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FINAL EVALUATION OF THE HEALTH COMMUNICATIONS PARTNERSHIP (HCP II) PROJECT

FINAL REPORT

April 19, 2013

This document was produced for review by the United States Agency for International Development (USAID/Uganda). It was prepared by i-Train and Evaluate Center (i-TEC).

FINAL EVALUATION OF THE HEALTH COMMUNICATIONS PARTNERSHIP PROJECT (HCP II)

Final Report

Submitted by

I- TRAIN AND EVALUATE CENTER (I-TEC)
Plot 19, Ntinda View Crescent - Naguru
P.O Box 918, Kampala – Uganda
Phone: +256 – 772 – 193860/ +256-775-772771
Fax: +256 - 312 - 283585
E-mail: rrwampororo@evaltrain.com; Kasingye@aol.com
Website: www.evaltrain.com

Contracted under Order Number: AID-617-O-12-00013

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ACKNOWLEDGEMENTS

i-TEC team wishes to express its deep appreciation for the guidance and accessibility provided by the USAID/Uganda Mission to various relevant stakeholders who were involved in the HCP II project implementation. These included but were not limited to the government and institutional partners, implementing partners, GOLD (Generating Opportunities for Leaders and Professional Development) program graduates, community members who also willingly participated in the focus group discussions, and HCP II senior project management and staff. Specifically, our special thanks go to USAID/Uganda Mission Director, Ms. Leslie Reed and the HCP II Final Evaluation Task Managers (Ms. May Mwaka, Ms. Rhobbinah Ssempebwa, and Ms. Charmaine Matovu) who provided us with technical feedback. The Mission team was involved as key informants during the design stage. They reviewed our evaluation instruments and responded to some of our evaluation questions. They also provided comments and observations on the draft report.

Special thanks also go to HCP II staff both at Headquarters and in the field, especially the Chief of Party, Ms. Cheryl Lettenmaier, without whose unwavering support it would not have been possible to conduct and complete this evaluation exercise successfully. The HCP II team were also instrumental in providing the program overview, reviewing and harmonizing the program's secondary data, and following up with locating the respondents included in this evaluation field exercise.

Our appreciation goes to Dr. Esther Kaggwa and her team for providing us with the data generated from the survey conducted by John Hopkins University (JHU) on the "Evaluation of Behavior Change Interventions in Uganda" without which our findings would not have been as rigorous. The extra quantitative data helped us to triangulate findings from different sources and validate many of our conclusions.

Our sincere thanks also go to all the stakeholders in the 12 districts covered during this evaluation exercise for their valuable time and support. Many thanks also go to the youth, PLHIV, media organizations, and community members who participated in the consultations.

THE i-TEC EVALUATION TEAM

USAID/UGANDA commissioned i-TEC (i-Train & Evaluate Center), a recognized performance-based evaluation consulting firm in East & Southern Africa (ESA) Region, based in Kampala, Uganda to design and conduct the external final evaluation of the HCP II project (2007–2012). A multidisciplinary team comprising of experienced evaluators drawn mainly from Uganda conducted the evaluation, with overall coordination and technical guidance provided by Dr. Rosern K. Rwampororo, i-TEC's President.

The rest of the team members included other i-TEC Senior Associates as follows: (1) Mr David Ouma Balikowa, who was the Team Leader for the Eastern Region; (2) Mr John Bosco Asiimwe, as Team Leader for Western Region; (3) Ms. Emilly Kemigisha, as Team Leader for Central; and finally (4) Ms. Pross Kansiime Karangizi, as Team Leader for Northern Regions. The team was supported by a group of seven experienced Research Associates, drawn from the Institute of Statistics, Makerere University. However, i-TEC takes full responsibility of the final product.

LIST OF ACRONYMS:

ACP	AIDS Control Program
ACTs	Artemisinin-Based Combination Therapies
AIC	AIDS Information Center
AIDS	Acquired Immune Deficiency Syndrome
AIM	AIDS/HIV Integrated Model District Program
AIS	AIDS Indicator Survey
ART	Antiretroviral Therapy
ARV	Antiretroviral
AMREF	African Medical Research Foundation
ANC	Antenatal Care
BCC	Behavioral Change Communication
CBOs	Community-Based Organization
CDCS	Country Development Cooperation Strategy
CDFU	Communication for Development Foundation Uganda
CHCT	Couple HIV Testing and Counselling
DCC	District Coordination Committees
DO	Development Objective
DHE	District Health Educators
EMHS	Essential Medicines and Health Supplies
ESA	East and Southern Africa
FBO	Faith-Based Organization
FGD	Focus Group Discussion
FP	Family Planning
FPRWG	Family Planning Revitalization Working Group
GBV	Gender Based Violence
GEM	Gender Equitable Male
GOLD	Generating Opportunities for Leaders and Professional Development
GOU	Government Of Uganda
HCT	HIV Counselling and Testing
HCP	Health Communication Partnership
HIPS	Health Initiatives for Private Sector
HIV	Human Immunodeficiency Virus
HSSIP	Health Sector Strategic & Investment Plan
IEC	Information, Education, and Communication
IDI	Infectious Diseases Institute

IPs	Implementing Partners
IPTP	Intermittent Preventive Treatment in Pregnancy
IR	Intermediate Result
IRS	Indoor Residual Spraying
i-TEC	I-Train and Evaluate Center
ITN	Insecticide Treated Mosquito Net
JCRC	Joint Clinical Research Center
JHU	John Hopkins University
JHU•CCP	John Hopkins Bloomberg School of Public Health Center for Communication Programs
KII	Key Informant Interviews
LCs	Local Councils
LLINs	Long Lasting Insecticide Treated Mosquito Nets
M&E	Monitoring and Evaluation
MJAP	Mulago – Mbarara Joint AIDS Program
MoH	Ministry of Health
MHS	Management Sciences for Health
MUSPH	Makerere University School of Public Health
NACWOLA	National Community of Women Living with HIV/AIDS in Uganda
NGOs	Non-Governmental Organizations
NUMAT	Northern Uganda Malaria AIDS and Tuberculosis Program
PACE	Program for Accessible Health, Communication, and Education
PLHIV	People Living with HIV
PMP	Performance Management Plan
PMTCT	Prevention of Mother to Child Transmission
PSFU	Private Sector Foundation Uganda
RDL	Radio Distance Learning
RHU	Reproductive Health Uganda
RLOs	Regional Lead Organizations
SBCC	Social and Behavior Change Communication
SCFU	Save the Children Fund Uganda
SCFUSA	Save the Children Fund USA
SMC	Safe Male Circumcision
SMP	Stop Malaria Project
SO	Strategic Objective
SOW	Scope of Work
SPEAR	Supporting Public Sector Workplaces to Expand Action and Responses against

	HIV/AIDS
STARs	Strengthening TB and HIV/AIDS Responses
STAR-E	Strengthening TB and HIV/AIDS Responses in Eastern Uganda
STAR-EC	Strengthening TB and HIV/AIDS Responses in East Central Uganda
STAR-SW	Strengthening TB and HIV/AIDS Responses in South Western Uganda
STIs	Sexually Transmitted Infection
SUSTAIN	Strengthening Uganda's Systems for Treating AIDS Nationally
TASO	The AIDS Support Organization
TAT	Technical Advisory Team
TB	Tuberculosis
TBCAP	TB/HIV Communication Campaign Partners
TOT	Training of Trainers
UAC	Uganda AIDS Commission
UBOS	Uganda Bureau Of Statistics
UDHS	Uganda Demographic and Health Survey
UHCA	Uganda Health Communications Alliance
UHMG	Uganda Health Marketing Group
UNICEF	United Nations Children's Fund
URC	Uganda Red Cross
USAID	United States Agency for International Development
VCT	Voluntary Counselling and Testing
VHTs	Village Health Teams
VMMC	Voluntary Medical Male Circumcision
YAGs	Young People Advisory Groups
Y.E.A.H	Young Empowered And Healthy

EXECUTIVE SUMMARY

Background:

1. Health Communication Partnership (HCP II) was a five-year project funded by USAID to develop and implement communication strategies on HIV/AIDS, tuberculosis (TB), family planning, and malaria and strengthen capacity in social and behavior change communication (SBCC) for improved health in Uganda. The HCP II objective on improved abilities of communities, families, and individuals to adopt practices that improve health is in line with the priorities of the Government of Uganda (GoU), which recognize the critical role of Behavior Change Communications (BCC). This $18 million project was implemented and managed by The John Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) from 2007-2012. Based on a design rationale to ensure streamlining of BCC activities from the national level to the grassroots and the desire to reach a wider target audience, the project was implemented through a network of partners: government entities such as the Ministry of Health (MoH) and the Uganda AIDS Commission (UAC); institutional partners such as the AIDS Information Center (AIC); the Communication for Development Foundation (CDFU) and a large number of local and international implementing partners including USAID funded partners.

Evaluation Purpose, Design and Methodology

2. The purpose of the HCP II project final evaluation was to assess the effectiveness of the major BCC approaches implemented under the project and to identify factors for success. Lessons learned and good practices from this evaluation will be used to inform designs of future health communication interventions by USAID and the Government of Uganda. The evaluation was conducted by i-Train and Evaluate Center (i-TEC) team from August 6, 2012 to March 31, 2013. i-TEC used a mixed-methods approach that entailed both quantitative and qualitative data collection techniques to arrive at the answers to the evaluation questions. The team triangulated data generated from various methods: (i) document reviews; (ii) key informant interviews with beneficiaries and key implementers such as HCP II staff and partners; (iii) focus group discussions (FGDs) with adults, youth, and people living with HIV; (iv) stakeholder analysis; (v) observations of signage and posters while in the field and/or at health facility sites; (vi) trend analysis of secondary data (HCP 2008 baseline and the 2010 midterm evaluation) plus data generated from the survey conducted by John Hopkins University (JHU) on "Evaluation of Behavior Change Interventions in Uganda," referred to as "BCC Evaluation, 2012" herein after.[1]

Key Findings

3. Extent of achievement of Strategic Objective on *Improved abilities of communities, families, and individuals to adopt practices that improve health:* - Evidence from the analysis of project monitoring and survey data indicates that the objectives of the HCP II program have been partially met; data on two out of the five selected performance measures at the SO level indicate that there has been an improvement in adoption of some healthy practices like HIV testing, disclosure of results amongst partners and use of modern family planning methods from the baseline in 2008 to 2012. However, there is an increase in risky sexual behavior across the different age groups[2]. Findings from youth FGDs indicated that adolescents were beginning to

[1] The decision to use data from the BCC Evaluation 2012 resulted in a two months lag in the contract.

[2] The two out of five performance measures achieved include: (i) percent of men and women 15–49 years old who took an HIV test and received their results in the last 12 months, from 38 to 76 percent for women against the Life of Project (LOP) target of 50 percent; and for men from 26 to 61 percent against an LOP target of 40 percent; and ii) percent of women aged 15-49 who are currently using any modern family planning method, from 25 to 35 percent against LOP target of 34 percent. The three measures, whose targets were not achieved include: (i) percent of sexually active men and women aged 15–49 years who know the HIV status of their sexual partner(s), from 51 to 53 percent against the LOP target of 59 percent; (ii) percent of sexually active males and females (15–49 years old) who had sex with only one partner in the

have sex as early as 15 years of age. Gender differences in the extent of change indicate a need to target women in future interventions**.**

4. Extent of achievement of Intermediate Result 1 on *Effective communication strategies designed and implemented to increase appropriate use of services and/or practices across identified priority programs:-* The key implementation approach under the HCP II project was to work jointly and support the MoH as a central government partner, other government institutions, and implementing partners (IPs) to develop and/or revise several communication strategies in HIV/AIDS, HIV/TB, family planning, and malaria. HCP II rolled out the above stated communication strategies through various programs implemented with the different implementing partners. HCP II promoted a multimedia approach for delivery of messages i.e. interpersonal communication; mass media and community-based activities. Evidence from various studies was used to inform the various campaigns and choice of media. Achievement under each key program area was as follows:

   HIV/AIDS: Despite the design and implementation of multiple strategies and campaigns to address HIV/AIDS, comprehensive knowledge about its transmission and prevention has stagnated between the baseline in 2008 and in 2012 at about 53 percent. There was evidence of declining trends in urban areas from 60 to 58 percent as compared to 52 to 51 percent in the rural areas. The evaluation discovered no significant relationship between comprehensive knowledge and the HCP II supported Rock Point 256 program and the National Health Hotline. Further analysis indicated that increased knowledge is linked to likelihood of adoption of risk reduction practices such as persistent condom use and reduced number of sexual partners. On the other hand, findings of the Uganda AIDS Indicator Survey (AIS) 2011 indicate that there is still a large proportion of the population (84%) still have more than two sexual partners and are not using condoms, an issue that can be addressed through BCC to contribute to reduction in HIV rates.

   a) There was an increase in knowledge practice of voluntary safe male circumcision (SMC) from 31 percent in 2008 to 81 percent in 2012. The evaluation revealed a significant and positive relationship between the HCP II supported Stand Proud, Get Circumcised Campaign and SMC practice especially amongst the youth (15-24 years).

   b) About 60 percent of respondents of the BCC Evaluation 2012 said they had seen or heard messages about the HCP supported campaign on HIV testing "*Go Together, Know Together"* in the past 12 months. Those who got the "Go Together, Know Together" campaign messages were influenced to take some action on testing and disclosure of status. Initially HIV testing was made easier by a policy adopted by Health Centers to testing every patient who reported with any sickness for HIV but this has been affected by stock-outs of HIV testing kits.

   c) Though there was no quantitative data to provide a concrete picture on adherence to ART by PLHIV, FGD participants indicated that they try to adhere to the treatment, visit health facilities whenever they fall ill, eat a balanced diet despite the economic hardships, and use condoms to prevent reinfection and infecting others. However, PLHIV also reported that it is difficult for adolescents to adhere to ARVs because of fatigue, while others fear being seen taking ARVs.

   Family planning: Results indicate that listening to the Nurse Mildred radio drama series was statistically significant (p-Value = 0.002) and was linked to current use of a family planning method. About 40 percent of those who were currently using a family planning method had listened to the radio program, compared to 67

past 12 months, from 83 percent to 72 percent against LOP target of 90 percent; (iii) There is a decline in the percent of unmarried young men and women aged 15–24 years who "have never had sex," from 52 percent in 2008 at baseline to 47 percent in 2012 against the LOP target of 57 percent.

percent who had not heard the Nurse Mildred message and were currently not using any family planning method.

Malaria: Evidence from the FGDs indicated that communities visited were knowledgeable about malaria across all regions. The knowledge has translated into behavioral change in terms of an increasing trend in the ownership and use of mosquito nets from 34 to 74 percent, according to the UDHS as a context at the national level.

5. Though BCC messages were instrumental in stimulating people to adopt practices and seek health services, observations at health facilities and interactions with patients have revealed that these services are not always available. Health service delivery is being impacted by low staffing levels and availability of products at the health centers which limits the full enjoyment of health communication benefits.

6. Extent of achievement of Intermediate Result 2 on *Supportive social environments fostered, to enable positive health-seeking behaviors and result in healthier individuals, families, and communities: -* As part of ensuring public support for services and practices that promote youth, HCP II supported MoH and the Uganda AIDS Commission (UAC) who are responsible for supporting policy formulation, providing direction, execution, leadership, and strategy development in the implementation of health communication programs. HCP II supported the roll out of the new policies in support of adoption of healthy behaviors. Increased awareness on the SMC and alcohol abuse policy was registered. However, there is decline in awareness of any law or government of Uganda policy regarding TB from 36 to 27 percent, which was attributed to the short (one year) duration of the TB campaigns.

   a) HCP II implemented the Y.E.A.H Campaign to raise consciousness and dialogue about social issues targeting mostly the youth. The campaign used media like Rock Point 256 (weekly radio drama series) and comic book series and youth groups such as the Young People Advisory Groups (YAGs). Audience feedback through listenership surveys by radio stations showed that Rock Point 256 had increased station listeners, especially the youth. Though there is an indication that messages from Rock Point 256 have influenced youth to take positive health actions, tests for significance did not fully confirm this association. YAGS and other youth group volunteers trained by HCP II as peer educators facilitated group discussions among the youths using comic books and videos to trigger discussions. On the other hand, findings from FGDs show that communication between adults and young people has not been strengthened.

7. Extent of achievement of Intermediate Result 3 on I*ncreased capacity for sustained health communication: - MoH* has increased its capacity to deliver quality health services through trained staff and health workers, particularly counsellors and VHTs for community mobilization. Practical skills development and partnerships have been created between MoH, AIC and other partners through their direct participation in the development and implementation of health campaigns and IEC materials. The project provided public access to communication strategies and materials during its tenure at the following web link www.k4health.org/toolkits/hcp. HCP II built the skills of health communication journalists to improve reporting on health issues to the target population. A total of 400 journalists from hosts of health talk shows at 21 radio stations around the country received training. The BCC working group, a strategic multi-stakeholder forum for coordinating and harmonizing BCC activities under the leadership of MoH, started with the support of HCPII is not functioning any more.

Effectiveness of BCC approaches

8. HCP II was conceived by USAID as one focal health communication project designed to support communication activities of various partners in the health sector. Government representatives have appreciated this as an effective model for promoting uniformity in health messages. Working together resulted in using single communication strategies for an individual health problem instead of having parallel ones. This model has also limited the duplication of activities and conflicts among the implementing partners as a result of better coordination.

9. To bridge the skills gap on health communication among implementing partners, HCP II through the *Generating Opportunities for Leadership and Professional Development,* GOLD, program set out to increase the number of young Ugandan professionals with the required job skills. The program trained 200 young professionals, with a 60 percent completion rate. About 93 percent of graduates trained are currently employed as health communications specialists in USAID-funded projects and others in the private and media sector. Out of the GOLD graduates interviewed, 64 percent said they were satisfied with the skills acquired during this internship. Some USAID funded IPs – a target group for absorbing these professionals sighted budgetary constraints to hire and fill communication positions at their organizations. The GOLD program is now run by the Private Sector Foundation of Uganda (PSFU) but its sustainability remains hinged on securing extra funding.

10. Given the high numbers of Village Health Teams (VHTs) country wide, HCP II designed the *Radio Distance Learning* program (RDL) as a low-cost option for refresher and continuing training. This has improved the VHTs' knowledge on health issues and their roles. Complaints on the lack of face to face interaction follow up by HCP and inadequate equipment for VHTs have been addressed by World Vision and UNICEF in the roll out of RDL into other districts.

Lessons Learned & Implications for Future Designs, Capacity Enhancement, & Partnerships:

11. To achieve its goal, HCP II implemented seven strategic approaches most of which were very effective. However, given the challenges cited in relation to each approach, it is necessary to change and/or improve the way future approaches should be designed. The following are some examples of strategies that will need to be continued and improved:

    a. **Promoting and directing clients to services:** Radio is still the most cost-effective channel to bring health messages to mass audiences. This is one communication medium that should be continued along with other multimedia channels like inter-personal communication and print.
    b. **Focusing on underlying social issues that influence behavior:** The gap in communication between adults and young people is a hindrance to the creation of a supportive social environment for youth. It is also important to note that some behaviors are challenging to change in the short run because of people's beliefs and traditions.
    c. **Strengthening strategic communication capacity:** Sustainability of this strategic approach is a challenge for MoH and IPs because it is costly to produce IEC materials that are used to promote positive behaviors and use of health services.
    d. **Fostering public supportive social environments:** Environments fostered though MoH and UAC for policy formulation, direction, execution, and leadership are still essential for any future design. What may need to change is the nature of the partnerships in terms of both accountability and resource mobilization for sustainability of the BCC programs.

e. **Building coalitions and strengthening partnerships:** This approach should be continued with a focus at the community level. HCP II worked well through partners to form coalitions mainly at the national and district levels. However, the failure by HCP II partners to allocate their own resources to support the continuation of HCP II interventions affected their ability to continue funding the activities after the end of HCP II.

Conclusions

12. Behavior change communication programming under HCP II has been effective in improving the abilities of communities, families, and individuals to adopt practices that improve health. Behavior changes in reduction in risky sexual behavior practices, uptake of SMC and HIV testing, and use of family planning methods have been linked to HCP programs. However, the National Health Hotline and Rock Point 256 program were not as effective in improving levels of comprehensive knowledge on HIV and health behaviors like use of family planning amongst its target community i.e. 15–24 year olds.

13. Levels of comprehensive knowledge on HIV/AIDS, risky sexual behavior (not using condoms and having multiple partners) especially among young men in the 15–24 age group, voluntary male circumcision especially among the 25–49 age group and use of contraceptives still remain below the targets set in the Health Sector Strategic Investment Plan and present areas for further investigation and development.

14. While behavioral communication interventions may stimulate healthy behaviors, current staffing and drug shortages at the health facilities are affecting access and utilization of services. Health services like SMC, HIV counseling and testing, and family planning need to be readily available and affordable to enable communities practice the newly acquired behaviors that will lead to better health outcomes.

15. HCP II as a focal organization on communication was deemed an effective model in terms of ensuring uniformity of behavior change messages and communication materials used. This approach also resulted in cost savings by avoiding duplication of efforts and cost savings as a result of working through partnerships. Strong relationships and leadership by the Ministry of Health was instrumental in coordinating multiple partners and enlisting commitment to use of IEC materials developed.

16. The Radio Distance Learning (RDL) designed as a cost effective mechanism for reaching the numerous VHTs across the country was successful in imparting knowledge to these teams who are regarded as the frontline service providers to communities. Efficiency gains are coming at a cost of potential effectiveness. Motivation of VHTs is a key issue that still needs to be investigated and addressed.

17. The capacity of MoH, local implementing partners, and USG implementing partners in behavior change communication has been improved as a result of the practical and targeted training, access to formative research, and joint design, development, and implementation of behavior change communication strategies and campaigns facilitated by HCP. The BCC implementers in Uganda now have access to e-resources on communication strategies and tools that can be reproduced upon demand.

18. HCP II supported communication campaigns, training and other capacity building initiatives like the GOLD program have not been found to be sustainable. Without HCP II and in other cases USG funding that is currently supporting several health projects, the MoH and local partners cannot continue to run health communication programs including re-production of materials due to inadequate financial resources.

Key Recommendations

Recommendations	Responsible Entity (ies)
Project Design, Strategies, and Approaches	
1. Ensure that projects follow the new project design guidance (2011), and have clearly defined performance indicators at all levels that meet the ADS 203 standards for good indicators.	USAID
2. Continued use of multimedia channels including interactive radio and drama series as communication mediums for reaching a larger target audience.	BCC Partners
3. Future programming should reconsider the target group and thereby the continued use of the national Health Hotline vis-à-vis the costs involved in running it.	MoH & BCC partners
4. Explore other appropriate strategies aimed at bridging the communication gap between adults and the young people (15-24 years).	MoH
5. Investigation into drivers and barriers affecting improvements in comprehensive knowledge on HIV/AIDS, risky sexual behavior especially among young men in the 15–24 age group, voluntary male circumcision especially among the 25–49 age group and use of contraceptives should be conducted to inform designs of appropriate interventions.	MoH, USAID and BCC Partners
6. The Ministry of Health should intensify efforts in improving availability and accessibility of critical health services through better staffing, provision of drugs, and health commodities to absorb the demand created through behavior change communication activities.	MoH
7. USAID should continue using a single communication partner with the capacity to coordinate and lead activities and provide technical assistance thus ensuring uniformity, efficiency, and leveraging of resources. A close partnership with the MoH is important to ensure a buy-in from other partners and rolling out of common messages, skills, and products.	USAID
Implementation & Achievement of Results	
8. Strengthen the BCC working group and develop a long-term resource plan for BCC activities to ensure continued implementation of BCC activities.	MoH & BCC Partners
9. BCC partners need to mobilize adequate resources to support the continued production of IEC materials in order to sustain the momentum created thus far.	BCC Partners
10. Future interventions should widen the age bracket to include adolescents who are below 15 because they are also becoming sexually active.	MoH
Strengthened Institutional Capacity	
11. In order to improve service delivery, future programming should consider improving and rolling out the RDL program nationwide since the program was effective in improving the skills of VHTs that serve community needs directly.	MoH

1.0 INTRODUCTION

The United States Agency for International Development (USAID) funded the Health Communication Partnership (HCP) II project to develop and implement communication strategies and strengthen capacity in social and behavior change communication (SBCC) for improved health in Uganda. This project, funded to the tune of about $18 Million, was implemented and managed by The John Hopkins Bloomberg School of Public Health Center for Communication Programs (JHU•CCP) from 2007 to 2012. This was a follow-on project to expand communication activities initiated between 2004 and 2007under a previous USAID award.

a) Social and Behavioral Change Communication

Behavioral Change Communication (BCC) activities in health have been on going in Uganda for a long time, disseminated mostly through radio and television, talk shows, features and documentaries, plus newspapers. The onset of HIV/AIDS in the mid-1980s intensified the use of BCC in order to slow down the spread of the pandemic by encouraging safer sexual practices. The MoH AIDS Control Program (ACP) added the use of Information, Education, and Communication (IEC) materials, while UNICEF in the early 1990s supported various BCC activities where children performed plays on HIV and child killer diseases. In addition, USAID-funded projects such as AIDS/HIV Integrated Model District Program (AIM) in 2001-2005, implemented a BCC collaborative partnership with selected local governments and used BCC to increase understanding of HIV and TB link, PMTCT, VCT, male participation, and ABC strategy in the different regions of the country.

However, the BCC activities were limited in scale, uncoordinated, and too scattered. The majority of them were not evidence based, not participatory in nature, and not developed following a systematic process. They were also mostly vertical, focusing on knowledge and behaviors at the expense of horizontal aspects such as the social environment. A supportive social environment was essential for influencing the adoption of health practices as well as the capacity of the service providers at the community level. BCC is an important component of the USAID/Uganda strategy as a supportive intervention for service uptake in the health sector. It is on this basis that USAID supported the comprehensive BCC initiative under HCP II to implement a broad communication support to the health sector in Uganda.

The underlying rationale behind the design and implementation of the HCP II project was that BCC should be organized and streamlined from the national level down to the grassroots. HCP II worked with the MoH, as the central government agency responsible for health promotion and education to lead and coordinate the design of evidence-based communication strategies, BCC and IEC materials, and provided capacity building to MoH and other implementing partners including the USAID funded partners[3] to design and implement effective BCC interventions.

The objective of HCP II was to improve the abilities of communities, families, and individuals to adopt practices that improve health through health communication. The HCP II goal, which focused on behavior change communication, is aligned to the MoH Health Sector Strategic Investment Plans (HSSIP 2005/06–2009/10 and 2010/11–2014/15) objectives. Among these objectives, HSSIP identified strengthening IEC materials used for BCC initiatives in order to bring about changes in health and related behaviors among the people of Uganda as one of the key interventions. However, the plan notes that lack of funds to produce IEC materials was affecting the ability of the MoH to meet the increasing demand for health information in the communities. HCP II was therefore able to fill such a gap and also supported other areas such as the media and VHTs, which are also listed in the plan as some of the key interventions necessary for health service promotion and health-seeking behaviors (HSSIP 20010/11–2014/15; p. 53–56).

[3] According to HCP II Report of 2012, there were 77 HCP II partners (5 government partners, 6 institutional partners, and 66 IPs. About 22 IPs are USAID-funded partners)

b) HCP II Project Summary

The HCP II project objectives were also aligned with Development Objective 3 (DO3) –*Improved Health and Nutrition Status in Focus Areas and Population Groups,* under the new Country Development Cooperation Strategy (CDCS). USAID working together with GoU, civil society, and the private sector provide support to address the heavy disease burden, malnutrition, and unmet need for family planning as well as to improve health service delivery systems and literacy rates. BCC interventions therefore provide the link to DO3 outcomes by creating demand for health services and are also crucial for enhancing adoption of health-seeking behaviors.

It is against this background that on July 1, 2007, USAID signed a new $6,000,000 Associate Cooperative Agreement with The John Hopkins University through the Health Communications Partnership to implement a three-year program of broad communications support for the health sector in Uganda. The agreement was later extended two years, through 2012. The purpose of this five-year program (HCP II) was to bolster the effectiveness of communication programming and implementation under the SO 8 Objective (Improved Human Health), and later DO3. Under this award, John Hopkins was expected to do the following tasks:

- Continue ongoing communication initiatives and partnerships such as Y.E.A.H, Be A Man, and TREAT and support malaria and family planning (FP) efforts, while initiating new areas of assistance and support (e.g., for tuberculosis (TB) and HIV counseling and testing).
- Contribute to shaping societal norms to enable social and behavioral change to take place.
- Contribute to capacity building of the Ministry of Health and local implementing partners (IPs) and increase the professionalism and standards of communication approaches that are most popular in Uganda including media, music, and drama.
- Serve as the source of expertise on communications for other IPs including development of communications materials to support their activities' intermediate results (IR) expected of HCP II, along with key results for each IR.

HCP II project was working in collaboration with other partners such as the Ministry of Health, the Uganda AIDS Commission (UAC), institutional partners such as the AIDS Information Center (AIC), and the Communication for Development Foundation (CDFU) as well as a big number of local and international implementing partners. About 22 out of the 66 IPs were funded by USAID. HCP II worked with selected districts to implement BCC activities and disseminate messages that ultimately contribute to changing attitudes and behaviors.

The HCP II Conceptual Framework

The "Pathways to Community Health" model was the conceptual framework underlying implementation of the HCP II project. This model identifies four communication domains: *engage individuals*, *stimulate community dialogue and action*, *create an enabling environment*, and *make services more user-friendly*. According to this model, the underlying theory of change stipulates that strategic communication interventions that address barriers in these domains will result in positive *changes in individual behavior and social norms, more supportive environments, and strengthened institutional and service system capacity*; these, in turn, *will contribute to improved health.* To achieve its goal, HCP II used seven strategic approaches: (1) help make services more clients centered; (2) promote and direct clients to services; (3) focus on underlying social issues that influence behavior; (4) improve community mobilization capacity; (5) form strategic partnerships with leaders and media representatives; (6) strengthen strategic communication capacity; and (7) build coalitions and strengthen partnerships.

c) Evaluation Purpose

The purpose of the HCP II project final evaluation was to assess the effectiveness of the major BCC approaches implemented under the project and identify factors for success. USAID/Uganda identified three key evaluation

questions (outlined below) to be answered by the evaluation in order to document major achievements in behavior change and successful approaches that contributed to these achievements. In addition, the evaluation was tasked with identifying HCP II's limitations, challenges, and opportunities for improvement (what could have been done differently to add to project achievements). Finally, the evaluation was also meant to establish lessons learned and good practices that should be adopted in future programs. Information from this evaluation will be used to inform designs of future program work by USAID and the Government of Uganda. The evaluation Scope of Work (SOW)[4] questions were as follows:

1. To what extent did HCP II achieve each and all expected outcomes under the three intermediate results?

2. Which project approaches contributed to major project achievements, and which project approaches may have resulted in poor or less-than-expected performance?

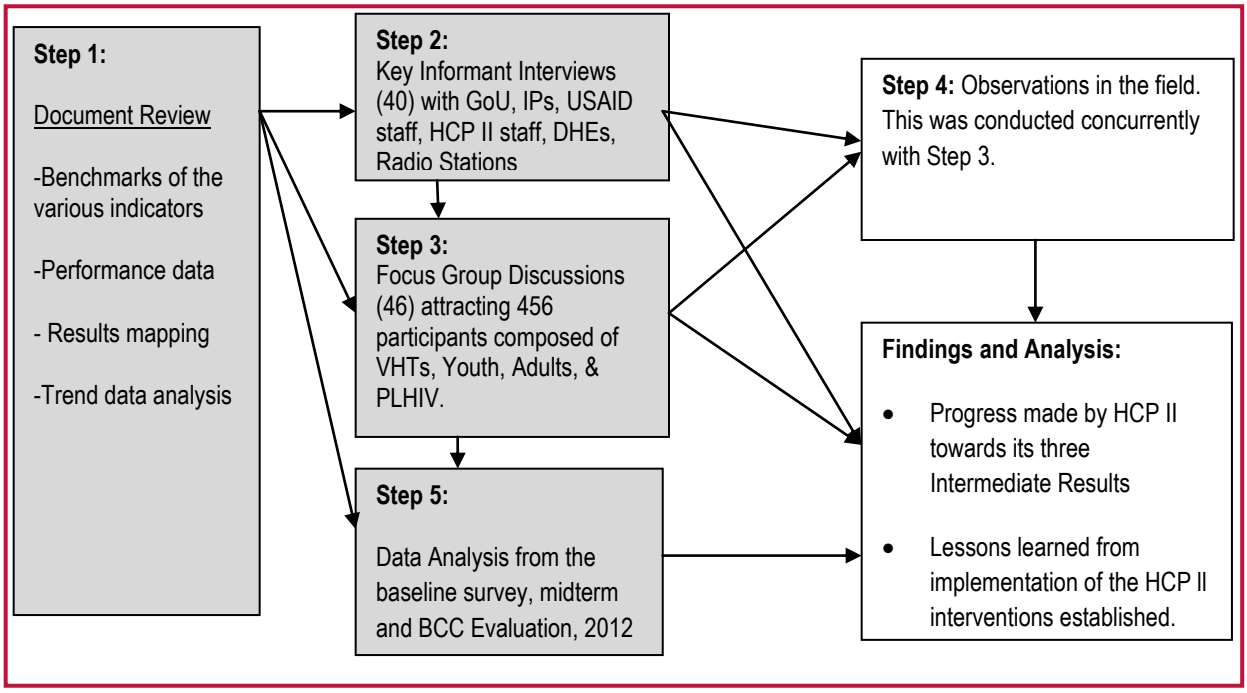
3. What is the impact of HCP II on the capacity of local IPs and the MoH to conduct communications activities without continued technical assistance?

2.0 EVALUATION DESIGN AND METHODOLOGY

2.1 Approach and Methodology for Addressing the Key Evaluation Questions

i-TEC used an evaluation approach that entailed mixed methods (both quantitative and qualitative), which was necessary to facilitate triangulation of data from all the different sources in order to corroborate findings. This approach ensures that the evaluation fully responds to the key evaluation questions as well as the purpose of the evaluation. The schema on how mixed methods were triangulated is presented in **Figure 1** below.

Figure 1: Triangulation of Methods



[4]The detailed SOW is attached as Annex 7.1

The detailed description of each of the qualitative and quantitative approaches, plus the major phases of this final evaluation is included under **Annex 7.2, Section A.**

2.1.1 The Selection of Districts and Target Population

For its own data collection, i-TEC evaluation team selected a purposive sample of 12 out of the 14[5] districts that were covered in both the 2008 and 2010 surveys, all of which are part of the districts that were also covered in the BCC Evaluation, 2012. Collecting qualitative data from districts similar to the survey enhanced comparability of results. The target population was selected from the women ages 15–49 and men ages 15–54, including youth. The list of selected districts is attached in **Annex 7.2, Section B.** The list of key informants and Focus Group Discussions is attached in **Annex 7.2, Section C and D** respectively. The list of Health Centers and Hospitals visited is also attached in **Annex 7.2, Section E.** The tools used for data collection are also attached at end of the report in Annexes 7.10 – 7.12.

2.1.2 Data Analysis Used in Getting to the Answers

Data analysis to generate the answers to specific evaluation questions as stipulated in the SOW entailed both quantitative and qualitative data analysis methods. Content analysis was used to analyse and interpret findings from the key informant interviews and focus group discussions. Trend analysis and results mapping were used to analyze the quantitative data. To corroborate findings, the final evaluation also used quantitative survey data drawn from the BCC Evaluation, 2012 conducted by John Hopkins in order take advantage of a much bigger sample. The BCC Evaluation is relevant to the HCP II final evaluation because it provides the necessary project performance status data in districts that are comparable to both the baseline and midterm surveys conducted by the HCP II project. Quantitative data analysis was carried out using SPSS on a number of data sets, including the following:

1. The HCP II baseline data that was undertaken in 2008 with a total of 2,438 respondents by John Hopkins University (JHU) Center for Communication Programs
2. The HCP II midterm evaluation survey data that was undertaken in 2010 with a total of 2,635 respondents was also undertaken by JHU.
3. The BCC Evaluation, 2012 by JHU with a national representative sample of 7,593 respondents. However, the analysis for this HCP II final evaluation is based on a sample of 2,246 respondents from the eight districts (Apac, Arua, Bushenyi, Hoima, Kampala, Kamuli, Lira, and Soroti), which matches those covered in the baseline and the 2010 survey.

The various data sets were analyzed independently to obtain indicators for trends on knowledge, behavior change, and practices related to HIV/AIDS, sexual behavior, SMC, malaria, and family planning. The datasets mentioned above targeted respondents in a reproductive age category of 15 to 49 years for women and 15 to 54 years among men. In addition, the team used the Uganda Demographic and Health Survey (UDHS) reports of 2006 and 2011 as a reference. Through triangulation, the findings of this final evaluation report can be said to be rigorous and trustworthy. The findings are representative of the target audience reached and their qualitative views and quantified responses on the HCP II project performance is corroborated from the different sources.

2.1.3 Evaluation Data Limitations/Constraints

The data presented in this final evaluation report is based on a mixed-methods approach, which is both qualitative and quantitative. Although qualitative data cannot be generalized to the entire target population, it is useful in providing a reflection of the true perceptions of beneficiaries. The inherent limitation is that it does not necessarily

[5]The two districts that were left out were not covered in the BCC Evaluation, 2012 survey.

establish causality[6] and should therefore be treated as a snapshot (anecdotal) of the beneficiary situations. Data limitations for the quantitative data are those specifically linked to the HCP 2008, 2010, & BCC Evaluation, 2012. Since these surveys were conducted in districts where other partners were conducting similar and additional BCC activities to what HCP was working in, the data limitation is that some of the achievements were not solely a result of HCP interventions. It is therefore important to acknowledge the contributions made by other USG and USAID-funded partners to the main outcomes of BCC. These include but are not limited to the following:

1) **AFFORD (meaning affordable health choices) project** supported the Sexual Network Campaign. This promoted several other campaigns such as Genext, Small Families Advocacy Campaign, and the "Good Life" initiative, which encourages people to view health choices as a part of creating the good life they are seeking.

2) **Health Initiatives for the Private Sector (HIPS) Project** supported the "Good Life at Work" Communication Strategy, which was developed in collaboration with the AFFORD Health Marketing Initiative. This promoted simple steps one can do every day to keep healthy and save money, thus improving the quality of life for employees, their dependants, and community members through daily health practices and decisions. HIPS was also implementing interventions that were geared towards increasing access and use of private sector services in the areas of HIV/AIDS TB, family planning, and malaria.

3) **Stop Malaria Project (SMP)** supported the Training of VHTs to carry out community sensitization and house-to-house visits providing information about prevention and treatment of malaria.

[6] **Note:** The purpose of this evaluation was not focused on establishing causality but more on determining effectiveness of BCC approaches and lessons learned.

3.0 HCP II FINAL EVALUATION FINDINGS

Evaluation Question 1: To what extent did HCP II achieve each and all expected outcomes under the three intermediate results?

3.1 Extent of Achievement of HCP II Project Results

3.1.1 Mapping Achievements to HCP II Projects Results Framework

The HCP II Results Mapping (Figure 2 on P.7 below), is based on the logical framework analysis, which illustrates progress achieved in expected results from specific interventions implemented by HCP II. The results framework allows for assessing the cause and effect linkages between the inputs/processes and the results achieved under each of the three intermediate results (IRs). Progress achieved towards the IRs and sub-IRs was assessed using data extracted from the baseline, midterm evaluation and BCC Evaluation, 2012 and other project monitoring data against HCP II's Performance Management Plan (PMP) targets. Findings indicate that performance was achieved for the following PMP results:

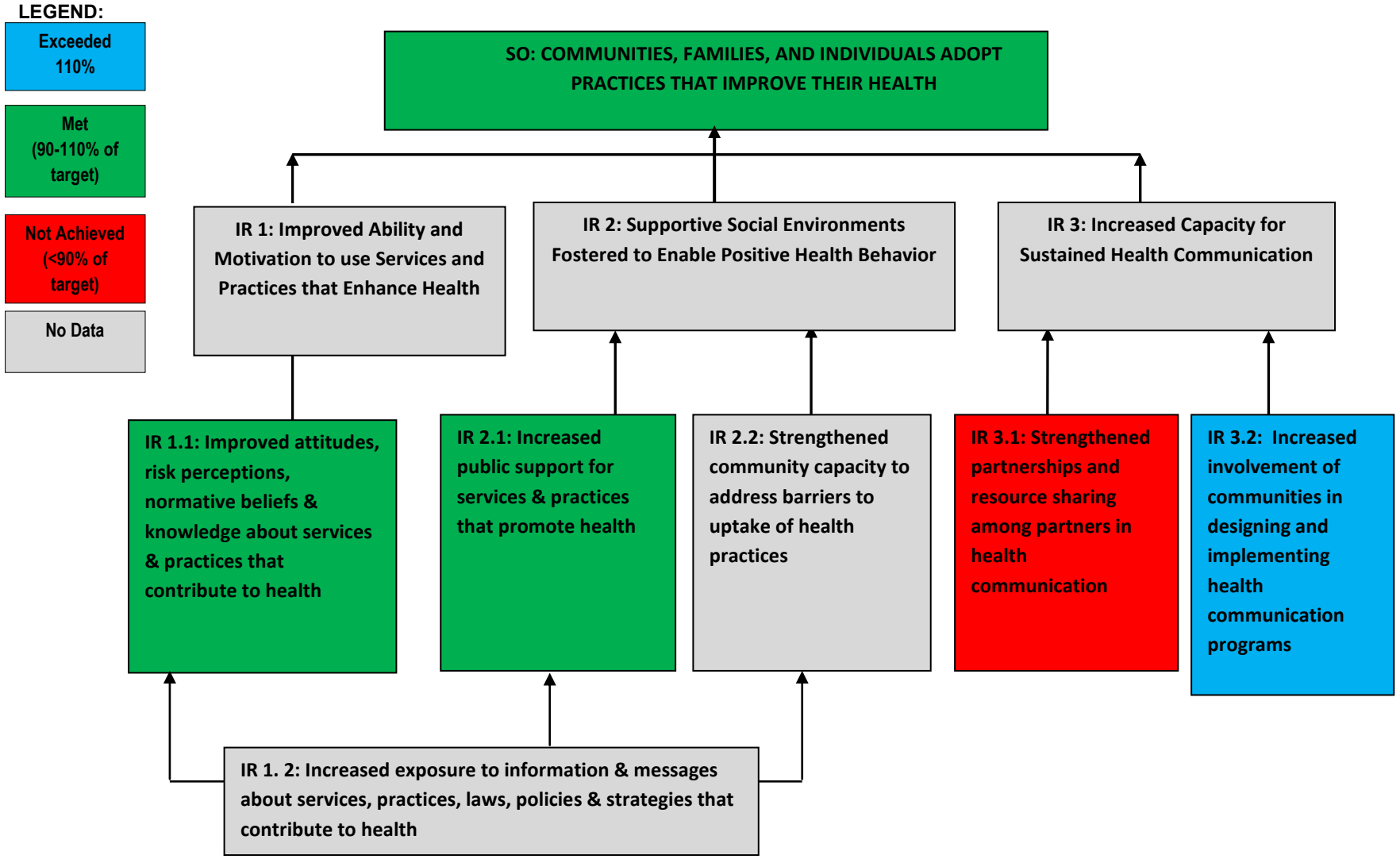
- **Strategic Objective (SO) level:**

Trend analysis indicates that only two out of the five performance measures originally selected to measure achievement of the objective **(Annex 7.3**) show a positive trend in adoption of practices by individuals from the baseline in 2008 to 2012. These include: (i) percent of men and women 15–49 years old who took an HIV test and received their results in the last 12 months, from 38 to 76 percent for women against the Life of Project (LOP) target of 50 percent; and for men from 26 to 61 percent against an LOP target of 40 percent; and ii) percent of women aged 15-49 who are currently using any modern family planning method, from 25 to 35 percent against LOP target of 34 percent. The three measures, whose targets were not achieved include: (i) percent of sexually active men and women aged 15–49 years who know the HIV status of their sexual partner(s), from 51 to 53 percent against the LOP target of 59 percent; (ii) percent of sexually active males and females (15–49 years old) who had sex with only one partner in the past 12 months, from 83 to 72 percent against LOP target of 90 percent; (iii) There is a decline in the percent of unmarried young men and women aged 15–24 years who "have never had sex," from 52 percent in 2008 at baseline to 47 percent in 2012 against the LOP target of 57 percent. More analysis on association of these results with HCP interventions is discussed in subsequent chapters. Table 1, illustrates the FY 2012 performance at the SO level for these same indicators, which also shows that only two out of the five targets were either met or exceeded. There are gender differences for percentage changes for each measure, with the rate of change for females being less than that for the males in most cases and thereby a need for greater targeting of women.

Table 1: FY 2012 Performance (Target Versus Actual)

FY 2012 PERFORMANCE (TARGET VERSUS ACTUAL)						
#	INDICATOR TITLE	BASELINE YEAR	BASELINE VALUE	2012 TARGET	2012 ACTUAL	Performance over Target
OUTCOME INDICATORS						
STRATEGIC OBJECIVE: COMMUNITIES, FAMILIES AND INDIVIDUALS ADOPT PRACTICES THAT IMPROVE THEIR HEALTH						
1	PERCENT OF MEN AND WOMEN 15 – 49 YEARS OLD WHO TOOK AN HIV TEST AND RECEIVED THEIR RESULTS IN THE LAST 12 MONTHS	2008	Male = 25.6%	Male = 40%	Male = 61%	21%
			Female = 38.3%	Female = 50%	Female =76%	26%
			Overall = 32.1%	**45%**	**68%**	**36%**
2	PERCENT OF SEXUALLY ACTIVE MEN AND WOMEN AGED 15-49 YEARS WHO KNOW THE HIV STATUS OF THEIR SEXUAL PARTNER(S)	2008	Male = 54.6%	Male = 62%	60%	-2%
			Female = 47.3%	Female = 55%	46%	-9%
			Overall = 50.7%	**58.5%**	**53%**	**-6%**
3	PERCENT OF UNMARRIED YOUNG MEN AND WOMEN AGED 15-24 YEARS WHO HAVE NEVER HAD SEX	2008	Male = 43.4%	Male - 55%	47%	-8%
			Female = 62.3%	Female = 60%	48%	12%
			Overall = 51.6%	**60%**	**47%**	**-10%**
4	PERCENT OF SEXUALLY ACTIVE MALES AND FEMALES (15-49 YEARS OLD) WHO HAD SEX WITH ONLY ONE PARTNER IN THE PAST 12 MONTHS	2008	Male = 71.8 %	Male = 80%	Male =70%	-10%
			Female = 93.5 %	Female = 99%	Female =78%	-21%
			Overal = 82.5%	**89.5%**	**72%**	**-18%**
5	PERCENT OF WOMEN AGED 15-49 WHO ARE CURRENTLY USING ANY MODERN FAMILY PLANNING METHOD	2008	25%	34%	35%	1%

Figure 2: HCP II Result Framework-Performance Mapping Based on FY 2012 Targets



Intermediate Results (IR) Level: The evaluation team was unable to map and analyse the extent of achievement of project outcomes due to missing data for indicators designed to measure the three Intermediate Results (IR) levels. Absence of such data weakens the analysis of cause and effect logic between the IR level and SO due to lack of credible evidence. The gap also brings into question the quality of performance management at the IP (HCP II) level and overall program level within USAID if there was no data being collected and utilized to track achievement of important project outcomes during the course of the project and guide relevant decision making and course corrections as may have been required. There was room for the HCP II to review and modify key performance indicators in liaison with USAID. Despite this weakness, performance at the sub-IR and output levels can and was used as proxy data by the evaluation team to assess their contribution towards the achievement of the IRs. It is important to note that using lower level data for this analysis in no way replaces the need for the real IR level data that better informs the BCC outcomes.

- **IR 1 -** *Effective communication strategies designed and implemented to increase appropriate use of services and/or practices across identified priority programs:* five out of six performance indicators that measure IR 1.1 (**Annex 7.3**) show that the trend except for the indicator: "percent of 15–49 year olds in project areas with comprehensive knowledge about HIV/AIDS transmission and prevention" which has stagnated. There is a slight decline in knowledge about HIV/AIDS from 56 percent in 2008 to 53 percent in 2012. There was no data for IR 1.2

- **IR 2 -** *Supportive social environments fostered to enable positive health-seeking behaviors and result in healthier individuals, families, and communities:* IR 2.1 had data for only one out of five indicators, which shows improvement in the "percent of currently married men and women 15–49 years old who discuss family planning with their partners/spouses" increased from 45 to 54 percent between 2008 and 2012. There was no data for IR 2.2

- **IR 3 -** *Increased capacity for sustained health communication,* IR 3.1 on strengthened partnerships and resource sharing among partners in heath communication had data but was not achieved. IR 3.2 on increased involvement of communities in designing and implementing health communication programs indicates performance exceed targets. Specifically, in terms of the number of communities involved in designing and implementing behavior change communication activities. While the target was to reach 125 communities, 601 communities were involved.

The performance at the sub-IRs levels may partially explain the achievement made at the SO level, even with missing data at the IR level itself to assess the real contribution. Nonetheless, based on our mixed-methods design, we will present findings from other data sources such as key informant interviews and FGDs that either support (corroborate) or disprove these project results as self-reported by the project for each IR. According to the evaluation team, the indicators with missing data also happen to be those that were not well formulated to measure the respective results both during the design stage and at the onset of implementation. There is a gap in the performance management of this program that needs to be addressed.

Note: IR 1 statement differs in several documents. It is sometimes stated as "improved ability and motivation to use services and practices that enhance health" as in the Results Framework below and the HCP 2007–2012 Final Report, May 2012. For purposes of this report, the evidence presented pertains to the IR 1 statement on "effective communication strategies" as provided in the evaluation SOW.

3.2 Progress towards Intermediate Result 1

Key Result: IR 1: Effective communication strategies designed and implemented to increase appropriate use of services and/or practices across identified priority programs:

The key assumption underlying the achievement of this result is that improving access to information and addressing key knowledge gaps, perceptions, and normative beliefs, among other things will enable individuals and society to adopt practices and behaviors to protect themselves from HIV/AIDS, malaria, and TB as well as reduce high-fertility rates.

3.2.1 Design & Implementation of Effective Communication Strategies

The key implementation approach under the HCP II project was to work jointly and support the MoH as a central government partner, other government institutions, and implementing partners (IPs) to develop and/or revise several communication strategies in HIV/AIDS, HIV/TB, family planning, and malaria programs. Instead of designing an overall BCC strategy, MoH as the lead coordinating body with the support of HCP II opted for program specific strategies. The strategies are detailed under **Annex 7.4** and these included the following:

- **HIV/AIDS:** (1) Pediatric HIV/AIDS; (2) Treat for Life; (3) Positive Living; (4) Couples HIV Counselling & Testing
- **TB/HIV:** The MoH already had a TB/HIV Collaboration Policy and a Communication Strategy. HCP II supported the Ministry together with TB Control Assistance Program (TBCAP) to review the communication strategy, identify gaps, and come up with a revised message and media plan that guided partners in implementing a multimedia TB/HIV communication campaign.
- **Family Planning:** Male Involvement Campaign and Unmet Needs Campaign
- **Malaria:** Malaria prevention and control

The strategies employed a multimedia approach composed of interpersonal communication (peer educators, counselors, National Hotline); mass media (radio, TV, newspapers); and community-based activities (community groups and meetings, village health teams). Various Information and Education and Communication (IEC) materials such as posters, signage, billboards, and comic books as well as job aids were produced.

HCP II rolled out the above stated communication strategies through various programs implemented with different implementing partners. The programs included Y.E.A.H; GOLD; CHCT; Family Planning; SMC; PLHIV; Adult ART/Positive Living; National Health Hotline; Radio Distance Learning program for VHTs; Pediatric ART; Malaria Communication; and TB/HIV Communication. More information on the purpose, scope, and communication channels used under each program is summarized in **Annex 7.5.**

These programs were anticipated to increase the levels of knowledge and practices in HIV/AIDS, family planning, malaria, and TB through campaigns. Desired behavior change outcomes from the campaigns included: (1) HIV/AIDS– consistent condom use, testing for HIV, reduced number of sexual partners, disclosure of HIV status to sexual partners, Safe Male Circumcision, and positive living/antiretroviral therapy (ART) adherence; (2) Family Planning – Use of modern contraceptive methods; (3) Malaria — Use of Insecticide Treated Mosquito Nets (ITNs), among other things. These outcomes and adopted indicators of measurement are consistent with measures defined under the HSSIP Monitoring and Evaluation plan. Specific details on the extent of achievement of results for the expected behavior change outcomes are presented in Section 3.2.2.

The above health communication program approaches were informed by evidence from various studies, which resulted into the design of tailored campaign strategies targeted at specific health problems, risk factors, age groups, gender, service providers, and partners. Examples of the studies and the campaigns they informed are included in **Figure 3.**

Figure 3: Core Messages from Studies & the Campaigns they Informed

Program Area	Core Message	Study
Family Planning Campaign	Findings indicated that 41% of women were not using modern family planning methods for fear of side effects.	UDHS 2006
The Y.E.A.H Campaign	Study found that alcohol consumption before sex increased the risk of acquiring HIV by 67% among men and 40% among women.	Study in Rakai in Uganda between 1994 and 2002.
The CHCT Campaign	Married couples were more at risk of acquiring HIV than the unmarried, accounting for about 65% of new infections. The study also pointed out risk factors such as multiple partners, non-condom use, and non-disclosure of HIV status to sexual partners.	SeroBehavioral Survey, 2004-2005
SMC Campaign	SMC coupled with less risky sexual behavior could reduce HIV infection by 60%	Study on Circumcision in HIV-infected men and its effect on HIV transmission to female partners in Rakai, Uganda, 2007.
The choice of radio as a major medium	Findings indicated that a high percentage of rural women and men (70% and 87%, respectively) listen to radio	UDHS (2006)

3.2.2 Increased Knowledge and Behavior Change

One of the key expected outcomes from the implementation of campaigns and other communication efforts is increased knowledge of HIV/AIDS, family planning, malaria, and TB prevention and treatment among intended population groups. Knowledge of health behavior and its benefits is a step towards behavior change but is far from being enough to prompt people to act. Quantitatively, the linkage between activities, knowledge, and behavioral change has been tested using cross-tabulation and multiple regression models in order to determine the strength of the relationships.

The evaluation findings demonstrate that there was increased knowledge about the various health issues. This section presents findings not only people's knowledge and behaviors about the different program areas supported by HCP II but also on perceptions of the particular behaviors, misconceptions, and challenges. To the extent possible, the regression model findings will be used to demonstrate whether the achievements made can be associated with the HCP II interventions.

3.2.2.1 Increased Knowledge Behavior/Practices of HIV/AIDS:

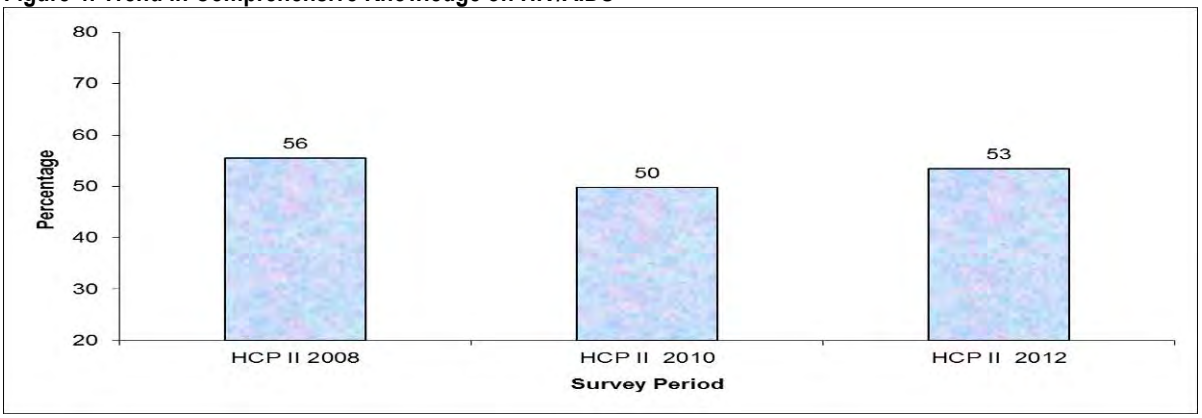
- **Knowledge**

HCP II implemented several programs/interventions that were targeted at improving knowledge, behavior, and practices in HIV/AIDs prevention: Young Empowered and Healthy (Y.E.A.H); Couple HIV Counseling and Testing (CHCT); Medical Safe Male Circumcision for HIV Prevention (SMC); Adult Antiretroviral Therapy (ART); Pediatric ART Family Planning Integrated Communication; and the National Health Hotline.

Evaluation findings indicate that comprehensive knowledge[7] on HIV/AIDS has declined from 56 percent at the baseline conducted in 2008 and thereafter stagnated at 53 percent in 2012 as illustrated in **Figure 4**.

[7]Comprehensive knowledge is defined as consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions (a healthy-looking person can't have the AIDS virus and that a virus can be transmitted through mosquito or other insect bites, by sharing food with someone who is infected, or by witchcraft or other supernatural means) about transmission or prevention of the AIDS virus (UDHS & AIS).

Figure 4: Trend in Comprehensive Knowledge on HIV/AIDS



Source: HCP II Baseline (2008), Midterm (2010), & BCC Evaluation, 2012

Comprehensive knowledge is less among women than men as can be seen in **Table 2.** There is a declining trend in comprehensive knowledge on HIV/AIDS in the urban areas as opposed to an upsurge in the rural areas between 2010 and 2012.

Table 2: Change in Comprehensive Knowledge on HIV by Gender and Residence

Sex	2008	2010	2012
Male	58.7	52.9	54.1
Female	52.1	46.8	52.8
Type of residence			
Urban	60.3	62.2	58.1
Rural	52.2	44.8	51.2

Source: HCP II Baseline (2008), Midterm (2010), & BCC Evaluation, 2012

Results from the AIDS Indicator Survey 2011 also indicate that there is stagnation on comprehensive knowledge from 42 to 43 percent for men, and a slight improvement from 31 and 36 percent for women, between 2006 and 2011.

Contrary to the quantitative analysis, qualitative data from Focus Group Discussions (FGDs) paints a more positive picture in terms of respondents' self-reported increase in knowledge of HIV. This was explored through focusing discussions on the following four key HIV interventions:

- **For Couple HIV Counselling and Testing (CHCT):** Findings from the four regions show that both male and female adults knew the importance of couple counselling and testing. Respondents reported that in cases where both husband and wife were found HIV positive, CHCT assisted them with knowledge on how to live positively together. The knowledge gained assisted them to adopt healthy practices that include condom use, ART adherence, reduction in number of sexual partners, and seeking treatment for sexually transmitted infections (STIs). In the cases where both were found to be negative, they said they remind each other about the need to remain faithful.

- **For Safe Male Circumcision (SMC):** The results from the FGDs indicated increased knowledge about SMC that was being taken up as a means of preventing HIV among men. The actual practice has been embraced mostly by the youth.
- **For People Living with HIV (PLHIV):** The campaign among adults living with HIV was only implemented from 2011 to 2012. However, the multichannel campaign provided targeted communication to enhance positive living among adults living with HIV. It also helped address challenges faced by adolescents living with HIV and improved the uptake of ARVs among children living with HIV.

- **For Youth:** Through the Y.E.A.H Campaign, young people (15–24 years) were influenced to adopt healthy sexual and reproductive health practices. Findings from youth FGDs indicated that youths know about the importance of key behaviors such as abstinence from sex, sticking to one partner, using condoms consistently at high risk sex, knowing one's HIV status and that of the partner, drinking alcohol responsibly or not at all, and treating partners non-violently.

Table 3: Comprehensive Knowledge on HIV and HCP II Campaign/Communication Medium

Heard program on the radio called Rock Point 256 for age 15–24	Comprehensive knowledge on HIV		p-value[8]
	Yes	No	
Yes	54.8	46.2	0.09
No	45.2	53.8	
Heard message in the last 12 months National Health Hotline			
Yes	25.2	25.1	0.934
No	74.8	74.9	
Heard program on sexual network (by AFFORD)			
Yes	49.1	43.5	0.002
No	51.9	57.5	

Source: BCC Evaluation, 2012;

Further analysis using cross tabulations by communication activity and its association with comprehensive knowledge on HIV also corroborates the findings from the HCP II trend data analysis in Figure 4 above. The findings (**Table 3**) indicate that there is no significant relationship between comprehensive knowledge and the radio drama series, Rock Point 256. Likewise, there was no association between the National Hotline as a channel of communication with comprehensive knowledge. However, findings demonstrate that there is a significant association between the Sexual Network Campaign, with comprehensive knowledge (supported by AFFORD). With regard to the latter, about 49 percent of respondents who listened to the sexual campaigns had more comprehensive knowledge on HIV, compared to 58 percent who did not listen to the program. The significance of the sexual network campaign demonstrates how other programs are also likely to have contributed to BCC outcomes achieved by HCP II.

Behavioral Changes

Data from the BCC Evaluation, 2012 was tested for the relationship between comprehensive knowledge on HIV and behavioral change. As can be seen from **Table 4** on the right, respondents who had comprehensive knowledge were more likely to have one sexual partner**,** compared to those who lacked comprehensive knowledge.

Number of Sexual partners	NOT COMPREHENSIVE	COMPREHENSIVE
None	9.7	8.6
1 partner	70.2	76.5
2+ partners	18.9	12.9
No response	1.3	2.0
Total percentage	100.0	100.0
Total number of respondents	795	983

Source: BCC Evaluation, 2012; $p = 0.020$

Other data from the AIDS Indicator Survey of 2011 indicate that the percentage of women and men in the

[8]p-value = probability value helping to measure the level of association between two factors. When p-value is less than 0.05 then there is a positive and statistically significant association between the two factors being investigated.

age range of 15–49 who had two or more sexual partners and were not using a condom during the last sexual intercourse was 84 and 85 percent, respectively. This shows that despite the changes in behaviour due to comprehensive knowledge, there is still a large proportion of the population who still have more than two sexual partners and are not using condoms, an issue that needs to be addressed if HIV rates are to be reduced.

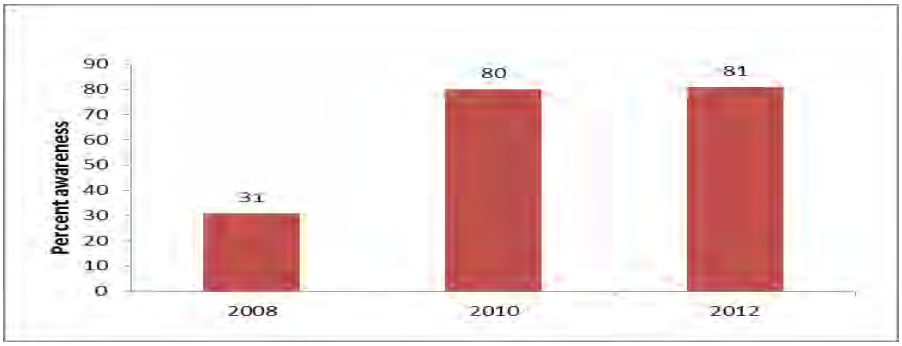
There has been a slight decline in the percentage of young (15–24), unmarried individuals who have never had sex in their lifetime from 52 percent at baseline to 47 percent at the end of HCP II, implying that a bit more unmarried youth are having sex. The percentage of young (15–24) sexually active, unmarried individuals who used a condom at last risky sex[9] increased for both women and men, from 48 to 64 percent for women and 54 to 58 percent for men (**Annex 7.6**). The BCC Evaluation, 2012 on condom use at last risky sex for the 25–49 years for both women and men were too few to provide conclusive findings (n=84 for men and n=26 for women**).** Overall, behavioral change in the population takes time and has not changed much over the HCP II period of implementation (2007–2012).

- **Knowledge and Practice of Safe Male Circumcision (SMC)**

Between 2007 and 2011, HCP II supported the MoH to educate the public about SMC and HIV prevention through dissemination of the SMC Policy Guidelines through mass media and public debates. In addition, HCP II designed IEC materials (Posters, Q&A book for health workers, and brochures) for men on SMC, its link to HIV, and the benefits.

HCP II launched the Stand Proud, Get Circumcised Campaign in 2009, which spoke to men and women about SMC. Results indicated that there was a surge in knowledge on SMC as a means of preventing HIV among men, from 31 percent at baseline in 2008 to 80 percent in 2010 after only one year of implementation of SMC interventions (SMC programming started in 2009). There was a slight increase in SMC knowledge from 80 percent in 2010 to 81 percent in 2012, which can partly be explained by the fact that the HCP-supported SMC campaign ended in 2011. Overall, there was an increase over the baseline (**Figure 5**). This can be attributed to HCP II supported HIV/AIDS campaigns, which were also later supported by the passing of a government policy on Safe Male Circumcision. The national Policy for SMC was launched in September 2010, two years after it was completed, which shortened the period for raising awareness about it.

Figure 5: Trends in Knowledge on Benefits of SMC in reducing chances of acquiring HIV/AIDS



Source: BCC Evaluation, 2012

[9] Risky sex in this survey means: lack of condom use at the last sexual intercourse.

Further analysis on the association of campaigns with the practice of SMC indicates that there was significant and a positive relationship between the Stand Proud, Get Circumcised Campaign and SMC practice. 90 percent of youth who were circumcised had obtained information on SMC from the Stand Proud campaign (**Table 5**).

Table 4: SMC and Stand Proud, Get Circumcised Campaign

Stand Proud, Get Circumcised Campaign	SMC		p-values
	Yes	No	
Yes	90.0	71.8	0.000
No	10.0	29.2	
Heard program on the radio called Rock Point 256 for age 15–24			
Yes	79.2	50.1	0.020
No	21.8	49.9	

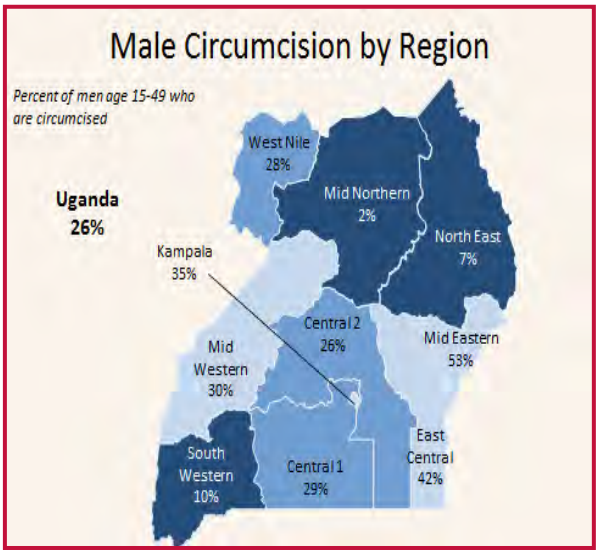
Source: BCC Evaluation. 2012

Increasing numbers of SMC were also a result of the scale up the SMC campaign nationwide that was supported by other partners that included Makerere University School of Public Health (MUSPH), STAR E, EC & SW, and IRCU. Interviews with SMC providers at health centers in Western Uganda indicated that the turn up for SMC has increased drastically as a result of massive campaign code named "Circumcision Week/Camp" funded by STAR-SW, another USAID-funded IP supported SMC. For example, figures from Kyabugimbi HCIV (Bushenyi) show that within just a period of six months from January to June 2012, the number of clients who turned up for HIV testing (5,850) after the campaign were more than what was achieved for the whole of 2011 or 2010, with a total of 3,500 and 3,300, respectively.

However, there were differential outcomes based on age. Male circumcision for the age group 15–24 years had increased slightly from about 20 percent in 2008 to 22 percent in 2012, while there was a decline for the 25–49 years, from 23 to 17 percent for the same period. This is corroborated by observations and exit interviews in Kamuli, which found that demand for SMC is higher among young people than married adults.

While the evaluation was not able to establish factors of variations in SMC uptake, AIS findings indicate that there are major regional variations in SMC uptake as can be seen from **Figure 6**. The highest concentration of male circumcisions was found in Mid-Eastern Region. Further research should be conducted to investigate the drivers for uptake in these regions and understand how these lessons can be used to drive improvements in other regions.

Figure 6: Male Circumcision by Region



Source: Uganda AIDS Indicator Survey 2011

- **Knowledge and Behavioral Change Among PLHIV**

The Positive Living campaign was implemented to increase the benefits of positive living and practices among adults living with HIV, address challenges experienced by adolescents living with HIV, and uptake of ARVs among children living with HIV. PLHIV campaign was communicated via several channels, which included the Radio Diary series, My Life My Story and Discussion Guides, Health Workers, the Positive Living Profiling Tool, Peer Educators, and Rock Point 256, among others. A total of 90 PLHIV FGD participants (42 male & 52 female) in 12 FGDs conducted in all the four regions reported living positively. PLHIV said they try to adhere to the treatment, visit health facilities whenever they fall ill, eat a balanced diet despite the economic hardships, and use condoms to prevent reinfection and infecting others. Participants in about two out of the 12 FGDs revealed that they had

opted to abstain from sex. Participants in about five out of 12 FGDs had HIV negative children at their last birth. However, in all the FGDs, participants reported that it is difficult for adolescents to adhere to ARVs because of fatigue, while others fear to be seen taking ARVs. This was especially the case for those adolescents who had not disclosed their HIV status to their parents.

3.2.2.2 Knowledge and Practices in Family Planning

Between 2007 and 2012, HCP II supported the MoH to implement two campaigns to raise awareness on use and availability of family planning services. These included the Male involvement in Family Planning (Fred and Bernard/ "Neighbors" drama series) and Nurse Mildred drama series. According to the BCC Evaluation, 2012, the percentage of currently married men and women 15–49 years old who discuss family planning with their partners/spouses has increased from 45 percent at baseline to 54 percent in 2012.

Table 5: Association between use of Family Planning Methods and selected HCP

Heard Nurse Mildred message in the last 12 months for age 15-54	Currently using family planning method		p-values
	Yes	No	
Yes	40.2	33.4	0.002
No	59.8	66.6	
Heard program on the radio called Rock Point 256 for age 15–24			
Yes	51.0	52.9	0.949
No	49.0	47.1	

Source: BCC Evaluation, 2012

The evaluation has established that there is a positive relationship between the use of family planning and selected HCP II campaigns. Listening to Nurse Mildred radio drama was statistically significant and linked to current use of a family planning method. About 40 percent of those who were currently using a family planning method had listened to the radio program, compared to 67 percent who had not heard the Nurse Mildred message, were not using any family planning method.

These findings are corroborated with findings from the FGDs. Participants in the adult FGDs established that adults knew about the different types of family planning methods (e.g. pills, condoms, implants, and injectables). However, knowledge of female condoms, moon beads, coils, and other permanent forms like tubal ligation was not as common across the various groups. Respondents were also able to cite the benefits of family planning. Those interviewed also identified the benefits of prevention of unplanned pregnancies, reduction of maternal deaths, better feeding, and better education.

Findings from the BCC Evaluation, 2012 show that the percentage of young sexually active, unmarried women (15–24 years) who used a condom at last sex increased from about 48 to 64 percent, while that for men in the same age bracket increased slightly from 54 to 58 percent between 2008 and 2012. This is corroborated by data from the UDHS surveys by UBOS between 2006 and 2012, which also shows an increase from 39 to 54 percent for women and from 58 to 63 percent for men. Family size has slightly reduced between 2006 and 2012 from 3.5 to 3.2 for the average number of children according to UDHS data. According to the studies conducted under the HCP program, the percent of currently married men and women (15–49 years) who want to have less than five children also increased from 47 to 63 percent from 2008-2012.

In all regions, there was self-reported use of family planning methods among females, and all the married female respondents said they had ever used at least one family planning method. However, some of these women had discontinued the use of family planning due to the associated side effects. For instance, injectaplan was reported to be associated with severe bleeding and pills with disruption of the menstrual cycles, frequent dizziness, back pains, and loss of interest in sex according to a group of eight women in an FGD conducted in Bushenyi. Service

providers at the health centers visited revealed that these side effects were more pronounced when the users of the different methods were not properly counseled or guided on the appropriate method to use. It was also reported that those who experienced side effects were not in the habit of seeking help from the health centers.

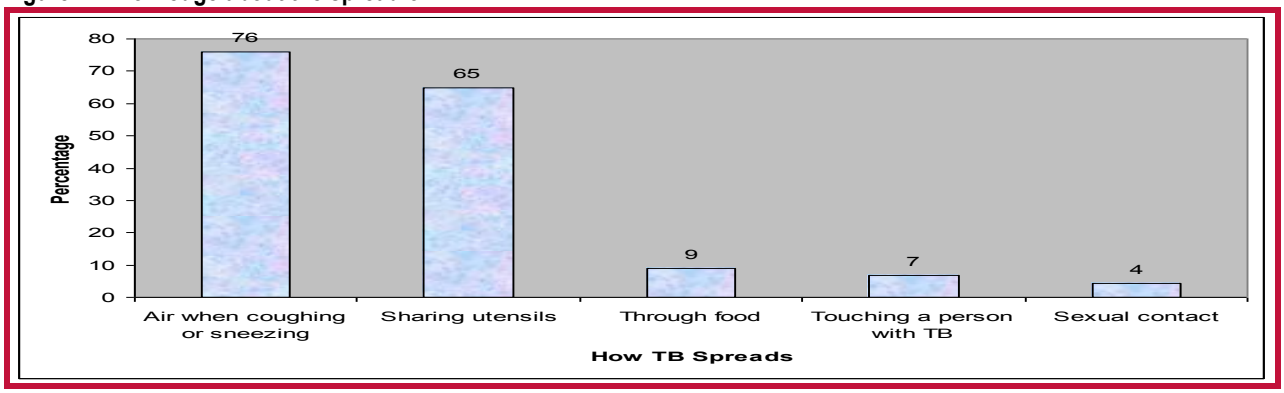
3.2.2.3 Knowledge and practices of Malaria & Tuberculosis

Between 2007 and 2008, the HCP II supported the MoH to increase public awareness of the new malaria treatment policy based on Intermittent Preventive Treatment in Pregnancy (IPTP) and Artemisinin-based Combination Therapies (ACT). MoH designed messages and media plans required to implement the Nation TB/HIV Communication Strategy. The malaria and TB campaigns were implemented over a period of one year.

- **Tuberculosis (TB)**

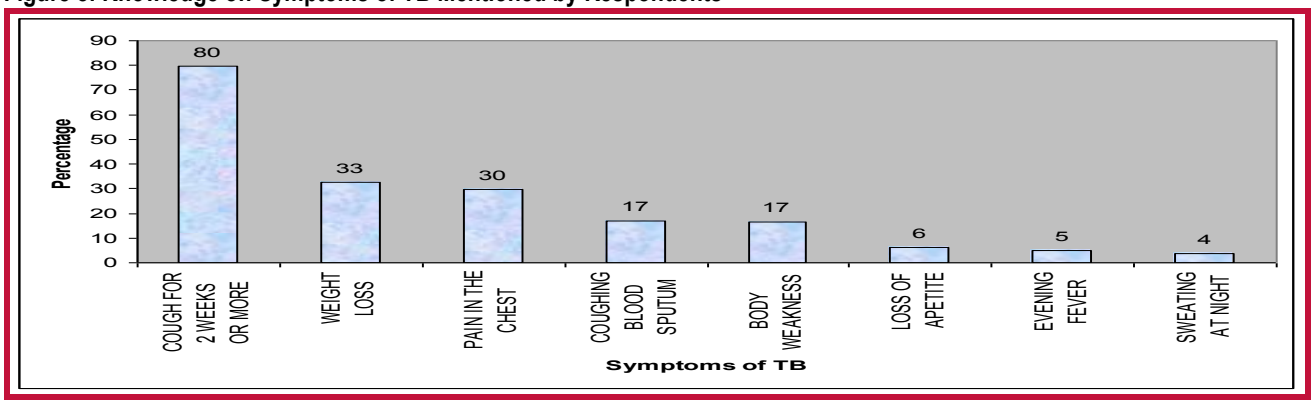
The BCC Survey findings show that about 93 percent of the respondents knew about a disease called tuberculosis (TB) and are knowledgeable on how it is spread as can be seen from **Figure 7** below.

Figure 7: Knowledge about the spread of TB



Respondents were also knowledgeable about the symptoms of TB including cough for two weeks (80%), weight loss (33%), and pain in chest (30%) as illustrated in **Figure 8**. FGD participants in the communities visited were knowledgeable about the linkage between TB and HIV/AIDS and were aware of some of the symptoms of TB. They revealed that because of their knowledge, when a cough persists for more than three weeks, they normally go for TB Screening. Participants also knew that TB is a curable disease and that the course of treatment is long. TB testing and treatment service is available at the health centers; seeking treatment early helps one not to develop complications like vomiting blood and lung problems. Adults who have ever tested positive for TB knew the importance of adherence to drugs.

Figure 8: Knowledge on Symptoms of TB Mentioned by Respondents



- **Malaria**

Evidence presented from the FGDs indicated that communities visited were knowledgeable about malaria. Findings also show that knowledge on the causes of malaria and its prevention was common across all regions. The increased knowledge has translated into behavioral change in terms of an increasing trend in the ownership and use of mosquito nets. FGD participants also knew that sleeping under an Insecticide Treated Mosquito Net (ITN) reduces one's chances of getting malaria. The use of nets as an adoption of behavioral change practices can be attributed to the increased knowledge about the causes of malaria and its prevention.

The BCC Evaluation, 2012 did not explore the questions on use of mosquito nets. Drawing from the national context, results from the UDHS datasets (2006 & 2011) indicate an increasing trend in the use of any mosquito net in a household from 34 percent to 74 percent. For those who own at least one ITN in a household, there is an increase from about 16 percent to 60 percent. Further analysis of data by region indicates that the percentage of households with at least one mosquito net is highest for West Nile (88%), followed by Kampala (82%), Western (78%), Northern (75%), Eastern (73%), South Western (72%), and lastly by Karamoja (68%).

3.3 Progress towards Supportive Social Environments (Intermediate Result 2)

The presence of a supportive social environment includes policies, laws, and community norms, which are necessary for families and individuals to adopt positive health practices, while access to services provide the linkage between communication activities and eventual adoption of health practices. HCP II designed and implemented communication approaches (**Annex 7.7**) that were meant to stimulate recognition of health issues, to debate and dialogue about health issues, and to identify and implement locally owned solutions. This was expected to result in services, policies, and community structures that support adoption and maintenance of positive health behaviors and discourage risky behaviors/practices.

3.3.1 Public Support for Services and Practices that Promote Health

A public supportive social environment entailed putting in place policies and structures that would encourage communities, families, and individuals to adopt practices that improve their health. These included community (leaders, adults, youth group roles) and public structures (health facilities, providers, and relevant policies) that were necessary to tackle social issues and barriers such as alcohol abuse, violence against women, discussion among couples about HIV status, SMC, and family planning. HCP II supported MoH and the Uganda AIDS Commission (UAC), which were responsible for not only supporting policy formulation but also providing direction, execution, leadership, and strategy development to facilitate implementation of health communication programs. The lead implementing partners (AIC & CDFU) mobilized communities and coordinated HCP II activities that targeted behavior change. AIC focused mostly on couple HIV/AIDS counseling and testing, while CDFU implemented Y.E.A.H programs that included National Health Hotline and Rock Point 256.

HCP II supported the roll out of the new policies on which health campaigns were based. For example, the HCP campaigns promoted the awareness of the SMC, alcohol, and TB policies among the public to encourage people adopt healthier practices. **Table 7** below shows trend data from the HCP II surveys from baseline, midterm, and the BCC Evaluation, 2012, which indicates that there is increased awareness about some of the government policies put in place in support of HCP II interventions for SMC and alcohol abuse. However, there is decline in TB awareness, which as mentioned in the previous section may be attributed to the short (one year) duration of the TB campaigns.

Table 6: Data on Policy-Related SMC, Alcohol, and TB- 2008 – 2012

Indicator	HCP II Baseline (2008) percent	HCP II Midterm (2010) percent	BCC Evaluation, (2012)percent
Percentage who heard about Uganda policy to encourage medical male circumcision	N/A	72.5	88.2
Percentage aware of any law or local policy regarding alcohol	36.3	N/A	41.4
Percentage aware of any law or government of Uganda policy regarding TB	36.2	N/A	26.8

Source: HCP II Baseline (2008), Midterm (2010), &BCC Evaluation, 2012

3.3.2 Youth supportive structures

Young Empowered and Healthy (Y.E.A.H) Campaigns were designed to raise consciousness and promote dialogue about social issues such as alcohol abuse, violence against women, HIV stigma, and smaller family size as well as discussion about HIV status between couples, male circumcision, and family planning. They were implemented between 2007 and early 2012 to encourage young people to abstain from sex, stick to one sexual partner or consistent use a condom, know their own and partner's HIV status, drink responsibly or not at all, and to treat partners nonviolently. The campaign was a continuation of the initiative started in 2004 and on Rock Point 256 (weekly radio drama series) and comic book series and youth groups such as the Young People Advisory Groups (YAGs). According to the BCC Evaluation, 2012, 51 percent of respondents aged 15–24 said they had listened to Rock Point 256. The latter started in 2004 under HCP and continued in 2007 to 2012 under HCP II. Eighty-two percent read comic books (shortened story versions of the Rock Point 256 drama series) in the past 12 months, compared to 43 percent for the 25–49 years olds and 43 percent for those 54 years and above.

The Y.E.A.H initiative was set up under the auspices of the UAC and CDFU as the lead implementing partners targeted the youth as their main audience. Y.E.A.H initiatives were instrumental in setting up youth structures such as YAGs, which worked with Regional Lead Organizations (RLOs) to carry out peer education in schools and communities using IEC materials. YAGs provided input into the work of the Technical Advisory Team (TAT), the Implementation Unit at CDFU as well as acted as the gateway for regional lead partners (RLOs). The latter included Save the Children Fund (SCFU, SCFUSA), Reproductive Health Uganda (RHU), Uganda Red Cross (URC), and AIDS Information Center (AIC) as well as youth clubs and schools in the districts and communities. YAGs delivered messages on HIV/AIDS and family planning. The youth group volunteers trained by HCP II as peer educators facilitated group discussions among the youths using comic books and videos to trigger discussions. Up to 81 percent of the survey respondents said they had in the past 12 months seen the comic books distributed through the youth structures.

- **Young people's sexual and reproductive health knowledge, attitudes, and self-perception of risk improved**

As a result of the Y.E.A.H campaigns, young people's sexual and reproductive health knowledge, attitudes, and self-perception of risk have greatly improved. In all the FGDs focused on youth, participants in 10 out of the 12 FGS were knowledgeable about the use condoms, SMC, responsible alcohol consumption, and treating partners nonviolently. Youth reported that they were trying to abstain or stick to one partner but noted that it was challenging. Below are quotes from FGD participants on risky sexual behavior, GBV, and alcohol abuse:

"When one is drunk, sometimes they don't listen to their partner's plea on using protection and when the partner insists, they may end up fighting and breaking the relationship" (youth respondents in Mukono, and Kabarole)."Alcohol puts you in mood for sex and you can't take precaution" (youth respondents, Arua, Kamuli, and Soroti).

- **Communication between adults and young people strengthened to provide nurturing environments for the youth**

Findings from FGDs show that communication between adults and young people has not been strengthened. Adults are not comfortable sharing information with young people about sexual behaviors. On the other hand, some adults who engage with young people sexually are more likely to expose them to risky sexual behaviors such as not using condoms. Adults FGDs mainly supported abstinence, which is not necessarily embraced by active young people. Such insights reveal that there is still a gap in communication between adults and young people.

3.4 Effectiveness of Project Approaches

This section looks at the effectiveness of one single broad and focal communication body supporting the communication activities of different implementing partners and the effectiveness of approaches HCP II used to implement its various programs.

3.4.1 Effectiveness of the One Focal Communication Project Supporting Different Implementing Partners

HCP II was conceived by USAID as one focal health communication project designed to support communication activities of various partners in the health sector. The 66 implementing partners included USAID-funded projects, government, institutional, and other implementing NGO partners.

Respondents from the government and institutional partners, i.e. UAC, AIC, CDFU, MUSPH, MoH agreed that HCP II as a focal communication project was an effective model of addressing health issues because it promoted uniformity and a centralized management system. This approach limited the duplication of activities and conflicts between the implementing partners. The model using participatory planning meetings brought together a diversity of government (MoH, UAC) and institutional (AIC, CDFU, MUSPH) partners in health, involved them in formative research and design of materials, and ensured that local partners also got similar training and IEC materials. The approach helped the MoH coordinate communication activities related to HIV and family planning. Working together resulted in single communication strategies for the same health problem instead of having parallel ones. Respondents at UAC, AIC, CDFU, and partners chose activities to implement as well as channels and messages to use based on shared evidence-based research coordinated by HCP II. This, they say, enhanced the uniformity in the messages communicated by different partners as well as a pool of designed material that they can reproduce whenever they need them.

USAID & USG implementing partners interviewed during the course of this evaluation reported that HCP II as a focal organization on communication helped coordinate the process of identifying and training service providers in ART, SMC, CHCT, and VHTs along the communication process implemented by various partners. Findings from USAID and USG implementing partner staff indicate that all of them were involved in the design of HCP II health communication interventions in some way. For instance, RHU was involved in planning meetings, SUSTAIN with partners in the area of Pediatric HIV, and Marie Stopes participated in developing FP posters, flip charts, radio dairies and drama series. TASO was involved in the design of communication materials on positive living, radio dairies, support messages on positive living, supporting PLWHAs. In addition, TASO supported MoH with other partners in developing the National pediatric curriculum on pediatric counseling, developed a pediatric strategy on communication, participated in family planning strategies and making factsheets for positive living, pediatric care

and SMC. The inherent benefit in this approach was the cost savings made in avoiding duplication of efforts if the trainings, design and dissemination of messages across uniform programs had not been properly coordinated.

Working through partnerships also helped reduce the costs of implementing some campaigns in the regions, districts, and communities. For example, CDFU reported that without the regional partners such as the Regional Lead Organizations (RLOs), an initiative funded under HCP II, it would have been difficult and very costly to put in place and maintain Y.E.A.H structures. Partners such as SCU, AIC, and RHU helped provide office space for YAGs, CD/DVD players, and the printing of comic books in four local languages (English, Luganda, Luo, and 4Rs).

The distribution of IEC materials was effected through partners who were responsible for cascading them down to health facilities and community level. Project performance data indicates that 2,254 leaders, media workers, and community resource persons received HCP-supported IEC materials exceeding their planned target of 700 people over the course of the project. Several key informants from IPs, MoH, and other institutions confirmed receiving and utilizing the IEC materials.

The majority of FGD participants who said they had seen IEC materials saw them at the health facilities. Participants in the Village Health Team FGDs also acknowledged the contribution of IEC materials in terms of knowledge sharing and training of counselors that have brought support and care to the affected families. "*IEC materials have assisted a lot because seeing is believing,*" as one VHT member put it. A MoH respondent commented that advocacy videos were pretested and relevant. An AIC respondent noted that "people like videos because the testimonies in the video influence couples to come for testing." For CHCT, empowered testimonies and certificates for tested couples were an effective approach. Evaluation findings also indicate that HCP II did not have a mechanism in place for monitoring the distribution and use of IEC materials by the IPs. Some IPs reported delays in receiving IEC materials, while some district health educators in Soroti said they did not receive adequate materials.

The evaluation team saw posters at HCT and ANC service centers at the several health facilities visited around the country during the course of the evaluation. The 18 HCs the evaluation visited had all the signage on CHCT, FP, SMC, and TB developed under the HCP II project. The Ministry and other IPs appreciated that they now have access to the electronic versions, which they can always reproduce. These materials can be found at the following web link www.k4health.org/toolkits/hcp. While this is the case for the USAID implementing partners with programs covering large parts of the country, budget limitations especially in the Ministry and among the local partners inhibit them from producing sufficient quantities of materials for mass reproduction.

3.4.2 Effectiveness of Knowledge and Behavioral Change-Related Approaches

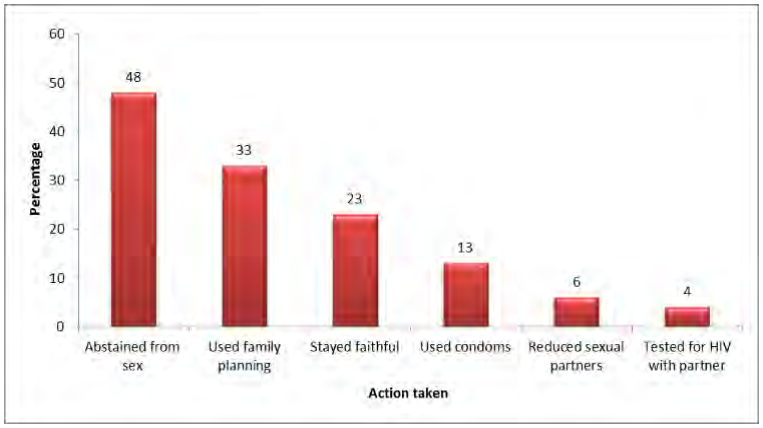
As reported under IR1, all the campaigns increased knowledge and to some extent contributed to behavioral changes. Campaigns, especially those that used a strong component of radio and the drama formats plus radio spots, were more popular in their outreach to the target audiences than others as indicated by the findings from the BCC Evaluation, 2012 reflected in the sections below.

- **Y.E.A.H Campaign**

The Rock Point 256 Radio program, which was part of the Y.E.A.H campaign, won several awards such as the AfroComNet Award for Excellence in HIV Communication in 2007, Best HIV/AIDS Program at the Africa Edutainment Awards in 2011, and the Best Radio Program by New Vision readers in 2010. Young, urban participants in FGDs cited radio, especially Rock Point 256, as their major source of information on HIV. Key informant interviews at radio stations revealed that although their listenership surveys are based on time segments

and not individual programs, audience feedback showed that Rock Point 256 had increased station listeners, especially the youth. The reasons given for its effectiveness were the entertainment format, use of young characters that the youth audiences easily identify with, plus drawing on familiar challenges that youth face in the communities.

Figure 9: How messages from Rock Point 256 influenced actions



According to the BCC Evaluation, 2012, respondents said that messages they got from Rock Point 256 influenced them to take actions such as: abstained from sex; use condoms; stay faithful to one partner; reduced number of sexual partners; test for HIV with partner; and used family planning (**Figure 9)**. It is important to note that analyses in previous sections showed that there was no significant association between Rock 256 and comprehensive knowledge on HIV. However, there was a significant relationship (p=0.02) between comprehensive knowledge on HIV and behavioral practices like reduced number of partners. While there were positive ratings and evidence of changes that can be associated with Rock 256 program, sustainability of such initiatives after the close of the program is weak. Already, some radio stations that had continued to air Rock Point 256 on a voluntary basis have since stopped. This leaves a major gap in the fight against HIV among the young people that needs to be filled by improving and replicating aspects of Y.E.A.H that worked. Youth FGDs mentioned peers and friends as another key source of information on HIV/AIDS and reproductive health. According to BCC Evaluation, 2012, 27 percent listed youth clubs as well as a source of information on family planning in the past 12 months.

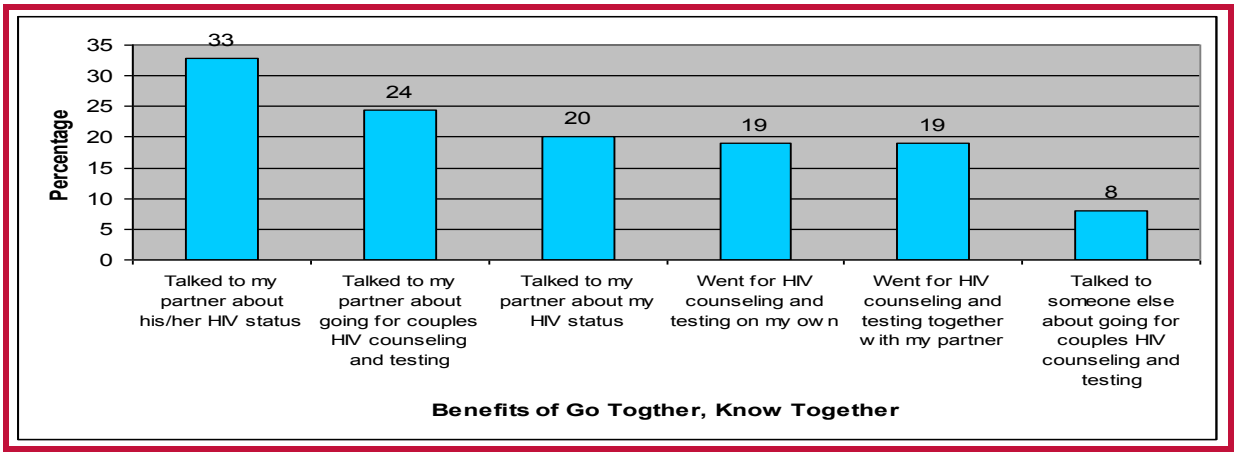
- **Couple HIV Counseling and Testing (CHCT)**

Between 2008 and 2012, HCP II supported the MoH and other partners to develop national policy guidelines and training materials on Couple HIV Counseling and Testing (CHCT). Using a multimedia campaign, "Go Together, Know Together," which run from 2009 until 2012, encouraged couples to talk to partners about going for HIV testing, getting tested together, and then disclosing the results to one another. The rationale behind the "Go together Know together" Campaign was that by getting tested together, couples who did not know their HIV status would recognize their risk of HIV, and this would build their belief that CHCT will benefit their relationships. The CHCT Campaign approach registered significant reach among the target audiences.

According to the BCC Evaluation, 2012, up to 59 percent of respondents had in the past 12 months seen or heard of a sign of a couple holding hands, and 58 percent of them said they understood it to mean as testing together for HIV (couple testing). Similarly, up to 60 percent said they had in the past 12 months seen or heard messages about the "*Go Together, Know Together"* Campaign.

The messages reached couples mostly through radio (65%), followed by posters (32%), health workers (13%), and bill boards (10%). Up to 61 percent of the respondents said they were influenced to take an action by messages they got from the "Go Together, Know Together" Campaign (**Figure 10**). The finding that those who got the "Go Together, Know Together" Campaign messages were influenced to take some action confirms a reasonable level of effectiveness of the approach.

Figure 10: Actions taken from the Knowledge gained from Go Together, Know Together Campaign



However, there were also cases of misinterpretation of the CHCT poster. When shown the "Go Together, Know Together" poster during fieldwork by the evaluation team, a female respondent in Arua said, "*It's a sign for toilets, which separate female from male toilets.*"

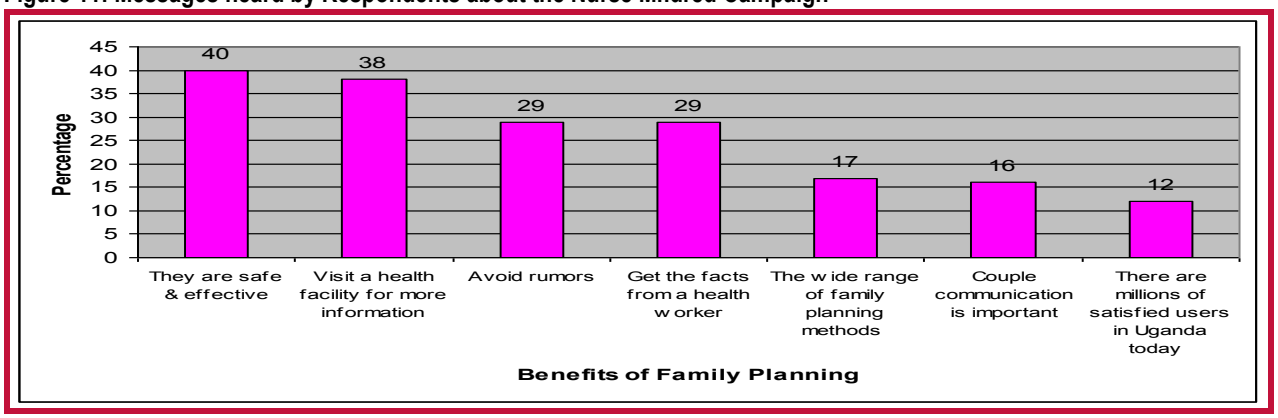
Survey information presented earlier indicated that HIV testing increased for men and women as well as those who know the HIV status of their sexual partners. This can be attributed to the fact that the promotions for CHCT were good and this led to an increased number of people seeking CHCT services. In addition, the HCs had a policy of testing every patient who reported with any sickness for HIV. While the demand for HIV testing increased as a result of the CHCT Campaign, conducting the HIV tests was affected by the constant stock-outs of HIV testing kits at health centers, which discouraged many service seekers. Survey information indicates that HIV testing increased from 38 to 76 percent for women and from 26 to 61 amongst men. The percent of individuals who know the HIV status of partner increased from 51 percent at baseline (2008) to 53 percent in 2012. It is important to note that while there have been improvements, these percentages are still low and a lot needs to be done in order to increase these levels close to the national targets. For HIV testing for adults 15-49 years who have ever tested, the national target is expected to 80 percent by 2015 as indicated in the National HIV Prevention Strategy for Uganda: 2011-15, Draft Version, February 2011. While women are getting close to achieving this target, men are still lagging behind.

- **Nurse Mildred and Neighbors Fred and Bernard**

The BCC Evaluation, 2012 found that 40 percent of the respondents had heard or seen messages about *Nurse Mildred* in the last 12 months. Findings show that those exposed to the Nurse Mildred Campaign got the key messages. **Figure 11** illustrates the actions taken as a result of these key messages, which confirms that behavior change can be influenced with increased knowledge about health issues, in this case family planning. About 40 percent respondents reported that they believe that family planning is safe and effective.

Radio was the major source of the information above: radio drama (41%); radio talk show (51%); and radio spots (30%).The radio drama/talk format also proved effective as it involved a nurse to put the drama into context and also respond to issues arising from listeners through calls. A host for a radio talk show, which carries *Nurse Mildred* at ETOP FM, said people in Soroti town have nicknamed her Nurse Mildred because of the popularity of the program.

Figure 11: Messages heard by Respondents about the Nurse Mildred Campaign



In comparison to Nurse Mildred, the Fred and Bernard Campaign was less effective. FGD respondents could hardly recall having listened to it. This could be attributed to the fact that the Nurse Mildred Campaign was more recent (2011–2012) than Fred and Bernard (2006–2009). Posters were cited as having been seen on both **Nurse Mildred** and **Fred and Bernard** for family planning. However, FGD findings indicated that the level of comprehension among both male and female respondents for the Nurse Mildred poster was higher than the Fred and Bernard one. This is attributed to the strong visual appeal (pictures), which at a glance communicates the message about the burden of having a large family size beyond ones means (Nurse Mildred is the picture on the Left). A lady in Western Region was able to recognize the family planning poster with a picture of a nurse beside a stressed large family.

Nurse Mildred Poster

Fred & Bernard Poster

The Fred & Bernard picture on the right was not as well understood. One respondent in Kabarole who mistook the Fred and Bernard poster to be about nutrition said," *I have seen that picture by the roadside. It is teaching us about a healthy diet and the need to work hard for what one wants in life."*

3.4.3 Behavioral Change Communication Campaigns and Health Service Delivery

Behavior change communication messages were disseminated to help educate and encourage audiences to take measures to protect themselves and communities against infections. They also encouraged them to seek health services such as HIV testing and treatment or Safe Male Circumcision from health facilities. While prevention requires that the individuals take personal protection measures, service-seeking behaviors require that the services promoted by communication are available, accessible, and

affordable at the health facilities people are directed to. Observations in the field indicated that signages for CHCT, family planning, SMC, and TB at all the 18 HCs visited were available and visible. (**Signage at Goma HC II, in Mukono in the picture**).

Respondents in both exit interviews at 18 health centers and FGDs said the signage helped service seekers to know which services were being offered at the health center. The evaluation discovered that signage does not necessarily ensure that the services advertised are actually available. Respondents said that their preferred family planning methods were sometimes not available. The health center staff decried shortage of staff, HIV testing kits, and contraceptives. For instance, the evaluation team found over 15 youths who had come for SMC at Namwendwa HC 1V waiting for several hours without being attended to because the trained staff had long queues of outpatients. In Northern Uganda, it was revealed that health providers are too few compared to the number of males who want to get SMC. In the Eastern and Western Regions, where SMC was matched with steady provision of the service supported by two USAID programs i.e. STAR – South West and STAR-East), there was a much more rapid increase in the number of people seeking the service. Health service providers at various HCs visited noted that the number of women seeking family planning methods increased on the days when Marie Stopes was scheduled to be at the health facilities. This was because Marie Stopes provides a wider choice of family planning methods than the pills HCs often dispense.

Health service delivery was therefore being impacted by low staffing levels and availability of products at the health centers. This is a country wide situation. Annual Health Sector Report, 2011/12 reported that only 58 percent of the approved positions are filled by health workers, up from 56 percent in 2011. The Service Availability and Readiness survey in 2012 indicates a general readiness score for health facilities at 66percent, looking at the availability of basic amenities, basic equipment, standard precautions for infection and prevention, diagnostic capacity and essential medicines. However, the report notes a decline in financial investment in the health sector from about 10 percent in 2009/10 to 8 percent in 2011/12. These examples demonstrate that though communication interventions may instill healthy behaviors (e.g. encouraging people to go for testing, use contraceptives, etc.), the health services that will support this behavior change such as SMC, counseling and testing, and family planning need to be readily available and affordable to enable utilization and enjoyment of full health benefits.

3.4.4 Generating Opportunities for Leadership and Professional Development (GOLD)

To bridge the skills gap on health communication among implementing partners, HCP II through the GOLD program set out to increase the number of young Ugandan professionals with the required job skills. The GOLD program targeted young graduates who had career interests in health communication and provided training and one-year work-based mentoring. The program trained 200 young professionals, but only 120 completed the one year placement and mentoring sessions. The call for applicants was advertised through universities, in newspapers before resorting to posters, Facebook, and the project website due to the high media advertising costs as reported by HCP II staff. The GOLD program was run by HCP II with the involvement of IPs on a voluntary basis. Meetings and training seminars were held at HCP II boardrooms but sometimes were rotated and hosted by various IPs. HCP II put emphasis both on skills development and finding placements for those recruited.

The evaluation team followed up with 30 graduates of the GOLD program, who could be easily traced to assess effectiveness of the GOLD program, and extent to which GOLD provided them with the necessary health communication skills, career guidance, and opportunities to young graduates. The findings indicate that there were significant ($p=0.002$) results in a short time and with very minimal resources. 93% (Twenty-eight out of 30 respondents interviewed) of the graduates are currently employed in influential positions with credible organizations mostly in health communications positions. These include communication and training, marketing, strategic communication, and communication research, among others. The organizations that have employed

them include USAID-funded projects and former implementing partners (IPs) of HCP II such as Marie Stopes, STRIDES, UHMG, CDFU, RHU, MSH, HIPS, and Stop Malaria. A few graduates have moved on to business companies (SHELL, private business) and the media sector (*The Monitor* and *Red Pepper*). About 64 percent of the beneficiary respondents said they were very satisfied with the extent to which the GOLD program provided them with the skills needed to secure professional employment and succeed in their new position.

In terms of GOLD as an effective approach for beefing up communication skills for implementing partners, the uptake of GOLD graduates by IPs seems to have been achieved. The IP's ability to hire and retain the young professionals will be a big factor in sustaining the gains of this approach plus their willingness to host future GOLD trainees. A number of them sighted budgetary constraints to hire and fill communication positions at their organizations. In 2012, the program was passed on to the Private Sector Foundation of Uganda (PSFU) which showed more interest in running it. While PSFU has continued to manage it, the prospects for its sustainability remain hinged on securing extra funding. The PSFU says they plan to charge young graduates tuition for the next enrolment in March 2013. The program also faces the challenge of finding placements for those enrolled. Part of the problem is that it puts emphasis on the skills development while leaving the hurdle of placements to the young professionals themselves. This is partly responsible for the high drop-out (15 out of 30) in the 2012 intake. Therefore, the long-term sustainability of the GOLD program is in question.

3.4.5 Radio Distance Learning (RDL) for Village Health Teams

The Radio Distance Learning program (RDL) was designed as a low-cost refresher and continuing training to Village Health Teams (VHTs) to enable them understand their roles in providing information and services in the target areas. VHTs are also community-based health structures, through which the communities participate in the management of health services. The VHTs are now referred to as Health Center One (HCIs) because they offer first line health services treating manageable diseases and refer cases to HCIIs, mobilize communities to seek health services, and take preventive measures. The design of Radio Distance Learning program started in 2009 but the actual broadcasts commenced towards the end of October 2010 and ran up to 2012. RDL involves VHT listening groups sitting around radio sets at the home of one of the members using guide books to follow and learn from the weekly radio broadcast sessions about issues such as HIV/AIDS, family planning and how to support communities to deal with these health challenges, among others. The program works with and supplements current VHT training efforts by providing continuing education, refresher training and transfer of knowledge and skills to VHTs on a regular basis and in a cost effective way.

RDL was implemented in six districts in Central and three districts in Northern Uganda. According to the Annual Health Sector Performance Report, 2011/12, there is a total of 66,321 VHTs countrywide; out of which there are 39,947 active ones. According to the HCP project PMP data, 12,483 individuals in FY 2011 participated in capacity building activities for VHTs, and another 4,000 in FY 2012. As such, the costs for conducting face-to-face training would have been exorbitant had it not been for using the RDL approach. Overall, all FGDs in the Northern and Central Regions showed that the VHTs were knowledgeable and could comfortably name at least three benefits of using various health practices, in which they were responsible for providing information. They also indicated that they now appreciate better their added role to disseminate health related information to the communities they serve. Lack of batteries for the radio sets to follow the learning and having to share one discussion guide book during the group listening and discussion sessions were some of the complaints raised by the VHTs during RDT **(Annex 7.9).**

World Vision has adopted the Radio Distance Learning (RDL) and has introduced child and maternal health in the training content for the VHTs. The VHTs in Masaka felt that the RDL is performing better under World Vision support. This was attributed to the fact that VHTs preferred face-to-face training provided by World Vision, where they could ask questions and understand better as compared to the RDL offered by HCP II. Face to face

interactions are necessary for adult learners who are not very illiterate as is the case in Uganda[10]. In addition, World Vision provided feedback on their performance and also conducted refresher trainings. World Vision supported MoH to produce 13 radio sessions and discussion guides on maternal and child health and increased the number of districts covered.

Though efficiency gains through the use of the radio to reach many VHTs at one go is evident, the effectiveness of this approach is questionable due to lack of feedback and follow up that could have been provided for through face to face interactions. This is particularly important in a knowledge and skills transfer set up for adult learners where continuous question and answer, feedback between the teacher and student is required.

The VHTs also felt that the sustainability of their activities will depend on the level of motivation they felt is lacking. They complained that HCP II did not provide them with a uniform (T-shirts), which helps them to get easily identified in the community, and also the IEC materials were scarce. For instance, not all VHTs received handbooks. World Vision, provided a full package (bag with gloves, required IEC materials, pens, etc.), which HCP II did not provide. According to HSSIP 2010/11–2014/15 the "attrition rate is quite high among VHTs because of lack of emoluments." The VHTs are volunteers and the standard service to population ratio is 1:1,000 or 25 households. Thus the need for a long-term strategy on the facilitation and training of VHTs given the important role they play in local service delivery.

3.4.6 National Health Hotline

In 2009, HCP II supported the UAC and MoH to start a National Health Hotline (0800-200600/0312-500600), as a supplementary channel to address health information gaps left by the other channels such as radio talk shows and also encourage those who wanted to seek health information in confidence or remain anonymous. The Hotline is managed by CDFU. The BCC Evaluation, 2012 found that only 25 percent respondents had ever heard of the Health Hotline; 58 percent had heard of the National Health Hotline in the last 12 months; 12 percent had called the Hotline in the past 12 months seeking information on HIV testing; and 12 percent had sought information on family planning. The use of mobile phones is still new especially in the rural areas but was reported to be increasing. Therefore, while the number of callers to the hotline is still low, the results demonstrate potential increase in use of this personalized channel through which people can ask questions about their health and that of their families.

Currently, CDFU is still managing the Hotline. Because it is a toll free number, its operational costs are very high. It costs CDFU up to $50,000 annually to maintain it. With financial assistance from HCP II, it was relatively easier to manage the Hotline. However, with the closure of HCP II activities, CDFU has had to partner with other organizations for the Hotline to continue operating. Marie Stopes has come in to train counselors. Save the Children, Baylor College of Medicine Children's Foundation, and World Vision have promised to participate and meet some of the operational costs. Given the low usage (12%), future programming may need to reconsider the target audience for the National Hotline vis-à-vis the costs involved in running it.

3.5 Impact of HCP II on the capacity of local IPs and the MoH (Evaluation Question 3)[11]

3.5.1 Capacity of Government through MoH

HCP II provided capacity-building support to the government, primarily the Ministry of Health (MoH) as the lead agent for behavioral change activities in the country. This was in terms of the following interventions: (1) training partners in strategic communication and mentoring them as they implement their programs; (2) sharing

[10] The national literacy rate is 73%; 69% in urban areas- Uganda Bureau of Statistics. Statistical Abstracts 2012.

[11] This section also doubles as a response to achievement towards IR 3 (Improved Communication Capacity). The evidence presented also highlights sustainability issues in terms of skilled personnel and availability of funding to provide continuity of the HCP II communication interventions after the life of the project.

innovations among partners and improving their ability to coordinate and share information; and (3) establishing and supporting local networks and partnerships. Findings indicate that HCP II had a positive impact on the MoH capacity in three ways:

1) **Improved capacity to deliver quality health services:** The expected outcomes for HCP II capacity-building interventions were to increase number of MoH officials, health workers, staff from partner organizations, and ad agencies with knowledge and skills in design, implementation, monitoring, and evaluation of strategic health communication interventions. For example, through training of health workers, particularly counselors and Radio Distance Learning of VHTs for community mobilization, HCP II increased the capacity of MoH to deliver quality health services. According to the HCP project PMP data, over 19,000 individuals (for both FY 2011 & 2012) participated in HCP-supported capacity building activities, including for VHTs over the planned 14,500 individuals that were to be reached. HCP II also increased the capacity of MoH and AIC directly. MoH benefited from HCP II training in the area of informative research in campaign tools design. According to MoH officials, participation in HCP II activities enabled MoH to appreciate the impact of well-researched and designed programs. MoH is now able to produce own materials subject to availability of financial resources.

2) **Ownership of the BCC Strategies & IEC Materials:** Study findings reveal that the process of developing IEC materials, which was participatory, created a sense of ownership for the MoH because of their direct involvement in the development, production, and distribution of IEC material as well as networking with HCP II staff. In addition, this participatory approach also improved knowledge and skills of health workers.

3) **Strategic management of the BCC activities:** HCP supported the MoH to conduct of quarterly BCC Working Group meetings, which structure enabled the MoH to coordinate and harmonize BCC activities in the country among IPs. The group was composed of communication personnel from USAID-supported IPs, local organizations involved in BCC, District Health personnel, etc., who used to meet at the MoH on a quarterly basis. The meetings were initially hosted by the IPs on a rotational basis, but the MoH later decided to host and chair them. The meetings helped the MoH coordinate BCC activities by the various IPs. The quarterly forums were a good feedback mechanism that enabled IPs to share experiences and learn about what others were doing. MoH is supposed to continue coordinating the meetings, but none has been held since the end of HCP II. The BCC working group would have been an ideal forum for developing joint communication programs and mobilizing / leveraging resources to scale up programs across the country. Absence of such a forum may lead to lack of coordination between partners regarding delivery of common messages on BCC communication.

3.5.2 Capacity of Local Partners

Findings presented in this section were gathered from local implementing partners involved in social and behavioral change, integration of health messages, in promotion of family planning, empowering young people, and provision of support to PLWHAs. Capacity building of IPs and institutional partners (CDFU, AIC, AC) and their partners was provided through technical support including numerous training in material development to improve health communication, training of trainers in child pediatric HIV, couple counseling, and development of posters, serial drama development sessions, and use of testimony videos. For the training of VHTs, HCP supported STRIDES, PACE and UHMG to train DHEs and VHTs in family planning. HCP II supported STOP Malaria to train VHTs in Mukono on malaria. HCP II also supported AI and MJAP (Mulago-Mbarara Joint AIDS) to train health workers at HCs in CHCT. HPACE and Baylor were also supported to provide training of health workers in positive living and pediatric counseling using the pediatric and HIV care and treatment guidelines. The two partners later rolled out the training at HCs.

3.5.3 Capacity for Communication/Media Organizations

- **Media Staff Capacity**

Uganda Health Communication Alliance (UHCA): Is one of the key media organizations that benefited from HCP II capacity-building initiatives. UHCA was chosen as a focal body to reach out and impart health reporting skills because it brings together health journalists in both the print and broadcast media across the country, so that that they could improve the low quality of reporting health issues such as family planning SMC, HIV among others**.** Makerere University School of Public Health (MUSPH) supported and collaborated with UHCA to build the skills of journalists in health communication in order to help them report better and reach out to the target population. A total of 400 journalists at 21 radio stations around the country benefited from the training**.** The journalists trained included the hosts of health talk shows like the Nurse Mildred drama series. Other key achievements for UHCA include the following: i) the creation of a pool of trainers in health communication who benefited from Training of Trainers (TOT) course under HCP II; ii) developed health communication modules for family planning and HIV/AIDS as a result of the training received from HCP II; and iii) developed health communication materials for journalists. UHCA has received support from the German Foundation for World Population to continue with the in-house training to radio media houses. They have also secured funding from Tobacco Control to continue with heath communication.

The level of radio station staff involvement was high. They got involved in translations of the English Version into their respective vernacular as well as hosting radio talk shows on health. The fact that the media staff were trained in-house exposed many of them to the training, including the programmers who were able to attend the training and be back just in time to change to the next program. This arrangement was better suited for all staff instead of using hotel conference halls as venues, which tends to leave others out.

Taking journalists to the field and be exposed to firsthand health rather than being fed with information from press conferences attracted more journalists. This is because journalists realized that they were building their own capacity in health reporting, and since HCP II had no copyright restrictions with their materials, it helped them to disseminate health materials more effectively and fast. For instance, the well-built capacity has attracted other health support programs such as DSW to advocate for tobacco control through the media.

4.0 LESSONS LEARNED

4.1 Implications for Future Designs, Capacity Enhancement, & Partnerships

To achieve its goal, HCP II implemented seven strategic approaches[12], most of which were very effective as per the evidence presented in this evaluation report. However, given the challenges cited in relation to each approach, it is necessary to change and/or improve the way future approaches should be designed. The following are some examples of strategies that will need to either be continued or shifted in focus and direction:

1. **Promoting and directing clients to services:** Radio is still the most cost-effective channel to bring health messages to mass audiences. This is one communication medium that should be continued along with other multimedia channels like interpersonal communication and print media.

[12] The strategic approaches included: (1) help make services more client centered; (2) promote and direct clients to services; (3) focus on underlying social issues that influence behavior; (4) improve community mobilization capacity; (5) form strategic partnerships with leaders and media representatives; (6) strengthen strategic communication capacity; and (7) build coalitions and strengthen partnerships.

2. **Focus on underlying social issues that influence behavior:** The gap in communication between adults and young people is a hindrance to the creation of a supportive social environment for youth. It is also important to note that some behaviors are challenging to change in the short run because of people's beliefs and traditions.

3. **Strengthening strategic communication capacity:** Sustainability of this strategic approach is a challenge for MoH and local IPs because it is costly to produce IEC materials that are used to promote health services.

4. **Public supportive social environments:** Environments fostered though MoH and UAC for policy formulation, direction, execution, and leadership are still essential for any future design. What may need to change is the nature of the partnerships in terms of both accountability and resource mobilization for sustainability of the BCC programs.

5. **Building coalitions and strengthening partnerships:** This approach should be continued with a focus at the community level, which was a gap. HCP II worked well through partners to form coalitions mainly at the national and district levels.

5.0 CONCLUSIONS

Overall, the project performance towards its objective of improving the effectiveness of comprehensive behavior change communication programming and implementation was partially achieved. Judging by the evidence presented, many desired behavior change outcomes in areas including HIV/AIDS, family planning, malaria, and TB were achieved although not to the expected magnitude.

Based on the evaluation findings, we conclude that behavior change communication programming under HCP has been effective in several ways towards improving the abilities of communities, families, and individuals to adopt practices that improve health. Behavior changes in reduction in risky sexual behavior practices, uptake of SMC and HIV testing, and use of family planning methods were all found to be statistically significant and positively associated with HCPII-related communication programs. The specific programs included the following: Nurse Mildred Campaign which was associated with use of family planning; Stand Proud, Get Circumcised Campaign with uptake of SMC; and CHCT with increased HIV testing. However, the National Hotline and Rock Point 256 program were not as effective in improving levels of comprehensive knowledge on HIV and health behaviors like use of family planning amongst its target community i.e. 15–24 year olds.

Despite sustained communication campaigns, levels of comprehensive knowledge on HIV/AIDS have stagnated, risky sexual behavior (not using condoms and having multiple partners) especially among young men in the 15–24 age group, voluntary male circumcision especially among the 25–49 age group and use of contraceptives still remain below desired levels. Subsequent communication and health service delivery programs need to continue to explore the barriers to behavior changes and respond with tailored interventions.

While behavioral communication interventions may instill healthy behaviors (e.g. going for testing and using contraceptives), current staffing and drug shortages at the health facilities are affecting access and utilization of services. Health services like SMC, HIV counseling and testing and family planning need to be readily available and affordable to enable communities practice the newly acquired behaviors that will lead to better health outcomes. Overall, findings indicate that behavioral change in the population takes time and has occurred somewhat but even less over the HCP II period of implementation (2007–2012).

HCP II as a focal organization on communication was deemed an effective model in terms of ensuring uniformity of behavior change messages and communication materials used. This approach also resulted in cost savings by avoiding duplication of efforts and cost savings as a result of working through partnerships. Strong relationships and leadership by the Ministry of Health was instrumental in coordinating multiple partners and enlisting commitment to use of IEC materials developed.

The Radio Distance Learning (RDL) designed as a cost effective mechanism for reaching the numerous VHTs across the country was successful in imparting knowledge to these teams who are regarded as the frontline service providers to communities. Efficiency gains are coming at a cost of potential effectiveness. Motivation of VHTs is a key issue that still needs to be investigated and addressed.

The capacity of MoH, local implementing partners, and USG implementing partners in behavior change communication has improved as a result of the practical and targeted training, access to formative research, and joint design, development, and implementation of behavior change communication strategies and campaigns facilitated by HCP. The BCC implementers in Uganda now have access to e-resources on communication strategies and tools that can be reproduced upon need.

HCP supported communication campaigns; training and other capacity building initiatives like the GOLD program which has contributed to creating a pool of behavioral change communication experts have not been found to be sustainable. Without HCP and in other cases USG funding that is currently supporting several health projects, the MoH and local partners cannot continue to run health communication programs including re-production of materials due to inadequate financial resources.

6.0 RECOMMENDATIONS

Given the approaches implemented, the recommendations below are geared towards improving not only the challenges presented in the report but also what can be done to improve future project designs and behavioral outcomes from the communication pathways model.

6.1 Project Design, Strategies, and Approaches

1. USAID should ensure that projects follow the new project design guidance (2011), which states that "sound project design requires that M&E be built into the design from the beginning." Future project designs should have clearly defined performance indicators at all levels that meet the ADS 203 standards for good indicators and thus data quality.
2. Continued use of multi-media channels including interactive radio and drama series as communication mediums for reaching a larger target audience is encouraged by all BCC implementers.
3. Given the low usage of the National Hotline (12%), and based on the finding that it lacks significant association with increasing comprehensive knowledge; future programming by the MoH and USAID may need to reconsider the target audience that should benefit from using a Hotline vis-à-vis the costs involved in running it.
4. Ministry of Health needs to explore other appropriate strategies aimed at bridging the communication gap between adults and the young people (15-24 years).
5. MoH and its development partners should conduct further investigation into drivers and barriers affecting improvements in comprehensive knowledge on HIV/AIDS, risky sexual behavior especially among young men in the 15–24 age group, voluntary male circumcision especially among the 25–49 age group and use of contraceptives to inform designs of appropriate interventions.
6. Ministry of Health should intensity efforts in improving availability and accessibility of critical health services through better staffing, provision of drugs and health commodities to absorb the demand created through behavior change communication activities.
7. USAID should continue implementation using a single communication partner with the capacity to coordinate and lead activities and provide technical assistance thus ensuring uniformity, efficiency and leveraging of resources. A close partnership with the MoH is important to ensure a buy in from other partners and rolling out of common messages, skills, and products.

6.2 Implementation & Achievement of Results

1. Ministry of Health should strengthen the BCC working group and develop a long-term resource plan for BCC activities to ensure continued implementation of BCC activities.
2. BCC partners need to mobilize adequate resources to support the continuation of IEC materials production in order to sustain the momentum created thus far.
3. Future interventions by MoH and its BCC partners should widen the age bracket to include adolescents who are below 15 because they are also becoming sexually active.
4. IPs should put in place mechanisms for monitoring the distribution and use of IEC materials in order to enhance accountability along the distribution chain.

6.3 Strengthened Institutional Capacity

1. In order to improve service delivery, future programming should consider improving and rolling out the RDL program nationwide since the program was effective in improving the skills of VHTs that serve community needs directly.

7.0 ANNEXES

Annex 7.1: Excerpt from the HCP II Final Evaluation Scope of Work

RFP: SOL-617-12-000016

Attachment "A"

Statement of Work
Health Communication Partnership Project - Final Evaluation
Kampala, Uganda

I. BACKGROUND

Strategic communication can foster social and behavioral changes that will improve availability, accessibility, and appropriate use of critical health services, leading to improved health status of the population. The Government of Uganda (GOU) recognizes the critical role of Behavior Change Communications (BCC) efforts in improving the overall health of the population, and the Ministry of Health (MOH) is therefore accelerating communication activities for HIV/AIDS; maternal, neonatal, and child health; family planning; and malaria. The United States Agency for International Development (USAID) likewise regards communication as an important tool to achieve improved health globally, and has invested in communication and behavior change programs for more than 30 years. As such, BCC is an important component of the USAID/Uganda strategy in the health sector.

In 2004, USAID/Uganda entered into a 3-year Associate Award (AA) with The Johns Hopkins University through the Health Communication Partnership, a Leader with Associates Cooperative Agreement within the Global Health Bureau. The purpose of the Associate Award was to design and implement a comprehensive behavior change communication (BCC) initiative intended to motivate young Ugandans between the ages of 15-24 to adopt healthy reproductive and sexual behaviors. The initiative was designed to support USAID and the Government of Uganda's efforts to reduce HIV/AIDS prevalence among youth, to reduce teenage pregnancy, and to improve young girls' prospects of staying in school. The AA led to the development and implementation of the highly visible and well respected Young Empowered and Healthy (YEAH) initiative, which deals with social factors that underlie risky sexual behavior. The AA ended in June 2007.

On July 1, 2007, USAID signed a new $6,000,000 Associate Cooperative Agreement with The John Hopkins University through the Health Communications Partnership to implement a three-year program of broad communications support for the health sector in Uganda. The Agreement was later extended two years, through 2012. The purpose of this five-year program ("HCP II") was to bolster the effectiveness of communication programming and implementation under the Investing in People objective. Under this award, Hopkins was expected to:

- continue ongoing communication initiatives and partnerships, such as YEAH, Be A Man, and TREAT, and to support malaria and family planning (FP) efforts, while initiating new areas of assistance and support (e.g. for tuberculosis (TB) and HIV counseling and testing)
- contribute to shaping societal norms to enable social and behavioral change to take place

- contribute to capacity building of Ministry of Health and local implementing partners (IPs) and increase the professionalism and standards of communication approaches that are most popular in Uganda, including media, music, and drama
- serve as the source of expertise on communications for other IPs, including development of communications materials to support their activities

Intermediate Results (IR) expected of HCP II, along with key results for each IR, are included in Annex 1.

II. PURPOSE OF THE EVALUATION

USAID/Uganda is commissioning the HCP II project final evaluation to assess the effectiveness of the major behavioral change communications approaches implemented under the project and identify factors for success.

By answering the evaluation questions below, the evaluation will document major achievements in behavior change and successful approaches that contributed to these achievements. In addition, the evaluation will identify HCP II's limitations, challenges, and opportunities for improvement (what could have been done differently to add to project achievements). Finally, the evaluation will establish lessons learned and good practices that should be adopted in future programs. Information from this evaluation will be used to inform designs of future program work by USAID and the Government of Uganda.

III. KEY EVALUATION QUESTIONS

The contractor will use empirical evidence from high-quality data to answer the following evaluation questions:

1. To what extent did HCP II achieve each and all expected outcomes under the three Intermediate Results presented in Annex 1? (Note: while the narrative may be limited to highlighting major achievements and opportunities for improvement and need not separately address each expected outcome, a table presenting summary performance data and a summary assessment of the extent to which each outcome was achieved will be required).
2. Which project approaches contributed to major project achievements and which project approaches may have resulted in poor or less than expected performance? Specifically, discuss the effectiveness of the model of one broad communications project supporting efforts of other Implementing Partners, the extent to which materials developed by HCP were utilized by other projects, and the effectiveness of the approaches used by the YEAH campaign and the GOLD program. To the greatest extent possible, analyze data from 2008, 2010, and 2012, and any other empirical data, to assess association and/or causality between project approaches and actual behavior change.
3. What is the impact of HCP II on the capacity of local IPs and the MOH to conduct communications activities without continued technical assistance?

Annex 7.2: Detailed Methodology, List of Selected Districts, & Summary of FGDs

A. Description of the Qualitative and Quantitative Approaches

Qualitative Approaches:

Qualitative approaches entailed the use of several methods: document reviews; key informant interviews (KII); focus group discussions (FGDs); a stakeholder matrix for assessing partnerships; and observation.

i) Document Reviews

The team conducted a thorough review of available literature and project performance reports on behavioral changes that were undertaken during implementation. Secondary data was also analyzed for trends or changes in key outcome indicators over time. Several key documents were reviewed by the team and include but are not limited to the following: Assessment of HCP II project; annual and quarterly reports; population-based surveys undertaken by HCP II; and YEAH evaluation reports, among others. The detailed list of the documents is attached in the Annexes as References. The document review was guided by the key evaluation questions.

ii) Key Informant Interviews (KII)

Another small sample of implementing partners was selected in each region as key informants to assess the extent to which their behavioral change interventions, communication initiatives, and partnerships were successful in contributing to the achievement of the project intermediate results. In addition to the sampled IPs, government and institutional partners were selected to corroborate the extent to which they believe the HCP II interventions led to the project results. The evaluation team also conducted a KII with the counselors from each region who hosted the call-in radio program.

iii) Focus Group Discussions (FGDs)

Focus group discussions (FGDs) were conducted by bringing together participants from homogenous community groups to determine beneficiary perceptions/views regarding the success and/or effectiveness of the various communication channels and media used by the project in delivering messages to target audiences. Discussions focused on access to messages communicated, their knowledge, attitudes and behavioral responses. FGDs targeted the youth, men, and women in the reproductive age group, VHTs, and People Living with HIV/AIDS (PLWHAs), which will constitute some of the homogenous groups.

Each team conducted at least four to five FGDs with about eight to twelve participants in the selected districts across the four regions of the country, bringing the total to about 43 FGDs. The location of the FGDs took into account urban or peri-urban centers and the rural localities. Composition of the FGDs also took into account gender and education level representation. The team sought assistance from the sub-county chief and health centers to mobilize FGD participants. The FGDs were conducted along the proposed discussion guidelines and questions and generally lasted about one hour on average. The interview guide questions were informed by document review and the key evaluation questions. The instruments were tested with a convenient sample of target community in Masuriita, a suburb of Kampala city. The FGDs were conducted by trained research assistants supervised by senior researchers on the evaluation team.

iv) Stakeholder Matrix

Interviews were conducted with all the various key stakeholders from government and other institutional partners to assess the partnerships and or synergies that may have been essential facilitating implementation of the project interventions. A stakeholder matrix was used to interview different partners on their perceptions about the effectiveness of the partnerships formed under HCP II.

v) Observation

Observations were also made at health centers and public places for posters and any other signs of Information, Education, and Communication (IEC) materials.

Quantitative Approaches:

For quantitative data, trend analysis was conducted using existing data from the 2008, 2010, and 2012 surveys, in order to answer the Evaluation Question 1 in particular regarding the extent to which HCP II was able to achieve each and all expected outcomes under its three intermediate results. A big part of this analysis also constitutes using the project PMP data to map results according to the results framework.

The Evaluation Phases

The evaluation design entailed four key phases, during which the first two phases were focused on collecting relevant information from both the quantitative and qualitative methods. The design also entailed assessing all aspects of project design, implementation, and reporting.The HCP II evaluation design phases were as follows:

- **Phase 1: Inception & Design Phase:** This included but was not limited to the following tasks: Desk review and design of evaluation approaches; presentation of the inception report and work plan; field testing of evaluation tools and their refinement; conducting key informant interviews (KII) with all relevant stakeholders within Kampala; and analysis and identification of the issues from the above to inform the redesign of the focus group discussions, where necessary.

- **Phase 2: Field Work Upcountry:** This included conducting both key informant interviews and focus group discussions; preparation of the summary reports that highlights key issues for each stakeholder category; preparation of a "Stakeholder Analysis Matrix," which was used to assess effectiveness of partnerships; concurrent trend data analysis and results mapping using the 2008, 2010, and 2012 surveys; and program performance data, respectively.

- **Phase 3: Preliminary Report Write-up & Submission:** prepared reports for each region; conducted content analysis across the various stakeholder categories and regions; triangulated data from the quantitative analysis (trend analysis & results mapping) with the emerging qualitative themes; prepared and submitted the draft preliminary report; and submitted the preliminary findings to the client, USAID/Uganda Mission.

- **Phase 4: Preparation of the Main Draft Evaluation Report – was conducted later in November–January and entailed the following:** prepared a summary of key variables that were necessary to inform the emerging themes presented in the Preliminary Report; extracted data on key from the JHU survey data on the selected key variables; generated descriptive statistics using SPSS; conducted cross tabulations (chi-square), t-tests, and regression analysis where necessary to assess the significance of assumed relationships based on the inherent development hypothesis for HCP II (as stipulated in the HCP II Theory of Change); triangulated data from the current quantitative analysis with findings presented in the preliminary report; completed the write-up of the main evaluation report; presented overall findings from the four phases to key stakeholders and the USAID/Uganda Mission; and incorporated comments and submitted the final evaluation report.

B. List of selected Districts

No.	Name of District	USAID Implementing Partner	Region
1.	Kamuli	HCP II, UHMG, STRIDES	East
2.	Soroti	HCP II, SMP,UHMG	
3.	Mbale	STAR-E,UHMG	
4.	Apac	HCP II, UHMG	North
5.	Lira	HCP II, UHMG	
6.	Arua	HCP II, UHMG	
7.	Kalangala	UHMG, STRIDES	Central
8.	Masaka	UHMG,SMP	
9.	Mukono	UHMG,SMP	
10.	Bushenyi	HCP II, UHMG	South West
11.	Hoima	HCP II, SMP	West

C. Summary of Key Informants

No KIII	ORGANIZATION	TITLE OF RESPONDENT	NAME OF RESPONDENT	TELEPHONE NUMBER	E-MAIL
1	AIC	Regional Manager, Kampala	Sam Wanamama	0772622040	swanamama@aicug.org
2		Counselor YEAH	Peace Busingye	0776844970	enidpeace@yahoo.com
3		Counselor HCCT	Grace Namwanje	0772547282	namwanjeagens@yahoo.com
4	CDFU	Executive Director-Projects	Anne Gamurworwa	0772426753	anne@cdfuug.co.ug
6		Hotline Counselor / Supervisor	Richard Mashero	0782885566	mashero@gmail.com
7		Hotline Alcohol Counselor	Lawrence Engurat	0712663166	cengurat@yahoo.co.uk
8	MOH	SEN Health Educationist / Co-coordinator Rep Health	Lillian Luwaga	0772423082	
9		National Co-coordinator for HBC	Dr. Apollo Kansiime	0772551377	akansiime@yahoo.com
10		HIV Response Coordinator – Private Sector	Simon Mwima	0779222111	Simonmwima@yahoo.com
11		ASST. Commissioner Health Services, Health Promotion & Education	Dr. Paul Kagwa	0712507799	paulkagwa@yahoo.co.uk
12	UAC	AG. Head National Response / YEAH Coordinator	Namulundu Joyce Kadowe	0772590246	Jajkadoweymail.com
13	SUSTAIN	Technical advisor	Dr.Cordelia	0752-368550	

No KIII	ORGANIZATION	TITLE OF RESPONDENT	NAME OF RESPONDENT	TELEPHONE NUMBER	E-MAIL
		Pediatrics HIV/AIDS	Katureebe		
14	Reproductive Health Uganda	Peer Educator YEAH	Isaiah Ainebyona	0782-294004	
15	Marie Stopes Uganda	BCC Manager	Duncan Musumba	759-244712	
16	World Vision	YEAH Coordinator	Richard Kintu	0702- 469017	
17	TASO	Counselor Trainer	Goretti Nakabugo	0752- 774175	
18	UHMG	Communication Manager	Daudi Ochieng	772- 506404	
19	NACCWOLA	Executive Director	Buluba Florence	0772- 474768	
20		Assistant Communication Manager	Andrew Kibirango	0703- 692181	
21	USAID/Uganda	Mission, M&E Specialist	May Mwaka		
		COR, HCP II	Rhobbinah Ssempebwa		
22	HCP II Staff	COP	Cheryl Lettenmaier		

D. Summary of FGDs

No FGDs	District	Sub-county &village	Group category	No male	No female	Total	KIIs	Exit interviews
	EASTERN						DHE	FGD with SMC clients in place of exit interview at Namwendwa HCIV
1	**Kamuli**	Bugabula/Saaza zone	Youth	5	4	9		
2		Bugabula/Buyinga	PLHIV	3	3	6		
3		Bugabula/Buyinga	Adults	4	4	8		
4		Bugabula/Buyinga	SMC	11	0	11		
6	**Soroti**	Arapai/Dakabela	PLHIV	2	2	4	DHE ,Voice of Soroti, ETOP	VCT, FP service providers, clients Princes Diana HCIV
7		Arapai/Dakabela	Youth	4	4	8		
8		Western Division Wire Cell	Adults	8	6	14		
9		Northern Division	Youth	6	4	10		
10	**Mbale**	Busboy	Youth	8	3	11	DHE, NBR FM in Ninja	VCT, FP service providers, clients at Busui HCIV
11		Busboy	Adults	8	3	11		
12		Northern Division/Bujoloto	PLHIV	8	3	11		
	CENTRAL							

No FGDs	District	Sub-county &village	Group category	No male	No female	Total	KIIs	Exit interviews
13	**Mukono**	Nnama/Katogo	Adults	6	5	11		
14		Nnama/Katogo	Youth	5	6	11		
15		Nnama/Katogo	PLHIV	2	2	4		
16		Mukono Town	VHT	3	5	8		
17	**Masaka**	Namasenene	Adults	7	5	12	DHE	VCT, FP providers, clients at Uganda Cares hospital
18		Namasenene	PLHIV	5	8	13		
19		Kyamulibwa	VHTs	7	7	14		
20		Masaka Town	Youth	4	5	14		
21	**Kalangala**	Kalangala Town	Youth	4	10	14	DHE, CDO, KFPLHIV	VCT,FP service providers and clients at Kalangala HCIV
22		Lutoboka Fishing Village	PLHIV/Adults	4	5	9		
	WESTERN							
23	**Hoima**	Kitoba	Youth	8	16	24		Service providers at Kigolobya HCIV
24		Kitoba	Adult	6	11	17		
25		Kitoba	PLHIV	1	8	9		
26	**Kabalore**	F/P Municipality	Youth	5	5	10		Service provider and clients at Kataraka HCIII
27		F/P Municipality	Adult	4	7	11		
28		F/P Municipality	PLHIV	2	6	8		
29	**Bushenyi**	Kyabugimbi	Youth	4	4	8		Service providers and clients at Kyabugimbi HCIV
30		Kyeizooba	Adult	4	4	8		
31		Kyeizooba	PLHIV	4	5	9		
	NORTHERN[13]							
32	**Arua**	Oli	Adults			11	AIC Regional Manager. DHO	VCT, FP, SMC service providers and clients at Arua regional referral hospital &Oli HC
33		Dubai	Adults			14		
34		Arua town	Youth			5		
35		Dubai	Youth			12		
36		Arua Town	PLHIV			8		
37		Oli	VHT			6		
38	**Lira**	Lira Town	VHT			8	DHE, AIC Regional Manager	Service providers and clients
39		Lira Town	PLHIV			7		
40		Ayago	Adults			8		
41		Ober	Adults			9		
42		Ayago	Youth			9		
43		Ogur	Youth			15		
44	**Apac**	Aduku	Adults			9		VCT, FP,SMC service providers and clients
41		Aduku	PLHIV			6		
42		Village Inn	Adults			5		
43		Apac Town	Youth			7		

[13] **Note**: The selected districts for Northern Region were Arua; Lira; and Apac; because Arua & Apac were part of the baseline districts. The list of districts in Table 2 of the Inception report included: Apac; Lira; and Dokolo, which are being covered in the JHU survey. However, as a team we had decided to follow mainly the baseline districts, which change was not reflected during the submission of the Inception report.

E. Health Centers and Hospitals Visited in the Four Regions

Central Region	Eastern	Western	Northern
Katoogo HCII – Mukono	Namwendwa HC IV - Kamuli	Kigorobya HCIV – Hoima	Oli HC – Arua
Goma HCII- Mukono	Princes Diana HC IV - Soroti	Kataraka HCIII – Kabarole	Ober HC – Lira
Masaka Hospital- Masaka	Dakabera HC 111 - Soroti	Kyabugimbi HCIV – Bushenyi	Ayago HC – Lira
Kalangala HCIV- Kalangala	Busiu HC IV - Mbale		Ogur HC - Lira
			Aduku HC – Apac
			Village Inn HC – Apac
			Ikwera HC – Apac

Annex 7.3: List of HCP II PMP Indicators & Trend Data from 2008 - 2012

#	INDICATOR TITLE	2008	2010	2012 (Data Source: BCC Evaluation 2012)
1	PERCENT OF MEN AND WOMEN 15- 49 YEARS OLD WHO TOOK AN HIV TEST AND RECEIVED THEIR RESULTS IN THE LAST 12 MONTHS	26	41	Male =61
		38	46	Female = 76
		32	44	**Overall = 68**
2	PERCENT OF SEXUALLY ACTIVE MEN AND WOMEN AGED 15-49 YEARS WHO KNOW THE HIV STATUS OF THEIR SEXUAL PARTNER(S)	55	61	Male = 60
		47	45	Female = 46
		51	*53*	**Overall** =53
3	PERCENT OF UNMARRIED YOUNG MEN AND WOMEN AGED 15-24 YEARS WHO HAVE NEVER HAD SEX	43	54	Male = 47
		62	66	Female = 48
		52	*60*	**Overall** = 47
4	PERCENT OF SEXUALLY ACTIVE MALES AND FEMALES (15-49 YEARS OLD) WHO HAD SEX WITH ONLY ONE PARTNER IN THE PAST 12 MONTHS	71.8	70.6	Male = 70
		93.5	90.5	Female = 78
		83	*81*	**Overall** = 72
5	PERCENT OF WOMEN AGED 15-49 WHO ARE CURRENTLY USING ANY MODERN FAMILY PLANNING METHOD			35
6	PERCENT OF INDIVIDUALS AGED 15-49 YEARS WHO INTEND TO OBTAIN SERVICES OR ADOPT PRACTICES PROMOTED BY HCP			Not collected
7	PERCENT OF MEN AND WOMEN (15-49 YEARS) WITH PERCEIVED SELF-EFFICACY TO ADOPT HCP-PROMOTED SERVICES AND PRACTICES			Not collected
8	PERCENTAGE OF INDIVIDUALS (15–49 YEARS) IN PROJECT AREAS WHO KNOW WHERE TO OBTAIN HCP-PROMOTED SERVICES			Not collected
9	PERCENT OF 15-49 YEAR OLDS IN PROJECT AREAS WITH COMPREHENSIVE KNOWLEDGE ABOUT HIV/AIDS TRANSMISSION AND PREVENTION	59	53	Male = 58
		52	47	Female = 56
		56	*50*	**Overall** = 53
10	PERCENT OF MEN AND WOMEN 15 – 49 YEARS OLD WHO HAVE EXPANDED KNOWLEDGE OF ARVS	**37**	**41**	Male = 37
		37	**48**	Female = 35
		37	45	**Overall = 36**
11	PERCENT OF CURRENTLY MARRIED MEN AND WOMEN (15 – 49 YRS) WHO WANT TO HAVE LESS THAN 5 CHILDREN	41	46	Male =60
		53	52	Female = 67
		47	50	**Overall = 63**

#	INDICATOR TITLE	2008	2010	2012 (Data Source: BCC Evaluation 2012)
12	PERCENT OF CURRENTLY MARRIED MEN AND WOMEN (15 – 49 YRS) WHO BELIEVE THAT MOST MEN AND WOMEN LIKE THEM IN THEIR COMMUNITY WANT TO HAVE LESS THAN 5 CHILDREN	38	29	Male = 79
		42	41	Females = 75
		40	35	**Overall = 77**
13	PERCENT OF MEN (15-49 YEARS OLD) WHO ARE AWARE THAT MALE CIRCUMCISION CAN REDUCE THE RISK OF MEN BEING INFECTED WITH HIV/AIDS	31	80	81
14	PERCENT OF INDIVIDUALS 15-49 YEARS OLD EXPOSED TO MESSAGES AND INFORMATION ON HCP-PROMOTED SERVICES AND PRACTICES			Not collected
15	PERCENT OF INDIVIDUALS 15–49 YEARS OLD AWARE OF POLICIES AND LAWS DISSEMINATED THROUGH ITERVENTIONS SUPPORTED BY HCP AND ITS PARTNERS			Not collected
16	PERCENT OF MEN 15-49 YEARS OLD IN SELECTED DISTRICTS WHO SCORE POSITIVELY ON THE GEM (GENDER EQUITABLE MALE) SCALE INDEX OF SEX EQUITY ATTITUDES	22	30	Not collected
17	PERCENTAGE OF CURRENTLY MARRIED MEN AND WOMEN 15–49 YEARS OLD WHO DISCUSS FAMILY PLANNING WITH THEIR PARTNERS/SPOUSES	50	51	Male = 51
		40	51	Female = 57
		45	51	**Overall = 54**
18	PERCENT OF MEN AND WOMEN (15 – 49 YRS) WHO APPROVE OF MEN AND WOMEN USING SELECTED SRH SERVICES			Not collected
19	PERCENT OF MEN AND WOMEN AGED 15–49 YEARS WHO HAVE ENCOURAGED OTHERS TO ADOPT OR CONTINUE USING PRACTICES PROMOTED BY HCP			Not collected
20	PERCENT OF MEN AND WOMEN AGED 15–49 YEARS WHO REPORT THAT THEY ENCOURAGED OTHERS TO START OR CONTINUE USING PRACTICES PROMOTED BY HCP AND ITS PARTNERS. PRACTICES PROMOTED BY HCP AND PARTNERS INCLUDE: RESPONSIBLE DRINKING, FAITHFULNESS, ABSTINENCE, CONDOM USE, TESTING FOR HIV, DISCLOSURE OF HIV PERCENT OF INDIVIDUALS 15-49 YEARS OLD WHO DISAPPROVE OF RISKY SRH PRACTICES AMONG YOUNG PEOPLE			Not collected

#	INDICATOR TITLE	2008	2010	2012 (Data Source: BCC Evaluation 2012)
21	PERCENT OF MEN AND WOMEN 15 – 49 YEARS WITH ACCEPTING ATTITUDES TOWARD PEOPLE LIVING WITH HIV/AIDS			Not collected
22	PERCENT OF DISTRICTS IMPLEMENTING ACTIVITIES, STRATEGIES AND POLICIES TO ADDRESS BARRIERS TO UPTAKE OF HCP-PROMOTED SERVICES AND PRACTICES IN THE LAST 12 MONTHS			Not collected
23	PERCENT OF HCP-SUPPORTED ORGANIZATIONS THAT SCORE AT LEAST 60% IN THE SIX CORE HEALTH COMMUNICATION COMPETENCY AREAS			Not collected

Output Indicators

#	INDICATOR TITLE	2008	2010	2012	Data Source
1	NUMBER OF INDIVIDUALS REACHED THROUGH RADIO WITH HCP SUPPORTED MESSAGES	1,299,447	ND	2,924,587	**USAID PRS**
2	NUMBER OF INSTITUTIONS THAT RECEIVE HCP SUPPORTED IEC MATERIALS	N/A*	89	1,228	**USAID PRS**
3	NUMBER OF STAKEHOLDER REPRESENTATIVES ORIENTED ON NEW HEALTH POLICIES OR STRATEGIES	N/A*	ND	958	**USAID PRS**
4	NUMBER OF LEADERS, MEDIA WORKERS, AND COMMUNITY RESOURCE PERSONS WHO RECEIVE HCP SUPPORTED IEC MATERIALS	1884	ND	2,254	**USAID PRS**
5	NUMBER OF HEALTH FACILITIES THAT RECEIVE HCP SUPPORTED IEC MATERIALS	496	ND	807	**USAID PRS**
6	NUMBER OF INDIVIDUALS WHO PARTICIPATE IN HCP-SUPPORTEDCAPACITYBUILDINGACTIVITIESFORVILLAGE HEALTH TEAMS (VHTS)	N/A*	ND	5,654	**USAID PRS**
7	NUMBER OF INDIVIDUALS WHO PARTICIPATE IN HCP-SUPPORTED COMMUNICATION CAPACITY BUILDING ACTIVITIES (EXCLUDING VHTS)	N/A*	ND	488	**USAID PRS**
8	NUMBER OF CALLS RECEIVED FROM THE HOTLINE	N/A*	ND	51,421	**USAID PRS**
9	NUMBER OF SERVICE PROVIDERS TRAINED	N/A*	ND	ND	**USAID PRS**
10	NUMBER OF HOTLINE CALLERS COUNSELLED, REFERRED OR PROVIDED INFORMATION	N/A*	ND	16,659	**USAID PRS**
11	NUMBER OF ORGANISATIONS COLLABORATING WITH HCP TO DESIGN, IMPLEMENT, MONITOR AND EVALUATE	402	136	176	**HCP Quarterly**

#	INDICATOR TITLE	2008	2010	2012	Data Source
	HEALTH COMMUNICATION PROGRAMS				**Reports**
12	NUMBER OF COMMUNITIES INVOLVED IN DESIGNING AND IMPLEMENTING BEHAVIOR CHANGE COMMUNICATION ACTIVITIES	306	926	601	**HCP Quarterly Reports**

N/A* means Baseline was in 2010.

Annex 7.4: Detailed Communication Strategies

1. **Strategies designed for HIV/AIDS included:**

- **Pediatric HIV/AIDS Communication Strategy:** HCP II provided technical support to the Ministry of Health, Baylor Uganda, and partners to develop the National Pediatric HIV/AIDs Communication Strategy, which the ministry and other implementing partners in this area use to guide their communication activities. In addition, HCP II provided the technical review of the institutional Communication Strategy for Baylor College of Medicine Children's Foundation-Uganda to promote its branding and public relations in the country.

- **"Treat for Life" Communication Strategy:** HCP II supported Joint Clinical Research Center (JCRC) to develop the "Treat for Life" communication Strategy to promote ART among adults and children living with HIV. The purpose of the campaign was to increase uptake and adherence for HIV/AIDS services offered by JCRC.

- **Positive Living Communication Strategy:** HCP II supported the Ministry of Health to develop the Positive Living Communication Strategy to promote positive living among PLHIVs and delay initiation to ART. HCP II coordinated the process with the involvement of other IPs; PACE, STAR–E, EC, SW. SPEAR and TASO.

- **CHCT Communication Strategy:** HCP II supported AIDS Information Center (AIC) as the coordinator and in collaboration with AIDS Control Program (ACP) and Makerere Mbarara Joint AIDS Program (MJAP) to develop the CHCT Communication Strategy to promote couple HIV counseling and testing as entry points to both HIV prevention and treatment in the country.

- **Communication Strategy for SMC:** HCP II partnered with the Makerere University School of Public Health (MUSPH) and supported the Ministry of Health to develop the Communication Strategy for SMC in Uganda. The strategy aimed at scaling up uptake of SMC services countrywide to enable Uganda to circumcise a specific number of men and achieve required targets on HIV prevention. The strategy is currently being implemented by Rakai Health Services Program, Makerere University Water Reed Project, STAR–E, EC, and SW.

2. **Strategies designed for TB/HIV included:**

- **TB/HIV Communication Strategy:** The MoH already had a TB/HIV Collaboration Policy and a Communication Strategy. HCP II supported the ministry to together with TB Control Assistance Program (TBCAP) to review the communication strategy, identify gaps, and come up with a revised message and media plan that guided partners in implementing a multimedia TB/HIV communication campaign. Partners who implemented the campaign include; TBCAP, Northern Uganda Malaria AIDS and Tuberculosis (NUMAT), Malaria Consortium, STAR-EC, and STAR-E.

3. **Family planning strategies included:**

- **Male Involvement Campaign Communication Strategy:** The HCP II worked with the MoH through the Reproductive Health department and with a consortium of family planning partners under the Family Planning Revitalization Working Group (FPRWG) to develop a national campaign strategy on Male Involvement Campaign. This guided the Fred and Bernard Campaign which included the "Neighbors" drama series to help increase male involvement in family planning.

- **Unmet Need Campaign Communication Strategy:** HCP II also worked with MoH and the FPRWG to develop a communication strategy for the family planning unmet need. This campaign guided the Nurse Mildred radio drama series among other communication interventions

4. **National Communication strategy on Malaria Control:** HCP II provided technical support to the Malaria Control Program of the Ministry of Health to develop a communication strategy on malaria prevention and control. The multilayered strategy focused on three areas of preventing malaria in pregnancy: Intermittent Preventive Treatment in Pregnancy (IPTP), promoting the use of Long-Lasting Insecticide Treated Mosquito Nets (ILLINs), and promoting Indoor Residual Spray (IRS) in Northern Uganda.

Annex 7.5: HCP II Programs & their Communication Channels

No	HCP II Program	Purpose	Communication channel used	Partners
1	**Young Empowered and Healthy (Y.E.A.H)**	Encourage young people to abstain from sex, stick to one sexual partner or use a condom, knowing own and partner's HIV status, drinking responsibly or not at all, treating partners nonviolently, PMCT, and SMC	Rock Point 256 (weekly radio drama) and comic book series	UAC, CDFU, Regional Lead Organizations (RLOs), Young People Advisory Groups (YAGs)
2	**Couple HIV Counseling and Testing (CHCT)**	Encourage couples to talk to partners about going for HIV testing, couples testing for HIV and knowing results together, disclose HIV status to partner,	Go together, Know Together (Multimedia; radio, TV spots, posters, billboards, community drama and video testimonies), logo and signage at health facilities	MoH, AIC, IRCU,
3	**Medical Male Circumcision for HIV Prevention**	Increase public understanding of SMC and HIV prevention	Public debates, radio and TV talk-shows, frequently asked questions materials and brochures	MoH, Makerere University School of Public Health (MUSPH), STAR E, EC & SW, IRCU
4	**Adult Antiretroviral Therapy (ART) and Pediatric ART**	Enhance understanding of positive living and practices among adults living with HIV Address challenges experienced by adolescents living with HIV Improve understanding and uptake of ARVs among children living with HIV	Radio Diary series *My Life My Story*, Radio Diary Discussion Guides, Health Workers, Positive Living Profiling Tool, Peer educators, Jessica and Mike Tool, interactive games (Make a Positive Start), posters, fact sheets, community leaders	MoH, PACE, JCRC,
5	**Family Planning**	Increase un met need for modern family planning methods	*Neighbors* (mini drama series) Nurse Mildred (weekly radio drama and call-in-talk-	MoH, RHU, PACE, Strides for Family Health, UHMG, Mari topes, IRCU and DHTs,

No	HCP II Program	Purpose	Communication channel used	Partners
			show) Rainbow with yellow flower at health facilities National Health Hotline	
6	**Integrated Communication** 1. National Health Hotline 2. Radio Distance Learning (RDL)	Provide a platform for delivering integrated messages on HIV prevention, care & treatment, SMC, CHCT, family planning, alcohol and GBV. Improve skills of VHTs	Telephone Hotline , Radio Booklets for group discussions Promotional posters	Hotline: MoH, UAC, CDFU, MoH, DHEs
7	**Capacity Building** 1. GOLD 2. Media for health promotion	Capacity strengthening of implementing partners. Improved knowledge and skills for young professionals and journalists.	Seminar Series and placements for GOLD	PSFU UHCA, MUSPH

Annex 7.6: Summary Trend Data FP, SMC, HIV, and Malaria (2006 – 2012)

(A) Indicator	(B) HCP II Baseline (2008); - %	(C) HCP II Midterm (2010) %	(H) BCC Evaluation (2012) %	(E) UDHS 2006 - %	(F) UDHS 2011 - %	(G) % Change =(F)-(E)
a) Comprehensive knowledge of AIDS[14] (men & women 15-49 years)	55.5	49.8	53.0	33.7	38.4	+4.7
b) Comprehensive knowledge on Condom source among 15-24 years (Men and women)	N/A	N/A	N/A	73.9	78.0	+4.1
c) Percent of young women (15-24 years) sexually active unmarried individuals who used a condom at last sex	48.0	51.9	63.9	39.3	53.6	+14.3
d) Percent of young men (15-24 years) sexually active unmarried individuals who used a condom at last sex	*53.5*	*60.6*	*57.8*	*55.9*	*62.7*	*6.8*
e) Percent of women (25-49 years) sexually active unmarried individuals who used a condom at last sex	*29.2*	*N/A*	*N/A*[15]	*39.2*	*42.5*	*+3.3*
f) Percent of men (25-49 years) sexually active unmarried individuals who used a condom at last sex	*36.9*	*N/A*	*N/A*	*61.9*	*69.7*	*+7.8*
g) Male circumcision (15-24 years)	19.5	21.5	22.3	21.4	29.8	+6.9
h) Male circumcision (15-49 years)	22.1	24.1	18.6	23.6	26.8	+1.2
i) Male circumcision (25-49 years)	23.0	25.0	16.9	25.2	25.9	+0.7
j) HIV testing and received results among women 15-49 years	38.3	46.3	75.5	24.8	71.0	+46.2
k) HIV testing and received results among	25.6	40.8	60.9	20.7	52.0	+31.3

[14]Comprehensive knowledge means knowing that consistent use of condoms during sexual intercourse and having just one uninfected faithful partner can reduce the chance of getting the AIDS virus, knowing that a healthy-looking person can have the AIDS virus, and rejecting the two most common local misconceptions (a healthy-looking person can have the AIDS virus and that a virus can be transmitted through mosquito or other insect bites, by sharing food with someone who is infected, or by witchcraft or other supernatural means) about transmission or prevention of the AIDS virus.

[15]Observations for 2012 selection too few to make conclusive findings

(A)	(B)	(C)	(H)	(E)	(F)	(G)
Indicator	HCP II Baseline (2008); **- %**	HCP II Midterm (2010) **%**	BCC Evaluation (2012) **%**	**UDHS 2006 - %**	**UDHS 2011 - %**	**% Change =(F)-(E)**
men 15-49 years						
l) Women who know that HIV transmission can be reduced by taking special drugs during pregnancy	N/A	N/A	N/A	65	78	+13.0
m) Women who know that HIV transmission can be reduced by taking special drugs during pregnancy	N/A	N/A	N/A	64	73	+9.0
n) Use of modern contractive method among married women aged 15-49 years	24.6	28.1	N/A	17.9	25.9	+8
o) Average number of children ever born by women 15 – 49 years	N/A	N/A	N/A	3.5	3.2	-0.3
p) Use of any mosquito net in a household	N/A	N/A	N/A	34.3	74.0	+39.7
q) Own at least one ITN mosquito net in a household	N/A	N/A	N/A	15.9	59.7	+43.8
r) Children below 5 years reported to have had fever in last 2 weeks prior to the survey	N/A	N/A	N/A	41.0	40.0	-1.0%

N/A=Not Available

Annex 7.7: HCP II Programs vis-à-vis Strategic Approaches

No	Program	HCP II strategic approach(es)	Approaches that were Effective
1	YEAH	Used all 7 approaches but centered on approach 3, which focused on underlying social issues that influence heath behavior to achieve individual and social behavior	**Rock Point 256** was a major success in imparting knowledge to the youth. Myths and negative attitudes were less pronounced among the youth, especially the males, than adults and were more responsive to the condom and SMC Campaigns than the married adults. Although the approach of focusing on underlying social issues that influence health behavior was not effective as anticipated with regard to practices, it did achieve the expected results to a large extent.
2	GOLD	Used approach 6: Strengthen strategic communication capacity through training and mentoring.	This was a very clear and focused program, which used one approach and was effective in building the capacity for BCC among young graduates. GOLD identified a BCC capacity gap among partners and bridged the gap through training and workplace mentoring. A significant number (28 out of 30) have since got jobs with IP. The approach achieved significant results.
3	CHCT	Centered on approach 2: Making services more client centered through client empowerment and training of health workers and counselors to promote and achieve couple HIV counseling and testing (behavior change).	The promotions were good and the number of people seeking HCT services increased. This could partly be attributed to the practice at most HCs to test every patient who reported with any sickness for HIV. The increase among women testing for HIV was also much higher than the men. However, the men accounted for the low figures of couples that went for testing together. The CHCT Campaign was also affected by the constant stock-outs of HIV testing kits at health centers, which discouraged many service seekers.
4	Family Planning	Used approaches focusing on 2, 3, and 5	The level of knowledge about FP methods was high among the respondents. Almost every female in the reproductive age group reported using at least one FP method. Many respondents listened to ***Nurse Mildred*** and could easily understand the associated poster. However, dealing with side effects remained a major challenge. Male involvement is increasing but at a slow rate. The approaches used have achieved modest results thus far.
5	SMC	Used approaches 1 & 2 – Promoting use of services for individual behavior change, client empowerment through training of health workers and orientation of health workers and counselors on the use of job aides.	The approaches used were very effective both in knowledge creation and health service-seeking practices. The campaign triggered a high demand especially among the youthmore than what the health centers could sometimes cope with. The approaches achieved significant results, especially in Eastern Uganda where it was already embedded in the cultural practices.
6	PLHIV -Adult ART/ -Positive Living	Used approaches 1 & 2 – Promoting use of services for individual behavior change	This is one of the HCP II interventions which were implemented towards the end of the project. The PLHIV exhibited a good understanding of the key elements of positive living including supporting adolescents living with HIV to cope with the challenges such as adherence to treatment.
7	National Health Hotline	Counseling and referral to services. Promoting utilization of available services across all above programs. Approaches 1 & 2.	The partners managing the Hotline reported a high number of callers averaging 400 per day. However, most respondents were still not aware of the Hotline and had never used it. The cost for maintaining the Hotline service by the partner is too high and prohibitive in the long run for it to be sustainable.
8	Radio Distance Learning program for VHTs	Used approaches 4 and 5 through experiential learning (training), community mobilization and capacity strengthening (training).	The RDL is a cost-effective mode of imparting knowledge to a large number of target groups as such was the case with VHTs. However, it has not been possible to keep track and control the learning outcomes. Some VHTs also complained experiencing lack of cells for the radio sets.
9	Pediatric ART	Used approaches 1 & 2 – Promoting use of services for individual behavior change	The participants living with HIV exhibited awareness about the need to go for PTC when expecting a child, testing children for HIV, early start on treatment as well as the feeding options for children living with HIV.

No	Program	HCP II strategic approach(es)	Approaches that were Effective
10	Malaria Communication	Used approaches 1 & 2 – Promoting use of services for individual and social behavior change	The communication campaign for malaria was short-lived (2008). The IEC materials (job aids, charts), radio spots, and talk shows on ACTs and IRS developed remained in place. These are currently used by the MoH and other partners especially at the health centers to continue the campaign. Context indicators from the UDHS 2012 indicate that use of any mosquito net in a household had increased from 34.3percent in 2006 to 74.0percent in 2012; while owning of at least one mosquito net in a house hold had increased from 15.9percent in 2006 to 59.7percent in 2012.
11	TB/HIV Communication	Used approaches 1 & 2 – Promoting use of services for individual and social behavior change.	Participants in the communities visited were knowledgeable about the linkage between TB and HIV/AIDS, and were aware of some of the symptoms of TB.

Annex 7.8: List of USAID & USG-funded IPs on HCP II Project

	USAID & USG IPs on HCP II	Technical Area of focus	Coverage
1.	Elizabeth Glazier Pediatric AIDS Foundation gets USAID funding and is implementing Strengthening TB and HIV & AIDS Response in South Western Uganda (STAR – SW)	The goal of the STAR-SW project is to increase access to, coverage of and utilization of quality comprehensive TB and HIV/AIDS prevention, care and treatment services within district health facilities and their respective communities in nine districts of South Western Uganda. **(TB, HIV)**	STAR-SW covers: Kisoro, Kabale, Kanungu, Rukungiri, Ntungamo, Busheyi, Isingiro, Kiruhura and Ibanda.
2.	Family Health International (FHI-360)	To increase access to family planning at the community level for underserved groups in Uganda by scaling up community-based access to injectable contraceptives (CBA) project. **(FP)**	Kanungu, Busia and Nakaseke
		FHI is providing technical assistance to partners implementing the CBA project. **(FP)**	Mubende, Mayuge, Luwero, Bugiri, Nakasongola)
3.	Health Initiatives for the Private Sector (HIPS)	The Project facilitates partnerships and provides technical assistance to design and implement comprehensive workplace health programs that maximize the accessibility of HIV/AIDS, TB & Malaria prevention and treatment services and improve use and knowledge of Reproductive Health and Family Planning services and products**. (HIV, TB, Malaria, FP)**	National
4.	Joint Clinical Research Center (JCRC)	JCRC is the largest ART center in Uganda with capacity to do sophisticated tests required for ARV therapy monitoring and detection of resistance to ARVs. JCRC implemented TREAT project which worked closely with MOH and organizations involved in the fight against HIV/AIDS, including AIC, TASO, NUMAT, Mildmay, Medical Research Council (MRC), CRS and IDI. **(HIV)**	National
5.	Malaria Consortium	One of the consortium members that manage Stop Malaria Project. **(Malaria)**	Stop Malaria is in 45 districts
6.	Marie Stopes Uganda	Address Uganda's high unmet need for FP and contribute to reductions of maternal and child mortality. **(FP)**	36 districts
7.	Minnesota International Health Volunteers	Malaria	West Nile
		FP	Mubende and Sembabule.
8.	Mulago - Mbarara Joint AIDS Program (MJAP)	To support the MOH to increase access to, coverage and utilization of quality HCT services to the private sector including civil society organizations (CSOs) and district Health Center (HC) 111s, 11s and their respective communities **(HIV)**	National
9.	Northern Uganda Malaria, AIDS and Tuberculosis Program (NUMAT)	To assist with expanding access to and utilization of HIV/AIDS, TB, and malaria prevention, treatment, care, and support in North Central Uganda **(HIV, TB, Malaria)**	Gulu, Lira, Kitgum, Pader, Apac, Oyam, Dokolo, Amolatar and Amuru
10.	Reproductive Health Uganda (RHU)	Community-Based HIV/AIDS Prevention, Care and Support **(HIV)**	Alebtong, Apac, Kabale, Kanungu,

	USAID & USG IPs on HCP II	Technical Area of focus	Coverage
			Kole and Lira
11.	Save the Children Uganda	Community-based family planning **(FP)**	Luwero, Nakaseke and Nakasongola
12.	Strengthening TB and HIV&AIDS Responses in East Central Uganda (STAR – EC)	Increasing access to, coverage of, and utilization of quality comprehensive HIV&AIDS and TB prevention, care, and treatment services within district health facilities **(TB, HIV)**	Bugiri, Iganga, Kaliro, Kamuli, Mayuge and Namutumba
13.	Strengthening TB and HIV & AIDS Response in Eastern Uganda (STAR – E)	To empower the communities in Eastern Uganda to effectively respond to the challenges of fighting the HIV/AIDS epidemic by focusing their efforts on key relevant interventions for: (i) Preventing the spread of HIV and TB (ii) Treating, caring for, and supporting those infected and affected by AIDS/TB (iii) Mitigating the health and social impacts of HIV and TB. **(TB, HIV)**	Eastern Uganda but not sure of districts
14.	Strengthening Uganda's Systems for Treating AIDS Nationally (SUSTAIN)	Increasing equitable access to ART by those in need, increasing access to prevention & treatment of opportunistic infections including TB, integrating prevention into all care & treatment services, supporting and expanding the provision of home-based care, and strengthening referral systems to other health facilities **(HIV, TB)**	National
15.	STRIDES for Family Health Project	To reduce fertility and lower maternal and child morbidity and mortality (FP)	15 districts
16.	The AIDS Support Organization (TASO)	Providing quality services to HIV Positive Individuals, Households, Families, and OVCs **(HIV)**	National
17.	Uganda Health Marketing Group (UHMG)	Empower, protect, and improve health of communities where markets for health products are vibrant and expanding and where consumer access affordable products and services **(HIV, Malaria, TB, FP)**	National

Annex 7.9: Quotes from FGDs and KIIs

- **RADIO:(*Rock Point, Nurse Mildred, Neighbors, RDL*, Rock Point 256)**

Quote: *"We go out and talk to listeners, ask about the programs they most listened to. Rock Point has been one of the major programs cited. Rock Point helped the station bring in youth listeners with very touching testimonies, it was designed well and contained music. It kept young people on board listening with the appealing music," said one of the informants.*

Quote: *"The program came at a point when people needed psychosocial support. The branding of the product was excellent. The characters involved in the drama series were interesting, the scripting and production were excellent. But even with the end of the contract, most of the stations have continued to broadcast the series due to long period of association with HCP [ll]and the hope that the program will resume in the near future." (Ekochu Jonathan, Voice of Soroti)*

- **Nurse Mildred and NeighborsFred and Bernard**

Quote from a Radio Presenter:

"Each time I had nurses in the studio, I would get 10-15 calls, which means that the program was very popular and because it was in the language that people understand. Everywhere I (presenter) go in town, people call me Nurse Mildred meaning people follow the program. The nurses were very helpful and tried to answer all the questions, but the time (30 minutes) was always not enough for the nurses to answer all the questions and referred callers to the National Health Hotline."

- **Young People's Reproductive Health Behaviors/Practice**

Quotes:

"Although condoms are free of charge at the health centers, most of the nurses are women in their forties, I feel shy to ask for condoms because I know that they will spread the rumor in the village, that so and so's son is ill-mannered"(youth in Kabalore).

- **Knowledge and Practices for People Living with HIV (PLHIV)**

Quotes:

- *"If you know your status and disclose, it makes you fit in society and you can easily get support and care from the people around you." (a mother living with HIV in Kamuli)*
- "*Before we knew our status, there was a lot of quarreling. Afterwards, there is caring, peace, and children are not infected. Health has improved.*" (a discordant partner, Arua)
- *"Sharing status with partner builds trust and confidence."* (PLHIV, Apac).

Quotes:

- *"We visit the health centers whenever we catch any disease. When there are drug stock-outs, we are advised to share amongst ourselves, until the situation is rectified." (a PLHIV in Bushenyi District)*
- "*After I was diagnosed with HIV, I have never been involved in sex and do not intend to do so to avoid infecting other people." (a woman in Kamuli district.)*

Quote:

"We tested together because we wanted to bond as a family to avoid mistrust especially in a situation where one was working away from home. " (Couple, Lira).

Quote:

"Even when it is said to be free, when one goes to Masaka Hospital, they are charged 20,000 shillings. It is only free in Rakai, but people do no not have transport." (male respondent in Masaka)

- **Perceptions on risky sexual behaviors, gender-based violence, and alcohol Abuse**

Quotes on risky sexual behavior, GBV, and alcohol abuse

- *"When one is drunk, sometimes they don't listen to their partner's plea on using protection and when the partner insists, they may end up fighting and breaking the relationship." (youth respondents in Mukono, and Kabarole)*
- "*Alcohol puts you in mood for sex and you can't take precaution." (youth respondents, Arua, Kamuli, and Soroti)*

- **Role of VHTs**

Quotes:

- *"I took a pregnant mother to Masaka Hospital for delivery and the nurses asked for money. But after I pulled my VHT T-shirt out of my bag and put it on, they stopped asking for money and worked on her immediately."* (VHT in Masaka)
- *"The implementation of Obanwa was very poor as VHTs were encouraged to gather at someone's home to listen, yet some of us come from far and sometimes the person with the radio would have no cells. They should have given us radios to listen in."* (VHT in Masaka)

- **Innovative Approaches for Reaching and Engaging Men Developed**

Quote:

"*Most men are unforgiving when a wife tests positive while the man is negative maybe the government needs to do more sensitization targeting men."(Hoima FGD participant)*

- **MoH Officials with Knowledge and Skills to Design, Implement M&E Strategic Communication Interventions**

Quotes:

- *The YEAH Campaign enhanced our profile because whenever the program is on, we are acknowledged." (UAC respondent)*
- *"HCP [II] has been beneficial in capacity development of government partners; We were trained and have had several refresher courses as a result of frequently asked questions by the communities targeted. HCP [II] consulted widely and this approach encouraged stakeholder participation. This approach helped organizations to serve communities better." (MoH respondent)*

- **Challenges of Improved Communication Capacity to Effectively Support Social and Behavioral Goals**

Quote:
"HCP [II] project was overloaded as it took on too many programs that were introduced at the same time. Each program should have been given enough time before introducing another one. Some programs like the Hotline should be upgraded but the budget is limited."

"Retaining former HCP [II] staff is difficult due to lack of funds. The management of resources is outside the ministry and this makes former employees of HCP [II] stranded as the Ministry cannot sustain their pay. On the other hand, USAID's policy of calling trained staff into new projects also constrains capacity built for program sustainability; this leaves capacity gap as staff for sure go for better pay from USAID-funded projects."

Annex 7.10: Introduction to KII and FGDs Guides

Introduction:

Greetings; we are here on behalf of USAID/Uganda and we are conducting an end of project evaluation for Health Communication Partnership (HCP II) Project. The project was delivered in partnership with JHU-CCP, Government Ministries and Agencies, Local NGOs and other Implementing Partners countrywide.

The project is an extension of HCP I and has since 2007 been promoting increased access to health services and behavioral change through different modes of communication strategies. This Evaluation covers the program life period from 2007 – 2012 and aims at assessing the effectiveness of the behavioral change communications approaches implemented under the project and to identify factors for success.

The findings of this evaluation will help in documenting sustainable results, drawing lessons on what worked and what did not and why, and make recommendations for ongoing and future interventions by USAID/Uganda and other development actors. **All information you provide is confidential,** and I therefore, kindly request you to share your honest views about this program.

The evaluation seeks to answer the following question;

1. To what extent did HCP II achieve each and all expected outcomes under the three Intermediate Results?
2. Which project approaches contributed to major project achievements and which project approaches may have resulted in poor or less than expected performance?
3. What is the impact of HCP II on the capacity of local IPs and the MOH to conduct communications activities without continued technical assistance?

Do you accept to be interviewed?

Yes …… (Continue with the interview)
No …… (Thank and leave the respondent)

Annex 7.10A: KII Guide 1 – USAID Managers/CORs

Interviewee's Designation ----------
Interviewer's name----------
Date of interview ----------

1. How appropriate and relevant was the design of HCP program?
2. Apart from the design, how effective and efficient was the mode of delivering communication strategies?
3. To what extent were various project outputs produced at reasonable cost and in accordance with USAID financial requirements?
4. How has program intervention logic and assumptions affected project achievements?
    - What external factors influenced project achievements?
5. In your view, to what extent did HCP II achieve all the expected outcomes under the three intermediate results? [in a scale of 1-5, describe the score given]
6. What would you say HCP implemented well and why?
7. What do you think did not work well and why?
8. How would you recommend the design of a similar program in future?

Thank you

Annex 7.10B: KII Guide 2 - Implementing Partners Staff

Interviewee's Designation ----------
Interviewer's name----------
Date of interview ----------

1. What was the extent of your involvement in the design of health communication interventions?
    - What was your role in the design of these interventions?
2. How appropriate and relevant were the design of communication strategies to the needs of the target audiences?
    - ➢ What were the strategies based on?
    - To what extent did the program target the right areas and population segments with the right interventions?
3. What mechanisms were put in place by the program to facilitate sharing among partners of behavioral change information; challenges and best practices?
4. How were the sharing mechanisms implemented?
    - Which sharing mechanism worked well and which one did not work well and why?
5. How has your partnership with HCP program enhanced the social environments for positive health seeking behaviors among the communities?
6. What project communication approaches has your organization adopted?
    - ➢ What has been the outcome of the adopted approaches?
7. To what extent has HCP communication strategies increased appropriate use of health services (Malaria, FP and HIV/AIDS)?
8. What contributed to the level of use of the above services?
    - Probe for implemented activities/outputs and subsequent outcomes (intended & unintended, positive & negative)
9. Did you have health communication strategies in place before HCP program?
10. How would you rate the level of your capacity in health communication, before and after HCP program?
    - ➢ How has the program interventions influenced the rating given above?
11. How have you implemented social and behavioral communication strategies and efforts?
12. What would you say went well during implementation of these strategies and why?
13. What constraints/challenges did you experience during implementation and why?
14. In what ways has the HCP empowered your organization to continue managing social and behavioral change communication activities? *(Probe for Structures in places and Indicators of sustainability).*
15. What were the operational problems met and what workable recommended solutions could be considered in future for a similar program?
    - ➢ Please share any lessons learned during your implementation of communication strategies.

Thank you

Annex 7.10C: KII Guide 3 - HCP II Program Staff

Interviewee's Designation ----------

Interviewer's name----------

Date of interview ----------

1) What were the key components of HCP II?

2) In your view, to what extent did HCP II achieve each and all expected outcomes under the three Intermediate Results? [Team may want to capture responses in a linear scale – say,1-5] followed by narrative description of the score

- Use the following five point scale of 1 – 5, where 5 = Highly Achieved; 4 = Somewhat Highly Achieved; 3 = Achieved; 2 = Somehow Achieved , 1 = Not Achieved;

Achievement of Expected Outcomes on the HCP II Intermediate Results	*Ranks*					*Comment Why or Why not Achieved*
	1	*2*	*3*	*4*	*5*	
IR 1: Effective communication strategies designed and implemented to increase appropriate use of services and/or practices across identified priority programs						
a) Extent to which specific behavior change messages were designed and disseminated?						
b) Extent to which knowledge of HIV/AIDS, family planning, malaria, TB prevention and treatment were increased among intended population groups?						
c) Extent to which there is evidence of Improved use of priority health services in geographic and programmatic areas where campaigns and other communication efforts were implemented?						
d) Extent to which, Risk behaviors associated with the following key public health problems were reduced among key populations: -multiple sexual partners, -inconsistent condom use, Inconsistent adherence to ART, -malaria treatment, etc)						
e) To what extent is there demonstrated increase in use of services as a result of HCP II interventions?						
IR 2: Supportive social environments are fostered, to enable positive health-seeking behaviors and result in healthier individuals, families, and communities						

Achievement of Expected Outcomes on the HCP II Intermediate Results	*Ranks*					*Comment Why or Why not Achieved*
	1	*2*	*3*	*4*	*5*	
IR 3: Improved communication capacity to effectively support social and behavioral goals and objectives						

What else could have done to improve the achievement of the three key intermediate results for HCP II?

3) Thinking of approaches like YEAH campaign, the GOLD program and others, which project approaches do you think contributed to major project achievements and which project approaches may have resulted in poor or less than expected performance?

List of Approaches	**Project Achievements**		
	Poor	**Medium**	**Major**

4) Do you think the model of one broad communications project like HCP supporting efforts of other Implementing Partners like the STARs is an effective model? Support your answer.

5) To what extent were communication strategies and IEC materials developed with HCP support utilized by other projects for real results? (Job aids, listeners guides, training modules, posters, banners, flyers, radio and TV spots drama series, and talk shows)

6a) Would you say HCP has left behind a sustainable capacity of indigenous organizations to design, develop and disseminate materials, lead campaigns and in general behavior change communication? Give examples (personnel, skills, networks, structures etc)

b) Where is the greatest success and where was HCP least effective? Has the capacity at the Ministry of Health improved and in what ways? (Develop and implement communication strategies, IEC materials, skills, training, networking and partnerships, resource mobilization)

7) Do you think HCP had the right organization structure, staff and management systems to achieve anticipated results? Why do you say so? (Request copy of organizational structure to be assed later with other findings)

8) Given the current trends in the HIV epidemic in Uganda (rising incidence) and rapid population growth, what are your ideas of an effective communication intervention? What should Uganda do differently?

9) Overall, what should HCP have done differently?

10) Where would you recommend the evaluation team visit and what should they be looking for?

Thank you

Annex 7.10D: KII Guide 4 – Communication/Media Organizations

Organization ----------

Interviewee's Designation ----------

Interviewer's name----------

Date of interview ----------

1. What activities were performed in partnership with HCP?
2. What was the nature of their support?
3. What would you say were the key results of this partnership with HCP?
4. Did the partnership with HCP improve your capacity to perform your roles better in health communication. If yes, how; if not, why not?
5. Which of the HCP approaches worked better and which ones did not, and why?
6. Do you think you are now in better position to continue health communication activities without further technical support and why?
7. What feedback back did you get from your audiences/partners about your health communication activities?
8. Do you think the activities you performed in partnership with HCP increased the exposure of Ugandans to better health information?
9. If yes, has this exposure helped them improve on their **knowledge**, **attitudes** and ability to choose better health **practices**? (Can you cite examples in HIV, family planning, malaria and TB, male participation etc?)
10. Have any of your communication activities helped mobilize communities, the public, health officials, opinion leaders, and local leaders support positive health practices?
11. Anything else you would like to share with us on HCP interventions?

Thank you

Annex 7.10E: KII Guide 5 - Government Partners

Interviewee's Designation ----------
Interviewer's name----------
Date of interview ----------

1. What was your organization's role during HCP supported communication interventions?
2. Could you describe communication tools that were utilized?
3. Which project approaches has the ministry/ commission found most effective in fostering actual behavioral change and why?
4. How have HCP interventions impacted the capacity of MoH/ Commission in promoting positive health behaviors'?
5. In your view what are the most important benefits of HCP project?
6. After HCP interventions, have you seen any improvements in behavior changes? Please explain
7. In your experience, what are the challenges of using HCP interventions?
8. Is there anything you feel that that could have been done differently?
9. Do you think your organization will continue to use/support HCP communication tools/approaches?
10. How will the program be sustained within the ministry / commission structures and the population?
11. Do you have any other comments or recommendations?
12. Someone from USAID/Uganda may want to learn more about some of the examples you described. Is it okay for someone to contact you to follow up?

Thank you

Annex 7.10F: Observation and Exit Interview Guide

OBSERVATION

1. Look out for and note any evidence of IEC materials displayed (public places, offices, health and service centers)
2. Key materials include posters, flyers, signage on HIV/AIDS, male circumcision, family planning, malaria and TB,

EXIT INTERVIEWS

Venues: HIV/AIDS counseling and testing facilities, family planning units, Safe male circumcision (SMC) at health centers visited

Clients

1. How did you come to know about this counseling and testing/ family planning/ SMC facility?
2. Was it easy to find? Why?
3. Did you come with your partner/spouse for testing/family planning?
4. (If yes to 3), why? If no, why
5. How did you learn about the importance of couple testing/family planning/SMC? (radio, TV, VHT, poster, brochure drama, health center/worker, hotline, neighbor, LC, prayer place/faith leader)

VCT/family planning/SMC service providers at health facility

1. Has the number of people coming for **couple** counseling and testing/family planning/SMC increased in the last five years? (try to get the numbers for each of the past five years)
2. If yes, why?
3. Do you think people seeking the testing/family planning/SMC service can easily find their way to this facility? Why?
4. If there is a signage, ask if it has helped ease accessibility by service seekers.

Annex 7.11: FOCUS GROUP DISCUSSIONS – GUIDES

Annex 7.11A: FGD Interview Guide 1 - Youths

Village TC/SC/District ----------
Interviewer's name----------
Date of interview ----------

As part of the HCP II Project, an Initiative by Young People for Young People called: **Young Empowered and Healthy (Y.E.A.H)** was introduced. It was meant to address six key issues that influence young people's ability to adopt healthy sexual and reproductive health practices. The issues include: Life skills; adult support; genuine participation; sexual exploitation; Gender issues; and Friendly services.

In order to stimulate discussion, self-reflection, and community action, Y.E.A.H was implemented through various campaigns. These included: True Manhood Campaign, True Manhood Alcohol campaign, True Manhood Violence against Women campaign and Rock Point 256.

KNOWLEDGE

1. What do you know about the importance of the following:

   HIV/AIDS
   a. Abstinence from sex
   b. Sticking to one partner or using a condoms
   c. Knowing your HIV status and that of your partner

   Risk factors
   d. Drinking alcohol responsibly or not at all (*probe link between alcohol and HIV infection)*
   e. Treating partners non-violently

SOURCE OF INFORMATION

2. What was the source of information/knowledge on the above (probe for major source)
   a. Radio (Rock Point 256 weekly radio drama?)
   b. Television
   c. Comic book series (probe if they have seen them)
   d. Billboards
   e. Fact sheets
   f. Alcohol self-assessment check lists
   g. Young People Advisory Groups (YAG) discussions

PRACTICE/BEHAVIOUR CHANGE

3. How many of you:
   a. Used condoms during last sex? If no, why?
   b. Are abstaining? If no, why?

c. Are sticking to one partner? If no, why?
d. Stopped or reduced on taking alcohol?
e. Have not practiced violence against female partner in last one year?
f. Know their HIV status?
g. Know the HIV status of partner?
h. Have had one sexual partner in the last one year?

BENEFITS AND CHALLENGES:

4. In your view what are the most important benefits and challenges of using the above practices. (We are interested in only people who have used the practices)

5. Is there anything else you would like to add about what we have discussed?

6. We may want to learn more about the issues we discussed, is it okay for someone to contact you for follow?

Thank you.

Annex 7.11B: FGD Interview Guide 2 – Adults

Note: Targets Male (25 – 54) & Females (24 – 49) respondents

Village/TC/SC/District ……..
Interviewer's name …….
Date of interview ……

Areas of Intervention
Family Planning:

- FP methods, mal involvement, unmet needs (women who fear FP /methods speak to a health worker

HIV/AIDS:

- Couple counseling and testing (knowing your HIV status, talking to your partner about your HIV status, going for VCT and getting results together)
- Safe Male Circumcision (voluntary medical circumcision and reducing risks of getting HIV)

KNOWLEDGE

What do you know about the importance of the following

- Family planning methods (probe about fears of FP methods, male involvement)
- Couple counseling and testing (probe about talking to partner about HIV status, going for testing and receiving results together), certificates for tested couples
- Male circumcision and HIV (probe on medical aspect of circumcision, and for Mbale about the risks of sharing knives and safer sex practices during traditional circumcision season)

SOURCE OF INFORMATION:

- What was the source of information/knowledge on the above (probe for major source)
  i. Radio (probe if radio drama e.g. Neighbors' and The Nurse Mildred Show, spot/advert e.g. Stand Proud Get Circumcised, talk shows)
  ii. TV (Probe if TV drama, spot/advert, talk show)
  iii. Newspapers,
  iv. brochure
  v. Poster
  vi. billboards
  vii. Signage
  viii. Video hall show
  ix. VHT
  x. Health worker
  xi. National Health Hotline
  xii. Faith leader
  xiii. Local councilor
  xiv. Neighbor, friend, relative

- What message do you get from each of the following materials? (show posters, signage)
  i. Posters (couple VCT, circumcision, family planning)

ii. Signage (HIV testing, family planning)
iii. Have they seen the posters and signage before?
iv. If yes, where did they see it?

PRACTICE/BEHAVIOUR CHANGE

- What action did you take after learning about the importance of the following (probe if knowledge translated into practice/behavioral change)
  i. Family planning methods (probe about fears of FP methods, male involvement)
  ii. Couple counseling and testing (probe about talking to partner about HIV status, going for testing and receiving results together)
  iii. Male circumcision and HIV (probe on medical aspect of circumcision, and for Mbale about the risks of sharing knives during traditional circumcision))

SEPARATE WOMEN AND MEN RESPONDENTS

- Do you know your HIV status?
  i. If yes, have you shared with your partner about your status
  ii. If no, why have you not tested

- Do you practice family planning?
  i. If yes, was your partner involved in the decision and come to the clinic with you? (if partner was not involved, probe why)
  ii. If no, why do you not practice family planning?

- Is there anything else you would like to add about what we have discussed?

Thank you.

Annex 7.11C: FGD Interview Guide 3 - Village Health Team (VHT)

Village/TC/SC/District ----------
Interviewer's name----------
Date of interview ----------

1. Name at least three benefits of the following health practices
    a. Family planning
    b. HIV testing and counseling
    c. HIV prevention and treatment in adults and children
    d. Safe Male Circumcision
    e. Drinking alcohol responsibly or not at all
    f. Treating female partners non-violently

2. Have you received any training on the above health issues?

3. Who conducted the training? (Probe if VHTs participated in Radio Distance Learning (RDL)

4. How useful were the training materials you were given? (Probe about listener guides, VHT handbook)

5. Did you find the Radio Distance Learning, listeners' guides and listening groups effective methods of training?

6. What did you not like about it?

7. What do you see as the benefits of the RDL(probe about strengthening link with health workers, VHTs understanding their roles, doing mobilization better)

8. Did you get any other Information, Education and Communication materials on the health issues discussed above? (posters etc)

9. Did you find them useful in performing your roles in the community?

10. Do you feel VHTs in your area can continue to perform their roles without further support? (Skills, Information, Education and Communication materials, networks etc)

11. Is there anything else you would like to add about what we have discussed?

12. We may want to learn more about the issues we discussed, is it okay for someone to contact you for follow up?

Thank you.

Annex 7.11D: FGD Guide 4 - People Living with HIV/AIDS (PLWHA)

Note: might consider including adolescents above 20?

Village/TC/SC/District ----------
Interviewer's name----------
Date of interview ----------

Areas of intervention

- Enhancing positive living among PLWHA
- Addressing challenges experienced by adolescents living with HIVAIDS
- Improving uptake of ARVs among children living with HIV/AIDS

KNOWLEDGE

1. What do you know about the importance of the following:
    a) Positive living among PLWHA? *(Probe about; seeking early ARV treatment, taking right dosage and regularly, routine medical checkup, feeding well to stay healthy, need to avoid new infections/HIV strains to self and others, use of condoms , PMCT, feeding options for new-born babies to reduce risk of infection from mother)*
    b) Condom use, disclosure of HIV status with sexual partners, adherence to ARV among HIV positive adolescents
    c) Improving uptake of ARVs among children living with HIV (*seeking testing and treatment by caregivers)*

SOURCE OF INFORMATION

2. What was the source of information/knowledge on the above (probe for major source)
    a. Radio (*probe about radio diaries series – My life My Story for Adults , Jessica and Mike on Rock Point 256 for Adolescents, radio call-in talk show on HIV positive children*)
    b. PLHIV Club sessions (probe if they have seen radio discussion guides)
    c. Comic books – Jessica and Mike
    d. Frequently asked questions book for adolescents
    e. Health worker
    f. Other (specify)

3. What message do you get from each of the following materials? (show posters, signage)
    a. Posters (caring for children living with HIV)
    b. Have you seen this poster before? Yes/No.
    c. If yes, where did you see it?

PRACTICE/BEHAVIOUR CHANGE

4. What action did you take after learning about the importance of the following (probe if knowledge translated into practice/behavioral change e.g. Benefits and Challenges)

    a. Positive living (feeding healthy, sought ARV treatment, etc.)
    b. Adolescents (adherence to ARVs, disclosure of HIV status to sexual partner, condom use
    c. Seeking testing and treatment of HIV positive child

BENEFITS AND CHALLENGES:

5. In your view what are the most important benefits and challenges of using the above practices. (We are interested in only people who have used the practices)

ADDITIONAL INFORMATION

6. Anything else you would like to share with us on what has been discussed?

7. We may want to learn more about the issues we discussed, is it okay for someone to contact you for follow up?

8. What type of treatment are you on?

9. Where do you get it from?

Thank you

Annex 7.12: Post-Training/Internship Evaluation for GOLD Program:

Background:

Generating Opportunities for Leadership and professional Development (G.O.L.D.) is a three-part program designed to provide recent university graduates with career relevant work experience, including:

- Competitive selection and placement of young professionals with host organizations;
- Work-based learning experiences and mentoring support to young professionals assigned to host organizations; and
- A 12-part Professional Development Seminar Series to transfer vital knowledge and skills to young professionals.

Note for Interviewers: If respondent received 'certification and graduated', which is the final step to mark successful completion of the GOLD program, then proceed with interview.

Post-Training Evaluation Form:

(A) This post-training evaluation form is designed to assist USAID/Uganda in assessing the participants' of the GOLD program satisfaction with the knowledge gained from the training and mentoring and get a quick feedback on the usefulness of the skills gained during their internship placement. Based on a five point scale of 1 – 5, where 5 = Very satisfied; 4 = Satisfied; 3 = Neither Satisfied nor Dissatisfied; 2 = Dissatisfied, 1 = Very Dissatisfied;
Please rate your satisfaction level on the various components

Gold Program Components & Internship Experience	*Rank*				
	1	*2*	*3*	*4*	*5*
1.0 Professional Development Seminar Series					
Effective Time management					
Preparing professional correspondences					
Preparing effective presentations					
Problem solving					
Career planning					
Preparing a professional curriculum vitae					
Interviewing effectively					
Professional dress and appearance					
Securing permanent employment					
2.0 Work-based learning and mentorship support					
Extent to which your Mentor Listened Actively					
If Mentor was able to Build your trust in him/her					

Gold Program Components & Internship Experience	*Rank*				
	1	*2*	*3*	*4*	*5*
Extent to which your Mentor was able to help you determining goals and capacity					
If mentor was Encouraging and inspiring					
3.0 Outcome/Impact of your GOLD Program Experience					
Relevance of the SOW specific tasks and your responsibilities as a Young Professional					
Extent to which completion of the GOLD Program provided you with the skills and business acumen needed to secure professional employment and succeed in your new position					
Extent t which the GOLD Secretariat was able to assist you in getting permanent placement with the participating organization at the end of the work placement period.					

(B) NARRATIVE FEEDBACK:

What components and/or skills were most relevant for your current job? Which ones could have been improved upon in the way this training was delivered or in the Internship? Explain

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What were some of the Lessons Learned (both positive and negative) during this training or internship placement? Explain.

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