CRS
CATHOLIC RELIEF SERVICES

Effects of faithfulness-focused curriculum on couples from three regions in Uganda

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

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ABSTRACT

Background

Even though a large share of new HIV infections in many African countries occurs within marriages, there are relatively few prevention programs specifically focusing on the couple as a unit of behavior change. An evaluation was conducted on The Faithful House (TFH) program, which involves a faithfulness-focused HIV prevention curriculum implemented through workshops centered on the couple, to determine its short-term and more sustained benefits for established couples in Uganda.

Methodology

The evaluation population consisted of couples from the Central, Western, and Northern Regions of Uganda, identified from the catchment areas of 12 community-level clinics. A convenience sampling method was used to allow couples to self-identify, and the list of names was then randomly and equally distributed between the intervention and control groups. In January–February 2011, the couples participated in focus group discussions, attended a three-day workshop based upon TFH curriculum, and completed baseline and post-test surveys on their attitudes, beliefs, and intended behaviors. A follow-up survey was conducted for control and intervention groups six months after baseline, as well as a final focus group discussion. Statistical analysis was conducted, using Excel and Stata, to compare baseline and six-month follow-up changes between the control and intervention groups.

Results

Surveys from a total of 599 individuals from the control and intervention groups were used in this evaluation. On average, men were older than women (average 38.8 vs. 31.9 years). Thirty-eight percent of couples were nonmarried cohabiting; 33% were married by religious institution, and 26% were married traditionally. Seventy-four percent of couples resided in rural areas. Statistically significant positive changes from baseline to six-month follow-up among the intervention group were observed for many factors that affect the couple's relationship and the family unit, particularly in the area of communication. Intervention group couples showed a larger increase in HIV testing compared to control group participants as well as a higher partner disclosure rate; control group participants did not show these same positive changes over the same period. Overall, perceptions and attitudes about behaviors that contribute to HIV risk within couple relationships were positively changed to a greater extent among the workshop participants compared to control group participants.

Conclusions and Recommendations

The changes observed from baseline to six-month follow-up among TFH workshop participants indicate that couples receiving the intervention retain

attitudes and perceptions on behaviors that reduce HIV risk among couples. Continued tracking of these couples to determine long-term impact is warranted. In particular, given the positive changes observed in strengthening couple communication and building conflict resolution skills, TFH is recommended as an HIV prevention couples intervention as well as a strong add-on component to gender development programs and programs aiming to increase male involvement in family well-being. THF curriculum should be used for married couples aged 18–44 years, and adapted for a pre-marital context to reach unmarried or soon-to-be married young adults.

PROJECT BACKGROUND

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. Critical epidemiological trends highlighted in recent national studies in Uganda and Kenya indicate that half of new HIV infections are occurring within marriages or stable unions[1]. While "concurrency," which is broadly defined as long-term, overlapping sexual partnerships, has been thought to be the key factor in contributing to the Africa region's HIV epidemic, the relationship between concurrency and the epidemiology of HIV is unclear. However, it is abundantly clear that "going outside" the relationship or marriage or, in other words, not being faithful or monogamous with your current partner, still remains a key area of concentration for HIV prevention programming. According to data from nationally representative surveys conducted during 2004–2006 in Cameroon, Rwanda, Uganda, and Zimbabwe (which included HIV testing of adult men and women), "Having fewer lifetime sexual partners and being faithful to spousal partner(s) are strongly associated with reduced risk of HIV infection. Thus, HIV prevention programs should focus more on promoting partner reduction and partner faithfulness, especially for men"[2]. Furthermore, these programs and subsequent research should address couples as a unit of behavior change and intervention[3].

This evaluation of The Faithful House (TFH) program by CRS aims to build on the theoretical and methodological foundation for couples-centered, faithfulness-focused HIV prevention. The Faithful House (TFH) curriculum was created collaboratively by CRS and Maternal Life International/Uganda, and includes skills building, positive peer mentoring, and creation of a safe environment for couple dialogue around quality-of-relationship issues and the attitudes and behaviors that contribute to sexual risk behavior. Over the course of TFH program implementation, pre- and post-workshop surveys have demonstrated improvements in communication between partners in areas such as finance, gender roles, power imbalances, sexual intimacy, parenting, and communication with children around

sex-related issues. However, longer term impact of the program has not been documented to date, and with the absence of a control population, rigorous conclusions cannot be made. CRS developed this ongoing evaluation of TFH program with the aim of bridging that evidence gap.

METHODOLOGY

Quantitative data methods were used to assess the effectiveness of TFH curriculum on the short-term perceptions, behavioral attitudes, and intended practices related to couple relationship satisfaction, partner communication, and HIV risk. Qualitative research, in the form of focus group discussions (FGDs) focused 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 of Uganda (Central, Western, and Northern) where CRS Uganda works with local partner organizations to conduct its AIDSRelief HIV Treatment and Care program, which is funded by the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). Twelve local partner treatment facilities (LPTFs) were identified as sites for the evaluation. A convenience sampling method was used to gather interested couples' names from the catchment areas of each LPTF: this couple list was then randomly and equally distributed 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 intervention group attended TFH workshop, and the control group was surveyed at baseline and the six-month follow-up period. The control group continued participation in ongoing activities available to couples and individuals who frequented the clinic. They will be offered attendance to TFH workshop after the conclusion of the six-month evaluation process.

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 communication, relationship satisfaction, and knowledge on HIV risk associated with concurrent partnerships. Specific objectives in the evaluation include:

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

Training, Data Collection, and Analysis

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.

Each participant was assigned a unique identifier (ID) to keep confidentiality with the data reported and pair couples' responses. Baseline survey data collection for workshop participants occurred the day before the workshop was to begin, at the workshop site. The corresponding control group was interviewed on 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 is routine with TFH workshops held in Uganda, voluntary HIV couples testing was offered after the workshop ended on the last day. For the six-month data collection, the intervention group was summoned to a central location and surveyed; the following day, the control group congregated at the same location for their follow-up survey. Individuals who did not have both a baseline and six-month follow-up survey were excluded from the data set for analysis (N = 260 individuals).

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

FINDINGS

Sample Characteristics

A total of 599 participants from the control and intervention groups completed both a baseline and six-month follow-up survey, and therefore were the participants used for the analysis below (see Table 1).

Table 1: Breakdown of Individuals Sampled

TARGET ZONES	INDIVIDUALS IN CONTROL GROUP (#)	INDIVIDUALS IN INTERVENTION GROUP (#)	TOTAL INDIVIDUALS SAMPLED (#)
Central	104	114	218
Western	108	102	210
Northern	95	76	171
Total	**307**	**292**	**599**

Control and intervention groups were comparable on all demographic characteristics. Summary demographics were as follows: On average, men were older than women (average 38.8 vs. 31.9 years). Thirty-eight percent of couples were cohabiting; 33%

were married by religious institution, and 26% were married traditionally. Sixty-five percent reported to be Catholic, 24% Protestant, 5% Muslim, and 6% Traditional or other religion. Males were more educated than the females on average, with 37% and 28% reporting attainment of secondary level education, respectively.

Table 2: Demographics

	CONTROL GROUP		INTERVENTION GROUP	
Average age of all participants (years)	35.8		35.0	
Average age males (years)	39.5		38.1	
Average age females (years)	32.0		31.8	
Employment status:	**M**	**F**	**M**	**F**
Housewife, never employed outside the house	0%	24%	0%	25%
Housewife looking for employment/currently employed outside the house	0%	7%	0%	9%
Farmer	50%	44%	44%	45%
Employed (government or business)	16%	12%	20%	7%
Self-employed	23%	11%	22%	11%
Unemployed	4%	3%	6%	2%
Average # of years married	11.9		11.9	
Place of residence:				
Urban	11%		11%	
Peri-urban	8%		19%	
Rural	78%		70%	
Highest level of education:	**M**	**F**	**M**	**M**
No formal education	7%	17%	11%	18%
Primary	39%	43%	35%	45%
Vocational	12%	7%	10%	4%
Secondary	38%	29%	35%	27%
University and others	4%	2%	10%	7%
Has biological children from other than current partner	21%		22%	
Caring for orphans and other vulnerable children (OVC)	50%		48%	
Average # OVC	2.5		2.4	

Note: Some categories do total 100%, due to exclusion of “other,” “don’t know,” and “no response” choices; OVC, orphans and other vulnerable children

The results presented in this section primarily capture perceptions and determinants of behaviors, not actual behaviors of the participants; they either affect the targeted 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 who responded to each question (including "don't know" and "no response").

Enhancing the Quality of the Couple Relationship

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

Table 3: Factors that Affect the Couple Relationship

	CONTROL GROUP			INTERVENTION GROUP		
Indicator	**Baseline**	**6-Month**	**◊**	**Baseline**	**6-Month**	**◊**
Participants were asked to rate the following variables:						
Quality of relationship ◊	7.5**	6.8	-.7	7.8**	8.4	+.6
Quality of communication ◊	7.5**	6.7	-.8	7.6**	8.4	+.8
Level of respect received from partner ◊	7.6**	7.0	-.6	7.9**	8.5	+.6
Level of sharing of personal income and financial assets ◊	6.7**	7.2	+.5	6.9**	8.4	+1.3
Level of adequate knowledge, values, skills to be faithful to partner ◊	7.7	7.1	-.6	7.7**	8.7	+1.0
Ability to have an open and frank discussion with partner about sex ◊	7.7	7.3	-.4	7.7**	8.6	+.9
Level of sexual satisfaction ◊	7.5	7.0	-.5	7.8**	8.3	+.5
% of participants that:						
Will confide in partner for personal problems	55%	57%	+2	54%	62%	+8
Believe a man can be faithful to one partner his entire lifetime	70%**	58%	-28	74%	71%	-3
Believe a woman can be faithful to one partner her entire lifetime	83%*	74%	-9	84%	86%	+2

* = statistically significant change from baseline to 6-month follow-up ($p<0.05$)
** = statistically significant change from baseline to 6-month follow-up ($p<0.01$)
◊ = On a 10-point scale (with 1 the lowest and 10 the highest)

What changed the most within your relationship because of your attendance at TFH workshop?

"My husband's secretive behavior has changed. He no longer hides from me when answering his phone calls. He used to be secretive and never wanted me to touch his phone but now that has changed."
— Female FGD participant

"Before the workshop, we were separated, now we live together. Our children were under the care of my grandparents but now we take care of our children and my husband is more responsible."
— Female FGD participant

"I am a nurse. He never wanted me to work away from home but now he is okay with it and he has allowed me to work again."
— Female FGD participant

"Open discussion about love and trust and I have stopped being unfaithful to my wife." **— Male FGD participant**

In the last 6 months, what have you done differently in your relationship with your partner because of the messages you learned at TFH workshop?

"I have been faithful to my husband." **— Female FGD participant**

"I was a dictator and controller, now we plan and make decisions together." **— Male FGD participant**

"My parent's opinions and decisions were more important, and I always disregarded my marital family's opinions and needs. Now my spouse comes first." **— Male FGD participant**

In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities; survey responses revealed that this struggle was also present 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 women: 26% compared to 7%, respectively. However, through a secret ballot held at each workshop, 65% of workshop participants (intervention group) reported having ever been unfaithful to their current partner in the past. Table 4 shows the breakdown of the results when participants were asked about unfaithfulness in the past six months.

Table 4: Unfaithfulness to Current Partner in the Past Six Months

	CONTROL GROUP		INTERVENTION GROUP	
	MEN N = 155	WOMEN N = 152	MEN N = 144	WOMEN N = 148
Baseline*	6%	5%	10%	1%
6-month follow-up	5%	5%	1%	2%

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 faithfulness, lack of love, poor communication, and sexual dissatisfaction emerged throughout the men's, women's, and facilitator/staff's discussions. Note that poverty was mentioned as a reason that women are unfaithful, but it was not applied to men. For men's unfaithfulness, both women and men cited 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. Two factors that underlie these barriers arose from the FGDs: gender norms and age at marriage. According to the FGDs, early marriage among women is still common in Uganda, and this exacerbates the pre-existing inequality within relationships derived from traditional gender norms. For workshop participants, confidence in ability to maintain a happy and strong union with their partners statistically increased ($p<0.001$) from baseline to the six-month follow-up collection: 8.3 to 9.0 (on a scale from 1–10). Control group participants reported a statistical decrease ($p<0.001$) in their confidence level, with an average score of 8.0 at baseline and 7.5 at the six-month follow-up.

See Annex A and B for further analysis of findings by age and marriage type.

Strengthening the Family Unit

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

Table 5: Factors that Affect the Family Unit

	CONTROL GROUP			INTERVENTION GROUP		
Indicator	**Baseline**	**6-Month**	**◊**	**Baseline**	**6-Month**	**◊**
% of participants that reported BOTH partners held:						
Responsibility for looking after the children	61%*	70%	+9	64%**	86%	+22
Decision-making power on important family matters	54%	54%	--	62%*	74%	+12
Decision-making power on when to have sex	63%	61%	-2	64%*	76%	+12
Decision-making power on accessing HIV services	70%	68%	-2	71%	77%	+6
% of participants that believe:						
Boys can abstain from sex until marriage	50%**	32%	-18	48%*	41%	-7
Girls can abstain from sex until marriage	49%**	34%	-15	50%	45%	-5
Comfort level in discussing sexual matters:						
With sons (10–18 years old) ◊	6.0	6.6	+.6	5.2**	8.1	+2.9
With daughters (10–18 years old) ◊	6.2*	7.0	+.8	5.4**	8.1	+2.7

** = statistically significant change from baseline to 6-month follow-up (p<0.05)*
*** = statistically significant change from baseline to 6-month follow-up (p<0.001)*
◊ = On a 10-point scale (with 1 the lowest and 10 the highest)

Discussing sex with children was a topic of discussion in the focus groups as well. At baseline, parents felt it was difficult to talk to their children about sex; they were concerned about what information should be shared, when, and how to most appropriately deliver these messages. They reported that while the

"With open communication, there is less conflict in our home."

"With less conflict we now meet each other's sex needs."

—Female FGD participants

responsibility for educating young people about sex is currently seen as the role of schoolteachers, they all felt strongly that, with training and guidance, this specific education should come from parents.

The participants were also asked questions about cultural and gender norms that increase HIV risk and weaken the family unit[4]. Intimate partner violence is still a pervasive social problem in Uganda[5]; thus, the quantitative survey posed a series of 18 questions about types and frequency of abuse 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. Acceptance of violence against women and men was then discussed in the focus groups. 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) those where the man has recently "come into money," and 2) working class households where 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. Note that all men in the pre-workshop and final FGDs felt that withholding or denying sex as a punishment to the man is considered violence. Table 6 describes the results of reported violence or threats of violence at baseline and six-month follow-up. Reported violence decreased in both groups, but more dramatically in the intervention groups. Sixty-three percent of the participants reporting as victims of physical violence were female. According the final FGD, the workshop was quite effective on helping couples resolve conflict that can lead to violence.

Table 6: Indicators on Partner Violence

	CONTROL GROUP		INTERVENTION GROUP	
	Baseline	6-Month	Baseline	6-Month
% of participants who report violence or threats of violence in their household in the last six months	53%	50%	50%	33%
% participants reporting to be victims of physical violence by their partner in the last six months	23%	18%	23%	14%

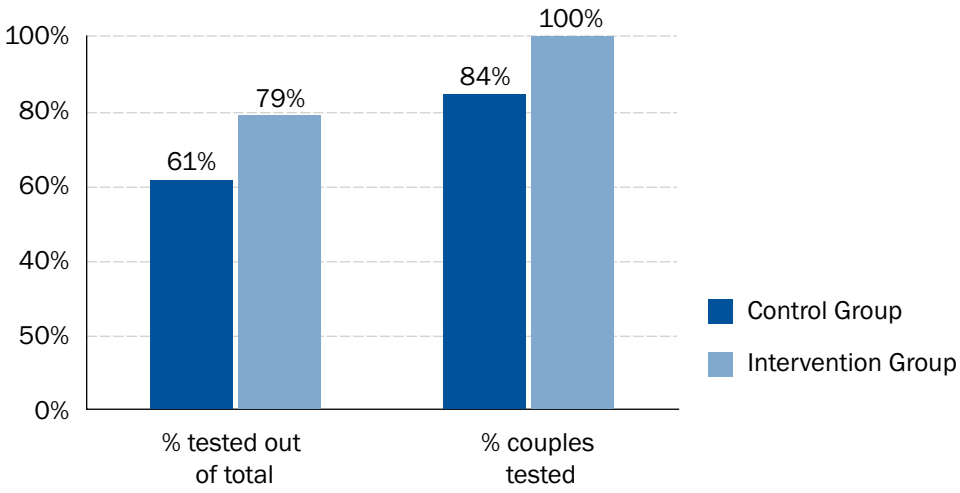
Reducing Risk-Taking, Increasing HIV Testing

Awareness of HIV status is an important aspect of reducing HIV transmission because there is little debate on the reduction of transmission that occurs once HIV-positive persons know their status. Given that half of new HIV infections are occurring within married or cohabiting relationships[5], three take-home points within the TFH curriculum are HIV testing, knowing your status, and sharing those results with your spouse/partner. Ninety-three percent of all evaluation participants reported wanting to be tested for HIV at baseline, with 15% reporting having never been tested for HIV. Women reported statistically ($p<0.001$) higher rates of ever tested than men. Out of the 85% of participants that have ever tested, 26% reported their last HIV test to have been over a year ago, and 66% 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[1]. Ten workshops offered voluntary HIV testing, and 292 workshop participants (79% of those offered testing) followed through with testing after the workshop. Fourteen individuals (4.8% of those tested) were found to be HIV-positive; eight were in discordant relationships. In comparison, only 61% of the control group had been tested for HIV in the past six months by a non-TFH effort, and 84% went as couples for this testing event (see Figure 1).

> *"My husband was willing to take an HIV test after the workshop unlike before. We took an HIV test and we are now living peacefully."*
> **—Female FGD participant**

Figure 1: Accessed HIV Testing



Note: Control group participants were not offered HIV testing from within the TFH evaluation; thus, results presented here from the control group were reported only on the survey and were not verified at the numerous clinic sites where testing could have occurred.

1 Ten workshops conducted HIV testing and two workshops did not offer the test due to political instability around the presidential elections (January–February 2011). When comparing the differences in HIV testing uptake between the control and intervention groups, these conditions should be considered (more workshop participants would have been offered testing).

Additionally, 30% of both control and intervention group participants did not know their partner's HIV status at baseline. At the six-month follow-up survey, 59% of those control group participants still did not know their partner's status, while only 21% of the intervention group did not know the status of their partner.

Male involvement in antenatal care (ANC) and Preventing Mother-to-Child Transmission (PMTCT) was also covered in TFH curriculum. Intended male involvement in ANC/PMTCT services statistically increased from baseline to six-month follow-up among males in both control ($p<0.05$) and intervention ($p=0.01$) groups: 79% (control) and 82% (intervention) originally reported attending ANC/PMTCT visits with their partner or would attend if their partner became pregnant, and this increased to 89% (control) and 91% (intervention) at the six-month follow-up collection.

Questions were asked regarding support group attendance to gauge involvement in any safety net structure. At baseline, 48% of participants in the intervention group were a part of some kind of support group, such as mothers/fathers clubs, HIV support groups, etc. This rose significantly ($p<0.001$) at the six-month follow-up survey, with 65% of intervention group participants reporting that they were attending a support group of some kind. Over this same period, control group participants also exhibited an increase from 55% to 59% in affiliation with a support group, but the change was not significant.

There were also questions regarding attitudes toward concurrency and other cultural practices, as well as to assess overall knowledge and perceived risk of HIV. These questions asked participants to "strongly agree," "agree," "strongly disagree," or "disagree" with specific statements (see Table 7).

Table 7: Statements on Cultural Norms and Views on HIV Risk and Multiple Concurrent Partners

% OF PARTICIPANTS WHO AGREED WITH THE STATEMENTS	CONTROL GROUP		INTERVENTION GROUP	
Statements:	**Baseline**	**6-Month**	**Baseline**	**6-Month**
Woman is justified in refusing sex with partner if she knows he has had sex with someone else.	68%	75%	68%*	80%
A married man having concurrent partners is not harmful as long as he is discrete/provides for family.	23%	20%	24%**	9%
There are exceptional cases where a man should be allowed to have sex with another woman.	28%*	39%	35%	26%
There are exceptional cases where a woman should be allowed to have sex with another man.	11%**	25%	20%	13%
A man should be allowed to produce children with another partner if his wife is infertile.	60%	54%	63%*	48%
A woman should be allowed to produce children with another partner if her husband is infertile.	31%	22%	37%**	20%
Once infected, the chances of a person living with HIV transmitting it to someone else are always the same.	97%	98%	94%*	98%

** = statistically significant change from baseline to 6-month follow-up ($p<0.05$)*
*** = statistically significant change from baseline to 6-month follow-up ($p<0.001$)*

Between baseline and the six-month follow-up survey, couples in both the control and intervention groups reported increases in their frequency of sharing information on how to strengthen the couple relationship and also on the HIV risk associated with multiple concurrent partners (MCP). However, the increases were greater in the intervention group. For example, the frequency response "at least once a month" increased from an average of 30%–38% in the control group and from 32%–47% in the intervention group for sharing information on how to strengthen relationships.

DISCUSSION

The changes from baseline to six-month follow-up survey indicate that attending TFH workshop has provided evidence for retention of attitudes and behavior change. Statistically significant increases from baseline to six-month follow-up among the intervention group were observed for many factors that affect the couple relationship and the family unit, most specifically around communication. While there were decreases in reported violence and threats of violence in the households, continued follow-up on these indicators would be helpful in knowing

Do you feel that your attendance in TFH workshop is still affecting your relationship with your spouse/partner today?

"Yes, my husband has become more responsible and realized the need to take care of his home – he even got a job!"
—Female FGD participant

"One night my wife asked if I notice that she is no longer rude to me and that I no longer ignore her. True, I was planning to look for another partner to comfort me but after the workshop, we talked about our weaknesses and I realized I do not need another partner."
—Male FGD participant

whether attendance to TFH has a sustained impact on the couple's conflict resolution and the associated partner-inflicted violence.

Significant positive changes in perceptions and attitudes toward HIV testing and cultural norms that contribute to HIV risk and MCP were seen from baseline to six-month follow-up among the intervention group but were not observed to the same extent in the control groups. The workshop provided a convenient opportunity for couples testing, and this resulted in high HIV testing for intervention group participants. The control group (not associated with TFH evaluation) also reported individual HIV testing but revealed poor HIV couple testing. On the other hand, the increase in intended male attendance to ANC visits with their pregnant partners was statistically significant for *both* groups and cannot be overstated. What remains unknown is whether these intentions will result in actual behaviors.

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, over the six-month period, couples significantly changed their views on 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.

While the data presented grouped all regions together, an analysis by region revealed the Northern Region as unique compared to the other two regions. Participants there generated much lower scores at baseline on all "equality in marriage" indicators (men in this region were still seen as the primary decision-maker for important family matters) as well as the lowest levels of sexual satisfaction. Higher tolerance of intimate partner violence was also reported. On a positive note, more participants in this region had (ever) tested for HIV and at last test, more couples went together for HIV testing. While 91% of faith communities in the North Region did not require pre-marital HIV testing when these FH couples were married, more couples in the North Region (52%) report getting tested as part of their pre-marital activities (or before cohabiting) in comparison to Central (29%) and Western Regions (38%). At this time, Northern Region participants also reported more regular consumption of alcohol (36% in comparison to 22% for Central Region and 24% for Western Region); 16% still believed that "a man has the right to physically hit his wife" (Central = 3%; Western = 7%); and reported partner violence was still elevated above the other two regions. A greater percentage of individuals from the North Region reported

having disputes with their partner after consuming alcohol. In comparison to the other two regions, more participants in the North also still felt that men have the primary decision-making power for family issues. Sexual satisfaction for this group was similar to the other two regions. Participants from the North Region were younger and had been married fewer years on average, which may account for the differences, but further investigation is warranted, as even the final FGD did not provide insights into these differences.

Evaluation Limitations

The criterion for inclusion into this analysis was that the participant had to have completed both a baseline and six-month follow-up survey. A total of 859 baseline surveys were collected from the control and intervention groups; for the six-month follow-up, a total of 634 surveys were collected. From these, 599 participants had both a baseline and six-month follow-up survey. While this loss of participants at the follow-up collection is anticipated in this setting, there is still potential for bias, as these "loss-to-follow-up" participants could be different than those participants that decided to return for the six-month follow-up survey.

Positive effects were exhibited among some indicators for the control group. This could be evidence of a type of measurement bias called "attention bias," where the survey informs the participants about what indicators the program wishes to improve and thus, the respondent will report improvements accordingly.

Other Considerations

To fit the entire process of pre-test, training, and post-test into 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 2.5 days, and many sections were only superficially discussed.

Note the convenience sampling methodology for the evaluation. All couple participants were self-selecting and only eligible if both partners could attend; thus, the results in this study may not be representative of the total population in Uganda, as the couple participants in this evaluation would be different than those that would not come to a "couples" intervention. This would introduce a voluntary response bias (also known as volunteer or referral bias) into the results, which needs to be taken into consideration when applying these findings to the whole of Uganda.

CONCLUSIONS

From both the quantitative surveys and the FGDs, cultural norms emerge strongly as affecting relationships. These norms provide an enabling environment for gender inequality, harmful traditional practices (such as concurrency and early marriage), intimate partner violence, and secret sexual relationships. 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. Compared to other prevention curricula, a particular strength of TFH that contributes to the noted successes of the intervention is the level of male participation. By drawing on faith values as its foundation, TFH curriculum showed short-term positive steps towards overcoming the culturally related enablers of HIV transmission within couples, and these results were sustained at the six-month follow-up collection. It will be important to continue to track these couples' over the next two years for additional follow-up analysis.

NEXT STEPS, FUTURE DIRECTIONS FOR THE FAITHFUL HOUSE

For future programming, the authors suggest a more tailored focus on couples age 18–44 years. The current TFH curriculum should be adapted into a pre-marital curriculum that **targets younger, unmarried individuals.** This curriculum would focus more on relationship preparation (specifically, how to identify and chose a compatible partner and right mate) and also discuss expectations within marriage (still with a FH foundation). It is also recommended for CRS to work with local faith communities to incorporate TFH into their pre-marital activities, given the low number of couples that report attending pre-marital counseling programs. This pre-marital 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 pre-marital counseling programs. Additionally, the current TFH curriculum should be used for **married couples under the age of 45 years**, where the workshop is implemented as a type of marriage retreat to re-establish and reinforce good marriage qualities/ practices. If CRS is interested in reaching couples 45 years and older, more research will be needed to better tailor the current TFH curriculum for their relationship needs. As seen in Annex A, the 45 years and older age group was least impacted by TFH.

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 PMTCT programs. The initial data presented from baseline to post-test to six-month follow-up changes on male's intended involvement in ANC/PMTCT visits are a good indication that TFH might be a good adjunct to PMTCT programs looking to increase male support for HIV-positive women and thus increase compliance to PMTCT protocols. Additionally, a subset evaluation of the couples that reported a pregnancy would be vital for documentation of TFH's added benefits to these programs. Other integration could occur with OVC programs, given the number of couples caring for nonbiological children. Additionally, based on TFH curriculum's skills building in the area of conflict resolution and increased couple communication, the workshop might also complement gender development programs or other activities aiming to reduce gender-based or intimate partner violence.

Support group formation and intended attendance were further successes related to Uganda's TFH implementation. 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 well-being.

ANNEX A: ANALYSIS OF KEY INDICATORS BY AGE (INTERVENTION GROUP PARTICIPANTS ONLY)

INDICATORS	AGE RANGES (YEARS)											
	18–24 N = 56			25–34 N = 99			35–44 N = 78			45+ N = 59		
	BASELINE N = 56	6-MONTH N = 45	◊	BASELINE N = 99	6-MONTH N = 108	◊	BASELINE N = 78	6-MONTH N = 76	◊	BASELINE N = 59	6-MONTH N = 63	◊
Participants rated the following variables:												
Quality of relationship ◊	8.0	8.7	0.7	7.5	8.4	0.9	7.9	8.2	0.3	7.9	8.4	0.5
Quality of communication ◊	7.6	8.5	0.9	7.5	8.4	0.9	7.4	8.2	0.8	7.9	8.5	0.6
Level of respect received from partner ◊	8.3	8.2	-0.1	7.8	8.7	0.9	7.7	8.2	0.5	8.2	8.7	0.5
Level of sharing of personal income and finances with partner ◊	6.1	8.4	2.3	6.9	8.5	1.6	7.1	8.5	1.4	7.5	8.4	0.9
Level of adequate knowledge, values, and skills to be faithful to partner ◊	7.1	8.6	1.5	7.6	8.9	1.3	7.8	8.6	0.8	8.1	8.7	0.6
Ability to have an open and frank discussion about sexual matters with partner ◊	7.7	8.5	0.8	7.8	8.7	1.0	7.5	8.4	0.9	8.0	8.6	0.6
Level of sexual satisfaction ◊	8.3	8.3	0.0	7.6	8.4	0.8	7.7	8.4	0.7	7.8	8.2	0.4
Confidence level in your ability to maintain a happy and strong union with partner ◊	8.4	8.6	0.3	8.2	9.0	0.8	8.2	8.6	0.4	8.4	8.5	0.1
% of participants that have:												
Ever been unfaithful to current partner	13%	–		17%	–		13%	–		29%	–	
Report being unfaithful to current partner In last 6 months	2%	4%	2%	9%	2%	-7%	4%	1%	-3%	3%	0%	-3%

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

ANNEX B: ANALYSIS BY MARRIAGE TYPE (INTERVENTION GROUP PARTICIPANTS ONLY)

INDICATORS	TYPES OF MARRIAGE								
	COHABITING			RELIGIOUS MARRIAGE			TRADITIONAL MARRIAGE		
	BASELINE N = 107	6-MONTH N = 107	◊	BASELINE N = 105	6-MONTH N = 105	◊	BASELINE N = 73	6-MONTH N = 73	◊
Participants rated the following variables:									
Quality of relationship ◊	7.9	8.4	0.5	7.9	8.4	0.5	7.4	8.2	0.8
Quality of communication ◊	7.6	8.4	0.8	8.0	8.4	0.4	7.2	8.4	1.2
Level of respect received from partner ◊	8.0	8.6	0.6	8.2	8.5	0.4	7.7	8.4	0.8
Level of sharing of personal income and finances with partner ◊	6.8	8.7	1.9	7.2	8.4	1.2	6.8	8.3	1.5
Level of adequate knowledge, values, and skills to be faithful to partner ◊	7.4	8.8	1.4	7.9	8.7	0.8	7.9	8.6	0.7
Ability to have an open and frank discussion about sexual matters with partner ◊	7.8	8.6	0.8	7.8	8.5	0.7	7.7	8.7	1.0
Level of sexual satisfaction ◊	7.8	8.4	0.6	8.0	8.5	0.5	7.6	8.1	0.6
Confidence level in your ability to maintain a happy and strong union with partner ◊	8.4	8.9	0.5	8.3	8.7	0.4	8.3	8.6	0.4
% of participants that have:									
Ever been unfaithful to current partner	22%	–	–	13%	–	–	15%	–	–
Been unfaithful to current partner in last 6 months	7%	3%	-4%	2%	1%	-1%	7%	1%	-6%

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

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