PEER REVIEW HISTORY

ARTICLE DETAILS

TITLE (PROVISIONAL)	Experiences of Nicotine Users Motivated to Quit During the COVID-19 Pandemic: A Secondary Qualitative Analysis
AUTHORS	Sharma, Ramona; Rodberg, Danielle; Struik, Laura

VERSION 1 – REVIEW

REVIEWER	McKell, Jennifer University of Stirling, Institute for Social Marketing
REVIEW RETURNED	16-Jan-2023

GENERAL COMMENTS	This is an interesting and well-written paper and I recommend it for publication. However, I also recommend it be revised, and in a way that accentuates the most novel findings from the research and the issues that were most prominent and particular to the time, for example the extreme isolation and the restrictions of leaving your home. Very interesting that some perceived smoking as an opportunity to leave their home during restrictions. Also, that one person said the pandemic caused them to start smoking due to being confined at home with smokers! We already know about the links between stress or boredom and smoking. I don't think this should be downplayed or ignored but I think more could be done to draw out and highlight what was different and new in this situation. Additionally, in terms of methods, I'd like to see more explanation of the terms 'auto-driven'. Also, could the term 'non-indigenous' be explained further? This may have particular resonance in BC or Canada generally but it's not clear to me who would make up a non-indigenous population. Furthermore, given over a quarter of the sample were from an indigenous population would it be possible to include any findings specific to this population, as I think that would be a valuable addition? Or is that the subject of another paper? I see that the authors acknowledge the need for cessation programs to be accessible to indigenous people at the end of the discussion so it feels like a missed opportunity to not highlight the perspectives of this population in the results. Regarding information on research ethics. I think it would be helpful to know within the text, the process for obtaining informed consent from participants in the original study such as: was an information sheet provided and how long were participants given to consider the information before making a decision to take part. Also, was informed consent provided in writing or verbally? I think it would also be helpful to make clear in the Patient Consent section that this wasn't required because the study involved secondary analysis.

	The references used are appropriate but there is a heavy reliance on Canadian statistics and research related to the Covid pandemic. There is one obvious reference to research from the Netherlands but I think it would be helpful to include evidence from other countries and regions of the world to set the study within a wider context, particularly if the intention is to appeal to an international audience. The SRQR checklist suggests that the authors have explored why they chose the qualitative approach that they followed but I don't think this has been explored. Can the authors provide a rationale for why they used the method that they used? Particularly, why they opted to analyse on the basis of key words used? Additionally, I think there could be more included about the context for the research, particularly the Covid restrictions implemented in BC at the time. The nature of restrictions in BC were included as a limitation to the study due to implications for generalizability but it's not clear what the restrictions were so it's difficult for readers to consider this.

REVIEWER	Kaufman, Pamela The Ontario Tabacco Research Unit, Centre for Addiction and Mental Health
REVIEW RETURNED	06-Mar-2023

GENERAL COMMENTS	This paper reports the results of a qualitative study that examined the cessation experiences of nicotine users (smoking/vaping) during the COVID-19 pandemic. Secondary data related to COVID-19 specific barriers and facilitators to quitting nicotine were obtained from a larger study that employed semi-structured qualitative interviews. The paper is well written and the results are timely and relevant to understanding and supporting cessation needs of people motivated to quit smoking and/or vaping within pandemic or post-pandemic contexts. I have just a few comments below: In the Introduction, the reporting of statistics for smoking and vaping pre-pandemic (2019) to pandemic (2020, 2021) are confusing. Specifically, on p.3 line 18-23, data from the CTNS is used to show an increase in vaping in 2021 (55%) compared to 2019 (44%). However, line 41-42 states that 14% of young Canadians reported vaping regularly in 2020, a slight decrease from 15% in 2019. It's not clear whether the age ranges are equivalent so appears contradictory. Also, the pandemic comparison years are different (2021 and 2020), and a 1% difference is not a strong comparison. Similarly, line 22/23 states that there was a 3% increase in smoking among Canadian smokers from before to during the pandemic; where line 43-45 states that cigarette use decreased considerably between 2019 and 2020 for aged 25+ (by 12%) and 15-129 (by 5%). I suggest describing only the primary trends for vaping and smoking from 2019 to 2021 using CTNS data preferably from same years and age categories. Table 1, 'Themes and sub themes identified in participant responses and their associated frequencies'. It is not entirely clear whether the frequencies represent the number of unique respondents who identified a theme and sub-theme, or the number of themes and subthemes. For example, are there 21 unique respondents who identified barriers to quitting, or are there 21 barriers to quitting identified among the 33 respondents (a respondent could presumably identify more than 1 barrier). This should be clarified in

	the text and Table. On p.9, line 39: Please double check reference 24. The statement is about social support as an integral element of cessation, but the reference is for a WHO document entitled 'COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide'. p. 9 (line 20-23): An important point its made about ensuring that people who face greater systemic barriers, such as Indigenous and rural populations, can access cessation supports. The authors may want to consider expanding on this, e.g., ensuring cessation programs are culturally appropriate, that necessary information and technology is available to access supports, confidentiality when using online discussion and video platforms, etc.

VERSION 1 – AUTHOR RESPONSE

Reviewer: 1 Ms. Jennifer McKell, University of Stirling

Comments to the Author:

1. This is an interesting and well-written paper and I recommend it for publication. However, I also recommend it be revised, and in a way that accentuates the most novel findings from the research and the issues that were most prominent and particular to the time, for example the extreme isolation and the restrictions of leaving your home. Very interesting that some perceived smoking as an opportunity to leave their home during restrictions. Also, that one person said the pandemic caused them to start smoking due to being confined at home with smokers! We already know about the links between stress or boredom and smoking. I don't think this should be downplayed or ignored but I think more could be done to draw out and highlight what was different and new in this situation.

RESPONSE: Thank you so much for this valuable feedback. We completely agree with the importance of accentuating novel findings from this research and highlighting how these were unique to the COVID-19 landscape, as opposed to generalizable under, e.g., stress and boredom as known from previous literature. To do this, we have expanded our Results in the following ways: for clarity, we have added an additional column in Table 2 describing the specific COVID-related impacts on participant nicotine behaviors (i.e., provided examples for each theme); we have included additional participant quotes as well as expanded a few previously included quotes to capture more context with respect to how these experiences were unique to the pandemic, e.g., isolation being exacerbated by the uncertainty of if/when COVID might end; and we have commended on these additional findings in the Discussion.2. Additionally, in terms of methods, I'd like to see more explanation of the terms 'auto-driven'. Also, could the term 'non-indigenous' be explained further? This may have particular resonance in BC or Canada generally but it's not clear to me who would make up a non-indigenous population. Furthermore, given over a quarter of the sample were from an indigenous population would it be possible to include any findings specific to this population, as I think that would be a valuable addition? Or is that the subject of another paper? I see that the authors acknowledge the need for cessation programs to be accessible to indigenous people at the end of the discussion so it feels like a missed opportunity to not highlight the perspectives of this population in the results.

RESPONSE: This makes perfect sense - thank you! Regarding the term “auto-driven”, we have expanded upon our description of our qualitative methodology - specifically the motivations and techniques behind secondary analysis - as well as defined “auto-driven”. We also note that the term

“auto-driven” is not a common one; as such, we have opted to utilize more current, descriptive, and widely disseminated terminologies regarding our methods, such as “supplementary secondary analysis” and “post-hoc retrospective interpretation”.

RESPONSE: Regarding findings from Indigenous participants, we acknowledge that our previous description of “non-Indigenous” may not be clear to readers outside a Canadian context, and further does not capture participant demographics at all. As such, for clarity and accuracy, instead of using that term, we have opted to instead provide a breakdown of participant demographic characteristics including race/ethnicity (Table 1). In addition, we have defined the term “Indigenous” as used in this paper in the first paragraph of the Results section.

RESPONSE: Although we are working on a paper focusing on Indigenous participant experiences as part of the primary study, that paper does not look at COVID-19 experiences. Therefore, we completely concur that as a quarter of this sample were Indigenous, including findings specific to this population and context is essential (and also because this is a vulnerable population with unique susceptibilities regarding tobacco and addition in a Canadian postcolonial context). We have re-examined our data comparing Indigenous and non-Indigenous participants; we did not find differences in endorsed themes, but we did find unique nuances in participant experiences regarding barriers faced (e.g., pandemic-specific traumas) and suggestions for programming (e.g., ceremonial and cultural practices for cessation). We have specified which quotes were endorsed by Indigenous participants to provide voice to them, and have discussed said nuances in our revised Discussion.

3. Regarding information on research ethics. I think it would be helpful to know within the text, the process for obtaining informed consent from participants in the original study such as: was an information sheet provided and how long were participants given to consider the information before making a decision to take part. Also, was informed consent provided in writing or verbally? I think it would also be helpful to make clear in the Patient Consent section that this wasn't required because the study involved secondary analysis.

RESPONSE: Absolutely - thank you for pointing this out. We have revised our Methods and Patient Consent sections to expand on the process of obtaining informed consent in the primary study and have incorporate your suggestions.

4. The references used are appropriate but there is a heavy reliance on Canadian statistics and research related to the Covid pandemic. There is one obvious reference to research from the Netherlands but I think it would be helpful to include evidence from other countries and regions of the world to set the study within a wider context, particularly if the intention is to appeal to an international audience.

RESPONSE: We completely concur with this and are grateful that you pointed this out. We have revised our Introduction to include statistics and trends regarding nicotine use during COVID-19 from various countries, i.e., the US, Scotland, and New Zealand.

5. The SRQR checklist suggests that the authors have explored why they chose the qualitative approach that they followed but I don't think this has been explored. Can the authors provide a rationale for why they used the method that they used? Particularly, why they opted to analyse on the basis of key words used? Additionally, I think there could be more included about the context for the research, particularly the Covid restrictions implemented in BC at the time. The nature of restrictions in BC were included as a limitation to the study due to implications for generalizability but it's not clear what the restrictions were so it's difficult for readers to consider this.

RESPONSE: This is very important. We have expanded our Methods section to include a greater discussion of our analytical procedure, why we chose to analyze data this way (both in terms of the overall qualitative methodology and on the basis of keywords), and why we chose the keywords we did.

RESPONSE: We are grateful for the insight this comments provides, and acknowledge that, outside a BC or Canadian context, the findings and discussions provided in this paper may not make much sense without providing the background behind the main reason for the isolation experienced by participants. As such, we have added a summary description of BC-wide COVID protective measures at the time of data collection towards the beginning of our Discussion.

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Reviewer: 2 Dr. Pamela Kaufman, The Ontario Tabacco Research Unit

Comments to the Author:

This paper reports the results of a qualitative study that examined the cessation experiences of nicotine users (smoking/vaping) during the COVID-19 pandemic. Secondary data related to COVID-19 specific barriers and facilitators to quitting nicotine were obtained from a larger study that employed semi-structured qualitative interviews. The paper is well written and the results are timely and relevant to understanding and supporting cessation needs of people motivated to quit smoking and/or vaping within pandemic or post-pandemic contexts. I have just a few comments below: 1. In the Introduction, the reporting of statistics for smoking and vaping pre-pandemic (2019) to pandemic (2020, 2021) are confusing. Specifically, on p.3 line 18-23, data from the CTNS is used to show an increase in vaping in 2021 (55%) compared to 2019 (44%). However, line 41-42 states that 14% of young Canadians reported vaping regularly in 2020, a slight decrease from 15% in 2019. It's not clear whether the age ranges are equivalent so appears contradictory. Also, the pandemic comparison years are different (2021 and 2020), and a 1% difference is not a strong comparison. Similarly, line 22/23 states that there was a 3% increase in smoking among Canadian smokers from before to during the pandemic; where line 43-45 states that cigarette use decreased considerably between 2019 and 2020 for aged 25+ (by 12%) and 15-129 (by 5%). I suggest describing only the primary trends for vaping and smoking from 2019 to 2021 using CTNS data preferably from same years and age categories.

RESPONSE: Thank you so much for your comprehensive feedback - we truly appreciate it. Upon revision of our Introduction, we agree that the manner in which we reported these statistics may appear confusing to readers. As such, we have attempted to present Canadian, as well as international statistics, in the manner described - from the same years and age categories. 2. Table 1, 'Themes and sub themes identified in participant responses and their associated frequencies'. It is not entirely clear whether the frequencies represent the number of unique respondents who identified a theme and sub-theme, or the number of themes and subthemes. For example, are there 21 unique respondents who identified barriers to quitting, or are there 21 barriers to quitting identified among the 33 respondents (a respondent could presumably identify more than 1 barrier). This should be clarified in the text and Table.

RESPONSE: We agree that this was unclear. We have added footnotes to each table as well as described in the body of the text immediately preceding the table what the ’n’ means and what the percentages are a proportion of. 3. On p.9, line 39: Please double check reference 24. The statement is about social support as an integral element of cessation, but the reference is for a WHO document entitled 'COVID-19 pandemic triggers 25% increase in prevalence of anxiety and depression worldwide'.

RESPONSE: Thank you for catching this error - we have revised this. 4. p. 9 (line 20-23): An important point its made about ensuring that people who face greater systemic barriers, such as Indigenous and rural populations, can access cessation supports. The authors may want to consider expanding on this, e.g., ensuring cessation programs are culturally appropriate, that necessary information and technology is available to access supports, confidentiality when using online discussion and video platforms, etc.

RESPONSE: Thank you for pointing out such an important element. This was also mentioned by another reviewer, and we completely concur that as a quarter of this sample was Indigenous, including findings specific to this population and context is key. To provide more than just lip service in discussing supports for this population, we re-examined our data comparing Indigenous and non-Indigenous participants; we did not find differences in endorsed themes, but we did find nuances in participant experiences on barriers faced and suggestions for programming. We have discussed these nuances in our revised Discussion and included examples of how cessations supports can face the unique vulnerabilities faced by Indigenous nicotine users in a more culturally appropriate manner.

VERSION 2 – REVIEW

REVIEWER	McKell, Jennifer University of Stirling, Institute for Social Marketing
REVIEW RETURNED	01-May-2023

GENERAL COMMENTS	My thanks to the authors for the extensive revisions to their earlier draft in response to my comments. I particularly appreciate the extra detail provided in relation to the methods used and also further information on the participant sample. I also appreciate that you have considered and highlighted in the paper potential differences in the experiences of Indigenous people. Unfortunately I have continuing concerns about the results section. I can see that the authors have responded to my request for them to accentuate the more novel findings from their study but I think this has highlighted something I didn't fully recognise before. I can more easily see now that the Results section lacks a level of interpretation and summary that makes it accessible and useful to readers. For instance the first section on barriers to quitting covers multiple issues including lack of opportunities to socialise; boredom; smoking keeping hands busy; uncertainty about Covid restrictions causing stress; Zoom fatigue, smoking providing opportunities to go outside; a lack of family support; living with smokers; being at home all day rather than at work being problematic, stress and lack of mental health support. The amount of detail is very hard for the reader to process and be able to distinguish between what was more or less important to the participants. What readers need from the authors is to guide us in what this detail essentially says. The authors are part of the way there in identifying the broader themes of barriers to smoking cessation in increased boredom and increased stress but these are partially hidden in a narrative busy with minority experiences, the wider meaning of which are difficult to discern. One theme that I think this discussion of barriers might be highlighting but doesn't identify is that perhaps smoking may have taken on new meanings for participants, for instance, as a way to cope with suddenly different home and work environments?? I think each of the results section would benefit from the authors taking a step back and considering what are the broader themes that are identifiable. Specific experiences are still important to highlight but only where their meaning cannot be included in discussion of a broader theme. Also, for similar reasons, I'm uncertain of the value of Table 2 involving such granular detail as well as including frequencies and percentage in what is intended as a qualitative paper. Two smaller issues include the use of the term 'auto-driven' and also some of the statistics discussed in the introduction. I think the term 'auto-driven' is confusing and unnecessary. The authors' welcome explanation of this term in the revised draft is sufficient to understand that this study

	arose from inductive themes that arose within interviews designed as part of a bigger study of barriers and facilitators to cessation and supports available in BC. I would recommend dropping this term in favour of your more transparent description. Additionally, I wanted to highlight an issue with the new Scottish statistics used in the introduction. The researchers behind these statistics ask for caution in interpreting the large drop in smoking between 2019 and 2021 due to a change in data collection for the relevant survey, due to the pandemic and the restrictions it introduced but this is not highlighted in the paper. I haven't checked whether surveys from other countries, also included in the introduction, also caution careful interpretation due to changes to data collection during the pandemic but this is a possibility worth looking into and highlighted if relevant. Finally, the SRQR checklist has not been fully updated since the last version with the manuscript now much longer.

REVIEWER	Kaufman, Pamela The Ontario Tabacco Research Unit, Centre for Addiction and Mental Health
REVIEW RETURNED	24-Apr-2023

GENERAL COMMENTS	Thank you to the authors for addressing reviewers' comments so comprehensively. Specifically, the comparison of Indigenous and non-Indigenous participant data, and inclusion of nuances regarding Indigenous participant experiences and suggestions for programming have elevated this paper's contribution.

VERSION 2 – AUTHOR RESPONSE

Reviewer: Ms. Jennifer McKell, University of Stirling

COMMENT 1:
I think the term 'auto-driven' is confusing and unnecessary. The authors' welcome explanation of this term in the revised draft is sufficient to understand that this study arose from inductive themes that arose within interviews designed as part of a bigger study of barriers and facilitators to cessation and supports available in BC. I would recommend dropping this term in favour of your more transparent description.

RESPONSE 1:
We understand that the term “auto-driven” might be confusing for readers and agree with your suggestion of dropping it in favor of the detailed description of our methods. We have removed the term “auto-driven” from the paper.

COMMENT 2:
I wanted to highlight an issue with the new Scottish statistics used in the introduction. The researchers behind these statistics ask for caution in interpreting the large drop in smoking between 2019 and 2021 due to a change in data collection for the relevant survey, due to the pandemic and the restrictions it introduced but this is not highlighted in the paper. I haven't checked whether surveys from other countries, also included in the introduction, also caution careful interpretation due to changes to data collection during the pandemic but this is a possibility worth looking into and highlighted if relevant.

RESPONSE 2:
We appreciate you bringing this valuable concern to light and agree that data collection differences before and after COVID subject any findings to biases. We have examined all the included statistics for warnings about methodological challenges/potential biases and found similar disclosures in the cited statistics reports from the US and the Netherlands. As such, we have included a caution to readers about this possible source of bias in our introduction (highlighted in green text with respective citations).

COMMENT 3:
The SRQR checklist has not been fully updated since the last version with the manuscript now much longer.

RESPONSE 3:
Thank you for bringing to our attention the missed details in the SRQR checklist. We have revised the checklist to mirror the most recent version of the paper (attached).

COMMENT 4:
Unfortunately I have continuing concerns about the results section. I can see that the authors have responded to my request for them to accentuate the more novel findings from their study but I think this has highlighted something I didn't fully recognise before. I can more easily see now that the Results section lacks a level of interpretation and summary that makes it accessible and useful to readers. For instance the first section on barriers to quitting covers multiple issues including lack of opportunities to socialise; boredom; smoking keeping hands busy; uncertainty about Covid restrictions causing stress; Zoom fatigue, smoking providing opportunities to go outside; a lack of family support; living with smokers; being at home all day rather than at work being problematic, stress and lack of mental health support. The amount of detail is very hard for the reader to process and be able to distinguish between what was more or less important to the participants. What readers need from the authors is to guide us in what this detail essentially says. The authors are part of the way there in identifying the broader themes of barriers to smoking cessation in increased boredom and increased stress but these are partially hidden in a narrative busy with minority experiences, the wider meaning of which are difficult to discern. One theme that I think this discussion of barriers might be highlighting but doesn't identify is that perhaps smoking may have taken on new meanings for participants, for instance, as a way to cope with suddenly different home and work environments?? I think each of the results section would benefit from the authors taking a step back and considering what are the broader themes that are identifiable. Specific experiences are still important to highlight but only where their meaning cannot be included in discussion of a broader theme. Also, for similar reasons, I'm uncertain of the value of Table 2 involving such granular detail as well as including frequencies and percentage in what is intended as a qualitative paper.

RESPONSE 4:
We appreciate your feedback on reporting of our findings and the use of summative versus deeper interpretive themes both in-text and within our tabled findings.

The aim of our study was to report experiences of nicotine users hoping to quit during COVID-19 using qualitative conventional content analysis as a specifically chosen methodology. As of today, there is not much known about the experiences of end-users during COVID. Based on previous literature and conventions, descriptive (rather than interpretive) methodologies such as content analysis are best suited when creating an evidence base around a topic that there’s little known about [1].

We chose inductive content analysis as an appropriate method in this situation as it generates organized categories of new information without imposing preconceived theoretical perspectives and interpretations on the findings [2]. Due to its classificatory nature, it is a hallmark of content analysis to report emergent and data-driven categories, themes, and sub-themes, as well as include descriptive statistics (e.g., frequencies and percentages of endorsement) to allow for quantification of categories, themes, and sub-themes within data [1, 3].

We have provided citations of existing literature (examples of content analysis) to situate applications of content analysis and demonstrate that our paper follows conventions for output in accordance with content analyses in the published literature:

Examples of qualitative content analyses published in BMJ:

1. Fitch MI, Nicoll I, Lockwood G. Exploring the reasons cancer survivors do not seek help for their concerns: a descriptive content analysis. BMJ Supportive & Palliative Care. 2020 Sep 21;bmjspcare-2020-002313.
2. Nickel B, Moynihan R, Barratt A, Brito JP, McCaffery K. Media coverage of calls to rename low-risk cancers: a content analysis. BMJ Open. 2020 Jul;10(7):e038087.

Examples of qualitative content analyses published in other journals:

1. Collins SE, Orfaly VE, Wu T, Chang S, Hardy RV, Nash A, et al. Content analysis of homeless smokers' perspectives on established and alternative smoking interventions. The International journal on drug policy [Internet]. 2018 Jan 1 [cited 2020 Jun 28];51:10–7. Available from: http://eds.b.ebscohost.com/eds/detail/detail?vid=5&sid=7faa7c11-19c1-4cfc-b877-7d77f8e40ca1%40pdc-v-sessmgr05&bdata=JnNpdGU9ZWRzLWxpdmU%3d#AN=29144995&db=cmedm
2. Pulvers K, Rice M, Ahluwalia JS, Arnold MJ, Marez C, Nollen NL. "It is the One Thing that has Worked": facilitators and barriers to switching to nicotine salt pod system e-cigarettes among African American and Latinx people who smoke: a content analysis. Harm Reduction Journal. 2021 Sep 16;18(1).
3. Swogger MT, Hart E, Erowid F, Erowid E, Trabold N, Yee K, et al. Experiences of Kratom Users: A Qualitative Analysis. Journal of Psychoactive Drugs. 2015 Oct 20;47(5):360–7.
4. Struik LL, Dow-Fleisner S, Belliveau M, Thompson D, Janke R. Tactics for drawing youth to vaping: A content analysis of e-cigarette advertisements. Journal of Medical Internet Research. 2020 Mar 28;22(8).

In contrast, reporting higher-level, interpretive themes (i.e., an "overall story") without a requirement of frequency counting is a hallmark of thematic analysis, an analytic procedure typically better-suited for generating new insights about an existing phenomenon [4]. For this study, a thematic analysis would have involved extracting high-level themes and providing insight on how these themes relate to one another [2-3]. However, we felt that wasn't appropriate for this topic as we wanted to remain true to the research question and to participant accounts by providing minimum interpretation with maximum description to allow for explanation of a new phenomenon (experiences of cessation during COVID), as opposed to generate new insights about an established phenomenon.

As such, based on the aims of our paper, we have opted to (a) maintain our reporting of categories, themes, and sub-themes as they are, and (b) include the granular findings (rather than collapse them based on our judgments) in order to (a) remain true to the methodology - rigorous content analysis - and (b) remain true and unbiased to participant accounts. By being presented prior to the in-text descriptions and quotations of participant experiences, Table 2 therefore provides the reader with a summative snapshot of the overarching categories and themes endorsed by participants, complete

with the details (including frequencies and percentages) that fall within these.

We hope the above explanation provides clarity behind our methodological rationale with regards to our interpretation and presentation of findings. For clarity, we have included the term “content analysis” and provided a bit more detail about what it entails at the beginning of our Methods section (highlighted in green text) as well as in the Abstract in addition to its previous inclusion in the Data Analysis sub-section.

References

1. Elo S, Kyngäs H. The qualitative content analysis process. Journal of Advanced Nursing [Internet]. 2008 [cited 2023 May 17];62(1):107–15. Available from: https://pubmed.ncbi.nlm.nih.gov/18352969/
2. Humble N, Mozelius P. Content Analysis or Thematic Analysis: Doctoral Students’ Perceptions of Similarities and Differences. Electronic Journal of Business Research Methods. 2022 Nov 8;20(3):89–98.
3. Heaton J. Reworking qualitative data. London; Thousand Oaks, California: Sage; 2004.
4. Vaismoradi M, Turunen H, Bondas T. Content analysis and thematic analysis: Implications for conducting a qualitative descriptive study. Nursing & Health Sciences [Internet]. 2013 Mar 11 [cited 2023 May 17];15(3):398–405. Available from: https://onlinelibrary.wiley.com/doi/full/10.1111/nhs.12048