Since January 2020 Elsevier has created a COVID-19 resource centre with free information in English and Mandarin on the novel coronavirus COVID-19. The COVID-19 resource centre is hosted on Elsevier Connect, the company's public news and information website.

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Evidence synthesis communities in low-income and middle-income countries and the COVID-19 response

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Evidence synthesis specialists have responded to the COVID-19 pandemic. In line with WHO's global roadmap for COVID-19 research,[1] we are working to summarise the available research to support evidence-informed decision making across all sectors for immediate and anticipated challenges, within the COVID-19 Evidence Network to support Decision-making (COVID-END). COVID-END is an umbrella organisation involving 50 evidence synthesis or evidence support organisations that are working together to promote collaboration and reduce duplication of effort in the conduct and translation of COVID-19-related evidence syntheses. As a network we have accelerated investment to enable infrastructure for evidence synthesis and to promote evidence use.

COVID-19 and its related impacts are likely to be felt for many years to come. As the low-income and middle-income country (LMIC) members of a global partnership, we believe that, for global evidence synthesis initiatives to benefit from LMIC expertise and be relevant to LMIC settings, it is important to recognise the conceptual and practical challenges that this pandemic presents to our evidence synthesis organisations.

LMIC evidence communities are well placed to support evidence-informed decision making. They include established, locally driven, experienced centres of excellence that are part of technical and regional networks and trusted by decision makers. Our teams and our strong networks are invaluable in promptly getting the best available evidence into the hands of policy makers. However, these achievements are often despite—and not because of—the circumstances in which we work.

Many of us work in countries where there are complex challenges. Weak health systems in LMICs are generally struggling to make the necessary responses to the COVID-19 pandemic and the prevalence of comorbidities are putting our populations at increased risk of the direct and indirect consequences of the pandemic.[2] Paramount to poorer and conflict-affected states are the pre-existing, and rapidly worsening, vulnerabilities due to inequalities and inequities, unemployment, hunger, and malnutrition.[3] Violence against women and children, unintended pregnancies, and risks to incarcerated populations are all escalating, as are disruptions to child vaccination programmes.[4] In addition to the mental health strain caused by a pandemic,[5] lockdowns, and resulting social and economic pressures, we are observing fear and stigma associated with COVID-19, quarantine, and isolation.[6] Home evictions linked to job losses, low levels of public health information in some settings, and the presence of migrant workers and refugees have exacerbated xenophobia and social unrest in some LMICs.[7] Older people, migrant workers, refugees, and students have all found themselves vulnerable and inadequately supported.[8]

For **COVID-END** see https://www.mcmasterforum.org/networks/covid-end

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In many countries, these challenges have come on top of entrenched economic, social, and political pressures and present considerable demands on researchers seeking to generate evidence in the COVID-19 response. The demand for evidence to inform decision making, and for effective implementation of such policies, typically outweighs our ability to respond. This situation is compounded by an increased demand for transparency, amid all the mistrust about science that some groups, including certain politicians, bring to the public discourse.[9]

As a broad community of evidence synthesis specialists based in LMICs, many of us are experiencing common difficulties arising from limited access to computer hardware and software, restrictions on database access, limited data storage capacity, inadequate data coverage, and low internet bandwidth. Our institutions, like many in poorer settings, are relying on the commitment of individuals, many of whom are using personal computers, living in unfavourable conditions, and working under pressure as they and their families and friends suffer the health, economic, and social impacts of the pandemic. Constrained funds are being repurposed from other projects to enable the increased efforts to generate timely and locally relevant evidence syntheses. In some cases, researchers are working without salaries or with job insecurity.

See Online for appendix

Despite these practical challenges, above and beyond those faced by all researchers producing rapid reviews during this period,[10] our networks continue to generate evidence syntheses to support our governments and strengthen their capacities and resilience. The value of the knowledge translation efforts and rapid response mechanisms to provide timely evidence synthesis is coming into its own, with evidence reaching the highest levels of governments. COVID-19 represents an opportunity to further strengthen and institutionalise evidence-informed policy making across LMICs. We encourage our governments to continue to make good use of, and invest in, the evidence services available to them.

Coordination of the research response to COVID-19 is not only crucial to avoid duplication and maximise benefits, but also to ensure that the capacity within LMICs is secured and strengthened for the benefit of us all. Local voices are important for the contextualisation and integration of evidence into decision making. These voices also have a role in shaping the global research agenda for this and future crises. Global initiatives to generate evidence for tackling COVID-19 and for the post-COVID-19 recovery must consider the conceptual and practical challenges faced by research teams in LMICs and recognise the need to strengthen and sustain the voices of LMIC researchers on a global scale. We call for much needed donor support to bolster LMIC evidence synthesis communities and their capacities. We need action from individuals, organisations, governments, and donors to enable and sustain the generation and use of evidence synthesis in LMICs if we are to tackle COVID-19 globally.

We declare no competing interests.

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No patient safety without health worker safety

The COVID-19 pandemic provides a stark reminder of the importance of health worker safety. Inadequate personal protection equipment (PPE) has been a problem in many settings and there have been too many examples of health workers becoming infected and dying from COVID-19.[1–3] The harsh consequences of inequalities have also been laid bare by the pandemic. In countries such as the UK and USA, a disproportionate number of infections and COVID-19 deaths have occurred among Black and ethnic minority communities and people in the lowest socioeconomic groups.[4] Women comprise about 70% of the health and social care workforce[5] and have been on the front lines of the response to COVID-19, where they are at increased risk of severe acute respiratory syndrome coronavirus 2 (SARS-CoV-2) infection; women are also likely to be hard hit by the caregiving burdens and economic losses resulting from the pandemic.[5,6]

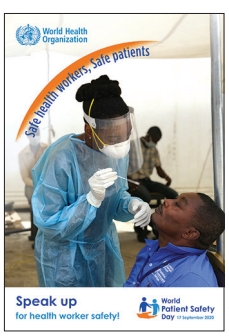
But what the COVID-19 pandemic has also made clear is how dependent patient safety is on health worker safety. On Sept 17, as we mark World Patient Safety Day 2020, it is crucial to highlight that there can be no patient safety without health worker safety. As in previous outbreaks of Ebola virus disease, Middle East respiratory syndrome, and severe acute respiratory syndrome, only when health workers are safe can they keep patients safe and provide health systems with stability and resilience.[7]

Patient safety is an essential component of universal health coverage and patients should not have to choose between no care or unsafe care.[8,9] Equally, when health systems are put under extreme pressure, and health workers are asked to go above and beyond their usual duties, the health workforce too must be kept safe.

In high-income and low-income countries alike, there have been many deaths from COVID-19 among health workers. Although attempts are being made to quantify them, this remains challenging.[10] Failure to provide health workers with adequate protection against threats to their health cannot simply be attributed to inadequate resources. Many countries have revealed insufficient preparedness to protect their health workers in the event of a disaster.[2,11,12] Yet the ability of health workers to protect citizens depends on health worker safety. If health professionals are to provide safer care for patients, all stakeholders need to swiftly and decisively address the global need for health worker safety.

Although some variation exists between the risks health workers face in different settings, they fall broadly into similar categories and so a united, systematic global approach can be applied. The general categories relate to environment and infrastructure, physical safety, mental health and wellbeing, and security.

Environment and infrastructure can limit the ability of staff to complete necessary safety functions; physical incidents are often trivialised as "slips, trips, and falls" but are occupational hazards that cause injuries to health workers and detract from the delivery of safe, high-quality care.[13] Furthermore, environmental challenges around infection prevention control (IPC) have been one of the biggest threats to health worker safety, especially in low-income and middle-income countries.[11,13] Exposure to respiratory and blood borne pathogens is increased in the hospital setting.



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For more on **World Patient Safety Day 2020** see https://www.who.int/campaigns/world-patient-safety-day/2020