

THE TWO-WAY STREET

Exploring reciprocal innovation in implementation research

GACD thematic workshop

Tuesday 25 November 2025

Sitting A at 08:00–10:00 UTC // Sitting B at 16:00–18:00 UTC



GACD

GLOBAL ALLIANCE FOR CHRONIC DISEASES
AN ALLIANCE OF HEALTH RESEARCH FUNDERS

Ndewo

IGBO

selamat datang

MALAY

Καλωσόρισμα

GREEK

mišto

avilǎn

Romany

欢迎

CHINESE

مرحباً

ARABIC

स्वागत

HINDI

Bienvenue

FRENCH

NAU MAI
HAERE MAI

MĀORI

Witamy

POLISH

Afio

mai

SAMOAN

WELCOME

Fáilte

IRISH

Welkom

AFRIKAANS

Chào
mừng

VIETNAMESE

Ласкаво
просимо

UKRAINIAN

Bienvenido

SPANISH

WILLKOMMEN

GERMAN

Bem-vindo

PORTUGUESE

Қош келдіңіз

KAZAKH

Hoş geldin

TURKISH

ようこそ

JAPANESE

Karibu

SWAHILI

Housekeeping



The workshop will be **recorded** and will be publicly available after the event



If you can, **switch on your camera**



To reduce background noise, **please mute yourself** when not asking a question or making a comment



Please use the 'raise hand' function to ask a question or make a comment



You can use the **chat box** at any time to share a question or reflection



Slides and links to resources will be available on the GACD website after the event

Short introduction to GACD



Turning tradition on its head



Illustrating the journey from innovation to impact



Reflections on the reality of reciprocal innovation



Practical steps to make reciprocal innovation the new normal



Reversing the trend: What do we know about LMIC to HIC health innovations?



Mind the gap: Bringing Indian mental health success to the UK



Rooted in wisdom: Reimagining implementation with Indigenous innovation



There and back again: The HOPE-4 Study in Canada and Colombia



GACD

GLOBAL ALLIANCE FOR CHRONIC DISEASES
AN ALLIANCE OF HEALTH RESEARCH FUNDERS



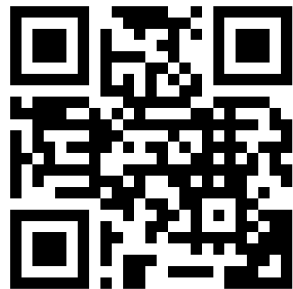
www.gacd.org



linktr.ee/gacdmedia



admin@gacd.org



The only collaboration of international research funders to address chronic, non-communicable diseases (**NCDs**) in low resource settings and in underserved populations, e.g. Indigenous Peoples in high income countries.



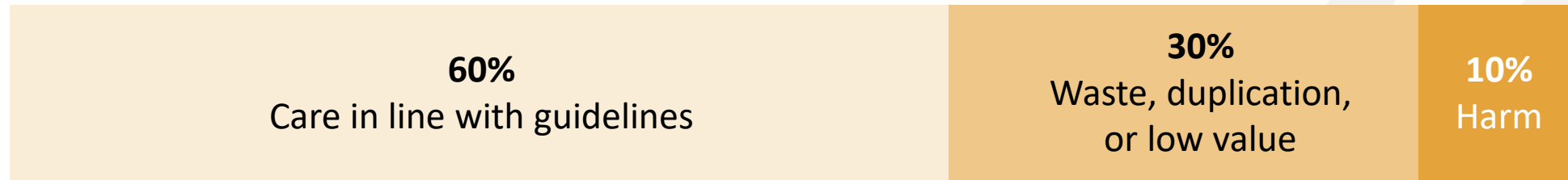
Invest in **impactful implementation research**



Facilitate **collaborations and partnerships** to support impact



Build **implementation science capacity** in relation to NCDs



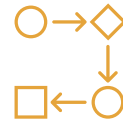
Braithwaite, Glasziou & Westbrook (2020) BMC Med 18, 102

In the past two decades, it has been estimated that **more than half of cancers could have been prevented** by applying knowledge that we already have

Emmons and Colditz (2017) N Engl J Med 376(10):986-990.



Products



Procedures



Programmes



Practices



Policies



Pills



Principles

Does THE THING *work*?

How can we best help people and places to *do* THE THING?

Implementation strategies are the *stuff we do* to help people and places do THE THING

Implementation outcomes are *how much* and *how well* they do THE THING

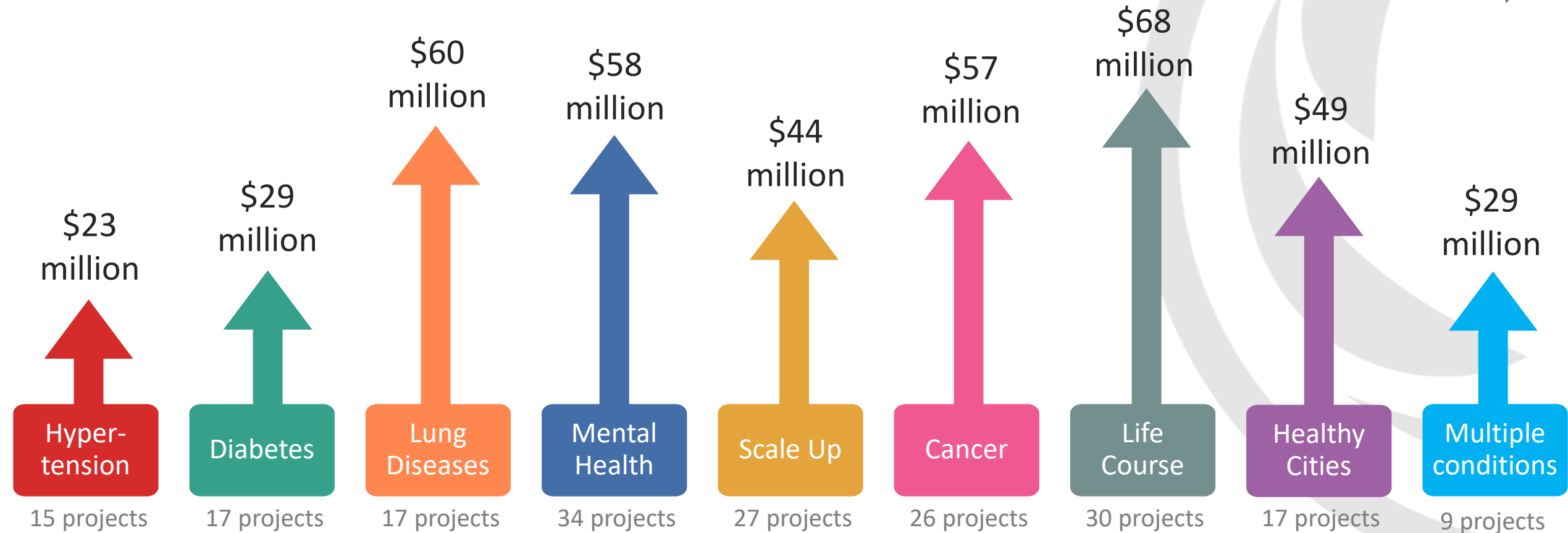


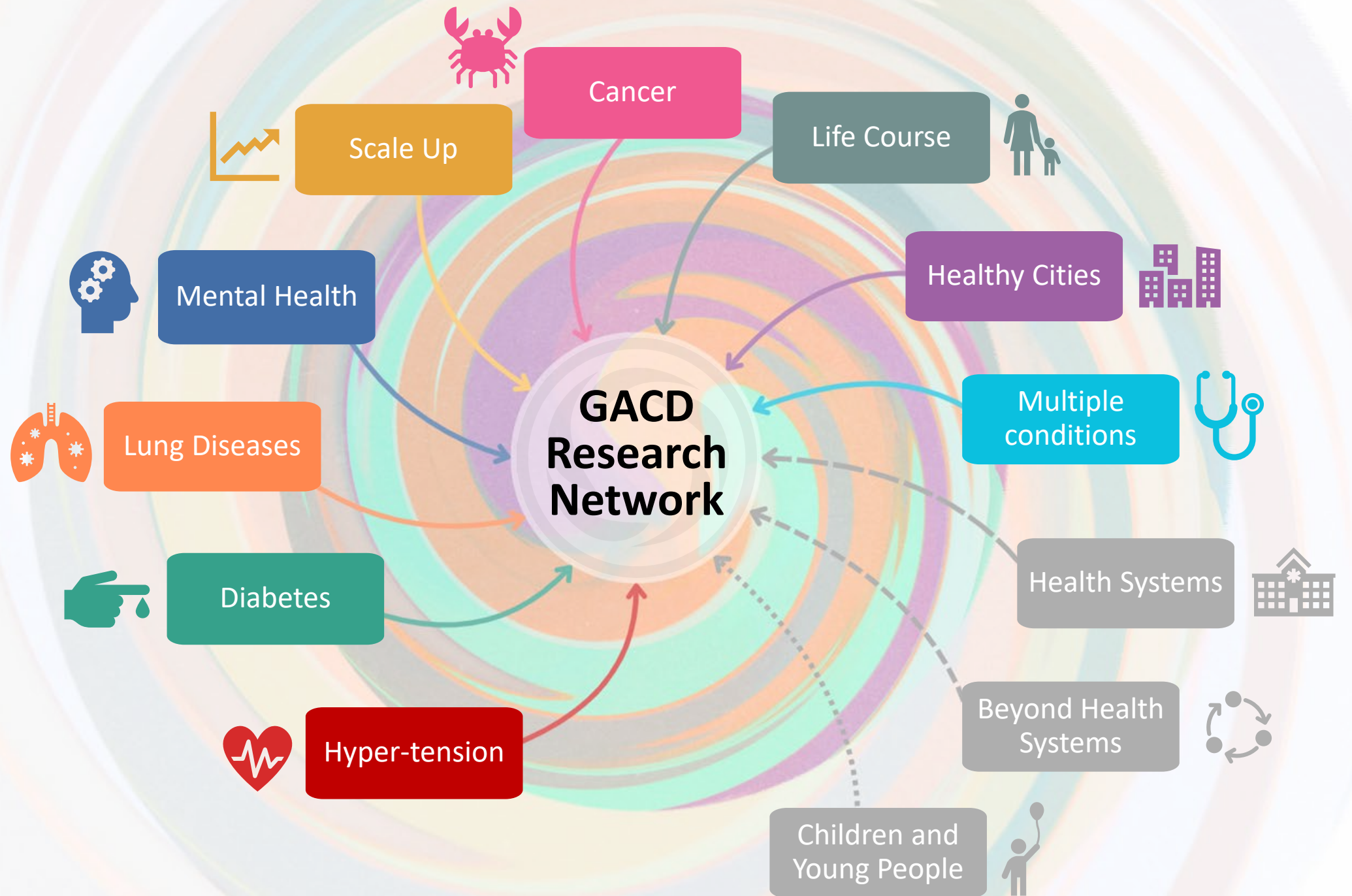
To learn more about implementation research, visit the GACD e-Hub for open-access resources and curated learning programmes: implementationscience-gacd.org

GACD has invested US \$400+ million

2012

2025





Turning “tradition”

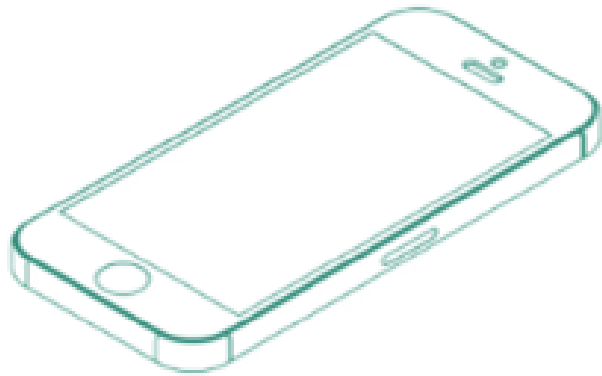
on its head

Izzy Bandurek – Research Capacity Manager, GACD



Grab your phone
(or open a browser window)

1



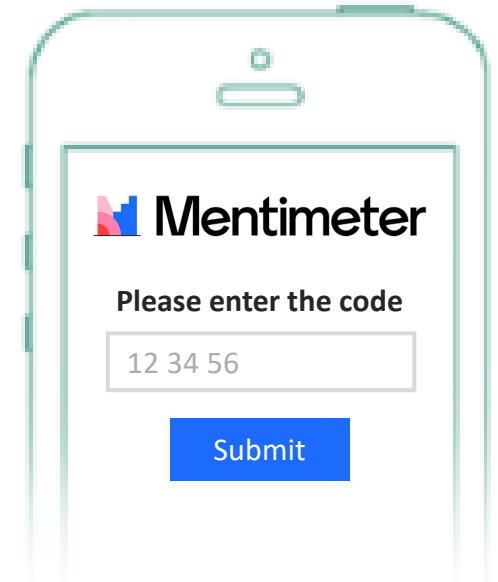
Go to www.menti.com

2

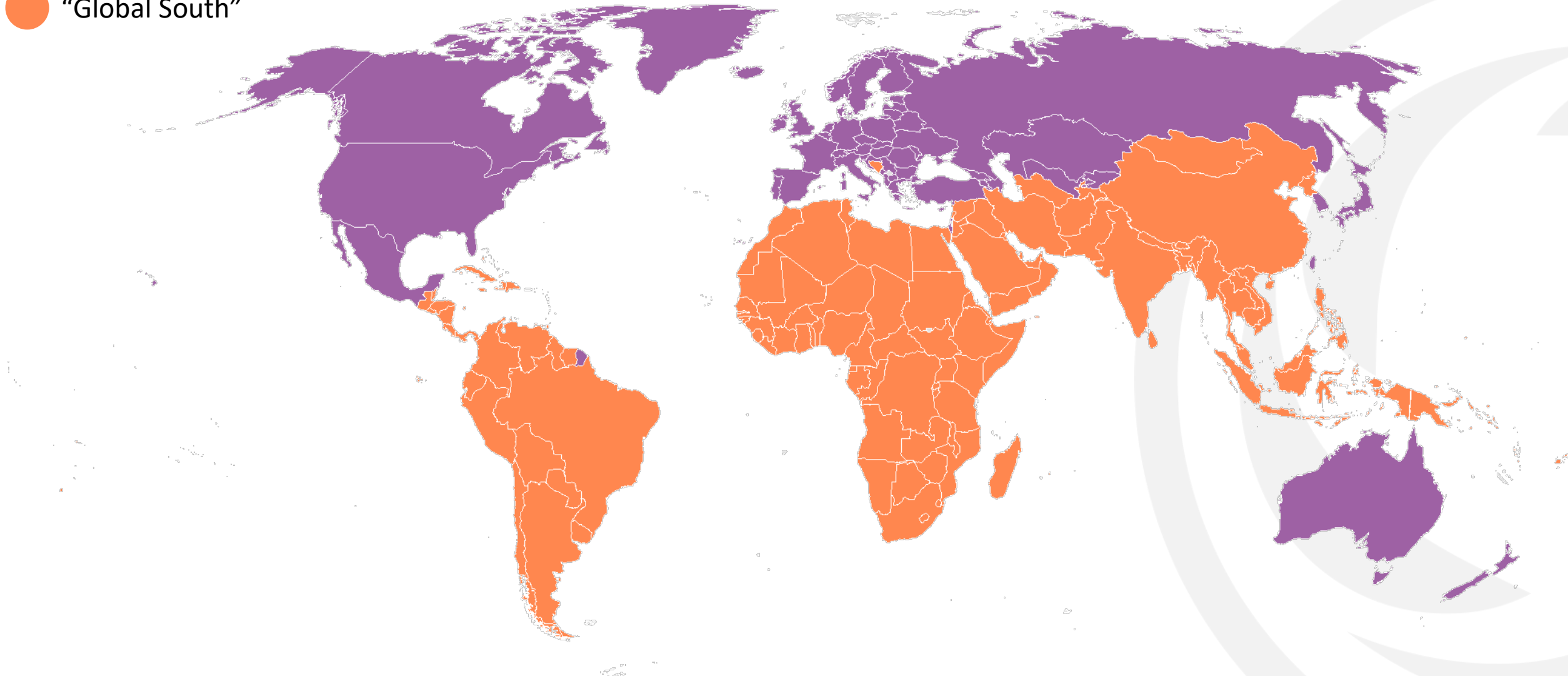
Your phone (or browser window) will be
like a games console for the voting

Enter the code

3

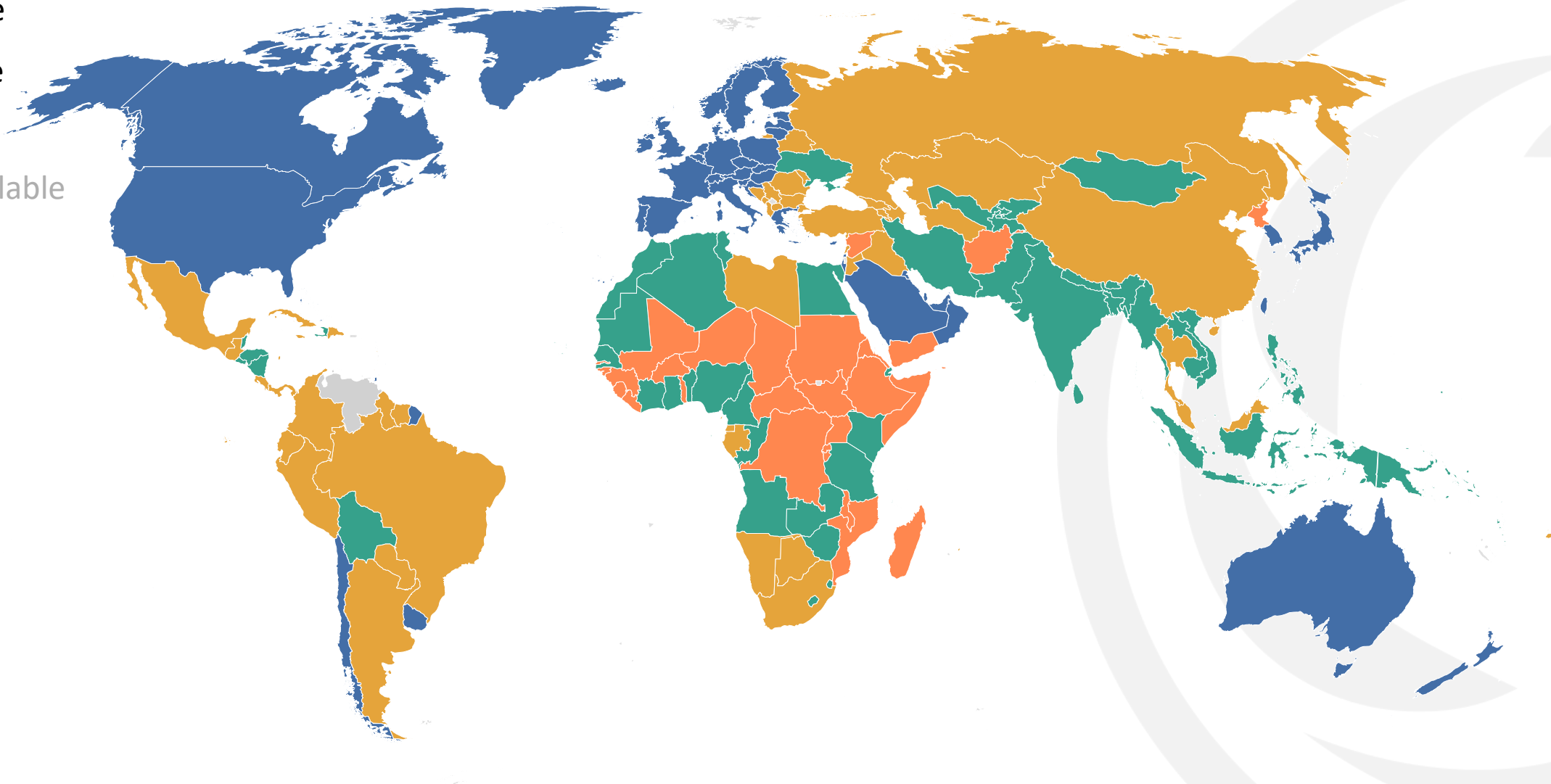


- “Global North”
- “Global South”

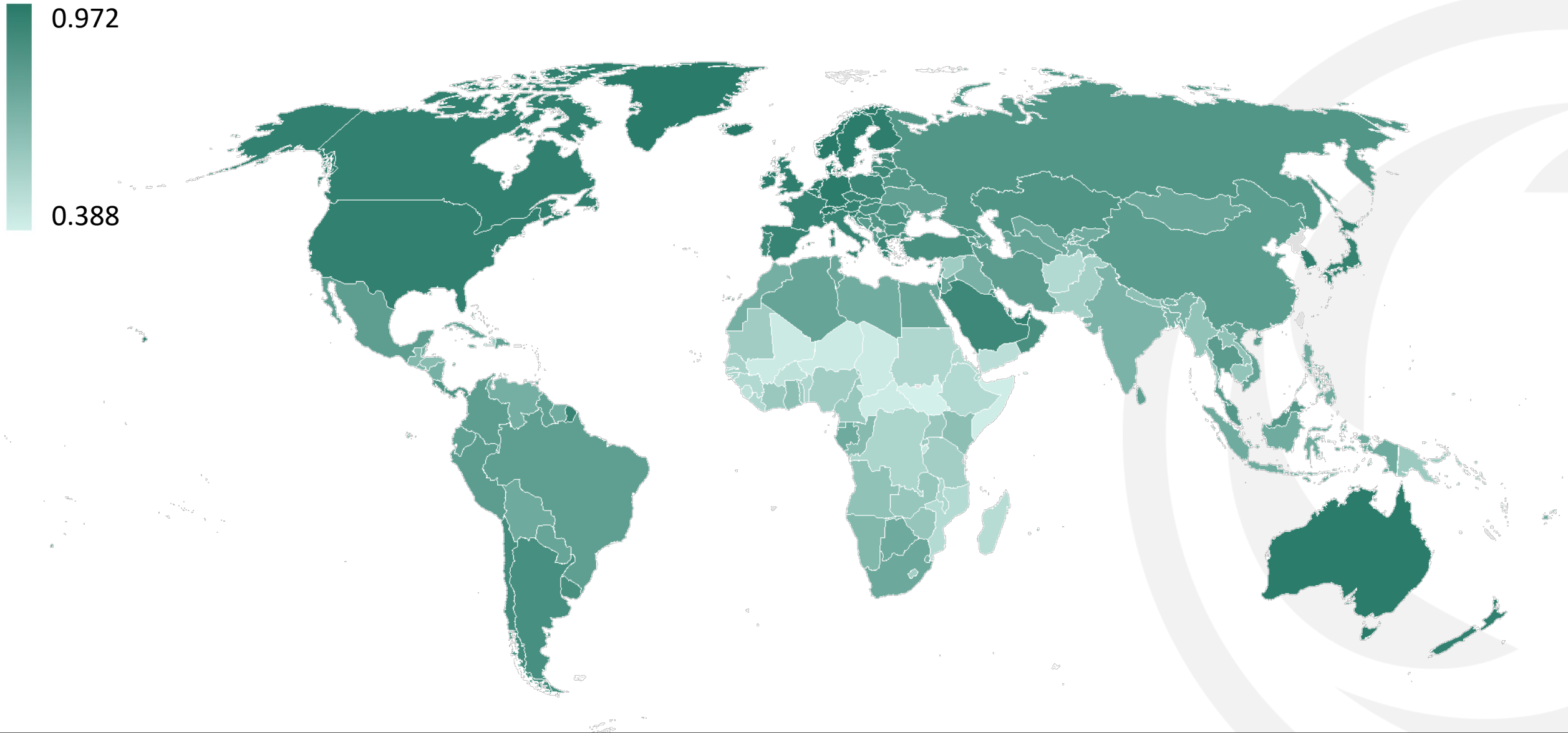


The Brandt Line (1980s)

- High
- Upper middle
- Lower middle
- Low
- Data not available



Country-level income category (World Bank)



Human Development Index



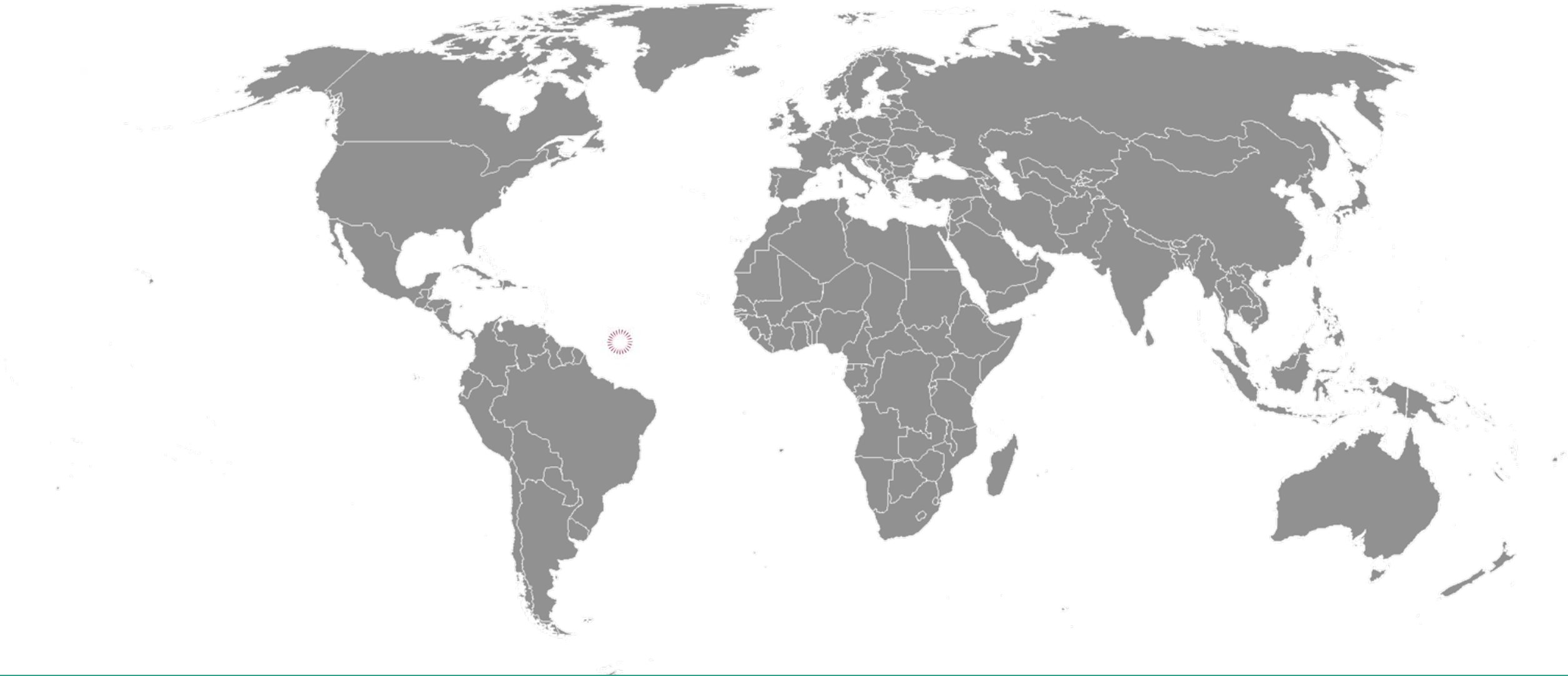
Resourcefulness and
Frugal Innovation Metric?

Future-readiness and
Foresight Indicator?

Problem-Solving
Agility Quotient?

Novelty and
Utility Score?

Ingenuity index?



Innovation can – and does – happen anywhere



“Reciprocal innovation harnesses a **bidirectional, co-constituted, and iterative** exchange of **ideas, resources, and innovations** to address **shared health challenges** across diverse global settings.”



Rooted in **reciprocity, mutual learning, and equity** across partner institutions

Bi-directional and co-constituted approach to identifying shared health challenges

High-quality innovations for **demonstration, replication, and dissemination** in diverse settings

REVERSING THE TREND

What do we know about LMIC to HIC health innovations?

Jepchirchir Kiplagat

Moi University College of Health Sciences, Kenya



What is already known?



Health innovations can come from anywhere and benefit people everywhere – showing how connected our world is, with great potential for cross-pollination.



Sharing successful ideas across countries – whether rich or poor – has been happening for decades in healthcare and other fields.



But when innovations move from LMICs to HICs, it's rarely written about or studied.



That means we still know very little about how these ideas are transferred, what helps or blocks the process, and which methods actually work.

Time for a scoping review...

Objectives

- To identify and analyse examples of health innovations developed in LMICs and transferred to HICs.
- To explore frameworks, methods, barriers, and facilitators in the transfer process.
- To support the concept of reciprocal innovation (mutual exchange of ideas and strategies).

Methods

- Scoping review using PRISMA-ScR guidelines.
- Searched 4 databases and grey literature (2000–2022).
- Included 13 articles (12 unique studies).
- Data extracted on intervention type, countries, frameworks, and outcomes.

Publication	The study	Innovation developed in...		Transferred to...
Absetz et al 6 ; van Olmen et al 7	Co-created, context-specific T2D self-management	South Africa and Uganda	→	Sweden
Adams et al 29	Assessing acceptability of financial incentives for preschool vaccinations	LMICs*	→	UK
Batey et al 22	FRESH: Adapting HIV stigma-reduction intervention in healthcare settings	Lesotho, Malawi, South Africa, Swaziland and Tanzania	→	USA
Behforouz et al 23	Directly observed HIV therapy via CHWs addressing social barriers	Haiti	→	USA
Depasse and Lee 2	Secondary report of three innovations	India, Kenya, Haiti	→	USA
Hanselmann et al 24	Interactive training for health workers to build empathy and self-care skills	South Africa	→	Germany
Ibe et al 25	Adapting community engagement strategy to strengthen healthcare links	Uganda	→	USA
Sors et al 5	Secondary report of three innovations	Kenya, Malawi	→	USA
Stephenson et al 26	Adapting couples HIV testing	Sub-Saharan African countries*	→	USA
Sugarman et al 3	Secondary report / framework	LMICs*	→	USA
Wright et al 27	Exploring barriers to implementing WHO-recommended approach for trachoma	LMICs*	→	Australia
Zieff et al 28	Adapting car-free street events to promote active living	Colombia	→	USA

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Meena Daivadanam from the SMART2D Project is speaking as a panellist in Sitting B

I will share some reflections on the AMPATH Program shortly...

Commonalities: **TMFs and outcomes**

Most commonly used TMFs:

- Diffusion of Innovation Framework (3 mentions)
- The Model for Reverse Innovation (3 mentions)
- The Reciprocal Innovation Model (3 mentions)

Most commonly reported implementation outcomes:

- **Adaptation** (mentioned for nearly every study)
- Other common outcomes:
 - Feasibility
 - Acceptability
 - Sustainability
 - Adoption

Themes: Barriers and facilitators

Facilitators

Stakeholder engagement: Engaging community members, policymakers, and innovators builds trust.

Local relevance: Tailoring interventions to cultural contexts ensures solutions resonate and are accepted.

Simplicity and standardisation: Using easy-to-implement and standardised tools improves consistency and reduces complexity.

Funding and promotion: Adequate funding and strong promotion ensure sustainability and higher adoption rates.

Stakeholder gaps: Lack of involvement or poor communication among stakeholders weakens support and fragments efforts.

Contextual challenges: Cultural differences and scientific tools may not fit all settings, affecting community acceptance.

Complexity and coordination: Iterative cycles and coordination demands require significant time and resources to manage effectively.

Funding shortfalls: Inconsistent funding and staffing shortages undermine sustainability.

Barriers



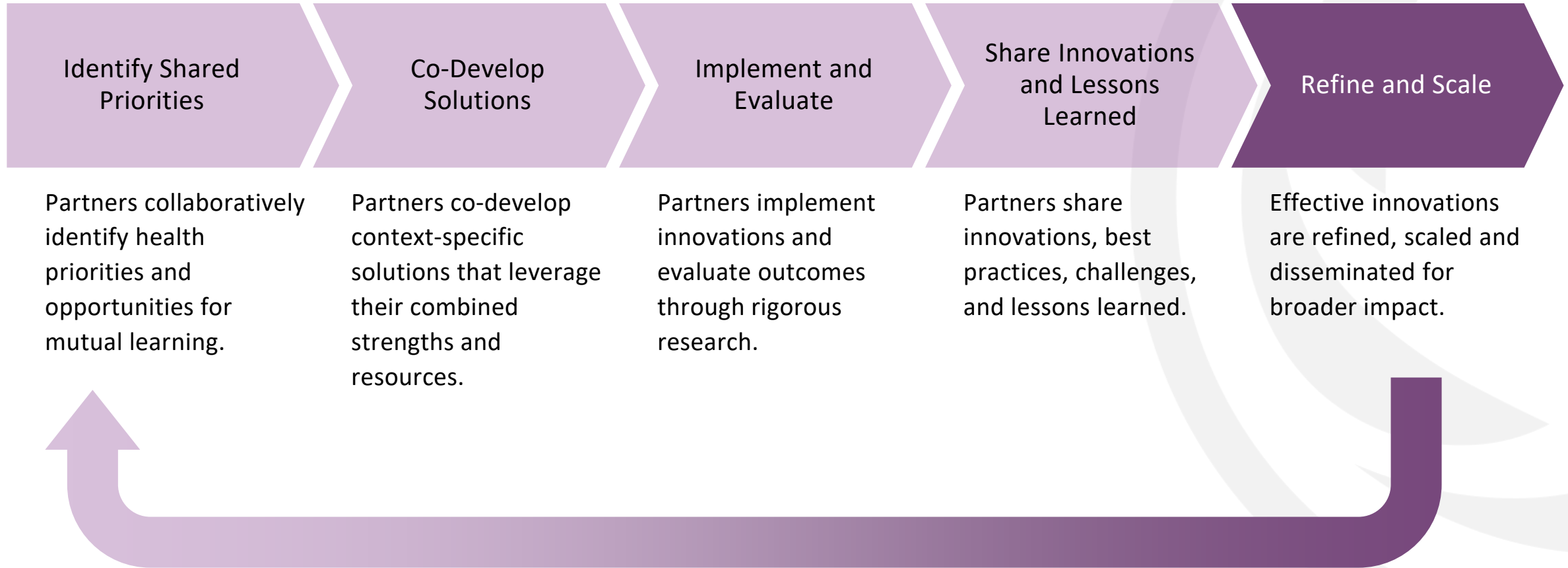
Reflections from the AMPATH Program



Key principles of AMPATH Partnerships

- **Shared belief in health as a fundamental right**
Partners share the belief that health is a fundamental right, and holistic care is needed.
- **Accountable to community needs**
Programming is designed based on needs identified by host partners.
- **Long-term engagement and equitable partnership**
Partners commit to long-term and equitable partnerships with mutual benefit and are responsive to institutional needs.
- **Counterpart relationships**
Host partners lead the way in their own countries.
- **Leveraging institutions**
Leverages power and responsibility of institutions of higher learning and their health system partners.
- **Enabling training and research**
Fosters a health ecosystem that enables research and training of the health workforce.
- **Collective impact**
Institutions work together in a deliberately complementary and collaborative way.
- **Self-correction**
Ability to make mistakes and self-correct.
- **Reciprocal innovation**
Collaborative innovation, co-learning with mutual benefit.

Reciprocal innovation



Indiana Reciprocal Innovation Program

- Established in 2018 as a module of the Indiana CTSI by a group of long-time AMPATH collaborators
- Goal to build research and institutional infrastructure and partnerships necessary to facilitate and grow RI
- Program created with three primary components:
 1. Stakeholder meetings and workshops
 2. Grants program
 3. Learning and dissemination platform

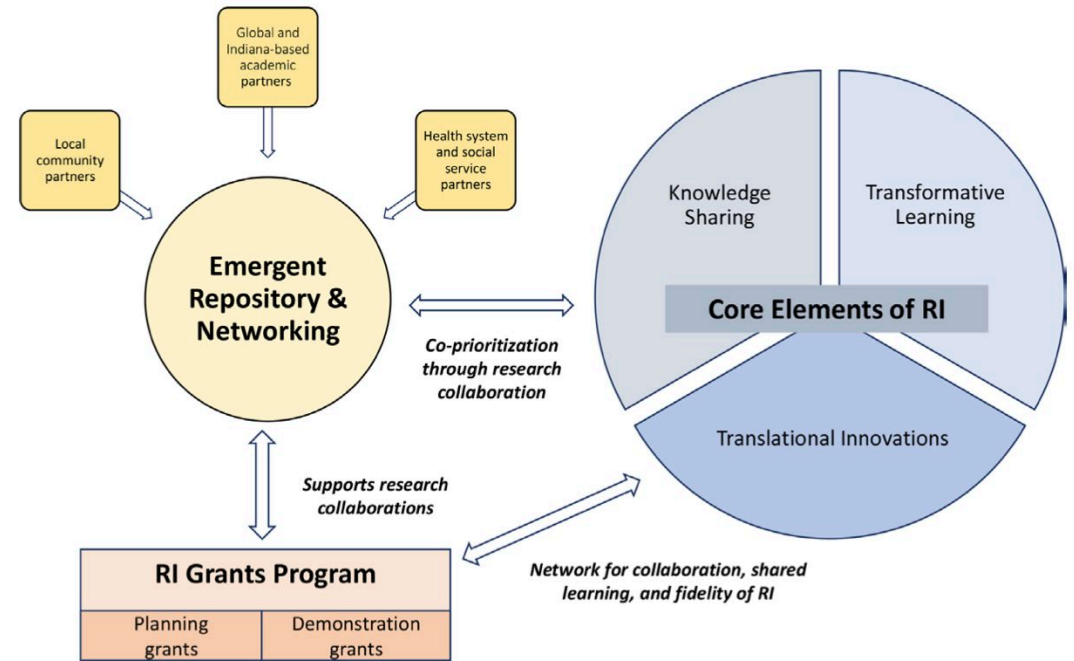


Figure showing the conceptual framework for Indiana's Reciprocal Innovation Program. Reference: Ruhl et al., 2023.

RI Program: Stakeholder meetings and workshops

- Brings together researchers at Indiana CTSI, AMPATH and partner institutions in LMICs, members of local public health and community organizations
- Through facilitated discussions and break out groups, these meetings serve to:
 - Educate stakeholders and disseminate the concept of reciprocal innovation
 - Identify shared health priorities in Indiana and in partner LMIC settings and potential areas for reciprocal innovation
 - Connect 'local' and 'global' investigators and partners to begin partnership and co-creation

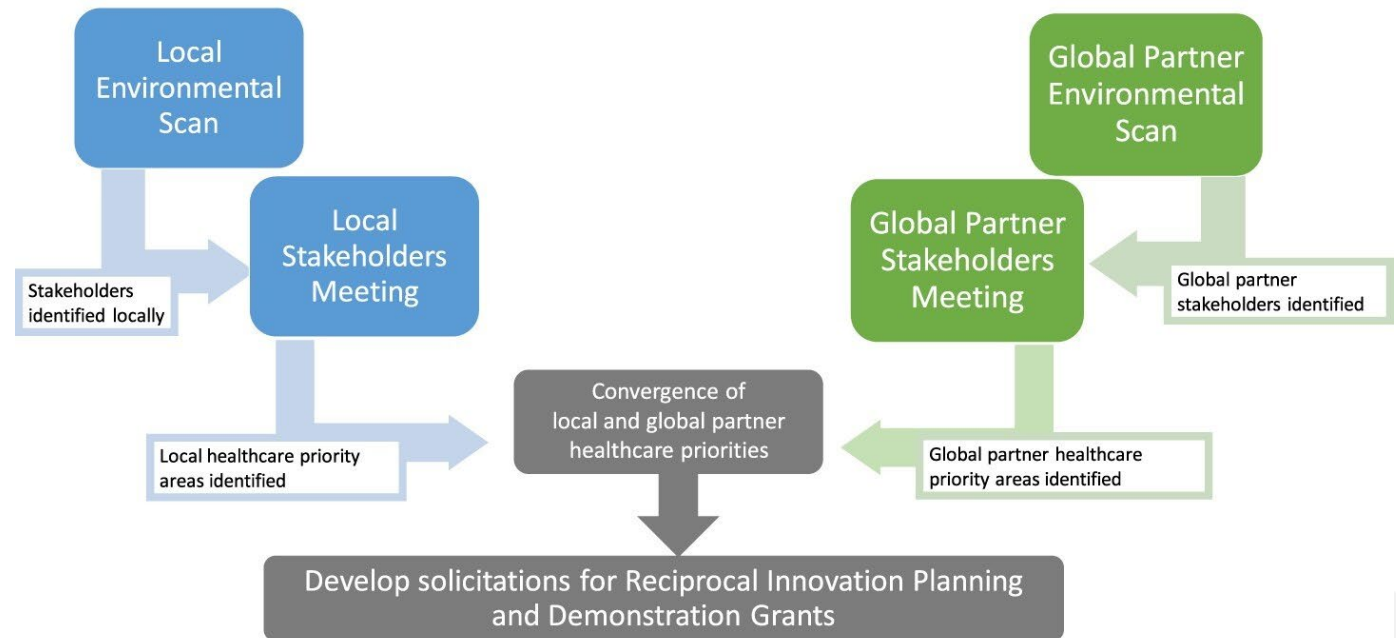


Figure illustrating the process in developing the Indiana RI program from (1) environmental scans to (2) stakeholder meetings to (3) identifying of shared health challenges and to (4) co-creation or adaptation of innovations. Reference: Sors et al., 2022

RI Program: Planning and demonstration grants

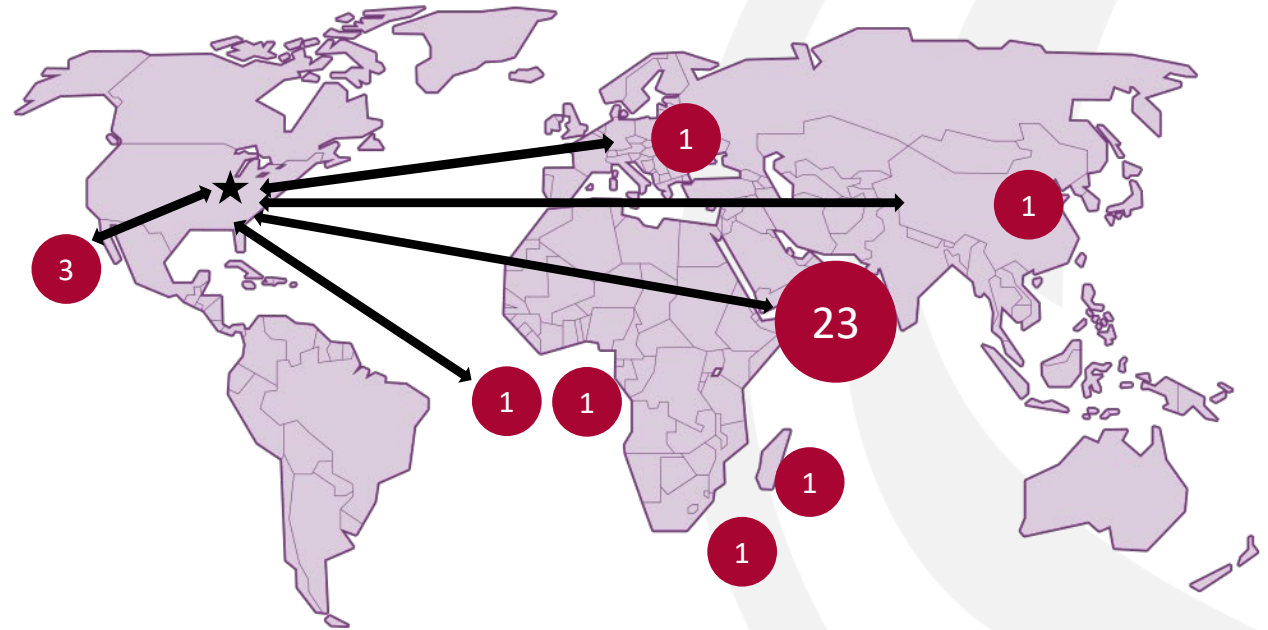
Two types of RI grants

- **Planning** – 1 year, \$10k to support partnership building, identifying shared priorities and co-developing research projects
- **Demonstration** – 2 years, \$50k to support initial testing or adaptation / implementation of a reciprocal innovation

Since 2018, 6 planning grants and 8 demonstration grants awarded (totally US \$530,000)

Outcomes:

- 92% reported new/deepened partnership
- 69% reported RI project used to fund subsequent grant application



Map illustrating the international partnerships with Indiana teams supported through planning and demonstration grants in the program to date. Note: Map includes awards funded under the previous Global Health grants program that operated prior to the RI grants program from 2016-2018.

RI Program: Learning and dissemination platform

- Need for an open and accessible platform for shared learning, collaboration and dissemination
- Created a “Global Health Innovation Exchange” that included information on funded RI projects like:
 - Collaborators and partnerships
 - Shared health challenge and priority being addressed
 - Intervention and/or adaptation being studied and process
 - Next steps for adaptation / scale
- Serves as repository of case studies of “RI in action”

GLOBAL HEALTH INNOVATION EXCHANGE Indiana Clinical and Translational Sciences Institute			
Priority Area	Country		
Principal Investigator	Project Title	Priority Area	Country
Adrian Gardner, Indiana University	Improving the Delivery of Complex Care to HIV Positive Patients through Guided Practice using the HIV AMPATH Tele-ECHO Platform	Infectious Disease	Kenya
Marya Lieberman, University of Notre Dame	Pharmaceutical Quality in Malawi	Access to healthcare	Malawi
Megan McHenry, Indiana University	Caregiver-Focused Intervention for Neurodevelopmental Delays in Young Children in Western Kenya	Infant and maternal health	Kenya
Rakhi Karwa, Purdue University	Bridging the Gap from the Hospital to the Clinic: Using Peer Navigators on the Inpatient Wards to Improve Linkage, Retention and Adherence to HIV Care in Western Kenya	Infectious Disease	Kenya
Ken Cornetta, Indiana University	Facilitating Home Hospice Care Via Telecommunication in Kenya	Access to healthcare	Kenya
Mary Ott, Indiana University	Addressing Barriers to Adolescent PrEP in Western Kenya Using an Implementation Sciences Approach	Access to healthcare;Prevention;Infectious Disease	Kenya
Molly Rosenberg, Indiana University	Microfinance and Investments in Health in Rural Kenya	Prevention	Kenya
Laura Ruhl, Indiana University	Chamas for Change: Adapting a community-based peer-support and health education model for pregnant and parenting adolescents in Kenya	Infant and maternal health	Kenya
Sophie Lelievre, Purdue University	Harnessing miRNAs to Prevent Early Breast Cancer Onset in Lebanese Women	Prevention;Chronic disease	Lebanon
Esperanza Angeles Martinez-Mier, Indiana University	Dental Caries Prevention Program Tailored to Rural Indigenous Communities in Mexico	Prevention	Mexico
Sherri Bucher, Indiana University	Feasibility, Acceptability, and Usability testing in Kenya of NeoWarm: An innovative biomedical device to prevent newborn hypothermia in low-middle income country	Infant and maternal health	Kenya

Moving RI forward

- Sustained funding opportunities with RI focus
- Siloed research and expertise into 'local' vs. 'global' camps
- Risks of de-prioritizing areas that are not shared health challenges
- Assessing strength of 'reciprocal' potential of new applications and innovations

Challenges

Lessons learned

- Importance of planning grants to creating/building partnerships for RI
- Facilitating 'connection points' and shared learning for developers and adapters / implementers of RI
- Prioritizing equity, trust and community engagement to RFAs and funding mechanisms

- Creating a RI Hub to speed up multinational community-academic partnerships across rural Indiana and AMPATH
- Leverage emerging partnerships with immigrant and refugee organizations and communities in Indiana
- Expanding opportunities for RI with partners

Next steps

Acknowledgements

- The Indiana Reciprocal Innovation Program was supported in part, with support from the Indiana Clinical and Translational Sciences Institute funded in part by Grant Number UL1TR002529 from the National Institutes of Health, National Center for Advancing Translational Sciences, Clinical and Translational Sciences Award. The content is solely the responsibility of the authors and does not necessarily represent the official views of the National Institutes of Health.
- We thank the leadership of Indiana CTSI and AMPATH for their support and the RI team at Indiana University (Kara Wools-Kaloustian, Laura Ruhl, Debra Litzelman, Adrian Gardner, Rish O'Brien, Michael Scanlon), Moi University (Winstone Nyandiko, Jepchirchir Kiplagat, Jeremiah Laktabai), Purdue University (Thomas Sors, Li Yuan Bermel, Sonak Pastakia), Notre Dame (Marya Lieberman, Nydia Morales-Soto), and Mount Sinai (Rachel Vreeman, David Plater).
- Grateful to NIH Fogarty International Center and GHRI for supporting and leading work in RI to build equitable and reciprocal global health research and partnerships!

Fogarty International Center
A Fireside Chat on Reciprocal Innovation
Roger Glass

Roger I. Glass, M.D., Ph.D.
Director, Fogarty International Center
Associate Director for Global Health Research, NIH
October 13, 2021

Indiana CTSI GH
Reciprocal Innovation Meeting
Powered by Zoom

Former Director of Fogarty International Center, Dr. Roger Glass, speaking at the 2021 Indiana CTSI Reciprocal Innovation stakeholder meeting

MIND THE GAP

Bringing Indian mental health success to the UK

Jasmine Kalha & Kaustubh Joag – Centre for Mental Health Law & Policy, ILS, India

Tessa Roberts – Queen Mary University of London, UK

Atmiyata: India to the UK

Example of a 'reciprocal' innovation

Jasmine Kalha, Kaustubh Joag, Tessa Roberts



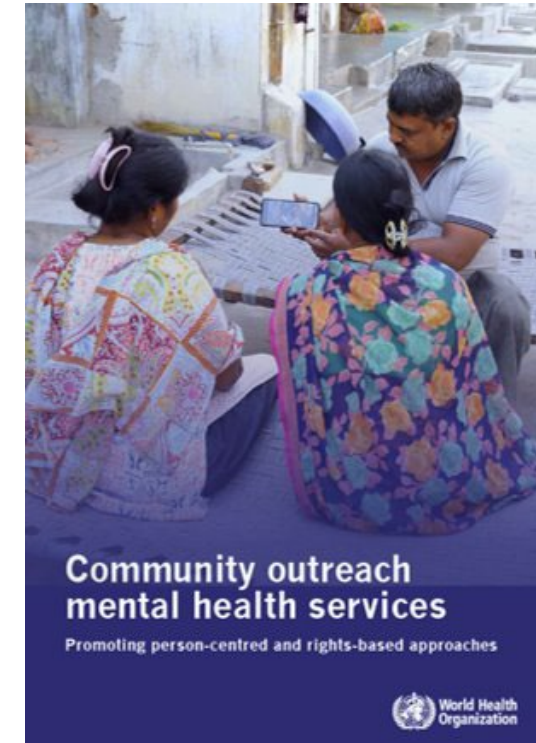
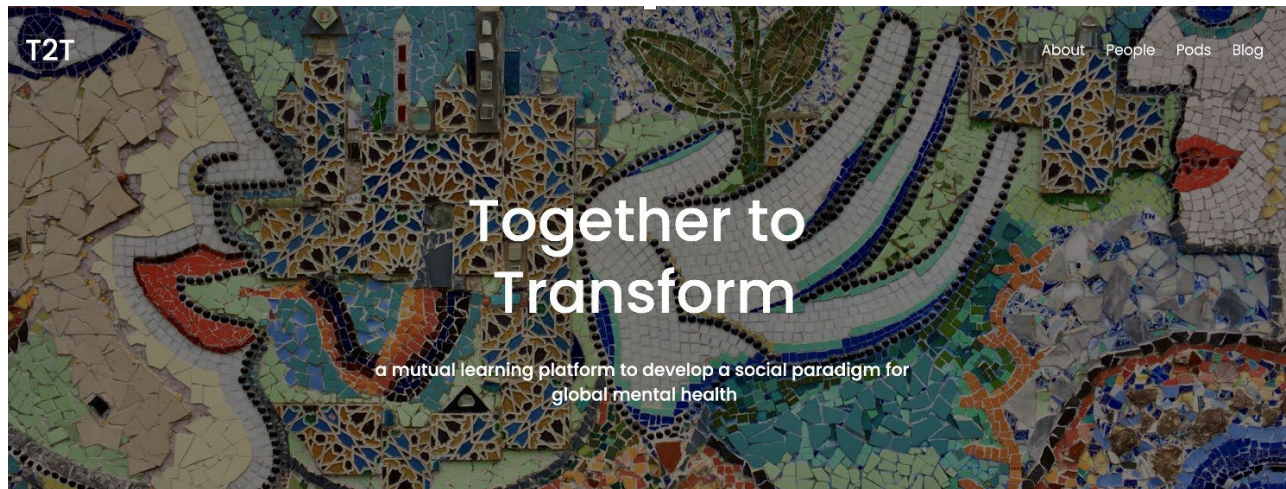
Funded by



Atmiyata collaboration

History of the collaboration

- Challenge power dynamics
- Who has 'access' to networks
- Shared framing of the problem & goals
- Importance of long-term relationship building



Scaling up across contexts

Scaling up within India – lessons learned

- Need to identify the 'core' of the model
- Working with partners - need for flexibility (e.g. adjusting delivery pathways to match the context)
- Value match and buy in (e.g. reciprocal relationships with community, social orientation, work on sustainability and scale)



Adapting Atmiyata for East London

- Working with local partners
- Balancing fidelity and local adaptation
- Learning from CMHLP team
- Challenging status quo



What's different about "reverse" innovation?

- Process of adaptation similar, regardless of direction of travel of intervention
- Regulation and safeguarding context
- Responses to project differ
- Questions about generalisability of research from LMIC
- Who gets credit
- Distribution of resources and power (linked to funding structures)



More about us

    @CMHLPIndia

 www.cmhlp.org

 info@cmhlp.org

CMH
Centre for
Mental Health
Law & Policy

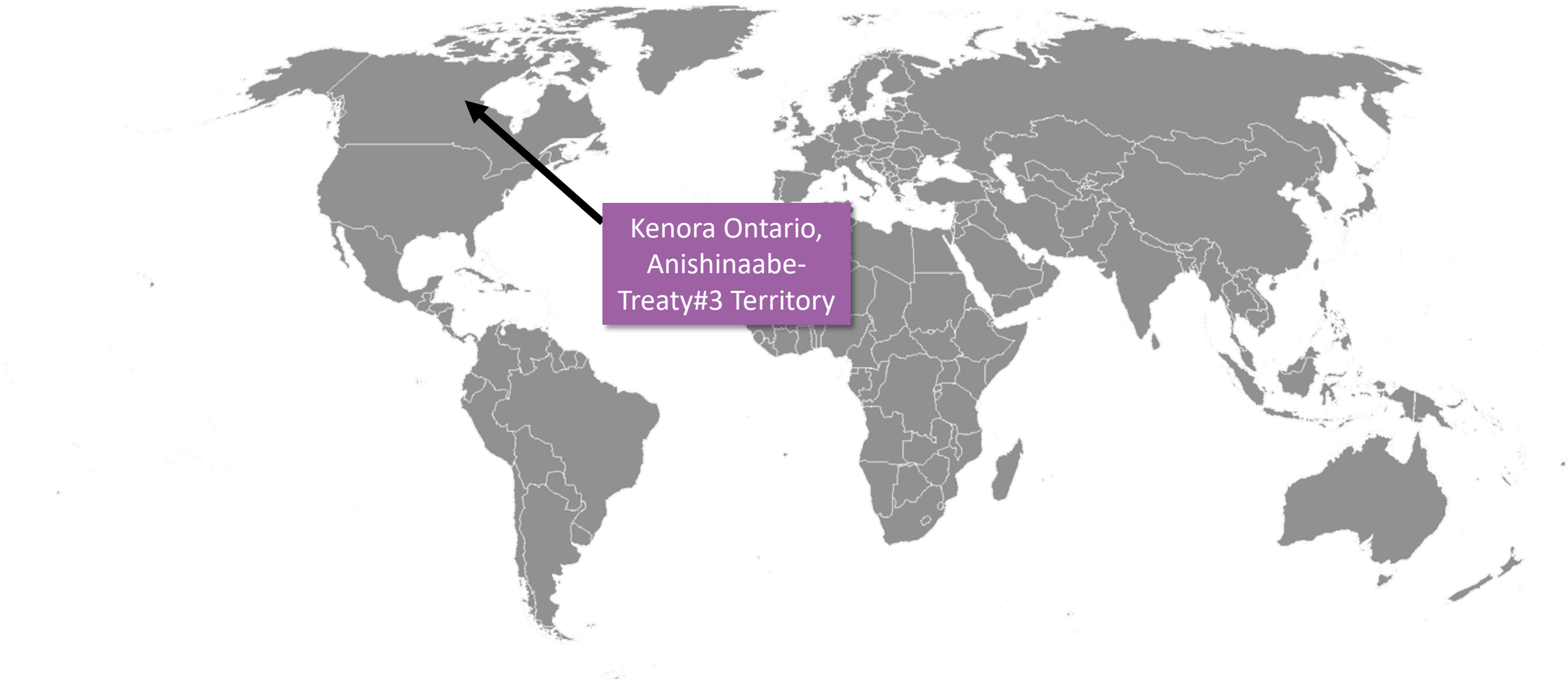


ROOTED IN WISDOM

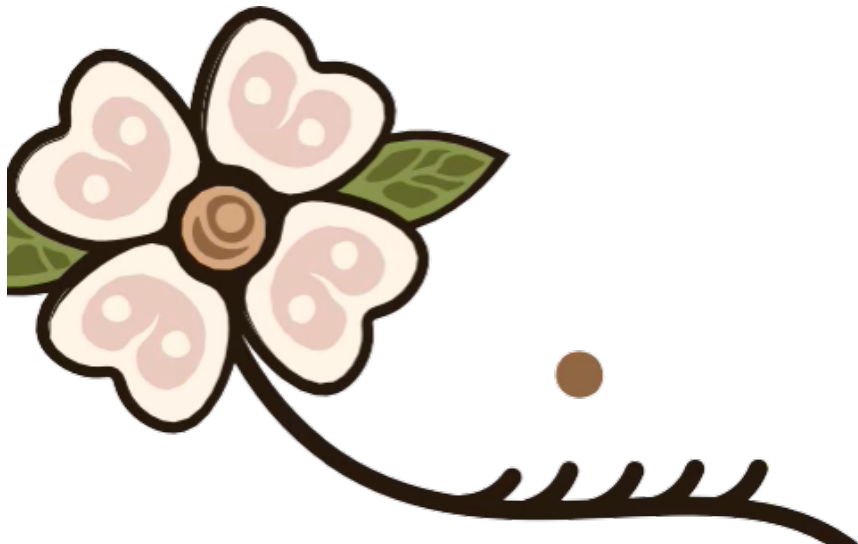
Reimagining implementation with Indigenous innovation

Lana Ray

Associate Professor and Canada Research Chair in Resurgent Methodologies for Indigenous Health, Athabasca University, Canada



“This is our way of life” – Kathy Bird



TRADITIONAL HEALING AS A GHRI

- In many cases Indigenous communities experience conditions similar to LMICs
- Innovations in LMICs can be discounted by implementers and policymakers in HICs and misperceptions about the quality and adaptability of innovations and technologies developed in LMICs (Sors et al., 2022)
 - further mediated by settler colonialism
- First Nations are sovereign nations that collaborate and engage in exchange with other First Nations and the Settler state/Settler institutions.
- Growing trend of the implementation of TH in Indigenous and non-Indigenous institutional health care settings. Accessed by Indigenous and non-Indigenous popns



THE INNOVATION

Embedding
Traditional Healing
Services into a
Health Care Centre

Access

- Transportation costs
- Low cost/equity scale
- “One stop” intervention

Wholistic Service

- Patient Centered
- Wholistic care (physical & mental)
- Wrap around supports

Patient Experience

- Generally non-invasive procedures
- Patient centered
- Welcoming/non-discriminatory environment
- Patient empowerment

Implementation Strategies

- Creation of an implementation support team (McGuier et al., 2024)
- Developing policies and procedures for use within the traditional healing clinics
- Training Indigenous peoples to respectfully and sustainably work with plant medicines
- Research using EPIS, Proctor's & BCW/Com-B



Facilitators and barriers to implementation

Facilitators

- Monthly implementation team meetings
- Expanding scope of practice for community workers/members/building up community and people
- Commitment to fidelity
- Community acceptability

- Working in distinct worldviews
- Reciprocal spirit largely not present among Western HSPs
- Lack of stable funding
- Misconceptions of TH
- Increased capacity/mobilization needed to scale up

Barriers

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THERE AND BACK AGAIN

The HOPE-4 Study in Canada and Colombia

Patricio Lopez-Jaramillo and Jose P Lopez-Lopez

Universidad de Santander, Colombia





HOPE 4:

Heart Outcomes Prevention and Evaluation 4 Study

Patricio Lopez-Jaramillo MD PhD
Jose P Lopez-Lopez MD

Masira Research Institute, Medical School
Universidad de Santander
Bucaramanga, Colombia

Disclosures/Funding

Grants for the conduct of this study:

- Global Alliance for Chronic Diseases
- Grand Challenges Canada
- Canadian Institute for Health Research
- Ontario Ministry of Health and Long-Term Care
- Boehringer Ingelheim
- The Department of Management of Non-Communicable Disease, World Health Organization
- Population Health Research Institute, HHS Research Institute
- Faculty of Medicine, Universiti Teknologi MARA, Selayang
- Santander Departmental Secretary of Health
- Universidad de Santander (UDES)
- Fundación Oftalmológica de Santander (FOSCAL)

HOPE 4 Intervention

Barriers

Patient:

- Conflicting knowledge/beliefs, high costs
- Challenging to implement treatment plans

Health Care Provider:

- Limited time and resources of physicians
- Treatment inertia
- Low use of ≥ 2 antihypertensives and statin

Health system:

- Fragmented care
- Availability of medications
- Costs/Travel/Access to care

Intervention

Task-sharing with NPHW:

- Community-based identification and treatment of HTN and CV risk factors
- Tablets with counselling and simplified management algorithms
- Supervised by primary care physicians

Provision of free CV medications:

- Combination antihypertensives (2 of ACEI/ARB/CCB/HCTZ)
- Statin (atorvastatin 20mg or rosuvastatin 10 mg)

Enhancing adherence:

- Family/friends (Treatment Supporters)

HOPE 4 Study

1) Study design

- Parallel-group, cluster-randomized controlled trial
- 30 urban and rural communities from Colombia and Malaysia
- Communities randomized to usual care or a comprehensive CVD risk detection and management program for 12 months

2) Study participants

- ≥ 50 years: new or uncontrolled hypertension (SBP > 140 mmHg)

September 2nd , 2019 in *The Lancet*

A community-based comprehensive intervention to reduce cardiovascular risk in hypertension (HOPE 4): a cluster randomised controlled trial



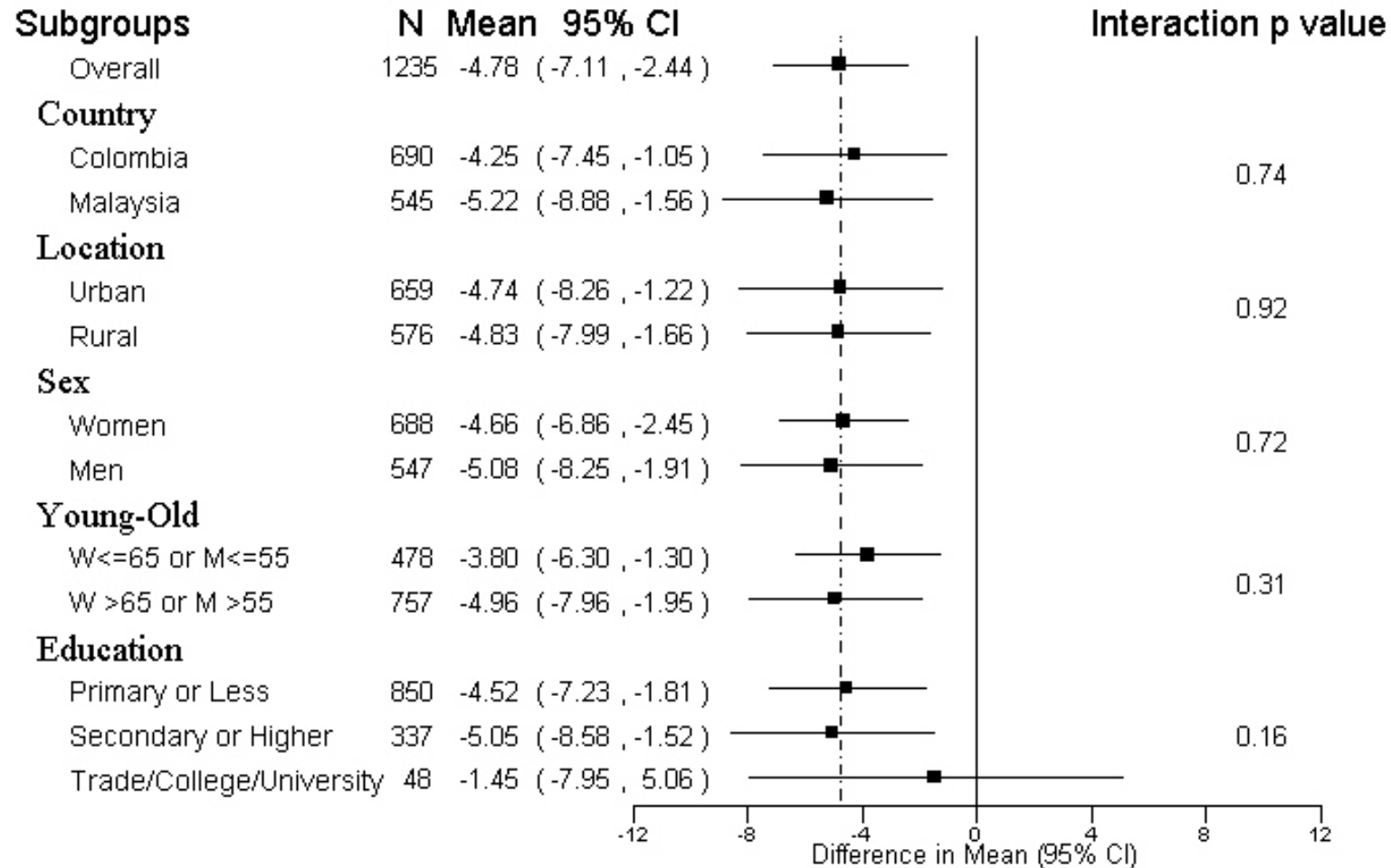
Jon-David Schwalm, Tara McCreedy, Patricio Lopez-Jaramillo, Khalid Yusoff, Amir Attaran, Pablo Lamelas, Paul A Camacho, Fadhlina Majid, Shrikant I Bangdiwala, Lehana Thabane, Shofiqul Islam, Martin McKee, Salim Yusuf

Medication and adherence at 12 months

	Characteristics	Control	Intervention	P Value
	Randomized	727	644	
Medications (%)	≥ 2 Antihypertensives	65	84	P<0.0001
	Statins	38	84	P< 0.0001

- Medication adherence to antihypertensives was 50% greater in the intervention group, P < 0.0001.

Subgroup Analysis of the Primary Outcome (FRS)



Differences Between Intervention and Control Group

2^o and 3^o outcomes at 12 months

Outcome*	Change at 12 Months From Baseline		Intervention vs Control at 12 months
	Control (n = 692)	Intervention (n = 607)	P-Value
Non-Lab-Based INTERHEART Risk Score	-1.9	-4.9	<0.0001
Physically Active: %	20.2	23.0	0.0467
Daily Vegetables: %	7.3	15.4	0.0070
Daily Fruits: %	6.6	21.6	0.0910
Daily Salty Foods: %	-7.9	-14.6	0.0275
Fried/Fast Food \geq 3/Week: %	6.9	-2.7	0.0786
Daily Meat/Poultry: %	0.1	-6.0	0.1061

*No change in smoking, weight, stress or depression

Conclusion

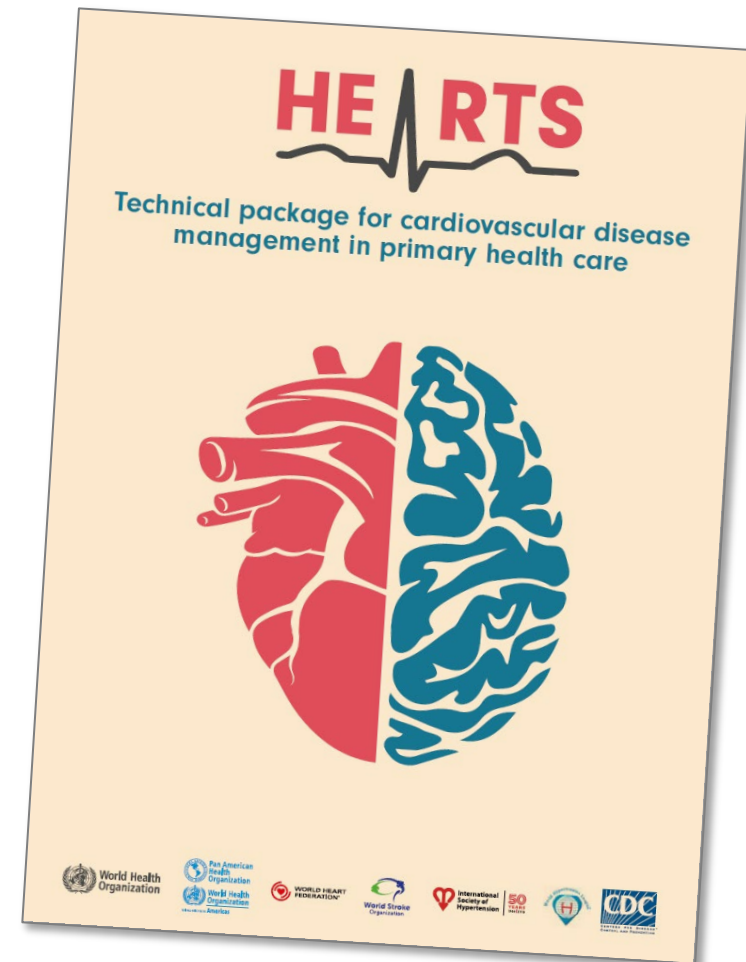
- A comprehensive model of care led by NPHWs, guided by algorithms on a tablet, involving primary care physicians and family, along with the provision of free antihypertensive drugs and a statin, **substantially** improved CVD risk and blood pressure.
- **Success** of the HOPE 4 NPHW-led strategy:
 1. Simultaneously addressed multiple barriers to CVD risk
 2. Community-based intervention adapted to local context
 3. Reinforcing adherence with treatment supporters
 4. Comprehensive intervention with computer-based algorithms

Where do we go from here?

- International Impact
- Next steps in:
 - Canada
 - Colombia
 - Spain
 - Chile
 - Dominican Republic

Non-Physician Health Worker Curriculum-WHO

The HOPE-4 curriculum has been adapted to the WHO's HEARTS Technical Package to improve management of CVD in primary health care



HOPE 4:

Canada

CJC Open ■ (2021) 1–9

Original Article

Exploring New Models for Cardiovascular Risk Reduction: The Heart Outcomes Prevention and Evaluation 4 (HOPE 4) Canada Pilot Study

Jon-David Schwalm, MD, MSc, FRCP,^a Tara McCreedy, PhD, MBA,^a Scott A. Lear, PhD,^b

Pablo Lamelas, MD, MSc,^{a,c} Len Garis,^d Hadi Musa, MHK,^a Kaitey Vincent, BA,^e

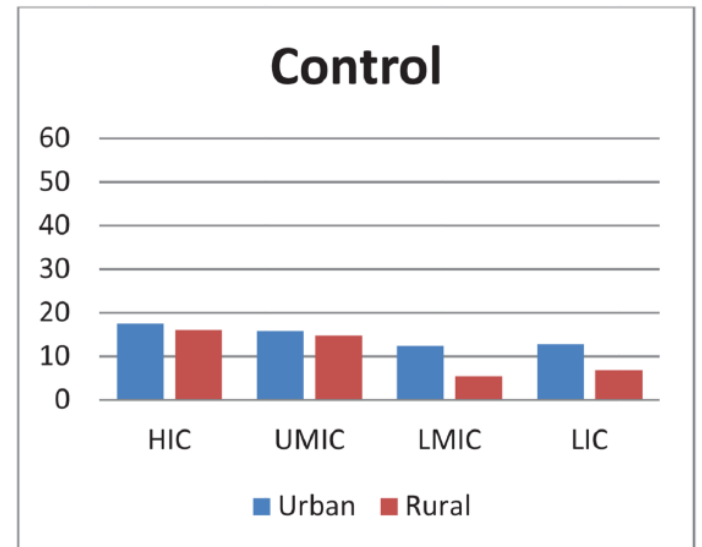
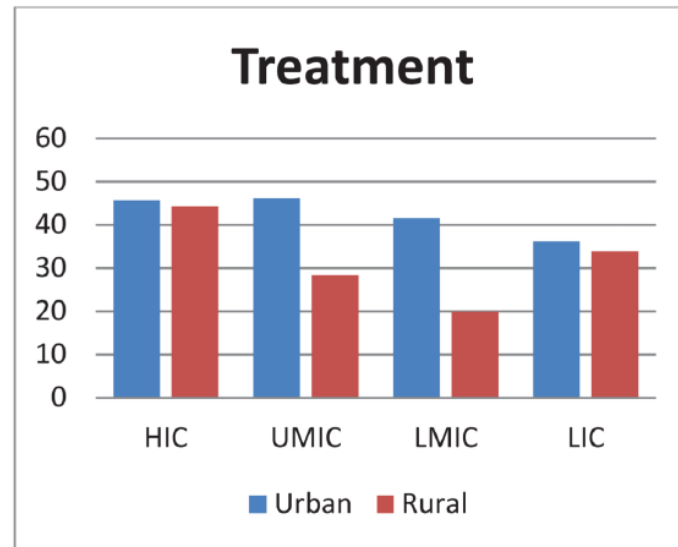
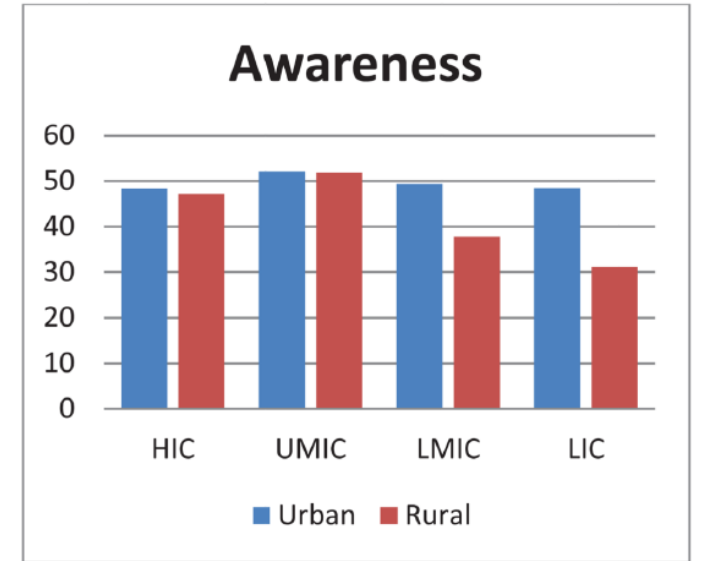
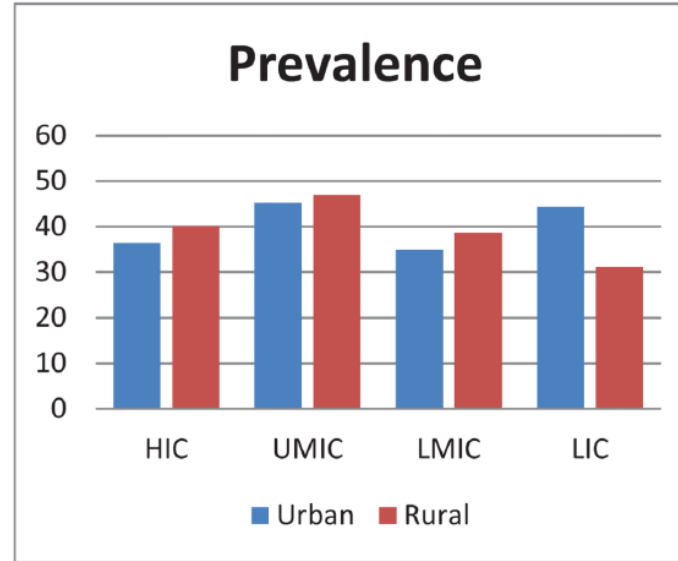
Shofiqul Islam, PhD,^a Amir Attaran, DPhil,^f

Martin McKee, CBE, MD, DSc, MSc, FRCP, FRCPE, FRCPI, FFPH, FMedSci,^g and

Salim Yusuf, MD, DPHIL, MRCP^a

What about Canada?

Hypertension detection, treatment and control is low even in HIC



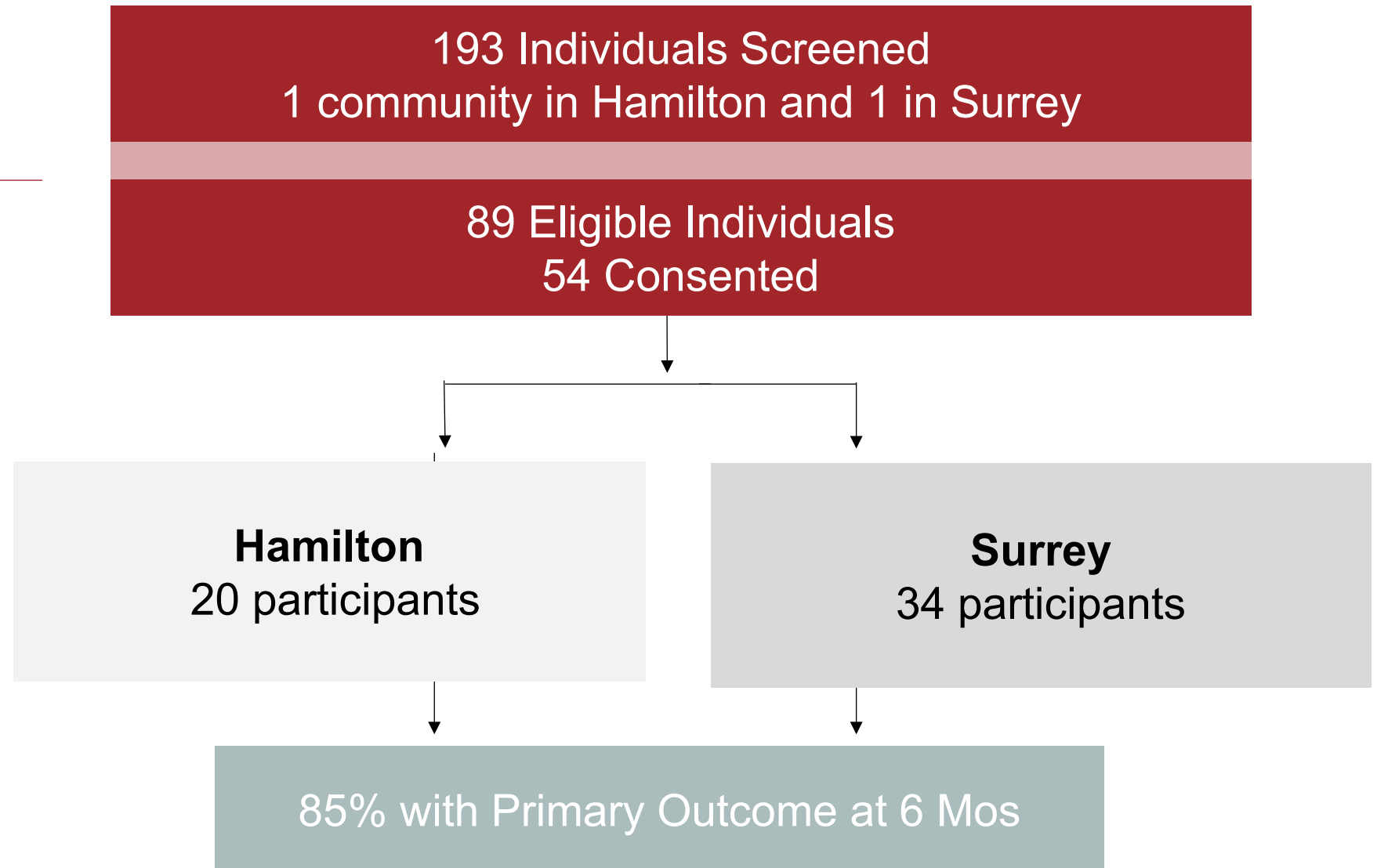
HOPE 4 Canada

Intervention: Same as HOPE 4 but no provision of antihypertensives or statin and NPHWs adapted to existing infrastructures

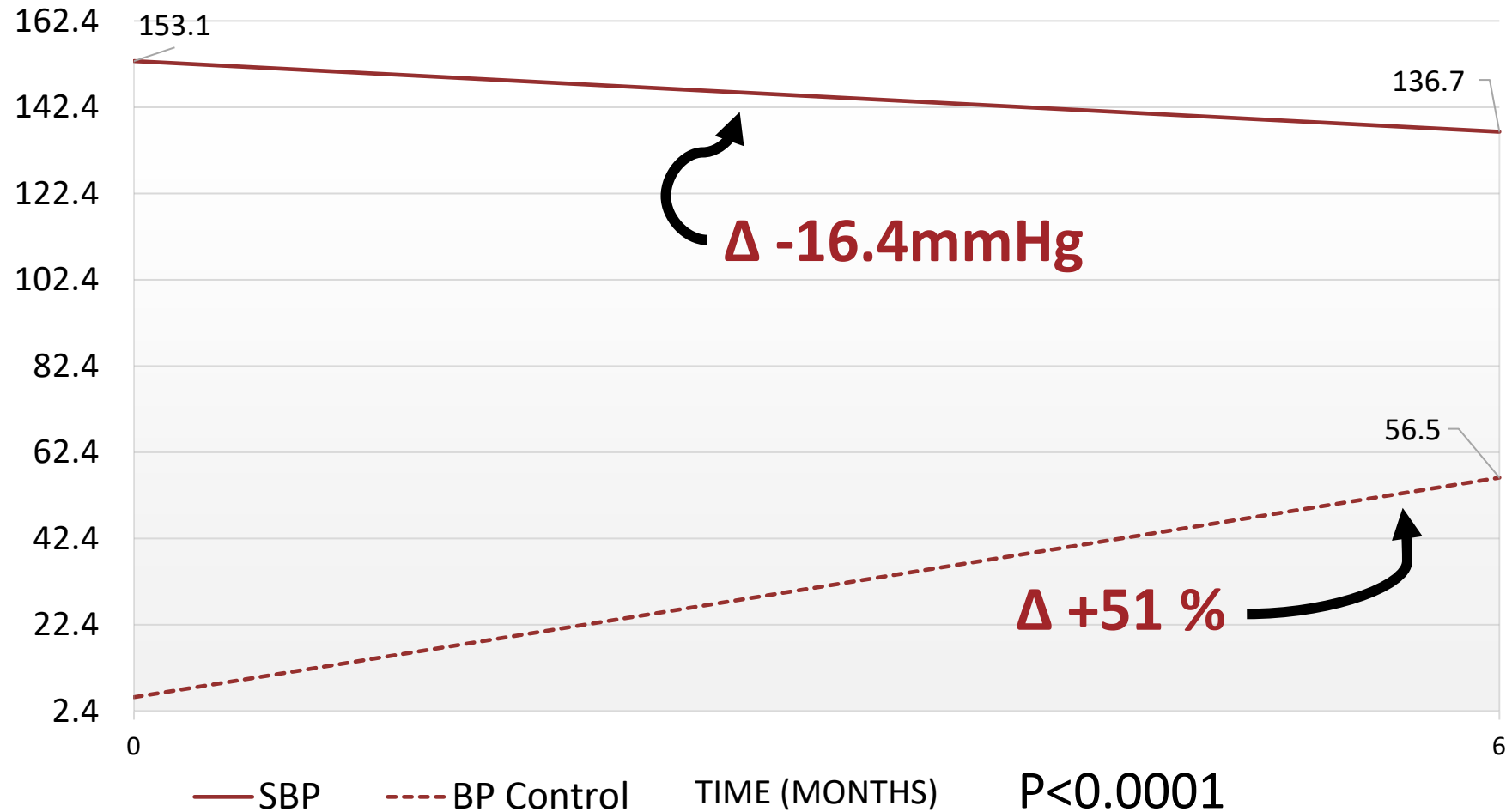
Design: Community-based, pre-post interventional study, involving one community in Hamilton and one in Surrey.



Study profile



% BP Control and Change in SBP at 6 Months



Canada: Outcomes at 6 Months

Outcome	Baseline (n=54)	6 Months (n=48)	P-value
Framingham Risk Score: Mean (SD)	18.4 (3.1)	16.1 (3.7)	<0.01
SBP (mmHg): Mean (SD)	153.1 (12.1)	136.7 (15.7)	<.01
Controlled SBP (< 140 mmHg): N (%)	3 (5.6)	26 (56.5)	<.01
Use of antihypertensives: N (%)	37 (68.5)	35 (76.1)	0.40
Use of ≥ 2 antihypertensives: N (%)	21 (54.5)	24 (68.6)	0.21
Use of a statins: N (%)	22 (40.7)	24 (52.2)	0.25
Total cholesterol (mmol/L): Mean (SD)	4.7 (1.3)	4.7 (1.1)	0.77
LDL (mmol/L): Mean (SD)	2.7 (1.1)	2.7 (0.9)	0.90
Smoker: N (%)	8 (14.8)	5 (10.9)	0.56
Physically active: N (%)	25 (46.3)	28 (60.9)	0.15

HOPE 4 Canada-Indigenous Population

- Indigenous peoples of Canada, have the highest rates of CV death compared to all other Canadians, regardless of income and education.
- Working with the National Indigenous Fire Safety Council to explore novel methods for community-based CVD risk prevention in this high-risk population.

BPIN 2020000100447

RE-HOPE STUDY

IMPLEMENTATION, INTEGRATION AND INSTITUTIONALIZATION OF A COMMUNITY-BASED CARE PROGRAM TO REDUCE THE RISK OF CARDIOVASCULAR DISEASE SANTANDER



1. **Capacidades en Ciencia, Tecnología e Innovación:** Estudio HOPE-4 y trayectoria de la Universidad de Santander en investigación.
2. **Capacidad financiera:** Financiación del SGR y de la Universidad de Santander.
3. **Sostenibilidad social:** Vinculación activa de la comunidad en conjunto con actores del sistema de salud.
4. **Sostenibilidad ambiental:** Fomento del ahorro, reducción, recuperación, reutilización y reciclaje.

CONVOCATORIA DEL FONDO DE CTEI DEL SGR PARA LA CONFORMACIÓN DE UN LISTADO DE PROPUESTAS DE PROYECTOS ELEGIBLES DE INVESTIGACIÓN Y DESARROLLO PARA EL AVANCE DEL CONOCIMIENTO Y LA CREACIÓN








Total: **\$3,573,313,612**
FCTel-SGR: **\$1,816,916,682**
Contrapartida: **\$1,756,396,930**
Supervisión: **\$306,000,000**



Plazo de ejecución: **36 meses**
Ejecutor: **Universidad de Santander**
Contempla: **Supervisión**

Factors associated with uncontrolled hypertension in santander, colombia: baseline findings from the RE-HOPE study

Jose P. Lopez-Lopez ^{1,3}, Yuri Sanchez-Martinez^{1,3}, Yesica Giraldo-Castrillon¹, Daniel Martinez-Bello ¹, Alvaro Castañeda¹, Claudia Garcia¹, Marianne Lopez-Cabrera ¹, Johanna Otero^{1,2} and Patricio Lopez-Jaramillo ¹ 

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In Latin America, hypertension prevalence varies widely, and control rates remain low, particularly in low-income communities, despite the proven efficacy of recommended interventions. We aimed to describe baseline characteristics and identify individual factors associated with uncontrolled hypertension in participants of the RE-HOPE study in Santander, Colombia. A cross-sectional analysis was conducted including participants ≥ 18 years old with hypertension, defined by self-reported history, antihypertensive use, or systolic BP ≥ 140 and/or diastolic BP ≥ 90 mmHg. Descriptive statistics were used for baseline characteristics. Mixed-effects logistic regression models stratified by sex were applied to identify factors associated with uncontrolled hypertension, adjusting for age, diabetes, obesity, medication intake, physical activity, and smoking. A total of 3 481 participants were included, with a mean age of 60.2 years (SD 13.7); 62% were female. Mean systolic and diastolic BP were 144 ± 16 mmHg and 86 ± 10 mmHg, respectively. Despite high levels of awareness (81%) and medication use (76%), only 26% of participants had controlled hypertension ($< 140/90$ mmHg), and 9.6% met the target below 130/80 mmHg. Control rates were higher in the capital city compared to peripheral and rural provinces. Being female was inversely associated with uncontrolled hypertension (OR = 0.62; 95% CI: 0.52–0.75). In contrast, age ≥ 60 years (OR = 2.19; 95% CI: 1.84–2.61) and current smoking (OR = 2.48; 95% CI: 1.54–4.00) were positively associated with poor control. This study highlights significant challenges in hypertension management, particularly early diagnosis and the identification of priority groups, and emphasizes the need for targeted public health initiatives and policy actions to enhance hypertension control.



Article

Perceived Barriers and Facilitators in Cardiovascular Risk Management in Colombia: A Qualitative Analysis of the RE-HOPE Study

Jose P. Lopez-Lopez ¹, Yesica Giraldo-Castrillon ¹, Johanna Otero ^{1,2}, Claudia Torres ¹,
Alvaro Castañeda-Hernandez ¹, Daniel Martinez-Bello ¹, Claudia Garcia ¹, Marianne Lopez-Cabrera ¹
and Patricio Lopez-Jaramillo ^{1,*}

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HOPE 4 Colombia and Jamaica:

Implementing and Scaling Up a Team-based Care Strategy for Hypertension Control in Colombia and Jamaica








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ORIENS EX OCCIDENTE LUX

1. Santander: Universidad de Santander, Fundación Oftalmológica de Santander
2. Nariño: Fundación Cometa
3. Atlántico: Clínica de la Costa
4. Cauca: Hospital Susana López de Valencia
5. Quindío: Fundación Cardiomet
6. Cesar: Universidad de Santander
7. Norte de Santander: Universidad de Santander



Article

Differences in COVID-19 Vaccination and Experiences among Patients with Hypertension in Colombia and Jamaica during the COVID-19 Pandemic

Jacqueline P. Duncan ^{1,*}, Siyi Geng ², Carene Lindsay ³, Trevor S. Ferguson ³, Katherine T. Mills ², Jose Patricio Lopez-Lopez ⁴, Hua He ², Paola Lanza ², Allison N. Marshall ², Makeda J. Williams ⁵, Veronica Tonwe ⁵, Mabel Reyes ⁴, Alfonso Campo ⁶, Patricio Lopez-Jaramillo ⁴ and Marshall K. Tulloch-Reid ³

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➤ [Res Sq \[Preprint\]](#). 2025 Sep 5:rs.3.rs-7454001. doi: 10.21203/rs.3.rs-7454001/v1.

Health Systems and Self-Reported Medication Adherence in Patients with Hypertension: A cross-sectional comparison of Jamaica and Colombia

Marshall K Tulloch-Reid ¹, Selena Lewis ¹, Carene Lindsay ¹, Siyi Geng ², Paola Lanza ²,
Jacqueline Duncan ¹, Trevor Ferguson ¹, Patricio Lopez-Jaramillo ^{3 4}, Jose Lopez-Lopez ³,
Farah Allouch ⁵, Lizheng Shi ⁵, Nadia Bennett ¹, Gregorio Sanchez-Vallejo ⁶,
Gustavo Aroca-Martinez ⁷, Jiang He ²

Affiliations [+ expand](#)

PMID: 40951277 PMCID: [PMC12425094](#) DOI: [10.21203/rs.3.rs-7454001/v1](#)

Use of an innovative community-based model for the management and follow-up by non-medical health personnel (PSNM), to improve the awareness, treatment and control of Arterial Hypertension (COTRACO)



PROGRAMA IBEROAMERICANO DE CIENCIA
Y TECNOLOGÍA PARA EL DESARROLLO



El conocimiento
es de todos

Minciencias



FIIBAP FUNDACIÓN PARA
LA INVESTIGACIÓN E
INNOVACIÓN BIOSANITARIA
DE ATENCIÓN PRIMARIA
Servicio Madrileño de Salud



Universidad Autónoma
de Santo Domingo

PRIMADA DE AMÉRICA / Fundada el 28 de octubre de 1538



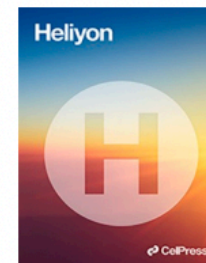
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Heliyon

journal homepage: www.cell.com/heliyon



Research article

Community-based model for management and follow-up by non-physician healthcare workers to improve awareness, treatment, and control of hypertension: The COTRACO study protocol

A.J. Lora Mantilla^a, L.A. Parra Gomez^a, P.A. Camacho-López^a, J. Otero-Wandurraga^b, B. Novella^{c,d,e,f,g}, A. González-Medina^h, O. Valdez-Tiburcio^{h,i}, F. Lanás^j, M.C. Rocha-Lezama^a, J. Alonzo-Arias^h, C. Rivilla-Piñango^e, C. Cáceres-Ramírez^a, S.J. Villabona-Flórez^a, Y.M. Giraldo-Castrillón^b, P. López-Jaramillo^{a,b,*}

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UDES




IN CONVERSATION

Reflections on the reality of reciprocal innovation

Morven Roberts – Chief Executive Officer, GACD

Jasmine Kahla, Kaustubh Joag, Tessa Roberts, and Chiri Kiplagat (Sitting A)

Lana Ray, Patricio Lopez-Jaramillo, and Jose P Lopez-Lopez (Sitting B)



Comfort
break





Visibility?

Funding?

Communication?

Trust and power?

Regulations and
governance?

Contextual fit and
feasibility?

Time and capacity?



PANEL DISCUSSION

Practical steps to make reciprocal innovation the new normal

Moderator: Morven Roberts – Chief Executive Officer, GACD



PANEL DISCUSSION

Practical steps to make reciprocal innovation the new normal



Morven Roberts

Moderator



Garry Aslanyan

ESSENCE on Health
Research (WHO)



Kenneth Yakubu

The George Institute for
Global Health, Australia

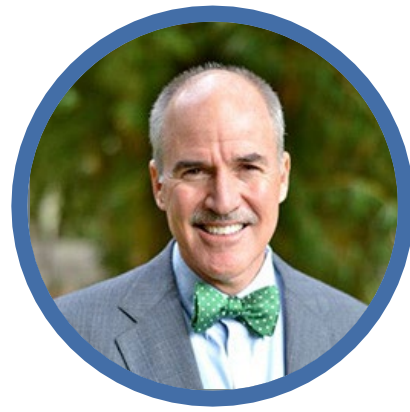


Devina Nand

Ministry of Health, Fiji

PANEL DISCUSSION

Practical steps to make reciprocal innovation the new normal



Peter Kilmarx

Fogarty International Center
(NIH), USA



Ramya Kancharla

Global Coordinating
Mechanism on NCDs (WHO)



Meena Daivadanam

Uppsala Universitet,
Sweden



Jhumka Gupta

George Mason University,
USA

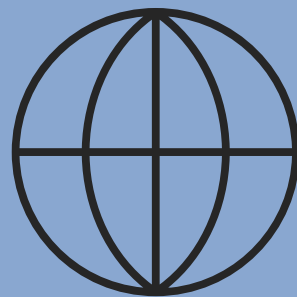
Summary and close

Morven Roberts – Chief Executive Officer, GACD





Reciprocal innovation is a powerful way to think about and conduct NCD implementation research



It is a commitment to equitable partnership, mutual learning, and more sustainable global health outcomes that benefits all nations



How can you embed reciprocal innovation principles in your own research, funding, or practice?



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Thank you!



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