**Guidance for the new Cochrane Review format**

The aim of the new Cochrane Review format is to make reviews:

* More responsive to the needs of users
* Less time consuming to write
* Easier to edit and to peer review
* Compatible with key [MECIR standards](http://methods.cochrane.org/mecir)

The format is designed to be easier for people making decisions to use Cochrane Reviews, including patients and the public, health professionals, and policymakers. The main changes that have been made to achieve this are to:

* Use a layered approach
* Provide a brief, top-level statement about the effect of the intervention and the certainty we have in the effect
* Reduce repetition by combining the abstract and the plain language summary in the top layer
* Making the full text concise and easy to read in the second layer
* Putting much of the methods, tables, figures, and additional information in appendices, in the third layer

In addition, some more information has been added for decision makers, to help put the findings of the review into a decision-making context, changes have been made to some of the standard headings in the top two layers, and some changes have been made to the layout and menus to make the reviews more user-friendly. A full report of these changes and the methods used to redesign Cochrane Reviews of effects can be found here.

The guidance provided here is intended to supplement guidance that is found in the Cochrane Handbook, not to replace that guidance or the MECIR standards.

**General guidance**

Use plain language:

* Avoid unnecessary jargon.
* Explain useful jargon.
* Use terms consistently throughout the review.
* Include explanations of terms, if appropriate.
* If appropriate, suggest terms that should be added to the Cochrane glossary or a CRG glossary.
* Explain what is meant by terms that may be used in different ways; e.g. quality of care.
* Do not use abbreviations in the text (other than standard abbreviations found [here](https://community.cochrane.org/style-manual/abbreviations-acronyms-and-initialisms/common-abbreviations)). If abbreviations need to be used in a table, spell out the abbreviation in parentheses after (e.g. in the title or a heading) or spell them out in a footnote.
* Use measures of effect that can be understood easily. If this is not possible spell out and explain terms (e.g. odds ratio or standardised mean differences) and provide an interpretation
* Use standard terminology for study designs (See [Suggested terminology for study designs](https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/Resources-for-authors2017/what_study_designs_should_be_included_in_an_epoc_review.pdf" \o "What study designs can be considered for inclusion in an EPOC review and what should they be called?))
* Use consistent terms for describing the certainty of evidence throughout the review; avoid non-standard terms such as “solid evidence”; and use standard statements to describe effects based on the certainty of the evidence and the size of the effect (see [Reporting the effects of interventions](https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/Resources-for-authors2017/how_to_report_the_effects_of_an_intervention.pdf)).
* Remember to use simple, clear language. Short sentences are generally easier to read and understand than long sentences.
* Ask someone in your target audience, who is not an expert on the topic, to read the review and check that it is understandable and makes sense.
* Don’t use ‘statistically significant’ or ‘not statistically significant’.
* Avoid repetition and stating the obvious.

**Summary layer**

This is the top layer of the review. It will be outside of the current paywall. It replaces both the abstract and the plain language summary. The Summary, like an abstract or a plain language summary, should be able to function as a stand alone document; e.g. in PubMed or in a database of plain language summaries, such as the one found on Cochrane.org. The length, not including tables and “more information about the intervention” should be under 1000 words. It should not include links to the rest of the review, which is behind the paywall.

**Background**

The background text here should not be more than a few sentences and should only provide explanation that is essential to the understanding of the key messages. The last sentence should state clearly what the primary objective of the review is. If any terms are used that are likely to be unfamiliar to key audiences, these should be explained.

A link to more information about the interventions will automatically be placed at the end of the background. See ‘More detail about the interventions’ below.

**What this review is based on**

This section has three standard sentences at the beginning. The first sentence is automatically inserted: Cochrane Reviews are based on systematic and robust selection of relevant studies. The second sentence should report the number of included studies. The third sentence links to a standard table and is automatically inserted: See what studies we searched for and what we found.

## What studies we searched for

The first sentence is a standard sentence indicating how up-to-date the review is: “We searched for studies published up to . . .”. The rest of this paragraph summarises what studies were searched for; i.e. the selection criteria for the review.

## What we found

This is a summary of the key characteristics of the included studies.

**Main findings**

This is the key messages of the review. Each message should be a standard sentence of a key finding, such as:

→ **Electronic cigarettes compared to placebo**: Electronic cigarettes may increase the proportion of people who abstain from smoking for at least six months (low certainty evidence)

→ **Electronic cigarettes compared to nicotine patches:** It is uncertain how effective electronic cigarettes are compared to nicotine patches (very low certainty evidence)

→ **Adverse effects:** There may be little if any difference in the frequency of adverse events for electronic cigarettes compared to placebo electronic cigarettes or nicotine patches. The most frequently reported adverse events were mouth and throat irritation. None of the included studies reported serious adverse events considered related to using electronic cigarettes (low certainty evidence)

Guidance for preparing plain language statements such as the above can be found [here](https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/Resources-for-authors2017/how_to_report_the_effects_of_an_intervention.pdf). Quantitative results should not be included in these statements, but should be included in a Summary of Findings table, which will be linked to in shortened versions of the Summary (e.g. in PubMed) and will be outside the paywall.

**Summary of findings 1**

Summary of Findings tables should be numbered when there are more than one. Number 1 should be the one that appears in the Summary. This can either be for the main comparison or, if there are multiple comparisons, it can be a Summary of Findings for more than one comparison. We are proposing using interactive Summary of Findings (iSoF), but a decision has not yet been taken regarding this. iSoF tables can improve understanding and use of evidence of the effects of healthcare interventions by allowing producers (review authors and editorial teams) to tailor the presentation to the main target audience; and users to interact with the presentation by viewing more or fewer outcomes, more or less information about each outcome, information about the absolute effects as numbers, words or graphs, cursor over explanations and links to more detailed explanations of basic concepts (e.g. “95% CI”) and specific content (e.g. a specific outcome such as a pain scale). Because iSoF tables are interactive, they allow relatively simple presentations that enable users who need explanations or want more information to easily access that information.

**Authors’ conclusions**

This is one or two sentences stating the main conclusions. These should flow directly from the key findings, and should not be recommendations.

**Links to more information**

Links to the Full text of the review (the second layer), Additional details (the third layer) and these three links to more information will be automatically inserted at the bottom of the Summary:

See also: Information for decision-makers

See also: Related systematic reviews

See also: Messages for media

All of this information will be outside of the paywall. This information will also be accessible from the menu on the right of the screen.

## Information for decision-makers

This information is intended to help patients and the public, health professionals, and policymakers put the findings of the review into a decision-making context. There are four standard headings for each of these target audiences. These headings are not mandatory and can be edited. For example, for a review of all treatments for a condition, the heading ‘What other options are there?’ would not be relevant.

**For patients and the public**

**What are the [intervention(s)]?**

This should describe what the intervention(s) are in two or three plain language sentences. Information about the intervention(s) can come from ‘Description of the intervention’ in the Background section of the full text of the review.

**Who can use or administer [the intervention(s)]?**

This should describe who can use the intervention(s) for what condition or purpose in two or three plain language sentences. Information about who can use the intervention(s) can come from ‘Description of the condition’ in the Background section of the full text of the review.

**What other options are there?**

This should identify other options that could be used for the same condition or purpose.

**How do people experience the [intervention(s)]?**

This should describe how people experience the intervention(s) or [treatment burden](https://www.bmj.com/content/363/bmj.k4065.full) in two or three plain language sentences. This should not repeat the main findings of the review. Information about how people experience interventions can come from studies included in the review or from sources such as “[Database of Individual Patients’ Experiences” (DIPEx) databases](http://www.dipexinternational.org/members/our-members/).

**For health professionals**

This information is similar to what might be found in pharmacopoeias or comparable resources for non-drug interventions, such as the [Handbook of Non-Drug Interventions](https://www.racgp.org.au/clinical-resources/clinical-guidelines/handbook-of-non-drug-interventions-(handi)).

For health system interventions and other interventions that are targeted at populations rather than individuals, this section might not be relevant. It can either be removed or, if relevant, the subheadings can be removed and key implications of the intervention(s) for health professionals can be summarised under the main heading in two or three sentence, or alternative headings can be used (e.g. there might be different implications for different cadre, in which case the headings could be, for example, ‘Implications for physicians’, ‘Implications for nurses’, etc.

**Indications and contraindications**

This should state indications for using the intervention(s) and important contraindications in two or three sentences. This should not repeat information about indications for using the intervention(s) that is in the Background of the Summary.

**Delivery**

This should describe key information for health professionals about how the intervention is are delivered in two or three sentences.

**Precautions**

This should describe key precautions that health professionals should be aware of in two or three sentences.

**Counselling patients**

This should describe key information that health professionals should provide to patients

**For policy decisions**

**Policy options**

For clinical interventions, this should describe in two or three sentences key options that policymakers might consider to regulate or manage use of the intervention(s). If there is important uncertainty about the benefits and harms of an intervention, policy options should take this into consideration (e.g. a policy option might be coverage with evidence development). For health system interventions and other interventions targeted at populations, this should describe key options for implementing the interventions - or, if this information would be redundant with what is in the Background of the Summary, this subheading can be removed.

**Equity considerations**

This should address potential differences in effects of the policy options for disadvantaged populations within countries. What, if any impacts are the policy options likely to have on disadvantaged populations and equity?

The following questions can be considered when making judgements about the potential impact a policy or programme option is likely to have on disadvantaged groups, and on equity in low-income countries:

1. Which groups or settings are likely to be disadvantaged in relation to the option being considered?

Consideration should be given to the following groups or settings:

* + **Economic status**: low-income populations are more likely to be responsive to changes in the prices of goods and services. Because they have less disposable income, tobacco tax increases, for example, could make such populations more likely to quit. But they would also be made more vulnerable as a result of having to spend more money on tobacco if they did not quit smoking
  + **Employment or occupation**: employer-funded insurance schemes may result in differences in coverage, with less coverage being likely for those who are unemployed, self-employed or employed in small companies
  + **Education**: school-based programmes would be expected to differentially affect those who attend versus those who do not attend schools. Information campaigns that rely on printed materials to improve the utilisation of health services might have differential impacts on illiterate or less-educated populations
  + **Place of residence**: access to care is commonly more difficult in rural areas. Any strategy, therefore, that does not take into account the need to improve the delivery of effective clinical or public health interventions is likely to be less effective in rural areas
  + **Gender**: strategies for involving stakeholders in priority setting may affect women and men differently, resulting in priorities that may have different impacts on women and men
  + **Ethnicity**: ethnic groups (e.g. those groups who consider themselves, or are considered by others, to share common characteristics which differentiate them from other groups in society) may have beliefs and attitudes relating to the acceptability of a particular policy or programme. Delivery strategies that do not take these perspectives into account are likely to be less effective amongst ethnic groups where an otherwise effective policy or programme might not be readily accepted

1. Are there plausible reasons for anticipating differences in the relative effectiveness of the option for disadvantaged groups or settings?
2. Are there likely to be different baseline conditions across groups or settings such that that the absolute effectiveness of the option would be different, and the problem more or less important, for disadvantaged groups or settings?
3. Are there important considerations that should be made when implementing the option in order to ensure that inequities are reduced, if possible, and that they are not increased?

See: [SUPPORT Tools for evidence-informed health Policymaking (STP) 10: Taking equity into consideration when assessing the findings of a systematic review](http://www.health-policy-systems.com/content/7/S1/S10)

**Economic considerations**

What are the most important economic consequences that policymakers should consider?

1. What are the most important economic consequences?

Examples of potentially important economic consequences that should be considered include:

|  |
| --- |
| *1. Changes in use of healthcare resources* |
| * Intervention   + Human resources/time   + Consumable supplies   + Land, buildings, equipment * Additional (or fewer) hospitalisations, outpatient visits or home visits * Additional (or less) use of laboratory tests or examinations * Paid transportation (e.g. emergency transportation) |
| *2. Changes in use of non-healthcare resources* |
| * Home adaptation * Special diets * Transportation to healthcare facilities * Social services (e.g. housing, home assistance, occupational training) * Crime (e.g. theft, fraud, violence, police investigation, court costs) |
| *3. Changes in use of patient and informal caregiver time* |
| * Visits * Hospital admissions * Time of family or other informal caregivers |
| *4. Changes in productivity* |
| * Changes in productivity and the intrinsic value of changes in health status should be captured in the value or importance attached to health outcomes and should not be included as resource consequences. |

1. Are there important considerations regarding the distribution of the costs and benefits of the intervention?

Who pays should not determine whether resource consequences are considered (i.e. a broad ‘societal’ perspective should be taken). However, who pays and who benefits may be an important consideration with respect to equity.

1. Is there information about the total resource implications of expanding coverage of the intervention and sustaining it and what are the implications for scale up?
2. Is there important uncertainty about medium to long term economic consequences?

The length of follow-up in the available studies may be an important consideration, if there is important uncertainty about longer term economic consequences.

1. Is there important uncertainty about the applicability of reported economic consequences?

If possible, important economic consequences should be considered in natural units in the summary rather than as monetary values, which cannot easily be applied across different settings since resource use (which may differ across settings) cannot be separated from unit costs (which are likely to differ across settings).

* The quality of evidence for economic consequences should be considered using the same (GRADE) criteria as those used for other impacts, if possible.
* Be cautious about reporting the results of cost-effectiveness or cost-utility analyses, since they often will not be applicable across different settings because of differences in resource use, unit costs, and the assumptions that are made. If only monetary values are reported or the results are limited or potentially misleading – leave out the results of cost-effectiveness analyses. Only include the results of cost-effectiveness analyses if they provide a good sense of the magnitude of the costs in relation-ship to the effects of the intervention that is likely to be similar across a range of LMIC settings.
* Do not make judgements about the balance between the net benefits and costs (whether an intervention is worth what it costs), but include any results and interpretation that could help decision-makers to do so.

See [SUPPORT Tools for evidence-informed health Policymaking (STP) 12: Finding and using research evidence about resource use and costs](http://www.health-policy-systems.com/content/7/S1/S12)

**Monitoring and evaluation**

1. Is monitoring necessary?

The need for monitoring depends on the perceived need among relevant stakeholders to learn more about what is going on “on the ground”.

Whether it is worth the effort to set up a system for monitoring of a policy or programme may depend on several factors:

* Is there a monitoring system already in place that includes the needed indicators, or is a whole new set-up required?
* How much will it take to set up the required system? Is it as simple as adding a few items to data-collection procedures that already in place, or would additional large-scale household surveys be needed?
* Are the findings likely to be useful? What actions can or will be taken if monitoring reveals that things are not going as planned?

1. If monitoring is necessary, what should be measured?

Factors that need to be considered when selecting indicator(s) to collect for monitoring purposes include: validity, reproducibility, acceptability, feasibility, reliability, sensitivity to change, and predictive validity.

* In practice there will often be a trade-off between picking the optimal or desired indicators and having to accept the indicators which can be measured using existing data.
* There are good reasons not to select more indicators than needed: trying to limit the burden of data-collection being put on the health system, avoiding collection of data that are not utilised, and rather concentrate on collecting fewer data of high quality.

1. Is an impact evaluation necessary?

If there is insufficient evidence to be confident about the impacts of implementing a policy or action, the following should be considered. Positive answers to these questions suggest the need for well-designed field trials or “planned delays” in rolling out or scaling up an intervention.

* Is the intervention potentially ineffective or harmful?
* Are there important uncertainties about potentially important benefits, harms or costs (due to either the quality or applicability of the evidence)?
* Would evaluating the impact of the planned policy or action represent good value for money?
* Are the necessary resources for undertaking an impact evaluation likely to be available? If not, could they be obtained and would it be possible to collaborate with other countries?

1. If an impact evaluation is necessary, what should be evaluated and how?

* If a randomised trial is warranted and practical, what should be compared and what are the primary outcomes?
* If a randomised trial is not warranted or practical, what would be the optimal design and primary outcomes?

Implications for evaluation should be specific and they should be justified; i.e. what specific uncertainty should be addressed, how, and why addressing that uncertainty is important for people making decisions about an intervention (or how to address a problem) and key stakeholders. Statements such as “Evaluation is needed” are unhelpful and should not be made.

The following reasons for uncertainty can help to guide the types of research that might be needed:

|  |  |
| --- | --- |
| **By outcome for each of the most important outcomes** | **Possible implications for research** |
| Study design | Need for randomised trials, if appropriate |
| Risk of bias | Need for better designed and executed studies |
| Inconsistency | Unexplained inconsistency: need for evaluation in relevant subgroups |
| Indirectness | Need for studies that directly address the question of interest |
| Imprecision | Need for more studies with more participants |

See [SUPPORT Tools for Evidence-informed Policymaking in health 18: Planning monitoring and evaluation of policies](http://www.health-policy-systems.com/content/7/S1/S18)

## Related systematic reviews

An automated search for related systematic reviews will generate a list of potentially relevant systematic reviews. This list should be edited by the review authors and editorial team.

## Messages for the media

This section is for content generated for dissemination – press releases, blogshots, videos, etc. A separate project is needed to set this up.