Reflexive Thematic Analysis for Applied Qualitative Health Research

Karen A. Campbell
Western University, kcamp232@uwo.ca

Elizabeth Orr
McMaster University

Pamela Durepos
McMaster University

Linda Nguyen
McMaster University

Lin Li
McMaster University

See next page for additional authors

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Abstract

Thematic analysis is a widely cited method for analyzing qualitative data. As a team of graduate students, we sought to explore methods of data analysis that were grounded in qualitative philosophies and aligned with our orientation as applied health researchers. We identified reflexive thematic analysis, developed by Braun and Clarke, as an interpretive method firmly situated within a qualitative paradigm that would also have broad applicability within a range of qualitative health research designs. In this approach to analysis, the subjectivity of the researcher is recognized and viewed not as problematic but instead valued as integral to the analysis process. We therefore elected to explore reflexive thematic analysis, advance and apply our analytic skills in applied qualitative health research, and provide direction and technique for researchers interested in this method of analysis. In this paper, we describe how a multidisciplinary graduate student group of applied health researchers utilized Braun and Clarke's approach to reflexive thematic analysis. Specifically, we explore and describe our team's process of data analysis used to analyze focus group data from a study exploring postnatal care referral behavior by traditional birth attendants in Nigeria. This paper illustrates our experience in applying the six phases of reflexive thematic analysis as described by Braun and Clarke: (1) familiarizing oneself with the data, (2) generating codes, (3) constructing themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the report. We highlight our experiences through each phase, outline strategies to support analytic quality, and share practical activities to guide the use of reflexive thematic analysis within an applied health research context and when working within research teams.

Keywords

applied qualitative health research, reflexive thematic analysis, subjectivity

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Authors

Karen A. Campbell, Elizabeth Orr, Pamela Durepos, Linda Nguyen, Lin Li, Carly Whitmore, Paige Gehrke, Leslie Graham, and Susan M. Jack

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Karen A. Campbell
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Elizabeth Orr
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Pamela Durepos
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Linda Nguyen
School of Rehabilitation Science, McMaster University, Hamilton, Ontario, Canada

Lin Li
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Carly Whitmore
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Paige Gehrke
School of Nursing, McMaster University, Hamilton, Ontario, Canada

Leslie Graham
School of Rehabilitation Science, McMaster University, Hamilton, Ontario, Canada

Susan M. Jack
Arthur Labatt Family School of Nursing, Western University, London, Ontario, Canada

Thematic analysis is a widely cited method for analyzing qualitative data. As a team of graduate students, we sought to explore methods of data analysis that were grounded in qualitative philosophies and aligned with our orientation as applied health researchers. We identified reflexive thematic analysis, developed by Braun and Clarke, as an interpretive method firmly situated within a qualitative paradigm that would also have broad applicability within a range of qualitative health research designs. In this approach to analysis, the subjectivity of the researcher is recognized and viewed not as problematic but instead valued as integral to the analysis process. We therefore elected to explore reflexive thematic analysis, advance and apply our analytic skills in applied qualitative health research, and provide direction and technique for researchers interested in this method of analysis. In this paper, we describe how a multidisciplinary graduate student group of applied health researchers utilized Braun and Clarke's approach to reflexive thematic analysis. Specifically, we explore and describe our team's process of data analysis used to analyze focus group data from a study exploring postnatal care referral behavior by traditional birth attendants

in Nigeria. This paper illustrates our experience in applying the six phases of reflexive thematic analysis as described by Braun and Clarke: (1) familiarizing oneself with the data, (2) generating codes, (3) constructing themes, (4) reviewing potential themes, (5) defining and naming themes, and (6) producing the report. We highlight our experiences through each phase, outline strategies to support analytic quality, and share practical activities to guide the use of reflexive thematic analysis within an applied health research context and when working within research teams.

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Commonly, qualitative researchers identify thematic analysis as their method for data analysis yet fail to provide a clear description of the strategies applied to make sense of their data. Creating more challenges to the field, is the ubiquity of the term *thematic analysis* and its varied, and often inconsistent, definitions and application across different disciplines. Broadly, thematic analysis is an approach to qualitative data analysis that results in the development of themes reflective of the data (Braun & Clarke, 2006; Clarke et al., 2019; Gerritse et al., 2018; Guest et al., 2011; Roberts et al., 2019; Tuckett, 2005; Vaismoradi et al., 2013). While some approaches to thematic analysis have embedded assumptions and underpinnings that lend themselves towards a more positivist research stance, reflexive thematic analysis, developed by Braun and Clarke (2006), is an interpretive method firmly situated within a qualitative paradigm and as such a viable analytic option for qualitative health researchers. The purpose of this paper is to share our understanding of Braun and Clarke's reflective thematic analysis and outline our experience of applying the analytic method to an existing dataset – all while highlighting the applicability of the method for use within applied research contexts and researching with teams.

All contributing authors of this paper meet monthly as a group of graduate students interested in qualitative health research and supported by a faculty member (SMJ) who has extensive experience in designing, conducting, and teaching qualitative research. The majority of this group are registered nurses enrolled as students in the School of Nursing, McMaster University and Western University (Ontario, Canada) at the PhD or Master's level, and also includes a PhD student in the School of Rehabilitation Sciences. The group agenda focuses on student-generated items or topics, including student-driven explorations of qualitative methods, analysis of members' qualitative data sets, building research communication capacity, resource sharing, and peer support. A shared need identified by the group was for practical, "hands-on" experience in qualitative analysis; therefore, we sought to learn together and engage in the process of reflective thematic analysis as laid out by Braun and Clarke (2006).

Methodological and Data Analytic Approach Overview

Reflexive Thematic Analysis

Definitions of thematic analysis as well as methodological guidance for its use have been described in multiple, and varied ways, thus leading to considerable confusion among researchers and even inappropriate use (Braun & Clarke, 2019; Terry et al., 2017). Previously, authors such as Boyatsiz (1998) and Joffe and Yardly (2004) developed recommendations for the application of thematic analysis, however, Braun and Clarke have most significantly

demarcated this technique and designated it *reflexive* thematic analysis. In contrast to other approaches to qualitative data analysis, such as grounded theory (Glaser, 1992; Strauss & Corbin, 1998) or interpretative phenomenological analysis (Smith & Osborn, 2003), reflexive thematic analysis is described as independent of theory and epistemology (Braun & Clarke). This independence from a specific theoretical framework permits broad, and flexible application of the analytic approach across a range of epistemologies - including essentialist and constructionist paradigms (Braun & Clarke). From initial conceptualization of the research study to the process of data analysis, epistemology informs the description of data as well as how meaning is theorized (Braun & Clarke).

It is important to note that the epistemological flexibility permitted with reflexive thematic analysis does not mean that theory and epistemology are optional (Clarke & Braun, 2018). Rather, the researcher is responsible for selecting theory and epistemology, and ensuring that reflexive thematic analysis fits within that selected philosophical approach. Braun and Clarke argue that their *reflexive* approach to thematic analysis should be firmly situated within a *Big Q* qualitative orientation (qualitative research conducted within an interpretivist paradigm), instead of a *small q* qualitative orientation (qualitative tools used within a positivist paradigm; Clarke & Braun, 2018). Braun and Clarke (2019) have classified different subtypes of thematic analysis. These subtypes include: (1) reflexive thematic analysis, which takes an organic approach to analysis and is classified as Big Q thematic analysis; (2) codebook thematic analysis, which uses a structured coding process for analysis and is referred to as medium Q thematic analysis; and, (3) coding reliability thematic analysis, which emphasizes reliability and accuracy of the coding and is classified as small q thematic analysis (Braun & Clarke, 2019; Clarke & Braun, 2018). We have focused on reflexive thematic analysis because it allows the researcher to determine the outcome and focus of the work as opposed to being bound to a specific theoretical framework. We chose this given the applied nature of qualitative health research, along with our commitment to interpretivism.

Key Decisions in Reflexive Thematic Analysis

The flexibility of reflexive thematic analysis stems not only from its applicability to a range of theory and epistemologies, but also from the possible choices made available to the researcher within the approach. These choices require the researcher to make some key decisions related to what counts as a theme, as well as the type, approach, and level of analysis (Braun & Clarke, 2006).

What Counts as a Theme. Ultimately, what counts as a theme is determined by the sound judgement of the researcher. When deciding what counts as a theme, Braun and Clarke (2006) suggest considering the prevalence and *keyness* of a theme (i.e., the ability of the theme to capture what is important considering the research question) and applying the same criteria consistently across the data). Ideally, there will be numerous occurrences of a theme across the data set, but higher prevalence does not necessarily equate to higher importance. Rather, the *keyness* of a theme can be judged on whether it is essential to addressing the overall research question.

Type of Analysis. Another important decision concerns the type of analysis to focus on. Researchers have the option of providing a rich description of the entire data set, or an in-depth account about one particular aspect of the data (Braun & Clarke). Researchers must also decide whether to take an inductive or theoretical approach to analysis. In an inductive approach, the themes will be derived directly from the data themselves and may bear little resemblance to the questions asked of the participants or the researcher's theoretical interest in the topic (Braun & Clarke). In contrast, a theoretical approach will be driven by *a priori*

theoretical understandings of the topic. The latter approach tends to focus on a particular aspect of the data and may involve coding for a specific research question (Braun & Clarke).

Semantic or Latent Themes. The researcher must also consider whether themes will be identified at the semantic (descriptive) level or the latent (interpretive) level. Semantic themes identify and summarize the content of the data and capture the surface meaning (i.e., reflects what was explicitly said), while latent themes go beyond what was explicitly said, revealing the underlying ideas, assumptions, and conceptualizations within the data (i.e., reflects the analyst's theoretical frameworks and uses concepts to help explain the data; Terry et al., 2017). Braun and Clarke (2006) suggest that thematic analysis typically focuses primarily on one level or the other. However, in our use of reflexive thematic analysis, we found it useful to consider both semantic and latent analysis while conducting applied qualitative health research.

Analytic Process. Considering the often-ambiguous description of thematic analysis in qualitative research, there is a strong rationale for the inclusion of robust description of the analytic process (Braun & Clarke, 2006). This description, aligned with the theoretical and methodological literature on thematic analysis, should detail the active process by which the researcher identifies patterns and themes in the data (Braun & Clarke).

While reflexive thematic analysis remains a flexible approach to data analysis, this flexibility should not be mistaken for poor demarcation of this method from others (Braun & Clarke). In order to promote this flexibility while maintaining the integrity of the method, Braun and Clarke have described guidelines for six phases of reflexive thematic analysis (see Table 1). These six phases are not necessarily a linear process (Braun & Clarke). Instead, it is understood that for each of the phases, the researcher may return to a previous phase as required and as the analysis develops.

Table 1
Phases of Reflexive Thematic Analysis

Analytic Phase	Description	Actions
Data familiarization	• Immersing oneself in the data to understand depth and breadth of the content • Searching for patterns and meaning begins	• Transcribing audio data • Reading and re-reading data set • Note taking
Initial code generation	• Generating of initial codes to organize the data, with full and equal attention given to each data item	• Labelling and organizing data items into meaningful groups
Generating (initial) themes	• Sorting of codes into initial themes • Identifying meaning of and relationships between initial codes	• Diagramming or mapping • Writing themes and their defining properties
Theme review	• Identifying coherent patterns at the level of the coded data • Reviewing entire data set as a whole	• Ensuring there is enough data to support a theme • Collapsing overlapping themes • Re-working and refining codes and themes

Theme defining and naming	• Identifying the story of each of the identified themes • Fitting the broader story of the data set to respond to the research questions	• Cycling between the data and the identified themes in order to organize the story
Report production	• Presenting of a concise and interesting account of the story told by the data, both within and across themes	• Writing a compelling argument that addresses the research questions • Writing beyond the simple description of the themes

Adapted from Braun & Clarke (2006)

Data Source

A dataset was acquired from the Qualitative Data Repository at Syracuse University in the United States for the purpose of this secondary study. Data were originally collected as part of a doctoral student project, which aimed to explore the postnatal care referral behavior (e.g., factors promoting and deterring referrals) of traditional birth attendants (TBAs) to skilled health workers (HWs) in Nigeria. Therefore, the initial research question we posed was, "what are the postnatal care referral behaviors by TBAs in Nigeria?" The dataset consisted of transcripts from three audio-recorded focus groups conducted on August 3rd, 2016, at the Federal Teaching Hospital in Abakaliki, Nigeria. Participants were: (1) TBAs (n=10); (2) HWs (n=8); and (3) mothers with babies delivered by TBAs (n=10). Focus groups ranged from 74 to 87 minutes and were facilitated in English by two physicians/researchers employed at the hospital and a physician/doctoral student from the United States. Additional data traditionally collected by qualitative health researchers (e.g., demographics, audio/video files, and field notes) and details regarding the recruitment process were not available to the authors for this secondary analysis.

There are some limitations with the use of a secondary data source. Supplemental information regarding the participating mothers (e.g., age, marital status, socioeconomic status, urban/rural dwelling, number of deliveries/live births), TBAs (e.g., age, education) and HWs (e.g., age, gender, professional role/title) may have provided us with further insight into the study context and the range of perspectives represented by groups and subgroups, which could have influenced analysis. Having access to field notes, or the audio-recordings of the focus groups also would have aided in understanding the mood and atmosphere which characterized the interactions between the facilitator and the participants. We were not involved any aspects of the study design (e.g., developing an interview guide for data collection, guiding/probing further questions arising during data collection/analysis, sampling additional participants based on characteristics/perspectives), which potentially influenced the data collected thus affected the findings. As urban-dwelling Canadian women, we had limited knowledge and experience with the Nigerian culture, language dialect, attitudes or beliefs, non-Western healthcare and birth practices outside of North America. The dataset available for this secondary study may have been influenced by selection/response bias, cultural roles, beliefs, and expectations; therefore, inferences based on our interpretations are cautioned. Additional details pertaining to participant demographics, the recruitment process, and field notes would have supplemented the analysis, allowing for comparison and increased confidence, in the study findings.

Analytic Process

In this section, we outline how our team engaged in the reflective thematic analytic process to bring meaning to an existing dataset for the purpose of learning qualitative analysis through its practical application.

Phase 1: Familiarising Ourselves With the Data

Prior to familiarising ourselves with the qualitative dataset, we engaged in the iterative process of reflexivity. Reflexivity, as we understand it, is a process of self-examination revealing ourselves as individuals and researchers while understanding how our personal biases may influence the research process (Berger, 2015; Creswell, 2014; Pillow, 2003). It is an ongoing activity to situate the researcher within the analytic process including acknowledgment of social locations and positionalities, such as age, gender identification, ethnicity, and race (Thurairajah, 2018). As an exercise of self-examination, reflexivity should be practiced throughout all aspects of the research; for this experience, we all engaged in reflexive accounts individually and through group discussions, both about the biases and assumptions we held about the content matter as well as with respect to the analytic process. To stimulate our thinking on the latter concept, all members of the research team engaged in a structured reflexive exercise.

One team member (PD) developed guiding questions (Table 2), derived from the literature, and all team members reflected and documented any emerging responses, thoughts, or emotions. Through this activity the team members identified personal biases as a method to recognize, honor, and modulate our locations and positionalities when analyzing the transcripts.

Table 2
Examples of Guiding Questions for Team-based Reflexivity in Applied Health Research

1) What approaches have you used in the past for qualitative health research?
2) What demonstrates rigor to you in qualitative health research? For example, evidence of reliability between researchers, immersion in data, repeated reading of transcripts
3) What drives/has driven your analysis? For example, analysis based on data, based on theory/existing literature or both
4) What level of interpretation do you or have you used for qualitative health research? For example: interpretation of participants' words, interpretation of social meaning
5) How do you think qualitative findings should be reported? For example: themes with a central concept, domain summaries, an overall telling of the story in the data

Following the reflective exercise, we began to familiarise ourselves with the dataset. This first phase of data analysis requires an immersion in the data such that the "depth and breadth of the content" is fully known (Braun & Clarke, 2006, p. 16). In groups of 3-4 members, we reviewed one of the three focus groups. The goal of this familiarization process was to begin

to think of and search for patterns and meaning within the data. During this process we continued our reflexive discussions, particularly how we observed power dynamics and situations of privilege in what we were reading. Through group dialogue, we discussed and debated our understanding of the data set as we began the reflexive thematic analysis process. The research team then read and re-read all of the transcripts individually for an overall sense of the data, then came together again as a team to begin the coding process.

Phase 2: Generating Our Initial Codes

Following the active familiarization process, initial codes may begin to be generated in order to organize the data (Braun & Clarke, 2006). This organization represents *meaningful groups* of data (Tuckett, 2005), which are narrower than the themes that will be identified in the next phase. For example, words, sentences, paragraphs, etc. These initial codes may be data-driven, and thus dependent on the data, or may be theory-driven, allowing the researcher to approach the data with guiding questions (Braun & Clarke).

During the code-generating phase, we revisited our research question in response to what we perceived the dataset was telling us. As mentioned above this dataset was generated with the aim of understanding the postnatal care referral behaviors of TBAs and HWs. Following our generation of initial codes, our team identified that the data were also highlighting how women are supported in the perinatal process by HWs and TBAs and our subsequent analysis was guided by this revised research question: how do TBAs and HWs support women through the perinatal process? Our team dedicated two sessions to coding where interpretations were conceptually presented. Initially, researcher derived codes provided foundational and preliminary analysis. Each group member identified codes for one or more of the focus groups in isolation. As we came together, it was important to respect contrary codes and resist any impulse to inhibit other group members. A second session allowed us time to re-read transcripts, then return to refine and discuss how the codes worked together across the whole dataset and in relation to our identified research question.

Phase 3: Generating Our Initial Themes

Previously known as *searching for themes*, in their recent work Braun and Clarke have renamed this phase generating (initial) themes (Braun & Clarke, 2019; Terry et al., 2017). This change emphasizes that themes are actively created by the researcher and are not passively waiting in the data to be found. Following the initial code generation phase, the focus of analysis shifts to the sorting of codes into initial themes (Braun & Clarke, 2006). Moving beyond the explicit, the research team was able to identify themes around power and hierarchy, scope of practice, roles, context, and relationships among the three groups. To support this phase, the team met as a group to discuss the overarching narrative identifying key elements from each transcript for the stakeholder groups. One member (LN) was identified to be the notetaker and document the discussion. As the discussion continued, there were topics that arose such as the scope of practice of each stakeholder's role, which led to further discussions about topics such as power dynamics and cultural differences. With each discussion topic, additional details were shared about common characteristics among the three stakeholder groups. How individual codes identified in the previous phase of analysis overlap or interact with one another may be best organized through the creation of a diagram or a mind-map, by writing themes and their descriptions on cue cards, or by creating a table (Braun & Clarke, 2006). These visual representations and the opportunity for physical manipulation of codes and themes may help with organization, as well as decision making related to main themes, sub-themes, and those which may not fit at this time. Our team organized initial themes on a

chalkboard and initial diagramming was conducted to identify the relationships between these initial themes. The resulting diagram depicted a process including factors that influence how TBAs and HWs support mothers through the perinatal period (See Figure 1).

Figure 1
Group Diagramming
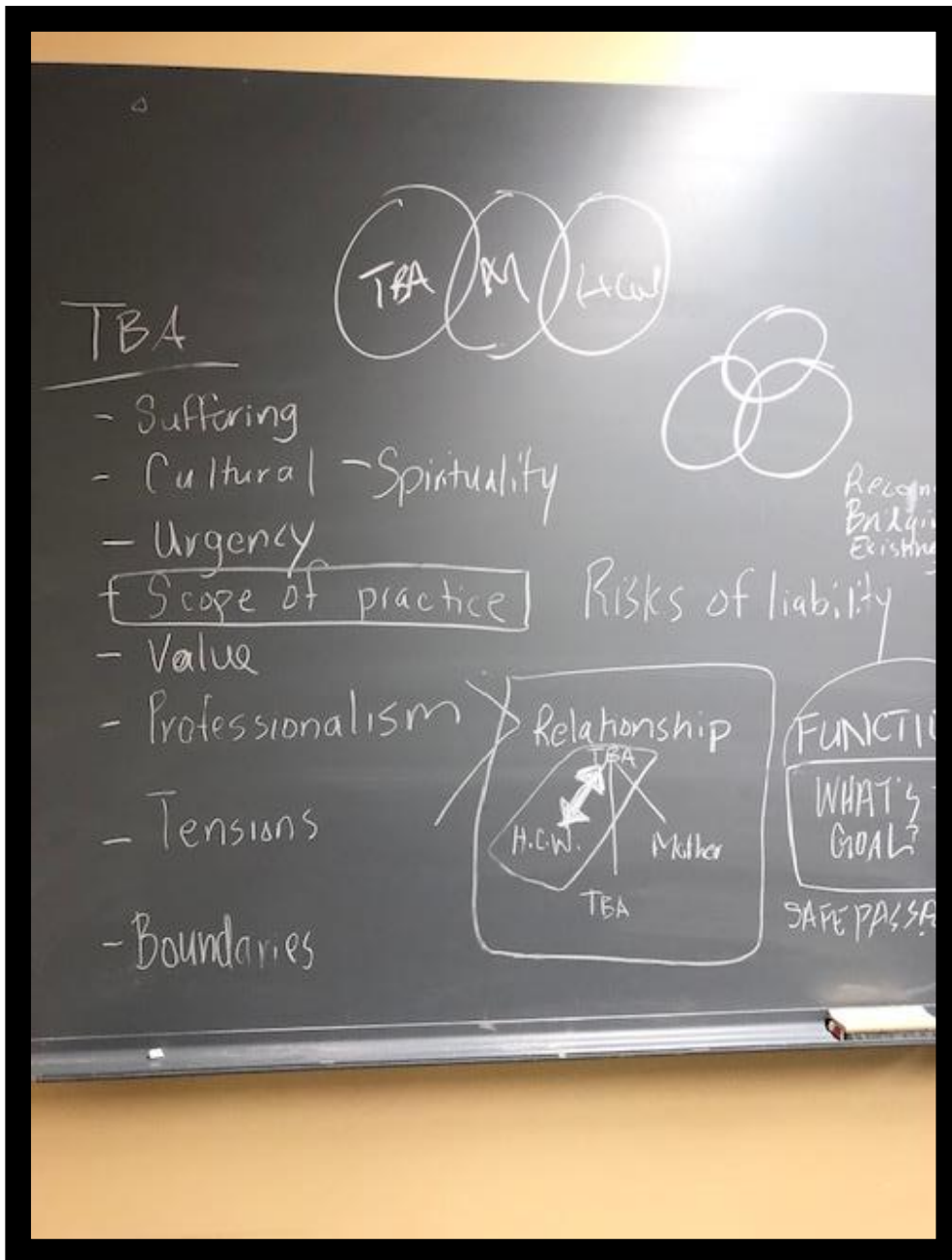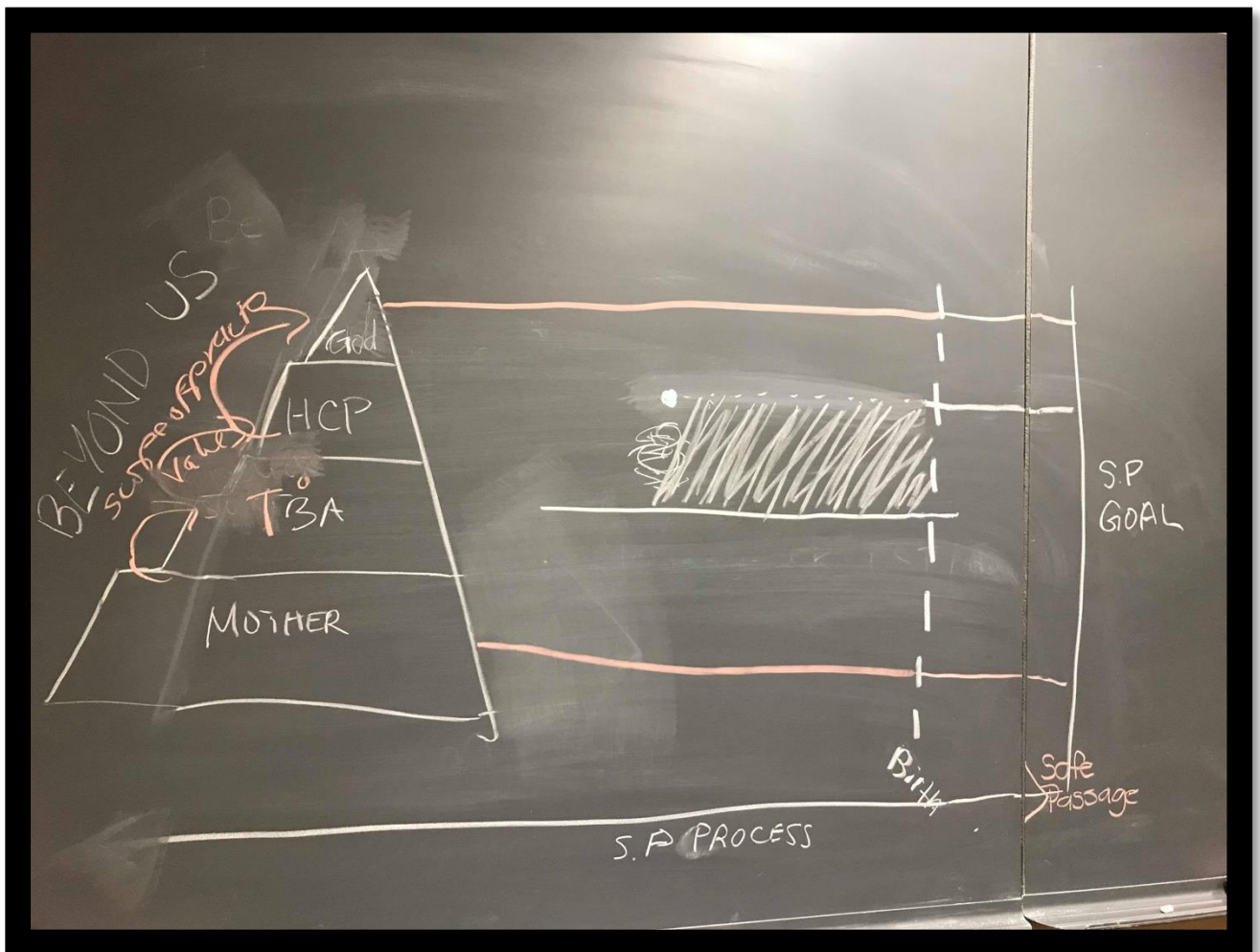
Phase 4: Reviewing Our Themes

Braun and Clarke (2006) identify two levels of review: 1) reviewing at the level of the coded data (from individual transcripts); and 2) reviewing the entire data set (capturing the meaning across the whole). Small groups were assigned to review and write a brief description for one of the three overarching themes: 1) Safe Passage; 2) Beyond Us; and, 3) Co-existence of Medical and Traditional Knowing. These brief descriptions helped our team to better understand the main message for each theme and to ensure that the themes were distinct from one another. The descriptions also included illustrative quotes and codes that could exemplify the theme. During this first level of review, all coded data extracts were checked to ensure coherent patterns were present (Braun & Clarke, 2006). As a large group, we shared the key components of each theme and description. In pairs, we then drew diagrams of how the overarching three themes might relate to each other as an analytic narrative and process of understanding how HWs and TBAs can support mothers through the perinatal process. This review made certain that the generated themes and developing thematic map were reflective of the data set, thus allowing the next phase of analysis to be started.

Phase 5: Defining and Naming Our Themes

Braun and Clarke (2013) recommend the use of "catchy", thoughtful names for themes that capture the essence of the analysis (p. 258). Theme names may come from a direct quote, such as our example below ("Beyond Us") or may involve the identification of an analytic take on or focus of the data (Safe Passage and Co-Existence; Braun & Clarke, 2013). Using the coded data, our team initially sought to collaboratively describe the themes identified. For example, in describing the overarching goal of safe childbirth (expressed by mothers, TBAs and HWs) it was noted that this goal also aligned with the process and experience of pregnancy, labor, and delivery identified in the focus groups. To capture the essence of this process while staying close to the data and the identified need for safety in the experience, this theme was named Safe Passage.

During this phase of analysis, the researcher will go back and forth between the data and the identified themes in order to organize the story into a "coherent and internally consistent account" (Braun & Clarke, 2006, p. 22). For each of the identified themes, the researcher will construct a detailed analysis beyond that of just a description or paraphrase of the data (Braun & Clarke). This will include an identification of the story of each of the themes (e.g., what the theme tells) as well as how this story and theme fits the broader story of the dataset based on the research questions (Braun & Clarke). As a large group, our team discussed the three themes and working diagrams and identified key elements that resonated with us and reflected the essence of the dataset. We described how we interpreted the theme and how it was represented in the diagram. There was a discussion about how the theme captured important aspects of the data, which were illustrated in a thematic map or diagram. The final diagram (or thematic map) was developed together as a group, in which there was an incorporation of the three themes and their relationship to each other. One member (CW) was responsible for making the electronic version of the diagram. Finally, each group member was provided with the opportunity to refine the diagram by adding elements and describing how the element could be visually depicted in a diagram.

Phase 6: Writing Our Report

Produced reports should involve a concise and interesting account of the story told by the data, both within and across themes (Braun & Clarke, 2006). This narrative should extend beyond simple description of the data to make a compelling argument that addresses your initial research question. As a team we have extensive experience with group writing and determined that report writing for the findings section would best be accomplished by one writer (EO). We recommend this approach to unify voices and express findings in a coherent and consistent manner. As a final step, we reviewed and revisited our completed thematic map and the meaning of each theme. Being cautious not to persuade or lead any individual, we came to a common understanding of the data easily. This may be because of our similar backgrounds and professions, or it may have been an outcome of respectful and constant dialogue that occurred over the months that we engaged in the process of reflective thematic analysis. Each member of the group was responsible for writing one section of this paper. The lead author (KAC) organized, synthesized, and edited the paper for flow and consistency. Finally, the senior author (SMJ) reviewed, edited, and offered the group suggestions to enhance the quality of the paper.

Findings from Our Analytic Process

Writing the findings or analysis section represents the final stage of the reflective thematic analytic process. To be clear, you do not complete your analysis and then write it up

– "writing is the process through which the analysis develops into its final form" (Braun & Clarke, 2013, p. 249). This final phase involves selecting extracts from the coded and collated data to illustrate the various aspects of the theme and then writing a narrative around those extracts to tell a clear and compelling story about the data and what they mean (Braun & Clarke).

Three themes were generated from our groups' engagement in the reflective thematic analytic process: (1) Safe Passage; (2) Beyond Us; and, (3) Co-existence of Medical and Traditional Knowing. These themes serve to answer our research aim and highlight the complex nature of supporting women throughout the perinatal process using both TBAs and HWs. In the following paragraphs the theme *safe passage* is presented and serves as an illustrative example of analysis in its final form. The themes *beyond us* and *co-existence of medical and traditional knowing* are presented in Table 3 but without this final level of analysis applied; by comparing and contrasting these themes with *safe passage*, one can see how the selection of vivid and compelling extracts are vital in convincing the reader of the analytic points you are making about your data (Braun & Clarke).

Safe Passage

The mother's perinatal journey is defined by the theme *safe passage*. Safe passage is both a goal and a process. As a goal, safe passage is viewed as the safe delivery of the baby and care of the mother and baby following delivery; this is consistently described as an overarching goal across groups (mothers, TBAs and HWs). A HW speaking of a TBA articulates this belief "she believes that the safety of the mother and that of the baby is the important thing, regardless of where the delivery was done" and also implies that this belief is shared between HWs and TBAs. How safe passage is defined however, varies for each of the groups. For HWs the emphasis of safe passage is on "modern age" practices and focuses on the prevention of poor health outcomes such as reducing "the incidence of maternal and infant death, as well as other complications associated with delivery." For TBAs, the emphasis is more on holistic care of the mother and focuses on traditional practices and relationships with the mother. As one mother describes,

> I like [the TBAs] services because they are readily available unlike the health facility that will leave you in the pains and will pay attention to you only when the baby has engaged. But the TBA will hold you and console you while in pains till you deliver your baby.

The process of safe passage also varies for each group. While safe passage is a goal of the mothers, they do not see themselves as active decision makers in the process, instead, relying on the knowledge and experience of the HWs and TBAs for safe passage. This is evident in the discourse across the three focus groups of the women needing to be "told" or "asked" to do things considered important for their health and the health of their baby, "some who are good in attending to birth will ask you to go. I have had different experiences and their services are not the same. A good birth attendant will ask you to go to the hospital after delivery." From the HWs perspective, safe passage consists of a series of steps or actions that must be completed to achieve the desired goal of healthy women and babies.

> After a woman has delivered in my health center and has been monitored for a day or two, and observed that all is alright with her, and the proper immunizations given to the child, I usually ask her to come back after six weeks. And when she comes back after the six week,

we still run a checkup on her and the baby. But before she leaves the health center, we would tell her to come back if there is any problem before that six weeks.

Safe passage for the mother and baby also requires acknowledging the importance and permanency of the role of the TBA and the need for collaboration while still adhering to best practices.

> …so, going to the TBA for postnatal care is okay, but they should only take care of the minor things, because they don't have much to do for them when there is complication. So, it is preferable that they go to the health center. It does not mean that the health center knows everything, but they are quick in referring out the case when it gets beyond them.

For HWs, the process of safe passage includes building strong relationships and sharing knowledge and skills with TBAs with the goal of improving perinatal care, "we should encourage them first, before correcting them on how to work. She should not under look them as if they know nothing."

In contrast, the process of safe passage for the TBA focuses primarily on the events surrounding labour and delivery in uncomplicated cases and their care largely seems to end after the birth, "our role is to assist the women in the community during the deliveries. We assist them based on our ability, but when the issue is beyond us we send them to the health center where they will meet the professionals". While some of the TBAs undervalued their role in comparison to the role of HWs in safe passage, "their services are quite professional and cannot be compared with ours". This TBA illustrates how without them some women may otherwise be left alone in the safe passage process:

> …like I have already said that I do mine out of charity or that the woman has no money to go to the health facility. Considering the fact that the women do not have the money, most of them do not give me anything at that point in time, they usually come later for that. The truth is that they don't have the money, some of them are women abandoned by their husbands, and you can't watch your fellow woman suffering like that.

Safe passage as common ground for HWs and TBAs can serve as a foundation for working together (a desire of both groups).

> our work is good, but we should be conscious of our ability in doing that. We should refer the woman to the hospital early enough for the ones we cannot do, so that both the mother and the child will live (TBA).

However strained relationships historically and power differentials between the two roles threaten this cooperation:

> Most of them do not even seek for advice from us, it is only very few of them that do that. Others behave as if we are at war with them. But we should work together for the health of these women and the children (HW).

Table 3

Additional Themes Reviewed and Defined

Beyond Us	• The theme of "beyond us" builds on the concept of roles and scope of practice, with an added layer of hierarchy and power differentials.
	• All three groups (mothers, TBAs, and HWs) expressed that more complicated deliveries are "beyond" the abilities of TBAs, due to the lack of medication, equipment, knowledge, and skills to treat complications. HWs are seen to be more knowledgeable and are able to provide a higher level of care.
	• Both the women and TBAs believe that birth complications can be "beyond" all earthly beings and safe delivery and the health of the mother and the infant depends on trust in God.
	• Despite the consensus that HWs can better manage birth-related complications, TBAs do not consistently refer mothers to the health center when they encounter complications "beyond them." This lack of referral is attributed to negative working relationships between TBAs and the health center, risk of liability or (criminal?) punishment, overconfidence in overstepping boundaries, and desire for payment.
	• When TBAs do not make timely referrals to the health center, the mother's safe passage is at risk and she endures unnecessary suffering.
Co-existence of medical and traditional knowing	• There is a common perception of hierarchy with the mothers at the bottom, then TBAs, HWs, and God at the top. These rankings are consistent across groups, but the gap between each power level is influenced by the weight of different value systems (e.g., medical, traditional, spiritual).
	• When the medical value system carries greater weight, there is a greater status gap between HWs and TBAs. When tradition is valued, this hierarchical gap is smaller. For example, HWs, who greatly value medical knowledge, appear confident that their ways of practicing are far superior to the traditional ways of the TBAs. TBAs also feel that HWs are better, but there is a diminished sense of superiority.
	• The mothers seem to hold the status of HWs only slightly above that of the TBAs. For example, mothers feel that HWs are more knowledgeable, consistent, and better resourced, but they also express preferences for the practices of TBAs over those of HWs.
	• For both TBAs and mothers, the spiritual value system holds significant weight; this diminishes the power gap between TBAs and HWs, and places God at the top of the hierarchy. There are tensions between these value systems which hinders relationships and leads to the "othering" of mothers and TBAs by HWs.
	• Currently these value/knowledge systems simply "co-exist"; however, they need to be reconciled if TBAs and HWs are to work together toward the common goal of safe passage.

Using Extracts or Quotes in Findings

Extracts of raw data or quotes are ubiquitous in qualitative research; however, it is important to note that analysis does not involve simply paraphrasing a string of data extracts. Analysis must tell the reader what is interesting about the data, including particular extracts, and why it is relevant and interesting (Braun & Clarke, 2013). In reflexive thematic analysis, data extracts can be used illustratively or analytically, and both functions can be utilized to represent the final analysis. An illustrative extract serves as an example from the raw data of a claim made by the writer; for example:

> *Claim:* some of the TBAs undervalued their role in comparison to the role of HWs in safe passage

> *Illustrative extract:* "their services are quite professional and cannot be compared with ours" *note: this would be an example of a semantic theme

Where using an extract analytically involves discussing particulars of the data extract with specific aspects or features forming the basis for analytic claims (Terry et al., 2017). For example:

> *Claim:* mothers, they do not see themselves as active decision makers in the process

> *Analytic extract:* This is evident in the discourse across the three focus groups of the women needing to be "told" or "asked" to do things considered important for their health and the health of their baby, "Some who are good in attending to birth will ask you to go. I have had different experiences and their services are not the same. A good birth attendant will ask you to go to the hospital after delivery". *Note: this would be an example of a latent theme

Finding a balance between analytic narrative as well as both illustrative and analytic extracts is an important feature of quality findings.

Using Thematic Maps

As mentioned in the description of our analytic process, creating a visual thematic map or diagram can be a useful tool in exploring the relationships between codes and themes and developing the final analysis (Braun & Clarke, 2013). Once this working map is finalized it can also be a useful visual representation of the findings that augments the analytic narrative. Our final thematic map (Figure 2) highlights how our three themes are distinct but also connected to the overall understanding of our research question. For example, mapping the safe passage process allowed us to understand specific timepoints where the co-existence of medical and traditional ways of knowing were particularly pronounced and how these time points represent areas of tension among our participants groups, but also opportunities to reconcile medical and traditional ways of knowing toward to the goal of safe passage.

Figure 2
Thematic Map
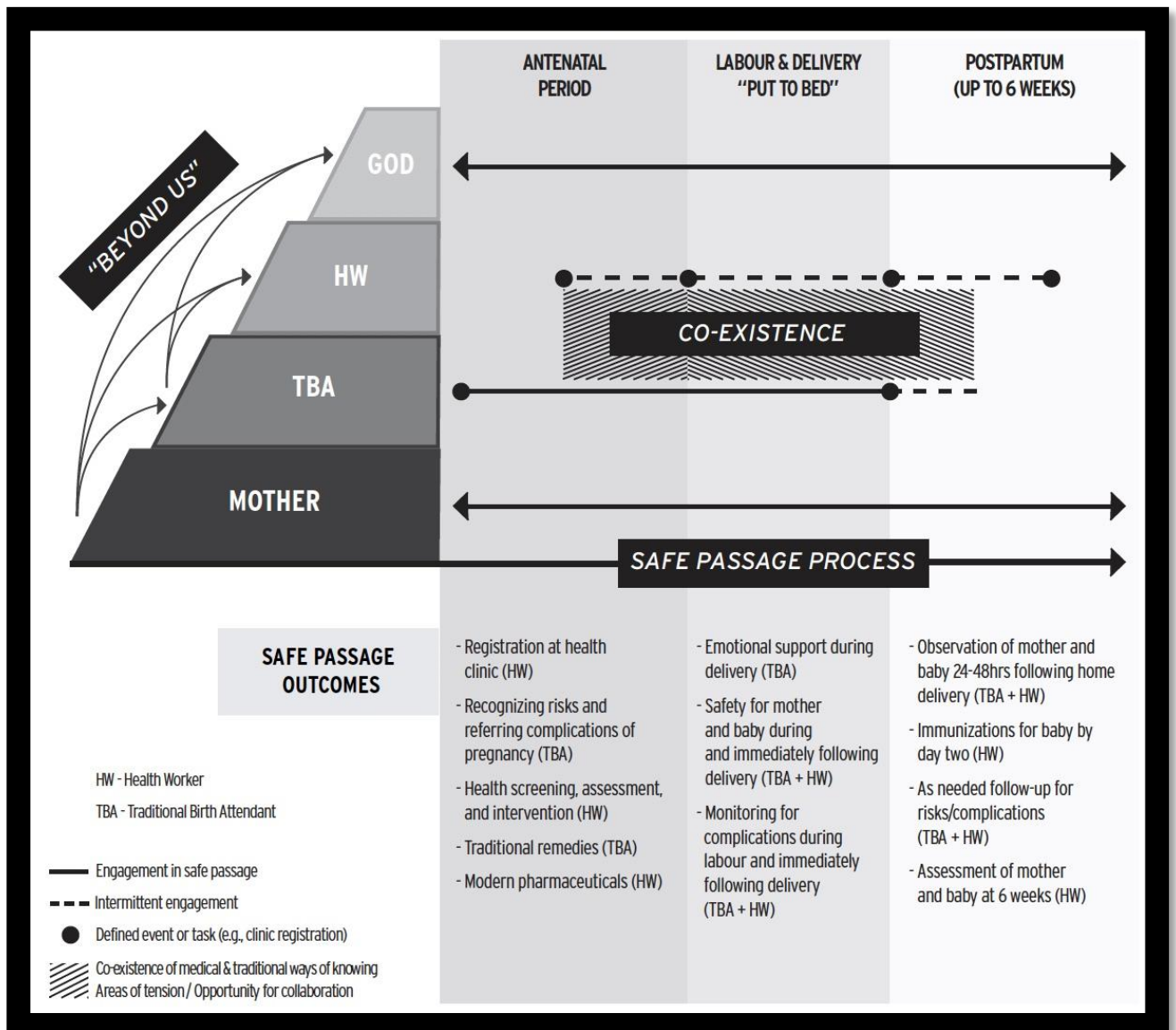
Application of Reflexive Thematic Analysis

An important feature of reflexive thematic analysis, particularly when used in applied research contexts, is that the final themes should be able to point to actionable items. For example, our theme of safe passage was a common goal for women and babies across all groups. It may provide clinicians with a greater understanding of the experiences of mothers, TBAs, and HW and help identify the ways in which collaborative care can occur in this setting. This could also lead to the development of policies or protocols outlining the necessary steps to achieve this goal. Conceptualizing power hierarchies within the context of infant and maternal care in Nigeria may have implications for future research.

As a practical method of analyzing qualitative health research, reflexive thematic analysis could be beneficial to students, clinicians, and researchers. The guidance provided in each phase reinforces the need for deep immersion into the data as well continuous reflexive accounts. Our exploration of the analytic process, following Braun and Clarke's method,

supports the notion that this is not linear. Indeed, we engaged in reflexive discussions, together and in isolation, throughout the entirety of the process. New understandings of what was important in the data led to decisions to revise our research question on more than one occasion. Coding, theming, and developing thematic maps were activities that overlapped and returned us to earlier phases. If researchers can be open to the iterative and emergent process, reflexive thematic analysis could provide useable findings that are meaningful to practice.

Our paper adds the functionality of reflexive thematic analysis both as a tool to support group analysis and a pedagogical tool. Initially we were unsure how a reflexive process that respects subjectivity could work within a group setting. Through our experience, we learned that guiding questions helped us to reflect, while respecting our differences and opened discussions that otherwise may have been missed. This may not work well in a group with challenging interpersonal dynamics or where power influences who guides the direction of findings. However, using a pre-existing dataset offered an opportunity to practice data analysis that did not belong to any of us and therefore, we held no allegiances to the narratives. Rather than just read about this analytic process, practicing it together allowed us to learn from each other and encourage growth as researchers.

Finally, applied qualitative health researchers may specifically find this method to be beneficial. It is not theory-laden or tied to any particular philosophical stance. Qualitative researchers who are applying methodologies grounded in the social sciences (e.g., ethnography, phenomenology, and grounded theory) are encouraged to grapple with how this method fits within the tenets of their method. For researchers following pragmatic methods designed for applied research (e.g., interpretive description, focused ethnography, or qualitative description), Braun and Clarke's reflexive thematic analysis may provide direction and guidance through the analytic process.

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Author Note

Karen A. Campbell, RN, PhD, is a Postdoctoral Scholar at Western University, Arthur Labatt Family School of Nursing, and an Ontario Women's Health Scholar funded by the Ontario Ministry of Health and Long-Term Care. Her research focuses on intersections of women's health with physical and social geography. Please direct correspondence to campbk7@mcmaster.ca.

Elizabeth Orr, RN, MSc, is a PhD student in the School of Nursing at McMaster University and Lecturer in the Department of Nursing at Brock University, Ontario, Canada. Her current research is focused on understanding the complex processes of hospital-to-home transitions, specifically the transition from NICU to home among vulnerable populations.

Pamela Durepos is an Assistant Professor in the Faculty of Nursing at the University of New Brunswick. Her program of research focuses on a palliative approach and family caregiving for people with dementia at end-of-life. Pamela uses mixed method designs to understand diverse experiences and operationalize complex concepts relevant to nursing.

Linda Nguyen, BHSc, MSc, is a PhD Candidate in the School of Rehabilitation Science and CanChild Centre for Childhood Disability Research at McMaster University. Her doctoral studies are focused on understanding the experiences of siblings of youth with a disability during the transition to adulthood, using patient-oriented and qualitative research approaches.

Lin Li, RN, BScN, BFA is a PhD student in the School of Nursing at McMaster University and registered nurse at McMaster Children's Hospital. Her research interests include qualitative health research, health services for children and youth with medical complexity, youth transition to adulthood, and family partnership in research.

Carly Whitmore, RN MScN, is a PhD student and Vanier Canada Graduate Scholar in the School of Nursing at McMaster University. Carly has experience in the design and conduct of mixed methods research and pragmatic trials. Her research focuses on supporting community-dwelling older adults and interventions to improve mental health.

Paige Gehrke, RN, BScN is currently a MScN student at McMaster University. Her research interests are situated in the field of critical care, organizational policy, and leadership. Her thesis research will explore ICU nurses' responses to moral distress to understanding their desired organizational interventions to reduce or manage moral distress.

Leslie Graham, RN, is faculty in the Ontario Tech University-Durham College Nursing Program. Being a passionate educator, her interests focus on simulation as pedagogy. As result of work in the field, she has been the recipient of numerous awards, most recently the INACLS Spirit of Leadership Award and the President's Award.

Susan Jack, RN, PhD, is Professor, School of Nursing and Associate Member, Department of Health Research Methods, Evidence and Impact at McMaster University. Her program of research focuses on community-based approaches to the prevention of family violence, including child maltreatment and intimate partner violence.

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