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REACHING YOUTH THROUGH FAITH LEADERS: EVALUATION OF THE FAITH MATTERS! INITIATIVE

Udhayashankar Kanagasabai,
Tiffiany Aholou,
Michelle S. Chevalier,
James L. Tobias,
Jackson Okuku,
Ray W. Shiraishi,
Robb Sheneberger,
Yvonne Chilufya Pande,
Clifton Chifuwe,
Lauren Erickson Mamane,
Gillian Njika,
Chris Obongo,
Viva C. Thorsen

Udhayashankar Kanagasabai, MD, MPH, MSc, Tiffiany Aholou, PhD, MSW, Michelle S. Chevalier, MD, MPH, James L. Tobias, MS, GISP, Ray W. Shiraishi, PHD, Lauren Erickson Mamane, MPH, and Viva C. Thorsen, PhD, MPhil, MPH, are affiliated with the Division of Global HIV and Tuberculosis (TB), Center for Global Health (CGH), Centers for Disease Control and Prevention (CDC), Atlanta, Georgia. Jackson Okuku, MD, MPH, is affiliated with the Division of Global HIV & TB, CGH, CDC, Lusaka, Zambia. Yvonne Chilufya Pande is affiliated with Expanded Church Response, Lusaka, Zambia. Robb Sheneberger, MD, is affiliated with the University of Maryland, Lusaka, Zambia. Lauren Erickson Mamane, MPH, is also affiliated with the Office of the Director, CGH, CDC, Atlanta, Georgia. Gillian Njika is an Independent Researcher and Global Master Trainer, Kenya. Chris Obongo is a Regional Measurement Specialist and Global Master Trainer at PATH, Kenya. Clifton Chifuwe is Executive Director and Global Master Trainer at the Centre for Peace Research and Advocacy, Zambia.

Abstract

Faith leaders can be uniquely positioned to guide and support young people on health issues, particularly HIV/AIDS and sexual violence. Faith Matters!, a 2-day training workshop for faith leaders, was delivered in September 2021 in Zambia. Sixty-six faith leaders completed a questionnaire at baseline, 64 at posttraining, and 59 at 3-month follow-up. Participants' knowledge, beliefs, and comfort communicating about HIV/AIDS and sexual violence were assessed. More faith leaders accurately identified common places where sexual violence occurs at

Address correspondence to Viva Combs Thorsen, PhD, MPhil, MPH, Division of Global HIV and Tuberculosis, Center for Global Health, Centers for Disease Control and Prevention, 1600 Clifton Rd., MS H21-6, Atlanta, GA 30333. vcc5@cdc.gov.

the 3-month point compared to baseline: at church (2 vs. 22, $p = .000$), the fields (16 vs. 29, $p = .004$), parties (22 vs. 36, $p = .001$), and clubs (24 vs. 35, $p = .034$). More faith leaders stated that they engaged in conversations that supported people living with HIV (48 at baseline vs. 53, $p = .049$ at 3-month follow-up). These findings can inform future HIV/AIDS initiatives focusing on increasing the capacity among communities of faith.

Keywords

faith-based organizations (FBOs); young people; HIV; sexual violence; religious entities; communities of faith; faith leaders

INTRODUCTION

Youth populations worldwide and in sub-Saharan Africa are heavily impacted by the HIV/AIDS epidemic. Of the 1.5 million adolescents between the ages of 10 and 19 living with HIV in 2020, more than 90% lived in sub-Saharan Africa (UNICEF, 2021b). Although antiretroviral treatment coverage among adolescents and young people (AYP) has increased over the years in sub-Saharan Africa (UNICEF, 2021a, 2021b), historically, it has been significantly lower than coverage rates among adults. Results from a systematic review suggest that more than half of the countries in sub-Saharan Africa have adolescent adherence rates less than 90% (UNICEF, 2021a, 2021b). In order to reach the UNAIDS 95–95-95 target goals for HIV testing, treatment, and viral suppression among these populations, there is an urgent need for a tailored approach to address the unique challenges faced by adolescents living with HIV (ALHIV) (Kim et al., 2014; World Health Organization [WHO], 2019).

Numerous circumstances and challenges collectively can contribute to low access to HIV treatment and poor treatment adherence among adolescents and young people (10–24 years of age) living with HIV (AYPLHIV) (Archary et al., 2020; Nasuuna et al., 2018; Office of the Global AIDS Coordinator, 2018; UNAIDS, 2016). First, adolescents are in a period where peer pressure is high, particularly pressure to initiate and engage in sexual relationships (Brown et al., 2018; Groves et al., 2018; Hosek & Henry-Reid, 2020). Second, once adolescents reach age 15, they transition from pediatric to adult HIV care, which may lead to poor support for health-care continuity for perinatally infected youth (Abaka & Nutor, 2021; Sander et al., 2020). Third, adolescents may not be receiving HIV care and services that best fit their needs, because national HIV/AIDS programs have historically focused on either younger children or adults (Hodgson et al., 2012). This is reflected in the suboptimal declines of AIDS-related mortality among youth, despite significant declines among adults (Archary et al., 2020; Nasuuna et al., 2018; Office of the Global AIDS Coordinator, 2018; UNAIDS, 2016).

Sexual risk behaviors (e.g., intercourse without condom, multiple sexual partnerships, and early sexual debut) among youth can result in negative long-term consequences and increased risk of HIV acquisition (Faini et al., 2020; Kayibanda et al., 2012; VanderEnde et al., 2018; Woldeyohannes et al., 2017). Furthermore, violence can impact HIV transmission and acquisition directly (through forced sex by an infected person) and indirectly (through

increased sexual risk-taking behaviors) (Dunkle et al., 2004; Gibbs et al., 2018; Jewkes et al., 2010). Several studies have elucidated the links between youth sexual risk-taking behaviors, violence, and HIV transmission (Christofides et al., 2014; Dunkle et al., 2004; Jewkes et al., 2010). Sexual violence in particular has been associated with increased risk of HIV transmission (Chiang et al., 2015; Decker et al., 2005; Sabri et al., 2019; Swedo et al., 2018). In addition, sub-Saharan Africa reports some of the highest rates of sexual violence, particularly among adolescent girls and young women aged 10–24, a group that also has the highest incidence of HIV (Hillis et al., 2016; UN Women, 2017, 2020; WHO, 2021). However, less has been written about the role that faith-based organizations (FBOs) play in communicating healthy messaging on topics such as HIV and sexual violence among young people in sub-Saharan Africa.

In sub-Saharan Africa, religion plays a significant role in people's lives, often positively influencing health-related behaviors and attitudes (Green, 2003; UNICEF, 2021a). Given both their reach and influence, faith leaders are one potential resource for HIV-related information, including HIV counseling, testing, linkage to care services, and knowledge about child sexual abuse (Olowu, 2015). Faith-based organizations promote healthy sexual behaviors, increase self-efficacy and social control, and establish groups (e.g., Bible study or prayer groups) where members encourage and hold each other accountable for their actions (Blevins et al., 2019; Green, 2003). A national survey in Zambia among 5,534 youth between the ages of 13 to 24 found that being part of a religious affiliation or Christian denomination that opposed premarital sex was associated with delayed sexual debut (Agha et al., 2006).

Faith and community leaders can be drivers of change within the faith and overarching community (Green, 2003; Karam, 2015);, thus an HIV educational intervention targeting these leaders may support positive changes within a community. In Zambia, a predominantly Christian nation (75%–95%), faith-based organizations and religious institutions have made significant strides in changing social norms/laws around child sexual abuse and have substantially contributed to HIV case-finding efforts for hard-to-reach populations such as men and children via direct service delivery and community engagement (Karam, 2015; Mash & Mash, 2013; Morgan et al., 2014).

However, despite demonstrated positive outcomes, some religious belief systems may also have a negative impact. First, studies suggest that faith leaders and communities of faith can perpetuate HIV/AIDS stigma and discrimination, particularly when engaging with ALHIV, given the moral standards and religious rules that govern sexual engagement at a young age (Haddad et al., 2008; Idele et al., 2014; Morgan et al., 2014). Second, although the faith-based community has engaged in HIV/AIDS initiatives, these efforts have predominantly focused on adult populations, with adolescents' needs inadvertently being overlooked. These observations imply that the faith-based community could benefit from greater awareness, education, information, and skills to positively impact, support, and guide adolescents and ALHIV.

PEPFAR'S FAITH AND COMMUNITY INITIATIVE (FCI)

In 2018, Zambia was one of 10 PEPFAR countries selected to receive funding for PEPFAR's Faith and Community Initiative (FCI). The goal of the FCI was to leverage the unique platform and contributions of FBOs and communities to address key gaps toward controlling the HIV epidemic and ensuring justice for children. FCI investments supported evidence-based programming through partnership with faith communities and traditional community organizations, with a focus on two priorities: (a) help find undiagnosed men, youth, and children living with HIV and support prompt linkage to treatment and continuity of care services; and (b) prevent sexual violence among children and accelerate justice for children who are victims of such violence (Hillis, 2021). One of the interventions used by the FCI was the Faith Matters! Training (Centers for Disease Control and Prevention [CDC], n.d.; PEPFAR, 2021).

FAITH MATTERS!

Faith Matters! is a 2-day training workshop based on the evidence-based Families Matter! Program (FMP) targeting parents (Kamala et al., 2017; Poulsen et al., 2010) and on guidance from subject matter experts of faith-based programs in sub-Saharan Africa. Faith Matters! targets faith and community leaders from diverse traditions (e.g., Christian and Muslim). It is different from other trainings in the sense that it focuses on the unique needs of adolescents in all their diversity, particularly ALHIV, preparing faith leaders to become more aware of the issues that adolescents face, helping adolescents to address these issues, and supporting them in making responsible sexual decisions. Faith Matters! includes information about sexually transmitted infections, HIV prevention and treatment, HIV testing, effective communication skills, gender-based violence and child sexual abuse, and available community resources. Faith Matters! is delivered in four interactive sessions, with two sessions per day delivered over two days. The following topics are covered: (1) overview of faith matters and pressures adolescents and young adults face; (2) information about sexually transmitted infections, HIV and AIDS, and other HIV-related issues; (3) understanding child sexual abuse; and (4) guiding and supporting adolescents and young adults living with HIV.

Faith Matters! was developed with the understanding that individuals have diverse learning styles, and therefore the program reflects strategies that maximize the retention of information. The training curriculum applies an interactive pedagogical approach utilizing experiential learning activities and includes (1) large-group discussions; (2) brainstorming; (3) role-plays; (4) songs and icebreakers; (5) mini lectures; (6) participant handouts; (7) proverb/poster discussions; (8) audio scenarios; and (9) follow-up discussions. The training is conducted in English.

Based on the training that faith leaders received during the 2-day Faith Matters! workshop, the primary objective of this evaluation was to assess changes in faith leaders' (1) knowledge of HIV prevention, treatment, and sexual violence; (2) beliefs about HIV prevention; and (3) comfort and communication about HIV and sexual violence.

METHODOLOGY

STUDY SITE AND POPULATION

Faith Matters! was evaluated among a convenience sample of faith leaders from the most common Christian denominations (e.g., Pentecostal, Catholic, and Methodist) in Lusaka, Zambia, between September 2021 and January 2022. The implementing partner, Expanded Church Response (ECR), recruited participating churches via a letter that included purpose, time, location, and eligibility criteria to participate in the training and evaluation study. The letter was sent 3 weeks prior to the training date. The churches provided ECR with a list of eligible participants and their contact information. Prior to participating in training, eligibility of all participants was confirmed at the training venue by the study staff. The faith leaders were selected using the following eligibility criteria: A faith leader who

- consistently delivered sermons or messages over the past 12 months in a church or large gathering or had significant influence as a leader within respective community;
- was 21 years of age or older;
- permanently resided in Lusaka, Zambia, and did not expect to move in the next 6 months;
- was able to read and write in English;
- agreed to complete a training evaluation questionnaire at three different time points: at baseline (before starting the training workshop), immediately after the completion of the training workshop, and 3 months following the training workshop;
- was willing to share the content or topics learned in the 2-day training workshop with members of their congregations or communities; and
- agreed to complete a program feedback questionnaire.

All participants who attended the training provided written consent prior to participating in the study.

EXPANDED CHURCH RESPONSE

Expanded Church Response (ECR) is a faith-based organization implementing orphans and vulnerable children (OVC), gender-based violence (GBV), HIV/AIDS, and other programs to mitigate human suffering and to bring transformational development. ECR has implemented programs funded by the CDC, USAID, the European Union, UNICEF, and the Global Fund either directly or through a range of highly regarded local and international organizations. The mission of ECR is to empower the church in Christ's love, character, and wisdom in Zambia and beyond to facilitate a comprehensive and coordinated development response, thereby contributing to the physical, emotional, and spiritual wholeness of individuals, families, and communities (ECR, 2023). ECR staff have been training faith leaders across the country using Faith Matters! since 2019. ECR staff who are certified Faith Matters! facilitators have completed a 5-day facilitator training. They have at least

the following minimum requirements: a postsecondary certificate or diploma education; 25 years old; 3 years' experience in facilitating groups of adults, working with faith leaders and/or faith-based organizations, experience in child and adolescent development, sexual violence prevention/child protection and/or HIV prevention; are comfortable and confident in openly discussing sexuality issues; and are culturally competent, committed, and passionate about working with faith leaders to equip them with skills that help them support adolescents and young adults.

DESIGN

To assess the impact of the 2-day training, a one-group pretest-posttest-follow-up design was adopted to evaluate Faith Matters! conducted in Lusaka, Zambia, in 2021.

DATA COLLECTION TOOL: PRE, POST, AND 3-MONTH FOLLOW-UP

The training workshop 19-item evaluation questionnaire was written in English and contained four sections: (1) Demographics—gender, age, marital status, educational level, role in church, years of experience in church, and size of congregation; (2) HIV/AIDS knowledge and sexual violence—four questions with response options being: yes, no, and I don't know; (3) HIV/AIDS and sexual violence attitudes and beliefs—five questions with response options being: yes, know, and I don't know; and (4) HIV communication and outreach—responses to 10 questions related to comfort in communicating about HIV and sexual violence topics were captured using a 5-point Likert scale (1 = *very uncomfortable*, 2 = *uncomfortable*, 3 = *neutral*, 4 = *comfortable*, 5 = *very comfortable*). The 2-day workshop was conducted by the trained ECR staff.

DATA COLLECTION PROCEDURES

Pretest data were collected before the start of the training. Posttest data were collected directly after the training was ended. Follow-up data were collected 3 months after the training was over and religious leaders had returned to their pastoral stations.

To prevent the potential bias that could be reflected in giving socially desirable responses, data collection was conducted by independent trained study staff. Before the start of the training, the study staff introduced the study and its purpose, answered questions about the study, obtained written consent, and distributed questionnaires that were filled out by the participants. Participants were requested to respect each other's privacy while completing the questionnaire. After the questionnaires were filled in, participants were asked to put them in a sealed box. The study staff took this box when they left the training room to allow for the training activities to commence. The study staff was not present during the training and only returned at the end of the last training day, when they were reintroduced to administer posttest data. Participants were invited to fill out the follow-up questionnaire. Participants were not given any compensation beyond refreshments during the 2-day training period.

The study team explained procedures for the follow-up assessment. Participants who were willing to be contacted 3 months after the training were asked how they would prefer to be contacted (e.g., telephone, e-mail, or other social media) and to provide their contact

details. Contact information was kept separately from the study data in a locked file cabinet to which only the study team had access. Two and a half months after the training had been completed, participants were contacted by the study team with a request to schedule an in-person session at a place preferred by the participant and that would also allow for confidential completion of the follow-up questionnaire. Once the session had been scheduled, the study team traveled to the agreed-upon venues and gave the survey questionnaire for self-administration.

DATA ANALYSIS

Completed questionnaires were entered and managed using REDCap electronic data capture tools hosted at the CDC (Harris et al., 2019). Statistical analysis was performed using Stata/MP 17 (StataCorp, 2021). We used descriptive analysis for participants' demographic characteristics, knowledge, beliefs, and comfort communicating to obtain frequencies and proportions at three time points: pretest, posttest and 3-month follow-up.

Changes in outcome measures (i.e., the previously described Sections 2–4 of the questionnaire on knowledge of HIV/AIDS and sexual violence, attitudes and beliefs around HIV/AIDS and sexual violence, and comfort communicating HIV and sexual violence-related messages) were tested by comparing the baseline and 3-month follow-up data using the Stuart-Maxwell and Wilcoxon signed-rank tests to account for repeated measures among participants (Maxwell, 1970; Stuart, 1955; Wilcoxon, 1945). Level of significance (p value) was set at a value less than or equal to .05. Only the results with statistical significance appear in bold type in the tables and are presented in the Results section.

ETHICS

The University of Zambia Biomedical Research Ethics Committee (UNZABREC) of Zambia approved the protocol. The protocol was reviewed in accordance with the CDC human research protection procedures and was determined to be research, but CDC investigators did not interact with human subjects or have access to identifiable specimens for research purposes. Informed consent was obtained from all study participants prior to administration of the interviews, and no personally identifying information was collected. The evaluation was conducted consistent with applicable federal law and CDC policy (see, e.g., 45 C.F.R. part 46, 21 C.F.R. part 56; 42 U.S.C. §241(d); 5 U.S.C. §552a; 44 U.S.C. §3501 et seq.).

RESULTS

A total of 66 faith leaders participated in the Faith Matters! evaluation. All 66 participants completed the first evaluation (baseline); 64 faith leaders completed the posttraining evaluation (immediately after the training); and 59 completed the evaluation at the 3-month follow-up point. Over the course of the three time points, seven participants dropped out of the study.

CHARACTERISTICS OF THE PARTICIPANTS

The mean age of participating faith leaders was 42 years (range: 20–71), with the majority being male (59.1%, Table 1). All the faith leaders were Christian, with 49 being Pentecostal (74.2%), followed by four who were Catholic (6.1%); the remainder were from other Christan denominations. Many participants (28, 43.1%) had more than 10 to 20 years of experience, and 27 (42.4%) led churches with less than 200 congregants. Many of the participants had some college education (26, 39.4%), and eight (12.1%) had completed a bachelor's degree, while the rest had completed primary (8, 12.1%), secondary (15, 22.7%), or vocational school (7, 10.6%).

KNOWLEDGE OF PARTICIPANTS ABOUT HIV/AIDS AND SEXUAL VIOLENCE

Between baseline and the 3-month postintervention assessment, statistically significant improvements in knowledge about sexual violence were seen (Table 2). Specifically, participants learned about places where child sexual abuse occurs in the community working/farming in the field (24.2% to 43.9%; $p = .0046$), at parties (33.3% to 54.5%; $p = .0133$), at clubs/bars (36.4% to 53%; $p = .0343$), and at church (3% to 33.3%; $p = .0000$). In addition, the number of faith leaders who noted that sexual abuse includes touching a child's genitals or private parts (56.1% to 75.8%; $p = .0124$), an adult exposing their private parts (51.5% to 75.8%; $p = .0017$), and a 14-year-old girl consenting to sex with an adult (40.9% to 57.6%; $p = .0116$) significantly increased from baseline.

BELIEFS ABOUT AWARENESS OF HIV AND SEXUAL ABUSE

The most significant change noted among faith leaders was the belief that they could help support and guide ALHIV by increasing their own awareness of the pressures that young people face ($p = .014$) (Table 3). Also, a significant number of church leaders reported that they were engaged in more supportive conversations with ALHIV, from 48 (76.2%) at baseline to 53 (91.4%) at 3 months ($p = .0498$). The number of HIV awareness events hosted by the churches also increased significantly, from 31 at baseline to 42 (63.6%) at 3 months ($p = .0116$).

COMFORT WITH COMMUNICATION

While changes in comfort with communication from baseline to 3-month follow-up were observed (Figure 1), none were statistically significant.

DISCUSSION

The findings from the evaluation of the Faith Matters! 2-day training workshop led to improved knowledge, greater comfort with communication, and changes in beliefs related to sensitive topics, including sexual abuse and HIV misconceptions. Historically, faith leaders have played an integral part in responding to public health issues, even dating back to the 1854 cholera outbreak when the Reverend Henry Whitehead worked with Dr. John Snow to communicate critical public health messages to the public (Chave, 1958). In the 2014–2016 Ebola epidemic in West Africa, faith leaders played a critical role in communicating safe burial practices to communities as part of an effective public health response (Blevins et al., 2019). Research in the United States has shown the important role that faith leaders

have had in shaping the conversation around a disease, social norms, and sexual health (Coleman et al., 2016; Derose et al., 2019; Maliski et al., 2010; Moore et al., 2015; Nunn et al., 2013; Obong'o et al., 2016; Pichon et al., 2016; Williams et al., 2014). In like fashion, our findings demonstrate the potential important role that faith leaders may play in HIV prevention programs by normalizing and destigmatizing HIV through open discussions with their congregants, which include AYP. While several studies have explored the use of FBOs and faith communities to tackle HIV/AIDS (Kagimu et al., 2012; Mpofu et al., 2014; Otolok-Tanga et al., 2007; USA-PEPFAR, 2021), this is the first evaluation from the PEPFAR-supported Faith Matters! that is part of the broader Faith Communities Initiative.

Participants' knowledge of HIV/AIDS did not significantly change, which is similar to findings reported in other studies conducted in eastern and southern Africa (CDC, n.d.; Karam, 2015; Mash & Mash, 2013; Morgan et al., 2014; Pusateri, 2010). The lack of a statistically significant increase in HIV/AIDS knowledge between baseline and postintervention assessment may be explained by long-term investments in HIV/AIDS awareness campaigns. However, the lower percentages of respondent knowledge about condoms, viral load, and voluntary medical male circumcision leaves room for further exploration and training. Pusateri (2010) noted that while increases in knowledge were observed early in the HIV epidemic, recent gains have been more marginal. In a survey conducted in Kumasi, Ghana, among 1,200 members of six religious congregations, one fifth of the congregation's members reported providing some support to people with HIV/AIDS in the past 6 months, mostly through prayer, financial support, and counseling (Bazant & Boulay, 2007; Campbell et al., 2011). Because of their social capital and platform, faith leaders and faith settings are poised to disseminate information that can increase awareness, change attitudes and behaviors, and reduce stigma and discrimination against PLHIV.

The increase from baseline to 3-month follow-up in awareness and acknowledgment that sexual violence can occur in churches, and that the definition of child sexual abuse includes inappropriate exposure, implies that prior to the training workshop, participants had a blind spot in the areas of sexual violence against children. Historically, religious institutions have typically been considered safe havens where people seek spiritual guidance and support from faith leaders on various aspects of their lives. As a result, faith communities have been found to avoid scrutiny and critical reflection on child sexual abuse (Nweneka, 2007). Similar to other studies that highlight the role that FBOs can play in preventing and responding to sexual and gender-based violence (Anugwom & Anugwom, 2018; Magner et al., 2015), our findings underscore the importance of informing faith leaders about sexual violence against children, especially regarding recognizing, responding to, and preventing sexual violence against children. As gatekeepers, faith leaders can also play a vital role in safeguarding children, including preventing violence victimization, dispelling myths and victim blaming, creating a safe space for survivors to disclose violence, and ensuring that policies are in place to screen all persons who interact with children, and to hold perpetrators accountable (USA-PEPFAR, 2021). Furthermore, while not statistically significant, from a practical standpoint, faith leaders could use their platforms to shift cultural norms, especially those related to child marriage (Karam, 2015).

The ability of faith leaders to be able to appropriately communicate with young people about topics such as HIV/AIDS stigma, misconceptions, prevention, and treatment adherence is one crucial way they can contribute to ending the HIV epidemic. While our study noted changes in the comfort level of faith leaders' communication on topics related to HIV and sexual violence, these changes were not statistically significant. This is most likely due in part to the study being underpowered and not having a large enough sample size to detect differences between time points (Button et al., 2013). Similar studies have noted that increased knowledge and investments in educating and engaging FBOs has led to stigma reduction (Mpofu et al., 2014; Otolok-Tanga et al., 2007). Of interest was the decrease in comfort levels of faith leaders in discussing sensitive issues reported immediately after the training workshop, with a subsequent increase above baseline at 3-month follow-up. This drop could possibly signify the need for participants to practice more in order to develop the skills required for improved communication. Programmatic implications of this finding could be the need to include more skill-building components into the 2-day training workshop to increase participants' comfort level in having these sensitive conversations.

Study participants reported increased frequency (1–3 times [baseline: 38.5% v. 3-month follow-up: 49.2%]; 4–7 times [baseline: 7.8% vs. 3-month follow-up 26.7%]) of talking about HIV-related topics with young members of their congregations in the past 3 months (Table 3). This may suggest that faith leaders felt empowered or a sense of responsibility to incorporate topics covered in Faith Matters! more frequently when engaging younger congregants. Although faith leaders' beliefs about HIV/AIDS did not change significantly between baseline and the 3-month follow-up (Table 3), study participants acknowledged that increased awareness and understanding of the pressures young people experience was one way they could provide support to ALHIV. This reflects the sometimes-contradictory role that faith and religious institutions may play in combating stigma and discrimination (Blevins et al., 2019; Nweneka, 2007). Evidence shows that the stigma that some key populations and sexual and gender minorities face are often religiously motivated and the need for engaging FBOs to combat this stigma (Blevins & Corey, 2013; Blevins & Irungu, 2015; Blevins et al., 2019). However, the role that religious and faith leaders play in providing psychosocial support for PLHIV, especially in settings where services for clinical counseling are nonexistent, cannot be overlooked. Moreover, faith leaders can also be instrumental in educating and empowering young members of their congregations by frequently and repeatedly delivering clear messages that target young people.

STRENGTHS AND LIMITATIONS

As previously noted, this is the first evaluation of the PEPFAR-supported Faith Matters! initiative. Furthermore, this evaluation goes beyond a pre-/posttest design to also assess knowledge retention and change in practice at 3 months. In addition, this article provides information on HIV and sexual violence–related topics that could potentially be discussed by sub-Saharan African faith leaders from various denominations with youth and thereby potentially increase knowledge and reduce stigmatizing behaviors, while encouraging access to available HIV services.

Conversely, this study has several limitations that warrant discussion. First, this was an exploratory evaluation and was not powered to examine a prespecified hypothesis. As such, the study sample size was a small convenience sample. Second, there was no randomization of the study participants or comparison group. Third, the findings from this study are representative of faith leaders in Lusaka, Zambia, and may not be applicable to other regions or countries. Fourth, the study participants were all from a single religion (i.e., Christian) and, as such, findings may vary if the intervention were implemented with leaders from other religious groups. Finally, due to the self-reported nature of the training workshop evaluation questionnaire, there is a possibility that participants gave socially desirable answers to some questions.

CONCLUSION

Faith leaders who have influence and access to community members, particularly adolescents who continue to be at the highest risk for HIV/AIDS, can be trained to effectively address health issues. A Faith Matters! 2-day workshop holds promise as a low-cost HIV-prevention intervention well suited for faith leaders. The evidence demonstrates that Faith Matters! can increase faith leaders' knowledge about sexual violence and their comfort in communication to better support and guide ALHIV on issues such as sexuality, peer pressure, child sexual abuse, HIV stigma, and HIV treatment and care. Moreover, the evidence can inform future HIV/AIDS public health initiatives that further increase the capacity and empathy among the faith-based community. As more faith communities are leveraged in the fight against HIV/AIDS, engaging a broad cross-section of faith leaders with varying perspectives will be essential to assure wider impact.

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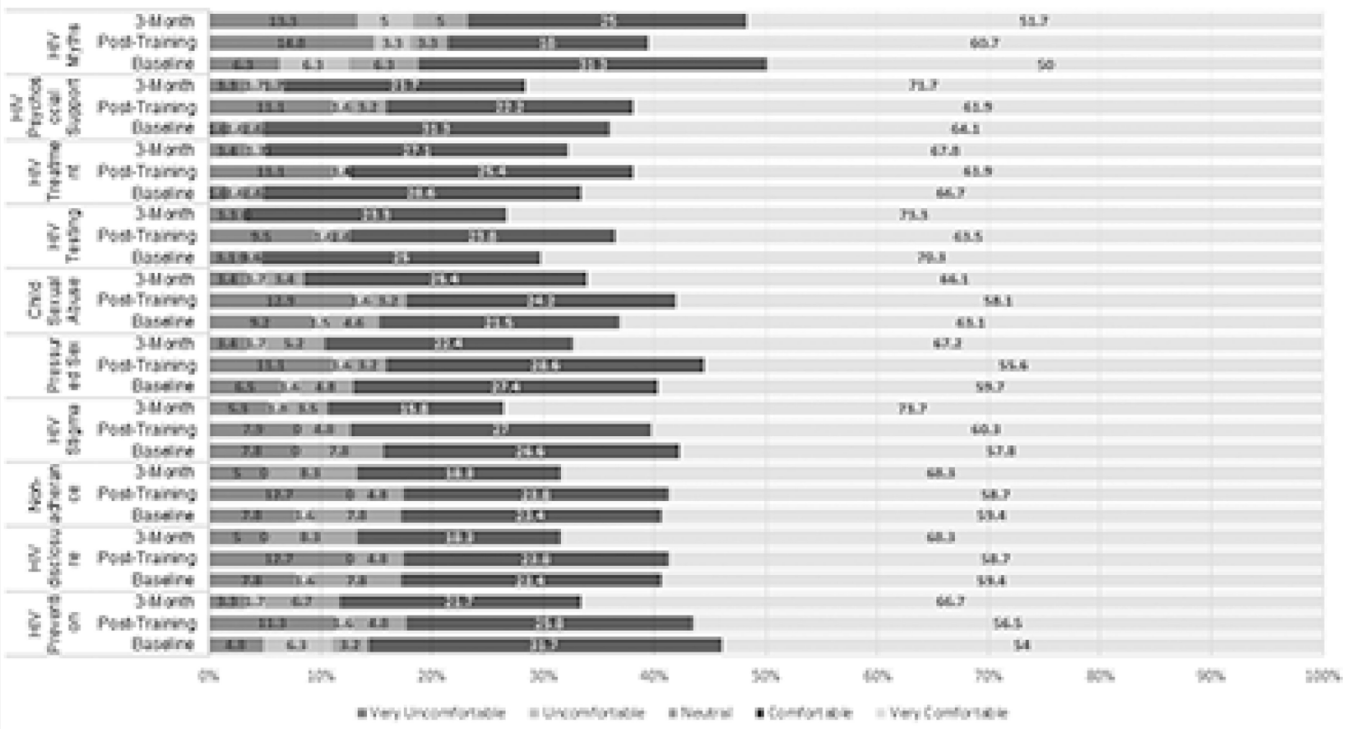

FIGURE 1.
Faith leaders' comfort levels.

TABLE 1.

Demographics of Faith Leaders (N = 66)

Variable	Response category	*n* (%)
Age (yrs)	<30	14 (21.2)
Mean: 42; Range: 20–71	30–39	14 (21.2)
	40–49	15 (22.7)
	50+	19 (28.8)
	MISSING	4 (6.1)
Sex	Male	39 (59.0)
	Female	26 (39.0)
	MISSING	1 (1.5)
Christian denomination	Catholic	4 (6.1)
	Pentecostal	49 (74.2)
	Baptist	3 (4.5)
	Other	10 (15.1)
Years of experience	< 1 year	2 (3.0)
	1–3 years	3 (4.5)
	4–5 years	6 (9.0)
	6–10 years	15 (22.7)
	10–20 years	28 (42.4)
	Others	12 (18.0)
Congregation size	<200	27 (41.0)
	201–400	14 (21.2)
	401–600	6 (9.1)
	≥600	6 (9.1)
	MISSING	13 (19.7)
Marital status	Single	20 (30.3)
	Married	41 (62.1)
	Divorced	3 (4.5)
	Other	2 (3.0)
Level of education	Primary school	8 (12.1)
	Senior secondary school	15 (22.7)
	Vocational school (seminary, construction, etc.)	7 (10.6)
	Some college or post-secondary school training	26 (39.4)
	Completed bachelor’s degree (college)	8 (12.1)
	Completed master’s degree (college)	2 (3.0)
Number of children	0	16 (25.0)
	1	7 (10.9)
	2	6 (9.4)
	3	7 (10.9)
	4	12 (18.8)
	5–6	10 (15.6)

Variable	Response category	*n* (%)
	7+	8 (12.4)

TABLE 2.

Change in HIV/AIDS and Sexual Violence Knowledge

Variable	Baseline *N* = 66 *n (%)*	Post-assessment *n* = 64 *n (%)*	3-month assessment *n* = 59 *n (%)*	Absolute % change (3M-baseline)	*p* value
Sometimes infections, including HIV and other sexually transmitted diseases, do not cause any sign or symptom at all, and the person infected will not notice anything wrong.	52 (80.0)	54 (87.1)	47 (79.7)	−0.30	.6065
HIV can be passed (transmitted) to others through bodily fluids, unprotected sex, through an infected mother to her baby, and through contaminated needles and sharp objects.	66 (100)	60 (95.2)	59 (98.3)	0.00	—
For someone who is HIV positive, having a high viral load is a sign that the person is doing well with his/her HIV treatment regimen.	35 (55.6)	34 (54.8)	34 (59.6)	4.00	.2151
All pregnant women should be tested for HIV so that if they are HIV positive, they can be given medications to prevent passing HIV to the baby and to keep them healthy.	63 (96.9)	61 (98.4)	58 (100)	3.10	.3679
Places where sexual abuse occurs in the community					
People's home	54 (81.8)	60 (90.9)	51 (77.3)	−4.50	.4669
At school	25 (37.9)	47 (71.2)	37 (56.1)	18.20	**.0143**
In the field/farm	16 (24.2)	35 (53.0)	29 (43.9)	19.70	**.0046**
At a party	22 (33.3)	40 (60.6)	36 (54.5)	21.20	**.0133**
Clubs/bar	24 (36.4)	38 (57.6)	35 (53.0)	16.60	**.0343**
Church	2 (3.0)	32 (48.5)	22 (33.3)	30.30	**.0000**
Other	22 (33.3)	28 (42.4)	25 (37.9)	4.60	.6015
HIV infection can be prevented by:					
Abstaining from sex	50 (75.8)	59 (89.4)	55 (83.3)	7.50	.2513
Always using a condom	42 (63.6)	52 (78.8)	42 (63.6)	0.00	1.0000
Having sex with one partner	43 (65.2)	38 (57.6)	39 (59.1)	−6.10	.4652
Abstinence is the only option for family planning.	12 (18.2)	12 (19.4)	10 (16.9)	−1.30	.5134
Learning about your HIV status sooner can help make the HIV treatment and care received more successful.	64 (97.0)	62 (98.4)	59 (100)	3.00	.1573
HIV/AIDS weakens the immune system, making it more difficult to fight diseases.	62 (93.9)	62 (98.4)	59 (98.3)	4.40	.0821
Voluntary medical male circumcision (VMMC) can prevent a man from getting HIV.	40 (63.5)	37 (59.7)	37 (61.7)	−1.80	.2161
VMMC increases the risk of a man's female partner getting cervical cancer.	7 (11.3)	8 (12.7)	9 (15.3)	4.00	.2138
Signs of child sexual abuse can be physical, emotional, and behavioral.	63 (96.9)	63 (100)	58 (98.3)	1.40	.6065
Knowledge about child sexual abuse					
Adult having sex with child	60 (90.9)	60 (90.9)	59 (89.4)	−1.50	.7630
Touching a child's genitals or private parts	37 (56.1)	51 (77.3)	50 (75.8)	19.70	.0124
Early marriage of girls	32 (48.5)	44 (66.7)	39 (59.1)	10.60	.1083

Variable	Baseline *N* = 66 *n (%)*	Post-assessment *n* = 64 *n (%)*	3-month assessment *n* = 59 *n (%)*	Absolute % change (3M-baseline)	*p* value
An adult exposing their private parts	34 (51.5)	49 (74.2)	50 (75.8)	24.30	**.0017**
14-year-old girl consenting to sex with adult	27 (40.9)	34 (51.5)	38 (57.6)	16.70	**.0116**
Knowledge about unhealthy relationship characteristics					
Equality and respect	8 (12.1)	5 (7.6)	5 (7.6)	−4.50	.3657
Trying to control one's partner	27 (40.9)	44 (66.7)	45 (68.2)	27.30	**.0015**
Hitting, grabbing, or shoving a partner	42 (63.6)	44 (66.7)	44 (66.7)	3.10	.6949
Open communication	3 (4.5)	3 (4.5)	4 (6.1)	1.60	.6547
Forcing a partner to have sex	42 (63.6)	48 (72.7)	48 (72.7)	9.10	.2207
Physical and emotional control of one's partner	42 (63.6)	47 (71.2)	43 (65.2)	1.60	.8185

Note. Results with statistical significance are presented in bold.

TABLE 3.

Change in Beliefs, Communication, and Supportive Activities Among Faith Leaders

Variable	Baseline *N* = 66 *n (%)*	Post-assessment *n* = 64 *n (%)*	3-month assessment *n* = 59 *n (%)*	Absolute % change (3M-baseline)	*p* values
Do you think church leaders or clergy play an important role in supporting or guiding adolescents living with HIV?					
Not important at all	1 (1.6)	1 (1.6)	2 (3.3)	1.70	.8366
Less important	2 (3.2)	5 (7.9)	1 (1.7)	−1.50	
Neutral (so-so)	5 (7.9)	2 (3.2)	2 (3.3)	−4.60	
Important	6 (9.5)	9 (14.3)	6(10.0)	0.50	
Very important	49 (77.8)	46 (73)	49 (81.7)	3.90	
Do you think that if clergy or church leaders talk to adolescents about sex that it will encourage them to have sex?					
Not important at all	19 (35.8)	24 (41.4)	21 (36.8)	1.00	.9735
Less important	6 (11.3)	4 (6.9)	7 (12.3)	1.00	
Neutral (so-so)	10 (18.9)	11 (19.0)	11 (19.3)	0.40	
Important	7 (13.2)	5 (8.6)	6(10.5)	-2.70	
Very important	11 (20.8)	14 (24.1)	12 (21.1)	0.30	
Do you believe that there is danger or harm to a child (<18 yrs) who marries an adult?					
Yes	48 (75)	58 (92.1)	51 (86.4)	11.40	.1100
No	4 (6.3)	3 (4.8)	3 (5.1)	−1.20	
Sometimes	12 (18.8)	2 (3.2)	5 (8.5)	−10.30	
Do you feel comfortable sharing food or sitting next to someone who is HIV-positive?					
Yes	57 (89.1)	57 (93.4)	55 (91.7)	2.60	.2615
No	3 (4.7)	3 (4.9)	4 (6.7)	2.00	
Sometimes	3 (4.7)	1 (1.6)	1 (1.7)	−3.00	
How do you think a church leader can support or guide adolescents living with HIV (ALHIV)?					
Increase their awareness about the changes and pressures adolescents face	40 (60.6)	54 (81.8)	52 (78.8)	18.20	.0143
Increase their knowledge about the health-related issues and challenges specific to ALHIV	61 (92.4)	56 (84.8)	53 (80.3)	−12.10	.0455
It is not the role of church leaders to discuss HIV/AIDS prevention and treatment with ALHIV	1 (1.5)	5 (7.6)	1 (1.5)	0.00	1.00
How frequently would you say that your church engages in activities to support and guide adolescents living with HIV?					
Daily	5 (7.9)	3 (4.8)	4 (6.7)	−1.20	.0744
Once a week	14 (22.2)	14 (22.2)	10 (16.7)	−5.50	
A few times per year	21 (33.3)	21 (33.3)	21 (35)	1.70	
Once a month	7 (11.1)	13 (20.6)	17 (28.3)	17.20	
Once a year	3 (4.8)	0 (0)	2 (3.3)	−1.50	
Not applicable	13 (20.6)	12 (19)	6 (10)	−10.60	
How many times in the last 3 months have you talked to adult members of your church about HIV-related topics?					

Variable	Baseline *N* = 66 *n (%)*	Post-assessment *n* = 64 *n (%)*	3-month assessment *n* = 59 *n (%)*	Absolute % change (3M-baseline)	*p* values
0	15 (23.1)	12 (19.4)	7 (11.9)	−11.20	.0786
1–3 times	25 (38.5)	31 (50)	29 (49.2)	10.70	
4–7 times	7 (10.8)	6 (9.7)	14 (23.7)	12.90	
8–10 times	3 (4.6)	6 (9.7)	2 (3.4)	−1.20	
More than 10 times	11 (16.9)	7 (11.3)	6 (10.2)	−6.70	
Not applicable	4 (6.2)	0 (0)	1 (1.7)	−4.50	
How many times in the last 3 months have you talked to adolescent members of your church about HIV-related topics?					
0	14 (21.9)	17 (27)	9 (15)	−6.90	.0432
1–3 times	25 (39.1)	28 (44.4)	24 (40)	0.90	
4–7 times	5 (7.8)	3 (4.8)	16 (26.7)	18.90	
8–10 times	5 (7.8)	10 (15.9)	2 (3.3)	−4.50	
More than 10 times	9 (14.1)	5 (7.9)	7 (11.7)	−2.40	
Not applicable	6 (9.4)	0 (0)	2 (3.3)	−6.10	
How many times in the last 3 months have you referred or linked a person to HIV prevention, testing, or treatment services?					
0	23 (36.5)	14 (23.3)	21 (35.6)	−0.90	.8927
1–3 times	22 (34.9)	29 (48.3)	24 (40.7)	5.80	
4–7 times	8 (12.7)	8 (13.3)	5 (8.5)	−4.20	
8–10 times	2 (3.2)	6 (10)	3 (5.1)	1.90	
More than 10 times	6 (9.5)	3 (5)	5 (8.5)	−1.00	
Not applicable	2 (3.2)	0 (0)	1 (1.7)	−1.50	
Does your church engage in activities or conversations to support and guide adolescents living with HIV?	48 (76.2)	47 (77.0)	53 (91.4)	15.20	.0498
Ways in which the church provides support to adolescents living with HIV (ALHIV)					
Hosting HIV/AIDS awareness events	31 (47.0)	42 (63.6)	42 (63.6)	16.60	.0116
Hosting social support groups for ALHIV and their families	20 (30.3)	31 (47.0)	28 (42.4)	12.10	.0736
Posting informational flyers about ways to prevent HIV infection at church/church events	19 (28.8)	21 (31.8)	25 (37.9)	9.10	.1797
Referring ALHIV and their families t.0o treatment and care services	22 (33.3)	26 (39.4)	22 (33.3)	0.00	1.00
Provide counseling to ALHIV and their families	37 (56.1)	39 (59.1)	36 (54.5)	−1.60	.8084
Pray for healing for ALHIV and their families	24 (36.4)	23 (34.8)	23 (34.8)	−1.60	.8348
We do not engage in any activities to support ALHIV	6 (9.1)	8 (12.1)	6 (9.1)	0.00	1.000
HIV testing	19 (28.8)	17 (25.8)	15 (22.7)	−6.10	.3711
HIV self-testing	17 (25.8)	14 (21.2)	16 (24.2)	−1.60	.8084
Other services not listed here	2 (3.0)	2 (3.0)	4 (6.1)	3.10	.4142
Don’t know	6 (9.1)	3 (4.5)	1 (1.5)	−7.60	.0588

Variable	Baseline *N* = 66 *n (%)*	Post-assessment *n* = 64 *n (%)*	3-month assessment *n* = 59 *n (%)*	Absolute % change (3M-baseline)	*p* values
Has your church or you had any challenges to supporting and guiding adolescents living with HIV?	40 (62.5)	38 (60.3)	34 (58.6)	−3.90	.5618