Global Alliance for Chronic Diseases

Research Network Webinar

16/17 April 2019

Your line has been muted on entry. If you would like to make a comment or ask a question, please let Gary know via the chat function. You will then need to unmute your line.
AGENDA

- Introduction & GACD overview
- Message from GACD Programme Committee
- Introduction of Scale-up Projects
- Research Network
  - Collaborative research efforts
  - Co-chairs
Welcome, introduction & GACD overview

Gary Parker

GACD Secretariat
London, UK
GACD Oversight Bodies

- Strategy Board
- Executive Committee
- Programme Committee (Prev. Management Committee)
- Secretariat
MISSION

To reduce the burden of chronic non communicable diseases (NCDs) in low- and middle-income countries, and in populations facing conditions of vulnerability in high-income countries, by building evidence to inform national and international NCD policies and contribute to the achievement of the Sustainable Development Goals under section 3.4.

- GACD Strategic Plan 2019-2024
MISSION

We do this by:

- **Investing** in impactful NCD research
- **Building** implementation science capacity and capability in relation to NCDs
- **Facilitating** collaborations and partnerships to support GACD investment

- *GACD Strategic Plan 2019-2024*
GACD RESEARCH NETWORK

- 900 Researchers
- 240 Institutions
- US$ 225 Million
- 87 Studies
- 66 Countries
- 15 Agencies
- 5 Research Programmes
The GACD currently funds implementation research projects across four programmes: hypertension, diabetes, lung diseases and mental health. Projects are conducted across 66 countries, incorporating over 250 institutions and over 900 researchers.
Research Network Offerings

- Annual Scientific Meeting
- Implementation Science Workshops/Schools
- Working groups
- Co-chairs
Annual Scientific Meeting
Annual Scientific Meeting

- Brings together funders & researchers from GACD
- Each project to send 1 HIC & 1 LMIC representative
- Share project findings, challenges & learnings
- 2019 ASM will be in Bangkok, Thailand, 11-15 November

https://www.gacd.org/research/research-network/gacd-annual-scientific-meeting-2018
Implementation Science Trainings

- Implementation Science Workshops
  - 2-day programme
  - Caters to all levels
- Implementation Science School
  - 5-day programme
  - Tailored for ECRs

https://www.gacd.org/research/implementation-science-capacity-building
Working groups

- Pivotal mechanism for facilitating collaborative research efforts across disease entities, geographies & expertise
- Often focus on issues that cut across traditional boundaries
Co-chairs

- Representatives from each Research Programme
- Represent the voice of the research network to GACD funders & Secretariat
New Co-chairs for DM & LD to be elected! Stay tuned for nomination & election process
GACD Programme Committee

Jennifer Gunning  
Canadian Institutes of Health Research  
Canada

Dr Rupinder Singh Dhaliwal  
Indian Council for Medical Research  
India
GACD Scale-up Projects
SU01: DIABFRAIL – LATAM

• DIABFRAIL – LATAM - A multi intervention exercise and education programme for elderly diabetes patients, which learns from the EC funded research. The project works with elderly “fragile” and “pre-fragile” diabetes across Latin America.

• Project sites: Colombia, Chile, Mexico, Peru, Argentina

• Funded by: EC

• Coordinator: Leocadio Rodriguez Manas
  (leocadio.rodriguez@salud.madrid.org)
SU02: SUNI-SEA

- Scaling-up NCD Interventions in South East Asia (SUNI-SEA) Indonesia, Myanmar, Vietnam
- Funded by: EC
- Aim: The project aims to contribute to healthy ageing through better prevention and control of hypertension and diabetes in Southeast Asia by scaling-up cost-effective interventions in this area.
- Project sites: Indonesia, Myanmar, Vietnam
- Coordinator: Maarten Postma (m.j.postma@rug.nl)
SU03: SCUBY

- Scale Up of an integrated care package for diabetes and hypertension for vulnerable people in Cambodia, Slovenia and Belgium
- **Project sites:** Cambodia, Slovenia and Belgium
- **Funded by:** EC
- **Aim:** This project examines the scale-up of existing evidence-based packages for control of diabetes and/or hypertension
- **Coordinator:** Josefien van Olmen ([jvanolmen@itg.be](mailto:jvanolmen@itg.be))
SU04: WHO-PEN@Scale

- **WHO-PENatScale** - Scaling up the WHOPEN package for diabetes and hypertension in Swaziland: a nation-wide cluster-randomised evaluation of three strategies in Swaziland
- **Project sites**: Eswatini (Swaziland)
- **Funded by**: EC
- **Aim**: The project aims to validate effective scaling up strategies of evidence based diabetes and hypertension prevention and management programmes, using the WHO-PEN protocols.
- **Coordinator**: Jan-Walter De Neve ([janwalter.deneve@uni-Heidelberg.de](mailto:janwalter.deneve@uni-Heidelberg.de))
SU05: Integrating and decentralising diabetes and hypertension services in Africa (INTE-AFRICA) Tanzania and Uganda

- Integrating and decentralising diabetes and hypertension services in Africa (INTE-AFRICA) Tanzania and Uganda
- **Funded by:** EC
- **Aim:** Integrating and scaling up services for diabetes and hypertension in clinics, either as standalone or integrated with HIV infection. The project builds on pilot studies that partners are conducting, funded by UK NIHR.
- **Coordinator:** Shabbar Jaffar ([Shabbar.Jaffar@lstmed.ac.uk](mailto:Shabbar.Jaffar@lstmed.ac.uk))
NIH Scale-up Funding Opportunity

Late-Stage Implementation Research Addressing Hypertension in Low- and Middle-Income Countries: Scaling Up Proven-Effective Interventions (UG3/UH3 Clinical Trial Optional)

GACD Collaborative Research Efforts
Contexts & Concepts

Meena Daivadanam on behalf of C&C working group
April 2019
Study 1

Context

5. NATIONAL or STATE
   - Socio-political climate
   - Health & social welfare policies

4. LOCAL or DISTRICT
   - Leadership & administrative practices
   - Physical environment (including food)

3. HEALTHCARE SETTING
   - Facilities, staffing & cost of care
   - Organization & practice setting

2. LOCAL COMMUNITY
   - Community engagement
   - Social norms & sources of support

1. INDIVIDUAL, FAMILY & WORK UNIT
   - Ability to pay & degree of social protection
   - Sources of knowledge
   - Commitment to work & work culture

Participating projects
(N = 20)
Poster at HSR 2018 in Liverpool
Article

• Just published

• Link: https://journals.plos.org/plosone/article?id=10.1371/journal.pone.0214454
Study 2

Concepts

- **Status update**
  - Data collection completed
  - Analysis completed
    - Framework analysis
    - Preliminary tree map
  - First draft being prepared for circulation
Where do we go from here? Some ideas.....

• Deconstructing interventions to evaluate the effect of context and adaptation to context
  • Idea raised by funders during the last GACD ASM

• Developing a checklist or guidance
  • Contextualization process – systematic incorporation of context data into intervention development / implementation process

• Any one interested, please contact Meena/Gary
GACD Diabetes Data Dictionary
Working Group Update

Meena Daivadanam – SMART2D, Uppsala University, Kristi Sidney Annerstedt – Karolinska Institutet & DD working group (Diabetes)

April 2019
Progress to date

Conceptualization & Data collection

Phase I (Mar-May 2017):
- n=5 (DM04, DM07, DM10, DM16, DM17) via SurveyMonkey

Phase II (Jan-April 2018):
- n=8 (DM01, DM02, DM06, DM08, DM12, DM13, DM14, DM15) via REDCap
- N=13/17 (76%) response from GACD Diabetes projects

GACD Project Survey

Data merged and cleaned for each domain
Descriptive stats (i.e. mean, median & 25% 75% percentile) for each variable under the 9 domains

Delphi Panel

Experts nominated by working group members (Dec 2017 – April 2018)
- 88 experts invited to participate via email/online survey between 3/7/18 and 20/9/18
- 3 reminders were sent
- 32 filled → 36% response rate

Variables w/ 75% consensus from GACD projects were deemed core
- Delphi panel was asked to evaluate variables between the median and 75%

Next Steps

1. Review the DP results and correlate with the original survey (Nov 2018)
2. Form writing group (ASM 2018)
3. Manuscript preparation underway
4. Submit manuscript (Aug 2019)
Contact: meena.daivadanam@ikv.uu.se

Thank you...
GACD-COUNCIL COPD progress update

April, 2019

J.F.M. van Boven
Background

- Successful COUNCIL initiative for diabetes and stroke
- Gaps in guidelines for the management of COPD in low- and middle-income versus high-income countries: a systematic review

- Lead: Job van Boven, University of Groningen (Netherlands)
- On behalf of Aizhamal Tabyshova (Kyrgyzstan), John Hurst (UK), Joan Soriano (Spain), Jennifer Alison (Australia), Will Checkley (USA), Tarana Farous (Bangladesh), David Meharg (Australia), Erick Huang (Taiwan), Patricia Alupo (Uganda), Oscar Flores (Peru), Antigona Trofor (Romania), Gonzolo Giannella (Peru), Niels Chavannes (Netherlands), Kamila Zvolska (Czech Republic), Gary Parker (GACD)
Project planning

- Dec 2018: Data extraction sheet
- Jan-Feb 2019: Systematic review PubMed and EMBASE (same keywords as diabetes guidelines review, see paper attached to invite email) + protocol registration in PROSPERO
- Feb 2019: Additional (targeted) search for COPD guidelines by collaborators and our network
  - Mar-Apr 2019: Data extraction from identified COPD guidelines (several assigned country guidelines per collaborator, final data sheet will be provided)
- May 2019: Data analysis
- Jun-Jul 2019: First draft paper and co-authors review round
- August 2019: Submit final paper
Contact: jobvanboven@gmail.com
Gaps in guidelines for the management of bipolar and unipolar depression in adults: a systematic review of evidence from high- vs. low- and middle-income countries

Yena Lee & Roger S. McIntyre

on behalf of the
Global Alliance for Chronic Diseases Mental Health Guidelines Working Group
Purpose

- To evaluate and characterize determinants of guideline development, dissemination, and implementation in existing practice guidelines;

- Compare contextually relevant factors between those from high- and low/middle-income countries; and

- Inform future guidelines that aim to improve health outcomes and cost-effectiveness
55 Collaborators in 30 Countries
Deliverables

- Currently conducting a **systematic review** of national and international practice guidelines for the
  - Assessment, treatment, and management of depression in
  - Adults with bipolar or major depressive disorder.

Study protocol is registered on PROSPERO ([CRD42019124759](CRD42019124759))
Comparison of Guidelines from High- vs. Low- and Middle-Income Countries

- **Quality** of guideline development processes
  - e.g., compliance to standards of clinical practice guidelines by the Institute of Medicine: transparency, conflict of interest, multidisciplinary and balanced guideline development group composition, systematic review of comparative efficacy research, strength of recommendation grading, articulation of recommendations, external review, scheduled guideline updating; rigour of development

- **Translatability**, applicability, and content of recommendations
  - e.g., attention to ease of implementation, evaluation of cost/resource limitations, consideration of ethical, legal, social, and economic issues, intervention

- **Stakeholder involvement** in guideline development and implementation
  - e.g., involvement of target users and population in evaluation of enablers/barriers
Progress

- Nov. 2018: Project and Mental Health Guidelines Working Group inception
- Dec. 2018: Call to GACD Network for collaborators
- Jan. 2019: Completed systematic search of 16 medical databases in 5 languages, review of >9800 abstracts in 13 languages
- Feb. 2019: Completed review of >350 full-texts in 18 languages
- Mar-Apr. 2019: Extracting data from ~100 national/international guidelines
- May 2019: Target project completion
National Guidelines for 62* countries (and counting)

*Excluding member countries of CINP, EPA, ISBD, WHO, and WSFBP
Yena Lee & Roger S. McIntyre

on behalf of the
Global Alliance for Chronic Diseases Mental Health Guidelines Working Group

yenalee.lee@mail.utoronto.ca
roger.mcintyre@uhn.ca
Towards Optimum Reporting of Pulmonary Effectiveness Databases and Outcomes (TORPEDO) study

Progress update

Job van Boven (Primary Investigator, University of Groningen, REG collaborator) & Gary Parker (GACD)

GACD webinar April 2019
Background

• Collaboration Respiratory Effectiveness Group (REG) with Global Alliance for Chronic Diseases (GACD)

• GACD Research Network is able to provide more respiratory disease experts from Lower Middle Income Countries (LMICs)

• REG are a group of mostly HIC pulmonary experts in real-world respiratory research
TORPEDO project aims

1. Development of a **checklist** with optimum and minimum required variables for respiratory research

2. Develop a **repository of respiratory databases** in which each database is characterised against this new checklist

- ✔ Phase I- Identifying the **full scope of variables** for an ideal database
- ✔ Phase II- Voting and endorsing of variables to **reduce the list** to the minimally required variables

- ✔ Phase III- Prioritization of the **minimally required variables**
Phase 3 update

Priorization survey sent out end of February 2019 to all respondents of 2nd Delphi round

Preliminary results
After analysing the results, of the initial 224 variables, immediate consensus (>66% agreement) was reached for 18 (8%) and partly agreement (50-66%) was reached for 44 (20%). The latter were discussed at the REG and GACD 2018 meetings and most were deemed relevant but some only for specific studies (e.g. retrospective database only or prospective clinical study) or only in asthma or only in COPD. As such, in total we have a remaining list of 62 variables and have arrived at the final Phase 3 of the Delphi panel: Allocation and prioritization of variables for different type of studies.

So, what’s now expected of you?
In the survey (link above), you will be presented with the list of minimum variables identified during Phase 2 of this initiative. In the survey, you will be asked to indicate which variables you feel are a minimum requirement for each of the study designs outlined below:

1. A prospective clinical asthma (field) study with original data collection;
2. A prospective clinical COPD (field) study with original data collection;
3. A retrospective asthma database study or
4. A retrospective COPD database study.
Response:

- 64 Invitations to participate were sent out, 39 people replied (61%) (Threshold at least 10 members)
- 5 people who did not select any variables were excluded for analysis.
- Variables will be included in the list of minimal criteria if at least 66% agreement between respondents (used for ISAR).
## Demographics

<table>
<thead>
<tr>
<th></th>
<th>Asthma_retrospective</th>
<th>Asthma_prospective</th>
<th>COPD_retrospective</th>
<th>COPD_prospective</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of birth</td>
<td>32 (94.1)</td>
<td>33 (97.1)</td>
<td>32 (94.1)</td>
<td>33 (97.1)</td>
</tr>
<tr>
<td>Gender</td>
<td>34 (100)</td>
<td>34 (100)</td>
<td>34 (100)</td>
<td>34 (100)</td>
</tr>
<tr>
<td>Ethnicity</td>
<td>11 (32.4)</td>
<td>18 (52.9)</td>
<td>11 (32.4)</td>
<td>18 (52.9)</td>
</tr>
<tr>
<td>Level of education</td>
<td>9 (26.5)</td>
<td>16 (47.1)</td>
<td>9 (26.5)</td>
<td>16 (47.1)</td>
</tr>
<tr>
<td>SEC</td>
<td>13 (38.2)</td>
<td>21 (61.8)</td>
<td>12 (35.3)</td>
<td>22 (64.7)</td>
</tr>
<tr>
<td>Geographical location</td>
<td>18 (52.9)</td>
<td><strong>23 (67.6)</strong></td>
<td>18 (52.9)</td>
<td><strong>23 (67.6)</strong></td>
</tr>
</tbody>
</table>
Next steps

- Finalize data analyses
- Publication

- Develop a database repository and apply generated checklist of minimal criteria for retrospective studies

Collecting databases, trials and characteristics from:
  - REG members
  - GACD members
  - Through literature search
  - Through Bridge to Data, ENCePP search engines

Applying the checklist
  Collaborators will **complete the checklist** on these databases and will present the overview on the web.
Data harmonisation of implementation measures in the mental health group

Research Network Webinars
16 & 17 April 2019

Melissa Pearson
University of Edinburgh & University of Sydney
Mental Health GACD projects

- 33 projects
- 5 continents
- 50 countries
- 78 outcome measures

<table>
<thead>
<tr>
<th>Condition</th>
<th>Count</th>
</tr>
</thead>
<tbody>
<tr>
<td>Schizophrenia</td>
<td>1</td>
</tr>
<tr>
<td>Dementia</td>
<td>3</td>
</tr>
<tr>
<td>Wellbeing</td>
<td>9</td>
</tr>
<tr>
<td>Depression</td>
<td>7</td>
</tr>
<tr>
<td>Suicide</td>
<td>2</td>
</tr>
<tr>
<td>Substance misuse</td>
<td>4</td>
</tr>
<tr>
<td>Psychosis</td>
<td>2</td>
</tr>
<tr>
<td>ADHD</td>
<td>1</td>
</tr>
<tr>
<td>Not available</td>
<td>4</td>
</tr>
</tbody>
</table>
Work to date

1. Grand Challenges Canada Core Metrics
2. Sent questionnaire to teams
3. Mapped responses to REAIM and Proctor domains
4. Decision to re-survey teams
5. Developing a simplified survey tool
### Core Metrics Reporting Categories

#### Development
1. Availability of situation analysis and report (including knowledge or innovation gap, plus barriers to implementation)
2. Availability of innovation product / protocol / manual
3. MOU or project agreement document signed with partner/s
4. Enumeration of (non-GCC) financial, human and other resources allocated by key stakeholders to innovation development and implementation

#### Delivery
5. Number of mental health care providers trained
6. Knowledge, attitudes and practices of providers (pre- and post-training score)
7. Continuous quality improvement mechanism in place (e.g. regular supervision)
8. Proportion of people in target population screened / identified
9. Expected time and cost for recipients to access innovation (travel time, transport cost and any fees paid out of pocket)
10. Expected proportion of target population with access to innovation medium (e.g. TV, radio, internet)
11. Number of people in target population receiving innovation (disaggregated by diagnosis, level of care, year of project etc.)

#### Evaluation
11. Symptom severity score / effect size (e.g. PHQ-9; SRQ)
12. Functioning score / effect size (e.g. WHODAS, WHOQOL)
13. Mental health & well-being score / effect size (e.g. "WHO-5" index)
14. Change in public perceptions, knowledge and attitudes about MNS disorders (KAP score or discrimination / stigma measure; e.g. DISC-10)
15. Cost-effectiveness (cost per unit improvement in symptom severity / function)

#### Scale up
15. Allocation of financial, human and other resources by key stakeholders for innovation scale-up
16. Mental health system profile, based on key global mental health indicators (including mental health policy and financial commitment, HR capacity, management and information systems, service infrastructure, etc.)
17. Number of health facilities or providers using the innovation
18. Proportion of people in target population who are seen and/or receiving innovation as intended (disaggregated by socioeconomic group)

#### Context
19. Change in public perceptions, knowledge and attitudes about MNS disorders (KAP score or discrimination / stigma measure; e.g. DISC-10)
20. Frequency of contacts with key stakeholders (e.g. meetings, conference calls)
21. List of identified strategies for overcoming barriers to innovation implementation or scale-up (based on situational analysis and/or context analysis, and for success of innovation)
# Mapped responses of MH Projects

<table>
<thead>
<tr>
<th>REAIM domains</th>
<th>Proctor domains</th>
<th>CM Project category</th>
<th>Projects (n)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reach</td>
<td>Penetration</td>
<td>Delivery</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Scale-up</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Appropriateness</td>
<td>Context</td>
<td>13</td>
</tr>
<tr>
<td>Effectiveness/Efficacy</td>
<td></td>
<td>Evaluation</td>
<td>20</td>
</tr>
<tr>
<td>Adoption</td>
<td>Adoption</td>
<td>Delivery/Scale-up</td>
<td>15</td>
</tr>
<tr>
<td>Implementation</td>
<td></td>
<td>Delivery/Implementation</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Acceptability</td>
<td>Delivery</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Feasibility</td>
<td>Scale-up</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Fidelity</td>
<td>Delivery</td>
<td>15</td>
</tr>
<tr>
<td></td>
<td>Implementation Cost</td>
<td>Evaluation</td>
<td>15</td>
</tr>
<tr>
<td>Maintenance</td>
<td>Sustainability</td>
<td>Evaluation/Scale-up</td>
<td>20</td>
</tr>
<tr>
<td></td>
<td>Sustainability</td>
<td>Evaluation at later time points</td>
<td>8</td>
</tr>
</tbody>
</table>
Survey redesign aims

• Simplify
  – Start with REAIM domains
• Avoid duplication
  – Incorporate previous responses
• Provide opportunities for links to learning or discussions
  – Propose webinars topics for projects to link with
• Encourage collaboration
  – Mapping as a potential way for projects to collaborate on theme, scale, setting level etc.
<table>
<thead>
<tr>
<th>Domain</th>
<th>Description</th>
<th>Example measures</th>
<th>Link to content</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>REACH</strong></td>
<td>The absolute number, proportion, and representativeness of individuals or settings who are willing to participate in a given initiative.</td>
<td>Exclusion Criteria (% excluded or characteristics)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Percent individuals who participate</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Characteristics of participants compared to non-participants or to target population</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Factors contributing to the participation/non-participation of the participants?</td>
<td></td>
</tr>
<tr>
<td><strong>EFFICACY</strong></td>
<td>The impact of an intervention on important outcomes, including potential negative effects, quality of life, and economic outcomes.</td>
<td>Measure of primary outcome with or w/o comparison to a public health goal (e.g. treatment for depression)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measure of broader outcomes (e.g. measure of QoL or potential negative outcome) or use of multiple criteria</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measure of robustness across subgroups (e.g. moderation analyses)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Measure of short-term attrition (%) and differential rates by patient characteristics or treatment condition</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Qualitative assessment of contextual factors contributed to the results</td>
<td></td>
</tr>
</tbody>
</table>
Redcap interface

<table>
<thead>
<tr>
<th>Project details</th>
<th>Condition</th>
<th>Project research focus</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project number</td>
<td>A randomised stepped wedge trial of the scaling</td>
<td>Delivery</td>
</tr>
<tr>
<td></td>
<td>up of a community-based alcohol education</td>
<td>Intervention</td>
</tr>
<tr>
<td></td>
<td>program in rural Sri Lanka</td>
<td></td>
</tr>
<tr>
<td>Project title</td>
<td>■ ADHD</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Dementia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Depression</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ MH first aid</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Prevention</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Psychosis</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Resilience</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Schizophrenia</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Screening</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Substance Use</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Suicide</td>
<td></td>
</tr>
<tr>
<td></td>
<td>■ Well-being</td>
<td></td>
</tr>
</tbody>
</table>

*Please select your project number from the list.*
*Please amend if incorrect.*
# Redcap interface

## REACH
The absolute number, proportion, and representativeness of individuals or settings who are willing to participate in a given initiative.

### Example measures
- **Exclusion Criteria (% excluded or characteristics)**
- **Percent individuals who participate**
- **Characteristics of participants compared to non-participants or to target population**
- **Factors contributing to the participation/non-participation of the participants?**

### Reach details to date
- Screening for whole population of village
- Approximately 20 villages of 250 people
- Intervention will be offered to whole village
- Baseline health clinic - 4000, Brief intervention - 100, Drama performance - 4000, Current

### Reach - general comments on aspects of reach your project will measure

### Method
- Quantitative
- Qualitative
- Both

### Tools
Please describe tools (scale, questionnaires, focus group, etc)
Contact: melissa.pearson@ed.ac.uk
Indigenous Populations Working Group
GACD

Co-Chairs:
A/Prof Gillian Gould, Dr Marilyn Clarke, Mr David Meharg
• Initiated as many (11) Indigenous projects are part of GACD
• Held 15-11-2019 at GACD Annual meeting Sao Paulo
• Chaired by Gould
• 15 people attended - Australia, Canada, Mexico and USA
• Dialogue on aims and purpose
• Interest areas include:
  • Share resources and stories
  • Conduct systematic review on barriers/enablers to Indigenous Implementation Science
  • Develop/publish model/statement about Indigenous implementation science
  • Prioritise Indigenous leadership
  • Plan an Indigenous workshop for GACD 2019
  • Commence temporary platform for email and sharing
  • Potential of GACD communication platform for WPs
Following IPWG GACD meeting

• Group leadership model- Dr Marilyn Clarke and David Meharg requested to co-chair WP with Gould (only Clarke and Meharg identified as Indigenous at meeting - Aboriginal Australians)

• Group email and share site at University of Newcastle
gacdindigenouspopulations@uonstaff.edu.au

• Clarke, Meharg and Gould discussed actions from inaugural meeting 5th March 2019

• Actions
  • Develop systematic review protocol (Clarke)
  • Request involvement of group in SR (Gould)
  • Invite others from GACD network to join (Gould)
  • Obtain list of Indigenous GACD projects to be descriptively analysed (Meharg)
Points for further discussion/action

- 23 EMAILS REQUESTING TO JOIN GROUP (NO ACTION YET)
- NO RESPONSE FROM MEMBERS HELPING WITH SR
- FURTHER MEETING PLANNED OF CO-CHAIRS 24TH APRIL 2019
- PRIORITIZE INDIGENOUS LEADERSHIP
- LEADERSHIP INCLUSIVE OF REPRESENTED INDIGENOUS POPULATIONS
- ASK MEMBERS TO VOLUNTARY DECLARE INDIGENOUS STATUS
- PREPARE FOR INDIGENOUS WORKSHOP IN GACD 2019
Contact:

gillian.gould@newcastle.edu.au

david.meharg@sydney.edu.au

marilyn.clarke@health.nsw.gov.au
GACD Multi-Morbidity Working Group Update, April 2019

John Hurst, London
On behalf of the whole working group
Rationale for the Group

• No introduction necessary to the scale of the challenge, addressing multi-morbidity in LMIC!
• Currently rising interest.
• As GACD Researchers:
  – We SHOULD say something.
  – Our unique collaboration and expertise gives us something important to say
    • Expertise in LMIC and Implementation Science.
    • We are Multi-Professional, Multi-Disciplinary, and Collaborative.
    • We have Data dictionaries, Outcome Definitions and Working Groups....
  – We have the ability to influence policy.
  – We can assist GACD to leverage new funds
GACD Multi-Morbidity: Recap

• Initial discussions at GACD Buenos Aires, 2017
• Group initiation call, March 2018
  – Develop a GACD Statement and Policy Briefs
  – Combination of GACD Data Sets
  – LMIC Multi-Morbidity Research Prioritisation
• Group discussion call, May 2018
• Workshop, GACD Sao Paulo, 2018
Principles of the Group

• Inclusivity
• Transparency
• Everyone taking part listed as ‘contributors’
Global Alliance for Chronic Diseases Researchers’ Statement on Multi-Morbidity

published 10th November 2018
Six Common Themes in GACD Research

- Relevance of multimorbidity to all HCPs
- Under-recognition of multimorbidity in health-care provision
- Absence of evidence-based guidelines on multimorbidity
- Need for greater access to expert, pro-active and holistic primary care that integrates NCDs
- Need for improved integration of health-care education around NCDs, including to people living with NCDs
- Need for further research addressing interventions to address multimorbid NCDs in LMIC
Our Researchers’ Statement

The GACD Research Network believes that a greater focus on multimorbidity is overdue and necessary to successfully improve global health outcomes.
Three Strategic Objectives

• To reduce the burden of NCDs in LMIC/VPHIC:
  – 1. Greater policy awareness and focus on multimorbidity
  – 2. Changes to the way research is commissioned, funded and delivered, to promote multi-professional, multi-disciplinary, integrated implementation science
  – 3. Alignment of health-systems research with universal health coverage
Next Steps (Sao Paulo 2018)

• Develop a Lay Summary of the Statement
  – In progress (Antigona Trofor & team)
• Develop a Multi-Morbidity Outcomes Review
  – In progress, for circulation to all interested (John Hurst & team)
• Develop a policy-brief
  – In progress (Josefien van Olmen & team)
• Research Prioritisation Exercise for MM LIMC
  – Preliminary stages (Roger McIntyre & team – other volunteers to assist welcome!)
More on the Outcomes Review

Recommended reading!

but this doesn’t consider the LMIC setting, and no specific recommendations
More on the Outcomes Review

We are considering...

1. Mortality – Rajesh Vedanthan
2. Generic HRQoL scales - Kamran Siddiqi
3. Health Economic Indices - Job van Boven
4. Health Care Access such as hospitalisation or other indices of unplanned care – Pallab Maulik
5. Treatment burden and medication adherence – Erick Huang supported by Pallab
6. Multi-dimensional indices such as Frailty Scores – Dinky Levitt
7. Measures of ‘Healthy Living’ such as exercise, exposure, nutrition and alcohol – Meena Daivadanam
8. Self-efficacy and social-functioning / Measures of Self Determination – Gina Agarwal

And with support from...
Ricardo Araya, Jaime Miranda, Mayowa Owolabi, Joan Soriano, Lijing Yan
Thank You, Apologies for my Absence and Discussion

John Hurst

j.hurst@ucl.ac.uk
Task-shifting for the management of hypertension: lessons from the Global Alliance for Chronic Diseases

Shifting specific tasks from physicians to health professionals with different level of education or to a person specifically trained to do a limited task
Objective

- Bring together projects with an element of task-shifting and analyse them collectively to understand the key challenges and opportunities of task-sharing on Hypertension/cardiovascular disease management
Methods

From each of the studies we obtained information on
- types of tasks shifted,
- professional level from which the task was shifted,
- training provided
- challenges faced.

After studies were completed, we collected granular and project specific data on
- ‘lessons learned’ throughout the implementation process
- ‘design to implementation’ changes that emerged.

Data were collated and mapped for comparative analysis of themes
Results

8 studies included across 9 countries in Argentina, Canada, Colombia, Ghana, India (2), Kenya, Malaysia, South Africa and Tanzania.

7 RCTs, 1 randomised feasibility study

NPHWs included nurses, community health workers, accredited social health activists, community health extension workers

NPHW education: 8 -14 years

Nurses: graduates from formal nursing programs

Tasks shifted from physicians to NPHWs – 4 studies
Tasks shared between two different levels of NPHWs – 4 studies.
Which tasks were shifted?

The tasks shifted to NPHWs included
- screening of individuals,
- referral to physicians for diagnosis and management,
- patient education for lifestyle improvement,
- follow-up of patients and patient reminders for medication adherence and appointments.

Training programs: 3 and 7 days + refresher training
Clinical decision support tools and m-health components – 2 studies
Challenges faced: system level barriers such as inability to prescribe evidence-based drugs, varying capacity and skill sets of NPHWs, high workload and high staff turnover.
## How to implement an intervention involving task-shifting?

<table>
<thead>
<tr>
<th>Process</th>
<th>Why?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Audit the health system</td>
<td>To understand the various factors which need to be considered in the implementation of the intervention from a health system’s perspective. E.g. are medicines available in the health centre?</td>
</tr>
<tr>
<td>Conduct qualitative assessment of key stakeholders</td>
<td>To gain a better understanding of the perception of key stakeholders. E.g. Will the community members accept the new role of the NPHW?</td>
</tr>
<tr>
<td>Pilot the intervention</td>
<td>To better understand enablers and barriers to the implementation of the intervention.</td>
</tr>
<tr>
<td>Train the NPHWs and assess training using a broad framework</td>
<td>To ensure NPHWs have gained the knowledge and skills required of them</td>
</tr>
<tr>
<td>Supervise/monitor the implementation</td>
<td>To ensure good quality health care to the community</td>
</tr>
<tr>
<td>Check fidelity of intervention</td>
<td>To ensure that the intervention is being implemented in accordance to the protocol</td>
</tr>
<tr>
<td>Conduct a process evaluation</td>
<td>To get a better understanding of what worked and why</td>
</tr>
</tbody>
</table>
Outputs

- Learnt from each-other
- Opportunities to collaborate outside the GACD projects
- 1 publication BMJ Global Health, October 2018
- Oral presentation at the World Congress of Cardiology
Contact: rjoshi@georgeinstitute.org
PROCESS EVALUATION WG

GACD Research Network Webinar

FELIX LIMBANI

16th and 17th April 2019
Background

• The research teams working in a variety of complex interventions

• Many incorporating process evaluation to support primary outcomes in trials.

• A working group that focuses on process evaluation was ideal.
Aims

• To share and exchange ideas, and establish everyone’s relative experience.
Since 2014

• Engaged external people to interact with the group
• Produced a set of guidelines for process evaluation
• Conducted a mapping exercise to understand teams’ relative approaches to PE
• Working group meetings - sharing PE progress and experiences
• Sharing process evaluation resources
• Joint paper
However

• The working group has been inactive for the past one year

• As the group started with HTP teams, later the focus was on the joint HPT PE paper

• Most HPT studies have closed, no drive moving forward.
Moving forwards

• New and emerging teams need to reflect if there is need sustain the working group

• If yes, a clear road map on its objectives need to be discussed and agreed.

• Volunteers must come up and champion the process.
Thank you
Contact: limbanif@yahooco.uk
Bernd Puschner
Ulm University, Germany

Thilini Rajapakse
University of Peradeniya, Sri Lanka