

Letters to the Editor

Epidemiology and public health research productivity in Africa

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Nachegea and colleagues make a comprehensive review of the current status and future prospects of epidemiology and public health training and research in the WHO African region.¹ We note, however, that the number of papers adjudicated to the Seychelles in the considered period (1981–2010) was substantially underestimated. If this occurred for other countries, it could have led to a commensurate underestimation of the true productivity in the region. The authors attributed 28 peer-reviewed articles that included at least one local co-author affiliated with an institution in the Seychelles. However, we are aware of at least 128 peer-reviewed manuscripts meeting the criteria, most of which have abstracts freely available on PubMed (a list is available from the authors). Many of these papers were published in high-impact medical journals, with the majority relating to population-based epidemiological research on noncommunicable diseases. Admittedly, research in Seychelles

(a country with a very small population and where a university was only recently created) benefitted from collaborative agreements with a number of large universities globally. These arrangements helped build, strengthen and sustain local research capacity. We agree with the encouraging conclusions reached by Nachegea and colleagues on the increasing research capacity in the African continent, but also call for renewed scrutiny when assessing papers published in the continent.

Reference

¹ Nachegea JB, Uthman OA, Ho YS *et al.* Current status and future prospects of epidemiology and public health training and research in the WHO African region. *Int J Epidemiol* 2012;**41**:1829–46.

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Authors' Response to: Epidemiology and public health research productivity in Africa

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We fully agree that the results of bibliometric analysis published in *IJE*¹ may be conservative given that our methodology may not have captured all the existing publications from some countries (e.g. Seychelles). We adopted the 'absolute country counting' method, where each country contributing to an article received

one paper credit based on the first, last or corresponding author originating from such country. Although we have attempted to eliminate potential flaws in our bibliometric analysis, some limitations were inevitable and are linked to the inherent problems of bibliometric analyses. For example, one possible

error that could arise from the indexing process is incorrect citation of origin for the authors. By using the author addresses listed in the bylines of research articles, one can only identify countries and organizations where the authors were employed when the research was done or where the article was written, or both. Whereas our bibliometric analysis results may be biased toward underestimation, it is good to know that the true reality may be even more encouraging. Despite this limitation, we strongly believe that our conclusions remain valid and informed by our results. The overall positive trend of manuscripts published over time speaks to the fact that epidemiological and public health publications are on the rise in the WHO/AFRO. However, more capacity building and training initiatives in epidemiology are required to promote research and address the public health challenges facing the African continent.

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Reference

- Nachega JB, Uthman OA, Ho YS *et al.* Current status and future prospects of epidemiology and public health training and research in the WHO African region. *Int J Epidemiol* 2012;**41**:1829–46.

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Limitless longevity: Comment on the Contribution of rectangularization to the secular increase of life expectancy

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Rossi *et al.* looked at the increase in life expectancy in nine European countries, including Sweden, from 1922–2006.¹ To do this, they used a method that allowed them to separate the two respective contributions to increased life expectancy of: (i) postponement of death, through rectangularization of the survival curve; and (ii) an upward shift in the maximum age at death, as a measure of longevity. They found that both factors have contributed to the increase in life expectancy in the nine countries in their study, but that increased longevity played a relatively greater role than postponement of death. They propose that changes in life-style factors, and particularly cigarette smoking, have been essential for rectangularizing the survival curve, but they have less specific suggestions

for explaining the upward shift in the age at death in the countries included in their study.

We previously analyzed mortality among Swedish centenarians in a cohort study based on individual data for all persons in Sweden who reached the age of 100 years from 1969–2009 ($n = 15\,231$).² In the analyses for this study we divided the data into a sequence of one-year cohorts. We used these data in an attempt to add some further insights to the findings by Rossi *et al.*

We could indeed confirm that longevity, measured as the maximum age at death, has increased steadily during the period that we studied (Figure 1), and this was also shown by others for an earlier period.³ This corroborates Rossi and colleagues' results, although