



Making better use of qualitative evidence to inform health policy and systems decisions: new methodological developments

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Outline



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- In what ways can qualitative evidence inform decisions?
- The growing field of qualitative evidence synthesis
- New tools and approaches for using qualitative evidence to inform decisions
- Challenges and opportunities

Background: evidence-informed decision making and qualitative evidence

Evidence-informed decision making - the role of qualitative evidence



- The systematic use of research evidence to inform health and social policies is widely promoted
- Systematic reviews of intervention effectiveness are now used frequently to inform policy decisions

Evidence-informed decision making - the role of qualitative evidence



- Of course, evidence of effectiveness is not sufficient to inform decisions on health and social interventions or programmes
- Decision makers also need information on the feasibility and acceptability of interventions, so as to better understand factors that may influence their implementation
- Evidence on equity, gender and human rights impacts is also important
- **Qualitative research is a key source of evidence on these issues**

Evidence-informed decision making - the role of qualitative evidence (2)



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- Qualitative evidence is also important in the context of the SDGs which can only be achieved through cross-sectoral policies and interventions
- In the SDG context, qualitative evidence can provide:
 - A more holistic and integrated view of people's experiences of health and social issues – people's experiences naturally cut across sector boundaries
 - Insights into people view different policy options for improving health and wellbeing within their socio-environmental context



The role of qualitative evidence in representing citizens' voices



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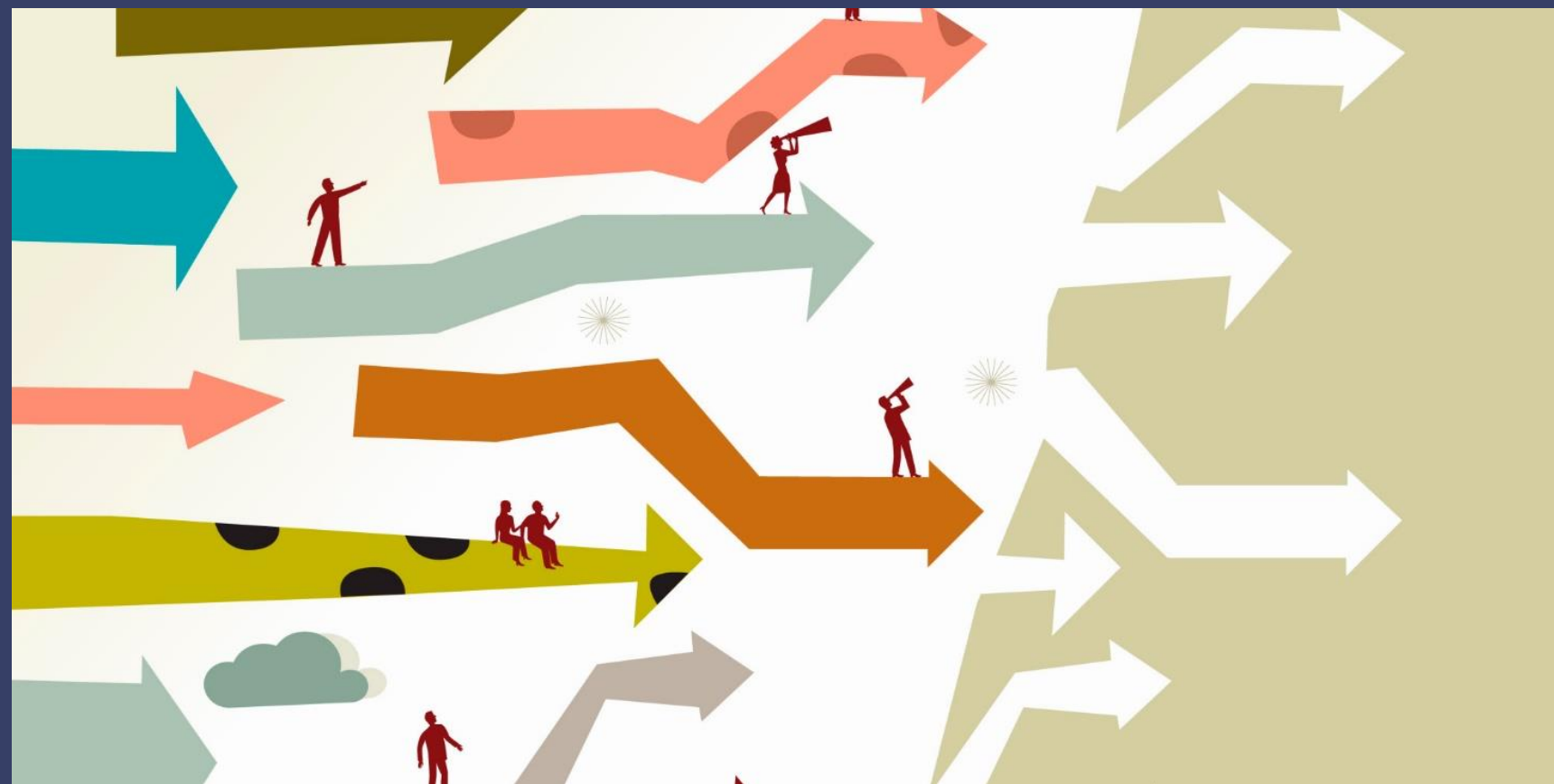
- One of the most important functions that qualitative evidence can play in decision-making is to represent the voices of a wide range of citizens and stakeholders
- May be particularly valuable in representing marginalizing voices
- The wider use of qualitative evidence may therefore contribute to increased transparency and accountability in public decision making

(Abelson et al. 2013; Davies et al. 2006; Lewin et al. 2018)



What is 'qualitative evidence'?

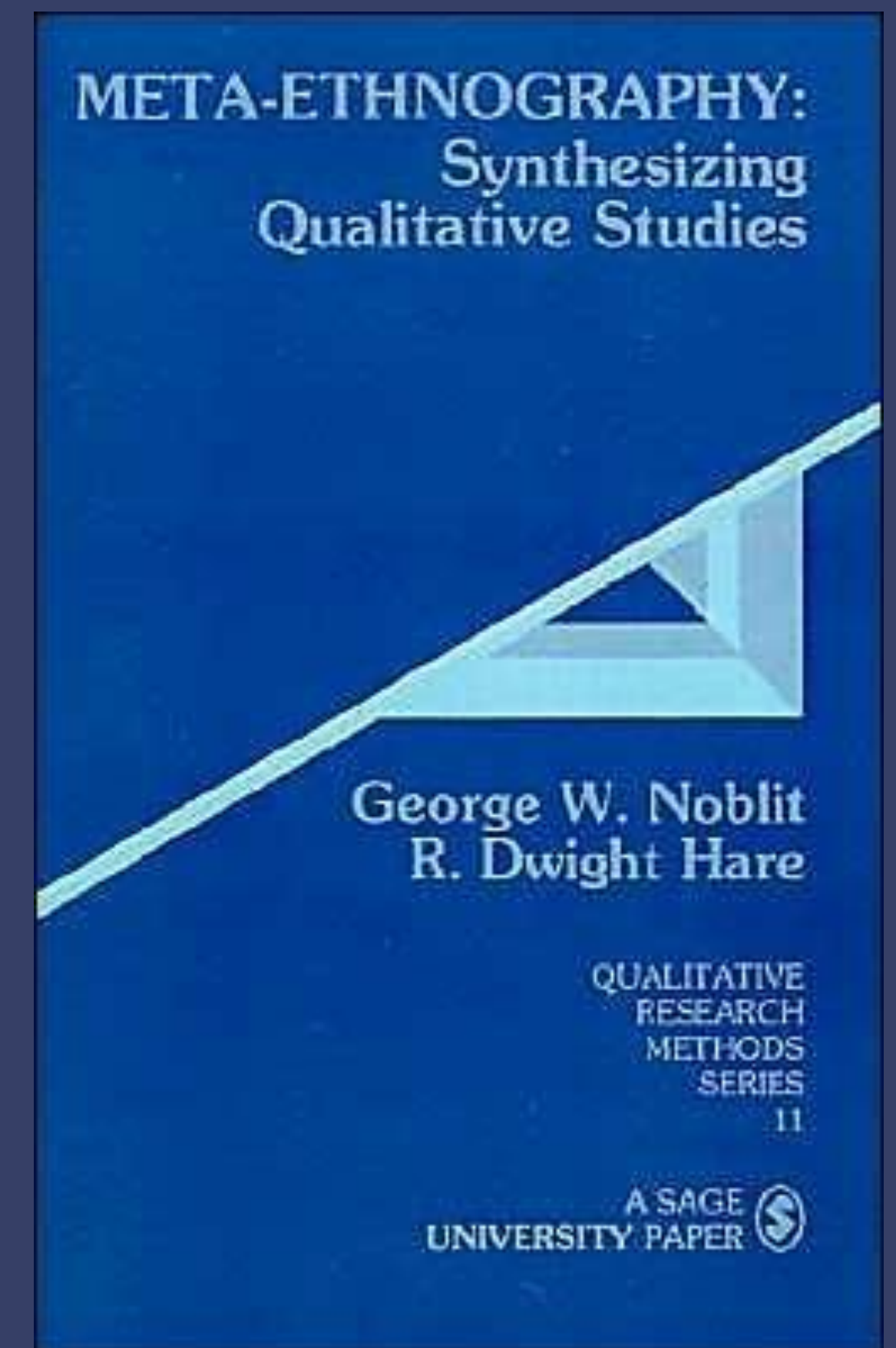
- Qualitative evidence is evidence that comes from research that has used qualitative methods of data collection and of analysis
 - Includes both primary and secondary qualitative research
- Qualitative research generally aims to describe and explore people's perceptions and experiences of the social world
- It is characterized by a naturalistic approach that accepts multiple perspectives and engages reflexively with the field of research



The growing field of qualitative evidence synthesis

Origins in the social sciences

- Meta-synthetic approaches for qualitative research were first developed within the social sciences in the late 1980s and early 1990s, particularly within sociology and applied anthropology
- The approach first appeared in the health-related qualitative literature in the mid-1990s
- Since then a large range of different approaches have emerged



Rapid growth in application of the approach



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Number of qualitative evidence syntheses indexed in Medline :

- 1995: 2 publications
- 2000: 18 publications
- 2005: 71 publications
- 2010: 260 publications
- 2015: 895 publications
- 2017: 1316 publications



How do qualitative evidence syntheses differ from systematic reviews of the effectiveness of interventions?



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Systematically search for relevant studies



Data extract + quality assess included studies



Synthesise the results of these studies



Assess confidence in the findings



What kinds of questions can be addressed by a qualitative evidence synthesis?



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| Stage of the policy cycle | Where there are questions concerning... |
|---|---|
| Diagnosing or understanding the problem | <ul style="list-style-type: none">■ People's (consumers, health care providers, policy makers) views or experiences■ Why a particular problem has arisen■ How to understand a particular problem conceptually |
| Assessing policy options | <ul style="list-style-type: none">■ How people value different policy options and views regarding these options; how people value different outcomes■ Insights into how an intervention might work – particularly useful for complex interventions |
| Exploring implementation strategies for a policy option | <ul style="list-style-type: none">■ Factors likely to affect the implementation of a policy option■ Views regarding implementation strategies |
| Monitoring the effects of a policy option | [Primary qualitative studies may contribute to subsequent qualitative evidence syntheses] |

Adapted from: Lavis JN. How Can We Support the Use of Systematic Reviews in Policymaking? PLoS Med. 2009; 6(11): e1000141.

Using qualitative evidence to inform decisions – new tools and approaches

Using qualitative evidence to inform decisions – new tools and approaches

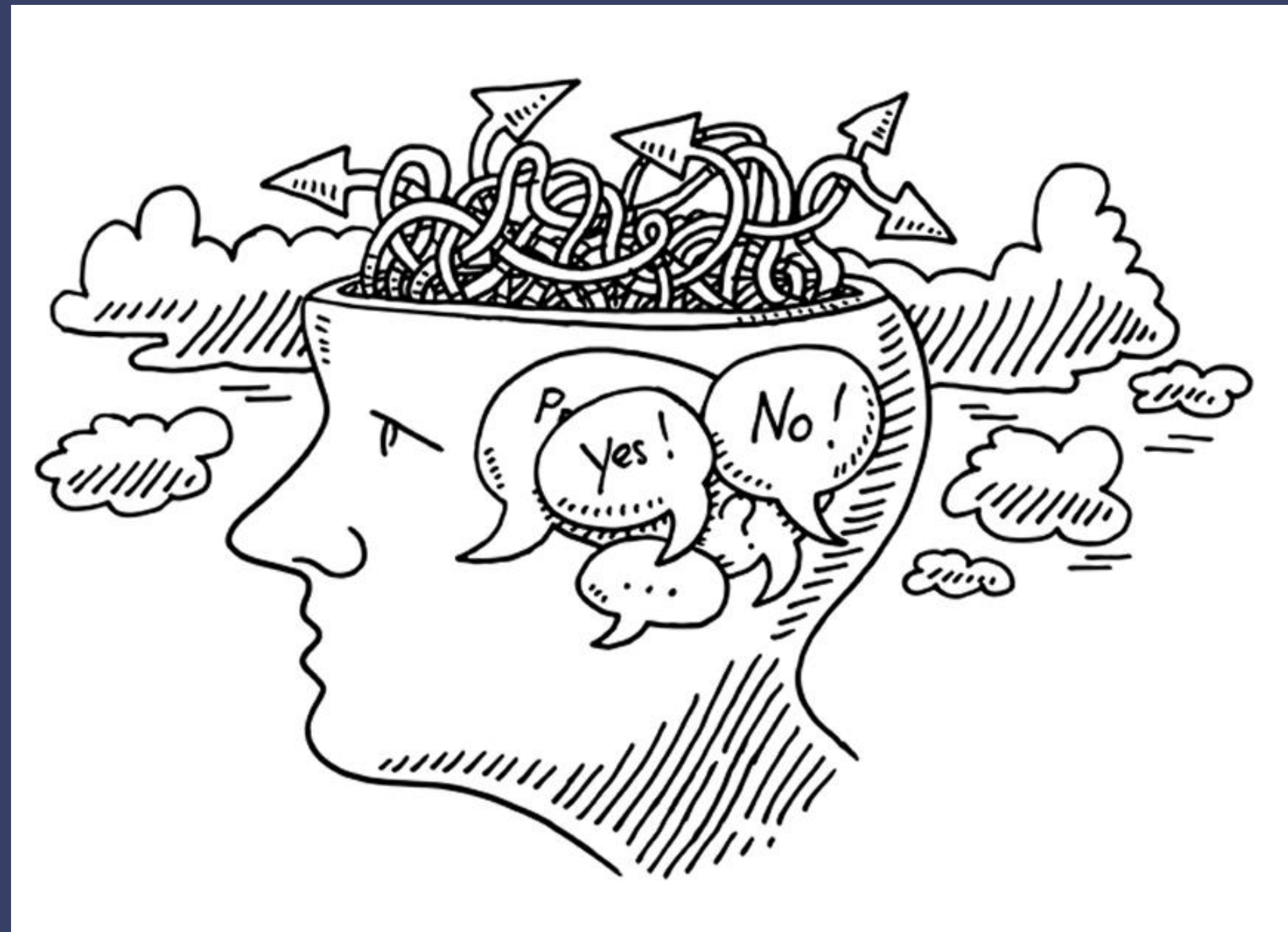


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- The GRADE-CERQual approach
- New state-of-the-art guidance on conducting qualitative evidence syntheses
- WEIRD tool for assessing the limitations of sources such as programme and intervention reports
- Packaging qualitative and other evidence for decision making

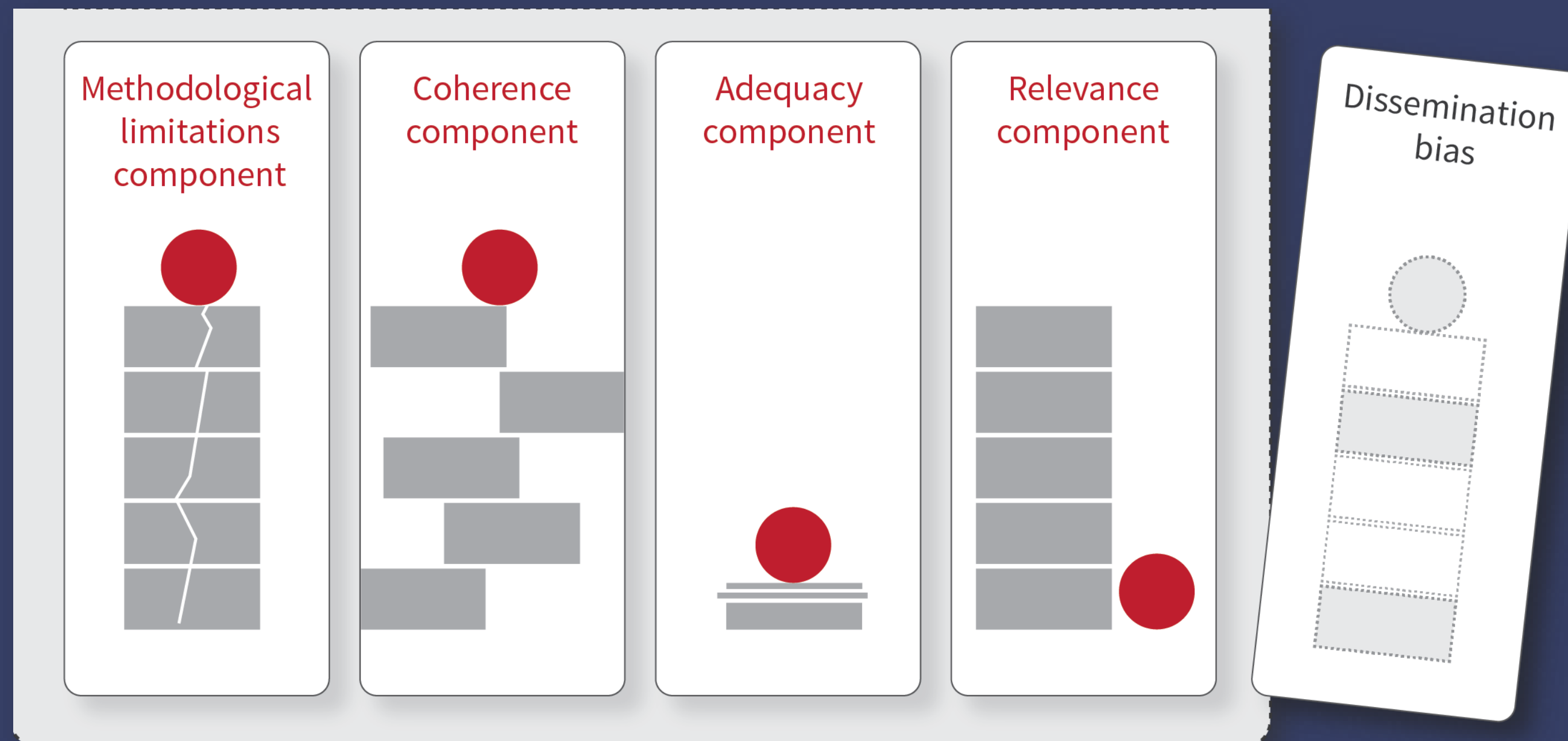
Assessing how much confidence to place in findings from qualitative evidence syntheses

Why assess confidence in qualitative evidence?



- Users of evidence tend to make judgements implicitly about how trustworthy evidence or information is
- Implicit bias, based on implicit attitudes and stereotypes, may drive these judgements (Greenwald et al. 2006)
- It may be therefore helpful to provide a systematic and transparent way of assessing confidence in evidence

GRADE-CERQual approach



GRADE-CERQual aims to transparently assess and describe how much confidence to place in findings from qualitative evidence syntheses (Lewin et al. 2015, Lewin et al. 2018)

CERQual is part of the range of approaches for assessing confidence in evidence developed by the GRADE Working Group

A key tool for facilitating the use of qualitative evidence in decision making processes

CERQual: Confidence in the Evidence from Reviews of Qualitative Research

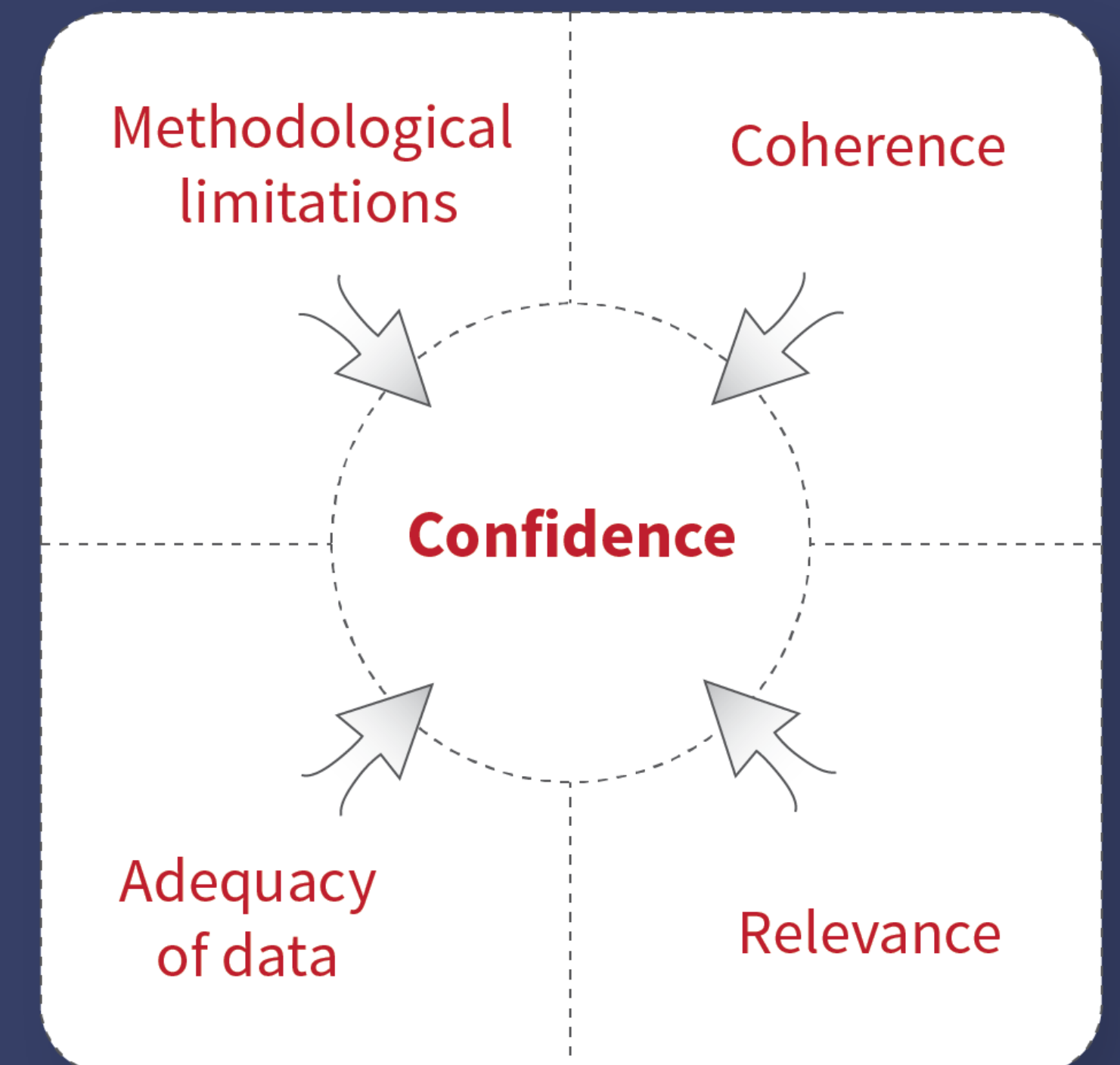
GRADE-CERQual approach (2)

Confidence in the evidence: the extent to which a synthesis finding is a reasonable representation of the phenomenon of interest

- i.e. the phenomenon of interest is unlikely to be substantially different from the research finding

A CERQual assessment of confidence is based on four components

The approach is applied to each theme or category that describes a phenomenon or an aspect of a phenomenon



CERQual uses *Summary of Qualitative Findings tables* to package findings for decision making

Objective: To identify, appraise, and synthesise qualitative research evidence on the barriers and facilitators to the implementation of lay health worker programmes for maternal and child health[#]

Perspective: Experiences and attitudes of stakeholders about lay health worker programmes in any country

Included programmes: Programmes that were delivered in a primary or community health care setting, that intend to improve maternal or child health, and that had used any type of lay health worker, including community health workers, village health workers, birth attendants, peer counsellors, nutrition workers, and home visitors

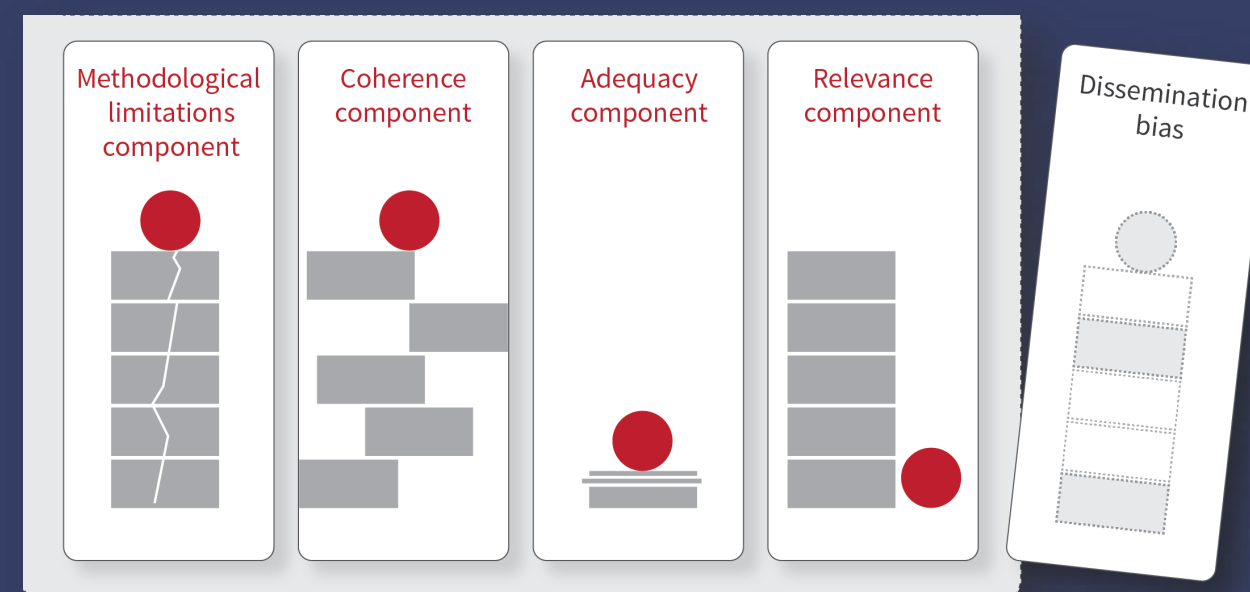
| Review Finding | CERQual Assessment of Confidence in the Evidence | Explanation of CERQual Assessment | Studies Contributing to the Review Finding |
|--|--|--|--|
| While regular salaries were not part of many programmes, other monetary and nonmonetary incentives, including payment to cover out-of-pocket expenses and “work tools” such as bicycles, uniforms, or identity badges, were greatly appreciated by lay health workers. | Moderate | This finding was graded as moderate confidence because of minor concerns regarding methodological limitations, relevance, coherence, and adequacy. | Studies 2; 5; 11; 12; 22; 29 |
| Some unsalaried lay health workers expressed a strong wish for regular payment. | Low | This finding was graded as low confidence because of moderate concerns regarding relevance and substantial concerns regarding adequacy of data. | Studies 5; 13 |

Use of GRADE-CERQual globally



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- Rapid growth in the last 5 years: now over 150 published qualitative evidence syntheses that have applied CERQual
- QES findings with CERQual assessments have been used in a large number of guidelines, including those produced by WHO, NICE and the Swedish HTA Agency
- WHO has included CERQual in its methods handbook for producing WHO guidelines



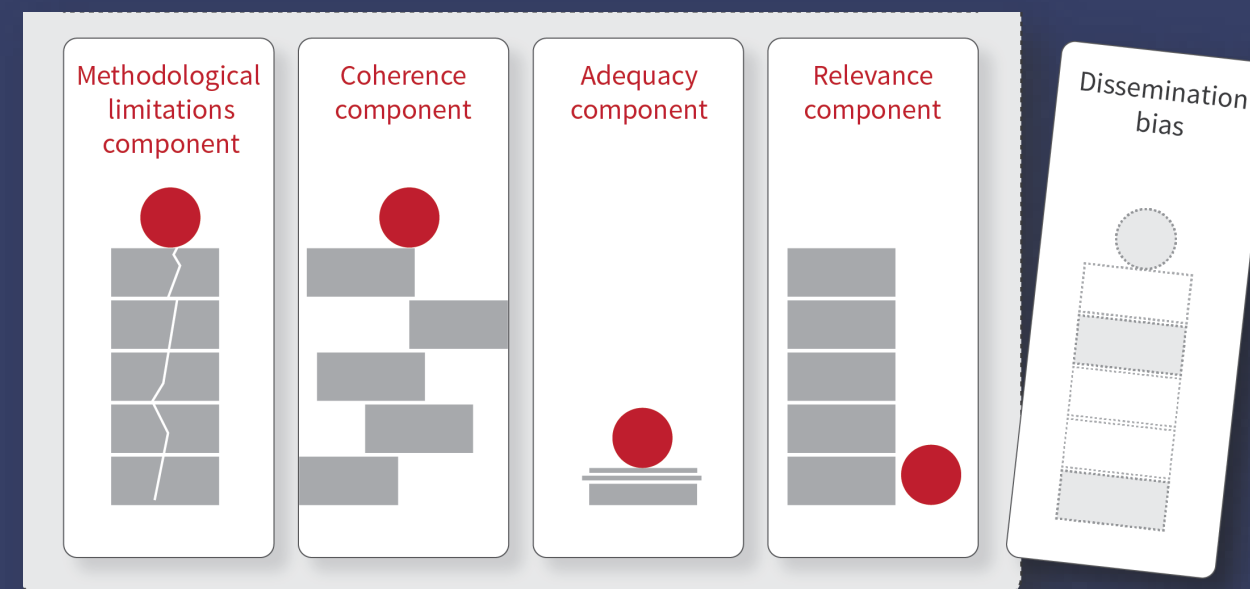
Next steps for GRADE-CERQual...



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interactive Summary of Qualitative Findings (iSoQF)

- Being developed with the Epistemonikos Foundation in Chile
- Will make it much easier to undertake CERQual assessments and to produce Qualitative Evidence Profiles and Summary of Qualitative Findings tables
- Will allow policy users to more easily navigate qualitative evidence synthesis findings, and move from summarised to more detailed findings
- Will allow open access archiving of Summary of Qualitative Findings tables, for example on Zenodo or Open Science Framework





Cochrane Methods
Qualitative and
Implementation



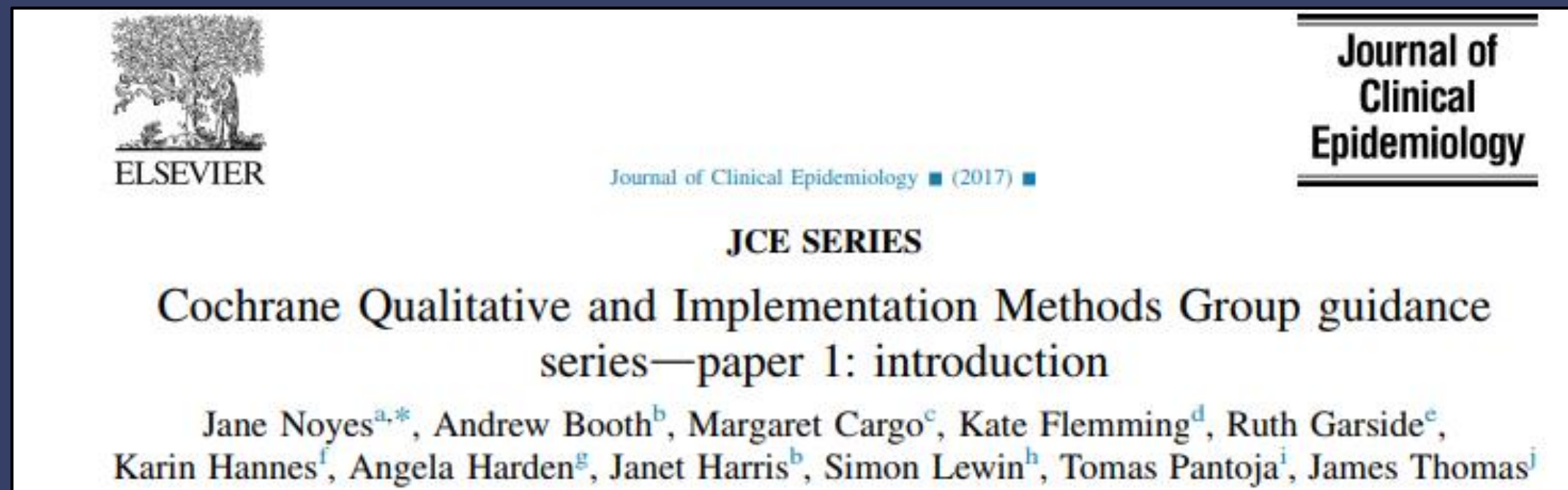
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Guidance on conducting qualitative evidence syntheses

Conducting qualitative evidence syntheses



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- Methods for conducting qualitative evidence syntheses are developing rapidly
- Review authors find it challenging to get an overview of the field and to identify up-to-date guidance
- A new series of papers from Cochrane helps to address this need

Complexity perspectives and systematic reviews



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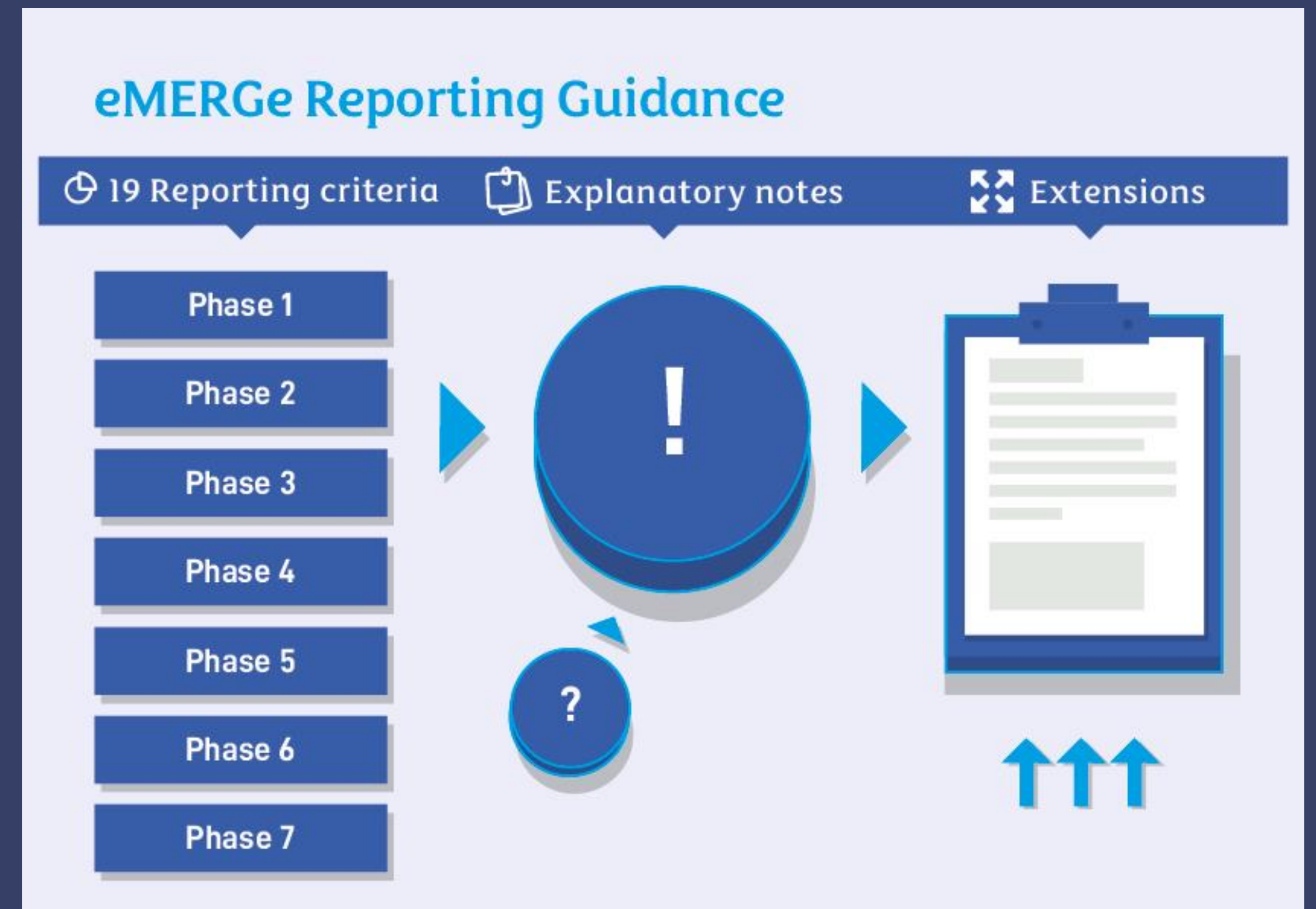
- A series of papers in BMJ Global Health looking at the implications of complexity for systematic reviews
- Provides useful guidance on taking context into account in systematic reviews



Susan L Norris et al. BMJ Glob Health 2019;4:e000963

Reporting qualitative evidence syntheses

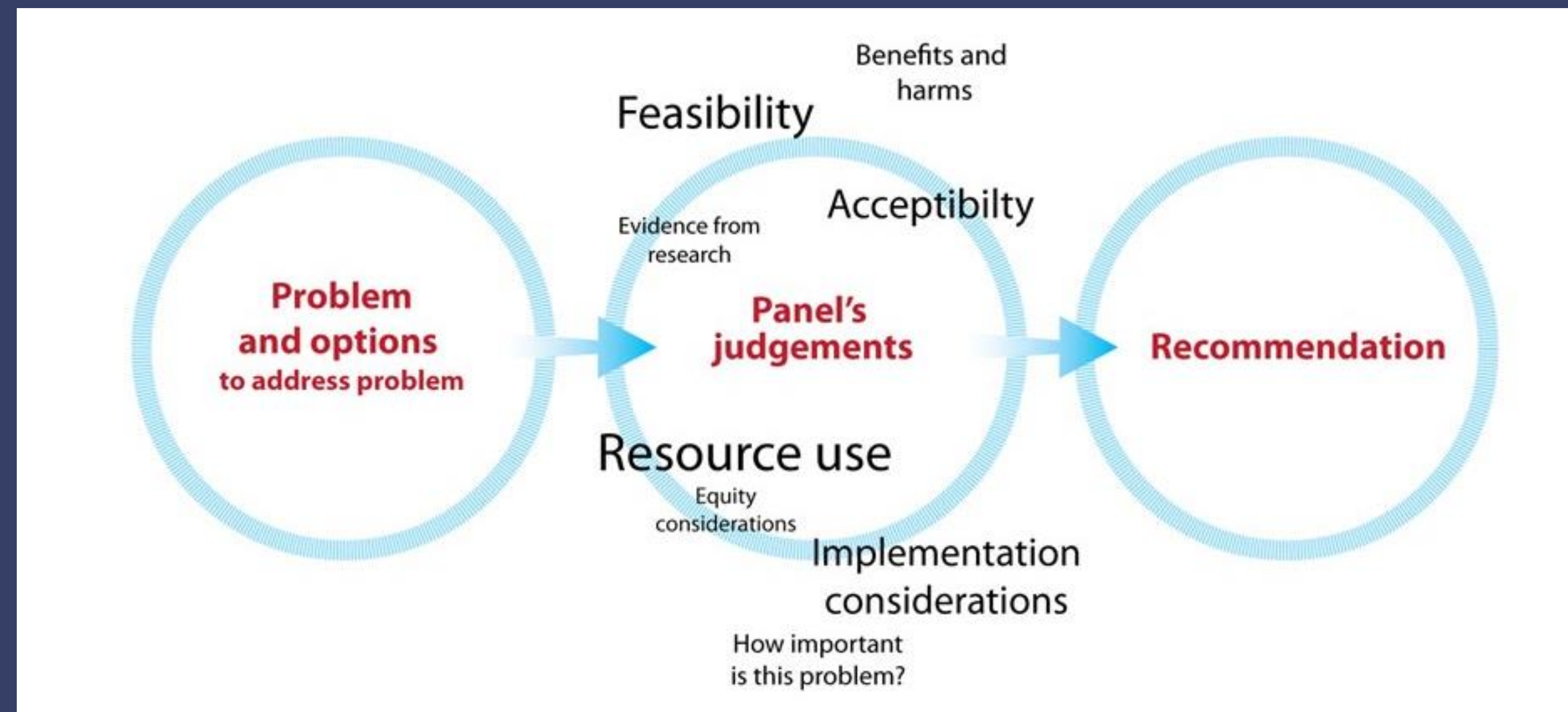
- Growth in guidance on reporting qualitative evidence syntheses:
 - Realist syntheses (Wong 2013)
 - Cochrane EPOC guidance on writing protocols for qualitative evidence syntheses and on sampling (EPOC 2018)
 - eMERGe – for meta-ethnographies (France et al. 2018)



Tools for packaging evidence for decision making

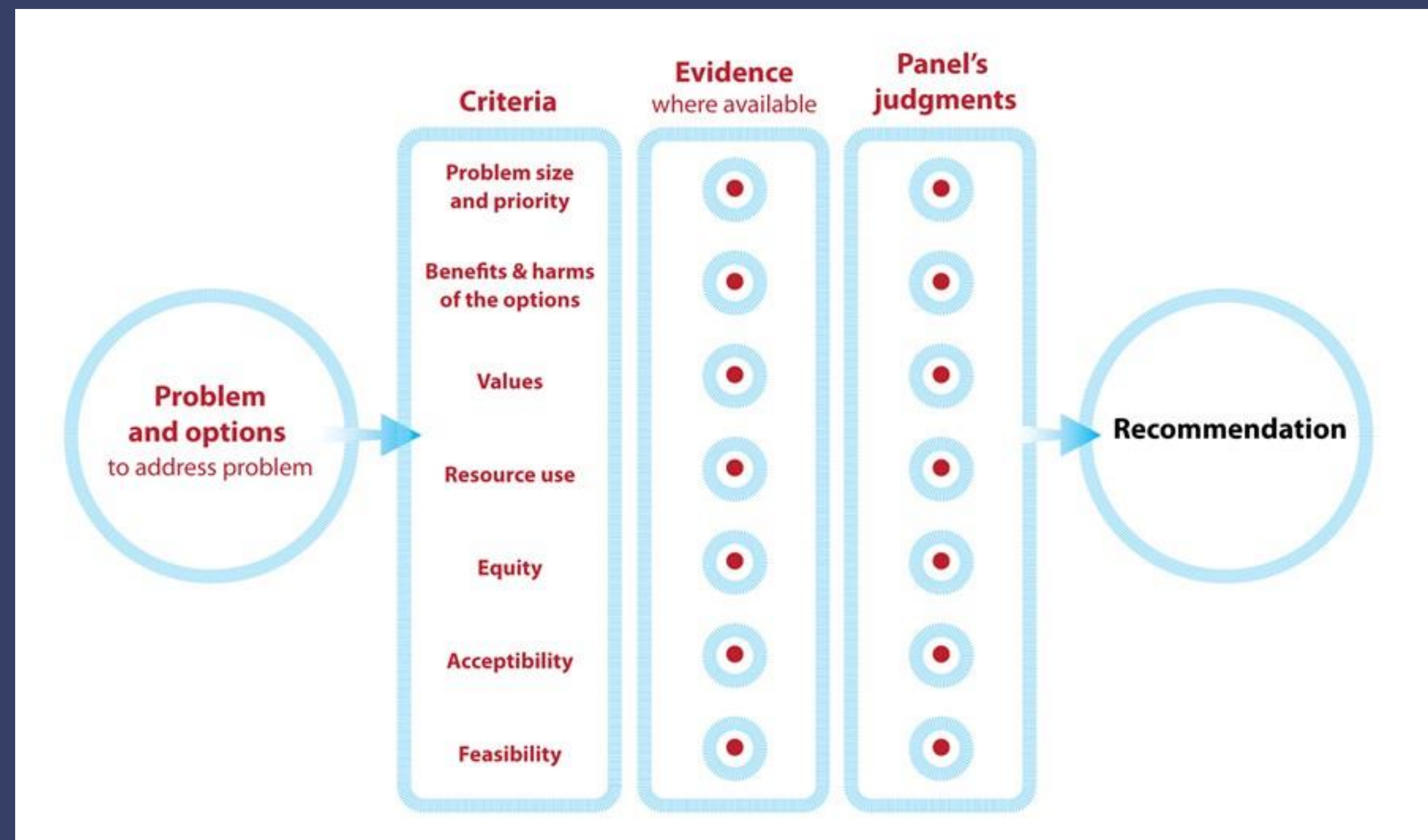
Packaging evidence for decision making (1)

Aim to move away from decision making in which different types of evidence are assessed in an adhoc way.....



Packaging evidence for decision making (2)

To more systematic and transparent assessment of relevant criteria, and the evidence for these, in decision making.....



A structured approach: GRADE evidence-to-decision frameworks

- Systematic review authors produce review or synthesis findings based on the evidence identified
- These findings are extracted and packaged into an evidence-to-decision framework
- The framework informs deliberations by a decision making structure, helping them to use evidence in a more structured way

Many different variants of this framework are now being used: evidence briefs for policy making, health technology assessments etc.

(Alonso-Coello et al. 2016, Moberg et al. 2018)

Criteria:

Problem

Values

Desirable effects

Undesirable effects

Certainty of the evidence

Balance of effects

Resources required

Certainty of evidence of required resources

Cost-effectiveness

Equity

Acceptability

Feasibility

Summary of judgments

Prepared by: Jerry Moberg and Andy Coello
Date: 28 January 2013

Evidence to recommendation framework - Health system and public health recommendations

Should collaborative care be implemented for the treatment of moderate and severe depression in (elderly) adults?

Problem: Moderate and severe depression in adults
Options: Collaborative care vs augment primary care
Comparison: Usual care
Setting: Primary care
Population: Health system

Background: Depression is common and causes a greater decrease in health state than some chronic diseases.¹ It results in high treatment costs as well as a significant personal, family and wider social impact.¹ Studies suggest that treatment of depression often does not adhere to recommendations in practice guidelines.²
There is evidence that collaborative care is effective in improving short-term (6 months) and longer-term (12+ months) outcomes for patients with depression.³ Collaborative care may include clinical interventions ranging from simple interventions, such as telephone contact, to more complex interventions such as intensive psychosocial follow-up, but should always comprise structured care involving a case manager working together with the primary care physician and with access to mental health specialist input.⁴

| Criteria | Judgments | Research evidence | Additional considerations | | | |
|--------------------------------------|---|---|---|--|---|--|
| PROBLEM | Is the problem a priority? No <input type="checkbox"/> Probably not <input type="checkbox"/> Yes <input type="checkbox"/> | Depression is the fourth highest cause of disability worldwide. ¹ In Norway it reduces the capacity for work, as is the reason for absence pay up to 15% of adults. ¹ In the UK it is the third most common reason for primary care consultation. ¹ International data suggest that management is often below evidence-based standards. ² The overall lifetime prevalence of depression in adulthood in Norway is 15.6%. | | | | |
| VALUES | Is there important uncertainty about how much people value the main outcomes? Probably not <input type="checkbox"/> Probably <input type="checkbox"/> No <input type="checkbox"/> | The relative importance or value of the main outcomes of interest: Outcome: Non-response to treatment Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-response at 12 months Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-adherence to medication Relative importance: No studies Certainty of the evidence: No studies | | | | |
| EVIDENCE | What is the overall certainty of the evidence of effectiveness? No <input type="checkbox"/> Very low <input type="checkbox"/> Low <input type="checkbox"/> Moderate <input type="checkbox"/> High <input type="checkbox"/> | Summary of findings: Standard care vs collaborative care for depression (first 6 months) (Outcome defined) Outcome: Standard care (%) Collaborative care (%) Difference (95% CI) Certainty of the evidence (GRADE) Non-response to treatment: 56.9 49.7 6.9 (5 to 15 weeks) BBB Non-response at 12 months: 47 48.4 2 (5 to 15 weeks) BBB Non-adherence at 12 months: 13 11.3 1.7 (5 to 15 weeks) BBB Non-adherence to medication: 51.8 30.8 20.9 (15 to 26 weeks) BBB Undesirable effects: No information | | Collaborative care has been shown to be most effective in trials conducted in the US. Sim for results would be expected in well-funded European health care systems although there may be big differences in the standard care used as the comparator in different studies, and the intensity and length of the collaborative care used between studies. The intensity of the intervention affects the outcome. ⁵ | | |
| RESOURCES | Are the desirable anticipated effects large? No <input type="checkbox"/> Probably not <input type="checkbox"/> Probably <input type="checkbox"/> Yes <input type="checkbox"/> | Main anticipated resource requirements: Resource: Case managers, Specialist support, Antidepressants, Psychological treatments, Follow up | | Patient and family costs are likely small. Municipality costs may increase or decrease depending on how collaborative care is implemented, e.g. the qualifications of case managers, healthcare costs (including the cost of antidepressants and psychological treatment) may be large. | | |
| RESOURCES | Are the undesirable anticipated effects small? No <input type="checkbox"/> Probably not <input type="checkbox"/> Probably <input type="checkbox"/> Yes <input type="checkbox"/> | In a review of economic evaluations of enhanced primary care for depression collaborative care management resulted in increased outcomes but were also associated with greater costs. When considering primary care depression treatment costs above GDP estimates ranged from 3.3 to 32% per additional episode cost-free day. ⁶ In a series of cost-effectiveness ratio acceptability net mean using cost-effectiveness acceptability thresholds, for a more defined care management approach there was a 65% probability that the cost-effectiveness of the intervention was less than \$20,000 per QALY and a 91% probability that it was less than \$50,000 per QALY. | | | | |
| EQUITY | What would be the impact on health inequalities? No <input type="checkbox"/> Probably not <input type="checkbox"/> Probably <input type="checkbox"/> Yes <input type="checkbox"/> | No evidence | | Patients in illness, resources, social support and access to care may benefit more than resource strong patients, thereby reducing inequities. | | |
| ACCEPTABILITY | Is the option acceptable to key stakeholders? No <input type="checkbox"/> Probably not <input type="checkbox"/> Probably <input type="checkbox"/> Yes <input type="checkbox"/> | No evidence | | Fewer patients seeking collaborative care left the trials. For any reason (including being lost to follow-up) than patients receiving usual care. Part of it may be explained by a higher level of acceptability, but this is speculative and the difference was small and non-significant. | | |
| FEASIBILITY | Is the option feasible to implement? No <input type="checkbox"/> Probably not <input type="checkbox"/> Probably <input type="checkbox"/> Yes <input type="checkbox"/> | No evidence | | There may not be sufficient mental health professionals to provide the enhanced input and care coordination for all primary care patients with depression. ⁷ | | |
| Balance of consequences | | Undesirable consequences clearly outweigh desirable consequences in most settings <input type="checkbox"/> | Undesirable consequences probably outweigh desirable consequences in most settings <input type="checkbox"/> | The balance between desirable and undesirable consequences is closely balanced or uncertain <input type="checkbox"/> | Desirable consequences probably outweigh undesirable consequences in most settings <input type="checkbox"/> | Desirable consequences clearly outweigh undesirable consequences in most settings <input type="checkbox"/> |
| Type of recommendation | | We recommend against this option <input type="checkbox"/> | We suggest not offering this option <input type="checkbox"/> | We suggest offering this option <input type="checkbox"/> | We recommend the option <input type="checkbox"/> | |
| Recommendation (text) | | Each municipality should create and implement a collaborative plan of care for patients with moderate to severe depression. The plan should define the responsibilities and communication between the various professional groups who have contact with patients, both in community health services and between local and specialist healthcare, and appoint health professionals with special responsibility for follow-up of patients. The plan should include procedures for referral to specialist services. Strong recommendation, moderate quality of the evidence. The plan may include organizational, educational and other measures that have evidence of moderate to high quality that they can lead to better outcomes for patients with depression. | | | | |
| Justification | | There is high quality evidence of improved care, adherence and patient outcomes. There is no evidence of adverse effects. The cost is uncertain, but is likely small for patients and their families, moderate for municipalities and moderate for the health services. The cost-effectiveness is similar to or less than many clinical interventions that are considered cost-effective. | | | | |
| Implementation considerations | | Implementation strategies should be tailored to municipalities (e.g. qualifications and location of case managers, communication and referrals) and may be helped by model plans, certification of options and support to select appropriate options. | | | | |
| Monitoring and evaluation | | Monitoring of indicators of the quality of care and patient outcomes is warranted and should be incorporated in collaborative care plans. | | | | |
| Research priorities | | Ongoing and future research should clarify the importance of various components of collaborative care and the applicability of alternative models in different settings. | | | | |

EBR Framework (Version 2.1): Collaborative care for depression in Norway

QUESTION

CRITERIA

CONCLUSION

Criteria typically considered in a GRADE evidence-to-decision framework

How large are the positive (desirable) effects of the intervention?

How large are the negative (undesirable) effects of the intervention?

What is the overall certainty of the evidence of effects?

Is there important uncertainty about or variability in how much people value the outcomes?

What is the overall balance of effects?

How large are the resource requirements?

What would be the impacts on gender, health equity and human rights?

Is the option acceptable to key stakeholders?

Is the option feasible to implement?

NIPH -

Criteria:

Problem

Values

Desirable effects

Undesirable effects

Certainty of the evidence

Balance of effects

Resources required

Certainty of evidence of required resources

Cost-effectiveness

Equity

Acceptability

Feasibility

Summary of judgments

Prepared by: Jenny Moberg and Andy Oomen
Date: 28 January 2013

Should collaborative care be implemented for the treatment of moderate and severe depression in (elderly) adults?

Problem: Moderate and severe depression in adults
Option: Collaborative care to augment primary care
Comparator: Usual care
Setting: Primary care
Perspective: Health system

Background: Depression is common and causes a greater decrease in health state than some chronic diseases.¹ It results in high treatment costs as well as a significant personal, family and wider social impact.¹ Studies suggest that treatment of depression often does not adhere to recommendations in practice guidelines.²
There is evidence that collaborative care is effective in improving short-term (6 months) and longer-term (12+ months) outcomes for patients with depression.³ Collaborative care may include clinical interventions ranging from simple interventions, such as telephone contact, to more complex interventions such as intensive psycho-social follow-up, but should always comprise structured care involving a case manager working together with the primary care physician and with access to mental health specialist input.⁴

| CRITERIA | JUDGEMENTS | RESEARCH EVIDENCE | ADDITIONAL CONSIDERATIONS | | | |
|--|---|--|--|--|--|---|
| PROBLEM Is the problem a priority? | No <input type="checkbox"/> Priority <input checked="" type="checkbox"/> No <input type="checkbox"/> <input checked="" type="checkbox"/> | Depression is the fourth highest cause of disability worldwide. ¹ In Norway it reduces the capacity for work or is the reason for sickness pay in up to 10% of adults. ¹ In the UK it is the third most common reason for primary care consultation. ⁵ International data suggest that non-adherence is often below evidence-based standards. ⁶ The overall lifetime prevalence of depression in adulthood in Norway is 15.6%. ⁷ | | | | |
| VALUES Is there important uncertainty about how much people value the main outcomes? | No <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | The relative importance or values of the main outcomes of interest: Outcome: Non-response to treatment Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-adherence at 12 months Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-adherence to medication Relative importance: No studies Certainty of the evidence: No studies | | | | |
| EFFECTS & BALANCE OF THE OPTIONS What is the overall certainty of the evidence of effectiveness? Are the desirable anticipated effects large? Are the undesirable anticipated effects small? Are the desirable effects large relative to undesirable effects? | <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input checked="" type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | Summary of Findings: Standard care vs collaborative care for depression (Risk? Roisman, et al) Outcome: Standard care (%) Collaborative care (%) Difference (%) (95% CI) Certainty of the evidence (GRADE) Non-response to treatment 56.9 49.7 -6.9 (low) (5 to 13 weeks) (BBB)⊕ High Non-adherence at 12 months 47 48.4 1.4 (low) (3 weeks to 6 weeks) (BBB)⊕ Moderate Non-adherence at 12 months 47 48.4 1.4 (low) (3 weeks to 6 weeks) (BBB)⊕ Moderate Non-adherence to medication 51.8 50.8 1.0 (low) (15 to 25 weeks) (BBB)⊕ Moderate Unintended effects No information | Collaborative care has been shown to be most effective in trials carried out in the US. Similar results would be expected in well-funded European healthcare systems, although there may be big differences in the standard care used as the comparator in different studies, and the intensity and length of the collaborative care varied between studies. The intensity of the intervention affects the outcome. ⁸ | | | |
| RESOURCE USE Are the resources required small? Is the incremental cost small relative to the net benefits? | No <input type="checkbox"/> Priority <input checked="" type="checkbox"/> No <input type="checkbox"/> <input checked="" type="checkbox"/> | Main anticipated resource requirements Resource: Case managers Specialist support Anti-depressants Psychological treatments Follow up In a review of economic evaluations of enhanced primary care for depression collaborative care was implemented in increased outcomes but were also associated with greater costs. When comparing primary care depression treatment costs alone ICER estimates ranged from 5.3 to £24 per additional course on the day. ⁹ In a series of cost-effectiveness analyses, using cost-effectiveness acceptability thresholds, for a nurse-delivered case management approach there was a 65% probability that the cost-effectiveness of the intervention was less than \$20,000 per QALY and a 91% probability that it was less than \$50,000 per QALY. | Additional information: Patient and family costs are likely small. Multi-professional care may be needed or less, collaborative care is implemented, e.g. the qualifications of case managers. Healthcare costs (including the cost of antidepressants and psychology treatment) may be large. | | | |
| EQUITY What would be the impact on health inequalities? | No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> No <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> <input type="checkbox"/> | No evidence | Patients with less resources, social support and access to care may benefit more than resource strong patients, thereby reducing inequalities. | | | |
| ACCEPTABILITY Is the option acceptable to key stakeholders? | No <input type="checkbox"/> Priority <input checked="" type="checkbox"/> No <input type="checkbox"/> <input checked="" type="checkbox"/> | No evidence | Fewer patients receiving collaborative care left the trials for any reason (including being lost to follow up) than patients receiving usual care. Part of this may be expected by a higher level of acceptability, but the association and the difference was small and non-significant. | | | |
| FEASIBILITY Is the option feasible to implement? | No <input type="checkbox"/> Priority <input checked="" type="checkbox"/> No <input type="checkbox"/> <input checked="" type="checkbox"/> | No evidence | There may not be sufficient mental health professionals to provide the enhanced equal care coordination for all primary care patients with depression. ¹⁰ | | | |
| BALANCE OF CONSEQUENCES | Undesirable consequences clearly outweigh desirable consequences in most settings <input type="checkbox"/> | Undesirable consequences probably outweigh desirable consequences in most settings <input type="checkbox"/> | I do not see between desirable and undesirable consequences is closely balanced or uncertain <input type="checkbox"/> | Desirable consequences probably outweigh undesirable consequences in most settings <input checked="" type="checkbox"/> | Desirable consequences clearly outweigh undesirable consequences in most settings <input type="checkbox"/> | |
| RECOMMENDATION | We recommend against the option <input type="checkbox"/> | | We suggest not offering this option <input type="checkbox"/> | | We suggest offering this option <input type="checkbox"/> | We recommend the option <input checked="" type="checkbox"/> |
| RECOMMENDATION (TEXT) | Each municipality should create and implement a collaborative plan of care for patients with moderate to severe depression. The plan should define the responsibilities and communication between the various professional groups who have contact with patients, both in community health services and between local and specialist healthcare, and appoint health professionals with special responsibility for follow-up of patients. The plan should include procedures for referral to specialized services. Strong recommendation, moderate quality of the evidence. The plan may include organizational, educational and other measures that have evidence of moderate to high quality that they can lead to better outcomes for patients with depression. | | | | | |
| JUSTIFICATION | There is high quality evidence of improved care, adherence and patient outcomes. There is no evidence of adverse effects. The cost is uncertain, but is likely small for patients and their families, moderate for municipalities and moderate for the health service. The cost-effectiveness is similar to or less than many other interventions that are considered cost-effective. | | | | | |
| IMPLEMENTATION CONSIDERATIONS | Implementation strategies should be tailored to municipalities (e.g. qualifications and location of case managers, communication and referral) and may be helped by model plans, clarification of options and support to select appropriate options. | | | | | |
| MONITORING AND EVALUATION | Monitoring of indicators of the quality of care and patient outcomes is warranted and should be incorporated in collaborative care plans. | | | | | |
| RESEARCH PRIORITIES | Ongoing and future research should clarify the importance of various components of collaborative care and the applicability of alternative models in different settings. | | | | | |

EHR framework (Version 2.1): Collaborative care for depression in Norway

QUESTION

CRITERIA

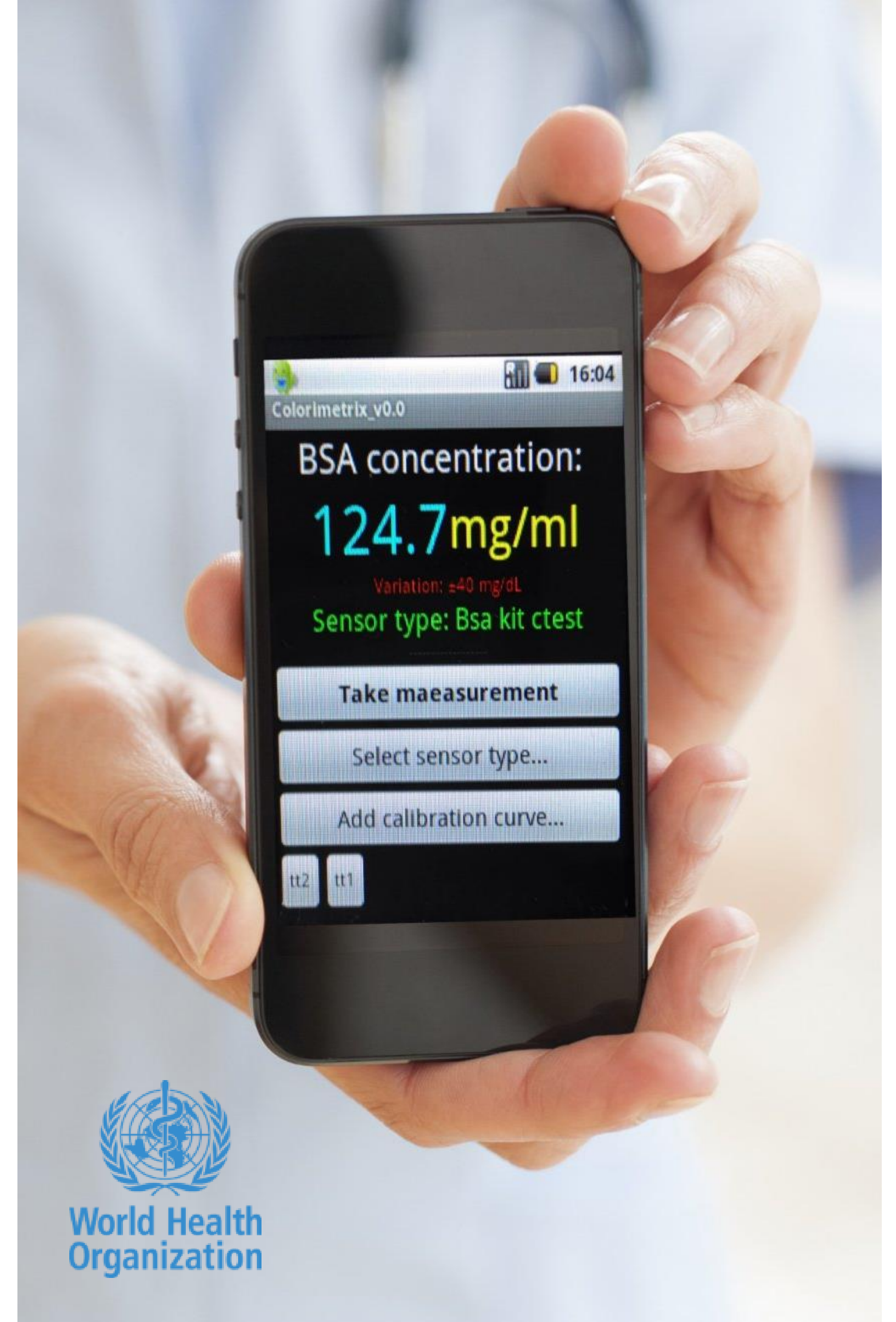
CONCLUSION

Using qualitative evidence in a decision process: WHO guideline on digital interventions for health systems strengthening (WHO 2019)

Growing use of mobile phones globally for:

- Communicating with patients and the public
- Telemedicine of various kinds
- Delivering health worker training
- Clinical decision support for health workers
- Birth and death notification

What should WHO recommend for implementation in this area, based on the best available evidence?



Guideline question: should targeted client communication via mobile phone be used for RMNCAH issues?

Targeted client communication involves sharing information by mobile phone, for example:

- health promotion messages
- reminders about health services
- diagnostic results

Communication may be uni- or bi-directional



Targeted client communication via mobile phone

What effects on healthcare utilisation, health behaviour, health status?

Systematic review of effectiveness (Palmer et al 2019):

- Overall - mixed effects or little or no evidence available

Resource use

No systematic review commissioned. Information based on expert opinion:

- Large start-up costs and large recurring costs



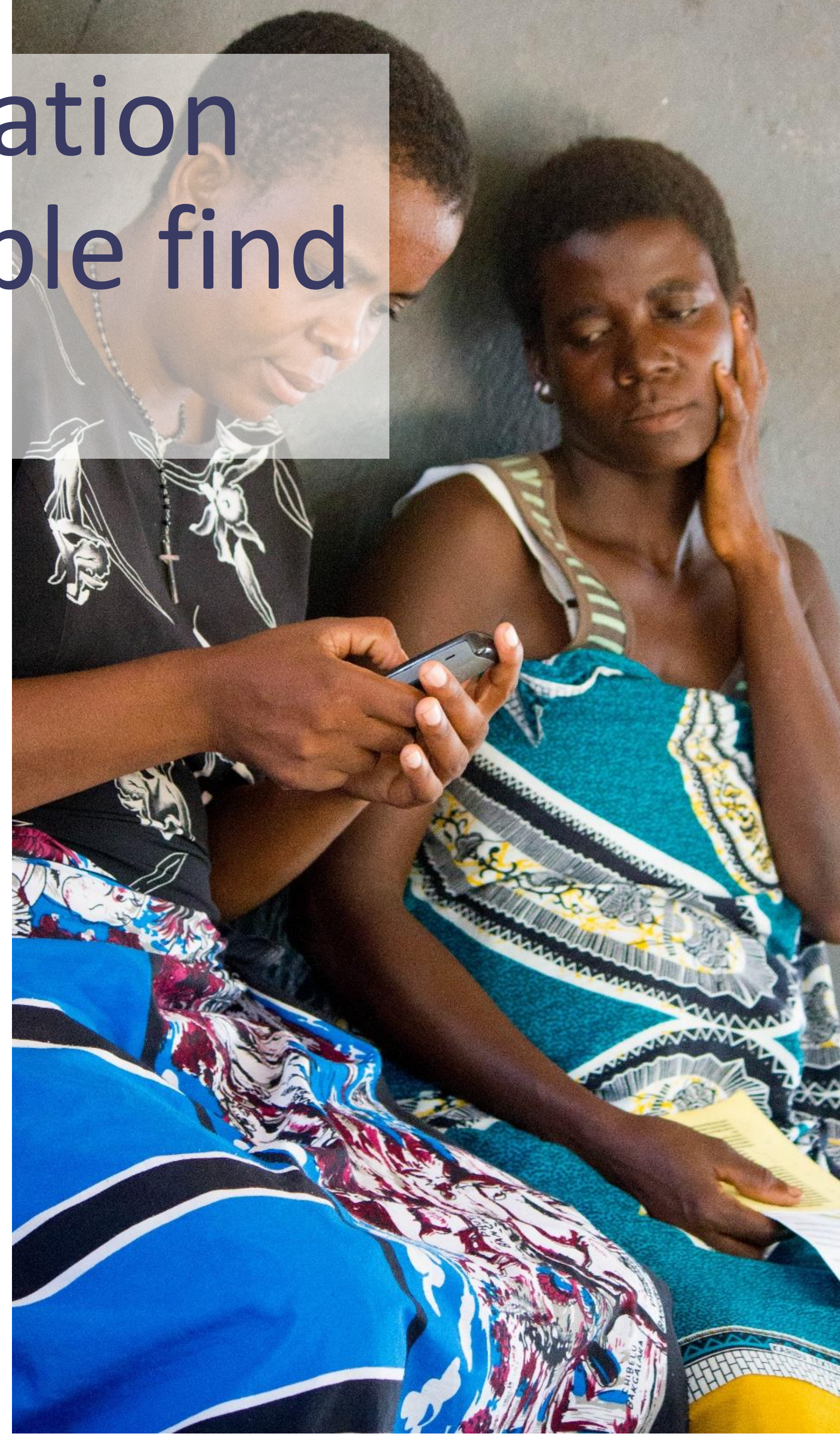
Targeted client communication via mobile phone: do people find it acceptable?

- *Qualitative evidence synthesis (Ames et al 2019):*
- Many clients **positive** to these services (moderate confidence):
 - Provides them with support and connectedness
 - Feels like someone is interested in their situation and cares about them
 - Gives a sense of direction, reassurance



Targeted client communication via mobile phone: do people find it acceptable?

...however, clients who are dealing with health conditions that are often stigmatised or very personal (e.g. HIV, family planning and abortion care) **worry that their confidential health information will be disclosed** (high confidence)



Targeted client communication via mobile phone: is it feasible?

Qualitative evidence synthesis (Ames et al. 2019):

- Problems in many settings with network connectivity, access to electricity, system integration and device usability (*high confidence*)
- Problems with clients who regularly change their phone numbers or clients who have poor access to phones (*low confidence*)



Targeted client communication via mobile phone: what are the impacts on health equity?

Qualitative evidence synthesis (Ames 2019):

- Communicating with health services via mobile phone may be particularly helpful to clients **with caring or work responsibilities, clients who live far from health facilities and clients with few funds** (low confidence)

However, access to these services may be particularly difficult for:

- People with **poor access to networks or electricity** (*high confidence*)
- People who speak **minority languages** or who have **low literacy skills or low digital literacy skills** (*moderate confidence*)
- People with **poor access to mobile phones**, particularly **women and adolescents**, who have to share or borrow a phone or who have access to phones controlled by others (*moderate confidence*)



Making the recommendation

The evidence was packaged into a GRADE Evidence-to-Decision framework.

In summary, the evidence showed that:

- Effectiveness of the intervention is unclear / mixed
- Resource use likely to be large
- Widespread acceptability, but important conditions / exceptions
- Feasibility challenges
- Equity implications mixed

NIPH -

Criteria:

Problem

Values

Desirable effects

Undesirable effects

Certainty of the evidence

Balance of effects

Resources required

Certainty of evidence of required resources

Cost-effectiveness

Equity

Acceptability

Feasibility

Summary of judgments

GRADE Evidence-to-Decision framework - Health system and public health recommendations

Prepared by: Jenny Moberg and Andy Osman
Date: 28 January 2013

Should collaborative care be implemented for the treatment of moderate and severe depression in (elderly) adults?

Problem: Moderate and severe depression in adults
Option: Collaborative care to augment primary care
Comparison: Usual care
Setting: Primary care
Perspective: Health system

Background: Depression is common and causes a greater decrease in health state than some chronic diseases.¹ It results in high treatment costs as well as a significant personal, family and wider social impact.¹ Studies suggest that treatment of depression often does not adhere to recommendations in practice guidelines.² There is evidence that collaborative care is effective in improving short-term (6 month) and longer-term (12+ months) outcomes for patients with depression.² Collaborative care may include clinical interventions ranging from simple interventions, such as telephone contact, to more complex interventions such as intensive psychosocial follow-up, but should always comprise structured care involving a case manager working together with the primary care physician and with access to mental health specialist input.²

| Criteria | Judgments | Research evidence | Additional considerations | | | |
|---|---|--|--|---|--|--|
| PROBLEM Is the problem a priority? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | Depression is the fourth highest cause of disability worldwide. ¹ In Norway it reduces the capacity for work, or is the reason for sickness pay in up to 10% of adults. ¹ In the UK it is the third most common reason for primary care consultation. ¹ International data suggest that the agreement is often below evidence-based standards. ² The overall lifetime prevalence of depression in adulthood in Norway is 15.0%. ¹ | | | | |
| VALUES Is there important uncertainty about how much people value the main outcomes? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | The relative importance or values of the main outcomes of interest: Outcome: Non-response to treatment Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-remission at 12 months Relative importance: No studies Certainty of the evidence: No studies Outcome: Missed prevention at 12 months Relative importance: No studies Certainty of the evidence: No studies Outcome: Non-adherence to medication Relative importance: No studies Certainty of the evidence: No studies Outcome: Unintended effects Relative importance: No studies Certainty of the evidence: No studies | | | | |
| EFFECTS What is the overall certainty of the evidence of effectiveness? Are the desirable anticipated effects large? Are the undesirable anticipated effects small? Are the desirable effects large relative to undesirable effects? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | Summary of findings: Standard care vs collaborative care for depression (Exact wording not defined) Outcome: Non-response to treatment Standard care (%) 50.9 Collaborative care (%) 48.7 Difference (95% CI) 19 lower (5 to 15 lower) Outcome: Non-remission at 12 months Standard care (%) 47 Collaborative care (%) 46.4 Difference (95% CI) 2 more (1 more to 0 more) Outcome: Missed prevention at 12 months Standard care (%) 43 Collaborative care (%) 41.3 Difference (95% CI) 1 more (0 more to 2 more) Outcome: Non-adherence to medication Standard care (%) 51.8 Collaborative care (%) 50.8 Difference (95% CI) 0.7 lower (1.5 to 0 lower) Outcome: Unintended effects Standard care (%) No information Collaborative care (%) No information Based on: The NICE guideline on the treatment and management of depression in adults 2010 Link to interactive Summary of Findings table Link to evidence profile | Collaborative care has been shown to be most effective in trials carried out in the US. Similar results would be expected in well-funded European healthcare systems although there may be big differences in the standard care used as the comparator in different studies, and the severity and length of the collaborative care used between studies. The integrity of the intervention affects the outcome. ³ | | | |
| RESOURCES Are the resources required small? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | Main anticipated resource requirements Resource: Care managers Specialist input Additional resources Psychological treatments Follow-up | Patient and family costs are likely small. Mainly family costs may occur in low collaborative care is implemented, e.g. the qualifications of case managers, healthcare costs (including the cost of antidepressants and psychological treatment) may be large. | | | |
| EVIDENCE Is the incremental cost small relative to the net benefits? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | In a review of economic evaluations of enhanced primary care for depression collaborative care management resulted in improved outcomes but were also associated with greater costs. When considering primary care depression treatment costs alone ICER estimates ranged from \$13 to \$21 per additional QALY gained. ⁴ In a series of cost-effectiveness analyses accessibility and value for money, using cost-effectiveness acceptability thresholds, for a nurse-delivered care management approach there was a 65% probability that the cost-effectiveness of the intervention was less than \$20 000 per QALY and a 91% probability that it was less than \$20 000 per QALY. | | | | |
| EQUITY What would be the impact on health inequalities? | Unclear <input type="checkbox"/> Probably harmful <input type="checkbox"/> Unclear <input type="checkbox"/> Probably beneficial <input type="checkbox"/> Beneficial <input type="checkbox"/> | No evidence | Patients in less resource, social support and access to care may benefit more than resource strong patients, thereby reducing inequities. | | | |
| ACCEPTABILITY Is the option acceptable to key stakeholders? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | No evidence | Fewer patients seeking collaborative care left the trials. For any reason (including being lost to follow-up) than patients receiving usual care. Full effect may be required to a higher level of acceptability, but this is non-specific and the difference was small and non-significant. | | | |
| FEASIBILITY Is the option feasible to implement? | No <input type="checkbox"/> Probably not <input type="checkbox"/> Unclear <input type="checkbox"/> Probably yes <input type="checkbox"/> Yes <input type="checkbox"/> | No evidence | There may not be sufficient mental health professionals to provide the enhanced input and care coordination for all primary care patients with depression. ⁵ | | | |
| BALANCE OF CONSEQUENCES | Undesirable consequences clearly outweigh desirable consequences in most settings <input type="checkbox"/> | Undesirable consequences probably outweigh desirable consequences in most settings <input type="checkbox"/> | The balance between desirable and undesirable consequences is closely balanced or uncertain <input type="checkbox"/> | Desirable consequences probably outweigh undesirable consequences in most settings <input type="checkbox"/> | Desirable consequences clearly outweigh undesirable consequences in most settings <input type="checkbox"/> | |
| TYPE OF RECOMMENDATION | We recommend against the option <input type="checkbox"/> | | We suggest not offering this option <input type="checkbox"/> | | We suggest offering this option <input type="checkbox"/> | We recommend the option <input type="checkbox"/> |
| RECOMMENDATION (TEXT) | Each municipality should create and implement a collaborative plan of care for patients with moderate to severe depression. The plan should define the responsibilities and communication between the various professional groups who have contact with patients, both in community health services and between local and specialist healthcare, and appoint health professionals with special responsibility for follow-up of patients. The plan should include procedures for referral to specialist services. Strong recommendation, moderate quality of the evidence. The plan may include organizational, educational and other measures that have evidence of moderate to high quality that they can lead to better outcomes for patients with depression. | | | | | |
| JUSTIFICATION | There is high quality evidence of improved care, adherence and patient outcomes. There is no evidence of adverse effects. The cost is uncertain, but a likely area for patients and their families, moderate for municipalities and moderate for the health services. The cost-effectiveness is similar to or less than many other interventions that are considered cost-effective. | | | | | |
| IMPLEMENTATION CONSIDERATIONS | Implementation strategies should be tailored to municipalities (e.g. qualifications and location of case managers, communication and referral) and may be helped by model plans, clarification of options and support to select appropriate options. | | | | | |
| MONITORING AND EVALUATION | Monitoring of indicators of the quality of care and patient outcomes is warranted and should be incorporated in collaborative care plans. | | | | | |
| RESEARCH PRIORITIES | Ongoing and future research should clarify the importance of various components of collaborative care and the applicability of alternative models in different settings. | | | | | |

EBR framework (Version 2.1): Collaborative care for depression in Norway

QUESTION

CRITERIA

CONCLUSION

Targeted client communication via mobile phone: what did the WHO guideline panel recommend?

Conditional recommendation: The intervention was recommended under the condition that potential concerns about sensitive content and data confidentiality can be addressed.

Implementation considerations: Implementers should:

- secure data confidentiality and informed consent
- ensure access to network connectivity and electricity
- ensure that the content, format and delivery of information meets the needs of different target groups
- involve stakeholders in the design of the programme



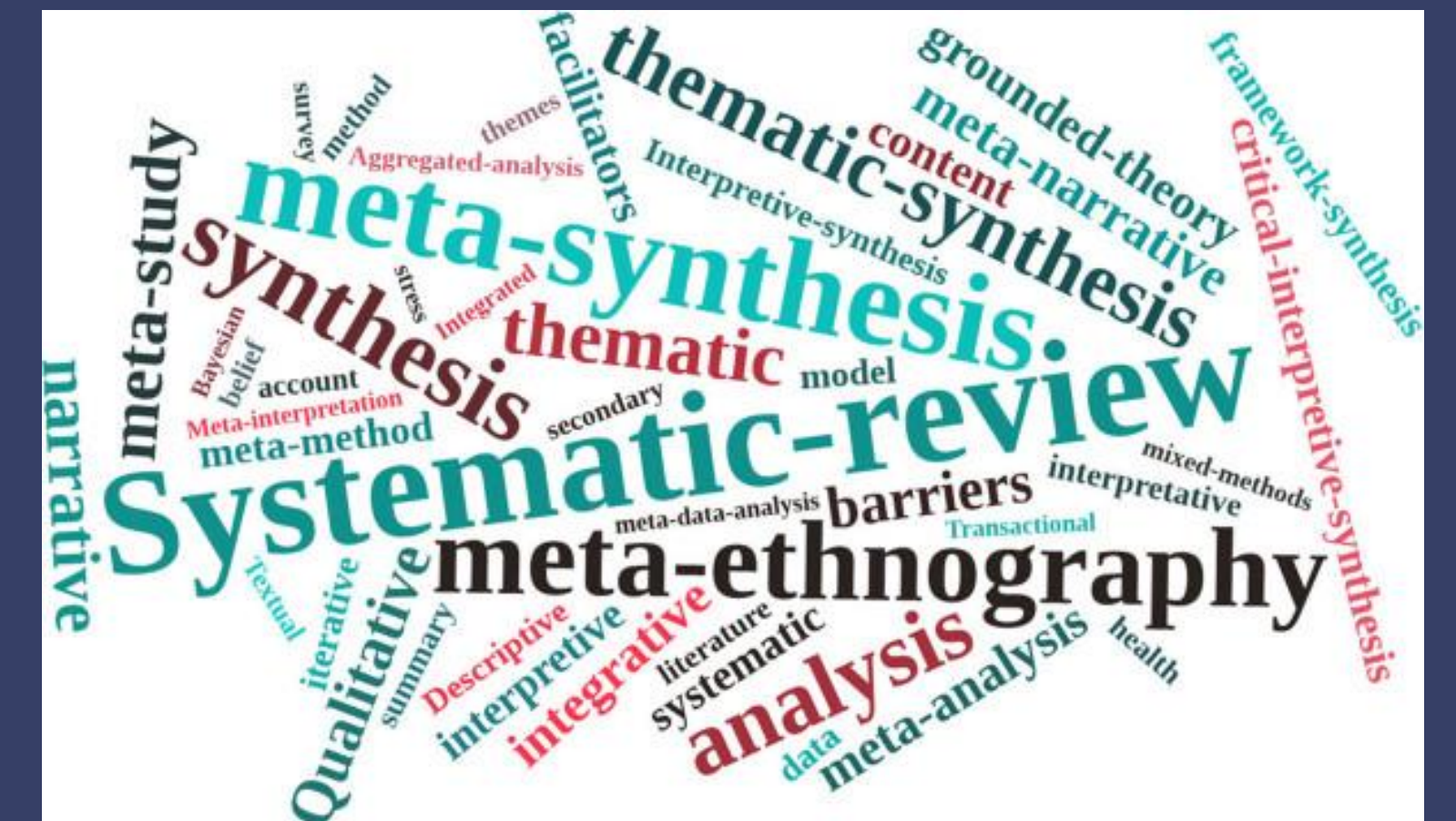
In summary, a range of tools are now available for using qualitative evidence in decision making



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This includes:

- Robust and well described methods for undertaking qualitative evidence syntheses
- Guidance on reporting these syntheses
- GRADE-CERQual approach for assessing how much confidence to place in findings from such syntheses
- Evidence-to-decision frameworks that facilitate the packaging of different types of evidence to facilitate transparent and systematic assessment by decision makers



Conclusions:
challenges and opportunities for using
qualitative evidence to inform decisions

A new era for qualitative research?



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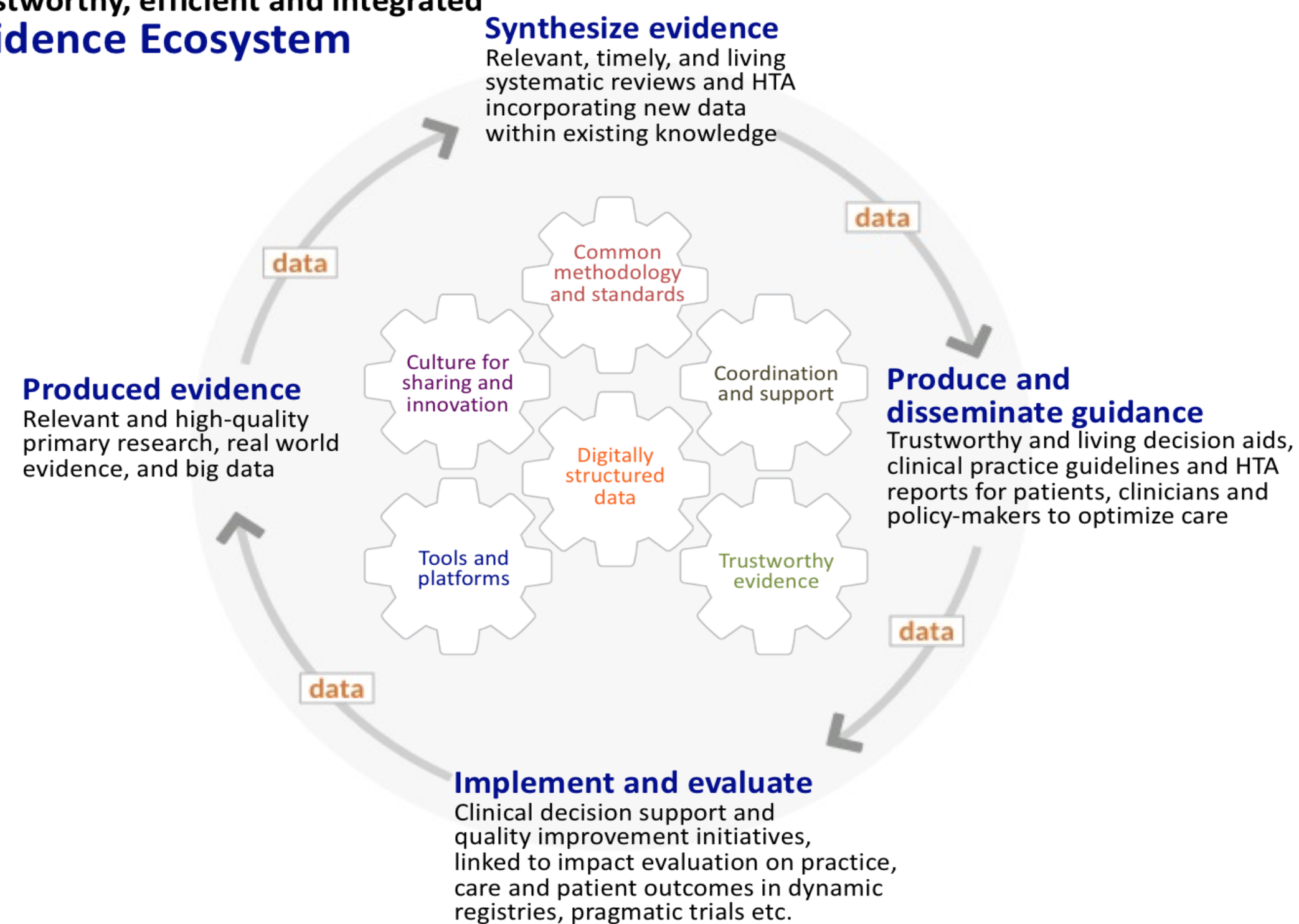
- In this talk I have tried to show that qualitative evidence is playing an increasingly important role in decision making processes in health and social care, and that new tools and approaches may further support this
- In addition, qualitative evidence can have much wider impacts by shaping how we view the social world, and health and social issues
 - Models and theories developed as part of qualitative evidence syntheses may have a particularly important role in this regard



Perhaps we are now entering a new era for qualitative research in which its value is increasingly recognized by decision makers, those who support them and other stakeholders?

An integrated evidence ecosystem

Trustworthy, efficient and integrated Evidence Ecosystem



It has been argued that for health systems to function optimally, evidence needs to be transferred seamlessly between:

- primary evidence producers
- evidence synthesizers
- groups producing guidance and other evidence-informed products
- people responsible for implementing evidence-informed options within health systems
- those involved in delivering and using health services, including service providers, service users and citizens

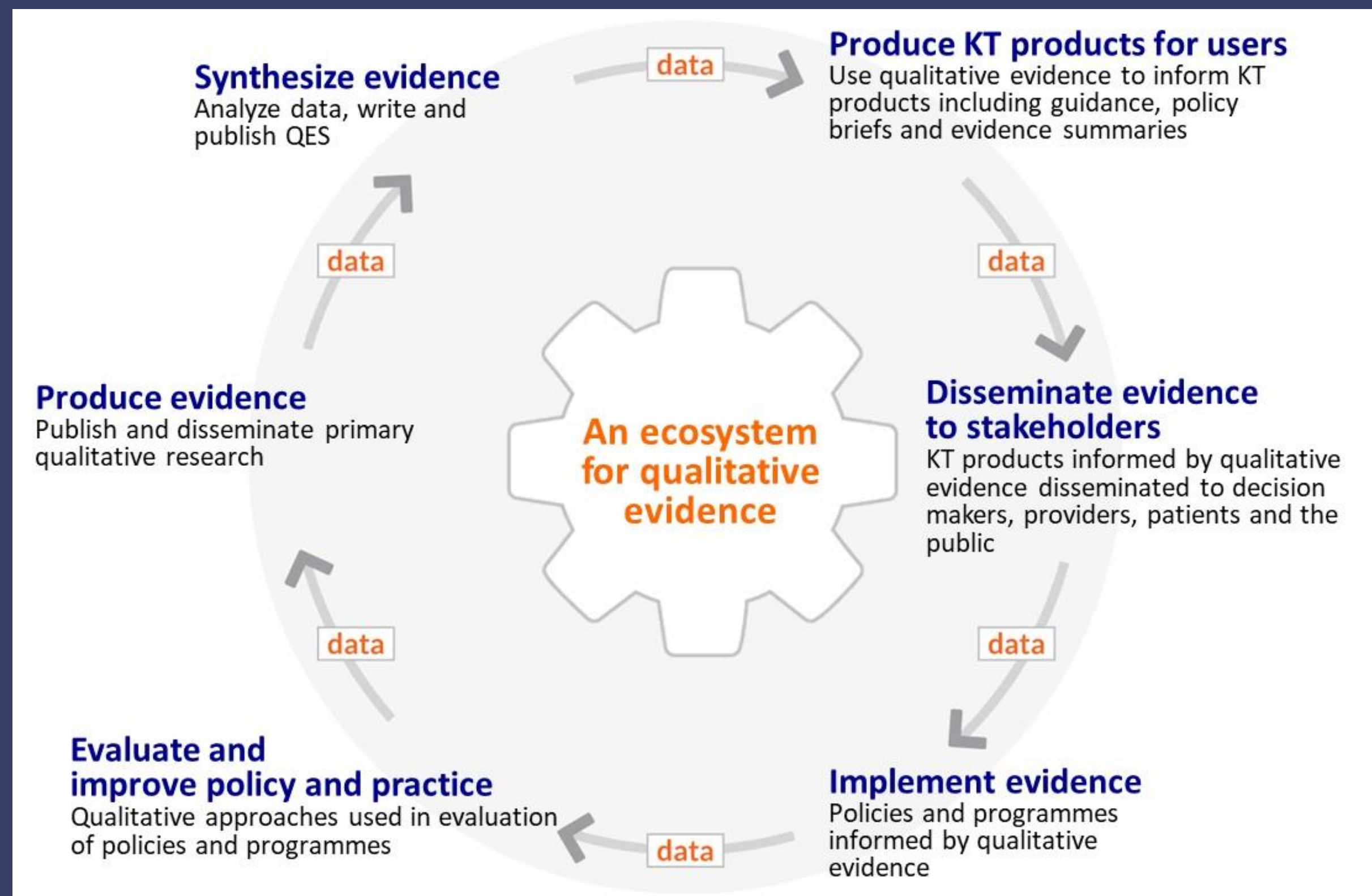
From: Brandt et al. A trustworthy, efficient and integrated evidence ecosystem. 2018. In press

This has been termed the evidence ecosystem

An integrated evidence ecosystem for qualitative evidence



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We now have most of the elements of an ecosystem for qualitative evidence in place:

- Evidence from primary qualitative studies is feeding into evidence syntheses
- Syntheses are being used in decision products such as guidance and policy briefs
- Decision products informed by qualitative evidence are being used to guide choices on health system options
- Health system strengthening initiatives are being evaluated through new primary qualitative research

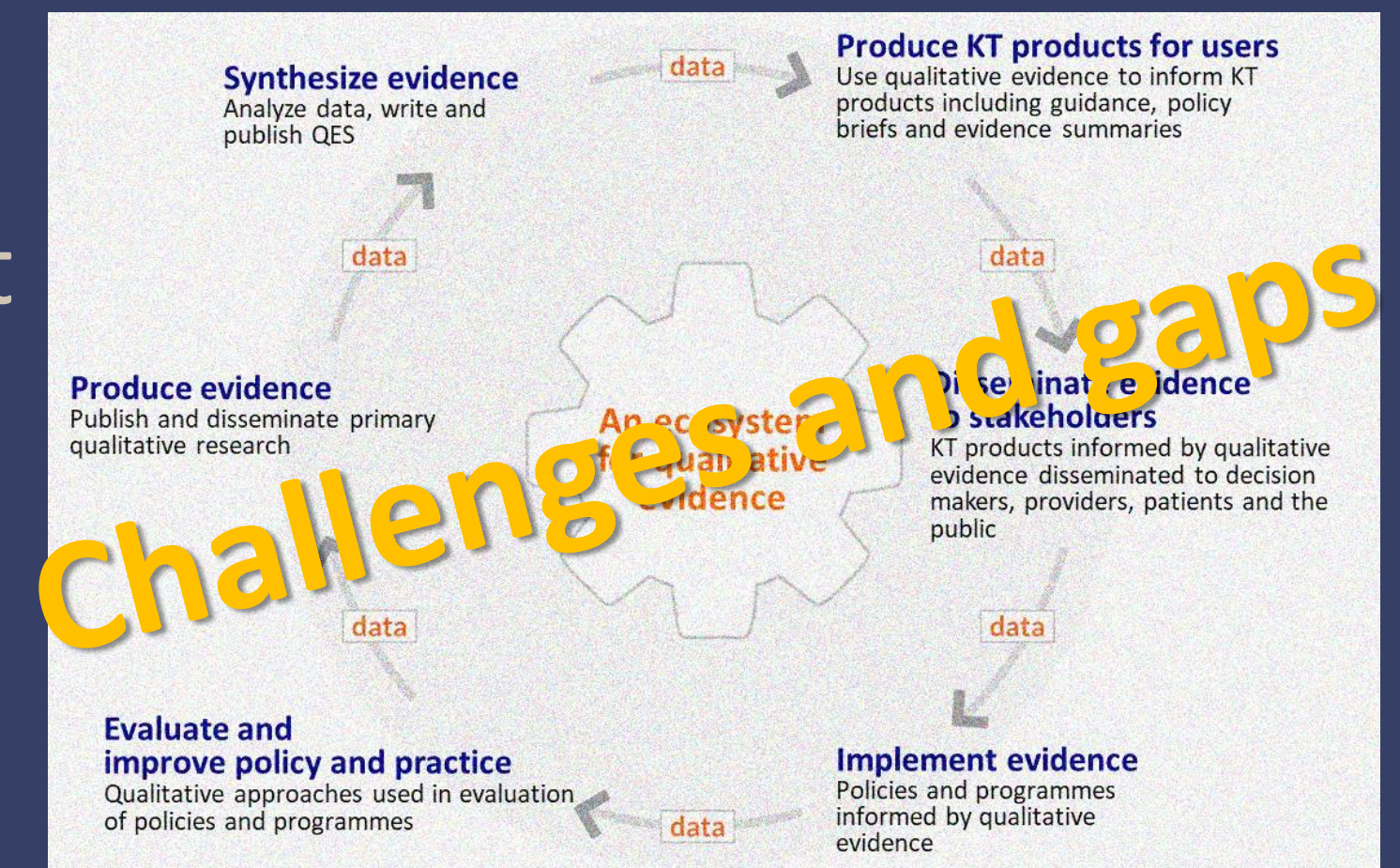
Adapted from: Brandt et al. A trustworthy, efficient and integrated evidence ecosystem. 2018. In press; Lewin and Glenton 2018

Conceptual challenges: understanding the roles of qualitative evidence in decisions



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- The evidence ecosystem approach constitutes a rather linear model of data transfer and use
- Contemporary approaches to the science-policy interface emphasise that stakeholders are expected to “negotiate what information is needed, what evidence is acceptable ...[]... and what the policy options are” (Heink et al. 2015)
- However, we don’t yet have a good understanding of how decision making forums negotiate and adjudicate different types of evidence (quantitative, qualitative) addressing different types of questions (effectiveness, feasibility etc.) across a range of decisions



Further research is needed in these areas

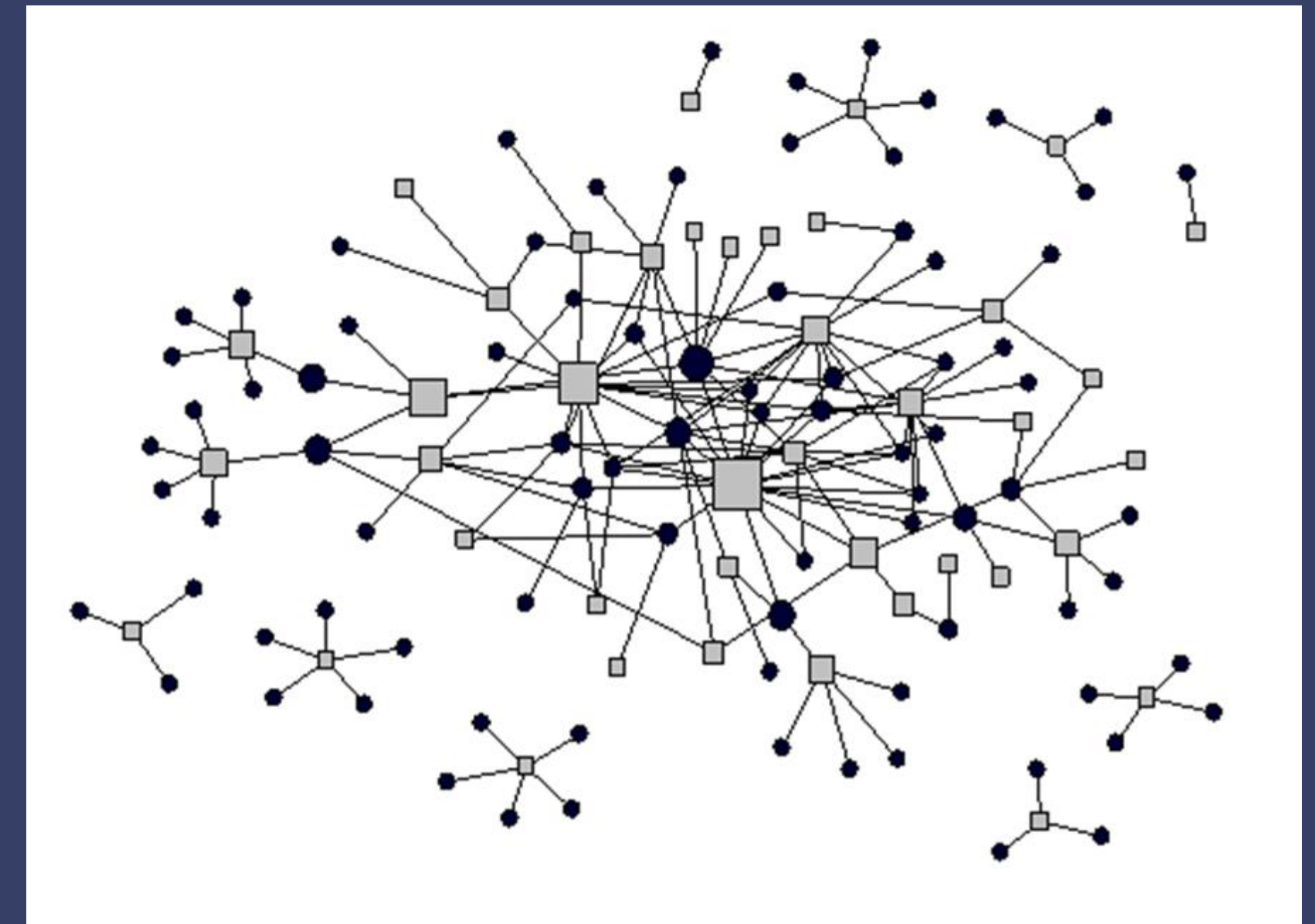
Wieringa et al.. 2018.

Conceptual challenges: applying theory to understanding decision making (1)



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- We have probably not yet done enough to utilise existing theory to help understand evidence use, including qualitative evidence
- For example, decisions in health and social care delivery can be viewed as taking place within complex, heterogenous, multiple actor networks
- These networks also involve a wide range of actors that transmit and shape information, including stakeholders from multiple sectors, evidence products such as frameworks and guidelines and regulations that govern different aspects of health and social care
- For each decision process, different elements are assembled into reality – this occurs at different decision levels and timepoints, and for an enormous and bewildering range of issues



Young et al. An Actor-Network Theory Analysis of Policy Innovation for Smoke-Free Places: Understanding Change in Complex Systems. 2010

Conceptual challenges: applying theory to understanding decision making (2)



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- While we know a lot about how to produce and package different kinds of evidence, we know far less about how these types of evidence, as actors within a network, shape the decisions or policies that emerge from the evidence-policy interface
 - Theory informed qualitative studies of these processes may provide insights into this

There are therefore many opportunities for taking forward our understanding of this field

Achieving wider use of qualitative evidence to inform decision making in health and other sectors

- Strengthen capacity across settings and institutions, particularly in LMICs, to produce, disseminate and utilise qualitative evidence and decision products informed by this evidence
- Build stronger links between the communities involved in the different parts of the qualitative evidence ecosystem, including across all sectors relevant to the SDGs
- Find the optimal ways of incorporating different types of knowledge – including qualitative evidence – into decision support products and processes, including decision frameworks
- Support policy users and stakeholders in engaging with different types of evidence and making judgements about these

I would like to end with a challenge....



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- The best way of learning is doing!
- We all need to look for opportunities in our settings:
 - To strengthen capacity to produce qualitative evidence, including primary studies and qualitative evidence syntheses, and
 - To support the wider use of qualitative evidence to inform decision processes across the sectors relevant to the SDGs

In this way we can help ensure that we do indeed enter a new era for qualitative research

Obrigado! Thank you!



Questions?

Thanks to

- Sarah Rosenbaum and Jane Noyes for allowing me to adapt some of her slides.
- Collaborators in the GRADE-CERQual Project Group and in WHO

Work on the GRADE-CERQual approach has been supported by the Alliance for Health Policy and Systems Research, the Brocher Foundation, Cochrane, the Research Council of Norway and WHO RHR.

For more information on the GRADE-CERQual approach:

- CERQual website: www.cerqual.org Twitter: @CERQualNet
- Implementation Science series:
<https://implementationscience.biomedcentral.com/articles/supplements/volume-13-supplement-1>

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References cited (1)



Norwegian Institute of Public Health

- Abelson J, Blacksher EA, Li KK, Boesveld SE, Goold SD. Public deliberation in health policy and bioethics: mapping an emerging, interdisciplinary field. *J Public Deliberation*. 2013;9(1).
- Alonso-Coello P, Schünemann HJ, Moberg J, Brignardello-Petersen R, Akl EA, Davoli M, Treweek S, Mustafa RA, Rada G, Rosenbaum S, Morelli A, Guyatt GH, Oxman AD; GRADE Working Group. GRADE Evidence to Decision (EtD) frameworks: a systematic and transparent approach to making well informed healthcare choices. 1: Introduction. *BMJ*. 2016;353:i2016.
- Ames H et al. Patients' and clients' perceptions and experiences of targeted digital communication accessible via mobile devices for reproductive, maternal, newborn, child and adolescent health: A qualitative evidence synthesis . *Cochrane Library*. Forthcoming 2019.
- Brandt L et al. A trustworthy, efficient and integrated evidence ecosystem. 2019. In press
- Davies C, Wetherell M, Barnett E. *Citizens at the centre: deliberative participation in healthcare decisions*. Bristol: Policy Press; 2006.
- Effective Practice and Organisation of Care (EPOC). EPOC Qualitative Evidence Synthesis: Protocol template. EPOC Resources for review authors. Oslo: Norwegian Institute of Public Health; 2018. Available at: <http://epoc.cochrane.org/epoc-specific-resources-review-authors>
- France EF et al. Improving reporting of Meta-Ethnography: The eMERGe Reporting Guidance. *Journal of Advanced Nursing*. Forthcoming 2018.
- Greenwald AG, Krieger LH. Implicit bias: Scientific foundations. *California Law Review*. 2006; 94(4):945-67.
- Lewin S, Glenton C, Munthe-Kaas H, Carlsen B, Colvin CJ, Gulmezoglu M, Noyes J, Booth A, Garside R, Rashidian A. Using qualitative evidence in decision making for health and social interventions: an approach to assess confidence in findings from qualitative evidence syntheses (GRADE-CERQual). *PLoS Med*. 2015;12(10):e1001895.
- Lewin S, Booth A, Glenton C, Munthe-Kaas HM, Rashidian A, Wainwright M, Bohren MA, Tunçalp Ö, Colvin CJ, Garside R, et al. Applying GRADE-CERQual to qualitative evidence synthesis findings: introduction to the series. *Implement Sci*. 2018;13(Suppl 1):2.

References cited (2)

- Lewin S, Glenton C. Are we entering a new era for qualitative research? Using qualitative evidence to support guidance and guideline development by the World Health Organization. *Int J Eq Health*. 2018; 17:126.
- Moberg J, Oxman AD, Rosenbaum S, Schunemann HJ, Guyatt G, Flottorp S, Glenton C, Lewin S, Morelli A, Rada G, et al. The GRADE evidence to decision (EtD) framework for health system and public health decisions. *Health Res Policy Syst*. 2018;16(1):45.
- Noyes J, Booth A, Cargo M, Flemming K, Garside R, Hannes K, Harden A, Harris J, Lewin S, Pantoja T, Thomas J. Cochrane qualitative and implementation methods group guidance series—paper 1: introduction. *Journal of clinical epidemiology*. 2018 May 1;97:35-8.
- Oxman AD, Lavis JN, Lewin S, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP): 1. What is evidence-informed policymaking? *Health Res Policy Syst*. 2009. 7(Suppl 1):S1.
- Thorne S. Metasynthetic madness: what kind of monster have we created? *Qual Health Res*. 2017;27(1):3–13.
- WHO. WHO recommendations: Optimizing health worker roles to improve access to key maternal and newborn health interventions through task shifting. Geneva, Switzerland: World Health Organization. 2012.
- Wieringa S, Dreesens D, Forland F, Hulshof C, Lukersmith S, Macbeth F, Shaw B, van Vliet A, Zuiderent-Jerak T. Different knowledge, different styles of reasoning: a challenge for guideline development. *BMJ evidence-based medicine*. 2018 Jun 1;23(3):87-91.
- Wong G, Greenhalgh T, Westhorp G, Buckingham J, Pawson R. RAMESES publication standards: realist syntheses. *BMC medicine*. 2013;11(1):21.
- Young D, Borland R, Coghill K. An actor-network theory analysis of policy innovation for smoke-free places: understanding change in complex systems. *American Journal of Public Health*. 2010;100(7):1208-17.