Cochrane South Africa
NEWSLETTER

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Volume 20, No. 1, July 2018

South African Guidelines Excellence project – findings and implications

The South African Guidelines Excellence project (SAGE) presented its final results at a public session in April. SAGE is a collaborative research effort involving Cochrane South Africa and the Health Systems Research Unit of the South African Medical Research Council; the Centre for Evidence-Based Health Care and Division of Physiotherapy of Stellenbosch University; and, the International Centre for Allied Health Evidence (iCAHE), University of South Australia, and was funded by the SAMRC's Flagships Awards Funding (SAMRC-RFA-IFSP-01-2013/ SAGE).

The aim was to consolidate methods and training for better clinical practice guidelines (CPG) development, implementation and use.

Main findings included:

CPG development - Primary care CPG development is complex, but includes a dedicated community of developers and needs to be underpinned by efficient, standardised processes – including declaring and managing conflicts, hearing constituent 'voices', and training. National co-ordination will enhance current CPG processes. SAGE identified novel approaches that could support better quality guideline writing and implementation (the three-tiers Adopt, Contextualise, Adapt model).

CPG implementation and use – One of the challenges is access to current CPGs therefore better distribution of documents as well as enhanced technology and ICT access is needed.

There was concern regarding the practicality of recommendations in CPGs for primary care. End-users wanted to have a 'voice' in CPG development to ensure practical issues are appropriately incorporated.

Lack of access to equipment or medicines is also a barrier to implementation.

Design features that could enhance CPG use include use of simpler language and summaries, local language support tools, and patient-engagement tools (e.g. posters).

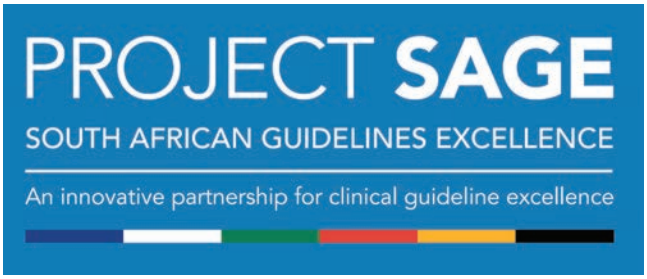
Both off-site workshops and in-facility training including post-workshop clinical support is needed to build clinical teams and enhance CPG use. Change champions in primary care in the provinces are leading and developing exciting programmes and systems to ensure use of the CPGs which should be shared.

CPG capacity development - Building capacity is crucial in South Africa and other low- and middle-income countries to facilitate uniformity and quality in how CPGs are developed and implemented. The SAGE team conducted a review of all CPG courses offered globally and found that these are mostly delivered by universities and professional groups. The team used an already available CPG module offered as part of the Masters in Clinical Epidemiology at Stellenbosch University (www.sun.ac.za/clinepi), and updated the content to be contextually relevant. The course was enhanced by developing an online, open-access CPG development toolkit

Contents

Jimmy Volmink and Taryn Young

Tamara Kredo (right) and Quinette Louw presenting the results of the SAGE project



(https://guidelinetoolkit.org.za/). Postgraduate students conducting research on CPG development or implementation were also supported.

CPG co-ordination unit

The need for co-ordination of national guideline activity was consistently raised through the research, by our Advisory Board, and from stakeholders. A project was developed to scope the structure and functions of guideline co-ordination units globally and 21 units were identified for inclusion. Their main tasks include CPG development; providing access to CPGs; approval and endorsement for implementation; adopt, contextualise and adapt CPGs; methodological support; and, health technology assessment. Other tasks included commissioning CPGs; critical appraisal; setting standards; capacity building; and monitoring and evaluation. Challenges reported included establishment and maintenance of the units due to funding and human resources, buy-in for the processes, and technical and methodological challenges. As we move to the National Health Insurance system, policy makers will need to consider how we bridge the private and public health services sectors. This scoping report is available to contribute to these discussions.

Conclusion

CPGs are useful tools for implementing best-available evidence to support health services and primary care CPG developers, implementers and users are committed to enhancing this work. However, there is a need for dedicated funding to support CPG development, including co-ordination and overseeing of CPG activities; recognition and remuneration of experts; and, investment in implementation. Involving healthcare providers in CPG activities is likely to enhance ownership and implementation. To address these challenges and opportunities, the SAGE project has been able to enhance capacity building opportunities for CPG developers and implementers.

"We want to ensure CPGs are credible, and applicable for primary care. Project SAGE's research and capacity building components aimed to contribute to the debate and growth of CPG activities in South Africa."

IMPLICATIONS FOR POLICY AND PRACTICE

To enhance CPG development:

- Harness the contributions and commitment of the CPG interest community.
- Develop a glossary of terminology.
- Agree on standards and methods for CPG development.
- Create platforms for input from healthcare providers and patients.
- Work towards setting up a nationally co-ordinated CPG unit.

To enhance CPG implementation:

- Build on the available implementation activities such as book and app development and dissemination, and regional training initiatives.
- Equip staff with implementation-related knowledge and skills to enhance uptake of available guidance products.
- Ensure adequate quality and quantities of CPG books are made available, particularly in rural areas.
- For healthcare providers: develop supportive implementation tools to enhance CPG use.
- For patients: develop resources including posters and leaflets (using local languages and relevant examples.
- Address health system challenges including budgetary and supply chain issues to ensure provision of equipment and medicines.
- Step up training workshops, in-facility educational outreach and post-training support.
- Provide leadership training for enhanced governance and stronger teams.
- Ensure supportive clinical audits with regular feedback.

The project published a comprehensive report which is available in a full-length and summary versions at:
http://www.samrc.ac.za/sites/default/files/attachments/2018-04-17/SAGEfinalReport.pdf
http://www.samrc.ac.za/sites/default/files/attachments/2018-04-17/SAGESummaryReport.pdf

Tamara Kredo
Cochrane SA

New programme for multidisciplinary vaccine implementation research within Cochrane SA

Immunisation is one of the most cost-effective and successful public health interventions of all time. Immunising a nation's children not only protects them from disability and premature death, it also boosts productivity, reduces poverty and supports economic growth.[1] While Africa has made tremendous progress toward increasing access to immunisation over the past decades, vaccination coverage has stagnated recently. The region currently has the largest proportion of unvaccinated children, with five of the 10 countries that are home to 61% of unvaccinated children in the world being in Africa.[2] Sub-optimal immunisation coverage leads to the untimely death of millions of people each year in Africa from vaccine-preventable diseases.

Against this backdrop, Cochrane SA has developed a new programme for multidisciplinary vaccine implementation research. The programme includes projects with the shared goal to generate, synthesise and disseminate evidence-based knowledge on vaccines and immunisation practices relevant to Africa. The overarching vision is that national and continental immunisation decision making and strategies are informed by high-quality, timely and relevant research evidence.

Many of our projects are focusing on the 'supply-side' of immunisation programmes, and the role of structural barriers in vaccine access and availability in Africa. One project is investigating missed opportunities for vaccination (MOV), a major challenge facing immunisation programmes.[3] MOVs occur when an unvaccinated or partially vaccinated child eligible for vaccination makes contact with a health service, but does not receive the vaccinations they need. Using data from Demographic and Health Surveys in Africa, we have been examining poverty- and education-related inequalities in MOVs in the region.[4, 5] We have found that children belonging to poor households and born to uneducated mothers are more likely to experience MOV, due to a range of contributing socio-economic factors such as neighbourhood socio-economic status, media access, and household wealth index. We have also conducted a systematic review on strategies for reducing MOVs, finding patient education, patient tracking, outreach sessions, and provider prompts reduce MOVs.[6] We are currently expanding this work to investigate the frequency and impact of MOVs in specific African countries and vaccines, including influenza and meningococcal conjugate A vaccines.

Securing a continuous supply of essential vaccines is an additional challenge facing many African countries, with 38% of countries in the region currently reporting national-level vaccine stock-outs.[7] Another of our 'supply' focused projects is examining the frequency, causes and effects of vaccine stock-outs in Africa, and strategies for mitigating their impact.

Vaccine hesitancy

Even when vaccines and vaccination services are available, they are not always taken up. Vaccine hesitancy, which represents a continuum between vaccine acceptance and refusal[8] is a growing threat to immunisation programmes in Africa.[9] We have highlighted the paucity of knowledge on the scope and causes of vaccine hesitancy in Africa and the lack of validated tools to measure it.[10] To address these evidence gaps, we are developing a multi-site research consortium on the continent to understand vaccine behaviours, decision making and acceptance, or what is typically understood as the 'demand' side of vaccination. Our project is investigating the extent and determinants of vaccine hesitancy and acceptance in Africa, constructing validated scales to measure these, and designing evidence-informed interventions to enhance the demand for and uptake of vaccines. Through this work we hope to expand the evidence base and build capacity for behavioural insights research on vaccine hesitancy in the region.

Other projects in our programme include:

- an investigation of the main strengths, weaknesses, opportunities and threats to immunisation programmes in South Africa, building on our previous work with national and provincial Expanded Programme on Immunisation managers;[11]
- an analysis of inequities in immunisation coverage between and within African countries;
- an investigation of the burden of meningococcal meningitis in the African meningitis belt countries;
- analyses of the efficacy and effectiveness of vaccines among people with sickle cell disease[12] and among HIV–infected and HIV-exposed uninfected children;
- a mapping of the existence and functionality of National Immunisation Technical Advisory Groups (NITAGs) in Africa; and,
- an analysis of vaccine trial activity in Africa.

Our multi-focal and multidisciplinary research programme seeks to complement the work of international immunisation advocacy organisations such as the WHO, UNICEF and GAVI Alliance in their efforts to help the continent maintain current immunisation accomplishments and make further progress. Through our projects, we hope to bring relevant information to policy makers and implementers in the region to facilitate timely evidence-informed decisions, thereby contributing to more equitable immunisation coverage on our continent and reducing the 'vaccination gap' between developed countries and their African counterparts. Africa is currently off track to achieve certain targets set in the Regional Strategic Plan for Immunisation and the Global Vaccine Action Plan, including obtaining 90% national immunisation coverage by 2020. More concerted efforts in the region are therefore essential and urgent, efforts which our programme hopes to catalyse and support.

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Sara Cooper, Alison Wiyeh, Anelisa Jaca, Chinwe Juliana Iwu, Duduzile Ndwandwe and Evanson Z. Sambala

Cochrane SA

Some of the members of the vaccine implementation research team hard at work. From left: Evanson Z. Sambala, Anelisa Jaca, Alison Wiyeh, Sara Cooper and Charles Wiysonge

Technical Summary
Prophylactic vaccination against human papillomaviruses to prevent cervical cancer and its precursors

Background

Persistent infection with high-risk human papillomaviruses (hrHPV) types is causally linked with the development of cervical pre-cancer and cancer. HPV types 16 and 18 cause approximately 70% of cervical cancers worldwide.

Objectives

To evaluate the harms and protection of prophylactic human papillomaviruses (HPV) vaccines against cervical pre-cancer and HPV16/18 infection in adolescent girls and women.

Search methods

The authors searched MEDLINE, Cochrane Central Register of Controlled Trials (CENTRAL) and Embase (June 2017) for reports on effects from trials. They also searched trial registries and company results' registers to identify unpublished data for mortality and serious adverse events.

Selection criteria

Randomised-controlled trials comparing efficacy and safety in females offered HPV vaccines with placebo (vaccine adjuvants or another control vaccine).

Data collection and analysis

Cochrane methodology and GRADE were used to rate the certainty of evidence for protection against cervical pre-cancer (cervical intraepithelial neoplasia grade 2 and above [CIN2+], CIN grade 3 and above [CIN3+], and adenocarcinoma-in-situ [AIS]), and for harms. The authors distinguished between the effects of vaccines by participants' baseline HPV DNA status. The outcomes were pre-cancer associated with vaccine HPV types and pre-cancer irrespective of HPV type. Results are presented as risks in control and vaccination groups and risk ratios (RR) with 95% confidence intervals in brackets.

Main results

Twenty six trials (73 428 participants) were included. Ten trials, with follow-up of 1.3 to 8 years, addressed protection against CIN/AIS. Vaccine safety was evaluated over a period of six months to seven years in 23 studies. Studies were not large enough or of sufficient duration to evaluate cervical cancer outcomes. All but one of the trials was funded by vaccine manufacturers. The authors judged most included trials to be at low risk of bias. Studies involved monovalent (N = 1), bivalent (N = 18), and quadrivalent vaccines (N = 7). Most women were under 26 years of age. Three trials recruited women aged 25 and over. The effects of vaccines in participants who had at least one immunisation are summarised.

Efficacy endpoints by initial HPV DNA status

hrHPV negative: HPV vaccines reduce CIN2+, CIN3+, AIS associated with HPV16/18 compared with placebo in adolescent girls and women aged 15 to 26. There is high-certainty evidence that vaccines lower CIN2+ from 164 to 2/10 000 (RR 0.01 [0 to 0.05]) and CIN3+ from 70 to 0/10 000 (RR 0.01 [0.00 to 0.10]). There is moderate-certainty evidence that vaccines reduce the risk of AIS from 9 to 0/10 000 (RR 0.10 [0.01 to 0.82]).

HPV vaccines reduce the risk of any CIN2+ from 287 to 106/10 000 (RR 0.37 [0.25 to 0.55], high certainty) and probably reduce any AIS lesions from 10 to 0/10 000 (RR 0.1 [0.01 to 0.76], moderate certainty). The size of reduction in CIN3+ with vaccines differed between bivalent and quadrivalent vaccines (bivalent: RR 0.08 [0.03 to 0.23], high certainty); (quadrivalent: RR 0.54 [0.36 to 0.82], moderate certainty). Data in older women were not available for this comparison.

HPV16/18 negative: In those aged 15 to 26 years, vaccines reduce CIN2+ associated with HPV16/18 from 113 to 6 /10 000 (RR 0.05 [0.03 to 0.10]). In women 24 years or older the absolute and relative reduction in the risk of these lesions is smaller (from 45 to 14/10 000, RR 0.30 [0.11 to 0.81], moderate certainty).

HPV vaccines reduce the risk of CIN3+ and AIS associated with HPV16/18 in younger women (RR 0.05 [0.02 to 0.14], high certainty and RR 0.09 [0.01 to 0.72], moderate certainty, respectively). No trials in older women have measured these outcomes.

Vaccines reduce any CIN2+ from 231 to 95/10 000, (RR 0.41 [0.32 to 0.52]) in younger women. No data are reported for more severe lesions.

Regardless of HPV DNA status: In younger women HPV vaccines reduce the risk of CIN2+ associated with HPV16/18 from 341 to 157/10 000 (RR 0.46 [0.37 to 0.57], high certainty). Similar reductions in risk were observed for CIN3+ associated with HPV16/18 (high certainty). The number of women with AIS associated with HPV16/18 is reduced from 14 to 5/10 000 with HPV vaccines (high certainty).

HPV vaccines reduce any CIN2+ from 559 to 391/10 000 (RR 0.70 [0.58 to 0.85], high certainty) and any AIS from 17 to 5/10 000 (RR 0.32 [0.15 to 0.67], high certainty). The reduction in any CIN3+ differed by vaccine type (bivalent vaccine: RR 0.55 [0.43 to 0.71] and quadrivalent vaccine: RR 0.81 [0.69 to 0.96]).

In women vaccinated at 24 to 45 years of age, there is moderate-certainty evidence that the risks of CIN2+ associated with HPV16/18 and any CIN2+ are similar between vaccinated and unvaccinated women (RR 0.74 [0.52 to 1.05] and RR 1.04 [0.83 to 1.30] respectively). No data are reported in this age group for CIN3+ or AIS.

Adverse effects

The risk of serious adverse events is similar between control and HPV vaccines in women of all ages (669 versus 656/10 000, RR 0.98 [0.92 to 1.05], high certainty). Mortality was 11/10 000 in control groups compared with 14/10 000 (9 to 22) with HPV vaccine (RR 1.29 [0.85 to 1.98]; low certainty). The number of deaths was low overall but there is a higher number of deaths in older women. No pattern in the cause or timing of death has been established.

Pregnancy outcomes

Among those who became pregnant during the studies, the authors did not find an increased risk of miscarriage (1618 versus 1424/10 000, RR 0.88 [0.68 to 1.14], high certainty) or termination (931 versus 838/10 000 RR 0.90 [0.80 to 1.02], high certainty). The effects on congenital abnormalities and stillbirths are uncertain (RR 1.22 [0.88 to 1.69], moderate certainty and (RR 1.12 [0.68 to 1.83], moderate certainty, respectively).

Authors' conclusions

The authors concluded that there is high-certainty evidence that HPV vaccines protect against cervical pre-cancer in adolescent girls and young women aged 15 to 26. The effect is higher for lesions associated with HPV16/18 than for lesions irrespective of HPV type. The effect is greater in those who are negative for hrHPV or HPV16/18 DNA at enrolment than those unselected for HPV DNA status. There is moderate certainty evidence that HPV vaccines reduce CIN2+ in older women who are HPV16/18 negative, but not when they are unselected by HPV DNA status. The authors did not find an increased risk of serious adverse effects. Although the number of deaths is low overall, there were more deaths among women older than 25 years who received the vaccine. The deaths reported in the studies were judged not to be related to the vaccine. Increased risk of adverse pregnancy outcomes after HPV vaccination cannot be excluded, although the risk of miscarriage and termination are similar between trial arms. Long-term follow-up is needed to monitor the impact on cervical cancer, occurrence of rare harms and pregnancy outcomes.

Citation: Arbyn M, Xu L, Simoens C, Martin-Hirsch PPL. Prophylactic vaccination against human papillomaviruses to prevent cervical cancer and its precursors. Cochrane Database of Systematic Reviews 2018, Issue 5. Art. No.: CD009069. DOI: 10.1002/14651858.CD009069.pub3.999

Consumer Summary
Educational interventions for improving complementary feeding practices

Background

Complementary feeding is the period when an infant moves from taking only breast milk or breast-milk substitutes (such as infant formula) to family food. It is a critical period in the life of an infant. Inappropriate complementary feeding practices, with their associated adverse health consequences, remain a significant global public health problem. This is because inappropriate complementary feeding practices, such as introduction of semi-solid foods too early (before six months of age), poor hygiene or giving foods that do not contain adequate nutrients, are all major causes of illness. Such illnesses include malnutrition, diarrhoea, poor growth, infections and poor mental development of children. Education has been proposed as an effective means of improving complementary feeding practices.

Review question

Does education improve complementary feeding practices of caregivers of infants as well as the health and growth of the infants?

Study characteristics

The authors searched for randomised-controlled trials (a type of experiment in which people are randomly allocated to one or more treatment groups) up until November 2017. The search identified 23 studies involving a total of 11 170 caregivers and their children. The ages of the children ranged from birth to 24 months. The caregivers received educational interventions alone while the control group received no intervention, usual care or any other non-educational intervention. The educational methods included printed materials such as leaflets, counselling, teaching sessions, peer support, videos and practical demonstrations. Generally, the education messages were focused on the introduction of semi-solid foods at the appropriate age, the types and amount of complementary foods to be fed to infants, and hygiene.

Key results

Education reduced the number of caregivers who introduced semi-solid foods to their infants before six months of age by up to 12% (moderate-quality evidence). Hygiene practices of caregivers who received education also showed some improvement compared to those who did not (moderate-quality evidence). In studies conducted in the community, education increased the duration of exclusive breastfeeding, but not in studies conducted in health facilities. There was no convincing evidence of an effect of education on the growth of children (low to very low-quality evidence). The authors could not combine the results from different studies for diarrhoea, knowledge of caregivers and adequacy of complementary food. However, from the individual reports of the study authors, education led to a reduction in diarrhoea and an improvement in the knowledge of caregivers. It also led to improvement in the quality and quantity of complementary foods fed to infants.

Overall, the authors found evidence that education improves complementary feeding practices.

Citation: Arikpo D, Edet ES, Chibuzor MT, Odey F, Caldwell DM. Educational interventions for improving primary caregiver complementary feeding practices for children aged 24 months and under. Cochrane Database of Systematic Reviews 2018, Issue 5. Art.

Cochrane Africa Network priority-setting process

The Cochrane Africa Network (CAN) was formally inaugurated in November 2015 and launched in September 2018 at the Global Evidence Summit in Cape Town with the overarching aim of stimulating an increase in the production and use of high-impact systematic reviews to inform healthcare decision making in Africa. The problems of resource constraints, high infectious disease prevalence and an emerging non-communicable disease burden in Africa has meant a focus on systematic reviews on priority conditions with an influence on policy and practice in the region.

In 2017, in line with Cochrane's vision 2020 and in furtherance of CAN's overall objectives, the three hubs (West African, Francophone and Southern Eastern) of the network undertook region-specific priority-setting activities to identify high-priority and relevant systematic reviews. This was followed by a scoping of the literature and analyses of outputs to identify gaps that need to be filled in terms of: 1) new reviews, 2) reviews requiring updates, 3) reviews needing dissemination, and 4) reviews requiring translation.

Use of priority-setting principles

The approaches adopted were guided by accepted principles that define successful priority setting including: the use of an explicit process, stakeholder engagement, information management, consideration of values and context, as well as having mechanisms in place for reviewing decisions.

In the West African Hub comprising Anglophone countries Nigeria, Ghana, Liberia, Gambia and Sierra Leone, the focus was on communicable and non-communicable diseases. A modified Delphi approach was adopted with burden of disease data analysis and extensive stakeholder involvement at panel discussions. This included consumer groups such as disease-specific patient groups. An agreement on priority questions depended largely on *a priori* factors such as prevalence of the condition; likelihood the condition will cause death or disability; cost effectiveness; likelihood of the intervention improving health outcomes; and, feasibility of the intervention. Programmatic aspects of malaria interventions and infections ranked highly leading to consideration of reviews on '*Community-based versus facility-based directly observed intermittent preventive therapy in pregnancy for preventing malaria'* and '*Hand hygiene for preventing infections in neonates'* respectively.

In the Francophone hub, co-ordinated by Cameroon, a multi-modal, iterative approach was used with; door-to-door meetings with key Ministry of Health staff, policy makers and community-based organisations; evidence-based practice workshops with stakeholders; systematic review workshops with clinicians; as well as emails to participants. These resulted in identification of relevant priority reviews and the subsequent formation of evidence taskteams to manage the translation to French of priority reviews and the development of evidence assessments to inform policy and practice. A key question that emerged led to a review proposition on the '*Effects of structured ART treatment interruptions in chronic suppressed HIV infected African adults'*.

A multi-level stakeholder approach was adopted by the Southern-Eastern hub involving Kenya and focused specifically on chronic kidney disease. The process included identification of a topic area (priority field) and relevant stakeholders; engagement with the relevant Cochrane review group; engagement with a professional society; formulation/ranking of priority questions; and, matching with existing systematic reviews leading to the identification of the most relevant question for which there is systematic review gap. The key question here was *'In patients with end-stage renal disease (ESRD), what are the effects of different frequency (e.g. thrice versus twice per week dialysis) or duration of dialysis (e.g. 3 hours versus 4.5 hours) on quality of life and cost-effectiveness outcomes?'*. This was of great concern to specialists given the enormous costs involved in managing the condition and great disparities in the distribution of kidney disease specialists in Africa. It has led to the registration of the review title *"Less-intensive versus conventional haemodialysis for people with end-stage kidney disease"* with the Cochrane Kidney and Transplant Group.

Some lessons have been learned following an assessment of the priority-setting activities across CAN hubs. Although the approaches have been different, the outcomes reflect region-specific priorities. The iterative nature of the approaches underscores the need to allow for an open and transparent process. Leveraging existing burden of disease data is a useful step but needs to allow for input from stakeholders on the ground. Stakeholder involvement across the entire process is a *sine qua non* for successful outcomes reflective of the health priorities of the hubs in addition to enhancing evidence uptake. Although time consuming and resource intensive, door-to-door meetings to obviate poor access to the internet have proven to be useful. Finally, for Cochrane, the involvement of the appropriate review group remains an imperative.

Emmanuel Effa
Cochrane Nigeria

The Cochrane Africa Network was officially launched at the Global Evidence Summit in 2017

Launch of new, improved PACTR

The Pan African Clinical Trial Registry (PACTR) has been redeveloped with the aim of providing a more user-friendly, easy-to-navigate website for researchers, policy makers, funders and the public. PACTR is a regional clinical trials registry which aims to serve the needs of African clinical trials, clinicians and trial participants.

The revised database is available at www.pactr.org.

Some of the improved features include:

- Easy navigation
- An easy-to-search GIS map showing clinical trial locations by subject
- Optimised search functions with easy-to-download formats

PACTR is the only African WHO-endorsed primary registry of clinical trials conducted in Africa. It is open-access and trials are registered free of charge. PACTR was originally developed in 2006 with a focus on AIDS, Tuberculosis and Malaria. In 2009 it was expanded to include all conditions and renamed PACTR. PACTR is based at the South African Medical Research Council and is managed by Cochrane South Africa with initial funding from the European and Developing Countries Clinical Trials Partnership (EDCTP).

"The overall aim is to increase transparency by promoting clinical trial registration and also to provide a consolidated platform to search for information on clinical trials," said Tamara Kredo, Deputy Director of Cochrane SA. "PACTR aims to assist in the regulation, registration and ethical oversight of clinical trials in Africa."

"PACTR is increasingly becoming the registry of choice for African trials and recently registered the 1500th trial," said Elizabeth Pienaar, PACTR Project Manager.

"PACTR is unique in recognising that African trialists often face additional challenges in trial registration and seeks to provide ways of overcoming these. For example, a common problem in sub-Saharan Africa is limited, unreliable and costly internet access. With this in mind, the registry provides manual registration for those without reliable internet access," said Pienaar. "These features are included and updated in the new version."

Feedback on the website and its new features is welcomed at pactradmin@mrc.ac.za or elizabeth.pienaar@mrc.ac.za.

Michelle Galloway
Cochrane SA

COCHRANE WORKSHOPS

This workshop was conducted in response to a request from the South African Medical Research Council, Research and Capacity Development Division and was facilitated by Joy Oliver, Alison Wiyeh and Ameer Hohlfeld from Cochrane SA. The aims were to teach participants to find, understand, appraise and use Cochrane Reviews of effects of interventions. Participants were from the Walter Sisulu University and the University of Fort Hare. They were from diverse backgrounds, including laboratory and clinical research fields. There were also deans, senior lecturers, principal investigators, and masters and PhD students starting out in their research work.

Cochrane SA, the Cochrane Africa Network and the South African Medical Research Council combined forces to present a workshop on evidence-based healthcare, systematic reviews and Cochrane in Harare, Zimbabwe in May. The workshop was in response to a request from the Zimbabwe Evidence Informed Policy Network and involved 15 participants from various sectors including government departments, the Zimbabwe Medicines Control Council, USAID, ZeipNet and the Biotechnological Research & Training Institute.

DONATED GLOBAL EVIDENCE SUMMIT CONFERENCE BAGS FIND THEIR HOME

Some of the donated bags from the Global Evidence Summit were given to children from a crèche in Delft in the Western Cape. The crèche has been run by the ACVV (Afrikaans Christelike Vroue Vereeniging) for the past 30 years and uses an accredited programme to prepare the children for school. Delft is an underprivileged area in Cape Town.

EVIDENCE 2018: We hope to meet you there

EVIDENCE 2018 will take place from 25 – 28 September 2018, and registration for the event opened 1 March 2018. This is the third biennial event by the Africa Evidence Network (AEN) and will be hosted at the International Convention Centre in Pretoria, South Africa. The conference is aimed at anyone who works in Africa and has an interest in evidence, its production and use in decision making. This includes those working in government, civil society, universities and the private sector.

The objectives of the conference include the following:

1) Growing our understanding of evidence for informed decision making (EIDM) in Africa by sharing learning and advancing discussions in how best to support EIDM in Africa;
2) Increasing engagement across the AEN and broader EIDM community, spanning the many divides that prevent researchers and decision makers from working together, and building relationships to move towards to our shared goals; and,
3) Situating our evidence community as a global player in, and an umbrella body for, EIDM in Africa.

Aiming for success

The EVIDENCE 2018 conference theme 'Engage, Understand, Impact' resonates particularly well with current priorities and concerns in South Africa and the African continent and is an apt topic for a number of reasons. Firstly, there is a need to encourage and promote EIDM in Africa, thereby contributing to the development of effective public policies, efficient implementation of services, as well as joint learning on interventions that tackle poverty and inequality in African countries. Secondly, there is a need to communicate these advances, share lessons learned and explore opportunities for the application of EIDM in Africa. And last, but not least, to build a community of relevant institutions, organisations and professionals through the AEN to act as a regional resource hub.

For more information about EVIDENCE 2018:
W: http://www.evidenceconference.org.za/
E: corne@confsa.co.za
T: @Africa_evidence | #EVIDENCE 2018 | #africalovesevidence

Siziwe Ngcwabe
Africa Centre for Evidence (ACE)

Conferences

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

PHASA Annual Conference | 10 – 12 September
Parys, South Africa
https://www.phasa.org.za/phasa-conference-2018/

25th Annual Cochrane Colloquium | 15 – 18 September 2018
Edinburgh, Scotland | Theme: 'Cochrane for all – better evidence for better health decisions'
uk.cochrane.org; @CochraneUK #cochraneforall; facebook.com/CochraneUK

9th EDCTP Forum | 17 – 21 September 2018
Lisbon, Portugal | Theme: Clinical research and sustainable development in sub-Saharan Africa: the impact of North-South partnerships | Tel: +351 215 870 925
E-mail: edctpforum2018@leading.pt
http://edctpforum2018.org/

EVIDENCE 2018 | 25 – 28 September 2018
CSIR International Convention Centre, Pretoria, South Africa
danielle@confsa.co.za | Tel: +27(0)12 349-2301
http://evidenceconference.org.za/

Healthcare Innovation Summit Africa 2018
17 – 18 October 2018 | Johannesburg, South Africa
http://www.healthcareinnovationsummit.co.za/

Science Forum South Africa
12 – 14 December 2018 | Pretoria, South Africa
http://www.sfsa.co.za/

Summary of Cochrane reviews on immunisation available

In April Cochrane South Africa published a selection of the plain language summaries of recent Cochrane reviews on immunisation (2010 – 2018) for African Vaccination Week. The publication is available at http://southafrica.cochrane.org/summaries-cochrane-reviews

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

SAMRC advancinglife

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We welcome contributions and article ideas for the Cochrane SA newsletter. If you would like to 'pitch' an idea contact us at michelle.galloway@mrc.ac.za.