# The Road to Washington: Meeting #1

## The role of health systems, families, communities and social systems in PMTCT


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# Strengthening the linkages: Health systems and community systems

Shaking and holding hands

# Focus

- No data
- Identify some useful frameworks for thinking about the issues
- Illustrate with some examples how they have been and might be applied
- Problematise community

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# Primary emphasis

- Draw on less used and possibly forgotten frameworks and less well know approaches
- Expanding the Clinical Systems Mentorship Approach (ICAP model)
- Participation
- Integrated Model of Communication for Social Change

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Mobilised around the focal question

How do we strengthen the health system and community systems and build their connection to work in concert.

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# What do we know

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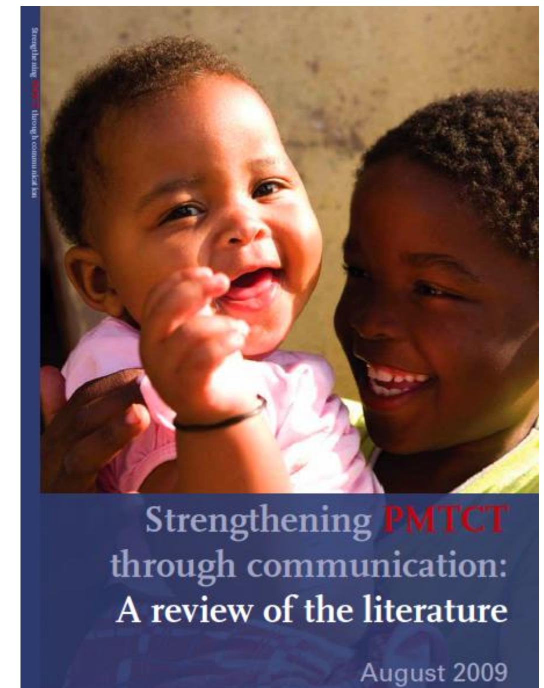
# A lot about barriers

Recent literature review
for SA communication strategy




(Frizelle, Solomon & Rau, 2009)

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# Barriers

- Poor healthcare infrastructure
- Shortages of staff
- Poor referral links and communication between services and within
- Poorly integrated PMTCT
- Poor-quality counselling and healthcare workers' poor attitudes and interactions with clients.

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# Barriers

- Gender-related issues, particularly the role of the male partner in reproductive issues and his involvement in PMTCT services
- Poverty and structural barriers.
- Cultural factors
- PMTCT, and stigma, including perceptions of poor social support and discriminatory perceptions of PMTCT practices.

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# Barriers

- Awareness and knowledge about HIV/AIDS and MTCT in the general population and among pregnant women or mothers, particularly regarding PMTCT information and services.
- Unaddressed reproductive and health needs of youth.
- Psychological barriers, such as denial, fear of death, or fear of HIV testing and disclosure.

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# We also know

- Efficacy – Effectiveness
- About innovative and successful projects, small and large
- Cost effectiveness
- Johri & Ako-Arrey (2011) conclude their cost effectiveness PMTCT systematic review with an emphasis on the how.

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# What is needed

- Useful frameworks
- A process oriented approach
- Integrated approaches
- A non-negotiable emphasis on participation

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# Barriers are multi-dimensional

- Structural
- Psycho-social
- Cultural
- Economic

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# Our strategy must be similarly multi-dimensional

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# Making the linkage

- How can health-system – community systems engagement and participation be facilitated?
- No single answer
- Lots of answers
- Who is the we of which we speak?
- One key point – it need not be uni-directional and needs to be bi-directional

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# Strengthen Health Systems and..

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# Clinical Systems Mentorship

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# Some history

- The shift to mentorship approaches involves:
  - The history of mentorship in HIV programme implementation, WHO, ICAP and others
  - The history of supervision and precepting
  - A transition from training to capacity building
    - Trainer centered approaches versus adult learner centered approaches
  - Transformation in models of care - acute, episodic to chronic, continuous, family models
  - Mentorship in ICAP

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- Mentorship emerged as a key approach for ongoing training, continuing professional development, transformation, quality promotion, capacity building……..
  - WHO scale up  (remember 3 x 5?)
  - Other contexts (VCT lay counselling)
- Need for Clinical Mentorship became clear as episodic trainings proved inadequate to support site function
- Older training models were clearly problematic

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# But it was more than a training problem

- *A more comprehensive, ongoing, continuous, relational, developmental approach was recognised as valuable*
- *The problems, challenges and opportunities are not only at the provider level but* ***systemic***
- ***Transformation, change, development, sustainability, all require a different supportive, capacity building and monitoring - or quality promotion approach.***

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# We asked: How do we support ongoing care that is feasible, of high quality, and sustainable?

Through Clinical Systems Mentorship.

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# Clinical Systems Mentorship (CSM)

- CSM is the name of an integrated methodology developed by ICAP-NY
  - broadens the principles of clinical mentorship to the context of public health programming and health systems strengthening.
- The goal of the CSM methodology is to
  - Implement high quality programs
  - Build capacity to sustain these programs
- CSM has an agenda

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# CSM

- The foundation of CSM is continuous data-driven assessment, intervention, and re-assessment across multiple levels
  - Tools are an important component of the methodology
  - Approaches are outcome oriented, systematic, context-specific and concrete

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# CSM

- CSM is a blend of mentorship approaches expanded across systems

And

- Process oriented systems consultation
  - e.g. Schein's consultation models

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- Mentorship is a
  - ***voluntary***
  - ***relationship***
  - ***entered into***
  - ***with a clear purpose***,
  - mobilised around change, transformation, development and growth.

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# CSM Vs. Clinical Mentorship

## Similarities

- Positive
- Relational
- Developmental
- Outcome oriented

## Differences

- CM: One mentor
- CSM: Teams can be mentors
- CM: Individuals

  CSM: Individuals and Systems
- CM: Developed

  CSM: Developing

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# So to recap…

- Mentorship is ***relational***
- Mentorship is an ***interpersonal process*** engaged in ***between*** health professionals
- Mentorship occurs in a ***context***
  - a system
  - a programme
- Mentorship ***mostly*** happens “outside” the management line
- CSM subsumes traditional mentorship but goes beyond this

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# To do….

- Site support:  Organized approach, standardized approach: skills and tools
- Capacity building: Working with providers, mdt's, patients, community, governments
- Working internally: Building internal expertise, working within one's own organization, one's own team

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# Key objectives of CSM

1. Implementing a/the Model of Care (MOC)

2. Improving Quality of Care (SOC)

3. Building Capacity and Transitioning

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Site Start-up

**Implementing the model of care**

SOC readiness

**Enhancing quality**

High quality program

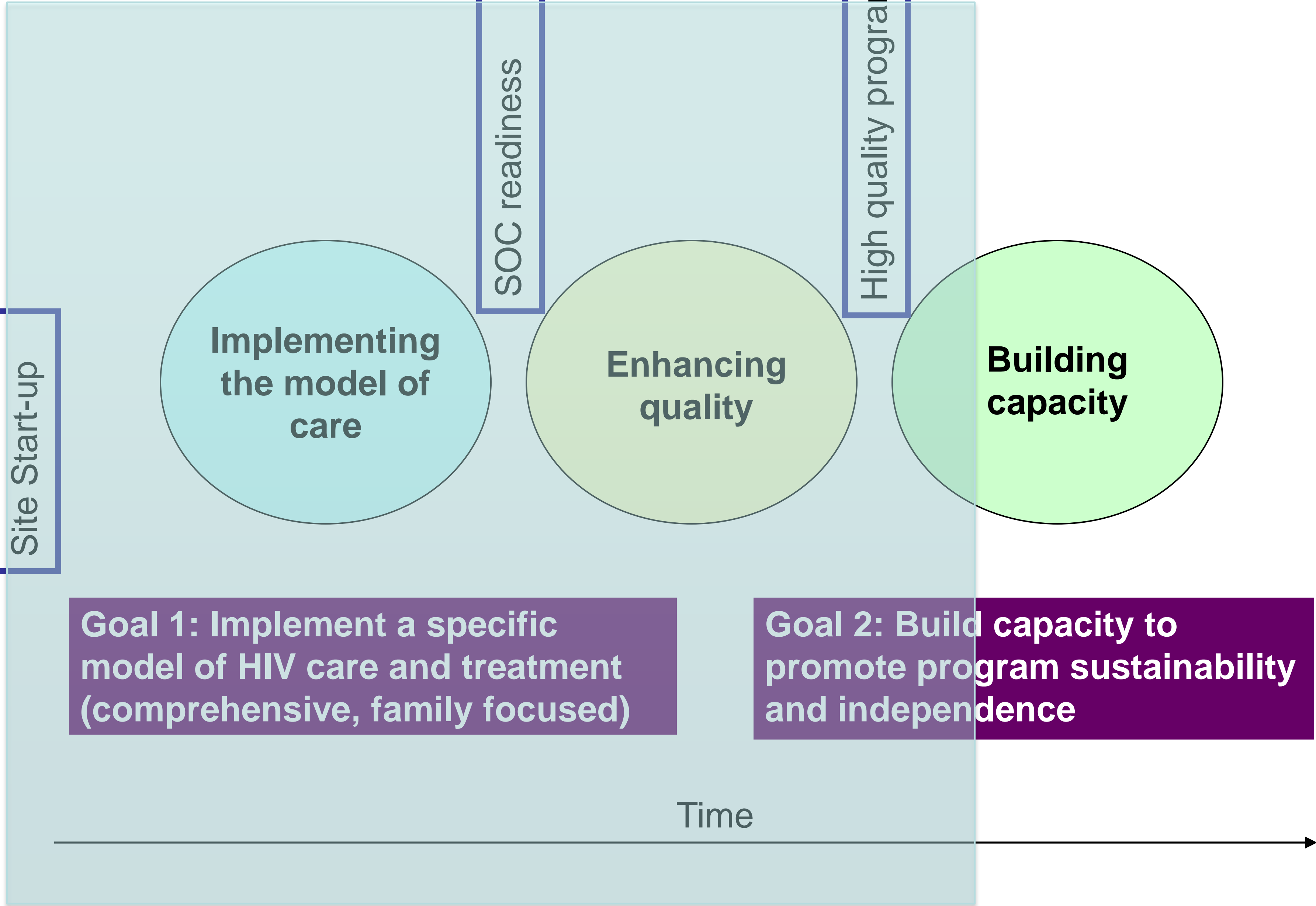
**Building capacity**

Site Independence

**Goal 1: Implement a specific model of HIV care and treatment (comprehensive, family focused)**

**Goal 2: Build capacity to promote program sustainability and independence**

Time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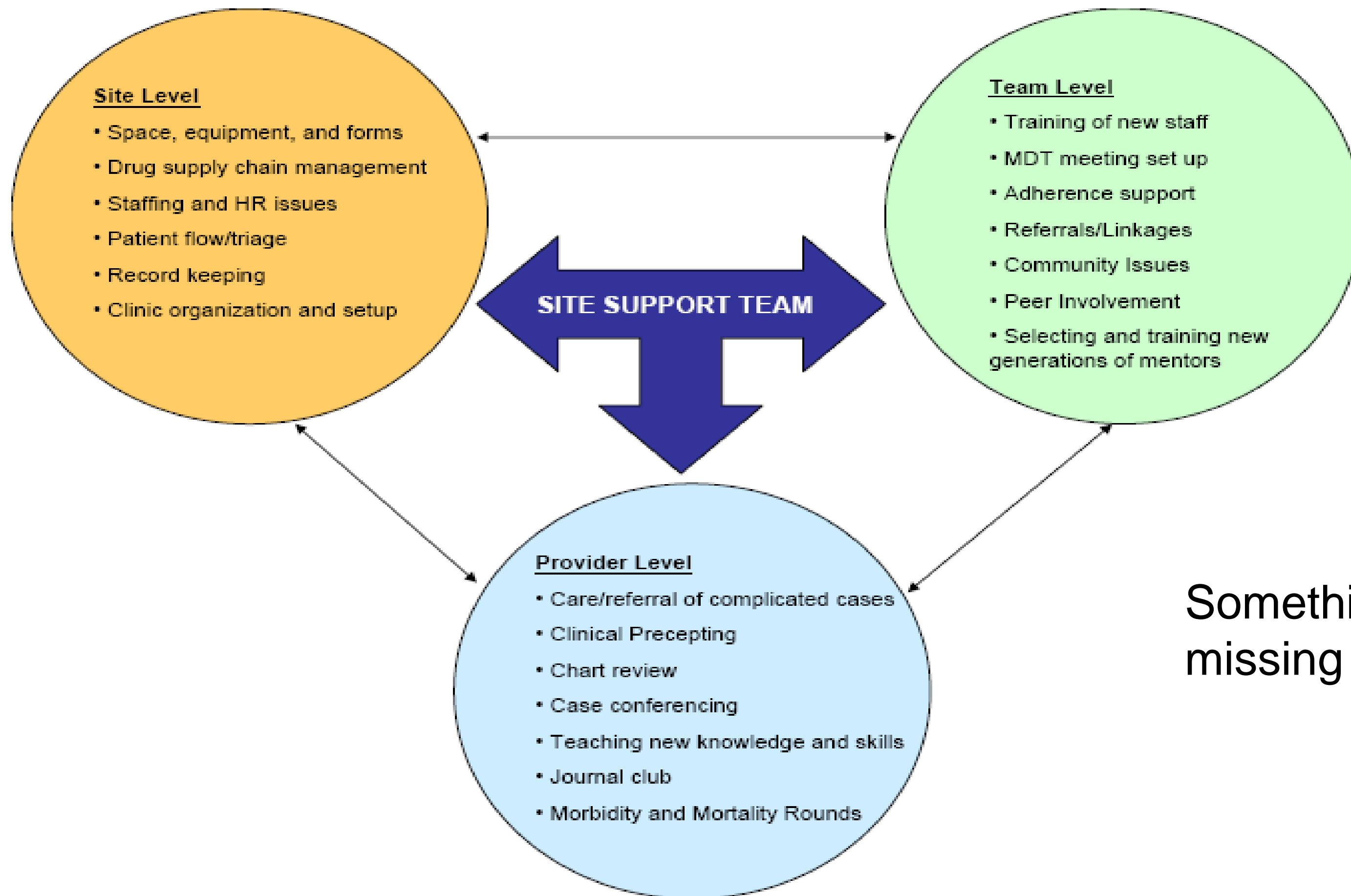
# Three levels of Clinical Systems Mentorship




Something is missing

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# It can do much more

- Proposal 1
- Develop, expand and implement the CSM approach for whole system development

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# MSH formative supervision

- Suh, Moreira & Ly (2007) (Senegal)
- Facility and community action plans
- Measured community involvement in service quality improvement via completion rates of collaborative action plans

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# Integrated Model of Communication for Social Change

- Figueroa, M.; Kincaid, L.; Rani, M. & Lewis, G. (2002). Communication for Social Change: An Integrated Model for Measuring the Process and Its Outcomes. The Communication for Social Change Working Paper Series: No.1. JHUCCP/The Rockefeller Foundation: New York.

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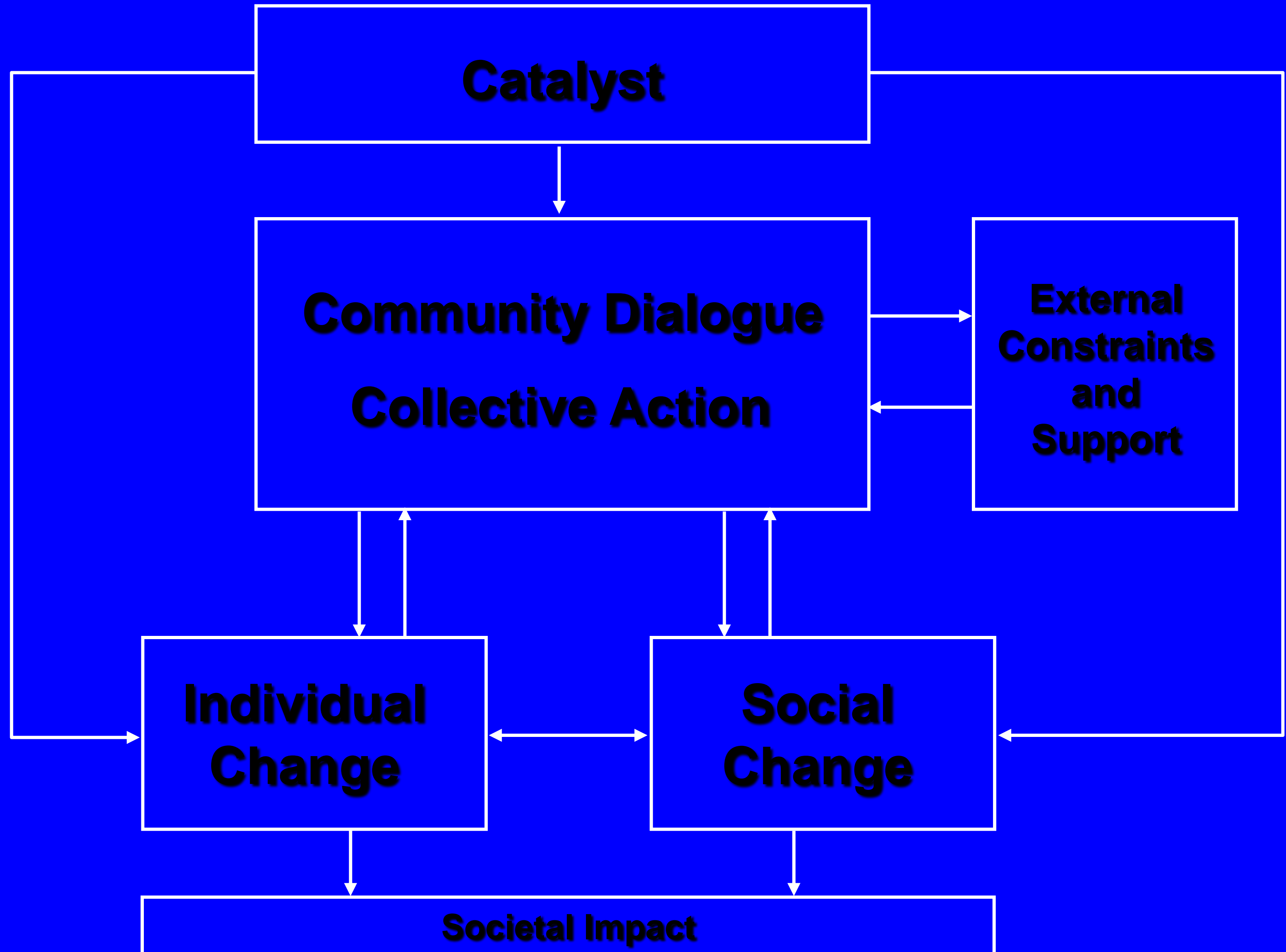
# Integrated Model of Communication for Social Change



# Catalysts

Internal Stimulus

Change Agent

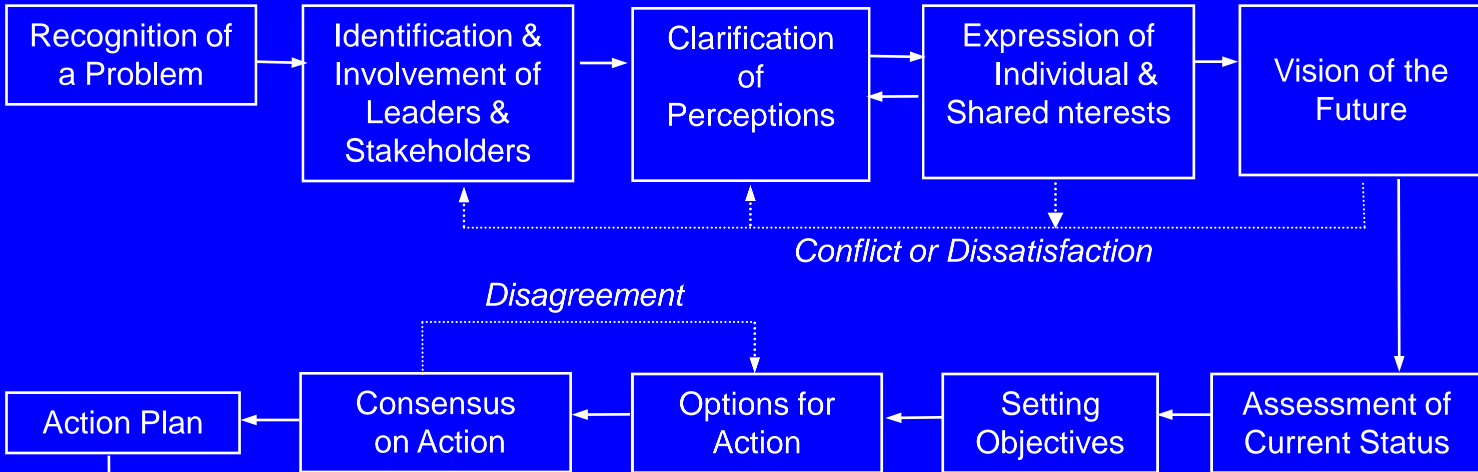
Policies

Technology

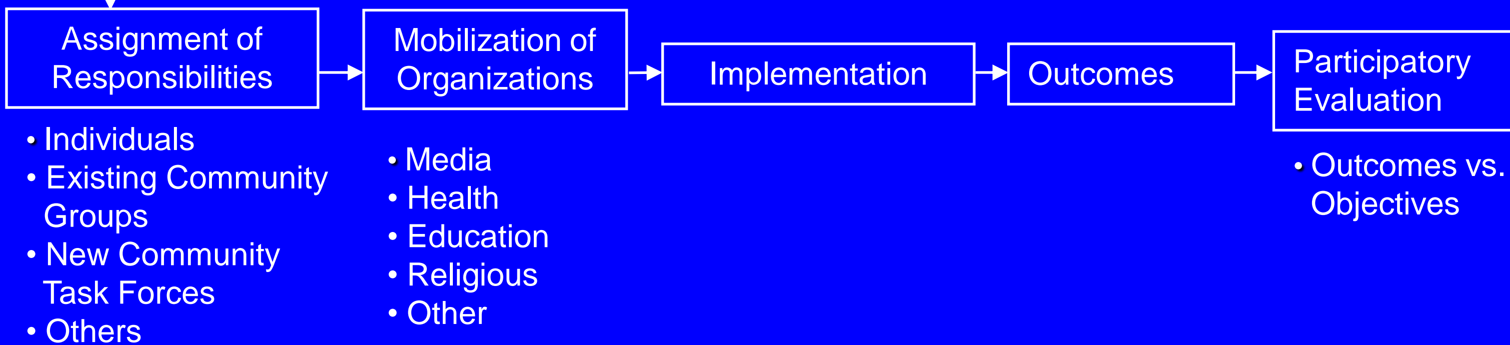
Innovation

Mass Media

# Community Dialogue




# Collective Action




Value for Continual Improvement

External Constraints and Support

## Social Change Outcomes

- Leadership
- Information Equity
- Collective Self-Efficacy
- Sense of Ownership
- Social Norms
- Social Cohesion and Trust
- Social Capital

## Individual Change Outcomes

- Skills
- Ideation
- Knowledge, Attitudes, Perceived Risk,
- Subjective norms
- Self-efficacy
- Social influence, & personal advocacy
- Intention
- Behavior

# Participation and Communication

- No matter how well grounded the mass communication messaging is in formative research
- In the absence of ongoing local participation and local communication, the community strengthening possibilities are limited or missed
- Synergy between mass media and local communication is critical

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# Caution

- Participation is laborious
- Time consuming
- Difficult to maintain
- But critical

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# Illustrative examples

- MSH  Formative supervision Suh, Moreira& Ly (2007)
- ICAP
- PHASA conference case study 2003
- AIDS Stigma study group health facility intervention programme (Holzmer, Uys et al.) Developed for and in collaboration with the “Perceived AIDS Stigma: A Multinational African Study” Team

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- Proposal 2
- Research and develop a process oriented “generic” communication for change model
- Link an expanded CSM model with community engagement and vv

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# Conclusion

- CSM has the potential to improve quality and strengthen the service and the system,
- And..bridge the gap in the awkward handshake
- Catalysed and localised communication for social change processes can produce the kind of collaborative angaged outcomes we hope for.
- Only participation and process oriented models are likely to be effective.

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