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Infosheet
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NEWSLETTER OF COCHRANE NIGERIA, CALABAR INSTITUTE OF TROPICAL DISEASES RESEARCH AND PREVENTION, UNIVERSITY OF CALABAR TEACHING HOSPITAL.

INTERMITTENT PREVENTIVE TREATMENT REGIMENS FOR MALARIA IN HIV-POSITIVE PREGNANT WOMEN

Malaria in pregnancy remains a global public health issue, affecting mainly women living in the tropics, especially sub-Saharan Africa. The World Health Organization reported that sub Saharan Africa had 233 million cases of malaria and that about 12.7 million women were exposed to malaria during pregnancy in 2022 in the same region[1]. In pregnancy, malaria is associated with increased morbidity to the pregnant mother, her foetus and even the neonate. It specifically, increases the risk of maternal anaemia, placental parasitisation, miscarriages, premature birth, low birth weight and neonatal mortality. The malaria parasites are sequestered in the placenta so that even when asymptomatic, the foetus may still be affected.

Pregnant women who have HIV infection are more prone to the complications of malaria in pregnancy because of their reduced immunity. Coincidentally, low- and middle-income countries also have a very high burden of HIV infection. Sequestration of malaria parasite in the placenta increases the risk of mother to child transmission of HIV. Therefore, in this group of women, there is need for effective chemoprophylaxis for malaria.

The World Health Organization (WHO) has recommended a multipronged approach for the prevention of malaria in pregnancy. Central to the preventive measures is the use of Intermittent Preventive Therapy in pregnancy (IPTp). The WHO recommends the use of Sulphadoxine-Pyremethamine (SP) for intermittent preventive therapy during pregnancy[2]. The WHO also recommends the use of daily Cotrimoxazole for the prevention of opportunistic infections. The use of IPTp-SP is contraindicated in HIV positive mothers because of the potential sulphonamide induced adverse drug reactions thereby denying these very vulnerable women of effective malaria chemoprophylaxis[3]. This gap justifies the need to review the current body of evidence to identify effective and safe drugs for IPTp in pregnant HIV-positive women.

Recently, Pons-Duran and colleagues[4] conducted a systematic review on Intermittent preventive treatment regimens for malaria in HIV-positive

Contents

pregnant women. In the review, the authors aimed at assessing the safety and efficacy of intermittent preventive treatment regimens for malaria prevention in HIV-positive pregnant women. They searched Cochrane Central Register of Controlled Trials (CENTRAL), MEDLINE, Embase, LILACs, the Malaria in Pregnancy Library and trial registries up to 31st January 2024. Randomized controlled trials that compared any intermittent preventive treatment regimen for preventing malaria in HIV positive pregnant women against daily cotrimoxazole prophylaxis alone, placebo, current or previous standard of care, or combinations of these options were included in the review. The authors included 14 randomized controlled trials that recruited a total of 4976 participants. The trials were conducted in sub-Saharan Africa (Benin, Central African Republic, Gabon, Kenya, Malawi, Mozambique, Nigeria, Tanzania, Togo, Uganda, and Zambia). The primary outcomes of interest were maternal peripheral parasitaemia at delivery (blood film), maternal anaemia at delivery and low birth weight. The review also had secondary outcomes that included placental parasitisation, maternal parasitaemia during pregnancy, mean haemoglobin concentration, cord blood parasitaemia, prematurity and severe adverse events.

The findings from this review showed that, daily cotrimoxazole plus either mefloquine or dihydroartemisinin/piperaquine (DHA-PPQ) probably leads to a lower risk of maternal peripheral parasitaemia in HIV positive pregnant women (detected by the amplification methods) at delivery (moderate certainty evidence). This finding was based on data from 5 randomized controlled trials that recruited a total of 2406 participants. In addition, the review found that daily cotrimoxazole prophylaxis with another drug regimen (mefloquine or DHA-PPQ) probably results in a decrease in placental malaria measured by blood smear (1337 participants, 3 trials; moderate-certainty evidence) and little or no difference in low birth weight (2915 participants, 5 trials; moderate-certainty evidence).

However, due to the probability of increased risk of mother to child transmission of HIV and poor tolerability of the drugs in women who receive mefloquine, the authors also examined the results of DHA-PPQ specifically. The results showed that daily cotrimoxazole with dihydroartemisinin/piperaquine may result in little or no difference in mother-to-child HIV transmission (1063 participants, 2 trials; low certainty evidence). The review also found high-certainty evidence, that daily cotrimoxazole in combination with DHA-PPQ prophylaxis resulted in fewer women with placental malaria measured by histopathologic analysis (1570 participants, 3 trials) and moderate certainty evidence that it probably results in little to no difference in maternal peripheral parasitaemia (1517 participants, 3 trials) or anaemia at delivery (1454 participants, 2 trials).

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3. World Health Organization. Malaria in HIV/AIDS patients. 2017. Available from who.int/malaria/areas/ high_risk_groups/ hiv_aids_patients/en/
4. Pons-Duran C, Wassenaar MJ, Yovo KE, Marín-Carballo C, Briand V, González R. Intermittent preventive treatment regimens for malaria in HIV-positive pregnant women. Cochrane Database of Systematic Reviews 2024, Issue 9. Art. No.: CD006689. DOI: 10.1002/14651858.CD006689.pub3. Accessed 20 December 2024.
5. Art. No.: CD014573. DOI: 10.1002/14651858.CD014573. Accessed 13 August 2024.

EFFECTS OF DAILY ORAL IRON SUPPLEMENTATION DURING PREGNANCY

Key messages

Women taking daily iron supplements may have reduced anaemia and iron deficiency when they give birth around their due date, compared with placebo or no iron.

From the evidence in this review, we are less certain about the impact of iron supplements on other outcomes for the woman and her baby.

What is anaemia?

Anaemia is a condition with fewer red blood cells or less haemoglobin (a red substance found in blood that combines with oxygen and carries it around the body) in each red blood cell than normal. Iron deficiency is the leading cause of anaemia; additional factors such as micronutrient deficiencies of folate and vitamin B12 also cause anaemia. If pregnant women develop anaemia or become deficient in iron or other nutrients, they are unable to supply them in sufficient quantities to their baby. Low iron and folate levels in women can cause anaemia, which can make women tired, faint, and at increased risk of infection.

What did we want to find out?

We wanted to find out if taking daily iron supplements (either alone or with folic acid or other vitamins and minerals) during pregnancy would improve the health and nutrition of pregnant women and their babies.

What did we do?

We searched for studies that examined the effects of daily iron supplementation during pregnancy (either alone or with folic acid or other vitamins and minerals). We compared and summarised the results of the studies and rated our confidence in the evidence, based on factors such as study methods and sizes.

What did we find?

We included 57 trials involving 48,971 women in this review (40 studies on daily oral iron supplementation compared to placebo/no iron and eight comparing iron with folic acid compared to placebo/no iron and folic acid).

The largest study was amongst 18,775 participants and the smallest study was amongst 13 participants. The trials were conducted in 27 countries around the world; most studies were done in the United Kingdom (14) and United States of America (eight). Studies were mainly funded by government agencies, universities, health ministries within countries, and pharmaceutical companies.

Iron supplementation compared to placebo or no iron

Women taking iron supplements during pregnancy may have reduced anaemia, iron deficiency, and probably reduced iron-deficiency anaemia when they give birth around their due date. There is probably little to no difference in the risk of other maternal outcomes, including maternal death; however, the evidence is very uncertain for adverse effects, or severe anaemia in the second or third trimester. No trials reported maternal clinical malaria or infection during pregnancy.

Women taking iron supplements during pregnancy were probably less likely to have infants with low birthweight (less than 2500 g), but the evidence is very uncertain for infant birthweight. There was probably little to no difference between groups for preterm birth and little to no difference in birth defects or death of a baby in the first 28 days of life.

Iron + folic acid compared to placebo or no iron + folic acid

Women taking daily iron + folic acid supplements probably had reduced anaemia or may have reduced iron deficiency when they gave birth around their due date; however, the evidence is very uncertain for iron-deficiency anaemia, or maternal death. The evidence is uncertain for any adverse effects, and the evidence is very uncertain for severe anaemia in the second or third trimester. No maternal deaths were reported,

and no trials reported maternal clinical malaria.

Women taking iron + folic acid supplements during pregnancy probably had infants with increased birthweight, but there may be little to no difference between groups for other outcomes, including low infant birthweight (less than 2500g), preterm birth, death of a baby in the first 28 days of life, or birth defects.

What are the limitations of the evidence?

Few studies reported the main outcomes, including maternal deaths, adverse effects, severe anaemia, maternal clinical malaria, or infection during pregnancy, and other infant outcomes, including birth defects, and infant iron status, growth, and development. In addition, studies included pregnant women at different iron levels and gestational age at enrolment with different doses of iron, and timing of outcome assessments, which constrains the comparability of evidence for some outcomes in pregnant women and children.

How up-to-date is this evidence?

This review is an update of the previous review. The evidence is up-to-date as of 18 January 2024.

Reference:
Finkelstein JL, Cuthbert A, Weeks J, Venkatramanan S, Larvie DY, De-Regil LM, Garcia-Casal MN. Daily oral iron supplementation during pregnancy. Cochrane Database of Systematic Reviews 2024, Issue 8. Art. No.: CD004736. DOI: 10.1002/14651858.CD004736.pub6. Accessed 12 December 2024.

DO DIETARY AND ACTIVITY STRATEGIES HELP PREVENT OBESITY IN CHILDREN AND YOUNG PEOPLE AGED 12 TO 18 YEARS?

Key Messages

Strategies to encourage adolescents to change their diet or activity levels (or both), to prevent them becoming overweight or developing obesity make no or very little difference to their body mass index (BMI; an estimate of the amount of body fat according to height and weight).

Based on the very little information available about serious adverse events, there appears to be little or no effect of dietary or activity strategies, or both, to results in serious harms (e.g. injuries).

Due to a lack of evidence, future research should focus on community settings (e.g. in youth clubs) and research involving adolescents with disabilities.

Why is preventing obesity in children and young people important?

More adolescents are developing overweight and obesity worldwide. Being overweight as an adolescent can cause health problems, and people may be affected psychologically and in their social life. Puberty and moving into adulthood is a challenging time, and many struggle with their mental health. Overweight adolescents are likely to be overweight or obese as adults and continue to experience poor physical and mental health.

What did we want to find out?

We wanted to find out if strategies to help adolescents modify their diet or activity (or both) were effective at preventing obesity. We also wanted to know if these strategies were associated with any serious harms.

What did we do?

We searched scientific databases for studies that looked at ways of preventing obesity in children aged 12 to 18 years. We excluded studies aimed at adolescents who were already overweight or living with obesity. However, we included studies where the sample was a whole group (e.g. a school), which may have included those living with overweight or obesity. We only included studies if the methods they used aimed to change the children's diet, their level of activity (i.e. increasing physical activity or reducing inactive time), or both. We looked only for studies that randomly placed children into groups receiving different strategies (which may include changing nothing). We assessed the rigour of the studies to get a sense of how confident we were in their results. We grouped studies together for analysis depending on whether they aimed to improve diet, activity, or both.

What did we find?

We found 74 studies involving 83,407 children and young people. Sixty studies were based in high-income countries (e.g. USA and in Europe). In 57 studies, the strategies were tried in schools, although 12 were based at home or other places like community settings (five studies) such as youth groups. Fifty-one strategies were implemented for fewer than nine

months; the shortest intervention lasted one visit and the longest over 28 months. Sixty-two studies declared non-industry funding; five studies were partly funded by industry (food suppliers, a PlayStation manufacturer, a gym equipment supplier, a healthcare device manufacturer and a private healthcare facility).

Our analyses included results from 54 studies of 46,358 adolescents (20 studies did not report their results in a way that could be included in our analyses). We found that adolescents who were helped with a strategy to change their diet or activity levels (or both) either did not reduce their BMI, or any reduction was meagre, compared to adolescents who were not given a strategy.

Only a few studies reported any possible harms of the interventions, and none identified serious harms.

What are the limitations of the evidence?

Overall, we have limited confidence in the beneficial effects of these interventions in preventing obesity in children and adolescents. It is difficult to be confident that funding more studies, at least more school-based studies, would produce a much higher level of confidence in the results. Four main factors reduced our confidence in the evidence.

1. Results were very inconsistent across the different studies.

2. Many studies had limitations in how they were done (e.g. in some studies, the methods used to randomly place people into groups were not adequate or the results of some of the studies were not analysed correctly).

3. There were not enough studies reporting particular types of outcomes, such as BMI (an estimate of the amount of body fat according to height and weight) or zBMI (comparison of a child's BMI with other children of the same age and sex) for a particular duration of follow-up to be certain about the results for some comparisons. Also, certain settings (e.g. community settings) were under-represented.

4. Results from some studies were not reported in a way that we could include them in our analyses (e.g. without any detail of the difference in change between the intervention and control groups) and this may have an impact on the results of our analyses.

This review does not provide sufficient information to be able to assess how well strategies work for adolescents with disabilities, or whether those implemented in community settings are effective.

How up to date is this review?

This review supersedes our previous review. The evidence is up-to-date until February 2023.

Reference:

Spiga F, Tomlinson E, Davies AL, Moore THM, Dawson S, Breheny K, Savović J, Hodder RK, Wolfenden L, Higgins JPT, Summerbell CD. Interventions to prevent obesity in children aged 12 to 18 years old. Cochrane Database of Systematic Reviews 2024, Issue 5. Art. No.: CD015330. DOI: 10.1002/14651858.CD015330.pub2.

IS MAGNESIUM SULPHATE FOR WOMEN AT RISK OF PRETERM BIRTH BETTER THAN PLACEBO FOR PROTECTING THEIR BABIES' BRAINS?

Key messages

Magnesium sulphate given to women at risk of preterm birth for protecting their babies' brains reduces cerebral palsy, and the combined outcome of death or cerebral palsy, in their children up to two years of age, when compared with placebo.

Future research in this area should focus on the effects of treatment:

- on children when they are adolescents and adults; and
- for different groups of women at risk of preterm birth, and with different ways of giving magnesium sulphate.

What is magnesium sulphate?

Magnesium sulphate is a common medicine used across the world for different complications in pregnancy.

Why is this important for women at risk of preterm birth and their babies?

Babies born early (preterm, before 37 weeks of pregnancy) have a higher risk of complications including death and disabilities, such as cerebral palsy. In recent years, magnesium sulphate has been given to women who are likely to have their babies preterm (because of spontaneous preterm labour, or a medical indication to plan an induction of labour or caesarean birth early) to help protect their babies' brains and prevent these complications.

What did we want to find?

We wanted to find out if magnesium sulphate is better than placebo (a 'dummy' treatment that does not contain any medicine but appears identical to the medicine being tested) at protecting the brains of babies likely to be born preterm.

We were interested in the effect of magnesium sulphate on important outcomes, including: death (of the babies, or later as children), cerebral palsy, and major 'neurodevelopmental disability' (which might include serious outcomes like cerebral palsy, blindness, deafness, or global cognitive or intellectual impairment). We were also interested in the effect on important outcomes for women, including serious complications of magnesium sulphate (death, respiratory or cardiac arrest), and stopping treatment because of side effects.

What did we do?

We searched for studies that looked at whether magnesium sulphate caused benefits or harms for women and their preterm babies when compared to placebo or no treatment. We compared and summarised results and rated our confidence in the evidence, based on factors such as study methods and sizes.

What did we find?

We found six studies involving 5917 women at less than 34 weeks of pregnancy and their 6759 babies. The studies were all conducted in high-income countries. The included studies compared magnesium sulphate with placebo.

Main Results

Compared with placebo, magnesium sulphate in women at risk of having their babies preterm:

- reduces cerebral palsy (evidence from 6 studies with 6107 children) and the combined outcome of death or cerebral palsy (6 studies, 6481 children) for children up to two years of age;
- probably makes little to no difference in death (6 studies, 6759 children), major neurodevelopmental disability (1 study, 987 children), or the combined outcome of death or major neurodevelopmental disability (3 studies, 4279 children), for children up to two years of age;
- may make little to no difference in the above-mentioned outcomes for children at early school age;
- may make little to no difference in serious complications of treatment for women (4 studies, 5300 women), but probably increases women stopping treatment because of side effects (3 studies, 4736 women).

What are the limitations of the evidence?

We are confident in our finding that magnesium sulphate reduces cerebral palsy, and the combined outcome of death or cerebral palsy, in children up to two years of age.

We have little confidence in the evidence for outcomes of children at school age, as studies could not provide data for all children, and there are not yet enough studies/ data to be certain about the results.

We have little confidence in our finding that magnesium sulphate makes little to no difference in serious complications of treatment for women, as there was only one complication reported in one study. We have moderate confidence in our findings that magnesium sulphate probably increases women stopping treatment because of side effects, as the findings differed across studies, probably because of different decision-making processes for stopping treatment.

The results of further research for the outcomes in which we have limited confidence could differ from the results of this review.

How up to date is this evidence?

The evidence is current to 17 March 2023.

Reference:

Shepherd ES, Goldsmith S, Doyle LW, Middleton P, Marret S, Rouse DJ, Pryde P, Wolf HT, Crowther CA. Magnesium sulphate for women at risk of preterm birth for neuroprotection of the fetus. Cochrane Database of Systematic Reviews 2024, Issue 5. Art. No.: CD004661. DOI: 10.1002/14651858.CD004661.pub4.

DOES TREATMENT WITH SGLT2 INHIBITORS PREVENT COMPLICATIONS FOR PEOPLE WITH CHRONIC KIDNEY DISEASE AND DIABETES?

Key messages

- Treatment with sodium-glucose co-transporter protein 2 (SGLT2) inhibitors decreases the risk of death and kidney problems for people with chronic kidney disease and diabetes.
- We are not sure whether SGLT2 inhibitors are better than other diabetes drugs as not enough clinical research has been done directly comparing them in clinical studies.

What is Chronic kidney disease and diabetes?

Diabetes is a common disease caused by reduced insulin activity (the hormone that controls glucose levels in the blood) and increased insulin resistance. Diabetes decreases health-related quality of life and leads to heart attacks, stroke, limb amputation, death and depression at an early age, especially in people with chronic kidney disease. SGLT2 inhibitor drugs are now used to treat people with chronic kidney disease and diabetes. New studies are emerging, and combining the results of these trials together is essential to have the most up-to-date understanding of whether these drugs are safe and beneficial when compared with other treatments.

What did we want to find out?

We wanted to find out whether SGLT2 inhibitor drugs prevent diabetes problems in adults and children who have both chronic kidney disease (reduced kidney function) and diabetes.

What did we do?

We searched for all trials that assessed the benefits and harms of randomly allocating SGLT2 inhibitors to people with chronic kidney disease and diabetes. We compared and summarised the trials' results and rated our confidence in the information based on factors such as trial methods and sizes.

What did we find?

We included 53 clinical studies involving 65,241 adults with chronic kidney disease and diabetes. People in the studies were given an SGLT2 inhibitor, a sugar pill (placebo), standard care alone, or a different diabetes medication (e.g. metformin or insulin). The treatment allocation was decided by random chance (like tossing a coin). No studies were done on children.

Combining all the studies, we found that treatment with SGLT2 inhibitors decreases the chance of death, including death directly due to a heart problem or stroke. We also found that SGLT2 inhibitors prevent kidney failure, meaning that fewer people on this treatment needed dialysis or a kidney transplant. The effects of preventing a heart attack or a stroke are unclear. We also could not be sure whether SGLT2 inhibitor treatment was better or worse than other treatments because few data are available comparing it to other diabetic medications in clinical studies.

What are the limitations of the evidence?

Some of the studies did not clearly report how many people had chronic kidney disease, so some data could not be included. Adverse events were rarely and inconsistently reported, so we are uncertain about these outcomes. While we included studies in people with type 1 diabetes, not enough data was available to explore the effects of SGLT2 inhibitors in these people properly.

How up to date is this evidence?

The evidence is current to November 2023.

Reference:

Natale P, Tunnicliffe DJ, Toyama T, Palmer SC, Saglimbene VM, Ruospo M, Gargano L, Stallone G, Gesualdo L, Strippoli GFM. Sodium-glucose co-transporter protein 2 (SGLT2) inhibitors for people with chronic kidney disease and diabetes. Cochrane Database of Systematic Reviews 2024, Issue 5. Art. No.: CD015588. DOI: 10.1002/14651858.CD015588.pub2.

RECENT EVENTS

COURTESY CALL TO THE CHAIRPERSON, NIGERIAN UNION OF JOURNALISTS (NUJ), CROSS RIVER STATE CHAPTER

Cochrane Nigeria paid a courtesy call to the recently inaugurated chairperson of the Nigerian Union of Journalists, Cross River State on 20th November 2024. The meeting began with an opening address by Mr. Mike Abang, Secretary of the NUJ, Cross River State Council. He welcomed the Cochrane Nigeria team and introduced the Chairperson, Mrs. Archibong Bassey, who happens to be the first female Chairperson of the Cross River State Council. He also introduced Mrs. Bernadine Anam, the Auditor of the NUJ Cross River State Council.

Mrs. Moriam Chibuzor, (Senior Research Officer, Cochrane Nigeria), introduced the Cochrane Nigeria delegation, comprising Dr. Ekpereonne Babatunde Esu (Associate Director, Strategy and Methods Coordination), Mrs. Benice Justman Omini (Research Assistant) and Ms. Pricilla Agida (Research Assistant). Mrs. Chibuzor stated the purpose of the visit which was to pay a courtesy call on the new NUJ administration, acknowledge previous collaborations, and introduce Cochrane Nigeria's mission and activities. In her speech, she emphasized the organization's focus on synthesizing health research evidence for interventions and fostering partnerships with the media.

Dr. Esu congratulated the Chairperson on her historic leadership role, acknowledging the path she is paving for future female leaders. He elaborated on Cochrane Nigeria's long-standing collaboration with the media since 2012, including hosting media round tables on topical health issues. He noted that these sessions offer updates on current trends, disease burdens, evidence summaries, and media briefs for evidence-based health care reporting. Dr. Esu expressed the organization's readiness to continue collaborating with the NUJ under its new leadership.

In response, Mrs. Archibong Bassey welcomed the Cochrane team and expressed enthusiasm for the partnership. She emphasized the value of collaboration in empowering NUJ members with knowledge and skills. She assured the Cochrane team of her administration's openness to supporting their initiatives and expressed confidence that the partnership would yield mutual benefits. She invited Cochrane Nigeria to share newsletters, research evidence, and other communications directly with her for dissemination across NUJ platforms, including radio and television stations. This approach, she suggested, would ensure wider reach and visibility, even among members who may miss email updates.

This visit mirrored the mutual commitment of Cochrane Nigeria and the NUJ to encourage impactful collaborations. The meeting ended on a pleasant note, with assurances of support and shared goals for future projects.

New and Updated Reviews & Protocols from the Cochrane Library

The following new or updated reviews and protocols, published recently in the Cochrane Library, were authored or co-authored by Nigerians.

New or updated Reviews & Protocols

- **Fenoldopam for preventing and treating acute kidney injury**
  Christopher I Esezobor, Girish C Bhatt, Emmanuel E Effa, Elisabeth M Hodson. Issue 11, 2024
- **Antioxidant supplementation for sickle cell disease**
  Abiola B Bolarinwa, Olabisi Oduwole, Joseph Okebe, Ann A Ogbenna, Oluwakemi E Otokiti, Adejoke T Olatinwo. Issue 5, 2024

Other Recent Reviews

- **Interventions for improving coverage of childhood immunisation in low- and middle-income countries**
  Angela Oyo-Ita, Olabisi Oduwole, Dachi Arikpo, Emmanuel E Effa, Ekpereonne B Esu, Yusentha Balakrishna, Moriam T Chibuzor, Chioma M Oringanje, Chukwuemeka E Nwachukwu, Charles S Wiysonge, Martin M Meremikwu. Issue 12, 2023

- **Hand hygiene for the prevention of infections in neonates**
  Bankole Peter Kuti, Tinuade A Ogunlesi, Olabisi Oduwole, Chukwudi CMO Oringanje, Ekong E Udoh, Segun Bello, Delia Horn, Martin M Meremikwu. Issue 6, 2023

Announcements

• Join Us for the 5th Cochrane Africa Indaba in Nairobi!

We are pleased to announce that **Cochrane Kenya** will host the **5th Cochrane Africa Indaba**, an esteemed international conference on evidence-based healthcare, at the **Argyle Grand Hotel** in **Nairobi, Kenya** from **14-15 May 2025.**

Conference Theme: ***"Advancing Evidence Synthesis for Health Decision-Making in Africa: Promoting Health Equity and Access"***

This year's Indaba will focus on promoting health equity and access through evidence-informed

decision-making. The event will explore the following sub-themes:

1. **Strengthening the Evidence-Policy Nexus**

   Topics include evidence for informing guidelines, capacity building for evidence use in decision-making, and creating a cohesive evidence ecosystem.

2. **Enhancing Capacity for Evidence Synthesis and Informed Decision-Making**
3. **Embracing Innovation in Evidence Synthesis**

This conference will gather a diverse group of participants, including researchers, health professionals, policymakers, Cochrane Africa collaborators, patient and community advocates, students, and stakeholders at all levels. Together, we'll explore advancements, share insights, and discuss the future of evidence synthesis across Africa.

EVENT HIGHLIGHTS: *The Indaba promises a dynamic two-day program featuring plenary sessions, interactive workshops, panel discussions, poster presentations, and networking opportunities, all designed to foster collaboration and inspire progress in evidence-based healthcare.*

For more information and to register, please visit: https://africa.cochrane.org/cochrane-africa-indaba-2025/about

• Introducing Cochrane Evidence Synthesis Unit Nigeria

Cochrane is excited to announce the launch of its first **Evidence Synthesis Units (ESUs),** with **Cochrane Evidence Synthesis Unit Nigeria** among the five newly established units across the globe. These ESUs are pivotal in Cochrane's mission to deliver reliable, high-quality evidence that addresses critical health challenges worldwide.

The Evidence Synthesis Units are collaborative research groups tasked with producing high-impact evidence for health decision-making, with a special emphasis on innovation, health equity, and stakeholder collaboration. These units include:

- **Australia:** Lead – Sally Green
- **Iberoamerica:** Lead – Eva Madrid
- **Germany:** Lead – Nicole Skoetz
- **India:** Lead – Meenu Singh
- **Nigeria:** Lead – Martin Meremikwu

Under the leadership of **Prof. Martin Meremikwu**, the Cochrane Evidence Synthesis Unit in Nigeria aims to leverage the expertise of academics, researchers, clinicians, and public health professionals from the West African hub of the Cochrane African Network. This unit will play a crucial role in producing evidence to inform health policy and practice across sub-Saharan Africa and beyond.

The launch of the Evidence Synthesis Units aligns with Cochrane's broader commitment to advancing health equity and supporting diverse, global health needs. These units will implement Cochrane's new Scientific Strategy, strengthening Cochrane's adaptability and responsiveness to evidence needs across various regions.

As Karla Soares-Weiser, Cochrane's Editor in Chief, notes, "*The Future of Evidence Synthesis programme is having a transformative impact on Cochrane's ability to deliver reviews that respond to the needs of our users worldwide.*"

We are proud to share this exciting development with our community and look forward to the impactful work ahead!

• Get Social with Cochrane Nigeria!

Join Cochrane Nigeria as we work to put trusted evidence at the centre of health decision-making across Africa and beyond. We are committed to producing high-quality systematic reviews and ensuring that our evidence is accessible to support informed health choices. Follow us on social media to stay updated on our work, connect with our community, and access the latest health evidence.

Follow Cochrane Nigeria on Your Favourite Platforms:

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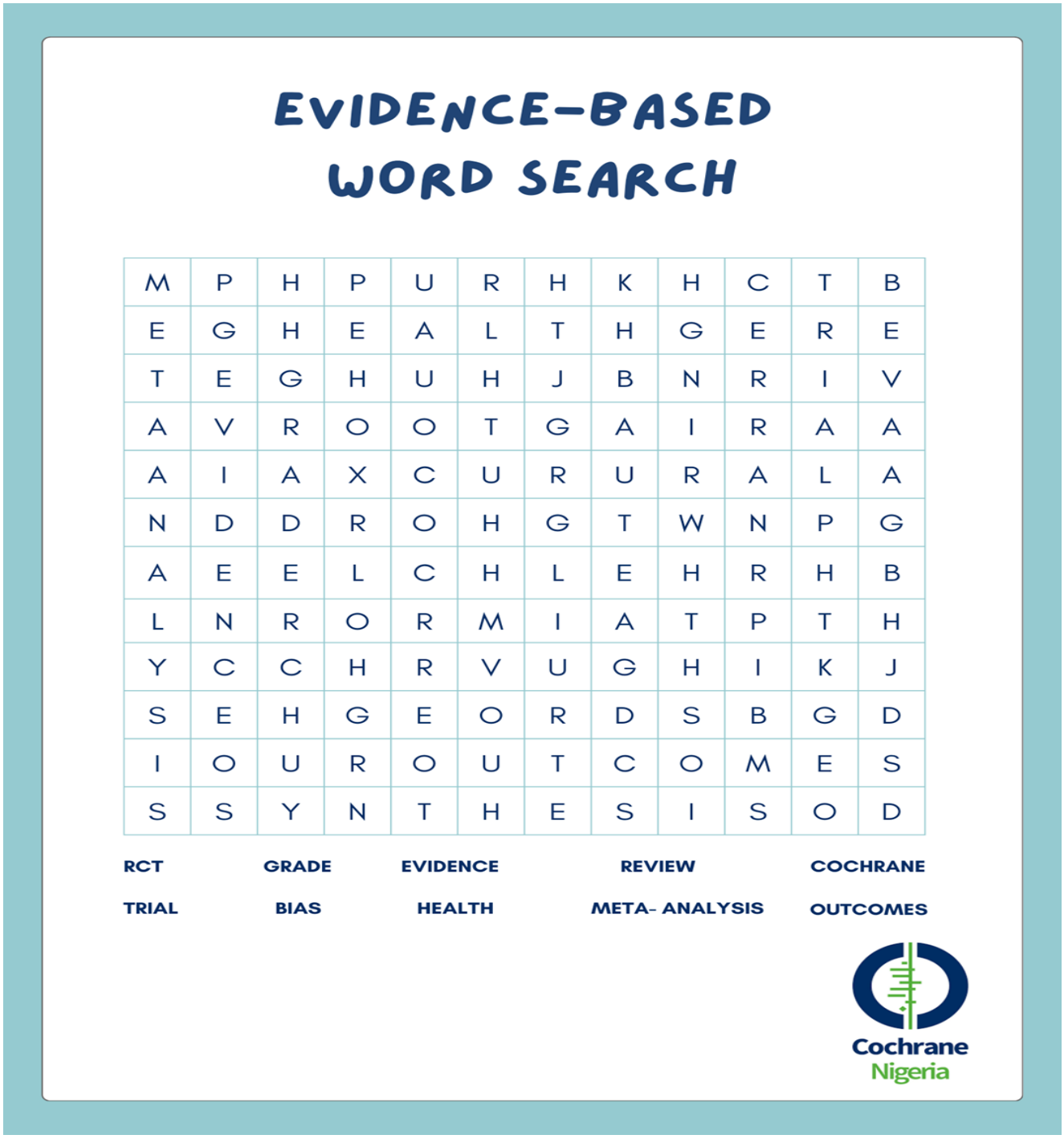
Stay connected and be part of the movement to make evidence-based health information accessible to everyone. Share, tag us, and help spread Cochrane reviews.



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