

Panelists identified a number of potential long-term and emergent issues related to COVID-19 that need to be prioritized for evidence syntheses (which the COVID-END team has organized according to the COVID-END taxonomy), as well as a number of additional considerations.

In future reports, the COVID-END team will note where the identified issues have been addressed by an existing evidence synthesis in COVID-END's soon-to-be released inventory of 'best evidence syntheses' or whether there is a gap that needs to be filled.

## **Prioritized issues**

### **Public-health measures**

- 1) Politicization of adopting some evidence-informed public-health measures (e.g., mask use)
- 2) Sustaining and/or increasing adherence to public-health measures (e.g., physical distancing, mask wearing, and testing of symptomatic individuals)
  - a. One panellist noted that over 50% of Australians with cough and fever do not get tested
- 3) Reducing turn-around times in test-track-trace systems to increase their effectiveness
- 4) Balancing public-health considerations and economic and social cost considerations in lower-income countries (e.g., restricting travel versus consolidating limited screening resources in airports and other points of entry)
- 5) Planning for wave 2 in the northern hemisphere where many countries will need to concurrently manage COVID-19, influenza and undifferentiated chest and other infections
  - a. Risks to influenza-vaccination programs
  - b. Opportunities to learn from the southern hemisphere

### **Clinical management of COVID-19 and pandemic-related conditions**

- 1) Improving access to supplies (or alternatives or resource-allocation guidance) needed for case identification (e.g., lack of reagents and equipment for PCR testing, which leads some physicians to substitute with CT scans of the lungs) and case management (e.g., oxygen)
- 2) Capitalizing on the increasing need for, and receptivity to, virtual care and identifying optimal combinations of virtual and face-to-face care

### **Health-system arrangements**

- 1) Considering the public versus private mix in the COVID-19 response (e.g., balance the potential efficiency and privacy considerations in allowing the private sector to develop and manage test-track-trace apps)
- 2) Considering the balance between top-down (e.g., national) vs bottom-up (e.g., local) approaches to organizing the health-system response
- 3) Preparing for temporary health-worker shortages if/when significant numbers of them develop COVID-19, especially in fragile health systems
- 4) Appropriately resourcing and building or renewing capacity in the public-health sector and ensuring strong connections between the public-health sector and other parts of the health system like the home and community care, primary care, hospital care, and long-term care sectors

### **Economic and social responses**

- 1) Balancing the public-health considerations that can drive decision-making about school interruptions with broader educational, social and other considerations (e.g., missing educational milestones and dropping out of school permanently; losing access to free or subsidized meals and healthcare services; losing access to spaces for play; being exposed to increased risk of domestic violence while not being regularly seen by teachers who can prevent, detect or address abuse)
- 2) Understanding the benefits, harms, costs, and student and teacher experiences with pedagogical innovations, including with an equity lens
- 3) Engaging local communities in address the pandemic (as was done so extensively in China)

- 4) Addressing the unique needs for fragile countries that were experiencing war, civil unrest, etc. before the pandemic began (e.g., Libya and Yemen)
- 5) Continuing to invest in international aid (and supporting global solidarity more generally) as high-income country governments also take on increasing domestic debt burdens as part of their own pandemic response

## **Additional considerations**

### **Use of evidence and coordination of initiatives**

- 1) Understanding the role of evidence in the pandemic response and valuing different types of evidence
  - a. Moving beyond only 'top-down evidence-based medicine' approaches to include more local, contextualized evidence
  - b. Accommodating different evidence needs for different levels of decision-making complexity (e.g., shutting down can be simpler than opening up in a staged way that reflects different types of risk)
- 2) Encouraging demand for research evidence where little demand exists and contextualizing research evidence to the local state of the pandemic and pandemic response, institutional capacity, etc.
- 3) Investing in, and making better use of, behavioural science to support decision-making in all areas
- 4) Coordinating this horizon-scanning process with related initiatives (e.g., mitigation modeling being undertaken by UN agencies)

### **Resources shared by panelists**

- 1) Report on [protecting children's right to learn](#)
- 2) Initiative aiming to promote research on [behavioural, environmental, social and system interventions](#) for pandemic preparedness
- 3) Survey underway to assess the [impact of COVID-19 on policing](#), with a request for support to extend the translated versions to include Arabic and Mandarin

Citation: Bullock HL, Lavis JN. Insights from COVID-END's global horizon-scanning panel meeting on 29 July 2020. Hamilton, Canada: COVID-19 Evidence Network to support Decision-making about COVID-19 (COVID-END); 31 July 2020.