

SOUTH AFRICAN COCHRANE CENTRE

Editorial

What a packed year 2009 has been! The summer holidays will, fortunately, bring respite for the South African Cochrane Centre (SACC) staff who are beginning to look increasingly jaded as the year draws to a close. Happily, the knowledge that much has been achieved provides a sense of buoyancy and satisfaction which helps to propel us towards the finishing line.

A highlight for the Centre this year has undoubtedly been the Pan African Clinical Trial Registry (PACTR) achieving World Health Organisation (WHO) Primary Registry status. This registry is now the only one of its kind on the continent, which fulfils the International Committee of Medical Journal Editors' requirements for trial publication. To quote the WHO: "it is an important milestone in the history of clinical trial registration, and for the future of research oversight and transparency in the African region."

The Centre had its second five yearly Medical Research Council (MRC) unit review in 2009, which required all hands on deck to ensure that all administrative requirements were met on time. Although the final decision by the Board is not yet known we believe the Centre made a favourable impression on the external panel of experts and anticipate approval of further funding. Our sincere thanks to Sally Green, from the Australasian Cochrane Centre, for her important contribution to the review process as a member of the panel.

In October, Centre staff made a strong showing at the Colloquium in Singapore, with active participation at all levels from plenaries to posters. Hearty congratulations to Nandi Siegfried on being awarded the 2009 Kenneth Warren prize for her influential review: *Male circumcision for prevention of heterosexual acquisition of HIV in men*. Congratulations also to Taryn Young for winning a prize for her poster presentation at the International AIDS Society Conference in Cape Town and to Babalwa Zani and Amber Abrams for a similar award at the 40th TB Colloquium hosted by the MRC.

Capacity building remains a central focus of our work. We are delighted that the number of Cochrane Reviews completed by people in our reference region is growing strongly. We thank our partners at the Nigerian branch of the SACC and the many active contributors in Africa and elsewhere, for their enthusiastic involvement in training and mentoring activities.

This year saw old friends returning to Cape Town for a Reviews for Africa (RAP) completion course. Paul Garner and Sarah Donegan from the Liverpool School of Tropical Medicine, as well as Sally Hopewell from the UK Cochrane Centre once again travelled many miles to support our efforts to provide training for African authors. Thank you!

Another regular visitor, Mike Clarke, Director of the UK Cochrane Centre, spent three weeks with us in July, participating in our academic programme and providing staff and students with his valuable and critical insights. We benefit enormously from his visits and hope he and his family will consider returning on an annual basis. We may even put his name on the Visiting Scientist Office!

George Rutherford from the University of California, San Francisco, paid a surprise visit to the Centre. The HIV/AIDS group was invited to assist in collating and grading the evidence for an update of the WHO antiretroviral treatment guidelines. The timelines were short and George spent a week working with Nandi and the HIV/AIDS satellite editorial office team at the Centre to produce a host of required reviews in rapid succession. Well done!

Finally, on behalf of all of us at the Centre, thank you to all our friends and collaborators for their support and all good wishes for an enjoyable festive season and a peaceful and prosperous 2010.

Jimmy Volmink
Co-director, SACC

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ARTEMISININ-BASED COMBINATION THERAPY FOR TREATING UNCOMPLICATED MALARIA

BACKGROUND

The WHO recommends artemisinin-based combination therapy (ACT) as the first line treatment for uncomplicated *Plasmodium falciparum* malaria due to high levels of resistance to older monotherapies. The decision about which ACT to adopt as the first-line national treatment policy will require information on efficacy, safety, local resistance patterns, cost, and simplicity of administration. Systematic reviews can contribute to this decision by providing evidence on the:

- relative effects on cure between combinations;
- safety and risk of adverse effects of the combination;
- impact on gametocytes;
- impact on haemoglobin levels; and
- the relative effects on *P. vivax*.

In addition, the WHO have set two standards for antimalarial combinations to help guide national policy decisions:

- a new drug entering the market should have a 95% cure rate,
- a cure rate of below 90% should trigger a change in national policy

OBJECTIVES

To compare the effects of ACTs with other available ACT and non-ACT combinations for treating uncomplicated *P. falciparum* malaria.

MAIN RESULTS

Forty-six of the fifty included trials were conducted between 2003 and 2009. Thirty-one trials were conducted in Africa, 17 in Asia, one in South America and one in Oceania.

There is obvious regional variability in which drugs are being studied and this reflects the regional differences in resistance. Trials from Asia mainly involve artesunate plus mefloquine, artemether-lumefantrine and dihydroartemisinin-piperazine. In Africa, lower levels of resistance means that combinations including amodiaquine and sulfadoxine-pyrimethamine have also been considered.

The study population in Asian trials is older, with exclusion of children aged less than one year. African studies concentrated more on children and included those as young as six months. These differences are explained by regional differences in transmission intensity. In Asia where transmission is low and seasonal, with low levels of acquired

immunity, adults bear a greater proportion of infections and are an important patient group. In Africa high levels of transmission produce a high risk of severe illness in infants and young children, with adults acquiring some immunity. Pregnant and lactating women were excluded from all trials.

In the African context, artemether-lumefantrine and artesunate plus amodiaquine have been the most widely adopted combinations. Dihydroartemisinin-piperazine is a new combination which may offer an effective alternative. The three comparisons given below are therefore the most useful to African decision making.

DIHYDROARTEMISIN-PIPERAZINE VERSUS ARTEMETHER-LUMEFANTRINE (SIX DOSES)

Six trials (four in Africa, one in Asia and one in Oceania) assessed this comparison. Allocation concealment was assessed as low risk of bias in four trials and laboratory staff were blinded to treatment allocation in five out of six trials.

In trials from Africa dihydroartemisinin-piperazine performed significantly better than artemether-lumefantrine at day 42 (RR 0.39 [0.24, 0.64], $p < 0.001$, three trials, 869 participants) and achieved a cure rate above 95% in all three trials. No significant difference was observed in Asia (RR=0.77 [0.16, 3.76], $p=0.75$, one trial, 317 participants) or in Oceania (RR=2.31 [0.85, 6.23], $p=0.099$, one trial, 151 participants). No significant difference has been shown in the frequency of serious adverse events (RR=1.71 [0.66, 4.46], $p=0.27$, five trial, 2010 participants).

DIHYDROARTEMISININ-PIPERAZINE VERSUS ARTESUNATE PLUS AMODIAQUINE

We found only two trials (one in Africa and one in Asia) which assessed this comparison. Allocation concealment was assessed as low risk of bias in one trial and unclear in the other. In both trials laboratory staff were blinded to treatment allocation, but other staff and participants were unblinded. In both Africa and Asia, there was no significant difference in the risk of treatment failure; RR=0.59 (0.27, 1.27), $p=0.18$, one trial, 458 participants and RR=0.15 (0.02, 1.22), $p=0.076$, one trial, 171 participants, respectively. The risk of serious adverse events was also not significantly different between treatments.

ARTEMETHER-LUMEFANTRINE VERSUS ARTESUNATE PLUS AMODIAQUINE

We found 12 trials (all in Africa) which assessed this comparison. Three of these trials were excluded after sensitivity analysis due to baseline differences which had the potential to bias the result in favour of artemether-lumefantrine. Of the remaining nine trials allocation concealment was assessed as low risk of bias in five trials

and laboratory staff were blinded to treatment allocation in four trials.

A pooled analysis of seven trials with a total of 1610 participants showed no significant difference between these treatments (RR=1.65 [0.95, 2.87], $p=0.077$). Subgroup analysis seems to suggest important regional differences, with studies from East Africa showing benefit with artemether-lumefantrine and recent studies from West Africa favouring artesunate plus amodiaquine

No difference has been shown in the frequency of serious adverse events (RR=1.11 [0.59, 2.08], $p=0.74$, six trials, 2749 participants).

IMPLICATIONS FOR PRACTICE

All five ACTs performed adequately to be used as first-line therapies, in most sites where they were studied, however there are examples of failure rates above 10% with all combinations, emphasizing the need for continued monitoring and evaluation. There is now a growing weight of evidence available to justify the use of dihydroartemisinin-piperazine as a first-line treatment option for *P. falciparum* malaria. Evidence of the safety of artemisinins is accumulating. Serious adverse events with these drugs appear to be rare. However, these trials are not powered to detect rare but clinically important events and so it is imperative that active monitoring continues.

IMPLICATIONS FOR RESEARCH

There are several new ACT combinations in development which are likely to become commercially available in the next few years. Policy makers therefore have a greater range of potential products. In these circumstances, improved information on comparative efficacy, adverse events, and tolerability is invaluable for informed decision making. Many trials are using relatively standardized primary outcomes. A move towards standardized approaches to measuring and reporting secondary outcomes, and adverse events, would greatly improve comparability between trials.

The most vulnerable populations (pregnant women and very young infants) were excluded from all trials, and represent a critical gap in current knowledge.

REFERENCE:

Sinclair D, Zani B, Donegan S, Olliaro P, Garner P. Artemisinin-based combination therapy for treating uncomplicated malaria. *Cochrane Database of Systematic Reviews* 2009, Issue 3. Art. No.: CD007483.

Babalwa Zani
Scientist, SACC



GRADING THE EVIDENCE

I had the pleasure of visiting the SACC in early July 2009 to work on a series of systematic reviews that the HIV/AIDS Group has undertaken for the WHO. While we have produced systematic reviews for guidelines developments in the past, the use of the Grading of Recommendations, Assessment, Development and Evaluation (GRADE) system, is a new tool used for guidelines development. It combines assessments of the quality of evidence for a body of literature (as opposed to individual studies), the risks and benefits of an intervention, the feasibility and desirability of introducing a new intervention and the cost effectiveness of the intervention. WHO has adopted a policy of requiring GRADE for all new guidelines.

In collaboration with the SACC, the U.S. Centers for Disease Control and Prevention, the U.S. National Institute of Child Health and a group of U.S. universities (Johns Hopkins University, Stanford University, the University of California,

Berkeley, the University of California, San Francisco, and the University of Minnesota), the HIV/AIDS Group has undertaken preparing the systematic reviews and the GRADE tables and an assessment and the risks and benefits to support WHO's guidelines revisions for treatment of HIV infection in adolescents and adults and for prevention of mother to child transmission of HIV. The adult ART guidelines include the following:

- Optimal ART regimens for ART-naïve patients
- Optimal timing of ART initiation
- When to switch from first-line to second-line therapy
- Optimal ART regimens for ART-experienced patients (second and third line)

For prevention of mother-to-child transmission, the research questions include: Optimal timing and regimen for pregnant women who require antiretroviral therapy for

their own health

- Optimal timing for antiretroviral prophylaxis for pregnant women
- Optimal antepartum and intrapartum prophylactic regimens for pregnant women
- Optimal postpartum prophylactic regimens for breastfeeding women
- Optimal postpartum prophylactic regimens for non-breastfeeding women
- Optimal postnatal prophylactic regimens for breastfeeding infants
- Optimal postnatal prophylactic regimen for non-breastfeeding infants

These reviews represent a massive amount of work, and I personally am exceptionally grateful to the SACC for conducting the detailed and complex literature searches that underlie these reviews. The SACC has also taken on two of the more complicated of these reviews: optimal timing of ART initiation and optimal prophylactic regimens for pregnant women (including postpartum prophylaxis).

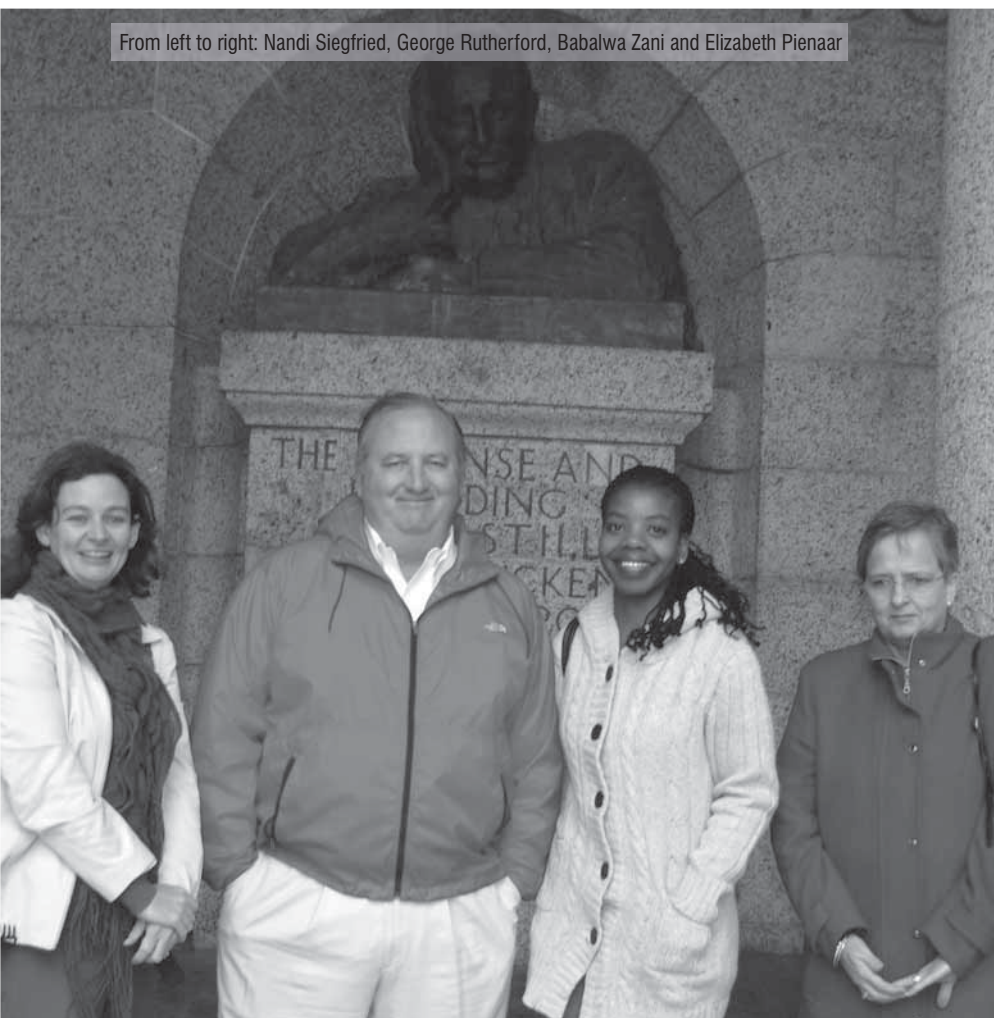
We are expecting this work to bear much fruit. First, we will see several new Cochrane Reviews in the coming months as we convert the reviews we did for WHO into Cochrane format. Secondly, we will see new WHO guidelines on the treatment of HIV infection in adults and adolescents and on the prevention of mother-to-child transmission of HIV. Finally, we fully expect that we will be asked to do more of these sorts of reviews in the future and are already working, for instance, on reviews of the treatment and prevention of diarrhoea in HIV-infected children.

I would like to thank the SACC for its partnership in the HIV/AIDS Group and for enthusiastic support of these projects.

George W. Rutherford, M.D.

Salvatore Pablo Lucia Professor of Epidemiology, Preventive Medicine and Pediatrics
School of Medicine, University of California, San Francisco
Coordinating Editor, Cochrane Collaborative Review Group on HIV Infection and AIDS

From left to right: Nandi Siegfried, George Rutherford, Babalwa Zani and Elizabeth Pienaar



THE FIRST WHO-ENDORSED REGISTRY ON THE CONTINENT

– THE PAN AFRICAN CLINICAL TRIALS REGISTRY

In recent years, more and more attention has been paid to under-reporting and selective result publishing that comes from a clinical trial process that is largely un-regulated. As such, the 2004 Ministerial Summit on Health Research called on the WHO to establish: “a network of international clinical trials registers to ensure a single point of access and the unambiguous identification of trials”

In May 2005, the above call was endorsed by 58th World Health Assembly. In 2005, the International Committee of Medical Journal Editors (ICMJE) released a statement explaining that they would only publish the results of trials registered prospectively. In 2007, the ICMJE updated their statement mandating that only trials registered on WHO-endorsed primary registers can be published, making trial registration mandatory for publication in one of eleven participating member journals. Thus, in order for a clinical trial's information to reach the public, registration of the trial in a WHO-endorsed registry is necessary.

The need for a registry on the African continent became evident, particularly considering that African trialists face challenges that others may not (such as limited or unreliable and costly internet service). In the early years of the twenty-first century this seed of an idea grew out of the SACC and onto the pages of a European and Developing Countries Clinical Trials Partnership (EDCTP) grant application. In 2007, with funding from the EDCTP, the South African Cochrane Centre launched the AIDS, TB and Malaria Clinical Trials Registry (ATM Registry). The ATM Registry was intended as a proof of concept test for a Pan African registry and launched its internet services in February 2008. Over the next year, the ATM Registry staff worked tirelessly on developing the look and feel of the portal, on disseminating the message of the need to register trials and on developing networks and collaborating with stakeholders to increase the registry landscape and infrastructure on the African continent.

When I arrived in March 2009, as a part-time administrator, the ATM was a fully-functioning web-site in the midst of an overhaul. Complete with new colours and a variety of new options, I was tasked with “debugging” the site as the Working Group members geared up for a second round of applications to the World Health Organization for primary status endorsement. This application process involved expanding the remit of the registry to include all diseases and accepting registration from all nations on the continent. Thus, in late May, the AIDS, Tuberculosis and Malaria Clinical Trials Registry officially became the Pan African Clinical Trials Registry (PACTR). Although our first application to the WHO for primary status was denied (in 2008), we refused to accept defeat. After gaining endorsement of individual nations, through the WHO-supported African Vaccine and Regulatory Forum (AVAREF), we applied again.

The weeks from April to mid-June were filled with a constant volley of emails and meetings between our Working Group, our IT development team, the WHO and various other stakeholders as new “bugs” were discovered and ironed out. As we ran up to our mid-June deadline for submission, adding last minute aspects to the site to meet the ever-developing best-practice guidelines of the WHO, the various stakeholders with interest in the PACTR really began to come together as a cohesive unit. My special thanks to Nanda Mishra and Hazim Timimi (of WHO), Joy Oliver (of SACC) and Grant Louw (of AL Indigo design team), for their tireless help with the portal design. In the early weeks of July, we were notified that we had received primary status endorsement from the WHO. The PACTR, as the first WHO-endorsed primary registry in Africa, is the registry of choice for all trialists conducting trials in Africa, who are concerned with abiding by the guidelines of WHO and the International Committee of Medical Journal Editors (ICMJE).

The decision to coincide the official launch of PACTR as a primary registry with the fourth AVAREF meeting was a strategic decision, not only to pay homage to the network without whose support our WHO-endorsement may never have occurred, but also to share with Africans before anyone else, our good news for the continental trial landscape and infrastructure. On 25th Sept 2009, with my heart beating loud enough to drown out the pleas of the French-language translators to slow down (this was my first big presentation representing PACTR), I introduced the PACTR to AVAREF members and WHO representatives in Abuja, Nigeria. At the same time, the MRC, EDCTP and the SACC coordinated press releases to all press contacts possible to disseminate the message that the African continent now had its own WHO-endorsed primary registry.

Less than a month later, I was in Arusha, Tanzania, representing the PACTR at the Fifth EDCTP Forum. I was prepared, practicing daily to speak slowly, and had managed to quiet my heart-beat down to a mild thumping during my plenary presentation on the first day of the conference. While the plenary presentation was very useful for disseminating the aims of the initiative and progress to-date, even more useful was the “EDCTP Marketplace” which allowed me the opportunity to network with various stakeholders, educate trialists on the application process (walking them through the site on a PowerPoint presentation – because internet was not available in the Marketplace area) and even meet the Vice President of Tanzania (see photo)!

In the upcoming months, I will be representing the PACTR at the Public Health Association of South Africa (PHASA) conference in Durban, and at the Annual Regional Conference on Immunization, a WHO-supported Task Force on Immunizations meeting in Harare, Zimbabwe to continue to



Amber with the Vice President of the United Republic of Tanzania, Ali Mohamed Shein at the PACTR launch

PACTR's mission to harmonize and network regulatory, registration and ethical clearance efforts

The Pan African Clinical Trial Registry aims to increase transparency of clinical trials in Africa. The goal of the registry is to help harmonise the regulation, registration and ethics of clinical trials on the continent. As the first primary registry on the continent, PACTR wants to make its goal of networking clear, to ensure localised national registries that we do not intend to compete with their efforts, and hope only to foster collaboration and networking.

disseminate the message on the importance of trial registration and an African-based venue in which to do it. I look back over the last six months at the growth of PACTR (and my own growth) and realize the exciting verge this project rests on – with the support of all countries in Africa, the PACTR can make an instrumental difference in African contribution to trial knowledge and information and to the infrastructures that support

and protect prospective trial respondents. I look forward to the next six months of PACTR's growth and hope we can keep up the fast-paced momentum of the past six months.

Amber Abrams
PACTR Project Manager

Pan African Clinical Trials Registry

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Why register a trial
Benefits of registering a trial
Frequently asked questions
How to register a trial
Links to other information
Governance

The Pan African Clinical Trials Registry (PACTR) is a regional register of clinical trials conducted in Africa. The registry is an African initiative serving the needs of Africans. It provides a platform where clinical trials can be registered prospectively. In addition, it also provides a searchable, electronic database of planned trials and trials currently in progress. The PACTR is unique in recognising that African trialists face additional challenges in trial registration and seeks to provide feasible ways of overcoming these. For example, a common problem for individuals living in sub-Saharan Africa is limited, unreliable and costly internet access. With this in mind, the registry provides alternative means of trial registration for registrants who do not have reliable access to the internet. Trials may be registered manually by email, postal mail or facsimile correspondence and trial registration is free.

Partners

The PACTR is funded by the European and Developing Countries Clinical Trials Partnership (EDCTP) and the primary partners are:

1. The South African Cochrane Centre (SACC), based at the South African Medical Research Council (MRC)
2. The Cochrane Infectious Diseases Group (CIDG), based at the Liverpool School of Tropical Medicine.

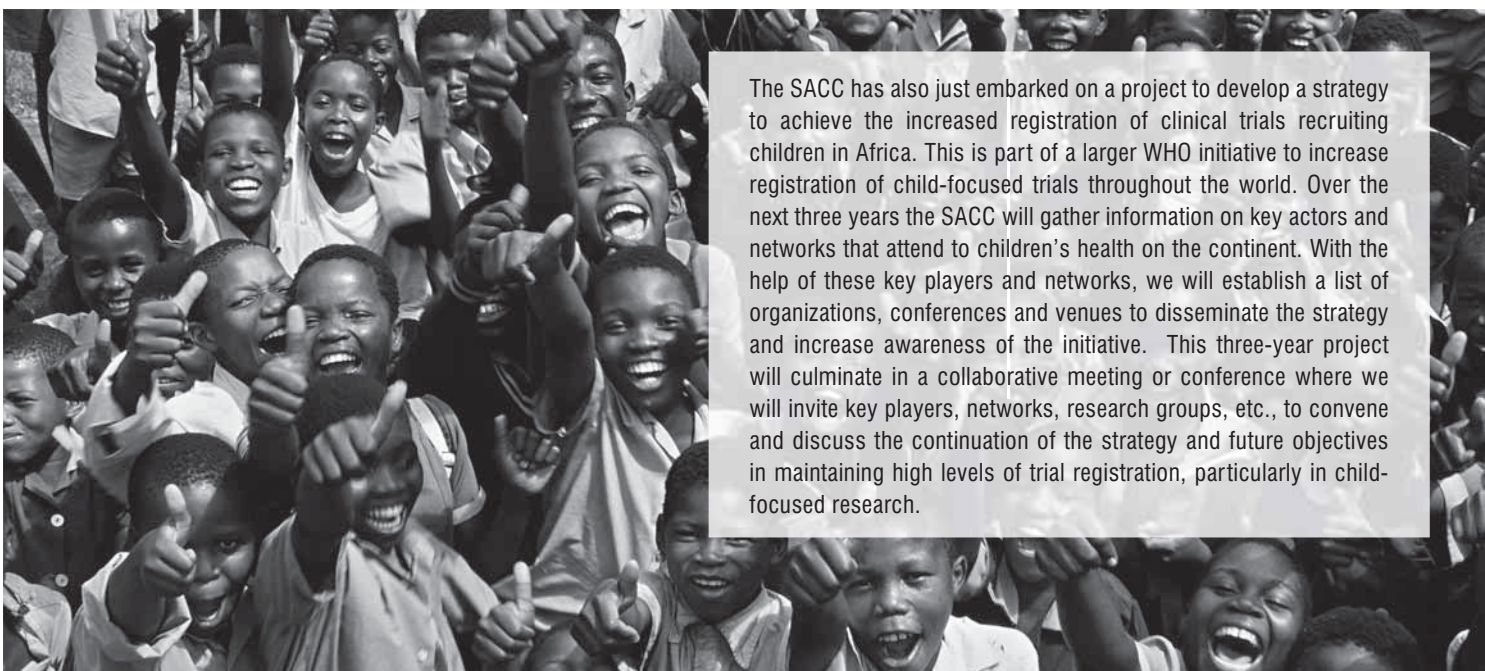
The registry is working in close collaboration with the Cochrane HIV/AIDS Group (based at the University of San Francisco and the SACC), and the World Health Organization (WHO).

Please note: The ATM Clinical Trials Registry has been expanded to include all health conditions and renamed the **Pan African Clinical Trials Registry (PACTR)**.

The European and Developing Countries Clinical Trials Partnership | The South African Cochrane Centre | MRC | LIVERPOOL SCHOOL OF TROPICAL MEDICINE

Screenshot of the PACTR Website

THE CHILD STRATEGY



The SACC has also just embarked on a project to develop a strategy to achieve the increased registration of clinical trials recruiting children in Africa. This is part of a larger WHO initiative to increase registration of child-focused trials throughout the world. Over the next three years the SACC will gather information on key actors and networks that attend to children's health on the continent. With the help of these key players and networks, we will establish a list of organizations, conferences and venues to disseminate the strategy and increase awareness of the initiative. This three-year project will culminate in a collaborative meeting or conference where we will invite key players, networks, research groups, etc., to convene and discuss the continuation of the strategy and future objectives in maintaining high levels of trial registration, particularly in child-focused research.

THE EFFECTIVE CARE RESEARCH UNIT WORKSHOP

It was my great pleasure to co-facilitate a research methods workshop on systematic reviews and clinical trials for the Effective Care Research Unit (ECRU) in East London in June this year. ECRU was established in the Eastern Cape in 2000 by Prof Justus Hofmeyr, an SACC associate staff member, and one of the first South African Cochrane review authors. The unit aims to promote evidence-based affordable care appropriate to the needs of low-income communities.

The research methods course has run extremely successfully for the last nine years and receives support from WHO Human Reproduction programme. This year additional support from the Eastern Cape Department of Health Training and Development Grant made it possible to support the attendance of a larger number of participants from the Eastern Cape, many of them medical registrars and research midwives. Altogether, 35 participants attended with 15 participants hailing from other African countries. The workshop was interactive and exercise-based and everyone enjoyed getting to grips with RevMan as evidenced by the overwhelming positive evaluations. Three participants have registered Cochrane Review titles since attending the workshop.

The Centre is delighted to be associated with the Unit which fulfils a huge need in a very poor part of our country. Next year will be the tenth anniversary of the ECRU workshop and we look forward to contributing to the event and celebrating this important milestone.

My special thanks go to the ECRU team, especially Mandisa Singata and Bongwiwe Makwedini for their superb organization, and to the participants for their enthusiasm.

Nandi Siegfried

Co-director, SACC



INCREASING COCHRANE ACTIVITIES IN AFRICA – THE BENEFITS OF RAPPING!

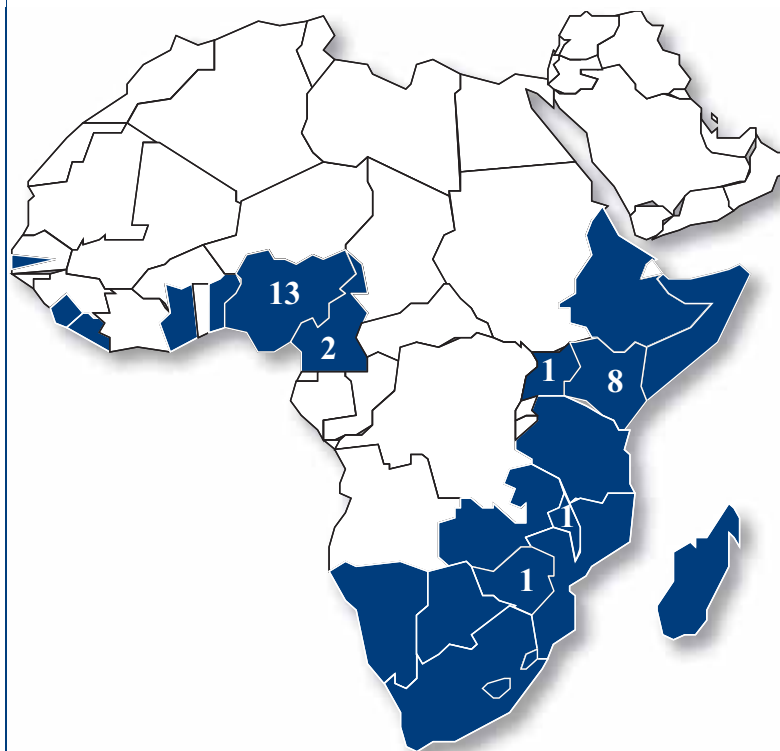
In 2005 the SACC, in collaboration with the Cochrane Infectious Diseases and HIV/AIDS Review Groups began the Reviews for Africa Programme (RAP), funded by the Nuffield Commonwealth Programme. RAP combines courses conducted at the SACC with mentoring and support offered by experienced Cochrane authors.

From inception, 26 participants (from Cameroon, Kenya, Malawi, Nigeria, Uganda, and Zimbabwe) have joined the programme. All participants have attended a 4-week intensive protocol development course and 24 have attended the 3-week review completion course. Nine reviews and 25 protocols have been published in *The Cochrane Library*. Since completing the two intensive courses, participants have conducted presentations and facilitated workshops on evidence-based health care in their home countries, and have provided training of under- and postgraduate students on the principles of research synthesis. Successful 3-day courses on systematic reviews and meta-analysis have been held in Cameroon and Malawi. In October 2007, a 2-day workshop on translating research into policy and practice was convened by participants based in Kenya. Participants are also actively sharing the knowledge they gained by mentoring new Cochrane authors and co-authoring Cochrane Reviews. In Nigeria, there is interaction and dialogue with the Nigerian Branch of the SACC and participants were instrumental in the implementation of RAP Nigeria in October 2009.

RAP is an important training model integrating components of comprehensive on-site training, mentoring and support. Cochrane Review Groups might consider how they can build on this approach in partnering with skilled groups in poorer countries to promote research synthesis.

Taryn Young and Elizabeth Pienaar
Consultant and Senior Scientist, SACC

Where do the RAPPers come from?



■ Shading denotes countries within the SACC area of responsibility with numbers indicating the number of RAPPers from that country.

THE 17TH COCHRANE COLLOQUIUM: THE LION CITY WELCOMES THE COCHRANE COMMUNITY

For the first time in history, Asia hosted the 17th Cochrane Colloquium in Singapore. This came at a time of growing interest among the region's policy makers in integrating evidence into health care decision making. We received a warm greeting in the form of the Lion Dance. The lion is the symbol of power and wisdom, and the Merlion (a unique creature with the head of a lion and a body of a fish) has been adopted as Singapore's symbol. This is evident everywhere, from buildings to lovely little gifts; the Merlion greets you with wisdom and authority. Singapore is well maintained (be sure to be greeted with a fine should you not abide by the rules). Her beauty calls you to defy the heat and humidity to view all you possibly can, from the animal kingdom to the artificial beach created with high-level technology.

The Colloquium was officially opened by Prof. K. Satku, the Director of Medical Services of the Ministry of Health, who highlighted two objectives of the Collaboration of particular interest to Asia; prioritizing topics for Cochrane Reviews and collaboration with agencies involved in the development of guidelines. The groans of labour-pains were heard, as the birth of a working relationship between the Cochrane Collaboration and Evidence-Informed Policy Network (EVIPNet) seemed a very close possibility. EVIPNet was launched by the WHO in June 2005 and, like the Collaboration, advocates for the production and use of evidence-base in decision making. Its focus is on low and middle income countries.

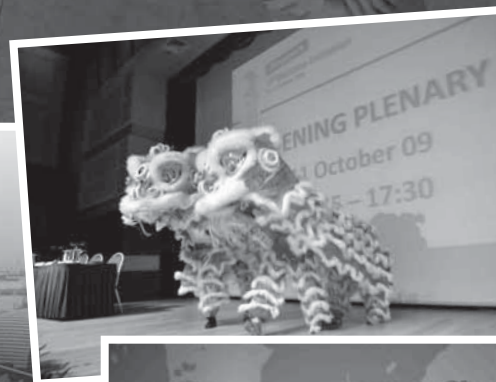
The strategic review of the Collaboration presented re-affirmed the primary purpose of the Collaboration to be the production of systematic reviews. Additional purposes, including training, methods development, advocacy for evidence-based decision making and others were formalized. Plenary sessions highlighted the Collaboration's impact on capacity development, methods of dealing with complexity of Cochrane Reviews and the brave new world of *The Cochrane Library*. Meetings and workshops provided an opportunity

for interactive training, collaboration and discussion - from trial search co-ordinators to those presenting evidence to policy makers.

The South African flag flew very high, with lively interactions during the "Meet the entities" session, three posters presented by myself, Joy Oliver and Charles Okwundu. Jimmy Volmink presented at a plenary, Taryn Young an oral presentation and finally, Joy and Charles facilitated a workshop on challenges and opportunities for Cochrane authors from developing countries.

Excitingly - though presently forming a very small percentage - the Twitter and Facebook generation was not left behind. With new and interactive websites, as well as Facebook groups and conversations to join, the Keystone Colloquium in 2010 is bound to attract more young people.

Babalwa Zani
Scientist, SACC



NEW STAFF

AMBER ABRAMS



Amber Abrams was appointed as a senior scientist in August 2009. Her appointment at the SACC followed five months of contract employment as administrator for the Pan African Clinical Trial Registry (PACTR). Amber represents the registry at forums and meetings focused on regulation, registration and ethics oversight, increasing awareness of the PACTR. Before joining the MRC, Amber was a Teaching Assistant in the Department of Social Anthropology at the University of Cape Town and has held researcher, assistant researcher and project manager positions at the Human Science Research Council, Groot Schuur Hospital, University of Cape Town, the University of Connecticut and the University of Reading. Amber is an anthropologist with a BA from Columbia University and an MPhil in HIV/AIDS and Society. She is looking forward to pursuing her PhD in the near future.

VICKI BADENHORST



Vicki Badenhorst joined the SACC on the 01 August 2009. Previously she worked as a Training Coordinator at South African Airways. As the Senior Administrative Officer she is responsible for secretarial support, travel and workshop co-ordination at the Centre. In addition she provides support to visitors.

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The South African
Cochrane Centre

ANNOUNCEMENTS

JOINT COLLOQUIUM OF THE



Joint Colloquium of the
Cochrane & Campbell
Collaborations

Bringing Evidence-Based Decision-Making to New Heights
18 - 22 October 2010 - Keystone Resort, Colorado, USA

COCHRANE & CAMPBELL COLLABORATIONS

Bringing Evidence-Based Decision-Making to New Heights

18 - 22 October 2010 - Keystone Resort, Colorado, USA

In 2010 the Joint Colloquium of the Cochrane & Campbell Collaborations will be held at the Keystone Resort in Colorado, USA. This will be the first time for these two groups to hold a joint colloquium.

The colloquium will focus on raising evidence-based decision-making to new heights. In this region, known for its towering mountain peaks and natural beauty, we will come together for multidisciplinary learning and sharing at its best.

KEY DATES

29 March 2010	Abstract Submission deadline
1 June 2010	Consumer & Developing Countries Stipends deadline
6 July 2010	Early Registration deadline
7 September 2010	Hotel Registration Deadline

For more information, please visit: <http://www.cochrane.org>



THE NEW COCHRANE JOURNAL CLUB ONLINE

Cochrane Journal Club presents a recent Cochrane review, together with relevant background information and resources, podcasts by the authors explaining the key points of the review, and discussion questions to help you to explore the review methods and findings in more detail. In addition, Cochrane Journal Club provides downloadable PowerPoint slides containing key figures and tables, ready for you to present the paper to your Journal Club group over that much needed cup of coffee. Every Cochrane Journal Club article is specially selected from the hundreds of new and updated reviews published in each issue of *The Cochrane Library*.

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