

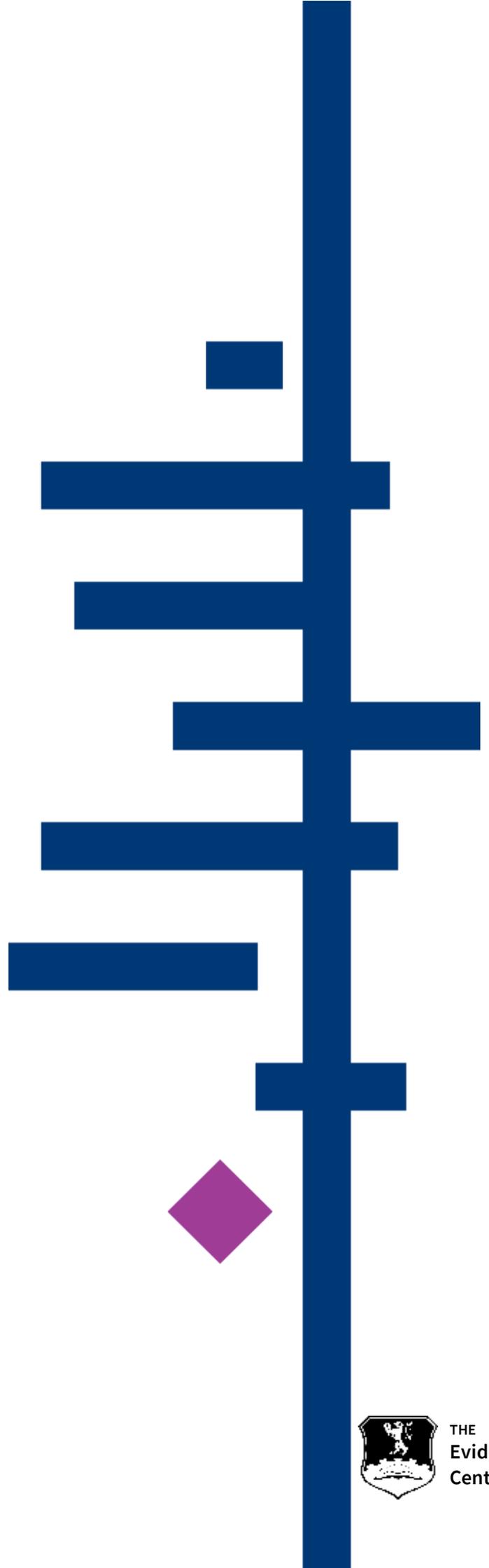
How could Cochrane be even more inclusive?

Feedback from over 1300 people

January 2022

Coproduced by members of the Cochrane community and an independent team

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Foreword

Diversity and inclusion are critically important for Cochrane's success as a global collaboration. The Governing Board is committed to taking action to address biases that exist within the organization to ensure that Cochrane is continuously working towards becoming more accessible, diverse, and inclusive.

We wanted to know the current views and experiences of community members to ensure that we are targeting our resources in the right way, so we commissioned a 'listening and learning' exercise that has been completed over the last six months. The following report summarizes what has been heard during this process and will be used to help us establish a strategy for increasing diversity and inclusivity in Cochrane.

The Governing Board would like to thank the Program Board that oversaw this work, the Community Advisory Group who provided valuable feedback throughout the process, and all of the members of the Cochrane Community who participated in the process.

This is only the first step in our diversity and inclusion program, but this report provides important findings that will help us set our future direction. It is important that we take time to consider what we have heard and then use this learning to take actions that help make Cochrane even more diverse and inclusive - as the organization has always aspired to be.

Cochrane Governing Board

11th April 2022

Key messages

What did we do?

Seeking feedback about diversity and inclusion in Cochrane

Cochrane is a worldwide organisation. We want to be diverse and inclusive, so that the Cochrane community continues to be made up of people with many varied characteristics (diversity) and so people feel welcome, listened to and able to participate in ways that they want (inclusion).

Over the past decade, Cochrane has undertaken many initiatives to keep building our diversity and inclusiveness. In 2022 we will create a Diversity and Inclusion Strategy to prioritise practical next steps. As part of this journey, we wanted to understand whether members of the Cochrane community felt as included as they wanted to be, what is getting in the way and their suggested priorities for strengthening inclusion in future.

In November/December 2021, we compiled readily available information about who is part of Cochrane and who is using Cochrane evidence. We also invited people using Cochrane evidence, volunteers and paid team members to share their experiences of diversity and inclusion in Cochrane.

Over 1300 people from around the world shared ideas during 36 online discussion groups, telephone conversations, by email and through an online survey. People were from a variety of countries, roles, age groups and genders. 2 out of 3 had a main language other than English.

Over 100 members of the Cochrane community helped to review the themes in people's feedback and coproduce this summary, facilitated by an independent team outside Cochrane.



What did we learn?

Diversity and inclusion is essential to Cochrane's mission

People referred to 'diversity' in Cochrane as meaning an organisation run by, with contributions from and benefitting people with a variety of demographic, language and geographic characteristics as well as different levels of experience and professional expertise. They also used 'diversity' to mean synthesising evidence about a wide variety of topics, using various methods and dissemination routes, mindful of different local needs.

Those taking part thought that diversity and inclusion should be fundamental to Cochrane. They thought that if Cochrane celebrates and strives for difference, we will benefit from new ideas and be better able to understand and respond to people's varied evidence needs. This will help us achieve our mission of supporting people to make evidence-informed decisions about health and healthcare, no matter where they are in the world. Being diverse and inclusive will ensure we provide evidence about topics and in formats that people want, so we stay relevant, worthwhile and sustainable.

How diverse is Cochrane?

It is difficult to get a clear picture of who is contributing to and benefitting from Cochrane because information has not been collected consistently. There are plans to improve this. In the meantime, we know that:

- Cochrane's Governing Board has some diverse characteristics, with 42% of Board members having a main language other than English, 17% based in low or middle income countries and 67% female or non-binary gender. Our Central Executive Team may be less diverse, with 2% based in low or middle income countries and 85% whose ethnicity is known describing themselves as 'White'.
- Only one of the Cochrane Groups leading on producing reviews is based in a low or middle income country.
- Over 110,000 people are registered with Cochrane accounts, meaning they are members of the Cochrane community. 12% of these are from low and middle income countries. We do not routinely collect people's gender, age or profession.
- People from countries around the world use Cochrane's websites and resources, including in many languages. 14% of visitors to the Cochrane Library website are from people in low and middle income countries, and half access the website in a language other than English.

Do people feel included?

People taking part defined 'inclusion' as the extent to which people felt welcome, engaged and able to be as involved as they wanted in Cochrane activities.

In a survey of 1194 people, including volunteers, paid staff, and people who are not actively involved in Cochrane:

- 7 out of 10 people thought that Cochrane was doing some things well to include a wide range of people. Most said more could be done.
- **4 out of 10 said they felt as included in Cochrane as they wanted.** 6 out of 10 wanted to be more included. These people were from all different countries, ages, genders and language groups.



It seems that once people are actively participating in Cochrane activities they feel more involved and welcome, but many people said they found it difficult to become part of the Cochrane community and get involved in the first place. In 36 discussion groups and the survey, people said that barriers to feeling included were:

- not knowing **how** to get involved
- not being **offered** opportunities
- not feeling confident to take part, perhaps due to limited **training** or experience
- the **geographic** location and perceived Anglocentric mindset of Cochrane activities
- not feeling **accepted** or valued, including due to experience, language, roles or lack of academic background



What did people recommend?

The things people commonly suggested that Cochrane could do next were:

1. Prioritising diversity and inclusion

- Recognising that diversity and inclusion is **essential** for Cochrane to achieve its mission and framing striving for further diversity and inclusion in a positive light, as a ‘must have’
- Acknowledging that Cochrane is not as diverse and inclusive as it could be and has work to do to address systemic **institutional biases** in Cochrane’s systems, processes and attitudes
- Establishing a workstream specific to developing diversity and inclusion in Cochrane as well as building diversity and inclusion into all workstreams, with **specific resources** allocated

2. Building capability and leadership in diversity and inclusion

- Providing diversity and inclusion **training** to all leaders and paid staff, including in Cochrane Groups, to help people understand systemic biases and practical strategies to aid inclusion
- Expanding the **diversity of senior leaders and paid staff**, including succession pipelines and targeted mapping of potential internal and external people; having a ‘high potential’ leadership programme; and identifying role models to build and champion
- Targeting and supporting people from **low and middle income countries** and people who speak a variety of languages to be decision-makers, authors and volunteers
- Rolling out a **mentoring initiative** for peer support, including for early career professionals

3. Prioritising and resourcing practical changes

- Reviewing and **prioritising** all of the suggestions community members made, deciding which will be progressed in the short and medium term, and allocating appropriate resourcing.
- Developing **tools and guidance for Groups and teams** focused on ‘getting the basics right’ such as responding to people who express an interest, ongoing clear and appreciative communication, having transparent criteria when selecting participants, proactively seeking out different types of people to volunteer or as paid staff, ringfenced funding for reviews of interest to low and middle income countries, regular online opportunities to participate and more focus on sharing evidence widely, using locally appropriate formats
- Continuing to build a supportive community and upskill people, including providing **online and face-to-face activities** to create a sense of community and help people feel welcome
- Making Cochrane resources more **accessible**, including a user friendly website; free access to evidence; resources in many languages; training and manuals that are easy to use no matter how experienced people are; and sharing and promoting Cochrane evidence widely

4. Measuring and promoting diversity and inclusion

- Being transparent about what Cochrane wants to achieve, such as setting inclusion **targets**
- Developing **metrics** that Cochrane reports on each year to show progress with diversity and inclusion, and requiring Cochrane Groups to routinely compile and report on such metrics
- Celebrating successes, including **showcasing stories** of inclusion; annual awards for good practice; and featuring diverse speakers and participants at events such as Colloquia

In 2022 Cochrane will reflect on this feedback when creating a Diversity and Inclusion Strategy that sets out plans to keep building an inclusive network.

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Acknowledgements

Cochrane would like to thank everyone who provided feedback, facilitated discussions, helped to organise the process or contributed in other ways. More than 1350 people contributed as participants, organisers or facilitators.

This report was coproduced by over 100 members of the Cochrane community, assisted by an independent organisation, The Evidence Centre. The ideas in this report reflect the feedback gathered, not necessarily the views of Cochrane as an organisation or any specific Cochrane Group or team.



1 What did we do?

This section describes why we wanted to hear people's experiences of inclusion in Cochrane, how we sought feedback and who contributed.

1.1 Why focus on diversity and inclusion?

Purpose

Cochrane is a leading international organisation in synthesising research evidence. In 2022 we will develop a Diversity and Inclusion Strategy prioritising and planning how to keep building diversity and inclusion in Cochrane.



This document describes feedback from a 'Listen and Learn' process in 2021 that asked what members of the Cochrane community thought about diversity and inclusion in Cochrane, and what Cochrane could do to be even more inclusive.

It is designed to be used by Cochrane leaders and teams, alongside other information, to help shape strategies and actions for improvement. Over 1350 people contributed by sharing their experiences, organising or guiding the process and/or compiling the themes. The report was co-written by 104 members of the Cochrane community, facilitated by an independent team outside Cochrane.

Importance of diversity and inclusion

Diversity and inclusion are important to Cochrane because:

- **It is the right thing to do.** Increasing participation and access, and minimising bias, are founding principles of Cochrane. As a leading international organisation, Cochrane has a responsibility to facilitate equity and to lead by example.
- **It is the best thing to do.** Cochrane needs expertise from a wide range of backgrounds, perspectives, lived experiences and ways of working to stay relevant, worthwhile and sustainable. We want to attract, retain and nurture a diverse range of people and to reflect the communities we serve.
- **It is what we are setting out to do.** We need to be diverse and inclusive in order to achieve our mission of supporting people to make evidence-informed decisions about health and healthcare, no matter where they are in the world. Diversity and inclusion are part of our Organisational Strategy.

We have over 230 Groups producing and/or disseminating Cochrane evidence around the world. Over 9 million people visit the Cochrane Library website a year, from different roles, genders, age groups, languages and countries. Some might argue that this means that Cochrane is already 'diverse'. However, it would be complacent to say that this means that Cochrane is as diverse and inclusive as it could be.

For many years Cochrane has indicated that it could improve global participation in its activities and the relevance of our reviews to citizens and health systems across the world. Cochrane has highlighted the need to support the inclusion and advancement of people of different genders, career stages, geographic regions, languages and personal circumstances. We have also compiled evidence about people's characteristics, gaps and areas for improvement.¹ This report is a step in our ongoing journey and commitment and builds on this past work.

Cochrane already does many things to encourage people with differing characteristics to be part of our network. We want to be transparent about what we are doing well and where we could do even better. We want to understand whether Cochrane, like other organisations, has systemic inequalities in the range of people we involve and how they are involved. By focusing on diversity and inclusion we are not suggesting that it is a 'problem', but rather part of the solution to our continued survival and success.

Definitions

Words matter. Discussions about equity, diversity, inclusion and advantage are sensitive. The words we use can inspire, irritate or alienate people for many reasons. We know that the words we use in this report may not be as sensitive or appropriate as they could be, and that they may cause offence. That is not our intention.

We want to be explicit about how we have used words in this report:

- We use the terms 'diversity' and 'inclusion' broadly, to take into account the variety of perspectives and definitions used across the Cochrane community. We wanted to understand how people associated with Cochrane defined diversity and inclusion.
- We use 'diversity' to mean the range of different people who make up Cochrane and the variety of their characteristics. We recognise that people are more than 'boxes' or characteristics. People also have multiple characteristics and identities (intersectionality).
- We use 'inclusion' to mean the extent to which people feel they can be meaningfully involved in a way that they wish. Inclusion is about inviting contribution, input and insight from a diverse group. It includes a sense of being welcome and valued. It is about having space for everyone and valuing the richness that comes from different experiences.
- We use the term 'we' to refer to Cochrane as a worldwide network, and all of the people who contributed their views and experiences as part of this listening process. We use 'Cochrane community' to mean anyone associated with Cochrane, in any way. We have used the active tense to make the report more readable, but we emphasise that the perspectives expressed throughout the report do not represent an 'official Cochrane' organisational or team view.
- We use 'Cochrane Groups' to mean Cochrane groups, fields, centres, networks, affiliates and other entities working towards Cochrane's mission and formally linked with the Cochrane name.

1 Examples of past work include Cochrane Groups financial and resources reporting (annual), Increasing the participation and recognition of women leaders (2011), Enhancing global participation (2011), Author survey (2021), Membership dashboard (annual), Cochrane author profiles (2019), Gender analysis of Cochrane reviews (2020), Diversity of reviewers (2020), Review activity by Cochrane groups (2011), and International activity within Cochrane review groups (2012).



1.2 Listening and learning

Who did we listen to?

Before we identify and prioritise opportunities as part of a Diversity and Inclusion Strategy, we wanted to understand more about our communities and their experiences of being part of Cochrane. We set out to begin filling a gap in Cochrane's knowledge: understanding people's perceptions about whether Cochrane is inclusive, and their suggestions for development.

In November/December 2021, Cochrane undertook a Listen and Learn process to find out more about:

- the **characteristics** of the people who make up the Cochrane community
- the extent to which people feel **included** and part of Cochrane
- the things that people think should be **prioritised** so that Cochrane continues to develop how we include people

We particularly sought feedback from:

- participants in Cochrane Groups and teams of all types
- other active members and supporters of the Cochrane community, including but not limited to review authors, peer reviewers and translators
- other groups such as the Consumer Network, Early Career Professionals, Students 4 Best Evidence and Central Executive Team
- people who were interested but may not feel as included in Cochrane activities as they wanted

How did we listen?

We used four methods to learn more about diversity and inclusion in Cochrane.

- **drawing together existing information** about the characteristics of people associated with Cochrane, including the number of people registered with Cochrane accounts, anonymised demographic characteristics of employees and leaders, the country of origin of Cochrane authors, and where in the world people access our evidence from
- an **anonymous online survey** advertised via Cochrane Groups, a pop up for people visiting the Cochrane community website and via email and newsletters for people with a Cochrane account. The survey was available in Spanish and English. 1194 people took part
- **36 online discussion sessions** advertised through social media, newsletters and the survey, including 3 discussion groups with the Central Executive Team and 4 targeting early career professionals. Sessions were available in languages including Arabic, Chinese, English, French, German, Gujrati, Italian, Japanese, Malay, Portuguese and Spanish. 180 people took part
- **39 telephone interviews**, mainly in languages other than English, to include people who did not have easy access to online sessions or who wanted to speak one-to-one or in another language

Appendix 1 contains more details about the methods we used. We chose these methods because we could achieve them rapidly and with minimal resources. We know that these methods do not provide exhaustive information, and that other perspectives will be available. The information was collected during the COVID-19 pandemic, when people had other priorities. This is a step in our journey, not a final destination.

1.3 Who took part?

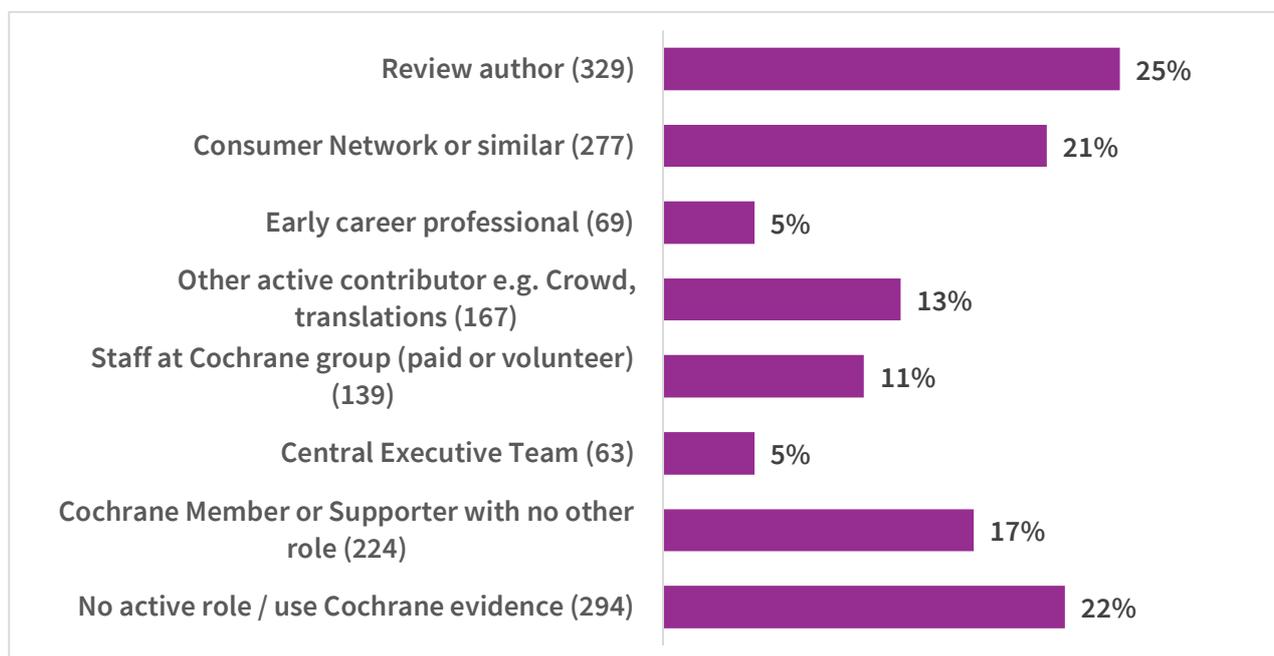
Characteristics of people who shared their views

A total of 1312 people shared their views across discussion groups, interviews and the online survey in November/December 2021.² Those who took part were a good mix of people actively and not actively involved in Cochrane, from many parts of the world and with a variety of personal characteristics.

Figure 1 shows the main ways that participants were involved with Cochrane. Two thirds of people were engaged to some extent, such as being review authors (25%), members of Cochrane's Consumer Network or similar (21%), paid or volunteer staff at Cochrane Groups (11%), members of the Central Executive Team (5%) or people who volunteered for ad hoc tasks (13%). People could have more than one active role.

4 in 10 people who took part were not actively engaged at this stage (39%). They were either people who had used Cochrane evidence in the past or were registered with a Cochrane account, but not actively involved in Cochrane activities.

Figure 1: Main Cochrane roles of people who took part in interviews, discussion groups and survey



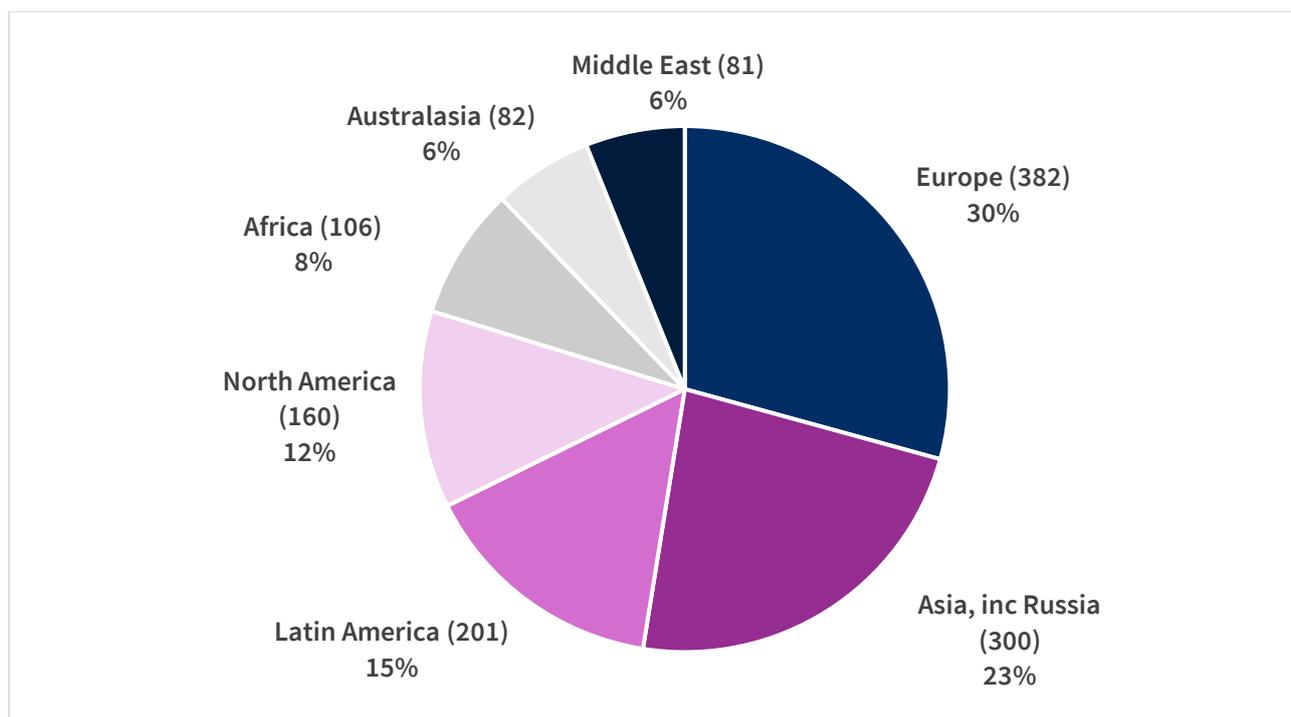
Note: 1312 people took part in total. Proportions add to more than 100% as people could have more than one role, such as being a review author and staff at a Cochrane Group. Actual numbers are in parentheses. People who took part in both the survey and a discussion group are not counted twice.

² 180 people took part in 36 discussion groups, 39 in one-to-one interviews and 1194 in the online survey. 101 of the people who took part in discussion groups had also provided feedback by survey. The survey and discussion groups asked different questions. All 104 people who took part in coproduction sessions to review and prioritise themes in people's feedback had taken part in an interview or discussion group or facilitated a discussion group.

Figure 2 shows that people based in many parts of the world took part.

The largest proportion of people took part by responding to a survey. 4 in 10 survey participants were from low and middle income countries (43%) and two thirds had a main language other than English (65%). About 4 in 10 were women, non-binary or preferred to self-describe their gender. 1 in 10 said they had a life limiting long-term condition or disability (see Figure 3).

Figure 2: Geographic location of people who took part in interviews, discussion groups and survey



Note: 1312 people took part in total. The numbers combine people taking part in the survey, interviews and discussion groups. Actual numbers are in parentheses. People who took part in both the survey and a discussion group are not counted twice. People participating in discussion groups and interviews were more likely to be based in Africa, Asia, Latin America and the Middle East because people from those regions were prioritised to book into discussions.

Representativeness

Our Listen and Learn approach did not set out to be generalisable or to represent the entire Cochrane community, or people who may wish to be part of the community. We wanted to hear from anyone willing to share their experiences and suggestions.

In total, only about 1% of all members of the Cochrane community took part. But, this is based on anyone that has ever registered for a Cochrane account, rather than those who are actively using or contributing to Cochrane currently. About 40% of those in paid roles in Cochrane Groups took part, 55% of the Central Executive Team and 13% of all Cochrane members or supporters who are healthcare consumers (service users), so those groups are well represented.

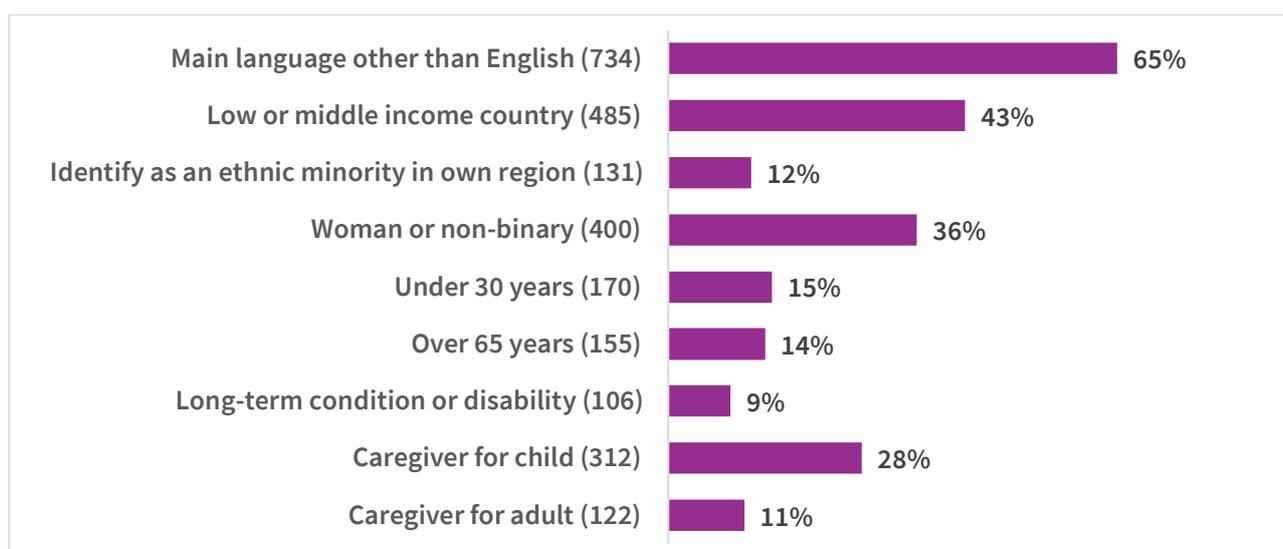
We recognise that our methods have not reached everyone who may have wanted to share their experiences, particularly those who may not have felt comfortable speaking in groups or who did not have easy access to the internet. This is emphasised in feedback from our survey, where 82% said they had access to a stable electricity supply, 82% had a strong stable internet connection, 93% had a desktop or laptop computer and 86% had a mobile telephone or other mobile device. This means that around 1 in 7 people taking part did not have easy access to stable electricity or internet, but this under-represents those in similar circumstances who may have wanted to contribute.

However, given that we only sought feedback over an 8-10 week period and at a time when the COVID-19 pandemic meant that people had many other pressures and priorities, we were pleased with the wide range of people who felt able to contribute. We were particularly happy that **feedback was provided by a large number people who speak languages other than English, by those in low and middle income countries and those outside Australasia, Europe and North America, and by those who are not actively engaged with Cochrane at present.** Everyone's experiences are important, and we believe the range of people who contributed strengthens the variety of what we heard and the suggestions for development.

It is important to highlight that the feedback and quotes used throughout this report are people's opinions and feelings. They are not necessarily factual, and some readers may find the wording or opinions hurtful or unjustified. It is not our intention to cause offence, but rather to provide a frank summary of the range of views that people expressed, to show the strength of people's opinions.



Figure 3: Characteristics of people who took part in the survey



Note: Based on 1194 people who took part in the survey. Actual numbers are in parentheses. People could have more than one of these characteristics. We believe that a greater proportion of women completed the survey than is reflected in these figures, but the question was asked in a list of characteristics so people may have inadvertently missed this question.

2 What did we learn?

This section summarises how people defined diversity and inclusion in Cochrane, what we know about the characteristics of Cochrane community members and staff and the extent to which people feel included.

2.1 How did people define diversity and inclusion?

Diversity

We asked people what diversity and inclusion meant to them in the context of Cochrane. This is to help develop shared understandings. People reflected that ‘diversity’ was about variety and difference. Interestingly, people emphasised that diversity to them was about more than demographic characteristics, but also about variety in the roles, professional backgrounds and experience of those involved in producing and accessing Cochrane’s work. People emphasised the importance of diversity of opinion and experiences, not solely variation in demographic characteristics. They also focused on the variety of topics, methods and types of research that Cochrane focused on (see Box 1).

Box 1: Components of diversity Cochrane should consider according to people sharing their views

Diversity in characteristics of people organising and creating content

- People of different languages, genders, countries, age groups, socio-economic status
- People from a variety of professional backgrounds, including consumers, health and care professionals, public health, academics, technical and IT specialists, communications specialists
- People with different levels of experience, including early career professionals and students

Diversity in characteristics of people using Cochrane content

- People from different countries, social economic status, ages, genders, languages
- People from different professional backgrounds such as policy makers, academics, consumers, journalists and health and care professionals

Diversity in features of Cochrane content

- Available in multiple languages
- Available online and in print for those who do not have easy online access; and open access
- Topics relevant to varied audiences
- Types of evidence included
- Types of methods used to identify and compile evidence
- Range of approaches used to disseminate evidence synthesis

Characteristics of Cochrane activities

- Various ways to be involved such as through creating evidence, disseminating evidence, using evidence and championing evidence-informed decision-making
- Variety in the location of Cochrane Groups
- Spread of governance and leadership across regions
- Spread in the funding, resourcing and staffing for Cochrane Groups



Some defined diversity as about the people who create and manage Cochrane evidence and activities. This included the demographic characteristics of individuals, but also the geographic location, language and mindset of leadership and activities.

“Diverse means bringing together characteristics that make us unique and make the group more enriching’, such as including people from different countries, ages, gender and professions. Each region has its particularity. It means nobody is excluded due to race, gender or language spoken. And also people with hearing disabilities and other characteristics.” (Discussion group participant)

“Diverse means to me that there are opportunities for participation, taking into consideration the physical, cognitive, socioeconomic and cultural limitations and barriers to participation. It needs to take into account different ways of thinking and doing things. The needs and daily challenges of groups that are marginalised, such as women, people with disabilities, childcare commitments, sexual orientation, ethnicity. It is about celebrating these differences and recognising them. It is about reflecting the characteristics of the population into the organisation.” (Interview participant)

“Over half of the Cochrane Review Groups are based in the UK and the rest are mostly based in developed countries like New Zealand, Canada and the US. Almost none in developing countries. Diversity should allow more participation of developing countries, such as being reviewers, lecturers and members. In the past two years, we felt alienation with Cochrane.” (Discussion group notes)

There was also a focus on diversity of the professions and level of experience of people involved in creating and using Cochrane content.

“You must have members from all backgrounds, regions of the world, different levels of students, other specialities of practice. Diversity of academic levels, being from different professional backgrounds. It includes IT professionals, social media, nurses, family, doctors.” (Discussion group participant)

“Diversity to me means different fields of research or by sectors or topics, by people of different levels of experience including those early in their career working with the more experienced, and different professions. It is about having a wider team of different people and contexts (ethnicity, background, occupation). We learn more from different kinds of people rather than people from similar settings because you are exposed to new ideas to share. Diversity within the team helps the research itself because you are able to understand different perspectives and ways of thinking. Technology has allowed us to work remotely collaboratively and all over the world.” (Discussion group participant)

Others said that diversity also referred to the variation in the topics covered in Cochrane reviews, and the methods used to create and disseminate evidence.

“The population in developing countries count for about 70-80% of the world’s population. But the Review Groups are mostly based in developed countries so when you register a title, they will tell you that is not their priority. Cochrane is an international organisation, but its representativeness of developing countries is not enough. They judge whether a topic is prioritised based on themselves, rather than taking a global view.” (Discussion group notes)

“Diversity means having products other than systematic reviews such as translated summaries, podcasts and blogs, colloquiums and events. And the contents should not only be on medicine, but also wider healthcare, leadership, technology, psychology and sociology related to health.” (Interview participant)

How could Cochrane be even more inclusive?



Inclusion

In the survey and discussion groups, we asked what ‘good inclusion’ in Cochrane would look like. The feedback was similar regardless of how people gave feedback or their own demographic characteristics. Inclusivity was perceived to be about being open and welcoming to all, creating a sense of community where people were engaged and felt valued, and striving to make content, methods and approaches relevant, whilst acknowledging and respecting differences.

Box 2: What ‘good inclusion’ in Cochrane would look like according to people surveyed

Being open to all

- **Offering opportunities to all**, including those from different professions, countries, languages, and levels of experience (29%)
- Wide **accessibility** of content e.g. open access, large font, subtitles, languages, time zones (15%)
- Actively **seeking out underrepresented groups** to support, including creating more Cochrane Groups in low and middle income countries (14%)
- **Listening** with tolerance of different views and proactively engaging with and responding to people who want to take part (10%)

Being relevant to all

- **Wider range** of people involved in decisions, activities and **senior roles** (19%)
- Broader range of topics in Cochrane reviews, wider study types and **implications** of reviews for diverse groups and regions explicitly stated (4%)

Building a community

- Activities to create a **sense of community** e.g. two way communication, forums, local in person and online networking events so people can meet and interact (15%)
- Sharing **skills**, free training, pairing more and less experienced people through mentoring or buddy systems to build skills and relationships (10%)

Acknowledging and tackling issues

- Allocating **resources** to recruit, train and involve people, including **training about inclusion** and inclusive HR policies that allow people to be hired wherever they are in the world (5%)
- **Transparency** about how diverse and inclusive Cochrane is and what it is doing to improve (5%)
- Reimbursement / **acknowledgement** for work (2%)

Note: Proportions are based on 1194 people responding to the survey.

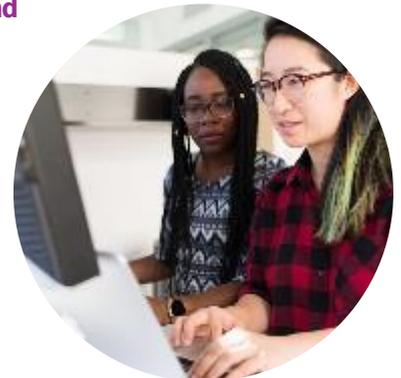
People defined good inclusion as respecting, welcoming and giving people opportunities to contribute, and listening to different perspectives and experiences. They often linked this to values such as social justice, addressing discrimination and equality of opportunity.

“Good inclusion in Cochrane would be an organisation that welcomes people from all walks of life regardless of their age, disability, gender, sexuality, belief, background. One which values everyone's contributions and treats everyone with respect. A place where there is no place for bullying, sexual harassment, discrimination, intimidation, inappropriate remarks or abuse of any kind.” (Survey participant)

“Good inclusion would be greater representation outside of the UK amongst the central editorial unit and central staff. There are lots of initiatives claiming to promote the involvement of contributors in low and middle income countries, consumers, and those from different backgrounds but little direction or resources to support Groups in implementing this. Despite efforts to promote translation, the primary language of publication of reviews and other products makes it difficult to work with individuals without advanced English proficiency.” (Survey participant)

“Inclusion is about more than gender, age, culture or other types of identity balances in a group. Inclusion is also about a willingness to hear different opinions, disrupt existing power mechanisms, create a forum for all and create collective understanding. It is about opportunities for everybody to speak without fear. Welcoming insights from different groups, culturally and generationally speaking, is what can aid in keeping an organisation young and updated to new needs. It fights stagnation. People walk faster when they are alone or with likeminded people, but they would walk further with opposing and different viewpoints feeding discussions and processes. Inclusion is pretty much core to the central question of the whole Cochrane community: what works for whom under which circumstances? And are we willing to sacrifice our own needs and interests for the sake of those in less powerful positions to achieve social justice?”

(Interview participant)





2.2 How diverse is Cochrane?

Cochrane has previously compiled information about the characteristics of Cochrane members and authors which we do not replicate here.³ However we present some statistics to show the type of information that is available about those managing, creating and using Cochrane evidence, and the gaps in what is known. This is not meant to be an exhaustive assessment of the extent to which Cochrane is made up of diverse people, but rather a way to contextualise some of the suggestions for change people made (presented in Section 3). We have not included data about the diversity of Cochrane’s outputs, topics or methods. All data were provided by the Central Executive Team.

Spread of Cochrane Groups

As of July 2021 there were 245 Cochrane Groups registered. Of these, 30% were based in low and middle income countries. However only 1 of the 51 Cochrane Review Groups which create Cochrane systematic reviews was based in a low or middle income country.

Table 1: Spread of Cochrane Groups as of July 2021

Type of Cochrane Group	Total number of Groups	Number In low and middle income countries	Number in countries other than Australia, Canada, UK and USA
Cochrane Review Group (CRG)	51	1 (2%)	14 (27%)
CRG Network	8	0	2 (25%)
CRG Satellite	27	5 (19%)	17 (63%)
Field	12	1 (8%)	9 (75%)
Geographic Affiliate	61	39 (64%)	45 (74%)
Geographic Associate	46	21 (46%)	44 (96%)
Geographic Centre	23	7 (30%)	20 (87%)
Methods Group	17	0	3 (18%)
Total	245	74 (30%)	154

3 Examples of available information include:

- <https://community.cochrane.org/organizational-info/resources/support-cet/membership/membership-dashboard>
- <https://docs.google.com/document/d/1ZK5O03DCSpSDMUo5lV-AxrEN69splrf7wSOLWIV67c/edit?usp=sharing>
- <http://2011.colloquium.cochrane.org/abstracts/c4o2-testing-selective-responses-cochrane-groups-request-conducting-cochrane-systematic-re.html>
- <https://abstracts.cochrane.org/2019-santiago/class-inclusion-medicine-and-disability-faculties-medicine-learn-patients-and-train>
- <https://abstracts.cochrane.org/2019-santiago/profile-cochrane-review-authors>
- <https://abstracts.cochrane.org/2020-abstracts/gender-diversity-analysis-cochrane-systematic-reviews>
- <https://abstracts.cochrane.org/2019-santiago/diversity-reviewers-diverse-researcher-perspectives-systematic-reviews-may-help-reduce>
- <https://abstracts.cochrane.org/2012-auckland/international-activity-within-cochrane-review-groups>

Cochrane's global resource distribution reflects global inequality patterns: most of our income and human resource is in Europe and in high-income countries. 81% of our Groups and 90% of Cochrane's income are in high-income countries as classified by the [World Bank](#).

Many of the best funded Groups are Geographic Centres with strong relationships with national funders. However, under Cochrane's current Group structures and functions, Geographic Groups do not lead on review production.

Cochrane leaders and staff members

Table 2 shows the characteristics of people on Cochrane's Governing Board and how this has changed in recent years. As of July 2021, 42% of the 12 Board members had a main language other than English, 17% were based in low or middle income countries and 67% were female or non-binary gender.

Table 3 shows the characteristics of Cochrane's Central Executive Team. As of July 2021, 2% of the 115 Central Executive Team members were based in low or middle income countries and 77% were female or non-binary gender. 85% whose ethnicity is known described themselves as 'White' and 2% reported a disability or impairment.

Across the Cochrane network there are over 300 full-time-equivalent paid staff working in Cochrane Groups. 71% of our Group staff are based in just 10 countries (UK, South Africa, Italy, Denmark, United States, Brazil, Australia, Canada, France and Mexico). Cochrane does not yet routinely collect the demographic characteristics of paid team members or volunteers in Groups.

Table 2: Characteristics of people on Cochrane's Governing Board

	Dec 2018	Dec 2019	Dec 2020	Jul 2021
Total number on Governing Board	12	13	12	12
Number from low and middle income countries	1 (8%)	1 (8%)	2 (17%)	2 (17%)
Number from countries other than Australia, Canada, UK and USA	5 (42%)	5 (38%)	6 (50%)	6 (50%)
Number who are female or non-binary	8 (67%)	8 (62%)	8 (67%)	8 (67%)
Number with a main language other than English	4 (33%)	4 (31%)	5 (42%)	5 (42%)

Table 3: Characteristics of people in Cochrane's Central Executive Team

	Dec 2018	Dec 2019	Dec 2020	Jul 2021
Total number in Central Executive Team	92	93	114	115
Number from low and middle income countries	2 (2%)	2 (2%)	1 (1%)	2 (2%)
Number from countries other than Australia, Canada, UK and USA	29 (32%)	26 (28%)	31 (27%)	33 (29%)
Number who are female or non-binary	67 (73%)	67 (72%)	84 (74%)	89 (77%)
Number with a main language other than English	Unknown	Unknown	Unknown	Unknown

Cochrane members and supporters

People register for Cochrane online accounts in order to access some of Cochrane's content and activities. This provides an idea of who is using Cochrane content (supporters), and who wants to be part of a network by contributing to Cochrane's work (members).

When they register, Cochrane invites people to provide optional information about the country in which they are based and their language preferences. Information is not currently collected about gender, age, stage of career or profession, and information about language preferences is inconsistent.

More than 110,000 people had Cochrane accounts as of July 2021. 14% of these were based in low and middle income countries and 34% stated a main language other than English.



Over 2800 people had been part of the author team on a Cochrane review over the past 12 months. Of these, 4% were based in low or middle income countries. Over 2700 people had contributed to Cochrane in other ways in the past 12 months, including volunteering to translate or peer review materials, or to take part in activities via Cochrane Crowd or Task Exchange. Of these, 7% were based in low or middle income countries (see Table 4).

Table 4: Characteristics of Cochrane members, authors and contributors

	December 2018	December 2019	December 2020	July 2021
Total Cochrane members and supporters	65191	79342	100911	110157
Proportion of members and supporters from low and middle income countries	Unknown	10%	13%	14%
Proportion of members and supporters from countries other than Australia, Canada, UK and USA	Unknown	60%	62%	63%
Proportion of members and supporters who have a main language other than English, where known	Unknown	Unknown	Unknown	34%
Proportion of members and supporters who are healthcare consumers as their main role	Unknown	Unknown	Unknown	2%
Total number of Cochrane authors in past 12 months	5256	4414	4334	2859
Number of authors from low and middle income countries	147 (3%)	144 (3%)	129 (3%)	121 (4%)
Number of authors from countries other than Australia, Canada, UK and USA	2390 (45%)	2021 (46%)	1951 (45%)	1192 (42%)
Total number of other contributors in past 12 months (Crowd, translation, Task Exchange and peer reviewing)	Unknown	Unknown	3799	2747
Number of other contributors from low and middle income countries	Unknown	Unknown	360 (9%)	198 (7%)
Number of other contributors from countries other than Australia, Canada, UK and USA	Unknown	Unknown	2196 (56%)	1599 (58%)

People using Cochrane evidence

The most common countries from where people accessed the Cochrane.org website were the USA, Spain, Russia, UK, Brazil and France.

There are about 9 million visitors to the Cochrane Library website each year. Of these, about 12% of visitors access the site from low and middle income countries and 47% use web browsers in a language other than English (see Table 5).

Table 5: Characteristics of people using the Cochrane Library website

	Dec 2018	Dec 2019	Dec 2020	Sep 2021
Total number of unique visitors in past 12 months	2,312,647	8,703,683	9,135,619	7,419,499
Proportion from low and middle income countries	7%	10%	10%	12%
Proportion from countries other than Australia, Canada, UK, USA	56%	59%	64%	67%
Proportion using web browsers in a language other than English	41%	40%	44%	47%

Based on the limited information available about the characteristics of those managing, producing and consuming Cochrane evidence and activities, the group involved in coproducing this report inferred that:

- Cochrane’s Governing Body appears to have diverse representatives in terms of gender, geographic location and preferred language, but the Central Executive Team may not be equally diverse in terms of language, geographic spread or ethnicity.
- It appears that those creating most Cochrane evidence (in Review Groups) are headquartered in a narrow range of countries. There are few authors or other contributors from low and middle income countries. Geographic groups generate much Cochrane funding, but do not currently have a leading role in creating Cochrane reviews. The functions and structure of Cochrane Groups is under review.
- The lack of information routinely collected about gender, age or career stage, profession and language preferences is a gap in Cochrane’s ability to monitor diversity in those working or volunteering for Cochrane.
- A large portion of people accessing Cochrane evidence use languages other than English, but only about 1 in 10 visitors to the Cochrane Library is from low or middle income countries.



2.3 How inclusive is Cochrane?

What does Cochrane do well?

We wanted to understand people's perceptions of the things Cochrane is doing well at present, both to celebrate those and consider their continuation or expansion.

In discussion groups, people said that things that Cochrane is doing well to support diversity and inclusion include:

- moving towards open-access resources and giving access to some content and online training free
- Cochrane Crowd and Task Exchange platforms, where participants do not need a technical background to engage
- specific networks such as the Early Career Professionals group and the Consumer Network
- grants for students, consumers and those from low and middle income countries to attend events
- the Colloquium and other opportunities to network with a wide range of people
- collaborating with authors and contributors from different countries when working on specific reviews or projects
- having discussions as part of the Listen and Learn process, including sessions in local languages
- large number of Cochrane members and supporters, including from different parts of the world
- large number of Groups across the world
- Geographic Group activities in local languages
- translation of reviews and dissemination materials into a variety of languages
- high proportion of women in leadership roles
- Governing Board elections with specific slots for people from low and middle income countries

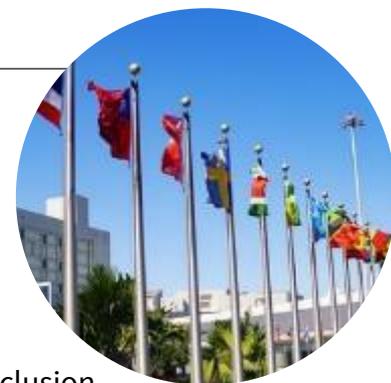
“In Cochrane Colloquiums, it is very good that there were stipends for students and consumers. This allows us more opportunities to get closer to Cochrane and to learn about its core, then bring them back and share with our colleagues. We can also get to know more people this way who are happy to help us in developing countries.” (Discussion group participant)

“The Task Exchange and Crowd platform make it easy to get started with Cochrane step by step. The reward badges and membership help recognising the progress and contributions one has made. The more you get involved, the more you can collaborate.” (Discussion group participant)

“We must celebrate what we have achieved in the past 25 years. Cochrane has opened doors for people, including women and people of colour. We have a broad footprint with Geographic Groups all around the world. There is a real richness of people working around the world. We need to remember those successes as we also focus on not being complacent.” (Discussion group participant)



How could Cochrane be even more inclusive?



How included do people feel?

We asked people the extent to which they felt included in Cochrane and whether they believed that Cochrane was doing a good job of supporting diversity and inclusion. People who took part in the survey were generally positive about the extent to which Cochrane was supporting diversity and inclusion, giving people opportunities to be involved and including leaders from diverse backgrounds (Figure 4). However some people did not have much knowledge about Cochrane so could not answer these questions. Cochrane authors were more likely to be positive than those with no active roles. Women were less likely to be positive (see Table 6).

Figure 4: Perceptions about diversity and inclusion in Cochrane amongst those surveyed



Note: Based on 985 to 1078 people who answered these questions.

Table 6: Differences in what people thought about inclusion based on their personal characteristics

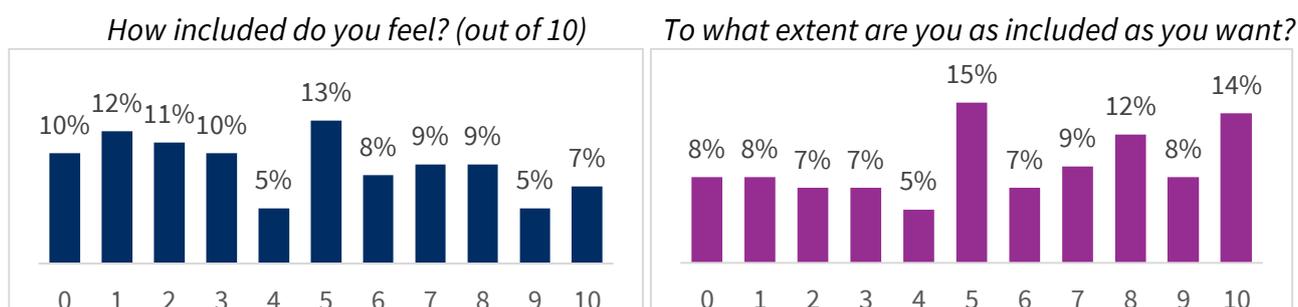
% that agreed	Cochrane is doing a good job with diversity and inclusion	Cochrane includes people well, no matter where they live or who they are
All surveyed (1078 & 985 responses)	74%	76%
Low or middle income country	76%	77%
Language other than English	77%	79%
Woman or non-binary	66%	69%
Under 30 years	87%	86%
Over 65 years	75%	79%
Caregiver for child	73%	75%
Caregiver for adult	79%	73%
Life limiting condition or disability	65%	65%
Central Executive Team member	50%	75%
Staff at Cochrane Group	62%	64%
Author	72%	77%
No active role in Cochrane	63%	66%

People surveyed had widely differing feedback about the extent to which they felt included in Cochrane and whether they were as included as they wished. On average, people scored the extent to which they felt included as 4.5 on a 10-point scale. They scored an average of 5.5 as to whether they were as included as they wanted to be, but there was a wide range (see Figure 5).

“I have always felt included. I believe Cochrane Crowd to be a friendly and caring group. What has solidified this feeling is the friendly and caring nature of all communications - emails, training materials, invitations to participate, response to questions. I believe I can try any task I want and I can also contact someone if I have a question. Even my suggestions are taken seriously. I am impressed by the high number of countries where participants come from. I have noticed that there are varied start times for the screening challenges. To me, this shows you are trying to include people from different time zones.” (Survey participant)

About 6 out of 10 people said they did not feel as included in Cochrane as they wanted to be. There was no significant difference in the extent to which people from different age, gender, language or regional groups felt as included as they wished. This suggests that people’s feelings about being included were not based largely on demographic characteristics, but rather the extent to which they had had opportunities to engage with Cochrane (see Table 7).

Figure 5: Extent to which people surveyed felt included in Cochrane



Note: Participants rated both questions from 0 to 10 where 10 was the highest / most.

Table 7: Differences in the extent to which people felt included based on their personal characteristics

% that scored 7+ out of 10	How included do you feel	Feel as included as you want
Total surveyed (1194 responses)	30%	43%
Low or middle income country	31%	46%
Language other than English	31%	46%
Woman or non-binary	28%	35%
Under 30 years	27%	42%
Over 65 years	33%	48%
Caregiver for child	29%	39%
Caregiver for adult	30%	42%
Condition or disability	32%	42%
Staff at Cochrane Group	57%	61%
Central Executive Team member	83%	75%
Author	50%	54%
No active role in Cochrane	0%	33%

How could Cochrane be even more inclusive?



People who took part in discussion groups and interviews were generally less positive overall about the extent to which Cochrane was supporting diversity and inclusion and giving a wide range of people opportunities to take part.

“Being inclusive would mean that we enable people to participate regardless of their background, not expecting them to adjust to and adopt the Western, Anglophile way, but working together to come up with ways that work for everyone. The people who are from other backgrounds now and part of Cochrane are the ones who have already adapted themselves to the Western, Anglophile way. We are not as inclusive as we should be. I think quotas to ensure people from certain backgrounds / marginalised groups are part of leadership and committees is a route we should explore, as well as decision-making processes that require to take into account, systematically assess and transparently communicate the impact of strategic and operational decisions on people from different backgrounds and marginalised groups.” (Discussion group participant)

“I am so tired of hearing leaders in Cochrane say how diverse we are. We should acknowledge that we, as much as any organisation in this sort of environment, are part of the problem of structural inequity. Our leaders like to talk about the importance of diversity and inclusion, they think they know what they are talking about, but they don't usually get what it actually means. They need to let the disadvantaged and marginalised lead.” (Interview participant)

We prioritised inviting people who may not feel involved to discussion groups as we wanted to hear what the barriers might be and their suggestions for development.

“I don't feel at all I am included as much as I want to. The website feels like it doesn't have all the information. We don't know how to get involved. I am not sure if I will be of use to Cochrane as I am lacking training. I don't know how Cochrane works as an organisation. I want to know, but don't know how to know. Also, I worry, I am not good enough, I don't know things at all. Maybe if the website was segregated in first person language in a step wise manner or had a trial programme I would join. Training is the key so that the individual can understand requirements.” (Discussion group participant)

“Cochrane feels quite removed. Although there is a lot of communication, it feels like information giving rather than involvement. I volunteered to be a member of the Cochrane Consumer Network for a certain group. All you ever did about it was send me some newsletters. There was no patient engagement with me on your part. That was very discouraging and not at all consumer oriented.” (Discussion group participant)

Some said they had tried to get involved, but that they had not had positive experiences.

“I don't feel involved at all. I have requested to have collaboration with my organisation and never received any response. It feels like Cochrane is a very closed organisation, not interested in others. They do not even respond to messages.” (Discussion group participant)

“I feel excluded. I started work on a review and had Zoom sessions and then everything stopped and there has been no communication. I emailed the team leader and had no response. They got everyone started on updating a review and then just stopped with no communication. I want to be involved and help, but no-one responds.” (Interview participant)

Perceived barriers to inclusion

In the survey, people said that the main barriers to being more involved in Cochrane were a lack of information about how to get involved, a lack of encouragement or opportunities to engage, people not feeling they had appropriate skills or feeling unwelcome.

Box 3: Perceived barriers to being involved in Cochrane amongst those surveyed

Knowledge and information

- **Do not know how** to get involved (18%)
- Do not know the **options** for involvement or not being offered opportunities (15%)

Experience and confidence

- Lack of **training** / perceived lack of skill or experience or being early in career (14%)

Anglocentric focus

- **Geographic** location, lack of Cochrane presence in country, time zones for meetings (15%)
- **Language** barriers (9%)

Feeling excluded

- Perception that Cochrane Groups are **not accepting of new people** e.g. focused on people with specific qualifications or younger people, or not welcoming in their approach (13%)
- Volunteered but received **no response** (6%) or poor **communication** (6%)

Narrow focus

- Lack of focus on **areas of interest** / narrow methods so do not feel Cochrane is relevant (6%)

Structure and organisation

- Complexity of organisational structure including division between Cochrane centre and Groups (5%)
- Lack of networking opportunities and ability to meet people to feel part of a community (3%)

Resources

- Lack of resources such as **open access** to Cochrane materials (3%), lack of funding (2%), or lack of internet (1%)



Note: Percentages are based on 904 survey responses.

In discussion groups and interviews, people described these barriers in more detail. A number said that they did not feel that Cochrane was welcoming of diverse groups of people, and that there were systemic biases in the processes, requirements and ways of working that made it more difficult for some types of people to be involved. As in the survey, people acknowledged the need to maintain quality of Cochrane outputs and approaches, but some felt that this was used as an ‘excuse’ to limit involvement in Cochrane’s work.

“Cochrane’s leaders are mainly the same type of people based in the same countries. Systemic institutional biases are disguised using the excuse of quality.” (Discussion group participant)

“Cochrane has become an exclusive club for savvy statistical know-it-alls and is far away from the inclusive community it used to be. Some Groups seem racist and do not allow the inclusion of members from other countries. Cochrane now looks like a sort of private club, mainly from UK.” (Discussion group participant)

“There are important biases against non-native English speakers in the way the organisation is built. Cochrane has become increasingly less culturally diverse in its core processes. This also means lower participation of early career professionals, unless they are from ivy league Universities (many med students can author a Cochrane review if they are affiliated to a certain university, but senior researchers from Latin America cannot register a title).” (Survey participant)

People expressed a strong desire for leadership and management teams to better understand and acknowledge the barriers to inclusion, and to avoid trying to change people to fit into a single ‘mould’.

“The Central Executive Team is too UK, White, middle-class focused. CET needs to role model inclusivity. We need to have a strategy that is not about pulling people to be 'more like us...' I think we expect people to code switch all the time. There is a strong divide between those who understand systematic reviews and those who don't - those who don't are deemed lesser beings! However their skill in communications, design, presenting, conveying information, leadership, team work and emotional intelligence could be far superior. It is to Cochrane's detriment that this hierarchy exists.” (Survey participant)

“We are embedding inequality in health if our systems and leaders are not diverse. Inclusion to me starts with being actively anti-racist, anti-colonialist, and, for White people with privilege to explicitly take action to change your behaviour and impact. You then have to be a safe place for people to engage with you - which means that there has to be people who look like them in the group. You have to start with ‘how can we design this project differently to engage the marginalised’. Not ‘we're doing this great thing, come join us and do what we want you to do!’” (Survey participant)

Some were concerned with changes to the way Cochrane is structured and staffed, which they perceived as reducing inclusivity. Participants from China and India were particularly concerned about the structure of Cochrane Groups in those regions, and other participants were concerned about restructuring in the Central Executive Team and across Cochrane Groups.

“The most prominent barrier is the hierarchy decision-making structure within Cochrane. Collaboration has been taken out of the organisation and all decisions and processes are handled strictly at the top. While communication and management with members is polite, authors and review groups are used as unpaid labour and concerns are rarely taken seriously.” (Survey participant)

Many felt that Cochrane had specific criteria for participation which excluded people who wanted to be involved.

“Language is barrier. Non-native English speakers are not in the same position as those who are coming from English speaking countries. The distance from Cochrane offices could also play a role. Also, you can no longer start reviews on topics that are of interest or relevance to you, and instead have to conform to someone else’s agenda.” (Discussion group participant)

“Cochrane has great potential to help people. But 95% of the world’s population does not speak English as our first language and only 1 in 5 speaks English at all. Cochrane does not represent us.” (Survey participant)

“I do not know how to be more closely involved. It seems this community works on invitations which you only get when you know someone. Your expertise, publications etc do not get you a pass in. I do not have an academic role. I perceive that for Cochrane my four decades of experience working in healthcare does not measure up to someone with a recent PhD.” (Survey participant)

“We don't work at a university, but in the transgender community. Cochrane has little interest in such activities. It is a university club.” (Survey participant)

Others said that they wanted to take part, but did not feel they had the skills or experience needed, and had limited opportunities to build these skills.

“I would like to be included in the projects of Cochrane. I am from an underdeveloped country and I cannot afford training in research writing and I am learning it on my own from books and videos. People like me can only be included if we get free training in different steps of research.” (Interview participant)

“Language is a barrier at times. Especially in low income countries, few people have access to English classes that teach English at the level required for successful participation in scientific discussions and collaboration.” (Discussion group participant)

Language was a barrier for some, but others pointed to a more general Anglocentric focus. It was not just ‘words’ that were mainly in English, but also ways of working and thinking. People said that infographics were created in English, social media use did not account for some platforms being difficult to access or blocked in some parts of the world (such as YouTube or Facebook) and that review topics or dissemination methods of more interest outside the Western world were discounted. This was off-putting to potential participants and made them question whether Cochrane was relevant.



Another barrier for involvement was a lack of awareness about what Cochrane does and how to get involved. People felt that raising awareness would encourage more people to get involved.

“People don’t know Cochrane’s standing, impact, and what is it doing. If you don’t search for it proactively, you even don’t know the entrance. The awareness of Cochrane is too low. To participate you need to first know about it.” (Discussion group participant)



3 What could we do next?

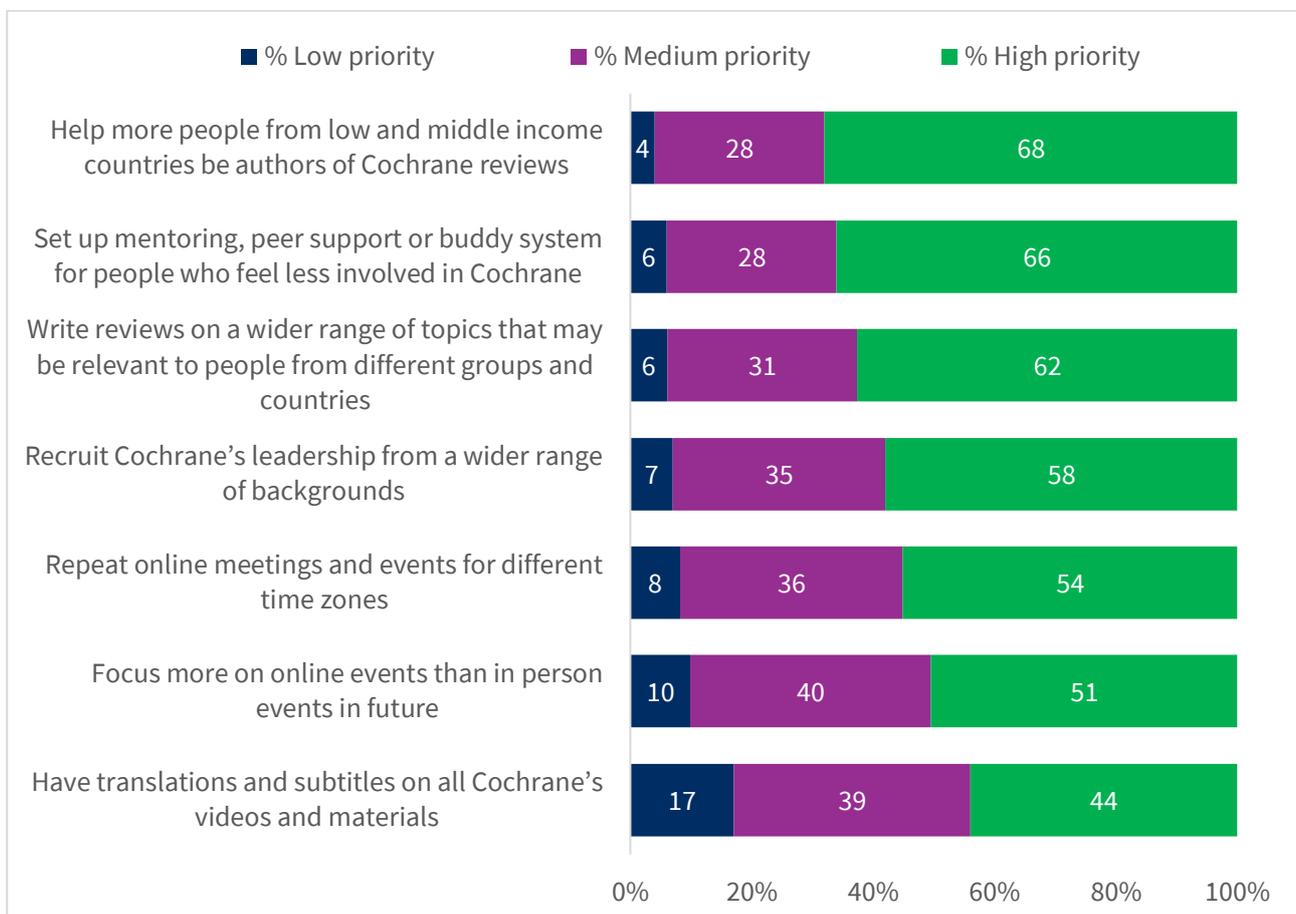
This section describes what people recommended that Cochrane prioritise in future to continue building a diverse and inclusive network.

3.1 People’s recommendations for the future

Cochrane’s Central Executive Team is interested in practical things that can be prioritised to improve diversity and inclusion. The survey invited people to prioritise some practical steps, based on ideas from an Advisory Group and pilot testing. The survey also invited people to share other ideas, as did the discussion groups and interviews.

The key priorities reflected barriers already described. There was more focus on helping a wide range of people to proactively engage and strengthening leadership than on more operational issues such as translations, subtitles and time zones (Figure 6).

Figure 6: Extent to which people surveyed prioritised potential practical next steps



Note: Based on 1192 survey responses.

The most highly prioritised potential next steps were largely similar regardless of people's personal characteristics and roles in Cochrane, though there were some key differences. Those based in low and middle income countries and people aged under 30 years were the most likely to say that Review authors should be sought out from low and middle income countries and that there should be a mentoring scheme. Those who did not currently have an active role in Cochrane were more likely than those with active roles to prioritise diversifying leadership, focusing on review topics of wider relevance and implementing mentoring schemes (Table 8).

Regardless of role or demographics through, the focus on engagement and a sense of community was prioritised over technical elements to bolster inclusivity. This was also mirrored in discussion groups.

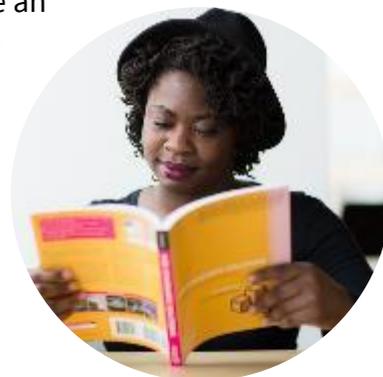


Table 8: Differences in the extent to which people prioritised potential next steps

% suggested high priority	Build LMIC authors	Mentoring	Relevant topics	Leadership	Time zones
Total surveyed (1194)	68%	66%	62%	58%	54%
Low or middle income country	80%	73%	67%	64%	54%
Language other than English	70%	68%	62%	59%	52%
Woman or non-binary	70%	63%	65%	59%	55%
Under 30 years	84%	77%	67%	71%	58%
Over 65 years	62%	61%	60%	50%	50%
Caregiver for child	68%	66%	68%	65%	65%
Caregiver for adult	69%	66%	58%	62%	54%
Condition or disability	64%	60%	68%	53%	58%
Staff at Cochrane Group	69%	62%	64%	60%	56%
Central Executive Team member	82%	64%	80%	80%	67%
Author	66%	68%	62%	59%	56%
No active role in Cochrane	67%	100%	100%	100%	67%

Note: LMIC = low and middle income countries. The question wording is in Figure 6.

Acknowledge that Cochrane may have inbuilt biases

We now describe some of the suggested priorities in more detail. Cochrane may already be doing some of these things. In describing people's feedback we are not commenting on what is or is not currently done, simply reflecting what participants would like to see.

Across the discussion groups, interviews and survey, people suggested that an important next step was to acknowledge and understand the importance of diversity and inclusion in Cochrane. This included:

- recognising that Cochrane has more work to do and that there may be **biases** and barriers in Cochrane's way of thinking about and doing things, including perceived potential elitism
- focusing on the **benefits** of being inclusive so this is framed positively
- publicly affirming Cochrane's **commitment** to diversity and inclusion as one of our organisational commitments
- **defining** what diversity and inclusion means to Cochrane and placing a commitment to this on the webpage, near to the mission
- developing an **engagement strategy** and consultation process so diverse communities are involved in collectively deciding next steps as part of the Diversity and Inclusion Strategy

“Institutional bias is the collective failure of an organisation to respond appropriately to people because of their characteristics. This can occur in processes, attitudes and behaviours which discriminate through unwitting prejudice, thoughtlessness, ignorance and stereotyping. A first step to tackling it is admitting it.” (Interview participant)

“Inclusion needs to be a ‘must do’, not a ‘nice to have’. It is fundamental to Cochrane’s survival. Cochrane could get more funding, be more productive and help achieve worldwide improvements if it was more inclusive.” (Discussion group participant)

“There is (rightly) fatigue in people from discriminated and marginalised communities being asked to contribute to these conversations when there is no sense that there will necessarily be any change (based on long and previous experience), and that these exercises can be token and non-transformative at the structural level.” (Email contribution)

“We don’t have an inclusive culture. The teams are close knit, with a cliquy culture. Even after years of working here, I feel like an outsider. But everything can be done remotely so there is no excuse. We need to change the culture. The whole organisation needs to own up to the fact that it is snobby and excluding people, and that some people are excluded more than others. Admitting there is an issue publicly for all staff and volunteers would be a massive step.” (Discussion group participant)



Make sure that leaders and staff are diverse and informed

People suggested that practical next steps would depend on appropriate resourcing and leadership. They therefore prioritised ensuring that Cochrane had appropriate structures and leaders who were passionate about collaboration and inclusion. This included:

- recruiting **leaders** and staff from different countries, languages, professions and characteristics so that diversity is visible and helps shape decisions
- making sure that **HR processes** support diverse recruitment and flexible working
- having a workstream and **named lead** to help the organisation and Groups improve on diversity and inclusion, with allocated funding
- providing **training** and tools for all staff and regular volunteers about systemic biases and practical ways to be more inclusive. Some Group members said they would like to be more inclusive but did not know how to do this effectively

“Leadership is not aware or does not acknowledge issues. The leadership is mainly UK based. Other cultures are not in senior management. This means they cannot understand our perspectives. Even small things like lots of cultural references in examples such as ‘BBC’. The leaders and staff should be trained so they understand different cultures and more people should be leading from different parts of the world. There should also be more bilingual programmes, such as was planned for the Chile colloquium.”

(Interview participant)

“We are going through review of Cochrane structure – but diversity and inclusion is not being taken into account in this. I am worried that plans for the future are led by a limited group of people who are not diverse. Our strength is our large international collaborator base, but these people are not engaged in planning for the future. We need to have management diversity. We don’t know what we don’t know.”

(Discussion group participant)



“We have had an issue when recruiting: only able to recruit people with work permits. Cochrane should support teams and Groups to open recruiting to around the world. The HR team do not listen when we raise this. It feels like there is provision for people in Europe and not elsewhere. Cochrane needs to say that it is ok to spend extra time and extra money on recruiting staff and leaders more diversely. We could learn from how organisations like Google work not just go for the easy option of hiring people locally instead of internationally. We need to revamp our HR processes to recruit internationally.” (Discussion group participant)

“I am glad that Cochrane is doing this diversity and inclusion assessment and I think there should be an established Diversity Council to follow up and make sure that the recommendations are implemented. Such an entity will be able to continuously monitor achievements in terms of having a more diverse community.” (Discussion group participant)

Proactively offer opportunities to get involved

A common suggestion was to proactively engage with a wider range of people, providing direct opportunities for involvement. This may include:

- targeting and supporting people from **low and middle income countries** and people who speak a language other than English to be authors and volunteers
- **recruiting** editors/contributors/champions from wider regions and backgrounds by specifically approaching people or organisations to partner with
- offering opportunities to all who express an interest, making it easier to see how to get involved and **actively welcoming** people when they volunteer
- **revising the website** and promotional materials to be more user-friendly and contain clear information about the range of opportunities available
- creating a **register of interests** and using this to match people with available opportunities
- asking people **what they are interested** in when they register for a Cochrane account and adding this to a searchable register of interests, so colleagues from around the world are able to make contact
- asking people whether they are at beginner, intermediate or advanced level when they join, and using this to send invitations for training and networking. People could update their **profile** as they build their skills and experience
- mailing everyone with a Cochrane account to explain what **Task Exchange** is and to clarify that it is open to beginners
- considering how we recognise and **reward** people's contributions, so they know they are valued
- having **Cochrane champions** in every country to publicise evidence and proactively recruit and train volunteers

Importantly, 'involvement' did not mean simply authorship, but rather a myriad of other opportunities to be part of the Cochrane volunteer team.

"If we want to open up to people with lived experience, then we need to improve how we involve people as coproducers of research. Only 1 in 10 Cochrane reviews at maximum has consumer involvement as part of the author team. Patient volunteers are drawn from a limited part of the world i.e. English speaking high income world. Researchers and professionals are getting paid for their time by their own organisation, but consumers are not compensated."

(Discussion group participant)

"We need to encourage the engagement of our early career researchers. This is extremely important because this group will play a vital role in the delivery of healthcare in the region. More opportunities such as fellowships, leadership roles, trainings, exchange programs, will all ensure the inclusion of this group." (Discussion group participant)

"In non-profit volunteer management, there are two things that work well: (1) retain people who are already doing a good job and (2) reward people for their involvement, even if it's with something small. I'd recommend Cochrane use a contact management system to manage communications with existing contacts, which would allow them to see who is staying involved. Could also offer people who are not in academia some small financial compensation or other recognition for their time. Standards exist for this." (Survey participant)

Build a supportive collaborative community

Another high priority was helping people feel included by creating supportive, safe and collaborative environments. This included:

- providing regular online and face to face activities to help people meet others, create a **sense of community** and help people feel welcome. Some suggested regular online forums or drop in sessions
- making it an expectation that every Group runs at least **1-2 online events each year**, open to anybody, to network. These events could be repeated in different time zones. Some said that there was perceived elitism, where Cochrane teams from some countries ‘looked down’ on those from other regions. People suggested that regular opportunities to meet might help to overcome those barriers
- offering events such as the **Colloquium online**. Many people said that this was an ideal opportunity to learn more about Cochrane and feel involved, and they were disappointed with a perceived lack of large online events recently
- providing **mentoring**, peer support or buddy systems to help people learn from each other and build networks



“Some of it is basics - like making it clear what time zone a meeting is in, scheduling meetings so all time zones can participate, running meetings in a way that helps people feel comfortable about speaking no matter their experience/background. It's hard to understand why such basics are not yet common practice in an organisation like Cochrane.” (Survey participant)

“It is very difficult to establish international collaborations unless you were able to study or work abroad. We feel that authors have a bias towards our country. They do not respond to us. They think they are important and we are not worth taking the time for. There needs to be a way where we can contact people, go to meetings and get to know people.” (Discussion group participant)

“It would be good to be able to access people and talk online. I have no idea of whom I should contact to get involved. People do not respond when I email. I don't know where to start. To whom should I present myself? It would be good to have basic information. The Cochrane website ‘contact us’ does not invite involvement, just send newsletters of what other people are doing.” (Interview participant)

Build capacity in underrepresented groups

People also prioritised providing training and tools to help people build their skills, particularly underrepresented groups. This included:

- offering **free training** and opportunities to contribute so people can build their skills and confidence. Some suggested having a bookable calendar online for all workshops running, including sessions facilitated by Cochrane Groups
- recording **training about review methods in multiple languages** and placing it online
- considering using a sliding scale for **fees** to encourage students and people with limited means to take part in training
- **simplifying** the Cochrane handbook so that it is more accessible
- **translating** the Cochrane handbook

“The English language is a barrier. It is very important to create a translation of the Cochrane Handbook.” (Discussion group participant)

“More trainings are needed for researchers from our region on how to conduct robust systematic reviews. This should be tailored to both junior and senior researchers here because of the urgent need. This could be delivered in local languages and recorded to be shared.” (Discussion group participant)

“Is there a tension between diversity and quality? Resources are not distributed equally across the world. It is hard to bring people in from less well-resourced areas. There is no funding there for those groups, so do we reduce quality to include those without resources? We need to maintain our quality and reputation so have to reject reviews due to low quality. So a solution is to do capacity building in low resourced areas to improve the quality.” (Discussion group participant)

“There is plenty of information available online, but some resources are paid. We understand the need to make profit, but it is a barrier for researchers from low and middle income countries. The training courses are too expensive for researchers who need to invest from their own pockets to pay for their continuous education.” (Discussion group notes)



Consider Cochrane structures

A number of people suggested that the Cochrane Group structure and processes were barriers to inclusion. They felt that single organisations or small groups in some regions acted as gatekeepers. The suggested:

- formally **reviewing** the functionality and inclusivity of Groups
- listening to feedback from people from **particular regions** such as China, India and South America, where concerns were expressed about links between central Cochrane teams, Groups and local involvement
- investing in resources and infrastructure to support **remote work**
- considering whether it would be appropriate to **set author targets** such as requiring all reviews to have at least one author from a low or middle income country, a healthcare consumer and an early career professional to encourage Group structures to seek out more diverse participants
- considering whether Cochrane fields, geographic groups and others could have a more leading role in **creating reviews**
- considering what could be done to build **sustainability** of Group processes, given that staff in Groups change relatively frequently, which may lead to inconsistency



“Allow Fields to register titles. Fields can cover the topics that cannot be addressed by the Cochrane Review Groups. Review Groups may have little knowledge in an area, but the Field can establish Specialist Groups and have access to experts in the area.” (Discussion group notes)

“We need to think about how Cochrane is structured so that diversity is not just focused on countries. Everyone in high income countries does not have equal access, and everyone in low and middle income countries is not the same. The ‘country-level’ sometimes does not represent inclusion. For instance, to have leaders based in a rich city in a developing country only increases inequalities in science. Usually, the main stakeholders in several countries are the ones from prominent universities, big rich cities, etc. Inclusion means giving the opportunity to all who want to take part, but also increase awareness for underprivileged groups. If we set author targets or try to recruit volunteers, we need to look at those nuances.” (Survey participant)

Increase the relevance of Cochrane products

There was a push to widen the topics that Cochrane reviews focused on and the range of studies included to be more relevant to wider audiences. Suggestions included:

- involving a diverse range of people in **decision-making** to shape what Cochrane does and how it does it so that topics and dissemination routes are more widely relevant
- compiling evidence about **topics relevant** to people in a wider range of places and professions, and broadening the methods to include other relevant evidence
- reducing **newsletter content** focused on central Cochrane activities, and broadening instead to include material of interest to Groups
- including a section with the **practical implications** of evidence in every review, including implications and costs for low and middle income countries

“Priority setting is not done very well and it determines what issues get addressed. Reviews that are important are put forward but not put into action, like for malaria treatments, Chinese medicine. More representation in setting priorities is needed especially for lower income countries. Cochrane needs to think from a global view when prioritising topics.” (Discussion group notes)

“Include more themes pertinent to medium / low income countries, because many times Cochrane makes reviews on very interesting themes, but very distant from the reality of these countries.”
(Survey participant)



Link diversity and inclusion to knowledge translation

As described earlier, people defined diversity and inclusion in terms of Cochrane's reach, not solely the characteristics of team members involved. Here people thought that Cochrane could prioritise:



- making Cochrane resources more **accessible**, including a user friendly website; free access to the Cochrane Library; resources in many languages; training and manuals that are easy to use no matter how experienced people are and considering the time zones and accessibility of platforms that Cochrane uses
- translating and **disseminating** key themes from evidence more quickly
- reviewing the **terminology** used. Some suggested that Cochrane uses British or US-focused language and phrases, which are not always understandable
- revising Plain Language Summaries, social media content and similar so they are more accessible and user friendly, and considering having them drafted by laypeople
- sharing and **promoting** Cochrane evidence widely, as people felt strongly that increasing awareness of the Cochrane brand would lead to more people wanting to be involved. Some suggested collaborating with professional groups and societies in local regions to introduce professionals to Cochrane
- reviewing all materials to check their accessibility for people with **visual and hearing** impairments

“It would be good to do an audit of communications channels used to communicate with the community. There are so many websites and newsletters and not enough clarity of message or contemporary design. Less could be more, just better targeted communications that are properly evaluated e.g. use analytics to determine what groups within the community are engaged or not.” (Survey participant)

“Cochrane uses Twitter, YouTube and Google frequently. But these are blocked in some places, like mainland China, so people do not see Cochrane news, policies and training recordings quickly. The time zones are also usually focused on Europe. It is simple to use alternative platforms and repeat sessions for different time zones.” (Interview participant)

“Translating the abstracts and Plain Language Summaries to more languages is very important. Many countries do not offer a wide access to English language training so it is a real barrier to inclusion if nothing is in our language. Why will we get involved if we cannot use any of the outputs?” (Interview participant)

Draw on evidence

As an evidence-informed organisation, people said that it was important for Cochrane to build an evidence-base about diversity and inclusion. This included:

- being transparent about what Cochrane wants to achieve and how it is progressing, such as setting **targets** and monitoring diversity and inclusion each year
- developing indicators and consistently **collecting information** about the characteristics of staff, volunteers and members
- requiring Cochrane Groups to collect and report on the characteristics of people within the Groups as part of an **annual reporting** cycle
- examining **literature**, examples of good practice and gaining expert input into organisational strategies and tools to enhance diversity and inclusion
- celebrating and **sharing successes**, including potentially having awards for good practice, sessions at Colloquia specifically to discuss diversity and inclusion, and sharing information on Cochrane's website about how diverse people are involved
- considering a **newsletter** focusing on examples of diversity and inclusion in Cochrane or including good news stories and tips in existing newsletters
- **evaluating progress** formally regarding the implementation of the Diversity and Inclusion Strategy, which may include running a survey or discussion groups every 3-5 years

“Document how much less effective we are without inclusion. Show this is something we must fix. It is not a ‘nice to have’ thing. It is a systemic issue so it needs a systemic solution. We pride ourselves in being evidence-based, so we should build the business case for diversity and inclusion. We need to measure things and look at evidence of whether we are diverse – but not just tick boxes.”

(Discussion group participant)

“Creating opportunities for feedback and monitoring is important. This is the first time I engage in a conversation about diversity, so I was really excited to attend this meeting. I think integrating this type of assessment in the work of Cochrane is important because it will allow for more feedback to be collected anonymously. So anyone, at any point in time, will be able to share their insights because they know that they will be heard.” (Discussion group participant)

“Support and celebrate difference, such as showcasing stories and experiences of researchers from groups who are less represented in Cochrane. This is helpful because it encourages those researchers to be more engaged in the Cochrane community.” (Discussion group participant)



This is a long list of suggestions and Cochrane is unlikely to be able to action all of them, at least in the short to medium term. The specifics though are likely less important than the overarching themes, which were about culture change, building capability, resourcing and implementing practical changes and monitoring progress to strive for ongoing improvement.



4 Summary

This section summarises the key points to consider when planning next steps.

4.1 What is new?

Cochrane has already done work to acknowledge and explore inequity in access to evidence and participation in Cochrane activities. In 2022 a Diversity and Inclusion Strategy will formalise next steps so this remains high on our strategic agenda. It could be argued that this Listen and Learn process merely repeats what we already know: that Cochrane has more work to do to be as diverse and inclusive as it wants and needs to be. However, the Listen and Learn process has added to what we already know. It has shown that:

- There is a real **strength of feeling** amongst some in the Cochrane community about the need to increase diversity and inclusion and the benefits of doing so for the organisation. Over a short space of time, more than 1300 people wanted to share their views and engage in this process.
- In discussion groups, people often spoke passionately about wanting to be involved but feeling excluded. Some said that this was the first opportunity that they had ever had to engage with Cochrane and meet others from the community. They wanted to **continue having opportunities to shape what Cochrane does**. We have astounding human resources available to us as an organisation, if we are able to harness them.
- People said that they would like to see Cochrane **acknowledge** that, as with other organisations, Cochrane is affected by systemic biases and that there is work to do from the grassroots through to leadership level. It is important that Cochrane does not think of diversity and inclusion as a ‘problem’ to be solved, but rather as an essential component of driving continuous improvement, engagement and evidence-informed decision-making. People wanted Cochrane leadership to hear that diversity and inclusion is not about ticking boxes or assembling a proportion of people with various characteristics. It is about understanding why those differences are valuable and maximising the value. Cochrane does not need external ‘diversity specialists’ – it already has a passionate global team willing to help.
- Cochrane has a range of resources available, including free training, newsletters and opportunities to take part in activities through Crowd and Task Exchange. However, many **people did not know about existing opportunities**. Therefore one way to respond to some of the suggestions is considering how to engage people in the opportunities already available.
- Some of the barriers to inclusion involve societal and structural issues that Cochrane cannot address alone. Other barriers are within Cochrane’s control and involve **‘getting the basics right’** such as genuinely wanting to collaborate, making it easy for people to contribute, responding to people when they volunteer, and showing appreciation. Some felt that Cochrane’s structures, including the way Groups are organised and managed, was not conducive to collaboration and focused too extensively on universities. They suggested that if Cochrane is serious about diversity and inclusion, an overhaul of structures and processes may be needed, not simply ‘fiddling around at the margins’, so a multipronged strategy is required.

How could Cochrane be even more inclusive?



Some elements of becoming a more diverse and inclusive may involve ‘quick wins’ or targeted strategies, whereas others may need more fundamental changes to structures, values and ways of working. Diversity and inclusion likely needs to be linked to all elements of Cochrane’s work and values, not an ‘add on’. In order to move forward, Cochrane may need to consider what diversity and inclusion means to it as an organisation, and the extent to which this is a priority.

“A problem can’t be properly tackled if it is not admitted and clearly identified. No action plan will make a difference if Cochrane does not really believe there is a problem.”

(Discussion group participant)

“Everything we do relies on us attracting and retaining people to our network by creating a diverse, inclusive and trusting environment. Cochrane has much to be proud of, but there is also much we must change to stay relevant and useful. Everyone needs to commit to improving the culture and continuing to strive to be the best we can all be.” (Interview participant)

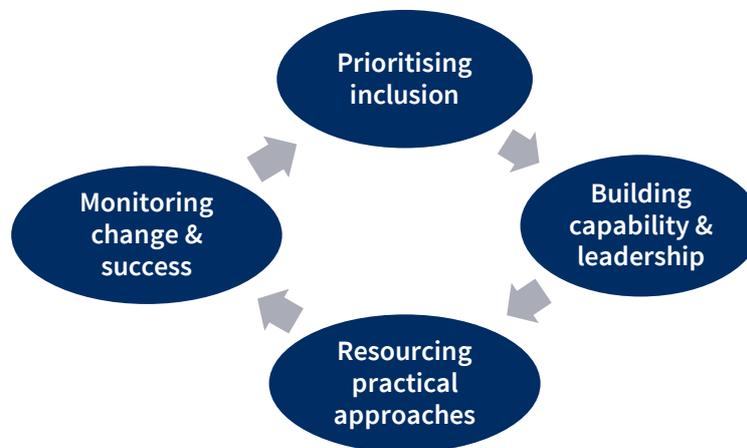
A key learning point is that people at various levels want to see Cochrane be more collaborative and inclusive, but may feel disempowered or not know how. General members of the Cochrane community who shared their views often felt strongly that Cochrane needed to concentrate more on diversity and inclusion. They sometimes had the impression that this was not important to Cochrane as an organisation or to leadership teams.

However, members of Cochrane’s Central Executive Team and paid staff working in Cochrane Groups showed that this was not necessarily the case. They frequently indicated a desire to improve diversity and inclusion, but felt that this needed structural change, prioritisation of values and resourcing at the highest level. Some said that Cochrane’s approach to diversity and inclusion so far had lacked focus and clarity. Leaders, managers, editors and coordinators faced many competing priorities. They reported a lack of follow-through from past commitments to implementation and monitoring, saying that people were not held accountable for inclusion. Amongst paid team members, there was perceived to be a lack of ringfenced staffing, time and financial resources to make the necessary changes and a perceived unfair load placed on some colleagues thought to represent ‘diverse groups’.

Another learning point is a potential difference in understanding about what it means to be ‘involved’ or included. Some members of the Central Executive Team highlighted the need to be realistic about the extent to which Cochrane could welcome new people as they assumed that this meant engaging less experienced people as review authors. However, the Listen and Learn process emphasised that when people say they want to be involved or contribute to Cochrane, this does not necessarily mean they want to author reviews. Some people want to be involved in setting priorities for review topics, others in helping to interpret findings for practical application or disseminating learning. Others may want to take part in networking events, receive newsletters and keep up to date with events and training relevant to them. They wanted to be part of a community of people interested in evidence-informed decision-making, not necessarily to be involved in creating the evidence. Based on this feedback, Cochrane’s forthcoming Diversity and Inclusion Strategy could focus on wider priorities than simply involving people as authors.

4.2 What next?

People's suggestions for next steps in the short to medium-term fell into four priority areas:



Prioritising diversity and inclusion

- Recognising that diversity and inclusion is **essential** for Cochrane to achieve its mission, and that Cochrane's continued relevance, usefulness and sustainability depends on this. This includes reframing striving for further diversity and inclusion in a positive light, as a 'must have', rather than as a 'nice to do' or as a problem to be addressed
- Recognising and explicitly **acknowledging** that Cochrane is not as diverse and inclusive as it could be and has work to do here. There are likely to be systemic institutional biases in Cochrane's systems, processes and attitudes that are barriers, as is the case in other large and international organisations. This recognition is needed at senior levels and cascaded through the organisation as a starting point for meaningful change
- Establishing a committee or **workstream** specific to building diversity and inclusion in Cochrane, potentially with subcommittees focused on gender and low and middle income countries. This should include appropriate resources allocated in line with diversity being part of Cochrane's mission
- Building diversity and inclusion into all workstreams so everything is looked at through an **inclusivity lens**, including resource allocation, content and operational priorities, staffing, training and leadership

Building capability and leadership in diversity and inclusion

- Providing diversity and inclusion **training** to all leaders and paid staff, including in Cochrane Groups, focused on understanding systemic bias and practical strategies to support inclusion
- Involving a wider range of people in making **decisions** about what Cochrane does and how. Expanding the diversity of senior leaders and paid staff may include succession pipelines and targeted mapping of potential internal and external people; having a 'high potential' leadership programme; and identifying at least 100 role models to champion
- Targeting and supporting people from **low and middle income countries** and people who speak a variety of languages to be decision-makers, authors and volunteers
- Providing a **mentoring** initiative for peer support to help a wider range of people feel included and to raise awareness of different perspectives amongst those mentoring

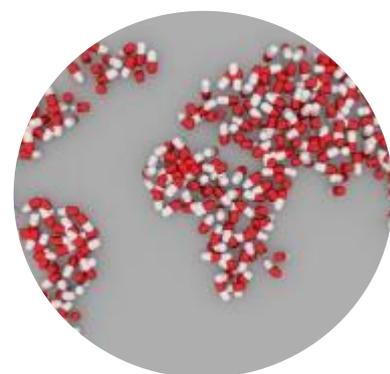
Prioritising and resourcing practical changes

- Reviewing and prioritising all of the **suggestions** community members made during this Listen and Learn process, deciding which ones will be progressed in the short and medium term, and allocating appropriate resourcing.
- Developing a **toolkit** for Groups and teams with information about expectations and goals related to inclusion, focused on ‘getting the basics right’. This includes signposting how people can get involved; responding to all people who express an interest; ongoing clear and appreciative communication; transparent criteria for selecting people to take part in opportunities; proactively seeking out different types of people to volunteer and as paid staff; regular online meetings and opportunities to participate; more focus on knowledge translation and sharing evidence widely using locally appropriate formats; and a campaign about the value of seeking out new perspectives
- Continuing to build a **supportive community** and upskill people, including online and face-to-face activities to help people meet others, create a sense of community and feel welcome; offering free training and opportunities to contribute so people can build their skills and confidence; using a registry of skills and interests to match people with opportunities; providing mentoring, peer support or buddy systems; and providing training and practical tips about inclusion and tackling institutional biases for the Governing Board and all staff
- Making Cochrane resources more **accessible**, including a user friendly website; free access to evidence; resources in many languages; training and manuals that are easy to use no matter how experienced people are; and sharing and promoting Cochrane evidence widely. People felt strongly that Cochrane should focus more on knowledge translation to build its profile globally, as they believed that increased awareness of Cochrane would increase the number and type of people wanting to engage
- Considering the **relevance** to diverse audiences of the topics of Cochrane reviews, the type of research included and the way that Cochrane shares evidence. This may include changes to how review topics are chosen or prioritised and ringfenced funding for reviews of interest to low and middle income countries or specific target audiences

Measuring and promoting diversity and inclusion

- Being transparent about what Cochrane wants to achieve with diversity and inclusion and how it is progressing, such as setting **targets**, collecting data consistently and reporting progress annually. Appendix 2 provides examples of the types of topics it may be useful to develop indicators about
- Requiring Cochrane Groups to routinely compile and report on diversity and inclusion **metrics** as part of the annual reporting cycle
- **Celebrating successes**, including showcasing stories of positive inclusion; having annual awards dedicated to examples of good practice and featuring diverse speakers and participants at events such as Colloquia

Diversity is part of Cochrane’s mission. In 2022, Cochrane will use the ideas people shared in this Listen and Learn process to prioritise what can be done straight away, what may take longer and what may not be strategically aligned at this stage. We will also continue listening, learning and testing ways to improve.





Appendix 1: Listen and Learn approach

This appendix describes how people were invited to contribute to the Listen and Learn process.

The Listen and Learn process was overseen by an Advisory Group made up of people from different countries, genders and at different stages of their careers, and supported by Cochrane's People Services team. We drew on advice from specialist diversity and inclusion advisors and coproduced the process with over 100 members of the Cochrane community and an independent organisation.

Survey in multiple languages

The Advisory Group developed survey questions with the help of diversity and inclusion advisors and an independent team. Over 50 members of the Cochrane community pilot tested this to check that the language and questions were appropriate.

We used MS Forms to host the anonymous online survey, which was available in Spanish and English. We asked Cochrane Geographic Groups to translate the survey questions into local languages. No other Group was able to do so, but this was during the COVID-19 pandemic.

We knew that surveys would not necessarily be the best way of hearing from people that feel less engaged or involved with Cochrane. However, we used this as part of our approach as it allowed us to invite a large number of people to provide anonymous feedback about the extent to which they feel included. We kept the survey open for 8 weeks, beginning in October 2021. We promoted it using:

- advertising in regular newsletters
- email to all members of the community who had opted in to receive communications
- Slack, Twitter and Facebook messages
- a pop up on the Cochrane community website
- emails to Cochrane Groups asking them to promote to their networks
- discussions at Cochrane meetings

1194 people took part in the survey. Their characteristics are described in the main body of the report.

Discussion groups

We ran 36 online discussion groups at different times of the day and evening on weekdays and weekends over a 6 week period in November/December 2021. We used various online platforms, taking into account what could be accessed in various parts of the world.

180 people took part. 10 discussion groups were facilitated by members of the Cochrane community and the rest by an independent team. The discussion groups were run in Arabic, Chinese, English, French, German, Gujrati, Italian, Japanese, Malay, Portuguese and Spanish. We set up an online booking form and invited people to take part by expressing an interest in further discussion after they had completed the survey; by sending emails to people in certain regions or with characteristics under-represented in the survey; and asking Cochrane Groups to suggest or recruit people.

We prioritised people in regions outside Europe, North America and Australasia to make sure we heard from people who may feel less involved than they wanted. We did not exclude people from these regions and some did take part. We simply opened invitations to other regions first.

We included 3 discussion groups specifically for members of the Central Executive Team and 4 for early career professionals. We asked Cochrane Groups to facilitate a session for people they worked with, including in local languages. Two groups did this and a third attempted to do so but was not able to recruit participants in the time period.

We considered emailing people from the Cochrane database who had not been active recently to invite them to complete the survey or take part in a discussion group or interview, but this was not possible.

The main aim of the discussion groups was to explore what helps and hinders people from feeling a part of Cochrane and their suggestions for next steps. The main topics we covered were:

- How do people define and think about diversity and inclusion?
- Do people feel as included as they want in Cochrane's work? And if not, what are the barriers?
- What do people think Cochrane is doing well and less well in terms of diversity and inclusion?
- What practical things should Cochrane prioritise to work on or change first?

We used a template with structured questions to take notes so that there was some consistency between discussion groups, but the groups adapted to discuss issues that were most important to the participants. The feedback was treated in confidence and anonymised notes were taken by facilitators.

We also encouraged members of the Advisory Group to engage in discussions at Cochrane meetings they were taking part in over an 8 week period, such as with the Senior Executive Team, Cochrane Council, Equity Methods Group, Early Professionals Group and Consumer Network. This was primarily about promoting the Listen and Learn activities, but we encouraged the Advisory Group to feed in any reflections from their discussions.

Interviews

In November/December 2021, we had telephone conversations with 39 people who expressed an interest but were unable to take part in discussion groups, either because they were not comfortable contributing in those languages, did not have good internet access, preferred not to speak in a group or were not available at the discussion group times. These people were recommended by Cochrane Groups or by people who took part in discussion groups, or they expressed an interest by email or on a booking form.

Compiling themes

All of the information we collected during discussion groups and in the survey was anonymised, including quotes used for illustration in the report.

In December 2021, we sent a 2-page summary of emerging trends to everyone who had taken part in discussion groups or interviews and everyone who facilitated discussion groups. 104 people said they would like to help review the findings. We held 9 meetings in January 2022 where these people reviewed the themes and helped to construct this report. We used a constant comparative method to identify themes based on a grounded theory approach, rather than using a pre-defined theoretical framework.

Appendix 2: Monitoring diversity

Monitoring diversity is essential to review our progress. This appendix contains people's suggestions about what Cochrane should monitor.

People taking part in the Listen and Learn process felt that Cochrane should set diversity targets and monitor performance over time, as they felt that things that are measured are prioritised. They also said that as Cochrane is an evidence-based organisation, it is important to have data to inform decisions, though this should not be only a 'tick box exercise'.

The aim of this appendix is not to develop specific metrics, but to show the types of characteristics that were most important to community members and which may form part of a dashboard that the Governing Board and senior leadership could review and publish annually, as part of the annual report.



Participants suggested Cochrane could consider the following in tracking diversity:

- collecting information about the characteristics of people registering for Cochrane accounts (people using Cochrane evidence and contributing to Cochrane)
- setting targets for the proportion of leaders, paid staff and authors with specific characteristics
- setting organisational targets
- using a dashboard to report on progress across any priorities agreed as part of Cochrane's forthcoming Diversity and Inclusion Strategy

Characteristics of people with Cochrane accounts

Cochrane asks people to provide some information when they register for Cochrane accounts, but this has not been consistent over time. It would be possible to update the characteristics that people are asked about routinely, and to invite everyone to update their account profiles.

In the survey, people gave 1482 suggestions about the personal characteristics that Cochrane could seek information about:

- Country / region (sometimes stated as ethnicity) (44% of people who made a suggestion)
- Age categories or stage of career (44%)
- Experience / expertise / education (31%)
- Professional role or work environment (30%)
- Gender (26%)
- Interests / topic areas / what they are interested in doing with Cochrane (20%)
- Languages spoken (15%)
- Disabilities or conditions if adaptations may be needed e.g. visual impairment (8%)
- Whether socially or financially less advantaged (8%)

A small proportion of people suggested other characteristics such as caregiver status (4%), religion/belief (4%), access to IT resources (3%) or sexual orientation (3%).

These suggestions were a mix of asking for information that may help Cochrane proactively approach people to participate (professional role, type of involvement desired) and characteristics to help monitor whether a broad range of people are maintaining membership (country, age, gender, languages and disabilities).



Characteristics of Cochrane leaders and staff

In coproduction sessions, we discussed potential metrics related to the characteristics of senior leaders, paid staff and those with other Cochrane roles. An example would be to examine the proportion of people in different roles who are women or non-binary gender, from low and middle income countries, with a main language other than English or early in their careers.

	% Low and middle income countries	% Women, non-binary or self-described gender	% Early career professional (potentially defined by age)	% Main language other than English
Governing Body				
Senior Management Team				
Paid members of Cochrane (in Groups or Central Executive Team)				
Members				
Authors				
First and last authors				
Reviews published with an author from target group				
Editors				

Examples of organisational targets

At coproduction sessions, people also suggested organisational targets that could be monitored annually, including:

- % of total Cochrane funding allocated to low and middle income countries
- % of Cochrane (Review) Groups based in low and middle income countries
- Wage equity amongst paid members of staff, including gender comparisons
- % of paid staff and leadership who have taken part in diversity and inclusion training within the past 3 years

Coproducers also thought that it would be valuable to review the components of diversity set out in Box 1 of the main text of this report and develop indicators for those decided to be priorities for Cochrane.

Example of dashboard

People who took part in coproduction sessions were eager to see Cochrane report annually against a formal Diversity and Inclusion dashboard. Some of the indicators may apply to the organisation as a whole and others could be developed specific to Cochrane Groups. Group collaboration agreements, induction and guidance may need to include clearer instructions about reporting requirements, including what to collect information about and when.

The dashboard structure would depend on what is prioritised in the forthcoming Diversity and Inclusion Strategy, but examples of potential activities and indicators are below.

	Aim 1: Prioritising diversity and inclusion	Aim 2: Building capability, capacity and leadership	Aim 3: Resourcing and implementing practical change	Aim 4: Monitoring progress and celebrating successes
Examples of activities	<ul style="list-style-type: none"> Put governance and accountability processes in place Develop Strategy Internal campaign to raise awareness and build support for culture change 	<ul style="list-style-type: none"> Training for leaders and staff Recruit staff and leaders from diverse backgrounds 	<ul style="list-style-type: none"> Toolkit and guidance for teams and Groups Revise website and communications to streamline and be more accessible Review awards and recognition to ensure inclusive 	<ul style="list-style-type: none"> Improve management information to track progress Build into annual reporting of Groups and organisation Benchmark performance with other organisations
Examples of performance indicators	<ul style="list-style-type: none"> Diversity and inclusion stated as priority on website and in all relevant documents Strategy developed and adequately resourced 	<ul style="list-style-type: none"> % of leaders and staff completed training within 3 years % surveyed think Cochrane leadership is diverse % surveyed think Cochrane is inclusive 	<ul style="list-style-type: none"> Number of networking opportunities run by Groups Number and type of new volunteers each year 	<ul style="list-style-type: none"> % of members and staff from target groups % visiting website from low and middle income countries % accessing resources in language other than English

