Global Evidence, Local Adaptation (GELA) Project

Factors that influence the provision of early enteral feeding for critically ill children in paediatric intensive care: a rapid qualitative evidence synthesis

Work Package 2: SYNTHESISE

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Abstract

This is a protocol for a qualitative evidence synthesis for the Global Evidence, Local Adaptation (GELA) project. The objectives are as follows:

To explore factors associated with the provision of early enteral nutrition for critically ill children under the age of 12 in paediatric intensive care.

Introduction

The Global Evidence, Local Adaptation (GELA) project aims to maximise the impact of research on poverty-related diseases through enhancing decision makers' capacity to use global research to develop locally relevant Clinical Practice Guidelines (CPGs) for poverty-related diseases (PRDs) in the field of newborn and child health. Specifically, it will support decision makers in Malawi, Nigeria and South Africa, and build on and add value to the large-scale programme of child health CPG development led by the World Health Organization (WHO) with adaptation and implementation led by the WHO Afro regional office and national ministries of health.

This work is being done through the completion of a number of work packages (WPs). Work package 1 (WP1) entailed the identification of up to three priority questions in population, intervention, comparator, and outcome (PICO) format for guidelines and recommendations per country related to PRDs in the field of newborn and child health. Work package (WP2) entails the identification and adaptation, if necessary, of appropriate existing guidelines and recommendations for each of the identified priority questions per country. If existing guidance is not available to answer priority questions, evidence on these questions will be identified, evaluated, and synthesised using rapid or fast methods, and guidelines and recommendations will be developed following a *de novo* approach. A WP2 adolopment algorithm and Standard Operating Procedure for the algorithm have been developed (informed by the GRADE Adolopment algorithm; Schünemann 2017) to unpack, tailor and support the implementation of WP2 for the GELA project. Please refer to the WP2 adolopment algorithm and the Standard Operating Procedure document for full details on how this protocol fits into WP2 implementation.

A priority PICO question in Malawi on early versus delayed enteral nutrition for reducing in-hospital morbidity and mortality in critically ill children aged one month to 12 years was identified by WP1. A scoping review of guidelines by WP2 did not identify an existing guideline with a matching recommendation suitable for adolopment, and a scoping of published qualitative evidence syntheses (QES) did not yield a relevant existing synthesis or one that could be updated, Thus, a de novo QES will be conducted. This is the protocol for a QES on factors that influence the provision of early enteral feeding for critically ill children under 12 years of age in paediatric intensive care settings.

Background

Description of the condition

Nutritional support can be defined as the supply of energy (i.e., in the form of glucose, protein, or lipid) to provide calories (dietary energy) and substrate for metabolism (Joffe et al-,2016). Evidence suggests that nutritional support is one of the key pillars to avoid undernourishment in critically ill children (Kratochvíl et al., 2022; Solana et al., 2023. Given that there may be a significant malnutrition rate (up to 25%) at the time of admission to the pediatric intensive care unit (PICU), nutritional support should be tailored to each child's specific needs (Kratochvíl et al., 2022).

Illness-related malnutrition in PICU children

Malnutrition is common in the pediatric intensive care unit (PICU) (Li & Chen, 2021; Solana et al., 2023) with 15–25% prevalence rates in developing countries (Li & Chen, 2021; Tume et al., 2020). Malnutrition does not only prolong the course of the disease, but also leads to the development of multiple organ failure (Li & Chen, 2021). Malnutrition in hospitalised children may result from nutrient loss, reduced nutrient intake, increased energy expenditure, or changes in nutrient utilisation; these are frequent in acute illnesses such as trauma and infections, as well as chronic diseases such as cystic fibrosis, chronic kidney disease, malignancies, congenital heart disease, gastrointestinal diseases, and neuromuscular diseases; and longstanding malnutrition may be characterized by stunting (Mehta et al., 2013). Compared to adults, children are particularly vulnerable to malnutrition, having lower energy reserves and greater nutritional requirements per unit of body weight, to account for growth.

Poor nutritional condition in the PICU is linked to post-discharge morbidity, higher mortality, and inpatient morbidity (Bunyani et al., 2015; Daniel et al., 2019; Kratochvíl et al., 2022; Tume et al., 2020). Paediatric patients who are malnourished at admission to PICU are at an increased risk of infection, death, prolonged mechanical ventilation and usage, as well as length of stay (Albadi & Bookari, 2022; Bagri et al., 2015). Low- and middle-income countries bear the greatest burden of childhood malnutrition, especially those in sub-Saharan Africa and Asia, making children in these countries more likely to be nutritionally at risk on admission to PICU. With few skilled persons available to give nutritional interventions, nutrition care for these children is highly limited in resource-constrained countries like Malawi. Therefore, it is evident that clinical nutrition support is required in low-resource hospital settings to enhance the standard of care for vulnerable children (Daniel et al., 2019.

Description of the intervention

Enteral nutrition, also called tube feeding, is the provision of nutrition, most often in the form of a special liquid formula, using a tube feeding directly into the gastrointestinal tract bypassing the oesophagus. Most commonly, tube feeding is initiated using a nasogastric feeding tube (NGT), but nasoduodenal, nasojejunal, gastrostomy and jejunostomy tubes are also used to access the gastrointestinal tract.

Over the past decades, parenteral nutrition was the major route of nutritional support. Over time, there has been a shift from parenteral nutrition to enteral nutrition as evidence suggested that the parenteral route promoted sepsis and proved harmful (Jeejeebhoy, 2007). Enteral nutrition is an essential intervention in the management of critically ill children who are not able to eat or drink orally. In fact, enteral nutrition is one of the most common methods of providing nutritional support for critically ill paediatric patients (Joffe 2016).

Enteral nutrition has been shown to result in multiple benefits including fewer infections and better healing during ICU dependency, as well as overall, better short- and long- term clinical outcomes in paediatric critical care patients (Srinivasan et al., 2020). Timing is especially important and for enteral nutrition to be effective, it needs to be implemented early (within the first 48 hours after indication for enteral nutrition) as demonstrated in randomised control trials (Solana et al., 2023). Early enteral nutrition has been associated with better outcomes compared to delayed enteral nutrition, as it promotes and maintains gastrointestinal mucosal integrity including higher caloric intake and fewer complications. Furthermore, a study by Chisti et al. (2018) found that early initiation of enteral nutrition significantly reduced mortality and improved nutritional outcomes in children with severe acute malnutrition in Bangladesh. Similarly, a study by Maitland et al. (2011) reported a significant reduction in mortality among critically ill children who received early enteral nutrition in Kenya. These findings suggest that early enteral nutrition could be a valuable intervention to improve outcomes in critically ill children requiring enteral nutrition in Malawi.

How the intervention might work

Children admitted to neonatal and paediatric intensive care units (ICUs) are at increased risk of mortality due to the complex nature of their illnesses posing a burden on paediatric care (Abukari & Acheampong, 2021). In addition, critical illness initiates a cascade of metabolic and hormonal derangements, which can lead to severe macro- and micronutrient deficiencies (Orellana & Coss-Bu, 2021).

Introduction of enteral nutrition therapy aims to maintain or restore the nutritional status of individuals who fail to maintain a sufficient oral intake (Ista & Joosten, 2005). Providing nutrition in the form of tube feeding is often considered a priority during critical illness in children and infants. Early enteral nutrition works by reducing the metabolic stress response,

preventing oxidative cell damage and regulating the immune response. It also maintains the integrity and function of gastrointestinal mucosa (Li & Chen, 2021). Components of enteral feeding include the site of feeding (gastric versus enteric), the type of feeding tube, enteral nutrition formula, modality (continuous, intermittent, bolus), and timing of nutrition initiation and advancement. Several factors affect decisions about these components, with medical conditions, risk of complications, and the expected enteral feeding duration being the among the most important.

Despite research indicating that early enteral nutrition can improve clinical outcomes in critically ill children, clinicians tend to avoid it (Srinivasan et al., 2020; Zaher, 2022). This may be due to a number of factors including a lack of education and training on optimal feeding of patients, interruptions due to perceived intolerance, withholding of enteral feeds in advance of procedures or operating department visits and insufficient dietitian coverage (Tume 2020, Zaher 2022). Other factors that have been reported include lack of nutritional awareness, estimation rather than measurement of nutritional needs of an individual child, under prescription, lack of routine assessments of patients, inadequate delivery of nutrients and interruptions of nutritional support (Mara et al., 2014). It is also important to note that there are absolute contraindications to initiating enteral nutrition such as severely impaired gastrointestinal function, complete intestinal obstruction or gastrointestinal perforation. Further, there may be relative contraindications such as intestinal dysmotility, necrotizing enterocolitis, toxic megacolon, diffuse peritonitis, gastrointestinal bleeding, and high-output enteric fistula (Yi, 2018).

Why is it important to do this review?

Specific nutritional interventions for critically ill children have often been based on expert opinion or on extrapolations from studies of adults and non-critically ill children (Fivez 2015). Previous reviews on health care workers' knowledge, attitudes, and beliefs about nutritional support in intensive care do not specifically focus on nutritional support for critically ill children (Lyons et al., 2022). Similarly, previous reviews on parents' and family experiences of enteral feeding have focused on chronically ill children and gastrostomy-tube feeding in particular rather than on children who are critically ill (Nelson et al., 2015).
Guidelines and recommendations for enteral nutrition in critically ill children can provide healthcare providers with evidence-based guidance on the initiation, monitoring, and adjustment of enteral nutrition to optimize clinical outcomes and minimize complications (Mehta et al., 2017). Furthermore, the standardization of enteral nutrition practices through guidelines and recommendations can improve the quality of care, reduce variability in clinical practice, and promote adherence to best practices (Rogers et al., 2016).

Qualitative evidence can provide useful information about the acceptability, feasibility and equity of interventions, which in addition to effectiveness and resource evidence, is important to inform decisions about guideline recommendations (Alonso-Coello et al., 2016; Downe et al., 2019). Through synthesising qualitative studies exploring key stakeholders' experiences and perceptions of enteral feeding, we can identify factors that guideline

developers should consider when making recommendations about enteral nutrition for critically ill children.

Objectives

The objective of this review is to explore factors associated with the provision of early enteral nutrition for critically ill children in paediatric intensive care settings.

Methods

Before beginning the proposed systematic review, we searched Epistemonikos (epistemonikos.org) for existing systematic reviews, broad syntheses and structured summaries to identify if there was a QES we could use or update for the guideline development process. We were, however, unable to identify any reviews that covered our topic of interest.

When preparing this protocol, we used the EPOC protocol template for qualitative evidence synthesis (Glenton et al., 2019).

Review co-production with relevant stakeholders

The topic of this review was determined through a process using best practice priority setting methods to identify priorities for guidelines in newborn and child health in South Africa, Malawi and Nigeria, including of stakeholder consultations, online priority-setting surveys and consensus meetings with representatives from the Ministry of Health of Malawi and with Malawian clinical experts, guided by a national Steering Group. To further refine the scope of this review, we will invite clinicians from hospital settings where enteral feeding is provided to participate in a structured discussion using the TRANSFER conversation guide (Munthe-Kaas et.al. 2020). During this discussion, we will ask them to identify contextual factors that they believe are likely to influence the review findings. These could be factors tied to, for instance, the clinical setting, the type of healthcare workers providing care, or the age of the study. We will use these factors as a basis for possible study sampling strategies and subgroup analyses. We will also consider these factors when assessing the 'relevance' component of our GRADE-CERQual assessment (see below) and when carrying out our analysis. Finally, we will consider involving some or all of these stakeholders when developing the 'Implications for practice' section of this review (see below).

Criteria for considering studies for this review

Types of studies

We will include primary studies that use qualitative study designs such as ethnography, phenomenology, case studies, grounded theory studies and qualitative process evaluations.

We will include studies that use both qualitative methods for data collection (e.g., focus group discussions, individual interviews, observation, diaries, document analysis, open-ended survey questions) and qualitative methods for data analysis (e.g., thematic analysis, framework analysis, grounded theory). We will exclude studies that collect data using qualitative methods but do not analyse these data using qualitative analysis methods (e.g., open-ended survey questions where the response data are analysed using descriptive statistics only).

Due to time constraints, we will include published studies only.

We will include mixed methods studies where it is possible to extract the data that were collected and analysed using qualitative methods.

We will include studies regardless of whether they were conducted alongside studies of the effectiveness of early enteral nutrition in critically ill children.

We will not exclude studies based on our assessment of methodological limitations. We will use this information about methodological limitations to assess our confidence in the review findings.

Topic of interest

This synthesis will focus on the views, attitudes, experiences and behaviours of children, caregivers, health care providers, and any other stakeholders potentially affected by a recommendation on the use of enteral feeding to critically ill children in a hospital setting, with a focus on early versus delayed introduction of enteral feeding, if possible.

By 'children' we mean persons between the age of 0 and 18. By 'caregivers', we mean anyone who is directly involved in caring for the child or making the decision of accepting the intervention on behalf of the child. By 'health care providers' we mean any cadre of healthcare workers involved in the provision of enteral nutrition for critically ill children, as well as any other staff involved in supporting the provision of enteral nutrition for critically ill children, e.g. administrative, managerial or supervisory staff.

By enteral feeding we mean the delivery of nutrition directly into the GI tract through a tube, e.g., a nasogastric tube, gastrostomy tube or jejunostomy tube. We will exclude studies that focus only on parenteral feeding, i.e., intravenous provision of nutrition.

We will include studies that focus on the provision of enteral feeding for critically ill children in any hospital setting, including general paediatric ward settings as well as acute hospital settings. We will exclude studies where the primary focus is on child enteral feeding in home or community settings.

We will exclude studies where the primary focus is on children with Severe Acute Malnutrition (SAM) or children with chronic health conditions (e.g., neurological impairment, genetic disorders) who require long-term enteral feeding.

Search methods for identification of studies

Electronic searches

An information specialist will develop the search strategies in consultation with the review authors.

We will search the following electronic databases to identify eligible studies:

- MEDLINE via Ovid
- CINAHL via EbscoHost
- Embase via Ovid
- Scopus via Elsevier

We will develop search strategies for each database. We will not apply any limits on publication date. We will search all databases from their inception. Where applicable, we will include a methodological filter for qualitative studies. See Appendix 2 for the MEDLINE search strategy, which we will adapt for other databases. We will provide appendices for all strategies used.

Because of the limited time of the project, we will only search for studies in English, and we will not search for grey literature.

Searching other resources

We will review the reference lists of all the included studies and key references (i.e. relevant systematic reviews).

We will consider checking effectiveness studies that were included in the linked intervention review that will be carried out as part of the GELA project in order to identify any qualitative studies that were associated with these studies.

We will consider contacting authors of included studies to clarify published information and to seek unpublished data.

Selection of studies

Two review authors will independently assess the titles and abstracts of the identified records to evaluate eligibility. We will retrieve the full text of all the papers identified as potentially relevant. Two review authors will then assess these papers independently. We

will resolve disagreements by discussion or, when required, by involving a third review author.

We will include a table listing studies that we excluded from our review at full text stage and the main reasons for exclusion.

Where the same study, using the same sample and methods, has been presented in different reports, we will collate these reports so that each study (rather than each report) is the unit of interest in our review.

We will include a PRISMA flow diagram to show our search results and the process of screening and selecting studies for inclusion.

Machine learning

To maximise efficiency, we will consider using machine learning functions in the screening and study selection processes.

Sampling of studies

Qualitative evidence synthesis aims for variation in concepts rather than an exhaustive sample, and large amounts of study data can impair the quality of the analysis. Once we have identified all studies that are eligible for inclusion, we will assess whether their number or data richness is likely to represent a problem for the analysis and will consider selecting a sample of studies.

To allow for the broadest possible variation within the included studies, we will use maximum variation purposive sampling to select from the eligible studies (Ames 2019; Suri 2011). Potential sources of variation include participants' age and healthcare condition, type of enteral feeding, the year in which the study was conducted and the geographical region. We will also consider assessing the data richness of eligible studies, for instance by using the approach used by Ames (2019). Once we have determined suitable variables, we will create a sampling frame and map all eligible studies onto the frame. We will then review the studies within each cell of the frame and decide how many studies to include in the review.

Data extraction

We will develop a data extraction form for use when extracting the following descriptive information:

- First author of the study, year of publication, country of study, study setting (level of care).
- Participants' age, socioeconomic status, healthcare condition, cadre of health worker (e.g., nurse, doctor, midwife, or other cadre identified as the health provider), type of

enteral feeding (e.g., nasogastric tube, gastrostomy tube, jejunostomy tube) and type of feed (e.g., commercial feed, hydrolysed feed, staple food, modified staple food)
- Any other information identified as important for subgroup analyses, such as the country setting (e.g., high- or low-/middle-income country setting)
- Information about study design and sources of funding

Secondly, we will extract all data relevant to the review objective. This includes data describing the views, experiences, and behaviour of children, caregivers, healthcare workers and others involved in the provision of enteral feeding of critically ill children. See further details under 'Data management, analysis and synthesis'.

At least one review author will extract the data, and another will cross-check the data to ensure that all relevant data has been extracted. Disagreements will be resolved by discussion or in consultation with a third review author.

Assessing the methodological limitations of included studies

At least two review authors will independently assess methodological limitations for each study using a quality assessment tool for qualitative studies used in previous Cochrane Reviews (Ames 2017; Ames 2019; Houghton 2020). Where any of the review authors are also authors of included studies, they will not be involved in assessing the study's methodological limitations. We will resolve disagreements by discussion or, when required, by involving a third review author.

We will assess methodological limitations according to the following domains.

- Are the settings and context described adequately?
- Is the sampling strategy described, and is this appropriate?
- Is the data collection strategy described and justified?
- Is the data analysis described, and is this appropriate?
- Are the claims made/findings supported by sufficient evidence?
- Is there evidence of reflexivity?
- Does the study demonstrate sensitivity to ethical concerns?
- Any other concerns?

We will report our assessments in a Methodological Limitations table, using a 'yes/no/uncertain' rating and with explanations of any concerns we have. We will use these assessments to support our GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) assessment of our confidence in the review findings (Lewin 2018).

Data management, analysis and synthesis

We will use a thematic synthesis method as our analytical approach (Thomas & Harden, 2008). We will select the article that most closely answers the review objectives and create a data extraction sheet based on these codes. Two review authors will then code the data

extracted from this article. These authors will then code the subsequent articles using the data extraction sheet, adding new codes from subsequent articles as they emerge. Data extraction will be verified by other review authors. Review findings will then be synthesised from the data that has been given the same codes across the studies. Findings will be shared with co-authors to review. Finally, we will re-read the included studies to check that we have extracted all data relevant to the findings.

Once we have finished preparing the review findings, we will examine each finding, identify factors that could influence the implementation of the intervention/s, and develop prompts for future implementers. These prompts will be presented in the implications for practice section. These prompts are not intended to be recommendations but will be phrased as questions to help implementers consider the implications of the review findings within their context. We will share this section with a few stakeholders involved in the wider GELA project to gather their feedback about the relevance of these prompts and the manner in which they are phrased and presented.

Assessing our confidence in the review findings

At least two review authors will use the GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) approach to assess our confidence in each finding (Lewin 2018b(Lewin et al., 2018)). GRADE-CERQual assesses confidence in the evidence, based on the following four key components.

1. Methodological limitations of included studies: the extent to which there are concerns about the design or conduct of the primary studies that contributed evidence to an individual review finding.
2. Coherence of the review finding: an assessment of how clear and cogent the fit is between the data from the primary studies and a review finding that synthesises those data. By cogent, we mean well supported or compelling.
3. Adequacy of the data contributing to a review finding: an overall determination of the degree of richness and quantity of data supporting a review finding.
4. Relevance of the included studies to the review question: the extent to which the body of evidence from the primary studies supporting a review finding is applicable to the context (perspective or population, phenomenon of interest, setting) specified in the review question.

After assessing each of the four components, we will make a judgement about the overall confidence in the evidence supporting the review finding. We will judge confidence as high, moderate, low, or very low. The final assessment will be based on consensus among the review authors. All findings start as high confidence and will then be graded down if there are important concerns regarding any of the GRADE-CERQual components.

Summary of Qualitative Findings table(s) and Evidence Profile(s)

We will present summaries of the findings and our assessments of confidence in these findings in the Summary of Qualitative Findings table(s). We will present detailed descriptions of our confidence assessment in an Evidence Profile(s).

Review author reflexivity

Our review team consists of authors with different disciplinary backgrounds, but all the review authors are researchers working in evidence-based health science departments in universities. Seven review authors are health systems or public health researchers (CG, SMB, SL, NMM, IIK, CN, AB). Three authors have clinical healthcare backgrounds (NMM, SMB, CN), while two review authors have other academic backgrounds than healthcare, namely library sciences (LVN) and architecture (ES), food science and microbiology (AB).

The topic of enteral feeding was identified through a process of stakeholder consultations carried out as part of the GELA project. The review team was drawn from the pool of researchers already involved in the GELA project. However, our familiarity with this topic specifically varied. CN is a registered dietician with training and experience in providing enteral feeding to adults and children in hospital settings in South Africa and the United Kingdom, SMB has provided enteral feeding as a clinician, though only nasogastric feeding, and NMM provided enteral feeding as part of nursing training 20 years ago. None of the authors have any personal experience with enteral nutrition as a recipient or as a caregiver to a child receiving enteral feeding. Furthermore, with the exception of CN, none of the review authors had carried out or were otherwise familiar with the research literature on enteral feeding before starting work on this review.

None of the review authors had specific opinions on enteral feeding other than the awareness that early enteral feeding is a recommended practice. As such, we have few preconceptions about what the review will find. This lack of preconceived notions may allow us to approach the data with an open mind, but our lack of previous knowledge can also hinder our understanding of the issues raised in the studies we find.

However, based on our experience as health systems researchers, our preparatory reading of literature on the topic, as well as our initial experiences of review co-production with stakeholders, we do expect to find a range of individual and systems-level factors that may create barriers to the provision of enteral feeding. We believe these factors may be related to healthcare providers' skills, training, knowledge, and awareness as well as to their access to human resources, infrastructure, and supplies. Other factors that may play a role include caregivers' awareness, the cost of enteral nutrition and the type of feed available. However, given our lack of experience with the topic, none of us has clear expectations about the review findings.

In keeping with quality standards for reflexivity within qualitative research, we will maintain a reflexive stance throughout all stages of the review process. We will consider how our individual and collective views, beliefs and experiences could influence our choices regarding

the scope of the review and our review methods, our interpretation of the data and our interpretation of our findings.

Ethical considerations

As the research project is based on publicly available documents, we will not seek approval for conduct of the project.

Protocol registration

This protocol will be registered to the international prospective register of systematic reviews, PROSPERO (https://www.crd.york.ac.uk/prospero/).

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When preparing this protocol, we used EPOC's Protocol and Review Template for Qualitative Evidence Synthesis (Glenton C, Bohren MA, Downe S, Paulsen EJ, Lewin S, on behalf of Effective Practice and Organisation of Care (EPOC). EPOC Qualitative Evidence Synthesis: Protocol and review template. Version 1.1. EPOC Resources for review authors. Oslo: Norwegian Institute of Public Health; 2020. Available at: http://epoc.cochrane.org/epoc-specific-resources-review-authors)

Declarations of interest

The authors have no interests to declare.

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Appendices

1 Search strategy for Epistemonikos

#	Search strategy designed for Epistemonikos
#1	((enteric* OR enteral* OR tube* OR gastric* OR support*) AND (nutrition* OR feeding*))
#2	child* OR infant* OR newborn* OR pediatr* OR paediatr* OR PICU*
#3	((hospital* OR in-hospital* OR inpatient* OR in-patient*) AND ((critical* AND (ill OR illness) OR "high risk")) OR ICU OR PICU* OR ((intensive OR critical*) AND care))

2 Search strategy for PubMed MEDLINE

#	Search strategy designed for PubMed MEDLINE
#1	Enteral Nutrition/
#2	((enteral or enteric or force or tube or gastric or intragastric or intestinal or intraintestinal or support) adj (nutrition* or feeding*)).tw.
#3	1 OR 2
#4	exp Child/
#5	exp Infant/
#6	Minors/
#7	exp Pediatrics/
#8	exp Adolescent/
#9	(child* or infan* or newborn* or neonat* or kid or kids or boy or boys or girl or girls or underage* or under-age* or juvenil* or p?ediatric* or adolescen* or preteen* or midteen* or teen* or youth* or youngster*).tw.
#10	(young* adj (person* or individual* or people* or male* or female*)).tw.
#11	or/4-10
#12	Hospitalization/
#13	Inpatients/
#14	(hospital* or inpatient*).tw.
#15	or/12-14
#16	11 and 15
#17	Child, Hospitalized/
#18	Adolescent, Hospitalized/
#19	or/16-18
#20	3 and 19
#21	Interviews as Topic/ or Focus Groups/ or Narration/ or Qualitative research/
#22	(("semi-structured" or semistructured or unstructured or informal or "in-depth" or indepth or "face-to-face" or structured or guide) adj3 (interview* or discussion* or questionnaire*)).tw,kf.
#23	(focus group* or interview or qualitative or ethnograph* or fieldwork or "field work" or key informant or mixed method*).tw,kf.
#24	or/21-23

#25 20 and 24