Carrying out a qualitative evidence synthesis

Method Specific data extraction

Prof Jane Noyes

Acknowledgement Ruth Garside QIMG – sharing slides

Types of findings from qualitative research

- Definition of a new concept
- Description of a phenomenon
- Creation of a new typology
- Description of processes
- Explanations or theories
- Development of strategies

Acknowledgement Ruth Garside QIMG – sharing slides

What does qualitative data look like?

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

Acknowledgement Ruth Garside QIMG – sharing slides

Member of staff – “Some of them … when they get agitated and stuff … you know, you can ask them, ‘Would you like to go outside for a little while?’ And for some of them it really cools them down. It calms them to be outside and away from whatever was agitating them.”

Member of staff – “When I take residents out into the garden, especially those from the dementia care unit who don't speak, they make a deep sigh, as if they are at peace.”

How do we make sense of the world? (Levels of interpretation)

- 1st order constructs :
  - Everyday ways of making sense of our world (seen as participant quotes and descriptive themes)

- 2nd order constructs:
  - social science researchers' interpretations of this "common sense world" to academic concepts and theories

- 3rd order constructs?
  - Reviewers' interpretations of the researchers' interpretations.

(After Schultz)

CVD prevention programmes

Quote (1st order)	Researchers' interpretations (2nd order)	Reviewers' interpretation (3rd order)
"Pamphlets involve a lot of reading…food sampling gives them the opportunity to feel relaxed and ask questions."	Practical demonstrations have more impact than provision of written information.	Personalised support, allowing relationships to develop & facilitating questioning, may have more impact.
"Sue was great, she had lots of information and advice."	Programme "champions" allow personalised information about the interventions to be disseminated.	

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Looking for findings in a paper

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A Socially Excluded Space: Restrictions on Access to Health Care for Older Women in Rural Bangladesh

Abul Hossen[1] and Anne Westhues[2]

Abstract

This study was an exploration of the experiences of 17 women, age 60 or more years, from Bangladesh. The women were asked about decision-making processes with respect to their access to health care and whether they perceived that there were differences based on age and sex in the way a household responds to an illness episode. The overall theme that characterized their experiences was "being in a socially excluded space." The themes that explained this perception of social exclusion included gender- and age-based social practices, gender- and class-based economic practices, religious beliefs that restricted the mobility of women, and social constructions of health and illness that led the women to avoid seeking health care. We conclude that the Bangladesh constitutional guarantee that disparities will be eliminated in access to health care between rich and poor, men and women, rural and urban residents, and younger and older citizens has not yet been realized.

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Findings

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

Exclusionary Social Practices

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

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

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

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

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

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

The needs of other household members come first. Women also reported being reluctant to disrupt the household by taking time from their domestic chores to seek treatment or be admitted to hospital. These women were socialized not to complain about illnesses or pain, and to continue working for the welfare of their families even when quite ill. Explaining how this affected access to health care, one participant said, "After my daughter died her two children came to me. It is my responsibility to take care of them. I cannot go to hospital and leave them alone." Another participant said, "I find it difficult to have time for myself. I don't want to wait for four hours in the hospital and be absent from housework."

Exclusionary Economic Practices

Work is at home, not in the wage economy. Although this is beginning to change, women in Bangladesh traditionally did not have direct access to means of production such as land. They had access to land only through their male guardians, their male children, or their spouses, and did not work outside the home. All participants in the study followed this traditional pattern and hence earned little or no income. Because they had no income of their own, the threshold for defining a need for health care tended to be high for them. They identified this economic barrier to health care access with comments such as, "Since men are involved in income-earning activities, they should have priority in getting treatment." Several participants made observations such as the following: "If we had a job, we could earn money and spend it on our health." This shows that they understood that it was not only family poverty that created a barrier to health care for women, but their exclusion from having sources of income over which they had control.

Being poor. Family poverty and lack of savings because of the cost of day-to-day living were common reasons given for not seeking health care. The influence of poverty on health-seeking behaviors was explained by several participants, who described how they prioritized the health needs of other household members over their own. A family situation of debt and limited resources led many women to remain silent about their condition. As one participant explained, "Money is the biggest problem for us. I try not to think about it, but it seems to always be there, over my head."

The cost of medications was often mentioned as a barrier to getting help. Even if free care was available at the health center, medicines were not always free. Participants reported that it was common for medicine to be out of stock at the health center, so it became necessary to pay for it at the drug store. As one participant observed, "In hospital you might get a prescription if doctors are available, but where will you get medicine? The difficult thing is, although you have a prescription, there is no money to buy it. This is expensive." Another participant explained, "The only thing you might get from hospital is a prescription or at best two tablets. They will tell you to buy the medicine. I don't have money." Another explained that money might be available for medications initially, but if the need for them continued, the family could not afford it:

> I have been suffering from an eye problem for five years and taking medicines, but recently I stopped. I am now tired of taking medicine, it never works. So I would really like to go to another doctor but due to my husband's financial condition, I cannot.

Exclusionary Religious Beliefs

Restricted mobility. Purdah is an important religious practice that restricts the mobility of women members of Bangladeshi society. A strong tradition of purdah acts to seclude women within their homes. It is unacceptable for women to go to a health center without an escort, for example. One participant explained, "If I go to hospital by myself, it might destroy the *shomman* [image] of the family in the community." In a more extreme interpretation of purdah, another participant said, "You cannot go outside of the house since this is not allowed by *Shariah* [Islamic law]. At this age I should not disobey the *Bidhan* [code] of Islam."

Restrictions on contact with men outside the family. In rural Bangladesh, ideologies of purity and shame remain so important to the status of women that Muslim female patients cannot speak directly to male doctors. Instead, husbands or sons explain the women's health concerns to the doctor on their behalf (Rozario, 1995). Illustrating this point, one participant said, "A man seeing a woman's body not only leads to sins of the wife but also of the husband and the family. Totally against our religion, you see, and that is why we do prefer a lady doctor." Another said,

> I feel *lojja* [shame] to talk to a male doctor about *mayali* [female] problems. Male doctors do not understand some *mayali ashukh* [female diseases]. You can talk about *mathabetha* [headache] to a male doctor, but how can you show your *book* [breast] to a male doctor?

Many participants said they preferred women health care providers because of greater comfort talking to them compared to men physicians. One participant said she preferred a woman provider because "she is my kind," and because it would be easier to share problems with a woman. Three others said that they believed that a woman doctor had a better understanding of their problems: "If I tell a male doctor that I have a *mashiker gondogole* [menstrual problem], he does not know what it is to have a menstrual problem. He will not understand me directly." This applied particularly to "women's problems," probably because they thought that a doctor who had shared or would share the experiences of menstruation, pregnancy,

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Findings

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

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

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

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

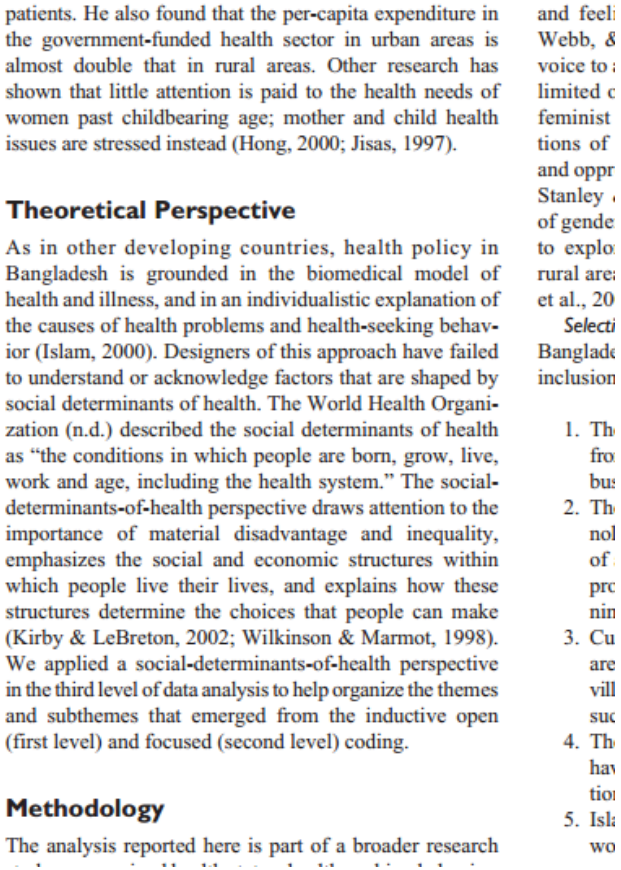
May use a theory to interpret findings

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

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

Acknowledgement Ruth Garside QIMG – sharing slides

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



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

Theoretical Perspective

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

Methodology

The analysis reported here is part of a broader research

Found between the Introduction and the Methodology sections

Found in the Discussion section:

age routine preventive health practices and attention to symptoms in their early stages.

Our findings suggest that the constitutional guarantee that the state will adopt effective measures to reduce disparities in access to health care between rich and poor, men and women, rural and urban residents, and younger and older citizens has not yet been realized for the older women in this study. Bangladesh has had a series of policies in place since 1995 that promote the goals of poverty reduction and greater gender equity (Pal, 2001). The National Action Plan for Advancement of Women (BMOHFW, 2005b) sets out strategies to achieve the commitments Bangladesh has made to the Beijing Platform for Action

Stop, think and reflect

- What have you learned thus far?
- Which methodological approach (aggregative or interpretive/configurative would you select for your review and why?
- Talk to your partner.