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#8 - Interpreting Conflicting Results of a Violence Prevention Programme in Rwanda using the Prevention Triad

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Objectives/aims
This presentation will apply the Prevention Triad to help interpret contradictory results found when evaluating the impact of a couples curriculum designed to prevent intimate partner violence (IPV) in Rwanda. The original curriculum led to a significant reduction in women's experience of IPV whereas an adapted version led to an increase in women's experiences of IPV. The triad is a tool developed by the Prevention Collaborative to consider how multiple elements – programme model, implementation quality, context and population, and operational foundations—combine to determine the impact of a programme. This moves away from the common emphasis on whether or not a model "works."

Methods
Once conflicting results became known, researchers of both evaluations spent considerable time together to compare the markedly different outcomes. Qualitative interviews were conducted with partners who implemented both programmes and staff from both evaluations to help explore differences. Available documentation including programme timelines, monitoring and evaluation data, and CVs of facilitators across both programmes was reviewed.

Main findings
Applying the Prevention Triad to this case study illustrated how the conflicting evaluation findings were largely due to significant differences in implementation quality, which were exacerbated by unrealistic timelines and different contracting arrangements. To a lesser extent, disparities may have evolved from differences in design of the couples curriculum, differences in the study designs, and differences in the enabling environments created by other programme components. This case

study advocates for the importance of giving attention to all elements of the Prevention Triad to not only equip programme effectiveness, but to inadvertently avoid causing harm.

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#35 - Digital health implementation knowledge co-produced with people with living experience of brain injury

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Objectives/aims
Acquired brain injuries (ABI), such as stroke and traumatic brain injury, commonly cause cognitive-communication disorders, in which underlying cognitive difficulties also impair communication. As communication is a two-way exchange, close others such as family and friends also experience the impact of cognitive-communication impairment. It is therefore internationally recommended best practice for speech-language pathologists to provide communication support to both people with ABI and their close others. Current research also identifies a need for neurorehabilitation professionals to support digital communication after ABI, such as via social media. However, with more than 135 million people worldwide affected by ABI, alternate and supplementary service delivery models are required to ensure people with ABI and their close others can access this communication support. The 'Social Brain Toolkit' is a novel suite of three interventions to deliver communication rehabilitation via the internet. However, digital health implementation is complex, and minimal guidance exists for ABI.

This study aimed to support the implementation of the Social Brain Toolkit by co-producing digital health implementation knowledge with people with living experience of ABI, close others, clinicians, and leaders in digital health implementation. Specific aims were to (1) prioritise theoretically informed implementation targets for the Toolkit, (2) understand the identified implementation considerations, (3) co-produce targeted implementation strategies to address them, (4) explore potential interrelationships

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between implementation considerations and strategies to identify the most influential, and (5) collaboratively reflect on the co-production process.

Methods

A maximum variation sample (N=35) of individuals with living experience of ABI, close others, clinicians, and digital health implementation leaders participated in an explanatory, sequential, mixed methods study. Stakeholders quantitatively prioritised the top four of seven theoretical domains of the Non-adoption, Abandonment, Scale-up, Spread, and Sustainability (NASSS) framework for perceived importance to Toolkit implementation via electronic surveys and interviews, with qualitative interview and focus group data focussed on these four stakeholder-identified priorities. Qualitative data were collected and deductively analysed against the NASSS framework together with stakeholder co-authors. A collaborative autoethnography of the research was conducted with stakeholder co-authors, and relationships between identified implementation considerations and strategies were identified through post-hoc visual network analysis.

Main findings

Across the four most highly prioritized domains of the 'Condition', 'Technology', 'Value Proposition' and 'Adopters', 48 digital health implementation considerations and 52 tailored strategies for both intervention developers and clinicians were generated. The post-hoc visual network analysis revealed 172 unique relationships between identified implementation considerations and strategies, with user and persona testing and responsive design identified as the most connected, and therefore most potentially most impactful, strategies. The collaborative autoethnography described both benefits and challenges of co-production.

Conclusions

People with ABI, close others, clinicians, and digital health leaders co-produced new knowledge of digital health implementation considerations for adults with ABI and their close others, along with implementation strategies tailored to address them. Complexity-informed network analysis offered a data-driven method to identify the two most potentially impactful strategies from many options. Although the study focused on four NASSS domains and was limited by the underrepresentation of some participant demographics, the wealth of actionable implementation knowledge

produced supports the co-production of implementation research with mutually beneficial outcomes for stakeholders and researchers.

This study aligns with first subtheme of the conference, directly addressing the notion inequality by co-producing implementation research knowledge together with stakeholders including adults with ABI, their close others, and clinicians. By outlining how a data-driven network analysis was used to identify the most influential of the co-produced implementation strategies, it also directly addresses the fifth conference subtheme, concerning the resource-intensive nature of implementation research and a subsequent need to determine which implementation strategies are ‘best bets’ and ‘minimum viable’ implementation supports.

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#41 - Victorian Allied Health Assistant Workforce Recommendations and Resources in Victorian public health: Implementation coaching program

Summit subtheme: 3. What works and how to do it: Evaluating implementation and impact

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Acknowledgements
Sandra Glagovski, Jessica Huglin, Abby Foster, The Victorian Department of Health

Background
The role of the Allied health assistant is well known within the health sector. Governance structures and training for this workforce have been the subject of discussion and reports in Victoria for over a decade with multiple resources available. However, it remains that assistant workforces are not being utilised optimally in health, disability or aged care settings.

The Victorian Allied Health Assistant Workforce Project, commissioned in 2019 by the Department of Health (DH), has delivered 18 recommendations and accompanying resources supporting the optimal utilisation of Allied health assistants across health, aged care and disability sectors. This project (2020-2022) has built on several initiatives conducted in the past decade seeking to develop and increase the size of the assistant workforce. In late 2022 the core principles, recommendations and accompanying resources were finalised. These recommendations and resources are available online and since their inception, there has been 17,000 visits to the webpage and over 5000 resource downloads. The project team has since

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commenced an implementation coaching phase to provide support to Victorian public health services to utilise the developed recommendations and resources, therefore increasing their utilisation of the Allied health assistant workforce in their workplaces.

Objectives/aims
The aim of the current and final project phase is to embed the Victorian Allied health assistant workforce recommendations and resources into practice across select Victorian public health settings.

Methods
A non-experimental, pre- and post- mixed methods design is being used to evaluate the outcomes of the tailored implementation coaching program. This study is being conducted utilising both quantitative and qualitative methods. Monash Health Human Research Ethics Committee approved this research (HREC Approval number RES-20-0000-356L / ERM 64899) and all participants were provided with written informed consent.

Presentation of this work would be ideally via a presentation and panel discussion with coaching candidates as panel members to discuss the process, their experience during the coaching period and sustained changes after the coaching period.

Main findings
At the time of conference, two workplaces will have undergone their full coaching period and four others will have commenced their sixteen-week coaching program. Results will include organisational readiness for change, pre and post implementation workforce survey results and post implementation interview results for the two completed coaching periods.

Outcomes related to the AHA workforces achieved by participating workplaces will be described. This will include domains such as supervision and training, workforce structure and grading, student placements, competency-based training and clinician attitude and knowledge regarding the Victorian Allied Health Recommendations and Resources

These results will be further supported by the presentation of Project team reflections on the process, the barriers, and the enablers to success.

Conclusions:

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This research will provide insight into the supports required to enhance implementation of workforce recommendations and resources in public health settings. The experience of tailored implementation coaching will also be explored. In addition, the barriers and enablers to successful implementation will be better understood. This will provide a model and learning opportunity for other health networks hoping to implement the Victorian Allied Health Assistant Workforce Recommendations and Resources.

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#58 - Leveraging School Principals to Address Learning Loss in Indonesia Through Group and Individual Targeting

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Objectives/aims
In Indonesia, COVID-19 pandemic-induced school closures led to a significant loss of learning among students, necessitating remedial learning programs. This study aimed to explore whether differentiated remedial teaching can improve the foundational numeracy skills of students and if the improvements would be better in schools with added individual tutoring. It also aimed to understand whether additional training of school principals would strengthen the results. The four interventions were implemented in 25 primary schools in Indonesia with 1,545 students over eight weeks.

Methods
Mixed methods – A/B testing and qualitative study in 25 primary schools in Indonesia.

Main findings
We identified six key findings: (1) trained teachers could implement the targeted group and individual tutoring; (2) The biggest challenge for implementation was in scheduling the sessions, while the biggest barrier was teachers' belief in students' ability to progress; (3) all the interventions were effective in improving student outcomes; (4) two interventions performed the best: (a) trained teachers implementing the group and individual targeting sessions, and (b) trained teachers supported by a trained school principal implementing the group targeting sessions; (5) teachers in schools with trained principals had better compliance in inputting student outcomes data on time; and (6) in addition to instructional leadership skills, school principals need additional training on management and soft skills.

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#62 - The Impact of Covid19 on Elementary and Secondary Education in Japan

Presenting Author
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Objectives/aims
In this study, we first summarize Japanese research studies on the impact of Covid19 on primary and secondary education. Then, by comparing the results of similar studies in the UK, we will identify the characteristics of the impact of Covi19 in Japan. Furthermore, we aim to summarize the implications for the use of evidence in unpredictable times such as Covid19, based on the results of a survey on school closures in the aftermath of the Great East Japan Earthquake.

Methods
First, an overview of Japanese research studies on coronas will be reviewed. Then, by comparing it with corona research in other countries, we will clarify the characteristics of Japan's corona countermeasures. Furthermore, we aim to mention how research studies can be used as a reference for decision-making in schools in unpredictable times.

Main findings
We conducted a comparative analysis of Japanese and English article reviews from three perspectives. The results of the category analysis showed that in Japan, more than half of the studies were on learning, a large difference compared to the UK. In the case of the UK, mental care accounted for more than 30%. Other comparisons of research design and speed of research production between Japan and the U.K. revealed significant differences in design features and speed.

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#70 - Evidence in Education Network: Balancing global and local evidence ecosystems in education

Presenting Author(s)*
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Objectives/aims:
The aim of the Evidence in Education Network is to build a collaboration between organisations that are interested in shared evidence infrastructure at the global level but contextually relevant evidence generation, translation, and mobilisation. Each organisation is focuses on building evidence infrastructure in their region or country, while benefitting from sharing practice at the global level.

Network governance groups support evidence generation, evidence synthesis and evidence use. The Education Endowment Foundation is the What Works Centre for Education in England and a convening member of the network.

Methods
The EEF will present (20 minutes presentation using slides) on the collaboration, drawing on examples where building global evidence infrastructure through a living database of studies is enabling organisations across the world to present local relevant evidence and work with schools and policymakers to embed evidence in context specific ways. The presentation will outline the possibility of a more shared evidence infrastructure across global education.

Main findings
The current outcomes of the collaboration include: a shared central database of 3500 studies from across the world that form the central evidence infrastructure of the

network; a commitment to shared methods and reporting standards across evidence generation; and a growing collection of locally relevant evidence informed resources and initiatives. These range from the Teaching and Learning Toolkit in England – an evidence portal accessed by 70% of school leaders, to efforts in Latin America and Jordan to embed evidence into teacher training courses, and innovative approaches to communicating evidence through storytelling in Cameroon.

The experience across network organisations has highlighted some of the challenges and opportunities when exploring the transferability of evidence. We will discuss the balance between qualitative and quantitative evidence when considering how to responsibly consider how evidence transfer between contexts, and highlight a recent project funded by the Centre of Excellence for Development Impact and Learning (CEDIL) that utilise mid-level theory to explore the transferability of evidence portals between different contexts.

A key finding from the network is that while there are elements of sharing best practice and infrastructure that can support evidence-use, the actual implementation of evidence is best owned locally. The future aspiration of the network is to support evidence functions to develop in a growing number of systems that can drive forward evidence generation and use, while benefitting from the shared infrastructure of a network.

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#74 - Assessment of Violence Against Women and Implementing Safe Space Policy for Gender Equality in Nigeria

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Abstract
In recent times women and young girls have been experiencing violence and other related issues affecting their well-being. Violence against women, including young girls, is one of Nigeria's most widespread, persistent, and devastating human rights violations. The report shows that every third woman experiences physical, sexual, or intimate partner violence, is the victim of human trafficking, or is subject to violent social norms. This research will examine Violence against Women and Implementing a Safe Space Policy for Gender Equality in Nigeria. The need to have policies that guarantee safe space for gender equality in Nigeria is also a concern for the global community. Using the qualitative research methodology, the study will engage the use of secondary data from articles, journals, government records, and the Internet. The empirical review of various sources will be done through information content analysis. Finding indicated that, with the wave of violence against women and young girls, the need to curb societal menace is inevitable. Violence against women and girls has created a gap in the realization of gender equality in Nigeria and pushed back the country from attaining the United Nations Sustainable Development Goals. But with the need for action and fights against violence against women in the country, the government and stakeholders must work on implementing the safe space policy that will protect women and young girls from violence, including domestic crime. Furthermore, attaining the needed policies will support gender equality in Nigeria.

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KEYWORDS: Violence, Women, Safe space policy, Gender equality, Nigeria

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#76 - Key Learnings from the implementation of Domestic Abuse Recovering Together (DART)

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Objectives/aims
DART is a therapeutic group work programme which supports mothers and children following domestic abuse. It was originally delivered and developed by a UK charity, the National Society for the Prevention of Cruelty to Children (NSPCC). Following an initial positive impact evaluation, DART was scaled up in other local authorities and small voluntary organisations.

An implementation evaluation of the scale-up of DART aimed to:

- Find out the barriers and facilitators of the implementation of DART

Following adaptions to the model, based on these evaluation findings, a second impact evaluation was conducted which aimed to:

- find out whether or not families attending DART at non-NSPCC sites achieved similar outcomes as those who attended DART at the NSPCC

Methods
- The implementation evaluation was mixed methods, with surveys and interviews conducted with staff involved in DART delivery.

- The impact evaluation used a quasi-experimental design, with two comparison groups. One comparison group consisted of families waiting to attend DART at the NSPCC, and the other was made up of families who

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attended one of the 8 original NSPCC DART services. The intervention group was comprised of the families attending DART at a non-NSPCC site, supported by the NSPCC to deliver DART. Participants completed standardised measures such as the Rosenberg self-esteem scale, Parent-Child Relationship Inventory and Strengths and difficulties questionnaire at two time points.

Main findings
The implementation evaluation identified that although professionals were very positive about DART, there were a number of implementation issues. These included staffing issues, insecure funding streams and other practical and logistical barriers. In response to these findings the NSPCC implementation team made some changes to the programme and implementation process which seemed to significantly improve the uptake and sustainability of DART. These changes included making some of the criteria needed to deliver the model less restrictive and having more rigorous ‘readiness assessments’.

The impact evaluation, conducted after these changes were embedded, found that there were no significant differences between the outcomes achieved with families attending non-NSPCC sites and those who completed the programme at an NSPCC site. There were significant improvements for families who attended DART: an improved mother-child relationship, mothers having greater self-esteem, and children presenting with fewer emotional and behavioural difficulties. These improvements in outcomes were significantly greater than the ‘waiting list’ comparison group. This suggested that NSPCC sites and non-NSPCC sites were equally as effective at supporting these families.

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#77 - Valuing new information: How can we take better decisions about what evaluations to pursue?

Presenting Authors
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Abstract
Do development decision-makers spend too much/too little on gathering evidence? The development community at large agrees that decisions should be based on evidence, but what tools do we have to help decision-makers decide whether new evidence generation activities (like evaluations) are worth the cost?
A small team at IDinsight has been working to turn the concept of value of information (VoI) into a rigorous and practical approach to estimating the value of new research in the international development sector. We suspect that too little is spent on gathering new evidence in some contexts and too much in others because decision-makers rarely base the research funding decision on the question: “how much will our social impact improve based on this information?” Even when new research is clearly valuable, studies are often designed based on defaults for academic studies, rather than optimized for the cost-effectiveness of information given the decision at hand. Our goal is to develop practical methods for reducing the social impact lost due to poor research funding decisions: either the failure to fund research that would be high VoI or the choice to redirect funds from impactful programs to low-VoI research.

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In this session, we will present our approach to calculating the optimal investment in new research given the decision needs at hand and helping decision makers better assess which evaluations are worth pursuing. There will be plenty of time for feedback and discussion on whether VoI approaches are valuable in this context, how our methods could improve, and how we can collectively innovate to ensure funds are directed towards the most impactful research.

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#83 - Guiding interventions for inpatients' shared decision making on antibiotic therapy: a mixed-methods study using COM-B

Presenting Author(s)

1. Angela Chow
2. Huiling Guo

Background

Antimicrobial resistance (AMR) is among the top ten global public health threats facing humanity and is commonly driven by overuse and misuse of antibiotics. Shared decision-making (SDM) with patients has evidently improved antibiotic use in primary care clinics, but antibiotic decisions in tertiary-care hospitals are predominantly made by doctors. Although desired, inpatients are rarely involved in SDM on their antibiotic therapies. We aimed to understand the facilitators and barriers to SDM in the context of tertiary-care inpatient settings, to inform the design and implementation of interventions to empower inpatients to engage in SDM on their antibiotic therapies.

Methods

This is a convergent parallel mixed-methods study. From 2019 to 2022, we conducted in-depth interviews with 23 inpatients purposively sampled with maximum variation from the three largest adult tertiary-care hospitals and a cross-sectional survey on 636 inpatients receiving antibiotic therapy for ≥1 day in the second largest adult tertiary-care hospital in Singapore. The interview guide explored topics related to inpatients' knowledge of and experiences with their antibiotic therapies during the current hospitalisation, including interactions with healthcare professionals pertaining to their therapies. The survey assessed their awareness of being on antibiotic therapy, knowledge of antibiotic therapy received (name of antibiotic(s), dosing frequency, duration, potential side effects), involvement in SDM (7 items adapted from SDM-Q-9 scale), and empowerment in personal healthcare in three dimensions: decisions, interactions with healthcare professionals, and degree of control (20 items from HCEQ-10 scale). Both qualitative and quantitative findings were triangulated and mapped onto the COM-B model to identify areas for intervention.

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Results

One-quarter (23%) of inpatients reported a high-level of involvement in SDM on his/her antibiotic therapy. The capabilities of inpatients to engage in SDM on their antibiotic therapies were limited by knowledge. Although 90% were aware that they were on antibiotic therapy, two-thirds (68%) knew the dosing frequency, 37% knew the duration, but only 11% knew the name of the antibiotic(s) received. Less than one-third (31%) knew that the antibiotic(s) could cause side effects. Majority lacked the skills to actively query their doctors on their antibiotic therapies, with only 24% reported having a high level of interactions with healthcare professionals on their hospital care. One of the cited reasons was the lack of opportunity for interaction with healthcare professionals. Often, inpatients were informed of their antibiotic therapies by nurses during medication administration. Only one-fifth (22%) of inpatients reported a high level of empowerment in decisions on antibiotic therapy. There was a lack of motivation in SDM, due to perceived paternalistic relationship with doctors, trust in doctors' professional know-how and mission to provide best treatment, and perceived lack of medical knowledge to engage in SDM. Interestingly, inpatients who previously experienced allergies or side effects with antibiotics were more likely to question doctors or nurses on their antibiotic therapies.

Conclusion

To engage inpatients in SDM on their antibiotic therapies, inpatients should first be educated on appropriate antibiotic use to build up their capabilities to query and jointly make antibiotic decisions. Potential side effects of antibiotics could be highlighted to stimulate motivation to ask questions about their antibiotic therapies. The hospital environment could also be redesigned to provide more opportunities for active interactions between inpatients and healthcare professionals. Besides doctors, nurses could be engaged as antibiotic stewards to educate inpatients on AMR, the appropriate use of antibiotics, and their specific antibiotic therapies. Furthermore, visual cues (such as badges worn by nurses inviting inpatients to ask questions about antibiotics) could be used to initiate conversations around antibiotic therapies, creating opportunities for interactions and motivating inpatients into engagement in SDM.

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#97 - Adolescent Girls Initiative – Kenya: scaling up evidence-based programming via local governments

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Objectives/aims
The Adolescent Girls Initiative – Kenya (AGI-K) is a multi-sectoral, multi-level program for young adolescent girls ages 11-14 in Wajir County – an area of Kenya along the border of Somalia with very high rates of non-school enrolment and child marriage among girls. An initial cluster randomized controlled trial (cRCT) of an NGO-implemented program conducted between 2015-17, which included community conversations (CC) on gender norms and the value of girls education, a cash transfer (CT) conditioned on school enrolment, and girls empowerment (GE) groups with health, life skills and economic content, found long-term increases in school enrolment and decreases in child marriage among girls who were out of school at baseline (Austrian et al, 2022). A second cRCT was conducted to evaluate the impact of a streamlined version of the original program implemented by the county government. The objective of this study is to a) measure the impact of the government-implemented version of AGI-K on girls school enrolment and b) assess the feasibility, scalability and cost of the government implemented program model.

Methods
A cRCT design has been implemented in a total of 30 villages across six sub-counties in Wajir County. Village level inclusion criteria were: presence of at least one primary school, a functional community health unit and a gender gap favouring boys in primary

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school enrolment of at least 10 percentage points. The remaining 30 villages were randomized at a public lottery with village leadership present to one of three arms: Arm 1) CC+GE, Arm 2) CC+GE+community incentives conditioned on community level school enrolment or Arm 3) CC+GE+CT. The intervention was delivered by Community Health Assistants and Community Health Volunteers via the existing, government run Community Health Unit structures. A baseline survey among adolescent girls and household heads was conducted in April 2022 (n=1107). School enrolment was taken in June 2022, August 2022, October 2022 and February 2023. An endline survey is currently being conducted and will be completed in June 2023. In-depth interviews will be conducted with adolescent girls, parents and key community and government stakeholders in August 2023.

Main findings

While final endline data is currently being collected (and will be available to present by the time of the conference), school enrolment data indicates that among girls who were out of school when the program started, 19% of girls in Arm 1, compared to 55% in Arm 2 and 47% in Arm 3 were enrolled in school at the start of the 2023 school year. In addition, field lessons indicate that government-led implementation is indeed feasible, the intervention can be integrated into the ongoing responsibilities of the community health infrastructure and county level staff can provide sufficient monitoring and supervision. Policy barriers must also be addressed in addition to implementation challenges as well – therefore parallel work to support the passing of a Community Health Services Bill and inclusion of AGI-K in county policy and planning documents has been a critical component of successfully establishing the pathway to scale for AGI-K.

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#98 - Implementing care coordination hubs using improvement practices and a rapid, relevant and responsive evaluation approach.

Presenting Authors
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Objectives/aims
We would like to present on the results of the implementation and service evaluation of an unscheduled care coordination hub (USCCH). Unscheduled care coordination hubs could be a potential solution to overburdened ambulance demand and pressures on accident and emergency (A&E) departments in the UK. They offer a single point of access for unscheduled care where a multidisciplinary team takes calls off the ambulance service call stack and rather than send an ambulance, attempt to provide care to patients in their normal place of residence in less time. The aim is to reduce ambulance conveyance rates and improve patient experience. Implementation science principles along with improvement practices ('tests of change' and 'plan, do, study, act' (PDSA) cycles) were used to implement the care hub. A rapid, relevant and responsive evaluation was carried out to evaluate implementation and aimed to capture the complexity of the implementation process, generate transportable findings and facilitate 'within system learning' and implementation success.

The aims of this study were:

- To develop a process map of the implementation of the USCCH hub model (including the engagement process and the tests of change).
- To capture in detail the complexity of the implementation journey i.e. the interaction between the USCCH, the ever-changing context and the test of change approach

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- To understand what worked well, what didn't work well and identify key practical insights and transportable findings for implementation elsewhere.
- Use the Consolidated Framework for Implementation Research to understand multi-level contextual determinants of implementation.

Methods

For the implementation, a process of engagement was followed by an initial 5-day test of change. This was then followed by three one-month tests of change. For the evaluation rapid qualitative analysis techniques (Stanford Lightning reports) were used to capture 'within system learning' that occurred across the test of change period. Baseline and end-of-study interviews were also conducted. The idea was to capture contextual evidence about what worked well, what didn't go well and any key insights from participants or from our research team on 'how to' practically implement USCCH. Results were consolidated into transportable findings and the Consolidated Framework for Implementation Research was used to understand multi-level contextual determinants of implementation. The methodology therefore presents a combination of improvement science practices and implementation science techniques with the aim of producing transportable findings suitable for use across contexts, systems and cultures.

Main findings

The initial engagement period and the tests of change proved to be an effective approach to implementation. The evaluation proved to be useful in capturing 'within system learning' and producing transportable findings. It also facilitated the implementation effort. High tension for change, relative priority of the intervention, planning, external change agent, and key stakeholder engagement were strong facilitators of implementation while goals and feedback, and political drivers had a strong negative influence.

The combination of improvement practices and implementation science techniques offered an effective approach to implementing unscheduled care provision. Engagement seems to be an important precursor to this approach. It might be a good idea for implementation researchers to move from traditional, top-down research approaches to participatory and embedded implementation research evaluations as

this seems to be a good way to produce transportable findings and practical implementation knowledge.

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#99 - Monitoring the Implementation of a Bespoke Community Intervention to Reduce the Influence of Crime Networks on Children.

Presenting Author
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Country of residence
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Objectives/aims
A minority group of children are responsible for up to 50% of all youth crime in Ireland. These children who typically live in disadvantaged communities are at significant risk of involvement in a criminal network (Naughton, Redmond & O'Meara Daly, 2022). The influence of crime networks on children's offending behavior is a significant global social issue (Coliandris, 2016; van Dijk et al., 2022), necessitating state intervention (e.g., Victoria State 2018 amendment to Crimes Act 1958- SECT 321B). The Greentown Project is data-driven and builds on a gap for evidence-informed programs that intervene with child grooming for crime by coercive criminalized adults. Greentown is a partnership between the Department of Justice and the University of Limerick.

Methods
Phase 1: To gain insights into this societal challenge, an innovative research design, *Twinsight*, was developed. A network map produced by social network analysis using police crime and intelligence data was used as a tool to capture the expertise of local police confidentially. This provided an understanding of the architect of local crime networks and the mechanisms used to recruit and retain local marginalized children into the crime network. A comparative analysis of three case studies identified that the structure and mechanisms of crime networks could differ depending on the local context (Naughton et al., 2022).

Phase 2 involved a deliberative design process informed by the 'wicked problems' literature (Rittel & Webber, 1973). The design team included social workers, youth justice and community workers, law enforcement, probation and child protection and

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international academic experts. Informed by the project's research findings, the team designed a multi-pillar program integrating child welfare, community development and tactical law enforcement. Safeguarding vulnerable participants was at the fore of the program. The model allowed for adaptation depending on the local context.

Phase 3 involved the trial of the intervention in two high-crime locations, one a large urban area and the second a large town. The research team worked closely with the service providers to provide scientific support and monitor the initial implementation of the intervention. Adaptions to the model (necessitated by the developmental nature of the program and the dynamic and chaotic environment) were documented using Hickmann et al. (2006) 's logic, assumptions, and risk framework matrix. In a participatory approach, the services manager recorded quarterly facilitated discussions with their project team on the progress of young people and their families through the program, providing a longitudinal narrative on the program's operation. Regular meetings of the local advisory committees (representatives from police, probation, child welfare, service providers, local CBOs, the Department of Justice, and the research team) were recorded. These provided data on program oversight, local challenges and problem-solving initiatives. Reach was determined by matching the children referred to the program with those identified using the Twinsight methodology.

Main findings

Case studies of young people provided insights into the young people's context and the program inputs, activities, mechanisms, outcomes, and impact. A progress report outlined: What was supposed to be done; What was done and why; What was different and why; What challenges were faced; and What remains to be done, for each trial location. Barriers and enablers due to local context were identified (e.g. (non) pre-existing interagency relationships that (dis)enabled data sharing and collaboration). Currently the research team are codesigning the second phase of the program's outcome and process evaluation with the service providers to determine contribution.

#105 - Agile and adaptive processes for ethical practice in prototyping: Reflections from a system change focused place-based initiative

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Presenting Authors
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We wish to acknowledge The Auckland Co-Design Lab and The Southern Initiative, especially Dr Penny Hagen for her guidance and generosity in helping us navigate this work over several years.

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Aotearoa/New Zealand

Objectives/aims
The SASWB has well-established relationships in the social sector space within South Auckland, New Zealand as it fulfils its purpose of influencing strategic system change to enhance whānau wellbeing in response to local learning. These positive relationships are enabled by a lean but effective implementation office (IO) at the SASWB which provides a 'back bone' function, including the generation of local evidence and insights, and the communication of learning to inform new ways of working and system change.

The SASWB has an iterative 'test, learn, adapt' way of working which does not align neatly into existing operational service delivery models or traditional research frameworks, and it became evident that this 'prototyping' way of working is not enabled by standard ethics processes. To work meaningfully with whānau (families) and communities experiencing multiple stressors, and our system partners, our learning and implementation methodologies need to be agile and responsive to what whānau and communities are telling us matters most to them. This means that our ethics approval processes must also reflect this responsivity and adaptive approach – a static ethics application form for a specific programme/intervention is not fit for purpose in our context. The aim of this presentation is to describe the adaptive ethics approval processes and way of working that was developed, illustrated through reflections by Evidence and Insights practitioners in the prototyping space.

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Methods
The SASWB worked with another place-based initiative and one of our partner organisations, The Auckland Co-Design Lab and The Southern Initiative (TSI) at Auckland City Council, to assist with the development of ethics-based practices and ways of working with whānau experiencing multiple life stressors. We received endorsement to ethically prototype through a supportive and accessible relationship with the New Zealand Ministry of Social Development (MSD) Ethics Panel. This allows the IO to seek advice and straddle multiple structures, systems, and stakeholders to prototype and embed meaningful change for whānau, drawing on formal ethical guidance and advice where required.

Main findings
Reflections from Evidence and Insights practitioners describe some of the benefits of this approach to guiding safe and ethical practice in complexity and the prototyping space. These advantages will be illustrated in the presentation with specific reference to our prototypes.

Flexibility
This has been a more adaptive and dynamic process compared to standard ethics approval processes that are frequently non-flexible (for example, submitting a lengthy ethics application form to a committee detailing highly specific procedures that cannot practically be followed in the test-and-learn space). The approach of an ongoing dialogue and working relationship with the Ethics Panel enables adjustments to the agreed-upon process to be made, based on evolving circumstances and emergent opportunities.

Fit-for-purpose
The approach encourages genuine and meaningful engagement with whānau (family) and other stakeholders in the consenting process. Instead of focusing heavily on the provision of documents (e.g., wordy consent forms and participant information sheets) to grant ethics approval, as is often the case with traditional ethics committees, the entire ethical approach is discussed with the Ethics Panel, including, for example, an emphasis on genuine ongoing authorising conversations with whānau (families), with supporting materials such as infographics.

Customisability
Recognising that a one-size-fits-all ethics approach is not suited to all the work of the SASWB, the flexible approach we have adopted allows for tailoring to the specific needs and context of those participating in individual prototypes (for example, we may

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need to use different consenting processes for whānau than we would with staff members of government agencies). Our Ethics Panel is composed of individuals with diverse backgrounds who contribute to the ethical considerations of prototypes from a variety of perspectives.

Adaptability
The approach encourages regular meetings with the committee to discuss any challenges or issues that arise during our general mahi (work) rather than focusing on individual projects. This provides the opportunity to modify the approach based on evolving needs, changes in the scope of our work, or insights gained through ongoing conversations between Evidence and Insights Practitioners, whānau and our government agency partners.

Impact on prototype and systems development
The use of this flexible ethics approach has a direct influence on the work taking place in prototypes, and on the wider system through our "test, learn, adapt (and embed)" process. For example, ethical requirements for robust data management have shaped approaches to data-sharing systems on prototypes, which will in turn influence these processes at a systems level.

These advantages will be illustrated with reference to specific examples from our prototypes.

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#106 - Start Well: Supporting parents and whānau (families) experiencing psychosocial distress

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Start Well was established in November 2017 as one of the prototypes of the South Auckland Social Wellbeing Board (SASWB); a cross sector Place Based Initiative in South Auckland focused on learning from prototypes to drive system change and to inform insights for equity. Enabled by a low ratio co-worker model: expert paediatric nurses and senior social workers work collaboratively and closely with whānau (families) to understand their needs and aspirations, at a pace whānau set themselves. Start Well is a relationship based model of care for young mothers and their whānau, beginning in pregnancy and continuing until their children are aged at least five. It is a whole-of-whānau life-course approach to health and social support in the early years.

SASWB and Start Well partnered with a local primary mental health care provider, Fresh Minds, to provide flexible, responsive psychological support to Start Well whānau through a life-course approach, in a place of comfort chosen by whānau themselves. An integrated, whole of systems approach was used - reorientating resources towards what matters most to whaanau; including coordinated strengthening, healing and prevention activities that were led by whaanau, provided in the context of their existing trusted relationship with the Start Well team, and included shared care planning between the Start Well team and the Psychologist.

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Whaanau psychosocial needs were also supported in this holistic relationship-based way of working by traversing the spectrum of psychosocial distress, mental health, trauma, child development (e.g., foetal alcohol spectrum disorder) and parenting and attachment in a home-based setting or place of safety (vs attendance at parenting programmes).

Methods

The following learnings have been collected from the start of the prototype (July 2019) alongside the Start Well/Psychologist team through various mechanisms:

- Quarterly reporting by Psychologist (July 2019 - September 2020)
- Evidence and Insights interviews with Start Well staff and psychologists throughout the prototype (2019 - 2022)
- Whaanau experiences and voice have been expressed through Start Well staff and their relationships with whaanau (2019-2022)
- Discussions with the wider Start Well team, SASWB team & Agency Change Leads and our SASWB partner agencies about systems opportunities (2022-2023)

Opportunities from these learnings have been linked to wider insights in the early years and systems change space as well as broader SASWB prototype learnings.

Main findings

Overall, staff and whaanau have found significant value in the integrated psychosocial support approach. The support provided has met a need for whaanau who are unlikely to seek out clinic-based support for psychological / psychosocial distress due to system barriers. Support has traversed the spectrum of mental health, alcohol/drug, child development (e.g., FASD) and trauma, which is traditionally siloed across the system - with differing assessment, diagnosis, primary and specialist care, and multiple agencies involved e.g., Health, child protection, Accident Compensation Corporation, Corrections.

The key features of the psychological support prototype that have enabled this way of working include:

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- The psychologist being 'part of the team' (ideally from the start) - adapting roles to ensure needs can be met by a trusted team, instead of a referrals model to multiple services
- Being able to work in a 'whole of whaanau' way vs individual-based therapies
- Outreach approach that enables staff to go anywhere to meet whaanau in whaanau-determined safe spaces. This has resulted in higher engagement for Start Well whaanau compared to traditional services
- Having a dynamic approach to understanding whaanau needs and aspirations vs a more static psychosocial assessment and response
- Flexible working and modes of communication
- Coaching for frontline staff to grow capability and resilience for working in relational ways with whaanau experiencing multiple stressors - this goes past traditional supervision approaches.

The Start Well co-worker model approach also demonstrates the importance of the frontline team being able to share responsibility, soundboard and 'decompress' together. This has provided whaanau with confidence of continuity of support. Adoption of some of the key features of this approach in other health and social spaces, could enable supports that are more equitable, meaningful to whaanau experiencing multiple psychosocial stressors in the early years, and better suited to their needs and aspirations.

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#128 - Key Drivers for Success: Implementing a Motivational Programme for Offenders in Singapore Prison Service.

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Objectives/aims
Looking Forward is a brief motivational rehabilitative programme delivered to offenders in Singapore Prison Service. This group-based programme is conducted by correctional officers who play a rehabilitative role in offender change. The programme facilitates a better officer-offender relationship, which is a crucial factor in offender management and rehabilitation. After the pilot of Looking Forward in SPS, the larger-scale implementation of Looking Forward in 2019 referenced the Active Implementation Framework (NIRN) (n.d.).

The process evaluation on the implementation of Looking Forward aimed to examine the facilitators and barriers which influenced implementation outcomes.

Methods
This submission will focus on the qualitative findings of the implementation evaluation. The submission will highlight the implementation barriers key implementation strategies which contributed to the successful implementation of Looking Forward (“best bets”), and revisions that were undertaken to improve the adoption and sustainability of the programme.

Main findings

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Looking Forward contributed to multiple intra- and interpersonal benefits for offenders such as increasing their motivation to change, preparing them for future group sessions and improving relationships between offenders and staff. While challenges in implementation were evident such as competing demands placed on group facilitators and fatigue, there were three key implementation drivers of note. **Training and coaching (competency drivers), facilitative administration (organizational drivers)** and **leadership** were identified to be essential for the successful implementation of Looking Forward.

The comprehensive training package designed to equip staff with knowledge of LF and skills and the ongoing coaching framework to ensure that staff received regular supervision and coaching, increased quality in their day-to-day delivery of the initiative. At the organizational level, the facilitative administration provided by coordinators ensured that staff's feedback was taken into consideration in shaping the processes within the institution. Finally, the leaders in some institutions set up processes and systems within the institution to facilitate the running of LF, such as purposeful allocation of manpower and scheduling of LF sessions with backup sessions planned for. During the focus group discussion sessions, it became evident that those who had such environmental supports within their institutions expressed a preference for the system they had and felt that it was easier to perform their role as a facilitator more effectively.

Leveraging on improvement cycles as part of the active implementation framework, several refinements were made to improve the programme, strengthen the implementation drivers and address the implementation barriers to improve the adoption and feasibility of the implementation of LF. For instance, platforms were instituted to further support and develop facilitators, and leadership involvement was further galvanised.

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#130 - Advancing new approaches to implementation process measurement

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Objectives/aims
We aim to demonstrate the integrated use of process measures and implementation frameworks using the Exploration, Preparation, Implementation, Sustainment (EPIS) framework and Stages of Implementation Completion (SIC) process measure. We also discuss the wide-ranging implications of this approach for implementation research and practical implementation work, such as improved implementation planning and enhanced empirical study of implementation mechanisms.

Methods
EPIS phase definitions from two foundational EPIS papers were extracted and parsed for key markers and activities that delineated the phase. SIC activity definitions were drawn from the Universal SIC codebook and matched to EPIS phase definitions, allowing for SIC activities to be sorted into EPIS phases. Example definitions of SIC activities in relation to their functional purpose within the EPIS implementation process were generated.

Main findings
Results provide practical guidance on using SIC to provide more nuanced assessment of moving through the EPIS phases. This analysis yielded outcomes mapping SIC activities/stages to EPIS phases and EPIS determinants to SIC activities. This study advances implementation science by better articulation of implementation process and underscores important future directions for framework-measure integration.

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#131 - Kailo: supporting local efforts to address the social determinants of young people's mental health.

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Objectives/aims
Research on the social determinants of health has created a crucial framework for understanding how complex social, economic, and environmental factors can affect people's health. This is variably used to inform macro-level policy and research activities. However, there is limited understanding of how these social determinants manifest at the local level (i.e., local government and community level), the contextual factors that influence what can be done at this level to affect change, and how this impacts social inequalities.

Kailo is a programme of research and design that aims to work with local communities, young people and public service partnerships to understand the local determinants of young people's mental health, and inequalities associated with them, to co-design contextually relevant, evidence-informed responses. This presentation will explore the key findings from the early implementation of the Kailo programme in two areas of the UK (a rural and an urban context). If not pre-recorded the presentation will include Mentimeter (live-voting tool) questions to allow greater audience engagement.

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Methods

Kailo utilises a complexity-informed research and design approach that aims to support young people and community members in producing systems-level change to improve adolescent mental health. The programme has three key phases: (i) Early Discovery, (ii) Deeper Discovery & Co-design (iii) Implementation & Adaptation.

Over a period of twelve months, the Kailo team held a number of participatory research and design engagements with young people and community members living and working in two distinct community contexts in the UK. Overall, we spoke to over 400 individuals through multiple cycles of inquiry to identify key locally relevant priorities for co-design to support young people's mental health.

Various approaches were used to ensure the programme was focused on the needs of young people disproportionately impacted by the negative impacts of social determinants in each area. This included system and power mapping, qualitative and exploratory engagements with young people and community partners (ad-hoc street engagements, workshops and interviews). Engagement approaches ensured a focus on unheard voices, surfaced through consultation of community members and consideration of extant literature on young people disproportionately impacted by poor mental health outcomes.

Main findings

The process of identifying local priorities has highlighted the complex influence of multiple local factors on young people's mental health outcomes. The Kailo team used community-based participatory research to long-list 8-12 interconnected emerging priorities in each area, which were then reviewed, refined, and further prioritised down to two or three key priorities, through various cycles of engagement with community members. In the rural community context (Northern Devon), these included consideration of how to (i) promote mental health literacy; (ii) foster a sense of identity and belonging; and (iii) awareness, access and creation of a more diverse range of future opportunities. In the urban context (Newham in London), priorities included: (i) youth and community safety and trust; and (ii) inclusion and exclusion in school.

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Through this process, community members identified specific facets of inequality that were considered when narrowing priorities, including: (i) young people who were not involved in their practice or service; (ii) those not represented in academic research; (iii) socioeconomically disadvantaged or marginalised groups; (iv) geographically isolated groups; and (v) groups with high levels of vulnerability and exposure to mental health issues.

The approach taken by Kailo allowed for flexibility and continual awareness of the needs of the local population and emphasised the importance of young people's voices in spaces where unequal power dynamics can exist, allowing for their perspectives to be heard and topics to be identified that may have been overlooked by many community professionals but are deemed important by young people for their health and wellbeing.

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#146 - Innovating the delivery of allied health services for primary schools in rural and remote Australia

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Country of residence
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Objectives/aims
Changing educational outcomes, engagement and wellbeing for geographically isolated school communities requires trust, workforce and technological capacity, specialist expertise and skill.
This project harnesses the trust and deep relationships Royal Far West has developed over 97 years of addressing the health and education needs of country kids. By bringing this mix of expertise, relationships and resources together as a single offering for school communities that cannot currently or consistently access cohesive and integrated support, we will pilot a unique support program that aims to be deep, broad, and impactful.
This project pilots wrap around services provided by a multidisciplinary team throughout the 2023 calendar year. The multidisciplinary team works closely with each participating school community to recognise and address the combined impacts of developmental vulnerability, disadvantage, and trauma, and the impacts of Covid-19 for their community. To address these impacts allied health services, speech pathology, occupational therapy, psychology and social work, are delivered to primary schools using the response to intervention framework. The pilot aims to operationalise these services to support the scalability of wrap around allied health services to schools in rural and remote Australia. The pilot is being completed in 5 primary schools across NSW, QLD and Vic.

Methods
A consistent clinical team supports each school via intensive twice-yearly visits, complemented by consistent care via telehealth.

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Examples of services include:
• developmental assessment services, identifying & supporting children with, or at risk of, developmental challenges and mental ill health
• intensive individual allied health therapy for children with specific needs
• group allied health & wellbeing programs to strengthen overall classroom learning environment, build individual & cohort resilience, support trauma recovery
• capacity/skill building for parents/carers & teachers, enabling them to better support the children in their care

These are being reviewed via an evaluation plan which collects both qualitative and quantitative data to measure the impact and outcomes for individuals, families and whole school communities. Each school has formulated three achievable goals with the multidisciplinary team to measure the success of the program for the school community. These goals are tailored to their current needs as a school community and co-designed to ensure expertise of the multidisciplinary team can support the school community.

Main findings
Initial findings that are including the implementation of the pilot include:
• Face to face visits to the school community are important for building relationships for continuity of care supported by a telehealth model.
• Short professional development opportunities have been highly valued by school staff.
• Schools are diverse in what they see as priority areas and being able to adapt to this requires robust systems and procedures.
• Developing a framework to be able to tailor services to each schools needs is a crucial step to ensure that delivery of services is high quality and responsive.
•A remote and diverse workforce is incredibly valuable to developing creative solutions within project limitations. Connection, communication and skill development of the multidisciplinary team is crucial to the success of the project.
• The multidisciplinary team enjoy working in this dynamic way and establishing relationships with internal and external stakeholders, to overcome challenges, has contributed to the satisfaction of this way of working.

PRE-RECORDED ORAL PRESENTATIONS

#158 - Implementing the brief intervention toolkit at headspace Wollongong. An implementation case study

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Objectives/aims
Referrals to **headspace** centers have notably increased since their inception, both in relation to total numbers of young people and those with greater complexity of needs (Hilferty et al., 2015). With increasing demand for youth mental health services, headspace centers are exploring strategies to respond to increasing waitlists for youth mental health services. The 'Brief Interventions Clinic' (BIC), which provides brief interventions for mild mental health symptoms, was identified by service leaders as a promising strategy for facilitating timely access to care at headspace centres.

The aim of this project was to explore factors that supported the implementation of a brief intervention clinical service model from the perspective of service staff and leaders at a primary youth mental health service (headspace) in Wollongong, Australia. In partnership with headspace Wollongong, Orygens Knowledge Translation team, who drive translation of research into evidence-based practice, explored and mapped the behavioural drivers, contextual factors, and strategies involved in implementing a sustainable brief intervention clinic. The goal in identifying

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these factors would then be used to inform other services who are considering using a BIC as a waitlist management strategy in their local context.

Methods

The project used a structured, collaborative approach to understand and map strategies involved in implementing Brief Intervention Toolkit at Wollongong headspace.

Key service staff were identified who were involved in implementing and delivering the brief intervention clinic. Participants were invited to partake in interviews facilitated by a member of the Orygen Knowledge Translation team via Zoom. Interview questions were designed using the Exploration, Preparation, Implementation and Sustainment framework and the Consolidated Framework for Implementation Research to identify key phases and strategies that were used during implementation of the BIC. Interviews were transcribed and thematically analysed by members of the Orygen Knowledge Translation team using a combined inductive and deductive approach.

Interviews were conducted with the following people at headspace Wollongong, over February 2022

- Former clinical service manager
- Clinical lead
- Brief Intervention Stream co-ordinator
- Intake clinician

Main findings

There were four key factors identified from the interviews that were reported as supporting successful implementation of the brief intervention clinic at Wollongong headspace. These factors included:

- Scoping and adapting to context.
- Approach to staffing.
- Leadership engagement.
- A whole service approach.

Participants highlighted the importance of local context in the implementation process, with service staff emphasising the value of aligning with – and leveraging – other initiatives occurring in the system. Finidngs show how an evidence-informed model could be both rigorous and flexible in adapting to local resourcing and service

processes.

The identification of factors that supported the implementation of the BIC at headspace Wollongong may assist other headspace centres considering using this as a waitlist management strategy to improve service access for young people seeking mental health support in Australia. Despite the varied local contextual factors across national headspace services, using implementation theory to understand the contextual factors and strategies that helped to support implementation and sustainment of the BIC provide key considerations for services seeking to implement this model.

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#167 - Using a web-based expert-system to help spread the TREAT journal club format into clinical services.

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Objectives/aims
A structured journal club (JC) format, TREAT (Tailoring Research Evidence and Theory) was co-designed by researchers and clinicians in 2016. TREAT uses 12 evidence-based components to enhance a JC's effectiveness tailored to the local context. A 7-year program of research progressively developed and refined the TREAT JC format. TREAT was shown to improve individual allied health clinicians' evidence-based practice skills and lead to changes in clinical practice within a large Australian health service. The next progression of the TREAT format was to make it available beyond the local setting. Thus, the current research explores the effectiveness and feasibility of implementing a web-based expert system to spread TREAT JCs to health professionals globally. This presentation will focus on the process of developing the web-based system and provide preliminary results regarding its effect in spreading the JC format.

Methods
The Knowledge to Action cycle was used to inform a mixed methods research project to develop the web-based TREAT system and evaluate its spread. Firstly, we took an agile approach to develop the system, with iterative feedback from a group of multi-disciplinary consumers. Secondly, the reliability of the web-based system was assessed. JC implementation strategies suggested by the web-based system were compared to the original TREAT's 'in person' process following identical responses to a customised questionnaire to help understand JC culture and context. Agreement between the web-based and 'in person' formats were analysed descriptively and by Cohen's Kappa. To assess spread, we collected website analytic measures. Interest

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and usage were assessed from visitor numbers, geographic location, number of resource downloads, and number of registered users and the demographics of the users and their JCs.

Main findings

A group of 10 consumers from nursing, allied health and medicine provided feedback regarding the design, content and functionality of the web-based system and its associated website (www.treatjournalclubs.com) which launched in January 2022. Reliability of the web-based system to generate tailored implementation strategies was assessed iteratively using questionnaire responses from three consumers. Preliminary results suggest excellent agreement with a kappa estimate between 0.78 to 0.95. At the time of abstract submission, the treatjournalclubs.com website had 3200 unique users visit the website from 49 countries. Two hundred users registered a JC through the website mostly from Australia or the United Kingdom, with users representing over 13 professions including allied health professionals, nurses and doctors. Approximately 134 registered users accessed the web-based expert system to yield a tailored implementation plan for their JC with evidence of 1920 downloads of resources. Sources of traffic were predominately direct or from organic search or social media. Further updates regarding spread will be provided.

This study highlights the impact and feasibility of using a web-based approach to spread an evidence-based intervention internationally to multiple professions. Lessons learnt through the development and implementation process will be discussed. Further evaluation of the impact of the JCs implemented through the website are currently underway.

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#174 - Efficacy, scale-up and sustainment of the Get Outside, Get Active program in early childhood services

Presenting Authors
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Country of residence
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Objectives/Aims
The presentation will describe a program of work consisting of findings from three randomised controlled trials (RCTs). The trials will describe the process of establishing an effective intervention, developing implementation and scale-up strategies and planning for sustainment. The specific aims are:

1. To describe the impact of a scalable intervention (increasing outdoor free play time) delivered in early childhood and education care (ECEC) services on childcare physical activity
2. To describe the development and impact of a scalable dissemination and implementation strategy to increase the amount of outdoor free play time in ECEC post-intervention.
3. To describe the development and pilot evaluation of a strategy on sustaining increased indoor-outdoor free play opportunities in ECEC.
4. To summarise the learnings from this program of work.

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Methods

This presentation describes a program of work consisting of three RCTs describing the efficacy, implementation and sustainment of the Get Outside, Get Active program in ECEC centres. The first RCT seeks to establish the efficacy of increasing outdoor free play time in ECEC centres on child moderate to vigorous physical activity. This cluster RCT trial was undertaken with 439 children recruited from 10 ECEC settings. The primary outcome was the mean daily minutes that children spent in moderate-to-vigorous physical activity (MVPA) while in care, assessed using accelerometers. Following this, we undertook a parallel group RCT with approximately 100 ECEC settings to identify effective implementation strategies to increase the provision of outdoor free play at scale. The primary outcome for this trial was fidelity, operationalised as mean minutes that ECEC services provided children with the opportunity for outdoor free play per week. This was assessed using a Free Play Record, adapted from existing ECEC measures of outdoor play. Secondary outcomes included level of educator interaction with children during outdoor free play as assessed using the Movement Environment Rating Scale (MOVERS). Lastly, we designed a low-intensity sustainment strategy to ensure ongoing provision of indoor-outdoor free play opportunities in ECEC settings. The trials were prospectively registered and reported consistent with the CONSORT and CONSORT-pilot guidance.

Main findings

Overall, this presentation will describe the process of moving from efficacy to scale-up and reflect on our learnings from this program of work. It will briefly include the processes for selecting the intervention and implementation strategies, and describe findings from the RCTs described above. The first RCT found that the intervention significantly improved child MVPA when attending care (p=0.03), with no significant observed adverse effects. In the second RCT, the process for selecting a scalable implementation strategy will be described and preliminary findings reported (between group differences of approximately 25 minutes of increased outdoor free play time, p=0.04). Lastly, we will describe the development and evaluation of a pilot RCT examining how to ensure the sustainment of indoor-outdoor free play opportunities.

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#177 - Scaling up an intervention to improve the implementation of nutrition guidelines in ECEC centres

Presenting Author
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*If your abstract is accepted, all presenting authors must register for summit in order for your abstract to appear in the program. For a panel, please list all panel members.

Country of residence
Australia

Objectives/aims
The presentation will describe the process of scaling up of an implementation strategy to improve the provision of healthier foods in early childhood and education care (ECEC) centres. The specific aims are to describe:

5. the barriers and enablers to planning healthy menus in ECEC centres consistent with nutrition guidelines.
6. findings from a three-arm RCT of different intensity implementation strategies to improve menu planning in ECEC centres
7. the process of adapting, developing and evaluating an online menu planning tool to support scale up of the strategy.

Methods
This presentation describes a program of work seeking to scale up an implementation strategy to improve the provision of food consistent with nutrition guidelines for ECEC centres. It will firstly describe findings from a systematic review and quantitative survey based on the Theoretical Domain Framework, assessing

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barriers and enablers to provision of healthier foods on ECEC menus. This is followed by a presentation of the results from a three-arm RCT with 75 ECEC centres. The RCT aimed to assess the impact of different intensity implementation strategies on provision of foods on menus, assessed using a detailed menu audit by two trained dietitians. Following this, the presentation will describe the process of adapting and developing an online menu planning tool incorporating the effective components identified via the RCT. Lastly, we will describe findings from the evaluation of the online menu planning tool via a Type 2 Hybrid RCT and outline the broad reach of the tool.

Main findings
Overall, this presentation describes the process of scaling up an implementation strategy to improve provision of foods consistent with nutrition guidelines in ECEC centres. Our barriers assessment found that the key barriers related to social influence, environmental context and resources, knowledge, skills, and beliefs about consequences. Using this information, we designed two strategies (high intensity and low intensity) to target these barriers and evaluated it in a three-arm RCT. Our RCT found that the high intensity strategy improved provision of food relative to control, while the low intensity intervention did not. These findings were used to inform the development of an online menu planning tool. The evaluation of this tool found that centres in the intervention arm had improved provision of food and improved child dietary intake. Funding was obtained for broader dissemination of the intervention in 2017 and 2019, and initial data in 2019 suggested over 4000 centres registered to use the program.

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#179 - Pathfinding, peace-making, power, and passion: experiences of facilitation during implementation of Canada's recovery guidelines

Presenting Author
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Country of residence
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Objectives/aims
We build on a 5-year project to implement Canada's mental health recovery guidelines using the co-produced Walk the Talk Toolkit (https://walkthetalktoolkit.ca). Facilitation is explored from multiple stakeholder perspectives to embed lived experience within the Toolkit, enhancing appeal and inclusivity.

Methods
This pan-Canadian qualitative study explores facilitation as an active and ongoing process propelling the work of mixed implementation teams. 40 interviews with facilitators, alongside those who use and deliver services across 7 mental health organisations, examined improving facilitation from each stakeholder's perspective, during planning, implementation, and coaching. Thematic analysis reveals what is important to stakeholders during facilitation, and how this can be used to enhance the experience and outcomes of future implementation efforts.

Main findings
Findings revolve around themes of people, process, pitfalls, and payoff. A safe space for those in recovery to engage in implementation is necessary. Laying the groundwork for implementation within the context of frontline work is advised for facilitators, as is preparation for contributing to implementation work for service-users and providers. Conviction, cultural competence, and a nurturing approach are valued facilitator attributes, complemented by skills such as navigation, marshalling, troubleshooting, firefighting, and cheerleading. Establishing parity amongst stakeholders, striking a 'sweet spot' between being directive and

enabling, are helpful during coaching. Momentum and motivation are improved via the prospect of tangible outcomes at an individual and organisational level. Culture, rather than gender, influences implementation team dynamics. Despite efforts to de-mystify the CFIR, the language of implementation science remains baffling to many.

Co-producing implementation toolkits needs meaningful engagement at all stages involving all stakeholders. Generating ownership during coaching improves success of recovery-oriented interventions, but a shift in leadership can be challenging. Engaging in successful implementation can initiate a legacy of change at an individual and collective level. Work with equity deserving groups including indigenous and LGBTQ+ communities to improve cultural inclusivity is underway. Scaling up across international health and social care is planned.

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#181 - Strategies to implement evidence-informed practice at an organizational level: Findings of a rapid review.

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Objectives/aims
The capacity of public health organizations to realize evidence-informed decision making (EIDM) and to implement evidence-informed practices (EIPs) varies considerably from organization to organization across Canada. The National Collaborating Centre for Methods and Tools (NCCMT) conducted a rapid systematic review to describe and synthesize what is known about strategies to implement EIDM. This review includes evidence from studies exploring the implementation of EIDM processes as well as EIPs, with an intent to support public health organizations in change efforts to practice in an evidence-informed way.

Methods
Relevant studies were identified through a systematic search of the evidence in addition to a targeted search of key author publications. Studies were systematically screened, appraised for methodological quality, and key data relevant to the review objectives was extracted. The COM-B model for behaviour change, where capability (C), opportunity (O) and motivation (M) influence behaviour (B), was used to organize and report study findings.

Main findings
A total of 59 studies were deemed relevant and included in this review. Of these, 38 were studies of EIDM implementation and 21 were studies of EIP implementation.

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Common strategies utilized in both EIDM and EIP approaches include establishing specialized roles, providing staff education and training, developing processes or mechanisms to support new practices, and demonstrating leadership support. Due to the heterogeneity of included studies, it was not possible to discern which implementation strategies for EIDM or EIP are more effective.

Facilitators and barriers identified for EIDM and EIP align with the COM-B model for behaviour change. Facilitators for capability include the development of staff knowledge and skill, establishing specialized roles, and knowledge sharing across the organization, though staff turnover and subsequent knowledge loss was a barrier to capability. In terms of opportunity, facilitators include the development of processes or mechanisms to support new practices, forums for learning and skill development, and protected time, and barriers include competing priorities. Facilitators identified for motivation include supportive organizational culture, expectations for new practices to occur, recognition and positive reinforcement, and strong leadership support. Barriers include negative attitudes toward new practices, and lack of understanding and support from management.

In consulting evidence to inform EIDM and EIP, it is important to understand if these public health programs reduce inequities rather than widen them. Where the evidence base does not adequately determine the impact of programs on such groups, EIDM and EIP efforts should likely not proceed until it is clear that inequities will not be widened by their implementation.

The assessment of this evidence also provides insights related to research designs. For example, randomized controlled trials are not always well-suited to evaluate strategies promoting EIDM and EIP implementation. There is opportunity however, to conduct rigorous single-group studies, such as prospective cohort analytic studies using validated measures, or qualitative descriptive analyses of case studies with thorough descriptions of interventions and context, to inform future initiatives in this field.

Overall, despite the similarity of EIDM and EIP implementation challenges, both use distinct strategies for implementation. The facilitators and barriers described in the

included studies provide insight for planning and realizing greater implementation success in the future.

PRE-RECORDED ORAL PRESENTATIONS

#184 - From Composition to Function: Combining Theory of Change, Realist Evaluation and Contribution Analysis

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Objectives/aims
Evaluations that begin with a theory of change or logic model risk generating evidence on the 'boxes' in their theory rather than the 'arrows' connecting them, on their composition rather than their function. This limits their ability to unearth and interrogate explanations of how, why, for whom and in what contexts programmes work, to help those in policy and practice understand the places and people interventions are most likely to work with. Alongside partners from the Universities of Exeter and Plymouth, Dartington is strengthening its ability to conduct explanation-driven evaluation by combining Theory of Change with Realist Evaluation and Contribution Analysis in two formative evaluations of complex interventions supporting children and young people.

Methods
We developed a theory of change made up of four sub-theories, each focused on different stages of the change process: implementation, intermediate outcomes, ultimate outcomes and unintended consequences. Each sub-theory was summarised by a hypothesis statement made up of four components, drawn from Dalkin et al.'s amended Context-Mechanism-Outcome (CMO) configuration, the building block of Realist Evaluation (2015): "(1) If a **Mechanism Resource** is introduced (2) then an **Outcome** will occur. (3) This is because the resource will lead to a **Mechanism Response** among a particular group. (4) This will be influenced by **Context**." Each component was then defined in detail, both functionally (what it *did*) as well as well as compositionally (what it *was*) (see Figure 1).

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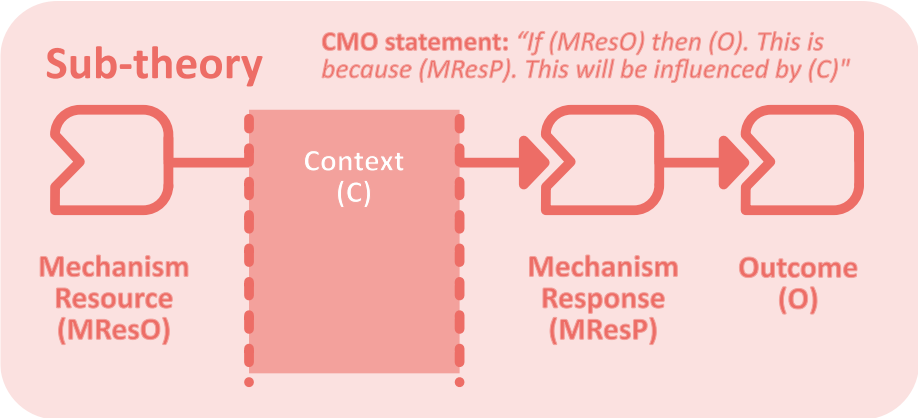

Data collection, analysis and synthesis were then structured to arrive at 'contribution claims' for each sub-theory. These are tools from the Contribution Analysis field that enabled us to evaluate not just whether a theory component occurred, but the degree to which each component functioned as expected by contributing to proximal components. Each claim was assembled by compiling evidence on the extent to which:

1. The Outcome happened…
2. …Due to the Mechanism Response…
3. …Which was due to the Mechanism Resource…
4. …The link between which was mediated by Context…

Figure 1: Structure of each sub-theory within the theory of change

5. … With rival influences having been considered.

Main findings

Realist Evaluation oriented the team towards examining the underlying features and functions of mechanisms and contexts, as well as their composition – their physiology, as well as their anatomy. This introduced greater stability into the programme theory, by enabling it to hold and provide a means of interpreting a range of experiences among programme participants without this variety undermining the theory's validity. For example, an important contextual factor in both studies was the expectations placed on young people, and the strength and alignment of these expectations to programme principles. Their source – whether from family, school, or society – could

(and did) vary considerably. Gathering evidence on function thereby supported the accumulation of useful and transferable learning.

Theory of Change offered solutions to areas where Realist Evaluation has been found wanting, including retaining a focus on the intervention as a whole and providing a visual and more accessible format for engaging delivery partners in theory development.

Contribution Analysis offered a means of operationalising this function-focused theory; it introduced a systematic approach to gathering evidence on the relative contribution of the interventions and other influencing factors to results, a challenge observed in both Realist Evaluations and those based on theories of change. It also focused our attention on rival influences (something theory-driven evaluations often overlook) and allowed us to gather evidence on the interventions' promise, despite the lack of comparison groups.

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#189 - Supporting Parents in Children's Early Learning: Families Connect Evaluation and Impact results

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Objectives/aims
Families Connect is a programme developed by Save the Children UK (SCUK) to support and engage parents in their children's learning in the home and build relationships between parents and schools.

The independent evaluation aimed to provide evidence of programme impact and effective implementation to feed into further development of Families Connect and wider parental engagement work in the early years.

Methods (Oral presentation online with slides with 3 presenters, one from SCUK, NFER & QUB)

A randomised efficacy trial explored a range of parent and child outcomes and an implementation process evaluation provided the methodological framework for the evaluation.

The evaluation involved four strands: 1: Secondary analysis of existing data. 2: Small-scale efficacy RCT: randomisation of 483 families in 31 schools across UK; focusing on children aged four-to-six; in schools with school level FSM > 20%; baseline and two follow-ups measuring vocabulary and numeracy, and social/emotional outcomes; baseline and one follow-up measuring parents' confidence and engagement in their child's learning. 3: Process evaluation: four strands exploring: programme model; implementation and fidelity; schools' experiences; parents' views/home learning

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environment. Informed by Humphrey et al.'s (2016 updated 2019) guidance for implementation and process evaluation and Sharples et al. (2018). 4: Costs evaluation: to establish costs of the intervention to schools, and cost per pupil per year.

Additional analysis using regression models and mediation was carried out to assess the relationship between social disadvantage and the programme's theory of change, and which aspects of the theory of change have the potential to impact on children's future attainment.

Main findings

The evaluation found that Families Connect increases parental engagement in children's learning, improves parental skills, and improves aspects of children's social and emotional development. Results showed no impact on children's receptive vocabulary or numeracy skills. However, it identified key areas for improvement that would further strengthen the development of the programme and contribute to broader understanding of how to support key early learning outcomes.

Additional analysis of the findings demonstrated that Families Connect was more impactful on the home learning environment for families on lower incomes and those eligible for free school meals. It was also found to have a greater impact on parent–child enrichment scores for families on lower household incomes and a greater impact on parent–child interaction scores for parents with lower education levels.

Parents who took part had higher levels of interaction with their children inside the home, took part in more enrichment activities outside of the home, and had a stronger feeling that they knew how to help their child to learn.

An increase in parental efficacy led to important behavioural changes for children. It led to reductions in children's total difficulties, peer problems, and emotional problems, six months after. These changes did not affect attainment as hypothesised. However, caution should be applied to dismissing the potential relationship between child behaviour and attainment: both changes in child behaviour, and the measures used to assess attainment, were measured at the same time point after six months.

Increases in parent-child interactions led to increases in children's softer skills, which led to an increase in attainment. Children's softer skills was the only variable to significantly impact attainment in the hypothesised direction and to act as a significant

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mediator between an intermediary outcome and attainment. The importance of changes to parent-child interaction within the home environment to improvements in children's softer skills, and the relationship between softer skills and attainment supports growing evidence on the importance of the home learning environment whilst providing additional focus on the role of children's softer skills.

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#192 - Addressing Gender-based Violence (GBV) through Health Systems Strengthening: Evidence from Nigeria

Presenting Author(s)*

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Country of residence

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Objectives/aims

This presentation will discuss practice-based learnings from the implementation of a Grants under Contract mechanism implemented by USAID Nigeria's Integrated Health Program (IHP), in collaboration with WI-HER, to strengthen the Nigerian health care systems capacity to respond to and care for survivors of Gender-based Violence (GBV). The program worked with local civil society organizations and other stakeholders in Nigeria to design and implement a model that built capacity of healthcare professionals on GBV prevention and response in three states – Bauchi, Kebbi and Sokoto. All three states face unique challenges in addressing widespread GBV driven by cultural and social norms and difficult economic conditions.

IHP's work recognized the criticality of the health sector as an entry point for responding to GBV and providing support to survivors of GBV and designed its interventions to not only improve service delivery and access for survivors of GBV but also improve overall documentation and data-generation to better understand the drivers and prevalence of GBV across the three states. It drew on global guidance on best practices in the field of GBV program design to develop a curriculum that is sensitive to the Nigerian context and adaptable across states and improve the quality of care available to survivors including being able to access legal services, additional medical care and psycho-social services. IHP piloted a holistic system of GBV prevention and response starting by building capacity of healthcare workers to be more responsive to the needs of survivors, utilize referral pathways effectively and link facility level learnings and data to a wider national level GBV data system.

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Methods
The IHP model relied on a hybrid approach composed of a cascade training model, a cluster training and mentoring support system and on-site supportive supervision to reinforce knowledge and skills transfer. The presentation will discuss findings based on dialogues with participants and healthcare professionals and implementing partners. It will also build on data generated from the IHP monitoring and evaluation unit which captures patterns of change in data based on program implementation. It will discuss how the program is being scaled-up in other states and how the team has applied lessons learnt to enhance productivity and outcomes in other states. It will also discuss how the training deployed a series of data-capturing tools to build the capacity of healthcare workers to document GBV cases and has helped strengthen a wider GBV data generation system at the local and national level by putting together and deploying various tools and standard operation procedures to guide data management.

Our presentation will use the lightning talk format and use interactive exercises and participatory discussions to generate discussion and build on lessons learned.

Main findings
The presentation will discuss key outcomes of the program including:

- Substantial increase in reporting of GBV cases across all three states;
- Increase in referrals services for GBV survivors including warm referrals and updated referral directories.
- Program learnings on how to build a cohesive GBV data-gathering system that is cohesive and scalable from local to national levels and across states;
- Qualitative impact on professional capacity of healthcare workers and survivors of GBV;
- Sustainability and scalability of the program.

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#193 - A lifecycle of projects for 'implementation to spread' to prevent secondary fractures

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Objectives/aims
Over the last decade a multidisciplinary team at one regional health authority in British Columbia Canada has worked to address the osteoporosis care gap through identifying, adapting, implementing, spreading, and now working on scaling, an evidence-based based program. In this presentation we aim to show the iterative activities, resources, and commitments that were required to do this work. Demonstrating not only the resources and time implementation, scale, and spread takes but also how one committed team has stayed the course to make it happen.

This program of work began with identifying a best practice program for addressing the osteoporosis care gap and implementing it at one community hospital. Next, we sought to implement and evaluate implementation strategies at different types and contexts of hospital (community, rural; regional, urban; community, urban). Now we are embarking on a policy project to spread the program at a provincial level.

Methods
In this series of projects, we have used the Knowledge to Action model, the Consolidated Framework for Implementation Science (CFIR) and the RE-AIM framework. Each has made unique and useful contributions to the design, process, and tools used for this program of implementation projects. What we are presenting

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here is this program of work as a case. The data collection methods have included: administrative and clinical data, satisfaction surveys, key informant interviews, patient journey mapping, focus groups, systematic rapid reviews, and soon a deliberative dialogue. The implementation activities include: transdisciplinary team (including patients), champions, stakeholder engagement, site-based implementation teams, strong evidence, tailored messaging, and adapting while maintaining fidelity to core components.

Main findings

In this presentation we share themes from this program of work regarding what it has taken to move an evidence-based program through implementation sustainability, scale, and (the first steps toward) spread. These themes include: a diverse, committed, and patient, team and leader; focus on addressing an issue (not completing a project); stakeholder engagement (site based and broadly); being open to opportunities; use of implementation frameworks; and, a well evidenced and supported intervention. The team has supported the successful implementation of the program at three hospitals and has an established working relationship with the provincial Ministry of Health to support spread. We also draw on the experience of a failed implementation attempt at one site. There are many lessons to share through this presentation that can further the conversation and practice on implementation strategies.

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#199 - Digital health to reduce caregiver burden: A qualitative study of enablers and barriers of digital health among caregivers in Singapore

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Objectives/aims
Understanding digital health enablers and barriers among caregivers to reduce caregiving burden in Singapore

Methods
The study utilised a qualitative approach to unpack nuances of expectations from digital health to reduce caregiving burden. A qualitative approach was adopted to understand caregiver expectations as it helps examine underexplored phenomena with the fluidity and openness needed to accommodate varying perspectives.[1] Seventeen semi-structured interviews were conducted with caregivers in Singapore.

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Insights surrounding their caregiving responsibilities and digital health expectations were drawn. Data was thematically analysed using constant comparison method.[1]

Main findings:
Two broad themes namely digital health enablers and digital health barriers, along with four sub themes were identified.

In terms of digital health enablers, caregivers conveyed expectations surrounding two core concepts namely, attitude towards technology and caregiver-aligned technology.

Attitude towards technology: Possessing an attitude of openness/trust in the assistive nature of technology facilitated a greater inclination to adopt digital health tools to simplify caregiving responsibilities (e.g., openness/current engagement with tools such as health apps for doctor appointments).

Caregiver-aligned technology: Similarly, the need for technology to be aligned to their contexts through customised support (e.g., patient monitoring tools) enabled an opportunity for building the necessary mindset to adopt technology for caregiving.

In terms of digital health barriers, caregivers conveyed setbacks around two core concepts namely perceived incapability of technology and cost.

Perceived incapability of technology: Perceived technology incapability covered ideas of a lack of knowledge and belief in the ability of caregiving technology to be a replacement for health tools/services that are not digital (e.g., resistance to technology as it is seen as impersonal and devoid of face-to-face immersive experience).

Cost: Investment in technology was largely perceived of as expensive. This was particularly the case where multiple technologies were required to ensure support and for at-home care (e.g., monitoring, scheduling and communicative tools).

In conclusion, there are context-specific barriers and facilitators that affect the adoption and use of digital health for caregiving. Healthcare practitioners and policy makers can benefit from identifying uniqueness in contexts to build and deploy digital health services that ensure efficient support.

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#231 - Development and validation of a quality instrument for a father-engagement intervention in the Rohingya-refugee context

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Objectives/aims

As part of the Play to Learn initiative, NYU Global TIES for Children is evaluating the impact of a BRAC IED- led home-visiting and group-based program that engage both mothers and fathers of 0-2 year old children. The intervention, part of the BRAC-IED's

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‘Humanitarian Play Labs’, has been working with mothers of 0-2 year old children to maximize positive outcomes of child development. The additional father component works to promote fathers’ wellbeing by improving their emotional literacy, encourage fathers to develop relationships with their spouses and children, and encourage responsive caregiving practices among fathers (BRAC & Sesame Workshop, 2022). This father's engagement has been ongoing with the Rohingya refugee and host community populations of Cox’s Bazar, Bangladesh.

Programs that target fathers of early childhood aged children are an innovative, and hence barely studied, intervention model specifically in low and middle-income countries (Jeong et al, 2021). Our study explores the quality of implementation of the above father engagement program by developing and validating an instrument to measure the process quality (NICHD, 2002), i.e. the quality of interactions at the point-of-service between fathers and facilitators.

Methods

As an initial step in the development process, the research team examined literature on father engagement interventions, specifically those in LMIC or emergency contexts, and met with experts on father and masculinity related interventions. The team then observed six sessions of the intervention, three in the Rohingya camp context and three in the host community context. The first version of the instrument was then developed based on these observations, the literature, and expert consultation of the intervention. The instrument includes 24 items divided among four subscales: (1) relationship between father volunteer and caregiver/father; (2) responsiveness to family strengths, culture, needs, and circumstances; (3) active listening and; (4) parent engagement. The initial instrument was tested on four video recordings of the intervention that were used to create gold codes for enumerator training.

As part of the psychometric analyses, we will conduct item response theory analyses to ensure that the items cover a range of difficulties and have discriminating power. We will conduct factor analyses to investigate the instrument’s empirical factor structure of the instrument. Finally, we will investigate concurrent validity by testing associations between the instrument and facilitator well-being as measured through self reports of anxiety, depression, and professional quality of life.

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Main findings

At the time of writing, data collection is ongoing for the instrument. Psychometrics are expected to be completed by September 2023 and if accepted, early psychometrics will likely be presented as part of this presentation. In addition, we will focus on the process of developing and implementing such an instrument in a humanitarian context and complex language environment and provide recommendations to other researchers interested in conducting this type of implementation science.

The development and usage of this instrument contributes to the emerging knowledge on measuring program quality and fidelity, particularly in emergency and LMIC contexts. Measuring the quality of these interactions and testing their associations with target outcomes, such as father's wellbeing and child development, will allow us to understand "how" and "why" father engagement programs work and aid in their further refinement. Measuring quality of interactions also allows us to "make things work" by coaching facilitators and improving program quality on an ongoing basis.

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PRE-RECORDED ORAL PRESENTATIONS

#239 - Identifying evidence-based components of nutrition and physical activity interventions in childcare: a systematic approach

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Objectives/aims
To describe a systematic evidence-mapping process to identify components of existing ECEC-based nutrition and physical activity guidelines that are well supported by research evidence.

Methods
This study involved an evidence-mapping process using published randomised controlled trials included within high quality, contemporary systematic reviews.
First, we conducted a systematic review to examine ECEC-based nutrition and physical activity guidelines to describe specific recommendations included within these guidelines, mapped to the Analysis Grid for Environments Linked to Obesity framework. We identified 36 discrete recommendations for nutrition and 45 discrete recommendations for physical activity and movement, across 38 guidelines.

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To identify a comprehensive record of randomised controlled trials (RCTs) examining ECEC-based interventions to improve child healthy eating and physical activity, we conducted four systematic reviews: i) a Cochrane systematic review of ECEC-based nutrition interventions; ii) a review of reviews of ECEC-based physical activity interventions; iii) an update of a systematic review of ECEC-based physical activity interventions and iv) a systematic review of interventions delivered specifically in family day care settings.

We repurposed data from these existing reviews as an efficient and pragmatic method to identify relevant RCTs. From these RCTs, two authors extracted healthy eating and physical activity discrete intervention components and the direction of effect on key healthy eating and physical activity outcomes. Where one intervention involved multiple components, all discrete components were extracted. Healthy eating outcomes extracted were diet quality and fruit, vegetable, fruit and vegetable, sugar-sweetened beverages and discretionary food intake. Physical activity outcomes extracted were total physical activity, moderate-to-vigorous physical activity, sedentary behaviour and energetic movement (measured by counts and steps).

Based on the extracted data, authors mapped each intervention component to the relevant guidance outlined in the guideline review. Where a discrete component was not able to be mapped to existing guideline recommendations, this was recorded separately as a recommendation. One author undertook the mapping process, and this was checked by a second author, with a third author resolving any discrepancies.

For each component, we used a vote-counting approach based on standardised direction of effects to determine the number of studies reporting positive or negative effect on nutrition and physical activity outcomes, consistent with that recommended by the Cochrane handbook. Effectiveness of each intervention component on nutrition and physical activity outcomes categorised as:

- Likely effective: ≥75% of the included primary studies showed positive finding on any one of the examined outcomes.
- Promising (more evidence needed): the majority (50-74%) of included primary studies showed positive findings on any one of the examined outcomes.
- Probably ineffective (more evidence needed): the majority (≥50%) of included primary studies were ineffective on any one of the examined outcomes.
- Ineffective: all included primary studies show negative findings on any one of the examined outcomes.
- No conclusions possible due to lack of evidence: ≤2 primary studies examining this for any one of the examined outcomes.

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Main findings

The results of this mapping process will identify evidence-based components of ECEC-based nutrition and physical activity interventions. These components are likely to warrant implementation support.

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#243 - Promoting healthy and active living: pilot study to better engage men from target CALD backgrounds in a community health-based program in Melbourne's West

Presenting Author(s)*

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2. Western Bulldogs Community Foundation
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Country of residence

Australia

Objectives/aims

The Western Bulldogs Community Foundation's Sons of the West (SOTW) is a gender-sensitised, place-based primary prevention program for women. It involves 10 weekly 2-hour sessions, including an hour of interactive evidence-based health education covering a range of physical- and mental health-related topics and an hour of physical activity tailored to participants' fitness levels.

Traditionally, the program has engaged a cohort of middle-aged men of which half are from Culturally and Linguistically Diverse (CALD) backgrounds, however research shows a "one-size-fits-all" approach to engaging CALD communities in health initiatives can be detrimental. Men from CALD communities can be reluctant to access health services due to barriers such as language, lack of representative service providers, and stigmas in discussing topics such as mental health, cultural differences, and beliefs. These barriers underpin existing health disparities and health service accessibility for many of these communities. With Melbourne's West being one of the fastest-growing and most culturally diverse areas in the state, a critical need was

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identified to better engage men from CALD communities in SOTW as a step towards more equitable access to healthcare.
The primary aims of the study were to: (1) Develop and implement an inclusive consultation process with male Vietnamese community members to identify barriers and enablers of participation in community health-based programs; (2) pilot a place-based SOTW program that reflects cultural and community values for a target cohort; (3) determine the health, wellbeing, and lived experiences of participants pre- and post-program, and (4) Identify key considerations to inform CALD Engagement Guidelines for future CALD-focused community health programs.

Methods
A mixed-methods, design-thinking approach was adopted to engage a target community throughout program development, delivery and evaluation. Tailored versions of the 10-week SOTW program was co-designed with, and for, men from the Vietnamese community in 2022 and 2023. The program model took a hybrid form (whereby the Vietnamese men attended the in-language education separate to a group of SOTW participants receiving education in English, with the two groups coming together for the physical activity component).
Quantitative and qualitative data were collected using surveys and focus groups before and after the program to gain an understanding of participants' health and wellbeing, as well as their expectations and experience of the program.

Main findings
This presentation will address the implementation and outcome evaluation of CALD-tailored SOTW programs across 2022 and 2023. A total of 42 men have participated to date. Average age was 59 years; average weekly attendance was 10 participants; and 46% identified they had one or more chronic health concerns before the program. Preliminary results are available (for the 2022 cohort). Positive changes were recorded for physical activity, mental wellbeing, and health self-efficacy. In addition, 80% reported greater group connection, 80% learned about local health services, 100% shared health education information with others, and 100% reported lifestyle changes / impacts relating to diet, physical activity, healthcare and leisure activity access, and confidence.

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Thematic analysis from the 2022 post-program focus group identified five core themes: impact of program environment; experience of health education; sense of connection; health improvements; and barriers / opportunities for future programs.

This exploratory study has identified a number of important factors for CALD participant engagement, including: (1) having representative bilingual facilitators, (2) delivering health education and education resources in language, (3) choosing accessible venues, (4) working with existing community organisations and groups for pathways in and out, and (5) creating a safe space for participants to develop and maintain positive health habits, social networks and mental resilience.

Data analysis of the 2023 program is underway, and findings will be incorporated into the overall results for the Conference presentation.

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#256 - Streamlining Implementation Science: Simplifying Concepts for Lay Stakeholders

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Objectives
To initiate a thoughtful dialogue within the evidence-based practice communities regarding the importance of developing user-friendly concepts for lay people, to promote their active involvement in research and its practical application.

Methods
Extensive evidence indicates a consistent failure to effectively translate valuable biomedical and health research findings into practical clinical applications and policy implementation. It often takes an average of two decades for interventions to reach patients' bedside, indicating a significant delay in the transfer of research outcomes into practice. To bridge this gap and facilitate the application of research findings, numerous concepts, models, and theories have been developed as guides for experts. However, there is a lack of simplified explanations of these concepts tailored for lay stakeholders, including patient representatives who have the potential to contribute significantly to clinical and other health research endeavors. To address this issue, we developed user-friendly definitions of three commonly used concepts: knowledge translation (knowledge generation), dissemination and implementation. Knowledge Generation: ‘The creation of evidence-based new knowledge or intervention based on a systematic method to translating or synthesizing existing scientific evidence’; Dissemination: ‘The well-thought distribution of new knowledge or intervention to the relevant stakeholders who will benefit from the knowledge’; Implementation: ‘The

application or adoption of new knowledge using different strategies based on stakeholders' preference to a specific setting'. Additionally, we propose a simplified framework that establishes connections among these concepts, aiming to facilitate their understanding and practical utilization.

Main findings

The absence of simplified definitions to explain research in practice creates ambiguity among stakeholders with minimal expertise. To facilitate meaningful participation and reduce the time required to apply research outcomes to patient care, it is crucial to provide user-friendly scientific knowledge for non-experts. Addressing this need will contribute to more effective engagement and collaboration among stakeholders, ultimately improving the translation of research findings into practical applications.

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#261 - Implementing a systems approach to understand gender related barriers to education in Kenya.

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Objectives/aims
The Evidence for Gender and Education Resource (EGER) – is a program of work and online resource that seeks to address gender inequalities and injustices in global education. By providing easily accessible data and evidence, we support the gender and education community as a knowledge partner and inform programs and policies that shape the global agenda. EGER generates and synthesizes evidence through the creation of various research publications and mapping current gender and education practice. Currently EGER's mapping includes over 600 organizations and 700 programs working at the global level. We also translate evidence into more digestible formats for a variety of stakeholders by creating briefs, online and interactive data visualizations, and compelling communications. We build partnerships and collaborations with advocates, donors, policymakers, and practitioners to ensure we're responsive to the field's most pressing questions and create pathways for evidence uptake. EGER's broad objective is widening the needs, evidence and practice overlap to focus investments where they are needed most. The original phase of EGER was designed as a global resource. However, it was hypothesized that to shape policy and programs and be a useful resource at a national level, country-specific adaptations needed to take place. Therefore, EGER Kenya was developed to work to promote dialogue on gender and education evidence and practice with a view to reduce gaps and misalignment and enhance collaboration.

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Methods

Since 2021, the EGER Kenya team has worked closely with the Ministry of Education to understand the gender and education evidence, policies, and programs both at the national and county levels. We have done this through conducting an ecosystem mapping nationally and in 8 counties to understand who the actors are in the gender and education space. In total, 342 organizations and 486 programs operating in Kenya were identified. We conducted secondary data analysis of education gender gaps and a literature review of what works in education and gender in Kenya and the East African region. We mapped gender and education policies, laws and plans that have been adopted and implemented in Kenya since 1990 to enhance understanding of gender and education policy landscape and how it has evolved since 1990, inform future gender and education policy development, implementation, monitoring, and evaluation processes and enhance understanding of perennial gaps and opportunities for further development of effective gender and education policies. The evidence generated through EGER is now being used to inform the review of Kenya's 2015 Education and Training Sector Gender Policy. The policy review process has included capacity building on gender mainstreaming and use of evidence in policy making for the Ministry of Education and collaborative development with a wide range of stakeholders.

Main findings

Kenya has made tremendous achievements toward gender parity at the national level. However, gender inequity remains a challenge in nearly half of Kenyan counties. These disparities are more so in Arid and Semi-Arid Areas (ASAL), very rural and poor counties and pockets of urban counties particularly in informal settlements. The 2019 census data shows that access remains below 40% among males and females aged 6-22 years in four counties (Turkana, Mandera, Garissa, and Wajir). Further data has also demonstrated that gender gaps in attainment were driven by gaps in primary school enrollment in several counties and by higher dropout rates by girls in others. Nearly all counties have high retention in school for girls and boys younger than age 18, but school leaving at ages 18-22 is high, especially for girls. By adapting a global resource to a specific country context, it has been possible to align policies and programs with the greatest needs and the most effective solutions, ensuring that

gender and education stakeholders make evidence-based decisions and collaboratively forge a better path toward gender equity.

PRE-RECORDED ORAL PRESENTATIONS

#263 – EdTech Hub Innovation Sandboxes

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Objectives/Aims
With 258 million children out of school globally and many more experiencing disruptions due to Covid-19, we are currently facing a global education crisis, with the poorest children most adversely affected (UIS, 2019). In light of this, the role of digital and education technology (EdTech) in transforming the education sector has become increasingly paramount. However, decision-makers lack the evidence to make rigorous decisions about how to invest in education technology. The EdTech Hub, a global non-profit research partnership that exists to empower stakeholders by providing the necessary evidence for informed decisions about technology in education - but we know that this evidence is not enough. We also need to work alongside decision-makers to implement evidence and understand ‘what works’ in the real world.

To do this, we have pioneered an approach to establishing EdTech Sandboxes. In the world of technology development, a "sandbox" is a term borrowed from the concept of a physical sandbox, where children can safely play and experiment. In tech, a sandbox is a safe, isolated environment that mimics the live or production environment but does not affect it. This environment is used for testing, experimenting, or learning purposes.

Methods
The Sandbox approach, used to scale education technology across LMIC for five years, creates a ‘safe space’ to test approaches and take account of real world outcomes in order to iterate and adapt based on those outcomes. The efficacy of the Sandbox approach will be exemplified through three specific cases in Uganda, Bangladesh and Tanzania.

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In Uganda, we tested "listening centres" as a mechanism for remote learning over 12 weeks, using a rapid RCT methodology that resulted in significant improvements in basic literacy competences. In Tanzania, we co-created a theory of change with government officials to pivot from a virtual learning environment for students to one for teachers, positively influencing a $50m investment in Zanzibar. Lastly, in Bangladesh, we used staggered deployment in a multivariate test for refining interventions, the outcomes of which provided a clear direction for investment in multi-media classrooms and teacher training.

Main Findings

Our presentation will share findings on two levels. First, we will discuss the specific outcomes of each sandbox in Uganda, Tanzania, and Bangladesh, highlighting how the experimental approach has informed strategy and implementation. Second, we will show the broader implications of these findings, presenting the Sandbox approach as an effective methodology for implementation research, especially in the field of EdTech.

Our findings not only shed light on how to strategically harness EdTech to mitigate the effects of the ongoing global learning crisis, but they also offer valuable insights into addressing the implementation challenges that governments and funding agencies encounter when leveraging technology in education. In doing so, our presentation aligns with the Summit theme, presenting innovative and high-quality research that has tangible relevance and utility for the field of implementation science.

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#278 - Contextualize Community-based Hypertension Control Strategies in Nepal: Lessons from China, Bangladesh, Pakistan, and Sri Lanka

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Abstract
This study contextualizes the implementation of community-based hypertension control strategies in Nepal, drawing insights from successful programs in China, Bangladesh, Pakistan, and Sri Lanka.

Objectives/aims
The overall objective of our work is to develop and optimize a smartphone-based App that empowers frontline health workers (FLHWs) and female community health volunteers (FCHVs) to improve the management of hypertension in rural Nepal. The

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specific aims were to (1) Identify facilitators and barriers to hypertension care; (2) Optimize and upgrade the smartphone-based hypertension management App for Nepal's context by incorporating FLHWs; (3) Assess the feasibility and acceptability of the program.

Methods

Our team collectively had conducted several cluster-randomized controlled trials in China, Bangladesh, Pakistan, and Sri Lanka, demonstrating the effectiveness of community-based hypertension control strategies. We had completed two feasibility studies in Nepal and found that FCHVs were willing and able to be trained to digitally support FLHWs for better management of people with hypertension in their communities. In the present study, we draw on insights gained from other countries and Nepal to contextualize these community-based interventions in rural Nepal. We adopted a mixed method and multistage design and chose rural Panchkhal and Bethanchowk municipalities as our study sites. In phase I, we conducted face-to-face interviews with multiple stakeholders recruited using a convenience sampling method to understand the barriers, facilitators, and needs for hypertension care in rural Nepal. Interviewees ranged from health providers (health professionals, FLHWs, and FCHVs) and patients to government officials and NGO officers. Furthermore, online interviews were done with Nepali software engineers to understand their perceptions of the technical challenges of mHealth in Nepal. In Phase II, the App and a message bank will be developed using a prototyping approach and optimized based on the insights and lessons learned from our previous work in China, Bangladesh, Pakistan, and Sri Lanka. The App will be refined to suit the rural Nepali context, leveraging the Community Health Toolkit framework to ensure its appropriateness. FCHVs and FLHWs will be trained on the use of the App and provided with necessary knowledge relevant to hypertension. Trained FCHVs will test out the App by identifying patients with hypertension from approximately 200 residents from their communities and tagging the screened participants with abnormal blood pressure reads to FLHWs. Identified patients will be followed up and receive healthcare and reminder text messages. Phase III will include in-depth interviews and focus group discussions conducted with purposively selected FLHWs, FCHVs, and hypertensive patients to better understand their experiences, perceptions, and challenges encountered during App utilization, as well as program feasibility. Additionally, quantitative data will be collected relating to the satisfaction and acceptability with the App and its perceived usefulness.

Main findings

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The preliminary findings of the Phase I study revealed several facilitators and barriers to hypertensive care identified through qualitative interviews. Hypertensive patients considered facilitators as availability of free services from government health centres, medicine for hypertension, awareness of symptoms in hypertension before diagnosis by health workers, trust towards health workers and health facilities. Some other facilitators were health insurance, good socioeconomic status of family along with support from family and FLHWs at health posts. In addition, FCHVs perceived facilitators to provide hypertension care included knowledge about hypertension and self-motivation on providing services. FLHWs felt the coordination with FCHV as an important aspect in identifying hypertensive patients in the community. However, stakeholders also identified several barriers to hypertensive care, including difficulty reaching health facility due to mountainous terrain and the unavailability of certain free medication. Stakeholders showed interest in implementing the smartphone-based hypertension management program for hypertensive patients through FLHWs, but also acknowledged challenges such as illiteracy and potential problems with internet connectivity. We have developed a beta-version of the smartphone-based App and will contextualize it throughout all remaining phases. Research activities will conclude by October 2023 and new findings will be promptly updated.

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#279 - Identify Strategies to Improve the Implementation of Alcohol Screening and Brief Intervention in Hong Kong

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Objectives/Aims
Harmful use of alcohol is a known risk factor for more than 200 types of diseases as well as injuries. The World Health Organization recommends alcohol screening and brief intervention (SBI) to be implemented in primary care settings. This Delphi study aimed to identify strategies to improve the implementation of SBI as suggested by primary care physicians and nurses in Hong Kong, China.

Methods
This study is ongoing. A three-round online Delphi study is carried out among physicians and nurses working in primary care settings in Hong Kong. The first-round questionnaire consisted of open-ended questions to generate ideas about strategies to overcome barriers and enhance facilitators based on the Consolidated Framework for Implementation Research which were obtained from our previous mixed-method study. In the second round, participants will be asked to indicate how applicable and feasible they find each strategy. In the third round, items without consensus will be systematically fed back with their previous own ratings, group median ratings and interquartile range scores.

Main findings
This study is ongoing and the first round was completed. A total of 56 physicians and nurses completed the survey. After content analysis, a host 67 of implementation strategies were generated (Intervention characteristics: 13; Outter Setting: 10; Inner Setting: 32; Characteristics of Individuals: 7; Process: 5). The suggested implementation strategies are rated by the participants on their applicability and feasibility in the second round which is ongoing. The results of the whole Delphi Study will be available in July 2023. This study serves as a reference framework for health

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authorities to devise strategies for improving the implementation of SBI in primary care settings both in Hong Kong and other places with similar health systems.

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#282 - Impact and implementation of a teacher-led mindfulness intervention for primary school students

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Objectives/aims
This paper presents findings from the Minds@Play cluster randomised controlled trial. We aimed to determine whether:
1. Compared to controls, children who receive a mindfulness intervention within the first years of primary school have better outcomes in the areas of attention, executive functioning, social-emotional well-being, emotional regulation and behavior; and
3. The implementation predicts the efficacy of the intervention and the cost effectiveness relative to outcomes.

Methods
This is a cluster RCT with an embedded implementation and economic evaluation. This enables findings to inform the benefits of the intervention compared to current practice, identify for whom and under what conditions the intervention is beneficial, and provide an indication of the cost-benefits of the intervention.

19 primary schools from disadvantaged areas were recruited due to the higher prevalence of social-emotional difficulties reported for students in these areas. All school entry students (age 6-7 years) were approached to participate, with a final sample of 706 children. Consent was explicitly forcused on participation in the data collection, with the intervention provided to all students in the classes.
After baseline data collection, schools, stratified by school sector, were randomized to control or intervention by a researcher independent of the study team, and group allocation was concealed from research team members involved in data collection.

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In the schools randomized to intervention, teachers in each year received professional learning delivered via a self-directed online module, as well as a two-hour virtual workshop. The professional learning focused on the theoretical and practical foundations of the program and instructions for implementing the program. The teachers were asked to embed the 12-week intervention into their classrooms, using the manual to help them to learn, practice, incorporate, and reflect on the activities and strategies.

Main findings

Outcomes of the intervention were measured using parent, teacher and child face to face data collection at the end of Grade 2 (October 2022). Measures were chosen to measure proximal and distal outcomes that align with our intervention's theory of change. Constructs included student social-emotional, executive functioning, attention and self-regulation, as well as teacher and parent mindfulness practice and well-being. In addition, during the intervention's implementation, teachers completed fortnightly surveys will enable implementation to be monitored, as well as understand whether teacher perception of benefits of the intervention influenced their ongoing implementation.

The final outcomes are currently being analysed and will be presented at EIS.

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#285 - Scaling success: Empowering program managers with a toolkit for taking employment programs to scale

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Objectives/aims
Scale up is a deliberate effort 'to increase the reach and impact of innovations successfully tested in pilot or experimental projects to benefit more people'. The ‘Changing Perceptions in Employment’ (CPiE) program was a pilot initiative that successfully changed attitudes around employment and improved employment outcomes for participants and there is appetite for taking the program to scale. The success of CPiE has also prompted further desire to understand scaling employment programs more generally.

Here we unpack the scaling challenges faced by program managers in the employment and human services sectors. We conducted three phases of research to arrive at a toolkit for scaling employment programs. This work represents a collaboration between BehaviourWorks Australia (Monash University), the Victorian Department of Jobs, Skills, Industry and Regions, and the City of Casey.

Methods
The first phase of research comprised three activities to better understand the scaling challenges in these sectors: (1) evidence review of academic literature to find factors and activities related to scaling employment program; (2) practice review with employment program managers to understand how those factors and activities translate to on-the-ground scaling; and (3) scalability assessment of the CPiE case study.

The search strategy for the evidence review yielded 3,811 records, with 20 (9 academic, 11 grey literature) included in the review. The practice review used semi-structured interviews to capture practice insights for scaling from 10 employment program managers, with themes extracted via qualitative analysis. The scalability

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assessment took existing scaling tools and structured an interview schedule around their key insights, which were then discussed with the program lead for the CPiE program. Ethical clearance was provided by the Monash University Human Research Ethics Committee. Culminating from these research activities was a list of success and risk factors for scaling employment programs.

The second phase of work used principles of co-design to develop a preliminary scaling toolkit. Workshop participants considered the insights from the first phase of research, then discussed potential users of a scaling toolkit and their needs, as well as ranking themes from Phase 1 on dimensions of perceived importance to scaling and whether they would fall under program managers' sphere of influence. This allowed us to ensure that we were designing tools that would be maximally useful for program managers. Once a preliminary toolkit was created it was then validated with program managers, before being disseminated among relevant communities of practice within Victoria.

Main findings

This presentation will unpack the key themes from the first phase, as well as the results of the co-design phase. The key themes from phase 1 include: (the context in which the program is delivered; the philosophy/values of the program (e.g. using person-centred approach); skills and competencies of staff; jobseekers and their attitudes and awareness; employers awareness and perceived benefits of the program; system factors (e.g. strength of economy, funding priorities; and program content (e.g. delivering content online rather than in person). These themes were prioritised in the co-design workshop to assist in the selection of key issues to consider when attempting to scale employment programs. The highest priority issues included: philosophy/values of the program, skills and competencies of staff, and employers' awareness and perceived benefits of the program.

Furthermore, the toolkit design process highlighted that factors that make successful programs do not necessarily make for successful scaling. For example, the philosophy of the CPiE program – its person-centred, wraparound approach – was a major factor in its success but also a major barrier to its scaling.

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#299 - Scale-up and Integration of Depression Screening and Treatment in Primary Health Care in India

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Objectives/aims
Depression is the leading cause of disability worldwide, and accounts for more than one-third of Disability Adjusted Life Years attributed to mental and substance use disorders. Despite this, treatment coverage for depression is inadequate. Access to mental healthcare in low- and middle-income countries remains limited due to both, demand- and supply-side barriers such as lack of trained mental health professionals, low rates of identification and, lack of contextualized psychosocial interventions.

Our study is a Hybrid Type 2 Implementation-Effectiveness Cluster Randomised Controlled Trial that aims to reduce the treatment gap for depression through the integrated implementation of interventions in facility and community platforms in Goa, India. We present findings from the formative research and embedding phase of the trial which focusses on (1) conducting universal screening at all primary health care (PHC) centres in Goa; (2) scaling-up the delivery of an evidence-based psychosocial treatment for depression by training existing PHC staff.

Methods
A situational analysis to identify the cadres of PHC workers who can be trained to deliver the treatment; (2) Training the identified PHC staff in the psychosocial treatment for depression; (3) Group discussions with the trained PHC workers to identify potential barriers and ways to overcome them to ensure effective implementation and sustainability of the program and; (4) Assessing institutional

readiness to change using the Organizational Readiness for Implementing Change [ORIC] tool.

Main findings

The situational analysis highlighted that there is dearth of staff. As a result, a range of different cadres of PHC staff were nominated from all centres- staff nurses and medical doctors to those working in maternal health and traditional medicine.

We conducted five week-long training sessions and trained around 60 PHC staff members from all over Goa. The pre- and post-knowledge test as well as the skill-based assessment demonstrates that there was a positive change in competencies of these healthcare workers. The trained staff are now undergoing their 'internship' period wherein they are providing treatment to people living with depression under supervision.

Based on our experience in the embedding phase, we found that while the State Health Ministry saw this as an important part of their role in implementing the country's flagship health program called Ayushman Bharat, many of the trained staff had poor levels of motivation and engagement as they found the delivery of an intervention for mental health as an additional responsibility to hold and monitor on a regular basis. Barriers to meaningful engagement with our program included (a) lack of time due to existing responsibilities and the wide range of administrative and documentation-related work they are engaged in; (b) feeling overburdened; (c) low motivation as they do not receive monetary incentives for this 'additional' work; and (d) lack of job security and thereby, decreasing levels of motivation to adapt to new responsibilities.

We also learned that conducting universal screening at the PHC level is possible by building trust and rapport and generating awareness with PHC staff like the registration clerk who could encourage service users to be screened. We also faced several challenges like hesitation from service users to be screened for depression due to the prevailing stigma, their concerns with confidentiality due to the sensitivity of information, and lack of time.

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The findings relating to organizational readiness for change will be analysed and ready in time to be presented at the conference.

Overall, we learned that each health centre functions differently and there is a need to take a bottom-up approach which involves working closely with the local health officers to develop systems that work for their respective facility.

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#302 - Addressing the Digital Divide and Co-creating innovative health service delivery strategies for the new normal

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Background and Objective
COVID-19-related health system disruptions brought about changes in the delivery of primary health services. This project aimed to document patient and provider experiences and co-create innovative strategies to address identified gaps and challenges observed during the COVID-19 pandemic restrictions.

Methods
Three Philippine municipalities were selected for the study. Surveys, key informant interviews, and focus group discussions were conducted among end-users and healthcare workers involved in essential health services (Maternal and Child, TB/HIV, NCD, and COVID-19) during the COVID-19 pandemic. For the co-creation component, human-centered design (HCD) approaches were implemented, which included patient journey mapping, World Cafe activities, and prioritization grid exercises. These activities were selected to engage community members in designing and selecting innovative health service delivery strategies adapted to the new normal.

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Results

The various activities provided a comprehensive perspective of the critical needs and gaps in local health systems during the COVID-19 pandemic. The main themes identified were related to health systems delivery disruptions, local government response and adaptations, and community engagement and mobilization challenges. Meanwhile, the survey revealed that the three municipalities experience varying degrees of health system disruption in consultation (4.3-4.8/10), diagnostic tests (2.3-4.1/10), and medication delivery (2.1-5/10). Even with the observed disruptions, only 36.4% (28/77) of respondents have availed of any mobile/ online consultation type. It parallels the stated difficulty of 48.1% (37/77) of respondents who found it difficult to find a reliable network connection in their area. Even with the reported findings, the majority of respondents (56/77) still noted openness to trying online/ mobile consultations provided that the connection is reliable in their area.

Through the HCD activities, an innovative pathway was co-created with the community. The innovation has three main components: a blend of a telemedicine platform, the teleconsultation referral script, and the engagement of volunteer community health workers as teleconsultation facilitators. A pilot run was implemented in one of the partner communities where the team taught the telehealth referral pathway, referral process, and script, refresher course on proper vital signs, telehealth-facilitated physical examination, and basics of two-way radio communication. During the workshop, the participants shared previous instances where the innovation could have been useful, particularly during health emergencies. Additionally, the effects of the digital divide were observed, particularly in remote and underserved areas with limited internet and network connectivity.

Conclusion

The findings of this study can inform policymakers in designing innovative health service platforms that address the challenges posed by the COVID-19 pandemic. Telemedicine facilitators can help bridge the gap between communities that are hesitant to adopt new technologies in health services. The utilization of human-centered design approaches, coupled with the consideration of the digital divide, can contribute to building resilient health systems and ensuring access to essential and equitable health services during times of crisis.

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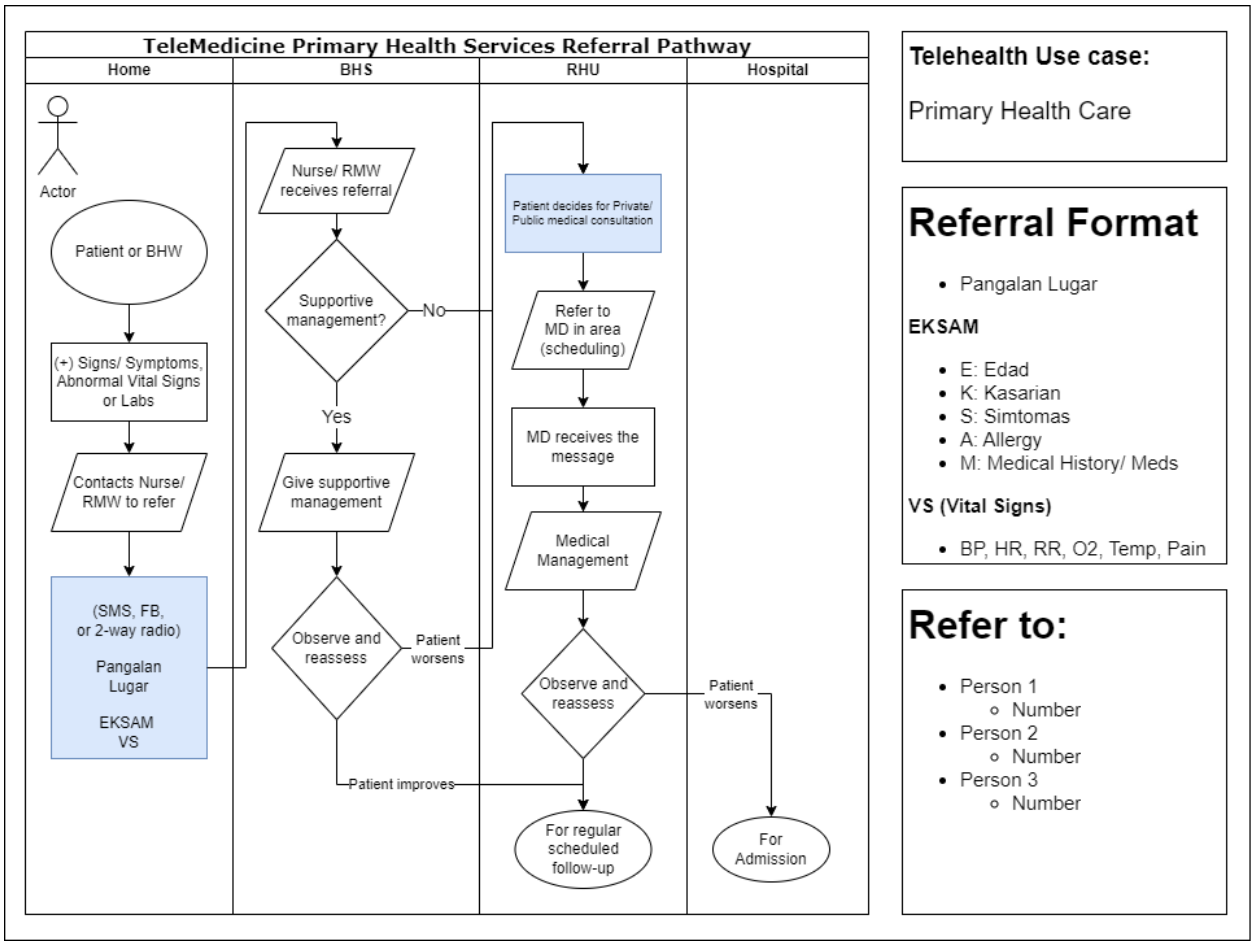

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#303 - So you think you can adapt? Design research for adapting SEL across conflict-affected contexts

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Objectives/aims
In 2021, approximately 449 million of the world's children, roughly 1 in 6, were living in conflict-affected zones, with Africa having the highest number (180 million) of children impacted by conflict (PRIO, 2022). Earlier studies indicate that children in these contexts are often out of school, an estimated 1 in 4 (UNICEF, 2016) or have lost access to schooling due to protracted crises e.g. 75% of all school-aged children in Nigeria (OCHA, 2018). It has long been acknowledged that even those with access to schooling are not learning. For example, 91% of primary school children in grades 2-4 across 3 provinces in eastern Democratic Republic of Congo could not respond correctly to a single reading comprehension question on a test designed for lower and middle income countries (Aber at al, 2012). While guaranteeing the right to "inclusive and equitable quality education at all levels' is among the 2030 Sustainable Development Goals (UNESCO, 2015), delivering on this goal in contexts of conflict and crisis requires a redoubling of effort. The International Rescue Committee's (IRC) mission is to support people affected by conflict and disaster to survive, recover and gain control over their future. Providing safe, quality educational opportunities for children, youth and adults is one of our 5 areas of programming.
Abuse, neglect, loss and other traumatic adverse experiences common in conflict-affected contexts affect children's physical and mental health, cognition, ability to

learn, behaviour and relationships. However, rigorous neuroscience research, largely generated in stable high-income contexts, indicates that the impacts of this 'toxic stress' can be reversed. With a commitment to being evidence-based and evidence-generating, the IRC has conceptualized, piloted and rigorously evaluated education and protection interventions that integrate social emotional learning in our efforts to address the toxic stress carried by many of the children we serve while improving their learning outcomes. For over a decade and in partnership with academic institutions, we have implemented, adapted and rigorously tested versions of our Healing Classrooms approach and other SEL-infused activities to promote academic and social emotional learning across 12 crisis contexts. While we have seen positive impacts on learning outcomes, the impacts on social emotional outcomes have been mixed and sometimes absent.

So what explains this vexing problem? Why is it that despite extensive adaptations to evidence-based teacher SEL manuals: translations, and imagery even the length of training and guidance documents, we still found lacklustre results? Why, in some contexts, were teachers complaining that teaching SEL was harder than teaching math? Only through iterative qualitative design research with teachers, students, coaches and parents did we arrive at clear answers and opportunities.

The objective of this presentation is articulate IRC's journey towards investment in implementation science and, in this case, design research in order to improve the relevance, contextual and cultural meaningfulness, effectiveness and cost efficiency of its SEL programs. We will also highlight not just how outcomes improved for the specific interventions in Nigeria and Lebanon but how this experience changed IRC's approach to evaluation more generally.

Methods

The studies used mixed methods and multi-level cluster randomized designs, design research, cost efficiency and effectiveness analyses. For the presentation, we suggest a pre-recorded talk-show style interview between the presenters.

Main findings

IRC not only increased the quality, fidelity of its SEL interventions with positive indication of effectiveness (impact evaluation underway) but also drastically reducing costs per child (from Over USD $600 to $7).

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#306 - Contextualized parenting in humanitarian settings; An IRC evidence-based approach.

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Objectives/aims
This presentation assesses implemented International Rescue Committee (IRC) recognized parenting approach in protecting and reducing child violence. This is crucial to building and strengthening child protection systems within their wider ecology beginning with the family. While parenting programmes show positive results when transferred across contexts, this presentation demonstrates interventions in humanitarian context tailored for a specific at-risk group can result in targeted outcomes specific to the child rights violations. The presentation highlights key findings for parenting interventions development process: 1) evidence-based research, 2) development and adaptation, 3) feasibility and acceptability, and 3) implementation quality.

Methods
To understand protection risks and barriers for violence against children, a review analysis using impact evaluations of parenting programs implemented by IRC between 2009-2023. The evaluated studies included, randomised control trials, formative and

research publications, evidence-based desk reviews, mixed methods studies, in depth interviews and participants engagement across the diverse humanitarian setting landscape.

Main findings

Earlier findings in high income countries show parenting interventions have positive effect on prevention of child abuse and neglect (McCloskey 2011). In the last decade, IRC has pioneered parenting interventions adaptions and translations in humanitarian settings reducing the risks of violence against children (Sim et.al. 2011). Using the parenting approach in conflict and post conflict settings, the reintegration of Children Associated with Armed Forces and Armed Groups (CAAFAG) indicates that parenting interventions tailored to them improves caregiver well-being, promote positive child-caregiver relations, and strengthen the knowledge and practices of caregivers. (IRC,2022)

Parenting interventions can also be integrated within various multi-sectoral interventions to achieve child protection. For instance, economic interventions consisting of Village Savings and Loan Associations (VSLAs) and educational components consisting of Healing Families and Communities (HFC) discussion sessions reduced poverty by promoting caregiver's ability to protect and provide for their children. Randomized impact evaluation showed improved parenting skills by discouraging harsh physical and verbal discipline in the homes. Parenting programs impact caregiver practices improving their behaviors toward their children and reducing violence against children. (Annan, J. et.al 2013, IRC 2013)

These integrated parenting interventions explore the importance of context, how evidence-informed solutions can be both rigorous and flexible and implemented in humanitarian contexts. The IRC contextualized evidence in different humanitarian settings suggest parenting interventions are feasible and can be delivered in resource-constrained, culturally diverse, and post-conflict settings. Parenting skills building interventions have been shown to promote positive parenting strategies and practices that improve parent-child interactions and unanticipated positive changes reducing marital conflict and improved communication within household. (IRC, 2013)

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#319 - Assessing the impact of blended teacher professional development on teacher knowledge, attitudes and practice towards learning through play for mathematics at Foundation Phase in South Africa: A Case Study of VVOB's BLEND project.

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Objectives/aims
South Africa's learning crisis continues as highlighted by several benchmarking studies such as TIMSS 2019 and PIRLS 2023. There are multiple factors that have contributed to the learning crises which include teaching resources and teacher knowledge. In response to COVID and supporting blended teacher professional development to strengthen knowledge and practice, the BLEND project was conceptualised by VVOB and implemented across Vietnam and South Africa. This study focuses only on South Africa and only discusses the contribution of a blended training intervention on teacher knowledge, attitudes and practice towards learning through play (LtP) for mathematics. The intervention was administered to two cohorts, an asynchronous (online only[1]) cohort where teachers completed online modules and participated in an online social learning page, and a synchronous (blended CPD) cohort which included the completion of online modules, participation on the social learning page and three professional learning community site-based support visits by content facilitators (who were from CSOs).

Methods

[1] After attending a face-to-face orientation session.

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This study utilised mixed methods. A pre-post-test assessment was designed and built into the online learning management system (LMS). A longitudinal survey was administered across baseline, midline and endline. The total sample of educators enrolled in the asynchronous cohort was 423 while 471 educators were enrolled in the synchronous cohort**.** The surveys in the longitudinal study were administered either online or telephonically. Additionally, focus group discussions and classroom observations were conducted.

Main findings

A total of 894 educators enrolled for the BLEND online course (471 synchronous and 423 asynchronous) and 632 educators (347 synchronous and 285 asynchronous) completed the course. Thus enrolment and completion rates were somewhat higher for the synchronous cohort. The course designers estimated that participants would spend around one hour per module online (1x7 = 7 hours) however, the majority of educators reported spending 24+ hours engaging online to complete the course.

The synchronous cohort were also more likely to report receiving a LtP resource toolkit (93%) than the asynchronous cohort (47%). Implementers had oversight of the distribution of toolkits to the synchronous cohort whereas the asynchronous cohort received their toolkits via official education system channels.

The asynchronous cohort had a slightly higher mean (48.4%) than the synchronous cohort (45.4%) in the pre-test, and also the post test (49.8% vs 49.5%). There was an overall mean gain for the participants overall of 2.5 percentage points from pre-test to post-test which was statistically significant at 5% significance (p=0.0481) with a small effect. No significant difference was found between the average scores of the two modalities for either the pre- or the post-test at 5% significance. However, there was a significant difference in the pre-test means at 10% significance (p=0.0770), suggesting that the asynchronous cohort may have had better knowledge of LtP than the synchronous cohort at baseline. No statistical difference was found for the gain of 1.4 percentage points from pre- to post-test scores of the asynchronous cohort (p=0.3767). The gain in pre- to post-test scores of 4.1 percentage points for the synchronous cohort was statistically significant (p=0.0464) with a small effect, suggesting that it did not occur by chance.

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The longitudinal survey assessed self-reported knowledge, attitudes towards LtP and self-reported practice of LtP and found large shifts from baseline to endline which were statistically significant for the participants overall, with a small effect, but the difference in shifts between cohorts were not statistically significant.

Shifts were also found in attitudes towards online learning – an unintended outcome of the project – and participating in BLEND appeared to increase access to and participation in professional learning communities (PLCs) – a key peer-led lever for teacher professional development in South Africa. Participants also reported that participating in PLCs had enhanced their knowledge, changed their attitudes towards LtP and increased their practice of LtP.

Conclusion and implications

BLEND was a pilot implemented at scale in 250 rural and urban schools in KwaZulu-Natal, a province in South Africa. The findings from a mixed methods study were that BLEND is the most likely contender to increased knowledge about LtP and improved attitudes towards LtP as a pedagogy for teaching FP mathematics and online learning in general. Enrollment and completion rates, knowledge gains and attitude changes were greatest for the synchronous cohort - who also received school-based support to implement - as compared to the asynchronous cohort - who did not – however – with the exception of knowledge gains - in most cases the differences were not statistically significant. Overall it is clear that there has been a benefit to all participants for completing the BLEND project and that there is evidence that the synchronous modality is slightly more effective. There are lessons to be learned for the design and delivery of online and blended learning in rural and resource-constrained contexts.

PRE-RECORDED ORAL PRESENTATIONS

#329 - The big sister approach: Organizational coaching for successful implementation

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Objectives/aims
Ontario is implementing publicly funded evidence-based psychotherapy program – the first of its kind in Canada. Following a 3 year pilot, in which the program was implemented by four organizations, the program expanded across the province to include 6 additional organizations. Each organization was tasked with implementing the provincial model in their region which included hiring and training staff for two service (intake and therapy), implementing measurement based care and data collection methods, and engaging and communicating the program to stakeholders. CarePoint Health (CPH) was one of the new organizations and established a partnership with Waypoint Centre for Mental Health Care which had been a pilot organization and was further along in implementing the model. Through the partnership, Waypoint supported key activities on behalf of CPH allowing CPH to slowly build their team and focus on key activities. The aim of this presentation is to share the key learnings of Waypoint and CPH of such a partnership as well as the benefits and challenges for each.

Methods
The format of the session will be a 20 minute oral presentation in which each partner will present a frank perspective of how the partnership supported the implementation of the program in a new region and the challenges and benefits of the partnership for each organization.

Main findings
The implementation partnership resulted in:

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- Early launch of services for the region served by CarePoint Health
- Slow and steady growth of the program at CarePpoint Health (e.g., able to slowly grow team while still serving clients)
- Learning from key leaders at Waypoint which including coaching to specific roles (e.g., Clinical Lead to Clinical Lead; data quality lead to data quality lead)
- High quality data collection from the outset as data collection tools were replicated on what already existed
- CPH was able to focus on community engagement and change management while key aspects of the program were managed by Waypoint

Some challenges of the partnership included:

- Balancing the needs of both organizations including finding adapting the current service offerings to a new region with a different population demographic.
- Additional workload on Waypoint team members who were providing coaching and support to the new team

Overall, the organizational coaching strategy allowed CarePoint to overcome key challenges associated with scaling up.

PRE-RECORDED ORAL PRESENTATIONS

#337 - The impacts of mental health recovery innovations: capturing conceptual complexity with the new IMRI framework

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Objectives/aims
Implementing mental health recovery guidelines entails organisations implement new recovery-oriented innovations. The aim however should not be to just offer a new service but rather to shift organisational culture and transform services towards a recovery-orientation. Thus the concept of "impact" when implementing recovery innovations is multifaceted and complex – involving many levels and diverse perspectives (from individual, to service, to organisation). The aim of this study was to develop a conceptual framework for impact, grounded in the views of service providers, service users, managers, families and knowledge users.

Methods
This qualitative impact sub-study (Piat et al. 2022, *International Journal of Mental Health Systems*) was part of a 5-year study on the implementation of mental health recovery guidelines into services. Seven organisations in five Canadian provinces providing mental health and housing services to people living with mental health challenges, participated in a facilitated planning process. Implementation teams were established and researchers provided external facilitation to take the recovery guidelines and translate them into an implementation plan for one recovery-oriented innovation. Organisations chose and implemented one of the four following innovations: hiring peer support workers, Wellness Recovery Action Planning (WRAP), a family support group, and staff recovery training. 90 service users, service providers, family members, managers, other actors and knowledge users participated in 41 post-implementation group, individual or dyad semi-structured interviews. The interview guides included open-ended questions eliciting participants' views regarding the impact of implementing the innovation on service users, service providers and their organisations. We applied a collaborative qualitative content

analysis approach in NVivo12 to coding and interpreting the data generated from these questions.

Main findings

Eighteen impacts of implementing recovery innovations were identified. Impacts were organised around four overall categories of impact forming the IMpacts of implementing Recovery Innovations (IMRI) conceptual framework: *Ways of being, Ways of interacting, Ways of thinking, and Ways of operating and doing business.* Three impacts of working as an implementation team member and as part of a research project were also identified. A strength of the framework is that it is grounded in the views of multiple stakeholders who were: prompted to consider impact at multiple levels, from diverse organisations, and had experienced the implementation of one of four different recovery innovations. IMRI stands to advance evaluation efforts in mental health recovery research because too often impact is narrowly evaluated as individual-level outcomes. When implementing recovery innovations aimed at system transformation, we need a broader view of impact that includes, but is not limited to, individual-level impacts. The IMRI conceptual framework fills this gap by encompassing service provider and organisational impacts.

PRE-RECORDED ORAL PRESENTATIONS

#340 - Walk the Talk toolkit: an implementation strategy for translating mental health recovery guidelines into action

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Objectives/aims
Transforming mental health services to a recovery-orientation is a policy priority worldwide. Guidelines for implementing recovery are an important resource for meeting this priority However, guidelines are challenging to implement due to their length and complexity. The aim of this research was to develop an innovative implementation strategy for implementing the Canadian Guidelines for Recovery-Oriented Practice and to make it freely available as an online bilingual toolkit called Walk the Talk/De la parole à l'action (walkthetalktoolkit.ca, delaparolealaction.ca)

Methods
A three-stage implementation strategy was designed and tested in seven organisations across Canada as part of 5-year research project. These stages were: 1) Establishing an Ad-hoc committee (aim: choosing a service and recruiting an implementation team), 2) the 12-meeting planning process (aim: for the implementation team to choose one recovery innovation and plan for its implementation), and 3) ongoing implementation coaching (aim: succeed in implementing the recovery-oriented innovation). Subsequent funding enabled all of the materials to be re-worked into the format of an online toolkit. Creators worked with an expert panel made up of facilitators and implementation team members from the original research project, and with a social enterprise specializing in website and digital content development. Two organisations were recruited as "Early Adopters" of the toolkit and appointed an internal facilitator to use the toolkit. Internal facilitators received and continue to receive coaching from the toolkit creators. Coaching sessions are being recorded for future analysis.

Main findings

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All seven organisations in the original research project completed the three stages and implemented one recovery-oriented innovation based on the guidelines. The Walk the Talk toolkit was launched in February 2022. The Toolkit includes a step-by-step implementation process and lay language resources. It helps organizations to optimize organizational readiness and ensure leadership commitment and stakeholder buy-in for change from the earliest stages of implementation. It translates implementation frameworks and theories into games, videos and consensus-building activities. Each of the three stages is broken down into discrete objectives and includes facilitator guides and materials to handout to implementation team members for each activity. All materials can be downloaded freely. It is gaining traction across continents with over a thousand users accessing its content in either language. The two early adopter organisations are still in the process of using the Walk the Talk toolkit. We are paying close attention to users' feedback on how to make the implementation science terminology more accessible. Facilitators and implementation team members appreciate the way in which the toolkit enables choice, empowers service users and families, and places control over decision-making in the hands of the implementation team, not the facilitator. Funding has been secured for a new study on adaptation in which we will work with organisations across Canada serving equity-deserving groups to adapt and use the toolkit.

PRE-RECORDED ORAL PRESENTATIONS

#351 - Examining factors affecting WIFS program coverage in state government schools of Delhi: Implications for policy and practice

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Objectives/aims

Anemia poses a pressing public health challenge in India, specifically impacting adolescent girls, and Delhi is no exception. As per the National Health and Family Survey-V, 52% of adolescent girls and 19% of adolescent boys aged 15 to 19 in Delhi are affected by anemia. This study aims to evaluate the delivery and implementation process of the Weekly Iron and Folic-acid Supplementation (WIFS) program under the Anemia Mukt Bharat strategy in the schools administered by the Government of National Capital Territory of Delhi (GNCTD). We aim to understand the factors contributing to the effective implementation of WIFS at the school level by exploring the implementation strategies and identifying areas for improvement.

Methods

Our study employs a mixed-method approach, combining Three rounds of quantitative surveys over 4 months covering a total of 900 adolescent students studying across 26 GNCTD schools. Targeted qualitative surveys with state, district, and school-level

officials and parents of school-going adolescents, and Observations at schools with good and poor coverage, as identified through the quantitative surveys

Main findings

Our findings reveal wide disparities in WIFS coverage, with consistent receipt of tablets ranging from 38% to 100% and consumption of tablets varying from 13% to 93% across the schools covered. Generally, girls received and consumed Iron Folic Acid (IFA) tablets more consistently than boys. At the school level, all-girls and co-ed schools tended to demonstrate higher coverage rates than all-boys schools. The variations in WIFS program coverage across schools are not solely attributed to teachers' performance. Instead, the primary concern lies in the absence of explicit school-level guidelines, resulting in inconsistencies in school-level processes. Schools demonstrating better coverage tend to follow these processes: WIFS nodal teachers themselves distribute tablets in each classroom, teachers conduct follow-ups with absent students, and students consume tablets in the presence of teachers.

Main Findings

From a quick monitoring exercise, we identified some immediate solutions that can improve the efficiency of the WIFS program in Delhi. The study recommends developing operational guidelines for school principals, WIFS nodal teachers and class teachers for standardizing distribution processes at the school level. We also recommend training the WIFS nodal teachers on standardized operational guidelines to ensure efficient distribution and consumption of WIFS tablets. By implementing simple measures such as distributing tablets on subsequent days for absent students and encouraging consumption in the presence of teachers, we can mitigate issues related to missing tablets due to absenteeism and loss of tablets by students. This study presents a use case of how simple, periodic and targeted surveys can drive implementation improvements for large-scale programmes.