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)
• **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