

Patterns of Substance Use and Barriers to Support Among Youths in Mbare, Harare: An Exploratory Mixed-Methods Study

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DOI: <https://doi.org/10.63363/aijfr.2026.v07i05.8535>

Abstract

Substance use among young people is a growing public health concern in Zimbabwe, but little is known about how it looks within specific high-density communities or how young people experience the help available. This exploratory mixed-methods study describes the substances used by youths in Mbare, Harare, and the supports they can reach. Structured records from 12 substance-using youths aged 15 to 24 years were combined with eight youth interview records, six key informant interviews and four field observations, which were analysed thematically. Mutoriro (crystal methamphetamine) and cannabis were the most common primary substances (three respondents each), followed by brongo (codeine cough syrup) and sedatives (two each). All seven males used mutoriro or cannabis, while all five females used brongo or sedatives. Use often began in early adolescence. Peers gave first access, but continued use was linked to unemployment, grief, school pressure, exhaustion and worry. A polyclinic, the Friendship Bench, NGO programmes, churches, families and outreach workers were available, yet stigma, fear of police involvement, cost, waiting times and weak referral limited their use. In this small sample, substances served practical and emotional purposes, and trust, not only availability, decided whether services were used. Larger studies should test these patterns. The findings support confidential, gender-aware, community-based pathways into care.

Keywords: substance use; youth; Zimbabwe; mutoriro; support systems; help-seeking; mixed methods

1. Introduction

Substance use among young people is rising in many parts of sub-Saharan Africa. The United Nations Office on Drugs and Crime has projected that the number of people who use drugs in Africa could grow by about 40% between 2018 and 2030, largely because the continent has a young and fast-growing population (as cited in Marandure et al., 2023). Zimbabwe is part of this picture. Decades of economic hardship, high unemployment and widespread poverty have been linked to stress and mental health problems, and these are known risk factors for substance use (Marandure et al., 2023). Substances of concern in the country include illicit home-brewed alcohol, cannabis, codeine-based cough syrups and crystal methamphetamine, which is known locally as mutoriro (Marandure et al., 2023). Commentators have also warned that the COVID-19 lockdowns may have pushed more young people towards illicit substances (Mukwenha et al., 2022).

Despite this concern, the evidence base is thin. Marandure et al. (2023) point out that Zimbabwe has no national system for monitoring substance use and that many claims about a crisis rest on anecdotal or secondary sources. Most of what is known comes from national or provincial summaries. Far fewer studies describe what substance use looks like inside a single high-density community, and fewer still ask young people themselves how they use, why they use, and what happens when they try to get help.

The response side of the problem is also weak. Zimbabwe has a large treatment gap for mental, neurological and substance use disorders (Chibanda, 2017), mental health services run on very limited resources (Kidia et al., 2017), and specialist drug and alcohol treatment facilities are few (Marandure et al., 2023). The Friendship Bench, a programme in which trained lay health workers deliver problem-solving therapy in primary care settings, has shown that low-cost community models can work for common mental disorders (Chibanda et al., 2016). Yet it is not clear how far such models reach young people who use drugs. A qualitative study of 30 young people in Harare identified fear of imprisonment, stigma, poor awareness and cost as barriers to treatment for crystal methamphetamine use (Nyashanu et al., 2024). That study did not link these barriers to the wider pattern of substances used, to gender, or to the informal supports young people rely on.

Mbare is one of the oldest and most crowded high-density suburbs of Harare. It began as a settlement for migrant workers and today combines overcrowded housing, a very active informal economy and under-resourced public services. These conditions make it a useful place to examine how substance use, social stress and support systems fit together. Two theories guided the study. Pearlin's (1989) social stress theory argues that chronic strain from conditions such as poverty and unemployment can overwhelm a person's coping resources and make maladaptive coping more likely. Engel's (1977) biopsychosocial model argues that health problems arise from the interaction of biological, psychological and social factors rather than from any single cause. Together they suggest that substance use should be read as a response to pressure that unfolds within peer, family and service environments.

This paper reports part of an exploratory mixed-methods study of substance use, psychosocial functioning and support systems among youths in Mbare. It addresses two questions. First, what substances do youths use, and what patterns and reasons for use can be seen? Second, what formal and informal supports exist, how accessible are they, and how do young people and service providers describe their usefulness? A companion paper reports on depression, anxiety and social functioning in the same sample (Madziva et al., 2026).

2. Materials and Methods

2.1. Design and Reporting

The study used an explanatory mixed-methods design (Creswell & Plano Clark, 2017). A structured survey gave basic numerical descriptions, and interviews and observations were used to explain and add depth to those descriptions. Quantitative reporting follows the STROBE guidance for cross-sectional studies (von Elm et al., 2007), and qualitative reporting follows the COREQ checklist (Tong et al., 2007). Because the sample was small and the survey was not a probability sample, the study is presented as exploratory and descriptive.

2.2. Setting and Participants

The study was carried out in Mbare high-density suburb, Harare, Zimbabwe, in 2026. Eligible youths were aged 15 to 24 years, lived in Mbare, and had used an illicit drug or misused a psychoactive substance for non-medical purposes at least once in the previous 12 months. Participants were recruited through community contacts and referral chains, starting from seeds identified with trusted community organisations [CONFIRM: seed number and recruitment details]. Key informants were selected purposively because of their roles in health, community or church-based work with young people.

The analysed records comprised 12 structured survey records, eight youth interview records (five full extracts and three summary notes), six key informant interviews and four field observations. This is smaller than the sample of 150 youths, 15 to 20 youth interviews and 8 to 10 key informants that was planned in the study protocol. The full set of planned records was not available for analysis at the time of writing. Participants in the structured survey are identified by anonymous codes (SQ-01 to SQ-12), youth interviewees by Y-01 to Y-08, and key informants by KI-01 to KI-06. The raw files did not contain a verified key linking the survey codes to the interview codes, so the two sets of youth records were treated as separate sources and were not merged.

2.3. Instruments and Procedures

The structured questionnaire was interviewer-administered and was translated into Shona and checked through back-translation [CONFIRM]. It recorded age, sex, the primary substance used, age of first use and frequency of use, using a modified version of the World Health Organization Alcohol, Smoking and Substance Involvement Screening Test (ASSIST; Humeniuk et al., 2008), with local substances such as mutoriro and brongo listed by name. Detailed multi-substance histories were complete only for the first five survey records (SQ-01 to SQ-05). Items on awareness, use and perceived helpfulness of services were also available for these five respondents.

Youth interviews and key informant interviews used semi-structured guides that covered the history of use, reasons for use, daily life, family and school or work, and experiences of formal and informal help. Interviews were held in Shona or English in private places agreed with participants and, with consent, were audio-recorded [CONFIRM]. The researcher also made four field observations at a market area, a polyclinic waiting area, a community outreach session and a church-based community talk. Observation notes recorded only what could be seen. For example, the contents of one observed bottle and package were not verified and were not labelled as drugs.

2.4. Analysis

Survey data were summarised using counts, percentages, means and standard deviations. No population prevalence was estimated, because every survey respondent was already a substance user, and because the recruitment information needed for respondent-driven sampling weights was not available. Interview, key informant and observation records were analysed thematically following the six steps described by Braun and Clarke (2006): familiarisation, coding, theme development, theme review, naming and reporting. Themes were then compared with the survey results in a joint display (Table 4), which is a standard way to show how quantitative and qualitative findings agree or differ (Fetters et al., 2013). Quotations are used only where the exact wording was available in the records.

2.5. Ethics

The study followed the Declaration of Helsinki. Ethical approval was granted by [NAME OF ETHICS COMMITTEE] (approval number [NUMBER], date [DATE]). Participants aged 18 years and above gave written informed consent. For participants aged 15 to 17 years, written consent from a parent or guardian and the participant's own assent were obtained [CONFIRM]. Names and addresses were not recorded. Participants who scored 10 or more on depression or anxiety screening tools were told sensitively and referred to local counselling services, as set out in the protocol [CONFIRM that referrals were made].

3. Results

3.1. Participants

The 12 survey respondents were aged 15 to 24 years (mean 20.3, SD 2.7). Seven were male and five were female. Their characteristics and recorded primary substance are shown in Table 1. The qualitative sample included school-going girls, a domestic worker, young men in informal piecework, and participants as young as 15 and 16 years. Duration of use in the interview records ranged from about eight months to seven years.

Table 1. Age, sex and recorded primary substance of survey respondents (n = 12)

Code	Age	Sex	Recorded primary substance
SQ-01	22	Male	Mutoriro
SQ-02	17	Female	Brongo
SQ-03	20	Male	Cannabis
SQ-04	19	Male	Cannabis
SQ-05	23	Female	Sedatives
SQ-06	21	Female	Brongo
SQ-07	24	Male	Mutoriro
SQ-08	15	Male	Cannabis
SQ-09	18	Female	Sedatives
SQ-10	22	Male	Cannabis + alcohol
SQ-11	20	Female	Brongo + sedatives
SQ-12	23	Male	Mutoriro

3.2. Substances Used and Differences by Sex

Mutoriro and cannabis were the most common single primary substances, each recorded for three of the 12 respondents (25.0%). Brongo and prescription sedatives were each recorded for two respondents (16.7%). Two respondents had combined patterns: cannabis with alcohol (n = 1) and brongo with sedatives (n = 1). These figures describe the make-up of this small sample and should not be read as the share of all Mbare youths who use each substance.

A clear pattern appeared by sex (Table 2). All seven males had a primary substance of mutoriro, cannabis or cannabis with alcohol. All five females had brongo, sedatives or brongo with sedatives. With so few respondents, this cannot show that young men and women in Mbare use entirely different drugs, and it may partly reflect who was reached. Still, the key informant evidence pointed the same way. KI-01 described mutoriro and cannabis use among boys as visible and group-based, and use among girls as more hidden. The female youth interviews fitted this description. Two school-going girls (Y-02 and Y-04) said brongo helped them calm down, sleep or cope with pressure, and a young woman working as a domestic worker (Y-06) described using prescription sedatives and alcohol.

Table 2. Recorded primary substance by sex (n = 12)

Primary substance	Male (n = 7)	Female (n = 5)
Mutoriro	3	0
Cannabis	3	0
Cannabis + alcohol	1	0
Brongo	0	2
Sedatives	0	2
Brongo + sedatives	0	1

3.3. Starting Use, and Reasons for Continuing

Use often began in early or mid-adolescence. Among the first five survey respondents, the age of first use ranged from 13 to 20 years, with SQ-03 starting cannabis at 13, SQ-01 at 14, SQ-02 at 15 and SQ-04 at 16. Interview participants gave similar accounts. Y-01 started cannabis at about 14 and later moved to mutoriro, Y-03 started cannabis at 17 and later added mutoriro, and Y-08 began with inhalants and cannabis in early secondary school.

Peers were usually the route of first access, but the records do not support a simple story of peer pressure. Friends, older students and relatives supplied the first substance, yet the reasons for carrying on were more personal and more practical. Participants spoke of bereavement, family separation, hardship at home, examination pressure, joblessness and the need to cope with painful feelings. Y-02 received brongo from a school friend at a time of examination stress. Y-01 was first offered cannabis after a period of family hardship.

For many, the substance had a job to do. Mutoriro was described as giving energy for long hours of informal work and easing tiredness and physical pain. Brongo and sedatives were described as helping with sleep and worry. Y-01 said, "At first I took it for work. Later it became something else." This sentence captures a change that several participants described, from using a substance as a tool to feeling that it had taken over their routine. Frequency also varied. SQ-01 reported daily mutoriro and cannabis use, SQ-03 daily cannabis use and SQ-04 weekly cannabis and alcohol use, while some younger school-going participants described less frequent or more recent use. Combined use appeared too. Y-05 described taking a stimulant and a sedating substance at different points in one cycle, and KI-03 said some youths deliberately use two or three substances to manage the "up" and the "down".

3.4. Availability

Participants described substances as easy to get. They mentioned tuckshops, informal pharmacies, known selling points and street networks. KI-02 and Y-06 both said that WhatsApp groups were used to share prices and locations. The researcher's observation at the market area recorded busy informal trade that was consistent with this picture, although what was exchanged could not be verified. These accounts suggest that supply is not tied to one place, so closing one outlet may move the network rather than remove access.

3.5. Support Systems Identified

Support was present in Mbare, but it was spread across many providers and none offered a full route from first contact to long-term recovery (Table 3). Formal options included the polyclinic, the Friendship Bench linked to the clinic, a youth NGO drop-in programme, hospital or specialist referral and community health outreach. Informal supports were family and relatives, friends, and church or religious leaders.

Table 3. Support systems identified in the field data

Support	Type	Strength described	Limitation described
Mbare Polyclinic	Formal	Known to several participants; general care and referral	Long waits; transport and time costs; fear of judgement or police
Friendship Bench	Community mental health, linked to clinic	Seen by KI-02 and KI-04 as useful for mild to moderate problems	Limited capacity; referral gap for severe cases
Youth NGO drop-in	Formal or community	Basic counselling, food support, referral	Unstable funding; trust can collapse if linked to police
Hospital or specialist referral	Formal	Route for severe mental health or addiction needs	Distance, crowding, fear, delays
Family and relatives	Informal	Emotional and practical help for some	Conflict, stigma, poverty, absence
Friends and peers	Informal	Belonging and daily listening	May sustain or normalise use
Church and religious leaders	Informal	Trusted, non-judgemental, food and listening	Not a replacement for clinical care
Community health outreach	Community bridge	Reaches youths who never visit a clinic	Under-resourced; limited coverage

The five detailed survey records show how little formal help was used. SQ-01 had used family, friends and religious support but no formal service. SQ-02 had seen a school counsellor once and did not return because the visit was not helpful. SQ-03 had used no service, SQ-04 relied on friends and an older brother,

and SQ-05 had spoken to no one about her substance use or emotional difficulties. This is a very small group, but it shows that formal help-seeking was rare even though most of these respondents scored in the moderate to severe range on depression and anxiety screening tools (see Madziva et al., 2026).

3.6. Barriers to Help

Trust came up more often than cost or distance. The main barriers, and the sources that supported each, are summarised in Table 4 together with the other joint findings. Stigma and fear of being labelled were reported by four of the five detailed survey respondents and in the interviews. Fear of police or authority involvement was raised by two survey respondents, one youth interviewee and two key informants. Other barriers were transport cost, long waits, expectations of disrespect, not knowing where to go, doubt that help would work, limited specialist capacity and unstable funding.

KI-03 gave an example of how quickly trust can be lost. When a rumour linked an NGO programme to the police, attendance reportedly fell to zero for several weeks. In KI-03's words, "Trust takes months to build and minutes to destroy." Waiting time also mattered. Y-01 left a clinic after a long wait and did not go back. During one observation the polyclinic waiting area was crowded and a young woman left before she was called, although her reason could not be confirmed. For youths who earn money from daily piecework, a half-day at a clinic can mean a lost day's income.

3.7. What Young People Want from a Service

Despite low use of formal care, participants were clear about what would make a service acceptable. The most repeated features were confidentiality, staff who do not judge, low or no cost, a location inside Mbare, walk-in access, short waits, workers who understand local substances, the same helper over time, and outreach for those who will not enter a clinic. Women raised privacy and, in one case, a women-only option. SQ-01 said, "It must be a place where no one judges you. The nurses must talk to you like a person, not a criminal. It must also be free." Y-01 said, "Even one room and one helpful person can be enough." The observations agreed with this. The outreach worker knew young people by name and spoke to them where they were, and at the church talk a young person could speak openly and receive a calm response. Neither setting could replace specialist treatment, but both worked because they were built on relationships.

Table 4. Joint display of survey, qualitative and practical findings

Question	Survey finding (n = 12)	Qualitative explanation	Practical meaning
Which substances, and who uses them?	Mutoriro and cannabis 25.0% each; brongo and sedatives 16.7% each; two combined patterns; clear split by sex	Visible, group-based use among boys; hidden use among girls; combined use to manage effects	Prevention and outreach should differ by substance and gender
Why start and continue?	First use at 13 to 20 years in the five detailed records	Peers gave access, but hardship, grief, school and work pressure kept use going	Offer safer ways to meet the need the substance is meeting

Question	Survey finding (n = 12)	Qualitative explanation	Practical meaning
Are services used?	Little formal help in the five detailed records	Stigma, police fear, cost, waiting, low trust	Services must be trusted and confidential, not only available
What would help?	Not measured	Local, free, walk-in, non-judgemental, outreach	Community-based stepped care with clear referral

4. Discussion

This exploratory study describes substance use among youths in a high-density Harare suburb and the supports around them. Three findings stand out. Substance use differed by gender, it often served a practical or emotional purpose, and the main barrier to help was a lack of trust rather than a lack of services. The gender split is the most striking result, and it needs careful handling. All males in the survey sample used mutiro or cannabis, and all females used brongo or sedatives. The small sample means this could be a feature of who was reached, and the study cannot estimate how widespread the pattern is. Even so, key informants and girls' own accounts described the same difference, and they also described why it matters. Use that is loud and visible draws attention from families, police and clinics, while use that is quiet may not. Programmes that rely on street-based outreach could therefore miss young women who use sedating substances in private. This is a hypothesis for larger studies, but it is a useful one. In our reading, we did not find earlier work that compared the substances used by young men and women in a community like Mbare.

The second finding is that substances often had a function. Mutiro helped some young men work longer, and brongo helped some young women sleep or manage worry. This fits social stress theory, which expects chronic strain to push people towards coping behaviours that bring short-term relief (Pearlin, 1989). It also echoes the self-medication idea, which holds that some people use substances to manage painful emotional states (Khantzian, 1997). These accounts do not make use safe, and several participants said that use had become a problem in its own right. The practical point is that messages telling youths to "just stop" ignore the job the substance is doing. The biopsychosocial model helps here, because it reminds us that peers, family, work conditions and mood all sit together in the same story (Engel, 1977). Peer influence was real, but it was the doorway rather than the whole house.

The third finding concerns services. Mbare is not empty of help. A polyclinic, the Friendship Bench, an NGO programme, churches, families and outreach workers were all named. What was missing was a trusted path between them. Fear of police involvement, expectations of judgement and the memory of a programme being linked to the police all made formal help feel unsafe. This agrees with the Harare study by Nyashanu et al. (2024), which also found fear of incarceration and stigma to be central barriers. It also adds something. In our records, a service that exists on paper can become unusable overnight if the community doubts its independence, and informal settings such as outreach and church talks were trusted precisely because they were relational. Our participants' fear of police involvement suggests that a

punishment-centred image of drug control may keep young people away from the very services meant to help them. The Friendship Bench model suggests that lay-delivered, community-based care can work in Zimbabwe (Chibanda et al., 2016), and what young people asked for, a local room and one helpful person, is close to that model. The records also show its limits. The Bench was described as suited to mild and moderate problems, and severe cases still need a clear route to specialist care.

For practice, three suggestions follow. Prevention and outreach should be tailored by substance and gender, with confidential entry points for young women. Services should state their confidentiality rules clearly and keep a visible distance from law enforcement. And community-level supports such as outreach workers, churches and the Friendship Bench should be linked by a simple referral pathway to specialist services, so that trust built at the first contact is not lost at the second.

4.1. Limitations

This study has important limits. The analysed sample was much smaller than planned. Twelve survey records and eight youth interviews cannot represent the youth of Mbare, and the study does not report prevalence. Recruitment through referral chains tends to reach people who are connected to peer networks, and may miss isolated youths. Detailed histories and service-use data were complete for only five survey respondents. Substance use and service use were self-reported and may be under-reported because of stigma and fear of police. The three youth interview records available only as summary notes were less detailed. The interview and survey codes could not be matched, so individual-level links between the two sources could not be examined. The data are cross-sectional and cannot show cause. The researcher also acted as the main data collector and analyst, so reflexive checks by a second coder would strengthen future work [CONFIRM whether a second coder reviewed the themes]. Finally, the findings come from one suburb and should not be applied to other communities without further research.

5. Conclusions

In this exploratory sample of youths in Mbare, substance use differed by gender, often began in adolescence, and was tied to work, hardship, grief and emotional strain as much as to peer influence. Support services existed but were used little, mainly because young people doubted that they would be treated with respect and kept confidential. Larger and more complete studies should test the gender pattern and the link between service trust and help-seeking. In the meantime, the findings support local, confidential, youth-friendly and gender-aware services that are connected to specialist care.

Author Contributions: Conceptualization, T.M.; methodology, T.M.; investigation, T.M.; formal analysis, T.M.; writing—original draft preparation, T.M.; writing—review and editing, T.M. and [SUPERVISORS]; supervision, [SUPERVISORS]. All authors have read and agreed to the published version of the manuscript. [CONFIRM]

Funding: This research received no external funding. [CONFIRM]

Institutional Review Board Statement: The study was conducted in accordance with the Declaration of Helsinki and approved by [NAME OF COMMITTEE] (protocol code [NUMBER], date [DATE]).

Informed Consent Statement: Informed consent was obtained from all participants. For participants under 18 years, consent was obtained from a parent or guardian and assent from the participant. [CONFIRM]

Data Availability Statement: The data contain sensitive information about people who use drugs, including minors. They are not publicly available for privacy and ethical reasons. De-identified summary data are available from the corresponding author on reasonable request, subject to ethical approval.

Acknowledgments: The author thanks the young people, key informants and community organisations in Mbare who took part in the study. [CONFIRM]

Conflicts of Interest: The authors declare no conflicts of interest.

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