Evaluation of the Pilot Stepping Stones Program

Fiji

Pacific Regional HIV/AIDS Project
2007

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List of Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
CATD	Centre for Appropriate Technology and Development
CDO	Capacity Development Organisations
FJN+	Fiji Network for People Living with HIV/AIDS
GEM	Gender Equitable Men's Scale
HIV	Human Immunodeficiency Virus
MoH	Ministry of Health
M&E	Monitoring and Evaluation
MSC	Most Significant Change
NAC	National AIDS Council Committees
PRHP	Pacific Regional HIV/AIDS Project
SPC	Secretariat of the Pacific Community
SS	Stepping Stones
UNAIDS	The Joint United Nations Programme on HIV/AIDS
UNITAR	The United Nations Institute for Training and Research
VIDA	Volunteers for International Development Australia

1.0 Executive Summary

The evaluation of the pilot Stepping Stones (SS) program in Fiji was conducted throughout March - April of 2007. The aims of the evaluation were to describe and assess the implementation of SS in Fiji and provide recommendations for the future scaling up into other Pacific Island countries. This evaluation focuses on four communities: all three communities that have implemented the entire SS package and one community (purposely chosen) that has 'part' implemented SS.

SS remains a program that has had remarkable success worldwide, improving negative gender norms and empowering communities to bring about change specific to their needs in relation to HIV vulnerability. A total of twenty-three facilitators from thirteen communities were trained at the inaugural SS workshop carried out in Fiji from the 13th-23rd June 2006.

Positive outcomes uncovered from this evaluation include a number of inspiring client and implementer 'Most Significant Change' (MSC) stories from Waikubukubu and Sasa village, improvement in gender equitable attitudes among men who participated in SS training, and the creation of a Youth Council in Sasa village, an initiative that was a direct result of young men and women completing the SS program.

A total of fifteen MSC stories were collected from participating communities as part of the Fiji pilot evaluation. One domain, (improved HIV related behaviour) was chosen amongst two categories (client and implementers).

Evidence from the fifteen stories collected (10 client and 5 implementer) showed that SS had facilitated improved HIV related behaviour change amongst both clients and implementers of SS. Of the ten client stories collected, six reported an improvement in communication with their community, family or sexual partner and spoke of new skills and confidence to speak about HIV and sexual health issues. This in-turn led to clients reporting improved relationships with sexual partners, less community fighting and better communication and trust between parents and children. Seven of the ten sampled client stories and three of the five implementer stories reported that SS had facilitated an increase in HIV related knowledge, particularly modes of transmission and prevention strategies. Six client stories also reported an increase in positive HIV related skills such as assertive communication and 'I statement' skills.

This evaluation was used as an opportunity for the Pacific Regional HIV/AIDS Project (PRHP) to pilot the AIDS Competence Community Self Assessment as a future SS monitoring and evaluation tool. Evidence from this evaluation found that when well implemented, the Community Self

Assessment can be an effective way of monitoring program outcomes and capacity development. Its strengths lie in its inclusive approach and its encouragement of communities to become empowered to find their own responses to HIV/AIDS. In particular, the evaluator observed that Sasa village, a community that went through the pre and post Community Self Assessment was prompted to think of program outcomes early, and therefore had well thought out suggestions for their 'final requests' ceremony. In addition to this, during community discussion around risk and vulnerability to HIV/AIDS, Sasa village identified alcohol use and criminal activity as an issue affecting the community. In response to this, and a process initiated by the AIDS Competence Assessment, the village approached the local police department and asked them to give awareness sessions on drugs and alcohol to community members. While this activity wasn't a direct result of Stepping Stones, it does demonstrate how the Community Self Assessment can assist communities in clarifying issues that are relevant to them.

The 'Gender Equitable Men' (GEM) Scale questionnaire also proved to be an effective and easy way of obtaining pre and post program data on gender norms from male SS participants. All men reported finding the questions easy to answer and many men stated they liked being challenged by some of the questions that were asked. Evidence from the GEM Scale questionnaires conducted in Sasa and Fiji Network of positive people (FJN+) found that there had been an improvement in positive gender norms as a result of SS, (fifteen and twelve point improvement respectively). In addition to this, male SS facilitators reported that it was an easy monitoring and evaluation tool to administer.

2.0 Introduction

Stepping Stones (SS) is a program that aims to improve an individual's sexual health and decrease HIV/AIDS through community participation and local level decision making. It is a program that is firmly based in participatory learning techniques, and focuses on improving cross gender communication, relationship skills and consequences of risk-taking behaviour. SS was originally developed in the early nineties for use in rural African communities, but since this time has been adapted and implemented in over a hundred countries including Asia, Europe and Latin America and to date has been translated into thirteen languages (Wallace 2006).

The original SS program consists of a fourteen module manual that is implemented over a four – twelve week period. Each session builds upon the one before with the ultimate aim of enabling positive behaviour change to take place. It involves participants working in age and sex appropriate peer groups in order to create a non-threatening environment and encourage trust and openness to discuss taboo topics such as sexual health, relationships issues and gender. At designated points throughout the program the different peer groups come together to present key issues through the use of skits and/or drama. Upon completion of the program, participants are given the opportunity to present 'special requests' to their community, which may involve asking their community to change in relation to such things as violence, unsafe sex, alcohol consumption or other risk taking behaviour.

In June 2006 the Pacific Regional HIV/AIDS Project (PRHP) piloted the SS program in Fijian communities, a description of this implementation is provided later in the report. This evaluation report analyses the effects of the SS program in Fiji and provides recommendations for the scaling up of the program into other Pacific Island countries.

3.0 Objectives

The Fiji SS evaluation was conducted in four communities in April and May 2007. The objectives of the evaluation were to:

- Describe the implementation of SS in Fiji
- Assess the implementation of SS in Fiji
- Describe and assess the effects of the SS program on implementers
- Describe and assess the effects of SS program on community members
- Make recommendations relating to the future scale up of SS in other Pacific Island countries

- Pilot the use of the AIDS Competence Programme and Self Assessment Framework as a future SS monitoring and evaluation tool
- Pilot the use of the Gender-Equitable Men Scale (GEM Scale) as a future SS monitoring and evaluation tool

4.0 Research Process and Methods

The evaluation involved the following steps:

- Desk review of SS documents and articles
- Review of the findings from the October 2006 SS support workshop in Nadave (conducted by PRHP)
- Semi-structured interviews with key informants. The evaluator gathered quantitative data from SS facilitators regarding number of community members trained, age and sex breakdown of participants and feedback comments upon completion of each SS module. Field work to collect Most Significant Change Stories, Community Self-Assessments and GEM scale was also carried out
- Analysis of data
- Report writing

4.1 Table A: Evaluation Objectives, Methods and Responsibilities

Objective	Method	Responsible
Describe the implementation of Stepping Stones in Fiji	▪ Document review ▪ Key informant interviews	PRHP Health Promotion Officer
Assess the implementation of Stepping Stones in Fiji	▪ Document review (Nadave workshop notes) ▪ Key informant interviews ▪ Quantitative data analysis	PRHP Health Promotion Officer
Assess the affects of the Stepping Stones program on implementers	▪ Most Significant Change (MSC) interviews ▪ AIDS Competence Community Self Assessment (ACCSA)	PRHP Health Promotion Officer Stepping Stones facilitators
Assess the affects of the Stepping Stones program on community members	▪ MSC interviews ▪ ACCSA ▪ Pre-Post tests of knowledge ▪ Gender Equitable Mens Scale (GEM) Questionnaire	PRHP Health Promotion Officer 2 x Stepping Stones participants
Make recommendations relating to the future scale up of Stepping Stones in other Pacific Island Countries	▪ Content analysis of evaluation data	PRHP Health Promotion Officer

Pilot the use of the AIDS Competence Community Assessment Questionnaire and GEM Scale Questionnaire as future SS M&E tool	▪ Key informant interviews ▪ Content analysis of data	PRHP Health Promotion Officer Male SS facilitators

Note: GEM scale, ACCSA and MSC are all participatory, conversational, narrative monitoring and evaluation (M&E) techniques. Much like the SS approach itself, these M&E techniques sit within the highly regarded *Participatory Learning and Action* approach. A description of each evaluation method is provided later in this report.

5.0 Overview of Implementation

PRHP consulted with a variety of organisations including, CDO coordinators, NAC Committees, SPC, Ministry of Health personnel and Dr Alice Welbourn, creator of SS for ActionAid Africa regarding the implementation of SS into Fiji.

Upon completion of the consultation, PRHP contracted two experienced SS facilitators from Africa to run the inaugural training of facilitators in Fiji from the 13th – 23rd June 2006. The Fijian Ministry of Health (MoH) along with the National Health Promotion Department assisted PRHP in identifying participants for the June training. The Ministry also identified health promotion officers who were to act as support personnel for the SS facilitators. In line with SS philosophy, PRHP requested that a male and female facilitator from each participating community be identified.

A total of thirty-five participants attended the 2006 training. Those in attendance included:

- Twenty-five community members (thirteen male, twelve female) from eleven communities around Fiji (western, northern and central/eastern division)
- Three MoH SS support officers, (two from the western division and one from the northern division, no support officer was identified from the central/eastern division)
- Four PRHP staff and three staff from the Secretariat of the Pacific Community (SPC), HIV & STI section.

On the final day of the ten-day training participants designed work-plans for the implementation of SS into their communities. It was noted by PRHP and SPC staff attending the workshop that this process was left until the afternoon on the final day, and time restraints meant that work-plan development was left partly unfinished. Due to other work commitments and distance of participating villages in the north, the northern division MoH support officer was unable to commit

to community visits or time available to support SS facilitators. There was also no support officer present for the central/eastern division and therefore PRHP project officers were to provide support until an appropriate MoH officer was identified. In addition to this, despite the fact that PRHP requested facilitators from the same village, many came from neighbouring villages and in most cases these villages were a substantial distance apart. This made work plan development difficult for these facilitators as they weren't able to commit to a set plan for an eight – twelve week period.

In late August 2006, an Australian volunteer as part of the VIDA program commenced a work placement with PRHP. One of their roles as Health Promotion Officer was to evaluate, follow-up and support the implementation of SS in Fiji.

From the 29th October – 4th November 2006 a support workshop for all SS facilitators was organised and held at the CATD - Nadave. The objectives of the workshop were to:

- Re-visit the philosophies of SS
- Review the progress of SS within the piloted communities
- Review Evaluation tools
- Introduce and provide training in MSC
- Collect MSC stories for SS evaluation

A total of 15 participants (8 males and 7 females) from the Northern, Western and Central Divisions attended the training. Those present included:

5.1 Table B: Participant List for SS Support Workshop in Nadave

Division	**Representatives**
Northern	
Naduri Village	1 male
Somosomo - Taveuni	1 female
Nukubalavu (Savusavu)	1 female
Dreketi	1 male 2 female
Reproductive & Family Health Labasa	1 male
Western Division	
Waikubukubu Village	1 female
Sasa Village	1 male 1 female
Red Cross Lautoka	1 male
Health Promotion – Western Division	1 male
Central Division	
Reproductive and Family Health Association Suva	1 male 1 female
FJN+	1 male

There were a number of SS facilitators from the Central/Eastern division who did not attend the support workshop. Reasons for this included: clashing work/family commitments, inability to locate SS facilitators and lack of motivation or reluctance to attend as they had not implemented SS in their communities.

The support workshop highlighted that there had been some implementation problems for many of the SS facilitators when it came to returning to their communities and putting their new knowledge into practice. There were however a number of communities that implemented SS in differing ways to differing degrees in their communities. See Table C (below) for a brief 'status report' on implementation of SS in all targeted communities in Fiji.

Picture: SS facilitators sharing lessons learnt at the support workshop

Picture: SS facilitators re-visiting SS energiser activities

5.2 Table C: Status Report of Participating SS Communities in Fiji

Location of participating community	Facilitator	Implementation (full, part or not at all)	Comment
Western Division			
Waikubukubu	1 female 1 male	Full implementation with females Not implemented with males	Male SS facilitator reported conflicting community duties and lack of time
Sasa	1 female 1 male	Full implementation with males and females	
Korogaga	1 females 1 male	SS not implemented	Facilitators stated lack of confidence and support.
Lautoka	1 male	SS not implemented	Facilitator was transferred to the National office in Suva prior to implementation. Conflicting work commitments prevented implementation.
Nadroga	1 female 1 male	SS not implemented	Facilitators stated lack of confidence.
Central Eastern Division			
Korovou	1 female 1 male	SS not implemented	Facilitators from different communities. Stated lack of money and support
Tamavua-i-wai	1 female 1 male	SS not implemented	Facilitators could not be reached for comment
Qauia settlement Lami	1 female 1 male	SS not implemented	Facilitators stated ack of time and support.
Northern Division			
Naduri	1 female 1 male	SS not implemented	Facilitators stated lack of confidence and facilitation skills.
Savusavu	1 female 1 male	SS not implemented	Facilitators from different communities

Lekutu	1 female 1 male	SS not implemented	Facilitators could not be reached for comment
Naiviivi	1 female 1 male	Part implementation (3 modules) run by the female facilitator.	Facilitator stated lack of resources and money as reasons for 'part' implementation
Eastern Division			
FJN+ (Suva)	1 male	Full implementation of SS	
Suva - Reproductive and Family Health Association (RFHA)	1 female 1 male	Part implementation of SS (2 modules)	RFHA incorporated some of the SS modules into their already existing HIV/AIDS prevention programs.

6.0 Sampling

This evaluation describes and assesses the quantity and quality of implementation of SS in all three communities that implemented all fourteen modules of the program, (A, B and C) and one community, (D) that implemented components of the SS program. Community D was chosen as it ran three SS modules and would therefore provide M&E information on the effectiveness of 'part' versus 'full' SS implementation.

Semi-structured interviews to elicit MSC stories using PRHP's MSC Interview Guide were conducted in all sampled communities. Table D below gives details on the number of interviews conducted in each community.

6.1 Table D: No. of MSC Interviews in Each Sampled Community

Community	Male	Female	Facilitator	Total number of MSC stories collected
Waikubukubu (A)	0	2	2	4
Sasa (B)	2	2	1	5
FJN+ (C)	2	0	1	3
Naiviivi (D)	2	0	1	3
Total	**6**	**4**	**5**	**15**

7.0 Monitoring and Evaluation Techniques Used

7.1 Pre/Post Test Questionnaires

Prior to commencing SS training participants were asked three HIV/AIDS knowledge related questions so that quantitative data on knowledge acquisition could be obtained. While pre/post questionnaires aren't a mandatory process for monitoring and evaluating SS, PRHP wanted to obtain quantitative data from the pilot project. SS implementation had already commenced in two communities (Waikubukubu and Naiviivi) and facilitators did not conduct pre test questionnaires. Evaluation using pre/post questionnaires was therefore only conducted in Sasa and FJN+ communities.

7.2 The AIDS Competence Programme' and 'Community Self-Assessment Framework

This evaluation was used as an opportunity for PRHP to pilot the use of the UNAIDS/UNITAR's **AIDS Competence Programme** as a potential monitoring and evaluation tool for the SS program. The AIDS Competence Programme, first launched in February 2003 uses the **Community Self-Assessment Framework** to allow a community to 'define their needs (weaknesses) and strengths in different areas' in relation to HIV/AIDS. Areas of interest stipulated by the framework and used within this evaluation included:

- acknowledgement and recognition
- inclusion
- care and prevention
- access to treatment for STI's
- identifying and addressing vulnerability

Before the commencement of SS, participating communities were taken through a guided and semi-structured group discussion where they were asked to describe and assess where they feel their community was located for each of the above framework areas. Communities were asked to give themselves a score out of five, (one representing the lowest score and five representing the highest possible score). In addition to this, communities were also asked to give their community a score out of five to represent where they hoped their community would be upon completion of SS. Lessons learnt from the first Community Self Assessment run with FJN+ saw the evaluator design a list of probing questions in order to assist the community to accurately score themselves against framework areas. For an outline of the questions used by the evaluator to prompt self assessment refer to page 57 of this report.

Upon completion of SS communities underwent the same post focus group discussion and again scored their communities out of five. As Waikubukubu and Naiviivi had already completed the SS training before this evaluation a Community Self Assessment was only possible of Sasa and FJN+ communities.

7.3 Gender Equitable Men's Scale (GEM Scale)

Violence against women remains a huge problem for many Fijian women. Statistics released by the Fiji Women's Crisis Centre (2000) estimated that within a sampled population size of 1575 women, 80% of those had at sometime in their life witnessed violence within the home. More worryingly, 66% of females taking part in the survey reported being abused by their partners. Tolerance of domestic violence within Fiji is still high, with cultural and social conditioning thought to play a leading role in this.

It is well accepted that addressing inequitable gender norms, particularly those that define masculinity are an important part of HIV prevention programs. SS has been built around this philosophy and attempts to increase communication between men and women with the hope of creating more gender equitable attitudes from participating communities. To gain information on gender norms the SS pilot project used the **Gender-Equitable Men's Scale** – or GEM Scale to determine whether there had been any attitudinal shift among men who had participated in SS. The GEM Scale, designed in Latin America in 1999 consists of 35 questions related to gender roles in the home, community and relationships. An evaluation of the GEM Scale questionnaire conduct by USAID (2006) found that a, 'decreased agreement with inequitable norms over one year was significantly associated with decreased reports of STI symptoms'. In fact, in one study group, young men who became more supportive of equitable norms were, 'approximately four times less likely to report STI symptoms over time'. These findings highlight the importance of establishing and improving gender norms within communities as one means of preventing the spread of STI's including HIV.

For the Fiji pilot evaluation 17 of the 35 GEM Scale questions were asked of men who participated in SS. GEM Scale questionnaires were run with Sasa and FJN+ as these were the only two communities that ran SS with male participants where a pre/post assessment was possible. In order to remain gender sensitive the male facilitators from these communities were asked to administer the questionnaire. In the case of Sasa village where the training commenced with a male SS facilitator and finished with a female SS facilitator, the men were asked to self complete the post questionnaire. This was seen as an appropriate alternative as they had already had a facilitated pre GEM Scale questionnaire therefore were comfortable with self completion upon finishing SS.

Each man participating in SS was asked to respond to 17 GEM scale questions, (refer to page 56 for a full list of questions) stating whether they**; (1) Agreed, (2) Partially Agreed, or (3) Disagreed** with the statements. High scores represent high support for gender equitable norms. The highest score any community could obtain was 51. Average scores were taken to make up a community GEM Scale score pre and post SS implementation for Sasa and FJN+ communities.

7.4 Most Significant Change (MSC) Story Collection

MSC story collection is a participatory evaluation technique that is used in order to obtain information on project impacts and outcomes. Benefits of MSC story collection include allowing program clients to provide personalised, (and often) inspiring stories of change, giving depth to an otherwise clinical and data orientated evaluation. While MSC can not be used as a sole form of evaluation, it was a main technique adopted for the SS pilot project as it could be implemented in all four pilot communities. Two 'clients' (SS participants) from each participating gender group and all five 'implementers' (SS facilitators) were interviewed from the four SS communities. One on one interviews were conducted with each of the above interviewees where they were asked to describe ways in which their HIV related behaviour had changed as a result of SS. Refer to pages 48-54 for 'best' client and implementer MSC stories.

8.0 Findings for Sampled Communities

8.1 Fiji Network for People Living With HIV/AIDS (FJN+)

Background

The Fiji Network for People Living with HIV/AIDS was established, (with assistance from PRHP's NAC and Competitive Grants Program) in 2005 and is the only NGO operating solely for the rights, care and support for HIV positive people living in Fiji. The majority of their activities involve support, advocacy, awareness raising sessions and peer education throughout Fiji. FJN+ currently has 21 members.

SS Implementation

Mr Emosi Vukialau ran all fourteen modules of SS over a two week period with ten young men comprising of FJN+ members and HIV positive people. The sessions were run Monday – Friday from 9am – 4.30 pm. There was an 85% attendance rate for FJN+ males attending the training.

SS Results

Pre/post test

Question One: What body fluids are HIV found in? (Participants must identify, sexual fluids, blood and breast milk to receive a correct answer)

	No. & % of Pre-Test Participants who answered Q1 correctly		No. and & % of Post-Test Participants who answered Q1 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
FJN+ community (10 young men)	1 (10%)	n/a	7 (70%)	n/a	10	n/a

Pre test results showed that only one male (10%) was able to correctly identify all three body fluids that transmit HIV. These results were some what surprising as FJN+ participants had all had previous education in HIV/AIDS. It is however worth noting that all participants identified 'blood' as a body fluid containing HIV but failed to identify 'sexual body fluids' and 'breast milk'.

Upon completion however, seven (70%) males correctly identified all three body fluids. Of the three who did not correctly identify all three body fluids they did identify sexual body fluids on post assessment, but sill failed to mention 'breast milk' as a mode of HIV transmission. As sexual transmission is the leading cause of HIV transmission in Fiji it was pleasing to note that all participants on post assessment correctly identified blood and sexual body fluids.

Question Two: Name three ways HIV is transmitted? (Participants must correctly answer three modes of transmission to obtain a correct mark).

	No. & % of Pre-Test Participants who answered Q2 correctly		No. and & % of Post-Test Participants who answered Q2 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
FJN+ community (10 young men)	5 (50%)	n/a	10 (100%)	n/a	10	n/a

Only five (50%) men were able to name three ways in which HIV is transmitted on pre assessment. Of the five that did correctly answer question two, all stated unprotected sex as one mode of transmission. This was of particular interest, as in Question 1, *'What body fluids are HIV found in?'* only one person correctly identified sexual body fluids. These figures suggest that FJN+ participants were not able to make the link between unprotected sex, sexual body fluids and HIV transmission.

On post assessment however, ten (100%) of men correctly identified three ways in which HIV is transmitted. Analysis of Question 1 and 2 suggests that SS participants displayed a clearer understanding of the HIV virus; not only the modes of transmission but also how and where HIV survives inside the body.

Question Three: Name two ways of preventing HIV?

	No. & % of Pre-Test Participants who answered Q3 correctly		No. and & % of Post-Test Participants who answered Q3 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
FJN+ community (10 young men)	10 (100%)	n/a	10 (100%)	n/a	10	n/a

All participants (100%) could name two ways of preventing the transmission of HIV pre and post SS. While it was pleasing to note perfect pre test scores, on analysis with Questions 1 and 2, this again supports piece meal understanding of HIV amongst participant's pre SS. As is common with one off HIV educational programs, while they may be effective in spreading the, 'use a condom' message, many fail to give complete information regarding HIV awareness which is vital in order to reduce transmission and dispel myths, discrimination and stigma surrounding HIV.

Evidence from FJN+'s pre/post test questionnaires support that SS has facilitated an increase in HIV related knowledge amongst participants. In addition to this, findings suggest that SS has contributed to a more in-depth understanding regarding HIV, and has given participants the information that will enabled them to more clearly identify risk behaviours in regards to HIV transmission.

FJN+ GEM Scale

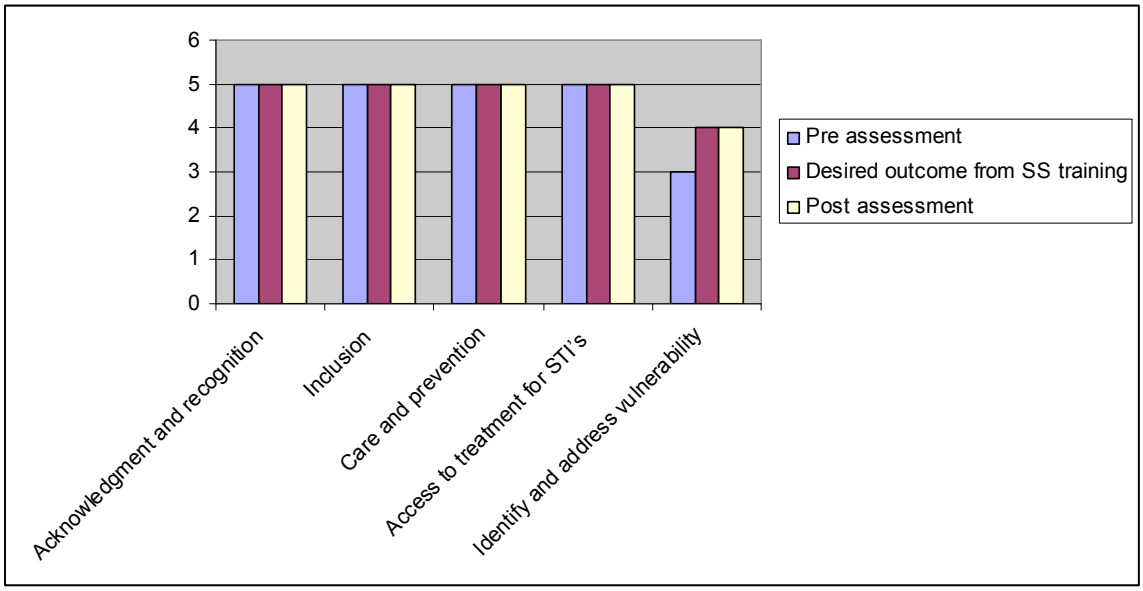
GEM Topics	**GEM Scale** **1=Agreed** **2=Partially Agreed** **3=Disagreed**	
	Before Stepping Stones Exercise	**After Stepping Stones Exercise**
It is the man who decides what type of sex to have	1	2
A woman's most important role is to take care of her home and cook for her family	1	1
Men need sex more than women do	1	1
You don't talk about sex, you just do it	2	3
Women who carry condoms on them are seen as 'easy'	1	3
Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility	1	1
It is a woman's responsibility to avoid getting pregnant	1	2
A man should have the final word about decisions in his home	1	2
Men are always ready to have sex	1	1
There are times when a woman deserves to be beaten	1	3
A man needs other women, even if things with his wife are fine	1	2
If someone insults me, I will defend my reputation with force if I have to	3	3
A woman should tolerate violence in order to keep her family together	1	2
I would be outraged if my wife asked me to use a condom	1	2
It is okay for a man to hit his wife if she won't have sex with him	2	3
I would never have a gay friend	3	3
It disgusts me when I see a man behaving like a woman	3	3
Total	**25**	**37**

There was a twelve 'gender' point improvement by FJN+ men participating in the SS training. Most encouraging was the improvement from, **'agree'** to **'disagree'** for the statement, ***'there are times when a woman deserves to be beaten'.*** Other improvements include an attitudinal shift by men participating in the training, where they originally **'agreed'** that women who carry condoms are seen as 'easy', to post assessment where they '**disagreed'** with this same statement.

It should be noted that FJN+ men had no corresponding female gender group, therefore did not get the opportunity to present or view key role play's and or dramas with women or partake in community peer group meetings. While it was encouraging that FJN+ men showed improvement in gender equitable norms, their scores did not show the same level of improvement when compared to Sasa village, (where both men and women completed SS sequentially).

These findings do however demonstrate the strength of the gender specific peer approach, and although more significant changes may have been seen with a female gender group participating, as one male from FJN+ stated, "learning from the other men in the group was a good process for me." Evidence from FJN+'s GEM Scale supports that SS is a program that can contribute to an improvement in gender equitable norms from participating communities.

Graph B: Range of Self Assessment Results for FJN+ community



The Community Self Assessment conducted with FJN+ highlighted the possible weakness of self assessments, and the potential that a community may over-estimate their ability to respond to HIV. In the case of FJN+, community members scored themselves the highest possible score of 'five' for four of the five areas stipulated in the AIDS Competence Framework.

It became clear, especially on analysis of pre test questionnaires that FJN+ had over-estimated their competence in relation to certain framework areas, (particularly 'acknowledgement and recognition' and 'identify and address vulnerability'). As this evaluation was used as an opportunity to pilot the Community Self Assessment, the evaluator designed probing questions to assist communities and ensure that a more accurate score was given for future Community Self Assessments.

It was difficult to draw conclusions from FJN+'s Community Self Assessment as the results obtained were not an accurate pre assessment. The process did however highlight to the evaluator that while the Community Self Assessment process is something that must be guided and decided upon by its members, a more defined and active role needs to be played by a facilitator to ensure that accurate scoring takes place. When post assessment occurred all FJN+ members stated that they thought they had over-estimated themselves on pre assessment.

8.2 Sasa village

Background

Sasa village is a community located about fifteen minutes north of Ba town on the Western side of Viti Levu Fiji. As at the last census, (1996) the population of Sasa stood at 261 community members with approximately 50 households, the majority of community members are Indigenous Fijians.

SS Implementation

Sasa village facilitators implemented the entire SS training package over a six week period with both young men and young women from the community. Kelera Vauvau, (female SS facilitator for Waikubukubu) assisted Diyaunisi Naqiri Ra to facilitate the young women's sessions. Mr Sevuloni Ratu, (experienced peer educator from the Fiji Red Cross and SS participate at the June training) assisted Mr Savenaca Junior Nasiga to implement the young men's sessions. Unfortunately, in the second week of the training, Mr Sevuloni Ratu was transferred to the Suva branch of the Red Cross, and due to distance and increased work commitments he was unable to continue assisting Mr Nasiga in the implementation of SS. Due to lack of confidence, Mr Nasiga did not continue with the implementation of the men's sessions. After consultation with the young men of Sasa it was decided, (with their approval) that Kelera Vauvau would facilitate the men's sessions for the remainder of the training.

The training in Sasa was run Tuesday – Friday from 8.30pm-10.30pm in the village community hall. There were a total of 10 young women and 14 young men that attended the training. Of those who

commenced SS training in Sasa, there was a 100% and 97% attendance rate for males and females respectively.

Picture1: Participants preparing for peer group meeting in Sasa village

Picture 2: Female participants doing group work

SS Results

Pre/post test

Question One: What body fluids are HIV found in? (Participants must identify all three body fluids to receive a correct answer)

	No. & % of Pre-Test Participants who answered Q1 correctly		No. and & % of Post-Test Participants who answered Q1 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
Sasa Village (14 males, 10 females)	0 (0%)	0 (0%)	12 (85%)	8 (80%)	14	10

While there were a number of participants from Sasa who correctly identified blood as a body fluid containing HIV, like the FJN+ community they failed to mention sexual body fluids or breast milk. Other common responses pre test included sweat and urine as body fluids containing HIV.

As can be seen by the above table there was a dramatic increase in knowledge relating to all three body fluids containing HIV upon completion of SS. There were no males or females who answered

question one correctly from Sasa village prior to SS yet upon completion, 80% of females and 71% of males correctly identified all three body fluids.

Question Two: Name three ways HIV is transmitted?

	No. & % of Pre-Test Participants who answered Q2 correctly		No. and & % of Post-Test Participants who answered Q2 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
Sasa village (14 males, 10 females)	4 (28%)	5 (50%)	12 (85%)	10 (100%)	14	10

Again, post test scores in Sasa were impressively high upon completion of SS. Common responses to question two prior to SS included kissing and as a means of transmitting HIV. Pre and post test results from Sasa village show an increase of 56% for men and 50% for females participating in SS.

Question Three: Name two ways of preventing HIV?

	No. & % of Pre-Test Participants who answered Q3 correctly		No. and & % of Post-Test Participants who answered Q3 correctly		Total No. of Participants	
Village/community (no. participants)	Male	Female	Male	Female	Male	Female
Sasa village (14 males, 10 females	13 (93%)	10 (100%)	14 (100%)	10 (100%)	14	10

Pre test knowledge relating to how to prevent HIV was high amongst participants with 93% of males and 100% of females correctly identifying condoms and abstinence as a way of preventing HIV. Upon completion of SS 100% of males and 100% females correctly answered question three.

GEM Scale – Sasa village

GEM Topics	**GEM Scale** **1=Agreed** **2=Partially Agreed** **3=Disagreed**	
	Before Stepping Stones Exercise	**After Stepping Stones Exercise**
It is the man who decides what type of sex to have	1	3
A woman's most important role is to take care of her home and cook for her family	1	3
Men need sex more than women do	1	2
You don't talk about sex, you just do it	3	3
Women who carry condoms on them are seen as 'easy'	1	3
Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility	2	3
It is a woman's responsibility to avoid getting pregnant	3	3
A man should have the final word about decisions in his home	1	2
Men are always ready to have sex	1	2
There are times when a woman deserves to be beaten	3	3
A man needs other women, even if things with his wife are fine	2	2
If someone insults me, I will defend my reputation with force if I have to	2	3
A woman should tolerate violence in order to keep her family together	2	3
I would be outraged if my wife asked me to use a condom	1	2
It is okay for a man to hit his wife if she won't have sex with him	3	3
I would never have a gay friend	2	3
It disgusts me when I see a man behaving like a woman	2	3
Total	**31**	**46**

Sasa village showed the greatest improvement in gender equitable norms with a 15 'gender' point increase on post GEM Scale evaluation. Findings of interest include male SS participants in Sasa prior to SS training 'agreed' that, *'It is the man who decides what type of sex to have'*. Post SS GEM scale assessment however reported men disagreeing with this same statement. Similarly, pre assessment found that men from Sasa agreed with the statement, *'Women who carry condoms on them are seen as easy'*. Post SS however reported that men now disagreed with this same statement. Attitudes relating to violence against women also showed improvement based on GEM Scale findings. Pre assessment showed that men 'partially agreered' with the statement, *'a woman should tolerate violence in order to keep her family together'*. Post assessment with the same men found that all now disagreed with this statement.

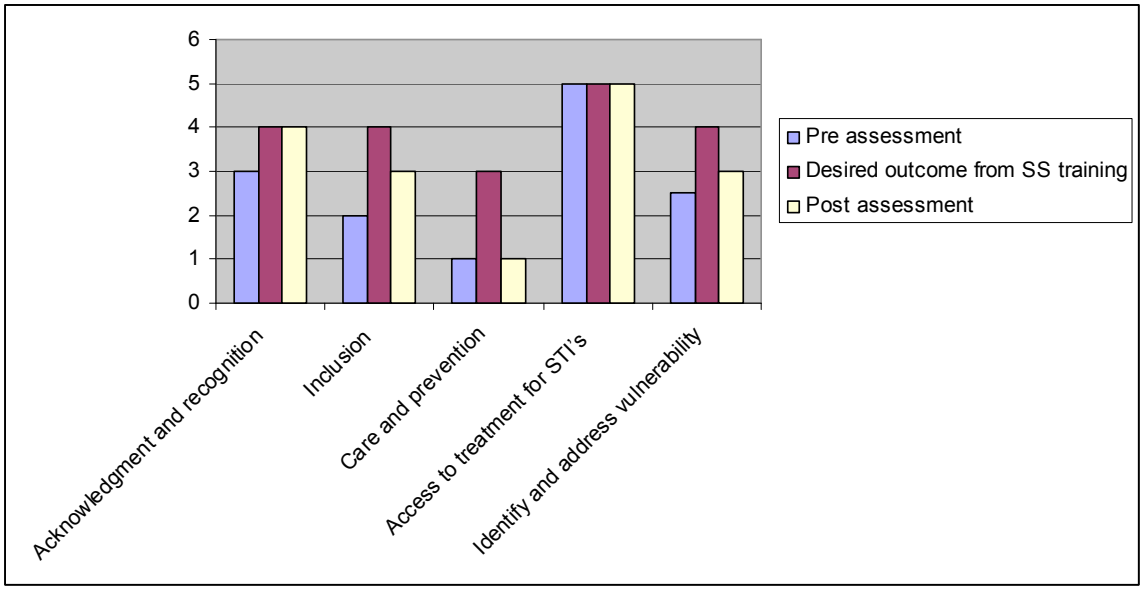
Sasa's GEM Scale results were further supported with a number of girls reporting an improvement in male's behaviour as a result of SS.

> ***Before SS boys and girls in my village didn't really talk closely. If the boys did talk with us it would be about rude stuff or trying to get us to sleep with them. The 6 weeks we spent doing SS brought the boys and girls together. I think we are more like friends now and they don't seem to always call rude things out to us. I think SS made them see us more as people rather than just girls to have sex with.***
>
> Source: excerpt from interview with female SS client

Sasa's GEM Scale results demonstrate that there have been improvements in gender equitable norms from men participating in SS. Possible reasons for this lie in the fact that both young men and young women of Sasa went through the SS training together. This process allowed the young men to view the role plays of the young women, and also gave both genders the opportunity to challenge and verbalise opinions and ideas in the peer group meetings and after the nights training. As one male participant stated, "after the training we would sit around and drink grog and really talk about important things like how we feel when people treat us badly."

Community Self Assessment

Graph A: Range of Self Assessment Results for Sasa village



The above graphical representation of the Community Self Assessment conducted in Sasa shows a post assessment improvement in three of the AIDS Competence stipulated framework areas (acknowledgement and recognition, inclusion and identify and address vulnerability). Sasa community members scored themselves the maximum of five points for, 'access to treatment for STI's' therefore no improvement was possible or necessary. To ensure that community members gave themselves as accurate a self assessment as possible the evaluator used the question guide on page 58 of this report to probe and encourage accurate community scoring.

Sasa community members that participated in the Community Self Assessment reported being clearer on areas of weakness prior to the implementation of SS. They stated that the pre self assessment process had prompted them into thinking as a community of areas that needed to change in relation to HIV. During the pre SS Community Self Assessment Sasa village identified peer pressure amongst youth, and alcohol and marijuana use as possible risk factors (vulnerability) for HIV transmission. In response to this, community members organised local police to come to their village and provide educational sessions around drugs and alcohol. In addition to this, upon completion of SS young men and women established a 'Youth Council' to advocate on behalf of the youth in Sasa. This youth council, currently running in Sasa has been given the opportunity by community elders to present key issues affecting youth in the village at each fortnightly community meeting. The Youth Council has already expressed their concerns regarding alcohol use in the community and has asked that no

drunken behaviour be allowed in the village. Sasa community members are no longer allowed to roam around the village drunk or drink 'heavily' inside the village. If someone does return to the village drunk they are made to go straight to their house and stay out of the way of women, youth and children. Other requests and findings from the Sasa SS training can be seen in the case study on page 44 - 45 of this report.

The Community Self Assessment with the use of the probing questions proved to be a positive evaluation tool for Sasa village. Community members stated they enjoyed the process of assessing their community and found it useful to encourage and facilitate community change. Upon post assessment the community was excited by the changes they had witnessed in their village as a result of SS, (establishment of youth council and initiatives to reduce alcohol and drug use) and spoke of motivation to continue the self assessment process.

8.3 Naiviivi Village

Background

Naiviivi Village is a small coastal community approximately thirty minutes boat ride off Taveuni Island in Vanua Levu Fiji. The village is only a short distance from Qamea Island, a popular and high end tourist resort in Fiji. The population of Naiviivi village, (Fiji Bureau of Statistics, 1996) stands at 129, with a total of 22 households. The vast majority of the community are Indigenous Fijians, many of whom are employed by the nearby resort.

SS Implementation

There has been part implementation of Stepping Stones within Naiviivi Village. The female SS facilitator visited the village for three days from 13th – 15th September 2006. Modules that were covered included:

- Session C - What is love?
- Session E - HIV
- Session F - Condoms

As implementation of SS had already been completed prior to this evaluation and pre/post test questionnaires, GEM scale and Community Self Assessments were not collected, MSC story collection was the only form of evaluation used for Naiviivi village.

SS Results

MSC story collection did highlight some positive outcomes from the Naiviivi training, these included clients reporting increase knowledge pertaining to HIV/AIDS, more motivation to learn about HIV and an awareness of some of the risk factors associated with HIV transmission.

> ***"[Before] I didn't care to learn about HIV… After the 3 days I began to think that HIV was very dangerous and I needed to be more careful with my health."***
> Source: excerpt from interview with male SS client
>
> ***"I would follow peer pressure groups and would use alcohol and have sex with girls… I wanted to remove myself from my peer group. It has been very hard and I am slowing making different friends."***
> Source: excerpt from interview with male SS client

The female facilitator for Naiviivi Village had not adhered to the gender-specific methodology of SS and ran training with young men in Naiviivi village. While none of the young men identified this as a barrier, the vast amount of research around peer education supports that people are more likely to learn and share ideas when done so in the safe and supportive environment of their 'peers'. To be implemented to its full potential it is essential that SS is done so within the confines of small peer and gender appropriate groups. Lack of adherence to this principle methodology undoubtedly affects the outcomes of SS training.

In addition to this, the facilitator from Naiviivi only implemented three of the fourteen SS modules. From observational evaluation and conversations with SS participants who had undergone the training there seemed to remain a lot of fear around HIV. In one particular MSC story collected upon completion of SS a participant stated, 'HIV scares me as there is no cure and it kills people'. As SS is a program that aims to reduce fear and discrimination surrounding HIV/AIDS this was a disappointing comment. It is however support for the fact that SS must be implemented sequentially and completely in order for participants and communities to feel the full effects of the program. By simply running three sessions over a three day period it was impossible for the facilitator to bring about any sustained change in behaviour or attitudes. Furthermore, the trust that is built up over the

four-twelve week period it takes to run the SS allows participants to talk openly about their concerns and fears. It is in this environment that myths and fears around HIV are most likely to be dispelled.

8.4 Western Division - Waikubukubu Village

Background

Waikubukubu is a small village located on the western side of Viti Levu Fiji, about one hour past Tavua town. The village has a population of 175 community members with approximately 33 households. The village is one of the Fiji's Ministry of Health's 'Health Promoting Villages'.

SS Implementation

The female SS facilitator ran all fourteen modules of the program with seven young married women in Waikubukubu village throughout August 2006. The sessions ran from 7pm-9pm three days per week (Monday, Tuesday, and Wednesday) for four weeks.

Mr Meli Ratubalvu, the male SS facilitator is also the Turaga Ni Koro (village headman) for Waikubukubu village. It was thought this would be a great asset to the training as gaining the interest and support of male community members would be easier for a man held in such high regard. Unfortunately, this was not the case and due to time constraints and Tuaga Ni Koro duties Mr Ratubalvu did not implement SS.

As implementation of SS had already occurred prior to evaluation and the SS facilitator did not collect pre/post test questionnaires, GEM Scale or Community Self Assessment, MSC was the only form of evaluation use for Waikubukubu village.

SS Results

MSC story collection in Waikubukubu found a number of positive outcomes as a result of SS. Both clients interviewed spoke of improved relationships amongst women participating in SS, which has in turned resulted in more support and group initiated action taken to address HIV vulnerability.

"Before SS I wondered if my husband ever had sex with other women but I would never ask him about this. I just thought that was something that men did and having sex with other women was something that you should tolerate…After talking with the other women during SS we all thought that way and it was good to listen to how they felt. We were all scared about it and decided that we should not tolerate it from our husbands. We all decided to talk with our husbands and tell them they weren't allowed to have sex with other women."

Source: excerpt from interview with female SS client

"Didn't have many people in the village (apart from my mother) that I could share secrets with… After going through the training with them women I have much more friends and feel close to more women in my village."

Source: excerpt from interview with female SS client

The above excerpts from MSC interviews highlight the potential for SS to go beyond typical one off HIV educational sessions. The MSC stories and anecdotal evidence collected by the evaluator found that the women from Waikubukubu felt a real shift had occurred in their status as women in the village. They were now actively asking for changes to happen in relation to infidelity with their partners, and were continuing to meet informally to act as a support group for fellow SS participants.

In addition to improved communication within relationships, the SS evaluation also found evidence of improved communication between female SS participants and village headmen.

I didn't and the women in my village didn't really ask for things from our village headmen. I didn't think it was the woman's place to do this. After finishing SS and having the special requests I am much more confident to ask for things to happen in my village.

Source: excerpt from interview with female SS client

The training in Waikubukubu was facilitated and supported from the onset by the Tuaga Ni Koro, (he was originally identified to facilitate male SS training). The results of this support are highlighted in the above MSC excerpt where an SS participant reports being more confident to ask for changes to occur. This story provides further evidence of the importance of gaining community and village headmen support prior to implementation of SS. This is particularly important in Fiji, a country where community life still heavily revolves around community hierarchy and traditional protocols.

While there were undoubtedly positive results from the SS training in Waikubukubu village it was unfortunate that males did not also participate in the training. As one female participant stated, "*I have a lot more trust for my husband now because we talk more about our relationship and about sex. I think this could have been even better if the men in my village also went through SS".* For the full affects of SS to be achieved it is important that both males and females participate in the training and are given the opportunity to discuss, present and facilitate community action together.

Picture: Preparing for meeting with village headmen

9.0 MSC Story Collection

MSC story collection was the main evaluation technique adopted for the SS pilot project. In this section of the report all interviews from all communities will be discussed. While it should be noted that MSC can not be used as a sole form of evaluation, PRHP has begun using it as a principle tool for its grants program as it is a useful way to obtain stories of positive change at a community level. MSC stories allow program clients to provide personalised (and often) inspiring stories of change, giving depth to an otherwise clinical and data orientated evaluation.

A total of fifteen MSC stories were collected from all four participating SS communities. One domain, (improved HIV related behaviour) was chosen amongst two categories, (clients and implementers). Two client stories of change were collected from each gender group that participated in the training and all four SS facilitators were interviewed as implementers.


MSC Interviews with SS clients

Collection of MSC stories occurred through site visits by the PRHP Health Promotion Officer during the months of April and May 2007. All stories were brought back to the PRHP office and a selection panel comprising of the PRHP Team Leader, Grants Manager, Health Promotion Officer and the two Project Officers selected the most significant stories. The selection panel met on the 8th May 2007.

9.1 Client MSC Story Collection

There were a number of positive outcomes identified as a result of MSC story collection. Of the ten client stories collected, five SS clients reported having a better relationship with the opposite gender as a result of the training.

> ***"Before SS boys and girls in my village didn't really talk closely. If the boys did talk with us it would be about rude stuff or trying to get us to sleep with them. The six weeks we spent doing SS brought the boys and girls together. I think we are more like friends now… I think SS made them see us more as people rather than just girls to have sex with."***
> Source: excerpt from interview with female SS client
>
> ***"The girls and boys in Sasa didn't really know each other very well. SS brought us together. I got to understand the girls in my village more and also after the training we would sit around and drink grog and really talk about important things like how we feel when people treat us badly"***
> Source: excerpt from interview with male SS client

Seven MSC stories referred to an increase in HIV related knowledge as a result of the SS training.

> ***"[Before] I didn't know much about preventing HIV… [After] I know it's really important and I know that condoms is how you prevent getting HIV. I can also use them the right way."***
> Source: excerpt from interview with male SS client
>
> ***"[Before] I didn't know that much about HIV and about how it is transmitted… After SS I know a lot more about HIV and also about condoms and how to use them and where to get them from."***
> Source: excerpt from interview with male SS client
>
> ***"[Before] I didn't think HIV was something that I needed to think about. I didn't know much about it and had no interest in learning about it… After SS I know much more about HIV and also think it is important to know about it. Even if you don't have HIV it is good to know about it so that you can help and understand people who do have HIV."***
> Source: excerpt from interview with female SS client

Six of the ten clients interviewed reported an improvement in communication with community members, family members and/or sexual partners as a result of the SS program.

"[Before] My husband never cared about women's sicknesses. If I had a stomach ache and he wanted sex he would just have it… [After] now my husband tries to understand me as a woman. He talks to me more about women's sickness and if I don't feel like sex he is more understanding."

Source: excerpt from interview with female SS client

"[Before] our village never spoke about sex especially about sex and youth even though the youth in our village do have sex. We use to pretend it didn't happen…After SS the women got to show their dramas to the village and we have even had a film made in our village about SS. Our village headmen are proud our village was chosen to be on TV and they are much more open to talk about sex and HIV.

Source: excerpt from interview with femlae SS client

"[Before] I didn't talk about sex with my girlfriend… [After] my girlfriend went to the girls SS training. Now we both talk more openly with each other. We both speak about the importance of only one sexual partner."

Source: excerpt from interview with male SS client

9.2 Implementer MSC Story Collection

There were a total of five implementer (SS facilitator) stories collected as part of the Fiji pilot evaluation. Of these stories, three implementers spoke of how they could not talk openly or comfortably about sex before the inaugural training of SS facilitators. Upon completion of the training all three story tellers reported confidence in talking publicly about sexual health issues and HIV/AIDS.

"[Before] I could never imagine a time that I would feel free to bring up the topic of sex and HIV with my family or community. After SS I am free to talk about HIV with my family and my community members. I now have a much better relationship with my family and will definitely talk with my young daughter about sex and HIV when the time is right."

Source: excerpt from interview with female SS implementer

"[Before] I felt ashamed to talk about sex and HIV in my village as it is a taboo subject…[After] I have become much more confident and open and I am very passionate about spreading the word about HIV. I think it is very important to break down the taboos that will help spread HIV."

Source: excerpt from interview with female SS implementer

"I was very ashamed to talk about sex and HIV information with community members. I felt it was something discussed in private with only your partner. After SS I now realise the importance of a community openly discussing HIV and sex. I'm no longer ashamed or embarrassed and often initiate HIV conversation in the village, especially when drinking grog with youth."

Source: excerpt from interview with SS female implementer

9.3 Most Significant Clients Story

Of the ten MSC stories collected from clients of the SS training it became impossible for the selection panel to choose only one 'most' significant. For this reason, it was decided that for the client stories the, 'best' MSC story signalling individual change and the 'best' MSC story citing community change would be chosen.

For the most significant individual change story, the selection panel chose **'Use a condom'** as told by Siteri Qata from Sasa village. The complete MSC interview can be viewed on page 47 of this report.

The panel selected the above story as it showed a marked improvement in HIV related behaviour, and demonstrated the client's acknowledgement of past risk taking behaviour and current change in behaviour with her now actively seeking out and using condoms when having sex with boys from nightclubs.

> ***"I would go out to nightclubs and would have sex with boys but not protect myself. I believed the saying about flesh to flesh being better. After SS I know that I have been very dangerous in my behaviour. After SS I use condoms every time and always get condoms from Di (SS facilitator in Sasa village) or go to the pharmacy to buy them… Looking back to before SS I can say I really don't know why I did it to myself and why I put myself at risk! I feel angry with myself for doing it. Now I am certain that I won't have sex without a condom with boys from nightclubs anymore... I want to protect myself for the future. I have to be alert and be careful so I can grow old and have a family of my own."***
>
> Source: Excerpt from interview with SS client – 'Best' MSC story: Siteri Qata

Additionally, the selection panel felt that the use of words such as, 'certain' and, 'I have to be alert' by the story teller demonstrated a clear understanding of her past risk taking behaviour and her commitment to accessing and wearing condoms for future sexual activity.

Another very positive aspect that emerged from the above story was the improvement in the relationship between young men and women in Sasa village who participated in the SS training.

"Before SS boys and girls in my village didn't really talk closely. If boys did talk with us it would be about rude things. The six weeks we spent doing SS brought the boys and girls together. I think we are more like friends now and they don't speak so rude".

Source: excerpt from interview with SS client - 'Best' MSC story: Siteri Qata

This story accurately highlights the strength of the SS gender approach and the importance of breaking participants into gender specific groups to allow a safe environment to discuss personal and often taboo subjects. This improvement in relationship was also highlighted in three other MSC stories from Sasa village, and although not chosen as the 'best' MSC stories, reiterated and supported the change that has occurred between young men and women in Sasa.

The second 'best' client MSC story selected due to its significant change in community related HIV behaviour was, **'Speak out'** told by Veniana Wagawai from Waikubukubu village (refer to page 49). The selection panel felt this story was also the most significant as it demonstrated the female SS participants making a group decision on what they will do in response to HIV risk in their community.

The story teller reveals the fear she had regarding her husbands fidelity, and tells of how through sharing these fears with the other women in SS she was able to gain strength to act upon her fear.

"I wondered if my husband had sex with another woman… after talking with the other women we all thought that way and it was good to listen to how they feel. We were all scared about it… we all decided to tell our husbands they couldn't have sex with another woman".

Source: excerpt from interview with SS participant, 'best' MSC story: Veniana Wagawai

This group decision making process and associated action showed a remarkable shift in how women believed they should be treated in Fiji, a country that typically does not encourage such assertiveness in women.

"I didn't and the women in my village didn't really ask for things from our village headmen. I didn't think it was the woman's place to do this. After finishing SS and having the special requests I am much more confident to ask for things to happen in my village".

Source: excerpt from interview with SS participant – 'best; MSC story: Veniana Wagawai

9.4 Most Significant Implementer Story

Again, the quality of implementer stories meant that the selection panel was unable to identify only one story, therefore two MSC stories were chosen as it was felt they both demonstrated very different, but equally important benefits of SS. The complete MSC stories can be seen on pages 51 - 54).

The first story selected by the panel was, **'Condoms prevent HIV'** by Diyaunisi Naqiri Ratu from Sasa village. This story was chosen as it demonstrates a great personal change in the implementer, which also resulted in her initiating HIV prevention activities in her village.

"I wasn't an important person in my village and I didn't have a particular role or responsibility… After SS I am seen as a very knowledge person when it comes to HIV. People often come to me and ask question and I have lots more confidence. People look at me differently now and I like it!"

Source: excerpt from interview with SS implementer – 'best' MSC story: Diyaunisi Naqiri Ratu

The personal change of increased confidence and self esteem in the implementer lead her to proactively seek and distribute condoms in her village, a fact that was supported through conversation with a number of SS participants in her village. Informal conversations with Diyaunisi uncovered that she is now the main access point for condoms amongst youth in her community. She has made contact with the local BA Health Service and walks to them every month to obtain a monthly supply of condoms. This was a particularly encouraging consequence of SS as it shows Diyaunisi's sustainable self motivation for HIV prevention in her community.

"I was very ashamed to talk about sex and HIV in my community … I would never think about distributing condoms… I am no longer ashamed or embarrassed and often initiate HIV conversation in the village, especially when drinking grog… After SS I am the one who distributes condoms in my village. I will go into town once a month and collect supplies and make sure I always have enough condoms for people in my village".

Source: excerpt from interview with SS implementer – 'best' MSC story: Diyaunisi Naqiri Ratu

The second 'best' MSC story selected by the panel was **'Self respect'** by Kelera Vauvau from Waikubukubu village. The story highlights a substantial shift in self-worth and gender rights for the implementer, an important change that the selection panel wanted to promote through its evaluation.

My husband left me and my daughter two years ago and does not pay child support. Before SS I was not able to insist on being treated a certain way…. After SS I am much more assertive… I am going to court next month to make my husband pay child support. If he doesn't pay it he will go to jail".

Source: excerpt from interview with SS implementer – 'best' MSC story – Kelera Vauvau

Through discussions with Kelera it became evident that a major shift in her beliefs had occurred as a result of SS. She has accessed legal services, and has begun the process of suing her husband for child support. In the context of Fijian culture this showed remarkable courage and strength.

In addition to this, Kelera spoke of how SS, and her involvement as the female facilitator has contributed to her community viewing her in a more positive and important manner.

"[Before] I thought I wasn't good enough to be a role model in my community – especially since my husband left me and I am now a single mother…[After] Even though I am a single mother I have a lot to teach other young women in my village and they know they can come to me and ask me for advice."

Source: excerpt from interview with SS implementer – 'best' MSC story – Kelera Vauvau

10.0 AIDS Competence Programme

When well implemented the Community Self Assessment can be an effective way of monitoring program outcomes and capacity development. Its strengths lie in its inclusive approach and its encouragement of communities to become empowered to find their own responses to HIV/AIDS. In particular, the evaluator observed that Sasa village, a community that went through the pre and post Community Self Assessment was prompted to think of program outcomes early, and therefore had well thought out suggestions for their 'final requests' ceremony. In addition to this, during community discussion around risk and vulnerability to HIV/AIDS, Sasa village identified alcohol use and criminal activity as an issue affecting the community. In response to this, and a process initiated by the Community Self Assessment, the village approached the local police department and asked them to give awareness sessions on drugs and alcohol to community members. While this activity wasn't a direct result of Stepping Stones, it does demonstrate how the Community Self Assessment can assist communities in clarifying issues that are relevant to them.

The Community Self Assessment can however be a lengthy process, and to be done correctly involves focus group discussion for a minimum of two-three hours. In addition to this, experience in focus group facilitation is important, and all SS facilitators would require appropriate training in order to carry out this process effectively so as to not bias the results.

The FJN+ Community Self Assessment raised questions around reliability of data as the evaluator felt that they over rated themselves on all framework indicators. To combat this problem it is important that those facilitating the process are able to ask probing questions and encourage participants to assess themselves critically without impeding on the self assessment process. A list of probing questions used in this evaluation can be seen on page 57 of this report. These questions are by no means an exhaustive list and can be further developed depending on facilitator needs.

For this evaluation time constraints meant that enough time was not given to communities between completing the SS program and collection of post community assessment data. Post assessment for the Community Self Assessment happened one week post completion in FJN+ and two weeks post completion in Sasa village. In order to obtain a more accurate and relevant self assessment it is recommended that post assessment occurs approximately three months post SS training. It is thought that this time frame would allow the community to witness changes that are occurring in their village and more clearly link these to SS activities and HIV prevention.

11.0 GEM Scale

The GEM Scale questionnaire also proved to be an effective and easy way of obtaining pre and post program data on gender norms from male SS participants. All men reported finding the questions easy to answer and many men stated they liked being challenged by some of the questions that were asked. Evidence from the GEM Scale questionnaires conducted in Sasa and FJN+ found that there had been an improvement in positive gender norms as a result of SS, (fifteen and twelve point improvement respectively). In addition to this, male SS facilitators reported that it was an easy M&E tool to administer. For the future scale up of SS into other Pacific Island countries, the GEM Scale questionnaire would be an effective way of monitoring changes in gender equitable attitudes. In line with current research and readings available for GEM Scale use it is recommended that in order to remain gender sensitive only male facilitators administer the questionnaires to participants. This may therefore mean that male SS facilitators need training in questionnaire administration to ensure responses aren't biased and respondent anonymity it maintained.

12.0 Lessons Learnt and Recommendations

The SS support workshop held from the 29th October – 3rd November 2006 was an opportunity for facilitators to highlight difficulties that they had encountered during the implementation of SS into their respective communities.

Challenges highlighted by facilitators included:

- They didn't have the technical confidence to conduct the sessions without support from PRHP or MOH staff
- They didn't have a male or female counterpart to co-facilitate sessions
- Many male community members (target group) were seasonal workers (sugar cane farmers) and were not in the village when the females had planned to commence SS. Many of the men lost motivation as too much time passed between being trained as facilitators and implementing SS
- Large geographical distance between facilitators within the same division made travelling to common communities and the provision of support difficult
- Heavy workload for MOH support personnel meant providing visitations and constant support was difficult
- Facilitators did not feel they had adequate presentation skills to conduct SS sessions

- Many of the facilitators identified by MoH did not have a high enough level of English literacy to read and deliver the SS manual (which is currently only available in English)

Facilitators at the support workshop were also given the opportunity to give feedback on the inaugural June 2006 training. The suggestions provided by the first round facilitators as well as the findings from this evaluation formed the basis of the recommendations for the future scaling up of SS into other Pacific Island countries.

1. A minimum of one female and one male facilitator from each participating community should be identified as facilitators. Lessons learnt from the inaugural June training demonstrated that if facilitators were from different communities, there was a high likelihood that the training would not take place. This was mainly due to geographical distance, cost of travel or loss of motivation upon return to respective villages. In addition, the evaluation showed that Sasa village, (the only community that had both men and women participating in SS) showed higher levels of change in relation to improved gender norms, and reported more significant improvement in communication amongst male and female community members.

2. Potential SS facilitators need to undergo a selection process. SS training requires a number of facilitation skills in order to successfully challenge community attitudes around risk-taking behaviour, communication and gender violence. Such skills include: knowledge of STIs including HIV/AIDS, an understanding of sexuality and an understanding of communication skills including assertiveness skills. Lessons learnt from the first round of SS facilitator training found that most of the participants did not feel they had the basic knowledge around HIV, STIs, teenage pregnancy and group facilitation. As SS facilitator training is already a lengthy and expensive process, it is recommended that for future scaling up, a selection criterion using the above basic skills is used to ensure that appropriate candidates are identified. Findings from this evaluation did also highlight the importance of motivation and interest as key selection criteria for SS facilitators. The two most successful SS facilitators from the Fiji pilot were without a doubt the female facilitators from Waikubukubu and Sasa village. Neither of these women had any previous experience in HIV/AIDS awareness, but both showed remarkable motivation in implementation of SS. Ideally, all future SS facilitators should demonstrate equally high levels of eagerness and have some experience in the delivery of HIV educational programs.

3. Retention of male SS facilitators had a negative impact on the total affects of the Fiji SS program and the 'final requests' and community action initiated upon completion of the training. Traditionally, male facilitators have been difficult to recruit as they prioritise work commitments and

other community duties as more important. This posed a problem for the Fiji SS program as males; (especially older 'gate keepers') have an overwhelming impact on local level decision making and changes that occur within Fijian communities. Even if all women undergo SS training and decide that they would like changes to occur within their village, without the support or approval of the men, little to no change is likely to take place. An example of this was seen in the implementation of SS in Waikubukubu village. While males did not attend SS training there was good support offered by the Turaga Ni Koro (village headman) therefore increasing other community members support for the program.

Findings from Sasa village best exemplify the potential for change if village headmen support and both male and female participants are involved in SS. Sasa village was the only community that implemented SS with both males and females and clearly showed an increase in positive and respectful relationships with the opposite gender. Of the four MSC stories collected in Sasa village, three of the stories cited improvement in relationship between males and females who attended the training.

Many countries have found that male facilitators have been difficult to retain. Issues that need to be considered include support and encouragement of males so they gain the confidence in group facilitation, and being aware of conflicting work commitments (such as farming) which may prevent males from committing to the eight-twelve week program.

4. Absence of males as SS participants, particularly husbands lessens the likelihood of joint community progress, especially in relation to improved gender norms. Men from Sasa reported much higher levels of change in relation to gender roles and attitudes towards women, as can be seen in their pre/post GEM Scale scores. The opportunity for Sasa males to view and present role plays to the women on issues such as ideal men and women, teenage pregnancy, gender violence and negotiating condom use allowed the peer groups to share and learn from each other in a safe environment. The trust that had been established over the six weeks of SS training meant that both groups were able to ask for changes at the final community requests meeting. In addition to this, one of the female participants from Waikubukubu village commented in her MSC story that the involvement of men also under going SS training would have assisted the females in facilitating more change within their community. All communities involved in SS need to commit to males and females undergoing the program.

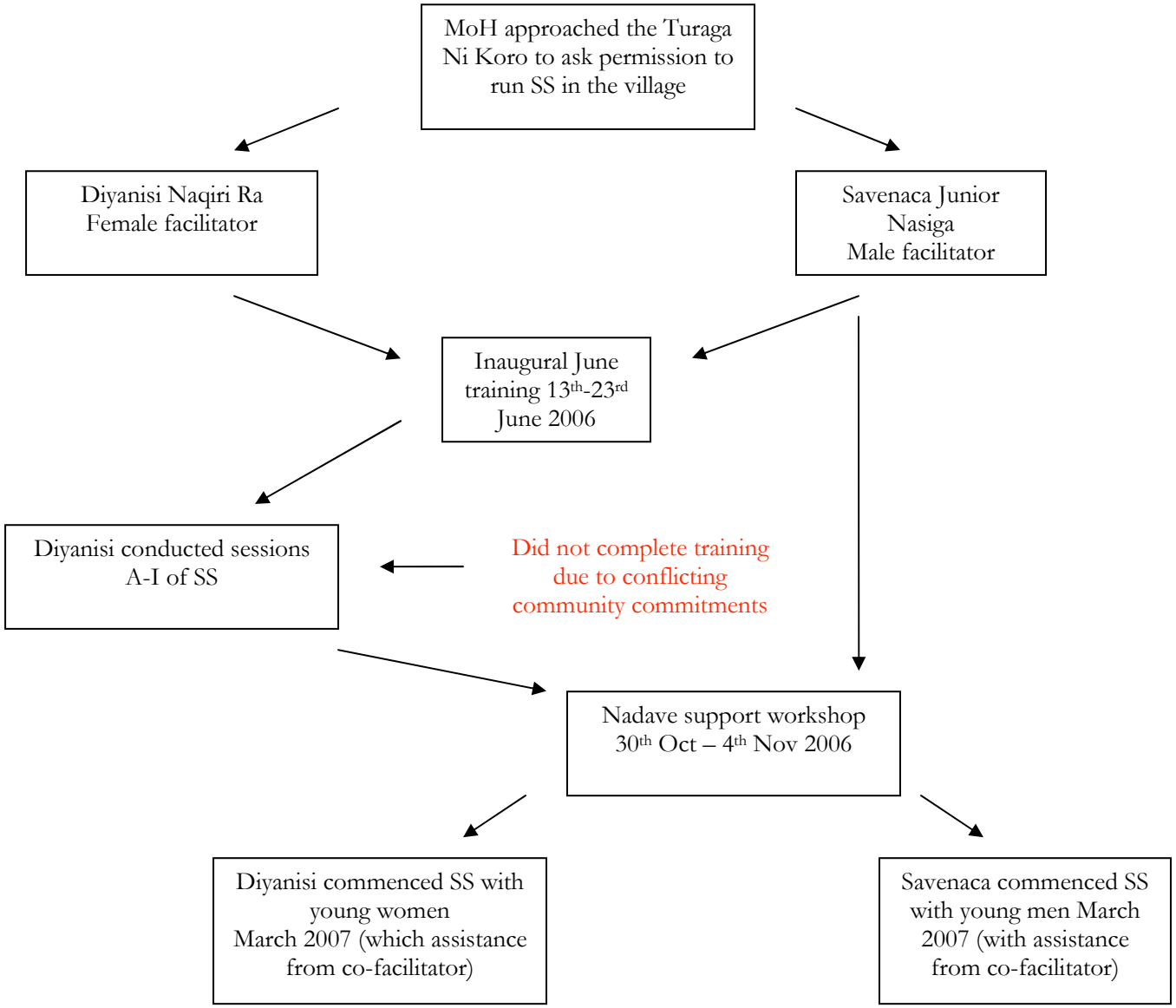
5. Many communities attempted a 'part' implementation of the SS program, or incorporated it into their existing HIV/AIDS or sexual health training. Unlike many other HIV/AIDS educational packages, SS has not been developed with this methodology in mind. It is important that the complete SS package is delivered in sequential order, as each session builds upon the last. One community, (Taveuni) where part implementation was carried out showed little change in relation to behaviour change as a result of the training. It is thought that this was not a reflection of the SS program but of 'part' versus 'full' implementation. For the future scale up of SS into other Pacific countries it is important that facilitators are able to commit to the implementation of the complete program which involves a commitment of a minium of four weeks.

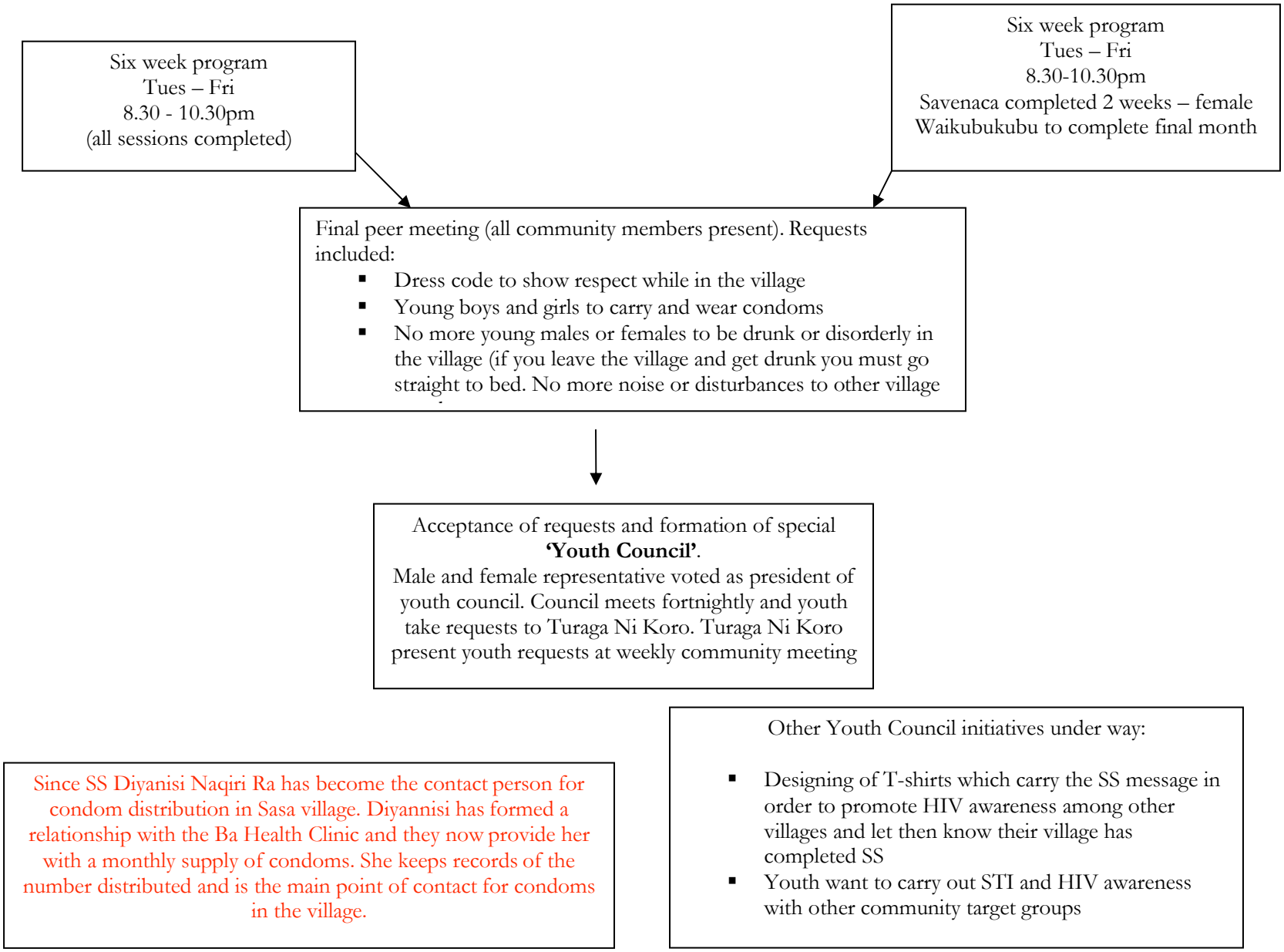
6. There needs to be more support and follow-up for local facilitators including access to materials, (such as butcher's paper) and technical assistance for facts based sessions such as conception and contraception. While MoH support officers were identified for SS facilitators in Fiji, due to time and other work commitments they were unable/unwilling to carry through with this support. For the future scale up of SS, support personnel should be identified, and Terms of Reference and time spent supporting the communities' needs to be written into job descriptions and work plan development.

7. Communities that allowed adequate time to implement SS showed greater improvements in relation to SS outcomes. For future scale up facilitators should be supported to run the training over a minium of a four week (preferably eight – twelve week) period. This is important as SS's success is based on participants learning new skills and having the time to practice these skills in their daily lives before they process to more difficult behaviour change practices. Participants from the FJN+ community, who went through the training over a two week period, did not report the same outcomes or participant satisfaction as seen by Sasa and Waikubukubu communities, where SS was fun over a four-six week period.

8. Clear monitoring and evaluation techniques need to be built into future SS workshops. There were some difficulties in the evaluation of the pilot program in Fiji as many of the facilitators did not collect any quantitative data, and were not aware of the importance of evaluation for the continual improvement of SS. Future scale up of SS should involve training facilitators in monitoring and evaluation techniques so that future regional evaluations have adequate data to analyse. Suggestions for M&E include: GEM Scale, AIDS Competence Community Self Assessment, MSC, workshop data such as number of participants, age of participants, attendance rate, number of workshops run and participant feedback upon completion of each session.

13.0 Community requests and actions as a result of Stepping Stones – Case Study: Sasa Village




Six week program
Tues – Fri
8.30 - 10.30pm
(all sessions completed)
Six week program
Tues – Fri
8.30-10.30pm
Savenaca completed 2 weeks – female
Waikubukubu to complete final month
Final peer meeting (all community members present). Requests included:
Dress code to show respect while in the village
Young boys and girls to carry and wear condoms
No more young males or females to be drunk or disorderly in the village (if you leave the village and get drunk you must go straight to bed. No more noise or disturbances to other village
Acceptance of requests and formation of special 'Youth Council'.
Male and female representative voted as president of youth council. Council meets fortnightly and youth take requests to Turaga Ni Koro. Turaga Ni Koro present youth requests at weekly community meeting
Since SS Diyanisi Naqiri Ra has become the contact person for condom distribution in Sasa village. Diyannisi has formed a relationship with the Ba Health Clinic and they now provide her with a monthly supply of condoms. She keeps records of the number distributed and is the main point of contact for condoms in the village.
Other Youth Council initiatives under way:
Designing of T-shirts which carry the SS message in order to promote HIV awareness among other villages and let then know their village has completed SS
Youth want to carry out STI and HIV awareness with other community target groups

14.0 Annexes

14.1 Story Collection Guide for Stepping Stones

Background

PRHP in partnership with Fiji Ministry of Health implemented Stepping Stones, a community HIV prevention project into various communities in June 2006. In order to monitor activities and continually improve the project we are hoping to capture some stories about changes that you may have experienced as a result of Stepping Stones. If you're happy with this, I will ask you 3-4 questions and write the answers down in my note book. Is now a good time to begin? (If not, when can we do this?) It should take about 20-30 minutes.

We hope to use the stories and information collected from your interviews for a number of purposes including:

- To help us understand what participants think is good and not as good
- To make improvements to our (PRHP & CDO) work
- To tell AusAID what has been achieved

Confidentiality

We may like to use your stories for reporting to our donors, or sharing with other participants and trainers. Do you (the story teller):

- Want to have your name on the story (tick one) [x] Yes [ ] No
- Consent to us using your story for publication (tick one) [x] Yes [ ] No

Contact Details

Name of story teller:Siteri Qata
Name of person recording story: Emily Miller
Location: Sasa
Project Name: Stepping Stones
Date of recording story: 4th May 2007
* (If they wish to remain anonymous, don't record their name or contact details, just write occupational status & location if they are happy with that)

Questions

(This is the introduction question when interviewing your project clients)
Tell me how you first became involved with the project?

I am related to Di, the Sasa SS trainer. Di shared SS with us in the home and asked me to come along to a community training that she was going to give. I agreed to come along to the training.

Please list the most important changes in the table below that you feel have resulted in you participating or being part of Stepping Stones.

Changes:

Before	After
I would always tell stories about other people in my village	After SS I realised the importance of keeping secrets and have made strong friends with the other young women in my village. I feel bad for my past gossiping and don't talk about people anymore.
I would go out to nightclubs and would have sex with boys but not protect myself. I believed the saying about flesh to flesh being better.	After SS I know that I have been very dangerous in my behaviour. After SS I use condoms every time and always get condoms from Di or go to the pharmacy to buy them. I am also not going out to nightclubs as much anymore and sometimes just stay in my village with my family or friends.
Before SS boys and girls in my village didn't really talk closely. If the boys did talk with us it would be about rude stuff or trying to get us to sleep with them.	The 6 weeks we spent doing SS brought the boys and girls together. I think we are more like friends now and they don't seem to always call rude things out to us. I think SS made them see us more as people rather than just girls to have sex with.
Before SS I would take big risks with my health.	Looking back before SS I can say I really don't know why I did that to myself and why I put myself at such a big risk! I feel angry with myself for doing it and SS made me and my girlfriends see how bad we had been treating ourselves.

From your point of view, select the most Significant change of all changes you have listed above. Describe this change in the form of a story [i.e a beginning (what it was like before); a middle (what happened); and an end (what it is like now)].

Now protecting myself from HIV has been the most important change for me. Before SS I would go to the nightclubs and have sex with boys. I believed the saying that flesh to flesh sex was best.

Now I am certain that I won't have sex without a condom with boys from nightclubs anymore. I make sure that I have condoms on me that I get from Di or that I buy from the pharmacy. I still go to the nightclubs with my friends but not as much anymore.

Why did you choose this particular story? Why is it significant to you?
I want to protect myself for the future. I have to be alert and be careful so I can grow old and have a family of my own one day.

What title would you give this story?
Use a condom!

14.2 Story Collection Guide for Stepping Stones

Background

PRHP in partnership with Fiji Ministry of Health implemented Stepping Stones, a community HIV prevention project into various communities in June 2006. In order to monitor activities and continually improve the project we are hoping to capture some stories about changes that you may have experienced as a result of Stepping Stones. If you're happy with this, I will ask you 3-4 questions and write the answers down in my note book. Is now a good time to begin? (If not, when can we do this?) It should take about 20-30 minutes.

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Confidentiality

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- Want to have your name on the story (tick one) [x] Yes [ ] No
- Consent to us using your story for publication (tick one) [x] Yes [ ] No

Contact Details

Name of story teller: Veniana Waqawai
Name of person recording story: Emily Miller
Location: Waikumbukumbu
Project Name: Stepping Stones
Date of recording story: 4th May 2007
* (If they wish to remain anonymous, don't record their name or contact details, just write occupational status & location if they are happy with that)

Questions

(This is the introduction question when interviewing your project clients)
Tell me how you first became involved with the project?

Kelera came back to Sasa after being trained in Suva. We had a community meeting about SS and Kelera asked the village head men if she could run the training. They said yes and she asked me to attend.

Please list the most important changes in the table below that you feel have resulted in you participating or being part of Stepping Stones.

Changes:

Before	After
Didn't really know much about HIV. I had heard of it before and MoH had come and talked to us about it but I still wasn't really sure about how you got it.	Now I know a lot about HIV and how you get it and also how you prevent it.
Didn't talk to my husband about sex and I didn't have an open relationship to talk about my feelings or fears. I always wondered if he had had sex with other women.	I have a lot more trust for my husband now because we talk more about our relationship and about sex. I think this could have been even better if the men in my village also went through SS.
I didn't and the women in my village didn't really ask for things from our village headmen. I didn't think it was the woman's place to do this.	After finishing SS and having the special requests I am much more confident to ask for things to happen in my village.

From your point of view, select the most Significant change of all changes you have listed above. Describe this change in the form of a story [i.e a beginning (what it was like before); a middle (what happened); and an end (what it is like now)].

Didn't talk with my husband about sex or relationship issues.

Before SS I wondered if my husband ever had sex with other women but I would never ask him about this. I just thought that was something that men did and having sex with other women was something that you should tolerate.

After talking with the other women during SS we all thought that way and it was good to listen to how they felt. We were all scared about it and decided that we should not tolerate it from our husbands. We all decided to talk with our husbands and tell them they weren't allowed to have sex with other women.

Why did you choose this particular story? Why is it significant to you?

Because it has made my relationship with my husband more open and I now tell my husband how to treat me rather than being quite and scared.

What title would you give this story?

Speak out

14.3 Story Collection Guide for Stepping Stones

Background

PRHP in partnership with Fiji Ministry of Health implemented Stepping Stones, a community HIV prevention project into various communities in June 2006. In order to

monitor activities and continually improve the project we are hoping to capture some stories about changes that you may have experienced as a result of Stepping Stones. If you're happy with this, I will ask you 3-4 questions and write the answers down in my note book. Is now a good time to begin? (If not, when can we do this?) It should take about 20-30 minutes.

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- To help us understand what participants think is good and not as good
- To make improvements to our (PRHP & CDO) work
- To tell AusAID what has been achieved

Confidentiality

We may like to use your stories for reporting to our donors, or sharing with other participants and trainers. Do you (the story teller):

- Want to have your name on the story (tick one) [x] Yes [ ] No
- Consent to us using your story for publication (tick one) [x] Yes [ ] No

Contact Details

Name of story teller: Diyaunisi Naqiri Ratu

Name of person recording story: Emily Miller
Location: Sasa
Project Name: Stepping Stones
Date of recording story: 4th May 2007
* (If they wish to remain anonymous, don't record their name or contact details, just write occupational status & location if they are happy with that)

Questions

(This is the introduction question when interviewing your project clients)
Tell me how you first became involved with the project?

Sasa village is an MoH 'Health Promoting Village'. Yasin, the MoH Health Promotion Officer came to Sasa and asked my torani koro to chose 1 female and 1 male to be trained up as SS trainers. I was chosen as the female trainer for my village. I then attended the 2 week training course in Suva in June 2006.

Please list the most important changes in the table below that you feel have resulted in you participating or being part of Stepping Stones.

Changes:

Before	After
I was very ashamed to talk about sex and HIV information with community members. I felt it was something discussed in private with only your partner.	After SS I now realise the importance of a community openly discussing HIV and sex. I'm no longer ashamed or embarrassed and often initiate HIV conversation in the village, especially when drinking grog with youth.
I wasn't an important person in my village and I didn't have a particular role or responsibility.	After SS I am seen as a very knowledgeable and important person (esp amongst youth) when it comes to HIV and sexual health. People are often coming to find me to ask me questions and I have lots more confidence and am proud about what I can tell them. People look at me differently now and I like it!
Would never think about distributing condoms to people in my village.	After SS I am the one who distributes condoms in my village. I will go into town once a month to collect supplies and make sure I always have enough condoms for the people in my village.
Didn't have much contact with people from other villages or clubs	After SS word has spread to near by communities about the HIV work we are doing in Sasa. People from other communities are coming and asking me to join their youth clubs and teach their youth about HIV and sexual health.

From your point of view, select the most Significant change of all changes you have listed above. Describe this change in the form of a story [i.e a beginning (what it was like before); a middle (what happened); and an end (what it is like now)].

Distributing condoms and information/advice is the most significant to me. Before SS there was not easy access to condoms and youth in my village had to go into town to buy them, which many youth didn't want to do. Since SS I have realised the importance of condoms. We can not tell youth to wear condoms and have safe sex and not give them the condoms. Now, I go into town and get condoms every month from the health clinic. They (nurses from the health clinic) know I have had SS training and are happy to help me as they know I am giving them out in my community. Youth in Sasa are much more likely to wear condoms now as they don't have to go into town and know they can come and ask me for condoms and I won't tell anyone.

Why did you choose this particular story? Why is it significant to you?
Because there is no cure for HIV and wearing condoms is the only way to prevent it.

What title would you give this story?
Condoms prevent HIV!

14.4 Story Collection Guide for Stepping Stones

Background

PRHP in partnership with Fiji Ministry of Health implemented Stepping Stones, a community HIV prevention project into various communities in June 2006. In order to monitor activities and continually improve the project we are hoping to capture some stories about changes that you may have experienced as a result of Stepping Stones. If you're happy with this, I will ask you 3-4 questions and write the answers down in my note book. Is now a good time to begin? (If not, when can we do this?) It should take about 20-30 minutes.

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- To help us understand what participants think is good and not as good
- To make improvements to our (PRHP & CDO) work
- To tell AusAID what has been achieved

Confidentiality

We may like to use your stories for reporting to our donors, or sharing with other participants and trainers. Do you (the story teller):

- Want to have your name on the story (tick one) [x] Yes [ ] No
- Consent to us using your story for publication (tick one) [x] Yes [ ] No

Contact Details

Name of story teller: Kelera Vauvau
Name of person recording story: Emily Miller
Location: Waikumbukumbu
Project Name: Stepping Stones
Date of recording story: 4th May 2007
* (If they wish to remain anonymous, don't record their name or contact details, just write occupational status & location if they are happy with that)

Questions

(This is the introduction question when interviewing your project clients)
Tell me how you first became involved with the project?

I was chosen by my village elders to attend the Stepping Stones training in June 2006. I attended the training and then came back to my village to implement SS with the women in community.

Please list the most important changes in the table below that you feel have resulted in you participating or being part of Stepping Stones.

Changes:

Before	After
I could never imagine a time that I would feel free to bring up the topic of sex and HIV with my family or community	After SS I am free to talk about HIV with my family and my community members. I now have a much better relationship with my family and will definitely talk with my young daughter about sex and HIV when the time is right.
My husband left me and my daughter 2 years ago and does not pay any child support. Before SS I wasn't able to insist on being treated in a certain way. I let people take advantage of me.	After SS I am much more assertive and now insist on being treated well. I am going to court next month to make my ex-husband pay child support. If he doesn't pay it he will go to jail. SS has given me a lot more self respect.
Didn't think I could do anything about the health of my community. Thought I wasn't good enough to be a role model in my community – especially since my hisband left me and I am now a single mother.	SS showed me that everyone has a responsibility for the health of their community. Even though I am a single mum and have a lot to teach other young women in my village and they know they can come to me and ask me for advice.

From your point of view, select the most Significant change of all changes you have listed above. Describe this change in the form of a story [i.e a beginning (what it was like before); a middle (what happened); and an end (what it is like now)].

For me, more self confidence is the MSC story. Before SS I thought that my husband leaving me was my fault and I was ashamed and thought that everyone in my village thought I was not a good wife or mother. I didn't like living in my community and I would not be involved in community activities.

After SS and the experience of talking openly about taboo topics such as sex and relationships I found out that many young women have problems like mine. It has made me feel less alone and being an SS trainer I can share my new knowledge and help other young women through their relationship problems. Women don't get much power in Fiji and SS gave me the confidence to tell people how they had to treat me. I will make my ex-husband pay child support as she is his daughter and he has to help raise her.

Why did you choose this particular story? Why is it significant to you?

It is important to me because I have a daughter and I want her to grow up being strong. She needs to have a strong mother so she can see how to behave.

What title would you give this story?

Self respect.

14.5 The Gender-Equitable Men Scale (GEM Scale)

Respondents are to answer; Agree (1), Partially Agree (2) or Do Not Agree (3)

	Agree (1)	Partially Agree (2)	Do not Agree (3)
1. It is the man who decides what type of sex to have			
2. A woman's most important role is to take care of her home and cook for her family			
3. Men need sex more than women do			
4. You don't talk about sex, you just do it			
5. Women who carry condoms on them are seen as 'easy'			
6. Changing diapers, giving the kids a bath, and feeding the kids are the mothers' responsibility			
7. It is a woman's responsibility to avoid getting pregnant			
8. A man should have the final word about decisions in his home			
9. Men are always ready to have sex			
10. There are times when a woman deserves to be beaten			
11. A man needs other women, even if things with his wife are fine			
12. If someone insults me, I will defend my reputation with force if I have to			
13. A woman should tolerate violence in order to keep her family together			
14. I would be outraged if my wife asked me to use a condom			
15. It is okay for a man to hit his wife if she won't have sex with him			
16. I would never have a gay friend			
17. It disgusts me when I see a man behaving like a woman			

14.6 AIDS Competence Programme Self-Assessment Framework

	1 BASIC	2	3	4	5 HIGH
Acknowledgement and Recognition	We know the basic facts about HIV/AIDS, how it spreads and its effects	We recognise that HIV/AIDS is more than a health problem alone	We recognise that HIV/AIDS is affecting us as a group/community and we discuss it amongst ourselves. Some of us get tested	We acknowledge openly our concerns and challenges of HIV/AIDS. WE seek others for mutual support and learning	We go for testing consciously. We recognise our own strength to deal with the challenges and anticipate a better future
Inclusion	We don't involve those affected by the problem	We co-operate with some people who are useful to resolve common issues	We in our separate groups meet to resolve common issues (eg, PLWHA, youth, women)	Separate groups share common goals and define each member's contribution	Because we work together on HIV/AIDS we can address and resolve other challenges facing us
Care and Prevention	We relay on externally provided messages about care and support	We look after those unable to care for themselves (sick, orphans, elderly). We discuss the need to change behaviours.	We take action because we need to and we have a process to care for others long terms	As a community we initiate care and prevention activities, and work in partnership with external services	Through care we see changes in behaviour which improve the quality of life for all
Access to Treatment	Other than existing medicines, treatment is not available to us.	Some of us get access to treatment	We can get treatment for infections but not ARV's	We know how and where to access ARV's	ARV drugs are available to all who need them, are successfully procured and effectively used
Identify and Address Vulnerability	We are aware of the general factors of vulnerability and the risks affecting us	We have identified our areas of vulnerability and risk	We have a clear approach to address vulnerability and risk, and we have assessed the impact of the approach	We implement our approach using accessible resources and capacities	We are addressing vulnerability in other aspects of the life of our group

14.7 Probing questions for Community Self Assessment

1. Acknowledgment and recognition

- Do you know three ways that HIV can spread?
- How often does your community discuss HIV?
- Where do you discuss HIV?
- When you discuss HIV what do you talk about?
- When you discuss HIV who do you talk to?
- Have you ever thought about having an HIV test?

2. Inclusion

- Would your community involve HIV positive people?
- In what ways would you involve HIV positive people?
- Does your community work with other communities to talk about HIV?
- Do your village headmen include all community members when they are discussing important issues?
- Do different groups meet to discuss problems (youth, women, positive people)?

3. Care and prevention

- Do you wait for outside people before you respond to issues?
- Does your community rely on outside agencies to tell them about care and support options for HIV positive people?
- Would your community care and support an HIV positive person?
- In what ways would your community help care for HIV positive people?

- Does your community actively help to care and support those who are unable to care for themselves?

- What does your community do to care for others?

4. Access to treatment for STI's

- Is there treatment available for STI's in your community

- Do you know where you can receive this treatment?

- How would someone in your community access this treatment?

5. Identify and address vulnerability

- What are the factors in your community that could lead to HIV transmission?

- Have people in your community discussed these issues?

- Is your community doing anything to address these problems?

- What is your community doing to address these issues?

- Are you using your own resources or do you need to rely on outside people?

- Is your community addressing other vulnerabilities such as unemployment, alcohol and violence

15.0 References

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