Preventing & Responding to VAWG

What works to prevent VAWG:

*Stepping Stones & Stepping Stones Plus*

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Salamander Trust

Panama City
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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
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.
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 promote HR

*Thanks to Carmen Logie for additional analysis of quantitative responses
Achieving sexual and reproductive health and human rights for women living with HIV

- Sex life
- Pregnancy and fertility
- Treatment and side-effects
- Financial security
- Mental health

- Human rights
- Gender equality and social justice
- Meaningful involvement of women living with HIV
- Protective laws

Welcome to our house: for all our diversities from con(tra)ception to old age in healthcare, at home, in the community.
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
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)
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
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)
DISTRIBUTION OF NEW HIV INFECTIONS AMONG POPULATION GROUPS BY REGION

2014

Source: UNAIDS special analysis, 2016

- Latin America and the Caribbean

- Sex workers: 6%
- People who inject drugs: 2%
- Gay men and other men who have sex with men: 30%
- Transgender people: 3%
- Clients of sex workers and other sexual partners of key populations: 23%
- Rest of population: 36%

Source: AVERT.org 2016
WHO/UNA IDS ‘16 Ideas” to address VAW (2013)
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
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.

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.
Climbing the mountain, seeing more.....

The Gambia initial hopes

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

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

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

Promoting happiness, **SAFETY** and well-being for all in a rights-based framework

Timely Offer of Treatment to people living with HIV

Respect, care, rights & support for women living with HIV in all their diversities

Why ‘safety’??
Multiple positive outcomes:

older women’s group, Buwenda, after 16 months

- Neighbours sharing and supporting each other
- Alcohol reduction (so more $)
- Will-writing for inheritance rights
- Care and support for sick & their carers
- Communication (reduced IPV)
- Peer-based condom distribution
- Talking to Children about sex & relationships (prevention education)
- Marriage rights
- Talking to Children about sex & relationships (prevention education)
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)
What does Stepping Stones consist of?

Package made of manual + DVD

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

The Participant as the principal actor
The shapes, sizes & strengths of these circles will vary with context and time

- Peers
- Family
- Community
- Me and my sexual partner(s)
- School/work
- Faith group
Stepping Stones is based on the Socio-Ecological Model of behavioural change.
Socio-Ecological Model in the context of violence against women

- Norms granting men control over female behavior
- Acceptance of violence as a way to resolve conflict
- Notion of masculinity linked to dominance, honor, or aggression
- Rigid gender roles

- Poverty, low socioeconomic status, unemployment
- Associating with delinquent peers
- Isolation of women and family

- Marital conflict
- Male control of wealth and decision-making in the family

- Being male
- Witnessing marital violence as a child
- Absent or rejecting father
- Being abused as a child
- Alcohol use

Source: Adapted from Heise 1996 (210)
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
The 4 peer groups’ paths...
Stepping Stones Structure:

1: GROUP COOPERATION - A,B,C,D

2: HIV & SAFER SEX - E,F

3: WHY DO WE BEHAVE AS WE DO? - G-J

4: WAYS IN WHICH WE CAN CHANGE - K-N

5. MOVING FORWARD TOGETHER - O-R

Plenary

INTRODUCTION - Plenary1

The 5 Themes of Stepping Stones & Stepping Stones Plus (Updated 2016)
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*
Fission and fusion...

- **Safety** in peer groups
- **Sharing** across genders & generations
- **Building** bridges across identities & views
- From ‘I’-dentity to ‘We’-dentity
- Creating shared solutions
- **Acting** together
Intimate Partner Violence in Many Different Cultures & Contexts
STEPPING STONES
FOR PEACE AND PROSPERITY

STEPPING STONES
WITH CHILDREN

A transformative training for children affected by HIV and their caregivers

Gill Gordon
### Table 3: Characteristics of the Stepping Stones program implementation

<table>
<thead>
<tr>
<th>Authors</th>
<th>Target groups</th>
<th>Intervention duration</th>
<th>Content of the manual</th>
<th>Language of the manual</th>
<th>Number of facilitators</th>
<th>Duration of training</th>
<th>Partners and training organizers</th>
<th>Local context: cultural, political or ethnic diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Jewkes et al. [32]</td>
<td>Young men</td>
<td>6–8 weeks</td>
<td>13 sessions; 3 h each</td>
<td>English</td>
<td>11 facilitators</td>
<td>3 weeks</td>
<td>PPASA</td>
<td>Rural, subsistence farming region: 1.5 h drive from town</td>
</tr>
<tr>
<td>Jewkes et al. [34]</td>
<td>Young women</td>
<td></td>
<td>Second SS South African edition (Jewkes et al. 2002)</td>
<td></td>
<td>4 facilitators</td>
<td>4 days for controls</td>
<td></td>
<td>Family households supported by working elsewhere, grants and pensions. Highest unemployment rate in South Africa: 48.5 % (2004). Mobile young men</td>
</tr>
<tr>
<td>South Africa</td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>1 day in-service training/month</td>
<td>PRHP; CDO Coordinators; NAC Committees; SPC: Ministry of Health; National Health Promotion Department Two expert African facilitators</td>
<td></td>
</tr>
<tr>
<td>Pacific Regional HIV/AIDS project [31]</td>
<td>Younger men and women</td>
<td>2, 4 or 6 weeks</td>
<td>14 sessions; 3 sessions original manual</td>
<td>NR</td>
<td>23 facilitators from 13 communities</td>
<td>10 days workshop</td>
<td>ESTAMOS ACORD; FAA (Armed Forces of Angola); GAV(NGO); ETANGO (NGO) ACORD; AIDS Outreach Nyakato; TANESA; AMREF; Kivulini Women's Rights Organisation; CARE Mwanza; Mwanza City Council ACORD; CARPP community organization NESSA</td>
<td>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 (FJN+). Majority indigenous Fijians</td>
</tr>
<tr>
<td>Fiji</td>
<td>Younger men and women</td>
<td>1 year, Two stages</td>
<td>19 sessions, additional topics: STIs; domestic violence</td>
<td>Portuguese translation Kiswahe version Luo translation</td>
<td>18 facilitators from ACORD, 30 community activists</td>
<td>10 days workshop</td>
<td>5 days training workshop</td>
<td></td>
</tr>
<tr>
<td>Hadjipteras et al. [37], i Angola ii Tanzania iii Uganda</td>
<td>Younger men and women</td>
<td>1 year between 1 year</td>
<td>19 sessions, additional topics: VCT; STIs, family planning Some sessions omitted: video excluded</td>
<td></td>
<td>13 facilitators (7 men/8 women), 20 community facilitators</td>
<td>2 weeks workshop</td>
<td>ACORD; CARPP community organization NESSA</td>
<td>Multiple ethnic backgrounds and political affiliations. Cultural diversity HIV rate 2.8 %. Post-war situation Mobile population. Implemented in army and pastoralist community (Makubai) Political and social stability HIV rate 6.4–11.9 % (12 % women; 9 % men) Agricultural setting Conflict and displacement area Overall HIV rate 7 % HIV rate in Gulu district 11 %; HIV rate in camps 37 % Highly vulnerable women/children. High dependency</td>
</tr>
<tr>
<td>Pain et al. [38]</td>
<td>Younger men and women</td>
<td>10 weeks</td>
<td>Adapted for Gambia Added topics: infertility prevention (Shaw, 2002).</td>
<td>Local language</td>
<td>4 supervisors 3 field workers 9 facilitators</td>
<td>10 days workshop</td>
<td>Gambian Dept. of State of Health; Family Planning Association; Action Aid Gambia; Medical Research Council; local clinics</td>
<td>Predominantly Muslim country. Relatively low HIV prevalence: 1.2 % HIV-1; 0.9 % HIV-2. Implemented in rural area with highest prevalence HIV-1, HIV-2 (18–3%); high syphilis rate. Illiteracy high</td>
</tr>
</tbody>
</table>
### Table 3 continued

<table>
<thead>
<tr>
<th>Authors</th>
<th>Target groups</th>
<th>Intervention duration</th>
<th>Content of the manual</th>
<th>Language of the manual</th>
<th>Number of facilitators</th>
<th>Duration of training</th>
<th>Partners and training organizers</th>
<th>Local context: cultural, political or ethnic diversity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bhattacharjee and Costigan [39] Ethiopia</td>
<td>Younger men and women</td>
<td>3 months</td>
<td>Revised version Added topics: social mapping HIV timeline risk matrix</td>
<td>NR</td>
<td>24 facilitators (14 male, 10 female)</td>
<td>2 weeks training</td>
<td>SCUK; OSSA (NGO)</td>
<td>Very poor country. Large population. Civil war, unemployment, food crisis. HIV rate 4.4% (5% women; 3.8% men)</td>
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<tr>
<td></td>
<td>Older men and women</td>
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<tr>
<td>Bradley et al. [3] India</td>
<td>Unmarried men and women</td>
<td>5-6 months</td>
<td>Adapted by ICHAP: 11 modules with 72 exercises; 4 main themes</td>
<td>Local language, Audio-taped Translated</td>
<td>12 supervisors 230 paid link workers</td>
<td>12 days training, 4 times refresher training</td>
<td>CIDA; Action Aid India; KHPT India; ICHAP and ICHAP, performed by KHPT.</td>
<td>Localized HIV epidemic has declining trend. National HIV prevalence rate 0.36%. Injecting drugs predominant in HIV transmission. Implemented in Karnataka – high HIV prevalence state</td>
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<tr>
<td></td>
<td>Young married men and women</td>
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<tr>
<td></td>
<td>Older married men and women</td>
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<tr>
<td>Jarju et al. [23] The Gambia</td>
<td>Young men</td>
<td>NR</td>
<td>Original SS package: Muslim adaptation Additional modules: STIs infertility</td>
<td>Local language, Diagram techniques designed for non-literate people</td>
<td>NR</td>
<td>NR</td>
<td>Gambian government; MRC; Action Aid; Gambia Family Planning Association; Worldwide Evangelization for Christ mission</td>
<td>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</td>
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<tr>
<td></td>
<td>Older men</td>
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<td></td>
<td>Mixed age women</td>
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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.
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
Evaluations

Many different contexts, including:

- Gambia evaluation (2002, AJAR )
- A review of evaluations up until 2006 (T. Wallace)
- RCT South Africa (Jewkes et al, 2008, BMJ)
- Regional evaluations (eg C. America 2012, Fiji 2007)
- COWLHA Malawi evaluation (2015)
<table>
<thead>
<tr>
<th>Authors/year Country</th>
<th>Infection rates</th>
<th>Change in risk behaviours</th>
<th>Increased knowledge about HIV/AIDS</th>
<th>Change in attitudes</th>
<th>Improved skills discussing sex</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reduced HIV incidence</td>
<td>Reduced HSV-2 incidence</td>
<td>Transaction sex</td>
<td>Partner violence</td>
<td>Multiple partnering</td>
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</tr>
<tr>
<td>1.</td>
<td>Jewkes. et al. [32, 34]</td>
<td>No</td>
<td>Yes</td>
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<tr>
<td>South Africa</td>
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<td>2.</td>
<td>Pacific Regional HIV/AIDS project</td>
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<td>Fiji</td>
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<td>3.</td>
<td>Hadjipanayis et al. 37</td>
<td>NR</td>
<td>NR</td>
<td>NR</td>
<td>NC</td>
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<tr>
<td>i. Angola</td>
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<td>Pain et al. 38</td>
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<td>Bhattacharjee and Costigan 39</td>
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<td>Bradley et al. 3</td>
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<td>Jarjour et al. 23</td>
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NR not reported, NC no change, ↓ decreased, ↑ increased
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**.
Stepping Stones and Creating Futures

• Combines Stepping Stones (gender transformation, HIV- & IPV-prevention) with Creating Futures (livelihoods strengthening)

• 21 extra sessions, each ~3 hours 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
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.
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.
Costings of Stepping Stones (2010)

**Zimbabwe** town: $3450 for 30 participants = $115 each with accomm.
  rural: $820 for 20 participants = $41 each

**S Africa**: ca $33 per participant

**India**: ca $55-65 per participant initially, falling to $43 per participant

**Zambia** (Lusaka): ca $62 per participant - high room hire costs

**Russia**: 15 days sessions for 80 people = $11,000 (total costs) = $140 per person

**Mozambique**: 2003 – World Bank. 500,000 participants $1.19 per participant over 4 years. Fully achieved 10 of the 16 UNAIDS benchmarks. Partially achieved 4 more (eg no homophobia training, limited M&E, not schools-based)

**The Gambia**: 2006 - $295 per participant (1 village 500 participants 1 year) down to $15 per participant on scale up (to 20 villages of 500 participants each in 1 year – ie 10,000 participants)
Scaling up – some lessons so far

Revising the Script
Taking Community Mobilization To Scale
For Gender Equality

- 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
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
Introduction to Stepping Stones on
http://tinyurl.com/SteppingStonesDocumentaries
Thankyou!

The *Stepping Stones* training programme is a project of Salamander Trust

*Stepping Stones & Stepping Stones Plus* is now published by Practical Action Publishing

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