

**Population Services International (PSI) / Papua New Guinea  
Rapid PEER Qualitative Evaluation of the  
HIV PREVENTION AND CONTROL IN RURAL DEVELOPMENT  
ENCLAVES PROJECT:  
“TOKAUT NA TOKSTRET!”  
MARITAL RELATIONSHIP TRAINING**

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## ACRONYMS

ADB	Asian Development Bank
AusAID	Australian Agency for International Development
GBV	Gender-Based Violence
HCT	HIV Counselling and Testing
M&E	Monitoring and Evaluation
MARP	Most at-risk Population
MRT	Marital Relationship Training
NACS	National AIDS Council Secretariat
NDoH	National Department of Health of Papua New Guinea
NZAID	New Zealand Agency for International Development
PEER	Participatory Ethnographic Evaluation and Research
PI	Peer Interviewer
PNG	Papua New Guinea
PSI	Population Services International
SRH	Sexual and Reproductive Health
STI	Sexually Transmitted Infection
TnT	<i>Tokaut na Tokstret!</i> (Talk Out and Talk Straight)
UTI	Urinary Tract Infection

## EXECUTIVE SUMMARY

Population Services International is working in Papua New Guinea to counter stigma against condoms, build condom skills, increase risk perception of HIV and other STIs, increase social support around HIV, and improve marital relationship satisfaction and communication.

A key approach to the above is through Marital Relationship Training (MRT). During a four-day workshop married couples aged between 20-39 are provided with a range of information and skills with the aim of decreasing the proportion of people who have multiple, concurrent sexual partnerships; and increasing the proportion of sexually-active men who consistently use condoms with their non-cohabitating partners. Underlying these objectives is the assumption that concurrent partnerships will be reduced by addressing relationship satisfaction, personal risk perception for HIV and other STIs, social support; 'sexual intelligence'; understanding of sexual health issues; increasing condom use and negotiation skills in order to maintain healthy and happy sexual relationships. At present many husbands and wives try to meet their emotional and sexual needs through concurrent partners. Condom use is expected to increase with the reduction in condom-related stigma, increased social support, increased sexual intelligence related to contraceptive use, and increased risk perception.

A qualitative evaluation using a rapid, highly participatory methodology was used. The methodology (Rapid PEER) was specifically developed for use with vulnerable community members and people with low levels of literacy. The evaluation visited 3 sites in which MRT had taken place within the last six months. The purpose of the evaluation was to investigate and understand what changes had occurred as a result of MRT, and making optimal use of the 'voice' of participants to support the evaluation findings. The evaluation also aimed to provide greater clarity on participants' attitudes to sexual relationships and sexual health related issues and make recommendations on how the project can effectively move forward.

The evaluation findings indicate that PSI/PNG has developed an innovative and potentially ground-breaking training package that addresses the fundamental causes (rather than the consequences) of men and women seeking concurrent sexual partners outside marriage, gender-based violence, and the breakdown of marriages and households.

The evaluation shows that MRT is facilitating a structured, dynamic process of change in which participants are provided with **new knowledge and skills**, which are then used autonomously by married couples to **bring about a process of change**. This process of change is underpinned by women's increased agency and men's increased risk perception of HIV, **resulting in significant levels of behaviour change**, particularly in relation to sexual concurrency, gender-based violence and risk of HIV infection. The findings reported in the 'Skills' section of the full report are particularly significant as they demonstrate the ways in which communication and

negotiation skills provided by MRT have been taken up by both men and women to bring about highly significant changes within marital relationships.

In addition to reducing gender-based violence, sexual concurrency and increasing condom use, an unexpected result of MRT is the wider benefit to households particularly the positive impact on children.

MRT is a new, innovative, small-scale intervention which appears to be achieving a high-level of impact in key areas. Unsurprisingly the long-term sustainability of change is not yet known, however, there is clear evidence of continuing improvement in the quality of marital relationships, and progress towards the strategic objectives of the project. Requests from local pastors, health workers and participants themselves for MRT to be scaled up, and provided to young married couples as a means of preventing HIV transmission and gender-based violence, indicate its relevance, suitability and likelihood of achieving long-term impact in areas (geographical and issue-based) prioritised by the Government of Papua New Guinea and international development agencies.

Recommendations are made at the end of the evaluation report as to how the MRT curriculum can be strengthened and improved. Guidance is also provided on targeting participants, scaling-up and monitoring and evaluation in order to provide insights into the long-term impact of MRT.

## 1. INTRODUCTION

*“Marital Relationship Training is not an ordinary training, it changes people’s life.”*  
(Male Peer Interviewer)

Population Services International (PSI) is a non-profit, non-governmental organization (NGO) specialising in social marketing of HIV and sexually transmitted infection (STI) prevention, family planning and maternal and child health products and services. PSI has been operating in Papua New Guinea (PNG) since 2007 and is a partner in the Asian Development Bank (ADB), Australian Agency for International Development (AusAID), Papua New Guinea National Department of Health (NDoH) and New Zealand Agency for International Development (NZAID) funded HIV and AIDS Prevention and Control in Rural Development Enclaves Project.

A key component of PSI/PNG’s activities within the Rural Development Enclaves Project (see Box 1 for a definition of a rural development enclave) is the ‘*Tokaut na Tokstret!*’ (Talk Out and Talk Straight) behavior change initiative. A key component of the TnT initiative is a four-day Marital Relationship Training (MRT) workshop for married couples. MRT aims to prevent transmission of HIV by reducing married men and women’s number of sexual partners outside the marriage (concurrency).

As part of the routine monitoring and evaluation (M&E) of TnT, PSI/PNG and funders of the Rural Development Enclaves Programme requested Options Consultancy to undertake a qualitative evaluation of the MRT at three sites in order to better understand:

- Attitudes to sexual relationships and sexual health related issues.
- How the project is making a difference; to whom, and how?
- The challenges the project is facing and how they are being overcome by investigating what is working, what is not working, and why?
- How the project can effectively move forward?

Value was added to the evaluation by using it as an opportunity to train PSI/PNG research staff in the qualitative methodology used in the evaluation, and to build their capacity, through in-country and desk-based support, to undertake similar studies in the future. The methodology used is rapid, highly participatory and focuses on capturing the voice and stories of programme beneficiaries and staff as a way of understanding not only the direct impact of the programme, but contextual issues that support or challenge its successful implementation.

### **Box 1: Definition of ‘Rural Development Enclave’**

A particular area in a rural setting that has a significant private sector investment employing a relatively large number of people, has become a cash economy amongst a generally subsistence rural economy in the surrounding communities, and typically has become the major, or only, economic driver in the area.

(Source: [www.adb.org/Documents/PAMs/PNG/39033-PNG-PAM.pdf](http://www.adb.org/Documents/PAMs/PNG/39033-PNG-PAM.pdf))

## 2. CONTEXT

### 2.1 HIV and AIDS in Papua New Guinea

Papua New Guinea is the most significantly affected country in the Oceania region. It has a generalised HIV epidemic with a national prevalence rate of 0.9%. Eight provinces account for 93% of all reported cases of HIV.

HIV transmission in PNG primarily occurs through unprotected sex. The diversity of sexual cultures, values, norms, beliefs and practices together with early sexual debut, multiple concurrent sexual partnerships (including polygamy and sexual relationships outside marriage), gender-based violence (including rape), transactional sex, low and inconsistent condom use, and increasing geographic mobility (particularly relevant in rural development enclaves) all provide potential for heterosexual transmission of HIV. Women in PNG are particularly vulnerable to HIV infection due to social, cultural and structural factors which result in extremely high levels of gender-based violence (GBV).

Men working in economic enclaves are considered to be “mobile men with money”, one of PNG’s most at-risk populations (MARP). Risk factors include high levels of mobility and having regular access to cash. Recent studies of enclave workers indicate high levels of transactional sex, relatively low levels of knowledge about HIV prevention, multiple and concurrent sexual partners, and variable levels of condom use<sup>1</sup>.

### 2.2 The HIV and AIDS Prevention and Control in Rural Development Enclaves Programme

The Asian Development Bank funded programme (other partners are AusAID, NDoH and NZAID) supports the Government of PNG’s national Medium-Term Development Strategy, the National Strategic Plan for HIV and AIDS and efforts to achieve the Millennium Development Goals. The programme focuses on supporting the Government to contain the spread of HIV among rural populations living in and around development enclave sites. The programme has four key components:

**Component 1:** Establishing public-private partnerships with rural development enclaves to improve and extend community health services including primary health care, HIV counselling and testing (HCT) and treatment and care for sexually transmitted infections (STI) and HIV and AIDS.

**Component 2:** Developing competency of civil society organisations to work with affected communities, including sustainable behaviour change programmes and social marketing of condoms.

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<sup>1</sup> National Research Institute, Behavioural Surveillance Research with More At Risk Populations in Rural Development Enclaves in Papua New Guinea, 2010 and Population Services International. Papua New Guinea (2008): HIV TRaC Study Evaluating HIV Risk Behaviour Among Men in Six Economic Enclaves. Round 1. 2008

**Component 3:** Strengthening and expanding the sentinel surveillance system in both high-and low-risk populations and settings.

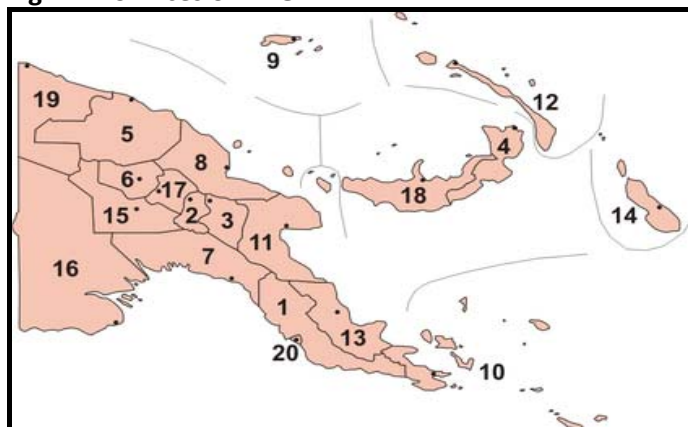
**Component 4:** Project management, planning, partner coordination, and M&E.

### 2.2.1 Tokaut na Tokstret!

PSI/PNG's HIV prevention activities fall under Component 2 of the HIV and AIDS Prevention and Control in Rural Development Enclaves Programme. The six rural development enclaves (activities are also undertaken in villages within one kilometre of the enclaves) in which PSI/PNG is working are:

- Kula (formerly Higaturu) Oil Palm Plantations (Oro Province)
- Ramu Agri-Industries (Madang and Morobe Provinces)
- Barrick Kainantu Limited Gold <sup>2</sup> (Eastern Highlands Province)
- Oil Search Limited (Southern Highlands Province)
- Porgera Joint Venture Gold Mine (Enga Province)
- WR Carpenters Tea & Coffee plantations (Western Highlands Province)

**Fig. 1: Provinces of PNG**



**Key to PSI/PNG sites:**

- 3. Eastern Highlands Province
- 6. Enga Province
- 8. Madang Province
- 11. Morobe Province
- 13. Oro (Northern) Province
- 15. Southern Highlands Province
- 17. Western Highlands Province

(Source: [http://en.wikipedia.org/wiki/Provinces\\_of\\_Papua\\_New\\_Guinea](http://en.wikipedia.org/wiki/Provinces_of_Papua_New_Guinea))

Initially Tokaut na Tokstret activities focussed on providing public opinion leaders and men aged between 15-49 years with sexual health education. This was later expanded to Marital Relationship Training for married men.

### 2.2.2 Marital Relationship Training

After initially working with married men aged between 15-49 years PSI/PNG increased the coverage of MRT (at the request of participants) to married couples with an emphasis on those aged 20-39. It is this component of MRT, in place since 2010, which is the focus of this qualitative evaluation.

<sup>2</sup> BKL closed in 2008 and activities have been largely discontinued in that area. PSI/PNG now works with employees and people living in villages within one kilometre of the remaining five enclaves.

During a four-day training workshop husbands and wives learn simultaneously in groups separated by gender about sexual health issues, partner communication, HIV/STIs, using condoms, the benefits of having one partner, and decision-making and goal-setting skills. A series of homework sessions are set at the end of some training days. The training is designed using a gendered approach. In PNG, men typically have more power, privileges, and control than women, particularly in marital relationships where a wife is expected to obey her husband<sup>3</sup>. Men are also expected to have strong sexual urges and satisfy them regularly and it is accepted or encouraged for men to have multiple partners while women are expected to submit to their husband's infidelities and continue to shoulder the bulk of household duties. The MRT is done simultaneously to provide a safe place for men and women to learn about sexuality, traditionally a taboo subject in many PNG cultures, and a safe source of information that can be introduced into couple communication without fear of being accused of getting that information from other sexual partners. At the same time, MRT uses sessions on empathy to expose couples to a companionate type of relationship where husbands and wives help and listen to each other; moving beyond traditional gender roles in their relationships.

The MRT curriculum aims to achieve:

- A decrease in the proportion of people who have multiple, concurrent sexual partnerships
- An increase in the proportion of sexually-active men who consistently use condoms with their non-cohabitating partners.

In PNG, PSI operates with the assumption that concurrent partnerships will be reduced by addressing relationship satisfaction, higher personal risk perception for HIV and other STIs, social support and 'sexual intelligence'; understanding of sexual health issues; and increasing condom use and negotiation skills in order to maintain healthy and happy sexual relationships. At present many husbands and wives are trying to meet their emotional and sexual needs through concurrent partners. Condom use is expected to increase with the reduction in condom-related stigma, increased social support, increased sexual intelligence related to contraceptive use and increased risk perception.

PSI undertook a review of strategy to guide their implementation of the project. Based on a review of available research on the two key behaviours, PSI prioritized the following:

- **Countering stigma against condoms** that is prevalent in Papua New Guinea. Many believe incorrectly that condoms promote promiscuity and are used only by the promiscuous and those who already have HIV<sup>4</sup>. As a result, it is

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<sup>3</sup> National AIDS Council Secretariat, Integrating Gender into HIV and AIDS Activities: A Guide for Implementers, 2006)

<sup>4</sup> Gibbs P, Mondu M. Sik Nogut O Nomol Sik: a study into the socio-cultural factors contributing to sexual health in the Southern Highlands and Simbu Provinces, Papua New Guinea. Caritas Australia.2010

difficult for those who feel at risk of HIV, or would benefit from the birth spacing and family planning benefits of condoms, to use them. TnT specifically sought to improve positive attitudes towards condoms among participants by emphasizing their benefits for birth spacing.

- **Building condom skills** among participants.
- **Increasing risk perception** of personal risk of HIV and other STIs.
- **Increasing social support** so more Papua New Guineans can easily find someone to talk to if they have concerns about HIV.
- **Increasing couple relationship satisfaction and communication** among MRT participant couples. This is addressed through:
  - Sessions on empathy, intimacy, communications, cheating, conflict de-escalation, gender roles, and couple goal setting.
  - Education to increase 'sexual intelligence' including facilitating a better understanding of how their and their partner's body works, especially in terms of reproduction, sexual dysfunction, arousal; and countering misconceptions that commonly trigger extramarital relationships, such as the belief that pregnant and menstruating women should not have sex.

In addition to the MRT, PSI is working to increase access to male and female condoms through condom social marketing and to further address stigma against condoms and low risk perception through campaigns using a mix of media channels.

### 3. METHODOLOGY

#### 3.1 Rapid PEER

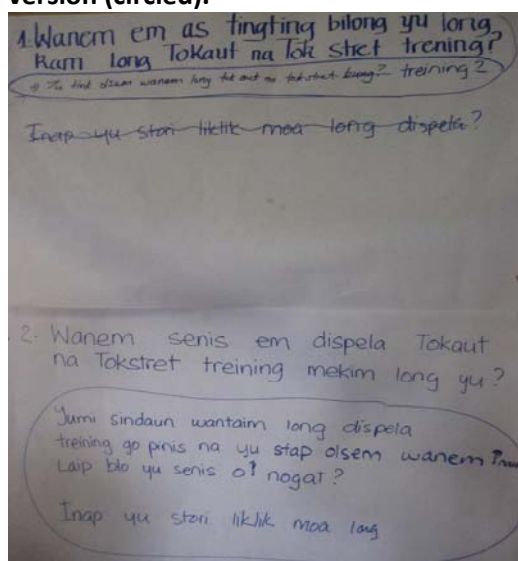
The evaluation used a well-established, rapid, highly participatory methodology designed to explore sensitive issues with non-literate/poorly educated, marginalised populations. Rapid Participatory Ethnographic Evaluation and Research (Rapid PEER) enables projects to gain in-depth insight into the beliefs, behaviours and understandings of beneficiaries, in the full context of their lived experience. This unique ‘insider perspective’ allows interventions to be monitored and adapted using a process which accounts for underlying drivers of behaviour change and existing perspectives on health interventions.

Rapid PEER enables collection of detailed qualitative information on project impact within the wider context of beneficiaries’ social worlds. It also allows the voice of the beneficiaries to be clearly heard at all stages of the evaluation. Rapid PEER is based upon training non-elite ‘ordinary’ members of the target group, in this case married men and women living in or adjacent to rural development enclaves and who had attended MRT to become Peer Interviewers (Photo 1).

**Photo 1: P.I.s practicing interviewing during training**



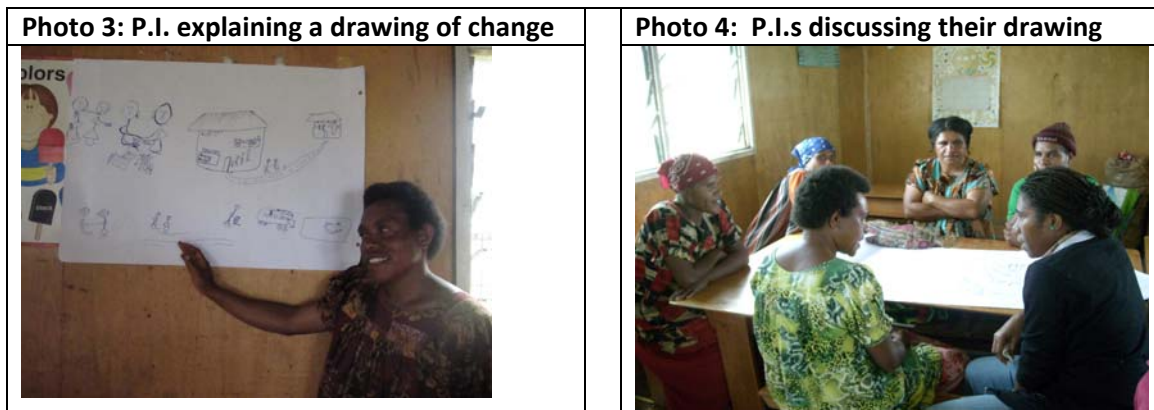
**Photo 2: Interview questions in ‘formal’ Tok Pisin and agreed ‘informal’ final version (circled).**



The Peer Interviewers (P.I.) were trained to carry out in-depth conversational interviews designed to obtain targeted information from others in their own social group who had also attended MRT. Five key questions which formed the structure of the conversational interview process were agreed with the P.I.s and translated by them from formal Tok Pisin into a more conversational format for use with interviewees (Photo 2). Non-literate P.I.s drew pictures to represent each question.

In addition to undertaking two interviews, P.I.s also participated in group discussions facilitated by their own drawings illustrating and

explaining changes they perceived among couples who had participated in MRT (Photos 3 & 4).



A key feature of Rapid PEER is that all interviews are conducted in the third person. Interviewees are **not** asked to talk about themselves. They are asked to talk about “other people they know” or what other people in their social network say. The use of third person interviewing techniques avoids a normative response bias, where interviewees give replies which reflect what they feel they **should** say rather than identifying what people **actually** say and do. In some instances interviewees and P.I.s chose to talk about their own experiences but this is a voluntary rather than a required component of the method.

The Rapid PEER process takes 5 days:

- *Day 1:* Rapid PEER training workshop with Peer Interviewers.
- *Day 2:* Peer Interviewers interview their friends.
- *Day 3:* Peer interviewers interview their friends; Rapid PEER specialist debriefs Peer Interviewers.
- *Day 4:* Rapid PEER specialist debriefs remaining Peer Interviewers.
- *Day 5:* Final workshop with Peer Interviewers.
- *Following days:* Rapid PEER specialist undertakes desk-based data coding and analysis.

In all three evaluation sites the following process was undertaken:

**a. Peer interviewer training**

Ten P.I.s (generally five men and five women) attended a one-day participatory training workshop specifically adapted to the needs of the evaluation. Following training on interview techniques and ethics, conversational prompts were developed to guide the interviews the P.I.s would undertake with two friends. These were translated by the Peer Interviewers from ‘formal’ Tok Pisin into everyday language as spoken within their own social networks.

## b. Data collection

Data collection was carried out over a two-day period, during which the P.I.s held conversations with two same-sex friends who had also attended MRT. Immediately following the final interview, the P.I.s were de-briefed by a Rapid PEER Specialist and/or PSI staff being trained in Rapid PEER, in order to obtain detailed in-depth information from each P.I. on what was said by each of the friends they interviewed. The de-briefing process was also used to probe P.I.s for broader contextual information and how this related to the responses given by their friends during the interview.

## c. Data analysis

The narrative interview data were analysed thematically by the Rapid PEER specialist, with particular attention paid to similarities and differences by both site and gender of respondents.

## d. Capacity building

Three PSI research staff (two from PSI/PNG and one regional researcher) participated in all stages of the evaluation at sites 1 and 2 in order to gain experience in undertaking Rapid PEER.

The two PSI/PNG researchers led the evaluation at site 3 without the support of the Rapid PEER specialist and data collected were sent to the Rapid PEER specialist for thematic coding and analysis.

This report represents findings from all three Rapid PEER evaluation sites. The findings are reported by theme and gender rather than by site; however, when clear differences were noted between sites these are also reported. A detailed outline of the methodology is provided in Annex 1.

## 3.2 Evaluation sites and participants

The Rapid PEER evaluation was undertaken in three sites, two of which (Bunum Wo and Ambogo) are rural development enclaves. The remaining site (Ibutaba) is a village peripheral to a rural development enclave. Details of the sites and Peer Interviewers are provided in Table 2 below.

**Table 2: Rapid PEER research sites and Peer Interviewers**

Site No.	Province	Site Name	Enclave Partner	Peer Interviewers	
				Male	Female
1.	Western Highlands	Bunum Wo	WR Carpenters	5	5
2.	Southern Highlands	Ibutaba	Oil Search Limited	6 <sup>5</sup>	4
3.	Oro	Ambogo	Kula (Higaturu) Oil Palm	6	5
	<b>Total</b>			<b>17</b>	<b>14</b>

<sup>5</sup> One male P.I. was not able to carry out any interviews.

In addition to interviewing two friends<sup>6</sup> (male P.I.s interviewed male friends, and female P.I.s interviewed female friends), the P.I.s also provided information on their own experiences of engaging in the Marital Relationship Training. Not all P.I.s were able to interview two friends, but in some cases other P.I.s interviewed more friends than requested. In total the 31 P.I.s interviewed 49 friends. Thus the findings of the report are based on direct responses from a total of 80 participants in the MRT. In addition, the group discussions with P.I.s on days 1 and 5 of the Rapid PEER process at each site often included comments on and descriptions of other couples in the community who had also attended the training.

The majority of data gathered during fieldwork represent the voice of participants in the MRT. At each site, however, a key local facilitator of the MRT was interviewed. These facilitators were either a local community health worker, or administration staff of the enclave partner. They were able to provide information on how participants were recruited for the MRT and give insight into changes they observed within the local community following the training.

The report includes many quotes to illustrate the evaluation findings. Attribution of all quotes is as follows: (Site No., Peer Interviewer No., Friend No., and Gender of Friend). Thus a quotation ending “.....” (Site 1, P.I.2m, F1) is from Site 1 (Bunum Wo) and was provided by Peer Interviewer No. 2, who is male, debriefing on Friend 1 who will also be male.

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<sup>6</sup> At one site (Ibutaba) P.I.s were only able to interview one friend each due to the Rapid PEER process having to be reduced to four days.

## 4. FINDINGS

This section of the report presents the key findings of the evaluation. The findings focus on the difference the project has made, to whom, and how. P.I.s and their friends, and separately the MRT trainers, also identified challenges in terms of participating in and conducting the MRT. Suggestions on how the project can effectively move forward are provided in Recommendations (Chapter 6 'The Future' and Chapter 7 under 'Recommendations').

The qualitative findings indicate that the MRT is a highly effective method of reducing concurrent partnerships by men reached through BCC interventions. Significant progress has been made towards achieving the aims of the project strategy, particularly the key aims of:

- Increasing risk perception.
- Increasing couple relationship satisfaction and communication

And to a lesser extent:

- Countering stigma against condoms
- Building condom skills
- Increasing social support

Participants reported that, because MRT enabled them to communicate effectively with their husband or wife and, as a result, household conflict, GBV and concurrent sexual partnerships, all of which are significant risk factors in vulnerability to HIV transmission, were ceasing. This reduced their perceived need to use condoms with their marital partner, though some respondents did report an intention to use condoms with outside partners. This is a highly significant finding which would be strengthened by quantitative evidence to support the findings of this qualitative evaluation.

MRT has only been running since 2010 and the sustainability of the reported behaviour change is not yet known, however, the evaluation findings indicate that **PSI/PNG has developed an innovative and potentially ground-breaking training package that addresses the fundamental causes (rather than the consequences) of men and women seeking concurrent sexual partners outside marriage, gender-based violence, and the breakdown of marriages and households.**

As a result it appears that the MRT is making a small (because of the limited scale of the training) but highly significant contribution towards achieving the purpose and goal of the wider TnT programme: 'to contribute to the reduction of the transmission of HIV and STIs in PNG'.

The findings demonstrate perceptions of the importance and impact of the marital relationship training and illustrate the way in which it is reducing concurrency and GBV among couples who attended the training. Many positive examples of change were independently endorsed (triangulating the findings) by health service providers and others interviewed separately as part of the evaluation.

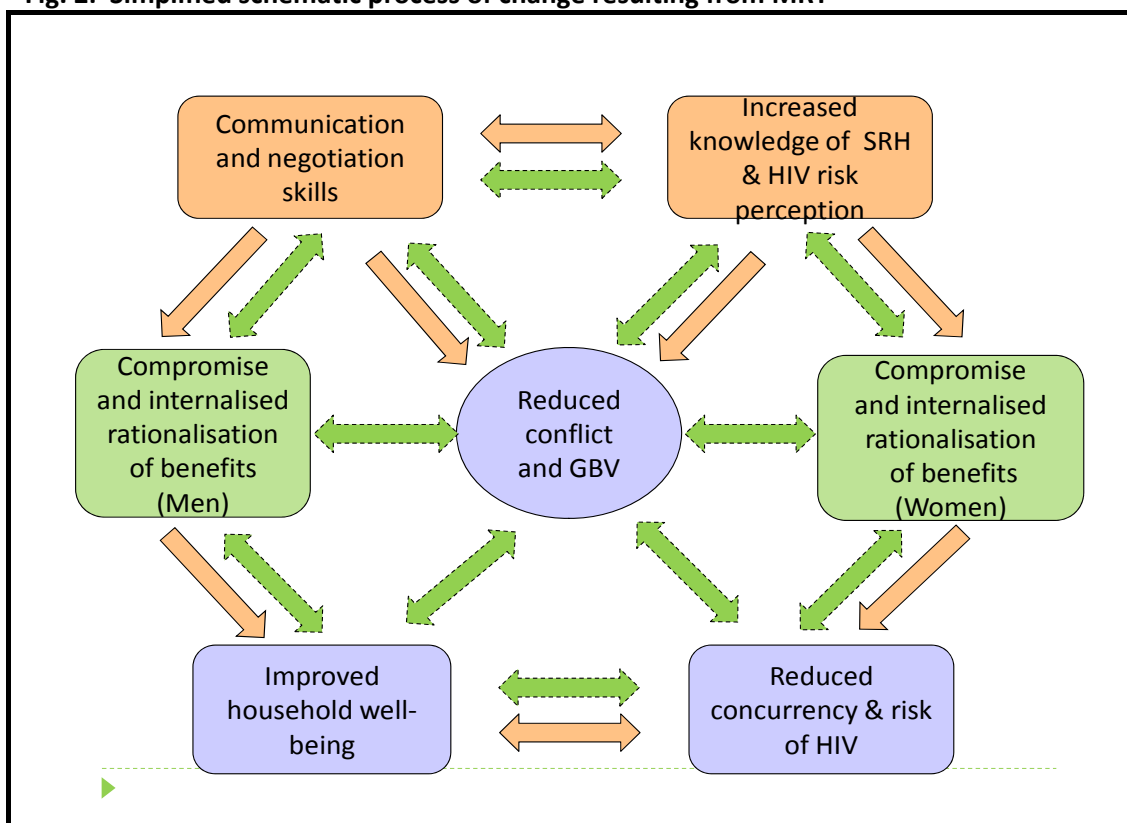
A further, unintended result of MRT is that children of participating households are benefiting from the project as a result of increased household harmony, greater allocation of household income to food, clothes and other goods. As a result children are attending school regularly and paying better attention in class.

This chapter reports the key findings of the evaluation. It is structured to show both the results and the process of change resulting from the MRT by:

- *Firstly*, demonstrating **increased knowledge and HIV personal risk perception** gained by participants.
- *Secondly*, showing how participants have been provided with **new skills**.
- *Thirdly*, how participants have used new skills and knowledge to bring about a **process of change** which enables women to use what agency they have with their husbands to reduce infidelity and increase access to household income. Men are also engaging in a process of change by incorporating increased HIV risk perception with improved communication skills.
- *Fourthly*, and finally, how the above are **resulting in behaviour change** which is reducing concurrency, GBV and risk of HIV infection.

By providing participants with knowledge and skills what is, essentially, a top-down method of training has resulted in a dynamic, participant-led, process that results in significant levels of behaviour change which matches the overall programme goal. Fig. 2 below sets out a simplified version of this process and its outcomes.

**Fig. 2: Simplified schematic process of change resulting from MRT**



**Key:**

Intervention model	Process of transformation	Key outcomes
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#### 4.1 Increased knowledge and personal risk perception

A key aim of the MRT is to provide participants with information on:

- Sexual and reproductive health (including HIV and AIDS)
- Female and male condoms
- Arousal and intimacy with their marital partner
- Access to condoms and health services

Participants reported gaining knowledge on all these key issues. For some issues the knowledge was viewed as important, appropriate and very welcome. Some issues were less well received due to perceived challenging of traditional custom, embarrassment and fear on the part of participants, and perceived contradictory messages. These latter issues are addressed in the ‘Challenges’ chapter of this report. However, on the whole, information provided during MRT has increased participants’ risk perception, particularly in relation to HIV.

#### 4.1.1 Sexual and Reproductive Health (SRH) including HIV and AIDS

##### *Information about sexual intercourse during menstruation and pregnancy*

At all three sites participants described how their knowledge of SRH had increased as a result of the training. Several issues were described very positively in terms of their usefulness or value to participants. The key information, however, which was discussed most frequently by both men and women, was learning that sexual intercourse can take place safely during menstruation and pregnancy. This information challenges traditional custom (although custom varies greatly within PNG). Despite this, however, the information given during training was widely accepted and acted on.

*It was a breakthrough for us. Previously our custom did not allow us to sleep with pregnant women. Now I know I can use a condom and sleep with her. The second breakthrough is when she is having menstrual period it is possible to sleep with her. Our custom forbids this but now I can sleep with her. After a month, if his wife gives birth to a child, he can sleep with the wife. Custom does not allow us to sleep with our wife after a month. Now he can use a condom to sleep with his wife. That has helped me not to go out and look for other sexual partners to satisfy myself and that has helped my family and we are ok. (Site 1 P.I.1m, F1)*

*Some things that have changed: before he would get drunk and beat his wife because he wanted to have sex with her and she refused, probably because she had her monthly period so he got angry and bashed her. After training both husband and wife know he can have sex with her during her monthly period so it's better. (Site 1, PI.9m, F1)*

*We get scared of having sex (when pregnant) because this might affect the baby inside our stomach. But PSI has taught us that the baby will always be safe inside the womb and having sex in different positions will not affect the baby. When they (couples) are following this school (MRT) now they do not fight and get cross. (Site 2, P.I.9w, F2)*

This knowledge was considered important by participants as abstaining from sex at these times was acknowledged to be a major cause of frustration (on the part of men) and arguments between husband and wife with the frequent result that men sought out other women for sexual relationships. Women described using this knowledge to continue to have sex with their husbands during these times in order to prevent infidelity.

*Now we know this and we have learnt about this disease we keep our husbands in the house even when we're pregnant. Before, when women were pregnant they don't like to sleep with their husband because they thought it would harm the baby but now after the training women sleep with their husbands. Before the training we didn't know about ourselves and we were scared if husband comes close to us because we don't know if this will cause our body to not function – it may cause our veins to break. Before these are some of the fears, but now after the training we have learnt these things. They've put away these fears. We now know. (Site 1, PI.3F, F1)*

Some resistance to this information was reported by both men and women who found it hard to believe new knowledge which challenges traditional custom or, in the case of women, because of discomfort caused by having sexual intercourse during pregnancy and continued misconceptions about the safety of the baby in the womb during sex (see Challenges).

*My friend said that when mothers are pregnant our custom has taught us that this is the time when we should not be sleeping with our husbands but the training taught us that it is ok to do this when we are pregnant because there are ways that this can be done but we are not comfortable doing these different sexual positions. (Site 2, P.I.7w, F1)*

Despite concerns about which knowledge to prioritise – information given during MRT or traditional customs – some participants described reaching a compromise between the two. This was achieved by using other information provided during MRT to adapt their sexual behaviour during a wife’s menstruation or pregnancy by abstaining from sex with her while not seeking out other sexual partners; and then using condoms following the baby’s birth.

*In that training the husband found it difficult that men can still have sex with his wife even when she is still pregnant. Men can have sex with their wife two months before they deliver and that was against his custom and his parents had told him that that was not moral act. So he would not have sex with his wife. The husband said if his wife is pregnant then sex is not like a food that he has to eat to fill his stomach. He loves his wife and the unborn baby and would stay till the wife gives birth to the child. He can live without having sex with his wife, and use a condom if wife has given birth to the child a while ago, but not when the wife is still pregnant. If he have sex with his wife then he believes that will affect the unborn baby (Site 3, P.I.5m, F1)*

#### *HIV and AIDS*

Prior to MRT, participants’ at all three sites had varying levels of knowledge about HIV and AIDS. Most were aware of HIV but less certain about methods of transmission.

*We have heard about HIV being a sickness that kills a lot of people in Africa and PNG but we never knew the way people get infected with HIV. It was very important that we learnt this. (Site 1, P.I.m)*

*The government tells us things but they go to health centres in big cities and put posters and sign boards up about HIV but they don’t come to very rural places where people live They talk to people who are sick or go to the clinics, but not to the general public at community level. (Site 1, P.I.m)*

*During the training, when they were giving out condoms my friend said that this sick (HIV) is already growing big in this area – how are we supposed to stop it? (She didn’t understand the link between condom and HIV). What she thought is that this training came into this area a bit too late – she thinks most people are already sick. She thinks that if men do not take care of themselves they will bring the sick upon themselves – for the wages of sin is death. (Site 2, P.I.7w, F1)*

Following MRT participants reported that they now understood how HIV is transmitted within heterosexual relationships, and how to prevent this through use of condoms and/or not engaging in unprotected sex outside marriage. The descriptions that participants gave of methods of preventing HIV transmission are relatively simplistic and limited in detail. This does not reflect the quality of the information provided during the training, but instead reflect the reality of participants' lives and the aspects which they viewed as significant to their lives.

*The most important thing (learnt) was avoid HIV/AIDS by using condom and be faithful with one partner only. (Site 1, P.I.1m, F3)*

*Another thing that I thought it was important was about how we can get infected with HIV. This was something that I had learnt in the (MRT) school. I learnt that if my husband is not faithful to me then he can bring back this sick to me at home or how it can bring this sick to my house and family if my husband and I are not careful with controlling our sexual activities. Because of this, I am trying my best to make my husband sit down with me at home and talk so that we can have this trust between us. He has to trust me and I have to trust him. (Site 3, P.I.2w, F1)*

*All people should know about the Tokaut na Tokstret: that the sick HIV/AIDS does not have any cure but people will just die from it so we have protect ourselves and be faithful to only one partner. (Site 3, P.I.8w, F1)*

The information provided during MRT increased participants' perception of risk of HIV transmission and understanding of self-efficacy by learning how HIV is transmitted, how to prevent this, and what behaviour change will enable prevention of HIV and STIs.

*When husband and wife are separate and living apart this can cause the man to bring sick AIDS into the family. But now we have seen that if we live well like a family where the husband talks and listens with his wife, and the wife listens and talks to the husband, and the husband and wife talk to the children and the children have time to listen, and we live happily as a family then this will not allow the Sick to come into the family. (Site 2, P.I.w)*

*We've learnt a lot of different things about the training but the part I liked is about HIV/AIDS and how you can get infected from going around with different people because my husband does that and learning about this has helped us – my husband is scared after knowing this and does not go out anymore to hang with friends in the night or watch movies – he just stays at home – this is a very big change. (Site3, P.I.8w)*

*In my opinion, I think that this change will last because those people are scared of this sick HIV and would not want to have that sick so they will live happy with their family. (Site 3, P.I.4w, F3)*

*He is someone who gets scared very easily and also he does not talk that much so I know that this change is going to last because this man now knows about this sick and I know that he will continue this good way of living with his family to protect them. (Site 3, P.I.6w, F1)*

There is also some evidence that knowledge learnt about HIV and AIDS during MRT is also contributing to reduction in stigma and increasing awareness of the importance

of providing both practical and emotional support to people living with HIV. This is important since high levels of stigma and discrimination have been reported in studies of the impact of HIV in PNG and are one of the causes of reluctance to attend HCT.<sup>7</sup>

*If one of our neighbours or family member is sick, like if there is a pain in the private parts, or pain around the waist, or if another person is losing a lot of weight and people suspect that person of HIV then we can stay with them. We will encourage them not to feel bad that we are seeing them. We will advise the right people for that sick person to go and see and get help. We will ask him to tell us his condition of the sickness and we will tell that sick fellow that we can arrange for that sick person so he can meet the community health worker in secret. Sometimes if we suspect them of having HIV, we share betel nut and then we start to ask them if they have any problem or not. If they that are suspected is resisting then we would advise them not to be ashamed of us but to tell us the truth so that we can help them. When they tell us we refer them to the right people. But if they are ashamed to go to the clinic then we tell them we can arrange for that person to meet the health worker in secret. (Site 3, P.I.9m, F2)*

The overall impact of this knowledge was reported to be reduction in concurrent sexual partners, and some increase in condom use. The latter, however, was described less frequently. Instead, participants described how other aspects of the marital relationship training had resulted in a loss of desire for extra-marital relationships and, thus, no perceived need to use condoms. The reasons for this significant behaviour change are explained later in this chapter.

### *Sexually transmitted infections (STI)*

Female interviewees talked about the information provided on STIs during MRT, describing how they had learnt about symptoms of STIs, what to do if they experienced symptoms, and how to prevent them by using condoms.

*The other big thing she has learnt during the training is the knowledge of how she can protect herself from getting sexually transmitted diseases. (Site 2, P.I.,7w, F1)*

*Many women around also say that they feel big pains around their hips and their urine goes really dark yellow and it burns and they usually see yellow pus coming out of their female private parts (vagina). Most women said they usually get this and I hear about this a lot. (Site 2, P.I.10w)*

*The big thing that I have learnt is genital health and hygiene for women. If I see symptoms or any signs of genital dischargers then I should go to the nearest health clinic. When I feel that I have back ache and the also stomach ache towards my lower abdomen and also discharge from the vagina then I should go to the clinic... some have STI's but most do not come out and talk about it, but they just stay there in the village. (Site 3, P.I.10w)*

<sup>7</sup> Kelly, A., Kupul, M., Man, W.Y.N., Nosi, S., Lote, N., Rawstorne, P., Halim, G., Ryan, C. & Worth, H. (2011) Askim na save (Ask and understand): People who sell and/or exchange sex in Port Moresby. Key Quantitative Findings. Papua New Guinea Institute of Medical Research and the University of New South Wales: Sydney, Australia; ADB (undated) HIV/AIDS Prevention and Control in Rural Development Enclaves Project Supplementary Appendixes A to H

Health workers interviewed during the evaluation described STIs as being rife among most communities. They also described, however, limited attendance at health facilities for testing and treatment. For example at Site 2 it was reported that approximately 4 women per month attended specifically for treatment of STIs. Instead, if women reported pains in her head, back or knees these was known by health workers to be proxy indicators (in terms of verbal description by women) of an STI.

*Women use euphemisms when talking about private parts or ill health related to these. She will say "I have abdominal pain, backache, head ache or knee pain". This means she has a UTI or STI. She will also talk about her 'private body'... (Site 2, Community Health Worker)*

This may be because, as reported by a health worker, STIs are so common that their existence is viewed as a normal part of a married woman's life. This may be one reason why they were not discussed in detail during the interviews. An additional reason may be that custom forbids men and women to talk about or mention their genital area. Learning about the symptoms of STIs involves this and was viewed by participants as an aspect of MRT which they found extremely challenging and during the interviews many women still perceived symptoms of STIs as side-effects of contraceptive methods (see Challenges).

#### 4.1.2 Arousal and sexual intimacy

An innovative aspect of MRT is provision of information on arousal and intimacy. This was one of the most frequently discussed issues during participant interviews. Provision of this information was not widely appreciated, however at Site 3 in particular where participants were generally better educated and living in close proximity to an urban environment, there was recognition that this information had improved the quality of some participants' marital relationship and was preventing husbands from seeking additional partners in order to gain new sexual experiences or because sex with their wife was unsatisfactory.

*The important thing or main thing that he learnt was to enjoy sex. Because I learnt to enjoy and stay with my wife and not to have sex outside of marriage. (Site 3, P.I.11m, F1)*

*The wife is picking up or learning the new styles of sex slowly because the husband is from Sepik. Sepik people are known for having sex at the back. The woman is picking up slowly, meaning that she is starting to practice the different acts of sex now, because previously the wife would say to the husband 'what are you trying to do?' She would accuse the husband of watching blue movies or being with the prostitutes and trying that different type of sex. The husband, his friend, has followed the sexual training and his sexual relationship with the wife has improved and his family is happy and ok now, not like previously. (Site 3, P.I.1m, F2)*

Increased sexual satisfaction was not limited to men. In a few instances examples were given of wives who had previously sought sexual relationships outside marriage

due to dissatisfaction. As a result of the information gained from MRT this aspect of marriage had improved.

*The wife said she sexually enjoyed her husband after they both went back from the training. That meant that she never enjoyed her husband so she went outside of the marriage. Now she said they would be happier because the husband satisfied her....The husband learned new things that he never used to do with his wife. Different ways of having sex and now the wife told the husband that she was enjoying sex with her husband very much. The different acts of sex were very challenging for the husband but he tried to practice it and his friend said the wife loved him more. For the husband it was taking time and slowly trying the new acts with his wife. (Site 3, P.I.5m, F1)*

Knowledge about foreplay prior to sexual intercourse was more frequently reported at all sites as useful information which helped improved sexual relationships within marriage. Men described successfully using this new knowledge as a way of encouraging previously reluctant wives to have sex.

*They have told me to take my wife and make sure the woman is satisfied before you have sex so she will be fully satisfied. Sometimes I play around with her so she is fully satisfied. From my view the training is very important and is helping me a lot. I tried to put into practice what I learnt and it has turned out very good and I am very happy with what I have done. Previously his wife does not react to the husband, but now she is trying to be more active and satisfy her husband so he does not go looking for someone else. (Site 1, P.I.7m, F1)*

*The most important thing that he learnt was the outer play or play before sex. That was very important because you have to do that to stimulate your wife before having sex with her. You are satisfied yourself and also the wife is satisfied. That what he said was the main or very important thing. (Site 3, P.I.11m, F2)*

#### 4.1.3 Male and female anatomy and reproductive systems

During MRT information was provided on male and female anatomy and the reproductive system. This section of the training was frequently discussed during participant interviews, especially by women, and was a particularly contentious aspect of the training (see Challenges). A few participants, however, described this information as interesting and useful. This was particularly the case at Site 3 where participants were generally better educated than at the other two sites.

*Anything to do with the inside of our body makes women worry – it is a concern for them – yesterday my friend told me she wants PSI to come back and train another 50 women. The mothers are worried about the inside of their body and want to know more. I don't know about the fathers. (Site 1, P.I.3w, F1)*

*When I asked my friend about the third question (the most important thing they learnt during MRT) he said.....the reproduction system. On the training he learnt about male reproduction organ and also for the female reproduction organ as well. (Site 3, P.I.1m, F1)*

*There were some things that we learnt that were good and I really liked that training. In my opinion, what I did not know about such things as the body parts of a man and a woman were new things and I enjoyed learning about them. (Site 3, P.I.2w, F1)*

*The other important things that I have learnt was...also on men and women's reproductive organs. (Site 3, P.I.10w)*

One woman at Site 2 described how this information had helped her to understand how a baby's sex is determined. This is highly significant as having only female children is a frequent reason for men divorcing their wives. Failure to have a male child is a major fear among women.

*We have also learned about the male and female body parts and most of us have said this is something really big that we have learnt because it's new for us. We have learnt a lot of new things – things that God has created but we did not really understand, now this school (MRT) has helped us to understand things such as how the baby is formed in the womb and how sperm can travel up to meet the egg inside the woman's body and also how twins are formed from their parents eggs and sperm – this was one of the very interesting things, not only for myself but for other women in the village from what they have told me after the training. We used to think 'why is it that women only bear a male child or only a female child?' but now we understand how this is formed... when a woman only bears boys or only girls this causes the husband to get cross and argue and fight – so if most people can learn this course then they would understand. Because of the woman only giving birth either to all female or all male children this causes the man to go and marry other women. Because of this my friend thinks it is good to teach young men and women about how the children are formed and that the gender of children is not formed because of the mother or father's choice but by what happens inside the women's body. (Site 2, P.I.8w, F1)*

#### 4.1.4 Condoms

Interviewees described how MRT had provided them with information on male and female condoms. The information covered the use of condoms for prevention of STIs and HIV, and their role in birth spacing. Interviews with participants provide evidence that knowledge has increased and more men and women are using condoms as a result of MRT (Story 1).

**Story 1:** *Before the training I always ask about condoms to my friend. I did not like it because I did not know how to use it. My husband had some idea about using it but I did not feel comfortable with it so I did not use it with my husband. I used to get scared of condom just by thinking if a woman does not have sick and if her husband has sick and then when she uses a viworu (male condom) with him if it breaks and the man's fluid goes into her body then she might get the sick. When they use condom I used to wonder how they feel. Skin to skin is good and we do not like using condom. At the training, I then ask the trainers if condom was strong and good enough to use because it might break. So the trainer went and fetched water in the condom and came back into the classroom with that condom filled with water and asked us all to see if there water leaking from this condom down to the floor and there was nothing. And the trainer said that sigarap (rough sex) will cause the condom to break but if they have good easy sex then the condom will not break. And that was when I stopped disliking condoms. My husband and I give out condoms and most of the time it is the young men and women that come to get condoms from us to use. One day one young lady came to ask me for condoms and that time we did not have any male condoms so I gave her a female condom. She did not want to take it but she had no choice because she really wanted to have sex with this random guy and wanted to protect herself from getting HIV. (Site 3: P.1.6w, F2)*

Although few participants at all sites described increased use of condoms, overall MRT appears to reduce stigma against condoms and resulting in increased use among some couples.

*I and my husband now use condoms. My husband is educated and we are open-minded about using condoms. Other people question why me and my husband use condoms and they often say 'why are these two using condoms?' My husband is educated and he told me that we have to use condoms to protect ourselves and our marriage. When other people don't want to use them we say "give them to us and we'll use them". (Site 1, P1.3w)*

*In my married life my husband and I both use condoms and family planning... It was knowing about condoms – training about using condoms makes us happy. (Site 1, P1.3w, F2)*

*We went through HIV. They (trainers) said to use condoms, but that it's not 100% safe. It is 98% - 99% safe. They also told us, if you are a married man, don't go outside the marriage. You might bring HIV to your family. Some don't know what they are doing. They learnt many things from the course. It helped them a lot. We asked many questions. They said condoms prevent HIV and help with spacing children. The men say they will try, and the trainers distributed them (condoms). I heard from many men that they used condoms as they were distributed free. Most of us used them. (Site 1, P.1.4m, F1)*

*I was happy with the demonstrations because sometimes I used to hear people say if you don't use the condom properly it can get loose, and the female condom too. So I wanted to know how to use it. (Site 2, P.1.5m)*

*Condom is also to protect us from syphilis, gonorrhoea, and HIV if we want to have sex outside of marriage. (Site 2, P.1.1m)*

*This school (MRT) has taught us new things such as the use of condoms. Sister W (community health worker) used to encourage us to use condoms before but the training helped us to understand the use of condoms. (Site 2, P.1.8w)*

*Some of the men and women in the village have also said that condoms should not be supplied randomly. But many of us, the mothers in this village, have said that there are a lot of different sicknesses coming around and we have to know about the use of condoms because using condoms is good not only for married people but also for young men and women. (Site 2, P.I.10w, F2)*

*My husband did not like using condom before the training but now after the training my husband and I are using condoms because we have discussed about it and we have agreed to use condoms. We are using both the female and male condoms as family planning methods. And now we are living well. (Site 3, P.I.4w, F2)*

*My husband and I have also tried using condoms. One night when we were trying to use the condoms after the training, I found it hard to push the female (condom) into my vagina (samting blong mi) but my husband did not mind this so we then used that male condom instead. Now I am happy about using condom to have sex (koap). We are happy we have sex using condoms. We are happy inside the (bed) room. (Site 3, P.I.4w, F3)*

A few interviewees described how they had passed on information about how to use condoms correctly to others who did not attend MRT. Communicating new knowledge is important, particularly when access to formal information is difficult.

*Others who attended the training went out and taught some of their friends on how to use condoms to protect themselves from HIV, gonorrhoea and other STIs. I'm not sure of the other sicknesses. (Site 2, P.I.3m, F1)*

*When my husband's family comes for a visit I often tell them about condoms and I even show them how to use the condoms. These are especially young men and women. I usually tell them that condom is to prevent everyone from getting sick HIV. I teach young married man and woman to use condom as family planning method and also for prevention of diseases. (Site 3, P.I.4w, F2)*

*He is alright in using both the male and female condoms and he is also someone who openly talks about condom because he likes it. He does not feel shy about it and he talks to other young men and women about it as well...I advise my daughters and daughter-in-laws to be good wives to their husbands and I also teach them about the things I learnt from MRT. I give them condoms for family planning and also to protect them also if they want to have extra-marital sex. (Site 3, P.I.4w)*

Many participants, however, described finding it hard to achieve legitimacy with their friends and colleagues in terms of sharing new information. This is addressed further in Recommendations.

There was little discussion of preference regarding male and female condoms; however, it seems that there may be less reluctance among women to use the female condom than is often encountered in other countries. It is not clear why this is, although it may be that behaviour change messages relating to condoms are less well established in PNG, or due to desire to protect women in an environment where rape is so prevalent.

*Another thing is that during the training when they gave us the female condoms they said that times when we want to go shopping in Lae, Hagen or Mendi we should wear the female condoms for protection – just in case there is a hold-up and if men want to rape us then a condom should be worn for protection but my friend did not feel comfortable with this because we do not wear female condoms to go around shopping. (Site 2, P.I.7w, F1)*

*...the other thing that the wife learnt during the training was that danger is just around. They the husband and wife have discussed and agreed that where ever the wife has to carry condom with her all the time for her safety. If someone in town or on the way to town tries to rape the women then she could ask them to use the condom. Just to prevent sickness from coming into the family. Sickness like HIV and STIs (gonorrhoea and syphilis). Both the husband and wife have agreed to carry condom around with them. (Site 3, P.I.5m, F1)*

*His friend said he learnt ...safe sex method in using condom, male and female, inside the marriage for family planning. He also learned how to use female condom. His friend also tried out the condom that was given to him. He also tried out the female condom that was given to him with his wife. He also encourages other friends that they can use female condom because it was good. (Site 3, P.I.11m, F1)*

#### 4.1.5 Family planning (including access to services and condoms)

MRT provided participants with information about methods of and access to family planning (FP). This information was described as useful, particularly by female participants (and especially at Site 2). Almost all interviews focussed largely on the benefit of the skills learnt as a result of MRT and the impact this has had on behaviour change (discussed in detail in the following sections of this chapter). As a result, little detail was provided on knowledge gained about family planning methods; however there are clear indications that participants learnt about appropriate methods and were particularly interested in using FP for birth spacing and to have sexual intercourse, without fear of pregnancy, in order to prevent husbands seeking other sexual partners.

*I went to the Health Centre after the training – it was N (MRT trainer) who really encouraged me to have family planning and she has encouraged other women too. (Site 1, P.I.3w)*

*We got information on different methods of family planning. (Site 1, P.I.2w, F2)*

*The ones, who used it (condoms), used it as a family planning method, not to get pregnant one after the other. (Site 2, P.I.3m, F1)*

*It has helped them a lot in maintaining peace at home and helped them to do family planning. We used to have a lot of problems but now some of them have been reduced and it has helped us a lot. (Site 2, P.I.2m, F1)*

*My friend does not use condoms but gets family planning pills – she agreed to use these with her husband. (Site 2, P.I.7w, F1)*

*I usually say to myself condom is for family planning, it's not to encourage you to have sex. (Site 2, P.I.4m, F1m)*

*During the training we learnt that we should wait about 3 years to have another child and if we are taking medicine we can stop after three years. If you don't space your children after 8 months or a year between each other this will affect the womb and the mother may die. I have 5 children and this is about right – my children are grown-up and I don't want to have another child...They talked about different types of family planning – pills, injections and condoms. The teachers told us especially those who don't know about taking the pill to follow instructions and when it's finished come back for another packet. (Site 2, P.I.6w)*

*And also family planning was also mentioned in the training and it was good for his friend's side because he just got married and had a first born daughter. (Site 3, P.I.1m, F1)*

*My husband and I had so many children because we did not receive the school and we have so many children. I did not get pills or depo but now after the school (MRT) I have gone to have an operation to stop myself from having children. (Site 3, P.I.6w, F3)*

Participants reported knowing how to access condoms: directly from MRT trainers, their workplace or from health facilities or local shops. There is evidence that the course has reduced embarrassment about accessing condoms but challenges still remain terms of enabling men to ask female shopkeepers for condoms and vice versa. There is also anxiety that if a married person asks for a condom they will be seen as either a sex worker (in the case of women) or unfaithful (in the case of men).

*Some people are very shy and would not want to go and ask the shopkeeper for condoms. I hear from some people that they use ice-block plastic (a long thin plastic packet as condoms – non-stretchable and breaks easily). I hear from people that this is what they do. For people who did not attend the training it would be very hard to go and ask for a condom, but for the people who attended the training it would be easy. (Site 1, P.I.7m, F1)*

*There is a clinic distributing condoms so those who went for the training, it's easy to ask the health extension officer for them. If there is a man in an outlet (e.g. pharmacy) it's easy for the man to buy condoms but if there's a woman shopkeeper it would be very hard. She won't have attended the training and he will be feeling very shy. He will be trying to explain to her and she won't understand. So he must take a condom in his pocket. The health worker hands out as many as people want – they have to ask for them or all (condoms) would go and then be re-sold. (Site 1, P.I.9m, F1)*

## 4.2 New skills

Participants gained important new skills during MRT – specifically regarding communication and negotiation within marriage. Acquiring these skills, descriptions of putting them into practice, and the impact of this (see 4.3 and 4.4 below) formed the main content of both men’s and women’s interviews at all three sites. This information was consistently described as the most important aspect of MRT, and led to highly significant behaviour change both in relation to prevention of HIV (Story 2) and in terms of reducing household conflict that leads to GBV (Story 3).

**Story 2:** *For myself I never really understood my wife but after the training it opened my brain and my heart. I learnt a lot of new things: physically and spiritually. When looking back at the training he has changed a lot, about others he doesn't know. He asked me (P.I.) how the course made me feel, did anything change? I said 'I was in a cave but the training has opened my thoughts and understanding'. My friend said 'the same happened to me. If we listen to each other it's like we are protecting our family from diseases that are trying to come into our family; and our children will grow healthy. Sick AIDS is everywhere. It's in front of our door. So if we go outside it will come into our home. Communicating means we are protecting our family'. (Site 2, P.I.1m, F1m)*

**Story 3:** *We are starting slowly to follow all the things that PSI has taught us, but the big difference is to do with the attitude of helping because before we don't have time to listen to each other. Men and women would stand far away from each other and just scream back and forth. But PSI said that this way of communicating is not good because it will destroy your family. You must communicate well between each other. Talk kindly to each other and this will not make your wife or husband get cross with you and you will understand each other even better and not get cross all the time. This is the big thing that I have learnt from the training and I am following this in my family. There were a lot of good things that we have learnt during the training but the big thing is the way of communicating. I learnt that if I speak well to my husband, everything else I learnt from the training will fall into place. Things such as the issues about sex. Because if I talk well I will understand better. PSI has taught us to have time to listen to our partner's views and concerns; because having time to listen to them will help us understand them and this will also help us both. So talking and listening to our partners is very important. Before, our husbands used to think that they will be the only ones talking and that women should not talk and because of this the man does not listen to women's opinions and concerns. An example is women may need to buy new clothes and when they ask their husband for money the husbands usually scream at them or do not even bother to respond to them. And the women worry a lot about this and they often get sick and some who have been worrying about their husbands not looking after them and their needs for a while have also died of worrying. Now the big thing is that we have learnt what PSI has taught us. That is to listen to each other. Husbands listening to wives; and wives listening to husbands. (Site 2, P.I.10w, F2)*

The quotes below represent only a small fraction of the descriptions that were provided, both of the value of communication skills, and how they link in with the everyday life of participants.

*The most important thing my friend learnt from doing the training is the way of talking and agreeing about things. Before the man does things on his own and women also do the same but now we have learned that, just like what the bible preaches, we have to talk to each other about what we want to do and the places we want to go to because when we don't talk to each other that's when we get cross and fight. Not only agreeing to do things together but also about men and women staying together (sex) is something big I have learnt. Now they are following what they've been taught. (Site 2, P.I.8w, F1)*

*He said the MRT training is designed in a way that talks about what is affecting the marriage life in PNG. It is also designed in a way that would also change marriage life in PNG...the marital relationship he likes it very much...This training, I would grade it 100%. Why? Because before I got that training I was not ok or lived a good life. I use to make my own decisions in my family and not taking family planning as that important. I never took family as that important for mother and children and other things. I never spent enough time with my family members. In helping my wife and children sometimes I never use to take them with me to town and never walked with them as a family. I would go by myself. After attending MRT I realized my mistakes and from there through the mistakes I decided to submit to what sometimes she says. Being close with my wife and get her views, or have time to listen to her and express my opinion and we come up with a decision in the house.... His friend said the most important thing that he learnt is communication skills... When we understand each other very well solutions or decisions just finds itself it so we would agree on what we want to do. Example sex life, and problems in family between husband and wife. If the wife's family has a problem then both the husband and wife would contribute to help and if the husband's family has a problem then it has to be the both husband and wife putting a hand in it. (Site 3, P.I.9m, F1)*

*This MRT training has helped me and husband to talk between ourselves. My husband and I have now agreed and now when my husband wants to talk I have to listen and if I want to talk then he will listen. We have learnt this in the training and now we have changed our ways. Before, when my husband wants to talk then I talk back at him as well and now after the training that we went to, this has helped us to learn how to listen first and now we live happily and we do not get cross and fight. Because of this, our neighbour has also changed their ways of living. They also get cross and fight but they are changing because of us. (Site 3, P.I.8w, F1)*

*Previously the husband use to think that he is the head of the family and never had time to listen to the concern of the woman, what problem or anything that bothered the woman and she wanted to bring to the attention of the man. The man wanted to be a dictator in the house and never wanted to listen to the woman. But now he has changed because of the marital training that was conducted by PSI. So he has time to listen to his wife and considers what the woman is trying to say and sees that the woman has worries that she wants the husband to listen to - her problems that (before) she kept secret. (Site 3, P.I.3m, F2)*

The communication skills training not only covered general communication between husbands and wives, for example appropriate times to discuss problems and frustrations; and how to do this. It also taught communication in relation to sex: when to have it, explaining reasons for reluctance to have sex, how to resolve these difficulties. This was also reported as extremely valuable by both men and women.

*Now the husband and wife can communicate and discuss when to have sex and when not to. So some of the problems they used to face have reduced. (Site 2, P.I.4m, F1)*

*It's a good training that you will learn about family welfare, church and how to look after the family and sex. Family staying happy... His friend said better communication and sex life. He never discussed about his thoughts or shared his ideas previously but now he did. Like when to have sex, his opinions and views about sex and some ideas to make a family happy. Now he can talk properly with his wife and these are some of the changes that the friend saw in his life. Previously he would just come in and say what he wanted to say and he would just leave. Now he has time to talk to his wife and discuss about a decision with his wife and explains to the wife why and the reason he made that decision. (Site 3, P.I.11m, F2)*

*The good knowledge was about communication between husband and wife. Like his friend never use to read the body language of his wife on whether she is happy to have sex with him or not. Like if she does not talk to him and moving her body and refusing, and trying to get the husband's hands off her body - he never really understood. During the training he learnt it very well. The training was so good that his life has changed. 'Now I do not argue or fight with my wife more. This training learned us to love each other'; and he gave an example like intimacy. 'How to strengthen our relationship by supporting each other in work that we do have, have time for each other and be happy'. That's what he found out about better communication and better living. So now there is happiness in the house. (Site 3, P.I.3m, F1)*

The key value of providing participants with skills as well as knowledge is that it has enabled them to utilise newly learnt information in ways appropriate to each individual and married couple. This has resulted in MRT becoming a dynamic learning tool. It starts as a top down learning method imparting information from trainers to participants; but then enables participants to actively use new skills and integrate knowledge into their daily lives to bring about behaviour change reducing both GBV and risk of transmission of HIV (and STIs). This comes about through a reduction in unprotected sex with concurrent partners outside the marriage. Participants in MRT who had also attended training by PSI and other organisations on HIV and sexual health described why they viewed MRT as more effective in terms of impact than other interventions.

*The marital relationship training is better than the HIV training: it's more beneficial because it will make me be faithful to my wife and stay with my family and not to go and have sex outside the marriage. (Site 1, P.I.5m)*

*Before when we used to have Tingim Laip (another HIV intervention) trainings we do not hear these good things that PSI has changed because they were only talking about HIV sick. But PSI have brought some different things to teach us. It (MRT) was about men and women and how they should live in their family. This made a lot of difference. Tingim Laip only talks about avoiding the sick and condom use only but they did not talk about men and women and how they should live. The MRT training helps us to be faithful to our husbands and they should also to be faithful to us and we will not get sick. They (other organisations) are always talking about sick, and not about how men and women live ... so this training has helped men and women to understand and learn how to live well together. (Site 3, P.I.8w, F1)*

As part of the communication skills training participants were also shown how to address other key issues that lead to frustration within marital relationships. These were frequently related to sex, but the training helped participants reveal the underlying causes of this frustration. Most frequently these were due to women's anger with their husbands for either expecting sex when women were tired from undertaking hard physical work (the gender balance of labour in PNG is highly unequal, with women responsible for housework, working in gardens, preparing food, doing washing, carrying heavy loads etc.). Another cause of resentment among women, particularly in Sites 1 and 3 where there is a cash economy was men spending the majority of their Fortnight (wages) on beer, cigarettes, betel nuts, gambling and other women, and not sharing this income with their wife to enable her to buy food, clothes, school uniforms and other household necessities. This resentment led to a vicious circle forming of women being reluctant to have sex with their husbands, husbands thus seeking out concurrent partners, leading to further resentment among wives. The MRT training emphasised the value of both shared communication and mutual emotional and physical support

*In the training the husband learnt to help the woman in every work. Help out in the house hold, break firewood, buying present for the woman and even in the afternoon sharing ideas together. Like make budget together for children school fess, clothes and food etc.... But his friend use to tell his wife that he is a man and he is the head of the family and the boss. He never considered his wife's views or advice. But when his friend and his wife attended the training they both learnt about communication skills. For his friend himself he never used to have time to listen to his wife. He had no time to sit down and listen to his wife. The wife also did the same. His friend said he failed to listen to his wife and PSI helped him to have an intimacy. The five to six things that a husband should do to make a wife happy. The two things that changed him were intimacy and communication... PSI identified their weak areas during the training time. Their relationship was ok again. After the training the important thing, and the main thing he learnt, was that family relationship is important - and it is alright now. In this year after going back to the house after the training, for six months his family ok and happy now. (Site 3, P.I.7m, F1)*

The above quote also shows how the project's gendered approach is increasing women's agency within marriage. This agency is, however, still limited and mediated by many factors including custom, community and social norms, and religion. Although MRT is empowering them through provision of knowledge and skills, and increasing their access to services (as the quote below shows); they are still vulnerable.

*Now, from the school I have learnt about family planning. Because my husband has not shown support for me I must get family planning so I can sleep with my husband and know that I may not get pregnant and my husband doesn't know I am taking family planning, because for me to satisfy my husband I must sleep with him, but he doesn't support the children so I must use family planning. (Site 1, P.I.2w, F2)*

An unintended consequence of MRT, and one which will be helped by PSI's other communications programmes, is that increasing men's risk perception of HIV transmission also increases the vulnerability of women known, or rumoured, to be

HIV positive. While uptake of HCT is low wives and girlfriends run the risk of being divorced or abandoned by husbands and men who may themselves have transmitted HIV to their sexual partner(s).

*That guy did not attend the training on the very first day. He went to pick coffee. Then he heard from his friends who said there is very good training for you and for everyone. He goes round with lots of ladies, so he decided to go....At that time he had a girlfriend who had HIV.<sup>8</sup> He was the one who was asking lots of questions about how to get HIV and he was told about how to use the right sort of condom and how men and women need to use condoms to prevent HIV. I asked him about difference. He said after getting the training he came out and decided to tell that woman who had HIV to get out of his life. He told his relatives that he has to get rid of that lady. They paid compensation to her for staying with him for some time. He decided to get rid of her because if he always uses condoms with her and then one time he did not then he could get HIV and pass it on to his other wives and this will affect his family. So he decided to pay compensation to her instead. (Site 1, P.I.7m, F2)*

### 4.3 Process of change

Having been provided with new knowledge and skills, participants in the MRT training described how they used these, after the training, to develop a process of change within their marital relationship.

The process of change was similar for both men and women in that it involved both internal rationalisation of levels of compromise felt to be acceptable in order to achieve their individual and marital goals; but also shared communication about existing frustrations/dissatisfaction, and how to address these.

The key gender difference evident in the findings is that for women this process of internal rationalisation translated into agreeing to have sex more frequently with their husbands in return for, and because it resulted in, reduced infidelity, and increased sharing or, in some cases, wives gaining control of the Fortnight salary at Sites 1 and 3 (where there was a cash economy), cessation of GBV, reduced household conflict, and increased levels of affection and happiness (Story 4).

**Story 4:** *When my husband wants things then I have to help him. He wants to have sex with me so I have to think about him and help him satisfy his desires. I have to think about all these things and try to talk about it because if we don't he may go and get into an accident (be unfaithful) on the road. I have to satisfy his needs so that he would not go out of the house but stay at home and we will all be happy. I have to follow my husband's wishes so that we can be happy and I will be happy also. And our family life will be good. When my husband asks me that I want to drink beer then I should allow him to buy drink and bring it back home so that he can drink at home and then go to sleep. And if he wants to go out then he has to let me know. And if I want to go out then I have to let him know so we will live happily together. Before we do not do this but after we learnt from the training then now we are doing this...So it is good that the PSI training come here and helped us very well. (Site 3, P.I.8w, F1)*

<sup>8</sup> The full interview showed that this woman's HIV status was unknown. The assumption that she was living with HIV was based on rumour.

*Now, after I got the school I have learnt to love my husband and sleep with him, care for him, and if I don't spend time with him he may go and sleep with other women and bring HIV into the family. (Site 1, P.I.2, F2w)*

*If I don't give myself to my husband he may sleep with other women and bring HIV into the family, so I must give myself to him...When I first married him I really liked him. I started to realise he doesn't have a good way of living. I stopped giving myself to him. There are many times that he wants to come and sleep with me and I usually say no. He says why won't you sleep with me? I say: 'I used to like you, I married you and I had two children with you....but you don't respect us and give us any money. That is why I don't like you and don't want to sleep with you – because you don't give us any money'. Now, after I got the school (MRT) I have learnt to love my husband and sleep with him, care for him and if I don't spend time with him he may go and sleep with other women and bring HIV into the family. (Site 1, P.I.2w, F2w)*

*About having sex with their wives, after the school some men have now realized they have to give time to their wives and respect their wives – there are some men who always insist on having sex with their wives but the training has helped them to be considerate and realize that their wives sometimes maybe tired and that they should respect her. During the training we were taught that men should help their wives with work so that it makes it easier for her to do less work so when she does not have much to do this makes her happy and then she has time and energy for her to sleep with her husband. When the mother has a lot of work to do she will not want to sleep with the father because she will feel so tired, and at times like this that is when the father goes out to see other women and such problems happen. One of the changes they (men) have seen is that when they are helping us with work we are happier and their body looks good and so they're all happy. (Site 2, P.I.7w, F1)*

*The change she has seen is that now he helps her a lot – he helps her to do work and to feed the pig and he also helps her to wash their little adopted son and to take care of him whenever she goes out for the fellowship with women. My friend also says that when her husband asks her to have sex with him and she says yes to him and that makes him happy so then he helps her with the housework. I think that they will continue to live this way because my friend's husband is a good man. (Site 2, P.I.8w, F1)*

*PSI brought two important things that helped the mothers and taught the fathers that the way they are living is not good and now they are starting to change. The two important ways covered by PSI were firstly, the way to help married couples in marriage – that is men helping women, and men agreeing to help women with work. And secondly, is about how to live in marriage, especially about sex. We learnt that we have to talk to each other before sex. Women have to agree with men, and they both have to agree before they have sex. Before the training men will always beat up their wives and do not talk openly about sex. This happens when men usually feel their wives are not accepting them. Most mothers, when they are tired, they just go to sleep; and when the husbands see that they will just come and hit their wives to take out their frustrations that their wives do not want to sleep with them because of tiredness...Now, after the training, the fathers' minds are now becoming clearer and they are starting to change slowly. I have started to see this change happening, not only in my own life but in others in the community. (Site 2, P.I.10w, F1)*

For men the process of rationalisation and compromise took the form of realising that if they helped their wife with household work and food production, shared their fortnight wages, did not argue or beat her, stopped relationships with other women, and showed greater understanding when sex was refused then in the long term they benefited from increased sex with their wife, fewer arguments and increased household wellbeing. This also led to greater happiness within the household (Story 5).

**Story 5:** *Now after the training my husband's attitude has changed. Now my husband will go to the garden with me...he would say 'I have to keep her company so that she will cook well for me'. Before I would always go to his office to fight with him when some people '5 bucks' (reports) to me about him seeing other women. But now we have changed. When I go to work and come back and feel tired and if I do not feel like cooking then my husband will come home and cook for the family. He even goes and looks for vegetables for me. And when he comes back home with those vegetables and when women see him...they will ask him to give some of those vegetables to them and he would tell them: 'My wife will not be happy if I give you some of this vegetables because they are all for her. If my wife is not happy then her 'little sister' (vagina) won't be happy with my 'little brother' (penis) and we will not 'enjoy the night'. So I must make my wife happy and give her all these vegetables. If I give you these vegetables then you will make your husbands' happy and at night you will both be happy and hugging each other and going to sleep while me, on the other hand, will be cold and lonely because my wife will be cross with me and will not want to sleep with me in our room'. (Site 3, P.1.6w, F3)*

*Previously I never used to help my family. Now I help my family. We help each other and there is unity in the family...Previously we used to have a lot of problems one after the other because men would want to sleep with their wife and she refused. Or the wife would want to sleep with her husband and he refused. But now that problem is reduced because we talk to each other and there is time for me to sleep with my wife and there is time for my wife to sleep with me, so there are not many problems.... If people see a man helping his wife with her work they say why is that guy helping his wife? In my case if I want to help my wife, myself being a man – sometimes I don't have money. If I want to go for a coke to drink, if I ask her for money she will give it to me because I have already helped her. She would also give me food. Women are the ones who look after the house so if he helps her she will make sure the house and family are ok. (Site 2, P.1.2m, F1)*

*That guy, sometimes he used to bash his wife because she was refusing to have sex with him. Sometimes I see now he is starting to help his wife in some of her work. Previously he used to stay around the market but now he is behaving differently... now I realise the importance of why he had changed. (Site 2, P.1.5m, F1)*

*We never understood each other. If I talked she would not agree with me. But after the training she came to agree with me and we communicated. I also came to agree with her. Something that improved was that we were discussing when to have sex, and how to budget money: if we have 100k we agreed to spend 50k and to save 50k...They share responsibility...Sometimes if the wife is very busy then the husband will complete his tasks first and then he would help his wife. They have five children and the husband usually helps his wife by babysitting the children, he plays with them and talks to them and distracts them so that the wife completes her jobs like washing clothes or working in the garden... He said*

*“communication is important because if my wife asks me to go and fetch water and I refuse, then in return if I ask her for something (sex) she will say ‘you always disobey me. Why should I help?’” (Site 2, P.I.1m, F1)*

*(He is) helping the woman in sharing the heavy workload like breaking firewood. Some of the other changes are women never use to cook dinner on time but now she does, she is listening to the husband. Lots of things have changed... she opens up when husband asks her to have sex and she agrees. (Site 3, P.I.9m, F2)*

*His friend said he is a kind of person who drinks a lot of beer. The wife is a woman who has a very big mouth and when he is under the influence of alcohol the wife would shout at him and lock him out of the house. He said: So I would get angry, kick the door open and when I’m in the house everything in the house would be destroyed by me... I thought drinking beer was fun and good but it was not good. Another (improvement) is my sexual relationship with my wife...If she was not happy I would argue and fight with her or do other bad things. I complain and fight with my wife all the time. We lived this kind of life. Till our names were selected for the training...PSI came with good knowledge especially intimacy. When I went back I did away with the bad behaviours. I went back and enjoyed sex with my wife, I still drink beer but would bring it home and sit with my family and drink beer. These are the changes... I and my wife we never use to work together but now I and my wife are working together... I meet my wife’s needs and also my children and she meets my needs. We do all these things and we are happy and the family relationship is alright. (Site 3,P.I.7m, F2)*

In addition, there were descriptions of uptake of newly learnt coping mechanisms when conflicts did arise in order to prevent their escalation into long-term disagreements and GBV.

*My husband and I usually get cross and when we have an argument we usually talk back at each other and exchange so many words but now after the training we are trying our best to avoid that. Now after that training, when we get cross we just walk away from each other and try not to talk but spend time to think to ourselves. Sometimes I go to sleep before my husband comes back home and he just goes to sleep as well. When he comes back we do not get cross anymore because we have already cooled down from whatever had caused us to feel angry between us. I do not get cross when my husband come back home because while my husband had gone I made peace within myself. If he stayed home then this may cause me to see his face and still talk so my husband just walks off. This walking away from arguments helps us to cool done and not think of getting cross at each other. (Site 3, P.I.2w, F1)*

There was also evidence that MRT had increased participants’ levels of self-awareness of drivers of risk and this was resulting in moderation of their own behaviour in order to avoid triggers leading to high risk behaviour such as concurrency.

*He decided to change because he realised ‘if I continuously bash friends or destroy parties, then people will not be happy with me so they will retaliate or make sorcery on me’. So he decided to quit his bad behaviour. (Site 1, P.I.5m, F2)*

*He decided to change some of his behaviours like getting drugs or drunk, (when) he used to go out and look for prostitutes. After the training he decided not to. Once he’s taking drugs*

*or getting drunk he would look for prostitutes, he had no control over it. He decided to get some control over himself and look after his family...If the husband can satisfy himself in the house with his wife then the budget will be better<sup>9</sup>. He will not take any extra money to bribe prostitutes (Site 1, P1.9m, F1)*

#### 4.4 Behaviour change

This section describes the impact of behaviour change due to MRT. Men described how the training had resulted in a reduction in smoking, drinking and gambling. Sometimes because they realised that these activities led to sex with sex workers and local women (it was reported by interviewees that lack of sustained behaviour change was often due to peer pressure from other men at popular drinking and gambling sites who had not attended MRT). They also described realising the benefits to the household, including their children.

Many women said they had not changed their behaviour as they felt there was no need to. In most of these cases they described that their husbands, however, had changed. The most commonly reported behaviour change among women were stopping 'nagging' their husbands and, instead, engaging in discussions; demonstrating physical affection within the house; and a greater willingness to have sex with their husband and reduction in seeking out other men for sex.

*There have been more changes in women than in men. Before women don't do this but now after the training when men come home the women hug them on their legs and say 'I'm happy for you my husband' and that makes him happy. When the wife does this to the husband he is really happy about this so when the families come together both from man's and woman's side they are really happy and they share things...The same thing the wife does to the husband the husband does back to the wife and they're both happy. (Site 1, P.1.3w, F2)*

##### 4.4.1 Reduction in concurrent sexual partners (HIV risk perception)

In this evaluation quantitative data on reduction in concurrency was not collected. The interviews, however, provide detailed descriptions of behaviour change in this area. In some instances interviewees, both male and female, described how, as a result of changes brought about by the MRT, they were no longer looking for sexual partners outside marriage. In other instances descriptions were less specific but phrases such as 'I no longer go out', and 'I stay at home' mean, in the context of the interviews, that the interviewee is only having sex with his/her spouse.

<sup>9</sup> Breakdown of average plantation worker's budget (provided by participants):

Fortnight (earnings): 70k – 80 Kina

Going out drinking and socialising with sex workers: 20–30 Kina (includes 'getting the woman drunk')

Therefore going out reduces the household budget by approximately one third to a quarter.

Most men can only go out once a fortnight due to lack of time. Coffee pickers have no time.

The only free time to spend money is on Saturday after receiving the Fortnight on Friday afternoon.

*...they told us about male and female going around with other people (then) they will get the sick; and knowing about this has changed men's ways of going around with other women and now families are happy. (Site 1, P.I.10w)*

*I asked them about the most important thing that they learnt in the marital relationship training. The husband got up and said they learnt good things in the training and understand each other very well and there is better communication. The women said the same thing but stressed that they never had communication with each other very well. So the woman said when going out she had in her mind of having sex outside of marriage and looking for other men. After the training they both learned the techniques of communication, how marriage breaks and it has helped them in their marriage. Now they can communicate very well. Marriage breaks because during the Fortnight the husband would not give money to the woman, but spends it with other women, by drinking beer. Coming back to the wife and lying that he got only PGK40.00, and the interest of husband toward the wife starts to separate... After the training both the husband and wife said they do not want to have sex outside of marriage. (Site 3, P.I.7m, F2)*

*Marital relationship is the most important training we got because it's to help husband and wife be faithful. If the husband is getting drunk somewhere, in the market or club he knows that his wife is available and will have sex with him because she has attended the training so he will go home to her and not go outside the marriage. (Site 1, P.I.9M, F1)*

*He decided to change his behaviours in the house. Bad habits like beating his wife in the public place, having multiple sex partners and even forcing his wife to have sex with him when she did not want to have sex... He said the training has changed his life... He changed his habits of arguing with his wife and beating his wife. Now his friend is starting to help his wife in doing things like breaking the firewood and cooking. So when his friend wants to have sex with his wife, before the training they used to 'give their backs to each other' and sleep. But after the training they are facing each other and sleeping. When his friend wants to use the wife's body the wife used to refuse. The training got his friend knowledge that they should communicate to have sex. Previously they never used to communicate when to have sex but now they do communicate when to have sex and when not to have sex...They both suspected each other of having sex outside of marriage... when he wanted to use the woman's body the husband would force the women to have sex with him. The husband said he never used to enjoy that sort of life before. After this training it has taught him well and he got some good knowledge. He found out that how to make the relationship work was to help his wife and work together with her. (Site 3, P.I.3m, F1)*

*He decided to change because he realised when he was doing the training that the gambling area was one of the places where he was socialising with people, so when he was there he would find women to have sex with. So he doesn't go there to gamble any more. (Site 1, P.I.5m, F1)*

As shown earlier in this chapter, both men and women widely reported that a key factor in reducing concurrency was knowledge provided during MRT, challenging traditional custom, that sex can take place when a wife is menstruating or pregnant.

*There is a change in families. When woman is pregnant arguments start – we have custom – but the training told the women that men can have sex with wife when they're pregnant so men don't go outside. Another custom is that when women have periods men must stay away from them so this causes problems for couples – now they know that the man and wife can stay together and can have sex together. (Site 1, P.I.m)*

Additional evidence of reduced concurrency can also be seen in comments about a perceived contradiction between the MRT content and provision of condoms for participants by MRT trainers (see Challenges). This was seen as contradicting the key message of MRT which was faithfulness within marriage.

Although no quantitative data are available (and these would be useful), it appears – and this is demonstrated in the quotes used throughout this report – that MRT is having a significant impact on reducing concurrency and thus, also, reducing risk of HIV transmission in an environment where condom use is rare.

#### 4.4.2 Increased condom use

There is evidence of increased intent among men to use condoms with concurrent partners, based on knowledge gained from MRT.

*If he falls into temptation then he would use a condom so that he does not bring sickness into the family. (Site 3, P.I.11m, F1)*

*When I go out into the Oil Palm Blocks and see other women in the blocks I often forget my wife so I have to carry my condom and go out. If I go without condom then I might bring sickness back. Just in case any women wants to have sex with me then I will not have sex ('koap') with her 'skin to skin' (without a condom) but I will use a condom to protect myself because I do not want to bring this sickness back to my wife. (Site 3, P.I.4w, husband of F3)*

Although stigma against condoms is still prevalent the quotes above, and in other sections of this report, indicate that MRT is having some impact on increasing awareness of the benefits of condoms both for HIV and STI prevention, and for birth spacing.

#### 4.4.3 Reduction in household conflict and gender-based violence

Lying at the heart of the findings of the evaluation is a reported decrease among couples who participated in MRT of household conflict and associated gender-based violence. Although reduction in GBV is not included in the original strategy, this is a highly significant achievement, both in its own right but also as, in this case, a proxy indicator for reduction in sexual partners outside marriage and thus reduction in the risk of HIV transmission. This can be inferred as extra-marital sexual relationships were frequently attributed to being a consequence of arguments and violence between husband and wife, due to, and resulting in women's reluctance to have sex with their husband; and general lack of sexual satisfaction within marriage.

*I think the training is good in that it has helped families to live more peacefully with each other. (Site 1, P.I.8 F)*

*Before in the village there used to be big fights happening, but after the training there are not many big fights happening. Now most families are living happily – especially the ones who have been to (MRT) school. (Site 1, P.I.3, F2w)*

*Before the training the two of them would fight and go to court but after that training the fighting and arguing and going to court has stopped and the people around have noticed. (Site 1, P.I.6w, F1)*

*He used to bash his wife and drink beer but the training has helped him a lot and he has changed a lot. (Site 1, P.I.9m, F1)*

*I used to see a lot of young ladies around the compound, they were crying because their husbands were bashing them. Now they aren't crying and the place is very quiet. I think some practice different ways of sex because they aren't fighting and that's a sign of the husband understanding the wife and the wife understanding the husband. (Site 1, P.I.9m, F2)*

*For me as a person who drinks beer and when I want to sleep with my wife, and if she is not around at home or nearby I would go and look for her and start to argue with her and bash her up and drag her home. But now after the training I would not do that but have to wait and not treat her like a prostitute, and that behaviour I have changed. (Site 1, P.I.1m)*

*The continuous arguments between him and his wife have been reduced. (Site 2, P.I.5m, F1)*

*The friend of mine, before, she and her husband fight and get cross a lot but after the training they live happily with each other in that they don't fight and get cross – she's my friend and I've also see a change in her. (Site 2, P.I.6w, F1)*

Many of the P.I.s participating in the evaluation were known to external stakeholders as victims or perpetrators of GBV. In some cases this was admitted to by the P.I.s themselves and the change in their behaviour, as a result of attending MRT, was described by them and confirmed by managers and health workers who live and work within the communities.

#### 4.4.4 Wider behaviour change resulting from MRT

At Site One, in particular, participants described the way MRT led to wider behaviour change, brought about by participants themselves by utilising knowledge and skills learnt in MRT. Although the changes described below (increased public displays of affection between husbands and wives, and fathers and their children; and children attending school regularly) do not provide direct evidence of reduced concurrency and GBV, they can be used as proxy indicators since they provide evidence of greatly improved, less violent, marital relationships.

*Both men and women are helping each other. Some men previously didn't carry their children on their shoulders. Now they do because they are going around together with their family. Before they told their wives and children 'you stay at home, I don't want to go out with you people' because he wants to seem young and see 'other people'. Now I see some of them going around with their wives and they have their children on their shoulders. I think this is very good.<sup>10</sup> (Site 1, PI.9M, F1)*

*There are changes in the family and in the marriage...the type of change is that now the husbands give money to their wives and buy them clothes and the wives make good food and buy things for the house and the children are happy, when the wife is happy she cooks good food for husband. Another change is that the men used to eat elsewhere and walk around. Now they stay at home and are responsible for their children and pay school fees and the family is happy. (Site 1, PI.3w, F2)*

*He said: you know me, I'm such a person who is not a good person. I used to bash my wife and we have been around here for a very long time. I used to drink and had some bad behaviours but after going through the training I changed. After getting my Fortnight I would get my money and spend it on my own will. And when his wife got her Fortnight she spent it with the kids, but after going through the training he decided not to spend his money on his own – like gambling or spending it with other women, but to spend it on his wife and family. The way I used to live, he said 'you know me'. I said, 'yes, I know you'. He said I have seen you (P.I.) change and then he said I have changed a lot too and I am thinking of staying like this until I get old. Or if I go back (to his village), staying like this. (Site 1, PI.5m, F3)*

*Previously when there was no communication there were arguments between husband and wife. Now the husband and wife sit down and when the husband talks the wife takes time to listen, and when the wife talks the husband takes time to listen. There is a budget for everything in the house – for school fees, clothes, books, biros and food for the family. After good communication the husband spends time with the family, not going around elsewhere. He sleeps at home and the husband and wife have time for each other. The children are also happy and they have basic food in the house and so they go to school, and because the children are happy they pay attention in class. (Site 1, P.I.w)*

*I have seen changes in the women who attended the course. Before the training most couples fight and women end up with black eyes and they come for court...They used to come for court all the time. Now there are big changes and they no longer do that. I have seen some holding hands with their husbands and walking together. (Site 2, Health Worker)*

An additional proxy indicator, this time for HIV risk, is the reported reduction in alcohol consumption among men. Alcohol consumption has been shown to be a risk factor in HIV transmission and participants reported that, as a result of MRT they are either drinking less, or buying beer to consume at home rather than in places where they are likely to meet women and engage in transactional sex.

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<sup>10</sup> Within the cultural context of PNG this is highly significant behaviour change. A traditional saying for men is "You don't carry your children on your shoulders because you will grow old very quickly." Men who are now carrying their children on their shoulders are publicly demonstrating affection in a way that would not have happened prior to MRT.

It was widely reported by participants that household conflict had a clear negative impact on children: *'When fights break out it's hard to eat and sleep so children run away'* (Site 2, P.I.2m, F1). A reported result of reduced household conflict between husbands and wives was that children were more settled (not 'running around'), were benefiting from increased food due to husbands sharing their income with their wives, and because the wife also was able to purchase pens and school uniforms the children were not only attending school more frequently but were paying better attention in class.

*I used to get cross with other women and also our children and now I have stopped after training. (Site 1, P.I.10w)*

*Before I attend the training the house was very hot (many problems, and very noisy because of fights and arguments). There was a misunderstanding between the husband and the wife and they would argue and fight over small issues. But when the husband and wife came to the training PSI built a bridge between the husband and wife. When they went back they worked together to build the family. When the bridge was built between the husband and the wife that brought them together and also gathered the children with the parents. So the PSI training saved the family that (before) went separate ways. (Site 3, P.I.7m, F1)*

*His friend has followed the sexual training and his sexual relationship with the wife has improved and his family is happy and ok now, not like previously. Before his friend was a man who goes around the streets drinking beer and has multiple partners. This training has helped his friend reduce some of his bad behaviours and he is starting to buy food for the family, help the wife and making sure that all the children go to school. The father is paying school fees, buying new clothes for the children and giving money to the children for lunch. The husband told him that he was a very bad father but the training has changed him. (Site 3, P.I.1m, F2)*

The overall impact that MRT has had on participants' lives can best be summed up by drawings and explanations provided by the male participants at Sites 2 and 3 (Story 5). These demonstrate the holistic impact of new knowledge and skills and the way in which they have been taken up and used by participants to not only directly reduce concurrency and HIV risk, but by being used to change the way in which couples relate to each other with marriage it has benefited the entire family. The benefits that both husbands and wives see resulting from this behaviour change is, in turn, leading to further reductions in previous high risk behaviour.

**Photo 4: Family life before MRT**



**Photo 5: Family life after MRT**



*“We have two pictures: the left is before the training, the right is after the training. When the training did not happen this is how the family lives. The dots represent the tears of the family. Husband stands by himself and wife stands by herself. Around them are two girls and one boy child. Husband always goes drinking and when he comes home he fights with the mother so they don’t stay together. They go their separate ways.*

*After training they have changed their way of living. Now they are working and living together. This drawing of everyone in the canoe represents everyone living peacefully together. In the canoe the husband sits at the back and steers the canoe, and the wife sits in the front. In between the husband and the wife are the children. They have in the canoe: sago to represent food, fish, firewood, an axe for cutting firewood, bush knives and arrows (for hunting protein). They have everything they need. The arrows represent the husband and the wife paddling together.” (Site 2, P.I.m)*

**Story 5:** *Before we were like the house that had only four posts. The foundation of the house was not that strong to keep the whole family together. But now after the training the post of the house has increased to eight and the house is very strong. There is support in the family from husband and wife. After the training we got new ideas so it was like new post to support the house to stand strong. (Site 3, P.I.9m, F2)*

## 5. CHALLENGES

MRT appears to have enabled many participants to bring about significant changes in their married lives, particularly in terms of reductions in GBV and concurrent sexual partners. However, participants also perceived significant challenges within the four-day training. These challenges centred on the content of specific parts of the training (linked to issues of cultural sensitivity); how the knowledge imparted by trainers was perceived by participants (creating fears about promiscuity and conflict with traditional custom); and, to a lesser extent, how new knowledge could be acted upon (particularly in terms of accessing and using condoms).

### 5.1 Content of training

MRT training was undertaken by experienced PNG nationals. Despite this, many participants reported that some aspects of the training content were not sufficiently sensitive to traditional custom and existing levels of knowledge within communities. From Trainers' and key informants' reports of the training it appears that the level of concern created by elements of the MRT was not fully understood; and perceptions of the level of adjustment and acceptance of participants to these aspects of the training have been under-estimated (particularly at Sites 1 and 2 which were most rural). Trainers and key informants reported that participants became more accepting of new information and ways of discussing previously taboo subjects during the four days of training until, by the end of the training, this was no longer problematic. Interviews with participants during this evaluation indicate that this was not the case, and that it remained an on-going problem which needs to be addressed in the future.

#### 5.1.1 Human anatomy and the reproductive system

Participants reported being deeply upset at learning about human anatomy and the reproductive system (linked to extremely low levels of existing knowledge). This new information was not only surprising but deeply disturbing to many men and women, both young and old.

*The part I did not like, and most of us did not like, was the drawings of women and men - of their private parts that they were hanging on the walls and showing to us and I did not like it...We were scared of those pictures because this is the first time we see these pictures – we have never seen these things before. (Site 1, PI.8w)*

*During the training, when they came to the part when they saw pictures of private parts and they were explaining it, I could not look at it and it was very hard to understand. The way men and women live together and about their sex lives and all this, me as a person I know this, but to display it in public and talk about it was very hard. (Site 2, P.I.2m, F1)*

*While we were attending the training PSI were telling us straight. They got a picture and just showed it to us. PSI say the main message is Tokaut na Tokstret – be straight and tell the truth. It was like getting an axe and just cutting us straight down the middle or straight on*

*the head. While we were trying to describe private parts they were just saying the words and it was a little bit difficult for us... In our custom, if I want to describe a woman's or man's private parts I have to describe them in parables, otherwise it's like cutting that person with an axe on the head. We don't discuss about these things openly and it's very hard to talk about it... The training was to help us protect our family from sickness and what PSI did is help us protect ourselves from sickness. But the way PSI told us was very embarrassing and offensive for us to digest the information. (Site 2, P.I.m)*

During the evaluation efforts were made to understand the reason for such high levels of concern being caused by pictures and models of human anatomy. We were assured that drawings and models are not themselves culturally inappropriate, nor were they associated with witchcraft (a common belief). It appears that it is partly linked to cultural taboos and social embarrassment linked to discussing genitalia but, equally, to lack of knowledge and perceived need to know about human anatomy.

### 5.1.2 Methods of sexual intercourse

Many participants also disliked the information provided during MRT on sexual positions, both during and outside pregnancy. This was included in the training as it is believed that sexual boredom and frustration, particularly among men, leads to them seeking out sexual relationships outside marriage. The majority of participants, particularly at Sites 1 and 3, reported disliking this information, and seldom used it.

*The different types of sex - most people were used to only one way, so the different styles were very difficult for them. They were embarrassed to see some of the different types of sex and the parts of men and women, and the pictures of sickness (STIs) – that was very embarrassing. (Site 1, P.I.5m)*

*During the training we learnt some things about the styles of having sex. We never knew this. We learned this and we discussed it. We (felt like) we are outsiders here. We have learned things against our customs. They (MRT trainers) said 'we don't believe in these things'. They are trying to promote sex: 'We have 101 different ways of having sex'. We never (before) saw such diagrams. When we first came across them it made us feel uncomfortable and we stayed like that. I saw the faces of many men during that lesson, and they were very uncomfortable. (Site 1, P.I.4m, F1)*

*There were some things that I found hard and was embarrassed to do, and it was that PSI taught us when mothers are pregnant they can still have sex with their husbands because there are different sexual positions that they can do. I found it hard to do those different sexual positions. (Site 2, P.I.10w, F1)*

*Oral sex is not going well with him. It's the most difficult thing to do; and have sex with a pregnant woman...Because of religion and culture it's hard for him to practice it. That was the hardest part of the training that he learnt and he did not agree to put it into practice. He also touched on sex on the anus...He suggested that the above is challenging so leave it at that: 'I will put in to practice what I think is best for me'; so he is putting other things into practice. Because of culture and religion it was very hard for him to practice. If his wife is pregnant he would use other method like masturbating, hugging and kissing with his pregnant wife. (Site 3, P.I.11m, F1)*

*The most difficult thing to do was having sex during pregnancy and anus sex. It's not easy to do that or follow it. Have sex during pregnancy is not popular, or our parents never talked about that in our custom and culture. Because it was new to most of the people I knew they opposed it. (Site 3, P.I.11m, F2)*

*In that training the husband found it difficult (to learn) when men can still have sex with his wife even when she is still pregnant. Men can have sex with their wife two months before they deliver and that was against his custom and his parents had told him that that was not moral act. So he would not have sex with his wife. (Site 3, P.I.5m, F1)*

Several participants explained that the traditional sexual position is the missionary position. Other sexual positions are associated with sex workers. It was felt that encouraging sexual experimentation within marriage could have a detrimental effect on the marriage by either causing men to view, and thus treat, their wife as a sex worker or causing the wife to believe that her husband has been engaging in, or affected by, witchcraft.

*We discussed this and feel the training is about promoting sex – going through 101 patterns. Having different types of sex with your wife can make you think of her differently as that's what prostitutes do. For most of us, when we do new actions to a woman, or anyone we like, we blame this on witchery. If you suggest a new position your wife will say you have been practicing some sorcery or you have been bewitched. (Site 1, P.I.4m, F1)*

Dissatisfaction with sexual relations were described as being a key symptom of marital conflict and the primary cause of both men and women seeking out other sexual partners. However, what was very clear at all three sites during the course of this evaluation and what interviewees felt lay at the heart of resolving this conflict, was improving communication between husband and wife and, as a result, enabling increased sex within marriage. What was described as important by participants to reduce concurrent partnerships was the amount of sex they were able to have within marriage rather than how they had sex.

## **5.2 Perceived impact of aspects of the training**

Although participants described many positive aspects of the impact of training, they also expressed concerns that some of the content (particularly) that related to condoms would lead to increased promiscuity. This is a common challenge in such training programmes and, similar to many other projects, participants expressed fears that encouraging condom use would have a particularly negative impact on the sexual behaviour of young, unmarried men and women. In some instances it was also felt that there was a strong focus (correctly) on condoms as a means of preventing HIV; however, as much of MRT also focussed on encouraging faithfulness within marriage, participants (particularly at Sites 1 and 2) felt that this was giving mixed messages (see Recommendations).

*When they told us to use condoms if we were scared of HIV and AIDS – that is the part I did not like – I was not happy about it and I didn't want to use the condom so I threw it away. I don't like this because why would we go out and sleep with other men – so I was not happy when they gave this to us. (Site 1, P1.8w)*

*During training we learnt how to use condoms, both male and female, and we practiced; and because of that husbands may go out and sleep with other women. Now they use condoms it may encourage promiscuous behaviour. This is what most of the mothers have said – this is their fear. (Site 1, P.1.2w, F2w)*

*Everything about TnT is good but the part about the condom is the only thing I did not like because I have been in church and I don't 'go around', and I see the condom is for people who go around...so I didn't like it when they gave out condoms – I didn't want to take it – I tell them not to give it to me. (Site 1, P.1.6w)*

*During and at the end of the training they were given PSI condoms. They got these and sold them. Some were sold to unmarried people. They used them but not properly. Next time PSI must say the condoms are for use by married people only. (Site 2, P.1.3m, F1)*

*This is good for married couples, as for the young people it's not good – with the condoms that are available on the streets it makes the young people want to go out and have sex with other young men and women. It is good that they bring condoms but it has to be kept in one place and not sold on the streets and in small stores. Also if the family or married couples get condoms it is alright, but they (PSI) should not supply it to other young men and women. What my friend says is there are other young men and women who are not married and are getting the condoms to use and she feels this is not the right thing – they should only be used by married people. (Site 2, P.1.7w, F1)*

*Condom is good but it should not be sold in the streets and in the small stores around this area – it should be kept with the sisters at the health centre for them to give out only to those that need them – this is because if they are sold in the streets and little stores young men and women will have easy access to them and this can spoil their lives meaning that they don't have the interest in getting married but instead go around sleeping with other men and women. (Site 2, P.1.6w)*

### **5.3 Age of participants**

Recruitment for MRT was strongly guided by PSI but ultimately key contacts based at each site held the decision-making power on whom from the community should attend. As a result of cultural tradition, personal relationships and lack of full understanding of the content of the training those recruiting participants often selected older, respected members of the community, pastors and mixed generations of the same family. This led to embarrassment and difficulty in actively taking part in the training among participants, particularly in the case of older men and women.

It was also reported that provision of condoms to participants created difficulties for older couples as some were laughed at, either because they were given to older

women who had not been able to have children or because older men were not perceived by younger participants to be sexually active.

Many participants felt that MRT was particularly appropriate for young, newly-married couples as it would enable them to avoid marital conflict beginning and thus lead to reduced risk of HIV transmission and GBV.

#### 5.4 Challenging custom

As many of the quotes above illustrate, certain components of MRT are seen to challenge traditional custom. It is apparent from the interviews that in some cases (particularly relating to sex during menstruation and pregnancy) the perceived benefits of following MRT information led people to prioritise this over custom. In other instances (particularly concerning types of sex and sexual positions) the perceived benefits were minor and participants generally preferred to follow custom. A more significant challenge is that challenging custom sometimes led to anxiety and concern, embarrassment and a reduced willingness to actively participate in the training. This challenge could be easily removed by adapting the content of the programme.

Overall, the view of most participants was that the inherent purpose of MRT matched well with custom and, with minor alterations to content and language, the majority of information was easy to accept. This led many participants to request scaling-up of the programme throughout PNG.

*My view is we should get young married people and train them, and if we introduce that into a curriculum into all schools in the country, it would change the country – starting from Grade 6. The older people – some of them had to go through lots of initiation in our custom, and now they are having to learn something new, and it is hard to change. Some younger people have not gone through initiation or they have cross cultural marriages and so they have no custom. (Site 1, P.I.1m)*

*What PSI does is not really contradicting but using some of the languages that are very embarrassing and offensive to us. It's like slapping us on the face with a broom. The old people did not like what PSI was saying because it was new and something very foreign to them. For young people it is good for a healthy marriage and it was very helpful. (Site 1, Pastor)*

*His friend said the training happened exactly as what we used to do in our custom – like teaching the people. But they were teaching everything 'straight' and teaching the private parts of men and women and that was a little bit difficult. (Site 2, P.I.4m, F1)*

#### 5.5 Reinforcing new knowledge

Participants reported uptake of many aspects of MRT, however, in some cases the interviews showed that some information, particularly on the safety of sex during pregnancy and symptoms of STIs had not been remembered, or it had not been fully synthesised and absorbed by participants.

*Everything that I have learnt, I have been doing but the only thing that I think that it was no good to follow was to have sex during pregnancy or when the woman has her monthly period... I don't think this was good because it may make the husband want to have sex during pregnancy. I don't think it is healthy to be doing that because that baby has already been formed in my stomach and he already has bones and if my husband and I have sex then the baby might die. (Site 3, P.I. 8w, F1)*

*The part about using a condom is good – that she liked because other medicines that we usually take were causing us to have knee problems and back aches but using condoms has caused all these problems to go away. (Site 2, P.I.6w)*

Given the amount of information imparted during the four-day workshops, and the fact that much of this information was new to participants this is hardly surprising and does not reflect a weakness of MRT. It does, however, indicate a need for some aspects of MRT to continue to be reinforced over a period of time. In terms of risk perception this should happen as a result of PSI's continuing multi-media campaigns, but there are also potential opportunities for facilitating on-going community based support (see Recommendations).

## 6. THE FUTURE

ADB funding for TnT finishes in 2011. PSI, however, intends to continue with activities, including MRT, under different funding sources. With this in mind, participants in the qualitative evaluation were asked what they would like the project to do in the future.

The responses at all three sites were very similar and focused on suggested amendments to the content of the training, requests for specific targeting of young married participants, and scaling-up of the programme to enable more couples to benefit from the training.

*His friend suggested the trainer must come back again and tell us more. There were only a few of us who attended the training. The majority did not, so PSI could come back and teach the others who did not attend. There are a lot of communities round here and lots of people did not attend so there is a need to train these people so they understand. For the people who attended the training, some of our problems have been reduced... The training must be conducted again here, it's very nice for young family unity (Site 2, P.1.4m, F1)*

*The school should come back to teach young men and women and to prevent bad sick (HIV). There are many young people here who do not sit and talk to each other and agree on what they would do within their small and new family so this school has to come back and teach them how to build family up to be happy because most of these young married men are still having thoughts of getting married to other women. (Site 2 P1.8w)*

*...the mothers in this village, have said that there are a lot of different sicknesses coming around and we have to know about the use of condoms because using condoms is good, not only for married people but also for young men and women. It is better for PSI to come back and teach our young men and women as well because they do not know what is going to happen in the near future, but they are only concerned about satisfying their bodies right now. So PSI whom we know have more good things to teach our married couples as well as young people. What we have learnt is more valuable and is good to our lives and we would like PSI to come back and teach us more. (Site 2, P.1.10w, F2)*

*To sum up I see that the training that PSI is doing is one of the best training and it looks at real life situations which PNG is facing. PSI must train more trainers to go to remote areas to educate and teach it in a way to correct and make people understand. I don't like the training being done only in the towns and cities but to go to the remote areas to teach the uneducated. Marital relationship training is not an ordinary training but changes people's life and I'm one of the people who has changed. I encourage this training to go to other places to improve the lives of the families. (Site 3, P.1.9m, F1)*

*I feel that these should be taught to young couples so that they may know how it is like to be married because I feel that most young men and women just rush into married life. So if they go through this training then they will understand how to keep their marriage together instead of getting cross and fighting all the time. (Site 3, P.1.2w)*

There were also numerous requests for follow up training. Participants in the evaluation described the need for consolidation of the information they received during MRT. The training is intense, covers a wide range of issues, many of which are new to participants, challenges traditional custom and seeks to change traditional behaviour.

*There has been no complete or total change but people are changing bit by bit. Another training would help people change more. (Site 2, P.I.m)*

Although significant behaviour change was reported, it is ambitious to assume that one four-day workshop will be able to produce long-term sustained change among couples, many of whom face constant challenges in the form of cultural norms, peer pressure, low income, separation from traditional support networks (at Sites 1 and 3 where participants are company employees and not from local communities) and, also at Sites 1 and 3, a prevailing culture of drinking and gambling among men, and concurrent sexual relationships among both men and women. Participants at each site reported finding participation in the evaluation interesting and useful as it served as a reminder of the training content. Peer Interviewers described undertaking interviews with friends as reinforcing in their own minds the importance of what MRT had taught them, reminding them of parts of the training they had forgotten, and the positive impact it was having on participants. Interestingly, several participants also requested some form of follow-up evaluation by PSI to assess the extent to which MRT had resulted in change.

*That was the very first training we received in my life. In my view if they come back to make an assessment to see what we remember or forget that would be helpful...Secondly they have to come back and check to see if we are still following what they taught us. If we are they must move us to the next stage to learn more new things. (Site P. I.1m, F3m)*

A limited number of participants also requested more detailed information on HIV. This is an issue felt to be important by the evaluation team. At present the training focuses on HIV prevention. However, many participants highlighted increasing levels of HIV infection and the need for information on treatment, positive living and home-based care.

*We have information about communication for four days but we do not go deep into HIV. If we are infected, how do we get help? How to take care of ourselves? How to take the HIV medicine and what it does? That we did not touch or go into. This is because we know we have some people living with HIV with us. If we are learning more about this we can go out and help them...Women round here would like to know. (Site 1, P.I.2w, F2)*

*This sick (HIV) is going to come in and infect people so they should talk more about this. (Site 1, P.I.8w)*

## 7. CONCLUSION & RECOMMENDATIONS

### 7.1 Conclusion

PSI’s Marital Relationship Training four-day workshop is a highly innovative HIV and GBV prevention intervention. Focussing on preventing HIV transmission through reducing concurrency due to improved marital relations it provides participants with new knowledge and communication skills. Following the training there is clear qualitative evidence that these are then used by both male and female participants to negotiate, compromise, and rationalise what behaviour change will bring about desired levels of behaviour change.

Reported behaviour change goes beyond the aims of the project and includes:

Project outcomes	Project impact
<ul style="list-style-type: none"> <li>• Reduced concurrency</li> <li>• (Some) increased use of condoms</li> <li>• Reduced alcohol consumption among men</li> <li>• Decrease in gender-based violence</li> </ul>	Reduced risk of HIV transmission
<ul style="list-style-type: none"> <li>• Improved communication between couples</li> <li>• Understanding of consensual sex within marriage</li> <li>• Increased levels of sex within marriage</li> <li>• Greater gender equality in domestic labour</li> <li>• Sharing individual incomes</li> </ul>	Improved marital relations
<ul style="list-style-type: none"> <li>• Increased ability to purchase food and other goods</li> <li>• Increased stability for children</li> <li>• Increased school attendance by children</li> <li>• Improved progress at school by children</li> <li>• Increased affection between husbands and wives</li> <li>• Increased happiness of husbands, wives and children</li> </ul>	Improved household well-being

What appears to be a top-down intervention is, in fact, facilitating a dynamic process of change led by the participants themselves due to the combination of knowledge and skills provided during the training. What is not known at present is whether the positive impacts reported are sustainable in a challenging environment without follow-up training or support by either PSI or key local stakeholders/community members).

Participants report challenges to taking part in the programme and adopting some suggested behaviours, requiring some adaptation of this new intervention (see Recommendations below). Importantly, the purpose and main focus of the training is seen to tie in closely with traditional custom, making it acceptable to influential individuals within the community (pastors, health workers, traditional leaders) as well as to married couples. At present some of the training content and the way in which it is communicated are not considered sufficiently culturally sensitive, or

necessary. These components of the training have been highlighted in this report and are addressed in Recommendations below.

**One of the most innovative and exciting aspects of the training is the way in which, rather than focussing on prevention of high-risk behaviour, MRT focuses on enabling married couples to resolve many of the underlying causes or factors that lead to high-risk behaviour such as GBV, concurrent sexual partners, marital conflict and sexual dissatisfaction within marriage.**

Although MRT is time and labour intensive and, at present, a small-scale intervention the results of this evaluation show that it is a potentially highly effective initiative and consideration should be given to investigating ways in which it could be adapted for scaling-up to reach greater numbers of married couples both within PNG and in other regions.

## 7.2 Recommendations

### 7.2.1 Content of MRT

- Amend the content of MRT, removing sessions on sexual positions, oral and anal sex. Although this information was included in response to requests from male participants attending earlier (male only) MRT, it appears that, in reality, this information adds limited value, particularly in comparison to the potential benefit of including issues that participants considered necessary but which are not currently addressed.
- Provide increased information on access to HCT services and providers of family planning services. The content of MRT is broad and provides in-depth information on a number of issues. Increasing the amount of information provided on HIV, such as treatment and positive living would not be appropriate. In fact, there may be a need to simplify some aspects of the curriculum e.g. family planning, but support this by providing explicit information on external sources of support, information and services. This could be complemented by providing basic training to some key community members and additional training to health workers (see 7.2.4 below) on key issues such as family planning methods including the 'rhythm method' (this was reported to be the most frequent method used but participants had little/incorrect knowledge of this – particularly on when sexual intercourse is/is not safe).
- Increased information needs to be provided on different methods of family planning, with particular attention paid to providing information on side-effects of the different methods. Female participants frequently described symptoms of STIs as, instead, being due to using contraceptive methods.
- Modify the existing session on birth spacing to make clearer/give more emphasis to the part condoms can play in birth spacing (an unintended consequence of MRT is that couples appear to be having sex more frequently without consistent

use of contraceptives). This would also help to resolve the conflict of mixed messages perceived by participants (condoms should be used in relationships outside marriage but MRT is encouraging couples not to have concurrent sexual partners. Thus distribution of condoms during the training is seen as contradictory by participants).

- Information should be clearer on the importance of testing for HIV in relation to safer sex within marriage. Participants appeared to be unaware of the risk of HIV transmission through unprotected sex between married couples. The role of condoms in HIV prevention was only described as appropriate for sexual intercourse outside marriage. Participants appeared to be unaware of the risk that either husbands or wives could already be HIV positive.

### 7.2.2 Increased cultural sensitivity

- Greater recognition needs to be given to the anxiety among participants caused by 'straight talking' about human anatomy, different types of sex (particularly oral and anal sex), and genitalia. Custom in some PNG cultures frowns on discussing either; and discussion of sexual relationships with neighbours, friends and relations. Traditionally this is overcome by the use of euphemisms (such as 'Bird of Paradise' for penis) and parables ('I went out last night and ate sago/taro' for 'I had sex with someone other than my husband/wife'). Using non-biomedical/non-technical terms would reduce participants' embarrassment or upset, they would understand what was being discussed and would be more able/willing to engage in these parts of the training.
- Care should be given to selecting venues for MRT. Based on feedback from participants, the sexual content of the curriculum makes it undesirable to hold the training in church-related buildings such as church halls (as at Site 2). Appropriate sites for MRT are health facilities and other non-religious buildings. In rural areas, in particular, where church-owned facilities are the only ones available then efforts should be made to discuss:
  - a) Possible alternative sites with key local stakeholders
  - b) Discuss the content of the training in advance with pastors and the community
  - c) Give consideration to modifying the content of MRT if necessary.
- Many participants in development enclaves live in houses which are shared with other married couples. Children also often sleep in the same room as their parents. Increased sensitivity should be given to asking participants to do 'homework' which involves sexual intimacy at a specified time. This is hard to accomplish as most couples find it difficult to obtain privacy within their living conditions. The content of the homework should be clarified with participants, emphasising that 'intimacy' need not only constitute physical intimacy but can also mean expressing affection verbally. Participants should also be reassured that homework is not compulsory.

### 7.2.3 Recruitment and Targeting

- Greater guidance and oversight by PSI in recruiting participants for MRT. The content of the training makes it inappropriate for different generations of one family to attend as this causes embarrassment to both parents and their adult children and reduces their ability and willingness to fully engage with/participate in the training.
- It would be beneficial if a day/part of a day could be spent by MRT trainers in each community before the start of training. 'Tok tok' or 'Tok save' (social introductions and conversation) is culturally important as a precursor to significant discussions. Its absence was noted by participants who stated that it would reduce anxiety at the beginning of the training.
- The training is most appropriate for younger married couples although consideration should be given to providing MRT training to key older individuals/couples within communities (such as pastors and their wives, development enclave (e.g. plantation) managers and their spouses, and health workers) in order to gain community buy-in and put in place opportunities for on-going guidance within communities for couples once the MRT is completed.<sup>11</sup>

### 7.2.4 Community based support and reinforcing MRT messages

- Not all information provided during MRT was correctly remembered by participants. This was particularly the case in terms of recognising symptoms of STIs, correct understanding of side-effects of family planning methods, and the safety of sex during pregnancy. There is a need to investigate ways in which messaging can be reinforced not only through mixed-media but at community level.
- Many participants, particularly at Sites 1 and 3 (where there are highly mobile populations) described wanting to share the knowledge and skills they obtained through MRT but being unable to do so due to being perceived as 'ordinary' members of the community. This led to frustration, disappointment and requests for PSI to instigate some form of follow-up messaging. Providing formal MRT follow-up would not be cost effective, however, it seems feasible for PSI to provide influential members of the community who already have a mediation/health role, such as pastors and their wives, traditional leaders and local health workers with information on sexual health, communication and negotiation skills and other components of MRT (and in the case of health workers, particularly information on family planning methods and couple counselling). This would enable couples motivated by MRT to seek on-going support if desired and enable key information to be disseminated and reinforced

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<sup>11</sup> Careful consideration would need to be given to selection of participants and MRT content would need to be adapted to include issues of ethics and confidentiality if these couples were to under-take provision of on-going guidance and support to community members.

within communities on a on-going basis. This also applies to reinforcing messages to reduce stigma associated with condom use.

- It would also be beneficial to explicitly include within MRT information on sources of support, and access to services, relating to HCT.

#### 7.2.5 M&E

- Internal evaluation of new project content and activities is a routine component of PSI's work. The findings of this external evaluation indicate the challenges of obtaining accurate feedback from participants. Responses to PSI's request for feedback on MRT content, immediately following the training, were that participants found some modules (particularly those on body parts and intimacy/arousal) 'challenging' but acceptable, and that participants became increasingly confident about using specific words and terms as the training progressed. The findings of this evaluation, however, indicate that this was not the case. The disparity in responses is likely to be due to challenges faced a) by participants who find it hard to express criticism in person to trainers (particularly given their recognition of the overall value of the training and appreciation of the opportunity to attend); and b) by PSI in developing training evaluation methods which are appropriate for use with low/non-literate participants. Use of conventional anonymous written feedback questionnaires is, in these situations, not feasible. Two possible internal training evaluation methods are suggested:
  - Trainers ask participants to assess each module/component of the training by reading out the name and a synopsis of the module to participants and asking them to individually mark a pictorial Likert scale. These pictorial scores can be completed anonymously and placed in a box at the end of the session, and then scored by PSI.



- Shortly after the completion of MRT participants can be asked by a member of PSI who was not part of the training team what 'other people' who attended MRT said about each component. Participants could also be asked to draw what aspects of MRT they most/least liked and then asked to explain their drawings or verbal responses. The key feature of this approach is that it must be emphasised as a learning opportunity for PSI, it must be made clear that it is not a test of knowledge, and that responses will help to improve future MRT sessions. Asking for generalised, 'no name' (as opposed to personal/individual) information helps to reduce the likelihood of receiving normative responses

<sup>12</sup> Source: <http://www.flickr.com/photos/12701326@N02/3757564190/>

- A valuable addition to this qualitative evaluation would be quantitative evaluation of outcomes and impact. This would give greater insight into the value for money of this intervention and would demonstrate whether, and to what extent, it is leading to increased condom use and other key behaviour change indicators. (At the time of writing this report, a quantitative baseline study is planned by PSI for January 2012, to be followed by an end-of-project quantitative evaluation).
- The current project indicators need adapting to incorporate the findings of this evaluation. The current focus on specific areas of SRH knowledge and condom use are not adequate or appropriate for MRT, particularly given the findings of this qualitative evaluation.
- A very valuable (although possibly costly) input to the project would be to roll-out MRT within one region/district in which wider TnT interventions, including social marketing of condoms, were taking place and to undertake comparative M&E with another 'control' region/district which had similar inputs but no MRT.

## 8. ANNEXES

### 8.1 Rapid PEER Methodology

#### **DAY 1: Peer Interviewer Workshop**

The consultants will liaise with the appropriate project staff prior to arrival to ensure the correct group of project beneficiaries/participants is selected for this workshop. Eight – ten people who are involved with the project should be selected. They should be available to work with the consultant for 4 consecutive days. Timings of activities will be planned around their existing commitments (e.g. work), as far as possible.

The consultant will give guidance to the project staff prior to arrival as to what needs to be provided for the day of the workshop (materials, venue, support staff, translators etc). It is anticipated that the main requirements will be a room large enough for ten people to hold a workshop, flip chart paper, marker pens and refreshments/meals/childcare as appropriate.

The following is template for the workshop, which will be adapted to the timeframe available and the needs of each target group:

#### **10.00am – Introductions**

1. Explain to participants that we are here to help tell the story of their project from their point of view, and from the point of view of other people they know who have been involved in the project.

2. Group discussion with participants:

- Ask participants to write or draw what the project means to them on a section of wall covered with paper. Participants will be probed with questions such as:
  - How does involvement with the project make you feel and why?
  - What changes have you seen as a result of the project?
  - What's the most important part of the project to you?

#### **10.45am – Break and snacks**

#### **11.00am – Peer Interviews in pairs**

3. In pairs, ask participants to interview each other (using 'everyday language') to find out:

- How they got involved in the project and why?
- What difference the project has made to them and why?

- What difference the project has made to other people like them, and why?
- What changes have they seen in their everyday lives as a result of the project?
- What they have found most challenging?
- How they think the project could be improved in the future?
- Finally, in order to generate stories for the final workshop with project staff, each peer interviewer should ask for stories of change resulting from the project.

4. Feedback: participants tell the group what they have found out from their partner, focussing on stories and examples that capture the project's impact.

**1.00pm – Break and lunch**

**2.00pm – Preparing to interview others**

5. Explain to participants that over the next two days we need them to talk to other people who have participated in the project, to capture their stories. They need to talk to two 'other people they know' about how the project has made a difference to their lives.

To prepare for this, participants will be asked, 'in addition to the questions that you used to interview your partner before lunch, what questions could you ask your friends to get them to tell their story of what the project means to them and how it has made a difference?'

The group will then brainstorm ideas for good questions. The issue of asking 'probing' questions to get more detailed information will be discussed.

The participants will then practise introducing the interview to their friend, describing why they are asking these questions, for example, by explaining that the people supporting this project are interested to hear their story and share it with others.

6. Finally, a timetable for meeting and de-briefing all peer interviewers will be set.

**By 4.00pm - End**

## **DAY 2: In-depth interviews with key informants**

We will ask that selected key informants are available to talk to us for an hour each during the day.

Simultaneously, participants from the Day 1 workshop (the peer interviewers) will be interviewing other programme beneficiaries.

The consultant will discuss the following key issues with key informants:

- The difference they consider the project to have made, how, why and to whom.
- What they think is most important about the project?
- What challenges they think are associated with the project?
- What they would like the project to do in the future?

#### **DAY 3 and 4: One-to-one debriefing with peer interviewers**

On days 3 and 4 the consultant will meet with different peer interviewers over the course of the day. The consultant will debrief the peer interviewers to capture the stories and narratives that they have heard from interviewees

#### **DAY 5: (Morning) final peer interviewer workshop (c. 2 hours long)**

Peer interviewers will meet with the consultant as a group. The main activities are:

- Peer interviewers discuss as a group what they think are the most important findings from their interviews with peers.
- Consultant probes the group with any remaining unanswered questions that may have arisen over the week
- Peer interviewers are thanked and given a small gift/certificate for their participation (as appropriate)

#### **DAY 6: - Significant change workshop with project trainers**

At the final significant change workshop, project trainers will meet with the consultant for approximately 1-2 hours to discuss what they feel to be the most significant change from a selection of stories presented to them (which have been collected by peer interviewers). Trainers will be encouraged to explain why they have chosen to prioritise certain stories. This process gives the consultant an insight into programme priorities and values, perceived impact, and how these might differ between staff and project beneficiaries.