

Sister to Sister

DESCRIPTION

Sister to Sister is a brief (20-minute) one-on-one, skill-based HIV/sexually transmitted disease (STD) risk-reduction behavioral intervention for sexually active African American women 18 to 45 years old who have male partners. The intervention is designed to provide women with the knowledge, beliefs, motivation, confidence, and skills necessary to help them make behavioral changes that will reduce their risk for STDs, especially HIV. The intervention is highly structured and implemented in a primary health care setting by nurses, health educators, or other professional clinic staff using an implementation manual. It is educational, engaging, and gender-appropriate and uses videos, brainstorming, experiential exercises, and skills-building activities. It is designed to be easily integrated into the health care provider's standard clinical practice. As such, the Sister to Sister intervention is an effective tool for addressing the needs of both patients and providers in primary care clinics.

Sister to Sister has been packaged by CDC's Replicating Effective Programs project. An intervention package, training, and technical assistance are available from CDC. The intervention package will be provided only to agency staff attending the 1-day, 8-hour Sister to Sister training conducted by CDC's training partners, the STD/HIV Prevention Training Centers. Planning and implementation information (including the starter kit and technical assistance guide) can be found at www.effectiveinterventions.org. The implementation manual, facilitator's teaching guide, training of facilitator's curriculum, 2 video clips, and other materials used in the intervention will be available at the end of 2009.

Goals

The purpose of Sister to Sister is to provide intensive, culturally sensitive health information to empower and educate women in a clinical setting, help women understand the various behaviors that put them at risk for HIV and other STDs, and enhance their knowledge, beliefs, confidence, and skills to reduce their risk for STDs, especially HIV.

Sister to Sister has 4 goals:

1. Increase participants' perceived vulnerability to HIV/STDs.
2. Build participants' self-confidence (self-efficacy) and skills to use condoms correctly and consistently.
3. Build participants' self-efficacy and skills to negotiate condom use or abstinence with their partners.
4. Bolster positive beliefs and outcome expectancies regarding condom use.

In addition to the intervention goals, Sister to Sister has 6 intervention objectives:

1. Identify the correct information regarding the transmission and prevention of HIV.

2. Identify participants' feelings about being vulnerable to HIV infection.
3. Identify and demonstrate the correct steps to using a condom on anatomical models.
4. Describe ways to make using condoms fun and pleasurable.
5. Help participants negotiate with a partner about using condoms or abstaining from sex.
6. Help participants feel more empowered by demonstrating a stronger sense of pride, self respect, and responsibility in practicing safer-sex strategies.

How It Works

Sister to Sister is intended to be delivered during the course of a routine medical visit. At this time, a health care provider (e.g., a nurse or health educator) with similar demographic characteristics as the participant engages her with a caring attitude and interest in the participant's health as it relates to HIV/STD acquisition. The provider delivers a brief risk assessment to the participant and, based on the participant's responses to the questions, initiates a discussion about HIV/STD risk reduction. The provider opens with engaging statements to emphasize the woman's worth and value as it relates to preventing HIV/STD infection.

Throughout the 20-minute discussion, the health care provider gives epidemiologic and statistical information about incidence of HIV/AIDS in the participant's community and assists the participant in identifying her personal feelings about using condoms. The provider also teaches the participant correct information regarding HIV/AIDS, its transmission, etiology, and prevention; negotiation skills through role-playing activities and discussion; and how to make condom use fun and pleasurable. Finally, the provider demonstrates correct condom use; builds the participant's confidence in negotiating condom use with her sex partner through practice, reinforcement, and providing constructive supportive feedback; and shows 2 educational video clips—one emphasizes personal vulnerability to HIV/STDs and the other reinforces the communication messages taught in the intervention.

Sister to Sister has 3 unique features that make it an effective behavioral intervention for sexually active African American women:

1. Sister to Sister focuses on the fact that women can make a difference in the HIV epidemic by respecting and protecting themselves and believing that they can adopt responsible and safer sexual behaviors. Women must also believe that they must change their behavior not only for themselves but also for their families and that they have the confidence and the skills to negotiate and practice condom use.
2. Sister to Sister focuses on caring. The concept of caring is a motive for building confidence (self-efficacy). The health care provider must demonstrate that she cares about the woman, her health, and her future; she supports her and believes in her; and she truly wants to help strengthen her confidence and skills to negotiate and use condoms.
3. Sister to Sister focuses on pride and respect. Women experience periods of confusion, mixed emotions, and uncertainty about sexual behavior. Sister to Sister addresses these feelings by emphasizing that making proud and responsible safer-

sexual choices can feel good. Women's sense of pride, self-confidence, self-satisfaction, and self-respect are reinforced throughout Sister to Sister, especially during the role-plays and other skill-building activities.

Theory Behind the Intervention

Social cognitive theory (Bandura, 1977) guided the development of the intervention. This theory provides prescriptions to change the presumed mechanisms that underlie health behavior. Two components of the theory are especially pertinent for Sister to Sister: perceived self-efficacy and outcome expectancies. The theoretical components of the Sister to Sister intervention are the following:

1. Self-efficacy—the participant's perception that she has the confidence to engage in the proposed behavior (e.g., using condoms).
 - Participant believes that using condoms is easy.
 - Participant believes that getting one's partner to use a condom is easy.
 - Participant believes that talking to her partner about condom use is easy.
2. Outcome expectancy—the participant's perception that positive outcomes will happen as a result of the new behavior.
 - Partner reaction—participant believes that partner will not leave her or cheat if condoms are introduced in the relationship.
 - Hedonistic beliefs—participant feels that condoms will not ruin sexual pleasure.
 - Prevention beliefs—participant feels that HIV can be prevented by using condoms correctly and consistently.
3. Perceived risk—the participant's awareness of personal risk if behaviors are not altered.
 - Participants realize that by having unprotected sex they are at risk for HIV/STDs.
 - Participant realizes that the proud and responsible thing to do is to protect herself.
4. Skill acquisition—acquiring skills needed to implement the proposed behavior (e.g., using condoms correctly and consistently).
 - Participants learn and practice negotiation skills.
 - Participants learn how to use condoms.

The intervention was designed to increase positive outcome expectancies regarding condom use, increase self-efficacy to negotiate and use condoms correctly, and increase negotiation and condom use skills.

Research Findings

The purpose of the original study (Jemmott, et al., 2007) was to identify effective, single-session, gender-specific, culturally appropriate HIV/STD risk-reduction interventions for African American women ages 18 to 45 that could be implemented by nurses in a primary care setting. Participants were 564 African American women (mean age 27 years) who were recruited at a women's health clinic of an inner-city hospital. The women were randomly assigned to 1 of 5 interventions: 2 kinds of intervention content, information vs. behavioral skills; 2 methods of delivery, group (200 minutes) vs.

individual (20 minutes); or a health promotion group (control group). The women participated on a Saturday morning, and baseline STDs were assessed before the intervention. Participants completed pretest measures, received their specific intervention, and then completed a posttest immediately after the intervention. The women returned to complete confidential questionnaires at 3, 6, and 12 months after the intervention, and clinical exams were conducted at 6 and 12 months. Return rates were 92%, 90%, and 87% at the 3, 6, and 12-month follow-ups, respectively.

The results of the study indicated that compared with women in the control group, more women in the skill-building interventions reported that they consistently used condoms. They also were more likely to have used condoms at their most recent intercourse, used condoms more consistently, and had fewer days of unprotected sex. These results were significant at the 3-month follow-up and 12-month follow-up, but none of the differences was significant at 6-month follow-up. Women in the skills-building intervention were also less likely to test positive for an STD at the 12-month follow up than were women in the control group. These results indicate that relatively brief but intensive culturally sensitive and gender-specific HIV risk-reduction interventions can improve HIV risk behavior and decrease STD incidence among African American women. Practicing condom use and sexual negotiation skills can be helpful, and nurses and other primary care providers can implement the intervention in clinical settings.

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory on which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

The core elements of Sister to Sister are organized into two sections: content core elements and implementation core elements. Content core elements are the essential elements of what is being taught by the intervention that is believed to change risk behaviors. Implementation core elements are the essential characteristics of the intervention that relate to the logistics that result in a positive learning environment.

Sister to Sister has the following 4 content core elements:

1. Teach, demonstrate, and practice negotiation and refusal skills.
2. Teach, demonstrate, and practice using condoms.
3. Bolster 3 outcome expectancies (sexual pleasure, prevention, and partner reaction).
4. Build self-efficacy to empower the women to want to be safe sexually.

Sister to sister has the following 4 implementation core elements:

1. Demonstrate a caring attitude.
2. Integrate and use all core intervention materials (facilitator's teaching guide, participant guide, videos, posters, risk assessment handout, and penis model).

3. Should be implemented by a specially trained female health care provider who completed the 1-day training session.
4. Should be implemented in a primary health care clinic (e.g., primary care clinic, family planning clinic, STD clinic, or agency clinic site).

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 target population.

Sister to Sister has the following 5 key characteristics:

1. The trained clinic staff delivering the intervention can vary (e.g., nurse, social worker, health educator).
2. Epidemiologic data for women and zip codes where the prevalence of HIV/STDs is highest (provided in the teaching guide) can be specific to state/region.
3. Setting can be any confidential room (e.g., an examination room or a counseling room).
4. Risk assessment inventory can vary by site on the basis of what the site is implementing.
5. The pictures of women on the cover of the brochure that illustrates positive aspects of womanhood and sisterhood can vary.

Procedures

Procedures are detailed descriptions of some of the elements and characteristics listed above. Procedures for Sister to Sister are as follows:

Showing a caring attitude

Health care providers engaging the female participant with a caring and interested attitude for her health is a foundational component to getting women to listen and hear the prevention messages covered in the intervention.

Personal vulnerability

Using epidemiologic data for the selected geographic area will help begin the discussion of how women similar to the participant have been affected by HIV/STDs. In addition to using local epidemiologic data, the intervention identifies several zip codes in the communities where Sister to Sister is being delivered to participants to emphasize the effect HIV/STDs have had in specific areas. A brief video clip of personal testimonies from women who may be at risk for acquiring HIV/STDs is shown during the brief intervention to illustrate how women may be at risk.

Communication and negotiation skills

The intervention teaches women a 4-step communication technique called SWAT. SWAT stands for **say** no to unsafe behavior, be prepared to say **why** you want to be safe, provide **alternative** safe behaviors, and **talk** it out with your partner. A brief video clip is shown during the intervention to illustrate how a woman uses these 4 steps with her partner to negotiate condom use.

Practicing techniques

During the intervention, the health care provider not only reviews specific communication and negotiation techniques but also allows the participant to practice proper condom application techniques and communication skills that have been demonstrated in the video clip.

ADAPTING

Sister to Sister may be adapted for different populations of sexually active women by varying the ethnicity of the health care provider, modifying the epidemiologic or statistical information for different ethnic groups of women in different areas, and adapting to geographic areas where high rates of HIV/STDs among women are reported.

RESOURCE REQUIREMENTS

Staff

Sister to Sister needs 1 female full-time paid, experienced nurse, health educator, or other health care professional (preferably of similar ethnicity of the women served); 1 part-time (25% time) program coordinator for supervision, quality assurance, and evaluation; and 1 part-time (20% time) administrative assistant for triaging participants. The facilitator can have bachelor's level training in nursing, health education, or other health field but should be a staff person who has a natural point of contact with clinic patients. The facilitator should have experience working with people at risk for HIV/STDs.

Facilitators should attend the 1-day, 8-hour Sister to Sister training conducted by CDC's training partners, the STD/HIV Prevention Training Centers. The program coordinators and managers, who oversee the intervention and supervise the facilitators, are also encouraged to attend the Sister to Sister training. Program coordinators and managers and those interested in learning more about the intervention are encouraged to read the Sister to Sister starter kit found at www.effectiveinterventions.org.

Space

Sister to Sister was designed to be delivered in an examination room during a routine medical visit. It has also been delivered effectively in public health departments and private family-planning clinics. Regardless of location, the space should meet the following requirements:

- Accessible at a variety of times for flexible scheduling.
- Private and secure, so that confidentiality of participants can be ensured.
- Quiet and without interruptions (such as people entering and exiting the room or outside noise).

Supplies

The Sister to Sister intervention package comes with generic marketing tools, such as printed promotional literature. Sister to Sister also will require the following:

- A handheld portable DVD player (a DVD and television or video monitor; a remote control or laptop computer capable of playing DVDs would also suffice).
- Anatomically correct penile models for condom demonstration.
- Male condoms, lubricants, and latex barriers.
- Take-home packets of condoms and lubricants.
- Incentives or promotional items, such as a key chain with the intervention logo (optional).
- A handheld mirror.

RECRUITMENT

Agencies are encouraged to screen potential participants to determine whether they are appropriate for the intervention. Three processes should be considered when developing a plan to select the most appropriate women to recruit for Sister to Sister:

- Recruit all sexually active women who meet the eligibility criteria and who are seeking medical services.
- Train a select number of health care providers, and recruit the patients seen by those providers.
- Develop an alternative recruitment plan to select the participants.

Developing a recruitment strategy that will work in the selected setting before implementation is necessary for program success.

POLICIES AND STANDARDS

Before an agency attempts to implement Sister to Sister, the following policies and standards should be in place to protect participants, the agency, and the Sister to Sister intervention team:

Confidentiality

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

Cultural Competence

Agencies must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. Agencies should hire, promote, and train all staff to be representative of and sensitive to different cultures. In addition, they should offer materials and services in the preferred language of participants, if possible, or make translation available, if appropriate. Agencies should facilitate community and participant involvement in designing and implementing prevention services to ensure that cultural issues are incorporated. 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 this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and participant confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

Agencies must have a consent form that carefully and clearly explains (in appropriate language) the agency's responsibility and the 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.

Legal and Ethical Policies

By virtue of participation in Sister to Sister, participants living with HIV/AIDS may learn of or disclose their HIV status. Agencies must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners. Agencies are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. Agencies also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

Agencies must be prepared to refer participants as needed. For participants who need additional assistance in decreasing their risk behaviors, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and agency prevention programs. For potential clients who are experiencing severe violence in their relationship, providers must be prepared to refer them to intimate partner violence help.

Volunteers

If the agency uses volunteers to assist with or conduct this intervention, then the agency should know and disclose how their liability insurance and worker's compensation applies to volunteers. Agencies must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. Agencies must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing Sister to Sister:

Facilitators Training

Facilitators should complete a training workshop, including review of the intervention theory and materials, and participate in practice sessions.

Session Review

Agencies should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on adherence to session content, use of correct videos and adequate facilitation of discussions, accessibility and responsiveness to expressed client needs, and process elements (e.g., time allocation, clarity).

Record Review

Selected intervention record reviews should focus on ensuring that consent forms (signed by the client) are included for all participants and that session notes sufficiently document that clients are participating actively.

Participants

Participants' satisfaction with the intervention and their comfort should be assessed at each session.

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.

REFERENCES

Bandura, A. Social learning theory. Englewood Cliffs, NJ: Prentice-Hall; 1977.

Jemmott LS, Jemmott JB III, O’Leary A. Effects on sexual risk behavior and STD rate of brief HIV/STD prevention interventions for African American women in primary care settings. American Journal of Public Health. 2007;97:1034–1040.

KEY ARTICLES AND RESOURCES

An intervention package for purchase is also available through Select Media, Inc. at <http://selectmedia.org/>.

An intervention package, training, and technical assistance on the Sister to Sister intervention are available from CDC.

CDC. Draft CDC technical assistance guidelines for CBO HIV prevention program performance indicators. Atlanta, GA: US Department of Health and Human Services; 2003.

Office of Minority Health. (2001). National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services; 2001. Available at: <http://www.omhrc.gov/omh/programs/2pgprograms/finalreport.pdf>.