Short-term impact of faithfulness-focused curriculum on couples from three regions in Ethiopia

Abstract

Background

As the HIV epidemic continues to expand in sub-Saharan Africa, there is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address the context within which most infections of HIV occur: couple relationships. Even though a large share of new infections in many African countries occurs within marriages, there are relatively few prevention programs specifically focusing on the couple as a unit of behavior change. Furthermore, there is a lack of evidence of the long-term effectiveness of faithfulness-focused curriculum. The Faithful House (TFH) is an HIV-prevention curriculum focused on fidelity within relationships/marriage and implemented through workshops uniquely centered on the couple. An evaluation of the workshop was conducted in Ethiopia with middle-aged, more established couples to assess its impact on a population deeply rooted in traditional cultural and gender norms.

Methodology

The evaluation population consisted of 1,113 individuals (558 couples) from Addis Ababa, Oromia and Tigray regions. Working with five community partners and Idirs, participants were selected through convenience sampling and randomly distributed between intervention and control groups of equal size. Focus group discussions (FGDs) were conducted before the workshops with a representative group from all regions to provide qualitative baseline information. In March 2011, both groups completed a quantitative baseline survey prior to the workshop, and the post-test survey was conducted immediately following the workshop with the intervention group only. All data was entered into a Microsoft Access database and then cleaned and analyzed using Excel and STATA. Statistical analysis was conducted, comparing matched baseline and post-test changes between the intervention groups. A six-month follow-up survey will be conducted in September 2011 for both control and intervention groups.

Results

The average age of TFH intervention group (N = 557) was 43.6 years, with men on average 10.5 years older than women ($p<0.001$). Women were less educated than men ($p<0.001$). Over two-thirds were in traditional marriages and had been together for 22 years. Thirty-three percent of men reported being married to more than one wife. The couples were largely (90 percent) Orthodox Christians, and 87 percent lived in urban areas. Baseline and post-workshop data showed statistically significant improvement ($p<0.01$) in couples' perceptions on factors affecting relationship satisfaction and the family unit: quality of relationship and couple communication; joint decision-making about care of children, financial matters, sexual activity, accessing HIV services and other important family matters; self-efficacy and intention to discuss sexual issues with daughters and sons; and intended male involvement in antenatal care visits (ANC). Additionally, analysis by sex on baseline responses revealed statistically different ($p<0.01$) views on the quality of relationship, couple communication, partner's perceived ability to remain faithful, level of sharing financial information, ability to talk to partner about sex and sexual satisfaction (all lower ratings among women). Attitudes on cultural norms that contribute to HIV risk and multiple sexual partners also statistically improved ($p<0.01$) after the workshop.

Conclusions

This review of preliminary findings in the evaluation was important for understanding baseline knowledge, perceptions, attitudes and behaviors around the factors that affect couple relationships and the family unit, as well as on HIV testing and cultural norms that contribute to HIV risk. Even given the culturally rooted norms that emerged, the changes from baseline to post-test indicate that attendance to TFH workshop had a short-term effect on perceptions, attitudes and intended behaviors linked to those barriers within couples

that may lead to unfaithfulness in relationships. It will be important to track and analyze these initial changes at the six-month follow-up and note any long-term changes resulting from TFH participation.

Project Background

Summary of the Literature

As the HIV epidemic continues to expand in sub-Saharan Africa, there is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address the context within which most infections of HIV occur: couple relationships. Prevalence of HIV in some countries in sub-Saharan Africa is up to 50 times higher than the average for countries outside Africa. In order to explain and understand these differences, international discussions and modeling have focused on the factors (in many cases, behaviors) that could have accounted for the higher infection rate in eastern and southern Africa. In the 1990s, it was widely accepted in policy and scholarly dialogue that higher rates of risky sexual behavior in Africa explained the difference in HIV prevalence. However, a more in-depth examination of empirical evidence forced both social scientists and policy makers to acknowledge that most kinds of risky sexual behaviors are not exceptionally common in sub-Saharan Africa[1,2]. Contrary to this belief, data drawing back to the late 1980s show rates of risky behaviors to be considerably higher in affluent and middle-income countries with low HIV prevalence, including early initiation of sex, number of sexual partners, and premarital and extramarital sexual relations[3]. Confronted with that evidence, the argument narrowed to a single kind of sexual behavior: concurrency, which is broadly defined as long-term, overlapping partnerships.

According to data from nationally representative surveys conducted during 2004-2006 in Cameroon, Rwanda, Uganda and Zimbabwe (which included HIV testing of adult men and women), "Having fewer lifetime sexual partners and being faithful to spousal partner(s) are strongly associated with reduced risk of HIV infection. Thus…HIV prevention programs should focus more on promoting partner reduction and partner faithfulness, especially for men"[4]. This notion that concurrent sexual partnerships are especially common in sub-Saharan Africa and that this phenomenon explains the region's high HIV prevalence is accepted by many as conventional wisdom; however, the data surrounding multiple and concurrent partners (MCP) is still controversial, specifically on whether the differences between serial monogamy and concurrent partners could cause the epidemic proportions of HIV that are found in parts of Africa. Halperin, Mah, Epstein and Morris have contributed countless works of literature regarding MCP as the key driver in the HIV epidemic seen in Africa and a root factor in the proportions of HIV and AIDS on the continent today. However, contrasting the mathematical models of the potential role of concurrent sexual partnerships in facilitating the rapid spread of HIV in sexual networks, a recent analysis of household survey data in 22 countries, including 18 in sub-Saharan Africa, found no significant correlation between prevalence of sexual concurrency and HIV prevalence at the country or community level[5,6]. In addition, in one systematic review in 2010 by Sawers and Stillwaggon, the research seeking to establish a statistical correlation between concurrency and HIV prevalence either found no correlation or had important limitations that should dismiss such a conclusion. According to these authors, "Policy makers should turn attention to drivers of African HIV epidemics that are policy sensitive and for which there is substantial epidemiological evidence"[3].

Critical epidemiological trends, such as those emerging from the recent national studies in Uganda and Kenya, indicate that half of new HIV infections are occurring in married people[7]. This could be an area for focus, particularly for faith-based institutions. Being unfaithful to one's current partner still remains a key area of concentration for HIV-prevention programming. Recent evidence from a Zimbabwean study suggests that although age-disparate relationships are a concern for a sustained HIV epidemic, conventional intergenerational relationships—that is, married and long-term couples—post a greater risk of HIV infection than even "sugar daddy" relationships[8]. Thus, putting aside the discourse about MCP and its associated risk and role in the current African AIDS epidemic, there is a growing consensus that HIV prevention research and programming should address couples as a unit of behavior change and intervention[9]. From a faith-based perspective, strengthening the marriage would be the focal point of combating this issue.

Couples-centered approaches are one response, and although they appear initially promising, additional research is necessary to build a stronger theoretical and methodological basis for couples-focused HIV prevention[10]. Earlier studies provided preliminary evidence for the feasibility of couples-focused interventions for HIV—particularly the role of couples-focused voluntary counseling and testing[11,12]. Moving beyond the context of HIV testing and counseling, more general couples-focused HIV prevention programs may differ from individual-focused HIV prevention programs by addressing the ongoing dynamic and interactional forces within dyads that contribute to sexual risk behavior, including gender roles, power imbalances, communication styles, child-bearing intentions, intimate partner violence and quality-of-relationship issues (e.g., commitment, satisfaction, intimacy). Furthermore, there is a lack of evidence of the long-term effectiveness of faithfulness-focused or fidelity-focused curriculum. A systematic review showed that couples-focused programs only reduced unprotected sexual intercourse and increased condom use[10]. Note that faithfulness or fidelity within marriage or to one partner was not an indicator of study. This evaluation by CRS attempts to build on the theoretical and methodological foundation for couples-centered, faithfulness-focused HIV prevention.

Local Response

CRS has been working with community organizations and faith-based institutions to address HIV since 1986. CRS has had a presence in Ethiopia since 1958 and has worked in all but one region. Religion, spirituality and faith are deeply rooted in the cultures and traditions of all of Africa, and Ethiopia is no different. According to CRS, "Using this platform and network of community, which emanates trust and stability, can deliver a long-lasting intervention that supports positive change in people's lives. Values and behaviors which can lead to the increased HIV risk are expressed within the intimacy of a couple's relationship; the theoretical framework points to the couple's place in the causal relationship with the belief that if this couple relationship can be strengthened, HIV transmission through multiple partners, concurrent or not, will dramatically fall."

The Faithful House program was created collaboratively by CRS and Maternal Life International/Uganda to accomplish just this task. TFH is a faith-based, skills-building curriculum with the aim of strengthening the family through enhanced couple communication, achieved by skills building, positive peer mentoring and provision of a safe environment for couple dialogue around quality-of-relationship issues and other

attitudes and behaviors that contribute to sexual risk behavior. Currently, the curriculum is being used in 11 countries. Over the course of the three years of implementation, TFH program has collected pre- and post-workshop surveys from over 600 beneficiaries, and these surveys have demonstrated improvements in communication between partners in areas such as finance, gender roles, power imbalances, sexual intimacy, and parenting and communication with children around sex-related issues.

Two limitations have also emerged over this time period: 1) long-term impact of the program on attitudes and behaviors has not been documented to date; and 2) the absence of a control population has limited rigorous conclusions. CRS has responded to these critiques and challenges by developing an evaluation to assess the effectiveness of the three-day TFH curriculum on short-term knowledge gain and attitude changes (outputs) and long-term attitude and behavior change (outcomes).

Evaluation Description

The Barriers to Intended Behaviors

In the FGDs and quantitative surveys, lack of love, poor communication between partners and sexual dissatisfaction were the top three reasons (barriers) named for both Ethiopian men and women having multiple sexual partners, even when the couple is married or in a long-term relationship.

Objectives of the Evaluation

This evaluation has been designed to assess the effectiveness of a couple-focused HIV-prevention intervention (i.e., TFH) in improving couple relationship satisfaction and communication and knowledge on HIV risk associated with MCP. Specific objectives in the evaluation include:

1) Assess the impact of this curriculum on couples' communication, quality-of-relationship issues and attitudes and behaviors that contribute to sexual risk behaviors.
2) Assess the impact of this curriculum on family strengthening.
3) Determine the attitudes and behaviors toward the issue of multiple and concurrent partnerships (in order to measure the impact of TFH on changing the acceptance of this behavior).
4) Identify the attitudes and practices surrounding MCP most and least consistently affected by TFH.
5) Identify the family strengthening attitudes and behaviors which are most likely to change as a result of couple discussion and peer mentoring in an interactive three-day TFH workshop.
6) Profile the beneficiaries most likely to share the lessons learned through TFH with neighbors and find out what information is being shared.

Methodology

Quantitative data methods were used to assess the effectiveness of TFH curriculum on the short-term perceptions, behavioral attitudes and intended practices related to couple relationship satisfaction, partner communication and HIV risk. Qualitative research was conducted using FGDs. The qualitative methods focused on topic areas of interest/concern that were uncovered in the quantitative data analysis, offering a complementary view of the data. Data presented reflects participants' feedback (perceptions, attitudes and intentions) regarding TFH curriculum.

The evaluation was conducted in three regions (Addis Ababa, Oromia and Tigray) where CRS Ethiopia works with partner organizations. These couples were pulled from predominantly urban areas in these regions, as urban adult HIV prevalence is higher (7.7 percent) compared to rural HIV prevalence (0.9 percent)[13]. Five community partners were identified within the three regions. The sample couples were allocated proportionally and distributed out of the total sample size. There were 16 workshops conducted throughout the three regions, with a maximum of 20 couples attending each workshop. The workshops, which were offered only for the intervention group, were held the day after the baseline data were collected from both intervention and control groups. Prior to conducting the baseline survey interview or participation in the FGD, written consent was collected from each participant.

Evaluation Population Selection

"Idirs", or commonly known local support associations in Ethiopia, were the source of the evaluation population. Idirs offer social and economic support when community members get sick or pass away, and, in theory, hold comprehensive lists of all community members/households in their catchment areas. The evaluation team, in consultation with project officers at each community partner, identified Idirs to contact for possible evaluation participants. Proportional sampling to a total size of Idir members was made prior to identification of each participant. The list of couples, however, was based on interest and availability of both the man and woman, and therefore resulted in a convenience sample. Although the use of Idirs created an opportunity to easily access the appropriate number of couples, the Idir source population was dominated by older couples. Therefore, an additional effort was made to mobilize younger couples from support groups and youth associations for the evaluation. After lists of interested couples were sent to the evaluation team, a randomized sampling method, using Microsoft Excel, was applied to divide the participant couples into control and intervention groups.

Training of Enumerators and Couple Facilitators

An international consultant conducted a one-day training for all enumerators, who would conduct the quantitative surveys. Unfortunately, due to changes in workshop dates, some original enumerators were unable to make all workshops. Thus, additional enumerators were hired and trained by the local consultant in Ethiopia. Couple facilitators, who led the workshops, were provided a week-long refresher training on TFH curriculum by TFH trainer of facilitators from Uganda.

Data Collection and Analysis

Unique identifiers (IDs) were used on the surveys in order to maintain confidentiality with the data reported. Baseline survey data collection for participants occurred at the workshop site the day before the workshop began. The corresponding control group was interviewed the first day of the workshop, while the intervention group was attending TFH. The post-test for the intervention group was conducted the day after the workshop ended. All workshop attendees returned to the workshop site for this post-test survey. Participants who did not have both a baseline and post-test survey completed and entered into the database were deleted from the data set and not included in analysis.

All data from the Microsoft Access databases was exported and manipulated in Microsoft Excel for the initial frequency analyses and unique patterns/associations. All cleaned data was then entered into

STATA, and statistical analysis was run on comparisons of baseline scores between the control and intervention groups, baseline and post-test comparisons for the intervention groups only, and sex stratifications.

Quantitative and Qualitative Findings

Findings from intervention group are presented in the results section. The control group, only sampled for the baseline, was found to be a comparable group and thus will only be presented in the analysis of the three-month follow-up comparisons.

Sample Characteristics

A total of 1,113 individuals were sampled. (See Table 1 for an exact breakdown of the sample between regions and intervention vs. control group.) All participants of the intervention group were interviewed in the post-test survey, and only those workshop participants who completed the workshop were included in this survey (all 279 couples).

Table 1: Breakdown Couples/Individuals Sampled

Target zones	# of couples in control group	# of couples in intervention group	Total # of couples sampled	Total # of individuals sampled
Addis Ababa	89	97	186	372
Oromia	101	108	209	416
Tigray	89	74	163	325
Total	279	279	558	1,113

The demographics of evaluation participants (see Annex 1) in the intervention group are as follows: The average age of the participants is 43.6 years, with men on average 10.5 years older than women ($p<0.001$). Women are less educated, 52 percent have never attended school, and only 12 percent have secondary or higher education compared to 23 percent of men ($p<0.001$). Over two-thirds are in traditional marriages and have been together on the average 22 years. Thirty-three percent of men report being married to more than one wife. The couples are largely (90 percent) Orthodox Christians, and 87 percent live in urban areas. The majority of women (69 percent) are housewives who have never been employed outside the home, and 56 percent of men are employed by government or a business/self-employed; unemployment is quite high among men (24 percent). Roughly 17 percent report having biological children with someone other than their current spouse/partner, and almost 30 percent of households are caring for nonbiological children (orphans or vulnerable children, or OVC) with an average of 1.7 children per household. Over half of respondents caring for OVC identified at least one these children as a “vulnerable child [with living parent(s)] that is related to them”, and 31 percent as an “orphan of a relative or family member”.

Preliminary findings are presented below in themes that combine indicators for The Faithful House program targets for perception, attitude and intended behavior change. At this point in the evaluation, the findings focus primarily on the baseline and post-test findings of the intervention group, with additional qualitative results presented throughout. The more significant and conclusive comparisons will be made in the final report, where the baseline and six-month follow-up data will be presented for both the control and intervention groups. The reported results presented in this section are mostly perceptions and determinants of behaviors, not actual behaviors of the participants; these perceptions and determinants either affect the particular attitudes and behaviors or address barriers to behavior change. All results are self-reported and are not verified through other sources. It is important to note that all changes reported are immediately post-intervention; long-term, sustained effects can only be concluded after the six-month follow-up collection.

Factors That Affect Couple Relationship Satisfaction

The perceptions and attitudes measured on the quantitative surveys and explored in the FGDs are centered around factors that affect the couple relationship. Associated indicators measured include but are not limited to overall relationship rating; quality of communication; level of respect received from and given to partner; sexual satisfaction; level of sharing of financial information; use of partner for confiding about personal problems and sexual issues; rate of couple's unfaithfulness; attitude toward male and female lifetime monogamy; attitude toward fault in unfaithfulness; and perceived level of adequate knowledge, values and skills to be faithful. The corresponding factors were identified through prior assessments, FGDs and interviews (outside this evaluation) as having an effect on perceived relationship satisfaction, with lower levels of satisfaction leading to detrimental or risky behaviors (such as unfaithfulness). Table 2 lists the perception and attitude changes from baseline to post-test; *all changes were statistically significant (p<0.01).*

Table 2: Indicators That Affect Couple Relationship Satisfaction

Indicator	Baseline	Post-Test
On a scale from 1-10, with 1 the lowest and 10 the highest:		
Quality of relationship*	8.2	9.6
Quality of communication*	8.1	9.5
Level of respect received from partner*	8.4	9.6
Level of sharing of personal income and financial assets*	8.1	9.5
Level of adequate knowledge, values and skills to be faithful to partner*	8.4	9.5
Ability to have an open and frank discussion with partner about sex*	6.4	8.7
% of participants who:		
Will confide in partner for personal problems	79%	88%
Believe a man can be faithful to one partner his entire lifetime	67%	82%
Believe a woman can be faithful to one partner her entire lifetime	79%	89%

* = statistically significant difference (p<0.05) between men and women (women reported lower ratings/percentages)

In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities, and this struggle was also evident in their own relationships according to the survey

responses. In the quantitative survey, participants were asked directly about unfaithfulness in their current relationship. Men reported significantly ($p<0.01$) higher rates of unfaithfulness than the women: 15 percent compared to 2 percent.

Two key objectives of TFH curriculum are providing strategies for strengthening the bond between couples and breaking barriers to faithfulness. On the post-test, more than one-third of participants reported they were experiencing barriers to faithfulness in their own relationships before coming to the workshop. In the FGDs and quantitative surveys, lack of love, poor communication between partners and sexual dissatisfaction were the top three reasons (barriers) named for having multiple sexual partners, even when the couple was married or in a long-term relationship. On the baseline survey, the level of sexual satisfaction reported was significantly ($p<0.01$) lower for women in comparison to men: 7.1 vs. 8.0 (on a scale from 1-10). When exploring deeper into the topic of sexual dissatisfaction and poor communication, the underlying issue for both men and women was a cultural taboo about discussing sexual frustrations or other issues with the partner. From the women's perspective, men feel that they "know better" about all decisions and issues, and therefore do not discuss issues with women. From the men's perspective, women were previously viewed as servants, and cultural views are just beginning to slowly change to view women as friends and partners.

Two attributing factors that underlie these three barriers mentioned are age at marriage between men and women and gender norms, both of which correspond to reasons for marriage. Men are typically older than women when they first marry (as seen in our sample), and they often do not marry their age-mates. This age difference further exacerbates the gender imbalances. Most marriages are not based in love, but rather made for economic reasons. These types of relationships often do not yield loving situations (taken from the FGDs). "Love" was seen as a protective factor in unfaithfulness, and according to one man in the FGD, "You won't ever have faithfulness if you don't have love."

After attending TFH workshop, participants reported a significant increase ($p<0.01$) of confidence in their own ability to maintain a happy and strong union with their partners. At baseline, the confidence levels (on a scale from 1-10) were 8.2 and at post-test, 9.7.

Factors That Affect the Family Unit

Family strengthening is an important desired outcome of TFH program, as the curriculum addresses issues that act as stressors both between the couple and the children. One of those stressors is the social and gender norms in the country context. Questions exploring gender roles in the marriage and whether or not those roles promoted equality were examined. TFH curriculum also discusses issues such as abstinence before marriage, delaying sexual debut and struggles that youth are facing relative to marriage preparations. Parents are encouraged to talk to their children about these issues, and the curriculum attempts to arm the couples with the accurate knowledge and skills to have these discussions. Factors affecting the family unit measured in the quantitative surveys include equality in marriage (gender roles), decision-making power in family matters, views and practices regarding children and youth, violence in the home and drug/alcohol use among participants. Table 3 shows initial attitude and perception changes between the baseline survey and immediately after the workshops. All changes seen from baseline to post-test were statistically significant at the 0.001 level.

Table 3: Indicators That Affect the Family Unit

Indicator	Baseline	Post-Test
% of participants who reported BOTH partners ("equality in marriage"):		
Responsibility for looking after the children*	54%	85%
Decision-making power in important family matters*	55%	87%
Decision-making power in when to have sex*	32%	81%
Decision-making power in accessing HIV services*	70%	92%
% of participants who believe:		
Boys can abstain from sex until marriage	35%	48%
Girls can abstain from sex until marriage	47%	56%
On a scale from 1-10 (with 1 the lowest and 10 the highest):		
Comfort level in discussing sexual matters with sons (10-18 years old)*	4.1	7.2
Comfort level in discussing sexual matters with daughters (10-18 years old)*	4.4	7.7

* statistically significant change ($p<0.001$)

The participants were also asked questions about views on cultural and gender norms that increase or fuel HIV risk and deteriorate the family unit[14]. Intimate partner violence is still a pervasive social problem, and thus the quantitative survey asked 18 questions about types and frequency of physical abuse or threats of physical violence in the household[15]. These inquired-about acts of violence included: insulting; swearing; threatening to hurt you; pushing, shoving, shaking, throwing something at you; slapping you or twisting arm; hitting you with fist or something else; threatening you with a knife or other weapon; kicking or choking you; forcing sex. Reported violence or threats of violence was highest in Addis Ababa and lowest in Tigray Region. Overall, 30 percent of participants were living in a household that reported some form of physical violence or threat of physical violence. Roughly 8 percent of participants reported being victims of physical violence, with 88 percent being women; 5 percent of participants reported being perpetrators of physical violence, and 16 percent were women. The men and women in the FGDs also reiterated that violence in homes was quite commonplace.

Perceptions and Attitudes on HIV Testing and Cultural Norms That Contribute to HIV Risk Behaviors

Awareness of HIV status is an important aspect of reducing HIV transmission, as there is little debate on the reduction of transmission that occurs once a person who has tested positive for HIV knows his or her status. Given that nearly half the new infections are occurring within marriage, three take-home points within TFH curriculum are testing, knowing your HIV status and sharing those results with your spouse/partner. Roughly 82 percent of participants reported wanting to be tested for HIV at baseline. However, an average of 30 percent reported having never been tested for HIV. The difference between males and females was also statistically significant ($p<0.01$) with more females reporting having been tested for HIV. Out of the two-thirds of participants that have been tested, roughly half went for couples testing at this last HIV test. When taking out the people who have never been tested and asking those who have been tested when their last HIV test was, 70 percent had been tested four months ago or longer, and more than one-third had been tested over a year ago. The likelihood of going for couples

testing in the next three months (on scale from *1 = definitely no* to *10 = definitely yes*), significantly increased (p<0.001) from 7.1 at baseline to 9.0 after the workshop.

Reported male involvement in ANC also statistically increased (p<0.01) from baseline to post-test: 75 percent reported attending ANC visits with their partner or would attend if partner became pregnant, and this increased to 91 percent. Many men consider accompanying their wives to ANC or prevention of mother-to-child transmission (PMTCT) visits a good practice, but in reality, only a few men actually do it. Thus, this indicator will require long-term tracking in order to see if TFH has a sustainable impact on men's behavior.

There were also questions regarding attitudes toward MCP and other cultural norms, as well as gauging overall knowledge and perceived risk of HIV. These questions asked participants to either "strongly agree, agree, strongly disagree, or disagree" with specific statements. See Table 4 for a complete list of similar questions on cultural norms and views on HIV risk as they relate to multiple and concurrent partnerships. *All increases were statistically significant (p<0.01*).

Table 4: Questions on Cultural Norms and Views on HIV Risk in Regard to MCP

All (Intervention/Workshop) Participants	Baseline	Post-test
Agreed: Woman is justified in refusing sex with partner if she knows he has had sex with someone else.*	76%	84%
Disagreed: A married man having concurrent partners is not harmful as long as he is discrete and provides for family.	85%	88%
Disagreed: There are exceptional cases where a man should be allowed to have sex with another woman.*	72%	82%
Disagreed: There are exceptional cases where a woman should be allowed to have sex with another man.*	79%	88%
Disagreed: A man should be allowed to produce children with another partner if his wife is infertile.*	53%	71%
Disagreed: A woman should be allowed to produce children with another partner if her husband is infertile.*	70%	83%
Disagreed: Once infected, the chances of a person living with HIV transmitting it to someone else are always the same.*	30%	38%

* statistically significant change (p<0.01)

Self-confidence or willingness/desire to share information, both on how to strengthen the spousal/partner relationships and on the HIV risk associated with MCP, increased after TFH workshop. The frequency response, "at least once a week" significantly (p<0.001) increased from an average of 27 percent to 67 percent in all groups for both topics. Also, women in all three regions showed more

change than men, overall, as their baseline reports of sharing at least once a week were much lower than men. When probing further about whom participants will share information with about strengthening their partner relationship, the most frequent response was “my neighbor”.

Discussion

This review of preliminary findings in the evaluation was important for understanding baseline knowledge, perceptions, attitudes and behaviors around the factors that affect couple relationships and the family unit, as well as on HIV testing and cultural norms that contribute to HIV risk and MCP.

The changes from baseline to post-test indicate that attendance to TFH workshop has a short-term effect on perceptions, attitudes and intended behaviors linked to those barriers identified within couples that lead to unfaithfulness in relationships. Overall, statistically significant increases from baseline to post-test collection were observed for quality of relationship, quality of communication, level of respect received from and shown to partner, and all “equality in marriage” indicators. Specific communication skills also increased with participants reporting an intended change in level of sharing financial information with partner, increased ability to have an open and frank discussion with partner about sexual matters, and improved comfort level in discussing sexual matters with children 10-18 years. Baseline reports unfortunately also reveal a tolerance of violence still present in these communities, with roughly 30 percent of households reporting physical violence or threats of physical violence.

Two patterns also emerged in the data: the differences between men and women and the difference of one region compared to the other two. Following the cultural patterns in most Ethiopian couples, the women in the sample were statistically ($p<0.001$) younger in age and less educated than men. The women also reported significantly lower ratings on six of the nine indicators listed in Table 2 for affecting couple relationship; the differences at post-test between men and women were not significant, indicating that female responses played a substantial role in closing the statistical gap when analyzing the change in the combined responses of men and women from baseline to post-test. Although the data presented grouped all regions together, an analysis by region revealed Tigray Region as an outlier to the other two regions. Participants from Tigray seem to enjoy a more gender-balanced household, less intimate-partner violence and more equality when it comes to views/attitudes regarding women. This difference will need to be further explored through FGDs and interviews with in-country staff.

Significant short-term changes in perceptions and attitudes toward HIV testing and cultural norms that contribute to HIV risk and MCP were seen from baseline to post-test. With one-third of participants never having been tested for HIV, and 70 percent having been tested four or more months ago, there are some crucial areas for improvement. The increase in intended male attendance to ANC visits with their pregnant partners is also significant and cannot be overstated if the intended practice shows to be the true behavior and attitude change. Even with the strong cultural roots present in the evaluation participants, TFH was able to make considerable short-term attitude changes in cultural norms that fuel

HIV risk behaviors (Table 4). Additionally, self-confidence or willingness/desire to share information, both on how to strengthen the spousal/partner relationships and on the HIV risk associated with MCP, significantly increased after TFH workshop. The six-month follow-up survey and final FGD will be critical for determining whether TFH has any long-term effects on all of the indicators measured.

Evaluation Limitations

The sample is made up of older, mature couples who may not be at much risk of HIV/AIDS. This demographic characteristic may be a limitation, as the ultimate purpose of TFH program is to reduce the transmission of HIV/AIDS occurring within couple relationships.

A second limitation experienced during data collection was the lack of supervision from the local consultant to the enumerators. Because most workshops were being conducted at the same time in each of three regions, the local consultant was limited in the amount of supervision available to verify correct translation and interpretation of questions, as well as explain any impromptu challenges that arose with the survey.

A third limitation resulted from a lack of time to translate the English version of the surveys into Amharic or even a few of the local languages. It is very possible that differences in interpretation or translation were used. Although enumerator training was provided, due to needs for multiple language translation, the local consultant did find differences in translation between enumerators during some field supervision, and corrected it when possible. However, in consideration of the first limitation mentioned, the magnitude of the translation issue is unclear.

Conclusions

From both the quantitative surveys and the FGDs, cultural norms come out strongly as affecting relationships. These norms provide an enabling environment for gender inequality/inequity, intimate partner violence and secretive sexual partners. The significant age and education differences between men and women at marriage or within relationships potentially pose a challenge for establishing healthy, gender-equal relationships. TFH workshop has increased overall attitudes towards sharing of decision-making power as well as couple communication around family finances, even though the differences in education, age and employment within couples remains the same. By drawing on faith values as its foundation, TFH curriculum has shown short-term, positive steps towards the culturally related enablers of HIV transmission within couples. The six-month follow-up survey will need to be completed in order determine long-term impact on attitudes and behavior.

In the FGDs, both men and women mentioned that counseling the youth before marriage and providing guidance to young couples interested in getting married might help in producing better matches or at least better prepare men and women for the expectations of married life. Note that even now, only 21 percent of participants' faith communities offer premarital counseling. Strengthening this area within faith communities could have a substantial impact on the future trends within marriage and related unfaithfulness. Additionally, in Ethiopia, the majority of couples go through a civil/municipal wedding;

fewer marry through a religious institution. Given the low number of couples reporting attendance to premarital counseling programs, faith institutions should work to provide this service, even when the marriage ceremony is not happening in the religious institution. This premarital counseling is a platform to address many aspects of marriage, including factors that lead to broken or unhealthy relationships. HIV couples testing should be an integral component of premarital counseling programs.

Given the initial success shown in strengthening the family, TFH curriculum might be a good add-on or supplement to other development programs that require a strong family foundation. The curriculum should be promoted in these other areas. One example might be PMTCT programs. The initial data presented from baseline to post-test changes on male partners' intended involvement in ANC visits are a good indication that TFH might be a good adjunct to PMTCT programs looking to increase more male support for women who are HIV positive, thereby promoting compliance to PMTCT protocols.

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Annex

Annex 1

Table 2: Demographics	Intervention Groups	
Average Age (years)	43.6	
Average Age Males (years)	48.5	
Average Age Females (years)	37.9	
Average Age Difference Between Spouses (years)	10.5	
Employment status:	Males	Females
Housewife, never employed outside the house	0%	69%
Housewife, looking for employment/currently employed outside the house	0%	12%
Farmer	0%	2%
Employed (government or business)	29%	4%
Self-employed	27%	9%
Unemployed	24%	0%
Type of marriage/union:		
Cohabiting	14%	
Church/religious marriage	8%	
Civil/municipality marriage	10%	
Traditional marriage	69%	
Average # of years married (years)	22	
Place of residence:		
Urban	87%	
Peri-urban	1%	
Rural	12%	
Highest level of education:	Males	Females
No formal education	22%	52%
Uncompleted primary	30%	20%
Primary	24%	16%
Secondary	14%	9%
Preparatory, vocational or tertiary level institution	9%	3%
Religion:		
Orthodox	90%	
Catholic	3%	
Protestant	4%	
Muslim	3%	
Frequency of religious services/activities:		
Daily	25%	
Weekly	58%	
2-3 times a month	8%	
Monthly	6%	
Yearly	4%	
Has biological children	96%	
Has children from other than current partner	17%	
Caring for other, nonbiological children (OVC)	29%	
Average # OVC	1.7	

Note: Some categories do not add up to 100%, as “other”, “don’t know” and “no response” percentages are not included.