

Stepping Stones & Stepping Stones Plus and its new daughter programme, *Stepping Stones with Children*, are both now published by Practical Action Publishing - <http://tinyurl.com/PAPStStwC>



World Health Organization

Building a safe house on firm ground

Core Team Members: Luisa Orza | Alice Welbourn | Susan Bewley | E. Tyler Crone | Marijo Vazquez

GRG members: Nushinaro Ao, Cecilia Chung, Sophie Dilmitis, Calorine Kenkem, Svetlana Moroz, Suzette Moses-Burton, Hajjarah Nagadya, Angelina Namiba, L'Orangelis Thomas Negrón, Gracia Violeta Ross, Sophie Strachan, Martha Tholanah, Patricia Ukoli, Rita Wahab.

WHO: Manjulaa Narasimhan




I'm sharing today some findings on violence against women (VAW) living with HIV from a global survey which we conducted in 2014. <http://salamandertrust.net/project/salamander-trust-survey-sexual-reproductive-health-human-rights-women-living-hiv/>

This is to raise the issue of VAW as experienced by women living with HIV for whom VAW is huge.

We conducted a global values and preferences survey on the SRH&HR of women living with HIV. Women from a number of LAC countries took part in this survey.

This was a huge collaborative effort, as all the logos show at the bottom of this slide. Two of us in the core team, Marijo Vazquez and myself, are women living with HIV. And all 14 of our Global Reference Group (GRG) members are leading women living with HIV around the world. They have diverse ages, are from diverse regions, have diverse routes of HIV acquisition and diverse other identities. We sought from the outset to develop a sense of inclusivity in this survey, reflected by the diversity of the GRG. We also worked closely with Dr Manjulaa Narasimhan of WHO, who commissioned us to conduct this survey, which was a values and preferences survey to inform the new guidelines on sexual and reproductive health and rights (SRHR) of women living with HIV, which is due to be published shortly.

Results from 58% of 832 survey respondents on Gender-Based Violence (GBV)

- **89%** reported experiencing at least one type of violence
 - From an **intimate partner**: 59%
 - From **family or neighbours**: 45%
 - In the **community**: 53%
 - In the **health care setting**: 53%
 - From **police / military / prison or detention**: 17%
 - **Fear** of violence: 68%
- High IPV levels before and after diagnosis. Higher levels of violence experienced **post**-diagnosis in **health settings** & in the **community**
- Experiences of violence in the health care setting often **worse** for women with *other* socially disadvantaged identities



Here are the results about GBV from the survey. The survey had 1 mandatory and 8 optional sections. GBV was highlighted in responses to *all sections* of the survey. 58% of the 832 on-line participants responded to the GBV section. Of these, 89% reported experiencing at least 1 type of violence.

While reported IPV was already high at 43%, pre-diagnosis, it rose to 59% after diagnosis.

The most marked increases were GBV from family or neighbours and from the community, which rose from 16% each pre-diagnosis to 45% and 53% respectively.

The highest increase was in relation to violence experienced by women in healthcare settings, which jumped from **6% pre-diagnosis to 53% after diagnosis**.

Examples of GBV in healthcare settings included: * Breach of confidentiality; * Coerced testing; * Coerced disclosure to partner and in-laws, which can trigger violence from *them*;

- Coerced treatment initiation; * Coerced abortion; * Coerced sterilisation; * Coerced long-term contraceptives; * or Withdrawal of contraceptive services on the basis that women should not be having sex or children;
- Verbal abuse; * Lack of support during delivery; * And women reported even worse experiences if they were sex workers, lesbian, trans or women who used drugs or who had other disabilities than HIV.

These experiences resulted in women: avoiding health services if possible; fearing to start treatment; and resulting in poor health outcomes in many ways, both for themselves and their children.

Orza L et al. *Journal of the International AIDS Society* 2015, 18(Suppl 5):20285
<http://www.jiasociety.org/index.php/jias/article/view/20285> | <http://dx.doi.org/10.7448/IAS.18.6.20285>

Results from 59% of 832 survey respondents on Mental Health*

- **82%** reported depression; **78%** rejection
- 1/5 reported MH issues *before* diagnosis
- This increased by **3.5 times** *after* diagnosis
- 45.8% had multiple 'socially disadvantaged identities' (SDIs)
- More SDIs ⇔ More mental health issues
- MH affected ability to enjoy SRH and to access services
- MH included: depression, rejection, social exclusion, sleep problems, intersectional stigma, challenges with sexual & intimate relationships, substance use, sexual risk, repro health barriers, human rights (HR) violations

Respondents recommended psychological support & counselling, funding for peer support & interventions to challenge GBV and to promote HR

* Thanks to Carmen Logie for additional analysis of quantitative responses



One-fifth reported mental health issues before HIV diagnosis. Respondents reported experiencing a 3.5-fold higher number of mental health issues after diagnosis (8.71 vs 2.48, $t[488]23.00$, $p<0.001$). Nearly half ($n=224$; 45.8%) had multiple identities which can make them socially disadvantaged (SDIs), in addition to HIV. The number of 'SDIs' was positively correlated with experiencing mental health issues ($p<0.05$). Women described how mental health issues affected their ability to enjoy their right to sexual and reproductive health and to access services. These included depression, rejection and social exclusion, sleep problems, intersectional stigma, challenges with sexual and intimate relationships, substance use and sexual risk, reproductive health barriers and human rights (HR) violations. Respondents recommended that policymakers and clinicians provide psychological support and counselling, funding for peer support and interventions to challenge gender-based violence and to promote HR. Orza L et al. *Journal of the International AIDS Society* 2015, 18(Suppl 5):20289 <http://www.jiasociety.org/index.php/jias/article/view/20289> | <http://dx.doi.org/10.7448/IAS.18.6.20289>



Here we have the image of a house that we used to present the survey report, which we entitled “Building A House on Safe Ground”. There are different key elements of a house, similar to different key elements of a woman’s life. You need all these elements to make a house stand up firm and strong – all are important, all are needed. The house reflects the holistic nature of the survey, where we explored the psycho-social, sexual, physical, material and spiritual well-being of women’s lives across the life-span, from conception to death.

You will see that the absolute foundation stone for the house was SAFETY.

<http://salamandertrust.net/project/salamander-trust-survey-sexual-reproductive-health-human-rights-women-living-hiv/>

Findings: Micro- (Individual) Level Treatment Barriers

- **Violence** & fear of violence most commonly cited barriers – partner; family; community
- Includes stigma and discrimination
- Side effects of HIV treatment: eg appearance; sexuality
- Inability to meet basic needs: housing, food security, livelihoods – women prioritising children & others



I also want to share this research we have done with UN Women on global treatment access barriers for women living with HIV – and again VAW plays a major part of a barrier.

<http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/>

1. Violence against women living with HIV: this, coupled with fear of violence, were the most commonly cited barriers for women.
2. In the home, fear and experiences of stigma and discrimination: this leads to non-disclosure of status, which is linked to lower adherence and higher rates of depression. This effect is amplified among women. Lack of privacy was also cited in relation to having no safe space at home or work to take medications.
3. Side effects of HIV treatment: these were consistently cited as a barrier to treatment access in the form of long-term adherence for women, and some side effects – especially changes in body shape¹⁰ – had mental health or emotional repercussions, particularly around gender norms and expectations for women's bodies and sexuality.
4. Inability to meet basic needs: including livelihoods, food security, nutrition and housing, and each of these in turn served as a barrier to HIV treatment access and adherence. In the case of food security and nutrition, women reported prioritizing children over themselves making it difficult for women to access the healthy diets they need to take treatment effectively.

Findings: Micro- (Individual) Level Treatment Barriers

- *"What affected me most is that I do not feel attractive to my husband he does not say anything, but that is how I feel and that is why I get depressed."* (FGD Cochabamba, Bolivia,)
- *"Me too my husband literally said, "and I do not want you, **you no longer attract me**". (FGD, Cochabamba, Bolivia)*
- *The hardest thing is **abuse** in the family, I got to a point where I got fed up and I left the house, they gave me **a separate plate**, everything separate and made harsh comments saying "God knows why you've become infected". (FGD, La Paz and El Alto, Bolivia)*



1. Here we have some quotes from women in Bolivia where one of our focus group discussions took place.

<http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/>

Findings: Meso-Level Treatment Barriers

Gender roles and responsibilities

Violations of rights to privacy, confidentiality and bodily integrity in healthcare services

Violations during and after labour, including forced and coerced sterilization

Poor communication in healthcare



1. Violence at meso-level, including in healthcare settings, was also a concern for women.

<http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/>

Findings: Meso-Level Treatment Barriers

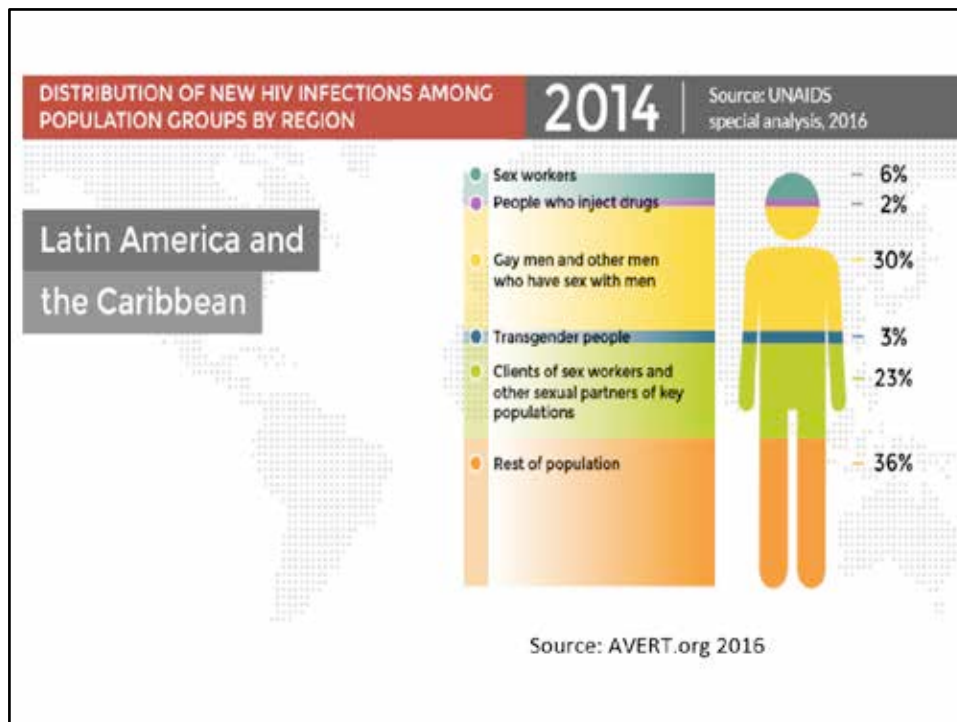
- *"When I was in Dutch Hospital, the nurse said "where is the lady who has AIDS?" Just like that in front of everyone, this was **how my family found out**, health personnel's attitude changed, the residents there have been freaking, they took pictures of me, recorded videos of me on their cell phones, they did not see my child, they did not change his diapers, they did not give him milk, it was a damn ordeal I went through."*
- *"I feel bad for the pregnant women, they are young but already they have already had their tubes tied, the doctors insist on tubal ligation [**sterilization**] when they do their caesareans, really they tell you "do not have children." It shouldn't be like that, their duty is serving us."*

(FGD, La Paz and El Alto, Bolivia)

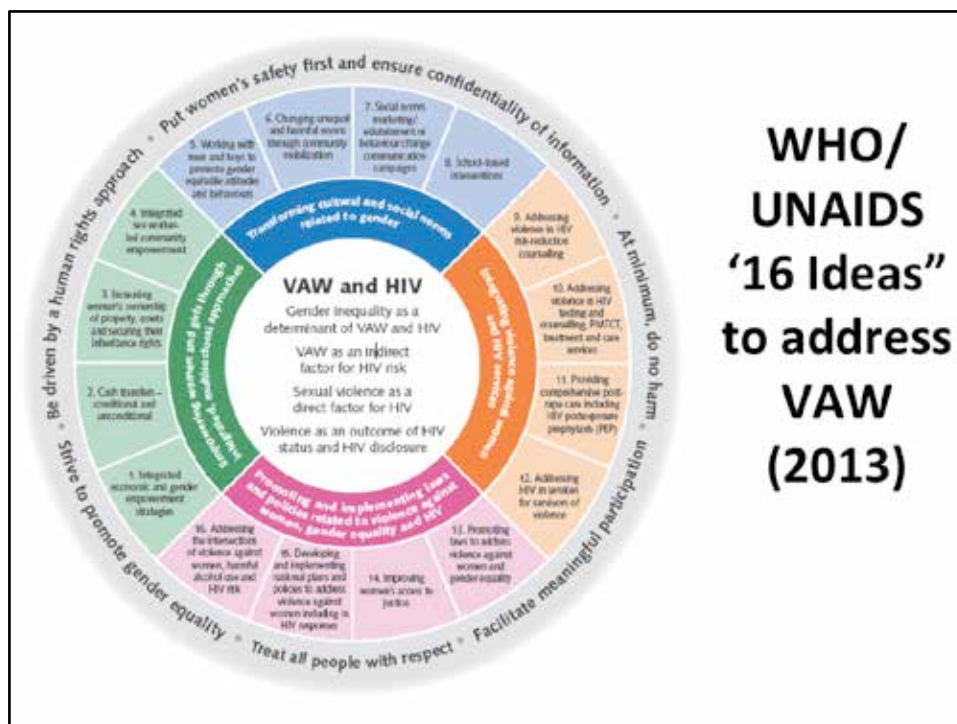


1. Again we have some quotes from women respondents in Bolivia.

<http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/>



Here we see that women living with HIV form part of the picture in LAC. If we look at the legs of this image and suppose that at least half of this 36% of “rest of population” are women, then that is at least 18% of 2 million people living with HIV in LAC – which = 360,000 women. So if we want to think of no-one being left behind, as especially when we see the especial gravity of women in all their diversities – including women sex workers, women who use drugs, lesbian and/or bisexual women and trans women, we really need to include women living with HIV as well in this initiative.



We have also been working with UNAIDS on a research programme to extend and strengthen the evidence base around interventions which address VAS and HIV.
<http://salamandertrust.net/project/research-interlinkages-gbv-hiv-unaids/>

We have made use of the WHO/UNAIDS “16 ideas wheel” above.

If we look at the next slide, we can see how the 4 different sections of this wheel connect with the next slide as follows:

Empowering women through integrated, multi-sectoral approaches – this overlaps with quadrants 1, 2 and 3 of the quadrants of change matrix

Transforming cultural and social norms related to gender – this overlaps with quadrants 1 and 3

Integrating violence against women and HIV services – this overlaps with quadrant 2

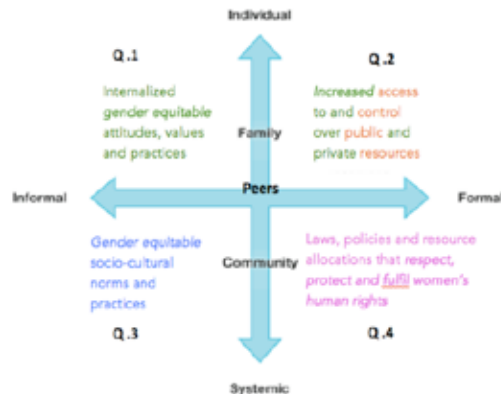
Promoting and implementing laws and policies related to violence against women, gender equality and HIV – this overlaps with quadrant 4.

Stepping Stones is listed in the 16 Ideas report as relating to Segment 6 challenging norms). In fact it also relates to Segments 5 (men and boys), 3 (property & inheritance) and 16 (alcohol).

UNAIDS ALIV[H]E framework

Our quadrant of change: based on Gender At Work

- Quadrant 1: Internalized **gender equitable** attitudes, values and practices
- Quadrant 2: **Increased** access to and control over public and private resources
- Quadrant 3: **Gender equitable** socio-cultural norms and practices
- Quadrant 4: Laws, policies and resource allocations that **respect, protect and fulfil** women's human rights



So here we have also been using this quadrant of change matrix in the UNAIDS work. You can see an animated film of this quadrant of change matrix made by the Global Fund for Women here: <https://www.globalfundforwomen.org/our-impact/#.WEXg85JpNE> (scroll down the page to find the film)

<http://salamandertrust.net/project/research-interlinkages-gbv-hiv-unaisd/>

Haberland: 2015 Comprehensive Review of Sexuality & HIV education evaluations

RESULTS: Of the 22 interventions that met the inclusion criteria, 10 addressed **gender** or **power**, and 12 did not. The programs that addressed gender or power **were five times as likely to be effective as those that did not**; fully 80% of them were associated with a significantly lower rate of STIs or unintended pregnancy. In contrast, among the programs that did not address gender or power, only 17% had such an association.

CONCLUSIONS: Addressing gender and power should be considered a key characteristic of effective sexuality and HIV education programs.

International Perspectives on Sexual and Reproductive Health, 2015, 41(1):31–42, doi: 10.1363/4103115

Next we find this comprehensive review of sexuality and HIV education evaluations by Nicole Haberland of the Population Council really interesting also, since it highlights the critical importance of programmes including gender and power. We believe this applies to VAW programmes also.

<http://www.popcouncil.org/research/the-case-for-addressing-gender-and-power-in-sexuality-and-hiv-education-a-c>

What is *Stepping Stones* and what does it seek to achieve?

A training programme on gender, generation, HIV & AIDS, communication and relationship skills and community mobilization

Designed to enable participants to define, analyse, articulate and *realise* their visions in relation to various factors (power imbalances) which influence their sexual and reproductive health, HIV status, *gender* and *inter-generational* relations and rights



So in the context of the slides above, here is a brief introduction to the *Stepping Stones* methodology.

This is what we see as what *Stepping Stones* is and what we seek to achieve with it.

<http://salamandertrust.net/resources/stepping-stones-plus/>

Climbing the mountain, seeing more..... The Gambia initial hopes

Table 1: Prioritisation of urgency of sexual reproductive health problems by peer group

	NOW	SOON	LATER
Old Women	Grandchildren are awake when wanted by husband Wife beating STIs AIDS Unwanted pregnancy	Husband looking for a new wife Wife tired when husband wants sex Tiredness after delivery No money	Jealousy Menopause pains Husband wants sex when wife is unwell or pregnant Headaches
Young Women	Too many children Husband wanted sex by force AIDS STIs Unwanted pregnancy Wife beating	Sex during menses Husband refusing condom Deflowering of young girls	Pain during sex Sex after delivery when woman is tired
Old Men	Too many wives Malaria Epi-gastric problems	Having casual sex Headache General body pain	Jealousy STIs Sexual weakness High blood pressure
Young Men	Unsafe sex Spread of STI AIDS	Infertility Unplanned family Stomach ache Joint pains	TB Headache Worms Boils

However we believe it is important to start at where communities are rather than trying to impose something on them. This is what implementers in the Gambia did, starting their programme with asking participants what *their* priorities were. This is what they responded (see <http://www.ajol.info/index.php/ajar/article/view/7117>)

Positive changes identified later: The Gambia

POSITIVE CHANGES SEEN NOW IN THE VILLAGE, February 2000

GOOD CHANGES	W	VM	OM
More DIALOGUE in the home	##	##	##
Less quarrelling amongst couples (violence)	##	##	##
More trust and confidence between couples and the community	##		
Fewer sex partners		##	
*Practise safer sex	##	##	
**Stay with husbands during breastfeeding	##	##	
Husbands provide more fish money	##	##	##
More understanding and respect in the home	##	##	##
Husbands buying presents for wife and children	##		
Husbands helping wives with difficult jobs at household level	##	##	##
Husbands granting permission for wives to visit relatives	##	##	
Talking to children about sex	##		##
Safer sex even outside marriage	##	##	##
Awareness		##	##
Safe drinking water ⁴		##	

*By this, participants meant that they used condoms

**Normally, women leave their husbands while they are breastfeeding and go to their parents' houses as a contraceptive method. Now due to knowledge gained from Stepping Stones programme, they can remain with their husbands and have normal sexual relations with them without the fear of getting pregnant because they have access to contraceptive methods like condoms.

⁴ A well is now being constructed in the village with funding from another donor

But here we see that after the programme, when different peer groups were separately and simultaneously asked what changes they had seen, they all mentioned more dialogue in the home, less quarrelling amongst couples (violence) and More understanding and respect in the home.

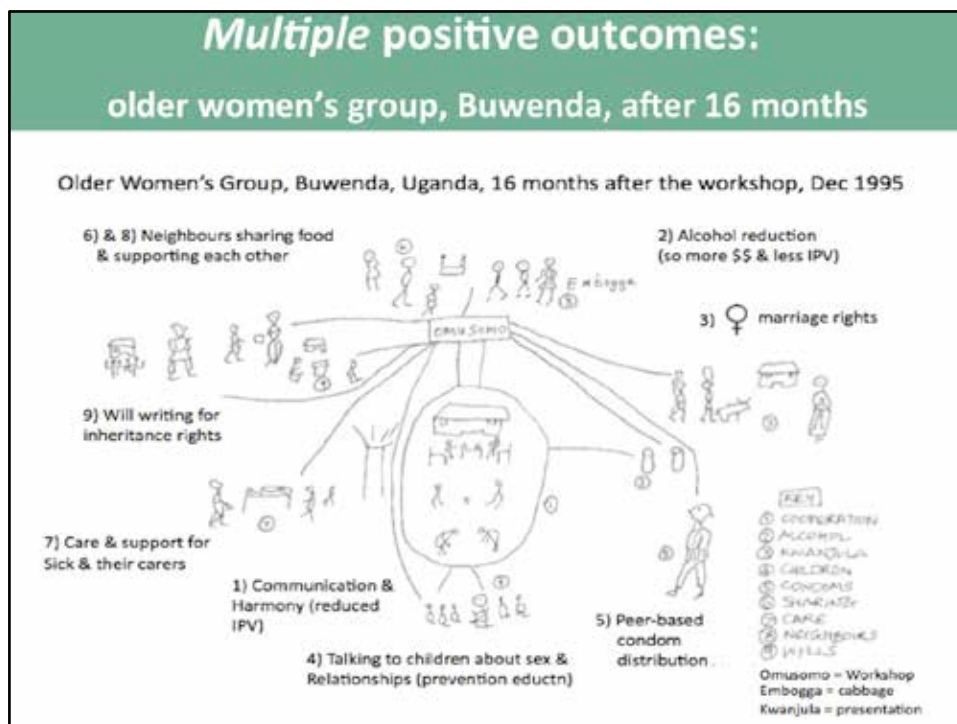
(Nb there were originally 4 peer groups but at the time of this review, there were not enough female staff to interview two groups of women, so the women agreed to form one group for the purpose of this review.)

So all four groups, even though they had their own separate priorities, concurred on some key positive changes which took place.



So what is *our vision* for change? First of all, we are keen to use positive language in our intervention, based on the latest inter-personal neurobiology which emphasises the power of positive language and thinking. If we say “ending violence” that is a double negative which creates a vacuum. So instead we promote safety (see <https://unaids.webex.com/cmp3100/webcomponents/docshow/docshow.do?isPluginInstalled=yes&siteurl=unaids&rnd=0.9468706871131068>)

We also see the fundamental importance of ensuring respect and support for the rights of women living with HIV in all their diversities and women who have already experienced violence, so that those who have do not feel fearful about others knowing that they have. Sometimes violence prevention or HIV prevention programmes can make women who do experience violence or who do have HIV feel as if they have “failed” and this is of course unjust and inequitable.



This is a drawing done by women from the older women's peer group 16 months after the original training workshop. The drawings are all theirs and it shows how Stepping Stones works even with participants who cannot read or write. The key was written in just afterwards by the NGO facilitator. The green printed writing highlights all the different issues that the women had mentioned. This shows the **multiple positive outcomes** that the women identified in this drawing, in response to the basic question: "what has changed for you in this community since the *Stepping Stones* workshop?"

We see how some of the changes they identified are related to existing national or international indicators. These we know as "SMART" indicators. However there are also other outcomes here which are not reflected in these indicators. These include trust, mutual sharing and support, talking to children. We call these SPICED indicators, since they are created by participants themselves. (See <https://unaids.webex.com/unaids/ldr.php?RCID=e877e9f2b90122a58703d8575f79c647> for an explanation of SMART and SPICED indicators.)

SMART: 1) The percentage of women aged 15 to 49 who own **property and productive resources** in their own name. Various surveys have defined such resources as land, house, company or business, livestock, produce or crops, durable goods, tools, money, and bank accounts. (See 3 and 9 above for SPICED versions)

SMART: 2) The proportion of people living with HIV who received **alcohol** reduction counseling and support at their encounter with a health provider (see 2 above for SPICED version)

SMART: 3) Proportion of women and men who consider **wife beating** an acceptable way for a husband to discipline his wife for any reason, at a specified period in time. (See 1 and 2 above for SPICED version)

SMART: 4) Number of males circumcised as part of the voluntary medical male circumcision (VMMC) for HIV prevention program within the reporting period (Not recognised then)

SMART: 5) Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months and who report the use of a **condom** during their last intercourse (See 5 for SPICED version of this)

SPICED: Sharing, kindness, sense of community, women talking to their children, parents sitting together to plan their children's future (4,6,7 and 8 above)

With whom has Stepping Stones been used?


Many different contexts, including:

- People with disabilities (eg India)
- Pastors and Imams and their congregations (Kenya, Gambia)
- School pupils and teachers (many countries)
- NGO staff (eg Tanzania)
- People living with HIV and AIDS (eg Zimbabwe, Namibia)
- National and constituency AIDS Control Councils (Gambia..)
- Girls and boys out of school (many countries)
- Women's rights groups (many countries)
- Health staff (Mumbai)
- Drug using communities (Myanmar)
- People in prison (Morocco, India)
- University staff and students (Namibia)
- LGBT communities (Jamaica, Pacific)

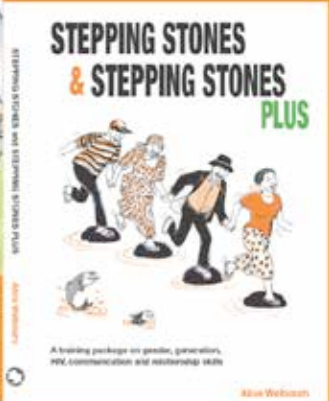


We welcome adaptations of this programme, provided you contact us for guidelines and support and provided the basic foundation stones highlighted here are fully observed.

What does *Stepping Stones* consist of?



Paso a Paso




STEPPING STONES & STEPPING STONES PLUS

Package made of manual + DVD

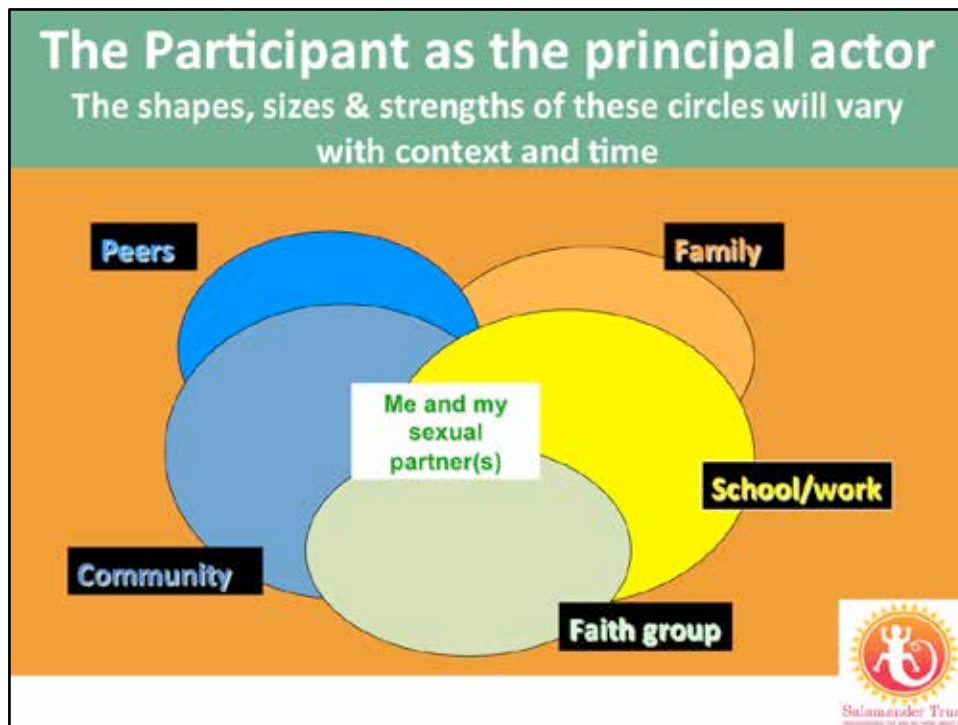
Community-based programme (approach that uses workshops and exercises to engage members of a community).

First workshop in Uganda in 1994 – manual 1995 : longest running programme of its kind



Salamander Trust
Sustaining the life of the world

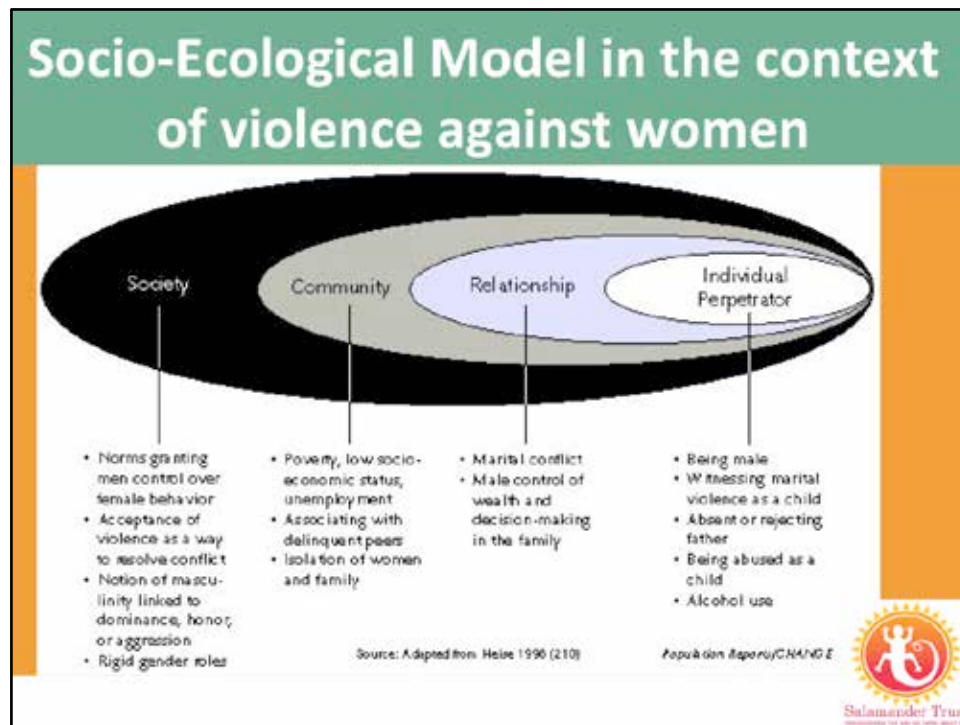
Here is an image of the front cover of the Latin America adaptation of the original Stepping Stones programme (see for example <https://www.youtube.com/watch?v=Qu1BXRh6VvY>)



This diagram illustrates some of the multiple identities that we can all have as individuals. It echoes the socio-ecologic model. (next 2 slides)

Stepping Stones is based on the Socio-Ecological Model of behavioural change





Here is another version of this same model. Intimate Partner Violence (IPV) is recognised both as increasing women's vulnerability to acquiring HIV: and women when diagnosed with HIV can face increased IPV.

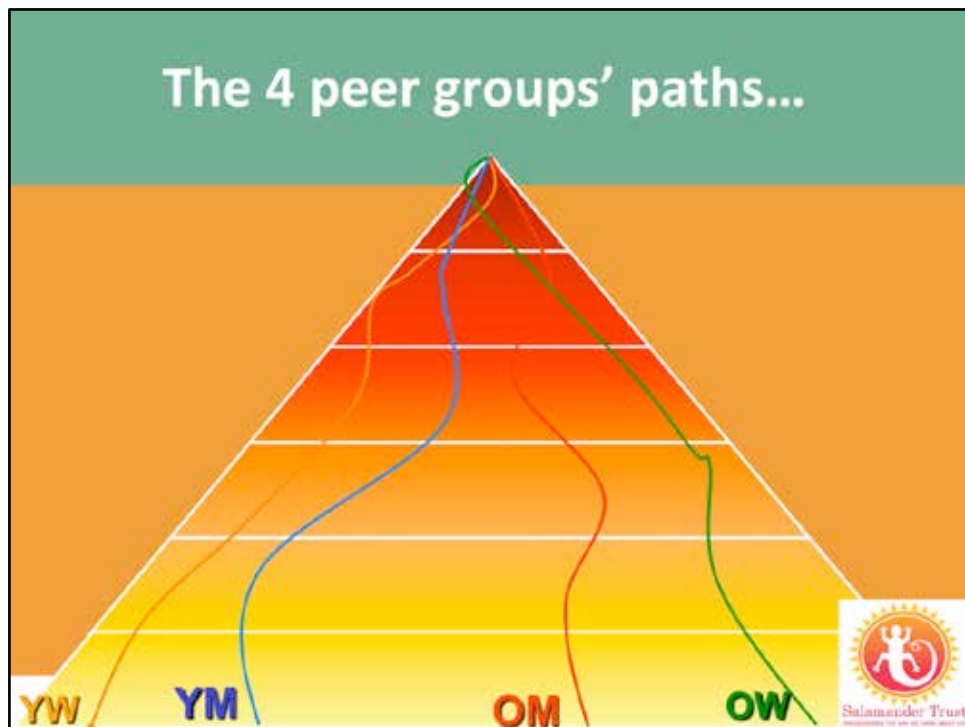
Stepping Stones is recognised to reduce IPV in communities.

How does it work?

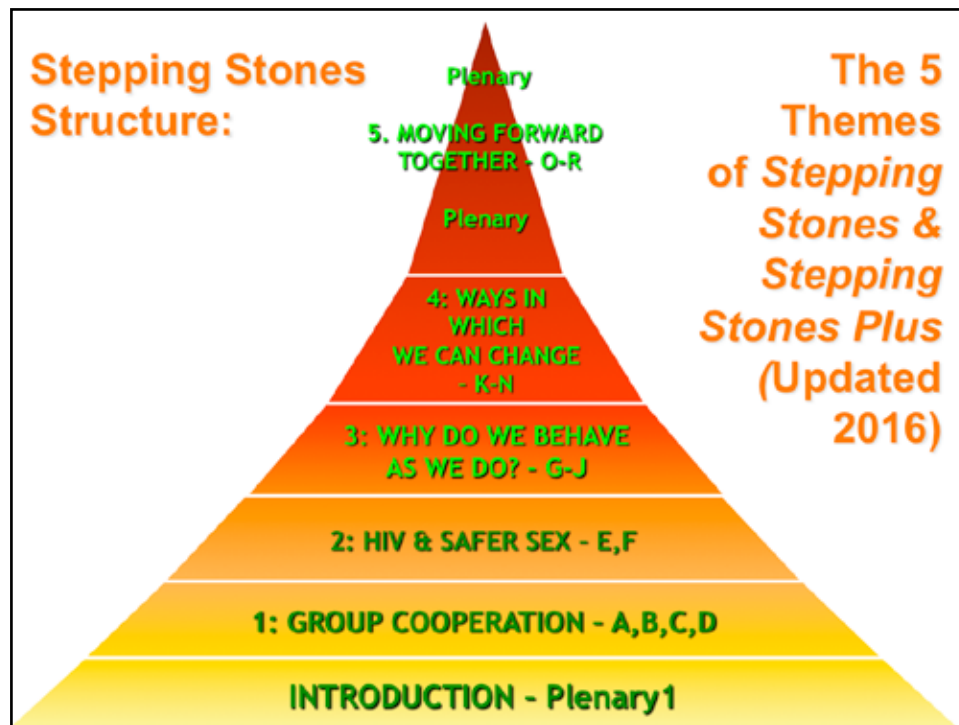
4 peer groups:

- based on gender and age
- ca. 50 hours contact time
- over 18-23 sessions
- over ca. 3 months
- staircase approach





There is no monopoly on the “right” way up a mountain. This image shows how the four peer groups each have their own way up and that these different ways need to be mutually respected by us all.



Some people think Stepping Stones has no structure. That is incorrect. There is a clear progressive structure, like a staircase, or like climbing a mountain. There are 5 themes: progression on purpose (from getting to know each other and working together to talking about sensitive subjects, addressing one's own behaviour and reflecting on ways to change). Stepping Stones was breaking barriers because of its development of critical literacy & routes to address gender norms + its framework for analysis of what is going on in our lives: it is developing participants' critical literacy skills ie the ability to step outside, reflect on and evaluate their own and others' lives & on power relationships between themselves and others around them. [Critical literacy is the ability to read texts in an active, reflective manner in order to better understand power, inequality, and injustice in human relationships. Accordingly, songs, novels, conversations, pictures, movies, etc. are all considered texts.]

Stepping Stones Foundation Stones...

Involvement of all stakeholders:

- *Four-peer group work and discussions, gender- and age-based – and emphasis on these relationships*

Holistic response to HIV:

- Focus on *rights-based* sexual and reproductive health & gender issues – with *multiple positive outcomes*
- All can address their *own* most pressing issues
- *Ownership* of the process by the community

Experiential learning structure:

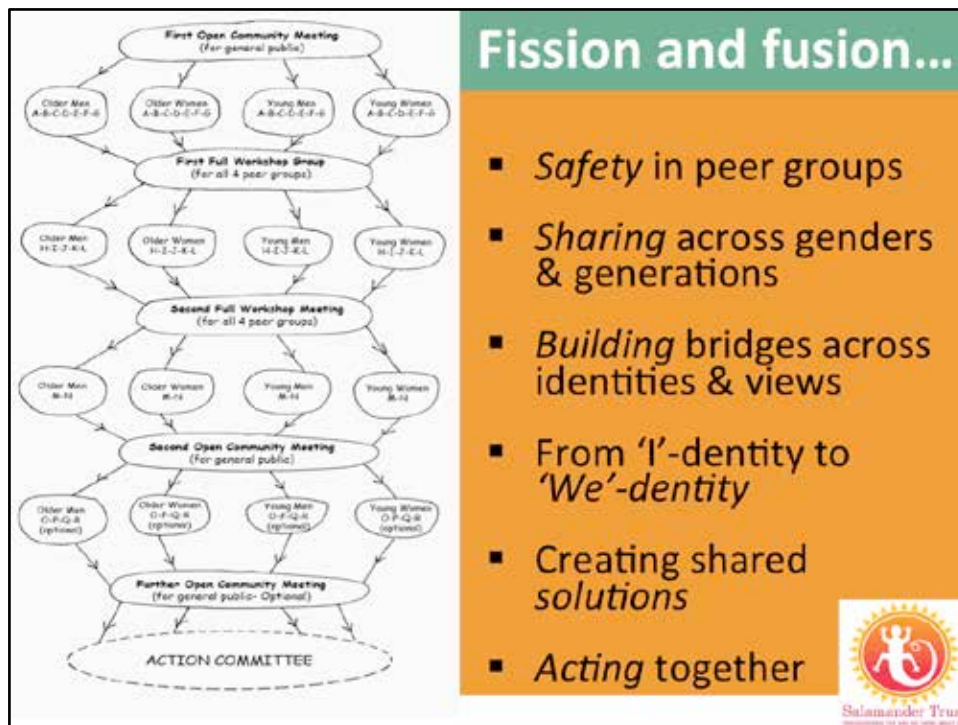
- Interactive discussions, role plays, diagrams
- Self reflection, critical literacy
- Fission and fusion approach
- Around *50 hours* contact time

Facilitators as guides not teachers

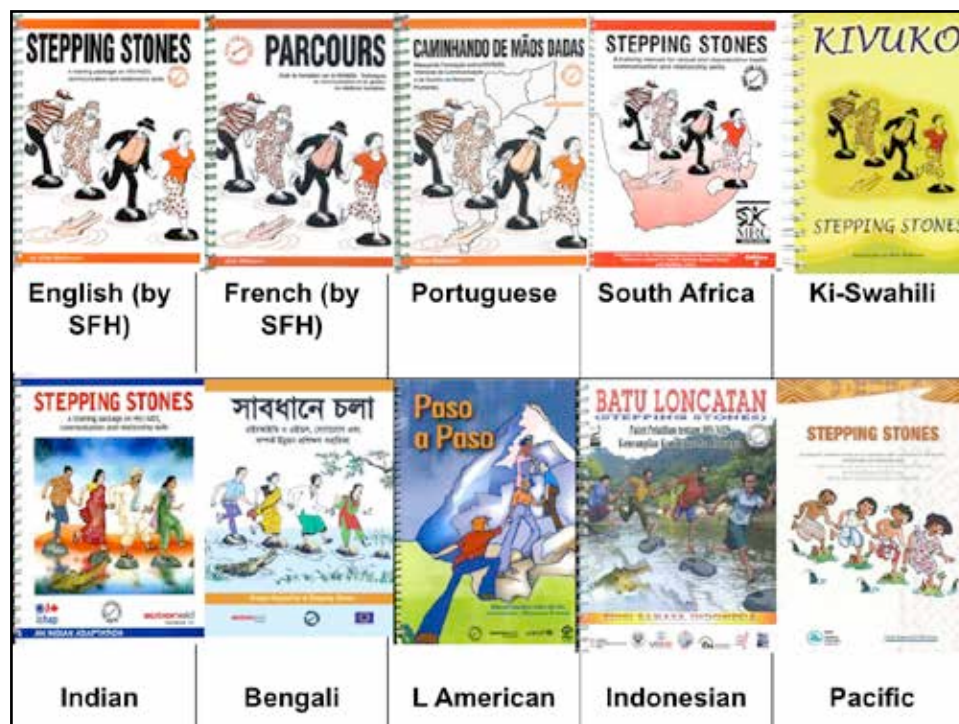


Here are some key ‘foundation stones’ of the *Stepping Stones* approach. They are not unique to *Stepping Stones* but if they are not present without strong reasons (eg availability of only two peer groups) then the programme is not *Stepping Stones*.

The approach of self-reflective experiential learning is key. This is why some people think there is no structure. There *is* a structure, but it is not spelt out explicitly. Instead, participants have to work out what they are learning far more for themselves. This process of deep reflection connects to much deeper processes of learning and change within us than more traditional IEC materials.



The process of peer groups working in safe separate parallel peer groups and then coming together to share and compare what they have learnt every few sessions is what we call “fission and fusion”. Here is an organogram of the whole workshop process. In this way, bridges are slowly and carefully built across the community’s genders and generations.

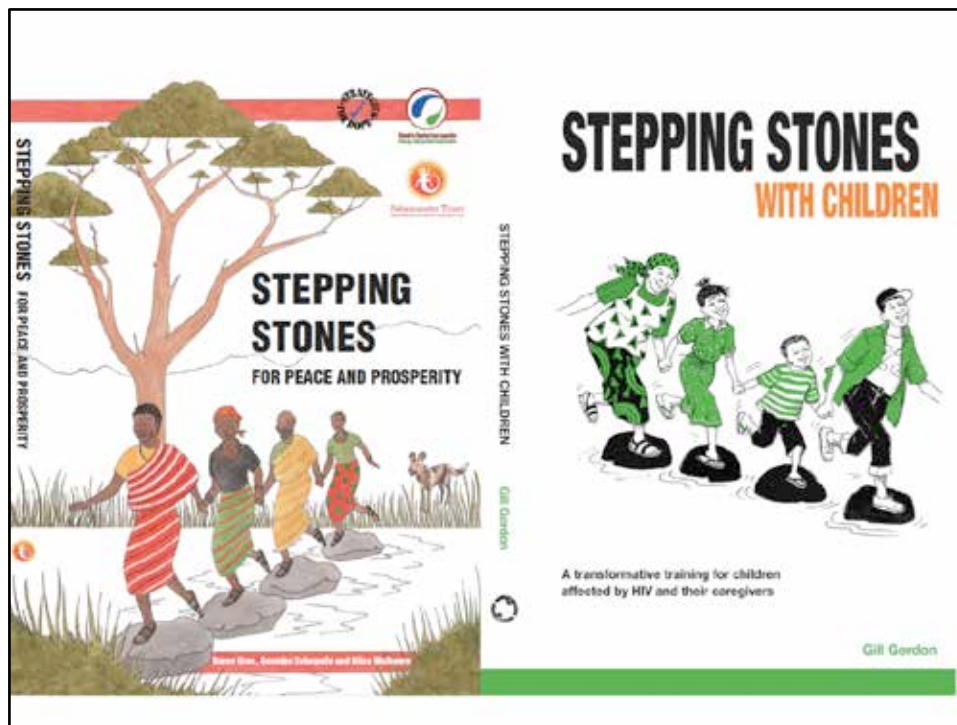


Some of the covers of the translations of the original manual... If you want to translate or adapt *Stepping Stones* please contact us first for guidelines and support on how to do this properly.



The programme has since gone global to over 100 countries. Adapted and translated into at least 30 languages, it reduced intimate partner violence (or IPV) in an RCT conducted by the South African Medical Research Council. The What Works for Women website grades it as Gray II evidence level for effectiveness, both in addressing violence against women and transforming gender norms. Women in countries including Malawi, India (where it has also ended child marriage in communities where it's been used) and the Gambia. have *themselves* reported IPV reduction, in response to being asked “what has changed for you?”.

Jewkes et al 2008 ***Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial*** BMJ 2008; 337 <http://www.bmj.com/content/337/bmj.a506>
<http://www.whatworksforwomen.org/search?utf8=%E2%9C%93&q=%22Stepping+Stones%22>
<http://pag.aids2014.org/flash.aspx?pid=1806>
 (eg COWLHA/Salamander Trust 2013; Bradley et al 2011, Paine et al 2002).



Other recent adaptations by Salamander Trust: a) for pastoralists in relation to sexual violence in fragile communities. Published by Salamander Trust and Strategies for Hope, in partnership with Network for Stepping Stones Approaches, Uganda.
 b) *Stepping Stones with Children and their Caregivers* for 5-8s, 9-14s and their caregivers. Published by Practical Action Publishing. Created in partnership with PASADA, Dar es Salaam, Tanzania.

How delivered: part 1

Table 3. Characteristics of the Stepping Stones program implementation

Authors	Target groups	Intervention duration	Content of the manual	Language of the manual	Number of facilitators	Duration of training	Partner and training organisations	Local context: cultural, political or ethnic diversity
Jewkes et al. [32]	Young men	6-8 weeks	3 sessions; 3 h each	English	11 facilitators (25 groups)	3 weeks for 55	PPASA	Rural, subsistence farming region. 1.5 h drive from town
Jewkes et al. [34]	Young women		Second 35		4 facilitators (control group)	4 days for controls		Family households supported by working elsewhere, grants and pensions. Highest unemployment rate in South Africa: 48.3 % (2004). Mobile young men
South Africa			(Jewkes et al. 2002)			1 day in-service training/month		
Pacific Regional HIV/AIDS project [31]	Younger men and women Older men and women	2, 4 or 6 weeks	14 sessions; 3 sessions original manual	NR	23 facilitators from 13 communities	10 days workshop	PROF, CDO Coordinators, NAC, Communities, SPC, Ministry of Health, National Health Promotion Department	Close to highland tourist resort. One village belongs to Fiji Ministry of Health. 'Health Promoting villages'. Implemented in Fiji Network for people living with HIV/AIDS (FN+) Majority indigenous Fijians
Hadjipouras et al. [37]	Younger men and women	1 year	19 sessions; additional topics: STDs	Portuguese translation	13 facilitators from ACORD	10 days workshop	ACORD, FPA (Armed Forces of Angola), GAVINCO, ETANGO (NGO)	Multiple ethnic backgrounds and political affiliations. Cultural diversity
Angola		Two stages				5 days training		HIV rate 2.8 %. Post-war situation
Tanzania	Older men and women	1 year	4 sessions; violence	Kiswahili version	30 community activists		ISTAMOS	Mobile population. Implemented in army and pastoralist community (Maasai)
Uganda	Younger men and women	1 year	19 sessions; additional topics: VCT, STDs	Local translation	13 facilitators (7 men/6 women)	2 weeks	ACORD, AIDS Outreach Nyakur, TANESA, AMREF, Kivuli Women's Rights Organisation, CARE Mwanza, Mwanza City Council	Political and social stability
	Older men and women		family planning		20 community facilitators		ACORD, CARPP community organisation MESSA	HIV rate 6.4-11.9 % (12 % women, 9 % men)
	Younger men and women		Safe sex/sex control video		18 trainers			Agricultural setting
	Older men and women		excluded		84 community facilitators			Conflict and displacement area
Pain et al. [38]	Younger men and women	10 weeks	Adapted for Gambia	Local language	4 supervisors	10 days workshop	Gambian Dept. of State of Health, Family Planning Association, Action Aid Gambia, Medical Research Council, local clinics	Over 80 HIV rate 7 %; HIV rate in Gambia 11 %; HIV rate in camps 37 %
The Gambia	Older men and women		Added topics: fertility prevention (Shaw, 2002)		3 field workers			Highest prevalence HIV-1, HIV-2 (1.8-3 %); high syphilis rate. Literacy high

This is from “A Systematic Review to Quantitatively Evaluate ‘Stepping Stones’: A Participatory Community-based HIV/AIDS Prevention Intervention.” Suzanne M. Skevington • Elena C. Sovetkina • Fiona B. Gillison
AIDS Behav DOI 10.1007/s10461-012-0327-6

For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website.

How delivered: part 2

Table 3 continued

Authors	Target groups	Intervention duration	Content of the manual	Language of the manual	Number of facilitators	Duration of training	Partners and training organisations	Local context: cultural, political or ethnic diversity
Bhattacharjee and Coaquira [19]	Younger men and women Older men and women	3 months	Revised version Added topics: social mapping HIV timeline risk matrix	NR	24 facilitators (14 male, 10 female)	2 weeks training	SCUK; OSSA (NGO)	Very poor country. Large population. Civil war, unemployment, food crisis HIV rate 4.4 % (5 % women; 3.8 % men)
Bradley et al. [1]	Unmarried men and women Young married men and women Older married men and women	5-6 months	Adapted by ICHAP: 11 modules with 72 exercises; 4 main themes	Local language. Audio-capted Translated	12 supervisors 230 paid link workers	12 days training, 4 times refresher training	CIDA; Action Aid India; KIRPT India; ICHAP and ICHAP, performed by KIRPT.	Localised HIV epidemic has declining trend. National HIV prevalence rate 0.36 %. Injecting drugs predominant in HIV transmission. Implemented in Karnataka - high HIV prevalence state
Jurjue et al. [23]	Young men Older men Mix of age women	NR	Original SS package: Muslim adaptation Additional modules: STIs, infertility	Local language. Diagram techniques designed for non-literate people	NR	NR	Gambian government; MRC; Action Aid; Gambian Family Planning Association; Worldwide Evangelization for Christ mission	Predominantly Muslim: mainly agriculture and fishing. HIV rate 2 % Men suspicious of Family Planning services; strongly supported by some Muslim clerics. Polygamy. Male and female circumcision widely practiced

ARTS Review

This is from the same article as the previous slide. For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Recommended Delivery for good quality: Part 1

- ✧ Minimum ca 50 hours
- ✧ 4 peer groups: 2 male, 2 female, 2 younger (ca. 15-24 yrs);
2 older (ca. 25 - ?) – or based on eg parenthood *their* choice
- ✧ 1 facilitator of same gender and similar age per peer group
- ✧ Facilitators trained: eg **5 weeks over 10 weeks:**
 - a) 2 initial residential weeks as *participants* [3 weeks break;]
 - b) 2 more weeks to be trained as *facilitators* of the main programme; [2 more weeks break;]
 - c) 1 final week to be trained as *asst. facilitators* of the *supplementary* sessions; plus progress review; & sign up to on-going in-service training processes.



This is *our* recommended delivery structure to maximise effectiveness of the programme delivery. For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Recommended Delivery for good quality: Part 2

- ✧ From Assistant Facilitators to Lead Facilitators:

- a) ideally work alongside a more experienced facilitator for three full workshops before becoming a lead facilitator

- ✧ From Lead Facilitators to Trainers:

- b) refresher 2 week review & training of trainers course to become full Stepping Stones trainer of other facilitators

- ✧ NATIONAL NETWORKS development to retain contact among key trained facilitators & trainers beyond project lifespans



For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Evaluations

Many different contexts, including:

- ☐ Gambia evaluation (2002, AJAR)
- ☐ A review of evaluations up until 2006 (T. Wallace)
- ☐ ACORD: Uganda, Tanzania, Angola (2006)
- ☐ RCT South Africa (Jewkes et al, 2008, BMJ)
- ☐ Regional evaluations (eg C. America 2012, Fiji 2007)
- ☐ COWLHA Malawi evaluation (2015)



For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Evaluation Findings

Table 4 Summary of biological, psychological and social changes resulting from the Stepping Stones intervention

Authors/year Country	Infection rates			Change in risk behaviours			Increased knowledge about HIV/ AIDS	Change in attitudes			Improved skills discussing sex		
	Reduced HIV incidence	Reduced HSV-2 incidence	Trans- actional sex	Partner violence	Multiple partnering	Alcohol before sex		Condom use	Gender equity Men make decisions	Women have rights	Stigma towards PLHA	Partners	ChM
1) Jewkes et al. [32, 34] South Africa	No	Yes	↓	↓	↓	↓	Yes	↑	NR	NR	NR	NR	NR
2. Pacific Regional HIV/ AIDS project [32] Fiji	NR	NR	NR	↓	NR	NR	Yes	NR	↓	↑	NR	↑	NR
3. Hadjipateras et al. [37]	NR	NR	NR	NC	NR	NR	Yes	↑	NC	NC	↓	↑	↑
i. Angola	NR	NR	NR	↓	NR	NR	Yes	↑	NC	↑	↓	↑	↑
ii Tanzania	NR	NR	NR	NC	NR	NR	Yes	↑	NC	NC	↓	↑	↑
iii Uganda	NR	NR	NR	NR	NR	NR	Yes	↑	NR	NR	NR	↑	↑
4. Paine et al. [38] The Gambia	NR	NR	NR	NR	NR	NR	Yes	↑	NR	NR	NR	↑	↑
5. Bhattacharjee and Conigan [39] Ethiopia	NR	NR	NR	NR	↓	↓	Yes	↓	NR	NR	NR	↑	↑
6. Bradley et al. [3] India	NR	NR	NR	NC	NC	↓	Yes	↑	↓	↑	↓	↑	NR
7. Jarjai et al. [25] The Gambia	NR	NR	NR	↓	NR	NR	Yes	↑	NR	NR	NR	NR	↑

NR not reported, NC no change, ↓ decreased, ↑ increased

NR not reported, NC no change, ↓ decreased, ↑ increased

For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

The original *Stepping Stones* programme has since gone global to over 100 countries. Adapted and translated into at least 30 languages, it reduced intimate partner violence (or IPV) in an RCT conducted by the South African Medical Research Council. The What Works for Women website grades it as Gray II evidence level for effectiveness, both in addressing violence against women and transforming gender norms. Women in countries including Malawi, India (where it has also ended child marriage in communities where it's been used) and the Gambia, have *themselves* reported IPV reduction, in response to being asked "what has changed for you?".

Jewkes et al 2008 ***Impact of Stepping Stones on incidence of HIV and HSV-2 and sexual behaviour in rural South Africa: cluster randomised controlled trial*** BMJ 2008; 337 <http://www.bmj.com/content/337/bmj.a506>
<http://www.whatworksforwomen.org/search?utf8=%E2%9C%93&q=%22Stepping+Stones%22>
<http://pag.aids2014.org/flash.aspx?pid=1806>
 (eg COWLHA/Salamander Trust 2013; Bradley et al 2011, Paine et al 2002).

There are some inconsistencies in the table shown in this slide. Eg the Paine et al (note misspelling) talks at some length about improved communication and the reduction in dissent between couples, as well as women's increased capacity to negotiate and achieve condom use. However this table has partner violence recorded as 'not reported'.

Stepping Stones with Children Preliminary Findings

- Relationships between caregivers and children became more **loving** (e.g. using positive discipline instead of *beating*).
- Preliminary data suggest increased treatment **adherence** in some children.
- Children have formed small **groups** for mutual support, thereby strengthening their resilience to the impact of HIV
- HIV **counselling services** for children have **improved**
- Children have been able to make **their own films** about the changes brought about by the workshops & **advocate** for children's rights

38

I also want to share some findings from our new programme, *Stepping Stones with Children* for which we have some preliminary findings. We know how very important the early years of childhood are in relation to future pathways for the children's lives. This programme works with children aged 5-8, 9-14 orphaned by and/or vulnerable to HIV and AIDS; and their caregivers.

Preliminary results have been particularly important around reducing violence against the children as well as their feeling less isolated and more able to build on their resilience. See <http://salamandertrust.net/resources/stepping-stones-children/>

Stepping Stones with Children lead author is Gill Gordon. Our partner in its development is PASADA, Dar es Salaam Tanzania, with funding from Comic Relief and UNAIDS.

See further details above.



Stepping Stones and Creating Futures

- Combines Stepping Stones (gender transformation, HIV- & IPV-prevention) with Creating Futures (livelihoods strengthening)
- 11 extra sessions, each ~3hours long, delivered by trained peer facilitators, to groups of 14-20 participants (single sex)
- Participatory sessions: dialogue, drama, body mapping etc.
- Project is a joint effort of HEARD at UKZN, Project Empower and the South African Medical Research Council, with LSHTM supporting costing
- Currently funded through: What Works to Prevent Violence Against Women and Girls? Global Programme, led by the SA MRC

Logos: HEARD, UNIVERSITY OF KWAZULU-NATAL, SK MRC, PROJECT EMPOWER, LONDON SCHOOL OF HYGIENE & TROPICAL MEDICINE, WhatWorks, UKaid

I have also been asked to talk about *Stepping Stones Creating Futures*, which is written as a *supplement* to the South African adaptation of *Stepping Stones*. It is a great programme which we are recommending to anyone to use after the main programme.

Stepping Stones and Creating Futures Pilot & RCT

- 2012-2013: 232 women and men followed up over 12m found that:
 - Women and men's mean earnings in past month increased
 - Men and women reported more equitable gender attitudes
 - Men less controlling behaviours
 - Women a 34% reduction in past 3 month sexual and/or physical IPV
 - Reduced men's depressive symptoms
- Now undergoing large RCT (34 clusters, 1360 participants, 24m follow up), includes qualitative process evaluation and cost-benefit analysis - final results 2018
- Laura Washington (laura@projectempower.org.za); Andrew Gibbs (Andrew.gibbs@mrc.ac.za)



Scaling up - examples

The Gambia: to 20 villages of 500 participants each in 1 year – ie 10,000 participants

India: translated into Telugu, Hindi, Bengali, Kannada, Urya, Tamil, Marathi, Gujarati. Also Braille English edition.

In India, in Karnataka alone, approx. 3,400 women and 3,400 men completed training in 202 villages. Drop-out rate was 15%, highest among older men.

Malawi: took Stepping Stones to scale across 144 communities in 12 districts.




Here you can see some examples of where *Stepping Stones* has been taken to scale. In all these examples, reduction in VAW has been achieved. In Karnataka, there was also an end to child marriage.

For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Investing in *Stepping Stones*

- Scale up of effective *Stepping Stones* programmes requires major investment. Donors, NGOs and communities need to be sure that this represents a good use of scarce resources.
- Evaluations that provide *statistical* evidence of *Stepping Stones*, value-added for public health outcomes, require a large sample and expert researchers. This is costly and may be difficult to attribute and generalise. RCT costs....
- Evaluations using *participatory* qual. & quant. methods triangulated with *formal* quant. & qual. methods are grounded in reality; and if they converge from a large number of sites, they represent strong evidence



This slide speaks to the limitations and costs of formal research processes such as RCTs. To hear more about this topic and the importance and need for more holistic research processes, see <https://unaids.webex.com/unaids/ldr.php?RCID=d4f44e9bbdc1b135a768252b3e79db78>

See also Raab and Stuppert's review of VAW evaluations, commissioned by DFID. This highlights the importance of involving participatory approaches to evaluation alongside formal evaluation to gain a more rounded picture of what is happening and to develop a more sustainable programme: https://assets.publishing.service.gov.uk/media/57a089b440f0b652dd00037e/61259-Raab_Stuppert_Report_VAWG_Evaluations_Review_DFID_20140626.pdf

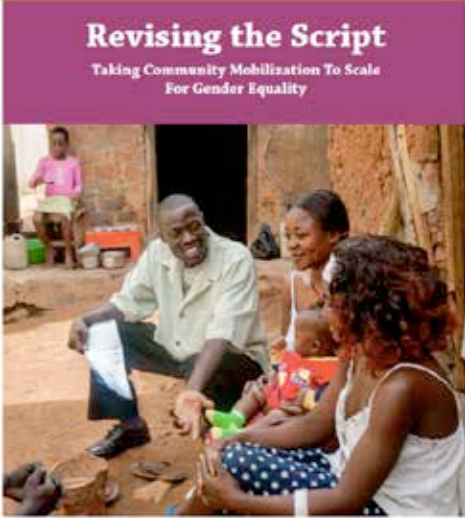
For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website



Here we have some costings of different programmes from 2010. It gives some ideas of the reduction in costings as organisations have scaled up the programme in different settings.

For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website


Scaling up – some lessons so far



Revising the Script
Taking Community Mobilization To Scale
For Gender Equality

ICRW International Center for Research on Women
Raising Voices

- IMAGE, PRACHAR, SASA! Stepping Stones, Tostan
- More research needed by implementers
- Govt. partnerships...(?)
- Fidelity to staircase approach of original programmes
- **Duration and dosage are key**
- Scale-up vs quality of adaptation
- Funding



To access this new policy brief see here: http://raisingvoices.org/wp-content/uploads/2013/03/Revising-the-Script_10-26_update.pdf

We were glad to be invited to contribute a case study to this valuable document.

For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website

Summary Lessons and insights

- ✓ Importance of **adaptation**; **TALK TO US!** ☺ **Partnerships** between researchers, practitioners and policy-makers
- ✓ INVEST in **TIME** & funds at the outset to build a solid group of trainers & facilitators
- ✓ Need for costing / implementation science etc. to understand complexities of **effective sustainable responsible scale-up**
- ✓ MIXED METHODS – formal and informal, quantitative & qualitative research
- ✓ Absence of evidence.... : need to build wider base of **women**-centric indicators
- ✓ Strengthening/expanding the evidence base – Need more Quadrant 1 & 3 indicators....
- Huge issues facing women living with HIV in all their diversities **from healthcare settings** as well as communities and IPV



See eg Raab and Stuppert paper for DFID on formal and informal, quantitative and qualitative holistic research

See also ALIVHE webinars – especially 3 and 4: <http://salamandertrust.net/project/research-interlinkages-gbv-hiv-unaided/>



Through this link, you can view several films about *Stepping Stones* and its use in different contexts in Uganda and Malawi, including what happened in the original community where *Stepping Stones* was implemented, 12 years later. The Tanzanian documentary is about our new *Stepping Stones with Children* programme.



For more information see the www.steppingstonesfeedback.org website.

For more information about *Stepping Stones with Children*, also published by Practical Action Publishing, see our website and <http://tinyurl.com/PAPStStwC>

With huge thanks to all our collaborators over the years!

To read more about *Stepping Stones* around the world, see here: <http://salamandertrust.net/news/celebrating-21-years-stepping-stones-1995-2016/>