**Online Workshop: Qualitative Research Synthesis**

**Session 3: Methods for synthesizing qualitative evidence**

Presenter: Dr. Ruth Garside

A webinar sponsored by SEDL’s Center on Knowledge Translation

For Disability and Rehabilitation Research (KTDRR)

Text version of PowerPoint™ presentation:
[https://www.ktdrr.org/training/workshops/qual/session3/index.html](http://www.ktdrr.org/training/workshops/qual/session3/index.html)

**Slide 1: Title**

Online Workshop: Qualitative Research Synthesis

Session 3: Methods for synthesizing qualitative evidence

Ruth Garside, PhD, University of Exeter

A webinar sponsored by SEDL’s Center on Knowledge Translation for Disability and Rehabilitation Research (KTDRR).

800-266-1832. www.ktdrr.org

Copyright 2015 by SEDL, an Affiliate of American Institutes for Research. All rights reserved.

Funded by NIDRR, US Department of Education, PR# H133A120012. No part of this presentation may be reproduced or transmitted in any form or by any means, electronic or mechanical, including photocopy, recording, or any information storage and retrieval system, without permission in writing from SEDL (4700 Mueller Blvd., Austin, TX 78723), or by submitting an online copyright request form at [www.sedl.org/about/copyright\_request.html](http://www.sedl.org/about/copyright_request.html). Users may need to secure additional permissions from copyright holders whose work SEDL included after obtaining permission as noted to reproduce or adapt for this presentation.

**Slide 2: Title**

Top half of slide: Image of building identified as Knowledge Spa, Royal Cornwall Hospital, European Centre for Environment & Human Health.

Title: Methods for synthesizing qualitative evidence.

Dr. Ruth Garside, Senior Lecturer in Evidence Synthesis.

Logos: University of Exeter Medical School, European Centre for Environment & Human Health, EUROPEAN UNION Investing in Your Future European Regional Development Fund 2007-13, European Union Social Fund Investing in jobs and skills, Convergence for economic transformation.

**Slide 3: Plan of the session**

* Approaches to synthesis: Aggregative and interpretive methods
* Examples of qualitative synthesis methods: thematic analysis and meta-ethnography
* Presenting a qualitative evidence synthesis
* Knowledge translation

**Slide Template:** White background. Blue bar at the bottom. On the left, logo **of** University of Exeter Medical School. In the center, logo of European Centre for Environment & Human Health, ecehh.org. On the right, images that alternate (scientist looking at cell culture dish with samples; adult and child riding bicycle on the beach; 3 bathers looking at wave on rock wall; elderly man walking on a forest path; a group exercising on a beach; picture of beach with old stone buildings from above; couple walking in low water at beach; view of people near beach on cool day; woman looking at something in tall grass; danger radioactive substances sign outside glass door; close up of backlit wildflower; gloved hand holding tray with liquid filled tubes; gloved hand holding tool near trays with liquid filled tubes).

**Slide 4**: **Follows on from presentations about:**

* Nature of qualitative research
* Systematic review methods for qualitative research
* Searching for qualitative research
* Quality appraisal of qualitative research
* Data extraction

**Slide 5: What is “synthesis”**

* Combination of two or more items into a new whole
* The combination of ideas to form a theory or system
* NEW knowledge is generated which goes beyond the sum of its parts

**Slide 6: Why synthesise qualitative research?**

* Strategic
* Less wasteful
* Create more powerful explanations, higher order conceptualisation
* Broader, more encompassing theories
* Belief that it “will yield truths that are better, more socially relevant, or more complete” (Paterson et al, 2001)
* Enhance transferability of findings

**Slide 7: Framework for systematic reviews of qualitative research** (Garside 2010)

This table offers a framework for the stages of a systematic review of qualitative research. It shows some of the possible differences between qualitative and quantitative reviews.

There are two columns: Stages on the left, Typical activities on the right; and nine rows.

1. Developing research question: Assemble team, Consult, Agree approach.

2. Scoping exercise: Identify relevant research, Refine methods.

3. Identifying relevant literature: Develop Inclusion/Exclusion criteria; Focused searches; Citation searches.

4. Initial assessment of study reports: Preliminary reading; Identify theories; Assess utility/relevance.

Highlighted in yellow: Stages and Typical Activities 5-8

5. Analysis and Synthesis: Reading & rereading study reports; Constant comparison; Assess validity.

* 6. Preliminary synthesis: Categorising; Tabulating; Mindmaps; Explore relationships.
* 7. Full synthesis: Thematic analysis; Translation of findings; Theory development; Rival explanations.

8. Dissemination: Target audiences; Limitations of review.

9. Throughout: Multiple viewpoints; Reflexivity; Audit trail; Ongoing consultation; revisit review purpose.

This presentation will focus on the Analysis and Synthesis stage.

**Slide 8:** **Range of approaches and terminology**

* Umbrella terms:
	+ Qualitative Evidence Synthesis (2007)
	+ Meta-synthesis (1996)

**Slide 9: Range of approaches and terminology**

* Specific approaches:
	+ Meta-Ethnography (1988)
	+ Meta-Study (2001)
	+ Narrative Synthesis (2002)
	+ Realist Synthesis (2002)
	+ Meta-Narrative review (2005)
	+ Critical Interpretative Synthesis (2006)
	+ Qualitative Interpretive Meta-Synthesis (2013)

**Slide 10: Approaches to synthesis (I)**

* Aggregative
	+ More “additive” approach
	+ Summation/ aggregation of the existing themes
	+ Concepts clearly pre defined
	+ More deductive

**Slide 11: Approaches to synthesis (II)**

* + Interpretative
	+ Interpretation of existing findings
	+ Develops concepts and theories to explain evidence base
	+ Inductive

**Slide 12: Methods of evidence synthesis**

This diagram tries to situate different synthesis approaches along a continuum form aggregative to interpretative or “configuring” reviews.

It shows two overlapping ovals for configuring (left hand side) and aggregating (right hand side) and synthesis methods.

Under these ovals text shows approaches to theory for these different types of reviews - more interpretative methods on the left try to generate theory, those on the far right (most aggregative approaches) test theory and between these two, reviews explore theory.

More configuring methods, such as meta-ethnography (on the far left), build meaning through interpretation during the process of synthesis and generate theories to explain phenomenon (inductive)

Thematic synthesis is also to the left/ configuring side of the diagram.

More aggregative methods include those in quantitative reviews (such as meta-analysis) as well as content analysis and thematic summaries of qualitative research. In such reviews, any interpretation happens before and after synthesis – used to frame the review questions or apply the findings. These reviews might test existing theories using a deductive approach.

Between these two extremes, theory is explored through the synthesis – the methods listed here are realist synthesis and framework synthesis.

**Slide 13: Choosing a method**

* Experience
* Time & resources
* Purpose of review
* Audience and purpose
* Type of evidence available

**Slide 14: Examples of synthesis I: Thematic analysis**

**Slide 15: Origins**

* Echoes thematic analysis in primary qualitative research
* May use line by line coding or extract themes before coding
* Codes often descriptive, but may build up to be more conceptual

**Slide 16: EPPI Report**

On the left of this slide is a screenshot of a key text using thematic analysis.

It is an EPPI Centre report from October 2003 called “Children and Healthy Eating: a systematic review of barriers and facilitators”

<http://eppi.ioe.ac.uk/EPPIWebContent/hp/reports/healthy_eating02/Final_report_web.pdf>

**Slide 17: Review questions**

(i) What are children's perceptions of and attitudes towards healthy eating?

(ii) What do children think stops them from eating healthily?

(iii) What do children think helps them to eat healthily?

(iv) What ideas do children have for what could or should be done to promote their healthy eating?

**Slide 18: Three analytic steps described**

1. the coding of text 'line-by-line‘ (data driven codes);
2. the development of 'descriptive themes'; and
3. the generation of 'analytical themes‘ (theory driven codes).

**Slide 19: Synthesis approach**

* Findings of each study examined in turn, each sentence or paragraph assigned a descriptive code (e.g. children prefer fruit to vegetables). (NVIVO) 36 initial codes.
* Similarities and differences between codes sought to group them into a hierarchical tree structure.
* New codes were created to capture the meaning of groups of initial codes. 13 descriptive themes.
* A narrative summary of the findings across the studies organized by these 13 descriptive themes was then written.

**Slide 20: Figure 6.1 Interrelated descriptive themes identified across studies of children’s views (N=8)**

This diagram illustrates the hierarchical tree coding structure.

To the right are the 13 descriptive themes.

There are 2 primary nodes – Understanding of healthy eating and Influences on food eaten. The latter considers 2 subgroups of food eaten – food children choose for themselves and food provided for them by others. Subgroups for provided food are those at school and those at home.

3 descriptive themes related to Understanding of healthy eating. These are awareness and understanding of healthy eating concepts; good and bad foods, health consequences.

Similarly, there are 2 themes related to food in the home: Parental influence and food rules, and breaking rules and asserting independence.

Each of the nodes encompasses 2 to 5 of the 13 descriptive themes.

**Slide 21: Example textual paragraph**

'Good' and 'bad' foods

Three studies asked children to name 'good' and 'bad' food and their reasons for these classifications (Edwards and Hartwell, 2003; Hart et al., 2002; Mauthner et al., 1993). Children in all these studies readily used the 'food-health' or 'food-nutrition' links described by Hart et al. (2002) as reasons for labelling food good and bad (e.g. fat is bad because it causes heart disease; vegetables are good because they provide vitamins). Examples of bad food  included: cereals with sugar in them; sweets and chocolate; junk foods; and 'fattening food'. Examples of good food included: fruit; vegetables, nuts; and milk.

**Slide 22: Policy relevance?**

* Reviewers inferred from these themes the factors that help and hinder healthy eating.

**Slide 23: Final 6 analytic themes related to policy question (i)**

(1) children do not see it as their role to be interested in health;

(2) children do not see messages about future health as personally relevant or credible;

(3) fruit, vegetables and confectionery have very different meanings for children;

**Slide 24: Final 6 analytic themes related to policy question (ii)**

(4) children actively seek ways to exercise

their own choices with regard to food;

(5) children value eating as a social occasion; and

(6) children see the contradiction between what is promoted in theory and what adults provide in practice.

**Slide 25: Examples of synthesis II: Meta-ethnography**

**Slide 26: Key text from1988**

This slide shows the textbook by Noblit and Hare published by Sage as part of their Qualitative Research Methods Series in 1998. It is called “Meta-ethnography: Synthesising Qualitative Studies”

Noblit GW, Hare RD. (1988). *Meta-ethnography: synthesizing qualitative studies*. London: Sage.

**Slide 27: Picked up as a methods of synthesis in 2002**

Screen shot of first page of article: Britten N, Campbell R, Pope C, et al. (2002). Using meta ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Policy*. *7*(4):209-15.

**Slide 28: This is primarily approach to synthesis**

* No guidance in the original text about:
	+ Search strategies
	+ Inclusion criteria
	+ Quality appraisal tools applied outside of the synthesis
* Noblit:
	+ - “amazed” that the method “is being used mostly in fields of professional practice, as in evidence based practice”1

 1. Thorne S, Jensen L, Kearney MH, Noblit G, Sandelowski M. Qualitative Metasynthesis: Reflections on Methodological Orientation and Ideological Agenda. Qualitative Health research. 2004;14(10):1342-65.

**Slide 29: Definition of synthesis is explicitly interpretative**

 Activity or the product of activity where some set of parts is combined or integrated into a whole…

 (Synthesis) involves some degree of conceptual innovation, or employment of concepts not found in the characterization of the parts as a means of creating the whole

Strike & Posner (1983) quoted in Noblit & Hare (1988)

**Slide 30: Seven stages of synthesis**

1. Researcher interest key
2. What may be learnt form their inclusion in the synthesis as relevance to audience (much happier with selective approach)
3. Familiarity building, dynamic immersion in the data and looking for key metaphors, themes, quotes etc.
4. Listing and juxtaposing key quotes, themes, concepts, metaphors. Preliminary ideas are how they relate to each other. Reciprocal translation, refutational translation, building a line of argument – across the studies.
5. Allows central metaphors from each to be maintained and their relation with each other.
6. Comparing interpretations to see if types of translation can encompass each other (higher order concepts).

**Slide 31: Key method of synthesis:**

* Translation
	+ “One case is like another except that……” (p.38)

**Slide 32: Translation occurs:**

* At the level of existing interpretations of the data (how the researchers interpreted their data)

Translation occurs at the conceptual level

**Slide 33: How do we make sense of the world? (Levels of interpretation)**

* 1st order constructs:
	+ Everyday ways of making sense of our world
* 2nd order constructs:
	+ social science researchers’ interpretations of this “common sense world” to academic concepts and theories
* 3rd order constructs?
	+ Reviewers’ interpretations of the researchers’ interpretations.

 (After Schultz)

**Slide 34: CVD prevention programmes**

This table illustrates how the different levels of interpretative constructs might be seen, using an example from CVD prevention programmes. There are three columns and three rows.

The left hand column is headed ”quote, 1st order” constructs - quotes from participants about interventions they have received are shown here.

The central column is labelled “researchers’ interpretations or 2nd order” constructs – it shows their interpretation of these quotes.

The final column is labelled “reviewers’’ interpretation or 3rd order” constructs which encompasses both of the primary researchers’ constructs.

Row one shows study 1 – and gives and example of 1st, 2nd and 3rd odder constructs - the participant says “Pamphlets involve a lot of reading…food sampling gives them the opportunity to feel relaxed and ask questions” shown in the left hand column.

The researcher’s interpretation of this shown in the middle column is s that “Practical demonstrations are more effective than provision of written information”

Row 2 shows study 2 – in the first column, the participant says “Sue was great, she had lots of information and advice” and in the 2nd column the researchers interpret this to mean that “Programme “champions” are effective at disseminating information about the interventions”.

In the final column there is a single cell for both study 1 and study 2 rows - The reviewer translates this concepts as being about similar issues and offers an overarching explanation for the two: “Personalised support, allowing relationships to develop & facilitating questioning, may be more effective.”

**Slide 35: Translation types I:**

* Reciprocal translation
	+ “in an iterative fashion, each study is translated into the terms of the others and vice versa”
	+ “attention to which metaphors, themes, organizers, enable us to fully render the account in a reduced form.”

**Slide 36: Reciprocal translation**

* Similar to constant comparison
* Look for overlap, similarities, contradictions
* Are some concepts “better”? (scope, utility, explanatory power).
* Reviewer interpretation crucial (third order constructs/ concepts/theory)
* Different ways of juxtaposing concepts (tabulation, mind maps, colour coding, short text descriptions)

**Slide 37:** **Table 4. Experience of visiting the doctor for heavy menstrual bleeding**

* Garside R, Britten N, Stein K. The experience of heavy menstrual bleeding: A systematic review and meta-ethnography of qualitative studies. Journal of Advanced Nursing. 2008;63(6):550-62.

A 6 column 4 row table is presented entitled: “The experience of visiting the doctor for heavy menstrual bleeding (HMB).”

It shows how the 2nd order concepts from 4 studies (the 4 middle columns – with headers relating the study author names) included in a synthesis about HMB have been translated into each other.

The reviewer’s conceptual label for each translated concept is shown on the far left in column 1 labelled Garside (the reviewers name), whilst explanatory 3rd order interpretation is shown on the far right in column 6 – labelled “interpretation”.

The table shows how many of the included studies contributed to each translation, for example the third row is labelled by me as the reviewer as “Medical model unhelpfully privileges blood loss” the first column shows that study 1 had a 2nd order interpretation that “GPs miss the point” if they concentrate on blood loss” while the study in row 3 shows “Women assumed that these range of symptoms would not interest a gynaecologist”. The following 2 columns are blank because these 2 studies did not have concepts that were thought to be about these ideas. The final column showing the reviewer’s interpretation of these ideas says that ”women and doctors may conspire to privilege blood loss. The disease model unhelpful to doctors as well as women.”

The following slide will focus on the first row in more detail.

**Slide 38: Interpretation Doctors may not value subjective descriptions of symptoms**

* Garside R, Britten N, Stein K. The experience of heavy menstrual bleeding: A systematic review and meta-ethnography of qualitative studies. Journal of Advanced Nursing. 2008;63(6):550-62.

This table shows one translated concept. Each of the following concepts, one from each paper has been considered as being like the others, being about the same issue in relation to encountered of women with HMB and their doctors:

Women’s need to be listened to and understood

Drs need to hear and respond in a way that is concordant with women’s needs and concerns.

Drs did not listen to women and failed to take women’s concerns seriously.

Women were repeatedly told that nothing was wrong.

These have been given descriptive label that Drs fail to acknowledge women’s experience of symptoms

In the context of problems defining and measuring HMB in general practice, this was interpreted as showing the doctors did not value the subjective descriptions of symptoms that women provided during consultations.

**Slide 39: Meta-ethnographic synthesis**

This slide shows a 3 column, 4 row table taken from a meta-ethnographic synthesis by Britten et al 2003. The paper is about patient approaches to taking their prescribed medication.

This takes a similar approach to presenting meta-ethnographic translation to the previous example.

In the first column, the table shows descriptive concepts from across the primary studies, the second column shows second order interpretations of those concepts and the final column shows the third order interpretations.

For example the first row lists the following concepts from the primary studies in the first column:

Adherence/ compliance: correct and routine medicine taking

Self-regulation: problematic adherence; leaving off drugs

Aversion: dislike of taking drugs, harmful side effects

Alternative coping strategies: e.g. traditional medicines

2 second order interpretations of these concepts are shown in the second column:

A) Pts conduct a cost-benefit analyses – weighing up risks and benefits of medicine taking.

B) Medicine taking is influenced by cultural meanings and resources.

In the third column, these interpretations are collected under the 3rd order interpretation:

Self-regulation includes the use of alterative strategies.

**Slide 40: Translation types II:**

* Refutational translation
	+ “a specific form of interpretation”
	+ Oppositional/ counter argument findings
	+ Specific search for metaphors, themes, and concepts that oppose/ refute emerging patterns.

**Slide 41: Table 3 Themes reflecting uncertainty and influences on seeking help**

Another table from the HMB review is shown about women’s uncertainty and influences in their clinical help seeking.

It shows how the 2nd order concepts from 4 studies (the 4 middle columns – with headers relating the study author names) included in a synthesis about HMB have been translated into each other.

The reviewer’s conceptual label for each translated concept is shown on the far left in column 1 labelled Garside (the reviewers name), whilst explanatory 3rd order interpretation is shown on the far right in column 6 – labelled “interpretation”

I focus on the final row, which shows refutational findings from 2 of the included studies:

One found that women with HMB were encouraged to “enter the sick role” and regard their bleeding as problematic and unusual by other people – friends and family.

Another study found that friends and family often belittled women's suffering with heavy bleeding and didn’t take the problem seriously. There were not obvious reasons for these differences in terms of the populations and context of the studies. The Reviewer therefore concluded that both findings showed women were influenced by external influences, but that these might wither encourage or discourage them in accepting the validity of their experience as problematic.

**Slide 42: Translation types III:**

* Line of argument
	+ “What can we say about the whole?” (p. 62)
	+ Development of a new model, theory or understanding through the synthesis

**Slide 43: Flow chart image**

This diagram shows a model of medicine taking which was the overarching product of the synthesis trying to understand how people with chronic conditions take their medicine. It attempts to move beyond ideas about people being “compliant” or “noncompliant” with drug regimens.

It developed a typology of medicine use, with people who are prescribed medicines categorised as being:

1. Passive accepters - who accept medicine without question and follow their prescription.

2. Active accepters – who may have some worries about medicine. In this group, some will accept the regimen after evaluating it and follow their prescription. Others wont have their concerns answered after evaluating them and may become a member of one of the other groups – rejecters or active modifiers. Both these groups show resistance to following prescribed regimens.

3. Rejectors do not take the medicine at all. Some members of this group may do this from the start, and not evaluate pros and cons first like the active accepters and active modifiers.

4. Active modifiers alter their drug taking behaviours after evaluation and may take the medicine, but not as prescribed – altering dose or frequency for example.

**Slide 44**: **Figure 1 The patient illness model for heavy menstrual bleeding**

This diagram illustrates the patient (pt) illness model and the medical disease model for HMB (taken from Garside et al. 2008)

It shows a large circle on the left, which represents the patient illness model. This slightly overlaps with a much smaller circle on the right, which shows the medical disease model.

It shows how little overlap there is between the two.

The medical model defines HMB as loss of more than 80ml of blood. This is the only symptom in the small circle.

However women experience a much broader range of symptoms that concern them. In the pt illness model there are two broad themes – physical symptoms and impact on life.

Physical symptoms include:

The type of blood loss, is colour, sensation of loss and clots.

Associated symptoms such as bloat, breast tenderness, pain and fatigue.

The amount of sanitary protection needed (which represents the amount and duration of bleeding)

Change in these symptoms from prior experience

Comparison with other women about experiences

Impact of life includes:

Leaks and staining of clothes and bedclothes.

Associated embarrassment and feeling unclean

Restrictions on women’s normal social, professional, familial and sexual roles.

Finally the slide states that this lack of overlap between the medical disease model and the pt illness model is problematic for both women and doctors, leading to communication problems in consultations, and the possibility of over or under treatment the condition.

**Slide 45: Outcomes of qualitative synthesis**

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

Given that qualitative research studies usually ask open questions, the outcomes of such studies are varied, depending on the purpose of the study and the nature of the data and its analysis.

Continuing with the asthma paper discussed earlier to give examples of each of these kinds of outcomes:

* A new concept is the ‘self regulation’ of prescribed asthma medication
* A new typology is the grouping of the sample into 3 groups: accepters, deniers and pragmatists (who were in between the other 2 groups)
* The study described the processes (adaptive strategies) used by the deniers to manage their ‘bad chests’ such as not going outdoors in the summer
* The study provides an explanation for ‘non compliance’ with asthma medication
* The findings suggest some possible strategies for managing asthma which would focus on the diagnosis rather than the treatment

**Slide 46: Presenting findings of qualitative synthesis**

* Textual description
* Tables of findings
* Summary statement
* Conceptual frameworks/ diagrams

**Slide 47: Resources**

**Slide 48: Cochrane Qualitative and Implementation Methods Group**

Screen shot of the Cochrane Qualitative and Implementation Methods Group website.

[cqim.cochrane.org](http://cqim.cochrane.org)

**Slide 49: ASQUS Discussion List**

<http://www.jiscmail.ac.uk/asqus>

Screen shot of the ASQUS discussion list page

**Twitter:** [@CochraneQual](https://twitter.com/cochranequal)

**Slide 50: EPPI Centre**

Screenshot of the EPPI- Centre website

[eppi.ioe.ac.uk/](http://eppi.ioe.ac.uk/cms/)

**Slide 51: References**

* + Britten N, Campbell R, Pope C, et al. Using meta ethnography to synthesise qualitative research: a worked example. *J Health Serv Res Policy*. 2002;7(4):209-15).
	+ Dixon-Woods M, Bonas S, Booth A, Jones DR, Miller T, Shaw RL, Smith J, Sutton A, Young B. How can systematic reviews incorporate qualitative research? A critical perspective. *Qualitative Research* 2006*;* 6: 27-44.
	+ Garside R. (2008). *A comparison of methods for the systematic review of qualitative research: two examples using meta-ethnography and meta-study*. University of Exeter.
	+ Garside R, Pearson, M, Moxham, T. What influences the uptake of information to prevent skin cancer? A systematic review and synthesis of qualitative research. *Health Education Research* 2010; 25 (1): 162-182.
	+ Garside R, Britten N, Stein K. The experience of heavy menstrual bleeding: A systematic review and meta-ethnography of qualitative studies. *Journal of Advanced Nursing* 2008; 63 (6): 550-562.
	+ Gough, D, Oliver, S, & Thomas, J. (2012). *Introduction to systematic reviews*. London: Sage.
	+ Harden A, Garcia J, Oliver S, Rees R, Shepherd J, Brunton G, Oakley. Applying systematic review methods to studies of people’s views: an example from public health research. *Journal of Epidemiology & Community Health* 2004; 58:794-800.

**Slide 52: References (cont.)**

* + Lucas PJ, Arai L, Baird, Law C, Roberts HM. Worked examples of alternative methods for the synthesis of qualitative and quantitative research in systematic reviews. BMC Medical Research Methodology 2007; 7(4).
	+ Martin Hilber A, Kenter E, Redmond S, Merten S, Bagnol B,Low, N, Garside R. Vaginal practices as women’s agency in Sub-Saharan Africa: a synthesis of meaning and motivation through meta-ethnography. *Social Science and Medicine*. 2012; 74: 1311-1323.
	+ Paterson BL, Thorne SE, Canam C, Jillings C. (2001)*. Meta-Study of Qualitative Health Research. A Practical Guide to Meta-Analysis and Meta-Synthesis*. Thousand Oaks, CA: Sage.
	+ Pope C, Mays N, Popay J. (2007). *Synthesizing Qualitative and Quantitative Health Evidence: a Guide to Methods.* Maidenhead: Open University Press.
	+ Smithson J. Garside R. Pearson M, Barriers to, and facilitators of the prevention of unintentional injury in children in the home: a systematic review and synthesis of qualitative research. *Injury Prevention* 2011; 17:119-126.
	+ Sandelowski M, Barroso J. (2007). *Handbook for Synthesizing Qualitative Research.* New York: Springer.
	+ Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews*. BMC Medical Research Methodology* 2008; 8:45.

**Slide 53: Thank you.**

Questions?

R.Garside@exeter.ac.uk

**Slide 54: Thank you for participating!**

We invite you to:

* Provide your input on today’s session
* Share your ideas for future sessions
* Participate in the Community of Practice to continue the dialogue
* PLEASE CONTACT: joann.starks@air.org

Please fill out the brief Evaluation Form:

[**http://www.surveygizmo.com/s3/1883006/QualSynth-3**](http://www.surveygizmo.com/s3/1883006/QualSynth-3)

**Slide 55: Disclaimer**

This presentation was developed for grant number H133A120012 from the National Institute on Disability, Independent Living, and Rehabilitation Research (NIDILRR), Office of Special Education and Rehabilitative Services (OSERS), U.S. Department of Education. However, the contents do not necessarily represent the policy of the Department of Education, and you should not assume endorsement by the federal government.