Int J Public Health 52 (2007) 265–266
1661-8556/07/050265-2
DOI 10.1007/s00038-007-0222-5

The quality of evidence: enhancing uptake of qualitative evidence for gender equity and health

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The IJPH / WHO Gender Equity and Health Supplement provides opinions and evidence on the validity of, and the need for, establishing both women's and gender-sensitive health indicators to monitor and improve women's health and equity. The field test described by Haworth-Brockman et al. (2007) illustrates how and which of the WHO core set are applicable in one setting and, in the full project analysis, identifies policy implications for each indicator. The test verifies what Lin and others (Abdool et al. 2002; Lin et al. 2003; Lin et al. 2005) have predicted: that national level data (even if available) will undoubtedly mask important variation and diversity within populations. Wherever possible and feasible, data should be gathered *and* analyzed at local and regional levels, certainly at the level of health delivery. The commentary and articles in the Supplement also acknowledge that while surveillance data can describe *what* is happening (and should do so over time), they fall short in describing *why* and *how*. The authors agree that quantitative surveillance data should be complemented with qualitative research and analysis. In health services policy research and decision-making, calls for the inclusion of qualitative evidence have been made repeatedly. But very rarely does this lead to action, the actual application of qualitative research in evidence-based decision-making. In other words, there is 'buy-in' but little 'uptake'.

We speculate that one impediment to action is the persistent tension between the population focus of most health policy makers, and the focus of qualitative research on micro and/or meso-level analysis. The biomedical model of health and its dependence on quantitative evidence for clinical intervention, policy development and decision-making is deeply entrenched. While there may be formal acknowledgement that other forms of evidence exist and can inform health policy, there are few institutional structures or resources to support the introduction and establishment of these evidence models as credible, routinely collected, analyzed and usable sources of information. The lack of institutional architecture to apply qualitative evidence is related to policy analysts' lack of capacity to assess and utilize it. That is, the resistance to 'uptake' may not (simply) issue from methodological ideology, but rather from a lack of application capacity (Eakin & Mykhalovskiy 2003).

Uptake of qualitative evidence by policy analysts and decision makers could be improved, we argue, by developing their capacity to:

– appropriately assess the quality of qualitative research and evidence, and
– apply qualitative evidence via the development of 'horizontal/analogical' reasoning.

Hills (2000) notes: "The 'holy trinity' of orthodox science – reliability, validity and generalizability – by which quantitative methodologies are judged is not easily translated to qualitative methodologies" – nor, many assert, should they be. While some qualitative researchers are wary of mirroring the quantitative paradigm, others have promoted the adoption of criteria for rigour such as consistency, credibility, and applicability.

Consistency in qualitative research refers to the "dependability of the process used to generate the data and the findings themselves" (Hills 2000). Researchers create 'audit trails' to document their methods and the research process so that others can assess their strategies and analysis. *Credibility,* comparable to the concept of validity, refers to 'truth value' or the alignment of interpretations of data with the observed situations and experiences of human subjects. "Validation becomes the issue of choosing among competing and falsifiable interpretations, of examining and providing arguments for the relative credibility of alternative knowledge claims" (Hills 2000). *Applicability* or 'transferability' refers to the ability to use or transfer findings and analysis from one study to another. Sandelowski (2004) makes a useful distinction between

formal generalization "foundational to utility in quantitative inquiry" and *analytic generalization* or "theoretical transferability" which underpins the utility of much qualitative research.

In quantitative research, usefulness is derived from "the generalizability of findings from study samples to populations not studied but deemed to be like those samples" (Sandelowski 2004). However, in qualitative research, where attention to the uniqueness of human experience is a core value, analytic generalization focuses not simply on the applicability of *findings*, but of *theories* to situations other than the ones from which they were derived. "Indeed, the key objective of grounded theory is the development of successively more abstract and formal theories that are both empirically faithful to the cases from which they were developed and enduring beyond the single case" (Sandelowski 2004). The practice of analogical/horizontal reasoning can enhance decision makers' grasp of the applicability of qualitative evidence.

Analogical reasoning (Code 2006) entails the ability to reason across situations, modes of knowledge and domains of inquiry. It requires reading statistical evidence with and against experiential evidence, moving between generalization and particularity, allowing analogies to move inquiry forward, and disanalogies to initiate productive rethinking (Code 2006). Particular experiences are local – they cannot stand in for other specific situations. However, local experiences are also *located*, and in the detail of its situational sensitivity and its exposure of the practices of power, experiential evidence makes a crucial contribution to knowledge. Qualitative research is not simply a prelude to more powerful quantitative methods – it can be used to interrogate more fully relationships of power and privilege revealed in quantitative evidence (Weber 2006). "While [analogical thinking] has been discredited as subjective, particularist, and situational, […] it is often more carefully attuned to situated empirical evidence and thus more responsible to its subject matter than conventionally respectable deductive-nomological reasoning can be" (Code 2006).

Historically, the discipline of health promotion has demonstrated an affinity with qualitative research evidence and has used it to inform policies and interventions. Health systems managers, however, have relied almost exclusively on quantitative data, despite frequently asserting their desire to use qualitative data. By educating analysts and decision makers about how to assess qualitative evidence, and by promoting the practice of analogical reasoning, health researchers can help enhance capacity to apply qualitative research in health systems management and delivery. In turn, this will enhance the range and quality of evidence available for addressing gender inequities in health.

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References

Abdool S, Visandjee B, Desmeules M, Payne J (2002). Towards Gender-sensitive Health Indicators. Centres of Excellence for Women's Health Research Bulletin 2*(2)*: 6–8.

Code L (2006). Ecological Thinking: The Politics of Epistemological Location. Studies in Feminist Philosophy. New York: Oxford University Press.

Eakin JM, Mykhalovskiy E (2003). Reframing the evaluation of qualitative health research: reflections on a review of appraisal guidelines in the health sciences. J Eval Clin Pract *9(2)*:187–94.

Haworth-Brockman M, Donner L, Isfeld H (2007). A field test of the gender-sensitive core set of leading health indicators in Manitoba, Canada. Int. J. Public Health *52*: S49–S67.

Hills M (2000). Human science research in public health: The contribution and assessment of a qualitative approach. Can J Public Health *91(6)*: I-4–I-7.

Lin V et al. (2003). Comparative Evaluation of Indicators for Gender Equity and Health. Women and Health Program. Kobe: World Health Organization Centre for Health Development.

Lin V, L'Orange H, Silburn K (2005). Developing Gender-sensitive Health Indicators: relevance and practice. Ottawa: Bureau of Women's Health and Gender Analysis, Canada.

Sandelowski M (2004). Using Qualitative Research. Qualitative Health Research *14(19)*: 1366–86.

Weber L (2006). Future Directions of Feminist Research: New Directions in Social Policy – The Case of Women's Health. In: Hesse-Biber S (ed.). Handbook of Feminist Research: Theory and Praxis. Thousand Oaks, CA: Sage Publications

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