Network organisation: the impact of dominant paradigms?

Gaëtan Absil (APES-ULg), Michel Demarteaue (Observatoire de la Santé du Hainaut)

December 10th 2009, 10th BAPH Symposium "Networks in Public Health", Mons, 2009
Purpose

- Influence of the paradigms* structuring the two networks which aim to prevent language difficulties in children from vulnerable backgrounds

  - The two networks exist within the dynamics of the *Plan Régional de la Santé des Enfants et des Jeunes (PRSJ)* (Regional Health Plan for Children and Young People) in the Provence-Alpes-Cotes d’Azur (PACA) region in France.

  - This assessment was sought in 2005 to define the conditions for making these networks permanent

* According to Kuhn
Cases

- Clinical network: detection (large area), cases classification, from speech therapist to neurologist

- Support network: local work, local actors implications, close/comprehensive/global care
Method

- Semi-structured interviews with the key actors in these networks (n=32).

- Actors: different roles within the networks: funders, co-ordinators, field workers and beneficiaries

- Comparisons between the two networks focussed on several criteria:
  - depiction of work in the network
  - actors
  - geographical spread
  - synchronies
  - network objectives
  - structure, effects
  - the role of beneficiaries
  - long-term conditions
  - overlap with existing networks
## Results

<table>
<thead>
<tr>
<th></th>
<th>Clinical network</th>
<th>Support network</th>
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</thead>
<tbody>
<tr>
<td><strong>Depiction of work in the network</strong></td>
<td>Public health, equity, resources, national stakeholders, to be cured to be a citizen</td>
<td>Health community, very fine environmental diagnostic, to be a citizen in the cure</td>
</tr>
<tr>
<td><strong>Actors</strong></td>
<td>Mainly medical (lack social workers) Work with</td>
<td>Balanced social, school (lack GP), Work together</td>
</tr>
<tr>
<td><strong>Geographical spread</strong></td>
<td>Spread, large, base on physical geography (dale)</td>
<td>Focus, Local, neighbourhood</td>
</tr>
<tr>
<td><strong>Synchronies Network</strong></td>
<td>Hard to manage between time of cure and time to manage Need fast intervention before it’s too late</td>
<td>Adequation between professional and everyday’s live time, Longtime work with the population, life-span development</td>
</tr>
<tr>
<td><strong>Objectives Structure</strong></td>
<td>To prevent and to cure, To give all the population an access to high quality services</td>
<td>To care, To cure, To learn « how deal with » in such social context</td>
</tr>
<tr>
<td><strong>Effects the role of beneficiaries</strong></td>
<td>Population as object in a detecting/curing process</td>
<td>Population as object, but too as partner</td>
</tr>
<tr>
<td><strong>Long-term conditions and overlap with existing networks</strong></td>
<td>Lack implication of existing networks</td>
<td>Good work with existing networks</td>
</tr>
<tr>
<td><strong>Paradigm speech trouble as</strong></td>
<td>Neurological</td>
<td>Socio-cognitive</td>
</tr>
</tbody>
</table>
Conclusion

A. The leadership of certain actors, sometimes initiating action, had an influence on the ‘networks rationale’ for action

- one was established as a *test network* and the other as a *support network*
  - **Test network main paradigm**: 
    - neurological/biological definition of speech trouble
    - Classical epidemiology
  - **Support network main paradigm**:
    - socio cognitive - constructionist definition of speech trouble
    - Comprehensive epidemiology

- become “implicitly” influenced by one “rationale for action”

B. ‘Networks rationale’ are never (?) an object of process evaluation vs impact, efficiency, efficacity

- influence the quality and the efficiency of the networks: detecting children, relations between institutions, organisation of care, professional training

- don’t manage with the social context (risk of stigmatisation, restrictions on the offer of services, lack of centre of reference …)
Thanks for your attention

Bibliography

