C-CHANGE COMMUNICATION FOR CHANGE

CASE STUDY

ADDRESSING AIDS FATIGUE WITH NON-TRADITIONAL COMMUNICATION APPROACHES:

THE C-CHANGE COMMUNITY CONVERSATION TOOLKIT—PARTICIPATORY DEVELOPMENT, USE, AND EVALUATION

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Recent years have seen greater focus on HIV prevention among youth in southern Africa resulting in less attention on adults older than 20 years of age.[1] Being able to internalize personal risk to HIV, learn how to live with HIV, and take action in response to HIV among peers, family members, community leaders, and others in communities are critical skills for this group. C-Change developed the Community Conversation Toolkit (CCT)—a set of HIV prevention tools—to mobilize adults with lower literacy skills aged 20 and older through a series of interactive materials and activities. The CCT allows adults to interact, reflect, discuss, and determine what actions to they want to take in response to HIV in their communities.

Background

Most national and regional HIV prevention campaigns use broadcast media to convey information to literate and non-literate audiences alike. Practitioners tend to support community-level services, organizations, and peer networks with print media such as posters, leaflets, and booklets that require literacy skills for effective communication. Although interactive formats such as flipcharts and diagrammatic materials are also used, support materials for low-literacy audiences are not widely available.[2]

Lower literacy has been linked to adverse health outcomes.[3] Low literacy also has negative impacts on self-esteem and self-confidence.[4] Moreover, although the links between low literacy and vulnerability to HIV infection are well-documented, governments have done little to incorporate and focus on low literacy in HIV prevention.[5] One way of addressing low literacy is through interactivity. An interactive format allows audiences with lower literacy to form connections and engage with the topic by acting out a situation or talking about it, rather than just passively watching or listening. It can also trigger problem-solving and dialogue in ways audiences can understand and internalize, creating pathways for change for individuals and communities.[6] Recent studies on HIV prevention among adults in southern Africa show the critical importance of audience involvement in preventing HIV. Results include the need to give priority to approaches that move away from

[1] Patterson, J. 2011. *A youth HIV prevention campaign addressing multiple and concurrent partnership.* AISTAR-One: Reports and fact sheets; UNESCO. 2012. *Leaders to lobby for HIV prevention and Sexual Health.* Retrieved from http://www.unesco.org/new/en/media-services/single-view/news/leaders_to_lobby_for_hiv_prevention_and_sexual_health_for_youth_in_eastern_and_southern_africa/; UNAIDS. 2012. *Reaching youth with HIV Prevention Messages.* 2012. Geneva: UNAIDS; Parker, W., Rau, A., & Peppa, P. 2007. *HIV/AIDS communication in selected African countries: Interventions, Responses and Possibilities.* Lusaka: SIDA.

[2] Parker et al., 2007.

[3] DeWalt, D.A., Berkman, N.D., Sheridan, S., Lohr, K.N., Pignone, M.P. 2004. Literacy and Health Outcomes: A Systematic Review of the Literature. Journal of General Internal Medicine, 19(12): 1228-1239

[4] Medel-Añonuevo, C. & Cheick, D.M. 2007. *Making the connections: Why literacy matters for HIV Prevention.* Hamburg: UNESCO.

[5] Medel-Añonuevo and Cheick, *Making the connections: why literacy matters for HIV prevention.* UNESCO. 2007.

[6] UNAIDS. 2010. *Combination HIV Prevention: Tailoring and Coordinating Biomedical, Behavioural and Structural Strategies to Reduce New HIV Infections: A UNAIDS Discussion Paper.* Geneva: UNAIDS.

vertical, top-down communication toward communication between people at the community level that allows for reflection and relevant problem-solving.[7]

The Community Conversation Toolkit

The CCT highlights key HIV epidemic drivers including concurrent partnerships, cross-generational sex, alcohol abuse, and gender-based violence. Tools in the kit include "throw-boxes" and buttons with proverbs and idioms in local languages, playing cards that pose prevention-related questions instead of passive messaging, and thematic picture codes for role plays with tips for discussion (around reasons, risks, rights, and responsibilities), as well as finger-puppets. All of these can be used to enable in-depth discussions on HIV-related topics. A community mobilizer's guide helps identify key issues and challenges, outlines stakeholder consultation processes, and illustrates the steps to develop and implement action plans.

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.

The CCT stimulates individual and social actions that are non-prescriptive and that allow participants to internalize HIV and AIDS concepts.

FIGURE 1: TOOLKIT COMPONENTS

1. Facilitator's guide
2. Community mobilizer's cards
3. Role play cards
4. Storytelling finger puppets
5. Proverbs and question throw boxes
6. Promotional playing cards
7. Dialogue buttons

7 Parker, W., & Borwankar, R. 2012. *Research Brief: HIV prevention among adult women in Namibia and South Africa: Opportunities for social and behavior change communication.* June 2012. Washington DC: C-Change.

Participatory Material Development

C-Change used a participatory action research methodology called Action Media to develop understanding of how lower-literacy audiences make meaning of HIV and AIDS.[8]

The Action Media approach involves workshops where facilitators and participants develop new approaches to communication to address health among audience sub-groups and communities.[9] Methods include small group discussions, reflection and sharing sessions, role-plays, and creative exercises that draw out culturally relevant meanings for addressing health challenges.[10] Ideas and concepts are then developed into draft communication materials that are reviewed with audience members and then refined and produced for similar audiences.

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

Recommendations from the workshops that guided the development of the CCT included using the following:

FIGURE 2: ROLE-PLAYING DURING THE ACTION MEDIA WORKSHOP IN SOUTH AFRICA

- local languages into communication products, tools and activities
- short textual information supported by visual elements to aid interpretation
- local idioms and proverbs to foster discussion
- interactive activities and games that allow for critical reflection to support problem-solving dialogue
- role-plays and creative activities to support interpretation and meaning in relation to HIV and AIDS

The interaction with participants illustrated the importance of speaking about sexual matters in language acceptable to the group, whether or not this included graphic language, graphic depictions of sex or sexual risk practices. Although most workshop participants knew something about HIV and AIDS, some knew little about prevention practices and needed to assimilate and process information on HIV prevention discussed during the workshop. A further finding was that lower-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.

[8] C-Change. 2012. *C-Modules: A Learning Package for Social and Behavior Change Communication*. Version 3. Washington, DC: FHI 360/C-Change; C-Change (Communication for Change). 2012. *C-Bulletins: Developing and Adapting Materials for Audiences with Lower Literacy Skills. Bulletin 4: Using Participatory Processes to Develop SBCC Materials*. Washington, DC: FHI 360/C-Change; Parker, W. 2009. Action Media: Consultation, Collaboration and Empowerment in Health Promotion. In T. Gokah, (ed). Contemporary Discourses on IE&C Theory and Practice, London: NovaScience.

[9] The methodology has been used in diverse settings with an emphasis on marginalized communities including, for example, youth and injecting drug users in China, sex workers and men who have sex with men in the Caribbean, and vulnerable youth and young adults in South Africa.

[10] C-Change. 2012. *C-Modules: A Learning Package for Social and Behavior Change Communication*. Version 3. Washington, DC: FHI 360/C-Change; C-Change (Communication for Change). 2012. *C-Bulletins: Developing and Adapting Materials for Audiences with Lower Literacy Skills. Bulletin 4: Using Participatory Processes to Develop SBCC Materials*. Washington, DC: FHI 360/C-Change.

Concept Testing and Adaptation

Following the Action Media workshops, the C-Change team and graphic designers further developed ideas that emerged from the workshop and drafted products that participants in Limpopo reviewed in a follow-up workshop. This provided insight for further refinements and led to a regional CCT prototype that was assessed through evaluation research. C-Change and the Soul City Institute for Health and Development Communication in Malawi, Namibia, Zambia, and Zimbabwe concept-tested the regional CCT prototype through three focus group discussions with men, women, and community educators aged between 20–40 years. Additional concept-testing sessions were held at taverns with selected materials. Findings included:

- appreciation for the content and format of materials
- appreciation for short, catchy messages, bright colors, and accessibility of the buttons

FIGURE 3: **CONCEPT TESTING IN MALAWI**

- requests for larger fonts on materials that used text
- requests for changes to the double-headed character design envisaged for the playing cards
- preferences in Malawi and Zambia for a proverb format for the throw-boxes that aligned better with local cultural and oral traditions instead of "best kept secrets" phrases

In each country, focus group participants contributed locally relevant proverbs and idioms that could be included on the throw-boxes and buttons.

Based on the concept-testing, a facilitator's guide was developed to support community health volunteers and peer educators in leading small group sessions using the CCT.

The CCT was adapted to include stakeholder consultations with government counterparts, donors, and partners for technical input and buy-in. The final regional CCTs were translated into languages appropriate to each country and the region they were adapted for, as shown in Table 1.

TABLE 1: **CCT 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 CCT has been adapted in seven countries and is used by a total of 41 NGOs. The CCT is flexible in cost and quality. The cost per copy varies, depending on the option chosen, and decreases with the number of toolkits printed.

ADAPTING THE CONVERSATION TOOLKIT IN SWAZILAND

In Swaziland, materials were translated into Siswati. The CCT was pretested with intended audiences and in close consultation with the National Emergency Response Council on HIV and AIDS (NERHCA) as well as 13 local implementing partners. Local proverbs and idioms were used in the throw boxes and visual elements were revised to depict the local Swazi context. At NERCHA's request, components were added that address male circumcision and condom use to align with the Swaziland HIV Prevention Strategy.

C-Change printed 200 copies of the Community Conversation Toolkit and a C-Change partner in Swaziland—PACT—supported printing 50 additional copies of the CCT for their implementing partners. C-Change then trained staff from 44 local organizations as well as NERCHA on how to use the CCT. Training included processes of running dialogue groups and monitoring CCT implementation through existing reporting structures.

Implementation and Monitoring

Implementation Partners

To evaluate the CCT, C-Change worked with four community-based organizations (CBOs) of the Southern African AIDS Trust[11] (SAT) engaged in HIV prevention in Malawi and Zambia to use the CCT. Friends of AIDS Trust (FAST), Hope for Life, Contact Youth Trust Association (CTYA), and Kuba Lusa implemented the CCT in Malawi and Zambia. These organizations had existing relationships with key community groups, many of whom were at higher risk for HIV infection. They used the CCT with 23 community groups with whom they were working. Peer educators were trained to prompt dialogues that fostered reflection, problem-solving, and action for individuals and groups.

Phased implementation approach

The implementation approach of the CCT in Malawi and Zambia used four phases. These are illustrated on page 6.

Phase I

C-Change oriented CBO leadership on using the CCT to facilitate dialogues with community groups, identifying individual and group actions, and understanding potential program implications as they used the CCT with existing activities. Together, the CBO leaders and C-Change trained existing peer educators on how to use the CCT and to facilitate and monitor group dialogues.

Ten staff and 49 peer educators with varied backgrounds,[12] but a good experience working on community AIDS prevention, were trained in observation and note-taking to facilitate dialogues with 23 community groups[13] in Malawi and Zambia. Peer educators were organized into teams of a facilitator and note-taker to carry out the dialogues in their respective CBOs.

Phase II and III

Following training, CBO leadership facilitated action plan development that included identifying participant groups in each community,[14] engaging with stakeholders, establishing participant groups, and carrying out dialogues. Peer educator teams were assigned to community participant

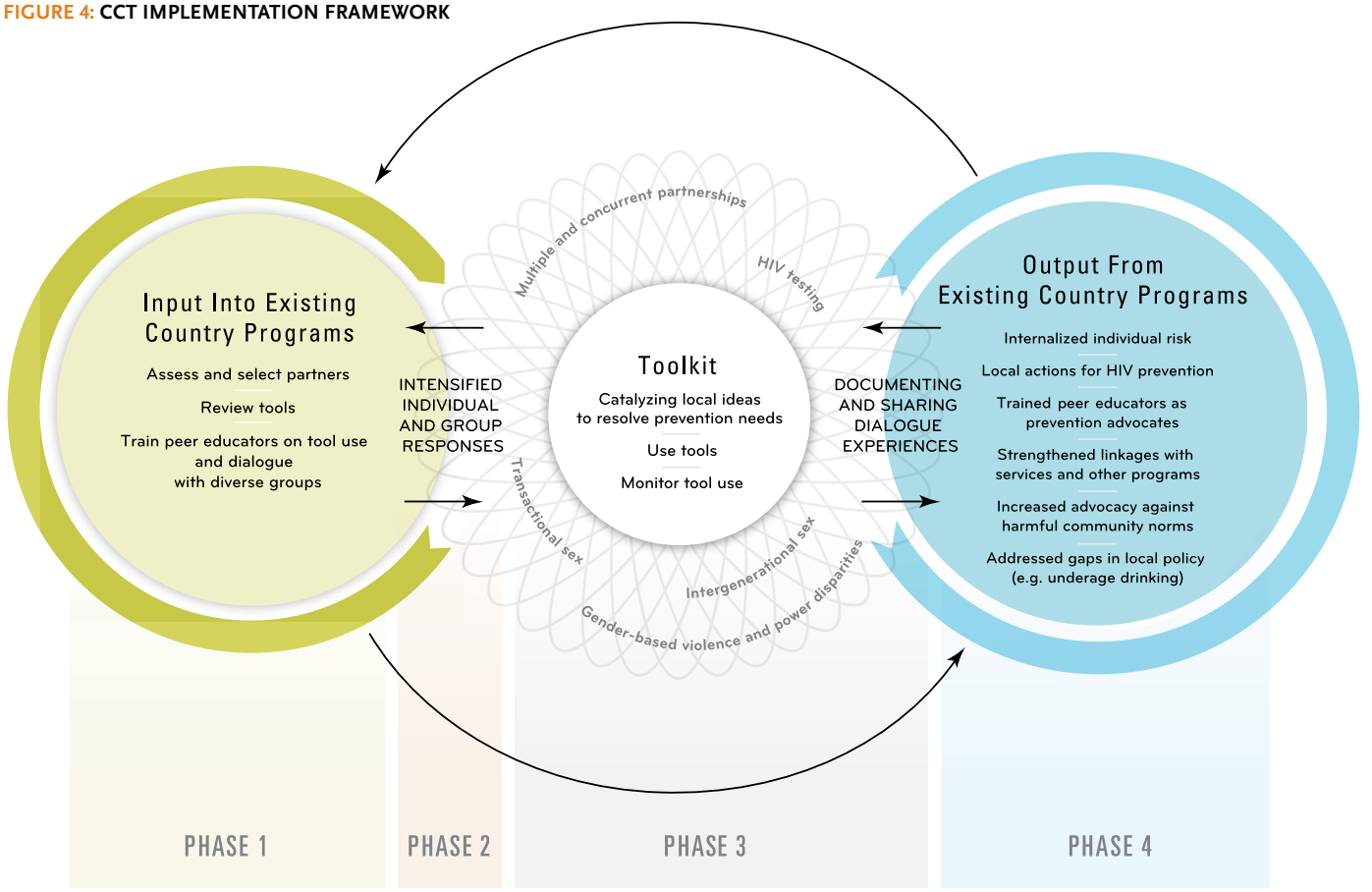
[11] SAT is a regional funding and capacity development organization that provides assistance to 130 community-based organizations, national advocacy organizations, and networking agencies across six countries in Southern Africa. C-Change and SAT have ongoing partnership to infuse SBCC capacity into their network through training and mentoring of partners in five countries.

[12] Peer educators came from a variety of backgrounds, including a local chief, a university lecturer, former-sexual cleansers, Muslim peer leaders, and a preacher.

[13] The dialogues took place in Nsanje and Zomba in Malawi and in Kasempa and Livingstone in Zambia. Community groups included: community leaders, women involved in small business, middle class men (with high level positions in government and local businesses), people living with HIV (PLHIV), youth PLHIV, Muslim women PLHIV, and HIV-discordant couples.

[14] Some of these were established groups, while others were community members that the CBOs had existing relationships with through their ongoing programs.

FIGURE 4: CCT IMPLEMENTATION FRAMEWORK



groups based on the background, skills, and orientation of peer educator teams.

Each dialogue group had eight to 12 participants. The facilitator prompted dialogue by using the CCT components to foster reflection, problem-solving, and action outcomes for individuals and groups. The note-taker documented specific actions that participants proposed to undertake and the facilitator followed up on these actions in subsequent sessions. Each group met a minimum of four times.

Phase IV

Over 80 dialogues were conducted. Dialogue outcomes identified through monitoring include:

Internalization of individual risk to HIV

A number of participants were prompted to go for HIV testing following the dialogues, including men in Kasempa, Zambia who were previously unmotivated to know their HIV status. Many participants with no history of condom use felt motivated to do change their behavior. Bicycle taxi drivers coerced to accept sex in lieu of cash payment for taxi services re-evaluated their own and their partner's risks to HIV.

"There are many women here who get on 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...I would accept that. Now with the coming of the CCT and realizing how many women I have slept with, fear has come upon me.

—Bicycle Taxi Operator, Nsanje, Malawi

Reaching out to others

Participants changed behaviors to reduce their own risks to HIV; they also reached out to others, e.g., they advised friends, family, and community members to test for HIV. Participants spoke to their sexual partners about HIV prevention, thus, overcoming cultural constraints to talking about sex. In Zomba, Malawi, a group of Muslim women asked to be trained to use female condoms which prompted dialogue with husbands around HIV prevention.

CCT facilitators as HIV prevention advocates

CCT facilitators involved in the dialogues stepped up their roles as community prevention advocates, assisting and accompanying dialogue participants for HIV testing, distributing and demonstrating female condoms, promoting community-level dialogue, and training other peer educators in the CCT. Participants who engaged with harmful practices such as sexual cleansing explored alternative approaches to minimize the risks of HIV transmission.

"We have various tools before. These tools were very suitable for adult learning and people who have not gone far with education. These people learn better if the lessons are practical and the aspect of play was to reduce boredom."

—Peer Educator, Zomba, Malawi

Strengthened linkages with HIV and AIDS support services and organizations

Using dialogues, partner CBOs deepened their connection to different community-based groups—youth groups, people living with HIV, out-of-school youth. Connections were enhanced with other agencies that provide HIV-related services, such as clinics and HIV testing facilities.

Increased advocacy among local leaders and stakeholders

The four partner CBOs engaged community leaders and stakeholders in their dialogue groups. Community leaders are now better informed about the many challenges faced by the different groups and are better positioned to lead ongoing discussion and change processes around risky cultural practices, such as sexual cleansing.

Applying what they learned, community leaders are enacting new bylaws or enforcing existing legislation to better protect their communities, such as reporting rape to police in Kasempa, Zambia, and preventing informal drinking areas (shebeens) in Livingstone from opening before 4 p.m. as the law requires rather than the previously unregulated hours of operation.

"For me the major difference that I observed was, from the previous activities that we have had before with other groups, you would find that someone just comes and says you should do this and not do this in front reading and explaining to you. But with the Toolkit...we all participate and are involved in finding answers."

—Community Member, Kasempa, Zambia

"The Toolkit has broken the silence of discussing sensitive issues. It enabled a critical review of issues which affect different groups which was not there before."

—NGO Leader, Nsanje, Malawi

Understanding change processes

To understand change processes, the assessment used a model that addressed cultural change processes by identifying cultural scripts (see Figure 1). Goddard and Wierzbicka note that cultural scripts "are intended to capture background norms, templates, guidelines or models for ways of thinking, acting, feeling, and speaking, in a particular cultural context."[15] Cultural scripts reveal underlying dimensions of relationships between people, individual agency and self-efficacy, expression of needs, and perceptions of social norms.

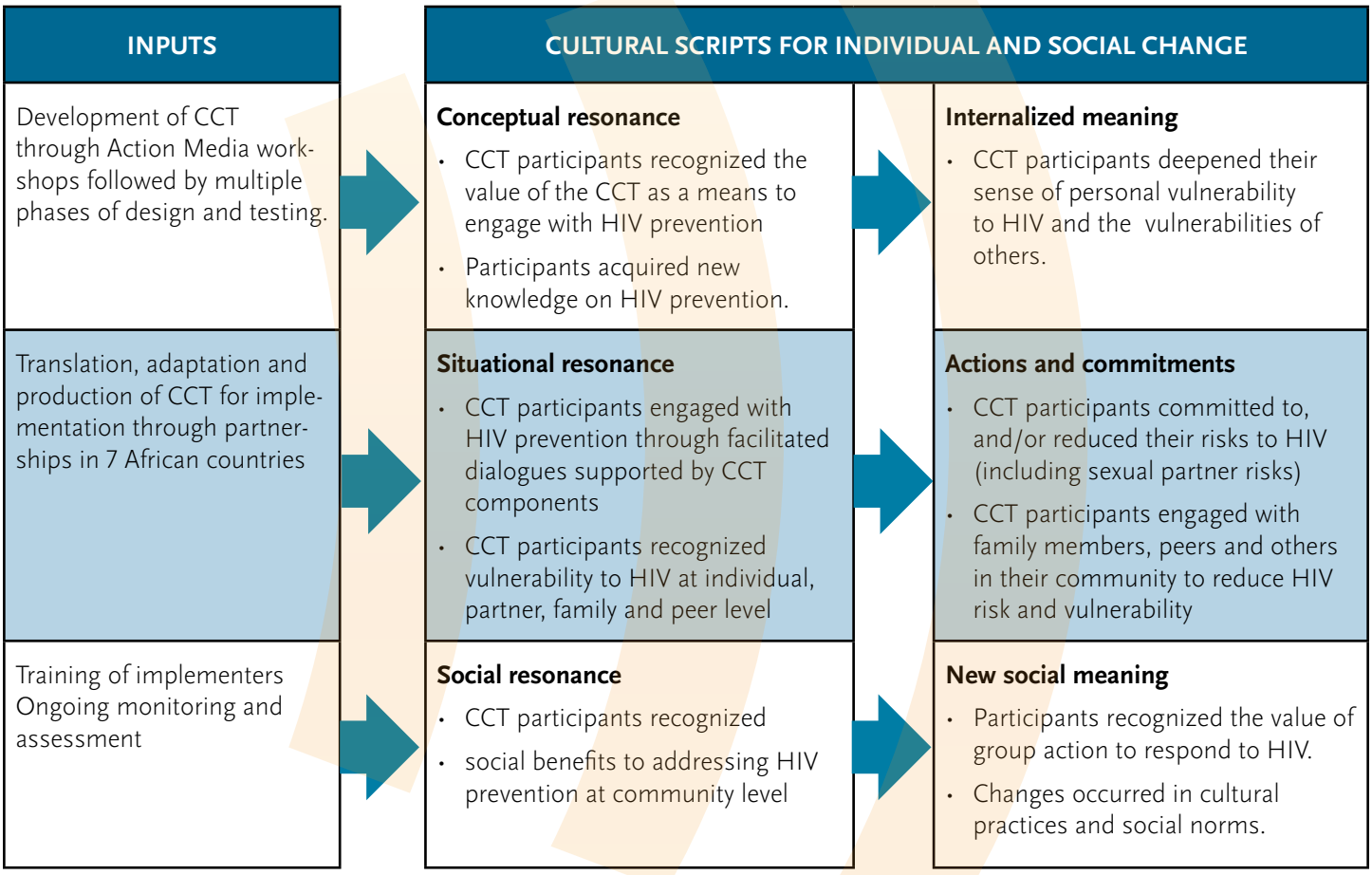
Cultural scripts recognizes that health interventions bring about change, and that interventions are only effective if they change individual knowledge and risk behaviors as well

[15]Goddard, C., & Wierzbicka, A. 2004. Cultural scripts. What are they and what are they good for? *Intercultural Pragmatics,* 1-2:153–166

as collective efficacy,[16] resulting in changing relevant social practices and norms.

In applying this change model to the CCT, the evaluation explored how the CCT design and implementation evolved, including the participatory dialogues conducted in Malawi and Zambia. Figure 5 below illustrates the change processes identified during the evaluation.

FIGURE 5: CULTURAL SCRIPTS FOR INDIVIDUAL AND SOCIAL CHANGE[17]



Evaluation Findings

Few toolkits have been evaluated. The evaluation of the CCT in Zambia and Malawi followed the dialogue activities and included a desk review of program documentation, interviews with C-Change implementing staff, interviews with staff of partner organizations, small group discussions with peer educators, interviews with community stakeholders, and focus group discussions with a sample of CCT dialogue participants—17 out of the 23 groups that participated in both countries.

[16]Collective Efficacy is defined "as social cohesion among neighbors combined with their willingness to intervene on behalf of the common good" of a neighborhood or community." Building the community capacity to act for the common good is essential for health and development. Sampson, Robert, J., Stephen W. Raudenbush, Felton Earls. 1997. "Neighborhoods and Violent Crime: A Multilevel Study of Collective Efficacy." Science, Vol. 277 no. 5328 pp. 918-924

[17] A model for understanding cultural scripts in relation to social change for health was developed through evaluations of an HIV prevention campaign in Namibia, and of a social mobilization program to address violence against women in South Africa. Parker, W. & Connolly, C. 2011. *Break the Chain, Namibia: Final evaluation report*. Windhoek: UNICEF; Parker, W. 2012. Prevention in Action: A social mobilization model. Cape Town: Project Concern International.

"In older days we use to dictate the HIV/AIDS topics to the learners and it was more like teaching them. The Toolkit has made discussions more participatory and the participants are the ones who choose a topic."

—NGO Leader, Zomba, Malawi

"Toolkit enables people to talk. The last meeting that we had, we invited middle class people...and their spouses...It enabled people to participate they were able 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 because of the tool kit."

—Peer Educator, Kasempa, Zambia

The CCT evaluation explored partner, peer educator, and dialogue participant perceptions and how practical it is to use the CCT, dialogue and engagement processes, and outcomes for HIV prevention. Attention was given to changes in HIV prevention knowledge, changes in the sexual behaviors of participants, shifts in attitudes, and engagement with others in the community to address HIV prevention.

Implementing partners placed high value on the participatory approach and ability to engage audiences in contexts rife with AIDS "fatigue". The toolkits deepened understanding of the disease and motivating change.

CCT dialogue participants deepened their understanding of HIV vulnerability and risk, internalized their own risk enough to change their behaviors, and engaged partners, family members, peers, and community members in addressing risky practices.

Implementing partners, facilitators, and participants strongly appreciated the components of the CCT, noting that each component prompted thinking, reflection, and problem-solving.

Constraints in using the CCT were mainly logistical and financial, citing transportation and refreshments, as well as funding to support stipends for volunteer CCT peer educators. There were several requests for additional copies of the CCT from community members and other partners.

FIGURE 6: DIALOGUE SESSION USING THE THROW BOXES WITH BICYCLE TAXI OPERATORS IN MALAWI

C-Change had funds for a limited print run for the implementation in the four locations and was not able to respond to all requests for additional CCT copies. However, partners have been able disseminate a limited number and also loan out copies of the CCT. Conducting a small, high quality print run can be costly, but the CCT can also be printed in black and white on regular paper or in color on card stock. The cost per copy varies, depending on the option chosen, and decreases with the number of toolkits printed.[18]

The CCT showed that communication tools can generate individual, interpersonal, and social-change to address HIV risks in sexual relationships and risks embedded in harmful traditional practices. Participants supported changes they discussed beyond the dialogues, and implementing organizations worked to find funding for continued implementation. The evaluation validates the need for nontraditional communication approaches that spur homegrown solutions, focus on relationships, and foster critical group thinking.[19]

[18]Printing Options
COLOR ON CARD STOCK *(does not include assembly)*:
100 copies (full set) = $26 per toolkit | 500 copies = $21 | 1000 copies) = $20
COLOR LAMINATED *(professionally assembled and includes solid blocks inside the cubes and metal backing for the buttons)*:
100 copies (full set) = $165 per toolkit | 500 copies = $60 | 1000 copies = $48

[19]Parker, W. (2012). Group dialogue and critical reflection for HIV prevention: An evaluation of the C-Change Community Conversation Toolkit. Washington, DC: C-Change Project, FHI 360.

Lessons Learned and Way Forward

Participatory development leads to relevant and valued communication resources

The CCT was developed and adapted into local language through continuous and rigorous process of engaging lower literacy and HIV-affected sub-groups. CCT components were refined, reviewed and tested with audiences in multiple countries. The final CCT implemented in Malawi and Zambia, among other countries was, well accepted by implementers, peer educators, and participants alike. CCT components were also effective in stimulating dialogue and problem-solving that led to individual and social change. Lower literacy participants were able to interact with the material content, think critically, and take active role in the group sessions.

Ongoing support to peer educators is necessary

Peer educators participated in workshops to gain sufficient skills in recruiting participants and conducting a series of dialogues with community groups that led to individual and social change to address and prevent HIV. Following the initial workshop, partners provided the needed ongoing technical support to peer educators following dialogue sessions. Although in-depth sessions were conducted, refresher trainings would improve fostering and documenting behavioral change and social action outcomes that emerged from the dialogues.

All CCT components were effective in prompting dialogue

Participants appreciated the interactive and game-like approach to using the CCT components and they valued having components in local languages. In addition, they found that CCT components were relevant and applicable to lower-literacy audiences; as most participants could easily use the combination of short texts and visual elements. Participants appreciated speaking directly and honestly about sexual matters, and the dialogues eased social restrictions of being secretive about sex.

The proverbs and provocative questions on the throw-boxes stimulated thinking and contributed to varied discussions that led to group consensus. The buttons, which included statements and questions, were used during sessions as well as to prompt enquiry from others in community activities such as marches. The role-cards were appreciated for their visual depiction of risk contexts—particularly in relation to sexual networks. Although the finger puppets were initially perceived as overly childish, they were used by a number of groups, including community leaders and bicycle taxi operators in Malawi. The puppets created a useful distance between the user and the puppet character they wanted to express.

Individual and group support to change

Although dialogue participants readily internalized change processes in relation to their own HIV vulnerabilities and risks, they were also motivated to encourage others to change. They employed one-on-one strategies which allowed for confidential discussion as well as group "interventions" which offered broader engagement and support.

The CCT supports individual and social change

A key value of the CCT for effecting individual change is that it overcomes AIDS fatigue that is produced by reiterative messaging on how to prevent or address the disease. Such messaging leads people to assume that there is nothing new to be learned and leaves them unsure of how to internalize and act upon what they know in the context of their own lives. The interactive dialogues that were directed toward reflection and problem solving led participants to more deeply understand and internalize their relation to HIV—in particular how to address HIV prevention in their sexual partnerships and within community radius. The cultural scripts framework show how the CCT led to individual and social change.

The CCT supports existing programs and community structures

The CCT resources, training, and engagement with community groups complemented ongoing HIV and AIDS activities of implementing partner organizations. Working with established CBOs and through their existing linkages to volunteers, affected sub-groups, community stakeholders and leaders, strengthened opportunities for action. Established relationships and networks helped dialogue groups make connections with community leaders and authorities. Partners were able to connect groups with service providers, police officers, counselors, and traditional leaders to address issue the community identified.

Ongoing activities and sustainability

Implementing organizations voiced the need for financial and logistical support if they are to implement the CCT. For an organization these include resources for training, transportation, monitoring activities, supporting peer educators and group actions. Financial requirements for ongoing implementation are modest—stipends for peer educators and refreshments. Although the focus of the CCT is on HIV prevention, the conceptual approach can also be used to address issues related to HIV treatment, care, and support or other health challenges.

During implementation in Malawi and Zambia, activities emerged related to sustainability—funding CCT production and roll-out by government, offering a library "check-out" system for loaning CCTs to interested groups, continuing to support existing dialogues and conducting community actions, and strengthening partnerships with local service providers.

Accessing the CCT

The CCT has been adapted in seven countries and is available in 10 different languages (It is available for download from http://www.c-hubonline.org/resources/community-conversation-toolkit-hiv-prevention-english).

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