# EVALUATING STEPPING STONES

## A review of existing evaluations and ideas for future M&E work

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## About ActionAid International

**We are an international development agency whose aim is to fight poverty worldwide. Formed in 1972, for over 30 years we have been growing and expanding to where we are today – reaching over 13 million of the world's poorest and most disadvantaged people in 42 countries worldwide, helping them fight for and gain their rights to food, shelter, work, education, healthcare and a voice in the decisions that affect their lives.**

In December 2003 we began the process of making all our country programmes equal partners with an equal say on how we operate, and in April 2004 we established a new head office in Johannesburg, South Africa. In all of our country programmes we work with local partners to make the most of their knowledge and experience. Our partners range from small community support groups to national alliances and international networks seeking education for all, trade justice and action against HIV&AIDS. Our work with these national and international campaign networks highlights the issues that affect poor people and influences the way governments and international institutions think.

We have a unique vision and direction. We do not impose solutions, but work with communities over many years to strengthen their own efforts to throw off poverty. We constantly seek new solutions and ask ourselves how we can make the greatest impact with our resources. We make the most of our skills and abilities by working at many levels - local, national, regional and international.

For more information, email us on mail.jhb@actionaid.org or telephone +27 11 880 0008.

## Acronyms and abbreviations

| | |
|---|---|
| **AAI** | ActionAid International |
| **ABC** | Abstinence, Be faithful, use Condoms |
| **ACORD** | Agency for Co-operation and Research in Development |
| **AIDS** | Acquired Immune Deficiency Syndrome |
| **AIDSCAP** | AIDS Control and Prevention |
| **BCC** | Behaviour Change Communication |
| **CHEP** | Copperbelt Health Education Project (Zambia) |
| **DFID** | Department for International Development (UK) |
| **EU** | European Union |
| **FACT** | Family AIDS Caring Trust (Zimbabwe) |
| **FHI** | Family Health International |
| **GEM** | Gender equality measurement |
| **HIV** | Human immunodeficiency virus |
| **ICPD** | International Conference on Population and Development |
| **IDPs** | Internally displaced persons |
| **KAP** | Knowledge, attitudes, practice |
| **KAPB** | Knowledge, attitudes, practice and behaviour change |
| **MOE** | Ministry of Education |
| **MRC** | Medical Research Council |
| **M&E** | Monitoring and Evaluation |
| **NGO** | Non governmental organisation |
| **PLWHA** | People living with HIV&AIDS |
| **PRA** | Participatory rural appraisal or participatory reflection and action |
| **QMUC** | Queen Margaret University College (Scotland) |
| **RCT** | Randomised controlled trial |
| **SA** | South Africa |
| **SCF** | Save the Children Fund |
| **SIPAA** | Support to the International Partnership against AIDS in Africa |
| **SRH** | Sexual and reproductive health |
| **SS** | Stepping Stones |
| **SS TAP** | Stepping Stones Training and Adaptation Project |
| **STD / STI** | Sexually transmitted disease / infection |
| **UNAIDS** | United Nations Joint Programme on AIDS |
| **UNFPA** | United Nations Population Fund |
| **UNICEF** | United Nations Children's Fund |
| **VCT** | Voluntary counselling and testing |
| **WB** | World Bank |
| **WCHP** | Women Centred Health Project (India) |

**Note:** It has not been possible to include in this table all acronyms and abbreviations used in the report, as some were contained in quotes from documents which themselves did not spell them out fully.

# Executive summary

## Introduction

Work with Stepping Stones (SS)[1] has taken place across a range of NGOs and agencies in many countries in the past 10 years, yet there is a paucity of well-recorded monitoring and evaluation data available in the public domain. For a methodology that has been so widely adopted, much of the evidence collected seems piecemeal and short-term, and the richness of how, why, where and when SS works as an effective HIV&AIDS prevention tool, a tool for gender equality, a community mobilisation tool, a tool for individual and community empowerment and to promote the rights of PLWHA remains relatively unexplored. The documentation clearly does not reflect the wealth of learning about the experiences of using SS over the last 10 years for any of the implementing agencies, and this needs rectifying.

This report has been commissioned by ActionAid International to review the existing publicly available M&E data on SS for two main reasons. First, AAI wishes to contribute to the understanding of what SS has and has not been able to achieve during the past ten years, in a wide variety of contexts, used by a wide range of different agencies. Second, this review is a timely opportunity to critique existing M&E documentation on SS and improve it in the future. The intention is not to summarise or present all SS evaluations to date, but to highlight the key issues emerging from them - including how systematic and comprehensive the existing documents have been, the key processes and methodologies used, and the most significant overall findings - and to identify the gaps which need filling.

## Key findings

One striking finding is the almost universal support for, and appreciation of, SS as a change process from those with first-hand experience of using it or seeing it used. The written and verbal feedback from NGO observers, trainers and facilitators is consistent and positive. While some external assessors see this as anecdotal or unscientific, the consistency of feedback and the volume of it from agency staff, independent facilitators, and outside observers is too strong simply to be ignored.

Almost every review reported an improvement in communication, usually between spouses or children and parents, as a result of the SS training. This was seen as critically important in contexts where discussing sex is difficult yet essential in the fight against the spread of HIV&AIDS. Most reviews also report positive increases in the knowledge and understanding of HIV&AIDS, its causes and how to prevent its spread; many of the findings of the different reviews were similar and supported the view that SS does contribute to changes in knowledge and attitudes around sexual behaviour, gender relations, and those affected by HIV&AIDS.

The findings on behaviour change were strong, with most reviews referring to positive changes in behaviour such as a greater take up of condoms, more respect for women, less domestic violence, respect for women to refuse sex within marriage, better communication between couples and parents-children, and more co-operation around household chores and income. The caveats to these findings are that they are often rather generalised, based on self-reporting or observation soon after trainings end, and the changes are not explored in any detail. Only a few evaluations qualified their findings and clarified who had/had not learned and understood the correct information, and acknowledged that new attitudes were tempered by

1 Alice Welbourn, 1995. Stepping Stones: a training package on HIV/AIDS, communication and relationship skills, London, ActionAid, Strategies for Hope: Training Series No.1.

continuing external pressures. Sometimes the findings are verified by reference to other sources such as condom distribution figures, local court proceedings, talking to outside observers and key informants, and sometimes not. It is important to say that more could be done to triangulate the information gathered with a range of data available in the community.

Only a few reviews refer to the issue of spread/coverage, but the figures given in those cases are significant. In Uganda in 1997 the survey indicated that 22,400 adults had been through SS training, the majority of them women. The World Bank estimated that AAI in Mozambique had reached 500,000 over the four years from 1999-2003, while in Zambia the coverage was 3,500 young people and over 100 adults. In the same year, 2004, the Malawi training reached 1,150 teachers and SS was to be rolled out across the entire primary school sector, reaching 55,000 teachers in 2006. For most reviews, though, there are no coverage figures provided.

For some donors/public health observers the critical question remains: has the introduction of SS led to a decline in the spread of HIV&AIDS? The evidence collected does not allow that question to be easily answered, although the findings indicate positive behaviour and attitudinal changes that certainly do relate to limiting the spread of HIV&AIDS. The challenges of trying to tie participatory interventions aimed at behaviour change and long-term attitude change to figures on the spread of HIV&AIDS, however, are many. Multiple factors are important in enabling prevention to take place including for example good health services and the availability of reliable VCT, economic empowerment for women, and positive government support for work on HIV&AIDS. Many NGOs question anyway whether this single public health measure is the appropriate yardstick for assessing a participatory approach such as SS, when so many factors contribute to effective prevention on the one hand and SS is about far more than prevention on the other.

## Methods used to date

Methods used have included surveys, questionnaires, participatory approaches, randomised controlled trials and collection of biological data from blood and urine tests. The work so far indicates that there is a convergence of findings between the different methods, with as many differences between those gathered by participatory methods as those between qualitative/quantitative methods. The most informative and detailed reviews used very different methods but were carefully recorded and written up, explored trends and exceptions, raised unexplained findings and nuanced the results with care. They were time-consuming and costly processes all involving external players, including academics. This is not the norm for evaluations of NGO work at the moment, or indeed of SS evaluations. But they do indicate that the methods used might matter less than the rigour, independence and quality of the review work.

## Shortcomings identified

Reviews to date have differed significantly in their scope, the time they took, and their costs. While the time and costs are rarely documented, it is clear that some were done relatively cheaply and quickly, while others used large research teams, involved complex data collection and analysis, and spanned many months. However many of the reviews lack clarity on essential information, such as when the programme started and whether it is finished or on-going, a timeline or any sense of the shape and duration of the work, information on the budget, data on the numbers of staff/facilitators and trainers and who was selected and how, information on the nature of the training and the quality of implementation, whether the work was aimed at the whole community or key target groups, the coverage and reach of the project, how many participated and who did not, rates of attendance, and issues of follow-up. They often appear to assume a detailed knowledge of SS and do not say which

sections of the manual were emphasized or omitted, and which were modified. Few refer to the action plans made by the groups after the training or the requests for change that people made and whether these were achieved or not. Only a few go deeply into the SS process and outcomes, explore the methodological issues, and analyse in some detail the achievements and challenges from using the SS approach.

## Recommendations

- **When SS is introduced there needs to be clarity about why**, the problems it is designed to address, for whom. What elements in the context will support positive change and what are the barriers, external to the SS process, which need to be taken into account? **A baseline** needs to be collected so that changes can later be compared with this.
- **For M&E it is important to be clear who needs what information**, how it can best be collected, who can fund it, who is the best team/individuals to do it and what measurement tools are most appropriate.
- **More resources need to go into monitoring and evaluation**, to ensure a build-up of learning and knowledge from the grassroots experience to feed into modification, adaptations and policy work around HIV&AIDS prevention and mitigation. The nature and quality of the SS training needs to form part of any review, given that the outcomes will probably be related to the way the process was implemented; if not that would be a very interesting finding.
- **Monitoring skills need to be prioritised and developed**, with trainers, facilitators and staff implementing SS, and the results of monitoring need to be collected and analysed by HIV&AIDS teams, both for using in evaluation and for sharing with others working in this area. They need to be accessible to others working in this field wherever possible.
- **All evaluation reports need to meet some minimum standards** of describing the programme, presenting the key aims, the budget and basic costs, the implementation process, the methods used and why they have been chosen and the key findings - with overall trends and exceptions, coverage and reach, and where possible who benefited most and how, and who benefited least and why.
- **A range of methods should be used**, including revisits to old sites 3-5 years after SS has ended. More use of participant observation, triangulation of reported change, social surveys, and group reflection can be used to deepen and widen the evaluation data available.
- **There needs to be an open, accessible means for the storing of M&E** on SS, well publicised and available to all. This poses challenges because of the range of organisations involved, and therefore may not be solved through a single site – but every implementing agency should make much more serious efforts to publicise and disseminate the M&E data they have or produce.

Section 1

# INTRODUCTION TO STEPPING STONES AND THIS REVIEW

## Introduction to Stepping Stones

Stepping Stones (SS) is a participatory training package[2], which was originally designed in the mid-1990s to address the prevention and spread of HIV&AIDS in sub-Saharan Africa and increase the care of people living with HIV&AIDS (PLWHA) at the community level, through promoting communication and relationship skills within households and communities. It aims to enable individuals and communities to find their own solutions to the threat of HIV&AIDS, both avoiding it and coping with the reality of AIDS. It focuses on filling gaps and addressing the shortcomings of the most prevalent HIV&AIDS messages, which were and continue to be focused on the dangers of AIDS, promoting the ABC (abstinence, be faithful and use condoms) approach to prevention. These messages are usually targeted at women, although few women in strongly patriarchal societies have the power to negotiate sexual relationships, especially if they are poor. The SS package openly explores the realities of sex and sexual relationships with communities, explicitly recognising the gender inequalities that characterise these relationships.

The training programme is lengthy and spread over many sessions, each one building on the one before enabling real behaviour change to happen and be supported during the process. It involves people working in separate age and sex groups, to encourage openness and discussion; it is designed to enable women and men and the wider community to decide how to promote respect, listening and communication between sexual partners and within families, and how best to care for those living with HIV&AIDS. While people work essentially within their peer groups, there are periodic community meetings held to share issues and, at the end, present 'special requests', which involve asking others to change their attitudes and behaviour on specific, locally identified issues. There is an accompanying video, for use during the training process, presenting illustrative material in short clips, which was developed in a village in Uganda where the work was piloted.

The theory underlying the training package is based on an understanding of how people can learn to change their behaviour and actually make changes that last - drawing, for example, on principles and practice used by other change processes such as Alcoholics Anonymous. Alcoholics Anonymous focuses on long-term behaviour change in individuals supported by their wider community, recognising that major changes in behaviour are hard to sustain and require both long-term support and a shift in the norms of what is seen as acceptable behaviour. SS recognises the challenge and fear of change and the need for on-going support for those taking part. The training is conceived as a journey, building up confidence over time to enable people to learn how to negotiate and cope with HIV&AIDS, through self- realisation, learning, sharing, and caring for those most affected. Behaviour change, because it is difficult, is best achieved through individual change, peer support and wider community changes, which includes rethinking negative social and cultural norms together.

Once the training started it quickly became apparent that the manual would need to be constantly adapted for use in different cultural contexts; to be relevant the training has to be properly rooted in local understandings of sex, sexual behaviour, gender and family relationships, age hierarchies, and cultural beliefs and practices. This process of adaptation was expected and encouraged from early on, and SS has been adapted and used in a wide range of different ways since its inception. While in the early days there was an active attempt to monitor who requested and received the manual, how it was used and its many adaptations – essential for ensuring relevance early on – it has grown so significantly that it is now well beyond the ability of any one individual or organisation to track its evolution and progress. Appendix 1 gives an idea of the way it has spread and the number of organisations, individuals and countries that now use it, in full or in part.

During this review it became clear that in addition to the use of SS in its entirety, the SS approach and elements of it have been taken out and incorporated into other participatory approaches to HIV&AIDS awareness raising, prevention, care and mitigation. Some of these appear to have lost key elements of the SS concept, including, for example, the building of knowledge over

2 Alice Welbourn, 1995. Stepping Stones: a training package on HIV/AIDS, communication and relationship skills, London, ActionAid, Strategies for Hope: Training Series No.1.

time and in sequence, and the need to work with people in separate sex and age peer groups as well as together. Other elements also seem, at times, to have been misunderstood: for example the recent review of the use of SS with primary school teachers in Malawi[3] queried the lack of gender in the package, yet the manual is predicated on the need to empower women to gain respect and participate in decision-making and negotiation around their own health and safety. Involving men to ensure changes in gender relationships can actually happen is central to the SS approach.

Another critical element in SS that is sometimes in danger of getting lost is the need for trainers and facilitators themselves to explore their own attitudes and beliefs and change their own behaviour. The package involves training trainers, who in turn train facilitators, often from the community, and all are expected to learn and change as they undergo the training process, but evidence shows that some trainers focus only on community behaviour change. SS requires good facilitation if it is to become a live participatory process, yet the fundamental principles of self-awareness and change appear, at times, to have been superseded by a more technical and even mechanistic approach to the SS training. The training can be delivered in a wide range of ways and the issues of quality control and who should maintain or oversee the quality and core principles are certainly problematic.

This review will focus not only on what SS has achieved in different communities, but also on the prior issues of who facilitates the training, how they are chosen, how well the training is delivered and how far the understanding and analysis underlying SS is really grasped by those using it.

### The origins and focus of this review

A number of factors led to this review, which comes at a time when other NGOs (notably ACORD and Christian Aid) and researchers, including some from the Medical Research Council, are seeking to improve their understanding of SS and other participatory approaches to the prevention and mitigation of HIV&AIDS and its influence on behaviour change at individual and community levels. A recent workshop[4] in Edinburgh highlighted both the interest in understanding and evaluating these approaches to behaviour change and their role in the prevention and mitigation of HIV&AIDS.

The motivations include the well-known weakness of NGOs in documenting and learning from their work and SS is no exception. Work with SS has taken place across a range of NGOs and agencies such as UNICEF, yet the available documentation and learning is poor. AAI especially felt the need to explore whether to undertake a major review based on past learning because of the very substantial investment of AAI in working with SS over many years and across many of their programmes. Another factor was the challenge being raised by some donors and observers, who see the widespread adoption of SS but question whether the evidence exists to show that it works and is really effective.[5] The professional HIV&AIDS community want better evidence, some requiring tested medical review processes about whether SS does prevent the spread of HIV&AIDS and whether or not to invest in it in future. Others want to know more about how SS works to develop community cohesion, provide support for changes in gender relations, encourage better care for those who are affected, and address the problems of stigma for PLWHA.

Undertaking this review of existing evidence about SS did show that while a range of documented evaluations of SS exists, overall there is a paucity of well-recorded monitoring and evaluation data available in the public domain, given the scale of its use. Almost every review calls for more and better monitoring and evaluation (M&E) to guide SS work in the future, so thinking about how to improve and increase the M&E on SS work is certainly timely and appropriate.

AAI commissioned this research report and the AAI International HIV&AIDS Advisor helped to track evaluations and provided those held by AAI. The author of SS, who keeps in touch electronically with a wide range of users, then added to this list. Once the review was under way, people contacted during the review process sent

3 Prescilla Latinga, AAI Malawi, UNICEF and MOE, Evaluation of SS training for HIV/AIDS prevention among secondary school teachers, Malawi. 2004.

4 Medical Research Council and Queen Margaret University College convened a workshop in Edinburgh 22-24th March 2006, Evaluating participatory, community-based sexual health interventions.

5 For AAI this came to a head during the mid-term review of their Support to the International Partnership against AIDS in Africa (SIPAA) project, when the Department for International Development (DFID) consultants concluded that because they saw no written evidence to support AAI's belief in SS as an effective behaviour change methodology, it should be removed from the SIPAA approach. They did not look at any SS work or visit any communities involved with the process, but rejected it as an effective approach only on the basis of the lack of good, available documentation. This decision had a negative knock-on effect within the SIPAA project, where the loss of work at the community level on behaviour change and awareness raising around HIV&AIDS caused problems in the work, especially for example in Ghana. It also caused problems beyond AAI because DFID suspended all funding to SS work by other NGOs as well. The issue of what kind of evidence DFID needs to enable funding to resume/continue remains uncertain, though informal discussions suggest good basic monitoring and review data collected using a range of methods, well disseminated, would be very useful. Indeed the real problem lay initially in the lack of easy access to review reports rather than in detailed concerns about their methodology or quality.

in other documents. However, without personal contacts it is hard to access much of the existing review material; there is no open central forum where the growing body of evidence is stored and many working in the field are unaware of the range of available reports. The lack of a good, accessible site for the materials means that even those lessons and evidence that have been collected are probably not being well used.

Only documentation accessed through these channels has been used for this review, though it is expected/hoped there might be more evaluative material 'out there' given the widespread use of SS. The list of documents used is listed in Appendix 2. The intention in this review is not to summarise or present all of them, but to highlight the key emerging issues - including how systematic and comprehensive the existing documents have been, the key processes and methodologies used, and some of the key overall findings - and to highlight the gaps which need filling in future.

**The fast-changing external context**

The world has changed significantly in relation to HIV&AIDS in the last ten years, yet SS has continued and usage has grown. It has been adapted to meet the new opportunities and challenges presented by the evolution of the epidemic and the responses to it. For example, new issues of treatment have come into the picture; there has been a rising awareness of the need to enable PLWHA to be open and to participate meaningfully in policy development around HIV&AIDS. The need to address religious issues has become more important in the context of both the rise in fundamentalism and the new global security agenda. The changes in policy, especially in the United States, around sexual and reproductive health have become critical issues for agencies, communities and individuals, and as SS has moved beyond rural communities in Africa important issues such as injecting drug use, the challenges facing commercial sex workers and men who have sex with men have been highlighted.

There is clear evidence of SS taking on many of these issues through new adaptations, although how well SS trainers have been able to understand and work effectively in fast-changing contexts is hard to assess from the existing materials. What is undoubtedly the case is that, as an approach, SS can and does develop and change as the external and cultural contexts change. This is a significant advantage for a methodology that is working with HIV&AIDS, which is rapidly evolving and also presents differently in different places.

**The nature of the existing reports**

The documentation is disparate and wide-ranging. It is clear from the reports that SS is being used to achieve a very wide range of different things. The aims range from awareness-raising and information sharing about HIV&AIDS to promote prevention strategies, including in some places the promotion of abstinence, through to community mobilisation, conflict resolution, improving the care and treatment of PLWHA, tackling stigma, advocacy on treatment, depending on the priority needs in the context or the aims of the agency introducing it. The aims usually - but not always – include understanding gender inequalities and how to redress them, given that these inequalities are a key driver of the epidemic and also significant in issues of care and mitigation.

The purposes for introducing SS are varied, covering everything from prevention to mitigation of the impact, and enabling those affected to face and handle the issues around death and loss; they also include addressing gender inequity, and promoting the rights of those most affected. The reasons for undertaking the reviews and the methods used are also varied. Some focus more on assessing the quality of the training, implementation and adaptation of the manual, while others seek to find out what impact/influence SS has had on those who have been trained and the wider community. Only a few try to do both. The methods used include participatory reviews, where those that took part define the purpose of the training and the criteria for assessing its effectiveness; these rely heavily on self-reported findings about change. Others combine participatory reviews with questionnaires and focus group discussions with key external informants; these tend to state prior to the review what kinds of change were expected from using SS rather than leaving these solely to the participants. A few evaluations were more quantitative and normative in approach, using initial surveys and follow-up questionnaires before and after the training, or using control villages/groups who did not undergo the training to try and tease out what impact SS had on the knowledge, understanding and behaviour of those who were trained. In one or two cases the methodology of randomised control trials was used, using medical standards of evidence to test claims of behaviour change; these included the collection of biological data, such as blood and urine tests, as well as interviews and observation.

Evaluations of this work, which straddle social and medical models of change and assessment, draw on a range of traditions from participatory to standard social science surveys to medical models. Each approach raises interesting questions and each has strengths and weaknesses; some raise ethical questions that need further

discussion. The very fact of their range makes a simple synthesis difficult, although it has been possible to draw out some key trends.

The reviews have differed significantly also in their scope, the time they took, and their costs. While the time and costs are rarely documented, it is clear that some were done relatively cheaply and quickly, while others used large research teams, involved complex data collection and analysis, and spanned many months. The issues around how to cover the costs of good evaluation and who is willing to pay will be discussed briefly later.

Many of the reviews lack clarity on essential information, such as when the programme started and whether it is finished or on-going, a timeline or any sense of the shape and duration of the work, information on the budget[6], data on the numbers of staff/facilitators and trainers and who was selected and how, information on the nature of the training and the quality of implementation, whether the work was aimed at the whole community or key target groups, the coverage and reach of the project, how many participated and who did not, rates of attendance, and issues of follow-up. They often appear to assume a detailed knowledge of SS and do not say which sections of the manual were emphasized or omitted, and which were modified. Few refer to the action plans made by the groups after the training or the requests for change that people made and whether these were achieved or not. Only a few go deeply into the SS process and outcomes, explore the methodological issues, and analyse in some detail the achievements and challenges from using the SS approach.

The table on page 10 summarises the evaluations consulted and groups them according to the type of report and the methods used to collect the data on which the report is based.

6 This is critical at a time when many donors are looking for cost effective interventions. When the basic costs are not recorded it is impossible to assess the relative value of a particular approach. Some recent indicative figures from ACORD suggest that the costs per person are not high (about £40 per person); however, up till now discussions about costs effectiveness appear to take place in a vacuum. Even basic information about project costs is not included in most evaluations yet.

**Table 1: The evaluations consulted, grouped by methodology**

| Training reports and short reports on specific experiences with SS | Participatory reviews, sometimes including questionnaires and survey approaches | Social surveys, randomised control trials, quantitative and qualitative data collected |
|---|---|---|
| Proposed article for Oxfam (DIP) India, 2000 | Pilot programme evaluation, Mozambique, 1999 (AAI, Unicef and SCF) | Gambia review, 2002 MRC and others |
| Adaptation workshop East Africa, 2000 | SSTAP feedback from users 1997 | Malawi primary teachers evaluation 2004 AAI |
| Kisumu workshop 2001 (AAI) | Tanzania review 1998 SSTAP | Zambia review, (Weston Mutale Bowa, Copperbelt Health Education Project) 2004 |
| Kenya review workshop 2002 (AAI) | Uganda review 1998 SSTAP | Monitoring and evaluation framework, Ethiopia (SCF) 2005 |
| Review of Swahili SS 2002 (AAI) | Zimbabwe review 2001/2 | Gambia review 2006 (Concern) (not seen) |
| Voices from the field, Estamos 2002 | Desk review of participatory approaches 2001 | Jewkes, RCT in SA 2006. |
| Promotion of SS methodology in AIDS related behaviour change- annual report 2003 (FACT) | Ghana review 2001 | |
| Institutional field visits 2003 (FACT) | World Bank sourcebook on participatory approaches | |
| Progress report, AJWS 2003 | SIPAA review 2005 (AAI) | |
| Men's involvement, (WCHP) Mumbai, 2003 | Buwenda, Uganda revisit report and video (Baron Oron) 2006 | |
| | ACORD on-going participatory review 2004-6 (Interim reports seen) | |

The reviews listed in columns 2 and 3 are the ones most relied on for this review process, because they were reviews or evaluations rather than training reports or monitoring reports on specific events, and had used recognised methods for collecting and analysing the data.

## The excitement of those that implement SS

One striking finding from this review that needs emphasising before moving on to analyse the existing documentation on SS is the almost universal support for, and appreciation of, SS as a change process from those with first hand experience of using it or seeing it used. Some who have been trained as facilitators talk vividly of changes in their own lives and relationships, and the increased understanding they bring to their marriages and family relationships – they can see their improved communications and knowledge and the effect these have had in their lives. Those that have visited communities where SS has been undertaken talk of real changes in people's lives: the growing assertiveness and confidence of the women, better inter-generational communication, more openness about discussing sex, less stigma and more care for those with HIV&AIDS, and a willingness of PLWHA to be open. The written and verbal feedback from NGO observers, trainers and facilitators is consistent and positive.

While some external assessors see this feedback as anecdotal or unscientific, the consistency of feedback and the volume of it from agency staff, independent facilitators, and outside observers is too strong to be simply ignored. Examples from this body of first hand experience will be used in the report and some quotes – to give a feel of it - are included in Appendix 3. The consistency and quantity of this kind of verbal and informally shared experience, through emails, in conferences, at meetings, is significant and needs to form part of the assessment of the value and role of SS in bringing change to people's lives.

Section 2

# METHODOLOGIES USED TO EVALUATE SS

## Monitoring

While there is inbuilt monitoring in the SS process, it is not known how well it is used because it is rarely documented for use beyond the community and those involved in the training. While the critical importance of those involved learning and monitoring their own changes ***cannot be underestimated***, and indeed they are in many ways the primary learning group, little of this data is available more widely.

While a number of NGOs, especially AAI, have adopted SS as a central methodology in their HIV&AIDS strategy, any learning from monitoring reports has largely remained in the communities and districts where the training was done, or with the trainers and HIV&AIDS staff. Reports that may exist are not easily available even at the country level, and annual reports from the different NGO agencies using SS either do not exist or are not available (with very few exceptions, e.g. a short annual review from Christian Aid). The lack of good, available monitoring data means that much that has been learned about SS at the local level is not disseminated.

The lack of monitoring data certainly affects the quality of the evaluations that have been undertaken, almost all of which – except in the Gambia and the South African research - have no real baseline or monitoring data to work with and build on. The most commonly available monitoring reports are training reports, which, while useful, tend to be descriptive and focused only on who attended and the events in the training. There is little evidence about how trainers are selected, who dropped out and why, how well the facilitators were able to work, where there were serious problems of understanding or resistance to change. The early reviews did indicate that while most participants hoped to continue meeting after SS ended, in fact there were many barriers to doing this and this remained a hope rather than a reality. There is little recorded evidence monitoring initial attitudes and behaviours, or which were making women and men most vulnerable, nor what changes in attitudes and knowledge occurred during the training. While many report e.g. an increase in condom use or a rise in the care for those affected immediately after the SS training, there is little on-going work to show who was making these changes or whether they were sustainable. Much of the on-going monitoring data appears to be ad hoc, lacking any kind of baseline, often inaccessible and too generalised to provide a sound basis for subsequent evaluations.

### Purposes of evaluations

These are wide-ranging and have changed over time, as the focus of concerns around HIV&AIDS and the use of SS have changed. The earliest evaluations in the late 1990s explored how people were implementing SS, their use of the manual and the video and how it was being adapted, with a view to contributing to the adaptation work and making recommendations on future use.[7] This was entirely appropriate given the experimental nature of the package and the need to learn how it worked and how well it transferred between different countries and contexts. They also monitored changes in communities and peer group behaviour, and changes in the trainers themselves.

Over time the priority became increasingly the impact of SS; fewer reviews assessed the quality of implementation and the delivery of the SS package, though some did. In Zimbabwe in 2000, an extensive review was set up by AAI, the implementing partner and an external consultant, to understand the conditions under which the program had been run and to evaluate the impact of the program on the knowledge, attitudes and practices (KAP) of participants - exploring the differences between ‘exposed’ and ‘unexposed’ communities. It also explored the attitudes and experiences of the program facilitators and tried to identify the sustainability of the intervention beyond the limits of the formal program.

In 2001 a desk review of all existing documentation (including an early draft of the Medical Research Council (MRC) Gambia report put out in 2002) was undertaken by Gill Gordon and Alice Welbourn[8] to explore especially the successes and challenges of involving men in SS, a key, unique characteristic of SS at a time when sexual and reproductive health knowledge and attitude work

7 These reviews were carried out under the auspices of SS TAP - the SS Training and Adaptation Project - within AAI UK.
8 G. Gordon and A. Welbourn, 2001. SS life skills and sexual well-being, a desk based review, highlighting male involvement.

was mainly focused on women.

The MRC review of SS in the Gambia (circulated in 2002) explicitly set out to remedy the paucity of existing evaluation data. This lack struck them as surprising given that

> *it is a UNAIDS-recommended resource for community mobilisation (UNAIDS, 2000b) and has proved popular around the world: more than 2000 organisations in over 100 countries have received the package. Yet rigorous evaluations have yet to be undertaken on the effectiveness of this programme (Gambia MRC report, 2002, p.5)*

They undertook an extensive review to document the changes in the lives of villagers involved in SS and to compare their knowledge, attitudes and behaviour changes with people in matched control villages. This evaluation also explicitly piloted ways of collecting quantitative as well as qualitative data on SS.

In 2003 ACORD set up a long term participatory evaluation process with a view to learning how to play a constructive role in developing an 'AIDS competent society', working on the causes and consequences of HIV&AIDS and finding ways to enable communities to take the lead on the work from service delivery to national policies. SS was integral to their approach, and the purpose of a two year funded review within this process was to look specifically into the impact of SS in three countries (Tanzania, Uganda and Angola)

> *to test the effectiveness of Stepping Stones to achieve sustainable change in gender relations and to mobilise communities to engage in advocacy activities resulting in positive improvements in their environment. The work will also entail the promotion of and support for follow-up activities and advocacy initiatives directed at local and national level and culminating in an international conference aimed at sharing the findings with development practitioners, researchers, policy makers and donors at an international level. (ACORD proposal)*

Also in 2003 the World Bank (WB) looked at AAI work in Mozambique to learn about the SS participatory prevention methods and approaches, for inclusion in a WB manual on HIV&AIDS education and prevention. In Zambia in 2004 the primary aim of the CHEP review was to explore whether SS could enable people to emerge from their cultural boxes and find ways to avoid risky behaviour, especially by improving communications between partners and families and by practising abstinence, while in Malawi the focus of an AAI review in the same year was on the extent to which a SS training process for primary school teachers had impacted on family health and relationships, with a view to rolling out the programme to all primary school teachers. They also explored the gender sensitivity of the training as a package for use with primary school teachers.

SCF commissioned some work in Ethiopia in 2005, with the specific intention to

> *review their 'Stepping Stones' training project in Harar, in order to develop a monitoring and evaluation framework, which could be used to measure the community-level impact of Stepping Stones in future in a more methodical way' (P. Bhattacharjee and A Costigan, Report to SCF 2005)*

Recently published evidence from on-going research led by Rachel Jewkes in South Africa, while not classed by the researchers as an evaluation, has evaluative components. The purpose of this research is to identify appropriate methods for carrying out baseline surveys, which would then enable researchers to design and assess a 'behavioural intervention trial aimed at reducing HIV incidence'[9]. This was designed as a randomised controlled trial designed to meet medical research standards to explore the impact of a specific intervention on people – only in this case the intervention was not a drug but a behaviour change process broadly based on SS- on preventing the spread of HIV&AIDS among young people.

9 R.Jewkes et al, 2006. A cluster randomised controlled trial to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa: trial design, methods and baseline findings. Tropical Medicine and International Health.

In contrast, in 2006 in Uganda, a SS trainer and person involved with SS from the beginning (Baron Oron[10]) revisited the pilot village ten years on, with the main purpose of recording experiences and changes in people's lives over the past ten years, since their involvement with SS. A video is currently being made focusing on individual case studies, to illustrate the range and depth of changes people attributed directly to the work they had done with SS. In this case the focus went well beyond prevention to look at a wide range of change issues.

The purposes for introducing SS were varied, and the expectations of what SS could achieve covered a wide range from the prevention of the spread of HIV&AIDS through individual behaviour change and changing sexual norms and behaviours across communities, to increased care for PLWHA, a decrease in stigma and discrimination, support for treatment and adherence to drug regimes, improved gender relations and less domestic violence, promoting community harmony, community mobilisation to enable communities to claim their rights and make demands on government, and more. Often the purposes named are quite wide, and while many of these elements are inter-related, the breadth of the expectations and the frequent lack of prioritising certainly make assessing the role and impact of SS difficult.

**The methods used**

The methods used also varied. While most use participatory methodologies, others undertook surveys, and others have combined purposive or random sample survey methods with biological data collection, the latter drawing on medical research models to test the validity of the SS package. The methods varied according to purpose, and also according to the background and experience of those commissioning and carrying out the research. Those from participatory backgrounds worked closely with qualitative data, those from social science backgrounds included surveys as well as more participatory methods, and those from more public health backgrounds included quantitative elements from the methodology of randomised trials. A few used the concept of 'controls' or 'before and after', whichever methods they worked with.

The presentation of the data varied greatly, from short reports using key headings and illustrative quotes, to much longer, more analytical reports presenting detailed data analysis, and occasionally statistics verified using recognised statistical packages.

It would be all too easy at this stage to pit the quality and value of the different methodologies against each other, placing greater weight on what are often perceived to be more rigorous quantitative reviews. There is evidence that this has been happening in relation to SS in the past.[11] The debates about the merits and demerits of the different approaches have filled many books; however, by now the validity of stories, narratives, and people's own perceptions of their experiences have been well established and are widely accepted within the social sciences (e.g. Roche 1999, Thomas, Chattaway and Wuyts 1998, Cracknell 2000, and Tsoukas and Hatch 2001[12]). Social science methods, including ethnography and surveys, purposive and random sampling methods, interviews and questionnaires, alongside narratives have a lot to offer. These are, however, less readily accepted by some scientists, who continue to favour more controlled and quantitative methodologies tried and tested in the field of medicine. HIV&AIDS work does at times appear to be caught between two models – the medical and the social - and the reviews of SS show that SS is no exception, with the polarisation evident especially between participatory and medical evaluation methods.

However, both qualitative and quantitative methods have their own validity and place in the canon of evaluation methodologies, and there is a wide range of qualitative methods as well as quantitative methods, which are often simply lumped together. These try to capture complex realities in different ways, recognising that the number and range of variables and influences on any one person, community and society are numerous, complex and constantly changing. All reviewers and evaluators working in the field of development face problems of attribution; the validity of controls and finding ways of establishing proven links are problematic for all when so many factors need to combine to achieve positive outcomes[13]. What is universally needed though is for evaluations to be well conducted, based on clear methodologies, and well

10 B.Oron, 2006, SS in Buwenda: ten years later, a qualitative study (draft). Kampala.

11 The workshop convened by MRC and QMUC in Edinburgh in March 2006 was specifically intended to try and bridge the gap that currently exists around evaluating participatory methods in HIV&AIDS work.

12 C. Roche, 1999. Impact assessment for development agencies: learning to value change. Oxfam, Oxford. A. Thomas et al, 1998. Finding out fast: investigative skills for policy and development. Sage, The Open University. B. Cracknel, 2000. Evaluating development aid: issues problems and solutions. Sage, London. Tsoukas and Hatch, 2001. Complex thinking and complex practice: the case for narrative approaches to organisational complexity. Human Resources 54 (8)

13 These include political leadership at the top, through to empowered and informed individuals and communities, good services, a viable economy and access to economic opportunities, the ability of people to demand for services, accountability at local and national levels, and attitude and behaviour changes at all levels in favour of equality, justice, and democratic processes.

recorded - including the exceptions and problems as well as the achievements and overall trends. These elements were often very uneven in the documentation of SS reviewed here.

It is also essential, when selecting or promoting a particular methodology, to take into account what it is really important to know, by whom, and at what costs in terms of intrusion, ethics, time and money.

**Surveys**

A few evaluations were based on written, mailed questionnaires. For example in 1997 SS TAP commissioned Andrea Cornwall of the Institute of Development Studies (UK) to conduct a survey of users to date. 691 questionnaires were mailed to those who had received the SS material –the manual and the video- in Africa and Asia. 108 (16%) replied, a good response for this methodology. However, the questionnaire was not attached to the final report, and there was limited statistical analysis of the returned questionnaires in the widely circulated summary of the evaluation. The findings were presented under the four headings representing the key components of SS: learning, sharing, caring and behaviour change and the data were presented in the form of individual quotes, which while illustrative of the range and nature of the changes attributed to SS training did not enable readers to really understand the coverage of these changes. This reviewer unfortunately did not see the longer version of this evaluation.

In Zambia in 2004 the implementing organisation administered questionnaires that were focused especially on SS effectiveness in preventing the spread of HIV&AIDS. They piloted the questions with 9 couples and 15 young people the previous year. 401 young people and 234 adults completed the questionnaires, and the data were presented under each key question asked, showing what percentage answered positively and negatively in response to named changes around sexual behaviour and attitudes. The focus of the questionnaire was on cultural norms and how they affected the spread of HIV&AIDS, whether people felt able to challenge these norms and change behaviour, and their attitudes to preventing the spread- with an emphasis on building mutual respect. The questionnaire also explored how well they understood the issues around sexual risk. One key question for this exercise was around abstinence as they had adopted SS to promote a commitment to abstinence by the youth.

Very few other surveys have been undertaken so far, either with SS participants or those who have never have been trained. It is an underused methodology, as are other social science tools including literature reviews and situating the methodology within a theoretical context; locating the work clearly within the wider political and economic context, including within current poverty reduction strategies; in-depth case studies to understand how SS works when it works; participant observation; triangulation of self reported behaviour with community data such as health centre statistics; long term community studies; and ethnography. Surveys have however been central to the work of Family Health International[14]; they have undertaken behavioural surveillance surveys prior to starting many of their participatory programmes on HIV&AIDS prevention in a wide range of countries. Their website covers in detail the pros and cons of different methods and why baseline data is so critically important. They provide a wide range of surveys, which provide examples of how this work might be done. They also provide a good review of the costs and ethical issues around other methods, including the collection of medical specimens, which are interesting.

**Participatory approaches**

The majority of reviews were based on participatory evaluation approaches. For example, the 1998 SS TAP commissioned review in Uganda was based on a three-day design and training workshop involving four community members, four facilitators and four trainers as well as one external reviewer. Eight days were then spent in the field in two villages which had undergone intensive SS training over 21 days, using participatory approaches such as mapping, flow charts, diagrams, trends, role play to explore changes in behaviour as a result of SS. A great deal of rich data was collected, and some critical issues were raised for example about how different participants were using the learning from SS in their own lives, relations with those not included in the training, and the sustainability of the groups after the training finished. One of the challenges for this qualitative review was the lack of baseline data against which to compare current knowledge, attitudes and practices, something that is true for most SS (and indeed most NGO) evaluations. The lack of a baseline made it difficult for the reviewers to assess the reported changes, e.g. in the rising use of condoms, or try to understand what might be attributed to SS directly.

The review team said that there had been a lack of clarity about how to do M&E; they also noted that the participatory methodology was time consuming and a process that as well as establishing relations of trust with the community required very skilled recorders; these all take time and cannot be rushed. While being seen as a strong methodology yielding up a lot of insights

14 www.fhi.org

and information the high costs and other limitations were acknowledged.

SS TAP used a slightly different participatory approach in Tanzania where the focus was on talking primarily to the users of the manual (the trainers), as well as contacting some youth who had attended the SS training. In this case take- up had been relatively low and people were hard to find. The method used was primarily interviews. A review in Mozambique in 1999 was done by a several agencies working together and again focused on face to face interviewing, with 22 groups who had and had not participated in SS training: the concept of the control group was used in this informal interviewing approach. 28 individual interviews were also held with key informants, including community leaders and heads of institutions to go beyond self reported data to include the observations of outsiders.

Another review using PRA techniques was undertaken by a team (funded by AAI and a partner) led by Kesby, an external consultant, in Zimbabwe in 2000. The methodology was

> *participatory reflection and action (PRA) (which) was conducted to learn about the main aspects of the community which are important for preventing and coping with HIV&AIDS as well as to prepare for Stepping Stones workshops. The process involved collecting data using participatory techniques including the use of day plans, historical time lines, income and expenditure pie charts, mobility maps, problem analysis ratings, venn diagrams, social maps, problem trees, transect lines, weekly schedules, and flow diagrams. The PRA sample was made up of fifty participants who were divided into four peer groups as follows: 15 adult males, 9 adult females, 19 youth males and 7 youth females. The rationale for this arrangement was to capture the gender and demographic deviations and to allow peers to articulate issues without feeling embarrassed. The level of participation was high except for the young women's group. (Zimbabwe report 2000 p2)*

In this review they followed many of the approaches used in Uganda in 1998, and also did purposive sampling and interviews with key informants including facilitators, SS participants and non-participants (again using the concept of a control group), clinic staff and commercial sex workers. They conducted ballot style Knowledge, Attitude and Practice (KAP) surveys, asking people to tick or cross on paper whether they agreed or disagreed with a statement read out to the group. While the methodology was firmly rooted in a participatory approach the report attempted to correlate the observed or reported changes with those who had/had not attended SS training, and recorded in some depth the meaning and sometimes contradictions of the replies collected.

ACORD in Tanzania underwent a very intensive reflection process in 2003, involving all the staff involved in the HIV&AIDS work and invited community members. The process of learning through reflection and discussion was spread over a five-month period, and included a workshop and two round table discussions. In 2004 ACORD then undertook a knowledge, attitudes, practice, behaviour change (KAPB) baseline survey, and conducted face to face interviews to provide pre-SS training information, which would allow follow up post SS training after 6 and 12 months. Their evaluation processes were based on participatory methods to ensure ACORD could hear directly from participants what the training meant for them and what changes they attributed to the experience of SS training.

**Reviews using a range of different methods**

Two reviews used quantitative methods supported by qualitative data: the work led by MRC in the Gambia in 2002, and the on-going research by Rachel Jewkes and her team in South Africa.

The Gambia review and report is probably the most widely known to date of the SS external reviews, carried out under the auspices of MRC. It was done by a group of agencies and individuals, including external consultants, and used a wide range of methods. Two SS villages and two control villages were carefully selected after matching them statistically across a range of criteria to ensure they were in fact closely comparable villages. They then carried out 84 interviews and focus group discussions. They administered a KAP survey to 25% of adults, randomly sampled, at three different points in time, using questions that had been validated by use in other studies e.g. by AIDSCAP (of FHI), UNAIDS, Global programme on AIDS and other agencies in West Africa:

> *The question guide covered village structure, implementation of the intervention, knowledge acquired, changes in health-seeking behaviour, changes in condom use and supply, reasons for non-participation, and overall impact (Gambia report).*

In addition they observed groups and SS participatory workshops, and monitored condom supplies. The report compared and contrasted the control/non-control villages, ensuring that self reported behaviour was clearly highlighted. They saw what changes did/did not correlate with undergoing SS training, and where possible they triangulated findings with other evidence such as take-up of condom supplies. The data was analysed by both sex and age, reflecting the SS peer groupings.

Rachel Jewkes and her team published their mid-way findings on South Africa in a peer-reviewed journal, a rare example of this in relation to SS[15]. While publication and peer review count highly in the public health field, most NGOs do not publish their review findings in journals, nor do they (or most donors) see this as especially important.

The Jewkes methodology was as follows:

*A cluster randomised controlled trial (RCT) conducted in 70 villages in rural South Africa. A behavioural intervention, Stepping Stones, was implemented in 35 communities in two workshops of 20 men and 20 women in each community who met for 17 sessions (50 hours) over a period of 3-12 weeks. Individuals in the control arm communities attended a single session of about 3 hours on HIV and safer sex. Impact assessment was conducted through two questionnaire and serological surveys at 12-month intervals. The primary outcome was HIV incidence and secondary measures included changes in knowledge, attitude and sexual behaviours. Qualitative research was also undertaken with 10 men and 10 women from two sites receiving the intervention (one rural and one urban) and 5 men and 5 women from one village in the control arm. They were interviewed individually three times prior to the workshops and then 9-12 months subsequently.*

The findings of the whole trial, which used part but not all of the SS elements, will be available later in 2006.

The Ethiopia review undertaken by Bhattacharjee and Costigan for SCF in 2005 looked at the SS programme run by SCF in Harar and came up with a number of pointers towards improving the methodology for evaluations in future. These included getting absolute clarity on the goal of the project at the start, doing a baseline survey and needs assessment before starting to understand where the most vulnerable groups are, and collecting data widely, ensuring the data is not reliant on self-reported behaviour but is corroborated by external data. So they recommended collecting

*sentinel surveillance, records on STI, VCTC, and AIDS-related hospital bed occupancy … to develop an overall picture of the seriousness of HIV and AIDS in Harar. In addition, factors enhancing risk would be identified, and HIV vulnerable sub-populations and 'hot spots' identified and mapped. (SCF report 2005)*

Priorities should be set at the start for the programme – including identifying who is most at risk, who is not being reached and how to maximize the returns on the efforts made. Clarity about the expected results - framed in terms of the reduction of risk and vulnerability – and how these can be measured should be established at the start, along with clear M&E tools; these would then help to think through which activities would meet the specific goals within the budget and timeframes. Ideally, the authors say, while monitoring should include biological baselines and measurements, these are costly and raise ethical issues and are probably well beyond the reach of most implementing agencies. Donors may ask for such information but may not be willing to fund their collection, or support the training needed for staff to do it. However, proxy indicators can be used to suggest a reduction in the incidence of new HIV infections, for example, a reduction in the level of new STI infections. Tracking change in risky behaviour in the general population or identified sub-populations can be undertaken: 'for a small project such as in Harar, the NGOs concerned (SCUK Ethiopia and OSSA) may be contented with risk behaviour reduction and vulnerability reduction indicators' (these were carefully defined for this area).

The authors stressed the need for process monitoring along with impact monitoring and noted that Stepping Stones as a tool does encourage adult learning and reflection on change during the process. It is critical to monitor the process because it has a major impact on the likelihood and sustainability of behaviour change:

15 R.Jewkes et al, 2006, op cit.

*Some of the sessions within the manual can be used as monitoring tools. Sessions on ideal and reality, loving and non-loving relations, joys and sorrows of sex can be used both to establish baseline and for concurrent monitoring. Again as mentioned earlier the session on Special Request can also be used to monitor both the process and impact. (Bhattacharjee and Costigan report to SCF 2005)*

**The need for clarity on expected changes and possible measurements of change**

Many of the reviews highlight the need for clarity on what changes are expected/being sought as a result of using SS. What are the critical issues being addressed in any particular context and with each peer or target group? What is SS intended to achieve? What have been the unexpected/unintended consequences of the SS training? These questions can be answered by the participants in SS training and developed together in participative ways; they may also be answered, initially anyway, by those introducing SS into a community, recognising they may change as knowledge of the challenges and problems deepens through the training.

Several of the SS programmes reviewed were rather unclear about their specific objectives, they had wide ranging and often broadly defined goals within the overall aim of reducing the spread of HIV&AIDS and improving the ability of communities and individuals to cope with it. Almost all were implemented without any baseline information. A few had specified the goals more clearly, for example the promotion of inter-family communication, reaching specific target groups, encouraging certain physical prevention methods, or reducing stigma. Overall, the wide ranging aims and the lack of clarity about what kinds of knowledge or behaviour change are specifically needed or being sought makes it hard to undertake clear evaluations. While some have addressed the problem of the lack of baselines through the use of control groups, many have not. A few reviews established control groups, though some social scientists question the ethics of control group work on issues such as HIV&AIDS[16].

Most participatory reviews encourage the participants to define the issues of importance to them and the changes they valued in their own words, some provide a range of questions and issues for participants to respond to. The World Bank study of SS in Mozambique used the UNAIDS 16 point list of benchmarks/indicators against which to assess behaviour change methodologies - again these are very wide ranging and diffuse (see Appendix 4). Only a few projects and evaluations defined more precisely what kinds of changes they were looking for and why.

For example, the Gambia review focused specifically on knowledge about STIs and HIV - especially among women - and the actual uptake of condoms, while also looking for increased dialogue on sexual issues and supportive male behaviour within households. The proposal to SCF suggested evaluation focused on how far the key risk factors had changed, exploring the physical risk factors that increase the chances of infection (many sexual partners, no condoms etc), and the key vulnerability factors – i.e. the social relations, the cultural and political contexts that affect behaviour and lead to risky behaviour if they are not addressed. These latter include norms and laws pertaining to issues such as domestic violence, female genital mutilation, ‘conjugal rights’, sex work, wife inheritance and alcohol/drug use. These risks need to be defined in each context to focus attention on what the real physical and vulnerability risk behaviours are, which group takes which risks, and what needs addressing in order to enable people to take fewer such risks.

The ACORD approach, in contrast, is trying to promote a very wide range of changed attitudes and behaviour around women and gender relations, including increased respect for women and less domestic violence; increased decision making outside the home; as well as increased condom and VCT use to enhance prevention. For PLWHA they aim to promote increased representation in local decision-making structures, and for broader gender and HIV&AIDS issues they want increased interest and involvement by local officials. They are looking for increased capacities within communities to enable them to cope with HIV&AIDS. While all these factors are inter-related and affect the ability of individuals and communities to prevent and better manage HIV&AIDS, finding ways to assess how far such diffuse and complex changes have taken place remains a challenge. Their report on the two-year M&E process they have been involved in, funded by Comic Relief, will be out later in 2006.

Biological markers are used in some cases and do provide concrete data about the sexual behaviour of those tested, but they are costly and raise ethical and practical issues. Reviews

16 Problems with control groups can be addressed if there is sufficient time and money to ensure they receive adequate knowledge and training after the review is finished, but lack of resources makes this difficult in most contexts.

considering these as indicators also look for other markers, such as the rise/fall in STIs reported at clinics, an increased use of services and VCT, who is occupying the hospital beds etc.

How far the project should set indicators or markers for change in advance of the SS training, and how far the participants and trainers should set them and change them during the SS process remains a point of debate. For some external observers, worried about the lack of existing evidence of impact of SS, the preference would be for some clearly defined, appropriate behaviour changes to be monitored; others, especially those working with SS, often prefer the required changes to emerge during the process, and to be shaped by the participating women and men themselves. Prevention – and indeed HIV&AIDS - are not necessarily the first priority of communities; their concerns often focus more widely on sexual and reproductive health issues, and issues such as poverty. Responding to and meeting their needs can take the SS training away from the focus many public health workers have, which is primarily on whether SS helps to reduce the spread of HIV&AIDS.

Some of the reviews, and discussions around them, focused on the need for targeting high-risk groups rather than tackling the issues in the whole population, given the nature of the epidemic. The WB argues that targeting is more cost effective and saves working with many people who are at low risk. Others hotly dispute this functional approach and argue for the need to equip all communities to manage HIV&AIDS given the prevalence of the disease, especially in Africa.

Either way, more clarity is needed in some of the programmes about which groups are being targeted and why, which groups are hard to reach and why, and how to work with the most marginalized including the disabled[17], people from minority ethnic or religious groups, refugees/displaced people, PLWHA and so on. Some projects have focused especially on sex workers, usually female, but have not easily been able to reach the men who come to them. Some- very few- have explicitly targeted couples, believing this enhances the chances of sexual behaviour changes within partnerships, although to date the numbers are small and the assumption is hard to test.

Interestingly, while SS is explicitly a process for empowering women and shifting the balance of gender relations, few reviews set out to analyse where the key problems for women lie, what their major barriers to access and control over key resources are, what their role in household and sexual decision-making is, and how far these have changed post SS; these of course form a central part of the analysis groups undertake during the training. While there were certainly self-reported findings around a reduction in domestic violence, an increase in household task co-operation, and increased sharing of household budgets, these are often framed in broad terms and the exact patterns of change in these critical areas and how many underwent these changes in the short term, remain generalised. There has been only one longitudinal study in Uganda, and that is small scale and self-financed (Baron Oron).

While mention is repeatedly made of the need for SS to change attitudes towards PLWHA, through addressing stigma and discrimination, and increasing the care for them in the community, few evaluations have focused specifically on the views/experiences of PLWHA (though the Uganda video, 2006 does have testimonies from PLWHA) in the SS process, and few have really explored what kind of care is increasing in the community, and how sustainable it is. There is still a heavy reliance on self-reported behaviour change soon after training has finished, with little evidence that positive people are even being asked specifically for their views at this stage. There is almost no real follow-up through observation, visits, and longer term studies in the community.

There is only limited evidence of reviewers trying to triangulate self reported behaviour changes, through for example home visits, looking at clinic and VCT records, checking condom distribution (which is anyway not the same as use) and so on. While the need for triangulation with biological data is not advocated by most, there is a need –stressed in a few reviews - for more systematic cross checking of reported changes to corroborate people's perceptions of change. Having said that, visitors to places where SS has taken place often do report being aware of a wide range of changes, including an increase in caring, a decrease in stigma and evidence of women's growing confidence and leadership. Observers do see an excitement around the SS process and evidence of new attitudes, though this is not systematically recorded.

A wide range of 'unintended consequences' have been reported by those using SS and by participants, including a decrease in domestic violence, greater respect for each other, more sharing of household tasks and income (men apparently sharing more than women economically in the household), better parent-child relationships and communication. While these could be expected in a programme designed to address issues of respect, communication and relationships, they are often not explicitly part

17 VSO has done some interesting work around disability and HIV&AIDS in a workshop for southern Africa, held in Namibia in 2004.

of the purpose of SS and are defined as unexpected benefits. The changes are often simply reported as quotes, without further investigation or questioning of how and why these changes came about, how many shared the change experience, and whether it was lasting.

The many quotations and the consistency of these reported findings deserve more detailed attention in future, perhaps through the collection of in-depth case studies. For the moment many of these changes are encapsulated in quotes in various reports. There is clearly a wealth of lived experience and first hand knowledge of SS that motivates people who have worked with it and been involved in different ways, though this appears often more related to broad changes in communities rather than specific changes in sexual behaviour reducing risky sex.

While short term changes are certainly important, and widely reported, especially around protection, prevention and care for those with HIV&AIDS, many implicit changes expected from SS are long term and involve major shifts in cultural thinking and practice, e.g. around the roles and responsibilities of women and men and changes in the status and value of marginalized people. These might be expected to take a longer time to evolve and they have not been examined to date.

Section 3

# KEY FINDINGS

Synthesising the results proved difficult because of the wide range of purposes for SS, the different methods used for evaluation and the diverse styles of implementation and recording. In many cases the reviews are not comparing like with like, for example the implementation of SS with youth only in SA research, under controlled conditions, is very different from the holistic approach to HIV&AIDS and community competence undertaken by ACORD in East Africa. Also the way SS has been used has changed significantly over time, and as new issues have become relevant, it is hard to compare evaluations of these with the early findings.

### 1. The spread/coverage of SS

Only a few reviews even refer to the issue of spread/coverage, but the figures given in those cases are significant. In Uganda in 1997 the survey indicated that 22,400 adults had been through SS training, the majority of whom were women. The WB estimated that AAI in Mozambique had reached 500,000 over the four years from 1999-2003, while in Zambia the coverage was 3,500 young people and over 100 adults. In the same year, 2004, the Malawi training reached 1,150 teachers and SS was to be rolled out across the entire primary school sector, reaching 55,000 teachers in 2006.

For those reviews that provided figures the coverage appears extensive and the numbers of those involved high. For most, though, there are no data.

### 2. The reasons for introducing SS

The reasons for introducing SS were – as already discussed- varied. In Uganda the focus in 1997 was on addressing the vulnerability of women and youth to HIV&AIDS, in Ghana in 2001 the work was especially designed to support the opening of a new clinic to ensure demand was high for HIV&AIDS services. In the Gambia in 2002, the MRC researchers were convinced of

*the need for context-specific STI/HIV prevention programmes.... Evidence suggests that successful programmes need to equip participants with life-skills and promote self-efficacy, using face-to-face techniques (Kamb et al, 1998; Shain et al, 1999; Celentano et al, 2000). The Cairo Programme of Action (UNFPA 1994) supported the development of innovative programmes that serve the needs of women, and enable men and women to share and accept responsibility for the prevention of STIs. Yet many sexual and reproductive health interventions and services are directed specifically towards women (Hawkes and Hart, 2000). Ideally, an intervention should work with the different concerns and requirements of both men and women, whilst empowering the latter to realise their full social, financial and health potential. Few programmes that succeed in achieving these aims have been described (Gambia, 2002, p4).*

They wanted to illustrate the effects of the approach, especially because while there was low HIV&AIDS prevalence there was evidence of growing rates of STDs e.g. syphilis, and they recognised an urgent to reach 'out of school' kids and those without radio access.

In Mozambique the aim was to widen AAI's work on HIV&AIDS and to contribute to building community cohesion after the floods, while in Zambia in 2004 good knowledge about HIV&AIDS was seen not to be translating into behaviour change around sex; condoms were poorly used and the implementers saw a need to bring peers, family and community together to make changes rather than focusing only on individuals. Working together and working things through for themselves were seen as key. In Malawi the focus was directly on changing the behaviour of primary school teachers, in their personal and their professional lives, to enable them to support children in their education work, in and out of school.

The ACORD work was focused on reducing the vulnerability of young girls and women, seeing if SS could radically address gender relations; they defined gender inequality as fuelling the epidemic. A similar motivation was seen in Mumbai where the WCHP wanted to include men in the HIV&AIDS work to ensure that there was the chance of real change for women. In the SIPAA review SS was seen as a key tool for mobilising communities both to change their behaviour and prevent the spread of HIV&AIDS and to make demands on the new services being introduced, to ensure governments were meeting the needs of populations. Without

education/training many rural people especially find it hard to relate to and make demands on government services and staff.

**3. The quality of the implementation of SS**

The early reviews especially focused in part on assessing the quality of the way SS was used. In Uganda (1997) they found 64% of those receiving the SS materials used them; others could not because of lack of time and resources. Some used only parts of the manual, and some could not use the video because of their lack of equipment and electricity. It proved hard to have review meetings after the training, and groups that wanted to go on meeting were struggling to find ways to do this.

Some of the common themes around the process – from this and some other reviews (including Mozambique, Uganda, Tanzania, Zimbabwe) - were:

- Many people enjoy the SS process; it provides space for discussion and reflection, the ice breakers and methods such as role play are often fun
- The participatory work is highly appreciated; people enjoy the chance to explore their own issues in their own ways and it enhances their sense of control over their lives
- Many trainers experience changes in their own lives with raised self esteem, greater confidence, more tolerance, fewer partners for sex and more use of condoms
- More support and supervision is needed by some facilitators
- Some find the process over-structured
- Some participants find the explicit sexual language difficult and challenging, and especially in joint group working care has to be taken to address sensitivities around sex and relationships
- Only a few use the whole package; often the video cannot be used for logistic reasons, or is found to be culturally less appropriate; the resources needed for the full course are many, especially time
- Attendance fluctuates, with people often managing only 30-50% of sessions
- It is not always possible to run separate age and sex groups because of a lack of appropriate facilitators
- There is almost always a call for more topics to be covered and materials to be available to take away (these are not part of the SS package)
- Simple, practical methods for M&E of participatory approaches to SRH are needed
- Special adaptations are need for sex workers (India) and to ensure local relevance
- The inclusion of men is highly appreciated
- Some reviews are concerned about the quality of the facilitators, others have excellent ones
- There is little follow-up and continuity after the training, and the lack of groups meeting after the end of SS was a common concern
- Tensions between women and men and different age groups are not always solved, and inappropriate messages and beliefs can continue post SS
- It is not clear how misinformation or negative views held by one or more groups are resolved in the community workshops
- Sometimes attendance among men is better, sometimes among women; but overall involving men is seen to be the greatest challenge - they are encouraged if the training includes issues of concern to them, such as a focus on preventing infertility (Gambia)
- Adaptation is essential for different contexts and cultures, but it is important to keep the concept of the sequence of SS and the integrity of the model (India). It is not an a la carte menu, though some use it as such and pick and choose certain bits
- SS also works well for community mobilisation
- Time is always an issue; so too is location, which needs to be accessible, meetings at right times etc. There have been repeated requests to explore how/whether the process can be shortened and some do this anyway. There is not a high attendance rate in many cases with people doing less than 50-60% of the course
- Selection of participants, trainers and facilitators is a challenge and critical. There is little detailed data or learning on what makes a good trainer/facilitator, how best to support them, and the problems they face

The review for SCF produced a set of process indicators for this aspect of the work, which are included in Appendix 5. They could be used as the basis for developing future review work on quality and issues around implementation.

**4. Increase in communication**

Almost every review and discussion paper reported an improvement in communication, usually between spouses or children and parents, as a result of the SS training. This was seen

as critically important in contexts where discussing sex is difficult yet essential in the fight against the spread of HIV&AIDS. This finding was very nearly universal, so only a few illustrative examples are provided here:

> *The evaluation team was please to find that the various research tools repeatedly revealed that parents who participated in stepping-stones are now prepared and able to talk to their children about sex and HIV. This was reported by both male and female participants and independently confirmed by interviews with untrained youths within their households. Many of the youths reported heeding the messages given by their trained parents and it was also important to note that youth identified that AIDS was a threat to development. Many trained youth appreciated the skills gained in SS workshops and they felt empowered to speak freely on issues of AIDS to their parents to the extent that some could freely tell promiscuous parents to use condoms and avoid multiple partners (Zimbabwe 2000).*

In India WCHP reported that women shared very personal experiences with each other. They discovered shared similar experiences around sexual harassment, their lack of choice in sex, and constrained roles in decision-making. The listening exercises made men realise that they rarely listen, and enabled people to explore sex and relationships and discuss safer sex across the male/female divide.

For the Gambia,

> *consequences reported from both villages independently included: more dialogue between couples, better communication skills, less quarrelling, acceptance of a wife's refusal to have sex, less wife-beating, increased provision of money for fish and condiments by the husband, safer sex outside marriage and awareness of STIs. (Gambia, 2002, p.11)*

In a published article reviewing participatory approaches to HIV&AIDS [18] the author said that

> *it was clear that the programme had had an impact, particularly on communication about sexual issues both in general and between men and women. The analyses we have undertaken identified three primary areas of change: risk awareness, condom use, and dialogue within marriage. Information acquired during Stepping Stones was viewed as more meaningful than from other sources: the participatory process seems to give greater credibility to the programme as a source of information (Kesby, p25)*

In the review for SCF in Ethiopia,

> *this review confirms that SS has very real strengths as a community mobilization tool and addresses the context in which sexual decisions are made. One of SS most valuable contributions is that it reaches men as sexual decision-makers, and provides time and space for them to reflect. The power of this is evident from the commitments that older men have made in Harar to eliminate wife inheritance, female circumcision, reduce alcohol consumption, and violence against women. The importance of such a contribution cannot be overemphasized. (Ethiopia review, 2005, p29)*

The weight of evidence here is strong.

### 5. Changes in knowledge and attitudes

Most reviews report positive increases in the knowledge and understanding of HIV&AIDS, its causes and how to prevent its spread; many of the findings of the different reviews were similar and supported the view that SS does contribute to changes in knowledge and attitudes around sexual behaviour, gender relations, and those affected by HIV&AIDS.

18 Dr Mike Kesby, Re-theorising empowerment through participation as a performance in space: beyond a theory of tyranny to a transformative praxis Development and Change, School of Geography, University of St Andrews, Fife, Scotland KY16 9AL

Most of the evidence gathered, however, is self-reported and the findings are often presented in a generalised fashion. Only a few evaluations qualified their findings and clarified who had/had not learned and understood the correct information, and said that for some new attitudes were tempered by continuing external pressures. One example was Zimbabwe where the details of what attitudes had changed and for who were carefully presented:

> *Among trained people there remained however some harmful areas of poor knowledge: (a) some young men's belief that HIV can only be transferred if one ejaculates, (b) many people's continued conflation between HIV and AIDS and the proposal that those with HIV can be identified by the way they look, (c) a few people's belief that sleeping with a virgin can cure AIDS and (d) the persistent belief among some women that the lubricant in condoms has the HIV virus (e) you cannot use a condom with a virgin (f) some STDs increase sexual vigour (h) while youth were aware that substance abuse puts you at risk some still believe brandy prevents ejaculation. In addition it should be remembered that previous academic work (Kesby, 2000) has suggested that improving knowledge is only one element of the struggle against HIV, and that the crucial factor is finding ways to facilitate people to act on their knowledge. This view is consistent with our KAP survey results that showed that all peer groups had a good knowledge of condoms but that few individuals used them. (Zimbabwe 2000)*

The other reviews that were also written up systematically relating who had and who had not been able to change and why (Zambia, Gambia for example) showed that while there were some clear trends, e.g. women who knew less have learned the most from the sex information, these were not uniform and some negative attitudes and behaviours persisted in some groups, for a range of reasons. The exceptions and the problem areas are not explored in most of the evaluations, making it hard to see whether it is women who benefit most from knowledge across the board, who is not enabled to change and why, and what wrong information/ideas persist.

Few explicitly explored the role of SS in changing attitudes towards PLWHA, though many talked of more caring and respectful attitudes and an increase in the provision of care. There was little evidence of PLWHA being interviewed specifically for their views and experiences of SS. Many of the reviews talked of improved attitudes towards women and the status of women in the community, and some gave examples of women moving into leadership positions or speaking at public meeting, though these examples do not appear to have been analysed or worked on in depth, and how many benefited in what ways is usually not clear.

While negative elements in culture are addressed, there has been some concern expressed that SS does not focus enough on the positive elements in any culture that do support attitudes and knowledge that enable people to minimise their risks, and work more supportively together.

### 6. Changes in behaviour – around sex and gender

The findings on behaviour change were strong, with most reviews referring to positive changes in behaviour such as a greater take up of condoms, more respect for women, less domestic violence, respect for women to refuse sex within marriage, better communication between couples and parents-children, and more co-operation around household chores and income. The caveats to these findings are that again they are often rather generalised, based on self-reporting or observation soon after trainings end, and the changes are not explored in any detail. Sometimes though they are verified by reference to other sources such as condom distribution figures, local court proceedings, talking to outside observers and key informants, and sometimes not.

On the very positive side, for example, one year on in Gambia:

> *Consequences reported from both villages independently included: more dialogue between couples, better communication skills, less quarrelling, acceptance of a wife's refusal to have sex, less wife-beating, increased provision of money for fish and condiments by the husband, safer sex outside marriage and awareness of STIs.*
> *Thematic analysis of the data from focus-group discussions and in-depth interviews showed that participants enjoyed the programme and had found the content relevant. (Gambia 2002, p.11)*

Similar findings were reported in the Zimbabwe study, although there was caution and the findings were nuanced; not every finding applied to all participants. Some were coping with difficult economic circumstances and continued risky behaviour:

> *The UAN participatory rural appraisal report suggested that the level of promiscuous behaviour was "shocking" including by married women. Commercial sex work and sugar daddies/mummies were seen as very common phenomena and on the increase. This phenomena [sic] was reported to be on the decline in the community but continued to be rampant at Mbalambala. Promiscuity declined because most men had changed their behaviour due to fear of AIDS, reduction in beer drinking parties, and because of the economic situation most men were unemployed hence now lived with their wives in the villages. This was reported to have increased marital union sex and further more use of income within family. Semi-structured interviews revealed hidden levels of promiscuous behaviour as some women in desperate situations were no longer openly soliciting for sex but had discrete regulars including some trained married men highlighting that poverty and drought are challenges that might affect SS gains. Youth were worried that adults no longer acted as role models for children in terms of their sexual behaviour as they fend for their families. (Zimbabwe 2000)*

The important and almost universal areas of change identified in the Zimbabwe study, which worked hard to triangulate findings and minimise reliance on self-reported behaviour, were a positive rise in risk awareness, condom use and dialogue within marriage. Christian Aid reviews of the SS work they support showed there was a decrease in sexual partners, an improvement in household relations and increased tolerance, a greater use of condoms and reduced violence. They have not done a long-term impact study yet but this is planned. Another study (Tanzania, ACORD) recently found an increase in the participation of women and PLWHA in community life and saw the enforcement of the rights of widows, along with greater government awareness of the issues, and stronger community structures[19].

> *Overall, the findings show strong, consistent themes including an increased use of condoms; fewer sexual partners; better relationships; less drunkenness; saying 'no' to unwanted sex; the writing of wills; more sharing of money within households; more male contribution to household chores and more women caring for sick husbands. There were reports of fewer sexual harassment cases and a rise in the age of first sex. SS was seen to be a powerful process for change. For some staff and community members concerns about condoms leading to promiscuity remained however. What is still lacking in the evidence is clarity about the coverage of these changes – who changes and who does not and why – and how sustainable they are over the longer term.*

A few of the reviews reported on the limits of behaviour change and the lack of on-going support once the training ended. Some participants did not change their ways, and a few commentators noted that while the problems of e.g. poverty and illiteracy persisted the limits of change would be real. Women need a whole range of support and services to enable things to change significantly, including the need for family planning and overcoming women's shyness about going to seek help for STIs, confidential services for VCT, and support for women and men telling the results to their partner. While most reviews did not tackle the wider context, a few did note the need for better services- health and education- for women, appropriate drugs and good access to drugs, ways to address poverty, and more responsive government support structures for women and PLWHA if lasting change was to be secured.

For some donors/public health observers the critical question remains: has the introduction of SS led to a decline in the spread of HIV&AIDS? The evidence collected does not allow that question to be easily answered, although the findings indicate positive behaviour and attitudinal changes that certainly do relate to limiting the spread of HIV&AIDS. The challenges of trying to tie participatory interventions aimed at behaviour change and long-term attitude change to figures on the spread of HIV&AIDS, however, are many. Multiple factors are important in enabling prevention to take place including for example good health services and the availability of reliable VCT, economic empowerment for women, and positive government support for work on HIV&AIDS. Many NGOs question anyway whether this single public health measure is the appropriate yardstick for

19 S. Amoaten, ACORD: responding to HIV and AIDS, ACORD, Tanzania

assessing a participatory approach such as SS when so many factors contribute to effective prevention on the one hand and SS is about far more than prevention on the other. In addition, donor/agency requests for evidence are always short-term, while these changes may take a long time to become evident enough in communities to feed into government statistics.

The data on SS contributing to behaviour change is strong, yet it is important to say that more could be done to triangulate the information gathered, which is often self-reported, with a range of data available in the community. Too few resources so far have been put into finding observable changes locally that can confirm the findings largely obtained through self-reporting and short-term observation.

**7. Other reported changes**

Other reported changes include practical actions such as the writing of wills, continuing work in peer groups (there was little evidence of this happening though it was a widespread aspiration), better sex life, less drinking and less sexual harassment.

Areas where SS has little impact or has less to say are issues such as poverty and illiteracy, something of concern to some observers. The significance of poverty in promoting risky behaviours, especially for women and girls, is well known. It is not clear from the reviews how far those working with SS try to link up with others working on issues such as economic need and female literacy, although the ACORD approach is clearly rooted in a holistic analysis of what enables/disables women and men to change their behaviour including poverty, disempowerment and lack of voice in policy.

Some negative effects were reported, for example in some cases those trained in SS felt superior to those who had not been, and there was limited evidence of those with training working to enable others outside the group (except their children) to benefit as well. Some observers saw boys using their new skills to woo girls and get their own way with them without resorting to violence, knowing now how to make them feel valued because of their SS training (Uganda 1999).

While there was a decline in the sale of sex in some places it was still prevalent in others and not all women and girls could insist on condoms because of the loss in earning this can cause. While one study found a decline in wife inheritance (a major risk factor in the spread of HIV&AIDS) condom use did not rise (another major risk factor). Harmful beliefs persisted according to some reviews, and new knowledge still did not enable many to change their behaviour because of other factors in their context (Kesby 2000). The uptake of condoms seemed variable, higher in some studies, lower in others.

**8. The quality of the evidence available**

The evidence is there, and relatively consistent across the different studies whatever methods were used, and the findings are positive about the changes SS can promote at individual and community level. But with a few exceptions the data remain generalised, coverage and reach is unclear, and the evaluations lack detailed analysis. The conclusion to the Zimbabwe study seems appropriate 6 years on:

> *As UNAIDS best practice SS could prove to be one of the most effective community-based interventions to prevent STIs, fulfilling the ICPD objectives, because it involves men. Further evidence, on a larger scale, and over a longer period, needs to be generated to determine whether this is the case (Zimbabwe 2000, p.26).*

This was echoed in the WB study, which said that M&E is weak across the board. There are data available and some of it is strong, and the trends are certainly clear. But for a methodology that has been so widely adopted the evidence collected seems piecemeal and short-term, and the richness of how, why, where and when SS works as an effective HIV&AIDS prevention tool, a tool for gender equality, a community mobilisation tool, a tool for individual and community empowerment and to promote the rights of PLWHA remains relatively unexplored. The documentation clearly does not reflect the wealth of learning about the experiences of using SS over the last 10 years for any of the implementing agencies and this needs rectifying.

Section 4

# THE RELEVANCE OF THE FINDINGS FOR FUTURE EVALUATION WORK

## Some of the critical factors affecting the quality of SS reviews and the validity of the findings emerging from this review include:

- A lack of good on-going monitoring on which evaluators can build their work
- The lack of clarity about what issues are central to each context and why SS was seen as the right approach to address these
- The lack of baseline data
- The lack of data on the costs of the training, the length of time required, whether it is on-going or finished, what follow-up
- The lack of analysis of the quality of the SS training process and how that directly relates to the changes later identified (or not)
- The balance between accountability to participants, facilitators and donors
- Fitting the M&E to the specific purposes of SS in each context, while looking for comparative material where possible
- The degree of independence of the review process and whether those commissioning evaluations have a strong agenda that affects the final reports/discussions on the findings
- The skills, the quality and rigour of the work, and the quality of final analysis and reports all need to be strong whichever methods are used
- The need to situate SS within the wider political, cultural and service support context to understand its role and relevance
- A better analysis of the pros and cons (including cost, ethics, feasibility, intrusiveness, time, skills) of different methods for evaluation
- Better co-ordination and dissemination of the findings across evaluations.

The most informative and detailed reviews (most especially Gambia and Zimbabwe, also Zambia, Uganda, and the early reports from ACORD) used very different methods but were carefully recorded and written up, explored trends and exceptions, raised unexplained findings and nuanced the results with care. They were time-consuming and costly processes all involving external players, including academics. This is not the norm for evaluations of NGO work at the moment, or indeed of SS evaluations, and could not perhaps be widely replicated. But they do indicate that the methods used might matter less than the rigour, independence and quality of the review work.

## Recommendations for addressing current emerging concerns include:

**When SS is introduced there needs to be clarity about why,** the problems it is designed to address, for whom, and how it fits into the wider context of people's lives. What elements in the context will support positive change and what are the barriers, external to the SS process, that need to be taken into account? **A baseline** needs to be collected clarifying the current context so that changes can later be compared with this.

**When considering M&E it is important to be clear who needs what information**, how it can best be collected, who can fund it, who is the best team/individuals to do it and what measurement tools are most appropriate, given the purposes in each case.

**More resources need to go into monitoring and evaluation**, to ensure a build-up of learning and knowledge from the grassroots experience to feed into modification, adaptations and policy work around HIV&AIDS prevention and mitigation. The nature and quality of the SS training needs to form part of any review, given that the outcomes will probably be related to the way the process was implemented; if not that would be a very interesting finding.

**Monitoring skills need to be prioritised and developed**, with trainers, facilitators and staff implementing SS, and the results of monitoring need to be collected and analysed by HIV&AIDS teams, both for using in evaluation and for sharing with others working in this area. They need to be accessible to others working in this field wherever possible.

**All evaluation reports need to meet some minimum standards** of describing the programme, presenting the key aims, the budget and basic costs, the implementation process, the methods used and why they have been chosen and the key findings- with overall trends and exceptions, coverage and reach, and where possible who benefited most and how, and who benefited least and why.

**A range of methods should be used**, especially establishing baselines and including revisits to old sites 3-5 years after SS has ended; case studies/ethnographies in one community exploring how SS affected the lives of those attending and what changes were possible or not and why. Existing evaluations could be used as baselines for this work. More use of participant observation, triangulation of reported change, social surveys, and group reflection can be used to deepen and widen the evaluation data available. These will amplify and complement the existing evaluations and the ones about to report including Concern Gambia, Acord's three-country study and the randomised controlled trial of Rachel Jewkes et al in South Africa.

**There needs to be an open, accessible means for the storing of M&E** on SS, that is well publicised and available to all. This poses challenges because of the range of organisations involved, and therefore may not be solved through a single site – but every implementing agency should make much more serious efforts to publicise and disseminate the M&E data they have or produce.

**Overall it is important to ensure there are ways to learn from experience and sharpen the use of SS by recognising and addressing the following issues:**

1. ***There are so many purposes for the use of SS and for the evaluations*** done to date that generalising is hard. The various purposes need to be grouped and learning shared across these, so that its role in e.g. addressing prevention can be assessed, the issues around SS as a tool for promoting changes in gender relations, enhanced communication, reducing violence, addressing stigma can be better understood and learning can be shared across countries around key issues
2. ***There is a range of methods to use including*** medical models of controlled trials, before and after questionnaires with verified and tested questions, drawing on models tested by others (such as the GEM scale or the behaviour surveillance surveys of FHI, or the in-depth research work of scholars, such as S. Paxton[20], and the work of others doing participatory work around HIV&AIDS), in depth case studies (not really well used yet), and a whole range of participatory methods undertaken by people situated differently in the process. Reporting and analytical styles need to be improved, as do the overall quality, time spent and depth of the reviews
3. ***The motivations and whom the learning is for*** vary widely, even within the participatory approaches. Sometimes the purpose is to enable communities to see what they have achieved, sometimes it is for agency M&E purposes to ensure future work is based on real learning, sometimes it is to promote the value of the methodology, sometimes for accountability to donors for funding. The purpose (or purposes) needs to be clear.
4. ***The ethics and efficacy of different methodologies*** – e.g. the degree of intrusion, the extractive nature of reviews, the empowerment (or not) of the M&E methods themselves, the appropriateness of controlled trials, what constitutes adequate evidence in relation to addressing the spread of HIV&AIDS etc do not appear to have been deeply explored yet. There is no agreement about the critical questions to be asked, nor what a methodology such as SS needs to achieve in order to be widely accepted as a useful approach across all stakeholders. There is need for much more debate across the HIV&AIDS sector about the critical issues SS is addressing, how best to assess the different purposes it is used for, and what level of evidence is

20 The GEM scale work in Measuring equitable gender norms for HIV/STI and violence prevention with young men: Development of the GEM Scale, Julie Pulerwitz, ScD, Horizons Program/PATH and Gary Barker, PhD, Instituto PROMUNDO. S.Paxton, The impact of utilising HIV-positive speakers in AIDS education, AIDS education and prevention, Vol 14, No. 4 2002 and her manual on lifting the burden of secrecy on the website of www.gnpplus.net/regions/asiapac

enough to ensure future funding.

5. ***There is a sense that for some external observers (including donors) quantitative, controlled trails are more valid***, while for those focusing on behaviour change and empowerment, participatory methods owned by communities make most sense. The apparent degree of hostility/competition between the different approaches needs to be replaced by looking for areas of complementarity, recognising the diverse nature of the findings yielded by different methodologies
6. ***Almost no reviews to date situate the work on SS in the wider cultural and political/economic contexts***, yet these play a major role in shaping outcomes: future evaluations must include recognition of them.

The review threw up some interesting questions and findings that can be used to guide future decisions about how best to review SS and other participatory approaches to HIV&AIDS.

- Do the different methods lead to different findings or not? The work so far indicates that there is a convergence of findings between the different methods, with as many differences between those gathered by participatory methods as those between qualitative/quantitative methods. This can be explored further when the three new sets of reviews (Concern in the Gambia, Jewkes in SA and ACORD's 3 country study) are added into the mix. The crucial ingredients for sound reviewing may lie less in which methods are used and more in using the most appropriate methods to a high standard and undertaking critical and detailed analysis and writing.
- Comparative costs - some evaluations are done quickly, on low budgets and written up in easily accessible language for those participating; some are extensive, costly, time consuming and written for those expert in English and even academic language. How comparable are they, which kind of review is most appropriate when, and where is the funding for this essential work to be found?
- What costs, time and degree of independence of reviewers are acceptable/needed to ensure that the findings have the confidence of both those involved – facilitators and communities/participants - and external players? What funding is actually available for this work, in a context where reviews by e.g. DFID/EU are now often done in 7-10 days even for multi-million pounds projects (e.g. SIPAA and an EU disability programme in Kenya)? How does SS review work fit with current donor M&E trends and practices, where the current focus is on huge budget programmes, with less attention to projects?
- Can findings in one place be generalised to another given the major factors of context, political will, culture, gender relations, service provision available which enable/inhibit changed behaviours? The lack of generalisation possible needs to be compensated for by collecting a wide range of sound M&E data on the use of SS in multiple contexts, continents, and with a range of target communities and groups.
- AAI and others now espouse a rights-based approach to development. More thinking is needed about how a rights framework shifts and changes the questions that need to be asked of SS. A rights approach may result in a shift towards seeing how far it is enabling women and men to lead healthy lives, able to access key services and resources, and to ensure their voices are heard in policy and implementation fora. A rights approach might take the focus in a different direction to some of the current concerns around e.g. whether SS leads to an uptake in condom use.

#### Into the future

It is hoped that this review of the existing publicly available M&E data on SS will contribute to the on-going debates around participatory approaches to HIV&AIDS in a number of ways. It should make a contribution to the understanding of what SS has and has not been able to achieve during the past ten years, in a wide variety of contexts, used by a wide range of different agencies. It has raised questions about how much seems to be expected of this training and how often the purposes it is used for remain rather vague and wide-ranging. The need to link the quality and experience of the training to the outcomes should by now be clear, as should the need for agencies to follow some clear minimum standards for monitoring, evaluating and reporting on this work.

It is hoped that the issue of what assessment/performance methodologies to use to evaluate participatory methods has been opened out and that in future these discussions can take place within a clear understanding of the need to link methodology to the overall purposes for, and the contexts in, which SS is being used. Above all the need for independent and critical review alongside community and agency monitoring should now be clear; this needs to be widely disseminated to promote shared learning and deepen understanding of the role and potential of participatory approaches to behaviour change. The time is ripe for several

research and evaluation programmes on these approaches to enable communities, NGOs, donors and public health agencies to understand the value of committing resources- time, staff and money - and what the likely benefits of working participatively around the challenging personal and public issues of sex and gender relations will be.

# Appendix 1

## Examples of the adaptation and spread of Stepping Stones

This is certainly not a complete record, but gives an indication of the spread and use of SS globally. In each context SS is being used in a wide variety of ways with different groups, so for example in East Africa CARE uses it with IDPs, GOAL with community based facilitators, National Union of Disabled Persons with the disabled, Plan International with PLWHAs and AAI with a wide range of groups including religious leaders (Christian and Muslim) and settled and pastoralist communities.

| Country | Language | Agency |
|---|---|---|
| Angola | Portuguese + | ACORD and local partners |
| Burkina Faso | French : « Parcours » + | International HIV/AIDS Alliance and local partners |
| Burundi | French : « Parcours » + | ActionAid, International HIV/AIDS Alliance and local partners |
| Cameroun | English and French + | Cameroun Women Doctors' Association |
| Ethiopia | English + | ActionAid, SCF UK, AJWS and local partners |
| Ghana (adapted) | English + | ActionAid, Christian Aid, Plan, Prolink and respective partners |
| Guineau Buissau (adapted) | Portuguese + | ACORD and local partners |
| Kenya | Ki-Swahili and English + | ACORD and local partners |
| Liberia | English + | ACORD and local partners |
| Malawi | English + | ACORD and local partners |
| Mali | French + | ACORD and local partners |
| Morocco (adapted for prisons) | French | ACORD and local partners |
| Mozambique | Portuguese + | ACORD and local partners |
| Namibia (adapted for schools and university students) | Afrikaans + | ACORD and local partners |
| Nigeria | English + | ACORD and local partners |
| Rwanda | English and French + | ACORD and local partners |
| Sierra Leone | English + | ACORD and local partners |
| South Africa (adapted for urban contexts) | English + | ACORD and local partners |
| Tanzania (adapted) | Ki-swahili | ACORD, PASADA, TANESA, Adventist Relief Agency and others |
| The Gambia* (adapted) | English + | MRC, GFPA, ActionAid et al |

| Country | Language | Agency |
|---|---|---|
| Senegal | French and local languages | Alliance Nationale Contre le SIDA |
| Uganda (adapted) | English + | Acord, ActionAid, PLAN, CARE. National Union of Disabled Persons, GOAL and partners |
| Zambia (adapted) | English + | Copperbelt Health Education Project, PPAZ, VSO, Ndola Catholic Diocese, E Province of MoH |
| Z'imbabwe | English + | FACT (Family AIDS Caring Trust) |
| **Asia and Pacific:** | | |
| Bangladesh | English and Bengali | ActionAid and local partners |
| Cambodia (adapted) | Khmer | KHANA / International HIV/AIDS Alliance |
| China (based on India version) | Chinese translation and adaptation (under way) | ActionAid and local partners |
| Myanmar (adapted for communities where there is a lot of injecting drug use) | | World Concern |
| Fiji and Solomon Islands | Proposed | PRHP (Pacific Regional HIV/AIDS Project) |
| India (adapted) | English and Hindi, used in additional local languages | Indo Canadian HIV/AIDS Project, ActionAid and partners |
| Indonesia | | PCI |
| Kyrgyzstan (based on India version) | Russian (under way), with community level use in Kyrgyz | Swiss Red Cross and UNDP, with technical assistance from ActionAid |
| Nepal (based on India version) | Nepali | ActionAid and local partners |
| Philippines (adapted for use by boy scout and girl guide groups) | | International HIV/AIDS Alliance and Phillipines Girl Guides and Boy Scouts Associations |
| Sri Lanka | Singhala | International HIV/AIDS Alliance, ActionAid and local partners |
| Vietnam (based on India version) | Vietnamese | ActionAid and local partners |
| **L America and the Caribbean: (adapted)** | | |
| Argentina | Spanish | Fundación Red |
| Bolivia | Spanish: “Paso a paso” | Plan and many local partners |
| Brazil | Spanish: “Paso a paso” | UNVs |
| Chile | Spanish: “Paso a paso” | Plan and many local partners |
| Colombia | Spanish: “Paso a paso” | Plan and many local partners |

| Country | Language | Agency |
|---|---|---|
| Dominican Republic | Spanish: “Paso a paso” | ActionAid, Plan and many local partners |
| Ecuador | Spanish: “Paso a paso” | Plan and many local partners |
| El Salvador | Spanish: “Paso a paso” | ActionAid, Plan and many local partners |
| Guatemala | Spanish: “Paso a paso” | Plan and many local partners |
| Haiti | French: “Parcours”<br>Haitian Creole - proposed | ActionAid<br>Plan |
| Honduras | Spanish: “Paso a paso” | ActionAid, Plan and many local partners |
| Jamaica | English | Christian Aid and local partners, with technical assistance from ActionAid |
| Nicaragua | Spanish: “Paso a paso” | Plan and many local partners |
| Peru | Spanish: “Paso a paso” | Plan and many local partners |
| Paraguay | Spanish: “Paso a paso” | Plan and many local partners |

**Key** + equals ‘used in local language’

Table developed from data provided by Alice Welbourn, with additional information from Linnea Renton of ActionAid International.

# Appendix 2

## Documents consulted

**A. Evaluations documented for SS and who undertook them**

| Date | Title | Who did the review |
|---|---|---|
| Nov 1977 | SS TAP, feedback from users | Andrea Cornwall, IDS,Sussex and SS trainer, for SS TAP. 691 users contacted |
| 1998 | Participatory review of SS in Tanzania | SS TAP staff and 16 SS users (NGOs) |
| 1998 | Participatory review of SS in Uganda | SS TAP organised a participatory review of users at different levels |
| 1999 | SS: pilot programme evaluation. Zambezia, Mozambique | AA Mozambique, SCF UK, UNICEF |
| 2000 | Review and evaluation of the SS participatory HIV education project run by Umzingware Aids Network in Irisvale resettlement Area, Zimbabwe | I.Moyo, L. Malamane, M.Kesby (independent consultant from University of Fife), I. Tarengwa, E Chtoni. Funded by ActionAid and Umzingware |
| 2000 | A proposed article for DIP, Oxfam: SS- a participatory tool to integrate gender into HIV/AIDS work | P. Bhattacharjee, India. |
| 2000 | Adaptation workshop on SS | ActionAid India, facilitated by P. Bhattacharjee |
| 2001 | Results from Irisvale, Zimbabwe | M.Kesby et al |
| 2001 | SS life skills and sexual well-being, a desk based review: an examination of this training package, highlighting male involvement | Gill Gordon and Alice Welbourn (author of SS). Funded by USAID and IGWG |
| 2001 | Kisumu workshop on SS | Chris Ouma and Joyce Waititu, AA Kenya |
| 2001 | Experiences with Stepping Stones in the Volta region, Ghana | Tuen Bousema, Stichting Katholieke Noden (Holland) in collaboration with AA Ghana |
| 2002 | Review in Kenya, AA, done by staff from other EA countries | Still trying to track this one down |
| 2002 | Before we were sleeping, now we are awake: preliminary evaluation of SS sexual health programme in the Gambia | MRC in the Gambia, LSHTM, National Aids Secretariat Matthew Shaw also wrote about this experience in Realizing Rights |
| 2002 | Review of Kivuko, the Swahili version of SS | AA Tanzania, Baron Oron, freelance consultant from Uganda |

| Date | Title | Who did the review |
|---|---|---|
| 2002 | Voice from the field, quarterly newsletters on SS | Estamos, Mozambique |
| 2003 | Responding to HIV and AIDS: Tanzania | ACORD, HASAP, Tanzania. |
| 2003 | Promotion of SS methodology in AIDS related behaviour change communication in southern AFRICA | Family AIDS Caring Trust, Zimbabwe, for SIPAA, ActionAid International |
| 2003 | Institutional visit (monitoring) | FACT visit to 4 southern African countries and key implementing partners |
| ? | Gender, sex and HIV: preliminary results of SS work currently underway in Angola, Tanzania, Uganda | ACORD, Angela H. |
| 2003 | 6 month report: progress report | Report to American Jewish World Service, from Pro-link, Ghana |
| 2003 | Education and HIV/AIDS: a sourcebook of HIV/AIDS prevention programmes | Alexandria Valerio and Don Bundy for World Bank/BRD |
| 2003 | Increasing men's involvement in reproductive health: experiences of Women Centred Health Project (WCHP), Mumbai. | Sundari Ravindran, WCHP, Public Health Department of Municipal Corporation of Greater Mumbai, Society for Health Alternatives and Royal Tropical Institute, KIT, Holland |
| 2004 | Evaluation of the SS training for HIV/AIDS prevention among primary school teachers | Prescilla Latinga, for AAI Malawi |
| 2004 | Comic relief; application to Africa grants programme on integrating gender into community based HIV and AIDS responses | ACORD in Tanzania, Angola and Uganda. |
| 2004 | SS review, Zambia | W. Bowa, CHEP |
| 2004 | Samvaad: Report of the National Sharing Workshop on Stepping Stones | ActionAid India |
| 2005 | SS final summary report to the Board, Zambia | W. Bowa, CHEP |
| 2005 | Support to International Partnership against Aids in Africa: Overview report of participatory review | Tina Wallace, funded by SIPAA. SS formed a small element in this 10 country review process |
| 2005 | Review of HIV/AIDS, Tanzania, newsletter | ACORD/HASAP |
| 2005 | SS review report, Harar, Ethiopia; Monitoring and evaluation framework for projects implementing Stepping Stones | Both by P. Bhattacharjee and A. Costigan, for SCF UK |
| 2005 | Review in the Gambia (not yet available) | James Allen, Concern james.allen@concern-universal.org |
| 2005 | Overview on HIV/AIDS work globally | Christian Aid, HIV Unit annual report |
| ? | Facilitation of SS for Women Centred Health Project, Gujerat | P. Bhatterjee facilitated TOT for WCHP, India |

| Date | Title | Who did the review |
|---|---|---|
| 2006 | A cluster randomised controlled trial to determine the effectiveness of Stepping Stones in preventing HIV infections and promoting safer sexual behaviour amongst youth in the rural Eastern Cape, South Africa: trial design, methods and baseline findings, Tropical Medicine and International Health | Rachel Jewkes and a research team (Nduna M, Levin J, Jama N, Dunkle K, Khuzwayo N, Koss M, Puren A, Wood K, Duvvury N) from MRC, Pretoria. Independent research study |
| 2006 | The impact of stepping stones BCC package on the people of Buwenda Sub County, Uganda (a revisit to the SS pilot villages in Uganda) | Baron Oron, freelance consultant and member of EA Network of SS trainers, and original member of Uganda SS team in 1995. |

**B. Other written resources**

1. Reviews of Strategies for Hope booklets, 1989-2000 undertaken for SFH by Tina Wallace and Jennifer Chapman, with a summary by Susan Holden. Summary of overall learning from SFH available on AAI website under the title 'Inform, inspire, encourage' by Tina Wallace
2. 9 country review reports carried out for the SIPAA review in 2005, for AAI regional office, Nairobi. These are summarised in an overview report by Tina Wallace, 2005, available from AAI.
3. SIPAA notes on meetings with FACT who carried out extensive preparatory work on Stepping Stones for the SIPAA project in 2003, although their work was not in the end funded under the DFID grant.
4. Mid term review by DFID consultants for SIPAA 2003. This is the document that queried the role of SS in the SIPAA project, which led to it being cut from the SIPAA programme and from DFID funding more widely.
5. STAR guidelines: AAI has combined SS with Reflect to form a new approach, called STAR, 2005
6. J. Pulerwitz (Population Council) and G.Barker for PROMUNDO, Measuring equitable gender norms for HIV/STI and violence prevention with young men: development of the GEM scale. (no date provided)
7. HIV/AIDS: the global tsunami – can participatory approaches stem the tide? Alice Welbourn, 2006, unpublished paper
8. Family Health International website: behaviour surveillance survey data (BSS) listed for several countries, from 1999 onwards, providing a baseline against which to measure behaviour change
9. VSO, 2004, HIV/AIDS and disability workshop in Namibia.
10. Mike Kesby, 'Re-theorising empowerment through participation as a performance in space: beyond a theory of tyranny to a transformative praxis' Development and Change (School of Geography, University of St Andrews, Fife, Scotland KY16 9AL mike.kesby@st-and.ac.uk)
11. Discussions with Christina Aid consultant/reviewer who is currently looking at HIV/AIDS prevention methodologies and evaluations within CA's work
12. Paxton S. (2002) The Impact of Utilizing HIV-Positive Speakers in AIDS Education. AIDS Education & Prevention 14(4): 282-94; Paxton S. (2002)The Paradox of Public HIV Disclosure. AIDS Care 14(4): 559-67 . Also

    'Lifting the Burden of Secrecy - A Manual for HIV-Positive People Who Want to Speak Out in Public', available from www.gnpplus.net/regions/asiapac.html
13. Relevant books on evaluation including Chris Roche (1999), Impact assessment for development agencies: learning to value change. Oxford, Oxfam; Alan Thomas, Joanna Chataway and Marc Wuyts (1998), Finding out fast: investigative skills for policy and development. London, Sage and Open University; Basil Cracknell (2000), Evaluating development aid: issues problems and solutions. London, Sage.

# Appendix 3

## Quotes on the power of SS: two examples of a wealth of similar feedback and comment

**From Susan Amoaten, Regional HIV Adviser, Concern Worldwide, Maputo, Mozambique:**

ESTAMOS has found SS to be a strong behaviour change communication (BCC) tool. Men and women participated in separate groups weekly over a three month period but were brought together on occasions to discuss what they had been learning and discussing in their groups. Couples were encouraged to participate in SS at the same time. The impact on behaviour change, attitude change and communication between men and women has been remarkable. Sexually transmitted infections (STIs) have been reduced in the home, and greater open communication exists between couples about condom usage. In addition, one of the most positive impacts according to couples is greater marital harmony in the home and shared financial management.

Many men stated that in the past they thought 'their wives were nothing," but they came to realise that she is a person who can contribute her ideas, and manage money. So this is one initiative that is tackling the issue of Women and HIV but by bringing men and women along together instead of separately.'

In Angola our HIV adviser, Thomas Damaso, adapted Stepping Stones to help raise the level of knowledge of HIV issues from a broad perspective with staff who have little HIV background.

We have found Stepping stones invaluable as a method of raising HIV issues in a way that is non-threatening, non-judgemental and helps address issues of power and stigma at the same time.

**From Dr. Ninfa Leon Jimenez, National Council of Women, Quito, Ecuador, after an introductory workshop to develop Paso a Paso, a Latin American version of SS:**

I would like to share with you the learning that the workshop Paso a Paso left to me, since I think that it has been one of the most interesting experiences I have ever had.

During the three days of the workshop I felt really involved with the other members of my group and with myself in a very deep dimension. It was not a rational but an emotional and spiritual involvement that changed my perception about me and my life in different ways. First, as a woman, I felt more confident with myself, a feeling of ownership of my sexuality developed and many fears disappeared. I felt I had the right to feel pleasure and to look for it.

Secondly, as a doctor and a professional, I could see clearly the link between gender and health. Till this moment my understanding of that connection was rational, but while I experienced the different activities of the workshop and I heard the testimonies of other women that came from different backgrounds and experiences, I understood how gender inequalities operate in sexuality and determine women's vulnerability, particularly for HIV and ITS. I learned that HIV positive women are the extreme expression of gender inequities in sexuality and health.

Thirdly, as a mother of three adolescents, I learned that the best way I could help them to prevent HIV infection was promoting their empowerment and autonomy.

Fourthly, as a consequence of the whole experience, I developed a personal commitment with HIV prevention, and HIV positive women. For the first time in my life I felt the importance of devoting my energy and knowledge for others benefit. All these experiences and feelings changed my life. I think that in the future, I will try to contribute, from any position I have, to change the perception society has of HIV-AIDS, of the persons living with HIV, particularly women, and to rethink the way all of us live sexuality.

Since Paso a Paso can help to introduce important changes in people's behaviors, I will like you to share my impressions with persons that can contribute to the dissemination of this methodology.

# Appendix 4

## UNAIDS education and HIV/AIDS behaviour benchmarks

- Recognition of the child/youth as a learner and actor
- Focus on common risks and responses
- Knowledge combined with attitudes and skills for prevention
- Understanding of the impact of relationships on behaviour
- Based on learner needs and wider situational analysis
- Training and continuing support for teachers
- Multiple and participatory approaches/activities
- Involve the wider community
- Ensure sequence and progression and continuity of messages
- Placed in an appropriate place in the curriculum at school
- Last long enough to build change
- Co-ordination with health programs
- Factual and consistent messages
- Political support for the work through advocacy
- Sees sexual activity as healthy and normal
- M&E

# Appendix 5

## Proposed list of process indicators for SS[21]

### Training of facilitators

- Project staff/ facilitators are trained in the tool
- Reorientation of the facilitators in the tool after one pilot training
- Training of the facilitators on participatory tools, gender etc on a regular basis
- Regular meetings of the facilitators to share experiences, challenges and good practices

### Participants

- Participants are divided in peer groups (gender, age, marital status) of 20 – 25 as per the community need
- Special groups in the community like sex workers, disabled etc get representation or form separate groups
- Participants are selected in such a way that different social groups in the community find representation

### Place and time of Stepping Stones

- Sessions take place in a place recommended by the participants
- Sessions take place at a time suggested by the community. Frequency of the training is also finalized after community consultations
- The place where sessions take place is private and big enough for groups to sit

### Process

- Advocacy with the power structures in the community done to ensure their support
- Session wise time table is prepared in consultation with the community
- Pace of the session is maintained as per the pace of the peer group
- Groups work separately for nay sessions
- Join periodic meetings are organised to share ideas and thoughts after completion of every theme
- Theme wise sequencing is maintained with adaptations as per the community needs
- Emphasis on WE and US and not on THEY and THEM
- Participatory techniques like drawings, role plays etc are used in sessions
- Sitting together in circles to ensure everyone is equal
- Participation of the facilitators in the sessions to ensure that everyone is equal
- No competition between peer groups

- Ensuring the participants get time after the session to think about the session and practice
- Ensuring the participants share each session with friends and family
- Ensuring facilitators have information about other services related to HIV like STI clinics/ VCTC/condoms
- Ensuring that participants get positive reinforcement for their changed behaviour
- Good session wise documentation

### Post Stepping Stones

- Develop post SS plans with the groups
- Develop plans to undertake SS with Volunteers for other groups
- Support linkages of the groups with services

21 Bhattacharjee and Costigan, SCF UK, 2005. Monitoring and Evaluation Framework for Projects Implementing Stepping Stones.