**The barriers and facilitators experienced by patients, carers and healthcare professionals when managing symptoms in infants, children and young people at end-of-life: a mixed methods systematic review protocol**

Dr Katie Greenfield1

Dr Simone Holley1

Dr Daniel Eric Schoth1

Dr Emily Harrop2

Dr Richard Howard3

Ms Julie Bayliss4

Dr Lynda Brook5

Dr Sat Jassal6

Ms Margaret Johnson7

Professor Ian Wong8

\*Professor Christina Liossi1,3

1 School of Psychology, University of Southampton, United Kingdom, Highfield, SO17 1BJ, UK

2 Helen & Douglas House Hospices, 14A Magdalen Road, Oxford, Oxfordshire, OX4 1RW, UK

3Great Ormond Street Hospital for Children NHS Foundation Trust, Department of Anaesthesia and Pain Medicine Level 4, Old Building, London WC1N 3JH, UK

4Great Ormond Street Hospital for Children NHS Foundation Trust, The Louis Dundas Centre, Great Ormond Street London WC1N 3JH, UK

5Alder Hey Children's Hospital, Eaton Road, Liverpool, L12 2AP, UK

6Rainbows Hospice, Lark Rise, Loughborough LE11 2HS, UK

7Patient & Public Representative

8UCL School of Pharmacy, BMA House, Tavistock Square, London WC1H 9JP

\* Corresponding author:

cliossi@soton.ac.uk.

0044 (0)238059 4645

School of Psychology, University of Southampton, United Kingdom, Highfield, SO17 1BJ

Word count: 3483

## ABSTRACT

**Introduction.** This protocol describes the objective and methods of a systematic review of barriers and facilitators experienced by patients, carers and healthcare professionals when managing symptoms in infants, children and young people (ICYP) at end-of-life.

**Methods and analysis.** The Cochrane Library, PROSPERO, CINAHL, MEDLINE, PsycINFO, Web of Science Core Collection, ProQuest Dissertations & Theses Database, Evidence Search and OpenGrey will be electronically searched. Reference screening of relevant reviews and inquiries to researchers in the field will be undertaken. Studies will be selected if they apply qualitative, quantitative or mixed-methods designs to explore barriers and facilitators experienced by patients, carers and healthcare professionals when managing symptoms in ICYP at end-of-life.

Articles will be screened by title and abstract by one reviewer with a second reviewer assessing 10% of the articles. Both reviewers will read and screen all remaining potentially relevant articles. For included articles, one reviewer will extract study characteristics and one will check this.

Both reviewers will undertake independent quality assessments of included studies using established and appropriate checklists including The Critical Appraisal Skills Programme Qualitative Checklist; The evaluative criteria of credibility, transferability, dependability and confirmability; The Quality Assessment Tool for Quantitative Studies, and The Mixed Methods Appraisal Tool. Data synthesis methods will be decided after data extraction and assessment.

**Ethics and dissemination.** This review will inform our understanding of symptom management in ICYP at end-of-life. The findings will be reported in a peer-reviewed journal and presented at conferences. The study raises no ethical issues.

**Trial registration number** CRD42019124797.

## ARTICLE SUMMARY

## Strengths and Limitations Of This Study

## This systematic review can give us a greater understanding of symptom management in paediatric palliative care - highlighted as a research priority by the National Institute for Health and Care Excellence (NICE) and could inform the design of evidence-based interventions to support more effective medicine management

## The systematic review will follow robust guidelines and the quality of included articles will be assessed using validated tools

## The heterogeneity of the included studies, which may use qualitative, quantitative or mixed-methods approaches, could limit the overall data synthesis

## KEYWORDS

Paediatric Palliative Care

Pain Management

Qualitative Research

Symptom management

End of life care

## INTRODUCTION

Approximately 49,000 infants, children and young people (ICYP) are living with a life-threatening or life-limiting condition in the UK 1. These include congenital anomalies; cancer; and neurological, haematological, respiratory, genitourinary, perinatal, metabolic, circulatory and gastrointestinal conditions. There were nearly 3000 child deaths due to medical conditions in England in 2017, of which over 2350 were due to a known life-limiting condition or neonatal death 2.

ICYP’s palliative care needs often differ to those of adults, and the diversity of conditions in this population means that practitioners must manage a wide range of complex symptoms 3. A particular challenge is managing continuous ‘background’ pain as well as bouts of severe, sudden-onset ‘breakthrough pain’, both of which are common in ICYP with a terminal illness 4 and are known to be under-assessed and undertreated 5.

Family carers play a vital role in supporting ICYP with a terminal illness, allowing patients to be cared for and die at home where possible. However, there is little research on carers’ experiences of administering medicines for symptom relief to ICYP receiving palliative care. Managing symptoms such as pain is potentially difficult for carers of children at home. They may lack the necessary skills and confidence required to balance symptom relief and side-effects while fear of errors can lead to insufficient or inappropriate doses of analgesics. Families will move ICYP away from their preferred place of care if symptoms, including pain, are not managed effectively 6.

Community nurses and doctors may also lack the skills and experience required to support carers. A systematic review found that GPs experience anxiety regarding their competency to deliver appropriate palliative care 7 while healthcare support workers providing end-of-life care in the community require training in palliative care to cope with emotionally demanding situations 8.

The recent National Institute for Health and Care Excellence (NICE) guideline 9 is based on evidence from 20 systematic reviews investigating different aspects of planning and management of end-of-life care for ICYP with life-limiting conditions. These include reviews on what information is perceived as helpful and what social and practical support is effective for ICYP and their caregivers. The findings indicate that timely, honest and consistent information that meets individuals’ needs (e.g. developmentally appropriate for patients) is beneficial, including information about access to services, community and medical resources. One study also found that parents wanted information on how to use equipment that a child/ young person required 10. However, symptom management was not identified as a major theme in these reviews 9.

Four other reviews looked at the effectiveness of pharmacological and non-pharmacological interventions for pain management, agitation, respiratory distress and seizures 9. Only the pain management review found any studies that met the inclusion criteria and all of these involved pharmacological interventions only.

Although these reviews provide essential guidance in managing end-of-life care for ICYP, to our knowledge no systematic review has examined the barriers and facilitators to symptom management in ICYP at end-of-life for healthcare professionals, caregivers and patients. NICE highlights pain management in palliative care as a research priority 9 and a greater understanding of this could inform the design of evidence-based interventions to support more effective medicine management.

**Objectives**

The main objective of this systematic review is to identify and synthesise the existing literature that explores the barriers and facilitators experienced by children and young people themselves and their carers and healthcare professionals when managing symptoms in ICYP at end-of-life.

## METHODS

This protocol follows the Preferred Reporting Items for Systematic Review and Meta-Analysis Protocols (PRISMA-P) 11 guidelines (online Supplementary File 1—PRISMA-P checklist) and is registered (ID CRD42019124797)12 on PROSPERO, an international register of systematic reviews 13. Any changes to the protocol will be recorded on PROSPERO.

The reporting of the systematic review will be informed by the Centre for Reviews and Dissemination 14 and the Cochrane Qualitative Research Methods Group guidelines 15 and will follow the Enhancing Transparency in Reporting the Synthesis of Qualitative Research (ENTREQ) 16 and the PRISMA statements 11 for reporting systematic reviews (see online Supplementary File 2). In the case of sections applicable to qualitative systematic reviews that are included in PRISMA, but are not covered by ENTREQ, these will also be reported.

**Eligibility Criteria**

The criteria outlined below will be used for study selection. Following the recommendations of the Cochrane Qualitative and Implementation Methods Group Guidance 15, we have used STARLITE (Sampling Strategy, Type of study, Approaches, Range of years, Limits, Inclusions and exclusions, Terms used, Electronic sources 17) to report our search methods.

*Sampling strategy:* This review will consider all studies carried out worldwide that involve carers, healthcare professionals or patients’ views on symptom management in ICYP up to the age of 24 years at end-of-life care. A cut-off age of 24 years will be used since this corresponds to adolescent growth and current understandings of this stage in life 18.

*Type of study:* The review will consider qualitative, quantitative and mixed-method studies including questionnaires, surveys, interviews, focus groups, case studies, and observations. Trials, cohort and intervention studies that assess barriers and facilitators to symptom management will all be considered.

*Approaches:* In addition to searching electronic databases, the search strategy will include hand searching of reference lists of identified eligible studies. Finally, active researchers in the field who have contributed to this literature will be contacted.

*Range of Years:* Studies published from the inception of each database will be included.

*Limits:* Articles written in any language other than English due to a lack of funding for adequate translation; masters theses; conference abstracts; reviews.

*Inclusions:* Barriers and facilitators experienced by carers, healthcare professionals, and the patients themselves, when managing symptoms in ICYP with terminal illnesses receiving palliative care and/or at end-of-life. All definitions of ‘end-of-life’ will be included since there are a wide variety of definitions and there is a paucity of research in ICYP symptom management in this area. Data on carers; healthcare professionals; and patients’ views, attitudes, opinions, perceptions, beliefs or feelings will be included.

*Exclusions:* Studies that focus only on the effectiveness of pharmacological treatments for symptom management will be excluded.

**Searches**

*Electronic sources:* The Cochrane Library and PROSPERO will be searched initially to check for any existing systematic reviews on this topic. As recommended by the Cochrane Qualitative and Implementation Methods Group 15, CINAHL (Cumulative Index of Nursing and Allied Health Literature) via Ebsco and Ovid MEDLINE will be searched, as well as PsycINFO via Ebsco and the Web of Science Core Collection. To identify any additional unpublished work, the ProQuest Dissertations & Theses Database; Evidence Search; and OpenGrey will also be searched. The search strategy will include hand searching of reference lists of eligible studies for additional records. All searches will be run during February 2019.

*Search terms used:*A search strategy was developed based on the ‘Managing Pain’ search strategy used in the NICE guideline 'End-of-life Care for Infants, Children and Young people with Life-limiting Conditions: Planning and Management (NG61) 9. The strategy incorporated search terms in four blocks: 1. ‘Patient Population’; 2. ‘Caregivers and Patients’; 3. ‘End-of-life’; and 4. ‘Pain and Symptoms.’ Additional searches used in the Palliative Care Search Filter 19 were also incorporated into Block 3 for each database.

Combinations of keywords, text words, Medical Subject Headings (MeSH) and other terms relevant to the four blocks were selected for each database to optimise the search sensitivity and specificity. The search strategy was piloted and adapted for each database. A professional healthcare research librarian assisted in the development of the strategy. Please see Supplementary File 3 for the full search strategy for each database.

**Data Management**

All records and data will be saved to Endnote X8 20. This software will be used to identify potential duplicates. The researchers will check this and remove all confirmed duplicated.

**Selection Process**

Articles will be screened by title and abstract by one reviewer (KG) with a second reviewer (SH) assessing 10% of the articles, randomly selected. At this stage, articles will be judged as either a) ‘not relevant’ or b) ‘potentially relevant’. Both reviewers will read and screen all remaining potentially relevant articles. The reviewers will independently apply the criteria at all stages of the selection process. Inter-coder agreement will be evaluated using Cohen’s kappa coefficient. A minimum kappa value of 0.75 will be taken to represent high agreement 21.

The full text of all remaining potentially relevant articles will then be obtained. If the relevance of a study cannot be ascertained from the abstract, then the full article will be obtained. The full articles will be read by two reviewers independently (KG and SH) to make the final decision about whether they should be chosen for inclusion in the review. A third reviewer (CL) will resolve any uncertainties. Additional information will be sought from authors if necessary at the stage of full-text assessment.

**Data Collection Process and Items**

The following information will be extracted into a piloted data collection form for all included studies: Study aims; patient population (infant/child/adolescent); participant population (patient/caregiver/healthcare professional); inclusion and exclusion criteria; sample size; recruitment; design; intervention and comparator group (where applicable); date and duration of data collection; setting; country; data collection; analysis methods; data describing the participants’ views/experiences of barriers and facilitators to symptom management. For qualitative data, the authors’ interpretations (presented through themes and categories) will represent these data 22*.* KG will extract this information and SH will check it, with any disagreements resolved through discussion with CL.

**Quality assessment (including risk of bias)**

A quality appraisal of included studies will be conducted independently by two reviewers (KG and SH). Disagreements will be resolved by discussion between KG and SH, with CL if required.

Three checklists will be used depending on each study’s design. These were chosen since they are all validated and have been used in published systematic reviews within healthcare research. For each study type, Cohen’s kappa coefficient will be used to measure inter-rater agreement between the two reviewers. A minimum kappa value of 0.75 will be taken to represent high agreement with disagreements resolved via discussion with CL.

As recommended by the Cochrane Qualitative and Implementation Methods Group 15, we will not calculate total quality scores across domains since domains of quality are not equal. Instead, KG, SH and CL will determine how each study’s methodological limitations affect confidence in the findings via discussion. We will not exclude studies based on poor quality but will record and highlight methodological issues.

Qualitative studies will be quality appraised using the *Critical Appraisal Skills Programme for Qualitative Studies (CASP)* 23. The CASP assesses clarity of research aims; research design; recruitment methods; data collection; relationships between participants and researchers; ethical issues, analyses; description of findings; and valuableness of the research. It is comprised of nine closed questions (e.g. “Was there a clear statement of the aims of the research?” Yes/Can’t tell/No) and one open-ended question (“How valuable is the research?”). For each question, there is the option to add comments to explain the reasoning for each rating. Currently, the CASP is the most frequently used qualitative research synthesis tool in the Cochrane Library and World Health Organisation guideline research 24 and has been used in similar systematic reviews assessing barriers and facilitators within healthcare e.g.25 26. However, because the CASP tool does not address aspects of the research validity and can favour papers that are less insightful as long as they comply with ‘expectations of research practice’ 27, in addition, the evaluative criteria of credibility, transferability, dependability and confirmability 28 will be applied.Included studies will be assessed as to whether they apply the techniques suggested for ensuring study quality according to Guba and Lincoln’s 28 criteria i.e. prolonged engagement, persistent observation, peer review, triangulation, negative case analysis, referential adequacy and member checking to ensure credibility; thick description for transferability; inquiry audit for dependability; confirmability audit, audit trail, triangulation and reflexivity to ensure confirmability. Studies will be rated as ‘high quality’ if they meet at least three of the four criteria, ‘medium quality’ if they meet two of the criteria and ‘low quality’ if they meet one or none.

*The Quality Assessment Tool for Quantitative Studies (QATQS)* will be used to assess all clinical studies with or without randomisation and control groups, including quasi-experimental and before-and-after studies 29. The QATQS is comprised of 22 closed questions and an overall rating of strong, moderate or weak in eight sections: selection bias; study design; confounders; blinding; data collection; withdrawals and dropouts; intervention integrity; analysis. It has been shown to be a valid tool for assessing quality; comparing studies and addressing threats to validity of findings 30.

*The Mixed Methods Appraisal Tool (MMAT-Version 11)* will be used to assess the quality of any mixed methods studies 31. This tool consists of five closed questions assessing the research question; research design; integration of qualitative and quantitative methods; integration of qualitative and quantitative data; and consideration of methodological limitations in mixed methods studies. As reported by the Cochrane Qualitative and Implementation Methods Group, this tool has been used widely in systematic reviews and has the advantage of being able to assess interdependent qualitative and quantitative elements of mixed-methods research 24.

**Outcomes and Prioritisation**

The main outcomes sought are carers’; healthcare professionals’; and patients’ (CYP) views on the barriers and facilitators to effective symptom management in ICYP at end-of-life.

**Data Synthesis**

Although it is unlikely that the majority of included studies will be quantitative, if this is the case then random-effects meta-analysis will be conducted to synthesise group means and standard deviation from individual studies using Comprehensive Meta-Analysis (CMA) version 3 32.

For meta-analysis to be conducted, data must be available from two or more eligible studies reporting similar barriers or facilitators. The studies must report the number of participants reporting that barrier/facilitator and the total number of valid participant responses for that survey item. A random-effects model will be used for all analyses since, unlike a fixed-effects model, this can be used when statistical heterogeneity (I2) is present in the results of the included studies 33. Where evidence of statistically significant heterogeneity is present, sensitivity analyses will be conducted where possible to verify the robustness of the study conclusions, assessing the impact of methodological quality, study design, sample size and the potential effects of missing data. We will use funnel plots to detect potential reporting biases and small-study effects where data is available from 10 or more studies 34.

If the included studies are all qualitative or a combination of quantitative and qualitative, there are several approaches that could be taken for data synthesis. Some of the most commonly used methods to synthesise qualitative health research include thematic analysis 35; grounded theory 36 and meta-ethnography 37 38. However, there is no consensus on the best approach, which will depend on the type and number of included studies 39 and the form and nature of the research question 38. As such, we will make a final decision on the most appropriate method after selecting and quality assessing the included articles, as recommended by the Cochrane Qualitative and Implementation Methods Group 39.

We will first analyse and synthesise data related to the experience of patients, care providers and healthcare professionals separately before deciding whether it is appropriate to aggregate data between these groups. These data will likely include themes, concepts and categories of information. If data are relatively ‘thin’ then we will consider using thematic synthesis to undertake line-by-line coding and development of descriptive and analytic themes. If the included articles include sufficient ‘thick’ data (e.g. details about the context and background of the studies and participants 40), we will consider a more interpretative approach such as meta-ethnography 37. This method goes beyond aggregating data to generate new interpretations of the findings.

As recommended by the Cochrane Qualitative and Implementation Methods Group 24 the GRADE‐CERQual (Confidence in the Evidence from Reviews of Qualitative research 41) will be used to summarise our confidence in synthesised qualitative findings (e.g. in the themes that we identify). The CERQual is made up of four key components i.e., methodological limitations of included studies, coherence of the review finding; adequacy of the data contributing to a review finding; relevance of the included studies to the review question. After assessing each of the four components, overall confidence will be graded as high, moderate, low, or very low. The barriers and facilitators to symptom management will be divided into overarching themes for each group (patients; healthcare professionals; carers); and presented in a matrix along with our CERQual assessment of confidence in the evidence of each theme and an explanation of this assessment.

The GRADE guidelines 42 will be used to appraise the quality of any quantitative findings. The GRADE guidelines include four elements for which quantitative findings will be rated against: risk of bias (‘Study limitations’), inconsistency, indirectness, imprecision, publication bias.

**Patient and public involvement**

Consultation with young people, parents and health care professionals has been used to determine their perception of the barriers and facilitators they experience when managing symptoms in ICYP at end-of-life. It is based on their perspectives that this systematic review was deemed to be timely and crucial to conduct to inform further research work. Moreover, patient and public involvement (PPI) is represented in the authorship (MJ) of this manuscript. MJ is the PPI representative at the UK National Institute for Health Research (NIHR) Pain and Palliative Care Clinical Studies Group-Children. MJ is a parent of four children, one of whom died from T-cell acute lymphoblastic leukaemia at the age of 12. She has supported many families of children with cancer including those receiving palliative and end-of-life care.

**DISCUSSION**

This systematic review will be the first to synthesise and report barriers and facilitators experienced by patients, carers and healthcare professionals when managing symptoms in ICYP at end-of-life**.** The dearth and heterogeneity of the included studies, which may use qualitative, quantitative or mixed-methods approaches, could limit the overall data synthesis we are able to conduct. As we expect there to be a lack of suitable studies, they will not be excluded on the basis of quality, which may limit the confidence in our findings. The review findings will be used to inform our ongoing work to develop a structured educational tool to support carers and healthcare professionals to administer pain and symptom relief to ICYP at the end-of-life.

**Ethics and dissemination**

As this is a systematic review of published literature, ethical approval will not be sought. We will publish the protocol and our findings in peer-reviewed journals aimed at paediatric palliative care clinicians and researchers as well as health commissioners. We will present our work at the growing numbers of national and international meetings focused on paediatric palliative care and pain.

**Acknowledgements**

We would like to thank Dr Liz Jamiesonfor hercomments on an earlier version of this protocol.

**Author Contributions**

EH, RH, MJ, IW and CL conceived the idea, planned and designed the study protocol. KG, SH, DES planned the data extraction and statistical analysis and wrote the first draft; JB, LB and SJ provided critical insights. All authors have approved and contributed to the final written manuscript.

**Funding**

This study was supported by Great Ormond Street Children’s Charity and SPARKS (Grant number: V5118).

**Competing Interests**

None declared.

**REFERENCES**

1. Fraser LK, Miller M, Hain R, et al. Rising national prevalence of life-limiting conditions in children in England. *Pediatrics* 2012;129(4):e923-9. doi: 10.1542/peds.2011-2846 [published Online First: 2012/03/14]

2. Petrou S, Fraser J, Sidebotham P. Child death in high-income countries. *The Lancet* 2014;384(9946):831-33.

3. Himelstein BP, Hilden JM, Boldt AM, et al. Pediatric palliative care. *New England Journal of Medicine* 2004;350(17):1752-62.

4. Oostendorp LJ, Rajapakse D, Kelly P, et al. Documentation of breakthrough pain in narrative clinical records of children with life-limiting conditions: Feasibility of a retrospective review. *Journal of Child Health Care* 2018:1367493518807312.

5. Friedrichsdorf SJ, Postier A. Management of breakthrough pain in children with cancer. *Journal of Pain Research* 2014;7:117-23. doi: 10.2147/JPR.S58862 [published Online First: 2014/03/19]

6. Brombley K. Understanding the Factors that Influence Parents as they Plan and Manage their Child's End of Life Care Rome: Foundazione Maruzza; 2016 [Available from: http://www.childrenpalliativecarecongress.org/congress-2016/wp-content/uploads/2016/02/PROGRAMMA\_2016\_REV\_11\_bassa.pdf].

7. Mitchell GK. How well do general practitioners deliver palliative care? A systematic review. *Palliative Medicine* 2002;16(6):457-64. doi: 10.1191/0269216302pm573oa

8. Herber OR, Johnston BM. The role of healthcare support workers in providing palliative and end‐of‐life care in the community: a systematic literature review. *Health & Social Care in the Community* 2013;21(3):225-35.

9. National Institute for Health and Care Excellence. End of life care for infants, children and young people: planning and management (NICE Guideline NG61), 2016.

10. Hunt A, Coad J, West E, et al. Together for Short Lives, The Big Study for Life-limited Children and their Families – Final research report 2013 [Available from: http://clok.uclan.ac.uk/8951/2/TfSL\_The\_Big\_Study\_Final\_Research\_Report\_\_WEB\_.pdf].

11. Moher D, Liberati A, Tetzlaff J, et al. Preferred reporting items for systematic reviews and meta-analyses: the PRISMA statement. *Annals of Internal Medicine* 2009;151(4):264-69.

12. Greenfield K, Holley S, Schoth D, et al. Systematic review of the barriers and facilitators experienced by patients, carers and healthcare professionals when managing symptoms in infants, children and young people at end-of-life CRD42019124797: PROSPERO; 2019 [Available from: http://www.crd.york.ac.uk/PROSPERO/display\_record.php?ID=CRD42019124797].

13. Booth A, Clarke M, Dooley G, et al. The nuts and bolts of PROSPERO: an international prospective register of systematic reviews. *Systematic Reviews* 2012;1(1):2.

14. Undertaking systematic reviews of research on effectiveness: CRD's guidance for those carrying out or commissioning reviews. York: University of York: NHS Centre for Reviews and Dissemination 2001.

15. Harris JL, Booth A, Cargo M, et al. Cochrane Qualitative and Implementation Methods Group guidance series—paper 2: methods for question formulation, searching, and protocol development for qualitative evidence synthesis. *Journal of Clinical Epidemiology* 2018;97:39-48.

16. Tong A, Flemming K, McInnes E, et al. Enhancing transparency in reporting the synthesis of qualitative research: ENTREQ. *BMC Medical Research Methodology* 2012;12(1):181.

17. Booth A. "Brimful of STARLITE": toward standards for reporting literature searches. *Journal of the Medical Library Association* 2006;94(4):421-29.

18. Sawyer SM, Azzopardi PS, Wickremarathne D, et al. The age of adolescence. *The Lancet Child & Adolescent Health* 2018;2(3):223-28. doi: 10.1016/S2352-4642(18)30022-1 [published Online First: 2018/09/01]

19. Sladek R, Tieman J, Fazekas BS, et al. Development of a subject search filter to find information relevant to palliative care in the general medical literature. *Journal of the Medical Library Association* 2006;94(4):394.

20. Endnote X8 Referencing Software [program]. New York, NY, 2017.

21. Landis JR, Koch GG. The measurement of observer agreement for categorical data. *Biometrics* 1977:159-74.

22. Munabi‐Babigumira S, Glenton C, Lewin S, et al. Factors that influence the provision of intrapartum and postnatal care by skilled birth attendants in low‐ and middle‐income countries: a qualitative evidence synthesis. *Cochrane Database of Systematic Reviews* 2017(11) doi: 10.1002/14651858.CD011558.pub2

23. CASP. CASP Qualitative Checklist 2018 [Available from: https://casp-uk.net/wp-content/uploads/2018/03/CASP-Qualitative-Checklist-2018\_fillable\_form.pdf] accessed 18.01.2019 2019.

24. Noyes J, Booth A, Flemming K, et al. Cochrane Qualitative and Implementation Methods Group guidance series—paper 3: methods for assessing methodological limitations, data extraction and synthesis, and confidence in synthesized qualitative findings. *Journal of Clinical Epidemiology* 2018;97:49-58.

25. Panagiotopoulou N, Ghuman N, Sandher R, et al. Barriers and facilitators towards fertility preservation care for cancer patients: a meta-synthesis. *European Journal of Cancer Care* 2018;27(1) doi: 10.1111/ecc.12428 [published Online First: 2015/12/18]

26. Graham-Rowe E, Lorencatto F, Lawrenson JG, et al. Barriers and enablers to diabetic retinopathy screening attendance: Protocol for a systematic review. *Systematic Reviews* 2016;5(1):134.

27. Dixon-Woods M, Sutton A, Shaw R, et al. Appraising qualitative research for inclusion in systematic reviews: a quantitative and qualitative comparison of three methods. *Journal of Health Services Research & Policy* 2007;12(1):42-47.

28. Guba EG, Lincoln YS. Naturalistic inquiry: Newbury Park, CA: Sage, 1985.

29. Thomas H. Quality assessment tool for quantitative studies. Effective Public Health Practice Project. McMaster University, Toronto, 2012.

30. Armijo‐Olivo S, Stiles CR, Hagen NA, et al. Assessment of study quality for systematic reviews: a comparison of the Cochrane Collaboration Risk of Bias Tool and the Effective Public Health Practice Project Quality Assessment Tool: methodological research. *Journal of Evaluation in Clinical Practice* 2012;18(1):12-18.

31. Pluye P, Gagnon M-P, Griffiths F, et al. A scoring system for appraising mixed methods research, and concomitantly appraising qualitative, quantitative and mixed methods primary studies in mixed studies reviews. *International Journal of Nursing Studies* 2009;46(4):529-46.

32. Biostat: comprehensive meta-analysis (Version 3)[Computer software] [program], 2015.

33. Haidich A-B. Meta-analysis in medical research. *Hippokratia* 2010;14(Suppl 1):29.

34. Higgins JP, Green S. Cochrane handbook for systematic reviews of interventions: The Cochrane Collaboration; 2011 [Version 5.1.0 [updated March 2011]:[Available from: www.handbook.cochrane.org].

35. Thomas J, Harden A. Methods for the thematic synthesis of qualitative research in systematic reviews. *BMC Medical Research Methodology* 2008;8:45. doi: 10.1186/1471-2288-8-45 [published Online First: 2008/07/12]

36. Glaser BG, Strauss AL, Strutzel E. The discovery of grounded theory; strategies for qualitative research. *Nursing Research* 1968;17(4):364.

37. Noblit GW, Hare RD, Hare R. Meta-ethnography: Synthesizing qualitative studies: Sage 1988.

38. Dixon-Woods M, Agarwal S, Jones D, et al. Synthesising qualitative and quantitative evidence: a review of possible methods. *Journal of Health Services Research & Policy* 2005;10(1):45-53.

39. Booth A, Noyes J, Flemming K, et al. Guidance on choosing qualitative evidence synthesis methods for use in health technology assessments of complex interventions. Integrate-HTA2016.

40. Ponterotto JG. Brief note on the origins, evolution, and meaning of the qualitative research concept thick description. *The Qualitative Report* 2006;11(3):538-49.

41. Lewin S, Glenton C, Munthe-Kaas H, et al. 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 Medicine* 2015;12(10): e1001895.

42. Guyatt GH, Oxman AD, Schünemann HJ, et al. GRADE guidelines: a new series of articles in the Journal of Clinical Epidemiology. *Journal of Clinical Epidemiology* 2011;64(4):380-82.