Programme Brief

Applying Effective Communication for Development Interventions to HIV Prevention among Adolescents

Zukiswa, 13, sits smiling at Asiphilisane Camp for Children with HIV in Pretoria, South Africa. © WeShare

About this brief

This brief[1] highlights recent findings from relevant research and presents recommendations on the development and implementation of effective Communication for Development (C4D) for HIV prevention initiatives in Eastern and Southern African countries, with a focus on HIV prevention among adolescents and young people. The brief is intended for use by UNICEF colleagues and partner programmers as they work to meet UNAIDS 90-90-90[2] and UNAIDS 2030 Fast Track[3] HIV prevention, treatment, care and support targets.

Background

Recent successes in HIV prevention include reduced rates of mother-to-child transmission of HIV, the scale-up of voluntary medical male circumcision (VMMC) and the institutionalization of comprehensive sexuality education in many countries of Eastern and Southern Africa (ESA). However, due to a range of issues including gender inequality, lack of access to HIV prevention information and services, sexual violence, perceptions of low risk of HIV infection, low rates of condom availability and use and barriers to HIV testing, programmes are not on track to reduce new HIV infections nor meet recently-articulated prevention targets, especially among adolescents and young people. In 2015, an estimated 63% of the world's children (0 to 14 years old) and adolescents (10 to 19 years old) who were living with HIV resided in the ESA region, and 50% of new HIV infections among adolescents 15 to 19 years old globally occurred in the ESA region.[4] Girls and young women are most at risk: 78% of new infections among 15- to 19-year-olds in ESA are among females.[5] Despite strides in the HIV response, two-thirds of young people in ESA do not have correct and comprehensive knowledge about HIV.[6]

1 This brief was prepared by Paul Nary, Sr. Specialist HIV & AIDS Prevention and Adolescent Development, and Mandi Chikombero, Communication for Development Specialist, UNICEF Regional Office for Eastern and Southern Africa.

2 By 2020, 90% of all people living with HIV will know their HIV status; 90% of all people with diagnosed HIV infection will receive sustained antiretroviral therapy (ART); and 90% of all people receiving ART will achieve viral suppression. (UNAIDS, 2017 estimates.)

3 By 2030, the above 90-90-90 targets will each be achieved at 95% rates; by 2020, new infections will be reduced to 500,000 world-wide and to 200,000 by 2030; and "zero discrimination" will be achieved by 2020 and maintained until 2030. (UNAIDS, 'Fast-Track, Ending the AIDS Epidemic by 2030', 18 November 2014 <www.unaids.org/en/resources/documents/2014/JC2686_WAD2014report>, accessed 5 June 2017).

4 UNAIDS, 2017 estimates.

5 UNAIDS, 2017 estimates.

6 UNAIDS, Prevention Gap Report, 2016.

A group of young people sits outside a youth club in Blantyre, Malawi and discusses HIV using brochures and booklets. © WeShare

A renewed emphasis on HIV prevention - in particular, is more effective C4D approaches and interventions - are needed, if we are to achieve the goals of the United Nations 2016 Political Declaration for Ending AIDS:

1. Reduce the number of new HIV infections among adolescent girls and young women to below 100,000 per year;
2. Ensure that 90% of young people have the skills, knowledge and capacity to protect themselves from HIV;
3. Ensure that 90% of young people in need have access to sexual and reproductive health services and combination HIV prevention options by 2020.

Addressing these challenges requires an understanding of the underlying behavioural and structural factors that contribute to HIV infection rates. It also requires strategic approaches that promote positive changes in knowledge, attitudes and behaviour. Recent evidence supports provision of HIV prevention through a combined response that involves structural, behavioural and bio-medical interventions and that addresses social norms and creates demand for HIV prevention and health services. C4D can make important contributions to such efforts.

Conceptual approach

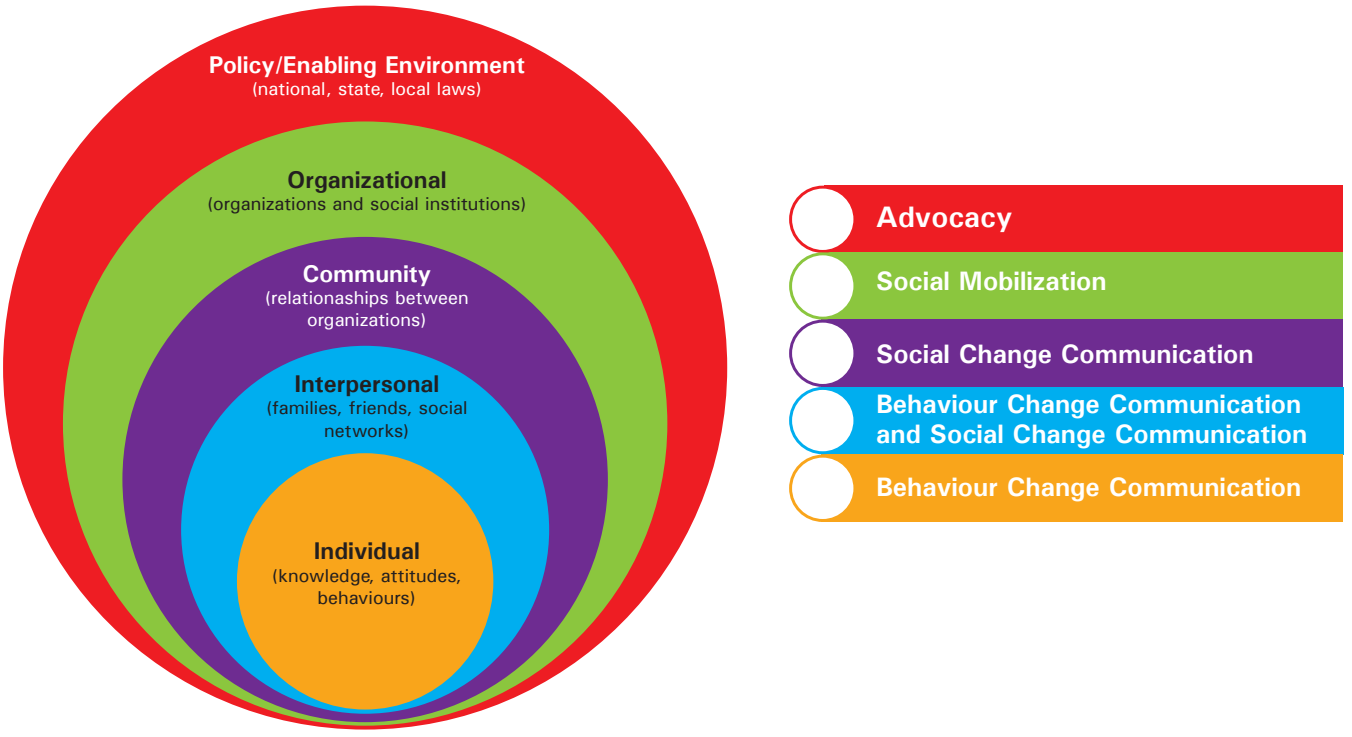
The Socio-Ecological Model

C4D uses research that identifies barriers and opportunities related to knowledge, attitudes, perceptions and socio-cultural practices and norms in order to inform communication to facilitate interpersonal dialogue and that uses various types of media to inspire positive changes at individual, community and societal level. C4D programming empowers individuals and communities with knowledge and practices that promote attitudes and values for positive behaviour and the utilization of relevant services. C4D is based on the following four strategies that promote change, but are most effective when used in combination:

1. Behaviour change communication
2. Social mobilization
3. Communication for social change
4. Advocacy

UNICEF C4D programming is informed by the Socio-Ecological Model, a conceptual approach that "facilitates careful consideration of how social and environmental dynamics influence development

Figure 1. The Socio-Ecological Model



outcomes at the individual, household, community, institutional and societal level. C4D programming is therefore able to address variables at the level of individual and group knowledge, and in relation to attitudes, beliefs, individual and collective efficacy, motivations, behaviours, social and cultural norms, community and institutional infrastructure, and in relation to policy advocacy and governance."[7]

Combination Prevention

The Socio-Ecological Model also resonates well with the Combination Prevention approach to HIV prevention, defined as the strategic, simultaneous use of different classes of prevention activities (biomedical, behavioural, social/structural) that operate on multiple levels (individual, relationship, community, societal), to respond to the specific needs of particular audiences and modes of HIV transmission, and to make efficient use of resources through prioritizing partnerships and engagement with affected communities.[8]

Table 1 illustrates that the Socio-Ecological Model and Combination Prevention approaches can offer a blended framework for examining recent evidence to strengthen C4D for HIV prevention, by promoting the kinds of results that are expected from HIV programming that targets individual, community, organizational and policy level variables for adolescents.

Table 1. Socio-Ecological Model and Combination Prevention

Socio-Ecological Model	Combination Prevention
GOAL: Behavioural and Social Change	GOAL: HIV Prevention
Individual/Interpersonal level & Biomedical level (client uptake and adherence)	Behavioural (at individual and small group level)
Community level	Behavioural, biomedical and structural (at community level)
Organizational (behaviour change at organizational level)	Biomedical level (quality service provision)
Policy/enabling environment/societal level	Structural level (environmental, policy/ legal, societal norms)

7 UNICEF ESARO C4D Strategic Framework 2015-2017.

8 Joint United Nations Programme on HIV/AIDS, 'Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections, a UNAIDS discussion paper', UNAIDS, September 2010, <http://www.unaids.org/sites/default/files/media_asset/JC2007_Combination_Prevention_paper_en_0.pdf>, accessed 5 June 2017.

What works:
a summary of the evidence

Recent research findings suggest that C4D programming can promote specific HIV-prevention outcomes in the context of HIV programming.

Individual Level

Interpersonal Communication/Counselling is one of the most effective C4D interventions for promoting individual behaviour change.[9] A multi-country review of interpersonal communication interventions in sub-Saharan Africa (SSA), found that those that "rely on… individual and group counselling, both within and beyond clinical settings, can enhance the uptake of and continued engagement in care."[10] Interpersonal communication can also effectively promote adherence to anti-retroviral therapy (ART), which can limit the spread of HIV.

Peer education **has been shown to be** effective when combined with other interventions in promoting individual behaviour change (condom use) and service uptake, including HIV testing and counselling (HTC), VMMC and needle exchange.[11] Quality evidence shows that in-school interventions can positively impact HIV-related outcomes such as self-reported sexual risk behaviours.[12] A review of school-based sex education that included 15 sub-Saharan African countries found that students who received school-based sex education were better informed with HIV-related knowledge; had greater self-efficacy for refusing sex or using condoms; had fewer sexual partners or were better able to delay initiation of first sex.[13]

Promoting demand for services: A review of communication interventions that promote uptake of VMMC services found success with school campaigns, musical artists and use of radio in Tanzania, Zimbabwe, South Africa and Uganda. The use of radio broadcasts was found to increase adolescents' intention (a predictor of action) to attend VMMC services.[14]

A USAID/Project Search systematic review and meta-analysis of condom social marketing campaigns between 1990 and 2010 found that "in general, persons exposed to condom social marketing were approximately twice as likely to use a condom as those not exposed."[15] Community-based and mass media communication campaigns have been shown to increase attendance at HTC services. For example, people who were exposed to a combination of community-based and mass media campaigns in Malawi were 1.4 times more likely to test for HIV.[16]

Community Level

In the area of HIV prevention, community mobilization interventions have demonstrated success in increasing condom use, improving service access and quality, increasing social capital or social cohesion, and in promoting uptake of HTC services among men and women 18 to 35 years of age in South Africa. Often however, community mobilization interventions lack a clear theory-based, conceptual framework or fail to identify core community mobilisation components around HIV prevention and care. Both are critical to scale-up of interventions that utilize mobilization approaches.[17]

Community engagement strategies have been shown to provide an "unambiguous impact" on factors including access to services, coverage, adherence to ART, virological and immunological outcomes, patient retention and survival and, in particular, to enhancing ART scale-up.[18] A randomized controlled trial in rural Uganda found that involvement of community-based peer treatment supporters lowered loss-to-follow-up by 44% compared with a control group without support.[19]

9 Eaton L. et al., 'Meta-Analysis of Single-Session Behavioural Interventions to Prevent Sexually Transmitted Infections: Implications for Bundling Prevention Packages', American Journal of Public Health, 2012 November <www.ncbi.nlm.nih.gov/pmc/articles/PMC3477958>, accessed 5 June 2017.

10 'Impact of Health Communication on Continuum of Care', www.hivsharespace.net/system/files/SBCC%20HIV%20Evidence-Continuum%20of%20Care%20Feb2015.pdf, accessed 5 June 2017.

1 Eaton L. et al., 'Meta-Analysis of Single-Session Behavioural Interventions to Prevent Sexually Transmitted Infections: Implications for Bundling Prevention Packages', American Journal of Public Health, 2012 November <www.ncbi.nlm.nih.gov/pmc/articles/PMC3477958>, accessed 5 June 2017.

12 Mavedzenge et al, Mavedzenge et al (2014). 'Effective Approaches for Programming to Reduce Adolescent Vulnerability to HIV Infection, HIV Risk, and HIV-Related Morbidity and Mortality: A Systematic Review of Systematic Reviews. Journal of Acquired Immune Deficiency Syndromes, 66:S154-69.

13 Fonner et al., 'School Based Sex Education and HIV Prevention in Low- and Middle-Income Countries: A Systematic Review and Meta-Analysis', PLOS ONE, 4 March 2014, <http://journals.plos.org/plosone/article?id=10.1371/journal.pone.0089692>, accessed 5 June 2017.

14 Impact of Health Communication on Voluntary Medical Male Circumcision. PEPFAR, USAID, Health Communication Capacity Collaborative, 'Impact of Health Communication on Voluntary Medical Male Circumcision', 2015, www.malecircumcision.org/resource/impact-health-communication-voluntary-medical-male-circumcision, accessed 5 June 2017.

15 USAID/Project Search, 'Condom Social Marketing: rigorous evidence-usable results', June 2011, www.jhsph.edu/research/centers-and-institutes/research-to-prevention/publications/csm.pdf, accessed 5 June 2017.

16 Kaufman, et al, 'Using social and behaviour change communication to increase HIV testing and condom use: the Malawi BRIDGE Project', AIDS Care, 16 April 2014, www.ncbi.nlm.nih.gov/pubmed/24735337, accessed 7 June 2017.

17 Pettifor et al, BMC Public Health 2015

18 Wouters, E. et al, 'Impact of Community-Based Support Services on Antiretroviral Treatment Programme Delivery and Outcomes in Resource-Limited Countries: A Synthetic Review', BMC Health Services Research, 2012, <www.ncbi.nlm.nih.gov/pubmed/22776682>, accessed 5 June 2017.

19 Chang et al, Effect of Peer Health Workers on AIDS Care in Rakai, Uganda: A Cluster-Randomized Trial, PLoS One, 2010

Two adolescent girls are interviewed about HIV by a reporter in Gaborone, Botswana. © WeShare

Organizational Level

One review of HIV communication capacity strengthening of individual competencies of health, social service providers and community workers assessed a training and mentoring programme for 29 women's NGOs in Uganda, Zambia and Zimbabwe. The review found increased understanding of Behaviour Change Communication (BCC) processes; sharing of information within organizations; diagnosis of organizational problems and building of staff relationships[20] as well as a greater ability to use various media and needs assessments to guide communication strategy development and pre-testing of messages.[21] The same review examined reports on capacity-building efforts of peer-led HIV BCC programmes for adolescents using a training approach, and found improved skills and confidence to share knowledge, speak publicly, conduct situational analyses, plan programmes and implement HIV prevention activities.[22]

Policy/Structural Level

There are a number of interventions in which C4D has played a role in promoting policy change and an enabling environment for better HIV-related outcomes. In South Africa, for example, the advocacy efforts led by the Treatment Action Campaign increased government budget allocations for PMTCT and ART medication and service provision.[23] C4D also played a role in the success of Kenya's VMMC scale-up, including the use of "focused campaigns" (In 2010, Kenya led ESA countries on VMMC coverage rates).[24] And there is positive evidence that social protection interventions such as cash transfers can contribute to lower HIV prevalence rates.[25] Studies have also shown that microfinance interventions can promote uptake of HTC services, yet there are mixed results related to condom use and ineffective or even harmful results related to HIV incidence (increasing incidence).[26] Incentive-based interventions that focus on keeping young people in secondary school may reduce adolescent pregnancy rates, but further studies are needed to confirm this.[27]

C4D can address the structural challenges of reducing stigma and discrimination to better ensure an enabling environment for HIV prevention, care, support and treatment. Brown et al concluded that "information is not sufficient to change attitudes or effect behaviour toward those living with HIV/AIDS" and that "contact with people living with HIV and AIDS might be one of the most promising approaches, though it is clearly not sufficient without improved understanding of the disease."[28] The articulation by Brown et al. of intervention categories to reduce stigma and discrimination (closely linked to C4D) is still applicable today.[29]

20 Lettenmaier, C. et al., HIV Communication Capacity Strengthening: A Critical Review, J. Acquired Immune Difficiency Syndromes, Volume 66, Supplement 3, August 15, 2014

21 Ibid

22 Ibid

23 Overy, Neil, 'In the Face of the Crisis: The Treatment Action Campaign Fights Government Inertia with Budget Advocacy and Litigation', International Budget Partnership, August 2011, <www.internationalbudget.org/wp-content/uploads/LP-case-study-TAC.pdf >, accessed 5 June, 2017.

24 Dickson et al, 'Voluntary Medical Male Circumcision: A Framework Analysis of Policy and Program Implementation in Eastern and Southern Africa', PLOS Medicine, 29 November 2011, <http://journals.plos.org/plosmedicine/article?id=10.1371/journal.pmed.1001133>, accessed 5 June 2017.

25 Pettifor, A. et al, 'Can money prevent the spread of HIV? A review of cash payments for HIV prevention', AIDS Behaviour, October 2012, <www.ncbi.nlm.nih.gov/pubmed/22760738>, accessed 5 June 2017.

26 Editorial, 'The Prevention Issue', The Lancet HIV, July 2016, <www.thelancet.com/journals/lanhiv/article/PIIS2352-3018(16)30061-3/fulltext>, accessed 5 June 2017.

27 Mason-Jones, A.J. et al, School-based interventions for preventing HIV, sexually-transmitted infections and pregnancy in adolescents, Cochrane Library, 8 November 2016, published on-line: http://onlinelibrary.wiley.com/wol1/doi/10.1002/14651858.CD006417.pub3/abstract

28 Brown L. et al, Interventions to Reduce HIV/AIDS Stigma: What Have We Learned? AIDS Education and Prevention, 15 (1), 49-69, 2003

29 Ibid (Intervention categories include: information-based approaches (written); skills-building (participatory learning sessions to reduce negative attitudes); counselling/support (support groups for PLHIV); and contact with affected groups (interactions between PLHIV and others, including small group discussions).

Additional research is needed to demonstrate how C4D contributes to reduced HIV incidence and prevalence. Further research using experimental designs will lead to better understanding, and strengthen the role of C4D in demand-creation interventions. Examples of possible C4D interventions are presented in Annex 1.

UNICEF Goodwill Ambassador Angelique Kidjo with adolescents at a community sports festival in Cape Town, South Africa. © WeShare


MOUNT VIEW

Recommendations for action

- C4D for HIV prevention should be evidence-based, **designed strategically and use multiple communication interventions**. C4D should reach well-defined populations in specific locations and link to provision of quality services and commodities. C4D should never be about just one, isolated intervention.
- **Context is key** and must be taken into account to ensure C4D messages and interventions are culturally and socially appropriate.
- For adolescents, HIV prevention interventions should be based on a clear **analysis of the needs, behaviours and preferences of adolescents**, and should be linked to services and commodities that are accessible and acceptable to them. Communication messages and interventions should **respond to the changing needs of young people** as they transition from early to late adolescence. Well-crafted messages must remain relevant, fresh and attractive to adolescents while ensuring that the benefits of recommended behaviours are clear.
- C4D interventions for HIV prevention should be **carefully monitored, evaluated and open to re-design**, including the participation of target populations, such as adolescents, to craft messages. Evaluation findings should be used to improve design and implementation of future, similar interventions.
- Government representatives, programme implementers and donors should prioritize further rigorous studies to better understand the effective use of **C4D that reduces HIV incidence and prevalence** (not just behaviour change), and the role of biomedical HIV prevention interventions among adolescents, including VMMC, pre-exposure prophylaxis (PrEP), prevention of mother-to-child transmission (PMTCT) of HIV, and ART.
- Advocacy is needed to ensure donors and partners invest in **well-designed C4D interventions at scale that ensure sustained behaviour and social change**. Such investments should include innovative approaches to C4D such as the use of social media, where appropriate.

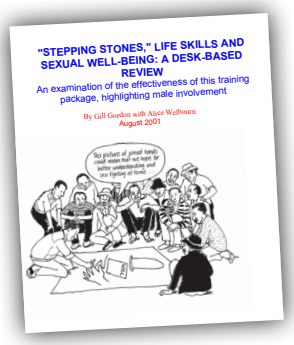
17 year old Sylvester Benedicto watches as a peer youth counselor speaks to him about safe and protected sex in Lilongwe, Malawi. © WeShare

Annex 1: Examples of C4D interventions for HIV prevention

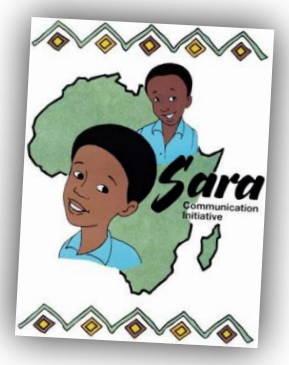
SOCIO-ECOLOGICAL MODEL	COMBINATION PREVENTION	INTERVENTION OBJECTIVES	WHAT C4D COULD LOOK LIKE
Individual/ Interpersonal	Behavioural and biomedical (client uptake and adherence)	• Increase knowledge and information of HIV and HIV prevention services and commodities e.g. correct and consistent condom use; knowledge of one's HIV status, uptake of VMMC. • Support adherence to behaviour change (e.g. abstinence, single partner); promote consistent/ correct adherence to treatment.	Behaviour change communication for condom promotion, VMMC, PrEP, opioid substitution, therapy/ needle exchange programmes and ART; peer education promoting individual behaviour change and service uptake; social marketing.
Community	Behavioural, biomedical and structural	• Generate demand for services; • Promote change of community norms; • Support adherence to behavioural and social change; • Promote reduction of stigma and discrimination.	Social change communication using community-engagement strategies that promote uptake of HIV counselling and testing; promotion of safe behaviours; improvement in knowledge of HIV; support for ALHIV; change in community norms including gender norms.
Organizational	Biomedical (quality service provision)	• Promote behaviour change among service providers and staff; • Ensure providers offer quality services and commodities.	Social mobilization of service providers and community workers such as community volunteers or village health workers; HIV communication capacity strengthening to build individual competencies; mobilization of adolescent/youth organizations to conduct outreach; supportive materials and tools (job aids); essential prevention, care and treatment messages; and support for referrals to complimentary services.
Policy/Enabling Environment	Structural (environmental, policy/legal, societal norms)	• Ensure an enabling environment for effective HIV prevention interventions; • Generate demand for fulfilment of human rights of stigmatized populations; • Support policies and protocols for provision of services and commodities to adolescents at risk or in need of care, support and treatment; • Promote change in social norms.	Advocacy to promote and support policy change, (e.g. comprehensive sexuality education, key population rights, age of testing, and social protection) for vulnerable adolescents.

Annex 2: A Regional Snapshot: C4D Interventions for HIV Prevention in Eastern and Southern Africa

In recent years, C4D interventions have effectively promoted behavioural and social change concerning HIV-related issues in Eastern and Southern Africa. Many interventions have focused on youth and adolescents; a few have focused specifically on adolescents.



Stepping Stones (ESA region, South Africa) – The Stepping Stones community training programme was first developed in Uganda in 1994 to support behavioural and social change on HIV/AIDS, communication and relationship skills. It has since expanded to numerous countries across the globe. A cluster, randomized controlled trial of men and women 15 to 26 years old in South Africa found that Stepping Stones contributed to significant reduction among men in reported perpetration of intimate partner violence, less transactional sex and problem drinking. Although there was no evidence of reduced incidence of HIV, Stepping Stones was associated with a 33% reduction in the incidence of HSV-2.[30]



Sara (Tanzania and continent-wide)– The UNICEF Sara campaign has empowered thousands of African girls with stories of a charismatic, young heroine named Sara; utilizing a comic book, an animated film and supporting print materials. The stories addressed child rights, in particular gender issues. UNICEF's multi-stage cluster evaluation of Sara in 25 of 54 districts of Tanzania since 2000 determined that 32% of respondents recognized the Sara brand, although only 8% could recount the plot of their favourite episode, a strong argument for exposure through group learning processes.[31]

LIFE®
loveLife

LoveLife (South Africa) - LoveLife is a youth-focused HIV prevention initiative utilising a variety of media platforms to reach young people with information and support on HIV and life skills. An evaluation (2011) of the impact of LoveLife on HIV and related risk behaviours in four provinces of South Africa found that 90% of young people exposed to LoveLife had spoken to their teachers about HIV/AIDS. Young people reported that LoveLife enabled them to talk to their friends about sex, sexuality and relationships (79%), reduced their number of sexual partners (76%) and encouraged them to use condoms more regularly (74%).[32]

HEART (Zambia) – In 2000, the Helping Each other Act Responsibly Together (HEART) campaign aimed to reduce the sexual transmission of HIV among young people 13 to 19 years old in Zambia. Post-broadcast surveys have found that the campaign reached about half of Zambian adolescents, and 74% of males and 68% of females reported taking at least one action as a result of having seen the campaign. Viewers were more likely to report being abstinent than non-viewers, and viewers who were sexually active were more likely to report condom use than non-viewers.[33]

30 Jewkes, R, Nduna, M., Levin, J., Jama, N., Dunkle, K., Puren, A. & Duvvury, N., 'Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: Cluster randomised controlled trial', BMJ 337: a506, 2008

31 Evaluation of the Sara Regional Communication Initiative. UNICEF, 2000. www.unicef.org/lifeskills/files/SaraCommunicationInitiative.pdf

32 LoveLife, 'Talking Points: A study on HIV, sexual risk behaviour, and access to opportunity among young people in South Africa', 2012.

33 www.thenationalcampaign.org/sites/default/files/resource-supporting-download/mm_casestudyheart.pdf

Soul City (South Africa) – Soul City is a long-running health promotion initiative that uses television, radio, print media and face-to-face communication to reach adults, adolescents and children in rural and urban areas of South Africa. The Soul Buddyz series aired television drama episodes that dealt with issues of HIV/AIDS, targeting eight to 12 year old children and their parents. An evaluation of the 2007 series found that following exposure to Soul City print materials, an additional estimated 1.2 million adults took an HIV test. The population's exposure to multi-media and radio was also associated with a rise in HIV-testing, and all Soul City interventions were associated with a reported increase in condom use. Other results suggested that exposure to Soul City interventions led to a willingness to participate in community actions that supported people living with HIV.[34]

MTV Shuga (Nigeria) – Experimental evidence indicated that MTV Shuga, a TV drama programme promoting HIV awareness to a youth audience in Nigeria, improved knowledge and attitudes of viewers, led to an increase in HIV testing and reduced risky sexual behaviours. An evaluation in 2016 found that individuals who watched Shuga were 35% more likely to report getting tested in the previous six months (9.3% versus 6.9% in the control group). Individuals in the treatment group were 14% less likely to report having had concurrent sexual partners in the six months prior to the survey (18% versus 22% in the control group) and reported having fewer partners at the time of the survey. The programme, however, did not lead to increased condom usage.[35]

OneLove (Southern Africa) – During five years of implementation (2007-2011), the OneLove regional campaign reached an estimated 27 million people across the Southern African region, promoting HIV testing, increased knowledge about HIV and AIDS, shifts in attitudes and norms, and greater interpersonal communication. In Lesotho, multimedia exposure was associated with increased HIV-testing, and a dose-response relationship was demonstrated (46% unexposed, 52.8% exposed to one medium, 59% exposed to two media). In Malawi, of the men with multiple partners who were exposed to OneLove radio programming, condom use at last sex rose 7%. Among the general population exposed to OneLove TV, there was a 22% increase in condom use.[36]

34 Soul City Institute for Social justice, 'Soul City Series 7 Evaluation Report', 2006, <www.soulcity.org.za/research/evaluations/series/soul-city/soul-city-its -real-evaluation-report-2006/soul-city-series-7-qualitative-evaluation-report/view>, accessed 5 June 2017.

35 The World Bank i2i Fund, 'Experimental Evaluation of MTV Shuga: Changing social norms and behaviors with entertainment education', <www.pubdocs.worldbank.org/en/438421467236362785/Entertainment-Edu-workshop-Flyer-6-3-16.pdf>, accessed 5 June 2017.

36 OneLove, 'Regional HIV Prevention Campaign: Evaluation Summary 2013', One Love, 5 December 2013, <www.comminit.com/africa/content/onelove-regional-hiv-prevention-campaign-evaluation-summary-2013www.soulcity.org.za/research/evaluations/regional-programme/onelove-regional-hiv-prevention-campaign-evaluation-summary-2013/view>, accessed 5 June 2017.

For more information please contact:

Anurita Bains
Regional Advisor - HIV/AIDS
UNICEF Regional Office for Eastern and Southern Africa
Nairobi, Kenya
E-mail: abains@unicef.org

Deepa Risal Pokharel
Communication for Development Specialist
UNICEF Regional Office for Eastern and Southern Africa
Nairobi, Kenya
E-mail: drpokharel@unicef.org

unicef | for every child