

South African

COCHRANE CENTRE

GREATER GLOBAL PARTICIPATION WITHIN THE COCHRANE COLLABORATION

One of the challenges faced by The Cochrane Collaboration is the mismatch between the global burden of disease and the review topics being addressed in *The Cochrane Library*. A large number of authors conduct reviews that represent the needs of well-resourced countries with different disease burdens from those affecting the majority of the global population. Guiding principles of The Cochrane Collaboration include enabling wide participation and striving for relevance and those contributing to the goals of the Collaboration should be mindful of the needs of people, regardless of nationality, sex, language, culture or access to resources. A challenge for the Collaboration is that authors are mostly from rich countries (figure), are more often English-speaking, and more commonly male.

This year's mid-year meeting of The Cochrane Collaboration in Split, Croatia, showed the Collaboration's ongoing commitment to addressing the challenge of more equitable global representation within the organisation. The strategic session, broadcast live from the meeting, was entitled '*The Cochrane Collaboration enables better global participation*'. This session provided a platform to address barriers to broader involvement and working groups were given time to suggest practical solutions. The overarching objective of the session was the formation of a strategic framework for The Collaboration to take forward.

Three broad strategies to enhance global participation were proposed: 1) support for authors including formal training and mentoring programmes, 2) strengthening regional geographic or linguistic networks and structures, including providing language support, and 3) harnessing external partnerships with organisations that share the vision of evidence-based practice and policy. It is likely that all of these strategies will be engaged to different degrees. The process of prioritising is underway following this consultation process.

How do we address issues to enable greater inclusivity and opportunities for those in our region? The South African Cochrane Centre (SACC) staff strive to provide training and support to review authors and to ensure greater involvement of the growing network of contributors from the African region through the thriving HIV/AIDS mentoring programme, currently in its 11th year, and the many workshops that aim to build skills for both new and experienced authors. Fortunately there are encouraging signs that global participation is improving. In 2005, 15% of authors listed in Archie were from Africa, Asia and South America, and this has increased to 25%. Whether this rate of change is adequate is up for debate, however, what is clear, is that there is more that can and should be done to ensure that contributors from the under-represented regions increase. For now, we hope that the enthusiasm of SACC staff, the opportunities on offer for authors to grow as researchers and the ideal of contributing to the greater aims of The Collaboration, continue to make a positive difference in the African region.

Tamara Kredo
SACC



Figure: Countries sized according to number of Cochrane authors (source: Archie 2010). Acknowledgements to P Ravaud

What's in this issue:

| | | | |
|----------|--|--------|--|
| Page 1 | Editorial – Greater global participation within The Cochrane Collaboration | Page 6 | Systematic reviews of complex interventions www.pactr.org growing bigger and better |
| Page 2-3 | From <i>The Cochrane Library</i> | Page 7 | The ever changing RevMan |
| Page 4-5 | From the east to the west of Africa | Page 8 | Announcements |



ARTESUNATE REDUCES DEATH FROM SEVERE MALARIA

Severe malaria occurs when infection with the malaria parasite is complicated by serious failure of the body's major organs, and results in over a million deaths every year. Sometimes severe malaria is associated with coma and is known as cerebral malaria. Following cerebral malaria a small proportion of children suffer with long-term neurological disability. This review of trials assessed the effectiveness of artesunate, compared with the standard treatment quinine. Eight trials involving 1664 adults and 5765 children were identified, from study sites in Asia and Africa. Treating adults in Asia with artesunate instead of quinine would prevent an extra 94 deaths for every 1000 patients treated. In trials involving children, the proportion of deaths was lower than in the trials involving adults. This lower risk of death results in a smaller benefit in children than in adults, but would still save an extra 26 lives for every 1000 children treated. In the children who survived their illness, there were more neurological problems at the time of hospital discharge in those treated with artesunate than those treated with quinine. However, the majority of these neurological problems had resolved when they were reviewed 28 days later, and at this timepoint there was no difference between the two treatment groups. Artesunate should be the drug of choice for adults and children with severe malaria worldwide.

Citation: Sinclair D, Donegan S, Lalloo DG. Artesunate versus quinine for treating severe malaria. *Cochrane Database of Systematic Reviews* 2011, Issue 3. Art. No.: CD005967. DOI: 10.1002/14651858.CD005967.pub3

ZINC FOR THE COMMON COLD

The common cold is often caused by the rhinovirus. It is one of the most widespread illnesses and is a leading cause of visits to the doctor and absenteeism from school and work. Complications of the common cold include otitis media (middle ear infection), sinusitis and exacerbations of reactive airway diseases. There is no proven treatment for the common cold. However, a medication that is even partially effective in the treatment and prevention of the common cold could markedly reduce morbidity and economic losses due to this illness. Zinc inhibits rhinoviral replication and has been tested in trials for treatment of the common cold. This review identified 15 randomised controlled trials, enrolling 1360 participants of all age groups, comparing zinc with placebo (no zinc). We found that zinc (lozenges or syrup) is beneficial in reducing the duration and severity of the common cold in healthy people, when taken within 24 hours of onset of symptoms. People taking zinc are also less likely to have persistence of their cold symptoms beyond seven days of treatment. Zinc supplementation for at least five months reduces incidence, school absenteeism and prescription

of antibiotics for children with the common cold. People taking zinc lozenges (not syrup or tablet form) are more likely to experience adverse events, including bad taste and nausea. As there are no studies in participants in whom common cold symptoms might be troublesome (for example, those with underlying chronic illness, immunodeficiency, asthma, etc.), the use of zinc currently cannot be recommended for them. Given the variability in the populations studied (no studies from low- or middle-income countries), dose, formulation and duration of zinc used in the included studies, more research is needed to address these variabilities and determine the optimal duration of treatment as well as the dosage and formulations of zinc that will produce clinical benefits without increasing adverse effects, before making a general recommendation for zinc in treatment of the common cold.

Citation: Singh M, Das RR. Zinc for the common cold. *Cochrane Database of Systematic Reviews* 2011, Issue 2. Art. No.: CD001364. DOI: 10.1002/14651858.CD001364.pub3

THE EFFECT OF THE DRUG OXYTOCIN AS A TREATMENT FOR SLOW PROGRESS IN LABOUR

Slow progress in the first stage of spontaneous labour may be caused by weak contractions of the womb. Doctors and midwives commonly give a drug called oxytocin with the aim of strengthening contractions and speeding up labour to avoid harm to both the mother and the newborn infant. The belief is that managing the labour in this way will enable progression to a normal vaginal delivery and reduce the need for caesarean section. However, others have been fearful that it has no effect on the type of delivery a woman might have and in other ways may do more harm than good. This review of eight studies, involving 1338 low-risk women in the first stage of spontaneous labour at term, showed that oxytocin did not reduce the need for caesarean sections. Neither did it reduce the need for forceps deliveries or increase the number of normal deliveries when compared with no treatment or delayed oxytocin treatment. Oxytocin seemed to shorten labour by nearly two hours on average. The uptake of epidurals was no different. It does not seem to cause harm to the mother or baby, but the sample size was too small to determine if its use has an effect on the death rates of babies. The decision whether to undergo this treatment is one that can reasonably be left to women to decide in the context of a reduction in the length of labour. The included trials used different doses of oxytocin, and different criteria for starting treatment in the delayed oxytocin arm.

Citation: Bugg GJ, Siddiqui F, Thornton JG. Oxytocin versus no treatment or delayed treatment for slow progress in the first stage of spontaneous labour. *Cochrane Database of Systematic Reviews* 2011, Issue 7. Art. No.: CD007123. DOI: 10.1002/14651858.CD007123.pub2.

EFVIRENZ OR NEVIRAPINE IN THREE-DRUG COMBINATION THERAPY WITH TWO NUCLEOSIDE-REVERSE TRANSCRIPTASE INHIBITORS FOR INITIAL TREATMENT OF HIV INFECTION IN ANTIRETROVIRAL-NAÏVE INDIVIDUALS

The introduction of combination antiretroviral therapy has reduced morbidity and mortality due to HIV. Two of the most common medications given in first-line antiretroviral treatment are the non-nucleoside reverse transcriptase inhibitors (NNRTIs), efavirenz (EFV) and nevirapine (NVP). It is unclear which NNRTI is more efficacious for initial therapy.

OBJECTIVE

To determine which NNRTI, EFV or NVP, is more effective in suppressing viral load when given in combination with two NRTIs as part of initial ART for HIV infection in adults and children.

MAIN RESULTS

Description of studies

Seven randomized controlled trials (RCTs) with 1688 participants (range 58-1007) were included. The studies were conducted in low-, middle- and high-income countries including the Americas, Australia, Europe, Indian, Thailand, Spain, Mexico and South Africa. The duration of follow-up ranged from 24 weeks to 72 weeks. Three trials used methods of generating the allocation sequence that were free of bias, two adequately concealed the allocation sequence until randomization was completed and two trials were blinded.

Efavirenz 600mg versus Nevirapine 200mg twice daily

Virological success at 48 weeks was comparable in the two treatment arms [RR=1.02; 95% CI (0.96, 1.10), p=0.44, four trials, 1200 participants] and immunologic response was also similar [WMD=-2.00; 95% CI (-23.17, 19.18), p= 0.92, five trials, 1284 participants]. With regards to mortality, there were no differences between EFV and NVP containing regimens [RR=0.89; 95% CI (0.50, 1.57), p=0.66, three trials, 1157 participants]. The numbers of patients who progressed to AIDS while on treatment and those who discontinued treatment were also similar [RR = 1.32; 95% CI (0.53, 3.30), p=0.28, three trials, 1157 participants, and RR= 0.94; 95% CI (0.72, 1.22), p=0.62, four trials, 1215 participants, respectively].

Overall, the risk of serious adverse events was similar in the two treatment arms [RR=1.01; 95% CI (0.60, 1.70), p=0.67, four trials, 1054 participants]. Treatment with EFV was associated with a 41% lower risk of raised transaminases [RR=0.59, 95% CI (0.37, 0.95), p=0.03, two trials, 1015 participants], and with a 72% reduction in the

risk of neutropenia [RR=0.28, 95% CI (0.11, 0.76), p=0.013, one trial, 787 participants]. The commonly reported adverse events were rash, central nervous system adverse events, gastrointestinal tract adverse events, pyrexia, raised alkaline phosphatase, raised amylase and raised triglycerides and there were no significant differences observed between the treatment arms for these events. A single study contributed data on viral resistance and found that acquired resistance was 31% lower in the EFV-containing arm [RR=0.64, 95% CI (0.46, 0.91), p=0.01, 228 participants].

Implications for practice

EFV and NVP provide comparable levels of viral load suppression, but have different side-effects. Clinicians need to determine which is the more appropriate for their patients by weighing other factors like availability, pill burden, cost and concomitant medication. They must also consider individual tolerability and monitor for side-effects, some of which can be fatal. While subtle differences in risk of toxicity, discontinuation and resistance may exist, we found that EFV and NVP have very similar clinical efficacies. The use of NVP or EFV in paediatric populations remains very poorly studied in RCTs, and all inferences need to be drawn from trials conducted in adults.

Implications for research

Although more trials would provide a more robust body of evidence, it is unlikely that additional trials will be conducted, at least in adults and adolescents. Prospective cohort studies are the most likely source of improved data on side effects, discontinuation and development of resistance. One particular population of interest is women who have received single-dose NVP for prevention of mother-to-child transmission of HIV.

Citation: Mbuagbaw LCE, Irlam JH, Spaulding A, Rutherford GW, Siegfried N. Efavirenz or nevirapine in three-drug combination therapy with two nucleoside-reverse transcriptase inhibitors for initial treatment of HIV infection in antiretroviral-naïve individuals. *Cochrane Database of Systematic Reviews* 2010, Issue 12. Art. No.: CD004246. DOI: 10.1002/14651858.CD004246.pub3.

Babalwa Zani

SACC

Tamara Kredo

SACC

FROM THE EAST TO THE WEST OF AFRICA:

ETHIOPIA

The first national one-day awareness raising workshop on evidence-based practice (EBP) was conducted at Dreamliner Hotel in Addis Ababa, Ethiopia on 1 December 2010. The workshop was attended by over 70 senior managers from several organizations including the American International Health Alliance (AIHA)-Twinning Centre partners in Ethiopia, South Africa, Nigeria, Namibia, Zambia, and Tanzania. Jimmy Volmink and Taryn Young from the SACC and Stellenbosch University, and Paul Garner from the Liverpool School of Tropical Medicine (LSTM), also attended the workshop.

This workshop was organized by Omar Abdulwadud (a volunteer Health Corps) and the AIHA-Twinning Center Country Office in collaboration with the SACC and LSTM and was funded by the AIHA-Twinning Centre.

The one-day workshop focused on the principles of EBP, The Cochrane Collaboration and the roles of the SACC in promoting EBP in Africa. In addition, the participants

presented examples of EBP within their organizations and discussed how to promote this approach further in Ethiopia. Following the discussion, a committee was formed to develop plans for enhancing EBP in Ethiopia.

The successful workshop is a great testimony to the hard work and support of several individuals and organizations. We thank Dr. Dereje Gulilat (Dean School of Medicine, Addis Ababa University), Dr Nighist Tesfaye (Director, Urban Health Promotion and Disease Prevention Directorate, Federal Ministry of Health), Kidest Hailu (Country Director, AIHA-Twinning Center, Addis Ababa), Metti Midekssa, Aazamina Rangwala, Prof. Jimmy Volmink and Dr. Taryn Young (SACC), Prof. Paul Garner (LSTM), and Prof Yemane Berhane (Director, Addis Continental Institute of Public Health)

Omar Abdulwadud

Volunteer Health Corps, American International Health Alliance-Twinning Center
Addis Ababa, Ethiopia



RAISING AWARENESS ABOUT EVIDENCE-BASED PRACTICE

CAMEROON

In January 2011, the Centre for the Development of Best Practices in Health (CDBPH) in Yaoundé, Cameroon hosted a 4-day introductory workshop on systematic reviews and meta-analysis for 15 university lecturers and researchers.

The course was facilitated by review authors from the CDBPH, the 'Pontificia Universidad Catolica' in Chile, the University of Buea in Cameroon and the University of Cape Town, South Africa. The aim of the four-day workshop was to build systematic review skills in Cameroon. Participation was interactive and presentations were in both English and French. Many practical sessions were conducted with hands-on practice exercises on searching for primary studies and reviews, data extraction, interpretation of systematic reviews, and appraising study quality.

On the last day, more emphasis was placed on reviews in health systems and organisation of care. All presentations and additional supporting material were sent to participants by email. At the end of the workshop, participants identified topics on which they would like to conduct systematic reviews. The wide variety of identified topics was enriching for the participants and the facilitators.

Despite some technical difficulties, the participants evaluated the workshop favourably and appreciated the hands-on approach used. Among the three best things about the workshop, one of the participants cited, "*the methodological approach, scientific rigor and practical exercises.*"

Prior to this workshop, an advanced



workshop on systematic reviews was conducted for 18 university lecturers and researchers who participated in a workshop on introduction to systematic reviews and meta-analysis in Yaoundé in December 2009. The organizers of the workshops gratefully acknowledge the support received from the SACC, the Yaoundé Central Hospital, and the Global Health Research Initiative.

Lawrence Mbuagbaw

Centre for the Development of Best Practices in Health, Yaoundé Central Hospital, Yaoundé, Cameroon.

Charles Shey Wiysonge

University of Cape Town, Cape Town, South Africa

SYSTEMATIC REVIEWS OF COMPLEX INTERVENTIONS

Complexity in systematic reviews can be as a result of characteristics of the intervention, contextual factors, multiple outcomes, differential effects across populations or methodological issues. It's becoming more common for reviews to tackle such issues but it is rarely easy to provide a neat answer. This one day seminar held at the UK Cochrane Centre in January 2011 and presented by Sasha Sheppherd and colleagues from the Effective Practice and Organization of Care (EPOC) review group, attempted to provide guidance on how to address these issues.

One key issue that was emphasised was how, before a title is registered, issues of complexity need to be considered and addressed. For example, it is important to anticipate in advance what the major sources of heterogeneity are in interventions across studies otherwise interpretation becomes very difficult. Interventions are often multi-faceted and are rarely identical across studies. These factors are important, for example, if you are recommending an approach to policy-makers. Questions arise on which of the different components worked. Are you

able to disentangle effective from ineffective intervention components? You may have to consider splitting your review into smaller reviews. This then will naturally also lead to a more focussed search strategy. It is also useful to pilot your inclusion criteria to see if you are being overly inclusive or exclusive. Qualitative data that is reported alongside trial data can also be useful in managing the complexity of an intervention although the availability of such data is often limited and needs more attention in trial design. Currently there is little specific guidance for reviewers or consensus on approaches for systematically reviewing the evidence from complex interventions. However, there's currently a lot of methodological work being undertaken and clearer guidance is promised in the next publication of the *Cochrane Handbook for Systematic Reviews of Interventions*.

THE PUNT: *an intervention for going down a river in Oxford!*

If you were doing a review of trials of the effectiveness of a Punt compared to swimming

as a form of water transport for getting from A to B and one of your trials involved Punt trips from the Victoria Arms Pub to The Botanical gardens in Oxford, is it enough to know that they actually got there? Wouldn't you want some more information? Does the vehicle (age, condition, colour, design) or the driver (age, fitness level, enthusiasm, blood alcohol level) or the weather conditions (sunny, rainy, windy) matter if you are going to suggest this as the best way to get down the river?

Amanda Mason-Jones

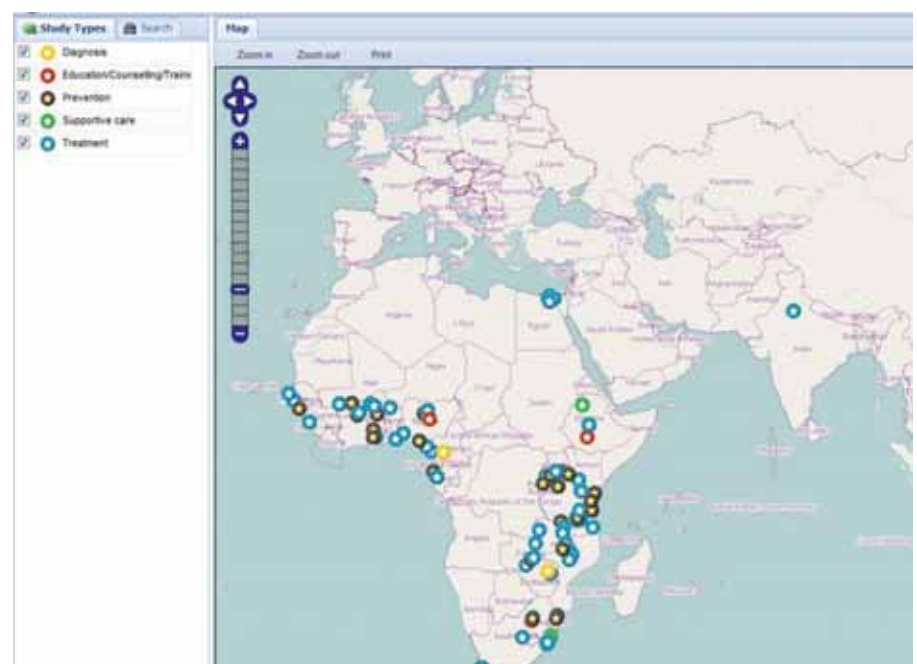
Health Systems Research Unit, South African Medical Research Council.



www.pactr.org GROWING BIGGER AND BETTER

In June 2011, the Pan African Clinical Trials Registry (www.pactr.org), marked the beginning of its third year as a member of the World Health Organization's (WHO) Network of Primary Registers, and remains the only one of its kind on the African continent. In the past year the registry has more than tripled in size, with most growth occurring during the first quarter of 2011. To date, trial applications mainly represent research on high burden diseases in the region, including HIV/AIDS, tuberculosis and malaria. Aside from the tremendous growth the registry continues to experience, we are delighted to announce the development of a GIS mapping component on the database, providing a visual display of trial locations as they are registered.

Promoting the registry and educating trialists on the importance of clinical trial registration has been the focus of 2010. The Registry was presented at eight international, two local conferences and/or meetings, and three lectures were delivered to MSc students on



www.pactr.org, and the importance of clinical trial registration. To meet our goal of assisting with the regulation, registration and ethical oversight of clinical trials, www.pactr.org, contributed to the first Working Group for meeting

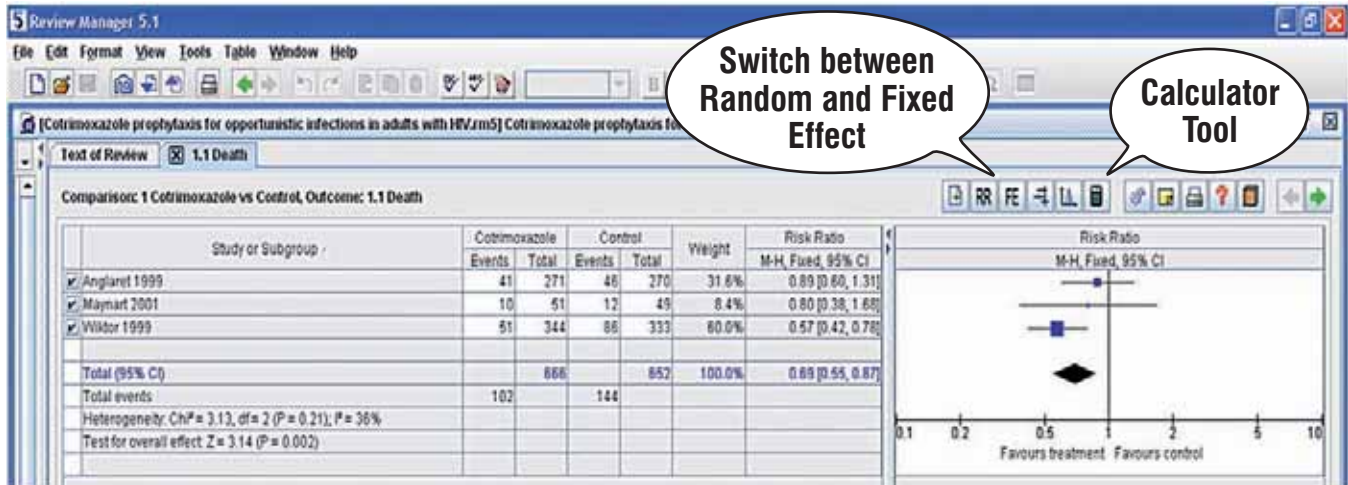
the Pan African Clinical Trials Alliance (PACTA), a WHO supported initiative, in November 2010.

Amber Abrams

SACC

THE EVER CHANGING REVMAN!

NEW DATA ENTRY AND ANALYSIS SCREEN



Review Manager or RevMan, the software used to prepare systematic reviews for publication in *The Cochrane Library*, never stays the same for long. Since the release of RevMan 5 in March 2008 it has been continuously updated as bugs were fixed and features enhanced. With the advent of Diagnostic Test Accuracy Reviews it became necessary to make some major changes to the software. On 22 March 2011 the latest version, RevMan 5.1, was released with some great new features added to simplify the process of review writing. The number of enhancements are too many to list, so I'm only highlighting a few. The complete list of changes can be found at <http://ims.cochrane.org/revman/documentation>

CHANGES IN THE RISK OF BIAS TABLE

| | |
|--|--|
| Separation of blinding | In the earlier version, biases related to blinding of participants, personnel and outcome assessors were all assessed within a single domain (although they may have been assessed separately for different outcomes). In the revised tool, bias related to blinding of participants and personnel is assessed in a domain separately from bias related to blinding of outcome assessment. |
| Nature of the judgement | The judgements are now expressed simply as 'Low risk', 'High risk' or 'Unclear risk' of bias. The questions have been removed, along with the responses 'Yes' for low risk and 'No' for high risk of bias. |
| Reconsideration of eligible issues for 'other bias' | The guidance for the 'other bias' domain has been edited to strengthen the guidance that additional items should be used only exceptionally, and that these items should relate to issues that may lead directly to bias. In particular, the mention of early stopping of a trial has been removed. |

WHAT ARE THE NEW FEATURES IN REVMAN 5.1?

Review Information

It is now possible for Cochrane Review authors to include more than one institutional affiliation. Multiple affiliations need to be recorded in their record in Archie in order for it to be linked to a review.

Text of Review

Authors now have the ability to split the screen and scroll each of these independently. This allows you to copy or cut text from one section of the review to another section. This is only applicable to the text of the review and does not apply to tables or figures within.

When you deactivate a subheading under which text have been typed, the heading will disappear, but the text will be retained.

Inserting links to studies or analysis

figures has become easier in that it is now possible to insert multiple links by holding down the CTRL key and choosing multiple items from the links menu.

Figures

PRISMA flow diagrams can be created and edited within RevMan. Choose PRISMA from the Figures menu and follow the wizard.

Tables

A Summary of Findings (SOF) Table created using software packages other than RevMan and imported into a review can now be edited within RevMan. When a SOF table is created in RevMan using the wizard you can choose which of the outcomes and columns you want to include in the table. Changes have also been made to the Risk of Bias tables as indicated in the table above.

Data and analyses

A calculator tool facilitates data entry by allowing single screen viewing of different effect

measures and switching between different confidence intervals. Quick toolbar buttons are available for switching between effect measures and random effects/fixed effects models.

Further details are available from:

<http://www.cc-ims.net/RevMan>

The latest version of RevMan is available for download from:

<http://ims.cochrane.org/revman/download>

If you have any suggestions as to how the software can be further enhanced you are welcome to add your ideas to the RevMan Wish list, which can be found at the above URL. Any bugs encountered while using the software may also be reported at the above URL.

For any queries or problems regarding the use of the software you are welcome to contact Elizabeth Pienaar at either email: epienaar@mrc.ac.za or tel: +27 21 9380835.

Elizabeth Pienaar
SACC

COCHRANE-WHO PARTNERSHIP

In January 2011, The Cochrane Collaboration was accepted as a Non-Governmental Organization in Official Relations with the World Health Organization (WHO), the public health arm of the United Nations, establishing formalized communication between the two organizations.

This partnership includes a seat for the Collaboration on the World Health Assembly, the WHO's decision-making body, allowing the Collaboration to provide input on WHO health resolutions. It provides the opportunity for the Collaboration to significantly influence the way research evidence is created and used by the WHO by improving the collection of reliable health information on which they base their policies. It promotes intersectoral collaboration and high-quality research between the organizations to produce the necessary evidence to ensure policies in all sectors contribute to improving health and health equity.



CONGRATULATIONS TO STEPHEN GICHUHI

Dr. Stephen Gichuhi, based at the University of Nairobi, Kenya, conducted a review on *"Interventions for squamous cell carcinoma of the conjunctiva in HIV-infected individuals"* and found no trials that fit the inclusion criteria. The review opened doors for Steve who has been awarded a three year PhD fellowship with the London School of Hygiene and Tropical Medicine to fill the gap in knowledge identified by his review. The SACC congratulates Steve and wishes him everything of the best for his studies in London.

GRADE WORKSHOP

Systematic reviews of the effects of interventions provide evidence for making clinical decisions, formulating policies, and developing clinical practice guidelines. To ensure accuracy and relevance of systematic reviews, rigorous and transparent methods should be used to assess the quality, analyze and present the evidence in a simple and understandable way. The GRADE system is an internationally recognized approach which uses a systematic method for assessing the quality of evidence. The SACC will host a GRADE workshop for Cochrane authors in the African region.

Dates: 20-21 September 2011

Venue: South African Cochrane Centre

The South African Medical Research Council, Cape Town

For further information, please contact Elizabeth Pienaar on the SACC contact details below.

DID YOU KNOW?

The Cochrane Database of Systematic Reviews (CDSR) Impact Factor has increased to 6.186

Some highlights of the 2010 Impact Factor include:

- The CDSR is now ranked in the top **10** of the 151 titles in the Medicine, General & Internal category
- This is the **4th** consecutive year that the CDSR Impact Factor has increased
- The CDSR Impact Factor increased by **9.4%** compared to 2009 which was 5.653
- The CDSR received the **7th** highest number of citations in its category

The Cochrane Official Blog has finally been launched

- The official blog found on [cochrane.org](http://www.cochrane.org/) <http://www.cochrane.org/> under 'News & Events' can be viewed on the latest submissions at <http://www.cochrane.org/blog>
- The Official Blog replaces the previous PDF version of Cochrane News, but still features 'News, information, resources & issues affecting The Cochrane Collaboration'
- One of the many benefits of this new format is that articles will be published soon after submission, rather than waiting for the three-month period. Readers will also have the option of commenting on posts, subscribing via RSS and navigating by tabs



THE 19TH COCHRANE COLLOQUIUM MADRID, SPAIN

Scientific evidence for health care quality and patient safety

Important dates:

| | |
|---------------------|------------------------------------|
| 25 July | Early registration deadline |
| 5 August | Meeting request deadline |
| 12 September | Workshop and meeting sign-up |
| 3 October | Registration cancellation deadline |

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

CONTACT US



The South African Medical Research Council
PO Box 19070, Tygerberg, 7505
Francie van Zijl Drive, Parow Valley, 7500
Cape Town, South Africa

Email: cochrane@mrc.ac.za
Tel: +27 21 938 0438; Fax: +27 21 938 0836