



South African COCHRANE CENTRE

NON-COMMUNICABLE DISEASES — THE NEW THREAT

When the South African Cochrane Centre (SACC) was established 14 years ago, the number of reviews contained in *The Cochrane Library* with relevance to people in low- and middle-income countries (LMIC) was disappointingly small. This led to a strategic decision on the part of the Centre leadership to prioritise the conduct of reviews that address high priority conditions in the African region, mainly HIV, TB and malaria. Staff of the Centre, and its branch, based in Nigeria, have since been active in producing reviews relevant to these diseases, and supporting their preparation through various outreach and capacity building initiatives in Africa, often in collaboration with colleagues from the Cochrane Infectious Diseases and HIV/AIDS Review Groups.

As a result of these efforts, as well as contributions from others, practitioners, consumers and policy-makers based in countries heavily burdened by HIV, TB and malaria, are now able to draw on a wide array of Cochrane Reviews when making decisions on what interventions to employ in the fight against these major killers. In the years ahead, new reviews will be needed and existing ones updated in light of ongoing research - so our work is far from done. However, it is important to appreciate that the health landscape in Africa has been changing and we must therefore ask: Is our single-minded devotion to reviews on infectious diseases still appropriate?

In September 2011, the United Nations General Assembly held a high level summit in New York to consider the threat to health and development of non-communicable diseases (NCDs), such as cardiovascular disease, diabetes, chronic respiratory disease and cancer. It was noted that the majority of NCD deaths now occur in LMIC, with an estimated 9 million deaths per year in people younger than 60. The NCD Alliance stressed that NCDs are a major cause of poverty, slow down economic development, and serve as a serious threat to the achievement of the Millennium Development Goals.

The signs are clear that the NCD tsunami is threatening to engulf Africa. In 2004, one-quarter of all deaths in Sub-Saharan Africa were due to NCDs; by 2030 this figure is expected to rise to almost half. NCDs share

several modifiable risk factors, in particular unhealthy diets, tobacco use, physical inactivity and excessive use of alcohol, and this presents important opportunities for prevention. Failure to stem the growing tide of NCDs will have profound human and economic consequences for African countries, already reeling under the weight of the 'unfinished agenda' of infectious diseases, maternal and child health issues and injuries. Action will, however, need to be underpinned by the best available evidence.

Fortunately, *The Cochrane Library* is already well populated with reviews of prevention and treatment strategies for NCDs. But these interventions will need careful scrutiny for their applicability to African settings. Given the concurrent infectious and NCD burden in Africa, as well as lifestyle and cultural differences, findings from high income countries cannot simply be extrapolated to African countries. In addition, treatment for NCDs is often very expensive and existing reviews may not be useful for decision-makers in resource-constrained countries. Given the early stage of the NCD epidemic in Africa and the limited access to health care in many countries in the region, it would seem that evidence on the effects of primary prevention strategies would be most useful at this stage.

Going forward there will be an increasing need for a collective effort to identify NCD reviews that are relevant to Africa and for useable summaries of these reviews aimed at various decision-makers. It is likely that new partnerships will need to be entered into with sections of government, civil society and healthcare provider groups. These new relationships will be crucial for guiding the prioritization of topics for future reviews and facilitating advocacy for local studies, where necessary. Are African review authors ready to take on the challenge of NCDs?

We wish all our readers a happy and peaceful festive season. Thank you for your support during the past year.

Jimmy Volmink
SACC

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METHODS FOR OBTAINING UNPUBLISHED DATA

This methodology review was conducted to assess the effects of different methods for obtaining unpublished studies (data) and missing data from studies to be included in systematic reviews. Six studies met the inclusion criteria, two were randomised studies and four were observational comparative studies evaluating different methods for obtaining missing data.

Five studies assessed methods for obtaining missing data (i.e. data available to the original researchers but not reported in the published study). Two studies found that correspondence with study authors by e-mail resulted in the greatest response rate with the fewest attempts and shortest time to respond. The difference between the effect of a single request for missing information (by e-mail or surface mail) versus a multistage approach (pre-notification, request for missing information and active follow-up) was not significant for response rate and completeness of information retrieved (one study). Requests for clarification of methods (one study) resulted in a greater response than requests for missing data. A well-known signatory had no significant effect on the likelihood of authors responding to a request for unpublished information (one study). One study assessed the number of attempts made to obtain missing data and found that the number of items requested did not influence the probability of response. In addition, multiple attempts using the same methods did not increase the likelihood of response.

One study assessed methods to obtain unpublished studies (i.e. data for studies that have never been published). Identifying unpublished studies ahead of time and then asking the drug industry to provide further specific detail proved to be more fruitful than sending of a non-specific request.

Those carrying out systematic reviews should continue to contact authors for missing data, recognising that this might not always be successful, particularly for older studies. Contacting authors by e-mail results in the greatest response rate with the fewest number of attempts and the shortest time to respond.

Citation: Young T, Hopewell S. Methods for obtaining unpublished data. *Cochrane Database of Systematic Reviews* 2011, Issue 11. Art. No.: MR000027. DOI: 10.1002/14651858.MR000027.pub2.

INTEGRATING HEALTHCARE SERVICES IN LOW- AND MIDDLE-INCOME COUNTRIES

In some low- and middle-income countries, healthcare services are organised around a specific health problem. This can cause fragmentation as people are required to visit separate clinics depending on their health

problem or need. The logic is that specialist clinics lead to better care and health outcomes because skilled healthcare providers then provide the specialised services and technologies related to the healthcare need. On the other hand, separating out services for specific diseases can be inefficient for both the provider, with service duplication, and the patient who has to visit different services for their health care. For example, a mother has to go to one clinic for family planning services and another for her children to be vaccinated, or a person with HIV and TB has to go to separate clinics for each disease.

One solution is to integrate healthcare services at the point of delivery or to strengthen the linkages between the services. The purpose of integration is to improve co-ordination and service delivery by providing services together, for example services for mothers and their children in one centre. It is believed that integration ensures that services are managed and delivered together, for an efficient and high quality service. It is also believed that integration of care leads to greater public access, including more equitable access for people from different communities and socio-economic backgrounds, a more convenient and satisfying service, and better health overall. Others believe that, with integration of care, healthcare professionals might become overloaded or not have the specialised skills to manage specific diseases, which could lead to poor quality services and poor health.

This updated review included nine studies that evaluated integrated care or linkages in care. The studies made two types of comparison.

- 1) Integration of care, by adding a service to an existing service (tuberculosis (TB) or sexually transmitted infection (STI) patients were offered HIV testing and counselling; mothers attending an immunisation clinic were encouraged to have family planning services).
- 2) Integrated services versus single, special services (family planning, maternal and child health delivered as a special vertical programme or integrated into routine healthcare delivery).

There was some evidence from the included studies that adding on services or creating linkages to an existing service improved its use and delivery of health care but little or no evidence that fuller integration of primary healthcare services improved people's health status in low- or middle-income countries. People should be aware that integration may not improve service delivery or health status. If policy makers and planners consider integrating healthcare services they should monitor and evaluate them using good study designs.

Citation: Dudley L, Garner P. Strategies for integrating primary health services in low- and middle-income countries at the point of delivery. *Cochrane Database of Systematic Reviews* 2011, Issue 7. Art. No.: CD003318. DOI: 10.1002/14651858.CD003318.pub3

ANTIRETROVIRAL THERAPY FOR PREVENTION OF HIV TRANSMISSION IN HIV-DISCORDANT COUPLES

BACKGROUND

Antiretroviral drugs reduce the risk of mother-to-child transmission of human immunodeficiency virus (HIV) and are widely used for post-exposure prophylaxis for parenteral and sexual exposures. Observational studies suggest that sexual transmission may be lower in couples in which one partner is infected with HIV and the other is not, and the infected partner is on antiretroviral therapy (ART).

OBJECTIVES

To determine if ART in HIV-discordant couples is associated with lower risk of HIV transmission to an uninfected partner compared to untreated discordant couples.

MAIN RESULTS

One randomised controlled trial (RCT), HPTN 2011, with 1750 HIV discordant couples and seven observational cohort studies with 9791 couples were included in this review. The RCT was conducted in nine countries (Botswana, Brazil, India, Malawi, Kenya, South Africa, Thailand, United States of America and Zimbabwe). While this trial mostly included heterosexual partners, homosexual partners were also included. Most of the observational cohort studies were conducted in African countries and focussed on heterosexual partners.

The included studies identified 464 episodes of HIV transmission, 72 among treated couples and 392 among untreated couples. In the RCT, the risk of HIV transmission was reduced by 96% [rate ratio=0.04; 95% CI (0.00, 0.27), $p=0.001$]. All index partners in this study had CD4 cell counts at baseline of 350-550 cells/ μ L.

In the observational cohort studies, the risk of HIV transmission was 66% lower in treated compared to untreated couples, [rate ratio=0.34; 95% CI (0.13, 0.92), $p=0.03$]. These studies had substantial heterogeneity ($I^2=73\%$) which was introduced by the two studies with inadequate person-time data. After excluding them from the analysis, the rate ratio was 0.16, 95% CI (0.07, 0.35) with no heterogeneity ($I^2=0\%$). Among couples in which the infected partner had a CD4 count greater than 350 CD4 cells/ μ L, the risk of transmission was 98% lower amount treated couples, rate ratio 0.02 95% CI (0.00, 2.87). In this subgroup, there were 61 transmissions in untreated couples and none in treated couples.

Fourteen percent of participants who received ART, regardless of their CD4 count, had one or more severe or life-threatening events (Grade 3 or 4), suggesting no increased risk associated with starting ART at high CD4 count [RR=1.06; 95% CI (0.84-1.33), $p=0.64$]. In contrast, there was almost a 50% increase in grade 3 or 4 laboratory abnormalities among participants receiving therapy with CD4 counts greater than 350

cells/ μ L (27%) when compared to participants receiving treatment at lower CD4 counts (18%) [RR=1.49; 95% CI (1.25-1.77), $p<0.00001$].

AUTHORS' CONCLUSIONS

Implications for practice

Based on the evidence provided by one randomised controlled trial and seven observational cohort studies, ART has been shown to be a potent intervention for prevention of HIV in discordant couples. An important question from a clinical standpoint is whether being in a serodiscordant relationship and having a CD4 count greater than 350cells/ μ L should be an additional indication for ART under World Health Organisation guidelines. European and United States guidelines already allow for starting at a CD4 count of up to 500cells/ μ L routinely and even higher for certain subgroups and based on clinician judgment. HPTN 2011 provides definitive data demonstrating a large positive benefit. Therefore, patients beginning ART may also be informed that adherence to ART can also reduce their risk of transmitting HIV to their uninfected partners. A related policy question is how much effort should be focused on treating individuals with CD4 counts greater than 350cells/ μ L when access to ART for persons with less than 350 CD4 cells/ μ L is far from universal. Significant questions remain about the durability of protection, cumulative antiretroviral toxicity, when to start treating an infected partner (for instance, at diagnosis or at a specific CD4 or plasma viral load level) and transmission of ART-resistant strains to partners. The success of this intervention likely relies on good adherence, especially in stable couples. Programmes should be designed that include counselling, support, follow up and mutual disclosure, as these components may have a role in supporting adherence. In addition to ART provision, limitations in resources needed to implement such expanded ART indications must be addressed.

Implications for research

Additional data are needed on durability of protection for uninfected partners, adverse events associated with initiation of ART on individuals with CD4 counts greater than 350cells/ μ L, including effects of longer-term ART, the potential for earlier development of antiretroviral resistance (resulting in a need to change regimens prematurely) and HIV morbidity, quality of life and the potential for risk compensation. There are multiple opportunities to examine these issues in existing cohorts.

Citation: Anglemeyer A, Rutherford GW, Baggaley RC, Egger M, Siegfried N. Antiretroviral therapy for prevention of HIV transmission in HIV-discordant couples. Cochrane Database of Systematic Reviews 2011, Issue 8. Art. No.: CD009153. DOI: 10.1002/14651858.CD009153.pub2.

Tamara Kredo

SACC

EFFECTIVE HEALTH CARE RESEARCH CONSORTIUM AFRICA PARTNERS MEET IN CAPE TOWN

The Centre for Evidence-based Health Care (CEBHC) www.sun.ac.za/cebhc, along with the SACC, hosted the second Africa Partners meeting of the Effective Health Care Research Consortium (EHCRC), at the CEBHC, Stellenbosch University from 5–7 October 2011. This event brought together partners from Cameroon, Kenya, Nigeria, The Gambia, Uganda and South Africa as well as lead Consortium partners from Liverpool, UK. Skype and teleconference facilities were used to engage partners unable to attend the meeting. The central aim of this second meeting was to take stock of what we have achieved thus far and to together plan how best to implement the various work packages in an effective and efficient way.



Partners were given an opportunity to share progress with their activities, describe their work environment and report on how they work with stakeholders. Everyone then actively participated in discussions on priority setting for relevant systematic reviews, and shared ideas on how best to establish and support author teams to produce high quality reviews. In addition, we spent time developing communication and dissemination strategies relevant to various stakeholders and identifying capacity development initiatives to strengthen the production and use of systematic reviews. Capacity development discussions focused on what each partner needs to do to enhance their own capacity to carry out Consortium activities. The meeting provided a wonderful opportunity to break away from day-to-day activities in order to reflect and plan as a group.

The EHCRC, (<http://www.liv.ac.uk/evidence>), funded by the Department for International Development (DFID), UK, aims to increase evidence-informed decisions to improve health and healthcare for the poor in low- and middle-

income countries. The primary aim is to produce, update and disseminate the results from systematic reviews to influence policy and practice. The Consortium is collaborative involving five international partners based in Africa, East-Asia, China, Norway and the UK. Together, partners work towards preparing and updating Cochrane Reviews about the effects of health care relevant to low- and middle-income countries; and identify approaches to ensure dissemination and use of the results of systematic reviews in decision- making in various settings.

In the insert below, Lawrence Mbuagbaw talks about evidence dissemination strategies in Cameroon.

Taryn Young

SACC

Centre for Evidence-based Health Care

Stellenbosch University



EVIDENCE-BASED APPROACHES FOR EVIDENCE DISSEMINATION IN CAMEROON

The Centre for the Development of Best Practices in Health (CDBPH) in Yaoundé, Cameroon is using a multipronged approach to evidence dissemination including training stakeholders on the use of evidence, how to conduct systematic reviews and disseminating translated summaries of systematic reviews based on pre-established priorities. In order to determine the priorities of the end-users of evidence, we created an e-list and sent out emails inviting them to rank a list of research themes in order of priority. These themes were derived from the EHCRC priorities and the Cameroon Ministry of Health. The initial email-based approach to priority setting was hampered by very low response rates due to infrequent use of emails and a lack of familiarity with the project objectives. We then initiated a door-to-door approach. The face-to-face encounters were particularly effective as a means to explain the goals of the project and to explain how to complete the forms to determine evidence priorities. At the end of the process the response rate had tripled and we had identified many more potential end-users of evidence. We also had a clear idea of our end-users' priorities and

are developing evidence summaries related to the identified themes. The door-to-door approach is an effective strategy often used in political, evangelical, marketing and immunization campaigns. With this approach, you know where and, who you've reached and you have a firsthand opportunity to interact with stakeholders. It presents an occasion to discuss the objectives of the project, the needs of the participants and most importantly, what we can deliver. It is also cost effective. Based on the success of this approach, we intend to use it to disseminate our products and to evaluate their use. Our experience calls to mind the fact that in our efforts to disseminate and encourage the use of evidence, we should use evidence based strategies to identify our stakeholders, determine their priorities and disseminate the evidence.

Lawrence Mbuagbaw

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

THE GUIDELINES INTERNATIONAL NETWORK CONFERENCE, KOREA, 2011

The 9th Guidelines International Network (G-I-N) conference was held in Seoul, Korea, 28-31 August 2011. In a plenary session on *Promoting quality of evidence and guidelines in the international community* I presented a descriptive review of the availability, quality and content of clinical practice guidelines for five priority conditions in the 14 member states of the Southern African Development Community (SADC). This project formed a part of the Southern African Regional Programme for Access to Medicines and Diagnostics aiming to harmonise regional guidelines and essential medicines lists to support improved procurement processes within SADC. My review used the AGREE II (Appraisal of Guidelines and Research Evaluation) tool to evaluate the quality of guideline reporting and a novel methodology for evaluating the concordance of the guidelines with available evidence.

This conference was a wonderful opportunity to reflect on the research and activities that are informing clinical practice guidelines in Southern Africa and to meet with global leaders in the field of guideline development, adaptation and implementation.

ABOUT G-I-N

GIN is an international not-for-profit association of organisations and individuals involved in the development and use of clinical practice guidelines. G-I-N seeks to improve the quality of health care by promoting systematic development of clinical practice guidelines and their application into practice, through supporting international collaboration. Founded in 2002, G-I-N is a global network comprising of 90 organisations and 92 individual members representing 46 countries from around the world. The network supports evidence-based healthcare and improved health outcomes by reducing inappropriate variation in clinical practice throughout the world. G-I-N has developed partnerships with many groups and organisations including The AGREE Research Trust, the GRADE Working Group and The Cochrane Collaboration to name a few.



“Tamara Kredo and Karen Daniels (on left), at the 9th GIN conference in Seoul”

G-I-N MISSION

To lead, strengthen and support collaboration and work within the guideline development, adaptation and implementation community.

THREE PRINCIPAL AIMS:

- Providing a network and partnerships for guideline organisations, implementers, end-users, researchers, students and other stakeholders
- Assisting members in reducing duplication of effort and improving the efficiency and effectiveness of evidence-based guideline development, adaptation, dissemination and implementation
- Promoting best practice through the development of opportunities for learning and building capacity, and the establishment of high quality standards of guideline development, adaptation, dissemination and implementation.

Tamara Kredo
SACC

THE WORKSHOP ON SYSTEMATIC REVIEWS AT THE MEDICAL RESEARCH COUNCIL OF SOUTH AFRICA

The staff of the SACC were delighted to host in-house training on accessing and interpreting systematic reviews of healthcare interventions for staff of the Medical Research Council (MRC) of South Africa. This two-day systematic review workshop was co-hosted by the SACC and the Research Capacity Development Sub-directorate of the MRC. MRC staff from the Cape Town, Durban and Pretoria offices attended the workshop. Tamara Kredo, Taryn Young, Elizabeth Pienaar and I co-facilitated the workshop which was attended by 19 participants. We focused on understanding the methodology involved in conducting systematic reviews, and supported training on accessing, appraising and interpreting the results of systematic review. Participants reported that they particularly enjoyed the interactive and informative nature

of the workshop. This awareness-raising workshop is an important offering from the SACC, because researchers may base their trials on gaps identified within Cochrane reviews. Many researchers may find that their interest in and appreciation for Cochrane Reviews grow as a result of these workshops. We hope that hosting these learning events will assist us to increase the number of people who access, read, interpret and eventually use Cochrane Reviews. We would like to thank the MRC Capacity Development team for supporting this training initiative.

Babalwa Zani
Scientist

GRADE TRAINING WORKSHOP IN CAPE TOWN, SOUTH AFRICA

The Grading of Recommendations Assessment, Development and Evaluation (GRADE) offers an explicit and comprehensive approach to appraising the quality of research evidence and strength of healthcare recommendations. GRADE is an emerging consensus on the rating of quality of evidence and is currently being used by many organizations; including the WHO and The Cochrane Collaboration.

GRADE aims to develop a common, simple, transparent, and sensible system for rating the quality of evidence and the strength of recommendations. GRADE now forms the basis for the preparation of Cochrane Summary-of-Findings tables.

The SACC held its first GRADE workshop in Cape Town, South Africa, in September 2011. This two-day event was attended by 17 experienced Cochrane Review authors from South Africa and other African countries,



including Nigeria, Ghana and Malawi. Many of the participants were partly or fully funded by the SACC to attend the workshop. We were delighted to have Newton Opiyo joining us from *The Kenya Medical Research Institute / Wellcome Trust Research Programme* to co-facilitate the workshop along with Tamara Kredon and myself.

The workshop aimed to enable participants to rate the quality of evidence using the GRADE approach. It was very interactive, including not only presentations but also discussions on the GRADE approach to rating quality of evidence

and hands-on sessions on the use of the GRADEpro software to generate Summary-of-Findings tables.

The participants gave positive feedback both on the interactive nature as well as the pace of the workshop.

The SACC looks forward to hosting similar GRADE workshops in the future.

Charles Okwundu

Centre for Evidence-based Health Care

GEORGE ELEJE'S TAKE ON THE GRADE WORKSHOP

Special greetings from Nnewi, Nigeria! I was excited when I received the invitation to attend the first ever GRADE Workshop at the SACC in Cape Town South Africa. The travel arrangements were excellent and I received the relevant documents in time which enabled me to have a hitch-free visa application for my second visit to Cape Town.

The international workshop was professionally executed by the very friendly and interactive instructors. It helped me understand that the GRADE approach offers an explicit and comprehensive approach to appraising the quality of research evidence. I learnt that GRADE now forms the basis for the preparation of Cochrane Summary-of-Findings (SoF) tables. My greatest joy came when I was nominated to give the last participant presentation using the SoF table.

I had a good time in the exquisite city of Cape Town and enjoyed the variety of food on offer and especially the dinner with Tamara, Babalwa, Charles and other participants. I also enjoyed interacting with other participants from different Cochrane Review Groups.

I look forward to including SoF tables in my forthcoming systematic reviews. Above all, I thank the organizers of this workshop especially for providing me with the part sponsorship to attend the workshop. Bravo!

George Uchenna Eleje

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THE CITY OF MADRID HOSTS THE 19TH COCHRANE COLLOQUIUM



The 19th Colloquium of the Cochrane Collaboration was hosted by the Iberoamerican Cochrane Centre in Madrid. The theme of the meeting was “*Scientific evidence for healthcare quality and patient safety*”. The event was a complete package as it also served as the 6th International Conference on Patient Safety organised by the National Agency for Health Care Quality at the Spanish Ministry of Health, the 8th annual meeting of the RED Iberoamericana-GPC and the 12th LatinCLEN XII Congress. The combination of the meetings was unique in the sense that it was a forum to address the broad scope of healthcare from research to policy issues that revolve around patient safety.

The Colloquium was an interesting mixture of group meetings, training sessions and of course the Collaboration’s annual general meeting. The meeting was off to lively start with pre-conference satellite workshops on the Summary of Findings Table and assessment of quality of evidence using GRADE as well as a symposium on methods in Cochrane Reviews. A highlight was the chance to watch Real Madrid live at the Estadio Santiago Bernabeu; a thrilling match that set the tone for the rest of the meeting.

Being my first Colloquium, I was keen to understand how the various aspects of the Collaboration fit together especially from the perspective of one living and working in a low income country. The plenary and workshop sessions brought together groups and discussed ideas that just about covered the spectrum of health care from problem identification to policy implementation. The training sessions were a must-attend. The tour through the new-look website, library and Revman provided quite a few extra resources that should help in accessing and using

these materials. I was particularly thrilled by the efforts of the South Asian Cochrane Centre to get around the challenge of access to evidence and to target the next generation of “Cochranites”. The “meat the entities” sessions were an appetising combination of work and talk served over delicious meals. I hope there will be a review of this intervention in The Cochrane Library in future!

One of the contributions of the SACC was a workshop to highlight the new features of RevMan 5.1 which was well-attended. Hendrik Larsson, from the Information Management System team, who implemented the new RevMan features was also present and provided valuable insights into the reasons for the incorporation of some of the new features.

One clear message at the meeting was that the Collaboration and its work are constantly evolving. There is an increasing need to clearly define the quality of the evidence that should guide healthcare practices across a wide range of settings. Also of interest are the changing roles of review groups, satellites and centres and the forces that drive this.

Madrid is indeed a lovely city with an interesting history, excellent museums and of course the delightful restaurants. The farewell party capped off a memorable four-day event. Next stop China and the 20th anniversary of the Collaboration. I would like to thank the Developing Countries Stipend Committee for awarding me the stipend for attending the Cochrane Colloquium
Muchas Gracias

Joseph Okebe

The South African Medical Research Council, The Gambia





Helen's PhD

We congratulate Helen Buchanan, an associate staff member of the SACC, on obtaining her doctoral degree from the University of Cape Town (UCT). Helen's thesis entitled "Evidence-based practice in the occupational therapy profession in the Western Cape and in South Africa" appraises the evidence-based knowledge, attitudes and practice of South African occupational therapists, before reporting on a randomised controlled trial of the implementation of evidence-based practice workshops. Helen was ably supervised by Dr Jennifer Jelsma of the Occupational Therapy Department at UCT and Dr Nandi Siegfried, previously of the SACC. Congratulations Dr Buchanan!



Announcements

New Baby

"Star light, star bright, the first star I see tonight; I wish I may, I wish I might, Have the wish I wish tonight"

Congratulations to Charles Okwundu and his wife Jennifer on the birth of their baby, Lotanna on the 26 August 2011.



Community service at Langa Township in Cape Town

In honor of Nelson Mandela, and to support his birthday initiative which encourages citizens to freely offer up time for community service on the 18 July, the SACC staff got their hands dirty by assisting the community gardeners from the Joe Slovo Community Garden in Langa. The Joe Slovo Community Garden is a community-run endeavor aimed at providing local employment, generating income and providing a cheap source of fresh food. The land was previously pretty much a trash heap, but has been transformed into a vegetable garden. Our attempts at weeding the garden beds required some guidance from the local gardeners on what was and wasn't a weed! It was a satisfying experience for the SACC team, especially since we could eventually see the fruits of our labours in the form of new beds ready for food seedlings!

DID YOU KNOW?

- The name of The Cochrane Collaboration's Secretariat has recently been changed to the 'Cochrane Operations Unit' (COU). This matches the name of the Cochrane Editorial Unit (CEU), and better denotes the diversity of the high-level executive functioning of the COU.
- The new website, "Cochrane Summaries" (<http://summaries.cochrane.org>), has been launched! Cochrane Summaries offers language translations, author podcasts and new Cochrane products (like PEARLS) all in one place!
- You can interact with The Cochrane Collaboration via Facebook and Twitter

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