PERCEPTIONS AND EXPERIENCES OF QUALITATIVE DATA USE IN HUMANITARIAN CONTEXTS: A CASE STUDY OF MÉDECINS SANS FRONTIÈRES (DOCTORS WITHOUT BORDERS)

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Perceptions and experiences of qualitative data use in humanitarian contexts; a case study of Médecins sans Frontières (doctors without borders)

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by

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Declaration:

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The thesis 'Perceptions and experiences of qualitative data use in humanitarian contexts; a case study of Médecins sans Frontières (doctors without borders)' is my own work.

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Table of content

Abstract	3
Abbreviations	4
Introduction	5
Background	5-8
Problem statement and justification	8
Study questions	8
Aims and objectives	8
Methods	8-12
Results	12-18
Discussion	18-23
Conclusion and recommendations	23
Acknowledgements	24
References	25-26
Appendices	27-39

Abstract

Literature shows that qualitative data can be useful in complex health emergencies, however it is not often used. Médecins Sans Frontières (MSF) is a big player in this field and has a mission to apply a more 'people-centred approach' in their mission.

Aims: Map the perceptions in MSF on qualitative data use in humanitarian settings and identify the barriers, enablers and needs to develop recommendations to increase qualitative data use in complex health emergencies in MSF.

Methods: Rapid qualitative appraisal design, all data obtained from semi structured interviews and observations were summarised in a RREAL sheet and analysed using a framework analysis approach.

Results:
Qualitative data are seen as subjective and descriptive and are used for needs assessments, evaluations and understanding the context of the community, however most participants had limited qualitative experience and knowledge. The main barriers described: lack of time, skills, knowledge and understanding the value. Main enabler described: the global/ MSF trend towards qualitative data with 'the people centred approach'. There was a need for training of MSF workers and a need to change the top to more value the qualitative approach.

Conclusion and recommendation: MSF workers perceive the use qualitative data in humanitarian settings as more subjective. They found these data useful, however, there is a limited use, knowledge and skills in the organisation. I recommend setting up a training on how to do rapid qualitative assessments and set up an intersectional workgroup to support MSF workers from the top in their work on qualitative assessments.

Key words: qualitative data use; humanitarian context; complex health emergencies; Médecins Sans Frontières (MSF)

Word count: 9807

Abbreviations

ICRC International Committee of the Red Cross

IFRC International Federation of Red Cross and Red Crescent Societies

MSF Médecins Sans Frontières

OCBA operational centre Barcelona Athens

OCA operational centre Amsterdam

OCB operational centre Brussels

OCG operational centre Geneva

OCP operational centre Paris

Introduction

As a medical doctor I have always been interested in the opinions of patients on their situation and disease. I believe it is a very important factor in their recovery and the way they cope with and handle their disease. The motivation to treat my patients and ask what they need, is the same which motivated me to contribute to this study. As a student in medical school, I experienced that there was a lot of focus on asking our patients how they feel about their disease, however, from an academic perspective there is little attention paid to qualitative data and qualitative studies in healthcare. In my experience, the medical doctor degree is academically driven by quantitative data, which is for a good reason since the numbers give us insightful information about different diseases. However, there is a gap in explaining the 'how' and 'why' in health problems. The needs of patients and their reasons for health decisions are not often studied in our health system. I have seen this also in the global health sector. After I specialised in tropical medicine, I worked for a couple of years in a rural hospital in Tanzania. I worked in a close community of Tanzanian doctors and nurses and saw many NGOs and humanitarian workers coming to our village to help and build capacity on various aspects. Not all expats took notice of the local context and asked the community what they needed to improve the quality of their healthcare in the place where I worked.
This study explored the perception of MSF (Médecins Sans Frontières) staff on the use of qualitative data in their projects. In addition, it explored how we could build capacity on the use of qualitative data in complex health emergencies. I feel there are many missed opportunities for qualitative data use within MSF, since the majority of MSF staff has a medical background and is not trained to collect and use qualitative data. As a tropical doctor, I have I have known about MSF for a long time, and I admire their work in the field. I have many colleagues and friends who work for this organisation, which interested me to work with them. When I started working with the research team RREAL, which stands for Rapid Research Evaluation and Appraisal Lab, I was introduced to the world of rapid qualitative research, which opened my eyes to how these techniques can be used in the fast world of medicine and humanitarian aid. There was a project with MSF to build capacity of qualitative data use in MSF through the use of a training program. I am very passionate to be part of the setup of this training, which gives me the motivation and personal objective for this study: When someone advocates for community engagement and qualitative data use, they should incorporate this into their own work. Hence, I developed, together with RREAL and MSF, this study to ask what MSF workers (the MSF community) think about and need for capacity building on qualitative data use. Do they think it is useful? And *how* would *they* make this happen?

Background

Humanitarian organisations

Humanitarian organisations have become more important in contributing in challenging public policies, concerns with human rights and complex health emergencies in the last decades [1]. They are, together with the United Nations, the big actors in responses to complex health emergencies. In these responses, humanitarian organisations normally concentrate their work on food distribution, shelter, water, sanitation and medical care [2]. They have several different characteristics compared to their private and public sector counterpart organisations; they do not use governmental or economic power, they often make use of volunteers and use their norms and core values to motivate their staff instead of using remuneration [1,3]. These core values are based on the 'humanitarian principles' outlined in the International Committee of the Red Cross Code of Conduct in 1994 [4]. In this code of conduct, the below principles are seen as the most important [3-5]:

- *Impartiality* describes that everyone should have access to aid based on their need, irrespective of nationality, race, political affiliation, religion, etc.
- *Independence* means that activities of humanitarian organisations should act independently of governments.
- *Neutrality* means that humanitarian organisations should not take sides in conflict situations.
- *Accountability* refers to the responsibility of their actions to the donors and beneficiaries as well as to those who need assistance during disasters.

The essential motivation of humanitarian organisations is the principle of humanity, which was described by the International Federation of Red Cross and Red Crescent Societies (IFRC) as 'the desire to prevent and alleviate human suffering wherever it may be found ... to protect life and health and to ensure respect for the human being' (IFRC 2001) [6].

MSF

Médecins Sans Frontières (MSF), also known as Doctors without Borders, is one of the important players in the humanitarian sector for responses to complex health emergencies. MSF was founded in 1971 in Paris by a small group of journalists and doctors who split off from the organisation ICRC, because they disagreed with the silence which came with humanitarian principle 'neutrality'. Currently, it is the second biggest non-governmental organisation in the world with 24 national and 18 branch offices, an annual budget of 1685 million euros in 2019, and nearly 65,000 people involved in the organisation [5,7]. It has 5 operational centres (OC) who directly manage the different humanitarian actions in the field. They decide when, where and what medical care is needed [7]. The different operational centres are:

- Amsterdam (OCA)
- Barcelona Athens (OCBA)
- Brussels (OCB)
- Geneva (OCG)
- Paris (OCP)

MSF specifies the values of the organisation in 5 working principles, which partly overlap with the core humanitarian principles from the code of conduct 1994 [7]:

- Impartiality
- Independence
- Neutrality
- Transparency and accountability
- Bearing witness

The latter 'bearing witness' makes MSF distinct from other humanitarian organisations [6] . This gives MSF the possibility to speak out when they witness violations of humanity. Being neutral does not forbid MSF to speak out when "access to lifesaving medical care is hindered, when our teams witness extreme acts of violence, when crises are neglected, or when the provision of aid is abused" [7]. They will advocate for their aid recipients if they feel international humanitarian law is actively abused or abused via silent diplomacy. They will speak out if they feel it is needed, sometimes using the help of the media [5,6].

Data use in complex health emergencies

In the last decades, data used in complex health emergencies are predominantly quantitative data [8]. It seems that quantitative data are perceived as the standard method to gain knowledge in the

humanitarian sector. Over the last years, integration of social science research is increasingly recognised, however, it is still delayed, inconsistent and removed from central decision making operations [8,9]. Social scientists have been speaking out and critiquing the humanitarian sector for having limited access to anthropologists, whose role it is to ask critical questions about processes, contexts, and organisations [10,11]. They argue that it is important that social science should 'give voice' to the communities and has the role of evaluating medical humanitarianism in order to protect the human rights of communities and the quality of humanitarian aid [10,11].

Literature shows that social science has contributed to a better understanding of and response to complex heath emergencies [12,13]. It is perceived as contributing to the complete life cycle of disasters by giving the possibility to include issues of vulnerability, perceived risks, individual and social responses, and coping strategies [14]. The Ebola outbreak in West Africa in 2013-2016 has made a global change in the use of social science. It increased the use of social science after social sciences had helped to understand the 'resistance' of the community to following the strict rules of the public health response to reduce disease transmission. Social scientists were able to contribute with qualitative data to give insights into community behaviour, including resistance and cultural funeral ceremonies. They highlighted sensitive issues impacted by Ebola such as reproductive health and rights and gave recommendations for policymakers that respected the culture of the community. This helped to understand the resistance of the community towards the strict rules around Ebola and to be able to positively change their behaviour [13,15,16].
Why are qualitative data important in complex health emergencies? Above example shows that in the Ebola outbreak these data were an important contribution. This is because health events are a mix of biological and social phenomena. Both social causes and consequences influence how a health event will evolve, since they have a huge impact on individual, community and governmental life and decisions. This has been perfectly shown in the last two years in the covid-19 pandemic. The behaviour of individuals, communities and governments have made a significant difference in how the pandemic developed in different countries and cultures. The same disease can have huge variations in disease profile when situated in different social contexts [8,17]. In addition, quantitative data seem to answer the 'what' and not necessarily the 'how' and 'why' of a health issue. To fully understand the context of a complex health emergency and be able react with an effective response, both quantitative and qualitative data are needed to not miss crucial elements of the situation. Qualitative data will help to identify the weaknesses of public health systems and can help to understand unexpected outcomes and unintended consequences [18]. Moreover, it can help to develop more people-centred services and can give a voice to the community.

Hence, it is clear that qualitative data are useful in complex health emergencies. However, as outlined above, it is not widely used. As earlier described, difficulty in access to humanitarian settings is seen by social scientists as a significant barrier [10,11]. In addition, ethical review processes, the challenge of building research teams and raising funds are seen as barriers to collecting and using qualitative data [19]. To understand the untapped potential of the use of qualitative data, RREAL developed a framework of barriers and enablers based on the findings from an exploratory study [8]. It identified six common barriers: lack of timely data access and availability, poor study recruitment, lack of collaboration, lengthy ethical review processes, limited time and funding, and lack of systematic methodology. The following five enablers were described: stakeholder involvement, frequent sharing of findings in accessible formats, collaborative networks, and flexible and transparent ways of working [8]. Furthermore, there is a global trend in the last decades to increase community engagement in health interventions [20,21]. This is supported by the global authorities, who have acknowledged the need for and importance of social science in complex health emergencies [13,22].

In response, RREAL, in collaboration with MSF, is exploring the possibility of setting up a training programme to develop capacity on the use of rapid qualitative data. The development of capacity on the use of qualitative data should take into consideration how the working environment, assumptions, and attitudes towards research and evidence might shape perceptions and capability of using qualitative data. It is important that the organisation is supportive to qualitative data use in order to successfully use qualitative data in response efforts [23].
Therefore, this study explored MSF workers' perceptions of qualitative data use. It identified factors that act as barriers and enablers for qualitative data use in MSF. It identified training needs and preferences and identified recommendations for its incorporation into routine use.

Problem statement and justification

As described above, qualitative data can inform and help decision making in different settings [8]. It can also promote community engagement [20,21]. However, currently the use of qualitative data in complex health emergencies is very limited and there is need to increase this [9,13]. Humanitarian organisations are a big player in this field. Therefore, it is important to involve them in increasing the use of qualitative data in responses to complex health emergencies. I explored the current perceptions towards the use of qualitative data in MSF and investigated the needs to improve this.

Justification
This study will address and explore the missed opportunities of the use of qualitative data in complex health emergencies. Lack of qualitative data use results in a suboptimal response in ongoing and future humanitarian operations in MSF. The study will support MSF in their mission to apply a more people-centred approach in their projects.

Study questions

1. What are MSF workers' perceptions of the use of qualitative data in complex health emergency settings?
2. Does MSF use qualitative data in complex health emergency settings? If so, how do they use it?
3. What are the needs of MSF and its humanitarian workers to build capacity to use qualitative data?

Aims and objectives

1. Map the perceptions in MSF of qualitative data collection and use in complex health emergencies.
2. Identify the factors acting as barriers and enablers in qualitative data collection and use.
3. Identify (training) needs and develop recommendations to increase qualitative data use in complex health emergencies in MSF.

Methods

Design
In this study we used a qualitative approach. To answer the research questions, we used a rapid qualitative appraisal design. Rapid appraisals were developed to collect and analyse data in a

targeted way within limited timeframes and 'diagnose' a situation [24]. A rapid appraisal design often combines two or more methods of data collection and then uses triangulation from different sources as a form of data validation [25]. It is based on an iterative process of collection and analysis, where "the researchers begin with information collected in advance, and then progressively learn from each other and from information provided by semi-structured interviews and direct observations" [26]. I choose for this rapid approach to be able to share my data during the study with an iterative approach and enable the start of capacity building for qualitative data use in MSF during the study.
This study was based on an appraisal RREAL has done to explore the barriers and enablers of qualitative data use in epidemic responses [8]. I did go beyond the barriers and enablers and explored the perceptions, use and needs for capacity building, since the appraisal described an untapped potential for qualitative data in epidemic responses.

Ethics
The study was approved by the UCL Research Ethics Committee (UCL REC): 6862/002 as part of a bigger study on health emergency responses. A detailed informed consent process ensured that the participants understood the nature and purpose of the research. Written consent was provided by participants before the interviews, and they were aware that they could withdraw at any stage. The personal details of the participants have been removed from the raw data to ensure anonymity. Data were recorded with an audio recorder and stored on a protected cloud of UCL.

Data collection
Semi-structured interviews were conducted via telephone or videoconference with 15 humanitarian workers at MSF in the two different operational centres, OCBA (operational centre Barcelona) and OCA (operational centre Amsterdam). The interviews focused on the perceptions, the actual use and capacity building of qualitative data use in complex health emergencies within MSF. I developed a topic guide based on the study questions to 'guide' the interviews and maintain consistency in the different interviews. See attached topic guide in the appendices.
The inclusion criteria were any workers from all different levels in the organisation who could speak good enough English for an interview and had an internet connection or telephone line available to join the remote interviews.
The data of the interviews were used with an iterative approach to develop a training on rapid qualitative assessments at MSF for MSF workers. We designed the training with a mixed team of MSF and RREAL. When we delivered the online training, we used observations of the participants during the training for our data collection.

Participants and characteristics
We interviewed workers selected through purposive and snowball sampling in two different MSF operational centres, OCBA and OCA. The participants were or have been working in different countries in Latin America, the Middle East and Africa (see detailed characteristics in table 1). From each operational centre we conducted interviews with people working at different levels in the organisation, we distinguished between office workers, leading field workers and field workers. Participants had to speak English to be able to be selected.
The observations of the rapid qualitative assessment training were done on 16 participants from OCBA unit working in Africa, the Middle East and Asia. The training was done online on Zoom. Notes were taken during discussions at the training and from the information participants had written about themselves and their motivation for attending the training.

Table 1. participant characteristics

Interview code	role	function	work region	unit	country based
P1	office	Medical learning advisor	general	OCBA	Spain, Barcelona
P2	office	Interim head of learning unit	general	OCBA	Spain, Barcelona
P3	leading fieldworker	medical coordinator	Yemen	OCBA	Yemen, Spain
P4	leading fieldworker	Community Engagement and Health Promotion Manager for Latin America Region	Latin America	OCBA	Colombia
P5	field worker	Health promotion manager	Cameroon	OCBA	Cameroon
P6	office	Health advisor	DRC, CAR, Cameroon	OCBA	Barcelona
P7	field worker, leading role	MD, field coordinator, PMR	Sudan	OCBA	Sudan, now between mission in Spain
P8	field worker leading role	Nurse, Project coordinator	Cameroon, Nigeria	OCBA	Cameroon
P9	leading field worker, national staff	Deputy project coordinator	Sudan	OCBA	Sudan
P10	leading field worker	project coordinator	Middle east	all 5 units	field
P11	leading field worker/national staff	deputy medical coordinator	Venezuela	OCBA	Venezuela
P12	field worker	Clinical psychologist, Mental health activity manager	Nigeria, Yemen, Libya	OCA/OCBA	field
P13	field worker	nurse	DRC	OCA	field
P14	field worker	nurse	Dhafour, Chad, Uganda, Ethiopia, Bangladesh	OCA	field
P15	field work/ leading field work	nurse, midwife, PMR	Africa; various countries	OCA/ OCBA	field/ Norway

Data analysis

All data obtained from the interviews were transcribed and summarised in a RREAL sheet [27] (see attached in the appendices the design of the RREAL sheet of this study). The RREAL sheet is a tool developed by RREAL to enable data collection and analysis at the same time. It is a flexible tool that is used as a working document to be able to identify gaps during data collection but also maintains

the consistency across different sites and over time. The RREAL sheet was used for the first analysis step to develop the analytical framework for the in dept analysis (see figure 1 for the analytical framework). This framework was used in the framework analysis approach to analyse the entire dataset [28]. Framework analysis was selected because it is a frequently used, dynamic and an idea generative method. It identifies common themes which inform subsequent data collection before identifying the relationships between the themes. The different themes were developed through both iterative and deductive approaches, as they were informed both by the research questions and by the themes emerging from the participants' responses. Reflexivity was taken into account through the entire process following Braun&Clarke's theory [29].
Limitations of this approach are possible missed categories arising from the participants after the analytical framework was developed. Therefore, I used the RREAL sheet to develop the analytical framework, as this allows the researcher to adapt the framework during the entire data collection process [27].

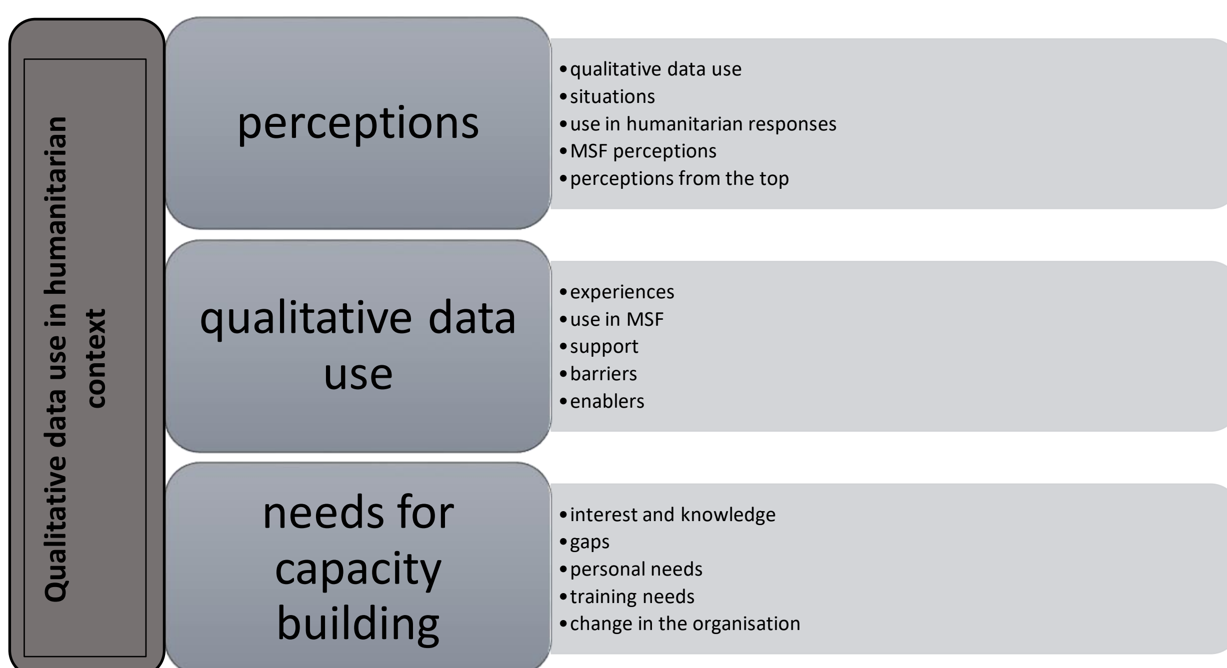

Figure 1. analytical framework

Reflexivity
As a medical doctor and student of international health, participants (MSF workers) seemed to trust me and identify with me, as we shared the values 'need of good access to healthcare' and 'equity in health'. This could have made it easier for them to share their opinions and experiences. They seemed to have interest in the topic and were willing to improve the use of qualitative data. The interviews could be seen as an opportunity for improvement, which encouraged them to share information.
I am a 36-year-old woman from a high-income country, which could have had influence on the responses of the different participants. Some participants could have responded easier or more difficult to a woman. However, the participants were diverse in age and gender, which compensated for the possible influence on responses. The fact that I am raised and educated in a high-income country and have the Dutch nationality, could have had influence on the responses of local and international staff. I am aware of the differences in background of my participants and have tried to engage with them as much as possible. Participants were from different backgrounds which compensates for the possible influence on this subject as well.

I am currently working for RREAL and are involved in different projects with RREAL and MSF to develop support and capacity building on qualitative data use in MSF. This study was done at the start of this collaboration. Since this study was done at the start of these projects, I believe it did not influence my view and interpretation of the data of this study, but I am aware of the impact my colleagues could have on the interpretation of the data.
I have never worked in the organisation MSF, which gives me limited experience in the contact of interviewees. This could have led to some assumptions. Being a white woman, trained and educated in The Netherlands, could have affected the view and interpretation of the subject, especially when interviewing local staff. However, as a researcher, I kept a critical and reflexive approach and acknowledged assumptions that came up during the research.

Results

In this section I present the emerging findings of the collected data. There were three main themes that arose during data collection: perceptions, qualitative data use, and needs for capacity building. These themes, with their different categories, were set out in an analytical framework, used for the analysis of the entire data set; see figure 1 in the methodology for the framework. I have used this framework to analyse the data and organise the results section.

Perceptions

This first theme shows how MSF staff perceive qualitative data and their views on how it's used. It describes how they see qualitative data sources in the context of MSF working in humanitarian settings. They described their definition and view on qualitative data and when they had and would use it. During data collection the category 'perceptions from the top' arose, since participants described this as an important factor on the perception on qualitative data use in the organisation MSF.

Qualitative data

The main consensus on the perception of qualitative data was that it is subjective and descriptive, rather than objective and numbered. Participants described it as being about feelings rather than about numbers. *'…About peoples' perceptions and feelings, more subjective rather than objective'* (field worker, OCBA, Cameroon) *'…Descriptive and subjective data. Related with language; information described by language'* (office, OCBA, Barcelona)
In addition, people said that it is complimentary to quantitative data and that it should be used together. It gives an extra layer to the data because it reflects reality; '*Qualitative data is how the data reflects the reality'* (leading field worker, national staff, OCBA, Sudan). People described it as an addition to quantitative data and numbers. It gives us a better understanding of what the quantitative charts and graphs show us. Quotes: '*to know the story behind the numbers'; 'the qualitative assessment and analysis is giving a soul to the quantitative data'; 'it's what make every project unique and different'* (observations from RQA training MSF staff)
Some people said they did not know what qualitative data were and they did not know how to use it. *'I guess I don't really know. Maybe….how does it effect the community? What is the impact on the community…. But I might be wrong.'* (field worker, nurse, international staff, OCA).

Situations

The main situations where qualitative data are used, were needs assessments and initial assessment before a project is started *'…..A project could be triggered by indicators but there is a need for a qualitative assessment before the project is started'* (office worker, OCBA) *'…..to start up a project, because you don't have the quantitative data to start with. So, you have to use qualitative data to*

analyse the situation in principle and write your proposal' (leading field worker, OCBA, Cameroon). Furthermore, one of the main reasons people would use qualitative data was for the evaluation of a project '*…..to assess services we have to know more about the impact we are having. And to know if we reached indicators to change or stop the work'* (leading field worker, OCA&OCBA, middle east).
In addition, it was mentioned that qualitative data is used in order to better understand what the community wants before and during a project *'…. to know why sudden changes in the community appear …… understand better the needs of the communities we work with….. to understand why the community is not responding'* (observations from RQA training MSF staff).
At the same time, it was stated that it is only used if they don't have accurate data or quantitative data *'….if you don't have very accurate data, you assume you give qualitative data. In MSF we speak about qualitative data if we don't have quantitative data'* (leading fieldworker, OCBA, Sudan)

Use in humanitarian responses

All participants agreed that the use of qualitative data is important in humanitarian responses, however it is not used enough. People found it important to understand the different contexts and situations where humanitarian organisations operate '….. *Humanitarian responses are intervention based and the interventions should be context specific and you have to use qualitative data to understand the context. There is a need to continue doing assessments during the interventions'* (field worker, OCBA, Cameroon). Additionally, it was said that it would help to make the right decisions without assumptions on community needs '…..*it is important to use qualitative data, because we make assumptions while we are working in different cultures; we should ask the people. For example: there was a situation where there was no trust in the health service; until they asked the community why they did not succeed to increase the use of the facility'* (office worker, OCBA, Spain). Others said that it is important to involve the community in the decision making and gaining their trust *'……it is important to find out how the community is affected. If you don't get this information, you won't get their trust. If you gain their trust, you can make big changes in your projects'* (field worker, OCA, different countries).
A few people mentioned that it is already often used but not always documented as qualitative data use ' *…. it is useful, it always happens but it is not always documented and not called qualitative data'* (field worker, OCA, DRC).

Perception of qualitative data use at the 'organisation MSF'

It was often stated that the use of qualitative data in MSF is limited *'…..MSF uses qualitative data, but it is limited. They are open for the use, but it is just not always very well known in the field how to use it '* (leading field worker, OCBA, Colombia) and that it sometimes is not much appreciated *'….. it is not so much appreciated yet, there is a lot of critique on the qualitative part. Not considered to be scientific enough'* (office worker, OCBA, Spain). Furthermore, people said that qualitative data are less important than quantitative data in MSF *'….. People are not against it, there is a huge appetite to collect data, also qual data, however, the focus is on quantitative data'* (office worker, OCBA, Spain).
However, many participants said that it is becoming more important at the moment and for the future '*…..it is changing; qualitative data and community engagement is becoming more important'* (leading field worker, OCBA, Colombia), which was often linked to the new 'people-centred approach' in MSF *'…..Perceptions are changing; there is more interest in quality improvement and qualitative data use. We are more and more focused on the people and put the people in the centre; this is coming from qualitative assessments. It becomes more and more integrated. This is the general perception across the organisation, intersectional'* (office worker, OCBA, Spain).

Perception from the top in MSF

This category was added in the framework during the interviews because it emerged as a finding during data collection. The main addition was that workers in MSF said that the top management in MSF did not see qualitative data as a priority and some did not value it as important because they didn't consider it as good quality data *'…..it is not so much appreciated yet, there is a lot of critique on the qualitative part. Not considered to be scientific enough'* (office worker, OCBA, Spain).

In addition, it was said that the top management sometimes stops qualitative data use initiatives *'…..the top sometimes blocks ideas for assessments'* (observations from RQA training MSF staff).

However, it was also said that in the top management, especially in OCBA, this sentiment is changing due to the 'people-centred approach' *'…..MSF started the people-centred approach; this will help to use more qualitative data; there is willingness ahead'* (leading field worker, OCBA, Cameroon).

Qualitative data use in MSF

This second theme contains information about the use of qualitative data by MSF staff. Participants spoke about their experiences when they were working in the field and what they have seen and heard from other colleagues working in MSF. It explains the situations when MSF staff have used qualitative data and have seen it been used by others. It also described what their perceptions are about the support from the organisation. Furthermore, they described the barriers and enablers of the use of qualitative data within MSF.

Experiences of qualitative data use in MSF

Most of the participants had some degree of experience using qualitative data in MSF projects or in their previous jobs. However, most people said that they have not used it a lot, so their experience is limited. Some people stated that it did not give them data they could use because they did not really know how to use it, or it was not collected or analysed correctly '….. *We have done a survey in north Syria to understand the situation and to design a strategy to help the people in the camps. We did interviews to the target population. We did not get any useful information because the interviews were not done well'* (leading field worker, OCA/OCBA, different countries).

Other people said it was useful and it made some changes in their projects *'…..in a maternity project they asked mums why they did not attend the hospital for deliveries; they changed the approach after this qualitative assessment which helped!'* (leading field worker, OCBA, Cameroon).

Quite a few people told us that there is a lot of 'hidden' qualitative data use within MSF; people use qualitative data in their projects, but it is not reported as official qualitative data use *'….. I did not do it myself officially. I use it all the time in my work, you have to use your observations to do your job as a PM*' (field worker, OCA, different countries). *'We always look for qualitative data, but not always document this'* (leading field worker, OCBA, Venezuela).

Use of qualitative data in MSF

The main consensus about the use of qualitative data in MSF projects was that it was not used often enough, and that quantitative data were more important than the use of qualitative data *'…..Humanitarian sector uses more quantitative data, but we forget that people's views are much more important* (field worker, OCBA, Cameroon & Nigeria). It was often stated that there is a lack of knowledge to use qualitative data properly. Some people said that they did not know about any qualitative data used in MSF projects, at least they had never heard of it *'…..not sure, it may have happened but I don't remember'* (field worker, OCA. DRC).

If people knew about the use of qualitative data in MSF they stated it was used in an informal way *'…..MSF does many qualitative assessments but it is informal, there is no structure or system set up to collect data or use it'* (field worker, OCBA, Cameroon). Additionally, people said they had seen it

been used for explorations ('explos') for new projects and for decision making within an existing project *'.....there was no trust in the ebola camps by the community; after observations they changed the fence which helped'* (office worker, OCBA, Spain).

Support for qualitative data use

In general, people said that the organisation did not support them very much to use qualitative data because it is not a priority in MSF. People got support on a personal level and experience if they wanted help *'......it is not well supported by the organisation as a whole, it is done on base of personal level and experience'* (leading field worker, OCBA, Latin America).

If support was reported, it was more on the use of quantitative data *'..... there is a team of researchers and epidemiologist who can help if you want to do research or collect data in the field, they support the medical teams in the field'* (leading field worker, OCBA, Yemen/Spain). People said that MSF as an organisation is supportive of its workers, it was reported that people are very open at MSF, but there is a gap for structural support to use qualitative data in the organisation.

Barriers to qualitative data use

Many people saw lack of time as one of the main barriers to collect and use qualitative data. MSF is operating in emergency settings where there is always so much work to do and one always has to prioritise what is most important *'.....qualitative data are seen as time consuming and consuming resources and they don't always have the time and resources in their settings. It is difficult to justify the qualitative data use because the same time and resources could be used to save lives'* (field worker, OCBA, Cameroon).

In addition to the lack in resources, some people said that there is a lack of skills and knowledge about qualitative data use *'....we don't know how to use it properly, due to lack of information about the qualitative approach'* (leading field worker national staff, OCBA, Venezuela).

A few people mentioned that there is no systematic way to collect and use the data and there is no structure in the organisation, which makes is difficult to start the collection of qualitative data. Another factor mentioned was that people and MSF as an organisation do not see qualitative data as a good source of data, because it is considered as too subjective and not of good quality *'.....it does not have the good credits to be scientific enough, some people think it does not give good quality data'* (office worker, DRC/CAR/Cameroon, OCBA). It was said that there is a lack of understanding of the value of qualitative data in MSF, a lot of people in MSF are not aware of the importance.

Enablers to qualitative data use

The most prominent enabler named by most participants was the new 'people-centred approach' in MSF. This people-centred approach is a general trend of the last years in MSF, led by OCBA unit. Most participants working for OCBA saw this as the biggest opportunity to start using more qualitative data in MSF *'.....the organisation changed (a general trend in MSF) to a more people-centred approach, which is an opportunity to start using more qualitative data'* (office worker, DRC/CAR/Cameroon, OCBA). One person mentioned as well that there is a global trend going on to listen better to the community which needs more qualitative approaches *'.....The (global) trend to listen more to communities. In the past we were looking into the communities and conclude ourselves without talking to them'* (office worker, OCBA, Spain). It was said as well that there is a trend in MSF which is following a trend in global health towards asking what a community wants and empowering the community, which involves qualitative data use and was seen as a big opportunity to increase qualitative data use in the humanitarian sector.

Needs for capacity building

This third theme explains what participants would need to start using qualitative data in their work in MSF projects and if workers in MSF would be interested in the use of qualitative data in their work with MSF. They also expressed what they would like to change to make the use of qualitative data more accessible in MSF if they wanted to use more qualitative data in their work.

Interest and knowledge of qualitative data

All participants expressed an interest to use more qualitative data in their work with MSF. Most people felt it was important to increase qualitative data use, especially because MSF is changing to a more people-centred approach *'…..the organisation should give more value to the qualitative approach if they want to have a more people-centred approach'* (office worker, OCBA, Spain). Also, most people said that they had little knowledge and experience on using qualitative data, however a few people had advanced knowledge and used it in their previous and current jobs. *'…..I can do it, but I am gambling to collect the data. I lack the knowledge to analyse the data'* (leading field worker, OCBA, Cameroon/Nigeria).

Gaps in qualitative data use in MSF

There was a consensus that standardisation of qualitative data use is missing in MSF. There is no structural way to collect and use qualitative data in MSF projects. In this vein, it was also mentioned that the focus of the organisation on qualitative data use is missing *'…..the whole organisation should be more focused on a macro perspective'* (office worker, OCBA, Spain).

Secondly, people mentioned that technical knowledge and skills about qualitative data use are missing in MSF as an organisation *'…..we are lacking the technical knowhow; how to collect and analyse the data*' (leading field worker, OCBA, Cameroon). One person said that the main problem was not only that knowledge and skills were missing, but that this was not part of the daily activities. Additionally, it was mentioned that there is a lack of awareness of the value of qualitative data in their daily work. *' ……we have to discuss why data are important and why this is making the life of fieldworkers easier……how it helps you to make better decisions'* (field worker, OCBA/OCA, different countries).

Personal needs to use qualitative data

There was a strong consensus from most participants that there was a need for training to increase the usage of qualitative data. People expressed they would like training about how to collect qualitative data, what methods they should use and how to analyse the data after collection *'…..I would need more training and help, I need more knowledge, I am still learning about different types of data collection'* (field worker, OCA, DRC). Furthermore, people said that they would like general training about the technical knowledge on how to design and conduct a qualitative study *'…..I would like to be able to design and conduct qualitative studies as a stand-alone study or mixed method study'* (observations from RQA training MSF staff).

The second main personal need expressed by a big group of the participants was the development of tools. People would like to have access to tools for collecting data (for example questionnaires) and tools to analyse the data *' …..a specific 'toolbox' with skills for communication, how to collect data and how to use the data in the field in a project for hands on use. We don't need extensive research, just hands on tools to use qualitative data in the field'* (leading field worker, OCBA, Yemen) *'…..a tool to collect these data, specific questionnaires who can be routinely used in the different situations* (leading field worker, OCBA, Latin America).

A few people mentioned that for them it was important to integrate qualitative data in primary assessments or 'explos' and in their daily work *'…..how to integrate the qualitative data in the*

primary assessment and in the numeric information. I would like know how to prepare to collect and use these data' (office worker, OCBA, Spain).

Training needs

The main training need was seen in technical knowledge on qualitative data use and collection. People wanted to learn more about how to collect the data and which methodology should be used. As well, people expressed the need to learn how to analyse and how to write up the data in reports. The technical knowledge on qualitative data use should be helpful to ensure the quality of the data and how to deal with subjective data *'….. methodology, how to collect the data, we need more tools how to collect the data….. and how to analyse and to manage the subjectivity of the data'* (leading field worker, OCBA, Nigeria/Cameroon).

People expressed a training need for communication skills regarding the collection of qualitative data. Field workers should be trained in how to conduct interviews and what different communication skills are needed to collect good quality data *'…..the quality of the data all depends on the person who is collecting the data'* (leading field worker, OCBA, Cameroon). *'…..train volunteers and community health workers on how to ask questions. They are often your only source of data*' (field worker, OCBA, Cameroon).

The introduction and explanation of simple tools was mentioned as an important training need. Tools for collection were seen as a key instrument for increasing the use of qualitative data in MSF, because in the MSF setting people do not have much time, and tools help in standardising the process *'…..tools to write the information and to systematise the process. We need to be trained in how to interpret the data to allow to compare the different needs of the communities or take decisions with it in an objective way'* (leading field worker (national staff), OCBA, Venezuela).

There was a strong request for training on what to do with the data and how to use them in the field once it was collected and analysed. Many people said that there is a need to increase knowledge on how to deliver the data to the community and make sure the people who helped giving the data would receive something back from the qualitative study. There were concerns that this was not done on a regular basis, and people expressed that they did not really know how do this correctly *'…..knowledge about how to use the data, how to make changes in the community with the data*' (leading field worker, OCBA, Latin America). *'We need to know how to deal with the community; how to give something back from the information they have given you'* (office worker, OCBA, Spain).

Additionally, it was mentioned that there is a need to train people how to set up a systematic way to collect and use qualitative data. Only when used systematically, it will be easy and more often used. Furthermore, people said the training should start with explaining what qualitative data are and why it is important to use it in MSF. Training should focus on why are they collecting data and for what purpose, if people understand why they are doing the things they are doing, it will make a change *'……Explain what qualitative data are and why they are important; use it to help the community'* (field worker, OCA, Dhafour/ Chad) *'…..discuss why data are important and why this is making the life of fieldworkers easier; how it helps you to make better decisions'* (field worker, OCA/OCBA, Nigeria, Yemen, Libia).

What should change in the organisation to use qualitative data

The main consensus about changes in the organisation to increase qualitative data use was that the change should be across the organisation. People said they would like to have more support from the headquarters to use qualitative data in the field and that there should be more value from the top given to the qualitative approach if they want to have a more people-centred approach *'……change the perceptions of qualitative data use of people in the top, give more space to the qualitative approach'* (office worker, OCBA, Spain). *' …..it needs to be an interdisciplinary approach, everyone in the organisation should be involved. Knowledge about qualitative data should be shared*

across the organisation and maybe introduced in the initial training for new staff' (leading field worker, OCA/OCBA, Middle East). It was also mentioned that the data collected in the field should be used at a higher level for decision making purposes.
Additionally, it was said that the organisation should increase awareness of qualitative data use and its support and advertise the use of it. People should understand the value of qualitative data in order to start using it *'…..understanding the long-term goals and collect qual data should be made in the day to day activities otherwise it always goes to the bottom of the pile, and it's not done'* (leading field worker, OCA/OCBA, Middle East). Furthermore, it was said that they should introduce qualitative data use in the teams in a way that they feel it is important and necessary and not always time consuming.

Discussion

This study was set up to firstly investigate the perceptions, use, enablers, and barriers of qualitative data use in MSF. Secondly, it sought needs and recommendations for capacity building on qualitative data in the organisation. The latter we used to develop a training with RREAL and MSF on rapid qualitative assessments using an iterative approach. We used the first data coming up from this study to develop the training content.

Summary of key findings
MSF workers perceived qualitative data as subjective and descriptive. They were seen as less important in the organisation compared to quantitative data, however this is changing, and they are becoming more used and valued. Needs assessments, evaluations and understanding the context were perceived as functions for qualitative data. In humanitarian responses 'decision making' and 'community engagement' were added to these perceptions. There was a lack of experience and support of the use of qualitative data. Common barriers were reported as lack of time, skills, knowledge and understanding the value of the data. The global trend, which was also reported within MSF, towards qualitative data and the 'people-centred approach' of the operational unit OCBA were seen as enablers of qualitative data use. The participants had a great interest but little knowledge on the use of qualitative data. Training was seen as most important for capacity building in the organisation. Knowledge of methodology, analysis, dissemination, communication skills and introduction of tools were seen as the main training needs. See figure 2 for summarised key findings.

Figure 2

Perceptions

The main consensus about the perceptions on qualitative data was that it is more about feelings, more subjective, more descriptive than quantitative data, and not about numbers. Ritchie and Lewis (2013) [30] confirm that some authors focus on the type of data collection which does not quantify the data. Leach et al (2020) [18] state that qualitative research is more than the absence of numbers. They state that qualitative data give an answer to different questions compared to quantitative data. While quantitative data answers the questions "what?" "how much?" and "why?", qualitative data focuses on answering the questions "why?" and "how?" [18]. This relates to the perceptions of the participants of this study that qualitative data are complimentary to quantitative data because it gives extra information about certain topics, which cannot be given while using only quantitative methods. Additionally, literature describes a perception that qualitative data are seen as data that focus on the documentation of aspects of the world through the eyes of others and they integrate the subjectivities of the researcher as part of the research process, also seen as reflexivity [31]. This relates to the terms 'constructivism' and 'positivism', used as different beliefs in qualitative and quantitative research. Constructivism holds that the reality we perceive is constructed by our social, historical, and individual contexts, while positivism is based on the theory that there is an absolute truth, a "reality," which research tries to discover [32]. I decided to not use a definition for qualitative data, because I did not want to give a definition to my participants in order to be open to their

perceptions and interpretations. After all, there are many descriptions of qualitative data in the literature, and I felt it would be limiting to use one definition.

The main situations in which participants would use qualitative data were needs assessments, initial assessment before a project is started and evaluation projects. This is in line with the functions of qualitative data described by Ritchie and Lewis (2013) [30]. They described qualitative data to be useful to give context to a situation, to explain situations, to explore new situations or use it for evaluations [30]. In addition, it was mentioned by participants that qualitative data should be used to understand the needs of the community, however, one person mentioned that qualitative data were only used when there were no accurate quantitative data available. Literature describes that qualitative data are used to give a complete overview of the situation, including individual and social responses and coping strategies of the community [14].

Participants agreed about the importance of using qualitative data in humanitarian responses, however acknowledged that it is not used enough. It was stated that these data are important to understand the situation where they operate, to make sure that we know the community needs and involve them in the decision making. This was also marked as very important in the Ebola crisis [12,13]. Hewlett and Hewlett (2007) describe that the involvement of the community has made a huge difference in understanding the resistance of the community towards the public health response and the effectiveness of implementing new responses [12].

Furthermore, some people said that qualitative data were often used in humanitarian settings in an informal way and not documented as qualitative data. The general perception about qualitative data use in MSF was seen as limited and not as important as the use of quantitative data. Participants mentioned that also in the top of the organisation, qualitative were not seen as a priority. However, there was a strong consensus that this is changing in the different layers in the organisation due to the 'people-centred approach' in MSF and in global health in general.

Qualitative data use in MSF

Most participants had some experience in the use of qualitative data. However, they often don't know very well how to use it and often there is some 'hidden' qualitative data use because people don't document it officially as qualitative data. Some people said it helped them in decision making in their MSF project. In general, qualitative data were not often used in MSF projects. People said that they have more often used quantitative data rather than qualitative data. This reflects the literature written about the topic; Chisnall (2020) has done an extensive literature review on the use of qualitative data in epidemic responses and found that there was a preference for the use of quantitative data and very limited use of qualitative data [8]. Abramowitz et al (2015) also describe a limited use of qualitative data in humanitarian contexts and if used, they state that they were unsure about the visibility, relevance, and value of the qualitative data use to humanitarian practitioners [10]. This relates to the fact that some of the participants said that qualitative data were more often seen in an 'informal' context and not documented as such, because there is a lack of methodology.

In terms of support from MSF on the use of qualitative data, people said there is not much support from the organisation, because it is not a priority in MSF. People got support on a personal level if they wanted help. The general support on data use was mostly on quantitative data use.

Lack of time was seen as the most important barrier to qualitative data use in MSF, because MSF mostly works in emergency settings where there is never enough time to do all the work in the field. Lack of skills and knowledge was also seen as a barrier. Another barrier is that there is no systematic

way to collect and use the data. This reflects partly the common barriers Chisnall (2020) has identified in collaboration with RREAL [8]. The two barriers 'limited time' and 'lack of systematic methodology' match the main barriers described by participants. However, Chisnall (2020) found lack of timely data access and availability, poor study recruitment, lack of collaboration, lengthy ethical review processes and limited funding were other prominent barriers to qualitative data use in humanitarian responses [8]. In addition, a few participants said that qualitative data were seen as too subjective and not of good quality data. There is a lack of understanding the value of using qualitative data in MSF projects, which is linked to literature describing social scientists not being taken seriously and valued in the humanitarian field [10,11].

The most prominent enabler to using qualitative data was seen by the participants as the 'people-centred approach' in MSF. There is a trend in MSF, following a trend in global health, to listen better to what communities need and put them in the centre. On operational unit level, OCBA has made the decision to make the 'people-centred approach' one of its core values. This will involve qualitative data and is seen as a big opportunity to increase the use of qualitative data in humanitarian organisations. Literature describes this same development over the last years. Social science has played a more central role in humanitarian crises to understand the context and be able to set up a better response [20]. Bardosh et al (2019) have written a report with the title 'Towards People-Centered Epidemic Preparedness and Response: From knowledge to action' [33]. It analyses the knowledge, infrastructure and funding gaps that limits the use of social science in epidemic responses and presents a roadmap with 17 priority recommendations to increase the use of social science in an epidemic preparedness and response. The Social Science in Humanitarian Action Platform [34] develops recommendations and works on the social dimensions of emergency responses. One of their latest articles have explored the community resilience on epidemic response and gives recommendations on how to overcome these [35]. These initiatives show that not only the participants from MSF have noticed a change towards a 'community' or 'people' centred approach, but there is ongoing global change. The covid-19 pandemic has made this even more urgent and has sped up this development [36].
Chisnall (2020) has described five additional enablers in the framework of barriers and enablers of qualitative data use: stakeholder involvement, frequent sharing of findings in accessible formats, collaborative networks, and flexible and transparent ways of working. They were described as positive influences on the use of qualitative data in an emergency response [8].

Needs for capacity building and practical implications
All participants said that it was important to increase qualitative data use in MSF, especially because the 'people-centred approach' was asking for this type of data, which is a core value of the operational unit Barcelona. Most people had little experience and knowledge so far, however a few were very familiar with the use of qualitative data.
The category 'personal needs to use qualitative data' came up with a strong need for training. People expressed the need for training on how to collect data, which methods to use and how to analyse the data. They wanted to gain technical knowledge on how to design and conduct a qualitative study. Additionally, people said they needed tools on how to collect and analyse qualitative data. Two people mentioned that it was important for them to learn how to integrate qualitative data in primary assessments and in their daily work.
This study was used as a base for the development of an online training about rapid qualitative assessments. The training was a collaboration between RREAL and the MSF operation unit Barcelona. The results of this study were used in an iterative approach to develop the content of the training. Many people mentioned that there was a need to explain what should be done with the data once it was analysed. People expressed the importance to make sure that data are

implemented and given back to the community. This category came up as important and was a significant addition to the training. The training was delivered in September 2021 to a mix of MSF workers from different operational centres. It was received very well, and the feedback was very good in general. People felt more confident in using qualitative data and gained knowledge and skills on how to do so. However, the amount of information was sometimes perceived as too much in little time and there could be more examples from MSF projects (see the training feedback summary in the annex). The aim is to repeat the training yearly and make rapid qualitative assessments more known and used in MSF.

After the training, several projects from MSF came with the request for support to do a rapid qualitative assessment. Currently, RREAL is supporting different projects to deliver training and support to perform qualitative assessments.

To increase qualitative data use in MSF, participants said that changes should be made across the organisation. It was not always seen that the top of the organisation values qualitative data enough to apply to their 'people-centred approach'. Additionally, the organisation should create more awareness on the importance of qualitative data use in the field. We could argue that it is unethical to not use qualitative data when it is needed or use these data without good knowledge. The different projects RREAL is doing with MSF is supporting the awareness of qualitative research and increasing the knowledge of how to conduct it. RREAL and MSF are planning to collaborate more in the future to increase the use and awareness of qualitative data in humanitarian settings. We developed an infographic from the data of this study to share the findings and increase awareness of the needs to use qualitative data in an humanitarian organisation (see attached the infographic in appendix F).

Limitations

This study used purposive and snowball sampling until saturation of data was perceived to address the aims and objectives of the study. Interviews were performed until saturation of data was reached. We interviewed MSF workers from different operational centres, however we were not able to reach all operational centres due to time and organisational constraints. The top of the organisation was difficult to reach, hence I was not able to include interviews with the top management. This limited incorporating the views of the whole organisation. The sample size was led by saturation, but it could have been bigger if all operational centres had been included. I focused on the operational units OCBA and OCA, since RREAL was asked to help building capacity with a possible training with OCBA with some additional people from OCA. Some of the participants had worked in all five units, which means the study was, to some extent, inclusive of the whole organisation.

Secondly, some people with no experience and knowledge of qualitative data might have interpreted the questions differently than expected. If people don't know what qualitative data are, it is difficult to answer the question of when they would use it. I used this information as a finding, which was useful to answer the research questions. However, people might have described situations which did not involve qualitative data because they had interpreted the term 'qualitative' differently than it is interpreted in the literature. This could also have influenced the recommendations these participants have made for capacity building and the barriers and enablers people have mentioned about the use of qualitative data.

I acknowledge the fact that the study might be limited by reporting bias as participants who wanted to join the study might have already had an interest in qualitative data. The observational data were collected in the training on qualitative data use, hence participants had expressed their interest in qualitative assessments by signing up for the training. However, snowball sampling brought me to some local MSF staff and some people who had never heard about these assessments and training.

The lack of in-person contact, due to covid restrictions and distance, might have influenced the way participants were responding in the interviews. However, video conference was a great help and made it possible for me to engage with the participants to minimise this bias. The nature of semi-structured interviews also helped the participants to respond at their own pace.
To be able to give a better insight on the views and perceptions of the humanitarian sector in general, further research on a wider group, including the top management, is needed. To be able to generalise the findings in the wider field, the study should be repeated in different organisations who are operating in the field of complex health emergencies.

Conclusion and recommendations

This study found that MSF workers perceive the use qualitative data in complex health emergency settings as more subjective than quantitative data and not about numbers. Qualitative data were seen as important and as an addition to MSF projects. However, there is limited use of qualitative data in MSF and there is limited knowledge and skills in the organisation. If it is used, this is mostly in the explorative phase of a project. People increasingly use qualitative data but, it is frequently not documented as qualitative data use; so it is considered 'not official' use. There is a change ongoing due to the 'people-centred approach', which leads to an increase in qualitative data use. For capacity building there is a training need for skills and knowledge to use qualitative data. MSF needs a more structural approach and support from the organisation.

Based on the findings of the study, there are a few recommendations that can be made. There should be more trainings developed on qualitative assessments and the use of qualitative data in the different operational centres. It seems that most MSF workers are interested and acknowledge the value of qualitative data but lack the knowledge and skills to do a qualitative assessment. Since MSF is an organisation that responds to emergencies, projects are quick, changing and need to be flexible, MSF projects would benefit from a rapid qualitative approach. I would recommend focussing on advocacy and training of a rapid approach of qualitative data. RREAL is specialised in the rapid approach, which could be seen as an opportunity in the collaboration between the organisations.
I have seen that the different operational units are operating in their own fields. Since qualitative assessment skills are a general topic, it could be useful to have an intersectional workgroup to support the different centres with their projects. Experiences with the different projects in MSF show that the projects in the different operations centres are struggling with the same problems and need similar support.
To be able to learn from the implementation process and be able to use tools and lessons learned in different projects, I would recommend monitoring the impact of qualitative data use on the different projects and decisions in MSF. More data are needed to support the results of this study, including incorporating a wider perspective of the humanitarian sector.

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Appendices

Appendix A: Topic Guide

Main study questions:

1. What are the perceptions of MSF to the use qualitative data in complex health emergency settings?
2. Does MSF use qualitative data in complex health emergency settings? If so, how do they use it?
3. What are the needs of MSF and its workers to build capacity to use qualitative data?

Topic	Question	Prompt(s)
Background participant	**1.1** What is your job/ role in the organization?	*(a) e.g. frontline worker, health authority, clinician, manager* *(b) what does this role entail?* *(c) how long have you been in this role?*
	1.2 What work did you do prior to this job? Have you worked in other humanitarian organisations in the past?	*no prompt(s)*
	1.3 What is your experience in research/ data collection?	*no prompt(s)*
Perceptions use of qual data	**2.1** How would you describe qualitative data?	*no prompt(s)*
	2.2 When would you use qualitative data? In what situation?	*e.g. to answer questions which need more descriptive answers*
	2.3 Do you think qualitative data can be useful in complex health emergency settings? If yes, in what context?	*e.g. get more insight in particular situations, when a project is stuck due to maybe cultural issues?*
	2.4 What is the perception towards qualitative data of MSF in your opinion? Do you share this perception?	*no prompt(s)*
Qualitative data use	**3.1** Did you ever use qualitative data in an MSF project? If yes, how?	*no prompt(s)*
	3.2 Did you ever noticed qualitative data use in an MSF project?	*no prompt(s)*

	3.3 Is there any support in the organisation to use qualitative data?	
	3.3 Are there any factors that act as barriers to the use of qualitative data?	*no prompt(s)*
	3.4 Are there any factors that help you to use qualitative data?	*no prompt(s)*

Needs to build capacity	**5.1** Would you be interested in using qualitative data in complex health emergencies?	*e.g. to have another tool to come up with solutions in complex cultural problems*
	5.2 If you had to use qualitative data in complex health emergencies, would you be able to do this?	*(a) do you have the knowledge/ capacity?* *(b) is there support from the organisation? Is there time and space?* *c) What is missing?*
	5.3 What would you need to start using qualitative data in complex health emergencies?	*(a) att what knowledge and skills* *(b) att support of the organisation*
	5.4 If there was training about qualitative data use, what skills or knowledge would you like to gain?	*no prompt(s)* *How should the training be delivered?* *When should it be delivered?*
	5.5 If MSF wants to increase the use of qualitative data in complex health emergencies, what would you advise them?	*no prompt(s)*

Appendix B: Ethics approval

UCL RESEARCH ETHICS COMMITTEE
OFFICE FOR THE VICE PROVOST RESEARCH

25 February 2020

Prof. Ramani Moonesinghe
Division of Surgery/Department of Targeted Intervention
UCL

Cc: Cecilia Vindrola, Heather Bailey

Dear Prof. Moonesinghe

Notification of Ethics Approval
Project ID/Title: 6862/002: Developing new rapid research methodologies to inform epidemic response efforts in low and middle-income countries: A rapid appraisal of epidemic response efforts

Further to your satisfactory responses to the Committee's comments, I am pleased to confirm in my capacity as Chair of the UCL Research Ethics Committee (REC) that your study has been ethically approved by the UCL REC until **25 February 2021.**

Ethical approval is also subject to the following conditions:

Notification of Amendments to the Research
You must seek Chair's approval for proposed amendments (to include extensions to the duration of the project) to the research for which this approval has been given. Each research project is reviewed separately and if there are significant changes to the research protocol you should seek confirmation of continued ethical approval by completing an 'Amendment Approval Request Form' http://ethics.grad.ucl.ac.uk/responsibilities.php

Adverse Event Reporting – Serious and Non-Serious
It is your responsibility to report to the Committee any unanticipated problems or adverse events involving risks to participants or others. The Ethics Committee should be notified of all serious adverse events via the Ethics Committee Administrator (ethics@ucl.ac.uk) immediately the incident occurs. Where the adverse incident is unexpected and serious, the Joint Chairs will decide whether the study should be terminated pending the opinion of an independent expert. For non-serious adverse events the Joint Chairs of the Ethics Committee should again be notified via the Ethics Committee Administrator within ten days of the incident occurring and provide a full written report that should include any amendments to the participant information sheet and study protocol. The Joint Chairs will confirm that the incident is non-serious and report to the Committee at the next meeting. The final view of the Committee will be communicated to you.

Office of the Vice Provost Research, 2 Taviton Street
University College London
Tel: +44 (0)20 7679 8717
Email: ethics@ucl.ac.uk
http://ethics.grad.ucl.ac.uk/

Final Report

At the end of the data collection element of your research we ask that you submit a very brief report (1-2 paragraphs will suffice) which includes in particular issues relating to the ethical implications of the research i.e. issues obtaining consent, participants withdrawing from the research, confidentiality, protection of participants from physical and mental harm etc.

In addition, please:

- ensure that you follow all relevant guidance as laid out in UCL's Code of Conduct for Research: http://www.ucl.ac.uk/srs/governance-and-committees/resgov/code-of-conduct-research
- note that you are required to adhere to all research data/records management and storage procedures agreed as part of your application. This will be expected even after completion of the study.

With best wishes for the research.

Yours sincerely

Professor Michael Heinrich
Joint Chair, UCL Research Ethics Committee

APPROVED: Ethics Extension 6862/002

VPRO.Ethics <ethics@ucl.ac.uk>
Fri 27/11/2020 14:38
To: Vindrola, Cecilia <c.vindrola@ucl.ac.uk>

Dear Cecilia

The REC has approved your attached extension request and the ethics approval of this study has therefore been extended to **25/02/2022.** Please take this email as confirmation of that approval.

IMPORTANT: For projects collecting personal data only

You should inform the Data Protection Team – data-protection@ucl.ac.uk of your proposed amendments, including requests to extend ethics approval for an additional period.

Best wishes,
Lola

Lola Alaska (she/her)
Research Evaluation Administrator

Please note, my working week is split across Ethics and REF, meaning I may not reply to your email immediately.

Office of the Vice-Provost (Research)
University College London, Gower Street, London WC1E 6BT
Email: l.alaska@ucl.ac.uk
Web: www.ucl.ac.uk/research

Please do not feel obliged to reply to this email outside of your normal working hours.

Appendix C: Consent form

Title of Project:

Perceptions and use of qualitative data in the context of humanitarian organisations: a case study of MSF

Consent form (Version 1.0, April 2021**): Phoneonline interviews**

Name of Researcher:

Please read the following statements and mark the boxes to show you agree

1. I confirm that I have read and understand the information sheet (Version 1.0, April 2021) for the above study. I have had the opportunity to consider the information, ask questions and have had these answered satisfactorily. ☐
2. I understand that my participation is voluntary and that I am free to withdraw at any time without giving any reason, without my legal rights or employment status being affected. ☐
3. I understand that my participation in these discussions will be carried out via Teams and recorded in the form of notes and an audio recording (optional). ☐
4. I understand that relevant sections of my anonymised data collected during the study may be looked at by members of the research team. I give permission for these individuals to have access to this data. I understand that this information will be treated as strictly confidential and handled in accordance with the provisions of the Data Protection Act 1998. ☐
5. I understand that data and quotations I provide may be used (anonymised fully) in future publication of this research. ☐
6. I agree to take part in the above study. ☐

____________________	__________	____________________
Name of participant	*Date*	*Signature*
____________________	__________	____________________
Name of person taking consent	*Date*	*Signature*

Appendix D: Participant information sheet

Perceptions and use of qualitative data in the context of humanitarian organisations: a case study of MSF

Participant information sheet: Telephone interviews (Version 1.0, April 2021)

Literature shows that rapid qualitative research could be beneficial during complex health emergencies to highlight context specific issues and help in the setup of a response. However, many opportunities are missed in these settings. In response, RREAL, in collaboration with MSF, are exploring the possibilities to set up a training program to develop capacity on rapid qualitative data use in humanitarian settings.

This study will explore the perceptions on qualitative data use and identify factors that act as barriers and enablers in MSF. It will identify training needs and preferences to provide recommendations for its incorporation into routine use.

The rapid appraisal in this project is using semi-structured telephone interviews with workers at MSF. The findings will be analysed in an in-depth qualitative study to generate guidance for the introduction of qualitative data use in humanitarian responses.

The study is being carried out by an interdisciplinary team from RREAL and MSF. You can contact us using the details printed at the back of this form.

The aim of this information sheet is to help you understand why we are carrying out this evaluation and what would be required of you if you decide to take part in the study.

1. ***Who has given ethical approval for the study?***

This study was approved by the UCL Research Ethics Committee.

2. ***Why have I been asked to take part?***

You have been asked to take part because you are currently working in the humanitarian sector at MSF. We wish to capture a wide range of views from the people working on humanitarian responses in MSF. We wish to speak with you because we believe you have a valuable perspective.

3. ***What does taking part involve?***

If you decide to take part, the researcher will ask you to sign and email a consent form. After the consent form has been received, she will liaise with you to arrange the time for an interview. The interview will take place at a time that suits you and will be conducted over the phone or via Microsoft Teams. The interview will last approximately 30 minutes and will be audio recorded. You can ask the researcher to avoid using a voice recorder and she will take notes instead.

The interview will include questions on your current role, experiences, perceptions on the use of qualitative data in your current role and any problems or concerns you might have encountered. You can ask the researcher to stop the interview at any time.

4. ***Do I have to take part?***

No, it is up to you to decide whether or not to take part. If you decide to take part, we will ask you to sign a consent form before the interview commences. You can request a copy of this consent form. Whether or not you decide to take part in the interview, your employment status or relations will not be affected in any way.

5. ***Is what I say confidential?***

Yes, we will not inform anyone outside the research team that you have participated in the study. Your personal information will not be collected. All information will be stored securely and will only be accessed by members of the research team. We will not identify you by name in any reports or publications. Your data will be archived securely for 10 years after the study's completion, before its eventual destruction.

If you disclose information that the researcher feels has implications for professional practice, we may report these concerns to the head of service or other managers. Any information passed on will be anonymised, ensuring you cannot be identified.

6. What if I change my mind?

You are free to withdraw from the study at any time. You do not have to give a reason for withdrawing. Even if you start an interview, you can stop it at any point if you want to. If you wish to withdraw, please contact us using the details at the end of this sheet. If you lose capacity to participate, we will withdraw you from the study automatically.

7. What are the risks of taking part?

Helping us with this study will take up a little of your time, but we will do our best to minimise any inconvenience to you by arranging to meet at a time that suits you.

If you feel uncomfortable discussing any aspect of this study, you can withdraw from the interview at any time. You can also contact the study team to discuss any concerns you have before and after agreeing to take part.

The researcher who conducts the interview will abide by a professional code of conduct.

8. What are the benefits of taking part?

There may be limited personal benefits emerging from the study, but the study aims to improve the approaches used in the response in humanitarian organisations. The findings from this study will be used for the development of training on rapid qualitative data use at MSF. The final results from the study will be shared across relevant networks and will be made available on the RREAL website.

9. How will information be stored?

UCL is the sponsor for this study. We will be using information from you in order to undertake this study and will act as the data controller for this study. This means that we are responsible for looking after your information and using it properly. UCL will keep the information collected for this study for 10 years after the study has finished.

Your rights to access, change or move your information are limited, as we need to manage this information in specific ways in order for the research to be reliable and accurate. If you withdraw from the study, we will keep the information that we have already obtained. To safeguard your rights, we will use the minimum personally-identifiable information possible.

You can find out more about how we use the information collected for this study by contacting the members of the research team listed below.

10. What will happen to the results of the research study?

The findings from this study will be presented to the staff leading the developing of the training of rapid qualitative data use. The final results from the study will be shared across relevant networks and will be made available on the RREAL website. We will publish our findings in scientific journals and present them at national and international scientific meetings and conferences. Your name will not be used at any time, but we may use some quotes form our notes or the interview recordings.

11. What happens if something goes wrong?

If you wish to complain, or have any concerns about any aspect of the way you have been approached or treated by members of staff you have met through your participation in the research, you may wish to contact the Chief Investigator (details below). You can also contact the UCL Research Ethics Committee at ethics@ucl.ac.uk if you would like to complain.

12. Where can I find out more about the research?

Further information can be found by contacting the study team:

PI

Dr Cecilia Vindrola
c.vindrola@ucl.ac.uk
Telephone: 020 3108 3232

Researchers

Hilde van Susante MD
hildevansusante@gmail.com
Telephone: +447395386421

Data protection officer

Ms Alex Potts
data-protection@ucl.ac.uk

13. Local Data Protection Privacy Notice

The controller for this project will be University College London (UCL). The UCL Data Protection Officer provides oversight of UCL activities involving the processing of personal data, and can be contacted at data-protection@ucl.ac.uk

The categories of personal data used will be as follows: name and email address in order to carry out the interview (this will then be deleted), information on current occupation, gender and age.

The lawful basis used to process special category personal data will be for scientific and historical research or statistical purposes.

Your personal data will be processed so long as it is required for the research project. If we are able to anonymise or pseudonymise the personal data you provide we will undertake this and will endeavour to minimise the processing of personal data wherever possible.

If you are concerned about how your personal data is being processed, or if you would like to contact us about your rights, please contact UCL in the first instance at data-protection@ucl.ac.uk.

No personal data will be transferred outside the EEA.

THANK YOU FOR TAKING THE TIME TO READ THIS INFORMATION

AND FOR CONSIDERING HELPING WITH OUR STUDY

Appendix E: RREAL sheet design

RREAL Sheet	
Categories	**Data**
group of interviewees: office, leading fieldwork, team fieldwork	
role in organisation	
background	
experience data collection/ research	
description qualitative data	
situations to use qualitative data	
use in humanitarian responses	
perception of MSF towards qual data use	
does participant shares MSF perception	
experiences of qualitative data use in MSF	
knowledge/awareness of qualitative data use in MSF	
support on qualitative data use in MSF	
barriers	
enablers	
interest in qualitative data use in MSF of participant	
knowledge on qual data use of participant.	
what is missing to use qual data in MSF	
what would participant need to (start) to use qual data	
training needs	
advice to increase qual data use	
key message	
good quotes, key recordings	
extra information, RREAL sheet	

Appendix F: infographic study for dissemination of the results

AIM

To map the perceptions of MSF staff regarding qualitative data use in humanitarian settings. To identify the factors acting as barriers and enablers to data use and develop recommendations to increase qualitative data use in complex health emergencies in MSF.

METHODS

Rapid qualitative appraisal based on semi-structured interviews summarised in a RREAL sheet and analysed using framework analysis.

RESULTS

PERCEPTIONS OF QUALITATIVE DATA

- Seen as subjective and descriptive.
- Used for needs assessments, evaluations, understanding context of the community.
- Qual data are becoming more important and used at MSF, but use is limited and seen as less important than quantitative data.
- At senior management levels, qual data are not seen as a priority, but this is changing.

QUALITATIVE DATA USE

- The majority of staff had limited experience.
- There is limited support from the organisation.
- Main barriers: lack of time, skills, knowledge and understanding the value.
- Main enablers: the global/ MSF trend towards qualitative data with the introduction of 'people-centred approach'.

CAPACITY BUILDING

- Staff identified the need to standardise the processes used to collect and analyse qualitative data across MSF.
- Staff identified training needs such as: knowledge on methodology, analysis, dissemination, communication skills and the introduction of tools in field research.
- Support at a senior level and an increase in awareness were seen as essential changes to develop capacity in the organisation.

RECOMMENDATIONS

Train staff on how to do rapid qualitative assessments.

Set up an intersectional workgroup to support staff with projects that require the collection and analysis of qualitative data.

Monitor the impact of data use on the different projects at MSF.

Hilde van Susante[1], Sylvia Lim[2] and Dr Cecilia Vindrola-Padros[1]
1. Rapid Research Evaluation and Appraisal Lab (RREAL)
2. Médecins Sans Frontières
@RREALwork www.rapidresearchandevaluation.com

Appendix G: Rapid qualitative assessment training schedule September 2021 MSF

Calendar - Rapid Qualitative Assessments - Week 1

	Monday 6 September	Tuesday 7 September	Wednesday 8 September	Thursday 9 September	Friday 10 September
	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)
	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00
	Introduction	Module 1	Module 1	Module 2	Module 2
Session	Live Online Session	Group Work (w/ Facilitators)	Live Online Session	Live Online Session	Live Online Session
Topic	Welcome, Introductions, Housekeeping	Group Discussion with Facilitators	Making Use of Available Data	Experience of Qualitative Methods - Brief Presentation & Discussion	Drafting an Assessment Plan
Facilitators	Learning Unit - Eamon Kelly	Sylvia, Ginger, Darryl, Hilde	Sylvia & Ginger	Sylvia & Ginger	Sylvia
Duration	~50 minutes	~40 minutes	~45	~30	~30
	15 minutes break	15 minutes break	15 minutes break	10 minutes break	10 minutes break
Session	Live Online Session	Live Online Session	Live Online Session	Live Online Session	Group Work
Topic	Introduction to Course & Case Study	Intro to RQA	Case Study - Presentation	RQA Methods: Data Collection Pt. 1	Produce Assessment Plan Pitch
Facilitators	Sylvia Lim	Cecilia	Sylvia	Cecilia (& Ginger)	(Hilde, Darryl, Sylvia)
Duration	~50	~60	~30	~45	~30
	15 minutes break	15 minutes break	15 minutes break	20 minutes break	20 minutes break
Session	Live Online Session	Live Online Session	Group Work	Live Online Session	Live Online Session
Topic	Course Needs Analyis	RQA - How & Why	Brainstorm - Case Study Theme	RQA Methods: Data Collection Pt. 2	Elevator Pitches: Assessment Plan
Facilitators	Hilde van Susante (RREAL)	Ginger	(Sylvia, Ginger, Hilde)	Ginger (& Cecilia)	Groups
Duration	~20	~15	~45	~45	~45
Session	Group Work	Self Study	Self Study	Self Study	Self Study
Topic	Tembo Forum: Introduce Yourself		Exploring secondary data sources	Watch interview videos	Resources - Reading
Facilitators		Tembo Platform	Tembo Platform	Tembo Platform	Tembo Platform
Duration	~15		~60	~30	~30
Session	Self Study				
Topic	Case Study, Quiz, and More				
Facilitators	See Section on Tembo Platform				
Duration	~60				

Calendar - Rapid Qualitative Assessments - Week 2

	Monday 13 September	Tuesday 14 September	Wednesday 15 September	Thursday 16 September	Friday 17 September
	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)	Time in CET (Central European Time)
	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00	*13:00 - 17:00
	Module 3	Module 4	Module 4	Module 5	Module 5
Session	Live Online Session	Self Study	Live Online Session	Live Online Session	Live Online Session
Topic	Ethical Issues	Review tools	Basic Qualitative Analysis	Translating findings for stakeholders	Group Presentation & Critque Pt. 1
Facilitators	Ginger	Tembo Platform	Cecilia	Darryl	
Duration	~30-45 minutes	~30 minutes	~60 minutes	~60 minutes	~60 minutes
	15 minutes break		15 minutes break	15 minutes break	20 minutes break
Session	Live Online Session	Group Work (w/ Facilitators)	Group Work (w/ Facilitators)	Live Online Session	Live Online Session
Topic	MSF & Ethics	Developing Interview Guide	Analyzing data using RAP Sheet	Dissemination of information (COVID)	Group Presentation & Critque Pt. 2
Facilitators	Rafaella Ravinetto (MSF ERB)	Two groups facilitated by MSF & RREAL	Ginger & Hilde (OCBA/OCA)	Cecilia & Ginger	
Duration	~45	~30	~60	~40	~60
	10 minutes break	10 minutes break	15 minutes break	20 minutes break	20 minutes break
Session	Live Online Session	Group Work (w/ Facilitators)	Live Online Session	Group Work	Live Online Session
Topic	Ethics, Case Study & Consent	Practice Interviews	Discussion/reflection on analysis	Create Presentation of Results	Reflections & Wrap Up
Facilitators	Darryl (Lead) & Ginger (Assist)	Ginger, Sylvia, Hilde (& OCA)	Ginger & Hilde (OCBA/OCA)		MSF & RREAl (Eamon)
Duration	~30	~45	~30	~60	~45
	10 minutes break	20 minutes break			
Session	Group Work (w/ Facilitators)	Live Online Session	Self Study		Self Study
Topic	Draft a Consent Script	Role-play: Interview	Additional resources & references		Additional resources & references
Facilitators	Ginger, Darryl, Sylvia, Hilde	Ginger, Hilde, Sylvia (& OCA)	Tembo Platform		Tembo Platform
Duration	~35	~40	~60		~60
	15 minutes break	10 minutes break			
Session	Group Work (w/ Facilitators)	Live Online Session			
Topic	Practice & feedback: asking for consent	Discussion/reflection on interviews			
Facilitators	Ginger, Darryl, Sylvia, Hilde	Ginger & Sylvia			
Duration	~30	~30			
Session	Group Work				
Topic	Develop Assessment Plan				
Facilitators	Sylvia to intro				
Duration	~30				

Appendix H: Feedback training summary

Wrap up; key take away points from participants

- It was really interesting. I was lost sometimes before, I have a better idea now. However, you are sometimes blocked by higher levels in MSF to do such assessments.
  Recommendation: good you're doing this course for us, but it would be good to train higher level personal so they can support us better in this kind of projects.
- It was very interesting…. I learned a lot about communication. It takes more than only a presentation to change peoples behaviour, that's my take away…..
- Ok now I know it, my next mission I have to explain to my team how to do it. I need to think about how to explain this in 30 min to start doing this with my team.
- I don't like to only use the numbers and now I have a new tool to justify decisions with something else than numbers.
- I would like more hands-on examples from MSF projects.
- It is the new way to understand better the numbers. If I would have had this information before, I would have made different decisions in my past projects…. This is very useful to use in practise, I will make different decisions in the future.
- I learned a lot from my team and the facilitators. It is part of my job and it was good to see my struggles and to reflect on them. Especially the discussions and input from facilitators was really good to go through how to do things.
- It was very nice to hear from experienced people how they do RQA, it's part of their job so it was great to get advice from them from real life.
- I have done a handful assessments before, I always wanted to do everything which was confusing and not possible….now I have more tools to do it better. Especially the team effort is something I will take with me, I will try to do this more in next assessments. In a team it is easier than doing it alone, which I did often in the past.
- I have done a lot of assessments. This training gives me another experience to push me more to use qualitative tools in assessments.
- Some lectures had too much information and it was difficult to process, we need more time for some parts to really understand it all.
- I was able to have discussions with my group about assessments which helps me to be able to have these discussions in real life in a project; to understand what they are talking about and help out.
- Sometimes the English language was too fast…. Most of us are not native speakers.
- I am ready to coordinate the project if I was asked to join, thank you.
- I don't have experience on RQA in the past, so I always found it very difficult. I learned a lot, especially the presentations of Cecilia and Ginger were so helpful to understand different tools and techniques.
- Sometimes it was a bit fast and difficult to follow, but I could take away enough.
- It was a lot of information so, I need to review all the presentations.

- I have a difficulty to scope in the field. I learned in this course to start simple and focus. Also, the close monitor and ability to change during an assessment was helpful.

- I learned how to share my findings, I never thought about to share my findings outside MSF. Thank you.

- It gave me a kind of idea of qualitative research which makes me want to be part of it in the future.

- I have been mainly working with quantitative data in the past. So, it is very interesting to learn that there is more to know beyond the figures and numbers. The steps and tools in the training were very practical and useful. I will use it in my future work.

- It was very good to join, I work for a long time with MSF and other organisations doing assessments. I never realised that it could be so easy and organised, my next assessment will be easier and better organised.