

Prof. Ruth Stewart

Evidence community must help to navigate the uncertainty –

A Q&A with Ruth Stewart

Prof. Ruth Stewart grew up in Malawi, studied in the UK and has worked in South Africa since 1998. She has a background in the social sciences and has worked on the production of systematic reviews, rapid evidence assessments and evidence maps to inform decision making. Ruth is the Director of the University of Johannesburg's Africa Centre for Evidence and Chairperson of the Africa Evidence Network, a network of nearly 3000 people from over 40 countries, including 22 African governments.

What do you see as the role of evidence-based work in this time of COVID-19?

There is so much for the evidence community to do in this time. On the one hand, we are facing unprecedented challenges due to COVID-19, as individuals, families, communities and countries, in relation to our health, our employment, our economy and much more. We have new and numerous questions for which we urgently need evidence to help us make decisions. On the other hand, there is an overwhelming amount of information being reported on a daily basis. Some of this is very broad, some very specific, sometimes literally about one individual on the other side of the world. Much of it is being released into the public arena 'pre-publication' and is being interpreted by the media and the public without scientific critique. There is a need for the evidence community to help to navigate the uncertainty that people are facing by critiquing and interpreting the evidence and ensuring it is accessible to inform decision making at all levels

Despite the rapid response of the global research community, obviously there isn't clear evidence yet for many of the issues – what would your recommendation be for countering the misinformation?

I think there are two issues here - overwhelming varied information and misinformation.

There is an overwhelming amount of varied information and the evidence community has a role to play in sorting through what we do know and helping to make sense of it. We need to be really clear where the evidence is not (yet) sufficient in quality or quantity to provide certainty, and we need to support decision makers in contextualising the evidence that we do have to help address the specific challenges they are facing. At the same time we need to document the contexts in which decisions are being made

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to support decision makers to understand when to follow the examples of other countries and when to act differently. And we need to ensure the impacts of decisions are closely monitored with clear feedback loops so that decisions can be adjusted accordingly.

There is also misinformation. This is sometimes due to jumping to conclusions based on incomplete information (and we need to be clear whether there is uncertainty), and sometimes due to deliberate misleading of others and promotion of conspiracy theories. This can be extremely dangerous and needs direct countering. Fact-checking organisations such as Africa Check are doing a great job in working to address this.

South Africa has imposed a strict (at times controversial) lockdown – what are your opinions on this and what lessons do you think have been learnt? Are we ready for what's ahead?

I can only imagine how difficult it has been for our leaders to make decisions about what to do. The evidence is patchy, and the pandemic has escalated extremely quickly. Like all countries in the world, South Africa's response was initially driven by the impending health crisis and was, as far as I could see, based on the best-available health evidence.

Like many people I am worried about the economic and social impacts of the strict lockdown that we've had in South Africa, and I'm glad that the lockdown is easing now for economic reasons, and I remain concerned about the health situation as infections continue to increase. Although I have friends and family on other continents who have had COVID-19, I don't know anyone here who has had the virus (yet). I do have friends and family here who have lost income and are facing extreme economic hardship because of the pandemic. We do need the economy to be up and running as far as it's safe to do so.

I think South Africa and other countries are still learning about the pros and cons of lockdowns, how to release from them, and the implications of these decisions. These learning loops are crucial. We can't guarantee that we're ready for any one situation but I do hope that we're getting

better at learning and adjusting. I'm not sure we're there yet – this is a whole new way of doing government and it is testing the very concept of a capable developmental state – but we're moving in the right direction in terms of learning from the evidence and that is encouraging.

Can you point to specific work or national/global initiatives that are important/having an impact at this time?

The most important initiatives that I've seen (and, in some cases, had the privilege to be part of) are networks and collaborations of people working together to share resources to find solutions together to this crisis, and to get ready to help find solutions for the problems that we anticipate we will be facing in the coming years. People are working together to collect and make sense of the evidence and ensure that it is integrated into decisions. This includes networks like Cochrane and the Africa Evidence Network, and global evidence initiatives like COVID-END.

Can you tell us about your organisation's response?

We've been very busy. First and foremost we have been

taking very seriously our duty of care to our team and our communities. These are difficult times and we have had to learn how to adapt and work in new ways very quickly. It's not been easy. And second we have been working on a wide range of efforts to provide evidence for decision makers to help find solutions to the wide range of issues we are suddenly facing. This has included very quick responses, for example collating the evidence for government on support for small and medium enterprises in the context of COVID-19, and some longer-term initiatives, for example building a one-stop-shop that provides decision makers and researchers with one place where they can navigate the large number of available evidence databases and repositories related to COVID-19 which are being developed all over the place with lots of duplication. We are also working to collate examples of how evidence is being used to address a wide range of decisions across Africa and making them freely available via the Africa Evidence Network so we can all be learning from one another. There is a lot more information about these responses at www.africacentreforevidence.org

From the Cochrane Library

Over the next few pages we present some of Cochrane's responses to COVID-19. The Cochrane SA website has also been updated with COVID-19 news see: <https://southafrica.cochrane.org/>

Cochrane Special Collections on COVID-19

Cochrane Special Collections are a collection of reviews on specific topics. The COVID-19 collection brings together reviews on topics relevant for the prevention and treatment of COVID-19. The collections are developed by experts from the global Cochrane network, based on World Health Organization interim guidance, and continuously updated.

Effective options for quitting smoking during COVID-19

Tobacco smoking has been identified as a specific risk factor for COVID-19. Cochrane has created a Special Collection of Cochrane Systematic Reviews that summarise evidence for people wishing to give up smoking. Options include nicotine replacement, behavioural support such as telephone, internet and text-messaging programmes, and gradual quitting. The evidence suggests that a combination of stop-smoking medicines and behavioural support give the best chances of success. <https://www.cochrane.org/news/special-collection-effective-options-quitting-smoking-during-covid-19>

Coronavirus (COVID-19): Optimising health in the home workspace

This Special Collection, developed in collaboration with Cochrane Work, brings together Cochrane reviews summarising evidence for maintaining health and wellbeing when working from home due to the COVID-19 pandemic. It includes systematic reviews that evaluate the effects of interventions related to maintaining physical activity, optimising the work environment, and preventing musculoskeletal and eye problems. <https://www.cochrane.org/news/special-collection-coronavirus-covid-19-optimizing-health-home-workspace>

Coronavirus (COVID-19): Remote care through telehealth

This Special Collection includes Cochrane reviews that address using telehealth to support clinical management of various conditions, including asthma, diabetes, cardiovascular disease, dementia, reproductive health and skin cancer. It includes reviews of using telehealth to provide carer and parent support especially during the COVID-19 pandemic as well as empowering patient self-management of their long-term conditions. <https://www.cochrane.org/news/special-collection-coronavirus-covid-19-remote-care-through-telehealth>

Evidence relevant to critical care

This Special Collection brings together Cochrane reviews identified as most directly relevant to the management of people hospitalised with severe acute respiratory infections. <https://www.cochranelibrary.com/collections/doi/SC000039/full>

Infection control and prevention methods

This Special Collection brings together Cochrane reviews identified as most directly relevant to the prevention of infection. <https://www.cochranelibrary.com/collections/doi/SC000040/full>

Regional anaesthesia to reduce drug use in anaesthesia and avoid aerosol generation

The COVID-19 pandemic has created unique challenges for anaesthesia. This Special Collection brings together evidence from Cochrane Anaesthesia to support decision making when planning anaesthesia in this context. <https://www.cochranelibrary.com/collections/doi/SC000041/full>

From the Cochrane Library

COVID-19 resources available from Cochrane

Cochrane has launched an extensive array of responses to the challenges of the COVID-19 pandemic. This includes rapid, living and fast-tracked reviews; special collections; as well as the COVID-19 study register; enhanced sections on the Cochrane Library app and regular news updates.

All of Cochrane's responses to COVID-19 are available via free access and, where possible and appropriate, are published in up to 12 languages. For full access to the resources see: <https://www.cochrane.org/coronavirus-covid-19-cochrane-resources-and-news>

COVID-19 Study Register

In April Cochrane announced the launch of its [COVID-19 Study Register](#) – a one-stop shop for primary research studies on COVID-19.

The aim is to support rapid evidence synthesis by all systematic review producers. The register helps systematic reviewers prioritise topics, identify evidence, and produce urgently needed reviews for front-line health professionals, policy makers, and research teams developing new therapeutic, diagnostic and preventive interventions for COVID-19. The Study Register supports rapid and living evidence synthesis by all systematic review producers, as well as Cochrane's work on COVID-19-related rapid reviews, systematic reviews and network meta-analyses. It provides a 'one-stop shop' for researchers to access all primary studies being published related to COVID-19. Study references are pre-evaluated to meet eligibility for COVID-19 reviews, reducing searching and screening time for author teams.

Just two months from its launch, Cochrane's COVID-19 Study Register has become one of the largest, most sophisticated and well-used resources for researchers needing to access and analyse the huge growth in primary studies being conducted on COVID-19. The register has attracted more than 10 000 users from around the world, accessing over 44 000 pages. The register is constantly improving with the

ambition of becoming the definitive source of studies on COVID-19.

Priority areas for future COVID-19 work

Cochrane has announced its COVID-19 priority areas of work over the next six months to help meet the healthcare evidence needs of policy makers, guideline developers and clinicians; and has made available a list of additional priority questions to help guide the work of other research organisations.

Since March, Cochrane has been gathering some of the most important questions related to the COVID-19 pandemic from health researchers, clinicians, policy makers, patients and carers, as well as guideline developers from different countries. Cochrane experts reviewed these questions in collaboration with health and policy decision makers, resulting in Cochrane's Question Bank, which is now being made available to the global research community.

The Question Bank includes approximately 150 questions, categorised to allow users to see the questions being addressed by Cochrane (through a rapid review or a normal systematic review); those being addressed by other systematic reviewers; and, those questions not yet being addressed.

These have been grouped into three main categories: Clinical management; public-health measures; and, economic and social responses.

See <https://www.cochrane.org/news/cochrane-identifies-its-priority-areas-future-covid-19-work-and-lists-other-critical-questions>

Cochrane Library app

The Cochrane Library app is available from Google Play (Android devices) or the App Store (iPhone and iPad).

From the Cochrane Library

Brief summaries of Cochrane COVID-19 rapid reviews

Personal protective equipment (PPE) for preventing highly infectious diseases due to exposure to contaminated body fluids in healthcare staff



To evaluate which type of full-body PPE and which method of donning (putting on) or doffing (removing) PPE have the least risk of contamination or infection for healthcare workers (HCW), and which training methods increase compliance with PPE protocols.

This is an update of reviews published in 2016 and 2019.



This update included 24 studies with 2278 participants that evaluated types of PPE, modified PPE, procedures for putting on and removing PPE, and types of training. Eighteen of the studies did not assess HCW who were treating infected patients but simulated the effect of exposure to infection using fluorescent markers or harmless viruses or bacteria. Most of the studies were small, and only one or two addressed each of the questions.



In addition to other infection-control measures, consistent use of full-body PPE can diminish the risk of infection for HCW.

For choosing between PPE types, there is very low-certainty evidence, based on single-exposure simulation studies. Covering more parts of the body leads to better protection but usually comes at the cost of more difficult donning (putting on) or doffing (taking off) and user comfort, and may therefore even lead to more contamination.

For changes to PPE, there is low- to very low-certainty evidence that adding tabs to gloves or masks or closer fit of gowns at the neck or the wrist decreases contamination.

There is very low-certainty evidence that double gloves and providing users with help or spoken instructions during donning and doffing may reduce the risk of contamination. Extra disinfection of gloves with bleach or quaternary ammonium may decrease hand contamination but not alcohol-based hand rub.

There is very low-certainty evidence that more active training (including video or computer simulation or spoken instructions) may increase compliance with instructions compared to passive training (lectures or no added instructions). No studies compared methods to retain PPE skills needed for proper donning and doffing in the long term.

The certainty of the evidence is low to very low for all comparisons because conclusions are based on one or two small studies and a high or unclear risk of bias.

There is a need to carry out a re-evaluation of how PPE is standardised, designed, and tested as well as a need for a harmonised set of PPE standards and a unified design for PPE.

Citation: Verbeek JH, Rajamaki B, Ijaz S, Sauni R, Toomey E, Blackwood B, Tikka C, Ruotsalainen JH, Kilinc Balci FS. Personal protective equipment for preventing highly infectious diseases due to exposure to contaminated body fluids in healthcare staff. *Cochrane Database of Systematic Reviews* 2020, Issue 4. Art. No.: CD011621. DOI: 10.1002/14651858.CD011621.pub4.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD011621.pub4/full>

Barriers and facilitators to healthcare workers' adherence with infection prevention and control (IPC) guidelines for respiratory infectious diseases: A rapid qualitative evidence synthesis



To identify barriers and facilitators to healthcare workers' (HCW) adherence to infection prevention and control (IPC) guidelines for respiratory infectious diseases.



This is a Cochrane rapid review of qualitative research ('qualitative evidence synthesis'). The review found 36 relevant studies and sampled 20 of these for the analysis. Ten studies were from Asia, four from Africa, four from Central and North America and two from Australia. The studies explored the views and experiences of nurses, doctors and other HCW when dealing with severe acute respiratory syndrome (SARS), H1N1, MERS (Middle East respiratory syndrome), tuberculosis (TB), or seasonal influenza. Most worked in hospitals; others worked in primary and community care settings.



HCW point to several factors that influence their ability and willingness to follow IPC guidelines when managing respiratory infectious diseases. These include factors linked to the guideline itself

and how it is communicated, support from managers, workplace culture, training, physical space, access to and trust in personal protective equipment (PPE), and a desire to deliver good care. The review highlights the importance of including all facility staff, including support staff, when implementing IPC guidelines.

The review highlighted questions around communication, workload, physical environment, equipment availability, training and education and patient relationships that may help ministries of health, healthcare facilities, and other stakeholders to plan, implement, or manage IPC strategies.

Comparable research is needed in the context of COVID-19.

There is a need to focus on developing and evaluating interventions that create a climate of safety and with clear IPC guidance consistent with international guidelines.

Future research also needs to look at training and education interventions as well as how to make best use of the available physical environment to reduce contamination risk while managing patient care adequately.

Better reporting is needed in qualitative research on this topic as well as rigour and transparency.

Citation: Houghton C, Meskell P, Delaney H, Smalle M, Glenton C, Booth A, Chan XHS, Devane D, Biesty LM. Barriers and facilitators to healthcare workers' adherence with infection prevention and control (IPC) guidelines for respiratory infectious diseases: a rapid qualitative evidence synthesis. *Cochrane Database of Systematic Reviews* 2020, Issue 4. Art. No.: CD013582. DOI: 10.1002/14651858.CD013582.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013582/full>

Quarantine alone or in combination with other public health measures to control COVID-19



A rapid review to assess the effects of quarantine (alone or in combination with other measures) of individuals who had contact with confirmed cases of COVID-19, who travelled from countries with a declared outbreak, or who live in regions with high transmission of the disease.



29 studies were included; 10 modelling studies on COVID-19, four observational studies and 15 modelling studies on SARS and MERS. Because of the diverse methods of measurement and analysis, a meta-analysis could not be conducted and reviewers conducted a narrative synthesis. The certainty of the evidence is rated as low to very low. This review includes evidence published up to 12 March 2020.



Despite limited evidence, all the studies showed quarantine to be important to reduce the number of infections and deaths. Results showed that quarantine was most effective, and cost less, when started earlier. Combining quarantine with other prevention and control measures had a greater effect than quarantine alone.

However, local context is important and to maintain the best possible balance of measures, decision makers must constantly monitor the outbreak situation and the impact of the measures implemented.

Different countries have been implementing combinations of prevention measures at different intensity and speed. Comparing the effectiveness of these strategies will provide more evidence for future pandemics.

Citation: Nussbaumer-Streit B, Mayr V, Dobrescu Alulia, Chapman A, Persad E, Klerings I, Wagner G, Siebert U, Christof C, Zachariah C, Gartlehner G. Quarantine alone or in combination with other public health measures to control COVID-19: a rapid review. *Cochrane Database of Systematic Reviews* 2020, Issue 4. Art. No.: CD013574. DOI: 10.1002/14651858.CD013574

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013574/full/es#CD013574-abs-0002>

The use of convalescent plasma to treat people with COVID-19



People who have recovered from COVID-19 develop natural defences to the disease in their blood (antibodies). These are found in blood plasma. Convalescent plasma and hyperimmune immunoglobulin have been used successfully to treat other respiratory viruses. The review aimed to see whether plasma from people who have recovered from COVID-19 is an effective treatment for COVID-19, and whether this causes any unwanted effects.



The review includes eight studies, including 32 participants who received convalescent plasma. None of the studies randomly allocated participants to different treatments and none included comparison groups.



Certainty (confidence) in the evidence is very limited because the studies were not randomised and did not use reliable methods. They had only a small number of participants, who received various treatments alongside convalescent plasma, and some had underlying health problems.

The results of the eight studies are uncertain. However, there are 48 ongoing studies, including 22 randomised controlled trials. This is a living review and will be updated as evidence becomes available.

Citation: Valk SJ, Piechotta V, Chai KL, Doree C, Monsef I, Wood EM, Lamikanra A, Kimber C, McQuilten Z, So-Osman C, Estcourt LJ, Skoetz N. Convalescent plasma or hyperimmune immunoglobulin for people with COVID-19: a rapid review. *Cochrane Database of Systematic Reviews* 2020, Issue 5. Art. No.: CD013600. DOI: 10.1002/14651858.CD013600.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013600/full/es>

Do video calls help to reduce social isolation and depression in older people?



With restrictions on people's movement to protect them from COVID-19 in place globally, this rapid review asked if video calls can alleviate and affect symptoms of depression or quality of life particularly in older people.



The review included three studies, with 201 participants. All took place in nursing homes in Taiwan between 2010 and 2020 and compared video calls to usual care.



Evidence from these studies suggests that video calls have little to no effect on loneliness after three, six or 12 months. There is also little to no difference in symptoms of depression after three or six months, although after a year, older people who used video calls may have had a small reduction in depression compared to those who received usual care. Similarly, video calls may make little to no difference to older people's quality of life.

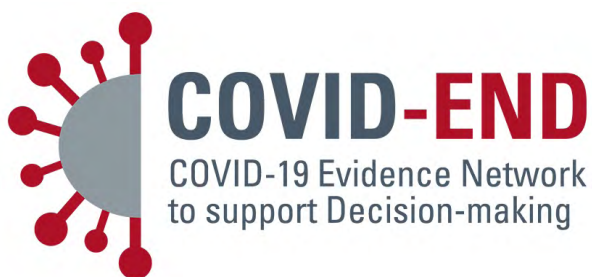
Certainty was limited due to the small number of participants, and lack of detail on the methods used. All the participants were in nursing homes, so the findings may not apply to older people living in other places, such as their own homes. Also, some participants may not have been feeling lonely or socially isolated.

Based on current evidence, it is not clear whether video calls help to reduce loneliness in older people. More studies, using more rigorous methods, are needed.

Citation: Noone C, McSharry J, Smalle M, Burns A, Dwan K, Devane D, Morrissey EC. Video calls for reducing social isolation and loneliness in older people: a rapid review. *Cochrane Database of Systematic Reviews* 2020, Issue 5. Art. No.: CD013632. DOI: 10.1002/14651858.CD013632.

<https://www.cochranelibrary.com/cdsr/doi/10.1002/14651858.CD013632/full>

Network aims to support high-level decision making regarding COVID-19



The COVID-19 Evidence Network to support Decision-making (COVID-END) <https://www.mcmasterforum.org/networks/covid-end> has been established to help health- and social-system leaders as they respond to the unprecedented challenges posed by the COVID-19 pandemic. COVID-END brings together partners, including

Cochrane SA and the South African Medical Research Council, drawn from diverse evidence-synthesis, technology assessment and guideline-development communities that have long track records of supporting local, national and international decision makers. Their activities span the full gamut of COVID-19 issues, including traditional infection prevention and control but also how to manage the impacts on mental health and family violence, health- and social-care systems, education, employment, financial protection, food safety and security, government services, housing, public safety and justice, recreation and transportation. Their activities also span the full array of contexts where the COVID-19 pandemic is playing out, including low-, middle- and high-income countries.

COVID-END prioritises the continuous maintenance of a [guide to COVID-19 evidence sources](#), to help co-ordinate

and avoid duplication and to develop scalable models for supporting evidence-informed decision making about COVID-19.

COVID-END's resources to support decision makers include:

1. a [guide to COVID-19 evidence sources](#)
2. a four-part [taxonomy](#) of the decisions that may need to be made as the pandemic and pandemic responses enter (or re-enter) different phases
3. a [rapid-evidence model](#) that can be adapted in any country to describe the evidence that already exists to inform a particular decision
4. [tips and tools](#) for those supporting decision makers

COVID-END's resources to support researchers include:

1. a [guide to all evidence sources](#) (to make it easier to identify unnecessary duplication and ways to

better co-ordinate the prioritisation, production and dissemination of evidence syntheses, technology assessments and guidelines)

2. [tips and tools](#) for researchers who are involved or who want to become involved in such work

To support this work, COVID-END has convened working groups in seven areas: scoping, engaging, digitising, synthesising existing evidence, recommending evidence-based approaches; packaging evidence and guidelines in ways that meet the needs of citizens, providers, policy makers and researchers in different contexts and languages; and, sustaining the efforts that strengthen institutions and processes so that we are even better prepared for future challenges.

The secretariat for COVID-END is jointly co-led by the McMaster Health Forum and its partners at the Ottawa Hospital and University of Ottawa.

Living mapping of COVID-19 research

Cochrane SA has also joined the <https://covid-nma.com/> project with Cochrane France and other partners. The project is performing a living mapping of ongoing research to monitor in real-time any new evidence that becomes available for treating and preventing COVID-19. The aim is to identify gaps and deficiencies in existing evidence early with an aim of prioritising and optimising future research. Through the process of living systematic reviews the group continuously collects and critically appraises all the available evidence addressing

specific clinical outcomes related to COVID-19, then, using network meta-analysis, synthesises the available study results and compares simultaneously all possible interventions that could be used in the same clinical setting.

A strict process is followed to identify, appraise and synthesise study results while identifying all studies and relevant results as rapidly as possible. Evidence sources will be modified and adapted as the situation develops.

For more information on the process and methods, [see the protocol](#).

This study receives some funding from a grant from the ANR (Agence Nationale de la Recherche).

Some perspectives from Africa

COVID-19 response in Ethiopia



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The first confirmed case of COVID-19 in Ethiopia was notified on 13 March 2020. Since then, a total of 36 624 suspected cases were tested, 250 confirmed and five died as reported on 11 May 2020. Many of the cases are from Addis Ababa, the capital city, but the virus is spreading across the country. So far, six of the nine regional states have reported confirmed cases. Most of the confirmed cases are imported with travel history and contact with confirmed cases. However, a few are with no contact with confirmed case and travel history.

In response to COVID-19, on 10 April 2020, the government declared a five-month state of emergency. All movements across borders are banned with few exemptions. Public

gatherings of more than four people are banned. Sports activities at all levels are prohibited and schools are closed. Mandatory quarantine of incoming international travellers is enacted. Despite all the efforts, the practice of preventive measures by citizens is quite low. The number of confirmed cases is increasing daily. Coupled with the low capacity for testing and contact tracing, the occurrence of sustained community transmission of COVID-19 in the country in the next few weeks is inevitable. Aggressive lockdown and stay at home are impractical for most citizens because of economic reasons. Thus, strong enforcement of relatively feasible preventive measures such as physical distancing, contact tracing, and masks are necessary to avert the worst consequences of the pandemic.

COVID-19 in Uganda



Prof. Harriet Mayanja Kizza,
Makere University

Uganda has had a health desk at the airport since the Ebola epidemics, and screens for yellow fever vaccine evidence.

With the spread of COVID-19, we also started screening for the infection, initially by categorising high-risk countries, and testing and quarantining travellers from these countries. However, it was noted that travellers from low-risk category countries were also presenting at the airport with fevers.

To halt transmission, the government set up a partial lockdown on travel on 23 March. This was insufficient to control public interaction, and the lockdown was upgraded to a more stringent form on 31 March which is in effect to date (5 May 2020). A curfew was introduced from 7pm to 6am for all individuals apart from truck drivers. Public and private transport including cars, buses, commuter vans and motorcycle taxis was halted and only essential workers were given car stickers from government allowing them to move to and from work.

Allowable transport included goods and food trucks, vans and motor cycles – with no passengers. Key personnel were later given stickers for continuation of critical services.

One glaring gap was how sick persons and pregnant women could reach health units. This remains a challenge as ambulances are few. Strict implementation of the president's guidelines by security forces led to some casualties, especially sick children, the elderly who cannot walk long distances, pregnant women – some giving birth along the road, delivered by husbands at home, and some hospital referrals losing lives. There were also cases of security personnel being over exuberant in enforcing the curfew.

All this said, the lockdown has had some positive outcomes. Uganda has of 5 May 2020 100 registered confirmed COVID-19 patient cases, 55 recovered and no deaths out

of over 40 000 individuals tested. About half of these were screened at the Uganda International Airport and there are about 10 in-country transmissions.

A concern was that many people living in informal areas around the city and towns do informal activities and depend on a daily income. Many are young, with limited skills. The government established a programme to distribute maize flour and dry beans – but coverage of all the needy remains a challenge.

The lockdown has been in effect for over a month now, and has impacted on persons employed in the private sector. For those in the public sector their jobs remain secured, and the monthly salaries come in. Those in private sector are at risk; some have already received communication on either being laid off till the situation improves, or may return to work on a part-time basis.



Local solutions for the shortage of ambulances

Cochrane Africa & GESI COVID-19 research survey

Cochrane Africa and the Global Evidence Synthesis Initiative (GESI) conducted a survey of network members in low- and middle income countries, to gather information on ongoing and planned research responses to COVID-19.

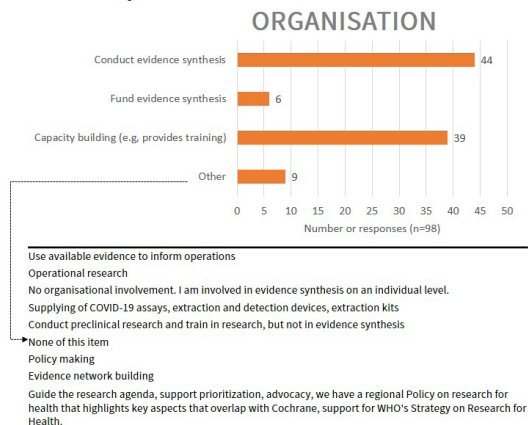
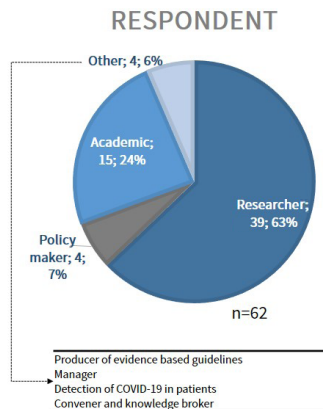
Sixty responses were received from 20 countries including nine African countries. Respondents were from universities and academic organisations, international organisations including the World Health Organization and private consultants.

The full summary of the responses is available [here](#). Results reported include information about the respondents and the organisations they work for, their plans to conduct primary or secondary research, COVID-19 research questions received from policy makers or practitioners, and respondents' willingness to share evidence briefs/ summaries/rapid reviews.

Of the respondents, 61% had been approached with priority research questions mostly from national government. The questions received were grouped into thematic areas:

- epidemiology which included estimates of incidence and prevalence and mathematical modelling;
- prevention and containment including quarantining, protection of healthcare workers, incubation and transmission, contact tracing, effective communication, containment in public transport and the use of masks;
- screening and diagnosis which included clinical symptoms and identification of asymptomatic cases;

involvement in evidence synthesis?



- Use available evidence to inform operations
- Operational research
- No organisational involvement. I am involved in evidence synthesis on an individual level.
- Supplying of COVID-19 assays, extraction and detection devices, extraction kits
- Conduct preclinical research and train in research, but not in evidence synthesis
- None of this item
- Policy making
- Evidence network building
- Guide the research agenda, support prioritization, advocacy, we have a regional Policy on research for health that highlights key aspects that overlap with Cochrane, support for WHO's Strategy on Research for Health.

- treatment which included specific therapeutics, the impact of co-infections with HIV and TB, individual risk factors, the effectiveness and safety of antiviral drugs;
- health systems response – including who should be hospitalised, how many beds and isolation units will be required and interventions for frontline healthcare workers; and,
- other – including seasonal flu vaccines and COVID-19 in pregnancy.

Respondents highlighted funding and inadequate supplies, low-quality evidence and information overload as well as the mental health impact as key challenges.

Twenty six per cent indicated that they were conducting or planning primary research, 45% that they were doing secondary research synthesis and 26% that they were contributing to local, national and international guidelines. An overwhelming 90% indicated a willingness to share their work to reduce global duplication.

The questions have been submitted to [Cochrane's list of priority questions](#). Available evidence summaries will also be submitted to the [Africa Evidence Network](#) and made available on the [McMaster COVID-19 evidence sources page](#).

Conferences

Our conference list has been a challenge to compile as many organisers don't yet know if their events will take place. We therefore provide information on a few conferences that have been cancelled or converted to online.

Evidence 2020 Online

23 - 25 September

<https://www.africavidencenetwork.org/en/events/19/>

Cochrane's Toronto Colloquium, October 2020

Cochrane's 27th Colloquium in Toronto, Canada, 4-7 October 2020 has been cancelled. Cochrane's Governing Board, with the agreement of Cochrane Canada, has decided to hold it instead in the Canadian Fall of 2022 following the Global Evidence Summit in Prague in 2021. Accepted abstracts will be published in the Cochrane Library.

Global Evidence Summit (GES) 2021

Hosted by the Czech National Centre for Evidence-Based Healthcare and Knowledge Translation

<https://community.cochrane.org/news/czech-republic-host-global-evidence-summit-2021>

2020 International Society of Vaccines Annual Congress

ISV will be postponing the 2020 conference. While the official date has yet to be finalised, ISV is anticipating late September/early October 2021. The Congress will remain at the Québec City Convention Centre. ISV is also planning to organise more regional and specialty conferences including a virtual conference on SARS-CoV-2 vaccines. See www.isv-online.org for updates.

Cochrane SA Webinars 2020

11 February	RevMan Web: A short introduction	Rebecka Hall IT Services, Cochrane Central Executive Team
21 April	Risk of Bias 2.0	Ameer Hohlfeld Cochrane SA
12 June	Health equity in systematic reviews	Vivian Welch & Jennifer Petkovic Campbell and Cochrane Equity Methods Group
14 July	Knowledge translation evaluation	Bey-Marrie Schmidt Cochrane SA
21 July	Appraising diagnostic test accuracy studies	Eleanor Ochodo Centre for Evidence-based Health Care, Stellenbosch University
11 August	Issue/policy briefs	TBC
18 September	Core outcome set development	Paula Williamson Core Outcome Measures in Effectiveness Trials (COMET)
13 October	Rapid reviews guidance	Chantelle Garrity Rapid Reviews Program, Knowledge Synthesis Group, Ottawa Hospital Research Institute