Aligning and organising development activity[1]

Example 1

Identifying needs

Challenge: Weak integration of services for neurodivergent children in an urban area leads to fragmented care, miscommunication among providers, inconsistent support across education and healthcare, delays in diagnosis and intervention, and stress for families navigating the system.
The needs and expectations of the diverse stakeholders were negotiated into shared needs for development activity as follows:

Neurodivergent children (Autism, ADHD, Dyslexia, etc.)

- coordinated support across education, healthcare, and social services
- safe, inclusive environments that support sensory and communication needs

Parents and families

- a single point of contact or case manager to help coordinate services
- easier access to diagnosis and services without long wait times

Educators and schools

- training on neurodiversity to provide better classroom support
- collaboration with healthcare providers to align educational and therapeutic strategies

Healthcare providers (Pediatricians, Psychologists, Therapists, Neurologists, etc.)

- a shared platform for patient history and treatment plans across multiple providers
- better collaboration with schools and social services to create a holistic approach to care

Social services and advocacy organisations

- streamlined eligibility and application processes for financial aid, therapy, and specialized programs
- stronger policies that mandate service coordination between healthcare, education, and social services

Government and policymakers

- regulations that require data-sharing and coordination across schools, healthcare, and social services

Conclusion: To improve outcomes for neurodivergent children, collaboration across healthcare, education, and social services is essential. An integrated system with a case management approach would help ensure consistent support and better long-term outcomes.

Defining goals and metrics

The needs were negotiated and translated among the stakeholders into shares goals and metrics for integrated support for neurodivergent children.

[1] The examples were created using ChatGPT and Copilot AI tools.

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Stakeholder	Short-Term Goals (1-3 Years)	Metrics (Short-Term)	Long-Term Goals (4-7+ Years)	Metrics (Long-Term)
Neurodivergent children	Ensure coordinated support across education, healthcare, and social services.	70 % of children receive individualized support plans. 80 % of schools implement sensory-friendly environments.	Create a seamless, lifelong support system across all settings.	90 % experience smooth transitions across care. 60 % increase in post-secondary education and employment rates.
Parents and families	Improve access to coordinated care and reduce burden.	60 % of families report having a case manager. 50 % reduction in wait times for diagnosis and intervention.	Establish a nationwide case management system.	90 % of families have access to a case manager. 70 % reduction in service fragmentation complaints.
Educators and schools	Strengthen educator training and collaboration with healthcare providers.	75 % of educators receive neurodiversity training. 50 % of schools establish formal healthcare partnerships.	Fully integrate neurodiversity-informed teaching into curriculums.	90 % of schools adopt inclusive learning practices. 80 % of school districts have permanent partnerships with healthcare providers.
Healthcare providers	Improved coordination of care and data-sharing across providers.	60 % of providers access a shared digital platform. 70 % increase in cross-sector meetings for integrated care planning.	Fully integrate a nationwide interoperable health system.	95 % of providers use interoperable EHRs. 75 % reduction in duplicate assessments and treatment delays.
Social services and advocacy	Streamline financial aid and therapy access; push for stronger policies.	50 % reduction in processing time for aid/therapy applications. 3 new policies introduced for cross-sector collaboration.	Guarantee equitable access to funding, support, and advocacy.	100 % of eligible children receive financial and therapeutic support. At least 10 major legislative reforms enacted.
Government and policymakers	Implement regulations mandating data-sharing and service integration.	80 % of public institutions comply with data-sharing regulations. 5 pilot programs launched for integrated neurodiversity support.	Establish nationwide mandates for integrated neurodiversity care.	95 % of agencies comply with coordination laws. Permanent funding secured for neurodivergent support initiatives.

Defining criteria for searching and identifying solutions

To identify a suitable integrated care model with case management for neurodivergent children, key criteria were defined:

Population suitability: Must support neurodivergent children (Autism, ADHD, Dyslexia) and their families with a family-centred, multi-sectoral approach in healthcare, education, and social services.

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Case management and coordination: Should include a single point of contact, a collaborative team of professionals, and streamlined access to diagnosis, therapy, and funding.

Data sharing and digital Integration: Requires secure EHR interoperability, online tracking portals, and AI-driven early intervention tools.

Policy and regulatory alignment: Must comply with data protection laws, government/insurance support, and cross-sector policies.

Scalability and transferability: Should be proven in similar settings, adaptable across systems, and engage key stakeholders.

By applying these search criteria across databases and case studies, an integrated care model was identified to improve care coordination and outcomes for neurodivergent children.

Performing transferability analysis

Transferability analysis was performed in a multi-professional team on Integrated Care Model with Case Management for Neurodivergent Children by using the THCS Transferability Analysis Tool.

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1. Solution content – assess the clarity and quality of the description of the solution

Sub-questions:

Is the solution sufficiently and clearly described to make decision of its transferability?

☑ Yes ☐ No / partly

Is the primary evidence on the outcomes of the solution useful and good quality?

☑ Yes ☐ No / partly

If no/partly, can you obtain more information of the solution?

☐ Yes ☑ Not applicable

Comments:
The integrated care model is clearly described, including core components such as case management, interdisciplinary coordination, early intervention, and use of electronic health records (EHR). The context, population, and outcomes are outlined in enough detail to assess transferability.

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2. Population – compare the population / target group of the solution to your population / target group and assess if the differences would affect achieving the outcomes

Sub-questions:

Are the population characteristics (epidemiologic, sociodemographic, cultural/social, cognitive, socio-educational, linguistic) similar enough for achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Would the perceptions of the population towards the solution (demand, motivation, acceptability, perception of health needs, trust towards the utility) be similar enough for achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Would the accessibility (financial, geographical, sociocultural) of the solution be similar enough for achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

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Is there sufficient mutual trust and cooperation between service providers and recipients for achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

If no/partly, can adaptations be made by keeping the original core elements or can other population-related barriers be resolved? How?
Yes, adaptations include:

- Strengthening outreach and early diagnostics for undiagnosed children
- Providing multilingual resources and interpreters
- Partnering with community-based organizations to build trust
- Using mobile clinics and telehealth to improve accessibility

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3. Environment – compare the key environmental requirements of the solution to your context and assess if the differences would affect achieving the outcomes

Sub-questions:

Does your health and care delivery and financing model allow implementing the solution and enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Does your health and care policies and regulations allow implementing the solution and enable achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Do you have necessary information system (data exchange, privacy standards and integration with the solution) available and does it enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Do you have necessary health and care facilities and equipment available, and do they enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Would the solution be acceptable among your health and care providers, administrators, and other stakeholders and does this enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Would the solution be acceptable within your political system structure and climate and does this enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Are other elements in your context supportive for implementing the solution and enable achieving the outcomes (e.g., no competing/antagonist initiatives)?

☑ Yes ☐ No / partly ☐ Not applicable

If no/partly, can adaptations be made by keeping the original core elements or can other context-related barriers be resolved? How?
Yes, actions include:

- Adapting financing to local insurance models through multi-source funding and advocacy
- Upgrading and integrating information systems with support and training
- Expanding provider capacity and training
- Engaging local political leaders and building support across different levels of governance

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4. Transfer – assess the support for transfer and implementation

Sub-questions:

Are there sufficient resources to coordinate the implementation of the solution?

☐ Yes ☑ No / partly

Is there sufficient expertise to make adaptations if needed, and to conduct evaluation?

☑ Yes ☐ No / partly

If no/partly, can sufficient support for implementation, adaptations and evaluation be arranged? How?

☑ Yes

Support can be arranged by:

- Collaborating with local health networks and universities for evaluation and adaptation
- Securing project funding through grants or public-private partnerships
- Establishing implementation teams with cross-sector expertise

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Conclusions – how can the “no/partly” responses be addressed to transfer the solution to your context?

Many elements of the original model are transferable with adaptations. Key adjustments include:

- Strengthening early detection and culturally sensitive outreach
- Enhancing multilingual and community-based support
- Investing in information systems, staff training, and infrastructure
- Addressing financing challenges through diverse funding streams
- Ensuring provider and political buy-in through stakeholder engagement and local collaboration
- Creating a coordinated implementation plan with expert support and continuous evaluation

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Example 2

Identifying needs

Challenge: Limited access to primary healthcare in rural areas results in delayed treatment, higher rates of preventable illnesses, overburdened emergency services, and increased health disparities.

The needs and expectations of the stakeholders were negotiated into shared needs for development activity as follows:

Residents in rural communities

- More local healthcare facilities or mobile clinics to reduce travel distances
- Affordable and timely access to primary care, including preventive screenings
- Reliable transportation options for accessing healthcare services

Healthcare providers (Doctors, Nurses, Community Health Workers, etc.)

- Incentives and support for healthcare professionals to work in rural areas
- Telemedicine solutions to provide remote consultations and follow-ups
- Better access to diagnostic tools and medical supplies in rural facilities

Local government and policymakers

- Investment in infrastructure to support rural healthcare services
- Policies that encourage and fund mobile health units and telehealth initiatives
- Loan forgiveness and incentives for medical professionals serving rural areas

Community organizations and NGOs

- Health education programs to promote preventive care and early intervention
- Support for community health workers to bridge the gap between residents and healthcare providers
- Funding for local initiatives to improve health literacy and disease prevention

Conclusion

To improve healthcare access in rural areas, a multi-faceted approach is needed, including expanding telehealth, increasing the number of healthcare professionals, and enhancing community outreach programs. Coordinated efforts among healthcare providers, government agencies, and community organisations can lead to better health outcomes and reduced disparities.

Defining goals and metrics

The needs were negotiated and translated among the stakeholders into shares goals and metrics for achieving better access to primary healthcare.

Stakeholder	Short-term goals	Metrics	Long-term goals	Metrics
Residents in rural communities	Increase access to mobile clinics and telemedicine services Improve public transportation options to healthcare facilities	Number of mobile clinics deployed Increase in telehealth appointment usage	Establish permanent local healthcare centres Ensure consistent access to preventive and primary care	Reduction in travel distances for medical care Decrease in preventable disease rates

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Healthcare providers (Doctors, Nurses, Community Health Workers, etc.)	Offer financial incentives and training programs for rural healthcare workers Expand telemedicine infrastructure	Number of healthcare workers recruited Number of telehealth consultations conducted	Retain healthcare professionals in rural areas Ensure full staffing of local healthcare facilities	Retention rates of rural healthcare workers Improved patient-to-doctor ratios
Local government and policymakers	Allocate funding for rural healthcare infrastructure Implement policies supporting mobile health units and telehealth expansion	Amount of government funding directed to rural health Number of telehealth-friendly policies enacted	Build sustainable rural healthcare systems Improve healthcare affordability and accessibility	Number of newly built or upgraded rural clinics Reduction in healthcare costs for rural residents
Community organisations and NGOs	Launch health education programs on preventive care and early intervention Train and deploy community health workers	Number of education sessions held Increase in community health worker presence	Improve long-term health literacy and self-care practices in rural populations Strengthen community-driven health initiatives	Measured improvement in health literacy levels Decrease in emergency care reliance due to preventable conditions

Defining criteria for searching and identifying solutions

To effectively achieve the shared goals for better access to primary healthcare in rural communities, solutions must be identified based on the following criteria:

1. Feasibility and sustainability
   - Affordability: Solutions should be cost-effective for stakeholders, including residents, healthcare providers, and policymakers.
   - Resource availability: Consider existing infrastructure, workforce, and funding opportunities.
   - Long-term impact: Ensure solutions provide lasting improvements rather than short-term fixes.

2. Accessibility and inclusivity
   - Geographic reach: Solutions should cover the most underserved areas with high travel barriers.
   - Affordability for residents: Healthcare services must be financially accessible, including low-cost or subsidized options.
   - Cultural and linguistic appropriateness: Solutions should align with local customs, languages, and health literacy levels.

3. Scalability and replicability
   - Adaptability to different regions: The approach should work across multiple rural areas with similar challenges.
   - Potential for expansion: Solutions should be scalable, allowing for gradual growth based on community needs.

4. Integration and collaboration
   - Multisector coordination: Solutions should promote collaboration among healthcare providers, policymakers, community organizations, and residents.
   - Technology and infrastructure Integration: Ensure seamless adoption of telemedicine, mobile clinics, and digital health records.

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By applying these criteria, the stakeholders found and identified an Integrated Rural Healthcare Access Model (IRHAM).

Performing transferability analysis

Transferability Analysis for Integrated Rural Healthcare Access Model (IRHAM) was performed by using the THCS Transferability Analysis Tool.

1. Solution content – assess the clarity and quality of the description of the solution
Sub-questions:

Is the solution sufficiently and clearly described to make decision of its transferability?

☑ Yes ☐ No / partly

Is the primary evidence on the outcomes of the solution useful and good quality?

☐ Yes ☑ No / partly

If no/partly, can you obtain more information of the solution?

☑ Yes ☐ Not applicable

Comments:
IRHAM is well-described, including its key components such as mobile health units, telemedicine hubs, and community-based service delivery in rural areas. However, more robust data on health outcomes, cost-effectiveness, and long-term impact are needed to better inform decisions about its transferability. These can be obtained through further consultation with implementing agencies or review of evaluation reports.

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2. Population – compare the population / target group of the solution to your population / target group and assess if the differences would affect achieving the outcomes

Sub-questions:

Are the population characteristics (epidemiologic, sociodemographic, cultural/social, cognitive, socio-educational, linguistic) similar enough for achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Would the perceptions of the population towards the solution (demand, motivation, acceptability, perception of health needs, trust towards the utility) be similar enough for achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Would the accessibility (financial, geographical, sociocultural) of the solution be similar enough for achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Is there sufficient mutual trust and cooperation between service providers and recipients for achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

If no/partly, can adaptations be made by keeping the original core elements or can other population-related barriers be resolved? How?

Yes, adaptations include:

- Expanding service focus to address mental health and non-communicable diseases in younger populations
- Ensuring culturally sensitive approaches, particularly around chronic illness and mental health
- Increasing community outreach and trust-building activities in new demographic contexts

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- Offering multilingual communication and health education materials

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3. Environment – compare the key environmental requirements of the solution to your context and assess if the differences would affect achieving the outcomes

Sub-questions:

Does your health and care delivery and financing model allow implementing the solution and enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Does your health and care policies and regulations allow implementing the solution and enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Do you have necessary information system (data exchange, privacy standards and integration with the solution) available and does it enable achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Do you have necessary health and care facilities and equipment available, and do they enable achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Would the solution be acceptable among your health and care providers, administrators, and other stakeholders and does this enable achieving the outcomes?

☑ Yes ☐ No / partly ☐ Not applicable

Would the solution be acceptable within your political system structure and climate and does this enable achieving the outcomes?

☐ Yes ☑ No / partly ☐ Not applicable

Are other elements in your context supportive for implementing the solution and enable achieving the outcomes (e.g., no competing/antagonist initiatives)?

☑ Yes ☐ No / partly ☐ Not applicable

If no/partly, can adaptations be made by keeping the original core elements or can other context-related barriers be resolved? How?

Yes, actions include:

- Adjusting financing to align with insurance-based and public-private healthcare funding models
- Engaging regulatory bodies early to address telemedicine licensing and privacy compliance
- Ensuring stakeholder alignment through consultations, joint planning, and co-design workshops
- Building national-level support to compensate for the lack of decentralization in the political structure

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4. Transfer – assess the support for transfer and implementation

Sub-questions:

Are there sufficient resources to coordinate the implementation of the solution?

☐ Yes ☑ No / partly

Is there sufficient expertise to make adaptations if needed, and to conduct evaluation?

☑ Yes ☐ No / partly

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If no/partly, can sufficient support for implementation, adaptations and evaluation be arranged? How?

✔ Yes

Support can be arranged by:

- Forming implementation partnerships with health NGOs and regional authorities
- Involving academic institutions in evaluation and adaptation efforts
- Securing dedicated funding through grants or public-private collaborations
- Creating a local task force to oversee deployment, training, and feedback cycles

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Conclusions – how can the “no/partly” responses be addressed to transfer the solution to your context?

The IRHAM model is adaptable and largely transferable, though several adjustments are required:

- Evidence: Strengthen evidence base through partnerships with existing IRHAM sites or additional evaluation studies.
- Population Fit: Modify service offerings to align with the needs of younger, more literate, and diverse populations.
- Trust-Building: Increase engagement and transparency with communities unfamiliar with mobile or telehealth models
- Policy Alignment: Engage policymakers early to ensure regulatory clearance and national-level support.
- Financing & Capacity: Secure sustainable funding and implementation capacity through coordinated resource mobilization
- Implementation Support: Leverage academic, governmental, and non-profit sectors to build expertise and manage adaptation.

With these changes, the core principles of IRHAM—mobile outreach, telemedicine integration, and community-centred service—can effectively address service gaps in the adopting context.

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Example 3

Identifying needs

Challenge: High obesity rates are driven by factors such as limited access to affordable healthy food, lack of safe spaces for physical activity, inadequate nutrition education, and socioeconomic barriers. This leads to increased risks of chronic diseases, reduced quality of life, and higher healthcare costs.

The needs and expectations of diverse stakeholders were negotiated into shared needs for development activity as follows:

Individuals at risk of obesity

- Affordable access to fresh, healthy food options
- Safe and accessible spaces for physical activity
- Education on nutrition and healthy eating habits

Parents and families

- Support for healthier school meal programs and better food options in cafeterias
- Community initiatives that encourage family-friendly physical activities
- Resources on how to prepare affordable, nutritious meals at home

Healthcare providers (Doctors, Dietitians, Fitness Experts, etc.)

- Training to provide culturally appropriate weight management support
- Integration of obesity prevention and management into routine primary care visits
- More funding for obesity-related research and patient education programs

Schools and educational institutions

- Nutrition-focused education programs incorporated into the curriculum
- Increased opportunities for physical education and active play during school hours
- Collaboration with local farms and food providers for healthier school meals

Local government and policymakers

- Urban planning that promotes walkability and access to parks and recreation facilities
- Regulations to improve food labelling and limit marketing of unhealthy foods to children
- Subsidies and incentives for businesses that offer healthy food options in underserved areas

Community organisations and advocacy groups

- Public awareness campaigns about the risks of obesity and benefits of healthy living
- Support for community gardens and farmers' markets in low-income neighbourhoods
- Initiatives to make fitness programs more affordable and accessible to all demographics

Conclusion

Addressing obesity requires a comprehensive approach involving education, policy changes, and community-driven initiatives. By improving access to healthy food, creating opportunities for physical activity, and integrating obesity prevention into healthcare, we can foster long-term behavioural changes and reduce obesity-related health risks.

Defining goals and metrics

The needs were negotiated and translated among the stakeholders into shares goals and metrics for addressing raising obesity.

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Stakeholder	Short-Term Goals	Metrics	Long-Term Goals	Metrics
Individuals at risk of obesity	Increase awareness of healthy eating through workshops and online resources Provide subsidized or free access to fitness programs	Number of participants in nutrition workshops Increase in enrollment for subsidized fitness programs	Reduce obesity prevalence in the community Increase the percentage of individuals engaging in regular physical activity	Percentage decrease in obesity rates over five years Number of individuals meeting recommended physical activity levels
Parents and families	Improve access to affordable healthy food in schools and local stores Introduce family-based physical activity programs	Number of schools implementing healthier meal options Participation rates in family fitness initiatives	Improve household-level nutrition choices Increase family engagement in active lifestyles	Percentage of families reporting healthier eating habits Reduction in childhood obesity rates
Healthcare providers (Doctors, Dietitians, Fitness Experts, etc.)	Implement obesity screening as part of routine primary care visits Provide additional training for healthcare professionals on obesity management	Number of healthcare providers trained in obesity management Percentage of patients screened for obesity risk factors	Improve early intervention for obesity-related conditions Enhance collaboration between healthcare providers and nutrition/fitness programs	Percentage of at-risk individuals receiving weight management support Reduction in obesity-related health complications (e.g., diabetes, hypertension)
Schools and educational institutions	Implement mandatory nutrition education in curricula Increase physical activity opportunities in schools	Number of schools adopting nutrition programs Increase in daily active playtime or PE participation rates	Reduce childhood obesity rates through sustained education and activity Improve student dietary choices within school environments	Percentage reduction in obesity rates among school-aged children Changes in student food choices in cafeterias
Local government and policymakers	Introduce subsidies for healthy food in underserved areas Implement urban planning initiatives to promote physical activity (e.g., bike lanes, parks)	Number of policies enacted to support food access and activity spaces Increase in the number of grocery stores offering fresh produce in low-income areas	Establish sustainable food policies that reduce obesity prevalence Improve overall community health indicators through regulatory support	Decrease in obesity rates across different socioeconomic groups Increased utilization of public recreational spaces
Community organisations and advocacy Groups	Launch awareness campaigns about healthy lifestyles Provide financial assistance for fitness and nutrition programs in low-income communities	Number of individuals reached through awareness initiatives Increase in program participation among at-risk populations	Create lasting behavioural changes in community health habits Advocate for long-term funding of obesity prevention initiatives	Sustained increase in healthy food consumption and exercise participation Continued government and private funding for obesity-related initiatives

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Defining criteria for searching and identifying solutions

To effectively address rising obesity rates, solutions should be identified based on the following criteria:

1. Feasibility and accessibility
   - Cost-effectiveness: Programs should be affordable and scalable for communities and stakeholders.
   - Ease of implementation: Solutions must be practical for schools, healthcare providers, and families to adopt.
   - Accessibility for all groups: Ensure solutions reach low-income and high-risk populations.

2. Sustainability and long-term impact
   - Behavioural change potential: Initiatives should encourage lasting healthy habits.
   - Policy and structural support: Solutions should align with long-term government and institutional policies.

3. Collaboration and integration
   - Multi-sector involvement: Solutions should encourage partnerships between healthcare, education, policymakers, and community organizations.
   - Technology utilization: Digital tools (e.g., telehealth, fitness tracking apps) should enhance engagement and reach.

By applying these criteria, stakeholders can identify effective, sustainable, and impactful strategies to combat obesity.

Performing transferability analysis

Transferability Analysis of COPLPI Community-Based Obesity Prevention and Lifestyle Promotion Initiative was performed in the Adopting Context.

1. Solution content – Assess the clarity and quality of the description of the solution

Is the solution sufficiently and clearly described to make a decision on its transferability?

☑ Yes ☐ No/Partly ☐ Not Applicable

Is the primary evidence on the outcomes of the solution useful and good quality?

☑ Yes ☐ No/Partly ☐ Not Applicable

If No/partly, can you obtain more information of the solution?

Not Applicable

Comments:

The solution is well described with clear objectives, delivery methods, and outcome data. No additional information is required for the transferability assessment.

2. Population – Compare the population/target group of the solution to your population/target group

Are the population characteristics (epidemiologic, sociodemographic, cultural/social, cognitive, socio-educational, linguistic) similar enough for achieving the outcomes?

☐ Yes ☑ No/Partly ☐ Not Applicable

Would the perceptions of the population towards the solution (demand, motivation, acceptability, perception of health needs, trust towards utility) be similar enough for achieving the outcomes?

☑ Yes ☐ No/Partly ☐ Not Applicable

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Would the accessibility (financial, geographical, sociocultural) of the solution be similar enough for achieving the outcomes?

☑ Yes ☐ No/Partly ☐ Not Applicable

Is there sufficient mutual trust and cooperation between service providers and recipients for achieving the outcomes?

☐ Yes ☑ No/Partly ☐ Not Applicable

If No/partly, can adaptations be made while keeping the original core elements or resolving barriers? How?

- Adapt program content to urban, multicultural settings.
- Include multilingual resources and culturally relevant messaging.
- Build trust through engagement with community leaders, schools, and advocacy groups.

3. Environment – Compare the key environmental requirements of the solution to your context

Does your health and care delivery and financing model allow implementing the solution and enable achieving the outcomes?

☑ Yes ☐ No/Partly ☐ Not Applicable

Does your health and care policies and regulations allow implementing the solution and enable achieving the outcomes?

☐ Yes ☑ No/Partly ☐ Not Applicable

Do you have the necessary information system (data exchange, privacy standards, integration) and does it enable achieving the outcomes?

☑ Yes ☐ No/Partly ☐ Not Applicable

Do you have necessary health and care facilities and equipment available, and do they enable achieving the outcomes?

☑ Yes ☐ No/Partly ☐ Not Applicable

Would the solution be acceptable among your health and care providers, administrators, and other stakeholders?

☑ Yes ☐ No/Partly ☐ Not Applicable

Would the solution be acceptable within your political system structure and climate?

☐ Yes ☑ No/Partly ☐ Not Applicable

Are other elements in your context supportive for implementing the solution and enabling outcomes (e.g., no competing/antagonistic initiatives)?

☑ Yes ☐ No/Partly ☐ Not Applicable

If No/partly, can adaptations be made while keeping the original core elements or resolving context-related barriers? How?

- Ensure alignment with centralized governance through national health strategies.
- Address regulatory gaps via advocacy and policy partnerships.
- Leverage urban infrastructure while closing gaps in underserved areas.

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4. Transfer – Assess the support for transfer and implementation

Are there sufficient resources to coordinate the implementation of the solution?

☑ Yes No/Partly Not Applicable

Is there sufficient expertise to make adaptations if needed, and to conduct evaluation?

☑ Yes No/Partly Not Applicable

If No/partly, can sufficient support for implementation, adaptation, and evaluation be arranged?

Not Applicable

Conclusions: How the "No/Partly" responses can be addressed to enable transfer

- Population-related differences can be mitigated by tailoring content, language, and community outreach.
- Trust-building through schools, community leaders, and participatory design is essential.
- Policy and governance barriers can be addressed via alignment with national health strategies and proactive advocacy.
- Implementation success depends on inclusive engagement, flexible delivery models, and leveraging both public and private sector resources.

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