

## Sharing and networking more important than ever in the post-truth world

### Global Evidence Summit plenaries highlight the need for more co-ordination and communication

If there were overall messages from the five plenaries of the Global Evidence Summit held in Cape Town from 13 to 16 September they would be about the urgent need for data sharing; the importance of integrating tools, methodologies, experience and knowledge across sectors and networks particularly in situations of humanitarian crisis; and, the vital need to communicate better and quicker with all stakeholders including the public especially in the post-truth world.

As Trevor Manuel, former South African Finance Minister and speaker in plenary 1, put it succinctly: “We are at a difficult point in world history ... The detail of evidence-based healthcare cannot be divorced from social development policy and general policy more broadly and the great leadership challenges the world faces ... There is a need for active citizenry.”

“We need to advance the methodology and place of evidence in the policy-making community,” he added. “Leaders never allow the facts to get in the way of a good story.”

This was strongly echoed by Caroline Weinberg, national co-chair of the March for Science, in plenary 4 which looked at evidence in a post-truth world. “We can’t assume the evidence speaks for itself,” she said, “we need to speak for the evidence. All of the evidence produced by science can be destroyed by someone with a good anecdote. The only way to counter a compelling story is with a compelling story.”

“We need to bring the world into the conversation of science,” she added. “Science belongs to everyone – but sharing it with the general public is where we have failed. We can’t in good conscience stay quiet. Science not silence.”

#### Evidence in crises

Plenary 3 looked at the use of evidence to solve global crises using Ebola as an example.

Vasee Moorthy of the World Health Organization stressed the interconnectedness of the world and the importance of sharing

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information. “Real change will come when everyone discloses the results of previous research,” he said.

He highlighted that the ring vaccine trial for Ebola in Guinea took 11 months. “This was faster than ever before but still too late. If we have existing phase I data we can proceed quickly.”

“If something is a problem over there it will soon be a problem over here in the world we live in,” he added.

Jodi Nelson of the International Rescue Committee pointed to the real challenges for humanitarian organisations.

“Existing human crises continue to burn while new one’s get added,” she said. “Too many humanitarian organisations are locked in a position of hindsight – looking in the rear-view mirror.”

She also addressed the funding issue. “Donors and decision makers still measure inputs and outputs not the outcomes for actual people,” she added. “We need transparent, consistent, well-defined research programmes to generate evidence to help people.”

Also addressing the issue of resources John-Arne Røttingen of the Research Council of Norway said: “We don’t know where the next outbreak will be or which pathogen will be involved – we need to share the risk in responding to outbreaks. We need capacity to respond.”



GES plenary speakers: from left Trish Greenhalgh, Trevor Manuel and Caroline Weinberg

## Need for a trustworthy evidence ecosystem

The need for integrated systems and the skills and capacity to run them, as well as the sharing of tools between sectors was emphasised in plenary 2 which set out to understand how explicit links are needed to close the loop between new evidence and improved care as well as a culture for sharing evidence combined with new methods and technology platforms. Jonathan Sharples of the Education Endowment Foundation pointed out that the education sector has been thinking in a systems-based way for a long time but added: “The evidence system sits within a range of other systems and must integrate.”

“There is a need for a trustworthy evidence ecosystem to increase value and reduce waste in research,” said Chris Mavergames of Cochrane. “There is no support or easy access to people, methods and tools in the current ecosystem.”

He pointed out that living reviews can now be produced very quickly “but we need people and processes to evolve to enhance this new ecosystem and we need community understanding of the methods”.

**“In SA 95% of the wealth is in the hands of 10% of the population. We need to look at the issue of inequality again and again – it’s not only wealth but also the underlying causes. We need to reframe the public discussion to understand the damage inequality causes to the social fabric.” - Trevor Manuel**

Karen Barnes of the Worldwide Antimalarial Resistance Network added that the most important thing is to produce evidence fit for purpose. Speaking about her work in the malaria field she pointed to challenges including the loss of data, data quality and heterogeneity, and the sustainability of platforms.

## New challenges in a new world

Plenary 4 looked at the enhanced challenges of evidence in a post-truth world. The rise of ‘post-truth’ requires us to go beyond ascertaining how robust the evidence is to how we can successfully

engage and influence the public, media and politicians at a time when facts are often less important than beliefs and appeals to emotion.

As Trish Greenhalgh of Oxford University highlighted: “There is a systematic manipulation of the audience using Big Data and social media. Self-styled leaders of populist movements exhibit intellectual vices and seek to foster these in others.”

“It’s a case of I believe therefore I’m right.”

But she emphasised the need to find constructive ways to counter this because “If we don’t ride the tiger of social media, it will ride us.”

Anim van Wyk of Africa Check also pointed to the need to approach audiences in appropriate ways. “You don’t change people’s minds by bashing them with the evidence.” she said.

The need to make evidence work to achieve a more equitable world for everyone was highlighted in the final plenary.

Sipho Mthathi of Oxfam South Africa indicated that the global research agenda often follows the patterns of inequity and asked whether “In a post-truth world we can learn from past efforts and build a stronger alliance for truth to advance accountability and solve pressing world problems.”

## Michelle Galloway

Cochrane SA



Trevor Manuel (centre) with Jimmy Volmink and Ruth Stewart



GES plenary speakers: from left Chris Mavergames, Jodi Nelson, Stephen Kennedy and Siphos Mthathi

# Cochrane Africa officially launched at the Global Evidence Summit

In 2017 the Cochrane Africa Network (CAN) was registered as a formal entity. This was celebrated at a public launch held at the Global Evidence Summit in Cape Town on 15 September 2017. The event attracted participants from Australia, Belgium, Brazil, Cameroon, Canada, Congo, Ethiopia, Italy, Kenya, Mozambique, Mauritius, Nigeria, Scotland, Swaziland, The Gambia, Uganda and South Africa.

## AFRICA – Access, Funding, Relevance, Individuals, Coaching/capacity development and A community

Taryn Young of the Centre for Evidence-based Health Care at Stellenbosch University sketched the development of the network upon the foundation laid by Cochrane South Africa, founded in 1997. Highlights included the launch of the HIV Mentoring Programme in 2000; the establishment of the Reviews for Africa Programme (RAP) in 2005 which focused on the conduct of reviews relevant for the Africa region; the work of the DFID-funded Effective Health Care Research Consortium since 2006; the first African Cochrane Contributors meeting in 2007 where CAN was first discussed; the launch of the Pan African Clinical Trials Registry and the STEPP project; and, the 2013 Africa Cochrane Indaba which furthered discussions on CAN and strengthened relationships. At this event in 2013 delegates put forward various needs to advance the network – summarised in the acronym AFRICA – Access, Funding, striving for Relevance, Individuals, receiving Coaching/ Capacity development and working as A community.

## Building a network

Solange Durão of Cochrane South Africa outlined the CAN governance structure, which consists of three regional hubs and a central co-ordinating unit. She outlined the priorities of Cochrane Africa as detailed in the five-year strategy including: the identification of priorities, gaps and author teams; mentorship and fellowships to support review production; the importance of translation of evidence into regional languages; partnerships with stakeholders; raising awareness about evidence-based healthcare and building the capacity of all stakeholders to use reviews to inform healthcare decision making on the continent; and, the importance of securing multiple funding to ensure the network's sustainability. She highlighted the guiding principles of the network, including the uniqueness of each country, prioritising to ensure relevance; collaborating; taking one step at a time; avoiding duplication; and building sustainability.

Going forward the aim is to expand the network, bring in new collaborators and countries, and to work together to increase the use of evidence to inform healthcare decision making in Africa. To illustrate this she ended with an African proverb which states: "If you want to go fast, go alone, but if you want to go far, go together".

## Taking Cochrane Africa forward

In the final session participants were asked to indicate how they would want to be involved in Cochrane Africa. Their answers included:

- Expansion – more local hubs, more young scientists/people, more search co-ordinators.
- Translation – the need to expand language translation efforts (including podcasts).
- Enhanced consumer involvement and end-user engagement by building consumer networks, accessing patients and support groups, and improving access and acquiring information for evidence users.
- Increased funding.
- Enhanced branding activities.
- More networking and collaboration including the development of a skills database and increased information sharing about projects.
- Increased capacity building – capacity and awareness building in academia, policy settings and media, students, policy makers/leaders, politicians, ministries of health and multi-sectoral engagement (e.g. finance ministries); mentorship of both individuals and institutions.
- Enhanced roles for Africans – more editorial roles, more involvement in methods development for Africa (Africans in methods group).
- Enhanced review production through prioritising relevant reviews; increased editorial skills, leading collaborative review groups, translational and user-friendly reviews.
- Guidelines development – co-ordinated in-country and regionally, and enhanced knowledge translation for guidelines and policies.
- Facilitating implementation in practice settings and the translation of evidence into policy

Acknowledgements: Cochrane Africa is partly supported by the Effective Health Care Research Consortium. This Consortium is funded by UK aid from the UK government for the benefit of developing countries (Grant: 5242). Cochrane Africa is also supported through the Cochrane Regional Initiatives funding and the South African Medical Research Council.

## Michelle Galloway

Cochrane SA



The launch of the Cochrane Africa Network at the GES

# The Global Evidence Summit – connecting the global evidence world

## Words, photos and brief news snippets from the GES

### Bringing together youth and experience – the Indaba Lounge sponsored by the National Research Foundation, South Africa

Young researchers and postgraduate students from all over the world attended the GES. A dedicated networking space was organised in the exhibition area, creating a relaxed atmosphere for participants to meet. Eleven senior researchers each met with 2 – 4 young/junior researchers. The sessions took place during the tea and lunch breaks of the Summit. Each session was 15 – 30 minutes and participants were very pleased with the interaction and mentoring, and most exchanged contact details before departing.



Young student reporters from the Cape Town's Children's Radio Foundation attended Plenary 4: Evidence in a post-truth world and were given the opportunity to interview the plenary speakers.



### Conference brings hope for Group of Hope

The Group of Hope is a community organisation run from the Worcester Male Correctional Centre outside Cape Town which supplied the beaded lanyards used at the GES and also had a stand for their beaded goods in the community market. The GES allowed the group to make the largest profit made in the past seven years. The money raised will be used for various community projects bringing hope to communities in the area and facilitating the rehabilitation of offenders.



The Indoni Dance, Arts and Leadership Academy wowed GES participants at the gala dinner with their performance of *Ikhaya* choreographed by Sbonakaliso Ndaba. The work depicted the real problems facing South Africa's youth including substance abuse and gender violence, and provided a fitting and emotional finale to an incredible Summit.



### Voices from the conference

"The summit has provided great opportunities for training and networking ... I've engaged some research teams in order to do some methodological research and I've received constructive feedback on our work." – *Juan Franco, Argentina*

"The conference was heavily focused on knowledge translation in the health sector, and while this is understood from the focus of Cochrane, those participants not from the health sector feel left out lost. In future, try to increase the focus to other sectors."

– *Eunice Williams, Kenya*

“Thank you for the opportunity to attend the conference ... It is the most organised, relevant and informative conference I’ve ever attended. The sessions on evidence-informed policy from across the world were particularly relevant and inspiring to me. The conference contained just the right mix of issues affecting both the developed and developing world.” – *Jeanette Dawa, Kenya*

“Ok, so the conference was really, really brilliant. I always come away from conferences feeling excited and motivated to get back to work, but this one was different. This was undoubtedly the biggest conference I’ve been to before, but it also had a very clear global vision. I learned so much that I hadn’t even thought about before, I spoke to people I’d never have met otherwise, and by the time I left I was feeling very hopeful for the coming years – both in terms of my own career and in our ability to include evidence in global health challenges too ... I really hope that this conference becomes an annual event, particularly because of the diversity of the audience. I was able to network with guideline producers, public health tacklers, researchers like myself, third-sector representatives, even patients, from all corners of the world. This diverse audience, and therefore diverse line up of speakers, really strengthened the programme, and ultimately made the conference a complete success for me.” – *Heidi Gardner, Scotland*, extract from <https://www.students4bestevidence.net/thoughts-from-the-global-evidence-summit/>



“As an early career scientist with an interest in knowledge synthesis and implementation science, I would say the GES has helped me set my research agenda for the next couple of years. The Summit brought immediate and extended research families together. For me, it became a career-defining networking opportunity. GES was an enriching experience. The plenaries, special sessions and workshops addressed real-life problems that many of my colleagues and I often encounter in our research, and community.” – *Dr Abdu Adamu, Nigeria*



“The plenary sessions were equally enchanting – particularly one that gave insight on how rapid reviews can be useful in emergency situations – as healthcare professionals, we always imagine that WHO should have a reflex and relevant response ready for any emerging situation, not appreciating the intricacies involved in coming up with guidelines under such situations like during the 2014/2015 Ebola outbreak in West Africa. I was also quite taken aback as a young researcher took the road less travelled and presented jaw-dropping findings of a systematic review of preclinical studies of the MVA85A/AERAS-485 vaccine – something that I know challenged all the vaccine researchers out there.” – *Monica Nyamusi Mochama, Rwanda*, extract from <http://www.gesiinitiative.com/gesi-blog/details/MY-EXPERIENCE-AT-THE-2017-GES-IN-CAPETOWN-SA#.WdeKcJDgFu8>, [twitter?platform=hootsuite](https://twitter.com/hootsuite)



“Some highlights included the Saturday plenary, ‘Evidence in a post-truth world’, delivered by Prof. Trish Greenhalgh, Anim van Wyk of fact-checking website, Africa Check and Caroline Weinberg of March for Science. The audience was encouraged to reflect on the challenges of communicating expertise and evidence in a world in which people have ‘had enough of experts.’” – *Roxanne Keyne, United Kingdom*, extract from <http://blogs.bmj.com/ebmh/2017/10/06/gesummit17-reflections-from-cape-town/>

“Attending the GES was a first and exciting experience for me. The GES was like a world of knowledge that came together to share and experience evidence-based research that can change how we’ve always looked at things. I enjoyed all the plenaries and long oral sessions because we had more time to listen and learn about what others are doing in terms of evidence-based research, I also met and reconnected with a lot of people from different fields of research and that’s what made my experience at the conference satisfying. Being at conference has inspired me to continue the work that makes better lives by using evidence-based research.” – *Lindi Mathebula, South Africa*.

## Consumer summaries

### Treatment for tuberculosis infection of the membrane around the heart

#### What is the issue?

Tuberculosis infection of the pericardium surrounding the heart is uncommon but life-threatening.

#### What is the aim of this review?

The aim of this Cochrane Review was to assess the effects of treatments for people with tuberculous pericarditis.

#### Why is this important?

Doctors prescribe anti-tuberculous drugs for six months, drain fluid from the pericardium if the patient has heart failure, sometimes remove the pericardium if it is thick and making the patient ill, and sometimes give corticosteroids to reduce the effects of the inflammation.

#### What are the main results?

Cochrane researchers collected and examined all potentially relevant studies and found seven trials, all conducted in sub-Saharan Africa. Six trials evaluated corticosteroids. Other treatments evaluated included *Mycobacterium indicus pranii* immunotherapy, colchicine and surgical removal of fluid under general anaesthesia. This review is an update of the 2002 review.

In people not infected with HIV, six trials found that additional steroids may reduce deaths overall (low-certainty evidence) and probably reduce deaths caused by pericarditis (moderate-certainty evidence). Steroids may prevent re-accumulation of fluid in the pericardial space (low-certainty evidence). However, we do not know whether or not corticosteroids have an effect on constriction or cancer among HIV-negative people (very low-certainty evidence).

In people living with HIV, most people evaluated in the included trials were not on antiretroviral drugs. For these patients, corticosteroids may reduce constrictive pericarditis (low-certainty evidence), but we do not know if this translates into a reduction in the number of deaths or cancer (very low-certainty evidence). Corticosteroids may have little or no effect on re-accumulation of fluid in the pericardial space (low-certainty evidence).

Colchicine was evaluated in one trial of 33 people, with insufficient data to make any conclusions about an effect.

Based on one trial, it is uncertain whether adding *M. indicus pranii* immunotherapy to anti-tuberculous drugs has an effect on any outcome in people with tuberculous pericarditis regardless of their HIV status (very low-certainty evidence).

Open surgical drainage of the fluid accumulating between the heart and the membrane using general anaesthesia may be associated with less life-threatening re-accumulation of fluid in people who are not infected with HIV, but conclusions are not possible as the number of participants studied was too small. We did not find an eligible trial that assessed the effects of open surgical drainage in people living with HIV.

The review authors found no eligible trials that examined the length of anti-tuberculous treatment needed nor the effects of other adjunctive treatments for tuberculous pericarditis.

#### How up-to-date is this review?

The review authors searched for trials published up to 27 March 2017.

Citation: Wiysonge CS, Ntsekhe M, Thabane L, Volmink J, Majombozi D, Gumedze F, Pandie S, Mayosi BM. Interventions for treating tuberculous pericarditis. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No. CD000526. DOI: 10.1002/14651858.CD000526.pub2.

## Vitamin A supplements for reducing mother-to-child transmission of HIV infection

#### What is the aim of this review?

The main aim of this review was to assess the effects of giving vitamin A supplements to HIV-positive women, during pregnancy or after delivery, or both, on the risk of mother-to-child transmission of HIV infection. Cochrane researchers collected and examined all relevant studies to answer this question and included five trials. This is an update of a review published in 2011.

#### What is the key message?

Giving vitamin A supplements to HIV-positive women, during pregnancy or after delivery, or both, probably makes little or no difference to the risk of mother-to-child transmission of HIV (moderate-certainty evidence).

#### What are the main results of the review?

Five trials met the inclusion criteria. Two trials were from South Africa and one trial each from Malawi, Tanzania and Zimbabwe. The trials compared women receiving vitamin A supplements to women not receiving such supplements. None of the participants received antiretroviral therapy (ART).

The review shows that in women living with HIV infection and not on ART:

- giving vitamin A supplements to HIV-positive women during pregnancy, immediately after delivery, or both, probably has little or no effect on the risk of mother-to-child transmission of HIV (moderate-certainty evidence) and may have little or no effect on child death by two years of age (low-certainty evidence);
- giving vitamin A supplements to HIV-positive women during pregnancy may increase the mean birthweight (low-certainty evidence) and probably reduces the number of low birthweight babies (moderate-certainty evidence), but it is uncertain whether the intervention has an effect on the number of preterm births, stillbirths, or deaths among the women (very low-certainty evidence).

The intervention has largely been superseded by ART, which is widely available and effective in preventing mother-to-child transmission of HIV.

#### How up-to-date is this review?

The review authors searched for studies up to 25 August 2017.

Citation: Wiysonge CS, Ndze VN, Kongnyuy EJ, Shey MS. Vitamin A supplements for reducing mother-to-child HIV transmission. Cochrane Database of Systematic Reviews 2017, Issue 9. Art. No. CD003648. DOI: 10.1002/14651858.CD003648.pub4.

## Using evidence to inform global health workforce policies: Four Cochrane overviews show the effectiveness of health system interventions

Four Cochrane overviews of systematic reviews show reliable evidence on the effects of different ways of organising, financing, and governing health systems in low-income countries. Strengthening health systems in low-income countries is key to achieving universal health coverage and systematic reviews on the effects of different health system arrangements are essential for making informed decisions.

Broad overviews of the findings of systematic reviews can help policy makers, their support staff, and other stakeholders to identify strategies for addressing problems with how their health systems are organised, financed and governed, and with identifying effective strategies for implementing changes. They can also help to identify needs and priorities for new evaluations of health system arrangements and for systematic reviews.

A team of Cochrane researchers from Argentina, Chile, Norway and South Africa prepared four overviews of the available evidence from up-to-date systematic reviews about the effects of health system arrangements in low-income countries. They included 124 systematic reviews in the four overviews. For each review, a user-friendly summary of key findings was produced (see <http://supportsummaries.org/>), enabling users to explore the overview findings in more depth. The summaries include over 480 key messages about the effects of health system arrangements in low-income countries.

**“These overviews are a key source of evidence for decision makers in low-income countries who are considering options for strengthening the health system in their setting. The overviews use a unique approach, based on user-friendly summaries of each contributing review, and we hope that this will make the evidence identified much more accessible to decision makers and those who support them.”** – Dr Simon Lewin, Joint Co-ordinating Editor of Cochrane’s Effective Practice and Organisation of Care Group and Cochrane author

An overview of **delivery** arrangements included 51 systematic reviews that included a total of 919 studies. These reviews found that many delivery arrangements probably have desirable effects, including task shifting or role expansion and strategies for co-ordinating care. The new overview ‘**Delivery** arrangements for health systems in low-income countries: an overview of systematic reviews’ ([10.1002/14651858.CD011083.pub2](https://doi.org/10.1002/14651858.CD011083.pub2)) was published on 13 September 2017, Issue 9, 2017.

An overview of **financial** arrangements included 15 systematic reviews that included a total of 276 studies. The effects of most of the financial arrangements that were reviewed were uncertain. This includes the effects of providing financial incentives and disincentives for healthcare workers, and the effects of most types of financial incentives and disincentives for people using health services. The new overview ‘**Financial** arrangements for health systems in low-income countries: an overview of systematic reviews’ ([10.1002/14651858.CD011084.pub2](https://doi.org/10.1002/14651858.CD011084.pub2)) was

published on 11 September 2017, Issue 9, 2017.

An overview of **governance** arrangements included 21 systematic reviews that included a total of 172 studies. These reviews found that restrictions on medicines reimbursement (pre-authorisation), community mobilisation, and disclosing to the public performance data on health facilities and providers probably have desirable effects. The effects of other governance arrangements that were reviewed were uncertain. The new overview ‘Governance arrangements for health systems in low-income countries: an overview of systematic reviews’ ([10.1002/14651858.CD011085.pub2](https://doi.org/10.1002/14651858.CD011085.pub2)) was published on 12 September 2017, Issue 9, 2017.

An overview of **implementation** strategies included 39 systematic reviews that included a total of 1332 studies. These reviews found that many different implementation strategies probably improve professional practice, including educational meetings, educational outreach, practice facilitation, local opinion leaders, audit and feedback, and tailored interventions. Many strategies targeted at healthcare recipients also probably have desirable effects on the use of healthcare. For example, mass media interventions lead to an increase in immediate uptake of HIV testing and reminders and recall strategies for caregivers probably increase routine childhood vaccination uptake. The new overview ‘**Implementation** strategies for health systems in low-income countries: an overview of systematic reviews’ ([10.1002/14651858.CD011086.pub2](https://doi.org/10.1002/14651858.CD011086.pub2)) was published on 12 September 2017, Issue 9, 2017.

**“These overviews come at an opportune moment, when African countries are considering the best approaches for achieving Universal Health Coverage. The overviews and the underlying user-friendly evidence summaries – the SUPPORT Summaries – are important resources for constructive engagement and exchange between Cochrane Africa and relevant national stakeholders for evidence-informed health decision making in Africa.”** – Dr Charles Shey Wiysonge, one of the overview authors and the Director of Cochrane South Africa



## New Staff

### Dudzile Ndwandwe

Dudzile has swapped the hustle and bustle of Gauteng to join the team at Cochrane South Africa in the Cape to work on the Pan African Clinical Trials Database (PACTR). She holds a PhD in Molecular Mycobacteriology from the University of the Witwatersrand and an MSc in Microbial Genetics from the same university. Dudzile was previously a Senior Researcher at the Wits Reproductive Health & HIV Institute where she was project lead for the HPTN 082, EMPOWER and HPTN 084 Studies. Between 2013 and 2015/02 she was a Senior Scientist (Science Writer/Project Manager) for the HIV Prevention Research Unit at the South African Medical Research Council. She has been the recipient of a number of fellowships and awards, has an extensive list of publications and presentations, and is currently supervising one student. Dudzile was born in Mpumalanga and is married with two children.

### Anelisa Jaca

Anelisa Jaca completed a Doctoral degree in Anatomical Pathology at the University of Cape Town in August 2016. Her field of study encompassed investigating the role of biological pathways in the development and progression of colorectal cancer. Subsequent to completing her PhD, she was awarded a post-doctoral fellowship at the Centre for Evidence-Based Health Care at Stellenbosch University, which she did for a year. Upon receiving the opportunity to further her career in this field, she undertook short courses in fundamentals of epidemiology, primer systematic reviews, biostatistics and clinical guidelines. She has recently been awarded a three-year post-doctoral fellowship, based at Cochrane South Africa, and will be working on a project entitled *Understanding the individual, community and society-level factors associated with missed opportunities for vaccination in sub-Saharan Africa*.

### Evanson Sambala

Evanson Sambala recently joined Cochrane South Africa as a Research Fellow. He is a trained epidemiologist with specific interests and experience in infectious disease surveillance and control. He has worked on surveillance systems, monitoring and evaluation for the last seven years. Evanson holds a BSc Environmental Health from the University of Malawi, a Masters of Public Health from the University of Bedfordshire, a PG Dip Epidemiology from the University of Brunel and a PhD from the University of Nottingham. His main research interest is the epidemiology of infectious diseases specifically focusing on influenza and Ebola transmission; vaccines and vaccinology, evidence-based policy and public health ethics. Evanson's recent work investigates how the philosophy of *Ubuntu* can be applied to public health decisions and how this can be translated to policy, including balancing the moral conflicts and tensions that arise between civil liberties and public health interventions during epidemics and pandemics. His work at Cochrane investigates the contextual and individual factors associated with low childhood immunisation coverage in sub-Saharan Africa. In addition, he is investigating the role of vaccine hesitancy and missed opportunities for vaccination in relation to vaccine coverage.



Dudzile Ndwandwe, Anelisa Jaca and Evanson Sambala

## Conferences

### Vaccines and Immunology Conference 2018

16 – 18 April 2018  
Tokyo, Japan  
[vaccines@sasummits.com](mailto:vaccines@sasummits.com), <http://vaccines.congressseries.com/>

### 10<sup>th</sup> Biennial Joanna Briggs Institute Colloquium 2018

2 – 4 May 2018  
Antwerp, Belgium  
Theme: Successful implementation of evidence-based practice: Hard work or good luck?  
<http://www.jbi-colloquium2018.org/>

### 5<sup>th</sup> South African TB Conference

12 – 15 June 2018  
Durban, South Africa  
Theme: Step-Up! Let's Embrace All to End TB!  
[www.tbconference.co.za](http://www.tbconference.co.za), [info@tbconference.co.za](mailto:info@tbconference.co.za)

### 22<sup>nd</sup> International AIDS Conference (AIDS 2018)

23 – 27 July 2018  
Amsterdam, The Netherlands  
<http://www.aids2018.org/>

### G-I-N 2018 Conference

12 – 14 September 2018  
Manchester, United Kingdom  
Theme: Why we do what we do: the purpose and impact of guidelines.  
<http://www.ginconference.net>

### 25<sup>th</sup> Annual Cochrane Colloquium

15 – 18 September 2018  
Edinburgh, Scotland  
Theme: 'Cochrane for all – better evidence for better health decisions.'  
[uk.cochrane.org](http://uk.cochrane.org); [@CochraneUK](https://twitter.com/CochraneUK) #cochraneforall; [facebook.com/CochraneUK](https://www.facebook.com/CochraneUK)

### Healthcare Innovation Summit Africa 2018

17 – 18 October 2018  
Johannesburg, South Africa  
<http://www.healthcareinnovationsummit.co.za/>

### International Conference on Evidence Based Healthcare

2 – 5 November 2018  
Ajman, United Arab Emirates  
Contact: Ravi Tipparaju at [ravi@gmu.ac.ae](mailto:ravi@gmu.ac.ae), <http://www.gmu.ac.ae>



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

### 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: [cochranesa@mrc.ac.za](mailto:cochranesa@mrc.ac.za) | <http://southafrica.cochrane.org/>  
<http://www.mrc.ac.za/cochrane> | Twitter: @SACochrane