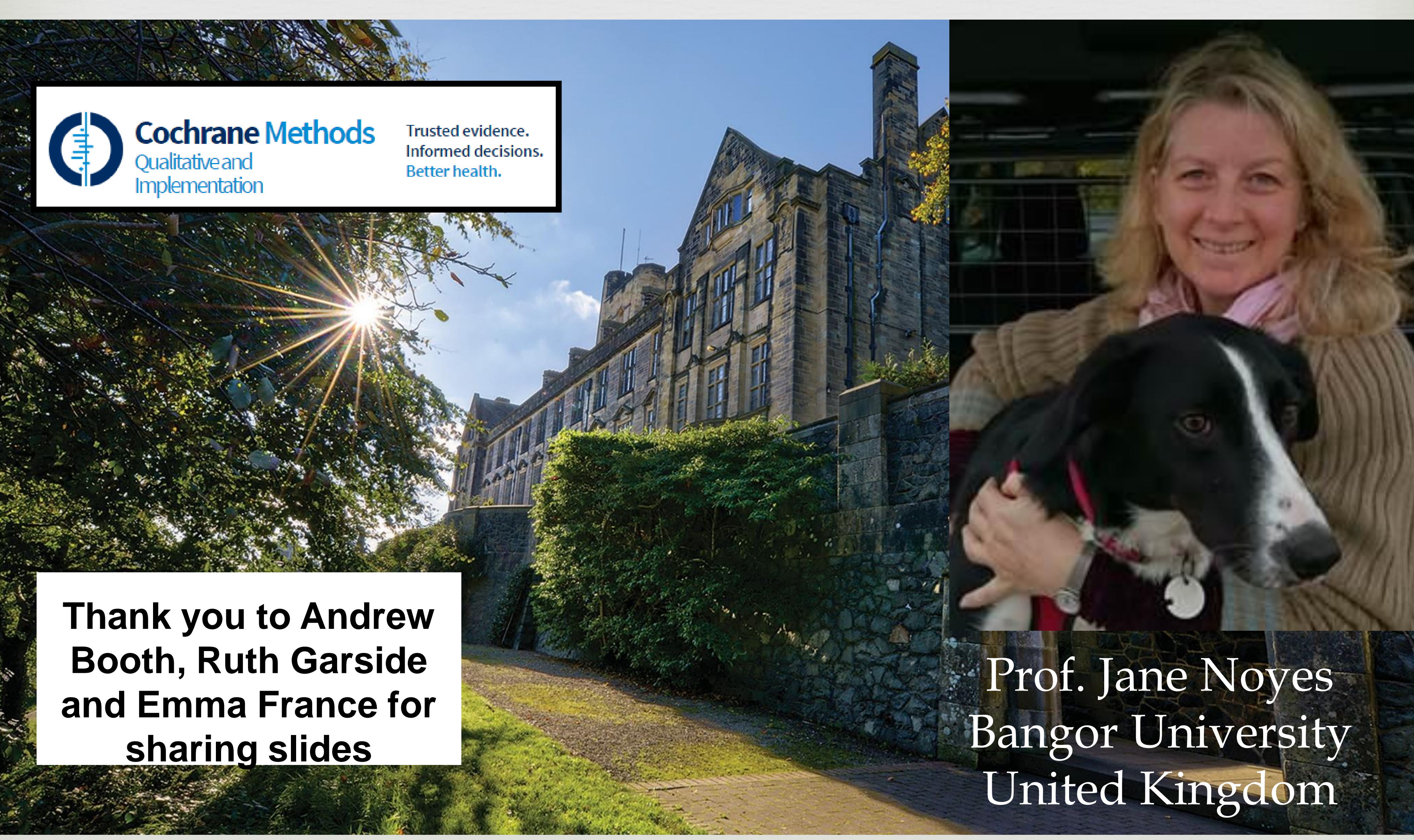
Undertaking a qualitative evidence synthesis to support decision-making in a Cochrane context



Conflict of Interest Statement

Lead Convenor CQIMG
Co-Chair Cochrane Methods Executive*
Member Cochrane Scientific Committee*
Editor Journal of Advanced Nursing*

No financial conflicts declared
(*receive expenses to attend meetings)

IP declarations:

Member of the core groups developing CERQual, eMERGe, ICAT_SR

Legitimate funding sources:

Employed by Bangor University, UK
Part funded by eMERGe project – NIHR England

JAN
Informing Practice and Policy Worldwide through Research and Scholarship

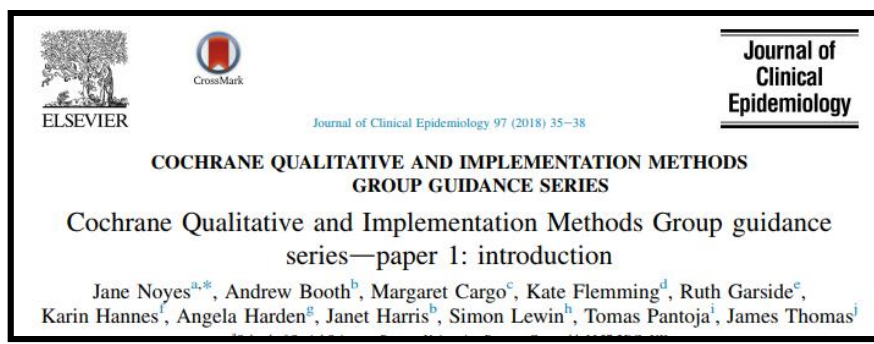
Please tell me about your experience of conducting a qualitative evidence synthesis?

A. No experience

B. Some experience

C. Lots of Experience

- Series of 7 papers outlining guidance published in the Journal of Clinical Epidemiology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Journal of Clinical Epidemiology 97 (2018) 35–38

Journal of Clinical Epidemiology

COCHRANE QUALITATIVE AND IMPLEMENTATION METHODS GROUP GUIDANCE SERIES

Cochrane Qualitative and Implementation Methods Group guidance series—paper 1: introduction

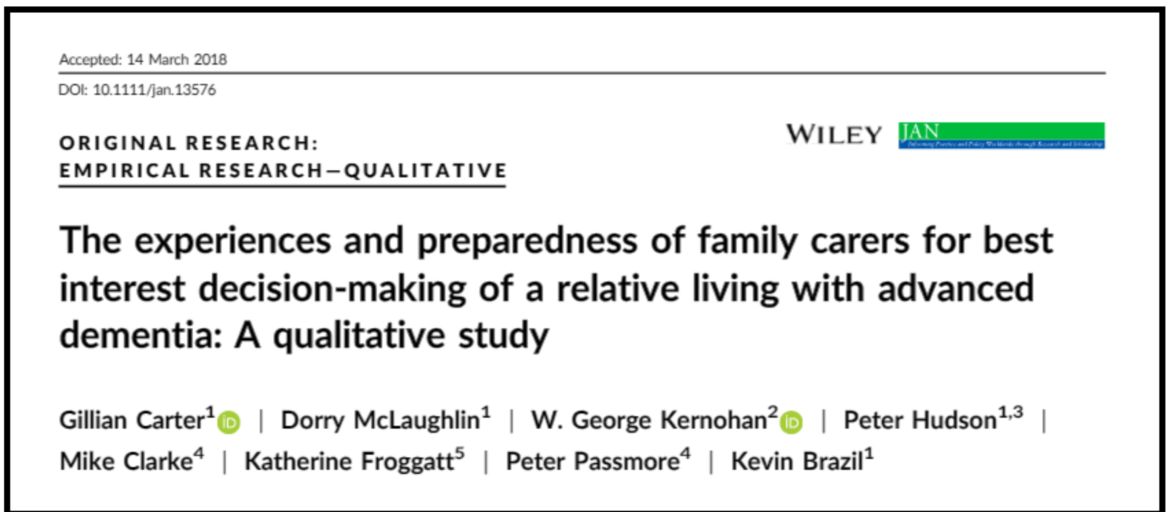
Jane Noyes[a,*], Andrew Booth[b], Margaret Cargo[c], Kate Flemming[d], Ruth Garside[e], Karin Hannes[f], Angela Harden[g], Janet Harris[b], Simon Lewin[h], Tomas Pantoja[i], James Thomas[j]

- WHO is about to publish a series in BMJ Global Health on systematic review methods for complex interventions implemented in complex health systems

What is qualitative research?

Uses a qualitative methodology and methods of data collection and analysis

Eg: Focus groups, interviews, observations to produce narrative findings that can be analysed


Accepted: 14 March 2018
DOI: 10.1111/jan.13576

WILEY JAN

ORIGINAL RESEARCH:
EMPIRICAL RESEARCH–QUALITATIVE

The experiences and preparedness of family carers for best interest decision-making of a relative living with advanced dementia: A qualitative study

Gillian Carter[1] | Dorry McLaughlin[1] | W. George Kernohan[2] | Peter Hudson[1,3] | Mike Clarke[4] | Katherine Froggatt[5] | Peter Passmore[4] | Kevin Brazil[1]

What type of questions can qualitative research address?

Can explore multiple phenomenon of interest that involve behaviour or attributing meaning to behaviour: Such as:

- Patient experiences of living with a disease or condition
- Patient experiences of living within a specific context with the disease or condition
- Patient experiences of an intervention
- Carers experiences
- Health care professionals experiences
- Other key stakeholder experiences
- Can also be used to develop new theory

Types of findings from qualitative research (and reviews)

- Description of a phenomenon (the issue of interest)
- Definition of a new concept
- Creation of a new typology
- Description of processes
- Explanations or theories
- Development of strategies

Acknowledgement Ruth Garside QIMG – sharing slides

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What do qualitative findings look like?

- Text (quotes, author's analysis)
- Tables (classifications, summary of themes)
- Conceptual figures
- Images (photographs, artwork)

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In Cochrane – a qualitative evidence synthesis is undertaken for a specific purpose:

- To better understand intervention heterogeneity, acceptability, feasibility, dose, reach, implementation etc

- Increasingly used to better understand implementation of complex health system level interventions (such as public health interventions)

  Such as feedback loops, health system adaptivity in response to the intervention.

- May also be undertaken to formulate patient centred questions and to better understand patient outcomes of interest when designing an intervention review.

Cochrane Methods
Qualitative and Implementation

Trusted evidence.
Informed decisions.
Better health.

The current Cochrane model :

The qualitative evidence synthesis may be undertaken using a separate protocol and subsequently integrated with the linked intervention effect review

Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: qualitative evidence synthesis (Review)

Glenton C, Colvin CJ, Carlsen B, Swartz A, Lewin S, Noyes J, Rashidian A

Lay health workers in primary and community health care for maternal and child health and the management of infectious diseases (Review)

Lewin S, Munabi-Babigumira S, Glenton C, Daniels K, Bosch-Capblanch X, van Wyk BE, Odgaard-Jensen J, Johansen M, Aja GN, Zwarenstein M, Scheel IB

OR

The qualitative evidence synthesis may be undertaken as part of a mixed-method protocol that includes conducting the intervention review

Cochrane Database of Systematic Reviews

Exercise interventions and patient beliefs for people with hip, knee or hip and knee osteoarthritis: a mixed methods review

Review

Michael Hurley, Kelly Dickson, Rachel Hallett, Robert Grant, Hanan Hauari, Nicola Walsh, Claire Stansfield, Sandy Oliver

ACCEPTABILITY			
	Is the intervention acceptable to key stakeholders? ○ No ○ Probably no ○ Probably yes ○ Yes ○ Varies ○ Don't know		

Detailed Judgement

ACCEPTABILITY: **Is the intervention acceptable to key stakeholders?**
Panel discussion

Detailed questions

Are there key stakeholders that would not accept the distribution of the benefits, harms and costs?

Yes | Probably yes | Probably no | No | Don't know

Are there key stakeholders that would not accept the costs or undesirable effects in the short term for desirable effects (benefits) in the future?

Yes | Probably yes | Probably no | No | Don't know

Are there key stakeholders that would not agree with the values attached to the desirable or undesirable effects (because of how they might be affected personally or because of their perceptions of the relative importance of the effects for others)?

Yes | Probably yes | Probably no | No | Don't know

Would the intervention (option) adversely affect people's autonomy?

Yes | Probably yes | Probably no | No | Don't know

Are there key stakeholders that would disapprove of the intervention (option) morally, for reasons other than its effects on people's autonomy (i.e. in relationship to ethical principles such as non-maleficence, beneficence or justice)?

Yes | Probably yes | Probably no | No | Don't know

Final judgement Is the intervention acceptable to key stakeholders?

No | Probably no | Probably yes | Yes | Varies | Don't know

FEASIBILITY			
	Is the intervention feasible to implement? ○ No ○ Probably no ○ Probably yes ○ Yes ○ Varies ○ Don't know		

Detailed Judgement

FEASIBILITY: **Is the intervention feasible to implement?**
Panel discussion

Detailed questions

Is the intervention (option) sustainable?

No | Probably no | Probably yes | Yes | Varies | Don't know

Are there important barriers that are likely to limit the feasibility of implementing the intervention (option) or require consideration when implementing it?

No | Probably no | Probably yes | Yes | Varies | Don't know

Section of the DECIDE evidence to decision framework that requires a synthesis of qualitative evidence to address

Qualitative and quantitative findings are needed to understand the big picture

Box 1: Incorporation of qualitative evidence synthesis in NICE guidelines on long term management of stroke[16,17]

Evidence from qualitative and quantitative studies (section 6.2.1)

- Inhibitory factors such as limited time, presiding professional routines and the single opportunity to meet clinicians post discharge for secondary risk management (three qualitative studies: low to moderate confidence in studies)
- Standard goal setting meeting, which is held away from the patient and with standard documentation, is not conducive to patient centred goal setting (quantitative study: low to moderate confidence)

Summary of challenges to patient participation in goal setting (6.2.3)[17]

- Five studies highlighted factors inhibiting patients from participating in goal settings. These factors include: limited time, presiding professional routines, goal setting meeting which is held away from the patient, single opportunity to meet clinicians post discharge for secondary risk management, stroke pathology with its highly unpredictable recovery prognosis and its effects such as aphasia

Translation to clinical guideline[16]

1.2.8 Ensure that people with stroke have goals for their rehabilitation that:
- Are meaningful and relevant to them
- Focus on activity and participation
- Are challenging but achievable
- Include both short and long term elements

1.2.9 Ensure that goal setting meetings during stroke rehabilitation:
- Are timetabled into the working week
- Include the person with stroke and, where appropriate, their family or carer in the discussion

1.2.10 Ensure that during goal setting meetings, people with stroke are provided with:
- An explanation of the goal setting process
- The information they need in a format that is accessible to them
- The support they need to make decisions and take an active part in setting goals

Is Your Question……

- **Fixed?** – Pre-defined as a PICO (Population-Intervention-Comparison-Outcome) or SPICE (**S**etting-**P**erspective- **I**nterest, Phenomenon of – **C**omparison- **E**valuation) – Question is an "Anchor"
- *(e.g. attached to an Effectiveness review)*
- What factors affect implementation of intervention x?

- **Negotiable?** – To be explored as part of initial review process – Becomes clearer as you examine data – Question is a "Compass"

- What do women conceptualise as 'good' antenatal care?

Journal of Clinical Epidemiology

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We recommend 3 methods of qualitative evidence synthesis:

1. Framework Synthesis
2. Thematic Synthesis
3. Meta-ethnography

Use the ‘chat’ to let me know if you have used any of these methods

Methods for the synthesis of qualitative research: a critical review.

Barnett-Page E, Thomas J. BMC Research Methodology 2009

Textual narrative synthesis	Ecological triangulation	Framework synthesis	Meta-ethnography	Grounded Theory	Thematic synthesis	Meta-narrative	CIS	Meta-study
Translation	Translation	Translation/ Trans-formation	Transformation	Transformation	Transformation	Transformation	Transformation	Transformation

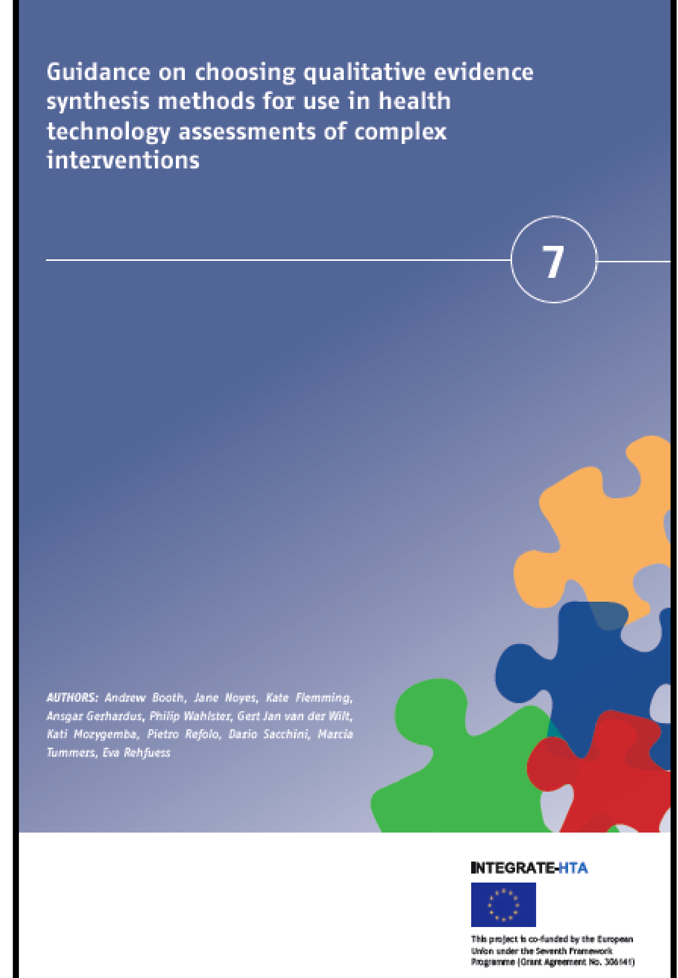
1st order constructs – quotes from the participants in primary qualitative studies

2nd order constructs - interpretations of the primary study researchers

3rd order constructs - new synthesised findings and hypotheses developed by review authors that move beyond interpretations reported in the primary studies

RETREAT framework

Research question
Epistemology
Time/Timeframe
Resources
Expertise
Audience & Purpose
Type of Data



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Journal of Clinical Epidemiology 99 (2018) 41–52

Journal of Clinical Epidemiology

REVIEW ARTICLE

Structured methodology review identified seven (RETREAT) criteria for selecting qualitative evidence synthesis approaches

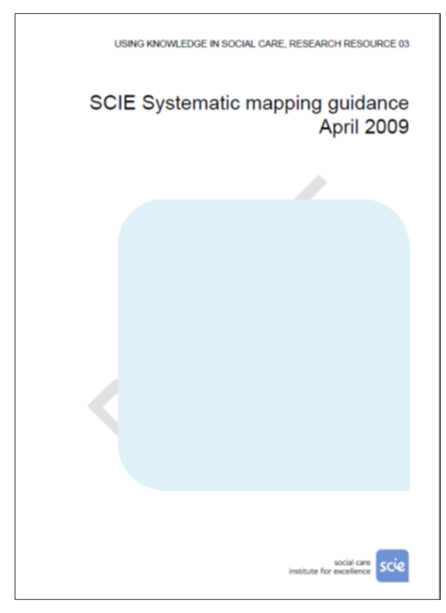
Andrew Booth[a,*], Jane Noyes[b], Kate Flemming[c], Ansgar Gerhardus[d], Philip Wahlster[e,f], Gert Jan van der Wilt[g], Kati Mozygemba[d], Pietro Refolo[h], Dario Sacchini[h], Marcia Tummers[g], Eva Rehfuess[i]

https://www.integrate-hta.eu/wp-content/uploads/2016/02/Guidance-on-choosing-qualitative-evidence-synthesis-methods-for-use-in-HTA-of-complex-interventions.pdf

Bad Reasons for Choosing Method

- Frequency of Use of Method (e.g. Meta-Ethnography)
- Popularity/"Sexiness" of Method (e.g. Realist Synthesis)
- What a friend/ colleague/ mentor has used (once!)
- Bad experiences of others (may have been inappropriate!)

When should you select your review design/methods?



Unless you have good knowledge of potentially relevant published qualitative studies – consider a knowledge map first

When the number, type, quality and richness of available qualitative studies is known – then select an appropriate review method and refine the review question in line with the selected method

How Rich (“Thick”) is Your Data?

- Qualitative data from “thin” studies (or textual responses to surveys) will not sustain interpretive approaches
- Limited to **Meta-Aggregation**,

- Rich/“Thick” reports will sustain Meta-Ethnography– may allow selective sampling

Usual scenario is a mixture of thick and thin studies:

Thematic Synthesis, **Framework Synthesis**,–type approaches

How ‘thick or thin’ are findings?

Finding the findings in qualitative research

Finally, saturation occurs when there is ongoing replication of data covering the emerging essential thematic elements of the phenomenon under study (Woodgate, Ateah, & Secco, 2008). In this study, the redundancy of data became evident after hearing the narratives of 8 participants.

Findings

The analysis of the interviews provided a deep understanding of the older rural women's perceptions of restrictions on their access to health care when they are sick, and the mechanism by which these processes work. The overarching or core theme that emerged to capture the essence of being an older woman seeking health care in rural Bangladesh was *being in a socially excluded space*. Being in a socially excluded space was defined by social practices that assumed an inferior role for older women within the family and less access to family resources than other family members; exclusion from the opportunity to participate in the wage economy outside the home; and exclusion from the broader community through the restrictions on mobility outside the home and contact with men who are not family members that are associated with the religious practice of purdah. The women interviewed also talked about the stigma associated with some illnesses and their inclination to avoid this stigma, which meant that they did not go for medical care when they were ill. These themes are developed below, and quotes provided to support the analysis.

Exclusionary Social Practices

Older women's health is treated as the least important in the family. In general, the women interviewed reported that the health of an older adult woman is treated as less important within the family than that of the rest of the family. They felt that limited attention was given to them during their sickness compared to the attention given to other members of the family. They identified both age and gender as factors that influence health care seeking, with younger people being given priority for health care within the family. Participants agreed that children with any illness were prioritized for treatment because of the common view that "children have not begun their life, but the elderly have almost lived theirs." For a typical family, the order of priority for seeking health care was: baby boy, baby girl, father, grandfather, mother, and then grandmother.

Husbands were more likely to pay for medical care for themselves and their children than for their wives. This attitude was inculcated through socialization to children, with the result that they also privileged older adult men over women. As one participant who had a heart problem said, "In our *shomaj* [society] women never get priority. My husband and I are both suffering from diabetes. My son brings medicine for my husband but he does not care for me. Actually, my name is not on the priority list." Most participants who were suffering from some type of illness perceived that they were unsupported in their illness. For example, one participant commented, "Because we are senior and women our sickness gets limited attention within the family. However, when my husband gets sick everybody becomes *chintitoto* [concerned] and brings *oshodpathha* [medicine and special food]. But they ignore my problems."

Others decide for you. When asked about how decisions were made within the family with respect to accessing health care, the women interviewed said that they informed someone in the family when they were sick. They usually discussed the sickness with their husbands first, or if the husband was deceased, with the eldest son. Participants explained that even if husbands did not accompany them to the health care providers, they played an important role in decision making for health care. In the words of one woman, "In case of any *ashukh Bishukh* [illness], the first person I talk with is my husband, because he knows who he can talk with for advice and also controls the money." Another participant stated,

> In case of any sickness, I talk with my family members first because without the family's permission I cannot see a doctor. It is not easy. You need money, you need somebody to accompany you, you also need to manage your daily chores before you go.

Demonstrating the relationship between decision-making processes and religious beliefs, one participant explained,

> My husband makes the decision but my *Bhasur* [husband's senior brother] is interested in where I go and what to do. If he learns that I have gone to the hospital, he gets mad. He says I am trying to destroy the *shomman* [image] of the family, because the family has a long reputation about purdah [women's seclusion in the home].

The needs of other household members come first. Women also reported being reluctant to disrupt the household by taking time from their domestic chores to seek treatment or be admitted to hospital. These women were socialized not to complain about illnesses or pain, and to continue working for the welfare of their families even when quite ill. Explaining how this affected access to health care, one participant said, "After my daughter died her two children came to me. It is my responsibility to take care

Findings

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Second order interpretations/constructs: how researchers interpret people's experiences

First order interpretations/constructs : how people make sense of their experiences

and not suffer. This is our *kismet* [destiny]."

Stigma associated with some illnesses. Considerable stigma was associated with diseases of the sexual organs, especially sexually transmitted diseases. Participants who thought they might have these diagnoses were very concerned about the consequences of detection and the possibility of being ostracized by their family and community.

Use of existing theory in qualitative research analysis:
Stigma (Goffman, 1963)
A well developed theory about how identity and acceptability are socially managed and constrained

Acknowledgement Ruth Garside QIMG – sharing slides

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Sometimes important information related to the findings isn't in the findings section!

patients. He also found that the per-capita expenditure in the government-funded health sector in urban areas is almost double that in rural areas. Other research has shown that little attention is paid to the health needs of women past childbearing age; mother and child health issues are stressed instead (Hong, 2000; Jisas, 1997).

Theoretical Perspective

As in other developing countries, health policy in Bangladesh is grounded in the biomedical model of health and illness, and in an individualistic explanation of the causes of health problems and health-seeking behavior (Islam, 2000). Designers of this approach have failed to understand or acknowledge factors that are shaped by social determinants of health. The World Health Organization (n.d.) described the social determinants of health as "the conditions in which people are born, grow, live, work and age, including the health system." The social-determinants-of-health perspective draws attention to the importance of material disadvantage and inequality, emphasizes the social and economic structures within which people live their lives, and explains how these structures determine the choices that people can make (Kirby & LeBreton, 2002; Wilkinson & Marmot, 1998). We applied a social-determinants-of-health perspective in the third level of data analysis to help organize the themes and subthemes that emerged from the inductive open (first level) and focused (second level) coding.

Methodology

The analysis reported here is part of a broader research

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Found between the Introduction and the Methodology sections

Safest Options!

If…

- There is a **Pre-existing Theory or Framework**….

Then

- **..Framework Synthesis (including Best Fit Synthesis)**

If…

- There is a **Proximate** (Close-ish!) **Theory or Framework**

Then

- **….Best Fit Framework Synthesis**

If…

- There is **No Theory or Framework**…

Then

- **…Thematic Synthesis** *(Can also act as first stage of Meta-Ethnography)*

If…

You want to develop a theory (and have rich studies)

Then

- **…Meta-ethnography**

Journal of Clinical Epidemiology 75 (2016) 78–92

Journal of Clinical Epidemiology

Current use was established and Cochrane guidance on selection of social theories for systematic reviews of complex interventions was developed

Jane Noyes[a,*], Maggie Hendry[b], Andrew Booth[c], Jackie Chandler[d], Simon Lewin[e], Claire Glenton[e], Ruth Garside[f]

[a]*School of Social Sciences, Bangor University, Bangor LL57 2EF, UK*

Guidance for review authors on choice and use of social theory in complex intervention reviews

Jane Noyes, Maggie Hendry, Andrew Booth, Simon Lewin, Claire Glenton, Ruth Garside, Jackie Chandler

Version 1 01.11.15 © Cochrane

How to Cite: Noyes J, Hendry M, Booth A, Lewin S, Glenton C, Garside R, Chandler J. (2015) *Guidance for review authors on choice and use of social theory in complex intervention reviews.* Version 1. Cochrane, London. UK.

Framework synthesis

Framework synthesis has five stages:

- *Familiarisation:* immersion in the included studies with the aims and objectives of the review.

- *Identifying or developing a thematic framework*:

- *Indexing*: Applying framework to code individual studies

- *Charting:* Charts contain distilled summaries of evidence

- *Mapping and interpretation:* Using the charts to define concepts, map the range and nature of phenomena, create typologies and find associations between themes as a way of developing explanations for the findings.

New – Best Fit Framework synthesis

Index of Codes - Barriers and facilitators to implementing tobacco harm reduction approaches; including user and provider perspectives

Capturing detail regarding population and intervention

Within each statement, add following to codes to each statement:

Theme, subtheme and subcategories
See index of codes overleaf. E.g 3.4(stress)

THEN

Intervention type
NRT = nicotine replacement therapy ; Ecig = e-cigarettes ; Bhv = Behavioural (counselling / self-help /GP advice)

AND

Selection method:
A = Self-initiated ; B = Medically /intervention prescribed ; C = Unclear

AND

Whose Voice:
M = Male; F = female ; gendmx = mixed gendU =unreported gender
Nurse = nurse; psych = psychiatrist/psychology ; GP = general practitioner ; SSC = smoking cessation counsellor ; pol = policymaker; Profmx = mixed group of professionals ; MHmx = mixed group of professionals

popEM = ethnic minority population ; popmx = mixed ethnicity ; popCau = White/Caucasian ; popU = ethnicity unspecified
SESL = Low SES ; SESH = High SES groups ; SESmx = mixed SES groups ; SESU = unspecified SES (note SES will capture info on education, income , occupation type)

(Other - only report if evident)
suc = successful reducers / CTQ / quitter ; unsuc = unsuccessful reducers / CTQ / quitter
NicH = strong nicotine dependency / regular smoker ; NicL = low nicotine dependency / infrequent smoker
MotH = highly motivated to quit/CTQ/SR ; MotL = low motivation/readiness to quit/CTQ/SR
MH = mentally ill; hosp = hospital inpatients or those awaiting surgery

Separate each group of codes with a '/' Within each group of codes separate with a '-'

e.g.
3.3/M-Teen-EM = perceived disadvantages of SR/CtQ in Ethnic Minority Teenagers
2.2/ecig-C/M-adult-SESL = reasons for self selecting ecigarettes in Male adults with a low socioeconomic background
3.4(stress)/gendmx-teen-SESH-NicH-MotH = psychological barrier of stress reported by mixed gender teenage population from high SES background who were heavy smokers and highly motivated to cut down.

Themes

Main Theme	Sub-theme (with some examples)
1. Perceived barriers and facilitators amongst smokers homes Environment State whether: Home / work / school / hospital /General	
P1.1 Social barriers	
P1.2 Social facilitators	
P1.3 Physical Barriers	
P1.4 Physical Facilitators	
P1.5 Travel barriers	
P1.6 Travel facilitators	
P1.7 Stress from environment	
P1.8 other	
2. Knowledge attitudes and beliefs and behaviours towards interventions to assist THR NB – intervention could be brief advice in healthcare consultation or ETS intervention	
P2.1 Indication of prevalence / popularity of referring / providing or prescribing intervention to assist THR	
P2.2 Attitudes towards or reasons for providing / referring / the intervention ***Whether providing advice to SR/CtQ is part of role*** P2.2(role)/Bhv-NRT-D/Nurse/ SMmx/: Almost all GPs believed that it was part of their job to advise and assist smokers to stop (96%)(McEwen 2005) P2.11(role)/Bhv-NRT-D/Nurse/SMmx/ : Almost all GPs believed that it was part of their job to advise and assist smokers to stop (99%)(McEwen 2005) ***Whether confident in ability to provide intervention*** P2.2(conf)/Bhv-D/GP/ SMTHR who smoked felt less effective in helping patients to reduce tobacco consumption than non-smoking GPs (39.4% versus 48.18%, $p<0.01$). GP smokers advised quitting to patients who smoked less often than non-smoking GPs (for both clinical scenarios) but results are not statistically significant. (Brotons 2005)	
P2.3 Attitudes towards or reasons for not providing / referring / the intervention	
P2.4 Benefits of specific intervention	
P2.5 Disadvantages of specific intervention P2.5/NRT/nurse: None of the nurses believed that nicotine patches are more likely to cause addiction than cigarettes, although 18% believed that they are equally as likely to do so (Borelli 2007)	

Level	Factors affecting implementation
Recipients of care	Knowledge and skills
	Attitudes regarding programme acceptability, appropriateness and credibility
	Motivation to change or adopt new behaviour
Providers of care	Knowledge and skills
	Attitudes regarding programme acceptability, appropriateness and credibility
	Motivation to change or adopt new behaviour
Other stakeholders (including other healthcare providers, community health committees, community leaders, programme managers, donors, policymakers and opinion leaders)	Knowledge and skills
	Attitudes regarding programme acceptability, appropriateness and credibility
	Motivation to change or adopt new behaviour
Health system constraints	Accessibility of care
	Financial resources
	Human resources
	Educational and training system, including recruitment and selection
	Clinical supervision, support structures and guidelines
	Internal communication
	External communication
	Allocation of authority
	Accountability
	Community participation
	Management and/or leadership
	Information systems
	Scale of private sector care
	Facilities
	Patient flow processes
	Procurement and distribution systems
	Incentives
	Bureaucracy
	Relationship with norms and standards
Social and political constraints	Ideology
	Governance
	Short-term thinking
	Contracts
	Legislation or regulation
	Donor policies
	Influential people
	Corruption
	Political stability and commitment

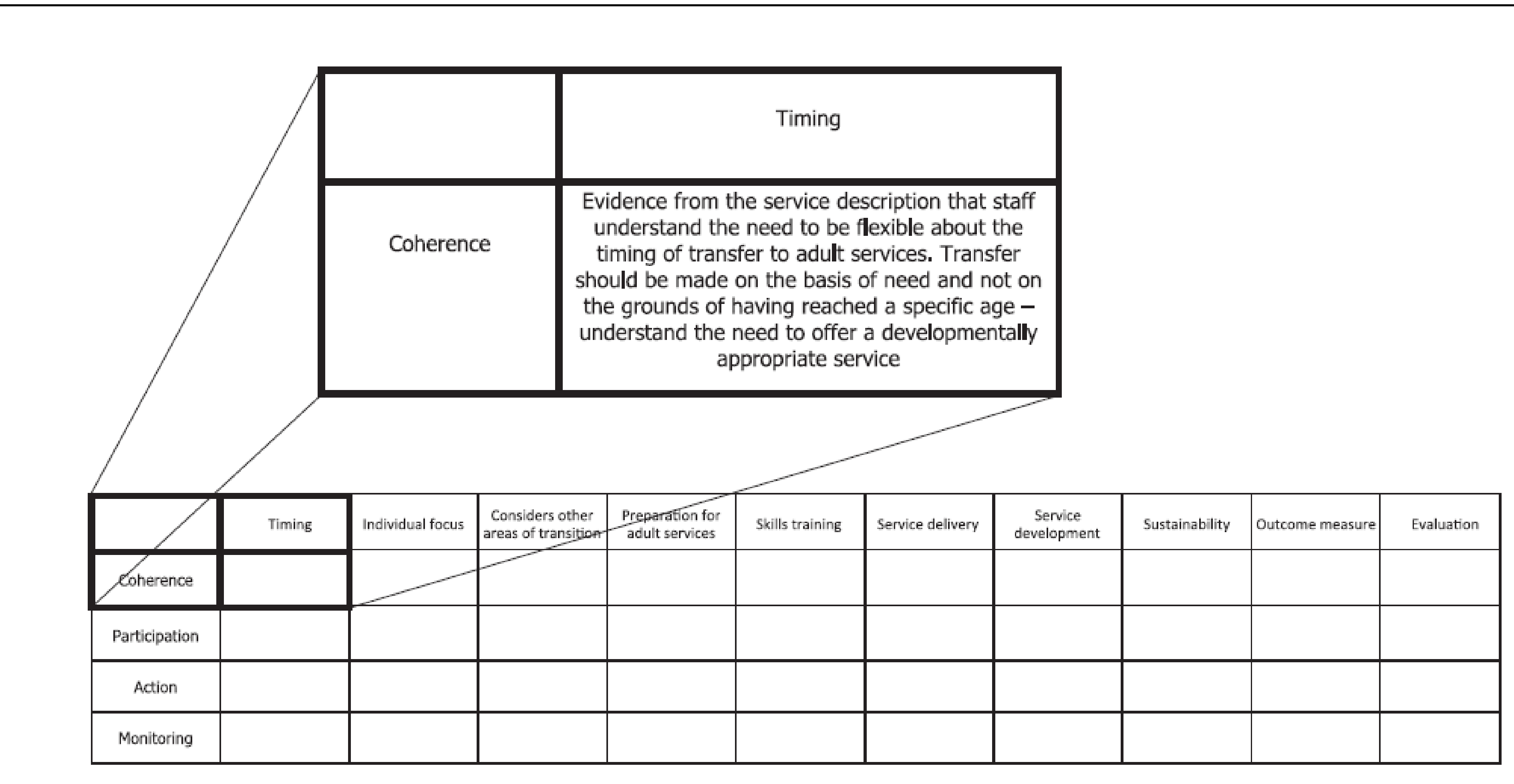
Choice of Qualitative Synthesis method:

Framework synthesis approach (Ritchie and Spencer 1993)

Used the **SURE Framework** as a theory-informed implementation framework for policy maker decision-making

Richie and Spencer Framework Synthesis Approach With Normalisation Process Theory Elements

Mid-range theory Watson et al 2011



	Timing
Coherence	Evidence from the service description that staff understand the need to be flexible about the timing of transfer to adult services. Transfer should be made on the basis of need and not on the grounds of having reached a specific age – understand the need to offer a developmentally appropriate service

	Timing	Individual focus	Considers other areas of transition	Preparation for adult services	Skills training	Service delivery	Service development	Sustainability	Outcome measure	Evaluation
Coherence										
Participation										
Action										
Monitoring										

Figure 1. Framework coding example (Parfitt 2008).

Several examples of Framework Synthesis in the Cochrane library:

Barriers and facilitators to the implementation of lay health worker programmes to improve access to maternal and child health: qualitative evidence synthesis (Review)

Glenton C, Colvin CJ, Carlsen B, Swartz A, Lewin S, Noyes J, Rashidian A

Use the ‘chat’ to share your thoughts on Framework synthesis

Thematic synthesis

Thematic synthesis – specifically Thomas and Harden's approach:

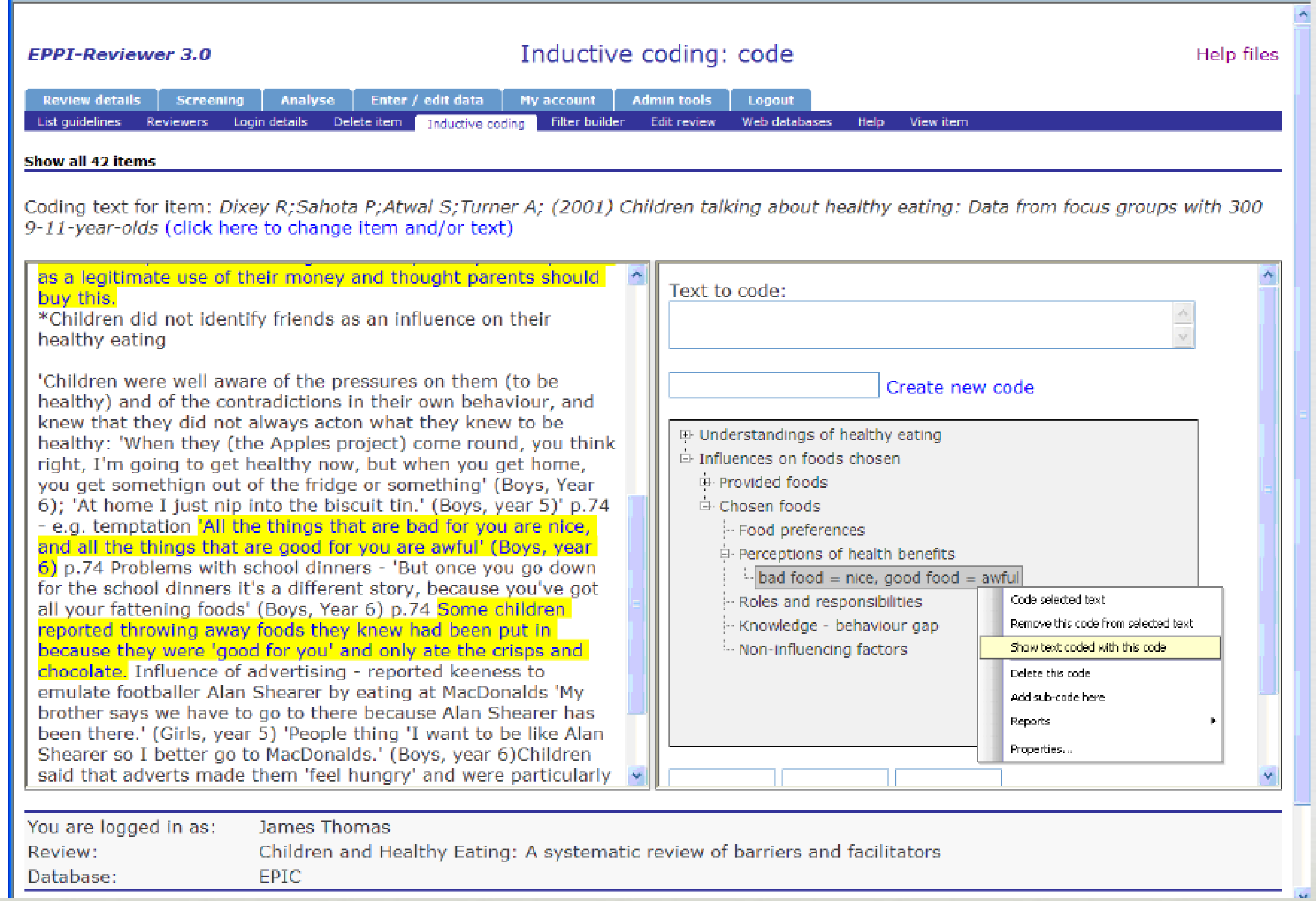
- 3 stage thematic synthesis - developed because Framework synthesis was too constraining

- Line by line inductive coding
- Development of descriptive themes
- Development of analytical themes

Methods for the thematic synthesis of qualitative research in systematic reviews

James Thomas*† and Angela Harden†

Stage 1 line by line coding

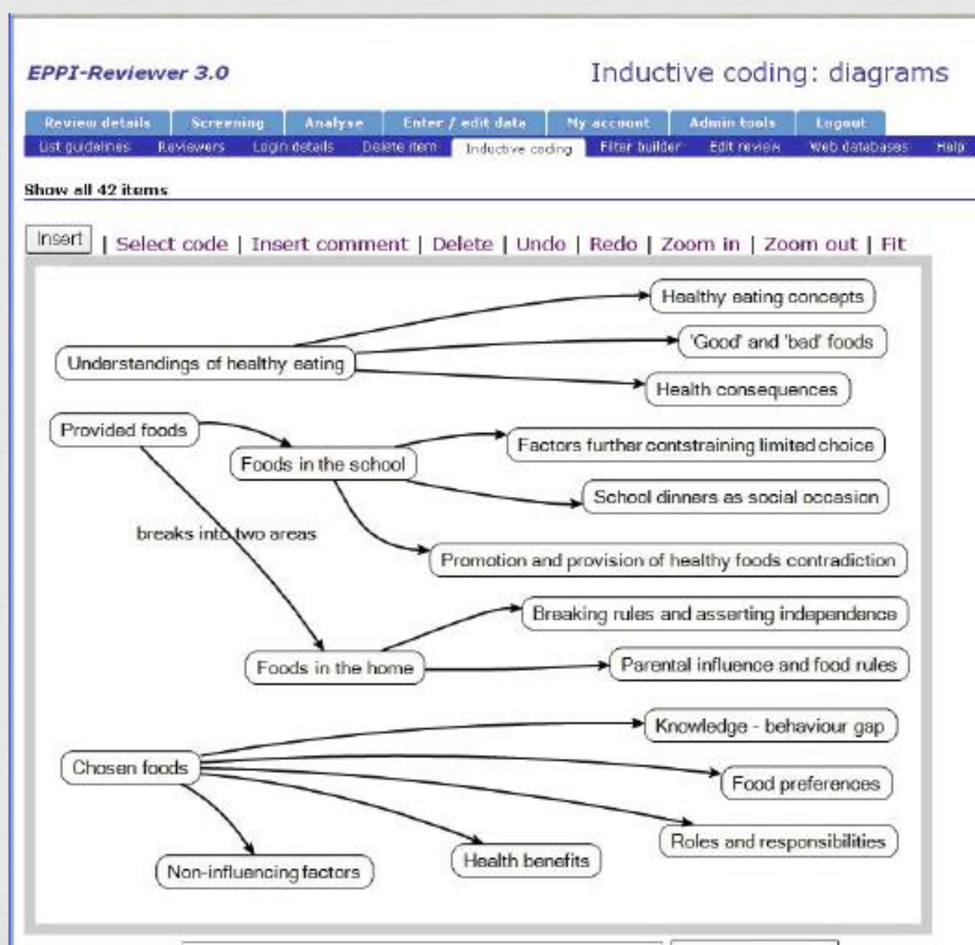


Research article

Methods for the thematic synthesis of qualitative research in systematic reviews

James Thomas*† and Angela Harden†

Stage 2. Development of descriptive themes



Children's views
Recommendation for interventions
Do not promote fruit and vegetables in the same way
Brand fruit and vegetables as an 'exciting' or child-relevant product, as well as a 'tasty' one
Reduce health emphasis in messages to promote fruit and vegetables particularly those which concern future health

Stage 3. Development of analytical themes

Example of Thomas and Harden's Thematic Synthesis

REPORT

October 2003

EPPI-Centre

Children and healthy eating: a systematic review of barriers and facilitators

Evidence for Policy and Practice
Information and Co-ordinating Centre

The EPPI-Centre is part of the Social Science Research Unit, Institute of Education, University of London.
http://eppi.ioe.ac.uk/

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BMC Medical Research Methodology

BioMed Central

Research article

Open Access

Methods for the thematic synthesis of qualitative research in systematic reviews

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Abstract

Background: There is a growing recognition of the value of synthesising qualitative research in the evidence base in order to facilitate effective and appropriate health care. In response to this, methods for undertaking these syntheses are currently being developed. Thematic analysis is a method that is often used to analyse data in primary qualitative research. This paper reports on the use of this type of analysis in systematic reviews to bring together and integrate the findings of multiple qualitative studies.

Methods: We describe thematic synthesis, outline several steps for its conduct and illustrate the process and outcome of this approach using a completed review of health promotion research.

http://eppi.ioe.ac.uk/EPPIWebContent/hp/reports/healthy_eating02/Final_report_web.pdf

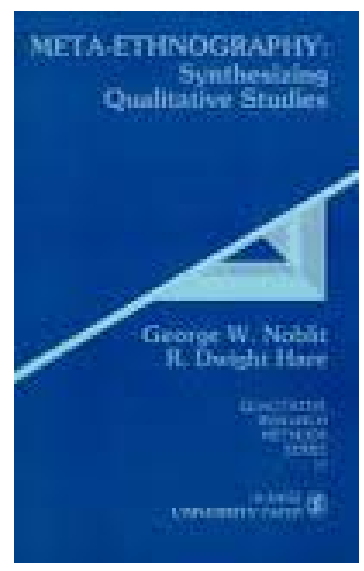
Use the ‘chat’ to share your thoughts on Thomas & Harden’s Thematic Synthesis

Meta-ethnography

Meta-ethnography developed by George W. Noblit and Dwight Hare, in the USA, in the field of education.

Noblit & Hare (1988). Meta-ethnography: synthesizing qualitative studies. Beverly Hills: SAGE Publications.

'Making a whole into something more than the parts alone imply' (p. 28).



George W. Noblit

The 7 phases of a meta-ethnography

Phase 1: Getting started

Phase 2: Deciding what is relevant to the initial interest

Phase 3: Reading the studies

Phase 4: Determining how the studies are related

Phase 5: Translating the studies into one another

Phase 6: Synthesising translations

Phase 7: Expressing the synthesis

Phase 5. Translating the studies into one another

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Nursing, Midwifery and Allied Health Professions Research Unit
Chief Scientist Office

- Reciprocal translation
- Refutational translation
- Line of argument synthesis

Phase 5. Translating the studies into one another

Reciprocal translation

Study 1

Concept X

Concept Y

Study 2

Concept x

Concept y

Concept z

Study 3

Concept *W*

Concept *Y*

Concept *Z*

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Nursing, Midwifery and Allied Health Professions Research Unit

Phase 5. Translating the studies into one another

Refutational translation

Study 1
Chronic pain
life changing

Study 3
Chronic pain
is imagined

Study 2
Chronic pain
not life
changing

Phase 5. Translating the studies into one another

Line of argument synthesis

Study 1
Being diagnosed

Study 2
Getting treated

Study 3
Recovering

Phase 6. New interpretations

Research participants' experiences

1st order constructs

Researcher interprets these experiences

2nd order constructs

Meta-ethnographer re-interprets the researcher's concepts

3rd order constructs

AN EXAMPLE OF DOING A META-ETHNOGRAPHY

Phase 1. Getting started

Using research about lay meanings of medicines as an example

Research question:

how do the perceived meanings of medicines affect patients' medicine-taking behaviour and communication with health professionals?

Phase 2. Deciding what is relevant to the initial interest

- Identified published qualitative studies
- Selected studies

Phase 3. Reading the studies

Concepts from the individual studies

Study 1

concept A – detailed concept description

concept B - detailed concept description

concept C - detailed concept description

concept D - detailed concept description

Study 2

concept a - detailed concept description

concept c - detailed concept description

Study 3

Concept *C* - detailed concept description

Concept *D* - detailed concept description

Study 4

Concept *A* - detailed concept description

Phase 4. Determining how the studies are related

Study 4
Concept *A*

Study 1
Concept A
Concept B
Concept C
Concept D

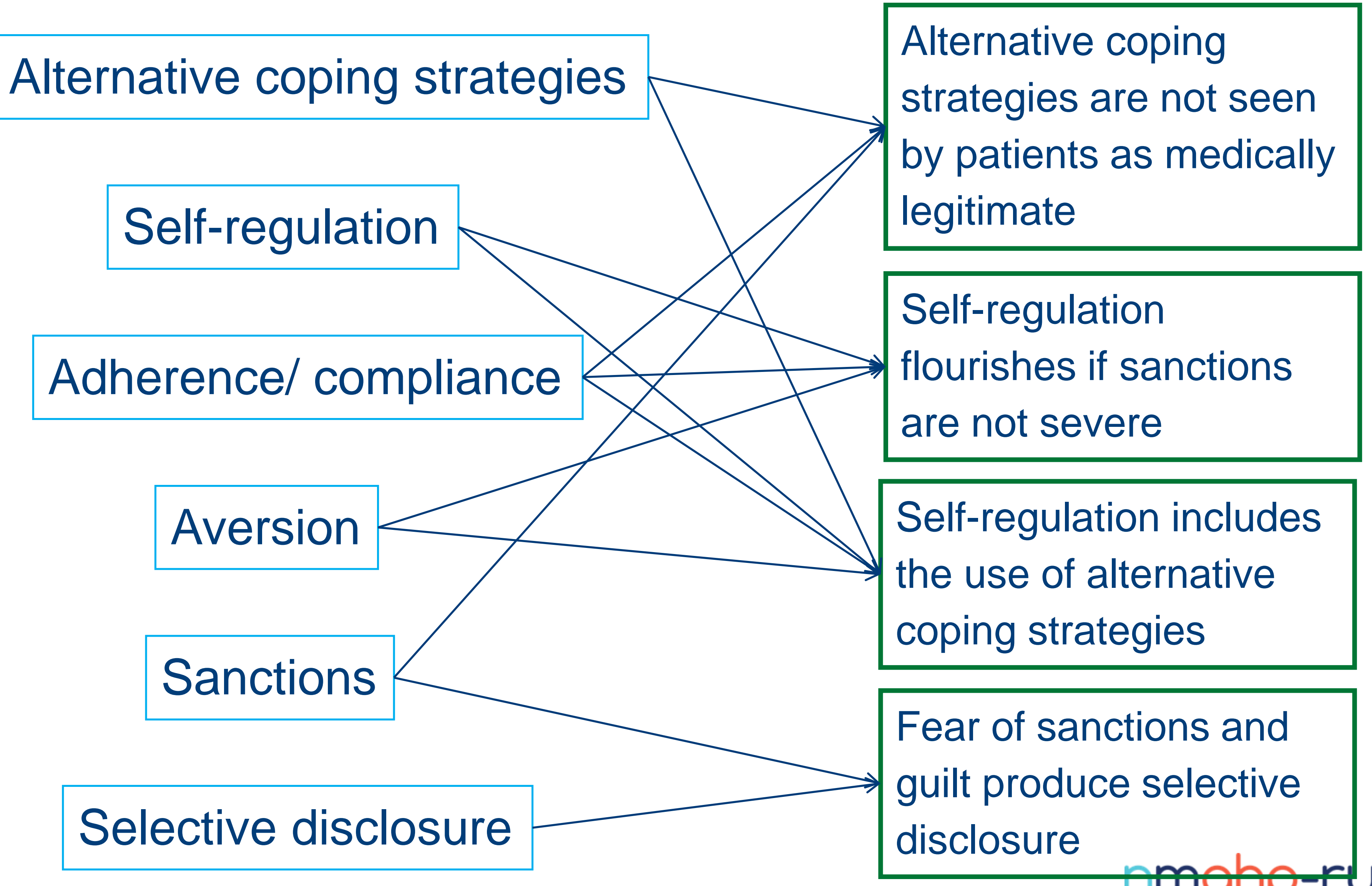
Study 2
Concept a
Concept c

Study 3
Concept *C*
Concept *D*

Phase 5. Translating the studies

Common concepts	Lay meanings of medicines			
	Study 1	Study 2	Study 3	Study 4
Adherence/ compliance		✓	✓	
Self-regulation	✓	✓	✓	✓
Aversion	✓	✓	✓	✓
Alternative coping strategies	✓	✓	✓	✓
Sanctions		✓		✓
Selective disclosure	✓			✓

Phase 6. Synthesising translations



Phase 7. Expressing the synthesis

Medicine prescribed

Passive accepters – accept medicine without question

Rejecters – reject regimen completely

Worries & concerns about medicine

These groups show **resistance**

Active Accepters – accept medicine after evaluating it

Some concerns can be dealt with through process of evaluation *

Active Modifiers – modify regimen after evaluating it

* Some concerns cannot be resolved through evaluation and may affect medicine taking.

Issues to do with identity may affect medicine taking

Take medicines and follow prescription

Take medicines but not as prescribed

DOI: 10.1111/1471-0528.13819
www.bjog.org

Systematic review

What matters to women: a systematic scoping review to identify the processes and outcomes of antenatal care provision that are important to healthy pregnant women

S Downe,[a] K. Finlayson,[a] Ö Tunçalp,[b] A Metin Gülmezoglu[b]

[a] Research in Childbirth and Health (ReaCH) group, University of Central Lancashire, Preston, UK [b] Department of Reproductive Health and Research including UNDP/UNFPA/UNICEF/WHO/World Bank Special Programme of Research, Development and Research Training in Human Reproduction (HRP), World Health Organization, Geneva, Switzerland

Correspondence: S Downe, Research in Childbirth and Health (ReaCH) group, University of Central Lancashire, Preston, PR1 2HE, UK. Email SDowne@uclan.ac.uk

Objective: to describe what women in high-, medium- and low-income countries want and expect from ANC, based on their own accounts of their beliefs, views, expectations and experiences of pregnancy.

Values

Acceptability

Equity

Feasibility

Benefits and harms

Example of meta-ethnography

Personal accounts of B&Hs to supplement quant data

Cochrane Database of Systematic Reviews

Factors that influence the uptake of routine antenatal services by pregnant women: a qualitative evidence synthesis (Protocol)

Downe S, Finlayson K, Tunçalp Ö, Gülmezoglu AM

Objective: To explore women's views and experiences of antenatal care; and factors influencing the uptake of antenatal care arising from women's accounts.

Values

Acceptability

Equity

Feasibility

Benefits and harms

Example of meta-ethnography

Personal accounts of B&Hs to supplement quant data

Use the ‘chat’ to share your thoughts on meta-ethnography

cerqual.org

cerqual.org

Confidence in the Evidence from Reviews of Qualitative Research

ABOUT CERQUAL WHAT IS THE CERQUAL APPROACH? WHERE HAS CERQUAL BEEN USED? HOW DO I USE CERQUAL? HOW DO I GET MORE TRAINING? WHERE CAN I FIND LITERATURE? HOW DO I JOIN THE GRADE-CERQUAL PROJECT GROUP? CERQUAL EVENTS CONTACT US

GRADE CERQual

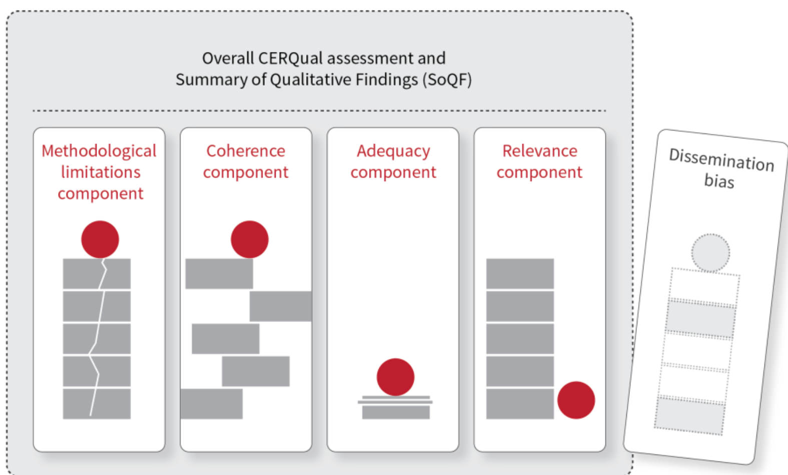
About CERQual

Search ...

The CERQual approach

A CERQual assessment is based on four components:

- **Methodological limitations** in the primary studies that contribute evidence to a review finding
- **Coherence** - how clear and cogent the fit is between the data from the primary studies and a review finding that synthesizes that data
- **Adequacy** - the degree of richness and quantity of data supporting a review finding
- **Relevance** - the extent to which the evidence from the primary studies supporting a review finding is applicable to the context specified in the review question



Reporting Guidance for Qualitative Evidence Syntheses

- ENTREQ

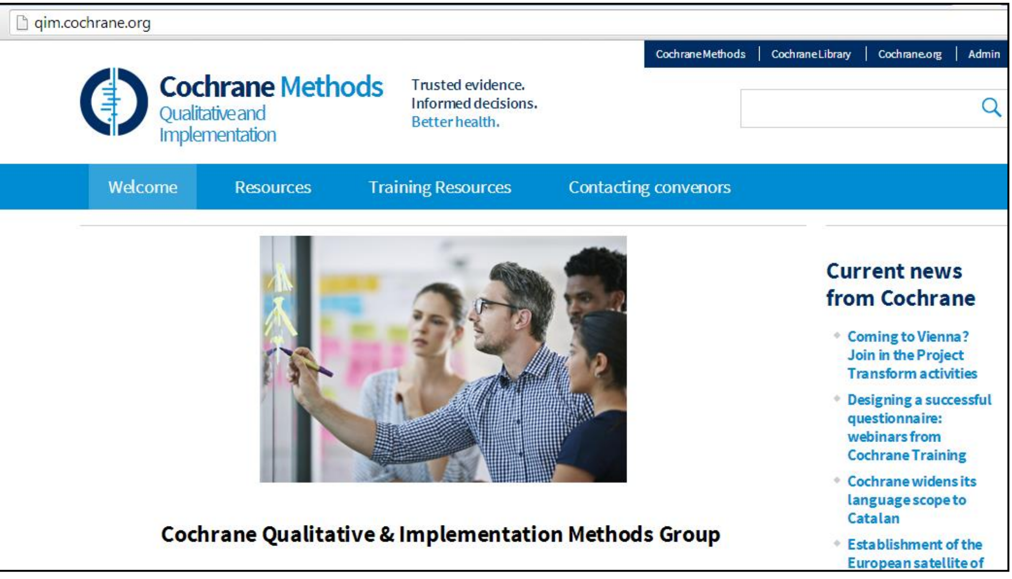
BMC Medical Research Methodology

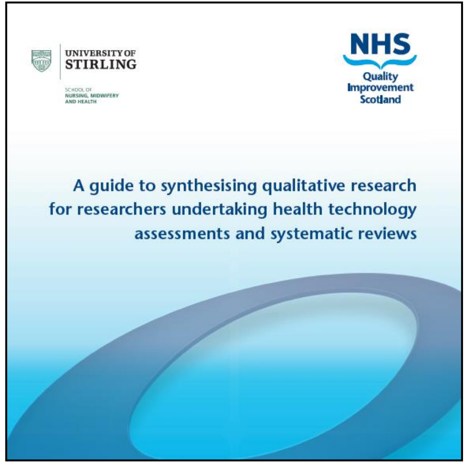
CORRESPONDENCE Open Access

Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ

Allison Tong[1,2*†], Kate Flemming[3†], Elizabeth McInnes[4†], Sandy Oliver[5] and Jonathan Craig[1,2]

- eMERGe





Realist synthesis: illustrating the method for implementation research

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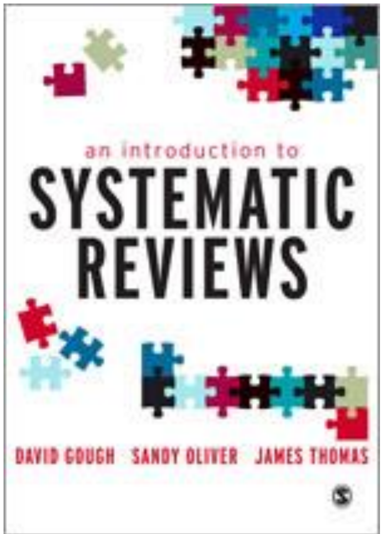

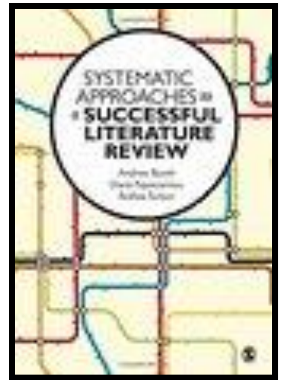

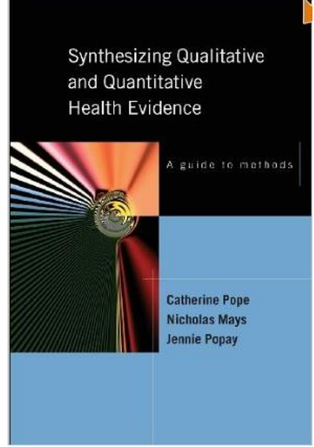

Integrating qualitative and quantitative evidence

Thanks for listening!

Jane.noyes@bangor.ac.uk

Common methodological issues in qualitative evidence synthesis reports

1. Question… not clear – or no question..
2. Method .. not a good ‘fit’ for the question or the type/number of included studies
3. Inappropriate choice of theory/conceptual framework or not applied
4. Search strategy … insufficiently specified or inadequate – seminal papers missing
5. Selection and sampling of papers unclear or inappropriate
6. Quality appraisal – inappropriate application of tools and judgements
7. Data processing and synthesis does not align with the stated method
8. Only one author or not clear how internal validity of data processing was addressed (rigor)
9. Only descriptive themes presented – nothing new
10. Authors make claims not grounded in data