Effects of a values-based curriculum on couples from Northwest Cameroon

CRS CATHOLIC RELIEF SERVICES

THE FAITHFUL HOUSE

ABSTRACT

Background

There is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address couple relationships, the context within which most HIV infections occur. Although a large portion of new HIV infections in many African countries occurs within marriages, relatively few prevention programs focus specifically 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. To determine the short- and long-term effect on perceptions, attitudes, and behavior change, a pilot evaluation of the three-day version of TFH workshop was conducted in Northwest Cameroon with couples actively involved in faith-based, peer-mentoring programs.

Methodology

Evaluation participants consisted of couples that were actively involved in ongoing family strengthening activities in the Diocese of Kumbo and the Archdiocese of Bamenda. Working with the Family Life Office in these dioceses, a convenience sampling method was used to gather the names of interested couples, which were then randomly and equally distributed between intervention and control groups. In September 2010, intervention group couples attended a three-day workshop based on TFH curriculum. They completed baseline and post-test surveys on their perceptions, attitudes, beliefs, and intended behaviors. The control group completed a baseline survey at the same time. A representative group from both regions participated in focus group discussions after the workshops. In April 2011, a seven-month follow-up survey was conducted with both control and intervention groups. All survey data was entered into a Microsoft Access database and then cleaned and analyzed using Excel and Stata to compare matched baseline and seven-month changes between the control and intervention groups.

Results

The mean age of evaluation participants (N = 121 individuals) was 43.7 years. Men were on average older than women (46.9 vs. 40.3 years). All couples were married and had been together for 17.8 years. Over two-thirds of all participants had completed secondary school or attended university. The majority (89%) was Catholic and actively involved in activities through their church community. The following baseline to seven-month follow-up changes in workshop participants' perceptions of factors that affect couple relationship and the family unit improved for quality of relationship; couple communication and level of sharing financial information with partner; participants' comfort level in discussing sexual

issues with partner, including sexual satisfaction; and joint decision-making about important family matters. These positive changes were not observed among control group participants. From baseline to seven-month follow-up, reported unfaithfulness during the previous six months decreased among workshop participants and increased among the control group. However, TFH attendance did not motivate any participants to obtain a first-time HIV test.

Conclusions

The comparison of baseline to seven-month follow-up surveys in this pilot evaluation indicates that attendance at a TFH workshop has a sustained effect on perceptions and attitudes linked to factors that promote unfaithfulness in relationships. Given the initial findings for increased couple communication and family strengthening, TFH might be a good supplement to premarital counseling programs for youth or other development programs that require strong family foundations or desire gender-equitable decision making among couples so as to maximize programmatic outcomes. Even though evaluated groups were not regionally or nationally representative, by drawing on faith values as its foundation, TFH curriculum showed positive steps toward addressing the root causes of unfaithfulness and culturally related enablers of HIV transmission that are common in these and other African couple relationships.

PROJECT BACKGROUND

Summary of the Literature

There is a tremendous need for culturally aware, locally developed, evidence-based programs that acknowledge and address couple relationships, the context within which most HIV infections occur. Critical epidemiological trends, such as those emerging from recent national studies in Uganda and Kenya, indicate that half of new HIV infections occur in married people[1]. For years, the specific notion of "concurrency," which is broadly defined as long-term, overlapping sexual partnerships, was thought to be the key contributing factor to the proportions of the African region's HIV epidemic (50 times higher than the average for countries outside Africa). However, this notion remains controversial. A recent systematic review by Sawers and Stillwaggon concluded that research seeking to establish a statistical correlation between concurrency and HIV prevalence either found no correlation or had important limitations that should dismiss that conclusion[2].

"Going outside" the relationship or marriage (i.e, not being faithful or monogamous with your current partner) remains a key focus of 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"[3]. Furthermore, these programs and subsequent research should address couples as a unit of behavior change and intervention[4].

This evaluation of The Faithful House (TFH) program by Catholic Relief Services (CRS) attempts to build on the theoretical and methodological foundation for couples-centered, faithfulness-focused HIV prevention. Created collaboratively by CRS and Maternal Life International/Uganda, TFH curriculum includes skills building and positive peer mentoring, and provides a safe environment for couple dialogue around quality-of-relationship issues and other attitudes and behaviors that contribute to sexual risk behavior. Over the course of TFH program implementation, pre- and post-workshop surveys have demonstrated improved communication between partners in areas such as finance, gender roles, power imbalance, sexual intimacy, parenting, and communication with children about sex-related issues. However, long-term impact of the program on attitudes and behaviors has not been documented to date, and rigorous conclusions cannot be made in the absence of a control population. CRS responded to these critiques by developing an ongoing evaluation of TFH program.

METHODOLOGY

The evaluation used quantitative data methods to assess the effectiveness of TFH curriculum on short- and long-term perceptions, behavioral attitudes, and intended practices related to couple relationship satisfaction, partner communication, and HIV risk. Unique identifiers in the quantitative surveys maintained data confidentiality. Qualitative research, in the form of focus group discussions (FGDs) for various groups, was also conducted at baseline and after the seven-month follow-up survey. The qualitative methods focused on key topic areas that were uncovered in the quantitative data analysis, offering a complementary view of the data. The data presented here reflect participants' feedback (perceptions, attitudes, and intentions) in response to TFH curriculum.

The evaluation was conducted in the Diocese of Kumbo, which encompasses two administrative districts (divisions), and the Archdiocese of Bamenda, which encompasses five districts. Together, these dioceses comprise Cameroon's entire Northwest Region, which has the highest HIV prevalence in the country (8.7%), far exceeding national prevalence (5.1%)[5]. These two dioceses were also chosen because CRS had a strong working relationship with the Family Life Office at each site, and the dioceses had already demonstrated an interest in family

strengthening. Additionally, the ultimate goal of the evaluation was to identify sites where TFH could be integrated into ongoing church activities.

Objectives of the Evaluation

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

- Assessing the impact of TFH curriculum on the couples communication, quality-of-relationship issues, attitudes, and behaviors that contribute to sexual risk behaviors.

- Assessing the impact of TFH curriculum on family strengthening.

- Determining attitudes and behaviors toward MCP (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 of the Diocese of Kumbo and Archdiocese of Bamenda in Cameroon and randomized equally into an intervention or control group. Couple selection adhered to a three-step process. First, only parishes that had some experience in conducting family life activities were chosen (in Kumbo, all 22 parishes were eligible; in Bamenda, 10 out of 33 parishes were eligible). Second, the directors of the respective diocesan Family Life Office purposefully prepared a list of 40 couples from the eligible parishes. Ability to understand and speak conversational English was the only eligibility criterion for the couples. Third, the directors submitted their lists to the program manager of CRS Cameroon, who used Excel's Rand formula to randomly assign the couples into intervention and control groups. Each group contained a maximum of 20 couples. The evaluation population (i.e., both control and intervention groups) analyzed below included 121 individuals (see Table 1).

Data Collection

Enumerators were used only for the control groups. In Kumbo and Bamenda, enumerators completed a two-day training program to learn how to conduct the baseline survey. The directors of the Family Life Office in Kumbo and Bamenda administered the training program, with assistance from the CRS program manager and a training guide text. Although enumerators were trained to conduct face-to-face interviews, they were told to allow respondents to complete the questionnaires themselves and to remain available to provide explanations for any issues that were unclear. Enumerators were also told to administer the

questionnaires to couples independently of one another. In total, the evaluation used 18 enumerators. All participants in the control group were interviewed at home in their respective parishes and communities. Enumerators distributed the questionnaires during these home visits. 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 interview both individuals on the same day because of the busy schedules of the respondents. Enumerator training for the seven-month follow-up survey required one day, and data collection (self-administration by respondents) was consistent with the methods used in the baseline survey collection.

For participants who were assigned to intervention groups, a total of two workshops were held in 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 for the entire length of the workshop. Workshop facilitators acted in the same capacity as control group enumerators. The baseline survey and post-test were both self-administered by the participants; however, workshop facilitators provided assistance 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.

For collection of the seven-month survey in April 2011, all intervention group couples were interviewed at home; control group couples were contacted and interviewed differently, depending on the region. In Bamenda, all the couples in the control group completed the seven -month survey just prior to training; in Kumbo, they were interviewed at home. The Archdiocese of Bamenda had planned to delay THF training for the control group in April to coincide with administration of the seven -month survey. Although the Diocese of Kumbo had the same plan, delays in starting the second training caused them to change their data collection plan. In both groups, some couples chose to answer the questions themselves and others asked the enumerators to read the questions aloud before providing their responses. Consistent with the baseline survey, most of the questionnaires were self-administered.

Analysis

All data from the Microsoft Access databases were exported and manipulated in Microsoft Excel for initial frequency analyses and to identify unique patterns/ associations. Despite a small sample size, all cleaned data were then entered into Stata, which ran a statistical analysis by comparing baseline scores between

the control and intervention groups, baseline and post-test comparisons for the intervention groups only, baseline and seven -month comparisons between the control and intervention groups, and sex stratifications.

QUANTITATIVE AND QUALITATIVE FINDINGS

Sample Characteristics

The pilot evaluation sampled a total of 121 individuals. Table 1 shows an exact breakdown of the sample between intervention and control groups.

Table 1: Breakdown couples/individuals analyzed

	BASELINE AND 7-MONTH FOLLOW-UP SURVEYS		
	Individuals in Control Group	Individuals in Intervention Group	Individuals in Sample
Kumbo	32	37	69
Bamenda	22	30	52
Total	54	67	121

The demographics of all evaluation participants (see Table 2) are as follows: The mean age of all participants was 43.7 years. On average, men were older than women (46.9 vs. 40.3 years). Couples in the control group had been married for 16.5 years and couples in the intervention group, 19 years. All couples but one were married by a religious institution (church). The majority (89%) was Catholic, and most participants reported attending religious activities/services weekly. Couples from Kumbo lived predominantly in rural areas, and couples from Bamenda lived in more urban areas. The reported rate of unfaithfulness to current partner differed markedly between men and women, and participants from rural areas reported higher rates of unfaithfulness than those from urban areas.

Table 2: Demographics

DEMOGRAPHICS OF EVALUATION PARTICIPANTS	KUMBO				BAMENDA			
	CONTROL N = 32		INTERVENTION N = 37		CONTROL N = 22		INTERVENTION N = 30	
Average age of all participants (years)	42.9		49.5		44.2		37.5	
Average age of males (years)	45.9		53.1		46.8		40.5	
Average age of females (years)	39.9		45.7		41.3		34.3	
Employment status:	M	F	M	F	M	F	M	F
Housewife, never employed outside the house	0%	27%	0%	25%	0%	0%	0%	14%
Housewife, looking for employment/currently employed outside the house	0%	33%	0%	32%	0%	82%	0%	35%
Farmer	13%	13%	26%	19%	20%	9%	7%	0%
Employed (government or business)	40%	13%	42%	6%	40%	0%	67%	36%
Self-employed	20%	7%	21%	19%	30%	9%	20%	0%
Average # of years married	17.3		25.3		15.7		12	
Place of residence:								
Urban	9%		28%		45%		48%	
Peri-urban	25%		17%		9%		24%	
Rural	63%		56%		45%		28%	
Highest level of education:	M	F	M	F	M	F	M	F
Primary	27%	25%	28%	41%	27%	27%	13%	7%
Secondary	33%	63%	28%	29%	18%	9%	13%	36%
Vocational	0%	6%	11%	6%	0%	9%	19%	7%
University and Others	40%	6%	34%	18%	55%	55%	50%	50%
Has biological children	100%		100%		100%		87%	
Has children from other than current partner	6%		17%		24%		22%	
Caring for other, nonbiological children	47%		70%		75%		66%	
Ever been unfaithful to current partner	M	F	M	F	M	F	M	F
	44%	0%	53%	0%	36%	0%	31%	29%

Note: Some categories do not total 100%. "Other", "Don't know", and "No response" options were excluded from the table.

In the control and intervention groups, 86.5% and 91% of couples, respectively, reported participating in other family life activities through their respective dioceses and communities at the time of the seven-month follow-up survey. Activities listed included Marriage Encounter, Christian Family Movement, Couple-to-Couple League, counseling programs, and HIV/AIDS programs. Importantly, 50% of the control group in Bamenda began attending these other family life activities between the baseline survey and follow-up survey, possibly reducing the extent of any observed differences TFH would have made between the intervention and control group in that area. Sixty-six percent of couples in the control groups and 87% of couples in the intervention groups acted as "leaders" for at least one of these program activities. Therefore, the majority of evaluation participants in this pilot evaluation could be considered "model" or "leader" couples in their communities.

Findings between the baseline survey and the seven-month follow-up survey are presented below. Tables 3–5 highlight the most significant differences between the control and intervention groups, summarized around the evaluation's objectives: enhancing the quality of the couple relationship, strengthening the family unit, and reducing risk (around MCP)/increasing uptake of HIV testing. The results presented in this section are mostly perceptions and determinants of behaviors, not actual behaviors of the participants; these perceptions and determinants either affect particular attitudes and behaviors or address barriers to behavior change. All results were self-reported and were not verified through other sources. Also, the denominator in the percentages reported in the following section is not taken from the total number of participants sampled, but rather from the total number of participants that responded to that given question (including "don't know" and "no response").

Enhancing the Quality of the Couple Relationship

The perceptions and attitudes measured by the quantitative surveys and explored in the FGDs center 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 affecting perceived relationship satisfaction and thus, the detrimental (such as unfaithfulness) or risky behaviors that often result.

Table 3: Indicators that Affect Couple Relationship Satisfaction

INDICATOR	CONTROL GROUP		INTERVENTION GROUP	
	BASELINE	7-MONTH	BASELINE	7-MONTH
Participants were asked to rate the following variables:				
Quality of relationship ◊	7.7	7.3	7.1*	8.4
Quality of communication ◊	8.0	7.2	7.6**	8.4
Level of respect received from partner ◊	7.8	7.6	7.7**	8.6
Level of sharing of personal income and financial assets ◊	8.4	7.7	7.2**	8.5
Level of adequate knowledge/values/ skills to be faithful to partner ◊	8.8**	8.1	8.0**	9.0
Ability to have an open and frank discussion with partner about sex ◊	8.4*	7.2	7.9	8.1
Level of sexual satisfaction ◊	7.5	6.9	7.4*	8.3
% of participants who:				
Will confide in partner for personal problems	76%**	53%	77%	83%
Have been unfaithful to their partner in the last 6 months	6%	15%	7%	6%

= statistically significant change from baseline to 7-month follow-up [p < 0.05)
*** = statistically significant change from baseline to 7-month follow-up (p < 0.01)*
◊ = On a 10-point scale (with 1 the lowest and 10 the highest)

Providing strategies for strengthening the bond between couples and breaking barriers to faithfulness are two key objectives of TFH curriculum. When FGDs explored reasons for unfaithfulness, themes including lack of love, poor communication between partners, and sexual dissatisfaction emerged throughout both the men's and women's discussions. In the pre-workshop FGD, the group unanimously felt that unfaithfulness was a problem in their communities, and survey responses showed that this struggle was also evident in their own relationships. A secret ballot held at each workshop revealed that 50% of workshop participants reported being unfaithful to their current partner in the past. Table 3 shows that reported infidelity in the last six months decreased slightly in the intervention group but more than doubled in the control group. However, perceived ability to be faithful improved from 8.0 to 9.0 (on a 10-point

scale) from the baseline survey to the seven-month follow-up survey in the intervention group, but decreased in the control group. Additionally, participants reported improved confidence in their own ability to maintain a happy and strong union with their partners. At baseline, confidence levels in the control group were 9.0 (on a 10-point scale) but decreased significantly to 7.9 at the seven-month follow-up ($p < 0.01$). For the intervention group, confidence levels rose from 8.4 at baseline to 8.8 at the seven-month follow-up.

On the post-test survey, workshop participants rated TFH workshop at 9.5 (on a 10-point scale) for its usefulness and extent to which it inspired couples to change or introduce new ideas into their marriage. Increased comfort, ability, and willingness to share knowledge, experiences, and skills are important aims of TFH program. Twenty percent of control group participants and 30% of intervention group participants increased their frequency of sharing with neighbors and friends over the last seven months on how to strengthen a couple's relationship.

Strengthening the Family Unit

Family strengthening and addressing gender norms is an important desired outcome of TFH program because the curriculum addresses issues that act as stressors between partners and between couples and their children. Those stressors sometimes derive from social and gender norms in the country context. Guided discussions examined gender roles in marriage and whether or not those roles promoted equality. TFH curriculum also discusses issues such as abstinence before marriage, delaying sexual debut, and struggles faced by youth. TFH coaches parents on how to talk to their children about these issues and encourages them to do so. Table 4 shows survey results regarding factors that affect the family unit.

Table 4: Indicators that Affect the Family Unit

% OF PARTICIPANTS WHO:	CONTROL GROUP		INTERVENTION GROUP	
	BASELINE	7-MONTH	BASELINE	7-MONTH
Reported BOTH partners should have decision-making power on important family matters	76%*	54%	79%	87%
Believe boys can abstain from sex until marriage	67%**	37%	69%	65%
Believe girls can abstain from sex until marriage	64%	51%	67%	66%
Discuss/have discussed sexual issues with sons (10–18 years old) in the last seven months	76%**	40%	79%	70%
Discusses/Has discussed sexual issues with daughters (10-18 years old) in the last seven months	92%**	64%	78%	75%

* = statistical change from baseline to 7-month follow-up (p< 0.05)
** = statistical change from baseline to 7-month follow-up (p< 0.01)

The baseline survey asked participants whether they discuss sexual matters with their sons and daughters (10–18 years old). The seven-month follow-up survey asked the participants whether they had actually discussed sexual matters with their children in the last seven months. The difference in reported past behavior at baseline and the percentage of participants who reported actually conducting the behavior at the seven-month follow-up differed markedly between the control and intervention groups (see Table 4). Although the comfort level in discussing sexual issues with children was similar between both control and intervention groups, only workshop participants reported actually holding discussions with their children about sexual matters.

Participants were also questioned about their views on cultural and gender norms that increase or fuel HIV risk and deteriorate the family unit, such as intimate partner violence6. The quantitative survey included 18 questions about different types and frequency of physical abuse or threats of physical violence in the household. Table 5 summarizes the answers. When combining the two interventions groups, the following indicators statistically improved (p<0.05) from baseline survey to seven-month follow-up: swearing (partner), threatening to hurt (respondent and partner), slapping or twisting arm (respondent and partner); and hitting with fist or object (respondent and partner).

Table 5: Indicators of Violence

| | KUMBO | | | | BAMENDA | | | |
| | CONTROL GROUP N = 32 | | INTERVENTION GROUP N = 37 | | CONTROL GROUP N = 22 | | INTERVENTION GROUP N = 30 | |
INDICATORS	BASELINE	7-MONTH	BASELINE	7-MONTH	BASELINE	7-MONTH	BASELINE	7-MONTH
Experienced violence or threats of violence from their partner (%)	59.4 N = 19	53.1 N = 17	59.5 N = 22	48.6 N = 18	45.5 N = 10	72.7 N = 16	60% N = 18	26.7 N = 8
Victims of physical violence (%)	9.4 N = 3	15.6 N = 5	24.3 N = 9	8.1 N = 3	9.1 N = 2	18.2 N = 4	16.7 N = 5	10 N = 3

Acceptance of intimate partner violence was a topic in the pre-baseline survey FGD. Most of the violence reported involved verbal threats, with fewer reports of physical violence (see Table 5). This data supports FGDs in which both men and women reported that physical violence is uncommon in most communities. When participants knew that intimate partner violence had occurred, most cited alcohol or drunkenness as a key factor. In our sample, 68% of the control group and 77% of the intervention group reported at baseline that they drank alcohol casually (during social events only). At the seven-month follow-up, this increased to 75% and 80%, respectively. Further investigation is warranted. However, over this same period, reported regular consumption of alcohol decreased among both the control (from 17% to 10%) and intervention (from 13% to 3%).

Reducing Risk-taking, Increasing HIV Testing Uptake

Awareness of HIV status is an important aspect of reducing HIV transmission, and there is little debate on the reduction of risk behavior that occurs once HIV-positive persons know their status. Given that nearly half of new HIV infections in Africa occur within marriage, TFH curriculum emphasizes three take-home points: testing, knowing your HIV status, and sharing those results with your partner. Roughly 96% of participants reported wanting to be tested for HIV at baseline. Often times, discordance over testing disrupts couple relationships and thus, deters testing. FGDs discussed barriers to couples testing. Because both men and women view a positive HIV test as signifying unfaithfulness, they fear going for testing together. When asked about the likelihood that couples would go together for HIV testing in the next three months, the ratings among workshop participants increased from 5.6 (on a 10-point scale) at baseline to 8.4 at post-test. In Kumbo, 49% of workshop participants and 15% of control group participants reported at baseline that they had never been tested for HIV and that status remained unchanged. In Bamenda, which is reportedly more urban

than Kumbo, 82% and 93% of participants in the control and intervention groups, respectively, said they had been tested for HIV since the baseline survey. In the control group, the three participants (all women) who reported at baseline that they had never been tested, all went for testing before the seven-month follow-up survey. Neither of the two participants (both men) in the intervention group who reported no earlier testing at baseline went for testing before the seven-month follow-up survey.

Additionally, the evaluation showed that discussing risky behaviors and modes of HIV transmission in social networks can lessen the stigma associated with couples HIV testing and increase the likelihood of discussion about HIV. In the the control and intervention groups, 24.5% and 30% of participants, respectively, increased their frequency of talking about MCP-associated HIV risk with neighbors and friends over the last seven months. In both groups, the majority of participants who increased their sharing frequency were women.

DISCUSSION

The changes from baseline survey to seven-month follow-up reported here indicate that TFH workshop attendance has a sustained effect on perceptions, attitudes, and intended behaviors linked to barriers that lead to unfaithfulness in relationships. Overall, participants reported improved quality of relationship and communication as well as increased respect between partners from baseline to seven-month follow-up. Specific communication skills also increased, and participants reported an intentional change in their level of sharing financial information with partner, increased ability to have an open and frank discussion with partner about sexual matters, and increased ability to have discussions about sexual matters with children (age 10–18 years). Workshop facilitators and participants reported couple communication as the top component affected by TFH attendance. Level of sexual satisfaction increased among workshop participants over the seven-month period, and reported unfaithfulness decreased. The evaluation found none of these positive changes in the control groups. Additionally, the percentage of control group participants who reported acts and/or threats of violence increased from 52% at baseline to 63% at the seven-month follow-up. However, the percentage of intervention group participants reporting violence decreased from 61% to 36% at the same data collection points.

When studying the effects of reducing gender inequities among couples, TFH participants shifted toward supporting more gender-equitable attitudes toward household decision making. TFH seems to improve communication between partners around financial sharing and income and expenditures, and it seems to

"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."

change attitudes on the importance of equal decision-making roles for important family matters, including financial issues and use of resources. This is important because women's ability to respond to changes in their bargaining position regarding total household resources may have important consequences in cases of marriage breakdown or abandonment7. Additionally, research continues to build on the benefits of women who control household finances. Children appear to benefit more when their mothers, rather than their fathers, are responsible for the financial management of household resources, both in terms of health outcomes and levels of child development8. Thus, TFH could be a useful supplement to economic strengthening programs as well as food/nutrition security programs that seek to improve the use of resources for better food and nutrition choices for the family.

Unfortunately, although workshop participants reported high confidence levels in their intention to get tested for HIV after the workshop, participants who had never been tested before did not go for HIV testing between the baseline survey and seven-month follow-up. In Kumbo, which is more rural, roughly 50% of the intervention group had not been tested at the follow-up survey. Although control group participants in Bamenda went for HIV testing, this may have been due to participation in one of many other family life activities (including HIV/AIDS programs). In the intervention groups, only participants who had previously been tested for HIV (before TFH attendance) reported going for an HIV test between the two data collection points. However, among previously tested participants, 39% in the control group were retested during the seven-month study period compared with 44% in the intervention group (both groups were 54% women). In a developing HIV epidemic in Cameroon, findings around multiple partners, unfaithfulness, and HIV testing indicate a real need for improved couples testing for HIV. However, this effect, as well as those mentioned above, might be much different among a more representative couple population from the Northwest Region of Cameroon.

Future iterations of this evaluation should continue to track the high percentage of individuals reporting casual consumption of alcohol. Recent studies showed that people who drink alcohol are more likely to engage in unprotected sex, multiple partnering, and commercial sex than nondrinkers9,10. More specifically, multiple studies have shown that drinking alcohol before sex or intoxication during sex links directly with HIV.

As shown in Table 2 , couples in the Bamenda intervention group were 12 years younger than those in the Kumbo intervention group and more than six years younger than couples in the Bamenda control group. In direct connection, couples in the Bamenda intervention group had also been married half as

many years as couples the Kumbo intervention group. The intervention group in Bamenda had the lowest baseline scores for discussing sexual matters with children (age 10–18 years), confiding in partner for personal problems, viewing partner as "best friend," and quality of relationship. This group also had the most women employed outside the home and reported the highest percentages of unfaithfulness in the last six months at baseline. The extent to which (younger) age affected the findings of both surveys is unclear. A larger sample population is recommended to determine the efficacy of TFH on the attitudes and behaviors of couples from the Northwest Region of Cameroon.

Limitations

Sampling Bias

This evaluation is not generalizable to the broader Cameroonian population for multiple reasons. The two populations studied here were located in an Anglophone region of the Northwest, which is known to be different than the Francophone regions. The Northwest Region of Cameroon is known for practicing "wife inheritance" and having "jumbas" (concubines), practices that are uncommon in other regions. In 2004, the Cameroon Demographic and Health Survey (DHS) results suggested a higher HIV prevalence in the Northwest Region, which likely were influenced by regional sociocultural/traditional practices that affect marriage and relationships.

Thirty-nine percent of participants had attained some university-level education. Additionally, all participants were from the parish community (Catholic), Nearly all couples were considered "model" couples, and most were peer counselors or held other leadership roles in their communities. Both dioceses had significant pre-existing family and marriage strengthening activities. These characteristics likely affected high baseline ratings associated with perceived relationship satisfaction, equality, and communication indicators. Therefore, the extent that this evaluation is generalizable to the larger parish community is unclear.

Because the pilot evaluation was conducted through the Family Life Office in both dioceses, couples were handpicked 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. Because both partners in each couple that attended the workshops had to be available for the three-day training session, younger, working-age individuals dropped out of the intervention group and older, predominantly retired individuals joined.

Given that evaluation participants mainly consisted of ''leader" couples, it is possible that a social desirability bias affected the results of both the baseline

survey and the seven-month follow-up.   Bias in the intervention groups would be even stronger because those participants attended TFH and knew which attitudes and behaviors the program is trying to affect.

Intervention Challenges
Time constraints limited the ability to conduct multiple rounds of field testing and revise the pre-test. This limitation was compounded by self-administration of the surveys. Self-administration resulted in many unanswered questions. Additionally, participants did not always follow skip patterns and instructions. Thus, the results may include inaccuracies related to such errors.

In control group households where the surveys were retrieved one day later, there is a possibility that answers did not remain confidential between partners; thus, a reporting bias could be present. For example, a wife who feared that her husband might read her survey might not want to answer all questions honestly.

CONCLUSIONS AND FUTURE DIRECTIONS

"The workshop made spouses to communicate and talk more freely…"

"If I knew then what I know now, my marriage would have been different".

If "leadership" couples in Cameroon struggle with unfaithfulness in their relationships, it is plausible that the issue has a much larger scope. According to TFH-graduated couples, the workshop provides a safe platform for discussion with other couples and conversation between partners about sensitive relationship issues. These peer exchanges and "couple time" help address some of the root causes of unfaithfulness in marriages. Many participants also expressed a need for the youth and young adult population to hear these TFH messages as a way of changing cultural trends and laying a solid foundation for marriage. Because most of these couples were integrally part of a faith community, TFH was suggested as a supplement to current premarital programs, which were viewed ineffective in addressing barriers to healthy marriages. Indicators identified as affecting the quality of couple relationship and the family unit consistently improved among workshop participants but showed little or no improvement in the control group. Therefore, TFH might be a good add-on to other development programs that require a strong, family foundation, such as Preventing Mother-to-Child Transmission (PMTCT), economic strengthening, or nutrition programs. The specific effects of TFH on introducing more gender-equitable norms and attitudes into couple relationships require further research. Additionally, although this pilot evaluation did not result in significantly increased HIV testing among previously untested individuals, the desire for testing must be weighed against access to testing. In Uganda, couples HIV testing was offered after every TFH workshop, resulting in an 86% increase in couples testing. Cameroon might consider this as an option for increasing the rate of HIV

testing among both new candidates and previously tested individuals. Overall, by drawing on faith values, TFH curriculum has shown sustained, positive steps toward the culturally related enablers of HIV transmission within couples.

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