

**Cost Analysis of the Caribbean  
Peer Promoter Initiative:  
The Impact of Budget Allocation  
Strategies on Program Participation  
and Retention**

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## 1 ABSTRACT

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This report aims to improve the understanding of program operations and funding strategies used by grantees with positive program outcomes within the Special Programs of National Significance (SPNS) Targeted Peer Support Model Development for Caribbeans Living with HIV/AIDS Demonstration Project. This initiative, funded by the U.S. Department of Health and Human Services, Health Resources and Services Administration, HIV/AIDS Bureau from 2003 to 2007, was comprised of five grantees using peer promoters within their programs to engage and retain HIV-positive Caribbean populations into care. This analysis compares the funds that grantees dedicated to different areas of their programs, including certain personnel and program activities, using two measures: the number of program participants and the percent of clients retained in the multi-site study. The quantitative analysis is complemented with qualitative information gained from interviews conducted with grantee staff. This report concludes with several funding recommendations for Ryan White HIV/AIDS Program grantees to consider. The main findings are as follows:

- Grantees that budgeted more funding for peer promoters tended to serve and retain more clients.
- To a slightly lesser degree, grantees that budgeted more funding for program activities (as opposed to evaluation activities) also tended to have better outcomes.
- Funding budgeted for client incentives had a positive, but very weak, effect on participation and retention.
- The relationship between direct costs (as opposed to indirect costs) and participation and retention was also weak, but negative.

## 2 INTRODUCTION

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The HIV/AIDS epidemic has heavily impacted the Caribbean region and Caribbean immigrants in the United States. The Targeted Peer Support Model Development for Caribbeans Living with HIV/AIDS Demonstration Project (hereby known as the Caribbean Initiative) was funded by the Health Resources and Services Administration (HRSA), HIV/AIDS Bureau through its Special Programs of National Significance (SPNS) from 2003 to 2007. The goal of the initiative was to explore the use of peer promoter programs (PPPs) in engaging HIV-positive Caribbean populations into care. Through one-on-one and group interactions with peer promoters, the intervention aimed to increase HIV-positive Caribbean immigrants' knowledge of HIV infection, their understanding of HIV treatment options and service delivery systems; and their timely use of appropriate HIV medical care and ancillary services (AED, 2007). As part of the SPNS initiative, grantees were also responsible for participating in a multi-site evaluation, during which survey and clinical data of treatment and control groups were collected and analyzed.

Grantees with the most effective enrollment and retention strategies were in a better position to achieve the goals of the initiative and the evaluation. Thus, crucial measures of a grantee's success were the number of clients who participated in the 6 month interventions and the number retained in the 9 month multi-site evaluation. By these measures, success varied markedly: among the five grantees, treatment group participation ranged from 13 to 52 clients,<sup>1</sup> and retention levels at the 9 month mark ranged from 28 percent to 96 percent. The goal of this report is to explore why some grantees were more successful than others at serving and retaining clients. The guiding hypothesis is that participation and retention levels depended at least in part on how grantees allocated funds in their budgets.

The following section contains a review of the need for HIV/AIDS care efforts that focus on Caribbean immigrants. The next section contains a review of the evidence that PPPs can help overcome barriers to care in cost-effective ways.

### 2.1 HIV/AIDS among Caribbean Immigrants

The Caribbean region has been deeply affected by the HIV epidemic (UNAIDS, 2005) and this phenomena is reflected in Caribbean immigrants within the United States (Wolf et al, 2003). A variety of factors contribute to higher rates of HIV/AIDS among Caribbean immigrants. Sheldin et al. (2006) found that Caribbean immigrants were not uniformly aware of the severity of the

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<sup>1</sup> Montefiore control group participants were considered treatment group participants because they also received encounters with peer promoters.

HIV/AIDS epidemic in their home countries. Immigrants also reported high levels of sexual risk, such as having multiple partners in the past 6 months as well as high numbers of unprotected sexual encounters.

Many immigrant groups in the United States face delays in accessing HIV/AIDS care (Harawa et al., 2002). To gain access to appropriate care, immigrants must overcome a number of serious barriers, including poverty, lack of health insurance, lack of fluency in English, and cultural differences, as well as the sheer complexity of the United States health system (Wolf et al., 2002). Furthermore, negative interactions with health care providers have an adverse effect on the quality of HIV/AIDS care (Bird et al., 2004). Because they lack access to high quality HIV/AIDS care, immigrants tend to be at greater risk of HIV/AIDS-related complications, progression to full-blown AIDS, and death (Wong et al., 2004; Sheldin et al., 2006; Deren et al., 2005; Harawa et al., 2002).

## **2.2 Success of Peer Support Models for Client Outcomes and Cost Effectiveness**

It is clear that targeted health advocacy programs are necessary to reverse the trend of high HIV/AIDS rates among the Caribbean immigrant population in the United States and to encourage HIV-positive individuals to seek necessary treatment. PPPs that focus on community norms and cultural beliefs can play an important role in shaping general health-seeking behavior among Caribbean individuals living with HIV/AIDS (Wolf et al., 2002). PPPs can provide HIV-positive individuals with education regarding access to health care, treatment options, and adherence to treatment regimens, either in one-on-one or group settings (AED, 2007). Peer promoters can also help health care providers work more effectively with people from different cultural backgrounds (Poss, 1999). Numerous studies demonstrate the general success of PPPs, particularly in terms of successfully bridging cultural gaps (Mason, 2003; Poss, 1999; Broadhead et al., 1998; Dickson-Gómez et al., 2003). For example, Oak Orchard Community Health Center in New York State used bilingual and bicultural health promoters and significantly increased access to health care for local Mexican migrant farm workers (Poss, 1999).

Moreover, research suggests that PPPs can be more successful and less expensive to implement than other types of outreach programs. One study compared the cost-effectiveness of a traditional HIV/AIDS outreach program using professional outreach workers to educate injecting drug users (IDUs) about risk reduction methods with a peer-driven intervention (PDI) employing active IDUs as peer promoters in their own drug-using networks. The PDI outperformed the traditional intervention with respect to the number of IDUs recruited, the ethnic and geographic representativeness of the recruits, and the effectiveness of HIV prevention education. In

addition, the cost of recruitment and education in the PDI program was only one-thirtieth the cost of the traditional intervention (Broadhead et al., 1998). While there are few studies that specifically address the effectiveness of PPPs among Caribbean immigrants, the available evidence indicates that community norms and cultural beliefs shape health-seeking behavior among Caribbean individuals living with HIV/AIDS (AED, 2007).

The effectiveness of PPPs led SPNS to make them the foundation of the Caribbean Initiative. Significantly, grantees within the initiative encountered different challenges and experienced varying levels of success at serving and retaining clients when using this model. Although grantees received the same level of funding and operated in similar environments, some grantees served and retained more than double the number of clients than others. This report examines the correlations between various budget allocation strategies as well as program participation and retention. The goal is to improve the understanding of program operations and to identify which budget allocation strategies were used by grantees with positive program outcomes. This analysis is limited both by the small number of grantees and by the use of budgetary data rather than expenditure data. Nonetheless, this report provides Ryan White HIV/AIDS Program grantees with information that will help sustain existing programs and inform successful program models in the future. Furthermore, this report provides Ryan White grantees with an analytical framework for evaluating funding strategies and their link to program outcomes.

## 3 METHODS

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This section describes the study sample, the outcome measures, and the budget allocation strategies that served as the focal point of the analysis.

### 3.1 Study Sample

The Caribbean Initiative aimed to encourage people of Caribbean origin with HIV/AIDS to stay engaged in primary health care through peer support programs. The following five organizations were awarded grants to design and implement interventions in their respective communities:

- Brookdale University Hospital and Medical Center, Brooklyn, NY
- Community Healthcare Network (CHN), Brooklyn, NY
- Lutheran Medical Center/Caribbean Women's Health Association (CWAH), Brooklyn, NY
- Montefiore Women's Center, Bronx, NY
- University of Miami, Miami, FL

Of all clients enrolled in the program, 51 percent were Haitian, 22 percent were Jamaican, and 14 percent were from Trinidad and Tobago. Additionally, eligible clients had to be new or sporadic users of primary health care. In the study population, 40 percent of clients had not attended an HIV care appointment in the 12 month period prior to enrollment.

Once enrolled, clients in the treatment group interacted with peer promoters, who were also HIV-positive individuals of Caribbean origin, in one-on-one and/or group sessions. Peer promoters provided culturally appropriate HIV education, social support, referrals to ancillary services, and encouragement to access medical care. Surveys were administered to clients and clinical data was collected from medical abstracts at baseline, 3 months, 6 months, and 9 months for evaluation purposes.

### 3.2 Outcome Measures

Grantee trends in budgeted expenditures were compared with program participation and retention to identify potential relationships between certain budget allocation strategies and positive program results. The strength of the correlation between the retention data and grantee budget information (described below) was assessed using Pearson's R Correlation.

Because grantees received the same level of SPNS funding (\$350,000/year for 4 years) and were located in similar settings (all five grantees were based in urban areas, four of them in New



York), this analysis assumes that all the grantees had the same capacity to recruit clients, provide peer promoter services to them, and retain them in the multi-site evaluation. These outcomes were assessed using two main measures:

- **Number of clients served by peer promoters during the duration of the interventions (6 months):** This measure aims to capture the number of clients who benefited from the intervention with peer promoters. It is defined as the number of clients in the treatment group who completed the 6 month survey.<sup>2</sup> Six months was used because, although the length of grantee interventions varied, they typically fell between 3 and 6 months.
- **Percent of clients retained in the multi-site evaluation:** This measure aims to capture the ability of grantees to retain clients in evaluation activities, an important characteristic for SPNS grantees. It is defined as the number of clients who completed the multi-site survey at 9 months divided by the total number of clients enrolled in the study.

Grantees varied widely in their ability to enroll, serve, and retain clients (Table 3-1). Although Montefiore did not enroll the largest number of clients, it managed to retain the largest share. Montefiore also served the greatest number of clients because members of both the treatment and control groups experienced encounters with peer promoters. Miami, by contrast, recruited a large number of people, but achieved a much lower retention rate. Lutheran had low numbers at enrollment and retention.

**Table 3-1: Clients Enrolled, Served by Peer Promoters, and Retained by Grantee**

	Montefiore	Miami	CHN	Lutheran	Brookdale
All clients enrolled at baseline	55	87	75	39	88
All clients at nine months	53	24	34	13	42
Percent of clients retained in the multi-site	96%	28%	45%	33%	48%
Clients served by peer promoters (6 months)	52	17	20	13	25

### 3.3 Budget Allocation Strategies

As noted previously, all grantees were awarded the same amount of money for the same length of time. However, their investments in specific program components varied. Four budget strategies were identified and selected for analysis not only because they were relevant to grantees within the Caribbean Initiative, but also because they could inform other Ryan White

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<sup>2</sup> Montefiore control group participants were considered treatment group participants because they also received encounters with peer promoters.

grantees, which must make similar decisions about how to better allocate grant resources. Notably, these budget allocation strategies are intended to reflect either the tradeoff in how grantees budgeted funding in one area versus another, or the total resources budgeted for a given position or activity. These four strategies are:

- **Share of budget allocated to compensating peer promoters:** Salaries and stipends paid to peer promoters, as opposed to funding for other staff positions.
- **Share of budget allocated to program activities:** Funds dedicated to implementing the intervention, such as recruiting clients and connecting them with peer promoters, as opposed to evaluation activities, such as data collection and analysis.
- **Share of budget allocated to client incentives:** Funds used to motivate clients to participate in either program or evaluation activities, including food, transportation, and gift cards, as compared to other program and evaluation non-salary related costs.
- **Share of budget allocated to direct costs (non-administrative costs):** Funds dedicated to direct costs associated with program activities and evaluation, as opposed to indirect costs, such as rent, and office supplies.

The budget allocation strategies were calculated by aggregating annual grantee SPNS budgets, and assessing grantees' surveys and interviews. First, grantees were asked to complete a survey describing what percent of each line item in their annual budgets was dedicated to program versus evaluation activities.<sup>3</sup> Second, line items from annual grantee budgets were summed across the 4 grant years and then collapsed into 6 major categories: Personnel, Travel, Client Incentives, Office Support, Indirect and Other. Personnel and Travel were subdivided into additional sub-categories. Table 3-2 shows a table shell of how line items from grantee budgets were allocated to different budget categories across program and evaluation activities. The complete table for all grantees across all years can be found in Appendix A.

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<sup>3</sup> Lutheran did not complete the survey.

**Table 3-2: Table Shell Presenting the Budget Categories**

<b>Budget Categories</b>	<b>Grantee</b>		
	<b>Program</b>	<b>Evaluation</b>	<b>Total</b>
<b>Personnel</b>			
Project Investigator			
Evaluation Staff			
Program Director			
Peer Support			
Peer Promoters			
Medical Personnel			
Fringe			
<i>Sub-total</i>			
<b>Travel</b>			
Grantee Meetings			
Local Staff Travel			
Client Travel			
<i>Sub-total</i>			
<b>Client Incentives</b>			
<b>Office Support</b>			
<b>Indirect</b>			
<b>Other</b>			
<b>TOTAL</b>			

Third, budget categories were collapsed even further to create budget allocation strategies. Each budget allocation strategy has a different numerator and denominator, composed of relevant parts budget categories (Table 3-3).

**Table 3-3: Numerator and Denominator in Budget Allocation Strategies**

<b>Budget Allocation Strategy</b>	<b>Numerator</b>	<b>Denominator</b>
Share of budget allocated to compensating peer promoters	Peer Promoter sub-category within the Personnel Category	All Personnel-related costs budgeted for Program and Evaluation
Share of budget allocated to client incentives	Client Travel sub-category and the Client Incentives category	All non Personnel-related costs budgeted for Program and Evaluation
Share of budget allocated to program activities	Program	Total Budget
Share of budget allocated to direct costs, such as the provision of services or evaluation activities	Everything excluding Office Support and Indirect	Total Budget

The budget allocation analyses described above were complemented with information from interviews regarding employees' opinions on staffing, budget allocation and program success<sup>4</sup>. This information is presented in the discussion section of this report.

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<sup>4</sup> For cost issues that could not be classified through these sources, a series of assumptions were made. For example, because it could not be specified how travel expenses were allocated between program versus evaluation components, travel costs were combined with other programmatic costs.

## 4 RESULTS

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This section presents the results of analyzing the relationship between the 4 budget allocation strategies and program enrollment and retention.

### 4.1 Funds for Peer Promoters

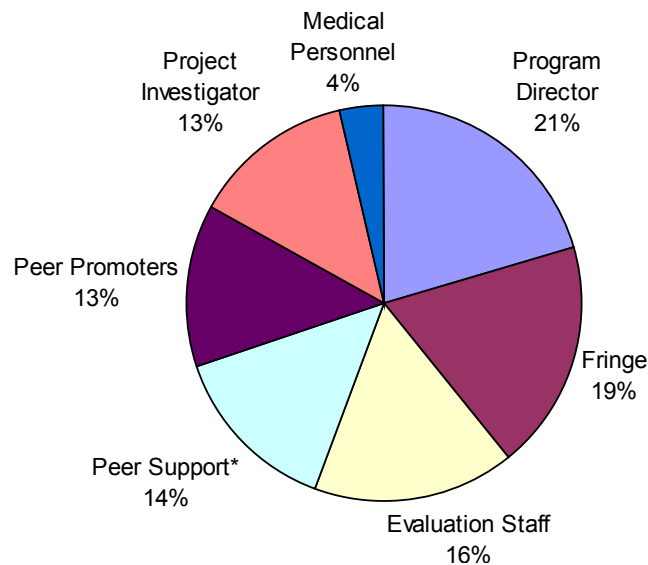
Given the importance of peer promoters in the Caribbean Initiative, they received little funding relative to other types of personnel. This investment also represents a small proportion of grantees' total budgets. No grantee spent even one-fifth of their total budget or one-quarter of their personnel budget on peer promoters (Table 4-1). Montefiore dedicated the most financial resources to peer promoters, while Lutheran dedicated the least.

**Table 4-1: Funds for Peer Promoters as a Share of Total Budget and Personnel Budget, Summed Across All Grant Years**

	<b>Total \$ for Peer Promoters</b>	<b>% of Total Budget</b>	<b>% of Personnel Budget</b>
Montefiore	\$237,457	17%	23%
Miami	\$164,628	11%	15%
CHN	\$116,347	8%	12%
Brookdale	\$121,900	9%	12%
Lutheran	\$54,840	4%	5%

As Figure 4-1 (below) indicates, only a small percentage of the total budget across grantees (13 percent) was used to compensate peer promoters; the bulk of the personnel budget went to contracted, salaried, and part-time personnel (almost 75 percent). By contrast, grantees allocated a higher percentage of personnel funds (34 percent) to paying high-level management staff – program directors/managers and project investigators. Grantees also invested less in staff that supported peer promoters both in their program activities and their professional development, such as trainers, non-peer outreach workers, and HIV testing and counselors (14 percent).

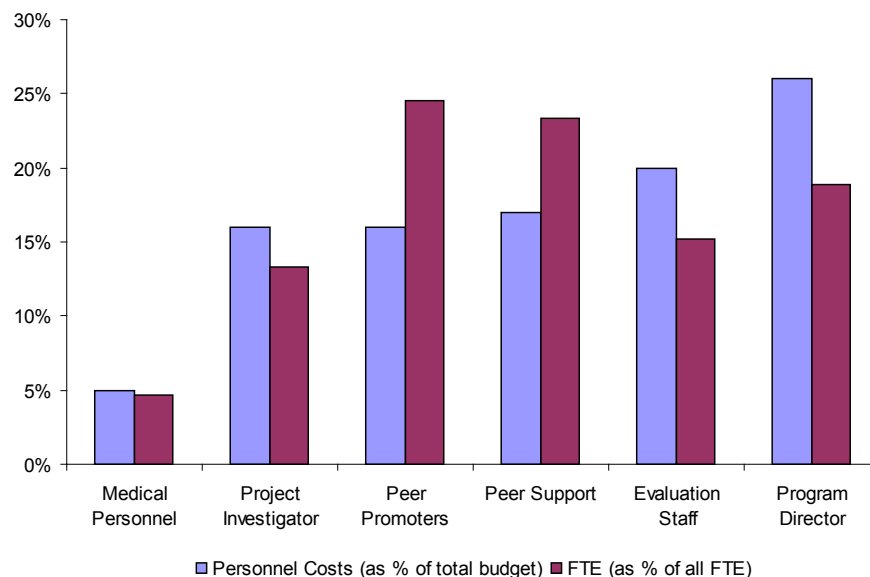
**Figure 4-1: Total Grantee Allocation of the Personnel Budget by Position**



\* Peer support refers to staff who support peer promoters both in their program activities and their professional development, such as trainers, non-peer outreach workers, and HIV testing counselors.

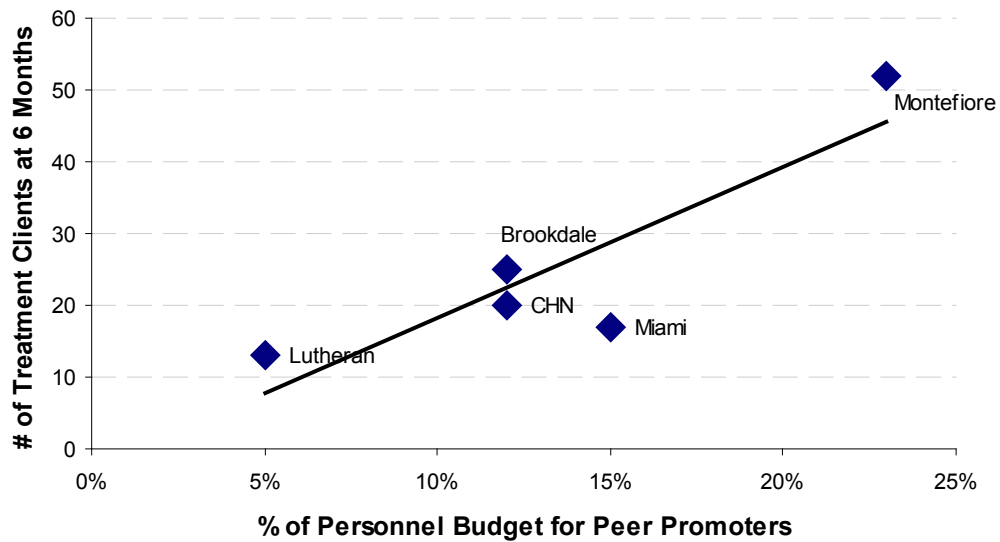
Notably, investments in peer promoters were low even though they provided a larger percentage of FTEs than did any other staff position. Moreover, the percentage of FTE supplied by peer promoters exceeded the percentage of the total personnel budget used to compensate them. For almost every other position, this pattern was reversed (Figure 4-2).

**Figure 4-2: Percentage of Total FTEs and Total Budget by Staff Position, Summed Across All Grant Years**



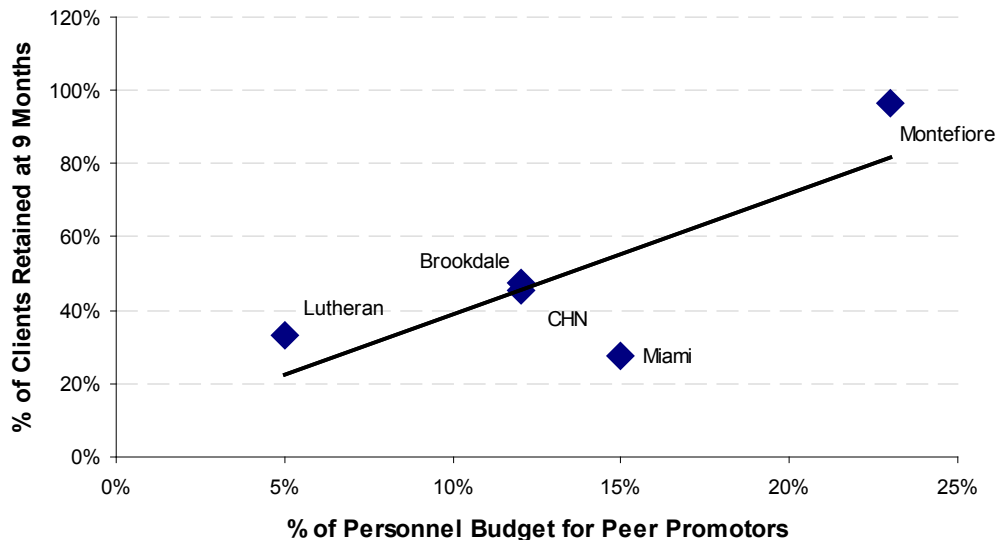
Increased investment in peer promoters was associated with greater client participation (Figure 4-3). The share of the personnel budget spent on peer promoters ranged from 5 percent to 23 percent, with Montefiore dedicating the most resources and Lutheran the least. These two grantees had the greatest and least number of clients who received services by peer promoters, respectively. The correlation between investment in peer promoters and retention was strong, with an r-value of 0.89. The p-value associated with the correlation was 0.05, a significant value despite the small sample size.

**Figure 4-3: Clients in the Treatment Group at Six Months and Share of Personnel Budget Dedicated to Peer Promoters, Summed Across All Grant Years**



The relationship between investment in peer promoters and client retention was also strong, with an r-value of 0.79 and a p-value of 0.11 (Figure 4-4).

**Figure 4-4: Clients Retained at Nine Months and Share of Personnel Budget Dedicated to Peer Promoters, Summed Across All Grant Years**



These findings indicate that investments in peer promoters not only can increase the number of clients served, but also improve retention in evaluation activities.

#### 4.2 Funds for Program Activities

Because all SPNS initiatives aim to identify and disseminate information on successful models of care, grantees conducted site-specific evaluations and participated in a multi-site evaluation. The expenses involved with these studies include specialized evaluation personnel and analytic software. Because this initiative used a control group (often run at a different program than the SPNS grantee) as part of its evaluation, investments in evaluation were expected to be high. However, grantees generally invested more heavily in program costs associated with the provision and administration of outreach and peer promoter services than in evaluation expenses (Table 4-2). CHN was the only grantee that dedicated less than 50 percent of its budget to program activities.



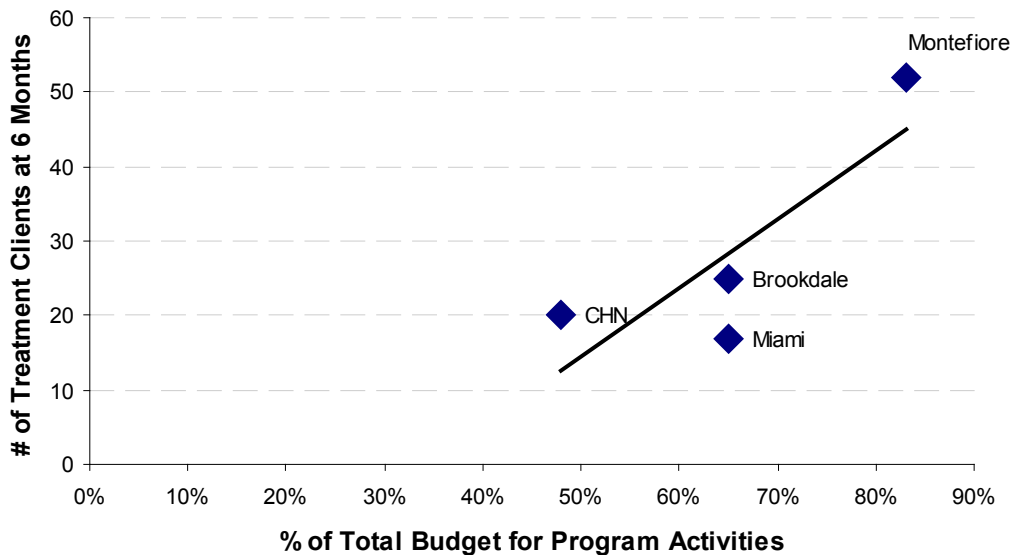
**Table 4-2: Share of Total Budget Allocated to Program Activities, Summed Across All Grant Years**

	Total \$ for Program Activities	% of Total Budget
Montefiore	\$1,186,811	83%
Miami	\$943,243	65%
Brookdale	\$789,923	56%
CHN	\$666,136	48%
Lutheran*	--	--

\*Note: Lutheran did not provide complete budgetary data, and therefore is not part of this analysis.

Investments in program activities were also correlated with client retention at 9 months (Figure 4-5). Montefiore dedicated the largest proportion of its total budget to program activities, (83 percent) which was nearly double the share CHN budgeted for program activities (48 percent), possibly because this work was conducted in-house at Montefiore. Despite CHN’s low investment in program activities, Miami had a lower number of clients that received peer promoter services than CHN. This correlation has an r-value of 0.83 and a p-value of 0.17. It is not surprising that this value is insignificant given the small number of observations.

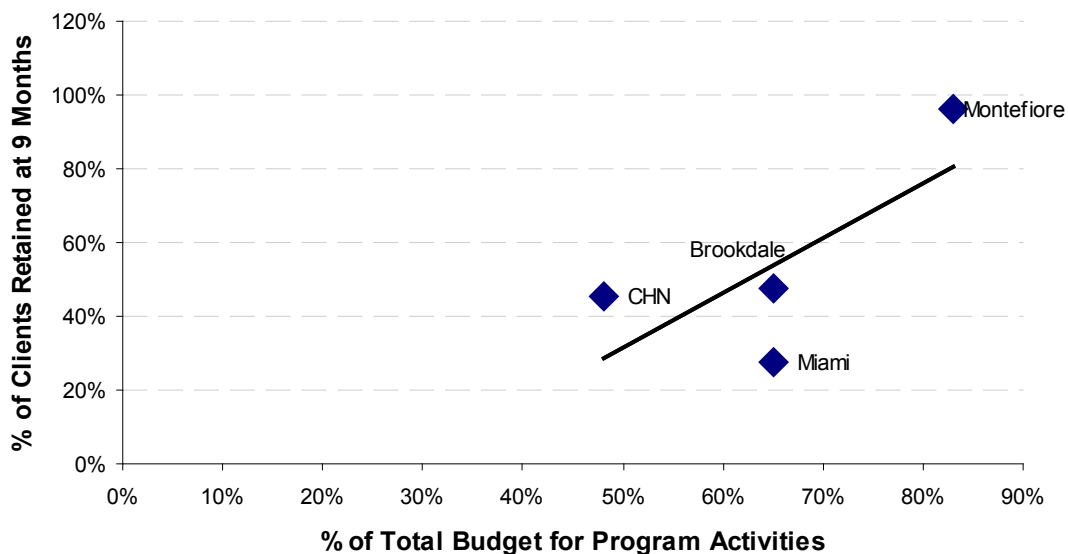
**Figure 4-5: Clients in the Treatment Group at Six Months and Share of Total Budget Dedicated to Program Activities, Summed Across All Grant Years**



The relationship between investment in program activities and client retention is not as strong, with an r-value of 0.72 and a p-value of 0.28 (Figure 4-4). This may indicate that the amount

spent on program activities reduced the ability of grantees to retain control group clients in evaluation activities.

**Figure 4-6: Clients Retained at Nine Months and Share of Personnel Budget Dedicated to Program Activities, Summed Across All Grant Years**



### 4.3 Funds for Client Incentives

Grantees responded to challenges in recruitment and retention partly by offering clients incentives to participate in various activities. For example, to encourage clients to complete the 45-minute evaluation surveys, grantees tended to use monetary incentives such as gift cards. By contrast, incentives for retention in care were typically services that responded to clients' needs, such as Metro cards, referrals to ancillary services, and food.

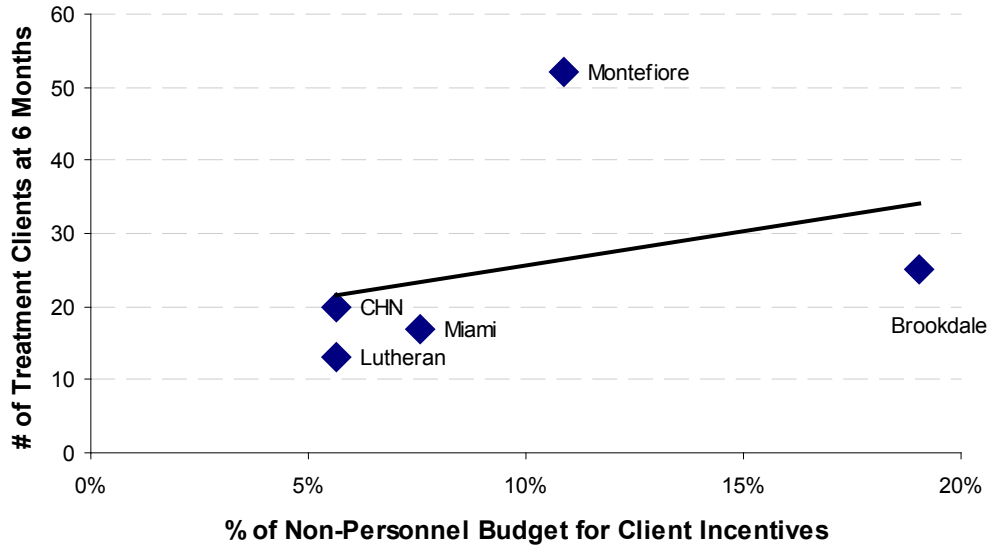
All grantees spent a sizable share of their budgets on client incentives, ranging between 1 percent and 5 percent of their total budgets, and between 6 percent and 19 percent of their non-personnel budgets. Significantly, these figures do not include the costs of ancillary services, such as mental health services and housing assistance, which may have motivated client participation but were covered by other programs providing these services.

**Table 4-3: Funds for Client Incentives as a Share of the Total Budget and the Non-Personnel Budget, Summed Across All Grant Years**

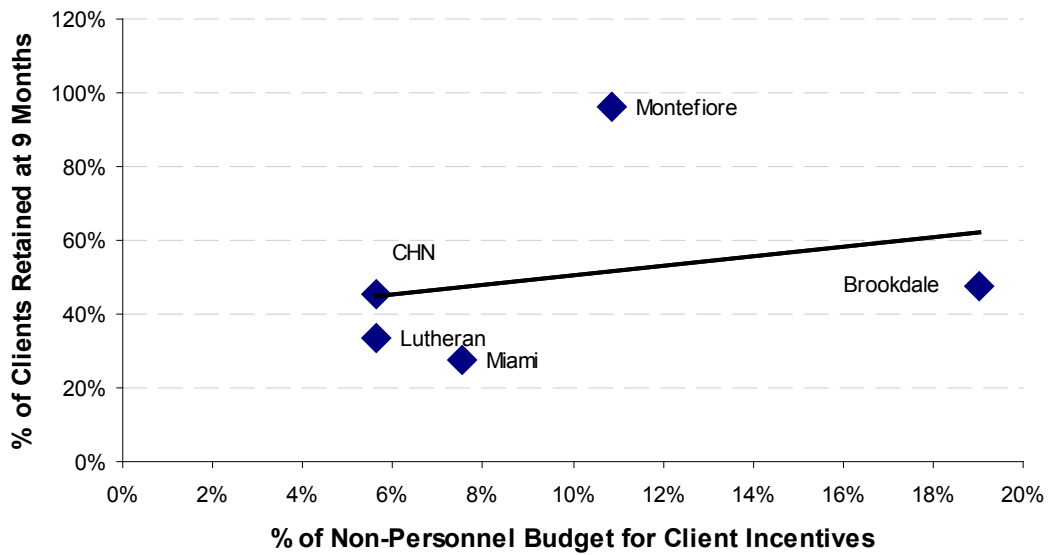
	<b>Total \$ for Client Incentives</b>	<b>% of Non-Personnel Budget</b>
Brookdale	\$66,700	19%
Montefiore	\$43,775	11%
Lutheran	\$29,496	9%
Miami	\$27,125	8%
CHN	\$25,480	6%

The relationship between client incentives and participation and retention is very minimal (Figure 4-7 and Figure 4-8). The share of the non-personnel budget dedicated to client incentives was more strongly correlated with the number of treatment clients served than with retention; the r-value for participation was 0.34, compared to 0.27 for retention. However, given the very high p values, this correlation is nearly indistinguishable from zero. Brookdale, with a 9 month retention rate of 48 percent, invested the highest percentage of its non-personnel budget in client incentives, at 19 percent. Montefiore also invested highly, dedicating 11 percent of its non-personnel budget to client incentives. It is important to note that Montefiore’s Women’s Health Clinic contributed heavily to the Caribbean Initiative by providing clients with meals, mental health services, and housing services. The importance of this relationship will be touched on in greater detail in the Discussion section. These benefits were not included in Montefiore’s budget, but likely contributed to Montefiore’s high level of retention. As indicated by their r-values, the correlations between incentives and recruitment and retention were far weaker than the correlation between investments in peer promoters and retention.

**Figure 4-7: Clients in the Treatment Group at Six Months and Share of Non-Personnel Budget Dedicated to Client Incentives, Summed Across All Grant Years**



**Figure 4-8: Clients Retained at Nine Months and Share of Non-Personnel Budget Dedicated to Client Incentives, Summed Across All Grant Years**



#### 4.4 Funds for Direct Costs

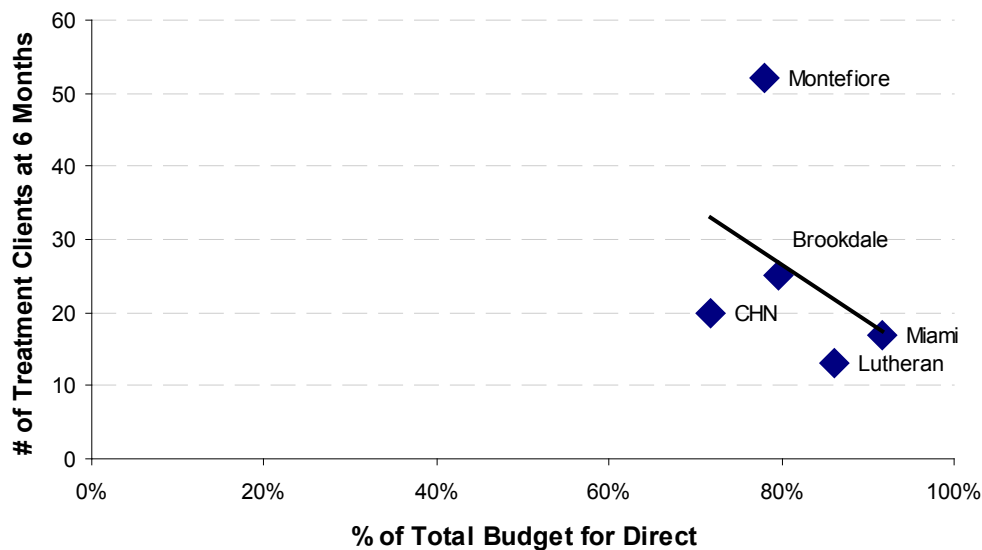
As with the other budget allocation strategies, grantees varied substantially in the resources they dedicated to direct costs, from nearly 72 percent to 92 percent of their total budget (Table 4-4). Direct costs are comprised of all personnel and other expenditures directly related to the provision of services or program evaluation. Direct costs exclude administrative costs, such as rent.

**Table 4-4: Funds for Direct Costs as a Share of Total Budget, Summed Across All Grant Years**

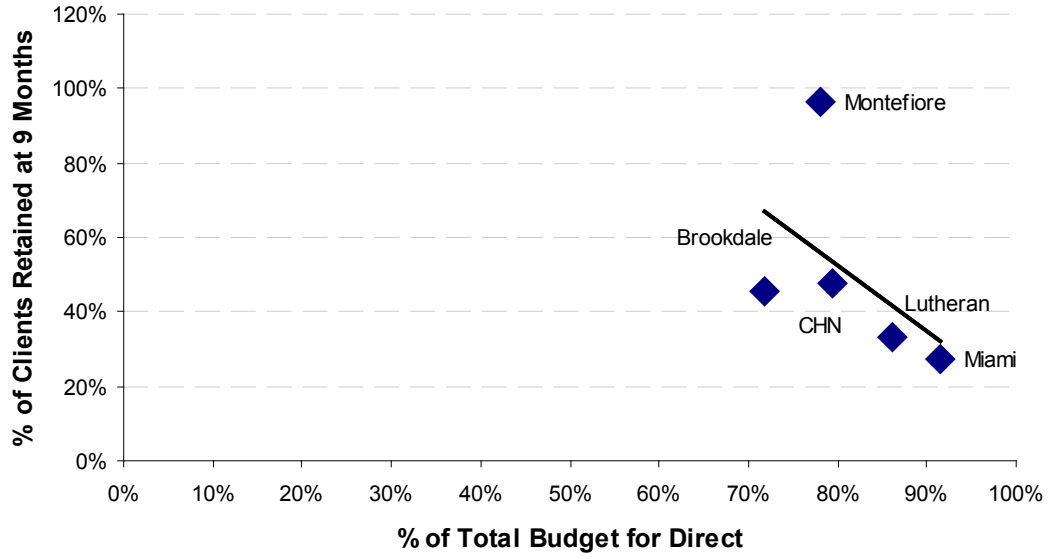
Grantee	Total \$ Amount	% of Total Budget
Brookdale	\$1,282,191	92%
Lutheran	\$1,209,076	86%
Miami	\$1,147,097	80%
Montefiore	\$1,120,244	78%
CHN	\$1,006,127	72%

Increased funds for direct costs were slightly negatively correlated with client participation and retention, having an r-value of -0.39 and -0.50. While CHN spent the least on direct costs, and Brookdale the most, grantee participation and retention trends did not follow this pattern (Figure 4-9 and Figure 4-10).

**Figure 4-9: Clients in the Treatment Group at Six Months and Share of Non-Personnel Budget Dedicated to Client Incentives, Summed Across All Grant Years**



**Figure 4-10: Clients Retained at Nine Months and Share of Total Budget Dedicated to Direct Costs, Summed Across All Grant Years**



## 5 DISCUSSION

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This section aims to identify trends in resource allocation that can provide Ryan White grantees with a more comprehensive understanding of how different distributions of resources are associated with successful program outcomes. This discussion draws upon findings from the analyses of budget allocations and client outcomes, grantee interviews, and where relevant, published literature to present a series of recommendations.

The findings are summarized below:

- Grantees that budgeted more funding for peer promoters tended to serve and retain more clients.
- To a slightly lesser degree, grantees that budgeted more funding for program activities (as opposed to evaluation activities) also tended to have better outcomes.
- Funding budgeted for client incentives had a positive, but very weak, effect on participation and retention.
- The relationship between direct costs (as opposed to indirect costs) and participation and retention was also weak, but negative.

### 5.1 Funding for Peer Promoters

The budget allocation strategy that most strongly follows trends in client participation and retention is investments in peer promoters. The use of peer support models within the Caribbean Initiative was primarily based on the belief that peers are an effective and cost efficient method of service provision for HIV-infected individuals. However, the effectiveness of peer promoters appears to depend at least in part on proper compensation.

Interviews with grantees revealed that compensation for peer promoters was not entirely under their control. Grantees stated they had to balance adequately compensating peer promoters without jeopardizing the public services they received. While higher salaries might have drawn workers with greater skills and decreased employee turnover, salaries/stipends could not be raised substantially without increasing the likelihood that peer promoters would lose their social services, such as Medicaid, food stamps, and welfare, due to an increase in their income. Thus, grantees decided to set wages at a level that ensured peer promoters retained such services. Hospital and State protocol also placed restrictions on employment type and salary. Because of these policies, no peer promoter received benefits. Grantees felt that low compensation increased turnover among peer promoters; many grantees blamed low client recruitment on their

inability to retain peer promoters and expressed considerable frustration with the lack of flexibility in compensation.

The recommendations below are aimed to help retain qualified peer promoters.

**Provide peer promoters with adequate compensation and support.** Peer promoters should receive benefits (when working full-time) and adequate salaries. Faced with limitations in directly compensating peer promoters, grantees tried to provide support in other ways. For example, in response to low recruitment numbers, Lutheran hired peer promoter trainers, HIV counselors, non-peer promoters, and a media consultant. However, Lutheran's continued low recruitment and retention numbers indicate that these strategies may not be effective unless used in conjunction with higher salaries. Adequately compensating peer promoters for their work might have led to better results, as Lutheran made the lowest investment of any grantee in their peer promoters. This issue becomes even more relevant when peer promoters find themselves in unfriendly work environments. Although this was not the case in this initiative, peer promoters can expose themselves to dangerous situations, often working during the night in unsafe areas. Compensation should take these factors into account.

**Reward good performance.** An evaluation related to intravenous drug users with HIV/AIDS found that peer promoters in a "peer-driven intervention" produced a greater reduction in risky drug behaviors when compared to traditional outreach workers (Broadhead et al., 1998). In this study, peer promoters were given \$10 per recruit. If during an evaluation, the recruit proved to have gained knowledge on risk reduction from his/her peer promoter, the peer promoter was compensated an extra \$10. These recruits could in turn be compensated for referring even more people to the program and educating them on HIV/AIDS.

In contrast, a pay-for-performance strategy was not utilized in this initiative, and should be considered in the future. Although Lutheran paid peer promoters for each intervention activity, the unpredictable work schedule and sporadic payment hindered recruitment. CHN, in its final year, tracked and publicized enrollment numbers to motivate peer promoter performance. Although payments were not attached to these recruits, according to program managers, public recognition was an effective incentive. Compensation should not be solely based on performance, but tying payment incentives to client outcomes could increase program enrollment numbers.

**Encourage a regular work schedule.** Interviews with grantees revealed that some peer promoters were paid monthly salaries and worked full-time, while others were compensated per activity. This latter policy often led to sporadic hours and low retention numbers, both among peer promoters and clients. Programs seemed to perform better when they had a place for peer



promoters to go on a regular basis and conduct outreach activities. In addition to providing a stable work environment and regular schedule, programs should ensure that supervisors are available during these times to support and guide the peer promoters.

**Provide more extensive training.** Grantees were tasked with training peer promoters. All grantees participated in a joint workshop and implemented on-site trainings with varying levels of intensity. At Brookdale, peer promoters were given 3 months of site-specific training, which was then reinforced with quarterly trainings. Peer promoters at Miami took specific courses as mandated by the State of Florida. Some grantees, such as CHN, took advantage of free training opportunities within New York City. Due to high turnover, however, training was often conducted on the job in informal settings. Montefiore conducted a 9 month training with its peer promoters and held weekly meetings throughout the program to discuss progress and setbacks. This intense investment paid off, as Montefiore had fewer peer promoter retention problems than other grantees and the highest number of clients retained at 9 months.

## 5.2 The Tradeoff between Program and Evaluation Expenses

SPNS plays an important role in identifying and disseminating information on HIV/AIDS-related programs. To conduct this work, resources must be channeled into programs' evaluation components. Almost 50 percent of grantee budgets were dedicated to evaluation activities for the Caribbean Initiative – a figure that is not surprising given that the personnel and tools necessary to collect and analyze data are often expensive. If the costs of the evaluation and technical assistance center in creating multi-site tools and training grantees on data collection were also included, this percentage would increase even more. While evaluation is valuable both for successful program management and accountability to funding sources, such a high percentage could cause other program components to suffer.

## 5.3 Encouraging Client Participation through Incentives

Client incentives can serve as an important function by lowering some barriers to care. Due to the stigma associated with HIV/AIDS in Caribbean communities, clients were often unable to accept their health condition, much less attend support groups and medical appointments. Furthermore, tasks associated with the evaluation component of the initiative placed an additional burden on clients as they were required to complete semi-annual surveys. To encourage clients to participate in both program and evaluation activities, grantees used various strategies. Most grantees used non-monetary incentives, such as gift cards, to encourage clients to complete the 45-minute evaluation surveys. In contrast, grantee staff were wary of utilizing a similar strategy for program activities because they wanted clients to participate in the interventions of their own volition. Grantees responded appropriately to this issue by paying for transportation costs and providing food at events. This form of compensation adequately

addressed the time and inconvenience of participation. Compensation was neither too low, which might have been exploitative, nor too high, which might have been coercive (Ensign, 2003).

Grantees that made greater investments in client incentives tended to have served and retained more clients, suggesting that client incentives could be an important factor for a successful program. However, this relationship was weak. Perhaps there is a threshold at which greater client incentives cease to make program differences or client incentives are not as significant as other factors influencing enrollment, such as investments in peer promoters. Alternately, it is important to note that Montefiore's Women's Health Clinic contributed to Montefiore's SPNS program by providing clients with meals, mental health services, and housing services. These costs were not included in Montefiore's budget, but likely aided Montefiore's high retention rate and could explain why participation and retention was high despite Montefiore's somewhat lower investment in client incentives.

The following issues should be taken into consideration by grantees when developing their individual incentive strategies.

**Consider the costs and importance of ancillary services.** Ancillary services can act as powerful incentives. For example, Montefiore worked in partnership with the Women's Health Center, which was able to provide extensive services to clients as they visited the program. According to Montefiore staff, these services encouraged clients to continue participating because many of their needs were met at once. Unfortunately, because these ancillary services were provided by a partner organization, their costs could not be estimated in this analysis. Still, grantees should take into consideration the importance of these types of ancillary services as innovative parts of their interventions

**Avoid relying on incentives as a main strategy.** Despite the generally positive association between incentives and client participation and retention, grantees should not rely on incentives as their primary outreach and retention strategy. Incentives must be accompanied by skilled and motivated outreach staff. In a study comparing the effects of non-monetary and monetary incentives on client enrollment and behavior within a HIV/STI prevention program, the results indicated that monetary incentives led to slightly higher enrollment rates. In contrast, clients receiving monetary versus non-monetary incentives did not differ in their rates of acquiring STIs once they had completed the program (Kamb et al., 2003). If grantees are not experiencing good retention rates among clients, they should not just increase the amount spent on gift cards, but reassess other program components and make appropriate modifications.

## **5.4 Limited Impact of Funding for Direct Costs**

The correlation between funding for direct costs and retention was negative, but weak. This is somewhat surprising given that it would seem beneficial for grantees to maximize funding for service provision and evaluation activities. Intuitively, grantees that spend more of their budget on indirect administrative costs, such as rent, should have lower participation and retention numbers. However, given the large p value associated with this analysis, this correlation may be indistinguishable from zero. Thus, further research is needed to determine the effects on client outcomes of spending on direct costs versus administration.

## **5.5 Limitations**

The cost analysis presented here is limited in several ways. First, the small number of grantees made it difficult to obtain statistically reliable results. Second, information was obtained primarily through programs' yearly budgets. Although these data were complemented by interviews with program implementers and financial managers, the data are not as accurate as actual expenditures. For example, CHN did not spend all its funding allocated in Year 1 due to problems in recruitment. This crucial aspect of CHN's program is not reflected in its budget. Third, complete data were not collected from all grantees; Lutheran did not complete the grantee survey and thus was excluded from an analysis. Lastly, this study was based on the assumption that the five grantees all had the same capacity to recruit and retain clients in care, when in reality the grantees likely faced somewhat different challenges, due to differences in program areas such as staffing, access to ancillary services, operational settings, and reputation among clients.

## **5.6 Conclusions**

This study highlights that certain budget allocation strategies, especially increased funding for peer promoters, were correlated with higher client retention. While the strength of these relationships cannot be evaluated with such a small sample of grantees, this investigation offers insights for designing initiatives and creating programs where resources are best used for successful program outcomes. Finally, this analysis can be used as an analytical framework for comparing different funding strategies with program success.

## APPENDIX A TOTAL GRANTEE BUDGETS BY CATEGORY

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<b>Budget Categories</b>	<b>Total</b>
<b>Personnel</b>	
Project Investigator(s)	\$693,504
Evaluation Staff	\$847,269
Program Director(s)	\$1,066,655
Peer Support	\$734,574
Peer Promoter(s)	\$695,172
Medical Personnel	\$189,545
Fringe	\$963,761
<i>Sub-total</i>	\$5,190,480
<b>Travel</b>	
Grantee Meetings	\$119,820
Local Staff Travel	\$39,388
Client Travel	\$57,877
<i>Sub-total</i>	\$217,085
<b>Client Incentives</b>	\$129,985
<b>Office Support</b>	\$359,334
<b>Indirect</b>	\$956,490
<b>Other</b>	\$227,185
<b>TOTAL</b>	<b>\$7,080,559</b>

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