

GROUP DIALOGUE AND CRITICAL REFLECTION FOR HIV PREVENTION

An Evaluation of the C-Change Community Conversation Toolkit

December 2012



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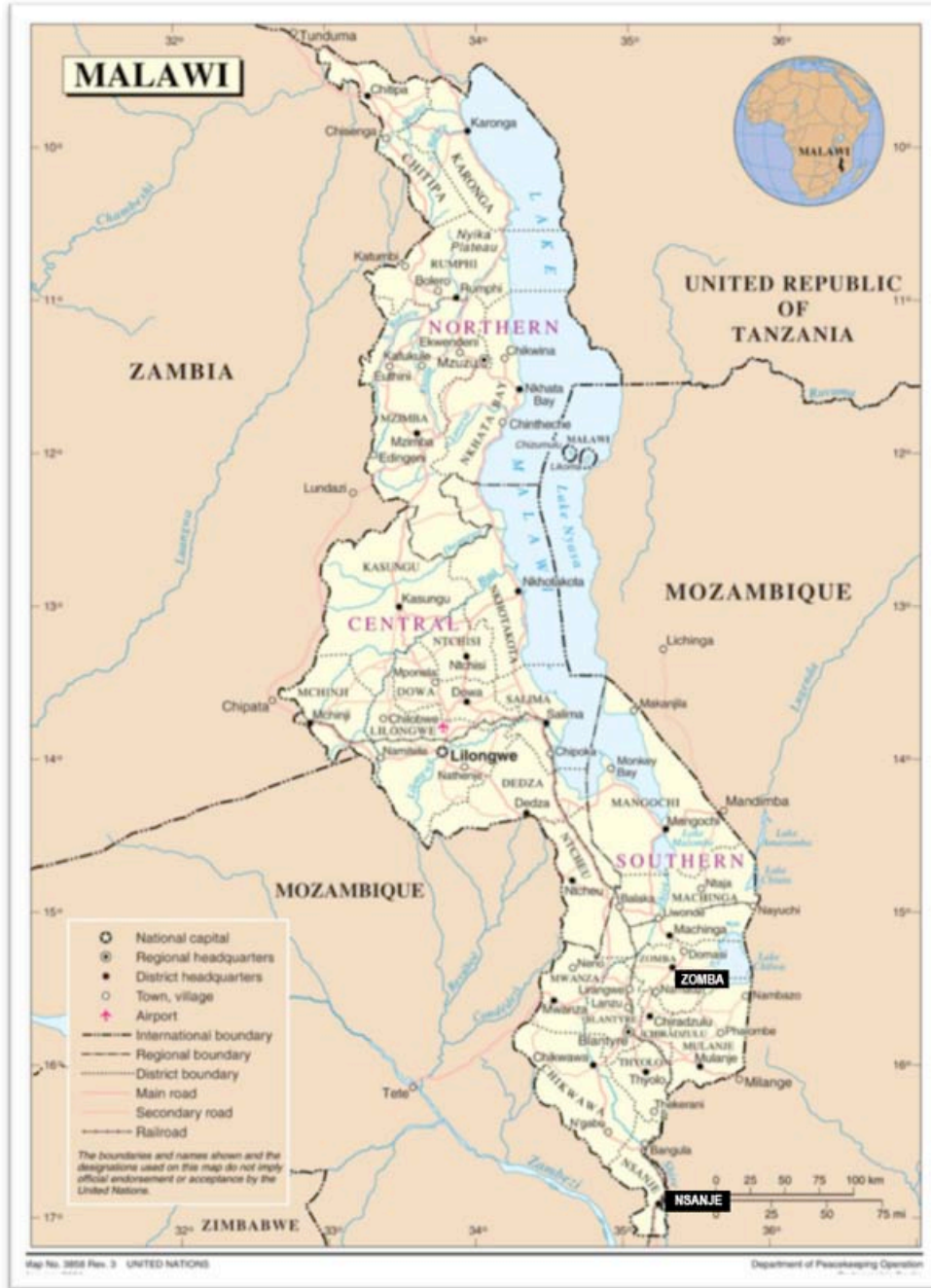
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Malawi Map and Partner Organizations

Zomba, Hope for Life; Nsanje, Friends of AIDS Support Trust (FAST)



Zambia Map and Partner Organizations

Livingstone, Contact Trust Youth Association (CTYA); Kasempa, Kuba Lusa



ACRONYMS

AIDS	Acquired Immunodeficiency Syndrome
CBO	community-based organization
C-Change	Communication for Change
CCT	Community Conversation Toolkit
CTYA	Contact Trust Youth Association
FAST	Friends of AIDS Support Trust
FGD	focus group discussion
HIV	human immunodeficiency virus
HFL	Hope for Life
IDI	in-depth interview
PLHIV	people living with HIV
SBCC	social and behavior change communication
SAT	Southern African AIDS Trust
USAID	U.S. Agency for International Development

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Executive Summary

Communication for Change (C-Change) set out to develop support tools that would foster interactive communication among low-literacy adults and prompt engagement on HIV prevention issues, including encouraging individual and group-oriented problem solving. The Community Conversation Toolkit (CCT) was developed using participatory approaches with lower literacy audiences and was extensively pre-tested in southern and eastern Africa. The CCT is a social and behavior change communication (SBCC) resource that comprises a set of interactive communication components including role play cards, throw cubes, playing cards, dialogue buttons, finger puppets, and guides for facilitation and community mobilization. The CCT has been adapted for use in seven countries and is available in ten languages.

The objectives of the CCT are to:

- Provide a resource for adult and lower literacy audiences to engage with issues related to HIV prevention through dialogue processes.
- Prompt open-ended problem-solving dialogues through interactive group sessions that contribute to internalization of HIV risk, and risk and vulnerability reduction, among participants.
- Strengthen linkages with HIV services and other programs.
- Prompt strategies and actions that engage with HIV prevention issues at the community level, including addressing risky practices as well as cultural, legal, and other factors that influence risk.

This evaluation of the CCT considered aspects of the development and implementation of the toolkit and assessed the implementation of the CCT in two areas in both Malawi and Zambia. The central questions of this evaluation were to determine: 1) whether CCT brought about changes in the behaviors, values, and practices of participants in relation to HIV prevention, and 2) whether processes of reflection and problem solving led to addressing HIV prevention-related change at the community level. The evaluation also sought to understand the relevance of the CCT as a resource for supporting participatory engagement with lower literacy adults for bringing about risk and vulnerability reduction in relation to HIV prevention in African settings. Evaluation methods included document review, interviews with the C-Change implementing team, and qualitative research in implementing areas in Malawi and Zambia.

Findings and Discussion

The CCT fostered changes in HIV-related risk and vulnerability at individual and community levels. The CCT's design included addressing 'AIDS fatigue' by offering a novel and interactive approach to exploring issues of HIV prevention. The CCT was perceived by participants as relevant to their immediate risks and vulnerabilities related to HIV, but was also acknowledged as having potential to contribute to change at peer, family, and broader community levels. CCT participants internalized new understandings of HIV-related risks and vulnerabilities through dialogue and engaged in a range of commitments and actions to address their own behaviors and practices, as well as influencing risk and vulnerability among others in their community. The CCT stimulated new social context-specific understandings in relation to HIV risk and vulnerability—for example, linking proverbs communicated through the CCT to engage with and critically reflect on HIV issues—while also addressing contextual vulnerabilities, such as contributing to

changes in cultural practices related to sexual cleansing, and strengthening legal processes in relation to rape.

While the CCT was initially developed to explicitly address lower literacy adult audiences, implementation of the CCT in Malawi and Zambia did not necessarily require that participants were of lower literacy, nor was there any process of measuring literacy skills of participants at the outset of sessions. Reflections on the experiences of lower literacy participants emerging from the evaluation data illustrate that the toolkit addresses the needs of lower literate audiences, but that it is also relevant to adults audiences in general. In relation to lower literacy, the toolkit components include short texts and graphic elements that do not require extensive literacy skills for interpretation. Participants also noted that the interactive and informal dialogue process emphasised mutual support, and this included literate participants assisting participants who were less literate when texts were not easily read or interpreted.

In relation to empowerment outcomes, it is clear that the CCT is a well-developed, comprehensively tested communication resource for addressing HIV that bolsters response at the community level. The considered, reiterative approach to the development cycle of the toolkit, including a strong emphasis on participation and perspectives of prospective audiences, has generated a set of tools that bring about dialogue, promote reflection, and foster problem solving among participants in CCT dialogue sessions. The sessions themselves employ sound principles of participation and adult learning that have harnessed existing knowledge and experience of participants to develop new insights into HIV, including how to address HIV vulnerability and risk at the level of oneself and others.

Observations and lessons emerging from the application of the CCT components include:

- The CCT evoked curiosity as a product of novelty, and this facilitated entrée into new ways of people engaging with HIV through dialogue. The CCT helped reach previously hard-to-reach groups, such as chiefs and community leaders.
- CCT components and related participatory activities such as games, role plays, and informal humor captivated the attention of participants and motivated continued participation.
- While some participants and groups were initially shy or reserved in their engagement on sensitive issues such as sexuality and sexual behavior, it was acknowledged that speaking directly and frankly was necessary to address the pressing health challenges of AIDS, and the CCT dialogues provided a forum for doing so.
- While some CCT components appear simple and childish—for example, finger puppets—they were appreciated and used meaningfully by adults.
- Open-ended proverbs and questions embedded in many of the tools prompted reflection on personal HIV risk. This allowed participants to engage with a wide repertoire of strategies and solutions that were relevant to their contexts.
- Participants were encouraged to engage with and make linkages with services – for example, through seeking HIV testing via VCT services; through accessing and distributing condoms; and through engaging with policing and other services.

- While CCT dialogues prompted critical thinking and a range of viewpoints, the goal of consensus within the participant groups allowed strategies and solutions to be refined through group reflection.
- CCT facilitators were well trained and able to conduct activities without participants being concerned about the age or gender of their facilitator.
- While the CCT was costly to produce in short print-runs necessitated by the research and development process, scaled-up production would reduce unit costs. Lead organizations also noted that logistical and other costs were minimal, making the approach more cost-efficient than other strategies for reaching into and engaging with communities.
- Some CCT components were used beyond the dialogue settings—for example, buttons and playing cards—and there is potential for such components to be used on a stand-alone basis, including as products that dialogue participants could be encouraged to use independently.

Studies exploring gaps in HIV prevention response in African contexts have highlighted perspectives of community members that persuasive communication and didactic peer education approaches are disempowering, and gaps in response have been noted to lack inclusion of community members in group formations that encourage engagement and reflection to address HIV prevention to the point of developing action strategies. The CCT is consistent with approaches to addressing HIV prevention that highlight the relevance of non-didactic non-prescriptive communication that fosters group engagement with a view to generating strategies for HIV prevention that are relevant to individual participants and also others in the community. Throughout its implementation in Zambia and Malawi, the CCT brought about processes of conscious reflection that were framed by ‘humanizing values.’ The approach reinforced ‘horizontal communication’ between people at the community level and empowered individual participants. Through such empowerment, participants were also able to confidently engage authority structures in their communities to the extent that harmful cultural practices were scrutinized and transformed—for example, through shifting practices of sexual cleansing. The legal rights of women were addressed and reinforced through engaging with police, and the responsibilities of liquor sellers were engaged through reinforcing local bylaws.

The CCT resources, training, and engagement with community groups complemented ongoing HIV and AIDS activities conducted by implementing partner organizations. Existing linkages to volunteers, affected subgroups, and community stakeholders and leaders strengthened opportunities for action. These linkages and existing networks helped dialogue groups make connections with community leaders and authorities. Implementing partner organizations were also able to connect groups with service providers, police officers, counselors, and traditional leaders to address issues the community identified.

While change and action emerged as a product of participation in the CCT dialogues, the extent and scale of change varied between participating groups. A strong moderating factor was the extent to which the dialogues were conducted, which was only four to five sessions, at which point further engagements could not be funded. While these repeat interactions were highlighted as being different from the more typical once-off engagements experienced previously, it was unclear how sustainability should be addressed, nor how change processes could be entrenched on an ongoing basis. There were, however, many groups and participants who were interested in extending the use of the CCT, as well as interest from organizations including government departments.

Recommendations

- The CCT is a well developed SBCC resource that fosters dialogue and critical reflection processes that contribute to the empowerment of HIV-vulnerable participants. As such, the CCT is suitable for replication in its current format.
- The CCT is a versatile resource that can be utilized with literate adults as well as adults with lower literacy skills. Potential use with youth audiences should be explored, noting that the content of the present toolkit would need to take into account age-appropriateness in relation to content regarding sexuality.
- The CCT complements existing HIV prevention activities and bolsters such activities by serving as a catalyst for spurring problem solving and action at individual, relationship, family, and community levels. It should thus be considered as a complementary resource to the work of organizations in facilitated or spontaneous situations.
- The CCT is available in a range of languages and includes context-relevant adaptations in the form of localized proverbs and questions. These are suitable for reproduction for use in a wide range of communities in the countries for which they were developed. Demand for such upscaling has already been voiced in study countries. (Costs are detailed in Annex 1.)
- The durability of the CCT was not assessed as part of this evaluation, and CCT components were only used a four to five times by the dialogue groups. Reproducing the CCT would require additional research to determine durability for more intensive use. (Durability options are detailed in Annex 1).
- While the broad curriculum and facilitation style attached to the CCT dialogues is appropriate and leads to action outcomes, it is unclear whether there is an optimal number of sessions or how participants could continue independently using the toolkits. Four sessions appear to be a suitable minimum. Strategies for expanding use within communities, and determining optimal intensity of use and 'saturation' per community, would need to be considered.

1. Background

Communication for Change (C-Change), implemented by FHI 360 and funded by the U.S. Agency for International Development (USAID), focuses on addressing the effectiveness and sustainability of social and behavior change communication (SBCC) across development sectors. A key focal area has been addressing the HIV epidemic in sub-Saharan Africa. SBCC employs theoretically grounded approaches to communication that incorporate interaction and research to bring about individual, community, and social change.

In the context of HIV prevention, SBCC moves beyond concepts of communication that are oriented toward linear-causal approaches to information transfer that seek to change individual risk behaviors. Instead, SBCC is oriented toward communication that enhances individual capacity to address risks and vulnerabilities to HIV including behavioral risks, while also focusing on contextualizing response within a broader social milieu. This process engages with a range of cross-cutting factors including information, motivation, ability to act, and social norms within a socio-ecological context that extends from individuals to the structural conditions that shape their lives. In relation to HIV prevention, these conditions include sexual relationships, family and peer relationships, and the broader community including people in authority and leadership. Even broader structural factors that shape HIV risk and vulnerability include access to services, economic conditions such as poverty, and political, religious, and other cultural, social, and economic systems are also considered.

HIV is recognized as a severe health-compromising epidemic that most severely impacts sub-Saharan Africa—particularly southern and eastern Africa (UNAIDS, 2011). It is well recognized that within this region, the HIV epidemic is heterogeneous between countries and within countries. Individual vulnerability to HIV infection, as well as individual risk behaviors and practices, vary between people, and approaches to addressing HIV prevention need to take into account variations between contexts of risk.

This evaluation addresses the development and implementation of a Community Conversation Toolkit (CCT) that was designed by C-Change to mobilize adult audiences, including adults with lower literacy skills, to take action in response to HIV. This process included seeking to deepen internalization of personal risk to HIV, addressing processes of living with HIV, and facilitating action in response to HIV among peers, family members, community leaders, and others in communities.

2. The Community Conversation Toolkit

Mass media communication—primarily broadcast media—has been utilized by national and regional HIV prevention campaigns to reach diverse audiences. These activities have been complemented by a range of communication approaches at the community level that are typically supported by print media such as leaflets, booklets, and posters, with pictorial and text-based materials such as flipcharts and diagrammatic materials also being used. Peer education activities as well as other formats of interaction, including drama, dance, poetry, and song, have also been applied. While such approaches reach diverse audiences, including those of low literacy, it has been found that there is a lack of emphasis on interactive tools for engaging with adult audiences in general on HIV prevention (Parker et al., 2007). The need to address literacy in relation to HIV prevention has also been recognized as a gap that has not been addressed by governments in countries impacted by HIV/AIDS (Medel-Añonuevo & Cheick, 2007).

Taking these factors into account, C-Change set out to develop support tools that would foster interactive communication among low-literacy adults and prompt engagement on HIV prevention issues including encouraging individual and group-oriented problem solving. The emerging CCT is an SBCC resource that comprises a set of interactive communication components. Development of the CCT was initiated in 2009, and the components within the toolkit had undergone through multiple rounds of testing and refinement, culminating in a final toolkit that was adapted in seven southern African countries during 2011 and 2012.

2.1 Development of the CCT

Developing audience-appropriate communication involves understanding audience needs, perspectives, and contexts in relation to communication products. While production of communication materials to address HIV prevention often devolves to approaches that integrate professionalized message development with pre-testing of emergent materials, it is recognized that such processes do not adequately address socio-cultural contexts and systems of making meaning of prospective audiences. With a view to enhancing understanding of the specific needs of low-literacy adult audiences in relation to HIV prevention and related communication, C-Change utilized the Action Media methodology to develop initial communication concepts (Parker, 2009).

Action Media follows participatory action research principles by bringing together health and communication professionals and audience representatives who jointly determine communication needs in relation to health, including developing concepts for communication materials and resources (Parker, 1997). The approach includes activities such as small group discussions, reflection and sharing sessions, role plays, and creative exercises that draw out culturally relevant meaning for addressing health challenges. Emerging ideas and concepts are then developed into draft communication materials which are then assessed with participants and other prospective audiences with a view to wider application.



Action Media participants engaging with a range of HIV communication materials.

To develop the CCT, C-Change conducted Action Media workshops with a group of 20 low-literacy participants in Elandsdoorn, an impoverished rural community in the Limpopo Province of South Africa. The workshops allowed for a deeper understanding of the challenges of low literacy in relation to HIV and AIDS communication, and provided substantial guidance on approaches to communication.

Recommendations from the workshops that guided the development of the CCT in relation to low-literacy adult audiences included:

- Ensuring textual information was kept brief.
- Complementing text with graphics and other visual elements to aid interpretation.
- Integrating local languages.
- Integrating local idioms and proverbs to link meaning to local cultural contexts.
- Integrating games, role plays, and other creative activities to support critical reflection and problem-solving dialogue.

While most workshop participants had some knowledge of HIV and AIDS, some had limited understanding of prevention practices and needed to assimilate and process information on HIV prevention discussed during the workshop. A further finding was that low-literacy participants had a good understanding of knowledge resources in their communities and were able to find answers to questions about HIV when prompted to do so.

Following the Action Media workshops, the C-Change team and graphic designers developed the emerging ideas into a range of draft products that were reviewed by participants in Limpopo, a province in South Africa, through a follow-up workshop. Materials included various formats of printed materials such as role-

play cards, a cube incorporating proverbs, finger puppets, and dialogue buttons. This assessment provided insight into further revisions and refinements and led to a regional prototype of the Community CCT that was assessed through evaluative research.

The CCT regional prototype was concept-tested and pre-tested by C-Change, the Southern African AIDS Trust (SAT),¹ and partner organizations during early 2010 and later in that year by the Soul City Institute for Health and Development Communication in Malawi, Namibia, Zambia, and Zimbabwe.² Soul City country partners in Malawi, Namibia, Zambia, and Zimbabwe oriented existing peer educators on how to use the materials to lead small group discussions to prepare for pretesting. Sessions were then observed, and facilitators and community members (separated by age and gender) participated in focus group discussions (FGDs) to explore their experiences. Through this process, C-Change was able to solicit in-depth feedback on the materials and gain insight into how intended audiences interacted and made meaning of the materials within their own context.

General findings included:

- Appreciation of the content and format of materials.
- Appreciation of short, catchy messages, bright colors, and accessibility of the materials.
- Requests for larger fonts on materials that used text.

In each country, FGD participants contributed locally relevant proverbs and idioms that could be included on the throw cubes and dialogue buttons. The findings as a whole contributed to the development of a final regional version of the CCT. Based on the concept testing, a facilitator's guide was developed to provide support to community health volunteers and peer educators who led small group sessions using the toolkit components. Adaptation of the toolkit included stakeholder consultations with government counterparts, donors, and partners for technical input and buy-in. The final version of the CCT included the components depicted in Illustrations 1–4.

¹ SAT is a regional funding and capacity development organization that provides assistance to 130 community-based organizations, national advocacy organizations, and networking agencies across six countries in Southern Africa.

² Pre-testing in each country was conducted in partnership with Soul City affiliates. These included: Pakachere Institute for Health and Development Communication in Malawi; Desert Soul Health and Development Communication in Namibia; Zambia Centre for Communication Programs in Zambia; and Action Institute for Environment Health and Development Communication in Zimbabwe.

Illustration 1 Role play cards and throw cubes with proverbs and questions

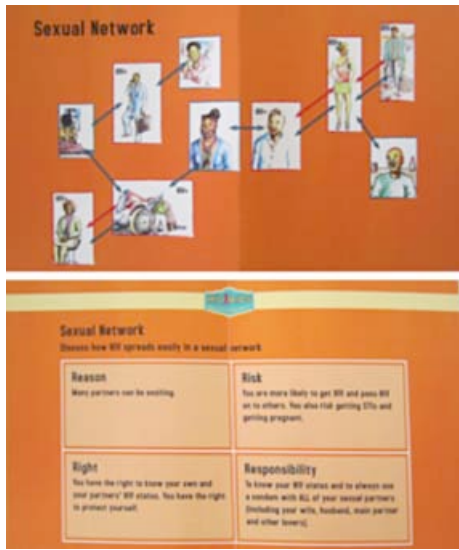


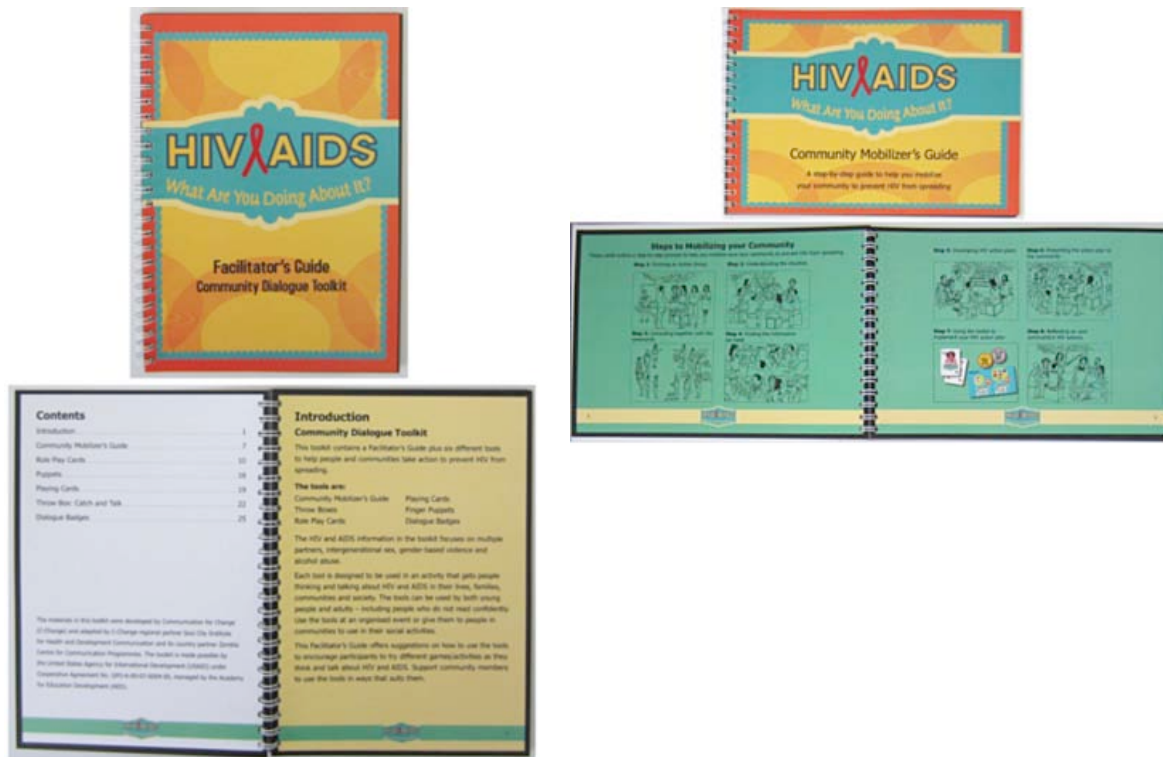
Illustration 2 Playing cards



Illustration 3 Dialogue buttons and finger puppets



Illustration 4 CCT facilitator's and mobilizer's guides



The final regional toolkits were adapted for use in seven countries and were made available in ten languages.³ Local partners in each country received training and went on to implement the CCT. Implementation countries and language adaptations are illustrated in Table 1.

Table 1: Toolkit implementation countries and languages

Country	Language
Lesotho	Sesotho
Malawi	Chichewa
Namibia	Oshiwambo, Silozi
Nigeria	English
South Africa	English, Sotho, Zulu
Swaziland	Siswati
Zambia	English, Kaonde
Zimbabwe	English, Ndebele

The objectives of the CCT are to:

- Provide a resource for adult and lower literacy audiences to engage with issues related to HIV prevention within their contexts through facilitated dialogue processes.
- Prompt open-ended problem-solving dialogues through interactive group sessions that contribute to internalization of HIV risk, and risk and vulnerability reduction, among participants.
- Strengthen linkages with HIV services and other programs.
- Prompt strategies and actions that engage with HIV prevention issues at the community level, including addressing risky practices as well as cultural, legal, and other factors that influence risk.

The implementation approach includes four phases and is outlined in Figure 1. Implementation of the CCT in two countries informed ongoing understanding of the implementation of the toolkit, including during evaluation in 2012.

Partnerships were established between C-Change and local community-based organizations (CBOs) during 2009 through C-Change’s relationship with SAT and its regional network. C-Change and SAT partnered to infuse SBCC capacity into their network through training and mentoring of partners in five countries. Collaboration with SAT and its partners for the implementation of the CCT provided an opportunity to build on existing relationships and apply learnings from the SBCC trainings. Partners in Malawi and Zambia were Hope for Life (HFL) in Zomba, Friends of AIDS Support Trust (FAST) in Nsanje, Contact Trust Youth Association (CTYA) in Livingstone, and Kuba Lasa in Kasempa.

A total of ten staff and 49 CCT facilitators were trained from the four CBO partners to facilitate the dialogues through participatory workshops in each country. The training approach adopted was the Visualization in Participatory Programs methodology (Salas et al., 2007). Sessions were conducted over five days and included introductions to the CCT components, recruitment of participants, participatory

³ <http://www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english>

techniques and practices, and monitoring and development of implementation plans. Participants also identified participant groups for implementation in each community.

Figure 1: CCT implementation phases

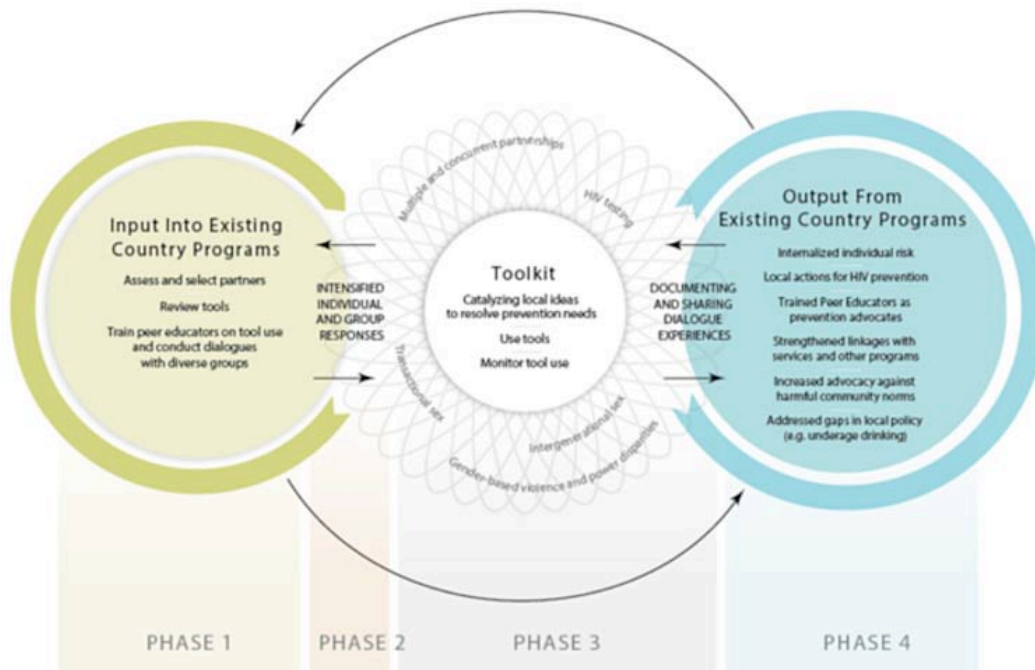


Table 2 outlines the participant groups that were selected in each country. Each group was relatively homogenous by age, most were engaged on a single sex basis, and a total of 23 groups took part in CCT dialogue sessions. The number of participants in each dialogue group ranged from eight to twelve.

Table 2: CCT implementation groups by country

Group Composition (<i>numbers indicate years of age</i>)	Country/Place
Community leaders	<ul style="list-style-type: none"> • Zomba, Malawi • Nsanje, Malawi • Livingstone, Zambia
Female small business operators, 20–30	<ul style="list-style-type: none"> • Kasempa, Zambia
Males, middle-class, 40+	<ul style="list-style-type: none"> • Kasempa, Zambia
Male people living with HIV (PLHIV), 30+; Female PLHIV, 30+	<ul style="list-style-type: none"> • Zomba, Malawi
Male PLHIV, 20–30; Female PLHIV, 20–30	<ul style="list-style-type: none"> • Zomba, Malawi
Female PLHIV, 20+	<ul style="list-style-type: none"> • Kasempa, Zambia
Muslim women (PLHIV)	<ul style="list-style-type: none"> • Zomba, Malawi
PLHIV, 20–35	<ul style="list-style-type: none"> • Livingstone, Zambia
HIV-discordant couples, 20–40	<ul style="list-style-type: none"> • Nsanje, Malawi
Couples who have tested for HIV, 20–50	<ul style="list-style-type: none"> • Nsanje, Malawi
Female Girl Child Empowerment Movement, 20–35	<ul style="list-style-type: none"> • Livingstone, Zambia
Male bicycle taxi operators, 3050 [Shapa Boys]	<ul style="list-style-type: none"> • Nsanje, Malawi
Former sexual cleansers, 20–50	<ul style="list-style-type: none"> • Nsanje, Malawi
Male and female church-goers, 30–50	<ul style="list-style-type: none"> • Kasempa, Zambia
Male and female church-goers, 20–30	<ul style="list-style-type: none"> • Kasempa, Zambia
Young adults out of school, 20–35	<ul style="list-style-type: none"> • Livingstone, Zambia • Kasempa, Zambia
Male and female students in higher education, 20–30	<ul style="list-style-type: none"> • Livingstone, Zambia

CCT facilitators conducted the dialogues in teams of two, with one serving as lead facilitator and the other as note-taker/monitor. The main role of the lead facilitator was to prompt dialogue among participants using the CCT components, and to foster reflection, problem solving, and action outcomes at the individual and group levels. The note-taker captured and documented discussions, including actions that participants proposed to undertake. These were highlighted in subsequent sessions. Each group met a minimum of four times, and more than 80 dialogues were conducted during the implementation phase between January and May 2012.

CCT Facilitators versus Peer Educators

In the context of HIV prevention, peer education involves sharing of information to vulnerable subgroups via peer educators who have similar demographic characteristics or HIV risk profiles. Rationale for using peers include assumed greater trust and comfort in discussing sensitive topics, having access to hard-to-reach audiences, and having potential to build solidarity and bring about collective action (Medley et al., 2009). While peer programs have been shown to produce change outcomes, sustained impacts are unclear (Kim & Free, 2008).

CCT facilitators represent a cadre of trained educators who have previous training as peer educators, or who were representative of at-risk subgroups (eg., students, ex-sexual cleansers) or who occupied elevated social positions (eg., clergy, traditional leaders, lecturers). The CCT facilitators were also tied to CBOs with established relationships within the communities in which they work. There are some variations between CCT facilitators and peer educators—notably, that facilitators do not necessarily have to be representative of the specific age or risk-profile of participants. Furthermore, while CCT facilitators share information, their specific orientation is to stimulate shared learning by avoiding didactic or formalistic teaching approaches. Rather, emphasis is placed on stimulating enquiry and empowering participants to build knowledge collectively through dialogue, with facilitators fostering consensus and assisting in drawing conclusions following discussion. CCT facilitators have specific skills regarding the application of the individual toolkit components utilizing participatory techniques, and are also oriented toward motivating participant groups to take action in relation to their own risk behaviors as well as becoming involved in

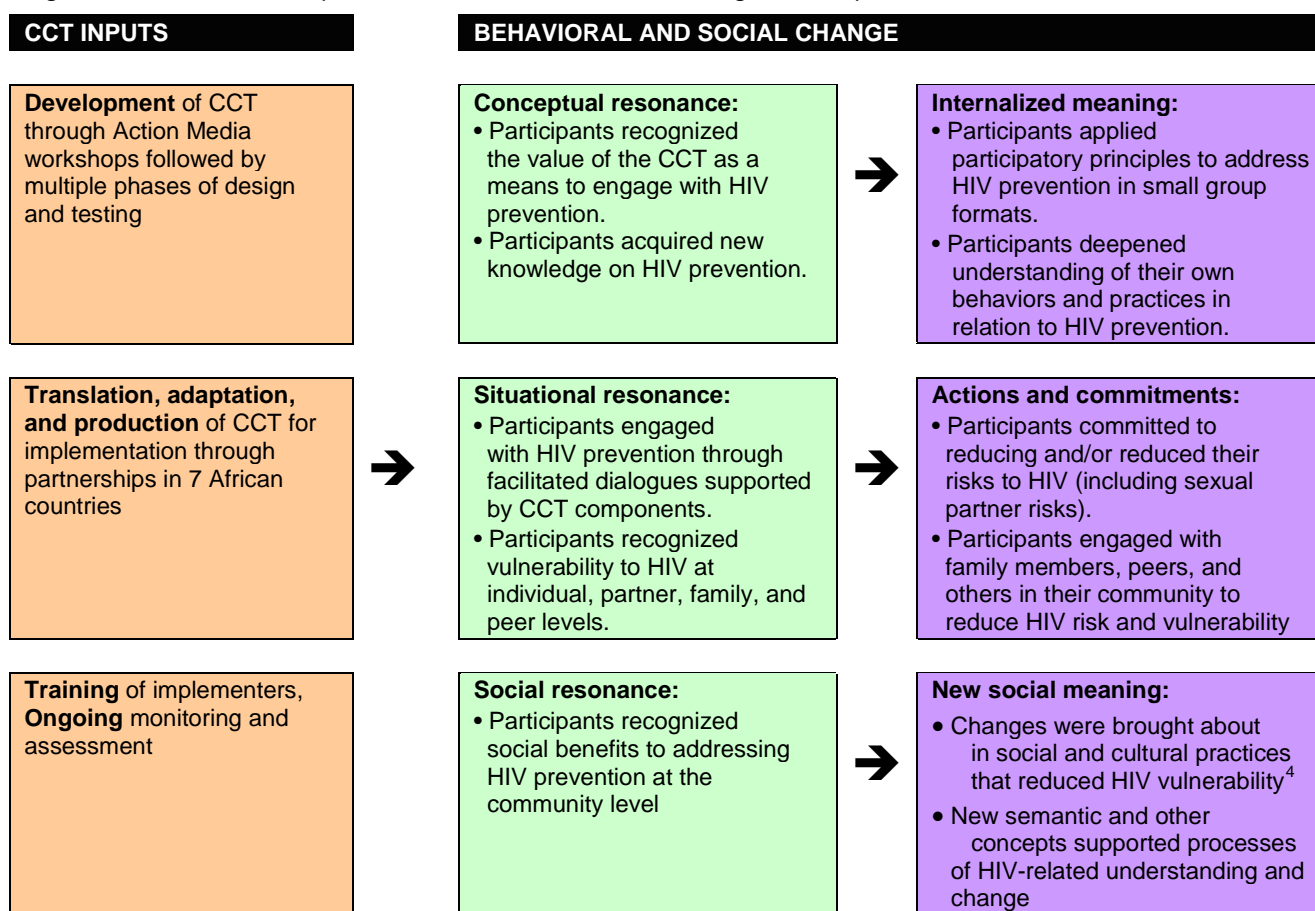
3. Framework and Methods of the Evaluation

This evaluation of the CCT considers aspects of the development and implementation of the toolkit and assesses the implementation of the CCT in two areas in Malawi and Zambia. The central questions of this evaluation are:

- Did the CCT implementation bring about changes in behaviors, values, and practices of participants?
- Did the processes of reflection and problem solving lead to actions to address HIV prevention-related change at the community level?

This evaluation also seeks to understand the relevance of the CCT as a resource for supporting participatory engagement with lower literacy adults for bringing about risk and vulnerability reduction in relation to HIV prevention in African settings.

Figure 2: Model of CCT inputs and behavioral and social change for HIV prevention



To determine whether the CCT has been effective, the evaluation draws on a model for behavioral and social change that identifies change processes (Figure 2). The model considers individual behavioral and

⁴ For example, participants recognizing the value of group action to respond to HIV.

social domains of change derived through the implementation of an SBCC intervention—i.e., the implementation of the CCT among subgroups of adults in various contexts—and draws on the concept of cultural scripts, which can be understood as reflecting “background norms, templates, guidelines or models for ways of thinking, acting, feeling, and speaking, in a particular cultural context” (Goddard & Wierzbicka, 2004). The model considers the relationship between the implementation of the CCT and internalization of key concepts related to HIV prevention by participants, including how these are translated into individual and social change. With a view to determining the outcomes and impacts of CCT implementation, the model incorporates the following elements:

- *Conceptual resonance*, which relates to participants understanding that the CCT was a resource that was relevant to introducing ideas on HIV prevention, and additionally, that participants acquired new knowledge on HIV prevention.
- *Situational resonance*, which relates to how participants applied their understanding of the CCT as a resource through dialogues related to their own context, and additionally, that these dialogues led to an understanding of their vulnerability in relation to themselves, their sexual partners, and others in their family and peer radius.
- *Social resonance*, which relates to participants recognizing the social benefits to addressing HIV prevention at the broader community level.
- *Internalized meaning*, which relates to conceptual resonance and includes the application of the CCT through participatory principles within a context of group dialogue, and additionally, deepening understanding of their own behaviors and practices in relation to HIV prevention.
- *Actions and commitments*, which relates to situational resonance and includes making commitments to change, reducing risk through adopting behavioral changes, and engaging with others including family members, peers, and others in the broader community.
- *New social meaning*: A key aspect of cultural scripts for social change is the integration of new ways of articulating and speaking about social issues that are semantic in nature. The findings illustrate how the CCT and its components introduced new ways of making meaning and symbolizing processes of addressing HIV and AIDS—for example, mobilizing proverbs to critically reflect on HIV issues, or encouraging dialogue through wearing of buttons to events or in the community. Additionally, participants spoke of the CCT as breaking through the barriers of ‘AIDS fatigue’ by evoking curiosity and engagement. With regard to broader changes at social level, change outcomes did not emerge from all groups. There were however examples of marked and profound changes that addressed HIV risk and vulnerability and risk at the community level—notably, changes in cultural practices relating to sexual cleansing, addressing alcohol abuse through legal frameworks, and strengthening legal processes related to rape.

Apart from a review of a range of documentation related to the pre-testing and implementation of the CCT and interviews with the C-Change implementing team, the main data source is interviews and focus group discussions with CCT implementers, stakeholders, and participants in two communities in each of two countries—Zomba and Nsanje in Malawi, and Livingstone and Kasempa in Zambia.

3.1 Instruments and Fieldwork

A preliminary field visit was conducted in Livingstone by the lead evaluator to inform the development of the data collection instruments and study design in both countries. Interviews and discussions were held with lead organizations, stakeholders, and participants in March 2012. C-Change lead implementers were interviewed in Washington, DC, during June 2012.

Interview and FGD guides were developed that addressed questions including understanding initial impressions and relevance of the CCT among lead organizations, CCT facilitators, and participants; the utility of the individual components of the toolkit to CCT facilitators and participants; the nature of the dialogues in relation to addressing HIV risk and vulnerability at individual, partner, and broader levels; perceptions of training processes for CCT facilitators; perceptions of the skill levels of CCT facilitators; conceptualization and conducting of actions; and further implementation and sustainability of the CCT.

Two local field researchers were contracted to conduct data collection in each country during July and August 2012. A total of 21 interviews and 16 FGD were conducted. Participants included:

- Senior staff of implementing organizations
- CCT facilitators
- Community stakeholders
- Dialogue participants drawn from three to five of the implementation groups in each community

Each interview and FGD was convened in a private area free from disruption and took between one and two hours. Participants were advised of the purpose of the study, their rights as participants including the right to withdraw, and the principles of confidentiality. An opportunity was provided to ask questions prior to consent being given. Discussions were conducted in the language of preference of participants. All interviews and FGDs were recorded using digital recorders. Data was translated into English where applicable, and transcribed into text files verbatim.

3.2 Ethical Considerations

The evaluative assessment draws on data gathered by C-Change through operational activities including monitoring data, program materials, and documentation. Further data was also collected through engaging with C-Change staff who have been involved in the CCT implementation over the November 2011 to May 2012 period.

The evaluation is guided by professional standards of evaluation as established globally and in Africa (UNEG, 2008; IEG-World Bank, 2007), including developing an understanding of the needs of participants in relation to the evaluation, protection of the evaluation participants from harm following standardized procedures, ensuring cultural competence of the evaluation teams, dissemination of evaluation findings to relevant stakeholders, and transparency in interpretation of findings. Participants received a detailed briefing on the study, including their rights to withdraw from the study, and consent was required prior to participation.

3.3 Strengths and Limitations of the Study

A strength of the evaluation study is that it sets out to understand the development of the CCT in relation to a theorized model for change. This theorized model focuses on the deeper aspects of ‘how’ the CCT brings about change, rather than addressing the micro aspects of implementation of the CCT in each setting.

While the purpose of theoretical models is to inform broad principles for implementation of approaches in a range of settings, the findings are not necessarily able to be generalized to all settings. Detailed review of implementation processes have instead formed part of the ongoing monitoring and reporting activities conducted by C-Change.

The evaluation took place after a five month implementation period. It would be useful to go back to these implementation sites after a longer period of time to explore how individual and group actions transpire over time. Furthermore, for practical reasons related to time and budget, only a few stakeholders were interviewed in each study community and this limits understanding of community viewpoints on the utility of the CCT. Similarly, not all dialogue groups were selected for inclusion in FGDs in the communities, and only a subset of participants were included in each of the FGDs. As a result, experiences and perspectives of some subgroups could not be documented for consideration in this study.

In addition, this study adopts a case study approach drawing on experiences of using the CCT in four communities in two countries. Strengths of a case study approach include allowing experiences to be documented and understood in particular contexts, allowing deep insights into complex issues of communication, and being relatively low cost.

4. Findings

Community perspectives of the CCT are reflected in a range of data including pretesting of the CCT components as well as interviews and FGDs with participants following implementation in Malawi and Zambia. This data is explored as a whole and then related to the model for behavioral and social change (Figure 2). Perspectives of implementing partners, stakeholders, CCT facilitators, and participants are then presented in relation to implementation processes.

4.1 Development of the CCT

The development and pretesting of the CCT placed a strong emphasis on participation of prospective adult audiences, including participants who are literate as well as those with lower literacy. This approach illustrated a commitment to the broad values of avoiding the top-down imposition of HIV/AIDS information, which is uninspiring to the point of ‘AIDS fatigue’ among audiences. This phenomenon can be attributed to the reiterative nature of simplified messages about AIDS that work against internalization of risk and toward denial, as Schefer et al. (2012) point out: “There is a need to seek creative ways to impart HIV prevention and safer sex messages that are not explicitly referent to HIV, but link rather with broader issues concerning relationships, lifestyle and identity.”

The CCT provides one interpretation of response toward countering such ‘AIDS fatigue’ by exploring questions related to how adults make sense of the AIDS epidemic within their own contexts. As a stakeholder in Zambia observed, during pretesting: “*These are very interesting materials. They present another dimension of looking at HIV/AIDS prevention. Different from the usual day-to-day interventions being used*” (Soul City pre-test, Zambia).

Throughout the pre-test dialogues, participants were often initially puzzled by some of the prototype CCT components, but then recognized their value when examples were provided of their practical use in stimulating discussion on HIV. As a pre-test study participant observed: “*When I first saw this cube, I thought maybe there are condoms in there. I did not know that they are proverbs meant for teaching us*” (Soul City pre-test, Malawi).

Such points of view were also reflected in the early development processes when ideas derived through Action Media were adapted through a creative process into prototype concepts and products, with a lack of clarity regarding what would emerge as workable products: “*...so there was constant testing and pre-testing*” (C-Change team member). It was also noted that there was initial cynicism about the products among some stakeholders in agencies involved in HIV prevention working in the region, who saw such materials as poorly conceptualised: “*A lot of the partners were really put off by some of the formats: the finger puppets, the buttons...*” (C-Change team member). Critics felt that materials were ‘*not prescriptive enough,*’ that it was unclear ‘*what kind of content they were getting across,*’ and that ‘*such materials are not appropriate for people in [x country]*’ (C-Change team member). Such views transitioned to appreciation of the CCT as the pre-test findings emerged, although it was noted that the buy-in process had to be carefully negotiated through dissemination of findings and introduction to the potentials and merits of the prototype products. Similar challenges were faced when the CCT was introduced to stakeholders in-country at the start of the formal rollout, although these concerns were also ameliorated as the CCT was implemented: “*I couldn’t believe that the community leader, an old person in the community, will prefer using a finger puppet, because at first they’ll say, these things are childish... But in the process they’re able*

to like it and say, ‘Ah, this is the right way of raising cultural types of issues’” (Manager, Lead organization, Malawi).

A further challenge highlighted during the prototyping and early production phases was the cost of short print and production runs, with each country version requiring specific adaptations—for example, variations in languages and country-relevant proverbs on the throw cubes. Higher quality and more durable options also ‘*changed the economies of scale.*’ As a C-Change team member noted: “*We’ve been still dealing with the issue that the toolkit is too expensive per toolkit.*” It was observed, however, that while the toolkit might be relatively expensive in comparison to other approaches, the kit obviated the need for supplementary costs that were typically seen as necessary:

Usually, in an AIDS campaign meeting, it’s like ‘business as usual.’ People procure T-shirts, a fleet of vehicles, transport to a venue... and there are so many types of entertainment activities. At the end of the day, the impact that is attained after that is that there’s no value for money in the process. But with the Community Conversation Toolkit, we have seen a significant type of value for many attached to it. Because at the end of the day, if you procure those toolkits, and some logistics, which are not so exorbitant anyway, you could find that the impact is better. Because communities will be able to tell you that we want to do it like this (Manager, Lead organization, Malawi).

Other key lessons in the development process were summarized by the C-Change team and included the relevance and value of:

- Using a formative and participatory research approach to develop concepts (Action Media).
- A thorough process of multiple iterations of pre-testing and adapting in various countries.
- Working with in-country organizations on pre-testing and adaptation.
- Conducting stakeholder consultations in each country, including at the national level.
- Developing partnerships with implementing organizations that included capacity strengthening.

A primary capacity strengthening input was the training of organizational leaders and CCT facilitators that involved participatory approaches embedded in the Visualization in Participatory Programs methodology: “*There was a community leader... He was like, ‘I’ve never been to a training like this where I’ve been so involved, it’s been so participatory.’ There were so many practice role play sessions...*” (C-Change team member).

As implementation of the CCT expanded, interest emerged from a range of different entities. The CCT was adapted for use in Swaziland by the First Lady; integrated into the work of the Ministry of Agriculture in Zambia; and adopted by the senior Chief in Kasempa who was keen to expand topics to include gender violence and rape, and distribute additional kits to local chiefs. A sense of ownership among pre-test teams and organizations also emerged, leading to the CCT being actively promoted by these organizations.

4.2 Perceptions of the CCT Among Users

Previous involvement in community-level activities among CCT participants in Malawi and Zambia was explored. Some participants had been part of savings clubs or church groups, while others had more direct

previous involvement in HIV and AIDS activities, including volunteering as home-based caregivers of people living with HIV (PLHIV), assisting with orphan care, being members of PLHIV support groups, supporting community-level condom distribution, membership in drama groups, and involvement in income generation activities.

Multiple challenges were mentioned when it came to communicating about HIV in Malawi and Zambia. These included limited skills among volunteers, lack of condoms, lack of bicycles for transport, lack of branded items such as T-shirts, and expectations that money or food would be provided for attending education sessions. Interest and attendance was also impacted by the need of community members to address more pressing issues, for example, having to tend crops.

Talking about HIV in family contexts was noted to be difficult, as discussions about sex between children and parents are considered taboo. Among couples, it was considered inappropriate for one partner to introduce options for addressing HIV such as HIV testing, as this was seen as disrespectful of the other partner. This was particularly difficult for women, even if they were dealing with the issue of testing for HIV in the context of pregnancy: *“Even on the voluntary counseling and testing part, you find that the women are the ones going for [these services] while they are pregnant. If they ask their husbands to test, they refuse. Women are on the forefront while their partners do not know their status”* (FGD, CCT facilitators, Kasempa). Similarly, discussing HIV and AIDS in the general community when one did not know a person well was also considered to be inappropriate, and people might think *‘that you are provoking them.’*

Most participants were selected for inclusion in CCT activities based on participation in previous community or health activities, particularly related to HIV. Many had links to the implementing organizations and were motivated to continue contributing to HIV prevention: *“I was interested because I wanted to get the information and teach my neighbors in my community. I wanted to share and help in the prevention of HIV”* (FGD, Young adults out of school, 20–35, Kasempa). Others were chosen as a product of representing a particular subgroup in the community—for example, community leaders. A subset of participants were recruited to participate in the dialogues by friends on the basis that they were known to be at risk for HIV, with their inclusion being motivated by a concern about their risky sexual behaviors.

The discussions with CCT participants illustrated a good general understanding of HIV including the interplay between underlying factors and sexual behaviors. For example: *“Some guys have girlfriends, and their girlfriends are materialistic and demand a lot of money from them. They do not care whether the boyfriend works. So the guy will get involved with a sugar mummy and get money in exchange for sex.”* (FGD, Young adults out of school, 20–35, Kasempa). Understanding such linkages deepened as the CCT process unfolded.

‘AIDS fatigue’ was mentioned as a factor that closed people off from discussion and that hampered HIV prevention efforts. Offering a new slant to raising HIV and AIDS issues in communities was acknowledged to be difficult: *“There are a lot of people and a lot of organizations in Livingstone talking about HIV/AIDS. The challenge for us now comes on how unique we can be. How can we engage those people so that we can have a better impact and together champion the cause?”* (Interview, CCT participants, Livingstone). The CCT transcended the over-reliance on linear formats of persuasive health communication that emphasized closed ended messages over discussion and reflection: *“[The toolkit] brings dialogue. It makes people start*

talking. People have been approached in different ways before, but this toolkit is different. It makes it easy to get people to talk... Communities have been spoon-fed information before and now these materials allow them to interact” (CCT facilitator, C-Change monitoring visit, Zomba).

Low literacy and lack of materials in local languages was highlighted as a barrier: *“You will find that there are people who are illiterate, especially those in rural areas. The only information that they might get will be in English, but how are they going to utilize the information and how are they going to put those things into practice?”* (Interview, CCT participant, Livingstone).

The CCT was seen as providing new ways of engaging with HIV that *‘provided the missing link’* and *‘bridged the gap’* between information delivery and community involvement. The CCT also evoked curiosity among participants: *“Some people thought [AIDS education] a bother and would undermine us by scorning us, saying ‘what can you tell me?’ and showing anger. They would say ‘matenda anabwerera anthu’ [this disease came for people]. But with the toolkit people are curious and give us a listening ear”* (FGD, Male and female PLHIV, 20–30, Zomba). Similarly, the toolkit increased the credibility of CCT participants as community activists for HIV prevention—for example, when encouraging participation in meetings:

We could put up posters inviting people to come for a meeting. When people come to our meetings and see the tool container, our credibility as counselors on HIV prevention goes up. They become attentive to the message and they trust us (FGD, Male bicycle taxi operators, 30–50, Nsanje).

Participants were quick to recognize that the participatory orientation of the CCT, in combination with fostering participant-led problem solving, contrasted sharply with previous experiences of more didactic peer education approaches:

From the previous activities that we have had before, you would find that someone just comes and says you should do this and not do this, reading and explaining to you. But with the kit it is everybody... especially with the cube as you throw it and playing games, you start learning. So that is one difference I observed. With [other approaches], it is more of teaching. But with the kit we all participate and are involved in finding answers” (FGD, Male and female church-goers, 30–50, Kasempa).

It was highlighted that the CCT supported new ways of expressing HIV risk and vulnerability, particularly with a visual dimension, as well as opportunities for greater clarity. For example, the proverbs drew attention to HIV prevention: *“We were captivated with proverbs being used for HIV prevention”* (FGD, Male and female PLHIV, Zomba). Illustrations of inter-generational sex and sexual networks provided clarity in understanding risks of HIV transmission: *“The picture of lovers in a network. It was clear to us that with two lovers you have entered into a network. It clearly shows the danger”* (FGD, Female PLHIV, Zomba).

Other perspectives on the CCT in comparison to previous experiences of HIV communication included:

- Reaching previously hard to reach audiences, such as traditional leaders and chiefs.
- Allowing for repeated contact with participants over time, rather than once-off meetings.

- Fostering dialogue by not providing answers, but instead promoting problem solving through reflection: *“The toolkit has helped in a way that the community is given the chance to sit down and come up with their own solutions to the problems they are facing. It has also increased community-based advocacy”* (FGD, CCT facilitators, Livingstone).
- Fostering dialogue beyond the participant groups—for example, inviting spouses to join a CCT session allowed participants to *“talk about topics that they fail to talk about at home... It just makes it easy for husband and wife to discuss certain things about HIV/AIDS”* (FGD, CCT facilitators, Kasempa).

The various interactive tools contributed overall to a stimulating environment during the sessions. The game-like orientation stimulated participants and encouraged interaction. The tools were said to have motivated learning and ongoing participation *“...because they were more like a game. It’s not just learning where you get bored”* (FGD, CCT facilitators, Kasempa). The tools also allowed entrée into discussion on sensitive topics and fostered an opportunity for *‘everyone to speak.’* In



CCT implementation team, Livingstone, Zambia.

addition, participants highlighted that the components that included proverbs and idioms facilitated later recall of issues of risk and reinforced commitment to prevention.

The importance of engaging with HIV and discussions about sex and sexuality in a forthright manner was highlighted by many participants, including those who were elders: *“When we go for sharing, we speak straight. We want people to speak straight. Otherwise why did you leave your home to come this far while you can’t talk straight?”* (FGD, Community leaders, Nsanje).

While implementation of the CCT considered low literacy among participants to be an important gap that the CCT could address, participants were not assessed in relation to their literacy skills. Participant groups also included younger and older adults. Given that the CCT was specifically designed and repeatedly tested to ensure that lower literacy participants would be able to engage with the toolkit components easily, problems related to lower literacy were few and far between. For example, as a community leader observed, pictures aided interpretation of text: *“The picture is captivating to people and even those who could not read were able to learn well”* (FGD, Community leaders, Zomba). For participants who could not read at all, a general practice was that a participant alongside would read for them: *“If he can’t read, his neighbor will read for him”* (FGD, Male and female PLHIV, 20–30, Zomba).

A general observation was that the CCT was relevant for adults and youth, irrespective of literacy:

I would say, it can also work even for those with higher literacy levels. Meaning, it was not just designed for that [lower literacy] group. I think it cross cuts because I think it has been evidenced that you can use it even for adults but also youths” (Interview, Lead organization, Zambia).

4.2.1 Throw Cubes

Most groups of participants highlighted the throw cubes as the most useful tool in the CCT. Cubes included versions with local proverbs and also questions related to HIV vulnerability and risk. It was observed that the cubes allowed a range of topics to be discussed and prompted participatory dialogue as various perspectives on a given proverb or idiom prompted inputs from multiple participants: *“I liked the cube because it made every one participate. There was no dull moment”* (CCT facilitators, Livingstone).

The proverbs and idioms were localized, and participants were generally comfortable with using the concepts as a starting point for discussion: *“[The cubes] resonate well with our culture because proverbs are an important part of traditional discourse in our society”* (FGD, CCT facilitators, Zomba). In some instances, meanings of the proverbs were unclear in relation to HIV prevention, although the discussion process allowed meaning to emerge through dialogue: *“‘Mapanga awiri abvumbwitsa’ [Two holes makes a rat wet]—We could not tell the meaning. We thought it means if you go there in the rain you will be wet. But now we understand the meaning that it is better to stick to one partner”* (FGD, Male and female PLHIV, 20-30, Zomba). The proverbs were also said to be easy to recall, and were said to stick in the minds of participants, allowing the related HIV prevention and other concepts to be recalled afterwards.

The cubes also allowed for a light-hearted and relaxed atmosphere, and the humor embedded in the discussion prompted later sharing with others beyond the participant group: *“They were good because they helped us laugh. Some of the questions were really funny and broke the ice in the group. And when you go home you would share and remember what you said and laugh about it”* (FGD, Young adults out of school, 20–35, Kasempa).

The value of the throw cubes for stimulating dialogue and reflection was also highlighted by participants in the pre-test studies. For example: *“It makes you think deeper and reflect on your own behavior. It will encourage people to change”* (Male participant, C-Change concept test, Zambia). It was also said that the cubes revealed the ‘truth,’ that they led one to look at HIV from ‘a different dimension,’ and that they prompted engagement: *“This cube is in your hand so you cannot ignore it like you could with radio or TV”* (Female participant, C-Change concept test, Namibia).

4.2.2 Finger Puppets

While there were some suggestions that the finger puppets appeared ‘too childish’ for use among adults, they were nonetheless used and appreciated by various CCT participant groups—for example, local leaders in Nsanje referred to the finger puppets as ‘being very famous here’ as a product of their use value, and it was noted that the puppets were useful for participants to show how certain characters reflected on AIDS issues. The finger puppets were also well liked by the Shapa Boys in Nsanje, community leaders in

Livingstone, and young adults out of school in Kasempa. Interaction with the puppets allowed for unscripted dramas to emerge spontaneously, and these were said to be “*easy and fun and interactive for that group*” (FGD, CCT facilitators, Kasempa).

Participants in the pre-test phases noted that the puppets added an emotional dimension to illustrating the effects of HIV: “*I like them because they display different emotions of people infected and affected*” (Peer educator, C-Change concept test, Zambia). Identification was also fostered as “*People will put themselves in the puppet story*” (Female participant, C-Change concept test, Namibia). The use of the puppets was also said to ‘*open one’s mind.*’

4.2.3 Dialogue Buttons

The dialogue buttons were used both during sessions and also beyond sessions, with outside use including wearing buttons to work, at home, or during other social activities in the community.

Wearing a button prompted inquiry from others and led to a discussion about HIV and AIDS: “*I think it is a good way of teaching people who did not attend this workshop. I remember the day I went to work and all my friends were inquisitive about them and I was able to explain to them, even at home*” (FGD, Male and female church-goers, 30–50, Kasempa).



Discussion prompted by a dialogue button...

Participants in Livingstone used the buttons during a Women’s Day march and prompted discussion with bystanders. As implementers observed: “*[The buttons were] able to popularize the different things that the toolkit is trying to promote. And we ended up getting a lot of people trying to invite us to go and hold dialogues with their different groups, with just the use of the dialogue button*” (Interview, Implementing partner, Livingstone).

Some used the buttons in a direct manner, to prompt discussion with friends whom they knew were at risk for HIV. For example: “*One was written, ‘Sugar daddies are not sweet.’ I liked it because when I put on that button and meet a friend who is involved with sugar daddies, the button would speak on my behalf*” (FGD, Young adults out of school, 20–35, Kasempa).

Participants in the pre-test studies felt that the buttons were useful to ‘*describe our reality,*’ that one could contribute to ‘*mainstreaming*’ HIV in other programs by wearing such buttons, and that the buttons acted as a reminder for HIV prevention, as if one was being observed by an elder relative: “*These buttons are acting as aunties in our communities*” (Male participant, C-Change concept test, Zimbabwe).

4.2.4 Playing Cards

The playing cards encouraged dialogue as a product of the messages prompting discussion, and also teasing out topics for discussion among groups where secrecy around sexual topics was the norm. For example: *“The playing cards have helped us a lot. Muslims used to hide. Other churches are free. But we try to help them”* (FGD, Muslim women, PLHIV, Zomba). The cards were also said to be ‘age friendly’ and ‘user friendly’ and could be used by any age group.

While acknowledging the benefits of the cards, CCT facilitators also noted that the wide range of topics on the cards made for confusing discussion, as many issues were touched on, and it was difficult to document emerging issues: *“It was very difficult for us to summarize all the topics discussed and come up with an action plan. It looks like you have brought a confusion of topics”* (FGD, CCT facilitators, Zomba). This view was however contrasted by the Shapa Boys, who noted that *“The playing cards have many issues so we love them for that”* (FGD, Male bicycle taxi operators, 30–50, Nsanje).

It was felt that the cards could be used on a stand-alone basis, and should not be limited for discussion in CCT group sessions. As participants in Zambia noted: *“If I have access to them at home, I can call maybe my friends to come, and we can discuss HIV while using them... We can discuss what each card means”* (FGD, Girl Child Empowerment Movement, 20–35, Livingstone).

Pre-test study participants noted that while the cards could be used to play games, *“At some point, they will stop playing, read the messages and start debating”* (Male participant, C-Change concept test, Zambia). The cards were also seen as applicable in a wide range of social settings including in families and at schools, where they could be used to prompt discussion on difficult topics and ‘secret issues.’ One participant felt that the cards might, however, lead to conflict: *“I do not like them, but I do like the messages on them. I do not like to play with things that cause arguments. Some of us have short tempers, and we end up fighting.”* (Male participant, Soul City pre-test, Namibia).

4.2.5 Role Play Cards

The role play cards were appreciated for their illustrative value, for example, depicting sexual networks. As participants who were leaders noted: *“When we show pictures and explain, people understand better. Without pictures, people don’t understand”* (FGD, Community leaders, Zomba). It was also said that the cards helped participants to ‘organize facts’ appropriately, and that they were also useful for prompting and supporting role plays.

During the pre-test studies, the potential for use of such cards in other settings was raised: *“When I went for testing and was counseled, I was so bored. It would make the counseling interesting for the counselor and client if aided by these cards”* (Female participant, C-Change concept test, Namibia).

4.3 Mobilizing Action

Mobilizing individual and community-level action through participation in CCT dialogues was the broad outcome envisaged by C-Change. In dialogue sessions, action was supported by the community mobilizer guide, which included steps to action. Pre-test participants were impressed by the guides, for example, noting that *“I think you can’t go wrong, because all the information is given to form a group. You can just*

go there and do it” (Female participant, C-Change concept test, Zambia), and “*Sometimes you can have ideas, but you do not know how to put them together, but these [illustrations] unlock your mind*” (Male participant, C-Change concept test, Zambia).

There were a wide range of general outcomes involving outreach to others by CCT participants in Malawi and Zambia as a product of the dialogues. These outcomes included visiting schools, speaking to chiefs and religious leaders, speaking to families, and engaging with PLHIV. Dialogue activities were typically supported by condom distribution and voluntary counseling and testing referrals.

Local leader participants in Zomba noted that there were numerous examples of people who they had engaged going for HIV testing, disclosing their HIV status to their children, or ceasing drinking. The group also promoted strategies for vulnerability reduction—for example, following the sexual abuse of a young girl by an older man, school children were advised to walk in groups and not alone.

Participants who were teachers appreciated the opportunity to highlight issues of risk—for example, a discussion on ‘*sugar daddies*’ and ‘*sugar mommies*’ in Zomba was linked to the risks of relationships between teachers and pupils: “[*Teachers were*] *complaining that that school boys are proposing love to madam teachers. Even school girls provoke sex deliberately to their male teachers, dressing and acting in a seducing manner*” (FGD, Male PLHIV, 20-30, Zomba).

Engaging others in the community and prompting action, however, was not always seamless. For example, an HIV-positive male participant in Zomba recounted how he had encouraged another male to disclose his positive HIV status, but the man’s wife disapproved as she feared the risk of ensuing stigma.

Sharing lessons learned in dialogues with one’s partner and family also needed to be sensitively addressed, for example, disclosing one’s potential risk to HIV through previous partners, including gendered dimensions that could lead to relationship break-up: “*If you open to reveal your past love life, he will lose interest in you. But if the husband confesses such things, the woman understands and marriage life goes on*” (FGD, Female PLHIV, 20-30, Zomba).

4.3.1 Group versus Individual Action

There were varied perspectives on the benefits of group versus individual actions, as related to participants expanding upon their CCT experiences and communicating with others about HIV risk and vulnerability. For example, people might be dismissive if one was alone, but going in too large a group might also be intimidating. Taking action in smaller groups of two to three participants was thus favored. Having one-on-one meetings was, however, noted to be relevant if one wanted another person to ‘*confide in you.*’ As such, the approach used was determined by the context and intended outcome.

Privacy was also an important consideration—for example, while a discussion might be initiated at a marketplace, the sensitivity of issues discussed might require an alternate venue: “*I met a certain lady at the market. I opened up to her. But because the market was so public, the lady asked me to meet her at a private place. When I met her she explained that she and her husband are both HIV positive...*” (FGD, Female PLHIV, 20-30, Zomba).

Group actions also faced challenges of ‘AIDS fatigue.’ For example, a community ‘*HIV talk*’ in Zomba was abandoned because invitees ‘*scorned*’ the CCT participants who had organized the discussion.

However, this did not discourage the group, who used the CCT as a means to stimulate interest: “*We followed them into their homes and they understood us. With the toolkit it made them inquisitive to learn*” (FGD, Female PLHIV, 20-30, Zomba).

A group of Muslim women noted that their sheikh encouraged ‘*speaking straight*’ (referring to speaking frankly about sex and sexuality) to ensure people understood each other. However, the group also acknowledged that such openness only applied to speaking to other women, as such talk was forbidden with men. It was also noted that this group of women had successfully raised the issue of intergenerational sex, and were encouraged by the local chief to form groups to take action, which they had done.

4.3.2 Transforming Cultural Practices

Participants observed that cultural norms and practices were not easily challenged, even if they involved HIV risk. For example, when it came to questioning cultural practices, youthfulness and lack of understanding were voiced as counter-arguments:

When you go to them [elders] and talk about these issues, sometimes they would say ‘You! Go away! You are still a young man. You should not play around with tradition. Tradition has been there for so many years and you guys in the fight against... HIV/AIDS want to do away with the tradition. You don’t know the advantages, the merits that we have in this tradition’ (FGD, Male, Young adults out of school, 20-35, Livingstone).

However, it was also found that the CCT dialogues strengthened capacity to address cultural practices in relation to HIV risk, including engaging with elders.

For example, local leaders and other groups participating in CCT dialogues in Nsanje led innovative transformative changes in the practice of sexual cleansing of widows and widowers. The latter practice is rooted in a traditional belief that a widow becomes unclean through the burial ceremonies of their spouse and thus has to be ‘cleansed’ through sexual intercourse with a person appointed by community elders (see Maleche & Day, 2011). In Nsanje, cleansing is carried out by a small group of sexual cleansers. Condom use during cleansing is not allowed, and risks of HIV transmission are high. FAST had already been conducting some activities in this focal area through working with ex-sexual cleansers and community leaders to engage with HIV risks associated with the practice.

Addressing the issue was bolstered by the CCT dialogues and resulted in an alternative practice being identified and promoted. This alternative practice, which involved allowing a couple related to the widow to have sex on behalf of that person, instead of requiring that this be done by a sexual cleanser was endorsed by the local chiefs:

That will have fulfilled the ‘kulowa kufa’ [sexual cleansing] custom. The chiefs now [impose] a [monetary] fine on those who follow the old traditions in this area... Women are now able to refuse, even if they tell her that we want you ‘kuti utchene’ [become more beautiful]. The woman refuses citing HIV (FGD, Local leaders, Nsanje).

As a local leader in Nsanje highlighted, change is necessary when the broader interests of the community are at stake: “If we don’t participate then our community will remain backwards. We will be in problems. This is why we accept, to reduce the problems facing this community” (Interview, Community leader, Nsanje).

One of the Shapa Boys explained how he had contributed to questioning this custom:

My relative passed away leaving a wife. As is the custom here, there was supposed to be sexual cleansing to rid the village of the evil that death had brought. The chief and other people from the wife’s side came and discussed that they should find a man. I was part of the discussion. With the messages we shared on HIV prevention [in the CCT dialogues], this was a contradiction. They asked me if I had any comments. I told them: ‘Do you know what killed my relative? Maybe this lady has also been infected? Do you know the man who you will hire, if he is HIV positive or not? If he is HIV positive, he will infect this woman. Or this woman might infect that man... They got convinced and therefore agreed to find another couple who could have sex [as a proxy] to cleanse the village in place of my relative (FGD, Male bicycle taxi operators, 30–50, Nsanje).

4.3.3 Prompting Change among Others

Many participants related stories of how they had been prompted to help friends transform their personal risk behaviors, as well as prompting HIV testing. For example, in Nsanje, a former sexual cleanser explained how her friend was now healthier following ongoing dialogue:

I went to a certain woman who is my friend. She was sick. I used to tell her that we should go for an HIV test. She would refuse. I kept on until she accepted. She tested and is positive and is now on [antiretrovirals] and well. I feel good when I see her and know that I have helped somebody (FGD, Former sexual cleansers, 20–50, Nsanje).

Among CCT participants who were leaders in Nsanje, it was reported that the dialogues had encouraged engaging with others who were known to be placing their sexual partners at risk:

In our area we are seeing changes in people who have participated in the dialogue sessions. For example, there is a certain man there who used to not sleep at home, moving from one community to another, following ladies. He could come from one community, passing his house and wife, and going to the other. He was rarely at home. However, when we reached him with the message, he changed, and he is now sharing HIV prevention messages with others. Now he is always at home. He has completely stopped that behavior (Interview, Local leader, Nsanje).

Another example given was of a local chief who was known to be promiscuous, who became engaged in a discussion on risk by the CCT participants who were leaders and encouraged to change his ways, leading to a transformative outcome: “We sat down with him and even pulled him into our group and now he’s changing. His wife is testifying that he is changing. He was very problematic when it comes to promiscuity” (Interview, Local leader, Nsanje).

4.3.4 Transforming HIV Risk and Vulnerability

The Shapa Boys engaged actively with a particular and common risk they faced through providing transport services—offers of sex by female passengers instead of cash payments:

You see, there are many women here who get on our bikes to be carried somewhere, yet they have no money or they don't want to spend money on transport. What they say is that I don't have money, but we can just have sex as payment. So I would accept that (FGD, Male bicycle taxi operators, 30–50, Nsanje).

However, participation in the dialogues led to internalization of risk, as the same participant illustrated: *“Now with the coming of the toolkit and realizing how many women I have slept with, fear has come upon me”* (FGD, Male bicycle taxi operators, 30–50, Nsanje).

These perceptions complemented previous engagement with the Shapa Boys conducted by FAST, with the CCT allowing for reiteration of internalization of HIV risk and further exploration of risk and vulnerability reduction. Through the dialogues, various strategies were adopted by Shapa Boy CCT participants. These strategies included going for HIV testing, going for HIV testing with one's wife, reiterating one's commitment to monogamy, and steadfastly refusing to accept sex in exchange for transport services.

When women refused to pay for transport services, assistance in resolution was sought from the chief or the police: *“In those days, when women say I don't have money, we used to have sex. But not now. I would go to the chairman to sort our case. If not, the police would help”* (FGD, Male bicycle taxi operators, 30–50, Nsanje).

Among some CCT participant groups, condom use was treated dismissively at first, but such views shifted through the deeper engagement allowed by the dialogues:

I now know the consequences of my decisions. For instance, I know that if I have sex with a condom I'm protecting myself and if not then I'm killing myself. It has also made the burden light for me, because I can easily teach my children about condoms and HIV, even my other family members. It is easy for me to give a family member a condom because I am protecting my household (FGD, Male PLHIV, 20–35, Livingstone).

Another participant highlighted how he had engaged with his son, to avoid alcohol and reduce his HIV risk: *“My son has stopped drinking. I told him the facts about HIV, that if he gets it he will die and he will not come back, so he stopped drinking alcohol”* (FGD, Male PLHIV, 20–35, Livingstone). The same group had plans to distribute condoms by using drumming and drama at the local market to attract people, and then to speak about HIV and distribute condoms.

Vulnerability of Shapa Boys and Their Clients

“A few days ago, I was in town doing my [transport] business...As I was going home a woman called me, addressing me as the chairman and thinking she knows me, so I stopped. She said I am going to Mbenje. I said K200. She said I don't have money. I just looked at her and asked her if it is true, that she had nothing, and what was in the bag she was carrying? She said only clothes, and if I am disturbing your business, then I will walk on foot. So I told her: 'You tell me how much you can afford,' thinking I have children and any little would help me care for them. I picked her up. On the way I said: 'Have you thought on how much you are going to pay me?' She replied saying '*Ine sibungwene pan,*' meaning that 'The only thing I have of value is a private part for sex'” (FGD, Male bicycle taxi operators, 30–50, Nsanje).

Some of the married women who were part of the CCT dialogues developed a strategy of placing condoms in the bags of their husbands when the men went away on business trips. While it was said that when the men discovered this, they were ‘*shocked,*’ the act prompted dialogue between husband and wife.

A young woman who was part of the out-of-school CCT participants in Kasempa related how she had learned to assert her desire to use condoms: *“I always thought the power was in the man’s hands, but now I am able to demand for condom use before sex... Before I would wait for the man to initiate and if he didn’t, I would just have sex. I even carry condoms with me now”* (FGD, Female, Young adults out of school, 20–35, Kasempa). Other participants spoke about choosing to be abstinent, engaging in dialogues with their partners to confront HIV risk, or ending their patterns of having multiple or concurrent sexual partners. There was a strong emphasis on advising siblings and friends to use condoms. In Livingstone, the young adults out of school focused on the risks of alcohol abuse, with dialogues in the community focusing on regulating times that bars could be open.

In Kasempa, CCT participants recognized that rape was common in the area, but reporting of cases to the police was avoided. Some CCT dialogue participants said that they had themselves been raped in the past by teachers and relatives, observing that rape went unreported as a result of fear of stigma, shame, or lack of support from their families. In some instances, rape cases were adjudicated by a local pastor who arranged for a settlement such as providing groceries or livestock to the family of the victim.

Actions prompted by the CCT dialogues included engaging with the police, sensitizing officers at the police station, and obtaining commitment by police to follow up with rape cases. As a result, it was noted that police were being proactive: *“We hear now that the police took action and followed up on those girls. So this type of toolkit, which to me is unique, is a very good supplement in terms of prevention. It has worked very well”* (Interview, Lead organization, Kasempa).

Monitoring visits by C-Change staff also highlighted other actions—for example, CCT participants discussed how local by-laws prohibiting the sale of alcohol at beer halls before 4 p.m. were being flouted, with alcohol being served as early as 9 a.m. Participants took action by speaking to community leaders who enforced opening times and also addressed the issue of underage drinking. Another example was a pledge to avoiding ‘*bad behavior*’ by female CCT participants in Kasempa who were engaged in small business activities. Through discussion the group had identified that trips out of town to obtain supplies often included risky sexual encounters and unprotected sex.

A participant in Zomba related how she had seen her friend who mistrusted antiretroviral treatment die of AIDS, and that this was a strong motivation for the participant to continue activities that had been prompted by her friend’s involvement in HIV-related volunteering: *“To see a friend die when I know a way out, I feel very bad. This is what makes us continue volunteering”* (FGD, Female PLHIV, 20–30, Zomba). Seeing people improve their lives after having received such services also reinforced commitment to ongoing voluntary involvement. Participants also highlighted that for their voluntary work in HIV to be effective, it was necessary to behave in an exemplary fashion oneself.

Working in groups was seen as more effective for reaching larger sections of the community, with one participant observing: *“One finger cannot pick lice. We would all work better as a team and put all the knowledge we have together”* (FGD, Male PLHIV, 20–35, Livingstone). The value of the problem-solving approach was also noted to be that pathways to action were contextualized and sustainable. As a lead

organization representative noted: *“Solutions that are generated by participants are more or less sustainable. They will stick to working toward meeting the actions that they generated themselves”* (Interview, Lead organization, Zomba).

It was noted that through having improved knowledge about HIV, previous fear and shyness in speaking to others about the virus was replaced with confidence: *“When we learned about the dialogue, I understood and I felt good, so I also told my friends about what we learned”* (FGD, Male, Young adults out of school, 20–35, Livingstone).

The dialogues improved confidence and assertiveness, for example, in being able to refuse unwanted overtures for sex: *“It has helped me in how to talk to someone when they ask for sex. I am very much able to say ‘No!’”* (FGD, Girl Child Empowerment Movement, 20–35, Livingstone).

4.4 Impressions of the CCT Facilitators

CCT facilitators were said to have fostered open discussion about sexuality and invited participants to speak freely: *“The peer educators were very open and so we also opened up. Some secret or private words were being spoken so everybody was open”* (FGD, Female PLHIV, 20-30, Zomba).

They were also seen as respectful and humble by participants, as a product of their non-authoritative, non-judgmental approach to discussions that was inclusive of all participants:

“No one could fear and be uncomfortable to talk” (FGD, HIV-positive women, 30+, Zomba). It was also said that chiefs and authority figures were engaged with due respect, but at the same time retained the informal orientation of the tools:

“Like on throwing a cube to a chief, they would say, ‘sorry, our chief, we will be throwing a ball today.’ That way the chief would take it and read, and then start chairing the discussions until everybody speaks something.

This was like a game” (FGD, Community leaders, Zomba).



A dialogue session in progress in Livingstone.

The participatory approach was acknowledged to be non-didactic and led to new knowledge. As one participant observed: *“Everybody was participating. It was not teaching”* (FGD, Muslim women, PLHIV, Zomba). This was contrasted with previous experiences where peer educators used flip-charts and ‘lectured’ without any discussion. Other values mentioned included allowing for consensus, treating discussions confidentially, and offering personal testimonies.

Participants were of the view that it was not necessary to match the gender of CCT facilitators to that of the group. For example, a group of men in Livingstone indicated that they were *‘happy to see that a lady was open to us,’* and that they were able to speak freely after adjusting to the arrangement: *“At first we were uncomfortable with saying everything to a lady, but because we were told to be free, it made us happy”* (FGD, Male PLHIV, 20–35, Livingstone). Age differences between participants and CCT facilitators were also not seen as a barrier. As a group of women in Kasempa observed: *“Though they looked younger, we never concentrated on that but paid attention to what was being taught”* (FGD, Female small business operators, 20–30, Kasempa). Similarly, a community leader highlighted the value of new knowledge: *“When a younger one comes to teach you, you receive the information because sometimes you don’t have the knowledge that the younger one has, so why should I feel shy?”* (FGD, Community leaders, Livingstone).

4.5 Logistical Issues

It was noted by CCT facilitators that recruitment of participants posed logistical problems. In some instances there were too many interested participants and it was difficult to select appropriately. This challenge was addressed by asking representatives of the subgroup to choose participants themselves. Accessing transport and providing refreshments were general problems for facilitators, especially when expectations had previously been raised—for example, when monies for transport and refreshments were delayed. Transport to meetings was also a problem for participants. Devaluation of the kwacha affected planning and costing, and thus undermined the capacity of implementing organizations to meet expectations.

A common initial focus of discussion was the value of condoms and the need for consistent condom use. While condom provision was included as part of some workshop activities, supplies were not always sufficient. HIV-positive couples were also unclear as to whether or why they should use condoms.

In some instances, venues proved unsuitable for discussion. For example, holding discussions among young women who were church-goers was constrained by being held within church premises, as one was not supposed to talk about sex in such contexts. Participants also felt they were under scrutiny from others using the premises for religious purposes. A change in venue resolved these problems. Community leaders were also not easily convened because many had competing time pressures, and some also expected to be paid to participate.

In many instances, participants wanted to continue discussions beyond the agreed-upon time. Some participants came late, and facilitators stressed the importance of time-keeping.

Organizations faced a challenge of drop-outs among trained CCT facilitators who largely worked on a volunteer basis, and who moved on to other work or study opportunities as these emerged. Facilitators also felt that the workloads exceeded what they had anticipated, for example, reporting and monitoring activities.

The overarching concern among implementing organizations, facilitators, and participants was that there was a need for more kits to allow participants to expand dialogues to other groups. It was also felt that the kits could be used with audiences beyond the initial age range identified—for example, in schools. In Zomba it was said that engaging with chiefs in other areas with the CCT concept would usefully open up access to wider audiences. Other potential participant groups mentioned were fishermen, pastors, persons with disabilities, prisoners, and sex workers. It was also felt that high literacy groups would benefit from the CCT, while engaging and training sectors and networks (for example, PLHIV networks) and providing toolkits would maximize reach.

4.6 Change Processes

The foregoing findings illustrate a wide range of engagements with the CCT that provide evidence for key elements of change. These engagements can, in turn, be related to the hypothesized model for behavioral and social change.

- **Conceptual resonance:** Participants acknowledged that the CCT was relevant to HIV prevention, and that it went beyond previously established approaches to communicating about HIV and AIDS. Notably, the CCT addressed ‘AIDS fatigue.’ Participants also recognized that they increased their HIV knowledge through using the CCT.
- **Situational resonance:** The CCT was acknowledged as a means to engage in dialogues about HIV that impacted one’s own behaviors in relation to HIV risk and vulnerability. This knowledge was also applied to partners, family members, and friends, as the CCT was seen as a means to begin dialogue.
- **Social resonance:** Participants had a general awareness that addressing HIV was not only important for themselves and their immediate radius of partners, family members, and friends, but that HIV prevention was a pressing social issue that needed to be addressed for broader community health.
- **Internalized meaning:** Participants spoke about how dialogue processes in conjunction with using the CCT components increased their understanding of HIV in relation to their own risk and vulnerability as well as that of others.
- **Actions and commitments:** Participants revealed a range of actions and commitments to action that addressed HIV vulnerability and risk. These included changing their own risk practices by adopting safer sex or other strategies, and engaging with partners as well as family, friends, and community members to address HIV.
- **New social meaning:** This larger outcome did not emerge from all groups, but there were examples of marked and profound changes that addressed HIV risk and vulnerability and risk at the community level—notably, changes in cultural practices relating to sexual cleansing, and strengthening legal processes related to rape. The CCT and its components also introduced new ways of making meaning and symbolizing processes of addressing HIV and AIDS—for example, mobilizing proverbs to critically reflect on HIV issues, or encouraging dialogue through wearing of buttons to events or in the community. Additionally, participants spoke of the CCT as breaking through the barriers of ‘AIDS fatigue’ by evoking curiosity and engagement.

Taken as a whole, the findings fit with the hypothesized model for transformative change.

5. Discussion and Conclusions

5.1 Lower Literacy and the CCT

The concept of literacy is associated with the ability to read and write text, and, more broadly, infers being able to obtain, absorb, and process information to deepen knowledge. As such, literacy involves a set of skills and practices, and literacy and learning are interlinked (UNESCO, 2005). While literacy is generally defined as the ability to read and write materials of familiar content, the concept of functional literacy includes being able to interpret and understand unfamiliar vocabulary and concepts (Watters, 2003). Related concepts are numeracy and oral competency, which are also both related to the capacity to link ideas to day-to-day activities and social practices. It is recognized that literacy and empowerment are linked, with literacy affecting capacity to engage with the world by developing individual and social capacities to contribute to social transformation (Freire, 1970).

While much of the emphasis on developing individual literacy skills has focused on the relationship between texts and the capacity to read texts, there is also a growing understanding that people interpret a wide range of information that is not specifically text-based. This broader view of literacy is derived from semiotics theory, in which the development of language is linked to the understanding of ‘signs,’ and there is recognition that meaning may be made from a wide range of symbolic interpretations including images, gestures, music, art, and other forms of communication (Hodge & Kress, 1999). Interpretations of diverse formats of communication are linked to the social contexts within which signs are ‘read’ (including texts and non-textual information). Formats of communication are also changing rapidly—for example, the growth in digital communication such as via mobile phones, computers, and digital tablets, among other technologies.⁵ Table 3 illustrates the differences between skilled readers and low literacy readers (C-Change, 2012).

Table 3: Differences between skilled readers and lower literacy readers

Skilled Readers	Lower Literacy Readers
Read with fluency	Read slowly
Understand meaning of words in context of text	May miss meaning of words in context of text
Able to determine meaning of unfamiliar words	May skip unfamiliar words
Do not need illustrations to understand meaning	Understand meaning better when photographic and graphic elements are included
Can understand abstract images against a monochrome background	Have difficulty understanding abstract images Are more likely to understand an image placed within its own context than one pasted against a monochrome background
Can read text presented in wide range of typographic styles	Can be distracted by wide range of typographic styles
Are comfortable reading long texts	Are uncomfortable reading long texts
Are able to easily produce texts themselves	Have difficulty producing texts themselves
Access texts in multiple media formats, including digital content	Access texts in limited media formats and may have less access to digital content

⁵ Such technologies also provide new opportunities for literacy education. For example, a program in Niger integrated mobile phones into teaching literacy and numeracy (see Aker et al., 2010).

Given the definitional challenges associated with the concept of literacy, it is acknowledged that statistics on illiteracy are not readily determined. However, using a general definition, such as defining literate persons as those who can, ‘with understanding, both read and write a short simple statement on his or her everyday life,’ and applying this definition to people aged 15 years and older, provides the basis for adult literacy estimates. In southern Africa, levels of adult illiteracy are high. For example, UNESCO estimates for 2000 indicated that 28% of adults in Malawi were illiterate, while in Zambia the proportion was 22% (Aitchison & Rule, 2006). Lower literacy and numeracy levels in African contexts have been found to be associated with lower knowledge about HIV, although it has been found that this does not necessarily impact utilization of HIV-related health services such as HIV testing or prenatal care (Ciampa et al., 2012). Nonetheless, a study in South Africa found that lower literacy did indeed impact health of PLHIV, including lower overall health status, lower antiretroviral drug adherence, and negative health care perceptions and experiences (Kalichman & Rompa, 2000).

While the CCT was initially explicitly developed to address lower literacy adult audiences, implementation of the CCT in Malawi and Zambia did not necessarily require that participants were of lower literacy, nor was there any process of measuring literacy skills of participants at the outset of sessions. A few reflections on the experiences of lower literacy participants emerging from the evaluation data illustrate that the toolkit addresses the needs of lower literate audiences. Specifically, the toolkit components include short texts and graphic elements that do not require extensive literacy skills for interpretation. Participants also noted that the interactive and informal dialogue process emphasised mutual support, and this included literate participants assisting participants who were less literate when texts were not easily read or interpreted.

5.2 Health Literacy and the CCT

This study also clearly shows that the CCT is relevant for adult audiences in general, and the range of participant groups who actively and comfortably engaged with the CCT is illustrative of this. Apart from accommodating a range of literacy skills, the CCT also fostered ‘health literacy,’ a concept that draws together the capacity of people to read and interpret information and knowledge related to health including individual health, health at the community level, health systems, and socio-political aspects of health. Approaches to health literacy include functional health literacy, conceptual health literacy, and health literacy as empowerment.

- *Functional health literacy* is focused on information related to the health care environment—for example, receiving information from health care workers, taking medication correctly, and keeping appointments.
- *Conceptual health literacy* includes broader understanding of health, health risks, and quality of life, including capacity to obtain and use health-related information—for example, understanding personal health, health systems, the relationship between scientific and cultural health systems, accessing information, and understanding health communication (eg., advertisements, programs).
- *Health literacy as empowerment* focuses on the application of health knowledge into active citizenship whereby rights to health, rights within health delivery systems, and community and social health are linked to advocacy and mobilization (Kanj & Mitic, 2009).

Incorporating the concept of empowerment into health literacy has implications for approaches to communicating about health, notably, an emphasis on fostering participation to address social action and change that includes a focus on social determinants of health (Nutbeam, 2008). A literature review of participation and community health identified seven domains of empowerment (Laverack, 2006):

1. Participation through working in groups, developing interpersonal trust, social networking, and health services.
2. Engaging through community-based organizations that build skills and facilitate mobilization.
3. Engaging leadership with a view to activating power relations to address health inequalities.
4. Resource mobilization, including raising resources within groups or seeking resources externally.
5. ‘Asking why’ as a form of critical engagement with factors underlying vulnerability and powerlessness.
6. Assessing and solving problems, including addressing barriers to health.
7. Linking with others, including through partnerships, alliances, and links with organizations.

5.3 Empowerment and the CCT

Communicating for empowerment in relation to health literacy involves a range of goals related to reducing vulnerability to ill health as well as improving self-esteem and capacity to engage with health issues and rights at a social level. Integrating participatory action research processes into health communication includes providing “an opportunity for community participants to work together to define and solve problems, develop necessary skills, critically analyze their socio-political environment and create mutual support systems” (Bergsma, 2004).

In relation to empowerment outcomes, this evaluation clearly shows that the CCT is a well-developed, comprehensively tested communication resource for addressing HIV vulnerability and risk that fosters HIV prevention response at the community level. The considered, reiterative approach to the development cycle of the toolkit, including a strong emphasis on participation and perspectives of prospective audiences, has generated a set of tools that bring about dialogue, promote reflection, and foster problem solving among participants in CCT dialogue sessions. The sessions themselves employ sound principles of participation and adult learning that have harnessed existing knowledge and experience of participants to develop new insights into HIV, including how to address HIV vulnerability and risk at the level of oneself and others.

Observations and lessons emerging from the application of the CCT components and related to empowerment include:

- The CCT evoked curiosity as a product of novelty, and this facilitated entrée into new ways of people engaging with HIV through dialogue. The CCT helped reach previously hard-to-reach groups, such as chiefs and community leaders.

- CCT components and related participatory activities such as games, role plays, and informal humor captivated the attention of participants and motivated continued participation.
- While some participants and groups were initially shy or reserved in their engagement on sensitive issues such as sexuality and sexual behavior, it was acknowledged that speaking directly and frankly was necessary to address the pressing health challenges of HIV/AIDS, and the CCT dialogues provided a forum for doing so.
- While some CCT components appear simple and childish—for example, finger puppets—they were appreciated and used meaningfully by adults.
- Open-ended proverbs and questions embedded in many of the tools prompted reflection on personal HIV risk and also on the development of contextualized and relevant strategies for vulnerability and risk reduction. This allowed participants to engage with a wide repertoire of strategies and solutions that were context-specific.
- Participants were encouraged to engage with and make linkages with services – for example, through seeking HIV testing via VCT services; through accessing and distributing condoms; and through engaging with policing and other services.
- While CCT dialogues prompted critical thinking and a range of viewpoints, the goal of consensus allowed strategies and solutions to be refined through group reflection.
- CCT facilitators were well trained and were able to conduct activities without participants being concerned about the age or gender of their facilitator.
- While the CCT was costly to produce in short print-runs necessitated by the research and development process, scaled-up production would reduce unit costs (see Annex 1). Lead organizations also noted that logistical and other costs were minimal, making the approach more cost-efficient than other strategies for reaching into and engaging with communities.
- Some CCT components were used beyond the dialogue settings—for example, buttons and playing cards—and there is potential for such components to be used on a stand-alone basis, including as products that dialogue participants could be encouraged to use independently.

Participatory approaches to communication, such as those fostered by the CCT, can be contrasted with ‘diffusionist or top-down’ communication (Servaes & Malikhao, 2005). As Chasi and Tomaselli (2011) observed, top-down approaches involve “the view that multitudes can be controlled and easily led, if only the right modes of communication are identified.” Participation in communication processes allows for the integration of cultural identity and for multiple levels of engagement with hierarchies of power that impact individual and social wellbeing. A similar tension exists in HIV prevention, where biomedical interventions that work in largely linear ways (eg., HIV treatment) are elevated as more important and relevant than behavioral, socio-cultural, and other approaches (Nguyen et al., 2011; Adam, 2011).

In contrast, it has been recognized that social and behavior change approaches, including participatory approaches, have ‘come of age’ and that group-level approaches are necessary (de Wit et al., 2011). Integration of community-level responses has been highlighted as central to a broad-based response that includes all spheres of intervention—behavioral, structural, and biomedical—through concepts such as

‘combination prevention’ (Merson et al., 2008). Developing community capacity through building groups, networks, and collectives that prioritize changes in social practices has also been emphasized as part of a new vision of ‘social public health’ where HIV prevention actions lead to changes that are adopted at community and social levels (Kippax, 2012).

While researchers and strategists have highlighted the relevance of empowering communities, this call has also come from communities themselves. For example, study on gaps and opportunities for HIV prevention among adult women in southern Africa found that community members were specific about the disempowering effects of persuasive communication and didactic peer education approaches, highlighting that a clear gap in response was the lack of inclusion of community members in group formations where HIV prevention could be addressed to the point of developing action strategies (Parker & Borwankar, 2012). Such processes require enabling environments for transformative communication, including a capacity to engage local authority structures and attention to sustainability (Campbell & Cornish, 2011).

The CCT is consistent with current thinking on approaches to addressing HIV prevention that highlight the relevance of non-didactic, non-prescriptive communication that fosters group engagement with a view to generating strategies for HIV prevention that are relevant to individual participants’ lives and also the lives of others in the community. Throughout its implementation in Zambia and Malawi, the CCT brought about processes of conscience reflection that were framed by ‘humanizing values.’ The approach reinforced ‘horizontal’ communication at the community level and empowered individual participants. Through such empowerment, participants were also able to confidently engage authority structures in their communities to the extent that harmful cultural practices were scrutinized and transformed—for example, through shifting practices of sexual cleansing. The legal rights of women were addressed and reinforced through engaging with police, and the responsibilities of liquor sellers were engaged through reinforcing local bylaws.

The CCT resources, training, and engagement with community groups complemented ongoing HIV and AIDS activities conducted by implementing partner organizations. Existing linkages to volunteers, affected subgroups, and community stakeholders and leaders strengthened opportunities for action. These linkages and existing networks helped dialogue groups make connections with community leaders and authorities. Partners were also able to connect groups with service providers, police officers, counselors, and traditional leaders to address issues the community identified.

While change and action emerged as a product of participation in the CCT dialogues, the extent and scale of change varied between participating groups. A strong moderating factor was the extent to which the dialogues were conducted, which was only four sessions, at which point further engagements could not be funded. While these repeat interactions were highlighted as being different from the more typical once-off engagements experienced previously, it was unclear how sustainability should be addressed, or how change processes could be entrenched on an ongoing basis. There were, however, many groups and participants who were interested in extending the use of the CCT, as well as interest from organizations including government departments.

6. Recommendations

- The CCT is a well developed SBCC resource that fosters dialogue and critical reflection processes that contribute to the empowerment of HIV-vulnerable participants. As such, the CCT is suitable for replication in its current format.
- The CCT is a versatile resource that can be utilized with literate adults as well as adults with lower literacy skills. Potential use with youth audiences should be explored, noting that the content of the present toolkit would need to take into account age-appropriateness in relation to content regarding sexuality.
- The CCT complements existing HIV prevention activities and bolsters such activities by serving as a catalyst for spurring problem solving and action at individual, relationship, family, and community levels. It should thus be considered as a complementary resource to the work of organizations in facilitated or spontaneous situations.
- The CCT is available in a range of languages and includes context-relevant adaptations in the form of localized proverbs and questions. These are suitable for reproduction for use in a wide range of communities in the countries for which they were developed. Demand for such upscaling has already been voiced in study countries. (Costs are detailed in Annex 1).
- The durability of the CCT was not assessed as part of this evaluation, and CCT components were only used four to five times by the dialogue groups. Reproducing the CCT would require additional research to determine durability for more intensive use. (Durability options are detailed in Annex 1.)
- While the broad curriculum and facilitation style attached to the CCT dialogues is appropriate and leads to action outcomes, it is unclear whether there is an optimal number of ‘sessions’ or how participants could continue independently using the toolkits. Four sessions appear to be a suitable minimum. Strategies for expanding use within communities, and determining optimal intensity of use and ‘saturation’ per community, would need to be considered.

Annex 1: Printing Options for the CCT

The toolkit can be printed in black and white on regular paper, or in color on card stock. The materials can also be laminated. The cost per copy varies depending on the option chosen, and decreases with the number of toolkits printed.

Color on Card Stock*	
Number of Copies (Full set)	Price (Per toolkit)
100	\$26.00
500	\$21.00
1000	\$20.00

**Does not include assembly.*

Color Laminated**	
Number of Copies (Full set)	Price (Per toolkit)
100	\$165.00
500	\$60.00
1000	\$48.00

*** Professionally assembled. This includes solid blocks inside the cubes and metal backing for the buttons.*

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