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THE USE OF QUALITATIVE METHODOLOGIES IN HEALTH SERVICES/SYSTEMS RESEARCH IN LOW AND MIDDLE INCOME SETTINGS

A NARRATIVE LITERATURE REVIEW

January 2010

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ABBREVIATIONS AND NOTES ON TERMINOLOGY

A common problem in international or inter-disciplinary work is that particular phrases can be used in very different ways. Without making any claims for these as privileged definitions, we use the following abbreviations and definitions in this report:

**HSR** (Health Services/Systems research). There are a number of definitions of both ‘Health Services’ and ‘Health Systems’ research, and a fair amount of overlap between them. Here we use the generic HSR to refer to both.

**Focus Group** This term is used to refer to any group interview.

**FSU** (Former Soviet Union). Those states that were part of the USSR until 1991.

**Qualitative Methods** Strategies and processes for data collection, generation or analysis that utilise and produce data primarily in the form of words rather than numbers.

**Qualitative Research** Research which addresses a qualitative question – ie one that refers to understanding the phenomenon of interest rather than measuring it. (In English, such questions tend to start with: why? how? or what?, rather than how many? or What causes ..?)
THE USE OF QUALITATIVE METHODOLOGIES IN HEALTH SERVICES/SYSTEMS RESEARCH IN LOW AND MIDDLE INCOME SETTINGS

A NARRATIVE LITERATURE REVIEW

SUMMARY

Aims

The aims of this review are to:

i) Use a case study of published literature on quality of care in the Former Soviet Union to identify current issues in the use if qualitative methods in health services/systems (HSR) research;

ii) Summarise what is known from the wider literature about the challenges and possibilities of transferring qualitative methodologies for (HSR) to low and middle-income countries;

iii) Identify the implications for the design of cross-national qualitative HSR studies.

Methods

We focus on the most commonly used qualitative methods of data collection (in-depth, semi-structured and group interviews), and on studies addressing qualitative research questions.

Given both the relatively small qualitative literature as yet published, and the different ways in which the term ‘qualitative’ is utilised in published studies, this review used a pragmatic narrative approach which drew on one systematic search (see Appendix 1), but also on hand searches of key journals and books, web resources and a small scale interview study of researchers to identify key issues. We aimed to include in this narrative review:

i) General methodological contributions to the literature;

ii) Case studies from low- and middle-income countries that illustrated particular challenges;

iii) All qualitative HSR studies from our case study area.

Themes were identified from this literature that related to the use of interviews in low/middle income countries or that related to doing qualitative work in cross-national studies.

Findings

There is a growing acceptance of the value of qualitative research in HSR internationally, but as yet a limited body of literature in English in our case study area (FSU).
studies for the review were largely drawn from Anglophone African or south Asian settings, and most included a high income country based partner. Despite a range of settings, topics and participants, we could identify some common themes across the literature.

There is a substantial body of literature addressing the problems and potential problems of transferring qualitative methodologies to low/middle income countries. In general, there appear to be no inherent reasons why the most commonly used methods of data collection, individual interviews and group interviews, cannot be used in most settings (where appropriate for the research question) for qualitative research on HSR. Clearly, all data collection techniques have to be adapted the local research setting and population, but this is a universal requirement of good research practice, rather than a particular issue of transferring methods to low/middle income countries. In cultural contexts where the interview format may be unfamiliar as a method for asking about views or experiences, more care need to be taken to build trust.

One area of particular debate is that of the requirements for good ethical practice, with the reliance on written and cumbersome consent procedures often seen as a barrier to good ethical practice in settings where there may be suspicion of written forms, and complex consent arrangement may cause anxiety. Again, this is also an issue in high income settings where increasingly complex ethical arrangements may similarly off putting.

The most pressing problems arise from the limited capacity in many low and middle income settings to conduct qualitative research. Where few local researchers have experience in designing and writing proposals, and analysing qualitative data, and where research funding in-country is limited, there is often a reliance on international collaborations funded through donor agencies. With limited local language skills among most high income country researchers, this leads to qualitative HSR being conducted in at least two languages: a local and international one. Conducting good quality, inductive analysis in translation is time consuming and complex.

Other challenges appear to relate to the low status of both social science methods and users’ views of health care in many low/middle income settings. Where social scientists have little status, and there are few locally trained qualitative researchers, the dominance of biomedical research paradigms leads to problems in finding fieldworkers who can conduct empathetic, open interviews and develop their skills in analysis.

**Conclusions**

Challenges from the low status of social research and the limited acceptability of qualitative methods in HSR reflect those typical of high income countries until recently. With limited resources and capacity for HSR in low and middle income countries, it is likely that qualitative HSR will continue for some time to be conducted by international teams of researchers. In addition to efforts to build research capacity, we therefore recommend particular attention is needed to methods for team analysis across languages.
INTRODUCTION

1.1. Qualitative methods in Health Services/Systems Research

‘Qualitative methodologies’ is a term which covers a wide range of epistemological approaches, styles of research and methodological techniques. It refers to both the kinds of research question addressed, and the type of data collection methods used (i.e., those that primarily generate words rather than numbers). The role that qualitative methodologies play in health services / systems research is now well recognised in high income countries (Black 1994, Green & Thorogood 1998, Murphy & Dingwall 2003, Fulop et al 2001, Murphy et al 1998), and becoming increasingly accepted in low and middle income settings (Rifkin 1995, Sofaer 2002). In summary, qualitative research contributes to our understanding of the ways in which health services and systems are structured, organised and develop.

Qualitative research in HSR has been widely used in programmes of research that look at all levels of the health care system. At the ‘macro’ level, this includes the use of approaches such as rapid appraisal to inform studies of developing integrated models for chronic care (Hopkinson et al 2004, Adeyi et al. 2007), stakeholder analysis to explore policy implementation (Brugha and Varvasovszky 2000) and case studies examining the impact of reform initiatives (Parkhurst et al 2005). This review focuses on research directed more at the ‘micro’ level of health services / systems research: those questions that relate to the ways in which health care is delivered and experienced. This would include studies of such issues as:

- Patient understandings of access to and quality of services
- Provider understandings of health systems or treatment protocols
- Communication between patients and providers
- Organisational culture of clinics, hospitals and other health care settings.

Thus, for questions about the ‘micro’ level of health systems, qualitative methodologies can contribute to an understanding of topics such as: public, patient and provider assessments of the appropriateness and quality of health services; the processes of providing care and the barriers to health policy implementation, to give some examples. There are now a range of materials, including text books and web resources (1) to support health systems researchers using qualitative methodologies and those who teach methodology (see eg Singal and Jeffrey 2008). There is now a substantial literature on the methodological challenges in either adapting or developing new methods in specific settings (see, eg Vissanjee et al 2002; Madden et al 1997; Glewwe 2005, Bowden and Fox-Rushby 2003, Cardona and Joshi 2007), and on the development of more

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1 See, eg Academy Health website on HSR methods (http://www.hsrmethods.org), Winch et al 2000
practical field guides for researchers working in a range of settings (see, eg, Brickci and Green 2007; Ellsberg and Heise 2005; Campbell et al 1999).

1.2. The challenges

However, there has been little methodological review work that draws together our general understanding of transferability of qualitative methods of data collection. Indeed, qualitative research is often cited as the answer to the question of how to adapt methods to a specific context. Published empirical studies have long noted the need to develop research protocols and instruments for the setting involved, and suggested that more qualitative methodologies is vital for ensuring validity in cross national survey work (see, eg, Stone and Campbell 1984, Kroeger 1983, Ramakrishna and Brieger 1987) or adapting quality indicators (Hansen et al 2008). In-depth techniques, particularly ethnographic approaches, are seen as ideal for understanding the relationships between social, political and cultural contexts and the research procedures needed to make sense of some phenomenon in that context. As one example, Geneau et al (2008) used qualitative methods in a study of willingness to pay for eye surgery, suggesting that the qualitative data (from focus groups) questioned a fundamental assumption built into the willingness to pay methods: that ‘willingness’ was an individual decision, that could be accessed through individual interviews, rather than a household one. Although it is relatively easy to gather similar examples of the worth of qualitative methods in informing other methodologies through their abilities to determine how questions can be asked and what the answers might mean, this leaves unexamined the question of how qualitative methods might be as culturally bound as more quantitative approaches. There are no a priori reasons for assuming that qualitative methods of enquiry are inevitably ‘context free’, and there has been little detailed exploration of how the principles of qualitative methodology might need to be adapted and rethought in a range of cultural settings.

There is a large degree of consensus around what the broad orientations of qualitative research are. These include an orientation towards the perspectives of those being studied; an emphasis on context, holism and process and the adoption of relatively flexible research designs (Murphy et al 1998: 3-4; Green and Thorogood 2009). Qualitative research is seen as properly orientated towards answering questions that relate to understanding the social world, rather than measuring it. Such orientations appear to be universal: these are surely principles which could be applied in any setting, whatever social or political context might shape the study design. However, two immediate challenges present themselves. One is separating ‘principles’ from how these are applied in practice. As an initial example, the focus on ‘the perspectives of those being studied’ is often translated into a need to uncover private or intimate views, as these are somehow seen as reflecting the more ‘valid’ perspectives of those studied, which are most likely to be gained by a good interviewer who can establish rapport in a private interview setting. However, as we discuss below, the ‘private’ space is not universally privileged, and it may be that not every culture prizes private thoughts about health care. What might matter most for an HSR study is generating the most appropriate kind of data. In a society where ‘private’ perspectives do shape
health care choices, these are important to gather. In a society where ‘private’ views are never utilised in social discourse, it may be that they are less important contributors to health care behaviour, and thus less urgent for us to research. In this example, the challenge lies in separating out differences in:

- cultural meaning - what meaning does ‘privacy’ have in this context? Does it matter if we can’t collect ‘private’ views?
- political context - are some people in this setting – such as patients, or women – systematically excluded from having a voice?
- capacity for qualitative methods - is there simply limited exposure to qualitative methods in the health system, such that the importance of listening to patients is not recognised?

In short, there are challenges in determining and distinguishing matters of principle and matters of local adaption, and there are likely to be problems of distinguishing local needs from political and historical capacities. Our first aim is therefore to ask what we know already about the **transferability of methodological principles and particular techniques** to different contexts.

These issues of mapping what principles are universal and what needs to be adapted for local use become particular urgent in thinking about cross-national or cross-cultural studies. Even within one country, we know that the specific context of the interview shapes the data generated (see, for instance, Green and Hart 1999, on how the different settings of a focus group study influenced both the content and style of the data generated). Across cultures or nations we need a far greater degree of reflexivity to take into account the ways in which local contexts shape the qualitative data that are generated. In a very practical sense, there are also going to be real challenges in developing protocols that are both flexible enough to maximise the strengths of qualitative methods (particularly in being iterative, flexible and adapted to local context) and standardised enough to enable comparisons. Our second aim in this review then is to address the challenge of **developing the potential for cross-country research which maintains the strengths of qualitative methodologies whilst allowing for robust comparisons**.

The legitimacy of qualitative methods in HSR in high income countries is relatively recent. Only ten years ago, introducing a special issue of the journal Health Services Research, Shortell (1999) noted that barriers of capacity and training were still limiting the use of qualitative methods in the USA: few researchers in the field had any training in qualitative approaches, and journals and funding bodies had problems in finding adequately experienced reviewers. However in high income countries, over the last decade, there has been a growing interest in the use of qualitative evidence and in the development of the skills of researchers in conducting and appraising qualitative research. In resource poor settings, the traditional low status of social science compared to biomedical science has had implications for training and workforce issues, with qualitative methodologies perhaps seen as more of a ‘luxury’ compared with training in
epidemiological or statistical techniques. Yach (1992), for instance, noted that in many low-income countries, social sciences have low priority in training, as such skills can appear less urgent that those of biomedicine, although they are of course needed to understand health and illness in context. Combined, he suggests, with the lack of cultural competence of many Western trained social scientists, this leads to a lack of capacity for good research. These remarks are pertinent to HSR, where research teams may face limited acceptance of the role of qualitative research and limited capacity for conducting it. Since Yach’s discussion, there has been a growing interest in the challenges of developing capacity for conducting and managing research in general in low/middle income countries (Sitthi-amorn and Somrongthong 2000, Mayhew et al 2008, Wight 2008). The third challenge with which this review is concerned with is therefore that of developing the research capacity in low/middle income contexts, in which training opportunities may be limited, particularly in the researchers’/students’ first language.
2. METHODS

2.1. Aims of the Review

We have suggested that the practical and philosophical challenges in adapting materials uncritically for use in low / middle income countries fall into three areas that are the subject of this review:

1. Questions about the transferability of methodological principles and particular techniques;
2. Developing the potential for cross-country research which maintains the strengths of qualitative methodologies whilst allowing for robust comparisons;
3. Research capacity in low / middle income contexts, in which training opportunities may be limited, particularly in the researchers’/students’ first language.

To address these issues, we need to understand more about how far methodological principles (that, for instance, access to ‘private’ perspectives generates meaningful data on views of services) have been derived from a rather culturally biased framework (that of north America and Europe) and how far they are cross-culturally valid principles, but which need to be applied differently in different settings. As a contribution to this task, we conducted this literature review to identify what is known already about these challenges and identify the implications for developing cross-national qualitative HSR.

Our particular focus of interest was in developing the capacity for qualitative research in studies related to quality of care in the states of the former Soviet Union. After the break-up of the Soviet Union in 1991, the former republics began to restructure their health care systems (Ahmedov et al 2007, McKee et al 2004), which acted as a spur to health services research in the region. Despite many similar structural and political challenges, the states of the FSU are diverse, ethnically, linguistically and culturally. Considering how qualitative methodologies can contribute to international HSR in this region is likely to shed light on the challenges more generally.

To address these issues, our aims in this review were to:

i) Use a case study of published literature on quality of care in the Former Soviet Union to identify current issues in the use if qualitative methods in health services/systems (HSR) research;

ii) Summarise what is known from the wider literature about the challenges and possibilities of transferring qualitative methodologies for (HSR) to low and middle-income countries;

iii) Identify the implications for the design of cross-national qualitative HSR studies.
2.2. Scope

This review focuses on the most commonly used methods for collecting qualitative data: individual and group interviews, and their use in micro-level studies of the health care system. Through doing this we will, though, be contributing to the knowledge and capacity needed to conduct larger programmes of work on health systems which generally rely on contributory smaller scale sub-studies.

By individual interviews, we refer to the range of types of qualitative interview used in health systems research, including all those that are designed to generate qualitative data, rather than structured instruments for use in survey research. This includes narrative interviews, unstructured interviews and semi-structured interviews for use with services users and providers and those in the community. Verbal autopsies using fully- or semi-structured questionnaires are also increasingly used in the region (Leon et al, 2007; Telishevska, 2001) and have some uses for qualitative as well as the more epidemiological aims.

There has been some criticism of the over-reliance of health researchers on interview data, especially when used uncritically as a method for accessing ‘perceptions’ (see, eg Silverman 1998), but they are likely to continue to be the most commonly used way of collecting data both as a stand-alone method in small scale projects, and as a contribution to larger programmes of work. Most health systems research relies on at least some interviewing (for instance, expert witness interviews, or stakeholder interviews) even if it is not the main way of collecting data, and there is therefore an urgent need to explore the methodological issues of the transferability of interview methods.

Group interviews can be a way of mitigating the weaknesses of individual interviews, given that they offer access to interaction, and to the processes by which social knowledge is produced. They are also seen as a potential route for altering the power imbalance between researcher and community, in that the group setting can off-set the researchers’ control over the agenda of the research and the framing of data generation. They are being increasingly used in the former Soviet Union, again, as a stand alone method in single health research projects (Dimitrova et al 2006), or as part of broader rapid assessments (Poletti et al 2007). By group interviews, we refer to the range of qualitative methods designed to generate data from groups rather than individuals (Green and Thorogood 2004: 108). This would include ‘focus’ groups, natural groups and community interviews, but not those groups convened to determine expert opinion (such as consensus panels or Delphi groups).

For both, we focus on face-to-face methods of collecting data (as opposed to telephone interviews, or emerging methods for using email or web based data collection) as these are first, most commonly used, and second, most likely to raise the methodological issues we are most concerned with (such as the impact of local social and political contexts on appropriate ways to generate data).
2.3. Literature and search strategies

The range of material potentially useful for the aims outlined above is large, including published papers and grey literature on a large number of countries and topics. We focused on identifying the key issues discussed in the following literatures:

1) General methodological papers discussing issues of transferability;
2) Case studies that reported methodological challenges of using qualitative methods in low and middle income settings;
3) A more focused review of one topic and area (access to and quality of health care in Caucasus countries) as a case study.

There are often good reasons why methodological difficulties are not described in research outputs, including lack of space, political sensitivities or reluctance to draw attention to possible threats to validity in publications. In addition to reviewing publications, we therefore also supplemented our knowledge with informal discussions with researchers and a pilot study conducted by an MSc student of researchers’ experiences in conducting qualitative methods in low and middle income settings (Njue 2009).

We developed a summary screening and appraisal instrument based on the qualitative evidence appraisal tool from CASP (http://www.phru.nhs.uk/pages/PHD/resources.htm) (see Appendix 2). This was used to identify appropriate case studies and to make an assessment of the quality of reported qualitative analysis for background information. Quality assessments have not been reported in this review.

Initially, a systematic search strategy was used for the focused review on access and quality of health care in our case study region, to identify published studies in English and Russian language. The search terms and summary findings of this are included as Appendix 1. Few relevant publications were identified using the systematic search, so this was supplemented by a broader search for candidate studies, which identified six peer-reviewed publications (see Section 3.1).

For the narrative review of general methodological papers and case studies, a thematic content analysis was used to identify common challenges, particular problems with using interviews and solutions proposed.
3. RESULTS

3.1. Case studies in FSU region

As a case study, we aimed to identify qualitative research in HSR from FSU states that addressed quality of care. To identify this literature, we first utilised a formal literature review (see Appendix 1) using a systematic search strategy to identify qualitative studies in the Caucasus region that focused on access to and quality of care. Whilst formal systematic reviews are useful for identifying the breadth of qualitative evidence on a topic, and methods for integrating the findings from qualitative studies are developing (Britten et al 2002, Dixon-Woods et al 2005), this exercise demonstrated the utility, but perhaps also the limits of a systematic search strategy in areas where there is little published research. As others have noted (Mathews et al 1999, Greenhalgh and Peacock 2005), protocol-driven search strategies may be less fruitful for complex literatures than less formal methods. The formal, systematic review was useful in identifying the common empirical problems (in this case informal payments), but it did not generate useful material for a review of methodological issues. First, only 3 papers were identified, and clearly it is difficult to draw any implications for HSR from such a small sample. Second, it was clear that ‘qualitative’ was a term often used to indicate a small survey or one using non-probabilistic sampling methods rather than a qualitative research study, and many papers initially identified did not fit the screening criteria (appendix 2).

We therefore used a broader search strategy to identify a large range of studies which utilised qualitative methodologies for studies of health service access or quality in the FSU. This identified six case studies (see Table 1). No appropriate Russian-language papers were identified from searching two databases (The Central Scientific Medical Library of the Moscow Medical Academy and the Institute of Scientific Information for Social Sciences of the Russian Academy of Science (ISISS RAS), (http://www.inion.ru) (see details of the search strategy for these in Appendix 1). Again, it is likely that there are appropriate Russian-language publications in social science journals, but these may be difficult to access from simple searches of public health orientated databases.

For the focused review of FSU cases, we included only those in peer-reviewed publications, where we can assume there has been some review of the quality of the study. There is an additional body of work reported in grey literature, done largely to support the efforts of international aid organisations in the region. These include NIVEL (undated) on maternity care in Kyrgyzstan and Tajikistan, Storey et al (1997) and USAID (2005) on family planning services, and Seitkazieva et al (2002) on reproductive health services in Kyrgyzstan. These papers illustrate the feasibility and utility of using techniques such as interviews and focus groups in projects looking at needs assessment and quality improvement, and we draw on them in the thematic review below, but none of the grey literature reports included enough
methodological details to include them in this case study. Similarly, a number of other peer-reviewed publications used qualitative methods of data collection in part, but not to address a qualitative question about health services. These included studies of variations in maternity care practice in Russia (Danishevski et al 2006) and a situational analysis of tuberculosis control (Coker et al 2003). The six papers identified that met the basic criteria for quality assessment (Appendix 2) (ie that they used qualitative methodologies appropriately for the research question) were included.

As Table 1 suggests, the reporting of qualitative methods in HSR from this region is of relatively recent introduction in the English language publications, with all identified studies published post-2000. Few of the papers reported specific challenges in using qualitative methods. Those that did reported issues that have been raised in the wider literature (see below), relating to problems of conducting interviews in private, and those of working across languages and cultures when including researchers from two countries. Both individual and group interviews were used to elaborate provider or user perspectives on health care quality.

All but one study included authors from a high income country institution as well as at least one from the country studied (the exception, Hopkinson et al 2004 had only high income institutional affiliations).
Table 1: Qualitative HSR studies from selected region

<table>
<thead>
<tr>
<th>Author, date</th>
<th>Country Setting</th>
<th>Setting</th>
<th>Topic</th>
<th>Design</th>
<th>Qualitative methods of data collection</th>
<th>Participants</th>
<th>Analysis</th>
<th>Reported methodological challenges</th>
</tr>
</thead>
<tbody>
<tr>
<td>Balabanova et al 2009</td>
<td>Georgia</td>
<td>Georgia</td>
<td>Diabetes Care</td>
<td>Rapid appraisal</td>
<td>Semi-structured interviews, unstructured interviews</td>
<td>Patients, providers, policy makers</td>
<td>Deductive and inductive</td>
<td>None</td>
</tr>
<tr>
<td>Djibuti et al 2007</td>
<td>Georgia</td>
<td></td>
<td>Disease surveillance</td>
<td>Qualitative study at 2 time points</td>
<td>Focus groups</td>
<td>Public health and health facility staff</td>
<td>Thematic analysis using pre-defined codes</td>
<td>None</td>
</tr>
<tr>
<td>Dimitrova et al 2006</td>
<td>Russia</td>
<td>Russia</td>
<td>Barriers to TB care</td>
<td>Qualitative study</td>
<td>‘Natural’ focus groups</td>
<td>Physicians, nurses</td>
<td>Mainly deductive thematic</td>
<td>None</td>
</tr>
<tr>
<td>Atun et al 2005</td>
<td>Russia</td>
<td></td>
<td>Barriers to DOTS implementation</td>
<td>Rapid assessment</td>
<td>Semi-structured interviews, focus groups</td>
<td>Providers, policy makers</td>
<td>Inductive, grounded theory</td>
<td>‘language, distance, culture’</td>
</tr>
<tr>
<td>Belli et al 2004</td>
<td>Georgia</td>
<td></td>
<td>Informal payments</td>
<td>Qualitative study</td>
<td>In depth interviews, focus groups</td>
<td>Providers, patients</td>
<td>Approach not reported</td>
<td>None</td>
</tr>
<tr>
<td>Hopkinson et al 2004</td>
<td>Kyrgyzstan</td>
<td></td>
<td>Diabetes as ‘probe’ for health sector assessment</td>
<td>Pilot for rapid appraisal</td>
<td>Unstructured interviews</td>
<td>Providers, patients, policy makers</td>
<td>Not reported</td>
<td>Lack of privacy for interviews</td>
</tr>
</tbody>
</table>
3.2. Appropriate methods of data generation

3.2.1. Interviews

Appropriateness of format

The individual interview has been the ‘method of choice’ for much high income country qualitative research, and has been widely used as either a stand-alone method or in combination with other methods of data collection in HSR in low and middle income countries.

An initial problem, noted particularly in rural settings, is that ‘the interview’, as a particular kind of social interaction in which one person asks questions to generate data on the views, attitudes or reports of experience of the respondent, may be an unfamiliar format for interaction, and therefore not necessarily always appropriate in all settings. In relation to conducting surveys, Stone and Campbell (1984) noted that the social format of ‘the interview’ may be familiar in high income countries, but less familiar in many non-western settings. Whereas the interview is a common cultural form in most high income settings (familiar from contexts such media uses and job selection as well research setting), the ‘meaning’ of being interviewed may be different where it is a less familiar format, particularly in more rural areas. The problems that have been noted with using the interview format uncritically include:

- Suspiciousness of strangers asking questions, leading to inaccurate or inadequate data (Kroeger 1983).
- ‘Courtesy bias’ in many cultures, which precludes open disclosure of personal or critical views (Smith et al 2008)
- Practical or social difficulties in finding private spaces for one to one interviews (Kohler Riessman 2005, Hopkinson et al 2004)

However, as suggested by the range of participants interviewed in the FSU case studies (above), these challenges are usually surmountable. Hopkinson et al (2004) for instance, note that in a setting where hierarchical working relationships might make it difficult to interview junior professionals on their own, one can compare the reports from private interviews and those with a senior present. Similarly, they note that in patient interviews, where the presence of others may have inhibited responses, they could offer an additional interview in a private space later.

The review identified interview studies from most regions of the world, including public, patient and professional participants. The main recommendations for adapting one to one interviews in settings where this may be an unfamiliar format are building trust and using an appropriate
interactive style. An appropriate style is one that uses an acceptable format for disclosing personal views in the setting. This may be culturally variable across a country. Lewin (2005) for instance, notes that in study interviewing nurses in South Africa, he had to amend his interviewing technique in talking with Xhosa participants, for whom long pauses and too many prompts were seen as intrusive rather than enabling. The threats to data quality arise from unreflexive use of the format, which is not a particular issue with low/middle income setting research, but a common problem in qualitative health research more generally (Silverman 1998). Particular problems related to the context of conducting interviews across languages are discussed below.

We discuss below the challenges of identifying fieldworkers with adequate skills in both conducting qualitative interviews and local languages. Traditional text book advice on appropriate persons to conduct interviews often centres on ‘matching’ interviewer and respondent characteristics were possible (eg on ethnicity). This advice is based on empirical findings, largely from from US studies, in which interviewers from same background are more likely to be given ‘deviant’ or less formal responses. Examples relevant to HSR include being more likely to report the use of non-formal health care (see Garrison 1977). However, there are of course also risks in matching, particularly in relatively small ethnic communities where being an ‘insider’ also compromises faith in confidentiality.

Gathering ‘private data’ from interviews

To generate the perspectives of those being studied, it is often assumed that qualitative enquiry should attempt to access what are called ‘private’ rather than ‘public’ views (Cornwall 1984). Textbook advice on interviewing addresses itself largely to ways of maximising such access, including how to establish rapport, maintain confidentiality and provide a private space to conduct the interview, where confidentiality can be protected, and the respondent trusts that the views they are expressing will not be passed on to others.

It is not at all clear, though, how far the notion of a ‘private’ sphere translates to other cultures. This has practical implications, in that ‘private’ spaces for interviews may be inappropriate or even threatening, and methodological implications, given the attempt to generate perspectives which may have very different social meanings to those assumed by western-derived methodologies. Thus, Beckerleg et al (1997) note that in a study of access to care among Bedouin women, that individual interviews would not only have been culturally inappropriate, but would not have accessed ‘meaningful’ views on access, as these are developed and shaped by the context of households, so it is reasonable to ask about these views in the context of a group interview. Similarly, Kohler Riessman (2005) discusses the difficulties in accessing private spaces to interview women in India about fertility, given that this was seen as a family and community problem: ‘My idea of privacy’ she notes ‘at least in village contexts, was clearly a foreign import’ (Kohler Riessman 2005: 478).
Cultural norms about courtesy, especially to strangers, may also limit the scope of interviews, particularly one off interviews, to access some private views. Smith et al (2008) for instance, note that in interviews in mainland China on family planning services, that short responses only were given to researchers prompting for details of personal narratives, in part due to a culture of courtesy preventing individuals overly critical of service providers. In a further study of DOTS for TB, this research team suggest that taking time to build trust with interviewees was important, as was de-personalising questions if possible, so the respondent was not asked about their personal views (Smith et al 2008).

It is not, though, possible to take uncritically assertions about the inappropriateness of privacy in particular settings, given that rights to privacy may be socially structured (eg denied to women), and there may be important ethical issues around offering and maintaining privacy (Ellsberg and Heise 2005: 38-9). The methodological problem thus goes wider than merely noting that issues such as ‘privacy’ are culturally determined. Kohler Riessman (2005) notes that when she was able to talk with women about fertility in private, they were relieved to discuss the issue, and could talk about aspects that could not be discussed in front of the family.

3.2.2. Focus groups

To offset both the practical challenges of finding privacy for one to one interviews, and the methodological barrier of individuals being an inappropriate unit of analysis for health care decision making, various kinds of group interview have been seen as the data collection method of choice for cultures in which health care decisions tend to be taken by groups (Khan and Manderson 1992), or in which there is more collective rather than individual focus (Obeng-Quidoo 1987).

There is an emerging literature on the need to adapt such data collection techniques as interviews and focus groups for different settings (Vissandjee et al 2002, Amoakohene 2005). However, we first perhaps need to distinguish what issues relate to the universal principle of having to adapt methods to context, and which may be more salient to the specific issue of transferability to low/middle income countries. Amoakohene (2005), for instance, in a review of how focus groups have to be adapted for African settings starts by noting that although focus groups may be particularly suitable for many African settings, in which people may be more group orientated and have strong oral traditions, the general guidelines from textbooks or learnt in social science courses are ‘idealistic, problematic and unsuitable’ (p168), and that practical issues such as time and time-keeping, choice of venue and recruitment all have to be rethought for African settings. Although she may be referring to market research stipulations rather than social science ones, the examples she gives suggests that it is not ‘African settings’ per se that differ from others, but rather that in Africa countries, just as in any other countries, one has to adapt the practical issues to the participants and environment. Thus, drawing on her own experience in Ghana, she notes that flexibility should be built into schedule to recognise typical late starts, and that ‘over-
recruitment’ may be problematic in settings where focus groups are relatively novel and therefore likely to attract curious extras.

Such considerations are perhaps the inevitable ones of developing appropriate tools for the setting, and it could be argued that health care researchers in African settings have a long and fruitful history of using group interviews successfully (see, eg Munodawafa et al 1995, Geneau 2008, Izugbara et al 2008). In adapting group interview techniques to particular settings, especially low/middle income country settings, the following considerations have been identified as key to success:

- address community concerns about the purpose of the research before conducting focus groups (Vissandjee et al 2002)
- Avoiding over-recruitment where group interviews are likely to be a novel attraction (Vissandjee et al 2002, Coreil 1995, Amoakhoene 2005)
- Consider local hierarchies, in that ‘natural groups’ may inhibit marginalised views (Coreil 1995, Vissandjee et al 2002)

3.2.3. The focus on oral data

Qualitative methods of data generation rely largely on techniques that generate words, and largely spoken words. There are some exceptions, and rapid appraisal techniques, for instance, often include more visual data such as maps, diagrams drawn by respondents and charts. In general, though, the basis of most qualitative methods is the analysis of utterances, with a range of ways of interpreting those utterances. The six HSR studies in our case study (above) all drew on interview data, although some also used other sources within rapid appraisal designs. The over-reliance on interview data in qualitative health research has been noted even in high income country contexts (Silverman 1998, Lambert and McKevitt 2002), with particular problems when utterances are taken uncritically as indicators of opinions, likely actions or even as typical of ‘what people say’.

The use of group interview methods may off-set the particular limitations of the one-off individual interview, which may be particularly prone to generating merely orthodox, ‘public’ opinions. However, group interviews still generate oral data, and there are two potential problems with transferring such methods of data collection uncritically to all settings. The first problem is cultural: assuming that the ‘status’ of talk, if sensitively generated and analysing adequately, is that it can be taken as an indicators of authentic, valid views. This may not be a universal assumption. Kohler Riessman (2002), for instance, suggests that the stress on spoken
words as indicators of authentic views can be culturally inappropriate, citing evidence from a Japanese-American researcher about the value of *ishin denshin* in Japanese communication – the idea that shared, profound understanding is rather more tacit, and that the ‘truest’ communication resides in the unsaid ambiguities, given that words cannot precisely represent complexity.

The second problem of over-reliance on interview methods relates to the relations of production of most HSR in low/middle income counties, in that they are often led or co-managed by high income country partners, particularly where the aim is to publish in international journals. The resulting international research teams can then over-rely on translations of transcripts, without the kind of ethnographic contextual information that might help make sense of what is said in interviews, and what the status of that data is.

### 3.3. Translation in data collection

The requirements for translation in more quantitative work, for instance in developing quality-of-life instruments that can be used in cross national studies have been much discussed (Ware et al 1995; Bowden and Fox Rushby 2003). This literature describes the challenges of finding adequate quantitative instruments for cross-national studies. When we are considering more in-depth methods, such as narrative interviews, or group interviews, the challenges go beyond language translation and involve challenging questions about our ability to generate data on underlying cultural knowledge, explanatory systems or social interaction (for instance) in ways that can be compared meaningfully (Larkin et al 2007, Temple et al 2006).

Language is central to qualitative research, and it has been noted that issues of linguistic competence and translation have received inadequate attention in international research (Mangen 1999, Larkin et al 2007). International teams conducting research in low/middle income countries typically have to manage data collection in languages where not all the research team are fluent in the local languages. More specifically, those designing, managing and writing up the research may be unfamiliar with the languages used in data collection.

One possibility is for those managing the research to conduct at least some fieldwork using local interpreters to facilitate interviews. ‘Passive translation’, where an interpreter translates each question of interviewer and each answer, before proceeding, is slow, reduces the ability of the research to establish rapport, and risks the interviewee becoming bored, frustrated or loosing focus (Picthforth and van Teijlingen 2005, Lewin 2005). Alternatively, interpreters can be more active, in the role of a research assistant, conducting the interview in a local language. This relies, however, on well trained local research assistants who can conduct good qualitative interviews. In well established international research teams, in countries with some capacity for social research, such expertise can be identified. Smith et al 2008, for instance, report that they conducted interviews and focus groups in Mandarin, ensuring they were done by a trained interviewer fluent in the local dialect and that transcripts were carefully checked for accuracy. However, in many settings, recruiting and training such assistants can be challenging. Pitchforth
and van Teijlingen, in a study of use of obstetric care in Bangladesh, report that even with well trained local interviewers, they identified problems with different expectations about how to conduct the interview between the researcher and assistant, for instance in over whether the interview should criticise the women’s decisions.

The availability of linguistically competent social scientists in the fieldwork setting is not a guarantee of good quality data generation. The development of translated interview prompts that will generate good quality data on the topic of interest is not a straightforward process, and relies on what are often known as ‘cultural brokers’ on the team who can not only translate the content of language, but also the cultural context and can contribute fully to the interpretation and translation of data after the interview (Temple et al 2006, Larkin et al 2007). Larkin et al (2007) note that preparing interview questions that will generate rich data is complex enough in one language, but when these have to translated such that there is linguistic and cultural equivalence there are real challenges. They suggest a process of using bilingual dyads of translators to work on interview prompts such that they are culturally equivalent, paying attention to such issues as how much deference/intimacy is suggested by the translated words, and the nuances of linguistic meaning.

In high income settings, resources and infrastructure may make it possible to generate simultaneous translation of focus groups conducted in a language with which the researcher is not fluent (see eg Esposito 2001). In resource poor settings, such infrastructure is unlikely to exist. A ‘middle path’ is sometimes adopted, with local research assistants conducting the interview, but stopping from time to time to summarise for the non-fluent researcher so they can ask for specific issues to be followed up, or check the interview is on track. Lewin (2005: 329), drawing on research conducted in three languages in South Africa, suggests (if resources allow) the possibility of two translators at focus group discussions. One can facilitate the group, whilst the other provides verbatim translations to the researcher.

### 3.4. Language issues in analysis

In many HSR studies, the qualitative data is used to provide ‘case study’ material, with summaries of participants’ experiences only. Researchers then report that a reasonably accurate translation of either transcripts or interview notes may be sufficient for the purposes of the study (Parkhurst and Rahman 2007, Pitchforth and van Teijlingen 2005). When more detailed analysis is needed, however, more attention has to be paid to how and when to translate if necessary for analysis (see Singal and Jeffrey 2008 for the differences that become apparent in notes, a rough translation and a more detailed one). We found little literature on methods for using flexible yet comparative protocols for international qualitative studies in low/middle income settings.

There are, however, indications that the potential challenges of doing this are barriers to the development of international HSR. The challenges of working across different languages have
been widely noted in the literature (Atun et al 2006, Belli et al 2004, Njue 2009), with acknowledgement that adequate time and resources need to be devoted to developing procedures for analysis. Even in a study in one country, Atun and colleagues (Atun et al 2005) report that regular meetings in Russia and the UK were required to facilitate analysis of Russian language interviews by an international team, as well as translation of transcripts into English. The problems become even more complex in international studies across several language groups. In a focus group study of family planning in four central Asian republics, for instance, Storey et al (1997) report that focus groups were held in local dialects, then transcribed into Russian, then translated into English.

Working across languages is time consuming. Atun and colleagues (2006), in a study of the implementation of primary health care reforms in Bosnia and Herzegovina, notes that the analysis and interpretation of data across languages and cultures was challenging and required ‘iterative triangulation’, but the interviews were either conducted in English or with a good local interpreter, with the analysis conducted in English and then discussed by local research teams.

There are a number of styles of qualitative analysis, with a rough distinction perhaps between the more deductive styles, in which the analysis follows the original research questions of the study, and the more inductive styles, in which the analysis is grounded in the emerging data. As an applied discipline, many HSR studies use deductive styles, such as framework analysis (Ritchie and Spencer 1994). Ideally, to develop generalisable theory as well as gathering local views, analysis should be detailed, and inductive as well as reflecting merely the ‘top level’ themes that are usually the subject of the interview topic guide. However, inductive data analysis relies on close reading of transcripts, and a good understanding of local languages, and how language is used in social interaction (see for instance Wilkinson and Kitzinger 2000, on the detailed understanding needed to interpret ‘feeling positive’ in focus groups interviews).

There are two main strategies available for managing translated data for analysis.

1. Translating all material into English (or international language) for analysis

   For the research published in English language journals, the norm appears to be that interview transcripts are translated into the international language for joint analysis by the research team (see eg Izugbara et al 2009, who translated from Swahili to English). The risks here are that the translations are then rather ‘thin’, and lacking the cultural context, unless the research team work on them together. As Pitchforth and van Teijlingen (20005) note, the translations they checked by back translating a sample of interview transcripts from Bangla were ‘accurate’ enough for a thematic content analysis for an applied health study, but lacked enough sensitivity to tone and interpretation to allow for such techniques as discourse analysis or conversation analysis.

2. Conducting initial analysis in local language and translating only samples
When capacity exists in each contributing country for qualitative analysis, that each local team does the analysis in the original languages of the transcripts, meets regularly to agree coding schemes and emerging themes, and only the extracts used in final reports are translated.

The disadvantages of the first are difficulties in knowing that translations are culturally competent, and understanding the cultural nuances of language – what is metaphor, what is a trope designed for easing communication rather than displaying views, for instance. The disadvantage of the second is that it relies on capacity for qualitative analysis within each local language used. In high income settings, this is possible, although still challenging. In a four country study in Europe, for instance, Green et al (2005) used this method for dealing with data in English, German, Italian and Finnish. However, this required considerable ‘process’ time for international team meetings (and for four teams with very different traditions of qualitative research), and still some translation costs of interim analyses to enable ‘meta-analysis’ of single country data (Green et al 2005). This is challenging enough across four high income country settings with capacity for qualitative research. It would be even more challenging to do across settings in which such capacity is less well developed.

Smith et al (2008) note that the key is team working, and if capacity exists, an iterative process by which coding is initially done in local languages, schemes are shared by the whole team, with discussions in English of important themes, aided by translated summaries of transcripts. They note an emerging problem with this iterative approach: that it is difficult to keep track of analytical decisions, which may be increasingly problematic as demands for qualitative researchers to be more transparent about data analysis methods grow. Their proposed solution is a useful one for teams which include trained qualitative researchers fluent in local languages:

“We recommend the coding framework is developed in the local language by more than one researcher, and is subsequently made available and discussed in a language common to the research team … Consensus on a final thematic framework was reached through discussion” (Smith et al 2008).

There are few detailed descriptions in the literature of the processes used by teams to develop robust processes for analysis across languages, and a need for more work on methods for doing this in international research.

3.5. Ethics: autonomy, privacy and consent

A concern in many published qualitative studies was the extent to which ethical principles and practices derived from high income country research contexts can and should be applied in other settings. A relativist position holds that such concepts as ‘confidentiality’, ‘autonomy’ or ‘privacy’ are culturally determined, and that it may be inappropriate to utilise them in the same
way in all settings (see eg Madden 1997, van der Geest and Sarkodie 1998). An example of this position is a covert ‘pseudo patient’ study of a Ghanian hospital (van der Geest and Sarkodie 1998), in which the authors argue that informed consent may be inappropriate in their study. The concept of ‘informed consent’, they argued, is culturally bound, and there was less interest in rural Ghana in privacy that one would expect in a Western setting. A more universalist position holds that these are basic principles of research, and doing research in low/middle income settings is no reason for not adhering to them. This is the position closer to that of the Nuffield Council on Bioethics (NCB 2003), which suggested respect for difference and sensitivity to local norms, but that underlying principles of ethics should be universal, and that doing research in a low income country should not be a reason to sidestep ethical requirements which would hold in a high income one.

Sensitivity to local norms whilst not exploiting them to do what would elsewhere be considered unethical research may be a sound principle, but one which nevertheless generates dilemmas. Kara (2007), for instance, has argued that the Western notion of autonomy, predicated on the idea of the individual conceptualising themselves as an autonomous self, may be an inappropriate one in more collectivist cultures. Drawing on a case study of Turkey, Kara notes that although values may differ across rural and more urban settings, there is a generalised notion of a ‘familial self’ may be more appropriate in thinking about health care consent decisions, and by implication research consent decisions. Although it is ethically important to be aware of the coercive as well as supportive aspects of family, Kara concludes that autonomy should not be ‘forced’ on those for whom it may be an alien concept. This has implications for the design of consent procedures based on models of individual autonomy, which may be a requirement of high income country ethics committees.

A similar barrier is the need for written consent to all elements of the interview (taking part, recording, agreeing for quotes to be used) following complex procedures to ensure the participant is informed. It has been noted that requiring signed forms can be threatening for many communities, even when highly literate. As Montgomery (2010) notes, complicated written procedures also potentially open the entire ethics procedure to ridicule. However, this has been reported in many populations, whether in high, middle or low income countries, and perhaps reflects the inappropriate ethics requirements demanded by high income country medically oriented ethics committees, rather than a specific issue of transferability.

Particular care should be taken with ethical considerations with vulnerable populations or sensitive topics. There are no inherently ‘sensitive’ topics: sensitivity differs from setting to setting. This has implications for the methods of data collection chosen. Belli et al (2004), for instance, report that in a study of informal payments, the responses gained from individual interviews and focus groups did not differ in Georgia, whereas they had in a previous study in Poland, suggesting that this topic was too sensitive to discuss in public there. However, there is also an interaction with context and sensitivity. What is ‘sensitive’ to discuss in some locations may be easier in others: Baker and Hinton (1999), for instance, report that in research in refugee
camps in Nepal, women found it easier to discuss some personal issues in the relatively public arenas of the camp than in their own homes.

There is often a problem with audio-recording interviews on ‘sensitive’ topics, with the assumption that respondents may be anxious and reluctant to disclose, for instance, dissatisfaction with services if recordings are made (see eg Parkhurst and Rahman 2007). Whilst written interview notes may record the key issues, and be useful for case studies of access to care, the lack of detailed transcripts clearly raises issues for data reliability and limits the potential for qualitative analysis.

Njue (2009) found that researchers working across different countries had to not only be careful about what was sensitive in other settings, but also what was sensitive to share with the particular person the researcher appeared to be: for instance, their gender, apparent marital status or whether they had children.

3.6. The political context of social research

The political context relates to both internal political and social factors in the country of the study, and those that relate to the relationships between high and low/middle income partners.

Within country, political factors relate to the relative status of social/qualitative research, the health policy system (eg whether users’ views are seen as valid) and the sensitivities around criticisms of the health care system. For instance, in post soviet states, it has been reported that quality of care issues may be difficult to research because of sensitivities about the impact on providers of ‘poor’ results, which may have attracted sanctions in early regimes (USAID 2005).

More broadly, although discussing public health research, not HSR, Yach’s (1992) points on the difficulties of challenging ‘medical hegemony’ in developing countries are relevant to this discussion. In many settings, there is still a bias towards biomedical models of research, in which ethnographic work or more qualitative methods are still seen as inherently less valid, or more subjective, by managers and health policy makers (Barker 1995, van der Walt and Mathews 1995).

This has a number of consequences for transferring methods. First, there may be assumptions about ‘status’ of knowledge from patients or from front line professionals: that it lacks any inherent worth. Conducting qualitative interviews presupposes an acceptance that the perspectives generated will be useful for practice or policy orientated research. In most high income settings, there are now policy obligations to “seek users’ views” and a widespread acceptance of the validity and utility of seeking user views, both as a method for understanding the health system in its entirety and for incorporating user perspectives in service planning. However, in many settings, traditional hierarchies in health care that position users as ‘patients’
with few rights mean that there is no immediate acceptance of the usefulness of qualitative enquiry, or indeed any research which aims to identify users’ views. The same may be true of junior health care professionals, who may be difficult to interview without senior staff present (Hopkinson 2005). This barrier can be overcome. An evaluation of a Quality Improvement programme for family planning services in Kazakhstan for instance, found that clinic staff came to understand the benefits of gathering clients’ views form exit interviews (USAID 2005:17).

These hierarchies can also provide challenges for conducting the research, with physicians potentially reluctant to be observed by non-physicians (USAID 2005). In a study of into variations in maternal care in Tula (Danisheveski et al 2008) Balabanova (personal communication) reports that local expectations were that junior doctors would do interviews. Even trained local social scientists might feel they have to stress their ‘medical’ credentials in introducing themselves to interviewees (Picthforth and van Teijlingen 2005), or request white coats in order to look more ‘professional’ in settings where social research has low status in the health sector. In high income countries, such ‘placing’ of the interviewer as a ‘medical’ person would be usually considered detrimental to good rapport and the chance of accessing private data, and textbook advice is usually to present oneself as ‘learning’ about the interviewee, rather than in a position of authority. In other settings, it is unknown what difference this makes to the data generated.

3.7. Writing up qualitative international HSR

The potential challenges for comparison influence every stage of the research, from developing appropriate field guides for researchers that will generate similar data in each setting, through to ways of writing up that will be appropriate both internationally and in each context. This can involve political decisions around, for instance, what to call particular geographical areas (see Lewando-Hundt 2000 for an example here), and local sensitivities around criticisms of health services.

A practical issue of conducting international research is that study findings may have to be disseminated in several languages, with each output possibly translated so that all authors can contribute to writing. In addition to the issues of language discussed above, there are also different cultures of communication internationally (Cortazzi and Jin 1997), with particular expectations of what an academic paper or policy report ‘should’ look like, in addition to disciplinary differences. These can add substantially to the time taken to co-write outputs.

Publications in an international language, preferably in a peer reviewed journal to ensure quality is assessed, is important for academic scrutiny as well as building an evidence base for qualitative HSR. Further, it is an important element of developing capacity for health research generally in low/middle income countries, such that researchers build both experience and external credibility as independent researchers (Wright 2008). If the research is written up in
English, then extracts from interviews used to illustrate key themes will need to be translated. It is good practice to include source data, so that readers can judge the credibility of translations, but most journals will not give space to include the original local language as well. However, it may be necessary to include key words or phrases in the original language. A key contribution of qualitative methods is that of understanding local concepts of health, disease and health care. Often these local concepts are particularly difficult to translate, and considerable care needs to be taken to render them into an acceptable English term.

However, the incentives to write publications in English for international academic audiences should not preclude publications in suitable formats for local policy makers, who may find both English and the technical language of scientific reports inaccessible (D’Souza and Sadama 2006).

3.8. **Capacity and workforce for social science**

Many of the challenges discussed so far relate directly to two linked problems: the limited capacity for qualitative health research within low/middle income countries and resource constraints. Together, these mean that much qualitative health research in low/middle income countries is funded by international or high income donors, and is led and managed by high income institutions, and by research leaders who rarely have the language skills necessary to conduct good quality qualitative research.

Resource constraints have been cited as an impediment to research capacity for health systems research in general in low and middle income countries (D’Souza and Sadama 2006), with research having a low priority in the face of more pressing problems for health care services and workforces. Research funding is often largely foreign donor led, with priorities thus led by international concerns rather than those of the local population or Ministry of Health. Funding alone does not increase the research capacity, and there is a need to build a cadre of adequately trained researchers. In a review of case studies, D’Souza and Sadama (2006) note that skills in analysis and writing are particularly scarce, with the inevitable result that research proposals continue to be foreign partner led. Wright (2007), drawing on a study in East Africa, additionally notes that the concentration of trained social scientists in consultancy, rather than academic research, in low/middle income countries contributes to the limited development of skills in writing proposal, academic outputs and in building capacity within the academy. Again, this limits the possibilities of developing within-country expertise to lead on research.

In contexts with limited research capacity in general, and where social science may have low status, the development of qualitative research capacity may be a particularly low priority. Apart from workforce capacity constraints from insufficient trained social scientists, other resource constraints that affect health research generally also apply to qualitative HSR: difficulties in accessing academic literature; and sometimes few structures in place to collaborate within-
country (eg between public health schools and social science departments, or between the university sector and ministry of health). Limited financial governance can be an impediment to developing in-country expertise when it restricts opportunities to hold grants for research within departments.

To be effective, capacity building takes considerable investment of resources from external funders, and time to build up trust between international partners (Mayhew et al 2008, Sithipamorn and Somrongthong 2000). Simplistic capacity building programmes risk being counter-productive. First, short term or poorly planned capacity building risks merely exacerbating the ‘brain drain’ of skilled researchers to high income settings (Wright 2008). Second, and particularly pertinent to qualitative research, Rifkin (1995), warns of dangers of qualitative research appearing ‘easy’ for health managers with little training, who may then go on to use qualitative methods inappropriately (eg when a quantitative design is needed) or with inadequate analysis of data, with bias evident. Of course this is not just a problem of low/middle income countries (indeed the growing demand for research-active health professionals in high income countries also contributes), but ‘increasing capacity’ for social science in low income countries is not a quick fix in countries where there might be little critical mass of capacity in social science thinking.

Training for students or employees with little experience of critical thinking is challenging, given the difficulties for research staff in setting aside their own social perspectives, such as those of stigma or dismissive attitudes to particular population groups. In settings where there is limited experience in general of qualitative methodologies, it can be difficult, for instance, to negotiate the necessity and legitimacy for purposive samples (rather than probability samples) and for flexible interview guides.
DISCUSSION

In our case study area, the FSU, we found a small literature using qualitative methods in HSR studies, published post-2000, and indicating the growing interest in using these methods within the region. Although few published articles discussed the challenges of transferring methods to middle income settings or developing them for cross national work, those that did reported challenges that reflected those in the wider literature. We reviewed this literature to identify what is known already about the challenges of transferability of methods, and identify what the implications of this are for developing international HSR.

The challenges of using qualitative research methods in HSR in low and middle income settings came under three, cross cutting, themes:

1. Those relating to the **resource constraints of the setting**: for instance, how the income level of a setting constrains research in a practical sense (eg the infrastructure or human resources needed for conducting research)

2. Those relating to **culture**: including practical issues such as the types of data generation methods that are culturally acceptable and more epistemological concerns about the cultural context of how, for instance, opinions are formulated in public settings and how we can gain knowledge of them.

3. Those relating to **politics**: how far power imbalances both between high and low income partners and within each country might shape the design, conduct, interpretation and dissemination of the research.

One problem is that it can be difficult to separate these issues in practice. In a setting where some stakeholders are adamant that it is culturally appropriate for doctors, rather than social scientists, to do the research interviewing, how do we determine whether this reflects a lack of legitimacy for social science, a lack of capacity in interviewer skills, or some genuine methodological strategy most likely to generate the information we need for the study? Indeed, one of our initial concerns was the extent to which it is possible to separate out challenges of doing research in a resource-poor setting from the issues of cross cultural transferability. Some of the issues described above, such as those relating to expectations of the dominance of a biomedical model, were also true of health research in most high income settings until recently, and a number of articles from the UK and USA in the 1990s were aimed at demonstrating the legitimacy of qualitative approaches to largely medical audiences (Pope and Mays 1995, Shortell 1999). Only with long term collaborations between research partners will it become clear how far the principles of qualitative methodologies developed in high income settings are transferable to particular low or middle income ones. There is a need for empirical work that sets out to test assumptions about data collection in a range of settings.
Transferability of qualitative methodologies

From the case study material and methodological contributions reviewed above, it seems that there is nothing inherently appropriate or inappropriate about particular methods of data collection/generation such as individual interviews or group interviews in any setting. The need to adapt the particular format of the interview to local contexts is universal: there are no absolute rules about whether, for instance, to match interviewer and interviewee for social characteristics, or whether individual or group interviews are more likely to yield rich, relevant data. In all settings, and for all methodologies (Cardona and Joshi 2007), a detailed and sensitive understanding of local cultural norms of communication and the meaning of the topic under consideration is needed. Where research teams are unfamiliar with the setting, an ethnographic approach is essential as a first step to build such understanding such that interview data is not used uncritically as an indicator of attitudes or experiences (Lambert and McKevitt 2002).

These issues of translation and language have perhaps been better debated in traditional methods such as ethnography, in which validity relies on the researcher spending considerable time in the field, learning not only what to ask and how, but how participants in the field think: how they classify and organise phenomena in the world and communicate that knowledge. In HSR, the needs are often for methods that have less depth but more breadth than those of traditional, single site, ethnographies. With the use of more formalised methods, especially in international HSR, where we require some comparability across sites, there is an urgent need to develop our understanding of how we can maintain these strengths of qualitative methodologies (high internal validity, rich thick description) whilst enabling the generation of comparable data. International studies are important for HSR to develop a more theoretical understanding of issues such as health care reform or policy implementation. They can also be an efficient use of research resources, capitalising on a joint infrastructure and drawing combined research designs. However, if a principle of qualitative research is flexibility of design, and a detailed understanding of context, it can be difficult to ‘standardise’ protocols and instruments enough to maintain these strengths whilst providing comparable data.

The case studies referred to above, from settings as diverse as Asia, Africa and FSU, also suggest that qualitative methodologies are not only transferable across diverse settings, but also welcomed as providing in depth information about crucial questions in HSR that are difficult to access in other ways. Qualitative methodologies have been used effectively to generate detailed understanding of health services that can contribute to quality improvement. At a broad level, there is considerable evidence that the principles of qualitative methodologies are transferable to a range of different health system contexts and cultural settings.

Indeed, many of the apparent debates about the adaption of methods to local contexts are similar to the challenges that health services/systems researchers in high income countries a decade ago. In both the USA and the UK, the acceptance of qualitative methodology in health research generally has been relatively recent. This reflects to some extent a growing acceptance of the
need to incorporate users’ (or patients’) views in the development and organisation of health care systems, and the consequent need to develop methods for accessing those views.

We conclude, therefore, that there is great potential to develop qualitative HSR in low/middle income countries using interview and focus group techniques to generate data, so long as these are sensitively adapted on the basis of good understanding of the context. To do this, more capacity is needed within countries in qualitative methodologies such that HSR studies can be designed by those who understand the local context.

**Implications for cross national qualitative HSR**

This review has identified a number of issues related to language and translation that arise largely from the (current) necessity for qualitative health research in low/middle income countries to be led by international teams.

Given the well documented constraints in the short to medium term for qualitative HSR to be funded and led within low/middle income countries, there will be a need for some time for research to be conducted across country settings, with high income country leads often responsible for leading on proposal writing and writing up findings for dissemination. Although there is now a considerable literature on capacity building to develop in-country expertise, for qualitative research there is an immediate problem in that it is rare for the high income partner to have the cultural and linguistic skills needed to ‘lead’ on qualitative components of projects. Adequate attention to issues of translation (at every stage, from interview topic guide development, through analysis, to writing up) is key to the success of qualitative HSR done in collaboration between high and low/middle income partners, and even more challenging where the study fieldwork is in multiple countries. We identified common problems in the time and resources needed to do this, but little published material on problems and processes for qualitative analysis across countries. In general, iterative processes of data analysis appear to be the most robust, which entail initial analysis in the source language, and then agreement of coding schemes in the international language of the team, utilising samples of translated transcripts for discussion. This requires the development of analysis skills in low/middle income countries and considerable time for meetings of the research team, and we recommend the development of training materials in non-English languages to help with this.

**Implications for capacity building**

However, such capacity will take time to build. With limited current capacity for qualitative HSR in many low and middle income settings, and limited funding sources for research, there will be a continuing need for international collaboration to build our understanding of health systems. In addition, to reach international audiences, there will be a need to publish research in English or other international languages. Perhaps the greatest current challenge to the transferability of of
qualitative HSR, and particularly the development of cross-national research, is the inadequate attention so far paid to how we deal with research across more than one linguistic culture by research teams that are unlikely to be fluent in all languages used.

**Limitations of this review**

We found systematic search strategies of limited value for this review, and therefore used a more narrative approach. However, as published qualitative HSR from low and middle income settings increases in volume, it will be useful to build a more integrated evidence base drawn from reviews. There is growing interest in methods to synthesis the findings and interpretations from qualitative empirical research (Dixon-Woods 2005, Britten et al 2002, Mays and Pope 2006). Such methods have proved useful for integrating findings on empirical health studies in high income countries. In qualitative HSR, especially if focused on particular geographical areas (see Appendix 1), our experience of a systematic review of research on health service quality in the FSU suggested that there may be limited gain from these methods where there is little peer-reviewed published work.

Many published studies did not discuss the methodological challenges of using qualitative methods in cross national HSR in low/middle income countries. Informal discussions with researchers suggested a number of reasons: lack of space in journal articles; not wanting to draw attention to potential threats to validity in the research; political sensitivities within research teams. It would be useful for future research teams if some of the problems and solutions were documented and in the public domain.
4. Conclusion

Based on a focused empirical review of qualitative HSR from one region (FSU) and a broader narrative review of the use of qualitative methods in low/middle income countries, we suggest that the challenges faced by researchers in using the most common methods of data collection (individual and group interviews) are similar to those faced in high income countries. Specifically, whatever the setting, researchers have to develop appropriate formats for the context, and consider such issues as the location, who will conduct the interview, and the most appropriate style of interview. Good practice requires other data collection methods in tandem with the main interviews in order to both enhance the research teams’ understanding of the context, and to explore how the data collection format is shaping the data generated. These are not issues that arise from either resources constraints or the particular social or cultural contexts of low/middle income settings. There are signs of the growing acceptability of qualitative methods in HSR in all regions of the world, and our FSU case studies illustrate the strengths of qualitative methods in addressing questions of access to and quality of care.

Similarly, the problems widely noted in low and middle income countries from working in health care systems that are still medically dominated, with little legitimacy for qualitative social science were not necessarily problems related to the low/middle income setting, but reflected the position of HSR in high income settings until recently. There is a need for more empirical studies which explicitly explore issues such as the effect of the interviewer’s status (eg medical, nursing, social science) on data.

However, the review did identify particular problems that arise from limitations of reliance on translated materials, with little published work on methods to strengthen validity in multi-lingual research. Working across several languages will continue to be a necessity because of lack of capacity in qualitative research, particularly analysis, in low/middle income countries and the limited language and cultural knowledge of high income partners. There is an urgent need to develop skills in low/middle income settings for conducting the analysis as well as data collection, but it is recognised that this is a long term goal which will require considerable resources. In the medium term, there is a need for training materials in non-English languages which fill the gap between applied training manuals and theoretical texts for experiences social scientists.

As international collaborations are likely to continue to be the primary way in which qualitative HSR in low/middle income countries is organised, we echo the widely reported recommendation of other teams that international studies require a substantial commitment of time to build trust and understanding, and to ensure that there is enough time for partner visits and developing a shared reflexive analysis of interviews.
References


Esposito N. (2001) `From meaning to meaning: the influence of translation techniques on non-English focus group research', *Qualitative Health Research*, 11: 568–79.


Wight D. (2008) Most of our social scientists are not institution based… they are there for hire - Research consultancies and social sciences capacity for health research in East Africa. *Social Science and Medicine* 66: 110-116

Appendix 1: Systematic review of patients’ perceptions of access to and quality of care in Caucasus countries

Dmitriy Pereyaslov

Background

The Caucasus is a geopolitical region located between Europe, Asia, and the Middle East\(^1\). The Caucasus countries include Georgia, Azerbaijan and Armenia became independent in 1991 after collapse of USSR. Became independent the Caucasus countries inherited the centrally planned Soviet health care system. The Soviet system provided the universal access and uniform quality of the delivered services\(^2\). But, the economic challenges and social disorder, wars in some countries following the breakup of Soviet Union led to severe under financing of health care systems. The literature demonstrates the low quality and outdated clinical practices provided characterized by poor responsiveness to patients and financial barriers to patients for accessing appropriate services\(^3\). Under the present circumstances, each of the Caucasus countries developing its own model of health care system. Reform aims to strengthen financing, decentralise the health care system and improve the quality of health services. The context of the reform varies between countries, but all countries want to keep the principle of universal access to care.

Objectives

The objective of review is to identify patients’ perceptions of access to and quality of health care. This will contribute to local health policy makers responsible for health care reform to improve the quality and delivery of health care.

Criteria for selecting studies for the review

To find eligible studies the following search strategy was applied. The study question divided on to three key concepts: “Patient perception of access to and quality”, “Health care services” and “Caucasus countries”. A systematic search of literature on Medline and Web of Science databases was carried out (see below). This was supplemented by references search in articles and grey literature search through web and contact of experts who have extensive experience of conducting qualitative research in low/middle income countries (see main report).
Each identified concept was searched twice. Once for synonyms in the title and abstract, and once using the subject headings. In order to exclude from the search the US State Georgia, country filter using subject headings option was applied. This could introduce the bias by for an example not inclusion of the multicountry studies conducted in both settings in to search, but the following searches in citation database and references search did not identify one. This filter did not exclude all US based studies from search, the US Georgia’s studies were omitted later by manual review of abstracts. Then searches were combined together. These search procedures found 121 articles Medline and 23 articles in Web of Science databases. Publications were included if they met the following criteria:

1. Study was conducted in geographical region defined as “Caucasus countries”.
2. Publication addressed “Patient perception of access to and quality” of “health care services”.
3. Study was collected the data using methods that are particularly associated with qualitative methods.

The eligibility criteria were checked twice by the same researcher in one-day interval by review the titles and abstracts of publications, then for that of particular interest the full text copies were obtained. Three studies were found that were met the inclusion criteria.

**Description of studies**

All reviewed studies were based on the survey design with structured or semi-structured interviews to collect a set of information. Skarbinski et.al., 2002\(^4\) conducted cluster survey of 248 households. Balabanova et.al., 2004\(^5\) analysed the data from cross-sectional surveys of adult aged 18 and over. Balabanova et.al., 2009\(^6\) analysed data from interviews of the adult diabetes service users. Methodological quality of included studies were assessed by the EPPI-Centre tool to assess the quality of qualitative and other types of studies of people’s perspectives and experiences\(^7\). Table 1 presents an overview of the qualitative assessment of the studies reviewed. Although the authors provide an adequate description of the sample design but from two studies Balabanova et.al., (2004) \(^5\), Balabanova et.al., (2009)\(^6\) it is, unclear that was the response rate and the sample size for both studies might not represent the study population. Moreover, Balabanova et.al., (2009)\(^6\) used the convenience sampling technique, to study disease with a high prevalence in the population, which again rise a concern about representativeness of this sample.
Table 1 Overview of the qualitative assessment by the EPPI-Centre tool.

<table>
<thead>
<tr>
<th>Appraisal question</th>
<th>Balabanova et al., 2004&lt;sup&gt;(5)&lt;/sup&gt;</th>
<th>Balabanova et al., 2009&lt;sup&gt;(6)&lt;/sup&gt;</th>
<th>Skarbinski et al., 2002&lt;sup&gt;(4)&lt;/sup&gt;</th>
</tr>
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<tbody>
<tr>
<td><strong>Quality of reporting</strong></td>
<td></td>
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<td></td>
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<tr>
<td>Are the aims of the study clearly reported?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is the context of the study adequately described?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there an adequate description of the sample used in the study and how the sample was identified and recruited?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Is there an adequate description of the methods used in the study to collect data?</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td><strong>Strategies for establishing reliability and validity</strong></td>
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<td></td>
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</tr>
<tr>
<td>Have sufficient attempts been made to establish the reliability of data collection methods and tools? (e.g. training for data collectors)</td>
<td>Yes, good</td>
<td>Yes, good</td>
<td>Yes, good</td>
</tr>
<tr>
<td>Have sufficient attempts been made to establish the validity of data collection tools and methods? (e.g. mention previous validation of tools, published version of tools, involvement of target population in development of tools)</td>
<td>Yes, good</td>
<td>Yes, good</td>
<td>Yes, good</td>
</tr>
<tr>
<td>Have sufficient attempts been made to establish the reliability of data analysis? (e.g. using more than one researcher to analyse data, use of a software package)</td>
<td>Yes, good</td>
<td>Yes, good</td>
<td>Yes, good</td>
</tr>
<tr>
<td>Have sufficient attempts been made to establish the validity of data analysis? (e.g. searching for negative cases; checking results with participants)</td>
<td>Yes, some attempt</td>
<td>Yes, good</td>
<td>Yes, some attempt</td>
</tr>
<tr>
<td><strong>Appropriateness of methods for studying people’s perspectives and experiences</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Does this study use appropriate data collection methods for helping patients to</td>
<td>Partially</td>
<td>Partially</td>
<td>Yes</td>
</tr>
</tbody>
</table>
express their views?

| Does this study use appropriate data analysis methods to help ensure that study findings are grounded in the perspectives of patients? | Yes | Yes | Yes |
| Were patients actively involved in the design/conduct of the study? | No | No | No |

**OVERALL JUDGEMENT ON QUALITY**

| Taking into account your quality judgments in the three areas above, what weight of evidence would you give this study in terms of whether its findings are really rooted in the perspectives of the patients studied? | High | High | High |

---

**Results**

Table 2 presents an overview of the key findings of the studies reviewed. Reviewed studies systematically represented data with the clear distinction between data and interpretation. All studies were consistent in highlighting the issue of out-of-pocket payments. Two studies (Balabanova et.al., 2004[5], Skarbinski et.al., 2002[4]) reported the self-treatment behaviour of the patient due to cost to access health care. Two studies (Balabanova et.al., 2004[5], Balabanova et.al., 2009[6]) conducted in both rural and urban settings demonstrated that less utilization of health care services associated with rural status of the patient. One study (Balabanova et.al., 2004[5]) responders demonstrated the lack of trust in the health system in general or health professionals in particular as an obstacle to access health care.

**Discussion**

The objective of this review was to identify patients’ perceptions of access to and quality of health care. The reviewed studies could introduce bias to conclusions drawn due to sample size, which could not represent the studied population. Recall bias, which is associated with the survey respondent answers and can be affected by the respondent's memory, should be taken in to consideration.

The key findings of the review will be useful to health policy makers in reform development and implementation. A major issue is to address informal payments as a major priority of health care reform. Strengthen the quality improving of services provided by health care system and improving the quality of health professionals especially in rural areas to aim urban/rural disparities.
Table 2 Overview of the key findings of the patient perception of the access to and quality of health services

<table>
<thead>
<tr>
<th>Key finding from each study</th>
<th>Balabanova et.al., 2004&lt;sup&gt;(5)&lt;/sup&gt;</th>
<th>Balabanova et.al., 2009&lt;sup&gt;(6)&lt;/sup&gt;</th>
<th>Skarbinski et.al., 2002&lt;sup&gt;(4)&lt;/sup&gt;</th>
</tr>
</thead>
</table>
| Affordability and access    | • Lack of money to pay for treatment  | • Patients have to pay to see the family physician | • Hospital care, physician visits, laboratory tests, or medicines are too expensive  
• Look for advice from a relative or friend or treat their condition with traditional medicines  |
|                             | • Self-treatment with home-produced remedies  | • Long waiting times to visit health professional  
• Purchase medicine directly from a pharmacist, without obtaining a doctor prescription  
• Long waiting times to visit health professional  
• Lack of trust in the health system in general or health professionals in particular  | • Patients must wait several days and take 6-7 visits to different locations before they obtain free insulin  |
|                             | • Patients have to pay to see the family physician  | | |
| Utilisation                 | Rural residents have less likely to obtain care when ill  | Regular access to the pharmacies in the district town for the patients in some rural areas may be burden  | |


### Search strategy

<table>
<thead>
<tr>
<th>Concept</th>
<th>Synonyms</th>
<th>Subject headings</th>
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<tbody>
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<td><strong>Patient perception of access to and quality</strong></td>
<td>Patient experience; Patient understanding; Patient awareness; Patient satisfaction</td>
<td>Patient Satisfaction; Health Care Quality, Delivery of Health Care (Health Services Accessibility); Access, and Evaluation; Quality Assurance, Health Care</td>
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<td>Hindrances</td>
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<td>Obstacles</td>
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<td>Health Services; Primary Health Care</td>
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<td></td>
<td>Primary health care; Secondary health care;</td>
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<tr>
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<td>Tertiary health care</td>
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<td>Transcaucasia; Commonwealth of independent states</td>
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<td>Armenia; Republic of Armenia; Azerbaijan;</td>
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Commonwealth of Independent States; CIS; former Soviet Republics;

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<th>Study design</th>
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<td></td>
<td>Focus group;</td>
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<td>Case studies;</td>
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Medline search strategy:

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<td>&quot;Delivery of Health Care&quot;/</td>
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<td>Hits</td>
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<td>((((Health care adj3 service*) or Health care) adj3 setting*) or Health) adj4 facilit*).mp.</td>
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<td># 4</td>
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</tr>
<tr>
<td># 5</td>
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<td>Databases=SCI-EXPANDED, SSCI, A&amp;HCI, CPCI-S Timespan=All Years</td>
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<td>Databases=SCI-EXPANDED, SSCI, A&amp;HCI, CPCI-S Timespan=All Years</td>
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</table>
Russian Language publications - strategy

Two main databases for Russian-language qualitative studies in Caucuses and Central Asian countries were searched:

1) The Central Scientific Medical Library of the Moscow Medical Academy named after IM Sechenov (CNMB) of the Ministry of Health of the Russian Federation (http://www.scsml.rssi.ru/). The library founded in 1919 and has over 3 million copies (more than 1.5 million items) of Russian, Soviet and foreign medical literature (including scientific works, translations, dissertations, deposited manuscripts, etc.).

2) The Institute of Scientific Information for Social Sciences of the Russian Academy of Science (ISISS RAS), (http://www.inion.ru) created in 1969, is the largest Centre of scientific information in the field of social and humanitarian sciences. The Library has over 13,5 million of books, periodicals abstract, bibliographic and analytical editions.

The following search strategy applied.

Цель исследования: Понимание пациентами доступа к, и качества медицинских услуг, а также взаимоотношения между пациентами и представителями медицинских услуг в странах Кавказа и средней Азии.

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<th>Синонимы</th>
<th>Предметные рубрики</th>
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<td>Опыт пациента; Понимание пациента; Осведомленность пациента; Степень удовлетворенности пациентов; Восприятие пациентом:</td>
<td>Удовлетворенность пациента; Качество здравоохранения, Качество оказания медицинских услуг (доступность услуг здравоохранения);</td>
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<td>Проблемы:</td>
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</table>

<p>| 2. Взаимоотношения между пациентами и представителями медицинских услуг | Взаимоотношения (отношения, связи, коммуникация, взаимодействие) <strong>ВРАЧ</strong> (доктор, специалист)/<strong>БОЛЬНОЙ</strong>(я,ые), пациент; | Отношения между Врачом и пациентом |
| 3. Учреждения, где оказываются услуги здравоохранения | <strong>Медицинские услуги</strong>; | <strong>Медицинские услуги</strong>; |
| | <strong>Медицинские учреждения</strong>; | <strong>Первичная медико-санитарная помощь</strong> |
| | <strong>Учреждения здравоохранения</strong>; | |
| | <strong>Клиники/больницы, поликлиники</strong> | |
| | <strong>Первичная медико-санитарная помощь</strong> (первичное звено здравоохранения); вторичная медицинская помощь; третичная медицинская помощь, квалифицированная и высококвалифицированная помощь | |</p>
<table>
<thead>
<tr>
<th>4. Страны центральной Азии и Кавказа</th>
</tr>
</thead>
<tbody>
<tr>
<td>Центральная Азия, Средняя Азия; Средний восток; Узбекистан, Республика Узбекистан; Казахстан, Республика Казахстан; Таджикистан, Республика Таджикистан; Туркменистан, Туркмения; Кыргызстан, Республика Кыргызстан, Киргизия; Афганистан; Исламская Республика Афганистан; Кавказ; Страны Кавказа; Закавказье Грузия; Армения; Республика Армения; Азербайджан; Азербайджанская Республика; Абхазия; Южная Осетия; Содружество Независимых Государств СНГ, бывших республик СССР;</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>5. Дизайн исследования</th>
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</thead>
<tbody>
<tr>
<td>Исследование качественных методов; Качественные методы исследования; Качественные исследования; Качественные методы; Исследования качества; Интервью; углубленное интервью;</td>
</tr>
</tbody>
</table>
First, each concept was searched separately for subject headings and synonyms. A number of studies on each concept were identified. The combined search was carried out as a second step of search strategy to limit studies to study question and to qualitative design. No studies fit the aims of the search were identified.

References


# APPENDIX 2 Checklist for Qualitative Case Studies included in review

<table>
<thead>
<tr>
<th>Author: ______________________</th>
<th>Date: __________</th>
</tr>
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</table>

## Section 1 Screening

1. Is there a clear statement of the aims of the research?  | Yes  | No |
2. Is this a qualitative study? | Yes  | No  | In part |
3. Region/Country setting | FSU  | Other |

## Section 2 Identify appropriateness for narrative review

4. Does the paper discuss methodological and/ or practical challenges? | Yes  | No |
5. Is the context (health care system, country, population) adequately described? | Yes  | Partly  | No |
6. Is the fieldwork in low/middle income country? | Yes  | No |
7. Does the research team involve a partnership including high-income/local partner? | Both  | High income  | Local only |

## Section 3 Quality Assessment

8. Is the sampling strategy appropriate for this study? | Yes  | No |
9. Is the sample sufficient to answer question? | Yes  | No |
10. Are data collection / generation methods appropriate to the research question? | Yes  | No  | Not described |
11. Are approaches to data analysis clear? (either described or implicit) | Yes  | No |
12. Have appropriate methods been used to maximise reliability? (eg training of interviewers, transcription of data etc) | Yes  | No / Not described |
13. Have sufficient attempts been made to maximise validity? (eg attention to deviant cases / sampling to saturation / clear division between analysis and interpretation / clear link between data extracts and interpretation) | Yes, good  | Yes, some  | No / Not described |

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### Section 4 Characterising the type of study

| Question                                                                 | Mainly Inductive | Mainly Deductive | Descriptive
<table>
<thead>
<tr>
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<tbody>
<tr>
<td>14. Data analysis was:</td>
<td></td>
<td></td>
<td></td>
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<tr>
<td>15. Findings, analysis and discussion were rooted in theory</td>
<td>Yes</td>
<td>Some</td>
<td>No</td>
</tr>
<tr>
<td>16. There was evidence of reflexivity around the researchers role, formulation of research question etc</td>
<td>Yes</td>
<td>Some</td>
<td>No</td>
</tr>
</tbody>
</table>