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
Primary emphasis

• Draw on less used and possibly forgotten frameworks and less well known approaches
• Expanding the Clinical Systems Mentorship Approach (ICAP model)
• Participation
• Integrated Model of Communication for Social Change
Mobilised around the focal question

How do we strengthen the health system and community systems and build their connection to work in concert.
What do we know
A lot about barriers

Recent literature review for SA communication strategy

(Frizelle, Solomon & Rau, 2009)
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.
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.
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.
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.
What is needed

• Useful frameworks
• A process oriented approach
• Integrated approaches
• A non-negotiable emphasis on participation
Barriers are multi-dimensional

- Structural
- Psycho-social
- Cultural
- Economic
Our strategy must be similarly multi-dimensional
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
Strengthen Health Systems and..
Clinical Systems Mentorship
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
• 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
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.
We asked: How do we support ongoing care that is feasible, of high quality, and sustainable?

Through Clinical Systems Mentorship.
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
The foundation of CSM is continuous data-driven assessment, intervention, and reassessment across multiple levels.

- Tools are an important component of the methodology.
- Approaches are outcome oriented, systematic, context-specific and concrete.
CSM

• CSM is a blend of mentorship approaches expanded across systems

And

• Process oriented systems consultation
  – e.g. Schein’s consultation models
Mentorship is a
- voluntary
- relationship
- entered into
- with a clear purpose,
- mobilised around change, transformation, development and growth.
## CSM Vs. Clinical Mentorship

<table>
<thead>
<tr>
<th>Similarities</th>
<th>Differences</th>
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<tbody>
<tr>
<td>• Positive</td>
<td>• CM: One mentor</td>
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<tr>
<td>• Relational</td>
<td>• CSM: Teams can be mentors</td>
</tr>
<tr>
<td>• Developmental</td>
<td>• CM: Individuals</td>
</tr>
<tr>
<td>• Outcome oriented</td>
<td>• CSM: Individuals and Systems</td>
</tr>
<tr>
<td></td>
<td>• CM: Developed</td>
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<tr>
<td></td>
<td>• CSM: Developing</td>
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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
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
Key objectives of CSM

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

2. Improving Quality of Care (SOC)

3. Building Capacity and Transitioning
Goal 1: Implement a specific model of HIV care and treatment (comprehensive, family focused)

Goal 2: Build capacity to promote program sustainability and 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
Three levels of Clinical Systems Mentorship

**Site Level**
- Space, equipment, and forms
- Drug supply chain management
- Staffing and HR issues
- Patient flow/triage
- Record keeping
- Clinic organization and setup

**Team Level**
- Training of new staff
- MDT meeting set up
- Adherence support
- Referrals/Linkages
- Community issues
- Peer Involvement
- Selecting and training new generations of mentors

**Provider Level**
- Care/referral of complicated cases
- Clinical Precepting
- Chart review
- Case conferencing
- Teaching new knowledge and skills
- Journal club
- Morbidity and Mortality Rounds

Something is missing
It can do much more

• Proposal 1
• Develop, expand and implement the CSM approach for whole system development
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
Integrated Model of Communication for Social Change

Integrated Model of Communication for Social Change

- **Catalyst**
- **Community Dialogue**
- **Collective Action**
- **External Constraints and Support**
- **Individual Change**
- **Social Change**
- **Societal Impact**

Figueroa & Kincaid, 2/2001
Community Dialogue

- Recognition of a Problem
- Identification & Involvement of Leaders & Stakeholders
- Clarification of Perceptions
- Expression of Individual & Shared Interests
- Vision of the Future

Conflicts or Dissatisfaction

- Disagreement

Consensus on Action

- Options for Action
- Setting Objectives
- Assessment of Current Status

Action Plan

- Consensus on Action

Collective Action

- Mobilization of Organizations
- Implementation
- Outcomes
- Participatory Evaluation

Assignment of Responsibilities

- Individuals
- Existing Community Groups
- New Community Task Forces
- Others

Value for Continual Improvement

External Constraints and Support

- Outcomes vs. Objectives
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
Caution

- Participation is laborious
- Time consuming
- Difficult to maintain
- But critical
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
• Proposal 2
• Research and develop a process oriented “generic” communication for change model
• Link an expanded CSM model with community engagement and vv
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 engaged outcomes we hope for.
• Only participation and process oriented models are likely to be effective.