Role of Implementation science in shaping Policy and practices: Learnings from multiple countries

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Enhance Chronic Disease Care

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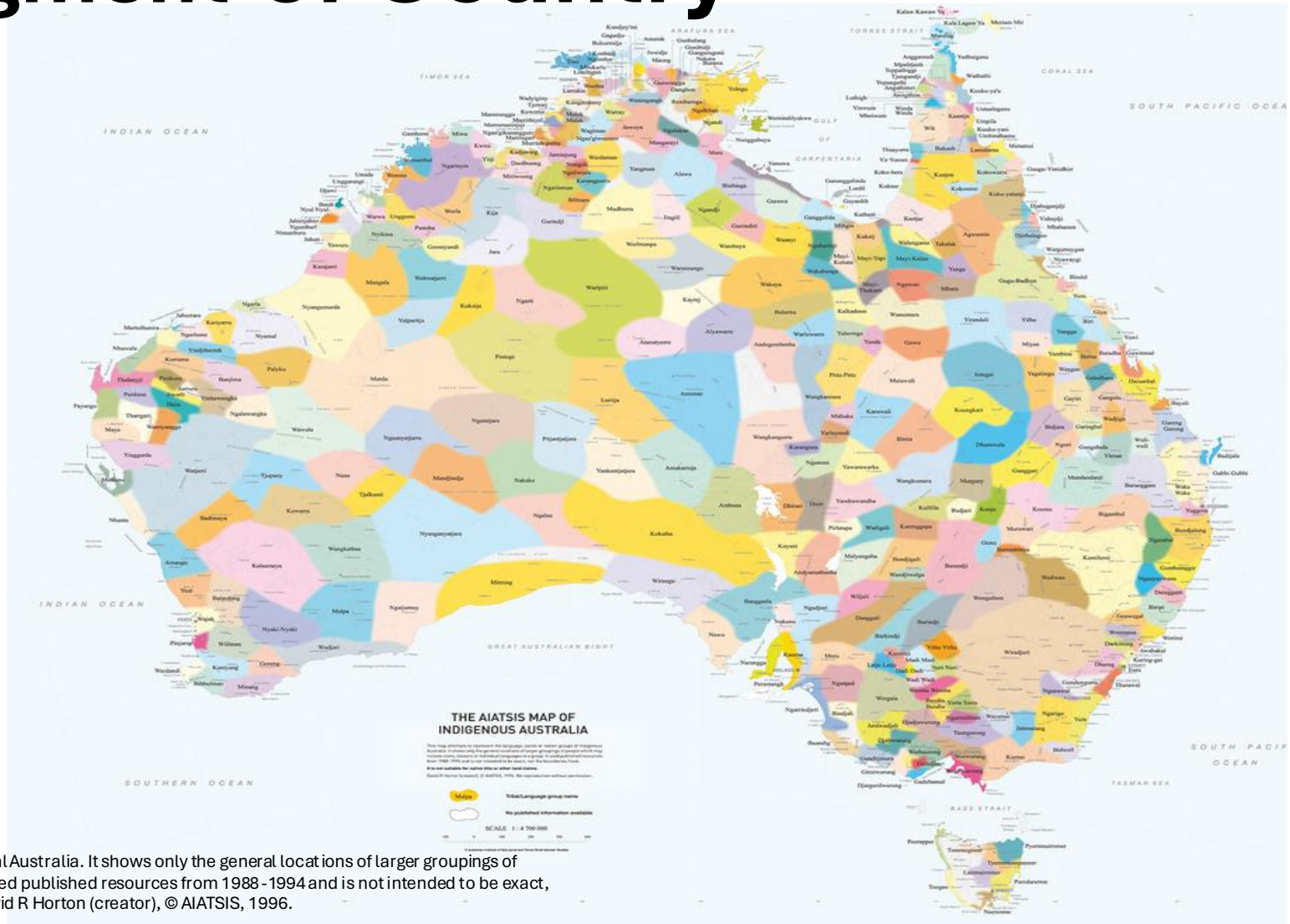
Acknowledgment of Country



This map attempts to represent the language, social or nation groups of Aboriginal Australia. It shows only the general locations of larger groupings of people which may include clans, dialects or individual languages in a group. It used published resources from 1988 - 1994 and is not intended to be exact, nor the boundaries fixed. It is not suitable for native title or other land claims. David R Horton (creator), © AIATSIS, 1996.

Contents

- Implementation science
- Case study-Australia
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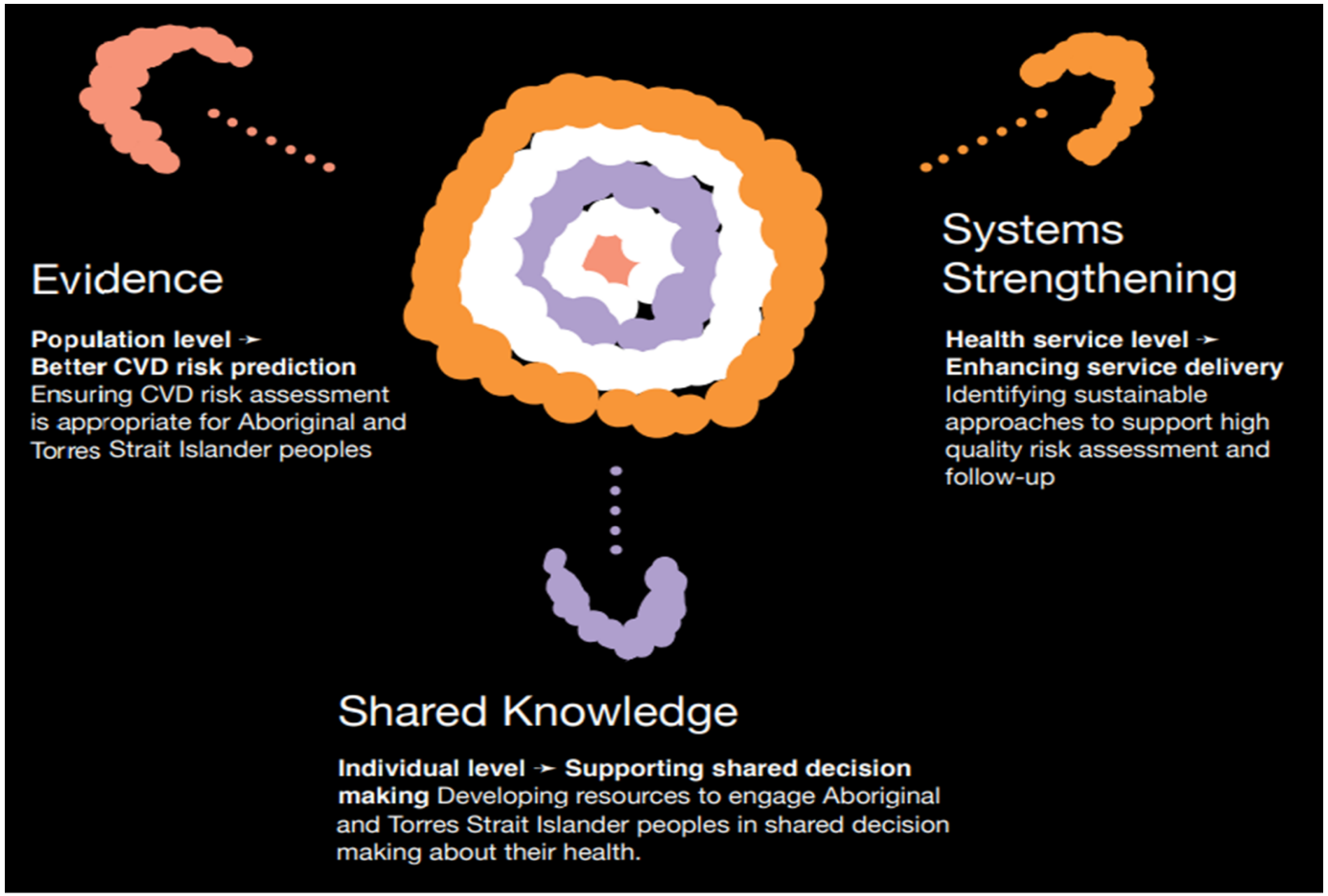
What is Implementation science?

- **Implementation science** is the scientific study of methods and strategies that facilitate the uptake of evidence-based practice and research into regular use by practitioners and policymakers (WU,2024)

- Implementation, evidence, and politics should operate together to increase the use of evidence in decision-making policy and practices (Stewart et.al, 2022).
- Barriers to the use of research evidence in the policy include lack of research–policy engagement, lack of policy-relevant research, differences in policymaker and researcher practice norms, time constraints, difficulties in coordination, and divergent languages and reward systems (Banks..Yadav, 2023)

1. Case study- Australia



Output-orientated policy engagement: a model for advancing the use of epidemiological evidence in health policy - PMC (nih.gov)

Kairuz et al. BMC Public Health (2021) 21:1302
https://doi.org/10.1186/s12889-021-11363-x

BMC Public Health

RESEARCH ARTICLE Open Access

Impact of racism and discrimination on physical and mental health among Aboriginal and Torres Strait islander peoples living in Australia: a systematic scoping review

Camila A. Kairuz[1,2], Lisa M. Casanelia[1], Keziah Bennett-Brook[2], Julieann Coombes[2] and Uday Narayan Yadav[1,3,4*]

Abstract

Background: Racism is increasingly recognised as a significant health determinant that contributes to health inequalities. In Australia efforts have been made to bridge the recognised health gap between Aboriginal and Torres Strait Islander people and other Australians. This systematic scoping review aimed to assess, synthesise, and analyse the evidence in Australia about the impacts of racism on the mental and physical health of Aboriginal and Torrens Strait Islander peoples.

Yadav et al.
Health Research Policy and Systems (2024) 22:34
https://doi.org/10.1186/s12961-024-01121-x

Health Research Policy and Systems

RESEARCH Open Access

A rapid review to inform the policy and practice for the implementation of chronic disease prevention and management programs for Aboriginal and Torres Strait Islander people in primary care

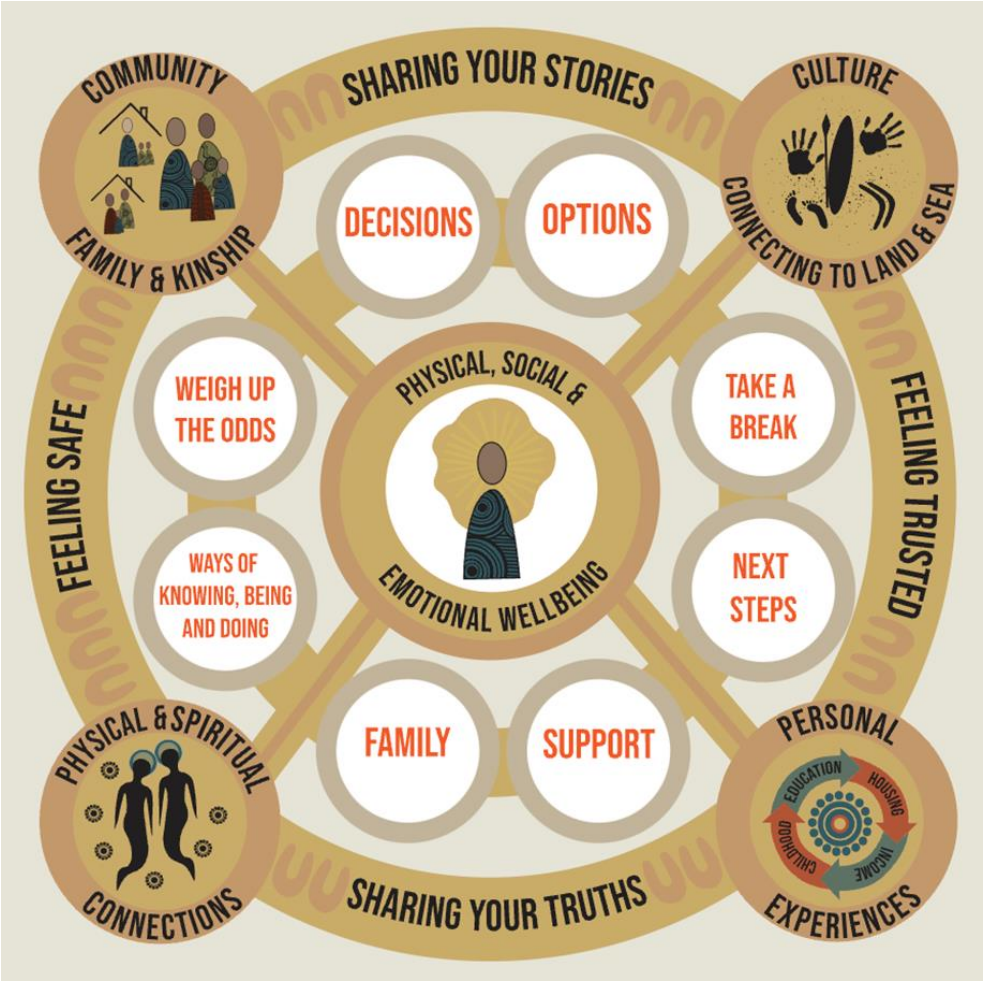
Uday Narayan Yadav[1,2*†], Jasmine Meredith Davis[3], Keziah Bennett-Brook[4], Julieann Coombes[4], Rosemary Wyber[1,5†] and Odette Pearson[6,7]

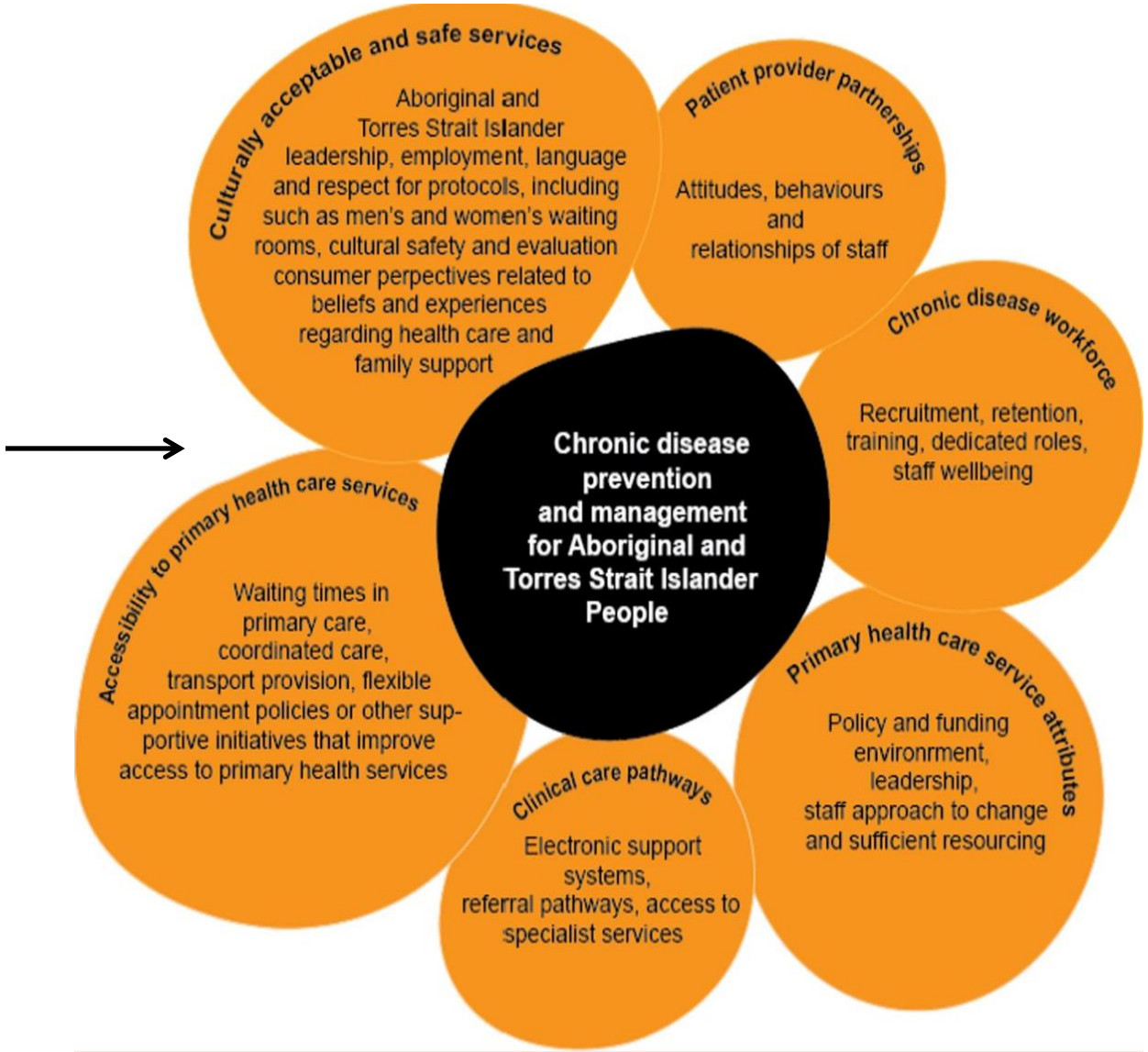
Abstract

Background More than 35% of Aboriginal and Torres Strait Islander adults live with cardiovascular disease, diabetes, or chronic kidney disease. There is a pressing need for chronic disease prevention and management among Aboriginal and Torres Strait Islander people in Australia. Therefore, this review aimed to synthesise a decade of contemporary evidence to understand the barriers and enablers of chronic disease prevention and management for Aboriginal and Torres Strait Islander People with a view to developing policy and practice recommendations.

Methods We systematically searched for peer-reviewed published articles between January 2014 to March 2023 where the search was performed using subject headings and keywords related to "Aboriginal and Torres Strait Islander peoples," "Chronic Disease," and "Primary Health Care". Quality assessment for all included studies was conducted using the Aboriginal and Torres Strait Islander Quality Appraisal Tool. The data were extracted and summarised using a conventional content analysis approach and applying strength-based approaches.

Results Database searches identified 1653 articles where 26 met inclusion criteria. Studies varied in quality, primarily reporting on 14 criteria of the Aboriginal and Torres Strait Islander Quality Appraisal Tool. We identified six key domains of enablers and barriers of chronic disease prevention and management programs and implied a range of policy and practice options for improvement. These include culturally acceptable and safe services, patient-provider partnerships, chronic disease workforce, primary health care service attributes, clinical care pathways, and accessibility to primary health care services. This review also identified the need to address social and cultural determinants of health, develop the Aboriginal and Torres Strait Islander and non-Indigenous chronic disease workforce, support multidisciplinary teams through strengthening clinical care pathways, and engage Aboriginal and Torres Strait Islander communities in chronic disease prevention and management program design and delivery.


SHARING YOUR STORIES
COMMUNITY
FAMILY & KINSHIP
CULTURE
CONNECTING TO LAND & SEA
DECISIONS
OPTIONS
WEIGH UP THE ODDS
TAKE A BREAK
PHYSICAL, SOCIAL & EMOTIONAL WELLBEING
WAYS OF KNOWING, BEING AND DOING
NEXT STEPS
FEELING SAFE
FEELING TRUSTED
FAMILY
SUPPORT
PHYSICAL & SPIRITUAL CONNECTIONS
PERSONAL EXPERIENCES
EDUCATION
HOUSING
INCOME
CHILDHOOD
SHARING YOUR TRUTHS


Culturally acceptable and safe services
Aboriginal and Torres Strait Islander leadership, employment, language and respect for protocols, including such as men's and women's waiting rooms, cultural safety and evaluation consumer perpectives related to beliefs and experiences regarding health care and family support
Patient provider partnerships
Attitudes, behaviours and relationships of staff
Chronic disease workforce
Recruitment, retention, training, dedicated roles, staff wellbeing
Chronic disease prevention and management for Aboriginal and Torres Strait Islander People
Accessibility to primary health care services
Waiting times in primary care, coordinated care, transport provision, flexible appointment policies or other supportive initiatives that improve access to primary health services
Clinical care pathways
Electronic support systems, referral pathways, access to specialist services
Primary health care service attributes
Policy and funding environrment, leadership, staff approach to change and sufficient resourcing

Sharing what works to improve chronic disease care for Aboriginal and Torres Strait Islander peoples — Summary of results, November 2023

Domain	Participant perspectives	Practice recommendations	Policy recommendations: Funding priorities	Policy recommendations: Domain-specific policy recommendations	Alignment: National Aboriginal & Torres Strait Islander Health Plan	Alignment: NACCHO Core Services and Outcomes Framework
Aboriginal and Torres Strait Islander Culture Recognition, celebration, and acknowledgment of Aboriginal and Torres Strait Islander culture underpins effective chronic disease care for Aboriginal and Torres Islander people. Chronic disease prevention and management requires a holistic approach which recognises the importance of cultural and social determinants of health.	*"And these mob here have integrity. They genuinely care about the people. They genuinely care about principles. They care about protocols. Cultural law. Cultural protocols, the whole lot of it." -Consumer*	• Ensure that leadership by Aboriginal and Torres Strait Islander people underpins primary care delivery and accountability. • Ensure cultural competency is a core element in staff recruitment, professional development review, and other education/training opportunities. • Increase the use of interpreters, local language and plain language communication resources. • Ensure environments are conducive to men's and women's business where appropriate. • Create welcoming and supportive clinic environments, potentially including tea/coffee, hairdressing or other services. • Recognise the role of families, carers and communities and ensure they are included in models of care delivery.	• Ensure needs-based primary care with scale and scope to reflect the burden of disease and the service delivery needs of Aboriginal and Torres Strait Islander people. • Ensure primary care funding models are flexible enough to be used for local priorities, potentially including provision of service user transport, creating welcoming environments, local language resources, innovative models of care delivery. • Review capacity for MBS rebates to recognise and renumerate flexible service delivery by multidisciplinary primary care teams, including outreach and extended hours services.	• Support process for transition to Community Control of health services. • Increase resourcing and workforce for use of translation and interpretation in local languages. • Resource and implement the 'Cultural safety in health care for Indigenous Australians: monitoring framework' with adaptation to primary care.	• **Priority 1** (genuine shared decision making and partnerships), Objective 1.2 (embed mechanisms to support Aboriginal and Torres Strait Islander nation building to self-determine health and wellbeing). • **Priority 3** (workforce), Objective 3.2 (improve cultural safety in workplaces across the health, mental health, disability, and aged care systems), Objective 3.3 Continue to support the leadership role of the Aboriginal and Torres Strait Islander Community Controlled health workforce organisations. • **Priority 8** (identify and eliminate racism), Objective 8.2 (improve cultural safety training across mainstream health services and settings).	Culture, Cultural Authority & Aboriginal and Torres Strait Islander Leadership are overarching and embedded **across the CSOF +** • **G3 Cultural authority and safety**: Ensure organisation-wide cultural safety policy, including regular monitoring of its implementation; effective orientation is required for non-Indigenous people. • **CE1 Individual and family health promotion**: Empower individuals and families to self-manage their health through individual and collective family actions; increase individual health literacy and health knowledge; Offer health promotion. • **CE2 Community Development**: Translate resources as per community need and provide in accessible formats.
Patient and provider partnerships Partnerships include the attitudes, behaviours and relationships between health care providers and consumers. Effective partnerships are critical to ensuring effective, longitudinal chronic disease care.	*Sometimes we'll notice a lot of older people with chronic disease, they tend to get very tired, and grumpy, but we just will leave them with their feelings for that day and come back and see how they're doing the next, or the next, and keep going back. But when they're ready. Like, we don't try to force them to come in and stuff like that. Not until they feel comfortable to come in." -Provider.*	• Support team-based models of care which may include Aboriginal and Torres Strait Islander Health workers/practitioners, nurses, general practitioners, midwives and allied health providers. • Ensure Aboriginal and Torres Strait Islander people are able to make their own health decisions and supported by the chronic disease team. • Support flexibility in consultation times and formats to foster genuine health care relationships. • Ensure mechanisms are in place to facilitate feedback and address provider behaviours and attitudes. • Support staff training in holistic needs assessment including social and cultural determinants of health. • Develop mechanisms to celebrate successes, milestones and health improvements.		• Resource implementation of the National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan. • Support equitable resourcing of Aboriginal and Torres Strait Islander chronic disease workforce. • Resource Communities of Practice to share best practices and mitigate burnout. • Celebrate strengths, successes, and improvement in health outcomes.	• **Priority 1** (genuine shared decision making and partnerships), Objective 1.1 (embed partnerships and shared decision making across the whole health, disability, and aged care systems). • **Priority 8** (identify and eliminate racism), Objective 8.2 (improve cultural safety training across mainstream health services and settings) and Objective 8.3 (ensure racism complaints procedures are available and accessible) in the National Aboriginal and Torres Strait Islander Health Plan.	**CSOF Framework principle:** Comprehensive primary health care as an accessible and generalist 'front-line' service **based on relationships** is the cornerstone of a sustainable health-care system. Alignment also in Core Service Domains: • **G3 Cultural Authority and Safety:** Implement accessible and appropriate client and community feedback mechanisms. • **G5 Organisation-wide commitment to provision of integrated person-centred care**: Develop, support and reinforce multidisciplinary teams to break down 'silos' in service delivery to holistically meet clients' needs; including adequate time/resources to integrate case-management.
Chronic disease workforce Delivering effective chronic disease care is contingent on an adequately resourced and supported Aboriginal and Torres Strait Islander primary care workforce.	*"This place is different because there are a core and a group of Aboriginal health workers who've come from the community who work in the service, right, and that is not something that happens in every Aboriginal health service." -Provider.*	• Prioritise employment of Aboriginal and Torres Strait Islander people and provide ongoing support for Aboriginal and Torres Strait Islander staff who service communities. • Explore workflows which include chronic disease portfolios within primary care and allow for team-based care. • Ensure staff training encompasses holistic chronic disease care and consumer priorities alongside biomedical considerations. • Facilitate professional supervision, peer support, and continuous learning as priorities for staff.			• **Priority 3** (workforce) in the National Aboriginal and Torres Strait Islander Health Plan • National Aboriginal and Torres Strait Islander Health Workforce Strategic Framework and Implementation Plan.	**G6 Human resources (HR) and staffing:** Prioritise recruitment, training, support and retention of Aboriginal and Torres Strait Islander staff at all levels. • **CE3 Cultural determinants and cultural affirmation**: Strengthen capacity of Aboriginal and Torres Strait Islander staff to lead health promotion activities. • **CE6 Economic benefits:** Offer best-practice terms and conditions for Aboriginal and Torres Strait Islander employees. • **Infrastructure, workforce and continuous quality improvement:** The local community is an invaluable source of staff and expertise. Workforce development will reduce reliance on temporary non-Indigenous staff.
Clinical Care Pathways Clinical care pathways support good chronic disease care by making it efficient and intuitive to deliver comprehensive, high-quality care. This includes clinical information systems, clinical guidelines, recalls, patient follow up, referral pathways and access to hospital specialist services. Clinical care pathways are especially important in settings of high workforce turnover to ensure continuity of care and reducing variation in care.	*"So, if they have any abnormal results, the doctor will put them on recall. A driver will be sent out to go to their houses to assist them with transport then. Sometimes, if they don't come at their normal recall, two or three occasions after, and then if follow-up isn't done by then, the health workers will go to their houses individually." -Provider.*	• Develop workflows which support implementation of the National Guide to Preventative Healthcare for Aboriginal and Torres Strait Islander people and other standards of care. • Support adaption of Health Pathways to provide locally relevant information for clinical management and referral. • Ensure staff training for the effective use of the full functionality of clinical information systems for recalls, reminders and reporting. • Develop systems to support navigation to local allied health and community services. • Use a variety of contextual approaches to follow up with service users, including phone calls, text messages and home visits. • Support the delivery of hospital specialist care in primary care settings wherever possible.		• Support strategic use of clinical information systems including training on effective use. • Support standards for clinical information system functionality in Aboriginal and Torres Strait Islander settings. • Invest in Health Pathways to mitigate some of the effects of high staff turnover and visiting staff by increasing continuity of care.	• **Priority 9 (**access to person-centred and family-centred care), Objective 9.3 (ensure access to telehealth, digital health and other technologies to enable better healthcare access and connection to services) and Objective 9.4 (enhance service linkages and integration for continuity and coordination of holistic are, including follow-up care and support services).	• **CS3- Adolescent and youth health; CS4- Health adults (25+); CS5- healthy aging of older adults and meeting the needs of frail elderly**: chronic disease care plans and their implementation; comprehensive multidisciplinary health assessment including social and emotional wellbeing at least annually, integrated treatment pathways including referral if required and individual follow-up according to evidence; clinical preventive services based on risk- early clinical intervention for risk factors and early disease. • **Infrastructure, workforce and continuous quality improvement**: mitigate risks from short-term locums and high staff turnover; achieve failsafe systems for handover, pathology ordering, on-referral to non-GP medical specialists and return to care"; maintain all clinical support systems necessary for highly productive, integrated multidisciplinary teams.
Accessibility Accessible primary care is available at the right place and time for people who need it. This includes waiting times, opening hours, appointment policies and physical accessibility through transport.	*" Our bus driver, patients like to talk to him too. And he gets to know them as well. And they open up to him as well and have a chat with him and – he's very important in our medical centre too." -Provider.*	• Offer maximally flexible models of service delivery, including outreach, extended opening hours and walk in services wherever possible. • Provide transport services for service users to attend primary care in settings where physical access is a barrier to care. • Support capacity of clinic drivers to have a role in health promotion and community engagement.		• Explore funding models for clinics to provide transportation services for service users to attend primary care services.	• **Priority 9** in the National Aboriginal and Torres Strait Islander Health Plan- Access to person-centred and family-centred care.	**CSOF Operating principle** Infrastructure enables and supports • **Infrastructure, workforce and continuous quality improvement**: advocate for the health of individual clients and secure the social-service interventions and supports necessary for the client's health and wellbeing.
Service Attributes Service attributes are the local policy and funding environment	*"Auntie previously mentioned this place is a hub. The range and diversity of the services available here, it's been very*	• Consider incentives for service users to support the uptake of 715 health checks. • Engage in continuous quality improvement processes for chronic disease care delivery.		• Co-design needs based funding structures to support high quality chronic disease care, including development of MyMedicare for the sector.	• **Priority 5** (early intervention), Objective 5.1 (increase the quality and uptake of health checks) and Objective 5.3 (enhance access to early	**CSOF Operating principles:** Infrastructure enables and supports. A suite of infrastructure is required including funding for 'support functions': electronic clinical information and management systems, technology (for example, telehealth),

Health checks implementation for prevention & management of chronic disease

BMJ Open

Understanding the implementation of health checks in the prevention and early detection of chronic diseases among Aboriginal and Torres Strait Islander people in Australia: a realist review protocol

Uday Narayan Yadav ,[1,2] Matthew Smith,[3] Jason Agostino,[3,4] Victoria Sinka,[5] Leonie Williamson,[1] Rosemary Wyber,[1,6] Danielle C Butler ,[7,8] Mary Belfrage,[9] Kate Freeman,[9] Megan Passey ,[10] Emma Walke,[10] Belinda Hammond,[9] Raymond Lovett,[1] Kirsty A Douglas[3]

To cite: Yadav UN, Smith M, Agostino J, *et al*. Understanding the implementation of health checks in the prevention and early detection of chronic diseases among Aboriginal and Torres Strait Islander people in Australia: a realist review protocol. *BMJ Open* 2023;**13**:e071234. doi:10.1136/bmjopen-2022-071234

► Prepublication history for this paper is available online. To view these files, please visit the journal online (http://dx.doi.org/10.1136/bmjopen-2022-071234).

Received 20 December 2022
Accepted 10 May 2023

ABSTRACT

Introduction Chronic disease remains the leading cause of morbidity and mortality among Aboriginal and Torres Strait Islander peoples in Australia. Regular structured, comprehensive health assessments are available to Aboriginal and Torres Strait Islander people as annual health checks funded through the Medicare Benefits Schedule. This realist review aims to identify context-specific enablers and tensions and contribute to developing an evidence framework to guide the implementation of health checks in the prevention and early detection of chronic diseases for Aboriginal and Torres Strait Islander people.

Methods and analysis The review will involve the following steps: (1) Aboriginal and Torres Strait Islander engagement and research governance; (2) defining the scope of the review; (3) search strategy; (4) screening, study selection and appraisal; (5) data extraction and organisation of evidence; (6) data synthesis and drawing

STRENGTHS AND LIMITATIONS OF THIS STUDY

⇒ The realist review addresses a policy initiative for Aboriginal and Torres Strait Islander peoples in Australia to promote the prevention and early detection of chronic diseases.

⇒ The methodological approach of combining learnings from published research and key stakeholders' experiences will provide a holistic view of the studied phenomenon.

⇒ Involvement of key stakeholders including Aboriginal and Torres Strait Islander peoples across project objectives, methodology, programme theory design, data extraction, interpretation and dissemination of study findings with valuing Indigenous viewpoints is a novel approach.

⇒ Certainty of the evidence generated may be limited by richness and relevance of available published literature.

Aboriginal and Torres Strait Islander health check – Adults (25–49 years)

MBS items 715 VR/228 non-VR

A good health check:

- is useful to the patient
- identifies health needs including patient health goals and priorities
- supports patients to take charge of their health and wellbeing
- provides a framework for primary and secondary disease prevention through healthcare advice, risk assessment and other measures
- is provided by the regular healthcare provider
- includes a plan for follow-up of identified health needs, priorities and goals.

Disclaimer: This is an example health check template that includes recommended core elements and is intended for use as a general guide only. Health checks should always be completed based on clinical judgement of what is relevant to individual patients and settings. Adaptation to local needs and priorities is encouraged, with reference to current Australian preventive health guidelines that are culturally and clinically suitable to Aboriginal and Torres Strait Islander needs, evidence-based and generally accepted in primary care practice, for example:

- *National guide to a preventive health assessment for Aboriginal and Torres Strait Islander people*, 3rd edition, The Royal Australian College of General Practitioners (RACGP) and National Aboriginal Community Controlled Health Organisation (NACCHO)
- *CARPA standard treatment manual*, 7th edition, Central Australian Rural Practitioner's Association (CARPA).

Where an individual practitioner or service has skills and capacity to provide culturally safe healthcare, the range of elements in the health check, and use of clinical screening and assessment tools, may be extended.

Key:

- Relevant to nKPIs
- Relevant to QI PIP

About the health check	Yes	No	N/A	
Eligible for health check (not claimed 715 or 228 in past nine months):				Date of last health check:
Consent				
Consent given after discussion of process and benefits of a health check:				
Consent given for sharing of information with relevant healthcare providers:				Who/details:
Date:	Doctor:			Nurse:
Aboriginal and/or Torres Strait Islander Health Worker / Health Practitioner:				
Location of health check:	☐ Clinic	☐ Home	☐ School	☐ Other:
Patient details				
Name:	Date of birth:		Age:	Gender:
Aboriginal and/or Torres Strait Islander status:	☐ Aboriginal	☐ Torres Strait Islander	☐ Aboriginal and Torres Strait Islander	
Address:				
Home phone:	Mobile phone:			
Emergency contact:	Relationship to patient:		Emergency contact phone:	
Medicare number:	Reference number:		Expiry:	
Pension/Health Care Card number:				

This template in its original form was developed as part of the 2019 NACCHO–RACGP Partnership Project
This template is supported by funding from the Australian Government under the Department of Health

Yadav *et al. BMC Public Health* (2024) 24:306
https://doi.org/10.1186/s12889-024-17736-2

BMC Public Health

RESEARCH Open Access

A rapid review of opportunities and challenges in the implementation of social prescription interventions for addressing the unmet needs of individuals living with long-term chronic conditions

Uday Narayan Yadav[1,2*], Grish Paudel[3], Saruna Ghimire[4], Bhushan Khatiwada[5], Ashmita Gurung[5], Shradha S. Parsekar[6,7] and Sabuj Kanti Mistry[2,8,9]

Abstract

Background People with long-term chronic conditions often struggle to access and navigate complex health and social services. Social prescription (SP) interventions, a patient-centred approach, help individuals identify their holistic needs and increase access to non-clinical resources, thus leading to improved health and well-being. This review explores existing SP interventions for people with long-term chronic conditions and identifies the opportunities and challenges of implementing them in primary healthcare settings.

Methods This rapid review followed the Preferred Reporting Items for Systematic Review and Meta-analysis guidelines and searched relevant articles in three databases (PubMed/MEDLINE, EMBASE, and Web of Science) by using subject headings and keywords combined with Boolean operators. The search encompassed articles published between January 2010 and June 2023. Two authors independently conducted study screening and data abstraction using predefined criteria. A descriptive synthesis process using content analysis was performed to summarise the literature.

Results Fifteen studies were included, with all but one conducted in the United Kingdom, and revealed that social prescribers help guide patients with long-term chronic conditions to various local initiatives related to health and social needs. Effective implementation of SP interventions relies on building strong relationships between social prescribers and patients, characterised by trust, empathy, and effective communication. A holistic approach to addressing the unmet needs of people with long-term chronic conditions, digital technology utilisation, compe-

Beyond medical script: why doctors prescribe social activities to treat chronic ailments

28 FEBRUARY 2024

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A government commissioned a working group to scope the opportunities of SP in the Australian Context

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2. Case study- Pakistan

Health Promotion International, 2022, **37**, 1–12
https://doi.org/10.1093/heapro/daac140
Article

OXFORD

Exploring the beliefs and experiences with regard to COVID-19 vaccine hesitancy and acceptance in a slum of Karachi, Pakistan

Rubina Qasim[1,†], Hakim Shah[2], Aqsa Sultan[3], Muhammad Yaqoob[1], Rukhsana Haroon[1], Sabuj Kanti Mistry[4], Amy Bestman[5], Mohammad Tahir Yousafzai[6,7,†], and Uday Narayan Yadav[4,8,*,†]

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[7]Kirby Institute, University of New South Wales, Sydney, Australia, and
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†Equal contribution.

Community centred co-design methodology for designing and implementing socio-behavioural interventions to counter COVID-19 related misinformation among marginalized population living in the squatter settlements of Karachi, Pakistan: a methodology paper

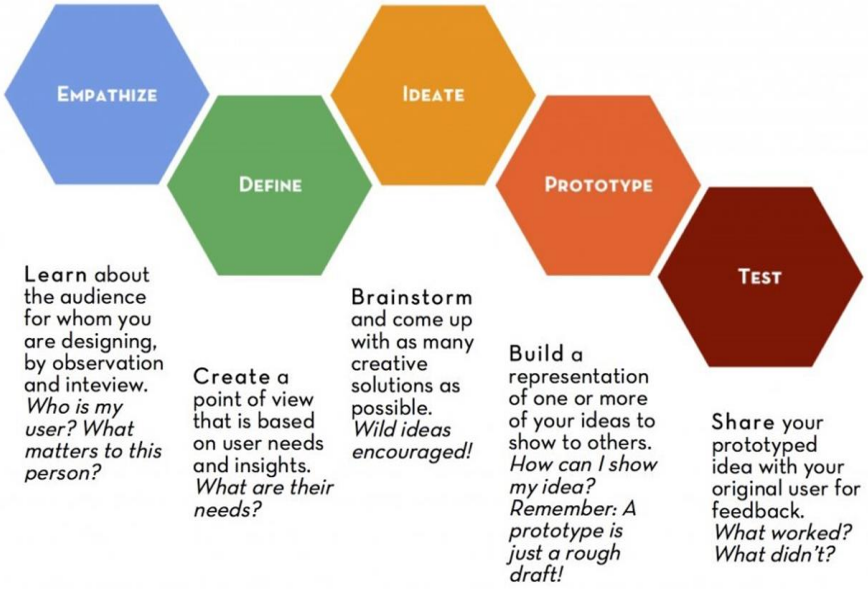
Rubina Qasim[1*], Waqas Ahmed Farooqui[2], Atiya Rahman[3], Rukhsana Haroon[1], Madiha Saleem[1], Muhammad Rafique[4], Fiza Noor[4], Afifa Ghani[5], Muhammad Yaqoob[1], Uday Narayan Yadav[6,7] and Mohammad T. Yousafzai[8,9]

From VARN2022: Shaping Global Vaccine Acceptance with Localized Knowledge
Virtual. 01-03 March 2022. https://www.vaccineacceptance.org/home-page/varn2022-conference/

Abstract

Background Misinformation regarding COVID-19 pandemic and vaccination is damaging COVID-19 vaccine trust and acceptance in Low- and Middle-Income Countries (LMIC). Identification of misinformation and designing locally acceptable solutions are needed to improve COVID-19 vaccine acceptance. This study aimed to utilize community-led co-design methodology to evaluate misinformation regarding COVID-19 and develop contextual interventions to address misinformation in a marginalized peri urban slum communities of Landhi town Karachi, Pakistan.

We are all DESIGNERS!



Australian National University

SABIN VACCINE INSTITUTE

UNSW SYDNEY

Intervention design

Implementation phase

- Improved COVID-19 Vaccine acceptance and reduced associated vaccine misconceptions.
- Intervention-informed state-level vaccination program for addressing misconceptions in the Sindh Province of Pakistan by the Sindh Government
- National level policy discussions +next phase funding

3. Case study- Nepal

Yadav *et al. Health Res Policy Sys* (2021) 19:17
https://doi.org/10.1186/s12961-020-00664-z

Health Research Policy and Systems

RESEARCH Open Access

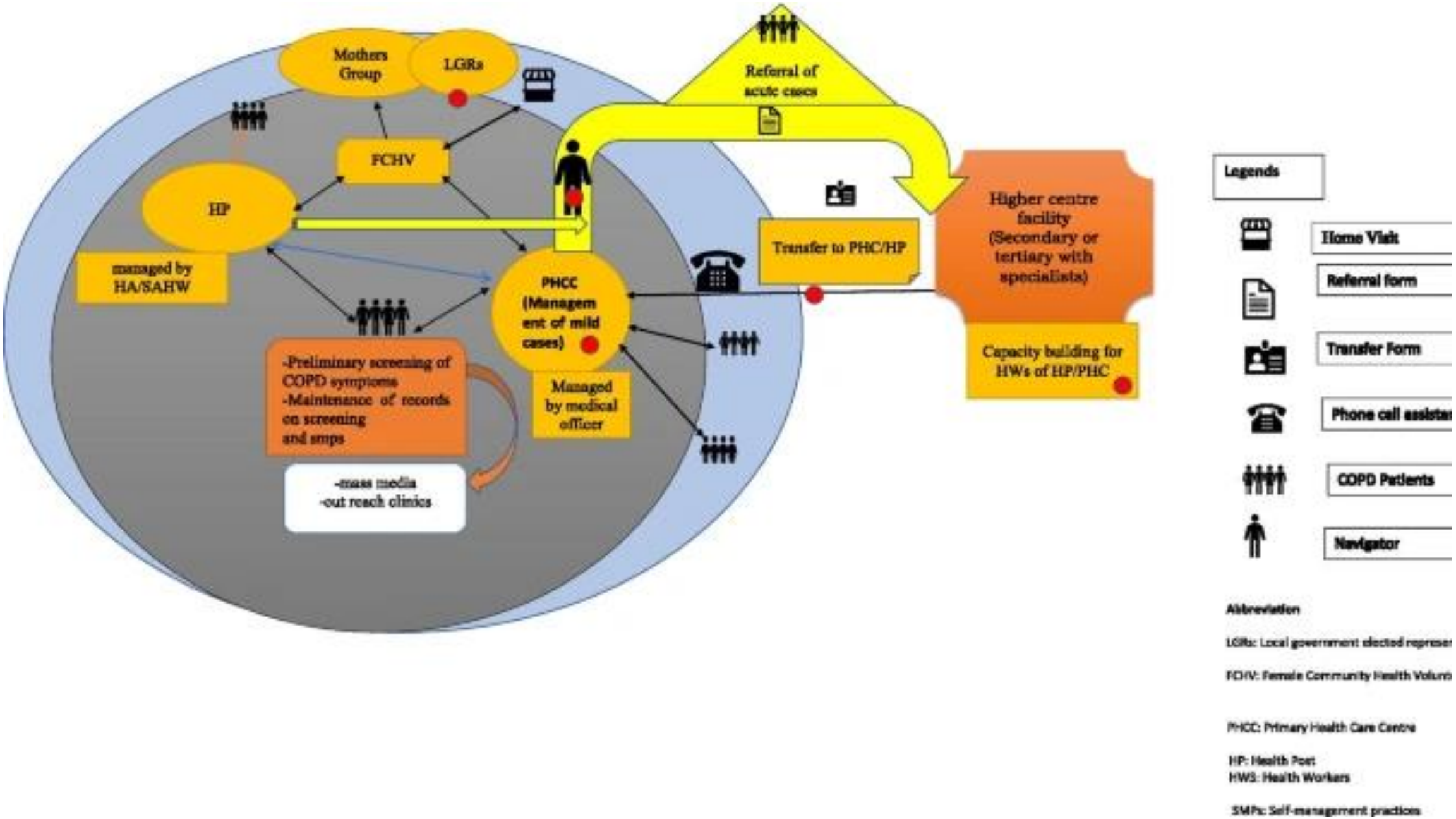
Using a co-design process to develop an integrated model of care for delivering self-management intervention to multi-morbid COPD people in rural Nepal

Uday Narayan Yadav[1,2,3*], Jane Lloyd[1], Kedar Prasad Baral[4], Narendra Bhatta[5], Suresh Mehta[6] and Mark Fort Harris[1]

Abstract

Background: People with chronic obstructive pulmonary disease (COPD) in Nepal are not receiving adequate support to self-manage their chronic conditions, and primary health care can play a key role in the effective management of these. In this study, we aimed to develop a model of care, using a co-design approach, for delivering evidence-based biomedical and psycho-social care to support self-management for people with multi-morbid COPD in rural Nepal.

Methods: A co-design approach, guided by the five stages of the design thinking model, was used for this study. Layering on "empathize" and "define" phases, we ideated a model of care that was further refined in a "prototype" stage, which included a series of consultative meetings and a 1-day co-design workshop with stakeholders. This co-design process involved a wide range of stakeholders from Nepal, including people with COPD and their families, community representatives, local government representatives, primary care practitioners, community health workers, policymak-


Mothers Group
LGRs
FCHV
HP
managed by HA/SAHW
PHCC (Managem ent of mild cases)
Managed by medical officer
-Preliminary screening of COPD symptoms
-Maintenance of records on screening and smps
-mass media
-out reach clinics
Referral of acute cases
Transfer to PHC/HP
Higher centre facility (Secondary or tertiary with specialists)
Capacity building for HWs of HP/PHC
Legends
Home Visit
Referral form
Transfer Form
Phone call assista
COPD Patients
Navigator
Abbreviation
LGRs: Local government elected represe
FCHV: Female Community Health Volun
PHCC: Primary Health Care Centre
HP: Health Post
HWS: Health Workers
SMPs: Self-management practices

Unique features of our co-designed integrated model of care

- ✓ Our designed integrated model of care included various elements(**except clinical information systems**) of the existing models of care designed to deliver chronic care management in different settings.
- ✓ Our designed model of care will be able to provide comprehensive care (promotive, preventive, and clinical care) to a wide range of prevalent long-term conditions.
- ✓ Our model of care adhered to the four principles of minimally disruptive medicine: addressing patients' workload for disease management; encouraging coordination in clinical practice; acknowledging co-morbidity, and prioritising patient perspective in the care process.
- ✓ Our care model is aligned with health policies and strategies developed by Nepal's government.

In progress

Lessons learnt

- Empowerment and educational activities must be adapted to the local language and culture
- Negotiations/adaptability/readiness
- Use of top-down (including political leaders) and bottom-up approach
- Commitment from local political and community leaders
- Networking/communication
- Creating a value-based respectful and trustful environment
- Funding constraints

Thank you for listening

Our ECDC team at ANU

Any questions?

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