

COMMENTARY

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Fair publication of qualitative research in health systems: a call by health policy and systems researchers

Social science approaches for research and engagement in health policy & systems (SHaPeS) thematic working group of Health Systems Global, Regional Network for Equity in Health in East and Southern Africa (EQUINET), and Emerging Voices for Global Health, Karen Daniels^{1,2*}, Rene Loewenson^{3*}, Asha George^{4,5}, Natasha Howard⁶, Gergana Koleva⁷, Simon Lewin^{8,1}, Bruno Marchal⁹, Devaki Nambiar¹⁰, Ligia Paina⁵, Emma Sacks^{11,12}, Kabir Sheikh¹³, Moses Tetui^{14,15}, Sally Theobald^{16,17}, Stephanie M. Topp¹⁸ and Anthony B. Zwi¹⁹

An open letter from Trisha Greenhalgh et al. [1] to the editors of the *British Medical Journal* (BMJ) triggered wide debate by health policy and systems researchers (HPSRs) globally on the inadequate recognition of the value of qualitative research and the resulting deficit in publishing papers reporting on qualitative research [2]. One key dimension of equity in health is that researchers are able to disseminate their findings and that they are taken into account in a fair and just manner, so that they can inform health policy and programmes. The Greenhalgh et al. letter and editorial responses [3, 4] were actively discussed within “SHAPES”, a thematic group within Health Systems Global, focused on Social Science approaches for research and engagement in health policy & systems (<http://healthsystemsglobal.org/twg-group/6/Social-science-approaches-for-research-and-engagement-in-health-policy-amp-systems/>) and within EQUINET, a regional network working on health equity research in East and Southern Africa (www.equinet africa.org). Our discussion precipitated in this follow up open letter/commentary, which has 170 co-signatories. Collectively, we feel that barriers to publication of qualitative research limit publication of many exemplary studies, and their contribution to understanding important dimensions of health care, services, policies and systems.

While we work on different aspects of health systems, we *all* feel that more serious recognition of the value of qualitative research is required, including to disseminate evidence

and contribute voice to advance equity in health. In the spirit of collective engagement for research excellence that makes a difference to the communities and systems with which we work, we add our voices to this debate. We are particularly disenchanted by our general experience of the limited and often inadequate publication of qualitative research in the major health and medical journals, and the resultant loss of important insights for those working in, or concerned with, health services and systems, including around clinical decision-making.

The editors of one major medical journal have, for example, asserted a desire to publish “*studies with more definitive—not exploratory—research questions that are relevant to an international audience and that are most likely to change clinical practice and help doctors make better decisions*” [4]. Even for medical journals, this reinforces a somewhat narrow view of health care, and of the forms of evidence relevant to clinical decision making [5]. Restricting publication to quantitative research risks marginalising important bodies of knowledge such as those concerned with the social nature of health and illness or the way in which service providers incorporate (or neglect) such knowledge. Given the complex nature of health, policy, services and systems, we would argue that more inclusive and wide ranging insights and perspectives – rather than fragmented ones – are required, and methodologies should not be limited to quantitative approaches [6, 7]. Doctors do not (and should not) make decisions about patients in a vacuum, but operate within the broader social, political and systemic contexts of health care. Appreciating the nature of such influences can assist in making better informed and more appropriate decisions, especially given that such influences are rarely only ‘technical’.

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Given the varied influences on clinical practice, Health Systems Global has observed that such decisions must take account of relationships and complexity in health systems, and cannot be addressed through simple causality models [8]. Qualitative social science approaches have a key role in uncovering these broader relationships and complexities, and can crucially inform decision making by providing them with necessary insights and engaging them in these dynamics. A greater appreciation of the value of qualitative approaches in the study of health care systems and policy can only improve decision-making in our age of high political consciousness and rapid information availability.

Working with the World Health Organization (WHO) in developing guidance and policies for maternal health, for instance, HSG members have found a demand from policy makers, planners, and implementers for qualitative research to inform decisions on health systems and clinical recommendations and to identify implementation considerations. Important evidence has been derived from both systematic reviews of qualitative studies and mixed-methods reviews, for example on the mistreatment of women in health facilities during childbirth [9] and concerning barriers and facilitators to task-shifting in midwifery services [10] and for lay health workers [11]. These reviews have been used in guideline development and have also stimulated wider public interest and debate, as in the case of the Bohren review, which was documented in the *New York Times* [12]. The WHO Handbook for Guideline Development recognises the importance of such evidence and includes a chapter on using qualitative research in developing guidelines [13]. The WHO and a number of other agencies have also supported the development of a new approach to assess how much confidence to place in evidence from systematic reviews of qualitative studies [14], to facilitate using such evidence to inform health care decisions. This experience highlights the crucial roles that qualitative evidence syntheses can play in gathering qualitative evidence addressing a health question, developing new insights and theory from this evidence to inform policy and practice (including clinical practice), and identifying research gaps. The major health and medical journals should encourage the submission of such syntheses in the same way that many encourage submission of systematic reviews of the effectiveness of health interventions and of diagnostic tests.

Decisions concerning health systems and medical practice globally are taken by a range of professionals, not only or even primarily, by doctors. Multidisciplinary teams play a key role in promoting more holistic equitable models of care, and other providers are crucial in those many parts of the world where there are no or not enough doctors. Here, many decisions need to be taken by wider health care teams and clients equally involved in health promotion and care plans. ‘Biopsychosocial’ models [of care] correctly identify disorders as outcomes of interactions between biological,

psychological and social determinants. Qualitative research demonstrates the subjectivity of health workers in the therapeutic alliance, relationships and communication between health workers and clients [15–17], and the role of social literacy and of people’s values, preferences, and lifestyles in medical decision-making process when assessing the merits of various treatment alternatives for specific health problems [18]. The expanding literature on ‘person centred care’ recognises these issues.

Qualitative research facilitates examination of quality of interaction [19] and identifies the patient as an individual (and member of a family and community) experiencing care rather than being the subject of a disease process [17]. Mixed methods help identify and explain the factors that influence outcomes, and important dimensions of care, such as trust and social support, not all of which can be ‘measured’ by numbers alone [17]. Qualitative research also facilitates better understanding of the political and social determinants of care [20] including gender, social literacy, values, preferences [18, 21, 22]. One area where understanding these complex dynamics is pertinent, is with the deploying of lay/community health workers [23], especially since they work so close to communities [18, 24]. Despite important randomised controlled trials on the effectiveness of lay/community health workers, and a systematic review of these trials [25], the review authors argue that qualitative research is still needed to explain the complexities of the review findings [26]. This is echoed by one of our signatories:

“I do love working on numbers ..., but I can only understand my findings and know how to model my data if I do have a clearer picture of the context and only after understanding the qualitative work. The latter facilitates my understanding beyond what the numbers show”. (Erlyn Rachelle Macarayan, *an Emerging Voice for Global Health* [<http://www.ev4gh.net/>] Philippines).

Participatory action research (PAR) is one form of qualitative research that has provided voice in research for marginalised groups and produced new evidence on risk-health patterning that has contributed to declines in work related ill-health and injuries [27–29]. This approach has also contributed evidence on environmental determinants of health; barriers and enablers in managing ill health; and on learning about the roles and social relationships contributing to effective prevention and care [30].

In health service decision making, anthropological and qualitative studies have elucidated citizen responses to insurance, including why people enrol or drop out, and how families use health insurance [31, 32]. In relation to the Ebola crisis, this kind of research is particularly important to overcome implementation and coverage deficits, and to address the gap between policy intention and policy in

practice [33, 34], to illuminate issues around trust and health service utilisation, and may contribute to building future health systems resilience [35].

The methodological diversity in qualitative research not only generates new evidence and knowledge for health systems policy, planning and practice, but also incorporates approaches to engage and participate with communities (and users of services) to utilise evidence and solutions to create change [30]. PAR and implementation research [30] embrace change through the co-creation of research with a range of stakeholders. For example, Othieno and colleagues [36] worked with women from low income communities in designing and implementing community mental health services [36]. Other examples of change and learning from change embedded within research, have been documented [30]. The methods systematize local experience and synthesize collective analysis on relationships and causes of problems.

The reflexive process is directly linked to new knowledge and action, influenced by understanding of history, culture, and local context and embedded in social relationships. In narrowly defining what research and thus what knowledge counts as important, the opportunity to learn from this richness is lost. Furthermore, this effectively silences the voices of community members, particularly those who are marginalised across all countries [37–40].

Such research belongs in mainstream publication on health and should not simply be assigned to ‘special interest journals’. Doing so risks devaluing work relevant to health services, weakens understanding of the interface between qualitative and quantitative research and undermines the breadth and quality of analysis. Furthermore, the perception that such work will not be considered, even before peer review, has already resulted in some of our members sending manuscripts to special interest journals, and consequently having it hidden from a more general audience who might have benefitted from its insights.

The inadequate publication space for qualitative studies is a generalised problem that undermines our understanding of and response to health system challenges. Addressing it calls for specific strategies, such as establishing panels of suitable reviewers and enhancing the quality of guidelines for researchers and authors.

We have cited numerous examples of the contribution of qualitative research to health service decision-making. It is problematic to reinforce the dichotomy between qualitative and quantitative research. Qualitative studies provide evidence that informs health services decision making, deepens interpretation and understanding, and assists all to better deal with the complexity inherent in health problems and the search for their solutions. Qualitative insights

will also assist in closing the policy-implementation gap. We look forward to further debate and publication, including in this journal, on approaches to overcoming barriers to publication of qualitative research on health policy and systems, for researchers and journals, to ensure that crucial domains of research and knowledge are not excluded from health systems policy and practice.

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Authors' contributions

This open letter has been conceptualised and drafted collectively by the signatories and co-signatories. It was prepared with input and review from many in SHaPeS and EQUINET. Karen Daniels and Rene Loewenson led the first drafts, with further extensive writing support from Anthony Zwi, Steph Topp, Asha George, Bruno Marchal, Kabir Sheikh, Sally Theobald, Natasha Howard, Moses Tetui, Emma Sacks, Ligia Paina, Simon Lewin, Devaki Nambiar and Gergana Koleva (in no particular order). The open letter has been read and approved by all co-signatories.

Competing interests

This letter has been written collectively and voluntarily, without funding support. We have read and understood the BioMed Central's guidance on competing interests and declare no competing interests.

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