

# Day 1

GACD Annual Scientific Meeting  
Monday 9 June 2025



**GACD**

GLOBAL ALLIANCE FOR CHRONIC DISEASES  
AN ALLIANCE OF HEALTH RESEARCH FUNDERS

Қош келдіңіз  
Qoş keldiñiz

स्वागतम्

환영  
Hwan-yeong

स्वागतम्  
Svāgatam

Fáilte

Witamy

ਸਵਾਗਤ ਹੈ  
Savāgata hai

**Murakaza neza**

ようこそ  
Yōkoso

добре дошли  
dobre doshli

*Bienvenue*

**Welcome**

**Karibu**

ຍິນດີຕ້ອນຮັບ  
Yindī t̄xnṛab

**Bienvenido**

أهلا بك  
'ahlaan bik

欢迎  
Huānyíng

Tervetuloa

Selamat  
datang

خوش آمدید

Afio mai

# Murakaza neza



# Housekeeping

	No fire alarm tests scheduled		Lunch and refreshment breaks
	Nearest emergency exits		Evening socials
	First Aid		Code of Conduct
	Nearest bathrooms		Phones, laptops, devices
	Wi-Fi codes on the table		Who to ask...



Margaret

*Senior Impact & Policy  
Manager*



Morven

*Chief Executive Officer*



Faye

*Operations & Governance  
Manager*



Jane

*Programme Manager*



Izzy

*Research Capacity  
Manager*



Sheree

*Admin & Events Officer*



Ekow

*Communications Officer*



Maisha

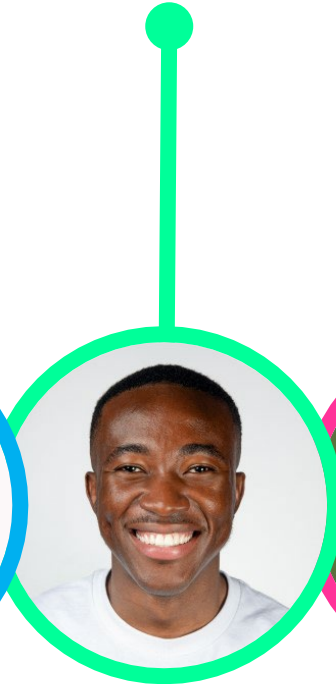
*Diabetes Report author*

Favourite colour is green and loves reading novels on his commute to work

Likes to crochet while watching horror movies

Has a cat called Azura and enjoys travelling

Enjoys pottery and a G&T (not at the same time!)

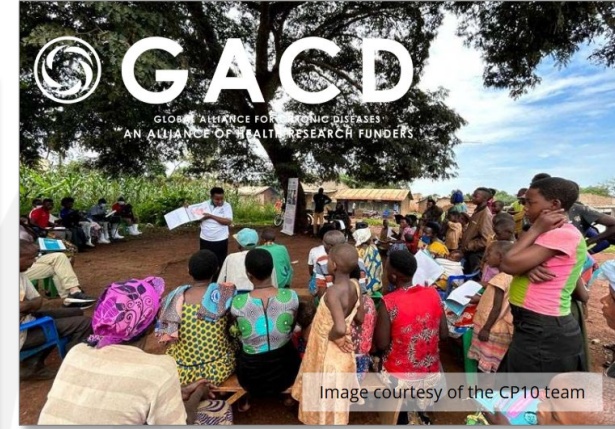


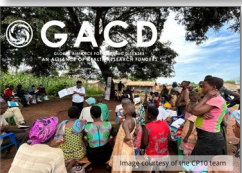
Loves a stand-up comedy show, even more if there's a glass of Pinot Grigio

Enjoys a rom com and learning languages

Enjoys a good hike and drinks the most tea of the GACD team

Likes creative writing with a virgin piña colada on the side





1

Find three new people who match your card and sit together at a table

2

In turn, allow each person at the table to introduce themselves

- Name
- Where they are from (or currently living)

3

Then, share a bit about your GACD project and/or current work **OR** your hobbies, favourite music, food, animal, colour...



~15 minutes



[https://tinyurl.com/  
GACD-2025](https://tinyurl.com/GACD-2025)

Username: delegate2025  
Password: G@CD-asm2025





### Programme reviewers:

Alice Ojwang

Colin Bell

David Ndetei

Edna Juga

Gade Waqa

Jaap Koot

Jacqueline Boyle

Katrina Kissock

Keiko Nakamura

Kim Quimby

Maria Alejandra

Wilches

Nushrat Khan

Pallab Maulik

Sagar Jilka

Seeromanie Harding

Simple Ouma

Sue Crengle

### Research Programme co-chairs:

Bernd Puschner

Josephine Birungi

Katrina Kissock

Arunah Chandran

Lana Ray

Andrew Vallely

Jill Murphy

Simple Ouma

Jacqueline Boyle

Ngozi Idemili-Aronu

Victor Mogre

**And to all our  
speakers, panellists,  
competition  
entrants, judges,  
and delegates!**

Monday


From 9:30am  
**Morning refreshments**

Tuesday

8:30–9:30am  
**Conversation groups**

From 9:30am  
**Morning refreshments**



 Hispanohablantes


Nutrition and food systems

Wednesday

8:30–9:30am  
**Conversation groups**

From 9:30am  
**Morning refreshments**



 Hispanohablantes

Using RE-AIM across GACD projects

Thursday

8:30–9:30am  
**Conversation groups**

From 9:30am  
**Morning refreshments**



 Hispanohablantes

Data privacy and research ethics

Planetary health special interest group

# Monday

10:00–11:00am

## 1. Setting the stage: Orientation and networking

11:00am–12:30pm

## 2. From intervention to implementation strategies

12:30–2:00pm

## Lunch

2:00–4:00pm

## 3. Technical workshops

4:00–4:30pm

## Comfort break

4:30–6:30pm

## 4. Knowledge sharing forum

*With a welcome drinks reception from 5:00pm*

# Tuesday

10:00–10:30am

## 5. CEO's welcome and update

10:30–11:15am

## 6. The policy and patient perspective panel

11:15am–12:00pm

## 7. Partnerships are the essence of implementation research: PRESCRIP-TEC

12:00–1:30pm

## Lunch

1:30–3:30pm

## 8. Research Programme workshops

3:30–4:00pm

## Afternoon refreshments

4:00–6:30pm

## 9. Roundtables and happy hour

# Wednesday

10:00–11:00am

## 10. Joint activities highlights

11:00–12:00pm

## 11. Hot topics in implementation science

12:00–1:30pm

## Lunch

1:30–2:00pm

## Hot topics in implementation science *continued*

2:00–5:00pm

## World Café: Equity across the implementation research community

3:00–3:30pm

*Integrated afternoon refreshment break*

From 6:15 PM **Networking**

From 7:00 PM **Gala Dinner**

# Thursday

10:00–10:30am

## 13. Connecting the dots

10:30–11:15am

## 14. Real world results spotlight: UPSIDES (MH23)

11:15am–12:00pm

## 15. Real world results spotlight: GREAT-4-DIABETES (SU23)

12:00–1:30pm

## Lunch

1:30–3:00pm

## 16. Film festival

3:00–3:30pm

## 17. Prize giving and close

3:30–5:30pm

## Open collaboration space

# Monday

10:00–11:00am

**1. Setting the stage: Orientation and networking**

11:00am–12:30pm

**2. From intervention to implementation strategies**

12:30–2:00pm

**Lunch**

2:00–4:00pm

 **3. Technical workshops**

4:00–4:30pm

**Comfort break**

4:30–6:30pm

**4. Knowledge sharing forum**

*With a welcome drinks reception from 5:00pm*

# Tuesday

10:00–10:30am

**5. CEO's welcome and update**

10:30–11:15am

**6. The policy and patient perspective panel**

11:15am–12:00pm

**7. Partnerships are the essence of implementation research: PRESCRIP-TEC**

12:00–1:30pm

**Lunch**


1:30–3:30pm

 **8. Research Programme workshops**

3:30–4:00pm

**Afternoon refreshments**

4:00–6:30pm

 **9. Roundtables and happy hour**

# Wednesday

10:00–11:00am

**10. Joint activities highlights**

11:00–12:00pm

**11. Hot topics in implementation science**

12:00–1:30pm

**Lunch**

1:30–2:00pm

**Hot topics in science**

2:00–5:00pm

**World C implementation commu**

3:00–3:30pm

**Integrat refreshm**

From 6:00pm

From 7:00pm

# Thursday

10:00–10:30am

**13. Connecting the dots**

**14. Real world results spotlight: UPSIDES (MH23)**

**15. GREAT-4-DIABETES (SU25)**

1:30–3:00pm

**In the Soko Restaurant**

**A: Behaviour change – Kilimanjaro Ballroom**

**B: Study designs – Rubavu Ballroom**

**Knowledge Sharing Competition  
Kilimanjaro Ballroom and Foyer**  
Stream 1 and Stream 2 concurrently

Please set up your entry in advance  
Everyone can vote for their favourite entry

# Monday

10:00–11:00am

**1. Setting the stage: Orientation and networking**

11:00am–12:30pm

**2. From intervention to implementation strategies**

12:30–2:00pm

**Lunch**

2:00–4:00pm

 **3. Technical workshops**

4:00–4:30pm

**Comfort break**

4:30–6:30pm

**4. Knowledge sharing forum**

*With a welcome drinks reception from 5:00pm*

# Tuesday

10:00–10:30am

**5. CEO's welcome and update**

10:30–11:15am

**6. The policy and patient perspective panel**


11:15am–12:00pm

**7. Partnerships are the essence of implementation research: PRESCRIP-TEC**

12:00–1:30pm

**Lunch**


1:30–3:30pm

 **8. Research Programme workshops**

3:30–4:00pm

**Afternoon refreshments**

4:00–6:30pm

 **9. Roundtables and happy hour**

# Wednesday

10:00–11:00am

**10. Joint activities highlights**

11:00–12:00pm

**11. Hot topics in implementation science**

12:00–1:30pm

**Lunch**

1:30–2:00pm

**Hot topics in implementation science continued**

2:00–5:00pm

**World Café: Equity across the implementation research community**

3:00–3:30pm

*Integrated afternoon refreshment break*

From 6:15 PM **Networking**

From 7:00 PM **Gala Dinner**

# Thursday

**A: Scale Up projects**

**15. Connecting the dots**

**B: Cancer projects**

**Spotlight:**

**LIPSIDES (MH23)**

**C: Life Course and Mental Health projects**

**15. Real world results spotlight: (23)**

**D: Healthy Cities projects**

**Lunch**

1:30–3:00pm

**Principal investigators' roundtable**

**Educators' roundtable**

**Indigenous Populations special interest group**

**GACD projects in Nepal**

# Monday

10:00–11:00am

**1. Setting the stage: Orientation and networking**

11:00am–12:30pm

**2. From intervention to implementation strategies**

12:30–2:00pm

**Lunch**

2:00–4:00pm

 **3. Technical workshops**

4:00–4:30pm

**Comfort break**

4:30–6:30pm

**4. Knowledge sharing forum**

*With a welcome drinks reception from 5:00pm*

# Tuesday

10:00–10:30am

**5. CEO's welcome and update**

10:30–11:15am

**6. The policy and patient perspective panel**

11:15am–12:00pm

**7. Partnerships are the essence of implementation research: PRESCRIP-TEC**

12:00–1:30pm

**Lunch**


1:30–3:30pm

 **8. Research Programme workshops**

3:30–4:00pm

**Afternoon refreshments**

4:00–6:30pm

 **9. Roundtables and happy hour**

# Wednesday

10:00–11:00am

**10. Joint activities highlights**

11:00–12:00pm

**11. Hot topics in implementation science**

12:00–1:30pm

**Lunch**

1:30–2:00pm

**Hot topics in implementation science** *continued*

2:00–5:00pm

**World Café: Equity across the implementation research community**

3:00–3:30pm

*Integrated afternoon refreshment break*

From 6:15 PM **Networking**

From 7:00 PM **Gala Dinner**

# Thursday

10:00–10:30am

**13. Connecting the dots**

10:30–11:15am

**14. Real world results spotlight: UPSIDES (MH23)**

11:15am–12:00pm

**15. Real world results spotlight: GREAT-4-DIABETES (SU23)**

12:00–1:30pm

**Lunch**

1:30–3:00pm

**16. Film festival**

3:00–3:30pm

**17. Prize giving and close**

3:30–5:30pm

**Open collaboration space**

# Monday

10:00–11:00am

**1. Setting the stage: Orientation and networking**

11:00am–12:30pm

**2. From intervention to implementation strategies**

12:30–2:00pm

**Lunch**

2:00–4:00pm

 **3. Technical workshops**

4:00–4:30pm

**Comfort break**

4:30–6:30pm

**4. Knowledge sharing forum**

*With a welcome drinks reception from 5:00pm*

# Tuesday

10:00–10:30am

**5. CEO's welcome and update**

10:30–11:15am

**6. The policy and patient perspective panel**

11:15am–12:00pm

**7. Partnerships are the essence of implementation research: PRESCRIP-TEC**

12:00–1:30pm

**Lunch**


1:30–3:30pm

 **8. Research Programme workshops**

3:30–4:00pm

**Afternoon refreshments**

4:00–6:30pm

 **9. Roundtables and happy hour**

# Wednesday

10:00–11:00am

**10. Joint activities highlights**

11:00–12:00pm

**11. Hot topics in implementation science**

12:00–1:30pm

**Lunch**

1:30–2:00pm

**Hot topics in implementation science** *continued*

2:00–5:00pm

**World Café: Equity across the implementation research community**

3:00–3:30pm

*Integrated afternoon refreshment break*

From 6:15 PM **Networking**

From 7:00 PM **Gala Dinner**

# Thursday

10:00–10:30am

**13. Connecting the dots**

10:30–11:15am

**14. Real world results spotlight: UPSIDES (MH23)**

11:15am–12:00pm

**15. Real world results spotlight: GREAT-4-DIABETES (SU23)**

12:00–1:30pm

**Lunch**

1:30–3:00pm

**16. Film festival**

3:00–3:30pm

**17. Prize giving and close**

3:30–5:30pm

**Open collaboration space**

## Ingredients

300g [strong white bread flour](#), plus extra for dusting

1 tsp [instant yeast](#)

1 tbsp [olive oil](#)

### For the tomato sauce

1 tbsp [olive oil](#), plus a drizzle

2 [garlic cloves](#), crushed

200ml passata

### For the topping

8 mozzarella pearls, halved

small bunch [fresh basil](#)

## Method

### STEP 1

Tip the flour into a bowl, then stir in the yeast and 1 tsp salt. Make a well in the centre and pour in 200ml warm water (make sure it's not too hot) along with the oil. Stir together with a wooden spoon until you have a soft, fairly wet dough.

### STEP 2

Tip the dough out onto a lightly floured surface and knead for 5 mins until smooth. Cover with a tea towel and set aside for an hour or so until the dough has puffed up and doubled in size. You can also leave the rough, unkneced dough in the bowl, cover with a tea towel and leave in the fridge overnight and the dough will continue to prove on its own.

### STEP 3

Meanwhile, make the tomato sauce. Put the oil in a small pan and fry the garlic briefly (don't let it brown), then add the passata and simmer everything until the sauce thickens a little. Leave to cool.

### STEP 4

Once the dough has risen, knead it quickly in the bowl to knock it back, then tip out onto a lightly floured surface and cut into two balls. Roll out each ball into a large teardrop that is very thin and about 25cm across (teardrop shapes fit baking sheets more easily than rounds).

### STEP 5

Heat oven to 240C/220C fan/ gas 9 with a large [baking sheet](#) inside. Lift one of the bases onto another floured baking sheet. Smooth the sauce over the base with the back of a spoon, scatter over half the mozzarella, drizzle with olive oil and season. Put the pizza, still on its baking sheet, on top of the hot sheet in the oven and bake for 8-10 mins until crisp.



### Ingredients

300g [strong white bread flour](#), plus extra for dusting

1 tsp [instant yeast](#)

1 tbsp [olive oil](#)

#### For the tomato sauce

1 tbsp [olive oil](#), plus a drizzle

2 [garlic cloves](#), crushed

200ml passata

#### For the topping

8 mozzarella pearls, halved

small bunch [fresh basil](#)

### Method

#### STEP 1

Tip the flour into a bowl, then stir in the yeast and 1 tsp salt. Make a well in the centre and pour in 200ml warm water (make sure it's not too hot) along with the oil. Stir together with a wooden spoon until you have a soft, fairly wet dough.

#### STEP 2

Tip the dough out onto a lightly floured surface and knead for 5 mins until smooth. Cover with a tea towel and set aside for an hour or so or until the dough has puffed up and doubled in size. You can also leave the rough, unkneced dough in the bowl, cover with a tea towel and leave in the fridge overnight and the dough will continue to prove on its own.

#### STEP 3

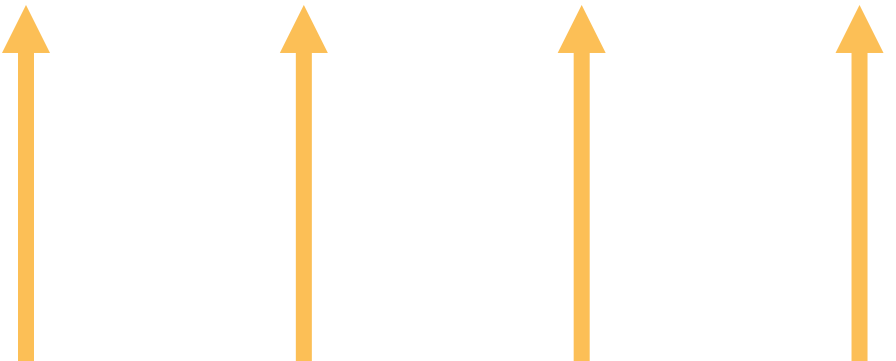
Meanwhile, make the tomato sauce. Put the oil in a small pan and fry the garlic briefly (don't let it brown), then add the passata and simmer everything until the sauce thickens a little. Leave to cool.

#### STEP 4

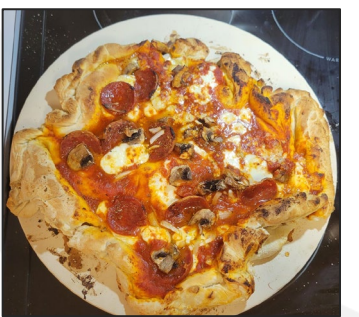
Once the dough has risen, knead it quickly in the bowl to knock it back, then tip out onto a lightly floured surface and cut into two balls. Roll out each ball into a large teardrop that is very thin and about 25cm across (teardrop shapes fit baking sheets more easily than rounds).

#### STEP 5

Heat oven to 240C/220C fan/ gas 9 with a large [baking sheet](#) inside. Lift one of the bases onto another floured baking sheet. Smooth the sauce over the base with the back of a spoon, scatter over half the mozzarella, drizzle with olive oil and season. Put the pizza, still on its baking sheet, on top of the hot sheet in the oven and bake for 8-10 mins until crisp.

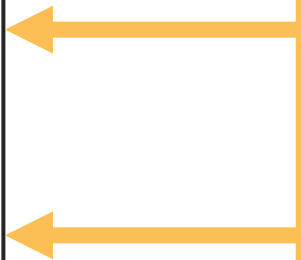
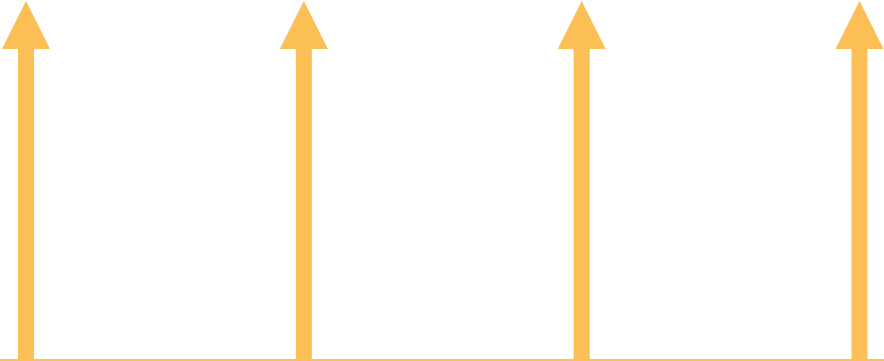


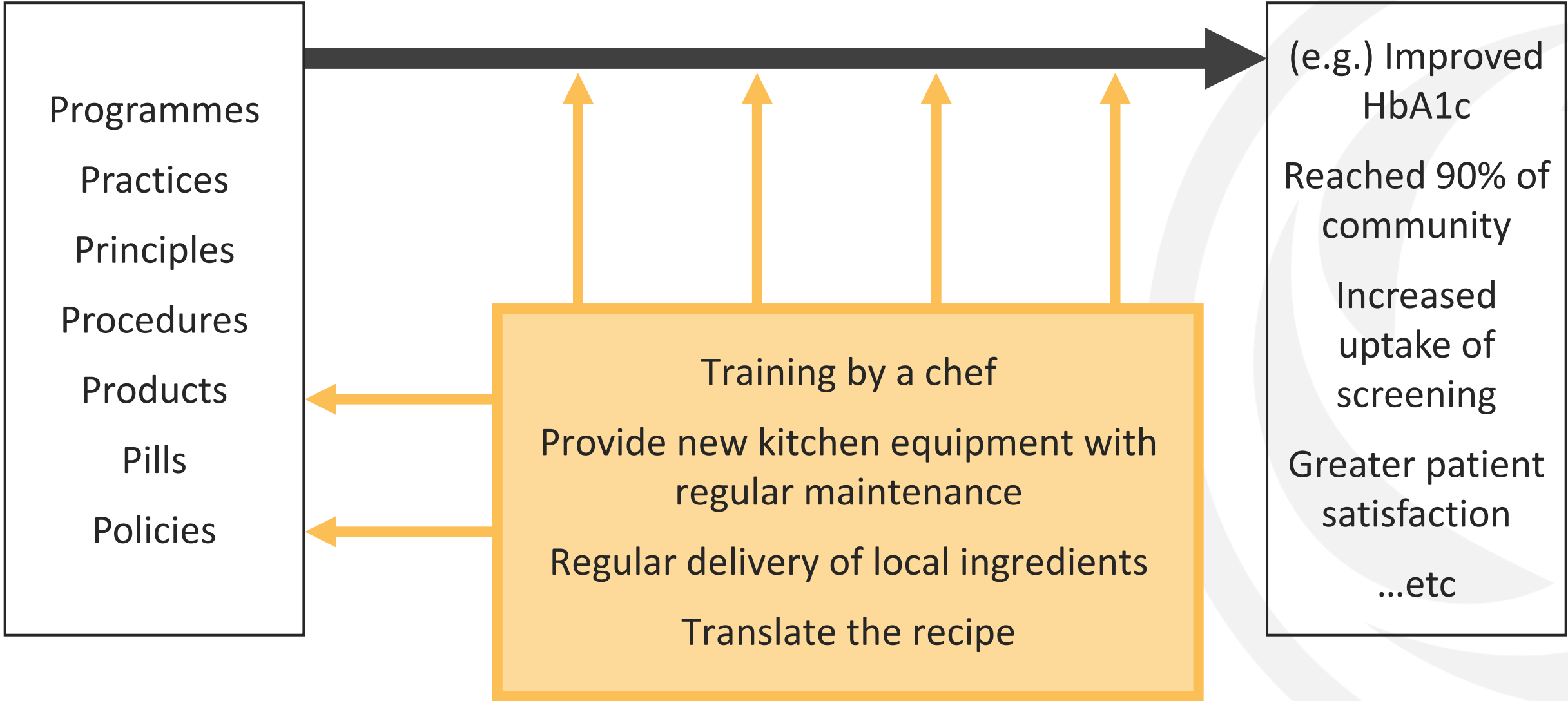
Training by a chef  
Provide new kitchen equipment with regular maintenance  
Regular delivery of local ingredients  
Translate the recipe

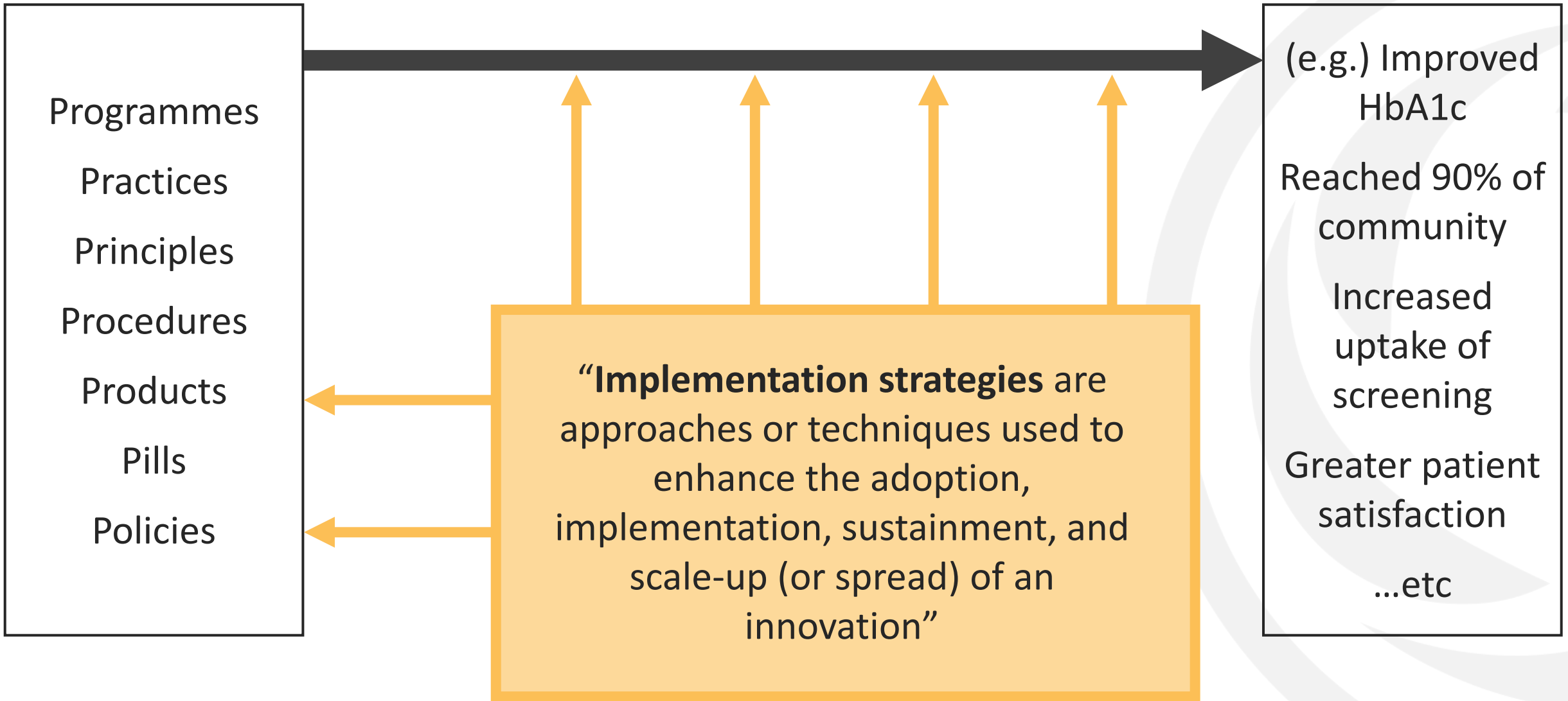


- Programmes
- Practices
- Principles
- Procedures
- Products
- Pills
- Policies

Training by a chef  
Provide new kitchen equipment with regular maintenance  
Regular delivery of local ingredients  
Translate the recipe







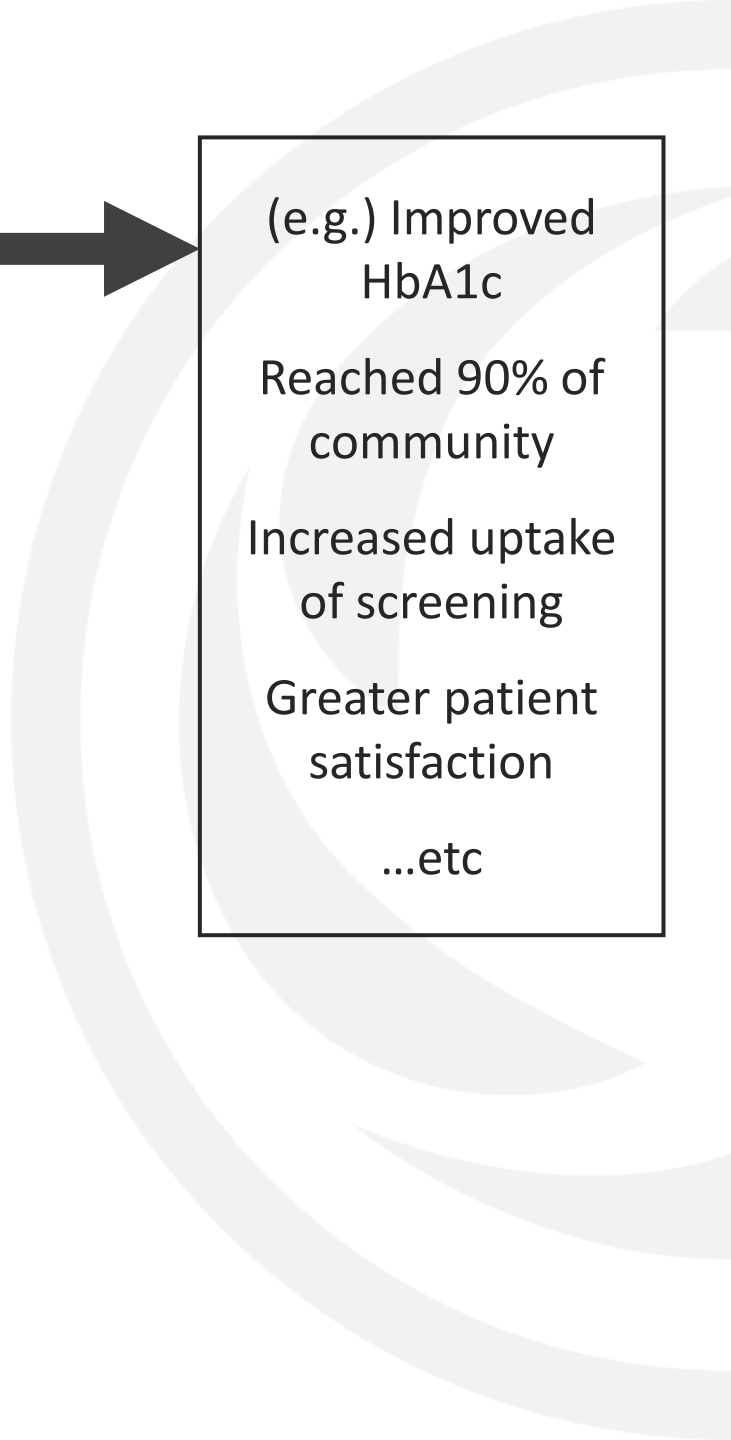
- Programmes
- Practices
- Principles
- Procedures
- Products
- Pills
- Policies



**“Implementation strategies** are approaches or techniques used to enhance the adoption, implementation, sustainment, and scale-up (or spread) of an innovation”

- (e.g.) Improved HbA1c
- Reached 90% of community
- Increased uptake of screening
- Greater patient satisfaction
- ...etc

**“Interventions”** ?



1

When you talk about ‘**interventions**’ in your implementation research project, what do you mean by this? What other terms do you use?

2

Is the **distinction** between **evidence-based intervention** and **implementation strategies** always clear?

# Homonymy

Same term  
Multiple meanings

## Scaling up (or upscaling?)

“Deliberate efforts to increase the impact of successfully tested health interventions so as to benefit more people and to foster policy and program development on a lasting basis”

WHO  
ExpandNet  
(2010)

**Scaling up:** Achieve greater numbers through adoption of the innovation

UNDP blog  
(2022)

**Scaling out:** Institutional and policy changes through adoption of the innovation

**Scaling deep:** Impacting culture through innovation that alters behaviours and norms

**Type I scale out:** Population fixed, different delivery system

**Type II scale out:** Delivery system fixed, different population

**Type III scale out:** Different population and delivery system

Aarons GA et al. (2017)  
Implementation Sci 12, 111

# Synonymy

Different terms  
Same or overlapping meaning

## Focus group discussion

- ✓ In-depth group interview
- ✓ Qualitative group discussion
- ✓ Targeted roundtable discussion
- ✓ User feedback session
- ✓ Collaborative exploration meeting
- ✓ Service perception workshop
- ✓ Thematic discussion group
- ✓ Guided group conversation
- ✓ Consumer insight forum
- ✓ Interactive feedback panel
- ✓ Guided group dialogue
- ✓ Product experience dialogue
- ✓ ...

# Leeman and colleagues (2017) = five categories

Dissemination  
strategies

Implementation  
process  
strategies

Integration  
strategies

Capacity  
building  
strategies

Scale up  
strategies



# The 'ERIC' project = 73 strategies (nine groups)

Evaluative and iterative strategies

Interactive assistance

Adapt and tailor to context

Develop stakeholder interrelationships

Train and educate stakeholders

Support clinicians

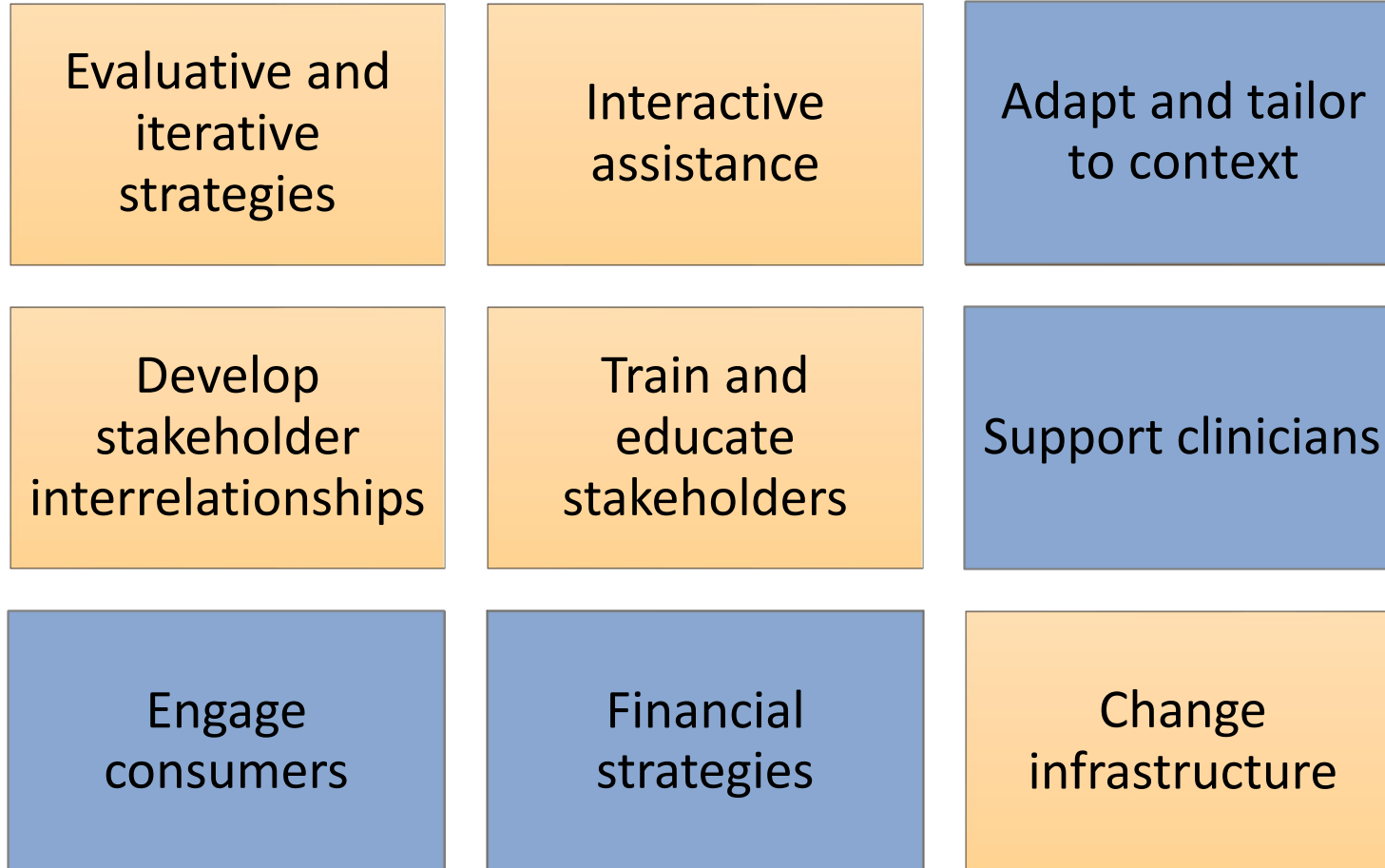
Engage consumers

Financial strategies

Change infrastructure



# How do frontline healthcare providers understand the 73 'ERIC' implementation strategies?



3

Same term,  
different meanings

Different terms,  
same meaning

What examples of **homonymy**, **synonymy**, or other **miscommunications** have you observed in your project or in the literature?

4

Do you use any **standardised categories** to describe your implementation strategies? Why or why not?

# From intervention to implementation strategies



**Arunah Chandran – International Agency for Research on Cancer (IARC/WHO), France**

**Darcelle Schouw – Stellenbosch University, South Africa**

# Reflections on questions 1 to 4...

1

When you talk about ‘**interventions**’ in your implementation research project, what do you mean by this? What other terms do you use?

2

Is the **distinction** between evidence-based intervention and implementation strategy always clear?

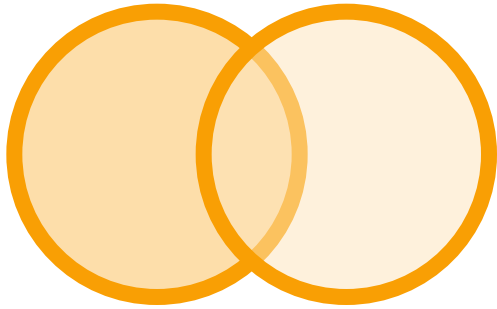
3

What examples of **homonymy**, **synonymy**, or other **miscommunications** have you observed in your project or in the literature?

4

Do you use any **standardised categories** to describe your implementation strategies? Why or why not?

## Overlapping terms



Terms like

***intervention***  
***programme***  
***initiative***  
***strategy***

are often used interchangeably,  
complicating the issue.

## Blurry lines



Interventions and  
implementation strategies are  
often complex, involving  
multiple components that  
interact with each other.

The philosophical and practical  
distinctions between them  
become blurry.

## Lack of clarity



Papers often lack key details on  
interventions and/or  
implementation strategies.

Elements such as dosage,  
duration, and delivery may be  
absent.

This makes it difficult to  
understand, replicate, and  
synthesise studies.

# What is GREAT for Diabetes?

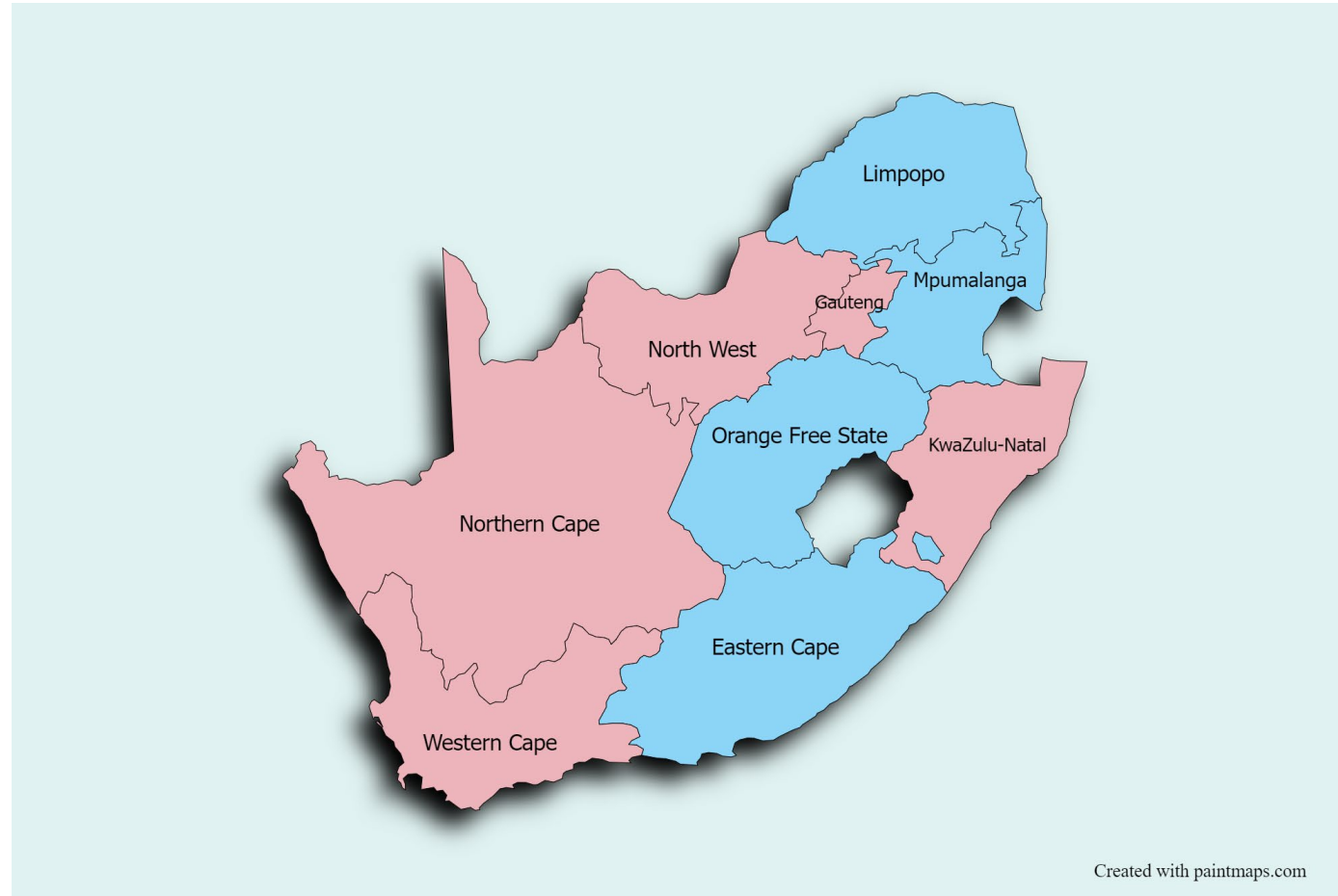


# What is GREAT for Diabetes?

- Group empowerment
- Four sessions
- 1-2 hours
- 10-15 people
- Trained facilitators
- Guiding style
- Resources for engagement and gamification



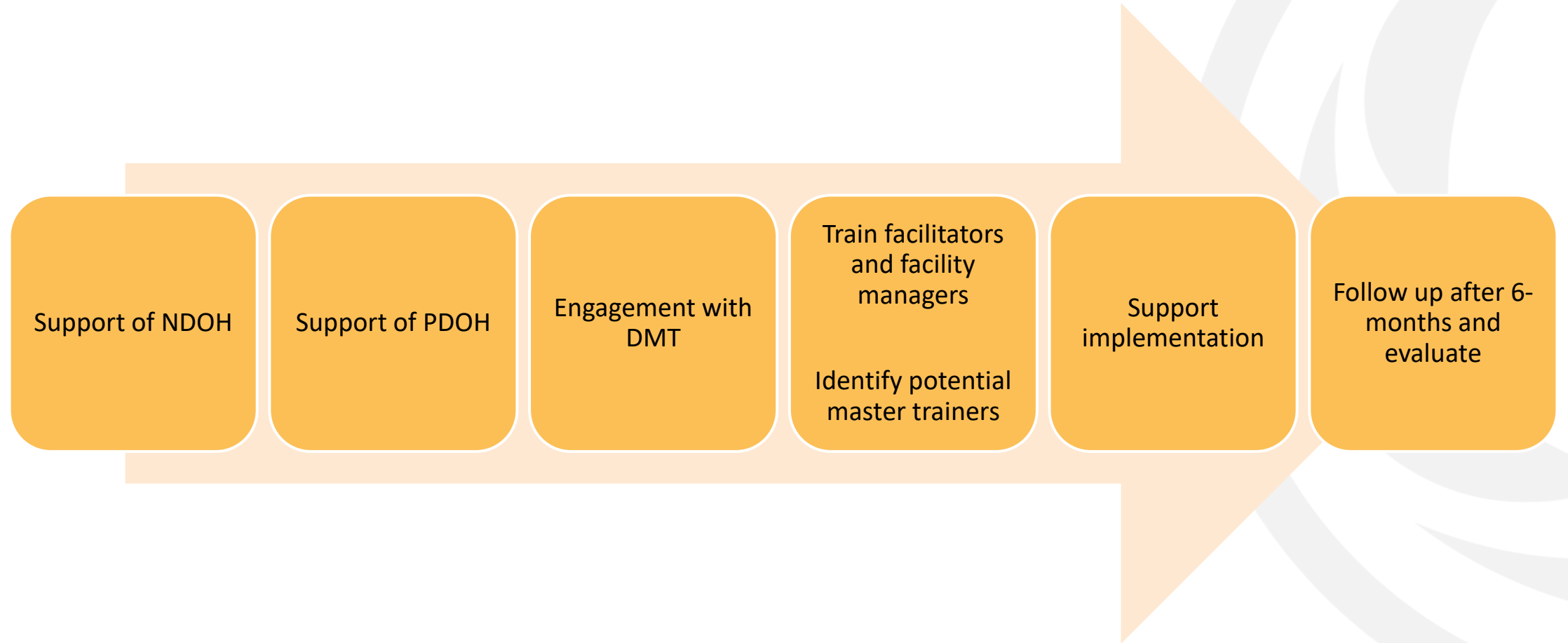
# Implementation of GREAT for Diabetes 2019-2022



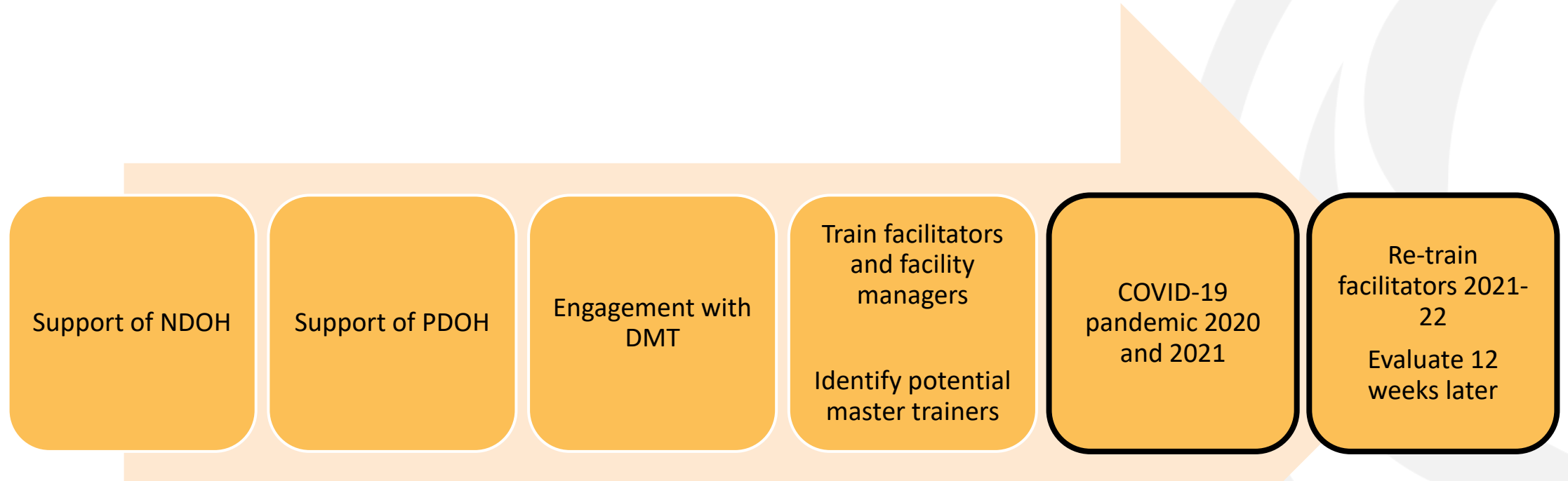
# Gold standard(s) for health education – proven elsewhere

Component	GREAT for Diabetes	DSMES / DESMOND
Structure	Structured, low-resource adapted	Structured, nationally accredited
Facilitators	Nurses & health workers	Certified educators
Focus	Empowerment, self-care, lifestyle	Self-management, psychosocial support
Follow-Up	Limited	Integrated into ongoing care
Cultural Fit	Locally tailored	Adapted across contexts

# Implementation strategy



# Implementation strategy after COVID-19

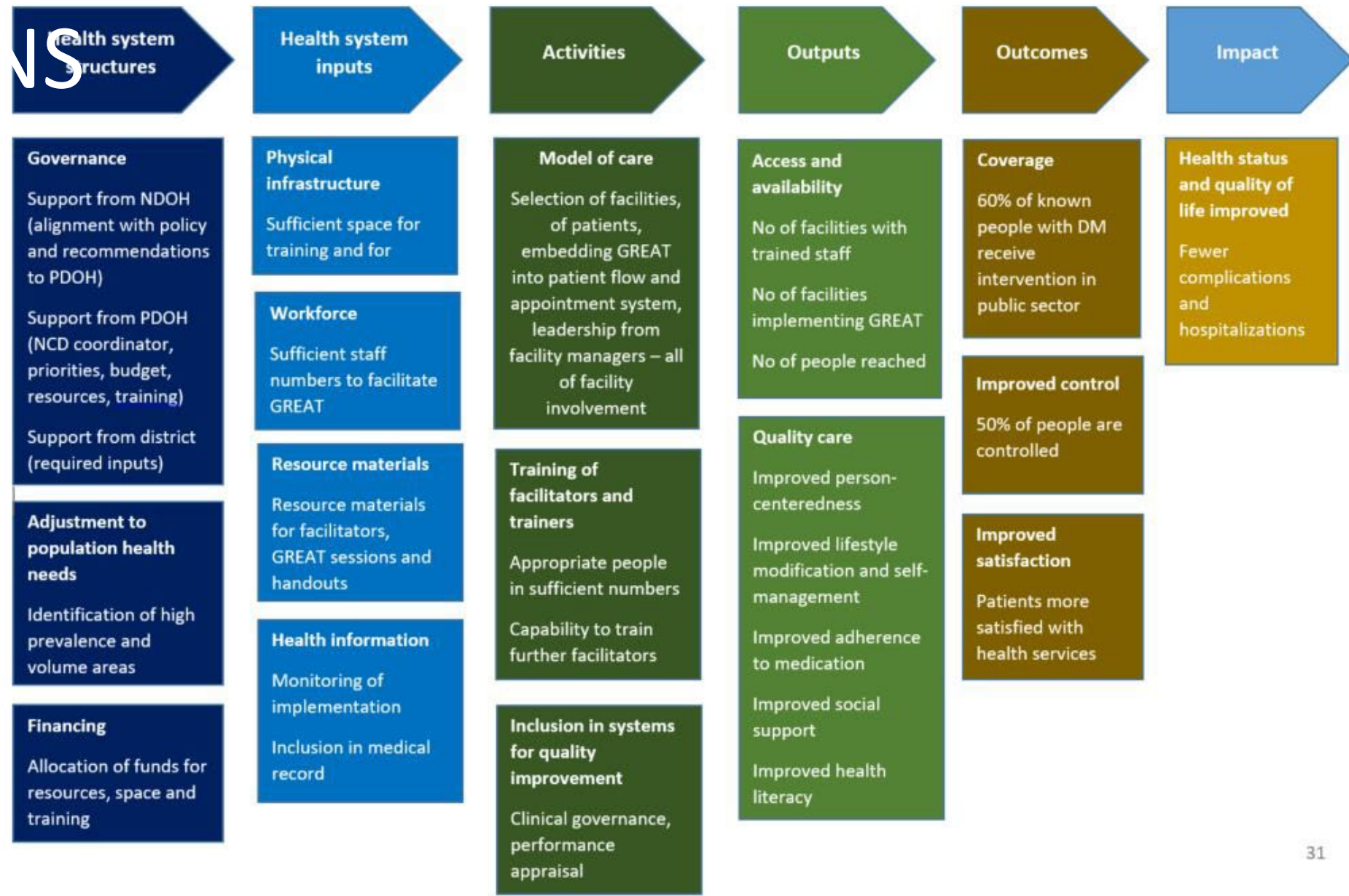


**Living GREAT with Diabetes initiative¶  
·Implementation strategy¶**

**Name of facility:¶**

¶	<u>Example:¶</u>	<u>Your facility:¶</u>
<b>Leadership¶</b>	<i>Facility manager/Operational manager/Family Physician---a champion is clearly identified¶</i>	¶
<b>Facilitators¶</b>	<i>Ensure sufficient people are trained to share facilitation, cover for leave and loss¶</i>	¶
<b>Space¶</b>	<i>Room with chairs for everyone to sit in a circle---identify where the group can meet, could even be a community venue. ¶ ¶</i>	¶
<b>Target groups¶</b>	<i>New and poorly controlled diabetics (HbA1c ≥ 10% is a suggestion)¶</i>	¶
<b>Patient flow and who must do what¶</b>	<ul style="list-style-type: none"> <li>• → <i>Appropriate patients identified during routine consultation by clinicians. ¶</i></li> <li>• → <i>Patient informed of GREAT and in file document patient must attend.</i></li> </ul>	¶

# Theory of change



## Outputs

### Access and availability

No of facilities with trained staff

No of facilities implementing GREAT

No of people reached

### Quality care

Improved person-centeredness

Improved lifestyle modification and self-management

Improved adherence to medication

Improved social support

Improved health literacy

# Access and availability

Province	Number of facilities implemented	Number of facilities planning to implement	Number of facilities not planning to implement	Number of patients reached
KwaZulu-Natal	3	7	1	37
Western Cape	6	2	0	435
North-West	2	6	0	40
Northern Cape	2	6	1	39
Gauteng JB	1	10	0	37
Gauteng TSH	0	7	0	37
<b>TOTAL</b>	<b>17</b>	<b>38</b>	<b>2</b>	<b>625</b>

# Expected outputs, outcomes and impact



# Adoption of GREAT for Diabetes: Key Insights

- **National Endorsement:** The NDOH found the initiative appropriate, acceptable, and aligned with national policy—supporting empowerment, quality of life, and person-centred care.
- **Provincial Uptake:** Five provinces adopted GREAT due to its evidence-based design, focus on social support, behaviour change, and alignment with HIV/AIDS strategies for chronic care.
- **District-Level Support:** District and facility managers acknowledged rising diabetes cases and supported the initiative for its potential to boost adherence, reduce medication use, and resolve organisational barriers.

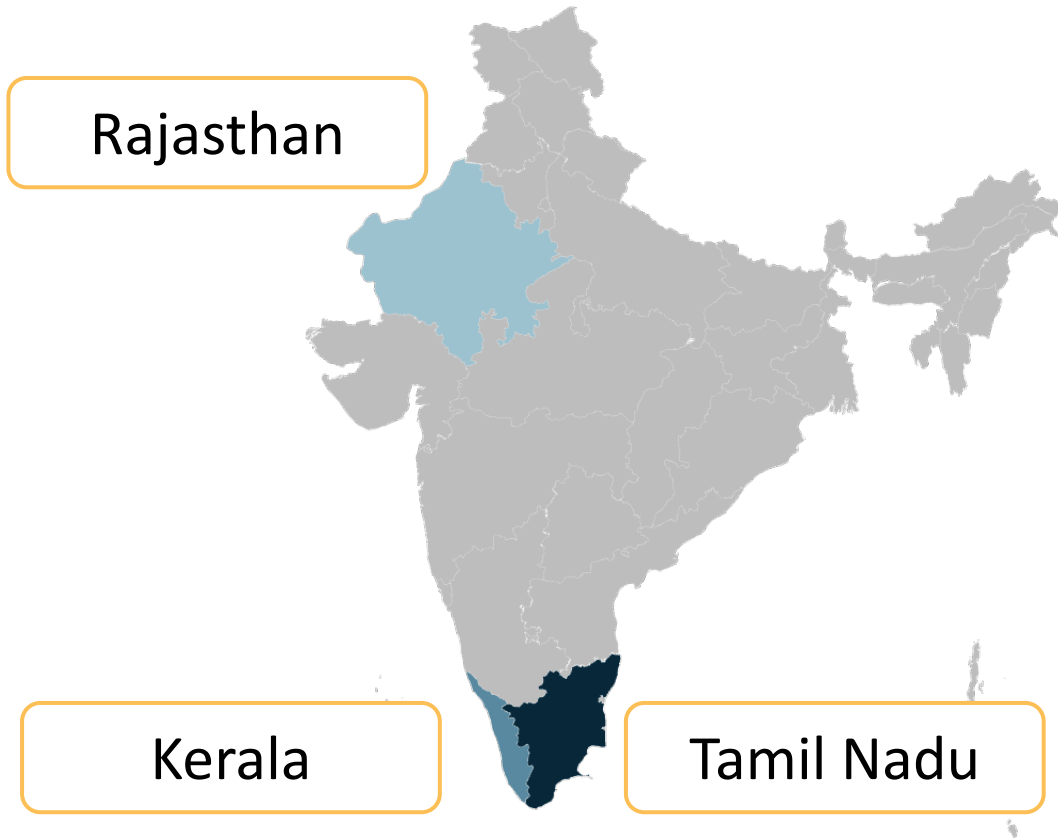
# Challenges of adoption across the provinces

- **Communication Gaps:** Some provinces did not adopt the programme due to a lack of communication from the NDOH and the GREAT team.
- **Leadership & Coordination Issues:** Absence of NCD coordinators, staff retirements, and lack of coherent programme leadership hindered adoption.
- **Internal Politics & Funding Constraints:** Political dynamics and insufficient funding disrupted decision-making and implementation readiness.
- **Missed Opportunities Despite Support:** Non-adopting provinces recognized the programme's value, and district managers saw its potential to improve adherence and reduce medication burden, but systemic barriers limited action.

# Sustainability of GREAT for Diabetes: Key Insights

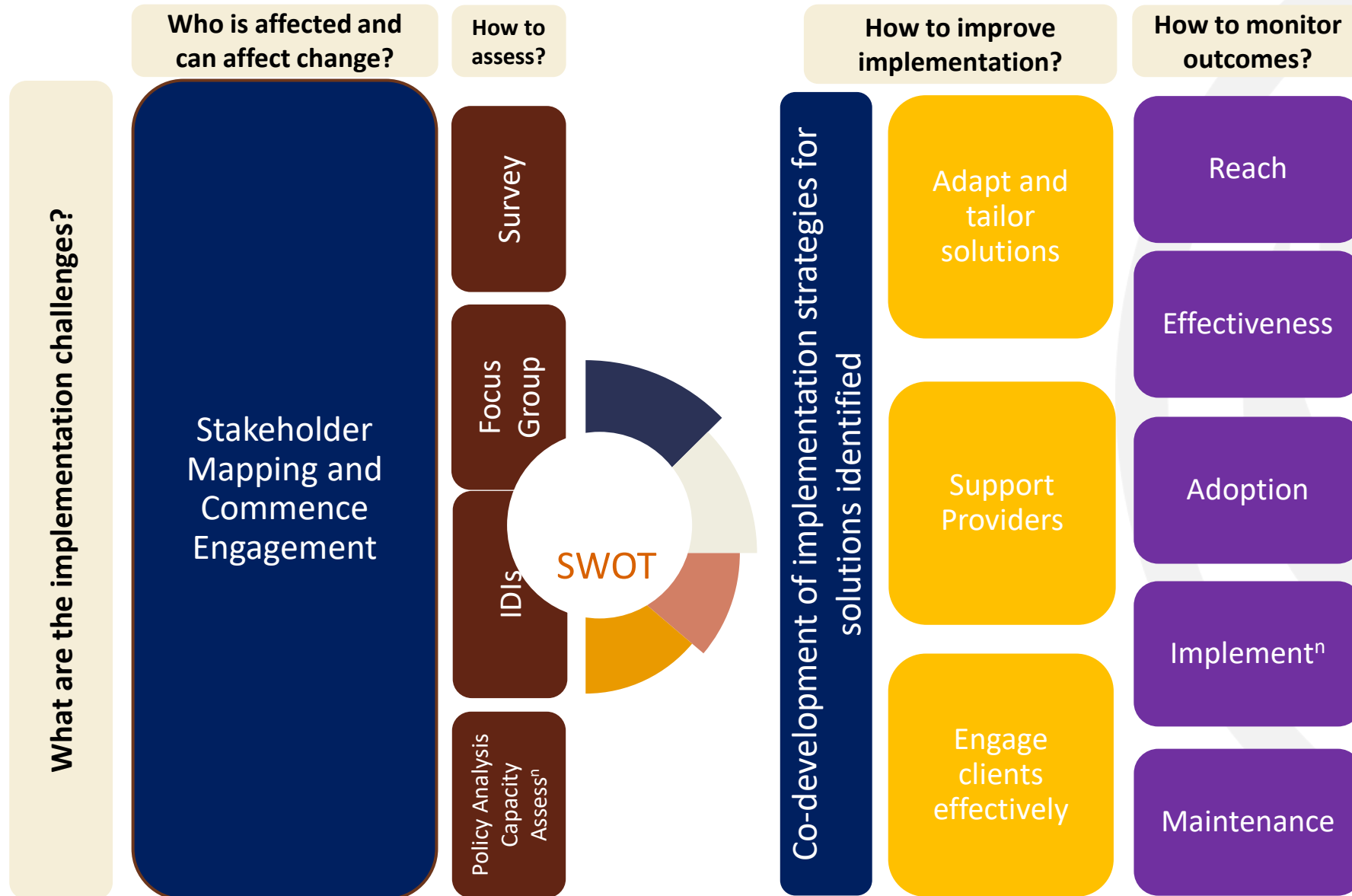
- **Success in Western Cape:** Sustainability and scalability were strongest in the Western Cape, supported by close relationships between university-based implementers and district managers, as well as health service prioritisation of patient empowerment.
- **Critical Enablers:** Engaging facility managers, motivating staff, and anticipating planning challenges were confirmed as key factors for sustainable implementation, aligning with the programme's theory of change.
- **Future Opportunities:** Expansion into community settings could enhance patient support and prevention efforts. There's also potential to adapt the programme to assist with insulin initiation.

# What is **Access Cancer Care India**?



To design and evaluate a strategy, integrated, and contextualised to the local health system, to improve access to the early detection and care continuum for oral, breast and cervical cancers among rural population in India.

# What is Access Cancer Care India?



# THEORY OF CHANGE

Capacity Assessment

Barrier Assessment

Stakeholder Engagement

Co-develop implementation plan and tools

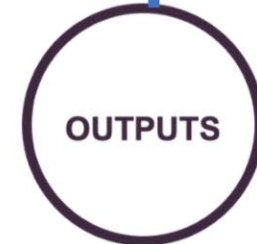


## ASSUMPTIONS

- ✓ Tamil Nadu has a high burden of cancer
- ✓ Current strategies lacks effectiveness and results in late-stage presentation.
- ✓ Strengthening early diagnosis and screening will lead to downstaging and improvement in survival
- ✓ Readiness to change from the health system perspective resulting in its potential sustainable integration within the health system.

## PRE-CONDITIONS

- ✓ Need for improvement exists
- ✓ Network to operate
- ✓ Health professionals willing to participate
- ✓ Stakeholders can identify existing barriers to screening systems and care pathways to be addressed



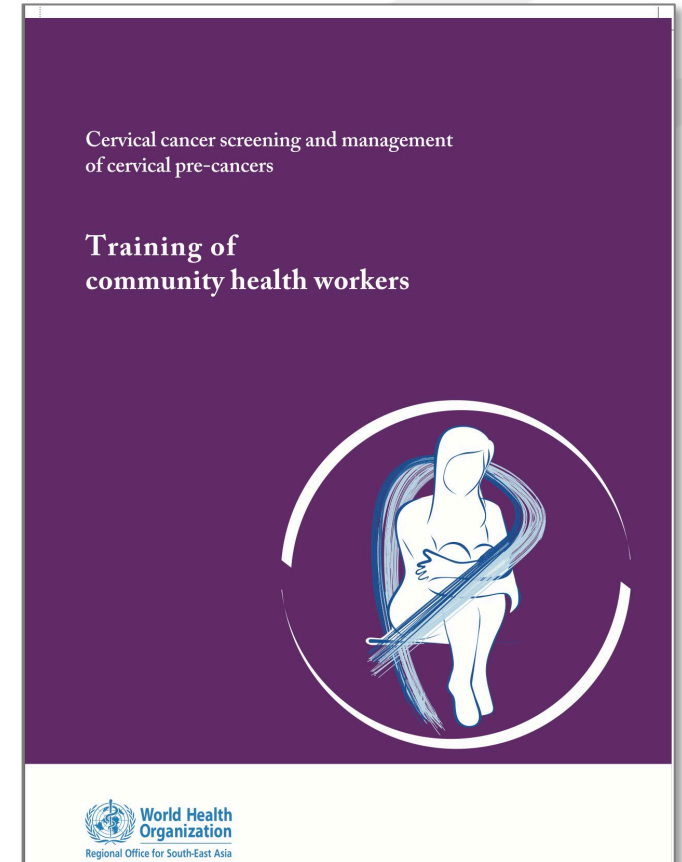
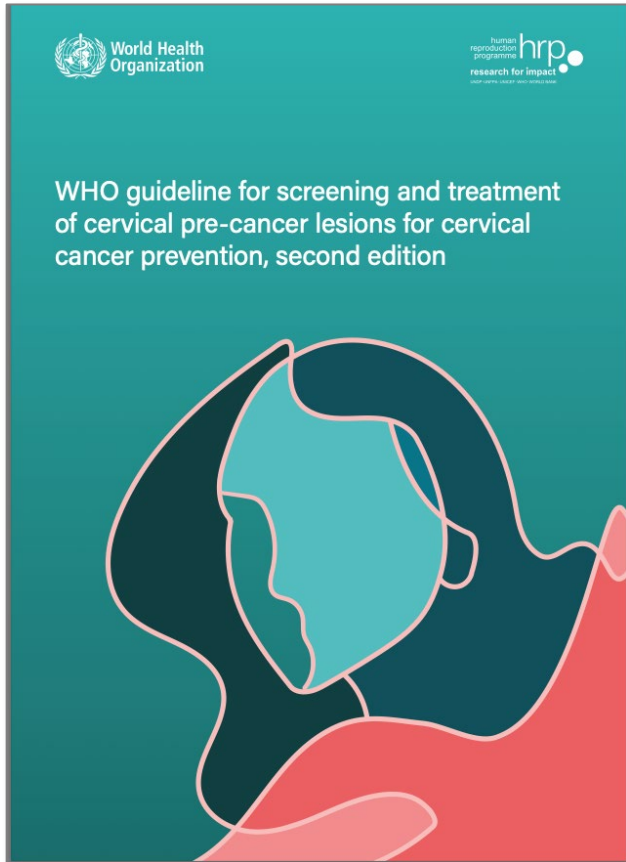
IMPLEMENTED MULTI\_PRONGED  
EARLY DETECTION STRATEGY

- CAPACITY BUILDING OF HEALTHCARE WORKERS
- BEHAVIOUR CHANGE COMMUNICATION
- INTRODUCTION OF SCREENING (FOCUS ON HPV TESTING) AND PATIENT NAVIGATION

OUR IMPACT

Stage Shifting and Improved Survival

CAPACITY BUILDING | EVIDENCE-BASED INTERVENTIONS | SUSTAINED ENGAGEMENT  
CROSS CUTTING THEMES:



Tools and guidelines that illustrates gold standard interventions in cervical cancer elimination



## General population survey

- How do they access care?
- What barriers and opportunities are there to improve screening behaviour?
- How can we help?



## Cancer Patient Survey

- How was their journey like?
- Did they experience delays in care? What were their main barriers to care? What helped? (Healthcare access and barriers)
- Knowledge and health-Seeking Behaviour
- Would they be willing to share experiences so that we can help future patients?



## Focus group discussions: community health workers and community groups

- What do they feel about their current work?
- Are they open to learning innovative solutions?
- How can we help?

## Lack of support at higher centers

- Navigation at higher centers
- Indirect costs at higher centres
- Delay in care

*“Some ladies think that why should we suffer? If we go to the hospital, they would ask us to go here and there, so it is better to stay home”*



## Program Focus and awareness

- Lack of awareness and training
- Focus on other NCDs
- Influence of social media

*“We haven't received any formal training, when we go to the hospital, we read pamphlets and gain some information, which helps us gain some knowledge”*



## Rigid customs & beliefs

- Fear, stigma & misconceptions
- Native treatment
- Limited health literacy

*“Once there was a situation where we waited for the local Bauji (Ojha) to give a nod to the referral advice that I gave. It is deep-rooted in their minds, some believe them more than us”*



# BARRIERS IN FACILITATING CANCER CARE

## Treatment & Referral

- Limited health infrastructure
- Negative communications
- Fragmented referral systems
- Transportation challenges

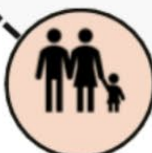
*“We conduct camps just for the count, only a very few people attend these camps, a few are not interested, while the majority lack the knowledge”*



## Role of family support

- Family hierarchy
- Male centric decision making
- Societal expectations
- Financial constraints

*“When we ask them for a screening test, firstly, they will take the advice of her husband or mother-in-law and then they will be like - Why do you want to do this test?”*



## Acceptability & Accessibility

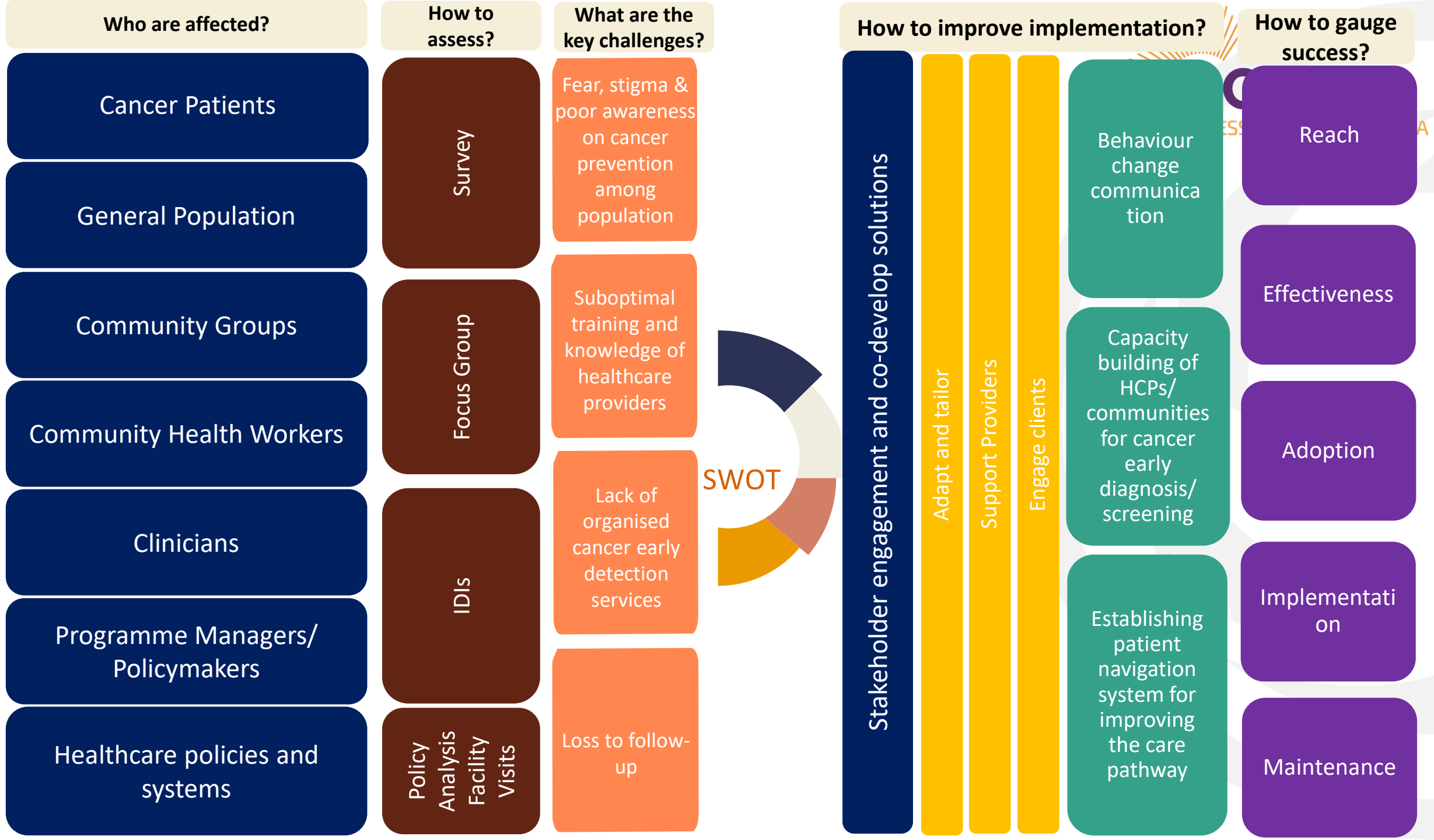
- Fear of getting diagnosed
- Accessibility to screening sites
- Loss of wages

*“There are two different responses when we go to a village. If the information spreads positively, they will voluntarily come for screening. If it spreads negatively, whatever we say, they will not try to understand”*





Co-develop solutions for improvement of cancer early detection services



**Who are affected?**

**How to assess?**

**What are the key challenges?**

**How to improve implementation?**

**How to gauge success?**

Cancer Patients

General Population

Community Groups

Community Health Workers

Clinicians

Programme Managers/  
Policymakers

Healthcare policies and  
systems

Survey

Focus Group

IDIs

Policy  
Analysis  
Facility  
Visits

Fear, stigma & poor awareness on cancer prevention among population

Suboptimal training and knowledge of healthcare providers

Lack of organised cancer early detection services

Loss to follow-up

SWOT

Stakeholder engagement and co-develop solutions

Adapt and tailor

Support Providers

Engage clients

Behaviour change communication

Capacity building of HCPs/ communities for cancer early diagnosis/ screening

Establishing patient navigation system for improving the care pathway

Reach

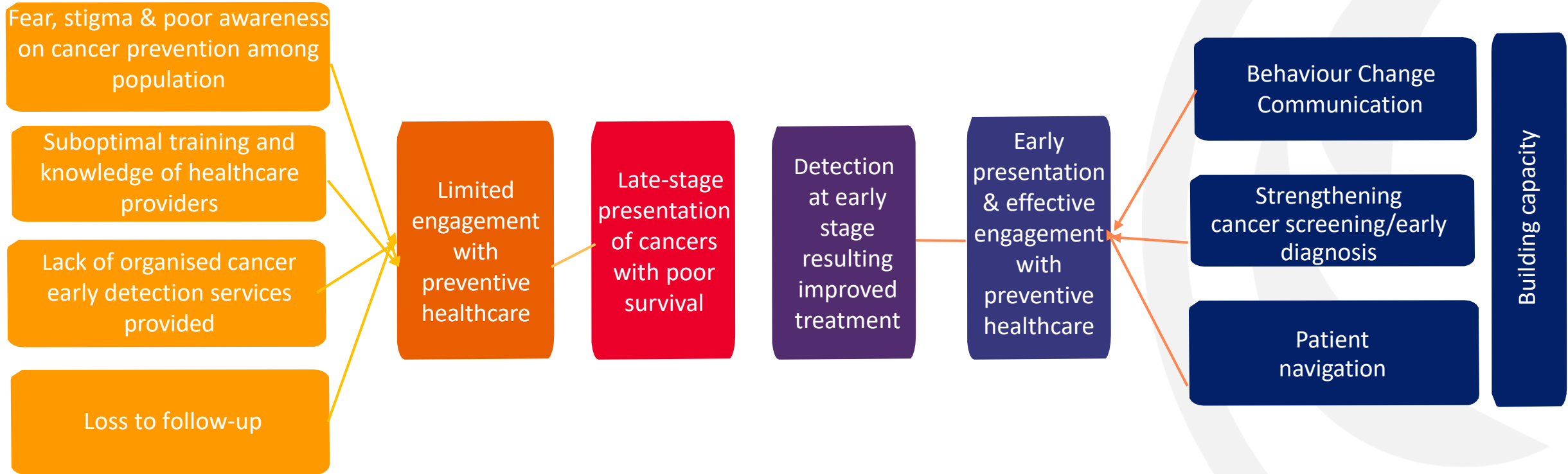
Effectiveness

Adoption

Implementation

Maintenance

# Turning barriers into solutions/strategies



We used a problem tree to identify goals and potential interventions and activities. The ideas generated were explored with the community and other stakeholders, to consider their feasibility.

# LOGIC MODEL

INPUT	ACTIVITIES	OUTPUTS	OUTCOMES	IMPACT
HPV self-sampling kit (Copan Swab)	Conduct home-based HPV self-sampling.	Number of women invited to participate	Increased participation in cervical cancer screening	Early detection of cancer cases
Point of care testing laboratory – Truenat platform, HPV-HR test Kit	HPV self-sampling at the facility	Number of HPV tests conducted.		
Project Staff (Health workers) and NCD Nurse	Transport samples to the testing laboratory.	Number of test positive women		
SMS communication system, Screening cards	Perform HPV testing	Number of referrals for further assessment.		
Training materials	Communicate screening results via SMS and personal communication for positive results and referral/navigation	Number of precancers/cancers detected through screening		
Budget for materials, logistics, incentives		Pre-cancers and cancers treated	Early detection of cervical pre-cancer/cancer through HPV self-sampling	Improved cancer survival rates and quality of life for patients
			Reduced incidence and mortality due to cervical cancer	

# Challenges and mitigation

## Regulatory Approvals

- Challenge: Multi-tiered ethics and regulatory approvals caused delays.
- Mitigation: Preemptive planning with local ethics boards; use of umbrella approvals where possible.

## Stakeholder Buy-In

- Challenge: Skepticism from frontline providers and community hesitancy.
- Mitigation: Early engagement workshops; CHW involvement as trust bridges; ongoing feedback loops

## Infrastructure Gaps

- Challenge: Lack of diagnostic equipment and referral systems.
- Mitigation: Leveraged existing programs; mobile units; created local referral pathways.

## Staff Turnover

- Challenge: High attrition among CHWs and field staff disrupted continuity.
- Mitigation: Onboarding SOPs, modular training packages, and mentorship support embedded in project.

## Programmatic Integration

- Challenge: Aligning research timelines with government program cycles.
- Mitigation: Joint planning with state NCD cells; inclusion of program staff in project governance.

## Political Disruptions

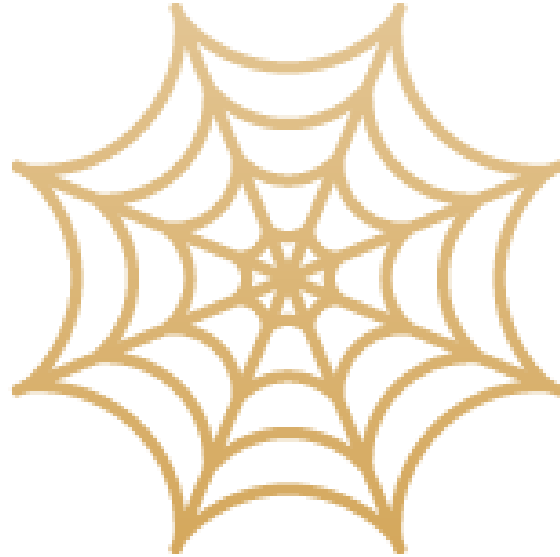
- Challenge: Elections delayed programmatic decisions and disrupted field activities.
- Mitigation: Built-in flexibility in timelines; continuous engagement with administrative counter-parts post-election.

# With Great Trust Comes Great Buy-In

**Superpowered implementation science  
from South Africa to India**



# Blurry lines



Interventions and implementation strategies are often complex, inter-**webbed** multiple components that interact with each other.

The philosophical and practical distinctions between them become **webbed**

# Why **trust matters** in implementation



- Evidence, science and frameworks alone doesn't create change.
- Trust, relationships, and local realities drive sustainable impact.
- Two case studies show the power of heart-centered implementation.



# South Africa's Neighborhood Hero

- Group education for type 2 diabetes in primary care.
- Flipcharts + trained local health workers.
- 3 evaluations show improved empowerment and behavior.
- Adopted in Western Cape with provincial funding.



Like Spider-Man, GREAT is agile, local,  
and community-centred



# Building the web before you swing

- **Focus:** Breast, cervical, and oral cancer screening.
- No implementation strategy initially.
- Long pre-implementation phase.
- 3 states – 3 *very* different strategies.



Sometimes being a hero means  
stopping to plan



# The super gadgets

- **Diabetes:** DSMES, DESMOND, GREAT
- **Cancer:** WHO strategies and screening guidelines but also adapted and developed tools in the formative phase



Even Spider-Man needs gadgets,  
but it's how you use them that matters



# Comparing the two projects

- **GREAT4Diabetes:** Structured from the beginning, scaling in Western Cape province
- **ACCI:** Started unstructured, now embedded different contextualized strategies in 3 diverse states.
- EBIs and strategies blend together in real life – **and that's okay.**



# Swinging into barriers

- **GREAT4Diabetes:** Communication gaps, turnover of staff, internal politics.
- **ACCI:** State-level variation, infrastructure gaps, political change



Like Spider-Man, we sometimes crash  
**...but keep swinging**



# Trust is the real hero

- Facility, district manager, policymakers buy-in is critical.
- People and patients engage more when the team is empowered.
- Time spent listening = time saved overcoming resistance.



With great trust comes great buy-in  
**...with heart**



# When the system wears the mask

- **GREAT4Diabetes:** Western Cape funds and owns the programme.
- **ACCI:** Strategies integrated into district/state systems.



When the system becomes the hero,  
you know you've won

# What's your superpower?

- Are you building trust?
- Are you OK with complexity?
- Are you co-creating change with heart?



**The science gives us the tools.  
The heart gives us the courage.**



After  
lunch...

2:00 to 4:00 PM

**Technical workshops**

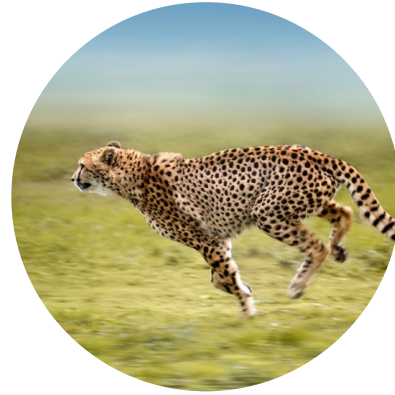
- A. Behaviour change
- B. Study designs

4:30 to 6:30 PM

**Knowledge sharing forum**

Competition judging from ~4:30 PM

Canapes and drinks from ~5:00 PM





How far did you travel to attend the Annual Scientific Meeting?

What do you see as the biggest opportunities for preventing and managing NCDs?

What is your guilty pleasure? (e.g., TV show, food, hobby...)

6,500 km  
~18 hours

