The Road to Washington: Mobilizing communities to create a supportive environment to help eliminate vertical transmission

Best Practices

2-3 December 2011

Rationale: Community Engagement

- Compelling reasons for engaging communities in PMTCT
- Feasible
- While high quality research is still needed, findings presented suggested community engagement can also produce impressive results

Frameworks

- Apparent consensus that the UNAIDS and socio-ecological frameworks presented were very useful.
- Proposed: Community groups be added as level in socio-ecological model
- Principles:
  - Supply, demand creation, advocacy (creation of enabling environments)
  - Involvement, Reach (certain groups), Integration (existing systems MNCH) and accountability
- Scaling up: Consider the process and not content of good practices

Best Practice General:

- **Contextualisation of approaches**
  - Work with people as contextualised beings (in communities, in families, in relationships)
  - Understanding the particular enablers and constraints/barriers in different contexts
  - Examples of use of cultural and social events to promote PMTCT uptake

- **Working towards goals that are broader than simply health outcomes**
  - Understanding the perceived needs of communities
  - Addressing the whole human being (social, emotional, economic and physical)
  - Non-medical model (emotional, educational and economic support)

Best Practice: General

- **Holistic care models and coordinated care**
  - Work across life cycle
  - Offer spectrum of care

- **Integration and Comprehensive Approaches and Service**
  - **Momentum across sectors (maternal health)**
  - Integrated approaches (One Stop Shop)
  - Linking services (PMTCT, MNCH, OVC Care and Support, ECD, Support Groups)
  - Referrals (case management approach)

- **Family- centred approaches**
  - Couple engagement, couples testing
  - Facilitating involvement of mothers and fathers with babies/children
  - Life, health but also about being a good parent
  - Fourth prong (ECD, infant nutrition etc.)

Best Practice: Supply

- **Networking and Partnerships with public and private sector and other CBOs**
  - Referrals
  - Identification of services in existence
  - Resource mobilisation
  - Feedback good practices from community to inform policy or strategy

- **Functional Training and capacity building**
  - Community members and health workers
  - Ensuring CHWs have the necessary competence/experience
  - Regular monitoring and supervision
  - Innovative approaches

- **Structural Barriers and Increasing access to services**
  - (Mobile clinics,
  - Home-based
  - Outreach

Best Practice: Supply

- **Extending the workforce**
  - **CHW, Network Support Agents**
  - Provide links to community members and health facilities
  - Tend to facilitate engagement, linkages, referrals
  - Can offer community based follow up
  - Can be used in contact tracing and partner notification
  - Issues – need solid training, appropriate background, regular monitoring and support, and training (on issues such as confidentiality)
  - Links to health facilities
  - **Traditional Birth Attendants**

- **Leverage community resources**

Best Practice: Supply

- **Early identification of the most needing services**
  - HTC, PPTCT, HBC
  - Case Management
  - Contact tracing
  - Community presence
- **4th prong**
  - 6 weeks testing
  - Home based testing (including children)
  - Mobilising additional resources beyond testing

Best Practice: Supply

- Economic Empowerment
  - IGA
  - Funding
  - Micro-finance

Best Practice: Demand

- **Male involvement**
  - Levels of engagement
  - Empower different groups to mobilise others (leaders-men)
  - Address pragmatic reasons for lack of involvement
  - Invite men directly

- **Inclusion, Engagement of stakeholders as Key and Active Change Agents and Building Capacity to Absorb and Support PMTCT**
  - Training of different stakeholders /gatekeepers (Traditional leaders; FBO, Traditional Birth Attendants
  - Sensitization

Best Practices: Demand

- **Addressing Barriers (expectant mothers, PMTCT)**
  - Companionship, mentoring support groups to reduce isolation
  - Responding to some very pragmatic reasons for non-engagement
  - Using CHWs as links between community members and health service personnel
  - Incorporating economic empowerment (for particular groups but also communities – mobilise community involvement

- **Employment of community-led, bottom up approaches**
  - Community conversations
  - Participatory community groups –problem-solving

- **Use of kits** – baby kits, clothing packs as incentives

Best Practice: Creating Enabling Environment

- **Advocacy**
  - Issues faced by community
  - Need for quality
  - Family friendly services
  - Supporting impactful community initiatives
  - Legal cases
  - Accountability and monitoring
  - Funding at community level

Best Practice: Enabling Environment

- **Tackle Stigma, Discrimination, prejudice and fear:**
  - In communities and health facilities
  - Through positive events and positive speakers and role models
  - Can be addressed early in pediatric ART support groups
  - Peer support groups
  - Community mobilisation
  - Meaningful involvement of PLHIV
- **Community Ownership**
  - Dialogues, forums
  - Talking with communities first

Issues Requiring Additional Attention

- Imperative to describe community engagement
- Funding community engagement to sustain motivation and to not pull the rug out from successful programmes
- Getting communities to the funding table
- Facilitating a single community voice
- Coordination, who manages and who funds this
- Need to push the merits of integration
- Working with government? Success stories
- Accountability for responding to increased demand
- Process evaluations
- Stigma and discrimination - critical barrier

Issues Requiring Additional Attention

- Sensitization – ECD value
- Maternal depression
- Compensation for volunteers – “peer workers”
- Costing - markers
- Community capacity building – Cost of working model
- Costing the community workforce model
- Social protection - Living costs – out of counter funding