

**4th Annual NIH Conference on the
Science of Dissemination and Implementation: Policy and Practice
March 21-22, 2011**

3G. EFFECTIVE GLOBAL DISSEMINATION IN CHRONIC DISEASE MANAGEMENT AND PUBLIC HEALTH – WHAT WORKS?

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Brief topic overview

The planned transfer of evidence-based public health programs between cultures and countries is generally done poorly. However, given the great health challenges confronting the majority of the world's population who live in low and middle income countries, this is an important and urgent challenge. Many different issues need addressing when programs are introduced into cultures very different to those from which they originated. Two of the key challenges are: (1) How to develop and implement programs/interventions that are more feasible and adaptable for transfer and 'scaling up' and (2) How to extend the reach of such programs to low and middle income countries as the current trial evidence based in such countries is currently very limited for most issues related to the prevention and management of chronic conditions? There is an urgent need for more collaborative and coordinated approaches that compare and contrast methods and approaches for adapting and spreading effective intervention programs between cultures and countries around the world. However, there are now some good examples of programs being appropriately adapted and transferred between settings, cultures and countries. HIV/AIDS, tobacco control, prevention/self-management of diabetes and peer support programs are all areas where there are some good recent examples. Each of the discussants in this session will consider the following questions in relation to their recent experiences in relation to dissemination and implementation of programs in different countries and settings.

Key questions

- 1) How can evidence-based public health programs be best tailored to different communities, settings, cultures and countries?
- 2) How should dissemination initiatives distinguish those components of programs that are standardized and important to effectiveness, versus those that may be tailored to local settings, needs, and opportunities?
- 3) How can researchers evaluate the adequacy of contextualization and the success with which active intervention ingredients were preserved?
- 4) What does treatment fidelity mean when interventions are to be implemented in diverse cultural contexts?

BOOTHROYD – Diabetes, Peer Support and Global Programs

Framed by Peers for Progress (www.peersforprogress.org), Dr. Boothroyd (i) discussed a coherent, yet flexible approach for intervention design, implementation, and evaluation of peer support programs around the world; (ii) introduced a decentralized "network/ing" approach for learning and dissemination among researchers (empirical evidence) and practitioners (experiential evidence) worldwide; and (iii) suggested thoughts and issues for global dissemination (e.g., different forms of evidence, influence of organizational infrastructure and supports).

THANKAPPAN – Implementation of evidence-based tobacco control in India

Framed by two projects, Dr. Thankappan discussed local processes of implementation and keys to their success, including status of the institution and its influence on buy-in, involvement of media, key leadership (e.g., secretary of health; men may smoke, but women are sources of support); and coalition building with stakeholders (e.g., schools,

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health centers, industry).

BEST - Systems thinking for tobacco control

Dr. Best presented an overview of systems thinking for dissemination and implementation, where the process is really greater than the sum of individual parts. Overall, it is important to embed products within relationships with people, organizations, and systems as those are the context for uptake. While doing so, it is also important to adopt a “realist review” of situations (e.g., organizational partnerships are often not structured to provide integrative, cross-agency, cross-topic kinds of services; “let it happen” versus “make it happen” approach to dissemination).

SETSWE – Transfer of HIV prevention programs to Sub-Saharan Africa

Dr. Setwe discussed factors associated with gaps in practice/uptake of research using a number of examples from HIV prevention in Africa (e.g., prevention of mother-to-child transmission, antiretroviral therapy, male circumcision). Factors included extent of research evidence, policy (both existence and actions to promote/apply/enhance them), multi-organizational support, workforce shortages, and technical support. Examples illustrated the interplay among many of these factors (e.g., despite policy and technical support, little uptake due to viewpoints of implementers; resistance when evidence based on theories less application to local context are imposed). Discussion focused on the importance of formative research to incorporate cultural context for enhancing relevance, reception, and uptake.

OLDENBURG – Uptake and implementation of diabetes prevention programs in different countries

Dr. Oldenburg discussed the spread of diabetes prevention programs across countries (e.g., Finland, Australia, Malaysia), taking the GOAL program and implementing it for real-world implementation in other developed and developing countries. In terms of taking things to-scale, important factors included setting, target population, program elements (and their fit with local context), funding, and partnerships with people and organizations.

Overall discussion and audience participation

Across speakers and discussants, the overall theme of global dissemination was one of integration – across content areas, populations, organizational silos, and features of settings, culture, and other contexts. In particular, questions and discussion addressed:

- Oldenburg’s diagram (see slides) and important features for adoption and uptake such as leadership (people in organizations who are keen on making something happen).
- How both theory AND understanding of local population and context are critical for influencing program development, especially cross-culturally. First, what kind of conceptual framework informed by research should/does inform program development (for coherence)? Second, do the same ideas demonstrated in one case apply to another place (relevance), and how would you know?
- Latency challenges in trying to utilize evidence from peer-reviewed studies in real-world environments when those studies were completed so long ago.
- Social marketing and communications are a critical, but often overlooked aspect of dissemination. Think about informational outlets (e.g., magazines) such as Consumer Reports and how they define, present, and market “evidence.”
- The relative importance – and tension – often associated with content and issues of fidelity. How important is content? Perhaps emphases should instead be on goals and problem-solving to allow the emergence of relevant content – “let it happen.”
- Process of identifying “minimum” intervention components – how do you know what it takes?
- Process of identifying the “critical mass” to keep some social network and change movement going? And this kind of critical mass could take more of a naturally organized set of leaders versus structured, traditionally-viewed leaders of agencies.
- The importance of monitoring and feedback for finding “what sticks” in terms of innovations and evidence-informed practices. Real-time tracking systems are critical.
- Think about scalability at the beginning of an intervention. It is important to design interventions to be BOTH effective and scalable.