# ACROSS

# Theory of Change Workshop Summary

As a part of preparation exercise for the second stage application of the ACROSS project a workshop on theory of change was organised for planning, engagement and participation of the key stakeholders as part of development of impact strategy. The workshop participants included cardiologists, psychiatrists, psychologists, nurses, occupational therapists, dieticians, physiotherapists, service users and other stakeholders from across Pakistan, Bangladesh, India.

The workshop went through a series of exercises/activities and discussions the summary of which is as below.

A summary of the key challenges and underlying causes that the programme seeks to address:

### Barriers and challenges

1. Limited number of CR centres (I) or No existing cardiac rehabilitation services in BD
2. Lack of resources (infrastructure/ skilled health personnel/ financial) in the health care facilities
3. Lack of knowledge of the health care providers regarding cardiac rehabilitation
4. Unawareness of the health care providers about the co-morbidities and socio-economic conditions of the patients
5. Lack of awareness on the benefits of CR among the patients, their families and healthcare providers
6. Poor health literacy or access to information
7. Non-compliance of the service users or poor adherence to treatment
8. No existing national protocol for usual care or cardiac management across the country
9. No formal education on CR among medical courses
10. Use of religious/natural treatment options
11. Time to interact with patients is insufficient due to the increased workload
12. Lack of involvement of the family members or social support groups in the cardiac management services or lack of community engagement
13. Lack of responsiveness & commitment of the health managers or policy makers in formulating policy
14. Lack of coordination between the clinicians, health managers, community leaders and policy makers or Lack of teamwork among healthcare providers
15. Variation in the cost of cardiac care/OOP in Govt. & private hospitals
16. Insurance reimbursements force reduced length of stay and thereby minimises success of initial CR programs
17. Community beliefs
18. Patient motivation
19. No continuity of care due to the organisation of the current healthcare system
20. Limited referrals to CR

## Consequences

The above barriers would result in low recruitment rates, high refusals, discontinuity of follow up, difficulty in getting permissions, negligence of the healthcare providers, no support from the policy makers. Moreover, due to COVID-19, patients may not be visiting hospitals and unable to travel for CR program and community engagement may not be possible.

## Drivers and key Stakeholders

| Who (Stakeholders) | How they might contribute? |
| --- | --- |
| Cardiac Patient groups | • By active participation in the rehabilitation process<br>• Good compliance with the instruction<br>• Good understanding the benefits of intervention (leads to reduce the health care cost and family burden)<br>• By being a motivation for other patients and family members or community people (role model) |
| Patients care givers /Family members | • By giving support (psychological and physical) to the patients<br>• To aware and educate the patients regarding the disease and assist in the rehab process which lead to empower them.<br>• To reduce socioeconomic burden on family<br>• Gaining trust on the health care providers |
| Health care providers | • Being accessible and tolerant to the patients<br>• Empower the patients and the caregivers or family members by motivating, educating and training them<br>• Becoming more empathized to the patients and inspired the family members. |
| Health managers | • Strengthening of cardiac services at the intervention facilities<br>• Continuous improving the quality of service<br>• Trained human resources<br>• Establish the chain of referral for CR<br>• Facilitates Policy development |
| Community or regional leaders (Government nominated leader-Chairman or councillor/religious leader/School head master/ community panchayat leader, voluntary organizations etc.) | • Making awareness to the community people regarding the disease process and management advice<br>• By providing healthy environment to the community<br>• Inspired and fascinated to the community people for being active and compliance the health advice |

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| | • Sometimes, they can help in establishing a community rehabilitation service centres as like the community clubs.<br>• They can take good heart health, or keep your heart healthy initiatives for all of the community people |
| Religious leaders | • Religious scholars are considered as an important part in raising awareness about CR. Educating religious scholars championing CR program in the community could help increase referrals and adherence |
| Policy makers (Political leaders, Health and education ministry, National health professional body-Bangladesh Cardiac Society/Rehabilitation council or Bangladesh Physiotherapy Association/ Bangladesh Clinical Psychology Society /Nutrition council/Nursing council etc.) | • Motivated to make changes in the management of cardiac patients throughout the country through policy change and implementation plans<br>• Involvement of ministry of health in CR programme would greatly contribute to improved outcomes at national levels<br>• Include cardiac rehabilitation chapter in the academic level and or arranging special training for health care providers/ graduate/ post graduate level) |

**Direct contributors:**

- Health care provider (Physician/cardiac surgeon/Rehab specialist etc.)
- Caregiver
- Family
- Patient

**Indirect contributors:**

- Insurance companies
- Health managers
- Human resources and infrastructure
- Employer
- Policy makers
- Religious leaders/Community leaders

**Our overall vision for this programme:**

Ensuring global access to affordable and effective rehabilitation for the people with heart disease to enable them to lead longer and healthier lives

### Pre-conditions which underpin this vision

### Our goals

| Short term (6 months – 2 years) | Medium term (2 – 5 years) | Long term (5 – 10 years) |
|---|---|---|
| Development of a culturally appropriate cost effective standard intervention protocol for cardiac patients | Increased knowledge & awareness regarding cardiac rehabilitation among the care givers (both family support groups and health care providers, i.e. cardiologists, nurses, physiotherapist, psychiatrist etc.) | Integration of the cardiac rehabilitation services in the routine cardiac patients management/ Sustainability of the CR services |
| Assessment of the knowledge of the physicians about the CR | Capacity development of the health care providers in the implemented health care facilities/ or development of trained health workforce | Removal of social stigma regarding cardiac care |
| Assessment of the patient's attitude towards the benefit of the CR | Strengthen cardiac services in the implemented health care facilities | Reduction of cost of care of the cardiac patients by minimizing hospital visit and admission |
| Estimate the cost of care of the cardiac patients with usual care in respect to Govt. & private health care facilities | Strengthen collaboration between the national & international organizations | Policy development regarding cardiac patients management |
| Involvement of the different stakeholders from the care givers to the policy makers | Increase adherence/ compliance of the patients to the cardiac treatment/management | Increase referrals to CR |
| Increase research capacity among the applicants/ investigators of the study | Improved health related quality of life of the cardiac patients | Improved health related quality of life of the cardiac patients |
| Review of the current situation of cardiac rehabilitation services in different countries | Develop health literacy | Modify educational programs for the HCP |
| | Motivated policy makers and health managers | Evidence generation through trial & dissemination |

## How we believe we can support changes and achieve our goals

| At individual level | At community level | At regional level | At national level |
|---|---|---|---|
| Service provider level | | | |
| Need to identify effective stakeholders - dedicated and motivated health care providers | Select appropriate community leaders | Promote an Easy accessible and effective health friendly environment | Evidence generation through trial & dissemination - helps to push policy makers |
| Provide job description and specify work overlap | Make understand the short and long term benefits of this health care management | Laid positive impact on the socioeconomic status at the community and regional level | Professionals body need to think positive for long term maximum patient benefits |
| Mutual respect and cooperation with multidisciplinary team approach | Also laid positive impact on the socioeconomic status at the community level | Make them understand that it helps to reduce the social burden | |
| Proper distribution of workload (task shifting) | | | |
| Service receiver level | | | |
| Need assessments of individuals | | | |
| Compliance on interventions and advice | | | |
| Motivated caregivers and family members | | | |

**An analysis of stakeholder’s roles and contributions in relation to this programme**

| At what level | Stakeholder | Type of contribution/intervention |
|---|---|---|
| | • Cardiac Patients | • By active participation<br>• Good compliance with the instruction<br>• Good understanding of the benefits of intervention<br>• May become a role model for other patients and family members or community people<br>• By obeying the advice leads to reduce the health care cost and family burden<br>• Caregivers and family members |
| | | • By giving support to the patients<br>• Giving aware and educate to the patients regarding the disease and rehab process which lead to empower them.<br>• Reduce socioeconomic burden on family<br>• Gaining trust on the health care providers<br>• Health care providers group |
| Individual | (cardiologists, nurses, psychiatrists, psychologists, , dieticians, physiotherapists, occupational therapists) | • Being accessible to the patients<br>• Empower the patients and the caregivers or family members by motivating and educating them<br>• Becoming more empathized to the patients and inspired the family<br>• Ensure proper follow up |

| | | |
|---|---|---|
| | | • Educate and improve health literacy and build rapport |
| Community | • Government nominated leader - Chairman or councillor<br>• Religious leader<br>• School head master<br>• Community panchayat leader<br>• Voluntary organizations<br>• Making awareness of the community people regarding the disease process and management advice<br>• Liaison establish among the primary and secondary level health care professionals<br>• Inspired and fascinated to the community people for being active and compliance to the health advice | |
| Regional | • Govt. Member of parliament<br>• City corporation Mayor<br>• Civil Surgeon officer<br>• Local NGOs<br>• Positively instruct to the community leaders<br>• NGOs can raise awareness through active participation of the community leaders<br>• Make liaison with the policy makers to establish the CR services | |
| National | • Ministry of Health and education<br>• National professional body<br>• National institute and NGOs<br>• National professional bodies and NGOs agree to develop academic training facilities<br>• Incorporate Cardiac Rehabilitation to the mainstream health care system<br>• Develop policy to improve staffing requirements and CR delivery | |

A summary of the key assumptions that we have made in developing our pathways, and which we will need to test throughout the lifetime of the programme.

**Overall Assumptions:**

The training, meeting or awareness campaign may not be feasible due to COVID-19 pandemic situation. Patient recruitment may be a problem due to same.

- At Individual level:
    - Awareness is poor
    - Motivation is poor
    - People may not be receptive
    - Patients may not understand the benefit of the CR
- At Community level:
    - Communities may not be receptive
    - Communities may not feel the importance of CR
- At Regional level:
    - Change may not be a viable option or difficult to make change

- At National level:
    - May not be feasible to create a large broader impact due to political instability or lack of commitment of the policy makers

**Tasks**

- Change belief systems
- Improve awareness and education
- Peer engagement
- Engage policy makers

Evaluation and Impact Assessment

Critical reflection of the learning questions to consider to test the model

**Think about**

- How will you inform and engage patients and the wider LMIC community about your work?
- How will your outputs influence the health and care system in the LMIC as a whole?
- What further funding or support will be required if this research is successful (e.g. from NIHR, other Government departments, charity, industry, or other non-governmental organisations)?
- What do you think the impact of your research will be and for whom?
- How will you share with study participants the progress and findings of your research?

| Areas of change | Lines of enquiry | Expected Impact<br><br>(Make sure these are measurable, realistic, achievable and time scaled) |
|---|---|---|
| Beliefs, attitudes, literacy | • Whether the patients are motivated?<br>• Whether the patients are complacence with the cardiac rehabilitation services?<br>• Improve health related quality of life (tool for measuring QOL index)<br>• KAP among patients/family | |
| Health system | • Whether the physicians or nurses or other health professionals are adequate in number to provide CR delivery?<br>• Whether the cost of CR is affordable?<br>• Whether the CR services are accessible easily?<br>• Whether the patient's referral for CR established?<br>• Whether CR services are sustainable?<br>• Increase knowledge of the health care professionals about CR (assess KAP at baseline & post training/ intervention)<br>• Reduce cost of cardiac care (in terms of reduce hospital visit & admission)<br>• Improve quality of care (can be measured by satisfaction level of patients)<br>• Check hospital registrar for patient readmission rate & days of hospital stay | |
| Community engagement | • Whether the community people are motivated?<br>• Whether the community people are contributing actively?<br>• Whether other community organizations are supporting the program? | |
| Regional/National | • Whether the CR service centre can be established in all the regions of the country?<br>• Whether any policy or strategy exists for CR?<br>• Whether any new policy or strategy needed for CR?<br>• Policy review document<br>• New Policy statement | |

**Summary of Impact:**

**Overall:** All of the cardiac patients will be able to receive sustainable, accessible and affordable cardiac rehabilitation- which will ultimately reduce the overall disease burden.

**At Individual level:** Expecting substantial reduce in the morbidity, mortality and disability due to CVDs and will improved the quality of life (QoL) of the individuals which will ultimately reduce the diseases burden.

**At Community level:** Expecting almost all the community people will be aware about the cardiovascular diseases process, and a substantial change in the practice of healthy lifestyle of the community people.

**At Regional level:** Expecting a specialized cardiac rehabilitation centres will be established in each of the region. All the health care professionals will get a training on cardiac rehabilitation process and an experts' group will be built to ensure the qualitative services in affordable cost.

**At National level:** Expecting for a good and culturally sensitive cardiac rehabilitation policy for the country as well as appropriate and pragmatic strategy should be taken for the implementation of the policy.

**Overall feedback about ACROSS from stakeholders (only in PK):**

Covid-19: There was a discussion around covid-19 pandemic and delivery of CR. All the stakeholders agreed that covid-19 can be a challenge in recruitment and delivery of the intervention if it continues when the project starts. However, they also agreed that since it is home based program it has its own benefits and could be delivered through maintaining physical distance. Integrating digital technology in the delivery of the program was also considered as a mitigating strategy to overcome this challenge:

Recruitment of patients: All cardiologist from different recruitment centres agreed that the sample size is not difficult to complete in the given time period. However, if required further recruitment centres could be approached and this should be mentioned in the application.

All stakeholders endorsed this hugely important work to be carried out especially in South Asian countries where CVDs are a major cause of mortality.