'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

this field to document its use or explore its theoretical underpinnings.

This presentation will outline the design and development of an ambitious programme of QL research, the Health Utilisation Dynamics Study, directed by PATH. This is a qualitative 'add on' to a large-scale evaluation of the Malaria Vaccine Implementation Programme in Ghana, Kenya and Malawi. QL enquiry is uniquely placed to investigate health and illness biographies, changing health policies, the delivery, uptake and sustainability of new treatments, and to produce dynamic case studies of local health care systems. These are central themes in this study. In particular, we will explore innovative ways to discern causal mechanisms across the micro-macro plane. Our aim is to reflect the dynamic, open-ended and fluid nature of social actions, reactions, effects and counter effects in complex systems of change.

REFERENCES

1. Calman L, Brunton L and Molassiotis A. Developing longitudinal qualitative designs: lessons learned and recommendations for health services research. *BMC medical research methodology* 2013;13:14.
2. Grosssoehme D and Lipstein E. Analyzing longitudinal qualitative data: the application of trajectory and recurrent cross-sectional approaches. *BMC research notes* 2016;9:136.

04 VIEWS OF KEY STAKEHOLDERS IN SAUDI ARABIA ON PROTECTIVE SEXUAL HEALTH STRATEGIES

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Background Approaches to sexual health education diverge between promoting abstinence-until-marriage and supporting harm reduction (HR). The latter acknowledges that adolescence is a period of risk taking and aims to reduce the harms of STIs and unplanned pregnancies. In Saudi Arabia, there is no sexual health education and the sensitivities surrounding sex-related issues in a country that rules exclusively by Islamic laws, creates challenges for the provision of sexual and reproductive health information. This study aimed to explore the views of key stakeholders in Saudi Arabia on the relative merits of adopting an abstinence-only approach or HR strategies within a proposed sexual health education program and to examine which approaches are likely to be feasible in Saudi Arabia, and by extension in other Muslim communities around the world.

Methods In this qualitative study, semi-structured interviews with 28 participants were conducted. Four different groups were targeted, policymakers (n=6); healthcare providers (n=10); teachers (n=9); and religious scholars (n=2).

Results The need for sexual health education for adolescents was universally acknowledged by participants. Stakeholders' views spanned a spectrum rather than fitting in clear cut categories of adopting abstinence vs HR strategies. The concept of harm was conceptualized, contrary to the conventional public health discourse, as strictly health-related but focused on social and religious harm. Those who opposed HR strategies believed that these messages can encourage premarital sexual activity and hence damage traditional family norms. While those who leaned towards adopting HR strategies viewed it as a necessary step in preventing infectious harm from pervading the rest of society. Opinions varied on who should formulate the program and in what context it should be delivered.

Conclusion The results showed that understanding the local interpretations of harm and HR strategies is vital to formulating a culturally sensitive sexual health education program that can expand beyond international public health definitions and messaging.

05 COMPETING EXPECTATIONS: ADVANCED CARE PLANNING FROM THE PERSPECTIVES OF DOCTORS AND NURSES IN THE SOUTH-EAST ASIAN CONTEXT

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Introduction Singapore has the fastest ageing population in the world, with the number of individuals aged 65 and older increasing to an estimated 9 00 000 in the next thirty years. Corresponding demand for health and social care among the aged could surge, especially in terms of palliative care, which will more than double by 2020 to over 10 000 patients per year. In response, the national Advance Care Planning (ACP) programme was launched in Singapore in 2011 with the purpose of improving quality of palliative care through enabling patients to express their end-of-life care needs and wishes to healthcare professionals and caregivers. The purpose of this study is to examine the perspectives of doctors and nurses on facilitation of end-of-life care conversations and decision-making in Singapore

Methods Eight focus group discussions and dyadic interviews were conducted with physicians and nurses. Discussions were facilitated by members of the research team and focused on participants understanding of their role as a healthcare professional in the context of end-of-life care and their adherence to precepts of ACP. Transcripts and audio recordings of FGDs were stored digitally and analysed through QSR NVivo. Themes emanating from transcripts were identified through a framework analysis approach.

Results Facilitation of end-of-life conversations and decision-making processes were influenced by life and death culture. The ACP programme was mostly conducted in acute medical settings, wherein the prevailing institutional philosophy was that of the biomedical model of care. Consequently, the organisation of services was primarily focused on curation, with doctors playing a leading role in terms of decisions on patients' care. Nurses were often disempowered in terms of making decisions on patients' pathways through care.

Conclusion End-of-life conversations were often conducted in acute care settings, in which the structure of services were often hierarchical and predicated on the biomedical model of care.

06 PREVENT DISSENT: IMPLICATIONS OF NEW COUNTER-TERRORISM DUTY ON PRACTITIONER FREEDOM OF CONSCIENCE

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Background The PREVENT policy introduced a duty for health professionals to identify and report patients they suspect may be vulnerable towards radicalisation. Research on