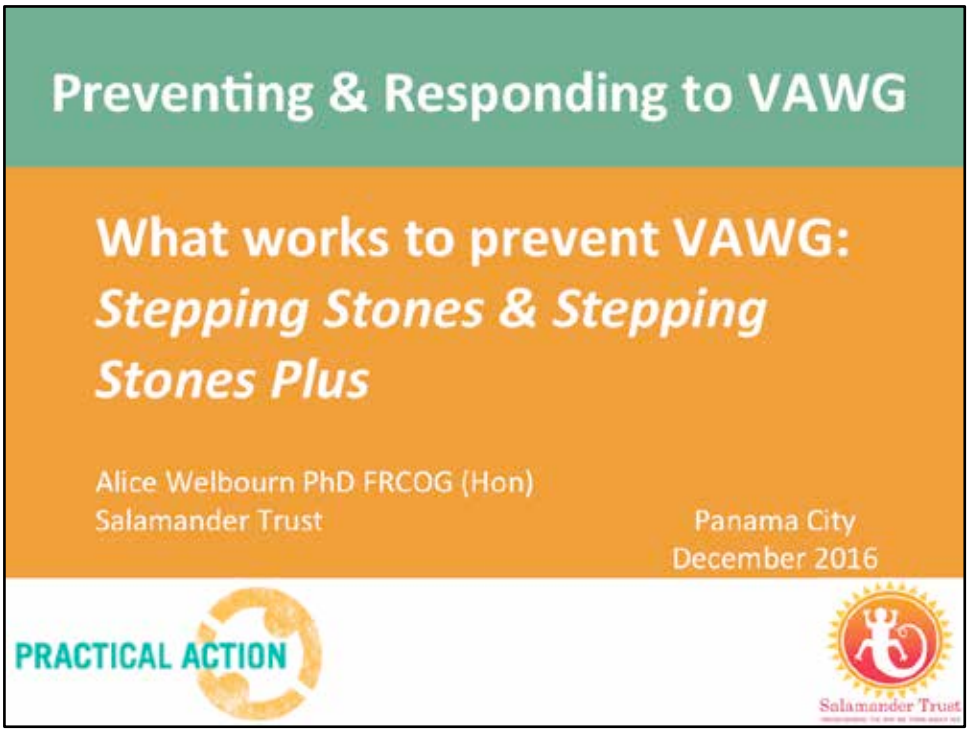


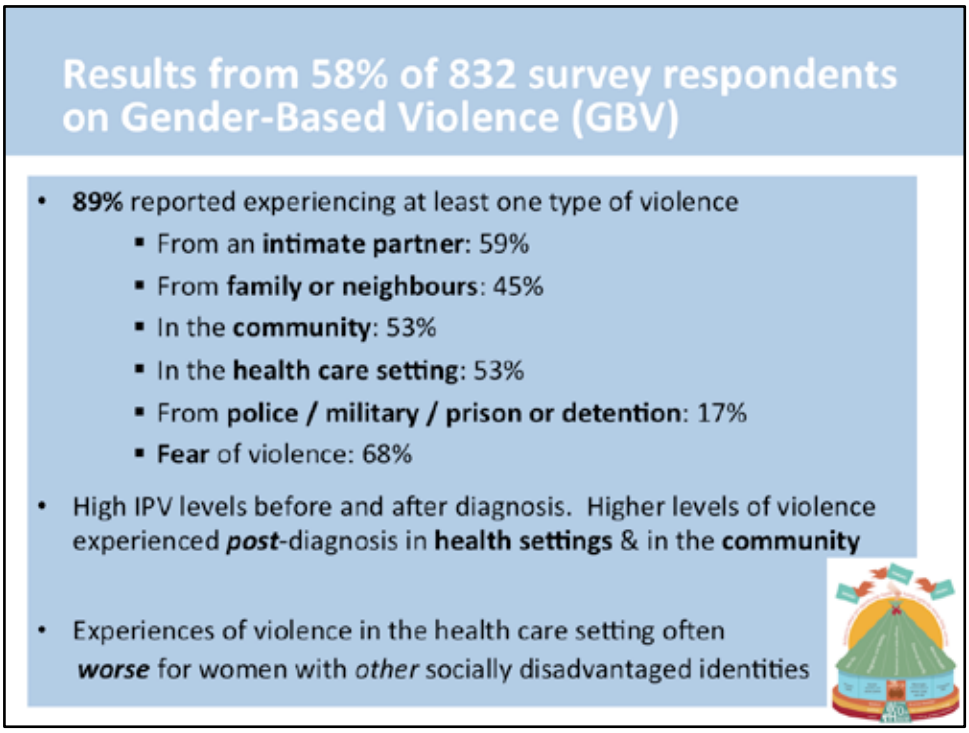
Stepping Stones & Stepping Stones Plus and its new daughter programme, *Stepping Stones with Children,* are both now published by Practical Action Publishing - http://tinyurl.com/PAPStStwC

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

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

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

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



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

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

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

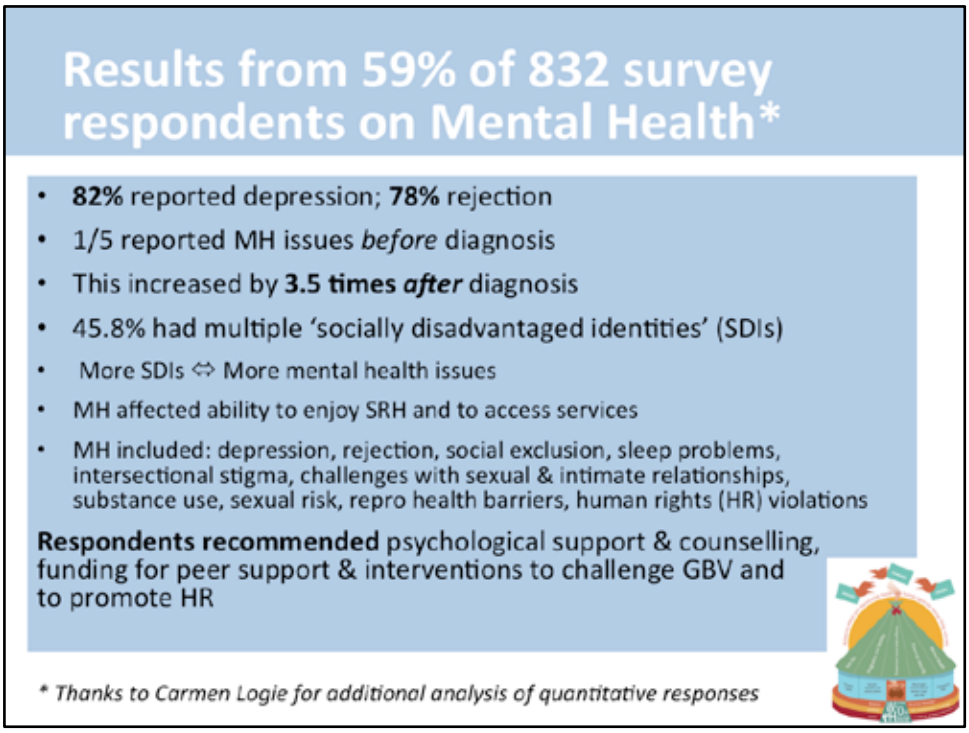
The highest increase was in relation to violence experienced by women in healthcare settings, which jumped from **6% pre-diagnosis to 53% after diagnosis.**

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

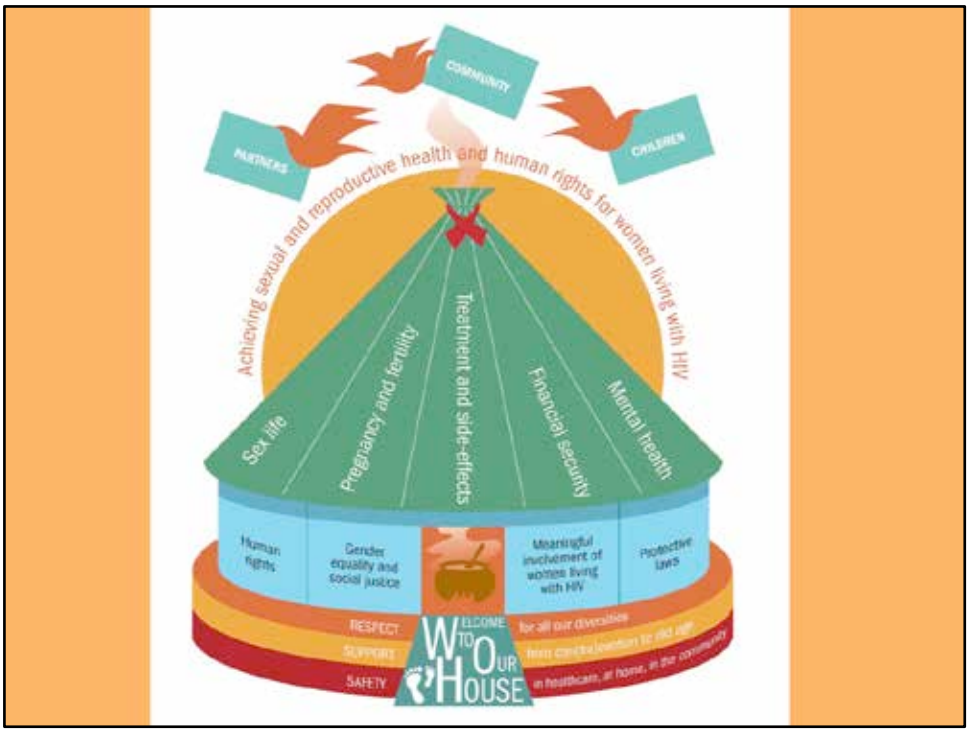
- Coerced treatment initiation; * Coerced abortion; *Coerced sterilisation; * Coerced long-term contraceptives; * or Withdrawal of contraceptive services on the basis that women should not be having sex or children;
- Verbal abuse; * Lack of support during delivery; * And women reported even worse experiences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

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

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



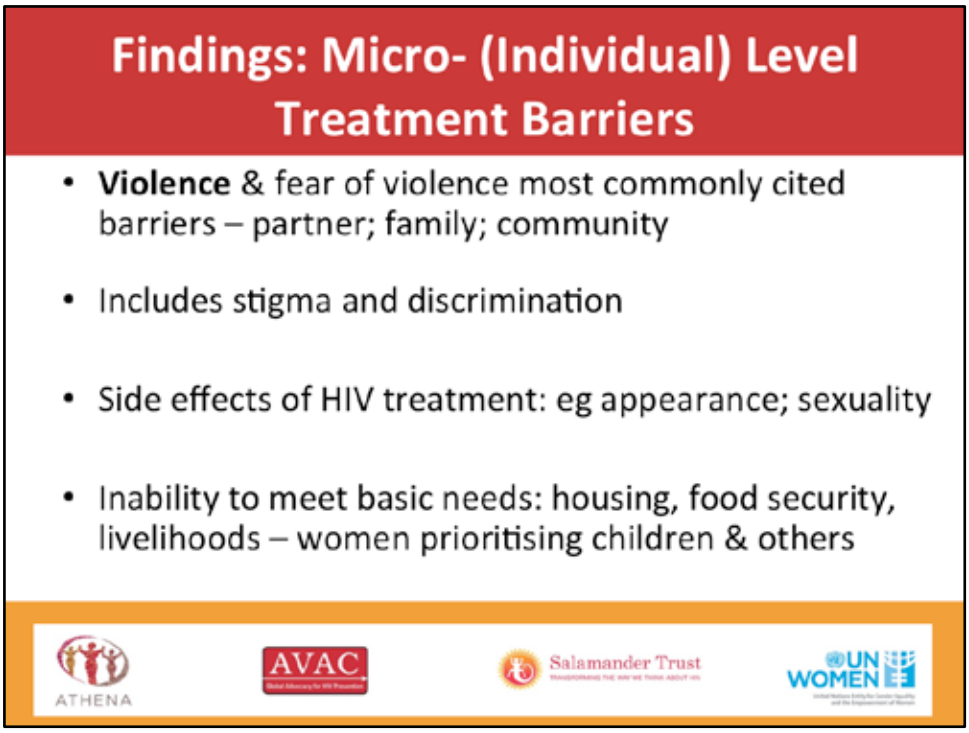
One-fifth reported mental health issues before HIV diagnosis. Respondents reported experiencing a 3.5-fold higher number of mental health issues after diagnosis (8.71 vs 2.48, t[488]23.00, pB0.001). Nearly half (n224; 45.8%) had multiple identities which can make them socially disadvantaged (SDIs), in addition to HIV. The number of 'SDIs' was positively correlated with experiencing mental health issues (pB0.05). Women described how mental health issues affected their ability to enjoy their right to sexual and reproductive health and to access services. These included depression, rejection and social exclusion, sleep problems, intersectional stigma, challenges with sexual and intimate relationships, substance use and sexual risk, reproductive health barriers and human rights (HR) violations. Respondents recommended that policymakers and clinicians provide psychological support and counselling, funding for peer support and interventions to challenge gender-based violence and to promote HR. **Orza L et al. Journal of the International AIDS Society 2015, 18(Suppl 5):20289 http://www.jiasociety.org/index.php/jias/article/view/20289 | http://dx.doi.org/10.7448/IAS.18.6.20289**



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

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

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



I also want to share this research we have done with UN Women on global treatment access barriers for women living with HIV – and again VAW plays a major part of a barrier.
http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/

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

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

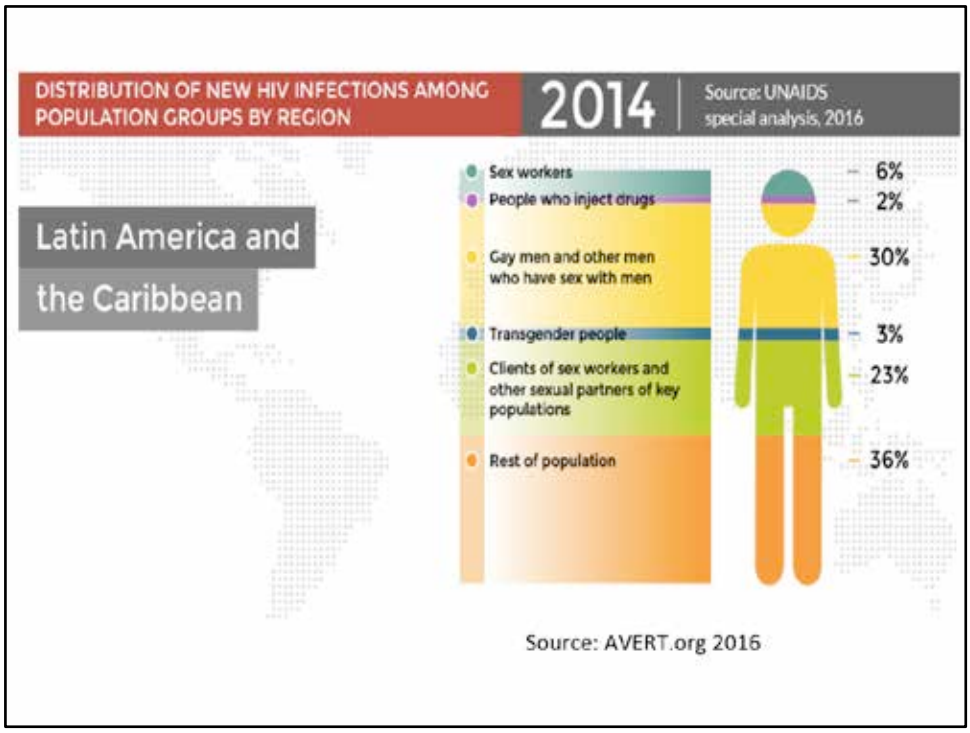
http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/

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

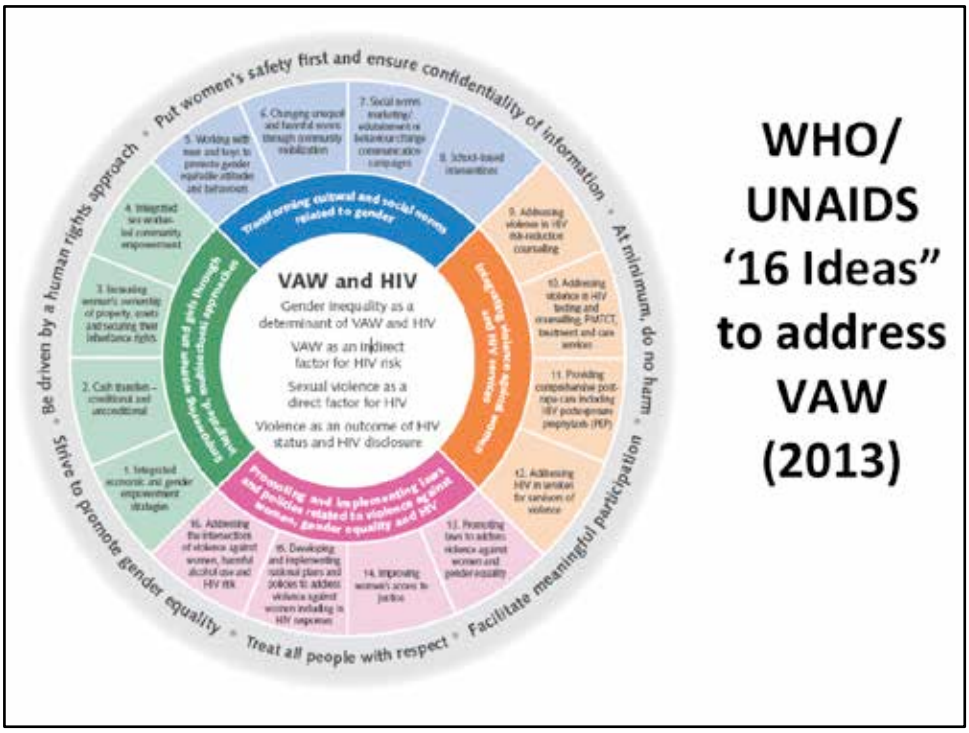
http://salamandertrust.net/project/global-treatment-access-review-women-living-hiv/

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

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



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

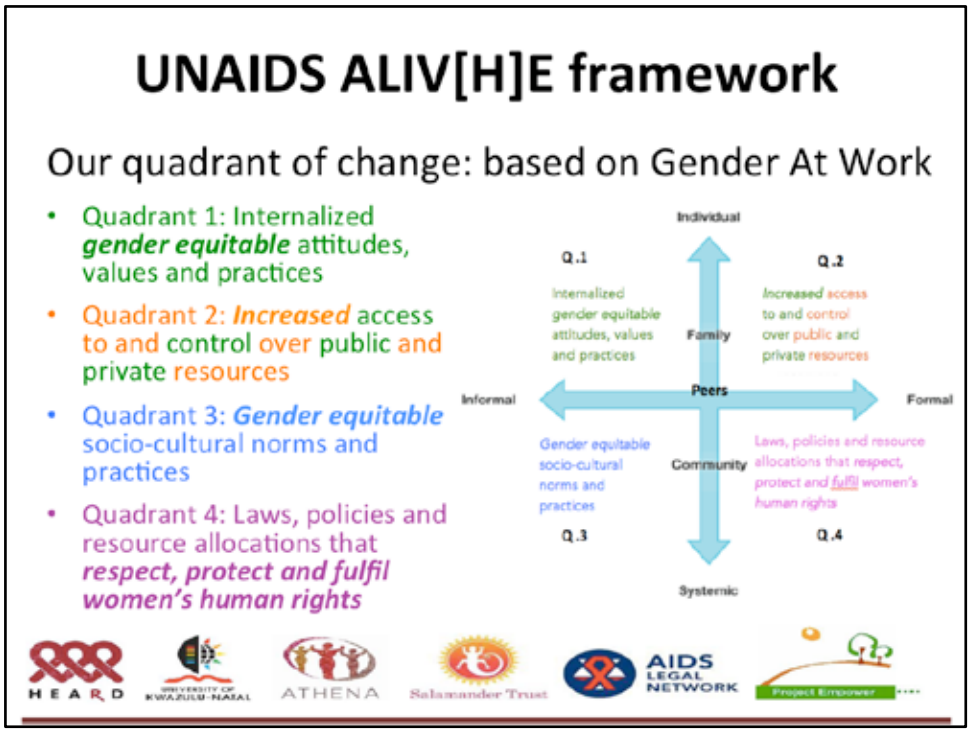


We have also been working with UNAIDS on a research programme to extend and strengthen the evidence base around interventions which address VAS and HIV. http://salamandertrust.net/project/research-interlinkages-gbv-hiv-unaids/

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

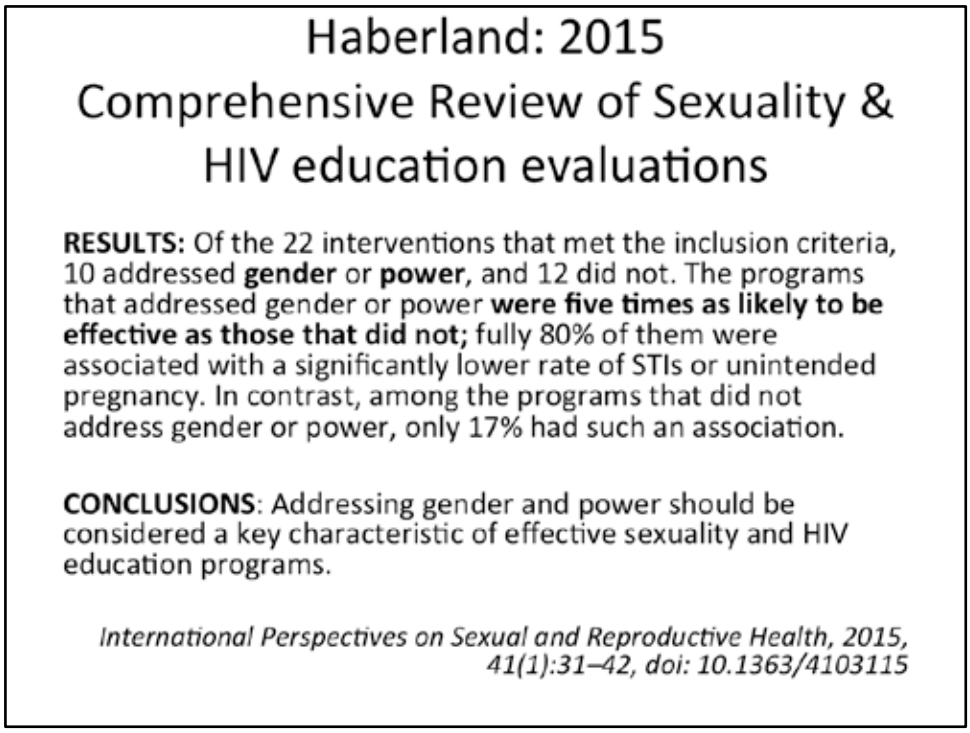
If we look at the next slide, we can see how the 4 different sections of this wheel connect with the next slide as follows:
Empowering women through integrated, multi-sectoral approaches – this overlaps with quadrants 1, 2 and 3 of the quadrants of change matrix
Transforming cultural and social norms related to gender – this overlaps with quadrants 1 and 3
Integrating violence against women and HIV services – this overlaps with quadrant 2
Promoting and implementing laws and policies related to violence against women, gender equality and HIV – this overlaps with quadrant 4.

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



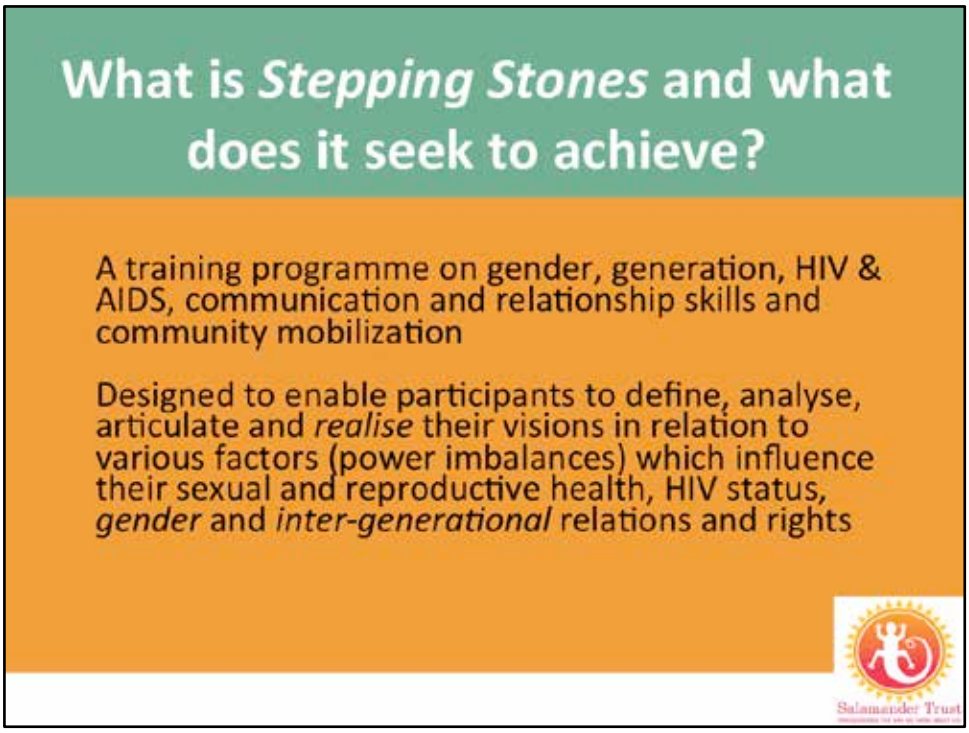
So here we have also been using this quadfant of change matrix in the UNAIDS work. You can see an animated film of this quadrant of change matrix made by the Global Fund for Women here: https://www.globalfundforwomen.org/our-impact/#.WEXg85JJpNE (scroll down the page to find the film)

http://salamandertrust.net/project/research-interlinkages-gbv-hiv-unaids/



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

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



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

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

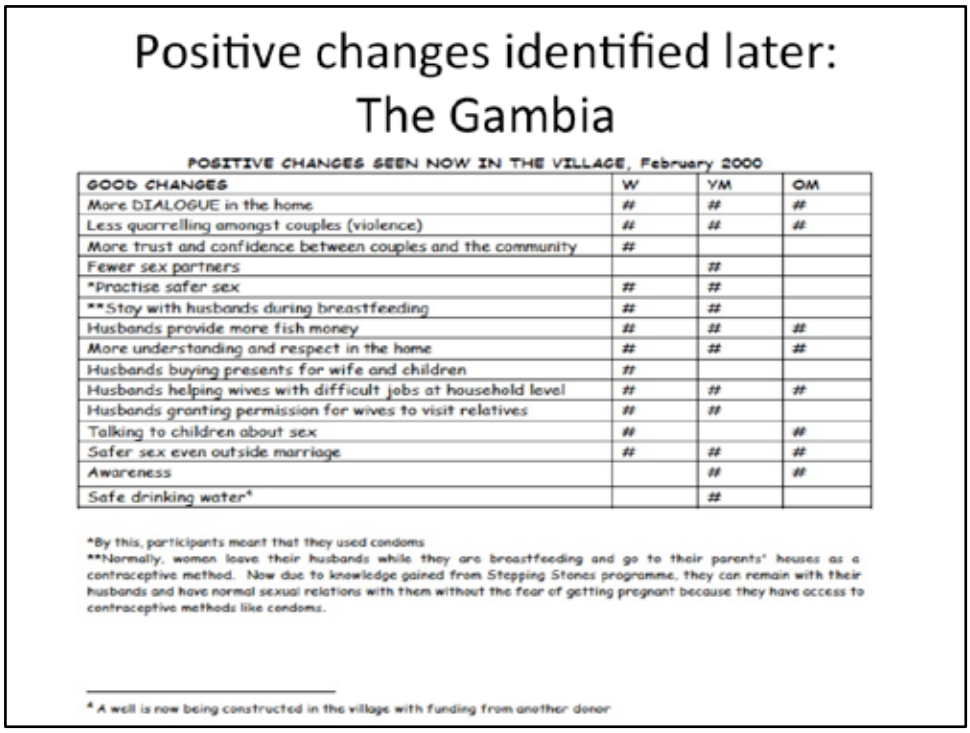
http://salamandertrust.net/resources/stepping-stones-plus/

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

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

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

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



Positive changes identified later: The Gambia

POSITIVE CHANGES SEEN NOW IN THE VILLAGE, February 2000

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

*By this, participants meant that they used condoms

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

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

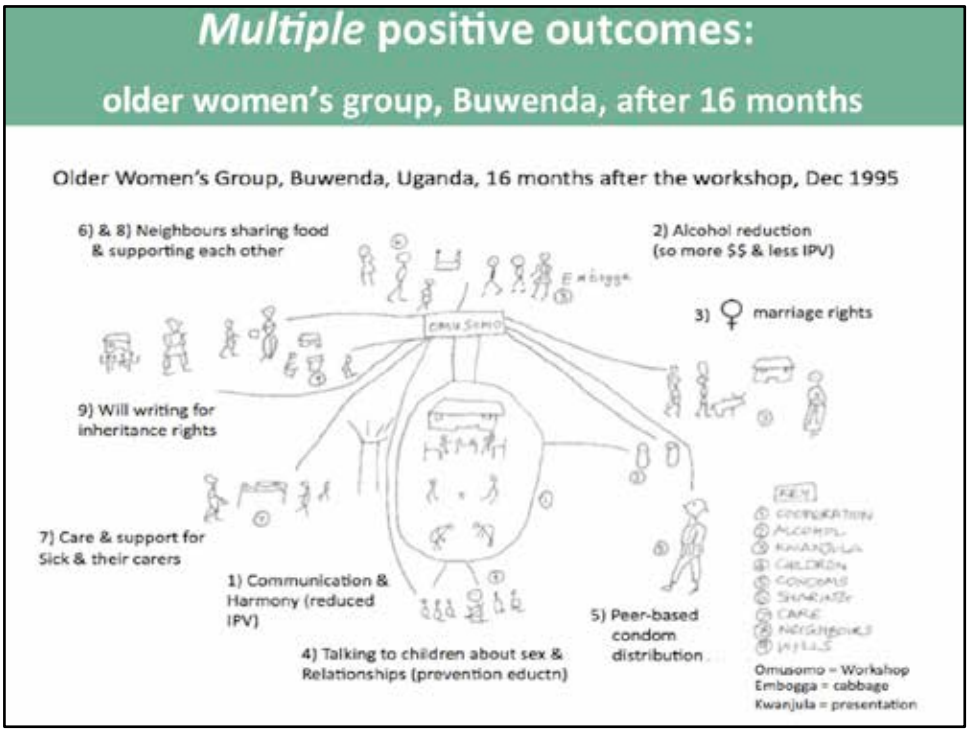
But here we see that after the programme, when different peer groups were separately and simultaneously asked what changes they had seen, they all mentioned more dialogue in the home, less quarrelling amongst couples (violence) and More understanding and respect in the home.

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

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

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

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



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

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

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

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

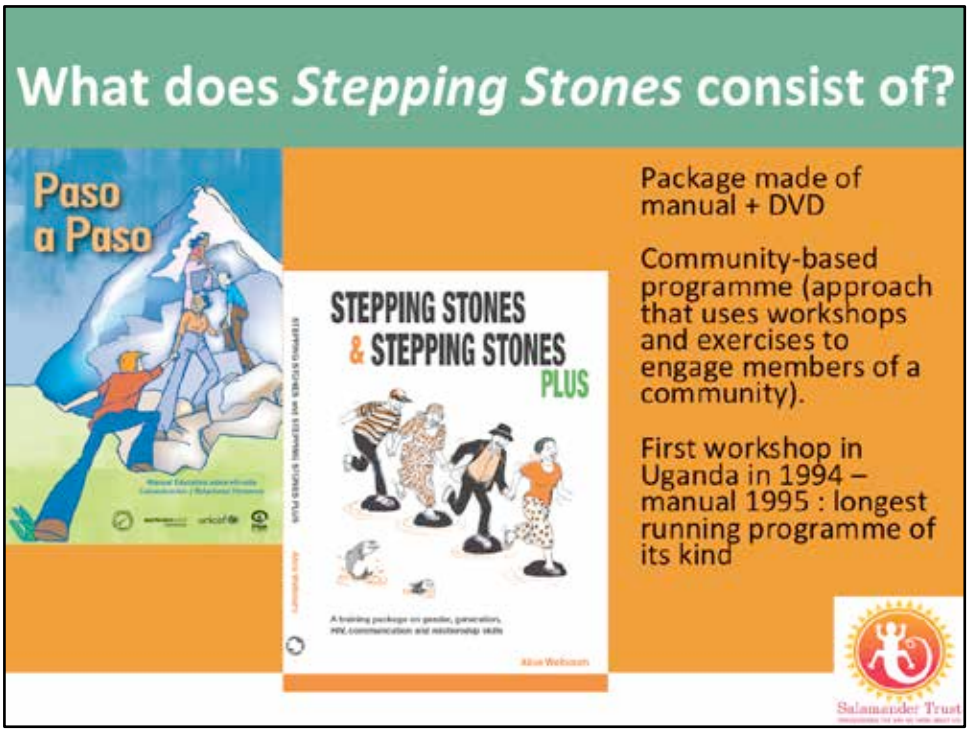
SMART: 3) Proportion of women and men who consider **wife beating** an acceptable way for a husband to discipline his wife for any reason, at a specified period in time. (See 1 and 2 above for SPICED version)

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

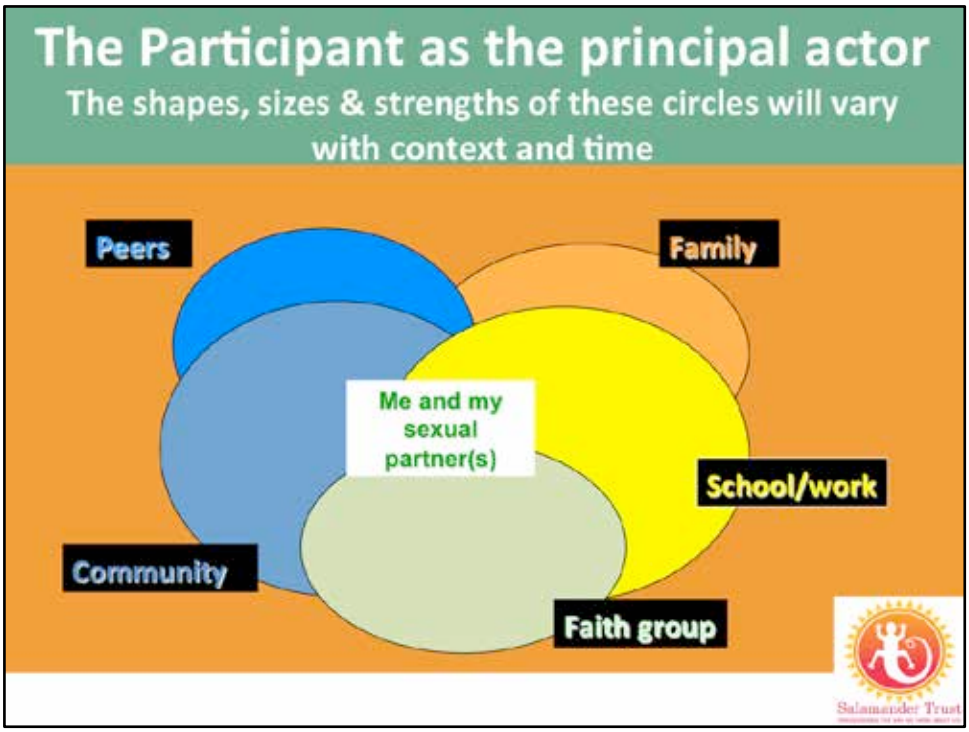
SMART: 5) Percentage of adults aged 15–49 who have had more than one sexual partner in the past 12 months and who report the use of a **condom** during their last intercourse (See 5 for SPICED version of this)

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

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

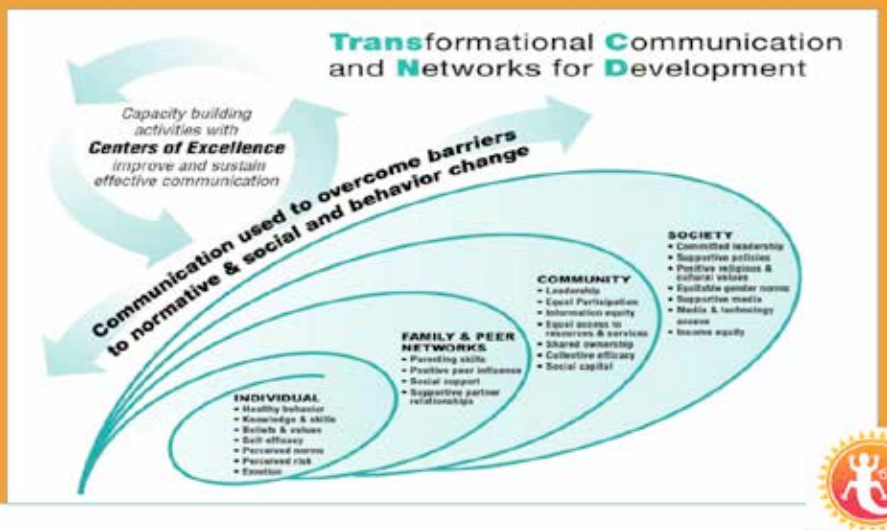


Here is an image of the front cover of the Latin America adaptation of the original Stepping Stones programme (see for example https://www.youtube.com/watch?v=Qu1BXRh6VvY)

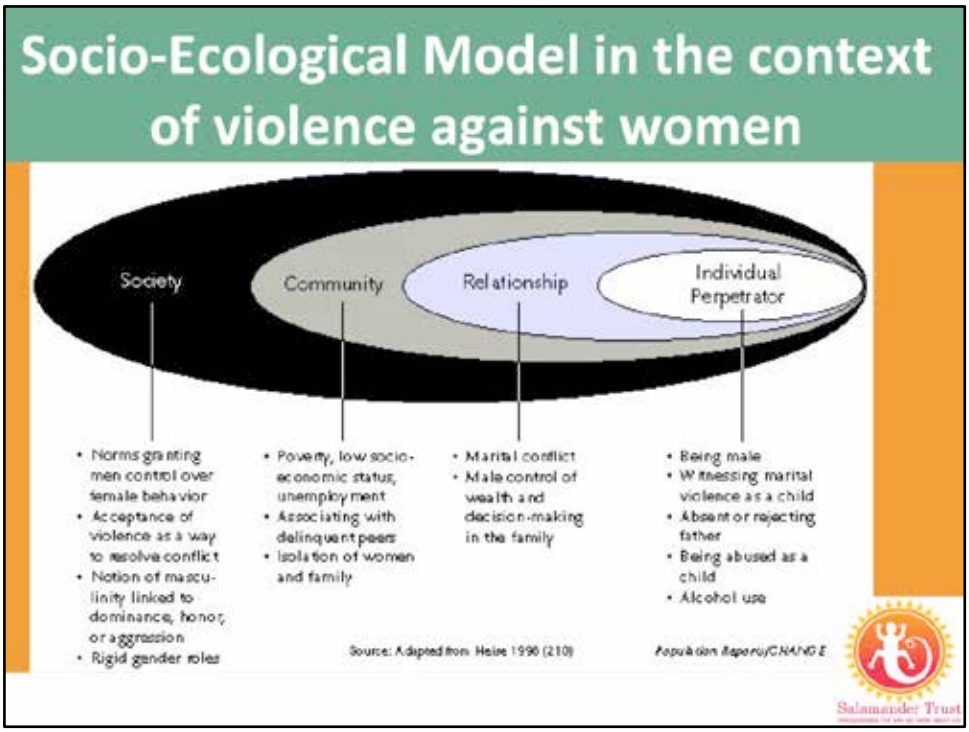


This diagram illustrates some of the multiple identities that we can all have as individuals. It echoes the socio-ecologic model. (next 2 slides)

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



Salamander Trust



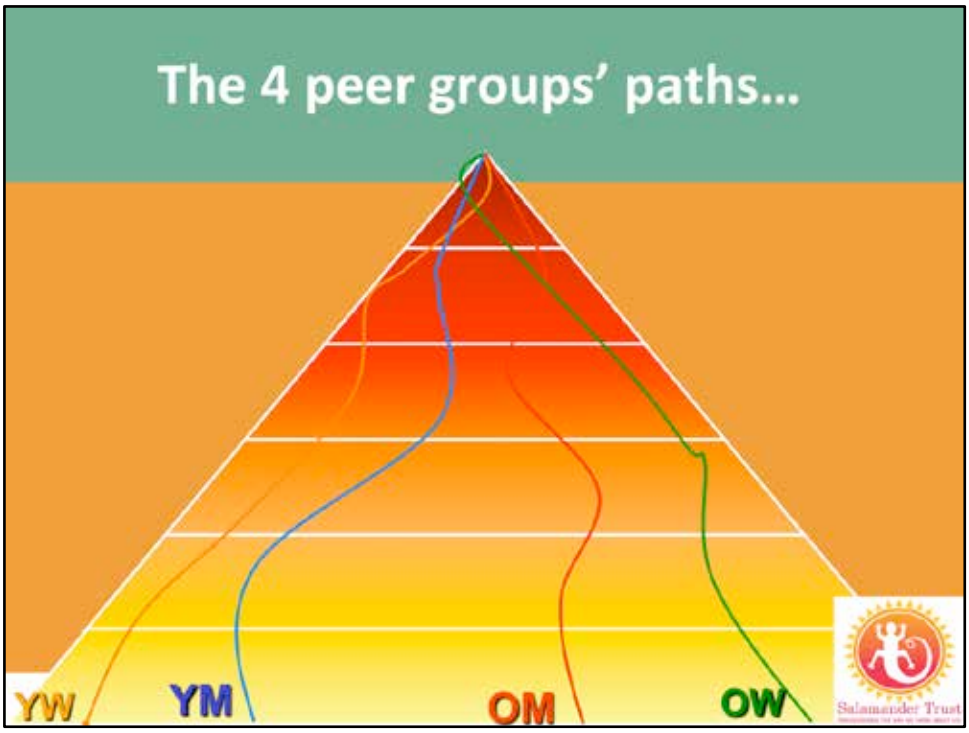
Here is another version of this same model. Intimate Partner Violence (IPV) is recognised both as increasing women's vulnerability to acquiring HIV: and women when diagnosed with HIV can face increased IPV.

Stepping Stones is recognised to reduce IPV in communities.

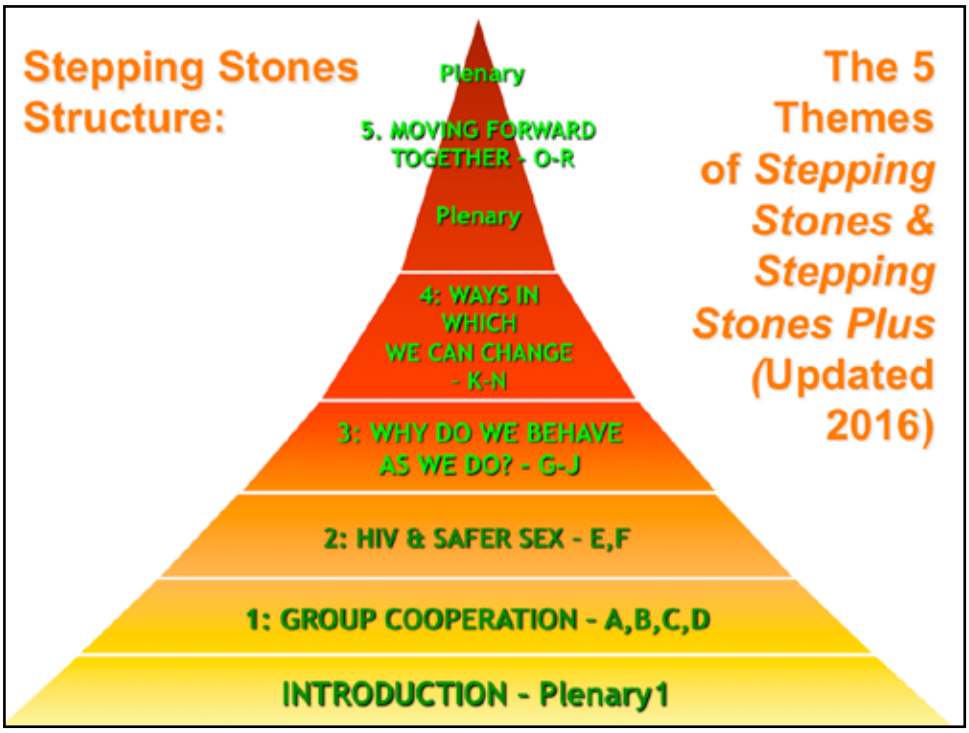
How does it work?

4 peer groups:

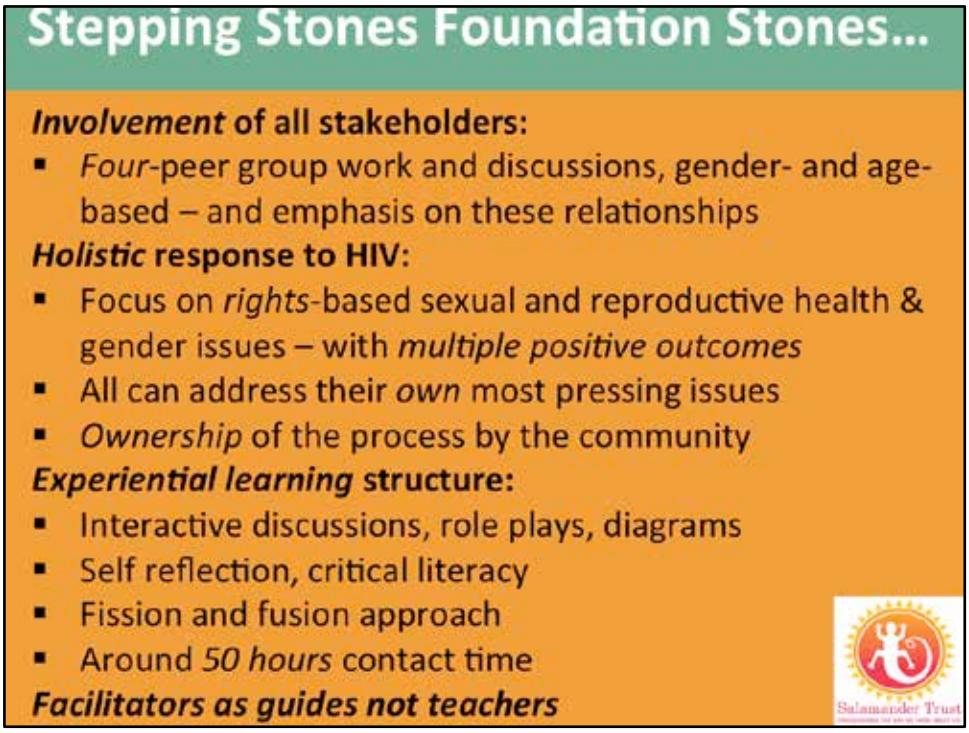
- based on gender and age
- ca. 50 hours contact time
- over 18-23 sessions
- over ca. 3 months
- staircase approach



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

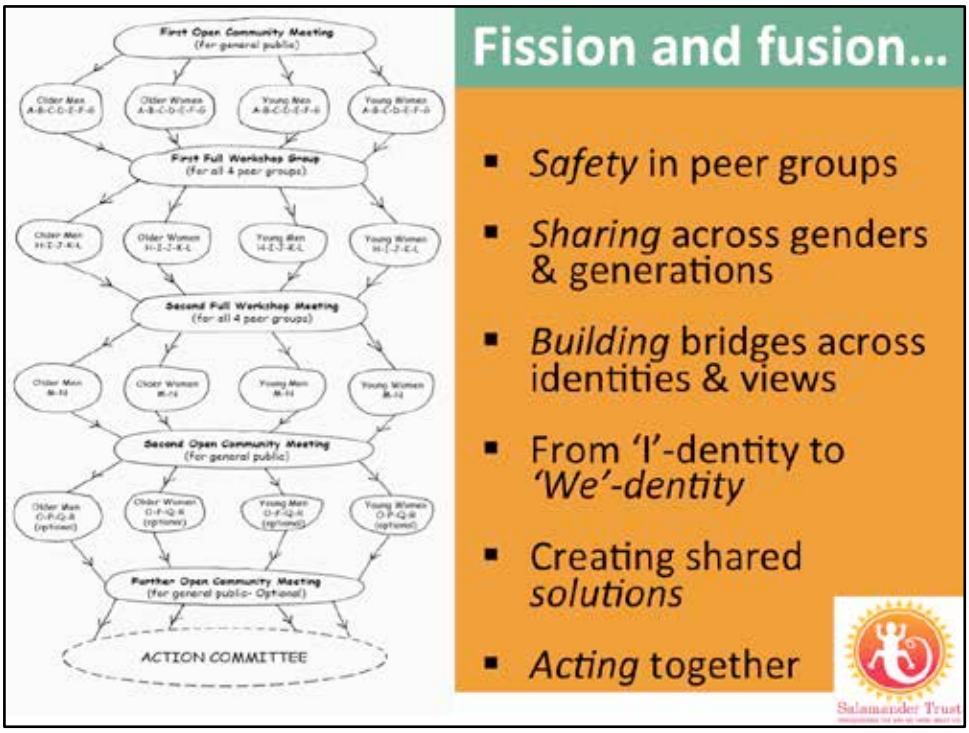


Some people think Stepping Stones has no structure. That is incorrect. There is a clear progressive structure, like a staircase, or like climbing a mountain. There are 5 themes: progression on purpose (from getting to know each other and working together to talking about sensitive subjects, addressing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

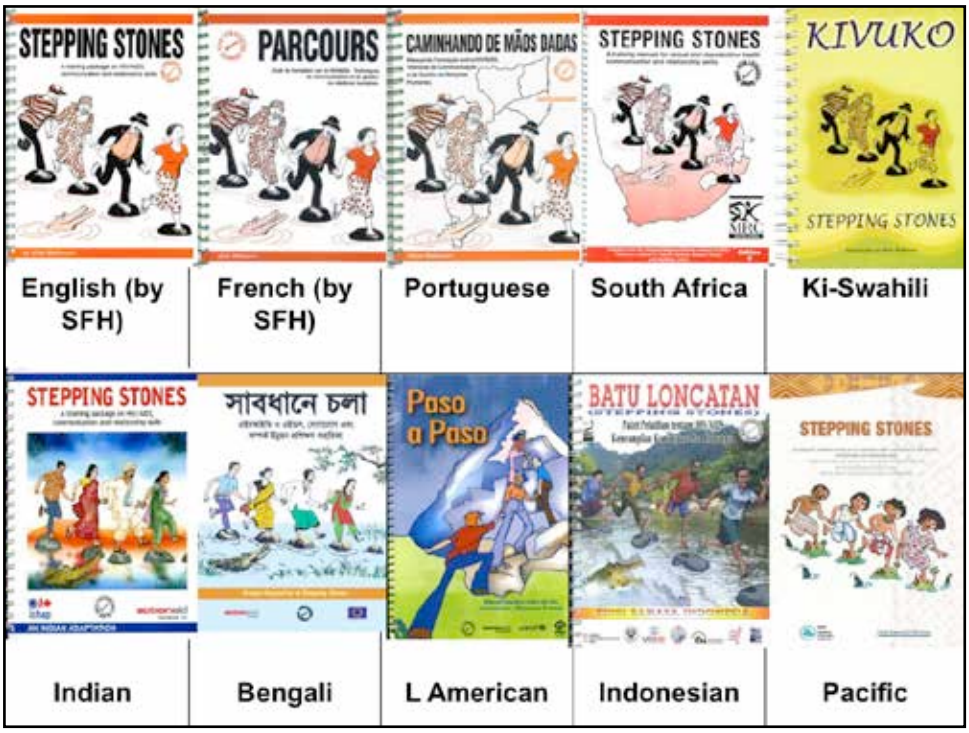


Here are some key 'foundation stones' of the *Stepping Stones* approach. They are not unique to *Stepping Stones* but if they are not present without strong reasons (eg availability of only two peer groups) then the programme is not *Stepping Stones*.

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



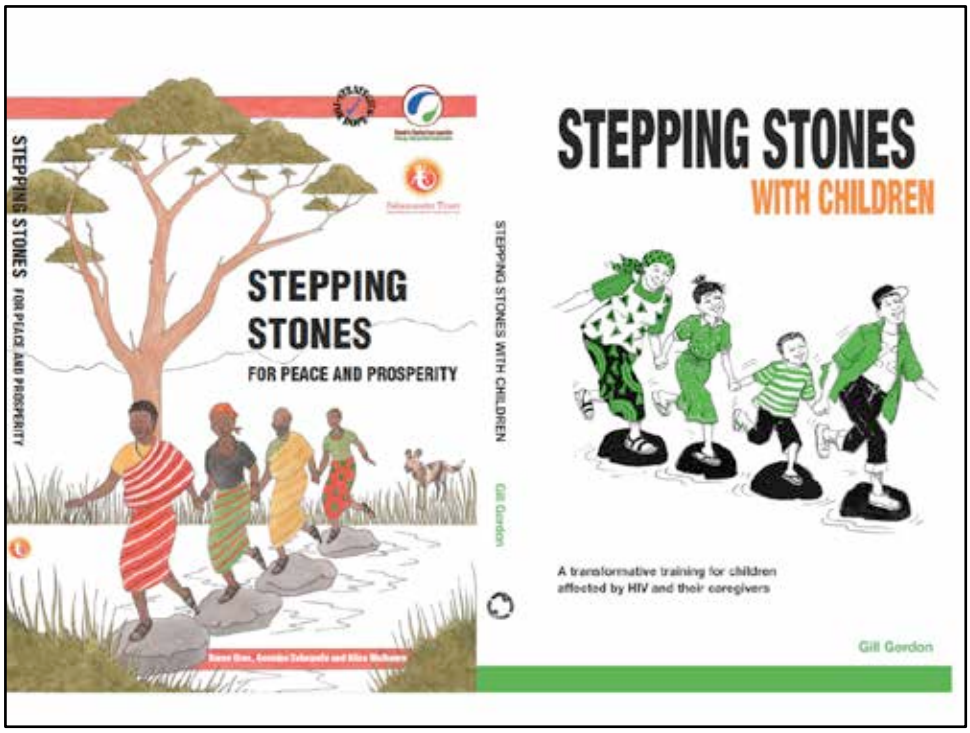
The process of peer groups working in safe separate parallel peer groups and then coming together to share and compare what they have learnt every few sessions is what we call "fission and fusion". Here is an organogram of the whole workshop process. In this way, bridges are slowly and carefully built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



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

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

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



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

How delivered: part 1

Table 3 Characteristics of the Stepping Stones program implementation

Authors	Target groups	Intervention duration	Content of the manual	Language of the manual	Number of facilitators	Duration of training	Partners and training organizers	Local context: cultural, political or ethnic diversity
Jewkes et al. [33] Jewkes et al. [34] South Africa	Young men Young women	6–8 weeks	13 sessions; 3 h each Second SS South African edition (Jewkes et al. 2002)	English	11 facilitators (SS groups) 4 facilitators (control groups)	3 weeks for SS 4 days for controls 1 day in-service training/month	PPASA	Rural, subsistence farming region. 1.5 h drive from town Family households supported by working elsewhere, grants and pensions. Highest unemployment rate in South Africa: 48.5 % (2004). Mobile young men
Pacific Regional HIV/AIDS project [31] Fiji	Younger men and women Older men and women	2, 4 or 6 weeks	14 sessions; 3 sessions original manual	NR	23 facilitators from 13 communities	10 days workshop	PIOP; CDO Coordinators; NAC Committees; SPC; Ministry of Health; National Health Promotion Department Two expert African facilitators	Close to highland tourist resort. One village belongs to Fiji Ministry of Health 'Health Promoting villages'. Implemented in Fiji Network for people living with HIV/AIDS (FJN+). Majority indigenous Fijians
Hadjiyannou et al. [37]. i Angola ii Tanzania iii Uganda	Younger men and women Older men and women Younger men and women Older men and women Younger men and women Older men and women	1 year Two stages 1 year between 1 year	19 sessions, additional topics: STIs; domestic violence 19 sessions, additional topics: VCT; STIs; family planning Some sessions omitted: video excluded	Portuguese translation Kiswahili version Luo translation	18 facilitators from ACORD; 30 community activists 13 facilitators (7 men/6 women); 20 community facilitators 18 trainers 84 community facilitators	10 days workshop 5 days training workshop 2 weeks	ACORD; FAA (Armed Forces of Angola); GAVINGO; ETANGO (NGO) ESTAMOS ACORD; AIDS Outreach Nyakato; TANESA; AMREF; Kivulini Women's Rights Organization; CARE Mwanza; Mwanza City Council ACORD; CARPP community organization NESSA	Multiple ethnic backgrounds and political affiliations. Cultural diversity HIV rate 2.8 %. Post-war situation Mobile population. Implemented in army and pastoralist community (Macabis) Political and social stability HIV rate 6.4–11.9 % (12 % women; 9 % men) Agricultural setting Conflict and displacement area Overall HIV rate 7 %; HIV rate in Gulu district 11 %; HIV rate in camps 37 % Highly vulnerable women/children. High dependency
Pain et al. [38] The Gambia	Younger men and women Older men and women	10 weeks	Adapted for Gambia Added topics: infertility prevention (Shaw, 2002).	Local language	4 supervisors 5 field workers 9 facilitators	10 days workshop	Gambian Dept. of State of Health; Family Planning Association Action Aid Gambia; Medical Research Council; local clinics	Predominantly Muslim country. Relatively low HIV prevalence: 1.2 % HIV-1; 0.9 % HIV-2. Implemented in rural area with highest prevalence HIV-1, HIV-2 (1.6–3 %);high syphilis rate. Illiteracy high

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

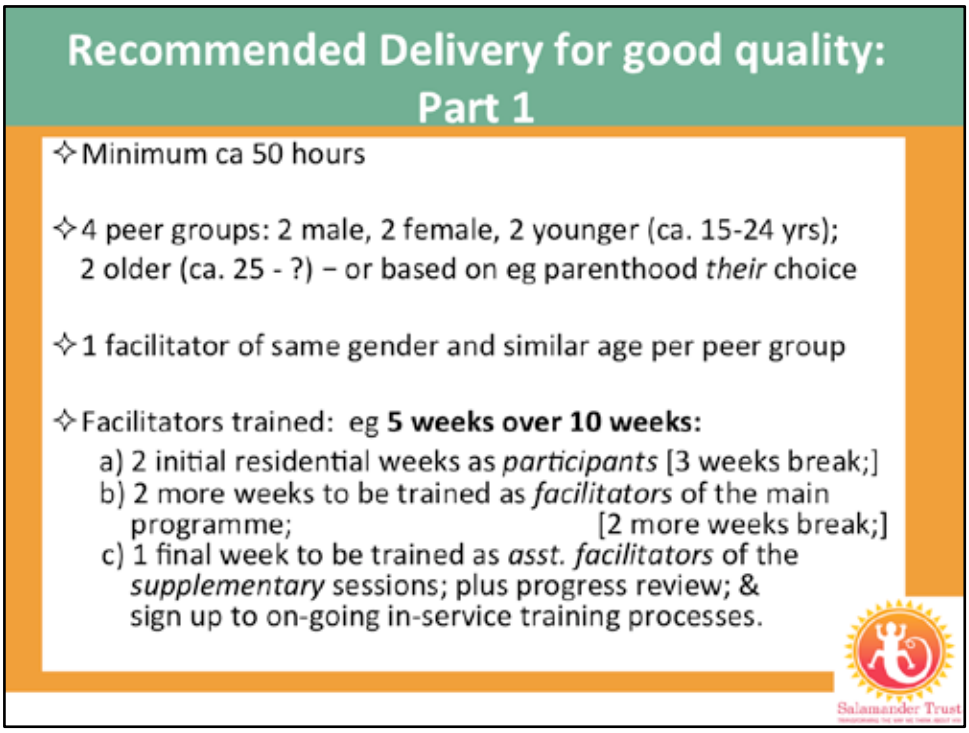
For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website.

How delivered: part 2

Table 3 continued

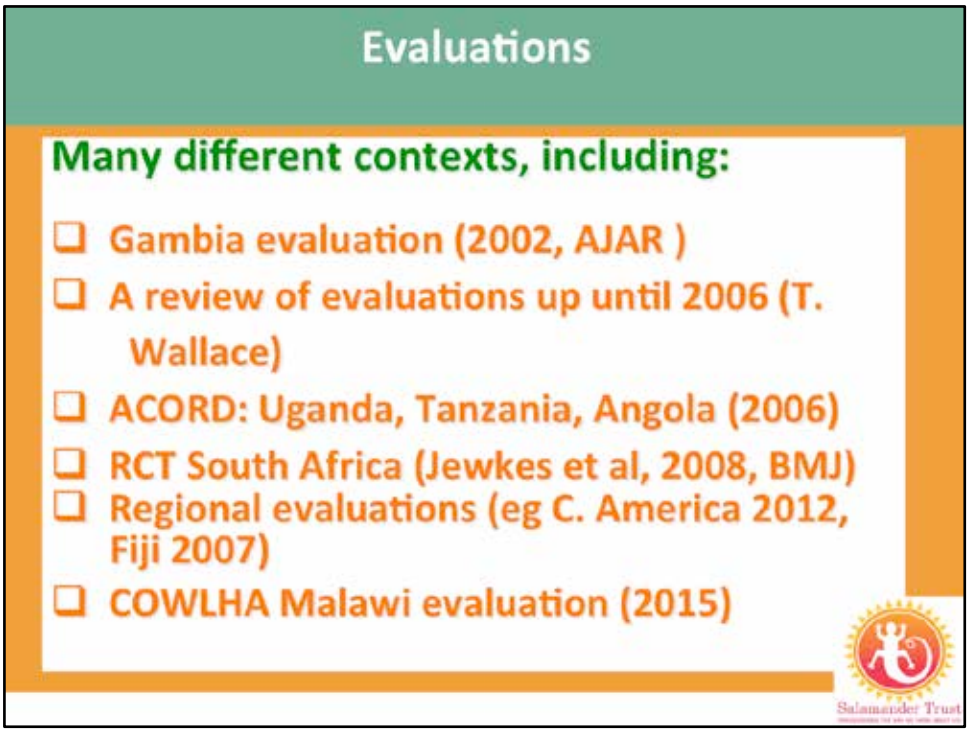
Authors	Target groups	Intervention duration	Content of the manual	Language of the manual	Number of facilitators	Duration of training	Partners and training organizers	Local context: cultural, political or ethnic diversity
Bhattacharjee and Ccostigan [39] Ethiopia	Younger men and women Older men and women	3 months	Revised version Added topics: social mapping HIV timeline risk matrix	NR	24 facilitators (14 male, 10 female)	2 weeks training	SCUK; OSSA (NGO)	Very poor country. Large population. Civil war, unemployment, food crisis HIV rate 4.4 % (5 % women; 3.8 % men)
Bradley et al. [7] India	Unmarried men and women Young married men and women Older married men and women	5-6 months	Adapted by ICHAP: 11 modules with 72 exercises; 4 main themes	Local language. Audio-taped Translated.	12 supervisors 230 paid link workers	12 days training, 4 times refresher training	CIDA; Action Aid India; KHPT India; ICHAP and ICHAP, performed by KHPT.	Localized HIV epidemic has declining trend. National HIV prevalence rate 0.36 %. Injecting drugs predominant in HIV transmission. Implemented in Karnataka - high HIV prevalence state
Jarjue et al. [23] The Gambia	Young men Older men Mixed age women	NR	Original SS package: Muslim adaptation Additional modules: STIs infertility	Local language Diagram techniques designed for non-literate people	NR	NR	Gambian government; MRC; Action Aid; Gambia Family Planning Association; Worldwide Evangelization for Christ mission	Predominantly Muslim: mainly agriculture and fishing. HIV rate 2 % Men suspicious of Family Planning services; strongly supported by some Muslim clerics. Polygamy. Male and female circumcision widely practiced

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



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

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



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

Evaluation Findings

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

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

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

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

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

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

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

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

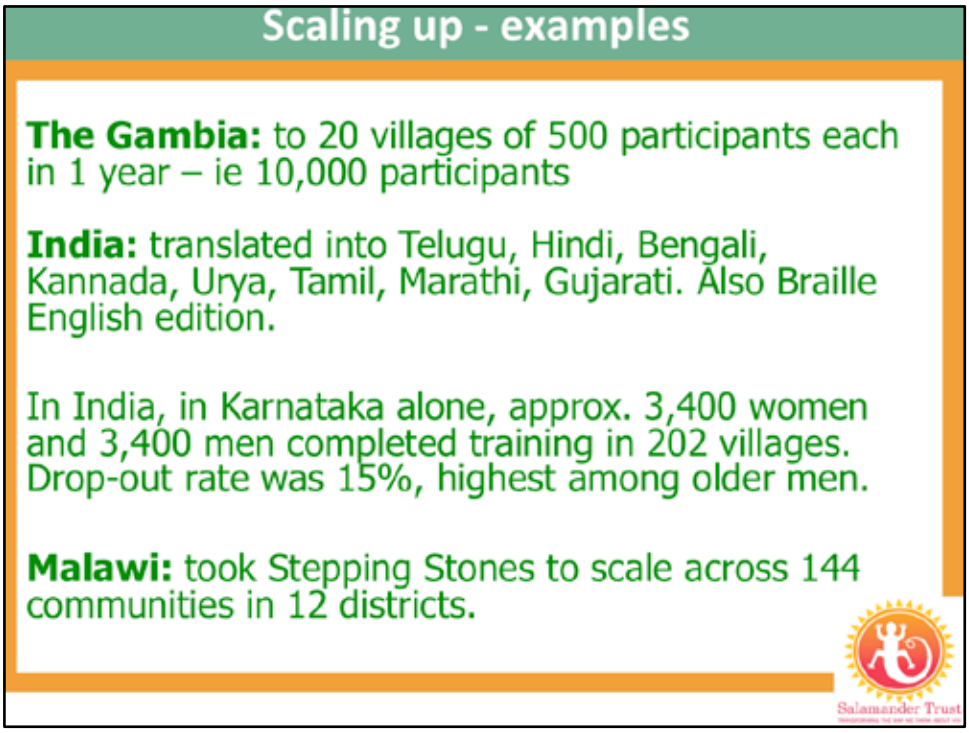
Preliminary results have been particularly important around reducing violence against the children as well as their feeling less isolated and more able to build on their resilience. See http://salamandertrust.net/resources/stepping-stones-children/

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

See further details above.

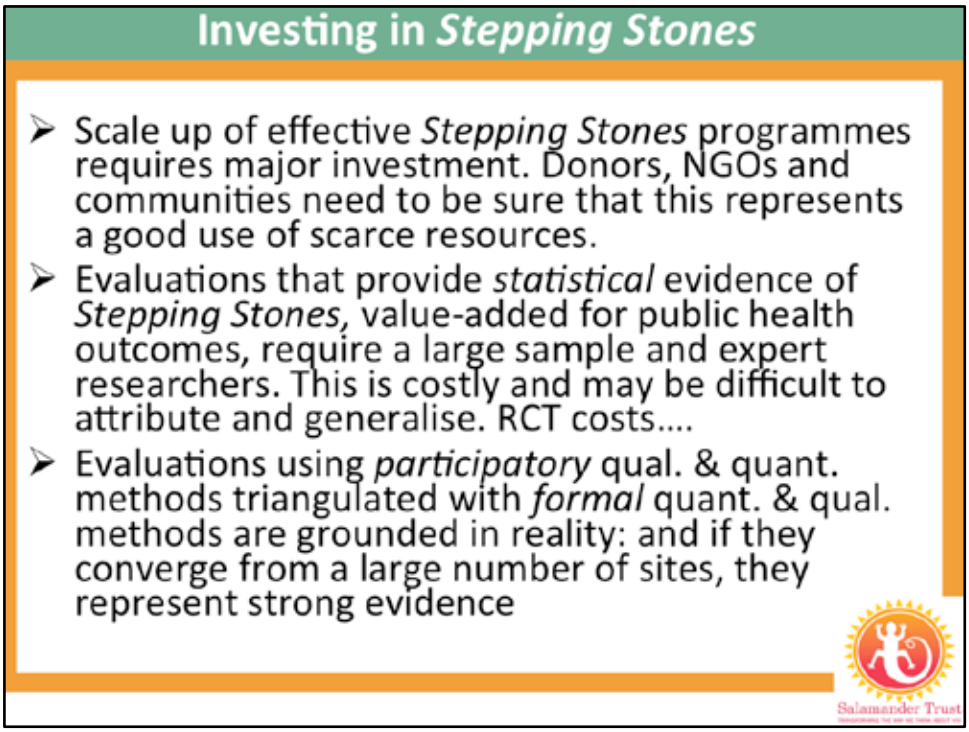
I have also been asked to talk about *Stepping Stones Creating Futures,* which is written as a *supplement* to the South African adaptation of *Stepping Stones.* It is a great programme which we are recommending to anyone to use after the main programme.


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



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

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



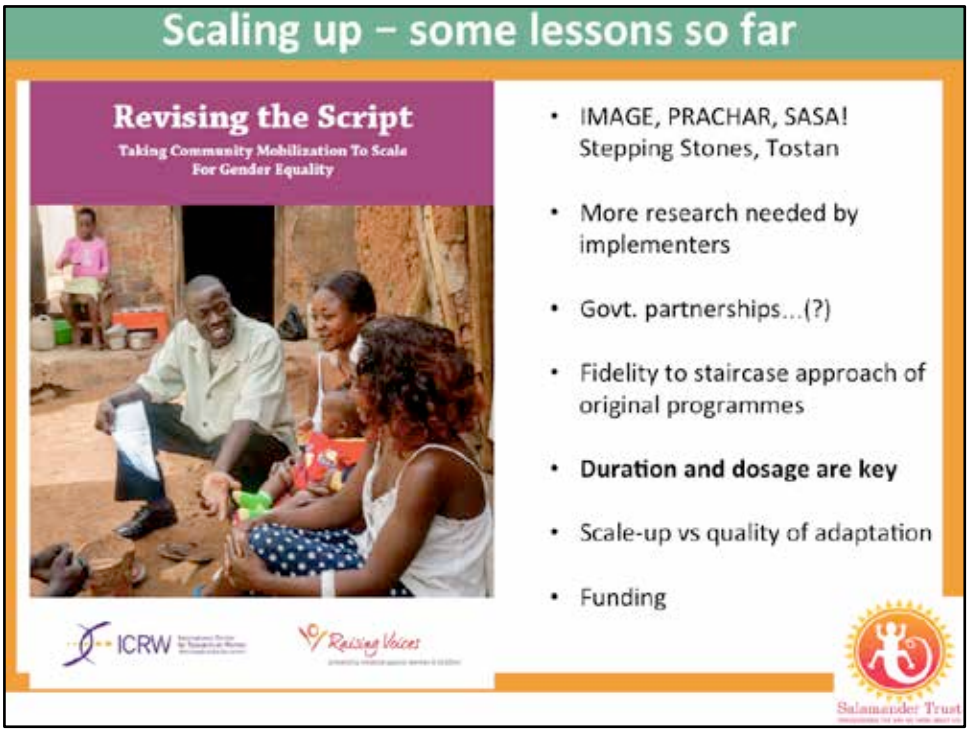
This slide speaks to the limitations and costs of formal research processes such as RCTs. To hear more about this topic and the importance and need for more holistic research processes, see https://unaids.webex.com/unaids/ldr.php?RCID=d4f44e9bbdc1b135a768252b3e79db78

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

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

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

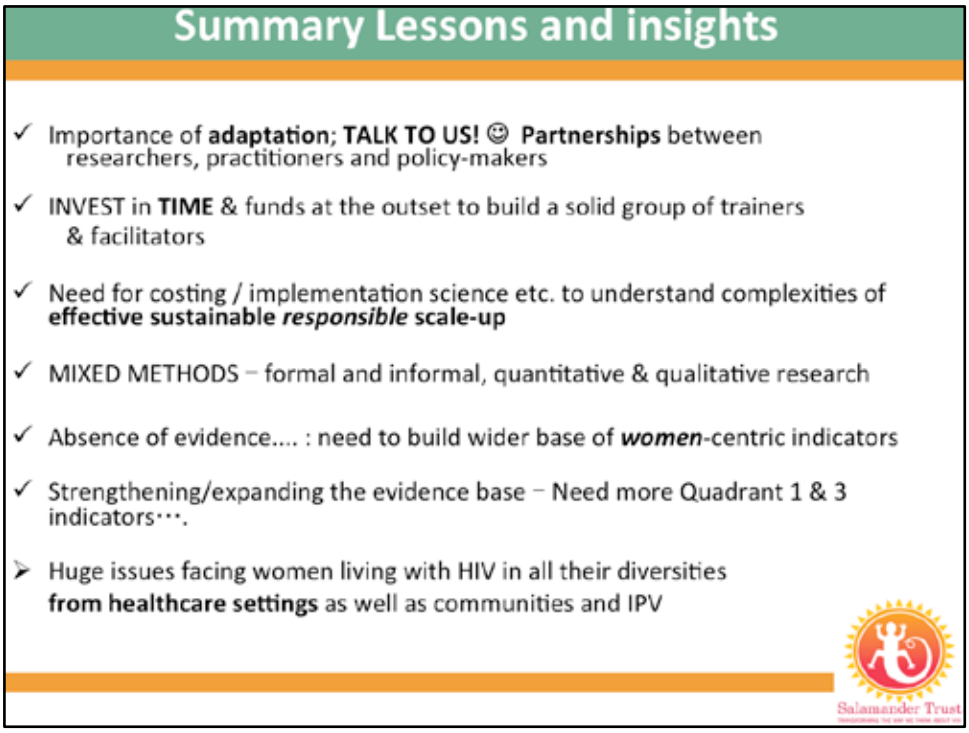
For more information about evaluations of the programme, see the www.steppingstonesfeedback.org website



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

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

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



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

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

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

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

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

With huge thanks to all our collaborators over the years!

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