5th ANNUAL SYMPOSIUM ON **DIABETES IN HUMANITARIAN CRISES**

Image: *Democratic Republic of Congo, February 2025, © Jospin Mwisha*

FULL SYMPOSIUM REPORT

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Mass General Brigham

LONDON SCHOOL of HYGIENE &TROPICAL MEDICINE

CENTRE FOR GLOBAL CHRONIC CONDITIONS

5th Symposium
on Diabetes in Humanitarian Crises

Geneva, October 2025

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ACKNOWLEDGEMENTS

Thank you to all who attended the Symposium, both in person and online, for so enthusiastically sharing knowledge and insights, which have provided such clear direction for future action by the alliance.

Particular thanks to those who presented in the plenaries and to those who moderated and rapporteured the breakout sessions. We would also like to thank the co-hosts, Mass General Brigham (MGB) and the London School of Hygiene and Tropical Medicine Centre for Global Chronic Conditions (LSHTM CGCC), for their collaboration and partnership in making the Symposium a success. In particular, we wish to acknowledge LSHTM CGCC for its tremendous contribution in leading the research session and overseeing the abstract review process.

Within the IADA secretariat, Anna Nakayama supported the organization of the Symposium itself, with on-site support from Seren Events and from Kelly Lai. Katy Cooper acted as rapporteur for the Symposium and drafted this meeting report.

We would like to express our deep gratitude to The Leona M. and Harry B. Helmsley Charitable Trust for its generous support.

LIST OF ABBREVIATIONS

Abbreviation	Definition
AI	artificial intelligence
CHW	community health worker
EMRO	Eastern Mediterranean Regional Office
GDM	gestational diabetes mellitus
IADA	International Alliance for Diabetes Action
IFRC	International Federation of the Red Cross
LMIC	low- and middle-income country
LSHTM CGCC	London School of Hygiene and Tropical Medicine Centre for Global Chronic Conditions
MENA	Middle East and North Africa
MGB	Mass General Brigham
MSF	Médecins Sans Frontières (Doctors Without Borders)
NCD	non-communicable disease
NGO	non-governmental organization
PLWD	people living with diabetes
SDGs	Sustainable Development Goals
UN	United Nations
UNGA	United Nations General Assembly
UNHCR	United Nations High Commissioner for Refugees
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USAID	US Agency for International Development
WHO	World Health Organization

SYMPOSIUM SUMMARY

The 5th Symposium on Diabetes in Humanitarian Crises, hosted by the International Alliance for Diabetes Action (IADA) in collaboration with the London School of Hygiene and Tropical Medicine Centre for Global Chronic Conditions (LSHTM CGCC) and Mass General Brigham (MGB), was held in Geneva, Switzerland, on 16–17 October 2025. The event brought together almost 130 people engaged in diabetes care during humanitarian crises from United Nations (UN) agencies, research organizations, non-governmental organizations (NGOs), philanthropic donors and the private sector, with strong representation from people with lived experience of diabetes in humanitarian settings. The discussions informed the development of IADA's Strategy 2026–2030 and helped set research priorities for the next five years. This is a crucial time for global health, covering the period of consultation and negotiation around the successors to the Sustainable Development Goals (SDGs), which come to an end in 2030.

Proceedings opened with a welcome from IADA to participants and thanks to the co-hosts (LSHTM CGCC and MGB) and the sponsor, The Leona M. and Harry B. Helmsley Charitable Trust. Dr. Sylvia Kehlenbrink acknowledged that the Symposium was held at a challenging moment: both the numbers of emergencies and the prevalence of diabetes are increasing, and the global health architecture and health funding are coming under unprecedented strain. The Symposium was an opportunity to revisit IADA's goals in this new era.

> '*We have to do more with less… to think creatively about how to address these challenges within the current evolving humanitarian landscape*' -Sylvia Kehlenbrink

The keynote address was given by Dr. Bente Mikkelsen (formerly World Health Organization (WHO) and now at the St Jude Children's Research Hospital). Despite the enormous challenges, there is cause for optimism: the noncommunicable disease (NCD) community has long experience of working with only limited funding and across silos, and high-level policy commitments on NCDs have recently acknowledged the urgency of action in humanitarian settings. She called on everyone to play their own part in addressing the crisis.

The first plenary, **Global funding changes and implications for diabetes care in crises**, situated the Symposium within the current geopolitical context. The discussions included: the need to reshape the humanitarian system to include NCDs and to centre the role of national governments and local actors (while continuing international support); the essential role of partnerships; and the urgency of mobilizing resources in ways that ensure integrated, patient-centered care.

The second plenary, **Turning global commitments into action**, focused on making the most of opportunities afforded by the embedding of humanitarian emergencies within the Political Declaration of the recent United Nations High-level Meeting on NCDs and Mental Health. Knowledge translation is necessary for the development and implementation of effective, contextualized policy, with the full involvement of people with lived experience, and with clear accountability for progress. All the speakers sounded cautious optimism that the reorientation of the global health architecture could be a moment for positive change for NCDs, particularly in humanitarian settings.

The final two plenaries both delved into topics that have not, to date, been a focus of IADA's work, but which have been identified as being of significant interest. **Addressing diabetes in pregnancy during emergencies** is a critical need for the health of both mother and baby. A lifecourse approach – before, during and after pregnancy – is needed to minimize health risks, and United Nations Relief and Works Agency for Palestine Refugees in the Near East (UNRWA) set out how maternal and child health can be integrated with NCDs, even in the most challenging settings. The Symposium heard powerful advocacy from a woman from Lebanon, who told her own story of the devastating consequences of inadequate care.

The final plenary addressed **Nutrition and food security for people living with diabetes in emergencies**. Concerns raised in the discussions included: the need for nutrition support for people living with diabetes (PLWD) to be prioritized so that they can better control their diabetes, the lack of guidelines and adequate coordination across sectors, and taking a pragmatic approach to nutrition advice, placing the patient at the centre. An ongoing pilot study in Somalia is working to better understand local challenges in accessing healthy food options.

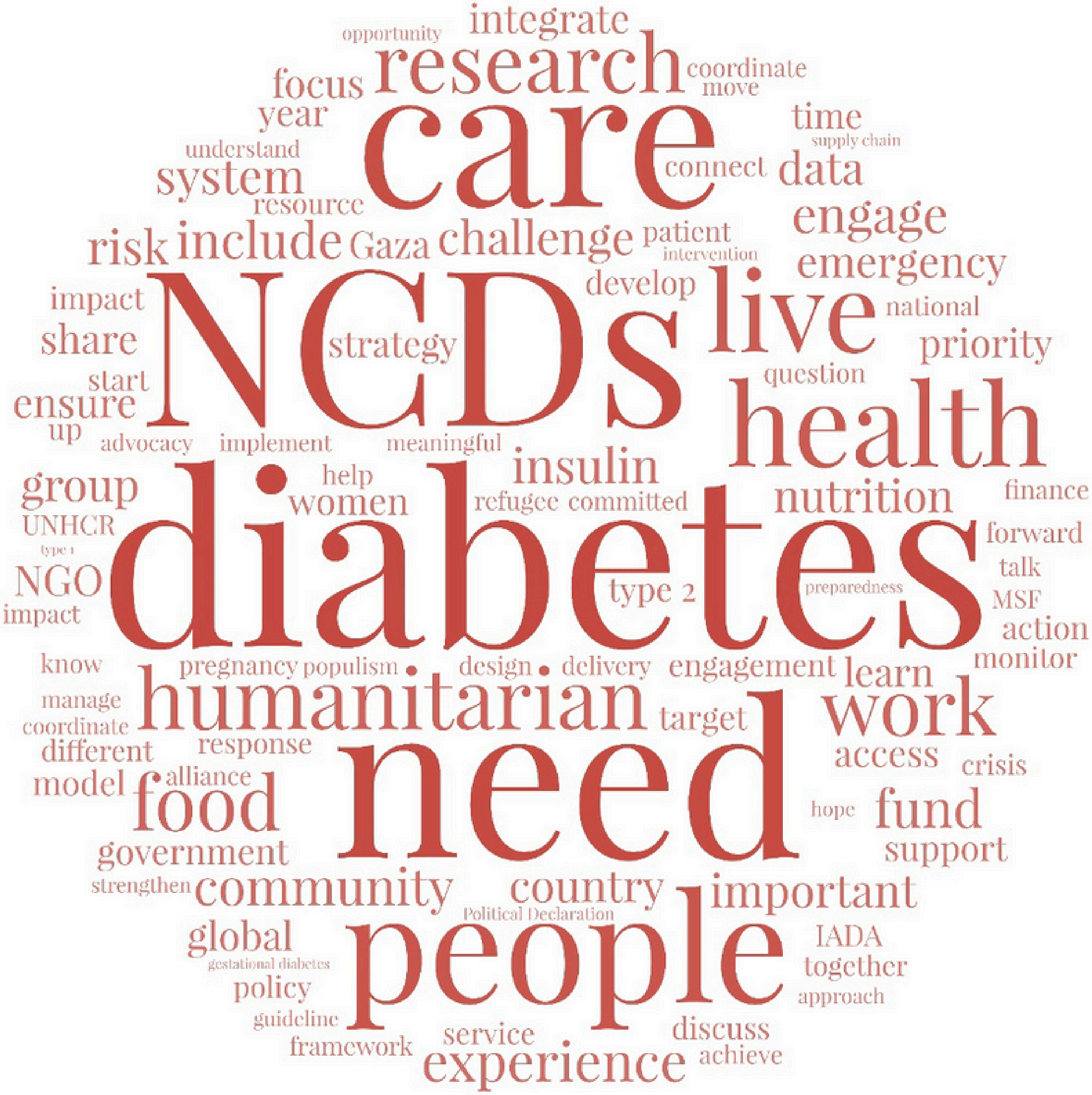
The selected research submissions in the call for abstracts were available to read throughout the Symposium, and the winning abstract was presented in plenary: 'Insulin supply in Gaza: lessons from three critical cold-chain incidents across the humanitarian supply chain.'

The Symposium fully embraced the importance of **meaningful engagement**, with a workshop and with participants living with diabetes speaking throughout the sessions. Despite the layer of complexity added by humanitarian settings, the challenges posed to genuine meaningful engagement are not insurmountable. PLWD are technical experts in their own lives, and this expertise is always present in communities: find it, nurture it, engage with it, use it, respond to it. Meaningful involvement adds significant value, right from the design of a program through its implementation and monitoring/evaluation: it should never merely be a box-ticking exercise at the end. A diversity of opinions should be sought, representative of the whole community and not restricted to the most vocal or empowered, in language that is readily understood. Regular feedback should be provided to those participating, to ensure that they have co-ownership of the process: one-off involvement can be both distressing and frustrating. IADA is committed to ensuring that meaningful engagement will be an intrinsic part of its future work.

A principal aim of the Symposium was to identify **research priorities** and, following the Symposium, participants were asked to vote for priorities that they would like to see IADA take forward into its Strategy 2026–2030. Group discussion revealed considerable overlap between IADA's proposed clusters of research questions, indicative both of the complexity of the issue and the need for systems thinking. Key considerations include mainstreaming lived experience throughout the whole research process, always remembering that what matters to PLWD is not the research per se but the impact that it has on their lives. A good understanding of what works for patients is needed, including the patient journey and referrals, and education to improve self-management. Data collection, indicators and rapid analysis are all vital to understanding people's needs in real time. Communication between researchers and local communities builds trust and enables co-production of research, and journals should be encouraged to publish more of this co-created work.

The final breakout session **looked back at achievements and identified unmet needs** that can be addressed by IADA over the next five years, across the four IADA workstreams: service delivery, access to medicines and diagnostics, data and research, and policy and financing. IADA is not an operational partner; instead, its role is to bring together current and future IADA members, combining their interests to maximize the benefits of the alliance, and monitoring the impact to ensure mutual accountability. Extending membership and re-engaging with existing members is vital, with regular communication opportunities within the alliance. Undertaking mapping of who is doing what, where and how is essential – including identifying and engaging partners who work with big-data sources and building an understanding of existing funding streams and financing mechanisms, such as pooled procurement. Participants highlighted the importance of completing existing projects, as well as suggesting new ideas, covering the continuum from emergency preparedness to response and recovery.

Dr. Alarcos Cieza (WHO) closed by thanking the Symposium for the enthusiasm and commitment to the cause. She encouraged seeking out the synergies between diabetes and other NCDs, and noted the key role that IADA plays in setting research priorities, on which WHO can then base its own recommendations. Finally, she reiterated the theme at the heart of the Symposium: meaningful learning from and engagement with people with lived experience.



Word cloud of the themes of the plenary sessions at the 5th IADA Symposium

THE SYMPOSIUM: CONTEXT, ATTENDANCE AND AIMS

2025 is a pivotal moment for global health. More than 120 million people are displaced by conflict and violence, a further 200 million are affected annually by natural disasters, and low- and middle-income countries (LMICs) are most heavily impacted. The burden of diabetes continues to rise, today affecting over half a billion people worldwide. This burgeoning crisis is now coupled with recent global funding cuts, which are forcing organizations to reassess priorities and programming.

The Symposium was held at the Mövenpick Hotel, Geneva, Switzerland, on 16–17 October 2025. It was attended by 129 people engaged in diabetes care during humanitarian crises – 75 in person and a further 54 joining online, drawn from all six WHO regions. Attendance included UN agencies, research organizations, NGOs, philanthropic donors and the private sector, with representation from people with lived experience of diabetes in humanitarian settings.

All five of IADA's Symposia have provided a platform for shared learning, strategic dialogue, and the advancement of collaborative efforts to drive equitable, sustainable solutions in emergency contexts and, this year, the discussions informed IADA's new Strategic Plan for 2026–2030.

The Symposium reflected on how to better align global commitments with operational realities, within the changing funding and policy landscape. To date, diabetes care has been under-prioritized and inconsistently integrated into emergency responses, so this is an opportunity to work to shape and inform the development of the new global health architecture in ways that better reflect global need. This demands pragmatism, partnership and renewed purpose.

The Symposium objectives were to:

1) assess achievements and remaining challenges in diabetes care in humanitarian settings since 2023, to help shape IADA's 2026–2030 Strategic Plan;

2) identify practical strategies to sustain and strengthen diabetes care in the face of changing global health and humanitarian financing; and

3) identify opportunities to align with and build on recent global declarations, ensuring the needs of PLWD in humanitarian settings are addressed, and to set clear research priorities.

The outcomes were expected to include:

1) agreed strategic priorities for the 2026–2030 plan;

2) actionable strategies for sustaining diabetes care under current and future funding realities;

3) a shortlist of priority actions for operationalizing global commitments, including PLWD engagement and targeted research areas.

SYMPOSIUM PLENARIES

WELCOME AND INTRODUCTION

Dr. Sylvia Kehlenbrink, executive director of IADA, welcomed those joining the 5th IADA Symposium, both in person and online, and thanked the co-hosts (LSHTM CGCC and MGB), as well as the sponsor, the Helmsley Charitable Trust.

Dr. Kehlenbrink began by acknowledging the impact of the extraordinary changes that have taken place in the world since the previous Symposium. This was echoed by **Dr. Lilian Kiapi,** IADA Board Chair, whose welcome noted that this is a pivotal time of unprecedented challenges, but also that extraordinary efforts are being made by colleagues worldwide, coupled with ongoing resilience among the communities that are served.

> *'Humanitarian principles are under threat – so it is all the more remarkable that we are all here, despite all of the resource constraints…. This speaks to your dedication and to the importance of the topic'*
>
> -Sylvia Kehlenbrink

Diabetes remains a huge challenge. Half a billion people are living with the disease, of whom almost half are undiagnosed and over 80% live in LMICs – and the number living with diabetes could rise to 1.3 billion by 2050. A parallel crisis is that of forced displacement, which is increasing every year, with most affected now living in protracted crises. Today, 123.2 million people are forcibly displaced, and the impact of climate-related crises could see this rise to 1.3 billion by 2050.

At this critical time, the Symposium is revisiting IADA's goals, first set out in the Boston Declaration in 2019 and updated in Krakow in 2021. Plenaries will look at new areas (diabetes in pregnancy and on nutrition) and breakouts and workshops will gather participants' ideas on research priorities and strategic direction. People with lived experience of diabetes will be at the centre of the Symposium, co-leading the group sessions and presenting in plenary. The Symposium could be a moment of opportunity to find new ways to work together to improve the lives of millions of people.

KEYNOTE ADDRESS

Dr. Bente Mikkelsen, Director of Global Engagement Strategies, Department of Global Pediatric Medicine, St Jude Children's Research Hospital

As Dr. Kiapi noted in her introduction, **Dr. Bente Mikkelsen** has for many years worked tirelessly to integrate NCD care within humanitarian settings. In her role at WHO, she convened a high-level technical meeting on NCDs in Copenhagen in 2024, and she remains a strong supporter of IADA.

Dr. Mikkelsen began by acknowledging that she had initially doubted whether it was appropriate for her to give the keynote address at all, having recently heard stories from frontline workers on the enormous difficulties that they face. But she has come to realize that everyone has a role to play in this agenda.

> *'We all have a job to do. We need to use whatever position we have in trying to influence making something happen'* -Bente Mikkelsen

Despite the immense difficulties of our time – conflict, climate change, polarization, fragmentation and aid cuts – Dr. Mikkelsen takes heart from a new approach that was evident at the recent UN General Assembly (UNGA) and World Health Summit: leaders from African Countries, in particular, have a determination not to bemoan the changes, but instead to rise to the challenge. 'We have long preached this in the NCD community: it is time to take the tools and start to mobilize country resources, doing things their way, not our way.'

And the extent of this challenge is immense: over 2 billion people live in fragile and conflict-affected settings, with average time for internal displacement reaching 10 years and almost a generation – 20 years – for external displacement. Despite the high prevalence of NCDs among crisis-affected populations, the traditional emergency response has focused largely on acute care, infectious diseases, maternal and child health, and mental health—leaving a critical gap in continuity of care for those living with chronic conditions. Humanitarian NGOs' approaches to NCD services vary widely, with no universally defined minimum standards for care in crises.

The COVID-19 pandemic helped to raise awareness of how much is still to be done to embed NCDs as part of preparedness and emergency response: COVID-19 left millions of people without the care they usually received for NCDs including diabetes, resulting in critical illness and death. Research found that only 16 countries of the world had emergency preparedness plans that included NCDs when COVID-19 hit. Since 2020, collaboration has improved – for example, the emergency division within WHO has increased its inclusion of and collaboration with NCDs and maternal and child health, focusing on continuity of care and recognizing the importance of the NCD emergency kits. Dr. Mikkelsen also reiterated the need to break the silos, whether between acute and protracted settings or between infectious and NCDs.

There have been other positive developments. Global health authorities, including the WHO and UN, and governments are increasingly advocating for better inclusion of NCD prevention and control as part of humanitarian response modalities, in both acute and more protracted situations and within the evolving emergency preparedness and health-system resilience configuration. Individuals including Dr. Slim Slama and organizations including IADA are making a difference. As Dr. Mikkelsen noted, 'This is often about people – why don't we celebrate that a bit more?' Policy is also being developed: the 2022 Diabetes Resolution included a paragraph on access to care in humanitarian crises and, most recently, the UN Political Declaration on the Prevention and Control of NCDs and the Promotion of Mental Health and Well-being[1] includes much more on NCDs in humanitarian settings than the previous (2018) Declaration. These commitments are made at the highest level of governments – and by the next Symposium there may be data to show what a difference these commitments can make when supported by all partners.

> *'Let's agree it is a continuum [across preparedness and response] and that we need to think differently: this has to be universal health coverage and about preparedness, looking throughout the whole health system. Preparedness is the most important part, and I have taken this to heart'* -Bente Mikkelsen

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[1] United Nations General Assembly. Political declaration of the fourth high-level meeting of the General Assembly on the prevention and control of noncommunicable diseases and the promotion of mental health and well-being. Draft resolution A/80/L.34, 8 December 2025. https://www.who.int/publications/m/item/political-declaration-of-the-fourth-high-level-meeting-of-the-general-assembly-on-the-prevention-and-control-of-noncommunicable-diseases-and-the-promotion-of-mental-health-and-well-being

PLENARY 1:
Global funding changes and implications for diabetes care in crises

Key points from the plenary:

- The world is facing a **confluence of crises** in which the growing prevalence of diabetes is coinciding with increasing numbers of humanitarian emergencies and a sudden decrease in already overstretched overseas development assistance.
- Health and funding systems need to be reshaped to **better integrate NCDs**. Bringing NCD prevention, diagnosis and care within primary health care enables a more patient-centered, holistic approach, which has the dual benefit of being more effective for people living with diabetes as well as being a more efficient use of scarce resources.
- Smart, **cross-sectoral partnerships** can streamline delivery of programs, activate economies of scale, align funding cycles and break out of disease-specific silos that have often sidelined people living with NCDs.
- Resource mobilization must continue and accelerate, both from domestic sources and from the international community and private sector. There needs to be improved **transparency in financing**, which will help to ensure that people living with NCDs are appropriately prioritized.

Dr. Paul Spiegel (Director, Johns Hopkins Center for Humanitarian Health) set out the challenges of the time, including the undermining of human rights and humanitarian law. The shifts in government funding towards defence and away from overseas development assistance by the United States and other Western governments are estimated by The Lancet to lead to 14 million additional deaths by 2030. Attacks on health facilities and health workers – including many colleagues of those attending the Symposium – are becoming the norm and are happening with impunity. But while it is hard to be optimistic, this could also be a moment of real change. There have been shortcomings in the humanitarian system for decades, so this may be the moment to form a more just and community-based system, in which international players cede power and funding to national-level NGOs.

> *'It is time for the global community to recognize that the UN and international NGOs are too big and too costly, and that we need a slimmed-down, appropriate response where the communities, national NGOs, and… government authorities that are legitimate and have capacity should take over and actually make the decisions'* -Paul Spiegel

Next to speak was **Dr. Teresa Zakaria**, Unit Head for Department of Health Emergency Interventions at the WHO Health Emergencies Program. Only 21% of the aid that the Global Humanitarian Overview estimates as needed in 2025 has been provided and, as a result, of the 81 million people targeted for health assistance, 57% will not receive the assistance that they need. Dr. Zakaria gave estimates of what this means in practical terms for PLWD: 518,000 people in Sudan who are living with diabetes could be excluded from care and in Yemen only 7% of health centers are providing full diabetes services. She also noted the need for data to be at the heart of planning emergency response, to avoid preventable deaths and to ensure an appropriately targeted response. Finally, PLWD themselves should be involved in the design, planning and implementation of diabetes programs.

> *'Even as responsibility is increasingly transferred to local actors in the health system, international support and resourcing must continue. We still have an obligation to provide the support and financing for our local partners to operate'* -Teresa Zakaria

Dr. Allen Maina is chief of the Public Health Section at UNHCR, an organization that is facing the dual challenge of burgeoning global crises coupled with internal job losses. Although UNHCR is trying to adapt to the funding crisis and has succeeded in keeping many services running, patients are more likely to develop complications in settings where referrals are not possible. UNHCR works with governments – although this is more challenging in the situations where there are several national authorities.

Dr. Maina particularly highlighted the difficulties faced by governments in including refugees in national health systems: over 70% of the world's refugees are located in LMICs, and it is in these countries in which 80% of the diabetes deaths take place. Solutions to funding challenges include making best use of innovation (such as electronic medical records and tools to strengthen patients' self-management), working to strengthen national and local systems, and supporting the resilience of local communities themselves. The private sector is also stepping up support for national systems, including provision of better-integrated packages of care that include nutrition, primary care and NCDs.

> *'Diabetes does not wait for stability! The crisis means we need to step up our collective efforts on the continuum of care for NCDs [in emergencies]'* -Allen Maina

The theme of partnership was developed by the next panelist, **Herb Riband**, Executive Director of Access Accelerated, which has brought pharmaceutical companies together in a technical partnership with the World Bank since 2017. A recently launched initiative, the Financing Accelerator Network for NCDs, works with countries to improve health-system financing through technical assistance, facilitating peer-to-peer country learning and providing catalytic seed funding for innovative programs. Integration of care and of funding (for example, pooled purchasing) is an important opportunity. There is a clear need for a sustainable market for insulin that joins up demand and supply, and interesting work is ongoing to develop a patient-centric package of care that enables patients to receive treatment and information in one place. Mr. Riband's reasons for optimism include the inclusion of humanitarian emergencies in the UN Political Declaration that centers NCDs on the political agenda, the growing value delivered by partnerships, and countries increasingly stating that now is the time to control their own destiny.

The final panelist, **Dr. Estrella Lasry**, answered the question of why the Global Fund has an interest in NCDs when its main funding is for communicable diseases. The answer is integration: more intentional work is now being done on this, with a 10-fold increase in funding for NCD co-morbidities in 2024. A primary care approach is more holistic, ensuring that care for all conditions can be provided at the same place at the same time, reducing stigma and ensuring appropriate referrals. There is much learning on models of care to be drawn both from inside and outside humanitarian settings: examples include Bangladesh, where NCD screening is now undertaken alongside infectious disease care among displaced Rohingya populations, in partnership with local NGOs. There are funding channels within the Global Fund that can be used in crises, including emergency reprogramming, the implementation of the 'challenging operating environments' policy that allows more flexibility in what can be included in packages in challenging settings, and access to emergency funding, which can free up space for NCD funding.

> *'[The global health community] know what needs to be integrated, but [funders] need more information on how this should happen, including for NCDs. We need the global community to help [funders] understand how to operationalize those funds and ensure that the funds go further and address the needs of people as a whole'* -Estrella Lasry

Dr. Stella Njagi from the International Rescue Committee gave a short description of the ongoing impacts of aid cuts on its programs. This has led to delays and confusion – but also to an ongoing reimagining of the humanitarian setting of the future. There is an urgent prioritization of programs, focusing on a move away from silos and towards partnership, localization, and avoiding duplication with other humanitarian implementers.

The discussion included questions about how best to streamline processes for governments to make it easier to access available funding. There are difficulties in aligning funding cycles between organizations – but if governments take the lead, funders can coalesce around the needs identified within a national NCD plan. It is vital to avoid vertical silos, which create enormous administrative burdens. This is not the time for a new global coordinating mechanism, which would create new layers of bureaucracy; instead, 'radical collaboration' is needed to bring organizations together, joining forces to achieve greater impact. Private-sector funding should be earmarked as little as possible. In some parts of the world, NGOs are not recognized, and here it is important to work with governments to support the community-based organizations that are at the heart of localization.

Financing for NCDs in humanitarian settings is a microcosm of a key challenge faced by NCDs as a whole over decades: lack of transparency. Being able to track money for NCDs right down to the level of the patient is key, and this information should be made readily available. Transparency is not always easy to achieve – but, as requests for integration across disease areas become more widespread, calls will increase for a better understanding of the impact of funding streams on NCDs. An example of a positive trend is that the UN Foundation has, for two cycles, looked at how humanitarian settings are included in Global Fund grants. Sometimes it may be so complex to unpick what is happening at a national level that it may be better to look at what is happening locally and then work back up through the system to understand the funding that has led to the result on the ground.

> *'We [in the global health community] each need to start with what we are doing, reach out to others, and model the collaborative, country-focused behavior we want to see and hope it becomes contagious!'* -Herb Riband

PLENARY 2:
Turning global commitments into action

Key points from the plenary:

- There is some **cause for optimism**, with significant momentum in global policy on NCDs in humanitarian settings, most recently the UN Political Declaration on NCDs and Mental Health (2025). The ongoing reshaping of systems of international aid is a once-in-a-generation opportunity to reorient the global health architecture towards a more equitable and holistic response to health needs.

- The active involvement of people living with NCDs promotes better outcomes, encourages government engagement and improves contextualization. **Meaningful engagement** is not always easy or comfortable for policymakers, but is essential for the development and implementation of effective action and for accountability.

- For policy commitments to become effective national action, there is a need for **knowledge translation** that builds a shared language, understanding and trust between researchers, policymakers and people living with NCDs.

- It is essential to redouble advocacy efforts, supported by research, to ensure that the needs of people living with NCDs in humanitarian settings are met in advance of the 2030 horizon for the SDGs and are included in the negotiations around **the successors to the SDGs**.

Dr. Rachel Nugent outlined the objectives of the session: to review global commitments, define policy areas for collaboration, and to identify practical strategies. She highlighted a recent article on barriers to operationalizing health in the humanitarian-development-peace nexus – among them, inadequate political support, competition and cultural differences between actors, and lack of control by national authorities – all of which were touched upon by those participating in the plenary.

Ms. Oria James is a consultant with the WHO Global Diabetes Compact and is living with type 1 diabetes. She set out the process and outcomes of the recently negotiated Political Declaration on NCDs and Mental Health – the fourth such Declaration, following earlier UN High-level Meetings on the topic in 2011, 2014 and 2018. The zero draft was published in May, and this was followed by a period of negotiation among WHO Member States, with WHO acting as technical advisor. The final version – which at the time of the Symposium was still formally to be adopted by the UNGA, but has since been adopted in December 2025 – focused less than the zero draft on diabetes, with a notable omission of any mention of insulin and the removal of reference to existing global diabetes targets.

However, the number of mentions of humanitarian settings increased in the final draft and (for the first time in a Political Declaration on NCDs) there is a paragraph on the need to involve people with lived experience. Ms. James encouraged investment in improving communications about global policy meetings and documents to people living with NCDs (‘what would it look like if we had many times more people living with NCDs doing the advocacy!’), and set out ways in which the Global Diabetes Compact has been working to better engage lived experience, including annual meetings and hiring people with lived experience.

> *‘Meaningful engagement is strategic, effective and necessary for meaningful change’* -Oria James

Alison Cox, Policy and Advocacy Director of the NCD Alliance, welcomed the Political Declaration's targets as they provide a useful basis for accountability, and noted that, although the Declaration is not politically binding, it is a clear recommitment by governments as to the importance of NCDs and mental health, including in emergencies. An additional target – that 80% of countries integrate NCDs into emergency preparedness and response – was omitted from the final draft. The reason for its removal is unclear as the negotiations on Political Declarations are conducted between governments behind closed doors, but it may have been because of overlap with the UN Pandemic Agreement, which itself was painstakingly negotiated.

In 2026, a new Political Declaration on Pandemic Prevention, Preparedness, and Response is due to be drawn up: inclusion of NCDs within this would be a good target for advocacy in coming months. Finally, the Eastern Mediterranean NCD Alliance is a good example of civil society action, holding a regional conference on the humanitarian response, developing a priority agenda for NCD care (including provision of care in crises) and publishing a shadow accountability report (using government data to better engage governments in a more effective response).

> *'[The NCD Alliance] is seeing the Political Declaration as a floor, not a ceiling, for what can be achieved. We need to go back to governments and use it as a hook or permission slip to have these conversations'* -Alison Cox

Dr. Hicham El Berri works as Senior Strategy and Policy Advisor and Officer-in-Charge, WHO Country Office, Libya. He put the Fourth UN High-Level Meeting on NCDs in context: it followed an initial call by the World Health Assembly in 2022 to strengthen NCD integration across the emergency cycle, a meeting in Cairo in 2022 that brought the regions together to discuss the issue, and in February 2024 there was a high-level technical meeting in Copenhagen to discuss it. The Eastern Mediterranean is the region of WHO (EMRO) with the greatest number of ongoing emergencies, and a regional framework has been developed and endorsed by all 22 EMRO countries, covering the domains of leadership/collaboration, financing, service delivery, community engagement and data. He also highlighted the need to strengthen monitoring and accountability. There is the knowledge to include NCDs in emergency response, and what is now needed is collaboration to deliver this.

> *'We now have political license – but how do we now implement this vision at national level in emergency preparedness and response plans?'* -Hicham El Berri

Dr. Mahmoud Tharwat, Global NCD Officer at the International Federation of the Red Cross (IFRC) in Geneva, explained how the unique auxiliary role status of the 191 national Red Cross societies enables them to work closely with Ministries of Health. The IFRC's framework on NCDs encourages greater focus on NCDs: currently, 93 of the national societies run NCD programs in local communities. Convening moments – such as the Symposium and a recent IFRC Bootcamp on NCDs in humanitarian settings – provide useful outputs, but it is policymakers who control the translation of these documents into reality, through funding and programming. The inclusion of lived experience is vital in encouraging government engagement. Dr. Tharwat stressed that there are different levels of accountability – not just from implementers to donors, but to communities themselves. Finally, alignment of stakeholders at country level is important, because emergency response can be much more effective where stakeholders are ready to work together: for example, the response to the 2023 Syrian earthquake benefited greatly from lessons having previously been learned on the importance of NCD integration.

> *'We need to move from convening to converting into realities'* -Mahmoud Tharwat

Dr. Nugent turned discussion to the global health architecture, which is being reshaped after the shocks of recent months. Alison Cox explained that the renegotiation of this architecture is an opportunity to redress an imbalance: today, only 2% of development assistance for health is for NCDs, despite clear evidence of their impact (most recently in the Global Burden of Disease report). Concerningly, the NCD community does not currently seem to be represented in these discussions. Immediate advocacy is needed to ensure that any new funding structures fully include NCDs. There was also a comment made that there can be tension when involving people with lived experience, who may be unclear where funding is coming from or may even be from a source with which they disagree.

Dr. Mohammed Seyam, IADA, reflected on the discussion from a lived-experience perspective. He noted that the Political Declaration's paragraph on meaningful engagement is a step forward, but that governments often do not know how to put this into practice and there are no metrics to measure it. People living with NCDs tend to be involved with civil society organizations rather than with governments, but there are ways to overcome this fragmentation and become involved with health systems – for example, Ministries of Health could hold progress reviews that include PLWD and NCDs.

> *'NCDs don't wait in a crisis. People living with diabetes can lose their lives without insulin, and governments know this – so why don't we see action?'* -Mohammed Seyam

The discussion picked up on many of the panelists' points, particularly knowledge translation and contextualization of data. Developing a shared language between different groups of stakeholders – from policymakers to local communities themselves – is important, as is ensuring that solutions are culturally appropriate. As Ms. James noted, 'we must provide the right information to the right people at the right time in the right way'. Theoretical buy-in by government is not enough: policymakers are not usually medical professionals, so they need to be provided with tools, structures and practical solutions that they can trust. In Armenia, for example, despite the government's desire to take action on diabetes, there is only a nascent understanding of how to address it or of the resources that are available. Finally, innovation can play a key role and documenting innovations could be a valuable pointer in bringing more initiatives to scale.

PLENARY 3:
Addressing diabetes in pregnancy during emergencies

Key points from the plenary:

- Diabetes in pregnancy is a **significantly under-researched issue**, despite its global prevalence and potentially serious health implications for both mother and child. Diabetes in all its forms is challenging to manage, as pregnancy involves continual changes in the body and requires ongoing adjustments to care.
- Understanding of diabetes in pregnancy, particularly in humanitarian settings, is **fragmented and incomplete**, and there is a lack of consensus around care, even in high-income settings. The first WHO guidance on diabetes in pregnancy was discussed and has published since the Symposium.
- **Powerful advocacy** was given by a woman living with diabetes in Lebanon, who told her own story of the personally devastating consequences of inadequate care and how she has now established her own NGO to ensure that others can better understand and navigate the risks of diabetes in pregnancy.
- Minimizing the risks requires a **lifecourse approach** (before, during and after pregnancy) and the integration of diabetes prevention, diagnosis and treatment with reproductive health in primary care settings. UNRWA aims to take this holistic approach, working to build the capacity of women themselves to ensure that decisions they make in crises are as informed as possible.

This is the first time that diabetes in pregnancy has been addressed at an IADA Symposium. It is an important area for investigation because, as **Dr. Philippa Boulle** (Médecins Sans Frontières (MSF) Switzerland, IADA) noted, diabetes leads to increased risks for maternal and neonatal health. It is associated with hypertension, pre-eclampsia and Caesarean section, and women who develop gestational diabetes (GDM) are 10 times more likely than those without GDM to develop type 2 diabetes in the following decade.

Dr. Chloe Zera (Chief, Division of Maternal-Fetal Medicine, Beth Israel Deaconess Medical Center) provided an overview of the challenges posed by diabetes in pregnancy. Even in high-income settings, care is often fragmented and incomplete, and there is even disagreement over the criteria to be used for diagnosing GDM. Prevalence of GDM is estimated to be around one in every five women worldwide (much higher than the prevalence of type 1 and type 2), and even 'mild' GDM can have a significant impact. There are significant treatment challenges, which differ according to the type of diabetes. For example, insulin resistance dramatically increases as the placenta grows, and people with type 1 diabetes may need up to three times their usual dose of insulin, and it is very hard to reach a steady state. Dr. Zera also highlighted the importance of care across the reproductive lifespan of women with diabetes, covering preconception, prenatal and postpartum care, and delivery planning.

> *'Care delivery for diabetes [in pregnancy] is incredibly complex… Even in highly resourced settings… it is fragmented and incomplete. There is opportunity there, but it is definitely a challenge'* -Chloe Zera

Cyrine Farhat is the founder of NGO Positive on Glucose and is herself living with type 1 diabetes. She generously and movingly shared her lived experience of pregnancy, which unflinchingly set out the consequences of a failure of poor prenatal care. She lives in Lebanon and in 2019 became pregnant. She sought out what she hoped was the best available care and made clear to her gynecologist and endocrinologist team that she had diabetes. Despite voicing her suspicion about pre-eclampsia to her doctor, her concerns were brushed aside, no testing was done, and she ultimately lost her baby at 35 weeks. During COVID-19 and the economic crisis in Lebanon, she set up Positive on Glucose to connect PLWD who were trapped in their homes, which made her much more aware of the benefits of advocacy. This experience gave her renewed confidence, when she became pregnant again, to change gynecologist, despite having to take two jobs to afford the care.

Her baby was born at 34 weeks – healthy, despite Cyrine's ketoacidosis and pre-eclampsia – because her doctor had listened and responded to her concerns. She emphasized that education of women prior to pregnancy is vital, even in societies where it is taboo to see a gynecologist before marriage. Young women and their communities need to know how to deal with the challenges that living with NCDs in pregnancy can pose, whether or not they are living in a humanitarian setting.

> *'I hope that this story gives you more insight into the patient as a person. We might not have been to medical school, we may not have the technical know-how, but we know when something's not right, and we shouldn't have to advocate this much to be heard'* -Cyrine Farhat

In the decades since the Millennium Development Goals, WHO, where **Dr. Doris Chou** is Medical Officer on the Maternal Perinatal Health Team, has been working on maternal mortality. However, it is only more recently that the NCD and maternal health sections of the organization have been brought together to investigate the intersection of pregnancy and NCDs. At national level, too, sexual and reproductive health and NCDs are rarely addressed together in humanitarian crises. Ideally, diabetes care and pregnancy care should be delivered together. Shortly after the Symposium, WHO published its first guidance on care during pregnancy for women with all forms of diabetes, drawing on research questions that looked at women's qualitative experience of care as well as at effectiveness. The guidance includes 27 recommendations, each with implementation advice. Dr. Chou highlighted the challenge posed by lack of evidence (particularly for guidelines on diabetes screening during pregnancy, which are due to publish in 2026) – but also that past experience has shown that, once guidance has published, evidence may then follow. Small studies can be aggregated, enabling meta-analysis. WHO wants to know not only what works, but what is acceptable to women.

> *'Maternal health [can be viewed] as a barometer for how a health system is doing: do well by mums and you will do well by your population'* -Doris Chou

Dr. Reham Jaffal (Chief of Health Protection and Promotion, UNRWA) focused on UNRWA's lifecourse approach to health. Family health teams integrate maternal and child health with NCDs, providing comprehensive care through multidisciplinary teams delivered at health centers. This aims to avoid parallel care and improve efficiency and health-system resilience, even during crises. Integration of NCDs within a full package of service, utilizing every point of care, improves prevention and early detection for both mother and child – preferably within existing health systems, as parallel systems are not sustainable. UNRWA encourages women to visit health centers at least five times during pregnancy and includes screening, diagnosis and risk assessment of diabetes. Building women's own capacity can ensure that any decisions that they have to make on their own in a crisis are as informed as possible. This can be aided by telemedicine, educational material and keeping communication channels open (such as online consultations with health professionals). Every patient registered with UNRWA has a medical file that enables real-time data analysis, which can also guide policymaking and strategy. If the e-health connection is lost, this is moved to collecting minimum data that helps to ensure that mothers continue to get early access to care. Finally, Dr. Jaffal reminded the Symposium of the importance of considering the wellbeing of UNRWA staff, who provide their services in extremely challenging situations.

> *'When the crisis starts, it becomes more and more important to keep integrating maternal services through the pre-existing systems, when the point of care for the mothers becomes a valuable opportunity to provide the full package of care'* -Reham Jaffal

Nelly Staderini, who is a midwife and Medical Leader of the Women and Children's Health Unit, MSF Switzerland, noted that it was the Syrian conflict that first catalyzed MSF's concerns around NCDs in crises, in response to requests for assistance from the field. For the first time, there was a real willingness to work on NCDs in pregnancy as well as on sexual and reproductive rights. Around half of the work of MSF on sexual and reproductive health is antenatal consultations, and a forthcoming obstetric guideline will include screening for diabetes. MSF's maternal and child health is provided primarily by midwives, and adding NCDs can add considerably to their portfolio. The main barriers to routine integration of NCDs within consultations are competing priorities, knowledge gaps in the workforce, and the lack of a simplified model of care.

Ms. Staderini gave an example of an ongoing, community-based pilot addressing hypertension and diabetes in pregnancy in Kiribati, which has, for the first time, established relevant indicators, such as prevalence of known diabetes, the number of women attending all antenatal visits and hospital referrals. The research has identified a need to strengthen community involvement to encourage attendance, with barriers to care including a shortage of midwives and inadequate record-keeping.

> *'The midwife has to deal with everything, and she is not a specialist [beyond sexual and reproductive health]… The workforce has little [diabetes] knowledge about what we are asking them to manage on a daily basis'* -Nelly Staderini

The discussion drew out more detail on priorities – including the need for diagnostic tools to be used in crises, for better nutritional support and advice (see also p. 19), and standardization of diagnosis of GDM. There is also a need for better understanding that diabetes in pregnancy can be managed in primary care settings rather than by specialists.

The final word of the plenary was given by Ms. Farhat, who welcomed the opportunity to be a full part of the discussion:

> *'Let's see how we can continue to share space at the table [with people with lived experience] and see how we can get policy to serve people in the sense that it makes their lives liveable'* -Cyrine Farhat

PRESENTATION ON WINNING RESEARCH ABSTRACT

Insulin supply in Gaza: lessons from three critical cold-chain incidents across the humanitarian supply chain (Shatha Albeik, UNRWA)

Every year, IADA puts out a call for abstracts on diabetes in humanitarian crises, a small number of which are selected by a robust, anonymized process to be presented as posters at the Symposium. Several of the finalist posters are from UNRWA, which uses its data for research even during crises, and Dr. Éímhín Ansbro applauded UNRWA's efforts.

The lead author of the winning abstract is invited to present the results to the Symposium – and, for the second year in a row, **Dr. Shatha Albeik**'s work was selected.

Cold-chain management can be threatened by border closures, transport delays, a lack of temperature monitoring (a lack of staff or of monitoring devices), damaged infrastructure and power cuts. Dr. Albeik's research sets out three incidents during the Gaza conflict in which the cold chain for insulin storage had been compromised. In one incident, border delays led to the engine of a cold truck being switched off, exposing insulin to higher temperatures; in another, repair of a cold room failed, dropping the insulin to below freezing for 90 minutes; and, in another, data from monitoring systems of a cold room were inconsistent, so it was unclear as to whether stock had, in fact, been compromised.

The priority during the ceasefire is to rebuild and repair infrastructure such as cold rooms. Securing cross-border clearance takes a couple of weeks and, even when approved, insulin takes up to 10 days to reach Rafah. Building resilience is essential, along with restoring supply.

PLENARY 4:

Nutrition and food security for people living with diabetes in emergencies

Key points from the plenary:

- **Lack of access** to an adequate supply of healthy, fresh food compounds the difficulties that people living with diabetes face in managing their disease, putting them at greater risk of complications, as an ongoing study in Somalia is showing.
- The **specific nutrition needs** of people living with diabetes must be more urgently prioritized in emergency planning frameworks and food programs, in both acute and protracted crises. This requires appropriate data to be gathered and used, before and during a crisis.
- Placing the **person at the center** of NCD care can enable people living with diabetes to make more informed, pragmatic decisions about how best to manage diabetes during periods of food insecurity.
- Taking a more **coordinated approach** to advocacy and action across the NCD and nutrition sectors would be mutually reinforcing, making the case for a healthier and more varied nutrition response to emergencies – which benefits all, not just to people living with diabetes.

This is the first time that nutrition and food security for PLWD in emergencies has been the focus of a Symposium plenary, and **Shelley Walton** (Senior Research Associate, Johns Hopkins Bloomberg School of Public Health) began by setting out the aims of the session: to map the challenges faced, highlight operational realities, research and lived experience, to identify gaps across food/nutrition and diabetes care, and to inform this agenda for IADA to take forward.

> *'Across multiple different guidance documents and policies, people living with diabetes are not noted as a vulnerable group to target [with nutrition assistance]. Nor are people living more broadly with NCDs acknowledged and included in a lot of the nutrition targeting in humanitarian assistance'* -Shelley Walton

Ms. Walton highlighted the intensifying nutrition crisis: 294 million people in 53 countries are living in acute food insecurity – and 80% of the world's refugees and displaced populations are experiencing some level of food insecurity. Parts of the world with the highest levels of food insecurity – Africa and the Middle East and North Africa (MENA) region – are also likely to see the greatest rise in diabetes by 2050. For people with type 1 diabetes, insufficient insulin with food or vice versa can both be problematic. For those with type 2 diabetes, routine and fresh foods are needed for good glycemic control, but rations are often high in sodium and carbohydrate. For women with GDM, nutrition needs change during pregnancy, and irregular access to quality food leads to poor glycemic control, with potential impacts on health of mother and child. For the baby, malnutrition at an early stage can increase the risk of type 2 diabetes later in life. Efforts to improve food security include food baskets (rations designed for an acute emergency, with minimal dietary diversity) and cash/voucher assistance (which can promote dietary diversity, but restrict choice to what is locally available).

Maysaa Hellani (Dietitian, MSF Lebanon) reiterated the importance of balanced nutrition for controlling diabetes – it is risky to miss meals, and in emergencies there may also be power cuts and limited access to insulin, which make this balance harder to strike. In the absence of the best nutrition, patients should be advised on choosing the best of what is available in practice – for example, eating regularly throughout the day, rather than one large meal.

She suggested some practical solutions, including peer support (such as a WhatsApp group for patients to share educational content and tips), working to address particularly risky behavior, building capacity of health professionals to provide guidance, and providing clear nutrition recommendations (such as portion-size diagrams). She recommended gradual introduction of carb-counting, in close consultation with health professionals, which can help PLWD to control their condition.

> *'Nutrition is not a luxury – it is an important part of treatment. And small adjustments and actions can make a big difference'* -Maysaa Hellani

Dr. Omar Haji (Deputy Health and Nutrition Coordinator, IRC Somalia) presented preliminary findings of an ongoing pilot to improve access to and consumption of healthy food by residents of Mogadishu living with diabetes and hypertension. The study aims to build understanding of how patients manage healthy food options and identify relevant system/policy challenges, with detail on implementation and outcomes expected in a year's time.

There have already been rich learnings from stakeholder workshops, key informant interviews, group discussions, food-environment assessments and data analysis. Many of the available foods are high in fat, sugar and salt, and tailored guidance is needed, focusing on traditional foods. Women need to be empowered to make food choices for their families (often it is men who lead decisions), and they often face safety issues and stigma linked to physical activity. Governance and leadership require better coordination, including integrated budget lines on NCDs and embedded NCD indicators within health information systems. Multisectoral collaboration improves the integration of nutrition and NCD policies, and can strengthen food systems (such as supporting women farmers). Patients noted that it is often hard to follow advice from health professionals because of limited locally accessible, affordable healthy foods. Social norms shape attitudes to food – for example, the culture of hospitality makes it difficult to refuse shared food.

The recommendations of the study include developing Somalia-specific NCD nutrition guidelines, expanding diabetes screening in the community, and enhancing training of health professionals on nutrition counseling. Next steps are to co-design a pilot with the community and the Ministry of Health and to advocate for NCD-sensitive actions in national policy. A dietary tool has also been developed and will be validated in the coming weeks.

> '*In general, while we found that people have high individual motivation, there are systemic economic, social and policy barriers, which make it challenging for people living with diabetes and hypertension*' -Omar Haji

Dr. Lamis Jomaa (Gillings School of Public Health, University of North Carolina) called strongly for the definition of 'vulnerable populations' in humanitarian settings to include people living with NCDs. This is not about implying weakness: instead, it gives a voice to this important group and helps to ensure that they are prioritized for assistance. Interventions should not look at nutrition in isolation – for example, a parent living with diabetes may prioritize feeding their family over their own medication, and food assistance tends to focus solely on undernutrition, rather than all forms of malnutrition. There is no robust academic framework on food insecurity and NCDs in LMICs, despite clear links between the two agendas, and guidance on managing type 1 diabetes in emergencies still tends not to mention nutrition. Dr. Jomaa called for more research on patient-centered approaches (such as integrating support for mental health and 'diabetes distress' – the exhaustion of managing the condition every day) and on the long- and short-term impacts of different forms of assistance. For example, 'cash-plus' approaches combine the provision of cash transfers with other initiatives, such as glucose monitoring.

> *'There are challenges of research in humanitarian settings… how do we balance practicality with rigor? We have to shift the research mindset to match our aspirations with practicality*[2] *'* -Lamis Jomaa

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[2] R. Asgary et al., 'A systematic review of effective strategies for chronic disease management in humanitarian settings; opportunities and challenges' (2022) Preventive Medicine 161: 107154 https://doi.org/10.1016/j.ypmed.2022.107154

Caroline Wilkinson (public health and emergency nutritionist) highlighted the need for policy frameworks to look beyond acute malnutrition and micronutrient deficiencies to include diabetes-related nutrition. Food assistance tends to be rapid and on a large scale, often aimed at children and pregnant women. A more patient-focused approach is needed: PLWD are rarely, if ever, considered in the design of food-assistance programs, and nutrition advice that patients receive must take account of the everyday realities that they face in accessing healthy, affordable food. She stressed the need for better data (including NCD indicators in emergency assessments), as this will give visibility to the lack of appropriate nutrition, which can then be brought into new policies. She also called for better coordination between sectors and for context-specific messaging.

> *'When [nutrition] counseling is offered, it falls short because it's just not practical for the people that are participating in nutrition education groups… and it's impossible to implement when you are told [what to do] but it is not available in the market'* -Caroline Wilkinson

Symposium participants were encouraged to document any pilot work that is being done on the intersection of nutrition and diabetes so that this can be included in any future iteration of WHO's policy brief on NCDs in all-hazards emergencies.[3]

Cuts in international development assistance – particularly USAID – are already having effects, making difficult decisions even harder. MSF recently created an advocacy document for UNHCR and the World Food Program that called for people living with type 1 diabetes to be classed as a vulnerable population for accessing food assistance – but MSF has received no response from the agencies.

Healthy food should be for all: the lack of healthy food is a driver of many NCDs, so spending more today on subsidizing healthy food or establishing taxes on unhealthy food will prove cost-effective over time. Finally, because of the synergies between nutrition and diabetes, coordination between these two agendas is likely to strengthen advocacy efforts. For example, the need for food security could be brought more closely into discussions about insulin security, as the two are inextricably linked.

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[3] The current iteration is available as WHO, Strengthening Noncommunicable Disease Integration in All-hazards Emergency Preparedness and Response: Policy Brief (2025) https://iris.who.int/handle/10665/38124

GROUP DISCUSSIONS

In-person participants at the Symposium took part in three group sessions over the course of the two days: a workshop on meaningful engagement of PLWD in the humanitarian response, a research prioritization session on shaping the research agenda for diabetes in humanitarian settings, and a breakout session to look back at IADA's achievements and forward to unmet needs. Together, these discussions will inform the IADA Strategy 2026–2030.

1. Workshop: Engaging people living with diabetes in the humanitarian response

This workshop, as **Dr. Kiran Jobanputra** (MSF, WHO, IADA) and **Emma Klatman** (Life for a Child, IADA) explained, explored how best to embed meaningful engagement within all that IADA does. The discussions were not intended to reach consensus or find specific solutions; instead, they explored potential avenues, building on the expertise of all in the room, and with feedback then provided in plenary.

> *'It is clearer than ever that not only is meaningful engagement an ethical requirement and core to health care, it also improves the relevance and quality of our work and helps find solutions'* -Kiran Jobanputra

Each of the four groups was co-facilitated by a 'dynamic duo' of practitioners, one of whom brought lived experience expertise: real progress towards an understanding of meaningful engagement is more likely to be made by combining the different expertise of PLWD and implementers. As Emma Klatman (who herself lives with diabetes) put it, 'Think about this symbiosis and why we need each other.'

Key points from the workshop:

- People living with diabetes in humanitarian settings are technical experts in their own lives. Ensuring that they are meaningfully engaged **before, during and after crises** will not only ensure co-ownership of programs but can also significantly improve health and wellbeing outcomes and the sustainability of initiatives.
- Engagement should never be tokenistic or included only in qualitative research. Instead, programs should be **co-created and co-owned**, from data-gathering to implementation to monitoring/evaluation and dissemination, and with regular feedback and opportunities for iteration.
- Even in the absence of formal community or civil society organizations, there are always communities within humanitarian settings who can be approached for their involvement and knowledge. A **wide range of experience** of all ages should be sought, going beyond the most vocal and already empowered advocates.
- This approach can bring challenges, including pushback against the power shift that true meaningful engagement entails. But these challenges are not insurmountable. There are **multiple modalities** that can be considered to ensure that people living with NCDs are appropriately involved. For example, health workers can be trained to better ask for and respond to the specific needs of individual patients.

Policy and financing

Consensus

This group agreed that the engagement of people with lived experience is essential and should begin from the first preparatory stages of any initiative and be maintained to completion. Meaningful engagement strengthens the relevance, quality and impact of policies and initiatives. Not only should those responding to requests for proposals include lived experience, but donors should be encouraged to include a requirement for meaningful engagement within their request for proposals. Too often, 'efficiency' takes precedence over a more people-centered approach, which is not only unethical but also overlooks the potential value-added of meaningful engagement.

Challenges

There are several barriers to meaningful engagement, including access and equity. For example, it is challenging to ensure a diversity of voices, with a tendency to choose advocates who may have good language skills and who will be cautious in what they say. People with lived experience are experts, and should be financially compensated appropriately. Different stakeholders may use different terminology or be interested in different data, so translating knowledge between these groups (and particularly to people with lived experience) is essential. Additionally, there are systematic and operational barriers. In some humanitarian settings, there may be no official government-sanctioned NGOs or local civil society organizations with which to work or through which to seek lived-experience expertise. However, there will always be communities, groups of patients, who are working together – sometimes using WhatsApp – that can be engaged in the processes. PLWD are ultimately human beings with inalienable human rights that must be respected.

Opportunities

Care must be taken to avoid tokenism: this is about full involvement. It is an important opportunity to move power toward the communities themselves, ensuring priorities reflect the needs and perspectives of those with lived experience rather than assumptions made by external actors or development partners.

Examples were provided that illustrated different approaches by policymakers. In Libya, a proposal to include people with lived experience in the launch of a strategic initiative was not taken forward by the Ministry of Health, highlighting an ongoing gap in recognizing the importance of bringing PLWD into policy conversations. In contrast, people living with NCDs have been included in government roundtables in Sudan, helping to formulate strategy and engaging in discussions on models of care. There are also tools to facilitate meaningful engagement, including from the WHO and NCD Alliance[4] - although these are not specific to humanitarian settings.

Additionally, examples of meaningful engagement in other sectors should be looked at for application in the diabetes space, for example other NCDs (such as cancer) and also other issues where meaningful engagement is utilized (such as women in the nutrition sector).

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[4] For example, WHO Framework for Meaningful Engagement of People Living with Noncommunicable Diseases, and Mental Health and Neurological Conditions (2023) https://www.who.int/publications/i/item/9789240073074 and NCD Alliance, Practical Guide to Strategic Advocacy Planning (2022) https://ncdalliance.org/resources/practical-guide-strategic-advocacy-planning

Service delivery

Consensus

The group agreed that a reframing is needed in the way PLWD can be understood as active partners in designing and delivering services because health systems, humanitarian actors, and researchers often do not see them this way. This is an area for improvement as there is always expertise within the affected communities. Examples include PLWD in Pakistan working to deliver insulin during floods, or the example of a mental health supervisor in Kenya, living with type 1 diabetes, who set up a peer-support group. Examples like these demonstrate that people living with NCDs are already at the front line: their involvement is essential in understanding what communities need and how best to deliver it. Programs should recognize, support and resource this leadership rather than treating it as an informal add-on

Challenges

However, ensuring that engagement is meaningful is not easy, particularly in emergencies where time, resources and security are constrained. It should intentionally include a wide diversity of lived experience, including children (and carers) and adolescents, who can be excellent change agents, and across gender and type of diabetes. However, lived experience experts can feel that their involvement is merely transactional if they perceive that their involvement is a 'should do' for the initiative, rather than an intrinsic, essential part of the process.

Opportunities

Engagement should be dignified and involve participants fully throughout, with active feedback loops (rather than one-off feedback) so that community views can continually refine the program and strengthen its impact on the community. For example, lived experience can inform the development of success indicators: biomarkers alone are not enough, as they do not reflect the impact of programs on people's lives.

It is also important to involve more than one person with lived experience in (for example) a meeting, as they may feel safer in sharing experiences when there are others with them in the room. Finally, it is people with lived experience who have the best understanding of who should be delivering messages about diabetes prevention and care – and this may be their peers, rather than medical experts, particularly in humanitarian emergencies.

Data and research

Consensus

The inclusion of meaningful engagement within research processes can create synergies that result in the achievement of significantly greater impact. Research frameworks that are sensitive to lived experience should be developed in advance of any emergency, to ensure that data can still be collected and utilized in a crisis in ways that are as sensitive as possible to the actual needs of PLWD.

Challenges

To achieve the above in practice, particularly within humanitarian settings, can be challenging. It requires: 1) a willingness to break out of silos, form partnerships and share decision-making between researchers, clinicians and PLWD; 2) ensuring that engagement is never a tick-box exercise or involve lived experience only as a qualitative addition; and 3) recognizing people with lived experience as experts whose time and expertise warrant full involvement and appropriate remuneration.

Opportunities

PLWD who provide their time and expertise should be fully engaged along the entire timeline of any study. Criteria within calls for proposals could include the requirement for meaningful involvement: this could be someone living with diabetes already within the research team, or patient organizations can be a useful conduit to relevant expertise. Resources and time should be allocated for meaningful engagement – for example, ELHRA explicitly includes budget for dissemination of studies not only to policymakers and donors but also to those with lived experience.

At the development phase, the research question and design (including outcomes and indicators) should be relevant and meaningful to the target community, and should be co-created. Implementation, monitoring and evaluation should also involve communities and people with lived experience.

Research outputs must be shared with policymakers, health workers, affected communities and people with lived experience, particularly those who contributed to the research study, creating feedback loops that can finesse the initiative and improve outcomes.

Although not used much to date in humanitarian settings, human-centered design is a powerful tool to use in study design, using iterative processes to reach the approach that is most acceptable and valuable to PLWD themselves. It is essential always to circle back to those who have lent their expertise, as this not only demonstrates the results but makes clear that their input has been acted upon.

Access to medicines and diagnostics

Consensus

Community organizations best know their needs in the humanitarian response. However, limited mechanisms to share these with operational humanitarian actors and less exposure to technical aspects of humanitarian response makes it more challenging to incorporate lived experience. To date, there has been limited effort to include the lived experience voices directly in access activities to medicines and diagnostics in the humanitarian response, and the group discussed two categories of successful examples of involvement outside a humanitarian setting.

Challenges

Not many challenges were discussed as the discussion leaned towards case studies. However, it was raised that meaningful engagement can and should be part of increasing access to medicines and diagnostics.

There are important nuances to consider here. Health professionals and clinicians who work to increase access to care, via research or advocacy campaigns, can at times assume a hierarchical dynamic in which it is expected that patients listen to these stakeholders, rather than taking a more collaborative approach. Capacity-building is needed to ensure that health professional understand how to ask patients for their own views and solutions.

Opportunities

It is by talking to PLWD that it becomes clear who can most effectively deliver messages about increasing access to essential diabetes care.

First, organizations who are working on access projects should actively seek involvement from ‘technical lived experience experts’, both in the donor application (including inclusion of quotes from those who will be impacted by the initiative) and in the design of the program itself, resulting in a more powerful application and stronger program design. To support meaningful participation, the language and materials shared must be accessible to those contributing their lived experience. Although not in a humanitarian setting, the ACCEDE project initiative (a study on continuous glucose monitoring in South Africa and Kenya) has woven meaningful engagement throughout all aspects of the clinical trial and results dissemination, which has resulted in better protocols and greater trust among those benefiting from it.

Second, there is scope to empower those with lived experience themselves to drive access initiatives. Examples of this are the recent strong (and ultimately successful) advocacy by PLWD for rapid-acting insulin to be included on the WHO Essential Medicines List, and also a situation in which patients were more successful than the local suppliers in sourcing supplies during a shortage, through their use of WhatsApp. People with lived experience develop their own innovative approaches, based on need, which can be expanded and leveraged to create greater impact. There are many lessons to be learnt from what has already been achieved, and advocacy can amplify solutions.

2. Research prioritization exercise:
Shaping the research agenda for diabetes in humanitarian settings

Dr. Éimhín Ansbro (LSHTM CGCC, IADA) introduced the research prioritization exercise, which drew on pre-existing work by ELHRA, identifying and prioritizing research questions on cardiometabolic health in emergency settings. Prior to the Symposium, IADA gathered key research themes, subthemes and specific research questions, drawing on the ELHRA work, published literature and stakeholder discussions. These were discussed in five thematic breakout groups: data and research innovation, health systems, care delivery models, active communities and empowered people.

Each group was asked to consider, based on participants' own experience and expertise: a) which existing research subtheme(s) are most important and will have impact in this thematic area? b) are there any other research subthemes/questions to add? c) what are the group's top three priority subthemes?

Given the limited time and the breadth of the discussions, not all groups achieved the level of wordsmithing required to vote on priority research questions. However, IADA took the suggestions from the discussions and refined the research priority questions, which were then circulated to participants for prioritization after the close of the Symposium.

Key points from the prioritization exercise:

- Humanitarian settings are undoubtedly challenging settings for research – but although there is a need for pragmatism, there is also scope for ambition, including the use of methodological and analytic **innovation** (e.g. the use of artificial intelligence in analysis).
- Research is needed across the **full spectrum** from emergency preparedness to response and recovery. Mapping existing data sources/systems and supply chains and understanding the patient journey within health systems provide the basis for appropriate responses in an emergency, centering the real needs of people living with diabetes.
- **Lived experience** of individual patients, communities and health workers all bring essential value to research, including indicator development, design of research, and feedback and evaluation. This requires building trust and strong channels of communication between communities, responders, local authorities and researchers.
- Finally, people living in humanitarian settings are interested in the impact of research on their lives. **Feedback loops** are essential and multiple approaches must be used to disseminate and foster collective learning, including communities of practice and use of case studies.

Data and research innovation

Four subthemes were suggested to the data and research group as a starting point for their discussion: indicators and data collection; care interruption and quality of care; methodological innovation; and epidemiology and burden. The group found this a challenging area to discuss, because the topic is so cross-cutting – but felt that priority probably lies with the first two subthemes.

Rapid data collection that is as robust as possible is needed for rapid response planning that allocates resources most effectively, as well as for improving evaluation of models of care. Concerningly, while there tend to be relatively large numbers of input indicators, there are far fewer output indicators, and almost no impact indicators at all.

A good starting point is to map the existing data sources, data systems and indicators, and the agencies that gather and use them, from individual health facilities upwards (each organization tends to measure in its own way). It is undoubtedly challenging to conduct research in crisis settings, and data-gathering methodologies will differ across settings – and this is not helped by the lack of a clear framework for the indicators to be used in acute versus protracted settings. Approaches need to be both feasible and readily adapted, with rapid assessment tools used to gather data that is as accurate as possible. Training of local community advocates can also be undertaken to ensure that data at local level can still be collected in a crisis, even when there is limited digital connectivity.

Methodological innovation is critical. Innovative channels can be used for data collection (such as the use of digital wearables), and artificial intelligence (AI) could also be put to use for innovative implementation of interventions. Analytical innovation is also needed, including adapting learning from other fields that are more accustomed to working with limited or missing data. This may include analysis using AI methodologies, and AI could also be used in analyzing the long-term projected impacts of climate change, which will lead to an increase of NCDs.

Health systems

The seven subthemes suggested to the health systems group for discussion were: policy and governance; financing; health workforce; continuity of care; multisectoral policies; preparedness, response and resilience; and nutrition. The seven subthemes were merged into just four, one of which was an overarching theme of the need for health systems to focus across the spectrum of preparedness, response and resilience. Policy and governance was merged with financing and multisectoral policies. Continuity of care was brought together with the health workforce and infrastructure/supplies. Nutrition was felt to be a final subtheme in its own right, as it is an important and often-neglected issue. Digital solutions have the potential to be considered across the subthemes – for example, training of health workers – rather than being a standalone research question.

Within the policy subtheme, the discussion recommended specifying that policy includes protracted crises, and that there is an urgent need to look at new opportunities for funding during the current challenging financing landscape, including from sources of domestic funding. Refugees and internally displaced people should be explicitly included in domestic financing mechanisms for NCDs. Discussion focused particularly on secondary prevention (including both diagnosis and treatment), including researching the cost-effectiveness of essential packages of NCD care.

The continuity of care subtheme included discussion on how best to build capacity and retain health workers in a crisis, how to ensure resilient supply chains through an emergency, and consideration of the best essential packages of care.

There is a need to identify gaps in knowledge about diet and related outcomes for those at high risk, such as people living with type 1 diabetes or chronic renal disease in humanitarian settings, and to work to better contextualize dietary advice.

Care delivery models

The four subthemes suggested to the care delivery group were: medicines and technology leapfrogging; care models; prevention; and integration. There was good debate in the group, for example around to what extent to focus on effectiveness in a clinical sense as well as on cost-effectiveness.

Most of the discussion focused on treatment and monitoring, and also education and self-management, which is an essential part of care models. Research is needed on how best to integrate education at all points of care delivery, throughout the patient journey, to better understand what is acceptable to patients and what works within the health system. This should cover not only nutrition and behavior, but also improve patients' understanding of medication and self-testing.

Other issues discussed included the newer treatments and self-monitoring devices that are most effective in humanitarian settings – for example, does this mean ultra-long-acting insulin or insulin pens? There was also a call to phrase questions on the use of diagnostic tools not simply as being on 'diagnosis' but on 'diagnosis and monitoring'.

Active communities

The four themes suggested to the active communities group as the basis for discussion were: knowledge, attitudes and practices; people living with NCDs and community-driven care; people living with NCDs and community-driven data and research; and active community and peer networks.

The discussion began with clarification of the difference between 'empowered people' and 'active communities': the former is primarily about the self-care of PLWD and their families, whereas the latter is about broader engagement and community service delivery. Myriad connections with the topics of the other three breakout groups were identified, and it also quickly became clear that there are important issues that cross-cut the four themes (for example, civil society organizations sit between 'community-driven data and research' and 'active community and peer networks'). Engagement with communities is essential across the spectrum from emergency preparedness, through to response and recovery. These multiple overlapping strands are indicative of the need for a broad, systems-thinking approach.

The group delved into shared experiences and areas that were felt not to be sufficiently highlighted in the existing subthemes. These include the importance of knowledge transfer and developing an appropriate lay language around NCDs, to improve health literacy and build strong community understanding without being stigmatizing of people living with NCDs. Trust is particularly important in challenging misinformation, and strong communication channels are needed between communities, first responders and local authorities. Trauma-informed care is also important, addressing the psychological impacts of the emergency alongside management of diabetes and other NCDs.

There was a strong emphasis on developing effective modalities for meaningful engagement and co-production with communities in ways that avoid tokenism. Too often, however, this work is not widely shared as it struggles to find a publisher: the journals should be challenged on this. One positive example is that the Norwegian Research Council is grading proposals based partly on patient engagement.

Community health workers (CHWs) are at the heart of communities and research would be welcome as to the appropriate and acceptable level of taskshifting from clinicians to CHWs – although the term 'taskshifting' was not felt to be helpful: this is about changing power relations.

Empowered people - reframed as 'Meaningful engagement"

The themes suggested to the empowered people group were: self-empowerment and digital support; exercise and nutrition; meaningful engagement in research; and patient costs. However, the discussion began with the immediate objection that the subthemes had been developed without the full engagement of people with lived experience, which undermines the purpose of the subtheme itself, as the start point should always be learning from lived experience. The word 'empowered' was criticized as being paternalistic, with the implication that if individuals have not become 'empowered' then they have somehow failed. 'Empowering people' was suggested as a more acceptable term, but 'meaningful engagement' would be even better: it is not possible to empower without first listening, and 'meaningful engagement' suggests a continual, collaborative process.

Meaningful engagement should be a thread throughout all five of the discussions in the research prioritization exercise: it should be the umbrella under which all research priorities are developed, embedded within design, implementation and monitoring/evaluation. This requires careful alignment of the language used by researchers and those on the ground, ensuring that messaging is relatable and clear on the objectives and aims of involvement.

There are already many communities that have appeared organically, whether during the COVID-19 pandemic or in specific humanitarian settings, such as recently in Gaza. Groups led by PLWD can be effective, and funding and strengthening these groups can ensure sustainability of the benefits of engagement over time. Identifying and listening to these communities will help to understand the challenges that are faced by people living with NCDs, with the research agenda then being set in response.

For example, UNRWA is very connected to local communities, and this closeness to people living with NCDs has enabled UNRWA to react more effectively. In Gaza, PLWD had been decreasing their insulin intake in response to a lack of food, so UNRWA worked with local communities to co-design specific education materials and meal plans to help individuals make decisions on how best to cope.

Finally, the point was powerfully and repeatedly made that PLWD care about the impact of research on their own lives, and certainly do not think in terms of research priorities. Research is not research for its own sake: ultimately, it is to make life easier and better for PLWD. This understanding needs to be at the heart of the conversation.

3. Breakout session:
Looking back — achievements and unmet needs

The aim of the final breakout session was to discuss how IADA can best address diabetes in humanitarian settings in the future. The IADA Secretariat is not an operating partner on the ground and cannot deliver this agenda alone; instead, its role is to act as convener for members, catalyzing and amplifying work that others can collectively undertake. IADA has set its strategic direction twice before – first in the Boston Declaration that grew out of the inaugural Symposium in 2019, and again in 2022 in Krakow – and this third iteration of the Strategy will look ahead to 2030 and beyond.

Discussion was centred on the four pillars of IADA's work – service delivery, access to medicines and diagnostics, data and research, and financing and policy – and aimed to draw out any new priorities, the actions and enablers that will help achieve these priorities, and the partners who will need to be involved. The feedback from the session will be reviewed, revised and fed into a draft 2026–2030 Strategy, which will then be shared with all IADA members for comment, to ensure shared ownership over the direction for the next five years.

Key points from the breakout:

- **Mapping** across a wide range of issues is needed: actors that are (or could) be involved in NCDs in humanitarian settings, including from other parts of the health sector; data sources and relevant indicators; supply chains for medicines and diagnostics; and the funding flows that currently exist across the humanitarian-development-peace nexus.
- An important aspect of **preparedness** is building the capacity of health workers, particularly in primary care, including through education on the ground or at university level, and through mentoring or other forms of network. The wellbeing of the health workforce themselves is also an important consideration, especially in crisis settings.
- IADA does not itself deliver programs, but can instead act as an **enabler and coordinator**, providing channels for coordination, and mapping the strengths and clarifying the roles of members.
- Improving **communication** between current and future IADA members and funders would ensure greater shared ownership of programs and catalyze new ideas, with engagement throughout of people with lived experience.

Service delivery

The service delivery group broadly agreed with the three overarching themes suggested for discussion, beginning with readiness to respond to emergencies. First, there is a clear need to continue mapping of services and insulin supply in emergencies. Ideas can usefully be borrowed from the response of other parts of the health sector – such as mental health and cancer support – and their networks drawn upon. Defining a minimum service package for diabetes would be useful, but with a clear caveat that these should be in place only in acute crises; their use should not be extended inappropriately in protracted emergencies. Standardized core indicators could also be developed in conjunction with IADA's data workstream.

The second theme discussed was education and support for frontline workers – for example, bringing agencies together to provide more structured education and a community of practice. Humanitarian response could be better integrated into university curricula for a wide range of health professionals – for example, included in modules on public or community health. Networks of providers could also be established to provide support, advice and mentoring, such as using moderated WhatsApp groups to connect experienced clinicians globally to frontline responders.

Finally, community education, support and engagement were discussed, including digital education and a suggestion of diabetes ‘camps’ in the recovery or protracted phase of a crisis to help to support people living with NCDs (including children), which could unlock new sources of funding. Training for peer leaders could also be extended to include preparation for emergencies.

Access to medicine and diagnostics

The access to medicine and diagnostics group focused particularly on expanding and ensuring access to medication and diagnostics and monitoring tools as a package (test strips and glucose meters as well as insulin pens), at a consistent, affordable price. There was considerable discussion on pooled procurement, which aligns with ongoing work by WHO. Where there is a system of pooling, supply can be ordered and managed in bulk, leading to greater efficiencies (price and supply management). It would be useful to undertake a market access exercise to look at pooling and volume guarantees, and to speak to individuals and organizations who are already working on procurement to better understand how available mechanisms can be applied in humanitarian settings. The Health Clusters, for example, have logistics groups that discuss prices and suppliers.

Newer medications were briefly discussed, particularly GLP-1s, which could help to reduce the diabetes burden. However, these are not routinely available and have not yet been piloted in humanitarian settings, as priority is given to access to lower-cost insulins and self-monitoring. Point-of-care technologies and diagnostics were also highlighted, such as testing not only HbA1c but also blood pressure, lipids, retinopathy and kidney function.

Data and research

The data and research group first considered how to strengthen the research ecosystem for diabetes in emergencies, including extending IADA membership (explicitly including people with lived experience) and engaging with non-member organizations (such as UN agencies) on their research priorities. After the Krakow Symposium, IADA had 160 members: they should be re-engaged and their strengths mapped (clinical, advocacy, policy etc.), to avoid duplication of efforts and to facilitate partnerships. IADA members could help to train or share training materials with other IADA members in specific areas of research. There is also a need for the dissemination of open-access global research goods (including code, regression analyses, research protocols and tools, and outputs) and potentially building a new community of practice.

Regular communication could be enabled through, for example, a quarterly Zoom meeting to share what each is working on, which would improve coordination and potentially unlock more resources within member organizations. IADA could also actively reach out to funders to influence their agendas and potentially act as a broker between funders and IADA members. It is important to have a small set of streamlined, impactful, appealing pieces of work that can be presented to funders.

In the discussion on predictive tools for a smarter response, interest is growing in mapping existing modeling tools (and potentially developing new tools) to estimate the impact of disruption on diabetes/NCD care. New partners that work in big data and AI analytics could usefully be brought in, such as WHO and the International Organization on Migration, or even Google and others in the private sector who have deep expertise in real-time data (including the movement of people, thanks to smartphone location services) and may have philanthropic arms.

Improving the integration of diabetes into humanitarian monitoring tools was discussed – including advocating for the inclusion of diabetes in multi-sectoral and inter-agency tools and, more specifically, completing the work on a proposed list of NCD indicators that has been developed by the informal Interagency Working Group on NCDs in emergencies, supported by IADA. IADA could potentially support the development of a dashboard to collate and present indicators on NCDs in humanitarian settings drawn from multiple agencies, building on UNHCR's work with District Health Information Software 2 (DHIS2) for this purpose. This tool could be used by emergency actors, possibly in collaboration with Ministries of Health, to monitor the burden of the problem, the scale of the response and the impact or quality of the response.

Another of this workstream's roles is to inform members and stakeholders on the knowledge base on NCDs in emergencies. This is distinct from the research ecosystem, as this reflects an intention of IADA members to collate and share learnings and to identify knowledge gaps and learning needs. This could include using methods other than formal research to share learning such as case studies, webinars, and "how to" papers, for example around how to influence policy.

Financing and policy

The financing and policy group finessed the three IADA priorities that it had been asked to discuss, and added a fourth. First, the group looked at how best to strengthen integration of diabetes and NCDs in emergency preparedness planning, including supporting IADA members and working across sectors. IADA should look beyond its current membership and across as many platforms as possible, involving, for example, the food and agriculture and maternal health sectors.

Secondly, coordination and transparency of financing is essential, including working across the wider humanitarian-development-peace nexus. Mapping the flows of financing in emergencies would enable a better understanding of who is funding what and where (and the impact of recent funding cuts), and what platforms could be created to better embed diabetes within funding streams. Investment cases can help to build donors' understanding that acting on diabetes and NCDs is a worthwhile investment in humanitarian crises. In addition, clear guidelines and policies on the source of funds are needed to mitigate against conflicts of interest. IADA has such guidelines which are under regular review. IADA could work as an enabler, helping to bridge the gap between the NCD and emergency response communities, funders and local communities themselves, and working in preparedness as well as response.

Strengthening integration within emergency response financing and policy frameworks and structures is also essential – for example, integrating diabetes prevention and management, and integrating NCDs with other health issues such as maternal and child health and nutrition. This again includes mapping of partners, models and training (nationally, regionally or locally) that IADA could then support.

Finally, the new priority area identified by the group was to ensure that NCDs in humanitarian settings are part of the conversations that will be taking place over the coming years to negotiate the successors to the SDGs, the horizon for which – 2030 – is coming up fast.

CLOSING REFLECTIONS

Closing reflections were given by **Dr. Alarcos Cieza**, head of the Management of NCDs Unit within WHO, who noted the three words that have resonated most closely with her from the Symposium: connection, priorities and learning.

First, **connection.** IADA's primary focus is diabetes, but there are myriad connections to other NCDs as well as to other disease areas including pregnancy, diabetes and mental health. WHO is increasingly bringing a health-systems perspective to NCDs, focusing not only on services but on the wider drivers that strengthen the health system and enable preparedness and resilience. This includes health financing, governance and health products, but also goes beyond the health system to include food, nutrition and the private sector. WHO is actively working on forging these connections – including having a focal point on emergencies within the NCD Department and an equivalent role on NCDs in the Emergencies Program. There are connections being made across WHO, starting with focal points in the African, European and South-East Asian Regions, and there are professional officers working on this agenda in many countries across these regions and in the Eastern Mediterranean.

Priority-setting is a work in progress: the environment is fast-changing and WHO itself is emerging from a painful prioritization process. But it is important to identify the most pressing priorities, whether on services, access or research, and work out how the different organizations can meaningfully contribute. She is keen to focus on priorities for research, including finalization of indicators to be used to assess NCDs in humanitarian settings. When organizations such as IADA conduct research and make evidence-based recommendations, this enables WHO to take the recommendations forward in a coordinated way.

Finally, **meaningful learning** – particularly from lived experience – is vital. This goes beyond meaningful engagement to understand with whom we connect, why, and how, and to ensure that people with lived experience are included in establishing priorities.

> *'Let's connect on looking forward to IADA's priorities and really learning from people with lived experience'*
> -Alarcos Cieza

She ended by thanking IADA for continuing to reach out to engage with WHO. She acknowledged the role of the Novo Nordisk Foundation and the Helmsley Charitable Trust in helping to move the diabetes agenda forward.

In closing, Dr. Sylvia Kehlenbrink thanked Dr. Cieza for her remarks – it is important that IADA continue to align with WHO's work. She then concluded by thanking all who have participated, particularly Philippa Boulle, who is moving on from IADA as she takes on a new role as Deputy Medical Director at MSF Switzerland.

ANNEX: POSTER ABSTRACTS

In 2025, IADA's winning research abstract was 'Insulin supply in Gaza: lessons from three critical cold-chain incidents across the humanitarian supply chain', by Shatha Albeik, Wesam Mummar, Zoheir Elkhatib, Rawan Saadeh and Akihiro Seita. (See p. 18 above for Shatha Albeik's presentation on the research.)

The runner-up abstract was 'Experiences of adolescents with type 1 diabetes in Palestine: exploring challenges to diabetes care' by Farah Sadder and Maysaa Nemer.

This, along with the other 11 abstracts selected to be presented as posters in the foyer throughout the Symposium, were as follows.

All can be found on the IADA website - www.iadadiabetes.org/symposium/2025-posters.

1. **Experiences of adolescents with type 1 diabetes in Palestine: exploring challenges to diabetes care**
   RUNNER-UP - Sadder F, Nemer M.

2. **A study of pharmaceutical supply dynamics for people with type 1 diabetes in Ukraine during martial law**
   Vlasenko I.

3. **Access restricted, rationing prevalent: Conclusions from T1International's Out-of-Pocket Expense Survey of people living with type 1 diabetes globally 2024**
   Toavs C, Kasper S, Mitchell C, Tahir M, Kamau Y, Pereira e Silva Gaspar SH, Gomez P, Braune K, Pfiester E.

4. **Cardiometabolic disease care and prevention innovations in humanitarian settings**
   Patel S.

5. **Evaluating integrated NCD-MH primary care services for type II diabetes: a retrospective quantitative study in conflict-affected settings in Iraq and Nigeria**
   Fuhs A, Melaku Y, Melis S.

6. **Evaluation of the National Diabetes Prevention Program in Palestine: implementation, achievements, outcomes and lessons Learned**
   Allabadi H, Aghabekian V, Eita RA, Shahin Y, Shakhra K, El Din LN, Khammash U.

7. **Health system barriers and facilitators to support integrated diabetes care in North and South Kivu provinces, Democratic Republic of Congo: a rapid appraisal study**
   Nyalundja AD, Muhanzi GA, Lukula MA, Bahizire E, Munane SB, Bapolisi A, Cikomola FG, Shindano TA, Lubambo G, Perel P, Roberts B, Cikomola JC.

8. **Insulin regimen patterns in UNRWA fields: gaps and opportunities in type 1 diabetes care**
   Elkhatib Z, Ballout G, Alfudoli H, Seita A.

9. **Interinstitutional training on diabetes and diabetic foot management in LMIC and humanitarian settings**
   Perone SA, Castellsague-Perolini M, Bourgeois A, Chappuis F, Savoy C, Jornayvaz F, Gariani K, Pataky Z, Vuagnat H, Benyaich A, Perrier A, Ha Van G, Kleinebreil L, Nair HKR, Abbas ZG, Cruzado Castro L.

10. **No diabetic patients left behind: UNRWA's emergency response to ensure diabetic care in north of West Bank of Palestine amid the escalations**
    Ramadan M, El-Khatib Z, al-Baik S, Akihiro S.

11. **Outcomes and lessons from the Integrated NCD–Humanitarian Response in Jordan (2020–2025)**
    Ireifij A, Saket S, Nsour A, Royal Health Awareness Society.

12. **Living with diabetes in a conflict one: mothers' voices from Gaza**
    Abdo S, Jaffal R, ELour I, Najjar S, Musadder H, Albeik S, Seita A.

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iada

75 State Street
Suite 100
Boston, MA 02109
USA

Contact: Program Manager, Anna Nakayama
anna.nakayama@iadadiabetes.org

Find us on **LinkedIn**

www.iadadiabetes.org