Pilot project
Process Evaluation
Preliminary results

Public Health Department Meeting
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Megweetch!!

- Mistissini, Wemindji and Ouje-Bougoumou communities
- All Awash team members, coordinators, and local partners
- All Members of the Evaluation Consultation Committee
- All AMA supporting staff and consultants

- Research assistants who helped collect and analyse the data
  - Dior Sarr, Master's Student, Yale University
  - Carine Flore NJINENG, MD, Master's student, UdeM
  - Michèle Boileau-Falardeau, MSc

Plan

- Brief overview of the context
  - Why AMA?
  - Why a pilot project?
  - Why an evaluation?
- Preliminary results
  - Phase 1
    - Timeline of implementation
    - Description of clientele & services
  - Phases 2 & 3
    - Barriers & facilitators to implementation
    - Clients' feedback on services
- Next steps
  - Finalisation of integrated reports
  - Comprehensive knowledge transfer

Brief overview of the context

Why AMA?
Why a pilot project?
Why an evaluation?

Why implement AMA?

- Early childhood is key to development and health for life (1)
- « Home visiting programs » have been shown to improve health and wellbeing of children living in « vulnerable » contexts (2)
- Experts in Aboriginal health field recommend that we implement such programs in Aboriginal communities, with the collaboration of parents and community partners (3)
- Cree families have expressed needs for more support (4)

(1) WHO (2008). Closing the gap in a generation: health equity through action on the social determinants of health. Final Report of the Commission on Social Determinants of Health. Geneva, World Health Organization

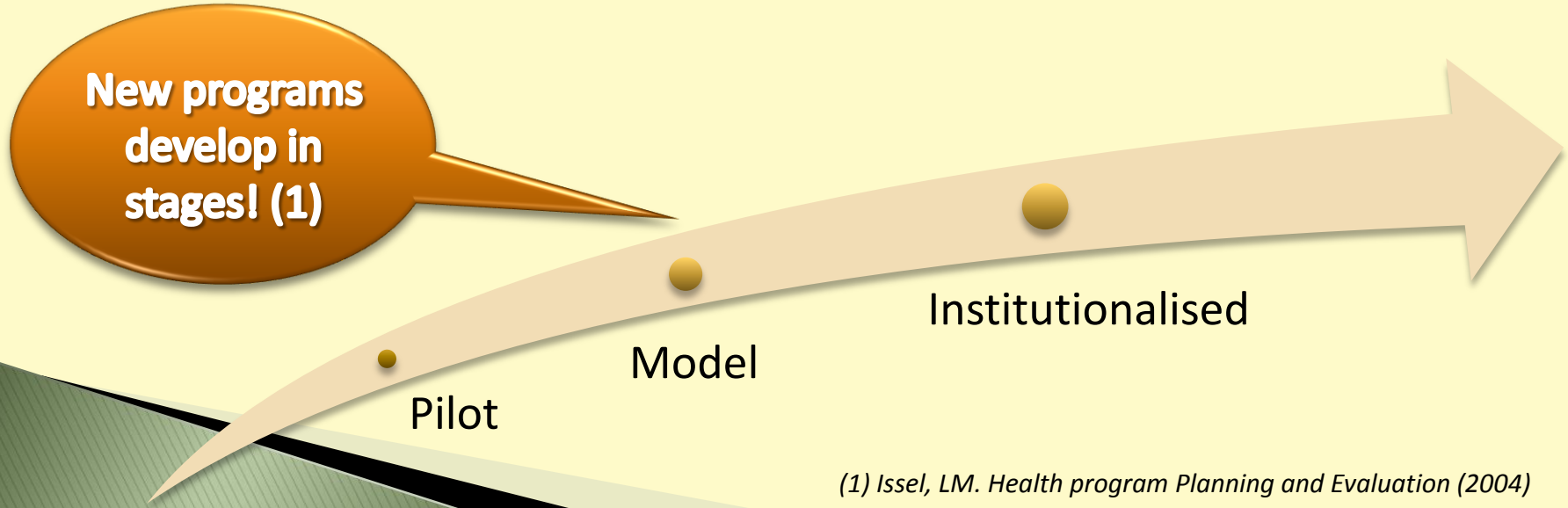
(2) Beauregard, D., Comeau, L., & Poissant, J. (2010). Avis scientifique sur l'efficacité des interventions de type Services intégrés en périnatalité et pour la petite enfance en fonction de différentes clientèles. INSPQ

(3)Bali, J. (2008). Promoting Equity and Dignity for Aboriginal Children in Canada. IRPP Choices 14 (7).

(4) Sioui, N. (2008). Évaluation formative et stratégique des Services intégrés en Périnatalité et pour la Petite Enfance à Mistissini (Amaskuupimatiseat Awas[illegible] Unpublished report. Chisasibi: Cree Board of Health and Social Services of James Bay

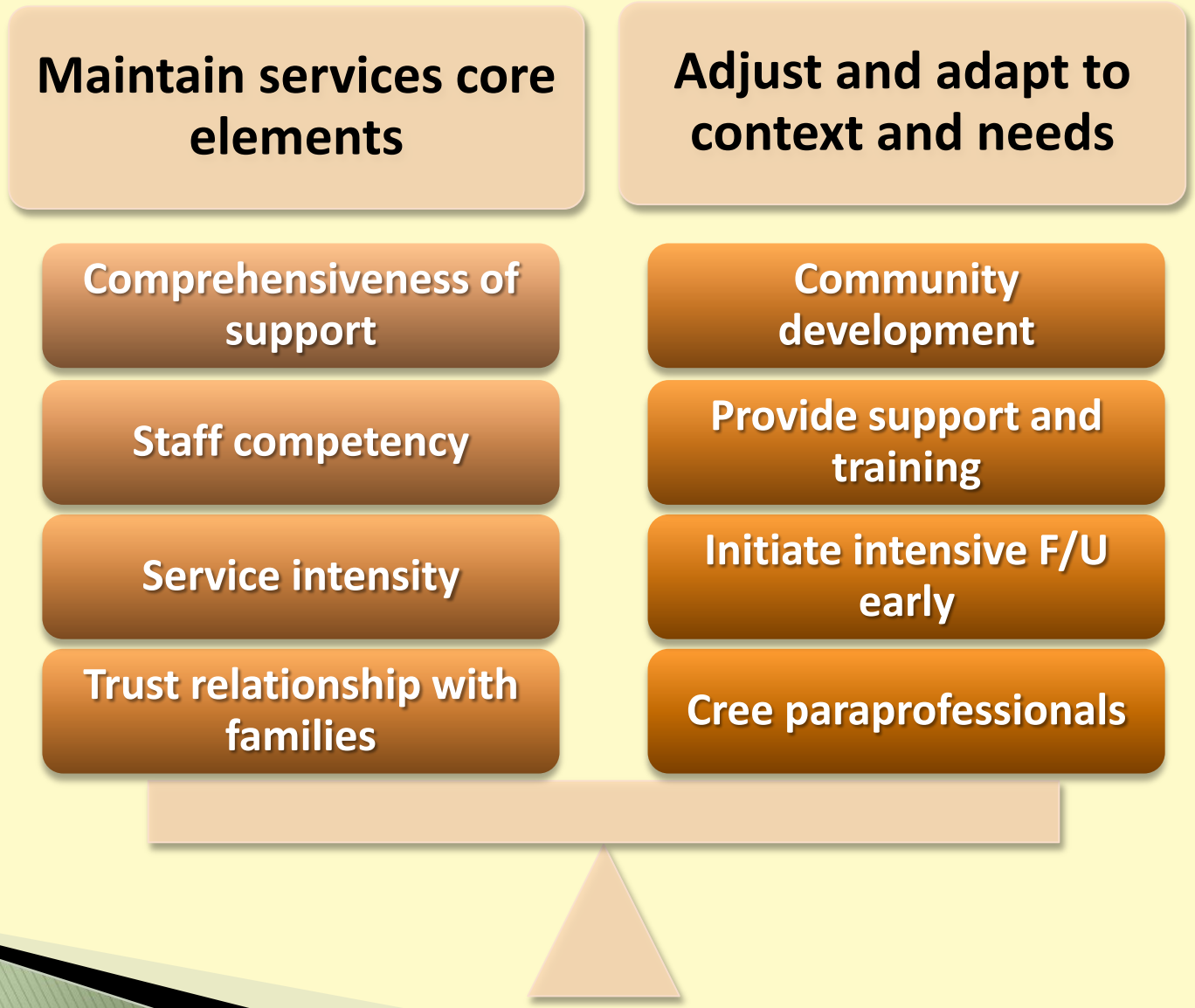
Why a pilot project?

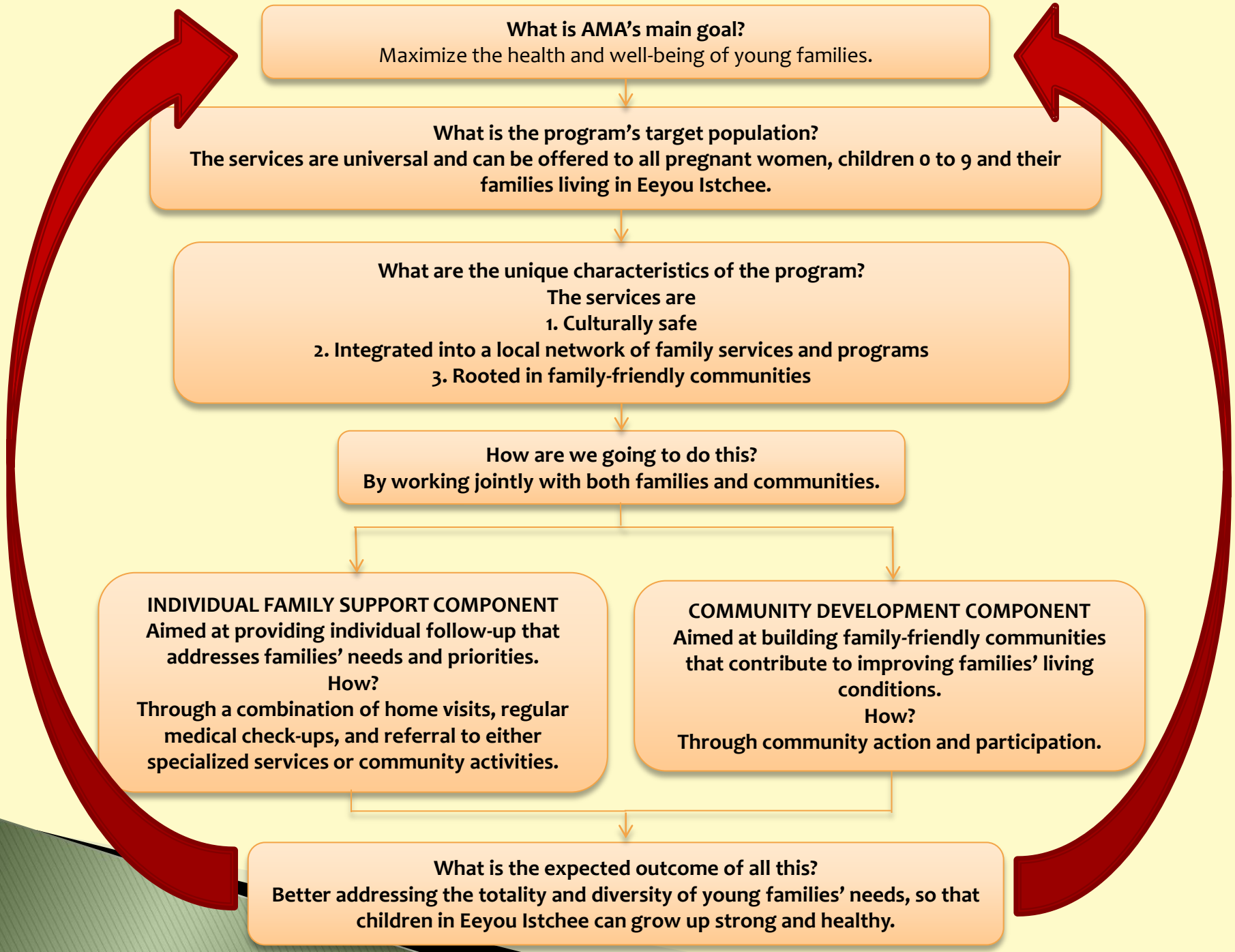
- Services are now being offered in Quebec : *Services integrés en périnatalité et en petite enfance (SIPPE)*
  - *Cree families' needs are not necessarily identical to those of the rest of Québec…*
  - *How can they be adapted to Cree vision of motherhood and parenting?...*
  - *Can they be deployed in a isolated community context?...*



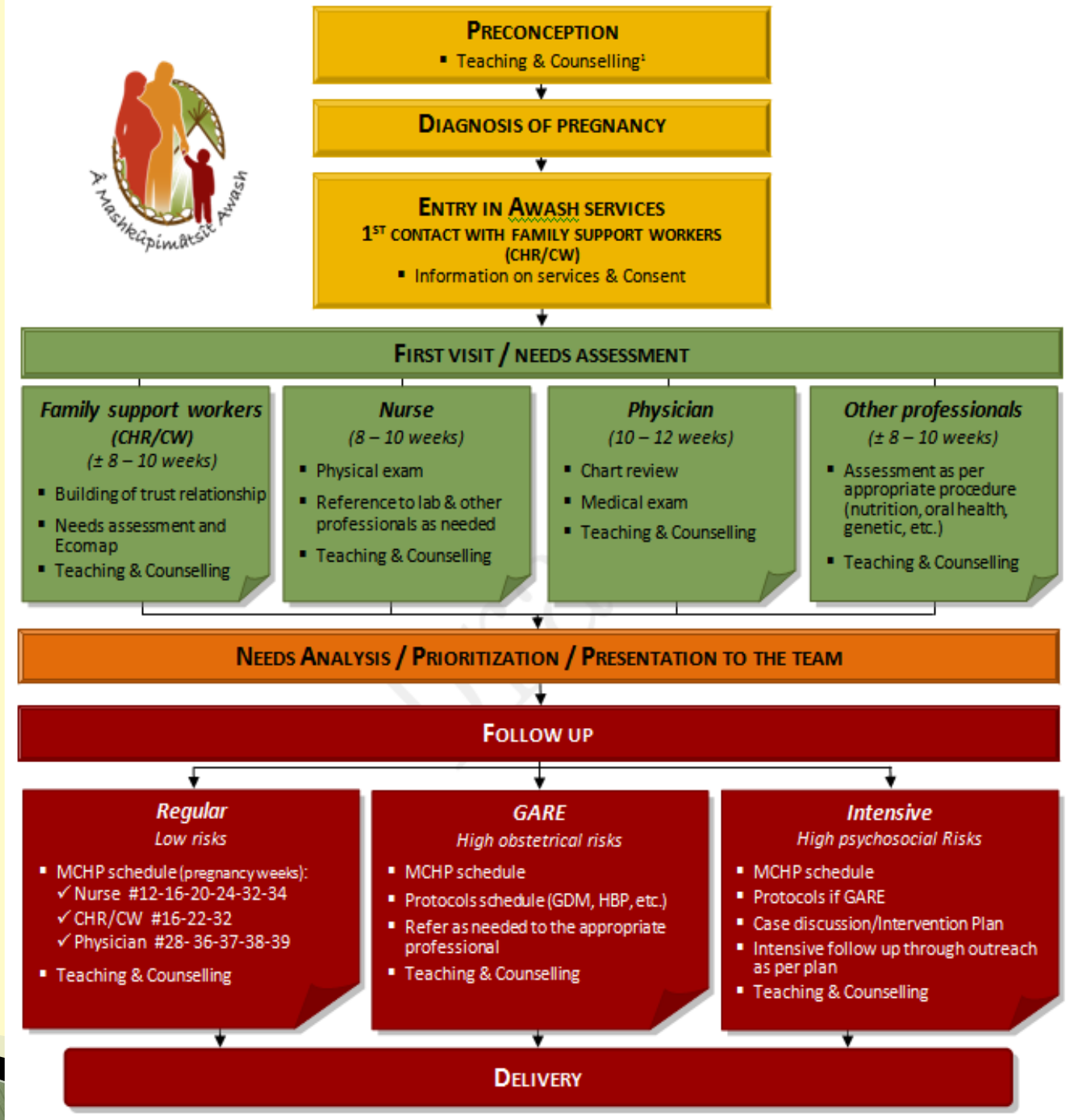
(1) Issel, LM. Health program Planning and Evaluation (2004)

Program adaptation: a balancing act





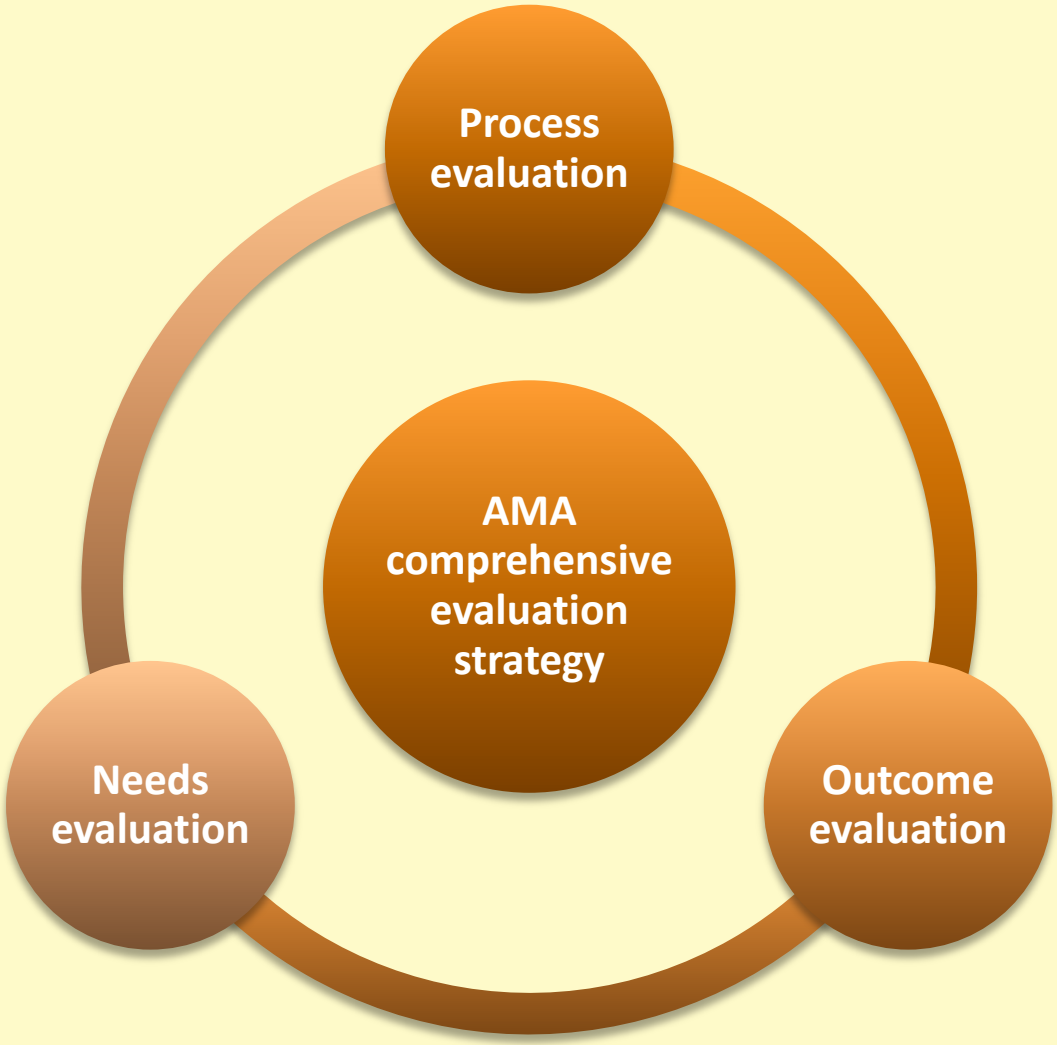
Universal Services – flexible intensity



Pimuhteheu Cree Board of Health and Social Services of James Bay, 2012

Why an evaluation?

- **Main goal**
  - Improve AMA services prior to expansion of the approach to all other communities in the region



What is AMA's main goal?
Maximize the health and well-being of young families.

What is the program's target population?
The services are universal and can be offered to all pregnant women, children 0 to 9 and their families living in Eeyou Istchee.

What are the unique characteristics of the program?
The services are
1. Culturally safe
2. Integrated into a local network of family services and programs
3. Rooted in family-friendly communities

How are we going to do this?
By working jointly with both families and communities.

INDIVIDUAL FAMILY SUPPORT COMPONENT
Aimed at providing individual follow-up that addresses families' needs and priorities.
How?
Through a combination of home visits, regular medical check-ups, and referral to either specialized services or community activities.

COMMUNITY DEVELOPMENT COMPONENT
Aimed at building family-friendly communities that contribute to improving families' living conditions.
How?
Through community action and participation.

What is the expected outcome of all this?
Better addressing the totality and diversity of young families' needs, so that children in Eeyou Istchee can grow up strong and healthy.

Needs evaluatio

Process evaluation

Outcome evaluation

Process evaluation – Objectives

Phases	Main Evaluation objective	Examples of evaluation questions which could be addressed
Phase 1	Obj 1 Describe the level of AMA deployment	Q1.1 Was AMA services implemented as planned? Q1.2 What is the profile of the families using the services? Q1.3 What are the services delivered?
Phase 2	Obj. 2 Understand successes & challenges in implementation	Q2.1 What were the barriers and facilitators in implementing AMA? Q2.2 How have these barriers and facilitators influenced the implementation of AMA?
Phase 3	Obj. 3 Explore clientele's perceptions of services	Q3.1 What do families think about the services ? Q3.2 What are their challenges to access? Q3.3 What are their unmet needs?

Participatory Evaluation process

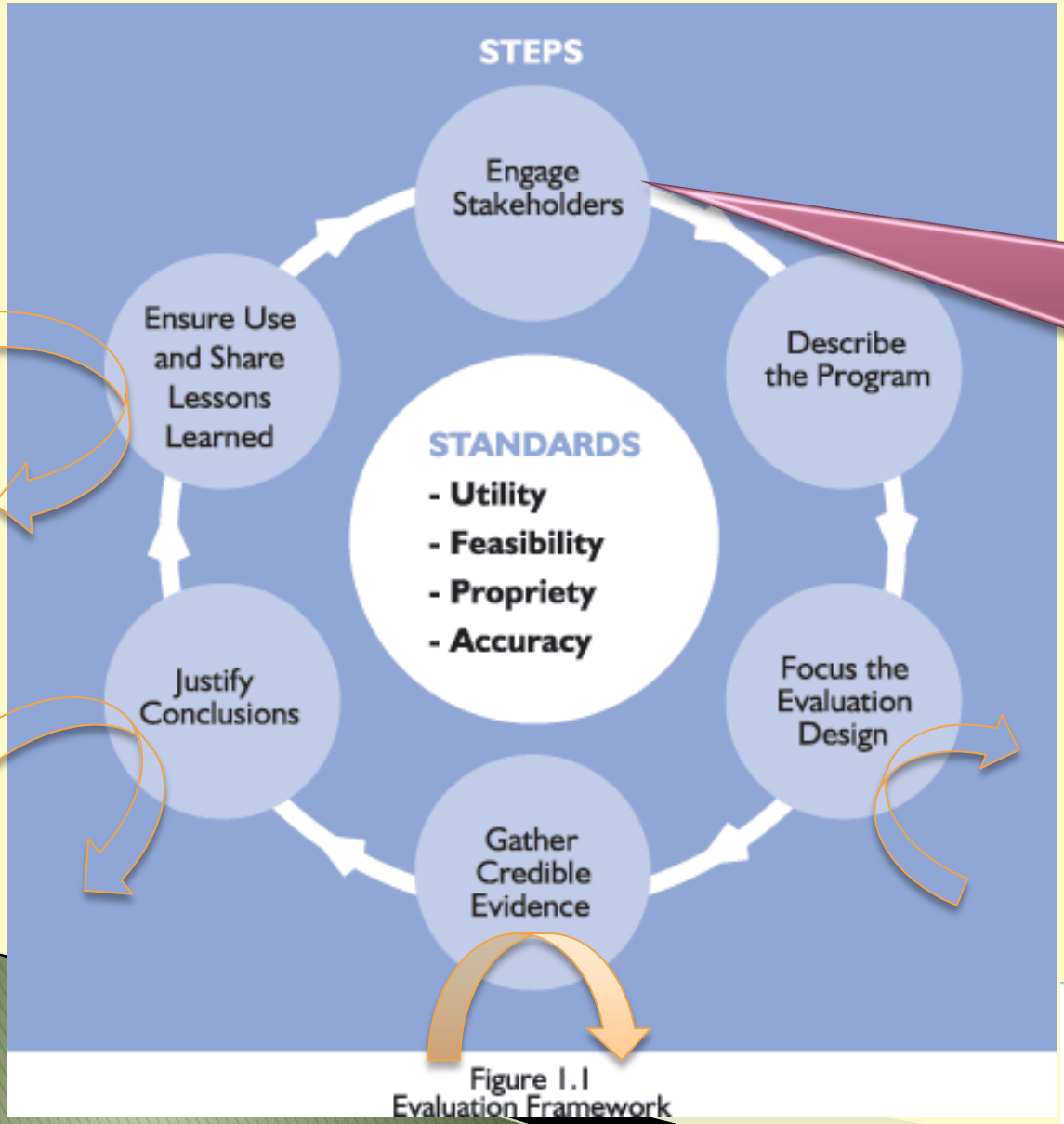


Figure 1.1
Evaluation Framework

Consultation committee
Nurses
Paraprofessionals
Heads
Community members

U.S. Department of Health and Human Services
Centers for Disease Control and Prevention.
Office of the Director, Office of Strategy and Innovation.
Introduction to program evaluation for public health programs: A self-study guide. Atlanta, GA: Centers for Disease Control and Prevention, 2011.

Presentation of some preliminary results

Phase 1

Phase 2

Phase 3

Process evaluation – Objectives

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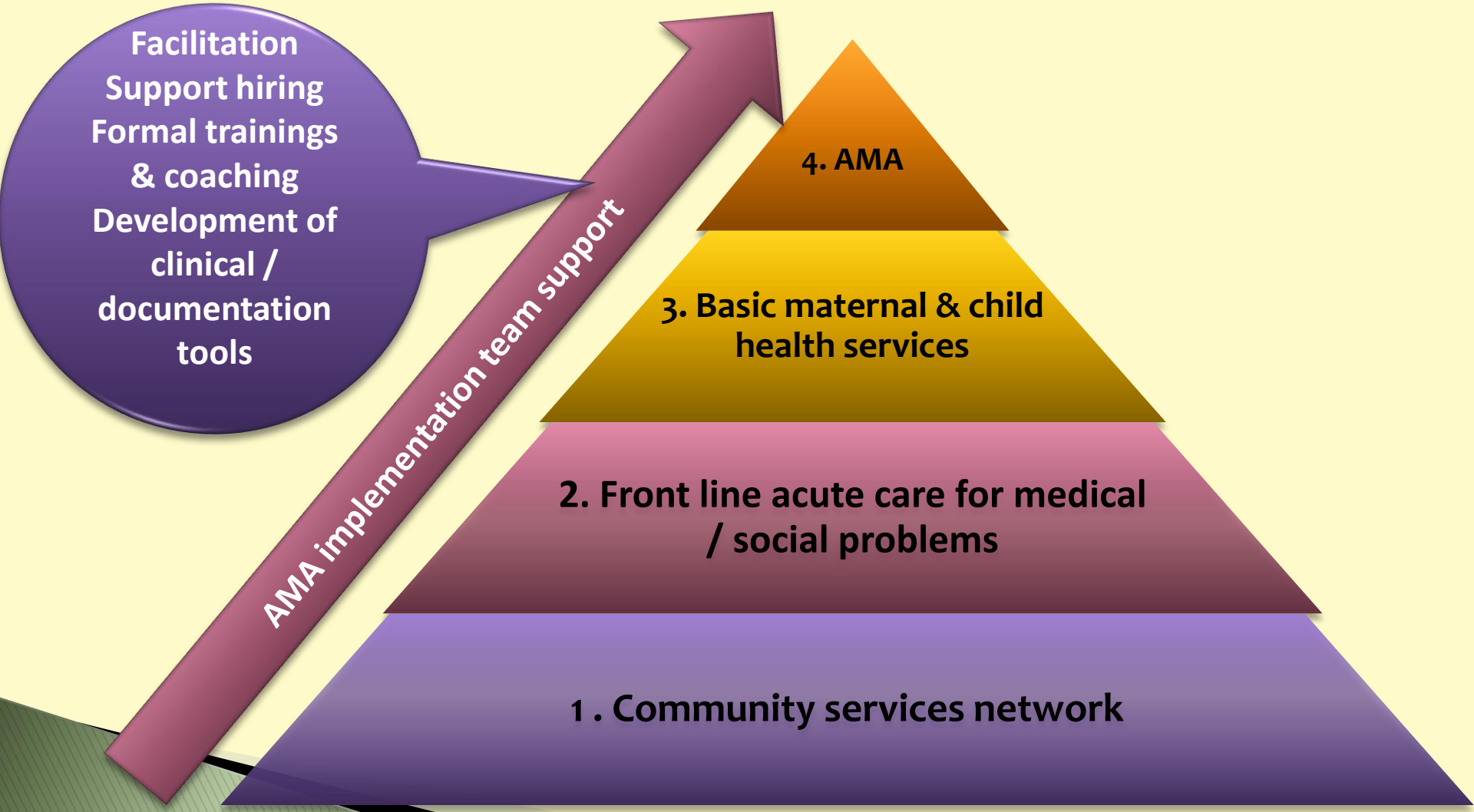
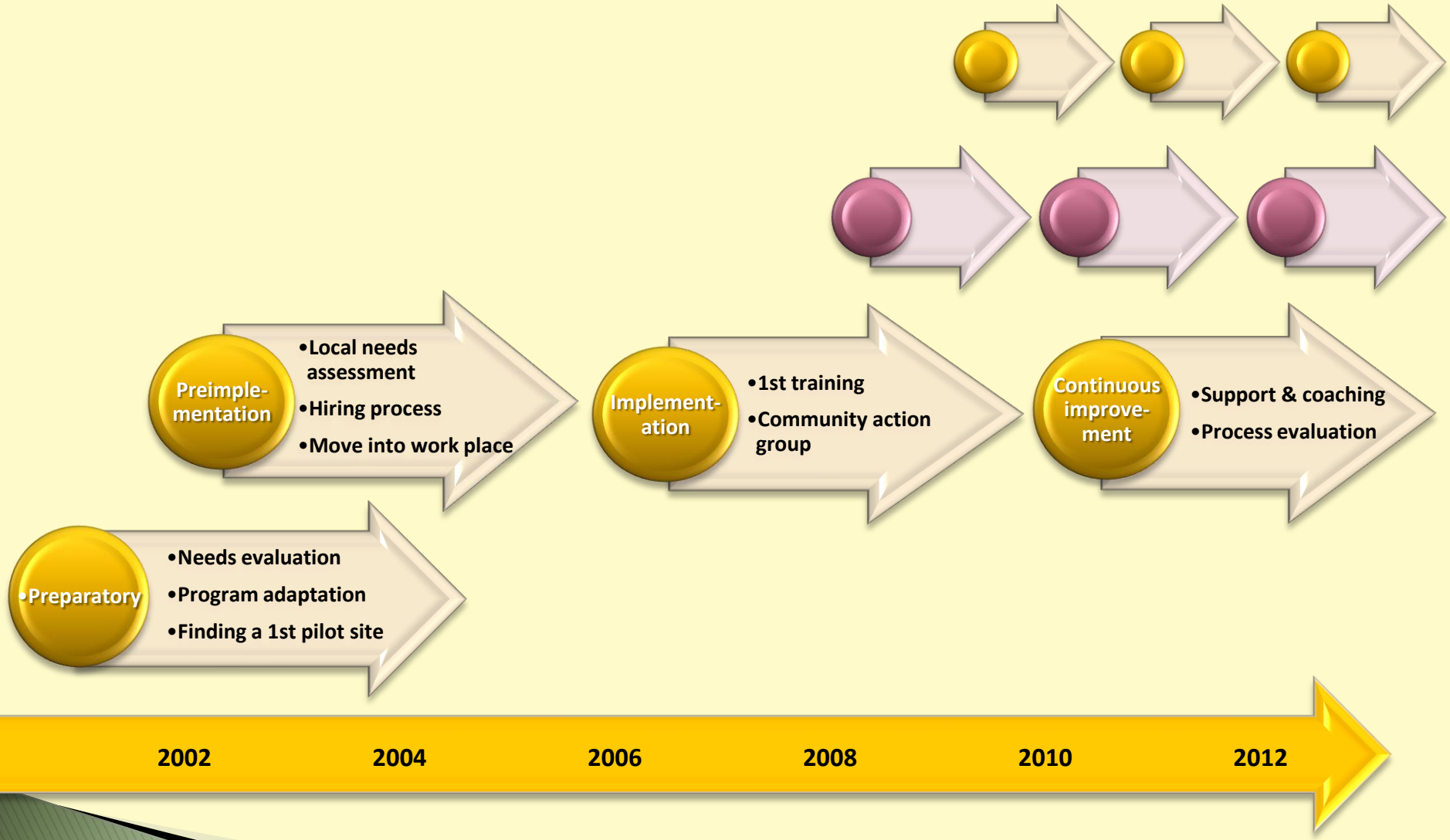
AMA implementation is a process in multiple phases



Pimuhteheu Cree Board of Health and Social Services of James Bay, 2012

AMA Implementation timeline



Was AMA services implemented as planned?

- Implementation process got faster as we went along
  - Implementation team got better as they practiced?
  - Different communities presented different contexts?

- Reasons for « delays »
  - Instability of working team 2ary to difficulties in hiring / maintaining / replacing team members (incl. Management)
  - Absence of working space
  - Reflection period (Confusion in the definition of mandates from AMA vs Awash vs CMC from every levels)

AMA implementation support (2013)

Type of support	Community A	Community B	Community C
Core team (as of 2013)	2 Nurses I Awash Coordinator 4 CHRs 1 Community Organizer 1 Secretary	1 Awash/Ushi Coordinator 1 Nurse 4 CHRs 1 Community Worker 1 Secretary	1 Awash/Ushi Coordinator 1 Nurse 1 CHR 1 Community Organizer
Trainings provided	14 trainings since 2008	13 trainings since 2009	12 trainings since 2010
Coaching	Ongoing visits by Godmother (± 1w/month) Nurse coach (± 4w/y.) Psychosocial coaching/mentoring offered by a Social Worker Clinical Support (mental health) Interdisciplinary teamwork (up to 3-5/year)		

AMA implementation support (2013)

Type of support	Community A	Community B	Community C
Tools provided	I**ntervention tools**: MCHP checklists, OBS forms from Ministry Pre/ post natal + childhood pathways, Needs assessment form and guide, Intervention plan and guide, Prioritization grid and guide, ASQ + Nipissing Screening tools and procedure, Parent/Child activity calendar 0-6 from CSSSPNQL, etc. **Promotion tools**: AMA pamphlet, Banner and poster, Magnets and stickers with AMA logo, Gifts given to moms to support breastfeeding (baby carriers, T-shirts, bags, diapers...) **Informational resources**: MCHP pamphlets, AMA guidelines PP presentations + Participants workbooks related to each of the training sessions , Various educational materials (placenta, uterus, foetus, posters, books...)		

Was AMA services implemented as planned?

- Implementation is taking a longer time than expected…
  - Many communities do not yet have all prerequisites in place…
  - But things are getting better as we go along…

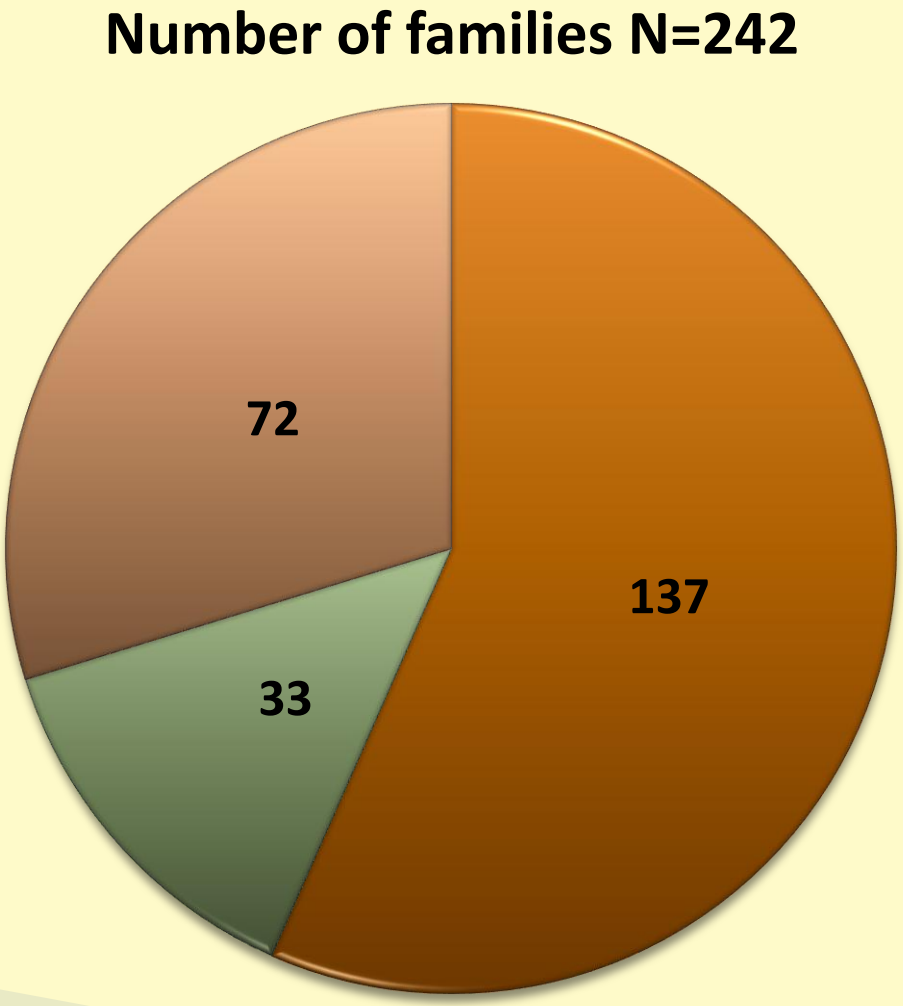
Medical Chart Review

- Design:
  - Transversal observational
- Population:
  - Who? All mothers and babies receiving AMA services
  - When? Babies born between January 2010 & June 2012
  - Where? in all 3 pilot communities
- Source of information
  - Medical Chart of mother and child
  - Limits - social desirability, incomplete, non standardized...

AMA clients profile

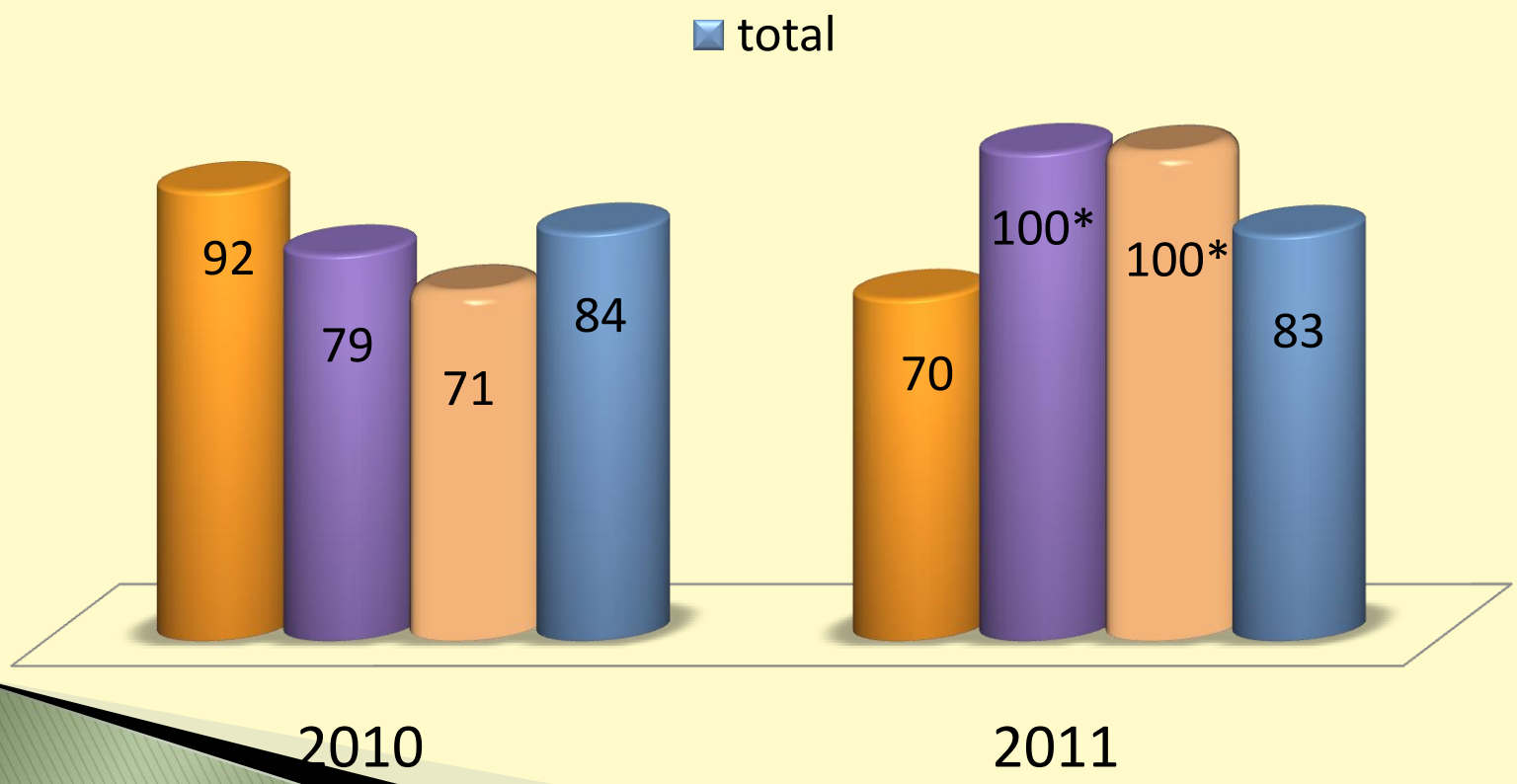
Socio-demographic, obstetrical and behavioural perinatal risk factors

How many families were followed between Jan 2010 and June 2012?

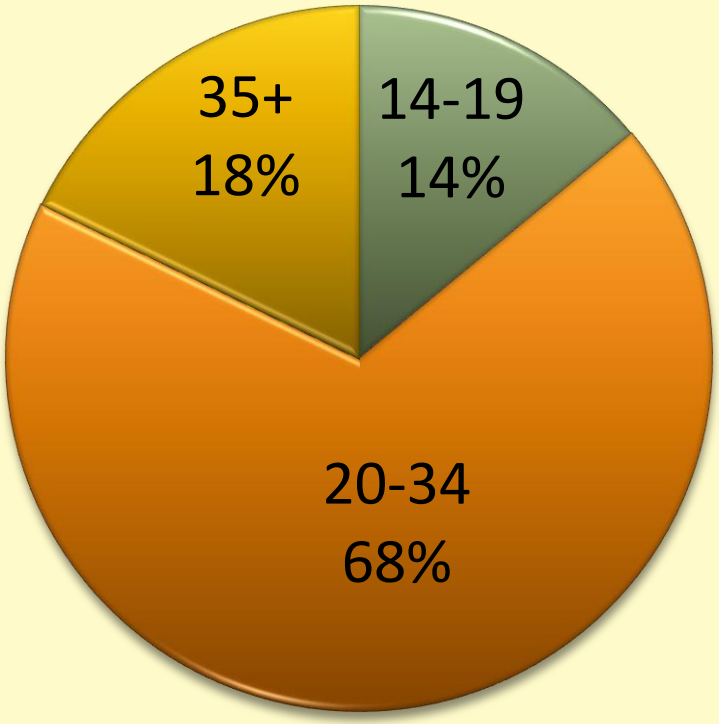


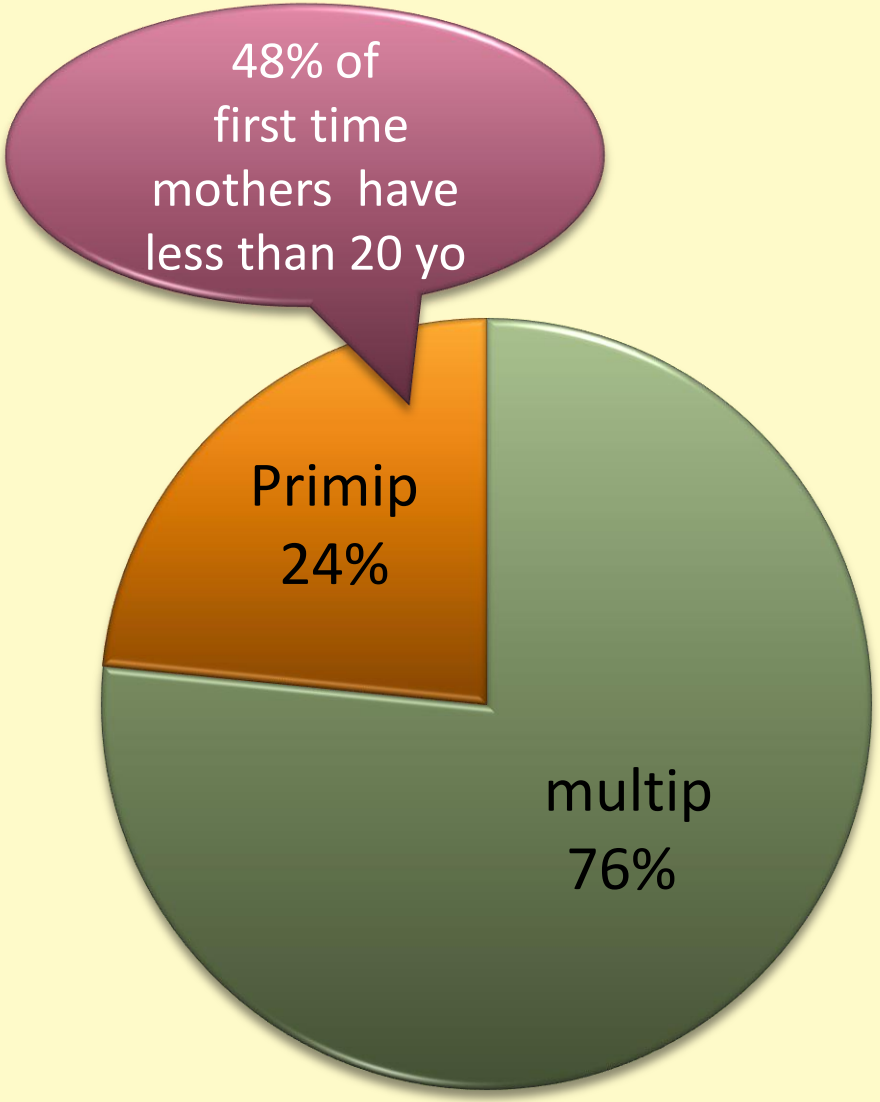
Are we seeing all the families in each community?

Coverage rates vary between 70% and 92%



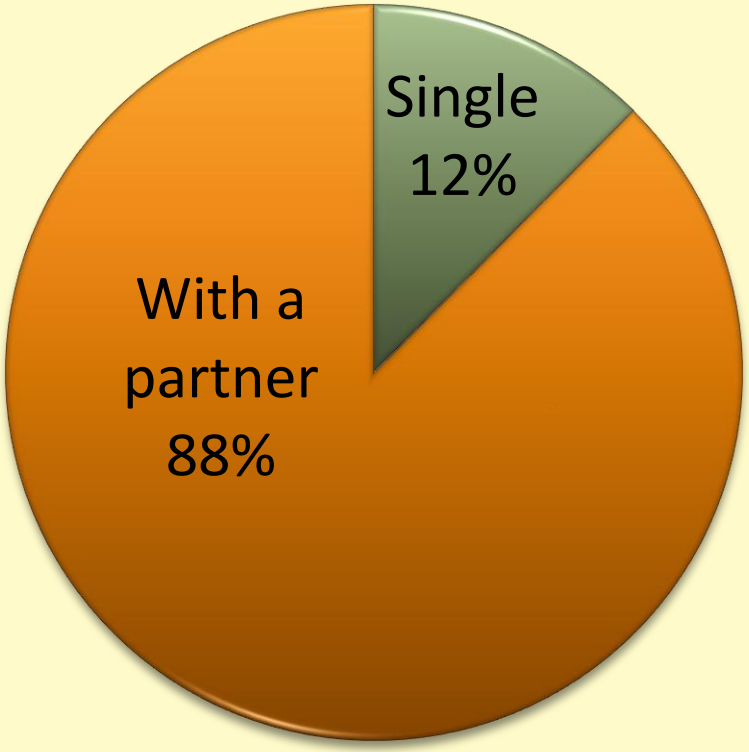
Age of mothers 2010-2012 N= 242



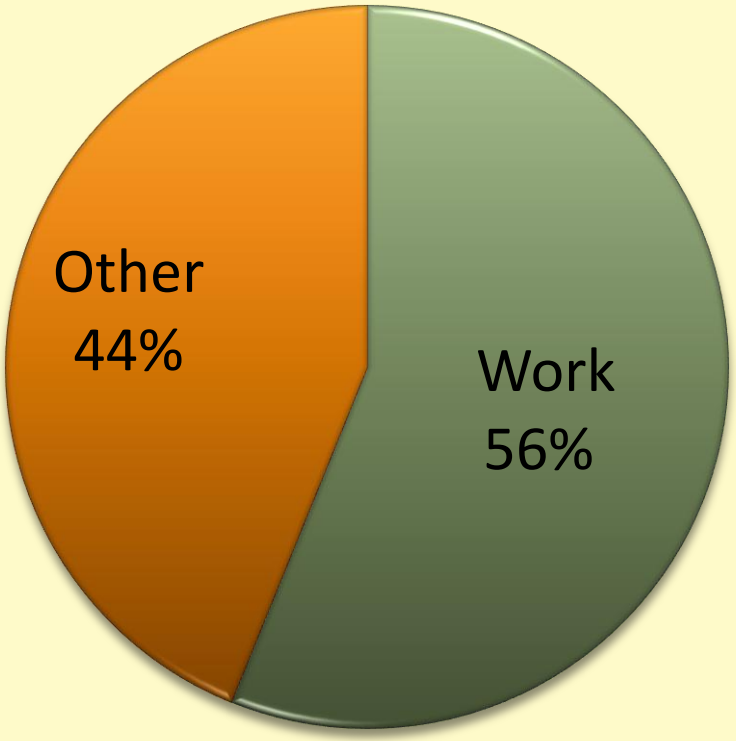


Socio-economical factors 2010-2012

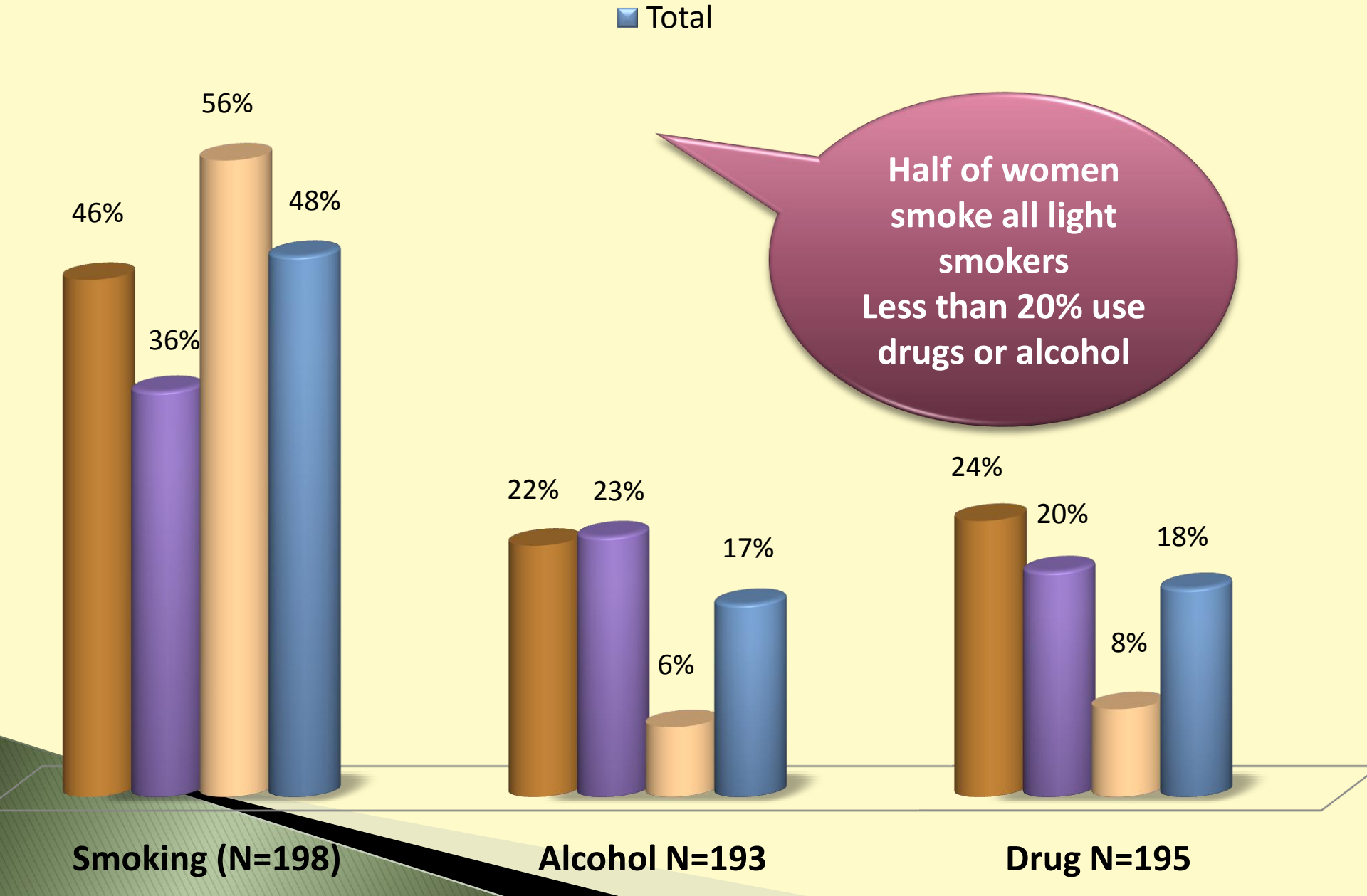
Marital status N=217



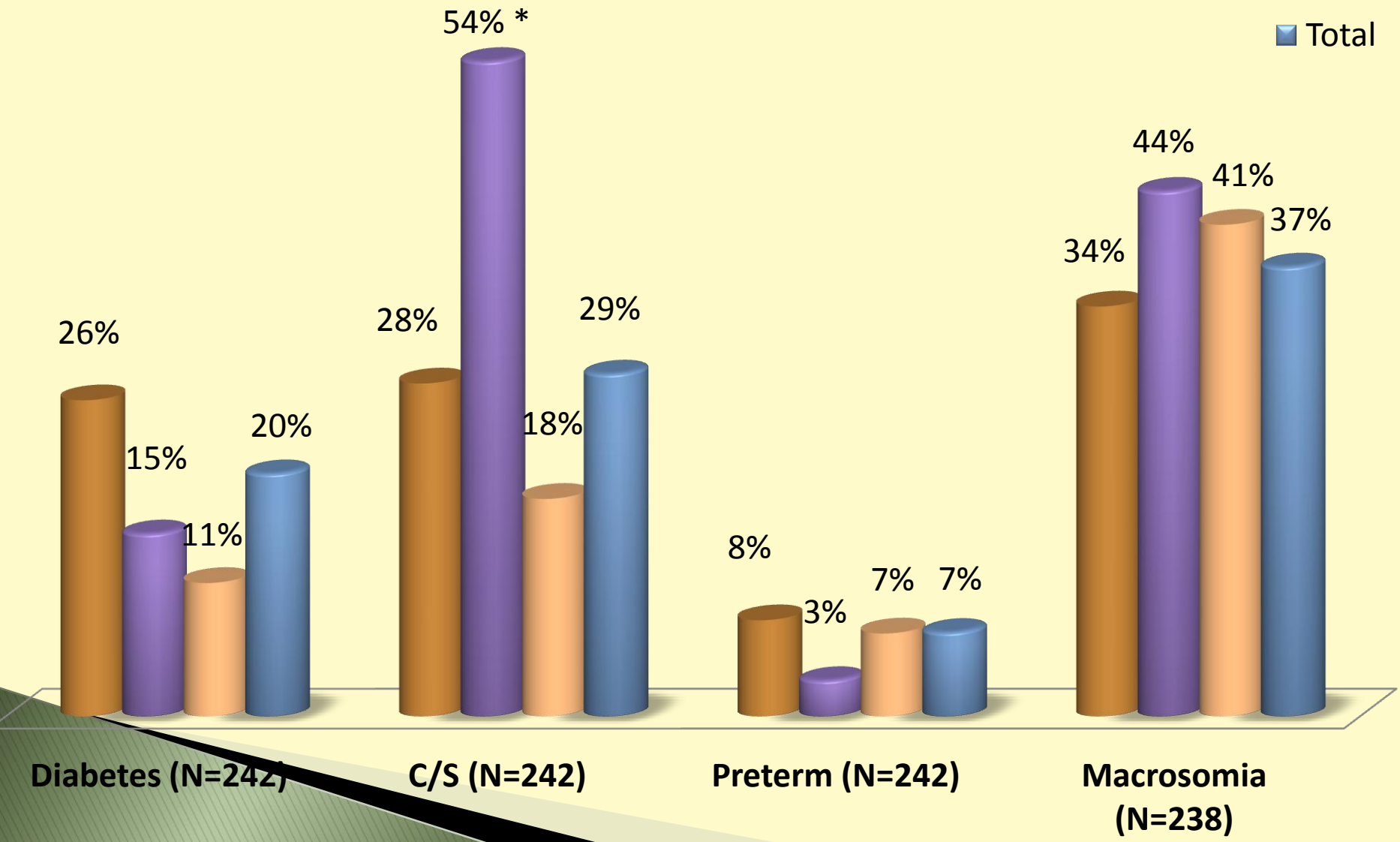
Source of income N= 199



Life style during pregnancy 2010-2012



Obstetrical profile AMA 2010-2012

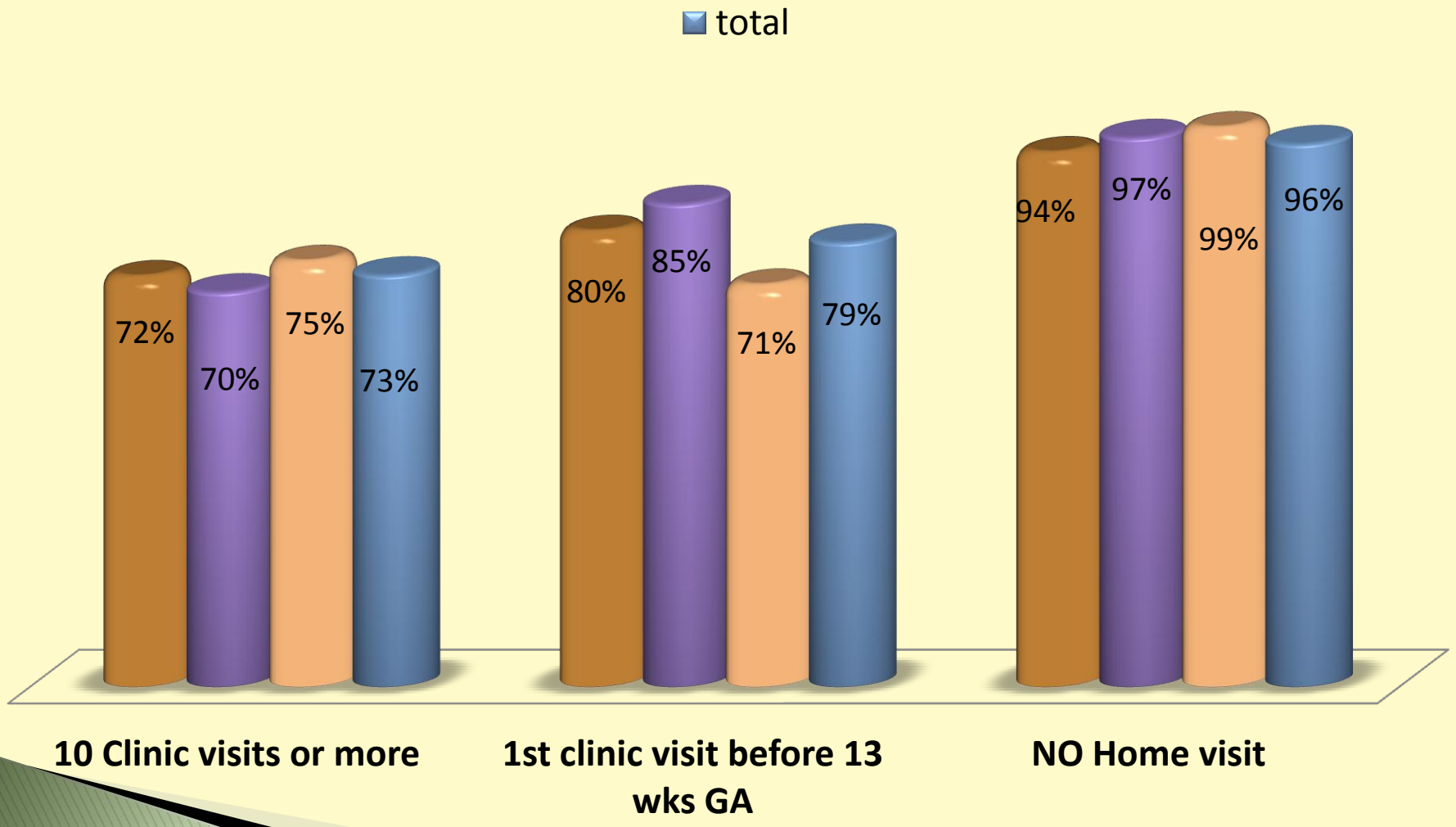


Summary clientele

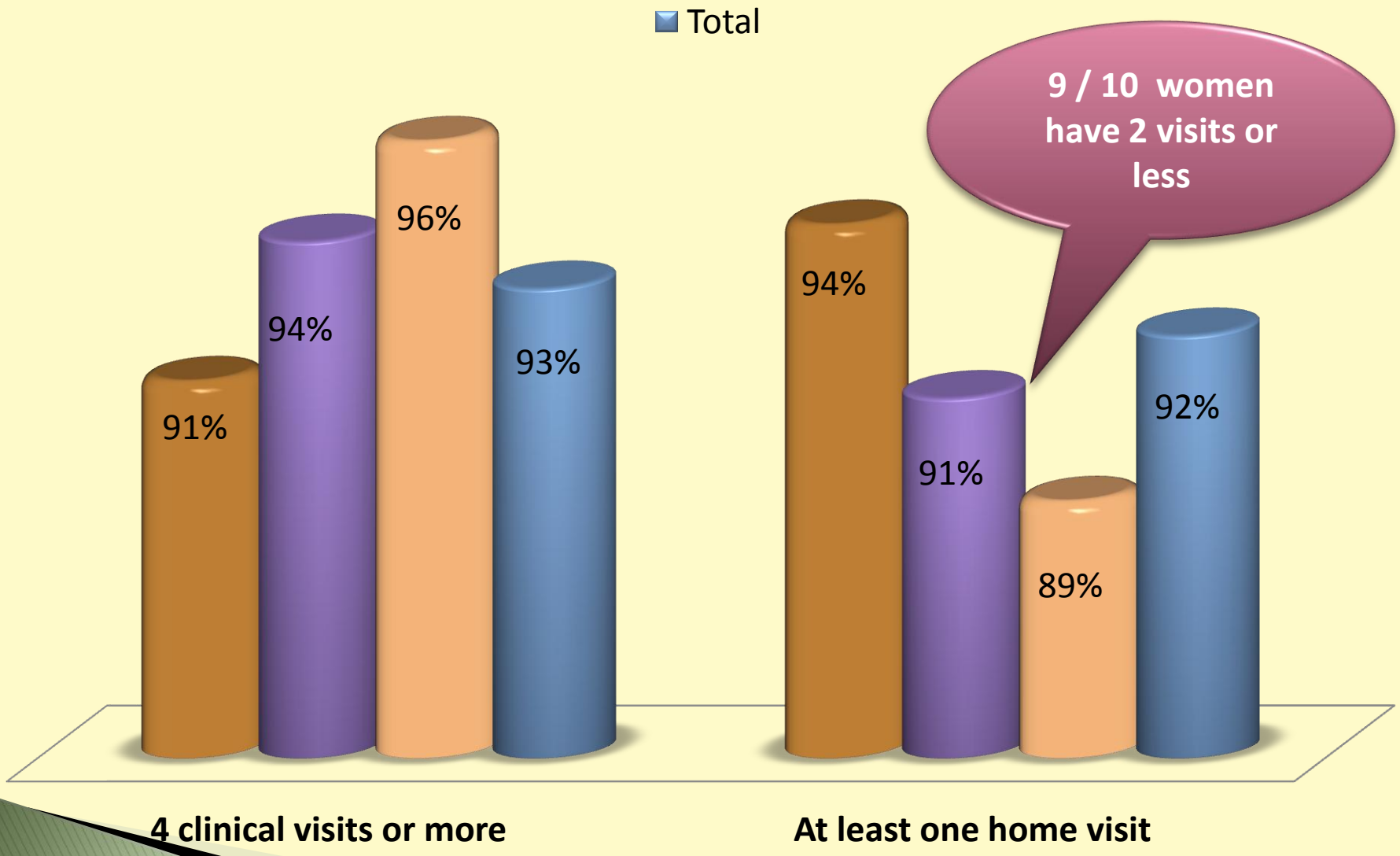
- Coverage - satisfactory
- AMA Clientele profile
  - Similar to regular Cree territory population
  - Families have many needs Obstetric + psychosocial
- Confirms need for intensive follow up

What services are families receiving?

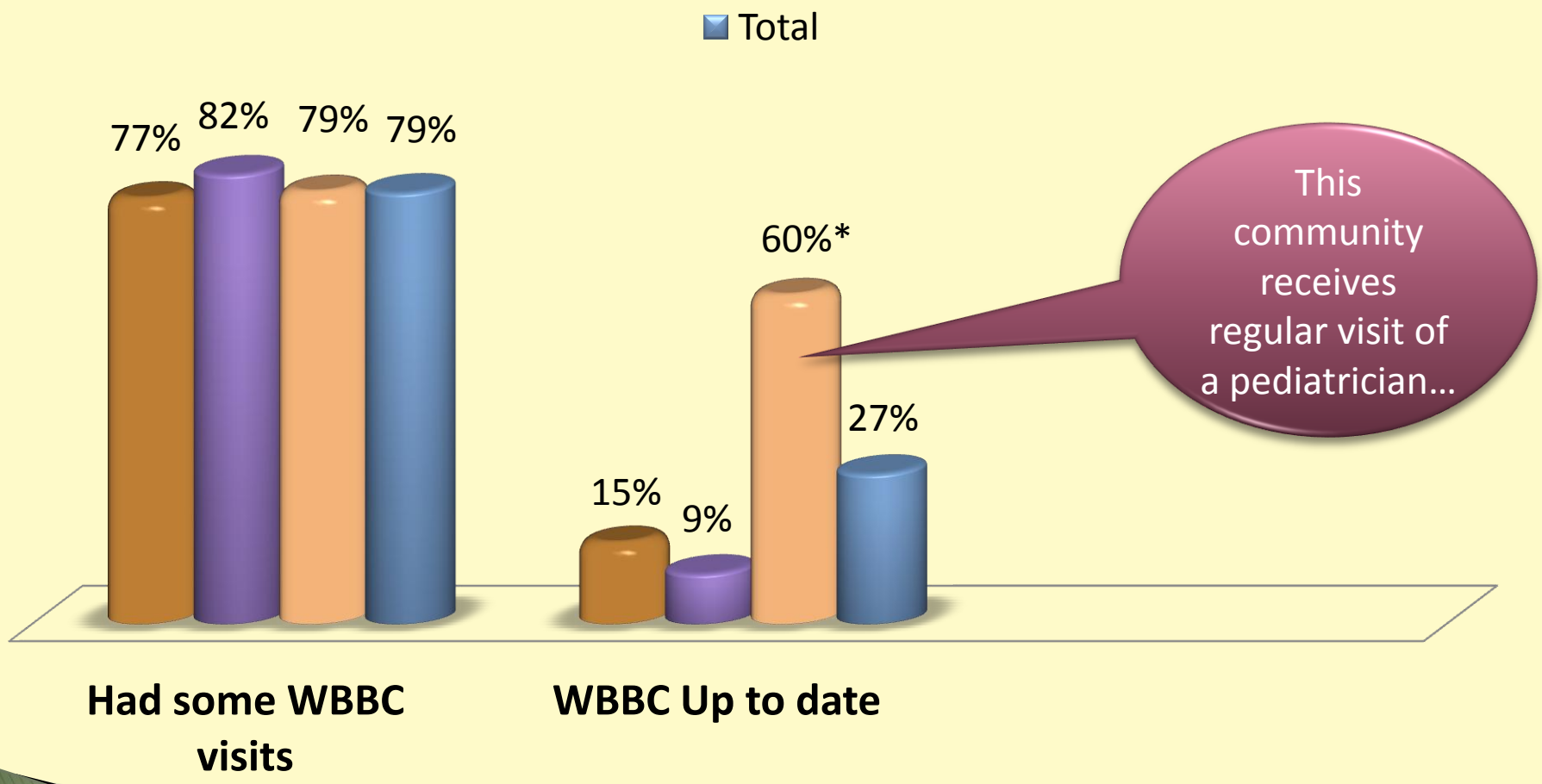
Prenatal follow up AMA 2010-2012
N = 242



Pospartum follow up



Children follow up up AMA 2010-2012 N=242



Summary: AMA services 2010-2012

- MCHP recommended visits very well done!!
  - Prenatal & postpartum clinic visits
  - 24-48 hr PP home visit
  - WBBC
- Implementing the intensive follow up a challenge…
  - Not documented in the medical chart?
  - Has improved since?

AMA EVALUATION

PHASE 2

Process evaluation – Objectives

Process evaluation phase	Main Evaluation objective	Examples of evaluation questions which could be addressed
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METHODS

- Conceptual framework:

  AMA as an **innovation**: « *a novel set of behaviors, routines, and ways of working that are directed at improving health outcomes, administrative efficiency, cost effectiveness, or users' experience and that are implemented by planned and coordinated actions.* » (Greenhalgh et al, 2004)

- Research design:

  Embedded multiple case study (Yin, 1994)

- Sampling strategy:

  Purposive sampling (non-probability sampling)

METHODS

- Tools:
  - Individual in-depth interviews
  - Group discussions (sharing circles)
  - Observations in CMCs
  - Documents
- Interviews were:
  - conducted in French or English, *in situ* or by phone;
  - recorded, unless the participant refused;
  - transcribed.
- Data analysis:

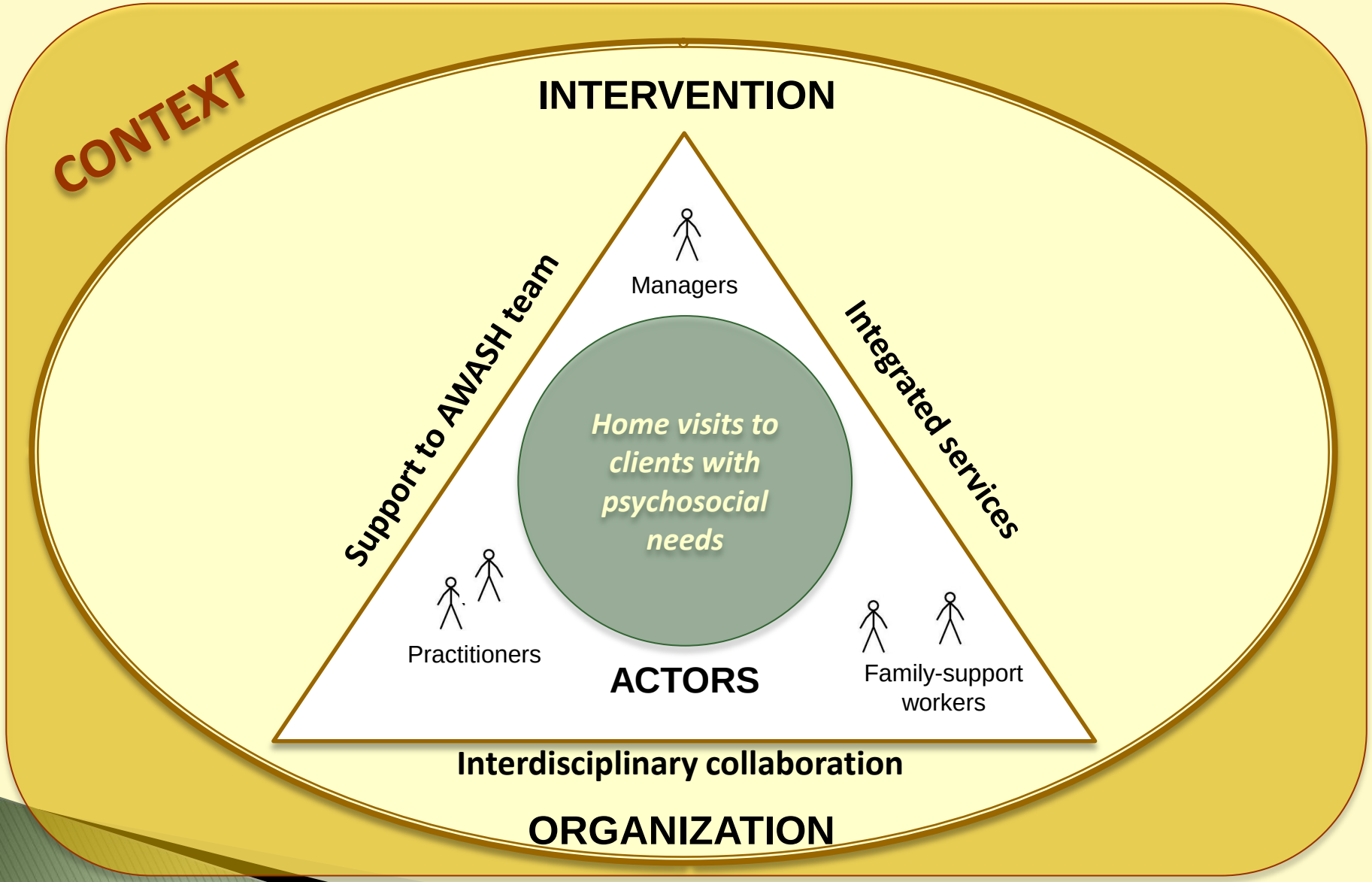
  Thematic analysis with Nvivo10 software

METHODS

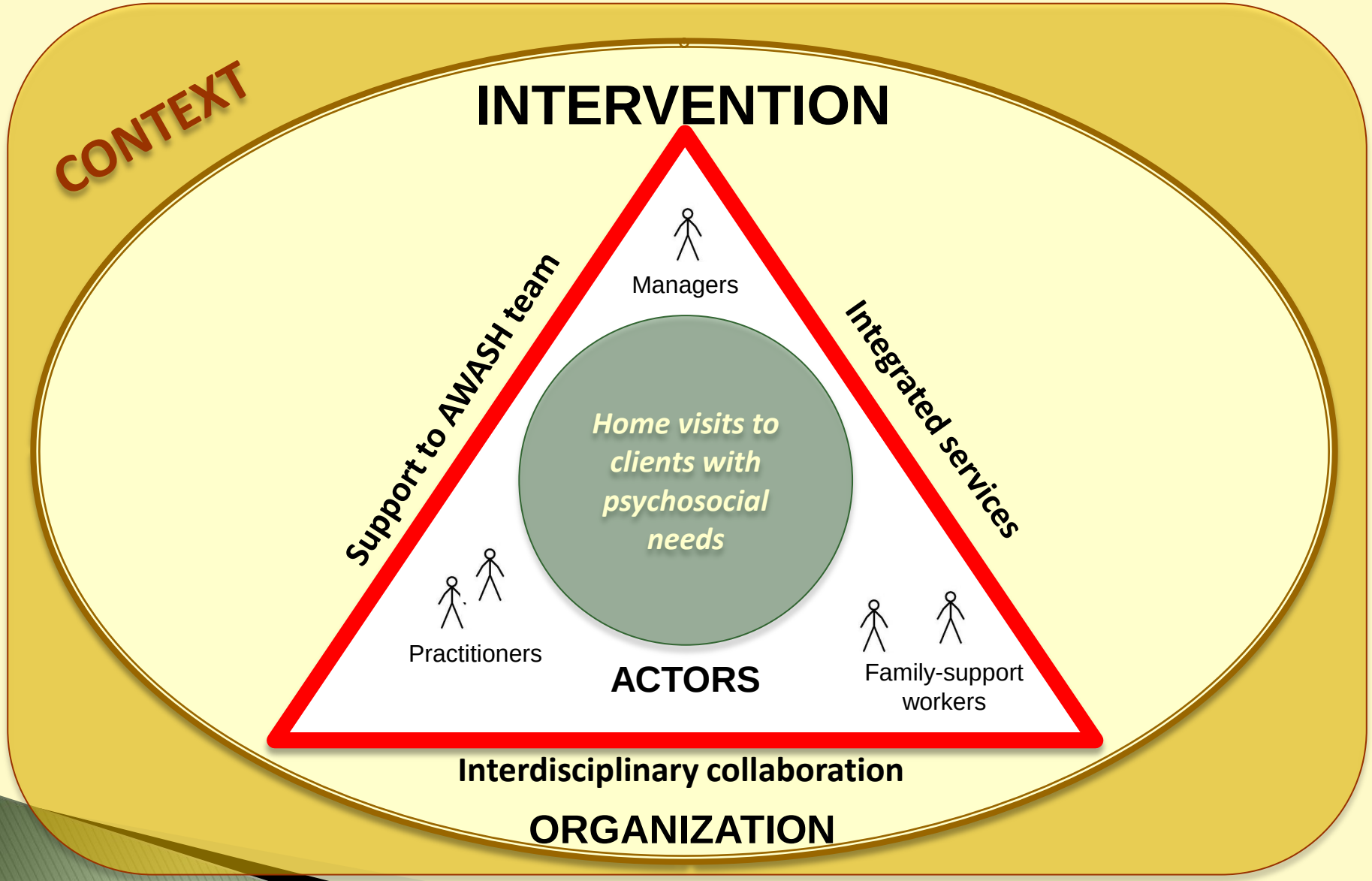
- Sample:

AMA regional implementation team	N=8
Local management	N=3
AWASH nurses	N=7
AWASH paraprofessionals	N=12
Community organizers	N=2
Other professionals	N=12

ANALYTICAL FRAMEWORK



LEVEL OF ANALYSIS

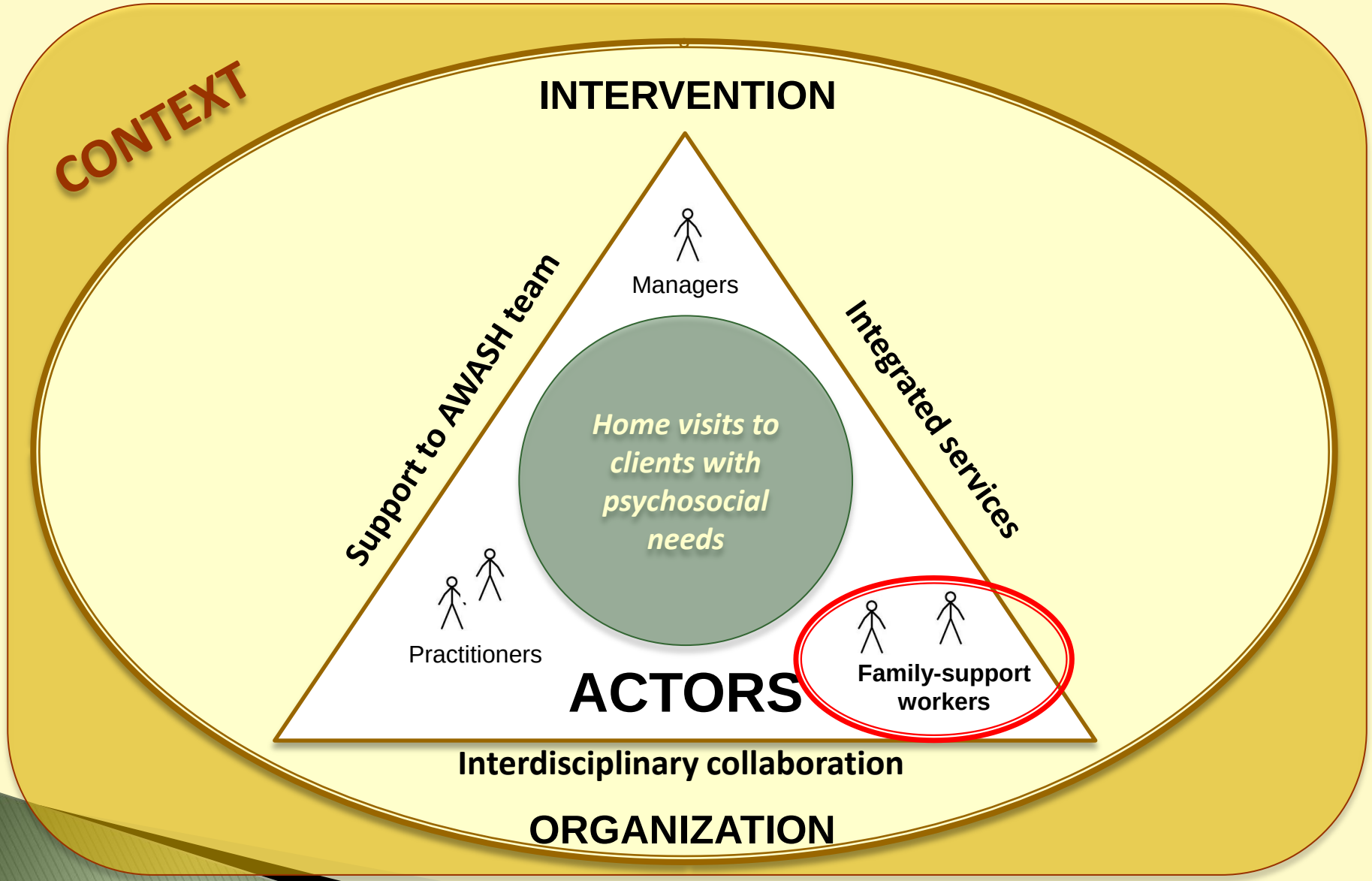


AMA as a radical innovation

Characteristics of innovation	Explanation
Compatibility: *Is AMA consistent with existing work procedures?*	• Challenges professional habits. • Requires new understanding of clientele's needs.
Complexity: *How far is AMA perceived as advantageous?*	• Requires new ways of working (collaboration / interdisplinary work) and additional tasks to be performed.
Observability: *How easy is it to witness the advantage of AMA?*	• No short-term results.
Knowledge: *How much knowledge is needed to implement AMA?*	• Requires intensive trainings on new materials and intensive on-site coaching. • Requires use of new tools.

AMA is an innovation which needs careful preparation and constant adjustment to ensure that it is implemented by the teams.

LEVEL OF ANALYSIS



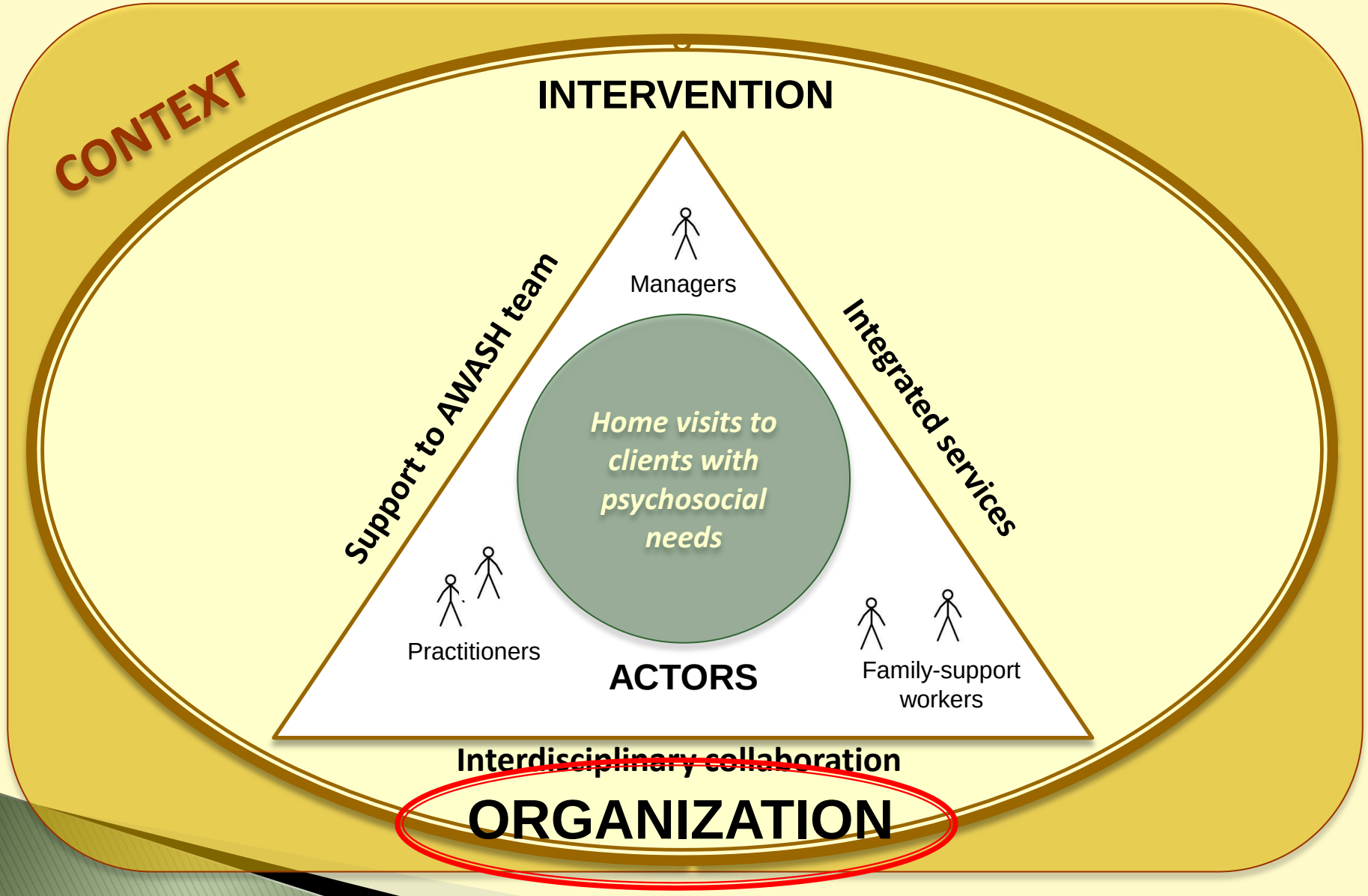
Barriers at the level of family-support workers

Lack of professional qualifications or tools**	• *"I wish I had more tools sometimes when I work with certain people. […] Sometimes inside I get frustrated because I feel like I'm going nowhere with certain people."*
Workers' background of psychosocial problems*	• *"But I saw a few things that I couldn't even deal with myself. […] that was a question I didn't like to ask because I'm also a – I'm a survivor."*
Negative perception of the pertinence of home visits*	• *"If you go and knock on their doors, they're going to bring more resistance. Because that's how I would feel if somebody kept knocking at least three or four times to check up my home."*
Fear or stress to experience physical or emotional distress*	• *"It was really scary. I had to say, okay, I'm a big woman. I can do it. […] I was screaming inside."*

Facilitators at the level of family-support workers

Positive past experience of home visits**	• *"At the beginning when we did the home visits, I wasn't sure. I felt kind of, okay. But it went well."*
Workers' personal background*	• *"They know who I am, even though I had a tough life […] you're a role model for the community. […] I can compare with their […] problems. […] It's what I went through."*
Personal motivation and interest*	• *"I wanted to be more out in the community, and I needed something more challenging."*

LEVEL OF ANALYSIS



Barriers at the organizational level (1)

Multiplicity of trainings and field visits***	• *"As soon as we finish a training, it seems like there is another one right after."*
Staff turn over and instability of team**	• *"Instability of working team (Fatigue from health care workers, individual life events and team dynamics)"*
Tension and lack of communication among team members*	• *"We need them... I would like to work more with them. They're amazing people; it's just that we have a hard time to integrate them in the team."*

Barriers at the organizational level (2)

Confusion between AMA and AWASH (reform of services)*

- *(no verbatim)*
- The **reform of health services** in Eeyou Itschee was implemented at the same time as AMA:
- It created confusion about AMA objectives among other health professionals in the clinic, raising their expectations for the

Lack of administrative support**

- *"The secretary plays a key role within the program. She calls the patients, she reaches them. […] Here we do a lot of secretarial work."*

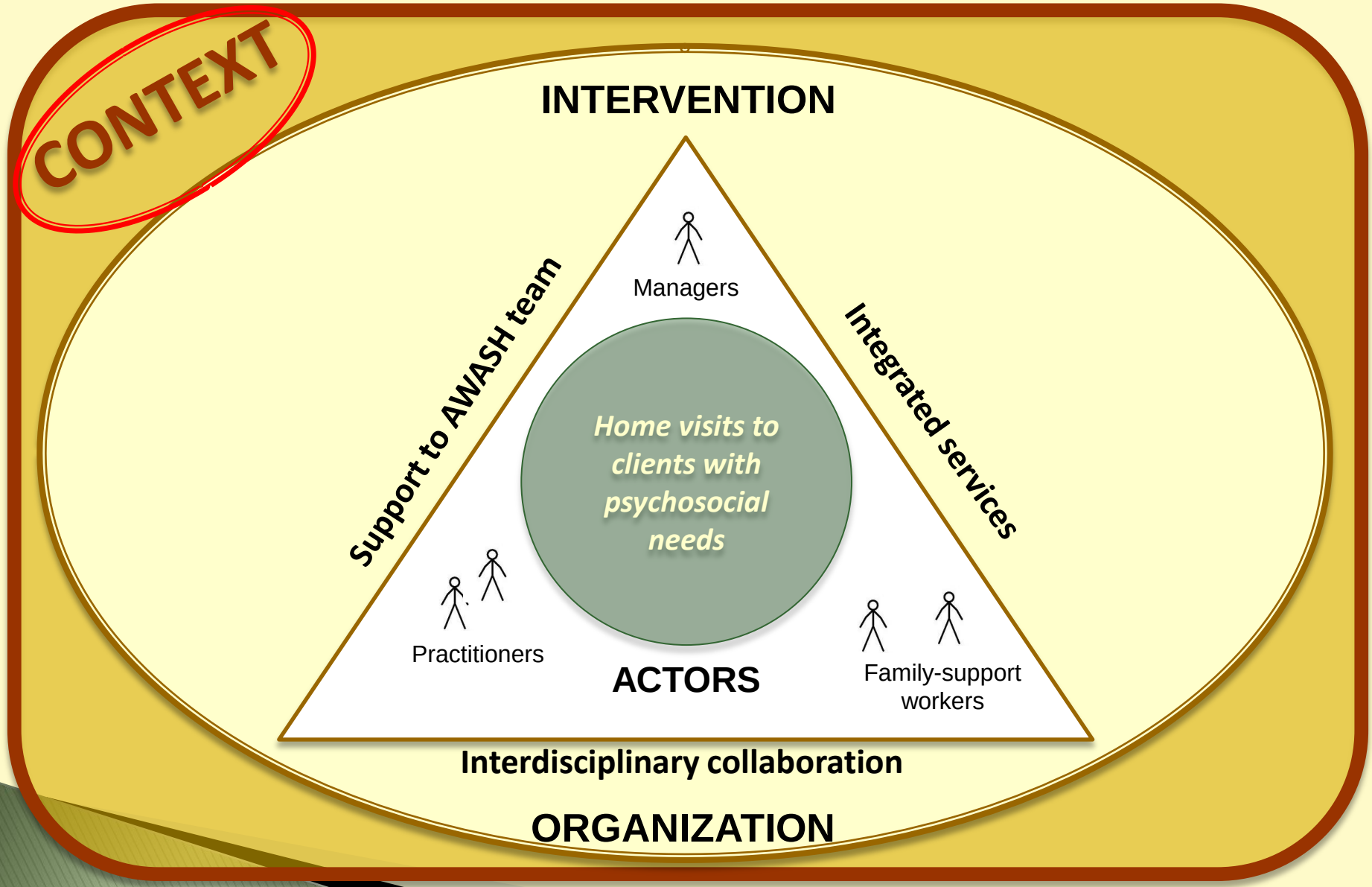
Facilitators at the organizational level (1)

Good communication and healthy collaboration**	• *"We have our ups and downs, like any other teams, but we always make it through it. I think sometimes we come out stronger than the last time."*
Team support***	• *"So, if ever I have a problem with something that I need help with or something that I don't understand, I go see them* (other paraprofessionals) *or the Awash nurse gives me a lot of support."*
Team stability*	• *"We've been working together for so long, it's like we're all family."*

Facilitators at the organizational level (2)

Step-by-step implementation*	• *"I didn't want us to go too fast because I could see how it was implemented else […] I didn't want the team to burn out."*
Leadership from the local management*	• *"I think it really is a matter of management. My boss was really […] It's a very articulate person and very very involved in the program."*
Management style*	• *"The team is very creative […] If they're given the chance to grow and told to follow, adhere to strict rules. Rules are very hindering."*

LEVEL OF ANALYSIS



Contextual factors

In a small community…

- *Potential conflict of interest due to filial connection and confidentiality breach;*
- *Easier to build trust with clients and make personal connection;*
- *Easier to mobilize community partners.*

In a large community…

- *Less potential conflict of interest as workers can exchange their clients;*
- *Bigger team so more opportunities to share work load and learn from each other;*
- *More difficult to create interpersonal bounds with community members and clients;*
- *More challenging to mobilize community partners.*

Why clients may feel uncomfortable when visited at home
(perceptions of practicioners)

Confusion between CWs and youth protection	• *"A lot of these girls knew where we worked before, the youth protection, and they feel uncomfortable because we were the workers."*
Fear of being judged	• *"I would be afraid a nurse coming in – I would say, '*You know, this house is not very clean*,' I would start judging myself."*
Low privacy at home	• *"But some of the home visits the woman would rather come here than in the home because it's more private, […] than in a home."*

Why clients may feel uncomfortable when visited at home
(perceptions of practicioners)

Fear of confidentiality breach and stigmatization	• *"In the past, there was some trust issues in the clinic. […] when patients come in, they're wondering, okay, why is she here? Is she pregnant, or did something happen? If you see a woman with a shiner in the eye then they're like really staring. And so they leave the clinic and they gossip a lot then."*
Filial connection	• *"Maybe a relation with one of the CHR, like, if they're cousin or something, somehow closely related, then the person wouldn't feel too comfortable […]."*

What would make clients more comfortable when visited at home (perceptions of practicioners)

Explaining the role of practicioners	• "(Paraprofessionnal quotes herself:) '*[…]* I don't know if the program was explained to you'. *But I really explained it and everybody's role in the team. So she's very open*."
Showing empathy and establishing trust relationship	• *"You know, whatever they went through in their past, I can relate to them, and I can, you know, be comfortable with them, and they feel comfortable with me."*
Demonstrating flexibility	• *"So, I call them back and I say, "I can come to your house if you want me to come, you know, if you feel more comfortable that way." Then they say, Oh no no no, I'm coming, I'll come to the clinic."*

AMA EVALUATION

PHASE 3

Process evaluation – Objectives

Process evaluation phase	Main Evaluation objective	Examples of evaluation questions which could be addressed
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METHODS

- Study design: Qualitative exploratory analysis
- Sampling strategy: Purposive sampling
- Tools:
  - Individual semi-directed interviews (n=19)
  - Group discussions in two of the three communities (n=3/7)
- Interviews were:
  - conducted in English or Creem, at home or at the clinic;
  - recorded, unless the participant refused.
- Participants included mothers with psychosocial needs, mothers with no psychosocial need, fathers, grandmothers.

METHODS

- Recruitment strategy:
  - List of clients suggested by AWASH teams, according to specific criteria
  - 1st contact made by Community Organizer or research professional
- Data analysis:

  Framework approach (Ritchie & Spencer, 2002)
- Limitations:
  - AWASH teams not in contact with families that are not willing to participate in AMA or that are dissatisfied with services
  - Little time to adjust the recruitment strategy

AMA services appear very valuable for clients

Clients appreciated the support offered by the Awash teams.	• *"I had a lot of support from the Awash team, when I met with the services, it helped me in so many ways."*
Mothers especially appreciated home visits when their baby was just born.	• *"Home visits are good because the young baby is more comfortable in the home, but after six months it's ok to go to the clinic."*
Moral and material support were felt necessary.	• *"It's nice because they come and listen, but they also and most importantly give a hand, and not just talk."*
Sustained interactions were appreciated by mothers with psychosocial needs.	• *"They're very helpful, they call me almost every day."*

Receiving psychosocial support could be a challenge for clients…

At first, clients would fear to be judged by workers.	• *"At first, I wasn't so comfortable, it felt like someone was watching (me) but then it was fine."*
There appears to be a negative connotation associated with asking for help.	• *"In the old days we did not ask for help as it was not available. We had to manage to be independent."*
Receiving help was perceived as stigmatizing by some clients.	• *"I refused to get help because I was shy and I didn't want to be seen as someone needing help."*

What makes clients more comfortable

Interacting with a Cree worker	• *"I felt comfortable with her because I know her and because she spoke Cree. Sometimes I'm just looking for words (…) it it is harder to express oneself when you are not using your maternal language."*
Using sense of humour	• *"I like their sense of humour."*
Creating personal connections	• *"They are like family to me."*

Clients' needs of services

- Clients' needs of services seem anecdotal:
  - Prenatal classes to prepare for birth
  - Support by fathers to fathers struggling with attachment
  - Support to find a baby sitter
  - Etc.

- However, suggestions are for **support services at the community level**, and not for medical services at the clinic level.
- **Community needs assessments** would provided context-specific understanding of clients' needs.

What next?
Knowledge Exchange and Translation

Objectives	Strategies
To inform stakeholders on AMA implementation	• Final report • Formal presentations in meetings
To support AMA implementation in other communities (recommendations)	• Working groups
To involve AWASH teams in finding solutions to their local challenges	• Briefs of findings • Sharing circles and working groups • Community-specific final reports
To share findings with the communities	• Meetings with the Consultative Committee

Questions and comments?

Fore more information

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