Komuniti Tok Piksa

Integrating Papua New Guinean Highland narratives into visual HIV prevention and education material

Final Report

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Final Report

KTP Phase 1

SUBMITTED BY

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ART	Antiretroviral Therapy
CHC	Centre for Health Communication
EHP	Eastern Highlands Province
HIV	Human Immunodeficiency Virus
KTP	Komuniti Tok Piksa
NAC	National AIDS Council
NACS	National AIDS Council Secretariat
NDoH	National Department of Health
NGO	Non-Governmental Organisation
PLWH	Person(s) Living with HIV (sometimes PLWHA)
PNG	Papua New Guinea
SHP	Southern Highlands Province
STI	Sexually Transmitted Infection
UOG	University of Goroka
UTS	University of Technology Sydney
WHP	Western Highlands Province
VCT	Voluntary Counselling and Testing

FIGURES

Fig1 KTP's project flow and methods 16
Fig2 KTP timeline 17
Fig3 Sampling of KTP's baseline study 18
Fig4 Baseline study: Opinions about condoms 28
Fig5 Baseline study: Sources of Information 29
Fig6 Baseline study: Places considered high risk for HIV infection 32
Fig7 Notes from the field by researcher Joys Eggins 69

TABLE OF CONTENTS

EXECUTIVE SUMMARY 1

1 INTRODUCTION 5

2 BACKGROUND 6

2.1. Contextualizing KTP in the National HIV response 8

2.2. The parameters of the project 9

3 PROJECT DESIGN 11

3.1. Brief overview 11

3.2. KTP methodology 11

4 BASELINE STUDY 18

4.1. Methods and Sample 18

4.2. Constraints and Limitations 25

4.3. Part 1: General Results 26

4.4. Part 2: Integrating critical issues raised by communities 31

4.5. Summary of key issues: the jumping off points for KTP 33

5 THE KTP FILMS: HARIM, LUKIM, PAINIM AUT 36

5.1. Wanem Rot Nau? - Enga Province 38

5.2. Mama Betty - Southern Highlands Province 40

5.3. Paul's Big Heart - Western Highlands Province 42

5.4. One More Chance - Eastern Highlands Province 44

5.5. Painim Aut - Chimbu Province 46

6 FINDINGS: SCREENINGS AND IMMEDIATE IMPACT 48

6.1 Dialogue and Reflection 48

6.2 Visual Learning and Identification 53

6.3 Community Mobilization and Individual Action 56

6.4 Advocacy and Ownership 60

6.5 Contributions of Findings to the National HIV & AIDS Response 63

7 DISCUSSION 67

7.1 An Indigenous Approach to Public Health Research 68

7.2 Involving Communities in Creative Media Production 69

7.3 Changing HIV and AIDS communication in PNG 71

8 DISTRIBUTION STRATEGY FOR FILMS 73

8.1 Facilitated Screenings and Film Advocacy Program 74

8.2 Mainstream Media 75

9 RESEARCH CAPACITY BUILDING 77

10 RECOMMENDATIONS AND CONCLUSION 79

11 REFERENCES 81

12 APPENDICES 82

12.1 Project and Publications Outputs Table 82

12.2 Baseline Interview Guide 83

12.3 Baseline Evaluation Questions 85

12.4 Consent Form Template 86

12.5 Tok Pisin Quotes Endnotes List 90

Executive Summary

This report presents the findings of the first phase of the Komuniti Tok Piksa (henceforth 'KTP') project, a research project commissioned by the National AIDS Council and AusAID under the large research grant funding round. The study, conducted by a team comprising researchers from the University of Technology Sydney and the University of Goroka, investigates the use of visual and creative tools in HIV and AIDS prevention and education in Papua New Guinea. Its initial run, from November 2009 to September 2011, focused on the PNG Highlands region, which is characterised by diverse and often-remote communities with low access to mass media.

The report accounts for the experiences and changes in experience of a diverse range of people across five PNG Highlands provinces involved in the KTP project. The report presents these experiences through narratives that encourage and facilitate reflection on people's involvement with KTP and its impact. These narratives are presented in both the traditional text-based report format and through the five films produced during the project. Most importantly, this report details how communities themselves contributed to the production and distribution of HIV prevention messages. Central here was creative collaboration among researchers, university personnel and students, and community representatives, which defines the unique KTP methodology. The experiences gathered through conducting KTP now provides a solid basis for involving communities in successfully using media tools for HIV awareness and communication in the culturally specific context of PNG. At the heart of KTP are adaptable and flexible communication processes that have proved effective in prompting attitudinal change in communities, and that also point to more long-term behavioural change.

Overall, KTP deployed a mixed-method research approach, prioritising qualitative and arts-based approaches to capture the complex narratives of PNG communities. First off, a baseline study using in-depth interviews was conducted in nine communities (n=118) to assess the existing knowledge level of communities about HIV and AIDS, and to form a basis for ongoing monitoring of views and attitudes in these communities. The principal findings of this baseline study are outlined in Chapter 4 of this report. Upon completion of the baseline study, community participants engaged in the collaborative production and visual exploration of stories around HIV and AIDS in their communities. A variety of creative products were produced, involving both community members, and students and staff from the University of Goroka.

This report then presents findings pertaining to the main five filmic outputs of the project. The film-making processes made tangible communities' experiences of HIV and AIDS, and the mode of their engagement with HIV and AIDS as social, personal

and medical problem: (1) reflection and dialogue (2) visual learning and identification (3) community mobilisation and individual action (4) ownership and advocacy. Each of these modes of engagement is elucidated in the Findings Chapter (Chapter 6).

Following evaluation of the initial screenings conducted in the communities, a film distribution strategy was developed to cater for PNG's unique media and communication landscape. This distribution strategy is designed to utilize both networks developed through the KTP project, and existing networks of health centres, education facilities and PACS, and these matters are outlined in Chapter 8 of this report. A major facet of the strategy is facilitated screenings and a facilitator's guide, which has been developed by KTP in consultation with local participants.

In course of its unfolding, KTP overturned a number of misconceptions surrounding HIV and AIDS, and reduced reluctance among community members to address these misconceptions. Community members tend to experience fear of the terminal effects of AIDS, leading to significant stigma and discrimination of PLWHA, and a reluctance among many individuals to deal with the threat of HIV and AIDS, including getting tested. Through addressing HIV and AIDS related issues in the films and during feedback discussions following on from film screenings, KTP has achieved considerable success with audiences in:

- Generating audience reflection and dialogue about HIV and AIDS related issues and practices;
- Mobilising communities to actively seek more information about HIV and AIDS;
- Encouraging audiences to address HIV and AIDS challenges and share practical strategies;
- Encouraging individuals to articulate their own risk behaviours, negotiate these with audience members and show willingness to change these behaviours;
- Introducing positive role models and stories of HIV and AIDS in communities through the films' central characters;
- Promoting HIV prevention in communities in language tailored to community members' understandings, interests and constraints;
- Prompting in many community members a desire to assist in the distribution and promotion of messages around HIV and AIDS, evident from their willingness to travel with the films and comment on them to various audiences.

A crucial component in the sustainability of KTP's approach was working to build research capacity at the University of Goroka. This was possible through the ongoing participation and training of early-career PNG students and researchers. These efforts at sustaining a sincere and practical student and local staff involvement have led to the establishment of a media research centre at UOG. Through the new Centre for Social and Creative Media the continuation of the HIV and AIDS-focused Komuniti Tok Piksa project is assured. Unique about KTP's approach is that local particpants were not only involved in using media technology in research processes, but tailored these processes to community needs and interests. These research processes were guided by a uniquely formulated indigenous research approach, emphasising the creation and maintenance of respectful and reciprocal relationships with community members. This sustainability and capacity building element of the project is described in Chapter 9.

Finally, this report provides insight into both the methodological and operational elements of the KTP project, and its unique and valuable findings from utilizing these processes. Through an unprecedented level of engagement with local Highland communities, KTP was able to gain considerable insights into and produce filmic outlets for community understandings, emotional responses, and experiences of HIV and AIDS. This process yielded a perspective often eschewed in awareness programs; a perspective that has the potential to change the way we approach health education in PNG, and one that may slow the spread of the disease in some of the most affected communities. This report presents the voices of local community members, health workers, educators and students, dissolving the barriers between participants and researchers through shared narratives, experiences and collaboratively produced visual materials.

1 Introduction

To date, HIV and AIDS prevention and education initiatives in Papua New Guinea have met a great variety of challenges. In 2003, Papua New Guinea was the forth country in the Asia-Pacific region to be recognized with a generalized HIV epidemic. In 2008, 99% of all HIV infections in the South Pacifc were in Papua New Guinea (UNAIDS, 2009, p. 2). Its cultural and linguistic diversity renders large-scale prevention and education solutions unworkable. Its huge geographic distances and large mountainous regions harbour yet further challenges, including the problem of reaching its many isolated communities, particularly in the Highlands region of the country. Communities are known to have strong culturally engrained taboos, rendering messages about HIV and AIDS inacapable of reaching vulnerable individuals. Finally, illiteracy rates are high and access to public media low, reducing the impact that media can have in raising awareness about HIV prevention.

To overcome these complexities, the KTP project deployed an innovative visual approach and resources that proved able to involve communities in addressing many of the challenges of communicating about HIV and AIDS. The project's approach and resources sought to adapt to a given community's situation, understandings and practices. KTP involved communities in the creation of prevention material to address the cultural diversity and the different levels of education of that particular community. This was achieved through the use of an indigenous (specifically PNG) framework that utilized existing and traditional community communication structures. PNG's strength in HIV and AIDS prevention efforts lies in the strong community linkages throughout the country, and it is these that KTP sought to use and capitalise on. Through its unique approach the project has been able to localise not only the production of education material but also, as this report shows, innovate its uses, relevance and distribution.

2 Background: Communicating HIV and AIDS Messages

Communication plays a vital role in the response to HIV and AIDS. Although ‘prevention communication’ has advanced considerably over the last few years, there is still considerable change that must occur to the way it is approached. The idea that simply providing information to previously uninformed populations will lead to behaviour change, the heart of many earlier efforts, has fast proven to be a misconception. Mounting evidence suggests that learning about HIV and AIDS and understanding one’s own risk is dependent on a number of social, cultural and economic factors. In other words, vulnerability to HIV is socially structured and conditioned. The interpretation of risk and people’s behaviour is not always informed by rational thinking and interpretation of information about HIV and AIDS culturally specific (Lie 2009).

In Papua New Guinea, this cultural specificty impacts significantly, largely contributing to the ineffectiveness of most prevention campaigns (Butt and Eves, 2008). As Reid has highlighted, the driving forces of the epidemic need to be determined (Reid 2008), and in the case of PNG this is a huge diversity of social and cultural issues, across multiple cultural groups.

Isolated approaches to HIV communication (for example focusing on messages about high-risk groups in the mass media) have also lost favour as an awareness and prevention approach, at times proving to increase stigma and discrimination rather than prevent it (Lie, 2009). Addressing HIV and AIDS today requires a multi-level approach; awareness alone will not lead to behaviour change. Working to foster existing support systems that provide people with choices about their health however, are important, and projects that work to strengthen these systems are more likely to succeed. HIV communication is inherently complex, involving numerous communities, individuals and stakeholders in working towards the same goal – the reduction of HIV infections. For prevention campaigns to resonate, they must address each of these groups. For an individual to feel comfortable learning about and questioning HIV, for example,

they must feel supported by the peers, networks and communities that surround them.

In an attempt to address these misconceptions and imagine new ways of approaching HIV and AIDS communication, Lie (2009) argues for three wider shifts

1. a shift away from mainstream HIV and AIDS mass media campaigning towards culturally appropriate responses to HIV and AIDS and the use of local community media
2. a shift away from seeing HIV and AIDS primarily as a health problem towards seeing it as a development problem and
3. a shift from a primary focus on behavioural change to a primary focus on social change.

Each of these conceptual shifts moves toward forming a basis for self-propelled change, rather than imposing an external idea of change onto others. Communication does not come from one or the other direction. Rather, it exists in the middle, between people and culturally embedded. Looking at media, for example, the edutainment model has shown significant success, with programs like Soul City and Love Patrol gaining wide and loyal audiences. This can be largely attributed to the fact that while these programs rely on mass media, they also take into account the culture and existing social structures for communicating information around HIV/AIDS through story telling and character development. In the case of Love Patrol, the organisation has also opened a number of clinics to support the series. A significant benefit of media is that it does not exist on its own; it relfects a societies' communication practices and behaviours and must be integrated within a number of initiatives.

Every country's ecology is unique and culturally specific. Communication strategies must therefore be developed locally to be effective, incorporating a variety of levels to target a variety of audiences (D'Silva, Hart and Walker, 2008). They must also adapt to the changing nature of people's communication patterns. This is particularly evident in Papua New Guinea, which has experienced an unprecendented influx of communication networks in recent years, such as the expanding mobile phone network and the increase of haus piksas in rural communities. These changing communication practices increase the need for evidence-informed and adaptable approaches. The question of how to disseminate effective HIV and AIDS awareness promoting behavioural change remains a complex one, unlikely to have a simple answer. In Papua New Guinea, the role of communication in prevention and education around HIV and AIDS remains significantly underexplored. Studies must explore their impact and be guided in the context of the PNG National HIV response. If approached in this way, communication strategies have the potential to address a wide range of cross-cutting issues. It is in this context and changing communication cultures that KTP situated itself.

2.1. Contextualizing Komuniti Tok Piksa in the National HIV response

According to the PNG National HIV & AIDS Strategy 2011 – 2015, the total number of people living with HIV was estimated at 34,100 in 2009 (National AIDS Council of PNG [NAC], 2010, p. 15). Despite an improvement in knowledge about the patterns of the pandemic, NAC notes that there is still a lack of epidemiological and behavioural data to steer the national response, specifically in planning for prevention initiatives (2010, p. 19). An ineffective prevention repsonse to date is considered the "most significant gap in the national repsonse" (p. 21). Prevention is considered is a key priority in the NACS 2011-2015 HIV and AIDS strategy.

Here, it is a strategic goal to reduce the risks of HIV transmission, to address the factors that contribute to vulnerability of HIV transmission of specific groups and create an enabling enviroment for HIV prevention. Stigma and discrimination remain high in Papua New Guinea, impacting considerably on the way HIV/AIDS is perceived. This does not only impact the way people living with HIV are treated, but also contributes to low testing rates and makes prevention initialtives more difficult, prompting a lack of interest in learning or wanting to know about HIV and AIDS. To address this, high-prevalence areas must be targeted, and gender-based disadvantages must be taken into account. The inclusion and utilization of PLWHA in prevention campaigns is also a NACS priority area (p. 23), particularly as this is a group that a large majority of previous prevention efforts has eschewed.

Previous awareness campaigns in PNG have faced enormous challenges, for the reasons discussed above; diversity in cultural and traditional beliefs and modernization being one of the most pressing and pervasive. NACS has undertaken a number of initiatives to create awareness in many church-based organisations (CBOs), non-governmental organisations (NGOs) and corporate organisations, developing various strategies aimed at each of these significant groups. One the major campaigns has been the ABC of HIV & AIDS. The strategic application of Abstinence, Being faithful to one partner, and using Condoms is being lauded as the cause of a decline in HIV and AIDS prevalence in other countries such as Uganda (Berry and Noble, AVERT.org). Despite the success of this approach in countries that share a diversity of cultures and languages, however, the ABC model in PNG has faced considerable lack of engagement from relevant stakeholders and various social undercurrents affecting the ability of this campaign to reach and impact high-risk groups.

Edutainment has shown some success in PNG, in both theatre and television drama. People appreciate information combined with entertainment, particularly as it reaches a largely illiterate population who might not have regular access to mass media (Corrigan, 2006, p. 4). Moving away from mass media campaigns, some initiatives have sought to use a more creative approach as a means of both awareness raising and research. VSO Tokaut AIDS Awareness Community Theatre Project is an action research project that trialed community-led theatre in rural areas (Corrigan, 2006, p. 5; Levy, 2008, p.1). The visual quality of theatre defied language barriers, as messages were played out to reflect the communities, and the realities of their day-to-day lives. Similarly, the approach of Community

Conversations has been adapted by the National AIDS Council. Community Conversations works to facilitate conversations within communities to identify the driving forces of the epidemic, specific to local settings (Reid, 2007).

The success of these recent research and awareness initiatives lies in their localized approaches, appropriations of technology, and valuing of community experiences and beliefs as ways of both facilitating message creation and increasing knowledge among participants. The importance of such approaches is further reinforced in a recent literature review (King and Lupiwa, 2008), which showed that they are critical to addressing cultural diversities, sensitivities and fears, all of which are delaying the success of the national response to HIV & AIDS.

2.2. The parameters of the project

Komuniti Tok Piksa has been set up as a pilot project to strategically investigate the use of audiovisual and participatory tools within the context of HIV and AIDS in Papua New Guinea. In 2009, the Highlands region accounted for 60% of all HIV positive cases in PNG (NACS 2010, p. 17). Despite the fact that the prevalence in the Highlands is said to be experiencing a downward trend (NACS 2010, p. 16) there remains much uncertainty around these statistics. The region is characterised by people living in remote communities and experiencing a lack of access to health services and testing facilities. While people in urban areas might be responsive to mass media campaigns because they are frequently exposed to them and have a higher level of media literacy, rural areas require an approach to media that is more localized, and more specific to their own culture to compensate for lower levels of media literacy. People in the highlands region rely more on interpersonal communication for information (Maibani-Michie et al. 2007), and that is often information that is specific to their cultural understandings and habits.

KTP, to address the unique needs of Highlands remote communities, sought to develop a PNG specific methodology that could integrate media tools and media development in culturally appropriate processes. Aiming to capitalise on the successes of such projects as VSO Tokaut and Community Conversations, KTP began with a creative and community-focused design, choosing to work with audiovisual and film mediums due to their potential to reach vast national and international audiences, something local theatre and community conversations alone are unable to achieve. From the outset, producing educational material that was both singularly local and had the potential for global publication and distribution was at the forefront of KTP's design.

Another cornerstone of the KTP method was a sincere and sustained focus on capacity building, both within the education facilities involved in the project, and within communities themselves. Thus, KTP hired staff, UOG students and community members were all actively involved in the project design and execution throughout the process, and, thanks to a newly eatablished media research centre at UOG, they will continue to be involved into the future. These processes were developed collaboratively between the KTP team, UOG student and staff researchers, and community members, with a focus on ensuring long-term PNG community 'ownership' of the resources.

3 Project Design

3.1. Brief overview

The KTP project emerged from the fundamental idea that sustainable and meaningful approaches to slowing the spread of HIV and AIDS must be developed by communities themselves in order to be successful (see Gibbs 2008). Once attuned to the general risk, communities and individuals in the communities will have to develop the skills and strategies to limit infection. To facilitate this process, a creative research approach was needed to move beyond the collection and analysis of research data, and involve participants directly in the creation of prevention messages that can subsequently be used to educate others in PNG.

KTP's research approach was designed by combining participative research with video feedback methods (Iedema et al 2006; Thomas 2011). This unique approach proved able to respond to the specific conditions and challenges of complex situations, such as accessing, communicating with and involving communities in media production across the Highland regions. The resulting KTP approach marks an unprecedented achievement in the PNG health promotion and education landscape: a uniquely Papua New Guinean method of research and education that involves communities and local health and education networks. Indeed, as much as possible, it was these groups that designed, executed and evaluated the KTP intervention. The diversity of voices and experiences elicited through KTP forms a rich collection of narratives that captures the varying emotional and behavioural responses to HIV in PNG. Through community involvement, KTP also achieved articulation and community consideration of people's tactical responses to managing relatives or friends living with HIV, and containing the threat of HIV.

The cornerstones of the KTP research method are ongoing and meaningful consultation with and involvement of local populations, sustainability of methods beyond particular project timelines, iterative consent from all parties to participate, and a core value system that emerges from local conditions. In the case of PNG, early consultation with local student researchers and communities identified respect, reciprocity, and relationships as three core values across PNG society, and the KTP method was developed with these values in mind. The next section of the report details the project design developed to reflect these methodological concerns, which will be expanded on in a later section. Here readers will find a succinct, step-by-step account of the various elements set in motion during KTP's timeframe.

3.2. KTP methodology

Establishment of project team & refinement of method

The first stages of KTP involved the establishment of a working project team, and the refinement of the method to be used in engaging local communities. These early steps were vital in ensuring the project as a whole continued to reflect the issues and values identified by local researchers and communities as of particular significance for HIV and AIDS education. Following the establishment of appropriate formal institutional links to the University of Goroka, the initial core KTP team sought to recruit the local staff and students that would form the backbone of the 'on the ground' work of the next 18 months.

This process occurred as follows:

» Recruitment of one masters, one honours, seventeen undergraduate students, and

numerous junior staff researchers to the project team;

- Discussions around the inclusion of students' individual research interests in the overall KTP project. This included the students' using KTP's visual methods in their own planned coursework research in nearby communites;
- Involvement of students and staff in a series of workshops to refine their research and visual production skills. These workshops were held between May and June 2011, and included workshops on ethnographic action research, visual research, Melanesian values, HIV and AIDS, and the consolidation of these various elements in KTP's methodological approach (see KTP Annual Report 2009/10);
- Following these introductory May/June sessions, an intensive one-week practical workshop was conducted to prepare participating students for using the sound and camera equipment provided by the project.

Community introductions; student research; piloting of KTP method

The second stage of the project saw the commencement of the 'on the ground' work that would establish the community relationships and methodological procedures that would eventually lead to the production of five films about HIV and AIDS in Highland PNG. The most significant aspects of this stage were to ensure that the communities with which the KTP team would work to produce the films had a full understanding of the aims and approach of the project, that the stories eventually selected appropriately reflected the voices and contributions of these communities, and that the method being iteratively developed was both appropriate and effective in these settings.

Initial community entry and student research ran as follows:

- UOG researchers identified the community where they had chosen to conduct their research. This was usually due to an existing relationship the student and/or UOG researcher had, ensuring or facilitating their entry into the group. A community introductory meeting was then held with the community, UOG researcher, and KTP team. The project was explained - both the students' specific focus, and the larger scope of KTP - and initial consent to participate was gained from the community;
- A baseline study was then conducted in participating communities. Observation and individual interviews were conducted to assess the general level of HIV and AIDS education and knowledge in the community (see Chapter 4 - Baseline Study of this report). From this study, researchers worked with the community to design project plans appropriate to their level of knowledge, the way in which information is disseminated, and the particular interests of the community;

- Students' and staff were then ready to begin their own research projects within the communities. These projects varied, but what they had in common was their use of the KTP visual method, and the focus on close collaboration with the communities. Ongoing feedback was incorporated to ensure participation of community members. The individual projects are outlined in the Appendix;
- Students and staff met regularly with the KTP core team to discuss any issues or challenges they had encountered during these initial community engagements, so that the design being piloted could be iteratively evaluated and refined. This included returning to the communities with the visual products and facilitating a community feedback session to ensure the participants remained satisfied with the process and the direction taken, and to ascertain whether they were interested in maintaining their involvement with KTP.

The principal outputs and achievements of these individual research works are outlined in the Appendix. Here we describe the project's short film, a 'photo voice' workshop and exhibition, a music workshop and an HIV and AIDS awareness song.

Final output production, ongoing evaluation and refinement of method

At the completion of these pilot projects, the KTP team turned its attention to the planning and production of what would ultimately represent its final outputs and deliverables: five films reflecting experiences of HIV and AIDS in Highland communities.

This process was facilitated as follows:

- Discussion of the pilot projects to assess which communities were most effectively engaged with KTP and had a desire to continue to work with the team and the visual methods. This discussion also addressed any stories that had

made a particular impression. Through this process, in consultation with student and staff researchers and communities, and given existing time and resource constraints, five communities were identified to continue production of their stories with KTP;

» These communities were again approached to gain updated consent for the particular stories and characters. Existing footage was used to produce a rough cut with which to consult the participants and wider community;

» This footage was screened back to participants and communities and a feedback session ensured consent was gained from everyone as the process unfolded. Each session gave participants, community members and KTP researchers the chance to engage in dialogue. Dialogue addressed HIV and AIDS issues raised in the film, and expanded to address issues affecting the broader community. This process was critical to the team's final editing decisions, including narrative choices, visual markers and sound cues;

» Having obtained the feedback from communities, the KTP film teams discussed the most effective ways of including it in the films. The team also returned to communities to shoot any additional footage if needed, and produced a penultimate edit of the films which was once again taken back to the community for consultation and sign-off.

These stages, although similar in approach, inevitably took different forms in each community, depending on the level of involvement, interest and understanding of particular regions. The details of the individual films are outlined in section 5 of this report. In regards to the planning and approach of the team, however, the method remained the same.

Final consent, early evaluation

In line with the iterative consent at the core of the KTP method, final community consent was required. This process involved a KTP screening team travelling to the five Highland provinces with

the student researchers initially responsible for the community introductions.

The final consent and early evaluation process was executed as follows:

» Screenings of the penultimate films were held in each participating community. The film was first screened to the 'talents' or participants alone, to gain their consent to conduct a wider community screening and to allow them to request any changes to the film, or raise any issues they had encountered as a result of their involvement. The film was then screened publically (where consent was gained – for KTP in all cases) to the wider community, and discussion about the film, its issues, and HIV and AIDS facilitated;

» Discussions after the film occurred in three stages. First came a public comment forum, facilitated by a student researcher or community leader, during which open-ended questions were asked and general comments encouraged. Communities were then asked to divide into gender and age groups (young men, married men, young women, married women) in order to conduct focus groups in an environment where people would feel confident to speak despite certain cultural taboos. A series of targeted

questions were asked during these sessions that sought to identify which elements of the films resonated most strongly, what did not, if the messages were understood, if they were appropriate, and if they were likely to be effective for others elsewhere (each stage of which was recorded for later reflection and analysis);

» Following this process, the footage of participant and community comments was taken back by the team and as far as possible incorporated into what would be the final film product of each community. Communities were also consulted about the ways in which they would like the films to be disseminated.

Completion of formal project and film dissemination

Having produced the five films that represented the final deliverables of the KTP project, the team turned their attention to the evaluation and dissemination of the film products.

This final stage of KTP involved:

» Preparation of this report providing a project overview;

» Development of a refined dissemination strategy inclusive of community and participant input. This dissemination strategy is outlined in detail in Chapter 8 of this report;

» Analysis of research data evaluating the project and films, which sought to identify the most effective elements of the films and the KTP methodology as a whole, in order to ensure that future uses of this unique methodology emphasise the strengths and improve on challenging elements.

The KTP methodology, although unique in its specific design and execution, drew on a number of existing research paradigms in its development. The various distinct yet interwoven stages of the project, for example, can be usefully considered in the context of participatory action research (PAR), which places emphasis on a cycle of reflection, and is centred on community engagement. The PAR cycle involves first observing the intended study site, reflecting on this observation, planning the research in consultation with community members, acting on this plan to execute the specific goals of the project, and once again returning to the observation and reflection stages. KTP's iterative consent and project design, ongoing community consultation, and focus on participant-driven content aligns with this PAR cycle, however it expands on it in two ways. First, KTP goes beyond its original community contacts to reach out to groups elsewhere. Second, KTP pushes the limits of 'research' to include inquiry into collaborative production of creative output and of traditional, community, or non-professional knowledge. This blurs the traditional line between 'researcher', 'trainer', 'researched' and 'trainee' in ways that anthropological and development disciplines are only gradually starting to utilise. KTP thus created a space for collaboration between these different participant groups with results including creative productions and public events involving community members, artists, researchers, collaborators and local audiences.

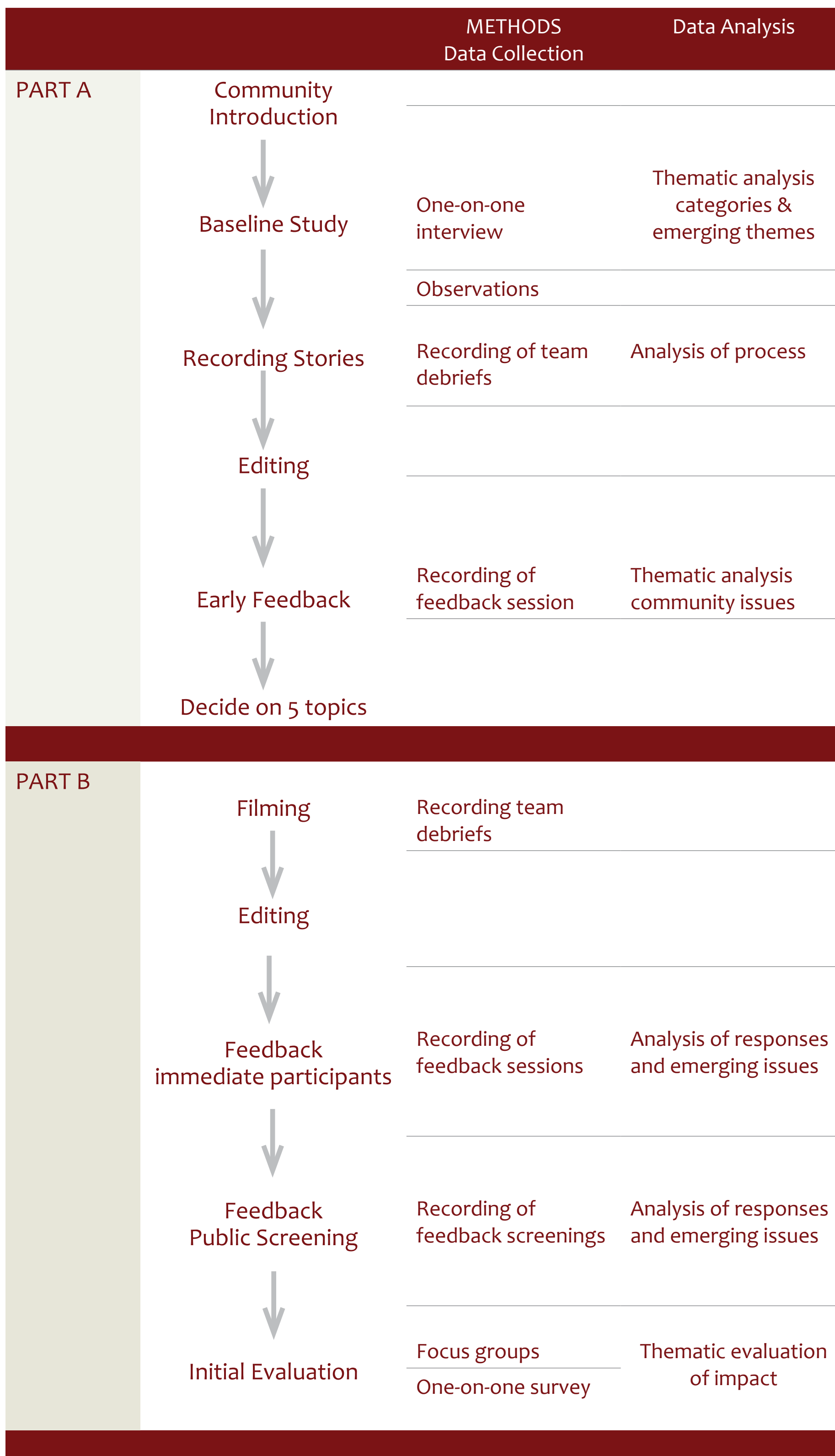


Figure 1: KTP's Project Flow and Methods

KTP Timeline

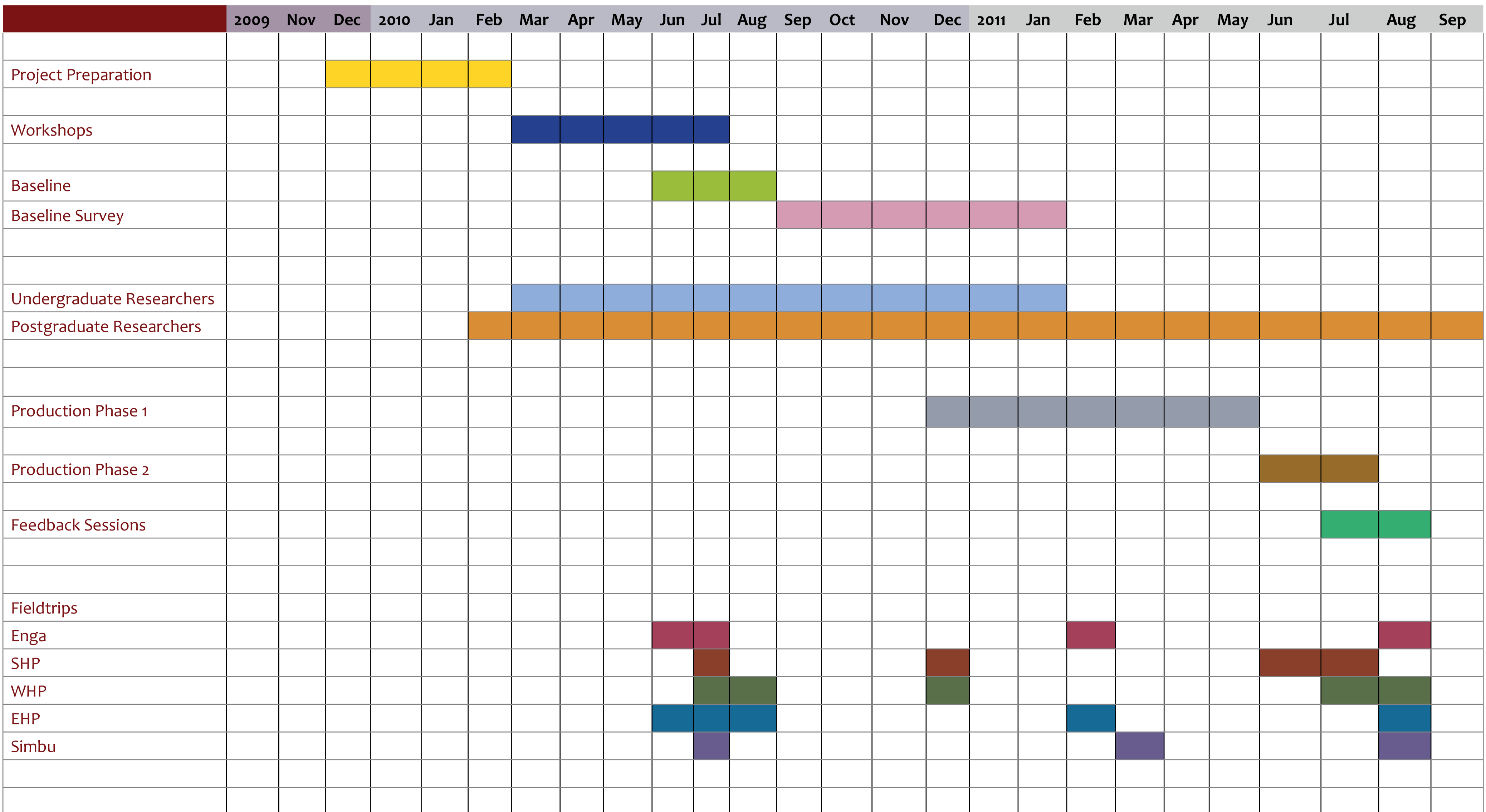


Figure 2: KTP Timeline

4 Baseline Study

A baseline research study was conducted by the KTP project in 2010. The baseline research served to support KTP's initial work in examining the use of visual narratives around HIV and AIDS in PNG Highland communities. The results presented here give a picture of the trends in terms of communities' level of knowledge around HIV and AIDS, associated perceptions and social narratives that impact on people's behaviour, decision-making processes and their understanding of their community and individual risk.

This baseline study forms the basis of KTP's education campaign that uses films (and subsequent related dialogue) as its main method of communication. The baseline study served to identify existing knowledge as well as sensitivity about communication about HIV and AIDS: the ways things are said and talked about. Further, these results allowed the research team to monitor progress in the participating communities through KTP's continuing engagement with these communities.

4.1. Methods and Sample

In order to capture community narratives and the way people themselves make sense of the impact of the HIV epidemic, qualitative methods were prioritized in this baseline research. An interview guide was developed, adopting an approach previously undertaken by the VSO Tokaut AIDS project (Levy 2005). In-dept interviews were conducted with individuals prior to any intervention by KTP team members. Facilitators were instructed to

Location	Province	Male	Female	Overall
Communities				
Aiyura	EHP	6	4	10
Okapa	EHP	5	5	10
Mu	Simbu	7	4	11
Kerowagi	Simbu	8	6	14
Hulpin	SHP	9	5	14
Koroba	SHP	4	3	7
Kuruk	WHP	8	9	17
Ruti	WHP	12	12	24
Niugke	Enga	7	4	11
TOTAL		**66**	**52**	**118**

Figure 3: Sampling of KTP's baseline study

be guided by people's responses while covering the themes in the interview guide.

Nine highland communities were involved in the study from June – September 2010. In each community a variety of people with different roles in the community were selected. In each community 10-15 participants were usually selected, with a total of 118 particpants interviewed. Overall gender was aimed at being balanced, however, it was often found that men were more forthcoming in talking to team members, which resulted in a slightly higher percentage of men participating in the interviews.

All interviews were transcribed in Tok Pisin, imported into qualtitative data management and analysis software Nvivo and coded according to existing and emerging themes.

Community Profiles

Western Highlands Province

Eastern Highlands Province

Simbu Province

Southern Highlands Province

Enga

Kuruk

[Mul District]

Kuruk village is located less than a kilometer from the Okuk Highway and 15 minutes drive from Mt. Hagen city. There is only one operating trade store servicing the community, a primary school including a health centre within walking distance, and a VCT centre some 20kms away. Like the other Highland communities, Kuruk relies on a mixture of coffee, garden crops and formal employment for a living. The Catholic Church is dominant in the area and church groups tend to be more organized and mobilized than other social structures. Mobile phones are the most regular form of communication, with people speaking Melpa, Tok Pisin and partial English. People access newspapers, radio, television and there are three video houses in the area.

Ruti

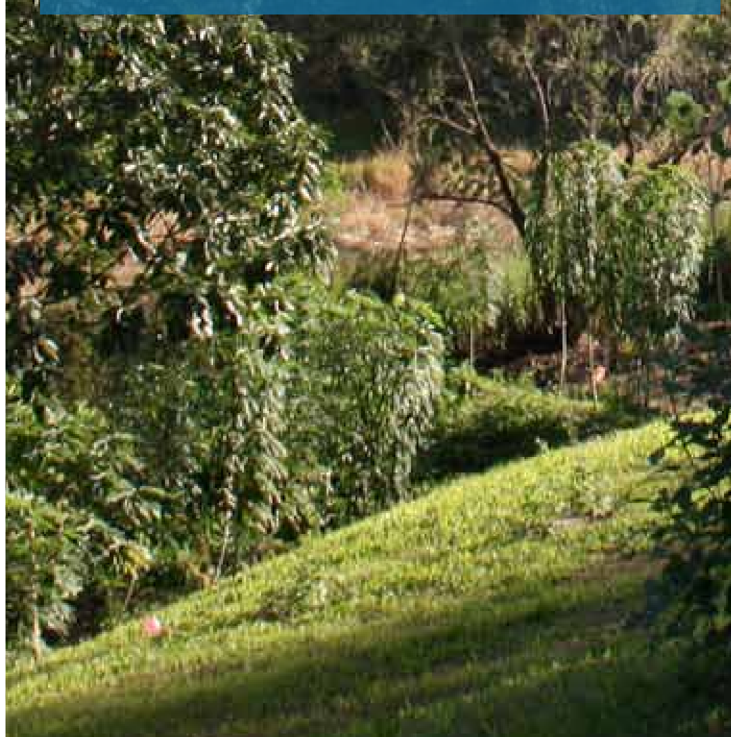
[Dei District]

Ruti is a small village of about 300-400 inhabitants who share a similar language break up as Kuruk. There is one elementary school, one primary school and a secondary school further away in Kitip (15 minutes drive). These facilities also house the community's health centre and other smaller office-type services (such as typing, photocopying, etc.). Ruti sits beside the old Highlands Highway, now refurbished and an increasingly key route (back-road) from Hagen city to Banz town and further down. There is no electricity in Ruti and people rely on coffee, garden crops and some on formal employment for a living. Groups within the dominant Lutheran Church and others are highly organized compared to social networks. Nonetheless, there are political affiliations that sometime impact community relationships. Community mobilization occurs during key events such as election periods, sports, bride price, school fee contributions and compensations among others. Media access is consistent with people accessing mainstream media along with entertainment from three video houses. Mobile phones are also highly utilized in this community.

Anamunampa, Aiyura

[Obura/Waninara District]

Anamunampa is located about 15 minutes from Kaintantu town, but also relies on four operational trade stores for its goods and services. With the main Okuk Highway about 7km away, Anamunampa has access to electricity, a health centre and a VCT centre, both of which are within 2km. The village sits in the same valley as the Summer Institute of Linguistics and the National Agricultural Research Institute, which includes the Aiyura National High School. With a population of about 5000, the dominant church is the Seventh Day Adventist (SDA). Languages used include Kasup (local language), Tok Pisin and (partial) English. The community relies on garden crops, cash crops such as coffee and some on formal employment to earn their living. The community is organized around church, community and political leaders. There is a strong youth group presence in the Church, with various peer groups forming during social/seasonal times for sports, politics, and other community events. Anamunampa members consistently access media and telecommunications products, with the mobile phone being a regular form of communication. People access newspapers, radio, television and social gatherings are centered around activities such as meetings, bride price, compensations, deaths and school fee contributions.



Ibusamoke

[Okapa District]

Ibusamoke is the one of the furthest away EHP communities visited, located 90km from the main Okuk highway (1hr 30 min drive from Goroka town). The road conditions are treacherous at some points and there is a government station (50 km away) providing policing, a health centre, VCT clinic and trade stores. Other services within walking distance of Ibusamoke are an elementary to grade ten school and two operational trade stores. People are largely subsistent and use garden crops and coffee to earn money. The population of more than 5000 speaks the North Fore language, Tok Pisin and limited English. The Seventh Day Adventist church is dominant, again with groups highly organized within it. Other social institutions such as sports clubs are non-existent, though the town does have a very inactive women’s group. Media use is sparse, with two of its video houses now closed, no television signal or sets, and radio and newspapers seldom accessed. Mobile phones continue to be the most used form of communication. Ibusamoke people, like other communities, do mobilize for cultural events such as bride price or compensations, death and also church-related activities.

Mu

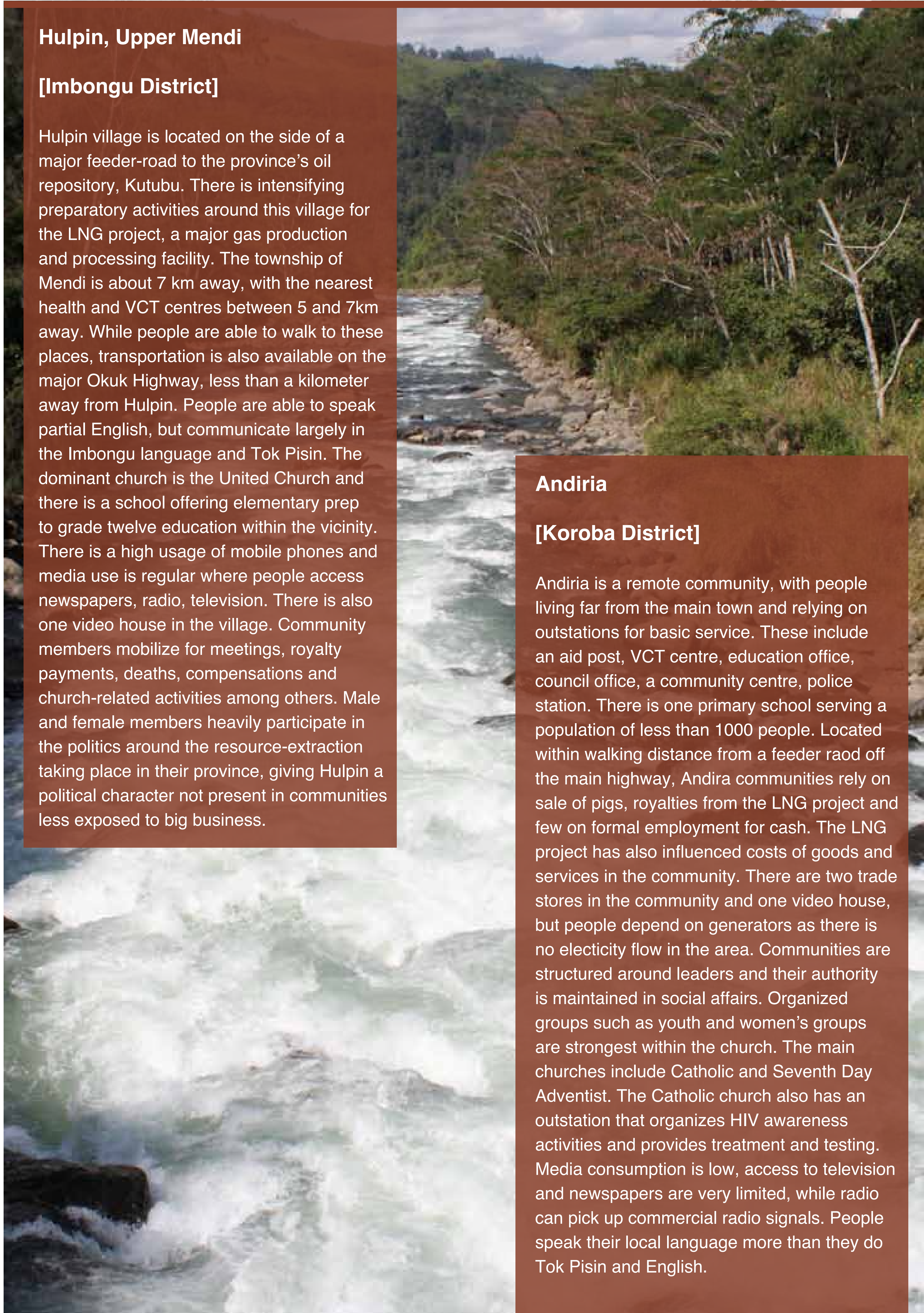
[Sinasina/Yongomugl District]

Another heavily populated community in Simbu, Mu village has around 23,000 people who speak the Tabare (Ka-Kondo and Ka-Malda dialects), Tok Pisin and partial English. The major church is the Evangelical Lutheran Church of PNG (ELC-PNG) with youth and women's groups highly active in church-related activities. There are pockets of political factions in Mu village and seasonal events such as coffee or elections contribute to problems associated with HIV and social issues. Mu travel up to 10 km to use the nearest health and VCT centre, and Kundiawa town is some 20 minutes drive from the village. There is a regular consumption of media products, with mobile phones being the most frequently used telecommunications service.

Gena

[Kerowagi District]

Kerowagi is heavily populated, with an estimated 15,000 people living in the area. People speak the Kuman language, Tok Pisin and limited English. Despite being about 2 km away from the main Okuk Highway and about 30 minutes driving time from Kundiawa town, there is no electricity. The health centre is within walking distance, and the nearest VCT centre is about 5 km away. Inhabitants of the community are largely Lutheran followers and there is one school providing elementary prep to grade twelve education. People rely on coffee and some on formal employment for a living. The community has both church and political leaders. Peer groups such as youth and women's groups are organized within churches, and ad hoc social sports like rugby league, volleyball and basketball are frequently played. Media access is average, with people using newspapers (seldom), radio, television, and mobile phones (majority). There are three video houses in the area. The community organizes itself around social events, but political factions are very common.



Hulpin, Upper Mendi

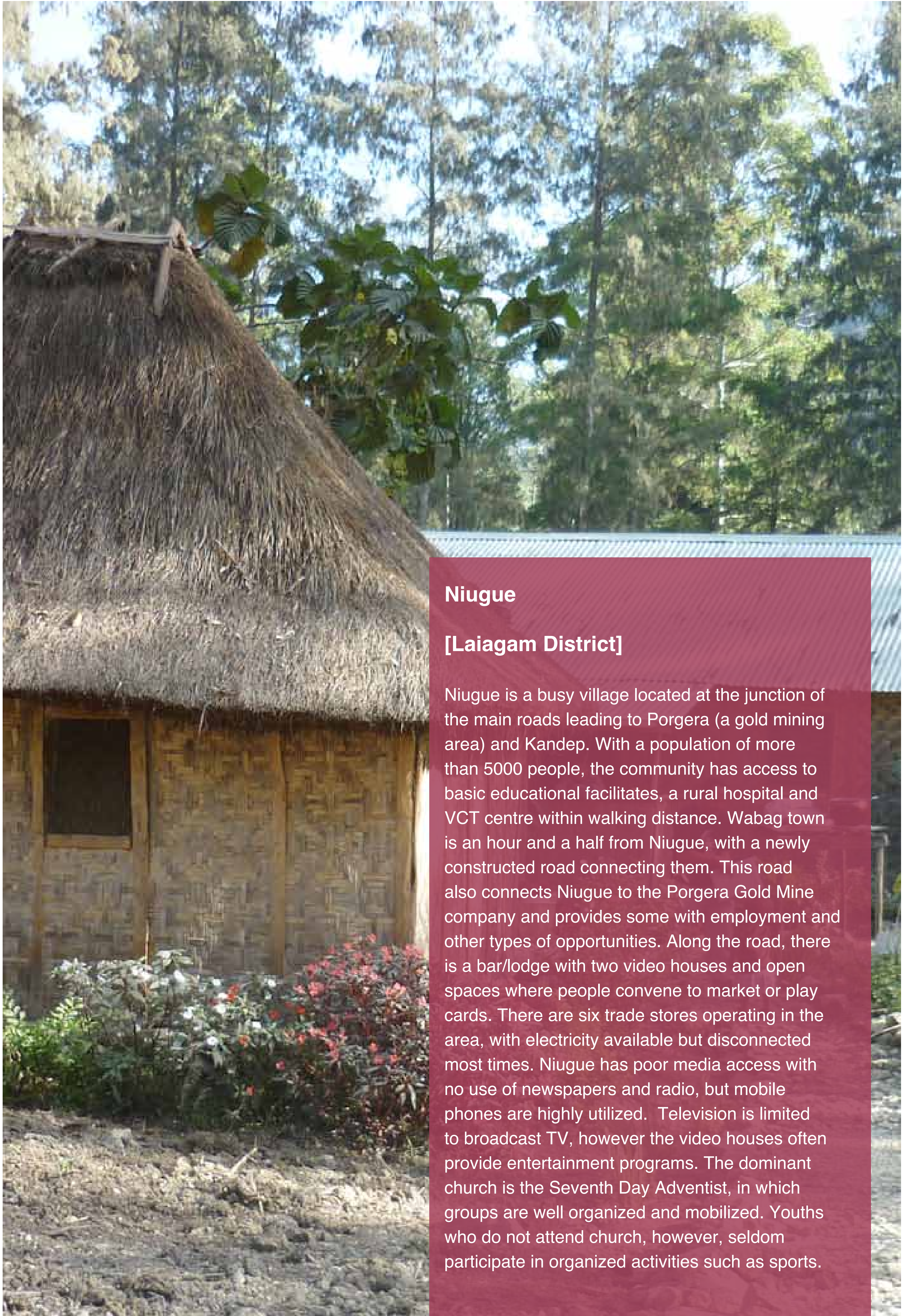
[Imbongu District]

Hulpin village is located on the side of a major feeder-road to the province's oil repository, Kutubu. There is intensifying preparatory activities around this village for the LNG project, a major gas production and processing facility. The township of Mendi is about 7 km away, with the nearest health and VCT centres between 5 and 7km away. While people are able to walk to these places, transportation is also available on the major Okuk Highway, less than a kilometer away from Hulpin. People are able to speak partial English, but communicate largely in the Imbongu language and Tok Pisin. The dominant church is the United Church and there is a school offering elementary prep to grade twelve education within the vicinity. There is a high usage of mobile phones and media use is regular where people access newspapers, radio, television. There is also one video house in the village. Community members mobilize for meetings, royalty payments, deaths, compensations and church-related activities among others. Male and female members heavily participate in the politics around the resource-extraction taking place in their province, giving Hulpin a political character not present in communities less exposed to big business.

Andiria

[Koroba District]

Andiria is a remote community, with people living far from the main town and relying on outstations for basic service. These include an aid post, VCT centre, education office, council office, a community centre, police station. There is one primary school serving a population of less than 1000 people. Located within walking distance from a feeder raod off the main highway, Andira communities rely on sale of pigs, royalties from the LNG project and few on formal employment for cash. The LNG project has also influenced costs of goods and services in the community. There are two trade stores in the community and one video house, but people depend on generators as there is no electicity flow in the area. Communities are structured around leaders and their authority is maintained in social affairs. Organized groups such as youth and women's groups are strongest within the church. The main churches include Catholic and Seventh Day Adventist. The Catholic church also has an outstation that organizes HIV awareness activities and provides treatment and testing. Media consumption is low, access to television and newspapers are very limited, while radio can pick up commercial radio signals. People speak their local language more than they do Tok Pisin and English.



Niugue

[Laiagam District]

Niugue is a busy village located at the junction of the main roads leading to Porgera (a gold mining area) and Kandep. With a population of more than 5000 people, the community has access to basic educational facilitates, a rural hospital and VCT centre within walking distance. Wabag town is an hour and a half from Niugue, with a newly constructed road connecting them. This road also connects Niugue to the Porgera Gold Mine company and provides some with employment and other types of opportunities. Along the road, there is a bar/lodge with two video houses and open spaces where people convene to market or play cards. There are six trade stores operating in the area, with electricity available but disconnected most times. Niugue has poor media access with no use of newspapers and radio, but mobile phones are highly utilized. Television is limited to broadcast TV, however the video houses often provide entertainment programs. The dominant church is the Seventh Day Adventist, in which groups are well organized and mobilized. Youths who do not attend church, however, seldom participate in organized activities such as sports.

4.2. Constraints and Limitations

Undertaking research in the Highlands of Papua New Guinea comes with numerous associated logistical and cultural challenges. Much of the communication with communities relies on interpersonal contact, which requires spending time in each community prior to undertaking any research. It can therefore be difficult to find a balance between cost-effective research and research that delivers reliable results and happens with participation of the community. Due to the remote location of some communities, difficulties in transportation, accommodation and time-expenditure were at times encountered, interrupting anticipated processes.

The baseline study was conducted by researchers from UOG, many of whom were undergraduate and postgraduate students. A training workshop in conducting the baseline study took place at UOG in June 2010, and the baseline was developed in collaboration with participating researchers. Due to the large number of different researchers and their relative inexperience, variations have occurred in the way the baseline questions were asked, how the conversations were conducted, and how results and other observations of these conversations were communicated back for inclusion in the overall baseline analysis. Despite the challenging elements of this aspect, KTP's ongoing commitment to buiding research capacity in UOG neccessitated such uncertainty and this learning curve, and proved in the end to be a worthwhile challenge. Further, due to the fact that the baseline was conducted in order to identify respondents' various personal narratives around HIV and AIDS, some variation and flexibility in method is acceptable, perhaps even desirable, allowing for interviewees to guide the course the data collection took, and reflecting the idiosyncracies and complexities of these narratives.

In regards to the actual conversations, we point to some limitations in the baseline method. It is likely that there were variances between responses received from men and those from women. Women in PNG communities are often shy in public discussions, particularly when speaking about taboo issues such as HIV, AIDS, and sex, whereas men are confident to talk, traditionally holding more power in community life. In an effort to counter-balance some of these risks and capture a robust interview sample representing all critical demographics, female respondents

were interviewed by female researchers and male researchers were interviewed by male researchers. In addition, due to the relational nature of the project and the selection of the sites by existing student relationships, interviews were often conducted by a researcher who knew the person being interviewed personally. This may have caused them to say less, or more, than might otherwise have been the case. Finally, most interviews were conducted in Tok Pisin and transcribed in Tok Pisin. However, some interviews were conducted in Tok Ples and then translated into Tok Pisin. Inaccuracies may have occured in these translations from Tok Ples.

In the following analysis, we first present general results that were found to be common to the nine locations involved. In the second part, locations are investigated based on their specific community context and trends are identified in terms of community indicators, specifying the factors that lead to a sometimes higher level of awareness and lowered risk behaviours among certain participants.

4.3. Part 1: General Results

This section provides an overview of trends that were identified from the 9 participating communities.

General Knowledge about HIV and AIDS

The most common Tok Pisin terms (and language translations) in use for HIV and AIDS are *'sik aids'* or '*sik nogut*'.

> *I'm not sure what others think, but in my opinion, the word HIV/AIDS refers to a bad disease - that's what people say. A bad virus that lives in a person's body.*[1] *(Married man, EHP)*

> *In the Enga language, we describe AIDS as bad sickness, meaning that there is no cure and so it kills people.*[2] *(Married woman, Enga)*

> *When people say HIV/AIDS, the first thing I think of is that it is a bad sickness. This sickness kills people and how are we going to stop this disease from entering our body? I often think about this.*[3] *(Married woman, WHP)*

HIV or AIDS is often referred to as a disease with no cure or no medicine. More than 38% of the respondents associated the disease with death.

> *I know that there is no cure for this sickness. I believe that having AIDS means death.*[4] *(Young woman, Enga)*

This was often backed up by saying that they knew people who had died of it. It is said to be spreading fast (24%) and that it is a foreign disease (12%).

> *AIDS has spread like bush-fire in our province, community and villages. How are we going to stop this sickness? And how are we going to avoid contracting it?* [5] *(Young man, WHP)*

Many people expressed that they are scared of HIV (Tok Pisin term used: '*poret*'). As a consequence of this people are also scared to get tested.

> *I hear about it and I'm afraid. There is no going back when you have it. We hear through awareness that it kills a lot of people. I am really scared of this sickness.*[6] *(Young man, EHP)*

> *I don't know, but people say not to share shaving machines or tooth brush. Another thing I know is that you can catch the virus through sex or if you are promiscuous. This is what makes me afraid of going near or using someone else's things.*[7] *(Married man, EHP)*

I am afraid of this disease. I became more scared when I heard that the sickness had come to our community. Now I don't live with people who have this AIDS sickness.[8] *(Married man, Enga)*

Responses about general knowledge of HIV and AIDS were overwhelmingly negative. Fear and lack of understanding were frequently expressed. Very few knew the difference between HIV and AIDS. People who had been educated at schools were predominantly the only participants who could correctly state the difference between HIV and AIDS.

A strong trend in opinions about HIV and AIDS focused on looks and physical symptoms. People frequently mentioned physical signs as evidence of an individual having HIV.

I know when someone has the sickness because their face becomes dusty like ash from the fire and their hair falls out. He turns into a skeleton and that's when we know they have the sickness.[9] *(Married man, EHP)*

We know when someone has the HIV/AIDS sickness by looking at changes in their body. Their skins begins to look bad, and becomes dusty and their hair falls out.[10] *(Married man, EHP)*

We really don't know what AIDS is. But when people start to lose a lot of weight then people say they have it. So those of us who live in the villages see loss of weight as a symptom of the sickness.[11] *(Married woman, SHP)*

Transmission And Diagnosis

In terms of the four main forms of transmission, 64% of respondents noted 'sex or unsafe sex', 20% noted 'needles or shaving razors', 21% noted 'blood' and 2% said 'mother-to-child' transmission. HIV and AIDS is also often associated with '*pasin pamuk'* (prostition / having sex outside marriage) and with being unfaithful.

They say that HIV is the result of adultery, when someone is unfaithful to their partner, so you have to look after yourself they say. That's why I am afraid of it. I am afraid because I see that they die, or they lose a lot of weight and die, but whether people have the sickness or not its hard to tell.[12] *(Married woman, SHP)*

Where there was no clear knowledge of HIV and AIDS present, ideas that touching or sharing a toothbrush or bedding were mentioned as modes of transmission. Despite the fact that people know that transmission occurs through blood, uncertainties

emerged regarding various other forms of bodily contact as modes of transmission, for example through sharing a toothbrush.

Respondents often knew that HIV can be diagnosed through a blood test (39%), with the hospital (31%) often mentioned as the main place to get checked. Some people also mentioned VCT clinics (6%).

Prevention And Opinions About Condoms

The most commonly mentioned ideas about prevention were being faithful to one partner (22%) and being faithful to God and the church (24%). Despite a larger response to condoms (28%) being a form of prevention compared to abstinence (24%), 39% of people think condoms are unsafe.

> *We will be okay if we remain under the word and laws of God. Only through this will we behave well and find peace and good well-being in the community.*[13] *(Married woman, Enga)*

> *I'm not sure if condoms will help or not? Condoms are encouraging promiscuity in our communities. Condoms will not stop this AIDS.*[14] *(Married woman, Enga)*

A common opinion is that condoms promote '*pasim pamuk*' (16%). Many respondents stated that condoms were a way of 'getting away with sleeping around'. They expressed themselves strongly against condom promotion on the basis that it promotes sex. Young people were more used to using condoms than older people, and tended to be more familiar with how to use them. The majority of participants, however, emphasized that condoms were not 100% safe, and commonly related narratives pertained to condoms having small holes (13%) in them. It was also frequently mentioned by male respondents that 'skin to skin' sexual contact was preferred and that there was a reduced sensation or pleasure when using condoms. Some respondents accepted condoms for family planning use only.

> *Once in a while I use condoms when I want to have sex with a woman, but I don't use it most times because I'd rather have the skin-to-skin sensation, that is better and so I don't use it.*[15] *(Married woman, WHP)*

Attitudes Towards PLWHA

People expressed mixed feelings toward PLWHA. People who had experienced caring for

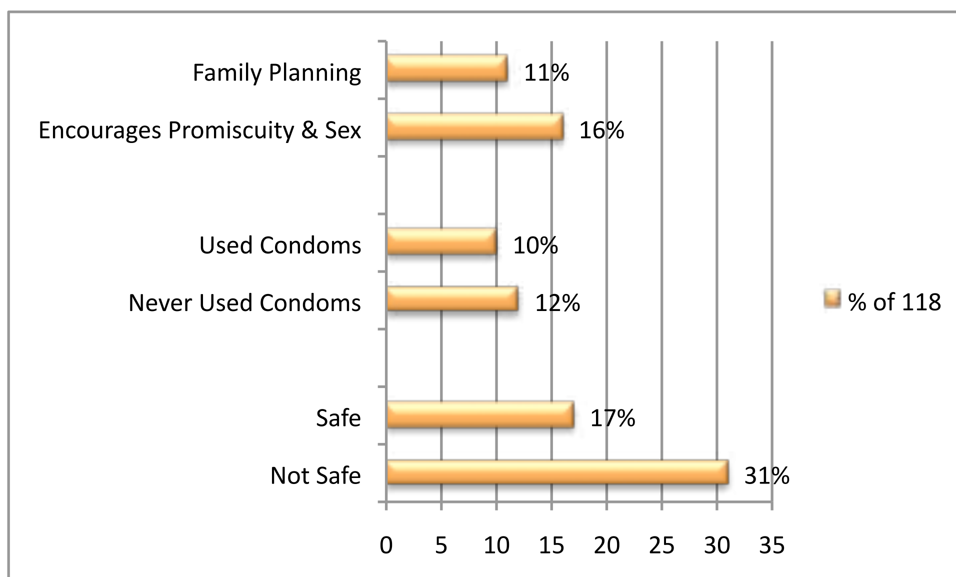


Figure 4: Baseline Study: Opinions about condoms

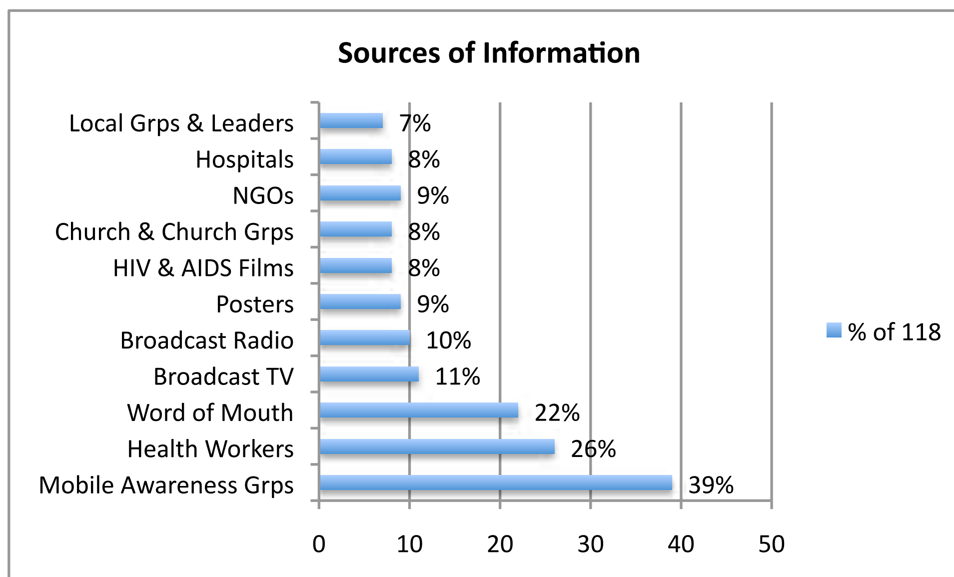


Figure 5: Baseline Study: Sources of Information

someone living with HIV and had received further information, or people who knew about someone in their community living with HIV, tended to be more accepting of PLWHA. Rejection PLWHA was commonly mentioned (35%). Fuelled by the sentiment of being afraid of HIV and AIDS, it was often expressed that PLWHA should be separated into segregated communities. In some communities strongly negative comments were made in regards to ART treatment in particular. It was sometimes argued that treatment should be abandoned to let PLWHA die in order for HIV to stop. Perception towards PLWHA also differed depending on how people experience other diseases. As one informant commented;

> *People will care for someone who becomes sick with something else. But if someone becomes sick with AIDS, people will not want to care for him or they will fear him. They will say "he was asking for it". Why should we worry for him, was it our fault he became sick?*[16] *(Married man, Enga)*

HIV and AIDS is strongly associated with behaviours that each individual is in control of and can avoid. Common narratives are that individuals who have engaged in '*pasin pamuk*' deserve to have HIV and should not receive treatment. Within church narratives people are often regarded as sinners, having transgressed the values of the church. Despite these strong sentiments, a good number of people expressed empathy for PLWHA (25%), particularly in their own communities. Empathy was also strongly felt for children.

> *I feel sorry for those who have the virus in our community because there is no cure and definitly, they will die.*[17] *(Married woman, WHP)*

> *I feel sorry for those infected and I'm so scared of getting married because I dont know my husband's behaviour.*[18] *(Young female, Simbu)*

> *We do take care of them but we do not share materials like towels, eating utensils, beddings, and clothes but separately provide their own just for safety sake.*[19] *(Married man, SHP)*

Despite feelings of affection, people often lack full comprehension about caring for and treating people living with HIV in their communities.

Sources Of Information On HIV And AIDS

Respondents most frequently refered to mobile awareness groups (39%) who visted their communities as their main source of information. They named health workers (26%) and hospitals (8%) as their main sources of information about HIV and AIDS. Media such as posters, radio and TV were mentioned only sporadically. Word of mouth was very commonly mentioned as a source for information (22%).

> *Whoever hears, immediately tells others. And so people don't want to care or help those who become sick with the virus because the message has reached each house and even public places.*[20] *(Married man, SHP)*

Sexual Negotiation Capacity

Sex was talked about as taboo and 'secret' in public community life. Shame was expressed about open discussion of sex. Both teenagers and parents felt ashamed to talk to each other about sexual issues. Due to gender roles women, when asked about sexual negotiation capacity, commented that it is not something you talk about.

> *Little children might hear this kind of talk, that's why we don't talk about it public. When awareness is on, we feel free to talk about it openly, but when we alone, we are ashamed to talk openly. Otherwise, we wouldn't talk openly.*[21] *(Married man, EHP)*

> *We don't talk about sex openly. We can talk now because it's just us. We wouldn't talk in public about it. People will say it's secret so I wouldn't talk about openly.*[22] *(Young female, EHP)*

Recommendation Made By People

Various recommendations were made by people regarding slowing the spread of HIV and AIDS in their communities. Suggestions ranged from banning nightclubs to initiating government interventions. In every community involved in the baseline study people asked for more information to be given to them. Government intervention and the Church was suggested by many as a way to improve the situation around HIV and AIDS.

> *We want the health department to come and talk to us about the illness that are occurring in the community. They will defeat this bad disease once they do that.*[23] *(Married man, EHP)*

> *It would be good to go as a group and do awareness. People know what AIDS is, but it would be good to go once in a while to tell them the truth. We shouldn't hide it. That's what I think.*[24] *(Married woman, SHP)*

> *So, in my opinion, I think that the old people back in the villages, the elders together with infected people and health workers who are making some awareness in the community must all come out in public and openly talk about HIV and sex rather than hiding it away and letting this dreadful disease kill the people.*[25] *(Married woman, SHP)*

4.4. Part 2: Integrating critical issues raised by communities

The analysis of the baseline data is strengthened when referenced to issues raised as part of communities' risk self-assessment. The main issues pertain to geographic location, health access, community characteristics and community resources:

Location: proximity to major road, proximity to major town centre, other major places nearby

Health Access: Distance to next health centre, distance to next VCT clinic

Community Characteristics: population level, language, leadership structure, predominant church and church groups, schools, stores, sports clubs, women and youth groups

Communication Resources: electricity (y/n), community assets, access to newspaper, radio, TV, mobile phones, haus piksas, income

In what follows we refer to each of these issues in turn, and relate them to the broader baseline study analysis.

❖ Location

Communities close to mining sites, such as Hulpin and Koroba in SHP, and Niugue in Enga, are experiencing a steady increase in cash flow and an increased dependency on cash products, often due to their proximity to natural resources, and the resultant industry and foreign presence. Being in close proximity to the road, such as in Niugue, was also an added factor to risky behaviour, as prostitution most commonly occurs along the highway.

❖ Health Access

Communities in closer proximity to health centres were more likely to be informed and often have a health worker living among them in the community. Further, communities closer to major established centres, such as the Summer Institue for Linguistics near Kainantu, evidenced a higher level of knowledge about HIV and AIDS. This could be attributed to a range of factors. The health centre may offer a health service facility, allowing for increased access to medical advice about HIV and AIDS; a number of people from the community may work at such centres and therefore receive information during working hours that they are then able to transmit to their community; or health workers may be more likely to conduct visits to nearby communities, thus ensuring an increased exposure to health messages and education.

❖ Community Characteristics

Of all community characteristics, church-related practices were mentioned most frequently. There was a dominant church in each of the communities participating in the baseline study. Church attendance varied in terms of the number of active members and how groups within the church were organised. For example, in the Mu community youths were strongly organised in a church group, whereas in Niugue, despite dominance of the SDA church, many youth stated that they did not attend. Both churches and related activity groups were unanimously identified as important to community life, particularly for youths and women.

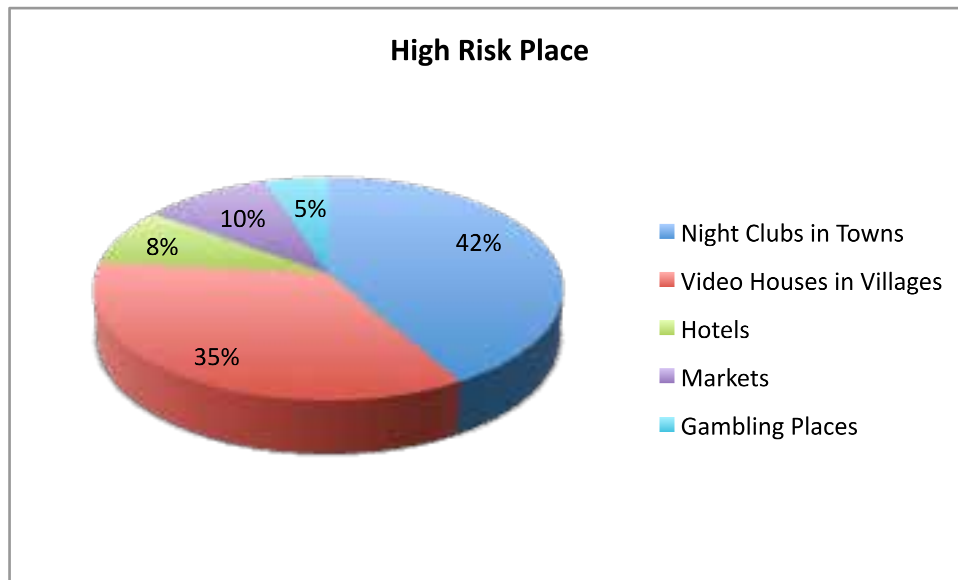


Figure 6: Baseline Study: Places considered high risk for HIV infections

❖ Community Resources

In rural areas, mass media were mentioned infrequently as an influence on HIV and AIDS awareness and practices. However, media outlets such as haus piksas were frequently mentioned as high-risk locations for the transmission of HIV. Mobile phones were also identified, most often by older people, as increasing high-risk behaviour among youth. A community's capacity to adopt new technologies translates into individuals finding themselves having to cope with new practices and social environments. Each of these practices and environments requires them to build up their capacity to assess and contain their own individual risk.

In communities like Mu, local associations are part of community resources. Locally organized groups like the 'Girl to Woman Association' for example caters for workshops, meetings, trainings and such. Schools have also become resources for villages where office-type services are provided (apart from education) like in Ruti village, WHP.

Respondents across all communities identified the most high-risk activities in regards to contracting HIV to be rising income levels leading to alcohol consumption. This would appear to put people in communities that have valuable local assets at a higher risk. For example, in the Kerowagi community in Simbu, people identified the coffee season as especially risky due to the increase in financial resources into the community and the rise in alcohol consumption during that time.

Communities in the PNG Highlands are very different from each other. The above mentioned factors are some that contribute to the uniqueness of each community. It is obvious that each community deals with different driving forces of the HIV epidemic, and therefore requires their unique approach to prevention. Such prevention must work with the invovlement and participation of these communities to firstly, identify the impacting factors and secondly develop solutions to address these.

4.5. Summary of key issues: the jumping off points for KTP

Overall, the baseline study identified that the closer people live to a town centre, the better their knowledge of HIV and AIDS was likely to be. However, simply knowing of HIV and AIDS may not be as critical as it appears. This is because a number of misconceptions persist due to limited understanding of the various aspects of HIV and AIDS. Thus, despite an awareness of the disease in a general sense, many respondants living in proximity to town centres evidenced misconceptions. People living closer to towns have been far more extensively exposed to awareness programs, which may explain their heightened awareness. They often commented 'We know of HIV and AIDS, it has been around for some time'. What was found to be frequently lacking however, is practical knowledge that could be characterised through a higher level of experience with HIV. That this practical knowledge was commonly lacking indicates that the awareness programs to which communities are currently exposed may not be having as significant an impact as may be hoped. Basic awareness of HIV is a strong foundation, however without elaboration and adaptation to local practices and risks, such general awareness is unlikely to yield positive outcomes.

People who had taken care of someone living with HIV, or communities where people with HIV were living openly, tended to demonstrate a much higher level of practical knowledge. This meant for example knowing that HIV is transmitted through blood, and not being worried about hugging an HIV positive person. The baseline study analysis revealed that general awareness of HIV and AIDS need not reduce misconceptions, and on occasions may even reinforce them.

Practical experience was revealed as one of the strongest components underpinning people's understandings of the various factors of HIV. For example the SDA church group in Aiyura organised for people to go to see people living with HIV and arrange for them to assist in caring for them. Through this program there has been a significant increase of practical knowledge in the community. This indicated to KTP that highlighting these everyday narratives of PLWHA in communities, and people in communities caring for PLWHA, particularly when audiences could empathise with these people, could prove an invaluable tool in raising HIV and AIDS awareness, and one that may have been overlooked in previous campaigns.

There were numerous such shared narratives around HIV and AIDS that the baseline study uncovered. From these shared narratives, themes emerged that resonated across communities, including:

❖ Fear and rejection:

- Negativity around the issue of HIV/AIDS. People strongly associate HIV with death, and therefore frequently reject those living with HIV.
- PLWHA are often seen as 'sinners'. Churches have a strong impact on experiences and narratives around HIV and AIDS.
- People fear HIV and AIDS. They are scared of getting infected themselves and fear the impact on themselves, their family and their community.

❖ Knowledge and awareness:

- People are aware of HIV and AIDS, however limited knowledge leads to misconceptions. These misconceptions define people's behaviours and attitudes.
- Physical appearance is often mentioned as an important criterion. It is sometime criticised that people on medication show no physical signs of the disease (this was sometimes seen as justification to halt or withhold ART).
- Young people are more knowledgable and less critical of condoms than older people.
- People are generally keen to receive more information about HIV and AIDS.

❖ Sources of risk:

- Video houses and night clubs are seen by people as most risky places within the community. Alcohol consumption and the increasing influence of a cash economy are also considered as influential.
- Condoms are not widely accepted. They are thought to promote promiscuity.

These themes served as 'jumping off' points for the gathering of KTP stories and their conversion into community films.

GUINNESS

5 The KTP Films: Harim, Lukim, Painim Aut

As seen in the previous section, the baseline study revealed a range of critical findings and themes. These findings and themes became the anchors for subsequent gathering of stories and footage, and for subsequent feedback discussions with community audiences held in response to viewing the footage.

In light of the overwhelming negativity around HIV, it was decided that KTP should offer communities an opportunity to explore and recount positive stories about living with HIV, and share accounts of PLWHA who play an active and valued role in their community. This strategy was adopted to counter the stigma and discrimination that were found to associate with the fear that HIV has no cure and that anyone can contract HIV. The stigma, discrimination and fear create a vicious circle of people refusing to get tested and hiding their HIV positive status to avoid discrimination, leading to further silencing of HIV discussion.

To counter this dilemma, KTP sought to provide community members with an oportunity to share effective and important knowledge held within communities themselves. Being articulated by community members, this knowledge was practical and accessible for community audiences. Community responses to film footage of community members discussing this knowledge were transformative – issues previously shunned turned out to be publicly negotiable after audiences viewed footage of stories told by community members. Further, community members were less inclined to maintain secrecy and more inclined to come forward with stories about how they manage people living with HIV and AIDS, or how they manage their own disease and social relationships.

The KTP stories collected as part of the project have been edited into five films. Each of the films emerged from close collaboration with different communities and community members (one in each Highland province). The resulting films are all different in style, ranging from narrated personal stories to documentaries and drama films. Participants were different for each film, and different creative local teams worked on each production. The films generally aimed to be appropriate to the HIV and AIDS knowledge level of the particular community, and captured what the community was interested in portraying or what they deemed important to present from their community.

The overall title 'Harim, Lukim, Painim Aut' (Hear, See, Find out) captures how the film series as a whole came about. The first film (Enga's 'Wanem Rot Nau?') sets the scene by including footage portraying the activities and reflections of the research team. This film shows KTP's process and engagement with communties and raises questions about existing risks around HIV and AIDS. For their part, the second, third and fourth films (SHP, WHP and EHP) show aspects of how people in the focus communities live with HIV/AIDS by portraying positive personal and family stories. The fifth film (Chimbu's 'Painim Aut') is a drama film that was scripted in consultation with the community. It calls for action, demanding a more engaged audience response.

Due to the different 'levels' of the films and corresponding impact they can achieve, outcome indicators have been developed to evaluate the response to each of the films individually. These were initially examined in the communities that the films were made in.

'WANEM ROT NAU?'
- ENGA PROVINCE

'MAMA BETTY'
- SOUTHERN HIGHLANDS PROVINCE

'PAUL'S BIG HEART'
- WESTERN HIGHLANDS PROVINCE

'ONE MORE CHANCE'
- EASTERN HIGHLANDS PROVINCE

PAINIM AUT
- CHIMBU PROVINCE

WANEM ROT NAU?

ENGA PROVINCE

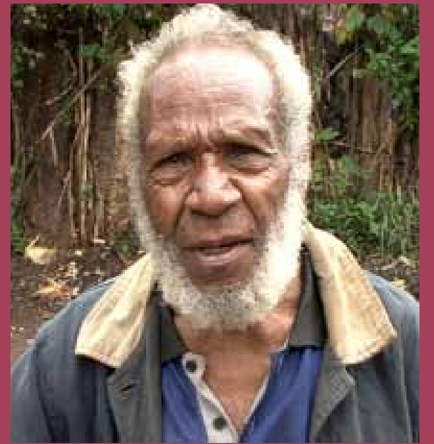
The community engaged by KTP in Enga, Niunge, was identified and approached by University of Goroka staff and KTP team member Alice Kuaba. Initial baseline study findings from Enga revealed a very limited knowledge of HIV and AIDS, a suspicion of awareness campaigns, condoms and ART, and significant pressures on communities resulting from a rapidly changing society due to the mining industry, proximity to the Highlands Highway, and intergenerational tensions. Awareness campaigns previously conducted in Enga, rather than meeting their educational and preventative goals, were seen to increase stigma and discrimination and discourage open communication about HIV and AIDS. The KTP team therefore felt, in accordance with the information provided to them by the community, that any intervention in Enga would have to be handled carefully, avoiding subjects that had proven barriers to open communication in the past.

In contrast to many of the previous awareness campaigns described by community members, therefore, the KTP team focused on the commonly-discussed traditional practice of the hausman, which, despite dwindling significance over recent years, was still an important talking point in the community. Using the hausman as entry point, the Enga component of the project began with considering the various perceived high-risk behaviours present in the community. This directed attention to what community members saw as the driving factors in the spread of HIV and AIDS: changing cultural values and tensions at play in the community, including changing values among youth, changes in financial practices, the advent of the highway, new work practices, and the lack of teaching facilities where traditional knowledge could be discussed. The footage gathered about these issues was edited into a film that portrays these issues from the perspectives of community members. The film is accompanied by a narration from Kauba, a community member who reflects on her experience of returning to her community to make the film, and the unique issues and challenges she encountered in trying to produce awareness in Enga. The reintroduction of a traditional hausman system, or similar community forum through the church is explored through the narrative, as the community seeks solutions to the new challenges they face as a result of their modernising society.

This film will serve as a kind of introduction to the KTP project as a whole. The issues it addresses are common to many communities in PNG, and provide an overview of high-risk places, behaviours and cultures as articulated by community members themselves. Despite the generally negative responses to previous health education initiatives in Enga, the KTP film was received very well, fostering much dialogue and reflection among community members about ways in which they could overcome the barriers to open discussion about addressing HIV and AIDS. The goals of this particular output, therefore, rather than direct education or prevention, pertain to fostering reflection, dialogue and an increased willingness to receive future health education.

MAIN OUTCOMES:

- The film prompted open and sincere discussion of the driving factors of the spread of HIV and AIDS during reflection sessions.
- Audiences engaged in reflection about potential barriers to HIV and AIDS prevention.
- Audiences sought additional information about HIV and AIDS.



MAMA BETTY

SOUTHERN HIGHLANDS PROVINCE

Like Enga, the Southern Highlands remain reasonably isolated and underexposed to education and awareness resources. Also like Enga, day-to-day life is changing rapidly with the increasing presence of mining and gas companies, and the influx of money and foreign influence this brings with it. Knowledge of HIV and AIDS and acceptance of PLWHA were found to be lower than in some other provinces. The KTP team were introduced to the village of Hulpin through a University of Goroka midwifery student and nurse, Jacklyn Tinol. Jacklyn facilitated the team's introduction to Mama Betty, a local woman living with HIV, supported by her adopted son Dominik and his family. The decision to produce a documentary about Mama Betty and her family reflected a positive story in a province where many PLWHA were not accepted by their communities, forced to live in isolation or without basic facilities. Mama Betty has been living with HIV for eight years and was confident to tell her story with the support of her adopted son Dominik.

'Mama Betty' tells Mama Betty's story, from her years living alone to her adoption of Dominik and his family, their life living together, and her health and active community life. Although this active community life is portrayed on screen, the true emphasis of the film is on the support Mama Betty receives from Dominik and his family, and their refusal to bow to community pressure to move out of her house. In the course of the film we see Mama Betty share meals, go to a health clinic to collect her ART, play volleyball, garden and care for her pigs, and care for her family. Through interviews with Mama Betty, Dominik and his wife Sina, the audience is engaged in dialogue about the stigma and false information that PLWHA encounter on a day-to-day basis.

'Mama Betty' serves to provide an example of a community that is providing positive experiences for PLWHA and a level of support that serves to directly improve both their quality of life and their health. The specific focus of this film on families caring for PLWHA in their own homes, the importance and effectiveness of ART, and the correction of a number of commonly held false beliefs, such as transmission through sharing meals or bedding, allow it to directly address health and education issues common to many communities in PNG.

MAIN OUTCOMES:

- Audiences express improved knowledge of ART.
- Audiences express increased willingness to care for PLWHA in their own homes.
- Audiences exhibit changed attitudes towards PLWHA.

PAUL'S BIG HEART

WESTERN HIGHLANDS PROVINCE

As part of the baseline study in the Western Highlands, the KTP team surveyed a number of communities. Although knowledge of and attitudes towards HIV and AIDS differed between communities, the overall sense gained was one of relatively high access to information, and increasingly well-supported communities of HIV positive people, although not always within their own communities. As with EHP, it was decided through consultation with the Kuruk community that the WHP narrative and film should emphasise the strengths of the community and tell a positive local story about HIV and AIDS. The team learned of a care centre being run by a local man for PLWHA, and after some negotiations agreed to produce a documentary about Paul Are, the founder and only staff member of the Kui Charity Hope Centre.

The film follows the day-to-day life of those living at the care centre, with an emphasis on the gardens and healthy meals that Paul assists his patients to prepare every day in an effort to restore their health. Through interviews with several of Paul's patients, as well has Paul himself, the film explores the importance of maintaining general health for someone living with HIV, and the value of providing such an environment for infected people, who often have nowhere else to turn. Through spending time at Paul's care centre many of his patients have been brought back to health, and been able to return to their own communities and forge a positive life for themselves. This emphasis on rebuilding health and returning to a full life in one's own community is the film's particular strength.

As one of the three documentaries in the KTP facilitators' guide that emphasises positive living and community support, Paul's Big Heart will be used to consolidate these messages as a whole, through the specific focus on healthy living, recovery of health, and return to community life.

Paul himself also serves as a positive example of someone not infected with HIV living and sharing meals with, and caring for PLWHA, highlighting the need for families and communities to provide a clean, healthy and supportive home for those relative and community members affected by HIV.

MAIN OUTCOMES:

» Audiences identify Paul as a role model in caring for PLWHA.

» Audiences take away knowledge about possibilities for improving the health of PLWHA.

» Audiences express an increased acceptance of PLWHA living in communities.

ONE MORE CHANCE

EASTERN HIGHLANDS PROVINCE

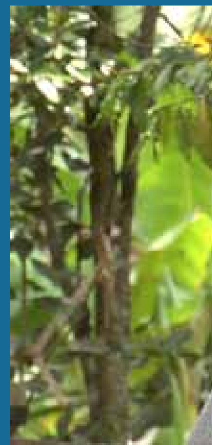
The EHP film was spearheaded by a team comprising of honours student Melvin Kualawi, Head of UOG Health Department Lillian Siwi and Community Liaison Paul Landu, in the Aiyura community, located approximately one and a half hours by road from Goroka. The link was made through the Garden of Eden care centre in Goroka, where a family from Aiyura was known to both Siwi and Landu. The baseline study conducted in Aiyura revealed a community with relatively high knowledge of HIV and AIDS, numerous examples of community members living openly and positively with HIV and AIDS, and a general enthusiasm for participating in the KTP project. Given the positive engagement of this community with both PLWHA and awareness messages more generally, the KTP felt that it provided a model community to highlight these behaviours, in the hope of demonstrating to communities lacking such a high level of acceptance and support the significant benefit to PLWHA of such attitudes and actions.

The EHP film, 'One More Chance' is a documentary film that tells the story of Siparo, a member of a local string band, who was diagnosed with HIV after being unfaithful to his wives while travelling with his band. Siparo initially withheld his status from both his family and his community, infecting his two wives with the disease before revealing his status. The film explores the family's daily life as they work their fields, share meals, interact with the wider community and play an active role in their local church. It highlights the valuable role PLWHA can play in their community where they are supported by their immediate and extended family, and the community as a whole.

In the context of the five films, Sirparo's story is designed to address the stigma associated with PLWHA in daily community life. Siparo and his family are seen taking their ART medication, sharing meals, working their gardens, interacting with community members, attending church, shaking hands with their minister, and going about their daily lives free of stigma or discrimination. Through visually showing this kind of community acceptance, it is hoped this film will improve the quality of life for other PLWHA by providing an example of community members living positively and openly with HIV and AIDS.

MAIN OUTCOMES:

- Audiences associate openness and community and/or family support with improved quality of life for PLWHA.
- Audiences agree that HIV positive community members should be accepted by the wider community and continue to participate in community activities.
- Audiences take away knowledge from the film regarding transmission of HIV.



PAINIM AUT

CHIMBU PROVINCE

The final film in the KTP package emerged from the Mu community in Chimbu. The project was driven by Bafinuc Ilai, who worked with KTP as a student researcher, conducting a music workshop and composing the music for a number of the films. The Mu community, like Aiyura in the Eastern Highlands, represented a well-informed and supportive community. Also like Aiyura, the Mu community was extremely engaged in the KTP project, and took possibly the most active role in producing their film. The resulting film addresses a number of issues identified throughout many communities as controversial or taboo, such as condom use, unfaithfulness in partners, pressure on young women to have sex, and most importantly in this case, getting tested for HIV. The film was conceived, scripted, performed and scored by the community, with the KTP team consulting only to ensure the health messages were clear and made as prominent as possible, to consult on technical aspects of production, and to provide editing.

The film follows the story of Esther, a teenage girl living in the Chimbu Province. Esther is a typical teenage girl, fighting with her overbearing mother about her grades, sneaking into town to visit her boyfriend Jimi, and gossiping with her friends. When she hears Jimi has other girlfriends, she is worried that they did not use a condom and she may have contracted HIV. After days of worry and isolation from her friends and family, she seeks the advice of an old school friend who lives with HIV. Karina is on ART drugs and supported by her family, and she encourages Esther to get tested. Esther eventually confronts Jimi, giving him an ultimatum: if you really love me, you will come and get tested with me. Painim Aut ends as Jimi, following considerable deliberation, joins Esther at the testing clinic, and they enter together to find out their status.

The film, although dramatic, reflects a number of issues identified as priority by NACS, including testing, multiple partners and condom use. It also addresses issues such as pressure from parents, mother to child transmission, healthy living, ART, and fear of the virus. It has tested extremely well in pilot screenings and early evaluation, and the community is calling for a sequel to be made. It provides an effective counterpoint to the introductory and documentary films KTP has produced, providing a different format and perhaps appealing to different audiences. The film has thus far proven to stimulate frank and engaged discussions of these taboo topics, pointing to the potential of dramatic film, particularly among youth.

MAIN OUTCOMES:

- Audiences express a willingness or desire to be go for a blood test and find out their own HIV status.
- Audiences engage in open discussion of condom use.
- Audiences actively seek further information about transmission, prevention, and/or treatment of HIV and AIDS.
- Audiences express a willingness or desire to advocate for the messages presented in the film to other communities.

6 Findings: Screenings and Immediate Impact

As discussed in section 3, KTP's approach was to remain open to the interests and concerns expressed by community members in the course of the project and gathering of information and stories. As a result, a great number of issues and topics arose as the project unfolded. Discussions tended to be ongoing, informal and specific to the particular community being engaged at the time. This section of the report outlines some of the most prominent issues to emerge from these discussions. This section also reports on the perceived impact of KTP in each community gauged using interviews, surveys and focus groups conducted after each screening. These interviews harbour significant information about the perceived effect of the project's intervention on the different communities. An in-depth analysis of the significance of this information will be presented, linking findings to existing literature and prevailing knowledge about HIV and AIDS prevention and education.

It is worth noting at this point that one of the strongest features of KTP is its ability to accurately assess not only the level of existing knowledge in communities, but also communities' willingness and readiness to further awareness through dialogue and education. The KTP project revealed that levels of knowledge, willingness to discuss and readiness to learn differed from community to community. The Enga community, for example, exhibited a lower knowledge of HIV and AIDS than in Simbu, Western Highlands or the Eastern Highlands. KTP activity in Enga, therefore, needed to be focused more on stimulating discussion in a general sense, and in laying the 'foundation' for awareness and attitudinal change, than on achieving behavioural change or mobilising existing forms of knowledge and advocacy.

We suggest that, without this foundational insight into communities knowledge, willingness and readiness, awareness campaigns are likely to fail. Communities may not yet be open to messages about HIV and AIDS generally, let alone about ART or condom use. One significant achievement of KTP, therefore, has been to not only recognise and show the importance of such foundation, but also to put in place tailored strategies for building upon its findings, and developing community engagement in ways that acknowledge existing states of affairs.

6.1. Dialogue and Reflection

The first stage in effective awareness campaigning must be a willingness in communities to discuss HIV and AIDS openly as a community, to reflect on one's own attitudes or behaviours, and to be willing to actively seek information where it is lacking. Indicators associated with this stage include:

» Communities engage in discussion following film screenings;

» Individuals reflect on their own relationship to HIV and AIDS;

» Individuals actively seek further information about HIV and AIDS.

The KTP team found that in all provinces involved in the project, dialogue and increased community reflection was one of the most apparent and significant outcomes. The level of openness to receive the KTP team and knowledge of HIV and AIDS itself varied considerably from community to community, and dialogue reflected this. The nature of the discussion that occurred following screenings was found to give a good indication of these levels of understanding and the relationships that had been formed with the KTP team, and provided an effective means of considering the next steps needed in awareness campaigns.

In Enga, for example, the film initially prompted primarily reflection on the daily life of the community, particularly how it was changing in response to modernisation, industry, and proximity to the rapidly expanding Highlands Highway. One young man commented publically after a community screening:

> *It is true that these things happen here in Niungk. When they wake up in the morning, they gamble till 6pm. Then they steal food from their parents. Others just roam around doing nothing until its night. The children are not being disciplined because their parents can see that the children don't accept advice.*[26] *(Young man, Niugue, Enga)*

Gambling, the influence of rising levels of income, generation gaps and the loss of traditional education practices such as the *hausman* and *hausmeri* were raised repeatedly in discussions in Enga. This dialogue about changing society and its relation to HIV and AIDS led to a discussion, facilitated by KTP researchers, about the factors driving the spread of the disease in Enga. Through this discussion, the community began to reflect on its own behaviours more critically. One man commented in a focus group following the screening that:

> *After seeing the film we are now beginning to think about ourselves. This program is the first of its kind in this community.*[27] *(Married man, Niugue, Enga)*

Another that:

> *After seeing the film, we understand. So we will try to change our behaviours and I am in favour of this film.*[28] *(Married man, Niugue, Enga)*

Key in maximising the benefit of discussions such as this is to relate them to actions the community may take having identified risk factors and risk behaviours. While this approach may seem to fall short of directly targeting behaviour change, it is critical to engaging community members with their own existing practices, confront the risks embedded in them, and devise for themselves and by themselves ways of minimising and averting those risks.

Without such initial involvement in community-based discussion and issue elicitation, there is little to no likelihood that communities will respond positively to any awareness intervention, or to calls for behavioural change. KTP's experience suggests that failure to acknowledge the need for such discussion and elicitation has been one of the most significant weaknesses of past interventions, and is one of the principal reasons for these interventions failing to achieve their purported aims. To avoid such pitfalls, KTP made establishing appropriate forums for discussion and elicitation its first priority.

In communities outside Enga where awareness programs had already had some impact, initial discussion and reflection was able to transition more quickly into critically reflective and activity-oriented outcomes (outcomes 1b and 1c). In the Southern and Western Highland provinces, individuals not only acknowledged the value of engaging in open discussion about HIV and AIDS ("Sex discussions are a cultural taboo but your approach is very educational to the people because the young ones will learn a lot." Married man, SHP), but also actively related these discussions to their own risk and behaviours (outcome 1b):

> *After watching the film, we feel very bad within ourselves. Now I will change my behaviour and approach towards people living with HIV/AIDS.[29] (Married Man, Hulpin, SHP)*

Following on from this kind of 'internalization' of critical issues, KTP was in a position to pursue a more independent attitude among communities towards finding and discussing further information. This could take the form of questions raised as a result of the film, as in the case of these SHP married men:

> *Married man: One of the things that I am scared of is the sweat of the person living with HIV/AIDS when we are playing together. HIV can pass through sweat.*
>
> *KTP Researcher: No, you won't be infected by sweat.*
>
> *Man: The other things is saliva?*
>
> *KTP Researcher: You won't be infected from saliva because HIV is transmitted only through blood.*
>
> *Man: I normally chew betelnut so I am thinking a lot about people who are dying so I just want to know if it is possible to contract HIV as a result of chewing betelnut?"[30] (Hulpin, SHP)*

These conversations were sparked by the contents of the films shown, and provided a good indication of both the clarity of messages or issues in the films, and the particular issues likely to pique community interest. It was interesting in this regard that in the Eastern Highlands, for example,

questions pertained more to medication and healthy living than to transmission, reflecting both issues raised in the film and the specific focus of community interest:

> *Can you explain what kind of medicine they're taking? The tablet that you give the couple. I saw in the garden scene.[31] (Married Man, Aiyura, EHP)*

In Chimbu, questions often centred on testing and the actual processes involved in the blood test:

> *It wasn't clear how the doctor would do the blood test.[32] (Young woman, Mu, Simbu)*

It is important to emphasise here that the initial aim of the KTP films is to provoke these sort of questions, and engender discussion about them. There are deliberate prompts in the films that encourage the audience to ask questions and seek further information. Much information about the issues raised will be provided in a Facilitators' Guide to be developed with the release of the films.

The importance of discussion and elicitation is further emphasised by the need early on to identify taboo topics. KTP found that if taboos were not established early in the process, subsequent discussion was unlikely to be productive, risking offence or irrelevancy to the audience. In both the Eastern Highlands and Simbu, community members raised the issue of taboo in their gender-specific focus groups:

> *Despite the fact that there is HIV/AIDS awareness, people are still too shy to come out and reveal their status and further promote HIV/AIDS awareness. People are too shy to talk about sex and that HIV is transmitted through blood.[33] (Married Man, Aiyura, EHP)*

When HIV/AIDS awareness groups come to the village they just come and talk and go away and people do not get their message. When KTP came into the community we thought that they were here to do their research so we took them as another awareness group. But now we see what they were here for and we were part of the film that they made and it's very good for the community to know more about HIV/AIDS. Therefore, I would like to thank KTP for what it has done in the community. This film that we have made is very good and it is powerful. The children can learn from it when they grow up so I am very happy.[34] *(Older man, Mu, Simbu)*

In communities that were able to reflect critically on existing awareness and their own risks and behaviours, the KTP films were found to be more likely to achieve outcome 1c, the move from reflecting to actively seeking information or considering steps they as individuals and communities could take to improve their situation. This was most evident in EHP and Simbu, where exposure to previous awareness campaigns was relatively high.

I see that this film is good for us to think of whether or not we have the virus. And if we do have it, we should speak out and get help at the hospital. It's up to each one of us now. It is not such a bad thing, it's good for us to assess ourselves.[35] *(Young woman, Aiyura, EHP)*

We want everybody to see this film and know for themselves that yes there is HIV/AIDS in the community so we must take good care of our body. At the same time we need HIV/AIDS trainings in the community. We desperately need to learn about HIV/AIDS so we can live healthy lives and also help our children and I am happy about the film.[36] *(Older Man, Mu, Simbu)*

Having facilitated discussions of this nature, the KTP team was better able to gauge the next steps to take in each given community. Where a basic lack of knowledge was encountered, it was important to continue to foster this discussion in a way that did not confuse, offend, or alienate community members. Where knowledge and readiness to accept awareness were already established, the team was able to move more

quickly towards identifying specific kinds of information the community might be interested in, or ways in which the films could be used to impact other local communities.

One of the most beneficial aspects of the KTP process, as mentioned above, is the effective assessment of community readiness to discuss and negotiate risks and solutions. As is becoming increasingly apparent in PNG, a 'one-size-fits-all' awareness program is unlikely to resonate in communities. Each Highland area has such varying levels of knowledge, access, support and incidences of HIV and AIDS, and such distinct cultures and solutions to the issue that a nationwide strategy is unlikely to account for these divergent situations. The KTP approach, through facilitating and effectively evaluating community dialogue in response to the films, was able to tailor its intervention in each community to suit these singular requirements to a far greater extent than more rigid and 'unidirectional' awareness campaigns.

Finally, the identification of specific areas of misconception is a direct outcome of initiating dialogue to inform future action. Functional knowledge of HIV and AIDS was often revealed to be low, and this was further complicated by widespread confusion about the safety of condoms; transmission through sweat, sharing food, toothbrushes and bedding, and hugging and kissing; and the physical manifestations of the disease. These factors are critical to positioning community members such that they can begin to engage with issues and practical matters at a level that suits their willingness and readiness. It is crucial, therefore, to facilitate dialogue that is attuned to the particular understandings and practical knowledge of HIV at work in each community.

6.2. Visual Learning and Identification

Following a general willingness or eagerness to discuss the issue of HIV and AIDS openly and honestly as a group, community members should be ready to begin to produce specific messages about the disease, its management and its prevention. These messages may pertain to stigma and discrimination, transmission, prevention, treatment, or advocacy. In these cases, questioning community members and allowing them to articulate experiences and knowledge in response to footage about community members' practices and knowledge remains the most effective way to ensure individuals engage with the issues raised. Outcomes of this stage include:

- Individuals express identification with the films' stories or characters;
- Communities evidence a reduction in stigma associated with HIV and AIDS;
- Individuals display increased knowledge of transmission, prevention or treatment of HIV and AIDS.

Fundamentally, KTP is based on the idea that individuals and communities are far more likely to engage with issues if these are represented in ways that they can identify with. The physical geography in terms of the locations in the films, the characters in the films; these can be identified to be from within their communities. These attributes enable the KTP films to provide an experience that places the viewers in direct social and personal relationships with the narrative. Awareness campaigns where communities were not able to develop a personal connection have been found to be ineffective in stimulating actual change, either attitudinal or behavioural. All communities commented on the strength of the KTP films in focus groups following screenings as being this aspect of issues being framed in recognisable ways.

I really liked the film because the people who were in the film are all from my community and I was excited to see them. It is good that you came and showed us the film.[37] *(Young man, Niugue,Enga)*

The community is in full support of this film. This film shows the true image of the community, our way of life and the way we live. [38] *(Married Man, Aiyura, EHP)*

One thing that makes me happy is that I'm from Simbu and this film comes from Simbu. I also hear my village mentioned in it and that makes my hair stand on end. Then the song in the film, its also Simbu, and specifically the lyrics and this makes me excited that this film comes straight from my village. That's what I was feeling when it came on.[39] *(Young woman, Mu, Simbu)*

This identification with characters and stories was linked to learning and change by communities themselves:

I saw that this is exactly what we girls do. Lying about sleeping over at an aunt's house, but going out. This is really what happens. For us here, we were watching familiar faces acting, but if the film goes out, that's what people will say. We will change after watching this.[40] *(Young woman, Mu, Simbu)*

The translation of this identification into changed attitudes and behaviours is something that is notoriously difficult to prove in HIV and AIDS awareness, both in terms of effectively evaluating impact, and in terms of sustaining immediate impacts. In the case of KTP, it remains too early to judge the long-term impact of the project. Outcomes of success at this stage are linked to expressed changes in attitudes (outcome 2b), and increased knowledge of specific elements of HIV and AIDS (outcome 2c). The specific areas of knowledge being assessed depended on the film to be screened (see Chapter 5 for a detailed account of the specific messages in each film). The most significant early impact of the films across all five provinces was repeated comments about a reduction in stigma and HIV and AIDS discrimination. Clearly, the experience of viewing 'real stories' of PLWHA on screen affected communities profoundly.

We were afraid to even sleep near them incase we caught the virus by breathing next to them. But I saw the part where they were sleeping together and that's nice, we can do that too. We can sleep near someone who is infected and not catch the virus. That was a nice scene in the film.[41] *(Married woman, Hulpin, SHP)*

The film inspires us to accept PLWHA. If we take care of them we will definitely give them back their lives and they will live longer. They must be close to them and share things with them so that they won't die. And we must not treat them like animals and tell them that it was your own fault that you have now contracted HIV.[42] *(Married woman, Aiyura, EHP)*

The KTP team also identified a link between acceptance of the disease in others and increased willingness to consider one's own risk or risk behaviour. This again is attributed to audiences feeling a sense of identification with the characters on screen.

One thing that I learnt was that I am a womanizer and I don't care about what I do. After watching the film I have now realized the impacts of HIV so I am scared.[43] *(Young man, Aiyura, EHP)*

When we saw the film we learnt a lot because when KTP came to [community] for the first it was all talking. But now that we've seen ourselves on the screen we have learnt new lessons.[44] (Married man, Niugue, Enga)

This last comment from the Engan man touches on what is perhaps the most crucial learning from these early impacts: the value of using visual resources in PNG. Audiences throughout the Highlands expressed the benefit of seeing the everyday lives of PLWHA and their carers, and the lessons learned through this experience. PNG has an extremely strong visual culture, and the KTP team heard repeatedly that to see something was the most effective way to learn given this visual emphasis.

They must see how we care for them. Our neighbours know she has the virus and they know how we care for her. They can learn from seeing how we care for her.[45] (Married man, Hulpin, SHP)

I learned a new thing because I usually think that when a woman gives birth to a baby and she is HIV positive, she automatically infects the baby but according to the film this is not true. The doctors at the hospital helped her and delivered the baby so the baby did not contract HIV.[46] (Married man, Mu, Simbu)

In the community, people are scared when they know that there is one PLWHA so this film will change their perceptions and they will come to accept them. We have learnt from HIV/AIDS awareness that you will not get HIV through hugging, or touching but its through blood. We must not be scared of them but live close to PLWHA. One very big lesson is to live and stay close to PLWHA.[47] (Young man, Aiyura, EHP)

The identification of film characters as role models was also identified as an effective means of engaging audiences in considering their own risk behaviours. In the regions that emphasised positive stories of HIV and AIDS, such as the Southern Highlands, Eastern Highlands and Western Highlands in particular, audiences were extremely responsive to the films in terms of emulating the behaviours they saw on screen.

Through Paul, I see this is a good thing he's doing. He's like Mother Theresa of Culcutta in India. What Paul is doing is big and in 10, 20 years time or if he's still alive, I think this will go out into world. Showing love, I think this is best. I've learnt that we should do the same and I'm happy about Paul's work.[48] (Married woman, Kuruk, WHP)

The film about Siparo and his wives is very good. They feel that they will live longer and we also make them forget about their sickness. This film is really good for the entire world. They can learn from Siparo and his two wives because they have children and it will be a good lesson for the parents out there to stop doing such things. We must learn from them and be faithful to our partners and children so that we can live longer and have grandchildren before we die.[49] (Married woman, Aiyura, EHP)

It made us think about going to the hospital. Esther got advice from Karina. She said she was taking the medicine to help her. So if we have the virus and don't get a blood test, then we wouldn't be able to get the medicine to help us too. It's made us think that if we get a blood test, we can start taking the medicine and live long.[50] (Young Woman, Mu, Simbu)

A final element of this relationship between the visual product and the educational impact of the

KTP films is the potential of the visual medium to overcome language and literacy barriers. The fact that the KTP resources are visual and locally produced proved to be extremely valuable in fostering the level of engagement and comprehension necessary for effective awareness to occur. A high level of community identification with characters, role modelling of principle characters, overcoming of language barriers, resonance with the visual culture of PNG, and translation of these elements into self-reflection, changed attitudes, improved knowledge, and ultimately into planned behavioural changes evidences the strengths of this approach, particularly in regions where awareness is currently limited or ineffective. The collective nature of viewing the films also had a positive impact on both conversation and on response to the messages embedded within them.

> *It's not like reading where you hide your face, we are all looking up at the same thing, learning at the same time, watching the same thing. Groups at the betelnut markets or darts places will recall this film. Because we've all watched it, we can learn from talking to each other. That's what way I see. Something like the reflections we're doing now. We can discuss about it to help each other.*[51] *(Young woman, Mu, Simbu)*

6.3. Community Mobilization and Individual Action

Having both stimulated discussion and generated community-specific health messages pertaining to HIV and AIDS, it was hoped that KTP could translate this improved dialogue and knowledge into attitudinal and behavioural change. Although it is too early for longitudinal assessment of these changes, early indications and community feedback demonstrate both a willingness and a desire from communities to effect these changes. Changes must happen on both an individual and community level in order to ensure effective and sustainable shifts in behaviour. Outcomes sought here include:

» Individuals express an intention to have a blood test;

» Individuals express an intention to reduce their number of partners;

» Individuals express an increased willingness to use condoms.

The ways in which communities are motivated to act or change following the KTP intervention and screenings were highly site-specific. Generalisations about the effectiveness of the visual resources, community stories and power

of the films to stimulate discussion could to some extent be made across all communities. However, the subsequent proposed and enacted changes in behaviour proved to vary significantly across the five pilot sites, depending on the subject of the film, education and knowledge levels of the community, their level of involvement or 'ownership' of the project, and the social, cultural and logistical circumstances of the village. Here the baseline studies and community profiles proved useful in shedding light on some of the prospective results of the film screenings.

In Enga, for example, where knowledge levels of HIV and AIDS were comparatively low, and community dialogue centred on the more general social drivers of the epidemic, the community resolutions pertained more to the role of traditional practices such as the hausman, or newly introduced institutions such as the church than to active and targeted HIV awareness.

> *I wasn't sure of what you did when you first came to this community but I am very clear now. Now that we have seen our film we will try not to do such activities but live like our parents who lived in the hausman and hausmeri. We would like you to teach us properly the next time you come back to this community.*[52] *(Married man, Niugue, Enga)*

> *We must go to church because God created our husbands and wives so we will get help from him. If we do not go to church we will be spoilt with such bad activities, even through money and we are most likely to get AIDS. The only solution is to go to church so that we will be good.*[53] *(Married man, Niugue, Enga)*

> *To help our children we must take them to the church. If we do not take them to the church they will also be spoilt.*[54] *(Woman, Niugue, Enga)*

> *I think it would be good for the community to set activities like sports so that we can play and at the same time stay with our parents and also make gardens and obeying what they say. Our parents must also teach us the way of the hausman so that we can avoid the sickness.*[55] *(Woman, Niugue, Enga)*

Solutions centred around the establishment or return to collective community life and education. The dissolution of traditional practices was revealed to be a significant problem for the village. KTP elicited self-reflection, facilitated dialogue around the issues raised, and prompted community members to reflect on possible solutions. Leadership was also revealed as a significant factor raising the impact of the films and discussions. Without someone driving the project from within the community, the potential effectiveness of KTP was found to be limited. In Enga for example, one community member commented that:

> *The leaders in the community did not even bother to further inform the community and therefore, we have not changed at all.*[56] *(Young man, Niugue, Enga)*

Across the other communities, there was considerable evidence that the films were effective in eliciting at least planned behavioural change through the increase in functional knowledge of HIV and AIDS. In each case, individuals expressed an intent to change particular behaviours after viewing the films and drawing lessons from them.

> *In the past we point fingers at those who had this disease we rejected them and did not came close to them. We did not share towels, soap and other things with them. We treated them very bad like dogs and many died of worrying too much. But this film tells a different story and I am touched. It gives us a better understanding of the disease and for us to live with the people. In the past we saw PLWHA as our enemies but this has now changed.[57] (Married man, Kuruk, WHP)*

> *If one of our own community members is infected with HIV/AIDS, we must not be scared of them. We can share the same plates and cups. If we take proper care of them they will be happy to live with us but if we do not take good care of them they will not be very happy and this I got from the film that I have seen. We must really take good care of our relatives who are sick. If we do that then they will find peace and will live happily.[58] (Woman, Kuruk, WHP)*

> *Watching the film, I thought of how, previously we were afraid of these people. This film shows us that these people are our friends. Its true, through sex people contract the virus. Before we were afraid to touch them or hug them because we might get the virus that way. That's not the case. Through sex people get HIV. Now I've seen the film and feel that we Christians should care for these people.[59] (Young woman, Epagla, WHP)*

> *If we hide people who are positive, there is a chance for it to spread through that person. Even us married women have to care for ourselves. Don't be blinded by men, tell them straight when they come to you. This family is giving us the big picture, its awareness, and we hear it. They've experienced it and we should learn from them.[60] (Married woman, Aiyura, EHP)*

> *One part in the film that interests me is Karina's parents loving and taking good care of her. Therefore if we have someone living with HIV/AIDS we must not reject them but instead take good care of and treat them well like we used to be before they got infected with HIV.[61] (Married man, Mu, Simbu)*

I have learnt from the film that most of the time I do have sex without using condom. Now I have realized that you won't know if a person is HIV positive but it will show out some times later. So now I think that I will use condom every time I want to have sex.[62] *(Young man, Mu, Simbu)*

In Simbu the film proved particularly successful in promoting blood testing among young men.

I saw the film and realised that I need a blood check because I might have the virus. You know, we just do with it without thinking.I need to go for a blood check at the VCT, we all need to get tested.[63] *(Young man, Mu, Simbu)*

We've seen the film, we've learnt something. We'r worried now, we'll get tested because we might have the virus.[64] *(Young man, Mu, Simbu)*

I think that I [might] have HIV/AIDS because on so many occasions that I had sex, I did not use condoms so I am definitely going for blood check.[65] *(Young man, Mu, Simbu)*

These specific achievements hinge on the particular content of the film screened. In future screenings, when the films will be delivered as a package, it will be possible to assess which film to screen based on the baseline study or initial community assessment and early dialogue. Depending on knowledge level, interest, audience and cultural considerations, screenings can be tailored to target particular issues, groups or demographics. Many of the areas identified by NACS as priority for 2011 – 2015 have evidenced impact through the films as a package (see Table on page 64), and early evaluation data is extremely favourable for the KTP method's potential to promote not only attitudinal, but behavioural change in these target issues. The three indicators developed to evidence this impact are linked to these three areas, however they could be substituted depending on the particular aspect of HIV and AIDS being targeted at a particular screening.

Each of the films shares the element of attempting to portray something positive around the issue of HIV and AIDS. Avoiding the commonly utilized approach of focusing on the dangers of HIV, the behaviours to blame for infection or transmission, or the disease's rapid spread, the KTP films portray PLWHA living positively, communities working together to nurture and support them, or characters responding to the risk of infection without resorting to blame, fear, or rejection. The positivity of the stories inspired communities to see the ways in which PLWHA can continue to be active and contribute to communities, can live long and relatively healthy lives, and can inspire others to improve their own behaviours in relation to HIV and AIDS.

I think that through the film people will learn a lot. It will also change the perceptions of the people and they will accept and treat people living with HIV with care.[66] *(Married man, Hulpin, SHP)*

I am very happy about the film because the film will help people to create a healthy environment were people living with HIV will live happily and not to have too many thoughts. We must also change our attitudes towards PLWHA and help them in whatever activities they engage in. We must make them feel comfortable and they will live healthy.[67] *(Married Man, Hulpin, SHP)*

Those of us who aren't sick, are happy and we pretend around the place and talk about those are sick behind their backs. We don't like them. But I see from the film that Paul likes everyone. Whether or not someone is sick, little children, old people, he likes them all. That's the great attitude he has that I wanted to share here.[68] *(Married woman, Kuruk, WHP)*

Now that we have seen the film, we can all go and do blood tests and also we must not be scared of those who are living with HIV/ AIDS. The film has really encouraged us to be positive.[69] *(Young man, Epagla, WHP)*

This film shows us to live with PLWHA. Eat whatever they eat and share everything with them. I think the community has really learnt as to how they will care for people living with HIV/AIDS.[70] *(Young man, Aiyura, EHP)*

People are always scared of PLWHA so I think it will really change that perception if this film is to be screened countrywide. So many people are scared so this will encourage them to change.[71] *(Married man, Aiyura, EHP)*

Although there remains much evaluation needed to assess the long-term impact of KTP and the film resources, the early indications are favourable to widespread individual and community change. Attitudinal change seems to emerge as an immediate effect in post-screening discussion, as communities are exposed to positive and identifiable role models living with HIV or AIDS. In a one-on-one survey conducted following all screenings, 97% of people surveyed across the communities (n=66) responded that the film had changed their views of HIV and AIDS. Across all communities this changed attitude was translated into intended behavioural change, which longitudinal evaluative data will need to confirm as the project continues to be disseminated and resonate.

6.4. Ownership and Advocacy

Having considered, discussed, and shared knowledge and prevention strategies, communities and individuals have been found to share these learnings with other communities and individuals. This is one the most effective ways to ensure the

spread and uptake of health campaigns. For groups to actively seek out others who have not been exposed to, or have not accepted, locally articulated and re-articulated health messages demonstrates both immediate success and sustainability of KTP. KTP found both communities and individuals willing to use the resources themselves to spread awareness and promote the health messages contained in the films. Outcomes sought here include:

» Communities express a desire to discuss HIV and AIDS with others;
» Communities express a desire to screen the films to others;
» Communities express a desire to advocate or produce further education resources.

Communities expressed the desire to share the film they had produced with other neighbouring communities, family and friends, and wider audiences. Communities had a strong sense of ownership of the films. Even more significant was the fact that community members interviewed for the films volunteered to become advocates for their particular insights, solutions or practical approaches to managing HIV and AIDS. This proved to be one of the key successes of the KTP process, and one area in which this method offers unique potential in the HIV and AIDS education landscape. The extent to which this voluntary bottom-up advocacy occurred varied from community to community, but it added a critical success component to KTP overall.

Many audience members stated that they would like copies of the film provided to them so that they may show their immediate family (particularly children in the case of parents) or other direct social networks.

> *This film also teaches the young people of this community and a very good lesson to the entire community. This film will help us train and inform our young ones on how best they can avoid this disease.*[72] *(Married man, Niugue, Enga)*

> *If we have the CD, we will do awareness and tell the community to come and view the CD so that they can learn and promote what Paul Are is doing.*[73] *(Young man, Epagla, WHP)*

> *I will be happy to view the CD with my family members if you give it back to me because my husband does not stay put in one place. My husband is not faithful and it will be good for him to see the film. My children can learn good lessons and my husband will also change his attitudes.*[74] *(Married woman, Mu, Simbu)*

Beyond the sharing of the film with immediate family and one's own community, many audience members expressed a desire to utilize their own existing wider networks to disseminate the film, for example through school, church or other community groups. Looking beyond personal networks indicates a wider commitment to spreading the awareness messages of the films, and a more nuanced knowledge of the need for information to travel more widely to effect significant change. This next level of desire to disseminate was also found in each community, although more resoundingly in communities with a higher existing exposure to awareness campaigns. In Enga, for example, many community members expressed this process of dissemination should be done by the KTP team.

> *I was not sure but now that you have shown us the film, this will definitely teach us all a good lesson about this disease. We have been taught a very good lesson so we want you to go to Kandep, Porgeran Wapanamanda and Kompiam and other places in the province to tell them about this sickness. The small children will also learn from this film and in the future they will live a good life.*[75]*(Married man, Niugue, Enga)*

We want you to do the same for other places so that they can learn for themselves and stay away from this sickness.[76] *(Married man, Niugue, Enga)*

Others were more active in considering taking active responsibility, expressing a desire to conduct the screenings and awareness raising themselves.

We would like you to produce the DVD and give it to the Pastor, church elder and village leaders in this community. We have many places where we can take this DVD to so that it can be screened in these communities.[77] *(Married, man, Niugue, Enga)*

We have to educate other communities and they must pass the information on so that this disease of roaming around night after night, women after women must stop. Dont bring this disease around. [78] *(Married man, Hulpin, SHP)*

We could bring it to school and show it to our peers. They would learn from this and change their behaviour or attitude.[79] *(Young woman, Epagla, WHP)*

If I do have the CD I will take it back to our communities so that they can see the film so the young people can avoid such things and become good people.[80] *(Married woman, Aiyura, EHP)*

Two things. First, I'd tell them to come watch a movie made by non-whites and made in my village. I'd attract people's interest that way. Secondly, as a teacher I'd use it as a teaching aid with the little children and whatever they see is interesting, they will pass the story onto their families. I'd teach them and they'd then go and teach others around them. This is a way I think will advertise the film too.[81] *(Young, woman, Mu, Simbu)*

The most engaged and overwhelming response to the further dissemination of the films emerged in Simbu, where the final stage of 'ownership', here designated advocacy, was emphatic and community-wide. Although in almost all cases the film subjects and direct participants expressed a desire to advocate the film and the issues it exposed, in Simbu this third 'stage' (outcome 4c) was not restricted to the individuals and families involved in the production of the film, but was evidenced across the community as a whole. This may have been to do with the larger number of people directly involved as a result of the film being fictional, and therefore involving script writers, musicians, camera operators and production assistants from the community in addition to the onscreen talents. It is difficult as this stage to assess the specific driving factors behind the groundswell of support and advocacy that occurred in Simbu, and further evaluation is needed to pursue this line of inquiry.

The evidence continues, however, to show a particularly high level of engagement with the film, and it is hoped that through further evaluation this result could be replicated in other communities. In Simbu, community members spoke frequently about awareness, advocacy and future projects to continue the work of KTP, and indications of this kind of sustainability is one of the most promising outcomes to be hinted at through early evaluation. Community remarks included:

> *The local boys from Mu can form an awareness team and use it to make awareness in other communities and tell them about the disease. What has been happening in the community will be brought to light and people can learn from that.*[82] *(Young man, Mu, Simbu)*

> *I have learnt a lot from the film but I think it is not enough and I would like to get more. I want to become a teacher and teach other people who have not heard or have heard little about the disease.*[83] *(Married woman, Mu, Simbu)*

> *If I get the CD, I know that Simbu Province will get the CD and with the existing networks that I have, all schools in the province will get copies so that the students can also learn about positive living, prevention, VCT testing and also the teachers can be trained to advocate about the disease back in their own communities so that they will realise that the use of film is an effective way to bring about the message of HIV/AIDS to schools and communities.*[84] *(Married woman, Mu, Simbu)*

Although not all communities expressed the same understanding of awareness and advocacy conceptually as in Simbu, many of them expressed a desire to continue to produce their own awareness resources, and to use the KTP methodology to do so. It has become apparent through these findings that a vital future step for KTP will be to train community members interested in acting as advocates, in order to ensure they are able to correctly and clearly discuss and negotiate the films' messages with local communities, and not reinforce or introduce further misconceptions about the disease.

6.5. Contributions of Findings to the National HIV and AIDS Strategy

KTP is predominantly situated within NACS' key priority area 1: Prevention. As an holistic approach operating in media and the production of educational materials however it addresses the National HIV and AIDS strategy on a number of different levels in all priority areas. Important cross-cutting issues being addressed are:

» The meaningful involvement of PLWHA

» Reducing HIV-related stigma and discrimination

» Capacity building and mobilization of people, community and organizations

The following table shows how the KTP film series and its process contribute to strategic priorities and clusters identified in the National HIV and AIDS Strategy 2011-2015.

Strategic Priority	Cluster	KTP 's Contribution and Example Quote
Priority Area 1: Prevention		
1. Reduce the Risks of HIV Transmission	1.1 Sexual Transmission of HIV and other STIs	**All films include information about HIV transmission and explore various social context that might contribute to the risk of contracting HIV.** *I have learnt from the film that most of the time I do have sex without using condom. Now I have realized that you won't know if a person is HIV positive but it will show out some times later. So now I think that I will use condom every time I want to have sex.*[85] *(Simbu)*
	1.2 Prevention of parent to child transmission of HIV	**The films One More Chance and Painim Aut inform about mother-to-child transmission.** *I learned a new thing because I usually think that when a woman gives birth to a baby and she is HIV positive, she automatically infects the baby but according to the film this is not true. The doctors at the hospital helped her and delivered the baby so the baby did not contract HIV.*[86] *(Simbu)*
2 Addressing factors that contribute to HIV vulnerability	2.1 Gender-related vulnerability	**Women were encouraged in participating in KTP discussions. It was also commented that the films would provide a way for women to raise the issue of HIV with their husbands.** *My name is Kogeil and I am happy to comment. I will be happy to view the CD with my family members if you give it back to me because my husband does stay put in one place. My husband is not faithful and it will be good for him to see the film. My children can learn good lessons and mu husband will also change his attitudes.*[87] *(Simbu)*
	2.2 Vulnerability of young people	**Young people were encouraged to discuss their risk behavior as part of participatory workshops. The film Painim Aut directly deals with vulnerability of young people.** *I saw that this is exactly what we girls do. Lying about sleeping over at an aunt's house, but go out. This is really what happens. For us here, we were watching familiar faces acting, but if the film goes out, that's what people will say. We will change after watching this.*[88] *(Simbu)*
	2.3 Vulnerability of children	**The film One More Chance shows the impact of HIV on children and families.** *They feel that they will live longer and we also make them to forget their sickness. This film is really good for the entire world. They can learn from Siparo and his two wives they have children and it will be a good lesson for the parents out there to stop doing such things. We must learn from them and be faithful to our partners and children so that we can live longer and have grandchildren before we die.*[89] *(EHP)*
3 Create supportive and safe environments for HIV prevention	3.1 National and local social and cultural events	**The films can be used at events and can be shown in video houses (haus piksas) in communities.** *We have video houses in the community so it would be good to show the film there. We normally watch movies produced by other people in from other countries so it will be good for us to see our locally produced film before watching other movies.*[90] *(Simbu)*

Strategic Priority	Cluster	KTP's Contribution
PRIORITY AREA 2: Counseling, Testing, Treatment and Support		
1 Scale up HIV counseling and testing	1.1 HIV counseling and testing	**The film Painim Aut encourages HIV testing.** *I need check my blood. This film has made me to go for blood check because we normally have sex without using condom. I need to go to a VCT Clinic.*[91] (Simbu)
2 Expand treatment, care and support services	2.4 Community and family support	**The films Mama Betty, Paul's Big Heart, One More Chance and Painim out all deal with community and family support and show the strength that PLWHA can get from their families and community.** *If one of our own community members is infected with HIV/AIDS, we must not be scared of them. We can share the same plates and cups. If we take proper care of them they will be happy to live with us but if we do not take good care of them they will not be very happy and this I got from the film that I have seen. We must really take good care of our relatives who are sick. If we do that then they will find peace and will live happily.*[92] (WHP)
PRIORITY AREA 3: Systems strengthening		
1 Improve strategic information systems	1.3 Social, behavioural and operational research	**The project has involved and trained a large number of UOG researchers and increased capacity at UOG to undertake qualitative and visual research.** *As a UOG staff member I am teaching HIV/AIDS here at this course and we always talk about having research about HIV so we can improve what we teach the students. When we didn't have KTP with us, from my experience, I was just teaching what – with the information supplied to me from NACS. But when I actually went out, to my village and collected the stories, what people were talking and their perceptions, it was completely different, the message is distorted out there you see. So when we go out to the community using this to come and teach HIV and AIDS education here, we are having an insight into issues outside, and issues about what we need to teach here, because we can't rely on outdated information. Alice Kauba, HIV/AIDS Lecturer UOG*
2 Strengthening the enabling environment for the national HIV response	2.2 Greater involvement of people living with HIV	**The films Mama Betty, Paul's Big Heart and One More Chance tell stories of people living with HIV and directly involved them in the production of the films.** *This is the first time I am in a movie and I am happy about it. We need to come out, we shouldn't have to hide. So this way we can help others and other communities.* [93] (EHP)
	2.5 Stigma and discrimination	**The films Mama Betty, Paul's Big Heart, One More Chance , and Painim Aut explore stigma and discrimination in different ways and show how people living with HIV live with their families. Feedback seesions have demonstrated the potential of the films to reduce stigma and descrimination.** *The film has taught us a lesson to take care of those living with this disease just like we do for our own family members. In the past we rejected them because we thought that if we only touch them we will be infected with this disease but this thought has now changed.*[94] (WHP)
	2.5 Stigma and discrimination	**The film has taught us a lesson to take care of those living with this disease just like we do for our own family members.** *In the past we rejected them because we thought that if we only touch them we will be infected with this disease but this thought has now changed.*[95] (WHP)

Strategic Priority	Cluster	KTP's Contribution
3 Strengthen organizational and human capacity for coordinating and implementing the National HIV and AIDS Strategy	3.1 Capacity Building	**The project addresses both research capacity building as well as community capacity building throught the collaboration of researchers and community participants.** *This film also teaches the young people of this community and a very good lesson to the entire community. This film will help us train and inform our young ones on our best they can avoid this disease.*[96] *(Enga)*
	3.3 Community Participation and action	**The project demonstrated that people involved in film production were encouraged to continue their participation in the project and to advocate for HIV messages.** *The local boys from Mu can form an awareness team and use it to make awareness in other communities and tell them about the disease. What has been happening in the community will be brought to light and people can learn from that.*[97] *(Simbu)*

7 Discussion

KTP's approach has been to deploy community members enrolled at educational institutions as researchers going back into their communities, and thus involve communities in sharing their stories. Moreover, KTP enabled student researchers to capture these stories because they were trained in sophisticated data gathering methods: interviews, focus groups, and film footage of people enacting their everyday lives and talking about it. The data produced through these methods was then fed back to the communities themselves, which led to very well-attended community gatherings where issues raised in the footage in particular were discussed, and where protagonists in the footage volunteered to stand up and deliver their insights and knowledge verbally to audiences. These outcomes created unheard of enthusiasm and willingness to discuss matters that heretofore were considered off limits.

KTP's baseline study confirmed the limited extent to which communities and community members were able to engage with HIV and AIDS related problems and risks within their own communities. The baseline study further confirmed that previous awareness campaigns, and health educational and promotional initiatives did not always have the intended outcome, with information provided becoming skewed in the course of community processing through ongoing and everyday dialogue.

KTP confirmed that a critical source of knowing and doing is precisely that ongoing, everyday dialogue among community members. That dialogue constitutes the source and basis of community members' understandings about and attitudes towards matters such as HIV and AIDS.

The baseline study was therefore critical on two fronts. First, it showed the extent to which communities had formal and accurate knowledge of HIV and AIDS health risks and management practices. Findings revealed considerable shortcomings in people's risk awareness and practical approaches to HIV and AIDS management. Second, the baseline study demonstrated that formal knowledge disseminated through health educational and promotional campaigns did not always meet its intended targets. This confirmed, in turn, that engaging with communities purely at the level of media production (resulting in ads, posters, education sessions, and so forth) risks missing out on engaging with the richness of everyday dialogue among community members.

It is precisely here that KTP registers its greatest achievement. By engaging communities in telling their own stories about how they perceive and live with HIV and AIDS, by engaging communities in transforming those stories into film products that can be shown back to them, their broader communities and other communities elsewhere, and by generating community-wide discussions through this reflexive process of issues otherwise seen as unmentionable, KTP has been able to plumb the rich vein of everyday talk through and from which community members obtain their understandings and confidence in particular insights and practices. Involving communities at this everyday dialogic level is a principle critical to understanding the real meaning and impact of KTP.

KTP's impact can be further explained by the fact that it involves community members in using and producing visual resources. These visual resources are produced using high-end film cameras, and the skills necessary for using these cameras were supplied during targeted, practical workshops whose aim was to induct student researchers into the basics of film-making, editing, sound design, and so forth. The visual dimensions of KTP rendered its methods and products immediately accessible for PNG communities, even ones who live in isolated areas and with limited access to mainstream media. This highlights another strength of KTP: involving communities in developing resources that pertain to them and their ways of talking about and managing health risks and problems enables those communities to establish a basis for themselves from which they can begin to develop their dialogues and practices oriented towards protecting themselves from the consequences of HIV and AIDS. The inclusion of PLWHA in both the film production and screenings is a crucial component of moving forward in regards to HIV and AIDS prevention and education in Papua New Guinea.

In what follows, we set out some of the theoretical principles underpinning KTP. The next section links KTP to indigenous research approaches developed for involving communities in more respectful ways in studies of problems and risks affecting them.

7.1. An Indigenous Approach to Public Health Research

Public health research in Papua New Guinea has long been dominated by Western approaches and paradigms, with indigenous values rarely being incorporated or acknowledged in PNG-based research methodologies and research processes

(Papoutsaki & Rooney, 2006b). Despite a slowly growing acknowledgement of the need to include indigenous ways of knowing and learning in research, there are limited examples of projects that apply an indigenous, or in PNG's case, a Melanesian approach (Thomas 2011). Undertaking research in PNG using an indigenous approach means being guided by Melanesian values. This further means remaining open to practices that may fall outside the 'traditional', 'objective' and knowledge accumulation model of Western research. In PNG, some of the strongest values that structure community life are relationships, reciprocity, and respect. In order to conduct what could be considered 'indigenous research', these values must be included at all stages of the research process, from intial project design to execution to subsequent analysis and dissemination of product or results (Wilson, 2008).

Where applied in a sincere, ongoing and meaningful way, the indigenous-Melanesian research paradigm becomes much more than a tokenistic effort at 'inclusion' or 'participation' of community members in the research occurring around them. Indigenous-Melanesian values have the benefit of affecting the research, opening new pathways to unexpected results and producing subsequent processes and further outcomes not foreseen in the planning of the work. KTP highlighted that the commitment, knowledge and talent of so many local researchers, students and community members was able to form an unprecedented nexus of creative engagement with the problem at hand. Here, researcher knowledge and conclusions were not the end point. Instead KTP sought and produced answers to the questions: how can we encourage communities to not only acknowledge and discuss HIV and AIDS, but use these discussions as a 'jumping off' point to change both their attitudes towards, and ultimately behaviours towards, the disease? The answer to this question, as KTP's considerable achievements demonstrate, does not lie with 'experts' or researcher outsiders. On the contrary, it comes from within communities themselves. It must emerge from the individuals for whom knowledge and change are imperatives.

Open Dialogue

Keep an open dialogue with communities. Story telling is great for gaining insights into perspectives and experiences. Be clear about;

» Community Benefits

» Consent

» Intended Output and foreseen impact

Respect for community values

Be aware of;

» Traditional gender divide [for sitting, talking, sleeping & bathing],

» Sacred sites,

» Personal behavior and attitude

» Religion and practices [such as prayer before meals, attending church and fellowships].

Listening and Observation

These are integral to indigenous forms of learning where a youngster listens and watches as the adult teaches.

» Be a student, learn [listen & observe]

Figure 7: Notes from the field by researcher Joys Eggins

7.2. Involving Communities in Creative Media Production

By engaging community members in telling stories that may become the basis of media productions a space is created for such stories that goes beyond once-off story tellings. Communities are fascinated when seeing their stories displayed on screen, and this experience invariably generates much discussion and response (Rodriguez, 2001). What further spurs involvement and interest is the process of giving communities opportunities to become involved in determining how

to present and portray their stories, who else to include in the visual edit as story-tellers or participants, what to include by way of portrayals of people's community contexts and situations, and so forth. Community members' involvement in these processes of visual data gathering and editing, as MacDougall showed some years ago, can be powerful, because it enables community members' practices, insights and knowledge to become explicit, tangible, and changeable.

It is not surprising, given the foregoing, that capturing Highland communities' stories on film and showing these films back to them had an overwhelming impact on the communities that had participated in the films' production. Screenings attracted large crowds, and attendance was animated, interested and engaged. Crowds stayed until the end of the screenings, interacted with the people on stage, some of whom appeared in the films, and listened keenly to their verbal renderings of what they had just seen on screen. This led to facilitated discussions which were lively and productive. Through this process, previously tacit and undiscussed matters were brought to light, sometimes because they were discussed using metaphors and images. Further, the stories themselves gained in stature through being represented on the screen, and this raised trust and confidence in communities to discuss HIV and AIDS risks and practices.

Critical to the success of KTP is its mobilization of a medium that to date apears to be largely reserved for the portrayal of non-PNG content (Rooney, 2004; Thomas, 2011). An overwhelming number of participants and audience members remarked that they had never seen Papua New Guineans, and particularly Highlanders, portrayed on 'the big screen', an experience they all found to be enjoyable, important and meaningful. In addition, mass media in PNG has failed to reach rural communities to date (Papoutsaki & Rooney, 2006a), and the low level of media literacy in these remote areas means that health messages are often not informative enough to provide an improved level of knowledge. Through KTP, community media and more localised media provided a springboard and platform for dialogue, a space for listening, questioning and discussing, and importantly for communities, an opportunity to redress the excessive reliance on and dominance of media produced by 'outsiders' about issues with limited (and perhaps even questionable) relevance to PNG communities.

Given the linguistic diversity in Papua New Guinea and the ineffectiveness of traditional health education and promotion relying on pamphlets and billboards as HIV and AIDS prevention strategies, KTP's integration of local story-telling, creative film making and design, participative editorial decision-making and reflexive community-wide feedback and discussion offers considerable advantages to health promotion and education in PNG. KTP enables communities to overcome language barriers through visual communication, engage communities in ways that are appealing and well-suited to existing cultures, and generate excitement by making the films and screening events relevant to local communities.

In that regard, KTP is an 'arts-based method' that aims at creating relationships and providing an "arena of exchange" for participants (Bourriaud, 2002, p. 18). Critical to generating such an 'arena of exchange' are visual potrayals and experiences: "Visual knowledge provides one of our primary means of comprehending the experience of other people" (MacDougall, 2006, p. 5). Visual information has greater and more immediate psychological impact (Arnheim, 1960). This point takes on extra significance, given that PNG is a particularly visual culture, with a rich history and tradition of visual arts and performance. By capitalising on PNG's visual tradition, KTP was able to open new channels of communication closed to more conventional awareness campaigns.

7.3. Changing HIV and AIDS communication in PNG

Health promotion and education in PNG are undergoing significant change. PNG is a unique country with myriad social and cultural complexities. No campaign can afford to ignore these complexities. Despite some modest successes, the vast majority of past campaigns has fallen short of achieving anticipated and projected levels of attitudinal and behavioural change (NACS, 2010). It is now widely recognized that mass media based campaigns have limited success in achieving attitudinal and behaviour change (Lie, 2009). In countries such as PNG, this problem is compounded due to the restricted reach of mass media, and limited faith in the acceptability of mass media messages. Despite the desire to reach as many people as possible, as soon as possible, PNG campaigns using mass media distributed messages, have been found to provide limited or

no information about HIV, and at times reinforce misconceptions and contribute to higher levels of stigma and discrimination. Even where communities or PLWHA have been consulted about campaigns and their impact, the results and implications of such consultations have been interpreted as warranting continued deployment of conventional and imported awareness raising techniques based on wide-reach and uniformity-of-message approaches.

It is only recently that a push towards a more localised, sincerely inclusive and creative approach to HIV and AIDS education has gained momentum in PNG and elsewhere. KTP situates itself within this emerging trend, bringing to it an additional element – wide-reach potential through the distribution of film as a medium that is adaptable to everything from showings on mobile phone and computer screens, intimate community showings using small projectors, national and international television, and the global internet. Projects such as Tokaut AIDS and Community Conversations paved the way towards more localised approaches for HIV and AIDS education. KTP recognises the need for localised approaches, but is also attuned to the importance of national and global distribution to reach wider audiences. The innovation of KTP's approach lies in its ability to short-circuit the local and the global. The defining features of KTP are that it is responsive to local concerns and interests, adaptable to suit unique social and cultural conditions, flexible in design and execution, and capable of capturing local and world imagination. This balance between local and global, community collaboration and wide dissemination, and unique content and targeted information, allows KTP to simultaneously advocate community experiences and needs, and achieve dissemination of its products in a wide range of environments.

8 Distribution Strategy for Films

Having produced the five KTP films over the course of the present project timeframe, the research team has turned its attention to the optimum distribution strategy, based on data collected from communities, networks built over the course of the project, and existing health education networks such as VCT clinics and education facilities. Phase One of the KTP project, as described in this report, has been able to demonstrate attitudinal change and audience's willingness to behaviour change. Screenings were held in the communities the films were produced in. The next phase of KTP will involve the films' distribution to wider audiences and further evaluation of its impact. The suggested distribution strategy will be linked to ongoing evaluation in regards to attitudinal and behaviour change in communities and of individuals.

The proposed distribution strategy involves four vectors of dissemination, in addition to a ready-to-use facilitators guide and use of social networking sites. The four principle avenues include: national/urban; regional/rural; education/schools; and health centres/NGOs. This strategy recognizes the unique situations and needs of these target groups, and seeks to work with the specific opportunities and strengths inherent in each. While some of the avenues of distribution will encompass all geographic target groups (such as mobile phones, radio, VCDs, engagement with VCTs and health centres, educational facilities, and promotional materials), some strategies are tailored to specific conditions and needs, and thus contribute to the impact of this campaign in distinct ways.

Komuniti Tok Piksa envisages an open and continuous dialogue with media organizations and social networks throughout the campaign period, particularly around the launch of the films nationally in 2012. The most significant immediate distribution of the films, however, despite the intended media utilization, will be the formation of national networks of schools, universities, VCTs and PACs, through which the films will be distributed in conjunction with the facilitators guide and appropriate training of future facilitators through KTP's unique training and film advocacy program.

8.1. Facilitated Screenings and Film Advocacy Program

A key component of the distribution strategy of the KTP film series will be a comprehensive facilitator's guide that a wide range of people (from community advocates, teachers and health workers) will be able to use in conjunction with film screenings and subsequent group discussion. The strategy has shown significant results in other countries such as South Africa (STEPS 2007, Levine 2007), in particular with hard to reach and largly illiterate audiences. KTP screenings have shown that while films provide information, they also raise a lot of further questions. The unique situation of group screenings where individuals seek further information needs to be used in order to provide these groups with information they require and that is relevant to them. This localised form of film distribution targets rural communities, educational institutions (such as schools and universities), as well as Health Centres. The training component also involves NGOs that work with communities so that the KTP Film Advocacy program can develop in a wider network and distribution can be improved over time.

Facilitator's Guide

The facilitator's guide will include the five KTP films, a guide to facilitating discussion around each specific film (for example, following the Simbu film Painim Aut, discussion could centre around getting tested, condom use, or familial pressure and intergenerational tension), and any resources that may be needed to answer questions raised as a result of the films or discussions (for example factual information about mother-to-child transmission, or what occurs in a blood test). This health information will draw from up-to-date, reliable and where possible local resources, and will be presented in an easily accessible format as part of the facilitators' guide. The facilitator's guide, at the time of its launch, will be ready to use, but a trained facilitator's network will be formed to ensure targeted distribution.

Training Facilitators

The KTP team will hold training workshops, through which interested representatives from NGOs, government, schools, universities, VCT clinics and PAC offices will be offered an intensive workshop in using the films and facilitators guide, as well as using the innovative KTP methodology to design further creative health education resources in their own communities. KTP will also train community facilitators through a community film advocacy program. These training workshops will ensure the development of a national network of trained facilitators able to disseminate the films in effective, efficient, appropriate and sustainable ways. Through establishing this network of individuals in strategic organizations throughout PNG, KTP aims to ensure that the questions and issues the films raise can be addressed immediately in all local areas through the facilitators guide and accompanying health information resources.

Distribution will be monitored to ensure a network can be built that will also assist in evaluating the impact of the films and its faciliated discussions.

❖ Community Advocates

One of the strongest elements of KTP has been the active and enthusiastic response from Highland communities to the KTP project and films. Community members in all provinces frequently expressed a desire to disseminate the film produced in their community themselves, showing a significant sense of ownership of and investment in the films (see section 7 Findings). The proposed distribution strategy therefore includes the training and equipping of community members to travel to their neighbouring communities and conduct screenings, and to distribute the films through their personal networks. Many teachers and church and community leaders throughout the course of the project expressed a strong interest in screening the films in their respective areas, and the utilization of these community leaders will be key in reaching notoriously difficult-to-access rural and isolated populations that often fall outside the reach of rural, mass media or print-based campaigns. Local haus piksas could provide a unique and extremely effective space for community-driven screenings, as well as school, church or traditional community gathering places. The KTP team would like to work with PACs to introduce and to monitor this localised distribution.

❖ Education – Schools and Universities

The KTP films have a significant potential in reaching and engaging youths due to their edutainment capacity. As one of the most at-risk groups for HIV & AIDS infection, this group requires targeted strategies to engage them in not only increased awareness but also, importantly, impacting on behaviour change (Tufte and Enghel 2009). This distribution strategy specifically targets this group through use of KTP resources in schools and universities. The issues addressed in the films, as well as the characters, are easily identifiable for youth. The education strategy includes building the characters and resources into existing HIV & AIDS curriculum, providing tailored education and facilitator packs (as well as training) to teachers, and targeted appearances by the film characters in schools. Training of peer educators and qualifying teachers will be done in consultation with lecturer's from UOG's compulsory HIV/AIDS course. Further, the campaign will make use of UOG's unique educational networks as the leading teacher training institution in the country.

❖ Health Centres – NGOs

As with teachers and educators, NGO and health centre workers will be provided with a tailored screening and facilitation guide, as well as promotional material around the campaign. The films will be provided, and where appropriate built into existing education and prevention strategies used by these organizations. VCDs will be widely distributed, and the networks already established through their existing programs utilized to organize screenings, competitions and distribution of promotional material. Both health centres and NGOs that the research team has already worked with have been enthusiastic about the resources, and have seen positive responses to them. The University of Goroka and Komuniti Tok Piksa team have strong ties with Highland VCTs, NGOs and health centres. The momentum already at work in these networks will be of significant advantage, as it allows distribution and promotion to proliferate outside the scope of the project team or mass media alone, and reach the audiences already engaged by these groups. Building these networks and partnerships will be invaluable to ensuring maximum spread of these resources.

8.2. Mainstream Media

This arm of the strategy will predominantly address audiences that are engaged with mass media, and utilize this engagement to build the profile of the films, the characters and stars of which will appear at selected launches and screenings. By beginning with a national/urban launch and an initial media campaign, the films will build a wider profile that

will complement the success of more localized elements that form the backbone of the distribution strategy outlined thus far. The media strategy will incorporate television, radio, mobile phones, and an online presence, as well as publicity through print media coverage of the films. Already KTP has had a significant presence in local media, indicating that the project is of interest to a variety of outlets.

The mass media campaign would utilize primetime television programming, local and national radio station spots, online and Web 2.0 marketing, including a Facebook page offering live chat, online games, live updates from screenings, discussion forums, and downloadable resources. The campaign will also take advantage of the huge popularity of mobile phones, particularly Digicel's bulk texting capacity, which UOG already use with distance learning students. Bulk texting would enable the project to reach wide audiences even where communities are geographically isolated, run quizzes and interactive games, and gather data about the demographics interested and participating in these intitiatives.

This distribution strategy targets both local and mass audiences. While the films have the potential to reach wide audiences, providing additional information with and around the films can have a significant impact in raising awareness and changing behaviours. Networks must be built between educators, institutions and communities to ensure that discussions can continue beyond the KTP films. This process must happen in consultation with all partners, including the communities that have been involved in producing the films thus far.

9 Research Capacity Building

Building research capacity was one of the primary objectives of KTP. Throughout the project, ongoing training, support and opportunities were provided to participants, particularly at the University of Goroka, where both students and staff were involved in workshops, fieldwork and research analysis in order to increase their capacity to continue to conduct visual and collaborative research at the completion of KTP's initial run. This capacity building element was in line with KTP's commitment to conducting research that was inclusive of local researchers and sustainable in the long term. Sustainability is key in ensuring longitudinal success of research projects, particularly when aimed at increasing health education and changing behaviours, which are goals that may only come to fruition over a significant period of time. By training researchers at the University of Goroka and actively involving them in all stages of planning, execution and analysis of the project, KTP has built a strong foundation from which to continue its work in HIV prevention and education.

A range of **strategies** were employed by the research team to foster increased capacity at UOG. In collaboration with the University of Technology Sydney, these strategies have been put in place over the course of KTP's eighteen months. The principle strategies included:

» Training researchers at all levels (undergraduate, postgraduate students and staff members). This training included a series of workshops (see Chapter 3 Project Design section); one-on-one meetings to discuss individual projects or interests; inclusion in fieldwork trips; 'on the job' training in data analysis, report preparation, qualitative data collection, and presentation of results; and support in attending and presenting at conferences, both nationally and internationally.

» Creating an atmosphere for researchers at all level to collaborate and work in teams;

» Exploring indigenous and participatory approaches as a team and encouraging researchers to design and contribute to the overall KTP research approach;

» Training researchers in the use of visual technologies and media tools;

» Directly working with communities and using researchers' exisitng links to communities;

» Mixing people from various faculty to address the complexity of the HIV issue;

» Establishing strong links to the HIV Committee at UOG;

» Bringing numerous international collaborators to UOG to share their various areas of expertise and assist in the training of UOG students and staff;

» Supporting undergraduate students in their own research under the broader framework of KTP, including the use of innovative visual methods;

» Encouraging local researchers to pursue conference presentations, publications, and other professional development opportunities, and supporting them in any way possible to do so.

Results:

» 7 undergraduate students submitted their final research reports, having undertaking their projects under KTP as their final year research project;

» 1 Honors and 1 Masters completed;

» PhD (in Sydney) still in progress beyond the initial funding of the project. The PhD student, Kate Britton, has continued involvement in KTP

following its initial run, and is planning to submit her thesis in 2013;

- The active involvement of six UOG staff members, all of whom will be involved in publications about the results of the project;
- The establishment of the Centre for Social and Creative Media at UOG to continue to develop and utilize the KTP methodology in a variety of projects. This includes five salaried positions to be taken up by KTP researchers;
- 8 international conference presentations by upcoming KTP researchers;
- 2 overseas Masters scholarships have been received by KTP members to continue research around HIV and AIDS in PNG.

In addition to increasing research capacity at the University of Goroka, KTP sought to increase the capacity of community members to actively collaborate on awareness programs, and to have some control in the subsequent use and distribution of the resources produced. KTP's commitment to ongoing contact with the communities involved in producing the films was a vital basis for supporting this increased capacity. Through regular discussions with community members about the films, their messages, and their distribution, the research team introduced a level of critical reflection to the community relationships, and worked with community members to ensure that their input and ideas were manifest in the final products. As is demonstrated in Chapter 6, many participating community members expressed a desire to be personally involved in distributing the films to their neighbouring communties, and in acting as an advocate for the messages embedded in the films. KTP is commited to ensuring that adequate training is provided to these and other interested parties, as outlined in the distribution strategy (Chapter 8). Through the faciliator's training programs the research team hopes to implement reflect another capacity building opportunity, as local community members, health workers, and educators will have the chance to become trained facilitators.

10 Conclusion and Recommendations

Komuniti Tok Piksa sought to break new ground in approaching research and HIV prevention in PNG. The cases included in the study demonstrate the need to further engage in meaningful communication about the disease, particularly in remote communities isolated from mass media and health centres. Considering the difficulty of accessing many communities, perhaps the most interesting short-term finding of the project is that communities are willing to be mobilised and trained to undertake awareness themselves, and that the filmic products equip people with the tools to bring HIV prevention messages across to others.

KTP produced five documentaries revealing the day-to-day HIV and AIDS management practices and knowledge of local community members. Without the filmic medium, their stories might never have surfaced. The constructive tenor of their stories inspired audiences around PNG, generating discussions about topics hitherto avoided and putting a human face to HIV messages. As individuals, these people enriched screenings by supplementing the documentaries with their presence and their voice, and extending their stories with further commentary and insights. The sympathy that this engendered during the screenings was palpable; the respect that it produced was obvious from audiences' silence, and the learning that it occasioned was evident from the discussions followed on from the screenings.

KTP's success is also due to those who were able to elicit the stories, the knowledge, the wisdom, and the community discussions. The principle of involving local researchers in a program that mediates between communities, researchers, public health agencies and national and international media is absolutely critical here. It is this principle that is directly applicable to other public health initiatives in PNG and elsewhere. KTP's local capacity building was strong: KTP engaged a total of 25 emerging researchers, provided scholarships for a masters and an honours student, and in the short time of 18 months established itself as a permanent research centre at the University of Goroka. UOG has agreed to continue the work that KTP began under a new research centre that will be established at the conclusion of KTP in the area of media and visual comunication. The KTP project will thus continue to run through the centre, seeking to continue to innovate research approaches with communities, as well as to continue producing educational HIV prevention material in various media. In this way, KTP has ensured that the high benchmarks reached in community involvement, participatory inquiry, visual research and filmic production are sustained in Papua New Guinea and carried into the future.

Recommendations

Based on the findings outlined in this report, the KTP team would like to make the following recommendations about approaches to HIV prevention and education in PNG, and in order to continue and sustain the impact that such projects can have:

1 Ensure community participation in public health projects

Participatory enquiry is fundamental in enabling community members to articulate concerns and insights around complex health issues. Increasingly, the need for communities to be trusted in addressing HIV and AIDS in their own way is being acknowledged in education and prevention efforts. This trust must become part of the processes of implementation and be made manifest by prioritising the maintenance of good relationships with communities by awareness teams. Building trust through ongoing consent and sincere collaboration is critical in enabling communities and individuals to learn and change.

2 Increase visual production and visual research in PNG

The success of the KTP project demonstrates the considerable potential of visual resources in PNG. More films and visual research should be considered to target specific goals of the NACS strategy. Important here will be the continuous involvement of communities and PLWHA to ensure such communication strategies are effective. Organisations and stakeholders should recognise the impact that participatory visual projects can have on the success of awareness programs, as KTP demonstrates. Considering the rapid change of communication patterns and behaviours in PNG, visual methods offer a unique opportunity to harness these communicative technologies for education and advocacy.

3 Build local capacity: innovating the use of media tools for social change

In order to continue to undertake innovative research that can account for the multiplicity of voices in PNG and capture some of the changing environments, research and production capacity must continue to be built in local institutions. The setting up of the new Centre for Social and Creative Media at UOG is one step forward in establishing institutional capacity to train people and increase the number of researchers and educators applying media tools for social change, however capacity building of this nature should be implemented throughout PNG, continuing to build networks and skill bases throughout the country. Beyond institutional capacity, programs should also address the training of community advocates and regional facilitators in HIV education.

4 Film advocacy: national media campaigns through locally-designed products

A critical assessment of existing mass media strategies should be undertaken to mitigate the potential reinforcement of stigma and discrimination that can occur as a result of these resources. NACS' role in assessing, coordinating and evaluating IEC material in the country is crucial to an effective national response. Media and communication strategies must be developed locally, involving a wider range of people in furthering health education about HIV and AIDS. Even when national distribution is anticipated, local or 'grassroots' communities must be involved in designing these messages. KTP's findings indicate that this kind of local development of media resources has a significant impact on the acceptance of such resources among the general population.

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Appendices 12

12.1. Projects and Publications Outputs Table

Conferences			
2010			
AAAPS Melbourne	*Exploring local methodologies through creative collaborations with Pacific communities*	Thomas, Papoutsaki, Mel	April 2010
AMIC Singapore	*Visual Dialogues, Community Action & Social Change: a South Pacific Islands HIV/AIDS project application*	Thomas, Papoutsaki, Eggins	June 2010
Pacific History Conference Goroka	*Em Mipla, Na Yu? – Using photo narrative as tool for expression of personal histories around HIV and AIDS*	Siwi, Thomas	September 2010
ASHM Sydney	*Visual narratives as HIV/AIDS prevention strategy in Highlands Papua New Guinea*	Kualawi, Thomas, Eggins, Britton	October 2010
ASHMA Sydney	*The use of photo narrative as method for self-expression of people living with HIV/AIDS: a case study of a care centre in the EHP of PNG*	Siwi, Thomas, Landu	October 2010
2011			
AMIC India	*Engaging the youth in community action: a visual methods approach to HIV & AIDS awareness*	Eggins, Papoutsaki, Thomas	June 2011
AMIC India	*Facilitating production of visual messages on HIV and AIDS with local communities: the dilemmas of collaboration, consent and ownership*	Thomas, Siwi, Barry, Eggins, Papoutsaki, Iedema	June 2011
IAMCR Turkey	*Focus on community participation work within an indigenous framework for the participatory research session*	Thomas, Eggins, Papoutsaki	July 2011
Visual Methods UK	*Komuniti Tok Piksa: Visual methods as strategy in HIV and AIDS awareness in Papua New Guinea*	Thomas, Siwi	September 2011
UOG Students			
Undergraduate	*The perception of Discrimination of HIV positive people: A comparitive study in urban and rural areas*	John Irum	
Undergraduate	*Socio-Economic Factors contributing to HIV/AIDS*	Robert Karenga	
Undergraduate	*HIV and AIDS education in regards to 'better care and support' of PLWHA*	Thomas Olong	
Undergraduate	*Communities' perspectives of PLWHA: A study in the Tabere area in the Simbu province*	Yamitna Gaima	
Undergraduate	*Incorporating Indig. Knowledge in Education & Prevention Strategies*	Johnson Andima	
Undergraduate	*The effectiveness of using photography in HIV and AIDS prevention: A case study in a secondary school in WHP*	Erikson Haskei	
Undergraduate	Modern music as a tool for HIV/AIDS awareness among teenagers	Bafinuc Ilai	
Masters Thesis	Creating HIV and AIDS Messages with Communities: An Indigenous Communication for Social Changes Approach	Joys Eggins	
Honours Thesis	The significance of visual communication in conceptualizing HIV and AIDS in PNG	Melvin Kualawi	

UOG Staff and others

UOG Staff	Rekindling of indigenous knowledge and practices of Enga in prevention of the spread of HIV AIDS	Alice Kauba
UogUOG Staff	Photo Narrative as tool for self-expression for PLWHA	Lillian Siwi
Community Liaison	Photo Narrative as tool for self-expression for PLWHA in counselling	Paul Landu

UOG Staff	Photo Exhibition Em Mipla, Na Yu	Siwi, Thomas, Landu
Masters Project	Film: Broken Home	Joys Eggins
Undergraduate Project	HIV awareness Song	Bafinuc Ilai

12.2 Baseline Interview Guide

1. Respondent's introduction:

First name, age, village of origin, education, marital status, children, occupation, interests, status in community (if relevant)...
(for community agents, please find out some more details about their group and affiliation)

2. Knowledge about HIV and AIDS and STIs

When you think about HIV and AIDS, what comes to mind? What do you think about?
What do people say about it? What do they call it?

3. Transmission

How is HIV transmitted?
Which group of people (possibly follow up; age-group) do you think are at risk?
What are the places that pose a higher risk than others?

4. Diagnosis:

How does one know one has HIV? How does one know one has AIDS?
Where can you find out? Where can you go for a test?
Who are the people providing tests?

5. Prevention:

Do you know how to prevent getting HIV & AIDS?
Are some ways safer than others?

6. Opinions about condom

Do you know what a condom is?
How do you personally feel about condoms?
Do you know how to use a condom?
Do you use condoms? (if you feel it is appropriate)
In your opinion, are condoms effective in preventing the spread of HIBV? Why/why not?
How are condoms available in your community? How much do they cost?
How should condoms be made available in your community?

7. Attitude and behaviour towards person living with HIV or AIDS

How do you look after people who have HIV or AIDS?
How does your community feel about people living with HIV or AIDS?
What stories around HIV or AIDS or people living with the disease are there in your community
Do you personally know of a person with HIV or AIDS?
Has anybody HIBV + come out in the open in your area? Tell a story…

8. Sources of information on HIV and AIDS

Where did you get your info about HIV and AIDS?
Tell in detail: what did you hear? What did you read?, What did you see?
Where was it: At Home? At church? At school? At the mama group? At the youth group? Others...
When discussing issues, who do you choose to talk to and why?
What do you talk about? What do you ask questions about?
Has this information helped talk about it? Has it helped change behaviour? Has anything changed?

9. Impact on attitude and behaviour

Have people changed their behaviour since they know about the virus? How?
What effect is this having on young women and men in relation to marriage?
Do you do anything to prevent getting infected?

10. Sexual negotiation capacity

How has the presence of HIV and AIDS changed the relationship of women and men?
Do you think changes are needed in the relationship between men and women?
How do people in your community talk about sex?

11. Your own community, the youth

What can you tell me about your community: Name the different categories of people inside your community?
Who has influence? What are their opinions, particularly concerning relationships and behaviours?
Are there any beliefs (religion), customs, or values that are strong in your community regarding behaviours and relationships? How does that affect individuals' attitudes?
If things have changed, what brought about these changes?
What are the things that work well inside your community?
What are the things that do not work well, that could be improved?

12. Information / action/ work with the community

In your opinion, what kind of information on HIB and AIDS is needed in your community? What would be the best ways to pass on this information?
Do people receive information through the media?
Is there a place where people with HIV or AIDS receive treatment?
Do you have any group or organisation in the community that can give ideas on HIV prevention?
What would you do in order to change attitudes in the your community?
What kind of information or work is needed in your community to change things, to improve people's awareness and prevention of HIV and AIDS?

13. Conclusions and Recommendations

Improvements/ suggestions?
What might be needed to bring more change in the community?
Who can bring that change?
Do you require more information about HIV and AIDS? Who should give that information?
Is there anything else you would like to say?

End of interview: Tenk yu tru…

12.3. Baseline Evaluation Questions

1. Igat sampla senis lo lukluk blo yupla wanwan long HIV & AIDS taim displa grup KTP bin kam pastaim long komuniti bilong yu?

Has anything changed since KTP came to the community? Have you changed anything? Has the first visit prompted any community action?

2. Aste yupla lukim piksa, yu gat sampla moa tingting lo displa? Piksa em givim wanem kain skul long yu?

Add anything to the screening comments? Have you had any further thoughts since then?

3. Igat sampla hap lo piksa you tingim yet? Yu bin laikim women hap blo piksa?

Which part of the film do you remember best? Which part did you like the most?

4. Stori lo displa piksa em tru save kamap long komuniti blo yu o nogat?

How has the film related to your experiences?

5. Nau yu ting yu ken mekim wonem samting insait long komuniti long senism pasin long sik HIV na AIDS?

Motivation for action (personally/for your community) How can it be achieved?

6. Sapos mipla givim displa piksa long yupla, bai yupla givim long husait? Na hau bai ol yusim?

Who would you give the film to? Why and how would they use it?

12.4. Consent Form Template

The University of Goroka
PO Box 1078
Eastern Highlands Province
Papua New Guinea

Centre for Health Communication
University of Technology Sydney
PO BOX 123
Broadway NSW 2007
Australia

COMMUNITY PARTICIPANT INFORMATION SHEET

TO BE KEPT BY PARTICIPANT

The following information is for those volunteering to take part in the research project called KOMUNITI TOK PIKSA. You do not have to be involved, but if you wish to, we very much appreciate your contribution to the study. The study is conducted in all five Highland provinces.

Title of the study:
KOMUNITI TOK PIKSA

The research team and project funder:
The research team that you will be working with is made up of students and junior staff of the University of Goroka. The National AIDS Council of Papua New Guinea is funding this project. The project is being done to better understand the driving forces and risks of HIV & AIDS in the country.

Introduction:
HIV/AIDS has been in Papua New Guinea since 1987. In 2004 it was considered a serious generalized epidemic, with 1% of the population affected. Infections have been increasing at approximately 30% per year since 1997. Everyone is in some way affected by the disease, as friends, community members of co-workers are infected with the virus. There is not always enough information about HIV and AIDS in PNG communities. Education campaigns are important to prevent a further spread of the virus. The study hopes to contribute to better understandings of HIV and AIDS within PNG Highland communities. In order to do so, we would like to understand what people know already and how people use their knowledge within their communities.

Please read this Participant Information carefully. Feel free to ask questions about any information in the document. You may also wish to discuss the study with a relative, friend, colleague or someone from the project. Feel free to do this. Once you understand what the study is about and if you agree to take part in it, you will be asked to sign the Consent Form. By signing the Consent Form, you indicate that you understand the information and that you give your consent to participate in the research study. You will be given a copy of the Participant Information and Consent Form to keep as a record.

The study:
KOMMUNITI TOK PIKSA will work with you to find out what your community knows and thinks about HIV & AIDS. Through storytelling and talking, both you and project members can share and exchange information about what is happening in communities. The research aims at talking about HIV & AIDS in order to create awareness within the community. A video camera will be used to record the storytelling taking place and the film will be played back to you and those who want to see it. Any feedback or thoughts arising from watching the film will help both of us to understand what communities are saying and know about HIV & AIDS. The stories will later be shared by showing the video to the other communities outside your own.

What will you do in the study?

You will be involved in:

- *An interview with a KTP researcher of about one hour. The questions you will be asked in the interview are about your specific knowledge of HIV & AIDS. The interview will be tape recorded and transcribed.*
- *group discussions and feedback sessions about issues surrounding HIV & AIDS.*
- *You may be asked to complete a survey. The questions you will be asked in the survey are about your thoughts of HIV/AIDS. Your answers to the survey questions will be recorded on a questionnaire.*

What are possible benefits?
Possible benefits include better understanding and knowledge of HIV & AIDS as well as a better understanding of what your community thinks about the issue. Your contribution will also help create awareness to other communities about HIV & AIDS. We cannot guarantee or promise that you will personally receive any other benefits from this study.

What are possible risks?
As the study deals with areas that can be emotional, there may be some issues raised in the interviews that can upset you. Counselling will be available free of charge at the University of Goroka to any participant who wants or needs counselling as a result of their participation in the study (Director Councelling: Ms Monika Pusal). You can suspend or end your involvement in the study at any time if you become upset. Previous study has shown that most research of this kind has a positive impact on interviewees as they have a chance to tell stories they may not otherwise be able to voice.

Participation is voluntary
Your participation in this research is voluntary. If you do not wish to take part you don't have to. If you decide to take part and later change your mind, you are free to withdraw from the study at any stage. Before you make your decision, a member of the research team will be available to answer any questions you have about the research study. You can ask for any information you want.

Privacy, Confidentiality and Disclosure of Information
Any information found in this project that will identify you will not be made public unless you give your permission. It will only be made public if you give your consent. If you say yes by signing the Consent Form, we plan to publish the results with the National AIDS Council PNG. The plan is also publish the results through educational DVDs, which will be available to the general public. In case you do not agree to be identified, your name and any identifying details will be removed from field notes and transcripts before analysis and publication. Original materials will be stored safely and only accessed by the core researchers of the project.

Contact Details
This project will be carried out according to the guidelines of the Ethical Committees of the University of Technology Sydney and the University of Goroka. Should you need any further information, have concerns as a participant in this research, or you have a complaint about the way in which the research is conducted, please contact:

The Executive Officer
Ethics in Human Research Committee
University of Goroka
P.O. Box 1078
Goroka, Eastern Highlands Province 441
Tel. (675) 731 1700
Fax. (675) 732 2620
We would like to thank for your time and interest in taking part in this study.

Community Consent Form to Participate in a Video-Filmed Sessions in the Research Project
KOMUNITI TOK PIKSA

I, ____
(please print your full name)

of,____
(village) (district) (province)

have been invited to participate in a video-filmed session as a result of my participation in a research project entitled *KOMMUNITI TOK PIKSA*.

I have read the information sheet related to this project and have been informed (verbally) of the following points:

1. Approval for the protocol has been given by the Human Research Ethics Committee (HREC) of the University of Technology Sydney and the Ethics Committee at the University of Goroka.

2. The aim of the project is to provide information about the understandings of HIV & AIDS in highland communities.

3. This video interview follows my participating voluntarily, and with full and informed consent, in an interview as part of the research study. As a result of this interview, I have been asked to participate in a video-filmed interview to be used in a final video product to be distributed nationally and potentially internationally.

4. I understand that counselling services are available to me at the University of Goroka in the event that I require them. In the event that I utilise these services, I understand that I will not incur any expense.

5. My involvement in this project may be terminated if distress occurs.

6. I can refuse to take part in filming, or withdraw from filming at any time.

7. I understand that neither my community nor myself will receive any monetary payment for the participation in the study.

8. I understand that by consenting to this video interview, I will be identifiable and that no de-identification will take place in video materials.

9. During the course of this study, I will be informed of any significant new findings (either good or bad) such as changes in the risks or benefits resulting from participation in the research or new alternatives to participation that might cause me to change my mind about participating. If such new information is provided to me, my consent to participate will be re-obtained.

10. Given that I have provided my correct address, I will receive a free copy of the final DVD product. I understand that is not promised to me that my interview will be part of the final DVD.

11. I declare that I am over the age of 18 years.

Please tick one of these boxes to indicate whether or not you wish to be identified in the film

☐ I agree to be identified in the film and agree that Komuniti Tok Piksa can use the material filmed for distribution worldwide in all media in perpetuity.

☐ I do not want to be identified in the film

After considering all these points, I accept the invitation to participate in this project.

I am aware that I will be given a copy of the Participant Information Sheet and Consent Form.

Signature: ________________________________ **Date**: _______ / _______ / _______
(of participant) *(day)* *(month)* *(year)*

Witness:________________________________ **Signature**: ________________________
(Please print name) *(of witness)*

Investigators' confirming statement:

I have given this research subject information on the study, which in my opinion is accurate and sufficient for the subject to understand fully the nature, risks and benefits of the study, and the rights of a research subject. There has been no coercion or undue influence. I have witnessed the signing of this document by the subject.

Date: _______ / ________ / _________
(day) *(month)* *(year)*

Investigator's Name: ____
(please print)

Investigator's Signature: ____

NOTE:
The University of Goroka's Ethics in Human Research Committee has approved this project. If you have any complaints or reservations about the ethical conduct of this project, you may contact the Committee;

The Executive Officer
Ethics in Human Research Committee
University of Goroka
P.O. Box 1078
Goroka, Eastern Highlands Province 441
Tel. (675) 731 1700
Fax. (675) 732 2620

Any issue you raise will be treated in confidence and investigated fully and you will be informed of the outcome.

tingting olsem displa kain name ya HIV/AIDS ya kain olsem emi sik nogut we olisave tok olsem ah…binatang nogut we stap insait lo bodi blo man or meri. (KTP_BL2010_EHP_Aiyura_Info02)

2. Mipela kolim AIDS. Long tokples Enga, mipela kolim siknogut. Minim olsem siknogat marasin na em save kilim I dai manmeri. (KTP_BL2010_Enga_Laiagam_Info05)

3. Em Olsem HIV/AIDS em ol tok. HIV first tingting bilong mi, mi tingting olsem em dispela sik nogut. Dispela sik em kam long kilim man idai olsem na hau bai mipela tambu dispela sik kam insait long bodi bilong mipela? Dispela mi tingting planti (KTP_BL2010_WHP_Kuruk_Info09)

4. Mi save olsem nogat marasin bilong dispela sik so ting bilong mi em mak bilong dai tasol. (KTP_BL2010_Enga_Laiagam_Info04)

5. …sik AIDS em bush fire insait long country long Province longe Komuniti long village long ples tu. How bai mipla stopim dispela sik? Na dispela sik how bai mipla ino painim dispela sik? (KTP_BL2010_WHP_Ruti_Info01)

6. Mi save harim na mi save poret tu ya. Em wanpela sik ya, em no save givim sans long ol man. Em wok long kilim planti man na ol save wokim awaness na mipela save harim long em ya. Na mi gat bikpela poret long dispela sik. (KTP_BL2010_EHP_Aiyura_Info03)

7. Mi no save but tai mol tokim mipla olsem ol man usim shaving masin o tit bras, ol tok ino ken usim, em displa ol tokim mipla lo em,em mi save na narapla em olsem taim man meri tupla go pas o igo faul, em displa rot bai u kisim. Displa em mekim mipla poret wer mi poret na mipla ino inap go klostu o ino inap usim samting blo narapla man. Displa em mekim mipla olsem bai luksave olsem bai mipla bai ino inap lo kisim displa sik (KTP_BL2010_EH_Okapa_Info06)

8. Mi save poret long dispela sik. Taim mi harim olsem sik ya kam stap long komiuniti, mi poret nogut. Na tu mi no save stap wantaim ol man I gat dispela sik AIDS. (KTP_BL2010_Enga_Laiagam_Info08)

9. Taim man igat dispela sik mi yet mi save lukim olsem sit blo paia em kamap long face igo igo na taim gras bilong kam aut na bebi gras em kamap ken nau, em mi save olsem em igat sik. Emi go skeleton na bun kakaruk nau, em mipela luksave olsem dispela sik ya em kamap.(KTP_BL2010_EHP_Aiyura_Info05)

10. Lukluk long bodi blo man, taim skin bilong em igo bagarap or skin blong em or gras bilong em raus nabaut or das kirap long skin blong em, mipela isave olsem em igat disla sik HIV AIDS. (KTP_BL2010_EHP_Aiyura_Info08)

11. Mipla ino save wanem samting tru em sik AIDS tasol ol wok long lusim skin na ol man meri wok long go liklik liklik em ol tok displa sik em kamap long ol. Na mipla ol lain man meri long ples mipla luksave long displa sik, taim mipla lukim skin blong ol man meri. (KTP_BL2010_SHP_Hulpin_Info03)

12. Ol save tok olsem sik HIV em save kam long pasin pamuk yu lusim man b long yu or meri lusim man na go faul wantaim narapla man sik bai kam olsem so yupla mas lukaut ol save tok olsem na mi save fret liklik long displa na nau mi laik stori olsem mi lukim disipla sik HIV em olsem planti sampla signs kamap long skin blong ol na ol dai na ol go lus weight na dai mi lukim stap mi wok lo ng fret na nau mi lukim em olsem sik stap long skin b long ol or nogat em mipla no save hard long luksave long displa (KTP_BL2010_SHP_Hulpin_Info05)

13. Yumi lotu gut na stap ananit long toktok/lo bilong Papa God bai orait. Dispeka rot tasol bai mekim yumi kisim gutpela pasin na kamapim gutpela sindaun long komiuniti. (KTP_BL2010_Enga_Laiagam_Info05)

14. Dispela em long usim kondom. Tasol mi no save gut kondom bai helpim yumi o nogat. Kondom kam stap long komiuniti na planti pasin pamuk I wok long kamap. Kondom bai ino inap stopim dispel sik AIDS. (KTP_BL2010_Enga_Laiagam_Info08)

15. Sampla taim em mi no save yusim kondom but wanwan taim mi save yusim kondom na havim sex wantaim wanpla meri em mi nonap kisim filings skin to skin em more best em mi save ting olsem na mi no save yusim kondom (KTP_BL2010_WHP_Ruti_Info06)

16. Ol lain long komiuniti bai i sori na lukautim gut sapos wanpela i kisim ol narepela sik. Sapos wanpela kisim sik AIDS na sik stap long komiuniti, em ol save less/poret long go klostu long em. Na tu ol bai tok, "em sikirap na hat wok em mekim na laikim long en em kisim. Yumi wari long wanem asua bilong yumi/komiuniti? (KTP_BL2010_Enga_Laigam_Info11)

17. Ol lain gat sik save kam stap namel long mipla, em mi save sori long em ken, becos marasin nogat na mast, bai yu dai na mi yet save filim sore long displa lain. (KTP_BL2010_WHP_Ruti_Info09)

18. Mi lukim ol lain infected mi sori long ol na tu mi prêt na mi prêt tu long marit becos mi no inap save man bilong mi go raun mi bai ino inap save. (KTP_BL2010__Simbu_Mu_Inf06)

19. Original quote in Huli language

20. Husait lain harem ol save hariap long toksave/tokim ol narepela ol i no harem. Olsem na sapos, ol lain i no harem bihan sakim tok na kisim sik, em ol lain save les long lukautim/helpim ol. Toksave save kamap long wanwan haus o long pablik ples.

21. Em olsem nogut ol liklik pikinini tu bai harim kain ol toktok olsem na mipela isave poret long toktok long public. Awareness taim em mipela ino save prêt, mipela isave tok aut nabaut na taim natin nabaut em mipela isave sem long toktok long ai bilong ol man. Mipela isave hait na toktok arere nabaut. (KTP_BL2010_EHP_Aiyura_Info08)

22. Nogat. Olsem long dispela yu tok sex side ya, em ol ino save tok aut ples klia. Olsem mitupela stori ya, em secret ya, olsem na mitupela yet bai toktok. Long public olsem, ol ino inap tok aut. Ol bai sem. Ol bai tok em secret blong mi so ol ino inap tok aut. (KTP_BL2010_EHP_Aiyura_Info09)

23. Mipla laik lo awanes mas kamap so ol lain lo health department bai kam na tokim mipla lo ol sik wer wok lo kamap lo komuniti. Na taim ol wokim olsem, ol bai daunim displasik nogut lo komuniti. (KTP_BL2010_EHP_Okapa_Info08)

24. Em igutpla olsem wanwan taim mipla ken go olsem grup na mekim awareness wanem ya because ol save pinis wanem samting em AIDS na wanem samting em displa so igutpla moa everytime olsem once in a while nambaut yumi ken go as a group na toksave lo ol na tokim ol the truth, yumi no ken

haitim, haitim olsem tok, givim ol sample na displa kain nogat igutpla yumi ken go aut na tokaut stret as grup na mekim bikpla awareness em mi ting em bai orait. (KTP_BL2010_SHP_Koroba_Info03)

25. Original in English

26. Em trutru em save kama long hia. Monini ol save kirap na kam long Niugu play kard nambaut go go go apinun 6 o'clock ol just go slip, stilim kaukau blong mamapapa na ol save slip monin kirap kam long hia na play kard. Just roam around hia na tudak go long haus, Ol papa mama ol ino save paitim na lainim ol pikinini becos ol lukim olsem ol go worse. Sampla ol depend long play kard, sampla ol kam long stori nambaut go kam na ol save bisi long displa. So em trutru ol save play kard long hia, trutru em save kamap long hia em mipla lukim piksa.

27. Mi laik tokim olsem long nau mipla lukim displa piksa em mipla tinim mipla yet nau. Long life taim blong mipla long displa village blong mi em mipla ino save gatim komuniti piksa program olsem.

28. Na taim mipla raun na mipla klia olsem na luk olsem mipla bai senism sampla pasin blong mipla. Mi lukim displa piksa na mi wanbel long displa team wei yupla kam long em.

29. Mipla watsim displa piksa em mipla olsem mipla fil nogut liklik long bel blong mipla. Nau mipla senism pasin nau olsem lukluk gut na mipla stap.

30. Mi wanpla chewer, chewim betlenut. Planti lain wok long usim ol laip blong yu yet so mi mi save kisim nating nating long sel haus na chewim betlenut so plant lain tok ol bai kisim long displa hap so em trutru ol tok o?

31. Long piksa mi lukim antap ol igo long garden na ol kisim displa kontainer, liklik kontainer blong marasin ok public ol save olsem em marasin tasol inap yu explain wanem marasin em stap insait long displa, liklik botol ol save kisim. Tablet wei yupla save givim ol marit yah.

32. Em long displa part tu tupla wantaim ino go insait na nurse na docta kam na kisim blood slide blong tupla wantaim na mipla ino klia liklik long displa sait tu.

33. Nau olsem tok pait blong HIV/AIDS, campaign blong HIV/AIDS em igo. Em igo tasol yu save man em i sem, planti man long ples mipla save ting olsem displa HIV binatang em pamuk sik. Em mipla save tingting olsem so man isave sem long putim em yet kam ples klia.

34. Taim planti group blong AIDS awarenss grup kam insait long komuniti ol kam tromoi toktok tasol na ol go. Wind kisim go planti man ol ino putim insait long het. Taim ol KTP kam insait taim, kam na mekim research blong ol na ol kam insait long komuniti planti blong mipla kominiti mipla ting olsem ol kam nating na awareness grup wankain olsem. Lukluk blong ol man kam olsem na ol ting ol kam nating. But nau mipla lukim movie blong em stret. Mipla yet go insait na part wei mipla playim mipla lukim em gutpla tru long olgeta komuniti bai save gut wanem rot HIV em save kam insait long em. So mi tok tenkyu long KTP kam insait na em ken mekim displa long komuniti mipa stap long em. Displa piksa wei yumi wantaim kamapim em kamap nice na narapla kain olgeta. Ol liklik mangi kam antap ol ken luksave na ol ken bihainim wanem step wei KTP wokim long em. So mipla hamamas. Mipla ol papa mipla hamamas long displa KTP kisim displa program long kam insait. Tenkyu

35. Long mi yet mi lukim displa piksa em gutpla long helpim mipla sampla. Mipla gat o mipla ino gat em gutpla long mipla yet long sekim mipla yet na mipla stap. Na mipla gat em gutpla long mipla tokaut na lukim hausik na wanem kain. Em mipla yet nau. Na narapla em ino gat em yet nau. So em gutpla long ol kisim displa samting kam insait long komuniti long mipla yet esekim mipla yet. Em ino nogut em gutpla long mipla sekim mipla yet, wanwan man.

36. Mipla olgeta yet mipla gat pikinini man na meri na mipla no laikim displa sik bai kamap insait long komuniti blong mipla na ol pikinini blong mipla bai bagarap long sik, olsem na em bikpla nid blong mipla so mi laikim olsem, displa piksa olsem ol mas actim planti olsem mipla mas lukim na ol pikinini man na meri mas lukim na save olsem igatim displa sik na mipla stap. Na tu mipla nidim planti trainin insait long displa komuniti tu. Mipla ol mama save raun long garden, ol sampla lain stap long em ol ken sapot na mipla mas save long sampla kain rot, skul na stap. Long helpim pikinini man na meri blong mipla na mipla yet tu. Olsem na mi hammas long displa piksa yupla kam soim na mipla lukim.

37. Em olsem olgeta piksa mipla lukim em olsem olgeta em save pes blong mipla na mipla hamamas long lukim ol. Em gutpla olsem yupla soim piksa long mipla.

40. Mi lukim olsem trutru em mipla ol gels save mekim long em. Giaman tok mipla go slip wantaim narpla anti uncle na mipla save go raun raun. Em trutru em samting em kamap. Mipla long hia mipla lukim save pes na mipla ino filim tumas. Olsem go aut na lukim ol bai tok em tok yah ol save mekim long em. Mipla lukim displa em bai mipla change.

41. Kain olsem em igat sik na silip wantaim o mipla save fret olsem mipla silip wantaim na pulim win blong em o displa kain olsem sampla mipla save fret. Tasol mi lukim displa hap ol slip wantaim em naise bai mipla bihain tu husait lain igat sik mipla ken silip wantaim em, em bai mipla ino inap gat fret long displa. Em mi lukim olsem naise.

42. Mi lukim long piksa nau em mipla gat bilip olsem husait igat binatang em bai mipla kisim olsem femili. Pastaim mipla ino tinim displa na mipla rejectim ol na ol stap longwei long mipla na mipla ting sapos mipla tasim, mipla kaikai wantaim bai mipla kisim displa sik mipla ting olsem but nau mipla lukim olsem displa kain tingting em pinis.

43. Mi yet mi lainim wanpla samting em olsem mi no save care mi man blong womanise, mi no save care. Mi lukim ken na mi pilim poret na mi lainim wanpla samting olsem mi lukim olsem mi no care tasol displa em trap mi yet mi setim long mi. Mi lukim olsem. Na mi tu mi gat bikpla fret ken.

44. Taim mipla lukim displa piksa bifo yupla kam stori tasol na em mipla ino kisim gut na nau em ol lain blong mipla yet ol bin appear long screen, mipla lukim na em mipla kisim gutpla save na tingting long displa.

45. Mipla bai lukim na senism mipla yet na mipla bai stap

46. Em ol mas kisim hau mipla save lukautim long em. Ol next neibour ol save. Ol save olsem displa meri em displa kain tasol ol lain save lukautim em gut.

47. Mi yet mi lainim wanpla samting em mi ting ol meri gat AIDS ol karim pikinini em automatic AIDS tasol displa movie em tokim mi olsem pikinini Karina karim yah em karim long hausik na ol docta careful olsem na pikinini ino gat AIDS but Karina em gat

AIDS.

48. Na wanpla tu em olsem displa man olsem victim em stap planti man save fret long ol displa kain man ol gat sik AIDS na displa kain. So ol lukim displa piksa ol bai traim long stap klostu long ol, helpim ol. Kain olsem awareness long AIDS mipla harim em olsem sapos man igat displa sik em bai no inap kalap kam long skin blong yu o em bai no inap, yu no inap kisim nating taim yu sikanim em na holim pasim em na yu kaikai hap kaikai blong em o usim wanpla klos, em bai kam tru long blood. Man igat displa sik na yumi nogat wanpla kat long skin na yumi fretim ol na yumi stap long wei long ol yumi mekim ol wari na yumi salim ol go hariap long ples nogut. Displa kain ino gutpla olsem yumi ol man ken stap klostu long ol na displa em olsem wanpla bikpla skul tu

49. Olsem long stori blong wanpla stori blong India, Mother Teresia blong Kalgata, displa em go wankain wantaim Paul. Olsem na mi lukim olsem em wanpla Mother Teresia blong Kalgata em wok charity na em wankain olsem Paul. Paul mekim em wanpla bikpla samting tu na bihain long 10 to 20 yias taim o sapos Paul ino dai na stap laip yet ting em bai go aut long world. Olsem na em wanpla gutpla samting em mekim, soim love na laikim ol na displa em bestpla wei. Mi lainim olsem yumi tu mas mekim wankain olsem na mi hamamas long Paul long wok blong em.

50. So nau displa tripla wokim displa piksa kam em blong gutpla blong mipla olgeta insait long hauslain. Wanpla samting mipla ino save pretim ol mipla lukism ol mipla save wokim gutpla long ol. So ol filim olsem ol bai stap na mipla mekim ol hamamas nau ol lus tingting long wanem sik ol gat insait long bodi blong ol em ol lus tingting long displa sik. So nau ol stap ol stap olsem mipla yah normal bodi. Wanpla samting ol putim displa piksa go insait olsem em blong gutpla blong olgeta world wide. Ol ken lukim piksa blong tripla nau sampla taim olsem ol mama papa mipla karim pikinini em blong bihain blong mipla mipla karim. Mipla mama papa mipla mas stap stret. Mipla lukim ol tripla nau mipla mas stap stret na lukautim ol pikinini blong mipla na ol pikinini blong mipla go karim tumbuna nau mipla holim han blong tumbuna na sampla sik painim mipla em olrait.

51. Em kirapim tingitng mipla laik go stret long hausikEsther go kisim advise long gel Karina. Em Tokim em olsem em wok long kisim marasin long helpim em. Na sapos mipla gat na mipla ino blood test marasin mipla ino inap kisim na em ino inap helpim mipla tu. Em olsem em kirapim tingitng blong mipla na mipla go blood test nau mipla kisim marasin na mipla ken stap longpla taim.

52. Nau yumi olgeta stap na lukim ino wanwan go hait na rid em olgeta ai blong mipla focus antap na mipla olgeta lainim everything. Olgeta lain mipla lainim at the sem taim. Em mipla lainim olsem kain olsem reflection mipla mekim olsem. Wanwan grup long buai market o dart ples o kain olsem mipla ken always rekalim kam bek ken long piksa mipla lukim. Becos ol lukim na mipla lukim mipla ken mekim discussion long helpim mipla yet tu. Em wampla wei mi lukim.

53. Tasol long first taim yupla kam em yupla kam long wanem samting tru, yupla kam long holiday na yupla go bek o mipla tinim wanem. Nau yupla kam na nau mipla klia. Sampla nau yupla kisim piksa blong mipla kam na mipla lukim. Ok next taim bai mipla no inap wokim olsem, mipla lainim gut bifo ol papa bin slip na nau tu mipla stap long em o ol bikpla brata long mi size long ol bai lainim mipla na mipla tu bai lainim pikinini blong mipla. Mipla lukim displa piksa bai mipla stap gut go, ating mipla bai olsem lapun na dai. Em tasol mi tok tenk yu long yupla long kam bek long ples wei Alice in born long em long Enga province long Laigama district long Niugu village. Next taim yupla kam na lanim mipla long sampla samting na go. Mi tok welcome long kam bek gen. Em tasol.

54. Sapos yumi go lon haus lotu – God kamap man bilong yumi meri bilong yumi em bai yumi kisim bikpela halivim. Sapos yumi no go long haus lotu, bai yumi bagarapim yumi yet long moni na kainkain pasin na sik AIDS tu bai yumi kisim. Wanpela rot tasol em yumi mas go long lotu na sindaun bilong yumi bai olrait.

55. Long halivim ol dispela liklik pikinini long bihain bilong ol, em yumi mas ksiim ol igo long haus lotu. Sapos yumi no ksiim ol go lon haus lotu, em ol dispela pikinini bai nogat hope – olgeta bai bagarap.

56. Long displa em mi tinim olsem gutpla em, kain olsem mipla save stap nating na play kas na mekim olsem, gutpla olsem komuniti mas setim sampla kain activity, kain olsem sports na mipla ken bisi long displa na liklik taim mipla stap, mipla stap wantaim papamama na wokim garden na wokim ol haus wok na harim tok blong ol. Na mipla stap wantaim ol tu ol mas lainim mipla long pasin blong hausman. Mipla bai bisi kain olsem na mipla bai abrusim kain sik birua.

57. Inap long ol wanwan lida ken skurim toktok long wanem yupela lusim na go tasol nogat wanpela em toktok long dispela olsem na olgeta go bek gen lo square one.

58. Long tingting blong mi mi senis. Bifo mi lukim sampla igat binatang na ol gat sik mi lukim olsem mipla spad long ol na pointim finger long ol na haus em yet em slip na tawel, soap or wanem samting mipla nogat, noken kam klostu. Maski long femili mipla putim ol olsem wanpis. Na displa planti stap wantaim wari na mi lukim olsem. Na mi lukim long ai blong mi stret na long piksa tu sampla ol kam na soim long em ol stap wantaim wari na go na ol dai na pikinini stap wari na ol traim long givim long narapla femili na ol femili wok long tromoi kaukau olsem dog na wokim kainkain samting. Tasol displa piksa nau mi lukim yah ino olsem. Em soim mi olsem em sori. Em wanpla kain sori piksa olsem blong ol kisim ol bek na stap insait long femili na lukautim ol na kaikai wantaimol na slip wantaim ol na sapos ol dai pikinini mipla mas lukautim na kain olsem. Em olsem samting isenis nau.

59. Sapos wanpla pikinini blong yumi o brata o sista, wanpla lain blong yumi long komuniti ikisim dipla sik yumi noken poretim ol. Yumi ken kaikai long wanpla plate na drin long wanpla kap. Yumi lukautim ol gut ol bai stap olrait wantaim yumi. Sapos yumi meki molsem ol lain blong yumi igat sik em bai ol ino inap pilim sen na pilim nogut. Em nau yupla soim mipla long piksa mi lukim na mi tokaut. Yumi mas lukautim ol lain blong yumi husait igatim sik. Displa wei bai ol painim bel isi na ol bai stap hamamas wantaim yumi inap ol lapun na ol dai.

60. Mi lukim displa piksa na mi gat tingting olsem pastaim em mipla save pret long ol displa ol lain ol gat HIV. Nau em displa piksa soim mipla olsem em ol friends blong mipla. Olsem tru long having sex em ol save kisim displa virus na nating em pastaim mipla fret na mipla ting olsem mipla go tasim ol displa lain em mipla bai kisim HIV o go hugim ol nambaut em mipla bai kisim HIV em nogat. Tru long sex tasol ol bai kisim HIV so nau em mi lukim piksa na mipla ol Kristen em mipla should look after them. Lukautim ol na protectim ol na givim strong olsem advice long ol nambaut na mekim olsem nau ol bai kisim gutpla tingting na mipla bai stap olsem wankain lain. Sapos mipla ino mekim olsem mipla fret long ol na go longwei long ol nambaut em ol bai tingting olsem mipla gat HIV na ol fret o. friends blong mipla na femili membas blong mipla rejectim mipla na em bai ol kisim bad tingting na ol bai dai hariap o wari bai kilim ol na ol bai dai

hariap so mipla should look after. Displa piksa em soim mipla gutpla ida long lukautim ol displa kain lain. Mi gat displa tingting olsem. Olsem nau mipla yanpla stap em mipla noken fret long ol displa kain lain. Em ol brata na sista blong mipla so mipla should lukautim ol gut. Insait long komunit blong mipla wanpla igatim displa sik mipla should lukautim ol displa lain gut na take care and lookim after long ol gut.

61. Yumi hait na putim stap em narapla igat long em putim ai long narapla man em gat long em em bai kam givim yu. Stil mi marit meri yet yumi mas was long skin blong yumi. Husait man em kam pasim ai o singautim yu, yu mas tok stret tokaut na tok em olsem olsem. Taim blong sik yumi mas stap wantaim man tru mitupla marit long em yumi stap olsem. Em bikpla piksa em femili putim em ol awareness na mipla harim.

62. Piksa insait em soim wanpla part wei papa mama bllong Karina ol kukim kaikai na ol lukautim olsem pikinini blong ol na ol respectim em narapla kain na em ken stap na em ken kisim marasin na survive longpla taim. Displa part tasol em mekim mi moa interest. Na nau mi lainim olsem wanpla blong mipla gat ating mipla noken rabisim em na putim em go lonwei mipla ken putim em kam klostu. Em hevi blong graun em kisim so mipla ken putim em kam klostu na lukautim em na givim kaikai. Sem treatment wei mipla save stap, mipla ken holim pasim em, slip, raun wantaim na ating em ken stap longpla taim wantaim mipla. Displa tasom em mekim mi moa interest tru.

63. Mi lukim displa komuniti piksa mi lukim olsem mi tinim olsem planti taim mi save go skin nating, mi no save werim kondom na go. Nau olsem mi tinim, mi lukim displa piksa na mi tinim AIDS em ino no save toksave olsem ol man igat AIDS istap. Kam lonpla taim nau em save so aut na yumi save lukim. So nau mi tinim mi bai usim kondom tasol. Olgeta taim mi bai usim kondom, nogat tu ino nid long sex tu. Taim mi laip sex mi mas usim kondom.

64. Mi lukim displa na tingting blong mi op liklik long sekim blood nambaut nogut mi gat sik tu. Yumi save go nating nating nambaut yu save. Mi nid long go long VCT mipla nid long go sekim blood long VCT.

65. Em displa samting em kamap pinis. Em olsem mipla lukim mipla lainim nau. So nau mipla belsut, mipla bai sekim blood nau. Mipla gat displa sik or nogat or?

66. Kain olsem mi nambaut mi ting mi gat. Hamamas taim mi wokim long skin nating kam na nau tumoro tru mi bai go long hausik na sekim.

67. Mi ting olsem ol bai lukim ol displa piksa nau olsem ol ken kisim gutpla tingting, ah displa ol mas mekim olsem but mipla save ting olsem displa kain displa tingting ol save gat. Ol save gat rong tingting nambaut stap long em yah mi ting olsem nau ol bai kisim gutpla tingting na bhianim ol displa step wea hau long lukautim ol o hau long treatim ol sik paitient

68. Mi hamamas long lukim displa piksa becos long komuniti ating displa piksa em givim gutpla tingting long mipla bai creatim wea mipla ol komuniti mas creatim healthy environment wea displa paitent man or meri olsem living in olsem day to day laip blong em mas insait long healthy environment wea ino inap long olsem tingting planti o displa kain

69. Mipla nogat sik long em mipla save hamamas na felings mipla save kisim na mipla act raun tasol sampla ol gat sik long em mipla save givim kainkain toktok o tok beksait long ol. Mipla ino save laikim ol. Tasol mi lukim piksa em Paul em save laikim olgeta lain. Sik man o nogat, olgeta yanpla o liklik o lapun em save laikim olgeta. Em displa gutpla pasin em save mekim long em mi lukim displa mi autim.

70. So nau yumi lukim ol piksa yumi ken go wokim blood test ok wokim sampla lain igat sik nambaut stap yumi noken fretim ol yumi go holim pasim ol, sindaun stori wantaim ol wokim gutpla toktok. Na sampla taim yumi save sindaun na tok beksait long ol, em gat AIDS yah, AIDS kam go. Yumi save tok olsem. Sapos yumi toktok olsem long face to back automatically bai yumi kilim ol. Em tintin blong ol bai kilim ol yet. So nau yumi lukim piksa ok em givim yumi sampla kain encouragement.

71. So displa piksa em soim klia olsem ol hauslain ol kisim displa kain tingting ol bai lukautim husait igat sik kain olsem sik AIDS kam olsem. Narapla narapla em mipla mas lukautim em olsem. So em bai stap longpla taim na em ken lusim laip o em ken stap na sik ken nonowei o kain olsem.

72. Because mi wokim displa em bai changim lukluk kain olsem na yumi toktok, ol save gat bikpla poret, kain samting yumi putim tru aut the kantri ol ken lukim, mipla save poret ol making na lukim ol savim laip blong ol. Kain lukluk ol bai gat. Olsem planti isave poret mipla encouragim ol long ino ken mekim displa kain.

73. Na displa piksa tu nau em mipla lukim olsem em soim mipla bikpla samting long skulim ol yanpla blong mipla long nau a deis. So displa piksa em mipla kisim gutpla leson blong yumi sampla ino kam na sampla liklik wei mipla stap klostu long hia em mipla lukim em bai mipla stori long displa piksa em olsem toktok em kam olsem long mipla bai lainim na stap gut long future long trainim yanpla blong mipla long displa komuniti.

73. Kain ol CD kam ok first em bai yumi wokim awarenss na tokim ol lain long komuniti long kam lukim pastaim nau ok ol lain slip danblo, slip long hapsait, slip long hapsait wara nambaut ol ken kam nau lukim pastaim. Lukim pastaim nau ol lain wei gat kain sik ol ino sure long laip blong ol na ol stap ok ol ken watsim CD nau ok kain olsem Paul helpim ol lain yah

74. Mi hamamas long toktok: Sapos CD yupla kisim kam givim mi mi hamamas long lukim wantaim femili blong mi. Man blong mi em man blong raunraun na yupla kisim kam mipla hamamas long mipla lukim. Em save mekim planti ol raunraun pasin olsem na mipla lukim em mipla hamamas. Tupla pikinini blong mi mipla lukim na disciplinim ol na man blong mi tu bai lukim na kisim sampla skul long displa.

75. Firstpla taim yupla kam mipla ino klia na nau yupla soim piksa ken long mipla na mipla lukluk igo nau yupla givim bikpla leson ol lain long hia na sampla hap tu bai yupla lainim olsem mipla tinim. Yupla givim gutpla idia long mipla olsem na mipla laikim tru. Mipla laikim yupla bai raun long Kandep nad Pogera na Wapanamanda and Kompiam na olgeta hap mipla laik yupla bai raun olsem na give leson long ol pipol. Nau mipla lukim piksa ken na mipla hamamas tru. Em ol liklik mangi tu bai kisim save long displa piksa na bihain bai ol tinim na ol bai stap gut mi tinim.

76. Na yupla kisim displa kain tok igo long olgeta hap na soim piksa long olgeta hap na tok raun long Pogera na Wabag or wanem hap yupla raun long em kisim tok olsem em yupla givim leson long ol liklik mangi na lapun meri tu na ol bai kisim save mipla tinim olsem. Yupla bai mekim wok moa yet long displa.

77. Mi laikim olsem wokim CD olsem na givim Pastor, church elder o mipla lida man long ples long komuniti. Mipla gat planti ples stap, ples blong meri blong mipla stap, ples blong mama blong mipla stap, ples blong papa lain stap, wanem hap mipla

gat planti poroman stap mipla ken go soim. Mekim CD na givim mipla na halipim bai mipla soim long olgeta hap blong Enga.

78. Mipla mas educatim ol narapla nearby komunities then displa komuniti mas surikum narapla go long narapla komuniti na sik blong raun raun long nait tu nait na meri tu meri na displa em mas stop, noken karim displa sik kam insait

79. Long skul mipla ken watsim wantim ol wan mate blong mipla wei ol stap long skul. Ol yet lukim wanem samting stap long CD na ol yet ken senism sampla behaviour na attitude blong ol.

80. Sapos CD pundaun long han blong mipla, ol meri mipla kam long narapla hap mipla kam marit long hia. Sapos ol givim mipla olsem mipla ken kisim na go soim long femili blong mipla na hauslain blong mipla? Ol ken lukim displa piksa nau bai ol ken kisim gutpla tingting na pikinini ol karim tu ol ken kisim dipla piks na bihain ol ken kamap gutpla pikinini man na pikinini meri na ol ken lukautim ol yet o?

81. Olsem mi yet bai mi lukluk long tupla. Wanpla bai mi tok olsem oh yupla olgeta kam na lukim displa movie ino ol whites wokim na olsem olsem em kamap long asples blong mipla kam lukim. So mi tok olsem mi bai pulim tingting blong na sindaunim ol gut nau em nau HIV/AIDS message bai go long ol. Em wan. Na tu olsem profession blong mi olsem teacher displa bai mi kisim go nau mi bai lainim ol liklik pikinini na ol liklik pikinini ol lukim displa nau em ol liklik pikinini ol lukim whatever em interesting o samting new ol bai tingting long toktok igo long femili blong ol. Mi bai teachim ol long clasrom nau ok ken bai kisim go nau bai ol toktok long ol arapla ausait long ol. So mi ting em sampla kain move olsem blong go long advertisim displa movie.

82. Sampla boys long hia kamap olsem awareness team na karim CD wantaim na go long sampla longwei longwei hap na givim CD na mekim sampla toktok na askim ol questions na ol bai understandim gut. Samting kamap long ples yah nau ol putim antap long piksa na ol bai understandim na ol bai ino inap mekim ol displa kain pasin.

83. Displa CD kam long helpim mipla olgeta yanpla, manmeri na lapun manmeri, marit. CD kam mipla lukim, mi yet mi lukim na mi kisim planti skul long displa tasol displa skul mi kisim ino inap long mi. Mi laikim olsem mi kisim moa skul long displa na mi laik kamap teacher na mi yet mi go raun na skulim ol arapla ino lukim displa. Mi laik kisim moa skul long displa.

84. Mi wanbel olsem displa CD em kam long han blong mi em luk olsem whole Simbu bai ol kisim displa CD na igat network insait long education bai olgeta skuls bai lo kisim na insait long teacher training tu mi bai go soim na lecture nau ok olgeta sessions bai mi givim long em olgeta em involve long displa, positive living, prevention, VCT testing an olgeta displa ol kam insait so em bai wanpla gutpla aid wei mi bai usim insait long trainim ol teacher so that ol bai go bek long skul komunities blong ol so displa skul komunities ol bai lainim planti samting long displa CD na displa strategy blong putim insait long movie form em bai kamap wanpla effective tool insait long skul komunities, ol lukim displa HIV/AIDS movie

85. Refer to endnote 62

86. Refer to endnote 46

87. Nem blong me em Kogeil na mi hamamas long toktok: Sapos CD yupla kisim kam givim mi mi hamamas long lukim wantaim femili blong mi. Man blong mi em man blong raunraun na yupla kisim kam mipla hamamas long mipla lukim. Em save mekim planti ol raunraun pasin olsem na mipla lukim em mipla hamamas. Tupla pikinini blong mi mipla lukim na disciplinim ol na man blong mi tu bai lukim na kisim sampla skul long displa.

88. Refer to endnote 40

89. Interest blong mi olsem piksa yupla givim mipla long em insait long komuniti igat video haus. Yupla burnim wanpla CD na givim mi long mi yet mi ting olsem bifo ol soim ol whiteman meri acting long em displa piksa wei yupla kamapim long em mipla mas kisim go na ol lukim pastaim na bihaim em ol ken go long narapla piksa wei ol ken lukim long em.

90. Interest blong mi olsem piksa yupla givim mipla long em insait long komuniti igat video haus. Yupla burnim wanpla CD na givim mi long mi yet mi ting olsem bifo ol soim ol whiteman meri acting long em displa piksa wei yupla kamapim long em mipla mas kisim go na ol lukim pastaim na bihaim em ol ken go long narapla piksa wei ol ken lukim long em.

90. Refer to endnote 49

91. Refer to endnote 63

92. Refer to endnote 58

93. On-camera interview with Yavito S. translated from Tok Pisin.

94. Mi lukim long piksa nau em mipla gat bilip olsem husait igat binatang em bai mipla kisim olsem femili. Pastaim mipla ino tinim displa na mipla rejectim ol na ol stap longwei long mipla na mipla ting sapos mipla tasim, mipla kaikai wantaim bai mipla kisim displa sik mipla ting olsem but nau mipla lukim olsem displa kain tingting em pinis.

95. Pastaim mipla ino tinim displa na mipla rejectim ol na ol stap longwei long mipla na mipla ting sapos mipla tasim, mipla kaikai wantaim bai mipla kisim displa sik mipla ting olsem but nau mipla lukim olsem displa kain tingting em pinis. Nau mipla ken lukim displa sik olsem wankain olsem narapla sik, bai mipla tekim ol olsem ol femili blong mipla. Mi lukim piksa em olsem.

96. Refer to endnote 72

97. Refer to endnote 82

Komuniti Tok Piksa Project Report

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