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

Thank you to Andrew Booth, Ruth Garside and Emma France for sharing slides

Prof. Jane Noyes
Bangor University
United Kingdom
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
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

• 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
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)

Acknowledgement Ruth Garside QIMG – sharing slides

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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.
The current Cochrane model:

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

OR

The qualitative evidence synthesis may be undertaken as part of a mixed-method protocol that includes conducting the intervention review.
Section of the DECIDE evidence to decision framework that requires a synthesis of qualitative evidence to address

<table>
<thead>
<tr>
<th>Health systems recommendations, from GRADEPro Guideline Development Tool (GDT) 31 January 2017</th>
</tr>
</thead>
<tbody>
<tr>
<td>Are there key stakeholders that would not accept the distribution of the benefits, harms and costs? (because of how they might be affected personally or because of their perceptions of the relative importance of the effects for others)?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>Would the intervention (option) adversely affect people's autonomy?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
<tr>
<td>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)?</td>
</tr>
<tr>
<td>Yes</td>
</tr>
</tbody>
</table>

**Final judgement: is the intervention acceptable to key stakeholders?**

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

<table>
<thead>
<tr>
<th>Is the intervention feasible to implement?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>

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

Panel discussion

**Detailed questions:**

<table>
<thead>
<tr>
<th>Are the important barriers that are likely to limit the feasibility of implementing the intervention (option) or require consideration when implementing it?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
</tr>
</tbody>
</table>
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\textsuperscript{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)\textsuperscript{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\textsuperscript{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 (Setting-Perspective-Interest, Phenomenon of – Comparison-Evaluation) – 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?
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

<table>
<thead>
<tr>
<th>Textual narrative synthesis</th>
<th>Ecological triangulation</th>
<th>Framework synthesis</th>
<th>Meta-ethnography</th>
<th>Grounded Theory</th>
<th>Thematic synthesis</th>
<th>Meta-narrative</th>
<th>CIS</th>
<th>Meta-study</th>
</tr>
</thead>
<tbody>
<tr>
<td>Translation</td>
<td>Translation</td>
<td>Translation/Transformation</td>
<td>Transformation</td>
<td>Transformation</td>
<td>Transformation</td>
<td>Transformation</td>
<td>Transformation</td>
<td>Transformation</td>
</tr>
</tbody>
</table>

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

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:

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, Atchah, & 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 shonan 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 shumitter [concerned] and brings asudupotaha [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 Bishish [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 Bhasar [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 shonan [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 came 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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First order interpretations/constructs:
how people make sense of their experiences

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

Exclusionary Social Practices

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As one participant who had a heart problem said, “In our shonma 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 chuinnito [concerned] and brings ajojhol [medicine and special food]. But they ignore my problems.”

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This week of other household members came 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 of them.”
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!

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

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

*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

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
Tobacco harm reduction (PH45)

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 codes to each statement:

Theme, subtheme and subcategories
See index of codes overlaid. E.g. 3.(stress)

THEN

intervention type
NRT = nicotine replacement therapy; EC = e-cigarettes; Bhv = Behavioural (counseling / self-help / GP advice)

AND

Selection method:
A = Self-selected; D = Medically / intervention prescribed; C = Unclear

AND

Whose Voice:
M = Male; F = Female; gendx = mixed gender; unrep = unreported gender
Nurse = nurse; psych = psychiatrist/psychology; GP = general practitioner; SSC = smoking cessation counsellor
pol = policy/maker; Profx = mixed group of professionals; Profm = mixed group of professionals

POO = ethnic minority population; MPOO = mixed ethnicity; WPOO = White/Caucasian; EPOO = ethnicity unspecified
SES1 = Low SES; SES2 = High SES groups; SES3 = mixed SES groups; SESU = unspecified SES (note SES will capture info on education, income, occupation type)

Other - only report if evident
A = successful reducers / CTQ; U = unsuccessful reducers / CTQ; Q = Failure

Notes:
M = Mentally ill; hosp = hospital inpatients or those awaiting surgery

Separate each group of codes with a /; separate each group of codes with a -

Subs.
1. M/Teen-TM = perceived disadvantages of SSC in ethnic minority by teenagers
2. C/O/A-Adult-TM = reasons for self-selecting barriers in adults with a low socioeconomic background
3. Stress/Gen-Dx/Teen-SES-Nich= Motivation 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 home / work / school / hospital / general
P1. 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 / prescribing intervention to assist THR

P2.2 Attitudes towards or reasons for providing / referring / the intervention
Whether providing advice to stop smoking is part of role
P2.2.1 (role)/by/NRT/4/Nurse/Smoker
P2.2.2 (role)/by/NRT/O/Nurse/Smoker

P2.3 Attitudes towards or reasons for not providing / referring / the intervention

P2.4 Benefits of specific intervention

P2.5 Disadvantages of specific intervention

P2.6/7/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 (Sorel 2007)
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

![Diagram](image)

**Figure 1.** Framework coding example (Parfitt 2008).

<table>
<thead>
<tr>
<th>Timing</th>
<th>Individual focus</th>
<th>Considers other areas of transition</th>
<th>Preparation for adult services</th>
<th>Skills training</th>
<th>Service delivery</th>
<th>Service development</th>
<th>Sustainability</th>
<th>Outcome measure</th>
<th>Evaluation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coherence</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
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
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

Stage 3. Development of analytical 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.
Example of Thomas and Harden’s Thematic Synthesis

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


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

- 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
Phase 5. Translating the studies into one another

Refutational translation

Study 1
Chronic pain life changing

Study 2
Chronic pain not life changing

Study 3
Chronic pain is imagined
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

1\textsuperscript{st} order constructs

Researcher interprets these experiences

2\textsuperscript{nd} order constructs

Meta-ethnographer re-interprets the researcher’s concepts

3\textsuperscript{rd} 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
## Phase 5. Translating the studies

<table>
<thead>
<tr>
<th>Common concepts</th>
<th>Lay meanings of medicines</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Study 1</td>
</tr>
<tr>
<td>Adherence/ compliance</td>
<td>✓</td>
</tr>
<tr>
<td>Self-regulation</td>
<td>✓</td>
</tr>
<tr>
<td>Aversion</td>
<td>✓</td>
</tr>
<tr>
<td>Alternative coping strategies</td>
<td>✓</td>
</tr>
<tr>
<td>Sanctions</td>
<td>✓</td>
</tr>
<tr>
<td>Selective disclosure</td>
<td>✓</td>
</tr>
</tbody>
</table>
**Phase 6. Synthesising translations**

**Concepts from studies**

- **Adherence/compliance**
  - Aversion
  - Sanctions
  - Selective disclosure
  - Self-regulation
  - Alternative coping strategies

**New interpretations**

- Alternative coping strategies are not seen by patients as medically legitimate
- Self-regulation flourishes if sanctions are not severe
- Self-regulation includes the use of alternative coping strategies
- Fear of sanctions and guilt produce selective disclosure
Phase 7. Expressing the synthesis

- **Passive accepters** – accept medicine without question
- **Medicine prescribed**
- **Rejecters** – reject regimen completely
- **Worries & concerns about medicine**
- **Some concerns can be dealt with through process of evaluation** *
- **Active Accepters** – accept medicine after evaluating it
- **Active Modifiers** – modify regimen after evaluating it
- **Take medicines and follow prescription**
- **Take medicines but not as prescribed**

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

Issues to do with identity may affect medicine taking.
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.

Example of meta-ethnography

Benefits and harms

Values

Acceptability

Equity

Feasibility

Personal accounts of B&Hs to supplement quant data
Objective: To explore women’s views and experiences of antenatal care; and factors influencing the uptake of antenatal care arising from women’s accounts.

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

Example of meta-ethnography

Values

Acceptability

Equity

Feasibility

Benefits and harms

Personal accounts of B&Hs to supplement quant data
Use the ‘chat’ to share your thoughts on meta-ethnography
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

About CERQual
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

- eMERGe
Cochrane Qualitative & Implementation Methods Group

Current news from Cochrane

- Coming to Vienna? Join in the Project Transform activities
- Designing a successful questionnaire: webinars from Cochrane Training
- Cochrane widens its language scope to Catalan
- Establishment of the European satellite of

Realist synthesis: illustrating the method for implementation research

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Integrating qualitative and quantitative evidence

We need another webinar to cover these methods!

Prof. Jane Noyes
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Thanks for listening!

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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