



Impact of faithfulness-focused curriculum on couples from three regions in Ethiopia

THE FAITHFUL HOUSE



Cover photo: Faithful House participants hold hands as they walk down the street. The Faithful House program is a three day workshop where couples are counseled to listen and work with each other, making their life together in faith the most important aspects of their lives so they can better provide for their children and community. *Photo by Karen Kasmauski for CRS.*

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ABSTRACT

Background

Even though a large share of new HIV infections in many African countries occurs within marriages or cohabiting relationships, there are relatively few prevention programs specifically focused on the couple as a unit of behavior change. The Faithful House (TFH) is an HIV prevention curriculum focused on fidelity within relationships/marriage and implemented through workshops uniquely centered on the couple. While short-term outcomes from TFH have been documented, longer term impact of the curriculum has not been assessed to date. Thus, an evaluation of TFH program was conducted in Ethiopia with the aim of bridging that evidence gap and determining the program's sustained impact on a population deeply rooted in traditional, cultural, and gender norms.

Methodology

The evaluation population consisted of 919 individuals from the Addis Ababa, Oromia, and Tigray Regions in Ethiopia. Working with five community partners and Idirs, participants were selected through convenience sampling and randomly distributed to the intervention or control group. Focus group discussions were conducted both before the workshops with men and women from each of the regions and also following the nine-month follow-up period, to provide supplemental qualitative information. In March 2011, both groups completed a quantitative baseline survey prior to the workshop, and in December 2011, a follow-up survey was conducted. 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 nine-month follow-up changes between the control and intervention groups.

Results

On average, men were older than women (average 47.1 versus 38.2 years) and more educated (24% of men reported no formal education compared to 54% of women) ($p < 0.001$). Nearly three-quarters (75%) of all participants were in traditional marriages and had been together for an average of 22 years. The couples were largely (91%) Orthodox Christian, and 87% lived in urban areas. Statistically significant positive changes from baseline to nine-month follow-up among the intervention group were observed for many factors that affect the couple relationship and the family unit. Particularly in the area of communication, control group participants did not show the same positive changes over the same period. Intervention group couples showed more HIV testing between the two survey collection points, as well as a higher rate of couple testing. Reported partner violence also decreased from baseline to

nine-month follow-up among workshop participants. Overall, perceptions and attitudes about behaviors that contribute to HIV risk within couple relationships were positively changed to a greater extent among the intervention group.

Conclusions

Even given the culturally-rooted norms that emerged and the gender differences in age and education that exacerbate the cultural power imbalances in relationships, the changes observed from baseline to nine-month follow-up among TFH workshop participants indicate that couples receiving the intervention retain attitudes and perceptions on behaviors that reduce HIV risk among couples. Continued tracking of these couples to determine long-term impact is warranted. Given the positive changes observed in strengthening couple communication and building conflict resolution skills, TFH is recommended not only as an HIV prevention couples' intervention, but also as an influential add-on component to gender development initiatives aiming to increase male involvement in family well-being.

PROJECT BACKGROUND

There is a tremendous need for culturally sensitive, locally adapted, evidence-based programs that acknowledge and address the context within which most infections of HIV occur: couple relationships. Critical epidemiological trends highlighted in recent national studies in Uganda and Kenya indicate that half of new HIV infections are occurring within marriages or stable unions¹. While “concurrency,” which is broadly defined as long-term, overlapping sexual partnerships, has been thought to be key contributing factor to the HIV epidemic in Africa, the relationship between concurrency and the epidemiology of HIV is unclear. However, it is abundantly clear that “going outside” the relationship or marriage or, in other words, not being faithful or monogamous with your current partner, still remains a key area of concentration for HIV prevention programming. 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”². Furthermore, these programs and subsequent research should address couples as a unit of behavior change and intervention³.

This evaluation of The Faithful House (TFH) program by Catholic Relief Services (CRS) aims to build on the theoretical and methodological foundation for couple-

centered, faithfulness-focused HIV prevention interventions. TFH curriculum was created collaboratively by CRS and Maternal Life International/Uganda, and includes skills building, positive peer mentoring, and creation of a safe environment for couples dialogue around quality-of-relationship issues and the attitudes and behaviors that contribute to sexual risk behavior. Over the course of TFH program implementation, pre- and post-workshop surveys have demonstrated improvements in communication between partners in areas such as finance, gender roles, power imbalances, sexual intimacy, parenting, and communication with children around sex-related issues. However, the longer term impact of TFH program has not been documented to date, and with the absence of a control population, rigorous conclusions cannot be made. Due to this, CRS developed this ongoing evaluation of TFH program with the aim of bridging that evidence gap.

METHODOLOGY

Quantitative data methods were used to assess the effectiveness of the TFH curriculum on the perceptions, behavioral attitudes, and intended practices related to couple relationship satisfaction, partner communication, and HIV risk. Qualitative research, in the form of focus group discussions (FGDs), was conducted both before the baseline survey and after the nine-month follow-up survey, with a group of approximately 10 women and 10 men, with equal numbers from each of the three regions. The final FGD focused on overall feedback regarding TFH key messages and any sustained behavior or attitude change, in addition to topic areas of interest/concern that were uncovered in the quantitative baseline data analysis.

The evaluation was conducted in three regions (Addis Ababa, Oromia, and Tigray) where CRS Ethiopia works with local partner organizations. These couples were drawn from predominantly urban areas in these regions because urban adult HIV prevalence is higher (7.7%) compared to rural HIV prevalence (0.9%)⁴. Five partner organizations were identified to conduct a total of 16 workshops throughout the three regions, with a maximum of 20 couples attending each workshop. Written consent was collected from each participant prior to conducting the baseline survey interview or participation in the FGD.

Evaluation Population Selection

“Idirs,” which are commonly known local support associations in Ethiopia, offer social and economic support when community members become ill or die; in theory, they keep comprehensive lists of all community members/households in their catchment areas. The evaluation team contacted the Idirs for referral of potential evaluation participants and used a convenience sampling methodology

to assemble the 640 couples needed for the evaluation. While the use of Idirs created an opportunity to easily access the appropriate number of couples, older couples dominated the Idirs' source population. Therefore, an additional effort was made to mobilize younger couples from support groups and youth associations for the evaluation. After the evaluation team received lists of interested couples, a randomized sampling method, using Microsoft Excel, was applied to divide the participant couples into control and intervention groups.

Objectives of the Evaluation

This evaluation has been designed to assess the effectiveness of TFH, a couple-focused HIV prevention intervention, on the couples communication, relationship satisfaction, and knowledge on HIV risk associated with concurrent partnerships. Specific objectives in the evaluation include:

1. Assess the impact of the TFH curriculum on the couple's 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.

Training, Data Collection, and Analysis

An international consultant conducted a day-long training for all enumerators on the quantitative surveys. When some original enumerators were unable to attend all 16 workshops, the local consultant in Ethiopia hired and trained additional enumerators.

Individual names were not documented on the surveys or in the database for analysis. Unique identifiers (IDs) were assigned to each participant at the data collection point to keep confidentiality with the data reported and to pair couples' responses. The list of names and associated unique IDs were kept on separate documents, stored in a secure location at the local CRS office, and accessed by only key members of the evaluation team.

In March 2011, baseline survey data collection began, and workshop participants completed the survey at the workshop site the day before the workshop was to begin. The corresponding control group was interviewed on the first day of the workshop, while the intervention group was attending TFH. In December 2011, all participants congregated at a mutually agreeable location to complete a nine-month follow-up survey. Individuals who did not complete both the baseline and nine-month follow-up surveys were excluded from the data set for analysis (N = 205 individuals).

All data from the Microsoft Access databases was exported and manipulated in Microsoft Excel for the initial frequency analyses and unique patterns/associations. Statistical analysis using Stata was run on comparisons of baseline results versus nine-month follow-up results between control and intervention groups.

FINDINGS

Sample Characteristics

A total of 1,124 individuals in the control and intervention groups were sampled at baseline, and 928 individuals were sampled at the nine-month follow-up. Because each individual had to complete both the baseline and nine-month follow-up surveys, a total of **919 participants in the control and intervention groups** were used for this analysis. Table 1 shows an exact breakdown of the sample between regions and intervention versus control group.

Table 1: Breakdown of Individuals Sampled

TARGET ZONES	INDIVIDUALS IN CONTROL GROUP (#)	INDIVIDUALS IN INTERVENTION GROUP (#)	INDIVIDUALS SAMPLED (#)
Addis Ababa	160	180	340
Oromia	148	175	323
Tigray	127	129	256
TOTAL	435	484	919

Control and intervention groups were comparable on all demographic characteristics (see Table 2). Summary demographics were as follows: On average, men were older than women (average 47.1 and 38.2 years, respectively) and more educated (24% of men reported no formal education compared to 54% of women). The majority (75%) of study participants were married traditionally^{1*}, 12% of individuals were cohabiting, and 8% were married by religious institutions. Ninety-one percent reported to be Orthodox Christian.

* There are three legally-accepted types of marriage in Ethiopia: traditional, religious, and civil. Traditional marriage is done by the community; religious marriage is done by religious leaders; and civil marriage is done by local government municipalities. Traditional marriage customs vary by ethnic group in Ethiopia, but there are commonalities. The man’s family sends selected, respected leaders (usually three men) to the woman’s family to make a request for marriage. If the woman’s family accepts the request, the wedding day is decided upon. On or before the wedding day, the husband and wife sign a written contract in the presence of three witnesses. In most cases, religious leaders (whether Christian and Muslim) do not participate in traditional marriages ceremonies.

Table 2: Demographics

INDICATORS	CONTROL GROUP N = 435		INTERVENTION GROUP N = 484	
	M	F	M	F
Average age (years):	42.1		43.4	
Average age males (years)	46		48.2	
Average age females (years)	37.4		38.9	
Employment Status:	M	F	M	F
Housewife, never employed outside the house	0%	64%	0%	69%
Housewife, looking for employment/currently employed outside home	0%	10%	0%	12%
Farmer	16%	4%	14%	2%
Employed (government or business)	20%	7%	22%	4%
Self-employed	34%	9%	34%	10%
Unemployed	11%	0%	14%	0%
Other	19%	5%	16%	3%
Type of marriage/union:				
Co-habiting	11%		13%	
Church/religious marriage	3%		8%	
Civil/municipality marriage	8%		8%	
Traditional marriage	78%		71%	
Average # of years married (years)	21.1		21.8	
Place of residence:				
Urban	86%		87%	
Peri-urban	0%		1%	
Rural	14%		12%	
Highest level of education:	M	F	M	F
No formal education	26%	56%	22%	51%
Uncompleted primary	33%	19%	30%	22%
Primary	21%	17%	25%	15%
Secondary	16%	6%	13%	10%
Preparatory, vocational, or tertiary institution	5%	2%	9%	3%
Religion:				
Orthodox	91%		90%	
Catholic	2%		2%	
Protestant	4%		4%	
Muslim	2%		3%	
Has children from other than current partner	14%		17%	
Caring for other, nonbiological children	25%		30%	
Average # of nonbiological children	1.51		1.75	

Note: Some categories do not total 100%. "Other," "don't know," and "no response" percentages were excluded from the Table.

The results presented below primarily capture perceptions and determinants of behaviors, not actual behaviors; they either affect the targeted attitudes and behaviors or address barriers to behavior change. All results are self-reported and unverified. The denominator in the percentages reported in the following sections is taken not as the total number of participants sampled, but rather as the total number of participants who responded to each question (including “don’t know” and “no response”). Unless otherwise noted, the number of respondents equals the total number sampled (see Table 1).

Enhancing the Quality of the Couple Relationship

The perceptions and attitudes measured on the quantitative surveys and explored in the FGDs are centered on factors that affect the couple relationship (see Table 3). These factors were identified through prior assessments, FGDs, and interviews (outside this evaluation) as having an effect on relationship satisfaction, which can lead to detrimental or risky behaviors, such as unfaithfulness.

Table 3: Factors that Affect the Couple Relationship

Indicator	CONTROL GROUP			INTERVENTION GROUP		
	Baseline	9-Month	◇	Baseline	9-Month	◇
Participants were asked to rate the following variables:						
Quality of relationship ◇	7.9 N = 432	8.0 N = 434	+1	8.0** N = 482	9.3 N = 483	+1.3
Quality of communication ◇	8.0 N = 435	7.9 N = 435	-.1	8.0** N = 483	9.2 N = 483	+1.2
Level of respect received from partner ◇	8.2 N = 435	8.1 N = 435	-.1	8.3** N = 483	9.3 N = 483	+1.0
Level of sharing of personal income and financial assets ◇	7.9 N = 435	8.0 N = 400	+1	7.9** N = 483	9.2 N = 470	+1.3
Level of adequate knowledge, values, skills to be faithful to partner ◇	8.1* N = 433	8.4 N = 435	+3	8.5** N = 482	9.3 N = 482	+8
Ability to have an open and frank discussion with partner about sex ◇	6.8** N = 317	6.0 N = 433	-.8	6.8** N = 316	7.9 N = 482	+1.1
Level of sexual satisfaction ◇	7.5 N = 413	7.5 N = 435	0	7.5** N = 455	8.6 N = 481	+1.1
% of participants that:						
Will confide in partner for personal problems	78%* N = 431	85% N = 434	+7	79%** N = 480	91% N = 484	+12
Believe a man can be faithful to one partner his entire lifetime	71% N = 435	63% N = 434	-8	68%** N = 483	80% N = 482	+12
Believe a woman can be faithful to One partner	81%* N = 435	74% N = 434	-7	78%** N = 484	86% N = 483	+8

* = statistically significant change from baseline to 9-month follow-up ($p \leq 0.05$)

** = statistically significant change from baseline to 9-month follow-up ($p \leq 0.001$)

◇ = On a 10-point scale (1 the lowest and 10 the highest)

In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities, and their survey responses showed that this struggle was also evident in their own relationships. The quantitative survey asked directly whether participants had ever been unfaithful to their current partner. Men reported significantly ($p < 0.01$) higher rates of unfaithfulness than the women: 13% and 4% (control and intervention groups, respectively).

Providing strategies for strengthening the bond between couples and breaking barriers to faithfulness are two key objectives of TFH curriculum. 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 a 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 than men in both control and intervention groups: 7.0 versus 8.1 (on a scale from 1–10). When delving more deeply into the topic of sexual dissatisfaction and poor communication, the underlying constraint for both men and women was the cultural taboo surrounding discussion of sexuality or sex-related issues. In fact, both men and women are prohibited from discussing a range of issues with their 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 and to view women as friends and partners.

For workshop participants, confidence in ability to maintain a happy and strong union with their partners statistically increased ($p < 0.001$) from baseline to the nine-month follow-up collection: 8.1 to 9.2 (on a scale from 1 to 10). Control group participants also reported increased confidence, with an average score of 8.2 at baseline and 8.4 at the nine-month follow-up; however, the increase was not significant.

Support group attendance (in the form of traditional Ethiopian coffee ceremonies) is the way that TFH curriculum builds in group accountability, further learning and sharing, and sustainability of key messages from the curriculum. Attendance to a support group increased similarly among both control and intervention groups (38% to 57%) from baseline to the nine-month follow-up.

Strengthening the Family Unit

Family strengthening and addressing gender norms are important desired outcomes of TFH program because the curriculum addresses issues that act as stressors between partners and between couples and their children. Those stressors sometimes derive from the social and gender norms in the country context. Guided discussions examine gender roles in the marriage and whether or not those roles promote equality. TFH curriculum also discusses issues such as abstinence before marriage, delaying sexual debut, and struggles that youth are facing. Parents are coached on how to talk to their children about these issues and encouraged to do so. See Table 5 for survey results regarding factors that affect the family unit.

What has changed the most in your relationship because of your attendance to TFH workshop?

MALE PARTICIPANTS:

- We have started to communicate openly with regard to sexual issues.
- I do not force her to have sex without her willingness anymore.
- Previously, I was the decision maker in all financial issues. Now I have started to share my expenditures with my wife.

FEMALE PARTICIPANT:

We have started to openly discuss, plan and decide on important issues together.

Table 5: Factors that Affect the Family Unit

Indicator	CONTROL GROUP			INTERVENTION GROUP		
	Baseline	9-Month	◇	Baseline	9-Month	◇
% of participants that reported BOTH partners held:						
Responsibility for looking after the children	54%** N = 434	62% N = 432	+8	54%** N = 482	76% N = 483	+22
Decision-making power on important family matters	59% N = 435	61% N = 435	+2	52%** N = 484	83% N = 483	+31
Decision-making power on when to have sex	32%* N = 432	39% N = 433	+7	31%** N = 484	61% N = 481	+30
Decision-making power on accessing HIV services	71%* N = 424	76% N = 432	+5	69%** N = 479	87% N = 484	+18
% of participants that believe:						
Boys can abstain from sex until marriage	34% N = 434	34% N = 434	0	36%** N = 484	51% N = 482	+15
Girls can abstain from sex until marriage	43% N = 435	43% N = 434	0	48%** N = 484	62% N = 482	+14
Comfort level in discussing sexual matters:						
With sons (10–18 years old) ◇	4.2* N = 226	5.1 N = 206	+.9	4.4** N = 226	7.0 N = 239	+2.6
With daughters (10–18 years old) ◇	4.9* N = 210	5.8 N = 196	+.9	4.4** N = 242	7.3 N = 236	+2.9

* = statistically significant change from baseline to 9-month follow-up ($p \leq 0.01$)

** = statistically significant change from baseline to 9-month follow-up ($p \leq 0.001$)

◇ = On a 10-point scale (with 1 the lowest and 10 the highest)

Discussing sexual matters with children was a topic of discussion in the focus groups as well. At baseline, parents felt it was difficult to talk to their children about sex (see Table 4). In the FGD, parents noted their concerns about what information should be shared, when, and how to most appropriately deliver these messages to their children. Although the responsibility for educating young people about sex is currently viewed as the role of schoolteachers, all parents felt strongly that, with training and guidance, this specific education should come from parents. During the final FGD, intervention group participants reported feeling much more confident in having discussions with their children regarding sexual issues. This also is also reflected in the significantly higher

ratings at the nine-month follow-up survey (see Table 4). Several FGD participants mentioned having actual discussions with their children in the last nine months on topics such as menstruation/puberty, HIV and AIDS, putting studies before dating or marriage, abstinence, and how to avoid rape.

The participants were also asked questions about their views on cultural and gender norms that deteriorate the family unit and often lead to increased risk of HIV5. Because intimate partner violence is still a pervasive social problem in Ethiopia, the quantitative survey included 18 questions about types and frequency of physical abuse or threats of physical violence in the household6. 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. Table 6 shows the results on these indicators.

How has TFH changed your partner’s attitude or behavior changed since TFH workshop?

My husband started to worry on the school performance of our children. He began looking into our children’s exercise books.

My husband used to come home late in the night drinking alcohol and did not care for his children. He quit drinking and started to come home early and ask whether the children have had their dinner.

Table 6: Indicators for Partner Violence

Indicator	CONTROL GROUP		INTERVENTION GROUP	
	Baseline N ≈ 433	9-Month N = 434	Baseline N ≈ 484	9-Month N ≈ 483
% participants that report violence or threats of violence in their household in the last nine months (combining 18 indicators)	32%	31%	34%	16%
% participants reporting to be victims of physical violence by their partner in the last Nine months (combining 6 indicators)	7%	4%	8%	3%

Men and women in the baseline FGDs reiterated that violence in homes was commonplace. After reviewing the reported rates of violence on the baseline survey during the final FGD, all participants felt the rates were too low and that, due to stigma, the true situation in households was not reported. Both indicators highlighted in Table 6 decreased among the control and intervention groups from baseline to the nine-month follow-up, with larger reductions among workshop participants. While it is assumed that household violence was underreported, participants in the final FGD (intervention group only) did corroborate a decrease in physical abuse and threats of violence. According to the final FGD, the workshop’s emphasis on increased partner-to-partner communication and joint decision making was very effective in helping couples resolve conflicts that lead to violence.

“Previously, I used to become angry and insult my wife when I feel that she is wrong in one matter, but now I have started to discuss openly and resolve the conflict.”

—MALE PARTICIPANT

Improving Attitudes on Risky Cultural Norms, Increasing HIV Testing Uptake

TFH curriculum also facilitates discussion about cultural norms that might fuel risk or contribute to the deterioration of a “faithful house.” The surveys included questions regarding attitudes toward multiple partners and other

cultural norms, as well as perceived risk of HIV. These questions asked participants to “strongly agree, agree, strongly disagree, or disagree” with specific statements. Table 7 includes a complete list of these questions and the subsequent respondent beliefs.

Table 7: Statements on Cultural Norms and Views on HIV Risk

Statements:	CONTROL GROUP		INTERVENTION GROUP	
	Baseline	9-Month	Baseline	9-Month
Woman is justified in refusing sex with partner if she knows he has had sex with someone else.	78%* N = 432	83% N = 433	76%** N = 484	87% N = 484
A married man having concurrent partners is not harmful as long as he is discrete/provides for family.	12% N = 433	9% N = 434	12%* N = 483	8% N = 484
There are exceptional cases where a man should be allowed to have sex with another woman.	26% N = 434	28% N = 431	25%* N = 483	20% N = 484
There are exceptional cases where a woman should be allowed to have sex with another man.	19% N = 434	22% N = 431	18%* N = 482	16% N = 484
A man should be allowed to produce children with another partner if his wife is infertile.	44% N = 435	45% N = 434	43%** N = 482	33% N = 483
A woman should be allowed to produce children with another partner if her husband is infertile.	27%* N = 435	22% N = 433	24%** N = 484	16% N = 483
Once infected, the chances of a person living with HIV transmitting it to someone else are always the same.	67%* N = 434	59% N = 434	65%** N = 483	49% N = 482

* = statistically significant change from baseline to 9-month follow-up ($p \leq 0.05$)

** = statistically significant change from baseline to 9-month follow-up ($p \leq 0.001$)

What is different about TFH in comparison to other family strengthening or HIV prevention workshops?

- *It discusses sensitive issues and the things that we consider taboo.*
- *It's the first workshop that made my wife and me share a bench and discuss freely in public.*

Awareness of HIV status is an important aspect of reducing HIV transmission, because there is little debate on the reduction of transmission that occurs once HIV-positive persons know their status. Given that nearly half of new infections are occurring within marriage or cohabiting couples, three take-home points within the TFH curriculum are testing, knowing your HIV status, and sharing those results with your spouse/partner. Roughly 81% of all evaluation participants reported wanting to be tested for HIV at baseline. However, an average of 32% reported having never been tested for HIV. Differences between males and females were also statistically significant ($p < 0.01$), with more females reporting having been tested for HIV (at baseline). At the nine-month follow-up survey, 50% of the control group participants reported being tested since the baseline survey, in comparison to 60% of intervention group participants. Of those participants,

72% of the control group and 82% of the intervention group went with their partner for couples' testing at this last HIV test. Two percent of participants in both the control and intervention groups reported having ever received a positive HIV test result.

TFH curriculum also emphasizes the importance of accessing antenatal care (ANC) services for pregnant mothers, with specific emphasis on the role of the male partner in these visits. Both men and women were asked on the survey about pregnancy, and whether they were accessing ANC services or would access services if they became pregnant. Table 8 outlines the small portion of couples that reported pregnancy and their responses regarding increased access to ANC services. Note that given the time between baseline and follow-up, nearly all pregnancies reported on the second survey were new.

Table 8: Pregnancies in the Sample and Increased Access to Antenatal Care Services

DISTINCT PREGNANCIES REPORTED*	BASELINE N = 9	9-MONTH N = 7	BASELINE N = 21	9-MONTH N = 14
Indicator:				
# of females reporting pregnancy*	8	5	18	11
% of pregnant females already accessing ANC services	25%	100%	44%	73%
# of males reporting that their partner is pregnant*	1	6	13	9
% of males who attended ANC visit with partner	100%	50%	62%	67%

* Distinct numbers of pregnancies reported and the number of males added to the number of females reporting a pregnancy do not equal due to couples reporting differently (i.e., men reported that their partner was pregnant but their female partner did not report the pregnancy). This could highlight a stigma, or the male partner could be reporting another partner's pregnancy (not the one interviewed). Also, women reported that they were pregnant, but their male partners reported that their partner was not pregnant. This could be due to the secrecies around pregnancies mentioned in the women's FGDs: Many women will not tell their partners about a pregnancy until it is physically noticeable (for fear of forced termination, anger, or abandonment). This significantly cripples efforts to increase access to ANC and Preventing Mother-to-Child Transmission PMTCT services among women in Ethiopia.

Between baseline and the nine-month follow-up survey, study participants in the intervention groups reported increased frequency of sharing information with their neighbors, family members, and friends on how to strengthen the couple relationship and also on the HIV risk associated with multiple, concurrent partners (MCP). At the baseline survey, 22% of the intervention group reported having shared information "at least once a week" in the last 6 months on how

to strengthen the relationship with their partner, and this frequency response significantly increased ($p < 0.001$) to 37% at the nine-month follow-up survey. The same was true for the indicator on sharing information on the HIV risk associated with MCP: the frequency response “at least once a week” increased among the intervention group from baseline to follow-up collection (29% to 41%), and the change was significant ($p < 0.001$). Control group participants reported decreases in the highest frequency response across both indicators.

DISCUSSION

The changes from baseline to nine-month follow-up indicate that attending TFH workshop has provided evidence for retention of perceptions, attitudes, and behaviors. Statistically significant increases from baseline to nine-month follow-up among the intervention group were observed for many factors that affect the couple relationship and the family unit, most specifically around improved communication. While there were decreases in reported violence and threats of violence in the households, continued follow-up on these indicators would be helpful in knowing if attendance to TFH has a sustained impact on the couple’s conflict resolution and the associated partner-inflicted violence.

Couples in the intervention group reported significant improvements in their comfort level with discussions of sexual intimacy, both between partners and between parents and children. These couples reported discussing sexual matters with their children in the last nine months on the survey; FGDs corroborated this data. Both men and women also reported conflict around sex decreasing in their household due to increased communication and openness. This finding is critical given the traditional barriers between men and women still present in the country, and the cultural taboo of discussing sexual issues. For many, TFH workshop presented the first opportunity to talk publicly about their marital issues, and this improved communication style also translated to issues regarding their children and families. However, it is important to consider the ability of TFH to change established communication styles, practices, and preferences with an older population, particularly in the area of sexual matters. See Annex A for further age analysis. Among participants who were 45 years old and older, the indicator regarding the ability to speak openly with partner about sexual matters was lower at baseline and less affected by TFH.

Significant positive changes in perceptions and attitudes toward HIV testing and cultural norms that contribute to HIV risk and MCP were seen from baseline to nine-month follow-up among the intervention group; this was not observed to the same extent in the control groups. More Compared to the control, individuals in the intervention group were tested for HIV between survey collections, and

a larger percentage of these reported going to testing as a couple. Given the problem of secret pregnancies among women in Ethiopia, TFH seems to show positive progress among those individuals that attended the workshop. In this intervention population, a higher percentage of men knew about their partner's pregnancies at the nine-month follow-up survey, and while the sample size is small, the findings are worth replicating in a larger population. In comparison to the rates reported on the baseline survey, greater percentages of pregnant women reported having already accessed ANC services at the follow-up survey collection, and higher rates of men reported having accompanied their pregnant partners to these visits.

Some indicators changed positively for both the control group and the intervention group between the baseline survey and the nine-month follow-up. For example, the following indicators exhibited statistically significant (beneficial) changes from baseline to the nine-month follow-up: level of adequate knowledge, values, and skills to be faithful to partner; will confide in partner for personal problems; sharing decision-making power on sex and accessing HIV services; sharing responsibility for looking after the children; comfort level in discussing sexual matters with sons and daughters; three of the cultural norm statements, and attendance to a support. It is possible that other programs influenced the results among the control groups, but this will require further clarification with CRS Ethiopia's community partners.

Evaluation Limitation and Other Considerations

The sample included some older, mature couples (approximately 46% were 45 years or older) who may not be at much risk of HIV. This demographic characteristic may be a limiting factor because the ultimate purpose of TFH program was to reduce HIV transmission within couple relationships (see Annex A for additional analysis).

One consideration to be taken into account was the use of English-only versions of the surveys. Each survey was reviewed during enumerator training and a consensus was reached regarding Amharic translation. However, it is very possible that differences in interpretation or translation were used during actual implementation of the survey, and some enumerators reported having to interview in local languages. During field survey supervision, the local consultant did find differences in translation between enumerators and corrected them when possible. However, the magnitude of the translation issue was unclear.

A second consideration regarded the follow-up survey. Due to unforeseen circumstances, collection of the follow-up survey was delayed by two months. While there could be advantages to a longer follow-up period between survey

collections, the questions on the baseline survey were asked in such a way as to be directly comparable the follow-up survey. Hence, while the baseline survey asked about a recall period of the prior seven months, the follow-up survey actually reflected a nine-month recall period.

CONCLUSIONS

Both the quantitative surveys and the FGDs strongly suggest that cultural norms affect relationships, particularly regarding couple communication. These norms enable gender inequality/inequity, intimate partner violence, and secretive sexual partners. Furthermore, significant age, income, and education differences between men and women at marriage or within relationships challenge the establishment of healthy, gender-equal relationships. Still, TFH workshop increased overall attitudes towards sharing decision making and improved couple communication around sexual matters and family finances. By drawing on its foundation of faith values, TFH curriculum showed short-term positive steps toward the culturally related enablers of HIV transmission within couple relationships, and these results were sustained at the nine-month follow-up. It will be important to continue to track these couples over the next two years for additional follow-up analysis.

NEXT STEPS, FUTURE DIRECTIONS FOR THE FAITHFUL HOUSE

In the FGDs, both men and women mentioned that counseling young men and women before marriage and providing guidance to young couples interested in getting married might help to produce better matches or at least better prepare men and women for the expectations of married life. At present, only 20% of the participants' faith communities offer premarital counseling. Strengthening this area within faith communities could have substantial impact on the future trends within marriage and related unfaithfulness. Additionally, the majority of couples in Ethiopia go through a traditional marriage ceremony and less frequently through a religious institution, even though 91% of couples reported being Orthodox Christian. Given the low number of couples reporting attendance to premarital counseling programs, it is recommended that CRS work with local faith communities to incorporate TFH into their premarital activities and offer this service even when the marriage ceremony does not happen in their religious institution. 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 its initial success in strengthening the family, TFH should promote its curriculum as an add-on or supplement to other development programs that

require a strong, family foundation, especially those that seek to increase male involvement in family well-being. The changes in both women's and men's access to ANC services indicate that TFH might be a good adjunct to PMTCT programs that seek to increase male support for HIV-positive women, and thus more compliance to PMTCT protocols. Finally, based on TFH curriculum's skills building in the area of conflict resolution and increased couple communication, the workshop might also complement gender development programs or other activities that aim to reduce gender-based or intimate partner violence.

ANNEX A: ADDITIONAL ANALYSIS

Annex A: Analysis of Key Indicators by Age (Intervention Group Participants Only)

INDICATORS	AGE RANGES (YEARS)					
	18-44			45+		
	N = 259*			N = 225		
	BASELINE	9-MONTH	◇	BASELINE	9- MONTH	◇
Participants rated the following variables:						
Quality of relationship ◇	8.0	9.2	+1.2	8.1	9.3	+1.2
Quality of communication ◇	8.0	9.2	+1.2	8.0	9.2	+1.2
Level of respect received from partner ◇	8.3	9.3	+1.0	8.3	9.3	+1.0
Level of sharing of personal income and finances with partner ◇	7.9	9.1	+1.2	8.0	9.3	+1.3
Level of adequate knowledge, values, and skills to be faithful to partner ◇	8.4	9.3	+0.9	8.7	9.4	+0.7
Ability to have an open and frank discussion about sexual matters with partner ◇	6.9	8.3	+1.4	6.5	7.5	+1.0
Level of sexual satisfaction ◇	7.8	8.7	+0.9	7.2	8.6	+1.4
Confidence level in your ability to maintain a happy and strong union with partner ◇	8.2	9.2	+1.0	8.0	9.3	+1.3
% of participants that have:						
Ever been unfaithful to current partner	6%	-	-	13%	-	-
Been unfaithful to current partner in last 6 months	1.9%	2.7%	-	0.9%	0.9%	-

◇ = On a 10-point scale (with 1 the lowest and 10 the highest)

* Thirty-four people reported their age quite differently on the two surveys. The baseline survey held precedence.

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