LEGACY BRIEF

Social and Behavior Change Communication in Uganda

ENHANCING GENERATION AND USE OF DATA FOR DECISION-MAKING

From 2013 to 2020, Communication for Healthy Communities conducted unique studies to generate data to guide the design of social and behavior change communication programs and strengthened the capacity of partners to use program data to continuously monitor and improve SBCC interventions.

Background

Effective social and behavior change communication (SBCC) programs require quality data to inform their design as well as improvements during implementation. Ministry of Health (MOH) staff in Uganda gained an appreciation of the value of such data while working with previous USAID projects, including the Health Communication Partnership II (2007-2012), which piloted formative research studies to guide the design of health communication programs.[1] As a result, the MOH's Health Promotion, Education, and Communication Department (HPECD) promotes the generation and use of data in SBCC design and typically requires implementing partners to demonstrate how data have been used to inform new program plans and materials.

A 2014 audit conducted by USAID's Communication for Health Communities (CHC) project found that most implementing partners recognized the importance of data to effective SBCC programming and reported attempts to use data in their decision-making processes.[2] However, the assessment identified several gaps, indicating limited generation and use of data in most SBCC programs. Only a few SBCC programs reported consistent use of formative research to inform their strategies. Collection and use of data to improve programs during implementation was also inconsistent across partners, especially among those working in HIV and TB, and most monitoring data were used primarily for reporting and accountability purposes. The audit concluded that many SBCC programs tended to omit formative research and data use for decision-making due to the constraints of project timelines and limited staff capacity.

Where we started

Prior to CHC, SBCC programs were characterized by:

- Inconsistent use of formative research and other data to inform program design
- Ad hoc use of monitoring data to inform improvements during implementation
- Constrained timelines that forced staff to omit critical SBCC design steps, including data generation and use
- Limited staff capacity to apply data for program improvement

Approach

CHC piloted a holistic approach that generated and applied new data without delaying SBCC program development and enabled SBCC implementers to use data to guide improvements during implementation. This approach included:

1. Generating data and evidence
2. Coupling formative research and design
3. Strengthening data for decision-making skills
4. Introducing GIS for better coordination

Generating data and evidence

CHC collaborated with the HPECD and other partners to design and execute 18 studies over the life of the project. These studies had three different purposes: 1) to evaluate the impact of SBCC and capacity building activities on their intended audiences; 2) to understand why individuals adopt (or do not adopt) recommended behaviors; and 3) to monitor how well SBCC interventions were being delivered.

The first type of study helped generate evidence on which SBCC interventions had the greatest impact, so that they might be expanded in Uganda or replicated elsewhere. These studies included quarterly listening surveys and evaluative surveys. The listening surveys regularly monitored exposure to SBCC interventions and changes in factors influencing behavior, such as attitudes and norms. The evaluative surveys went further by measuring the adoption of promoted behaviors and assessing whether exposure to SBCC interventions was associated with changes in behaviors as well as the factors influencing those behaviors.

The second type of study was conducted specifically to inform the design of SBCC interventions. Typically, these studies focused on specific problems impeding the achievement of project outcomes. For example, in East-Central region, CHC conducted rapid assessments to identify individual, health system, and structural barriers to HIV treatment adherence and use of family planning, and then worked with implementing partners to adjust their interventions based on the findings.

The third category of studies included activity assessments and feedback reports from partners, which were used to adjust the training, coaching, and other support that CHC offered partners to strengthen their SBCC interventions and the delivery of services.

Coupling formative research and design

In response to concerns that formative research adds too much time to the SBCC design process, CHC worked with the HPECD to introduce the Participatory Action Media (PAM) methodology. Rooted in participatory action research, PAM melds SBCC formative research with program design by engaging audiences to simultaneously generate data and make program design decisions.

A typical PAM workshop recruited 15 to 20 audience members to explore the barriers to and motivations for adopting recommended behaviors, community perspectives on appropriate messages, and channels for reaching the intended audiences. Workshop participants also developed prototype messages, activities, and materials, which accelerated the transformation of formative research insights into

A young woman in a Participatory Action Media workshop draws a mock-up of a poster to communicate the benefits of modern contraceptive.

program design decisions. These PAM workshops allowed CHC and its partners to generate the data needed to improve the impact of SBCC programs without delaying implementation.

Illustrative topics explored through Participatory Action Media

- Compliance with malaria treatment protocols among public and private health care providers
- Treatment discontinuation among children and adolescents living with HIV
- HIV and pregnancy prevention among adolescent girls and young women
- Antenatal care seeking and facility delivery among pregnant women
- HIV prevention among uniformed services personnel
- Pre-exposure prophylaxis use among sex workers and at-risk men

Strengthening data for decision-making skills

A key component of CHC's capacity building agenda was to develop the ability of district-level partners, especially district health educators (DHE), to collect and use data to inform decisions about the deployment and adaptation of SBCC interventions. CHC collaborated with the MOH and implementing partners to conduct regional data for decision-making workshops with DHEs and district biostatisticians to discuss the importance of using data to target SBCC interventions. Workshop participants learned to review data from the health management information system (HMIS) and identify areas where health service

indicators, such as facility delivery and antenatal care visit completions, were steadily declining or were falling below seasonal averages.

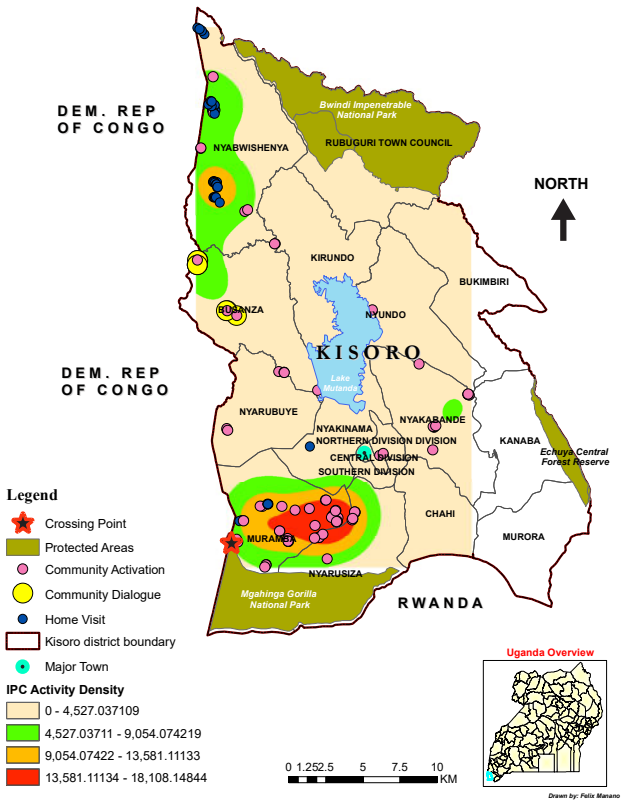
CHC then worked with district health authorities and implementing partners to integrate these analyses into planning and coordination meetings so they could be used to guide the deployment of SBCC interventions to areas most in need. Similarly, the results of CHC's listening surveys, client feedback loops, and other evaluative surveys were disseminated to national and district partners, who used the data to adjust SBCC strategies and tools.

Introducing GIS for better coordination

To further coordinate the distribution of SBCC interventions, CHC introduced GIS in 2016, providing a framework for capturing and analyzing spatial data linked to SBCC interventions. These data helped program implementers visualize how SBCC interventions could be deployed to respond to emerging health needs and how SBCC interventions should be coordinated with service delivery programs to improve linkages between demand creation and service delivery.

GIS analyses were particularly useful when CHC was engaged in 2018 to support Uganda's One Health line ministries[3] to prepare communities to respond to outbreaks of zoonotic diseases, such as Ebola and anthrax. With CHC support, the One Health line ministries were able to identify communities at risk of zoonotic disease outbreaks and to guide and monitor the deployment of risk communication activities to those communities (see Map 1 for an example). The GIS maps allowed for easy monitoring of SBCC intervention coverage in priority zones and provided a visual indicator of gaps that required the repositioning of district and national resources to ensure proper coverage.

Map 1: Spatial Model for Kisoro District Ebola Communication Activities



Results

An external evaluation completed in 2018 concluded that CHC's research efforts, including special studies, client exit interviews, feedback reports, evaluations, and listening surveys, had generated a wealth of information to contribute to SBCC program design.[4] The evaluation also highlighted how CHC was able to use PAM to integrate the normally separate phases of formative research and creative design to streamline the development of targeted SBCC messages and materials.

By the Numbers – Strengthened Data Use to Improve SBCC Interventions

Indicator	2015	2016	2017	2018	2019	2020*
Percentage of CHC health communication interventions that are informed by research	100%	100%	100%	100%	100%	100%
Number of collaborating institutions that contribute to at least one step of the development of SBCC research through CHC technical assistance	115	251	171	190	125	157
Number of knowledge sharing, dissemination, or learning events implemented by CHC and/or implementing partners through CHC technical assistance	115	135	242	208	199	118

* Data only from October to March 2020 (first half of FY2020)

Lessons Learned

CHC generated many lessons as it strengthened data generation and use by SBCC program developers and implementers.

- **Participatory research approaches can be integrated into design processes to deliver evidence-based SBCC programs without causing significant delays.** Such approaches, especially Participatory Action Media, are promising practices that can satisfy the needs of SBCC programs to generate and apply evidence while also ensuring interventions are relevant to audiences.
- **Dissemination and use of data and evidence requires dedicated resources and staff.** Not all implementing partners were able to absorb and apply the data and evidence that CHC produced through nearly 30 special research studies and PAM workshops. The use of data requires commitment, training, and ongoing support separate from the skills and efforts required to generate the data. Future projects with a mandate to improve data use should plan for dedicated resources and staff to support those efforts.
- **Data use is essential for targeting interventions.** Reviewing available data on a regular basis helped CHC and its partners better coordinate the deployment of interventions to areas where they were most needed. This was especially important when CHC was supporting partners to improve HIV case detection rates by reaching populations most at risk of HIV infection. Integrating GIS into data use efforts helped implementers who were less familiar with data use quickly identify areas of need.

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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. 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.
3. One Health line ministries include the MOH, Ministry of Agriculture, Animal Industry and Fisheries, Ministry of Water and Environment, and the Uganda Wildlife Authority of the Ministry of Tourism, Wildlife and Antiquities.
4. 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.

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