Evaluation komplexer Interventionen

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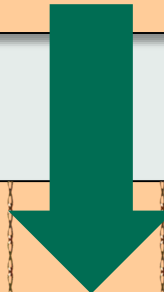
GeLang-BeLLa Workshop „Komplexe Interventionen“

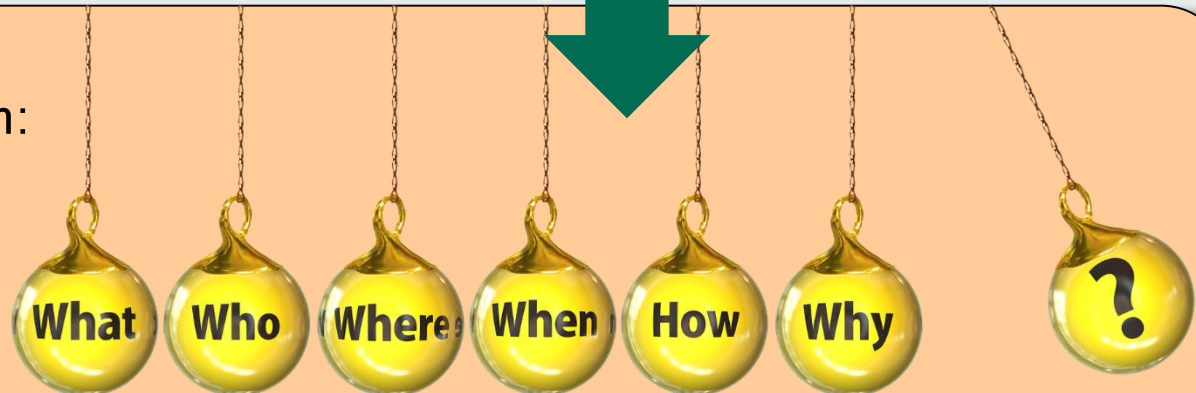
Anforderungen an die Evaluation komplexer Interventionen

kurz, mittel- und langfristige Effekte?

Outcome-Evaluation:



Prozess-Evaluation:

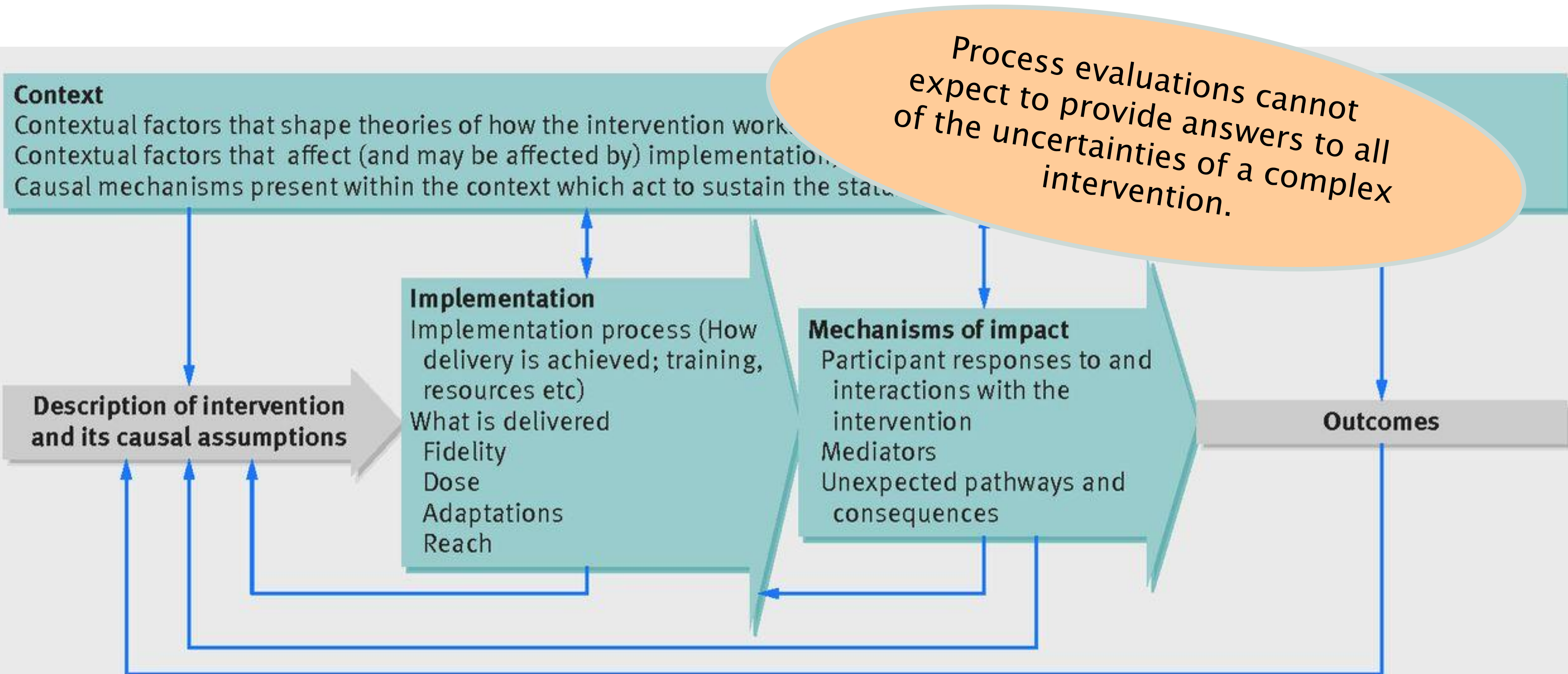


MRC process evaluation framework

Process evaluation of complex interventions: Medical Research Council guidance

2015

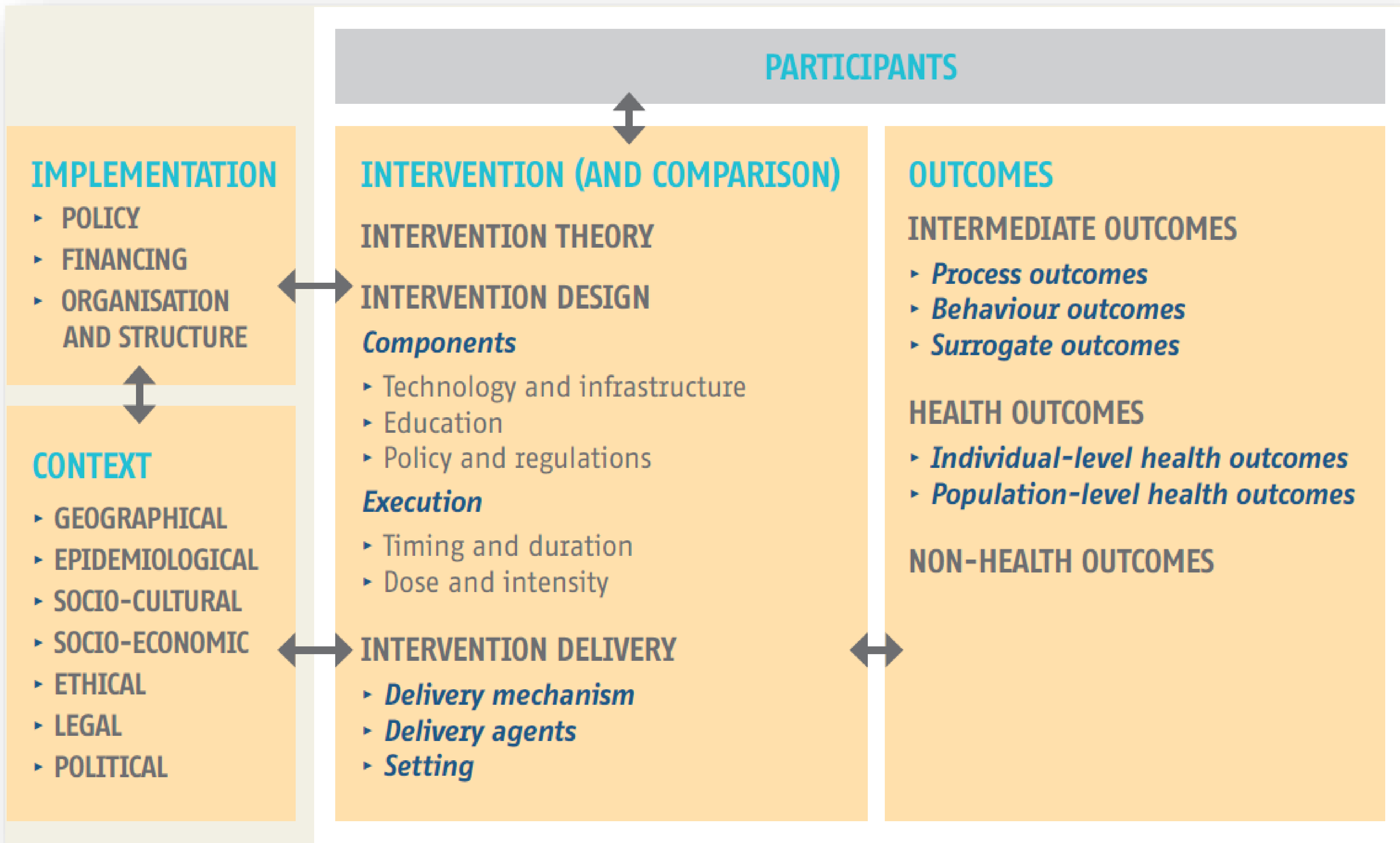
Graham F Moore,[1] Suzanne Audrey,[2] Mary Barker,[3] Lyndal Bond,[4] Chris Bonell,[5] Wendy Hardeman,[6] Laurence Moore,[7] Alicia O'Cathain,[8] Tannaze Tinati,[3] Daniel Wight,[7] Janis Baird[3]



Kernkomponenten der Prozessevaluation (blaue Kästchen)

Logic models of complex interventions

(System-based logic model template)



Rohwer et al. (2016) Guidance on the use of logic models in health technology assessments of complex interventions. http://www.integrate-hta.eu/downloads

De Silva *et al. Trials* 2014, **15**:267
http://www.trialsjournal.com/content/15/1/267

TRIALS

METHODOLOGY Open Access

Theory of Change: a theory-driven approach to enhance the Medical Research Council's framework for complex interventions

Mary J De Silva[1*], Erica Breuer[2], Lucy Lee[1], Laura Asher[1], Neerja Chowdhary[3], Crick Lund[2] and Vikram Patel[1,3]

Theory of Change-Ansatz

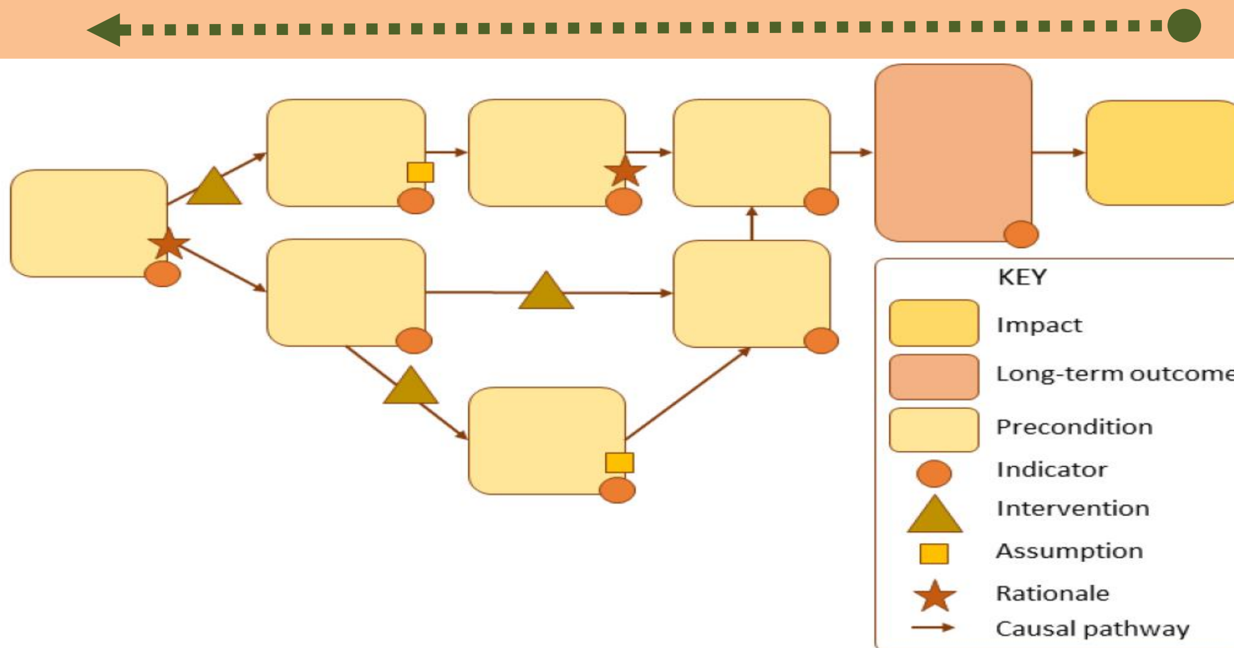
= systematischer Prozess im Rahmen der Interventionsentwicklung, um Wissen über das Wie, das Warum und die Umstände der voraussichtlichen Interventionswirkung zu generieren
(→ Wirkungsmodell als Produkt dieses Prozesses!)

- Definition der Interventionskomponenten
- Anforderungen an deren erfolgreiche Implementierung
- Rahmen für die Prozess-Evaluation

Using **Theory of Change** in the development, implementation and evaluation of complex health interventions (De Silva & Lee, 2014)

- Ausgehend von dem Interventionsziel werden jeweils rückwärtsgerichtet Zwischenziele als Voraussetzungen für das Hauptziel formuliert.
- Anschließend werden dafür erforderliche Maßnahmen mit den entsprechenden Annahmen und Begründungen,
- zu messende Indikatoren sowie
- fördernde und hemmende Faktoren definiert.

→ Dabei werden die Maßnahmen nicht streng linear in Beziehung gesetzt, sondern können auf verschiedenen Ebenen des Wirkmodells angesiedelt sein.



Resources | Identification | Treatment | Long-term Outcome | Impact

Intervention coordinator (IC) in post

Adequate ongoing program management and clinical supervision

In antenatal and immunization clinics, IFs able to: (ii)
1. Recruit and conduct regular supportive supervision of Peer Support Workers (PSWs)
2. Identify mothers with depression using screening tools and appropriately refer them for treatment (iii)
3. Conduct awareness raising in hospital clinics

Nurses encourage mothers to participate in program

Intervention facilitators (IF) in post. Hospital clinic nurses aware of programme.

Co-morbid psychosis/suicide risk

Co-morbid psychosis/suicide risk mothers receive specialist treatment in tertiary services (viii)

Recovering

No improvement after 3 sessions

No co-morbid psychosis/suicide risk

Mothers receive counselling as intended for the required duration (vi)

Primary outcome:
1. Improved clinical outcomes for mothers with depression treated by program (ix)

Secondary outcomes:
2. Improved social functioning (x)
3. Improved child health outcomes (e.g. adequate breast feeding, improvement in infant weight)

Reduction in treatment gap for maternal depression in district

Community Health Workers (CHWs) aware of programme (i)

CHWs able to:
1. Help the IFs identify, recruit and supervise PSWs
2. Conduct community awareness raising

PSWs in post & integrated into hospital system (iv)

PSWs able to:
1. Deliver counselling
2. Appropriately refer mothers
3. Conduct community awareness raising (v)

Ceiling of accountability

Community is aware of peer counselling and mothers are willing to seek help and receive treatment (vii)

Intervention needed

Assumption

Intervention

Rationale

(i) Indicator

Example assumptions

A. CHW's are engaged with the program, are willing to undergo mental health training and have the time to recruit and supervise PSWs.

B. PSWs with the necessary qualities to be counsellors exist in the community and have the time and motivation to be counsellors. Families of potential PSWs allow them to undertake counselling of depressed mothers.

C. PSWs are continuously supervised, supervisors are available to discuss difficult cases and to help PSWs cope the psycho-social burden of providing counselling.

D. Mothers with depression attend the antenatal/immunization clinics. Mothers consent to be screened for depression.

E. Mothers are willing to receive counselling by PSWs and be referred to tertiary care for specialist treatment if necessary.

F. Tertiary care providers are willing and able to accept referrals from IFs and to refer those who are recovering for counseling to PSWs

Example rationale

a. Evidence from implementation research that task shifting is not effective unless combined with ongoing supportive supervision

b. Evidence from systematic reviews that counselling is an effective treatment for depression. Evidence from RCT of Thinking Health Programme in Pakistan that THP is an effective treatment for maternal depression which also improves child outcomes.

c. Observational evidence that seeing people with mental illness successfully treated and return to social roles in the community reduces stigma and increases demand for services.

Example interventions

1. Training of IFs, nurses, CHWs and PSWs.
2. IC conducts regular supervision with IFs, nurses and CHWs.
3. IFs and CHWs recruit PSWs and conduct regular supportive supervisions.
4. CHWs and PSWs conduct awareness raising in community.
5. IFs & nurses conduct awareness raising in clinics.
6. IFs screen potential cases and refer mothers with depression for treatment according to the severity of their condition.
7. Mothers with co-morbid psychosis or at risk of suicide are referred to specialist care.
8. Mothers with no co-morbid psychosis and not at risk of suicide are referred PSWs for counselling.
9. Mothers with severe depression who are recovering are referred to PSWs for counselling. Mothers who show no improvement after 3 sessions of counselling are referred to tertiary care.

Example indicators (i)

i. 80% of CHWs in district are aware of program. 1 CHW per sub-centre is identified as a PSW supervisors

ii. 1 IF per hospital clinic has the core competencies post training to screen and refer women & conduct awareness raising activities.

iii. 80% of women attending the clinic are screened for depression and 80% of those diagnosed are appropriately referred.

iv. 8 PSWs in post and roles incorporated into structure of hospital.

v. 7 PSWs have the have the appropriate skills post training to deliver counselling, refer mothers and raise awareness.

vi. 80% of people treated by the program attend 60% of their counselling sessions.

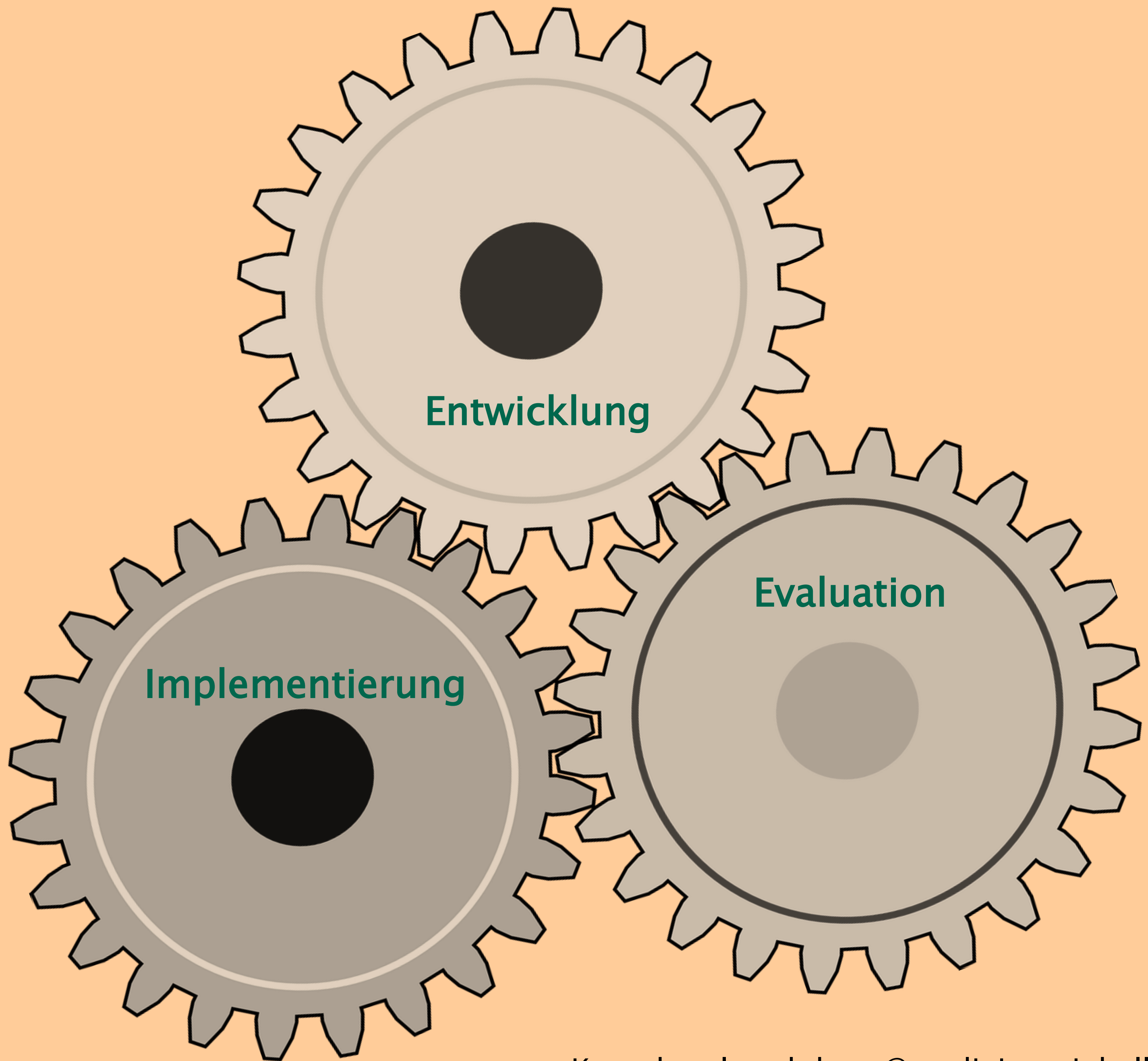
vii. 20% increase in mental health awareness and 20% reduction in stigma in community.

viii. 80% of cases referred to tertiary care received tertiary care services. 60% recovering cases referred back for counselling.

ix. 50% improvement in depressive symptoms at 3 months among mothers treated by the program compared to 30% improvement in control group.

x. 50% improvement in mothers social functioning score at 6 months compared to 30% improvement in control group.

"SHARE: peer counselling for maternal depression in Goa, India"; Beispiel aus: De Silva et al., Trials 2014



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