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31.1 Introduction

In the development and analysis of health policy, we continue to require in-depth, detailed descriptions of what happens in the policy environment, within implementing agencies, and to different policy actors. It is increasingly recognized that human, social, cultural, and political factors significantly influence the transferability of a policy or program from one context to the next. Further, what we often lack is an understanding of the interplay between these factors. Decision-makers can use qualitative research evidence to respond to these gaps in knowledge and gain a deep conceptual understanding of the factors that influence the identification, selection, implementation, and evaluation of health policies. In this chapter, the contribution of qualitative research evidence to the health policy process is discussed. First, the health policy work cycle is defined. Next the types of evidence that policy makers consider in developing and evaluating health policies are identified, and there is a discussion of the role of research evidence in the full health policy work cycle. Next, strategies and designs to consider

when planning policy relevant qualitative research studies are suggested. Finally, the chapter concludes with a brief discussion of the different ways that qualitative evidence can be utilized in decision making. The information in this chapter is intended for the qualitative health researcher new to health policy work, or the novice qualitative researcher, who is committed to finding opportunities to inform policy decisions through the introduction of qualitative evidence or to actively participate in health policy and systems research (HPSR).

When qualitative findings are reviewed in conjunction with other evidence types, a more nuanced understanding of the implications of a health policy on different stakeholders is realized. Basing decisions solely on the best available quantitative evidence would limit our understanding and identification of important conditions and influences that may ultimately define the success, or failure, of a health policy. In Canada, the allocation of federal funds to provinces and territories to deliver human papilloma virus (HPV) immunization programs provides a rich case study to examine not only the complexity of the policy process, but also insight into the contribution that qualitative research evidence can have. The estimated prevalence of HPV among Canadian women is 16.8 % with the highest rates reported in sexually active females under the age of 20 years (Moore et al. 2009). HPV-associated cancers occur in both males and

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females, with demonstrated causation between HPV type 16 and genital, oral cavity, and oropharynx cancers (Public Health Agency of Canada (PHAC) 2012). There is strong empirical evidence that HPV vaccines are efficacious in preventing certain HPV infections, including genital warts and cervical cancer (PHAC). Therefore, PHAC recommends the administration of HPV vaccine to all females and males between the ages of 9 and 26 years old, with priority given to vaccinating children age 9–13 years. It is assumed that vaccinating girls at this age will provide coverage before the commencement of sexual activity. However, as part of routine immunization schedules in Canada, all provinces and territories publically fund HPV vaccine for adolescent females only (PHAC).

If the public health policy process was simple and based solely on empirical quantitative data, decision-makers would determine that the research evidence suggests that HPV vaccines are efficacious, that few adverse events are reported post-vaccination and that implementing a public health policy to vaccinate all young adults would result in improved health outcomes for both men and women. However, the process of selecting and implementing a policy is complex and the prevailing quantitative evidence must be balanced with other sources and types of evidence. Decision-makers within the health policy arena are influenced by: the availability of resources; competing political agendas; the fit with existing health policies and service delivery systems; and the values, beliefs positions held by, and associated evidence referred to, a range of policy actors, including the government, health care providers, civil society, researchers and the private sector. In response to funding of HPV vaccination programs, federal and provincial government agencies, health care providers, and vaccine manufacturers were in strong support of this policy whereas some members of the scientific community and specific civil society organizations were opposed (Torgerson and MacAdam 2007). However, it is by reading the qualitative research conducted to explore different stakeholder perceptions about the vaccine that we develop a clearer understanding of what under-

lies some of this opposition, as well as an opportunity to identify those barriers or cues to action that may significantly influence parents' decisions to vaccinate their daughters. What emerges is a general low level of awareness about HPV, and its link to certain cancers; disagreement about the optimal age to vaccinate; recommendations to vaccinate boys as well as girls (Olshen et al. 2005); and fears that HPV vaccination may promote overconfidence in its protection and lead to either early sexual engagement or unsafe sexual health behaviors (Brewer and Fazekas 2007; Friedman and Shepard 2007). Additionally, despite the evidence of effectiveness, findings from a meta-ethnography of four qualitative studies illuminate that policy makers also experience uncertainty about: (1) the acceptability of the vaccine by the public; (2) the intentions and motives of the manufacturer of the vaccine, (3) the characteristics of the vaccine including length of immunity and long-term safety; and (4) the ability of the public health sector to support vaccine delivery systems (Hafid 2012). Insight into these important contextual issues, identified through the use of qualitative methods, provides decision-makers with valuable information that can ultimately inform the selection, implementation, and evaluation of a novel program, intervention, or policy.

A systematic and comprehensive search strategy was used to locate the most current literature related to the role of qualitative evidence and evidence-informed policy making and adapted for each different database or resource searched. Search terms were identified based on the chapter objectives and included the following MeSH terms: Qualitative Research, Evidence-Based Health Care, Evidence-Based Practice, Health Policy, Policy Making; key terms included *evidence-informed*, *policymaking models* and *research utilization*. The databases searched (from 2000 to October 2013) included MEDLINE, CINAHL, and the Web of Science. Given the prevalence of policy relevant documents published in the gray literature, a search was conducted also using general internet search engines (e.g., Google, Google Scholar) and websites of relevant Canadian organizations engaged

in supporting decision makers and researchers in developing and evaluating evidence-informed health policy (e.g., National Collaborating Centre for Methods and Tools, National Collaborating Centre for Healthy Public Policy).

31.2 Health Policy Analysis and Research

In the field of applied health research, researchers are increasingly motivated to conduct studies not only for the purpose of knowledge creation but to produce results that will inform practice or policy and lead to improved individual and population health outcomes. Health outcomes can be influenced by the implementation of evidence-informed interventions, programs, or health policies. These terms and other policy-related concepts are defined in Table 31.1. To achieve this goal, close collaboration and partnership is required among three sets of actors who traditionally have worked independently within their own unique cultural domains: (1) health policy analysts, often civil servants or administrators responsible for policy; (2) practitioners; and (3) researchers. The inherent challenge though is that

Table 31.1 Definitions of key terms

Term	Definition
Health care intervention	A type of treatment, preventive care, or diagnostic test, usually delivered to an individual with the goal of improving health or resolving a specific health problem. Examples could include medications, hospital or surgical treatment, diagnostic screening, or rehabilitation services (Agency for Healthcare Research and Quality 2013)
Public health intervention	Interventions focused on the prevention and management of diseases, injuries, physical and mental health conditions, through health surveillance and health promotion initiatives with the goal of improving the health of populations
Program	A group of activities implemented for the purpose of achieving policy objectives (WHO 2013)

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Table 31.1 (continued)

Term	Definition
Health policy	Decisions, plans, and actions undertaken to achieve specific health care delivery and health services goals within a society. Health policy goals may include defining a vision, establishing short-and long-term objectives, identifying priorities, describing the roles and functions of different actors, and informing individuals and populations of the planned process and outcomes (WHO 2013)
Public health policy	Health policy specifically focused on public health issues. Public health policy includes laws, regulations, guidelines, administrative practices, and funding decisions—developed and implemented by federal, provincial/state, or local levels of government or affiliated agencies and affecting outcomes and activities across multiple settings and sectors (Brownsong et al. 2009). Examples may include mandatory seatbelt legislation, tobacco control measures, and vaccination programs
Health policy and systems research (HPSR)	Empirical research conducted to describe and understand health system policies, organizations, stakeholders, and programs. Interactions between these elements are also studied, as well as identification and exploration of contextual and system issues that influence decision-making. HPSR also addresses questions of how policy agendas can be influenced to promote policy options that promote health and lead to health system improvements. Included in this field of research are also evaluations of policy content, process, and outcomes (Gilson 2012)
Health policy analysis	A retrospective or prospective analysis to describe and explain the interactions between stakeholders, organizations, government, interests and ideas in the policy process (Walt et al. 2008)

these actors each have complementary, but different, work cycles and distinct definitions of evidence (Jansen et al. 2010). Therefore, it is essential for researchers motivated to engage with decision-makers to have a working understanding of the health policy cycle so that they can determine opportunities to collaborate as well as strategies to promote the uptake and utilization of their research evidence.

The health policy work cycle can be separated into four phases: (1) problem identification, (2) policy formulation and decision-making, (3) policy implementation, and (4) policy evaluation. Core activities associated with each stage are identified in Table 31.2. The role of health policy analysts, prior to the selection of a health policy, can vary from providing senior decision makers with balanced and unbiased information,

Table 31.2 Overview of the health policy work cycle

Health policy work cycle phases	Characteristics	Qualitative HSPR research questions
Problem identification	<ul style="list-style-type: none"> • Identify an important health, social or public health problem • Political agenda setting or bringing the problem to the attention of key decision makers 	<ul style="list-style-type: none"> • What is the nature of the problem? • What happened previously in response to the problem? What were the perceived consequences? • How can popular and political support be established (or maintained) until the policy impacts are observable? • How do different stakeholders perceive the problem? Do stakeholders perceive the health issue targeted by the policy as one requiring intervention?
Policy formulation and decision making	<ul style="list-style-type: none"> • Conduct an assignment analysis by identifying the actors and sectors who need to be involved in the decision making process • Clarify goals and objectives • Identify, evaluate, and propose solutions and policy options • Conduct cost–benefit analysis and determine resource/budget availability • Engage in political decision-making process to negotiate and accommodate various interests • Select most appropriate policy option to adopt • Develop implementation plans 	<ul style="list-style-type: none"> • What are the goals of the policy makers? Policy implementers? • Who needs to be involved in the decision-making process? • Which actors will be affected by the health policy being considered? • How will the different policy options create, reinforce, or adjust social inequalities in health? • What are stakeholders’ perceptions and recommendations on how the problem should be addressed? • What are stakeholders’ perceptions of the proposed policy solution? • Is it acceptable to implement a policy to address the targeted health problem? • How acceptable is the proposed health policy in comparison to other proposed policies? • What are stakeholders’ perceptions about the feasibility, effectiveness, cost, and equitableness of implementing the proposed policy? • How acceptable is the degree of coercion associated with the health policy?

(continued)

Table 31.2 (continued)

Health policy work cycle phases	Characteristics	Qualitative HSPR research questions
Policy implementation	<ul style="list-style-type: none"> • Initiate process of putting policy solution into action • Monitor what, where, when, how, and by whom policy activities are implemented • Allocate and coordinate tasks 	<ul style="list-style-type: none"> • What happens when the policy is implemented and why? • How is the organization or agency implementing the policy? • How is the organization or agency able to promote the uptake and sustain the policy? • What factors (individual, social, organizational, environmental, cultural, political) are influencing the policy implementation process?
Policy Evaluation	<ul style="list-style-type: none"> • Monitor and evaluate the results of the policy • Determine outcomes and effects of policy • Conduct performance and financial audits • Provide recommendations for policy modification 	<ul style="list-style-type: none"> • What policy objectives were met? Unmet? • What were the unexpected outcomes or effects? • Was the policy implemented effectively? • How did the implementation context influence the effectiveness of the policy?

(Gilson 2012; Howlett and Ramesh 1995; Jansen et al. 2010; Rist 1998)

to advocating for a specific policy, to engaging in a process to compare the attributes and merits of competing policy options (Morestin 2012). Once a decision has been made and a health policy implemented, analysts have a role in evaluating the policy process and outcomes. In parallel to this process, researchers have the potential to engage with policy makers in two distinct ways: (1) to conduct, position and disseminate research evidence that is accessible, valuable, and relevant to inform the problem identification and policy development stages; or (2) to engage in health policy and systems research (HPSR) in collaboration with policy partners. As a health research field, HPSR has been developed to describe health policies and systems and to answer questions related to how they are implemented, how they work, and how can they be improved (Gilson 2012). More simply put, researchers can create the knowledge that informs the health policy analysis process or they can be involved in conducting health policy process and outcome evaluations.

In addition to substantial differences between the research, practice, and policy work cycles (Jansen et al. 2010), the actors within each of

these domains hold different perceptions of what constitutes the evidence upon which decisions should be based.

31.3 Nature of Evidence in Health Policy Decision-Making

Since the introduction of the term evidence-based medicine into the cultural lexicon, this concept has been adapted and adopted by multiple clinical practice fields including nursing, social work, and rehabilitation sciences. As part of this natural expansion, interest and efforts have also focused on the development of evidence-based, or more appropriately, evidence-informed health policy-making. Within the health policy arena Segone (2008) suggests that, to improve trust in the policy development process, actors' decisions should be evidence-based and informed by high-quality, valid, and credible research evidence. This stands in stark contrast, he argues, to opinion-based policy where a decision is heavily influenced by the political ideology or values and beliefs of one group; and where, if research evidence is used, it is used politically to support a predetermined

decision. The current reality however in developed nations, given the number and range of evidence types that policy makers must take into consideration, is a paradigm of evidence-informed policy where the political aspects of decision-making are acknowledged alongside an increasing use of research evidence within the policy process. There is overt consensus, however, that evidence-informed policy making is inherently a more complex process, and perhaps a less obtainable goal, compared to achieving evidence-based practice in clinical contexts at the level of the individual practitioner working with individuals, families or community groups (Black 2001; Lomas and Brown 2009; Oxman et al. 2009). Part of the complexity of this process is a result of how policy analysts define evidence and the diverse range of information sources that compete to inform health policy decisions.

Historically, researchers have narrowly defined evidence to be constituted from facts, results or findings represented as context-free research evidence (e.g., derived from quantitative studies) or context-sensitive research (e.g., derived from qualitative studies) that emanate from the conduct of systematic, explicit and rigorous scientific processes (Lomas et al. 2005). Within the paradigm of “evidence-based” practice, practitioners’ interventions are informed by health research evidence but their decisions and actions are also influenced by the feasibility, acceptability, applicability, and cost of the interventions (Jansen et al. 2010). In comparison, policy decision makers have a broader definition of evidence. Lomas and Brown (2009) conclude that, where researchers equate the term “evidence” with the term “research” in health policy contexts, evidence is “synonymous with *data*, *analysis*, or *investigation*” (p. 914). So for this group of decision makers, sources of evidence may include findings and conclusions from empirical studies or “research” alongside colloquial evidence such as gray literature, opinion polls, stakeholder experiences and interests, raw data (Lomas and Brown 2009), best practices- or policies and programs from other jurisdictions determined to be beneficial (Lomas and Brown 2009; Orton et al. 2011), or personal or profes-

sional experiences (Black 2001; Brownson et al. 2009; Morestin 2012).

Several models have been developed that define evidence-informed policymaking and delineate the multiple types of evidence that inform population health or health policy decisions. The National Collaborating Centre for Methods and Tools (NCCMT) (2009) model for evidence-informed decision-making in public health broadly identifies that research evidence, surveillance data, information about community and political preferences and actions, combined with information about available government, organization, and program resources are filtered through decision-makers who use this public health knowledge to provide expert recommendations for policy or program decisions. Oxman and colleagues (2009) further refine our understanding of the role of research evidence in the policy development process. First, they make an important distinction between global and local research evidence. Global evidence consists of research findings from a range of contexts that presents information on effectiveness or impacts of policies, programs, or interventions; this evidence may be constructed through rigorous single studies or systematic syntheses of data in such forms as systematic reviews or meta-syntheses. In comparison, local evidence focuses on the collection of data within the context or jurisdiction where policy decisions must be made and includes data about the scope of the problem, contextual factors, stakeholder needs, values or beliefs, costs, and other resources. Secondly, their model distinguishes between sources of evidence and contextual influences or modifiable factors that have a strong influence on the identification, selection or rejection of a health policy. These factors include such phenomena as: organizational constraints; stakeholder or societal values; economic factors or the availability of resources; and the readiness of the social environment to change. Other contextual factors may also include: political ideology or agendas; the influence of prior policies; and established historical precedence (Lomas and Brown 2009). Finally, this model expands on the role of expert opinion in decision-making, with the authors emphasizing that all evidence must be

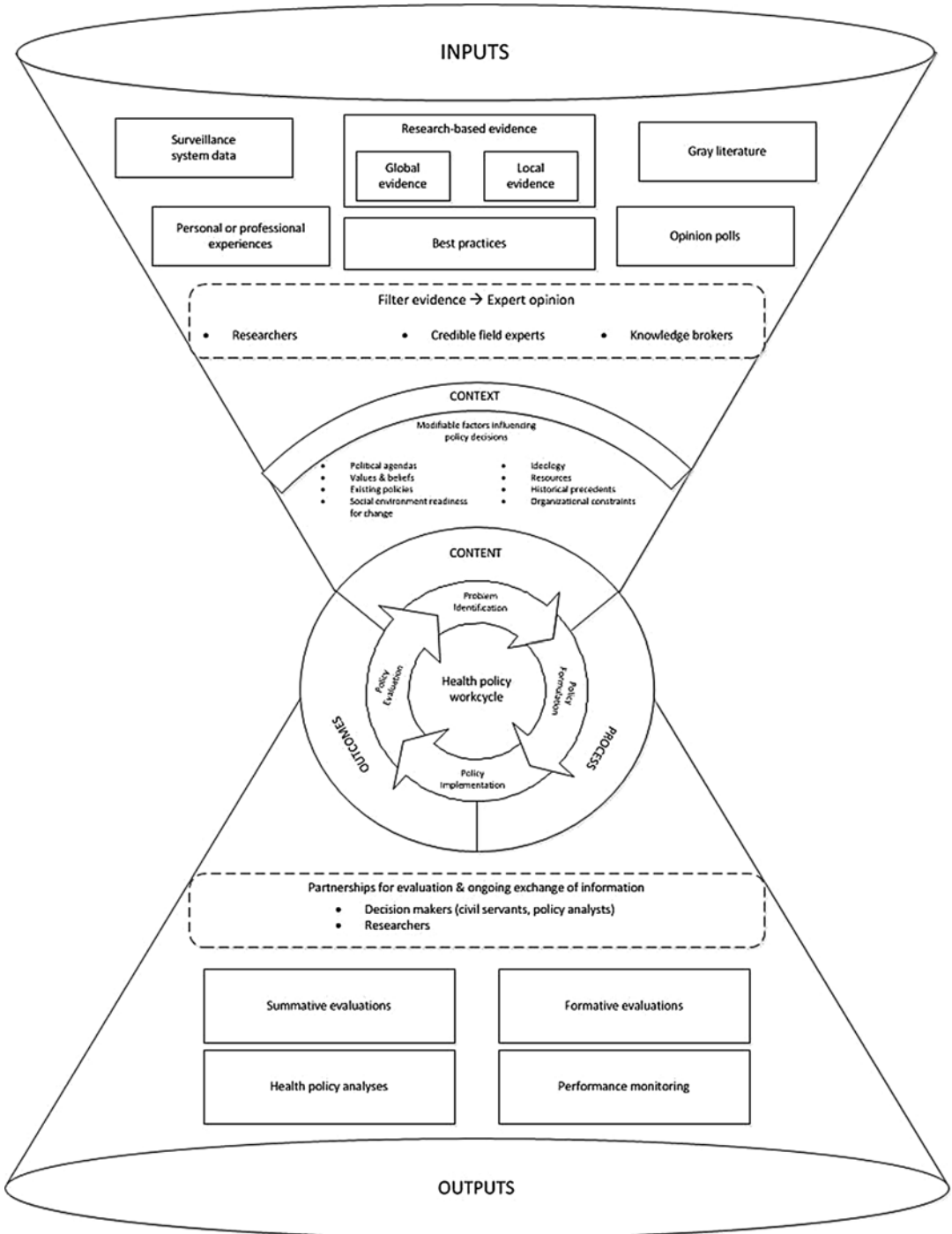


Fig. 31.1 Model of evidence-informed policymaking

accessed, appraised, synthesized and filtered by experts; and that they make explicit judgments about potential health policy options by examining the evidence and weighing the proposed benefits, harms or costs. The positioning of expert opinion as a filter, rather than solely another single source of information competing with other types of evidence to inform decisions, reaffirms the necessity of promoting opportunities for engagement and interaction between health policy decision makers or civil servants and experts in the field, including researchers (Lomas and Brown 2009). The emergence of expert opinion as having an essential role in shaping health policy was a significant finding in a systematic review of 18 studies examining the use of research evidence by public health decision makers within the context of universal health care systems (Orton et al. 2011).

Brownson et al. (2009) continue to add to the consensus that within the policy domain research evidence, both quantitative and qualitative, is only a single source of information, one that is considered within the context of other social, political, economic, and ideologic factors. In their framework however, they identify that research evidence informs three distinct domains of evidence-based policy and that there are specific types of research data most appropriate for informing each of these three domains. The first domain, *content*, involves identifying—from research data sources such as systematic reviews—the approaches and policy elements that are likely to lead to changes in health outcomes. The second domain is *process*, which involves locating evidence through local surveys or qualitative case studies on the best approaches to promote policy adoption and also collecting data to document the procedures involved in policy implementation. The final domain revolves around accessing surveillance system data or conducting policy evaluations to describe, measure, and interpret policy *outcomes*. The recognition of this third domain expands our discussion of the role of evidence within the health policy work cycle, moving from an exclusive focus on only how evidence informs problem identification and policy formulation, to a recognition that, within

this cycle, research evidence can be a vital output from the process. What is helpful about the identification of these domains is that they can be directly mapped onto the phases of the health policy work cycle. This allows researchers and decision makers or policy analysts to distinguish what types of research evidence are most suitable for different policy activities. In a qualitative study conducted with 18 civil servants from the Ontario Ministry of Health and Long-Term Care, Lomas and Brown (2009) further add to our conceptual understanding of how evidence is used in each stage of the healthy policy work cycle and how policymakers engage with research evidence in those different phases. Specifically, in the stage of problem identification or “agenda setting,” researcher evidence is predominantly directed or “pushed” to decision makers by groups or individuals trying to influence the agenda; when decision makers however are actively engaged in policy formulation, the nature of the relationship and demand for information changes, with civil servants engaged in seeking and “pulling” evidence to inform, support, or validate their decisions. While many of the evolving models of evidence-informed policymaking focus on the inputs into the health policy work cycle, Lomas and Brown highlight the importance of research evidence—and the relationship between civil servants and researchers—in the policy evaluation phase, where research evidence becomes an output of the policy work cycle.

Using core elements from each of these models or conceptualizations, I have developed a more comprehensive framework (see Fig. 31.1) that specifically links evidence inputs and outputs to the different phases of the health policy work cycle and identifies opportunities for decision makers and researcher engagement and partnerships. The inputs include different information or data sources, including research-based evidence that is filtered through experts, who act as opinion leaders or trusted filters of what information or evidence is relevant to the process. Decision makers, generally civil servants, then balance this information with modifiable factors within the social, political, economic, organizational contexts in which decisions are made and policies are

implemented. Once policies are implemented, there is a need to monitor the new or adapted programs and conduct formative and summative evaluations. This creates a second point of intersection for decision makers and researchers to work collaboratively on research outputs in the policy implementation and evaluation stages.

Challenges remain however on how to continually increase the influence that research-based evidence has overall on policymaking. Promoting the utilization of research evidence in the policy process is neither rational nor straightforward; thus researchers must be prepared to engage, collaborate and communicate with decision makers, in often-protracted processes, to see research evidence ultimately influence end-decisions. The attitudinal, knowledge and behavioral barriers that exist at both individual and organizational levels to accessing, appraising, adopting, and using research evidence in decision-making are well documented (e.g., Innvaer et al. 2002; Wallace et al. 2012). Furthermore, the technical language, complexity of interpreting results, variation in study quality, and the structure and length of research reports are commonly cited reasons limiting decision-makers' motivations or abilities to engage and utilize research evidence (Brownson et al. 2009; Dobbins et al. 2007). Numerous strategies and interventions however continue to be developed and tested to identify effective approaches for supporting the use of research evidence in policy making. However, what can be accomplished in this chapter is to outline for researchers the opportunities that exist for promoting qualitative evidence as an input into the health policy cycle and identifying how formative and summative evaluations of health policy can be enriched through the integration of qualitative methods.

31.3.1 Qualitative Research as Evidence in the Policy Work Cycle

Traditionally, research evidence has been categorized into three broad paradigms: quantitative, qualitative and mixed methods research. Within

the field of health policy and systems research field, the question is no longer about the supremacy of one paradigm over another, but more about how the findings from each can be uniquely utilized by decision-makers. One methodology is not superior over another per se; instead what is important to establish is that researchers have a responsibility to pick the most appropriate research design to answer the policy question that is being posed. However, qualitative methods can be used to produce inputs into the health policy work cycle, particularly as a part of these data sources: surveillance evidence, global evidence, local evidence and embedded within the gray literature. As an output, qualitative methods are extensively used in formative evaluations of policies, particularly as process evaluations, and embedded into summative evaluations.

In the problem identification and policy formulation stages, healthy policy analysts will draw extensively on surveillance system data, primarily constructed through the collection, analysis and dissemination of quantitative data, to describe the incidence, prevalence, risk indicators, and health outcomes associated with a particular issue. However, some comprehensive surveillance systems may also collect qualitative data in response to open-ended questions. In Canada, the Canadian Hospitals Injury Reporting and Prevention Program (CHIRPP) is a computerized information system that collects data on intentional and unintentional injuries on predominantly children and youth 19 years of age and younger seen at emergency rooms in ten pediatric and four general hospitals. Data are collected via questionnaire and close-ended questions are posed to answer the questions: (1) What was the injured person doing when the injury happened? (2) What went wrong? and (3) Where did the injury occur? However, there are also three narrative fields that allow the respondent to provide information about the specific circumstances of the injury. I am currently involved in a research project with epidemiologists from the Public Health Agency of Canada to analyze narrative data with respect to intentional injury (e.g., suicide attempt or completion) cases. Using qualitative content and thematic analytic strategies we

will be able to richly describe and answer questions about the context, social factors, and emotional state of youth prior to the injury. Combined with the quantitative data we anticipate this will provide a very in-depth and nuanced understanding of antecedent factors that contribute to youth suicide, with the long-term goal of developing programs or policies to prevent suicide.

Research-based evidence, both global and local, is most frequently employed to validate potential policy options or to inform policy formation. Typically, health policy analysts seeking policy solutions will seek data from typical global evidence sources such as systematic reviews, meta-analyses, and randomized controlled trials, which will be examined to answer questions about efficacy, effectiveness, cost, and adverse effects. Increasingly, qualitative evidence is being systematically collected, appraised, and included in systematic reviews to inform policy decisions. However, if quantitative findings are used in isolation, particularly those drawn from trials and systematic reviews, then there may be limits related to their relevance and utility for decision-makers attempting to select and implement solutions for contexts different from those in which the studies were conducted. It has been argued that quantitative findings intended to be generalizable at a population level may not meet the specific needs of policy makers at the local community level (Bell and Seidel 2012). Thus qualitative evidence plays a primary role in the development of local research-based evidence. It provides a counter-balance to this limitation, and particularly when conducted as part of a mixed methods study, provides the tools to describe and understand local and community level factors and conditions that may ultimately influence the implementation and implications of a health policy.

Qualitative research provides the tools to richly document the nuances of a range of human experiences and provide insight about perceptions unique and different compared to our own understanding of or experiences in the world. Thus a well-written qualitative narrative can become a powerful tool of persuasion in the policy process. Donmoyer (2012) suggests that policy makers can be influenced in their decision

making by the emotional nature of a richly detailed narrative and concludes that “policy-makers may value statistical data and analysis in their discourse; in private, however, if you want to convince them of something, tell them a good story” (p. 805). Brownson et al. (2009) argue that qualitative findings may act as “emotional hooks” and thus can be successful when used to influence the interpretation of a health problem, policy deliberations, and agenda setting (p. 1577). So if health policy decision-makers are deliberating on the option of implementing a model of midwife-led care for childbearing women, the results of a systematic review of 11 trials will provide them with a strong foundation of quantitative evidence that for low-risk pregnant women, midwife-led care is not only safe but, compared to other models of care, may result in reductions in the use of regional analgesia (risk ratio [RR] 0.90), episiotomies (RR 0.82) and instrument deliveries (RR 0.86). Additional benefits of midwife-led care for women include an increased sense of control during labor (RR 1.74), increased likelihood of having a spontaneous vaginal birth (RR 1.04), and initiation of breastfeeding following delivery (RR 1.35) (Hatem et al. 2008). But what might “tip” a senior health decision-maker to advocate for this type of model of care is learning of women’s experiences of being cared for by a midwife presented as qualitative themes. One would learn that women highly value the amount and quality of time that their midwife spends with them both through the pregnancy and the labor and that midwives work in a consultative manner, not directive, and provide holistic care that involves the engagement of all family members. As a result women feel empowered and supported (Moon et al. 1999).

Qualitative findings are also generally presented as written narratives, and more recently within the field of arts-based research expressed in such formats as photographs, paintings, dramatic plays, or other artistic forms. For policy analysts and senior political decision-makers, many of who lack training in epidemiology and research and thus the skills to interpret complex statistical findings, qualitative research may have an intuitive appeal to it. Essentially, it is easier to understand and often they can make sense of, or

relate to, the stories being shared. Bell and Seidel (2012) conducted a mixed methods study that involved quantitative mapping of interview transcripts and a qualitative critical discourse analysis of interviews with 18 senior health policy decision-makers from nine countries to understand their perceptions of useful research evidence. There was consensus among their study participants that while quantitative evidence is valued, it is perceived as highly technical and thus perceived as less accessible for use in decision-making by those policy makers who lacked the knowledge and skill to interpret findings. In comparison, qualitative research was perceived to be less technical and easier for participants to interpret and use. It was noted however that a limitation of qualitative research evidence was that it was perceived to be a less credible form of evidence by clinicians and the practitioners who would ultimately be responsible for implementing the high-level health policies.

Think tanks, health agencies, nongovernmental organizations, or similar institutions who assume a mandate to advocate for the needs of a particular population may also readily engage in the conduct of qualitative research and publish their findings in the gray literature, or documents that are informally published or disseminated using communication channels outside of the traditional peer-reviewed journals or commercially published books. For example, one of the goals of The Change Foundation (2010) is to support the redesign of the Ontario health-care system, once that takes into consideration individual users' and their caregivers' perspectives, values and experiences. One of their strategies to advocate for change was to collect and share, using qualitative data collection techniques, the lived experiences of patients and their caregivers about their experiences in the health care system, as well as individuals' recommendations for improvements and changes to the system (The Change Foundation 2012). Their work is a very powerful example of how the views, experiences and values of a key stakeholder group can be systematically collected, synthesized and shared to inform the policy work cycle. Further, to develop their strategic plan, they also conducted an envi-

ronmental scan that included key informant interviews and discussion forums with senior health and social care decision-makers, an advisory group, and representatives from primary, community, acute and long-term care sectors (The Change Foundation 2010). The collection and sharing of this qualitative evidence is one way to promote community engagement in informing the policy process.

While the challenges for moving research-based evidence into the policy arena have been acknowledged by many, for those continuing to seek avenues to have research influence policy, the goal of seeking both quantitative and qualitative evidence to present should be valued. To determine which type of evidence is more persuasive in influencing changes and attitudes, Allen and Preiss (1997) conducted an innovative meta-analysis of 16 studies comparing the influence of narrative accounts (qualitative findings) to statistical evidence (quantitative findings). They concluded that messages using statistical evidence were more persuasive than those that used a narrative approach. Based on this preliminary work, a subsequent study was undertaken to measure if messages containing a combination of both statistical and narrative evidence are more persuasive compared to messages containing only a single source of evidence (Allen et al. 2000). From a sample of 1270 undergraduate university students, they concluded that messages containing both narrative and statistical evidence were more persuasive than messages with statistical evidence only, followed by messages with narrative evidence only. Messages that contained neither form of evidence were the least persuasive.

The evolving conclusion then is that quantitative evidence provides proof of the effectiveness of a policy and a way to measure outcomes, and qualitative evidence provides a way to understand, interpret, and explain the human experience and context. This provides us with a compelling argument to use both types of research evidence to inform decision-making and a need to be able to articulate under which circumstances and when qualitative or quantitative evidence is most appropriate. Thus, for the novice researcher, it is essential to not only know

how to develop and conduct qualitative studies, but also to be able to do so in a manner in which findings are of relevance to decision-makers.

Often neglected in discussions of evidence-informed policy making is the role of research in the policy implementation and evaluation components of the health policy work cycle. Lomas and Brown (2009) explain that civil servants engaged in health policy work desire collaborative, ongoing relationships with researchers for the purpose of evaluating policies and creating new evidence to inform the work cycle. Increasingly process evaluations, with a significant emphasis on using qualitative methods, are being designed and conducted to describe how a policy is being implemented and to contribute to the comprehensive evaluation of complex interventions or policies (Lewin 2009). Specifically, the conduct of a process evaluation can help to answer how and why a policy succeeds or fails within different contexts. The primary functions of a process evaluation are to: (1) describe the components of an intervention, program, or policy; (2) determine if it is being delivered with fidelity; (3) describe implementation processes, including variances across different contexts; (4) link policy outcomes with implementation processes and in the policy evaluation phase to; (5) explain unanticipated or varied outcomes between jurisdictions (Linnan and Steckler 2002). Process evaluations, while often qualitative in nature, may also be one component of a larger mixed methods study. For example, in British Columbia, researchers from the Children's Health Policy Centre, McMaster University, along with decision-makers from the BC Ministries of Health and Children and Family Development are leading an evaluation of the Nurse-Family Partnership home visitation program. The two components of this 5-year evaluation, called the British Columbia Healthy Connections Project, are (1) a randomized controlled trial to measure the effectiveness of the NFP, compared to usual services, to improve maternal and child health outcomes among young, socially disadvantaged Canadian mothers, and (2) a process evaluation. While we will be using a convergent parallel mixed methods research design to address the process evaluation

objectives, the emphasis will be on the collection of longitudinal qualitative data from key stakeholders, including the public health nurses, supervisors, and Ministry of Health coordinators responsible for implementing this program: a key element of the new child health policy in that province.

31.4 Conducting Qualitative Health Policy Research

To address the perception that qualitative research is a less credible form of evidence, the onus is upon researchers to ensure that they adhere to the methodological rules of the designs they select and ensure that a qualitative approach is the most appropriate one to answer the questions being posed.

31.4.1 Policy Research Questions

The success of a health policy research study will depend on how clearly the researcher is able to articulate and focus the overarching research question. In qualitative research, the question ultimately guides the selection of the research design, the scope of the purposeful sample and perhaps even informs the type of data collection strategies to be employed. Reviewing the strategies listed below can assist novice qualitative researchers in designing their health policy research questions.

1. *Understand and establish stakeholder priorities.*

To ensure that findings are relevant and usable by policy analysts and decision-makers, researchers should engage and partner with knowledge users early in the research process. This is essential for defining the research priorities and understanding the scope of the project. To ensure that data are relevant to policy-makers and will inform subsequent decisions, the knowledge users can also provide insight about the key policy actors who should be included in a study (Gilson 2012). In partnership, they establish

which part of the policy work cycle the project will be informing; is the overall purpose to establish the acceptability of different policy options, to document the process by which a policy is implemented or to explain the impact (intended and unintended effects) that a policy has had on a specific stakeholder group.

2. *Determine what is already known about the topic.*

Early qualitative methodologists, particularly within the realms of phenomenology and grounded theory, encouraged researchers to enter the field with all of their preexisting knowledge and assumptions set aside. This has created a holdover belief among some novice qualitative researchers that literature reviews should not be conducted prior to initiating a study. However, a literature review is essential, for the purposes of providing background information on the policy context, describing what is already known about a topic, limiting redundancy and then identifying specific gaps in knowledge (Gilson 2012). As qualitative research is grounded in context, researchers may identify that stakeholder perceptions of an issue may have been studied in contexts quite different from the environment in which a planned policy is to be implemented. For example, in Hafid's (2012) literature review of qualitative studies of decision-makers' perceptions of the HPV vaccine, it was noted that studies answering this question had been conducted in the USA, South Africa, Columbia, India, Peru, Uganda, and Vietnam, but not Canada. This then provides a strong rationale to conduct a study of Canadian stakeholders' perceptions within the context of their universal, provincially funded public health programs. Similarly, a review of the literature may expose that the issue has been substantially studied within a specific group of stakeholders, for example parents or health care providers, but the perspectives of another core group, such as the adolescents targeted to be vaccinated, have not been examined.

3. *Determine the study purpose.*

Typically, the purpose of most qualitative policy research is descriptive, exploratory,

explanatory, or emancipatory. Descriptive studies involve documenting the actions, events, perceptions, structures, and processes related to a health policy. They are most typically stated as *what* questions. Exploratory qualitative research is conducted to understand the meaning of phenomena, to discover novel perspectives, or to document process. Exploratory research questions, often stated as *how* questions, also allow us to identify key categories and understand the relationships between categories. In policy evaluation research, much emphasis is placed on conducting explanatory studies where the goal is to identify the contextual factors, events, and stakeholder actions that explain the implications of a policy. Emancipatory studies engage research as a political act, one that is conducted to promote change. Questions in these studies are often structured to understand how a specific stakeholder group defines or understands the health problem and then seeks to identify solutions to the problem. The study purpose will also be determined by the stage of the policy work cycle in which the question is being asked.

Researchers working in the field of HPSR may collaborate with health policy analysts for the purpose of accessing and appraising preexisting research or conducting studies to provide policy makers with timely, contextually specific data. Morestin (2012) presents a framework for analyzing public policies that identifies six analytic components that influence decision-makers about their selection of public policies: effectiveness; unintended effects; equity; cost; feasibility; and acceptability. These dimensions can be useful in helping frame the overall study purpose. While the effectiveness of a policy will typically be measured using quantitative methods, when a policy is being considered for implementation in a context in which it has not been tested, Morestin recommends "to gather as much information as possible about the influence of the implementation context on effectiveness, to be able to form judgements [sic] about the transferability of a policy from one context to another" (p. 3). Similarly, when unintended

effects of a policy are identified, qualitative methods are appropriate for examining the nature of those effects, the conditions that led to the development of the unanticipated outcomes, stakeholder perceptions of the impact, and to identify strategies that could be utilized in the future to minimize those effects that were perceived as having a negative impact (Morestin 2012). The issue of equity is important to explore as well, as public health policies tend to be implemented at the population level yet will have varying effects on subgroups. Therefore the purpose of a qualitative study may be to explore the nature of the social inequalities related to a policy and understand the contributing conditions. Finally, in terms of studying the implementation of a policy, qualitative methods can be integrated into feasibility studies and used as a dominant method to explore acceptability.

Little has been written about how to structure and conduct policy acceptability studies. Acceptability refers to exploring and describing how various stakeholders perceive and understand the components of a policy. It may include examining the social, psychological and ethical acceptability of a health policy. Data about acceptability is essential in the policy formulation and decision-making phase as it provides insight into components that may be problematic and impede implementation and uptake if not addressed. Once the key policy actors and stakeholders are identified, Morestin (2012) recommends asking the following acceptability questions: (1) Is it acceptable to implement a policy to address the targeted health problem? (2) How acceptable is the proposed health policy in comparison to other proposed policies? (3) What are stakeholders' perceptions about the feasibility, effectiveness, cost, and equitableness of implementing the proposed policy? and (4) How acceptable is the degree of coercion associated with the health policy? Stakeholder perspectives however are static and different contextual conditions may alter how a policy is viewed. Therefore, questions about how, why and when stakeholders may find a policy more acceptable should be

explored. Returning to our case example of HPV vaccine, most parents may perceive administering the HPV vaccine to adolescents as acceptable but only if it is available to males and females, delivered as two doses versus three, and available to adolescents older than 13 years. In any process evaluations of the implementation of the policy, stakeholder perspectives may change over time and thus acceptability should be revisited due to the social, political, environmental, or technical changes within the society (Morestin 2012).

4. *Construct a focused, policy research question.*

A clearly articulated research question provides the reader with a sense of the scope and purpose of the study. The first step is to identify the appropriate qualitative words to briefly describe the purpose of the study. These may include: to explore (understand), to explain (develop), to describe (discover), or to emancipate (promote action) (Marshall and Rossman 2011). Alternatively, you may choose to emphasize that the research question is focused on the *perception* or *meaning* of a policy, the *context* in which the policy is (or was) implemented; or on documenting any processes associated with adopting, implementing or evaluating the health policy (Maxwell 2013).

A considerable amount of policy research will be contextually specific and about understanding the perceptions and needs of unique stakeholders within that environment. To guide this work, a good research question will then clearly articulate the population, phenomenon and context under study. Be as specific as possible in identifying the purposeful sample within the research question. Readers will be left with a sense of ambiguity if the research question incorporates such generic terms as "stakeholders" or "policy actors" (e.g., "What are stakeholders' perceptions of the acceptability of administering HPV vaccine to adolescent girls ages 9–13 years in the school setting?"). It is more meaningful to identify if you are most interested in examining the experiences specifically of parents, adoles-

cents, health care providers, the general public, educators or public health policy decision-makers. The phenomenon refers to the situation, event, problem, or policy under study. Integrating language that refers to the relevant phase of the policy work cycle can also increase the specificity of the research question. In the following question, the phenomenon of interest is the process of implementing electronic health records: “How did Canadian provincial and territorial ministries of health coordinate the electronic health record adoption and implementation process?” Finally, as contextual influences are largely responsible for the success or failure of a health policy, research questions should specify the specific setting in which the phenomenon is situated. A setting could relate to any country, jurisdiction, province/territory, organization or agency that is implementing, or impacted by, a health policy. To conduct an evaluation around the implementation of electronic health records in Ontario, a jurisdiction where implementation has been significantly delayed by a lack of leadership, procurement scandals, and relatively little progress given the investment of resources to date (MacAdam 2009), the context within the following question would be limited to the province of Ontario: “In Ontario, how did the implementation context influence the implementation of electronic health records by the Ministry of Health and Long-Term Care?”

31.4.2 Health Policy Research Designs

Researchers have a broad range of robust qualitative research designs, or approaches, to choose from to answer their policy-relevant questions. The choice of design should be influenced primarily by the research question being asked, but is frequently informed by the researcher’s training and field of discipline. It is essential at this stage in the evolution of health policy research to demand an increase in the quality and rigor in the qualitative studies being published in peer-

reviewed journals. There are three primary problems. The first being a tremendous dearth of detail frequently provided about the qualitative methods used to guide the conduct of a study. In a systematic review conducted to describe the volume and characteristics of 329 empirical qualitative research articles published between 1998 and 2008 in major health service journals, fewer than 40 % of the articles provided an extensive description of the study’s methods, and half of the articles (52 %) provided few details (less than one page of content) and omitted information on data collection, analysis, site selection, or study limitations. Shockingly, 9 % of the articles provided no account of the study methods (Weiner et al. 2011). The second related problem is that in some studies there was a complete absence of any apparent design to guide the conduct of the study. Weiner and colleagues concluded that approximately one-third (28 %) of the articles they reviewed described using a “general approach” to qualitative methods and did not follow a traditional qualitative approach. Finally, the third frequently observed problem is the articulation of the intent to use a particular qualitative design (e.g., grounded theory, case study, ethnography, narrative inquiry) followed by a description of procedures that do not align with the methodological rules of the intended approach, thus indicating perhaps a poor understanding of the philosophic tenets of the design or a lack of training in the development and conduct of qualitative research.

This section provides the novice health policy researcher with some ideas about common qualitative approaches that are most amenable to creating knowledge to inform policy content, achieving the goals of HPSR and two approaches (using stories and photovoice) that powerfully transform qualitative data into effective tools of persuasion.

31.4.3 Qualitative Meta-synthesis

There is increasing requirement for health policy analysts to understand stakeholders’ perceptions of health problems, the factors that contribute to

the problem and, following the implementation of a policy, their overall experiences. As the quantity of qualitative studies increases, tools for comparing, contrasting and synthesizing similar findings across studies are required. Synthesis of qualitative findings can assist in addressing common critiques of primary single studies: that is that findings are limited in their transferability because of small sample sizes and investigation of a phenomenon in a specific social context, with a unique group of participants in a given time period (Hansen et al. 2011). At the simplest level, these types of syntheses involve articulating a research question, defining inclusion criteria by which to select and include articles in the synthesis, conducting a systematic and comprehensive search of the published peer and gray literature, appraising the quality of each primary study, extracting the data and then, at various levels, aggregating or interpreting the collated findings. The intent is that by using a rigorous approach to integrating findings, higher level constructs and results will emerge with improved transferability to a range of contexts. This is appealing to decision-makers and health policy analysts who require a comprehensive understanding of health or social problems from multiple perspectives and who lack the time and perhaps resources and skills to independently search for, retrieve and appraise individual primary studies. Researchers however need to recognize that there is a range of methods for synthesizing qualitative methods and must be able to determine which method is most appropriate for answering their research question or addressing a policy problem. Examples of different approaches include meta-ethnography, thematic synthesis, meta-study, meta-narrative, and qualitative meta-summary. Barnett-Page and Thomas (2009) provide a valuable and detailed overview and critique of the different methods of synthesis, highlighting that the different methods can either be categorized epistemologically as idealist or realist approaches and may vary across the following dimensions: search strategy, quality assessment, problematization of the literature, question, heterogeneity of the included studies, and the final synthetic product created.

Box 31.2 The Role of Scientific Evidence on Legal and Political Decision-Making: A Case Study of Canadian Supervised Injection Facilities (Hyshka et al. 2013)

Insite is a supervised injection facility located in Vancouver, Canada that provides space, sterile injection equipment, safe syringe disposal services, health education, primary health care, and referrals to other health and social care services. Although it is illegal in Canada to possess specific controlled substances, Insite was granted a temporary legal exemption to operate by the federal government based on a plethora of scientific research evidence demonstrating the effectiveness of the intervention to reduce drug related harms. In 2006, the Conservative federal government attempted to revoke Insite's legal exemption; a 2011 ruling by the Supreme Court of Canada ordered an extension however of the initial exemption. A policy case study was conducted by sampling and reviewing jurisprudence, legislation, scientific evidence, and media texts. The objectives of the policy case study were to evaluate how scientific evidence influenced policy and legal decisions; analyze the legal ruling and explore the potential implications for other Canadian cities seeking a legal exemption for a supervised injection facility and to determine the likelihood of new sites being established. The authors conclude that it is unclear if new sites wanting to establish a supervised injection facility will be granted a similar exemption under the current ruling or if further court action will be necessary. The importance of establishing small-scale pilot sites as a strategy for influencing policy makers is identified.

31.4.4 Case Study

Qualitative case study methodology allows health policy researchers to holistically study complex

phenomena within their natural contexts using a variety of data sources and types. The use of multiple triangulation strategies results in robust, credible qualitative findings. Case study is a valuable method for developing and evaluating policies and it is extensively used in HPSR and health policy analyses (Walt et al. 2008). In their review of the characteristics of published health services qualitative research, Weiner et al. (2011) determined that among the 329 studies revised, case study was the most common qualitative approach used, with 59 % of articles using a multiple-case study design and 11 % describing use of a single-case design.

Case study methodology can be selected when: (1) the research question being posed is *how* or *why*; (2) the purpose is to discover core contextual conditions that are believed to influence the policy or health problem under study; and (3) the boundaries are not clear between the context and the phenomenon (Baxter and Jack 2008; Yin 2009). Explanatory case studies are used to answer questions that attempt to understand the relationship between policy components, implementation, and end effects or consequences and that are too complex to be evaluated using experimental designs (Baxter and Jack 2008). Exploratory case studies are conducted to understand situations where the policy being evaluated has no clearly defined set of outcomes (Baxter and Jack 2008; Yin 2009). Descriptive case studies are conducted to identify the components of a policy or problem, as along with their dimensions and properties (Yin 2009). Case studies are also frequently employed to document the policy implementation process as well as analyze the implications of particular policy decisions.

31.4.5 Interpretive Description

An exceptionally practical research method for applied health policy researchers is interpretive description (Thorne 2008). While developed within the field of nursing research to describe and interpret clinical phenomena, this qualitative approach provides a practical framework for describing health issues and policy processes.

Box 31.1 Single Mothers' Transition from Welfare to Work (Cook 2012)

Across the western world, welfare-to-work policies are being instituted that require low-income single mothers to reenter into the work force. Cook conducted a thematic synthesis of eight qualitative studies describing mothers' experiences of the welfare-to-work transition and the perceived impact of these programs on their health. This author summarizes that in this process, women experience multiple health and economic issues during this transitory stage, including various degrees of poor mental and physical health. For participants in the USA medical challenges were exacerbated by a loss of health benefits as they entered into low-wage jobs. The combination of reduced government subsidies with insufficient wages resulted in increased use of food banks and an inability to afford appropriate childcare. On the basis of these findings, the author concludes that welfare-to-work policies do not result in a more efficient distribution of resources, and that participation in the job market may result in fewer resources for single mothers and increased illness burden. She recommends that future welfare and employment policy examine the interactions between work incentives and disincentives and the family-care requirements for lone mothers.

What differentiates this approach from qualitative description is the analytic focus on interpretation and explanation by answering the all important question of "so what?" (Thorne p. 33). This method also fills an important void in current qualitative methodologies in that it provides a method that is flexible, suitable for addressing health policy content, process and outcome research questions, and allows for basic description but also encourages interpretation within the current social, political, and cultural context but does not require the high-level conceptual

abstraction required in such approaches as grounded theory, ethnography or phenomenology. Researchers often select one of the more traditional approaches to answer an applied research question because there is a basic appreciation that grounded theory is selected to study questions related to process, phenomenology selected to describe and interpret the meaning of phenomena and that ethnography provides tools to understand the symbols, patterns and routines within a defined culture. However, many health researchers lack the disciplinary and methodological training in the fields of sociology, philosophy or anthropology to adequately and robustly conduct these types of highly abstract and theoretical studies. What is also frequently noted in the health services and policy literature are researchers who adapt or only borrow a few techniques from an established social science method, do not follow the full set of methodological rules for the method they insinuate they are using, and thus run the risk of producing results of debatable credibility, dependability, or transferability.

In interpretive description, the research question must evolve from the field and be developed to address a specific practice, or in this case, policy goal (Thorne 2008). It is imperative also that researchers engage in the project with a sound understanding of what is already known, or not known, about the topic including empirical evidence and the tacit knowledge held by stakeholders. Through the interpretive lens, the researcher can then “deconstruct the angle of vision upon which prior knowledge has been erected and to generate new insights” (Thorne p. 35). The guidelines associated with this method will support health policy researchers in their goals of understanding the context in which policy decisions are made and also document and critically analyze existing “subjective, experiential, tacit and patterned” knowledge (Thorne, p. 36).

31.4.6 Developing Stories

One of the greatest challenges in translational research is identifying strategies to transform empirical evidence into understandable and

Box 31.3 Exploration of Parent and Student Perceptions of Implementing School Nutrition Policies (MacLellan et al. 2010)

MacLellan and colleagues used an interpretive descriptive approach to describe students', in grades 4–7, and their parents' perceptions of the barriers and facilitating factors that influenced the implementation of a school nutrition policy in Prince Edward Island designed to promote healthy eating habits within the school environment. Parents shared that communication between decision-makers and stakeholders was strong during the policy development process but that it was inadequate during the policy implementation stage. Parents and students were also concerned that they were not consulted about planned changes to food options sold at school during the lunch hour and that student food preferences were not taken into consideration. A significant barrier was the perception that it is a parent's, and not the school's, responsibility to address nutrition and dietary habits. The authors interpret that poor communication during the policy implementation stage resulted in parents' lack of understanding and awareness about the content of the policy. Additionally they explained that personal beliefs about who is responsible for children's health behaviors may influence long-term sustainability of the policy.

usable information that can be communicated quickly, and with effect, to key decision-makers. As identified earlier, qualitative findings when expressed as well-written narratives have an advantageous appeal in that they can be used to evoke emotional responses and be powerful tools to promote the adoption of a policy option or to explicate the implications or consequences of a policy decision. The transformation of qualitative data into stories—structured narratives that present a sequence of events to explain a process and the resulting outcomes—can be a useful way

to communicate essential background information on a health issue, descriptions of the target population and their experiences, and the steps taken to develop and implement a policy (Zwald et al. 2013). During a process evaluation, the development of stories can also be a short-term solution or deliverable to communicate to stakeholders about the progress being made and to share emerging results. This can be an important way of keeping stakeholders informed about progress being made even before the quantifiable impacts of a policy are known. The most significant challenge in the health field currently, however, is securing resources to develop and create the stories and supporting individuals to develop skills in writing them.

To ensure that the stories are viewed as credible sources of evidence and not just anecdotal accounts of an individual's experience, researchers can ensure that data collected to tell the story emerge from the findings of a structured research design, such as interpretive description (Thorne 2008) or narrative inquiry (Clandinin and Connelly 2000). The steps in the story development process create specific opportunities where researchers can implement certain methodological strategies to enhance the overall trustworthiness, and in particular the credibility, of the qualitative data that is embedded with the stories. For example, after conducting the primary interviews for the purpose of creating the basic story structure, there is a requirement to collect additional data to fill in any apparent gaps in the story. Researchers can therefore expand their sample to include other data sources, so that the story can be understood from the perspective of different stakeholders or about the role of different contributing levels of policy-makers. Beyond interviews with stakeholders, other data types can be collected and reviewed at this point, including media reports, observations, or policy documents. Both data type and data source triangulation will enhance the overall credibility of the data and thus the story that is narrated and disseminated. During this stage, as well as the stage of developing and refining the stories, opportunities to engage in member checking should be established as part of the protocol, or finding

opportunities to share the emerging storyline back with the main participants to ensure that their story is accurately being interpreted and represented in the final product.

The Centers for Disease Control and Prevention in their work to communicate various policy, systems, and environmental approaches used to prevent obesity, developed a seven-step framework for story development (Zwald et al. 2013). In adapting the framework proposed by Zwald and colleagues for qualitative researchers working to communicate to policy actors, there are several steps they can engage in. First, identify the target audience for the story and then determine if the story will focus on policy content, process or outcomes. It is important to also articulate at this stage the purpose of the writing the story; that may include increasing awareness about a policy, documenting lessons learned or to advocate for one policy option over another. The next step involves the collection of data using a qualitative approach and rigorous strategies for sampling, data collection and analysis. At this stage, it is important to determine if the final story will emerge out of a single narrative or will be comprised of a compilation of stories and experiences. Once this decision has been made, authors will then review and select stories, collect additional data to enrich the background information about the policy to fill any gaps in the storyline and then finish by refining the story. At this stage, it is recommended (Zwald et al.) that researchers secure the assistance of a technical writer to assist in writing the story by transforming the qualitative data into a suitable narrative form. Throughout the process, one can engage participants and other policy actors in determining the title for the story, one that will engage the reader and highlight the story focus. With this lens to informing or discussing health policy, one might consider that the story content could include, but not be limited to, a description of: (a) policy or program details; (b) implementation process; (c) short- or long-term outcomes, including both intended and unintended consequences; (d) identification of all stakeholder roles and partnerships; (e) the potential impact on population health; (f) lessons learned, including

identification of facilitators and barriers and recommendations for other jurisdictions; and (g) contact information. Once the story has been drafted, circulated for review and feedback from participants, then engagement of a graphic designer to select photos, design a story template and to confirm the story format (e.g., booklet, single page newsletter) is recommended (Zwald et al.). The final stage is to identify multiple communication channels through which to disseminate the stories to the various stakeholder audiences.

31.4.7 Photovoice

Upon entering the foyer of a local children's aid society, in a single instant I learned the power that a photograph can have on understanding a complex issue from a new perspective and that a photograph can act as a catalyst for change. The photograph collage observed was part of a photovoice project conducted with youth who were asked to take pictures of their experiences of being in foster care and also to share their visions for their futures. The collage consisted of a series of ten photographs of different front doors, with the title "You gave me a house when I needed a home [...]. I wouldn't have built a wall around me if I wasn't in care." (FCSGW 2012, p. 8). That image portrayed to me a broken foster care system that does not provide stability or security to our most vulnerable youth and results in tremendously negative health outcomes.

Photovoice, as a qualitative approach, has its foundations in participatory-action research and may be engaged as a part of an emancipatory research project where the goal is to share stakeholders' perceptions and experiences of a problem or situation and to use those findings to engage politically in promoting the development or uptake of positive social and health promotion actions (Marshall and Rossman 2011; Wang and Burris 1997). Photovoice as a tool for knowledge creation empowers individuals to describe and share their perspective of how they experience the world, or even a specific health or social condition, through the use of photographs. Explicitly,

the three overarching goals of a photovoice project are to: (1) have all participants document and reflect on an identified issue; (2) increase awareness and then to engage in a critical discourse with individuals or groups about the photographs; and (3) engage with policy and decision-makers to create an awareness of an issue and to promote for social change (Wang and Burris). There is no doubt that decision-makers at all levels are busy, inundated with information and may lack time, skills or resources to read published research reports. Photovoice however requires physical and verbal dialogue and interaction between the very people that a policy will impact and the individuals responsible for developing and implementing the policy options. Not only do photos have the power to convey messages, but the participatory nature of this approach allows for recipients of health policy to be actively engaged in defining the problem and presenting potential policy options (Wang 1999). As a participatory method, policy and decision-makers are also not just passive recipients of knowledge; instead they are invited to actively engage in different stages of the projects, not generally as photographers, but as advocates and liaisons for supporting the consideration and implementation of policy options suggested by participants.

31.5 Utility of Qualitative Research Evidence

In HPSR evidence can be utilized for different purposes including decisively guiding decisions, developing a new perspective on about a health problem, or to politically substantiate decisions that have already been made by policy makers. Given the time and resources that are invested in conducting qualitative studies, I think that researchers must also take on a certain level of responsibility for explaining to decision-makers *how* their inductively derived findings can be useful in the policy analysis process. At minimum, this should include providing detailed

Box 31.4 Flint Photovoice: A Critical Discussion Among Youth, Adults and Policy Makers About the Strengths and Assets in Their Community of Flint, Michigan (Wang et al. 2004)

A once vibrant community, primarily dependent upon a single automotive industry, the community members of Flint, Michigan have recently struggled with the health, social and economic impacts associated with deindustrialization, disinvestment and urban decay. To document and critically discuss this transition, youth, community members and policy makers engaged in a photovoice project to take photos of what they perceived were primary concerns and assets of their community. Together, 41 individuals, representing different ages, incomes, experiences, neighborhoods of origin and levels of social power, took photos and then engaged in a process of “freewriting” about one or two photos from their roll that they identified as particularly important. In reflecting on each photo, they were asked to answer the following questions: (1) What do you see here? (2) What is really happening? (3) How does this relate to our lives? (4) Why does this problem or strength exist? and (5) What can we do about it? Following group discussions, key themes were identified. The photos and themes were presented at interactive forums with invited policy makers, community members, the general public and members of the media. As part of this process, decision makers gained a new understanding about issues of safety and violence. The authors also identify that an important outcome of this type of research is also the development of new partnerships between community members and decision makers.

descriptions of the setting or context of the study, and characteristics and demographics of the study participants. This supports a reader’s abil-

ity to determine if the results are transferable and applicable to his or her own local context.

31.5.1 Instrumental Use

Instrumental use refers to the direct use of research findings to inform a policy decision (Amara et al. 2004). Qualitative data collected, often within the scope of pilot studies, to address questions of a program or policy’s acceptability with different stakeholders, can be immediately used to adapt, change or refine health policies before they are implemented or targeted to a larger group of stakeholders. Within Canada, my research team has been advocating for, and working with, decision-makers within local public health agencies and across different provincial ministries to consider a policy option of offering extended maternal-child home visiting (from early pregnancy through to a child’s second birthday) to vulnerable mothers. The program under consideration is the Nurse-Family Partnership, a nurse home visiting program for young, low-income pregnant women and first-time mothers. This program has been extensively evaluated in the USA over the last 35 years but its effectiveness in the context of the Canadian health care system is unknown. In 2008, a pilot study was conducted in Hamilton, Ontario to determine the feasibility and acceptability of delivering this program through a local public health agency. A qualitative case study was conducted to explore the acceptability of the program elements with a range of stakeholders including physicians, social workers, clients and their family members, public health nurses and public health managers (Jack et al. 2012). One important finding in this study was that public health nurses in Canada are unable to sustain the same caseload level of clients compared to US nursing colleagues delivering the same program. As a result of this finding, an instrumental change was made to the program guidelines and the recommendation to reduce caseload levels from 25 clients to 20 per nurse was implemented. Within the policy arena, the instrumental use of qualitative findings can play a significant role in the policy development phase

by identifying and then including recommendations and actions within the policy recommended by core stakeholders. In the evaluation phase, instrumental use also occurs by identifying barriers, facilitators, and unintended effects of the policy, or allowing decision-makers to clearly identify factors that contributed to the policy's success or failure. Once these have been identified, adaptations or changes can result.

31.5.2 Conceptual Use

Given the exploratory and descriptive nature of most qualitative findings, they will most commonly be used conceptually by decision-makers. Conceptual utilization has been referred to as an enlightenment process that provides the reader with insight about, or a novel appreciation of, contextual issues. Additionally, when studies are conducted to describe and explore stakeholders' perceptions, values, and beliefs, then this provides an opportunity for decision-makers to understand the nature of a problem from the perspective of others. Health policy issues such as homelessness, food security or wait times are complex. How an issue is defined, and the solutions proposed to address the problem, will differ by stakeholder group. Using qualitative evidence is one strategy by which decision-makers can access at least a summary of how the issue is seen by different groups, and to view the issue from a point of view that may differ considerably from the prevailing view that exists within the policy, agency, or government environment. For example, across North America, many professional health organizations and jurisdictions are advocating for the implementation of universal screening for intimate partner violence among women accessing health care services. The presumed intent of such policies is to identify abused women early and provide or refer them to appropriate supports and services to reduce their exposure to violence. Despite the lack of evidence in support of the effectiveness of screening (MacMillan et al. 2009), qualitative research also reveals to us that some abused women may choose to not disclose this information to health

care providers, and that they fear losing control over how, when, and what information is shared (Catallo et al. 2013). As a health care provider, I might perceive that when a woman discloses her abuse status, that this creates an opportunity to intervene and provide supports and services. However, this qualitative data helps the decision-maker to understand the issue from the perspective of the client and to conclude that there is perceived risk associated with screening and that for women, it results in increased feelings of powerlessness and vulnerability. It has been further argued that the conceptual use of qualitative evidence not only provides an opportunity to have new insight into an issue, but that it is through this process of heightened awareness and sensitivity that the potential for developing policies that are relevant and sensitive to the needs of the population can be created and implemented (Jack 2006).

31.5.3 Symbolic Use

A decision-maker may also selectively choose specific results or research studies to justify or validate a predetermined position or policy. Whereas the process of evidence-based or evidence-influenced policy requires decision-makers to access and consider a range of research evidence *before* making a decision, when evidence is used symbolically, it is retrieved *after* the decision is made. A qualitative multiple-case study was conducted to explore how senior child welfare decision-makers utilize research evidence in the policy process (Jack et al. 2010). In exploring participants' perceptions of how provincial child welfare policy is developed, they were critical of how they believed research evidence had been used in the process. They accused policy makers of handpicking evidence to support the policy changes and by even manipulating the research evidence to legitimize the political agenda. The challenge for researchers then becomes how to ensure that high quality research evidence is easily accessible and available for decision-makers, either before, or after a decision is made.

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