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Full Length Research Paper

Assessing Uganda's public communications campaigns strategy for effective national health policy awareness

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Uganda government's national health policy communication campaign strategy has been done in a socio-economic, legal and environmental context dominated by chronic poverty, ignorance, disease and official corruption. Deficiencies in the national health policy awareness, knowledge, risky behaviour and superstitions have increased the incidents of illnesses, diseases, deaths and poverty in Uganda. Published evidence on the effectiveness of the national health communication campaign strategy for stakeholders' empowerment was obtained and reviewed. Additional information was accessed using internet search engines and libraries. All documents that were obtained during the review process were used to broaden the search for primary information sources. Initially more information was sought from the databases of national, regional, and international agencies. In the searches, the author looked for documents on effectiveness of the objectives of effective health policy communication campaign strategy in influencing the audiences' knowledge, attitudes, perceptions, and behaviour towards adaptation to health seeking behaviour. It emerged that a combined use of both mass media and interpersonal communication channels provide the maximum audience exposure to the intended national health policy messages to the target audiences. Effective communication campaign strategy is critical in creating, raising, developing and sustaining the national health policy awareness for the desired health behaviour change in the country. The current national strategy does not synchronize epidemic dynamics with prevention messages. Its major focus on the mass media compromises the role of interpersonal communication to individuals in making personal decision. The message design is not audience-centred and too general to appeal to an individual audience.

Key words: awareness, communications, participation, audience, message, media

INTRODUCTION

Health equity is a human rights issue which has eluded most communities in Uganda. Health equity is not just about access to health systems; it is also about equitable access to information about health care and equitable health systems (Pointer, Norden, Loewenson, 2008). Knowledge and attitudes are key determinants of health seeking behaviour of communities in Uganda where ignorance alone, is the commonest cause of morbidity and premature deaths (MoH, 2005). The World Health organisation (WHO) and the International Labour Organisation (ILO) identified information, research and raising awareness among critical; areas for health collaboration (WHO and ILO, 2001). Ugandan Ministry of Health has attempted to disseminate messages about health, through communications strategy enshrined in the national health sector strategic plan (MoH, 2005). Despite its efforts in reaching out to people with health messages, the Ministry of Health has not developed any concrete communications strategy, and since we are not seeing the recommended changes in behaviour, this suggests that the messages are not effectively reaching the desired audience. For example, the focus of mass media messages is poorly aligned to sexual behaviours such as multiple partnerships and HIV discordance, so we are seeing rising infection rates in the country (Wendo, 2009). Due to this failure, in this study, we have investigated the basis of good communication strategies in order to advise the Ministry of Health on how to take

forward its work on disseminating health messages in Uganda.

METHODOLOGY

We undertook a literature review to establish: what existing communications programmes the MoH has undertaken and what strategies underlie the creation of these programmes; what communications strategies have been used in other countries; and what considerations need to be part of developing a successful health communication strategy. We chose to examine some of the best practices in countries for the review because they had applied similar HIV/AIDS communication strategies within their unique situations.

In the initial literature review, we conducted our search through various internet search engines and libraries. We also explored the websites of organizations with dedicated health communication campaigns and public communications campaigns, such as the World Health Organisation (WHO) database and the websites, Uganda AIDS Commission, United States Aid for International Development (USAID), the Capacity Project, (United Nations Development Programme (UNDP), the World Bank, the International Labour Organisation (ILO), United Nations AIDS programme, EQUINET and those of the government and the Uganda, Ministry of Health (MoH). More information was obtained from leading English language newspapers in Uganda which allow free access to their archives.

All documents obtained during the review process were used to broaden the search for primary information sources. Initially additional information was sought from the databases of AIDS Information Centre, national health departments and directorates some of which proved less successful. In the searches, we looked for documents referring to 'health communication strategy' that addressed audience, the media, the message, the channel, and destinations plus the models, theories, strategies, policy and strategic plan outputs. The review was biased in favour of published literature accessible through internet searches, and only English language documents were studied. Most documents reviewed are quite recent and country specific but a few of them are about ten years old, which may misrepresent the situation in some countries.

RESULTS

In this section we present our findings on the key elements important to developing communication strategies; summaries of 'best practice' strategies used in the 16 countries on HIV/AIDS communication strategies; and descriptions of health communications campaigns undertaken in Uganda, and any research done on the effectiveness of these campaigns.

Key elements of communication strategies

A successful communication must reach the audience, attract the audiences' attention, present an understandable message, promote change, and produce a change in behaviour for better health (Hubley, 19993). The key independent communication variables for health messages include: the source, the message, the channel, the audience, and the destinations. The goal, the audience, the media, the strategy, and the messages should interact with each other to create a successful campaign (Day and Monroe, 2000). A health communication campaigns should seek to: identify the channels used; establish the extent of audience exposures to the message formats; determine the impacts the campaigns; rank the effectiveness of the channels used in the campaigns; establish community participation in the process; relevance of the channels, and the message reach among the audiences (Okaka, 2006).

The media excel in raising awareness (Rogers, 1995). Behaviour change communication programmes use various tools to provide information, informed decision-making, and encourage community participation for behaviour change where the use of multiple media have a synergetic effect on the campaign goals and objectives (Lisa and Elliot, 2003). Appropriate media content arises if one considers what it takes for the media in Uganda to provide citizens with information, advice, and the relevance of content determines the extent to which they can participate actively (Chibita, 2003).

Communication strategy decisions should involve surveys to determine communication systems in a community; audience familiarity with and exposure to different media; characteristics of target groups; effectiveness of media choice; opinion leaders that can be engaged in the project (Curram and Gurevitch, 2000). Communicators, who wish to inform, persuade or simply hold the attention of their auditors must adapt more closely than in the past to what ordinary people find interesting, relevant and accessible (Wilmer and Dominick, 2005).

In evaluating communication strategies, both quantitative and qualitative methods should be used to assess changes in knowledge, attitudes, beliefs, self-efficacy, and perceived risk. Just as theory is important for developing a campaign strategy, it is important for campaign evaluation to provide the campaign with a theoretical base to support further development and implementation (Coffman, 2002a).

Health communications campaigns should be driven by relevant communication theories and models. It is also important to develop a gendered understanding of the audience, and at each stage in the health communications campaign check that the message design, delivery, monitoring, and evaluation process are purposely defined to understand gender. For instance, through priming theory, the media can raise awareness about new gender based conventions. Priming theory in media is related to the agenda setting theory (Figueroa, 2002). Priming is most important when issues are political, new, or where information is about a rare issue. Attitude change theory explains how people's attitudes are formed, shaped, changed and how those attitudes influence behaviour (Stanley and Dennis, 2003).

An effective strategy should use the media to inform, educate, and entertain the public about health issues, for example, risks, quality service delivery, frequent stock outs, expired drugs, and health rights as part of human rights. Media content is packaged to allow only the desirable interpretations at the expense of others (framing), which

allows for selective control over media content or public communication (Stanley and Dennis, 2003).

In framing messages, however, it is not only the content that is important, but also an understanding of how information is diffused through society, or: how, why, and at what rate new ideas spread through cultures. Information diffuses in five stages: awareness, interest, evaluation, trial, and adoption or rejection. People who initially use media content, interpret it according to their own values and beliefs, and then pass it on to opinion followers who have less contact with media (Rogers, 1995).

'Best practice' strategies used in other countries

In countries investigated, communications frameworks stress the role of government policy, socioeconomic status, culture, gender relations and spirituality in HIV/AIDS communications, entertainment-education, and communication programmes that involve local communities, local culture, and traditional communication media (UN AIDS, 2001).

Health communications strategies undertaken in Uganda

The health education and promotion component of the national health policy asserts that knowledge and attitudes of the population are key determinants of health behaviour of communities. The strategic health communication approach employs advocacy; advertising; promotions; events, sponsorship, community mobilization; publicity; and mobile vehicles, television, radio programs, music, meetings, parties, groups, drama, songs, dance, sports, and games to inform, entertain, and educate all the communities (MoH, 2005). In the next section we will look at two health education campaigns undertaken by Ugandan government for HIV prevention, and the national malaria control strategic plan advocacy strategy.

HIV prevention: The Uganda HIV/AIDS Sero-behaviour surveillance survey, 6.4 per cent of adults in Uganda was infected HIV (MoH, 2006). The international target is to halt and reverse the spread of HIV/AIDS globally by 2015. The Ugandan government's response to the Millennium Development Goal six (combat HIV/AIDS, malaria and other diseases) was to control and prevent HIV/AIDS by implementing behaviour change communication strategy (Outlook, 2006). The activities entailed mass campaigns using drama, meetings, radio, print media, and political rallies, with a plea to the cultural and religious leaders to join the fight (MoH, 2006).

The current sexually transmitted infections are very high in Uganda because most people are not aware that they have any sexually transmitted infection (STI). Results from the national HIV/AIDS Sero-behavioural survey show that 6.4% of Ugandan adults aged 15 - 19 are HIV positive. HIV prevalence is highest in Kampala at 8.5% and the HIV/AIDS epidemic data updates in Uganda involves sentinel surveillance and surveys of knowledge, attitude, behaviour and practice (MoH, 2006).

A study of the effectiveness of Uganda HIV/AIDS preventive campaigns examined what organizational variables and communication campaign design elements led to the initial success of HIV/AIDS campaigns in Uganda (Outlook, 2006). It found that financial resource; multiple channels, targeting and outreach personnel were directly linked to message reach (Outlook, 2006). But it lacked sustainability.

Accordingly, a recent HIV/AIDS transmission study in Uganda, the focus of mass media messages is poorly aligned to sexual behaviours such as multiple partnerships and HIV discordance since most new infection cases have shot up in the country (Nattimba et al., 2009). The findings of the study suggest that the focus of the national HIV/AIDS campaign messages has been bias in favour of the youth at the expense of the older audiences among whom HIV transmission continues unabated.

Another study found a lack of synchronization between the epidemic dynamic and prevention messages; interpersonal communication has also been neglected in favour of mass media which focuses on general audiences without appealing to the individual's conscience (Wendo, 2009). High awareness of condom use as a preventive measure (76.4% males and 83% females) failed generally due to strong misconceptions and myths about condom use.

Yet another study showed a clear disconnect between knowledge and behaviour change among many communities in Uganda. National awareness of HIV/AIDS is universal in Uganda. But the level of awareness is not matched by knowledge of how to avoid the infection. Misinformation persists countrywide. Health experts agree that behaviour change is a critical determinant of the decline in HIV infection in Uganda (Lisa and Elliot, 2003).

Referring to specific examples, the HIV prevalence rate at Riwo internally displaced persons camp in eastern Uganda has stagnated at 15% since 2006 because the local community has very little knowledge of HIV/AIDS, how it is spread, and prevented (Womakuyu, 2009). They have no access to HIV/AIDS sensitization information. At least 75% the camp dwellers believe they are bewitched by their enemies. Only a handful is willing to undergo HIV/AIDS tests due to fear that their own blood would be used to bewitch them (Womakuyu, 2009).

Results in Kumi and Bushenyi districts (Uganda} suggest that interpersonal communication was more effective in creating and raising HIV/AIDS awareness among the local communities there (Matovu, 2009). Uganda Population Services International survey in nine Universities found that campaigns against cross-generational sex overshadowed the known reason for the increasing rates of HIV infections among university students via peer-to-peer sex. It ignored the "public secret" that students are en-

gaged in unsafe sex among themselves (Kezaabu, 2009). There is also the government's claim that its key health achievements include community HIV prevention awareness and AIDS care has helped to curb other diseases in Uganda (MoH, 2008).

According to Womakuyu (2009) a study by a Ugandan Medical Health Officer, Dr. James Lemukol, has found that HIV/AIDS has soared from 2% to about 4% among mothers in Karamoja sub-region (Uganda) because the people there think AIDS only infects the urban dwellers. Some locals believe that there is no HIV virus but witchcrafts. Another (Womakuyu, 2009) related study conducted in the same Sub-region in Uganda by the Moroto District Health Officer, Dr. Michael Ebele, found that HIV/AIDS prevalence rate in the district has risen from 0.1 - 3.3% in last 10 years because are no people who are willing to carry out sensitization campaigns or create awareness on HIV/AIDS prevention there.

Although, Basudde (2009) the national HIV/AIDS epidemic transmission dynamics in Uganda has evolved significantly, the prevention messages and the target groups have not followed suit. The ABC strategy has been highly emphasised as a control for HIV/AIDS resulting in behaviour change but the messages on the abstinence and condom use do not have any practical promise because they do not address the needs of all people. Abstinence messages are not appropriate for marriage people while messages on cross-generational sex are not comprehensive.

The Norwegian (Okiror, 2009) government has been supporting the interventions to prevent the spread of HIV/AIDS through awareness, prevention, support, and care in 15 markets in Kampala and Mukono districts since 2003. But facts on the ground show that Kampala district has the highest HIV/AIDS infection rate in all the urban areas in the country. According to the Uganda government (2006) at least 12.4% of men and 22.8% of women do not know that a 'healthy' looking person can be infected with HIV/AIDS. This indicates that people are either not getting the right messages or they are sceptical about them.

According to the World Vision International (2009) report on Uganda, HIV/AIDS infected persons in northern Uganda has found an increase in HIV/AIDS at 11.9% compared to 6.4% national rate. This increase was attributed to lack of awareness among the people living in IDP camps. TASO counsellor in Gulu district (Uganda) reported continued HIV/AIDS spread in the sub-region due to food insecurity, lack of transport or resources for the HIV/AIDS counselors to create awareness in the villages. The same report indicates that AIDS is the leading (69%) cause of death in Gulu district.

World Relief Services International (2009) report attributed the HIV/AIDS spread to the 20 years of civil war which had prevented awareness campaigns. The relief agency report observed that the region is 10 years behind the rest of Uganda in terms of HIV/AIDs awareness. Myths and denial about the epidemic is rampant among the people in Gulu district where 65 % of the people do not know of a single method of prevention of the disease.

At the same time, the deputy director of the Population Services International, an HIV/AIDS NGO spearheading cross-generational sex fight in Uganda, has told a national conference in Kampala that, the NGO is losing HIV/AIDS fight in Uganda (Semwanga, 2009). Cross-generational sex is failing the campaign against the spread of HIV/AIDS in Uganda because of its strategic problems with the message design and delivery approaches to the intended national audiences in Uganda.

Lack (Namutebi and Nalwanga, 2009) of accessible HIV/AIDS information remains the most single factor which contributing the rise of the endemic scourge in Uganda. A master plan for compulsory HIV/AIDs test for all, the Uganda AIDS Information Centre document says at the moment, only 21% of Ugandan adults (2.5 million) know their HIV status. A national study done for by Makerere University for the Uganda AIDS Commission and UNAIDS (2009) found that about 650,000 Ugandans are unknowingly living with an HIV-positive partner and almost 85,000 will contract the virus this year (2009) if nothing is done to raise awareness.

The national malaria control strategic plan advocacy strategy: The National Malaria Control Strategic Plan advocacy strategy was expected to use multiple communication channels to influence attitude to malaria control activities at all levels (MoH, 2006). Most people in Uganda are aware of malaria. But their knowledge of its treatment and control is still low. The mass media such as: newspapers, local FM stations, village film shows, and TV phone-ins have triggered off unprecedented gender balanced public debates on malaria control efforts in Uganda (MoH, 2006).

Government produced designed and delivered a variety of messages to raise awareness of malaria disease. As a result, multiple household surveys indicate 90% public awareness of malaria and its dangers. Over 70% of households were exposed to the intended campaign messages. In the malaria strategy, the government used leaflets, posters, radio, films and newsletters, while health personnel disseminated messages to the public (MoH, 2006). But this apparent high awareness has not yet translated into knowledge of malaria treatment and control.

A team of Makerere University medical and pharmacy student researchers has found that although malaria disease kills about 100,000 people in Uganda annually, most people still think it is caused by either witchcraft or eating mangoes. The Ugandan medical health researchers, (Nyonzima et al., 2009) found that, despite enormous efforts by health professionals, educators and the government to fight Malaria, the disease remains the most significant health threat to Ugandans.

The team believes that the professionals who are leading the fight against malaria are not listening to the

voices of the people affected by the disease. As a result, programmes to educate them about malaria are failing. According to Nixon Nyonzima et al. (2009), the main problem in Uganda is lack of accessible information for the ordinary person to understand. The study was done in Tororo district (eastern Uganda) to establish malaria awareness; and it found that most locals believed that eating mangoes caused malaria.

Womakuyu (2009) researches were also stunned to learn that the locals thought malaria was caused by witchcraft or bad spirits. Similarly, most people there did not seek medical advice due to ignorance. The research team attributed all these problems to ignorance, lack of basic education, poverty, and cultural beliefs. This was a clear indication that people had not received the correct information on how malaria spreads. They also observed that there was a coincidence between the mango harvests and rain seasons in the swampy villages.

DISCUSSION

In promoting health, the first and most common ingredient is increasing knowledge and awareness as the starting point (Ethel, 2002).Influencing behaviour requires a multifaceted approach to communication that takes the complexities of culture, gender, power, economics, emotions, and social skills into consideration. This could work if it is grounded on the right communication campaign strategy.

Public service agencies which commission media campaigns to support their goals should use multi-media channels with multiple presentations in a variety of eye or ear-catching formats (Mody, 2002). The government aimed to achieve 95% public awareness for better health by involving the media in health education campaign (MoH, 2006). A review of studies on the effectiveness of mass media campaigns to promote HIV testing showed that the media were initially effective (Lisa and Elliot, 2003).

Accessible information communication technologies need to be used to address several medical challenges and diseases like HIV/AIDS (Litho, 2007). An assessment of ICT for health projects indicates that Uganda needs to do more to benefit ICTs for health. A variety of media contents provide the possibility for interaction by users when it is convenient to them (Emilija, 1999). Radio talk shows have turned into a civic forum through which citizens acquire information about public affairs, attempt to exert influence upward on political leaders, question, challenge, and demand accountability from official power holders, engage in public discourse and debate on collective public problems and policy, or simply let off steam (Mwesige, 2004).

Communication theory infusion in public campaigns is needed because part of the problem with the communication campaign is lack of awareness among the campaign practitioners, evaluators, and their sponsors about what outcomes and methods are appropriate and available (Coffman, 2002b). Health messages for community health empowerment should be framed strategically (Blumler and Guvercih, 2000).

The policy awareness campaigners need to be well informed about the attitudes, level of knowledge, listening and message comprehension abilities, social and cultural background of the communities (Mody, 2002).Therefore, more work is needed for capacity building and outreach activities for awareness-raising to ensure early warning information dissemination on health risks, epidemics, hazards, and disasters (ICSU, 2007). The local media can create messages that promote AIDS information campaigns in poor communities to reduce their vulnerability (UNDP, 2007).

Conclusion

Uganda still faces very low or lack of public awareness about the causes, signs and symptoms of illness and diseases, effects, management, prevention, treatment, new medical innovations, and health service delivery approaches to all communities. Well over 80% of all diseases in Uganda can be ascribed to ignorance and poor environmental conditions. There are huge gaps between awareness, knowledge, and practice. It is imperative that Uganda embarks on capacity building to develop an effective health policy communication strategy for community empowerment in Uganda. The country is yet to design and deliver a participatory public communication campaign approach which should raise awareness and ease communication barriers among the agencies, institutions, government departments, non-governmental organizations and community organizations involved in national public awareness campaigns and capacity-building efforts in the country. The health campaigns strategy should involve surveys to determine: familiarity with different media; characteristics of target groups; community “media diet”; effectiveness of different media channels; the socio-cultural, environmental, and economic fabrics of local communities. More time should be spent in the field to create, raise, develop, and sustain awareness and knowledge for the best practice. The current communication campaign strategy is wanting. Its message focus is not audience-centred.

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