LEGACY BRIEF

Social and Behavior Change Communication in Uganda

DELIVERING RESULTS THROUGH AN INTEGRATED PROGRAM

From 2013 to 2020, Communication for Healthy Communities helped the Ministry of Health and its partners unite a range of health communication initiatives in one integrated program with a recognizable brand.

Background

Several initiatives addressed health and behavior change communication in Uganda in the decade before the launch of USAID's Communication for Healthy Communities (CHC) project. One of these initiatives, the Health Communication Partnership, was recognized for providing an effective model for ensuring the consistency of behavior change communication messages and materials.[1] Many of the earlier programs produced campaigns that played a key role in the expansion of new services, including surgical male circumcision, couple HIV counseling and testing, and pediatric HIV treatment.

Despite these efforts, health service delivery programs continued to face significant gaps in service uptake and adoption of key practices. Health communication campaigns tended to reach mostly urban audiences and delivered top-down messages through mass media channels not linked with community-level approaches in mutually reinforcing ways. Most donor-funded health communication activities addressed a specific health issue, such as HIV/AIDS or malaria, resulting in siloed campaigns that were not tied to an integrated national strategy. Local communities were not engaged as partners in their own behavior change, making it difficult to address gender and other social norms that impede adoption of healthy behaviors and demand for health services.

Where we started

Prior to CHC, health communication programs in Uganda tended to:

- Focus on top-down messages delivered primarily through mass media
- Miss opportunities to create synergies between community-level and mass media activities
- Address specific health issues, without linkage to an overarching national strategy
- Limit communities' engagement in their own behavior change

Approach

CHC worked with the Health Promotion, Education. and Communication Department (HPECD) of the Ministry of Health (MOH) and its partners to develop Uganda's first fully integrated social and behavior change communication (SBCC) program. The program unified MOH communication strategies and policies in HIV/AIDS, tuberculosis (TB), maternal and child health, family planning, nutrition, and malaria. Key features of the approach included:

1. Developing a recognizable brand
2. Building interventions around audiences rather than health issues
3. Addressing external factors influencing individual behavior
4. Empowering communities through dialogue
5. Engaging religious and cultural institutions

Developing a recognizable brand

CHC and the HPECD built on formative research findings to develop an integrated, branded SBCC platform called *"Obulamu?"* A common Ugandan expression used to ask someone "How's life?," *Obulamu?* was designed to stand out in Uganda's crowded media landscape and provoke audiences to discuss and reflect on the small, doable actions they might adopt to improve their health. Over time, the MOH used *Obulamu?* to unite its previously siloed communication efforts for HIV/AIDS, TB, maternal and child health, family planning, nutrition, and malaria programs.

Obulamu?

CHC worked with the HPECD to deliver *Obulamu?* through a variety of communication channels — from mass media to interpersonal communication — so that key audiences were exposed continually to the same communication, which reinforced messages and facilitated audience recall. Implementing partners and district personnel further enhanced the reach of *Obulamu?* interventions by using its tools and materials to implement their own community outreach activities.

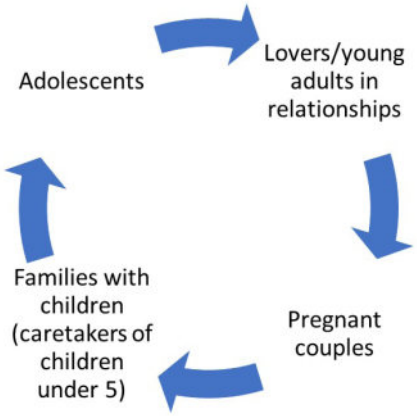
Building interventions around audiences

Integrated SBCC programs have a mandate to address multiple diseases and other health issues, which often requires the engagement of a broad, diverse cross-section of the population with different needs. Doing so under one SBCC program presents a challenge, because messages and activities must resonate with each key audience.

To overcome this challenge, CHC used a "life stage" approach, segmenting audiences according to the needs people face at critical transition periods over a lifetime, such as becoming sexually active or starting a family. CHC identified four distinct audience segments: young adults in relationships, pregnant couples, care takers of children under five years of age, and adolescents (see Figure 1).

CHC conducted participatory action media workshops with members of each audience segment to define a package of priority behaviors relevant to their life stage. This approach provided CHC with a simple framework to inform how behaviors could be grouped to facilitate the development of SBCC activities addressing the underlying factors — such as attitudes, skills, and social norms — that influenced uptake of all related behaviors.

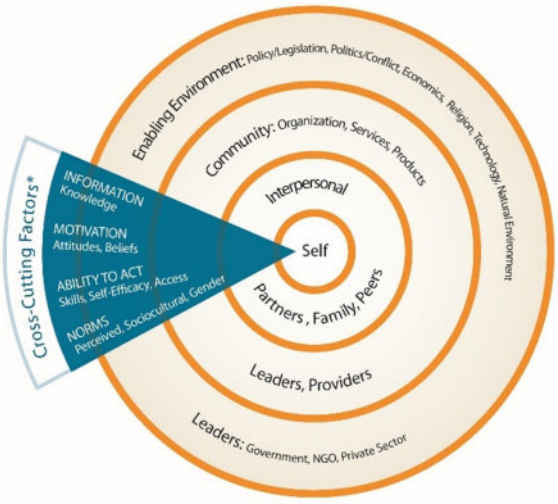
Figure 1: Audiences segmented by life stage



Addressing external influences on individual behavior

Traditional behavior change programs tended to focus on improving individual knowledge, skills, and motivation to achieve their change objectives. These programs demonstrated that individual behavior is often more strongly influenced by external factors, such as community norms and the attitudes of local leaders.[2] To more fully account for the external factors influencing behavior change in Uganda, CHC applied the FHI 360's Socio-Ecological Model for Change to guide the development of its SBCC strategies and approaches (see Figure 2).

Figure 2: FHI 360's Socio-Ecological Model for Change



Based on theories, models, and approaches from several disciplines, this model demonstrates that individual behavior is often influenced by factors beyond an individual's control, such as policies that restrict access to services or community norms that stigmatize the promoted behaviors. The model therefore recommends engaging several levels of influence beyond the individual to enable behavior change.[3] CHC's SBCC strategies and approaches worked at several levels of influence — from family and provider to community and leadership — to improve knowledge, skills, and motivation across all levels and create an environment that supported individuals to adopt recommended behaviors.

Empowering communities through dialogue

Health communication programs previously implemented in Uganda tended to focus on disseminating messages to inform and direct individuals to adopt recommended behaviors. This approach did not adequately address the social and gender norms that heavily influence individual decisions and behavior.

To address those norms and create a more supportive environment for individual behavior change, CHC positioned *Obulamu?* as a platform to encourage community dialogue and engagement. In *Obulamu?*'s mass media activities, concentrated, short-term campaigns centered around one discussion trigger, such as "How do you want your pregnancy to be?," generating dialogue about relevant issues within families and communities. CHC further powered these discussions through community dialogue and family counseling activities facilitated by Community Champions. These champions were influential community members, including religious and political leaders and teachers, who were trained and equipped with standardized *Obulamu?* tools and materials.

Results

An end line survey completed by CHC in 2018 found that more than 86% of respondents had heard of the *Obulamu?* integrated platform.[4]

By the Numbers – Delivering Results through an Integrated Program

Indicator*	Baseline	End line
Percentage of target audience who demonstrate comprehensive, correct knowledge about:		
Modern contraceptive use	**51.7%**	**71.3%**
Breastfeeding	**67.9%**	**80.7%**
Percentage of individuals who approve of the following health behaviors and/or health services promoted in *Obulamu?* messages:		
Using a modern contraceptive method	**82.1%**	**84.7%**
Seeking care for children with a fever	**99.8%**	**99.9%**
Percentage of individuals who intend to adopt the following health behaviors and/or health services promoted in *Obulamu?* messages:		
Seeking surgical circumcision for boys in own care	**76.3%**	**84.9%**
Completing 4 antenatal care visits	**67.4%**	**76.4%**

Comparisons of those who had been exposed to two or more *Obulamu?* messages about a topic versus those who had had no exposure demonstrate the impact of the integrated program on behavior change:

- Men ages 15 to 49 exposed to messages about surgical male circumcision were six times as likely to be recently circumcised.
- Over 63% of individuals exposed to messages about HIV testing reported receiving an HIV test in the previous six months versus only 29% among those who were not exposed.
- Individuals exposed to messages about TB were almost two times as likely to seek TB screening and testing services.
- Mothers exposed to messages about births in health facilities were more than twice as likely to have had their most recent baby delivered in a health facility.
- Over 81% of pregnant women exposed to malaria prevention messages reported initiating intermittent preventive treatment of malaria during pregnancy versus only 37% of those who were not exposed.

These results suggest that even in the context of a large, integrated program, it is possible to reach and effectively engage diverse populations with differing needs. The use of a brand and life stage approach to unify and target messages holds promise for achieving greater health impact through behavior change.

* See the CHC Project Indicator Progress report for a full account of results by indicator.

Engaging religious and cultural institutions

Religious and cultural institutions play an important role in the lives of most Ugandans and have enormous influence over how individuals behave. To expand the reach and impact of community activities, CHC established strong partnerships with these institutions and counted many religious and traditional cultural leaders among its cadre of Community Champions.

Religious and traditional leaders were engaged through breakfast meetings, radio talk shows, and joint implementation of activities to use their influence to encourage individuals and communities to adopt healthier behaviors. An easy-to-use handbook enabled religious and cultural leaders to link key health messages to specific verses of the Bible and Quran. CHC also worked with the Busoga and Buganda kingdoms to integrate HIV and sexual reproductive health discussions into traditional ceremonies and structures that support adolescents as they transition to young adulthood.

A CHC staff person orients village health teams in Butholya-Bundibugyo to a standardized job aid developed to support their Ebola risk communication activities.

Lessons Learned

- **Standardized tools facilitate efforts to integrate across health topics.** CHC and the HPECD developed standardized tools, such as implementation guides for partners, job aids for providers, and toolkits for Community Champions, to support delivery of SBCC interventions. These tools ensured consistency in the messages used by implementing partners and, because they were packaged according to life stage needs, supported integration across health topics. Regardless of an implementing partner's health topic focus, the information and discussion triggers included in each tool offered broader messaging on the health services and behaviors relevant to the target audiences.
- **Flexibility is key to ensuring interventions resonate in all communities**. One challenge of a large, integrated program is ensuring that standardized messages and activities resonate with diverse communities. To respond to this challenge, an integrated program needs to maintain the flexibility to adapt to highly localized but important cultural differences. CHC used its messages and tools as a starting point for adaptation and facilitated local workshops with audience members to review and adjust the tools to account for local traditions and norms.
- **Coordination with service delivery programs is often essential to ensuring behavior change.** The adoption of many recommended behaviors depended on service delivery programs. Clients were often frustrated with long wait times at facilities and the inadequacy of services offered during outreach events. To overcome these issues, CHC instituted joint planning and implementation mechanisms that leveraged the resources of service delivery programs and coordinated *Obulamu?* activities with their outreach.
- **Achieving optimal reach and intensity of SBCC interventions requires dedicated resources in every service delivery program.** CHC's role in community-level interventions was limited to standardizing messages and tools and supporting their rollout though service delivery partners. However, SBCC interventions were often under-resourced, which hampered their ability to address the factors known to affect demand for health services. Service delivery partners that were most successful at ensuring the reach and intensity of SBCC interventions were those with adequately resourced staff fully assigned to the management and supervision of the interventions.

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1. I-Train and Evaluate Center (I-TEC). (2013) Final Evaluation of the Health Communications Partnership (HCP II) Project. Kampala: USAID/Uganda.
2. World Bank. (2015) World Development Report 2015: Mind, Society, and Behaviour. Washington, DC: World Bank.
3. C-Change. (2012) CModules: A Learning Package for Social and Behavior Change Communication (SBCC). Washington, DC: C-Change/FHI 360.
4. Communication for Healthy Communities (CHC) Program. (2018) Evaluation of an Integrated Health Communication Campaign in Uganda: Report. Kampala: CHC/FHI 360.

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