

**Methodological and practical issues in cross-national qualitative research:
Lessons from the literature and a comparative study of the experiences of
people receiving a diagnosis of cancer**

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Keywords: cross-cultural research, cross-national research, comparative study, cancer diagnosis, qualitative research

3rd July 2017

Abstract

Social science and health services research have much to gain from cross-national qualitative research, yet the logistics involved in setting up such studies, especially where different languages and health systems are involved, can seem daunting. In this article we highlight issues to consider and suggest some solutions, drawing both on the literature and examples from our own cross-national research. We highlight the issues involved with synchronising staffing and funding, ensuring comparable methods, project management and communication between research groups, the consequences of the different criteria for ethical approval for recruitment, the challenge of working with multiple languages, with teams involving different disciplines and skill sets, and coordinating and timing data collection and analysis.

The aim of this article is to draw on the literature, which includes several useful insights, as well as reflections from our own cross-national research, to highlight considerations for cross-national qualitative research teams. Our approach is to highlight and discuss potential challenges and suggest potential solutions, using the format of an illustrated literature review.

Background

Cross-national research can add to our understanding of health and illness, and can contribute insights to health services research, policy and practice. Yet the field of cross-national comparative research has been dominated by large scale quantitative studies (eg: Berrino et al., 2007; Coleman et al. 2011; Walters et al., 2013). Qualitative studies, which usually stand alone, are also sometimes designed to complement quantitative studies, ‘revealing local contexts, explanations, interpretations, unique aspects and cultural nuances’ (Gomez & Kuronen, 2011, p. 694). Any cross-cultural research, especially when cross-national, introduces complexities alongside the benefits, for example, translating questionnaires can be a challenge (McGreevy, Orrevall, Belqaid & Bernhardson, 2014). *Qualitative* research is crucially important for the reasons given above, but is typically more reliant on the individual qualities of the field researcher, qualities that are impossible to standardise. This raises issues for any team based research requiring division of labour and multiple field workers; these issues are amplified when the research is being conducted across countries and in different languages. Some of these challenges have been discussed elsewhere (eg; Mangen, 1999; Treloar & Graham, 2003; Haak, Himmelsbach, Graqnabom & Lofqvist, 2013). We add to this literature, by highlighting the particular challenges we encountered when doing cross-national research and explaining how we dealt with these challenges.

Sources of data

When writing this article we used two main sources of data. Firstly we drew on the experience of a recent study, in which both (English) authors were involved, comparing the narratives of patients with lung and bowel cancer within and across three countries, England, Denmark and Sweden. This study, which for brevity we shall refer to as ‘the comparative cancer diagnosis experience study’ (the CCDE study) was initiated by UK health policy makers who initially brought together qualitative cancer researchers from four (one later had to drop out) European countries, chosen because the health systems, and cancer survival rates, differed in ways that were not easy to understand from the epidemiological data. Qualitative research was proposed to shed light on these differences through analysing patients’ accounts of how they came to realise a problem and their experiences of seeking healthcare. Retrospective epidemiological data show that survival rates for these cancers in England and Denmark were poorer than in many European countries with similar expenditure on health (Berrino et al., 2007, Coleman et al., 2011), partly due to differences in stage at diagnosis (Walters et al., 2013). Our study aimed to use patients’ accounts to extend understanding of potentially modifiable factors known to influence long-term cancer survival, including late presentation, delayed diagnosis and referral into specialist care. Teams of researchers from England, Denmark and Sweden conducted narrative interviews with recently diagnosed patients in the three countries. Before each interview informed consent was obtained. We sampled for diversity and aimed for maximum variation. Analysis was conducted within and between country data sets to identify when and why variations in routes to diagnosis occur. The study findings will be used to highlight opportunities for pathway and service redesign and promote early identification and diagnosis. When writing this article we used our own observations made during the CCDE study, and clarifications and comment from other members of all three teams (collected by email and informal conversations). We

were both involved in the CCDE study from the beginning, preparing the proposal, designing the study and as co-investigators.

Our second main source of data was a review of the literature, carried out between 2013 and 2017. When writing the research proposal in 2013 the first author, Alison Chapple, looked at reports of other cross-national research to see how other teams had conducted their analysis. Later, with the help of a health information specialist librarian based at our university, we devised a search strategy to identify other studies that reported international qualitative research. In June 2015 our specialist librarian searched Medline and the Web of Science for studies that were conducted after 2005, which called themselves international or cross-cultural qualitative studies, and which were written in English. The search terms included cross-cultural comparison, internationality, international cooperation, Africa, Americas, Asia and Europe, combined with terms such as qualitative, interview, focus groups and grounded theory. In May 2017 the same librarian did another search, this time including the database Cinahl. Search results left us with a total of 1409 records, but when screened to exclude those which were not qualitative studies and not conducted in more than one country we were left with 249 records. Of these, 189 were reports of the results of various studies, and 60 were specifically about methods. When writing this article we included references to some of the articles from these searches, and references to some additional studies which were cited in these articles. We chose to include studies which we thought might be the most helpful to other teams setting out to do a cross-national study.

Lessons from the literature and the comparative cancer diagnosis experience study

Funding the study

International collaborators sometimes attempt to conduct their comparative research without sufficient funds. For example, a study of obesity in five countries, was done ‘on a shoestring’, which led to difficulties, including a lack of resources for face-to-face meetings of the research team (Treloar & Graham, 2003, p.926). Our experience suggests that, especially for the start-up, analysis and writing stages of a comparative qualitative study, face-to-face meetings are vital. We have also found them to be an efficient way to combine understanding from three data sets without the necessity of translating all the interview data into a common language (see below).

A potential barrier to international collaboration is the risk that a proposed joint project will be approved and funded in one country but not in another (Research Councils UK – <http://www.rcuk.ac.uk/international/funding/collaboration/>). Originally four countries were involved in the CCDE study: England, Denmark, Sweden and the Netherlands. The plan was for each country to obtain their own funds to do the research in their own country. Members of the English team obtained funding from NAEDI (National Awareness and Early Diagnosis Initiative) <http://www.naedi.org.uk> for the English section of the research. The teams in Denmark and Sweden also managed to raise additional funding to employ research staff to conduct the interviews, but needed funding for the local research costs (travel, transcription etc) as well as additional costs for the collaboration, for example to attend face-to-face analysis workshops. The English team reapplied to NAEDI for extra funds to support the research and collaboration costs for the European collaborators. By this time the team in the

Netherlands had had to pull out of the project because a key player had moved on. The post-doctoral researcher who would have led the proposal in England was no longer within the time frame for post-doctoral funding, and had also moved to another job.

Understanding the context

Haak et al. (2013) point out that when doing cross-national research it is important that the researchers in the different countries understand the context in which the research is taking place. Haak et al.'s study aimed to understand the meaning and the experience of the home environment in four European countries. Early in their project occupational therapists from Sweden, Latvia, Germany and the UK created country specific reports, which included information on legislation, policy and other relevant structural issues, so that team members could gain 'contextual sensitivity' (Haak et al. 2013, p.334).

It is also possible that interviewers from different countries may have different views about what sort of probing is appropriate, although the extent to which this may affect the data is unclear. Redmond and colleagues (2003) set out to examine the experiences of young migrants who move across the European Union. The research teams were based in Greece, Portugal, Sweden and the UK. Research partners based in Greece, Portugal and the UK thought that it was appropriate to ask the question "*Why*", if they didn't fully understand a response, but the Swedish partners thought that in Sweden the question "*Why*" might not appear a neutral form of enquiry, and that the question often risks being seen as impolite. The Swedish researchers thought that the interviewers should seek clarity by saying either "*What are the reasons for this*" or "*Tell me more*" which was a better fit with local cultural norms.

During the first month of the CCDE study, members of the full research teams (co-applicants and field researchers) from Sweden, Denmark and England met in Oxford, England. The agenda included presentations on ‘recent political and health system developments and new research relevant to the project in each country’. This helped to attune the wider research group to differences between the three countries. For example, in England, guidelines stipulate that a patient consulting their general practitioner (GP) with symptoms that might relate to cancer should be referred to a specialist clinic within two weeks, while in Denmark and Sweden the timeframe for an urgent referral is less precise. The Danish guidelines are more open to interpretation and negotiation than the UK National Institute for Health and Care Excellence (NICE) guidelines. In England and Sweden patients can self-refer to accident and emergency services (A&E) but in Denmark they have to be referred by the GP; in England the initial colonoscopy findings are often discussed immediately after the procedure, while in Sweden and Denmark they are most often presented at a follow up appointment; only England has colorectal and lung cancer nurse specialists as central figures routinely coordinating patient care. Each subsequent face-to-face meeting for analysis and writing has also included an update on any changes in national context, including cancer awareness campaigns, media stories about local celebrities with cancer and national level policy documents and publications.

In the CCDE study data analysis has largely been focussed on considering differences in policy and practice, thus this has been a topic of discussion at all of the face-to-face analysis meetings (see Analysis, below). While the initial briefing on context was useful, many more variations in practice and patients’ experience have only emerged during the face-to-face analysis workshops when the researchers presented ‘cases’ to each other and discussed the extent to which the stories were recognisable in the other two country contexts.

Designing the interview topic and prompts guide

Designing a topic guide for qualitative cross-national research is challenging because researchers in all the countries involved need to agree on terminology and key concepts of interest (Quilgars et al., 2009; Bogaert, Bochenek, Prokop & Pilc, 2015). Gomez and Kuronen (2011 p.692), for example, when discussing cross-national research projects point out that the terms such as 'family', 'lone parent' and 'single mother' may mean different things in different cultures. They note that when they did their research the term 'lone parent' in Finland was a socially and culturally a less negatively loaded expression than the term 'single mother' in the UK. Others have noted that the concept of 'childhood' varies between countries (Redmond, 2003), and terms such as 'depression' or 'community' may be interpreted differently by different ethnic groups (Kokanovik et al., 2009; Shklarov, 2007). In the CCDE study early discussions highlighted that in Danish there is no word for 'colorectal cancer'. After some discussion it was agreed that 'bowel cancer', a less clinical term, could be translated in all three countries. The Swedish team also said that they struggled a little to formulate a couple of questions that were on our interview guide in everyday language. One question was concerned with how it felt to have the problem (signs and symptoms), what the sensation was like and what this meant to the patient at the time. The other question was concerned with what patients had researched or found out and how this might have changed attitudes to diagnosis and towards health more generally.

When interviews are intended to be relatively unstructured, for example to encourage narratives, there is a danger that this flexibility may leave the researchers unsure what to make of apparent differences in what people choose to talk about. In the CCDE study interviews started with an invitation for the participant to tell their story in their own words in

as much detail as they wished. This narrative part of the interview was followed by a semi-structured section, using questions from a topic guide, based on the literature, to ensure that all important topics related to potentially modifiable aspects of presentation and diagnosis were covered. The team agreed that the topic guides in each country needed to be similar in that the *meaning* of each question would be the same, even if not a literal translation. To facilitate this understanding a table was prepared with a detailed explanation and citations for each of the sections of the interview guide so that all three teams could develop a shared understanding of the reasons behind the questions. This was discussed in detail by the field researchers from all three countries during a series of phone conferences in the months before data collection began.

Ethics and Recruitment

As a comparative study it was essential that the interview methods, and the timing for data collection, were as similar as possible. If one country finished their data collection before the others there was a danger that any mid study changes to service organisation, or increased awareness of the conditions due to media reports, might jeopardise the comparisons between the data sets.

Data protection laws and ideas about what is ethically acceptable, may differ between the countries and affect recruitment. In January 2012, the European Commission proposed a comprehensive reform of data protection rules in the European Union. While the [Regulation](#) has been active since May 2016, it will only apply from May 2018. Thus even within Europe, at the time the research was conducted (2014-2015), there were different laws and different ideas about what is ethically acceptable. Universities or hospitals may also have their own research governance procedures including Institutional Review Boards (IRBs)

which also have to be consulted and which may affect the studies. Graffigna, Bosio, and Olson (2010, p 342) make this point clearly when they argue that:

The influence of IRB panels' decisions on study findings may be particularly pronounced in qualitative studies in which the data are collected in more than one country or where the project needs to be evaluated by two or more IRB panels that, due to different values, may have different ethical requirements.

Graffigna et al. (2010) believe that ethics assessment procedures affected their project, particularly recruitment and sampling. Their study aimed to explore how young people in Italy and Canada perceived the risk of HIV/AIDS and how they construct its meaning. The Italian members of the research team were based in the faculty of psychology, while the Canadian members of the team were based in the faculty of nursing. In Italy formal ethics review was not required. The study followed the ethics requirement for *social* sciences. Many decisions were left to the individual researcher's judgement. The researchers needed to obtain permission from their own university and from the universities where they planned to collect their data. The researchers did not have any particular limitations as to recruitment strategies or the format of the consent forms. In Canada the study was reviewed by a *health* sciences ethics board, which was more prescriptive, and did not allow some recruiting techniques, such as recruiting participants from the university campus by asking students if they were willing to take part in the research, as happened in the Italian part of the study. In Canada, the ethics board felt that people might feel coerced into taking part if approached directly, so participants were recruited mostly through posters and leaflets. Graffigna et al (2010), concluded that different ethical requirements led to differences in study design and recruitment in the two countries, which may have had an important influence on results. Canadian participants, for example, who had to respond to posters around the campus, had a more personal interest and knew more about HIV/AIDS than students recruited in Italy.

Seymour, Rietjens, Brown et al. (2011), who explored decision-making surrounding the application of continuous sedation until death in clinical practice in Belgium, the Netherlands and the UK, also believe that their study might have been adversely affected by the 'myriad of individual requirements imposed by different institutional review bodies'. In England, for example, the team had to have NHS research ethics committee approval, and they also had to gain 'research governance' approval from the organisations (hospital or expert palliative care sites) within which each study site was located. Seymour et al. (2011 p.7) report that they had to make 'significant adjustments to the study design (especially in terms of ways of accessing the deceased patients' clinical records) to comply with the strict yet somewhat different demands imposed by ethical and governance review committees in the three national contexts.' The authors note that researchers who were part of the clinical teams responsible for providing care to patients included in the study found it easier to access patients' records than those not connected with the clinical teams.

The CCDE study was also affected by different ethical requirements. Approvals for research ethics and governance were obtained separately according to the requirements in each country. The English team obtained ethics approval from the National Research Ethics Service, registered number 14/NS/1035. The original plan was to interview 30 patients with lung cancer and 30 patients with bowel cancer (within 6 months of diagnosis) in each country. Members of all the research teams agreed that, due both to salience and recall, participants' accounts might differ the longer they were from first becoming aware of symptoms. It was agreed that teams would try to collect data from patients at a similar stage, ideally around 3 months and with a maximum of 6 months since diagnosis. In all three countries almost all of the interviews took place in people's homes and were always

conducted by people with no involvement in the patient's care. Recruitment at such an early point was not easy, especially when relying on clinical gatekeepers. In England average time from diagnosis to interview was 20.5 weeks (range 5 to 39), while in Sweden it was just 11 weeks (range 2 to 35). In Denmark the average time between diagnosis and interview was 14 weeks (range 3 to 31) for bowel cancer and only 9 weeks (range 2 to 29) for lung cancer.

These differences were in part related to regulations about recruitment approaches. The Danish team had to inform the Danish Data Protection Agency but did not need permission from their local ethics committee. The Agency advised them how to generate data and store data in regard to the Danish jurisdiction on personal data processing. Nurses were allowed to hand out study information sheets to their patients. If the patients were interested in taking part in the study the nurses would note down the patients' names and telephone numbers. Afterwards the nurses were allowed to pass these details on to the researchers, who then called the patients to elaborate on the study. In most cases appointments for interviews were made at that stage. Thus the Danish researchers could contact patients themselves. They did not have to wait until the patients contacted them.

In Sweden ethics approval was obtained from the Regional Ethics Board, Lund, Sweden, registered number 2014/819. Partly due to a 1000 kilometer distance between the north and south of the country, in Sweden three nurse researchers conducted interviews for the study, based in three institutions in three different regions, with different healthcare policies. Ethics approval was needed, but like Denmark, a contact nurse was allowed to pass on details of suitable patients directly to the researchers. Some contact nurses asked the patients if they would like to take part, while others identified potential participants and gave their names and addresses to the researchers, who then sent a letter and information to the patient's home

address. The researcher worked closely with the contact nurses making it possible to choose whom to contact to assist purposeful sampling. Patients had the option to send back a slip saying they did not want to be contacted again, otherwise after two weeks the researchers could phone them to ask if they wanted to take part. The nurse researchers attended staff meetings in the hospital, and worked closely with clinical staff.

Initially the wider team thought that England might be at some advantage in regard to recruitment because of the presence of national 'clinical research networks' which are intended to streamline recruitment for studies that have been peer reviewed and funded by the major funding bodies.¹ However the researchers found themselves in an awkward loop with hospital research and development (R&D) departments who were often unable to supply the names of contacts within the Trust to help with the recruitment, even though the names of these contacts were required for the (national) NHS ethics application. At several hospitals, even after R&D approval, the researcher had to 'cold call' clinical staff to introduce the study and ask for help with recruitment. Since this was usually the first the staff had heard of the study they were understandably reluctant to prioritise recruitment. Staff spent more time checking whether the team really had R&D approval, even when the researcher had provided all the necessary R&D approved documentation and letters. They also explained that their workload and targets had been agreed without reference to the study and without having recruitment time allocated, so it was difficult to help.

Once the local clinical staff agreed to participate, the English researcher had to rely on them to give out information packs to suitable patients and if the patient wanted to participate he or she had to post a reply slip in a reply paid envelope. The researcher could only contact patients if they contacted him first. In England recruitment was therefore more difficult, as

unlike in Denmark and Sweden the field researcher was not allowed to directly follow-up patients who had been approached. Clinical staff also said that they were concerned about if and how they should approach someone who was upset about their diagnosis and suggested that it might have been easier for them to recruit patients 12 months after diagnosis.

Project management and Communication between the country teams

Treloar and Graham (2003 p.932) point out that when conducting cross-national, multi-centre studies it is important to appoint a project manager who can ‘respond to each centre’s unique needs or concerns while keeping the study structure relatively consistent across all sites’. In the CCDE study an operations manager, based in the English team, had a part-time (20%) role throughout the study. She was involved in start-up negotiations between the partner countries/institutions and legal and financial representatives of the lead institution. This process required tact and diplomacy to navigate between rigid institutional processes and the expectations of the collaborators at a point in time when the team relationships were new. The operations manager was the first point of contact for the collaborators, and worked closely alongside the principal investigator (PI) to ensure that timelines were met, that interim reports to the funders were prepared, that authorship statements were clarified and agreed by all parties. She also monitored the budget, and organised the face-to-face meetings including travel and accommodation, venue and catering. She also helped the English team to coordinate the patient and public involvement (PPI) and expert advisory panel input.

International teams need to find an appropriate balance between face-to-face and remote communication, via email, teleconferencing and video conferencing. They also need to carefully consider the implications for the study communication, data collection and analysis

if all members of the team do not have fluency in a shared language. A shared language is important for full participation in research and analysis meetings. In the CCDE study all of the team had fluent, or near-fluent, English. However, a member of the Swedish team said that it was still sometimes hard to find the right words to express herself spontaneously during meetings. Another said that it was difficult to communicate well on teleconferences without seeing faces, expressions and body language. One of the Swedish team also spoke Danish, but none of the English team spoke either Danish or Swedish.

Interviews were almost all conducted in the participant's own language, recorded and transcribed verbatim.² Interviews were not conducted in any languages other than English, Danish or Swedish. Research designs that require interviews with (recent) migrants would need researchers who were also bi-lingual with those languages, introducing another level of complexity to the work (Kokanovic et al., 2009; Almalik, Kiger & Tucker, 2010; Bjork Bramberg & Dahlberg, 2013).

In the CCDE study face-to-face meetings were held at the start of the project, after a few months and then twice with all the researchers, and most of the co-applicants, for analysis and writing workshops. During the latter stage of the study researchers also visited the other countries for a few days intensive writing. From the start of the project the field researchers from each country held monthly teleconferences to discuss and coordinate the interview process and consider early results. Initially a video conference link- frequently used in Denmark and Sweden- was tried but abandoned due to IT infrastructure difficulties in the English university setting. The monthly telephone conference helped the team establish good working relations and also helped iron out some misunderstandings. For example, during an early teleconference the Swedish team said they were concerned that the interviews

done in England seemed more structured than theirs, so an example transcript was shared between the teams to determine that the formats were equivalent. The three Principal Investigators (PIs) did not join all of the regular teleconference but had additional phone conversations to troubleshoot any problems and to plan agenda for the face-to-face meetings.

Cross national teams involving different disciplines and skill sets

Research involving different disciplines and perspectives can be successful and particularly enlightening (eg: Kumpers, Mur, Maarse & van Raak, 2005). However, cross-disciplinary interaction and collaboration can also be difficult, particularly in cross-national studies.

Researchers who are appointed after a project is funded may have ambivalent feelings about the design or even the aim of the project. There may be ‘unspoken tensions’ and ‘lurking resentments’, especially if some collaborators are natural scientists and some are social scientists (Fitzgerald, Littlefield, Knudsen, Tonks & Dietz, 2014, p.707). In an experiment in neuroscientific lie detection, described by Fitzgerald et al (2014, p.713), the neuroscientists in the group were more or less confident that the Magnetic Resonance Imaging scanner could reveal something truthful about brain function while the social scientists in the collaboration thought that this type of imaging was vastly over hyped and that confidence in its procedures was the “product of epistemological naivety” Members of the team wrote that, “even in avowedly transdisciplinary collaborations like ours, some knowledges have to interject and insist on their own usefulness; others have the privilege of taking their universal utility for granted”.

Collaborative qualitative research has its own particular challenges. Qualitative interviews using relatively unstructured methods require considerable flexibility, as well as the ability to interpret and reflect mid-interview, that few can accomplish without considerable training

and practice. In an interview study of the influences on uptake of technologies to minimize blood transfusions in 10 countries, two interviewers, who were social scientists, had been trained in qualitative interviewing, but the others, who were mainly medical scientists, had little or no training in interviewing. According to Treloar and Graham (2013 p. 927) the ‘inexperienced interviewers missed opportunities to follow up and probe interesting responses, perhaps in an effort to comply with the interview guide as it was written’. The more experienced researchers probed more fully and incorporated insights into later interviews. Treloar and Graham contend that having interviewers with such different training and experience in the 10 countries made it difficult to compare the data. Another qualitative multi-country research project, which was launched to study the high use of antibiotics in regions of Southeast Europe, used previously untrained local interviewers. The team felt that overall the project worked well but several challenges pertaining to research quality and feasibility were identified. In particular the untrained interviewers found it hard to obtain narratives, so the research design had to be changed. More interviews were done with each interviewee to compensate for lack of depth (Kaae et al. 2016).

The field researchers in the CCDE study came from a variety of backgrounds. The English field researcher is a sociologist, the Danish is an anthropologist and the Swedish field researchers comprised three nurse researchers. They had all conducted interviews before, yet had different levels of experience in analysing qualitative data and were familiar with different literature. During the analysis and writing retreats it became clear that while learning from the international comparisons, working inductively and linking theory were common goals, the theories of interest and the point at which theory entered the analytical process differed somewhat by group. For example, the Swedish group were especially interested in topics of clinical and theoretical interest in nursing, such as fragmentation of

care, and embodiment and symptoms, while the anthropologists and sociologists worked on analyses driven by their own disciplinary theoretical perspectives, including Zola's (1973) work. They drew on Zola's theories about how people experience symptoms such as pain, how specific triggers encourage them to seek medical care, and how people perceive barriers to seeking help. They also considered explanatory models, such as Andersen's healthcare utilization model, which he used to try to explain perceptions of need and use of health services (Anderson, 1995). The team agreed that each field researcher would have the opportunity to lead on the analysis of at least one aspect of the cross country data, and be first author on at least one article resulting from that analysis, and that their colleagues would support this with analytic summaries and illustrative translated extracts when these were requested.

Analysis

Qualitative research using relatively unstructured interviews uses interpretative methods, and traditionally there has been little division of labour. In the experience (and preference) of the authors, those who collect the interviews also usually analyse the transcripts and write articles. There is no single approach to qualitative analysis, for example researchers may use narrative analysis, or one of the many forms of thematic analysis or framework analysis or a mixture of several approaches. Some studies opt to translate the interviews and conduct all the analysis in one country, although this risks imposing a single perspective (often a high income country perspective) on international data (Redmond, 2003, p. 22). Mill, Davison, Richter et al. (2014, p. 165) pointed out that, 'research teams are [now] encouraged to work within research paradigms that favour partnership, equity, and the balancing of power across team members'. They conducted research in Canada and in low and middle income

countries, and they suggest that the drive to include all participating countries in all stages of the research may be a response to colonial or paternalistic structures of the past.

If there is more than one language involved there are other important decisions to make.

Where the analysis is done and who does it clearly affects the timing of the translation, and the stage that data is translated into a common language. Those involved in translation must constantly make decisions about the cultural meaning of certain words. It is often better to produce a *meaning* based translation rather than a word-for-word translation because not all expressions, metaphors, figures of speech, irony and so on can be easily translated (Mangen, 1999). Choi and colleagues write that Korean people are particularly likely to use metaphors, which makes word for word translation of interview transcripts inappropriate (Choi, Eastlick Kushner, Mill & Lai, 2012).

Translation may take place at various stages in a project (see Hudson, Santos, Black & Sandelowski, 2015). Hudson et al, (2015 p.142) compared two studies, one which introduced translation at a late stage, after the first draft of an article prepared for publication, and one that introduced translation early, as soon as interviews had been conducted. If translation is done early all those involved in the project can take part in every stage of the analysis. Hudson et al. believe that early stage translation ‘allows a more interactive process of data analysis among researchers and translators and minimizes the limitations associated with a lack of access to the entire data set for those researchers who do not speak the language used in the data collection’. However, translating all the interview data into one language is expensive and time consuming and could be unnecessary.

Researchers sometimes translate material late in the project, opting to remain in the native language as long as possible. In this case initial analysis is conducted by each country team. Woolhead et al. (2006) for example, who conducted a European study of dignity and communication with older people in health and social care settings, took this approach. All analysis was undertaken in the language of the individual country and then a report detailing the themes and codes arising from the analysis was written and translated into English. Quotations from the country reports were then combined without country identifiers, to give an overall sense of the findings. Then the quotations were rearranged into country specific quotations and the data were compared. Knutsen et al. (2015, p.3), who conducted a cross-national study of the experiences of managing type 2 diabetes in five European countries, also chose a similar approach. Members of the research group from each country analysed the transcripts from their own country, and then a sub-set of three countries (Norway, UK and Bulgaria) who had an interest and experience in qualitative analysis, met for a data workshop. After much discussion these three teams wrote a guideline to explain the procedure for further analysis, with illustrative examples of two Norwegian interviews as a template. Then the research teams in all the five countries developed case summaries of all the interviews in English. They also chose quotes to illustrate certain key themes or what the authors call 'properties', to illustrate how, for example, diet changes may lead to disruptions in daily life, and translated them into English. The teams used professional translators and conducted back and forth translations. Sixsmith et al. (2014) also translated data at a fairly late stage in their study of the perspectives of very old people in five European countries. Each team coded their own transcripts and identified key themes. Members of the entire group then convened a workshop to discuss 'overarching cross national themes', and discussed results.

In the CCDE study the researchers in each country-specific team coded and analysed their own data, using an agreed coding frame that was discussed and developed in the monthly telephone conferences. Emerging themes for analysis were identified before and during the workshops. NVivo software was used to help organise the categories. Although our distributed *analytic* approach did not require all of the data to be translated, this was needed for extracts for the English language co-publications. Funds were provided from the UK grant to pay for professional translation for publications, although in practice much of the translation was conducted by the bi-lingual Swedish and Danish researchers, with consequences for their time.

After data collection was complete the field researchers and most of the co-applicants met in Denmark, for a two day workshop to discuss anticipated theory-driven and emerging themes. The three country leads had agreed an agenda for the meeting and proposed that before the meeting each team should send ideas for two potential articles. The research teams had a productive discussion about how they might write up the findings and which member of the research group would take initial responsibility for drafting each of the articles. The meeting started with a presentation of individual patient interviews selected by the researchers to illustrate two routes to a bowel cancer diagnosis in their country - one complex and one straightforward – which were used to illustrate the different pathways to diagnosis between the three countries. This was a productive exercise which highlighted factors that were taken for granted in one country yet unfamiliar in the others. For example, the relative responsiveness of the system in Sweden, differences in conceptualisation of the ‘good patient’ between the three countries, and the fact that in Denmark patients cannot just walk in from the street to the emergency department, which is instead accessed through a GP. The

research teams also had to reflect on the nature of the patients' answers. For example, is the doctor equally busy when Danes and UK patients talk about 'the busy doctor'?

Four months later the team members met again for a four day analysis and writing retreat, this time in Sweden. Team members were asked to send an outline of the 'story' of the article(s) they were drafting before the retreat and then take turns to present the ideas over the first day. The initial plan was to spend much of the rest of the retreat improving on the drafts and comparing findings between countries. We soon realised that progress with analysis and writing had not been identical in every country, reflecting the differences in team composition and organisation, as well as working hours available for this project. The data collection phase had been particularly efficient in Sweden, which was the only country who recruited the intended sample within the determined time frame. In Sweden, with a distributed field team, one researcher collected only bowel cancer interviews, another only lung cancer and the third collected 28 of the interviews, covering both lung and bowel cancer. Each of the three field researchers coded 20 of the Swedish interviews, focusing on those conducted by colleagues to allow them all to be relatively familiar with the larger data set. The Swedish team also met before the workshop to discuss their coding and analysis. Data collection in England and Denmark each involved only one field researcher, who collected and coded all of the interviews, before discussing emerging findings with their local colleagues. When it came to analysing the interviews, and discussing the data at the cross-country workshops, the teams were therefore at different stages in the analysis process. Teams with a single researcher were at a relative advantage, with one researcher who was familiar with all of the data for that country. When we met for the analysis and writing workshop the English and Danish teams, who had a less distributed models of working, were able to use the retreat to present the wider group the ideas they were developing to address

particular gaps in the literature, request specific examples and responses from the other two teams, and work on drafting the articles they were leading. This discrepancy between the teams meant that the more developed ideas (led by Denmark and England) assumed greater prominence in the team discussions at the expense of more tentative proposals from the team who were working with a distributed team model.

It is also more difficult for the field researchers whose first language is not English to contribute ideas at points when the international workshop discussions moved fast (echoing the point made earlier about phone conferences). Sharing written versions was therefore an important way to avoid dominance from the native English speakers. At the time of writing there are plans for the researchers to visit each other for focussed work on specific articles, in preparation for a conference symposium where the main results will be presented to an academic and clinical audience.

Conclusions

This article has shed more light on the way cross-national qualitative research may be conducted successfully, and the difficulties that researchers may encounter. Reflecting on studies conducted by others elsewhere, and drawing on our own experience, and the experiences of other team members, we discussed the importance of understanding the context when planning and doing the research, the challenges involved in finding funding for large scale studies involving more than one country, and the need to understand how different ethics and data protection laws may affect recruitment in different countries. We also explained how we worked together to design the topic guides, how we made efforts to manage communication when three languages were involved, how we conducted the analysis and how we tried to meet the challenges involved when working with researchers from

different disciplines with various skill sets and different models of team-working. There are advantages and disadvantages to employing multiple researchers in a distributed team; the benefits and efficiencies are mainly felt during data collection (as we have discussed above). The disadvantage of having multiple researchers collecting interviews is that at the analysis stage considerably more time is needed for a distributed team to contribute equally. We encourage colleagues to consider carefully, where the logistics and funding arrangements make this possible, the consequences of single or multiple qualitative researchers, whether full-time or part-time, for their own research. Finally we stressed the importance of having a good project manager. Some of these observations apply to any study but they are particularly pertinent to qualitative cross-national collaborations.

We conclude that when planning a new study much can be learnt from reading accounts of other cross-cultural and international research. If the idea for the study originates in one country it is important that researchers in that country are aware that misunderstandings (including between co-applicants) may occur due to language difficulties, or contested concepts. Kokanovic et al. (2009 p 715) argue that reflexivity is not simply a state of awareness but 'is a matter of constant work to build, negotiate, and sustain the meanings embedded in the study'. Regular contact between research staff with fluency in a shared language is important. A combination of meetings, teleconferences and analysis workshops probably help to establish good working relationships and clarify misunderstandings without stretching the travel budget too far.

There is little doubt of the potential value of cross-national qualitative research. Researchers who are familiar with an issue within one main cultural group open themselves to a stimulating terrain when they compare results across countries (Seymour et al. 2015). Our

own qualitative cross-national study, the CCDE study, shed light on interesting differences in practice in the three countries we studied, and helped us understand delay in diagnosis. We identified differences between Sweden, Denmark and England in patients' understanding of when to re-consult with symptoms that do not resolve. In Sweden there was more clarity due to consistent 'action planning' at the end of the GP consultation. Thus evidence from cross-country studies often shows that things could be otherwise, challenging our assumptions about the rationality and inevitability of our own taken for granted systems and behaviours. Cross-national research takes time, adequate funding, clear and respectful leadership, regular communication, an enthusiasm for co-operation and cross cultural learning and genuine support for career development within the research teams.

Endnotes

1. The NIHR Clinical Research Network (NIHR CRN) Portfolio of studies consists of high-quality clinical research studies that are eligible for consideration for support from the Clinical Research Network in England. The NIHR Clinical Research Network supports researchers in developing, setting up and delivering high quality research to time and target in the NHS in England. The CRN offers a range of services across the research delivery pathway that will help study feasibility, set up and delivery to time and target, through a study support service (see <https://www.crn.nihr.ac.uk/can-help/funders-academics/nihrcrn-portfolio/>)
2. One participant in Sweden was interviewed in English, and one participant in England, who was from Sweden was interviewed in English.

Acknowledgements

We are very grateful to the people who took part in this study, to the study advisory panel, including patient and public representatives, who helped design the study, and to those who helped recruit participants. We should also like to thank our colleagues, who provided clarifications and comment on an earlier draft of this article, Rikke Sand Andersen, Britt-

Marie Bernhardson, Julie Evans, Lars E. Eriksson, Senada Hajdarevic, Louise Locock, John I MacArtney, Marlene Malmström, Trine L Overgaard Nielsen, Birgit H Rasmussen, Carol Tishelman and Peter Vedsted. We should also like to give special thanks to Nia Roberts, a specialist librarian working at the University of Oxford who helped identify other studies reporting cross-national qualitative research.

Funding

This publication presents independent research funded by organisations from 3 European countries as follows:

In the UK, the study was supported by the National Awareness and Early Diagnosis Initiative (NAEDI), <http://www.naedi.org.uk>. The contributing partners include: Cancer Research UK; Department of Health, England; Economic and Social Research Council; Health and Social Care Research and Development Division, Public Health Agency, Northern Ireland; National Institute for Social Care and Health Research, Wales; and the Scottish Government.

In Denmark, the study was supported by the Research Centre for Cancer Diagnosis in Primary Care, Research Unit for General Practice, Aarhus University, funded by The Danish Cancer Society and the Novo Nordic Foundation.

In Sweden, the study was supported by the Vårdal Foundation; the Strategic Research Program in Care Sciences (SFO-V), Umeå University; the Cancer Research Foundation in Northern Sweden; and from government funding of clinical research within the National Health Service, Sweden.

The views expressed in this publication are those of the authors, and not necessarily those of the NAEDI, Danish and Swedish funding partners.

The broader project study group is composed of:

University of Oxford, UK (Sue Ziebland, Julie Evans, Alison Chapple, Louise Locock, John MacArtney, Angela Martin)

Aarhus University, Denmark (Rikke Sand Andersen, Trine Overgaard Nielsen, Peter Vedsted)

Karolinska Institutet, Stockholm, Sweden (Carol Tishelman, Lars E Eriksson, Britt-Marie Bernhardson)

Lunds University, Sweden (Birgit Rasmussen, Marlene Malmstrom)

Umea University, Sweden (Senada Hajdarevic)

Declaration of conflict of interest

The authors declare that there is no conflict of interest.

accepted version

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