Day 2

GACD Annual Scientific Meeting

Tuesday 10 June 2025

GACD

GLOBAL ALLIANCE FOR CHRONIC DISEASES

AN ALLIANCE OF HEALTH RESEARCH FUNDERS

What's on today

5. **Welcome from the CEO** (10:00 – 10:15am)

6. **NCD perspectives from Rwanda** (10:15 – 11:00am)

7. **Joint activity highlights** (11:00am – 12:00pm)

8. **Research Programme workshops** (1:30 – 3:30 pm)
   - **Scale Up projects**
   - **Cancer projects**
   - **Life Course** and **Mental Health projects**
   - **Healthy Cities projects**

9. **Roundtables** (from 4:00pm)
With **happy hour** from ~5:00pm

NCDs cause a huge, inequitable health burden, everywhere

- The NCDs originally targeted in 2011 remain responsible for 80% of all premature NCD-related deaths.
- The populations with the highest burden also represent the greatest opportunities for improvement.

- The most common NCDs are also the most preventable.
- Evidence-based interventions for prevention are available, and it makes economic sense to implement them.
- NCDs need not be the killers they are

National Health and Medical Research Council, Australia

Sao Paulo Research Foundation, Brazil

Canadian Institutes of Health Research

European Commission

Indian Council of Medical Research

Agency for Medical Research and Development, Japan

Health Research Council of New Zealand

South African Medical Research Council

Health Systems Research Institute, Thailand

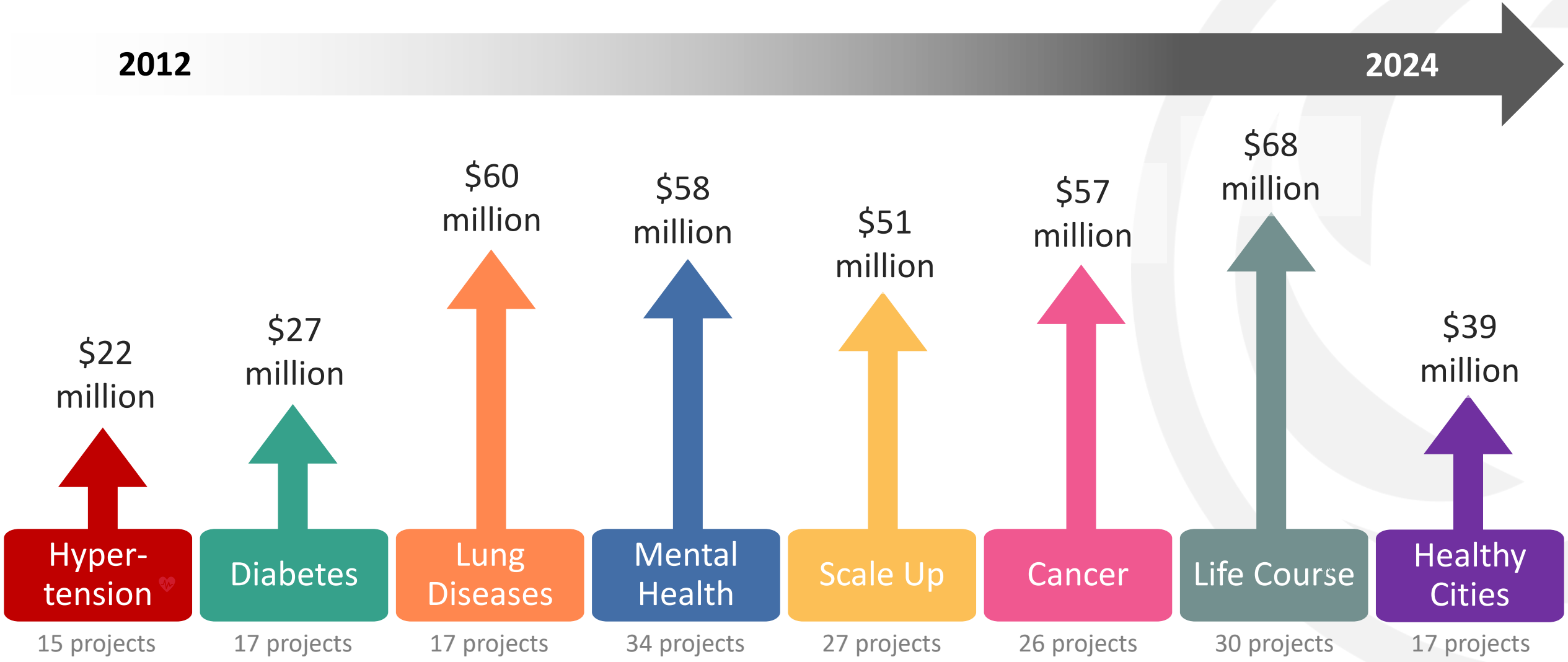
UK Medical Research Council

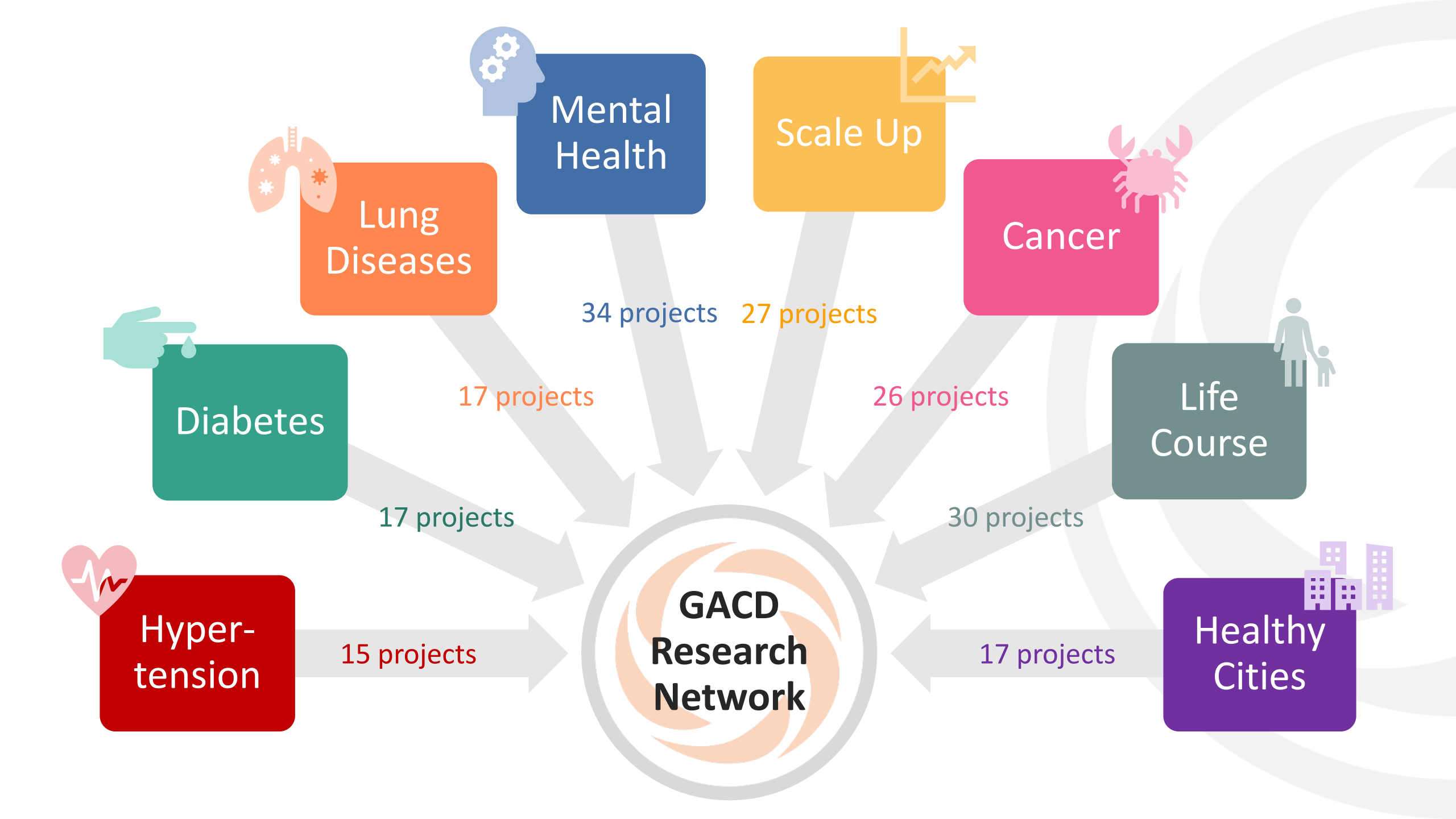
UK Department of Health and Social Care

US National Institutes of Health

www.gacd.org/about/people-and-organisation/associate-members

GACD has invested US $375+ million

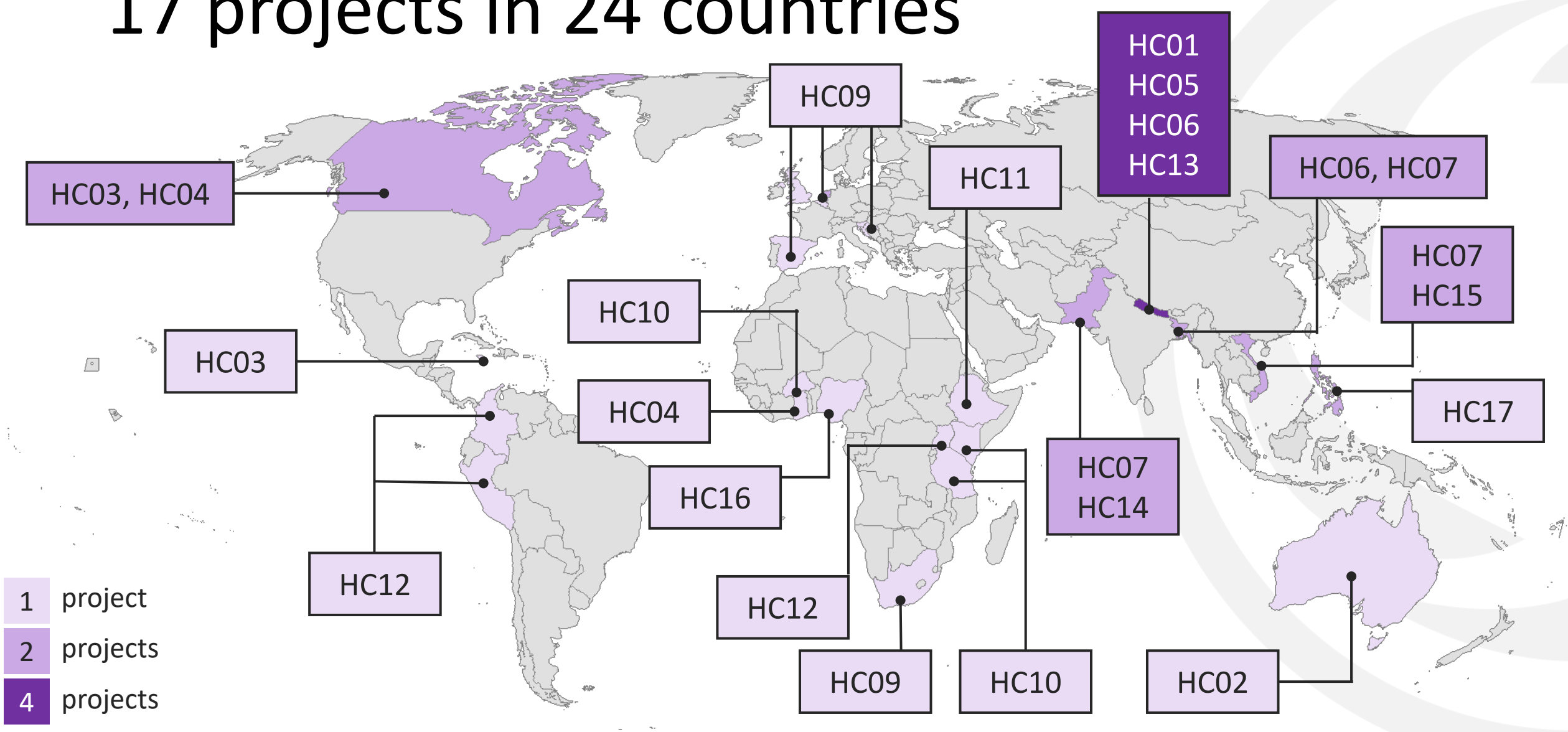



Mental Health
Scale Up
Lung Diseases
Cancer
34 projects
27 projects
Diabetes
17 projects
26 projects
Life Course
17 projects
30 projects
Hyper-tension
GACD Research Network
15 projects
17 projects
Healthy Cities

Healthy Cities Research Programme

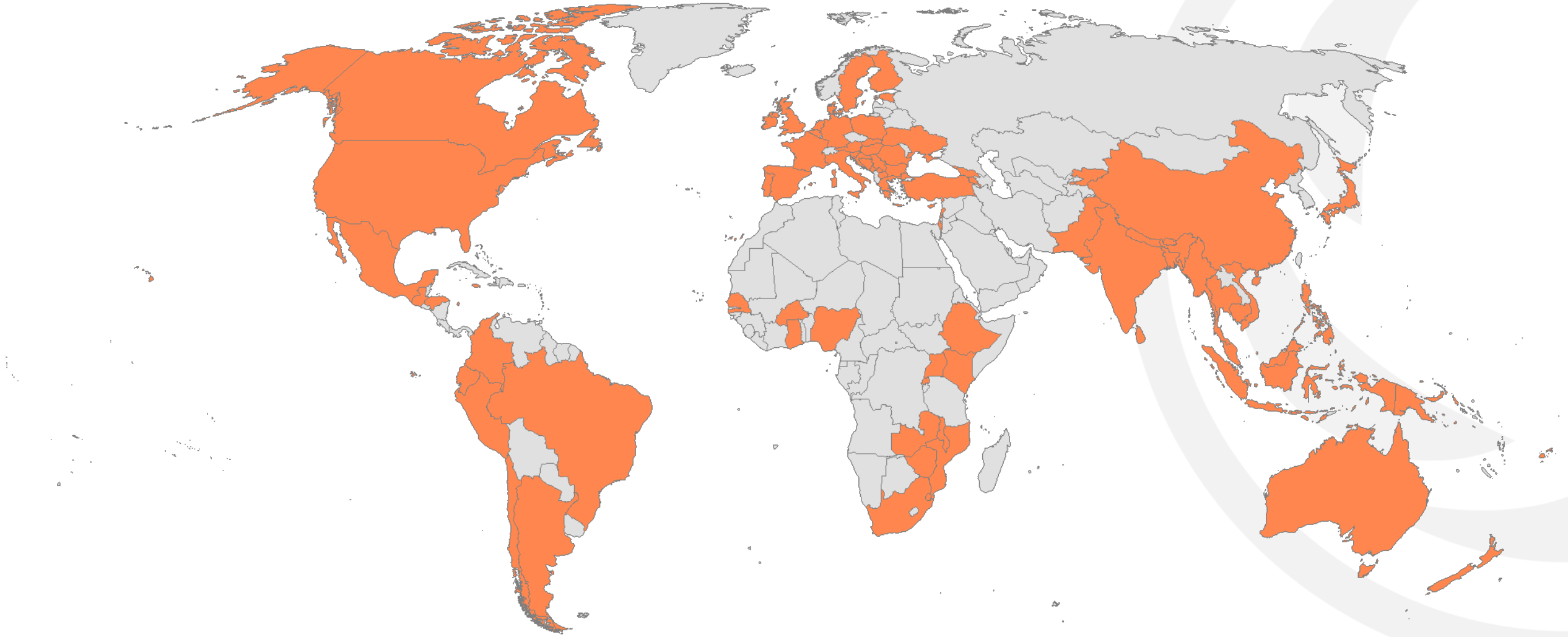
17 projects in 24 countries

17 projects in 24 countries



Source: tinyurl.com/GACD-project-library

180+ GACD projects across 84 countries



Source: tinyurl.com/GACD-project-library

Eighth Implementation Science School

- Six plenaries and five small group sessions in November
- Accessible entirely online
- Offered at no cost to participants
- Applications open until **21 July 2025**

www.gacd.org/research/capacity-development/schools

UN High Level Meeting on NCDs

Image: WHO / Menno van Hilten via www.who.int/teams/noncommunicable-diseases/on-the-road-to-2025

NCD perspectives from Rwanda

Moderator: Morven Roberts – Chief Executive, GACD

NCD perspectives from Rwanda

Abebe Bekele

University of Global Health Equity, Rwanda

Rose Gahire

Rwanda NCD Alliance

Francois Uwinkindi

Rwanda Biomedical Centre

Image: A view of Nyamirambo neighbourhood of Kigali from the top of Nyarugenge District Hospital's building | **Credit:** @benji1909 via unsplash

Joint activity highlights

Jaap Koot – University Medical Center Groningen, Netherlands // On behalf of the Systems approach to scale up working group

Gina Agarwal and Jasdeep Brar – McMaster University, Canada // On behalf of the SPARK working group

Kevin Mao – Baker Heart & Diabetes Institute, Australia // On behalf of the GACD e-Hub Team

Maisha Syed – UK Department for Health and Social Care // Lead author of the GACD Diabetes Research Programme Report

Systems approach to upscaling

SPARK
Scale up research reporting checklist

NCDs and acute infections

Inter-project contributions to the GACD e-Hub

GACD Diabetes Report

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Systems approach to scale up

Jaap Koot – University Medical Center Groningen, Netherlands

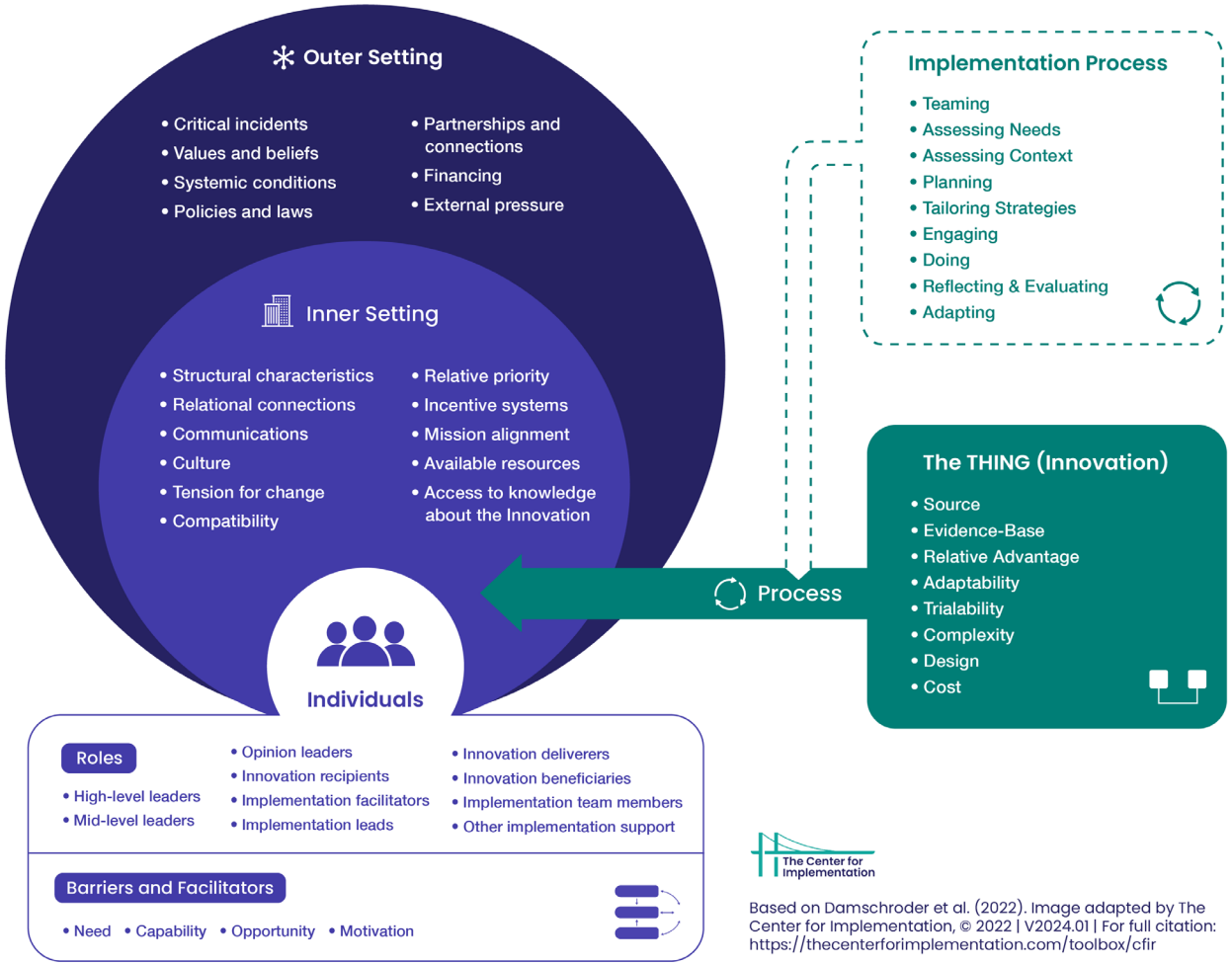
On behalf of Zinzi Pardoel and other members of the research team

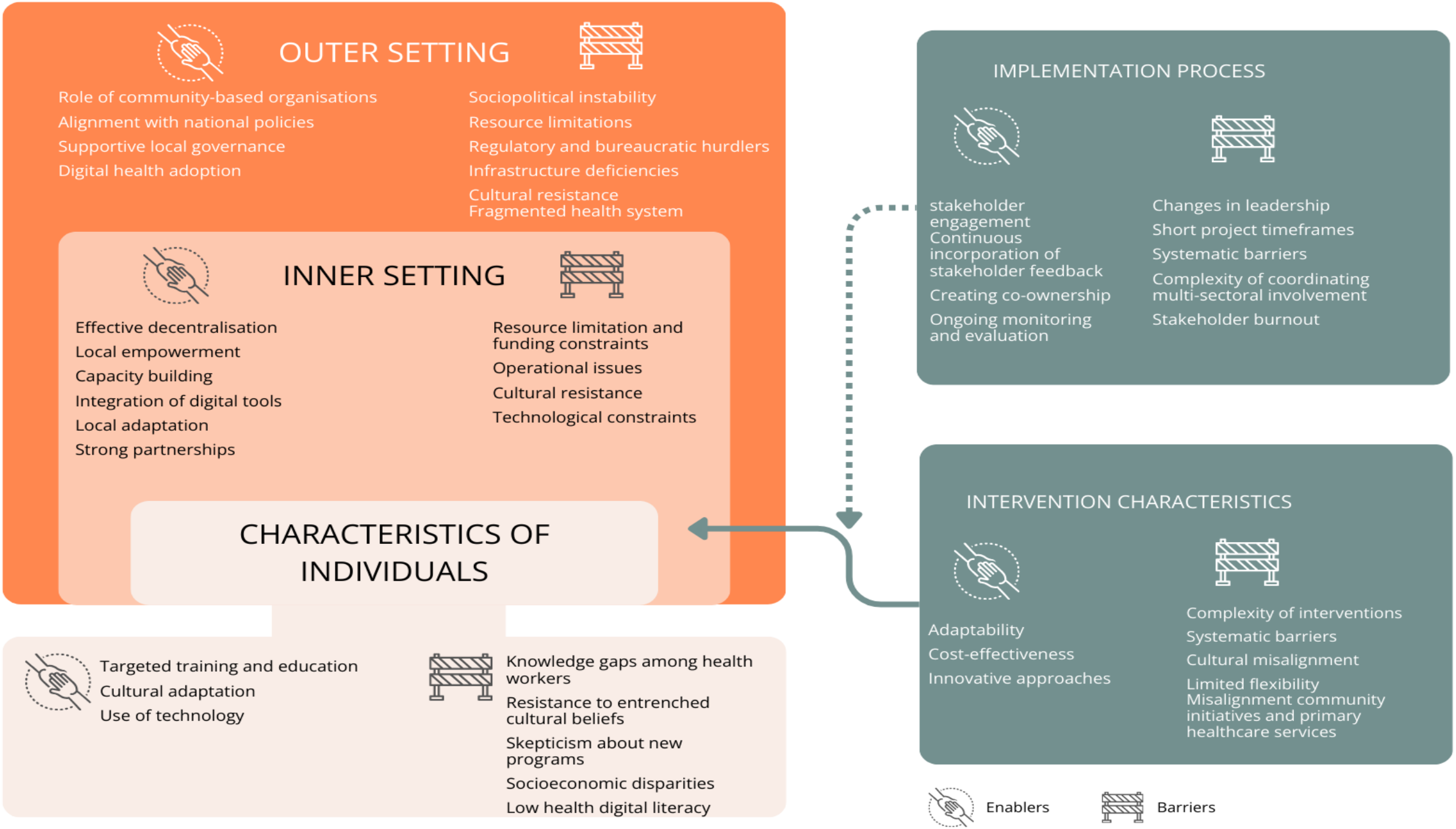
Enablers and barriers for scaling up non-communicable disease interventions across diverse global health contexts: insights from the Consolidated Framework for Implementation Research

Research question: what are the enablers and barriers influencing the scalability and sustainability of interventions for non-communicable diseases.

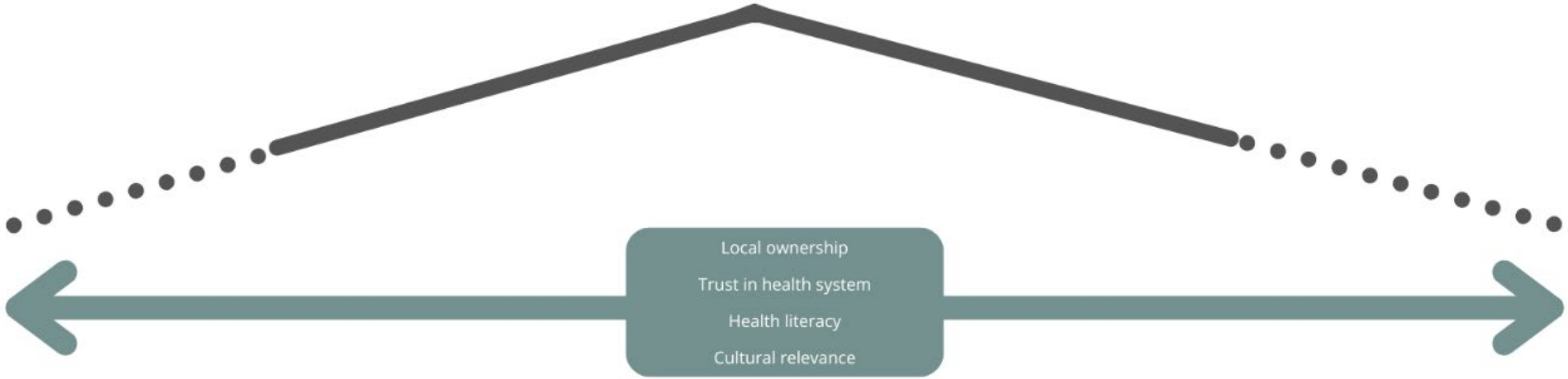
Methodology

- 15 GACD funded scaling-up (SU) projects
- 18 countries in 5 WHO regions
- Systematic document analysis (77 in total) and stakeholder interviews (18 in total)
- Consolidated Framework for Implementation Research
- WHO health system building blocks




OUTER SETTING
Role of community-based organisations
Alignment with national policies
Supportive local governance
Digital health adoption
Sociopolitical instability
Resource limitations
Regulatory and bureaucratic hurdlers
Infrastructure deficiencies
Cultural resistance
Fragmented health system
INNER SETTING
Effective decentralisation
Local empowerment
Capacity building
Integration of digital tools
Local adaptation
Strong partnerships
Resource limitation and funding constraints
Operational issues
Cultural resistance
Technological constraints
CHARACTERISTICS OF INDIVIDUALS
Targeted training and education
Cultural adaptation
Use of technology
Knowledge gaps among health workers
Resistance to entrenched cultural beliefs
Skepticism about new programs
Socioeconomic disparities
Low health digital literacy
IMPLEMENTATION PROCESS
stakeholder engagement
Continuous incorporation of stakeholder feedback
Creating co-ownership
Ongoing monitoring and evaluation
Changes in leadership
Short project timeframes
Systematic barriers
Complexity of coordinating multi-sectoral involvement
Stakeholder burnout
INTERVENTION CHARACTERISTICS
Adaptability
Cost-effectiveness
Innovative approaches
Complexity of interventions
Systematic barriers
Cultural misalignment
Limited flexibility
Misalignment community initiatives and primary healthcare services
Enablers
Barriers

SUCCESSFUL SCALE UP OF HEALTH PROGRAMS



	SERVICE DELIVERY	HEALTH WORKFORCE	HEALTH INFORMATION SYSTEMS	ACCESS TO ESSENTIAL MEDICINES	FINANCING	GOVERNANCE
Contextual factors	Health infrastructure Quality of care Cultural Competence Partnerships	Health beliefs and practices Workforce availability	Availability and reliability of healthcare data Digital literacy Digital health integration	Supply chain management Regulatory environment	Financial protection Public vs. private funding External donor dependence	Policy environment Political stability
Scale-up activities within the WHO building blocks	Tailoring interventions to local contexts Simplified intervention models Decentralized, locally empowered health systems	Capacity building and targeted training for healthcare workers Continuous professional development	Digital health tools Reliable, evidence-based digital platforms Ongoing monitoring and evaluation	Availability of affordable and accessible essential medicines Ensuring access to essential medicines	Focus on cost-effective interventions Guaranteed long-term funding	Early and continuous stakeholder engagement Robust governance frameworks and sustained leadership

Key factors for successful scaling up of NCD interventions

Local ownership
Trust in the health system
Health Literacy
Cultural relevance

For sustainable results

- Integrate interventions into existing healthcare structures
- Prioritize health systems strengthening
- Sustain engagement of local stakeholders, including healthcare providers and community members
- Strengthen local workforce
- Establish sustainable financing mechanisms

Thank you

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Z.E. Pardoel@umcg.nl

Authors: Pardoel ZE., Folkertsma I., Koot JAR., Ramani-Chander A., Thrift AG., Joshi R., Bandurek I., van Olmen J., Shrestha A., Rawal L., Wouters E., Maharai A., Delobelle P., Hueiming L., Theilmann M., Webster J., Sujarwoto S., Siddiqi K., Probandari A., Widyaningsih V., Jaime Miranda J., Zhang P., Stehr L., Hirsshorn LR., Alma M.

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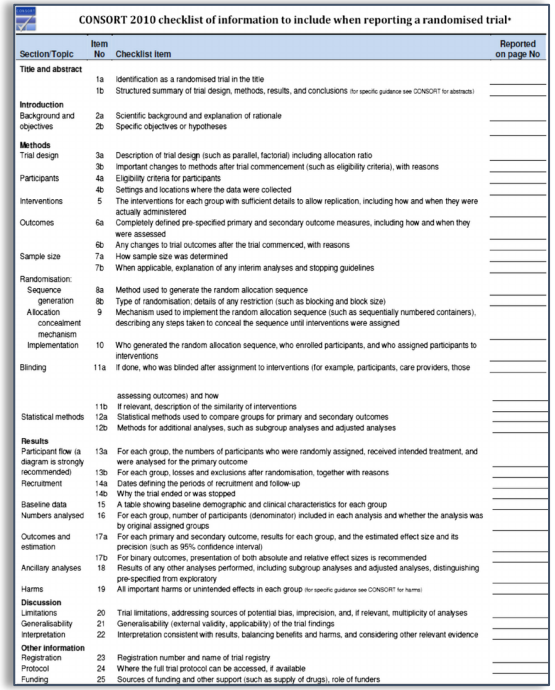
Scale u**P** rese**A**rch **R**eporting chec**K**list (**SPARK**)

Gina Agarwal and Jasdeep Brar – McMaster University, Canada

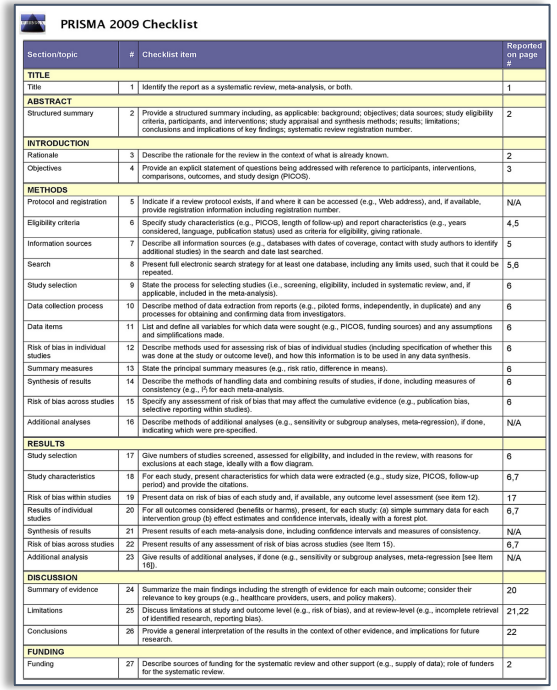
Reporting checklists for publications

"A checklist, flow diagram, or structured text to guide authors in reporting a specific type of research, developed using explicit methodology." (Equator Network)



CONSORT 2010 checklist of information to include when reporting a randomised trial*

Section/Topic	Item No	Checklist item	Reported on page No
Title and abstract			
	1a	Identification as a randomised trial in the title	
	1b	Structured summary of trial design, methods, results, and conclusions (for specific guidance see CONSORT for abstracts)	
Introduction			
Background and objectives	2a	Scientific background and explanation of rationale	
	2b	Specific objectives or hypotheses	
Methods			
Trial design	3a	Description of trial design (such as parallel, factorial) including allocation ratio	
	3b	Important changes to methods after trial commencement (such as eligibility criteria), with reasons	
Participants	4a	Eligibility criteria for participants	
	4b	Settings and locations where the data were collected	
Interventions	5	The interventions for each group with sufficient details to allow replication, including how and when they were actually administered	
Outcomes	6a	Completely defined pre-specified primary and secondary outcome measures, including how and when they were assessed	
	6b	Any changes to trial outcomes after the trial commenced, with reasons	
Sample size	7a	How sample size was determined	
	7b	When applicable, explanation of any interim analyses and stopping guidelines	
Randomisation:			
Sequence generation	8a	Method used to generate the random allocation sequence	
	8b	Type of randomisation; details of any restriction (such as blocking and block size)	
Allocation concealment mechanism	9	Mechanism used to implement the random allocation sequence (such as sequentially numbered containers), describing any steps taken to conceal the sequence until interventions were assigned	
Implementation	10	Who generated the random allocation sequence, who enrolled participants, and who assigned participants to interventions	
Blinding	11a	If done, who was blinded after assignment to interventions (for example, participants, care providers, those assessing outcomes) and how	
	11b	If relevant, description of the similarity of interventions	
Statistical methods	12a	Statistical methods used to compare groups for primary and secondary outcomes	
	12b	Methods for additional analyses, such as subgroup analyses and adjusted analyses	
Results			
Participant flow (a diagram is strongly recommended)	13a	For each group, the numbers of participants who were randomly assigned, received intended treatment, and were analysed for the primary outcome	
	13b	For each group, losses and exclusions after randomisation, together with reasons	
Recruitment	14a	Dates defining the periods of recruitment and follow-up	
	14b	Why the trial ended or was stopped	
Baseline data	15	A table showing baseline demographic and clinical characteristics for each group	
Numbers analysed	16	For each group, number of participants (denominator) included in each analysis and whether the analysis was by original assigned groups	
Outcomes and estimation	17a	For each primary and secondary outcome, results for each group, and the estimated effect size and its precision (such as 95% confidence interval)	
	17b	For binary outcomes, presentation of both absolute and relative effect sizes is recommended	
Ancillary analyses	18	Results of any other analyses performed, including subgroup analyses and adjusted analyses, distinguishing pre-specified from exploratory	
Harms	19	All important harms or unintended effects in each group (for specific guidance see CONSORT for harms)	
Discussion			
Limitations	20	Trial limitations, addressing sources of potential bias, imprecision, and, if relevant, multiplicity of analyses	
Generalisability	21	Generalisability (external validity, applicability) of the trial findings	
Interpretation	22	Interpretation consistent with results, balancing benefits and harms, and considering other relevant evidence	
Other information			
Registration	23	Registration number and name of trial registry	
Protocol	24	Where the full trial protocol can be accessed, if available	
Funding	25	Sources of funding and other support (such as supply of drugs), role of funders	



PRISMA 2009 Checklist

Section/topic	#	Checklist item	Reported on page #
TITLE			
Title	1	Identify the report as a systematic review, meta-analysis, or both.	1
ABSTRACT			
Structured summary	2	Provide a structured summary including, as applicable: background; objectives; data sources; study eligibility criteria, participants, and interventions; study appraisal and synthesis methods; results; limitations; conclusions and implications of key findings; systematic review registration number.	2
INTRODUCTION			
Rationale	3	Describe the rationale for the review in the context of what is already known.	2
Objectives	4	Provide an explicit statement of questions being addressed with reference to participants, interventions, comparisons, outcomes, and study design (PICOS).	3
METHODS			
Protocol and registration	5	Indicate if a review protocol exists, if and where it can be accessed (e.g., Web address), and, if available, provide registration information including registration number.	N/A
Eligibility criteria	6	Specify study characteristics (e.g., PICOS, length of follow-up) and report characteristics (e.g., years considered, language, publication status) used as criteria for eligibility, giving rationale.	4,5
Information sources	7	Describe all information sources (e.g., databases with dates of coverage, contact with study authors to identify additional studies) in the search and date last searched.	5
Search	8	Present full electronic search strategy for at least one database, including any limits used, such that it could be repeated.	5,6
Study selection	9	State the process for selecting studies (i.e., screening, eligibility, included in systematic review, and, if applicable, included in the meta-analysis).	6
Data collection process	10	Describe method of data extraction from reports (e.g., piloted forms, independently, in duplicate) and any processes for obtaining and confirming data from investigators.	6
Data items	11	List and define all variables for which data were sought (e.g., PICOS, funding sources) and any assumptions and simplifications made.	6
Risk of bias in individual studies	12	Describe methods used for assessing risk of bias of individual studies (including specification of whether this was done at the study or outcome level), and how this information is to be used in any data synthesis.	6
Summary measures	13	State the principal summary measures (e.g., risk ratio, difference in means).	6
Synthesis of results	14	Describe the methods of handling data and combining results of studies, if done, including measures of consistency (e.g., I^2) for each meta-analysis.	6
Risk of bias across studies	15	Specify any assessment of risk of bias that may affect the cumulative evidence (e.g., publication bias, selective reporting within studies).	6
Additional analyses	16	Describe methods of additional analyses (e.g., sensitivity or subgroup analyses, meta-regression), if done, indicating which were pre-specified.	N/A
RESULTS			
Study selection	17	Give numbers of studies screened, assessed for eligibility, and included in the review, with reasons for exclusions at each stage, ideally with a flow diagram.	6
Study characteristics	18	For each study, present characteristics for which data were extracted (e.g., study size, PICOS, follow-up period) and provide the citations.	6,7
Risk of bias within studies	19	Present data on risk of bias of each study and, if available, any outcome level assessment (see item 12).	17
Results of individual studies	20	For all outcomes considered (benefits or harms), present, for each study: (a) simple summary data for each intervention group (b) effect estimates and confidence intervals, ideally with a forest plot.	6,7
Synthesis of results	21	Present results of each meta-analysis done, including confidence intervals and measures of consistency.	N/A
Risk of bias across studies	22	Present results of any assessment of risk of bias across studies (see Item 15).	6,7
Additional analysis	23	Give results of additional analyses, if done (e.g., sensitivity or subgroup analyses, meta-regression [see Item 16]).	N/A
DISCUSSION			
Summary of evidence	24	Summarize the main findings including the strength of evidence for each main outcome; consider their relevance to key groups (e.g., healthcare providers, users, and policy makers).	20
Limitations	25	Discuss limitations at study and outcome level (e.g., risk of bias), and at review-level (e.g., incomplete retrieval of identified research, reporting bias).	21,22
Conclusions	26	Provide a general interpretation of the results in the context of other evidence, and implications for future research.	22
FUNDING			
Funding	27	Describe sources of funding for the systematic review and other support (e.g., supply of data); role of funders for the systematic review.	2

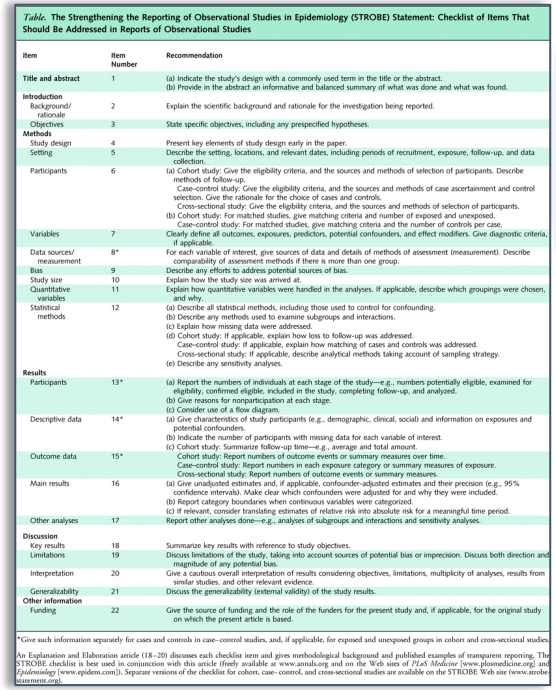


Table. **The Strengthening the Reporting of Observational Studies in Epidemiology (STROBE) Statement: Checklist of Items That Should Be Addressed in Reports of Observational Studies**

Item	Item Number	Recommendation
Title and abstract	1	(a) Indicate the study's design with a commonly used term in the title or the abstract. (b) Provide in the abstract an informative and balanced summary of what was done and what was found.
Introduction		
Background/ rationale	2	Explain the scientific background and rationale for the investigation being reported.
Objectives	3	State specific objectives, including any prespecified hypotheses.
Methods		
Study design	4	Present key elements of study design early in the paper.
Setting	5	Describe the setting, locations, and relevant dates, including periods of recruitment, exposure, follow-up, and data collection.
Participants	6	(a) Cohort study: Give the eligibility criteria, and the sources and methods of selection of participants. Describe methods of follow-up. Case–control study: Give the eligibility criteria, and the sources and methods of case ascertainment and control selection. Give the rationale for the choice of cases and controls. Cross-sectional study: Give the eligibility criteria, and the sources and methods of selection of participants. (b) Cohort study: For matched studies, give matching criteria and number of exposed and unexposed. Case–control study: For matched studies, give matching criteria and the number of controls per case.
Variables	7	Clearly define all outcomes, exposures, predictors, potential confounders, and effect modifiers. Give diagnostic criteria, if applicable.
Data sources/ measurement	8*	For each variable of interest, give sources of data and details of methods of assessment (measurement). Describe comparability of assessment methods if there is more than one group.
Bias	9	Describe any efforts to address potential sources of bias.
Study size	10	Explain how the study size was arrived at.
Quantitative variables	11	Explain how quantitative variables were handled in the analyses. If applicable, describe which groupings were chosen, and why.
Statistical methods	12	(a) Describe all statistical methods, including those used to control for confounding. (b) Describe any methods used to examine subgroups and interactions. (c) Explain how missing data were addressed. (d) Cohort study: If applicable, explain how loss to follow-up was addressed. Case–control study: If applicable, explain how matching of cases and controls was addressed. Cross-sectional study: If applicable, describe analytical methods taking account of sampling strategy. (e) Describe any sensitivity analyses.
Results		
Participants	13*	(a) Report the numbers of individuals at each stage of the study—e.g., numbers potentially eligible, examined for eligibility, confirmed eligible, included in the study, completing follow-up, and analyzed. (b) Give reasons for nonparticipation at each stage. (c) Consider use of a flow diagram.
Descriptive data	14*	(a) Give characteristics of study participants (e.g., demographic, clinical, social) and information on exposures and potential confounders. (b) Indicate the number of participants with missing data for each variable of interest. (c) Cohort study: Summarize follow-up time—e.g., average and total amount.
Outcome data	15*	Cohort study: Report numbers of outcome events or summary measures over time. Case–control study: Report numbers in each exposure category or summary measures of exposure. Cross-sectional study: Report numbers of outcome events or summary measures.
Main results	16	(a) Give unadjusted estimates and, if applicable, confounder-adjusted estimates and their precision (e.g., 95% confidence intervals). Make clear which confounders were adjusted for and why they were included. (b) Report category boundaries when continuous variables were categorized. (c) If relevant, consider translating estimates of relative risk into absolute risk for a meaningful time period.
Other analyses	17	Report other analyses done—e.g., analyses of subgroups and interactions and sensitivity analyses.
Discussion		
Key results	18	Summarize key results with reference to study objectives.
Limitations	19	Discuss limitations of the study, taking into account sources of potential bias or imprecision. Discuss both direction and magnitude of any potential bias.
Interpretation	20	Give a cautious overall interpretation of results considering objectives, limitations, multiplicity of analyses, results from similar studies, and other relevant evidence.
Generalizability	21	Discuss the generalizability (external validity) of the study results.
Other information		
Funding	22	Give the source of funding and the role of the funders for the present study and, if applicable, for the original study on which the present article is based.

*Give such information separately for cases and controls in case–control studies, and, if applicable, for exposed and unexposed groups in cohort and cross-sectional studies.

An Explanation and Elaboration article (18–20) discusses each checklist item and gives methodological background and published examples of transparent reporting. The STROBE checklist is best used in conjunction with this article (freely available at www.annals.org and on the Web sites of *PLoS Medicine* [www.plosmedicine.org] and *Epidemiology* [www.epidem.com]). Separate versions of the checklist for cohort, case–control, and cross-sectional studies are available on the STROBE Web site (www.strobe-statement.org).

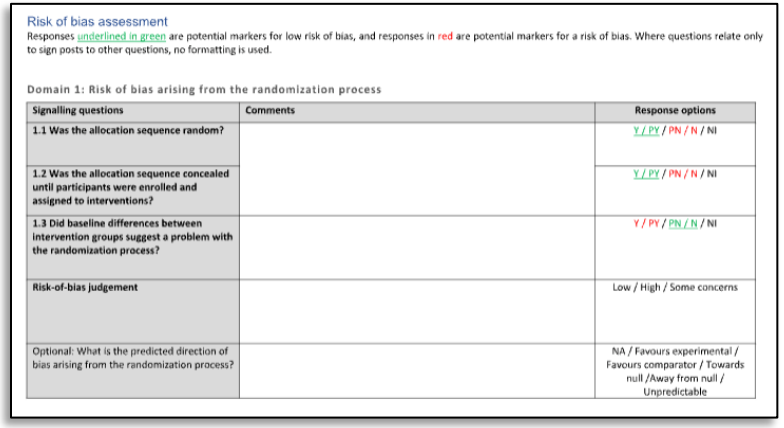
CHEERS 2022 Checklist

	Item	Guidance for Reporting	Reported in section
TITLE			
Title	1	Identify the study as an economic evaluation and specify the interventions being compared.	
ABSTRACT			
Abstract	2	Provide a structured summary that highlights context, key methods, results and alternative analyses.	
INTRODUCTION			
Background and objectives	3	Give the context for the study, the study question and its practical relevance for decision making in policy or practice.	
METHODS			
Health economic analysis plan	4	Indicate whether a health economic analysis plan was developed and where available.	
Study population	5	Describe characteristics of the study population (such as age range, demographics, socioeconomic, or clinical characteristics).	
Setting and location	6	Provide relevant contextual information that may influence findings.	
Comparators	7	Describe the interventions or strategies being compared and why chosen.	
Perspective	8	State the perspective(s) adopted by the study and why chosen.	
Time horizon	9	State the time horizon for the study and why appropriate.	
Discount rate	10	Report the discount rate(s) and reason chosen.	
Selection of outcomes	11	Describe what outcomes were used as the measure(s) of benefit(s) and harm(s).	
Measurement of outcomes	12	Describe how outcomes used to capture benefit(s) and harm(s) were measured.	
Valuation of outcomes	13	Describe the population and methods used to measure and value outcomes.	
Measurement and valuation of resources and costs	14	Describe how costs were valued.	
Currency, price date, and conversion	15	Report the dates of the estimated resource quantities and unit costs, plus the currency and year of conversion.	
Rationale and description of model	16	If modelling is used, describe in detail and why used. Report if the model is publicly available and where it can be accessed.	
Analytics and assumptions	17	Describe any methods for analysing or statistically transforming data, any extrapolation methods, and approaches for validating any model used.	
Characterizing heterogeneity	18	Describe any methods used for estimating how the results of the study vary for sub-groups.	
Characterizing distributional effects	19	Describe how impacts are distributed across different individuals or adjustments made to reflect priority populations.	
Characterizing uncertainty	20	Describe methods to characterize any sources of uncertainty in the analysis.	
Approach to engagement with patients and others affected by the study	21	Describe any approaches to engage patients or service recipients, the general public, communities, or stakeholders (e.g., clinicians or payers) in the design of the study.	
RESULTS			
Study parameters	22	Report all analytic inputs (e.g., values, ranges, references) including uncertainty or distributional assumptions.	
Summary of main results	23	Report the mean values for the main categories of costs and outcomes of interest and summarise them in the most appropriate overall measure.	
Effect of uncertainty	24	Describe how uncertainty about analytic judgments, inputs, or projections affect findings. Report the effect of choice of discount rate and time horizon, if applicable.	
Effect of engagement with patients and others affected by the study	25	Report on any difference patient/service recipient, general public, community, or stakeholder involvement made to the approach or findings of the study	
DISCUSSION			
Study findings, limitations, generalizability, and current knowledge	26	Report key findings, limitations, ethical or equity considerations not captured, and how these could impact patients, policy, or practice.	
OTHER RELEVANT INFORMATION			
Source of funding	27	Describe how the study was funded and any role of the funder in the identification, design, conduct, and reporting of the analysis	
Conflicts of interest	28	Report authors conflicts of interest according to journal or International Committee of Medical Journal Editors requirements.	

Examples of reporting checklists include CONSORT, PRISMA, STROBE, and CHEERS.

Critical appraisal tools

Instruments used to assess the methodological quality of research publications.

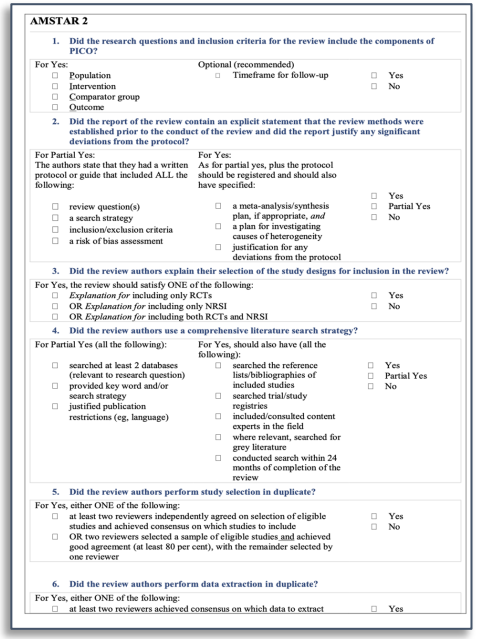


Risk of bias assessment

Responses underlined in green are potential markers for low risk of bias, and responses in red are potential markers for a risk of bias. Where questions relate only to sign posts to other questions, no formatting is used.

Domain 1: Risk of bias arising from the randomization process

Signalling questions	Comments	Response options
1.1 Was the allocation sequence random?		Y / PY / PN / N / NI
1.2 Was the allocation sequence concealed until participants were enrolled and assigned to interventions?		Y / PY / PN / N / NI
1.3 Did baseline differences between intervention groups suggest a problem with the randomization process?		Y / PY / PN / N / NI
Risk-of-bias judgement		Low / High / Some concerns
Optional: What is the predicted direction of bias arising from the randomization process?		NA / Favours experimental / Favours comparator / Towards null /Away from null / Unpredictable



AMSTAR 2

1. Did the research questions and inclusion criteria for the review include the components of PICO?

For Yes:
- ☐ Population
- ☐ Intervention
- ☐ Comparator group
- ☐ Outcome

Optional (recommended)
- ☐ Timeframe for follow-up

☐ Yes
☐ No

2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?

For Partial Yes:
The authors state that they had a written protocol or guide that included ALL the following:
- ☐ review question(s)
- ☐ a search strategy
- ☐ inclusion/exclusion criteria
- ☐ a risk of bias assessment

For Yes:
As for partial yes, plus the protocol should be registered and should also have specified:
- ☐ a meta-analysis/synthesis plan, if appropriate, *and*
- ☐ a plan for investigating causes of heterogeneity
- ☐ justification for any deviations from the protocol

☐ Yes
☐ Partial Yes
☐ No

3. Did the review authors explain their selection of the study designs for inclusion in the review?

For Yes, the review should satisfy ONE of the following:
- ☐ *Explanation for* including only RCTs
- ☐ OR *Explanation for* including only NRSI
- ☐ OR *Explanation for* including both RCTs and NRSI

☐ Yes
☐ No

4. Did the review authors use a comprehensive literature search strategy?

For Partial Yes (all the following):
- ☐ searched at least 2 databases (relevant to research question)
- ☐ provided key word and/or search strategy
- ☐ justified publication restrictions (eg, language)

For Yes, should also have (all the following):
- ☐ searched the reference lists/bibliographies of included studies
- ☐ searched trial/study registries
- ☐ included/consulted content experts in the field
- ☐ where relevant, searched for grey literature
- ☐ conducted search within 24 months of completion of the review

☐ Yes
☐ Partial Yes
☐ No

5. Did the review authors perform study selection in duplicate?

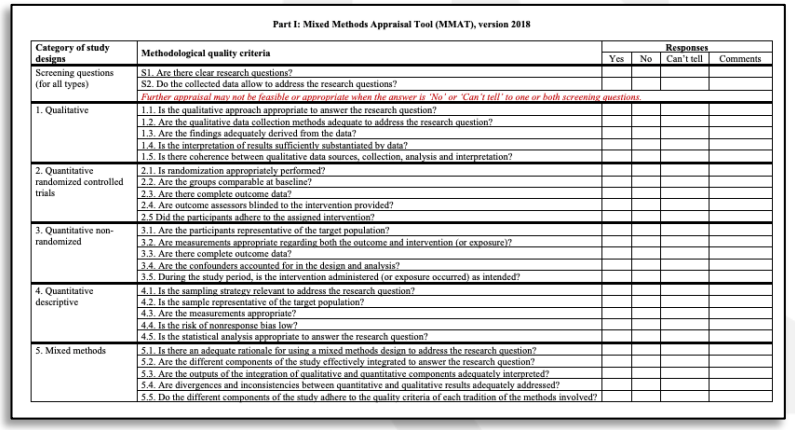
For Yes, either ONE of the following:
- ☐ at least two reviewers independently agreed on selection of eligible studies and achieved consensus on which studies to include
- ☐ OR two reviewers selected a sample of eligible studies and achieved good agreement (at least 80 per cent), with the remainder selected by one reviewer

☐ Yes
☐ No

6. Did the review authors perform data extraction in duplicate?

For Yes, either ONE of the following:
- ☐ at least two reviewers achieved consensus on which data to extract

☐ Yes



Part I: Mixed Methods Appraisal Tool (MMAT), version 2018

Category of study designs	Methodological quality criteria	Responses: Yes	No	Can't tell	Comments
Screening questions (for all types)	S1. Are there clear research questions?				
	S2. Do the collected data allow to address the research questions?				
	Further appraisal may not be feasible or appropriate when the answer is 'No' or 'Can't tell' to one or both screening questions.				
1. Qualitative	1.1. Is the qualitative approach appropriate to answer the research question?				
	1.2. Are the qualitative data collection methods adequate to address the research question?				
	1.3. Are the findings adequately derived from the data?				
	1.4. Is the interpretation of results sufficiently substantiated by data?				
	1.5. Is there coherence between qualitative data sources, collection, analysis and interpretation?				
2. Quantitative randomized controlled trials	2.1. Is randomization appropriately performed?				
	2.2. Are the groups comparable at baseline?				
	2.3. Are there complete outcome data?				
	2.4. Are outcome assessors blinded to the intervention provided?				
	2.5 Did the participants adhere to the assigned intervention?				
3. Quantitative non-randomized	3.1. Are the participants representative of the target population?				
	3.2. Are measurements appropriate regarding both the outcome and intervention (or exposure)?				
	3.3. Are there complete outcome data?				
	3.4. Are the confounders accounted for in the design and analysis?				
	3.5. During the study period, is the intervention administered (or exposure occurred) as intended?				
4. Quantitative descriptive	4.1. Is the sampling strategy relevant to address the research question?				
	4.2. Is the sample representative of the target population?				
	4.3. Are the measurements appropriate?				
	4.4. Is the risk of nonresponse bias low?				
	4.5. Is the statistical analysis appropriate to answer the research question?				
5. Mixed methods	5.1. Is there an adequate rationale for using a mixed methods design to address the research question?				
	5.2. Are the different components of the study effectively integrated to answer the research question?				
	5.3. Are the outputs of the integration of qualitative and quantitative components adequately interpreted?				
	5.4. Are divergences and inconsistencies between quantitative and qualitative results adequately addressed?				
	5.5. Do the different components of the study adhere to the quality criteria of each tradition of the methods involved?				

Examples of critical appraisal tools include RoB-2, AMSTAR 2, and MMAT.

Objective

To develop a reporting checklist and critical appraisal tool for scale up research: Scale uP reseArch Reporting checKlist (SPARK) and Scale Up Research Critical Appraisal Tool (SUCAT).

Methods

COMPLETED

1. Generated a list of indicators for quality scale up research by brainstorming with researchers, methodologists, journal editors, and funding agencies at the 2023 GACD ASM (Singapore).

2. Synthesised meeting notes into the first version of SPARK.

3. Held an introductory meeting with interested members to develop sub-working groups, clarify objectives, and solidify methods.

Special thank you to Izzy Bandurek for synthesizing meeting notes.

Methods

COMPLETED

4. Methodology was based on previous checklist development publications that are on the EQUATOR Network website and via feedback from the working group.

5. Registered SPARK on EQUATOR Network.

equator network

Enhancing the QUAlity and Transparency Of health Research

SPARK – Scale Up Research Reporting Checklist (registered 31 July 2024)

Scale up is an important aspect of implementation research, aiming to scientifically explore the widespread, sustained adoption of proven interventions to create a generalisable knowledge base. Typically, intervention implementation has already been piloted at a smaller, local scale, while scale up research refers to the study of processes and factors that influence the widespread, sustainable adoption of evidence-based interventions, practices, or programs beyond their initial pilot settings.

An international group of implementation research and global health researchers is working to develop a reporting guideline for scale up studies. An initial scoping review and a brainstorming session were conducted in 2023. A Delphi survey is planned. The Global Alliance for Chronic Diseases (GACD) is supporting the work by providing coordination and logistics and funding open access publications. The group plans to publish the reporting guideline in 2025, as an open access document.

- Contact: Gina Agarwal and Jasdeep Brar, McMaster University, Canada. E-mails: gina.agarwal@gmail.com and brarj14@mcmaster.ca

https://www.equator-network.org/library/reporting-guidelines-under-development/reporting-guidelines-under-development-for-other-study-designs/#SPARK

Methods

COMPLETED

6. GACD team's initial literature review on scale up research was shared with the working group with the aim of adding more literature on guidelines, tools, or criteria being used in scale up research.

7. The literature review group summarized literature into potential items for SPARK and SUCAT.

8. Using the literature review findings, we refined SPARK and developed SUCAT. These new versions were shared with the literature review group for feedback.

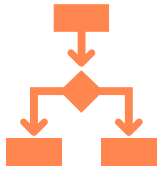
Special thank you to members of the Literature Review Group: Samina Akhtar, Ramya Nagarajan, Jackline Ngowi, Michaela Riddell, Rajshree Thapa, and Aripa Alonto.

Methods

COMPLETED

9. Created Delphi surveys for SPARK and SUCAT.

10. Obtained research ethics approval.

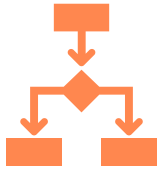


11. Distributed the Delphi surveys.

Special thank you to Ramona Hiltensperger for her Delphi methodology expertise and Izzy Bandurek for distributing the surveys.

Methods

TO DO



1. Coordinate the evaluation of the Delphi surveys.

2. Develop final versions of SPARK and SUCAT.

3. Pilot testing.

4. Prepare and create deliverables.

Deliverables

Publications

Open-access, peer-reviewed publications documenting the development of SPARK and SUCAT.

Explanatory documents

Detailed practical guides on how to use SPARK and SUCAT, which will be hosted on the GACD website.

Get involved!

Join our Delphi study to share your thoughts and expertise!

- Invitations have been sent via email.

SPARK link
https://surveys.mcmaster.ca/limesurvey/index.php/**218124**?lang=en

SUCAT link
https://surveys.mcmaster.ca/limesurvey/index.php/**919771**?lang=en

agarg@mcmaster.ca

brarj14@mcmaster.ca

Thank you!

Acknowledgements

Working group members: Anusha Ramani-Chander, Brian Oldenburg, Lisa Hirschhorn, Aripa Alonto, Abel Negussie, Josephine Andesia Kisato, Ric Angeles, Ramya N, Soumyadeep Bhaumik, Harriet Koorts, Jackline Ngowi, Jiani Ma, Julius Kiwanuka, Kerstin Klipstein Grobusch, Kufre Okop, Lavangi Naithani, Leslie Johnson, Leevan Tibaijuka, Martin Heine, Michaela Theilmann, Michaela Riddell, Nguyen The Phuong, Nicola West, Nneka Ubochi, Rajshree Thapa, Ramona Hiltensperger, Roxanne Keynejad, Samina Akhtar, Abha Shrestha, Karen Yeates, and Puhong Zhang.

Systems approach to upscaling

SPARK
Scale up research reporting checklist

NCDs and acute infections

Inter-project contributions to the GACD e-Hub

GACD Diabetes Report

SPECIAL INTEREST GROUP

Equity iN iMplementation rESearcH (ENMESH)

Poster text prepared by the GACD team

Why?

The rationale for the special interest group

IMPETUS

The potential of implementation research to improve public health and social outcomes is hindered by its adherence to Western-centric paradigms and colonial legacies.

A group focused on decolonising implementation research can challenge these paradigms, promote the use of diverse knowledge and practices, and foster a global movement for democratising research and implementation.

STARTING POINT

At the GACD Annual Scientific Meeting 2023 in Singapore, Nav Tapela led a plenary session, "Equity, equity, and decolonised, equitable implementation", which sought to move beyond reflection to collective action.

Delegates were invited to imagine alternate futures in global health and this working group will draw progress towards, identifying priority actions that can be taken by individuals and stakeholder organisations in the global GACD community.

OUR BROAD AIMS?

- Foster culturally sensitive and equitable approaches to implementation research.
- Develop and disseminate tools, guidelines, and training materials that promote decolonised, equitable implementation research.
- Enhance the research capacity of scientists from diverse backgrounds to conduct decolonised, equitable implementation research.
- Promote knowledge exchange and collaboration among researchers, practitioners, and community members from different backgrounds.
- Promote global collaboration between researchers and practitioners working on NCD implementation research in different parts of the world.

How?

What the special interest group has done (or will do) and how they worked across GACD projects

PROGRESS

Since the GACD Annual Scientific Meeting in 2023, the group has faced several barriers to launching in full. After careful discussion, the group transition from a working group (with a specific, time-limited goal) to a special interest group.

Our first open meeting as a Special Interest Group took place in March 2025, with people from 11 GACD projects and alumni of GACD Implementation Science Schools.

So what?

How the working group's efforts contribute to the field

Meeting attendees discussed ideas for where to take the Special Interest Group. **Where could we have impact?** Several ideas are under consideration, including:

- The GACD team to host an informal, safe space discussion between researchers and GACD funding agency representatives to explore the realities of persistent inequities in funding structures and their impacts at the individual, institutional, and national level.
- Develop and publish a set of practical recommendations directed to funding agencies that address the key drivers of inequity within implementation research funding structures.
- Explore how "patient and public involvement (PPI)" in healthcare is implemented in LMICs. While the UK and Australia have established guidelines and support for PPI, these may not be applicable across all countries.
- Collate, compare, and contrast equity-centered TMFs for implementation research. Then, identify and describe alternative non-TMF tools and methods for equivalent understanding.
- Map how research teams are addressing equity within their practices. This might include, for example, use of equity-centred TMFs, adaptations of methods, equity-specific or -sensitive implementation strategies, and operationalisation of equity measures.

Resources

Publications and other resources relevant to the working group

Do you regularly use resources or tools that might be relevant to ENMESH? Perhaps you have developed one you would like to share? Add it to our resource repository!

For example... relevant resources might focus on the broad conversation to address and demonstrate the academic system for global health research, **OR** might focus specifically on measuring equity-sensitive outcomes in implementation research projects, **OR** frameworks you have found helpful in guiding equity-focused projects **OR** anything else!

ENMESH member and GACD School alumna, Roxanne Keynejad, led on developing 10 tasks for early career researchers to drive decolonisation across global health:

Keynejad RC, Desai D, Ingenhoff R, Eck I, Nie H, Graff S, Adhikari TB, Zajac P, Makdoni ME, Sakaar A, Ichtchenko HD, Guellem I, Abena HH, Amate HH, Alemayehu SG, Mukushaa A, Grosse P. Decoloniality in global health research: 10 tasks for early career researchers. BMJ Glob Health. 2023 Nov 24;8(11):e014208. PMID: 38002727; PMCID: PMC10649907. doi: 10.1136/bmjgh-2023-014208.

WORKING GROUP UPDAT

Primary health care

Poster content reviewed by Bob Mash, Lisa Hirschhorn, Devarselly Praveen, Renu John, Inayat Kakar, and Manushi Sha

Why?

The rationale for the working group

BACKGROUND

The primary healthcare (PHC) systems in LMICs which have traditionally focused on infectious diseases and maternal and child health, are not effectively structured to incorporate NCD care. Consequently, they are inadequately equipped to address the challenges of preventing and managing cardiovascular diseases, diabetes, cancers, and chronic respiratory diseases.

To understand the most effective and sustainable PHC service delivery model for managing chronic diseases in resource-limited settings, the **PHCNET** sought support from GACD.

By analysing research projects funded by the GACD within a designated timeframe, valuable insights on PHC-centered service delivery models and strategies could be extracted.

OBJECTIVES OF THE STUDY

1. To identify key components of PHC service delivery models for NCDs in LMIC settings from the work funded by the GACD.
2. To identify what has been learnt by the GACD projects on strategies to implement these components.
3. To describe the contextual factors that influence the implementation of these strategies.

*The Primary Health Care Research Consortium (PHCRC) was established to support the development and sharing of research

How?

What the working group did and how they worked across GACD projects

STUDY DESIGN AND THEORETICAL FOUNDATIONS

A mixed methods study combining quantitative and qualitative data. Authors applied the Primary Health Care Performance Initiative (PHCPI) framework. The PHCPI framework assesses key components of PHC and informs improvements. It focuses on service delivery, divided into five subdomains and 21 components.

PROJECT SELECTION AND INCLUSION

The entire GACD database of funded projects until 2018 was reviewed to identify projects with a PHC focus. Projects were included if they focused on the general population and not a specific community or if the intervention was not delivered through or with PHC services.

DATA EXTRACTION

Data including project title, study design, and NCD focus were extracted from project website and protocol papers.

Co-authors used PHCPI subdomains to extract information on the study intervention. In each domain, the most important component was identified.

QUALITATIVE DATA

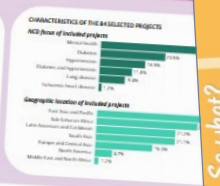
Sixteen projects were chosen for key informant interviews in 2023 to delve deeper into issues. Selection criteria included coverage of service delivery subdomains, NCDs, and diverse regions. The final number of interviews was based on data saturation.

ANALYSIS AND INTEGRATION

Quantitative categorical data on project characteristics were analysed descriptively using frequencies and percentages. Qualitative data were transcribed and checked for errors, and thematically analysed. This convergent mixed methods study aimed to integrate both quantitative and qualitative findings in the results section based on the study's objectives.

CHARACTERISTICS OF THE 84 SELECTED PROJECTS

NCD focus of included projects



What?

The working group's progress, findings, and key insights

The 84 selected GACD projects concentrated on specific subdomains related to service delivery within the PHCPI framework. The primary emphasis was on population health management, particularly proactive outreach to reduce NCD risks, enhance knowledge and broaden community-based primary care services for individuals with NCDs, often involving community health workers (CHWs).

Figure 1 shows the frequency with which more than one subdomain was targeted within the same studies. The most common shared subdomains were between facility organization and management, available PHC services, and digital health. For example, many studies engaged with task shifting and training to improve the comprehensiveness of NCD care.

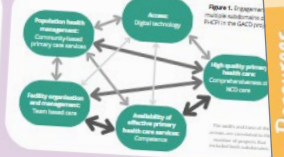


Figure 1. Engagement

In terms of facility management and organization, the focus was on team composition and shifting tasks to less trained but more affordable healthcare workers. Regarding access, there was significant utilization of digital technologies to boost service utilization or connect with individuals remotely.

Another area of focus within effective PHC services was enhancing the skills of existing healthcare workers through training and digital interventions, aiming to improve the comprehensiveness of services for NCDs. These focal points were frequently interconnected for instance, task shifting could be paired with training healthcare workers to elevate their competency and the overall quality of NCD care.

So what?

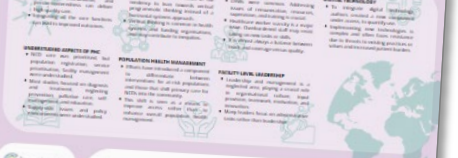
How this working group's efforts contribute to the field

KEY MESSAGE

PHC models for NCDs should focus on:

- Proactive outreach
- Community services
- Crisis
- Task-shifting
- Digital technology
- Training
- Comprehensive care

Future initiatives should enhance the entire PHC system instead of treating NCDs as a separate programme.



Resources

Publications and other resources relevant to the working group

Mash R, Ichtchenko LD, Kakar IS, John R, Sharma M, Praveen D. (2025) Global lessons on strengthening the delivery and services of primary healthcare for people with non-communicable diseases: a convergent mixed methods study protocol. Fam Med Community Health. 13:e003053. PMID: 39909505.

Primary health care research consortium (PHCRC)

Members

Robert Mash	Stellenbosch University	South Africa
Lisa Hirschhorn	Northwestern University	US
Inayat Singh Kakar	The George Institute for Global Health	India
Renu John	Manipal Academy of Higher Education	India
Manushi Sharma	The George Institute for Global Health	India
Devarselly Praveen	The George Institute for Global Health and Manipal Academy of Higher Education	India

SPECIAL INTEREST GROUP

Indigenous populations

Poster text prepared by Kym Yuke (Southern Cross University, Australia) and Violet Naanyu (Moi University, Kenya)

Why?

The rationale for the special interest group

WHO ARE WE?

The Indigenous populations working group was set up in 2019 to share learnings and best practices between Indigenous researchers and those working with Indigenous communities. To continue building on the successes of the working group, members decided in 2024 to become a Special Interest Group (the IPSIG). The IPSIG so become a Special Interest Group (the IPSIG). The IPSIG aims to work with Indigenous researchers and/or researchers working with Indigenous communities within and beyond the GACD Research Network.

BACKGROUND

- Indigenous Peoples commonly experience high levels of chronic disease as a consequence of colonisation.
- There has been a history of exclusion of Indigenous ways of knowing, being, and doing within research practice and academic institutions.
- Research has been poorly aligned to Indigenous Peoples' goals and values and there is an absence of Indigenous community engagement and voices.
- There is lack of cultural safety in research.
- There is a new era of Indigenous research with a stronger alignment of research ethics, methods and approaches with Indigenous values and worldviews, and more research led by Indigenous Peoples.

WHY THE IPSIG?

- To share learnings and best practices between projects working with Indigenous communities and Indigenous researchers.
- To facilitate knowledge sharing, mentoring and peer-to-peer support with the research communities who identify as Indigenous as well as non-Indigenous researchers who are allies in Indigenous research.
- To ensure there is a focus on research to address gaps in the implementation of evidence-based best-practice care for Indigenous communities.
- To understand what best practice for peer review and funding of research is working with Indigenous communities.
- To ensure that there is Indigenous guidance in any research with or about Indigenous peoples so that there is equitable, genuine and mutually beneficial collaboration between researchers and Indigenous communities.

How?

What the special interest group has done (or will do) and how they worked across GACD projects

RESEARCHERS' STATEMENT

In 2023, the Indigenous Populations Working Group published a statement in the Lancet on working in a culturally safe way with Indigenous populations. The review was led by David Wanyiri, Jennifer Allison, and Violet Naanyu, with input from the Indigenous Populations Working Group.

The statement:

- Draws attention to the health consequences of colonisation and research-centric research practices.
- Advocates for stronger inclusion of Indigenous ways of knowing, being and doing to guide research.
- Promotes the use of participatory-based approaches to co-design culturally safe research.
- Encourages the development of authentic relationships with Indigenous communities to co-design community-identified research and support the achievement of meaningful outcomes.

The statement can be found under Resources' below.

NEXT STEPS

The IPSIG is keen to carry out a systematic review, focused on implementation science with Indigenous Peoples.

FUTURE DIRECTIONS

Following consultation with the IPSIG members, the group is aiming to:

- Set up communities of practice to support both Indigenous researchers and those working with Indigenous communities to work together in a culturally safe and mutually beneficial manner.
- Run an online workshop to initiate these CoPs and promote culturally safe methods in Indigenous research.
- Create a database of relevant funding opportunities.
- Scope out best practice for reviewing and funding research with Indigenous communities and/or Indigenous researchers.
- Conduct a systematic literature review focused on implementation science with Indigenous Peoples.
- Develop and launch an online, on-demand training programme on the GACD e-hub, **Bridging Knowledge Traditions: Implementation and Honouring Traditions: Research on Non-Communicable in Indigenous Contexts**.

THE INDIGENOUS POPULATIONS SPECIAL INTEREST GROUP HAS...

71 MEMBERS

...from more than

35 PROJECTS

...in over

20 COUNTRIES

Interested?

Join our roundtable on Day 2, Tuesday 10 June, from 4:15 PM in the Kilimanjaro Ballroom

Anyone from an Indigenous community, working with Indigenous communities, or otherwise interested in learning more is welcome.

So what?

How the working group's efforts contribute to the field

The IPSIG continues to promote best practices, culturally safe approaches to working with Indigenous communities, and Indigenous researchers. In future, the IPSIG aims to provide career guidance and support for researchers from Indigenous communities, and to improve review and award practice for funders offering grants for research with Indigenous communities.

CO-CHAIRS

Kym Yuke (Southern Cross University, Australia) and Violet Naanyu (Moi University, Kenya)

INTERESTED IN JOINING THE SPECIAL INTEREST GROUP?

The IPSIG is open to new members. It seeks to grow its network and support more work with and by Indigenous People. It invites all who are working on a project with Indigenous communities or are from an Indigenous community to get involved.

Get in touch with admin@gacd.org

Resources

Publications and other resources relevant to the working group

RESEARCHERS' STATEMENT PUBLICATION

Wanyiri, DP, Naanyu V, Ramboldt D et al. The Global Alliance for Chronic Diseases researchers' statement on non-communicable disease research with indigenous peoples. Lancet Glob Health. 2023 Mar;11(3):e326-e326. PMID: 36796972.

FULL STATEMENT

www.gacd.org/perch/resources/gacd-pwp-full-statement-january-2024.pdf

WORKING GROUP UPDATE

IMPLEMENTING NCD PROGRAMMES IN Humanitarian settings

Poster text prepared by Pablo Perel

Why?

The rationale for the working group

NCDs are increasingly common in humanitarian settings, yet they remain largely neglected in crisis responses.

Proven interventions for NCDs exist but are not typically implemented in these settings.

These settings have unique challenges characterised by instability, mobile populations, extreme vulnerability, resource constraints, disrupted health systems, and unknown rates of complications and mortality.

Evaluating how to implement NCD interventions in these contexts is crucial to ensure their feasibility, potential impact, and sustainability.

There is a significant gap in implementation research for proven NCD interventions in humanitarian crises, which the working group aims to address.

How?

What the working group did and how they worked across GACD projects

The group started with a small team of researchers interested in NCDs in humanitarian settings, who hosted several virtual meetings to explore areas of common interest.

Due to the COVID-19 pandemic coinciding with the group's establishment and the lack of specific GACD humanitarian projects, we began by writing two NCD-COVID-19 papers:

- One was a narrative review examining factors influencing the implementation of remote (non-facility-based) delivery approaches for people with hypertension and/or diabetes to inform NCD care delivery during health service disruption in humanitarian crises.
- The other paper reported an online survey of humanitarian actors to explore factors affecting NCD care implementation (and adaptations) during the COVID-19 pandemic.

We supported and strengthened the **NCD in Humanitarian Settings Knowledge Hub**, an online platform (hosted by the London School of Hygiene & Tropical Medicine), which serves as a one-stop resource on this topic.

Members of the group collaborated in a research prioritisation exercise on NCDs in humanitarian settings, conducted by **ELHRA** (Enhancing Learning and Research for Humanitarian Assistance).

MOVING FORWARD

- After completing initial group projects, we will transition to a special interest group focused on knowledge exchange and networking.
- We aim to attract new researchers working on NCDs in humanitarian settings to expand our network.
- All individuals with relevant expertise, experience, or interest in the GACD Research Network are welcome to join!

What?

The working group's progress, findings, and key insights

By consolidating most ongoing research on this topic in one place, we **facilitated collaboration** among different research groups.

We contributed to **identifying research priorities**, including implementation research, within the ELHRA report.

In the narrative review, we highlighted the **complex and interdependent factors** influencing the implementation of remote NCD care, particularly in contexts where facility-based access is limited.

We identified key areas for implementation research, such as **context-adapted e-health, community-based approaches,** and **simplified clinical management strategies**.

In our online survey, **we called for the COVID-19 experience to prompt national and global health stakeholders** to strengthen the inclusion of NCDs in emergency preparedness, response, and resume planning.

We also shared key lessons learned on **remote care provision**, including:

- Adapting to NCD severity
- Integrating community health workers
- Providing context-adapted patient information
- Combating misinformation
- Strengthening cross-sectoral partnerships.

So what?

How the working group's efforts contribute to the field

Facilitate **knowledge exchange and capacity building** among researchers.

Collate, evaluate, and propose **best practice research** for NCDs in humanitarian settings for the benefit of the wider community.

Work with stakeholders (including funders, WHO, and humanitarian organisations) to **identify and facilitate research priorities** for NCDs in humanitarian settings.

Explore **one or two projects per year** to conduct as a group (e.g., standardisation of indicators, a paper on specific methodology).

Resources

Publications and other resources relevant to the working group

WEBSITE

NCDs in Humanitarian Settings Knowledge Hub

www.lshtm.ac.uk/research/centres-projects-groups/humanitarian-ncd

PUBLICATION

Ansbro É et al. (2024) Lessons from the COVID-19 pandemic to strengthen NCD care and policy in humanitarian settings: A mixed methods study exploring humanitarian actors' experiences. BMC Health Serv Res. 24(1):581.

PUBLICATION

Tatum C et al. (2023) Factors influencing the Implementation of Service Delivery Strategies for Non-Communicable Disease Care in Low- and Middle-Income Countries: A Narrative Review. Public Health Rev. 45:1606583.

Members

CO-CHAIRS

Pablo Perel and Emmi Ansbro - London School of Hygiene and Tropical Medicine, UK

INTERESTED IN JOINING THE GROUP?

Are you working in a humanitarian setting and interested in connecting with others? Do you have fresh ideas for a new joint project or other ways of knowledge sharing?

Then join our Special Interest Group!

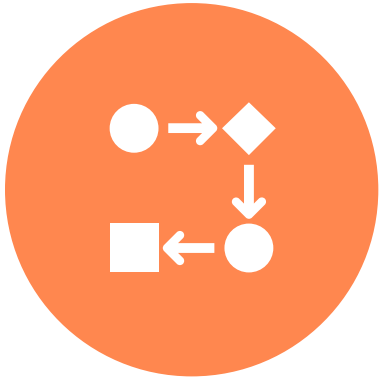
Get in touch with the group's GACD coordinator, Margaret: m.lee@gacd.org

GACD projects in Nepal

Roundtable
Tuesday 10 June
From 4:15 PM

Indigenous Populations special interest group

Roundtable
Tuesday 10 June
From 4:15 PM



How do GACD project teams use RE-AIM?

Conversation group
Wednesday 11 June
From 8:30 AM

Planetary health special interest group

Conversation group
Thursday 12 June
From 8:30 AM

Systems approach to upscaling

SPARK
Scale up research reporting checklist

NCDs and acute infections

Inter-project contributions to the GACD e-Hub

GACD Diabetes Report

Systems approach to upscaling

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Scale up research reporting checklist

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GACD Diabetes Report

NCDs and acute infections

John Hurst – University College London, UK

Lijing Yan – Duke Kunshan University, China

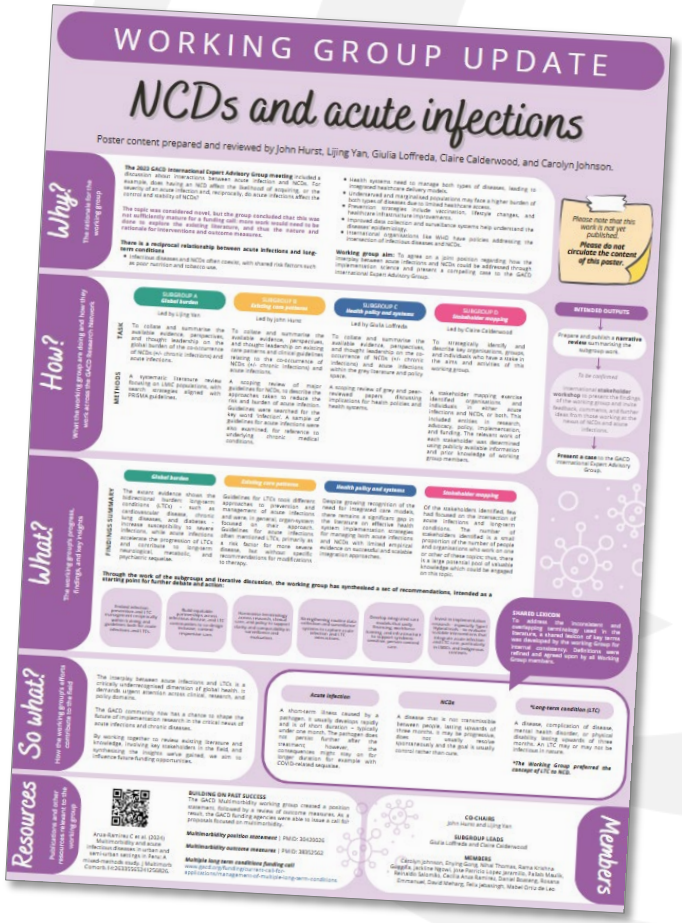
Giulia Loffreda – World Health Organization

Claire Calderwood – London School of Hygiene and Tropical Medicine, UK

John Hurst
University College London, UK

Subgroups

- Shared lexicon
- Global burden
- Patterns of care
- Policy and health systems
- Stakeholder mapping



Shared lexicon

- Overlapping, confusing, and poorly defined
- Health problems and/or disabilities that do not fit neatly into classifications

Long-term condition (LTC): a disease, complication of disease, mental health disorder, or physical disability lasting at least three months; may/may not be caused by infection.

Patterns of care

- Guidelines for LTCs were, in general, organ-system focused
- Guidelines for acute infections often mentioned LTCs, primarily as a risk factor for more severe disease, but without specific recommendations

Lijing Yan
Duke Kunshan University, China

Global burden

- The lived reality of millions of people is that LTCs and acute infections are important causes and consequences of each other.
- Critically under-recognised dimension of global health.
- Bidirectional burden.
- Full results of the global burden systematic review will be published in due course.

Giulia Loffreda
Alliance for Health Policy and Systems Research (AHPSR/WHO)

Policy and health systems perspective

- Critical gap between policy aspiration and health system implementation.
- Evidence on how to deliver scalable, sustainable models that address both infectious and chronic conditions concurrently is limited.
- Many countries still operate siloed disease programmes, with separate budgets, vertical reporting structures, and disease-specific performance indicators.
- The syndemic framework offers a valuable lens for understanding how social, economic, and environmental factors interact with disease clustering.

Stakeholder mapping

- 37 stakeholders, typically with narrow perspectives.
- Focus areas were either:
  - Infection-specific with LTC consequences **OR**
  - LTC-specific with infection causes/consequences **OR**
  - Supporting LTC patients during outbreaks
- Funders' scopes varied.
- Service models for LTCs rarely featured acute infections.
- Regional priorities differed.
- Key gaps:
  - Under-representation from Asia and parts of South America
  - Lack of digital innovation
  - No identified mental health interest

John Hurst
University College London, UK

Embed infection prevention and LTC management reciprocally within training and guidelines both for acute infections and LTCs.

Build equitable partnerships across infectious disease, and LTC communities to co-design inclusive, context-responsive care.

Harmonise terminology across research, clinical care, and policy to support clarity and comparability in surveillance and evaluation.

Strengthening routine data collection and surveillance systems to capture acute infection and LTC interactions.

Develop integrated care models that unify financing, workforce training, and infrastructure to support syndemic-sensitive, person-centred care.

Invest in implementation research – especially Type I Hybrid trials – to evaluate scalable interventions that integrate acute infection and LTC care, particularly in LMICs and Indigenous contexts.

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The GACD e-Hub:

Strengthening Implementation Science Capacity For NCD Programmes

Kevin Mao, Zahra Aziz, Esther Ye, Elly Francis-Pester, and Brian Oldenburg on behalf of the broader GACD e-Hub team

GACD IS Capacity Strengthening

School

Live sessions
Online
~Early career
Breadth first

GACD e-Hub

Self-paced
Online
Any career stage
Flexible and accessible

Masterclass

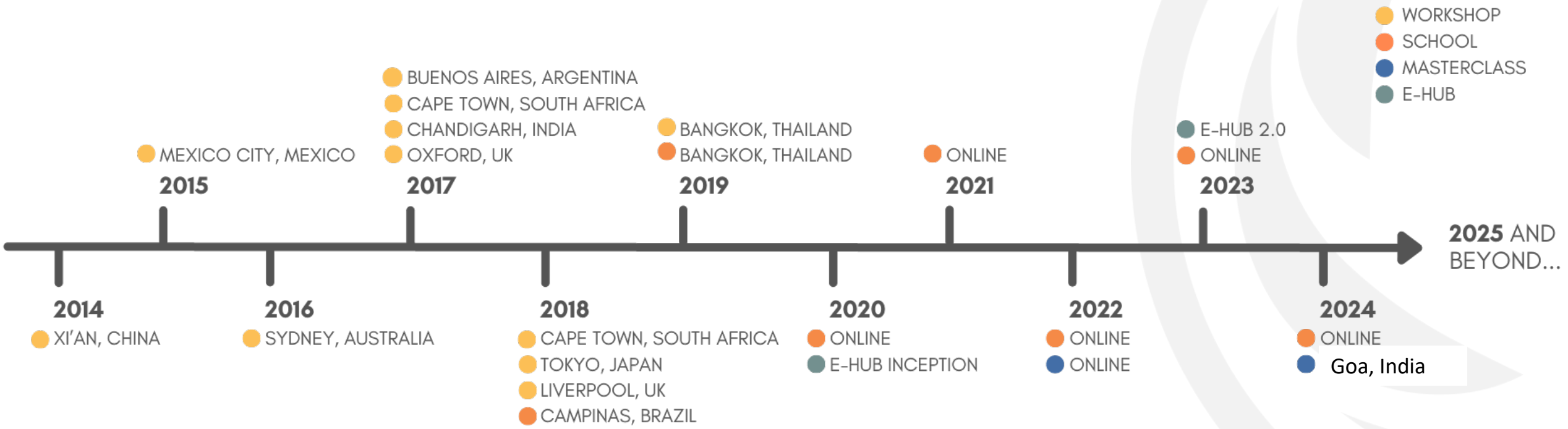
Live sessions
Online **and** in-person
~Mid-career
Scale up focused

Workshop

(mid-year)

Live session
Online
Any career stage
Thematic

Chronology of GACD Training



Navigating the e-Hub

01 **Training Programmes**

- 1.1 Fundamentals Programme
- 1.2 Advanced Programme
- 1.3 Express Programme (coming soon)

02 **Resource Toolkit & Database**

03 **Learning Collections**

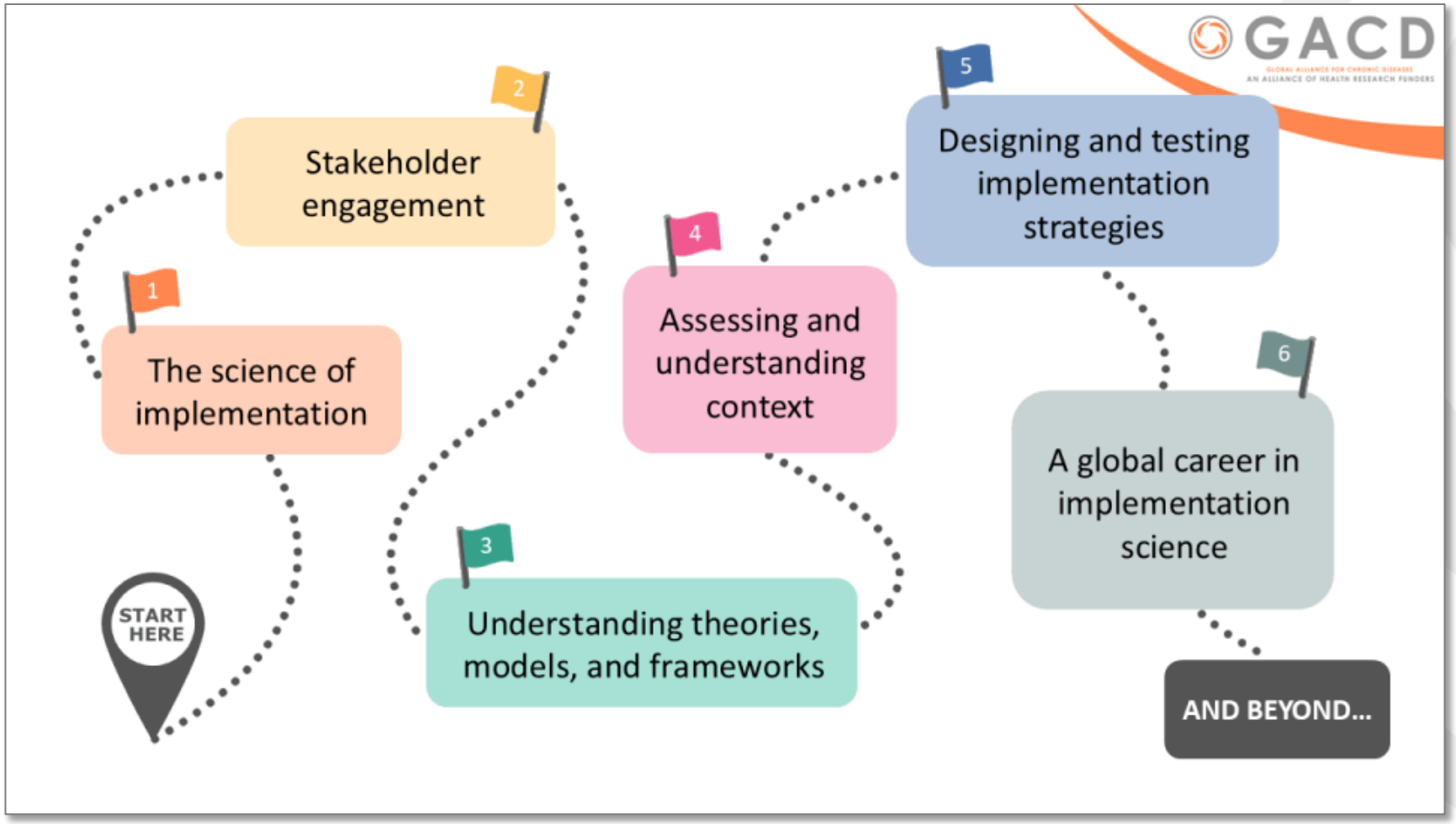
- 3.1 Stakeholder Engagement
- 3.2 Theories, Models and Frameworks

04 **Case Studies**

05 **GACD International Advisory Board**

06 **Acknowledgements**

1.1 Training Programmes – Fundamentals Programme

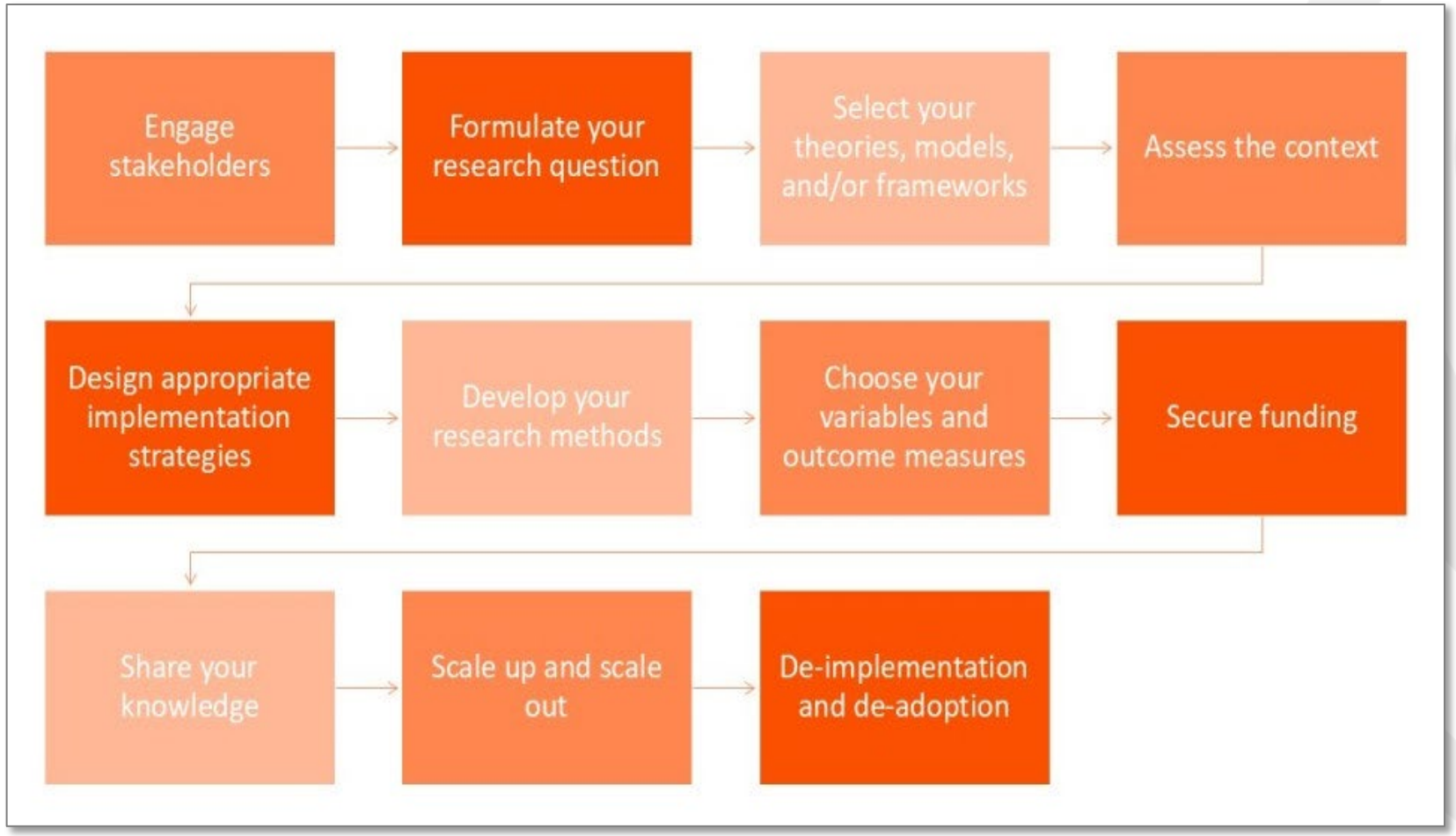


https://implementationscience-gacd.org/fundamentals-programme/

1.2 Training Programmes – Advanced Programme

https://implementationscience-gacd.org/advanced-programme/

2. Resource Toolkit and Database



https://implementationscience-gacd.org/getting-started/

3. Learning Collections

What are the e-Hub's Learning Collections?

Curated Learning Journeys: Targeted pathways through e-Hub content, bringing together relevant resources on specific challenges or ideas in implementation and scale-up science.

1. Stakeholder Engagement Collection

Focus: Structured introduction to **effective and meaningful stakeholder engagement** in implementation research, especially for NCD programs in LMICs.

2. Theories, Models, and Frameworks (TMFs) Collection

Focus: A structured guide to **understanding and applying TMFs** for NCD program implementation and scale-up.

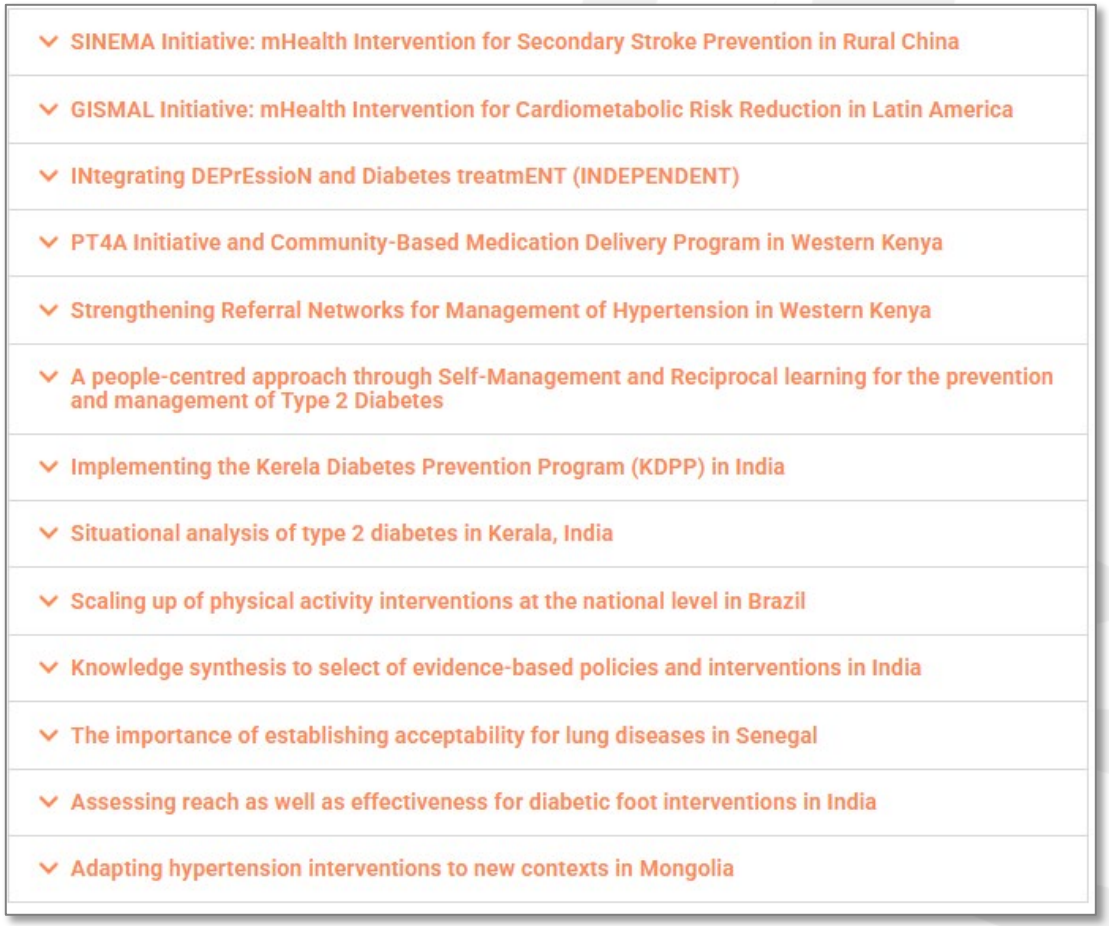
https://implementationscience-gacd.org/collections/

4. Case Studies

What You'll Discover:

- Explore diverse, real-world examples of implementation science principles applied to chronic and non-communicable diseases (NCDs) across various global settings and populations.
- Highlighting successful application of frameworks, strategies for overcoming challenges, and lessons learned from direct experience.

Want to see your work featured as a case study?
Visit our site at:
https://implementationscience-gacd.org/case-studies/

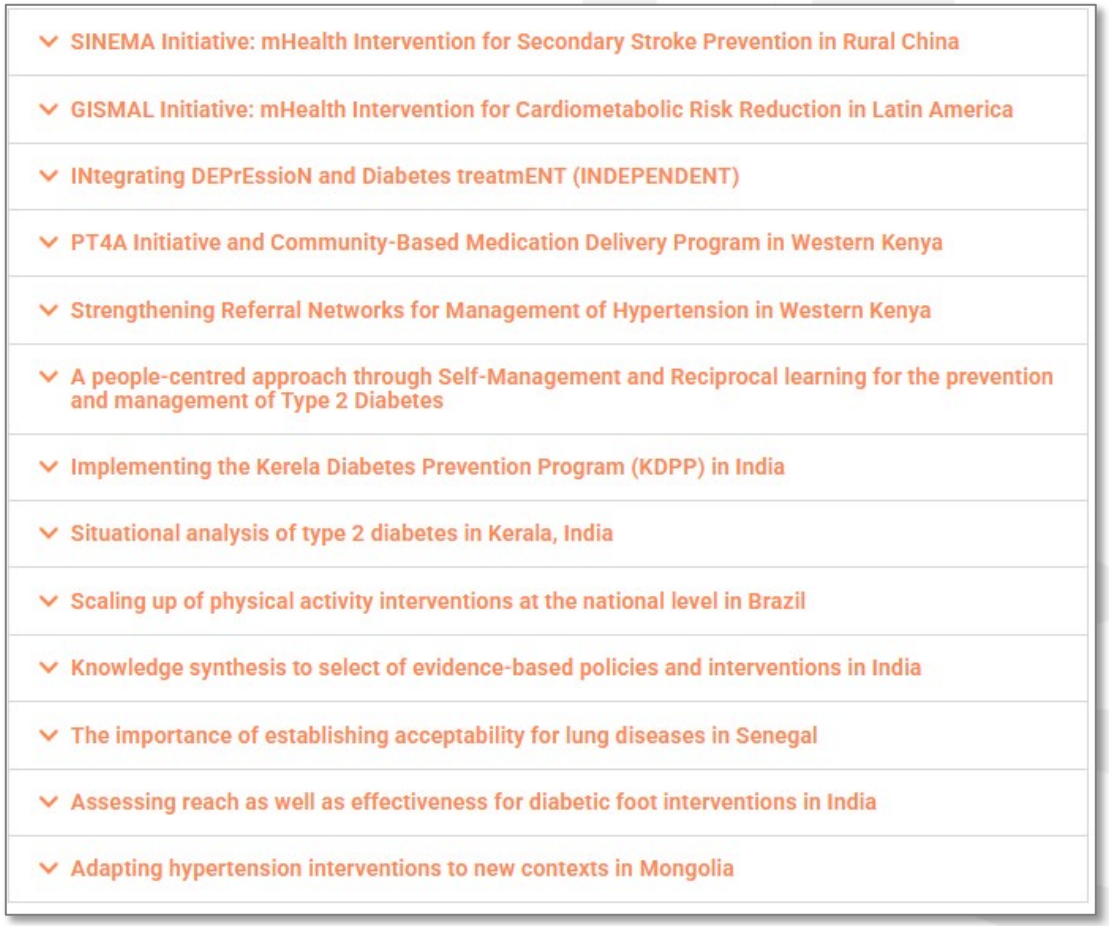


4. Case Studies

Impact & Scope:

- Drawn from the **GACD's portfolio of over 180+ projects** addressing implementation gaps in NCDs across **80+ countries**.
- Covering a wide range of NCDs, from stroke prevention and diabetes management to hypertension and physical activity interventions.

Want to see your work featured as a case study?
Visit our site at:
https://implementationscience-gacd.org/case-studies/



5. GACD International Advisory Board

Dr Kremlin Wickramasinghe

WHO Regional Office for Europe, Denmark

Dr Karin Geffert

WHO European Office for Prevention and Control of Noncommunicable Diseases, Russian Federation

Prof Pilvikki Absetz

Tampere University, Finland

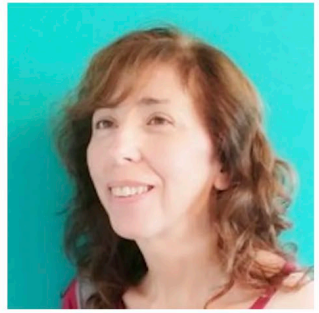
>> More

Dr Zahra Aziz

Monash University and University of Melbourne, Australia

Dr Edward Gregg

Royal College of Surgeons in Ireland, Ireland



Dr Vilma Irazola

Institute for Clinical Effectiveness and Health Policy (IECS), Argentina

Dr Catherine Kyobutungi

African Population and Health Research Center (APHRC), Kenya

Dr David Peters

York University, Faculty of Health, Canada

Dr Rachel Sturke

Fogarty International Center, National Institutes of Health (NIH), US

Dr Rajesh Vedanthan

NYU Grossman School of Medicine, US

Dr Lijing Yan

Duke Kunshan University, China

Prof Jaime Miranda

University of Sydney, Australia

6. Acknowledgements

Brian Oldenburg
e-Hub Director, **Australia**

Morven Roberts
CEO, GACD, **UK**

Isobel Bandurek
Research Capacity Manager, GACD, **UK**

Elly Francis-Pester
e-Hub Project Officer, **Australia**

Esther Ye
e-Hub Project Officer, **Australia**

Zahra Aziz
e-Hub Advisor, **Australia**

Thank You

For Your Attention

To access the e-Hub and all of the resources, - such as training videos, implemetation science resources, learning collections and the educator's portal - scan the QR code or log on to https://implementationscience-gacd.org/

We would love to hear from you:

kevin.mao@baker.edu.au

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GACD Diabetes Report

GACD Diabetes Report

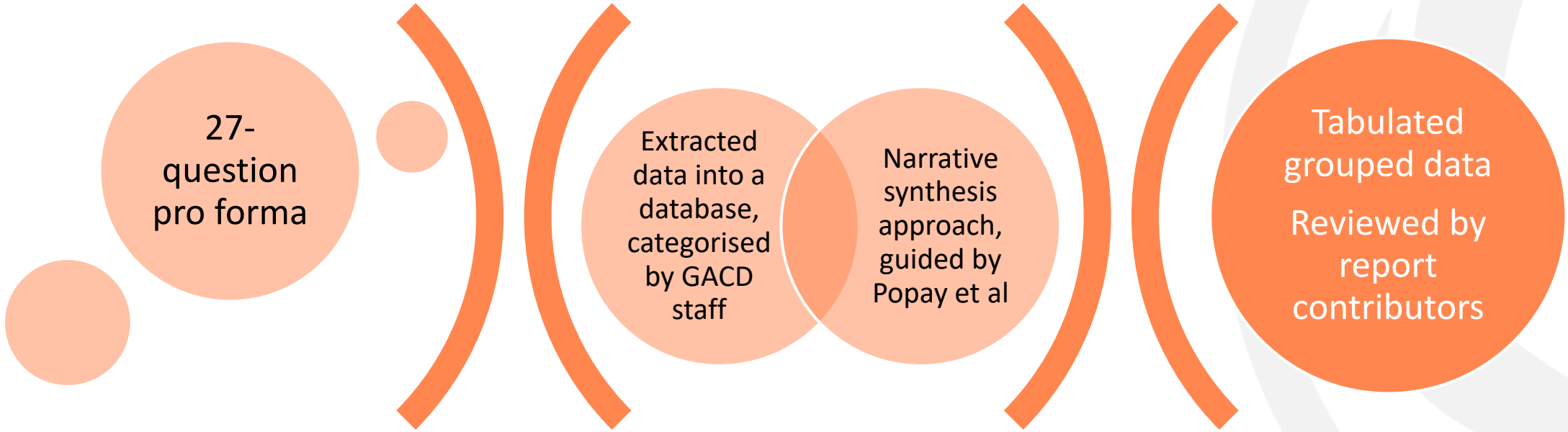
Maisha Syed – Global Alliance for Chronic Diseases

Aims of the report

1. **Summarise** the 14 GACD-funded diabetes implementation research projects
2. Provide an **initial synthesis** and appraisal of the methods, strategies, results, and impact
3. Serve as a **springboard** for researchers to further consider future meta-syntheses of implementation science projects
4. Invite readers to **build on the interpretations** presented

www.gacd.org/our-impact/diabetes-report

Preparation of the report



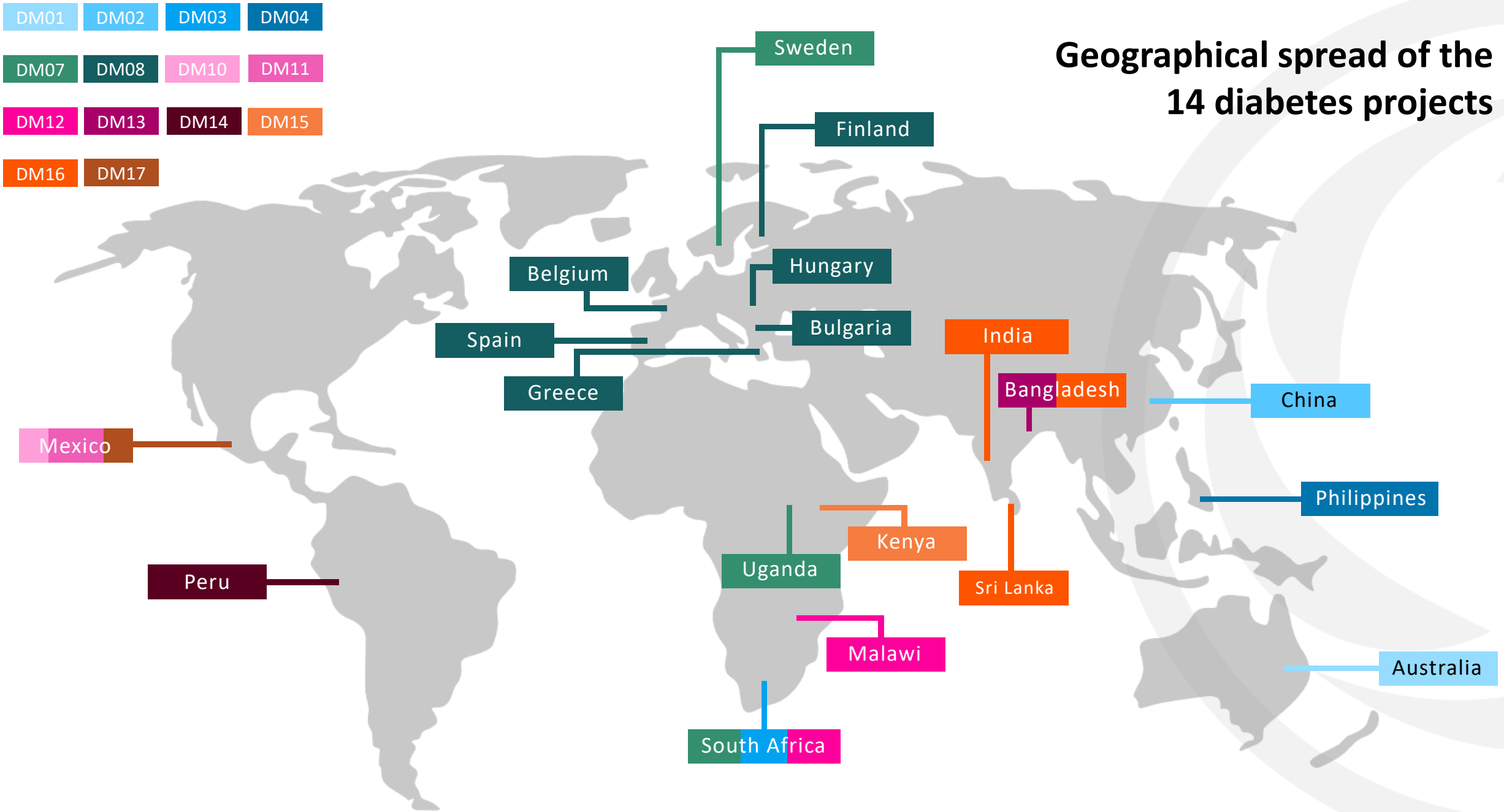
Data collection

Analysis

Interpretation

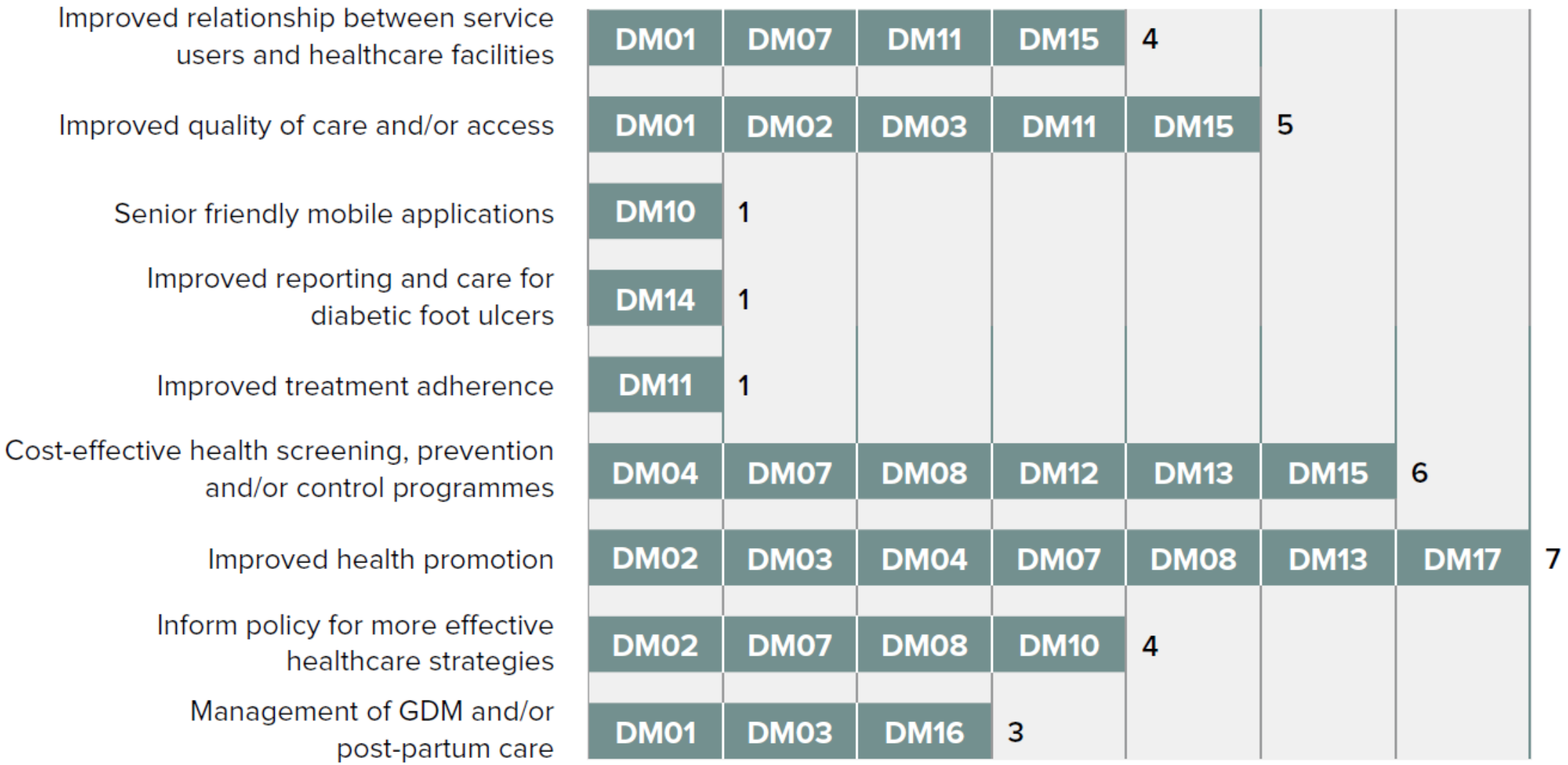
DM01	Improving the management of diabetes in pregnancy in remote Australia
DM02	SMART Diabetes: **S**ystematic **M**edical **A**ssessment, **R**eferral and **T**reatment for **Diabetes** care in China using Lay Family Health Promoters
DM03	IINDIAGO: **I**ntegrated **IN**tervention for **DIA**betes r**I**sk after **G**estati**O**nal diabetes
DM04	CHAPP: **C**ommunity **H**ealth **A**ssessment **P**rogram in the **P**hilippines
DM07	SMART2D: A people-centred approach through **S**elf-**MA**nagement and **R**eciprocal learning for the prevention and management of **T**ype **2** **D**iabetes
DM08	Feel4Diabetes (**F**amilies across **E**urope following a h**E**althy **L**ifestyle **4 Diabetes** prevention
DM10	Development of an interactive social network for metabolic control of patients with diabetes
DM11	Development and validation of software to provide medical treatment and patient empowerment to type 2 diabetics, through interaction with medical staff and real-time recording]
DM12	Mobile phone text-messaging to support treatment for people with type 2 diabetes in sub-Saharan Africa: a pragmatic individually randomised trial
DM13	The Bangladesh D-Magic Trial: **D**iabetes **M**ellitus **A**ction through **G**roups or **I**nformation for better **C**ontrol
DM14	Implementation of foot thermometry and SMS to prevent diabetic foot ulcer
DM15	BIGPIC: **B**ridging **I**ncome **G**eneration with **G**roup **I**ntegrated **C**are
DM16	A lifestyle intervention program for the prevention of type 2 diabetes mellitus among South Asian women with gestational diabetes mellitus
DM17	Tools and practices to reduce CVD and complications in diabetics in Mexico

Geographical spread of the 14 diabetes projects



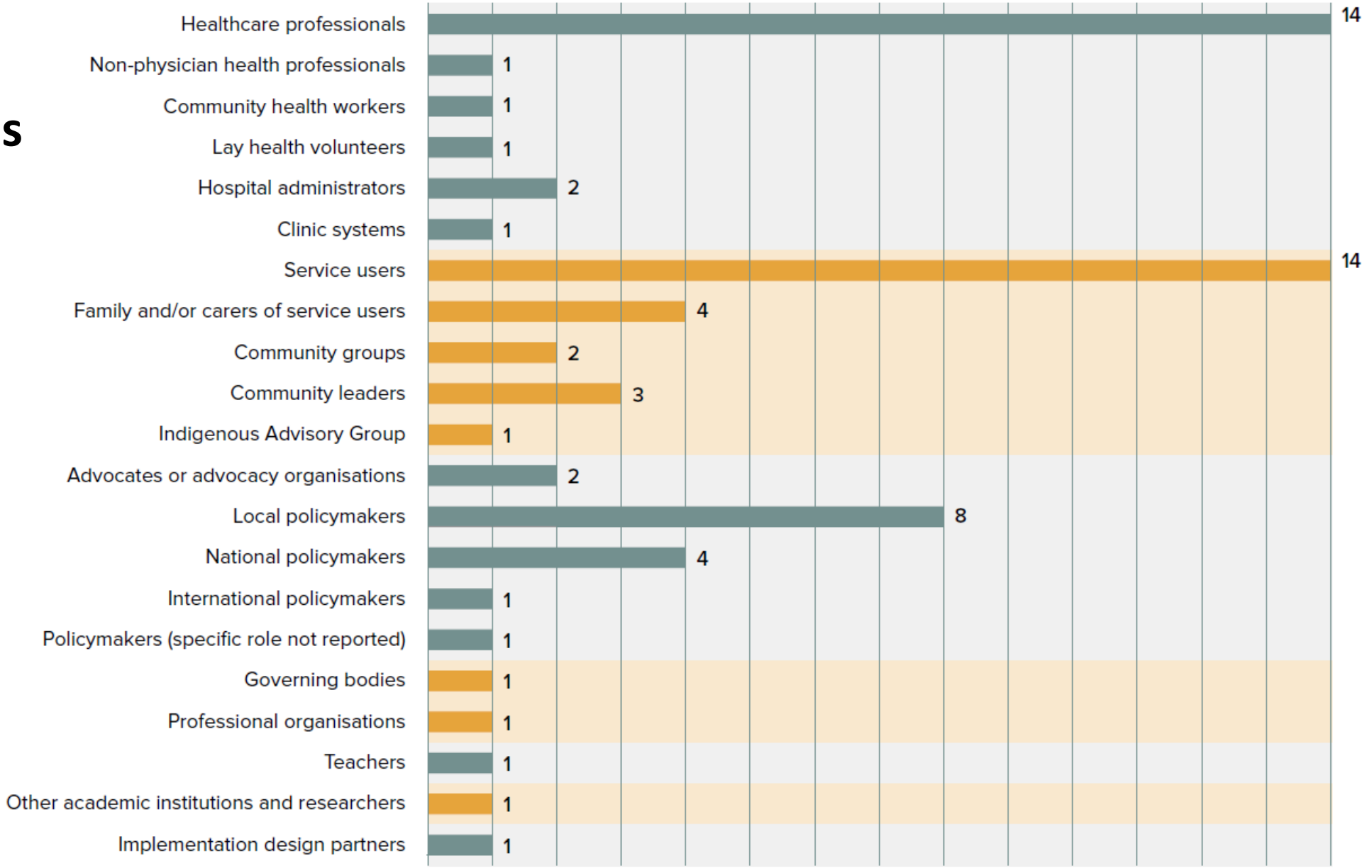
www.gacd.org/our-impact/diabetes-report

Implementation gaps addressed by the 14 diabetes projects



www.gacd.org/our-impact/diabetes-report

Stakeholder groups and frequency of engagement



Six different study designs were used across projects

- A feasibility study
- A prospective observational study
- Pre/post analyses
- A hybrid type 2 effectiveness-implementation study
- Individual randomised trial
- Cluster randomised trials

Mixed methods were the most favoured approach by researchers

Theories, models, and frameworks (TMFs)

Total

- 17 TMFs used across different functions

Most common

- COM-B, RE-AIM, and the MRC Framework

Applications

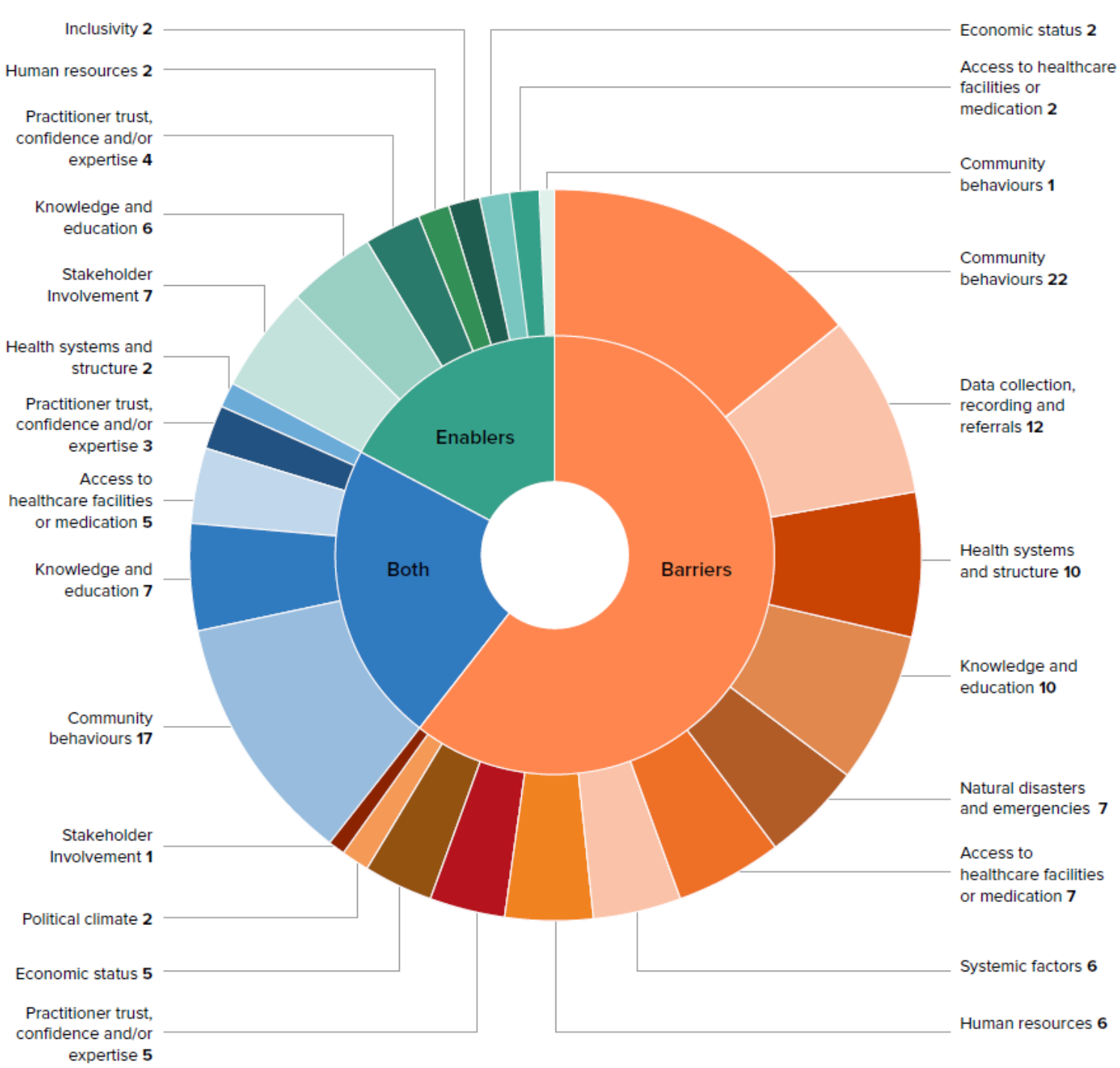
- Formative work, intervention implementation, strategy refinement, and evaluation

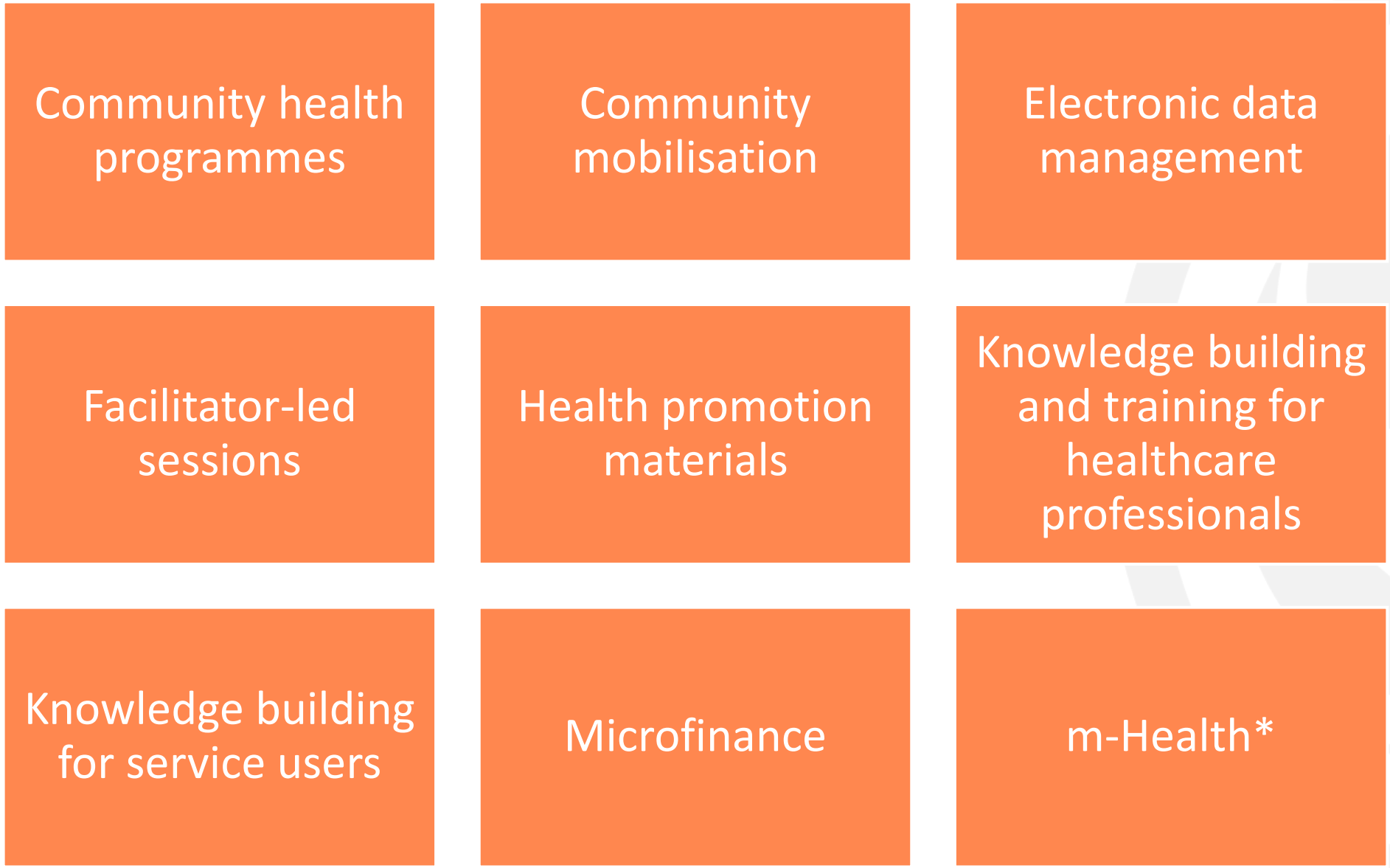
Multipurpose

- 11 TMFs were used for more than one purpose

Sunburst diagram of context-specific barriers and enablers faced

- Some contextual factors were consistently barriers **or** enablers across all projects
- Other factors differed depending on the setting





Xu et al. (2024) PMID: 38408460 | *Includes telephone calls, text messages, voice messages and mobile applications and/or software

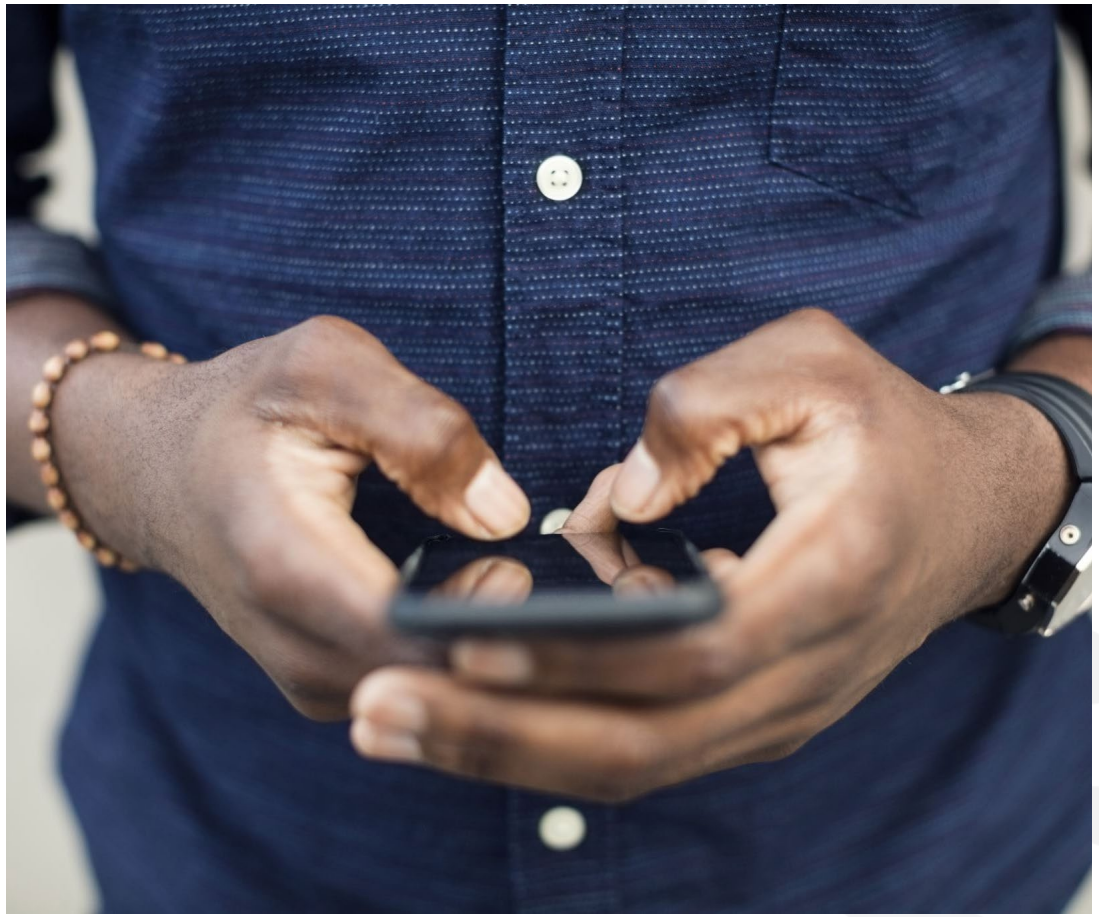
Community health programmes	Community mobilisation	Electronic data management
Facilitator-led sessions	Health promotion materials	Knowledge building and training for healthcare professionals
Knowledge building for service users	Microfinance	m-Health*

*Includes telephone calls, text messages, voice messages and mobile applications and/or software

The trends across commonly grouped themes create scope for future tailored research in these areas

Example 1

Telephone calls
and **voice messages**
were always accompanied by
facilitator-led group sessions,
but not vice versa



The trends across commonly grouped themes create scope for future tailored research in these areas

Example 2

Health promotion materials were always accompanied by knowledge building for service users, as were community health programmes and community mobilisation

Twelve projects reported impact

The most common themes of impact were:

Strengthened national health systems to respond to the burden of diabetes

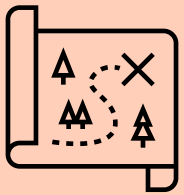
Influence on national health programmes, strategies or guidelines

Programme scale up

Six core lessons learned

Collaborate for success

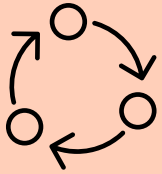
Tailor to context



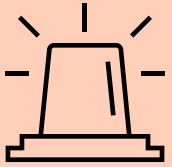
Technology is a tool, not a silver bullet

Address health inequities

Consider sustainability from the start



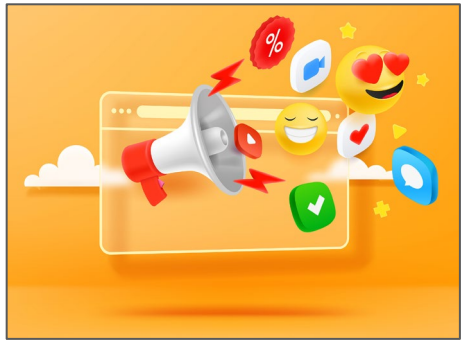
Expect the unexpected



Accompanying outputs

- Full report (open access)
- Key message flyers
- Full slide set
- Social media toolkit
- Coming next year… commentary publication

www.gacd.org/our-impact/diabetes-report



Lead author: Maisha Syed – GACD Research Assistant

On behalf of the GACD Programme Subcommittee: Patricia Ridgway – National Health and Medical Research Council, Australia

The GACD secretariat are indebted to the people who took the time and effort to collate data from across the duration of their project and kindly agreed to share it in the spirit of open collaboration.

Primary reviewers

- Gina Agarwal – McMaster University, Canada
- Peter Delobelle – University of the Western Cape, South Africa
- Edward Fottrell – University College London, UK
- Brian Oldenburg – Baker Heart & Diabetes Institute, Australia
- Francisco Salazar Gonzalez – Universidad De Monterrey, Mexico
- Josefien van Olmen – University of Antwerp, Belgium

www.gacd.org/research/research-network

Working group form

Special interest group form

Once-off event form

Download the **Research Network terms of refe**

Are you a member of the Research Network and
event? Download a proposal form and send it to

[Working group proposal form]

[Special interest group proposal form]

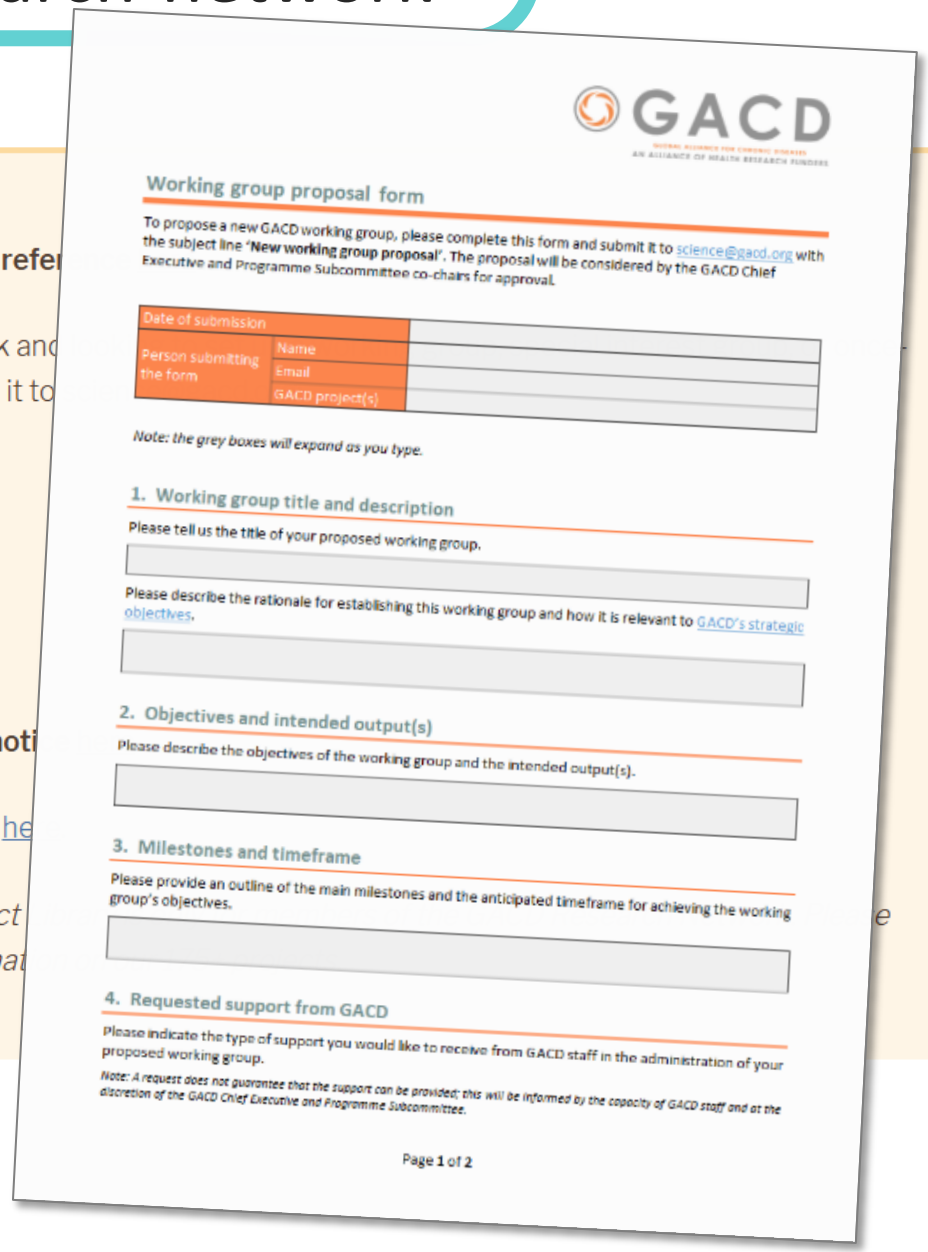
[Once off event proposal form]

Download the **Research Network privacy noti**

Download the **GACD Project Library guide** he

Please note that access to the GACD Project
visit our projects webpage for public informat

Share this page



GACD

Working group proposal form

To propose a new GACD working group, please complete this form and submit it to science@gacd.org with the subject line '**New working group proposal**'. The proposal will be considered by the GACD Chief Executive and Programme Subcommittee co-chairs for approval.

Date of submission		
Person submitting the form	Name	
	Email	
	GACD project(s)	

Note: the grey boxes will expand as you type.

1. Working group title and description

Please tell us the title of your proposed working group.

Please describe the rationale for establishing this working group and how it is relevant to GACD's strategic objectives.

2. Objectives and intended output(s)

Please describe the objectives of the working group and the intended output(s).

3. Milestones and timeframe

Please provide an outline of the main milestones and the anticipated timeframe for achieving the working group's objectives.

4. Requested support from GACD

Please indicate the type of support you would like to receive from GACD staff in the administration of your proposed working group.

Note: A request does not guarantee that the support can be provided; this will be informed by the capacity of GACD staff and at the discretion of the GACD Chief Executive and Programme Subcommittee.

Page 1 of 2

Lunch break 12:00–13:30

Invitation to early-career researchers: lunchtime networking – bring your food and meet us at the Soko Restaurant, from 12:15 (ish) ☺

After lunch…

8. **Research Programme workshops** (1:30pm – 3:30pm)

   Scale Up – Kilimanjaro 1

   Cancer – Rubavu Ballroom

   Life Course & Mental Health – Kilimanjaro 3

   Healthy Cities – Kilimanjaro 2

9. **Roundtables** (from 4:00pm)

With happy hour from ~5:00pm

Roundtables

Principal investigators' roundtable

~4:30 to 5:30pm | Rubavu Ballroom

Lead: Morven Roberts

Closed session for PIs of GACD projects

Educators' roundtable

~4:30 to 5:30pm | Kilimanjaro Ballroom

Lead: Kevin Mao

Open to anyone interested in teaching and strengthening capacity in implementation science

Indigenous Populations roundtable

~4:15 to 5:30pm | Kilimanjaro Ballroom

Lead: Seeromanie Harding

Open to anyone from an Indigenous community and/or working with and for Indigenous people

GACD projects in Nepal roundtable

~4:15 to 5:30pm | Kilimanjaro Ballroom

Lead: Rajshree Thapa

Open to anyone implementing a GACD project in Nepal (past and present!)