Short-term effect of values-based curriculum on couples from Northwest Cameroon: a pilot evaluation

Abstract

Background

As the HIV epidemic continues to expand in sub-Saharan Africa, there is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address the context within which most infections of HIV occur: couple relationships. Even though a large share of new infections in many African countries occurs within marriages, there are relatively few prevention programs specifically focusing on the couple as a unit of behavior change. The Faithful House (TFH) is an HIV-prevention curriculum uniquely centered on the couple and focused on faithfulness within the relationship/marriage. A pilot evaluation of the three-day version of the workshop was conducted in Northwest Cameroon with couples actively involved in faith-based, peer-mentoring programs in order to determine short- and long-term effect on perceptions, attitudes and behavior change.

Methodology

The evaluation population consisted of couples from the Diocese of Kumbo and the Archdiocese of Bamenda who were actively involved in ongoing family-strengthening activities. Working with the Family Life Offices of these dioceses, a convenience sampling method was used to gather interested couples' names, which were then randomly distributed equally between the intervention and control group. In August-September 2010, the intervention group couples attended a three-day workshop based upon TFH curriculum and completed baseline and post-test surveys on their perceptions, attitudes, beliefs and intended behaviors. The control group completed a baseline survey, which will be used to compare findings in the seven-month follow-up survey administered to both control and intervention groups. Focus group discussions (FGDs) occurred after the workshops with a representative group from both regions. All survey data was entered into a Microsoft Access database and then cleaned and analyzed using Excel, comparing matched baseline and post-test changes between the intervention groups.

Results

The mean age of the workshop participants (N = 68) was 42.7 years, with men on average 7.6 years older than their female partners. More than 50 percent had either completed secondary school or university. Nearly all (93 percent) were Catholic and actively involved in activities through their church community. Short-term baseline and post-workshop data showed improvement in couples' perceptions on factors affecting relationship satisfaction and the family unit: quality of relationship, couple communication and level of sharing financial information with partner; participants' comfort level in discussing sexual issues with partner and discussing sexual matters with their children; and intentions on joint decision-making about important family matters. Half of both men and women reported unfaithfulness to their partner, and over half the participants in Kumbo have never been tested for HIV. However, significant short-term changes were made in perceptions on ability to remain faithful and attitudes toward HIV couples testing, with the intention to go together for testing in the next three months increasing from 5.4 to 8.6 after the workshop (on a scale from 1-10).

Conclusions

A comparison of baseline to post-test surveys in this pilot evaluation 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. Given the initial findings for family strengthening and increased couple communication, TFH might be a good supplement to premarital counseling programs for youth or to other development programs that require a strong family foundation, such as prevention of mother-to-child transmission (PMTCT) programs. By drawing on faith values as its foundation, TFH curriculum has shown positive steps towards addressing the roots causes of unfaithfulness and culturally related enablers of HIV

transmission within couples. The seven-month follow-up survey will be important for determining long-term effect on attitudes and behavior.

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"—broadly defined as long-term, overlapping partnerships—was thought to be the key factor 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 or stable unions[5]. Models from Demographic and Health Surveys (DHS) have estimated between 60 to 99.9 percent of new infections among married or cohabiting adults in rural Zambia and Rwanda occurred within serodiscordant marital or cohabiting relationships[6]. This should be an area for focus, particularly for faith-based institutions. Roughly 70 percent of individuals with HIV in Cameroon are in discordant couple relationships[7]. 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 associated risk and role in the current African AIDS epidemic, there is a growing consensus that HIV-prevention research and programming should address couples as a unit of behavior change and intervention[8]. 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[9]. Earlier studies provided preliminary evidence for the feasibility of couples-focused

interventions for HIV—particularly the role of couples-focused voluntary counseling and testing[10,11]. 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 accomplish the task 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 has limited 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. Unique identifiers (IDs) were used on the quantitative surveys in order to keep confidentiality with the data reported. Qualitative research was conducted using FGDs. The qualitative methods focused on topic areas of interest/concern uncovered in the quantitative data analysis, offering a complementary view of the data. Data presented reflects participants' feedback (perceptions, attitudes and intentions) in response to the curriculum.

The evaluation was conducted in the Diocese of Kumbo, which covers two administrative districts (divisions), and the Archdiocese of Bamenda, which covers five districts. Together, these make up the entire Northwest Region of Cameroon, which has the highest HIV prevalence in the country at 8.7 percent, far above the country's prevalence of 5.1 percent[12]. These two dioceses were also chosen because CRS had a strong working relationship with the Family Life Offices in each of the sites, and these dioceses had already demonstrated an interest in family strengthening. Additionally, the ultimate goal was to find sites were TFH could be integrated into ongoing church activities.

Objectives of the Evaluation

This evaluation has been designed to assess the effectiveness of a couples-focused HIV-prevention intervention in improving couple relationship satisfaction and communication, as well as increasing knowledge about HIV risk associated with MCP. Specific objectives in the evaluation include:

1) Assess the impact of this curriculum on couples' communication, quality-of-relationship issues and attitudes and behaviors that contribute to sexual risk behaviors.
2) Assess the impact of this curriculum on family strengthening.
3) Determine the attitudes and behaviors toward the issue of multiple and concurrent partnerships (in order to measure the impact of TFH on changing the acceptance of this behavior).

Evaluation Population Selection

The evaluation population consisted of couples sampled out of communities within parishes in the Diocese of Kumbo and Archdiocese of Bamenda in Cameroon and randomized equally into the intervention or control group. For the couple selection, a three-step process was followed. In the first step, only parishes in these dioceses that had some experience in carrying out family life activities were chosen (in Kumbo, all 22 parishes were eligible; in Bamenda, 10 out of 33 parishes were eligible). Secondly, out of the eligible parishes, a list of 40 couples from each of the dioceses was purposefully prepared by the directors of their respective diocesan Family Life Offices. Ability to understand and hold English conversation was the only eligibility criterion for the couples. Thirdly, the lists were submitted to the CRS Cameroon program manager who randomly assigned the couples into the intervention and control groups using the Excel Random formula. Each of the groups consisted of 20 couples (see Table 1), for a maximum total of 80 couples in the evaluation.

For those participants who were assigned to the intervention groups, a total of two workshops were held in August and September 2010: one in the town of Kumbo and the other in the town of Bamenda, both headquarters of their respective diocese and archdiocese. The workshop was conducted over a three-day period, and all participants stayed the entire length of the workshop.

Training and Data Collection

Enumerators were only used for the control group. In Kumbo and Bamenda, enumerators went through a two-day training to learn how to carry out the baseline survey. The training was done by the Family Life Office directors for Kumbo and Bamenda, with assistance from a CRS program manager and a written training guide. Although enumerators were trained to carry out face-to-face interviews, they were asked to allow respondents to fill in the questions themselves. Enumerators were available to provide explanations for any issues that were unclear. They were also told to administer the questionnaires to couples independently of one another. In total, 18 enumerators were used. All participants in the control group were interviewed at home in their respective parishes and communities. Enumerators visited them at home and handed over questionnaires to them. In most instances, enumerators assisted the respondents in filling out the responses. Couples were interviewed separately. In some cases, especially in Bamenda, the questionnaires were retrieved a day or two after the respondent had completed them. Enumerators could not carry out the interview for both individuals on the same day because of the busy schedules of the respondents.

For the intervention groups, the workshop facilitators acted in the same capacity as the enumerators for the control group. The baseline and post-test were both self-administered by the participants; however, workshop facilitators provided assistance to the participants during the completion of the surveys by explaining or clarifying difficult or unclear instructions and questions. The baseline survey was conducted on the first day of the workshop, and the post-test was conducted at the end of the final day of the workshop.

Analysis

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

Quantitative and Qualitative Findings

Sample Characteristics

A total of 130 individuals were sampled in the pilot. See Table 1 for an exact breakdown of the sample between intervention and control groups.

Table 1: Breakdown Couples/Individuals Analyzed

	BASELINE SURVEY			POST-TEST SURVEY
Target zones	# of individuals in control group	# of individuals in intervention group	Total # of individuals sampled	# of individuals in intervention group
Kumbo	34	38	72	38
Bamenda	28	30	58	31
Total	62	68	130	69

The demographics of evaluation participants (see Annex) in the intervention group are as follows: The mean age of the participants is 42.7 years, with men on average 7.6 years older than their female partner. All couples were married in the church and have been together on average 18.6 years. Roughly 41 percent of participants are living in a rural area, whereas 20 percent and 37 percent live in a peri-urban and urban setting, respectively. The breakdown on highest educational level attained was 22 percent have completed primary, 25 percent have completed secondary and 32 percent have completed university. The majority (93 percent) are Catholic, and most participants report attending religious activities/services weekly. Roughly 18 percent have children from another person other than their current partner, and 58 percent of couples care for orphans or vulnerable children (OVC).

Preliminary findings are presented below in themes that group indicators for The Faithful House program targets for perception, attitude and intended behavior change. At this point in the evaluation, the findings focus primarily on the baseline and post-test findings of the intervention group, with additional qualitative results presented throughout. The more significant and conclusive comparisons

will be made in the final report, where the baseline and seven-month follow-up collections will be presented for both the control and intervention groups. The reported results presented in this section are mostly perceptions and determinants of behaviors, not actual behaviors of the participants; these perceptions and determinants either affect the particular attitudes and behaviors or address barriers to behavior change. All results are self-reported and are not verified through other sources. It is important to note that all changes reported are immediately post-intervention; long-term, sustained effects can only be concluded after the seven-month follow-up collection. Also, the denominator in the percentages reported in the following section are not taken from the total number of participants sampled, but rather the total number of participants who responded to a given 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; 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). Perceived changes on attitudes, beliefs and behaviors were measured at the post-test following the workshop (Table 2).

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	7.1	9.2
Quality of communication	7.7	9.4
Level of respect received from partner	7.7	9.1
Level of sharing of personal income and financial assets	7.2	9.1
Level of adequate knowledge, values and skills to be faithful to partner	8.0	9.3
Ability to have an open and frank discussion with partner about sex	7.9	9.0
% of participants who:		
Will confide in partner for personal problems	76%	90%
Believe a man can be faithful to one partner his entire lifetime	85%	97%
Believe a woman can be faithful to one partner her entire lifetime	87%	96%

In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities, and this struggle was also evident in their own relationships from the survey responses. On the baseline survey, 28 percent of participants reported having been unfaithful to their current spouse/partner in the past; men and women had quite different reports (Table 3).

However, through the use of a secret ballot held at each workshop, 50 percent of workshop participants reported having been unfaithful to their current partner in the past. Also, on the post-test, 64 percent reported experiencing barriers to faithfulness before coming to the workshop. As seen in Table 2, however, perceived ability to be faithful improved from 8.0 to 9.3 (on scale from 1-10) after the workshop. Additionally, participants reported an increase of confidence in their own ability to maintain a happy and strong union with their partners. At baseline, the confidence levels (on a scale from 1-10) were 8.4 and at post-test, 9.5.

Table 3: Gender Differences Between Partner Reporting Ever Having Been Unfaithful to Current Partner (Survey)

Sex	Kumbo	Bamenda
Male	53%	31%
Female	0%	29%

Two key objectives of TFH curriculum are providing strategies for strengthening the bond between couples and breaking barriers to faithfulness. When exploring reasons for unfaithfulness in the FGDs, lack of love, poor communication between partners and sexual dissatisfaction were all themes that emerged throughout both the men's and women's discussions. Many couples felt that men and women in Cameroon do not marry for love, creating a foundational problem that is exacerbated later in the marriage and leads to unhappiness in the relationship and infidelity. As far as sexual satisfaction, on the baseline survey the level for men was 7.7 and for women, 7.3 (on a scale from 1-10, with 10 being *very satisfied*). The couples expressed two main cultural barriers to sexual satisfaction: 1) women are not supposed to speak openly about sex with men, particularly in regard to their own desires; and 2) the cultural belief that having sex during pregnancy and breastfeeding hurts the baby and spoils the milk. Pressure from family members—about marriage, taking a second wife, children and so forth—was another common theme.

Factors That Affect the Family Unit

Family strengthening is an important desired outcome of TFH program, as the curriculum addresses issues that act as stressors both on the couple and the children. One of those stressors is the social and gender norms in the country context (e.g., 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 when preparing for marriage. Parents are encouraged to talk to their children about these issues, and the curriculum attempts to arm the couples with the accurate knowledge and skills to have these discussions. Factors affecting the family unit measured in the quantitative surveys include equality in marriage (gender roles), decision-making power in family matters, views and practices regarding children and youth, violence in the home and drug/alcohol use among participants. Table 4 shows initial attitude and perception changes between the baseline survey and immediately after the workshops. All "equality in marriage" indicators exhibited significant changes from baseline to post-test. Additionally, the two indicators regarding discussing sex with age-appropriate children was a significant preliminary finding.

Table 4: Indicators That Affect the Family Unit

Indicator	Baseline	Post-Test
% of participants who reported BOTH partners should have:		
Decision-making power in important family matters	79%	92%
% of participants who believe:		
Boys can abstain from sex until marriage	66%	91%
Girls can abstain from sex until marriage	65%	89%
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)	6.3	8.8
Comfort level in discussing sexual matters with daughters (10-18 years old)	7.6	8.7

The participants were also asked questions about views on cultural and gender norms that increase or fuel HIV risk and deteriorate the family unit, such as intimate partner violence[13]. The quantitative survey consisted of 18 questions about types and frequency of physical abuse or threats of physical violence in the household. These inquired-about acts of violence and/or threats of violence included: insulting; swearing; threatening to hurt you (participant or partner); pushing, shoving, shaking, throwing something at you; slapping you or twisting arm; hitting you with fist or something else; threatening you with a knife or other weapon; kicking or choking you; forcing sex. Sixty percent of participants reported violence or threats of violence in their household. On average, 21 percent of participants (N = 14) reported being victims of physical violence, with women accounting for 10 out of the 14 reports. Additionally, 22 percent (N = 15) reported being perpetrators of physical violence, and in Kumbo, 7 out of the 10 reports were women, while in Bamenda, 4 out of the 5 reports were men. Acceptance of intimate partner violence was a topic for the pre-baseline survey FGD. Interestingly, both men and women reported violence not to be common in most communities, which is quite contradictory to their own reports in the survey. In those cases where the participants knew intimate partner violence was occurring, alcohol or drunkenness was cited as the key factor.

Perceptions and Attitudes on HIV Testing and Risk

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 nearly half the new infections are occurring within marriage, three take-home points within the TFH curriculum are testing, knowing your HIV status and sharing those results with your spouse/partner. More than half of participants (53 percent) in Kumbo reported having never been tested for HIV, and this was split relatively evenly between men and women. In Bamenda, however, which was reportedly more urban, 97 percent said they had been tested for HIV. Of those tested in both areas, 97 percent reported sharing their test results with their current partner. Often times, discordancy in couples breaks up the marriage or relationships. Roughly 96 percent of participants reported wanting to be tested for HIV at baseline. In the FGD, barriers to couples testing were discussed. A common belief among men and women was that a positive HIV test signifies unfaithfulness; therefore, a couple might be fearful about going together for HIV testing. When asked the likelihood that couples would go together for HIV testing in the next three months (on a scale from *1 = definitely no* to *10 = definitely yes*), the ratings increased from 5.6 at baseline to 8.4 at post-test.

Self-confidence and willingness to share information on the HIV risk associated with MCP both increased after TFH workshop. For example, the sharing frequency response, "at least once a week" increased from an average of 30 percent to 51 percent in all groups for both topics.

Discussion

Review of preliminary findings in this pilot evaluation resulted in many lessons for future evaluations (see Limitations section). The evaluation was also important for understanding baseline knowledge, perceptions, attitudes and behaviors in couples around the factors that affect couple relationships and the family unit. It also shed light on couples' views of HIV testing. If model couples in Cameroon struggle with unfaithfulness in their relationships, it is plausible that the issue has a much larger scope. The changes from baseline to post-test indicate that attendance to TFH workshop has a short-term effect on perceptions, attitudes and intended behaviors linked to those barriers identified by couples that lead to unfaithfulness in relationships. Overall, increases from before and after the workshop were observed for quality of relationship, quality of communication and level of respect received from and shown to partner. Specific communication skills also increased, with participants reporting an intended change in level of sharing financial information with partner, increased ability to have an open and frank discussion with partner about sexual matters, and improved comfort level in discussing sexual matters with children 10-18 years. According to workshop facilitators and participants, couples' communication was the number one component affected by TFH attendance. Whereas FGDs reported a low frequency of violence, one-fifth of participants still reported being victims of physical violence by their partner.

Significant short-term changes in perceptions and attitudes toward HIV testing, specifically the importance of couples testing, was seen from baseline to post-test. Considering the widening HIV epidemic in the country, the findings around multiple partners, unfaithfulness and HIV testing indicate a real need for improvements in the area of couples HIV testing, 50 percent of both men and women reporting unfaithfulness to their partner and over half the participants in Kumbo never having been tested for HIV. The six-month follow-up survey will be critical for determining whether TFH has any long-term effects on all of the indicators measured.

Limitations

This evaluation cannot be extrapolated to the broader Cameroonian population for multiple reasons: The two study areas are in an Anglophone region of the Northwest, which is known to be culturally different than the Francophone regions. The Northwest region is known for practicing "wife inheritance" and having "jumbas" (concubines), which is uncommon in other regions. In 2004, DHS results suggest a higher HIV prevalence, which is likely influenced by these regional socio-cultural/traditional practices affecting marriage and relationships.

Also, 32 percent of participants had attained some university-level education, all participants were from the parish community (Catholic) and nearly all couples were considered "model" couples, with most being peer counselors or in community leadership roles. These two dioceses had significant pre-existing family and marriage strengthening activities. These characteristics likely had an impact on the high

baseline ratings associated with perceived relationship satisfaction, equality and communication indicators.

As the pilot was conducted through the Family Life Offices, couples were hand-picked for participation in the evaluation and TFH workshops. Although the initial list of couples was randomly divided into control and intervention groups, the final demographics of the two groups were statistically different in age and years of marriage. For couples to attend the workshop, both partners had to be available all three days of training, resulting in the younger, working-age individuals dropping out of the intervention group, and the older, predominantly retired individuals joining.

Due to time constraints, there was limited time to conduct multiple rounds of field testing and revising of the pre- and post-test. This was reflected in certain "confusing" questions on both surveys. This was compounded by the self-administration of the surveys. There were many questions misinterpreted or left blank. Also, skip patterns and directions within questions were not always followed properly. Thus, results include possible inaccuracies related to such errors.

Within the control group, in those households where the surveys were not picked up from the couples until one day later, there is a possibility that answers did not remain confidential between partners, and thus, a reporting bias could be present. For example, the wife might not want to answer all questions honestly for fear her husband would go through her survey before it was retrieved by the enumerator.

Conclusions

According to TFH-graduated couples, the workshop provides a safe platform for discussion with other couples as well as conversation between partners about sensitive relationship issues. For instance, one participant said, "If I knew then what I know now, my marriage would have been different." These peer exchanges and "couple time" help address some of the root causes of unfaithfulness in marriages, a risk factor for spreading HIV. Another participant stated, "The workshop made spouses to communicate and talk more freely and released the fear of going for the HIV test."

Many participants also expressed a need for the youth and young adult population to hear these TFH messages, as a way of changing the cultural trends around marriage and laying a solid foundation for marriage. As most of these couples were integrally part of a faith community, TFH was suggested as a supplement to current premarital programs, which were seen as ineffective in addressing barriers to healthy marriages. Additionally, given these initial findings in strengthening the family unit, TFH might be a good add-on to other development programs that require a strong family foundation, such as PMTCT programs. Overall, by drawing on faith values as its foundation, TFH curriculum has shown short-term, positive steps towards the culturally related enablers of HIV transmission within couples. The six-month follow-up survey will

> "*The workshop was an eye-opener. We were living in ignorance and the workshop opened our minds to see the problems and now we can assess the relationship. The foundation of the house is cracked and you're living there comfortably and until you know that those cracks can make the house fall or how to correct it, you just continue living."*

be important for determining long-term impact on attitudes and behavior.

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Annex

Table 2: Demographics	Intervention Groups
Average Age of All Participants (years)	42.7
Average Age Males (years)	45.8
Average Age Females (years)	39.7
Average Age Difference Between Spouses (years)	7.6
Employment status:	
Housewife, never employed outside the house	7%
Housewife, looking for employment/currently employed outside the house	10%
Farmer	9%
Employed (government or business)	37%
Self-employed	14%
Type of marriage/union:	
Church/religious marriage	99%
Average # of years married	18.6
Place of residence:	
Urban	37%
Peri-urban	20%
Rural	41%
Highest level of education:	
Primary	22%
Vocational	11%
Secondary	25%
University	32%
Religion:	
Catholic	93%
Protestant	2%
Traditional	4%
Frequency of religious services/activities:	
Daily	26%
Weekly	62%
2-3 times a month	5%
Has biological children	91%
Has children from other than current partner	18%
Caring for other, nonbiological children (OVC)	62%

Note: Some categories do not add to 100%. “Other”, “don’t know” and “no response” options were excluded from the table.