An Evaluation of Sisters Informing Healing Living Empowering: Increasing HIV Knowledge Among African American Adolescent Females Using an Evidence-Based HIV Prevention Intervention

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Background: In Detroit, Michigan, 85% of HIV cases are among African American youth. Approximately 53.4% of African American high school females have had sexual intercourse; 44.7% did not use a condom during the last sexual encounter. School-based sexual health education may be limited regarding HIV prevention. Sexual health education that is culturally and gender-specific is needed to provide knowledge that may impact condom self-efficacy and address the HIV epidemic among African American adolescents in Detroit. Community-based organizations may be used to implement an evidence-based educational intervention. **Methods:** A 1-group, pretest/posttest design was used to evaluate knowledge of HIV and condom use among 11 African American adolescent females who participated in an evidence-based intervention, Sisters Informing Healing Living Empowering (SIHLE), during 3-hr sessions over 4 consecutive Saturdays. There was 100% attendance among participants for all sessions. Knowledge of HIV and condom use was measured with a 16-item true/false survey before and after the intervention. **Results:** A significant difference between HIV knowledge at pretest and HIV knowledge at posttest was noted, $z = -2.322$, $p = .02$. **Conclusion**: Nurses and community stakeholders can be instrumental in addressing the HIV epidemic by implementing evidence-based interventions that increase knowledge of HIV prevention and condom use.

Keywords: adolescent female; African American; HIV knowledge; evidence-based; Sisters Informing Healing Living Empowering (SIHLE)

Introduction

Among young people between the ages 13 and 24 years residing in Detroit, Michigan, there are an estimated 2,191 cases of HIV, accounting for 21% of all cases in the city (Michigan Department of Community Health, 2014). The Centers for Disease Control and Prevention (CDC) report that nearly half (43.3%) of Detroit high school students have had sexual intercourse, and of these,

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34.2% did not use a condom during the last encounter (CDC, 2014). The CDC reports that nationwide, African American adolescents are knowledgeable about HIV/AIDS and sexually transmitted infections (STI); however, knowledge alone has not been sufficient in addressing the HIV epidemic in this population (CDC, 2015a).

Limited access to HIV prevention information that includes condom use may contribute to the high rates of HIV among African American adolescents in Detroit. Currently, the Michigan Revised School Code Act of 2004 prohibits the distribution of family planning drugs or devices, including condoms, in public schools or on school property. Although many Michigan schools have a sexual health education curriculum, components such as condom self-efficacy and birth control options are needed to ensure that complete and factual information is available to teens. In addition, urban African American female adolescents have unique risk factors for HIV/STI. The 2013 Youth Risk Behavioral Survey reported that African American females engage in sexual intercourse at earlier ages than their White counterparts (CDC, 2014), placing them at higher risk for contracting HIV and other STI. Gilbert and Wright (2003) found that adverse living conditions in impoverished urban communities contribute to a high risk of STI for African American girls, and Shambley-Ebron (2009) highlighted that early and frequent exposure to sexually explicit music lyrics, videos, internet, and television programs may negatively impact African American girls' self-image and sexual identity and play a contributing role in early sexual intercourse.

The CDC has indicated that theory-based, culturally specific, and gender-specific behavioral interventions are effective in reducing risky sexual behavior associated with HIV infections among many at-risk populations (CDC, 2015b). Because of the limitations of public school curriculum to address the HIV crisis among Detroit's youth, the authors reached out to a community-based organization to implement an evidence-based intervention, Sisters Informing Healing Living and Empowering (SIHLE), developed by DiClemente and colleagues (2004). The purpose of this article is to discuss the efficacy of SIHLE in addressing HIV knowledge among African American adolescent females during a community outreach event in the city of Detroit.

Background and Objectives

Adolescent health education policy is designed to facilitate healthy decision making and achieve specific health care goals. According to the CDC (2013), several best evidence HIV behavioral interventions have been rigorously evaluated and provide the strongest scientific evidence of efficacy in the reduction of high-risk sexual behavior and in increased HIV-protective behaviors. Yet in Michigan and other states, current health education policies fail to use the full extent of this data. Important components are needed to minimize the disparities associated with risky sexual behavior among African American youth and begin the eradication of preventable disease such as HIV/AIDS. These include increasing the adoption of evidence-based interventions, overcoming barriers related to current adolescent sexual health education policies, and promoting the role of the nurse as a viable change agent in addressing the HIV/AIDS epidemic in this population. Nurses have a strong presence in both school-based and community-based health environments, and they can play an important role in increasing the adoption of evidence-based behavioral interventions while influencing current health policy.

According to the CDC (2015a), African Americans make up 14% of the U.S. population but accounted for 44% of all new HIV infections in 2014. Although HIV is 100% preventable, African American youth are being infected with this debilitating and costly illness at an alarming rate, particularly in urban centers such as Detroit (Michigan Department of Community Health, 2014). African Americans make up approximately 82.7% of Detroit's population (United States Census Bureau, 2010) and account for 89% of all HIV cases (Michigan Department of Community Health, 2014). It is imperative that we engage urban African American youth in reducing health risks in a manner that is appealing to them.

Adolescence is a time when youth exhibit great creativity as well as risk taking and the development of poor health habits. The perpetual question in community outreach to adolescents is how to engage them to make health behavior changes. This study's main objective was to evaluate pre- and posttest HIV prevention and condom use knowledge among African American teen females in the context of the SIHLE intervention. SIHLE was one of only two interventions for HIV risk reduction that was cited by the CDC (2013) as specifically attending to African American adolescent females.

Sisters Informing Healing Living Empowering in a Large Urban Center

The SIHLE intervention was chosen to reflect the need and identity of the African American female adolescent population in Detroit Michigan. This intervention was thought to be the most optimal in a local Metro Detroit community setting with adolescent females based on its cultural and gender-specific relevance. DiClemente et al. (2004) developed the intervention for African American adolescent girls aged 14–18 years.

The behavioral intervention focused on ethnic and gender pride, healthy relationships, HIV/AIDS knowledge, and condom use skills and was later entitled SIHLE. In a randomized controlled study, the SIHLE intervention was initially evaluated among 522 nonurban African American girls residing in Birmingham, Alabama, who were sexually active (DiClemente et al., 2004). The intervention group received the SIHLE program, whereas the control group received exercise and nutrition information. The control and intervention group both received four 4-hr interactive group sessions, which took place on consecutive Saturdays at a family health clinic. Each group session included 10–12 participants and was facilitated by a trained African American female educator and two African American peer educators.

Based on the results of DiClemente and colleagues' (2004) study, at the 6- and 12-month assessment, participants in the intervention group were more likely to report fewer barriers to condom use, more favorable attitudes toward using condoms, more frequent discussions with male sex partners about HIV prevention, higher condom use self-efficacy scores, higher HIV prevention knowledge, and greater proficiency in using condoms. DiClemente and colleagues' study provides strong empirical evidence supporting gender- and culturally specific interventions in addressing the HIV epidemic among African American adolescent females. The purpose of this study was to implement and evaluate the effectiveness of the SIHLE program among urban African American adolescent females as a way of increasing HIV knowledge.

Each of the four SIHLE sessions has specific goals and key objectives (Table 1). In this study, all four SIHLE sessions were implemented, but only objectives for Sessions 2 and 3 were evaluated for the specific purpose of measuring HIV knowledge among participants. HIV knowledge was evaluated using a 16-item true/false survey. It was expected that after the SIHLE interventions, HIV knowledge would increase among the participants.

TABLE 1. SIHLE Sessions

Session 1: My Sistas, My Girls	Session 2: It's My Body
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: • Generate a discussion about what it means to be an African American female teen. • Highlight the important role and responsibility that African American females have to protect themselves, their families, and their communities. • Create a safe and open climate that encourages group participation and interactive learning. • Highlight the personal, social, and economic consequences of pregnancy, HIV/AIDS, and STDs.	The purpose of this session was to provide participants with basic information on STIs and HIV and their relationship to risky sexual behavior. This session had the following goals: • Review values, goals, and dreams of SIHLE participants. • Introduce the concept of risk behaviors. • Introduce STI and HIV information (or increase knowledge of HIV transmission). • Stress abstinence as the only way to be 100% protected from pregnancy, HIV/AIDS, and STIs.
Session 3: SIHLE Skills	**Session 4: Power and Relationships**
The purpose of this session was to develop skills regarding condom use skills and effective communication. This session had the following goals: • Increase the adolescents' skills in resisting pressure to engage in unsafe sex. • Enhance the adolescents' ability to recognize the difference between assertive, aggressive, and nonassertive communication. • Teach assertive communication. • Increase the adolescents' skills in negotiating safer sex. • Dispel common myths about sex and condom use. • Increase the adolescents' effective condom use skills. • Teach and model how to put condoms on properly and consistently.	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: • Improve the adolescents' ability to distinguish between healthy and unhealthy relationships. • Enable the adolescents to define abuse. • Increase the adolescents' ability to recognize the implications of partner selection.

Note. SIHLE = Sisters Informing Healing Living Empowering.

Research has indicated that use of peer education and peer modeling in sexuality health education supports healthy behavior changes and fosters an environment of mutual respect that enhances self-efficacy to change said behaviors in the context of social situations (Jennings, Howard, & Perotte, 2014). The SIHLE intervention uses peer educators to inform and guide discussions of HIV infection and prevention. The intervention, which employs constructs of social cognitive theory (Bandura) and Connell's theory of gender and power, is expected to enhance gender and ethnic pride, condom use skills, assertive communication skills, and sexual risk-reduction negotiation. Jennings et al. (2014) found that youth respond better to trainers with whom they can identify. The SIHLE intervention of this study used two peer educators who were relatable to the youth participants.

Methods

Prior to recruitment and data collection, full board review and approval of the SIHLE proposal was obtained by both the Michigan Department of Community Health Institutional Review Board (IRB) and from Wayne State University's IRB.

Recruitment of Participants

SIHLE participants were recruited by employees at a large community-based organization that serviced urban youth within the Metro Detroit area. IRB-approved flyers were posted at the facility and given to interested youth and parents. Eligibility criteria included (a) being African American and female; (b) being 14–18 years of age; and (c) providing written, informed parental consent.

The study objectives, purpose, and activities were thoroughly explained to the parents and participants prior to beginning the SIHLE intervention. IRB-approved informed consents were obtained and signed from parental guardians, and informed assents were obtained from the adolescent.

Recruitment of Peer Educators

The evidence-based SIHLE intervention uses one skilled adult facilitator, who is knowledgeable about youth culture, and two peer female facilitators (ages 18–21) to implement the SIHLE group sessions. In this study, the principal investigator (PI), a registered nurse with experience addressing health disparities in the adolescent community, served as the lead facilitator. The use of two peer youth educators was essential to fulfilling the fidelity of the SIHLE intervention workshops. Inclusion criteria for peer educators included being African American, between the ages of 18 and 21 years, and able to demonstrate interpersonal skills relatable to the participants and promote group norms related to HIV prevention (DiClemente et al., 2004). Peer educators were selected from a pool of applicants involved with local community organizations and agencies. Applicants submitted the required documents and were selected for interviews based on the inclusion criteria and written responses to questions related to leadership skills/capabilities, overcoming challenges, and peer education. Upon completion of the in-person interview, two peer educators were selected based on the noted criteria, including (a) ability to lead group discussions, (b) experiences leading youth-driven projects, (c) participation in youth leadership activities, and/or (d) previous experience as a peer educator.

The peer youth educators were trained by the PI over the course of 2 weeks prior to the start of the intervention. The peer educators and the PI facilitated all of the SIHLE sessions with youth participants as outlined in the intervention curriculum. The intervention was delivered with fidelity to DiClemente and colleagues' (2004) original program design with very minimal adaptations.

Measures

Demographic information was collected from the participants that included age, zip code, and grade level. HIV prevention knowledge was assessed using satisfactory psychometric measures used by the developers of the SIHLE intervention (DiClemente et al., 2004). The HIV prevention knowledge was measured at baseline and after administration of the SIHLE intervention using a 16-item, true and false HIV knowledge scale ($\alpha = .68$; DiClemente et al., 2004).

Intervention

The SIHLE intervention groups were scheduled over the course of four consecutive Saturdays from 11 am to 3 pm at a community center in Detroit, Michigan. The SIHLE sessions were 3 hr each, and lunch was provided, which took approximately 1 hr. Participants were evaluated prior to the start of the intervention to assess their baseline knowledge regarding HIV/AIDS. At the completion of the SIHLE intervention, participants completed the initial baseline assessment tool again to assess the impact of SIHLE on HIV knowledge. All assessments were deidentified, and participants were assigned a unique numerical code for comparison of pretest/posttest data. Participants received compensation for their time in the form of gift cards dispersed during the second and fourth sessions.

TABLE 2. Grade Level of Students ($N = 11$)

Grade Level	Number of Students
9th	3
10th	2
11th	5
12th	1

Results

Eleven African American adolescent females were recruited to participate in the 4-week intervention. Their ages ranged from 15 to 18 years, with a mean age 16.09 years ($SD = 1.136$ years). High school grade levels ranged from 9th through 12th (Table 2). Most of the participants resided in the city of Detroit (91%) with one participants residing in Sterling Heights.

There was 100% attendance and participation in the 4-week SIHLE intervention, and all participants completed the HIV Knowledge pretest and posttest (Table 3).

A Wilcoxon test was conducted to evaluate whether HIV knowledge among African American adolescent females increased from pretest (before SIHLE intervention) to posttest (after SIHLE intervention). Because of the implementation project's small sample size ($N = 11$), Wilcoxon signed-rank test was used to test the means of the pre- and post-HIV knowledge scores. Despite the small sample size, a significant difference between HIV knowledge at pretest and HIV knowledge at posttest, $z = -2.322$, $p = .02$, was established. Mean scores for HIV prevention knowledge among SIHLE participants rose from 67.6% ($SD = 18.29$) at pretest to 83.6% ($SD = 9.61$) at posttest (Table 4).

Interpretation

The results of this evidence-based intervention show that the amount of HIV knowledge increased from baseline. However, there are some limitations using this theory-driven model. Throughout the implementation of SIHLE, it became evident that many adolescent females had limited formal education in basic human development and reproductive anatomy. SIHLE participants had many questions pertaining to the correct anatomical terminology related to sexual organs and normal puberty changes. SIHLE participants also used slang terminology as a way to normalize and minimize risk associated with unsafe sexual practices. In those moments, peer educators and participants would explore the slang terminology and connect it to the formal terms. These discussions frequently distracted from the curriculum temporarily, but slang labels needed to be addressed and clarified prior to continuing with the

TABLE 3. Item Analysis

SIHLE Questions (True or False)	Pretest (%)	Posttest (%)	% Change
1. Douching after sex helps protect you from STDs. (F)	64	91	27
2. You can't get the AIDS virus through a cut in your skin. (F)	82	64	18↓
3. You can't always tell if your partner has an STD. (T)	91	91	0
4. Pre-ejaculatory fluids (pre-cum) carry the AIDS virus. (T)	64	82	18
5. People who have the AIDS virus generally feel sick right away. (F)	82	100	18
6. You can't get the AIDS virus by sharing knives and forks or a bathroom with a person who has AIDS virus. (T)	55	82	27
7. An untreated STD can possibly result in being unable to have children. (T)	64	73	9
8. Condoms with spermicide will protect you from most STDs. (T)	45	82	37
9. Women can spread STDs to men when they don't use condoms. (T)	73	91	18
10. If a woman uses birth control pills, it lowers her risk for getting the AIDS virus. (F)	73	100	27
11. Having an STD puts you at greater risk for getting the AIDS virus. (T)	73	82	9
12. If a person has the AIDS virus, it is still safe to kiss them on the lips, as you would kiss a friend or relative. (T)	64	100	36
13. The most effective way to prevent the spread of the AIDS virus is abstinence from sex. (T)	82	100	18
14. Sheep skin condoms are better than latex condoms for preventing AIDS infection. (F)	55	82	27
15. Using oil-based lubricants (Vaseline, Crisco) with condoms will reduce the risk of getting the AIDS virus. (F)	73	91	18
16. All STDs, except for the AIDS virus, can be cured with antibiotics. (F)	45	55	10

Note. STD = sexually transmitted disease; ↓ = decrease.

TABLE 4. Adolescent HIV/AIDS Knowledge

SIHLE	*M* (*N* = 11)	*SD*
Preintervention	67.6 (25–93.75)	18.29
Postintervention	86.36 (68.75–100)	9.61

Note. SIHLE = Sisters Informing Healing Living Empowering.

SIHLE curriculum. Assessing participants' knowledge on topics of human sexual development and providing a basic reproductive health review before implementing the SIHLE program is recommended.

The SIHLE intervention focused mainly on HIV transmission from risky sexual behavior, and there was very little content related to other ways of transmission such as intravenous drug use. Most of the questions on the pretest/posttest were related to risky sexual behavior and the transmission of HIV through sexual contact. The 16-item, true/false HIV knowledge questionnaire had one question that required participants to know that the AIDS virus can be transmitted through a cut in the skin. The question was worded as follows: "You can't get the AIDS virus through a cut in your skin"; the participants were asked to respond true or false. At pretest, 81% of participants had the correct answer; however, at posttest, the percentage of correct answers decreased to 64% (18% decline). This decline could indicate the need to provide more information related to the other ways that HIV can be transmitted. Despite these limitations, it is evident that the SIHLE model can be used in informal settings such as a community center to decrease risky sexual behavior among African American female teens.

Conclusion

As was demonstrated in this project, culturally and gender-specific comprehensive sexual health education that includes components such as condom self-efficacy and consequences of risky sexual behavior can be implemented in a community setting to increase the knowledge of HIV/AIDS. This project was able to address the barriers to consistent and appropriate condom use and thus demonstrates that the SIHLE program can be beneficial in reducing unprotected sex in African American adolescent females living in a large urban environment. The project worked with already established community organizations to provide age- and gender-appropriate comprehensive sexuality education to adolescents without the barriers found in the Michigan Public School System. The project demonstrated that through cooperation with community advocates, health care professionals can impact the risky sexual behaviors encountered by female adolescents in a manner that improves condom self-efficacy and knowledge of all birth control options.

There is overwhelming evidence collected by the CDC that supports the use of theory-based behavioral interventions to address the HIV/AIDS epidemic. This project supports the efficacy of an evidence-based HIV prevention intervention to increase HIV knowledge among urban African American adolescent females. The project outcomes also demonstrate its usefulness in community outreach programs. Prevention and health promotion is one of the foundations of nursing practice; therefore, nurses engaging with other community stakeholders to decrease the burden of HIV in a program that engages the adolescent females' intellect and creativity is not only a necessity but also feasible. Nurse's engagement with community outreach organizations can be facilitated by increasing the adoption of effective evidence-based, gender- and culturally specific interventions around a specified health outcome goal such as the reduction of HIV exposure. This project is a demonstration of how nurses can engage with community outreach organizations and implement the African adage that it "takes a village" to raise sexually healthy adolescents.

Implications for Practice

Health Policy Implications

Health policy implications abound when discussing educational programs to reduce the risky sexual behaviors in adolescents. Prior to 2009, most of federal funding as it relates to sexuality education focused almost exclusively on abstinence-only-until-marriage (AOUM) programs. According to the Sexuality Information and Education Council of the United States (SIECUS), more than $1.7 billion in federal dollars has been spent on reportedly inaccurate and ineffective AOUM programs (SIECUS, 2014). Federal policy continues to fund abstinence only programs despite the empirical evidence that supports comprehensive sexuality education in reducing sexually related risk factors.

SIHLE, along with other evidence-based interventions, provides comprehensive sexuality education proven to be effective in addressing adolescent risky sexual behavior. Increasing the use of these evidence-based interventions is necessary to effectively address the HIV/AIDS epidemic disproportionately plaguing the African American adolescent population. However, many of the evidence-based curricula assume that participants possess the knowledge necessary to comprehend reproductive health. Contrary to this belief, few adolescents are in possession of accurate sexual health information, and many believe they already know how

to remain safe. This lack of accurate information can lead to increased time required to deliver the intervention sessions and enable participants to complete all objectives effectively and with fidelity.

Overall, SIHLE is an effective evidence-based program for adolescent African American females and provides a strong basis for HIV prevention among high-risk populations. Like many other evidence-based curricula, adaptations to update facts, context cues, and other relevant culturally specific information need to be reviewed and evaluated to assess the efficacy of these programs. The most prevalent concern is ensuring that these interventions actually reduce the incidence and prevalence of HIV in populations of high risk (Jennings et al., 2014). Therefore, continuous assessment of instances and scenarios that adolescent can relate and respond to is necessary to ensure that participants build confidence in condom efficacy. In addition, communicative approaches will likely help improve outcomes of these type of culturally and gender-specific interventions. Youth must have a point of reference to relate to, and sometimes that may involve using a peer educator (supervised by a trained health educator) who can understand youth-driven issues and concerns. Educators serving as role models whom adolescents relate to can encourage change in risky behaviors in spite of current peer pressures (Jennings et al., 2014). This communicative approach can also involve using an alternative media message (role play, video game, text messaging) to help engage youth using current facts, scenarios, or challenges that mimic relationship issues faced by adolescent African American females (Klein & Card, 2011). To increase the desired outcome in curricula, it is imperative to use effective, evidence-based programs that influence skill acquisition and current youth terminologies.

This implementation supports the findings from this study and from DiClemente et al. (2004), the health policies related to adolescent sexual risk reduction need to be reevaluated. More funding needs to be allocated to evidence-based comprehensive sexuality education programs such as SIHLE so that these programs can be replicated and promoted in the communities we serve. Ultimately, a systematic review of current state policy regarding comprehensive sexuality education curriculum would be beneficial to confirm that adolescents are appropriately informed with knowledge for reproductive anatomy and functioning.

The implementation of a culturally and gender-specific behavioral intervention for African American adolescent females such as SIHLE will provide the skills needed to reduce risky sexual behavior and teach skills such as condom self-efficacy, safe sex negotiation skills, and increased comprehensive knowledge related to sexual health.

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