


# Commentary: Strengthening System Readiness for Health Interventions: Lessons for Implementing Interventions and Implementation Support in Low-And Middle-Income Countries

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## Abstract

In low- and middle-income countries (LMICs), barriers such as low system readiness, contextual mismatches, and resource limitations impede effective implementation of evidence-based interventions. This commentary offers insights into overcoming these challenges with a case study of the PRISM project, designed to reduce behavioral and psychological symptoms of dementia in older adults living in Thailand. The case highlights how combining two evidence-based models - the *Reducing Disability in Alzheimer's Disease* clinical intervention and the *Getting To Outcomes* implementation science process enhances program success. Using interviews with stakeholders across various health system levels, we identify factors critical to successful program implementation: (1) integrating interventions into policy frameworks, (2) empowering local implementers, (3) fostering collaborative learning, and (4) adapting interventions to local contexts. The case demonstrates that building system readiness through local engagement and ownership is central to scaling up health programs in LMICs. This commentary's contribution lies in its emphasis on the role of implementation science as a vehicle for translating research into practice. It presents a practical, adaptive model for embedding interventions into routine health systems, thereby offering a pathway for successfully scaling up evidence-based programs in LMICs. Such findings provide lessons for overcoming barriers to implementation in resource-limited environments.

## Keywords

readiness, implementation support, global health delivery, dementia care, PRISM, Thailand

## Introduction

One of the most significant and common challenges in global health development is translating the knowledge of successful intervention programs based on prior research into the practice of service improvement in new settings, particularly in low- and middle-income countries (LMICs). In these settings, problems are well recognized, but effective strategies to implement evidence-based interventions are often not yet established. Although key challenges contributing to the research-to-practice, or knowledge-to-practice, gaps have been identified—such as a lack of contextual understanding, low political priority, poor stakeholder partnerships, and resource and capacity constraints (Semahegn et al., 2023)—there is limited evidence on how to overcome these obstacles in LMICs.

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Over the past decade, implementation science has emerged as a promising strategy to address these challenges by promoting the systematic uptake of research findings and evidence-based practices into routine healthcare. This commentary highlights how key concepts and strategies from the science and practice of implementation support—such as readiness, motivation, capacities, adaptation, and support systems (Wandersman & Scheier, 2024)—are essential and need to be adapted for the context of LMICs. We present a case example illustrating the application of the *Getting To Outcomes* implementation process in a clinical intervention study. Based on stakeholder perspectives across multiple system levels, we identified several key drivers crucial for the successful implementation and scaling of evidence-based interventions. A holistic and comprehensive approach is essential to strengthen system-wide readiness for change and ensure effective implementation.

## Background

The rapid growth of the aging population in Thailand has led to an increased prevalence of dementia and a corresponding rise in care demands, particularly for older adults who experience behavioral and psychological symptoms of dementia (BPSD). Given that dementia is classified as a psychiatric disorder, coupled with the shortages of mental health specialists, insufficient funding for mental health services, and the growing evidence supporting the use of trained non-specialists to deliver dementia care (i.e., the *task-sharing* approach), the Partnership in Implementation Science for Geriatric Mental Health (PRISM) project, funded by US National Institute of Mental Health, chose to implement an evidence-based intervention model that relies on community-based health professionals (such as “care managers”) and community health workers (such as “community caregivers”) to deliver care (Chen et al., 2022).

The PRISM project focused on delivering an evidence-based caregiver training program called Reducing Disability in Alzheimer’s Disease (RDAD) (Teri et al., 2003) to older adults with dementia in Thailand. To ensure the successful implementation of the RDAD program, PRISM also employed another evidence-based intervention, the Getting-To-Outcomes (GTO) implementation science process (Chinman et al., 2013). The central goal of PRISM was to test whether the GTO implementation process model results in better outcomes than the RDAD program delivered under the standard government procedure for the implementation of evidence-based programs, which typically requires training frontline service workers, documenting activities, and reporting outcomes. Local practitioners identified common challenges in this “business as usual” top-down approach, such as overburdened staff, low motivation, superficial participation, and the tendency to “game the system” by reporting false data to meet mandatory reporting requirements.

During the wrap-up phase of the PRISM project, it became clear that the initiative generated significant interest from stakeholders eager to scale it beyond the research trial.

The culturally adapted intervention, based on RDAD, was integrated into routine care plans and practices within the long-term care (LTC) system. This commentary summarizes interviews with the research team and key stakeholders, examining their perspectives on how PRISM addressed common implementation challenges and factors influencing the successful implementation of similar interventions in Thailand. These findings may have broader implications for global health delivery in other LMICs.

## Case Overview and Stakeholder Perspectives

The following description is based on key informant interviews with stakeholders selected from various fields using purposive sampling in alignment with the Interactive Systems Framework for Dissemination and Implementation (ISF; Wandersman et al., 2008). Stakeholders included key personnel from the PRISM project, representing the “knowledge synthesis and translation system,” health care providers representing the “delivery system,” and clinical leaders and care managers trained as technical assistance providers representing the “support system.” The interview protocol covered topics such as the introduction of the intervention to different stakeholders, dissemination and scaling-up process, adaptations to the intervention, strategies for engaging key implementers, and factors influencing successful implementation and dissemination. The summary below provides a chronological overview of the PRISM project’s implementation process over its six-year duration.

### Year 1: Introducing the Project to National and Local Leaders

One of the most critical decisions made through the “knowledge synthesis and translation system” in the first year of the project was to introduce the project concept to national policymakers while also identifying the best service platform for implementing the proposed intervention and support strategies. Although the literature recognized dementia and the care of individuals with BPSD as growing challenges, the research team believed it was essential to first inform policymakers about both the severity of the issue and the potential of the proposed solution through the PRISM project.

The first challenge was presenting the project in a way that would capture the attention of system leaders and motivate them to establish a partnership for implementation. In a strategically structured meeting, the project team invited leaders from various sectors and employed several strategies to engage them: (a) frontline care providers from different provinces shared compelling case stories to illustrate unmet needs in their communities; (b) the team presented the evidence-based intervention protocol (RDAD), and the implementation process protocol (GTO); and (c) key figures, such as the deputy minister, the chairman of the Thai Alzheimer’s Association, and leaders from the Department of Health, were

invited to help facilitate discussions among attending system leaders. It's worth noting that policymakers were not only interested in the project because it addressed an important health issue (dementia), but also because it offered a potential solution to one of their ongoing concerns: the problem of policy implementation failure.

Several options were considered for determining the service platform for implementing and disseminating the proposed interventions. One option was to develop the project as a demonstration and integrate it into the quality-of-care framework through the Thai Healthcare Accreditation Institute. However, this option was not selected because the accreditation program at the time focused on higher-level hospitals, whereas the PRISM project aimed to support primary care and community-level services.

The second option was to integrate PRISM with the national District Health System Development Initiative (DHSDI), which aimed to strengthen rural health through District Health Boards at the district level. However, this option was also abandoned because the DHSDI program was too broad, addressing a wide range of rural health issues—such as disability, poverty-related health concerns, elder care, road accidents, and alcohol abuse—with little focus on long-term care. Another option was to engage the Family Physician Network, a promising new initiative. However, this network was not yet well integrated into the broader healthcare system, and the limited number of family physicians were already overwhelmed with general practice responsibilities.

The final option was the newly established Long-Term Care (LTC) system, created a year before PRISM program funding. The National Health Security Office had just started developing the LTC fund, asking sub-districts to provide essential support and care for elderly individuals in the community. The project team chose the LTC system because its focus on enhancing care for community-dwelling elders aligned with the PRISM project's goals. Leaders of the LTC system were interested in collaborating, recognizing that the PRISM project could help strengthen their existing training program with evidence-based intervention protocols. The leaders of the LTC system agreed that providing implementation support would be crucial for their personnel to effectively carry out the new tasks required by the intervention.

## **Year 2: Engaging and Empowering Local Implementers**

One challenge faced by the project team was engaging frontline implementers and ensuring they not only understood the nature of the target condition but also the significance of the project, which aims to improve care for individuals with dementia. The key implementers within the promising service program in the LTC system included local health service providers such as care managers (CMs), community caregivers (CCGs), and family caregivers. CMs, typically trained nurses, received training in assessing and designing recommended services to be incorporated into each care recipient's individualized care plan. They

also supervise community caregivers, often volunteers, who are trained to provide care based on the care plan's recommendations. Together, CMs and CCGs work closely with family caregivers to deliver health and social support to community-dwelling elders and their families.

In the second year of the PRISM project, the team conducted a pilot study that began with workshops and focus group interviews with CMs and CCGs. The workshops started by asking participants to share their experiences caring for older adults with dementia and the BPSD these patients often exhibit. After this exchange, BPSD was introduced as a clinical concept, which was easily understood by the group. Similarly, providers were asked to discuss their experiences with current care solutions and share their perspectives on the effectiveness of these approaches. Following this discussion, the project team introduced the core concepts of the proposed RDAD and GTO interventions—both to gauge the providers' understanding and to impart new knowledge and clinical skills.

During the pilot phase, the project team deliberately avoided involving too many policymakers so that the learning process would be more "organic" for local implementers, rather than being influenced by the need to respond to policymakers' expectations and suggestions. The interactive process, led by medical anthropologists, was particularly beneficial for several reasons. First, it minimized resistance by directly engaging the perspectives of community care providers who are often inundated with training requests as part of various top-down initiatives from the Ministry of Public Health or other regional and provincial offices (see [Table 1](#)). Second, providing opportunities for these providers to share their experiences validated the importance of their insights into the target problem and helped them recognize the relevance of the proposed intervention to their work. This "empowerment" made them more willing to engage with and learn about the intervention. Third, small-group discussions among peers on pre-arranged topics helped participants better understand new concepts by connecting them to their experiences and familiar scenarios often discussed in the group. Fourth, listening to local implementers' reactions during the workshops helped the project team in their tasks of translation and adaptation of the original intervention protocols.

## **Years 3–4: Preparing for PRISM Implementation**

Drawing on prior experience in launching similar intervention implementation projects, the project team organized several activities to prepare the entire LTC system for the implementation of the PRISM program. First, the team invited the originators of the RDAD and GTO intervention protocols, including Dr Linda Terry and Dr Abraham Wandersman respectively, to Thailand to train local health providers and administrative officers. These sessions included discussions on barriers to implementation and potential solutions, which significantly enhanced the readiness of frontline implementers and administrators and boosted the project team's confidence

**Table 1.** Comparison of Routine Implementation of a New Initiative with the PRISM Project

Key features	Business as usual	The PRISM Project
Demand vs. opportunity	Top-Down requirements	Opportunity for learning and exchange
Initial tasks	Defining goals and required tasks	Sharing relevant experience
Knowledge learning	Learning new concepts	Linking new concepts to their own experience

in carrying out the project. The exchanges helped clarify the critical components of the intervention, which proved essential in adapting RDAD and GTO to fit the local context. Lessons learned from this process have been documented elsewhere (Tongsiri et al., 2022).

The second preparatory task was organizing a “kick-off conference” before formally implementing the PRISM project. Local leaders, including representatives from the Department of Health, Department of Medical Services, National Health Security Office, Public Health Technical Office, regional and provincial health personnel training offices, leading physicians and representatives from the Dementia Association of Thailand, were invited. Since the PRISM project was considered an “extra” activity, the participation of providers heavily depended on the endorsement and support of local organizational leaders. A key purpose of the launch conference was to showcase the value and potential service improvements offered by PRISM to secure the backing of upper and mid-level administrators.

At the provincial level, the research team visited the Provincial Chief Medical Officer to introduce the project, and two officers were designated to help facilitate and coordinate research activities. Provincial support was critical to ensure that leaders of implementing organizations encouraged care managers and other implementers to participate. To further solidify local collaboration, a ceremonial event was held to sign a Memorandum of Understanding with leaders from 16 participating districts. Unlike conventional ceremonial events, which are often symbolic, this event was both educational and empowering. It emphasized the evidence-based nature of the intervention and the need to alleviate unnecessary suffering for families affected by dementia. Building a supportive climate through mobilizing a social network aimed at consensus-building and fostering collective political will proved essential in securing the commitment of frontline implementers and their supervisors to the new project.

The third activity involved training local health providers using the World Café method to promote collaborative learning. A World Café session is a structured approach that facilitates group dialogue and knowledge sharing through small group discussions. It is typically used to explore a topic from multiple perspectives, encouraging participants to contribute and form new connections. Since frontline providers in the community were often overwhelmed with training requests, they sometimes felt ambivalent—while training offered a legitimate break from their busy schedules, they often found traditional lecture-style sessions boring and associated training with an increased

workload. To address this, the project adopted the World Café format and organized a series of interactive workshops and conferences for CMs and CCGs, with the end result of fostering greater engagement and active participation.

The training conferences typically began with introductory lectures delivered by project team members, who developed the agenda and introduced key topics relevant to the PRISM intervention protocols. These included both clinical interventions for managing BPSD and implementation support interventions based on the GTO framework. The lectures incorporated storytelling and narratives of illness experiences, creating an atmosphere of empathy and empowerment.

Following the lectures, several rounds of World Café sessions were conducted, involving the following steps: (a) participants were divided into small groups of 6–10 people to discuss assigned topics by sharing their experiences, knowledge, and opinions; (b) each group selected 1–2 facilitators to summarize and document key discussion points on a board; and (c) the facilitator or group leader then presented these key points to the larger group. Unlike traditional didactic lectures that rely on a top-down approach, the World Café sessions emphasized a collaborative exchange of experiences and knowledge. This method not only helped participants connect new content with their prior experiences, enhancing “*understanding*” but also empowered them by encouraging active involvement. This “*empowerment*” fostered a more positive attitude toward learning, increasing their motivation to engage in the project’s implementation.

Additionally, the focus on improving patient symptoms and recovery highlighted the direct relevance of the training to their work, further boosting motivation. Participants found the intervention immediately applicable and valuable, recognizing how it improved caregiving processes, increased collaboration among providers, and made caregiving more systematic. The large conference, with hundreds of care managers and caregivers participating, also created a sense of solidarity, reinforcing the feeling that “*we are in this together*” on a new learning path, contributing to an overall climate of support.

The fourth activity involved collaborating with local medical professionals to identify and confirm cases for the intervention study. To meet the inclusion and exclusion criteria for participant enrollment, physicians—including psychiatrists and primary care doctors—were engaged as study physicians to confirm eligibility. The process began with care managers and nurses presenting patient profiles that screened positive for cognitive impairment and BPSD, along with other relevant medical information (e.g., chronic conditions) based on medical records. The study physicians then reviewed the information and determined whether



the patient should be included or excluded from the study (see Chen et al., 2022 for details on the PRISM protocol).

This case confirmation procedure is standard practice in research involving individuals with dementia and/or BPSD. The involvement of physicians, in collaboration with care managers and nurses, not only ensured the quality of clinical assessments but also helped care managers gain a deeper understanding of the target condition. This collaboration enhanced the credibility and value of the project, contributing to the overall “*climate of support*” for participation.

Identifying key strategic partners was critical for the successful implementation of the project. Effective collaboration empowered partners and fostered a sense of ownership in the intervention process. While each partner required tailored communication, the core messages consistently emphasized the suffering experienced by families of dementia patients, the empowering aspects of the intervention that facilitated the delivery of complex care, and the importance of engaging the right people at the right time. At a minimum, it was essential that all partners were fully engaged at the project’s crucial stages, particularly during the “take-off” and “landing” phases of implementation.

**The Evaluation Study.** Embedded within the PRISM project was a randomized controlled trial designed to examine the impact of an enhanced implementation support strategy, using GTO, on the delivery of the RDAD exercise and behavioral intervention for older adults with dementia and their family caregivers in community-based home settings in Thailand (see

Table 2). The cluster-randomized trial was conducted across 16 districts within one province. Eight districts were randomly assigned to receive the RDAD intervention with enhanced implementation support through the GTO framework (experimental arm), while the remaining 8 districts received only the RDAD intervention without GTO (control arm).

From an implementation perspective, the primary difference between the two study arms was in the training provided to community care providers (CMs and CCGs) who participated in World Café sessions and later served as interventionists. In the experimental arm, providers were trained to deliver the RDAD intervention along with the first six steps of the GTO implementation support process (i.e., Needs & Resources, Goals, Best Practices, Fit, Capacities, and Plan). In the control arm, providers were trained to deliver only the RDAD intervention, without any additional GTO content. The intervention was delivered over three months in both arms and was evaluated using pre- and post-assessments.

### **Years 5–6: Scaling up and Adaptation through Local Networks**

After the successful implementation of the PRISM evaluation study, preliminary outcome data showed positive effects of the intervention, and cost analysis indicated that the protocol met Thai policy requirements for acceptability. As a result, local government agencies and relevant offices expressed interest in scaling up the PRISM protocol and integrating it into the ongoing LTC service system across four provinces.

**Table 2.** Key Activities in Each Stage of the PRISM Implementation

Year	Stage/Focus	Key activities
Year 1	Introduction and initial engagement	<ul style="list-style-type: none"> <li>- Introduced project concept to national policymakers and system leaders</li> <li>- Organized meetings to present unmet needs through case stories shared by care providers</li> <li>- Discussed potential service platforms and chose the newly established long-term care (LTC) system</li> <li>- Secured collaboration with LTC leaders by aligning project goals with LTC system’s mission</li> </ul>
Year 2	Engaging and empowering local implementers	<ul style="list-style-type: none"> <li>- Conducted pilot workshops and focus group interviews with care managers (CMs), community caregivers (CCGs), and family caregivers</li> <li>- Empowered local implementers through participatory learning and small group discussions</li> <li>- Avoided involvement of policymakers to allow for “organic” learning among local implementers</li> </ul>
Years 3-4	Preparing for implementation and evaluation	<ul style="list-style-type: none"> <li>- Invited originators of RDAD and GTO protocols to train local providers and administrative officers</li> <li>- Hosted a “kick-off conference” for local and provincial leaders to build a supportive climate</li> <li>- Conducted world café sessions to foster collaborative learning among CMs and CCGs</li> <li>- Coordinated with local physicians to identify and confirm cases for the intervention study</li> <li>- Conducted an evaluation study using a randomized controlled trial</li> </ul>
Years 5-6	Scaling up and adaptation	<ul style="list-style-type: none"> <li>- Successfully implemented the intervention across 16 districts in Thailand</li> <li>- Local government expressed interest in scaling up the PRISM protocol</li> <li>- Developed a simplified “sufficient care for dementia (SCD)” protocol for routine LTC services</li> <li>- Integrated SCD protocol into the computerized workflow and routine community health service package</li> <li>- Maintained ongoing technical assistance for sustained implementation and support</li> </ul>

To initiate this process, local health authorities asked a group of medical professionals—mainly physicians and senior nurses from the region—to review the PRISM protocol and evaluate its feasibility for integration into routine LTC services. After reviewing the materials and listening to presentations, the group concluded that both the RDAD and GTO protocols used in the evaluation study were too complex to fit into standard clinical practice. Nonetheless, they decided to adapt the RDAD and incorporated additional elements from the WHO-recommended guidelines.

With consultative support from the PRISM team to ensure fidelity to the original content, the group spent a month developing a new service guideline called “*Sufficient Care for Dementia*” (SCD). This revised guideline was quickly endorsed by the professional group and recommended to the local government, which promptly approved it. Training manuals and learning packages were then developed, and necessary tools and documentation systems were integrated into the computerized workflow. Coordination procedures for other aspects of care—such as dental services, nutrition, and overall care plan design—were also established. As part of the follow-up scale-up effort, the SCD guideline was implemented in four new provinces, expanding beyond the original PRISM study area.

Although the SCD guideline did not include the GTO framework, the team involved in training care providers during the scale-up phase used the GTO and ISF frameworks to guide their planning and execution processes. With strong support from the local government, the SCD protocol gradually became a routine part of the community health service package within the LTC system in one of Thailand’s 10 regions.

The PRISM project’s pioneering work successfully convinced local stakeholders, including government administrators and medical professionals, of the importance of addressing BPSD. However, stakeholders recognized the need for protocol adaptation to ensure feasibility and promote a sense of ownership—key factors for motivating continued engagement during the scale-up process. This adaptation was spearheaded by an informal network of Thai researchers, field experts, and health leaders. The network’s involvement provided key stakeholders an opportunity to participate in a structured yet flexible adaptation process, which allowed for clinical flexibility needed to address common comorbidities often seen alongside BPSD in routine practice.

Members of the informal network reported that the adaptation process not only resulted in a new protocol but also fostered a sense of ‘*pride*,’ ‘*ownership*,’ and ‘*motivation*’ for further implementation and dissemination. Additionally, the process promoted knowledge exchange, deepened stakeholders’ understanding of the project, and created a supportive climate for both local health administrators and frontline service providers. Once adapted, training on the clinical service guideline emphasized fidelity, with clear instructions on what aspects of service delivery could be modified and which needed to remain

unchanged. Care managers (CMs) collaborated on finalizing the guidelines before disseminating them to community caregivers (CCGs).

The SCD clinical service guideline gained widespread support as it was integrated into the LTC system. This was facilitated by recent changes in the administrative structure of the LTC system, which increased pressure on CMs and CCGs to meet policy goals set by higher authorities. The SCD guideline was viewed as a valuable tool for translating policy priorities into clear clinical tasks and goals. Its requirements for fidelity monitoring, which could be easily incorporated into existing health data systems, further enhanced its appeal. The guideline’s practicality, feasibility, and cost-effectiveness were well-‘*aligned with policy priorities*.’ Ongoing technical assistance from academic faculty and key stakeholders within the LTC system was crucial in sustaining the implementation of the SCD guideline.

The network through which the scale-up occurred is depicted in [Figure 1](#).

### *A Working Model of System Readiness of Local Stakeholders*

The following model outlines the factors critical for the successful implementation of evidence-based support and clinical interventions (see [Figure 2](#)). These factors are grouped into three categories. First, *stakeholder activities* refer to the observable behaviors or actions that are perceived as key to advancing the implementation project. By engaging each of the main players in meaningful clinical, social, or psychological activities, they become mentally and behaviorally activated, contributing to the project’s progress.

Second, as a result of these stakeholder activities, *implementation drivers*—the mediating mechanisms—act as catalysts for the success of the implementation process. Frontline health workers, for example, feel empowered when their experiences and views are acknowledged and validated. Through active participation in adapting the intervention protocol and integrating it into routine clinical practice, healthcare professionals gain a sense of ownership and ensure that the intervention aligns with the cultural and institutional context. These efforts also help local clinical leaders reach an advanced or comprehensive level of understanding of the intervention, which is helpful as some of them are in the position to explain the intervention to other clinical staff.

Third, as a result of these implementation drivers, the overall readiness of the system to implement the intervention has significantly increased. This is evident in the heightened *motivation* of implementers at various organizational levels to engage with the intervention and in their deeper *understanding* of the intervention protocol. This understanding is strengthened by their ability to relate parts of the intervention to their personal experiences. Furthermore, the endorsement of the project by influential leaders fostered a *supportive climate*, leading to the emergence of new trends and directions

Figure 1. The Scale-Up Network Of The SCD Service Guideline

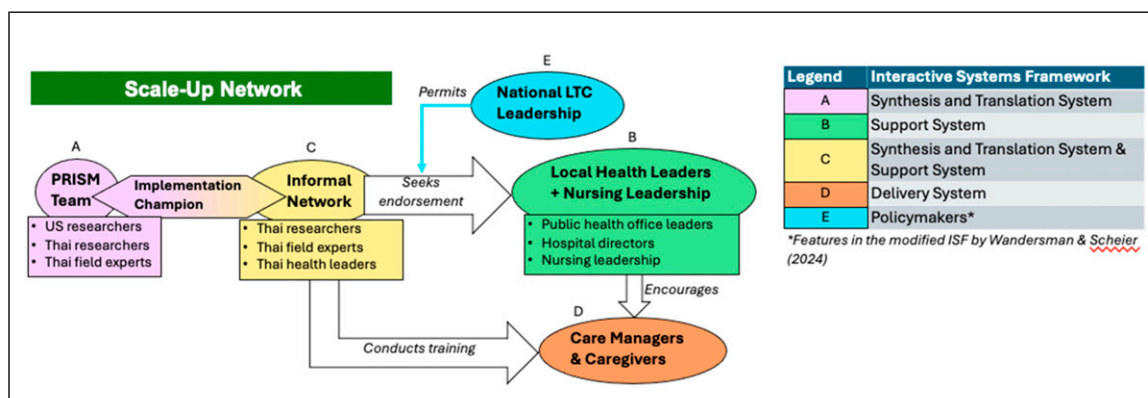
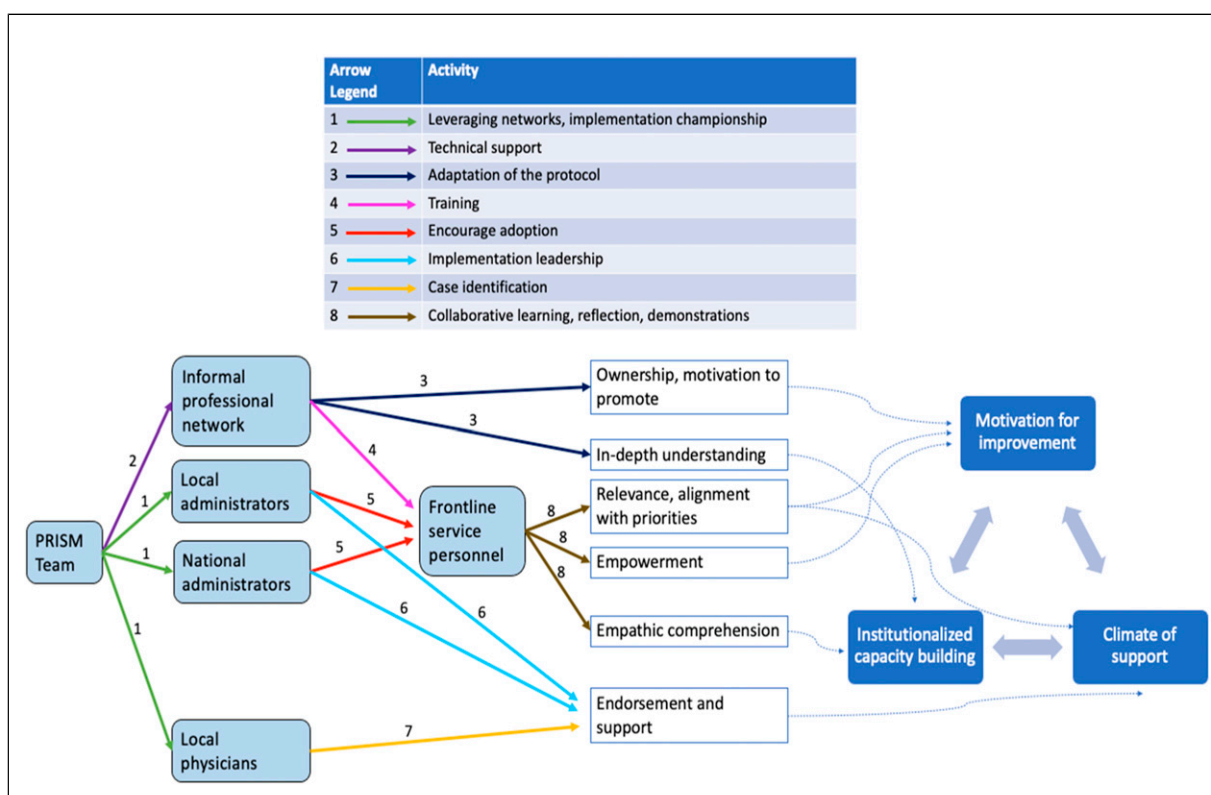


Figure 2. Pathways To Building System Readiness For Implementation And Dissemination



that clarify and enhance the intervention’s practical value within the organization.

### Discussion

The case of the PRISM project implementation in Thailand offers valuable insights into how implementers in Thailand became ready to deliver a new intervention, including many practical recommendations for introducing and implementing similar interventions in other LMIC countries. The conceptual model derived from this case study improves our understanding of the factors contributing to increased system

readiness for implementation. Our experience advocates for a realistic approach to implementation, acknowledging that clinical settings in global health are rarely blank slates ready to absorb new evidence-based solutions. In typical LMIC contexts, service providers are often overwhelmed with existing tasks. Thus, frontline workers, local medical professionals, and administrators must be sufficiently convinced and motivated to ask themselves: *Why should I take on extra work? Why would I be willing to adopt additional tasks as part of my routine practice beyond the scope of an initial pilot project?* This suggests that implementation research should focus on the perspectives of implementers, rather than merely viewing

knowledge transfer or training access as primary strategies to bridge the research-to-practice gap.

The Interactive Systems Framework (ISF) offers a more nuanced approach compared to traditional research-to-practice models by emphasizing the support system and service delivery system, in addition to the synthesis and translation system (Wandersman et al., 2008). Consistent with this framework, the PRISM project demonstrates that motivation is central to implementation and can be nurtured through social and psychological processes, such as empowerment, empathetic understanding, and creating a supportive climate. Our findings suggest that effective training and technical assistance (TTA; Wandersman & Scheier, 2024) in global health contexts requires more empirical research to understand how these processes contribute to successful TTA.

Our observations in Thailand are also highly relevant to the emerging concept of “readiness for change.” In this respect, the PRISM model aligns with Scaccia and colleagues’ emphasis on “motivation” and “capacity” (i.e.,  $R = MC^2$ ) as core components of organizational readiness (Scaccia et al., 2015). We expand on this view by incorporating the “*climate of support*” as a critical component of readiness, particularly in LMIC settings like Thailand, where social hierarchy and collectivist thinking are prevalent. In these settings, the endorsement of influential figures within the healthcare system can significantly elevate the perceived value of a recommended intervention. Given the interconnections among motivation, capacity, and climate of support, we propose that the term “*system readiness*” effectively captures the fundamental elements of organizational readiness in Thailand. This perspective aligns with literature advocating for a broader view of organizational readiness for change or innovation (e.g., Holt et al., 2010; Shea et al., 2014).

Unlike the readiness concept, Evans and colleagues (Evans et al. (2022) conducted a systematic review of implementation practice models used in LMICs, summarizing that these models share common characteristics centered around three fundamental tenets: opportunity (situational conditions), ability (task knowledge), and motivation (attitudes, beliefs, norms) (OAM). In this commentary, we incorporate elements of the OAM framework while emphasizing implementers’ capacity/ability and motivation. However, we place special focus on the role of empowerment and how experience-based and collaborative learning contributes to empathetic understanding.

While the OAM framework posits that perceived opportunity in the environment is a critical variable in behavioral choices, our findings suggest that collective or group influences play a crucial role in the initial phase of implementers’ psychological acceptance of a new intervention. Specifically, the presence of significant leaders or stakeholders at various levels, combined with institutional changes such as computerized workflows and policy requirements, creates a “climate of support” that can convince implementers of the value of change and facilitate the routinization of new practices.

Finally, we must acknowledge the critical role of the PRISM project team in Thailand, as shown in Figure 1. In the context of global health program development, which involves international collaboration and knowledge transfer, having a local team with strong leadership is a key determinant of successful implementation and dissemination of innovative interventions. Although not explicitly listed as a driver of implementation activities, the team’s leadership is essential in translating central concepts, identifying and networking with key stakeholders in both policy and clinical practice, championing the program through key decisions, creating opportunities to advocate for the program’s alignment with policymakers’ and practitioners’ needs, and occasionally managing tensions between international investigators and local implementation teams. The core leadership of the project consists of innovation champions who, as noted in Rogers’ Diffusion of Innovations (Rogers, 2003), typically possess a high level of confidence, persuasive communication skills, and an ability to navigate organizational politics effectively. These individuals are naturally equipped to recognize the value of changes early and to facilitate those changes before they become widely accepted.

### Author’s Note

The opinions expressed in this article are the author’s own and do not reflect the view of the National Institutes of Health, the Department of Health and Human Services, or the United States government.

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