

14

Gambian experiences with Stepping Stones: 1996-99

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● Introduction

The Gambia is an Islamic, Anglophone country situated in the middle of Senegal in West Africa. Its population is about 1.1 million, spread along the banks of the River Gambia. The main economic activity is subsistence agriculture (groundnuts, millet, livestock) and fishing. HIV prevalence is quite low at about 2% of the population and as yet no-one has publicly declared themselves to be HIV positive. Therefore many people are doubtful that HIV really exists. Moreover, many men are suspicious of Family Planning (including condoms) and this view is strongly supported by some Muslim clerics who believe it to be against the Koran. For economic reasons, men like to have many children, if they live in a rural area. In one area, the total fertility rate for men is 12.0 compared with 6.8 for women; men achieve this impressive fertility through polygamy (Hill and Ratcliffe, 1998-9). The practice of male and female circumcision is widely practised, as in other North African countries. For women, this usually consists of a type 2 circumcision, where the clitoris, clitoral hood and labia minora are removed without closure of the vagina.

What is Stepping Stones ?

The 'Stepping Stones Gambia' project is a collaboration between five organisations; The Gambian Department of State for Health, ActionAid - The Gambia (AATG), Gambian Family Planning Association (GFPA), Medical Research Council (MRC) - UK and the World Wide Evangelisation for Christ Mission (WEC). The partnership began in 1997 to adapt, implement and evaluate the original Stepping Stones workshop programme

(Welbourn 1995). This is a manual describing a series of participatory exercises designed to facilitate HIV prevention by encouraging a gender analysis of sex and its context. The workshops then move into assertiveness training, encouraging participants to be assertive about their feelings and dialogue with their partners, focusing on communication and relationship skills. It was originally designed for use in Sub-Saharan Africa, although has since been adapted and used in many different countries across the world. It operates around a workshop structure, with separate peer age and gender groups.

As outlined in the beginning of the Stepping Stones manual, the traditional ABC HIV prevention message (Abstain, Be faithful, use Condoms) is impractical. Abstinence is undesirable to most people, except in certain situations, such as after childbirth, and when not abstaining, condom use is unacceptable. It is unacceptable within marriage because of its contraceptive effect and generally, because it carries the message that one partner suspects the other of infidelity. When husbands have to support several wives, they may not have enough money to support them and their children adequately; providing an incentive for wives to seek help elsewhere.

Stepping Stones Gambia started because it was felt that the programme could help villagers develop more sensitive solutions to the problems of HIV prevention. One reason we have found the programme effective is that participants meet in age-sex peer groups: usually young men, young women, old men, old women. In the Gambia, (as in many African countries) this is the only forum in which sexual matters can be discussed relatively freely. Most villages are organised in these groups anyway and these are known as *kafos*.

The workshops last for about 10 one-day sessions. Within this period, the *kafos* meet twice to perform 'frozen pictures' or tableaux to each other. The way the workshops are arranged encourages assertiveness between groups of people. Peer group members can have sensitive conversations within their group, but can select what messages they give to other groups. This culminates in the final community workshop where each peer group makes a 'special request' to the whole assembled village, participants and non-participants alike.

Adaptation

Following discussions, the workshop programme of this original Stepping Stones programme was adapted in a number of ways and a Gambian Stepping Stones manual will be published shortly. Although very similar to the mother manual there are some changes. Certain exercises, such as those involving alcohol, were omitted, because the Gambia is an Islamic country, with very little alcohol. It was decided not to use video because electrification is rare in rural villages and very few organisations have portable screening facilities.

Entry into the village was a big problem. We often found men suspicious that this was a secret birth control programme, so we presented it as an infertility prevention package. Sexually transmitted infection is the biggest cause of infertility, and the way to prevent infertility is the same as to prevent HIV. This infertility approach proved to be very popular and we included exercises on 'questions and answers on sexually transmitted infections' and the causes of infertility as well as advice on how to conceive, drawing from the South African adaptation of the same training manual (Jewkes and Cornwall 1995). Most villagers did not know about the fertile period in a woman's menstrual cycle, even though delay in conceiving can often cause problems.

Many communities often guess well what development workers want to hear and play along because they think this will improve potential benefits. So we started the programme with a blind matrix scoring

exercise on health priorities. Facilitators used the fact that they represented a coalition of organisations to prevent people guessing their area of interest. We did this to try and assess how close the villagers' agenda was to ours. Sexual health problems tended to fall in the top 5, usually sexually transmitted infections, sexual weakness or HIV. In the last case, HIV, villagers felt they were ignorant about something they had gathered was an important issue.

Sometimes the men were concerned that when we took the women away for their separate meeting we might inject them with Depo-Provera¹. So it was important for the participants to know that every group did exactly the same exercises. The one exercise in the original manual where women do a slightly different activity was modified.

We also added body mapping of sexual 'turn-ons' and 'turn-offs'. This was to enable discussion of the difficult subject of female circumcision and orgasm. However female circumcision was not an urgent priority for the villagers, although there were other problems to do with the sex act itself. Exercise 'M' from the original manual (about will-making) was not included in our first adaptation because in the Gambia, the extended family has a responsibility to care for the bereaved. However we are now planning to include a modified version to try and have an impact on gender inequality in inheritance, which can contribute to poverty and financial dependence on sexual partners.

The basic structure of the workshop programme remains similar to that of the original Stepping Stones programme. An additional inter-peer group meeting was added so that the groups meet three times before having the final community meeting. More recently we have altered the exercise preparing for the final community workshop. Next time we will ask peer groups to produce a Group Action Plan based on 3 changes that they would like to see. They are then asked to select one of these changes to be presented as a 'special request' to the community. This means that the 'special request' is not necessarily the *most* important change that

¹A contraceptive.

each peer group would like to see, but may be the one which is *hardest* to achieve without the support of the rest of the community. Also, we found that preparation for the post workshop review has been weak. Yet this is most important for sustainability as it may lead to continued community mobilisation.

Timing of the programme.

Programme timing was very important. The Gambia has three rainy months every year, when all villagers are preoccupied with planting. The original manual suggested spreading the workshop over 9 weeks. Although the dry season would be the obvious time to run the programme, a PRA exercise suggested that many people migrated to the urban areas during this period. Therefore the pilot study took place in the harvest season as a compromise. Thus we could only work one day a week on the farmers' day off. This was the second time the GFPA teams had run the programme, and (although they felt pressed for time), they managed to cover all twenty six sessions in 10 days. We would recommend 14 days as the ideal length of time required.

Pilot evaluation

The MRC ran a pilot evaluation of the programme in the GFPA areas. This included a fieldwork report (process evaluation), interviews, focus groups and a KAP (Knowledge, Attitude, Practice) survey². We also planned a participatory evaluation although unfortunately, because of some confusion, the peer groups did not set their own targets for the changes they would like to see. The facilitators were asked to record the output of the workshops each week. However they tended to write down absolutely everything that happened. This made them less effective as facilitators, and made it very difficult to produce a field report at the end. The second time round, the exercises where it was important to record things, were clearly identified. When the Gambian Stepping Stones manual is produced it will include preprinted reporting forms for photocopying, designed to make a report readable when put together.

² A KAP survey is a formal questionnaire, based on a fairly rigid model, which tends to focus on health education.

The pilot villages were small hamlets with populations of 158 and 250. About half the population over 17 participated in each community. More women participated because of the population structure of the villages. Shortly after it began, MRC field workers interviewed 140 people (participants and non-participants) chosen at random from the two villages involved in the programme, and two control communities. The questionnaire included knowledge questions about the transmission and prevention of sexually transmitted infections and HIV, as well as questions about attitude. We also tried using 'secret ballots'. We believe this technique was invented by a local anti-circumcision NGO (BAFROW). Ballot forms were give to each member of the peer group. When the facilitator read out the question participants had to mark a triangle for yes, a circle for no or nothing for 'don't know'. At the end of the session participants, folded their ballot sheet and put it in a hat. The ballots were therefore anonymous but the peer groups were known, enabling us to analyse the responses by age, and sex (see Box 1).

BOX 1

SOME EXAMPLE OF QUESTIONS USED IN THE SECRET BALLOT

- Have you talked to your partner about sexually transmitted infections in the last year?
- Are you responsible for any children under 16?
- If so, have you discussed the bad side of sexual relationships with these children in the last year?
- Can a man or woman be infected with a sexually transmitted infection but not have any symptoms?
- Can a man have a discharge from his penis without having sex?
- If someone has a sexually transmitted infection which is treated and cured, is it OK to resume sex with their partner?
- Is a woman most fertile on the day after her menses?
- Can sexually transmitted infection make a woman barren?

● Results

Six weeks after the programme finished, we returned and conducted 50 key informant interviews, seven focus groups and repeated the KAP survey (140 interviews) and secret ballot. We will repeat these shortly, when a year has passed since the original intervention. Comparison of the 'before and after' results showed that intervention villages had gained a good understanding of the issues.

The KAP survey showed a significant increase in knowledge about sexually transmitted infections after Stepping Stones for women. However this is biased by the fact that young women are proportionally the largest participating group. When further analysed by age, the old women *kafos* usually gained least, maybe because many of them are no longer sexually active and the issues are less personally relevant. Men showed a strong trend in improved knowledge, but because they knew more in the first place, these changes were not significant. In most cases improvements could be seen when participants and non-participants from the Stepping Stones communities were included, even though workshop participants tended to keep their new knowledge to themselves rather than go out and share it. We did not set our expectations very high; e.g. knowing at least one way in which HIV can be transmitted earned a point. However at baseline, only half the women could answer this question. Next we will examine the men's responses using more stringent criteria.

In particular we found a much greater awareness of the risk of sexual activity in general and an appreciation by men of the importance of supporting their wives financially. The KAP survey supported the interviews in these results. For example 11/28 (39%) of women considered themselves to be at risk from HIV before the programme compared with 35/43 (81%) after the programme. Women in polygamous marriages were 9.7 times more likely to consider themselves at risk. These quotes are taken from recorded interviews.

"I have changed very much because I used to play about. I would sometimes leave my wives

for a week . But when I joined the programme I stopped that. (in-depth interview - young man).

"We the women have also reduced irresponsible sexual behaviours and unnecessarily travelling to be able to meet our needs" (focus group discussion - young woman).

The survey showed about half the respondents had ever had sex outside of marriage.

- Participants who had been involved in the condom familiarisation exercise were much more comfortable about using condoms. It was remarkable that the issues to do with sexual activity could be discussed openly in the whole village, which greatly impressed our government colleagues.
- Several key informants told us that wife beating had stopped completely in the Stepping Stones communities. This was because of improved dialogue between husbands and wives and also, through peer pressure. Many men were now too ashamed to be seen beating their wives, having agreed that wife beating was wrong at the final community meeting.

Most of the role-plays produced during the programme included wife beating in one way or another.

Drawbacks

Unfortunately the secret ballot was not successful; participants did not understand that a 'no' response could be correct and all it showed was that participating in Stepping Stones makes you more likely to vote 'yes'. We realised this because we got strongly positive responses to all questions, no matter whether they contained very negative or positive statements. This contradicted information collected using different techniques. However we will continue to develop this technique because we feel it could potentially be an appropriate monitoring tool to include in the manual. We also feel that an anonymous monitoring tool is important given the sensitivity surrounding change in sexual behaviour. In future, we will emphasise that a

'no' response can be correct and structure the groups more like focus groups, thereby restricting their size and probably keeping the membership of these groups the same from one occasion to the next .

Collecting information about behaviour has been our most difficult challenge. Before running the programme, we identified all the official condom distributors in the area and asked them to monitor the number of condoms they distributed to members of participating communities. However we found that very few participants got condoms from these sources, most of them using their own (limited) informal channels. These channels were almost impossible to identify before the programme, so we had no baseline data. Following the programme, each peer group chose to identify a distributor. These distributors refer clients to each other but keep the details of the people they supply confident. Although we supply the condoms at the moment, the distributors are variable in keeping records for us. We use a pictographic form, but the distributors often lose or forget to complete them. However although the demand for condoms from one individual is not the same as condom use, (people may take condoms to sell), demand does seem quite high and is probably higher than before the programme. In one village (population 250) 600 condoms have been given out in 12 months.

"Now if some men ask women for sex the women will ask them if they have a condom and if he says no then she will refuse." (in-depth interview- young man).

"According to my observations there are changes of behaviour, attitude and awareness, especially [with] the youths towards safer sex, with an increase in use and demand of condoms to avoid infections." (in-depth interview - young man non-participant).

Operational issues

Running the programme gave us several problems in terms of logistics and human resources. Firstly, it was difficult to find enough women staff to be facilitators. Secondly, between 1996 and 1998, the

programme was not completed six times in ActionAid areas. This was due to logistical reasons and from lack of enthusiasm from the communities.

Because they are posted evenly across their development areas, it proved difficult for the ActionAid community development workers to come together in one community at one time. It was a challenge for co-ordination and required extra fuel, (some staff having to travel up to 70 kilometres to attend the workshops). This was made worse because we failed to sensitise the middle managers at ActionAid, who therefore did not prioritise the programme in their action plans. Since these activities were budgeted at the national, rather than the area level, they were not included in the area work plan. Therefore area managers received no credit or incentive for programme completion. In all the pilot areas, the programme was disrupted by routine facilitator movements, or other trainings. This prevented consistent attendance in the Stepping Stones villages - which lost momentum.

In the GFPA area, community facilitators were employed. They managed to complete the workshop programme three times with substantial logistical support from the MRC and financial support from ActionAid. Initially they were salaried but this is unsustainable because of the intermittent and seasonal nature of the workload, and since our donors do not pay salaries. Transport was a problem: even though the Gambia is a small country, many villages have no public transport at all. Therefore the facilitators depended on MRC vehicles to get to the workshops, incurring a considerable fuel bill. Now facilitators are paid for three days per workshop, (one day's travel to the village and one day's return).

● Conclusions and future plans

In summary, we have found the following.

- The programme is popular and the infertility prevention approach is acceptable
- Changes were shown in the following areas; risk awareness, dialogue with

partners and peers, attitude to condoms and a reduction in wife beating.

- Young women are the main benefactors because they are less knowledgeable at the beginning
- Old women are less likely to gain knowledge or discuss in the community
- Secret ballots need further development.

Currently we are examining how to expand the programme sustainably, using some small UNDP funding.

We will pursue 4 strategies.

1. Stepping Stones as part of integrated rural development.

Following an EDF³ programme, all government extension workers are now organised into Multi-Disciplinary Facilitation Teams, (MDFTs), co-ordinated from the Department of Community Development. These teams combine all the extension workers from different government departments by locality, and have been involved in participatory needs assessments of all the communities in their areas. In a bottom-up planning process, these needs assessments are combined to make (electoral) ward development plans, which will become the agenda for the new area councils due to be elected next year in local government reforms. Sexually transmitted infections are already a high priority in the first plan to be collated. This matches our own initial matrix scoring.

These MDFTs have now been joined by the NGO sector, including ActionAid and GFPA. Next year the MDFTs will expand to new areas. We hope to integrate Stepping Stones fully into this process, so that, should reproductive health problems be identified, the programme will be offered.

2. Freelance facilitators

The problem with a lack of women staff remains. Therefore the 'employment' of dedicated community facilitators will continue. Although they are paid essentially on a per diem basis, their terms and conditions have been modified to include a monthly 'retention fee' given if their earnings fall below a certain point, along with a savings scheme. This is because many facilitators had

difficulty explaining their irregular employment to their families, who had heightened expectations of the amount of support they should give to the household. We hope these arrangements will attract more skilled women back into the workforce, and that as the popularity of the programme increases they will be increasingly contracted as trainers by outside agencies.

3. Non literate facilitators?

We would like to explore the possibility of a 'talking book', in which the instructions for the exercises are recorded on audio cassette in local languages so that facilitators do not need to be able to read. Another possibility is to make closer links with the ActionAid REFLECT⁴ adult literacy programme. There are many similarities between the two manuals and the material in Stepping Stones could be a good base for the adult literacy exercises.

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³ European Development Fund.

⁴ REFLECT Literacy Manual ACTIONAID London 1996.