What's Going on @SPNS

AN UPDATE FROM THE RWCA SPNS PROGRAM JANUARY 2007

Peers Can Play a Vital Role in Prevention With Positives

The Ryan White CARE Act Special Projects of National Significance (SPNS) Prevention with HIV-Infected Persons in Primary Care Settings Initiative—also known as the Prevention with Positives (PwP) initiative—comprises 15 clinical demonstration sites and an evaluation and support center that are implementing and evaluating prevention interventions with HIV-positive patients. The grants were awarded in fall 2003; the initiative is now winding down and will end in 2007.

The PwP initiative is the Health Resources and Services Administration HIV/AIDS Bureau's response to the need for interventions targeting people who are HIV positive who are receiving clinical care. The intervention's goals are to prevent HIV transmission to uninfected individuals and to prevent sexually transmitted infections among people who are already infected with HIV. HIV prevention efforts often focus on people who engage in high-risk sexual and drug-using behaviors. Even though research suggests that some people living with HIV/AIDS continue to engage in risky activities after becoming aware of their serostatus, much less attention has been given to prevention efforts with this population.

The Enhancing Prevention with Positives Evaluation Center (EPPEC), which is based at the AIDS Research Institute at the University of California–San Francisco, is conducting a cross-site evaluation of the project; as part of that evaluation, all sites but one are using an audio-computer assisted self-interview (ACASI) to collect data on individual client demographics, disease history, and risk behaviors and attitudes. Some interventions are using an additional, site-specific ACASI, which uses questions unique to those projects. The questions to be investigated include the following:

- Are provider-driven interventions in clinical settings effective?
- What specific models are most effective with different target populations (e.g., men of color who have sex with other men, heterosexual women, rural drug users, etc.)?
- How can clinicians effectively assess risk and produce behavior change, given time constraints?
- Do clinicians have the skills needed to effectively conduct prevention interventions? What can be done to strengthen clinician skills?
- What are the obstacles to conducting HIV prevention activities with HIV infected individuals in a clinical setting and how can they be overcome?
- What roles can multidisciplinary teams play in risk assessment and producing behavior change?

The SPNS initiative includes a wide range of intervention formats, including one-on-one and small-group counseling (either during or separate from regularly scheduled clinical visits for medical care) and physician-provided motivational interviewing. Each site is implementing a different intervention, although all are carried out in a clinical setting. Many projects involve prevention specialists. The interventions used can be broadly divided into four categories, based on who delivers the prevention messages: primary care provider, peer, prevention

PWP Initiative Grantees

- University of California–San Francisco (TA/Evaluation Center)
- DeKalb County Board of Health (Decatur, GA)
- Drexel University School of Public Health (Philadelphia, PA)
- El Rio Santa Cruz Neighborhood Health Center (Tucson, AZ)
- Fenway Community Health Center (Boston, MA)
- Johns Hopkins University (Baltimore, MD)
- Los Angeles County Department of Health Services
- Mount Sinai Hospital (Chicago, IL)
- St. Luke's Roosevelt Hospital Center (New York, NY)
- University of Alabama at Birmingham
- University of California–Davis
- University of California–San Diego
- University of Miami
- University of North Carolina (Chapel Hill)
- University of Washington (Seattle)
- Whitman-Walker Clinic (Washington, DC)

specialist (e.g., social workers or health educators), or mixed provider/specialist. This issue of *What's Going on @ SPNS* focuses on two grantees using peer-based intervention protocols: Drexel University School of Public Health and Fenway Community Health Center.

Protect and Respect program staff at the program offices.

Protect and Respect

The Protect and Respect Program for Women Living with HIV/AIDS at the Drexel University School of Public Health is focusing on preventing HIV transmission by reducing high-risk sexual behavior among female patients of the Partnership Comprehensive Care Practice, an academic ambulatory care center that is part of the Drexel College of Medicine. The clinic serves more than 1,300 HIV-positive adults. All the Protect and Respect participants receive ongoing prevention counseling from clinical providers that is specific to their needs, whether they are substance abuse issues, a partner who refuses to use a condom, or caregiving challenges. Intervention training for clinicians was provided by the Pennsylvania Mid-Atlantic AIDS Education and Training Center. Participants in the "enhanced intervention" group also attend a five-session group-level intervention (GLI) led by an intervention specialist and participate in at least two sessions of an ongoing peer-led support group. The evaluation is comparing self-reported risk behaviors among women in the two groups (enhanced vs. standard intervention).

Peer educators approach women in the clinic waiting room, explain the project, and invite them to participate. Participants are randomized to the enhanced or standard intervention. They complete the ACASI at enrollment and at 6-month intervals at four different time points when they come to the clinic for medical appointments. ACASI variables of particular interest to the project include sexual risk behaviors, birth control method, patterns of disclosure of HIV status, and pregnancy intentions.

To date, 186 women have been enrolled in the project, and preliminary data are available for 58 percent of the sample (107 participants, 54 in the control group and 53 in the enhanced intervention). Most of the women in the project are poor and African-American; a majority are heterosexual, and about half are single. Roughly three-fourths were infected through heterosexual sex. Women receiving the standard intervention have been HIV positive for an average of 11 years; those receiving the enhanced intervention have been seropositive for an average of 9 years.

Fenway Community Health Center HIV Prevention Project

The Fenway Community Health Center HIV Prevention Project is evaluating a multisession behavioral intervention to reduce high-risk sexual practices among HIV-positive men who have sex with men (MSM). Participants receive a four-session, one-on-one intervention from a peer intervention specialist (who is a seropositive MSM). The intervention, which occurs in a therapylike setting, is based on a workbook and is standardized—that is, it is administered in the same way for all participants. HIV-positive MSM who have been diagnosed for at least 6 months are eligible for the program; newly diagnosed men may be grappling with issues related to learning one's serostatus and are not eligible.

Patients in the project begin by participating in a basic module that examines their sexual behavior. Then they choose three of six possible interventions on topics that affect their health and well-being, including relationships, stress, culture, and substance abuse. The four sessions are usually completed within the first 3 months of enrollment in the project; most participants complete them within the first 4 or 5 weeks. Follow-up occurs at 3, 6, 9, and 12 months after enrollment.

So far, 196 men have completed the intervention. The mean age of participants in the Fenway project is 43; the range is 21 to 68. The mean time since HIV diagnosis is 10 years, and as with age, the range is wide (6 months to 22 years). The program generally reflects the demographics of the Fenway Clinic's patient population: 79 percent are non-Hispanic whites, 10 percent are black, and 6 percent are Hispanic. Median $CD4^+$ count is 508, and most participants have an undetectable viral load, reflecting widespread adherence to a HAART regimen.

Early Lessons

The Protect and Respect program and the Fenway project are still conducting follow-up and data analysis, so all findings are preliminary. EPPEC has analyzed some data on costs and implementation, the preliminary results of which are described here.

Protect and Respect

Initial analyses of the Protect and Respect program have resulted in several preliminary findings. At 6-month follow-up, women who received the GLI and participated in the peer-led support groups had higher average self-efficacy scores and were more likely to disclose their HIV status to their sexual partners than were women who received the standard intervention. Early analyses also concluded that the likelihood of having unsafe sex increases with participants' age. Michelle Teti, an interventionist with the project, emphasizes that the findings are preliminary. The data are based on an "intent to treat" design: 60 percent of participants assigned to the enhanced intervention group actually attended the GLI and peer-led groups. The researchers are planning to conduct additional analyses to further explore initial outcomes. Follow-up is ongoing; quantitative data will be collected and analyzed at 12- and 18-month time points. In addition, a qualitative analysis of the key group themes will contribute to the study's findings.

An unexpected project outcome, according to Teti, was "how much the peer leaders benefited from their positions. One peer leader said the job has changed her life—she has become more confident and assertive, [whereas] before she couldn't speak in front of a group." The other peer leader, says Teti, has become more confident about disclosing her status, and she has become an advocate in her church for people living with HIV/AIDS. Her willingness to disclose has made it easier for others in her congregation who are HIV positive to disclose their status and obtain support.

From a qualitative perspective, both groups have been a valuable experience for the participants. "It's nice to hear the women laughing out loud during the groups," says Teti. "The project participants face and overcome many life challenges. The peer group is one of the only spaces where they can talk openly about their concerns, with other HIV-positive women." Many women return week after week and view the groups as their "family," she says.

In Teti's view, the women have learned much from their participation. Many women enter the program wanting and needing to learn more about their bodies, their health, and HIV/AIDS. In the GLI, they receive up-to-date information about HIV, and they practice skills for disclosure and keeping themselves and their partners safe through role plays and other exercises. In the peer groups, they receive support and reinforcement for using those skills.

What should organizations hoping to implement similar interventions know? Teti has three "takeaways." First, the benefits of peer intervention go beyond the clients, as described earlier, and improve the lives of peer leaders in many ways. Second, the Drexel project highlights the value of using mixed methods to evaluate a project. The qualitative data gathered during the project help provide context for the quantitative data and reveal factors not captured by the quantitative methodology. Finally, women with HIV have complex lives; it is hard to measure all the benefits of the groups. "What we've seen is the women enjoying themselves, laughing, making friends, and feeling good about what they are learning and accomplishing," says Teti. That in itself is an important sign of success, she observes. This kind of group participation and supportive experience may ultimately affect women's risk behaviors, but it is difficult to make a direct link with the available methodology. Teti is in the process of analyzing the group transcript data to explore possible connections.

Fenway Community Health Center

No outcome data for Fenway are available yet, although anecdotal evidence indicates that participants are enjoying the sessions and are learning new coping skills and behaviors. "By and large, the intervention is very well received," says Conall O'Cleirigh, a clinical psychologist who is the behavioral scientist for the project. The workbook that is the basis for the interventions "looks great and includes curriculum information and worksheets. It is not boring or hokey." The workbook will be refined and disseminated once the evaluation is complete.

O'Cleirigh says that the goal was to "come up with [an intervention] that could piggyback onto ongoing care by being brief, flexible, and cost-effective." If the evaluation shows that the intervention was successful, the program will translate easily to other settings and will be cost-effective, in part because of the use of peers as the primary interventionists.

Recruitment has not been difficult because all participants are already receiving care at Fenway, says O'Cleirigh. He says that the program taps into two motivations. First, participants are often interested in contributing back to the community, and they see participation in the study as filling that purpose. Second, people get reimbursed for participation; they receive a $50 gift card for each of five assessments they complete.

Substance abuse and post-traumatic stress disorder (PTSD) are common among HIV-positive MSM, and the same is true of the Fenway study participants. (Substance abusers are not excluded from the study in the interest of creating an intervention that is broadly applicable and tested on a representative population.) O'Cleirigh suggests that, although it has been theorized that the experience of being diagnosed with HIV is

actually traumatizing and creates PTSD-like symptoms, rates of lifetime trauma (e.g., physical and sexual abuse) are quite high among HIV-positive MSM. The Fenway study refers people with mental health issues (which are outside the scope of the peer intervention) to mental health care providers based at the clinic.

O'Cleirigh notes that the intervention "works with real issues: substance abuse, PTSD, mental health disorders. If it has positive outcomes, the researchers won't have established that it works just with a circumscribed group but a group of people representative of people with HIV in Boston."

Evaluation Center Findings

Janet Myers, co-director of EPPEC, says that the center's analysis of cost data on peer interventions supports their use. First, peers are able to spend more time with patients than other providers are. In the PwP initiative, peers have spent an average of 1,630 minutes per month delivering prevention messages to patients; in contrast, primary care providers spent an average of 230 minutes per month and prevention specialists an average of 1,479 minutes per month. Although the cost per minute is about the same, peers and specialists are able to spend more time interacting with clients to disseminate prevention messages. The evaluation center has found good economies of scale in minutes delivered; that is, the more a program does, the cheaper it is.

EPPEC also has unearthed some interesting findings about implementing peer prevention programs, according to Kim Koester, a researcher with the center. Peer-based interventions have special staffing and training challenges. For example, recruiting and hiring peers can be time consuming, in part because peer interventionists face the same challenges as their clients (e.g., poverty, racism, and chaotic family life). In addition, peers may have a substance use background, lack of experience in clinical (and other) workplaces, and significant difficulty balancing work and family obligation, again because of structural challenges that parallel those of their clients. Peer training is often intensive and must cover a wide range of issues beyond prevention and the intervention plan, such as ethics and boundaries.

At the same time, peers are an invaluable source of feedback on prevention protocols and curricula. They can provide an important "reality check" for program developers for curriculum components such as language and sensitivity. At the same time, peers may feel a power imbalance and hesitate to provide honest feedback out of fear of losing their job. Consequently, program developers should take pains to create a feeling of partnership between themselves and the peers they hire. Koester notes that it is important to establish and follow through on clear roles and expectations.

EPPEC also found that implementation was most difficult at locations that used interventions based on primary care providers. Such interventions, to be successful, require both that providers change their clinical practices and that patients be willing to candidly discuss their risk behavior with their providers. In addition, it was more difficult to train providers because doing so required either after-hours training sessions or closing the clinic so that providers could attend training sessions. Moreover, "provider resistance was found in all clinics, ranging from concerns about clinic flow to ideological objections to behavioral counseling of any kind," says Koester. Sites spent significant time and money attempting to achieve provider buy-in. Although results on the effectiveness of provider interventions are not available yet, the issues involved in provider intervention, along with the sheer ability of peers to spend more time with patients, may suggest that provider interventions are not always the best option for prevention programs. At the same time, however, recruiting and retaining patients present significant challenges for peer-based intervention programs, whereas providers have a captive audience.

Looking Forward

One product of the initiative will be several handbooks based on interventions that show effectiveness. Each grantee will be submitting a manual describing its intervention, the target population, what is needed to implement it, and the results. The Prevention with Positives initiative will end in 2007, and the evaluation and support center will be releasing results over the next several years. Additional information on the evaluation, along with prevention resources, are available at the AIDS Research Institute website, http://ari.ucsf.edu/programs/policy_currentprojects.aspx.

For More Information . . .

For additional information on the Prevention with Positives Initiative, visit http://www.hab.hrsa.gov/special/pop_overview.htm.

The SPNS Project Officers for the PwP Initiative are

- Pamela Belton (301.443.9481; pbelton @hrsa.gov)
- Sandra Duggan (301.443.7874; sduggan@hrsa.gov)
- Katherine McElroy (301.443.0214; kmcelroy@hrsa.gov)
- Faye Malitz (301.443.3259; fmalitz@hrsa.gov).