Presentation Title:

Achieving Rapid Behaviour Change in the midst of the COVID-19 Pandemic

Hygiene Behaviour Change Coalition program implemented in Kenya, Uganda and Tanzania

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Presentation outline

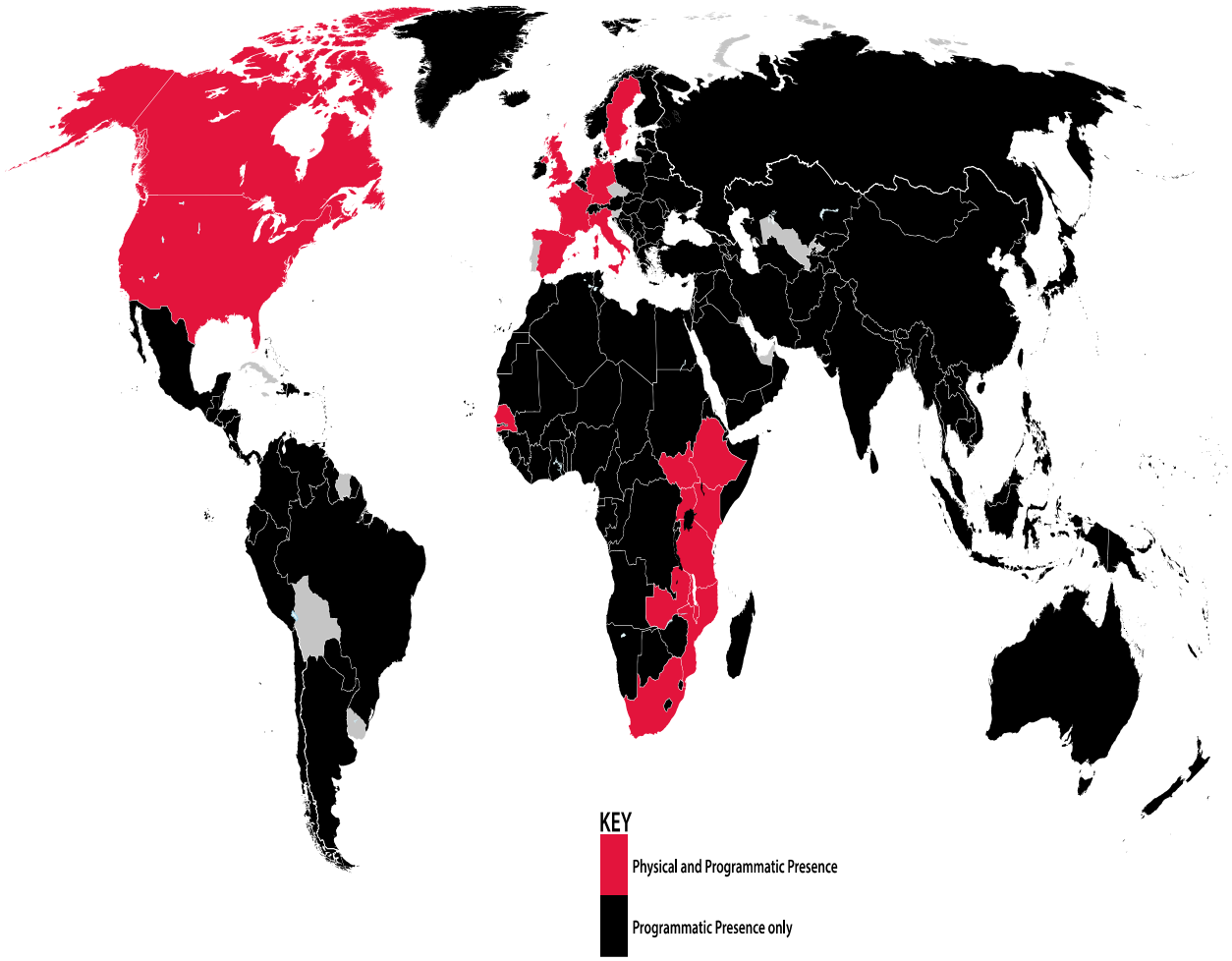
- Background
- General structure of Amref's response to COVID-19
- Brief on the Hygiene Behavioural Change Coalition project
- Approaches used to achieve the desired results
- Lessons learnt and successes
- Challenges

ABOUT AMREF HEALTH AFRICA & GLOBAL PRESENCE

Amref Health Africa is Africa's leading health NGO. Headquartered in Nairobi, we partner with communities in 35 countries to sustainably strengthen health systems and improve access to high-quality care.

Since starting out as the Flying Doctors of East Africa in 1957, we have always been driven by the belief that health is a human right, striving to remove the barriers that prevent people across the African continent from accessing life-saving care.

Almost 65 years on, this ethos continues to underpin everything we do



Amref Health Africa contributes to Sustainable Development Goals 2, 3, 5, 6, & 17

The high burden of disease remains the main challenge to African health systems (Africa Union, 2016). Sub- Saharan Africa, home to 11% of the world's population, bears 24% of the global disease burden and accounts for less than 1% of global health expenditure. As Amref Health Africa navigates through this challenging landscape, engaging in this cohesive vision of health systems strengthening, it focusses on the following SDGs:

The Brief

- Since May of 2020, Amref Health Africa has been at the forefront of the COVID-19 response in sub-Saharan Africa.
- The COVID-19 pandemic created an increased need for our unique expertise: not just in responding to the pandemic, but in strengthening health systems in a sustainable way - an essential step in preparing for future public health emergencies.
- As an organisation we reprogramed , raised emergency funds from various donors to enable us support the Ministries of Health call towards preventing , managing and controlling the spread of COVID-19.
- Both from COVID-19 itself and from conditions exacerbated by the pandemic, we launched ambitious interventions with in Kenya, Tanzania and Uganda. Noting that each country was approaching the pandemic differently it was important to accelerate messages that create Rapid behavioural change

Relevance to the SBCC summit theme

As part of the Hygiene Behaviour Change Coalition, Amref Health Africa teams in Kenya, Tanzania, and Uganda responded to the COVID-19 pandemic, contributing to the joint reach of 10,000,000 million people in 2021.

Today we share achievements and reflections on key lessons learnt from Uganda.

With funding from The Foreign Common Wealth Development Office and Unilever. Amref Health Africa in Uganda received 580,000Pounds for a period of one year to create awareness about COVID 19 and also accelerate good hygiene behavioural practices in two highly vulnerable districts of Kampala and Kyotera respectively. .

Challenge

- Accelerating Behavioural Change in a bid to stop the Pandemic,
- Enforcing the lock down Standard operating.
- Cultural settings and beliefs
- The challenge of Coordination and information management during the COVID-19 pandemics
- Politics and politicking
- Constrained health system and workforce

In Uganda we had started loosing health workers important to note is that for the ratio of doctor-patient and nurse-patient ratio is **approximately**

1:25000 and 1:11 000 respectively we had to work fast ,differently but in an accountable manner.

Scope and dimension of the Challenge

Amref 's response plan funded by the Hygiene behavioural Change Coalition in Uganda covered the two most affected districts.

The districts are high volume district together they have 4 million people by day and 2.5 million people by night. The are business and transit districts which made them highly vulnerable to the spread of COVID-19.

The project supported the reduction of the burden associated with the health threats in terms of mortality and morbidity reduction, hospitalization and demand for health care goods and services; maintaining essential services, protecting vulnerable groups (such as women, girls and children) and minimizing health, economic and social impacts in the long term.

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How Big was the problem

The strategic measures to contain the pandemic was based on the objectives below

- **Create awareness on how the virus was being spread because communities were not taking it seriously they felt the measured were too simple to fight such a deadly virus.**

- **Drive engagement and action** among everyone to practice hand hygiene, surface hygiene and homestead hygiene in the bid to control and manage the spread of COVID-19.

- **Increase uptake** of COVID-19 vaccines among all eligible populations and **bust the myths and misconceptions** about COVID-19 and the vaccines.

What was different that drove the SBCC agenda during the pandemic

Our response was structured around three pillars:

1) Preventing Transmission

2) Preventing Death

3) Preventing Social Harm

These pillars were reinforced by our trademark commitment to community engagement and awareness-raising that was delivered through:

- An extensive network of **Village Health Teams.**
- **Strategic partnerships** with already-existing structures like market vendor associations, truck drivers' associations, the health sector (both government and private) and media.
- **Ambitious mixed risk communication strategies** and accelerated homestead hygiene and vaccination against COVID-19. Using local media and virtual spaces as the main channels of information-sharing

Approaches used to accelerate behavioural change

The project's interventions were largely centered around the PASSWORD campaign developed by Unilever as part of HBCC1.

We together with our donors and government sought to reinforce hygiene behaviors, with the 'Don't let Corona disrupt your life' messaging that incorporated the SOPs as provided by WHO and MOH.

The overall goal of HBCC1 was to promote rapid behavioural change hygiene, public health, and social measures to prevent and control COVID-19 in Uganda through effective communication campaigns at scale on mass media channels including television, radio, out-of-home advertising and interface intervention bearing in mind the lockdown status and social distance.

Approaches that accelerated behaviour

Capacity-building for all stakeholders involved in the response: village health teams who were the content trackers. School children , teachers and women market vendors and also front line workers, Training was also provided to policymakers to ensure the right frameworks and strategies are in place, so interventions can be supported and under stood. Outreach / demand creation: taking the information to the people through partnerships with the leadership and political representative to the people. Wqmen mobilising communities to create demand by tackling vaccine hesitancy, myths and misinformation.

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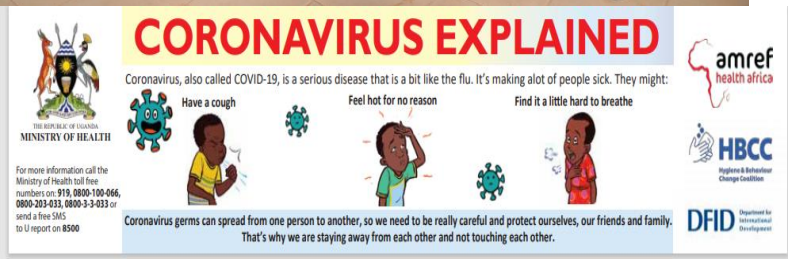
Media approach and The unique approach clustering of households for peer-to-peer support

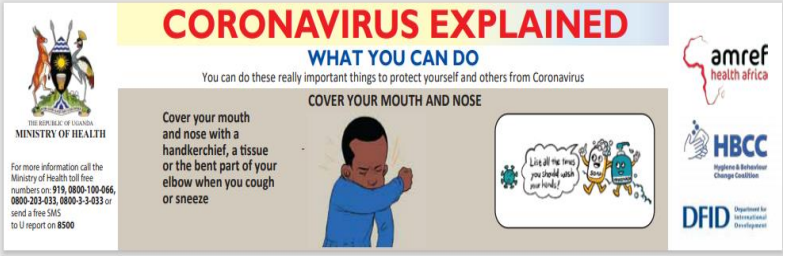
TV: The objective of TV was to drive awareness and educate. This objective was executed by selecting main reach stations with mass appeal that cut across the demographics, spot placement during high viewership programs and talk shows.

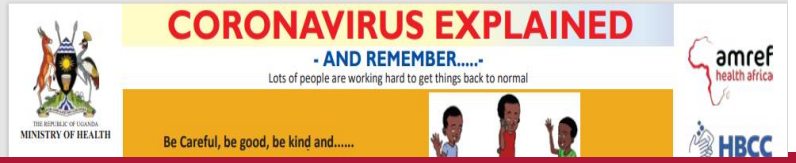
Radio: The objective of Radio was to drive tactical awareness. This was executed by running scripted mentions on high reach stations and talk shows using community influencers and celebrities to create awareness and drive top of mind consideration of behavioral change

OOH: The objective of OOH was to drive awareness and impact. This was executed by selecting static billboards in key regions and located on main arterial roads which target commuter traffic.

Methodologies Employed







COVID-19 vaccination sites.

Door-to-door home improvement campaigns

Risk communication and community engagement (RCCE) in Kyotera and Kampala Districts

- About **79,000 people were reached through 50,000 house-to-house visits** by 2,000 community volunteers - applying physical/social distancing guidelines following the reactivation of community engagement interventions by the authorities.

- Amref supported the local governments at the district level to publish COVID-19 posters, pre-recorded audio messages and training videos on different media platforms including social media like WhatsApp, Facebook, YouTube, Twitter, reaching more than 2 million views.

- **Scaled-up use of IEC materials:** 10,000 posters, 2000 PHASE kit booklets, 1,050 children's comic strips and 22 billboards as well as branding of COVID-19 testing sites, VHTs, health facilities and use of 10 vehicles mounted with megaphones reached an estimated 2,200,000 million people.

- **Health experts trained in RCCE responded to 1,620 calls** on questions and concerns on COVID-19 (3610 women, 1110 men) on 4 local radio stations.

Key learnings from HBCC Phase One

- **Put communities first**, gaining their buy-in.
- Ensure **local ownership and know-how** is at the core of behavioral change.
- Strong **individual and institutional leadership** is key.
- **Speed and agility** are paramount, but this must be combined with **accountability**.
- Create **coordinated partnerships** to support government stewardship.
- **Digital innovations** underpin effective responses.
- **Targeted and inclusive communication** and prevention measures is non-negotiable.
- A **fluid structure and lean governance model** with little bureaucracy facilitates agility and capacity to respond to evolving needs and exiting when targets need to be met.
- Engage and mobilise **young people** for far-reaching, and sustained impact.
- **Consistently monitor** project processes; documenting and disseminating lessons learned is key.

Challenges on COVID-19 Response through Hygiene Behavioural Change Coalition programme

- **Managing expectations from VHTs** including requests for stipends, inadequate PPEs for protection of VHTs during implementation of HBCC.
- **Communities were resistant to embracing the vaccines** when they were availed for fear of the myths and misconceptions surrounding the vaccines and ignorance.
- **Fear of COVID-19 patients**; this led to **high stigma** among the affected households within the communities.
- **District Task Forces** in the implementing districts were not as functional as expected, maybe due to the fact that most of them were also into politics so political activities had disrupted their functionality. Thus coordination of COVID-19 responses and use of politicians as behaviour change influencers was limited.

HBCC – COVID-19 Response Project – Remedies:

- **District Surveillance Focal Persons** resorted to working with the District Health Officers and District health teams in management of COVID-19 within the districts.
- Health Facilities mobilized some **face masks** for Village Health Teams (VHTs) to use in contact tracing.
- **VHTs were oriented and informed** of what they should expect from the project.
- **Sensitization of the communities** was through interactive radio talk shows to avert stigmatization of homesteads with COVID-19 patients.
- The **VHTs conducted house-to-house health education** as they undertook their routine activities using the clustering model of 10 homesteads being keepers of each other.

Acknowledgements

1. UK Foreign, Commonwealth and Development Office (FCDO)

2. Unilever

3. National Business Compact for COVID-19

4. Hygiene Behavioural Change Coalition

5. Uganda's Ministry of Health

6. Implementing districts leadership

Link to a video clip about the HBCC1

https://youtu.be/eGK4NpIKrzU


DON'T FORGET TO WASH HANDS
ALWAYS WASH YOUR HANDS WITH WATER AND SOAP

Thank you!