

## Social and Behavior Change Communication in Uganda

# ENHANCING CAPACITY TO DELIVER QUALITY PROGRAMS

From 2013 to 2020, *Communication for Healthy Communities* enhanced the capacity of the Ministry of Health and its partners through skills-building, “twinning,” targeted reinforcement of capacity, and collaborations with universities.

### Background

The Ministry of Health’s (MOH) Health Promotion, Education, and Communication Department (HPECD) has a national mandate to promote and support the implementation of quality social and behavior change communication (SBCC) programs in Uganda. It does so by developing national strategies and standardized tools to guide SBCC activities, and then supporting district-level authorities and implementing partners to apply them. Over the past two decades, development partners, including USAID, have supported this mandate by investing in projects to strengthen HPECD’s institutional and staff capacity to design and support the delivery of SBCC programs and tools.

Despite these efforts, the capacity to design and monitor the implementation of SBCC programs in Uganda has not always kept pace with international best practices. A 2013 assessment found that few implementing partners were applying the latest evidence-based approaches to SBCC. Previous capacity building efforts had been delivered principally through formal ministry-level training workshops, which largely benefited MOH central staff and implementing partners. A lack of post-training support and tailored mentoring limited participants’ application of their newly acquired knowledge and skills in SBCC program design.

These findings were confirmed by an audit completed by CHC in 2014, which concluded that few US Government-funded implementing partners applied best practices to design and implement SBCC

### Where we started

Prior to CHC, national capacity strengthening efforts:

- Benefited mainly national-level structures and implementing partners
- Were delivered primarily through ministry-level training sessions
- Applied a “one-size-fits-all” approach to capacity strengthening
- Offered no continuing support and mentoring to reinforce skills

programs.<sup>1</sup> Often the results were poorly designed SBCC activities that neglected important determinants of health-seeking behaviors, such as attitudes and norms. In addition, the greatly varied capacity of village health teams (VHTs) and community volunteers contributed to the inconsistent quality of SBCC community activities.

### Approach

CHC assessed and strengthened the capacity of the HPECD and implementing partners in the many facets of SBCC programs, including coordination, application of effective approaches and techniques, monitoring and evaluation, and knowledge management. This comprehensive capacity-building program was delivered by:

1. Conducting skills-building seminars
2. “Twinning” SBCC practitioners with more experienced counterparts
3. Providing targeted reinforcement of capacity
4. Collaborating with national universities

The approach built on existing tools to address the unique needs of each beneficiary and provide systematic capacity-strengthening support. Capacity-building priorities were selected for each partner type based on their roles and responsibilities in SBCC program design and implementation (see Table 1).

**Table 1. Capacity building priorities by partner type**

<b>Partner type</b>	<b>Priority competencies based on role and responsibilities</b>
HPECD	Apply best practices to design SBCC programs, tools, and materials (C-Process); coordinate SBCC programs; review, improve and approve tools and materials developed by partners; support district-level authorities to coordinate SBCC programs
USG implementing partners	Apply best practices in the design of SBCC programs, tools, and materials (C-Process <sup>2</sup> ); monitor SBCC programs; supervise field agents; collect and analyze program data to inform program adjustments
District health educators	Adapt national SBCC strategies, tools, and materials; monitor SBCC programs; supervise and coach interpersonal communication (IPC) agents; interpret data to inform messaging; document and share successes
VHTs and community volunteers	Correctly use IPC tools and job aids; facilitate community dialogues and events; document and share successes

### Building knowledge and skills

CHC collaborated with the HPECD to conduct a series of five-day skills-building seminars with key technical staff from the MOH and implementing partners. The series was adapted from FHI 360's global *C-Change SBCC Learning Package*, which uses highly participatory activities, such as small group work, structured brainstorming, and plenary discussions.<sup>3</sup> Seminar participants built new skills and gained an in-depth appreciation for and understanding of SBCC design and management principles and processes. For district health educators (DHEs) and implementing partners unable to attend the five-day seminar, this training was also offered as a self-paced online course.

To further extend the reach of the in-person skills-building seminars, CHC collaborated with the MOH, the Uganda AIDS Commission, and implementing partners to develop a cadre of facilitators who could cascade the C-Change SBCC Learning Package to partner staff at regional and district levels. Three training-of-trainer workshops equipped more than 230 facilitators with the skills to roll out regional- and district-level training. These facilitators subsequently trained staff from 58 implementing partners working in 112 districts.

### Coaching through a twinning model

Strengthening the capacity of community-level staff and volunteers to correctly deliver SBCC programs was a key priority of the HPECD. Knowing that a traditional one-time training model would not be sufficient to strengthen skills, CHC and the HPCED established a twinning program that provided on-the-job mentoring to DHEs, implementing partner staff, VHTs, and community volunteers. The model paired these SBCC practitioners with their more experienced counterparts, who worked with them to complete design and implementation tasks while modeling skills such as developing SBCC materials and providing immediate feedback to VHTs and community volunteers.

Typically, CHC regional staff were twinned with staff from the DHE office and implementing partners who coached them on SBCC program monitoring and supervision. CHC's IPC agents were twinned with community volunteers and VHTs, mentor mothers and fathers, peer educators and linkage facilitators, to help strengthen the delivery of SBCC activities such as home visits, small group discussions, and community shows.

### C-Change SBCC Learning Package

The five-day skills-building seminars and self-paced online course focused on the following core modules and skills:

- **Module 1: Understanding the Context** – skills to collect and analyze data and apply theory or models to SBCC design
- **Module 2: Focusing and Designing** – skills to negotiate strategic partnerships and develop communication strategies
- **Module 3: Creating Interventions and Materials** – skills to develop communication materials and tools, such as radio/TV spots, print media, and provider job aids
- **Module 4: Implementing and Monitoring** – skills to manage the implementation of communication strategies through work plans and coordination structures and to supervise and monitor SBCC program delivery
- **Module 5: Evaluating and Replanning** – skills to apply frameworks and mechanisms for measuring social and behavioral outcomes and using the results to adjust SBCC programs.



A village health worker, twinned with a CHC IPC agent, conducts a risk communication session with market vendors in Kanungu Town Council.

### Providing targeted capacity reinforcement support

CHC recognized early on that a one-size-fits-all approach would limit the capacity-building program's ability to respond to the unique program needs of each implementing partner. Instead, CHC support was designed to reinforce implementing partners' ability to design, implement, and monitor SBCC interventions tailored to address a project's specific needs and priorities. This support, informed by data, enabled partners to design micro-interventions, apply them to specific challenges and contexts, and scale up those that proved successful. Approaches such as demonstration, learning by doing, and coaching were applied to expand and enhance partners' skills.

### Collaborating with academic institutions

The sustainability of high-quality SBCC programs requires public health and SBCC professionals with state-of-the-art knowledge and training. Recognizing the important role Ugandan universities play in preparing public health professionals, CHC collaborated with Makerere University and Mukono Christian University to integrate SBCC modules into their social science, social work, and social administration curricula. CHC technical and research staff gave guest lectures on current SBCC practices, which were attended by over 170 post and undergraduate students at the two universities. CHC also supported master's program students to conduct SBCC research in collaboration with CHC research staff. These efforts contributed to the development of the next generation of SBCC professionals and enabled Ugandan academic institutions to update their curricula with the latest best practices and learnings on SBCC.

## CHC IMPACT

### No Longer "Stuck in The Old Ways"

The Family Life Education Program (FLEP) is a not-for-profit organization affiliated with the Church of Uganda's Busoga Diocese. Serving 10 districts in East Central Uganda, FLEP aims to increase access to and use of reproductive health, TB, and HIV/AIDS services, as well as general curative services.

When CHC first started working with FLEP in April 2015, FLEP was "not addressing the social determinants of health...we were stuck in the old way of doing things," recalls Project Coordinator Yusuf Kumbuga. As a result, FLEP staff were struggling to increase uptake of their health services and failing to achieve the targets for their USAID-funded activities.

*"With the knowledge and skills I acquired through CHC support, I have been able to mentor other FLEP staff, as well as our community volunteers, VHTs, and peer educators."*

— Yusuf Kumbuga,  
FLEP Project Coordinator

CHC started by training FLEP staff in the basic principles of SBCC and developed their skills to design evidence-based activities and materials. CHC then assisted FLEP staff in training their VHTs and peer educators to conduct community outreach activities, strengthening their interpersonal communication and group facilitation skills. CHC also provided ongoing tailored technical assistance to reinforce the skills of FLEP staff to supervise and coach VHTs and peer educators. To maximize the impact of FLEP community activities, CHC linked them with national campaigns by training FLEP staff, VHTs, and peer educators and equipping them with SBCC materials, tools, and job aides. With CHC support, FLEP also established linkages with important cultural institutions, such as the Obwa Kyabazinga Bwa Busoga (Kingdom of Busoga).

CHC support helped ensure that FLEP more directly addressed the behavior change needs of its audiences and not only achieved, but surpassed, its program targets. "Over the four subsequent years, we have been able to reach over 70,000 people with HIV, TB, and other health services, particularly those most-at-risk populations.

An assessment completed by CHC in 2018 found that implementing partner staff who had participated in skills-building seminars reported more consistent application of MOH-approved SBCC tools and materials, as well as regular use of program data and MOH research (such as the Uganda Demographic Health Survey) to prioritize and adjust SBCC activities.<sup>4</sup> This assessment also found that implementing partners increased their engagement with the MOH to develop new SBCC tools and materials and, in some cases, led the adaptation of SBCC materials to suit local context and language needs. A 2018 external evaluation similarly concluded that CHC’s leadership and collaboration had strengthened the capacity of the HPECD and implementing partners, which contributed to greater consistency and quality of SBCC programs throughout Uganda.<sup>5</sup>

## By the Numbers – Strengthened Capacity to Deliver Quality SBC Programs

Indicator	2015	2016	2017	2018	2019	2020*
Number of collaborating partner staff who increased their HC competencies	134	115	645	959	832	237
Number of collaborating partners that adopted one or more components of the HC strategy	115	135	242	208	199	118

\* Data only from October 2019 to March 2020 (1st half of FY2020)

### Lessons Learned

CHC generated many lessons through its capacity-strengthening program with the HPECD, implementing partners, DHEs, VHTs, and community volunteers.

- **Capacity strengthening in SBCC requires a culture of continuous learning** to update knowledge and ensure technical skills are in line with emerging best practices. The field is constantly evolving, and continuous learning should be a priority for every MOH department and implementing partner. It can be achieved through annual professional development plans and funding to encourage staff to participate in both internal and external capacity-building opportunities.
- **Consistent Internet access would reduce costs and strengthen programs.** CHC attempted to promote online collaboration tools, such as Google Groups, and communication via e-mail listservs, but those approaches had minimal effect, mainly because most district-level partners had inconsistent access to the Internet. Using web-based information technology platforms, such as webinars, to share information and learnings would significantly reduce the need for physical meetings and enable greater access to SBCC knowledge. To take advantage of such approaches, implementing partners or MOH departments must provide consistent Internet access.
- **Complementing skills-building seminars with onsite supportive supervision and mentorship was critical** to ensuring DHEs and implementing partner staff were able to contextualize and apply the SBCC

design and implementation skills they had acquired. The twinning model was particularly effective in helping implementing partners appreciate how applying best practices improved the quality and impact of their SBCC activities.

- **A lack of adequate funding was often the greatest barrier to adherence to best practices** in SBCC program design and implementation. Capacity-strengthening efforts can improve knowledge and build skills, but the results will not change if funding is not available to follow the necessary steps in SBCC program design. Projects with a community outreach and mobilization mandate must appropriately budget for SBCC design and implementation, including adequate funding to train and supervise the health care providers, VHTs, and community volunteers who conduct SBCC activities in communities.

<sup>1</sup> Communication for Healthy Communities. (2014) Findings of an Audit of Strategies, Activities/Materials, and Implementing Partners in 2013/2014. Kampala: USAID Communication for Healthy Communities.

<sup>2</sup> C-Change. (2012) C-Modules: A Learning Package for Social and Behavior Change Communication (SBCC). Washington, DC: C-Change/FHI 360.

<sup>3</sup> C-Change. (2012) CModules: A Learning Package for Social and Behavior Change Communication (SBCC). Washington, DC: C-Change/FHI 360.

<sup>4</sup> Communication for Healthy Communities. (2018) Assessment of Implementing Partner Feedback on the Obulamu Integrated Health Communication Campaign in Uganda. Kampala: USAID Communication for Healthy Communities.

<sup>5</sup> QED Group, LLC. (2018) USAID/Uganda’s Communication for Healthy Communities (CHC): Evidence-Based Learnings and Strategic Recommendations. Kampala: USAID/Uganda Monitoring, Evaluating and Learning Contract.