
October 2013
Copyright 2012 by KMCC – all rights reserved. This material may be freely copied and distributed subject to inclusion of this copyright notice, proper citation, and our World Wide Web URL: http://www.kmcc.org.ug

Citations for this report should be given as follows.

About KMCC

The Knowledge Management and Communications Capacity (KMCC) initiative is a programme that brings together expertise in HIV/AIDS, development, knowledge management and communications in Uganda. The initiative aims to work with the priorities of the Uganda AIDS commission (UAC), within the "three ones" framework for national-level HIV/AIDS response coordination.

KMCC is a core component of the support being given by the UK's Department for International Development (DFID) to the HIV/AIDS response in Uganda. As such, KMCC's work will be designed to align with Uganda's National HIV Prevention Strategy (which aims to coordinate the design and implementation of high-impact HIV prevention initiatives). It will also complement the work of a broad range of key Ugandan partners ranging from government partners (like the Ministry of Health) and donors (such as DFID, USAID, UNAIDS, JUPSA, CDC, and DANIDA) to universities, research institutes and networks and communities of people living with HIV.

Email enquiries should be directed to enquiries@kmcc.org.ug or sarah@kmcc.org.ug
Contents

1 Introduction ..........................................................................................................................9
2 Methodology ........................................................................................................................10
3 Government Responses to HIV/AIDS ..................................................................................11
  3.1 Government Responses to HIV/AIDS 1980s to 2000: Focus on Family Values ... 11
  3.2 Government Responses 2001-2012: Focus on Abstinence and Fidelity .......................13
  3.3 Summary of Government Responses 1980s to 2012 .....................................................15
4 Non-government Responses to HIV/AIDS ........................................................................17
  4.1 Non-government Responses to HIV/AIDS Since the 1980s .........................................17
  4.2 Specific Non-government Responses to HIV/AIDS Since the 1980s ..........................18
5 Responses Targeting At-risk Groups to HIV/AIDS ..........................................................20
  5.1 Responses Targeting At-risk Groups to HIV/AIDS Since the 1980s .............................20
  5.2 Key At-risk Groups ........................................................................................................20
  5.3 Summary of Responses Targeting At-risk Groups .........................................................23
6 Major Behaviour Change Communication Interventions Since the 1980s .........................25
  6.2 Major Interventions: 2001 to 2013 .................................................................................27
  6.3 Summary of Major Interventions 2001-2013 .................................................................32
7 Major Behaviour Change Communication Interventions: 2013 and Beyond ....................33
  7.1 “Cheating? Use a condom, Cheated on? Get tested” ....................................................33
  7.2 Future Campaigns ...........................................................................................................33
8 Key Lessons 1980-2013 ....................................................................................................34
  8.1 Best Practices Identified in Behaviour Change Communication in Uganda to Date........34
  8.2 Lessons from Unsuccessful Behaviour Change Communication Practice ..................36
  8.3 Lessons Learned from Behaviour Change Campaigns Elsewhere in East and Southern Africa ........38
9 Gaps and Challenges in Behaviour Change Communication Interventions in Uganda ..........44
  9.1 Services Underpinning Behaviour Change Campaigns Inadequately Funded ...............44
  9.2 Limited Coordination .....................................................................................................44
  9.3 Limited Data Collection, Monitoring and Evaluation ....................................................44
  9.4 Conflicting Messages ......................................................................................................45
  9.5 Message Delivery Techniques .......................................................................................45
  9.6 Coverage of Services .....................................................................................................46
  9.7 Need for Increased Reach to At-risk Populations ............................................................46
  9.8 One Size Does Not Fit All ..............................................................................................46
10 Ensuring a More Effective Response to Key Issues ..........................................................47
  10.1 Improving Behaviour Change Campaigns to Delay Sexual Debut ............................47
  10.2 Improving Behaviour Change Campaigns to Eliminate Unsafe Sex ...........................49
  10.3 Improving Behaviour Change Campaigns to Reduce Multiple Sexual Partnerships ..................................................................................................................52
  10.4 Improving Behaviour Change Campaigns to Discourage Cross-generational Sex ..................53
  10.5 Improving Behaviour Change Campaigns to Discourage Transactional Sex ..................55
  10.6 Improving Behaviour Change Campaigns to Address the Problems of Risk Compensation ..................................................................................................................56
11 Conclusion ........................................................................................................................58
References ..................................................................................................................................59
Executive summary

Introduction

Uganda was one of the worst hit countries during the initial AIDS epidemic in the 1980s, but successfully fought back and earned an early, international reputation for combating the disease. Uganda’s HIV/AIDS prevalence (the proportion of a population infected) fell to a low of 6.4% in 2005, but by 2011 prevalence had risen to 7.3% (according the 2011 Uganda AIDS Indicator Survey). In order to identify and recommend effective behavioural change communication (BCC) strategies for stemming this increase in prevalence, the HIV/AIDS Knowledge Management and Communication Capacity (KMCC) Initiative and its partners synthesised information about Uganda’s BCC responses to HIV/AIDS. The UK Department for International Development funded this work.

As a basis for this synthesis, we conducted a comprehensive literature review and interviews with BCC specialists who have been active in campaigns across Uganda and Africa. The report identifies gaps and best practice in previous behaviour change communications efforts, aiming to inform future campaigns.

Responses to HIV/AIDS

Government Responses (pages 11–16 & 25–32)

In response to the spread of HIV/AIDS 1980s and 1990s, the Government of Uganda set up the national AIDS Control Programme (ACP) in 1986, and the Uganda AIDS Commission (UAC) in 1992. Initial behaviour change communications campaigns promoting family values helped to bring down the prevalence rate. These campaigns include the ‘Zero grazing/Love carefully’ campaign and its successor, termed ‘ABC’ (Abstinence, Be Faithful and Condoms). Because of these efforts, Uganda earned an early reputation for successfully fighting HIV/AIDS. However, since 2005 infection rates have begun to rise.

Some government campaigns, especially since 2004, have favoured increased abstinence and fidelity messages, which, the literature suggests, negatively impacted on condom promotion. More recently, introduction of antiretroviral treatment and other biomedical interventions saw focus shift to these interventions, possibly at the expense of BCC interventions.

Non-state Responses (pages 17–19 & 25–32)

Non-state actors have played a significant role in Uganda’s struggle against AIDS. These types of organisations include, for example, non-governmental organisations (NGOs), community-based organisations (CBOs), faith-based organisations (FBOs) and civil-society organisations (CSOs).

One notable NGO is The AIDS Support Organisation (TASO). Formed in 1987, TASO developed an African model for post-test counselling. Another organisation, the Straight Talk Foundation (STF), won the AfriComNet 2007 Award for Excellence in HIV/AIDS Communication for its work informing the public, particularly youth, about sexual health.

Tackling HIV/AIDS is one of the biggest industries in Uganda, which gave rise to some very strong behaviour change campaigns from such groups. However, the vast number of players, our research suggests, could have led to redundancies, or inconsistencies and overlap in some messages and programs.

Key Lessons Learned

The analysis of BCC in Uganda to date presented here provides useful lessons for future campaigns. One of the main lessons learned is that communicating consistent, targeted messages promoted by multiple sectors and players can be a useful strategy. Other key lessons are that channels such as mass media and telecommunications are valuable but should be used strategically, and that conducting thorough research is needed to ensure appropriate messaging.
From Ugandan BCC Campaigns (pages 34–38)

Some Ugandan BCC campaigns used a multi-pronged approach in which a variety of institutions and stakeholders play a part. The majority of key players, for example, promoted ABC, and as a result the most of Uganda’s population knew the message. Involving multiple sectors strengthened the message of the campaign. This strategy proved very effective and teaches the importance of a multi-sector response.

Strategic and careful use of telecommunications in Uganda can also lead to successful discourse with audiences. The Straight Talk Foundation (STF) improved dialogue with their audience by setting up a free short message service (SMS) programme in 2010, using widely available mobile phone technology. Similarly, some Ugandan BCC campaigns have used mass media, such as radio, very effectively. The Y.E.A.H. (Young Empowered and Healthy) initiative produced the Rock Point 256 radio drama series. A survey showed that 56% of 15–24 year olds had listened to the series and, of these, 75% said that the drama influenced them to take action. These campaigns show the importance of strategically targeting specific groups, learning the groups’ characteristics, and then choosing the most appropriate messages and channels.

Ineffective elements of past campaigns in Uganda can also provide valuable lessons. Though the ABC campaign gave overall successful results, it could perhaps be argued that it also assumed too much: with its one strong message, it seemed to overlook the influence of gender, coercion and socioeconomics on decision making. This is now a lesson learned. Our literature review suggests that not taking into account such crucial societal influences may have left gaps in audience and messaging, which highlights the importance of thorough research as the basis of BCC campaigns.

From Elsewhere in Africa (pages 38–43)

Studying effective BCC campaigns elsewhere in Africa can reveal some important lessons. PATH Kenya’s Magnet Theatre interactive drama workshops, held regularly at fixed venues, engaged continuous audiences for well over a year at a time, displaying the value of engaging communities and sharing knowledge.

In South Africa, since 2004, the dance4life campaign has engaged and inspired young people using music, drama and dance. Once engaged, participants are taught how to discuss issues about HIV/AIDS openly, and are then sent back to their own communities as ‘agents of change’, spreading the HIV/AIDS awareness messages even further. dance4life is an excellent and reproducible example of a programme that engages communities through an effective medium.

The Love Test campaign in Swaziland framed HIV testing as an act of love, tripling the number of couples going for HIV counselling and testing – testing and counselling is effective because when both partners are educated about HIV at the same time, they tend to work together on changing their behaviour.

These campaigns were successful because they focussed on strategies to reach specific objectives concerning specific target groups (communities, young people and couples). Successful BCC campaigns target specific audiences with carefully crafted messages through appropriate channels. Therefore, our research suggests that campaigns should focus on research and strategy in order to achieve this.

Challenges in BCC interventions in Uganda

Messages Must Be Credible (page 44)

Behaviour change communication campaigns need to have a solid grounding in the realities of life in Uganda. For example, messages promoting the use of condoms will fall flat if condoms are not available. Availability of and funding for condoms have at times been inadequate, leading to periods in which demand outstripped supply. Such situations can lead to the public losing faith in the messages it hears.
Messages Must Be Consistent (page 44)

HIV/AIDS campaigning in Uganda has been somewhat fragmented with no central coordination by an official BCC governing body. As a result, there have been some conflicting messages in the past. To give one example, many campaigns promote the use of condoms while others are against their use, favouring abstinence messages instead. Our study of Uganda’s history of behaviour change communications reveals that coordinated and consistent messages across sectors could be a useful way to help achieve impact.

Plan Campaigns to Achieve Objectives (page 44)

Inadequate analysis of target groups and lack of baseline data have hindered some campaigns. Also, a lack of monitoring and evaluation has meant that the impact of many communications has not been measured extensively. This may partly explain why recent BCCs have not significantly progressed, and why infection rates are on the rise. As a part of good practice for any behaviour change communications campaign, prospective campaigns should build in a plan to actively monitor the impact of their messages to assess whether or not the campaign is working and how it might be improved.

Use Mass Media Strategically (page 45)

Communications campaigns have tended to favour mass media, whereas the literature suggests that other channels, such as interpersonal communication, may be more effective in delivering appropriate messages to specific target groups. Also, insufficient training in BCC can lead to the media having difficulties conveying information about HIV/AIDS accurately and in language that target audiences can understand. Moreover, mass media campaigns in Uganda often do not analyse the dynamics, social and cultural norms of target audiences. We recommend that campaigners give a lot of thought to the channels they use in order to best reach their intended audience.

Target At-risk Groups (page 46)

Whereas urban populations are better informed than others, behaviour change campaigns have fallen short with the most at risk populations such as sex workers and fishermen. Also, our research indicates that messaging has not yet singled out certain district-specific demographics in order to tailor messaging for best effect. Future BCC campaigns might want to consider specific audiences to reach in order to make a real impact on infection rates.

Recommendations to improve BCC to address key issues

Delay the Age of First Sexual Activity (pages 47–49)

Research has shown that the age at which people first have sex is an important factor in HIV prevalence – the older the age, the less prevalent HIV is. Young people who begin sexual activity at an early age are more likely to engage in risky behaviour such as cross-generational sex, multiple concurrent partners and unprotected sex. Furthermore, delaying sexual debut means fewer years at high-risk. Suggested recommendations are that sex education programmes gain a thorough understanding of young people, and that other media-based campaigns make involving the young people a priority both in planning and activities.

Use of Condoms (pages 49–52)

Condoms are the most effective way of preventing HIV transmission. But because at times there is not enough availability of and funding for condoms, demand outstrips supply. While it is essential that demand is met, condoms also have had a negative image in Uganda owing to their association with promiscuity and HIV. Using the right channels is a key strategy in achieving behaviour change – in this case, social marketing is one of the most successful ways to increase condom use and ensure that distributed condoms are actually used.
Multiple Concurrent Sexual Partners (pages 52–53)

Research shows that decreasing the overall number of sexual partners, especially simultaneous partners, is one of the most effective HIV incidence reduction strategies. BCC campaigns should be mindful of interrelated social, class, cultural and economic factors in Uganda when tackling this issue. Our literature review suggests that taking these sensitive issues into account could be effective for achieving more impact in future messaging.

Cross-generational Sex (pages 53–55)

Cross-generational sex puts young women in particular at risk: older men have higher infection rates, and young women are less likely to challenge an elder by negotiating for safe sex. BCC campaigns should aim to address the social and cultural factors associated with cross-generational sex, empowering women to demand condom use and tackling power imbalances in relationships. Suggested priority is research; BCC campaigns should have on a strong understanding of the complex culture dynamics at play. While educating girls is necessary to address this issue, male involvement may have been neglected – research shows that participatory group education is particularly effective at addressing issues of gender norms for men and boys.

Transactional Sex (pages 55–56)

Transactional sex – exchanging sex for financial or luxury rewards – is prevalent in Uganda. Some women see transactional sex as a way of supplementing their income in order to have luxury items. In Uganda, gifts can symbolise love and respect from the male, while many Ugandans see women ‘giving away’ sex as marking a lack of self-respect. Effective behaviour change campaigning requires a deep understanding of Uganda’s social and cultural norms in order to address these two problems. Suggestions are for campaigns to encourage working as an alternative source of extra income, and to create communications that empower women so that they feel able to say “no”.

Risk Compensation (pages 56–57)

BCC campaigns should emphasise that new technologies, such as safe male circumcision (SMC) and post-diagnosis antiretroviral treatment, do not make good sexual health practices unnecessary. The introduction of and funding for antiretroviral treatment has improved the lives of people living with HIV/AIDS, but there is a danger for those who are uninfected to see treatment as a safety net. SMC reduces the likelihood of transmission but not as comprehensively as condom use; complacency after SMC could lead to risky unprotected sex. To address this issue, recommendations are for health service providers to communicate that behaviour change is necessary alongside the use of new technologies, and for BCC campaigns to gain a strong understanding of the biomedical information.
1 Introduction

Uganda has endured a severe HIV/AIDS epidemic for over a quarter of a century. Beginning in the late 1980s, a comprehensive and multi-sectoral national response was designed and implemented. The early 1990s in Uganda were characterised by a remarkable and now much-cited decline in national HIV prevalence. After a peak in 1990–1991 in Nsambya, Kampala, a peak in 1992 in Rubaga, Kampala, and in 1991–1992 in Jinja, HIV prevalence rates among pregnant women declined significantly over time, resulting in an overall HIV reduction (Asiimwe-Okiror et al., 1997).

Other data shows similar results, with antenatal HIV prevalence in seven urban clinics peaking around 1992 (15–30%) followed by a steady decline by 2002 (5–12%), most markedly among women aged 15–19 and 20–24 years (Kirungi et al., 2006). In summary, HIV prevalence rose steeply between 1989 and 1992 and then declined precipitously between 1992 and 2002, reaching a national average of 6.4% in 2005 (Uganda Ministry of Health, 2006).

There has been contention over the reason but many note that changes in sexual behaviour led to the decline in prevalence of HIV in Uganda in the 1990s (Bessinger, Akwara, & Halperin, 2003; Kirby, 2008). In particular, there was a reduction in the number of sexual partners and breaking up of sexual networks and then increasing condom use reduced transmission with remaining partners (Kirby, 2008).

More recent estimates, however, suggest that the annual number of new HIV infections increased by 11.4% from 115,775 in 2007-08 to 128,980 in 2010-11 (Uganda AIDS Commission, 2011). Among adults, the annual number of new HIV infections rose by 16.4% during this period and national prevalence has risen to 7.4% (Uganda Ministry of Health and ICF International, 2012). Thus, behaviour change remains a challenge in the HIV/AIDS response.

Several reasons have been put forward to explain these trends, including an increase in risky sexual behaviour and decreased intensity of HIV/AIDS prevention programmes. Another possible reason is individual and organisational complacency (Uganda AIDS Commission, n.d.), most likely responding as a result of fatigue and a belief that HIV/AIDS was under control following reports of declining trends.

In Africa, sexual networks are responsible for transmitting the virus in most adult cases of HIV infection. Also contributing is that behavioural and biological risk factors for HIV epidemics evolve with the stage of the epidemic. As HIV epidemics change, the associated risk factors and drivers also change. More recent modifiable risk factors for HIV transmission in Uganda comprise multiple partnerships, HIV sero-discordance, inconsistent condom use, infection with sexually transmitted infections (STIs) and lack of male circumcision (Mermin et al., 2008). These factors operate alongside many other socio-demographic factors such as urban residence, age, being married or formerly married, being female and residence in northern Uganda (Uganda AIDS Commission, 2011).

Understanding factors related to HIV transmission, behaviour and practices is invaluable in designing appropriate behaviour change communication (BCC). BCC is an interactive process to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours; promote and sustain individual, community, and societal behaviour change; and maintain appropriate behaviours (Family Health International, 2002).

The important role of information education and communication for behaviour change in relation to HIV prevention in Uganda has long been studied and confirmed (Bessinger et al., 2003; Shelton et al., 2004; Stoneburner & Low-Beer, 2004). Despite the range of communication campaigns, the Uganda HIV prevalence is rising. There is therefore need to synthesise Uganda’s HIV/AIDS behavioural change communication guidelines/programmes and recommend high-impact behavioural change strategies for reducing new infections.
2 Methodology

A standard systematic review was conducted. Over 150 documents related to behaviour change communication in Uganda, East and Southern Africa were identified, reviewed and catalogued. Summaries of the documents were created focused on key characteristics behaviour and responses to BCC campaigns, the major BCC interventions in Uganda in respective decades, lessons from both effective and ineffective practice and reflection on impacts, key results, key lessons for Uganda and from the East Central and Southern Africa region. The documents included, UAC and MoH reports, The Uganda AIDS Indicator Surveys, The Modes of Transmission study, The National HIV Prevention Strategy and the National Strategic Plan, BCC design documents, BCC programme reports, published and unpublished papers on BCC in Uganda and East Central and Southern Africa.

Also documented were views on how to make BCC interventions effective and with results to change the indicators around delayed sexual debut; reduced unsafe sex practices; reduced multiple concurrent sexual partnerships and; stop cross-generational and transactional sex. These summaries were then used to produce the synthesis report. Eleven key informant interviews then were conducted to compliment the data.
3 Government Responses to HIV/AIDS

3.1 Government Responses to HIV/AIDS 1980s to 2000: Focus on Family Values

In January 1986, a new government, the National Resistance Movement seized power in Uganda. The new President, Yoweri Museveni, strongly responded to evidence of an emerging disease epidemic with a proactive commitment to prevention that promoted ‘family values’ (Allen & Heald, 2004). This disease, referred to as ‘slim’, had already been causing deaths in Uganda before those infected were diagnosed as having HIV/AIDS in 1982–83. The devastating impact of HIV/AIDS was acknowledged at the highest levels of government. Government also encouraged NGOs to participate in the response to HIV/AIDS.

President Museveni personally addressed and strongly encouraged government and civil society to tackle HIV/AIDS (Green, Halperin, Nantulya, & Hogle, 2006). He appointed motivated and competent people to prevent its spread and delegated authority to them. In addition, President Museveni spoke forcefully about HIV to the public. The government thus initiated many efforts to stop HIV/AIDS (Kirby, 2008). This initial political will of government to openly address HIV/AIDS provided a conducive environment for creating a national response (UNAIDS, 2001).

3.1.1 The National AIDS Control Programme 1986

In 1986, President Museveni directed the establishment of a national AIDS Control Programme (ACP) and a national sentinel surveillance system, which has tracked the epidemic since 1987 (Green et al., 2006). This constituted the beginning of a national response to HIV/AIDS that was characterised by an environment of openness, strong political commitment and support (Okware, Kinsman, Onyango, Opio, & Kaggwa, 2005).

3.1.2 National Health Education Programme 1986

The Uganda Ministry of Health (MoH) added a component known as the National Health Education Programme on AIDS to ACP in October 1986. The educational goals of the subcommittee were to inform people on how HIV/AIDS was transmitted, to help them change high-risk behaviour, and to promote non-risk sexual behaviour. Some of the program activities were to provide materials for seminars, air radio and television programmes, publish brochures and posters and address target groups in special campaigns (Elangot, 1987).

3.1.3 Zero Grazing – Love Faithfully 1987

The government recognised that most HIV infection occurred through consensual sexual acts and that national HIV/AIDS rates might be affected if population level change in risk-taking behaviours was mobilised.

The initial messages were termed “be faithful”, “zero grazing” and “love carefully.” These typically translated into: If you are married or in a long-term relationship, be faithful and do not have sex with others. If you are single, wait until marriage or have only one partner (Kirby, 2008). Nearly all the organisations involved in HIV/AIDS prevention focused on these clear and consistent messages.

3.1.4 The Health Educational Information, Education, and Communication Campaign 1989

The Health Educational Information, Education, and Communication (IEC) Campaign was to be the centre of the Uganda Education Programme with the main goals of: 1) mobilising all formal and informal sectors of Ugandan society; 2) providing IEC materials to all districts; and 3) ensuring district level, decentralised information and training (Slutkin et al., 2006).
IEC Campaign Activities

The principal activities of the IEC Campaign were the development of training packages and a “training of trainers” programme, public education materials development and dissemination, and district level mass mobilisation. This included “cross fertilisation” from one district to another, training educators from one district to be used in the next district. This IEC campaign was led by the MoH with assistance from the World Health Organization (WHO), United Nations Children’s Fund and from several other NGOs (Slutkin et al., 2006).

3.1.5 Condoms 1989

Though condoms were a part of the ABC strategy — they were not heavily promoted. In the early years of taking office, President Museveni was involved in an informal alliance with the Catholic leaning Democratic Party. Partly for this reason, but also partly because of his own beliefs and attitudes, condom use was selectively endorsed. President Museveni and other ministers went as far to make speeches denouncing condoms as un-African and raising doubts about their efficacy as a form of protection (Allen & Heald, 2004).

Beginning in 1989, Uganda began receiving millions of condoms from abroad. In 1991, the media began to dispel myths about condoms and to encourage their use. Condom social marketing advertisements appeared in The New Vision newspaper, but created controversy and were then banned for several years. In an effort not to offend religious or other groups, UAC pursued a policy of “quiet promotion” (Kirby, 2008). Over the years the denouncing of condoms has been toned down, but Museveni maintains that the success of his government’s programme has been to do with the promotion of ‘family values,’ which was its main focus (Allen & Heald, 2004).

3.1.6 The Uganda AIDS Commission 1992

Establishment and Mandate of the Uganda AIDS Commission

Recognising that HIV/AIDS had causes and consequences far beyond the health sector, the Uganda AIDS Commission (UAC) was established in 1992 by a statute of Parliament. UAC was mandated to oversee, plan and coordinate HIV prevention and control activities throughout Uganda. In particular, UAC is meant to: 1) coordinate the development of policies and implementation of HIV/AIDS guidelines; 2) forge the integration and harmonisation of efforts to combat HIV/AIDS; 3) monitor HIV/AIDS activities in the country; and 4) disseminate information on the HIV/AIDS epidemic and its consequences in Uganda. By 1993, the UAC had prepared a strategy document, the Multi-sectoral Approach to the Control of AIDS, and in 1994 a National Operational Plan was circulated to provide guidance to implementers and other stakeholders (Tumushabe, 2006).

UAC Activities

At the time of its launch, the UAC introduced an aggressive campaign that included print materials, radio, billboards, and community mobilisation for a grass-roots response against HIV/AIDS. It has trained thousands of community-based HIV/AIDS counsellors, both health and peer educators as well as other specialists. Led by their leaders’ examples, the general population eventually joined in the fight against HIV/AIDS, creating a sense of civic duty to support the effort. Spreading the word involved not just “information and education” but rather a fundamental behaviour change-based approach to communicating and motivating.

3.1.7 ABC Strategy

The “ABC” approach to sexual behaviour change, a strategy that was successfully pioneered in Uganda to fight HIV/AIDS. The acronym “ABC” means delayed sexual debut for youth (A, abstinence), partner reduction for the sexually active (B, be faithful), and factual information regarding condom use for those who were infected or involved in risky lifestyles (C, condom use) (Genuis & Genuis, 2005). When researchers began asking why HIV infection rates fell so rapidly in Uganda and not elsewhere in Africa, they concluded that these other countries had relied heavily on condom promotion, while Uganda had a range of programs that also encouraged abstinence, partner reduction and faithfulness. This strategy was eventually coined the “ABC” strategy by the Bush administration (Epstein, 2007).
Some speculate that the decrease in HIV prevalence was not just a result of abstinence, being faithful and condom use, but also as of deaths. These postulate that the decline in prevalence was primarily a result of so many people succumbing to the disease that the rate of new infections was simply outweighed by the numbers of HIV/AIDS deaths. Watching others suffer and die had a powerful, albeit short, impact.

3.1.8 Mobilisation of Local Councils

Also very active in promoting behavioural change were local councils, a creation of the government at this time. Initially, they operated in parallel with the civil service, but have subsequently been absorbed into it. In some nations, such as Botswana, years of efficient, centralised government lead to a systematic disempowering of local councils, while in Uganda, precisely the opposite occurred (Allen & Heald, 2004). They received their authority directly from President Museveni and were supported by the army. These local councils were also given autonomy in deciding how to operate. This coordinated the management of HIV/AIDS in local governments. The general public received IEC materials through local council and other key people such as “mass mobilisers” and community development workers.

Under this arrangement, HIV/AIDS committees and taskforces referred to as District AIDS Coordination Committees (DACCs) were established in all local councils. They were supposed to act as advocates for their people at each level of the administration, collaborate with aid agencies and monitor security. In some cases they also became active in not just promoting behavioural change, but also in enforcing it (Allen & Heald, 2004).

It is important to note that there was limited funding for the decentralised HIV/AIDS response and the DACCs to operate. BCC activities largely depended on other forms of support, for which funding is intermittent.

3.1.9 Alliance with the Media

President Museveni’s directness in addressing the threat placed HIV/AIDS on the development agenda encouraged national media coverage of all aspects of the epidemic, including emphasising behaviour change (Green et al., 2006). Mass media including daily drum-beating on the radio in the late 1980s was an important vehicle for raising awareness and fostering changes in behavioural norms.

3.1.10 Combined Effects with Government Responses 1980s to 2000

By the early 1990s Uganda was among the African countries worst hit by the HIV/AIDS epidemic. However, with the combined effect of strong political leadership, a willing and able civil society, donor investment, and an open and multi-sectoral approach, Uganda sustained an impressive response to HIV/AIDS. Through the technical oversight and direction of MoH, many programs were initiated. These include the first national blood transfusion service, the first voluntary, confidential counselling and testing service, the first HIV/AIDS care and support organisation and the first national sexually transmitted disease (STD) control program. These interventions jointly helped to slow down the epidemic with a combination of explicit and repeated presidential pronouncements and the committed engagement of the government, faith-based organisations, the military, the health system, and community-based and mass communications (Krenn & Limaye, 2009). This was all in the context of the stark reality of people dying from HIV/AIDS.

3.2 Government Responses 2001-2012: Focus on Abstinence and Fidelity

3.2.1 Presidential Initiative on AIDS Strategy for Communication to Youth 2002

In 2002, President Museveni launched the Presidential Initiative on AIDS Strategy for Communication to Youth (PIA SCY). PIA SCY is a school-based programme that has sought to address the HIV/AIDS epidemic in Uganda in a holistic manner, targeting young people, school personnel, parents and the wider community. PIA SCY’s objectives are to: 1) increase the capacity of a network of institutions to continuously increase behaviour change; 2) increase the skills and knowledge of teachers, parents, community leaders, and pupils that culminate in the practice of delayed sexual debut; and 3) promote a stigma-free school environment in

3.2.2 Response to US Presidential Emergency Plan for AIDS Relief 2003

Uganda’s more recent approach to the ABC strategy has come under scrutiny by some groups, with critics saying the Ugandan HIV/AIDS policy is strongly influenced by the United States. This accusation followed after the US significantly increased its international assistance to HIV/AIDS programmes in 2003. Under President George W. Bush’s PEPFAR, US funding for HIV/AIDS programs in Uganda doubled in 2004.

**The Purpose of PEPFAR in Uganda**

The purpose of PEPFAR is to “support national strategies to reach prevention”. In close collaboration with the Government of Uganda, PEPFAR supports the national HIV/AIDS response across all programme areas, including prevention, care, treatment services, health systems strengthening, and strategic information.

**PEPFAR Pushes for HIV Prevention through Abstinence**

The initial authorising legislation of PEPFAR required that 33% of total prevention spending be spent on abstinence-until-marriage. The US Institute of Medicine, in its assessment of PEPFAR, concluded that: “Despite the efforts of the Office of the US Global AIDS Coordinator to administer the allocation [of the abstinence-only requirements] judiciously, it has greatly limited the ability of country teams to develop and implement comprehensive prevention programs that are well integrated with each other and with counselling and testing, care, and treatment programmes and that target those populations at greatest risk” (Sepulveda J, 2007).

Reports also found that allocating one third of funding towards abstinence made it difficult for programme planners to allocate prevention resources appropriately on the basis of the available data. These findings, along with the work of several advocacy groups, resulted in these provisions being removed from the 2008 PEPFAR authorising legislation (Coates, TJ, Richter, L. Cacceres, 2008).

Criticism of PEPFAR has also resonated in Uganda, with many officials not only continuing but also escalating abstinence-only agendas. PEPFAR’s ABC guidance contains rules to follow in developing and implementing their sexual prevention strategies, including restrictions on the prevention messages that may be delivered to youths. Specifically, although funds may be used to deliver age-appropriate AB information to in-school youths, ages 10–14 years, the funds may not be used to provide information on condoms to these youths or distribute condoms in any school setting, even for those out of school (Murphy, Greene, Mihailovic, & Oluopot-Oluopot, 2006). This is of great importance with 12–13% of young women and men saying they had sex before age 15 and by age 18, 60% of young women and 47% of young men having reported initiated sexual activity (Uganda Ministry of Health and ICF International, 2012).

**Condoms Revisited**

Vice President Gilbert Bukenya, a medical professor, stated “Infection is high among adults now and we must ask ourselves why.” He continued that the issue of condom use needs to be reviewed as the country seeks explanations for the rising prevalence rates (Wakabi, 2006). UAC officials have also warned that de-emphasising the importance of condoms will hurt their efforts (Wakabi, 2006).

3.2.3 Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention of Transmission on HIV 2004

In 2004 President Museveni and the Ugandan government expressed a new view of HIV prevention strategies and altered the earlier open and inclusive approach to a more narrow focus on abstinence and faithfulness as the approved prevention strategies.

In November 2004, Uganda claimed to be the first country in the world to draft an official national policy on abstinence and fidelity, the “Uganda National Abstinence and Being Faithful Policy and Strategy on Prevention
of Transmission on HIV” (Human Rights Watch, 2005). The draft describes how abstinence and faithfulness will be promoted as the most effective means of preventing HIV and that “special emphasis will be placed on promoting delaying sexual debut among the young and faithfulness in marriage, eliminating sexual promiscuity” (Human Rights Watch, 2005).

3.2.4 Uganda National HIV Prevention Strategy 2011-2015

The Uganda National HIV Prevention Strategy (NPS) 2011-2015 aims at mobilising all stakeholders to work towards eliminating new HIV infections, putting an end to stigma and discrimination, and halting deaths from AIDS-related conditions by the year 2015. The vision of this National HIV Prevention Strategy is based on the global commitment to zero new HIV infections, zero AIDS-related deaths and zero discrimination. The Uganda National HIV Prevention Strategy states current educational and behavioural interventions in the country comprise mass media, interpersonal communication, community mobilisation, work place programmes and life skills training in schools (Uganda AIDS Commission, 2011). However, there are limited guidelines and policies guiding IEC, mass media, behavioural interventions, targeted services for MARPs, and programmes addressing environmental interventions for HIV transmissions.

3.2.5 National Strategic Plan for HIV/AIDS 2011-2015


The vision of this strategic plan is “A population free of HIV and its effects”, while the overarching goal is “to achieve universal access targets for HIV/AIDS prevention, care, treatment and social support and protection by 2015” (Government of Uganda, 2011).

One of the strategic objective is to scale up coverage, quality and utilisation of proven biomedical and behaviour HIV prevention interventions. One of the strategic actions in order achieve this is promoting ABC for HIV prevention. It states that since young people constitute half of the country’s population, they must be a key part of any strategy to combat HIV/AIDS. Thus, the priority areas for ABC are strengthening HIV/AIDS education in schools (through PIASCY), faith-based and community initiatives encouraging AB and family values and scaling up the Young Empowered and Healthy (YEAH) initiative.

3.3 Summary of Government Responses 1980s to 2012

Unfortunately, government responses to HIV prevention have at times been fragmented. Though many achievements have been made, including initiatives such as establishment of the ACP, UAC and DACCs, there is still much to be done regarding the government’s responses to the epidemic. This includes combating conflicting and/or confusing messages. On World AIDS Day 2012, the UAC was blamed for the rising prevalence of HIV/AIDS in the country, with methods like circumcision and condom use, that are included in the National Prevention Strategy, had caused more harm than good (Sadab, 2012).

Similar confusion reigns across national communications on HIV/AIDS and the public receive mixed messages. Arguably, this has led to a slower uptake of HIV prevention services such as safe male circumcision and condom use. Another factor has been relative under resourcing of prevention interventions, with a heavy concentration on treatment and care. In addition, negative stereo-typing, media campaigns and legal reform are adding to the type of stigma that deters risk reduction and health seeking behaviour. This includes the HIV/AIDS Prevention and Control Act of 2010 introduced by Parliament, criminalises HIV transmission, mandates HIV testing for certain people and requires medical personnel to disclose the HIV status of some individuals.

In the 1990s, Uganda gained international acclaim for promoting behaviour change with the ABC strategy and drastically cutting HIV infection rates. However, a combination of factors has seen the country lose the momentum. After the success in the 1990s, Uganda has gone from being a ‘consultant’ on how to fight
HIV/AIDS, to being one of the few African countries with rising infection rates. Study findings suggest the Ministry of Health and other stakeholders have become complacent about HIV/AIDS communication (Panos Eastern Africa, 2011). In the late 1980s and early 1990s, communication for HIV prevention was of great priority for the Government but seems to have slowed (Panos Eastern Africa, 2011). One key informant interview respondent stated, “The role of MoH in educating people about HIV transmission and prevention ended with the introduction of antiretroviral therapy (ART). Once these drugs were introduced, even the international donors shifted from helping institutions such as the AIDS Information Centre (AIC) and are now assisting those offering ARVs and more recently circumcision.”

The Modes of Transmission (MoT) Study by Wabwire-Mangen et al. states that the country is now committed to re-invigorated HIV prevention (Wabwire-Mangen, Odiit, Kirungi, Kisitu, & Wanyama, 2009). National policies and technical guidelines for key HIV prevention services are available, evidence-based and are regularly updated. These prevention services include particularly biomedical services, HIV counselling and testing (HCT), condom promotion, blood safety, sexually transmitted infection (STI) treatment, medical infection control, post HIV exposure prophylaxis and HIV/AIDS education in schools. National targets and roll out plans for most interventions have also been developed (Wabwire-Mangen et al., 2009).
4 Non-government Responses to HIV/AIDS

4.1 Non-government Responses to HIV/AIDS Since the 1980s

Uganda has prioritised prevention of HIV transmission since 1986 through intensified HIV/AIDS awareness and sensitisation campaigns and behaviour change communication. The government initiated efforts to stop the spread of HIV/AIDS, but an important aspect of Uganda’s response was the involvement of a variety of institutions and individuals, both inside and outside of the government sector (Allen & Heald, 2004).

4.1.1 Families and Communities

Much of the work in the fight against HIV/AIDS in Uganda remains with the affected families and communities. Many communities have designed their own interventions with little assistance (Tumushabe, 2006). As first-line providers of care and support, families as well as informal community groups make a major difference by providing palliative care and affecting well-being.

Information and a call for behaviour change were communicated by the media, health workers and influential people from a range of local community groups mobilised a grass-roots offensive against HIV/AIDS. While high-level political support was fundamental, personal communication networks in both urban and rural settings “predominated in communicating about AIDS.” Furthermore, it is these personal and community networks that at times are credited as being critical “to bridge the motivational gap between HIV prevention activities and behaviour change sufficient to affect HIV incidence” (Genuis & Genuis, 2005).

4.1.2 Agencies and Organisations

By 2001, there were approximately 700 agencies and organisations involved in HIV/AIDS activities and interventions in Uganda (Hogle J, Green EC, Nantulya V, 2002). These groups have transformed HIV/AIDS into one of the biggest industries in the country in terms of employment and financial resources.

The government promoted community mobilisation through civil society, school health programmes, cultural leaders, faith-based organisations and employers (Okware et al., 2005). HIV/AIDS communication, under the ABC model, was the responsibility of actors from various backgrounds who participated to communicate to identify groups within their spheres of influence. Over time these matured into an approach to fight HIV/AIDS involving systematic efforts by the media, schools, faith communities, youth organisations, women’s groups, non-governmental organisations, prisons and other groups including traditional healers (Kirby, 2008).

Civil Society Responses

Community initiatives played a key role in the country’s initial response to the epidemic. To date, civil-society organisation (CSOs) have sustained the response, especially at grass-roots level. CSO contributions have ranged from financial support largely from international CSOs to management of systematic programmes in HIV prevention; care and support for the infected and affected; and social and economic empowerment especially for the most vulnerable and marginalised populations (Uganda AIDS Commission, 2011).

Condom Promotion by CSOs

Most HIV/AIDS work with respect to promoting the use of condoms in Uganda has been left to CSOs as government sentiment favours abstinence and being faithful. Social marketing of condoms and condom shipments greatly increased. During the early to mid-1990s, some faith-based communities that had initially opposed the promotion of condoms reduced their opposition when they continued to see so many people dying of HIV/AIDS. During the latter part of the 1990s there may have even been more emphasis on condoms than on being faithful (Kirby, 2008). However, a similar trend observed in government responses has surfaced condemning condoms to promote abstinence.
CSO Responses Complement Government Responses

There is great responsibility left to the CSOs, but UAC sees this not as a weakness on the side of government but rather complementary. Government policies recognise the role of CSOs as partners in national development. Under the supportive policy environment, CSOs work with government to implement national priorities in various areas and sometimes receive financial and technical support from government through public and private partnerships. This is largely in recognition of their flexibility to involve communities in managing their programs which puts CSOs in strategic positions to respond easily to needs of people at the grass-roots. Some leaders in the civil society world have also reiterated CSOs role particularly in the fight against HIV/AIDS (Uganda AIDS Commission, 2011).

4.1.3 Religious Leaders and Faith-based Organisations

Religious leaders and faith-based organisations (FBOs) were also on the front lines in prevention efforts. Mainstream faith-based organisations wield influence in Uganda. Early and significant mobilisation of Ugandan religious leaders and faith-based organisations resulted in their active participation in HIV/AIDS education and prevention activities. Also, mission hospitals were among the first to develop HIV/AIDS care and support programmes in Uganda; for example, the Catholic Church and Catholic mission hospitals provided leadership in designing HIV/AIDS mobile home-care projects and special programs for HIV/AIDS widows and orphans (Green et al., 2006).

4.2 Specific Non-government Responses to HIV/AIDS Since the 1980s

4.2.1 The AIDS Support Organisation 1987

The AIDS Support Organisation (TASO) was founded in November 1987 by a group of 16 volunteers who had been personally affected by HIV/AIDS in various ways. TASO remains the lead agency in the country in providing post-test counselling and support. Since its beginning in 1987, TASO has grown into one of the largest national organisations, with eight branches nationwide and a registered clientele of 65,000. It works as the first referral point for the AIDS Information Centre (AIC) and other HIV/AIDS testing and counselling services for HIV sero-positive people. Other services provided by TASO include medical care, social support, capacity building and training, AIDS education and sensitisation and a resource centre. The organisation has inspired many other groups in sub-Saharan Africa.

4.2.2 AIDS Information Centre 1990

The AIDS Information Centre (AIC) is an NGO established in 1990 to provide the public with voluntary counselling and testing (VCT) for HIV. The mission of AIC is to prevent the spread of HIV and mitigate its impact by being a model of excellence in the provision and expansion of VCT, information and education, and the promotion of care and support. AIC started HIV/AIDS counselling and testing operations in 1990. In an effort to serve Ugandans living in urban and rural areas, AIC began operating satellite sites in 1992. The AIC carries out VCT of HIV and syphilis, and management of all STDs; provides family planning and tuberculosis services; sponsors a post-test club; trains volunteers in counselling and testing methods; and provides technical assistance. AIC has expanded coverage and offers HIV counselling and testing services through eight regional branches.

4.2.3 Traditional and Modern Health Practitioners Together Against AIDS 1992

An estimated 80% of Ugandans use traditional health care, either fully or in part. Herbal medicines are used for treatment of opportunistic illnesses resulting from HIV/AIDS, particularly among the poorer rural populations. Established in 1992, Traditional and Modern Health Practitioners Together Against AIDS (THETA) is the oldest collaborative project between traditional healers and biomedical workers in the HIV/AIDS field in Africa (Engel, 1998). THETA’s primary goal is to build a sustainable partnership between traditional and modern approaches to HIV prevention and HIV/AIDS treatment. The group meets each month to share information, experience and materials on HIV/AIDS, STIs, counselling skills and educational strategies.
4.2.4 Straight Talk Foundation 1997

“Straight Talk” started as a supplement in The New Vision, Uganda’s largest and partly government owned newspaper in 1993. In 1997, the publication was transformed into a non-governmental organisation called Straight Talk Foundation (STF). STF activities and interventions aim to improve the well-being of adolescents through behaviour and social change communication in HIV/AIDS, adolescent sexual reproductive health, gender, life skills, rights, and alcohol and drugs. STF established a toll-free short message service (SMS) programme in October 2010 to receive instant phone feedback and questions from people who listen to its educational radio shows and read its newspapers across the country. This service is anonymous and SMS messages get instant feedback (Bagyendera, 2012).

STF reaches approximately 85% of Uganda’s seven million adolescents annually with its health communication programs through print, electronic and interpersonal communication. It also reaches thousands of parents and teachers through its popular program on 33 radio stations in 12 languages.

4.2.5 Inter-Religious Council of Uganda 2001

Established in 2001, the Inter-Religious Council of Uganda (IRCU) brings together different religious institutions to address issues of common interest, one of which is HIV/AIDS. In regards to prevention, the IRCU focuses on promotion of abstinence and being faithful strategies, using a faith based approach. Activities range from using different communication channels that include films and drama shows, radio talk shows and spot messages to newspapers, rallies and life skills sessions. Other activities include training for religious leaders and other community mobilisers in basic HIV/AIDS counselling and referral, HIV/AIDS counselling and testing services and parenting workshops (Prevention: Inter-Religious Council of Uganda, 2011).

By 2011, a total of 2,528 religious leaders and peer educators were trained in HIV/AIDS prevention and communication. Approximately 17,000 in and out of school youth were reached with BCC that promotes abstinence and; as of June 2011 alone a total of 7,305 married and cohabiting individuals were reached (as couples and as individuals) with messages promoting fidelity (Prevention: Inter-Religious Council of Uganda, 2011).

4.2.6 Summary of Non-government Responses to HIV/AIDS

NGOs play an extremely important role that complements government efforts in Uganda’s struggle against HIV/AIDS. Uganda’s success depended on this extraordinary response by both government and civil society to meet the HIV/AIDS crisis and to support appropriate changes in sexual behaviour that would have an impact on HIV prevalence.
5 Responses Targeting At-risk Groups to HIV/AIDS

5.1 Responses Targeting At-risk Groups to HIV/AIDS Since the 1980s

The HIV epidemic in Uganda is country-wide; however, there are pockets of the population that are vulnerable and are considered to be at higher than average risk of HIV infection. When monitoring the HIV epidemic, it is important to identify populations that are more vulnerable to HIV infection at different times. Populations with a concentration of risk behaviours, such as risky sexual and drug use behaviours and alcohol abuse contribute to the overall burden of HIV/AIDS in the country. People with these behaviours are often the first to become infected and are at risk of being infected at a higher rate than those in the general population (World Health Organization, 2005).

In Uganda, behaviours such as sex with non-marital, non-cohabitating partners, and paying or receiving money to have sex are considered high-risk sexual behaviours (Uganda Ministry of Health, 2006). Populations in which there is a concentration of risk behaviours for HIV transmission may drive the majority of new infections.

### Most At-Risk Populations (MARPs) Network

As a response to a need to involve civil society in the national HIV/AIDS response, the STD/AIDS Control Program/Ministry of Health initiated a consortium of stakeholders involved in interventions among commercial sex workers (CSWs). This included CSOs, academic institutions and the public sector. The initial outcome of these efforts was the formation of the Uganda Network for Sex Work Projects (UNSWP). Although there was commitment from the MoH and member organisations, it was not possible to continue without support and funding to the Secretariat. Recognised as an important component in the efforts to harmonise activities among most at-risk populations (MARPs) organisations, AFFORD/UHMG took the lead in order to revive the network. With the guidance of the STD/ACP/MoH the network was re-launched with the aim of, targeting those most-at-risk of acquiring and transmitting STDs and HIV. Under the new name, the MARPs Network expanded their reach to include CSWs, their clients and population groups that were identified as MARPs in the Uganda HIV/AIDS Sero Behavioural (UHSBS) Survey 2004-05 and the National Strategic Plan (NSP) 2007-08 to 2011-12.

5.2 Key At-risk Groups

Although Uganda’s HIV/AIDS epidemic is generalised affecting all population groups, there are key populations that are more susceptible and therefore bear a disproportionate burden of HIV/AIDS. These groups play special roles in bridging infections to the general population. Therefore, research on the demographics and dynamics of the epidemic guides future actions. The Uganda National HIV Prevention Strategy has taken into account the dynamics of epidemics to significantly decrease new HIV infections in the country. The strategy explains the need for provision of tailored services for these groups, in addition to services for the general population (Uganda AIDS Commission, 2011). According to the Global AIDS Response Progress Report of Uganda Jan 2010-Dec 2012, behavioural, biomedical and structural HIV prevention interventions did not have universal coverage; the most at-risk populations (MARPs) were particularly underserved. Currently in Uganda, the key at-risk populations include commercial sex workers and their partners, long distance truck drivers, fisher folk and people in uniformed services.

5.2.1 Responses Targeting Sex Workers and Their Partners

There were very few responses targeting sex workers and their partners besides the creation of the Women's Organization Network for Human Rights Advocacy (WONETHA) that was set up in 2008 to advocate the empowerment of sex workers.

CSWs are predominantly women who trade sex for money and use sex as their primary means of income. Sex workers are particularly vulnerable to infection due to multiple sexual partners, frequency of sexual acts,
limited condom use, low bargaining power in condom use with clients and very complex sexual networks involving their clients, partners of their clients and the general population.

The Crane Study found HIV prevalence in female sex workers in Kampala (32.8%) was nearly three times that of women in the general population (11.5%) (Makerere University, School of Public Health, Kampala, 2010) and it is estimated that sex workers, their clients and partners of clients contribute 10% of new HIV infections in Uganda (Uganda AIDS Commission, 2011).

Similarly in 2011, Vandepitte et al. found HIV prevalence very high among women involved in high-risk sexual behaviour in Kampala (37%) compared with the national prevalence (approximately 6.4%) and with the prevalence among general population women from Kampala (12%). HIV prevalence was highest (44%) among women for whom sex work was the sole source of income but was still 34% among women reporting another income besides sex work (Vandepitte et al., 2011). Sex workers often face stigma and barriers in access to prevention services that the general population can easily access. They require targeted services.

**Suggested Key Messages for Sex Workers**

Key messages targeting this group include the following:

- **HIV infection risk** – sex workers and their clients carry a high risk of contracting HIV; messages should communicate high levels of risk, as well as behavioural changes on how to lower risk
- **Condom use** – messages should stress that condoms must be used correctly and consistently to reduce the risk of contracting HIV
- **Condom negotiation skills** – sex workers may fear that insisting on condom use will result in violence or loss of income; communication campaigns should build sex workers’ confidence and self-efficacy for effective negotiation
- **Protection with regular partners** – sex workers often do not use condoms with regular partners; messages should encourage sex workers to protect themselves in all types of relationships
- **Counselling, testing and STI treatment** – messages should stress the benefits of diagnosis and treatment.

(Krenn & Limaye, 2009)

Though proposed as key messages, there are limited responses for sex workers.

**Kawempe Community Health and Development Project 1999**

AMREF in Uganda initiated the Kawempe Community Health and Development Project in 1999 as a response to the socioeconomic needs of commercial sex workers. Its purpose was to improve the health of sex workers and communities living in slum areas and, more specifically, to reduce the spread of HIV and other STIs.

Activities implemented included HIV prevention awareness among CSWs, improving diagnosis and management of STIs, encouraging uptake of (VCT) and use of family planning by sex workers and the wider community, providing sex workers with alternative livelihood skills and supporting people living with HIV/AIDS (PLWHA). The initiative also strengthened community networks for reduced stigmatisation and discrimination. Many of the CSWs had adopted consistent use of condoms, regularly seeking for STI services, reduced the sex partners and some quit the trade altogether in favour of other income generating activities such as tailoring and hairdressing (Nyagero, Wangila, Kutai, & Olanga, 2010).

**Women’s Network for Human Rights Advocacy 2008**

Women’s Network for Human Rights Advocacy (WONETHA) was set up in 2008 to advocate for the empowerment of sex workers. WONETHA is a human rights organisation that advocates for a Ugandan society that respects and protects human rights, and supports economic empowerment of sex workers. WONETHA seeks to improve the health, social and economic well-being of adult sex workers in Uganda. It also promotes adult sex workers’ health seeking behaviour and safer sex practices through health education outreach, psychosocial support counselling, voluntary counselling and testing and sexual reproductive health services.
5.2.2 Responses Targeting Fishing Communities

This study found limited responses targeting fishing communities, but includes the Lake Victoria Livelihood Programme (LVLP).

The association between HIV/AIDS and human mobility has been documented worldwide. In many parts of the world, higher incidence of HIV/AIDS was observed in areas with reportedly high migration flows and which are situated along major transport corridors. In Tanzania and Uganda, for example, it was found that communities living in roadside settlements were more affected by HIV/AIDS than the general population (Barongo et al., 1992; Nunn et al., 1996). A 2005 study found in Uganda, the numbers of fishermen likely to be infected with HIV are higher than some of the groups that are most frequently mentioned as at highest risk for HIV (Kissling et al., 2005).

There are many factors that leave fishing communities vulnerable including a mobile or migratory lifestyle, a high-risk occupation that can contribute to a culture of risk denial or risk confrontation and alcohol use to help cope with the dangers or stresses of their occupation. These factors compound vulnerability to HIV/AIDS. Fishing communities are also often socially marginalised, which can cause, among men, exaggerated or ‘oppositional’ forms of masculinity that challenge norms of behaviour adopted by those in ‘mainstream’ society. Masculinity in this context often includes the expectation of multiple sexual partners (Allison & Seeley, 2004; Seeley & Allison, 2005).

Fishermen are often detached from their families for long periods. Their profession provides daily cash income that can be used for commercial sex and casual sexual relationships. Health seeking behaviour including for HIV prevention services is often poor and services are often unavailable or offered at inaccessible time and venues (Uganda AIDS Commission, 2011). This group needs dedicated and targeted comprehensive HIV prevention services tailored to their lifestyle, though through our search, we found limited literature on programs that target fishing communities. A study published in 2012 reporting on HIV acquisition and its associated risk factors in five fishing communities concluded fishing communities experienced high HIV infection, which was mainly explained by high-risk behaviour. There is an urgent need to target HIV/AIDS prevention and research efforts to this vulnerable group (Seeley et al., 2012).

A community-wide mapping and census of households in eight fishing communities was conducted. HIV prevalence was 26.7% and was higher among females than males, those who were single, those with five lifetime sexual partners reported alcohol use in previous 3 months, those who used alcohol before sex and those who used illicit drugs. Authors found HIV prevalence varied by occupation, highest among sex workers (66.7%), boat makers (50%), government employees (43%), bar owners (37.6%) and bar attendants (36.4%) (Ssetaala et al., 2012).

While investigating the relationship between alcohol consumption patterns and risky behaviour in two fishing communities on Lake Victoria, Tumwesigye et al. found the level of harmful use of alcohol was quite high as 62% of the male and 52% of the female drinkers had got drunk in previous 30 days. The level of risky sexual behaviour was equally high as 63% of the men and 59% of the women had unprotected sex at last sexual event. Findings conclude alcohol consumption is strongly correlated with having multiple sexual partners, sex with non-regular partner and engagement in transactional sex but not with consistent condom use at fish landing sites (Tumwesigye et al., 2012).

Lake Victoria Livelihood Programme 2005

Diakonia, a faith-based Swedish development organisation, has been working in the Lake Victoria region since 2006. Through the Lake Victoria Livelihood Programme (LVLP), Diakonia has contributed to a number of improvements in the livelihoods of communities living around the lake, including in HIV/AIDS. The programme was introduced in LVLP programme was introduced in Kasekulo and Kalangala in 2005.

The HIV/AIDS component of LVLP has been successful and has a very high level of ownership by communities. It has contribution to awareness creation, through advocacy with the message “breaking the silence” and development of community-based volunteers. LVLP has also mobilised religious leaders and FBOs.
Significant results from LVLP include coalition building among religious leaders from different denominations and beliefs, moving from discrimination of PLWHA to clear messages on their rights and an increased outspokenness on sexual and reproductive health and rights. The communities have given testimonies to changing behaviours with increased number of people disclosing their status, less stigma and discrimination (Diakonia, 2010).

5.2.3 Responses Targeting Long Distance Truckers

Our search found very few behaviour communication change initiatives for long distance truckers.

A study in South West Uganda on the trans-African highway found that prevalence among adults aged 13 years or more was 40.4% (Nunn et al., 1996). Long distance truckers constitute a special group of mobile men with money that often spreads HIV/AIDS through engagement with multiple partners along major transit routes. Pickering, et al (1997) in their Ugandan study on casual and commercial sex in a trading town found that 70% clients of “high-class” women who charged a mean price of over US $4/- per contact were truck drivers or their mates (Pickering, Okongo, Nnalusiba, Bwanika, & Whitworth, 1997).

The National Prevention Strategy suggests a workplace policy for long distance truckers would be ideal, but it has not been adequately rolled out (Uganda AIDS Commission, 2011). It goes on to mention that there are very few HIV prevention programmes along highways, with limited scope and coverage. Further, there is limited strategic information including the number of truckers, HIV/AIDS burden, behavioural practices and quality and coverage of HIV prevention programmes (Uganda AIDS Commission, 2011). This creates a major gap in prevention communication.

Though found in Tanzania and Kenya, we were unable to find truck driver BCC intervention in Uganda.

5.2.4 Responses Targeting Uniformed Officers: Uganda Police Force

The Uganda Police Force (UPF) personnel are noted to be at higher risk of HIV infection compared to the rest of the population mainly because of the nature of their deployments. Most are not with their families for long periods of time, which may lead to engagement of unprotected casual sexual encounters that increase the risk of HIV transmission.

Behavioural Change Communication Strategy on HIV and AIDS for the Uganda Police Force 2010

The AIDS Control Programme and Uganda Police Force developed the Behavioural Change Communication Strategy on HIV and AIDS in 2010 as guidance for all HIV/AIDS communication campaigns targeting behaviour and collective social change for HIV prevention among men and women of the UPF. Though this document has been created, we found very limited behaviour change initiatives for this group. Comprehensive BCC implementation is therefore necessary for this group to fill this gap.

5.3 Summary of Responses Targeting At-risk Groups

Despite being defined, there is limited programming for MARPs and yet conspicuous evidence highlights high prevalence rates among these populations (Makerere University, School of Public Health, Kampala, 2010). Further research on their demographics and the dynamics of the epidemic is needed to guide future actions, as the response in targeting these groups has been limited. There is a gap in responding to these at-risk populations.

Lesson learned from responses to MARPs include:
The dynamics of at-risk populations on epidemics can significantly decrease new HIV infections and must be taken into account.

- Target high at-risk groups
- There is an urgent need to target HIV prevention and research efforts to this vulnerable group, and
- There is a gap in responding to these at-risk populations.
6 Major Behaviour Change Communication Interventions Since the 1980s


6.1.1 ABC Approach, 1987

As previously mentioned, the government recognised that most HIV infections occurred through consensual sexual acts. As a result, the “ABC” approach was created and Uganda’s success in combating HIV/AIDS has become virtually synonymous with this approach to HIV prevention.

**Key messages**
This approach to sexual behaviour change sends three messages: delay sexual debut for youth (A, abstinence), be faithful to a single partner or partner reduction for the sexually active (B, be faithful), and factual information regarding condom use for those who were infected or involved in risky lifestyles (C, condoms) (Genuis & Genuis, 2005; Hearst & Chen, 2003). However, large-scale condom social marketing did not begin until the mid-1990s (Hearst & Chen, 2003).

6.1.2 Zero Grazing/Love Carefully 1980s to 1990s

As stated earlier, initially nearly all the organisations involved in HIV prevention focused on clear and consistent messages. These messages focused around the fact that most HIV infection occurred through consensual sexual acts.

**Key messages**
During the earlier years of the Zero Grazing/Love Carefully campaign, the messages were “be faithful”, “zero grazing” and “love carefully.” These typically translated into if you are married or in a long-term relationship, do not have sex with others. If you are single, wait until marriage or have only one partner. If you must have sex outside marriage or a long-term relationship, then always use a condom (Kirby, 2008).

The main message of the Ugandan Zero Grazing/Love Carefully program, as is well known, and which was well known at the time both throughout Uganda and throughout Africa (as the Uganda message) was “Zero Grazing.” “Zero Grazing” alludes to the traditional way cattle were fenced in, or tied to a stick, wooden pole or tree to limit grazing outside their own pasture (Allen & Heald, 2004). This clearly meant “stick to one partner” which was what was frequently said following the message or by way of explanation. This as it not only pertained to marriage, but to during dating as well. Many posters at the time emphasised a cow in a pasture surrounded by a fence (Slutkin et al., 2006).

Zero grazing as a BCC strategy acknowledged that some individuals were in polygamous relationships. It encouraged the men who had more than one stable sexual partner, to limit their sexual activity to only those partners.

**Outcomes**
A study in 1990 supported by WHO/GPA reported higher villager recall of the saying or having seen the posters “Love Faithfully” (30%), and “Love Carefully” (25%) than “Zero Grazing.” Over 70% of those aware of “Love Faithfully” interpreted this to mean “stick to one partner”; over 50% of those who heard or saw “Love Carefully” understood it to mean “choose your partner carefully,” and over half of those who saw or heard “Zero Grazing” thought it to mean “stick to one partner” (Slutkin et al., 2006b).
In the late 1980s and early 1990s, the “zero grazing” policy used a combination of explicit and repeated pronouncements focused on the reality of people dying from HIV/AIDS. This was paired with the committed engagement of FBOs, government, the military, and the national health system, aided by mass communications. The combination of these efforts achieved a tipping point, and avoiding risky sex became the social norm (Krenn & Limaye, 2009). This experience stresses the importance of having reinforcing messages delivered from a variety of different sources. The zero grazing campaign reported that multiple partner sexual behaviour dropped noticeably after the campaign was initiated (Krenn & Limaye, 2009).

A key informant interviewee remembered these messages very clearly stating, “I remember these strongly since I was a young man then. There was an intense engagement at that time. There was a lot of risk communication in terms of empowering people to recognise their risk. The implementers were not shy at that time to prescribe action. In this day and age, sometimes people are cagey about making calls to action. That campaign was elaborate and had intensity to it, compared to these days where you have it in a small area. For example if it is on radio, it is drowned by the telecom and beer companies. The intensity was to the extent that you would hear about it wherever you moved.”

6.1.3 Positive Living (TASO)

Positive Living, a TASO initiative, is about understanding the implications of HIV infection and undertaking positive choices to manage HIV infection including secondary infection and passing infection to uninfected sexual partners as well as unborn babies. It also includes the adoption of strategies to improve one’s health condition as mechanisms to fight the HIV/AIDS epidemic. It is a cross-cutting practice for PLWHA and those who are HIV negative; for families, communities as well as institutions.

For PLWHA, the package of Positive Living entails having the will to live and embracing practices that enhance the quality and longevity of life and maintaining hope.

Key messages
Positive Living messages for people who are HIV negative are about making and practicing choices that will keep them free of HIV/AIDS. The entry point to Positive Living and HIV/AIDS care and support is through taking an HIV test to know one’s status. The belief is that when you know your HIV status, you are empowered to lead a “responsible life” that reduces risks and prevents any new transmission of HIV. A responsible life involves avoiding practices that compromise one’s sense of judgment of potential risks such as alcoholism and drug abuse, practicing safer sex, avoiding multiple sexual partners and other harmful cultural practices and adopting tested technologies such as safe medical circumcision (SMC).

The philosophy of Positive Living transcends the life of an individual as it also takes account of practices, norms and conditions prevailing in our families, communities and institutions. In this aspect, positive living means creating systems and structures that take care and support PLWHA to lead meaningful, productive and happier lives while supporting people not infected with HIV to remain HIV free.

6.1.4 DISH Campaigns

In 1999, seven Delivery for Improved Services for Health (DISH) campaigns were launched. Through multi-channel campaigns, DISH assisted the districts to promote family planning, improved infant feeding practices, child health, immunisations, safe motherhood, malaria control, sexually transmitted disease management, HIV/AIDS prevention, voluntary HIV testing and counselling, prevention of mother-to-child transmission of HIV, and health facilities that meet basic standards of quality. Each of the seven campaigns included centrally produced print and mass media materials as well as district organised community outreach activities, addressing one or more of these health promotion activities.

Key messages
Topics of campaigns included AIDS prevention for youth, family planning, a family health logo, maternal health, sexually transmitted diseases, HIV counselling and testing, breastfeeding and infant nutrition.
The BCC component designed and implemented a series of nine phased and overlapping multi-channel health communication campaigns. Each campaign included a mixture of print and electronic media combined with educational community-organised activities such as village meetings, video shows, soccer matches, bicycle rallies, song contests, kitchen garden contests and community-based services.

**Outcomes**

When examining the influences of BCC campaigns on knowledge and use of condoms for prevention of HIV/AIDS in target areas of Uganda, study findings showed with respect to specific programmatic radio messages promoted in the DISH districts, 22% of women reported having heard advertisements for Protector Condoms in 1999, while 30% had listened to Capital Doctor. Capital Doctor is a radio programme on Capital FM. Following the same general exposure trend, more men than women reported having heard these radio messages: 36% for Protector advertisements and 42% for Capital Doctor. Also, the proportion of women who knew that condoms prevent STIs and HIV/AIDS was much higher among those reporting exposure to at least one type of BCC message, compared among those with no exposure. Increased condom use was seen as a result of the BCC campaign as well (Bessinger, Katende, & Gupta, 2004). These findings suggest targeted, programmatic radio messages can influence behaviour change.

### 6.2 Major Interventions: 2001 to 2013

Many of the interventions launched in the 1990s continued into 2001 and are still active.

#### 6.2.1 Straight Talk 1993

Straight Talk started in October 1993 as a newspaper supplement to provide comprehensive sexual health education for English-speaking usually in-school youth aged 15-24. This newspaper covers a range of issues from delaying sex, family planning and preventing abortion.

Radio is the biggest communication channel, reaching more people than any other medium and the first STF radio show started in 1999. Since then, STF has added more than one language a year. In 2013 there were weekly shows in 17 languages for young people (*Straight Talk radio*) and in nine languages for adults (*Parent Talk radio*). STF youth radio shows in Ugandan languages cover between 80-85% of the country linguistically.

Straight Talk was acknowledged for its work and was the winner of the 2007 Award Excellence in HIV/AIDS Communication in Africa Best Multi-channel Communication initiative from the African Network for Strategic Communication in Health and Development (AfriComNet). AfriComNet was established in October 2001 in recognition of the severity of the continent’s HIV/AIDS epidemic and the need for high-quality strategic communication to respond to the crisis. The AfriComNet award recognises outstanding contributions made by individuals/organisations in strengthening and popularising strategic communication as a necessary tool for health and development.

#### 6.2.2 Something for Something Love Campaign 2004

The “Something for Something” Love is a campaign to address transactional sex. Launched by the Y.E.A.H. initiative, in collaboration with the Health Communication Partnership (HCP), the “Something for Something” Love campaign was created by and for young people, to raise awareness and dialogue around transactional sex. Transactional sex is defined as a relationship where sex is given in exchange for favours, money, or gifts.

**Key messages**

For young people:

Young people were given three clear messages: abstain from sex until you are ready to settle down for a long-term relationship; set long-term goals that you do not compromise for material gain; and do not give or receive gifts or favours in exchange for sex.

For adults:

Adults were also given a message: examine your personal role in protecting young people.
“Rock Point 256”
Utilising the MARCH (Modelling and Reinforcement to Combat AIDS) approach, the weekly radio serial drama targeting young people between 15 and 24 years in Uganda “Rock Point 256” was developed as the centrepiece of the “Something for Something” campaign. Characters model positive behaviour change over time, and the campaign incorporates reinforcing radio spots, print and outdoor media, and a wide range of communication tools. “Rock Point 256” is broadcast to 14 radio stations and reaches an estimated weekly audience of five million youth. In 2007, “Rock Point 256” won the AfriComNet Award for Best Folk Media Initiative for a radio serial drama and comic book series.

Outcomes
By 2011 overall, 63% of 15-24 year olds surveyed had heard about “Rock Point 256”; and 56% had listened to it. Among those who had listened, 56% reportedly listened at least once a week. Overall, 75% of young people who listened to “Rock Point 256” reported that it had influenced them to take an action. Reported actions of those who listened include the following:

1. 62% Abstained from sex
2. 15% Started using a condom
3. 14% Decreased number of sexual partner
4. 9% Stayed faithful to one partner (Health Communication Partnership, 2010).

6.2.3 Be a Man 2006-2009
Y.E.A.H. launched the “Be a Man” campaign during the June 2006 World Cup football broadcasts on national television. The goal of the campaign was to reduce the number of young men with multiple sexual partners, improve communication between sexual partners, and encourage mutual disclosure of HIV status, respect, faithfulness, and non-violent means of resolving conflicts, active parenting, and responsible alcohol use. Along with television spots, the campaign included the production of posters and billboards, as well as discussion groups and training sessions. After World Cup fever, Y.E.A.H. continued the campaign activities in schools, workplaces, sports clubs, in the armed forces, in cultural groups, and generally in all places where men congregate.

Communication Strategies for Be a Man
The campaign had eight specific objectives:

- Empower young people to manage their sexuality
- Promote utilisation of available services
- Stimulate community-owned processed that create a supportive environment
- Identify and advocate against harmful social and cultural practices
- Build capacity to support, strengthen, and sustain coordinated behaviour change communication interventions
- Promote and facilitate gender equitable behaviour, and
- Promote gender equitable norms.

“Be a Man” television spots were aired during broadcasts on Uganda Broadcasting Corporation (UBC) of all 35 games in the 2006 World Cup. The spots were also distributed to 96 video clubs in Kampala that showed the World Cup matches on satellite, and were shown on video as part of the Ministry of Health mobile film van tours to rural communities. One of the spots features three young men drinking beer at a bar while watching the athletic match on a TV set in the bar. When an attractive, scantily-clad young woman walks by, they manage to ignore her and instead focus on watching the soccer game (all three cheering as a goal is scored) - while a voiceover suggests "Focus on the important things in life. Be a Man."
**Key message**
"Focus on the important things in life. Be a Man."

### 6.2.4 True Manhood 2009

Y.E.A.H. continued the “Be a Man” campaign until early 2009, then launched the “True Manhood” campaign in June 2009, which is designed to address alcohol use and abuse, violence against women, and transactional sex in relationships. The campaign is centred on a national contest to find a male role model and is complemented by radio, print, and interpersonal communication. The campaign is designed to empower young men with skills to be able to assess their personal risk of alcohol abuse and to commit to drinking responsibly or not at all, to solve conflict using non-violent means, and to be able to resist relationships where gifts, favours, or opportunities are exchanged for sex.

The national contest was central to the campaign strategy. It involved a search for the "Be a Man" man - a man who is faithful to his partner, respectful of women, non-violent, does not abuse alcohol, is honest, and who discourages other men from engaging in transactional relationships. The True Man regional contests were held during August 2009 in the central, northern, eastern, and south-western regions. Five finalists in each of the regions were drawn from the 555 True Men that were nominated across Uganda and were put to the test in front of the audience by puppet characters and the community.

**Outcomes**
Approximately 30% of 15-24 year old males in a 2010 survey recalled seeing or hearing a True Manhood message. Some 47% of young people in urban areas as opposed to 25% in rural areas remembered messages from the campaign. Slightly less than half (47%) of those exposed to the campaign said it had influenced them to take an action. Among those influenced:

1. 63% decided to abstain
2. 20% decided to stick to one partner
3. 13% started using condoms
4. 6% called the 0800 200 600 Hotline (Health Communication Partnership, 2010).

### 6.2.5 Go Together, Know Together 2009

This 2009 campaign was launched to address the increase in the HIV infection rate among married and cohabiting couples and the low rate of couples testing for HIV in Uganda. The campaign aims to empower married and cohabiting couples to assess their risk of HIV infection, test together for HIV, and adopt practices that improve their health. It is led by MoH with service delivery support from the AIC and technical assistance from HCP.

**Activities**
Its activities include branded service delivery sites; trainings for health care providers on how to counsel couples; provider and client support materials; a hotline for testing and counselling; outdoor and print media; video and audio testimonials from tested couples; radio spots; and interactive radio programs.

District Coordination Committees in the eight implementing districts met regularly to assess Go Together, Know Together progress.

The Go Together Know Together campaign continued from 2009 until 2012, expanding the number of partners implementing the community mobilisation activities over time. In 2011, the campaign was nominated and emerged first runner up in the AfriComNet Annual Award for Excellence in HIV/AIDS Communication in Africa, in the multi-channel category.
Outcomes

Data from service delivery partners and evaluation studies reveal that the couples HCT campaign influenced many couples to take action. AIC reported significant increases in the number of couples counselled and tested since the implementation of the campaign, from 31,093 in 2008 to 100,034 in 2012. 3,386 calls on couples counselling and testing and 4,025 calls related to HCT were received at the National Health Hotline between 2010 and 2012 and the HCP 2010 Survey found that more than half (53%) of the respondents exposed to the campaign were influenced to take action (Health Communication Partnership, 2012).

6.2.6 “Go RED” 2009

Go RED campaign, commissioned by PACE (Programme for Accessible Health, Communication and Education), is aimed at promoting faithfulness among married people or sexual partners as one of the best ways to prevent HIV infection among sexually active people. It encourages sexual partners to be Reliable, Exceptional and Dependable to each other by remaining faithful. The campaign is a response to findings that most HIV infections are occurring among married people or people in permanent sexual relationships.

The term Going RED represents a movement of men and women who stand for mutual faithfulness in marriage. “Go RED; for fidelity!” therefore promotes mutual faithfulness in marriage as the ultimate behaviour. The program seeks to create an environment in which couples see fidelity as the most prevalent and desirable option. This campaign, branded “Go RED for fidelity” aims at reversing the belief that unfaithfulness is a harmless and acceptable norm. The campaign also addresses, through increased risk perception, the growing challenge of multiple concurrent partnerships that are fuelling HIV infections. It is promoted with the symbolism of what a faithful person is or what the unfaithful should aspire to be.

The idea is to create a movement of passionate fidelity ambassadors, who choose to dress in red (be it a tie, wrist band, shoe or dress) and use that as a spark to ignite dialogue. These men and women are creating a buzz around their community where difficult aspects of marriage that have hitherto been considered sensitive are discussed.

Activities

The media campaign materials feature a red theme and a slogan “Go RED for fidelity”. These materials include strategically placed billboards, posters, and television and radio ads among others.

An interview respondent, however, states “introducing condoms in a marriage relationship is very complicated, and you would need a campaign that is well researched for it to work. In our culture there is a lot of trust within this group of marrieds or those in a stable relationship, especially in the urban areas, where there is some level of income and education and where there is serial monogamy.”

6.2.7 “Express Your Style with Condom O” Campaign 2010

“Express your style with Condom O” campaign launched in 2010 by Uganda Health Marketing Group (UHMG) aimed at increasing correct and consistent condom usage among urban men in Uganda. Using the campaign slogan “Express Your Style”, the campaign uses an experiential approach to promote a brand of condom known as “O”.

Activities

At bars, a team educates the public about Condom O and its unique qualities; Black, Studded and Contoured. In collaboration with various radio/television stations and other private sector companies, the campaign also engages the public in the “Express your style” campaign to win several prizes. Through periodic messages, listeners are asked to insert three empty packets of Condom O in an envelope and drop them off to the radio stations, or to the nearest Total fuel station (one of the sponsors of the campaign). This enables them to participate in a draw to win various prizes. In another competition dubbed the ‘O’ challenge, participants are blindfolded with condoms and challenged to dress up an artificial penis. The competition helps to increase knowledge and self-efficacy on condom use.
After four months of implementation, initial results of the campaign showed an increase in uptake of condoms by 82%.

This campaign won the Best Social Marketing campaign in the 2010 Excellence in HIV/AIDS Communication in AfriComNet Awards.

6.2.8 The GoodLife Campaign 2006

Implemented by UHMG, the GoodLife Campaign focuses on priority health concerns in Uganda specifically HIV prevention and palliative care, family planning and child survival. The campaign targets the entire family with a focus on young couples, care givers of children under five years of age, pregnant women and PLWHA. The GoodLife Campaign is a unique integrated marketing approach that provides strong continual links between products, practices and services while sustaining mutually beneficial private/public partnerships.

Activities

The GoodLife Campaign utilised an interactive multi-channel game show that aired weekly on television and radio and nationwide community road shows. Its entertainment–educative format broke message fatigue with each game episode aimed to increase knowledge, facilitate couple communication and promote positive health behaviours including correct and consistent use of social marketed products namely non-prescriptive family planning methods, insecticide treated nets, water treatment tablets, and oral dehydration salts (ORS). Launched in October 2007, the campaign aired 24 episodes on two national television stations; 24 radio episodes in 5 languages on 12 local FM stations; and conducted 120 roads shows reaching approximately nine million Ugandans through the three communication channels.

This campaign won the Best Social Marketing campaign in the 2008 Excellence in HIV/AIDS Communication in the AfriComNet Awards.

6.2.9 “One Love/Get off the Sexual Network” Campaign 2009

The UHMG launched a multi-pronged campaign seeking to discourage concurrent multiple partners and encourage individuals to get off sexual networks. The overall objective of the One Love Campaign is to increase serial monogamy among the target population by 5%.

Activities

With a mix of radio, outdoor, press ads, experiential teams, forum theatre and television commercials, the campaign seeks to warn the public about "side-dishes" in extra relationships because of the increased prevalence of HIV among couples. The fidelity campaign has been stretched further to incorporate social media networks like Facebook, YouTube and Twitter. The essence of this is to create debate, questions, share experiences and solutions about sexual networks on social forums like this while maintaining the core virtue of living a good life.

The One Love Campaign has been designed in four phases. The objective of phase three is to increase the understanding of the target audience on the simple things they can do to stay off the sexual network.

Key message

The main message is “Take interest in your partner’s passion.”

Phase four involves encouraging couples to go for HCT. The HCT campaign is running in collaboration with HCP to support their “Go Together, Know Together” campaign on HIV testing.

This campaign has earned UHMG a series of AfriComNet Awards, the Best Not for Profit award and was the Overall Winner for media advertisement in 2010 by Public Relation Association of Uganda.
6.2.10 Stand Proud, Get Circumcised 2011

Launched by MoH with the assistance of HCP and many other partners, the campaign strategy is designed to convince men who already intend to circumcise to get safe male circumcision services, while encouraging women to support their men to get circumcised and for both men and their partners to adhere to post-circumcision practices that promote healing.

The campaign uses a unique and provocative approach to convince men to circumcision. It speaks to men through women. According to qualitative and quantitative research conducted by HCP in 2009 and 2010, 41% of uncircumcised men said they intend to circumcise. The reason given by most men was that they want to reduce their risk of HIV. The main reason these men gave for not getting circumcised was that they did not know where to get the procedure or they were worried that the procedure would be painful. The majority of women who were interviewed wanted their men to be circumcised, and their main reasons were that they thought circumcised men were cleaner, and they wanted to reduce the chances that their men would bring HIV into their relationships. The Stand Proud, Get Circumcised Campaign builds on these findings. It uses a unique and provocative creative approach to convince men to act. It speaks to men through women.

**Activities**

Using a multimedia approach, the campaign promotes SMC as a way that men can reduce their risk of getting HIV.

6.3 Summary of Major Interventions 2001-2013

Though many campaigns surfaced in this time period, some believe they were not created with the same intentions as the previous decade. An interviewee responded, “In the earlier years particularly the first two decades, I think [campaigns] were relevant. They were more targeted and they were bringing something new to the people, and people were more open to listening to the communication that was being put across. This explains why we were able to substantially reduce the numbers of new infections in such a short time, in comparative terms with other countries that had a generic epidemic like we have. But after the 2000s, I think HIV/AIDS work became very attractive financial wise, and the people working on it lost a sense of commitment to saving lives. And it became business as usual. It became like any other development intervention that has been implemented in the world since the end of the Second World War. People lost any sense of urgency as far as dealing with HIV is concerned. This in my opinion is what happened after 2001.”
7 Major Behaviour Change Communication Interventions: 2013 and Beyond

7.1 “Cheating? Use a condom, Cheated on? Get tested”

A new Ugandan HIV prevention campaign developed by Uganda Cares that addresses sexual infidelity with the lines "Cheating? Use a condom" and "Cheated on? Get tested" began in January 2013. It however, is generating heated debate. Billboards erected in various parts of Kampala that bear the image of a broken heart and the slogans. The campaign aims to address the growing vulnerability to HIV/AIDS of couples in long-term relationships, because many new HIV infections in Uganda occur in these relationships.

UAC Response to “Cheating? Use a condom, Cheated on? Get tested”

The UAC, who is tasked with managing the country’s HIV/AIDS response, wanted the removal of the billboards - creating a debate over the direction of future campaigns. The UAC has since created key messages that should be communicated to the population, feeling that complacency in the public has been caused by confusing, contradictory, wrong and unclear messages.

<table>
<thead>
<tr>
<th>Key messages</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Adults should take an HIV test so that you get to know your status</td>
</tr>
<tr>
<td>2. When choosing to raise a family, remember that the baby is innocent and should be protected</td>
</tr>
<tr>
<td>3. Young people are to take responsibility for their future by avoiding risk of infection</td>
</tr>
<tr>
<td>4. Parents are to provide guidance to their children</td>
</tr>
<tr>
<td>5. A call to leaders to deliver the previous messages</td>
</tr>
</tbody>
</table>

After speaking with a UAC representative, there is a call for a governing body for all prevention communication throughout the country to ensure they align with their messages, but has yet to be determined. This may have grand implications on future campaigns.

7.2 Future Campaigns

Our search has not found any other BCC campaigns planned for the future.
8 Key Lessons 1980-2013

Key lessons from BCCs 1980-2013 are:

- The value of multi-sectoral approaches in which HIV/AIDS was openly addressed
- The value of using telecommunication channels
- The value of using mass media
- The importance of having reinforcing messages delivered from a variety of different sources; and
- Sexual behaviour change should be specifically targeted.

8.1 Best Practices Identified in Behaviour Change Communication in Uganda to Date

Many accredit Uganda’s initial success to three broad principles: (1) HIV/AIDS was openly addressed; (2) sexual behaviour change was specifically targeted; and (3) the programme was adaptable across population groups (Genuis & Genuis, 2005). The components of the “ABC” strategy (abstinence, be faithful and eventually condom use) worked together and served as a means of reducing infection risk and all were addressed from multiple sectors for its success. In Uganda each component of the ABC approach had a different and important role (Shelton et al., 2004).

Key Lesson in Uganda’s Initial Response
Providing consistent messages and knowing your population were essential to the initial response.

Key Lessons from BCCs in Uganda

There are three lessons to be learned from BCCs in Uganda. The first, BCCs can result in primary behaviour change on a large scale. The second, BCCs can reduce the number of sexual partners, most especially concurrent partners, which has a huge impact on HIV at the population level. The third, that behavioural change campaigns succeed because they make people think about their sexual behaviour, the consequences and avoiding risks they were able to avoid (Setswe, 2009).

8.1.1 Value of a Multi-sectoral Approach

A key lesson is the value of multi-sectoral approaches, for example in the ABC campaign, there was general acceptance and promotion. This also results in a strong sense of ownership and active support of this campaign and other BCC measures.

In response to the HIV/AIDS epidemic in the late 1980s and early 1990s, Uganda encouraged a “zero grazing” policy as well as the ABC strategy which encouraged people to reduce their number of sexual partners and/or use condoms. The policy in Uganda utilised a combination of explicit and repeated pronouncements and the committed engagement of GoU, NGOs, CBOs, CSOs, FBOs, families and communities, aided by mass communications focused on the reality of people dying from AIDS. The combination of these efforts achieved a tipping point, and avoiding risky sex became the social norm. This experience stresses the importance of having reinforcing messages delivered from a variety of different sources.

Helen Epstein, author of The Invisible Cure, has concluded the “collective efficacy” - the ability of people to join together and help one another - was responsible for the decline in HIV prevalence witnessed by the 2000s. There was compassion and hard work that brought the disease to the open, got people talking which reduced stigma and denial and led to a shift in sexual norms (Epstein, 2007).
8.1.2 Strategic Use of Telecommunications

A second key lesson is the value of using telecommunication channels. An example is STF’s use of a toll-free short message service (SMS) programme in October 2010 to receive instant phone feedback and questions from people who listen to its educational radio shows and read its newspapers across the country. The technology also allows STF to notify teachers when its newspapers are available at its district offices. As a result of the SMS programme, STF found increased dialogue with readers and listeners, improved monitoring of services and quickened corrections needed, as well as provide more effective and efficient service delivery (Bagyendera, 2012).

Similarly, in 2006, a warm-line was established in Rakai to support an antiretroviral therapy program and improve communication between patients, providers, and community members. The warm-line is not a crisis hotline, but is a source of support during certain hours of the day. A program evaluation was also administered to clinical staff and found a total of 1303 calls (3.5 calls per week-day) were logged. These calls addressed clinical issues including the need for urgent care, medication side effects, and follow-up needs. Most clinical staff felt that the warm-line made their jobs easier and improved the health of patients. An HIV/AIDS warm-line leveraged the skills of a limited workforce to provide increased access to care, advice, and education (Chang et al., 2008).

Between 2007 and 2008, HCP through the Y.E.A.H. Initiative identified a lack of youth-friendly services as well as a complete lack of specialized services to address alcohol and violence against women. Though radio programs were hosting health professionals on live phone-in talk shows, the number of callers and the issues raised far exceeded what could be handled in a one-hour radio program. This identified health information gap, coupled with evidence that by 2010 more than 10 million Ugandans would have access to mobile phones, sparked the idea of a free telephone counselling and referral service. The service would provide timely, accurate and reliable information to people about health issues and available services.

As a result, a National Health Hotline was created to provide health information to callers from all parts of the country and was met with overwhelming demand. The hotline receives up to 46,000 calls per month from callers across Uganda, including those residing in rural and urban areas. With the available funding, the hotline has been able to hire and train 12 counsellors. However, this was not enough to meet the high volume of calls. Between 2010 and 2012, the hotline responded to over 150,000 calls but received more than 10 times that number of calls and the need to expand the hotline services is apparent (Health Communication Partnership, 2012).

### Key Lessons for Use of Telecommunications

From YEAH and STF experiences, it is evident that SMS programmes can be very effective to reach many people, increase dialogue, monitoring of services and quickened corrections needed, as well as provide more effective and efficient service delivery. Though a growing mechanism for communicating messages, Uganda has shown promising results in its efforts to use telecommunications.

8.1.3 Strategic use of Mass Media

A third key lesson is the value of strategically using mass media, for example in BCC campaigns “Express Yourself with O” and “Rock Point 256.”

The liberalization of the mass media, particularly the commencement of private radio and television broadcasting in the mid-1990s, expanded public awareness of issues related to HIV/AIDS. Many new programmes were launched to inform the public and to fight the associated stigma. At a time when PLWHA were highly discriminated against in Uganda, the radio was used for education and sensitisation on the transmission of HIV and encouraged coexistence in society with PLWHA (Tumushabe, 2006).

### Key Lesson
The importance of having reinforcing messages delivered from a variety of different sources that are tailored to appeal to specific target populations and are contemporary in nature.
Success Story: Rock Point 256

Many campaigns use radio to communicate messages. Through “Rock Point 256”, the Y.E.A.H. initiative was able to see great impact. The half-hour weekly radio serial drama has broadcasted in four languages on 16 stations since 2005. It is designed to model behaviour change among characters that face transitions. These characters are also similar to the programme’s intended audiences. Between 2008 and November 2010, “Rock Point 256” focused on many topics including violence against women, alcohol abuse, transactional sex, sexual networks and concurrent partnerships, couple HIV counselling and testing, and HIV stigma.

Overall, 63% of 15-24 year olds surveyed had heard about “Rock Point 256”; and 56% had listened to it. 75% of young people who listened to Rock Point 256 reported that it had influenced them to take an action. The actions included 62% abstaining from sex, 15% started using condoms and 14% reduced number of sexual partners.

A comparison of young people who had listened to “Rock Point 256” with those who had not showed that listeners were significantly more likely to have beliefs and practices that are protective of their sexual reproductive health. This was particularly pronounced among 15-19 year old males.

Also, exposure to “Rock Point 256” increased listener’s intentions to practice safer sex. Young people who listened were more likely than those who did not to say they intended to use condoms during the next sexual encounter, get circumcised, get tested and counselled and discuss HIV status with spouse/partner (Health Communication Partnership, 2010).

Health communication strategies that are collaboratively and strategically designed, implemented, and evaluated can help to improve health in a significant and lasting way. Positive results are achieved by empowering people to change their behaviours and by facilitating social change. The field of health communication has evolved into what may be called the “strategic era,” which is characterised by utilising many different channels of communication, multiple stakeholders, and an increased emphasis on evaluation and evidence-based programming (Krenn & Limaye, 2009).

8.2 Lessons from Unsuccessful Behaviour Change Communication Practice

Key lessons from ineffective practice of BCCs 1980-2013 include:

- The need for research when planning
- There is a lack of a BCC communications strategy
- One must understand the target audience
- One must take into account the best mechanisms for dissemination of messages
- The importance of preventing corruption in use of donor funding

8.2.1 Research is Crucial/Strategy is Vital

Despite its efforts in reaching out to people with health messages, at the time of this synthesis, there was no concrete BCC communications strategy. Since there is need for improvement in preferred changes in behaviour, this suggests that the messages are not reaching the desired audiences in an effective way. Strategies and programmes are needed that combine multiple, evidence-based approaches with national guidance. Also found was limited documentation of use of theory and research in designing interventions.

8.2.2 Test Assumptions

BCC is not as easy as ABC

There are critiques of the ABC strategy. One is the assumption that individual decision making is the key site for risk minimization. This assumption ignores the contexts in which individuals attempt to change their behaviour. Economic contexts are named as a second limitation, with researchers not accounting for economic duress in decision making. The third is that these approaches are for individuals who face unchanging
conditions and geographic locations (Dworkin & Ehrhardt, 2007). The socioeconomic and political dimensions of HIV/AIDS determine how and where it is spread—and also how communities and individuals cope with it and adjust to its impact. However, the response of governments and development agencies to the virus focuses on treatment from health care facilities and prevention through the design and delivery of health education messages (Ford, Odallo, & Chorlton, 2003), not taking these other factors into account.

Once again, there are also critiques that the ABC strategy was not in fact the reason for dramatic declines in prevalence, but rather ABCD- where D is death. A surge of infections in the early 1990s is the cause of rising numbers of deaths. In 2001-2, 125 cases of sero-conversion added to the prevalence, and 200 died. It is reported that death alone accounted for a six percentage point reduction in HIV prevalence in the one year and overall, the HIV prevalence over the last decade declined 6.2 percentage points. There is also an estimate that mortality alone contributed five percentage points of the decline (Roehr, 2005).

8.2.3 Understand Target Audiences

Mass media messages must target specific audiences. Okaka found the focus of mass media messages was poorly aligned to sexual behaviours such as multiple partners and discordance, and therefore were ineffective. Population Services International—an NGO spearheading the cross-generational sex fight in Uganda—has said they are losing the fight because of its strategic problem with the message design and delivery approaches to the intended national audiences (Okaka, 2009).

Influencing behaviour change requires a multifaceted approach to communication that takes the complexities of culture, gender, power, economics, emotions, and social skills into consideration (Okaka, 2009). When behaviour change communication is not designed and delivered appropriately for their target audience, it is more likely to be ineffective.

A key informant interviewee added, “A few things which I think we need to do, or should have been done differently- I am a staunch believer in targeted communication. In my interpersonal relationships, I want to talk to somebody on a one-on-one, and give them opportunity to ask questions. This helps in cross checking information. This in my view is a key to HIV prevention, and other public health concerns. It helps in clarifying misconceptions, and to relate issues to real life.” The interviewee goes on to say, “I think the media that we have used particularly after the 2000 is more for the convenience of programmers than the target population. If you hear that going to schools to take HIV messages, you will be able to reach so many young people within an hour. You will find this very attractive isn’t it? But the question is; what will you deliver to a group of 60 people? What environment is this? Will someone stick out their heads to pose questions? They will not be able to do this, because it isn’t a confidential setting. They will leave with more questions and confusion than even when you walked into the classroom.”

**An example of importance of understanding your audience: Comparison of impact of soap operas in Tanzania, Cote d’Ivoire, Zambia and Cameroon**

In Tanzania, increased adoption of condoms was found to be associated with exposure to a radio soap opera that aimed to increase knowledge of AIDS, change attitudes, and encourage HIV prevention behaviours.
An evaluation of a television drama in Cote d’Ivoire found that men and women with heavy program exposure (having viewed 10 or more episodes) were more likely to have used a condom at last sex than those with no exposure.

On the other hand, a study evaluating the impact of a radio drama in Zambia did not find a change in general AIDS knowledge and condom use that could be attributed to exposure to the radio drama.

Similarly, an evaluation of a social marketing program that included mass media promotion of condoms targeted at youth in Cameroon found no evidence in increased use of condoms for STI prevention among youths exposed to the campaign (Bessinger et al., 2004).
Messages Need to Change as Circumstances Change

Interventions and messages should be revisited, as previous response may no longer affect behaviour change. A respondent describes the current situation she deals with: “In the beginning in the 1990s and 2000, in all groups practically, I think because of the state of the epidemic at that time, a lot of mortality, no treatment, under lot of fear of the disease made people very receptive to the campaigns. Especially the ABC was effective at such a point, but over the years people have normalised HIV, they are aware there is treatment and hence not much fear of HIV. In the younger populations in a study I read it says younger people are more concerned about pregnancy than HIV. It is therefore the “C” that would hold for them. This means that the AB has lost position. I think it isn’t received that seriously any more. People have this false safety net of ARVs and the condom, which kind of nullifies any effort of A & B, hence making these just an option.”

8.2.4 Prevent Corruption in Use of Donor Funding

In addition, donor support decreased due to corruption. In 2006, the Judicial Commission of Inquiry concluded that officials, from government ministers to workers at community organisations that nominally exist to help HIV-infected people, had stolen money from the $45.3 million disbursed to Uganda from the Global Fund to Fight AIDS, Tuberculosis and Malaria. As a result, Uganda, which had been widely praised for its exemplary response to its HIV/AIDS epidemic, has endured public humiliation (Cohen, 2008).

8.3 Lessons Learned from Behaviour Change Campaigns Elsewhere in East and Southern Africa

8.3.1 Effective Behaviour Change Campaigns in East Africa

Urunana Radio Soap Opera, Rwanda 1999

Produced by the Urunana Development Communication, Urunana (which translates as "hand in hand") radio soap opera is broadcast on BBC Great Lakes Service and Radio Rwanda with a focus on rural women of reproductive age and youth. Based on research and audience surveys, the radio soap opera utilises multi-pronged needs based and community participatory entertainment approaches to discuss HIV/AIDS and sexuality issues. These issues would ordinarily be considered taboo by the Rwanda community. Over 960 episodes have been broadcast since 1999 reaching more than 10 million people with messages on HIV/AIDS prevention, care and treatment, stigma and discrimination, HCT, prevention of mother to child transmission and nutrition for PLWHA.

Due to its success and appeal to the target audience, the Urunana radio series model has been adopted by other organisations to address other social issues in Rwanda. These are La Benevolencija soap opera with a theme on unity and reconciliation; Population Services International Solange radio drama series to address youth and sexuality; Ministry of Justice radio drama series on domestic violence; and Population Media Centre radio drama on agriculture. Based on the credibility of the Urunana radio soap opera, Urunana community development is now one of the national HIV/AIDS commission mandated organisations to review messages on HIV/AIDS (Hintjens & Bayisenge, 2011).

Magnet Theatre, Kenya 2002

Developed by PATH Kenya, Magnet Theatre is a BCC tool that seeks to provide an opportunity to individually and collectively adopt healthy behaviours over a specific period. It induces and sustains new practices through a process of intense dialogue and critical reflection that then moves through the community. Magnet Theatre repeatedly targets a specific audience at a fixed venue on a regular schedule, offering opportunities for audiences to participate in dramas, empowering them. This then provides a forum to discover their reality and find ways of mitigating these realities. This communication initiative allows people to participate and get involved in sharing meanings, knowledge, understandings, fears and experiences.

More than one year after PATH began holding the performances in fixed venues, they continue to draw eager crowds. Magnet Theatre is easy to adapt and conduct and inexpensive to replicate. The audience participates
by offering suggestions to the characters or by taking the place of an actor and acting out solutions to the dilemma. Magnet Theatre encourages audience members to discuss solutions and allows them to experiment in a safe environment, to encourage individual and community-wide change. Magnet Theatre is different from other forms of community theatre because it targets and attracts a specific and repeat audience, takes place at a regular time at a specific venue, and serves as a forum for magnification of behaviour change. Magnet Theatre has produced some of PATH’s most visible examples of behaviour change.

**Kwacha Afrika**

“After participating in a PATH workshop in Mombasa in February 2000, several youths formed a community-based organisation called Kwacha Afrika. They began by facilitating Magnet Theatre performances in Kisauni, a division in Mombasa. As they received more training from PATH they were able to expand their activities. They have created an office with a youth resource centre and internet cafe that generate income to support their activities as they coordinate youth-focused HIV/AIDS activities throughout the province.

Although the focus of Kwacha Afrika is on HIV and AIDS and reproductive health, the overall purpose is to improve the quality of life of young people in their community. Magnet Theatre performances continue to be a key component of Kwacha Afrika’s work.

Not only has PATH’s training supported the creation and expansion of Kwacha Afrika, but it has contributed to individual behaviour change among the members. Most of the members openly talk about their risky behaviour in the past and how they have changed and become role models in their communities. These frank and honest discussions appeal to young people and encourage them to reflect on and change their own high-risk behaviours” (PATH, n.d.).

**Abugida Radio Show, Ethiopia 2006**

Produced by BBC World Service Trust (BBCWST), Abugida is a weekly radio programme targeting young Ethiopians, directly addressing the sexual and reproductive health concerns of young people, including HIV/AIDS. The show adopts a magazine style, incorporating location interview, storytelling, audio diaries, radio play, poem and letter driven segments to explore issues around sexual health for young Ethiopians between 15-24 years.

Material is recorded from various locations around the country, with different show formats tested on people in both rural and urban areas. The findings played a central role in helping the production team to refine ideas, and clarify messages. Materials were then edited and compiled into engaging programmes that deliver clear messages on how to deal with sexual and reproductive health issues. The main objective of the show is to help young people feel sufficiently empowered enough to freely discuss their sexual health issues and to enable them make informed decision.

Continuous feedback on weekly broadcasts is received through audience letters and regular contact with listener clubs. In collaboration with two local non-governmental organisations, the Abugida show taps into a network of listener clubs that meet weekly to listen to the programmes and send their comments to the production team. Each club has a facilitator trained by the BBCWST who runs the feedback sessions.

**Betenga Radio Diaries, Ethiopia 2006**

Betenga (an Amharic word that refers to a welcomed guest who often visits one’s home) presents a unique insight into what it really means to be HIV positive in Ethiopia. Started in 2006, the Betenga Radio Diaries consist of personal stories, or diaries, narrated by PLWHA. The diaries are edited and broadcast in different formats. The formats include detailed discussions on topics raised in the diaries. In addition, the diaries/programmes are played over loudspeakers in some waiting room facilities for patients who are awaiting treatment or consultation. Issues raised in the diaries include teenage pregnancy, single parenting, children living with HIV/AIDS, commercial sex work, addictions, abstinence, rape, life in the military and living positively.
The diaries are currently broadcast on seven different stations, each broadcast once or twice a week in three different languages. So far, over 500 episodes have been broadcast, allowing listeners to share in the lives of ordinary Ethiopians, their everyday challenges and sorrows, strengths and triumphs. What makes the Betengna Radio Diaries popular is that even after the broadcasts are over, the discussions often continue, with listener discussion groups in different regions engaging further in the issues raised. Published discussion guides provide a structure for these community discussion facilitators, with relevant talking points to focus the discussions. The kits also include sections for providing feedback — essential to ensure that the Betengna Radio Diaries remain relevant to their audience.

8.3.2 Effective Campaigns Southern Africa

Love Test Campaign, Swaziland

The Love Test campaign, launched in 2009 by PSI in Swaziland, is designed to increase HIV testing, particularly among couples, by framing HIV testing as an act of love. The programme combines public awareness with clinical testing and counselling, and involves a media campaign, road shows, and provision of testing and counselling facilities.

The name 'Love Test' was chosen because it speaks of devotion and respect. While other HIV testing campaigns have often relied on messages that induce fear, the Love Test campaign instead suggests that testing is an act of love. The campaign poster also reflects these ideals, with it a drawing of a man kneeling before a woman, like he is proposing marriage. Campaign messages are being distributed through multiple channels including radio talk shows, print advertisements and live performances. The process of testing takes approximately 45 minutes, including a 30-minute counselling session and on-the-spot results. If results show one or both partners are HIV positive, PSI offers longer-term free counselling.

According to the PSI, Swaziland has an HIV prevalence rate of 26%, and only one in four people know their HIV status. Prior to the campaign, only 2% of people tested did so as couples. Since the campaign began in 2009, the number of couples testing has more than tripled. Neighbouring countries including Zambia, Mozambique and Namibia are also showing interest in adapting the campaign. Research has shown that HIV couple testing is one of the most efficient prevention methods, because if the couple is discordant, there is then a chance to avoid the transmission to the other partner by counselling on prevention methods. Also when both partners are educated about HIV at the same time, they tend to work together on changing their behaviour.

Tsha Tsha Television Series, South Africa

Tsha Tsha is a weekly television drama series for youth in South Africa. The drama focuses on young people living in a world affected by HIV/AIDS and other social problems. Set in a fictional rural village in the dusty streets of an impoverished rural town, the series follows the lives of four people in their 20s as they negotiate the path to adulthood, dealing with HIV/AIDS, relationships, sex and poverty. Although produced for a youth target audience, the series draws viewers across age and language groups.

Tsha Tsha series themes are translated into four major languages and broadcast by 60 local community radio stations reaching six million listeners. A national sample survey of 7,006 men and woman age 15-65 conducted in 2006 to measure impact found that:

- 47% of survey respondents had ever watched Tsha Tsha, which translates to 14 million viewers. Of those, 30% had watched half or more of the programs
- Condom use increased with increasing exposure to Tsha Tsha. 42% of males who had not seen any episodes of Tsha Tsha used condoms to prevent HIV, compared with 57% who had seen less than half the episodes, and 72% for those who had seen half or more. 29% of female respondents who had not seen any episodes used condoms to prevent HIV. This increased to 43% among those who saw less than half of the episodes, and 55% of those who had seen half or more (Health Communication Partnership).
The Zambia Creative Helping Each Other Act Responsibly Together (HEART) Contest was developed in 2005 with the goal of promoting youth access to health information, particularly HIV/AIDS through debates, drama, music and poetry. It modelled positive adult-youth communication in order to help youth address the health challenges through positive learning and creative experiences. Since the programme’s inception, there have been more than 60,000 participants with the winners of local contests moving on to district level competitions.

The contest provides a unique opportunity for young people to explore their own thoughts and ideas related to HIV/AIDS or other key issues affecting their communities. It also allows them to develop their opinions based on information they receive from mentors including teachers, health care providers and other adults.

dance4life, South Africa

Started in 2004, the slogan of this initiative is “Start Dancing – Stop Aids”, and the universal language of music and dance is the focus for engaging young people on issues of healthy living and HIV/AIDS. Although it is not a requirement to have dancing skills in order to become active in this project all participants are expected to learn the universal ‘dance4life drill’. Produced by dance4life international, the concept is built around young people, especially of school-going age (13-19 years old) who are drawn to the dance concept, and then become identified as ‘agents of change’ in their respective communities. Currently, 75% of these agents of change are based in Africa.

There is a three step process of, firstly, inspiring young people through music, drama and dance. The second step is enabling them with particular life skills (especially the promotion of open discussion about HIV/AIDS as well as sexual and reproductive health issues) and, finally, to activate them into doing something in their schools and communities.

The dance4life concept is built around the Confucian saying: “Tell me and I will forget, show me and I may remember, involve me and I will understand.” This project is now active in 20 countries; including seven in Africa. Every two years a networking event in each country is linked to the broader international project through satellite, creating synergy and networking on an international scale.

dance4life Lesson Learned

Epidemiological data on HIV infection rates in the targeted areas imply that HIV/AIDS directly or indirectly affects every student in the dance4Life South Africa programme. The programme’s emphasis on providing a wide range of HIV-related information and skills - while encouraging students to identify their own community health-related concerns - appears to increase awareness of HIV/AIDS’ impact. Students who have participated in the programme generally identify HIV infection as a primary cause of health-related concerns in their community, though the same emphasis is less likely prior to their participation (Govender & Parsonset, 2008).

Scrutinize Campaign, South Africa

Scrutinize is a campaign created in partnership with United States Agency for International Development (USAID), the Johns Hopkins Health Education in South Africa (JHHESA), and jeans label Levi’s that aims to encourage and equip young people to take responsibility to reduce their risk of HIV infection. It uses animated township characters (animerts) who illustrate daily life encounters that place young people at risk of HIV infection. The animerts, which are intended for 18-32 year olds in South Africa, aim to equip viewers with a new HIV/AIDS fact or insight to help them examine (or scrutinise) their own risky behaviours and beliefs.

Another aspect of the campaign is interpersonal communication (IPC) using entertainment-education approaches at schools and universities. The campaign also uses art, drama, song, dance, and interpersonal activities to reinforce those messages. Scrutinize is supported by private and public organisations, demonstrating that such agencies can work together to produce a high-quality, targeted campaign that is accepted by the local population.

After its first year, an evaluation found the animert communicating the risk of HIV infection in the first six weeks after infection was found to be effective with regard to partner reduction - particularly with young
males. Furthermore, young people with a higher degree of exposure to Scrutinize were more likely to use condoms than those not exposed to the Scrutinize Campaign. This was particularly true for young men.

The evaluation also found that:

- 53% of all young people with a high level of exposure to Scrutinize had discussed HIV testing with their friends, compared to 35% with no exposure
- 42% of those with high levels of exposure had asked their partners to get tested, compared to 33% of those with no exposure, and
- 43% of those with high levels of disclosure had disclosed their HIV status to their partners, compared to 31% with no exposure.

Overall feedback from a second evaluation indicated that the vast majority agreed that the campaign was educational, understandable, and had a positive reported impact. Because the animerts portrayed real life situations that participants could readily identify with, the campaign was deemed highly relevant. Humour was characterised as easier to relate to, able to evoke interest, and, hence, more effective in getting the message across in non-threatening way. The humour used facilitated open discussions on HIV/AIDS. The evaluation found that the overall positive slant of the animerts is more effective (compared to a fear-based approach); emotions are easily distinguishable (hence, messages are communicated more clearly); and animation is still realistic (portrays real people and real life situations) and were therefore relevant and easy to identify with. Animation allows for an easier portrayal of complex and potentially embarrassing situations, making it more acceptable for kids to watch.

One Love. Kwasila! Club Risky Business, Zambia

One Love. Kwasila!, which translates to “it is enough”, is a campaign to reduce HIV transmission through multiple and concurrent sexual partnerships (MCP) which has been recognised as one of the key drivers of the HIV pandemic in the region and country. One Love. Kwasila! was funded by USAID and implemented by CCP.

A two-phased campaign, One Love. Kwasila! provoked thought and dialogue about MCP and increased risk awareness in its target audience (men age 25-50 and women age 15-45) through its first phase, and focuses on rebuilding relationships by enhancing communication and mutual satisfaction in the second. The One Love. Kwasila! message was reinforced through conventional media, including TV and radio spots and talk shows, an SMS hotline, a music video, print ads and stickers, and social networking tools, including Facebook and Twitter. A centrepiece of the campaign was “Club Risky Business”, a TV miniseries. “Club Risky Business” tells the story of how (MCP) are a major factor in spreading HIV/AIDS. Illustrated through character stories, each story shows the audience a different side of what drives MCP. David (the central character) uses his wealth to attract women and frequently exchanges gifts in exchange for favours. Sachi thinks that he is safe because he only has ‘one’ other partner besides his wife and Charlie Lucky has multiple sexual partners but maintains that he is safe because he always uses condoms.

Initial follow-up indicated that the campaign was a huge success. It achieved widespread exposure; almost half of all urban television viewers were aware of the campaign and could site its slogan.

One Love. Kwasila! Lesson Learned

One Love. Kwasila! has been hailed as one of the most innovative, high-profile and thought-provoking HIV prevention campaign’s in Zambia’s history and has also attracted widespread international acclaim. Multiple reinforcing channels of communication have extended the reach and dosage of prevention messages. High levels of audience engagement (lively discussion among 3,300 Facebook fans, 10,000 SMS competition entries, and high volume of calls during talk shows) demonstrate that Zambians are eager to discuss the role of MCP in HIV transmission, and that new technologies such as cell phones and the Internet are important channels of communication that can and should be harnessed to prevent HIV in sub-Saharan Africa (Naqvi, Bharath Kumar, Chipanta, Mukamba, Tembo, & Mickish, 2010).
8.3.3 Summary of Best Practices from Behaviour Change Campaigns in Eastern and Southern Africa

In countries investigated, communications frameworks stress the role of socioeconomic status, culture and gender relations in HIV/AIDS communications. They use entertainment-education and communication programmes that involve local communities, local culture and media to be effective. Countries that have shown these best practices include Kenya, Rwanda, Ethiopia, South Africa, Swaziland and Zambia.
9 Gaps and Challenges in Behaviour Change Communication Interventions in Uganda

Though Uganda has made many strides in HIV prevention through behaviour change communication campaigns, with increasing prevalence in the country, there are still many gaps and challenges to be addressed.

9.1 Services Underpinning Behaviour Change Campaigns Inadequately Funded

The MoT study found that funding of some key prevention services that underpin BCC campaigns, such as providing condoms, social mobilisation and IEC-mass media has been erratic and is uncertain for the future. This has caused serious disruptions in delivery of some of these services, particularly condoms and HIV testing (Wabwire-Mangen et al., 2009). When campaigns encourage the population to take up services and the services are unavailable, behaviour change interventions can be met with hesitation and mistrust of service users.

9.2 Limited Coordination

In creating this synthesis, it was noticed that there is limited coordination. The number of international and national NGOs, local organisations, and government departments working on HIV/AIDS issues is numerous. While most groups have a focus, without an authorising body there is the likelihood and risk of redundancies, over even conflict, inconsistencies, and overlap in messages and programs. Even more harmful is the potential for gaps that will not be filled and key intervention areas that will be omitted altogether (Krenn & Limaye, 2009).

“I think the biggest problem has been coordination. Recently MoH has got a lot stronger but the Uganda AIDS Commission has not been coordinated at all. With the lack of coordination, you would end up with really disjointed messages. You will not be working on the same objective, or focusing on the same priority audiences, even from the same donor like PEPFAR, which is giving bits of money for communication to all these organisations.” Key Informant Interview respondent of synthesis

9.3 Limited Data Collection, Monitoring and Evaluation

In evaluating communication strategies, both quantitative and qualitative methods should be used to assess changes in knowledge, attitudes, beliefs, self-efficacy, and perceived risk. Uganda has systems and plans for tracking impact, outcomes and coverage of HIV prevention; however, the data collection, monitoring and evaluation systems and plans, especially for behavioural and structural interventions, are inadequate (Uganda AIDS Commission, 2011).

9.3.1 Development of the Uganda AIDS Information Survey

Strides have been taken to fill this gap, including the development of a new Uganda AIDS Indicator Survey (UAIS), a nationally representative, population based, HIV serological survey. The UAIS was designed with the
objective of obtaining national and sub-national estimates of the prevalence of HIV infection and other indicators of programme coverage, including knowledge, attitudes and sexual behaviour related to HIV/AIDS.

According to the UAIS, comprehensive knowledge – knowing two means of reducing HIV risk, rejection of two common misconceptions about HIV transmission and knowledge that a healthy-looking person can have HIV – among the population is startling. The proportion of women age 15-49 with comprehensive knowledge about HIV transmission increased from 28% in 2004-05, to 31% in 2006 and to 34% in 2011. Men, however, increased from 36% in 2004-05 to 42% in 2006 and declined to 41% in 2011 (Uganda Ministry of Health and ICF International, 2012). This suggests that recent behaviour change campaigns are only slightly increasing knowledge if at all. However, the majority of behaviour change communication programmes do not perform monitoring and evaluation to assess their own impact. Monitoring and evaluating of programmes is crucial in determining effectiveness of their work.

9.3.2 Limited Information of Coverage of Services

The MoT found a lack of adequate strategic information on coverage of most HIV prevention services- with major gaps in knowledge of the size of population groups and corresponding coverage of key prevention services. Indicators for monitoring coverage of biomedical programmes are available- such as HCT, PMTCT, condoms, and blood transfusion safety. Such information however, is not well consolidated for other interventions- especially behavioural interventions, IEC and mass media. This strategic information is necessary to guide performance and identify persisting problems (Wabwire-Mangen et al., 2009) and should be collected at a higher rate.

9.4 Conflicting Messages

As previously stated, there are many organisations working on HIV/AIDS issues. This has provided the population with numerous messages, which at times can be conflicting. For example, the Uganda Health Sector Strategic Plan III 2010-11 to 2014-15 strategies and key interventions for prevention of HIV/AIDS include increasing the distribution of free condoms targeting among others discordant couples and people in stable relationships and scaling up social marketing of condoms to general and high-risk populations. It also promotes the practice of male circumcision. These are in direct conflict with messages publicly denounces condom use and male circumcision while pushing for abstinence and being faithful.

9.5 Message Delivery Techniques

Although IEC/BCC services are widespread, they are intermittent. Some providers tend to favour mass media rather than interpersonal communication- not taking into account the best mechanisms for dissemination on many accounts. Coverage of mass media messages can be low, especially in rural areas and should be expanded.

Also, not all media are properly trained in terms of HIV and BCC. There are challenges associated with reporting the scientific side of HIV/AIDS that constantly require training and capacity enhancement. Media houses should increase their initiatives to develop their staff internally in these matters (Sserwaniko, 2007).

“We need to move towards being very dynamic with the messaging, like having messages to appropriately target people. For example a person who works in the market from morning till late in the night, without access to a radio. It would be nice to reach out to populations on a one-on-one at their work places. In the formal working environment, I know of corporate organisations that have workplace health policies. One particular workplace used to have a health week, and
would invite us to run health campaigns and talks for all their staff. The experience we had is that these highly educated people had very basic questions, and with many worrying myths and misconceptions.” Interview respondent (this study)

9.6 Coverage of Services
The coverage of some services has either declined or not changed recently. Outreach services for MARP groups, prevention among HIV-infected people, youth-friendly SRH, and programmes addressing the underlying factors for HIV transmission have not been sufficiently rolled out and their coverage remains sub-optimal. Furthermore, there is evidence of stagnation and even apparent reversals in uptake of preventive sexual behaviours and increase in risk-taking behaviour especially among young men (Wabwire-Mangen et al., 2009). New programs tend to pay less attention to older programs. For instance, ART programs should have comprehensive prevention interventions. This rarely happens in the public sector because of the number of patients they have to deal with in relation to the staff strengths.

9.7 Need for Increased Reach to At-risk Populations
As previously discussed, despite being defined, there is limited programming for MARPs and yet conspicuous evidence highlights high prevalence rates among these populations. Further research on their demographics and dynamics of the epidemic is needed to guide future actions as the response in targeting these individuals has been minimal.

9.8 One Size Does Not Fit All
BCC has had challenges in a lot of ways because organisations have tried to project uniform messages using billboards etc., but life is more complicated than that. Mass media messages delivered to an entire community, though their reach is especially wide, the personal relevance and specificity of their message is limited, potentially weakening their effect. Language barriers are also a challenge in translating and disseminating HIV/AIDS messages in multilingual and multicultural nations such as Uganda (Namyalo, n.d.). District specific and group specific messages are needed for the greatest response.

“Best practice” strategies in other countries stress the role of government policy, socioeconomic status, culture, gender relations and spirituality in HIV communications, entertainment-education, and communication programmes that involve local communities, local culture and traditional communication media (Okaka, 2009).

According to Parkhurst (2002), tailored messages to local populations are likely to be more effective than messages on any one generalised approach to behaviour change. A UNAIDS study has found that most models for sexual change show some results, but no one model emerges to be most effective. Different individuals and groups need “different motivations, information, or structural change to sustain sexual behaviour change. There is a need to facilitate many locally designed interventions, to propagate a multitude of messages targeted to specific group needs.”
10 Ensuring a More Effective Response to Key Issues

What Defines a Successful Campaign

Effective communication strategies are evidence-based. Evidence provides information about what individual and social behaviours, knowledge, norms, and practices need to change. Effective strategic health communication programs are also based in theory. The theory employed does not need to be complex, but it does need to be appropriate. In other words, the theory should reflect the evidence and the environmental and sociocultural variables specific to the target population (Krenn & Limaye, 2009).

Characteristics of a Successful BCC Program

A successful communication must reach the audience, attract the audiences’ attention, present an understandable message, promote change, and produce a change in behaviour for better health (Hubley, 1993).

When designing messages for any audience, communicators should consider the “Cs” of effective communication. The “Cs” of effective communication:

1. Consistent (messages should not conflict)
2. Constant (ongoing and not intermittent. Uganda’s BCC has been intermittent and is at times based on funding streams from external donors)
3. Current (should be evidence-based)
4. Contemporary (relatable to real life situations and life styles of the intended audience)
5. Comprehensive (should be supported by auxiliary services, e.g. education with HCT, etc.)
6. Coordinated (across parties: which is often not the case in Uganda)

10.1 Improving Behaviour Change Campaigns to Delay Sexual Debut

One way to reduce the spread of HIV infection is by encouraging young people to delay initiating sexual activity. Early sexual debut can place adolescents at increased risk of not only HIV but also other STIs and unintended pregnancy. Youth who begin sexual activity early appear more likely to have sex with high-risk partners or multiple partners and are less likely to use condoms (World Health Organization, 2006a).

Many factors affect the timing of first sex. A WHO review of studies in 53 countries found common protective and risk factors in all regions of the world: positive relationships with parents, teachers, and spiritual beliefs decreased the likelihood of early sex, while risk factors included engaging in other hazardous behaviours and having friends who are sexually active (World Health Organization, 2002).

10.1.1 Comprehensive Sexual Education Programmes

Delay of sexual debut is an important tactic in HIV prevention among youth, resulting in fewer years at high risk (AIDSTAR-One, 2011a). Older age at first sex appears to be one contributing factor in declines in HIV prevalence among youth in sub-Saharan countries with generalised epidemics.

In a review of sex education programmes, it was found that not only emphasis of the avoidance of sexual intercourse among young people, but also discussing the use of condoms and other modern contraceptives to prevent pregnancy and the spread of STIs do not increase sexual behaviour among adolescents and was effective (Kirby, 2011). USAID recommends, instead, comprehensive sexual education programmes that include sex education and information on abstinence, delay of sexual debut, partner limitation, condom use, and contraception (AIDSTAR-One, 2011a). USAID further recommends that efforts to delay sexual debut should be incorporated into such comprehensive sexual education programs and should begin early. They should offer age-appropriate messages over time.
Kirby (2011) found the characteristics of effective sex education programmes to have the following characteristics:

- Based on evidence - Involve experts in research on human sexuality, behaviour change and related theory
- Based on knowledge of target audience - Assess young people’s reproductive health needs, their behaviours, their beliefs and perceptions of risk, their attitudes and skills, and their intentions regarding sexual behaviour, condoms and contraception
- Use appropriate channels - Design activities that are sensitive to community values and consistent with available resources including staff time, staff skills, the space available for group activities and access to supplies
- Piloted - Test the programme using a pilot programme and obtain on-going feedback from the learners about whether and how the programme meets their needs.

Sex education programmes should:

- Focus on clear reproductive health goals
- Address specific situations that might lead to unwanted or unprotected sexual intercourse and develop skills to avoid them and to get out of them if they occur
- Give clear information and messages about behaviours to reduce risk of sexually transmitted infections or pregnancy
- Focus on specific factors that affect the risk of engaging in particular sexual behaviours that are amenable to change by the programme including, for example, knowledge about human sexuality, pregnancy and sexually transmitted infections; values about having sex or having sex with multiple partners and about using condoms or contraception; and intentions to avoid sexual risk behaviour
- Implement multiple, educationally sound activities designed to change each of the targeted factors

10.1.2 Use of Media and Telecommunication

As seen with the Y.E.A.H. Initiative and Straight Talk, radio, newspapers and SMS messages are appropriate and effective ways of communicating with youth.

10.1.3 Include Young People and Parents in Planning and Implementation

When creating behaviour change communication to delay sexual debut, one must involve young people. Assessing needs should be a group exercise involving those who are to benefit and/or be affected: Only young people themselves can describe their situation and how they feel. Participation cannot only ensure that activities respond to young people’s needs, but can also help to improve their psychosocial well-being and build their resilience (Ministry of Gender Labour and Social Development, 2008).

Consult the target group:

“I think we need to go and talk to the people themselves. The answer lies in those delaying and not delaying sexual debut. For the best campaign, it is best to get the youth/adolescents give us the message. They should be consulted on what drives them, so as to understand their needs better. For example can’t they determine and run their own campaign? They are very resourceful and creative, and they understand their needs better.” Key Informant Interviewee for synthesis
“It is important to attract young people by speaking their language. There is also need to tap into new media (social media); need to use entertainment, coupled with celebrity profiling whilst communicating targeted messages. The “peer-peer” approach through peer education should be enhanced. The Ministry of Gender and Social Development has got documents that could be reviewed as learning for the “peer-peer” model.”  

Key Informant Interviewee for synthesis

Many decisions that affect youths’ SRH are influenced by the household they live in. Young people will be influenced by their parents or carers, who may encourage them to abstain from sex or use condoms. In planning, one must identify different types of households, include parents and care givers in the mobilisation, and talk about household situations with young people and their effect on SRH. Parents and caregivers can provide great support to young people if they are sensitised and provided with basic information (Ministry of Gender Labour and Social Development, 2008).

Parental behaviour:

“Even before we get to delayed sex, we need to look at the drivers of particular behaviour. For example what drives the young people into early initiation of sex? It is a whole range of issues including parental responsibilities. There would be no “one tool fits all.” I learned towards the end of last year that one of my first nephews (barely 17 years old), impregnated a neighbour’s daughter. When I tried to figure out what had happened, I found that the neighbour was always going to very far off markets to vend commodities, hence leaving the daughters alone. These girls where then forced to seek for protection from my nephews, claiming that they feared spending their nights in a lonely house.”  

Key Informant Interviewee for synthesis

10.2 Improving Behaviour Change Campaigns to Eliminate Unsafe Sex

Unprotected sex is the leading cause of HIV transmission. When worn correctly, condoms serve the most effective barrier to the sexual exchange of secretions that carry HIV, providing protection against transmission. Consistent and correct use of condoms is associated with lower rates of transmission (AIDSTAR-One, 2012).

Programmes to promote the use of condoms have been implemented at many levels including mass media campaigns, community-level initiatives, and interpersonal communication. They have also targeted people in the general population who engage in higher-risk sex (e.g., multiple partners, concurrent partners, commercial sex workers). Although these initiatives have shown success, male condom use between longstanding sexual partners, such as married couples, does not persist over time. Consistent condom use requires not only long-term individual commitment but a reliable distribution system to provide condoms to people who often lack other basic needs (Hearst & Chen, 2003).
Despite widespread awareness of condoms among Ugandans, limited access, belief in certain condom myths, inadequate knowledge of proper use, and lack of faith in the effectiveness of condoms have all been reported to hinder their use.

### 10.2.1 Increase Availability

Demand for condoms in Uganda, however, exceeds availability. The MoH estimates that Ugandans need about 283 million condoms annually but only 97 million were in stock as of end of November 2012 (Nakkazi, 2013). However, an evaluation of condom use in Uganda found people were more likely to use condoms if condoms were available at sites identified for finding sexual partners, consequently, access to condoms at all sites should be increased (Ssengooba & Ssekamatte-Sebuliba, 2003). With a known shortage of condoms supply must be increased.

### 10.2.2 Increase Knowledge and Acceptability

Besides supply, acceptability of condom use is an issue in Uganda.

> “When those in longer-term relations talked about condoms, they would look like they are promiscuous. The message on condoms hasn’t really worked as well, because you do need people that are married to devote to this. If you think back historically, condoms were one of the first ever available family planning methods, with the main reason being preventing pregnancy. Couples used them. Now they are associated with HIV, promiscuity and all sorts of bad things. But I think the communication needs to be changed, but I do not know whether it is going to be easy to change. Mostly condom use has become like behaviour for young people, people going outside the regular relationship with regular partners, but not people they really care about.” Key Informant Interviewee for synthesis

Many see condoms for “people who are bad” such as commercial sex workers, mistresses, etc. An interview respondent believed,

> “You have to start to make this a normal behaviour that it is something that anybody can do, and not only for a sex worker. It is for anyone who wants to use it, that a condom is like any other family planning method, it is something you can use to protect yourself, against STDs, HIV, and you need to start doing general awareness again, instead of just focusing on high-risk groups.” Key Informant Interviewee for synthesis

Government influence has also had an effect on the use of condoms. An interviewee described the situation:

> “If you look at the message about abstinence, the US government has a lot of funding in for this in Uganda. There
has always been an inclination here since I came in 1994, that you can’t ever talk about using condoms without talking about abstinence. You always had to say Abstinence, Be Faithful, and if you can’t do the two, then use condoms. We are doing these young persons’ campaigns, and the kids are sexually active. And, if we are targeting them, then why are we telling them to abstain? We should tell them to use condoms, they should not move from one partner to another, and if they can’t, they can try to abstain.

George Bush (former US President) came up with these funds for abstinence-only campaigns and made all these rules about where you could put condoms, or where you couldn’t put them. Of course a lot of people in Uganda didn’t like the idea of condom promotion, and therefore there was reason for funding and hence everyone jumped in the band wagon. They took this as a licence not to talk about condoms. We therefore stopped promoting C and concentrated on promoting A and B. The A didn’t work very well, and the B was unrealistic. How can you tell people to abstain? It was just a waste. Then we started talking about promoting condom use among people of high risk e.g. truck drivers, sex workers, MSM, fishermen, hence making it seem like condoms were for these very promiscuous people, hence affecting use.

Honestly if you look at other countries, it is not just abstinence, but with something else. Together this brings the epidemic down. You cut out the condom; then you cut out one third of the equation. I think we have screwed up the campaign, because we haven’t given the people the choice to make their own decision, and associated condom use with all these high-risk groups. I know for young people, they are extremely uncomfortable buying or asking for condoms. In 1994, condoms were something that young people where becoming curious about. It was not something terrible, and they would ask you for condoms, since they wanted them. Now you go to a place, and people ask for them under the cover of darkness.”

Acceptability must be addressed. An intervention in Uganda found evidence that the uptake of condoms was much higher among men who received technical use skills in workshops and were encouraged to use condoms
than those who were not (Kajubi et al., 2005). Comprehensive programmes that promote condom use are of great importance in battling unsafe sex.

**Components of Comprehensive Programmes to Promote use of Condoms**

Recent guidance on HIV prevention recommends programming that combines multiple, evidence-based approaches to increase availability, accessibility, acceptability, and use of condoms in both targeted groups and the general population. Comprehensive condom programming remains an essential component of combination prevention programs. Components of comprehensive condom programmes are identified by the United Nations Population Fund:

- create demand: Understanding the local environment and characteristics of specific client groups is necessary to target individuals at higher risk and the venues they frequent
- increase supply and availability
- ensure high-quality and low cost: Making condoms available for free or at very low cost at key distribution points frequented by men and women (e.g., marketplaces, hair salons, and workplaces) can increase use, and
- address acceptability: Confront prevailing cultural myths and inaccuracies using media campaigns and behaviour change strategies to target specific groups and communities, as well as larger audiences.

10.2.3 Use Social Marketing of Condoms

Distributing free condoms is most effective for high-risk groups, such as sex workers, however condoms given to the general public often go unused. One of the most successful strategies is condom social marketing. Subsidised condoms are sold at affordable prices and promoted under brand names using the same advertising strategies as other consumer products (Hearst & Chen, 2003). The meta-analysis results show that individuals exposed to condom social marketing programmes were twice as likely to report using condoms compared to those who were not exposed (Sweat, Denison, Kennedy, Tedrow, & O'Reilly, 2012).

10.3 Improving Behaviour Change Campaigns to Reduce Multiple Sexual Partnerships

The most important mechanism of HIV transmission in Uganda is through unprotected sexual intercourse with an infected partner. Partner reduction is a prevention strategy focused on decreasing the overall number of sexual partners in order to lessen the risk of becoming infected with or transmitting HIV. Increasingly, partner reduction efforts have focused not only on reducing the number of partners, but also the number of concurrent partners. Multiple concurrent partnerships (MCPs) is the practice of having more than one sexual partner at the same time. MCPs are a major driver of the HIV/AIDS epidemic in Uganda, with the rate of change of sexual partners — and especially the number of concurrent partners — a key determinant in the spread of HIV/AIDS. Reducing the number of partners and more specifically the rate of change of sexual partners is therefore a key risk reduction strategy (Krenn & Limaye, 2009).

During the 1980s and early 1990s, behaviour change campaigns advocating partner reduction and fidelity among couples were launched in the Uganda along with other prevention strategies. Studies provide some evidence that these partner reduction campaigns contributed to the decline in HIV prevalence that began in the early 1990s. More recently, however, a 2011 study concluded multiple sexual partnerships may be more common in Uganda than generally supposed and downplaying the severity of HIV/AIDS is associated with having multiple partners. These findings have important implications for HIV/AIDS epidemiology and prevention (Kajubi et al., 2011).
10.3.1 Address Complex Dynamics of Culture

Partner reduction efforts must take into account complex, interrelated social, cultural, and economic factors. For example, social and gender norms play an important role in perpetuating attitudes and beliefs that encourage, or at least tolerate, men and/or women having multiple or concurrent partnerships. Despite knowledge about HIV transmission and prevention, these cultural factors contribute to people continuing to engage in high-risk partnerships and these must be taken in to account (AIDSTAR-One, 2011b). To effectively reduce concurrent partnerships, interventions must acknowledge this complexity and intervene at multiple levels to address the larger socio-economic factors influencing individual behaviours (Research to Prevention, 2011).

Given low awareness of the risks associated with multiple concurrent sexual partnerships (where partner reduction is usually the focus), programmes can begin by working to increase people’s perception of these risks.

Recommendations from Malawi and Tanzania

Recommendations for addressing multiple sexual partnerships can be learned from a Malawi and Tanzania based study and include the following:

- Address environmental-structural factors that create an enabling context such as poverty, labour migration and alcohol use
- Address unequal gender norms and strengthen injunctive norms against concurrent partnerships
- Strengthening injunctive norms
- Promote partner communication and conflict resolution strategies
- Develop parenting skills to discourage concurrency (Research to Prevention, 2011)

10.3.2 Use a Variety of Approaches

To be most effective, MCP programmes should use a variety of approaches, such as mass media messages, community mobilisation, and interpersonal activities that encourage people to adopt safer sexual behaviours. In creating an effective response, communities should be involved in framing MCP messages so they do not stigmatise specific groups. Information about local culture and behaviour can be used to shape messages to communicate the risks associated with MCP and to target behaviours that place individuals at increased risk of HIV (AIDSTAR-One, 2011c). The Makwapheni Campaign of Swaziland addressed MCP but was terminated early based on several challenges. The programme concluded that its interpersonal communication platforms may have been less than adequate to reinforce the mass media component. The mass media campaign relied too much on short and transient messages, which sparked people’s interest and created awareness, but which ultimately did not allow people to explore issues in depth (AIDSTAR-One, 2009).

10.4 Improving Behaviour Change Campaigns to Discourage Cross-generational Sex

A particular area of concern has been the disparity in HIV infection levels between men and women in many parts of Africa. Sexual relationships between individuals 10 or more years apart in age are referred to as “cross-generational” relationships. While these relationships take different forms, there is often focus on sexual relationships involving older men and young women.

Cross-generational sexual relationships put young women and girls at heightened risk because older men often have higher HIV infection rates than adolescent boys or young men. The age disparity may also decrease a young woman’s ability to negotiate for safer sex for a variety of reasons, including not wanting to challenge an elder (AIDSTAR-One, 2011d). In a review of cross generation sex literature, Luke and Kurz found find two portrayals of adolescent girls and their sexual experiences alluded. First, adolescent girls are depicted as passive victims of the larger structural and cultural factors that shape their risky sexual behaviours. This viewpoint underscores how girls can be “coerced” into behaviours by outside influences, including economic
constraints, peer and parental pressures, and social norms of male dominance and physical control (Wood, Maforah, & Jewkes, 1998).

A second portrayal is of girls as active social agents who rationally choose their behaviours and negotiate their relationships. This viewpoint emphasises that adolescent girls have learned that their sexuality is a valued resource, and they use it to receive money and gifts from older men for sexual services. They may also engage multiple partners simultaneously, in order to maximise the benefits of these relationships. Here, self-perceived risk on the part of adolescent girls is discounted in favour of the rewards received from the relationship (Luke & Kurz, 2002).

Effective programming to address cross-generational sexual relationships builds upon the social and cultural contexts that influence sexual behaviour. Promising practices have included a combination of microeconomic approaches (such as small loans or conditional cash incentives), interpersonal and community activities (such as support groups, youth groups, mentoring programmes, and clubs), and broad-scale interventions using the media. These activities challenge social norms that condone age-disparate sex and give girls support and information to empower them to make healthier choices (AIDSTAR-One, 2011d).

10.4.1 Address Complex Dynamics of Culture

In order to discourage cross-generational sex, the social and cultural factors associated must be addressed. Power imbalances in heterosexual relationships in Africa are the norm, where age, economic, and gender asymmetries have traditionally existed between marital partners. Due to changing social and economic conditions throughout Africa, these imbalances have become even more pronounced in marital and non-marital relationships, a trend that has serious repercussions for the transmission of HIV, particularly for adolescent girls (Luke & Kurz, 2002).

If cross-generational sex is based on real poverty programmatic responses could include:

- Income-generation activities for the girls (or their mothers).

For perceived poverty / habit / peer pressure:

- Parental support to delay sex from a young age (counselling cards for individual counselling to parents that would include encouraging them to communicate their own expectations and values to each child one-on-one)
- Life skills education on setting individual goals, valuing oneself, clarifying values about sex
- Communications to change an implicit norm that is a part of life, and
- Communications, materials, and social support to provide immediate benefits to girls who refuse offers from men (putting a sticker onto a card, and/or telling a youth club leader or religious leader for positive feedback) (Hope, 2007)

10.4.2 Education of Girls

Undoubtedly, education helps girls and women achieve greater control over their lives. Girls educated to secondary and tertiary levels are more likely to wait longer before having sex for the first time and are less likely to be coerced into sex. Girls who complete primary education are more than twice as likely to use condoms; girls who complete secondary education are between four and seven times more likely to use condoms, and they are less likely to be infected with HIV (Hargreaves & Boler, 2006).

For a girl’s belief that she cannot refuse:

- Teach life skills in saying “no” and refusing men (when, how); and
- Enhance community protection (including swift and public sanctions against teachers who have relations with their students (Hope, 2007)
10.4.3 Male Involvement

The greater involvement of men in prevention programmes that challenge gender and other social norms is another important programmatic component. There are several motivations of older men to engage in cross-generational sexual partnerships including regular access to sex, enhancement of prestige, domestic help, and maintenance of health (Luke & Kurz, 2002). These motivations must be challenged.

Emerging good practice in engaging men and boys include group education where activities critically reflect about masculinity and gender norms. Community outreach, mobilisation and mass media campaigns encompass a variety of interventions and approaches including: community meetings; training or sensitisation sessions with traditional providers, community or religious leaders; street theatre and other cultural activities; marches, demonstrations and street and health fairs; and mass media campaigns using radio, television, billboards or other media. WHO found effective and promising campaigns and community outreach reviewed overwhelmingly used positive, affirmative messages showing what men and boys could do to change, affirming that they could change and showing (whether in characters in theatre, television shows, radio dramas or print materials) men changing or acting in positive ways (World Health Organization, 2007).

10.5 Improving Behaviour Change Campaigns to Discourage Transactional Sex

Transactional sex is the practice of exchanging sex for financial or lifestyle rewards. Different from formal commercial sex, transactional sex is thought to be fairly common in sub-Saharan Africa (AIDSTAR-One, 2011d). Young women may engage in transactional sex with men to support their basic needs such as food, clothing, and school fees - or to obtain desirable goods like cell phones, clothing, jewellery, and expensive meals, and the social status that goes with them (Leclerc-Madlala, 2003).

Gifts and money are an intrinsic and pervasive part of adolescent sexual relationships. With a Ugandan study finding three-quarters of unmarried, sexually experienced women aged 15–19 having received gifts or money in exchange for sex suggests that transactional sex may be largely part of normal dating behaviour (Darabi et al., 2008). In southern Uganda, secondary school girls were reported to exchange sex to pay for necessities their parents cannot afford, but half said that, whatever their affluence, they would not have sex for free (Nyanzi, Pool, & Kinsman, 2001).

Such relationships may put women at increased risk of HIV. If material exchange is a young women’s main motivation to have sex, it encourages sexual activity that might not have occurred at all if young women had had other sources of income (Darabi et al., 2008). These women also may lose their power to negotiate condom use. During a study, the majority of respondents in focus groups believed that poor women and girls have extramarital relationships and engage in cross-generational sex in search for material gains, and a high social and economic statuses ending up sexually abused and even contract HIV (Panos Eastern Africa, 2011).

10.5.1 Address Complex Dynamics of Culture

Effective programming to address transactional sexual relationships builds upon the social and cultural contexts that influence sexual behaviour and addresses the social norms that inhibit these relationships. Reducing the acceptability of this practice is a key strategy (Krenn & Limaye, 2009). Given how embedded transactional sex in sub-Saharan African culture it will be extremely difficult to end without deep cultural change (Wamoyi, Wight, Plummer, Mshana, & Ross, 2010).

Promising practices have included a combination of microeconomic approaches such as income generating activities. Preventive interventions are more likely to be effective if they acknowledge the economic importance of sex for young women (Leclerc-Madlala, 2003). Alternative income generating schemes may reduce the transactional sex that is motivated by poverty. It is unclear to what extent providing young girls and women with income-generation opportunities may make them less inclined to engage in transactional sex. Nonetheless, the additional income from income-generation activities may be instrumental in making girls less dependent on a transactional sexual relationship. If a woman feels less reliant on a relationship that includes
transactional sex, she may be better positioned to negotiate condom use and timing of sex (Chatterji, Murray, London, & Anglewicz, 2004).

10.5.2 Education and Empowerment of Girls

Greater educational opportunities are needed. The low level of detailed knowledge about HIV/AIDS and pregnancy prevention shows that there is a great need for comprehensive sex education, including information on abstinence and contraceptive methods, particularly condoms. Comprehensive sex education should be taught to youth in and out of school (Darabi et al., 2008).

BCC programmes such as the “Girls Power Initiative” (GPI) in universities in Nigeria have shown interventions can reduce the likelihood that young women will engage in transactional sex by promoting female empowerment and the ability to say no.

GPI activities include:

- Career Development Tours to industries for exposure to careers beyond the usual stereotypes for females
- Home visits, counselling and referrals
- School outreaches and GPI corners in schools
- GPI Graduates' Forum and alumnae activities
- 16 days of activism against gender based violence
- Economic Skills training workshops
- Daughters/Parents Forum
- Radio and Television programmes managed by GPI girls
- Community intervention and social work by graduating girls

Current Successes

Successes in transactional sex campaigns can also be found in Uganda. In an evaluation of Y.E.A.H.’s Something for Something Love Campaign, positive associations between exposure to the programme and attitudes towards transactional sex were found. Those exposed to Something for Something Love tended to disapprove of men engaging in transactional sex. Exposure was also associated with disapproving young women having sex with sugar daddies.

Moving forward, programmers must identify and account for possible variations in the populations engaged in transactional sexual relationships, where age disparities are not involved, and how these various forms of sexual partnering affect HIV vulnerability in different settings. Successful programmes will also be based on an understanding of specific social norms that influence transactional sexual relationships (AIDSTAR-One, 2011d).

10.6 Improving Behaviour Change Campaigns to Address the Problems of Risk Compensation

The UAC believes the introduction of antiretroviral treatment and other biomedical interventions saw a focus shift to these interventions at the expense of behavioural interventions (Nantulya, 2013). These should rather be viewed as complimentary tools against the spread of HIV/AIDS.

Risk Compensation and ART

In a 2008 study in Uganda, some respondents believed HIV/AIDS was no longer a big threat, noting that ART would enhance positive change because of the provided counselling and the ability to make people live longer and healthier lives. This has created fears and misconceptions that enhanced access to ART will increase risky sexual behaviour and HIV transmission. Prevention programmes which are modified and specific to the needs of PLWHA should be developed and implemented, and should include information that HIV can still be transmitted, even when they are on ART (Atuyambe et al., 2008).
Risk Compensation and Safe Male Circumcision

The recent findings that medical male circumcision (MMC) substantially reduces the risk of HIV infection is an exciting development in HIV/AIDS prevention (Gray et al., 2007). However, this finding has quickly been clouded by concerns that risk compensation—if circumcised men believe that circumcision confers substantial or complete protection against HIV infection, they may engage in increased risk behaviour (Cassell, Halperin, Shelton, & Stanton, 2006). Significant risk compensation could reduce the protective effect of circumcision and possibly result in increased rather than decreased prevalence and incidence of HIV.

Tackling Risk Compensation

Advances in scaling up antiretroviral treatment in resource-poor countries, the benefits of male circumcision and the hoped for promise of pre-exposure prophylaxis and microbicides do not render behavioural strategies obsolete. If anything, behavioural strategies need to become more sophisticated, combined with advances in the biomedical field, and scaled up (Coates, Richter, & Caceres, 2008).

10.6.1 Education

Perceptions of personal risk seem to be associated with motivation to adopt behaviour change (Glanz, 2008). In tackling risk compensation, one must manage potential optimism about innovations in HIV prevention by communicating clearly and broadly that they will not eliminate the risk of HIV infection. Behaviour change should be an integral part of health services. Efforts to promote emerging prevention interventions at the community level should clearly explain the limitations of these approaches and should place emphasis on the adoption of safer behaviours (Cassell et al., 2006).

We must also build on previous successes of Uganda and other countries to appreciate the fact that behaviour change is a feasible and effective approach to preventing new HIV infections. A key aspect of Uganda’s early success was the collaborative development of a widespread perception that all sexually active people were personally at risk and that changing sexual behaviour was the best way to reduce this risk. It is essential that service providers diligently promote behavioural change and communicate the need to continue to engage in risk reduction or avoidance even as new prevention methods emerge (World Health Organization, 2006b).
11 Conclusion

BCC is a very complex and dynamic field. Despite the range of communication campaigns, Uganda’s HIV prevalence is rising. There is therefore need to revisit and revise Uganda’s HIV/AIDS behavioural change communication guidelines/programs and recommend high-impact behavioural change strategies for reducing new infections.
References


AIDSTAR-One. (2011d). *Transactional and Age-disparate Sex in Hyperendemic Countries*.

AIDSTAR-One. (2012). *Comprehensive Condom Use Programs*.


Bagyendera, J. K. (2012). Harnessing SMS technology to monitor and scale up access to services ND.


