

Global Evidence Summit
Using evidence. Improving lives.
12-16 Sept 17 | Cape Town South Africa

First-ever Global Evidence Summit to be held in Cape Town

Cochrane, together with four other leading organisations in the production and dissemination of evidence for decision-making in the global health, social and economic policy and practice sectors — the Guidelines International Network, the Campbell Collaboration, the International Society for Evidence-based Health Care, and the Joanna Briggs Institute — will join forces to hold the first Global Evidence Summit (GES) in Cape Town, South Africa from 12 – 16 September 2017.

The theme of the summit, ‘Using evidence. Improving lives’ will highlight and promote evidence-informed approaches to health policy and development, offering the most cost-effective interventions.

The summit will specifically focus on the opportunities and challenges facing low and middle-income countries. The event is expected to attract up to 2000 delegates and will bring together the evidence community to promote evidence-informed decision-making worldwide.

“This is a hugely exciting opportunity for the global evidence world. It is the first global meeting of its kind which will highlight how using evidence and information helps people make better decisions to improve lives, as well as enhance capacity development and future research in the fields of health and social development,” said Prof. Jimmy Volmink, Founding Director of Cochrane South Africa, the host organisation.

“This global event will show how the best-available evidence, clinical judgment and patient preferences are important components of healthcare decision-making,” he added.

“We hope the Global Evidence Summit will be a watershed moment in the appreciation of how evidence-informed policy and practice can improve health and development outcomes in both developed and low- and middle-income countries,” said Cochrane CEO, Mark Wilson. “The Summit will be a high-quality scientific conference; but we also intend that it will bring together international healthcare and development leaders with many of the world’s experts in the production and use of high-quality evidence across many disciplines. By expanding these relationships we will ensure that Cochrane learns more about the needs of policy-makers and practitioners, and can provide them in future with even more high-quality, accessible and useful evidence products and services that change lives for the better.”

Registration will open in late 2016 and more detail on important dates and the scientific programme will be announced soon.

Contents

| | |
|----|---|
| 02 | From the Cochrane Library – Consumer summaries |
| 03 | Technical summary — Interactive telemedicine: Effects on professional practice and healthcare outcomes |
| 04 | The experience of moving from doing an ‘empty review’ to a pioneer trial |
| 05 | Neglected tropical diseases get prime time in Systematic Reviews Primer in Accra, Ghana |
| 05 | South-South Collaboration: Africa Centre for Systematic Reviews at Makerere University co-hosts Cochrane GRADE Workshop |
| 06 | Targeting future journalists |
| 07 | Update on PACTR |
| 07 | Successful SAGE Summit |
| 08 | Announcements |



Find out more at www.globalevidencesummit.org
Twitter: @GESummit
Facebook: [facebook.com/globalevidencesummit/](https://www.facebook.com/globalevidencesummit/)

Consumer summaries of evidence

Subsidising artemisinin-based combination therapy in drug shops and pharmacies

The authors conducted a review of the effect of subsidising artemisinin-based combination therapy (ACT) drugs for malaria. They searched for all relevant studies up to February 2015 and identified four. The findings are summarised below.

Background

Malaria causes ill health and death in Africa, particularly in children under five years of age and poor rural populations. The World Health Organization recommends that people use ACT to treat malaria. ACT drugs are available at shops and pharmacies, but these drugs are expensive and people often choose cheaper, older, less-effective drugs instead. The Global Fund and other international organisations have therefore decided to subsidise the cost of ACT drugs so that people can buy them from shops and pharmacies at prices similar to, or lower than, those of the older, less-effective drugs.

What is the effect of delivery programmes that subsidise ACT prices?

Four studies were included. One study looked at the effect of subsidising ACT drugs for children under five years of age and three studies looked at subsidising ACT drugs for people of all ages. All studies were from rural districts in East Africa (Kenya, Uganda and Tanzania). ACT price subsidies were accompanied with activities (such as staff training at shops and pharmacies, community awareness and mass media campaigns) to promote appropriate use of antimalarial drugs in all except one study. In all four studies, the effect of subsidising the drugs was compared to not subsidising the drugs. Price subsidies ranged from 80% to 95% of the actual price and vouchers to households were used in one study.



The findings indicate that ACT subsidy programmes:

- (i) led to a substantial increase in the number of children under five years of age who used ACTs when they had a fever (high-certainty evidence);
- (ii) led to a substantial increase in the number of shops that stocked ACTs for children under five years of age (high-certainty evidence); the authors could not draw any conclusion on the effect on the number of shops that stocked ACTs for patients of any age because the quality of evidence was very low;
- (iii) led to a substantial decrease in the price of ACTs for children under five years of age (high-certainty evidence);
- (iv) led to a substantial increase in the market share of ACTs for children under five years of age (high-certainty evidence); and,
- (v) led to a decrease in the use of older, less-effective antimalarials among children under five years of age (high-certainty evidence).

None of the studies measured whether the subsidy programmes led to any harmful effects (such as the inappropriate use of ACTs, in other words, people who receive ACTs but do not actually have malaria). The review findings also showed that subsidising ACT prices using vouchers lead to an increase in the likelihood that an illness was treated with an ACT among people seeking treatment for fever or suspected malaria. However, vouchers also lead to an increase in inappropriate use of ACTs (high-certainty evidence).

Citation: Opiyo N, Yamey G, Garner P. Subsidising artemisinin-based combination therapy in the private retail sector. *Cochrane Database of Systematic Reviews* 2016, Issue 3. Art. No.: CD009926. DOI: 10.1002/14651858.CD009926.pub2.

Iron supplements for children living in malaria-endemic countries

Why the review is important

Children living in malarial areas commonly develop anaemia. Long-term anaemia is thought to delay a child's development and make children more likely to get infections. In areas where anaemia is common, health providers may give iron to prevent anaemia, but there is a concern amongst researchers that this may increase the risk of malaria. It is thought that the iron tablets will increase iron levels in the blood, and this will promote the growth of the *Plasmodium* parasite that causes malaria. The review authors aimed to assess the effects of oral iron supplementation in children living in countries where malaria is common.

Main findings of the review

The researchers searched the available evidence up to 30 August 2015 and included 35 trials (31 955 children). Iron did not increase the risk of malaria, indicated by fever and the presence of parasites in the blood (high-quality evidence). There was no increased risk of death among children treated with iron, although the quality of the evidence for this was low. Among children treated with iron, there was no increased risk of severe malaria (high-quality evidence). Although it is hypothesised that iron supplementation

might harm children who do not have anaemia living in malarial areas, there is probably no increased risk for malaria in these children (moderate-quality evidence). In areas where health services are sufficient to help prevent and treat malaria, giving iron supplements (with or without folic acid) may reduce clinical malaria. In areas where these services are not available, iron supplementation (with or without folic acid) may increase the number of children with clinical malaria (low-quality evidence). Overall, iron resulted in fewer anaemic children at follow up, and the end average change in haemoglobin from base line was higher with iron.

Conclusions

The authors concluded that iron supplementation does not adversely affect children living in malaria-endemic areas. Based on the review, routine iron supplementation should not be withheld from children living in countries where malaria is prevalent and malaria management services are available.

Citation: Neuberger A, Okebe J, Yahav D, Paul M. Oral iron supplements for children in malaria-endemic areas. *Cochrane Database of Systematic Reviews* 2016, Issue 2. Art. No.: CD006589. DOI: 10.1002/14651858.CD006589.pub4.

Interactive telemedicine: effects on professional practice and healthcare outcomes — a review update

Background

Telemedicine (TM) refers to the application of any telecommunication technology to provide healthcare at a distance. There are three categories into which these technologies are divided: (i) *remote monitoring*, for example a call centre with automated voice response software to guide patients; (ii) *store and forward applications*, such as the transmission of digital images to a clinician who is remote from the patient; and, (iii) *interactive applications*, for instance patient/healthcare professional communication, with the patient being at home and the clinician at a telemedicine centre. This review, updating one originally published in 2000, assessed the effects, costs and acceptability of interactive TM used by healthcare professionals and patients within an episode of care. The intervention was assessed as an alternative to, or in addition to, usual care, being face-to-face care or telephone consultation.

Methods

The search comprised accessing the Cochrane Effective Practice and Organisation of Care (EPOC) Group's specialised register, CENTRAL, MEDLINE, EMBASE, five other databases and two trials registers until June 2013, together with reference checking, citation searching, hand searching and contacting authors to identify additional studies. Only randomised controlled trials (RCTs) were included. Interventions comprising only of telephone or automatic self-management technologies were excluded. The clinical conditions for which the interventions were used, ranged from cardiovascular disease and diabetes to mental health and substance-abuse conditions. Outcome data for each condition that were sufficiently homogenous, were pooled, using fixed effect meta-analysis, with risk ratios (RR) and 95% confidence intervals (CI) for dichotomous outcomes, and mean differences (MD) for continuous outcomes. A sub-group analysis of grouped conditions was also conducted. Narrative summaries were provided when pooling was not possible.

Results

A total of 93 RCTs with 22 047 participants, were included with 50 conducted in the USA, 35 in Europe, two in Canada, Hong Kong and South Korea respectively, and one in Israel and China respectively. Sixty three additional trials were found and are awaiting classification. The TM, being remote monitoring in 55 studies and real-time video-conferencing in 38 studies, was used for (i) monitoring a chronic condition (41 studies); (ii) providing treatment or rehabilitation (12 studies); (iii) patient education and self-management (23 studies); (iv) specialist consultations; (eight studies); (v) assessment of clinical status (eight studies); and, (vi) screening (one study).

The technologies included, amongst others: various transmitting devices, fixed or mobile, used by patients to send their health information to either an automated or clinician-response service; self-management programmes on the Internet; and video consultations using a webcam and online virtual meeting programme.

No difference was found between groups on all-cause mortality for heart failure patients (RR 0.89, 95% CI 0.76 to 1.03; $I^2 = 44\%$; moderate to high certainty of evidence) at a median of six months follow-up. Admissions to hospital ranged from a decrease of 64% to an increase of 60% at median eight months follow-up (moderate certainty of evidence). No meta-analysis was conducted for this outcome because of high statistical heterogeneity across the studies. Some improvements in quality of life were observed (MD -4.39, 95% CI -7.94 to -0.83; $I^2 = 0\%$; moderate certainty of evidence) at a median three months follow-up. For diabetes, lower glycated haemoglobin (HbA1c %) levels were observed (MD -0.31, 95% CI -0.37 to -0.24; $I^2 = 42\%$; high certainty of evidence) at a median of nine months follow-up. A decrease in low-density lipoprotein cholesterol (MD -12.45, 95% CI -14.23 to -10.68; $I^2 = 0\%$; moderate certainty of evidence), and blood pressure (MD SBP -4.33, 95% CI -5.30 to -3.35; $I^2 = 17\%$; DBP -2.75 95% CI -3.28 to -2.22; $I^2 = 45\%$; moderate certainty evidence). No differences in the effect for video-conferencing therapy compared to face-to-face delivery were found for various mental health and substance-use problems. Findings from the other included studies varied, some showed evidence of improved blood pressure control in hypertension patients and improvements in patients with a respiratory condition, and one reported no difference in specialist consultation for a dermatological condition. Due to limited data, no findings were reported on patients' and healthcare professionals' acceptance of TM, neither on its costs.

Implications for practice

TM can be effective to improve the frequency, timeliness and access to healthcare to patients at a distance. Its effectiveness is confounded by the severity of the illness, study population, and what it is used for. It is also likely that the health system in which it is embedded, and the clinicians using it, also impact on its effectiveness. It is advisable to provide adequate training, and to assess potential barriers, prior to the implementation of a TM service. Though cost savings related to travel were reported, it is unclear how TM impacts on other healthcare costs to patients and hospital admissions. It is highly likely that TM systems will exponentially grow and change in response to the ever-increasing use and ownership of newer mobile technologies and applications.



Implications for research

Despite the challenge to keep research up to date with the latest developments in TM technologies, evident in the 63 studies awaiting classification, there are an encouraging number of RCTs conducted in this field. However, larger studies are needed that: (i) use standardised outcome measures; (ii) recruit well-defined clinically homogenous populations; and, (iii) offer specific guidance for health practitioners and decision-makers. The paucity of evidence on costs and user acceptance should be addressed in future research.

Reflections on the local context

Although telemedicine is reported to be effective for some settings and conditions, the lack of rigorously evaluated African studies,¹ and poor costing data make the application of these findings for the local context challenging. This may, in part, explain why telemedicine in our region has not yet attracted the political will to unlock its potential to improve healthcare in resource-constrained settings.²

The author

Gerd Flodgren is involved with evidence synthesis at the Welfare section of the Norwegian Knowledge Centre of the National Institute of Public Health, Norway.

Citation: Flodgren G, Rachas A, Farmer AJ, Inzitari M, Shepperd S. Interactive telemedicine: effects on professional practice and health care outcomes. *Cochrane Database of Systematic Reviews* 2015, Issue 9. Art. No.: CD002098. DOI: 10.1002/14651858.CD002098.pub2.

References

1. World Health Organization, and WHO Telemedicine. Opportunities and developments in Member States. Reports on the Second Global Survey on eHealth 2009. *Global Observatory for eHealth Series* 2010 (2).
2. Wamala DS, Augustine K. A meta-analysis of telemedicine success in Africa. *J Pathol Inform* 2013;4:6.

Willem Odendaal

*Health Systems Research Unit
South African Medical Research Council*

The experience of moving from doing an ‘empty review’ to a pioneer trial

In 2005, I was invited to attend the first Reviews for Africa Programme at Cochrane South Africa. One had to prepare a topic related to HIV/AIDS beforehand. There was no shortage of questions around ocular HIV-related conditions. One, in particular, bothered me a lot. We saw far too many tumours of the conjunctiva, the thin membrane that covers the white of the eye. Working in the national referral hospital also meant that we received the worst of them; late and large. Surgical excision was the mainstay of treatment but recurrence was an issue. Large tumours needed radical surgery such as enucleation (removal of the eyeball) or exenteration that involves removing the eye and all the orbital contents — the outcome is usually unsightly. I didn't enjoy doing this operation. I went into ophthalmology to save eyes and restore vision. Here, we were losing.

I found no randomised controlled trials in people living with HIV. We were treating a serious disease based on case reports and case series, the lowest level of evidence in the evidence hierarchy. It was difficult to draw conclusions from these reports. Doses varied widely, inclusion criteria varied, there were no comparison groups so bias could not be ruled out. I was disheartened to write an ‘empty review’ but was encouraged by Jimmy Volmink and others that this was a significant finding in that we had identified a knowledge gap.

After the review was published in 2007, I started thinking about doing a trial in Africa. In 2011 I received funding from the British Council for Prevention of Blindness through the Sir John Wilson Fellowship. This would allow me to do a PhD at the London School of Hygiene and Tropical Medicine and conduct a series of integrated studies on ocular surface squamous neoplasia (OSSN) in Kenya. We set off in earnest working in four eye-care centres in different regions of Kenya. The enthusiasm of clinicians in my country and study participants was a great boost. Everyone who heard about this project couldn't wait for the results. It touched on something that clearly concerned them. Most textbooks we read referred to this as a rare disease of elderly men but in Africa it was different. We had the highest incidence in the world. Over

two thirds (67%) of affected patients were women, young (mean age 41 years) and 74% were living with HIV. OSSN is an orphan disease that hardly received attention from both HIV programmes and eye care programmes. As it usually only affects one eye it is not an important cause of blindness. HIV health worker training programmes hardly mentioned OSSN.

The PhD project consisted of a series of six integrated studies on the epidemiology and management of OSSN. We conducted a systematic review of the epidemiology of OSSN in Africa and in 2013 updated the 2007 Cochrane Review where we found one cross-over trial of mitomycin C (MMC) but it enrolled elderly males who were probably uninfected with HIV. We conducted a randomised placebo-controlled trial of 5-Fluorouracil (5FU) chemotherapy eye drops given after surgery to investigate if this could reduce the recurrence of the lesions. The trial results were astounding. Post-operative topical 5FU substantially reduced recurrence of OSSN and was well-tolerated. Treatment with 5FU was associated with fewer OSSN recurrences (10.6% vs. 36.2%) than placebo (odds ratio 0.21; 95% CI 0.07-0.63, p=0.01).

The results were recently published in *The Lancet Global Health* (Gichuhi S, Macharia E, Kabiru J, *et al.* Topical fluorouracil after surgery for ocular surface squamous neoplasia in Kenya: a randomised, double-blind, placebo-controlled trial. *The Lancet Global Health*; **4**(6): e378-e385.). <http://www.thelancet.com/journals/langlo/article/PIIS2214-109X%2816%2930052-3/fulltext>

A commentary recognised that our research filled an important knowledge gap in the management of this disease.

Stephen Gichuhi

*Department of Ophthalmology
University of Nairobi*

Neglected tropical diseases get prime time in Systematic Reviews Primer in Accra, Ghana

The Noguchi Memorial Institute for Medical Research at the University of Ghana was the location for a 'Primer in Systematic Reviews' held from 9 to 12 May 2016. The course facilitators were Prof. Paul Garner and Dr Rachel Isba from the Liverpool School of Tropical Medicine, and Prof. Charles Wiysonge from Stellenbosch University and Cochrane South Africa. The aim of the course was to help participants understand, appraise and use systematic reviews specifically in the field of neglected tropical diseases.

It is now well established that well-conducted and up-to-date systematic reviews provide the best evidence to answer healthcare questions. Cochrane led the way in systematic reviews in tropical medicine, and there is now overwhelming empirical evidence that Cochrane Reviews are generally higher quality than some other systematic reviews. In the recent past systematic reviews in tropical diseases such as albendazole for filariasis and community deworming programmes have generated a lot of debate. There is a need for researchers to know how to identify, read, appraise and interpret systematic reviews; thus the need for this course. By the end of the course, participants were expected to be able to: (1) outline the rationale for, and the components of, systematic reviews; (2) conduct effective searches for systematic reviews; (3) critically appraise systematic reviews, including statistical interpretation of meta-analysis; (4) interpret a GRADE profile and how it can be used in guideline development; and, (5) consider health systems research questions in neglected tropical diseases, and how systematic reviews fit in.

The course brought together 24 healthcare professionals, researchers in applied tropical diseases, technical advisors to policymakers in neglected tropical diseases, and healthcare managers involved in neglected tropical disease programme design and delivery. This was a hands-on course, consisting of interactive seminars and group work sessions. A time for reflection



Primer participants in Ghana

was included at the start and end of each day; to assist participants in clarifying objectives, to find out whether set objectives were met, and to give participants time for feedback and questions.

The course was well-received by participants. "I am very grateful for this opportunity and cannot wait to implement knowledge into action," said one.

"The workshop was well facilitated and well organised," added another.

A large amount of preparation was required in advance of the course and on a daily basis. It will be important to maintain this approach when future Primer courses are delivered in Ghana or other African countries.

Charles Shey Wiysonge

Cochrane SA

South-South Collaboration: Africa Centre for Systematic Reviews at Makerere University co-hosts Cochrane GRADE Workshop

Kampala, the city of seven hills, is the capital of the 'Pearl of Africa' as Sir Winston Churchill observed during his Ugandan exploration. It is here that Makerere University, once known as the 'Harvard of Africa', hosts the Africa Centre for Systematic Reviews and Knowledge Translation. Together with colleagues from Cochrane South Africa, we held the first GRADE workshop in Uganda, three years after the founding of the Africa Centre. Our core mandate is to strengthen capacity for evidence synthesis and use, largely in the East African community through innovation, collaboration and open access.



Course participants at the training venue

The plot to co-host this event was hatched over the Africa team dinner during the 22nd Cochrane Colloquium in Vienna, Austria in October 2015. The group was receptive to the idea, which was actualised from 18 to 22 January 2016. The thirst for skills in evidence synthesis among African scientists is palpable and the applications were so overwhelming that it was necessary to have a bigger class than originally planned.

The 19 participants were from multidisciplinary backgrounds and from five countries — Botswana, Ghana, Tanzania, Kenya and mostly Uganda; and eight research institutions including the Kenya Medical Research Institute, Komfo Anokye Teaching Hospital, Ifakara Health Institute, the Tanzania Ministry of Health, and the universities of Dodoma, Botswana, Gulu and Makerere.

In this two-part course, the first two days were dedicated to the GRADE approach and the last three days focused on hands-on work to complete ongoing systematic reviews in group-work fashion.

Participants were also treated to an African cultural evening at the Ndere Centre in Kampala (<http://ndere.com/centre/>). From the feedback received most participants perceived the sessions as very useful with a great deal of learning.

This GRADE workshop was supported by Cochrane South Africa, South African Medical Research Council, through the Effective Health Care Research Consortium (<http://www.evidence4health.org/>). This Consortium is funded by aid from the UK government for the benefit of developing countries. We acknowledge the funding support from Dr Marie-Gloriose Ingabire of the Canadian International Development Research Centre, Ottawa.

Ekwaro A. Obuko

African Centre for Systematic Reviews and Knowledge Translation, College of Health Sciences, Makerere University

Targeting future journalists

Part of the mission of Cochrane South Africa (SA) is the dissemination of information on Cochrane and evidence-based healthcare (EBHC) to health stakeholders and the South African public. An obvious channel for such dissemination is the media. Cochrane SA decided to commence work at a basic level by targeting journalism students who are potential future health and science writers, and to introduce them to the concepts of EBHC and systematic reviews, the Cochrane Library and other useful resources for developing future media products.

“Opens our eyes to the scientific world and how science contributes to journalism, and how journalists can apply science.” - Student 1

The first two workshops were held in March and April at the Faculty of Journalism, Stellenbosch University and included 26 Journalism Honours students.

After a process of contacting all the communication, journalism and media studies departments at universities and colleges, Stellenbosch University indicated an immediate interest in organising a workshop for their Journalism Honours students and it was decided to use this opportunity to pilot the concept and materials.

Two two-hour sessions were organised with a month's gap in between allowing students to complete a homework assignment.

The topics covered included:

- introduction to EBHC;
- introduction to systematic reviews;
- introduction to Cochrane; and,
- using the Cochrane Library.

These were approached using a variety of learning techniques including interactive lectures; videos; case scenarios and exercises; practical demonstrations; and, small group work.

“I liked being exposed to science-based research and seeing people who are clearly passionate about this.” - Student 2

In the first session the students were introduced to a case scenario, shown how to find information on the review in the Cochrane Library and asked to discuss in groups how they would use this information for print media, TV, radio and twitter.

At the end of the first session they were given six review topics and asked to prepare as feedback for the class the steps they took to find the relevant evidence from the Cochrane Library, what the overall findings reported, their analysis of the evidence and their plan for how they would use this in a story. At the second session volunteers presented their work for discussion.

Future plans

Stellenbosch University indicated a desire for an annual workshop for Honours students and potentially a further workshop for Masters students.

“The research skills I learnt will be very beneficial to my work as a journalist.”

- Student 3

Now that the process has been piloted and evaluated it will be further refined. Further negotiations are also being undertaken with other higher-education institutions in South Africa regarding offering them similar workshops.

Michelle Galloway

Cochrane SA



Getting to grips with systematic reviews and working on potential stories

Update on the Pan African Clinical Trials Registry (PACTR)

PACTR is becoming the registry of choice for African trials with the database growing exponentially — 46% of the total applications were received in 2015 – 2016 .

On 8 June the number of registered trials reached 722. There are 552 single-centre studies in 32 countries and 170 multi-centre studies with 890 trial sites in 32 countries.

Five of the multi-national studies have sites in India, France, Belgium and Switzerland and the USA. Of the 750 principal investigators (PIs) listed for the 722 trials, 13 trials list multiple PIs and 660 PIs are from African countries. See Figure 1 for the numbers of trials per country.

PACTR ensures that African trial research is represented as comprehensively as possible in the global landscape through the WHO's central repository, the International Clinical Trials Registry Platform.

Elizabeth Pienaar

PACTR Project Manager

www.pactr.org

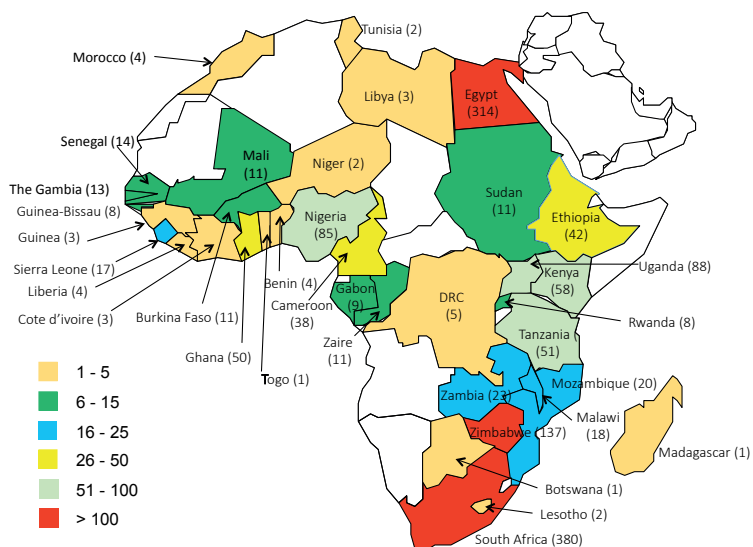


Figure 1: Number of trials per country in Africa

Successful SAGE Summit

In February over 60 local and international participants from sectors spanning the government, researchers, medical aids and private healthcare gathered for the SAGE Guidelines Summit. The event was opened by Dr Shaidah Asmall, representing the National Department of Health, Primary Health Care Directorate. The summit provided a platform to discuss the development and implementation of guidelines in South Africa via multi-sectoral panels that shared experiences and best practices in our setting.

The keynote speaker was Prof. Holger J. Schünemann, chair of the Department of Clinical Epidemiology and Biostatistics at McMaster University and recently appointed Director of Cochrane Canada. A plenary talk was also given by Dr Patrick Okwen of the Guidelines International Network (G-I-N) Africa Community (<http://www.g-i-n.net/>).

The summit was preceded by a GRADE Workshop presented by Schünemann, co-facilitated by Dr Nandi Siegfried and Dr Tamara Kredon.

The valuable discussions gave a clear impetus for conceptualising a national co-ordinating unit for guidelines development along the lines of the National Institute for Health and Care Excellence (NICE) in the UK.

Detailed reports on the summit and workshop can be found at: <http://www.mrc.ac.za/cochrane/sage.htm>

The SAGE Project is funded by the South African Medical Research Council in terms of the SAMRC's Flagships Awards Project SAMRC-RFA-IFSP-01-2013/ SAGE.



The summit participants at the SAMRC, February 2016

Cochrane Nutrition Field established

Cochrane South Africa (SA) is delighted to announce that a Cochrane Nutrition Field (CNF) has been established under the leadership of Cochrane SA, South African Medical Research Council and the Centre for Evidence-based Health Care (CEBHC), Stellenbosch University, along with international partners. Solange Durão of Cochrane SA and Celeste Naude of the CEBHC will be the Field's co-Directors, with guidance from an international advisory board comprising representatives from multiple stakeholder and partner groups.

The vision of the CNF is that Cochrane will be the independent, globally recognised go-to place for nutrition systematic reviews. The CNF will support and enable evidence-informed decision-making for nutrition policy and practice by advancing the production and use of high-quality, globally relevant nutrition-related Cochrane Reviews.



Cochrane Nutrition Field Directors Celeste Naude (r) and Solange Durão (l)

The CNF will focus on increasing the coverage, quality and relevance of Cochrane nutrition reviews, the impact of these reviews through knowledge translation activities, and on strengthening methods for conducting nutrition-related systematic reviews.



More details will follow in the next issue of the newsletter.

Contact us

Cochrane South Africa

PO Box 19070, Tygerberg 7505, Francie van Zijl Drive, Parow Valley

Tel: +27 21 938 0438 | Fax: +27 21 938 0836

email: cochrane@mrc.ac.za | <http://southafrica.cochrane.org/>

<http://www.mrc.ac.za/cochrane> | Twitter: @SACochrane



Cochrane South Africa is an intramural research unit of the South African Medical Research Council

Conferences

Public Health Association of South Africa

19 – 22 September 2016

East London, South Africa

<http://www.phasaconference.org.za/>



13th G-I-N Conference

27 – 30 September 2016

Philadelphia, USA

<http://www.g-i-n.net/conference/13th-conference>



BETTER EVIDENCE. BETTER OUTCOMES.
YEARS 1996-2016

Joanna Briggs Institute 20th Anniversary Better evidence. Better outcomes.

9 – 11 November 2016

Adelaide, Australia

<http://anniversary.joannabriggs.org/>



Evidence 2016 — Africa Evidence Network

20 – 22 September 2016

Pretoria, South Africa

<http://www.evidenceconference.org.za/Home/>



Cochrane Colloquium 2016

23 – 27 October 2016

Seoul, South Korea

<https://colloquium.cochrane.org/>



5th International Society for Evidence-based Health Care Conference Best evidence and healthcare decisions: Connecting the dots

7 – 9 December 2016

Kish Island, Iran

<http://isehc2016.com/en/>



8th EDCTP Forum

6 – 9 November 2016

Lusaka, Zambia

<http://www.edctpforum.org/2016/>



Global Evidence Summit 2017: Using evidence. Improving lives.

12 – 16 September 2017

Cape Town, South Africa

<http://www.globalevidencesummit.org/>

The What Works Global Summit 2016

Putting Evidence to Work

26 – 28 September, 2016

London, UK

<https://www.wwgs2016.org/>