Short-term effect of faithfulness-focused curriculum on established couples from three regions in Uganda

Abstract

Background

Even though a large percentage of new infections in many African countries occur within marriages, there are relatively few prevention programs specifically focusing on the couple as a unit of behavior change. This study evaluates The Faithful House (TFH) program—a faithfulness-focused HIV-prevention curriculum implemented through workshops centered on the couple—to determine its short-term benefits for younger, established couples in Uganda.

Methodology

The evaluation population consisted of couples from Central, Western and Northern regions of Uganda, identified from the catchment areas of 12 community-level clinics. A convenience sampling method was used to gather interested couples' names, and this list was then randomly distributed equally between the intervention and control groups. In January-February 2011, the couples participated in focus group discussions, attended a three-day workshop based upon The Faithful House curriculum, and completed baseline and post-test surveys on their attitudes, beliefs and intended behaviors. Statistical analysis was conducted, using Excel and STATA, comparing matched baseline and post-test changes. A six-month follow-up survey will be conducted with both control and intervention groups.

Results

Workshop participants (i.e., the intervention group of 438 individuals or 219 couples), were on average 37.5 years old for men and 31.6 years for women. Couples had been together for an average of 11.8 years, with 40 percent cohabiting and 57 percent married (traditionally or by religious institution). Baseline to post-workshop data showed statistically significant ($p<0.001$) improvement in couples' perceptions on factors affecting relationship satisfaction and the family unit, including: quality of relationship and couple communication; level of sharing financial information with partner; comfort level in discussing sexual issues with partner and self-efficacy and intention to discuss sexual matters with their children; and intentions of joint decision-making about sexual activity, accessing HIV service, and other important family matters. Attitudes on multiple cultural norms that contribute to HIV risk and multiple sexual partners also statistically improved ($p<0.01$) after the workshop. Intended male involvement to antenatal care (ANC) visits and support group attendance statistically increased from baseline to post-test. Lastly, there was an 86 percent uptake of couples expressed interest in couple HIV testing after TFH workshops.

Conclusions

A comparison of baseline to post-test surveys indicates that attendance to TFH workshop has a short-term effect on perceptions, attitudes and intended behaviors linked to those factors that promote unfaithfulness in relationships. It will be important to track and analyze these initial changes at the six-month follow-up and note any sustained effects resulting from TFH participation.

Project Background

Summary of the Literature

As the HIV epidemic continues to expand in sub-Saharan Africa, there is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address the context within which most infections of HIV occur: couple relationships. Prevalence of HIV in some countries in

sub-Saharan Africa is up to 50 times higher than the average for countries outside Africa. In the 1990s, it was widely accepted in policy and scholarly dialogue that higher rates of risky sexual behavior in Africa explained the difference in HIV prevalence. For years, the specific notion of "concurrency", which is broadly defined as long-term, overlapping partnerships, was thought to be the key factor in contributing to the region's epidemic HIV proportions. However, this notion is still quite controversial. In contrasting the mathematical models of the potential role of concurrent sexual partnerships in facilitating the rapid spread of HIV in sexual networks, a recent analysis of household survey data in 22 countries, including 18 in sub-Saharan Africa, found no significant correlation between prevalence of sexual concurrency and HIV prevalence at the country or community level[1,2]. In addition, in one systematic review in 2010 by Sawers and Stillwaggon, the research seeking to establish a statistical correlation between concurrency and HIV prevalence either found no correlation or had important limitations that should dismiss such a conclusion. According to these authors, "Policy makers should turn attention to drivers of African HIV epidemics that are policy sensitive and for which there is substantial epidemiological evidence"[3].

According to data from nationally representative surveys conducted during 2004-2006 in Cameroon, Rwanda, Uganda and Zimbabwe (which included HIV testing of adult men and women), "Having fewer lifetime sexual partners and being faithful to spousal partner(s) are strongly associated with reduced risk of HIV infection. Thus…HIV prevention programs should focus more on promoting partner reduction and partner faithfulness, especially for men"[4]. Critical epidemiological trends, such as those emerging from the recent national studies in Uganda and Kenya, indicate that half of new HIV infections are occurring in married people[5]. This could be an area for focus, particularly for faith-based institutions. Being unfaithful to your current partner remains a key area of concentration for HIV-prevention programming. Thus, putting aside the discourse about multiple and concurrent partners (MCP) and its role in the current African AIDS epidemic, there is a growing consensus that HIV-prevention research and programming should address couples as a unit of behavior change and intervention[6]. From a faith-based perspective, strengthening the marriage should be the focal point of combating this issue.

Couples-centered approaches are one response, and although they appear initially promising, additional research is necessary to build a stronger theoretical and methodological basis for couples-focused HIV prevention[7]. Earlier studies provided preliminary evidence for the feasibility of couples-focused interventions for HIV, particularly the role of couples-focused voluntary counseling and testing[8,9]. Moving beyond the context of HIV testing and counseling, more general couples-focused HIV-prevention programs may differ from individual-focused HIV-prevention programs by addressing the ongoing dynamic and interactional forces within dyads that contribute to sexual risk behavior, including gender roles, power imbalances, communication styles, child-bearing intentions, intimate partner violence and quality-of-relationship issues (e.g., commitment, satisfaction, intimacy). This evaluation by CRS attempts to build on the theoretical and methodological foundation for couples-centered, faithfulness-focused HIV prevention.

The Faithful House program was created collaboratively by CRS and Maternal Life International/Uganda to begin the process of building a case for faith-based HIV prevention through a skills-building curriculum aimed at strengthening the family through enhanced couple communication. TFH program includes skills building, positive peer mentoring and provision of a safe environment for couple dialogue

around quality-of-relationship issues and other attitudes and behaviors that contribute to sexual risk behavior. Currently, the curriculum is being used in 11 countries. Over the course of its implementation, TFH program has collected pre- and post-workshop surveys from over 600 beneficiaries, and these surveys have demonstrated improvements in communication between partners in areas such as finance, gender roles, power imbalances, sexual intimacy, and parenting and communication with children around sex-related issues. Two limitations have also emerged over this time period: 1) long-term impact of the program on attitudes and behaviors has not been documented to date; and 2) the absence of a control population limits rigorous conclusions. CRS has responded to these critiques by developing an evaluation to assess the effectiveness of The Faithful House's three-day curriculum on short-term knowledge gain and attitude changes and long-term attitude and behavior change.

Methodology

Quantitative data methods were used to assess the effectiveness of TFH curriculum on the short-term perceptions, behavioral attitudes, and intended practices related to couple relationship satisfaction, partner communication, and HIV risk. Qualitative research was conducted using focus group discussions (FGDs) on topics of interest/concern that were revealed in the quantitative data analysis. Data presented reflects participants' feedback (perceptions, attitudes and intentions) in response to TFH curriculum.

The evaluation was conducted in three regions (Central, Western and Northern) where CRS Uganda works with local partner organizations to conduct its PEPFAR-funded AIDSRelief HIV Treatment and Care program. Twelve local partner treatment facilities (LPTFs) were identified as sites and partners for the evaluation. A convenience sampling method was used to gather interested couples' names from the catchment areas of each LPTF, and this list was then randomly distributed equally between the intervention and control groups. Prior to conducting the baseline survey interview or participation in the FGD, written consent was collected from each participant. The workshop was held the day after the baseline survey was conducted.

Objectives of the Evaluation

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

1) Assess the impact of this curriculum on couples' communication, quality-of-relationship issues, and attitudes and behaviors that contribute to sexual risk behaviors.
2) Assess the impact of this curriculum on family strengthening.
3) Determine the attitudes and behaviors of toward multiple and concurrent partnerships.

Evaluation Population Selection

LPTFs' project officers each identified 40 interested couples, whose HIV status was unknown, for the workshops. The CRS project coordinator then assisted the LPTFs in producing a randomized sample (using Microsoft Excel) that divided the couples into control and intervention group members.

Training of Enumerators and Couple Facilitators

The consultant conducted a one-day training on the surveys for all enumerators. All enumerators were quite strong in the English language, and each held a strong understanding of the English interpretation of each question.

Data Collection and Analysis

Unique identifiers (IDs) were assigned each participant, in order to keep confidentiality with the data reported. Baseline survey data collection for workshop participants occurred at the workshop site the day before the workshop was to begin. The corresponding control group was interviewed the first day of the workshop, while the intervention group was attending TFH. The post-test for the intervention group was conducted after the workshop had ended on the last day. As routine with TFH workshops held in Uganda, voluntary HIV couples testing was offered after the workshop ended on the last day. Participants who did not have both a baseline and post-test survey completed were deleted from the data set and not included in analysis (N = 17 individuals).

All data from the Microsoft Access databases was exported and manipulated in Microsoft Excel for the initial frequency analyses and unique patterns/associations. Statistical analysis using STATA was run on comparisons of baseline scores between the control and intervention groups, baseline and post-test comparisons for the intervention groups only, and sex stratifications.

Quantitative and Qualitative Findings

Sample Characteristics

A total of 844 individuals were sampled for the control and intervention groups (Table 1).

Table 1: Breakdown of Individuals Sampled

Target zones	# of individuals in control group	# of individuals in intervention group	Total # of individuals sampled	Total # of couples sampled
Central	152	158	310	155
Western	126	136	262	131
Northern	128	144	272	136
Total	406	438	844	422

A total of 438 workshop participants completed both a baseline and post-test survey and thus were the participants used for the baseline and post-test comparisons presented below. The control group, only sampled for the baseline, was found to be a comparable group and thus will be presented in the analysis of the six-month follow-up comparisons.

Summary demographics are as follows (see Annex): On average, men were 37.5 years old and women were 31.6 years old. Approximately 40 percent of couples were cohabiting; 28 percent were married by religious institution, and 29 percent were married traditionally. Couples had been together for an average of 11.8 years. Thirty-nine percent of men reported being married to more than one wife; however, only 14 percent of women report their male partners are married to more than one wife or

have another regular partner. The majority of couples (75 percent) live in rural areas, and "farming" is the most commonly reported type of employment. Roughly 70 percent reported being Catholic, 20 percent Protestant, and 6 percent Muslim. Over one-third reported primary school as their highest level of education attained, and another one-third reported completion of secondary school. Roughly 20 percent have children with someone other than their current partner/spouse. Additionally, 48 percent are caring for nonbiological children (orphaned or vulnerable children or OVC), with an average of 2.9 children per household.

The findings focus primarily on the baseline and post-test results of the intervention group, with additional qualitative results presented throughout. The reported results presented in this section are mostly perceptions and determinants of behaviors, not actual behaviors of the participants; these perceptions and determinants either affect the particular attitudes and behaviors or address barriers to behavior change. All results are self-reported and are not verified through other sources. The denominator in the percentages reported in the following sections are taken not as the total number of participants sampled, but rather the total number of participants that responded to each question (including "don't know" and "no response").

Factors That Affect Couple Relationship Satisfaction

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

Intentions to change were measured at the post-test following the workshop. All increases shown were statistically significant changes (see Table 2). The "quality of communication" indicator revealed a statistically significant difference between men's and women's responses ($p<0.05$).

Table 2: Indicators That Affect Couple Relationship Satisfaction

Indicator	Baseline	Post-Test
On a scale from 1-10, with 1 the lowest and 10 the highest:		
Quality of relationship**	7.7	9.3
Quality of communication**	7.5	9.2
Level of respect received from partner**	7.9	9.4
Level of sharing of personal income and financial assets**	6.8	9.0
Level of adequate knowledge, values, and skills to be faithful to partner**	7.6	9.3
Ability to have an open and frank discussion with partner about sex**	7.6	9.0
% of participants who:		
Will confide in partner for personal problems**+	52%	72%
Believe a man can be faithful to one partner his entire lifetime*+	71%	81%
Believe a woman can be faithful to one partner her entire lifetime*+	82%	91%

* = statistically significant increase (p<0.01) ** = statistically significant increase (p<0.001)

+ = statistically significant difference at baseline between men and women (p<0.05)

In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities; survey responses reveal that this struggle was also evident in their own relationships. In the quantitative survey, participants were asked directly about unfaithfulness in their current relationships. Men reported significantly (p<0.001) higher rates of unfaithfulness than the women: 33 percent compared to 3 percent. However, through the form of a secret ballot held at each workshop, 65 percent of workshop participants reported having been unfaithful to their current partner in the past.

Providing relevant strategies for strengthening the bond between couples and breaking barriers to faithfulness are two key objectives of TFH curriculum. When FDGs explored barriers to unfaithfulness, lack of love, poor communication and sexual dissatisfaction emerged throughout all the discussions (men, women and facilitator/staff groups). Note that poverty was mentioned as a reason that women are unfaithful, but not for men. For men's unfaithfulness, both women and men mentioned reasons such as the woman's inability to cook or take care of the house well, women's "laziness", women's failure to dress up or "be clean" for the man, improper "care" of the man, and too much nagging from the woman. On the baseline survey, the level of sexual satisfaction with couples was 7.6 (on a scale from 1-10, with 10 being the highest), with no significant differences between men's and women's ratings. Two attributing factors that underlie these three barriers mentioned are gender norms and age at marriage between men and women, both of which correspond to reasons for marriage. According to the FGDs, early marriage among women is still common in Uganda, and this furthers the inequality within relationships caused from traditional gender norms. As one male FGD participant put it, "The issue of power comes in, and men believe they have been given this power over women from God."

After attending TFH workshop, participants reported a significant increase (p<0.001) in their confidence in their own ability to maintain a happy and strong union with their partners. At baseline, the confidence level (on a scale from 1-10) was 8.2 and at post-test, 9.4.

Factors That Affect Gender Roles and the Family Unit

Family strengthening is an important desired outcome of TFH program, as the curriculum addresses issues that act as stressors between partners and between the couple and their children. Those stressors

sometimes derive from the social and gender norms in the country context. Guided discussions examined gender roles in the marriage and whether or not those roles promoted equality. TFH curriculum also discusses issues such as abstinence before marriage, delaying sexual debut and struggles that youth are facing around preparation for marriage. Parents are coached on how to talk to their children about these issues and encouraged to do so. Factors affecting the family unit that are measured in the quantitative surveys include equality in marriage (gender roles), decision-making power in family matters, views and practices regarding children and youth, violence in the home, and drug/alcohol use among participants. Significant changes were exhibited in all "equality in marriage" indicators and comfort level in discussing sexual matters with age-appropriate children (Table 3).

Table 3: Indicators That Affect the Family Unit

Indicator	Baseline	Post-Test
% of participants who reported BOTH partners:		
Responsibility for looking after the children**	63%	88%
Decision-making power in important family matters**	56%	83%
Decision-making power in when to have sex**	65%	87%
Decision-making power in accessing HIV services**+	71%	88%
% of participants who believe:		
Boys can abstain from sex until marriage+	47%	51%
Girls can abstain from sex until marriage	49%	54%
On a scale from 1-10 (with 1 the lowest and 10 the highest):		
Comfort level in discussing sexual matters with sons (10-18 years old)**	5.4	8.1
Comfort level in discussing sexual matters with daughters (10-18 years old)**	5.4	8.0

** = statistically significant increase ($p<0.001$)

+ = statistically significant difference at baseline between men and women ($p<0.05$)

Discussing sex with children was a topic of discussion in the focus groups as well. In response to the question of responsibility for educating young people about sex, one male FGD participant said, "Parents have lost time for their children, and the burden is falling to teachers. It should go back to the role of the parents." The post-test survey results reflect parents' desire to be more involved in the education of their children regarding safer sex practices.

The participants were also asked questions about cultural and gender norms that increase or fuel HIV risk and diminish the family unit[10]. Intimate partner violence is still a pervasive social problem in Uganda[11], thus the quantitative survey posed a series of 18 questions about types and frequency of physical abuse or threats in the household, including: insulting; swearing; threatening to hurt you; pushing, shoving, shaking, throwing something at you; slapping you or twisting your arm; hitting you with fist or something else; threatening you with a knife or other weapon; kicking or choking you; forcing sex. Reported violence or threat of violence was found in 51 percent of the households across all three regions. Twenty-four percent of participants reported being victims of physical violence, and 58 percent of those were women; specifically, 30 percent of participants reported being forced to have sexual relations with their partner in the last six months. Nineteen percent of participants reported being perpetrators of physical violence, and 68 percent of those were men. Acceptance of violence against women and men was a topic for the pre-baseline survey FGD. Men reported violence happening in homes but said it was not common; all the women reported it was "very common". The women's FGD

mentioned two types of households especially at risk for partner violence: 1) When the man has recently come into money, the woman in that household will experience more domestic violence. 2) When it is a working-class family and the woman works outside the home. Both FGDs with men and women said that women beating men was not common in their communities, but it did happen. As shown in the reports from the questionnaire, men did report experiencing some form of verbal, emotional or physical abuse from the women.

Examples from female FGD participants:

"The rich man often feels power over the woman and has the right to do anything he wants."

"The working woman is probably educated, more independent, and may try to exert more decision-making authority which angers the man, since he is supposed to be head of household."

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

Awareness of HIV status is an important aspect of reducing HIV transmission, as there is little debate on the reduction of transmission that occurs once a person with HIV knows his or her status. Given that half of new HIV infections are occurring within married or cohabiting relationships[5], three take-home points within TFH curriculum are HIV testing, knowing your status and sharing those results with your spouse/partner. Eighty-two percent of participants reported wanting to be tested for HIV at baseline, with 17 percent reporting having never been tested for HIV. Also, women reported statistically ($p<0.001$) higher rates of ever having been tested than men. Of those that had been tested, 25 percent were tested over a year ago. Sixty-two percent of these couples went for couples testing at their last HIV test. Through partnership with local treatment facilities, couples HIV testing (using the rapid test) is usually offered on the last day of TFH workshop[*], and 86 percent of participants accepted voluntary testing for HIV. Seventy-five percent (a total of 323 persons) of all participants followed through with testing after the workshop. Fourteen individuals (4.3 percent of those tested) were found to be HIV positive; eight were in discordant relationships. Participants' "likelihood of going for couples testing in the next three months" (on scale from 1-10) significantly increased ($p<0.001$) from 7.9 at baseline to 9.0 after the workshop.

Male involvement in ANC was also covered in TFH curriculum. Reported male involvement in ANC services statistically increased ($p<0.001$) from baseline to post-test: 71 percent originally reported attending ANC visits with their partner or would attend if partner became pregnant, increasing to 82 percent post-workshop.

Questions were asked regarding support group attendance in order to gauge involvement in any safety net structure. At baseline, 49 percent were a part of some kind of support group, such as Mothers/Fathers clubs, HIV/AIDS support groups, etc. This rose dramatically at post-test, with 94 percent of participants reporting that they would be joining support groups. Eighty-one percent of workshop attendees also reported an intention to join TFH support groups after the workshop.

[*]Ten workshops conducted HIV testing and two workshops did not offer the test due to political instability, as mentioned in the Limitations section.

There were also questions regarding attitudes toward MCP and other cultural norms, as well as to assess overall knowledge and perceived risk of HIV. These questions asked participants to either "strongly agree, agree, strongly disagree, or disagree" with specific statements (Table 4).

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

All (Intervention/Workshop) Participants	Baseline	Post-test
Agreed: Woman is justified in refusing sex with partner if she knows he has had sex with someone else.	70%	79%
Disagreed: A married man having concurrent partners is not harmful as long as he is discrete/provides for family.	74%	80%
Disagreed: There are exceptional cases where a man should be allowed to have sex with another woman.*	66%	74%
Disagreed: There are exceptional cases where a woman should be allowed to have sex with another man.**	78%	88%
Disagreed: A man should be allowed to produce children with another partner if his wife is infertile.**	32%	49%
Disagreed: A woman should be allowed to produce children with another partner if her husband is infertile.**	57%	74%
Disagreed: Once infected, the chances of a person living with HIV transmitting it to someone else are always the same.	13%	17%

* = statistically significant increase ($p<0.05$) ** = statistically significant change ($p<0.001$)

Self-confidence or willingness to share information, both on how to strengthen the spousal/partner relationships and on the HIV risk associated with MCP, increased after TFH workshops. The frequency response "at least once a week" significantly ($p<0.001$) increased from an average of 24 to 73 percent in all groups for both topics. When probing further about whom participants previously shared this information with, 42 percent named family members or best friends. After the workshop, family members (61 percent) and best friends (47 percent) were still reported in high numbers, but now 77 percent said they would share information with their neighbors, which could indicate increased confidence with discussing sensitive matters outside the family/friend circle.

Discussion

The changes from baseline to post-test indicate that attending TFH workshop has had a short-term effect on couples' perceptions, attitudes and intended behaviors linked to couple relationships and family interactions. Statistically significant increases from baseline to post-test were observed for all "equality in marriage" indicators. Specific communication skills also increased, with participants reporting increased willingness to share financial information with partner and increased ability to have open and frank discussions with partner about sexual matters. Baseline reports unfortunately also reveal a tolerance of violence is still present in these communities, with roughly half of households experiencing violence or threats of violence.

Significant short-term changes in perceptions and attitudes toward HIV testing and cultural norms that contribute to HIV risk and MCP were seen from baseline to post-test. In a country with a generalized

epidemic, the findings around multiple partners, unfaithfulness and HIV testing indicate a real need for improvements in the area of couples HIV testing: 39 percent of men reported more than one consistent partner, 65 percent of all participants reported having been unfaithful to their partner; 17 percent had never been tested for HIV, and nearly 25 percent of those tested had not been re-tested in the past 12 months. On the other hand, the increase in intended male attendance to ANC visits with their pregnant partners is significant, the importance of which cannot be overstated. What remains to be seen is whether these intentions will result in actual behaviors. Additionally, self-confidence or willingness to share information, both on how to strengthen the partner relationships and on the HIV risk associated with MCP, significantly increased after the TFH workshop. The six-month follow-up survey and final FGD will be critical for determining whether TFH has any long-term effects on all of the indicators measured.

Couples report significant improvements in their comfort level with discussions of sexual intimacy, both between partners and between parents and children. Couples are more willing to discuss delay of sexual debut with children within their own families; however, couples did not change their views about the ability of boys and girls to practice sexual abstinence prior to marriage. This contrast suggests that the workshop supports positive behavior change within the homes of participants, but that societal changes will depend on broader community-based programs for youth that support the delay of sexual debut and the sanctity of marriage.

Lastly, although the data presented grouped all regions together, an analysis by region revealed the Northern Region as unique compared to the other two. The Northern Region reported much lower baseline views on all “equality in marriage” indicators (men in this region were still seen as the primary decision-maker for important family matters). Higher tolerance of intimate partner violence was also reported. On a positive note, more participants in this region had ever been tested for HIV, and at last test, more couples went together for HIV testing. Participants from the North were younger and had been married fewer years on average, which may account for the differences, but further investigation is warranted.

Evaluation Limitations

In order to fit the entire process of pre-test, training and post-test in a five-day block, the workshops concluded at noon on the third day to allow the voluntary HIV testing and counseling and post-test survey to begin after lunch. This meant compressing the already condensed three-day curriculum even further, to two and a half days, and many sections were only superficially discussed.

The workshops were being conducted from January to February 2011, and this overlapped with the presidential elections and associated political turmoil. These instabilities were most problematic for the North, with two workshops canceled. Two workshops in each of the other regions were unable to conduct the routine HIV testing offered after all TFH workshops due to unavoidable early dismissal.

A final limitation was the convenience sampling methodology. This could introduce a bias into the findings, as all couple participants were self-selecting and only eligible if both partners could attend.

Conclusions

From both the quantitative surveys and the FGDs, cultural norms come out strongly as affecting relationships. These norms provide an enabling environment for gender inequality, harmful traditional practices (such as early marriage), intimate partner violence and secretive sexual partners. The significant age and education differences between men and women at marriage or within relationships pose a potential challenge for establishing healthy, gender-balanced relationships. Even still, TFH workshops improved overall attitudes towards equality in marriage and increased communication between partners on many different gender-accommodating issues by providing a safe platform for discussion. By drawing on faith values as its foundation, TFH curriculum has shown short-term, positive steps towards overcoming the culturally related enablers of HIV transmission within couples. The six-month follow-up survey will determine longer-term impact on attitudes and behavior.

For future programming, the authors suggest that both "prevention" and "treatment" approaches are needed. The prevention approach would target younger, unmarried individuals and focus more on relationship preparation; specifically, how to identify a compatible partner and expectations within marriage (still with TFH foundation). The treatment approach would target married couples with current TFH curriculum, along the lines of a marriage retreat, to re-establish and reinforce good marriage qualities.

As seen from the demographic data presented, most couples are cohabiting and do identify themselves as married. Also, of those couples in Uganda that are married, most go through a traditional marriage (at least first) and fewer through a religious institution. This is a missed opportunity for faith communities to have an impact on couples. Given the low number of couples reporting attending premarital counseling programs, faith institutions should work to provide this service, *even when the marriage ceremony is not happening in the religious institution*. This premarital counseling is a platform for addressing many aspects of marriage, including factors that lead to broken or unhealthy relationships. HIV couples testing should be an integral component of premarital counseling programs.

Furthermore, given the initial success shown in strengthening the family, TFH curriculum should be promoted as a supplement to other development programs that require a strong family foundation. One example might be prevention of mother-to-child transmission (PMTCT) programs. The initial data presented from baseline to post-test changes on males' intended involvement in ANC visits are a good indication that TFH might be a good adjunct to PMTCT programs looking to increase male support for HIV-positive women, thereby increasing compliance with PMTCT protocols.

Support group formation and intended attendance were further successes. This aspect of the program could be a determining factor in long-term, sustained changes. These groups act as accountability groups, specifically continuing the discussion of how to be a better husband, wife and parent. This support group methodology is quite powerful and is critical for sustainability of not only the program, but also the reported attitudes, practices and behavior changes. Given the efficacy of other support group models in public health programming, it will be useful to look further into the impact of TFH support groups on couple relationships, accountability, health and family life.

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Annex

Table 2: Demographics	Intervention Groups	
Average Age of All Participants (years)	34.5	
Average Age Males (years)	37.5	
Average Age Females (years)	31.6	
Average Age Difference Between Spouses (years)	6.9	
Employment status:	Males	Females
Housewife, never employed outside the house	0%	30%
Housewife looking for employment/currently employed outside the house	0%	9%
Farmer	43%	41%
Employed (government or business)	18%	6%
Self-employed	25%	12%
Unemployed	5%	2%
Type of marriage/union:		
Cohabiting	40%	
Church/religious marriage	28%	
Civil/municipality marriage	1%	
Traditional marriage	29%	
Average # of years married or cohabiting	11.8	
Place of residence:		
Urban	9%	
Peri-urban	16%	
Rural	75%	
Highest level of education:	Males	Females
No formal education	11%	20%
Primary	34%	42%
Vocational	11%	4%
Secondary	36%	27%
University	7%	2%
Religion:		
Catholic	68%	
Protestant	19%	
Muslim	6%	
Frequency of religious services/activities:		
Daily	13%	
Weekly	66%	
2-3 times a month	16%	
Monthly	2%	
Has biological children	91%	
Has children from other than current partner	21%	
Caring for other, nonbiological children (OVC)	48%	
Average # OVC	2.9	

Note: Some categories do not sum to 100%, due to exclusion of “other”, “don’t know” and “no response” choices.