

## One-click access to Cochrane reviews: National *Cochrane Library* licence for South Africa

The South African Medical Research Council (SAMRC) recently procured a national *Cochrane Library* licence that will make evidence-based scientific reviews freely accessible to all South Africans. This collaboration between Wiley and the SAMRC offers free access, through IP recognition, to the *Cochrane Library* throughout South Africa.

“This national licence means that healthcare practitioners will have sustained access to reliable and unbiased Cochrane reviews in order to apply well-informed decisions at the point of care to deliver quality healthcare to patients”, said Cochrane South Africa Director, Prof. Charles Wiysonge. “We also know that systematic reviews of the evidence, such as those produced by Cochrane, can guide decision makers in the development of policies and clinical practice guidelines.”

Although some universities and hospitals have had access to the *Cochrane Library*, by way of institutional subscriptions, most healthcare practitioners are not directly affiliated with these institutions leaving access to the *Cochrane Library* largely unavailable in clinical settings. Similarly, government technical teams and healthcare workers, responsible for developing and implementing policies and guidelines, have limited access to the *Cochrane Library* and therefore do not always have easy access to evidence-based health information for decision making.

“A national licence for South Africa will ensure that all those looking for reliable, up-to-date evidence on healthcare interventions, would have simple ‘one-click’ access without discrimination,” said SAMRC President, Prof. Glenda Gray. “This will be of specific benefit to the many doctors and nurses working under less than ideal circumstances in rural and remote areas of South Africa.”

The *Cochrane Library* houses over 7000 systematic reviews. The national licence in South Africa will provide students, practitioners, researchers and patients with access to this leading resource in evidence-based research. To date, 506 South African researchers have contributed to Cochrane research.

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The national licence commenced in June 2017. In June alone there were 7820 full-text views.

*Cochrane Library*'s Acting Editor-in-Chief, Karla Soares-Weiser, has welcomed the national licence: “All countries need to ensure that scarce and limited health resources are used as effectively as possible. A national licence provides South Africa with unlimited access to the *Cochrane Library*. This is an important springboard for the further development of evidence-informed healthcare across South Africa giving students, practitioners, researchers and patients access to more than 7000 published Cochrane systematic reviews in healthcare interventions.”

The *Cochrane Library* is available at <http://cochranelibrary.com/>.



SAMRC President, Prof. Glenda Gray



## Consumer summaries of evidence

### Vitamin A supplementation for preventing disease and death in children aged six months to five years

#### Background

Vitamin A deficiency (VAD) is a major public-health problem in low- and middle-income countries, affecting 190 million children under five years of age. VAD predisposes children to increased risk of a range of problems, including respiratory diseases, diarrhoea, measles and vision problems, that can lead to death. Previous studies show that giving synthetic vitamin A to children aged six months to five years who are at risk of VAD may reduce the risk of death and some diseases.

#### Review question

This review aimed to evaluate the effect of synthetic vitamin A supplementation (VAS) compared to placebo (dummy pill) or no intervention for preventing illness and death in children aged six months to five years.

#### Review methods

The reviewers searched different databases that contain both published and unpublished results of medical studies. Only randomised-controlled trials (RCTs) were included. The results were combined mathematically to obtain overall estimates of effectiveness of VAS against illness and death. The literature search is current to March 2016.

#### Study characteristics

This review includes 47 RCTs representing 1 223 856 children. Studies took place in 19 countries: 30 (63%) in Asia, 16 in India; 8 (17%) in Africa; 7 (15%) in Latin America; and, 2 (4%) in Australia. The average age of the children was 33 months. Most of the studies included equal numbers of boys and girls, and lasted about a year. The quality of the included studies was variable; however, it was unlikely that death rates were influenced by potential errors in the study conduct.

#### Key results

Data on the effect of VAS for the prevention of death were available from 19 of the included studies, and the combined results indicate that vitamin A reduces overall risk of death and death due to diarrhoea by 12%. Vitamin A does not specifically reduce death due to measles, respiratory infections, or meningitis, but can reduce new occurrences of diarrhoea and measles. Giving oral synthetic vitamin A to children at risk of VAD reduces the risk of night blindness. It also improves levels of vitamin A in their blood. The only reported side effect was risk of vomiting within 48 hours of taking vitamin A in large doses, as recommended by the World Health Organization.

#### Quality of evidence

The reviewers rated the overall quality of the evidence using the GRADE approach, which considers methodological flaws within studies; consistency in reporting of results across studies; extent to which results apply to other settings; and, effectiveness of treatments. Based on these criteria, they judged the overall quality of the evidence to be high for benefits of VAS against overall risk of death and death due to diarrhoea. For the rest of the outcomes, the evidence was rated as low or moderate. One large, recently conducted study, which included about 1 million children, did not show any effect of VAS; however, when this study was combined with other, well-conducted studies, VAS still had beneficial effects for the prevention of death and illness.

In summary, VAS can reduce risk of illness and death in children aged 6 to 59 months of age who are at risk of VAD.

Citation: Imdad A, Mayo-Wilson E, Herzer K, Bhutta ZA. Vitamin A supplementation for preventing morbidity and mortality in children from six months to five years of age. *Cochrane Database of Systematic Reviews* 2017, Issue 3. Art. No.: CD008524. DOI: 10.1002/14651858.CD008524.pub3.

### Vaccines for preventing the common cold

#### Review question

The reviewers looked at whether vaccines can help to prevent the common cold.

#### Background

The common cold is caused by a viral infection of the upper respiratory tract, and people usually get better when the virus dies. People with common cold feel unwell, have runny noses, nasal congestion, sneezing, and a cough with or without sore throat, and slightly elevated temperatures. Treatments are aimed at relieving symptoms.

Globally, the common cold causes widespread illness. It has been difficult to produce vaccines to prevent the common cold due to the many viruses involved. The effect of vaccines on preventing the common cold in healthy people is still unknown.

For this update the reviewers searched the literature up to 2 September 2016.

#### Study characteristics

No new studies were found for this update. This review includes one previously identified randomised-controlled trial performed in 1965. This study involved 2307 healthy people at a training facility for

the United States Navy and evaluated the effect of a live-weakened (attenuated) adenovirus vaccine compared to a fake vaccine (placebo). This study was funded by a government institution.

#### Key results

There were no differences in the frequency of occurrence of the common cold between those who received the vaccine compared to those who received a fake vaccine. There were no adverse events related to the vaccine. However, due to the low numbers of people included in the study and numbers of colds, as well as flaws in the study design, the reviewers' confidence in the results was low. Further research may be able to clarify if vaccines can prevent common cold, since the current evidence does not support the use of the adenovirus vaccine to prevent common cold in healthy people.

#### Quality of the evidence

The reviewers assessed the quality of the evidence as low due to high risk of bias and low numbers of people included in the study and numbers of colds, which resulted in imprecision.

Citation: Simancas-Racines D, Franco JVA, Guerra CV, Felix ML, Hidalgo R, Martinez-Zapata MJ. Vaccines for the common cold. *Cochrane Database of Systematic Reviews* 2017, Issue 5. Art. No.: CD002190. DOI: 10.1002/14651858.CD002190.pub5.

## Technical summary

### Beta-blockers for hypertension

#### Background

Beta-blockers refer to a mixed group of drugs with diverse pharmacodynamic and pharmacokinetic properties. This diversity has given rise to their classification into first, second and third generation. First-generation beta-blockers exercise identical affinity for  $\beta_1$  and  $\beta_2$  adrenergic receptors and are categorised as non-selective beta-blockers (e.g. propranolol). Second-generation beta-blockers are more attracted to  $\beta_1$  than  $\beta_2$  receptors, and are classified as selective beta-blockers (e.g. atenolol). Third-generation beta-blockers are known for their intrinsic vasodilatory properties (e.g. nebivolol).

In 2007 we published a Cochrane Review on the effects of beta-blockers as first-line treatment for hypertension among adult men and women aged 18 years or older, which we have updated twice. We searched multiple databases up to June 2016 and followed standard Cochrane processes for data collection and analysis.

Thirteen studies met our inclusion criteria. These studies compared beta-blockers to placebo or no treatment (four studies), diuretics (five studies), calcium-channel blockers (four studies), and renin-angiotensin system inhibitors (three studies). Ten studies enrolled both men and women, and the rest enrolled only men. Most studies were conducted among white men in Western Europe and North America. The risk of bias in the included studies was variable.

We found that beta-blockers probably make little or no difference to the risk of deaths among people on treatment for hypertension. This effect appears to be similar to that of diuretics and renin-angiotensin system inhibitors, but is worse than that of calcium-channel blockers (moderate certainty evidence). In addition, beta-blockers probably make little or no difference to the risk of coronary heart disease among people treated for hypertension. This effect may not be different from that of diuretics, renin-angiotensin system inhibitors, or calcium-channel blockers. However, beta-blockers may reduce the risk of total cardiovascular disease compared to placebo (low-

certainty evidence). This beneficial effect may be a reflection of the substantial reduction in strokes with beta-blockers, since there is little or no difference in coronary events between beta-blockers and placebo (low-certainty evidence). The effect of beta-blockers on cardiovascular disease may not be different from that of diuretics or renin-angiotensin system inhibitors, but is worse than that of calcium-channel blockers (moderate-certainty evidence). In addition, calcium-channel blockers and renin-angiotensin system inhibitors probably reduce the risk of developing a stroke more than beta-blockers (moderate-certainty evidence). Finally, hypertensive patients on beta-blockers may be more likely to have side effects and stop medications than those on renin-angiotensin system inhibitors, although there may be little or no difference in side effects between beta-blockers and diuretics or calcium-channel blockers (low-certainty evidence).

All included studies added other antihypertensive medications to the initial treatment, in order to help achieve blood-pressure goals. Thus, poorer outcomes with first-line beta-blockers may equally have resulted from additional medications used. Atenolol (a second-generation or selective beta-blocker) was the beta-blocker used in three-quarters of participants in the beta-blocker arms. Thus, it is not possible to say whether the (lack of) effectiveness and safety seen with beta-blockers is a property of atenolol or is a class effect of all beta-blockers. In particular, there were no trials found that assessed the effects of vasodilating beta-blockers on mortality and hard cardiovascular outcomes. Finally, most of the evidence is of low certainty according to the GRADE approach, implying that further research is likely to change our confidence in the estimate of these effects.

The citation for the most recent update of the review is: Wiysonge CS, Bradley HA, Volmink J, Mayosi BM, Opie LH. Beta-blockers for hypertension. Cochrane Database of Systematic Reviews 2017, Issue 1. Art. No.: CD002003. DOI: 10.1002/14651858.CD002003.pub5.

**Charles S. Wiysonge**

Cochrane SA



## Excitement builds on eve of Global Evidence Summit



*Dr Tamara Kredo, LOC Chair*

With over 1200 confirmed attendees representing at least 67 countries; 13 plenary speakers; 202 long and short orals, 754 posters, 84 workshops and 40 special sessions; 98 stipends awarded; and, an exciting, wide-ranging programme – the Global Evidence Summit to be held in Cape Town from 13 to 16 September is on target to be an invigorating experience.

“We are working extremely hard with our partners and local and international colleagues to ensure an enriching and exciting summit for all the participants,” said Tamara Kredo, Chair of the Local Organising Committee. “We are very privileged to have 13 exciting plenary speakers lined up including former Finance Minister of South Africa – Trevor Manuel, who will address the opening plenary.”

The event aims to advance the use of reliable research evidence in addressing some of the world’s most serious health and social challenges. It is the first time that [Cochrane](#), [The Campbell Collaboration](#), [Guidelines International Network](#), [The International Society for Evidence-based Health Care](#), and [Joanna Briggs Institute](#) have joined forces to create this event with the theme of ‘Using evidence. Improving lives’.

“This partnership means that we have been able to bring together some of the best minds in this field,” said Kredo. “We believe we have an event lined up that will challenge and stimulate policy makers and practitioners to base their decisions on the best-available evidence.”

“The Summit will highlight and promote evidence-based approaches to policy and practice in order to target resources to the most effective health and social interventions,” said Jimmy Volmink, Founding Director of Cochrane SA and chair of the Global Organising Committee. “With the Summit taking place in South Africa the opportunities and challenges facing low and middle-income countries will be the key focus.”

“In situations of scarcity, it is important that resources are not wasted on useless or harmful interventions,” he continued. “It is therefore fitting that this gathering of world leaders in evidence-based practice, policy, methodology and advocacy, from five international organisations, is taking place in Africa. We are confident it will make a meaningful contribution to furthering our shared vision of a healthier, more equitable world.”

### Plenaries

Each of the five plenaries is linked to a threaded special session. Plenaries include:

**Plenary 1:** Evidence for Africa which is linked to three threaded special sessions: Evidence for social and economic policy; Evidence to action: start with the action; and, Engaging stakeholders in evidence-based decision making.

**Plenary 2:** Breaking down the silos: Digital and trustworthy evidence ecosystem which is linked to threaded sessions: From evidence production to synthesis; From evidence synthesis to dissemination at

point of care; and, Implementation, improved care, and back again.

**Plenary 3:** Evidence for emerging crises which is linked to threaded sessions: Evidence Aid on humanitarian crises, Refugee crisis in health and society; and, Global warming.

**Plenary 4:** Evidence in a post-truth world which is linked to threaded sessions: Separating fact from fiction – enhancing critical thinking to equip the next generation for the post-truth society; Telling good stories: A workshop in the art of persuasion; and, Post-truth world in health: Engaging stakeholders to use evidence to inform decisions.

**Plenary 5:** Evidence for equity: How evidence can achieve a more equitable world, for everyone.

“The programme is bold; the setting will be glorious; the networking will be unparalleled. Hope to see you there!” - Trish Greenhalgh

In addition to Trevor Manuel, the plenary speakers include Siphon Mthathi, the founding Executive Director of Oxfam South Africa; Trish Greenhalgh, Professor of Primary Care Health Sciences at the University of Oxford; Anim van Wyk, Deputy Editor of Africa Check; Jonathan Sharples, Senior Researcher at the Education Endowment Foundation at University College London; Jodi Nelson, Senior Vice President of Policy and Practice at International Rescue Committee (IRC) and Stephen Kennedy, a practitioner and researcher from Liberia with extensive experience in the recent Ebola crisis.

The Summit is intended as an intersectoral, multidisciplinary event exchanging ideas about how to best generate, summarise and communicate evidence to inform policy and practice. Input from a multitude of perspectives including education, social and criminal justice, environmental and gender health, health systems and clinical care and practice is anticipated. Delegates represent different sectors including researchers and scientists; policy makers and managers; and consumers and activists from the health, development and social justice fields.

Sponsors include the South African Medical Research Council, the National Research Foundation (South Africa); Wiley, Wellcome, Wolters Kluwer; TDR, the Government of The Netherlands, Elsevier and EBSCO Health.

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**Michelle Galloway**  
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## Cochrane consumers at the Cochrane mid-year meeting

The 2017 Cochrane Mid-Year Meeting was hosted by Cochrane Switzerland in Geneva on 4 and 5 April 2017. This meeting is the annual business meeting for Cochrane, and, for a complex, international collaboration like Cochrane, it's an opportunity for its different groups to gather to take the organisation forward.

One of those meetings is the Cochrane Consumers' Executive (CE). The CE was set up in 1995 to provide governance and leadership for the 1500 and growing international community of consumers (patients, caregivers, family members and others) who work to help produce and spread Cochrane evidence. You can read more about its work at <http://consumers.cochrane.org/>

### What we talked about

In 2015 the CE took a hard look at the way in which consumers are involved in Cochrane and wrote a plan to take it forward to 2020 (<http://consumers.cochrane.org/news/feature-story>) so the meeting's main business was to assess the plan's progress.

### Statement of Principles for Consumer Involvement in Cochrane

This is a statement that the whole organisation can sign up to and describes why the organisation involves its consumers and the

principles that guide the way we work with them. You can read more at <http://consumers.cochrane.org/news/elections-consumer-network-executive-open>

### Cochrane membership

You can join our independent network of Cochrane collaborators from around the world. Whether you're a researcher, healthcare professional, patient, carer, or just passionate about health, the Cochrane community welcomes you. <http://join.cochrane.org/>

The full papers for the meeting can be found here: <http://community.cochrane.org/news/governing-board-agenda-and-open-access-papers-now-available-mid-year-meeting-geneva>

Should you wish to know more or become involved in the Cochrane Consumer Network, please contact Richard Morley at [rmorley@cochrane.org](mailto:rmorley@cochrane.org) or Joy Oliver at [joy.oliver@mrc.ac.za](mailto:joy.oliver@mrc.ac.za)

### Richard Morley

*Cochrane Consumer Co-ordinator*

## Second round of workshops for Stellenbosch Journalism students

The mission of Cochrane SA includes 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 therefore decided to target journalism students who are potential future health and science writers, and to introduce them to EBHC and systematic reviews, the *Cochrane Library* and other useful resources for developing future media products.

The first round of workshops were held in 2016 at the Faculty of Journalism, University of Stellenbosch (US) and Cochrane SA was delighted to be asked to return this year to repeat the exercise. The 2017 workshops involved 23 Journalism Honours students.

Two 2-hour sessions were organised with a gap in between allowing students to complete a homework assignment.

Topics covered included an introduction to EBHC and systematic reviews; an introduction to Cochrane; and, using the *Cochrane Library*. These were approached using various learning techniques including interactive lectures; videos; case scenarios and exercises; practical demonstrations; and, small group work.

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 this session they were given six topics and asked to prepare 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

Plans to undertake similar workshops at other universities were unfortunately affected by 'Fees Must Fall' protests in 2016. However, now that the workshop has been further refined this experience and the positive feedback from the US faculty will be used to target other higher-education institutions in South Africa.

### Michelle Galloway

*Cochrane SA*



## PACTR maps Ebola clinical trial activity on the African continent

Ebola virus disease (EVD) results in acute, serious illness and, if untreated, can have a case-fatality rate averaging 50%. The 2014 outbreak of EVD in West Africa was declared a Public Health Emergency of International Concern by the Director-General of the World Health Organization (WHO). Currently there are no drug therapies proven effective against EBV. However, there is ongoing research into potential therapies with several trials ongoing in affected African countries.

The WHO International Clinical Trial Registry Platform (ICTRP) collects data from members of its Network of Primary Registers; this provides researchers with an overall picture of planned and ongoing trial activity. Mapping clinical trials can assist health policy makers, practitioners, researchers and funders in keeping abreast of current research activity and research gaps. Lags between trial conduct and publication result in delays in results reaching the public domain. Clinical trial registries provide publicly accessible study information curbing the negative impacts of these lags. Our study aimed to map African EVD trial activity as found on WHO's ICTRP and identify available results from the linked published trials.

### Method

We conducted a cross-sectional analysis of EVD trials registered on the WHO ICTRP. Data extraction included trial location, intervention studied, principle investigator location, participant age range, and funder. To identify published trials, we used registry identifiers to search PubMed and extracted citation data, trial start date, recruitment sites, country of principal investigator, intervention, population and results.

### Results

#### Planned and ongoing trials

WHO ICTRP was searched on 20 June 2016 and 83 EVD studies were identified. Of these, 45 listed recruitment countries in Africa. Intervention studies can be classified as biomedical prevention, including vaccines (25), biomedical therapeutics (17), including two trials studying the use of Chinese traditional medicine and trials on the use of convalescent plasma (1), health services and care (1), and diagnostic methods (2).

One study was registered in 2009 with most trials registered between 2014 and 2016. Current reporting on 'recruitment status' indicates three complete with publications, three complete – no publications, two withdrawn, one not started, 34 ongoing and two with unknown status.

Children were included in 24 studies with 21 adults-only studies. Financial support ranged from local universities and governments to European universities, non-governmental organisations and the US government. Sixteen studies received industry support.

#### Published studies

We searched PubMed on 14 October 2016, and identified eight records. One of these was a report on methods related to an already included study.

#### Conclusions

Mapping EVD clinical trial activity on the WHO ICTRP and searching for published study reports on PubMed can provide data on planned, ongoing or completed trials. EVD research focuses mainly on identifying safe and efficacious prevention vaccines including in children, however, few of these have been published. The low number of published trial reports indicates that evidence is not yet publicly accessible which may impact on evidence-informed policy development for the region.



Figure 1: Countries where registered trials are being conducted

### Why register with the Pan African Clinical Trials Registry (PACTR)?

Membership in the WHO-Network of Primary Registers allows researchers in Africa to register their trials with PACTR as the registry of choice for the region. PACTR feeds data into the global WHO International Clinical Trials Registry Platform central database ([www.who.int/trialsearch/](http://www.who.int/trialsearch/)), ensuring African representation in the global picture of planned, ongoing and completed clinical trials.

Access the site at [www.pactr.org](http://www.pactr.org) or contact the PACTR staff at: [pactradmin@mrc.ac.za](mailto:pactradmin@mrc.ac.za)

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## Shifting the way we do it: Sharing different methods for clinical practice guideline adaptation for use in South Africa

New clinical practice guideline (CPG) development is expensive and time-consuming and therefore often unrealistic with limited funding or resources. There is also no point in developing new guidelines when there are accessible, good-quality guidelines available to fit local needs. Various methods exist to adopt, adapt or contextualise guidelines from one setting to another. These development methods are a key vehicle for formal guideline teams, clinicians and decision makers to produce contextually relevant and robust guidance for their healthcare setting.

The SAGE (South African Guidelines Excellence) project therefore held a workshop in April to provide an opportunity for dialogue regarding different approaches to guideline development with key examples from the South African setting.

### The objectives were:

- To share different approaches for adapting CPGs.
- To outline the challenges and lessons learnt.
- To discuss the approaches that South African teams use when developing guidelines.

The workshop included four presenters all whom have been involved in guideline development in South Africa to share their experiences, the methodologies used, as well as the challenges and lessons learned.

Dr Bev Draper who consults as a public-health specialist for the National Department of Health in the field of guideline development presented on the development of a health-promotion tool for use in primary healthcare that addresses health risks and existing

chronic-disease conditions, as well as a training package for its implementation.

“Good graphics are an essential part of the end product – pictures are often more powerful than text,” said Dr Draper. “The final design needed to be robust and practical for the clinical setting – therefore a hard-cardboard design was used that could stand on a desk for easy access.”

“It’s also extremely important that health messages are carefully selected, refined and aligned with the local context, and are user-friendly and culturally appropriate,” she added.

Dr Dawn Erntzen, a Senior lecturer in Physiotherapy at Stellenbosch University presented on the development of a contextualised evidence-based CPG for the primary healthcare of chronic musculoskeletal pain in the Western Cape, South Africa.

She pointed to the challenge of finding appropriate, understandable wording for healthcare workers with different education levels. She emphasised that contextualising for the South African setting is very important, as is ensuring the appropriate composition and skill set of the development panel, and added that “Implementation remains challenging and sometimes controversial in the South African context.”

Michael McCaul is a registered emergency care practitioner currently working as a researcher at the Biostatistics Unit at Stellenbosch University. He presented on pre-hospital emergency care CPGs for the South African Emergency Medical Services.



“Not all available guidelines are of equal quality,” he said. “The levels of evidence classification are not necessarily homogenous.”

“It’s therefore important to search other sources not only primary-level evidence for CPGs,” he continued.

McCaul also pointed to the poor transition from guidelines to clinical practice and emphasised the importance of implementation and training aspects.

Dr Henk Temmingh, who is a consultant psychiatrist in the acute admissions unit at Valkenberg Psychiatric Hospital and lecturer in the Department of Psychiatry and Mental Health at the University of Cape Town, presented on guidelines for the management of severe mental disorders with co-morbid substance misuse in South African psychiatric settings.

“Lack of time was a huge challenge,” he said. “The first drafts were expected within a four-month period which was not realistic.”

“It’s also important to avoid scope creep – the group didn’t have capacity to include everything.”

He therefore stressed the need for careful planning, role definition and a large, nationally based panel with the inclusion of methodologists.

#### The following points were raised in the group discussion:

- South Africa needs fit-for-purpose guidelines.
- Existing appropriate, high-quality guidelines must be taken into account.
- The local context (including organisational factors and human resources) must be considered.
- There is a need for transparency/agreement on the values of the panel as this can influence the way evidence is viewed.
- An evidence-decision framework – like GRADE – should be used.
- Guidelines for Guidelines are needed to standardise the development process.
- Guidelines should have an in-built auditing/monitoring tool.
- Knowledge translation needs to be planned and budgeted for upfront.
- There is a need for a central, respected guidelines authority. Its tasks should include deciding which guidelines to prioritise (based on the national burden of disease); establishing rules and standards for the development process; and, promoting implementation and training for guideline use.
- Guidelines development should be a rigorous, transparent and inclusive process.
- These issues are not clear globally and South Africa should share its learnings in this field with others.

#### Michelle Galloway

Cochrane SA

#### Announcements



#### New staff

**Dr Sara Cooper** - SAGE Researcher, Cochrane SA Senior Scientist

Dr Sara Cooper is a newly appointed Senior Scientist at Cochrane SA working on the SAGE Project (South African Guidelines Excellence). She holds a Bachelor’s (Honours) degree in Psychology, a Master’s in Public Health from the University of Cape Town (UCT) and a PhD in medical sociology from the London School of Hygiene & Tropical Medicine. Her interests include the application and explanatory potential of social-science theories and methodologies within health research, policy and practice, and how qualitative health research can be both ‘critical’ and ‘applied’. Her most current research focuses on these issues in the realm of long-term chronic illnesses, including mental illness, HIV/AIDS, diabetes and obesity. Sara has extensive experience in conducting and building capacity for critical qualitative health research in sub-Saharan Africa (SSA), having worked as a senior qualitative researcher on a number of global public-health projects. Sara is also an Honorary researcher in the Division of Social & Behavioural Sciences in the School of Public Health at UCT and is on the editorial board of *Critical Public Health*.

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

## Conferences

#### Global Evidence Summit 2017: Using evidence. Improving lives.

13 – 16 September 2017

Cape Town, South Africa

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

#### International Summit on Quackery and Pseudoscience

20 – 21 November 2017

Stellenbosch, South Africa

<http://www.censcom.com/index.php/conferences/conference-program>

#### 8<sup>th</sup> International Conference for EBHC Teachers and Developers The ecosystem of evidence: Connecting generation, synthesis and translation

25 – 28 October 2017

Taormina, Italy

<http://ebhc.org/index.php>

#### Science Forum South Africa

7 – 8 December 2017

Pretoria, South Africa

<http://www.sfsa.co.za/>