'Crafting the future of qualitative health research in a changing world'

Oral presentations

Parallel session – Global Health (22 March 11:30 –13:00)

01 QUALITATIVE RESEARCH FOR LARGE-SCALE SUSTAINABLE IMPACT ON HEALTH IN LOW-RESOURCE SETTINGS

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Background To improve health in low-resource settings, it is imperative to enhance (a) design of interventions, (b) piloting of interventions, and (c) analyse the processes through which interventions are implemented and how they are used and perceived by key stakeholders. Applied qualitative research is a potential approach.

Objectives

- identify processes through which collaborations can be built in order to undertake focused studies in applied qualitative health research in low-resource settings;
- provide examples of how such collaborations have resulted in applied qualitative research that has impacted on policy and practice across a range of health issues and contexts.

Methods Much research to improve health in low-resource settings includes embedded qualitative studies, which may be exploratory, to support the design of interventions, may form part of pilot studies, or may form part of process evaluations or other types of explanatory work. They are typically constrained by relatively short timeframes and tight budgets. We have developed a collaborative approach to high quality focused qualitative studies that involves a process of co-designing protocols and ethics applications; co-designing data collection tools; collecting, transcribing and analysing data in an iterative and collaborative manner, which enhances the quality of the data collected; and co-writing publications and policy briefs. We have identified processes that have provided both high quality research findings and findings of direct relevance for researchers, practitioners, and policy makers.

Results Applied qualitative health research in low-resource settings has contributed to major impact on policy and practice at scale in settings such as China, India, Pakistan, Bangladesh, Nepal, Ghana and Sierra Leone, across a range of communicable and non-communicable diseases.

Conclusions Despite difficult timeframes and tight budgets, applied qualitative research can contribute substantially to impact on health policy and practice in low-resource settings.

02 'FREE HEALTH/FREE DIE': INVESTIGATING WOMEN'S HEALTH IN POST-EBOLA RURAL SIERRA LEONE

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In 2014–2015, Sierra Leone suffered through the Ebola epidemic which claimed 3,956¹ lives in Sierra Leone alone, led

to near global pandemonium, and indirectly resulted in additional deaths for untreated conditions when the health system collapsed; more specifically, it resulted in an estimated 3,297² additional maternal and neonatal deaths for a country that already has one of the highest maternal mortality rates in the world, 1,360/100,000³ live births. While, social research during the epidemic centered on understanding social and cultural traditions which would serve to reduce people's movements and encourage their compliance with response efforts, the reasons for communities' mistrust of the healthcare system went overlooked, and in practice military protocols and parallel health systems were commonly implemented. Since the post-Ebola recovery period, little attention has been paid to the social dynamics of the epidemic, which heavily contributed to its spread and impact, particularly in terms of relationships between community, state, and Development actors.

In 2018, I conducted ethnographic research to study women's relationship to the healthcare system, the social dynamics which impact women's access to health, as well as social and cultural factors that could inform a future outbreak. I lived for 5 months with a community and conducted participant-observation, 11 focus groups, and 60 in-depth interviews, within the surrounding local communities and with district and national stakeholders, both native Sierra Leoneans and expatriates.

Mistrust is still prevalent between communities and state healthcare system, but little has been done to address the relationship between the two. Government-run clinics have become a venue for rent-seeking behavior through the sale of private and public medical drugs, exacerbated by HCWs lack of integration within communities, as well as faults in HCW supervision. Additionally, responsibility and blame for health and illness is typically placed on communities, apparent in health strategies and language.

REFERENCES

1. World Health Organization; March 2016 Ebola Situation Report: <http://apps.who.int/ebola/ebola-situation-reports>; accessed Sept. 24, 2018.
2. UNFPA, 'Rapid Assessment of Ebola Impact on reproductive health services and service seeking behavior in Sierra Leone' March 2015.
3. World Health Organization; 2015 Maternal Mortality Rate: <http://apps.who.int/gdo/data/node.country.country-SLE?lang=en>; accessed Sept. 24, 2018.

03 MAINSTREAMING QUALITATIVE LONGITUDINAL RESEARCH AND RE-THINKING CAUSALITY IN A GLOBAL HEALTH CONTEXT

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As a rich and flexible methodology for discerning dynamic processes, Qualitative Longitudinal (QL) research follows the same individuals or small collectives prospectively, in 'real' time, as lives unfold. It has the power to mirror real world processes, to investigate how and why changes occur, and to discern the mechanisms that shape these processes (Neale 2018). This capacity is vital where people are required or encouraged to change their practices or otherwise adapt to changing circumstances or environments over time. In recent years this approach has been used increasingly in health services research.^{1,2} However, there have been few attempts in