

Community Engagement in HIV Biomedical Prevention Research: Use of Mobile Technologies and the Asset Based Community Development Approach

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BACKGROUND

Despite the increased implementation of Good Participatory Practices in HIV Biomedical Prevention, there are gaps in documenting outcomes of use of innovative technologies among key populations and sustainable long-term partnerships with communities. We analyzed two case studies (i) engaging populations classified as at-risk in a cohort study by the Kenya Medical Research Institute (KEMRI) Mtwapa research clinic – gay, bi-sexual, and other men who have sex with men (GBMSM), female sex workers in Kilifi-Kenya; (ii) long-term engagement with a community in Cape Town-South Africa.

METHODS

With support from IAVI and AVAC, we convened 19 community liaison officers (CLOs) working in Eastern and Southern Africa to share lessons learnt in engaging with at risk populations and general populations, in HIV prevention clinical trials in November 2017. After the meeting we followed up with Kilifi and Cape Town to review and document the key lessons learnt. The Kilifi case study aimed to assess the use of mobile phones and social media platforms in accessing health information services among at-risk populations. The South Africa case study assessed the use of the Asset Based Community Development (ABCD) approach in sustainably engaging communities whereby existing community assets such as systems, institutions, associations and forums are leveraged to engage communities in health and development issues.

RESULTS

Out of the 303 people classified as at-risk in a cohort study by KEMRI Mtwapa research clinic, 88% reported having a smart phone or feature phone, and 54% (143/266) were subsequently reachable at the time of the assessment. Reasons for being unreachable were: being outside network area (60%), call unanswered after several attempts (24%), number temporarily out of service (8%) and wrong number (7%).

In Cape Town, the community engagement team was able to access community assets such as the communities' ability to mobilize themselves to address issues of common interest; and existing youth-friendly outreach approaches. Both assets were capitalized to elicit community interest in HIV prevention research. Responding to other relevant community needs such as need to access further education and training centers and career guidance further strengthened the partnerships with communities. The communities leveraged the opportunity for collective advocacy to address development issues and general community health related needs.

CONCLUSION

The possession of smart/feature phones by majority of at-risk populations paves the way to use mobile telephones and social media for HIV prevention research interventions. We propose the inclusion of mobile and social media outreach in prevention research as an integral part of community engagement. For sustainable community engagement, CLOs should build on community strengths and community determined priorities, while emphasizing on existing assets as means to fostering community driven participation in HIV biomedical prevention research.



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