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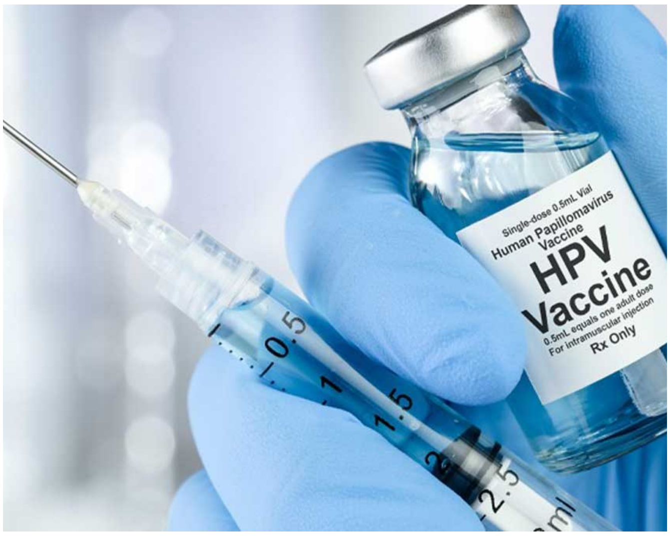
Infosheet
Jan – June 2025
Edition

NEWSLETTER OF COCHRANE NIGERIA, CALABAR INSTITUTE OF TROPICAL DISEASES RESEARCH AND PREVENTION, UNIVERSITY OF CALABAR TEACHING HOSPITAL.

Barriers and Facilitators of HPV Vaccination: Insights from a Cochrane Qualitative Evidence Synthesis



Human papillomavirus (HPV) is a sexually transmitted infection. Most infections are asymptomatic and resolve without treatment, but persistent infections with high-risk strains can lead to cervical cancer.[1] Cervical cancer is the second most common cancer in Nigerian women, with an estimated 14,943 new cases and 10,403 deaths annually.[2] HPV also causes genital warts (painless growths in the genital or anal areas), anal, penile, and oropharyngeal cancers.

Vaccinating adolescents (ages 9–19) with the HPV vaccine is one of the most effective ways to prevent these diseases. Despite the availability of HPV vaccines, uptake remains low in many countries, including Nigeria, which introduced the HPV vaccine into its routine immunization program for adolescents in 2023.[3] Globally, only about 27% of eligible girls have received at least one dose of HPV vaccine, which is far below the World Health Organization's target of 90%.[4]

A recent Cochrane qualitative evidence synthesis by Cooper et al.[5] explored the key factors influencing caregivers' and adolescents' views and practices about HPV vaccination. The review analyzed 71 studies from high-, middle-, and low-income countries, including Nigeria and other African countries, to identify recurring themes shaping HPV vaccine acceptance or hesitancy.

Key findings

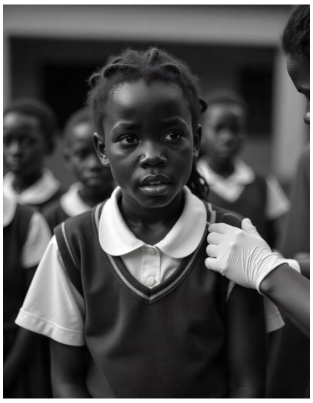
The synthesis identified eight major factors influencing the decision to get the HPV vaccination:

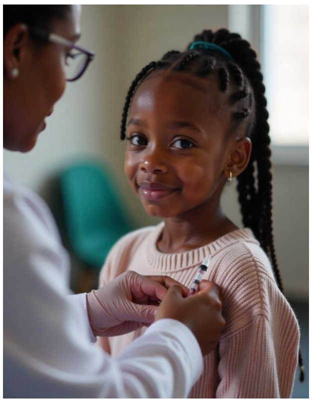
1. **Biomedical Knowledge** – There was often limited biomedical knowledge about HPV/HPV vaccination amongst adolescents and caregivers. In some cases, lack of biomedical knowledge reduced acceptance of vaccinations, but in other cases, it did not.

Contents

For some people, beliefs incongruent with biomedical knowledge, such as the belief that HPV vaccination would prevent HIV, influenced acceptance of the vaccine.

2. **Perceptions of Risks & Benefits** - (or lack thereof) of HPV vaccination – Concerns about side effects or adverse effects, uncertainties about vaccine effectiveness, vaccine "newness," fear or dislike of needles, beliefs that vaccination encourages early sexual activity or promiscuity were factors that influenced caregivers and adolescents' views and HPV vaccination acceptance. Perceptions of the severity of cervical cancer increased acceptance of the vaccination among many caregivers and adolescents, as well as perceived protection against HPV infection, STIs, cervical and other types of cancers.





3. **Views and experiences of other vaccines and vaccination programmes** – Prior positive or negative experiences with other vaccines or vaccination programmes appeared to influence acceptance or otherwise of HPV vaccination.

4. **Nuclear Familial Decision-Making Dynamics** – Family dynamics about who the primary decision maker(s) is appeared to influence views and practices around HPV vaccination. Decisions to receive, decline, or delay vaccination are made based on the view(s) of the decision maker.

5. **Social networks, communities and the media** – Extended family, social networks such as peers, religious leaders, and media played an important role in shaping the views and practices of both caregivers and adolescents and conversely, the acceptance or decline of the vaccine either positively or negatively (including misinformation by peers).

6. **Socio-Cultural Beliefs and Practices** – Socio-cultural beliefs and practices relating to adolescent sexuality, sexuality as a whole, parenting, and religious beliefs appeared to influence the views and practices of caregivers and adolescents towards acceptance or refusal of HPV vaccination. These included beliefs that the vaccination Infringed on their parenting rights, association of HPV with inappropriate sexual behavior, infringement on girls' sexual innocence, or beliefs such as 'health is governed by God, so vaccines interfere with God's jurisdiction', which generally reduced acceptance of the vaccine. Other beliefs such as HPV vaccination served as a safety net during adolescence (which was viewed as a time of sexual curiosity for men), enhanced acceptance of the vaccine.

7. **Trust or distrust in the institutions, systems and experts associated with vaccination** – Specifically, the review identified that trust of distrust in five key institutions/systems/experts associated with vaccination, influenced views and practices around HPV vaccination: 1) teachers and the school (trust impacted positively or negatively depending on teachers views); 2) the pharmaceutical industry; (largely associated with distrust) 3) government; (where there was trust, endorsement by government led to acceptance but if lacking, reduced acceptance 4) science and biomedicine (trust or distrust leading to enhancing or reducing

acceptance respectively); and 5) healthcare professionals (HCP) (trust impacted positively or negatively depending on HCP views; distrust led to reduced acceptance).

8. **Access, supply, and delivery logistics** – Access to and experiences of HPV Vaccination programmes and delivery services were found to influence the views and practices of caregivers and adolescents about HPV Vaccination through five major ways. These were the convenience or inconvenience of vaccination, the cost (free, low cost, having to pay the full cost of the HPV vaccination), language barriers while trying to access vaccination (for those from ethnic minority groups), feminization of the vaccination program, and other aspects related to the delivery of HPV vaccination in schools.

Implications

The review highlights that improving HPV vaccine uptake requires more than just education campaigns. Strategies should take into consideration the findings of this review, specifically:

- Gender equity issues in providing HPV Vaccination
- Community engagement
- Improved access
- Tailored communication to address myths and miscommunication (e.g., “vaccines cause infertility”) with culturally sensitive messaging.

HPV vaccination is a potentially lifesaving intervention, but its uptake depends on understanding and addressing the complex social, cultural, and structural factors influencing vaccine acceptance. This Cochrane review provides insights for designing more effective, equitable vaccination programs globally, including in Nigeria.

References

1) Bruni, L., Albero, G., Serrano, B., Mena, M., Collado, J. J., Gómez, D., Muñoz, J., Bosch, F. X., & de Sanjosé, S. (2023). Human papillomavirus and related diseases in the world: Summary report 10 March 2023. ICO/IARC Information Centre on HPV and Cancer (HPV Information Centre). https://hpvcentre.net/statistics/reports/XWX.pdf
2) ICO/IARC HPV Information Centre, author. Nigeria Human papillomavirus and related cancers, fact sheet 2018 [Internet] ICO/IARC HPV Information Centre; 2019. [cited 2020 Dec 10]. Available from: https://www.hpvcentre.net/statistics/reports/NGA_FS.pdf
3) World Health Organization. (2023, October 24). Nigeria to vaccinate 7.7 million girls against leading cause of cervical cancer [Press release] https://www.afro.who.int/countries/nigeria/news/nigeria-vaccinate-77-million-girls-against-leading-cause-cervical-cancer
4) https://www.who.int/news-room/fact-sheets/detail/immunization-coverage
5) Cooper, S., Schmidt, B. M., Jama, N. A., Ryan, J., Leon, N., Mavundza, E. J., Burnett, R. J., Tanywe, A. C., & Wiysonge, C. S. (2025). Factors that influence caregivers’ and adolescents’ views and practices regarding human papillomavirus (HPV) vaccination for adolescents: A qualitative evidence synthesis. Cochrane Database of Systematic Reviews, 2025(4), Article CD013430. https://doi.org/10.1002/14651858.CD013430.pub2

Evidence at your fingertips
(From the Cochrane Library)

Plain Language Summaries

How accurate are Truenat assays for detecting pulmonary tuberculosis and rifampicin resistance in adults and adolescents?

Key messages

- *Truenat MTB Plus was more accurate than Truenat MTB for detecting pulmonary tuberculosis. Truenat MTB misidentified many people as having tuberculosis when they did not, which raises concern.*
- *Xpert Ultra was more accurate than Truenat MTB.*
- *Evidence on the accuracy of the Truenat assay for detecting*

What is pulmonary tuberculosis?

Pulmonary tuberculosis is a lung disease caused by a bacterium (a germ) that spreads through the air via droplets from an infected person. In early stages, it remains dormant (does not multiply) and presents symptoms like fever, remains dormant (does not multiply) and presents symptoms like fever, cough, weight loss, and night sweats. When a person coughs and produces sputum (a mix of saliva and mucus) or blood-stained sputum, they are advised to visit a healthcare professional.

Drug-resistant tuberculosis is caused by bacteria that are not killed by at least one effective antibacterial medicine (for example, isoniazid or rifampicin) used to treat tuberculosis (called drug resistance). Delay in diagnosis of drug-resistant tuberculosis may increase spread from one person to another, and lead to further drug resistance. Diagnosis relies on demonstrating the presence of the bacteria or its DNA (which carries the genetic material needed for the bacteria to multiply) in a sputum sample. There are several ways of diagnosing tuberculosis. Examining a sputum sample under a microscope is easy and cheap, but it needs the presence of many bacteria so is not useful in early disease. Another way is to grow bacteria in a laboratory, but this takes weeks and is more expensive, particularly for poorer countries. The most-recent way is using a simple, quick, portable, and cost-effective assay to detect the bacteria within hours. These may be useful in poorer countries. While culture is the best way to confirm the disease, early and accurate identification is essential to start treatment and prevent debilitating and fatal illness. Assays would do this.

Why is improving diagnosis important?

According to the World Health Organization (WHO), in 2023, 10.8 million people had tuberculosis, and 1.25 million people died. The number of people with tuberculosis keeps increasing. It is crucial to have a test that accurately determines whether the disease is present (called a true positive) or absent (a true negative) without producing errors (like claiming the disease is present when it is not (false positive), claiming it is not there when it is (false negative), or invalid or inconclusive results). False-positive results cause unnecessary anxiety, and people will be monitored, requiring time and resources. These people may also be started on treatment with severe unwanted effects. False-negative results may miss cases, spreading disease in the general population. People with false-negative results may develop severe forms of tuberculosis with fatal outcomes due to delayed diagnosis and treatment.

What did we want to find out?

We wanted to assess the accuracy of three Truenat assays; two for detecting pulmonary tuberculosis (MTB, MTB Plus) and one for detecting rifampicin resistance (MTB RIF Dx) in adults and adolescents (aged 10 years and older) with suspected pulmonary tuberculosis.

What did we do?

We looked for studies assessing the accuracy of Truenat assays and compared them with another assay recommended by WHO (Xpert Ultra). The results of these tests were verified against culture for detecting pulmonary tuberculosis and tested for resistance to rifampicin, the most common antibiotic used to treat tuberculosis.

What did we find?

We found six studies (4081 people) for Truenat MTB, four studies (3073 people) for Truenat MTB Plus, and two studies (966 people) for Truenat MTB RIF Dx. Three studies also evaluated Xpert Ultra in addition to Truenat.

For the Truenat MTB assay, for 1000 people where 100 have tuberculosis confirmed by culture, 214 will be Truenat MTB positive. Of these, the assay will correctly identify 88 people with tuberculosis, but will incorrectly identify 126 people as having tuberculosis when they do not (false positives). Similarly, 786 will be Truenat MTB negative. Of these, the assay will identify 774 people as not having tuberculosis, of whom 12 will actually have tuberculosis (false negatives) and be missed.

For the Truenat Plus assay, for 1000 people where 100 have tuberculosis confirmed by culture, 127 will be Truenat MTB Plus positive. Of these, the assay will correctly identify 91 people with tuberculosis, but will incorrectly identify 36 people as having tuberculosis when they do not (false positives). Similarly, 873 will be Truenat MTB Plus negative. Of these, the assay will identify 864 people as not having tuberculosis, of whom nine will actually have tuberculosis (false negatives) and be missed.

For the detection of rifampicin resistance, the evidence was limited.

How confident are we in the results of this review?

We are confident of our results. We included a good number of studies and participants. Overall, the included studies were well conducted.

Who do the results of this review apply to?

The results of this review apply to people with symptoms suggestive of pulmonary tuberculosis.

How up-to-date is this review ?

The review is up to date as of 16 October 2023

Reference:

Inbaraj LR, Daniel J, Sathya Narayanan MK, Srinivasalu VA, Bhaskar A, Scandrett K, Rajendran P, Kirubakaran R, Shewade HD, Malaisamy M, Padmapriyadarsini C, Takwoingi Y. Truenat MTB assays for pulmonary tuberculosis and rifampicin resistance in adults and adolescents. Cochrane Database of Systematic Reviews 2025, Issue 3. Art. No.: CD015543. DOI: 10.1002/14651858.CD015543.pub2. Accessed 28 May 2025.

COMMUNITY VIEWS ON MASS DRUG ADMINISTRATION FOR SOIL-TRANSMITTED HELMINTHS: A QUALITATIVE SYNTHESIS

Key messages

People consider several personal, social, and historical factors before deciding to take medicine. Within one community, different individuals will experience benefits and harms associated with treatment, which shape their decision to participate. The decision to adhere depends on the perceived benefits compared to harms, the trust built between communities and the programme, the competency of people delivering the drugs to provide reassurance to the community members, and the perceived organisation of the delivery programme.

Our findings are largely consistent with those of a 2022 Cochrane review exploring people's views and experiences of mass drug administration (MDA) programmes for lymphatic filariasis. This evidence overlap suggests that there are key challenges in the design of MDA programmes in general that need to be addressed to increase adherence.

What was studied in this synthesis?

Mass drug administration (MDA) involves the periodic delivery of drugs to treat entire communities or groups, regardless of whether an individual has a particular disease. This method aims to prevent onward transmission of infection within the population. MDA is currently recommended for some disease-control programmes in low- and middle-income countries, including for soil-transmitted helminth (STH) infections. STHs are a group of parasitic worms, including roundworm, hookworm, whipworm, and threadworm. These MDA programmes are usually delivered within a

community or as a school-based programme. Successfully stopping STH infections through MDA depends on community members being willing and able to participate.

In this review, we looked for studies that explored how people view and experience mass drug administration programmes for STHs. We identified 17 studies relevant to this synthesis.

What was the aim of this synthesis?

In this synthesis of qualitative research, we searched for studies that explored people's views on MDA programmes for treating STHs in low- and middle-income countries. We wanted to understand how people view and experience mass drug administration programmes for soil-transmitted helminths. We were also interested in whether our findings would support, extend, or conflict with findings from a 2022 Cochrane review which looked at MDA programmes for lymphatic filariasis, another infectious disease caused by worms.

What were the main findings?

We included 17 studies in our analysis. The studies covered several countries in Africa and South-East Asia, and one country in the Eastern Mediterranean region. The included studies explored the views and experiences of community members and those distributing the medicines in low-income countries where STH infection is a considerable problem. From the data, four themes emerged. The 2022 Cochrane review of MDA for lymphatic filariasis identified three of these themes, highlighting the similarities between these programmes. One new theme emerged.

1. People weigh up benefits and harms in their decision to participate in MDA, though some may not have a choice. There are many outcomes to participating in the MDA programme, both positive and negative. For community members, several of these may exist at once, and the decision to partake is a careful balance of risk, benefit, and feasibility (we have high confidence in the evidence). Unpleasant experiences can quickly spread through the community (moderate confidence). Physical and social barriers (e.g. travel distance or not attending school, respectively) prevent some people from accessing treatment through the MDA programme (moderate confidence).
2. Many people are suspicious of MDA programmes, although trust may be built over time. Factors such as historical experiences, rumours, and mistrust of people involved in the programme affect overall trust in the programme. Past experiences can have a strong effect on people; negative experiences are likely to deter people from future participation (high confidence). Careful management of the relationships between people implementing the programme and people receiving the programme is important to building trust over time (moderate confidence).

3. The drug distributor's status in the community is often low, and they are not well-equipped to answer the communities' questions. People employed to distribute the drugs during STH treatment campaigns often lack a healthcare background, and in-depth training around the drug or the disease itself (moderate confidence). Whilst some community members prefer distribution from people who they know or trust (high confidence), others place value on the knowledge or status of the drug distributors, and may not participate if the community drug distributors cannot answer their questions related to the programme (moderate confidence).
4. (New theme) Many community members have ideas to improve delivery and want more involvement in the programme. Although some programmes conduct education and sensitization activities prior to drug distribution, many community members still lack awareness of the timing and purpose of the distribution (high confidence). People value distribution strategies that make it easy for everyone to participate, and express a desire for adults in the community to be included in the programme (moderate confidence). Many community members believe a more comprehensive health campaign which includes improved sanitation is necessary to tackle STH burden (moderate confidence).

How current is this evidence?

The evidence is current to November 2024.

Reference:

Fox T, Shrestha S, Kuehn R, Taylor M. Community views on mass drug administration for soil-transmitted helminths: a qualitative evidence synthesis. Cochrane Database of Systematic Reviews 2025, Issue 6. Art. No.: CD015794. DOI: 10.1002/14651858.CD015794.pub2. Accessed 23 June 2025.

XPERT ULTRA COMPARED TO XPERT MTB/RIF FOR DIAGNOSING PULMONARY TUBERCULOSIS AND RIFAMPICIN RESISTANCE IN ADULTS

Why is improving the diagnosis of pulmonary tuberculosis important?

Tuberculosis is one of the leading causes of death worldwide. While tuberculosis is largely curable when detected early and effectively treated, around 1.2 million people died of tuberculosis in 2019. Xpert MTB/RIF and Xpert Ultra (the newest version) are World Health Organization-recommended rapid tests that simultaneously detect tuberculosis and rifampicin resistance in people with tuberculosis symptoms. Rifampicin is an important antituberculosis drug. Not recognizing tuberculosis when it is present (false negative) may result in severe illness and death, and an increased risk of infecting others. An incorrect diagnosis of tuberculosis (false positive) may result in anxiety, additional testing, unnecessary treatment, and medication side effects.

What is the aim of this review?

To determine how accurate Xpert Ultra is compared with Xpert MTB/RIF for diagnosing pulmonary tuberculosis and rifampicin resistance in adults. An extensive review of Xpert MTB/RIF accuracy was recently published as a Cochrane Review.

What was studied in this review?

We compared the diagnostic accuracy of Xpert Ultra and Xpert MTB/RIF with results primarily measured against culture (detection of pulmonary tuberculosis) and drug susceptibility testing and line probe assays (detection of rifampicin resistance).

What are the main results of this review?

Nine studies (3500 participants) compared Xpert Ultra to Xpert MTB/RIF for diagnosing pulmonary tuberculosis, and five studies (930 participants) compared Xpert Ultra to Xpert MTB/RIF for rifampicin resistance.

How confident are we in the results of this review?

Confident. The review included sufficient studies and participants and used optimum reference standards. In the comparison between Xpert Ultra and Xpert MTB/RIF, most studies were at low risk of bias.

Who do the results of this review apply to?

People considered to have pulmonary tuberculosis.

What are the implications of this review?

The results of these studies indicate that, in theory, for a population of 1000 people where 100 of those presenting with symptoms have pulmonary tuberculosis, Xpert Ultra will miss 9 cases, and Xpert MTB/RIF will miss 15 cases. The number of people wrongly diagnosed with pulmonary tuberculosis would be 40 with Xpert Ultra, and 14 with Xpert MTB/RIF.

The results of these studies indicate that, in theory, for a population of 1000 people where 100 of those have rifampicin resistance, Xpert Ultra will miss 5 cases, and Xpert MTB/RIF will miss 5 cases. The number of people wrongly diagnosed with rifampicin resistance would be 8 with Xpert Ultra, and 11 with Xpert MTB/RIF.

How up-to-date is this review?

28 January 2020.

Reference:

Zifodya JS, Kreniske JS, Schiller I, Kohli M, Dendukuri N, Schumacher SG, Ochodo EA, Haraka F, Zwerling AA, Pai M, Steingart KR, Horne DJ. Xpert Ultra versus Xpert MTB/RIF for pulmonary tuberculosis and rifampicin resistance in adults with presumptive pulmonary tuberculosis. Cochrane Database of Systematic Reviews 2021, Issue 2. Art. No.: CD009593. DOI: 10.1002/14651858.CD009593.pub5. Accessed 28 May 2025.

Methodology Tips

AVOIDING BIAS IN STUDY SELECTION

Selecting studies for a systematic review is an important step in conducting systematic reviews, but if done poorly, it can introduce bias, skew results, and downplay the certainty of findings. Here's are some tips on how to avoid bias in selection:

1. Define Clear Inclusion/Exclusion Criteria Early

- Before screening, establish specific, objective inclusion and exclusion criteria (study design, population, outcomes, etc.).
- Document these in a protocol which is prospectively registered (e.g., on PROSPERO) to avoid post-hoc adjustments that favor certain findings.

2. Use Multiple Independent Screeners

- Have at least two reviewers *independently* screen titles/abstracts and full texts.
- Resolve disagreements with a third reviewer or through consensus discussion.

3. Mask Study Details That Could Influence Selection

- If feasible, blind reviewers to authors, journals, and institutions during initial screening to prevent prestige bias.
- Tools like Rayyan can automate this for large datasets.

4. Avoid Cherry-Picking "Favorable" Studies

- Don't exclude studies just because their results contradict your hypothesis.
- If excluding a study, justify it transparently (e.g., "wrong participants/population").

5. Search Broadly to Minimize Publication Bias

- Look beyond major databases (PubMed, Embase) to include gray literature (preprints, conference abstracts, trial registries).
- Contact experts to identify unpublished or ongoing studies.

6. Document Every Decision

- Keep a log of excluded studies with reasons (PRISMA flow diagrams help).
- This ensures reproducibility and accountability.

Final Tip: Pilot-test your screening process with a small batch of studies to refine criteria *before starting the screening.*

Want a deeper dive? Cochrane's Handbook Chapter 4 covers study selection best practices in detail.

REFERENCE:

Higgins JPT, Thomas J, Chandler J, Cumpston M, Li T, Page MJ, Welch VA (editors). *Cochrane Handbook for Systematic Reviews of Interventions* version 6.5 (updated August 2024). Cochrane, 2024. Available from www.cochrane.org/handbook.

RECENT EVENTS

Introduction to Cochrane Systematic Reviews Workshop in Ondo State

Group photograph of participants with the facilitators Prof. Babasola Okusanya, Prof Olabisi Oduwole, Prof Segun Bello

The Southwest hub of Cochrane Nigeria held a workshop on Introduction to Systematic Reviews from 25th- 27th March 2025 at Achievers University, Owo, Ondo State. The participants were a mix of physicians, medical laboratory scientists, pharmacists, nurses and other professionals from non-governmental organizations. They came from different locations across Nigeria including, Abuja, Delta, Ondo and Oyo States.

The aim of the workshop was to introduce participants to basic concepts for conducting systematic reviews of the effectiveness of interventions and to take them through the rudiments of developing and registering a systematic review protocol. This was achieved through a blend of didactic sessions, hands-on and group work. Topics that were covered included formulating a focused/ answerable research question, developing and running a search strategy, data extraction and risk of bias assessment among others.

By the end of the 3-day workshop, there was an improvement in the overall knowledge of Cochrane systematic reviews of the participants, as shown by their pre and post workshop scores.

In order to ensure that the newly acquired knowledge and skills are promptly put to use, the facilitators advised the participants to form review teams, identify systematic review topics relevant and

Prof. Oduwole facilitating a session

Group discussion during a hands-on session

Prof. Bello facilitating a session

Prof. Okusanya attending to some participants related to their specialty and engage with the facilitators. They were also encouraged to contact Cochrane Nigeria for methodological support as necessary and to get involved with Cochrane through other channels such as Cochrane crowd, task exchange, and the Cochrane Patient and Public Network.

There is need to acknowledge and commend the Vice Chancellor of Achievers University who provided support for some participants to attend the workshop.

For future training opportunities:

Contact:
080 5607 1976 | 080 3580 2349 | 080 3973 3998

Email:
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GELA ANNUAL MEETING

GELA (Global Evidence Local Adaptation) is a three-year European and Developing Countries Clinical Trials Partnership (EDCTP) funded project to enhance evidence-informed guideline recommendations for newborn and young child health in Malawi, Nigeria, and South Africa. The aim of the project is to maximise the impact of evidence for poverty-related diseases by increasing the capacity of decision makers and researchers to use global research to develop locally relevant guidelines for newborn and child health. The research teams and management of the various GELA Country partners recently held their annual meeting at the Lagoon Beach Hotel in Cape Town, South Africa from 24-28 February 2025. The aim of the meeting was to review progress on project deliverables, workshops/ working sessions on the various work packages, End-of Project planning and brainstorming on next steps after the project.

The meeting was very useful in tracking progress and wrapping up various work packages to ensure a successful close out of the project in July 2025. Planning for how to disseminate the processes and guidelines produced by GELA were also discussed. It was not all work however, there was time for networking between various country teams, sightseeing and other fun activities.

The European and Developing Countries Clinical Trials Partnership (EDCTP) is a public-public partnership between countries in Europe and sub-Saharan Africa, supported by the European Union. EDCTP focuses on enhancing research capacity and accelerating the development of new or improved medical interventions for the identification, treatment and prevention of poverty-related infectious diseases, including emerging and re-emerging diseases in sub-Saharan Africa, through all phases of clinical trials, with emphasis on phase II and III trials.

This project is part of the EDCTP2 programme supported by the European Union (grant number RIA2020S-3303-GELA).

More pictures from the GELA Annual Meeting in South Africa

LEARNING & RESOURCES - THE COCHRANE HANDBOOK OF SYSTEMATIC REVIEWS

Systematic reviews (a vital part of evidence-based healthcare) synthesize data from primary research to inform clinical practice and policy. One of the most trusted resources for conducting high-quality systematic reviews is *The Cochrane Handbook for Systematic Reviews of Interventions*.

Developed by Cochrane, a global leader in evidence-based healthcare research, this *Handbook* provides comprehensive guidance on planning, conducting, and reporting systematic reviews of healthcare interventions. It is an essential reference for researchers, clinicians, and policymakers committed to rigorous evidence synthesis.

The Cochrane handbook features guidance on:

- **Methodological Rigour**: Detailed instructions on formulating research questions, literature searching, risk-of-bias assessment, and statistical analysis.
- **Transparent Reporting**: Guidance for adhering to PRISMA (Preferred Reporting Items for Systematic Reviews and Meta-Analyses) standards.
- **Practical Tools:** Includes templates, checklists, and examples to assist with the review process.
- **Continuous Updates:** Regularly revised to reflect the latest advancements in systematic review methodology.

Whether you are new to systematic reviews or an experienced review author, the *Cochrane Handbook for Systematic Reviews of Interventions* ensures your work meets the highest standards of reliability and reproducibility. By following its guidance, you contribute to trustworthy evidence that can improve patient care worldwide.

Accessing the Handbook

The *Cochrane Handbook* for Systematic Reviews of Interventions is freely available online: https://training.cochrane.org/handbook

Stay tuned for more learning resources in our next edition!

WORDPLAY

- **Why did the researcher break up with their narrative review?**
  → *Because they wanted something more systematic!*
- **Why do systematic reviews never get lost?**
  → *Because they always follow a PRISMA flowchart!*
- **Why are systematic reviews like detectives?**
  → *They collect all the evidence before concluding.*
- **Why did the systematic review go to therapy?**
  → *It had too many biases to resolve alone.*
- **How do systematic reviewers like their coffee?**
  → *Filtered — just like their studies.*
- **Why did the systematic reviewer get a promotion?**
  → *Because they know how to handle meta-problems!*
- **Why did the systematic review reject the new study?**
  → *It didn't meet the inclusion criteria!*
- **What did one systematic review say to the other?**
  → *"Together, we're the gold standard!"*
- **Why did the reviewer wear glasses?**
  → *To improve their critical appraisal!*
- **Why did the systematic review file a police report?**
  → *Because data was missing!*
- **Why was the systematic review bad at speed dating?**
  → *It takes forever to screen potential matches!*

ANNOUNCEMENTS

Upcoming workshops, webinars, symposiums

- Certificated Online Systematic Reviews Advanced Author Training Course - October 2025: Cochrane Nigeria is organizing a 4-week Advanced Author Training course on Systematic Reviews from 7th - 30th October 2025. For full details of the course and how to register, please visit: http://bit.ly/4n0TuqO

- New Cochrane Website: The Cochrane Collaboration website has been redesigned and is wearing a new look. Visit https://www.cochrane.org

Get Social with Cochrane Nigeria!

Join Cochrane Nigeria as we work to put trusted evidence at the centre of health decision-making across Nigeria and beyond. We are committed to producing high-quality systematic reviews and ensuring that our evidence is accessible to support informed health choices. Follow us on social media to stay updated on our work, connect with our community, and access the latest health evidence.

Follow Cochrane Nigeria on Your Favourite Platforms:

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- **Facebook** - Cochrane Nigeria
- **LinkedIn** - Cochrane Nigeria

Stay connected and be part of the movement to make evidence-based health care information accessible to everyone. Share, tag us, and help spread reliable evidence to inform health care decisions!