Reviewer's report

Title: Using GRADE methodology for the development of public health guidelines.

Version: 1 Date: 16 February 2012

Reviewer: Andy Oxman

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I have made a number of comments that are reflections. Responses to these comments are all discretionary and do not necessarily require revisions. I don’t have any comments that warrant major compulsory revisions.

Discretionary Revisions


2. In the background or under the first challenge (‘The nature of public health interventions’) you might want to address the following:

   • How you have defined ‘public health interventions’ – several of the recommendations are clinical recommendations (that require implementation by individual clinicians in encounters with individual patients) and the distinction between those and ‘biomedical interventions’ (which might be equated with clinical interventions) is not clear.

   • The contrasts that are made between public health and clinical guidelines may paint a picture that seems more black and white than my perception; i.e. many clinical interventions (including drugs) are heterogeneous (e.g. different doses, drugs within the same class, co-interventions), complex (e.g. all drugs have multiple effects), and have long causal pathways (e.g. the biochemical pathway between swallowing a drug and ultimate changes in health outcomes that are important to people).

   • I might argue that the key differences between public health and clinical guidelines are that public health interventions are targeted at populations rather than individuals and decisions about what to do are made (e.g. by policymakers or public health professionals) on behalf of a population rather than by individuals or in clinical encounters.

   • An important implication of recommendations being targeted at policymakers rather than individuals is that recommendations are being made globally (for
different countries) or nationally (for different sub-national jurisdictions). This presents a challenge in that importance of the problem (and consequently the size of the effects), values, availability of resources, costs and cost-effectiveness often vary substantially. This challenge, which I would ascribe to the nature of making global (international) recommendations (whether for public health or clinical interventions) is ascribed to the nature of public health interventions (which is partly correct, but may confuse the challenge of making (any type of) global guidelines with challenges that are specific for public health guidelines.

3. P8 last para: “Many panelists at the guidelines consensus meeting were uncomfortable with relatively low rating of the quality of evidence.” – (panellists is missing an l.) Were the panel members concerned because they felt intuitively that they were more confident in the estimated effects than what was suggested using the GRADE approach (and if so, what made them more confident that was not captured by the GRADE approach?) or were they concerned because they felt that policymakers would not act if they were told there is uncertainty (or was it for other reasons, such as those listed in the reference suggested above)? My impression is that public health professionals are mostly worried about the impact of saying there is substantial uncertainty (low quality evidence) on policymakers and that this is because they are viewing this as advocates (wanting policymakers to take actions) rather than as scientists (wanting to inform decisions that policymakers must make without introducing their own values). I am not aware of any compelling evidence about how policymakers, in fact, react to being told that there is low quality evidence, but my impression is that many, if not most, policymakers are used to making decisions when there is a lot of uncertainty and that they might not share the concern about acknowledging that there often is low quality evidence for public health decisions.


6. P12 para 2-3: The last paragraph of the section on outcomes addresses indirect (surrogate) outcomes and the next heading is ‘Indirectness of the evidence’. This might be confusing to readers.

7. P13 para 1: You might want to refer to guides for making judgements about applicability (and possibly note whether these were used), including the Users’ Guides by Tony Dans and colleagues and an adaptation for health system interventions (which, like public health interventions, are targeted at populations rather than individuals): Lavis JN, Oxman AD, Souza NM, Lewin S, Gruen RL, Fretheim A. SUPPORT Tools for evidence-informed health Policymaking (STP). 9. Assessing the applicability of the findings of a systematic review. Health Res
8. P13 para 2: Implicitly, you appear to have taken the perspective of men who have sex with men and transgender people. You might want to make this explicit. This would be particularly important in countries where, for example, the Catholic Church is prominent and public values reflect this. You might also want to describe in this section how the panel took into consideration countries where the dominant values would be in conflict with the values used by the panel.

9. P14 para 1: You might want to note that the availability of resources and costs are likely to vary substantially across LMIC. This presents a particular challenge for all global (not just public health) recommendations. In addition, in the context of recommendations that are targeted at policymakers (rather than individuals), resource use (costs) is almost always a critical consideration that can affect not only the strength of a recommendation but the direction of a recommendation.

10. P16 para 2: This paragraph was a bit confusing. It might help to change ‘i.e.’ to ‘e.g.’ in the second sentence “(i.e. low or very low quality evidence), to insert a sentence after that saying that conditional recommendations can have four possible implications (or combinations of these), and numbering the first two (1. Signalling the importance of considering local values, 2. Signalling the importance of considering the prevalence or incidence of the condition in their setting). Did the panel indicate which of these considerations were important each time they made a conditional recommendation? It seems to me that would be helpful and it would be helpful to give examples of different conditional recommendations where different considerations were important.

11. P17: I don’t understand the logic behind the last challenge (recommendations for implementation). How are recommendations about implementation strategies different from recommendations about public (population) health recommendations? It is important for both to be clear about the intervention and to consider contextual factors and both are likely to be conditional recommendations.

12. P19 para 1: I don’t understand the message in this paragraph or what the common misunderstanding is. It seems to suggest that it is OK to develop guidelines without systematic reviews, appropriate consensus processes and appropriate management of conflicts of interest (i.e. that GRADE can be used “successfully” without those things). Although the GRADE approach to making judgements about quality of evidence and strength of recommendations can be used without those things, I would think there is a higher risk of it not being successful (i.e. poorly informed or inappropriate judgements being made) if a panel does not have a systematic review, does not use an appropriate consensus process or does not manage competing interests appropriately.

Minor Essential Revisions

13. MSM should be spelled out in the abstract.

14. There are several typos that should be corrected.
Major Compulsory Revisions
None.

Level of interest: An article of importance in its field

Quality of written English: Acceptable

Statistical review: No, the manuscript does not need to be seen by a statistician.

Declaration of competing interests:

I am a member of the GRADE Working Group and have collaborated with some of the authors.