Cochrane Africa Indaba 2021

Making evidence-based healthcare functional in Africa

ABSTRACT BOOK

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Contents

P1 Prevalence of ill timed pregnancies amongst antenatal clinic attendees at rural communities in the Niger Delta, Nigeria

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BACKGROUND

Ill timed pregnancies is a challenge to women of reproductive age especially in developing countries of the world. Opinions with regard to ill timed pregnancies, some literature countries use less than 6 months while others use less than 24 months. The World Health Organization (WHO) recommends child spacing for at least two years for pregnant women to recover physiologically from the previous delivery. Some of the reasons of ill timed pregnancies are poor awareness, affordability and accessibility of family planning services. In addition, cultural, social and religious practices contribute to ill timed pregnancies.

AIM

To determine the prevalence of ill timed pregnancies amongst antenatal clinic (ANC) attendees in a rural community (Ogoni and environments) In Niger Delta, Nigeria.

METHODS

This was a cross-sectional study of ANC attendees at Ogoni Communities and its environments (cutting across 4 Local Government Areas) In Niger Delta, Nigeria. Simple randomized sampling method was used. The study involved 128 consented ANC attendees using a structured pre-test survey questionnaire. Adequacy of antenatal care was assessed in relation to frequency of antenatal visit, women-provider relationship, information exchange and continuity of care. The Information was analyzed using SPSS version 25.

RESULTS

The mean age was 29.6 years. The modal Parity was 2. The mean gestational age was 24.9 weeks. The index pregnancies were desired in 118 (92.2%) of the respondents. One hundred and twenty one (94.5%) of the respondents were aware of family planning of which 104 (83.3%) preferred traditional methods. One hundred and one (78.9%) had used family planning methods in the past though 3 (2.3%) used modern methods of family planning. Twenty-four (18.8%) of the pregnancies were ill timed.

CONCLUSION

Ill timed pregnancies constitutes a problem at the community level. Though family planning awareness was high, this should be translated to increase use these services as to prevent ill timed pregnancies. There is need for couhnseling of patients on modern family planning methods during antenatal period especially in rural communities.

P2   # Attitude of health care workers to COVID-19 vaccination protocol at the Rivers State University Teaching Hospital

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BACKGROUND
One of the success stories globally with regards to the prevention of covid-19 pandemic is the advent of the covid-19 vaccine. With lots of challenges concerning religious, socio-cultural believes by the populace concerning acceptance of the vaccines globally; some health care providers have aversion whether to be vaccinated or not.

AIM
This study was conducted to determine the attitude of health care workers to covid-19 vaccination protocol at The Rivers State University Teaching Hospital (RSUTH).

METHODS
This was a cross-sectional study done over a two (2) week period at the RSUTH. Informed consent was obtained from each of the subjects. The information was extracted using a structured questionnaire, coded and analyzed using SPSS version 25.

RESULTS
Two hundred and ninety-two subjects participated in the study. The mean age was 32.4 ± 15.19 Years. For the subjects 131 were males (44.9%) while 161 were females (55.1%). Ten (3.4%) of the subjects had primary level of education, 60 (20.5%) had secondary level of education while 223 (76.1%) had tertiary level of education. One hundred and sixty (54.8%) of the subjects accepted to be vaccinated against covid-19 infections while 132 (45.2%) rejected the vaccination against covid-19. The reasons for the rejection of the covid-19 vaccination by subjects were; religious 35 (12.0%), social 12 (4.2%), cultural 1 (0.3%), others 10 (3.4%) and no reason 74 (25.3%).

CONCLUSION
The study revealed though the acceptance rate of covid-19 vaccination among health workers at the RSUTH was above average, the non acceptance rate was worrisome. However, 25.3% of the subjects rejected the covid-19 vaccination for no reason given. With the saying that charity begins at home advocacy for health workers to be vaccinated against covid-19 infections is imperative especially at the RSUTH.

P3   **The use of evidence and its contribution to action in sexual and reproductive health: Lessons from contribution mapping in Nigeria**

[1]Esu EB, [1]Arikpo D, [1]Chibuzor M, [1]Oringanje C, [1]Meremikwu M

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BACKGROUND
Despite the development of methods, strategies and structures, the translation of evidence about sexual and reproductive health (SRH) into policies and practices and ultimately better health, remains a challenge.

OBJECTIVES
We used a novel method, contribution Mapping to assess the use of evidence and its contribution to action in SRH research in Nigeria.

METHODS
This project was undertaken from September 2019 to January 2020. A qualitative approach was used, combining a search of the literature and policy documents and in-depth interviews (face-to-face and teleconference calls) with Nigerian stakeholders working in SRH. Eleven SRH research projects (cases) conducted in Nigeria between 2015 and 2019 were identified. These cases cut across non-governmental organizations, government agencies and academia. In depth interviews were conducted by two researchers with the use of digital audio recorders and notetaking to capture the non-verbal expressions of study participants. Each interview on average lasted about 35 minutes. Verbal and written consent were obtained before each interview. All interviews were transcribed verbatim and thematic analysis conducted.

RESULTS
The origins of research were generally based on problems identified in SRH programming and in routine medical practice. Research team compositions among academics was generally the same. Additional research team members were recruited based on the competencies and skills which were required to complete the research projects. For the NGOs and government agencies, the research teams tended to be larger and there was a lot more interactions with stakeholder external to the research team. The underlying motivation for many of the research projects were to solve problems while also advancing career progression. The stakeholder's ability to influence changes at the policy level appeared to be largely through their membership of National Technical Working Groups in SRH. It is through this medium that they are able to share their results using mainly PUSH knowledge exchange mechanisms. Cultural sensitivity still exists around sexuality, especially for young people. Funding streams for research are not properly institutionalized. Several participants felt interaction between researchers and policy makers were insufficient. There were different mechanisms and pathways through which change happened as a result of the projects. Some achieved change by advocacy and for other stakeholders, their dissemination efforts led to interactions that became the precursors for change.

CONCLUSION
In Nigeria, knowledge platforms for SRH exist and some efforts are made to base policy and recommendations of research evidence. These knowledge platforms however seem to be clustered at Federal level with only minimal activity at State level.

P4 Validation of community paediatric HIV risk Assessment screening checklist among 0 to 19 years old in selected Communities of Tabara State

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BACKGROUND

Recent studies have proven that it is important to standardize some of the innovative strategies which have improved the HIV case identification among children as traditional identification strategies have failed to locate the children amidst a large pool of unidentified cases. In Nigeria, various partners supporting HIV services have used different versions of the HIV risk assessment/stratification checklists to screen children, but these tools were not context or age specific nor were they validated. The National AIDS and STIs Control Program (NASCP) of the Federal Ministry of Health organized a national Paediatric HIV/AIDS stakeholders meeting to harmonize the various HIV Risk Stratification checklists being used by all HIV Implementing Partners and came up with a HIV risk stratification checklist that is context-specific and age-appropriate for use in the facility and community among children and adolescent's sub-population.

OBJECTIVE

The major objective is to conduct a national validation of both the facility and community-based HIV risk stratification checklists to determine their specificity and sensitivity and the number needed to test (NNT) to identify one HIV positive case among children and adolescents aged 0-19 years. Taraba State is among the 4 states to validate the tool in the community setting.

METHODS

The study employed a cross-sectional design for community and health facility screen for HIV infection among children aged 0 to 19 years of age in the communities and those accessing healthcare services in PEPFAR, and Global Fund supported and government of Nigeria sites.

RESULTS

A total of 3000 children aged 0 to 19 years were sampled across Ten communities in five Local Government Areas of Taraba state. The overall average age of the children was 10.55±5.49 years. There was a significant difference between the age children who tested positive (14.36±5.63) and those who tested negative to HIV (10.50±5.47). Out of 2257 children who were at risk, only 31 tested positives to HIV; meaning the sensitivity of the instrument was 1.4%. Of the 744 children who were not at risk, 738 tested negatives to HIV; meaning the specificity of the instrument was 99.2%. The positive predicted value (PPV) was 84% while the negative predictive value was 25%.

CONCLUSION

The risk stratification checklist showed a very sensitivity and a high specificity value. This shows that the instrument is not adequately sensitive to screen children aged 0-19 years for HIV test.

P5 Factors influencing parents' acceptance of routine childhood vaccination: A Cochrane qualitative evidence synthesis

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BACKGROUND

Sub-optimal childhood vaccination coverage is an ongoing challenge worldwide, particularly in sub-Saharan Africa. Vaccine hesitancy or nonacceptance may be one contributing factor. This Cochrane qualitative evidence synthesis developed a conceptual understanding of the factors influencing parental acceptance of routine childhood vaccination. This synthesis links to four Cochrane intervention reviews of interventions to improve coverage or uptake of childhood vaccination.

METHODS

We searched MEDLINE, Embase, CINAHL, Anthropology Plus, Web of Science Core Collection, and PsycINFO databases for eligible studies from 1974 to 2020. We used a meta-ethnographic approach to analyse the evidence; an adaptation of the Critical Appraisal Skills Programme (CASP) quality assessment tool to evaluate methodological limitations; and GRADE-CERQual to assess our confidence in each finding.

RESULTS

We included 145 studies and sampled 27 of these studies for our analysis. Studies included a diverse range of geographical and income-level settings. We organized the factors influencing parents' vaccination ideas and practices into four themes: 1) Ideas and practices surrounding (child) health and illness; 2) Social communities and networks; 3) Political events and processes; 4) Access-supply-demand interactions. We developed two concepts to describe potential pathways to reduced vaccination acceptance: 'Neoliberal logic' and 'Social exclusion'. We produced a line-of-argument which suggests that parents' vaccination views and practices are dynamic social processes that reflect multiple webs of influence, meaning and logic. Nearly half of the influencing factors we identified were not represented in any of the trial interventions included in the related Cochrane intervention reviews.

CONCLUSIONS

Our synthesis provides a theory of how social process influence vaccination acceptance, thereby extending more individualistic models on vaccination decision-making. The synthesis findings could guide the development of interventions to promote acceptance of childhood vaccination that are better aligned with the norms, expectations and potential concerns of target users.

P6 Application of Total Quality Leadership and Accountability approach using client experience to improve retention in ART

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BACKGROUND

ZNS GARRISON MIN HOSPITAL, 15 km South of Lusaka Main Post Office along Kafue Road, is one of the sixty (60) Zambia Defense Forces (ZDF) Heath Facilities, catering for both the military personnel and their families and the civilian catchment area with population over 9,000 people. The facility is also a centre for both Universal Routine HIV Testing and Antiretroviral Therapy (ART) services.

ZNS Makeni, has 2,515 active clients who are in compliance with their treatment regime by 28 October_2020 when the current Client Experience Associate was engaged in March 2020 under the FHI360 funded ZDFPCT project. The site has been making calls and SMS to clients through Client Experience Associate and managed to make 932 calls both late for pharmacy and making appointment and setting remainders for easy flow of clients at the facility. This resulted in an increase of 37.5% client flow at the facility. This contributed significantly to the call to care client retention at ZNS MAKENI surpassing the annual target of 245 to achieving 353 clients brought back to care with a contribution of 42% surplus against the target. The service client approach has made a lot of clients coming back to treatment because of the comprehensive service delivery

METHODS

I applied the Total Quality Leadership and Accountability (TQLA) controlling to support myself with target achievement to the sites with the greatest needs to accomplish significant results in the shortest time-frame of 6 months. I adjusted my leadership quality skills by fostering on regular feedback by clients with different needs and using granular data by:-

1. Engagement with all the sites staffs especially lay counsellors in client approach and satisfaction
2. Assessing the environmental needs with its specific progressive challenges
3. Identifying key intervention areas, classifying, prioritising and differentiating them appropriately so as to allocate human resource and time management accordingly.

My team (Lay Counsellors and Community Medicine Staffs) regularly meetings with the in-charge and ward masters (to have a daily follow up for those that had late pharmacy pick up) and brainstormed on solutions to arrive at mutual accountabilities. This TQLA approach was undertaken as follows:

a) Managing the daily appointment files according to the smart care
b) Providing clients with 24/7 client service calls;
c) Meeting the client's expectation and ART information of different services.
d) Introduction of weekend and night clinics for clients who cannot manage during the working days for comprehensive quality access to ART services.

This activity of Client Calls and SMS reduced number of clients being lost to care because of improved quality comprehensive service towards treatment care and support. We can also relate this data to suppression rate at ZNS Makeni.

RESULTS

Over the six months period I embark on the above stated activity precisely and the client's flow increased to an average of 37.5% without missing appointments. We achieved 353 restarts for FY 19 against the target of 245 translating in to 103 surplus of the projected target translating into 42%. This translated into an 88% client restarts recovery rate from March 2020 (as per chart below); the client's calls and SMS contributed 37.5% which makes it one of the approached that can be used in other programs.

	ZAMBIA NATIONAL SERVICE MIN HOSPITAL																				
	SUMMARY OF CLIENT CALLS/SMS TALLY SHEET																				
	Rescheduling/Confirming appointment												Other Inquiries								
	Pharmacy Appointment				Laboratory Appointment				Clinical Appointment				Drug Related				Laboratory Related				
	Male		Female		Male		Female		Male		Female		Male		Female		Male		Female		
MONTH	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	Working Hours	Non Working Hours	
FEB	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0	0
MAR	7	3	28	11	0	0	0	0	5	0	2	10	1	0	7	24	0	0	3	2	103
APR	15	3	18	2	0	3	10	2	10	4	8	3	4	0	8	0	3	0	5	1	99
MAY	4	8	6	9	5	4	16	10	2	1	5	3	7	2	0	0	2	4	7	1	96
JUN	16	5	11	7	9	13	8	14	10	16	5	4	6	4	0	0	9	17	7	2	163
JUL	16	7	3	6	3	1	0	8	21	24	10	15	0	0	1	3	0	0	8	10	136
AUG	15	10	7	10	20	12	23	18	17	13	10	2	0	0	3	0	18	5	6	4	193
SEP	13	6	12	3	0	7	9	3	15	8	16	2	0	1	3	0	23	16	4	1	142
TOTAL																					932

P7   # Community-level interventions for improving access to food in low- and middle-income countries: a Cochrane review

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BACKGROUND
Physical and economic access to food is crucial for food security, which could be addressed through community-level interventions. We conducted a Cochrane review to assess the effects of community-level interventions on access to food in low- and middle-income countries (LMICs).

METHODS
We included randomized controlled trials and prospective controlled studies conducted in LMICs on any population assessing community-level interventions addressing food access through improving buying power, food prices, infrastructure and transport, or social environment and support. We searched 16 databases up to February 2020. We followed Cochrane methodology to conduct the review.

RESULTS
We included 59 studies, mostly from Africa and Latin America. The findings were as follows: Unconditional cash transfers improve food security and make little or no difference to cognitive function, may increase dietary diversity and reduce stunting. Evidence on the proportion of household expenditure on food and wasting is very uncertain. Conditional cash transfers make little to no difference in the proportion of household expenditure on food and slightly improve cognitive function, probably slightly improve dietary diversity, and may make little to no difference to stunting or wasting. Income generation strategies make little or no difference to stunting or wasting, may result in little to no difference to food security and may improve dietary diversity. Food vouchers probably reduce stunting, may slightly improve dietary diversity and may result in little to no difference in wasting. Food and nutrition subsidies may improve dietary diversity. The effect on household expenditure on foods as a proportion of total expenditure is very uncertain. Community grants probably make little to no difference to wasting and may make little or no difference to stunting. The effects of village savings and loans on food security or dietary diversity are very uncertain.

CONCLUSION
This review provides a comprehensive evidence base evaluating a wide range of community-level interventions addressing food access in LMICs.

P8 Career prevalence of work related musculoskeletal disorders among Ghanaian physiotherapists and adopted coping mechanisms

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BACKGROUND

Physiotherapists are usually at risk of work-related musculoskeletal disorders due to the nature of their work, which involves assuming of awkward postures coupled with force exertions and contact stress during patient handling, transfers and treatment maneuvers. That notwithstanding, very little attention has been paid to the musculoskeletal health effects associated with the work hazards experienced by physiotherapist in Ghana. This study was conducted to determine the career prevalence of work-related musculoskeletal disorders among physiotherapists in Ghana and their adopted coping mechanisms.

METHODS

A cross-sectional online survey was conducted among registered physiotherapist in Ghana using a self-administered questionnaire adopted from similar studies. The questionnaires were redesigned in Google forms and links to the questionnaire sent to prospective participants via emails and other official social media platforms of the Ghana Physiotherapy Association. The obtained data was analysed in SPSS version 22.0. Descriptive statistics was used to summarise obtained data while chi-squared test was used to determine possible associations between participants' demographic information and work-related musculoskeletal disorders with a significance level set at $p < 0:05$.

RESULTS

There was an 85.98% career prevalence of work-related musculoskeletal disorders among physiotherapist in Ghana with the lower back and neck being the most prevalent body regions affected with a percentage of 65.42% and 37.38% respectively. Respondents' attributed the occurrence of work-related musculoskeletal disorders to treatment of large number of patients. Statistical findings revealed a significant association between participants' age, professional experience, marital status, and working hours per week and work-related musculoskeletal disorders. Participants reported modification of treatment position (74.03%) and adoption of appropriate body mechanics (53.25%) as means of coping with work-related musculoskeletal disorders.

CONCLUSION

There is a high career prevalence of work-related musculoskeletal disorders among Ghanaian physiotherapists. This high prevalence could be mediated by the implementation of appropriate worker training on safe patient handling and work methods.

P9 Providing training during the SARS-COV19 pandemic, an Online Protocol Development workshop

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BACKGROUND

Cochrane South Africa (CSA) provides training on conducting and disseminating high-quality Cochrane reviews to inform healthcare decisions. In 2019 we planned a face-to-face Protocol Development Workshop for researchers based in sub-Saharan Africa (SSA). Given the COVID-19 pandemic, this was not possible. As an alternative delivery, we delivered an online Protocol Development course using Cochrane Interactive Learning material supplemented by contact sessions and mentoring. Here we describe our approach to developing this course and implementation.

METHODS

The course was advertised via email and social media. We aimed to include participants with a working or registered SR title, who could most benefit from the course.

It ran over 9 weeks, covering Cochrane Interactive Learning modules' topics. They went through the online material on their own time during the week and applied the learning to relevant section of their review protocol. Participants were assigned a mentor for assistance. Weekly discussion and feedback sessions facilitated by CSA staff allowed participants to revise the online content and share their protocol's progress. To assess their knowledge participants completed a pre-post course quiz, and the course delivery was evaluated.

RESULTS

19 participants from SAA with working review titles were enrolled: 14 completed the online sessions and three attended all weekly facilitated sessions.

The post course evaluation results indicate that the course objective was clearly stated and covered; the online content was relevant, the duration and pace good. Lastly mentoring added value and they would recommend this course to other (Figure 1)

Fifteen participants completed the pre-post course quiz at the start and 8 at the end. Results showed some improvement in knowledge (Table 1).

CONCLUSION

In the face of a global pandemic, using available online technology, CSA successfully delivered SAA training. Future workshops will aim to improve feedback session attendance and quiz score for knowledge.
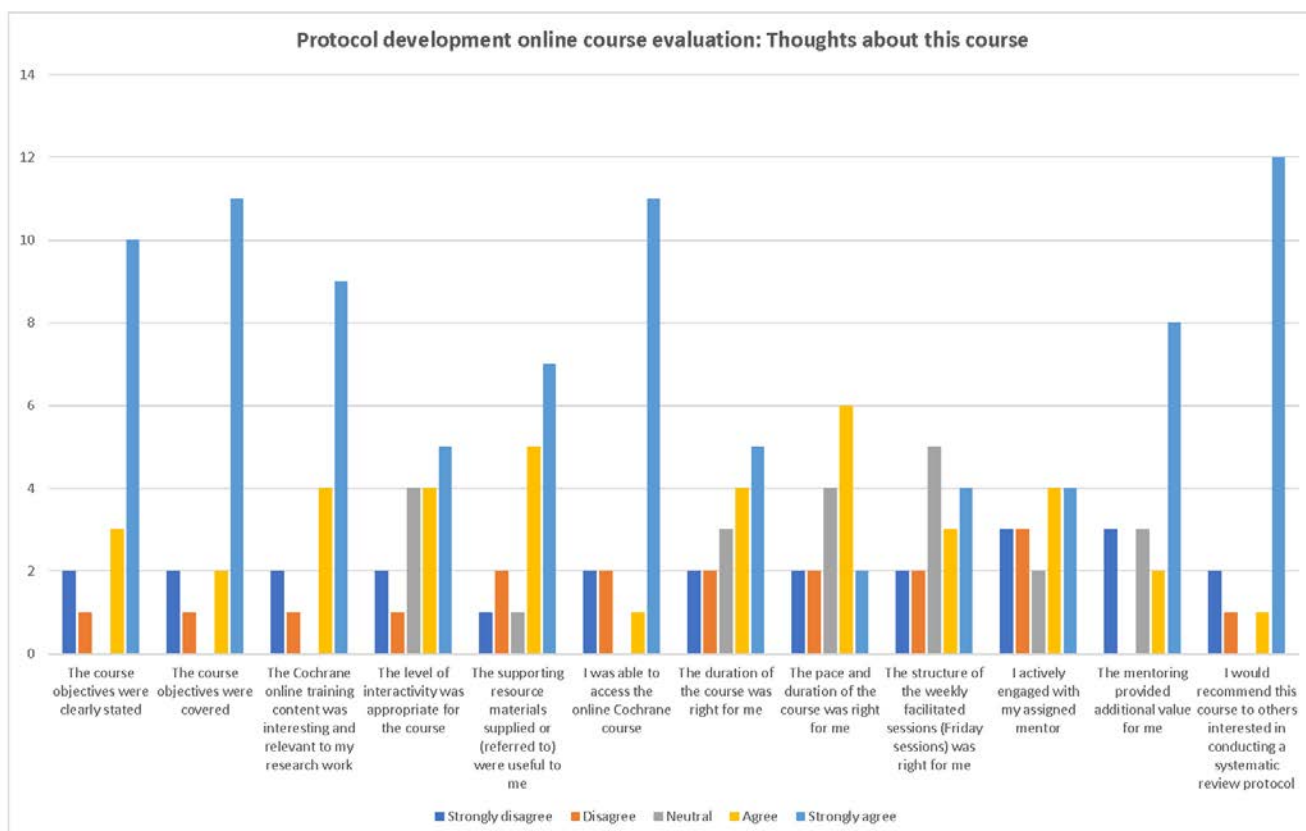
Figure 1. Protocol development online course evaluation: Thoughts about this course

Table 1. Pre-post course quiz

Question Theme	Question true/false	Pre-course answers correct (%)	Post-course answers correct (%)
Define a review question	A well-defined review question states clearly the participants, interventions, controls and outcomes that will be assessed in your review	100	100
	A well-defined review question will determine your eligibility criteria - that is, which studies are included in the review and which are excluded	60	75
	Authors of systematic reviews publish their protocols, but they can still adjust the methods of the review depending on the results they find	46.7	75
	Protocols are plans for the methods you will use in your review, that are documented in advance, before you begin to search for included studies and they help minimize bias in the review process	93.3	100
	Non-systematic reviews use robust methods to reduce bias in the gathering, summarizing, presenting, interpreting, and reporting of the research evidence *	86.7	62.5
Developing a search strategy	Searching PubMed will provide complete search results for your review	100	100
	Most publications appear in English and it is best to limit your search to English language publications	80	100
	Your review question is very important to guide your search strategy	93.3	100
	Data management (eligibility, data collection)		
	Assessing study eligibility and extracting data can be performed by one author *	86.7	87.5
	Inclusion and exclusion criteria for study eligibility is based on the pre-specified criteria in the protocol	100	100
	To assess eligibility of a paper, the full text article may be needed to make a decision	80	100
	Numerical data should never be converted when doing data extraction *	80	37.5
	Data extraction can easily be done without the use of data collection forms	86.7	87.5
	After a study is published, you may still contact authors for additional information	86.7	87.5
Risk of bias	A bias is a systematic error or deviation from the truth, in results or inference	86.7	100
	Bias generally leads to over-estimation of the result*	80	62.5
	There are a number of tools and checklists that can be used to assess risk of bias in Cochrane Reviews *	93.3	87.5
	Allocation concealment and blinding are similar concepts and the terms are used interchangeably	53.3	87.5
	Selection bias can be addressed by ensuring proper random sequence generation and allocation concealment	100	100
	Differential loss to follow up in the control or intervention group of a trial could indicate selective outcome reporting	73.3	75
Data analysis	Risk ratios are the appropriate measures of effect for continuous data	53.3	50
	Assessment of heterogeneity is an integral component of conducting a meta-analysis	86.7	100
	Subgroup analysis can be decided on when conducting the review	33.3	25
	All systematic reviews must include a meta-analysis	73.3	75

P10 Strategies to increase access to Cochrane training opportunities in South Africa and the African region

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BACKGROUND
Cochrane South Africa (CSA) provides training on conducting and disseminating high-quality Cochrane reviews to inform healthcare decisions. Ensuring equitable access to training in South Africa and sub-Saharan Africa remains challenging, with the small CSA team unable to match the demand for face-to-face training. We thus developed a strategy to address inequity in access to Cochrane training in South Africa and the region.

OBJECTIVES
To describe CSA's approach to increasing access to Cochrane training in South Africa and sub-Saharan Africa.

METHODS
Two approaches were implemented. We identified and reached out to health sciences faculties in 'historically disadvantaged institutions (HDIs), labelled so due to previous racial barriers to accessing adequate resources. We aimed to implement an introductory workshop on the principles of evidence-based healthcare. Workshops were evaluated through surveys. We shifted from face-to-face monthly methods training to monthly webinars directed at novice and experienced authors and evidence users. The webinars were evaluated through an online survey.

RESULTS
We delivered three workshops in 2019 to HDIs, with 82 health science post-graduates and practitioners attending (Table 1). 67 completed evaluations, all gave positive feedback (Table 2). Due to logistical matters, three HDIs postponed workshops to 2020. Nine webinars were presented in 2019 to 450 sub-Saharan Africa delegates, with a mean attendance of 46 participants from at least 8 African countries. Survey response rate was 6%. Most participants were involved with evidence synthesis and noted that webinars were important resources that allowed them to do their work using newly learnt skills (Table 3).

CONCLUSION
CSA as a regional Centre expanded the reach of its training through specific targeted approaches, to combat the historical inequities that still exist in attaining knowledge in the region. This process is in its infancy. Careful evaluations will continue. Allowing us to adapt and ensure greater reach and increased attendance.

Table 1.

University name	No. Participants	Departments
Durban University of Technology	25	Somatology, Medical Sciences, Librarians, Community Health, Emergency Medical Care, Research coordinators, Food and Nutrition, Nursing, Radiography, Medical Orthotics and Prosthetics, Chiropractic and Post-graduate students.
Fort Hare University	27	Deans and Heads of various health science departments, Senior Lecturers, Principal Investigators, Nursing Students, Human Movement Science.
University of the Western Cape	30	Pharmacy, Sports, Recreation and Exercises Science, Medical Biosciences, Education, Librarians, Child and Family studies, Social Work, Nursing, Biotechnology, Economic Management Science, Dentistry, Oral Medicine and Periodontology,

Table 2.

	Strongly Disagree	Disagree	Neutral	Agree	Strongly Agree	Total Responded out of 82	Response rate
The workshop objectives were clearly stated	3	0	0	17	47	67	82%
The workshop objectives were covered	3	0	0	20	44	67	82%
The content was interesting and relevant to my job	3	1	6	23	33	66	80%
The level of interactivity was appropriate for the workshop	3	0	0	24	40	67	82%
The supporting resource materials supplied are useful to me	3	0	2	24	38	67	82%
The workshop included helpful exercises that facilitated learning	3	0	2	12	50	67	82%
The duration of the workshop was right for me	3	3	4	19	38	67	82%
The pace of the workshop was right for me	3	2	5	18	39	67	82%

Table 3. Webinar Survey Responses

	Yes	No
Are you an evidence producer e.g. conduct systematic reviews?	20	7
Are you an evidence user e.g. policymaker?	8	18
Was the content of the webinars interesting and relevant to your job?	24	3
Have you been able to put into practice any of the knowledge gained from these webinars	25	2

P11 Publication practices of Cochrane authors in sub-Saharan Africa: a qualitative study

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BACKGROUND

Cochrane review authors in sub-Saharan Africa (SSA) can enhance the local relevance and applicability of Cochrane reviews. However, fewer Cochrane authors are publishing Cochrane reviews. This qualitative study explored SSA Cochrane author-publication practices.

METHODS

We purposefully selected SSA authors who have published at least one Cochrane and one non-Cochrane review in the past ten years, stratified by the number of systematic reviews (SRs) published in the past (3 or more vs less than 3 i.e., the 95th percentile). We conducted in-depth interviews virtually and performed a thematic analysis using manual coding.

RESULTS

We interviewed 12 participants from five countries. Eight had published less than three SRs in the past ten years. Authors felt that compared to other journals, Cochrane was perceived to have a robust review process and high-impact factor. However, publishing with Cochrane was hampered by protracted time to complete a SR; complex title registration process; inconsistencies within and among different review groups with regards to editorial practices; a lack of transparency and academic freedom in the writing process; high research output demands; limited recognition and capacity building for researchers in SSA. Nonetheless, authors preferred to publish with Cochrane and expressed their intent to continue publishing with Cochrane if they had sufficient time and if there were mentoring opportunities. Leading suggestions to improve the publication experiences of Cochrane authors were to increase academic freedom in the writing process, allow a balance between rigor and speed, increase review staff, centralize editorial processes, and provide oversight to support the functioning of review groups.

CONCLUSION

Our preliminary analysis has highlighted key facilitators and barriers to publishing Cochrane reviews and opportunities to enhance the involvement of SSA authors. Future work will include an electronic survey to determine the generalisability of our findings.

P12 Systematic review of uptake of antiretroviral therapy in integrated HIV/tuberculosis treatment programs in sub-Saharan Africa

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BACKGROUND

Compelling reports suggest suboptimal antiretroviral therapy (ART) uptake in programs integrating treatment of HIV and tuberculosis (TB) in sub-Saharan Africa (SSA). This study estimated ART uptake and investigated barriers to and enablers of ART uptake in these programs.

METHODS

A systematic review of studies published in 7 databases from March 2004 through July 2019 was performed. Random-effects meta-analysis was used to pool estimates of ART uptake. Thematic analysis was used to synthesize data on barriers to and enablers of ART uptake.

RESULTS

Of 5149 studies identified, 27 were included: 23/27 estimated ART uptake and 10/27 assessed barriers and/or enablers of ART uptake. The pooled ART uptake was 53%(95%CI:42%-63%), with high heterogeneity across studies. Sub-group analyses revealed considerably higher uptakes for: studies published from 2012 onwards (figure 1), studies from Southern and Central Africa (figure 2), retrospective studies (figure 3) and studies with≥1000 participants (figure 4). The principal socioeconomic and individual level barriers to ART uptake were stigma, low income, and younger age. The main health system related barriers were limited staff capacity, shortages in medical supplies, lack of infrastructure, and poor adherence to or lack of treatment guidelines. Clinical barriers included intolerance to anti-TB drugs, fear of drug toxicity, and contraindications to antiretroviral drugs. Health system related enablers included well-managed procurement, supply, and dispensation chain; convenience and accessibility of treatment services; and strong staff capacity. Availability of psychosocial support was the main enabler of uptake at the community level.

CONCLUSION

In SSA, integrated HIV/TB treatment programs do not, in general, achieve high ART uptake. But net improvements were observed in publications from 2012 (when revised guidelines on HIV/TB collaborative activities were issued) onwards and in large-scale studies. The recurrence of specific modifiable system-level and patient-level factors in the literature reveals key intervention points to improve ART uptake in these programs.
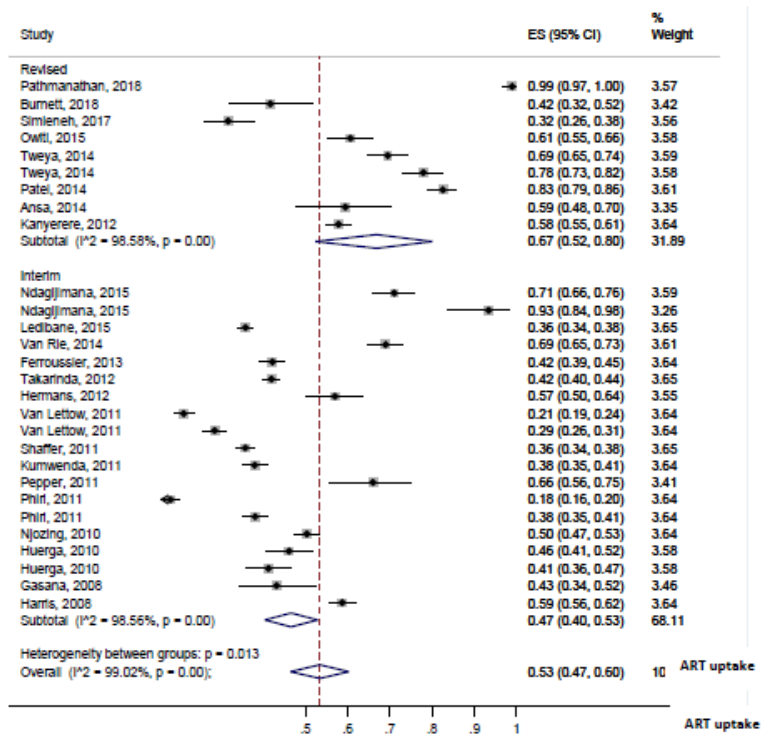
Study	ES (95% CI)	% Weight
Revised		
Pathmanathan, 2018	0.99 (0.97, 1.00)	3.57
Burnett, 2018	0.42 (0.32, 0.52)	3.42
Simieneh, 2017	0.32 (0.26, 0.38)	3.56
Owiti, 2015	0.61 (0.55, 0.66)	3.58
Tweya, 2014	0.69 (0.65, 0.74)	3.59
Tweya, 2014	0.78 (0.73, 0.82)	3.58
Patel, 2014	0.83 (0.79, 0.86)	3.61
Ansa, 2014	0.59 (0.48, 0.70)	3.35
Kanyerere, 2012	0.58 (0.55, 0.61)	3.64
Subtotal ($I^2 = 98.58\%$, p = 0.00)	0.67 (0.52, 0.80)	31.89
Interim		
Ndagijimana, 2015	0.71 (0.66, 0.76)	3.59
Ndagijimana, 2015	0.93 (0.84, 0.98)	3.26
Ledibane, 2015	0.36 (0.34, 0.38)	3.65
Van Rie, 2014	0.69 (0.65, 0.73)	3.61
Ferroussier, 2013	0.42 (0.39, 0.45)	3.64
Takarinda, 2012	0.42 (0.40, 0.44)	3.65
Hermans, 2012	0.57 (0.50, 0.64)	3.55
Van Lettow, 2011	0.21 (0.19, 0.24)	3.64
Van Lettow, 2011	0.29 (0.26, 0.31)	3.64
Shaffer, 2011	0.36 (0.34, 0.38)	3.65
Kumwenda, 2011	0.38 (0.35, 0.41)	3.64
Pepper, 2011	0.66 (0.56, 0.75)	3.41
Phiri, 2011	0.18 (0.16, 0.20)	3.64
Phiri, 2011	0.38 (0.35, 0.41)	3.64
Njozing, 2010	0.50 (0.47, 0.53)	3.64
Huerga, 2010	0.46 (0.41, 0.52)	3.58
Huerga, 2010	0.41 (0.36, 0.47)	3.58
Gasana, 2008	0.43 (0.34, 0.52)	3.46
Harris, 2008	0.59 (0.56, 0.62)	3.64
Subtotal ($I^2 = 98.56\%$, p = 0.00)	0.47 (0.40, 0.53)	68.11
Heterogeneity between groups: p = 0.013		
Overall ($I^2 = 99.02\%$, p = 0.00);	0.53 (0.47, 0.60)	10

Figure 1: Forest plot showing pooled ART uptake stratified by WHO TB/HIV treatment guideline (or year). *The dashed line on the Forest plot represents the overall pooled estimate. The grey squares and horizontal lines represent the individual study ART uptakes and their 95% confidence intervals. The size of the grey square represents the weight contributed by each study in the meta-analysis. The diamond represents the pooled estimate and its 95% confidence intervals.*
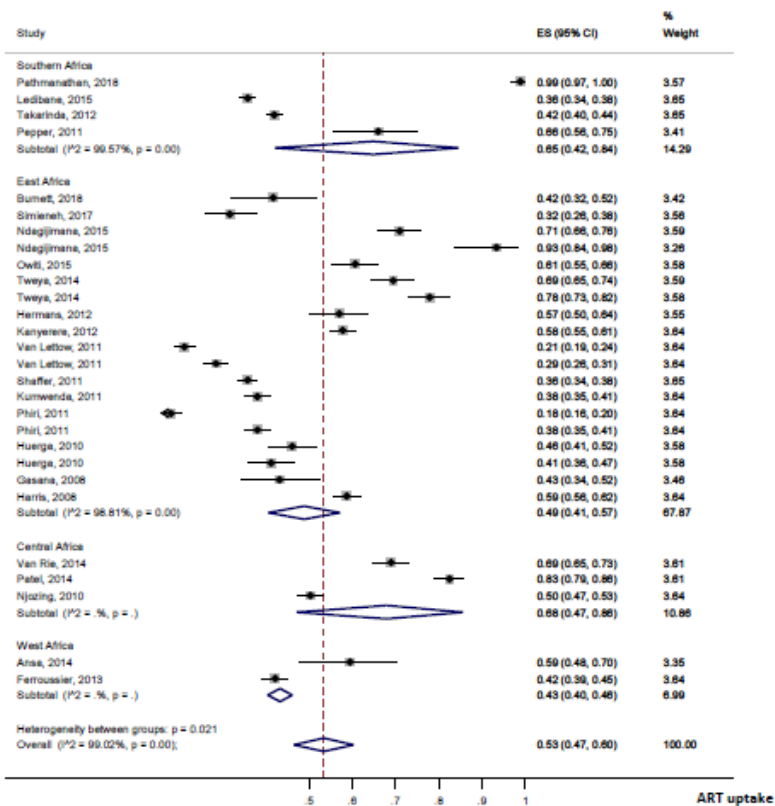

Study	ES (95% CI)	% Weight
Southern Africa		
Pathmanathan, 2018	0.99 (0.97, 1.00)	3.57
Ledibane, 2015	0.36 (0.34, 0.38)	3.65
Takarinda, 2012	0.42 (0.40, 0.44)	3.65
Pepper, 2011	0.66 (0.56, 0.75)	3.41
Subtotal ($I^2 = 99.57\%$, p = 0.00)	0.65 (0.42, 0.84)	14.29
East Africa		
Burnett, 2018	0.42 (0.32, 0.52)	3.42
Simieneh, 2017	0.32 (0.26, 0.38)	3.56
Ndagijimana, 2015	0.71 (0.66, 0.76)	3.59
Ndagijimana, 2015	0.93 (0.84, 0.98)	3.26
Owiti, 2015	0.61 (0.55, 0.66)	3.58
Tweya, 2014	0.69 (0.65, 0.74)	3.59
Tweya, 2014	0.78 (0.73, 0.82)	3.58
Hermans, 2012	0.57 (0.50, 0.64)	3.55
Kanyerere, 2012	0.58 (0.55, 0.61)	3.64
Van Lettow, 2011	0.21 (0.19, 0.24)	3.64
Van Lettow, 2011	0.29 (0.26, 0.31)	3.64
Shaffer, 2011	0.36 (0.34, 0.38)	3.65
Kumwenda, 2011	0.38 (0.35, 0.41)	3.64
Phiri, 2011	0.18 (0.16, 0.20)	3.64
Phiri, 2011	0.38 (0.35, 0.41)	3.64
Huerga, 2010	0.46 (0.41, 0.52)	3.58
Huerga, 2010	0.41 (0.36, 0.47)	3.58
Gasana, 2008	0.43 (0.34, 0.52)	3.46
Harris, 2008	0.59 (0.56, 0.62)	3.64
Subtotal ($I^2 = 98.81\%$, p = 0.00)	0.49 (0.41, 0.57)	67.87
Central Africa		
Van Rie, 2014	0.69 (0.65, 0.73)	3.61
Patel, 2014	0.83 (0.79, 0.86)	3.61
Njozing, 2010	0.50 (0.47, 0.53)	3.64
Subtotal ($I^2 = .\%$, p = .)	0.68 (0.47, 0.86)	10.86
West Africa		
Ansa, 2014	0.59 (0.48, 0.70)	3.35
Ferroussier, 2013	0.42 (0.39, 0.45)	3.64
Subtotal ($I^2 = .\%$, p = .)	0.43 (0.40, 0.46)	6.99
Heterogeneity between groups: p = 0.021		
Overall ($I^2 = 99.02\%$, p = 0.00);	0.53 (0.47, 0.60)	100.00

Figure 2: Forest plot showing sub-group analysis of ART uptake stratified by region. *The dashed line on the Forest plot represents the overall pooled estimate. The grey squares and horizontal lines represent the individual study ART uptakes and their 95% confidence intervals. The size of the grey square represents the weight contributed by each study in the meta-analysis. The diamond represents the pooled estimate and its 95% confidence intervals.*
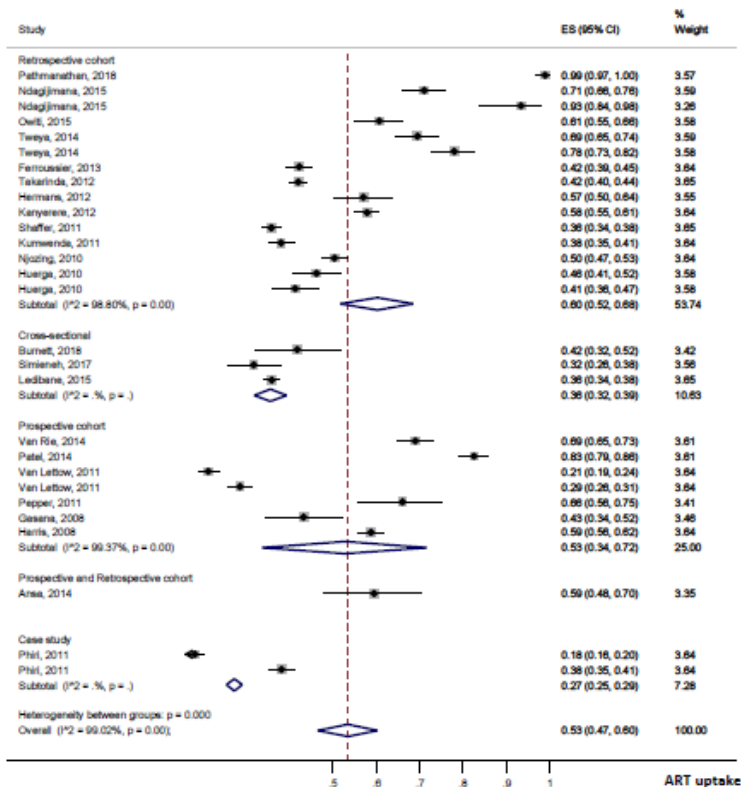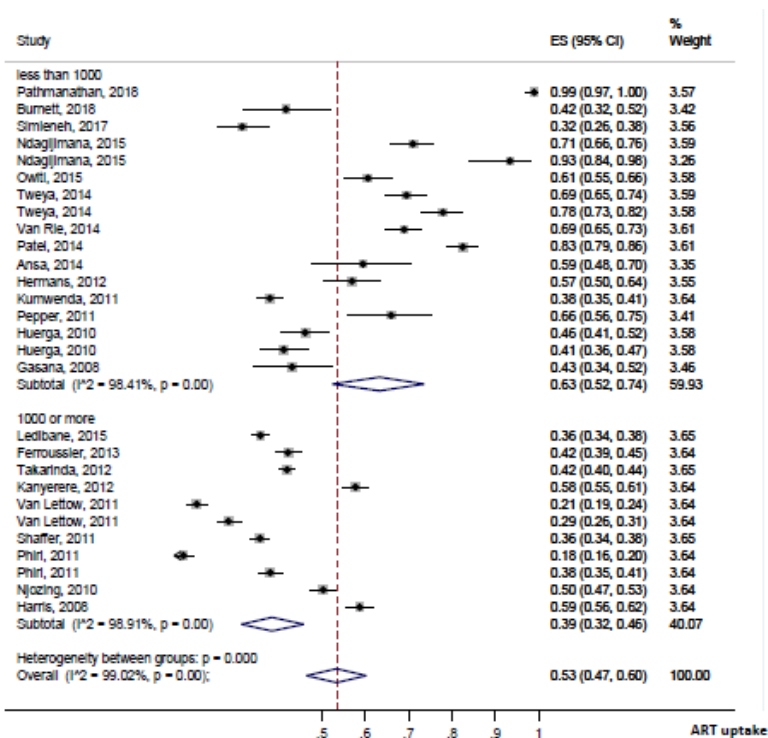
Figure 3: Forest plot showing pooled ART uptake stratified by study design. *The dashed line on the Forest plot represents the overall pooled estimate. The grey squares and horizontal lines represent the individual study ART uptakes and their 95% confidence intervals. The size of the grey square represents the weight contributed by each study in the meta-analysis. The diamond represents the pooled estimate and its 95% confidence intervals.*

Figure 4: Forest plot showing subgroup analysis of ART uptake stratified by sample size of studies *The dashed line on the Forest plot represents the overall pooled estimate. The grey squares and horizontal lines represent the individual study ART uptakes and their 95% confidence intervals. The size of the grey square represents the weight contributed by each study in the meta-analysis. The diamond represents the pooled estimate and its 95% confidence intervals.*

P13 Disseminating high quality research evidence by partnering with Media practitioners

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BACKGROUND

The mass media is a strategic means for communicating health information. Although internet is a popular source of health information, traditional media such as newspapers, radio and television are important in rural communities and low-and-middle-income countries where many people do not have access to internet or are not computer literate. In 2012, Cochrane Nigeria began an outreach to media organizations to improve coverage of health information from Cochrane systematic reviews and other important national health issues. This poster presents the outcomes from this outreach.

METHODS

Each Media roundtable was preceded by careful selection of topic for discussion/dissemination using the following criteria:

- Topical/critically vital health issue in Nigeria
- Availability of systematic review with clear evidence on effects of health care intervention(s).

Fifteen to twenty-five participants, including newspaper, radio and television reporters were invited by email and text messages. The State Chapter of the Nigerian Union of Journalists played a key role in mobilizing their members for the outreach.

Two presentations were made at each roundtable, in easy-to-understand language. The first presentation provided a background on the health topic while the second highlighted evidence from the selected systematic review(s). This was followed by interactive discussions to field questions and receive feedback from the participants. Each programme lasted for 90-120 minutes.

RESULTS

From 3rd April 2012 to 7 August 2020, Cochrane Nigeria held 10 media roundtable events. This resulted in 41 newspaper reports, 6 radio broadcasts and 2 television broadcasts. For full details see Table 1.

CONCLUSION

Media roundtable discussion led to dissemination of evidence-based health care information from systematic reviews to the Nigerian public through the media. It also helped to enlighten reporters about evidence-based health care and serve as a source of evidence-based information for their health/news stories.

Table 1: Media roundtable: Topics, Participants and Outcomes

DATE HELD	FOCUS OF ROUNDTABLE DISCUSSION	NO. OF PARTICIPANTS	MEDIA HOUSES /ORG REPRESENTED	OUTCOMES
3rd April 2012	Guidelines for management of severe malaria	18	2 local Newspapers, 11 national,2 Television stations, I radio station	8 newspaper articles 1 radio broadcast I television broadcast
24th Sept 2012	Malaria in Pregnancy	20	1 local Newspaper, 9 National Newspapers, 3Television stations, 1 Radio station, 1 International magazine	2 Newspaper articles
23rd July 2013	Impact of Salt Reduction on Hypertension & Deworming drugs for soil-transmitted Intestinal worms in children	13	9 National Newspapers, 1 Television station and 1 radio station	2 Newspaper articles
21 October 2014	Pneumonia and vaccines for Pneumonia	15	2 local Newspapers, 12 National Newspapers, 1 radio station and 1 Television station.	6 newspaper articles and 1 radio programme
12 January 2016	Chronic kidney disease	20	2 local Newspapers, 12 National Newspapers, 2 Television stations and 1 radio station	8 newspaper articles and 1 Television broadcast and 3 radio broadcasts (on 2 radio stations)
28 June 2016	Viral Haemorrhagic Fevers	27	1 local Newspaper, 16 national Newspapers, 2 Television stations, 4 radio stations	3 Newspaper articles
14 March 2017	Physical fitness training and Self Management Programmes for stroke patients	23	1 local Newspaper, 14 national Newspapers, 1 Television stations, 5 radio stations	2 Newspaper articles
17 October 2017	Hand washing for preventing Diarrhoea	20	1 local Newspaper, 11 national Newspapers, 2 Television stations, 5 radio stations	3 newspaper articles and 1 radio broadcast
30 October 2018	Post Traumatic Stress Disorder	12	1 local Newspaper, 7 national Newspapers, 1 Television stations, 2 radio stations	4 newspaper articles
7 August 2020	Face Masks, social distancing and hand washing for the prevention of COVID-19	13	1 local Newspaper, 11 national Newspapers, 1 radio station	2 Newspapers articles

P14 The Cameroon Health Research Evidence Database (CAMHRED): tools, methods and application of a local evidence mapping initiative

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BACKGROUND

Local evidence is important for contextualized knowledge translation, guideline adaptation and priority setting. However, there are challenges to identifying and delivering local evidence in a systematic way. The objective of this project was to develop a database of health research evidence for Cameroon and explore how it can be used for research prioritisation and decision making.

METHODS

To create the database, we searched 10 electronic databases and hand-searched the archives of non-indexed African and Cameroonian journals from October 2018 to May 2019. We screened titles, abstracts, and full texts based on these criteria: peer reviewed journal articles; published between 1999 and 2019; in English or French; investigating health-related outcomes in Cameroon. We extracted relevant study characteristics using a pre-established guide and developed a coding scheme to label studies and guide searches on the database. Studies were coded independently by two reviewers and discrepancies resolved by consensus. We then used evidence mapping to identify knowledge gaps on sexual and reproductive health priorities.

RESULTS

The Cameroon Health Research Evidence Database (CAMHRED) currently includes 4384 studies and is available here www.camhred.org. Most studies were published in English (79.7%); conducted in the Centre region (45%) with an observational design (71.6%). The most researched diseases and population were infectious diseases and children respectively. Our gap maps revealed: (1) geographic and demographic disparities in the local evidence on adolescents' contraceptive use (2) gaps in the type of local evidence needed for contextualisation and policymaking on obstetric fistula.

CONCLUSION

CAMHRED provides a systematic, comprehensive, and centralized resource for searching local evidence about health in Cameroon. It is freely available to stakeholders and provides an additional resource to support their work at various levels in the research process. The methods used to develop the database are adaptable to other countries.

P15 Trialtree: an interactive randomized trial design application

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3 Centre for Development of Best Practices in Health, Yaoundé Central Hospital, Yaoundé, Cameroon
4 Department of Global Health, Stellenbosch University, Cape Town, South Africa

BACKGROUND

The science of research on research has highlighted important gaps in the research enterprise, notably many studies that are poorly designed, executed and not replicable, amounting to research waste. About 50% of research waste in clinical research comes from poorly designed studies. Close to 21% of clinical trialists consider study design to be the biggest challenge they face. To date there are no electronic tools that streamline the trial design process, allow for collaboration among multiple researchers and support capacity building. We sought to develop such a tool.

METHODS

Using an iterative design process, user feedback from students and investigators, and current literature on trial design, we built an algorithm-based randomized trial design tool. A preliminary set of key features for trial design such as a clear research question, a knowledge gap, equipoise and a hypothesis were set and built upon. Feedback for flawed design choices and tips on how to optimise trial design were included. We also included access to additional resources including reporting guidelines, recommended checklists, choice of outcomes, statistical analysis plans and extensive resources on a wide variety of trial designs.

RESULTS

The electronic tool (TrialTree) is now freely available and capable of ensuring design consistency; co-design of trials from researchers in different parts of the world; standardized analytical plans and complies with current guidance for trial design. It includes direct feedback, trial design tips, and downloadable report and incorporates various tools for enhancing trial design. It can be used by both learners and seasoned researchers interested in optimizing the design of their randomized trials.

CONCLUSION

TrialTree is an innovative electronic tool that will enhance trial design and capacity building, especially in parts of the world where resources are limited. It can be accessed here: https://bit.ly/3ovDYWI.

P16 Interventions to improve the state of human resources for health in low -and-middle income countries: Collaborative evidence syntheses

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BACKGROUND

Nigeria is experiencing human resources for health (HRH) crises in an under-resourced health system that is presently incapable of delivering on the health needs of her citizens. To be able to deliver universal health coverage and meet the health-related SDG targets aligned to the country's Second Strategic Health Development Plan, relevant evidence-based HRH policies need to be in place. Stakeholder engagement to define the questions and generate the evidence is often required for effective buy-in and implementation. We planned to summarise the evidence around the relevant interventions with a view to influencing policy decisions of government in strengthening HRH management and planning.

METHODS

We worked with the WHO, policy makers and other stakeholders to formulate 30 research/ policy question(s) on HRH interventions across 10 thematic areas. These were refined and prioritized following which a scoping of the literature was done to identify systematic reviews relevant for each prioritized policy question and map identified gaps. Protocols were developed for two overviews of systematic reviews and two rapid reviews (where no relevant systematic reviews were identified). The Four reviews were done using recognised methods in collaboration with the WHO with periodic virtual feedback from policymakers.

RESULTS

Evidence synthesis: The process resulted in four reviews and three policy briefs on HRH across
1. Governance and leadership
2. Health workforce information systems
3. Attraction and retention of health workers in rural and underserved areas
4. Performance of health workers and quality of care

Dissemination: Full reviews published in peer reviewed journals and policy briefs shared with stakeholders and have influenced update of the HRH policy of Nigeria

Lessons learned: Prioritisation, stakeholder engagement, leverage of policy window, collaboration with key drivers (WHO) are effective strategies for evidence synthesis and dissemination.

CONCLUSION

Evidence from contextualized HRH interventions produced through stakeholder engagement are effective in administering HRH to improve health outcomes.

P17 Research priority dialogues for priority setting for systematic reviews on sexual and reproductive health in Nigeria

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BACKGROUND

In Nigeria and other LMICs, significant global health disparities exist despite a growing amount of research evidence. This 'know- do' gap cuts across all aspects of health. Attempts have been made to increase knowledge uptake and ensure that health decisions/policies are evidence-based. Cochrane Nigeria has been involved with the preparation, update and dissemination of Systematic Reviews of effectiveness of health interventions, since 2006. While several high-quality Systematic Reviews have been produced, their use in health policy and practice has been sub-optimal. The success stories have largely been because of PUSH efforts. We hypothesized that, demand-driven evidence syntheses that are contextualized in Research Priority Dialogues (RPD), and supported by locally specific translation-into-action strategies, will improve both policies and service delivery in key areas of sexual and reproductive health.

OBJECTIVES

To involve stakeholders in SRH in the identifying priority questions and the needs for research evidence on SRH in Nigeria.

METHODS

We identified the national policy aims and documents on SRH, studied population data and identified inequities in SRH in Nigeria using the PROGRESS framework. We shared the Evidence Brief from the process and invited Stakeholders to a one-day RPD. We used a questionnaire assess the perception of Stakeholders on research use and uptake. The Stakeholders ranked the 10 inequities identified using the PROGRESS framework in order of importance. The Stakeholders also repeated this activity at the end of the dialogue following the deliberations.

RESULTS

Priority themes and questions for Systematic Reviews were identified. We found paucity in the use of evidence in policy implementation and programme activities in adolescent sexual and reproductive health. Evidence for SRH service provision to internally-displaced populations is needed, given the widespread nature of ongoing internal conflicts in Nigeria.

CONCLUSION

Utilisation of research evidence in SRH in Nigeria is low. Efforts at use of evidence in policy decisions and programme implementation appears to happen at organisation level, and evidence-based decision making in SRH is yet to be institutionalised.