The UNICEF report makes it clear that the world has failed to improve how most young children are fed during early life,[3] partly because of system disconnects affecting first food environments.[5] These system disconnects, which include fragmented service delivery, poor co-ordination among sectors and inadequate infrastructure, have profound and multifaceted effects on IYCF, as reflected in suboptimal feeding practices, particularly in vulnerable communities.[3]

The South African National Department of Health (SA NDoH) adopted the joint World Health Organization (WHO) and UNICEF recommendations,[1] most notably in its 2013 IYCF policy.[5] The policy also includes recommendations on the use of commercial milk formula (CMF) and refers to the comprehensive legal framework governing the inappropriate marketing of CMF, related products and complementary foods,[5] known as Regulation 991.[6] Despite the national IYCF policy, guidelines and legislation, IYCF practices in the country remain far from ideal.[7] A systematic review by Kruger *et al.*[7] of the dietary intake and nutritional status of SA infants and children reported that, although breastfeeding initiation

rates remained high (>80%), EBF rates remained low (<30%). Complementary feeding practices were also found to be suboptimal. Infants were offered highly processed foods from a young age, with children aged 6 - 8 months consuming salty foods and sugar-sweetened beverages (SSBs). The situation was equally concerning among children aged 18 - 23 months, large proportions of whom reportedly consumed salty snacks and SSBs.[7]

The reasons for this bleak profile and poor uptake of IYCF guidelines have been investigated in various SA settings. Reported barriers to EBF and optimal complementary feeding practices include the cost of food in general and healthy foods in particular, insufficient time to prepare food, the marketing of certain foods, inconsistent messages about IYCF, including those provided by healthcare workers, cultural differences and taste preferences.[8] Reported enablers include recognition of the importance of IYCF messages and an understanding of how adherence to these messages benefits children's health.[9]

Although SA has policies intended to promote an integrated approach, government decision-making regarding nutrition lacks coherence,[10] and there is no explicit effort to align the different systems influencing nutrition.[11] Consequently, few forms of support for caregivers comprehensively align policies, programmes, resources and actions,[12] including those relating to first food environments. Addressing IYCF in vulnerable urban communities therefore requires a systems-based approach.[3]

The Nourished Child project aimed to define and communicate a systems-based approach to improve the quality of diets among children <5 years and women of childbearing age. The first phase of the project addressed the lack of qualitative insight into mothers' lived experiences within first food environments. It explored mothers' experiences of the role of food and other systems in their communities, particularly during and immediately after the COVID-19 lockdown, in two vulnerable communities in the Western Cape Province, SA. This paper describes mothers' lived experiences of IYCF and the system disconnects affecting first food environments in these settings.

Methods

This qualitative phenomenological study was conducted at the subnational (provincial) level, allowing greater consideration of context in relation to governance. This provincial level also offers greater potential for dialogue among government and food-system stakeholders. The two study sites were (*i*) Masiphumele ('Masi'), a low-income township on the Cape Peninsula, situated between Kommetjie, Capri Village and Noordhoek, approximately 35 km from the Cape Town city centre. It has approximately 40 000 residents and is densely settled, with a mix of brick houses, backyard shacks and shacks in an informal settlement; and (*ii*) Zweletemba ('Zwe'), a township on the outskirts of Worcester, one of the largest towns in the province, approximately 100 km from Cape Town. Worcester has an agricultural history and includes previously disadvantaged communities that remain vulnerable.

The study population lived in settings where existing systems and interventions were expected to intersect and interact. Lived-experience research is valuable for understanding complex social and health issues, particularly in vulnerable communities. By foregrounding the voices of those directly affected, this approach captures nuanced, context-specific insights that may be overlooked in quantitative data and reveals the emotional, cultural and relational dimensions of phenomena such as infant feeding, caregiving and health-seeking behaviours. Lived-experience research therefore helps bridge the gap between policy and practice, offering a human-centred lens that may enhance the relevance, equity and effectiveness of research and intervention design.[13]

Participants were eligible for inclusion if they were female, aged ≥18 years, the primary caregiver of at least one living child aged <5 years, resident in one of the two study sites, recipients of at least one child support grant (CSG) and able to provide informed consent, either in writing or by another approved means. Based on estimates in the research proposal, 15 - 20 participants per study site were expected to be required to achieve data saturation or sufficiency. The researchers also applied the reflective concept of 'power of information'[14] to determine when the data were adequate to address the research objective.

Owing to the COVID-19 protocols in place at the time of data collection, the data-collection methods had to be adapted. The researchers obtained approval for an amendment to the initial protocol allowing in-depth interviews (IDIs) to be conducted telephonically instead of in person. Interviews took place between February and April 2021.

The interviews aimed to explore mothers' experiences of the systems influencing what their children ate, particularly their perceptions of food, health and eating and the role of interventions directed at them, such as those delivered through local clinics. The authors also sought to understand the main systemic factors across household, social, economic and urban systems that mothers perceived as influencing what they and their children ate. In addition, they explored what would be required for mothers and their children to eat differently and which interventions might create greater coherence across systems. Interview questions typically addressed meals consumed at different times of the month, responsibility for food-related decisions, food preparation and storage, sources and frequency of food acquisition and expenditure on non-food items.

Participants were purposively recruited for the IDIs by established community facilitators. These facilitators had previously engaged with local study co-investigators, and a degree of mutual trust had therefore already been established. Using their existing social networks, the facilitators invited community members who met the inclusion criteria and were willing to participate in the Nourished Child project as part of a broader community-engagement process. Additional participants were recruited through snowball sampling.

Before the interview, all participants received a simplified participant information sheet. A trained local research assistant facilitated this process by sending each participant a photograph of the form by text message or WhatsApp. The sheet explained the study, what participation would involve and any potential risks. The researchers ensured that participants understood that participation was voluntary and that they could withdraw at any point in time without consequence. Participants were given an opportunity to ask questions. Those who agreed to participate received a photograph of the informed consent form (ICF) by text message or WhatsApp and were asked to respond with either 'no', if they did not wish to participate, or their name, if they consented to participate.

Before commencing the interview, interviewers asked consenting participants several demographic questions and recorded their responses. These questions addressed age, ethnicity, education, household income, employment status and occupation, head-of-household status and number of children.

All study materials were available in the three official languages of the Western Cape: English, isiXhosa and Afrikaans. As the forms were shared electronically, each participant retained a copy of the participant information sheet and ICF. Screenshots of the shared ICF and each participant's text response indicating whether they consented to participate were retained for the study records.

Interviews conducted in isiXhosa were translated and transcribed by a bilingual isiXhosa-English professional. Two members of the research team checked the transcripts. The research question and objectives provided an initial, flexible framework for coding. Each code was annotated with a description of the code to enable another researcher using the codebook to identify similar themes. Two primary researchers, both co-authors, reviewed and refined the codes, themes and definitions before agreeing on interpretations that best represented participants' accounts.

The researchers acknowledged their subjectivity and reflected critically on how their own perspectives informed the analytical process. Two members of the research team conducted a thematic analysis using NVivo software, version 13 (QSR International, USA).[15] Four transcripts were jointly coded to explore meanings and consider alternative interpretations of the interviews.

Results

A total of 32 participants were interviewed: 15 in Zweletemba and 17 in Masiphumelele. Participants had a mean age of 29 years of age and a mean of two children each. Most had completed high school or held post-matric qualifications. Fourteen participants were unemployed, seven worked full time, four worked part time, six were studying and one undertook seasonal work. All participants received a CSG of ZAR480 (approximately USD25) per month. Participants mostly lived in brick houses (n=20), while ten lived in shacks and two in backyard dwellings. Households comprised a mean of five people.

Four prominent themes emerged from the IDI data: (*i*) infant milk-feeding practices; (*ii*) complementary feeding practices; (*iii*) barriers to IYCF practices; and (*iv*) enablers of IYCF practices.

Some participants had not breastfed their first or second child but reported breastfeeding their youngest child, including EBF for six months and continuing to breastfeed for two years or longer. Those who reported feeding their infants in accordance with WHO guidelines described breastfeeding as affordable and enjoyable. They also reported that their babies preferred breastfeeding or would not take a bottle and that the COVID-19 lockdown enabled them to remain at home with their babies. Commonly reported reasons for not breastfeeding, using CMF or introducing solid foods before six months included a perceived insufficient breastmilk supply, the baby refusing the breast and returning to or seeking work. Women also perceived that their babies had grown too large to be sustained by breastmilk alone or remained hungry after breastfeeding.

> 'It's nice [breastfeeding] but it I think they are not full. The children are not getting full with breastmilk only. I bought that Nan [CMF brand].' (Participant 3, Masi).

Another common practice was the introduction of CMF and cereals at a very young age because of the perceived benefits of improved sleep and growth.

> 'When she was 2 months, I started feeding the baby food. Yes, the formula with the cereals and yeah, she started eating that. It helped me a lot because she was sleeping longer and also, I also saw that she was growing up … she was, she gained a lot of weight when she started eating other than when I was only breastfeeding her.' (Participant 1, Masi)

A small number of participants described stopping breastfeeding because their babies no longer wanted to breastfeed.

> 'She didn't want to breastfeed, so I just left her.' (Participant 10, Masi)

> 'Then I stopped when he was four months because he didn't want anymore.' (Participant 15, Masi)

Although participants did not explicitly describe fathers' contributions as a motivation for formula feeding, many characterised the fathers' role in narrowly circumscribed terms. Fathers reportedly paid for baby-specific items, such as CMF, rather than contributing to the child's general support.

> 'He's not helping so much. He bought the formula milk until the baby was two years old …' (Participant 1, Zwe)

Breastfeeding was particularly common among women who had young babies during the COVID-19 pandemic. Participants attributed this to being at home with their babies, having an insecure income, their babies preferring breastmilk and, in some cases, a desire to avoid medical visits. One participant from Zweletemba described this situation in detail:

> 'I just kept going and expressing the milk, because my mom said there's no other milk that is better than that milk. And a cousin of mine also has a child. So, I saw when they were feeding her with a bottle, they kept on going to the hospital. I'm like, okay fine, I have too much in my hands, I have this module that I have to do. I need to get some sort of income for my child so that she can have food. I need to have food, so that I can breastfeed her and okay, fine, let me just do the breastfeeding, at least I won't be going up and down to hospital, there's this Corona thing. Let's just avoid the hospital, continue with the breastfeeding, as hard as it was.' (Participant 3, Zwe)

Some women combined breastfeeding and formula feeding to accommodate their work schedules. Hand expressing reflected some participants' efforts to continue breastfeeding. In other cases, breastfeeding was described as tiring and associated with unintended weight loss. Infant-feeding advice in healthcare settings was described as focusing on the promotion of breastfeeding rather than providing detailed guidance on how to breastfeed.

> 'And then someone, like, when give birth at the hospital, nè? They'll say to you, you just breastfeed the baby. They don't even show you how to do it … just feed the baby. Breastfeed the baby, sisi. That's it.' (Participant 1, Zwe)

> 'Yes, they always recommend breastfeeding. They say it's best for the child so that's why I also went for that option.' (Participant 7, Masi)

Participants who formula fed reported that they were not provided with information or counselling on how to prepare or provide formula feeds correctly.

> 'Uhm, to be honest, I hardly get information. Only if it's my visits but if they see nothing wrong about her health, they don't say anything to me.' (Participant 1, Masi)

> 'So, they don't usually teach us how to give the baby formula.' (Participant 7, Masi)

Several participants mentioned the Road to Health Booklet (RtHB), a child health-monitoring tool used in SA, as a source of information that supplemented the limited advice received at clinics.

> 'Because in the clinic book, they check the baby, if you go for a check-up they also see there's a page with growth development and there is everything about children and what they should be eating at the same age. And then they will tell you this is what you should

try. There is something like that about the baby in the clinic book.' (Participant 4, Zwe)

> 'But they don't tell us how. But in the booklet, they show you how to give your baby food and what you must give your baby.' (Participant 15, Masi)

However, not all participants used the RtHB for specific IYCF guidance; some referred to it primarily for advice on rehydration when their babies had diarrhoea. Participants' accounts also suggested that more nuanced messages, such as information about breastmilk supply increasing in response to a baby's growing demand, were not consistently communicated. Older and more experienced women appeared more likely to learn from previous experience and to breastfeed exclusively for longer.

In some cases, participants sought feeding advice from clinics but were unable to follow the recommendations because of cost.

'But I did tell the other sister. They said they are going to put my child in the clinic and they gave me another paper, and they showed me what my child must eat. Because I was so concerned. Even though I knew what is making my child to lose weight, but I was worried and concerned, so I spoke to another sister. And then she told me that, she gave me another paper that my child must eat this and that. But the thing is, I can't even afford what is in there and I didn't even tell them that I can't afford that stuff.' (Participant 2, Zwe)

One participant suggested how the lack of detailed IYCF information at healthcare facilities could be addressed:

> 'So, someone that is going to stand in front of us and tell us how to feed the baby from zero to whatever month. You have to give her this and that. So, that that person can explain that in Xhosa [local language], so that everyone can understand. You, see?' (Participant 1, Zwe)

Participants generally reported introducing foods when their babies were between three and six months old. Early food introduction appeared to be associated with returning to work and a desire to reduce expenditure on CMF. Participants did not explicitly mention using incorrect CMF preparation ratios, but their accounts indicated that infant-feeding choices were influenced by formula being expensive and scarce.

> 'Since I knew that I would have to come back to work. So, I knew that I wouldn't be there to breastfeed so that's when I decided it was time. It's [CMF] too expensive. If it's only the formula, then maybe it would be finished before the end of the week.' (Participant 7, Masi)

Specific brands of CMF and baby food were viewed as aspirational or desirable owing to cost, convenience and palatability. Many of the products mentioned were ultra-processed cereals or porridges.

> 'She's eating Nestum.' (Participant 11, Zwe)

> 'So, I usually give her Cerelac, because it contains 60% of iron. Yes. and it costs about R30, the small one. In the morning, I give her that. Sometimes when I make porridge, I give her porridge. But what I like about the Cerelac is that it has that 60% of iron, that's why I bought it.' (Participant 3, Zwe)

> 'Purity pap cereal. And then vegetables and Smash and all other things.' (Participant 5, Zwe).

> 'For breakfast she's eating Kellogg's Corn Flakes, she loves it.' (Participant 10, Zwe)

Participants' accounts suggested that advertising influences how these products are perceived. When asked which foods they would purchase, participants frequently named products advertised specifically for children. Some also referred to health claims made in advertisements and appeared to accept these claims as accurate.

> 'There's this milk, I can't remember the name now, I used to see it in the television that it helps them crawl and it helps their muscles and their bones like health, if I had enough money, I could buy each and every that.' (Participant 4, Masi)

Foods frequently described as snacks for young children included yoghurt, two-minute or instant noodles and 'Smash', an instant mashed-potato product.

> 'And then in the afternoon, if we didn't cook something in the afternoon to eat something, I bought her that packet of Smash. She likes that a lot. If it's not Smash or the packet of noodles, she's eating the food that I'm eating.' (Participant 10, Zwe)

Discussion

The first phase of the Nourished Child project provided valuable contextual information on mothers' lived experiences of IYCF and first food environments in Masiphumele and Zweletemba in the Western Cape Province of SA.

Mothers who breastfed in the current study described their experiences positively. This is encouraging, given that SA's EBF rate[7] remains far below the global target of 70% EBF at six months by 2030.[16] Some mothers reported that the COVID-19 pandemic enabled them to remain at home with their babies and therefore continue to breastfeed. This may reflect inadequate breastfeeding support in formal and informal workplaces, which may make it difficult for mothers to continue their preferred infant-feeding practices after returning to work.[17]

In the current study, IYCF advice in healthcare settings focused on breastfeeding promotion rather than providing detailed guidance on how to breastfeed or prepare CMF feeds safely. This finding may reveal a lack of skills among healthcare workers to support breastfeeding and related IYCF practices. Various studies have reported inadequate IYCF knowledge and skills among healthcare professionals, limited coverage of breastfeeding in medical curricula and apathy toward breastfeeding in hospital settings.[18,19] Changes within the health professions are therefore needed to improve breastfeeding support, including strengthening health professions education on breastfeeding and newborn development.[20]

The high cost of CMF and increased awareness of the benefits of breastmilk and breastfeeding were reported as factors that supported breastfeeding. Participants' reasons for not breastfeeding or stopping breastfeeding and, consequently, using CMF or introducing solids foods early were consistent with those reported in the 2023 *Lancet* Breastfeeding Series.[17] These included perceived insufficient breastmilk supply, a crying, hungry or fussy baby and short night-time sleep duration. Some mothers in the current study also reported stopping breastfeeding because their babies refused the breast. The may indicate limited understanding of feeding cues or temporary breast refusal, sometimes referred to as a nursing strike. Pérez-Escamilla *et al.*[17] argue that parents, family members and healthcare workers commonly misinterpret normal infant behaviours as signs that the quality or quantity of breastmilk is insufficient. In addition, CMF companies have medicalised

normal infant behaviour and commercialised feeding challenges by marketing CMF as a solution, thereby further damaging breastfeeding practices.[20]

A context-specific finding was that fathers often paid for CMF rather than contributing to their child's general support. This finding should be considered against the backdrop of low paternal involvement in many SA children's lives, with a substantial proportion of fathers not residing with their biological children.[21] In an intervention study by Sonke Gender Justice,[22] participants described SA men using stereotypes such as absent, strong, unfeeling, uninvolved, violent, disengaged, uncaring and 'macho', as well as 'ATM fathers'. Others acknowledged that many fathers wished to be involved in the lives of their children and partners but were sometimes prevented from doing so by the mothers or other family members. In the context of the current study, fathers may have viewed purchasing CMF as a form of care and provision. However, this contribution may have had the unintended effect of undermining breastfeeding.

These findings underscore the importance of creating an enabling environment for breastfeeding that is protected from commercial influence and supported by advocacy.[23] Such efforts should include maternity protection measures, including maternal healthcare, antenatal and postnatal breastfeeding counselling and support, maternity leave, financial and medical benefits, job security, breastfeeding breaks, flexible working arrangements, such as working from home, protection from discrimination[24] and positive paternal involvement in domestic and caregiving roles.[21]

Ultra-processed commercially produced complementary foods (CPCF) were prevalent choices in the study sites. Participants' accounts indicated that these foods were desirable and that purchasing behaviours were influenced by marketing, including advertisements and health claims. Research conducted in SA has identified insufficient knowledge of appropriate complementary foods and how to prepare nutritious diets for children, together with the effort involved in food preparation, as barriers to optimal complementary feeding practices.[8] Low perceived self-efficacy in preparing traditional foods enriched with vegetables and fruits has also been identified as a barrier in this context.[8,25]

These challenges are compounded by the cost of healthy food, which is often higher than that of non-nutritious foods.[26] The global food system is characterised by the widespread availability of processed foods that are relatively cheap compared with unprocessed foods, while the food industry invests substantially in increasing their desirability.[26] Large food corporations can influence purchasing decisions by shaping consumers' perceptions of certain foods, particularly unhealthy foods and Ultra-Processed Products.[4] The proliferation of these products in the food system contributes to the obesity pandemic and the development of non-communicable diseases in adulthood.[27]

Barnard *et al.*[28] profiled CPCF for infants and young children in SA. They found that the national baby-food market was characterised predominantly by sweet CPCF that were high in sugar and frequently contained flavourings. Almost half of the cereals and porridges assessed were indicated as suitable for introduction from six months of age; however, most contained up to three flavourings, which may adversely affect taste and food preferences, dietary habits and health outcomes during childhood and later life.[29-31] Barnard *et al.*[28] also found that only half of the products assessed complied with all SA labelling regulations relating to flavourings, while most violated labelling regulations governing composition or nutritional claims. These findings demonstrate the need for structures to enforce the regulations and ensure compliance among baby-food manufacturers.

The findings of the current study also strengthen the case for promulgating the SA Draft Regulations relating to the labelling and advertising of foods.[32] These regulations aim to restrict the marketing of unhealthy foods to children and specify criteria relating to the age range covered (0 - 18 years), the times during which such marketing may not occur, the types of health messages permitted and the definition of unhealthy foods.[32]

Conclusions and recommendations

IYCF practices are shaped by multiple factors and by interactions among the systems within which people live.[4] Although SA IYCF policy and legislation explicitly support breastfeeding, guidance from healthcare facilities in the study settings was reported as insufficient. Mothers expressed a need for greater support and clearer translation of IYCF guidelines into practical advice. The finding that more mothers chose to breastfeed while at home with their children highlights the need for workplaces to take greater responsibility for promoting and protecting breastfeeding practices.

Early complementary feeding, often involving UPPs, was common and appeared to be driven by the high cost of healthy food in these urban communities, work arrangements, product desirability and food marketing. The IYCF practices and first food environments described in these vulnerable communities are cause for concern and may have important implications for immediate and long-term health outcomes.

The findings point to disconnects among the health, food, education, urban, social and economic systems. Greater alignment among these systems is needed to improve IYCF through a portfolio of complementary and mutually reinforcing actions. The healthcare system should prioritise effective education, advocacy efforts and practical skills development throughout the breastfeeding and complementary feeding periods. This should be supported by food-system measures that restrict marketing and misleading information that exploit the vulnerabilities of caregivers and children. Although consumer education is important, responsibility should not rest solely with end users.

Urban planning should promote more inclusive first food environments. Social and economic systems should also pay particular attention to issues of gender equality, given that women often bear responsibility for food provision and caregiving alongside paid work. Interventions to encourage greater paternal involvement and support are also recommended.

Policymakers and practitioners committed to improving IYCF will need to drive change across multiple levels of government through a co-ordinated, coherent and stepwise multisectoral approach. Initial actions should have an explicit child-centred focus and prioritise those most likely to improve first food environments.[33,34]

Limitations

Purposive sampling is commonly used in qualitative research; however, recruitment through known community facilitators may have introduced selection bias and excluded caregivers who were not part of the facilitators' networks. Similarly, snowball sampling may have resulted in a relatively homogeneous sample. Although remote or telephonic interviews have been widely used, particularly since the COVID-19 pandemic, this mode of data collection may have limited rapport, the depth of participants' responses and the researchers' ability to observe non-verbal cues.

Data availability statement. All relevant data in the article are available from the corresponding author on request.

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