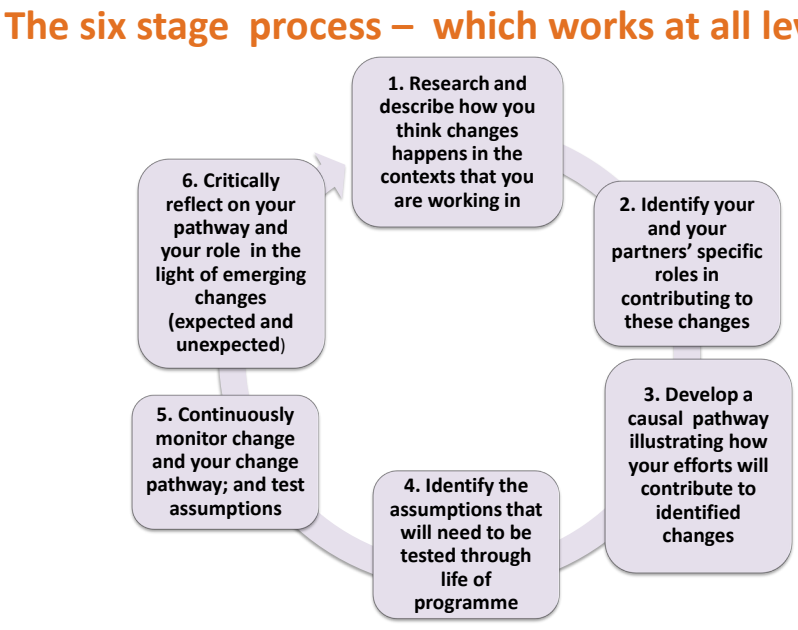
Theory of Change Narrative Document – Updated July 2023

Theory of Change

The theory of change (ToC) approach provides a robust foundation for impact assessment. It, as an approach describes how a programme brings about specific long-term outcomes through a logical sequence of intermediate outcomes.[1]

In line with theories of change, we can explore various elements, including stakeholder engagement, developing a shared vision and defining goals in the short, medium and longer term.[2] ToC gives a detailed and direct understanding of the links between activities that lead to the desired goals. This understanding also leads to better evaluation and measure of progress and in the long term an understanding of impact both planned and unplanned. ToC will also enable us to show that trial results have been adopted in practice. What barriers and challenges were faced during the trial? What assumptions were made in defining the goal?

Participants and carers as key stakeholders will be direct contributors to any planned and unplanned changes and their experiences and feedback will directly influence any adjustments need to be made.
Thus, a more explicit *Theory of Change* provides an aid to monitoring, for reflecting on developments, helping to see and explain any progress during and after an intervention, where impact is not yet manifest.[3]



Introduction

In April 2020, for the preparation of 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 and India. The workshop went through a series of exercises/activities and discussions and a causal pathway was developed in the context of the Covid 19 Pandemic, when social distancing and wearing of masks were mandatory and there was anxiety and concern as very little was known about the corona virus. Our research team uses the Feirean ToC framework as a standard framework for planning, stakeholder engagement, monitoring, evaluation and impact assessment.

As the context has changed significantly over the last 2-3 years, we brought our stakeholders together to test our model of change and to readjust our assumptions for the current conditions and update our ACROSS theory of change model.

Method

Two hybrid workshops led by Dr Rakhshi Memon were held on 6th and 18th June 2023 when the three country leads from Bangladesh, India and Pakistan brought together key stakeholders such as persons with lived experience and their carers, physicians, psychiatrists, psychologists, dieticians, physiotherapists, administrators, community influencers, alternative therapists, policy makers and other stakeholders. The participants conducted activities and exercises in their country groups and came together for discussion and feedback to the wider group.

Our overall vision for this programme

All stakeholders agreed on the following vision of success:
Ensuring global access to affordable and effective rehabilitation for people with multi-morbidities to enable them to lead longer, healthier and productive lives.
In real terms, we hope to contribute to Cardiac Care where

--- *Patients and families are able to access and seek good quality integrated cardiac rehabilitation services in a timely manner*

--- *Communities and primary care professionals are aware of the importance of home-based cardiac rehabilitation programs which are more accessible to patients and care givers and improve physical and mental health outcomes*

--- *Health professions and health system is able to provide affordable and accessible home-based cardiac rehabilitation care which empowers patients and families, is joined up, timely, effective and efficient from the time the patient arrives in emergency care, admitted in hospital, post discharge and continuing rehabilitation care.*

--- *Policy makers make holistic cardiac care, with mental health a core component of it a priority, and allocate funds and resources to build whole system capacity and capability so cardiac care is fit for purpose for heart attack survivors in Bangladesh, India and Pakistan*

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

Potential drivers and barriers for making change happen

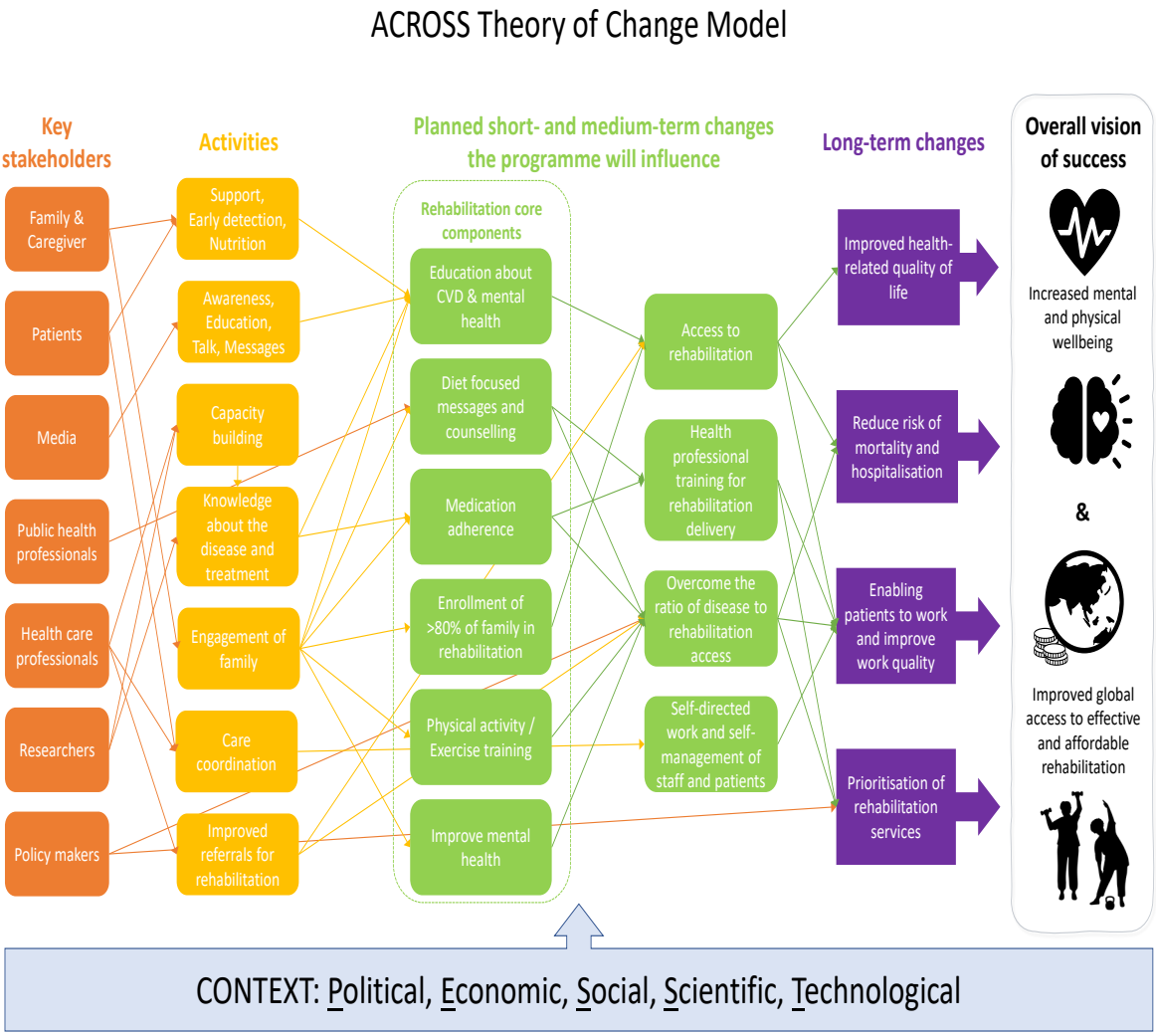
Barriers and Challenges	Consequences of them	Mitigating Actions/Solutions
Stigma /Cultural barriers	Low recruitment rate, high refusal rate, difficulty in getting permission	Raising awareness, community engagement, session and media
Enviornmental factors lack of social support	Unable to complete home based tasks	To involve family in physical and psychoeducation sessions
No compliance lack of adherence	Impact on recruitment and retention	Improving knowledge and understanding
Covid-19	Unable to visit hospitals for regular follow up, low recruitment	Involvement of community engagers, digital technology/online advise/following SOPs
Costs/financial constraints	High attrition rate	Reimbursement plan, social welfare system. Improving work opportunities.
No referrals from cardiologists	Low recruitment	Printed reminder dairies
Transport	Dropout rates	Home support, digital technology

Drivers and key Stakeholders

As researchers working with and for cardiac patients and their families , we believe we are a game-changer in terms of generating the evidence base to motivate and enable policy reform for cardiac care with integrated home-based cardiac rehabilitation service in Bangladesh, India and Pakistan. We have been able to draw together key stakeholders who are equally committed and passionate about improving cardiac and mental health care in Bangladesh, India, and Pakistan.

An analysis of our role and contributions:

Who (Stakeholders)	How they might contribute?
Patient themselves	▪ Patient to accept that cardiac rehabilitation will improve their quality of life and participate in the study ▪ To act and timely seek help ▪ Engage with self-help groups and act as support for other cardiac event survivors
Family members	▪ Offer support to reduce anxiety, provide encouragement to the patient and help improve quality of life
Health professionals (GPs, surgeons, nurses, physiotherapists, dieticians) Medical Service Providers	▪ Provide awareness to the patient and educate them about importance of rehabilitation program and offer treatment ▪ Improved health care pathways, better rehabilitation and on-going care ▪ Provide lifestyle/nutritional changes/monitoring/regular checkup and family support
Community Local leaders, Religious leaders, Local Jirga, Community and workplace champions, Peer groups/networks, different type of Counsellors etc.	▪ These are strong influencers and people look up to them. Hence, they can mobilise people to adopt new things and change behaviour and practice ▪ Change attitude towards survivors and promote more acceptance that they can continue to lead a normal life
NGOs	▪ Facilitate in raising awareness, offer advocacy and support community empowerment ▪ Help communities with population awareness and empowerment to ask for their rights
Policy makers	▪ Policy formulation, support in implementation and programme planning to make rehabilitation program a part of routine care
Media	▪ Awareness raising, positive messaging on exercise and life style, public education and information campaigns



Why we have opted to work in this way

The programme aims to empower cardiac event survivors, communities, health and public health providers and policy makers to take ownership of the development of integrated cardiac care in Bangladesh, India, and Pakistan. Through evidence-based workshops and peer led learning, stakeholders will be equipped to tackle the challenges and take opportunities to develop risk mitigating solutions.

A summary of assumptions we have made in designing this programme and change pathway:

Our Theory of Change for this programme has been developed through a very participatory planning process. Stakeholders have worked together to design a change pathway that they believe illustrates the way that they see change happening and their own roles in the process. Equally, we know that we need to be able to negotiate the ever-changing landscape in the current context but also the challenges that characterise the country we work in. We have therefore developed a list of assumptions that we need to test at regular intervals and as a result of which we will need to adapt and change some of our ways of working.

Tasks	Assumptions
Hiring and induction of research staff	People would be interested to apply and join the research team We will receive enough applications
Collaborations with health service providers	Health care providers will agree to join
Development of culturally adapted ACROSS intervention	Experts will work together to develop the intervention We will have first cardiac rehabilitation intervention for Bangladesh, India and Pakistan for assessment and management of home based cardiac rehabilitation
To deliver training and build capacity of the team	Research team will attend the training Trainers will deliver the training as per schedule
To organise supervision sessions	National and international supervisors will agree to offer supervision Supervision arrangements will be in place Supervision will go smoothly as planned
Development of awareness material	Research team will be able to design and distribute awareness material both in community and health settings
Recruitment of participants	Research team will have enough referrals from cardiologists and other health professionals Potential participants will agree to participate We will meet recruitment target
Development and refinement of rehabilitation program	All the potential stakeholders will be on board Participants will openly share their ideas on how to refine and adapt program
Delivery of rehabilitation program	Program will be delivered as per pre-defined schedule Participants will attend rehab sessions
Follow up assessments	Team will be able to schedule the follow up assessments Participants will attend the follow up assessment sessions We will be able to retain participants till last follow up

How and when our assumptions will be tested and how the results will be fed back into our planning processes

As our approach to planning and assessment, ToC process will continuously monitor change during research trial delivery and thus provide opportunities to adjust assumptions according to the changing conditions. Systematic analysis will allow reflection on the trial's contributions to planned changes for the target group. ToC assessment will actively seek to understand and report on unexpected/unintended impacts as well as those that were planned.

We have developed and built into our annual plans, a process for critical reflection of our roles and change pathway.
We have planned six monthly reflection meetings in which we will:

- --- Reflect on what's changed in terms of context– policies, people, priorities in the period
- --- In relation to our pathway and changes we expected to see, discuss and agree:
    - o What has actually changed? For whom?
    - o Were these changes positive/negative/intended/unintended?
    - o What (if anything) did we contribute to them (who/what else might have influenced these changes?

- How significant is this for our planned pathway?

--- Test some of our key assumptions against the short-term changes we plan to achieve
--- Consider how we should adapt our pathway in the light of this?

We have agreed that we will revise our pathway on an annual basis to reflect the results of this learning.

Programme Outcome:

All key stakeholders will work towards the realisation of the programme goal through its contribution to the achievement of the **primary programme outcome**:

The study team efforts towards achieving the primary programme outcome are articulated in four programme outputs which we have called Work packages.

Short term (0 months – 12 months)	**Medium term (12 – 36 months)**	**Long term (36 – 60 months)**
Identification of Staff and capacity building of the designated staff members for the implementation of the program.	Cardiac Rehabilitation program (implementation)	Improvement in HRQoL
Cardiac Rehabilitation program (implementation)	Strengthening capacity and capability	Evidence on effectiveness of intervention
Community Health care provider, Community Health workers providing home based care.	Evidence on feasibility and acceptability of rehabilitation program	Policy implications such as impact on guidelines and awareness about the healthy and balance diet, physical and mental health activities
Joint implementation between organizations	Better implementation & organized structure of physical and mental health	Relieves stress and anxiety of cardiac episode survivors and family
Training of family & close relatives of patients	Better understanding of prevention & management of cardiac care	Reducing mortality & morbidity, reducing burden of disease
Training of Service providers	Better referral system & management of cardiac patients	Reducing mortality & morbidity, reducing burden of disease

Sustainability and impact

This research study will address long---term sustainability on three levels:

- *Care sustainability* will be addressed through capacity and capability building and the improvement of effectiveness of cardiac care pathway by integrating ACROSS under WPs 3 and 4
- *Programme sustainability* will be achieved by strengthening of the capacities of the programme office; by giving greater visibility to trial's work and enhancing partnerships; and by building the capacities of the research staff to develop and implement sound programmes.

- *Financial sustainability*: through improved resource allocation and mobilisation.

It is of vital importance to categorise the vulnerable groups in order to plan for their safety at homes, work places etc. Most vulnerable population includes disabled, women and minorities. Cardiac care can be improved through proper legislation and infrastructure. We have legislations in place for environmental and public health initiatives, it is not impossible to have them in a similar way to promote nutritional and exercise at home and occupational settings.

Short term impact:

- Increased awareness regarding cardiac rehabilitation
- Better referral system
- Well informed community
- More referrals from cardiologists
- More acceptance towards mental health problems
- More acceptance towards psychological treatment as well
- Capacity building of health professionals
- Evidence on feasibility acceptability and effectiveness of the Rehab program

Medium term impact:

- A Rehab program available to be part of routine care All cardiology units familiar and using the program
- Guidelines on nutrition and exercise etc

Long term impact:

- Access to community rehabilitation program
- Legislation to ensure availability of rehabilitation program across the country
- Improved referral pathways
- High quality CR research (multicentric networks)
- Improved patient physical and mental health and well being
- Reduced mortality

This will lead to:

- Improved HRQoL
- Reduced mortality
- More knowledge about multi morbidity
- Reduced disease burden related to Cardio vascular disease

References:

1 Vogel I. Review of the use of ‘Theory of Change’ in international development. UK: Department for International Development (DFID); 2012.

2 O’Flynn M. Theory of Change for Planning, Monitoring, Evaluation and Impact Assessment, intrac program, 2012.

3 Reeler D and Van Blerk R. The Truth of the Work: Theories of Change in a changing world, 2017.