



UWI

ST. AUGUSTINE CAMPUS
TRINIDAD & TOBAGO, WEST INDIES

CCHSRD Newsletter

“Better Health Systems...Healthier Lives”

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Editorial

On the Journey to Better Health Systems... Healthier Lives

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EDITORIAL

CCHSRD: Three Years After Its Launch

After much deliberation as to what the focus of research of the Faculty of Medical Sciences should be, we decided that given our close relationship with the Ministry of Health, our focus should be on public health. In 2018, The UWI approved the establishment of the Caribbean Centre for Health Systems Research and Development.

The new Centre received very strong support from the sister Centres at Mona and Cave Hill and importantly from the Government of Trinidad and Tobago. This was in no small part due to our success in recruiting a well-respected academic, Professor Donald Simeon, as its Director. Since then, the Centre has hosted several courses to train faculty in research methodology including Research Skills Building Workshops (Basic Research Skills, Data Analysis, Ethics, etc.). It has also produced several policy briefs on public health issues.

A major focus of the Centre's work has been to bridge the gap between researchers and policymakers which it has been doing through the Evidence to Policy Fellowship Training Programme. This Programme provides a unique opportunity to develop the capacity of researchers and policymakers to find, appraise and use research evidence to inform decision-making, and to develop knowledge uptake products to support the policymaking process. This we hope will increase the impact of medical research in



CCHSRD: Three Years After Its Launch

Trinidad and Tobago, the wider Caribbean and indeed the world. The program begins with an intensive 4-day classroom training (online/face-to-face), followed by three (3) months of virtual coaching and mentorship to develop a health policy evidence brief addressing a priority issue.

Community engagement is one of its core functions and the Centre is working with the NGO - Working Women for Social Progress to develop a concept note for a community engagement project on Social and Child Protection: *The Implementation of an Innovative Social Protection Intervention Targeting Boys in T&T: Exploring and Alleviating Problems of Emotional and Physical Abuse Amplified by the COVID-19 Pandemic*.

The Centre has also established the **Caribbean Community of Practice for Health Policy and Systems Research (CoP4HPSR)** - a network of researchers, health professionals, policymakers, and stakeholders in CARICOM - to build health policy and systems research capacity and share knowledge towards the strengthening of health systems in the Caribbean. It also provides an open and free environment for collaboration between health decision-makers and researchers.

Initial Goals of the Centre and Some Achievements

The Centre's goal/mission is to be a world class centre, bringing together researchers, policymakers and communities, to achieve optimal population health outcomes. Some of the key achievements of the Centre have been through collaboration with local and international institutions and from these several knowledge translation products that have been developed.

Several collaborations and MOUs have been signed with local and international institutions including the Anton de Kom University of Suriname, the McMaster Health Forum of McMaster University, the Ministry of Health of Trinidad & Tobago (MoH-TT), the Ministry of Health, Guyana, the African Caribbean Cancer Consortium, and University of Western Ontario.

In collaboration with its stakeholders, the Centre has developed several knowledge translation products which include (1) Rapid Response Brief to address an urgent priority policy issue identified by the Permanent Secretary, MoH-TT i.e., *Accountability Mechanisms for Performance Improvement of Regional Health Authorities in Trinidad and Tobago*; (2) Evidence Brief for Policy (EBP), which was developed to strengthen Human Resources for Health in Trinidad and Tobago in support of the national goal of Universal Health Coverage, with emphasis on the primary healthcare workforce; (3) conduct of a stakeholder dialogue to allow stakeholders to deliberate on the EBP and to map the way forward to achieve impact.

CCHSRD: Three Years After Its Launch

Another important institutional strengthening goal of the Centre was to boost the research system in the Faculty of Medical Sciences (FMS). This has included hosting of research conferences and seminars to enhance the research culture – for example the Centre has hosted five COVID-19 symposia; the establishment of a research discussion forum and a mentorship programme; and the research skills capacity building workshops referred to above. The Centre has also hosted data analysis mini-workshops to introduce researchers to *Multi-level (Hierarchical Data) Modelling using the Stata Software and More Complete Answers to Research Questions: Transition from Bivariate Analysis to Regression Analysis* and an online 2-day Workshop for FMS staff: *Data Management using REDCap Software*.

From a governance perspective, the Centre was classified within The UWI family as a Campus Centre and from an institutional perspective the initial goals have been achieved. Now we have come to the end of the first three (3) years and a quality review is pending which I hope will support the work of the Centre and further propel us into the future.

- Professor Terence Seemungal
Dean, Faculty of Medical Sciences
The UWI, St. Augustine Campus



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On the Journey to Better Health Systems... Healthier Lives (2018-2021)



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CCHSRD
Caribbean Centre for Health Systems
Research and Development

ON THE JOURNEY TO *Better Health Systems...Healthier Lives* 2018-2021

In April 2021, the CCHSRD produced a brochure summarising two and a half years of work in Health Policy and Systems Research, since the Centre's launch in September, 2018. The summary, *On the Journey to Better Health Systems...Healthier Lives (2018-2021)* features the Centre's reports and publications to date; research grants awarded; collaborations and MOUs with regional and international universities, Ministries and agencies; and activities under the Centre's four core functions. The latter include Knowledge Translation; Research; Human Resources for Health Training and Development; and Community Engagement.

Catch up on the CCHSRD's Journey [here](#).

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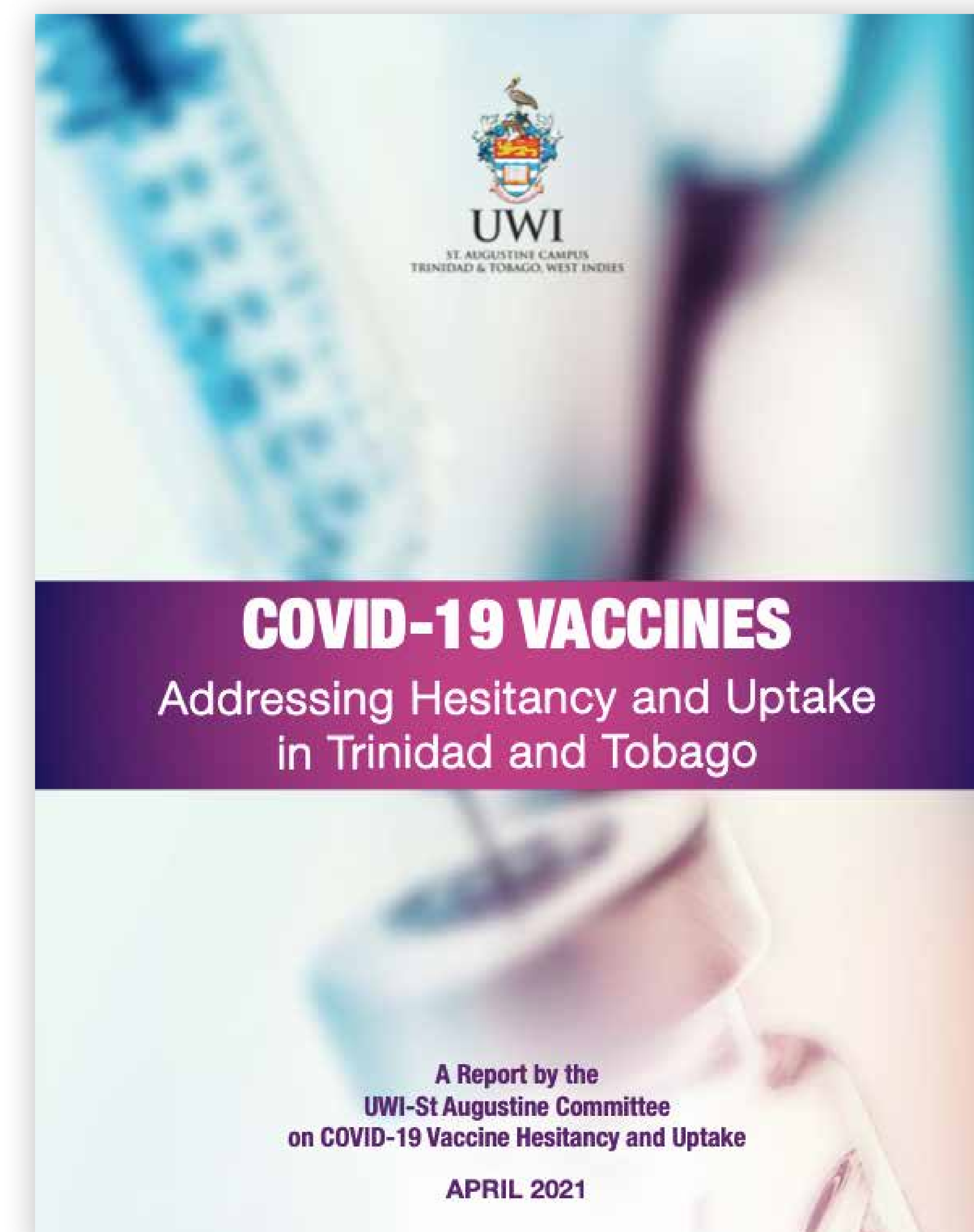
Report

UWI-STA Submits Strategies for Increasing COVID-19 Vaccines Uptake to the T&T Ministry of Health

- Prof. Donald T. Simeon
Director, CCHSRD

On May 5, 2021, The Honourable Terrence Deyalsingh, Minister of Health, Trinidad and Tobago received the report entitled *'COVID-19 VACCINES: Addressing Hesitancy and Uptake in Trinidad and Tobago'* from Professor Terence Seemungal, Dean of the Faculty of Medical Sciences, The University of the West Indies, St Augustine.

A few weeks earlier, Minister Deyalsingh had reached out to Professor Seemungal for support as his Ministry prepared to address the country's high rates of COVID-19 vaccine hesitancy. Professor Seemungal noted the urgency of the situation and promptly convened a multi-disciplinary team from the St Augustine Campus of The UWI, chaired by Professor Donald Simeon, Director of the CCHSRD. It comprised 10 professionals from the Faculty of Medical Sciences and the Faculty of Social Sciences with expertise in medicine, public health, evidence synthesis, sociology, psychology and social work. Its remit was to identify and



UWI-STA Submits Strategies for Increasing COVID-19 Vaccines Uptake to the T&T Ministry of Health

review the factors driving COVID-19 vaccine hesitancy in Trinidad and Tobago and propose strategies to maximize uptake. Vaccine hesitancy was defined as the delay, rejection or refusal to accept vaccines despite their availability.

The team synthesized the evidence for the preparation of the report. It noted the paucity of Caribbean research to complement the international literature but was able to capture local attitudes and beliefs through informal discussions with various groups and an analysis of social and traditional media.

Highlights of the concise but impactful report include sections on:

COVID-19 Vaccines–Myths and Misconceptions: This addressed the historical and current reasons for vaccine hesitancy including issues of trust and the need for credible information as people struggle with the COVID infodemic. Lists were presented with common myths and misconceptions along with the associated facts. The role and potential value of social media were also presented.

Key Strategies for Maximizing Uptake of the COVID-19 Vaccine: The communication goals to increase vaccine uptake were presented. The key uptake drivers were then identified i.e. creating an enabling environment (making vaccination easy, quick and accessible); harnessing social influencers (working with trusted members of the community); and motivation (having open and transparent dialogue within communities addressing their concerns and uncertainty regarding disease risks and the safety and benefits of vaccination). Guided by evidence-informed, international best practices, customized for

Caribbean populations, the report includes separate communication and uptake strategies for the three uptake drivers.

The report was carefully formatted to ensure that it was user-friendly. It also included Key Messages, and an Executive Summary. Notably, a draft of the report was used to guide the hosting of a live online town hall meeting on April 27 2021, the topic of the next article in this Issue of the CCHSRD Newsletter. That was the fifth online symposium that the CCHSRD had co-hosted to facilitate the use of research evidence in the country's COVID response.

CCHSRD looks forward to further collaborations with our colleagues at the Department of Behavioural Sciences, Faculty of Social Sciences as we generate research evidence and facilitate its uptake by policymakers to address the social determinants of health and the many behaviour related health problems in the Caribbean.



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Virtual Public Forum

COVID-19 Vaccines: Truths and Untruths

- *Ms Kershelle Barker*
Junior Fellow, Evidence Synthesis, CCHSRD



COVID-19 Vaccines: Truths and Untruths

The Caribbean Centre for Health Systems Research and Development (CCHSRD), the Faculty of Medical Sciences (FMS) and the Faculty of Social Sciences (FSS) at the St. Augustine campus of The University of the West Indies (The UWI) hosted a live virtual public forum on Tuesday 27th April, 2021. The theme was *COVID-19 Vaccines: Truths and Untruths*, and the forum took the form of a town hall meeting at which experts from The UWI responded to the general public's questions about the COVID-19 vaccines.

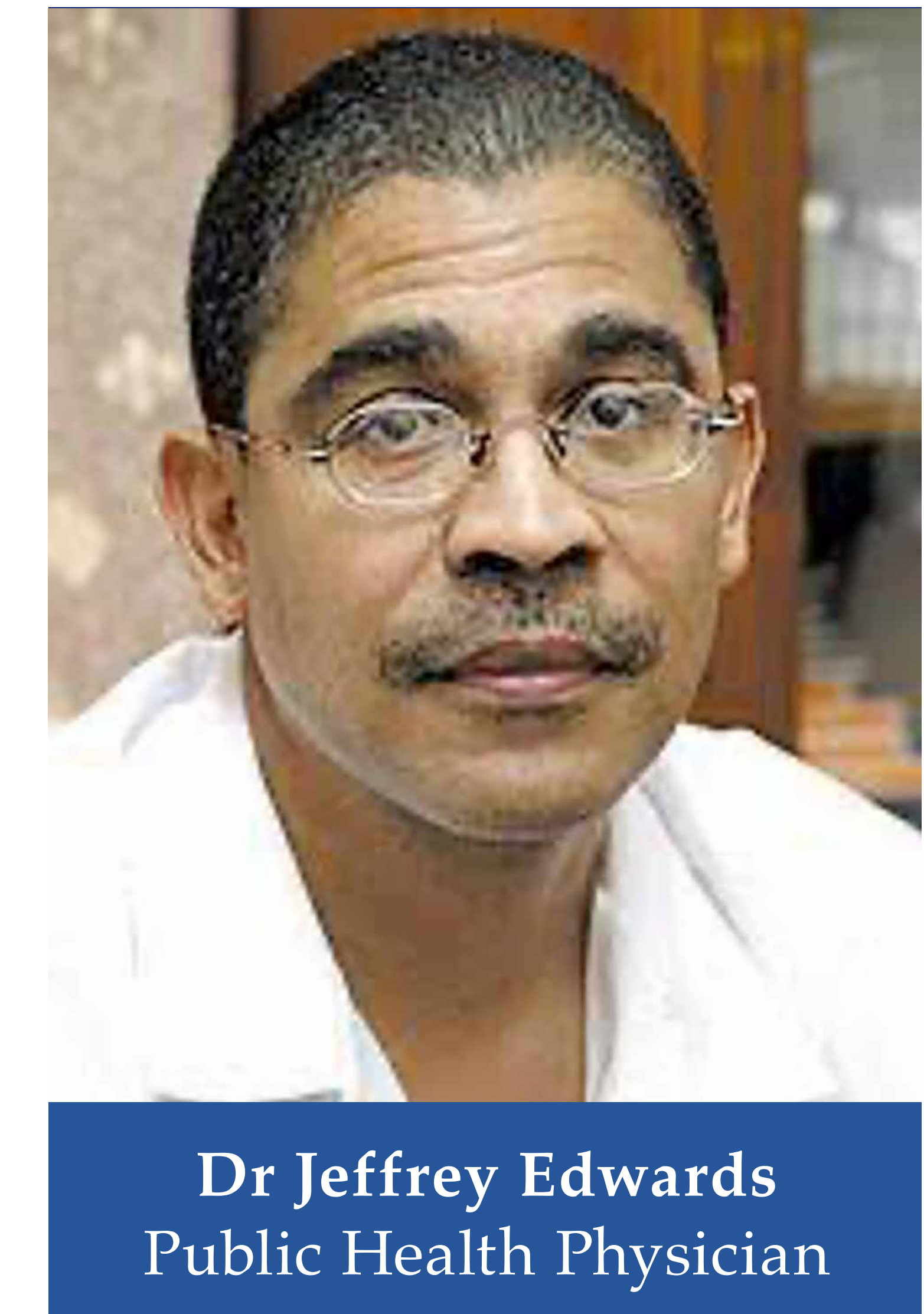
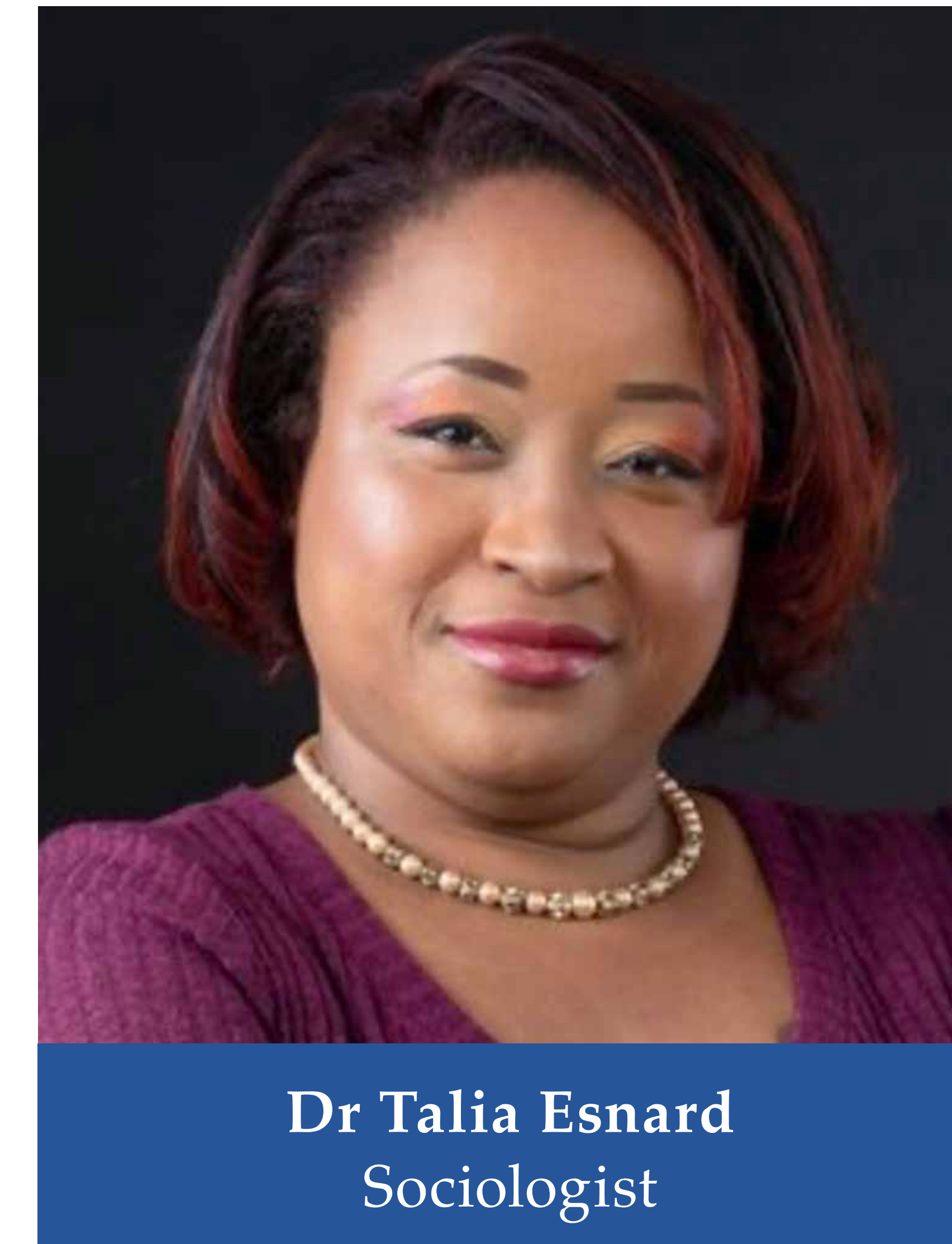
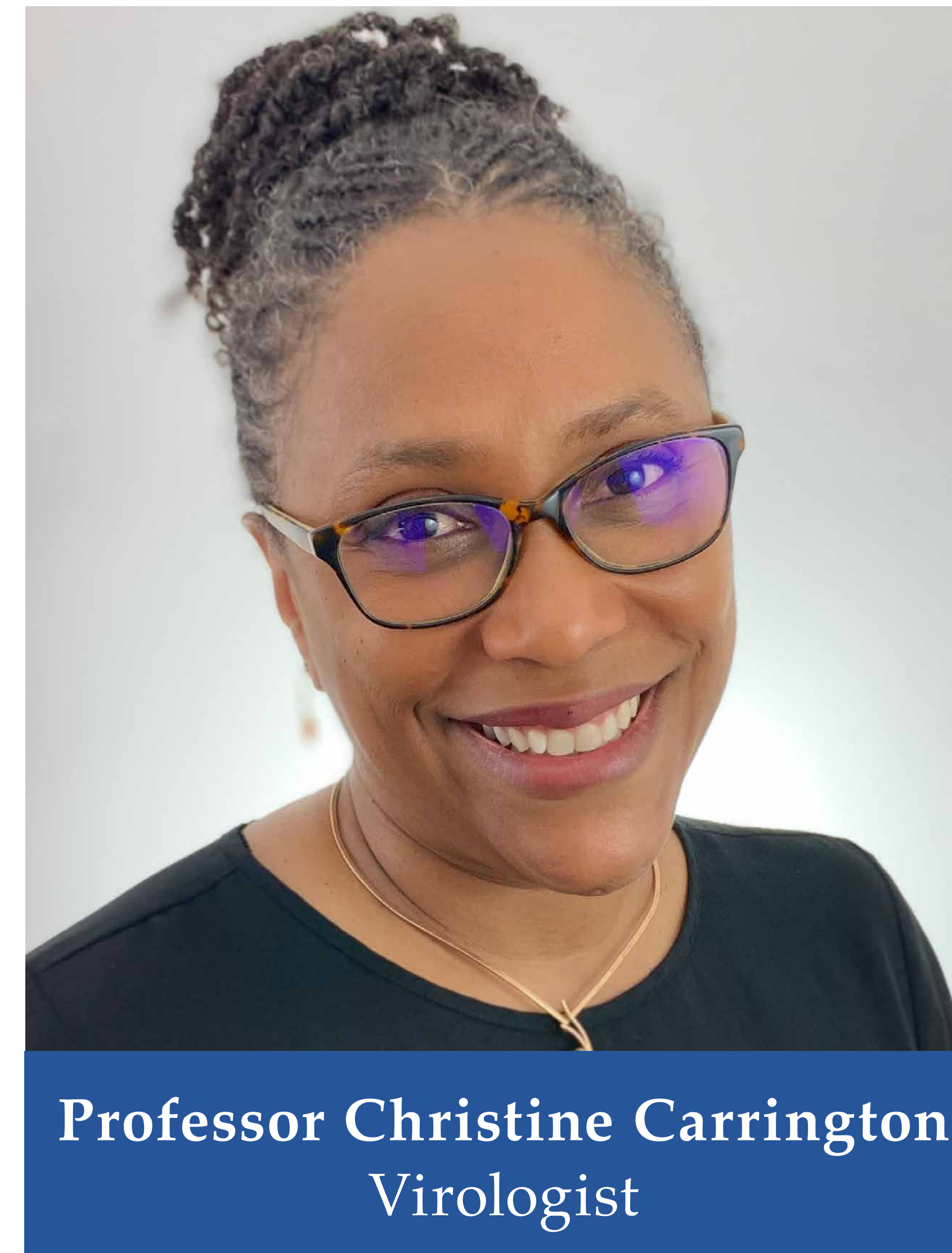
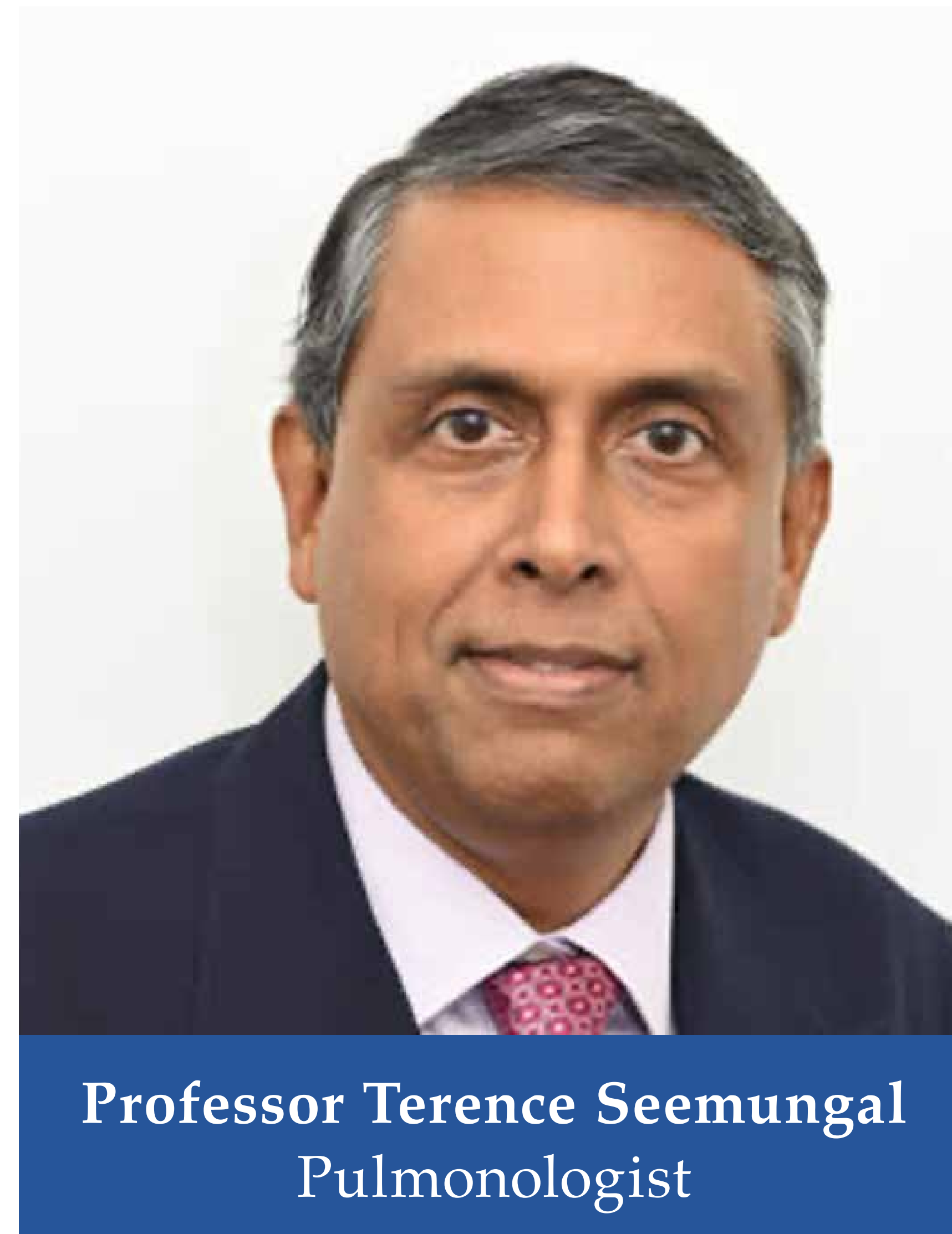
Broadcast live on UWItv's website and Facebook page, the forum was moderated by Professor Donald Simeon (Director, CCHSRD) and featured welcome remarks by Professor Terence Seemungal (Dean, FMS), Dr Acolla Lewis-Cameron (Dean, FSS) and Professor Clive Landis (Pro Vice Chancellor, The UWI Cave Hill and Chair, The UWI COVID-19 Task Force).

Missed the Forum?
View the Recording Here

(or see **Pages 14-19** for answers to some of the questions addressed at the meeting)

Virtual Public Forum – COVID-19 Vaccines: Truths and Untruths

The panel of experts comprised:



The Forum comprised two sessions. The first featured panellists' live responses to pre-recorded videos of members of the public asking questions, while in Session 2, the panellists fielded questions from the viewing audience, submitted via email, WhatsApp and live chat. A sample of the questions and summaries of the responses follow.

What is in the COVID-19 vaccines?

Vaccines have the same basic ingredients. There is material that instructs a person's immune system to fight off anything that looks like the virus. This material can be the virus after it has been rendered harmless (heat-killed, irradiated, or chemically treated); it can be a fragment of the virus such as a glycoprotein; or genetic coding from messenger RNA to generate these fragments. Vaccines will also contain antibiotics and preservatives to prevent contamination and stabilise the vaccine during transport and after the vial has been opened.

Importantly, vaccines are very safe, because they contain no infectious particles. The basic principle is to use a harmless mimic of the virus in order to teach your immune system to fight off the real thing.

What are the side effects of the AstraZeneca vaccine? What about the risk of blood clots?

Research has indicated that the AstraZeneca vaccine may cause blood clots, but these cases are very rare, lower than the risk of death by motor vehicles or airplanes, for example. It is important to weigh the risk of blood disorders or severe allergic reactions against the risk of death from COVID-19. The risks are balanced in favour of the vaccine, as advised by public health officials in all countries.

Reactions to the vaccines are usually very mild, including a bit of pain around the injection site, and flu-like symptoms in 24 to 48 hours post-vaccination, representing the immune system becoming activated.

How were vaccines produced so quickly, when the usual timeframe for certification is about three years?

SARS-CoV-2, which is the virus causing COVID-19 is not a new class of virus, and the idea of vaccine development is not new. Coronaviruses have been around for quite a while. For example in 2003, there was SARS-CoV-1, which is similar to this one, and scientists have been researching different ways of combating it since then. The COVID-19 vaccine development was relatively rapid, not just because of the available technology, but also because there is a history of previous attempts and information on similar viruses, and a global push to fund the development of these vaccines.

<p>Would the vaccine limit the risk or prevent you from getting COVID-19?</p>	<p>The COVID-19 vaccines produce protection against the disease as a result of the vaccinated person developing a quicker immune response to the COVID-19 virus. This immunity builds a person’s resistance to the virus’ exposure. Developing immunity from vaccination means that there is a reduced risk of developing illness and its complications.</p> <p>Clinical trials show that the COVID-19 vaccine will protect people from becoming seriously ill, being hospitalised or dying from COVID-19. However the extent to which the vaccine prevents a person from becoming infected with COVID-19 and the risk of transmitting the virus to others are unclear.</p>
<p>Why do I have to maintain social distancing, wear masks and not gather if I have been vaccinated?</p>	<p>There is a small possibility that people who are immunised may still be able to transmit or spread the virus. Therefore, even though vaccinated, persons need to continue to practice hand washing, physical distancing and mask wearing, to reduce the chances of being exposed to the virus or spreading it to others.</p>
<p>Is the COVID-19 vaccine using nano chips or micro technology to track or control the population?</p>	<p>No, there is no chip. But this question speaks to a wider issue of mis- and dis-information. On one hand, there is insufficient access to credible information about the vaccines while on the other hand, there is an overloading of misinformation coming from unauthorized sources on social media. In many of these cases, much of what is being shared is not rooted in science-based evidence or research, but in speculation.</p> <p>We therefore have more than one pandemic on our hands; COVID-19 and the infodemic, which is a crisis in the spread of misinformation, that circulates just as fast – and perhaps even faster – than the vaccine itself.</p>
<p>What underlying health conditions should the public be aware of (in relation to taking the AstraZeneca and other vaccines) and who should or should not be taking the vaccines?</p>	<p>According to the Ministry of Health’s guidelines, the persons who should not take the AstraZeneca vaccine are pregnant women, women who are breastfeeding, children under the age of 18, and persons who may have a severe allergic reaction to any component of the vaccine.</p> <p>The vaccine is considered safe in most other conditions, and is therefore also recommended for persons with chronic non-communicable diseases, for example, heart disease, hypertension and diabetes. Immunocompromised persons (such as with HIV) are at a higher risk for severe COVID-19, and available data is currently insufficient to assess vaccine efficacy or vaccine-associated risks in severely immunocompromised persons, including those receiving immunosuppressive therapy. People were encouraged to consult with their doctor or a health professional, if they were in doubt.</p>

Is empirical data from local, regional or international sources being gathered or monitored in order to advise persons, especially in the immunosuppressed community on the effects of the vaccine on their condition?

Yes, data is being collected. With the large studies being conducted in England, Israel and other parts of the world, evidence will soon be published to guide on this.

After being fully vaccinated, how likely am I to pass the virus to other persons?

In order to infect someone else, the virus has to be replicating inside of the infected person. Since the vaccine blocks infection in 60-95% of cases, the chance of transmission in vaccinated populations is also lower.

There is a small chance that a vaccinated person can still get infected, and in such a case, may be able to transmit it to someone else. This is why adhering to the public health measures is still important until enough people in the population are vaccinated.

How long do the effects of the vaccine last?

We will only know how long the vaccine lasts with time. This is not yet known but scientists estimate that these vaccines would be longer-lasting than annual flu vaccines for example, and may last two or three years, after which persons may need a booster shot. Over time, as variants emerge, vaccines may have to be updated.

Why do some people have no side effects, while others have lingering side effects? Why are some side effects only present in younger persons?

People have different immune responses, and would therefore have different reactions to any stimulus. Regarding the age factor, younger people have more active, healthier immune systems, so some vigorous reactions (e.g., fevers, chills, aches, pains, nausea) are evidence that the immune system is working as it should. It should also be noted that persons who do not experience the side effects also have a working immune system as research has shown comparable responses between persons with and without side effects.

Will taking the vaccine affect my body’s natural immunity and ability to fight other viruses?	No. In fact, there are simple things that you can do to strengthen your immune system regardless of COVID-19. One of the most important is sleep, which is a key determinant of the strength of your immune system. Secondly, eat a diet that supports a healthy heart (lots of fruits and vegetables), as this will also ensure a healthy immune system. Also manage stress, as uncontrolled stress responses are damaging to the immune system.
How effective is the vaccine in fighting the new variant strains that are suddenly appearing?	When the vaccines were developed, they were created with the original spike protein of the virus in mind. So the immune response that the vaccines elicit is matched to the original virus. With the variants, there may be a slight mismatch, resulting in some of the vaccines having a lower efficacy against some of the variants. This decreased efficacy applies to the mild and moderate cases of disease. So though the vaccine may not be as good at protecting against mild and moderate disease, it continues to be good at protecting against severe disease, hospitalisation and death.
People are experiencing “COVID-19 fatigue” and are fed up with the lockdowns and restrictions. What can we do?	There are social and psychological effects of the pandemic and concerns of an ensuing mental health crisis are well founded. Health care professionals, including mental health workers, social workers and other social services must work together to provide the necessary support. Some practical approaches include encouraging participation in physical activity (exercise), relaxation techniques, reaching out to family members and friends, acquiring new skills, etc.
Which vaccine is the safest?	The vaccines are all safe and effective, and have all been approved for use by the major regulatory agencies. In terms of side effects, extreme allergic reactions appear to be a little more prevalent in the Pfizer and Moderna vaccines, whereas rare blood clots are a little more prevalent in the AstraZeneca vaccine. These side effects are extremely rare and should not prevent people from taking the vaccines.
I received the flu vaccine a few months ago, is it safe to take the COVID-19 vaccine?	Yes, it is safe.

What drugs can you take after the vaccination? Are there any drugs that you *cannot* take?

Paracetamol may be taken for minor aches and pains. For severe reactions such as abdominal pains or severe headaches, persons are urged to check with a health care provider. Steroids or immunosuppressants should not be taken immediately after vaccination, as these would impair the immune system response to the vaccine. It is advised to wait a few days or weeks (unless life threatening) before taking immunosuppressants such as Prednisolone.

If an elderly person is on blood thinners for clots, can they still take the AstraZeneca vaccine?

Yes. Blood thinners are not a contraindication for the vaccine, but such patients should disclose this information at the time of the vaccination. There is no evidence that it would interfere with the activity of the vaccine.

What is the science to support a link between cases spreading as a result of persons being in certain environments?

This virus is effectively spread through shouting, singing and speaking. The most prevalent spread has been noted in nightclubs – a hub for all three. Looking at outbreaks at funerals, churches and choir sessions, it is because of the same thing – people are singing, speaking, and projecting more droplets. Similar outbreaks have been noted in workplaces with loud noise where workers have to shout, such as construction and meat processing, and places where many people are speaking in an enclosed space, such as in call centres. It is in these environments that there is the highest risk.

What is your prediction for the most likely date for the achievement of herd immunity in Trinidad and Tobago and the wider Caribbean, given the current rates?

Once the availability of vaccines becomes ramped up, and they are more evenly distributed, herd immunity can be reached when 70 to 80% of the population is vaccinated. It is difficult to accurately predict when this may be achieved, as it depends on the vaccine supply and distribution, as well as the public's acceptance of the vaccines. Hesitancy among the general public must be addressed, in order to move from vaccine hesitancy to vaccine uptake. Only when this is done and sufficient vaccines secured, can better predictions be made about herd immunity.

COVID-19 Vaccines: Truths and Untruths



In closing, panellists urged the public to:

- ✓ Obey the public health measures of mask wearing, physical distancing, personal hygiene and avoiding congregations;
- ✓ Rely on credible and trusted sources for information on COVID-19, such as PAHO/WHO and the Ministry of Health;
- ✓ Be media literate, and especially critical of information on social media; and
- ✓ Take the vaccine when it is available, as the risk to benefit ratio favours the vaccine.

The public was reminded that there is scientific evidence that vaccination will result in a reduction in the number of new cases, severe disease and mortality. Vaccination is our best and safest chance to overcome the COVID-19 pandemic.

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Evidence Informed Policymaking Project Formally Launched:

CCHSRD Welcomes Policymakers from Social Sector Ministries to the PEERSS Project

- *Mr Akil Williams*

Junior Fellow, Evidence Synthesis, CCHSRD

On May 4, 2021, CCHSRD welcomed officials from social sector Ministries in Trinidad and Tobago to the [Partnership for Evidence and Equity in Responsive Social Systems \(PEERSS\)](#) project. The event was attended by 29 representatives from the Ministries of Social Development and Family Services; Planning and Development; Labour and Small Enterprise Development; and Sport and Community Development. The delegates included Permanent Secretaries, Deputy Permanent Secretaries, Directors, Managers, Policy Officers, Research Officers, inter alia.

The purpose of the virtual project launch was to introduce these social sector partners to the CCHSRD team and to highlight the project's aim and objectives as well as the upcoming activities. Most importantly, the partners were able to ask questions to ensure that they fully understood the goals of the project, how the partnership works and to identify how they can best benefit from the opportunities.

These social sector partners had been previously informed of the project when they were initially invited to participate. However, the opportunity was taken to remind them of the potential benefits of the project such as building capacity towards strengthening evidence-informed policymaking in their Ministries. Evidence-informed policymaking is an approach to policy decisions that aims to ensure that the process is well-informed by the best available research evidence. CCHSRD was also pleased to announce its plans to promote a culture of evidence informed policymaking in the Social Sector through the establishment of a Social Sector Chapter of its Caribbean Community of Practice for Health Policy and Systems Research.

There was a short presentation on the elements of the evidence-informed policymaking (EIP) process in the health system and how this could be applied to policymaking in other social sector Ministries. It was noted that the EIP status and needs of

CCHSRD Welcomes Policymakers from Social Sector Ministries to the PEERSS Project



each Ministry was different so it was critical to customize the engagement with each. The focal points in each Ministry will therefore be working with the CCHSRD team to determine how best to build capacity towards the joint development of knowledge translation products that address priority issues (as defined by the Ministries). These products include 10-day and 30-day Rapid Response Briefs, Evidence Briefs, Citizen Briefs as well as Stakeholder Dialogues.

The next steps of the project include a Needs Assessment to determine how the different Ministries currently utilize evidence in decision-making, identify training needs and to define the most appropriate approaches and mechanisms for working together. Subsequently, the Ministries will engage in priority setting activities, followed by training, coaching and the co-creation of Evidence Syntheses.

At the launch, the officials were also introduced to the PEERSS webpage (with project details, links to Collaborators' sites, resources and Knowledge Translation products), its newsletter and the contact information of the PEERSS team at the CCHSRD.

PEERSS is an international partnership comprising institutions in 13 countries, which promote and support evidence informed policymaking in both the social and health sectors towards the achievement of the Sustainable Development Goals (SDGs). It is jointly funded by The William and Flora Hewlett Foundation and the International Development Research Centre (IDRC).

CCHSRD is the only Caribbean institution in the partnership.

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- *Ms Alissa Moore, Mr Michael Pierre*
Research Assistants, CCHSRD



CCHSRD conducted a one-day intensive online workshop on Evidence Informed Policymaking (EIP) for the Ministry of Health, Trinidad and Tobago on May 24th. This was consistent with the continued collaboration between the Centre and the Ministry, defined by their 2019 Memorandum of Understanding. Notably, at previous needs assessment sessions, the Ministry had requested bespoke training workshops for its staff as part of a program for institutional strengthening to support the use of evidence in policy and practice.

The Workshop aimed to build the capacity of persons involved in the policymaking process at the Ministry of Health to find, appraise and use evidence in its decision-making. It was initially designed as a 2-3 day in-person training; however, due to the COVID-19 restrictions, the workshop was converted to an intensive 1-day online training that included PowerPoint presentations, practical exercises, and group discussions.

There were 19 participants comprising Directors, Managers and Heads of Departments as well as Research and Technical Officers at the Ministry of Health. While CCHSRD staff led the facilitation of

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the workshop, we were pleased to have been joined by Ms Racha Fadlallah, Evidence Lead Specialist and Systematic Reviewer at the Knowledge to Policy (K2P) Center, American University of Beirut.

The main presentations included:

Role of Evidence in Health Policymaking (Shelly-Ann Hunte, Research Fellow, CCHSRD):

This provided the participants with a review of the fundamental stages in the policymaking process, highlighting the role of evidence. Some of the main challenges and proposed interventions to strengthen the use research evidence in policies and practice were shared.

Finding, Appraising and Using Evidence in Decision-Making (Akil Williams, Junior Fellow, Evidence Synthesis, CCHSRD):

There was an introduction to key databases that were available to search for evidence on health and social topics.

The importance and relevance of systematic reviews and their appraisal were then discussed.

Impact Oriented Approach to Link Evidence to Policy (Racha Fadlallah, K2P Center):

Examples of how evidence had been applied to inform policy and practice as well as when it was not used were presented and discussed. This highlighted success cases as well as missed opportunities.

Introduction to Key Knowledge Translation Products and Uptake Activities (Kershelle Barker, Junior Fellow, Evidence Synthesis, CCHSRD):

An overview of the different knowledge translation products and uptake activities was presented.

Complementary practical exercises were facilitated after the presentations to reinforce the material.

The workshop ended with a review of the additional technical support and training that the Ministry of Health needed from CCHSRD towards the continued strengthening of its EIP processes.

The evaluation of the workshop indicated that the participants felt that it was a very good and timely workshop. Indeed, they reported that the workshop met its objectives and that the content was relevant, well prepared and effectively communicated by the presenters.

The training was supported by the WHO-funded project entitled '*Building Institutional Capacity for Health Policy and Systems Research and Delivery Science*'. The K2P Center serves of the mentor institution for the project.

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Research Highlight

Study: Differential Associations of Adipose Tissues with Hypertension and Diabetes in Tobago Men

- *Dr Curtis Tilves, PhD¹, Dr Iva Miljkovic, MD, PhD²*

¹Postdoctoral Trainee, Johns Hopkins Bloomberg School of Public Health

²Associate Professor of Epidemiology, University of Pittsburgh Graduate School of Public Health;
Principal Investigator of the Tobago Health Study



Dr Curtis Tilves



Dr Iva Miljkovic

Obesity is associated with increased risk of cardiometabolic diseases. However, individuals at a similar level of obesity can have very different body compositions, which may be more important to health than obesity alone. Greater abdominal fat (subcutaneous and visceral) and thigh skeletal muscle fat are associated with increased diabetes and hypertension risk, with visceral fat being particularly pathogenic. In contrast, greater thigh subcutaneous fat and muscle are inversely associated with diabetes risk. There are also known racial/ethnic differences in body composition which may contribute to differential risk for cardiometabolic diseases. Many studies looking at body composition and cardiometabolic risk have focused on abdominal or peripheral body compositions alone, which may provide an incomplete picture. The few studies that do include measures in both regions often have low representation of individuals with African ancestries.

Our objective was to assess associations of both abdominal and thigh compositions with hypertension and type 2 diabetes in African Caribbeans, who have a very high burden of these chronic diseases. We used data available from the Tobago Health Study; this is an ongoing observational study of men from Tobago who were at least 40 years old at the study start (in 2004). At our most recent study visit (2014-2017), we conducted computed tomography scans of the abdomen and thighs, and clinical assessments and collected lifestyle measures.

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We found that having more abdominal subcutaneous fat – but not visceral fat – was associated with higher odds of being in a worse hypertension or diabetes category. This may indicate that excess abdominal subcutaneous fat can be harmful in populations that have low visceral fat, such as African Caribbeans. We also found that thigh muscle was inversely associated with diabetes, which speaks to the role of muscle in glucose consumption.

While our findings may not be generalizable to women, we hope to investigate associations of body composition with cardiometabolic diseases in our newly begun Tobago Women's Study. Future work could look at the utility of indirect measures of subcutaneous fat (e.g., waist circumference, skin folds) in predicting cardiometabolic risk in this population, which may be obtained easily in a clinical setting. These, and other relevant results from our study, may provide Tobago health officials with accurate and detailed data for developing health policies, clinical screening, and implementing programs to reduce the burdens of diabetes and hypertension.

We thank our Tobago Study participants and staff for making this research possible.



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