**Application form for establishing a Cochrane Geographic Group: Affiliate**

This form is for Cochrane members wishing to establish a Cochrane Geographic Group - Affiliate. Completed applications should be submitted to Karla Duque Jacome at [kduquejacome@cochrane.org](mailto:kduquejacome@cochrane.org)



**Terms of acceptance, if granted:**

* 12-month probationary period
* The host institution, proposed Affiliate Director, and Cochrane must sign Cochrane’s Geographic Group [Collaboration Agreement](https://community.cochrane.org/sites/default/files/uploads/inline-files/Collaboration%20Agreement%20-%20Geo%20Groups%20-%20TEMPLATE%2019Jan2024.pdf)
* Monitoring and evaluation metrics must be reported annually on [Cochrane’s M&E platform](https://community.cochrane.org/organizational-info/resources/resources-groups/geographic-groups-portal/reporting). Be prepared to carry out and report annually on at least 3 activities, such as:
* Training and learning opportunities
* Workshops
* Conferences or professional development (organized or attended)
* Curricula development
* Language translations
* Tools, methods, and materials development
* Methods research
* Priority setting (communicating national priorities to Cochrane to aid in organizational prioritization)
* Evidence production (Cochrane and other systematic reviews and meta-analyses
* Dissemination / Knowledge Translation of Cochrane Evidence
* Cochrane-Wikipedia Project
* Partnership development
* Consumer / Patient Involvement
* Contributions to the use of Cochrane evidence in healthcare guidelines
* Contributions to funding (grant writing, resource allocation, etc)
* Cochrane Colloquium committees, including abstract & workshop submission reviews, poster scoring, etc.
* Participation in Cochrane Networks (trainers, methods) and Workgroups (climate health, equity)
* Participation in Cochrane Mentorship programs
* Attendance and/or engagement in Cochrane Colloquium, which is held as the annual face-to-face Geographic Group meeting
* Participate in regional geographic group events and meetings
* All staff and signatories must read and agree to the terms of Cochrane’s organizational policies:
  + [Spokesperson](https://community.cochrane.org/sites/default/files/uploads/inline-files/Spokesperson%20Policy%20Revision%202020%20-%20Final%20-%20August%202020.pdf)
  + [Conflict of Interest](https://training.cochrane.org/sites/training.cochrane.org/files/public/uploads/Conflict%20of%20Interest%20policy_2023_05_v21.pdf)
  + [Logo and Branding](https://community.cochrane.org/sites/default/files/uploads/inline-files/Cochrane%20Brand%20Guidelines_Jan%202022%20Updated.pdf)

**Eligibility Prioritization:**The following criteria will be used in selecting new Affiliate Geographic Groups:

* The proposed group fills a geographic gap in which Cochrane currently has little or no presence, especially in LMIC\* settings. The application should clearly explain this.
* The proposed group will fill a technical / dissemination gap (i.e., policy influence, impactful partnerships, capacity development, training, language translation, and material development). This should be clearly explained in the application.
* One or some of the proposed staff have worked with Cochrane previously and have Cochrane expertise.\*\*
* Capacity to attend and participate in quarterly Geographic Group virtual meetings and other Cochrane events\*\*\*

\* Low- and Middle-Income Countries as defined by The World Bank: <https://datahelpdesk.worldbank.org/knowledgebase/articles/906519> \*\* Using and/or producing Cochrane resources and tools to access and utilize evidence-based healthcare information; partnership with existing Cochrane groups. Expertise in non-systematic reviews will be considered if the groups fill an important gap.  
\*\*\* Directors are expected to attend & participate in four Geo Group meetings annually or send a Deputy in their stead. Additionally, participation in Cochrane events and other regional meetings is encouraged.

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| **New Group Application** | | | | |
| **A. General Information** | | | | |
| **Where will the Group be located?** | | | Country, city, or region | |
| **Why is a CGG group needed in your city/region/country? Please provide information about the current situation regarding EBM (evidence-based medicine), KT(Knowledge Translation), and SR (Systematic Review).** | | |  | |
| **Name of Host Institution** | | |  | |
| **What makes your host institution a good place to establish a CGG?** | | |  | |
| **Which Gap would this group be filling?** | | | Technical/dissemination/methodological gap, specify **CLEARLY** how | |
| Geographical gap, specify **CLEARLY** how | |
| **B. Governance** | | | | |
| **Please fill in the known future members of the group. Per the collaboration agreement, we expect a minimum of 5 members, which together make up a minimum of 1 Full Time Equivalent (FTE)** | | | | |
| **Position** | **Name and title** | **FTE%** | **Background in Cochrane activities and Cochrane/non-Cochrane systematic review experience (1-2 sentences)** | |
| **Director (compulsory)** |  |  |  | |
| **Co-director or Deputy Director (optional)** |  |  |  | |
| **Admin (compulsory)** |  |  |  | |
| **Advisory Board** |  |  |  | |
| **Librarian** |  |  |  | |
| **General members** |  |  |  | |
| **Total** |  |  |  | |
| **Host representative (compulsory)(will need to sign the agreement form and should be different from the Director)** |  |  |  | |
| **C. Strategic Plan** | | | | |
| **Please create a tentative 1-2 year plan, detailing ‘SMART’ goals, including the following:.** | | | | |
| **Vision and Mission** | **Vision:** | What do you aspire to become? | | |
| **Mission:** | How do you envision achieving this? | | |
| **Situational Analysis** | **Internal Analysis:** | Assess your current strengths, weaknesses, resources, and capabilities. | | |
| **External Analysis:** | Analyse your market, industry, competitors, and opportunities/threats. | | |
| **Strategic Goals and Objectives** | **Goals:** | What are your aspirations? | | |
| **SMART Objectives:** | ‘SMART’ goal: statements that describe the results you are working to accomplish. They are designed using the SMART technique, so they are clear, understandable, and easy to follow. (S: specific, M: measurable, A: achievable, R: relevant, T: time-bound)(Minimum 3) | | |
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| **Identify Initiatives** | Outline specific projects or actions needed to achieve your objectives. | | | |  |
| **Assign Responsibilities** | Determine who is responsible for each initiative. | | | |  |
| **Set Timelines** | Establish deadlines for each initiative. | | | |  |
| **Allocate Resources** | Identify resources (financial, human, etc.) needed for each initiative. | | | |  |
| **D. Funding and support** | | | | |  |
| Detail any funding approved or to be approved, any funding should comply with Cochrane’s Conflict of Interest Policy. Specify what type of funding will be received and if there are any restrictions. | | | Example: We are in discussions with potential funding sources and have initiated conversations with (List Funding Agencies). The funding will be in wages and will help to maintain three permanent members. | |  |
| Detail activities that will be performed to increase and/or obtain resources | | | Example: Our strategies to maximize the likelihood of identifying and securing evidence synthesis and dissemination contracts include (List strategies) | |  |
| Cochrane Support; detail what type of support is expected from Cochrane Central or other Cochrane Geographic Groups | | |  | |  |
| **E. Compulsory requirements to join Cochrane** | | | | |  |
| **Operational Plans** | | | | |  |
| Accountability to Cochrane will be established and maintained through adherence to the provided Terms of Reference. | | | | Agree/Disagree |  |
| Quality assurance will be ensured through rigorous working practices, including supervision, clear lines of accountability, effective communication channels, checklists, and collaboration with other Cochrane Groups. | | | | Agree/Disagree |  |
| **Representation of Cochrane’s Core Values** | | | | |  |
| Confirm the interest of the Group to prioritize equitable representation, work transparently, and avoid vested interests and research waste in alignment with Cochrane’s core values. | | | | Agree/Disagree |  |
| Confirm that the Group intends to promote inclusivity and diversity. | | | | Agree/Disagree |  |
| **F. Conflict of Interest** | | | | |  |
| Declarations of Interest of the Proposed Director: The proposed Director must complete the Cochrane Conflict of Interest Declaration form below | | | | |  |
| **Name** |  | | | |  |
| **Position** |  | | | |  |
| **Date** |  | | | |  |
| **Financial interests** | | | | |  |
| **Received research funding: any grant, contract, or gift, commissioned research, or fellowship from The Cochrane Collaboration or a related organization (i.e., any organization related to health care or medical research) to conduct research?** | | | | Yes/No) |  |
| **Had paid consultancies: any paid work or consulting fees (in cash or kind) from a related organization?** | | | | Yes/No) |  |
| **Received honoraria: one-time payments (in cash or kind) from a related organization?** | | | | Yes/No) |  |
| **Served as a director, officer, partner, trustee, or employee, or held a position of management with a related organization?** | | | | Yes/No) |  |
| **Possessed share-holdings, stock, stock options, equity with a related organization (excludes mutual funds or similar arrangements where the individual has no control over the selection of the shares)?** | | | | Yes/No) |  |
| **Received personal gifts from a related organization?** | | | | Yes/No) |  |
| **Had an outstanding loan with a related organization?** | | | | Yes/No) |  |
| **Received royalty payments from a related organization?** | | | | Yes/No) |  |
| **Do you have any other competing interests that could pose a conflict of interest that would reasonably appear to be related to the primary interest?** | | | | Yes/No) |  |
| **Comment:** | | | |  |
| **G. Letters of Support** (at least 2 of the 3) | | | | |  |
| **Host Institution** | | | | Yes/No) |  |
| **Sponsor group: If applicable, please name the Cochrane geographic group with which you’ve been working or who will provide induction for you should you be selected. (not compulsory)** | | | | Yes/No) |  |
| **Cochrane member, or person with Cochrane and non-Cochrane- Systematic Review experience** | | | | Yes/No) |  |

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