

SIHLE

DESCRIPTION

The SIHLE (Sisters Informing Healing Living and Empowering) intervention is a social-skills training intervention aimed at reducing HIV sexual risk behavior among African American teenage girls, ages 14 to 18, who have been sexually active. It consists of four 3-hour sessions delivered by 2 near-peer facilitators and an adult facilitator in a community-based setting. Near-peer facilitators are young women aged 18 to 21 who are more mature than the intervention target audience but share common experiences around popular culture. The 4 small-group sessions can accommodate 10 to 12 African American female adolescents. Based on an adaptation of the SISTA intervention, SIHLE emphasizes ethnic and gender pride and enhances awareness of HIV risk-reduction strategies such as abstaining from sex, using condoms consistently, and having fewer sex partners. The sessions are gender-specific and culturally relevant and include behavioral skills practice, group discussions, lectures, role-playing, and take-home exercises that are suggested as a means of including partners or obtaining additional practice in real-world contexts.

Goals

SIHLE is intended to increase knowledge about HIV/AIDS and improve communication, decision making, and condom use among sexually active African American female adolescents aged 14 to 18 years.

Theoretical Framework

The SIHLE intervention is based on 2 social science theories, social cognitive theory and the theory of gender and power.

Social cognitive theory¹

Social cognitive theory views behavior change as a social process influenced by interaction with others in the social environment. As such, people learn by watching influential people in their lives who model behaviors or attitudes. Belief in their ability to perform the new behavior (i.e., self-efficacy) makes it more likely that the behavior will be adopted. Social cognitive theory, as applied to HIV/AIDS behavior change, suggests that before people can change risky behavior they need information about HIV risk, training in social and behavioral skills to apply risk-reduction strategies, knowledge about social norms, and belief that they can perform the new behavior (self-efficacy).

Theory of gender and power²

The theory of gender and power attends to gender-based power differences in male-female relationships. It examines the division of labor between men and women, the distribution of power and authority within male-female relationships, and the gender-based definitions of sexually appropriate conduct. The theory considers a woman's willingness to adopt and maintain sexual risk-reduction strategies in heterosexual relationships as it pertains to how much power she has, her commitment to the relationship, and her role in the relationship. This theory suggests that difficulties arise in practicing safer sex because self-protection is often influenced by abusive partners, economic needs, values around intimacy, and norms supporting women's passive behavior in sexual relationships.

Intervention process

SIHLE activities empower African American female teenagers by discussing and sharing experiences about gender and ethnic pride. Activities are designed to praise the strengths of African American women and identify African American female role models. SIHLE activities include the following:

- HIV risk-reduction skill building (e.g., assertive communication, condom use) in the context of gender-based inequalities, norms, and values, such as enhancing assertive communication skills, sexual risk-reduction negotiation, and condom use skills.
- Tasks with the aim of enhancing coping with emotions that interfere with practicing safer sex.
- Take-home assignments foster partner norms that support risk-reduction strategies.

The SIHLE intervention sessions are co-facilitated by 2 near-peer facilitators (18 to 21 years old) and an adult health educator in a community-based setting. If possible, all facilitators should be of the same race/ethnicity and gender as the target population in addition to being versed in HIV transmission and methods of preventing HIV transmission, having group facilitation skills, and having a nonjudgmental attitude toward youths at risk for HIV.

Each session begins with introductory and review components followed by the topics for the specific session. Participants initially create ground rules to guide the intervention process and sign a pact to motivate adherence and continued participation. Sessions are facilitated by using newsprint training charts that indicate participant input, role-plays and strategies for reinforcing messages from intervention components on communication, safer-sex negotiation, and HIV prevention behaviors. Condom demonstration is a key component; participants follow a set of systematic steps from sexual decision making to how to discard a used condom. The final session culminates when the girls sign a SIHLE agreement, participate in a graduation ceremony, and receive a completion certificate.

Research Findings

The SIHLE intervention was first implemented and evaluated at a health department in Birmingham, Alabama, in 1995.³ The study was originally conducted with 522 sexually active African American female adolescents aged 14 to 18. Results indicated that an intervention delivered in a community setting can increase condom use. Specifically, adolescents in the experimental group reported more condom use than did those in the control group. Adolescents in the experimental group also had fewer pregnancies and cases of chlamydia than did those in the control group.

Core elements, key characteristics, and procedures

Core Elements

Core elements are critical components of an intervention's conceptualization and design that are believed to be responsible for the intervention's effectiveness. These core elements are derived from the behavioral theories on which the intervention or strategy is based. **Core elements are essential and cannot be ignored, added to, or changed, in order to maintain intervention fidelity and intent.**

SIHLE has the following core elements:

- Conduct small-group sessions that meet the session goals.
- Implement SIHLE with female adolescents who have had sex and are from 14 to 18 years of age (inclusive).
- Use 1 skilled adult female facilitator who is knowledgeable about youth subculture and 2 near-peer female facilitators (ages 18 to 21) to implement SIHLE group sessions. Use facilitators (adult and near-peers) who are of the same race/ethnicity and gender as the intervention participants.
- Prevent new members from joining the intervention after session 1.
- Employ facilitators who possess group facilitation skills and a comprehensive knowledge of the intervention. Mastering co-facilitation skills is critical to implementation.
- Use materials that are age, gender, and culturally appropriate to maintain adolescents' interest throughout the sessions.
- Train adolescents in assertive communication skills to demonstrate care for their partners and to negotiate abstinence or safer sex.
- Teach adolescents proper condom use; SIHLE is designed to foster positive attitudes and norms toward consistent condom use and to teach girls how to place condoms on their partners.
- Discuss triggers that make negotiating safer sex for adolescents challenging.
- Emphasize the importance of partner involvement in safer sex; the homework activities are designed to involve the male sex partner.
- SIHLE must be implemented with passion, specifically with a high level of energy and charisma.

- Deliver the intervention to adolescents in community-based settings, not in a school-based setting or during school hours.
- Determine if your agency is required to obtain parental consent for adolescents' participation.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the community-based organization (CBO) or implementing agency. Adaptations may also be made to meet the needs of the at-risk target population.

SIHLE has the following key characteristics:

- Include 10 to 12 African American female adolescents in the intervention group sessions. Fewer than 10 adolescents may not allow for full interactive discussions, but more than 12 adolescents may be more difficult to manage.
- Each session should last approximately 3 hours.
- SIHLE can be adapted for different groups of African American, female adolescents. If white, Native American, Asian, Pacific Islander, or Hispanic/Latina adolescents wish to enroll in the intervention, they may fully participate with the other adolescents and should not be denied HIV prevention services.
- SIHLE may be publicized as a program that was developed by African American females for African American females.
- SIHLE may include HIV prevention discussions that address relationships, dating, and sexual health in the context of the female African American teenage experiences.

Procedures

Procedures are detailed descriptions of some of the elements and activities listed above.

Preparing to implement SIHLE

Pre-implementation is the first phase of implementing any intervention and involves activities that are necessary to begin the implementation. The CBO may take 3 to 6 months to specify community need and determine the applicability of SIHLE to that need, obtain project acceptance, develop community collaborations, establish a referral network, find a meeting location, and recruit and train staff. Before implementing the SIHLE intervention, CBOs should conduct a readiness assessment to determine whether they possess the capacity, or can build the capacity, to adopt and implement the SIHLE intervention. The success of SIHLE will depend upon CBOs having the appropriate recruitment mechanism, resources, and relationships in place.

Three implementation worksheets are provided—recruitment, logistics, and community collaborations—to help CBOs plan for and prepare to implement the SIHLE intervention. The recruitment worksheet explores various topics that must be addressed before identifying and enrolling adolescents into the program. The logistics worksheet provides a realistic examination of the logistical aspects to consider before implementing SIHLE. The community collaborations worksheet emphasizes how to involve other community agencies in a manner that benefits all parties involved. These worksheets are supplemented by sample documents (e.g., parental and participant consent forms, near peer recruitment flyers, facilitator interview protocols [adult and near peer]).

Conducting SIHLE sessions

The SIHLE sessions should occur on a weekly basis. Each of the sessions has specific goals, and key objectives. The goals of each of the sessions are as follows/

Session 1: My Sistas, My Girls. The purpose of this session is to discuss ethnic and gender pride and what it means to be an African American adolescent, emphasizing the importance of self-love, pride, and the positive qualities of being an African American adolescent. This session has the following goals:

1. Introduce facilitators and participants.
2. Provide the overview of the intervention and its purpose.
3. Establish ground rules and expectations for the intervention.
4. Generate a discussion about what it means to be an African American female teen.
5. Create a safe and open climate that encourages group participation and interactive learning.

Session 2: It's My Body. The purpose of this session is to provide participants with basic information on sexually transmitted diseases and HIV and their relationship to risky sexual behavior. This session has the following goals:

1. Review values, goals, and dreams.
2. Introduce the concept of risk behaviors.
3. Introduce sexually transmitted disease and HIV information (or increase knowledge of HIV transmission).

Session 3: SIHLE Skills. The purpose of this session is to develop skills regarding condom use skills and effective communication. This session has the following goals:

1. Increase the adolescents' skills in resisting pressure to engage in unsafe sex.
2. Enhance the adolescents' ability to recognize the difference between assertive, aggressive, and nonassertive communication.
3. Teach a model of assertive communication.
4. Increase the adolescents' skills in negotiating safer sex.

5. Dispel common myths about using condoms.
6. Increase the adolescents' effective condom use skills.
7. Teach and model how to put condoms on properly and consistently.

Session 4: Power and Relationships. The purpose of this session is to teach participants the difference between healthy and unhealthy relationships and reinforce the messages of assertive communication, correct condom use, and gender and ethnic pride. This session has the following goals:

1. Improve the adolescents' ability to distinguish between healthy and unhealthy relationships.
2. Enable the adolescents to define abuse.
3. Increase the adolescents' ability to recognize the implications of partner selection.

ADAPTING

There may on occasion be adolescent females who are not African American may enroll and enter the intervention, but the intervention should still be delivered as planned. HIV prevention services funded by the US government can not be denied to anyone on the basis of gender, race, or ethnicity.

Organizations may wish to adapt SIHLE for adolescent females who are not African American. Although this is possible, considerable changes will need to be made to make the intervention culturally appropriate for adolescent females who are not African American. Organizations should consider adopting an intervention that has proven effective in populations similar to their target population.

RESOURCE REQUIREMENTS

Facilitators

In addition to the program coordinator, 3 women should co-facilitate SIHLE sessions. The peer facilitators should be near-peers of the target population in terms of age, gender, and race/ethnicity (African American women between the ages of 18 and 21). **Skilled and experienced near-peer facilitators are the key to ensuring the success of the intervention.**

CBOs that have implemented SIHLE have found 3 co-facilitators (1 adult and 2 near-peer) to be more effective than 2. Three facilitators allow 1 facilitator to lead the discussions and activities while the others can monitor the mood and energy of the group as well as individual females. CBO capacity to hire 3 facilitators should be taken into

consideration. Two facilitators can be used when necessary; however, consideration must also be given to the role that the near-peer facilitators play in facilitating SIHLE. Since the intervention is peer-led, the near-peer facilitators conduct most activities in the sessions. Therefore, using 2 near-peer facilitators will allow for the high level of energy and focus that SIHLE requires. Additionally, since most near-peer facilitators are likely to be new to facilitation, having a back-up near-peer facilitator ensures support and continuity throughout implementation. The facilitators should be well-versed on HIV transmission and methods for preventing HIV transmission and should have a nonjudgmental attitude toward youths who may engage in risky sexual behaviors. Adult and near-peer facilitators should have group facilitation and leadership skills, have experience working with the target population, be comfortable with discussing sensitive issues, and preferably be sexually active. Facilitators should also share a common language and dialect with the participants.

Before implementing the intervention, facilitators should thoroughly review all program materials, plans, and logistics. Specific materials and instructions are provided in the intervention package. In addition, the staff should copy materials and purchase incentives and other materials necessary to implement the intervention. Facilitators should create a culturally sensitive environment and should understand the participants' cultural heritage and peer norms.

Training the near-peer facilitator

Since SIHLE is a peer-led intervention, the near-peer facilitators must either attend a SIHLE training of facilitators (TOF), or their agency must prepare a plan to indicate how they will be trained once the adult facilitator attends a TOF to receive training. Guidance on training the near-peer facilitator will be provided in the SIHLE starter kit.

Space

SIHLE needs an appropriate place where the sessions can be held. This space must be large enough for 10 to 12 people to sit in a circle and move around comfortably, easy to access by public transportation, private and secure, so that confidentiality can be maintained, and quiet and without interruptions (such as people entering and exiting the room or outside noise).

Supplies

A number of supplies are needed to effectively implement SIHLE:

- Penile and vaginal models for condom demonstrations and practice.
- A variety of male condoms and enough female condoms for all participants.
- Incentives for participants to encourage their attendance (e.g., bus tokens, toiletry items, food, child care, phone cards, music CDs, flowers)

- Intervention materials (e.g., the SIHLE implementation manual, session handouts, training chart paper)
- Culturally relevant and age appropriate room and table decorations (e.g., decorative cloths, photos, drawings) to make participants feel comfortable.

SIHLE uses materials that must be photocopied (e.g., handouts, session evaluations, Thought Works), so access to a photocopier is needed.

The SIHLE intervention package is available through trainings conducted by CDC. The intervention package includes an implementation manual with a facilitator's guide, pre-implementation and implementation information, activity handouts, evaluation tools, monitoring forms, and a technical assistance guide. In addition to the SIHLE intervention package, CDC provides additional information and tools for those selecting, implementing, or evaluating SIHLE. These materials can be found at www.effectiveinterventions.org.

RECRUITMENT

Recruitment of Participants

SIHLE was designed to target sexually-active, heterosexual African American teenage females ages 14-18 and at risk for HIV through sexual behavior.

To encourage participation, SIHLE should be publicized as a program for African American female adolescents; a program developed by African American females; a program that discusses dating, relationships, healthy sex practices; and a program that works to improve teen's ability to effectively communicate with sex partners.

Adolescents may be recruited from a CBOs' existing youth programs, health and social service organizations, family planning clinics, sexually transmitted disease clinics, community-based organizations, shelters, or focus groups. After the SIHLE program has become established, adolescents that have participated in the program themselves will be most successful at recruiting other adolescents into the project. Since they can speak from personal experience, they can be asked to recruit their peers to participate in the intervention.

CBOs should have a recruitment plan in place that details how participants will be recruited, recruitment venues and locations, recruitment/marketing tools, and number of participants to be recruited. Additionally, creating and using an advisory board can provide the agency with the answers to some recruiting questions, such as:

- Where is the best place to recruit?

- What are the best recruiting strategies for your populations?
- What might motivate members of the target population(s) to attend SIHLE?

Local Community Businesses

Obtaining support from community organizations and businesses is an important support structure for the SIHLE intervention. Local businesses can support the program in various ways. These include providing snacks, gift certificates, or other incentives. Businesses can be recruited for support via donation letters and face-to-face visits. Help should be solicited before the SIHLE sessions begin, since certain businesses donations have to be approved in advance by the agency executive director.

POLICIES AND STANDARDS

Before an agency attempts to implement SIHLE, the following policies and procedures should be in place to protect youths, the agency, and the facilitators.

Targeting of Services

Agencies must establish criteria for, and justify the selection of, the teen target population. Selection of appropriate adolescent populations must be based on epidemiologic data, behavioral and clinical surveillance, and the state or local HIV prevention plan created with input from the state or local community planning groups.

Parental Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the program participants' rights. Individual state laws apply to consent procedures for minors; at a minimum, consent should be obtained from each participant. Participation must always be voluntary, and documentation of this informed consent must be maintained in the participant's record.

Attendance Policy

CBOs should have an attendance policy in place. The policy should clearly explain the agency's expectation that participants attend every session and that the sessions are closed to new members. The attendance policy should also address tardiness and the notification process for absences. Each session builds on the previous session, so missing sessions undermines the ability of participants to fully participate and benefit from the intervention

Debriefing

SIHLE deals with issues that may cause emotional responses in both participants and the facilitators. Debriefing allows the facilitators a time to address those emotions and their effects on facilitating SIHLE.

Confidentiality and Informed Consent

A system must be in place to ensure that confidentiality is maintained for all participants. Before sharing any information with another agency to which a participant is referred, signed informed consent from the participant or permission from her legal guardian must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be sensitive to the populations they serve. In addition, they should offer materials and services in the preferred language of participants, if possible, or make translation available, if appropriate. Since SIHLE is a youth-focused intervention, facilitators should be familiar with local youth culture. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the [Introduction](#) of these guidelines for standards for developing culturally and linguistically competent programs and services.)

Data Security

CBOs should ensure data security and the confidentiality of participant information. Data should be stored (in a locked file cabinet, inside a locked office) away from the study site. Re-identification links should be stored in a separate (locked) file cabinet. Only the project coordinator and program evaluator should have access to the data set and re-identification links.

Legal and Ethical Policies

CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform participants of the organization's responsibilities if a participant receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform program participants about state laws regarding the reporting of dating violence, child abuse, and sexual abuse of minors.

Linkage of Services

Project staff should link program participants to care and prevention services (counseling, testing, and referral services) available to adolescents whose HIV status is unknown. Moreover, project staff should link participants to services that cater to adolescents involved in dating violence and abusive relationships.

Personnel Policies

CBOs conducting recruitment, outreach, health education, and risk reduction must establish a code of conduct for personnel. This code should include, but may not be limited to, the following: do not take on a parental role, do not use drugs or alcohol, use appropriate behavior with program participants, and do not loan or borrow money. This policy must be clearly stipulated to facilitators.

Referrals

CBOs must be prepared to refer participants for additional services as needed. For program participants who need additional assistance in decreasing risk behavior, facilitators must know about local referral sources for prevention interventions and counseling by providing them with a resource guide for services such as partner counseling referral services, mental health and abuse services, and other health department and CBO prevention programs.

Safety

CBO policies must exist to ensure the safety of facilitators and participants. Plans for dealing with medical or psychological emergencies must be documented.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, then the CBO should know and disclose how its liability insurance and worker's compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees.

QUALITY ASSURANCE

Quality assurance is the process by which someone familiar with the intervention observes its delivery and provides feedback and documentation on their observations regarding implementation and fidelity.

The responsibility for quality assurance falls to the program coordinator. Periodically, he or she should observe sessions. After each observation, the program coordinator can

provide the intervention team with feedback, help them in areas that need improvement, and discuss the need for further training or technical assistance needs.

MONITORING AND EVALUATION

Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the procedural guidance will include the collection of standardized process and outcome measures. Specific data reporting requirements will be provided to agencies after notification of award. For their convenience, grantees may utilize PEMS software for data management and reporting. PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management. CDC will also provide data collection and evaluation guidance and training and PEMS implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC by using PEMS or other software that transmits data to CDC according to data requirements. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies designed to assess the effect of HIV prevention activities on at-risk populations.

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