Results A total of 26 professionals participated in the interviews. The main facilitator for implementation of the CDSS was considered to be easy access to well-structured patient data, and the resulting reduction of MDTM preparation time and of duration of MDTMs. Less impact of the CDSS was expected on the quality of lung cancer services generated by MDTM decision-making. Main barriers for adoption included incomplete or non-trustworthy output generated by the system and insufficient adaptability of the system to local and contextual needs. Actionable findings for an implementation strategy were a usability test involving key users and a validation study in the organization's real-life setting prior to roll out.

Conclusion Using this CDSS in lung cancer MDTMs was expected to increase efficiency of workflows. Successful implementation is dependent on the reliability and adaptability of the CDSS and involvement of key users in the implementation process.

18 COLLABORATIVE QUALITATIVE RESEARCH ON SUICIDE AND SELF-HARM IN SOUTH ASIA: A REFLECTION ON CHALLENGES AND SOLUTIONS

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Trust is essential to planning and delivering impactful international research that is culturally appropriate and has the potential to change practice and policy on local levels. However, details on how this can be achieved, and a discussion of challenges encountered are often lacking. A better understanding of building and maintaining of trust in North-South research partnerships is essential, especially when tackling complex and sensitive issues such as self harm and suicide. Suicide is amongst the leading causes of death in South Asia.

This talk will reflect on experiences in the South Asia Self-Harm Initiative (SASHI), a global-challenges funded research project, led by co-investigators from the Global North and South. The research collects empirical evidence to inform the understanding of the nature of self-harm in the context of profound social, political and economic challenges in the global South as well as builds research capacity. We draw on Ben-Ari and Enosh's work (2010), which focuses on identifying incongruities that challenge our knowledge (*discovery*) and examine them in-depth as a source of new knowledge (*construction*) to come to a new understanding. The definition of trust is debated, and our starting point is Luhmann's (1999) approach that trust is expressed through social action in contexts we cannot fully know.

We argue that trust is a building block for fair and equitable international research partnerships and is continually developed and negotiated in relationships and activities. Power inequalities and contextual factors need to be acknowledged. Working on building and maintaining trust is emotionally and cognitively challenging. Our experiences suggest that building and maintaining trust relies on recognising similarities, which can foster respect and equality of status. Acknowledging and exploring differences can provide opportunities for reflection and joint learning. These issues are important to consider as they ultimately shape knowledge production and translation.

19 THE DYNAMICS OF TRUST AND STRUCTURAL COERCION WITHIN A MENINGITIS TRIAL IN SUB-SAHARAN AFRICA

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Background Clinical trials in sub-Saharan Africa typically offer better medical care than is routinely available. This can lead to structural coercion where an individual may consent because of a lack of alternative options and potentially despite being uncertain about the research. An inherent component of this decision making process is an assessment of trust. Trust in the treatment options, the research team, and the process as a whole. This may be polarised in the context of life-threatening illnesses where recruitment (or not) could determine survival.

Aim We sought to understand the dynamics of trust and structural coercion in a multi-site clinical trial for HIV-associated cryptococcal meningitis.

Methods We embedded an ethnographic study within a clinical trial for HIV-associated cryptococcal meningitis. We conducted in-depth interviews with trial participants and their next-of-kin in Uganda and Botswana. We combined these with direct observations and in-depth interviews with researchers working at the African sites and European partner institutions. Interviews were transcribed, translated, and subject to narrative analysis.

Results To date we have recruited 14 trial participants, five next-of-kin and ten researchers. Recruitment is on-going until March 2021. Participants and their relatives often felt they had no choice but to enrol in the clinical trial which was their best chance of survival. Despite the perceived benefits of participation, recruitment came at a cost to participants who agreed to invasive medical procedures such as lumbar punctures despite pre-existing beliefs they could cause death. The severity of the illness contributed to poor comprehension of what the trial entailed and the decision to participate was heavily based on trust in the research team.

Conclusions Structural coercion is a significant factor impacting recruitment into clinical trials in resource-limited settings. In the context of life-threatening illness, trust superseded the need for an in-depth understanding of the research process.

20 TRUST AND RELIANCE WITHIN SPECIALIST CLINICAL SERVICES: COUNTER-PRODUCTIVE OR HELPFUL FOR SELF-MANAGEMENT OF PEOPLE WITH NEUROMUSCULAR CONDITIONS?

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Current approaches to self-management de-emphasise dependency on healthcare services and focus on building confidence and capability. Our qualitative study explores self-management perspectives from individuals with neuromuscular conditions who attend regional specialist clinics, to inform implementation of a self-management intervention.