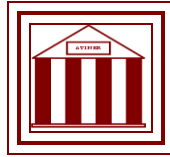


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**Challenges of Qualitative Health  
Services Research in Saudi Arabia**

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## **Challenges of Qualitative Health Services Research in Saudi Arabia**

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### **Abstract**

Saudi Arabia has a distinguished production and documentation of institutional-level quantitative health research that is mostly empirical, however the volume and quality of qualitative research into the health services is poor, especially towards organizational and structural reforms. The quantitative data is derived from mechanistic methodologies and statistical analysis that typically draws our attention away from the ground realities whilst some bureaucratic restrictions also undermine the quality and utility of this evidence.

This paper offers benchmarking insights into challenges of qualitative health research in Saudi Arabia and identifies inherent weaknesses, gaps, and fragmentation in the planning, production, and implementation. We suggests three levels of such challenges: policy, institutional, and individual, whereby establishing the value of quantitative methods in establishing relationships between variables but weak in identifying the reasons for such relationships. First, the need to promote qualitative research in design and assessment of 'policy tools' to bridge inherent gaps in macro-policy and its contextual implementation. Second, qualitative research mainstreaming would allow institutional empowerment and effective implementation. Third, the need for research into individual-level behaviours: from patients' complex mindsets and workplace attitudes of health managers to individual life-styles towards 'diseases of affluence' like obesity and diabetes. Here, the choice of qualitative approaches could help enhance the value of research outcomes.

This multi-dimensional model serves as a comprehensive (re)orientation to KSA health services research leadership – academics, policymakers, planners,

and managers, to help identify gaps in policy, implementation and individual-level behaviours

**Key Words:**

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## **Introduction**

Saudi Arabia has a distinguished production, documentation and publication of institutional-level quantitative medical and health research. Shaban and Abu-Zidan [2003] have reported that from 1987 to 2001, Egypt and Saudi Arabia were the two countries producing the highest number of published biomedical studies in the Arab world. Other studies have also confirmed this ranking [Deleu and Northway, 2001; Hanssens, Tadamouri, and Bissar, 2002; Bakoush *et al*, 2007; and **Benamer and Bakoush, 2009**]. The research that takes place in leading universities, research centers, and medical schools of Saudi Arabia is mostly descriptive; and being primarily empirical it only furnishes raw quantitative data.

In this context, we notice, two substantial gaps in terms of any evidence-based health reforms in Saudi Arabia that need filling up [Al-Borie and Abdullah, 2013]. First, there is a need for research on 'policy tools' that consume the raw data in bridging the inherent institutional gaps for structural reforms, from macro-policy making through to the individual-level life styles. This is important because formulation of effective evidence-based policies demand proper identification and application of such policy tools [Court and Young, 2006]. Second, the volume and quality of qualitative research on healthcare services and institutions is poor, which challenge institutional reforms, and analysis of complex individual-level behaviors, whereby qualitative research is otherwise gaining importance in the fields of both health care [Meyer, 2000] and health services management [Al-Busaidi, 2008]. Currently, researchers are establishing that issues related to the quality of health services can be resolved better by 'qualitative' health services research (Pope, Royen and Baker, 2008). Also there have been attempts to develop a deeper understanding of individual health-related beliefs and behaviors by using qualitative research [Meyer, 2000; Barry *et al*, 2000; Thompson *et al*, 2001; Bush *et al*, 2003, and Nordgren, Asp and Fagerberg, 2007].

In the context of Saudi Arabia, we therefore point towards a need for qualitative methods that must support and enhance the value of quantitative research outcomes. While statistical models indeed have been valuable and continue to be to so in examining relationships between variables, these do not have the depth required for identifying into the reasons for such relationships, or for answering the 'why' questions.

## **Challenges of Qualitative Health Research in Saudi Arabia**

This paper offers benchmarking insights into challenges of qualitative health research in Saudi Arabia and points to inherent weaknesses, gaps, and fragmentation in qualitative research planning and its institutional production. It serves as an orientation to Saudi health research leadership, i.e. the academics, policymakers, planners, and managers, in helping identify gaps in research policy, implementation and analysis of individual-level behaviors. So,

we identify and examine three levels of challenges: policy, institutional, and individual.

### **Policy-level**

#### *Insufficient Evidence*

For health policy and planning almost all the data comes from quantitative surveys, derived from mechanistic methodologies and statistical analysis, which typically draws attention away from the ground realities. Some bureaucratic restrictions also weaken the quality and utility of this data. In general, the organizational culture is also not supportive of utilization of the available evidence in policy making [Omer, 2012]. Health research is included as a strategy within national health plans but without any linkages that it must have in contributing to or resulting from a formal health research policy.

#### *Lack of Qualitative Research*

There is a need to promote the use of qualitative research in design and assessment of 'policy tools' for bridging inherent gaps in macro-policy and its contextual implementation. As a result, health policy making is fragmented, generalized, and not based on evidence from policy research, or data produced from healthcare institutions, i.e. the Health Management Information System (HMIS). The resultant 'patchwork' and overlapping in policy making and policy implementation could easily be avoided by using the qualitative models. Also, there have been no systematic efforts to follow the guidelines of international health agencies to incorporate research results into policy decision-making within the health sector (WHO, 2008).

### **Institutional-level**

In Saudi Arabia there appears no data in support of how and how much research evidence that is produced at the institutional levels (such as the hospitals and health centers) is used for policy making and planning. In the contemporary era, as the setting up of health priorities must be evidence-based, any serious agenda for health reforms must face the questions of what, where and how to get the evidence from?

Since implementation is a major problem of Saudi health policy and planning, there is a need to empirically examine at the tactical/institutional level how complex policy initiatives could not be implemented within a range of local health contexts. There is a need to explore how such an implementation is intended to operate and how any observed effects and outcomes of institutional research actually disseminates within the broader policy, managerial and academic communities.



When and if the two above points met, an institutional mainstreaming of qualitative health research would allow for institutional empowerment and effective implementation. For instance, for producing a cost-efficient and effective insurance policy, we are not sure of the availability, accuracy, and authenticity of demographic data on the entire KSA. So, there is the need for improving the existing HMIS for better health planning regarding all its stages: situation analysis, options appraisal, priority setting, project and program design, implementation, monitoring, and evaluation. The challenge is that the institution, which is a tactical level, appears to miss a decision-making mandate.

The Saudi health research institutions are apt in initiating disease/target-group based interventions. In recent years, the disease-targeted interventions are evident in the research surveys of a generation of Saudi public health practitioners. Still, there is a growing need to have qualitative assessments of the emerging public health concerns and we have called the 'new public health' paradigms [Al-Borie and Abdullah, 2013].

There is a rise in chronic diseases like diabetes and obesity, hypertension, mental illness, and coronary heart disease in Saudi Arabia. The WHO [2009] ranks Saudi Arabia as third in the world for prevalence of both diabetes (16.7%) and obesity (43.8%). Communities-based qualitative studies in prevention and education related to these diseases may have produced better outcomes. In this regard, the public health policy needs periodic 'qualitative' revisions, to be based not only on the evidence of disease patterns, but introduction of qualitative research approaches to disease prevention, healthy life-styles, and viable health promotion campaigns.

### **Individual-level**

General population, patients and healthcare professionals may have complex beliefs that cannot be easily confined in a questionnaire. Therefore, qualitative or mixed-method approaches can enhance the findings of a quantitative study. For the need of any research into individual-level behaviors; from patients' complex mindsets and professionals' workplace attitudes to individual and communities life-styles towards 'diseases of affluence' like obesity and diabetes, it would be the choice of qualitative approaches in parallel support in helping to enhance the value of research outcomes.

We now take examples of four leading public health issues in Saudi Arabia, i.e. obesity, diabetes, smoking, mental health, and road-traffic accidents, to focus on the relevance of qualitative research interventions into these:

#### *Obesity*

Over the last two decades, obesity has been on the rise in Saudi Arabia. Its prevalence ranges from 14% in children less than 6 years to about 83% in adults [Madani, 2010]. Obesity is a well-defined public health issue that also

produces other risk factors, like the coronary heart disease and diabetes. It is estimated that 20,000 Saudis lose their lives annually due to complications of obesity [NGHA, 2011].

While there is enough data on obesity's prevalence and patterns, its effective control program can only emerge if we have a deeper understanding of prevailing eating behavior and sedentary life-style among Saudis in general, but especially the youth. That may only be possible through qualitative studies, bringing along ethnographic, behavioral, and case-study approaches, among others. Contrary to this, we hardly find any qualitative research studies that address to this issue or fill in the evidence gaps for effective policy making and planning.

### *Smoking*

Smoking and related diseases are also on a rise in Saudi Arabia. We find loads of studies on prevalence of smoking. According to a review by Bassiony [2009], prevalence of smoking is from 2.4%-52.3% (median 17.5%). Quantitative research reports smoking in schools, universities and different healthcare facilities and highly common among medical students (Taha *et al*, 2010). However, when it comes to understanding a range of multi-disciplinary constructs of this risk behavior among the Saudis, there are hardly any in-depth studies available.

### *Mental Health Issues*

Mental health disorders like anxiety, depression, and stress among Saudis, even among youth is on the rise. A study indicated that 59.4% of secondary school boys had at least one of the three disorders, 40.7% had at least two and 22.6% had all the three disorders (Al-Gelban, 2007). We have no idea of the in-depth reasons for these illnesses and that again requires an examination through social research methodologies.

### *Road-Traffic Accidents*

The morbidity and mortality due to road-traffic accidents is also on a constant increase since the 1970s. The WHO reports Saudi Arabia to have the world's highest number of road-traffic deaths and principal cause of death in adult males aged 16 to 36 (WHO, 2009). It is also estimated that 6,485 deaths and more than 36,000 injuries in over 485,000 traffic accidents have occurred during 2008 and 2009 only. Risk behavior among young drivers has been an emerging reason for this situation. Again, there is little knowledge to unfold the complexities of this potentially fatal risk behavior in this age-group. There is also a dire need to emphasize and investigate the reasons 'why' young Saudi males take fatal risks, a phenomenon that is not so common or as serious in the rest of the Arab world.

## Recommendations

We suggest multiple-evidence sources for health research reforms in Saudi Arabia. While quantitative models should suit biomedical and epidemiological research to understand the nature of diseases and their prevention and treatment, qualitative research should be encouraged to examine health policy and systems, policy formulation and priority setting, management efficiency and effectiveness, monitoring, and evaluation, as well as socio-cultural and political-economic aspects of human and group behavior.

Similarly, social science and behavioral research is essential for examining social and behavioral determinants and influences on health and its relationship to equity, access, quality, life-styles and health-seeking behavior. This challenge must be taken up as a priority in Saudi Arabia. Operational-level research into the three tiers of healthcare institutions vis-à-vis performance and program effectiveness must be examined for producing holistic and systemic reforms.

## Conclusion

This paper serves an orientation to Saudi health services research leadership to help identify gaps in policy, institutional and individual behaviors. While quantitative models do help, especially at operational level, in Saudi Arabia these tend to draw our attention away from the ground realities, leading us to a paradox of *not seeing the forest for the trees*.

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