Implementation research, what's this? The example of FRESH AIR for chronic lung disease

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Langue Anglais

Often we hear recommendations, we read guidelines, or are taught about what works to prevent or manage a disease, and we think, yes, but when are we going to move from "we must" to "we will"?

In the case of Chronic Obstructive Pulmonary Disease (COPD), public health specialists, clinicians, patients and care-givers mostly know what the do's and don'ts are, but are missing the answers about how to translate them into real-life; how do we move from theory to practice?

Implementation science is about answering these questions.

What is Chronic Obstructive Pulmonary Disease (COPD)?

COPD is an umbrella name for non-contagious conditions that permanently restrict breathing capacity, such as emphysema and chronic bronchitis. Because of the damage is localised to the lungs, symptoms include wheezing, shortness of breath, persistent cough and chest tightness, . After cardio-vascular diseases and cancer, and together with asthma (chronic respiratory diseases), it is ranked as the third noncommunicable disease (NCD) in terms of prevalence and incidence and leading cause of death worldwide[1]. While COPD can't be cured, symptoms can be eased with access to appropriate medical care and treatment, particularly when screening detects COPD early. This video [1] explains COPD a bit more. Almost 90% of COPD deaths occur in low- and middle-income countries.

> *"Total deaths from COPD are projected to increase by more than 30% in the next 10 years without interventions to cut risks, particularly exposure to tobacco smoke." - ECC*

Implementation science: moving from theory to practice with FRESH AIR

The World Health Organisation (WHO) defines implementation research [2] as: *"the form of research that… identifies*

optimal approaches for a particular setting, and promotes the uptake of research findings: ultimately, it leads to improved health care and its delivery."

FRESH AIR[2] [3] specifically focuses on what works, for whom, in different contexts for COPD and asthma, in low and middle income countries (LMIC) or with vulnerable populations in higher income countries. The aim, as per any implementation science plan is to assess how existing research knowledge generated by academic studies is adaptable to on-the ground reality in an accessible and equitable manner. The project consortium members, working in Vietnam, Uganda, rural Greece and the Kyrgyz Republic are implementing evidence-based practices in the prevention, diagnosis and treatment of chronic lung diseases, based on the main risk factors: smoking and indoor air pollution due to cooking and heating. We are assessing if these can be implemented in primary care and scaled up in the existing low resource contexts and, where possible, in the three years of the programme, their impact.

For instance, using interviews in villages and remote areas, our teams assess the local population's knowledge and beliefs about the risk factors and test tobacco dependence treatment interventions and pulmonary rehabilitation. The introduction of safer cooking stoves and raising awareness about the harm of indoor smoke are also key components. The consortium is beginning to analyse baseline data, and to start rolling out some of the interventions, and should have a first set of results by the end of 2017.

Building awareness & evidence for policies

Beyond its clinical and pragmatic aim, the project is also designed to develop knowledge on how to best raise awareness about COPD at local, regional and national levels, in LMIC, to better prevent the disease where possible[3] and to change behaviours at individual and population levels. It will support our plea for more political uptake of policies to reduce the burden of chronic respiratory diseases.

> *"Implementation research doesn't just tell us how best to implement interventions to improve health in local contexts; it can also raise awareness and action on the need for policies to be developed to reduce the burden of respiratory diseases."*

About the Author

Catherine Hartmann is the secretary general of the European COPD Coalition (ECC) [4] (@EU_COPD [5]), a pan-European not-for-profit association, running programmes and activities to raise awareness on Chronic Obstructive Pulmonary Disease (COPD), and advocating for COPD to be part of the EU political agenda. She has been active in the field of European policies for over 15 years, and has worked on enhanced care practice, patient rights, patients and healthcare professionals' mobility, health determinants such as tobacco, training and specialisation of healthcare professionals, information to patients, pharmacovigilance and patient safety. Ms Hartmann is an adamant promoter of European public health policies and a keen supporter of EU and civil society dialogue. She works with a wide range of international and European partners to build cooperation. ECC is a member of the European Chronic Disease Alliance [6], the European Public Health Alliance [7] and the NCD Alliance.

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[1] Lozano R, Naghavi M, Foreman K, et al. Global and regional mortality from 235 causes of death for 20 age groups in 1990 and 2010: a systematic analysis for the Global Burden of Disease Study 2010. Lancet 2012; 380: 2095–128

[2] Free Respiratory Evaluation and Smoke-exposure reduction by primary Health cAre Integrated gRoups; part of the "Global Alliance for Chronic Diseases, Prevention and treatment of lung diseases" is an EU Research and Innovation funded project which spans over three years, with a budget of over 2.9 million euro.

[3] COPD is also caused by a rare genetic deficiency called Alpha Antitrypsin 1

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[1] https://www.youtube.com/watch?v=ln6oTPZ7YWU
[2] http://www.who.int/tdr/publications/year/2014/ir-toolkit-manual/en/
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