



Transferring evidence from a primary context to a target context in LMICs

Donna Shelley, MD MPH
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Outline

- Transferability and adaptation
- Tools and frameworks for assessing transferability and guiding adaptation
- PIET-T & Case example

TRANSFERABILITY AND ADAPTATION

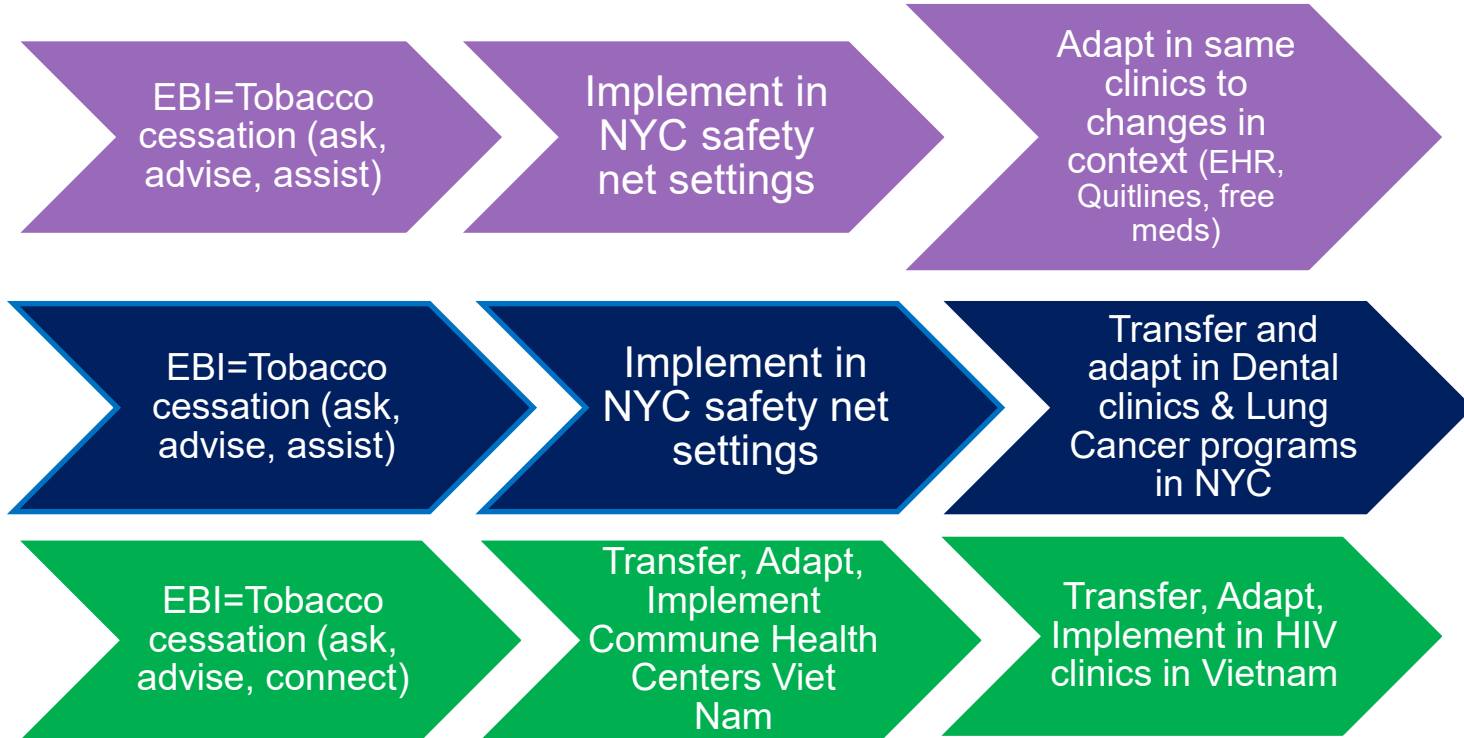
- **Transferability**

- Is the evidence transferrable? To what extent can outcomes of a successful health intervention and/or implementation strategy, evaluated in a primary context, be achieved in a target context?
- What factors may influence transferability? What local, contextual evidence is needed for making that decision?
 - Failure to achieve this goal: mechanisms that do not function in the new context, adaptations that violated causal logic, implementation failure or and weaknesses in original evidence.

- **Adaptation**

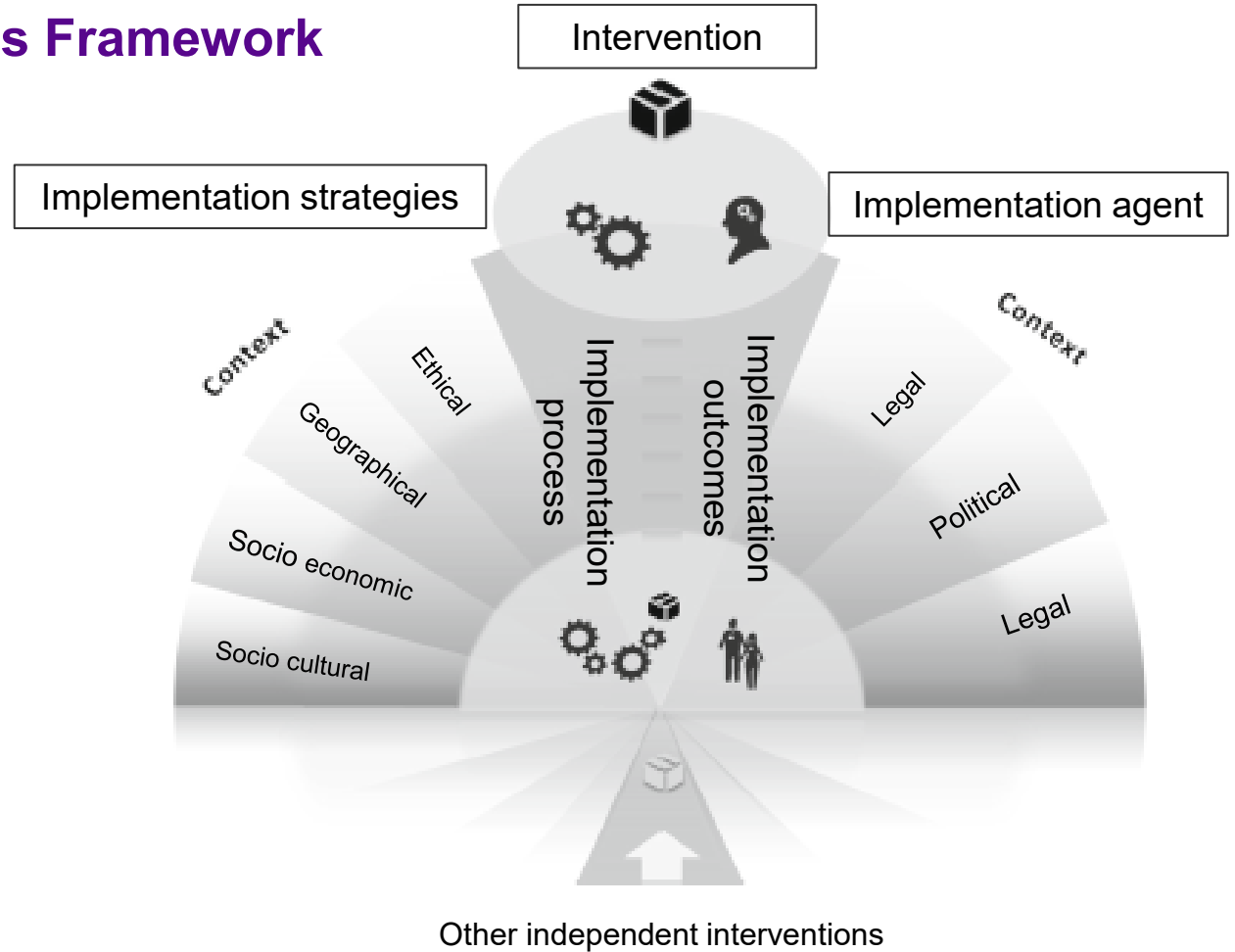
- Intentional modification(s) of an evidence informed intervention to achieve a better fit between an intervention and a new population and context.
 - Planned and/or Responsive (AKA Systematic vs Unsystematic, Proactive vs Reactive)
 - Adaptations are ongoing as context changes over time
 - Several definitions: strategy, outcome, process

TRANSFERRING AND ADAPTING ACROSS SETTINGS AND POPULATIONS



Context and Implementation of Complex Interventions Framework

- Context
- Implementation
- Setting



Tools and Frameworks

- Assessing transferability: TRANSFER Approach (Munthe-Kaas et al. BMC Med Res Method, 2020)
- Reporting adaptations: Framework for Reporting Adaptations and Modifications-Enhanced (FRAME) (Stirman et al. Impl Sci 2013)
- Planning for and undertaking adaptation
 - Iterative decision making for evaluation for adaptations: decision tree.... (IDEA) (Miller et al J Community Psychol, 2020)
 - Model for adaptation design and impact (MADI) (Kirk et al. Impl Sci 2020)
 - Population, Intervention, Environment, Transfer Model of Transferability (PIET-T) (Schloemer and Schröder-Bäck Impl Sci. 2018)

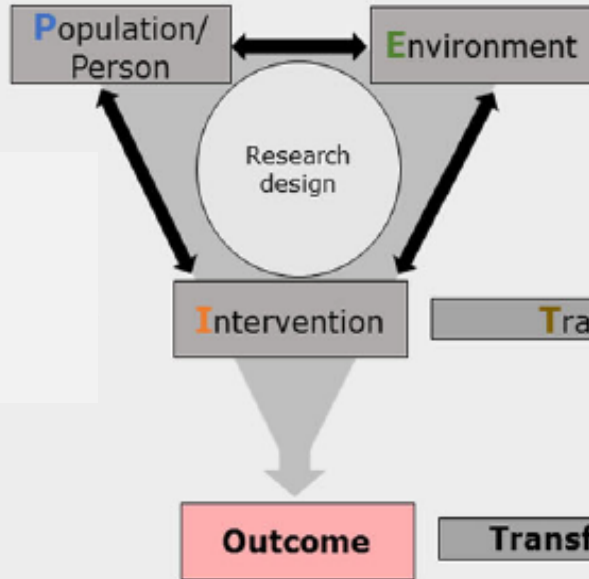
Selected literature about adaptation: Baumann et al. 2022

https://med.stanford.edu/content/dam/sm/fastlab/documents/Adaptation_annotated_reading_list.pdf

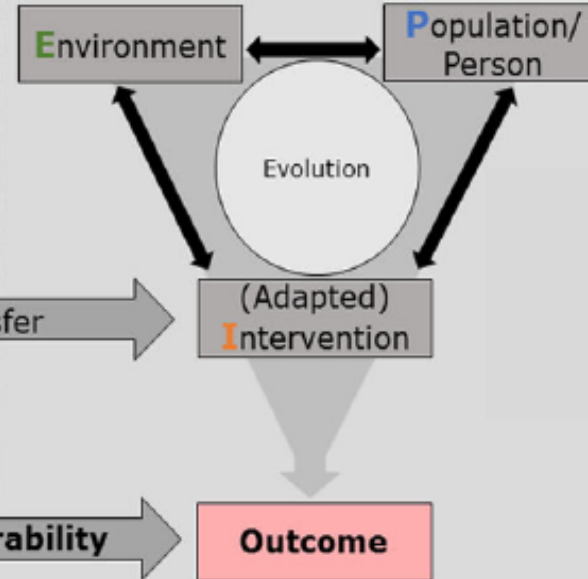
[Evidence-Based Cancer Control Programs \(EBCCP\): Cervical Cancer Screening Evidence-Based Programs Listing | Evidence-Based Cancer Control Programs \(EBCCP\)](#)

Population-Intervention-Environment-Transfer Model of Transferability: PIET-T

PRIMARY CONTEXT



TARGET CONTEXT

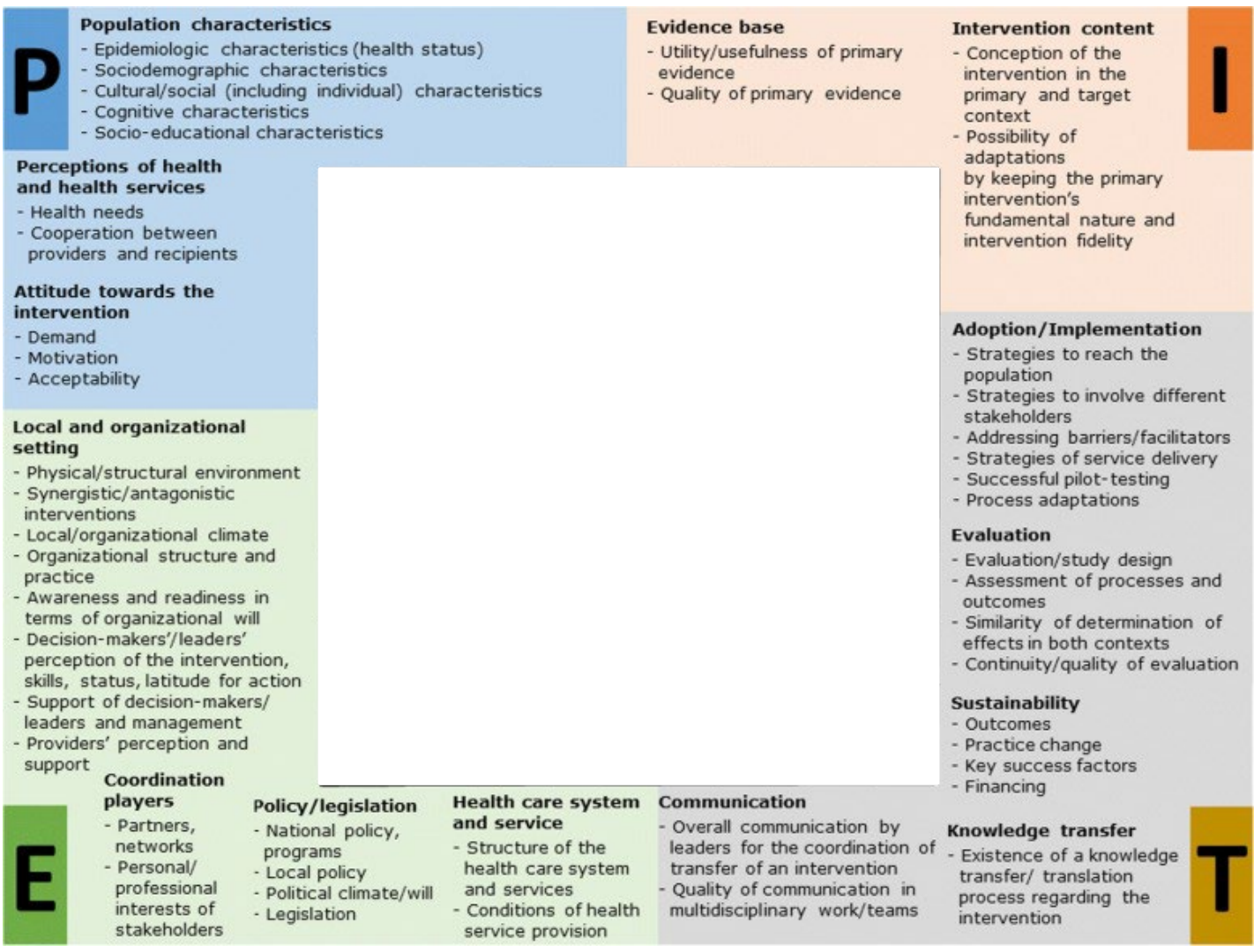


Transfer

Transferability

PIET-T

Process and determinants framework for adaptation



Case study: Transfer EB tobacco use treatment to Vietnam in CHCs and HIV clinics

	Commune Health Centers	HIV clinics
POPULATION	Characteristics: High smoking rates. waterpipe use common (30% dual users)	High smoking rates, +Substance abuse, +MH disorders, + smoking stigma, >50% dual users
	Perception of health svcs: Clinicians agree treatment is a priority, lack training, smokers aware of dangers, use of cessation svcs not well studied	Same, plus clinicians and patients not aware of specific HIV-related consequences, lack of experience quitting, stigma
INTERVENTION EVIDENCE	<p>Evidence:</p> <ul style="list-style-type: none"> • Primary context health care worker delivered 5As is evidence based. Quitlines and SMS also effective. <i>Evidence from HICs.</i> • Lack of EBIs for other tobacco products. <p>Intervention content: Requires adaptation to address specific context at individual and system level.</p>	<p>Evidence: Lack evidence for long-term effectiveness in primary and target context</p> <p>Intervention content: Requires adaptation to HIV patient-specific contextual influences (stigma, social isolation, fatalism etc)</p>

Case study cont. ENVIRONMENT

Tobacco use treatment in CHCs	In HIV clinics
Macro: WHO guidelines	PEPFAR no guidelines
Macro: Top-down decision making, Tobacco-related burden of disease growing, National Tob Strategy, SFA laws, but low Tax, <i>Barriers:</i> Lack coverage for medication, Lack of data to drive decisions, No plan to implement in CHC, smoking social norm, lack of grassroots advocacy <i>Facilitators:</i> Treatment guidelines, integrating TDT in NCD planning documents, Tobacco Fund	Same TDT in HIV clinics not a national priority, BUT growing recognition of NCD burden Social norm changing, strong HIV national program leadership, Free Quitline, Experience scaling HIV prevention and treatment & Integrating TB/STDs/PREP
Meso: <i>Barriers:</i> TDT not available across health system, lack of training <i>Facilitators:</i> VHW infrastructure for CHCs, task shifting	SAME <i>Facilitators:</i> screening for ETOH and SUD Referring patients to treatment

Case study cont: TRANSFER

	Adaptations	Rationale for adaptation	Function
<p>Arm 1 Ask all patients if they smoke Assist with brief counseling (2As)</p> <p>+ Quitline counseling</p>	<ul style="list-style-type: none"> Added waterpipe and HIV-specific information to provider-delivered brief counseling. No modification to content (standard service) 	<ul style="list-style-type: none"> High rates of dual use Lack of patient knowledge about risks of tobacco use in general and HIV-related health outcomes. 	<p>Health care climate Social norms</p>
<p>Arm 2 and 3 2As+ 6 session counseling</p>	<ul style="list-style-type: none"> Expanded 3 session manual to 6 Integrated content from Positively Smoke Free Addressed differences in individual, sociocultural, structural and interpersonal factors 	<p>Address theory-driven barriers to quitting among PWH who smoke. (e.g., build culturally appropriate refusal skills, address HIV referent themes-stigma, social isolation & cultural concepts such as “determination”)</p>	<p>Social support Self efficacy Risk perception</p>

Case study cont.: TRANSFER

	Adaptations	Rationale for adaptation	Function
Workflow mapping and redesign	Redefined roles and responsibilities	Integration into usual care visit	Fit & compatibility
Training and coaching guide	Training: Added HIV referent themes and data on waterpipe & modified to address specific theory-driven barriers to quitting among PLWH Guide: Adapted from NYCDOH 1-page guide reflect steps and scripts.	<ul style="list-style-type: none">• Dual use of cigarettes and waterpipe was common• Coaching guide reinforce training among HCPs with no previous experience delivering TDT	Self-efficacy, motivation, intention Fidelity to 3As+R
Referral system	Changed the standard Quitline referral system from reactive to proactive approach	<ul style="list-style-type: none">• Standard care approach for delegating intensive counseling	Feasibility

CONCLUSIONS

1. Transferring evidence generated in one context to another requires rigorous adaptation of both evidence-based interventions and proposed implementation strategies
2. Using theory to guide a systematic process provided strong justification for adaptations, and increases potential for generalizing to other sites
3. Balancing pragmatism with rigor using rapid analysis and multiple methods increased feasibility of the process
4. Adaptations were facilitated by engaging implementers in the process (not only as subjects) and ongoing engagement identifies need for additional modifications in early phase of study.
5. Deferring to country partners' expertise and local knowledge is critical for effective adaptation and implementation

Thank you

ds186@nyu.edu