Stepping Stones Review Report
Harar, Ethiopia

Client – Save the Children UK

Parinita Bhattacharjee and Aine Costigan, March 2005

Content

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About the Evaluators

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Abbreviations

AAC – Anti AIDS Club
ABC – Abstinence, Be faithful, use Condoms
AIDS – Acquired Immune Deficiency Syndrome
ANC – Ante Natal Care
BCC – Behaviour Change Communication
CDC – Center for Disease Prevention
CIDA – Canadian International Development Agency
FGA – Family Guidance Clinic
FGD – Focus Group Discussion
HAPCO – HIV/AIDS Prevention and Control Office
HIV – Human Immune deficiency Virus
IEC – Information Education and Communication
KI – Key informant Interview
MoH – Ministry of Health
NGO – Non Government Organisation
OSSA – The Organisation for Social Service for AIDS, http://www.ossa-ethiopia.org
OVC – Orphan and Vulnerable Children
PB – Polling Booth
PLHA – People Living with HIV/AIDS
PPTCT – Prevention of Parent to Child Transmission
PRA – Participatory Rapid Appraisal
PTCT – Parent To Child Transmission
SCUK – Save the Children, United Kingdom
SS – Stepping Stones
STI – Sexually Transmitted Infection(s)
TB – Tuberculosis
UNDP – United Nation Development Programme
VCT – Voluntary Counselling and Testing

1. Introduction

Stepping Stones (SS) is a communication, relationships and life skills training package, which also covers HIV prevention and sexual and reproductive health[1]. This well-known participatory training programme aims to prevent HIV infection by empowering participants to increase control over their relationships, particularly by addressing the engendered context of sexual and other negotiations. Commissioned by Save the Children UK (SCUK) Ethiopia, this report summarizes the review findings of a pilot Stepping Stones programme undertaken in Harar, Ethiopia. SCUK had found that evidence of behaviour and other changes resulting from the introduction of SS into target communities while positive, was largely anecdotal. The objective, therefore, of this review, was to evaluate the pilot programme, make recommendations for an improved behaviour change programme and to develop a monitoring and evaluation framework to measure the impact of this programme. The review took place in Ethiopia in January/February 2005. The monitoring and evaluation framework is not included as part of this report.

1.1 HIV and AIDS in Ethiopia

Ethiopia is one of the world's oldest continuous civilizations with a history dating back more than 2000 years. It is also the oldest independent country in Africa. Ethiopia's population reached an estimated 71 million in mid 2004 with 44% of the population under the age of 15 years. Eighty five percent of the population is rural (CSA, 1994 census). The annual per capita income is currently estimated to be US$100.

The first HIV infections in Ethiopia were identified in 1984 and the first AIDS cases reported in 1986. HIV/ AIDS increased rapidly during the 1990s. In 1985, the national adult HIV prevalence was estimated at .2 percent increasing to 3.2 in 1995 and to 4.4 in 2003. The cumulative number of people living with HIV/AIDS is about 1.5 million, out of which about 96000 are children below 15 years. The estimated number of new cases in the adult population in 2003 was 98000[2]. Trend analysis of prevalence from 1982 – 2003 shows a continuing gradual rise in national prevalence, an urban epidemic that has peaked and plateaued and a steady increase in rural prevalence.

HIV prevalence (2003) is higher among women (5%) than men (3.8%), is higher in urban (12.6) that in rural populations (2.6%). According to the ANC surveillance data, the group with the highest HIV prevalence in the country is women ages 15 – 24. Data indicate that heterosexual and PTCT transmission account for almost all HIV infection in the country. AIDS cases are grossly under reported. Among women AIDS cases peak between ages 20 – 29 and for men between ages 25 – 34.[3]

[1] "Stepping Stones" Life Skills and Sexual Well-Being: A Desk-Based Review, Gordon, Gill and Welbourn Alice, August 2001, p.4.
[2] AIDS in Ethiopia, fifth report, Disease Prevention and Control Department, Ministry of Health, June 2004
[3] AIDS in Ethiopia, fifth report, Disease Prevention and Control Department, Ministry of Health, June 2004

The relationship between HIV prevalence and socio economic factors is highly complex. Ethiopia's political history, poverty, civil war, current food crisis, cultural practices also affect HIV/AIDS dynamics. Ethiopia is one of the poorest countries of the world with a large population that is ethnically diverse. Civil war, border conflict with Eritrea has drained the country of its resources and has given limited scope for social development. About 16% of Ethiopians are facing starvation. War, unemployment and food crisis has resulted in migration, thus dislocating people and facilitating their exposure to new sexual networks. Ethiopia's mobile populations include rural residents seeking jobs in urban areas, military personnel, those displaced by war, drought or/and environmental degradation, male transport workers, sex workers, traders etc. Lack of food coupled with disintegration of families may place children on the streets where they are at risk of exploitation and abuse.[4]

The country's high maternal mortality rate is an indication of the poor status of women and poor access to health care services. Many Ethiopian women have little power in sexual negotiation with their partners. Almost 14 percent of currently married women in Ethiopia are in a polygamous union. About 80 percent have been circumcised. Poverty and unemployment are the main causes of increasing trafficking of Ethiopian women. Other issues that make Ethiopian women vulnerable to HIV include rape, abduction and early marriage.

Though knowledge of HIV/AIDS is high among Ethiopians, women are less knowlegable about ways to prevent HIV. The first BSS (2001–02) show low condom use and higher consumption of recreational drugs.

There is no accurate assessment of STI in Ethiopia. However several studies indicate that prevalence of herpes simplex virus type 2 is high and may be fueling the HIV/AIDS epidemic.

1.2 The Impact of HIV and AIDS

There is little data on the impact of HIV/AIDS in Ethiopia. AIDS is now known to be the leading cause of adult morbidity and mortality in the country. Between 2000 and 2008, it is projected that life expectancy will decrease from 54 to 48 because of AIDS. By end of 2003, 900,000 Ethiopians had died because of AIDS. By 2008, it is estimated that there will be accumulative total of 1.8 million AIDS deaths. About 38 percent of adult (15-49) TB cases were HIV positive during 2003. Given deep and persistent poverty in Ethiopia, HIV/AIDS will further strain coping mechanisms through its enormous and complex impact. At the end of 2003, there were 1 million orphans in Ethiopia that was projected to rise to 1.5 million by 2008. [5]

1.3 The Response to HIV and AIDS

The National HIV/AIDS Task Force was established in 1985 as a national response to the epidemic. The National AIDS Control Programme was later established as a department of the Ministry of Health in 1987. Two medium term prevention and control plans were designed and implemented in 1989 and 1996 respectively. The HIV/AIDS Policy was

[4] Lisa Garbus, HIV/AIDS in Ethiopia, AIDS Policy Research Centre, University of California San Francisco, April 2003

[5] AIDS in Ethiopia, fifth report, Disease Prevention and Control Department, Ministry of Health, June 2004

formulated by MOH and adopted by the Council of Ministers in 1998. This created an environment for HIV prevention and control. The HIV/AIDS Prevention and Control Office (HAPCO) was established in 2002 under the Prime Ministers Office. It is responsible for resource mobilization, advocacy and for the coordination of the sectoral responses. The priority interventions implemented in the country are IEC/BCC, condom promotion and distribution, VCT, STI treatment, blood safety, universal precautions, PPTCT, care and support, legislation and human rights, surveillance and research.

Numerous donors fund HIV/AIDS activities in Ethiopia. However building human capacity, improving coordination and using existing funds effectively and efficiently is most crucial. Although Ethiopians have started mobilizing against HIV and AIDS, years of centralized power have made the Ethiopian civil society weak and under developed. Many international, national and local NGOs have started getting involved in HIV prevention and care activities, including faith-based organizations.

2.0 Save the Children Fund, UK

Save the Children UK (SCUK) is an international non-government organization, founded in 1919, working in more than 70 countries around the world. It is a child-focus organization and the work is underpinned by the commitment to making a reality of the rights of children, first spelled out by the founders of Save the Children and now enshrined in the UN Convention on the Rights of the Child. Today, the focus of SCUK's long-term work is on improving the quality of and access to basic services, advocating for children's rights, responding to the HIV/AIDS epidemic, and supporting communities and partners to prepare for and respond to emergencies.

Save the Children UK started to work in Ethiopia in 1973 and are currently working in Somali region, Amhara region and East Hararghe. The main focus of the work has been to help families in the rural areas to have a secure food supply all year around. In food crisis Save the Children is also involved in distributing food aid. Emergency relief runs alongside long-term development and prevention work to help children, their families and communities to be self-sufficient. They also work on health, education and HIV/AIDS.

HIV/AIDS has been part of the work of SCUK in Ethiopia for the past 14 years. The work started with a focus on youth prevention. SCUK worked with establishing and building the capacity of Anti AIDS Clubs (AACs) as well as promoting peer education. The emphasis was on Information, Communication and Education (IEC). The work has then expanded to also include community mobilization and behaviour change programmes, community-based programmes for care and support for orphans and vulnerable children as well as impact mitigation for HIV affected rural households.

The current focus of work is

- to encourage young people to make safe sexual behaviour choices and ensure they have access to quality youth-friendly reproductive health services.
- to ensure that Orphans and vulnerable children (OVC) have access to quality community based care, support, protection and basic services.
- to mitigate the impact of HIV/AIDS in rural communities.

SCUK works closely with local government agencies, local NGOs and CBOs, and builds the capacity of community structures such as local CBOs (e.g. Idirs), NGO and HIV/AIDS committees.

The SCUK HIV/AIDS work since 1995 in Eastern Hararghe and Harar have been based on understanding young peoples sexual behaviour and the impact of HIV/AIDS as well as working with awareness rising through strengthening AACs and peer education acitivites. The HIV/AIDS work began 1995 with assistance and capacity building of six Anti AIDS clubs.

Throughout the world, communities have faced the painful realities of HIV and AIDS and the real difficulties of effecting sexual behaviour change for risk reduction. Most HIV prevention programming, relies heavily on the promotion of the risk reduction menu of abstinence, be faithful (mutually) and use condoms (ABC), complemented by the prompt

treatment of STI. And while technically sound, these risk reduction strategies have been only moderately successful in achieving behaviour change if promoted without taking into account the context of vulnerability, including all the gender inequalities that inform sexual negotiation for safer sex. In fact, there continues to be few documented examples of successful behaviour change strategies implemented at the community level. Still fewer examples exist of behaviour change strategies that reach men as sexual decision-makers with positive results in terms of risk reduction.

In recognition of the need to promote an empowering, community driven, gender sensitive, HIV prevention approach, in 2002, SCUK in partnership with a national NGO, OSSA, undertook a joint partnership to pilot a HIV prevention project in 16 Kebeles in Harar, Ethiopia, using the Stepping Stones (SS) training as the primary method for mobilizing communities and building their capacities. All OSSA/SCUK feedback to date indicates that the initial pilot project has been very successful. All SS training sessions have been well and consistently attended by community members despite the lack of participant incentives such as per diem payments. Anecdotal evidence suggests that considerable success has been achieved in 'breaking the silence around sex and sexuality' among participants and their families/sexual partners, and the ability to bring about a positive behaviour change in men and women, boys and girls, particularly in forging more equitable sexual relationships. In short, SCUK and OSSA staff and community mobilisers strongly feel that in comparison to other HIV initiatives, the impact of this pilot project has been remarkable.

At the end of 3 years, SCUK decided to conduct an review of SS in Harar, in order to have a more technical/systematic understanding of the successes and challenges to date, and to develop a monitoring and evaluation framework, which would be built into all future SS training. This would provide firmer ground for any promotion or replication of the SS approach within different regions, contexts and organizations. In sum, SCUK was keen to understand the successes of SS in a technically sound framework.

Review Objectives:

- To evaluate the current pilot Stepping Stones programme in Harar identifying areas for improvement or modification in order to create an effective behaviour change programme that addresses both gender equity and HIV/AIDS.

- To develop an improved Stepping Stones model for Ethiopia, which incorporates an effective framework for monitoring and evaluation that effectively measures its impact, in readiness for its promotion and replication elsewhere.

The first phase of the review which included evaluation of the pilot project, was conducted during January – February 2005. This is a report of the first phase of the review, which was funded by Canadian International Development Agency.

Details about Stepping Stones are available as annexure 1.
The terms of reference for the review are attached as annexure 2.

2.1 HIV and AIDS in Harar

Sentinel surveillance 2003 data estimates for Harar were 7.8%[6]. AIDS patients occupy between 50-55% of hospital beds, and VCT results range from 11-22% positive. In addition, SCUK estimated that there at least 850 AIDS orphans in Harar town. Harar town clearly has a serious problem with HIV and AIDS. Factors that increase the vulnerability of Harar to HIV include a larger male to female population ratio (94,000 men to 91,000 women), a massive presence of military personnel, an estimated 3,000 people flowing in an out of Harar every day, en route to Somalia and Djibouti, an estimated 1,255 street sex workers in the town, and a large number of traders attracted to Harar by cross-border contraband trading. Other factors such as high levels of alcohol and drug abuse, high unemployment, poverty, and unequal gender relationships provide a context of vulnerability in which HIV transmission can thrive.

2.2 Stepping Stones Project, Harar

In 1997, Save the Children Fund (UK) carried out two-linked community based research projects in East Hararghe, Ethiopia. This action research identified the reasons why young people and children in this area are vulnerable to the spread of HIV, and the impact of AIDS on their families. The research found that while young men had considerable power in sexual decision making, they may not have the resources or maturity to match with their given responsibilities. Adults were generally unable to support their children to maintain safe sexual health because they themselves lacked information and had inhibitions to talk about sex to their children because of cultural and religious norms. The sexual health of women was even poorer with the widespread practice of female circumcision that is embedded in cultural and religious norms. Efforts by schools and health services to respond to the needs of education on HIV and AIDS and for services to treat and support those infected was inadequate. The research also found that most families had very few assets or savings. Food security was poor and the families had to suffer if the productive member of the family fell sick. After consultation with key stakeholders in the area, Save the Children (UK) recommended the following for Harar[7]:

- Starting a community empowerment project in 20% of the communities using "SS approach". This approach would help in increasing awareness related to HIV and develop sexual health skills
- Follow up support to communities that have participated in the project for two years, supporting them to establish their own prevention and care activities
- Training on savings, credit and income generation that would be built into the SS process
- Sensitizing religious leaders and advocated with for their support
- Training health workers, teachers, to provide effective and accessible services
- Involving community members in selecting indicators of impact
- Involving young people in developing IEC materials

[6] A recent SCUK report, *The Situation of HIV/AIDS and Socio Economic Factors in the Operation Areas*, June 2004, cites Harar and the surrounding woredas in East Hararghe as the third worst in Ethiopia in terms of prevalence and incidence.

[7] Save the Children Fund (UK), Ethiopia, draft report on a study of sexual health amongst young people and impact of long term illness on children in East Hararghe and Harar, January 1998

Based on these recommendations, Save the Children (UK) in partnership with OSSA developed a 3-year proposal with the aim to reduce young people's vulnerability to the spread and impact of HIV/AIDS in Harar National Regional State. This project, funded by European Union, started in 2001.

The key expected outputs[8] of the project were:

- Strengthened capacity of OSSA's branch office in Harar
- Religious leaders sensitized on the risks of HIV infection, current sexual attitudes and behaviour of young people and opportunities for community empowerment
- Higher level government officials are oriented and sensitized on the risk of HIV infection, current sexual attitudes and behaviour of young people and opportunities of community empowerment
- Communities are empowered to take action against HIV/AIDS through successive training using the SS approach
- Community initiatives are identified and supported
- Access to sexual health information and services are improved

SCUK and OSSA planned to implement this HIV prevention project in 16 Kebeles in the Harar Region, covering an approximate population of 40,000. Until January 2005, the project had completed implementation in 13 Kebeles. In the remaining 3 Kebeles, SCUK and OSSA decided to implement the revised version of SS based on this evaluation.

By January 2005, at the time of the review, 443 women and 253 men had received SS training in these 13 Kebeles. For details of implementation, see annexure 3.

[8] Proposal titled *Reducing vulnerability of young people to the spread and impact of HIV/AID,* April 2001 – December 2003

3 The Review

The SS review was conducted in Harar, in January – February 2005. The key objectives of the review were:

- To assess the contribution of SS in Harar to HIV prevention
- To understand how the project used SS and to suggest adaptations
- To make recommendations to improve the impact of the project

3.1 Process of the review

The review process had the following different stages:

- Home-based desk review – the evaluators reviewed the project documents and articles on SS at home
- Formulation of tools and training of investigators – the draft tools were developed by the evaluators and were pre-tested with community members in a workshop mode. The tools were then modified and finalized based on the feedback. The evaluators also conducted 2-day training for the investigators who were participating in the review.
- Primary data gathering – the evaluators gathered primary data from the implementing institutions, Kebele-level SS facilitators, Kebele members, SS participants and non-SS participants, and health service providers in Harar.
- Analysis of the data – The quantitative and qualitative data gathered was then analyzed.
- Report writing – Based on the analyzed data, this review report was written.

The process of the review starting from desk review to report writing took two and half months (February - March 2005).

For the review the evaluators were in Ethiopia for 14 days. The first 2 days were spent in doing institutional review. The evaluators met key people in Save the Children UK and OSSA and tried to understand the background and relevance of the project. This was followed by 2 day facilitators' workshop at Harar. This workshop was co facilitated by local consultants. Since the review by design aimed at building local capacities, 2 days training was conducted to train the local facilitators and project staff / volunteers in review tools. Field planning was done along with the local facilitators and project staff. The evaluators spent 4 days in the field facilitating primary data gathering using tools like KIs, FGD and polling booths. The evaluators helped the local team to analyse the information gathered. A feedback session was organized on the 5th day where the evaluators reviewed the 4 days data gathering and analysis process and suggested improvements. The local team continued the primary data gathering process and sent the data to the evaluators. All the gathered data was analysed and this report was written. Before leaving the country, the evaluators also presented the key top line findings to other stakeholders in Ethiopia like CIDA, UNDP, HAPCO etc in a workshop organized by Save the Children UK.

3.2 Review tools used

A variety of qualitative and quantitative assessment tools were used to collect institutional, community, and service-level data ranging from in-depth interviews to focus group discussions. The details of the tools are given below:

- Institutional Review – A guided discussion tool was used to review the institutional context of this project. Both SCUK and OSSA senior personnel were interviewed. The tool is attached as annexure 4.

- SS Facilitators Review – This was carried out in a 2 days workshop mode. Twenty paid and volunteer SS facilitators attended a 2-day workshop. During the workshop the process of implementing SS in their communities was reviewed, a session-by-session review was conducted to understand specific successes and challenges, adaptations made, issues raised by men and women and possible ways of making the sessions more effective. During this review workshop participants shared the impact of SS on their own lives and on their communities. The agenda of the workshop is attached as annexure 5.

Stepping Stones Facilitators Review

- Community Review – Data was gathered from different community groups, using three main tools, the Polling Booth[9] (PB), Focus Group Discussion (FGD) and Key Informant Interviews (KI). The tools are attached as annexures 6, 7 and 8. The main groups reviewed were the four SS peer groups, younger men, older men, younger women and older women. Data was gathered from two SS Kebeles (Mutti and Kebele 19) and one non-SS Kebele (Kebele 18). The community review focused on understanding the community's perception of the tool, the process adopted in implementation of the tool and the impact of the process on community memebers' knowledge, skills, relationships and behaviour.

[9] This research tool has been developed and used in India and South Africa to collected private information about individuals in an unlinked and anonymous way.

- Services Review. A service assessment tool was used to conduct an indicative assessment of public and private health care services in Harar. This review was conducted to understand the quality of services offered by these institutions and project links to these services.

3.3 Community Review Sample Size

The community review sample size was 205. Of these, 69 respondents were SS participants (10% of total participants), 68 respondents were from SS Kebeles but did not participate in SS training and 68 participants were from Kebeles where SS did not take place.

Three Kebeles were chosen for the review, 2 Kebeles where SS took place and 1 Kebele where SS did not take place. The SS Kebeles - Aboker Mutti and Kebele 19 - were chosen to include 1 rural Kebele where SS took place 2 years previously (Mutti, 2002) and 1 Urban Kebele where SS had recently taken place (Kebele 19, 2004).

The sample selection was purposive to compare controlled and non controlled group.

Respondents	**SS Kebele**				**Non SS Kebele**
	Mutti		**Kebele 19***		**Kebele 18**
	SS participants	SS non participants	SS participants	SS non participants	SS non participants
Older women	10	10	10	8	20
Younger women	10	10	10	10	20
Older men	9	10			10
Younger men	10	10	10	10	18
Total	39	40	30	28	68

* Kebele 19 has only 3 peer groups

In the absence of a pre-project baseline, the review process used the control group method in order to understand SS impact in the context of people who were trained and people who were not. In addition, in the SS Kebele, non-particpants were reviewed to see if there was any impact of SS at the broader Kebele level.

In addition, 8 key informant interviews were conducted with influential key informants such as village and Iddir leaders, teachers, housewives, etc.

STI and VCT services were reviewed in the following institutions; Hiwot Fana Hospital, Family Guidance Association (FGA) Model Clinic, FGA Youth Clinic, and Mistak Arbegnoch Hospital.

3.4 Review Areas

The review focused on the following areas:

- Institutional Review
  To review the context and the progress of the project
  To review institutional context within which SS was launched

- Facilitators Review
  To review the process of SS implementation
  To review facilitators' experiences with SS training, including adaptation of sessions
  To review facilitators' perception of the impact of the project

- Community Review
  To review community's perception of the SS process
  To review the impact of SS process among the participants and the community in the context of knowledge, skills, relationships and behaviour change.

- Services Review
  To review the quality of services offered.
  To review the projects' linkages with these services.

3.5 Duration of the Review

The review took place between January–March 2005. A desk review and development of draft tools took place in the consultants' home locations in January 2005. Both international and local consultants undertook primary data collection in Ethiopia from 22 January-5 February 05. The local consultants continued with outstanding data collection until 28 February, 05. Both data analysis and report writing were completed in March 2005.

4 Findings of the Review

4.1 Overall Stepping Stones Project

The review found that essentially the project design was based on the implementation of SS as a stand-alone HIV prevention strategy and planned to implement SS in 16 Kebeles of Harar. Start-up training included a 2-week training for SS Facilitators and local OSSA staff from Harar and Jijiga (14 males and 10 females). Following this training, an initial start-up pilot project was undertaken by the OSSA SS Facilitators, with the aim to strengthen their facilitation and confidence. This pilot was undertaken under the supervision of Ms. Caroline Nicolson, a SCUK consultant. During this time a phased project implementation plan for the remaining 15 Kebeles was developed.

The implementation scheme that evolved was that a team of 4-5 facilitators, over a three-month period, one Kebele at a time, would undertake the SS training. Once the training was complete, the community developed various follow-up work plans, and the facilitators moved on to the next Kebele.

Before SS start-up in Harar, OSSA and SCUK jointly organised a workshop for influential people (including community and religious leaders) from the 16 target Kebeles. The workshop shared the aim of the project, sought and was given support. After the workshop a Steering Committee was formed to support and monitor the project. The Steering Committee included representation from Harar Regional Education Bureau, Harar Regional Health Bureau, Harar Regional Disaster Prevention and Preparedness, Harar Regional AIDS Prevention and Control Secretariat, Harar Town Municipality, OSSA and Save the Children. The role of the Steering Committee was to help OSSA select the Kebeles where SS should be implemented (based on surveillance, and STI data of the Kebele), conduct advocacy with the Kebeles were needed and to monitor the project.

Participants self select themselves for SS training through the following process. Before project start-up in a Kebele, the facilitators conducted a community meeting to introduce the project. They also held one-on-one advocacy meetings with the Kebele leaders to mobilize their support. Only with the leaders go-ahead were posters announcing the SS training and with a call for participants put up in the Kebele. The dates and timing of the training are agreed in consultation with the participants.

No Kebele-level risk assessment was undertaken to identify transmission dynamics specific to each particular Kebele, including "hot spots", vulnerable sub-populations or sexual networks.

The project was piloted in Kebele 12 in March 2002. This Kebele is associated with large numbers of military personnel in residence, and large numbers of PLHAs. However, while there was obviously some risk-assessment rationale to this Kebele selection, over and above the self-selected SS participants, there was nothing intentional built into the programme to reach military personnel or PLHAs, or no clear articulation of a deliberate outreach strategy.

Since then, the project has been implemented in 13 Kebeles. Though initially only one Kebele was taken at a time, once the facilitators were more confident, OSSA started implementing simultaneously in 2 Kebeles. The team of four/five facilitators take 4 groups (older men, older women, younger men, younger women) in each Kebele. Depending on the convenience of the participants, 2-3 sessions are facilitated in a week over 2-3 days. The timetable is attached as annexure 9. A full SS training programme takes 3 months in a Kebele. The training ends with a *grand finale*, called a "graduation ceremony" where all the participants present their "special requests" to the community and receive their SS training certificates from OSSA. By January 2005, OSSA had completed SS training in 13 Kebeles with 443 female and 243 male participants.

The project design involves a SS follow-up of a 1-2 day refresher-training workshop in the Kebele, and the development of an action plan that is supported primarily by community volunteers. Having finished SS training in a Kebele, SS Facilitators are expected to move on to another Kebele for three months to conduct the next SS training. Thus, each Kebele receives a three-month injection of training and support, and is then expected to continue its HIV prevention initiatives with community volunteers. Limited resources were made available for work plans that included the formation of Anti AIDS clubs, holding of traditional Ethiopian coffee ceremonies and so on. A range of 1,000 – 1,300 Ethiopian Birr (approximately US$ 118-153) is given to the Kebele after completion of SS to undertake their planned activities.

In sum, therefore, the essential design of SCUK/OSSA's HIV prevention project in Harar assumed that the introduction of SS training was a whole HIV prevention programme. Alice Welbourn, original author of the SS training cautioned against this:

> *Of course, people cannot be expected to change their approach to life on the basis of nine weeks' work. This workshop can only be seen as the starting point for changes within a community.*[10]

Therefore, both Harar and Kebele-level risk assessments should have been conducted at project start-up, and "risk reduction" plan drawn up. These plans should include a programme design that involves how to reach those sub-populations most at risk of HIV transmission and infection, defined objectives for sub-population and general population mobilization, and a clear plan to support risk behaviour reduction that minimally includes condom availability, accessibility and affordability, STI and VCTC services.

4.2 Institutional Review

The institutional review included both Save the Children and OSSA.

- **Save the Children (SCUK)**

Save the Children in Ethiopia has to date primarily focused on livelihood and relief issues. SCUK's venture into HIV prevention in Ethiopia started in response to an assessment in the Harar region that strongly recommended that HIV prevention with young people be undertaken. SCUK also recognizes that, as in other African countries, HIV and AIDS will

[10] Welbourn, Alice, Gender, Sex and HIV: how to address issues that on-one wants to talk about, Strategies for Hope Series, p.11.

reverse gains achieved in their traditional areas of livelihood and relief. Accordingly, SCUK launched a HIV prevention project in Harar in 2001, and also hired a HIV and AIDS specialist to support their HIV and AIDS work. Although plans are underway, to date, SCUK does not have a HIV and AIDS policy to guide its relief and development work in Ethiopia, and HIV and AIDS mainstreaming and monitoring and evaluation tools are also yet to be developed.

Still, as its HIV and AIDS programming debut, this evaluation is important for SCUK in order to have an objective understanding of the impact of SS and its potential replicability for other parts of Ethiopia.

This evaluation was undertaken at a time when SCUK, Ethiopia had already taken the decision to phase out of Harar in order to consolidate their work in the poorest regions of Ethiopia, especially in Somali and Amhara regions. Therefore, as the field review was underway, OSSA Harar was into its last two months of support for SS from SCUK. Thus, the evaluation was undertaken in the context of uncertainty with regard to the continuity of the project.

The biggest challenge for SCUK in this project has been sustaining change within a community after the SS training and likely relates to the limitations of the original programme design in which SS is seen as a stand-alone behaviour change initiative. The follow-up activities as were envisaged have had limited success. This is probably because activities such as group-income generation are notoriously difficult, without sustained and adequate financial resources and informed technical support. And also because the facilitators had no sustained support role to the Kebeles where SS training was completed.

The evaluators commend SCUK for recognizing the importance of integrating HIV and AIDS into its ongoing programmes and for bringing professional expertise on staff to support this process and for conducting an evaluation in order to learn from their own programme experience. Some limitations observed by the evaluators include the Harar programme design, whereby SS was launched as a stand-alone HIV prevention initiative, as opposed to what it really is – an extremely effective community mobilization tool. SCUK's choice of implementation partner – OSSA – was judicious, OSSA being the oldest HIV and AIDS NGO in Ethiopia. Still, the evaluators felt that SCUK could have played a more facilitative and active role in building OSSA's programme implementation capacity, especially in the area of strategic planning, linkages with services and monitoring change.

- **The Orgnization for Social Services for AIDS (OSSA)**

OSSA is a nationwide NGO working in the field of HIV and AIDS since 1992. The two main objectives of OSSA are the prevention of HIV infection and realizing community based care and support. OSSA has a central office in Addis Abba and a number of Branch Offices.

With 13 years HIV and AIDS experience, OSSA has come to realize that community ownership is key to any behaviour change, and therefore they chose to partner with SCUK to implement SS, a project which is based on building community skills to prevent HIV and care for PLHAs.

OSSA has set up Anti AIDS Clubs and promoted orphans and vulnerable children (OVC) care throughout Ethiopia. OSSA enthusiastically partnered with SCUK in the implementation of SS in Harar and feels that the success of this programme is due to the cultural openness of people in Harar and the community processes on which SS rests.

According to Dr. Ibrahim Yusuf, OSSA Director, OSSA feels that the key achievements of the SS project have been:

- Increased openness among young girls to talk about sex among themselves
- Reduction in sexual harassment
- Delay in sexual debut
- Increased respect for young girls
- Increased communication between spouses about sex
- Increased job sharing within families thus reducing work burden on women
- Increased condom use for dual purpose – pregnancy and sex

Dr. Ibrahim felt that a careful assessment should have been carried out in the community before starting SS. This would have helped in developing a baseline against which progress could have been measured and also in careful selection of participants. His main concern is that there was insufficient follow up in the community, as a 3-month process is not enough to fulfill raised demands and to make the process sustainable.

The evaluators felt that though the NGO at the national level had a vision for community ownership and sustainability, the local project in Harar needs substantial capacity building. OSSA Harar had not made any effort to link the SS communities with key government services or to ensure a ready supply of condoms to the mobilized Kebeles. Also there was no evidence of the NGO negotiating with SCUK on the need for strong follow-up in the communities beyond the 3 months training period. In fact, the same project model was in the process of being replicated by OSSA in a new rural site near Harar with another funder.

4.3 Facilitators' Review

A 2-day workshop was conducted with OSSA SS facilitators; both paid and volunteer, **to review their experiences with SS implementation**. The following are the overall findings:

- All the facilitators found SS very helpful in sharing information and bringing about behaviour change in the context of HIV/AIDS, communication and relationships
- To facilitate SS training, community groups based on age and marital status were formed.
- All the facilitators felt that SS had changed their lives by encouraging self-analysis and behaviour change.
- The volunteer facilitators found the process very enriching and hence felt motivated to be volunteers.
- Following SS, the facilitators have seen many changes in the community, such as an increase in knowledge and skills for self-protection, an increase in openness between parents and children to talk about sex, openness between sexual partners, sensitivity to reducing gender inequity, a decrease in fights within families - between spouses and between parents and children.
- The facilitators faced problems in forming groups of older men and controlling initial dropouts.

- The facilitators had received very limited training after the initial SS training in January 2003.

Review of manual with facilitators

Facilitators Feedback

"SS training is very good because it has changed my own personal life"

"Need to do SS in more groups since 4 groups in one Kebele is not enough. But we have no resources to do it"

"SS has provided me with a tool to help the community to solve their own problems with their own resources. It works well with urban and rural communities, literate or illiterate communities"

"SS promotes self analysis and therefore it is different from other HIV/AIDS trainings"

"SS builds very strong peer relationships and that develops a social norm."

"Since SS has a very strong participatory approach community members accept it. Though there is initial dropout, once they start coming regularly, they start enjoying and benefiting."

"SS is very good for our society as our society is very closed and talking about sex is a taboo. SS provides the space to talk about such topics in a way that it helps us"

"SS not only provides knowledge but also gives skills. It provides a space where we can challenge community values, traditions that are harmful"

The session wise review brought out the following issues:

- **OSSA facilitators were not using the original SS Manual**. The manual was adapted at two levels, first by the trainer, Caroline Nicolson, when she trained the team in the beginning of the project. At that time the manual was adapted to include sessions like Time Line and Risk Matrix. These sessions were included to help facilitators understand the HIV scenario in the community and also help in M&E. This manual also borrowed from the manual developed in the Gambia. The Manual was then translated in the regional language. The sequencing of the sessions was changed based on community feedback, and a session plan was developed to help the facilitators plan their sessions across 3 months.

- **The re-sequencing is not optimal**. It is not called "Stepping Stones" for nothing! The review revealed that the facilitators are not aware of the manuals 4 themes, or their sequencing rationale. This is important as any adaptation of these sessions risk being somewhat arbitrary and ad hoc, and as a result less effective. The themes are as follows: Theme 1 – Group cooperation, Theme 2 – HIV/AIDS, Theme 3 – Why do we behave the way we do; and Theme 4 – How do we change our behaviour. The sessions listed under each theme are intended to help participants experience the issues related to that overall theme and, for example, the complete process of developing peer relations, understanding HIV and risk, reflecting one's behaviour, learning skills to change that behaviour and reduce risk. However, in the "Harar adaptation", the session on Attack and Avoid, which originally belongs in Theme 4, "how can we change our behaviour"? is included in Theme 2 – HIV and AIDS. This session is part of a skills building process that is interrupted and less effective with such re-sequencing. Again, to quote Alice Welbourn, the original SS author:

  The methodology has been developed intentionally to raise certain topics in a certain order, and with sufficient depth…the sequence of sessions and covering all the "stepping stones" are important, as the topics and activities in each session build on previous sessions. [11]

- **The "Harar adaptation" includes some interesting additions**, such as Social Mapping, HIV Timeline, and Risk Matrix. These sessions help the facilitators to build rapport with the participants and also to understand the community and its risks. These sessions, if carried out at the beginning of the project can also be used to generate some baseline data and help the facilitators to monitor change in the community if they are repeated from time to time. This is not currently happening, and thus, the facilitators are not using the information generated from these sessions to maximum effect.

- **In response to community demand, sessions on VCTC and care are included in the sessions**. This is commendable and has helped the facilitators to cover a range of issues in the community from prevention to care. The sessions on STI and care could be made more interesting by inviting supportive doctors or nurses from relevant health centers to facilitate. This would start the process of linking the

[11] Welbourn, Alice and Gordon, Gill, Stepping Stones Life Skills and Sexual Well-Being: A Desk-based Review, August 2001, p.17.

community STI and care services. Similarly, inviting PLHA to speak to participants would also help in creating greater awareness and sensitivity and strengthening the project's care component.

- **The facilitators need more training and capacity building on gender issues**. The facilitators received a 12-day training prior to project start-up, and nothing since. The evaluators found them hungry for information, knowledge and inputs. And since SS challenges traditions and gender relationships, facilitators need more skills. Hence, the facilitators need refresher training on a regular basis, as once they are in the community; their knowledge is expected to be able to cover the spectrum of HIV and AIDS.

- **The facilitators do not have a clear idea how to assess change in the community**. The key risk reduction indicators in a HIV prevention programme such as increased condom use and STI treatment were not built into the overall objectives of the programme. Therefore, when the evaluators asked the question: "how do you know your efforts are successful", not one of the facilitators mentioned levels of condom use or STI treatment. When asked about levels of condom use in their Kebeles in the previous month, only one volunteer facilitator could answer. Basically, the project design is flawed, since after a 3-month association with the community, the facilitators move on to another community.

- **The documentation maintained by the facilitators is very systematic and good**. Currently the facilitators are maintaining session wise reports. The key discussion points of each of the sessions are documented in the formats developed by the project. During the review the evaluators saw documents maintained for each session, for each of the groups, for each kebele. These reports could be useful to monitor change in the groups. However, the evaluators found no evidence of using this documentation to monitor change.

Role Play of "Special Requests by SS Volunteer

"Special Requests" Highlights

"Special Requests" normally highlight the issues and concerns of the community. They also reflect the level of discussion among the groups. Some the special requests mentioned by the participants clearly show that Stepping Stones groups were engaged in discussions that challenged and questioned gender roles. This also reflects good facilitation skills.

Some of the key special requests were:

Younger men – the requests was specially to younger girls
- To address them in a proper way
- Not to dress provocatively
- Not to get carried way by gifts
- Willing to conduct premarital HIV test

Younger women – the requests were to younger men and family members
- Not to initiate sexual intimacy
- Help and assistance in continuing education and building a career
- Equal opportunity for girls and boys
- Protection from society against abuse and violence
- Openness in discussing about sex

Older women - especially from husbands
- Respect their feelings
- Be faithful
- Be free from drugs, chat and alcohol
- Be helpful in household chores
- Share money matters
- Keep hygiene and;
- Participate in civic activities

Older men – to wives
- Be loyal in marriage
- Understand their sexual interest
- Keep self clean

As a result the participants reported that there has been an increase in loyalty among partners, reduction in conflicts, challenging traditions like early marriage, genital mutilation, circumcision, wife inheritance etc. Husbands now discuss salaries and there is joint decision making about expenditures. For younger people, there has been reduction in spending money unnecessarily and increase in openness to talk about sex.

(As shared by facilitators during the review workshop)

4.4 Community Review

As mentioned above, the community review was carried out at three levels:

- An assessment of the knowledge and skills of SS participant.
- An assessment of the knowledge and skills of non SS participants (in Kebeles where SS was implemented and also in Kebeles where SS was not implemented)
- An assessment of the opinion and attitudes of community leaders about the project

Focus Group Discussions with Older women – Mutti

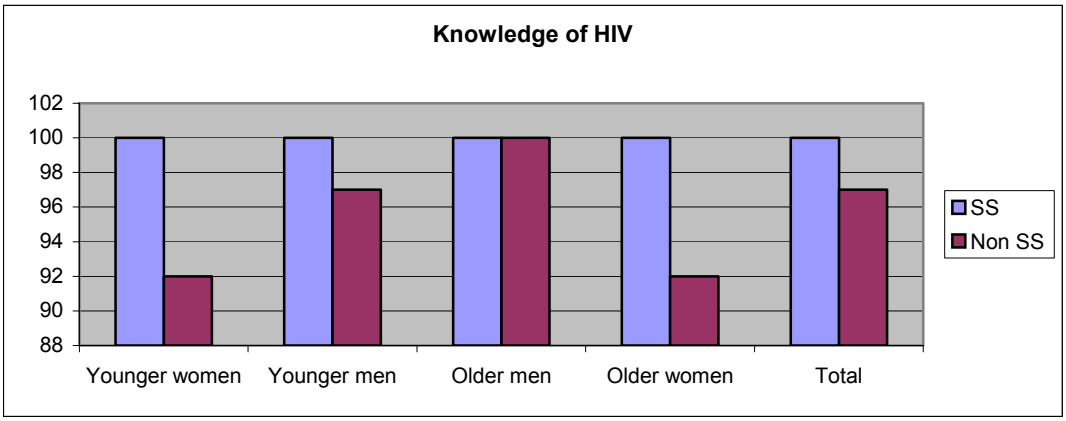
The assessment attempted to compare and contrast the responses of three categories of respondents namely, SS participants, non-SS participants both from Kebeles where SS was and was not implemented. It was hoped that these three groups would show different trends. However the polling booth data shows that while there were distinct differences between SS participants and non participants, there was not much difference between the two categories of non participants. Therefore in the report, all non-SS participant responses are reported together.

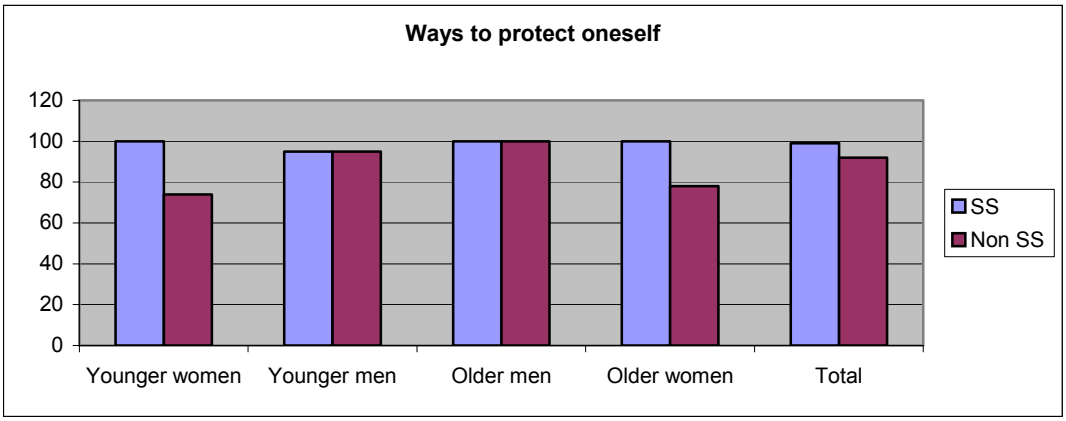
On analysis, differences between the responses of participants in Mutti (where SS was facilitated in 2002) and Kebele 19 (where SS was facilitated in 2004) were found in relation to sexual communication and access to condoms. Sexual communication among parents and children and among sexual partners and access to condoms was lower among respondents in Mutti compared to respondents in Kebele 19. However on further analysis with the participants it was confirmed that this difference was due to influence of Islam religion (respondents in Mutti believed that Islam did not allow them to talk about sex) and distance from the city (condoms are easily available in the city) rather than time difference in implementation. Hence in this report, all participant responses are reported together. However wherever there is considerable difference in responses, it is mentioned.

The findings of the community review are as follows:

- **Knowledge**

Knowledge about STI and HIV was very high among SS participants. They were aware of how HIV spreads, how it does not spread, the symptoms of STI and AIDS, etc. All the participants (across sex and age) were aware of at least 2 ways in which HIV spreads and all were aware of how to protect themselves from HIV. However among the non-SS participants, although around 97% of respondents knew 2 ways in which HIV spreads, only 74% of younger women and 78% older women knew how to protect themselves. This clearly shows that SS has increased the knowledge among participants.



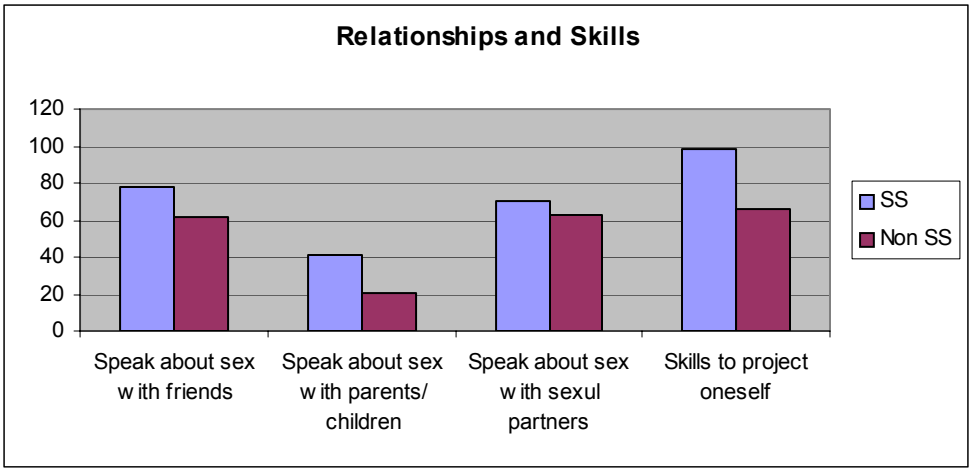


- **Skills and Relationships**

The review findings strongly suggest that SS has helped participants improve their sexual communication skills. With regard to talking openly with their friends about sex, 78% of SS participants as opposed to 62% of non-SS participants were able to do so. Perhaps the greatest reported change in sexual communication is between families. Thus 40% of SS respondents report that they can now openly talk to their parents/ children about sex in comparison to 20% of non-SS respondents. Similarly, 71% of SS participants reported comfort in talking to sexual partners about sex, as opposed to 63% of non-SS participants.

One SS trainee explains the impact that SS training had on her and her family:

> *I was very shy to speak about sex to my husband and my children. SS has helped me to understand our body, sex and risks. Now I feel confident and have open discussion with my children and my husband. Dinner time has become very exciting as my family waits to hear what I learnt in SS. This way though my family did not go through the training, they have become a part of SS since I have shared what I learnt.*



This significant result shows that SS has given the participants the knowledge and skills to communicate about sex with their friends, parents, children and sexual partners.

However it must be mentioned that higher number of SS participants in Kebele 19 reported improvement in sexual communication compared to SS participants in Mutti (80% in Kebele 19 vs 40% in Mutti).

In addition to improved sexual communication, 47% of SS respondents reported an improvement in their actual sexual relationships in the last six months, as opposed to only 34% of non-SS. This improvement was particularly significant for the older respondents, for example, 89% of older SS men reported an improvement in sexual relations compared to 45% of non-SS older men, and 85% of older SS women reported an improvement in their sexual relationship/s compared to 47% non-SS older women.

According to one SS trainee:

> *I thought getting pleasure out of sex was men's right. Men also determined in giving and getting pleasure. After the sessions on body mapping and sex , I know how to give and get pleasure. I now understand women also deserve pleasure. Now I communicate about sex and pleasure with my husband and our sexual life has improved considerably.*

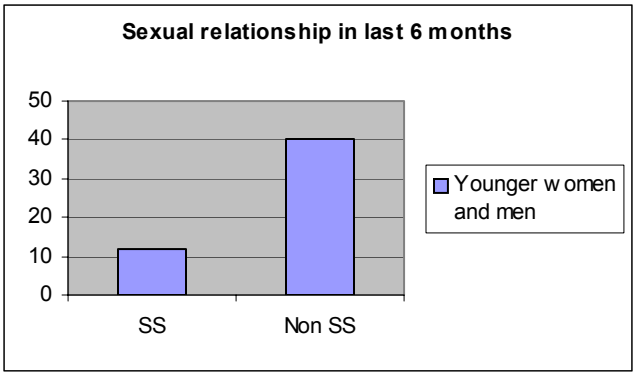
A full 98% of SS participants felt confident that they possessed skills to protect themselves from HIV, as opposed to only 66% of non-SS respondents. In the focus group discussions, all peer groups, younger women, younger men, men, older men and older women shared how SS has made them more knowledgeable and better communicators. Participants also

felt that in addition to better sexual communication between spouses and children, general family communication had improved and resulted in a decrease in quarrels and conflicts.

- **Behaviour**

Change in risky behaviour is a key indicator of success of any HIV prevention project. The behaviours that were assessed during the review were multiple partnering, condom accessibility, incidence of STI, use of alcohol prior to sex, traditional practices and discrimination against PLHA.

Only 12% of SS participant respondents reported sex with a girlfriend/boyfriend/sex worker in the last 6 months. However, among the non-SS respondents, 40% reported having sex with their boy/girl friend or sex worker in the last 6 months.



In the focus group discussions, SS participants shared that they had learnt the risks of multi partnering during the SS training. Their increased understanding of risks and protective behaviour had helped participants decide not to have sexual relationships. Young SS girls in the rural village of Mutti responded that while they have boy friends, their religion does not allow sex before marriage and hence they are following abstinence. Older SS men in the same village also reported a reduction in risk behaviour, but the polling booth indicated one participant had visited a sex worker in the past six months, and one had sex with a man.

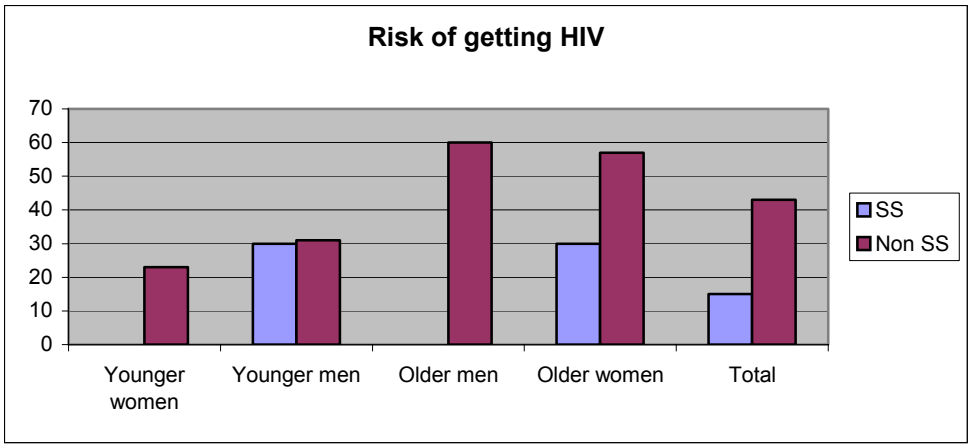
Both SS participants and non SS participants have seen condoms. However accessibility is an issue. Approximately 77% young men, 80% older men and older women could get condoms easily. But only around 40% of young women responded that they could access condoms easily. It is also interesting to note that there was a very stark difference between responses of two groups of younger women SS group. 40% of young women in Kebele 19 could access condoms compared to 0% of young women in Mutti. As mentioned earlier, the young women responded that their religion did not allow them to use or access condoms. However in general there was no significant difference observed among the participants and non-participants. In all the Kebeles, especially young men and women complained that there were no free condoms available. Young men also complained that the cost of the condoms can go as high as 3 birr and it can be unaffordable. One non-SS participant young man said, "when I can get a woman for 10-20 birr, why would I waste 3 birr buying a condom". In Mutti, young men asked the FGD facilitator's to help them access condoms. When the community volunteer was asked why he did not take responsibility to supply condoms in the village, he smiled somewhat sheepishly, saying that he did not know where to access them.

As mentioned earlier even though very few SS participant respondents reported sexual contact in last 6 months compared to non-SS participants, condom use show a different trend. Condom use among non-SS participants is higher that SS participants. In older men SS group, none of the participants reported using condoms with their wives (85% respondents reported having sex with their wives and none had sex with any other person). However among non-SS participants 25% reported using condoms with their wives and 5% with women other than wife (75% reported having sex with their wives and 5% with women other than wife). Among younger men both participants and non-participants reported using condoms with their girlfriends (10% participants and 39% non participants reported having sex with their girlfriends in last six months). In one of the young men non-SS group, 50% responded that they had problems negotiating condom use with their partners. The reasons given ranged from girls not wanting condoms to myths regarding condom use, lack of free condoms and lack of information about the correct use of condoms. In Mutti, the respondents also mentioned that their religion (Islam) does not permit condom use.

The incidence of STI seemed very low both among SS and non-SS participants. Women complained about the quality of health care facilities, although not specifically with regard to STI. Although most respondents were aware of STI, they were not aware of related health services. Of those aware of STI services, they felt that distance made them inaccessible.

Twenty seven percent of the non-SS male respondents reported alcohol use before having sex in the last 6 months as opposed to 0% of the SS male respondents. Consuming alcohol before sex indicates risk behaviour because studies show that alcohol use reduces decision-making power and the possibility of condom use in such situations is much lower.

Forty three percent of non-SS respondents perceived themselves to be at risk of HIV compared to 15% of SS respondents. The non-SS respondents felt that lack of knowledge and skills about HIV and condom use, lack of openness to talk about HIV and STI put them at risk of HIV. The SS respondents felt that since safe sex is partner dependent, their partners' behaviour may put them at risk of HIV.



The SS respondents also shared that SS had helped them to challenge traditional practices like polygamy, circumcision, wife inheritance etc. The respondents felt that it was quite

visible that after SS, there has been a decrease in such practices. For example, in the Mutti older men's SS FGD, the shared that following their SS training, when they understood the link between certain practices and vulnerability to HIV, they simply stopped wife inheritance and had made a community commitment to stop female circumcision. SS participants also reported a decrease in violence and increase in openness to talk about sex at home and between partners. Violence found a place in all discussions. Respondents shared that there exists violence within families (parents beating and abusing the children) and between spouses. Participants quoted examples of reduction in violence within families that has resulted in happier families. These are very powerful results and indicate what an effective mobilization-for-change SS is at the community level. Some the changes noted are:

> *I did not find sex interesting. Whenever my husband would ask me for sex I would make excuses and have arguments. Our beds were separated. After Stepping Stones, I learnt what good sex means. I learnt to communicate with my husband. I also understood that if I refuse sex, he will go out. Now I am ready to have sex an any time of the day and night. Now sex is wonderful. Stepping Stones joined our beds again.*
>
> *Married woman, Mutti Village*

> *I used to be always upset because I felt no one understood me. I used to have quarrels with my family and I used to cry. After Stepping Stones, I now know how to communicate with my family about my needs. I use 'I statements' and my assertive skills. Now I can discuss my issues with my family without fighting"*
>
> *Unmarried woman, Kebele 19*

> *Stepping Stones has increased my knowledge of sex and sexuality. I have gained confidence and now can confidently talk to my parents and my girlfriends about sex. Openness to talk to my girlfriends has improved our relationship.*
>
> *Unmarried man, Kebele 19*

Stepping Stones respondents shared that after the training, they became sensitive to PLHA. Respondents shared that SS helped them to overcome their fears and understand the issues and needs of PLHA. Many respondents have started taking care of the PLHA and their orphans.

> *Earlier we would take care of PLHA and orphans after death. We would collect money and do ceremonies. Now we have realized that they need care and support when they are alive. Our Stepping Stone group provides that support*
>
> *Married woman , Kebele 19*

The findings of the community review is presented below in a tabular form:

Questions	Response		z-Value
	SS participants (%) N=69	SS non participants (%) N=156	
Knowledge			
2 ways how HIV spreads	100	97	2.196**
Protect oneself from HIV	99	92	2.822**
Skills and Relationships			
Speak about sex with friends	78	62	2.531**
Speak about sex with parents	40	20	2.980**
Speak about sex with sexual partner	71	63	1.195
Possess skills to protect oneself	98	66	7.710***
Behaviour			
Sexual contact with boyfriend/ girl friend/sex worker in last 6 months	12	40	5.054***
Sexual contact with spouse***$***	89	75	2.735**
Seen condoms	96	90	1.782*
Get condoms easily	68	71	-0.449
Used condoms with wives***$***	0	25	7.211***
Used condoms with girlfriends***$$***	10	46	6.689***
Taken alcohol before sex	0	27	7.596***
Risk of getting HIV	15	43	4.789***

$ - respondents – older men

$$ - respondents – younger men

** denotes p <0.1, ** denotes p< .05 and *** denotes p < .001*

Across the groups, following concerns were raised with regard to the following:

- **The creation of fora to discuss issues of sex and sexuality**. The absence of such fora has created miscommunication or myths around STI and HIV. Lack of correct information makes one vulnerable to HIV and STI
- **The need for employment/recreational opportunities especially for young men**. Lack of employment or recreational facilities for men drives them to alcohol and/or sex. Young men get involved in sex as a way to spend time or as a recreational activity
- **The need for access to quality health services and commodities like condoms** is a demand across all the groups.
- Almost all respondents felt that **SS should have continued after the three-month training**, either through volunteer facilitators or through paid facilitators. The all felt that one training is not enough to change the community and sustain to sustain that change.

❑ Content and process of training

All SS participants enjoyed their training, in particular role-plays, drama and special requests. Some respondents mentioned that although in the beginning they were uncomfortable talking about sex, the facilitators made them comfortable with time. Stepping Stones trainees cited the following benefits of the training:

Young men – increased communication with parents, reduction in number of sexual partners, faithfulness to one partner, increased confidence
Older men – increased knowledge, skills to communicate about sex with children, increased confidence
Older women – increased openness to discuss sex, improved sexual relationship with husband, increased knowledge and confidence
Younger girls – reduction in harassment, reduction in child marriage, reduction in school dropouts, increase in confidence and openness

After the training, all the SS participant respondents felt motivated to work for HIV prevention and care. Some participants became volunteer facilitators and some others began educating other community member by inviting them to coffee ceremonies etc. However due to lack of follow-up and support from the project, these activities were not sustained for very long.

Sessions that participants found useful and interesting

Different groups found different sessions interesting. The review found that these opinions mostly reflected the concerns or need of the group.

Young women – body mapping, ideal images and personal destroyers, happy and unhappy relationship, images of sex, I statements
Older women – body mapping, special requests, loving and non-loving relationships
Younger men – traditions, ideal images and personal destroyers, images of sex
Older men – loving and non loving relationship, I statements, traditional practices

4.5 Services Review

Effective HIV prevention requires a complementary effort between community mobilisation and health and other support services. Mobilising a community for HIV and AIDS prevention and care will inevitably result in increased demand for both STI and VCT services. In the context of this Stepping Stones Review, the consultants thought it appropriate to conduct an indicative review of STI and VCT services in Harar town. In Harar, there are 4 government hospitals, 2 military and 2 civilian and 5 health clinics.

Voluntary Counselling and Testing: From a total of 4 VCT Centres (3 civilian and 1 military), the evaluators visited three civilian facilities and are happy to report that excellent VCT services exist in Harar town. The first VCT facility visited was in **Hiwot Fana Hospital**, a government referral hospital. The evaluators met the VCT counsellor, Sr. Birtukan, who reports to the hospital Medical Director. This VCT centre has been in existence for 12 years, but has become a fully operation VCT centre in the past three years, with a private room, rapid test kits, and a trained counsellor. In this hospital, clients have their test in the morning, the samples are then sent to the laboratory, and the results come back in the afternoon. This hospital, therefore, offers same day results with a waiting period of 2-4 hours. Although there are some diagnostic referrals, the bulk of the clients are self-referral. Every client receives pre and post-test counselling, blood samples are number coded to protect confidentiality, and consent is obtained through a consent form, which is

locked in the counsellors desk. The HIV test is free. This VCT centre has never distributed condoms to any VCT client. When asked why not, the counsellor replied, "nobody brought them". This VCT centre receives training support from CDC. During the three-month period, November 04–January 05, 133 men and 172 women were tested for HIV, and 16 men and 34 women tested HIV positive, or 16%.

The second VCT Centre visited was in the **Model Youth Clinic, Family Guidance Association (FGA)**. The evaluators met Mr. Agazl Alemu and Sr. Eskedar Mellige. The VCT clinic is part of the youth centre that offers comprehensive services for young people – a girls club, a boys club, a music and drama club, a peer-to-peer club, a youth council, sports, including table tennis and outreach services for street kids and young sex workers. Within their clinical services FGA offers treatment for both VCT and STI. All staff are trained VCT counsellors and this ensures continuity of service provision. All clients receive pre and post-test counselling, and fill out consent forms. They have private rooms for client counselling, use rapid kits for HIV testing, and clients receive their results within 20-30 minutes. This is a VCT service for young people, and clients are from 10-24. From age 14 +, they test without parental consent. They provide condoms to their clients. FGA charges 5 birr to under 24-year olds, and 10 birr to over 24-year olds. FGA counsellors also attend CDC-sponsored refresher training.

In the year 2004, Sr. Mellige tested 256 males and 189 females, of whom 28 (10.9%) and 14 (7.4%) were HIV positive respectively.

The third VCT Centre visited was the **Model Adult Clinic, Family Guidance Association (FGA)**. There, the VCT counsellor, Nurse Mesfin Asefa provided an overview of services. All clients receive pre and post-test counselling, and fill out consent forms. There is a private room for counselling, and FGA uses rapid kits for HIV testing, and clients receive their results within 20-30 minutes. They receive on average, 5 clients per day, and they are 14-15% HIV positive, although Nurse Mesfin informed that he had had 10 clients the previous day. In 2004, the tested 389 for HIV, of whom 42 were positive, 18 males and 24 females. The bulk of the people they test are walk-in clients. They charge 10 birr per client, and this is waived for clients who cannot afford to pay. They actively promote condom use for HIV prevention and provide clients with condoms.

With regard to VCT, therefore, Harar town is well served, with youth-friendly VCT available, as well as high quality low-cost or free testing. The only slightly off note was the hospital, with a time lag of 2-4 hours for results, and the fact that they had never promoted condoms. Still, the VCT counsellor informed that same-day results was a step forward from before, where clients would have to wait until the following day. And interestingly, the evaluators returned the next day to confirm the data given, and the VCT centre was already stocked with condoms!

Sexually Transmitted Infections: In Harar Town, STI services are not decentralised. Community members do not go to health stations for STI treatment, for example, one health station in Kebele 18 treated 2 people in 2004, and one health station at Jegol Area treated no one. Overall, STI services appear to be much weaker than VCT, perhaps reflecting weak technical support to this service. VCTC on the other hand, has been

receiving sustained training, supply of consumables and monitoring and evaluation support from CDC. In Harar town, four health facilities providing STI service were visited.

Hiwat Fana Hospital provides free STI diagnosis and treatment within their Obstetrics and Gynaecological Departments. Although there is a separate space for the treatment of clients, the room was locked when visited. STI are diagnosed syndromically, and treatment is free. In 2004, 82 clients were treated for STI, of whom 63 were women and 19 were men. They do not provide condoms as part of their service. Clearly, this is not a service with any serious uptake, and positioned as it is with the Ob/Gyn department, discourages men from seeking treatment. The whole area of STI had an aura of inattention and low priority. The Medical Director informed that there are plans to establish a separate STI clinic within the hospital. This may increase the number of clients who come for treatment.

STI services are also provided by the **Model Youth Clinic, Family Guidance Association.** Their laboratory carries out STI diagnosis and they promote condoms as part of their STI treatment. They treated 36 STI positive clients in 2004, of whom 24 were women and 12 were men. Modest charges apply, and risk reduction counselling is provided.

At the FGA Model Clinic (Adult) they use the syndromic guidelines for STI treatment, and carry out a clinical diagnosis where the doctor is unsure. According to Dr. Yared Dagnew, patients pay 5 birr for their card, 7 birr for their diagnosis and pay for their drugs. In 2004, they treated 163 female STI clients and 27 males.

At the **Mistak Arbegnoch Hospital**, 38 women and 17 men were treated for STI over the 4-month period, October 2004 to January 2005. Diagnosis is syndromic, and STI drugs are available. Treatment costs 5 birr.

Condom Availability, Accessibility and Affordability: It seems unthinkable that in a town such as Harar, with a HIV seroprevalence of almost 10%, condoms are not widely and freely available. Furthermore, many SS facilitators did not know if condom use had increased or not in the past month in their Kebeles. Focus Group Discussions, especially with young men, revealed that they want access to condoms, but don't have them. STI services do not promote condom use, and the Save the Children Office, does not have a supply of condoms. The evaluators observed, therefore, slackness in condom promotion at almost every level with serious consequences for communities, where the indications are that they are not easily and freely available and accessible. There is no excuse for raising demand for condoms in a community and having no plan in place to ensure supply.

A more comprehensive review would include an assessment of male STI health seeking behaviour, health personnel training needs, record keeping etc. But for the purposes of this SS review, it is clear that both VCT and STI health services exist in Harar Town and the promotion and supply of condoms is uneven. And what is startling is that there was absolutely no link between the SS community mobilisation process and health support services. During the facilitator's review, for example, the facilitators' (paid and unpaid) knowledge of where to refer community members for VCTC or STI services was hazy to non-existent. This lack of service and condom promotion points to a weakness in the leadership provided to the implementation of the SS programme from the local NGOs.

5.0 Conclusions

Based on the findings of the review it can be concluded that Stepping Stones process in the community has had positive impact among the participants in the area of knowledge, skills and behaviour. The findings clearly imply that in comparison to non participants, Stepping Stones participants had higher knowledge of transmission and prevention of HIV, better skills to communicate about sex with parents, friends and sexual partners and to protect themselves and most of all practiced safer sexual practices (participants had lower sexual encounters, did not consume alcohol before sex, used condoms in all sexual encounters). The participants also had started questioning some of the traditions and community norms which may make them vulnerable to HIV.

Comparisons between the 2 Kebeles where Stepping Stones was implemented (Mutti in 2002 and Kebele 19 in 2004) show that in certain areas the SS process had varying impact in the two Kebeles. The main difference can be seen in the context of openness to communicate about sex and accessibility to condoms. 80% of respondents in Kebele 19 responded being able to communicate openly about sex compared to 40% of the SS participants in Mutti. Similarly another notable difference was recorded in the context of accessibility to condoms where 40% of young women reported having access to condoms in Kebele 19 compared to none in Mutti (the other three respondent groups did not show such differences). However on further probing and analysis, it can be concluded that the difference is more to do with religion and geography (Mutti is Muslim dominated and a rural village) rather than time of implementation. This was confirmed by the fact that knowledge and skills among non-SS participants in Mutti have also been low (lower than SS participants in Mutti).

However what is interesting to note is that Stepping Stones has had very negligible influence on the non-participants in Mutti and Kebele 19. Though participants seem to have gained from the SS process, it has had low influence on non-participants in the same community. The knowledge, skills and behaviour of non-participants of SS Kebele and non SS Kebele had negligible difference.

The key conclusions of the review are summarized below:

- **Stepping Stones Facilitators**: From the point of view of the SS facilitators, SS was a great success, both personally and professionally. On a personal level, the facilitators felt that SS had helped change their lives, by encouraging self-analysis and behaviour change. At the same time, all the facilitators felt that SS was very helpful in promoting behaviour change in the context of HIV and AIDS. The facilitators also felt that they needed additional training over and above the initial 12-day training that they received prior to SS start-up. They also felt that they needed some support in mobilizing older men to come to the training and the follow-up meetings.

- **Stepping Stones and Community Mobilization**: 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. One of the difficulties that HIV prevention programmes have faced, is that the classic Information, Education and Communication (IEC) promoting Abstinence, Be faithful and use Condoms (ABC) as the HIV prevention solution, have not taken into account the context in which decisions to abstain, be (mutually) faithful and use condoms. These are all partner-dependent solutions and require the active cooperation of both sexual partners. In the words of Vikki Tallis:

Unequal parties are not in a position to negotiate when they have sex, how often and how they can protect themselves from sexually transmitted infections (STIs) and HIV. The double standard of condoning multiple sexual partners for men, and the expectation that men should know more about sex, puts them and their sexual partners at risk as well as preventing them seeking sexual health advice. [12]

- **Positive impact on Participants:** The review clearly shows that the project had a positive impact on the participants of SS. Undoubtedly knowledge of HIV and STI was high among the participants, their ability to communicate about sex with friends, parents and sexual partners had also increased considerably. Strikingly, the participants also had confidence that they possessed skills to protect themselves from HIV. Sexual relationship with girlfriends/boy friends/sex workers was significantly less among SS participants. Participants also did not have other risky behaviour such as consuming alcohol before sex. Though there was not much difference in accessibility to STI services and condoms, the participants clearly felt that they were at less risk of getting HIV. During the review it was also very evident that the SS participants were very confident especially woman participants, very open to talk about sex (which is uncommon in most societies), did believe that the SS process had benefited them and were motivated to take up a leadership role and involve in prevention and care activities.

- **HIV and AIDS Project Design in Harar**: SCUK Ethiopia and OSSA did not conduct a project baseline in Harar. Therefore, setting clear project objectives, and measures of success was not done in advance. This hampered the assessment of the success of SS at the Kebele level, and also the development of a longer-term community mobilization plan, of which SS training would be one important part. In addition, carrying out a baseline and identifying those groups most important to reach for SS training would add a degree of selection to the recruitment of SS participants.

- **Impact limited to the participants:** It was also very interesting to see that all the benefits of Stepping Stones have stayed mostly with the participants. There has been no proactive process to include non-participants in the same Kebele and therefore the change among the non-participants was negligible. This reflects on selection of

[12] Vicci Tallis, *Gender and HIV/AIDS Overview Report*, BRIDGE SERIES, Institute of Development Studies, University of Sussex, September 2002, p.2.

participants for SS, time spent by the project in the Kebele and involvement of the larger community. This also calls for change in the project design.

- **Religion and geography as a barrier:** As mentioned earlier, the difference between response of participants from Mutti and Kebele 19 in certain areas is stark. This difference is attributed to the fact that Mutti is a Muslim dominated Kebele and is also rural. This also reflects that this project may not have been able to adequately address religious barriers. Even though the knowledge and skills of SS participants in Mutti is better than non-participants, clearly showing the positive impact of the project, it also confirms that fact that a Muslim rural community would need special attention and special project design.

- **The Link to Services and other HIV programmes**: What SS provides is a process for all those concerned in a community to learn about sexual health, facts about HIV and AIDS, what motivates their own behaviour and behaviour change, and to listen and learn from other peer groups about their specific concerns. SS is also effective, because it works from the stated concerns of the training participants themselves. However, this is tricky, because it can be difficult to respond to the broad range of concerns identified in a community. It is also tricky because while the contextual determinants of HIV transmission are the most difficult to address or change, addressing HIV prevention directly must be part of any broader initiative. Therefore, reaching those most at risk, condom use, partner reduction, STI treatment and VCTC must be an integral part of any effective HIV prevention programme. Even though the project established linkages with other services that OSSA provided like Anti AIDS Clubs, care for OVC, the linkage was weak. Also Anti AIDS clubs in the Kebeles were formed as a follow-up of the Stepping Stones sessions. Therefore these clubs mostly had members who were SS participants thus making the groups a bit exclusive.

- **The Need for Capacity Building**: What the foregoing suggests is that both SCUK and OSSA require some capacity building in order to maximize the benefits from any HIV and AIDS programme, including SS training. Such capacity building could include how to conduct a HIV and AIDS baseline, and set up a project MIS and work plan, and link to service support.

Hence we can conclude that in the Harar project Stepping Stones had considerable impact on the knowledge skills and behaviour of the participants. However at the same time the project would have to make some changes in implementation design to break through the barrier of religion, geography (urban-rural) and more importantly have an impact on the community at large rather than just the participants.

6. Recommendations

- **Implement SS within a larger HIV context**: SS is not a stand-alone HIV prevention project; it is a good tool to mobilize the community and address issues related to gender and communication and other underlying factors that make people vulnerable to HIV. However SS alone cannot prevent HIV, without providing for services and commodities like condoms. Hence SS work best within a larger HIV project that address issues of prevention and care. This is a key learning from the project in Harar that only depends on SS to prevent HIV.

- **Need for a baseline and indicators**: Prior to any project start-up, the collection of baseline data is an essential first step. Without this, it is very difficult to answer the simple question: "how do we know that our project is successful"? There was no baseline data collected for the Harar project, although the selection of Kebeles was carried out with on-the-ground knowledge of risk. Thus, Kebele 12 was selected as a first starting point (military personnel, PLHAs). However, there were no indicators of risk and success identified. It is, therefore, important that the project develops indicators of success and shares it with the staff so that staff is aware of the progress made against the indicators. The indicators could be proximate indicators, such as increases in knowledge levels, condom use, and STI treatment, and decreases in multi-partnering and stigma and discrimination etc. Contextual indicators could include such not-so-proximate indicators as improved gender relations, improved communication about sex, decreases in violence and alcohol, female circumcision, etc.

- **A more sustained outreach strategy is required**: Linked to equating SS training with a full HIV prevention programme is the associated implementation strategy, whereby a group of facilitators go into a community for 3 months, conduct SS training and then move on to another community. Expecting people to change in three months is very optimistic. The process of SS needs to be spread out so that as people learn, they also get a chance to practice. Also while they are practicing or changing behaviour they also have support. In the project in Harar, the facilitators very successfully make people aware of risk and also committed to change but are not available to support the changed behaviour. Also, the link between the training of participants and more broad-based community mobilization for HIV prevention, within a Kebele requires longer than three months. The evaluation clearly shows that the participants of the training are currently practicing safer behaviour. However this change had not reached non-SS participants, even in the same Kebele. This is because enough time is not spent in the Kebele by the project and absence of a plan to reach the other members in the Kebele. Linked to this is the need to have a clear support structure in place for the whole project design. For example, once the Kebeles are mapped, - 16 – in this instance, they can be geographically grouped with each facilitator having specific responsibility for 3-4 Kebeles. These facilitators would have responsibility for producing monthly reports, holding monthly meetings with volunteer facilitators, ensuring a condom supply, conducting STI referrals, etc. For such a revised design, SCUK/OSSA would have to commit additional resources.

- **Being innovative**: The facilitators of SS can be innovative and perceptive of communities need. Literacy can be included in SS sessions. This would make the sessions interesting and would be also a tangible benefit of the programme. This may also attract more people to join SS

- **Breaking religious barriers to behaviour change:** In Harar, which is a Muslim dominated city, religion plays an important role. During the Stepping Stones session, sessions on religion should be included and religious barriers to safe sex should be identified and addressed. Issues of gender inequity in the context of religion should be also adequately addressed. The facilitators have to be skilled to facilitate these sessions, as religion can be a very sensitive issue.

- **A more conscious selection of participants is needed**: Strategic selection of participants for this training is crucial if the project cannot train everyone in the community. SS is a time and human resource intensive process. Hence, there is always the challenge of scaling up and reaching the maximum number of people using this tool. Strategic selection of participants could be the answer to this challenge. There are a number of options available: 1. A risk assessment could be carried out in the Kebele to identify people at greatest risk and prioritize them for this training. 2. The other option would be to map social networks of people in the community and identify representatives from different social networks to attend this training. Or some combination of 1 & 2 could be adopted. This way this representative can be encouraged to share the training with other members of their social network. In the Harar project, currently the participation is based on self-selection, and therefore participants mostly belong to one or two social network like members of the Anti AIDS Clubs. Hence the learning from the training stays within the same social network.

- **Observe the integrity of the manual steps**: SS is a process that is built step-by-step. There is a real need to rehabilitate the integrity of the original manual and re-train the facilitators in the rationale for these steps and this training flow. Of course, the additional sessions added in Harar (social mapping, HIV timeline, risk matrix) should still be included, but in the context of the overall process.

- **Build capacity at every level**: The evaluators identified the need for capacity building at every level. Both SCUK and OSSA at the institutional level require some training in HIV prevention programme methodology and how to maximize the use of scarce resources. Now that SCUK has in-house capacity with a technical HIV/AIDS position, this can be quite easily achieved. In addition, there is a need to build the capacity of the SS facilitators. They are expected to have good communication and facilitation skills, be sensitive to gender issues and have the ability to manage groups and conflicts etc. It is very difficult to find such multi-skilled facilitators. A single12-day SS training cannot impart all these skills. Hence refresher training and capacity building of facilitators is very important. In addition, the facilitators also require training in HIV prevention methods, in order to be able to place SS in a larger HIV prevention and care context.

- **Community mobilization and services support, an essential link**: For any successful HIV prevention and care programme, health and other service support is crucial. As already articulated, The Harar Project was mobilizing community concern for HIV

prevention but was not linking them to services. Hence, although participants were aware that sex with condoms is a safer option, they did not have access to condoms. The implementing NGO, OSSA did not provide condoms directly nor did it develop depots or volunteers in the community who could keep condoms. Similarly linkage with VCTC, STI and care services is essential. Also this is especially important for rural communities where such linkages are anyway very poor.

- **Sustainability:** Sustainability of projects is always a challenge especially HIV programmes where behaviour change needs to be sustained. To make the projects sustainable, the Harar project would have to increase its financial and time commitment to the community. The project should be involved in the community for at least two years. The SS sessions should be spaced so that participants get a chance to practice the skills learnt in the sessions. A plan of selecting participants from different social networks needs to be incorporated. Also participants should be proactively encouraged to share the learnings of the sessions with their other peers. A cadre of volunteer facilitators should be developed who can facilitate more groups in the community under the supervision of paid facilitators. SS encourages peer group formation. This group process should be strengthened to develop a community norm for safe sex and also to take up prevention and care activities. Linking the community with existing services is also essential to sustain behaviour change.

Annexures

Stepping Stones – a tool to address gender, sex and HIV

Introduction

Latest UNAIDS figures indicate that 33.6 million people worldwide are infected with the HIV virus. 4 million people in India alone are now HIV positive. Most of those infected are in the 15-49 years age group, which is the group which is most economically productive in society. The repercussions of this pose a huge threat to development – declining child survival rates, falling life expectancy, overburdened health care systems. Increasing number of orphans, labour shortages and falling business profits are some of the indicators HIV is not a problem which will go away by itself.

Initial Response

Initial responses to the epidemic focused the blame on others For instance, in different parts of the world, foreigners, sex workers, gay men, and women have all been blamed. In Africa, AIDS is often known as "American Initiative to Discourage Sex", an allusion to Western ideas about family planning and population levels. This led to exclusion of foreigners with HIV or forced testing of sex workers. In most countries, however it soon became clear that such measures were both unethical and unworkable. It has thankfully become increasingly clear, therefore, in most countries of the world, that blaming others only serves to increase fears, to reduce openness amongst one another and therefore to increase the chances of HIV gaining ground.

Those who were able to look beyond blame to a less biased and more measured approach began to develop public awareness campaigns, based on a public health "Information, Education and Communication" (IEC) model. These campaigns were based on the principle that if the public were given enough information about the issues, then they would surely halt their risk-taking activities, thereby stopping the chances of HIV spreading. Unfortunately, however well-intentioned, a lot of the campaigns were too negative, sombre and frightening for most viewers, who responded by laughing at the threat, or ignoring it, turning their heads away from the adverts.

Anti-HIV campaigns, like anti-smoking or health food campaigns, can rarely succeed through information alone. Recipients of the messages are not empty vessels and already have many of their own ideas and experiences, which influence their views. For instance many AIDS campaigns have ignored the facts that sex can also be enjoyable and creative. So by only focusing on the negative issues, and by only linking sex with death and not with life too, the messages have often been over-simplified and have just switched people off from wanting to hear any more.

As well as basing such campaigns on our great fears around sex and death, the campaigns presented the idea of a simple solution to our fears: namely the "ABC" approach to safer sex. This stands for "Abstain, Be faithful, or use Condoms". The "ABC" approach is extraordinarily difficult for most people to follow. It is a highly gender-insensitive message, which just does not meet the needs of most of its intended audience, men or women. For the vast majority of women in the world. who are economically dependent on their

husbands, and who are in danger of losing their children if they leave the marital home or who have to sell sex to feed their families, abstaining from sex, or using a condom for sex is difficult and even impossible in some situations.

Next, the "ABC" message has not adequately reflected the role that parenthood has in many countries of the world. Motherhood and fatherhood are central to adulthood in so many societies.

Thirdly, being faithful also presents a conundrum. No matter how much an individual is faithful to their partner, if the latter is having unprotected sex with others, that individual is at risk. For many women - as in the case of the Indian wives cited earlier - this has proved to be a huge challenge, since in many societies it is culturally acceptable for men to have sex with multiple partners without their wives' knowledge or consent; and culturally unacceptable for women to discuss such matters with their husbands.

There are huge problems for many men too. For instance, if a man has had unsafe sex in the past and fears that he may be infected, he may wish to use condoms in future with his wife. But if she wants to have children and also associates condoms with the sex trade, how can he start using them to protect her? There are huge dilemmas here both for women and for men and their relationships with one another

The simple "ABC" message fails to address any of them and provides very few members of the public with acceptable solutions.

Three lessons learnt for more recent responses
More recent responses have been based on three growing realisations.

- Firstly, we have learnt that people learn to find strategies to change their behaviour far more easily through discussions with their peers of their own needs and situations, than they do through being fed messages from others.
- Secondly, we have seen that HIV can often be more readily addressed by people as yet another branch of those sexual and reproductive health problems which have faced people for many years, such as unwanted pregnancy, sexually transmitted infections (STIs), infertility and so on, rather than as a totally new problem.
- Thirdly, we have learnt that HIV and these related issues are greatly influenced by gender inequalities, which need to be recognised and addressed if the challenges are to be overcome.

These three significant realisations have shaped current thinking on HIV community work.

Stepping Stones
Stepping Stones is a training package on HIV / AIDS, gender, communication and relationship skills designed both for use in existing HIV / AIDS projects and in general development projects which plan to introduce an ongoing AIDS component. This training package has been very successfully used in sub-Saharan African countries and is being successfully adapted for use in Asia, North and South America and Europe

SS grew out of a need to address the vulnerability of women and young people when it comes to decision making about sexual behaviour. The ABC of AIDS (Abstain! Be faithful! Use Condoms) !) on its own does not work and lectures on AIDS are too simplistic. The training package is designed to enable people to explore the huge range of issues which affect their sexual health – including gender roles, money, alcohol use, traditional practices, attitudes to sex, attitudes to death, and their own personalities. Addressing behaviour issues, particularly in the area of sexually transmitted diseases such as HIV / AIDS, calls for great sensitivity. SS is a participatory tool aiming at behavioural change for prevention and control of STD / HIV/ AIDS.

Basic Principles

- the best prevention strategies are those developed by community members themselves
- peer groups need their own time and space to identify and explore their own needs
- behaviour change will be more effective and sustained when all members of the community are involved

Approach

- all the work is based on people's own experiences
- Emphasis on we and us, not they and them .
- Using participants drawing and discouragement of note taking
- Sitting together in a circle
- working with groups, usually based on gender and age
- role-play, drawing, song and dance mean that everyone can take part, without formal education

The workshop sessions

The training package contains a 240 page manual for trainers and an accompanying workshop video of 15 five minute clips (though the manual can be used without the video too). The manual is authored by Alice Welbourn, PhD , researcher and trainer in participatory approaches to development and is based in Oxfordshire, UK.. The manual contains closely guided instructions on how to run around 60 hours of workshop sessions divided into 18 sessions over 10 – 12 weeks.

Spreading the sessions over several weeks like this enables community members who want to join the workshop to put what they have learnt into practice between sessions, turning rehearsal into reality. All the sessions are based on exercises using creative skills such as drawing, acting, song and dance, none of which need any formal education background for participants to take part. The drawing work is based on the PRA ideas of general development workers

Themes
There are four themes in SS

- **Group Cooperation Skills** - first theme, covering the first few sessions, establishes the identity of each group which has been formed and enables them to develop group cooperation skills. It helps participants to explore the risks that we take in our lives, helps them to think about how we judge ourselves and others, starts to look at the gender roles which we have in our lives and addresses the good feelings and concerns that we have about our sexual health.
- **HIV and safe sex** - The second theme covers HIV: its transmission, protection and condoms. Workshop participants are given information about different possible options presently available for them to practice safer sex. Each and every workshop participant has the individual opportunity, if they want to, to touch and feel a condom and learn how to use one effectively. (This is in sharp contrast to more conventional campaigns, where one "educator" has stood up in front of a large group of onlookers, whilst placing a condom on a dildo.) However, no workshop member is told that they must do one thing or another. Instead they are having the opportunity to ask questions of their workshop facilitator (who is of similar gender and age to themselves), to share their thoughts and experiences, and to work out for themselves what is best for them.
- **Why we behave in the ways we do** – This is where there is the big departure from more conventional health education approaches and where workshop participants really begin to start exploring for themselves the complexities of our lives. One session looks, for instance, at the role of alcohol in our lives - its pleasures, it dangers and how we might learn to control it rather than it control us (unsafe sex often takes place under the influence of alcohol or other drugs). Other sessions address household expenditure - who takes responsibility for paying what, and who takes decisions for expenditure within the household.) The sessions explore the fairness of existing systems. Another session looks at traditional practices. All societies have time-honoured practices, some of which may be good, others of which may have problems now attached to them. not be a wise option.
- **Ways in which we can change** – which explores assertiveness skills, "I" statements, trust, coping with death and planning for the future.

Of course, people cannot be expected to change their approach to life on the basis of nine weeks' work. This workshop can only be seen as the starting point for changes within a community. So workshop participants are encouraged to continue meeting by themselves after the last session is completed. We consider that these continued meetings enable participants to sustain the changes that they have decided to make in their lives and act as a support group.

Fission and Fusion Structure of the workshops

Groups are encouraged to meet alone and then to come together for large group exchanges This principle of "fission and fusion" allows two important things. It creates the private time and space for discussion of personal issues, which many individuals might find far too embarrassing or painful for wider group discussion. It also creates the public space where

the less powerful groups in a community have an equal platform with the more powerful groups other groups and the issues raised can then be discussed by everyone present.

The intimate details of the small group discussions can get ironed out of this public presentation, but it enables the young women, for instance, to present the dilemmas which they face with "sugar daddies" who pursue them for sexual favours in return for school fees; or for older men to present the loss of self-esteem that turns them to drinking when they are made redundant. These sharings between groups enable everyone in the community to develop more awareness of the needs and difficulties of others around them, as well as increasing their own self-esteem and self-respect through having their own needs appreciated more clearly. Such meetings produce many comments such as "I never realised that...." and "now I understand why..." As the community members begin to understand themselves and one another more, simultaneously at the individual level, with peer level support and also with wider community understanding, so the foundation stones for change are laid.

What Changes can Happen after using Stepping Stones?
The change occurs in four stages:

- **Learning** about our sexual health, HIV and other sexually transmitted infections;
- **Sharing** and discussing problems and ideas by talking with our peers, partners and children;
- **Caring** by accepting responsibility for the way in which our behaviour affects others, including those who are affected by AIDS;
- **Changing** Behaviour in ways, which we want, in order to improve our sexual health.

STEPPING STONES: A training package on HIV/AIDS, gender issues, communication and relationship skills.

WHAT IS IT?

A 240-page manual for trainers, and an accompanying workshop video of 15 five-minute clips (though the manual can be used without the video). Full, closely-guided instructions on how to run around 60 hours of workshop, divided into 18 sessions over 10 to 12 weeks. Designed to enable women and men of all ages to explore their social, sexual and psychological needs, to analyse the communication blocks they face, and to practise different ways of behaving in their relationships. The workshop aims to enable individuals, their peers and their communities to change their behaviour - individually and together - through the 'stepping stones' which the various sessions provide.

FOR WHOM?

Designed for use in existing HIV/AIDS projects, and in general development projects which plan to introduce an on-going AIDS component. Designed for use by a team of skilled people - ideally two male, two female - who work with peer groups of community members. Experienced trainers should be able to use the material straight away. Less experienced trainers may need a training course to help them start to use it.

WITH WHOM?

Originally for use in communities throughout sub-Saharan Africa. However, it is also being successfully adapted for use in Asia, North and Latin America and Europe. Most sessions are designed for people in small groups of 10-20, of their own gender and age. Occasional sessions bring everyone together.

WHY?

The ABC of AIDS (Abstain! Be faithful! use Condoms!) on its own does not work. Lectures on AIDS are too simplistic. SS grew out of the need to address the vulnerability of women and young people in decision-making about sexual behaviour. The materials enable people to explore the huge range of issues which affect our sexual health - including gender roles, money, alcohol use, traditional practices, attitudes to sex, attitudes to death and our own personalities.

HOW?

- All sessions use a participatory approach of adult learning through shared discussions.
- The exercises are all based on people's own experiences, and role play and drawing exercises enable everyone to take part. No literacy is needed.
- Participants discuss their experiences, act them out, analyse them, consider alternative outcomes, and then rehearse these together in a safe, supportive group.
- People feel safe because most sessions take place in groups of their own gender and age.

- Though designed with HIV/AIDS in mind, the package covers many related topics such as gender violence and alcohol use.

CONTENTS OF THE MANUAL

The SS workshops are designed to be held with four peer groups drawn from a community at the same time. They consist of 14 sessions held with separate peer groups, two meetings of the peer groups together and opening and closing meetings for the whole community.

The 14 sessions for the separate peer groups cover the following topics:

1. Let's Communicate

To help a peer group form itself. To help participants develop skills of listening and analysis of communication and cooperation.

2. Our perceptions

To help participants recognise how much perceptions influence our judgements of ourselves and others. A first look at images of sex.

3. What is love?

What we look for and expect to give in love.

4. Our prejudices

To challenge the judgements which we make about another

5. HIV

To explore our knowledge about HIV and "safer sex"

6. Condoms

To continue our discussions about safer sex and to familiarise participants with use of the condom.

7. Our options

To consider different possible future strategies which we may have in our lives

8. Let's look deeper (Part 1)

To study why we behave in the ways we do

9. Let's look deeper (Part 2)

A development of the previous session

10. Let's support ourselves

To find new skills to change the ways in which we behave

11. Let's assert ourselves

To develop more assertiveness skills

12. Let's change ourselves

To put these new skills into practice

13. Let's work together

To develop understanding between partners

14. Let's prepare for the future

To think of possible future decisions and changes

The video

An optional video can be used in conjunction with the SS manual.It consists of 15 short clips which provide a springboard for discussion on the topics listed above. The clips show members of a rural community in Uganda who have discussed and re-enacted their own problems and developed their own solutions.

Annexure 2

STEPPING STONES AND SAVE THE CHILDREN IN ETHIOPIA: a proposal for a qualitative evaluation and improved model

I. Introduction

Since 2001, SCUK in partnership with local NGO OSSA is implementing SS: a community based gendered approach to HIV and AIDS prevention, care and support in eight high risk communities (Kabeles) in the Harari Region of Ethiopia.. The implementing agency is now calling for proposals to review this 2-year pilot programme with the aim to understand its success and come up with a improved model for promotion and replication.

2. Stepping Stones

SS is a training package on , HIV and AIDS, gender, communication and relationship skills designed both for use in existing HIV and AIDS projects and in general development projects which plan to introduce an ongoing AIDS component. This training package has been very successfully used in sub-Saharan African countries and is being effectively adapted for use in Asia, North and South America and Europe.

SS grew out of a need to address the vulnerability of women and young people when it comes to decision-making about sexual behaviour. The ABC of HIV prevention, (Abstain! Be faithful! Use Condoms)!) outside of the context in which sexual negotiation and behaviour takes place does not work well and lectures on HIV and AIDS are too simplistic. Issues related to gender inequity, lack of practical options, taboo to talk about sex and sexuality acts as a barrier to all HIV prevention and care activities. SS is designed to enable people to explore the huge range of issues which affect their sexual health – including gender roles, money, alcohol use, traditional practices, attitudes to sex, attitudes to death, and their own personalities. Addressing behaviour issues, particularly in the area of sexually transmitted diseases such as HIV and AIDS, calls for great sensitivity. It is in this context that SS, a participatory tool aiming at behavioural change for prevention and control of STI, HIV and AIDS was developed in 1995.

2a. Stepping Stones: a gendered approach to HIV and AIDS prevention and care

The strength of the SS approach is its ability to facilitate the exploration of relationships, sexual and reproductive health and HIV AND AIDS in a way that identifies, explores and finds solutions to the gendered vulnerabilities of adults and youth. It is based on the principles that the best prevention strategies are those developed by community members themselves and that behaviour change will be more effective and sustained when all members of the community are involved.

SS encourages men and women, young boys and girls to address issues, which concern them. In doing so, the SS processes also challenge conventional attitudes about women's rights, about traditional gender roles and expectations about each person's own behaviour, as well as start to meet their own sexual and reproductive needs. While men and women challenge constructions of feminity and masculinity that make them vulnerable to HIV and AIDS, reflect on their own behaviour that encourages these constructions, they also come up with

solutions/options on how to change these constructions, norms and attitudes. This not only facilitates an improvement in gender equity but also an enabling environment for the prevention of HIV and the care of people living with HIV and AIDS.

SS also helps to ease the taboo and fear around subjects like sex, death and gender. UNAIDS considers SS as one of the most effective tools of community mobilization.

2b. Stepping Stones in Ethiopia

Since 1997 several attempts have been made to introduce SS in Ethiopia. Both Action Aid and Christian Aid have supported a training of trainers' workshops, but with little follow up after the training the momentum was lost. However in 2001, SCUK- in partnership with the local NGO OSSA Harari made the first real attempt to turn SS in a reality in Ethiopia by identifying 16 high risk communities (Kabeles) in Harari to implement SS over a two year period. The programme has been implemented in 8 Kabeles as a pilot and all reports received to date indicate that the pilot has been successful. There has been consistent attendance during the sessions despite the lack of incentives and anecdotal evidence suggests positive behaviour change.

3. Rationale for proposed review

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SCUK has supported the implementation of SS in various communities in Harari, Ethiopia. And although there have been anecdotal reports of positive behaviour change in the context of HIV and AIDS, and these have been credited to the SS processes, attribution is difficult. A structured evaluation process will help understand the extent to which SS has contributed to behaviour change and the ways in which this has occurred. Such an evaluation will also assist in the development of monitoring and evaluation tools to be included in any future SS training process.

The expected outcomes of the review are:

- An evaluation of the pilot programme that includes recommendations on modifications / improvements to the current SS training and community processes/inputs in order to create an effective behaviour change programme that address gender equity, HIV and AIDS.
- An improved SS model that incorporates an effective monitoring and evaluation framework to measure and track the impact of the approach and can be promoted and replicated elsewhere.
- Two trained local trainers who will represent a national resource in SS throughout Ethiopia.

3a. Design of the review

SCUK proposes that two international consultants will lead this review, supported by two local counterparts. These counterparts will contribute valuable local knowledge and use this opportunity to develop their skills and emerge as a national resource for training, implementing, monitoring and evaluating SS. The role of the international consultants is visualized at three levels/phases:

1. Evaluating the SS pilot programme, that will lead to the development of an improved SS model that can be replicated.
2. Building the capacity of local staff and consultants to implement the improved model, which includes a strong monitoring/evaluation framework.
3. Conducting a further evaluation of the new model, and making changes if needed and finalising the model for promotion and replication at the national level.

3b. Phases of the review

- **Level/Phase 1: Evaluation of the Pilot Programme**

Evaluation of the pilot programme in Harari is the first task of the consultants in this assignment. As stated above the objectives of the evaluation would be:

- To assess the contribution of the pilot SS programme in bringing about positive HIV and AIDS-related behaviour change.
- To develop a monitoring framework that can be incorporated in the ongoing programme and help the facilitators to continuously measure change in behaviour in communities where they are implementing SS.

SS aims to bring about changes in the community in four stages:

Learning about our sexual health, HIV and other sexually transmitted infections;
Sharing and discussing problems and ideas by talking with our peers, partners and children;
Caring by accepting responsibility for the way in which our behaviour affects others, including those who are affected by AIDS;
Changing behaviour in ways, which we want in order to improve our sexual health.

The evaluation will measure changes at all these four stages. Key indicators will be developed to measure changes at each of these four stages. The indicators will be also sensitive to measure changes in gender relations (decrease in violence against women, improvement in decision making about sexual health by women, improvement in communication between men and women, increased responsibility by men for safer sex etc) community participation (improved ability of the community to find solutions to their problems related to sexual health, improved collective responsibility of the community etc.) and so on.

The evaluation tools will be participatory including both qualitative and quantitative tools. Tools like in-depth interviews, focus group discussions and participatory learning and action (PLA) techniques will be used to access qualitative information. Other tools like the polling booth technique (see Appendix I)[13] will be used to access quantitative information. The evaluation will include the following main activities:

1. *Desk review of existing monitoring data*: This includes a review of all documentation with regard to STC Ethiopia and Ossa's presence in Harari. Any documentation pertaining to the introduction of SS is particularly germane. This also includes reviewing all reports of

[13] Pooling booth is a technique used to get private behaviour-related information from respondents in an unthreatening and private manner.

the facilitators and project staff to understand the SS processes adopted by the team at Harari. This will include reports of any informal review or documentation of experience-sharing or field notes of the facilitators etc. In addition, any STD or HIV and AIDS data for the Harari area prior to SS start-up will be reviewed. And finally, a review of any baseline data that was collected by STC/OSSA before starting SS in the communities in Harari.

This desk review will be conducted at their locations by the consultants. It will take 6 days[14]. However depending on the number of reports received, the time would increase or decrease.

2. *Draft evaluation framework*: A draft evaluation framework will be developed based on the literature review. Tools such as (FGD guideline, interview questionnaire etc) will be developed.

   This activity will be conducted at their locations by the consultants. It will take 8 days. It will be circulated to SCUK for comments and clarifications.

3. *Meeting with Staff and facilitators, finalizing framework*: A three-day workshop will be held with STC/OSSA staff and facilitators to understand their SS experiences, and review, amend and finalise the proposed evaluation tools and work plan. This will take six consultant days.

4. *Training of local consultants:* Immediately following the evaluation workshop with staff and facilitators, a two-day training of local consultants, and staff and field planning will be conducted. This would include training of local consultants and staff in monitoring framework and tools to be used for the evaluation.

   This activity will be conducted in Ethiopia and facilitated by the consultants. The finalisation of the review framework will take 3 days and the training and planning will take 2 days, 10 consulting days in all.

5. *Field evaluation*: After the training the pilot SS programme will be evaluated in the field. It will take 7 days. The field evaluation will include the following: in-depth interviews with key informants/stakeholders/community members, a review of 8 SS (2 groups each of older men, older women, younger boys and younger girls) and 4 non-SS community groups (one group of older men, older women, younger girls and younger boys). The methods to be used include an initial review using the polling booth technique, sex and age specific focus-group discussions and in-depth interviews and assessments. Note: the fast turn-around of the English-version reports from all in-depth interviews, FGDs, etc will be an essential component to build into the whole process and should be completed in the field prior to return to Addis Ababa.
   The consultants will lead the process with support from the local consultants and staff. This 7 day-field assessment will end with a debriefing workshop with SSUK and the evaluation team on the 6th day to share top line findings.

[14] Specific consultancy days mentioned for every activity includes days to be put in by both the consultants

6. *Analysis and report writing*: All the information gathered through secondary and primary sources will be collated, analysed and a report prepared. The report will include an assessment of any changes brought about in the community due to SS, and suggestions for improvement in the model if needed.

   The information will be analysed by the consultants at their locations. It would take 14 days to write this report.

7. *Development of a monitoring and evaluation framework*: Based on the field experience and the evaluation findings, a monitoring framework will be developed that can be integrated in the SS process. This will be finalized in consultation with SCUK team.

   The consultants would develop this framework at their locations. It would take 12 days.

- **Level/Phase 2: Capacity building of staff**

After the evaluation report and a monitoring frame-work is finalized, capacity building of staff in this framework would be undertaken. The aim of this activity is to build capacity of the local staff and consultants to integrate this framework in the SS process. Once the team is trained they would implement the improved model of SS (which includes the monitoring framework) in the remaining 8 Kebeles in Harari.

This activity will be undertaken by the consultants in Ethiopia. This will start with a one-day workshop with key stakeholders where this model would be presented for consultation and approval. A 4-day training of the staff in this improved model will follow this.

This activity would need the consultants to be in Ethiopia for 6 days, i.e. 12 consulting days.

Post this training the staff will implement the new model in the field.

- **Level/Phase 3: Finalisation of the new model**

The new model will be reviewed again after it has been implemented. Since by now the capacity of local consultants and staff would have been built, the external consultants would play a supportive role. During this activity, the new model would be evaluated. The evaluation would be mainly through interviews with staff and facilitators. It would include some field assessments. . It is because, the new model includes a monitoring framework and hence it is expected that the facilitators would have carried out a continuous monitoring process. Hence in this phase, the consultants will mainly interact with the facilitators to understand their ease in implementing the new tool (which includes monitoring framework) and changes they see in the communities where they are implementing SS.

The consultants would spend 6 days in Ethiopia at this phase i.e. 12 consulting days.

The consultants would then develop a final report of this process, which can be shared nationally. It would take the consultants 12 days to finalise the report.

2c. Timeframe

Following is the time frame for the complete review

Activity	**Months**							**No. of days**	**Locations**
	1	2	3	4	5	6	7		
Phase 1 – Evaluation									
Desk review of existing monitoring data	√							6 days	Own Location
Draft evaluation framework	√							8 days	Own location
Meeting with staff and facilitators, finalizing framework		√						6 days	Ethiopia
Evaluation framework training		√						4 days	Ethiopia
Field evaluation		√						14 days	Ethiopia
Analysis and report writing			√					14 days	Own location
Development of a monitoring evaluation framework			√					12 days	Own location
Phase 2 – Capacity Building									
Capacity building of staff in new model				√				12 days	Ethiopia
Phase 3 – Evaluate the new model									
Review the new model							√	12 days	Ethiopia
Final Report							√	12 days	Own Location
Total Days:									

Annexure 3

Implementation Calendar of Stepping Stones in Harar

Time	Kebele	Men	Women	Total
March – May 2002	12	18	36	54
June – August 2002	15	29	27	56
September – November 2002	2	23	20	43
December 02 – February 2003	7	21	42	63
March – May 2003	17	24	58	82
April – June 2003*	Mutti (rural)	38	27	65
July September 2003	9	21	57	78
September – November 2003	14	25	36	61
December 03 – March 04	19	30	44	74
February – April 04	8	16	28	44
May – July 04	5	26	27	53
June – August 04	Deker / Harawe (rural)	30	14	44
October – December 04	4	32	27	59

- By April 2003, OSSA started implementing SS parallely in 2-3 Kebeles

Annexure 4

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Institutional Review Tool

Objectives:

a) To assess the extent to which the organisations involved had a clear HIV prevention/care programme agenda;

Questions:

1. When did SCUK/OSSA start the SS Programme in Harar?
2. What did you hope to achieve?
3. How did you select Harar?
4. How did you select the target Kabeles?
5. How did you select the facilitators?
6. What role did you envisage for the facilitators?
7. How did you select workshop participants?
8. What other programmes does SCUK/OSSA have in Harar?
9. What relationship did you foresee between SS and the other programmes in Harar?
10. What lessons have you learned for SS implementation in any new communities?
11. Why did you choose SS ? How does this tool link up with existing HIV and gender strategies.

b) To assess the extent to which SCUK and OSSA were prepared to "tackle the outcomes of the SS process"

1. What timeframe did you envisage for the SS process?
2. What staffing requirements did you anticipate?
3. What budget did you allocate to the SS process?
4. Were you prepared to support facilitators to facilitate ongoing follow-up meetings in the community?
5. What community requests in terms of HIV prevention and care support did you anticipate? Prepare for?
6. What other community requests in terms of community priorities did you anticipate? Prepare for?
7. What unanticipated needs/requests did the SS process trigger?
8. What lessons have you learned for SS implementation in any new communities?

Annexure 5

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Facilitators Review Workshop

Day 1 – 26th January 2005

Time	Topic	Process	Facilitator(s)
Am	Introductions	Participatory	OSSA
	Context of the SS project and need for review including review design	Presentation	STC/ OSSA
	Overview of the workshop	Presentation	Parinita
	Expectations	Paricipatory	Aine and OSSA
	Energiser		
	Introduction to the project in Harar	Presentation	OSSA
	Lunch		
Pm	Experience sharing by facilitators	Guided Discussion	Aine and Parinita
	Review of SS Sessions	Theme wise Group Review followed by presentations 2 parallel groups	Aine and Parinita

Day 2 – 27th January 2005

Time	Topic	Process	Facilitator(s)
Am	Review of SS Sessions	Theme wise Group Review followed by presentations 2 parallel groups	Aine and Parinita
	Lunch		
Pm	Review of Open Community Meeting and special requests	Guided Discussions	Aine and Parinita
	Facilitators Suggestions for Future		
	Developing a plan for the review based on the understanding of last 2 days	Guided Discussion	Aine
	Evaluation of two day workshop		OSSA

Save the Children
Monitoring and Evaluation Review of Stepping Stones
Facilitators Review Discussion Tool

Session : Experience Sharing by Facilitators
Checklist for Guided Discussion

Selection and qualities of the facilitators

- How were you recruited as a facilitator?
- Why did the project select you or find you fit for this position?
- Why did you decide to take up this position?
- Did you know/ work on HIV/AIDS issues before this training?

Stepping Stones training for facilitators

- Did you go through any SS training yourself?
- What were the topics of that training?
- Was the training participatory?
- Did it include any discussion on implementation?
- How did the training help you?

Implementation of SS

- What preparation did you make for implementation of SS in your Kebele?
- How did you make the Kebele feel that HIV/AIDS is an important issue?
- How did you integrate HIV/AIDS into other needs of the Kebele?

Process of facilitating SS in the Kebeles

Timeline and sessions

- How long was the training? (weeks, months, years)
- How many times the groups met during this period?
- How many individual sessions and group sessions took place during the period?

Themes and Topics of the sessions

- What were the main themes of the training?
- List out the sessions (topics) of the training in sequence under each theme?
- Did you follow any manual for this training?
- How was it similar or different from the original manual?

SS groups

- How many groups were formed in your Kebele?
- What was the average size of each group?
- What were the problems faced in forming these groups?
- Were these groups already existing or newly formed for SS?
- Has participation in all your groups consistent?

- Did all the participants attend all the sessions?
- Which sessions did all members of your groups attend?
- During which sessions members of your groups dropped out?
- What are the reasons of good attendance?
- What are the reasons of drop out?

Interaction of the groups within themselves and with the larger community

- How many times did all the groups in this community meet?
- What were the topics discussed in joint workshop meetings?
- How did you think these joint meetings go?
- Do you think these joint meetings help in improving relationship?
- Were there arguments during joint meetings?
- What were the key issues of argument?
- How did you help them resolve?
- Has the larger community been involved in any other way during the training?

Key issues in the groups

- What were the key issues of different groups?
- Did you see any difference in issues in age and gender groups?
- How did you help them to handle these issues?

Post SS

- What has happened to your groups after completion of SS?

Impact of SS on the groups/Kebeles

- How has the process of SS helped your groups?
- What are the positive and negative aspects of SS that you see in the Kebeles you are working?

Institutional support

- What institutional support did you have before the SS training, during SS and after SS trainings?

Annexure 6

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Polling Booth Questionnaire

Respondents: younger women/ unmarried women

- Knowledge and skills

1. Do you know atleast 2 ways how HIV spreads?
2. Do you know how to protect yourself from STI/HIV?
3. Can you speak about sex openly with your friends?
4. Can you speak about sex openly with your parents?
5. Can you speak about sex openly with your boyfriend / sexual partner?
6. Do you possess skills to protect yourself from STI/HIV?

- Relationships

7. Have you had sexual contact with men in last six months?
8. Do you think your sexual relationships have improved in last 6 months?
9. Have you been forced to have sexual relations with someone in last six months?
10. Have you had an abortion in last six months?

- Behaviour

11. Have you had a problem with a foul-smelling white vaginal discharge, genital ulcers/sores or blisters in last 3 months?
12. Did you seek treatment for the same?
13. In last 6 months has there been an occasion when you had a white discharge and you could not get treatment?
14. Have you ever seen a condom?
15. Can you get a condom on your own easily?
16. In last six months, have you had problems negotiating condoms with your partner?
17. Do you think you are at the risk of getting HIV?

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Polling Booth Questionnaire

Respondents: older women/ married women

- Knowledge and skills

1. Do you know atleast 2 ways how HIV spreads?
2. Do you know how to protect yourself from STI/HIV?
3. Can you speak about sex openly with your husband/ sexual partner?
4. Can you speak about sex openly with your children?
5. Do you possess skills to protect yourself from STI/HIV?

- Relationships

6. Have you had sexual contact with husband / regular partner in last six months?
7. Do you think your sexual relationships have improved in last 6 months?
8. Have you had sex with men other than your husband/ regular partner in last 6 months?
9. Have you been forced to have sexual relations with someone in last six months?
10. Have you had an abortion in last six months?

- Behaviour

11. Have you had a problem with a foul-smelling white vaginal discharge, genital ulcers/sores or blisters in last 3 months?
12. Did you seek treatment for the same?
13. In last 6 months has there been an occasion when you had a white discharge and you could not get treatment?
14. Have you ever seen a condom?
15. Can you get a condom on your own easily?
16. In last six months, have you had problems negotiating condoms with your husband/ regular partner?
17. In last six months, have you had problems negotiating condoms with your sexual partners other than husband or regular partner?
18. Do you think you are at the risk of getting HIV?

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Polling Booth Questionnaire

Respondents: younger men/ unmarried men

- Knowledge and skills

1. Do you know atleast 2 ways how HIV spreads?
2. Do you know how to protect yourself from STI/HIV?
3. Can you speak about sex openly with your friends?
4. Can you speak about sex openly with your parents?
5. Can you speak about sex openly with your girl friend?
6. Do you possess skills to protect yourself from STI/HIV?

- Relationships

7. Have you had sexual contact with girls/women in last six months?
8. Have you had sexual contact with sex workers in last 6 months?
9. Have you had sexual contact with any man in last 6 months?
10. Do you think your sexual relationships have improved in last 6 months?

- Behaviour

11. Have you had a problem with genital ulcers, a burning sensation in your urine or a pus-like discharge in the last 3 months?
12. Did you seek treatment for the same?
13. In last six months has there been an occasion when you had these symptoms and you could not get treatment?
14. Have you ever seen a condom?
15. Can you get a condom on your own easily?
16. In last six months did you use condoms for every sexual encounter?
17. In last six months, have you had problems negotiating condoms with your partner?
18. Have you taken alcohol before sex in last 6 months?
19. Do you think you are at the risk of getting HIV?

Save The Children
Monitoring and Evaluation Review of Stepping Stones
Polling Booth Questionnaire

Respondents: older men/ married men

- Knowledge and skills

1. Do you know atleast 2 ways how HIV spreads?
2. Do you know how to protect yourself from STI/HIV?
3. Can you speak about sex openly with your wife/ sexual partner?
4. Can you speak about sex openly with your children?
5. Do you possess skills to protect yourself from STI/HIV?

- Relationships

6. Have you had sexual contact with wife / regular partner in last six months?
7. Do you think your sexual relationships have improved in last 6 months?
8. Have you had sex with women other than your wife/ regular partner in last 6 months?
9. Have you has sex with sex workers in last 6 months?
10. Have you had sex with men in last six months?

- Behaviour

11. Have you had a problem with genital ulcers, a burning sensation in your urine or a pus-like discharge in the last 3 months?
12. Did you seek treatment for the same?
13. In last six months has there been an occasion when you had these symptoms and you could not get treatment?
14. Have you ever seen a condom?
15. Can you get a condom on your own easily?
16. In last six months did you use condoms for every sexual encounter with your wife/ regular partner?
17. In last six months did you use condoms for every sexual encounter other than with your wife?
18. In last six months, have you had problems negotiating condoms with your partner?
19. Have you taken alcohol before sex in last 6 months?
20. Do you think you are at the risk of getting HIV?

Annexure 7

Monitoring and Evaluation Review of Stepping Stones
Focus Group Discussion Guideline
Community Group: SS Older Women

1.0 Content and Process of Training

1.1 Why did you decide to participate in Stepping Stones?
1.2 When did you go through this training?
1.3 What were the topics discussed in joint workshop meetings?
1.4 How do you feel about meeting the other groups and listening/seeing their presentations?
1.5 Do you think these joint meetings help in improving relationships?
1.6 What were the key issues of the group?
1.7 What did you do about these issues?
1.8 Which session did you like?
1.9 Which session did you not like?
1.10 What special request did your group make to the community?
1.11 What was the reaction of the community?
1.12 Has the larger community been involved in any other way during the training?
1.13 What the activities that you took up as a group after the training?

2.0 **Knowledge**

2.1 Do you know about HIV and AIDS?
2.2 How can a person get HIV?
2.3 How can a person not get HIV?
2.4 How can a person prevent getting HIV?
2.5 How do you know if a person has HIV?
2.6 Do you know about STI?
2.7 What are the symptoms of STI? For men? For Women?
2.8 Do you know where to go for STI treatment?
2.9 Do you know where to get condoms?

3.0 Skills

3.1 Did your husbands also participate in Stepping Stones?
3.2 Did communication between you and your husbands/children improve after Stepping Stones? In which areas of your lives?
3.3 Did Stepping Stones help you with decision-making in your life? How?
3.4 Was learning about assertive behaviour useful for you in your life? How?
3.5 Did Stepping Stones help you to speak more easily in public?

4.0 Relationships

4.1 Did Stepping Stones help improve overall relations with you and your husband? In household matters? In sexual matters? How?
4.2 Did Stepping Stones help improve overall relations with other family member/community members?

5.0 Behaviour

5.1 Did Stepping Stones help promote less chat or alcohol consumption in your community? In what way
5.2 Did Stepping Stones promote less violence towards female participants and community members? In what way?
5.3 After Stepping Stones, have you noticed any reduction in the number of sexual partners among the men and women of every age group in your community?
5.4 Do you feel better able to negotiate condom use in your life?
5.5 Do you feel better able to seek treatment for any STI symptoms?
5.6 Do you feel less at risk of HIV? In what way?
5.7 How do you now feel about PLHAs?

Monitoring and Evaluation Review of Stepping Stones
Focus Group Discussion Guideline
Community Group: SS Younger Men

1.0 Content and Process of Training

1.1 Why did you decide to participate in Stepping Stones?
1.2 When did you go through this training?
1.3 What were the topics discussed in joint workshop meetings?
1.4 How do you feel about meeting the other groups and listening/seeing their presentations?
1.5 Do you think these joint meetings help in improving relationships?
1.6 What were the key issues of the group?
1.7 What did you do about these issues?
1.8 Which session did you like?
1.9 Which session did you not like?
1.10 What special request did your group make to the community?
1.11 What was the reaction of the community?
1.12 Has the larger community been involved in any other way during the training?
1.13 What the activities that you took up as a group after the training?

2.0 Knowledge

2.1 Do you know about HIV and AIDS?
2.2 How can a person get HIV?
2.3 How can a person not get HIV?
2.4 How can a person prevent getting HIV?
2.5 How do you know if a person has HIV?
2.6 Do you know about STI?
2.7 What are the symptoms of STI? For men? For Women?
2.8 Do you know where to go for STI treatment?
2.9 Do you know where to get condoms?

3.0 Skills

3.1 Did your wives/girlfriends also participate in Stepping Stones?
3.2 Did communication between you and your wives/girlfriends/children improve after Stepping Stones? In which areas of your lives?
3.3 Did Stepping Stones help you with decision-making in your life? How?
3.4 Was learning about assertive behaviour useful for you in your life? How?
3.5 Did Stepping Stones help you to speak more easily in public?

4.0 Relationships

4.1 Did Stepping Stones help improve overall relations with you and your wives/girlfriend? In household matters? In sexual matters? How?
4.2 Did Stepping Stones help improve overall relations with other family members/community? In what way?

5.0 Behaviour

5.1 Did Stepping Stones help promote less chat or alcohol consumption in your community? In what way
5.2 Did Stepping Stones promote less violence towards female participants and community members? In what way?
5.3 After Stepping Stones, have you noticed any reduction in the number of sexual partners among the men and women of every age group in your community?
5.4 Do you feel better able to negotiate condom use in your life?
5.5 Do you feel better able to seek treatment for any STI symptoms?
5.6 Do you feel less at risk of HIV? In what way?
5.7 How do you now feel about PLHAs?

Monitoring and Evaluation Review of Stepping Stones
Focus Group Discussion Guideline
Community Group: SS Younger Women

1.0 Content and Process of Training

1.1 Why did you decide to participate in Stepping Stones?
1.2 When did you go through this training?
1.3 What were the topics discussed in joint workshop meetings?
1.4 How do you feel about meeting the other groups and listening/seeing their presentations?
1.5 Do you think these joint meetings help in improving relationships?
1.6 What were the key issues of the group?
1.7 What did you do about these issues?
1.8 Which session did you like?
1.9 Which session did you not like?
1.10 What special request did your group make to the community?
1.11 What was the reaction of the community?
1.12 Has the larger community been involved in any other way during the training?
1.13 What the activities that you took up as a group after the training?

2.0 **Knowledge**

2.1 Do you know about HIV and AIDS?
2.2 How can a person get HIV?
2.3 How can a person not get HIV?
2.4 How can a person prevent getting HIV?
2.5 How do you know if a person has HIV?
2.6 Do you know about STI?
2.7 What are the symptoms of STI? For men? For women?
2.8 Do you know where to go for STI treatment?
2.9 Do you know where to get condoms?

3.0 Skills

3.1 Did your boyfriends also participate in Stepping Stones?
3.2 Did communication between you and your boyfriends/husbands improve after Stepping Stones? In which areas of your lives?
3.3 Did communication between you and other family, community members improve after Stepping Stones? In which areas of your lives?
3.4 Did Stepping Stones help you with decision-making in your life? How?
3.5 Was learning about assertive behaviour useful for you in your life? How?
3.6 Did Stepping Stones help you to speak more easily in public?

4.0 Relationships

4.1 Did Stepping Stones help improve overall relations with you and your boyfriends/husbands? In household matters? In sexual matters? How?
4.2 Did Stepping Stones help improve overall relations with other family members/community?

5.0 Behaviour

5.1 Did Stepping Stones help promote less chat or alcohol consumption in your community?
5.2 Did Stepping Stones promote less violence towards female participants and community members? In what way?
5.3 After Stepping Stones, have you noticed any reduction in the number of sexual partners among the men and women of every age group in your community?
5.4 Do you feel better able to negotiate condom use in your life?
5.5 Do you feel better able to seek treatment for any STI symptoms?
5.6 Do you feel less at risk of HIV? In what way?
5.7 How do you now feel about PLHAs?

Monitoring and Evaluation Review of Stepping Stones
Focus Group Discussion Guideline

Community Group: Non-Stepping Stones – Older Women or Younger Women, Older Men and/or Younger Men (circle which group).

Questions:

1. Did you hear people talking about Stepping Stones? If so, what did you hear?
2. Do you know anyone who participated? If so, who? (your relationship with them).
3. Did you have a chance to participate? If yes, why did you decide not to participate?
4. What did people tell you about Stepping Stones?
5. What did you think about what they told you?
6. Did you notice any differences n your family or community after SS? If so, what were the differences?
7. Did you notice any difference in the service provided by health personnel? If so, what were the differences?
8. If there was another Stepping Stones, would you like to participate?
9. Do you participate in any activities related to Stepping Stones?

Annexure 8

Monitoring and Evaluation Review of Stepping Stones
Key Informant Interviews

Name of Interviewee:	**Name of Interviewer:**
Position of Interviewee:	**Date of Interview:**
Location/Kabele:	

1. Have you heard people talking about SS? If yes, what did you hear?

2. What do you think about what you heard about SS? What were the good things? What were the problems?

3. Did you notice any positive changes in the community during or after SS? If so, what were those changes?

4. Did you notice any negative changes?

5. Did you notice any difference in the service provided by health personnel? If so, what were the differences?

6. Did you notice any difference in the relationships between women and men? If so, what were the differences?

7. Have you noticed any difference in the way widows are treated when their husbands die? If so, what are the differences?

8. How do you think participants in Stepping Stones could share the benefits with other members of the community?

Annexure 9

Time Table for Implementation of Stepping Stones

OSSA, Harar, Ethiopia

OSSA has divided the Stepping Stones sessions into 4 parts or rounds for implementation. They have been completing these sessions in the community within 3 months. The sequence of the sessions have been adapted from the original manual based on field experiences. The sequence of the sessions are as follows:

Round 1

Sl.no	**Sessions**	**Time Required**
Session 1		
1	Attendance	10 minutes
2	Energiser and introduction	15 minutes
3	Adjectival Name	20 minutes
4	Ground Rules	15 minutes
5	Hopes and Fear	15 minutes
6	Trust and Confidentiality	30 minutes
7	Knotty Problem	15 minutes
8	Social Map	1 hour
9	Close	15 minutes
Session 2		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Risk Matrix	1 hour
4	HIV/AIDS Line	30 minutes
5	Listening Skills	30 minutes
6	Evaluation	10 minutes
Session 3		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Body Language	
4	Ideal Image and Reality	1 hour 30 minutes
5	Mime the Lie	30 minutes
6	1st Community Meeting to share ideal images and reality	

Round 2

Sl.no	Sessions	Time Required
Session 1		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Images of Sex	1 hour 20 minutes
4	Fruit Salad	15 minutes
5	What is love?	40 minutes
6	Prioritizing Problems	30 minutes
7	Evaluation	15 minutes
Session 2		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Happy and Unhappy Relationship	1 hour
4	Body Mapping	1 hour 30 minutes
5	Evaluation	15 minutes
Session 3		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Taking Risks	30 minutes
4	Language of sex	50 minutes
5	I have something to tell you	30 minutes
6	Attack and Avoid	40 minutes
7	Evaluation	
8	2nd Community Meeting to share body maps or happy/ unhappy relationship	

Round 3

Sl.no	Sessions	Time Required
Session 1		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	HIV/AIDS and Condoms	1 hour 45 minutes
4	Possible Future	40 minutes
5	Who is to blame?	30 minutes
6	Evaluation	10 minutes
Session 2		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Sexual Encounter	40 minutes
4	Money	30 minutes
5	Tradition	30 minutes
6	Long Journey	1 hour
7	Closing	10 minutes

Session 3		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	How do men and women mistreat each other	1 hour
4	Taking Control	30 minutes
5	Saying No	40 minutes
6	3rd Community Meeting sharing how do men and women mistreat each other	

Round 4

Sl.no	**Sessions**	**Time Required**
Session 1		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	War and Peace	15 minutes
4	Asking what we want	45 minutes
5	"I" Statements	1 hour
6	Assertive skills	30 hour
7	Evaluation	15 minutes
Session 2		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Change you would like to see	1 hour
4	Peer Group Action Plan	1 hour
5	Preparation for Special Requests	1 hour
Session 3		
1	Attendance	10 minutes
2	Energiser	15 minutes
3	Care And Support	2 hour
4	VCT	1 hour
5	Final Community Meeting sharing Special requests	

Annexure 10

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