OCR
Oxford Cambridge and RSA

Friday 17 January 2020 – Afternoon

Level 3 Cambridge Technical in Health and Social Care

05871 Unit 25: Research methods in health, social care and childcare

Pre-release material

Please write clearly in black ink.

Centre number | | | | | | Candidate number | | | | |

First name(s) _____

Last name _____

Date of birth | D | D | M | M | Y | Y | Y | Y |

GUIDANCE NOTES

- This pre-release material contains three research articles on three different themes.
- The question paper will require learners to respond to questions about research they have completed and questions which are associated with general research principles.
- Learners need to conduct research linked to the pre-release material in the five weeks they have access to the document.

INSTRUCTIONS FOR TEACHERS

- This material must be issued 6 weeks prior to the published examination date.
- This material must be printed on A4 only.
- Learners are permitted to summarise their research findings and record results/evidence/data gathered **in the notes pages at the back of this document only** (not in the margins or around the pre-release material itself or on additional sheets) and **must not exceed the 2 pages provided**.
- The notes section must **not** be used to produce a formal write-up of the research conducted.
- Teachers must collect in each learner's pre-release material and notes **one calendar week** prior to the exam date.
- Teachers must check that the notes made are appropriate and are the learners' own work in advance of the examination taking place.
- The pre-release and notes must then be returned to learners **immediately before the exam** commences.
- The pre-release and notes **must** be submitted along with the learners' Question Paper at the end of the examination.

INFORMATION FOR LEARNERS

- You **must** choose one of the research articles (source **A**, **B** or **C**).
- You **must** identify a specific focus from the article for further secondary research.
- You **must** then complete further secondary research related to your focus, using **at least two** sources.
- Your notes on the research **must not** exceed the pages provided in this document; no additional sheets may be taken into the examination.
- Your secondary sources **must be** recorded on page 9 of this document.
- Notes are only permitted on pages 10 and 11, not elsewhere within the pre-release material such as in the margins or around the sources themselves.
- You **must** hand in your pre-release material and notes with your question paper at the end of the examination.

SOURCE A

Adapted from:

Ipsos MORI and Dr Agnes Nairn (June 2011). Children's Well-being in UK, Sweden and Spain: The Role of Inequality and Materialism. A Qualitative Study.

Introduction

UNICEF's Report Card 7, published in 2007, put the low well-being of children in the UK firmly on the agenda. Compared with 20 other OECD (Organisation for Economic Co-operation and Development) countries, including substantially poorer countries such as Poland and Greece, the UK came bottom on three out of six dimensions of well-being, and came bottom overall in the league table. Other indices of children's well-being have also found the UK to be doing badly.

Research aims and objectives

The main research aim is to understand how, and to what extent, inequality and materialism affect children's experience of life, in order to improve children's well-being in the UK. We have endeavoured to dig beneath the statistics on child well-being to discover the lived experiences of children.

Methodology

A qualitative approach was used in the UK and our comparator countries Spain and Sweden. The research process spanned eight months. A two-phase qualitative methodology was used, consisting of ethnographic family case studies, followed by a series of friendship groups with children. Exactly the same methodology was used in each country to enable meaningful comparison.

Ethnographic case study allows us the opportunity to observe what naturally occurs in family life, and how this is experienced by children, rather than restricting responses to a set of preconceived questions. We chose to film each of our case studies, not only to make a record for analysis but in order that we could create edited clips to capture and present to stakeholders the totality of our findings: what was heard, what was seen and what was felt. We worked within the natural setting of the family unit in Spain, Sweden and the UK, using non-participant ethnography where the researchers played the part of observer. An average of six hours was spent with each family and the time was split between group interaction and time alone with children and parents.

For the second phase of the research, we conducted discussion groups with children aged 8-13 years, who were friends, and individual interviews with children who were more isolated.

All of the discussion groups were audio recorded, and moderators were asked to make a comprehensive set of field notes using a template to clarify important areas to focus upon, which included verbatim quotations from the audio files.

Executive summary

The research paints a complex picture of the relationship between well-being, materialism and inequality across Spain, Sweden and the UK.

Materialism: Whilst technology and clothes brands were actively coveted, for the majority of the eight to thirteen year olds across the three countries, new toys, fashion items and gadgets were not central to their well-being. Rather than wanting to acquire things for their own sake, material objects and consumer goods tended to fulfil a range of purposes in children's lives: utilitarian, symbolic and social. Whilst the more functional aspects of consumer goods such as a hockey stick to enable playing in a local team seem benign, the symbolic use of brands either to confer superior status or to avoid bullying is much more problematic. The role of consumer goods in the lives of children is therefore complex and multi-faceted and not easily reduced to a single notion of greed or acquisitiveness. Moreover most children across the countries agreed that it was not desirable to get everything you wanted with 'spoiled' children being universally derided. The notions of waiting, saving up for and earning material rewards were highly regarded by the vast majority of children.

However, whilst most children agreed that family time is more important than consumer goods, we observed within UK homes a compulsion on the part of some parents to continually buy new things both for themselves and their children. Most parents realised that what they were doing was often 'pointless' but seemed pressurised and compelled to continue. We also noticed that UK parents were often buying their children status brands believing that they were protecting them from the kind of bullying they experienced in their own childhood. This compulsive acquisition and protective, symbolic brand purchase was largely absent in Spain and Sweden where parents were clearly under much less pressure to consume, and displayed greater resilience.

Behind the statistics we find many UK children do not refer to material goods when talking about what makes them happy, and also understand the principles of moderation in consumption, but may have parents who feel compelled to purchase, often against their better judgement.

Inequality: In this research, the difference in inequality was more prominent for the older children in secondary school, when distinctions between groups of children started to be made on the basis of outward appearance rather than personality. At this stage material goods and brands began to play an important part in identifying and categorising people. In the UK and Sweden high status brands tended to be more important to children from less affluent backgrounds, presumably as a means of masking financial and social insecurities and bolstering self-esteem. Inevitably, expensive brands symbolised wealth with the rich and the poor marked out clearly by their possessions. Nonetheless, the children's attitudes to the 'haves' and the 'have-nots' were highly contested and ambivalent.

Whilst the links between brands and inequality created tensions and anxieties for children in all three countries to some extent, these feelings were only shared by UK parents. Swedish and Spanish parents seemed not to belong to a 'consumer generation' in the same way.

Behind the statistics we find children's growing awareness of inequality as they approach secondary school and the role of consumer goods in identifying and creating status groups within peer groups. Children have a very ambivalent attitude to those who appear to be able to afford all the latest status goods. Whilst many UK parents are complicit in purchasing status goods to hide social insecurities this behaviour is almost totally absent in Spain and Sweden. Inequality also has its part to play in access to sporting and creative activities in the UK.

SOURCE B

Extracts from:

Manjula Narasimhan et al. (published online Feb 2016). *Sexual and reproductive health and human rights of women living with HIV: a global community survey*. Bulletin of the World Health Organization; Type: Research Article ID: BLT.14.150912.

Introduction

WHO has guidelines on the care, treatment and support for women living with HIV and their children in resource-constrained settings, but these guidelines were published in 2006 and require updating. As an initial step in the updating process, WHO commissioned a global survey to listen to the voices of women living with HIV and determine these women's sexual and reproductive health priorities.

Methods

A core team created a global reference group of 14 women living with HIV and together they developed a global community online survey. The survey, which contained mandatory and optional questions, was based on an appreciative enquiry approach in which the life-cycle experiences of women living with HIV were investigated. The same set of questions was also used in focus group discussions led by the global reference group.

Findings

The study covered 945 women (832 in the survey and 113 in the focus groups) aged 15–72 years in 94 countries. Among the respondents to the optional survey questions, 89.0% (427/480) feared or had experienced gender-based violence, 56.7% (177/312) had had an unplanned pregnancy, 72.3% (227/314) had received advice on safe conception and 58.8% (489/832) had suffered poor mental health after they had discovered their HIV-positive status.

Conclusion

The sexual and reproductive health needs and rights of women living with HIV are complex and require a stronger response from the health sector. The online survey placed the voices of women living with HIV at the start of the development of new global guidelines. Although not possible in some contexts and populations, a similar approach would merit replication in the development of guidelines for many other health considerations.

Table 1. Details of the focus group discussions held, with 113 women living with HIV, in seven countries, 2014.

Country	Language	Participants[a]
Ethiopia	Amharic	One discussion with 20 rural women living with HIV and one with 10 sex workers
Jamaica	English	Eight women aged 41–63 years living with HIV
Myanmar	Myanmar bhasa	10 young female teenagers who were born with HIV
Nepal	Nepali	One discussion with 10 widows, aged 28–55 years, whose husbands were migrant workers, one with four sex workers aged 17–25 years, and one with five transgender women
Senegal	French and Wolof	One discussion with 20 sex workers aged 17–65 years and one with 10 women – some of whom were physically disabled
Thailand	Thai	Five women – two of whom were drug users
UK	English	11 migrant women – three of whom had been in prison or detention

[a] Ages are shown only when they were recorded.

Table 2. Numbers of respondents in the online survey of women living with HIV in 94 countries, 2014.

Language	No. of respondents	No. of respondents who were women living with HIV
English	568	480
Russian	135	99
Spanish	128	104
Chinese	80	57
French	46	42
Portuguese	44	28
Bahasa Indonesian	27	22
TOTAL	1038	832

Table 3. Key responses of the women living with HIV who participated in the online survey covering 94 countries, 2014.

Response	No. of women answering relevant question	No. of women answering yes (%)[a]
Had experienced violence or fear of violence[b]	480	427 (89.0)
Always or usually had a healthy libido and/or feeling of sexual desire	479	154 (32.2)
Found service providers to be well trained, knowledgeable, friendly and supportive	589	297 (50.4)
Had been supported by service providers to make fertility-related choices	318	169 (53.1)
Had had an unplanned pregnancy	312	177 (56.7)
Had accessed family-planning counselling	273	122 (44.7)
Had received advice on safe conception	314	227 (72.3)
Had received practical support on safe conception	304	168 (55.3)
Had had a mental health issue after the diagnosis:		
• Depression	486	360 (74.0)
• Shame	459	325 (70.8)
• Self-blame	478	334 (70.0)
• Feelings of rejection	468	327 (69.9)
• Insomnia	459	314 (68.4)
• Other[c]	473	285 (60.3)

[a] Of the women answering the relevant question.
[b] Before, since and/or because of positivity for human immunodeficiency virus.
[c] Anxiety, body-image problems, loneliness/isolation and/or very low self-esteem.

SOURCE C

Extracts and summary from:

Terrence Higgins Trust. *Uncharted Territory: A report into the first generation growing older with HIV,* 2017.

Executive Summary and Background

In 2010, Terrence Higgins Trust, Age UK and The Joseph Rowntree Foundation released a groundbreaking piece of research, *A National Study of Ageing and HIV (50 Plus)*, that explored the needs and experiences of over 400 people living with HIV aged 50 and over. Much has changed since then and this research aims to update the evidence based on the findings of 2010. This will provide the call to action needed for the HIV community and other advocates to push for change to ensure the needs of people ageing with HIV are fully met.

Methodology

This research project utilised a peer-led research design model. The inclusion criteria for this project, either as peer researcher or as participant, was that the individual must be aged 50 or older, be living with HIV and live in the UK. The first stage of data collection included a survey of 55 questions on topics including health, financial situation and emotional wellbeing. A total of 30 interviews and six workshops with individuals living with HIV aged 50 or over were conducted by the peer researchers. The interviews were designed under the life history model of qualitative interviewing. The workshops consisted of group discussion and activities inspired by deliberative event methodologies.

The impact of the availability of HIV treatment

The study has highlighted that there is a difference in needs and experience depending on whether an individual was diagnosed with HIV before or after the availability of effective antiretrovirals (ARVs) in the UK in 1996. Individuals diagnosed before 1996 were more likely to be dependent on benefits as their sole or main source of income. They were less likely to be in employment (full- or part-time). Individuals diagnosed before treatment was available were more likely to have three or more additional health conditions.

Poverty is impacting people living with HIV aged 50 and over

58% of survey respondents were defined as living on or below the poverty line. The situation has deteriorated since 2010 when 48% of respondents to Terrence Higgins Trust's HIV and Ageing survey were found to be living in poverty. Statistics available for the general population indicate that levels of poverty seen in people living with HIV aged 55+ are double those seen in the general population.

Over a third of individuals aged 50 and over living with HIV were reliant on welfare benefits. A third had not made financial plans for the future and 84% were concerned about future financial difficulties. The situation has deteriorated since 2010 with more people living with HIV aged 50+ having concerns about future finances compared to seven years ago.

Social care is not currently meeting the needs of people living with HIV

People growing older with HIV face the prospect of managing multiple long-term conditions that are made more complex by their interactions with HIV. Of people living with HIV aged 50 and over, 81% were concerned about how they would take care of themselves and manage daily tasks in the future. A quarter said they would have no one to help them if they ever needed support with daily tasks.

Altogether, 82% of over 50s living with HIV were concerned about whether they would be able to access adequate social care in the future and 88% had not made financial plans to fund future care needs.

Even when people living with HIV have been able to access social care services they have faced discrimination from social care professionals due to their HIV status, including in residential care homes. This is unacceptable. People living with HIV in care homes should not be treated differently from their peers. Instead, these actions are fuelling myths and stigma around HIV and further isolating older residents living with HIV in residential care.

Many people living with HIV aged 50 and over face social isolation and loneliness

A third of survey respondents were socially isolated and 82% experienced moderate to high levels of loneliness. People living with HIV aged 50 and over were at least three times more likely to experience high levels of loneliness than the general population. Wellbeing decreased with increased social isolation. The situation has deteriorated since the 2010 Terrence Higgins Trust 50+ research when 61% of people living with HIV aged 50+ were concerned about loneliness in the future - that figure is now 76%.

Conclusion

We are entering uncharted territory. A new generation of people living with HIV are living into older age. A very diverse generation.

While many will continue to live without the need for additional health and social care services or financial support, the 307 people involved in this research have shown that just as often this isn’t the case. There is a major cohort of individuals growing older with HIV who, now and in the future, require significant levels of support.

Many support needs are not unique to people living with HIV – the welfare and social care systems across the UK are failing many. However, we have found that living with HIV adds an extra level of need – additional necessities that go beyond the ‘standard’ experiences of ageing.

With reducing NHS, public health and social care budgets the future is uncertain. But the opportunity exists to ensure that the needs of people ageing with HIV are central to discussions, policy change and structural change that is currently happening.

People living with HIV aged 50 and over must be at the heart of this action – the voices of older people living with HIV have too often been absent.

Together we can be the generation that pushes for change to ensure that all people living with HIV have a positive experience of ageing.

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