

SOUTH AFRICAN COCHRANE CENTRE

WORLD CUP FEVER – ONE YEAR TO GO

The 11 June saw newly-elected South African president Jacob Zuma (JZ) kick off the one-year countdown

to the first Fédération Internationale de Football Association (FIFA) World Cup game to be played at the yet-to-be-completed Green Point Stadium in Cape Town. Despite the ongoing debate about whether investment in stadium construction and road maintenance really is the best investment strategy to address countrywide poverty, soccer fever has begun to grip the nation. It is striking how South Africans have risen to the challenge to deliver what seems to be the impossible, according to deadline. We must be doing something right as following a site inspection this month, FIFA rated South Africa's 'preparedness' to host the global extravaganza as 8/10.

Four days following JZ's much-publicised kick, the South African Cochrane Centre (SACC) held its own 'site inspection' when five external referees assessed our progress and delivery since 2004. Every research unit within the Medical Research Council (MRC) is evaluated on a five yearly basis to determine whether infrastructural and baseline support will continue for a further five years. Staff prepared diligently and presented the panel, chaired by Dr Ali Dhansay (MRC Vice-President of Research), with a comprehensive and lively overview of our work. We are grateful to the panel who were very encouraging in acknowledging our efforts, at times with a reduced staff complement. We are especially grateful to Professor Sally Green, Co-director of the Australasian Cochrane Centre,

who travelled so long and so far to contribute so wisely to the panel.

Her shared experiences and useful advice again convinced me of the benefits of belonging to the international network that is The Cochrane Collaboration. Thank you to all the panel members – we look forward to the verdict.

In addition to preparing for the unit review, we spent the first six months of 2009 meeting our many reporting responsibilities. Before March we had already completed our annual MRC budget report, prepared our contribution to the MRC annual report, and despatched the annual Collaboration Monitoring and Registration report. For those of us engaged in academic activities, regular reporting to justify expenditure is an essential, if sometimes onerous, part of our daily work. However, such activities do provide opportunities to reflect on our chosen careers, and both Jimmy and I believe that looking back is as important as looking forwards. The unit review certainly allowed us to do this and we were again struck by the performance and dedication of our staff during the period under review. I don't wish to be a doubting Thomas, but the gaping holes in the half-constructed roads and the roofless stadium don't always inspire me with the confidence that we will indeed be ready to host the soccer fans when they arrive this time next year. But I have no doubt that our staff will score a perfect 10/10 when it comes to preparing the SACC for 2010 and the years beyond.

Thanks to you all!

Nandi Siegfried
Co-director

What's in this issue:

Page 1: World Cup Fever - One year to go

Page 2-3: From *The Cochrane Library*

Page 4: *The Cochrane Library* Chief Editor visits the SACC

Page 5: The Protocol Development and RevMan Workshop

Page 6: Jimmy Volmink and Paul Garner visit Kenya

Page 7: In partnership with the Occupational Health Field:

Around Africa: The Evidence-based Practice Workshop in Namibia

Page 8: The SACC welcomes Alfred Musekiwa

David Sackett wins top award

Announcements



MATERNAL POSITIONS AND MOBILITY DURING FIRST STAGE LABOUR

Mothers' position during the first stage of labour

Women in the developed world and in health facilities in low-income countries usually lie in bed during the first stage of labour. Elsewhere, women progress through this first stage while upright, either standing, sitting, kneeling or walking around, although they may choose to lie down as their labour progresses. The attitudes and expectations of healthcare staff, women and their partners have shifted with regard to pain, pain relief and appropriate behaviour during labour and childbirth. A woman semi-reclining or lying down on the side or back during the first stage of labour may be more convenient for staff and can make it easier to monitor progression and check the baby. Fetal monitoring, epidurals for pain relief, and use of intravenous infusions also limit movement. Lying on the back (supine) puts the weight of the pregnant uterus on abdominal blood vessels and contractions may be less strong than when upright. Effective contractions help cervical dilatation and the descent of the baby.

The results of the review suggest that the first stage of labour may be approximately an hour shorter for women who are upright or walk around during the first stage of labour. The women's body position did not affect the rate of interventions. The review authors identified 21 controlled studies from a number of countries that randomly assigned a total of 3706 women to upright or recumbent positions in the first stage of labour. Nine of the studies included only women who were giving birth to their first baby. The length of the second stage of labour and the numbers of women who achieved spontaneous vaginal deliveries or required assisted deliveries and augmentation were similar between groups, where reported. Use of opioid analgesia was no different, although women randomised to upright positions were less likely to have epidural analgesia. In those studies specifically examining position and mobility for women receiving epidural analgesia (five trials, 1176 women), an upright or recumbent position did not change the length of the first stage of labour (time from epidural insertion to complete cervical dilatation) or rates of spontaneous vaginal, assisted and caesarean delivery. Little information was given on maternal satisfaction or outcomes for babies.

REFERENCE:

Lawrence A, Lewis L, Hofmeyr GJ, Dowswell T, Styles C. *Maternal positions and mobility during first stage labour*. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD003934. DOI: 10.1002/14651858.CD003934.pub2

MUSIC FOR STRESS AND ANXIETY REDUCTION IN CORONARY HEART DISEASE PATIENTS

Music to reduce stress and anxiety for coronary heart disease patients

Individuals with coronary heart disease often suffer from severe distress putting them at greater risk for complications, including sudden cardiac death. This review included 23 randomised controlled trials with a total of 1461 participants. The findings suggest that music listening may have a beneficial effect on blood pressure and heart rate in people with coronary heart disease. Music listening also appears to be effective in reducing anxiety in myocardial infarction patients. No evidence for anxiety-reducing effects of music was found for patients undergoing cardiac procedures. This may be due to the fact that anxiety was measured after the completion of the procedure rather than during it.

Music listening may also reduce pain and respiratory rate, however the magnitude of these effects is small and the quality of the evidence is not strong. Therefore, its clinical importance is unclear.

No evidence of effect was found for depression, heart rate variability, or peripheral skin temperature. Inconsistent results were found for mood. However, only a small number of trials investigated the effects of music on these outcomes. More research is needed.

The vast majority of the studies examined the effects of patients' listening to pre-recorded music. More research is needed on the effects of music offered by a trained music therapist.

REFERENCE:

Bradt J, Dileo C. *Music for stress and anxiety reduction in coronary heart disease patients*. *Cochrane Database of Systematic Reviews* 2009, Issue 2. Art. No.: CD006577. DOI: 10.1002/14651858.CD006577.pub2

INSECTICIDE-TREATED NETS FOR PREVENTING MALARIA IN PREGNANCY

Insecticide-treated nets for preventing malaria in pregnancy

In endemic areas, malaria in pregnancy is a major public health problem. It contributes to severe anaemia in the mother and low birth weight for babies, which are associated with poor infant health and early infant death. Also the unborn child and the pregnant woman may die from malaria in pregnancy. Protection with insecticide-treated bednets (ITNs) during pregnancy is widely advocated, but evidence of their benefit has been inconsistent. This review found five trials of ITNs in pregnant women. The four trials in sub-Saharan Africa compared ITNs with no nets and showed a benefit from ITNs in terms of fewer malaria infections, low birthweight babies, and fewer babies died before delivery. The effects on severe anaemia in the mothers were inconclusive. The one trial from Asia compared ITNs with untreated nets and showed a beneficial effect on anaemia in women and fewer babies died before delivery, but it had no impact on other outcomes. ITNs have been shown to be beneficial and should be included in strategies to try to reduce the adverse effects of malaria in pregnant women in endemic areas of the world.

REFERENCE:

Gamble C, Ekwaru JP, ter Kuile FO. *Insecticide-treated nets for preventing malaria in pregnancy*. *Cochrane Database of Systematic Reviews* 2006, Issue 2. Art. No.: CD003755. DOI: 10.1002/14651858.CD003755.pub2





MALE CIRCUMCISION FOR PREVENTION OF HIV ACQUISITION IN HETEROSEXUAL MEN

Background

Male circumcision can be conducted as part of a religious ritual (after birth or in childhood) or traditional ritual (initiation into manhood); or as a medical procedure (as treatment or prevention of infections, injury or anomalies of the foreskin). According to biological theories, circumcision removes the potential entry site for HIV, by removing the inner mucosal surface of the human foreskin which contains Langerhans cells that display CD4 receptors that attract HIV.

Our previous Cochrane Review on this topic published in 2003 included 35 non-randomised studies (updated to 37) conducted over the past two decades. The review concluded that insufficient evidence existed to support an *interventional effect* of male circumcision on HIV acquisition in heterosexual men, but supported previous review findings that the showed a *strong epidemiological association* between male circumcision and prevention of HIV, especially among high-risk groups.

In 2005 the results of a South African randomised controlled trial (RCT) of male circumcision for preventing HIV acquisition in men was published, followed in 2007 by Kenyan and Ugandan RCT findings. We are now able to assess the efficacy and safety of male circumcision as an *intervention* in this update of our Cochrane Review.

Review objectives

To assess the evidence of an interventional effect of male circumcision for preventing acquisition of HIV-1 and HIV-2 by men through heterosexual intercourse.

Main results

- Three large RCTs (n=11 054) were conducted in South Africa (n=3 274), Uganda (n=4 996) and Kenya (n=2 784) between 2002 and 2006.
- All RCTs were conducted on men from the general population.
- Participants were 18 to 24 years old (in two trials) and 15 to 49 years old (in one trial).
- Circumcision was performed using commonly-used surgical techniques under local anaesthesia (forceps-guided technique (two trials) and the sleeve procedure (one trial)).
- All three trials were stopped early due to significant findings at interim analyses.
- None of the trials clearly described the method used for generating the random

sequence. All trials reported sequential envelopes, but none ensured *sequential* allocation as well as *sealed* envelopes. Participants and study personnel could not be blinded to the intervention. In one trial blinding of outcome (HIV status) assessors was adequate; in the other two trials it was poorly described. Attrition was high in all three trials, but acceptable statistical survival analysis techniques were used. Risk of bias due to incomplete outcome reporting is low in all three trials. All three trials were stopped early due to data-dependent processes (formal-stopping rules) and this may have introduced a risk of bias.

- Reporting of methodological quality was variable across the three trials, but overall the potential for significant biases affecting the trial results was judged to be low to moderate given the large sample sizes of the trials, the balance of possible confounding variables across randomised groups at baseline in all three trials, and the employment of acceptable statistical early stopping rules.
- Survival estimates at 12 and also 21 or 24 months were combined in a meta-analysis using the random effects model on available case analyses. Incidence risk ratios (IRR) and 95% CIs were:
at 12 months: 0.50 (0.34 to 0.72)
at 21 or 24 months: 0.46 (0.34 to 0.62),
interpreted as relative risk reduction of acquiring HIV of respectively
50% (at 12 months) and 54% (at 21 or 24 months) following circumcision.
- There was little statistical heterogeneity between the trial results at 12 months ($\text{Chi}^2 = 0.60$; $\text{df} = 2$; $p = 0.74$) and at 21-24 months ($\text{Chi}^2 = 0.31$; $\text{df} = 2$; $p = 0.86$) with the degree of heterogeneity quantified by the I^2 at 0% in both analyses.
- Results from sensitivity analysis (reported IRRs, reported per protocol IRRs and reported full Intention-to-treat analysis) did not differ markedly from the available case meta-analysis (calculated IRRs).
- Meta-analysis of secondary outcomes measuring sexual behaviour for the Kenyan and Ugandan trials found no significant differences between circumcised and uncircumcised men. For the South African trial the mean number of sexual contacts at the 12-month visit was statistically

significant different (5.9 in the circumcision group versus 5 in the control group, $p < 0.001$) and remained significant at the 21-month visit (7.5 versus 6.4; $p = 0.0015$).

- Incidence of adverse events following the surgical circumcision procedure was very low in all trials, indicating that male circumcision conducted under these conditions is a safe procedure.
- There is strong evidence that medical male circumcision reduces the acquisition of HIV by heterosexual men by between 38% and 66% over 24 months.

Implications for practice

There is strong evidence that male circumcision is an effective measure to reduce HIV acquisition rates in heterosexual men for the first two years after circumcision. Current evidence is lacking for whether it also confers protection for women. Policy-makers should consider implementation of male circumcision as an additional measure in prevention programmes, if considered feasible and socially and culturally acceptable for local conditions.

Implications for research

Research on the effectiveness of male circumcision for preventing HIV acquisition in heterosexual men is conclusive. No further trials are required. Future research must focus on the effects of male circumcision on the women partners of circumcised men and whether it is protective, neutral or harmful for women partners. Other studies should focus on the feasibility of implementing the procedure into different contexts, the social and cultural issues regarding implementation and the cost-effectiveness of such implementation. The effects of male circumcision on HIV transmission during anal intercourse, both in men who have sex with men and between men and women, remains unclear.

REFERENCE:

Stegfried N, Muller M, Deeks JJ, Volmink J. Male circumcision for prevention of heterosexual acquisition of HIV in men. Cochrane Database of Systematic Reviews 2009, Issue 2. Art. No.: CD003362. DOI: 10.1002/14651858.CD003362.pu2.

Martie Muller

Senior Scientist and Statistician, Institute for Maritime Technology, and SACC Associate Staff

THE COCHRANE LIBRARY CHIEF EDITOR VISITS THE SOUTH AFRICAN COCHRANE CENTRE

I was delighted to be invited to the SACC recently. I travelled to Cape Town on 24th May and was able to visit the SACC on the 26th and 27th. It was interesting to hear at first hand how the SACC has developed into the important Centre it is today. The “Reviews for Africa” programme and the varied programme of activities are a testament to the passion and commitment that you have brought to your work. I was privileged to meet many of you who have been responsible for developing the Centre in Cape Town, the Branch in Nigeria, and a network of reviewers across Africa.

In my first few months in role of Editor in Chief of *The Cochrane Library*, I have heard repeatedly from people who are committed to increasing the impact of our work in resource poor settings, but this was an opportunity to observe that work in progress. It is vital that the Collaboration continues to build on your achievements. Whilst recognising the continuing limitations on internet access in your region, it is a high priority to do everything in our power to ensure we increase the visibility of *The Cochrane Library*. This will most effectively be achieved by ensuring that as many South Africans as possible, whether health professionals, policy-makers or consumers of health services, can enjoy “one-click” access, free at the point of use, to our product.

Two issues stand out from our meetings. Firstly the achievements of the SACC in contributing to systematic reviews aimed at the conditions that impact the most on those living in your region, in particular TB and AIDS. I was delighted to hear about Nandi’s media exposure, perhaps unwillingly, since publishing the review on circumcision and its effect

in preventing HIV transmission, in Issue 2, 2009. Secondly, you are working to create capacity and capability by reaching out to potential new reviewers across your continent. Your enthusiasm and optimism was always evident, although Jimmy Volmink’s attempts to convert a “pro-life” tobacco executive on a recent aeroplane journey, was probably taking optimism to a new extreme!

I was excited and inspired to hear of your achievements as a group. My role includes ensuring that the investment you make in your work is represented in the most positive and accessible manner within *The Cochrane Library*. We need to maintain and develop Cochrane’s reputation as a provider of world class systematic reviews, and support Cochrane Review Groups in meeting the challenges of updating. We must make sure that all Cochrane Reviews are relevant to real life healthcare problems, an approach that you exemplify. Finally, we must package our findings and recommendations in clear and accessible language.

All of these gave me much to ponder as my family and I trudged wearily down the Lion’s Head having reached its peak in a triumph that was heralded by the most magical sunset, stopping only to dodge the joggers bouncing between the boulders, for whom this was simply their normal evening exercise. Thank you again for your hospitality, and the opportunity to learn about your inspirational work, and visit your extraordinary country.

David Tovey

Editor-in-chief, *The Cochrane Library*



David Tovey (4th from left) with the SACC staff



PROTOCOL DEVELOPMENT AND REVMan WORKSHOP 2009

The SACC once again hosted its annual Protocol Development and RevMan Workshop from 4-7 May. This year nine participants attended the workshop. Five were from local academic institutions, with one participant travelling all the way from Durban and one from Pretoria. The workshop was also graced with the presence of four participants from other African states; two from Cameroon, one from Nigeria and one from Kenya. Their attendance at the workshop was made possible through the SUPPORT Programme (SUPPorting Policy-relevant Reviews and Trials).

During the four days participants were introduced to the steps involved in writing a protocol for a Cochrane Review. The technical aspects of the review writing software, Review Manager, (RevMan) were also presented.

The next protocol development and RevMan workshop will be held in 2010.

Elizabeth D Pienaar
Senior Scientist, SACC



Participants and facilitators

ERIC

From the 4-7 May 2009, the SACC organized a Protocol Development and RevMan workshop in Cape Town. Attendees came from South Africa, Nigeria, Kenya and Cameroon and the registered titles were from various medical fields such as ophthalmology, gynaecology, public health and endocrinology. The main objective of the workshop was to enable review authors to be familiar with methods involved in writing a Cochrane Review protocol and using RevMan.

Babalwa Zani and Alfred Musekiwa from the SACC joined us for that wonderful journey to discovering RevMan and the Cochrane Review process. Presentations were very interactive and most of them were followed by a practical session for a live illustration of courses. Attendees were given the opportunity to practice on assessment of risk of bias, study selection and data collection. The coffee and lunch breaks were important moments for fellowship and were an opportunity for participants to talk about their countries, professions and backgrounds.

We are grateful to Elizabeth Pienaar, Taryn Young, Joy Oliver and Lize van der Merwe for their wonderful presentations. Thanks to Charles Wiysonge for the wonderful time we spent at the Cape Town Waterfront. Thanks also to all the facilitators for the workshop as it enabled young authors to obtain a sound knowledge on writing Cochrane Reviews.

This is one step forward made by the SACC in establishing evidence-based medicine in Africa.

Eric Balti Vounsia (MD)

Research Associate, National Obesity Centre/Endocrine and Diabetes Unit, Yaoundé Central Hospital, Yaoundé, Cameroon

MILLICENT

Greetings from Kenya! I was excited when I received the invitation to attend the Cochrane Protocol Development and RevMan Workshop, at the MRC in Cape Town from 4-7 May 2009. The travel arrangements were perfect and the travelling hours so convenient I didn't even have to wake up early! Thank you Elizabeth.

I had a wonderful time in the beautiful city of Cape Town. The course was professionally executed by the very friendly and interactive instructors. They were able to make me understand the rationale for undertaking a Cochrane Review. I also became familiar with the methods involved in conducting a Cochrane Review. In a very simplified way, I was taken through the technical aspects of using RevMan and I was able to use it despite my limitation in technology. I was made to understand how The Cochrane Collaboration is organized as well as the procedures followed from registering a review topic to publishing a review. This was very helpful as I was at the stage of submitting my protocol. Being more of a clinician than a researcher, I was impressed by their ability to make the topics interesting even to someone like me. I even enjoyed statistics!

The food was excellent, I ate too much! and the company was great. I enjoyed interacting with the other participants from different regions of Africa and we really had a good time despite the cold weather.

I look forward to completing my review and I thank the organizers of the workshop very much for the wonderful work they are doing. Keep it up!

Millicent Muthoni Kariuki - Wayoike

Lecturer - Department of Ophthalmology, University of Nairobi and Consultant Ophthalmologist, Kenyatta National Hospital, Nairobi, Kenya



JIMMY VOLMINK AND PAUL GARNER VISIT KENYA

Professors Jimmy Volmink and Paul Garner visited Kenya from 6-9 May 2009, as part of an effort to strengthen and revitalize the Effective Health Care Research Programme Consortium (RPC) in Kenya. Their visit was hosted by Dr. Stephen Gichuhi and Dr. James M. M'Imunya both from the University of Nairobi. Meetings were held with a wide range of individuals including Prof. Isaac Kibwage (Principal College of Health Sciences, University of Nairobi), Dr. Mushtaq Ahamed (Dean, Aga Khan University), Prof. Benson B. Estambale (Director, UNITID), Prof. William Stones (Chair, Department of Obstetrics and Gynaecology, Aga Khan University), Dr. Dunera R. Ilako (Chair, Department of Ophthalmology, CHS) and Prof. Gilbert Kokwaro (Director, Consortium for National Health Research, Kenya).

I am delighted to report that the development of a Kenya Consortium of the RPC is now firmly on track, which will involve the University of Nairobi, Kenya Medical Research Institute (KEMRI) and Aga Khan University, with a secretariat based at the University of

Nairobi Institute of Tropical and Infectious Diseases (UNITID).

The main goals of the consortium are to promote and support the conduct of Cochrane systematic reviews and to advance Evidence-based Health Care in Kenya. Stephen Gichuhi is to be appointed the Scientific Coordinator while James Machoki M'Imunya will serve as the Policy and Communications Coordinator. Unfortunately, the schedule of the visit was so tight that, other than visiting a grocery shop to buy some Kenyan coffee, neither Jimmy nor Paul had an opportunity to enjoy the beautiful and diverse Kenyan fauna and flora. Maybe next time!

James Machoki M'Imunya

Deputy Director

Institute of Tropical and Infectious Diseases (UNITID)

University of Nairobi, Kenya



Jimmy Volmink centre and Paul Garner on his left with their hosts at the University of Nairobi

EVIDENCE-BASED PRACTISE (EBP) WORKSHOP IN WINDHOEK NAMIBIA

Twenty-one health professionals (20 occupational therapists and one medical practitioner) attended a 1½ day introductory EBP workshop in April. The workshop was facilitated by Helen Buchanan (Occupational Therapy lecturer, University of Cape Town) and Helga Burger (Namibian Occupational Therapist and Masters student, University of Cape Town), and was partially funded by the SACC and the Medical Research Council. The workshop aimed to introduce the key concepts of EBP and develop the skills needed to apply these. Presentations focused on the steps of EBP, the reasons it is needed, systematic reviews and The Cochrane Collaboration.



An individual exercise during the workshop

Most sessions were interactive with participants being guided through the 5 step process of EBP. They worked on developing their own Participants-Interventions-Controls-Outcomes (PICO) questions and search strategies. Thanks to the Polytechnical College of Namibia, who provided a computer lab free of charge, we were able to have a 3-hour online search session. During this time, participants were shown how to conduct effective searches in *The Cochrane Library*, OTseeker and PubMed. We encouraged the use of pre-appraised sources of evidence rather than trying to do a crash course on appraisal. It was encouraging that 12 of the 21 participants found evidence to answer at least one of their questions. The second day provided an opportunity for participants to clarify any issues from the previous day and culminated in a small group exercise in which participants identified what they would do to start becoming more evidence-based in their practice. It was a privilege to run the workshop and encouraging to see the enthusiasm and

excitement of the participants. We look forward to on-going contact with this group in the future.



Searching The Cochrane Library

Helen Buchanan

Senior Lecturer, Division of Occupational Therapy, School of Health & Rehabilitation Sciences, University of Cape Town and SACC Associate Staff

THE COCHRANE OCCUPATIONAL HEALTH FIELD AND SOUTH AFRICAN COCHRANE CENTRE WORKING TOGETHER



In March Dr Jos Verbeek, coordinator of the Cochrane Occupational Health Field (COHF), based at the Finnish Institute of Occupational Health, Kuopio, Finland visited the SACC.

The COHF (www.cohf.fi) aims to provide up to date evidence on the effects of occupational health (OH) interventions. The field maintains specific databases of occupational interventions and systematic reviews, organizes hand searching of occupational health journals, has developed search strategies for finding OH studies in PubMed, maintains a wish list of desirable systematic reviews, develops methodological support for occupational health

review authors and communicates with those interested in the field.

In collaboration with the SACC, the COHF hosted two successful workshops on Evidence-based occupational health during the 29th International Congress on Occupational Health (ICOH) in Cape Town. The two workshops on “Understanding Cochrane Systematic Reviews” and “How to conduct a Cochrane Systematic Review” were well attended. Participants actively engaged in discussions and concurred that more effort should be invested in the preparation, maintenance, and dissemination of systematic reviews in order to create the necessary evidence base for occupational health interventions.

Taryn Young

Consultant
SACC

“I enjoyed my visit to the SACC very much because of the inviting and friendly atmosphere. We had a superb collaboration in presenting The Cochrane Collaboration at the Congress of the International Commission on Occupational Health (ICOH), the world congress of occupational health professionals. I think it was exemplary the way the Centre and the Field worked together and prepared a flyer for the 1500 congress participants thanks to the work of Joy Oliver. I was very happy to do the workshop together with Taryn Young. It gave a professional impression of the Collaboration and we got positive feedback from the participants. This was another small but important step towards a better underpinning of occupational health and safety practice with evidence. I hope to be able to return to Cape Town in the near future and to make use of the visitor’s desk that was shown to me and looked very attractive.”

Jos Verbeek

Coordinator, Cochrane Occupational Health Field

DAVID SACKETT WINS TOP AWARD



A pioneer of McMaster University's medical school has been recognized with a prestigious international award for his groundbreaking research, which he dedicated to the millions of patients in history who have been wronged by doctors prescribing "dumb treatments."

Dr. David Sackett was named a Gairdner Wightman Award winner celebrating the impact of research that ensures doctors' treatment decisions are based on the best scientific evidence available.

One of seven winners this year of a Canada Gairdner award, and the only Canadian, Sackett, 74, founded Canada's first department of clinical epidemiology at McMaster's medical school.

He received a standing ovation yesterday from 200 medical luminaries after dedicating the award "to every patient who has ever been put at a disadvantage because of medical ignorance and arrogance."

In a speech titled, "Helping smart doctors stop prescribing dumb treatments," Sackett said history is replete with examples of well-intentioned interventions gone bad. They include treatments influenced by past practices, consensus and unsubstantiated science.

Evidence-based medicine, in contrast, teaches doctors how to separate good research from bad.

The SACC congratulates Dr Sackett.

Theresa Boyle
Health Reporter

The article was published by The Star (<http://www.thestar.com>) on 1st April 2009.

THE SACC WELCOMES ALFRED MUSEKIWA



Alfred Musekiwa was appointed as a Biostatistician MRC in Cape Town in November 2008. His appointment is a joint contract between the Biostatistics Unit and the SACC. His job entails working with Senior Biostatisticians on a variety of different projects in which he provides input with respect to data management, study design, reporting and presentation of statistical results. His focus at the SACC will be on

the statistical aspects of systematic reviews, such as meta-analysis and training in statistical concepts for Cochrane authors. He is also a teaching assistant for Principles of Biostatistics at the University of Stellenbosch's Faculty of Health Sciences.

Before joining the MRC, he was a lecturer at the University of Johannesburg. He holds a M.Sc. degree in Mathematical Statistics from the University of Johannesburg and he is looking forward to an opportunity to enrol for a PhD in Statistics.

ANNOUNCEMENTS

17TH COCHRANE COLLOQUIUM 11-14 OCTOBER 2009, SINGAPORE



The Lion City state of Singapore is delighted to host the 17th Cochrane Colloquium and extends a warm welcome to all who are passionate about generating, organizing, disseminating and applying the best evidence for health care. The Colloquium will focus on the key challenges and opportunities both for the region and for the Cochrane Collaboration. The scientific programme will embrace the future while maintaining a healthy respect for the traditions of the past.



KEY DATES

13 July	Early registration deadline
10 August	Meeting request deadline
11 August	Workshop and meeting sign-up opens
11 September	Cancellation deadline

For more information, please visit the website:
<http://www.colloquium.info/2009/>

NEWS FLASH

The 2008 Journal impact factors have now been published by Thomson ISI. The *Cochrane Database of Systematic Reviews* has an impact factor of **5.182**, ranking 12th out of 107 in the ISI category General and Internal Medicine. This is up from the 2007 impact factor of 4.654 and rank 14th out of 100.

The South African Medical Research Council

PO Box 19070 Tygerberg | South Africa
Francie van Zijl Drive | Parow Valley | Cape Town
Contact the South African Cochrane Centre at
email: cochrane@mrc.ac.za
Tel +27 21 938 0438 | Fax +27 21 938 0836



The South African
Cochrane Centre

FREE ACCESS TO THE COCHRANE LIBRARY

The Cochrane Collaboration is dedicated to making up-to-date, accurate information about the effects of healthcare readily available worldwide. The major product of the Collaboration is the Cochrane Database of Systematic Reviews which is published quarterly as part of *The Cochrane Library* by Wiley-Blackwell. Free or nearly free access to *The Cochrane Library* for developing economies appearing in the World Bank's list of "low income economies" means that, from Afghanistan to Zimbabwe

over 60 countries have FREE, one-click access to *The Cochrane Library* whilst an additional 40 economies are eligible for low cost access. Free access is available to band 1 countries via www.thecochranelibrary.com. If you are in a band 1 country **you do not need to sign up for this service as the software automatically detects the country you are connecting from and grants access accordingly**. Eligibility and band 1 and 2 lists are available on <http://www.who.int/hinari/eligibility/en/>