Summary of HIFA Discussion on

Systematic Reviews

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on behalf of HIFA working group, August 2017

Introduction

From 15 May to 23 June 2017 the HIFA Evidence-Informed Policy and Practice working group supported a HIFA thematic discussion on Systematic Reviews, around five questions. 89 messages, from 36 contributors, were received responding to the questions. This report summarizes the opinions expressed by those contributors around four of these five questions. The fifth question (What can be done to promote the production, interpretation and synthesis of SRs in low- and middle-income countries?) did not receive any specific responses. However, a number of points relevant to question 5 were addressed in the responses to the other questions. See here (under Publications) for the full (76p) and edited (22p) versions of the discussion.

1. What are systematic reviews? Why are they important?

Definitions

Contributors shared definitions and typologies from Wikipedia, the Cochrane Library, the Cochrane Consumers Network, and *The Lancet*. One definition, which covered most of the elements in these definitions, is that an SR is "a review in which bias has been reduced by the systematic identification, appraisal, synthesis, and, if relevant, statistical aggregation of all relevant studies on a specific topic according to a predetermined and explicit method"[1].

Why are systematic reviews important?

Systematic reviews are essential for guideline development and should help inform policy and practice. The discussion evolved around the role of qualitative research in SRs and in guideline development and how this could make results more useful and applicable. Two statements from two different contributors summarise this discussion well:

- *'Qualitative systematic reviews provide answers to several questions of relevance to implementation of health interventions in the real world.'*
- *'Findings drawn from qualitative reviews alongside other data, mean that the recommendations that arise can be tailored to context (whether that is resource driven, or culturally relevant, or whether it is other essential factors that require tailoring.)'*

2. What are the strengths and limitations of SRs to guide policy and practice in LMICs?

Contributors felt that the strength of SRs is that they provide the necessary foundations and justification for evidence informed policy and practice. Without it, medical and health planning, policy and practice would continue to rely on expert opinion or on single research studies, which are in general less reliable. In low resource settings, it is especially important to ensure that resources are allocated to treatments that have been proven to be effective (and indeed cost-effective). It was also suggested that SRs should inform not only guidelines, but also global programmes and strategies (citing global mental health initiatives as positive examples).

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[1] Moher D, Cook DJ, Eastwood S, Olkin I, Rennie D, Stroup DF. Improving the quality of reports of meta-analyses of randomised controlled trials: the QUOROM statement. Quality of Reporting of Meta-analyses. Lancet 1999;354(9193):1896-900.

But a number of limitations were also suggested (arguably none of these are limitations of SRs per se):

1. The quality of a given SR depends on the methods used and how well these methods adhere to standard recommendations (such as those developed by Cochrane). Tools exist to critically appraise SRs, including [ROBIS](#) and [AMSTAR](#).
2. The indexes that researchers use in their searches are much less likely to include journals of the Global South. The context of these countries may thus not be reflected in the world literature /sources used to produce SRs, making them potentially less relevant for policy and practice in these settings. However, efforts are made to [build a list of databases and websites](#) from around the world where randomised controlled trials have been found.
3. Capacity needs to be strengthened to conduct SRs in LMICs. Although it could be argued that it is more important to build capacity to use SRs than to produce SRs since SRs are a global overview of available evidence.
4. Guideline developers do not always take into account the evidence from SRs and/or they may be more ready to include lower levels of evidence.
5. Ideological resistance to SRs. As one contributor said: "It's quite 'staggering' to see how much resistance to considering these as reliable sources of evidence still exists."

3. What is the role of (global) SRs versus (local) single research studies (to guide policy and practice in LMICs)?

Contributors confirmed that in their experience policy makers rely more on local evidence (both in high-income countries and LMICs). One contributor wrote: '*Policymakers and practitioners tend to have a preference for, and are more likely to implement, the findings of local research (single studies conducted in their country or region). This is not a phenomenon unique to low- and middle-income countries. A similar tendency can be found in high-income countries where health (and social care) managers and policy-makers will want to try something that seems success in the neighbouring region/district or something they heard a friend talk about at a regional or national conference*.'

Contributors acknowledge that this reliance on local evidence is problematic, especially in places where the local research culture is weak, mainly observational, and often not peer reviewed.

4. What can be done to increase the relevance and usefulness of SRs (to guide policy and practice in LMICs)?

Suggestions made by contributors in response to this question all evolved around improving communication:

- '*It will be important to develop contextually relevant summaries for all kinds of situations, not just LMIC settings, but also those around humanitarian and crisis situations, where the evidence may exist but the resources may not.*'
- Policy makers expressed '*a real pleasure in being invited to hear about the research, discuss it and consider how to use it*.'
- And a web-based example of improving communication around available evidence was shared: '*The [WHO Reproductive Health Library](#) was the [response from Cochrane](#) in one very important topic area to need for more relevance of SRs to guide policy and practice in LMICS.*'