

# **PREVENTION FOR POSITIVES**

## **A Compendium of Interventions**

**Midwest AIDS Prevention Project 2006**

# **Prevention For Positives: A Compendium of Interventions**

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## **INTRODUCTION**

This compendium of interventions specific to prevention for HIV positive individuals reviews interventions and demonstration projects conducted throughout the United States. It focuses on the basic elements of effective interventions designed to support behavior change regarding HIV transmission and sexually transmitted disease (STD) infection for individuals living with HIV. Among these basic elements, characteristics are highlighted such as intervention type, target population, setting and staffing requirements. A further discussion of overall programmatic observations, intervention outcomes, challenges and facilitators for replication, cost implications and program limitations is included.

A total of twenty interventions are included in this compendium. The amount of detailed programmatic information provided for each intervention varies greatly due to depth of published materials. However, in the absence of extensive written materials, contact information for the specific programs and their principle investigators is provided. Efforts are ongoing in the creation and implementation of prevention for positives programs. This document represents information available in 2005.

Inclusion of a program in this compendium should not be considered an endorsement by the authors, rather the information is provided to better inform interested individuals in existing interventions.

## **BACKGROUND**

The efficacy of retroviral therapy and other treatment regimens for slowing the progression of the symptoms and infections leading from HIV infection to AIDS has been well documented. These drug therapies, although commonly rife with side effects, make it possible for persons living with HIV or AIDS (PLWH/A) to live longer and often healthier lives. Although these therapies appear to slow the progression of the disease, they do not provide a cure for HIV, nor do they decrease the likelihood that one will transmit HIV to others (Michigan Department of Community Health (MDCH), 2003).

Prior to 2000 relatively little was known about effective interventions addressing the HIV and STD prevention needs of people living with HIV and according to Kalichman, et al, “studies show that a significant minority of people living with HIV/AIDS continue to practice sexual behaviors that place their partners and themselves at-risk for HIV and other sexually transmitted infections.” Furthermore, “efforts to reduce HIV-transmission risk behavior have concentrated on strategies adapted from interventions for uninfected populations with disappointing results” (Kalichman, et al., 2001).

Persons with HIV/AIDS, living longer and healthier lives, pose a new challenge for health advocates. Historically, provision of services for PLWH/A has centered on care and coping with the psychological and physical challenges around being infected. These interventions have often focused on reduction of risk for opportunistic infections and

compliance with medical regimens. Today the focus must include not only care-related interventions, but also provision of health education, risk reduction information and skills building activities. Specifically, understanding and addressing the unique challenges faced by PLWH/As as they strive to make decisions about behaviors that may ultimately put themselves at risk for re-infection and/or co-infection with other sexually transmitted diseases (STDs) and transmit HIV to another individual. That is, in order to slow the spread of HIV it is essential that prevention interventions target those already infected with HIV. Unfortunately, little is known about which interventions work to help people who are positive sustain risk reduction behaviors (MDCH 2003).

Before Centers for Disease Control and Prevention (CDC) funding for Primary Prevention for HIV-Infected Persons (PHIP) in 2000, interventions addressing the prevention needs of HIV positive individuals were virtually nonexistent. Since that time, and heavily influenced by CDC's Advancing HIV Prevention Initiative (AHP) announcement in 2003, many prevention efforts have been created/adapted to address the prevention needs of PLWH/A's. Furthermore, the CDC has included three prevention for positives programs (P4P) in their Diffusion of Effective Behavioral Interventions (DEBI) program listing (Academy for Educational Development, (AED) Center on AIDS and Community Health, 2004).

Due to this recent acceleration of intervention development in the area of prevention for positives, there has yet to be developed a centralized compendium of interventions by which program planners may compare and contrast existing Prevention for Positives programs. This document seeks to serve as an initial mechanism for such analysis.

## **METHODS**

The objectives of the review were as follows:

- To locate and describe available interventions, which address the on-going prevention needs of persons living with HIV/AIDS.
- To catalog P4P interventions to facilitate easy sorting and selection for further review
- To highlight the challenges and facilitators to replication by intervention
- To summarize common attributes of effective interventions
- To identify areas of need for further intervention design and research

A web-based literature search was conducted to identify prevention for positive interventions. Furthermore, information was gathered regarding unpublished studies via professional conferences, program web sites and interviews with principle investigators.

Interventions focused on behavioral outcomes that decrease the risk of transmitting HIV infection to others, as well as those which reduce the likelihood of the HIV+ person becoming infected with another STD, or re-infected with HIV were included.

Interventions were cataloged by target population, intervention type, setting, and staffing requirements. Further review of available program information was conducted to illuminate intervention outcomes, challenges and facilitators to replication, cost implications, and program limitations. A standardized review form was developed to abstract information on each program to facilitate comparison among the interventions.

Lastly, common attributes of effective interventions were identified across all P4P interventions.

## **OVERVIEW**

Newly designed interventions which take into account knowledge of HIV positive serostatus and encompass individual, group, social and mental health support have begun offering more apparently effective interventions to reduce HIV transmission and STD's among people living with HIV.

At this time those choosing to address the continued HIV/STD prevention needs of PLWH/A's have a relatively few number of interventions with varying levels of proven effectiveness from which to choose. This compendium is intended to be utilized as a tool to assist individuals, institutions and community stakeholders in investigating interventions for replication.

Efforts conducted to provide HIV/STD prevention interventions to those living with HIV infection utilize one or more of the following models: GLI (Group Level Intervention) ILI (Individual Level Intervention) a combination of ILI and GLI, and Social Marketing interventions. Settings for these interventions range from community based organizations (CBO's), infectious disease/primary care clinics, prison systems or off-site locations as part of a CBO based intervention (home parties, retreats etc.).

Interventions conducted via CBO's may include agencies which house Ryan White case management; prevention activities, case management only activities, prevention only activities and/or case management programs linked to infectious/primary care sites. Interventions conducted via infectious/primary care clinics are typically conducted on-site during normal provision of clinic services and may or may not be linked to CBO supported case management and/or prevention activities. Interventions conducted while HIV positive individuals are incarcerated in state or federal corrections institutions typically are provided via medical care clinics and may or may not have programmatic links to CBO supported case management or prevention programs.

It is important to note the role of HIV positive individuals should play in formative P4P efforts as well as serving in program advisory functions and staffing. As stated in a AIDS Policy Research Center monograph, "It is only with this leadership from the community of infected people and the groups that represent their interests that primary HIV prevention designed for people living with HIV will be successful" (Collins, Morin, Shriver and Coates, 2000).

## **REVIEW BY TARGET POPULATION**

### **Men who have Sex with Men**

The HIV prevention interventions designed for HIV positive MSM's primarily utilized GLI forms to address social support/social norms changes. These GLI's incorporated didactic learning, role-plays, skills building exercises and healthy decision-making and consequences activities. Of the interventions that combined GLI's with ILI's or used ILI stand alone interventions, the ILI components focused on in-depth risk assessment and application of newly acquired skills/information to either pre-plan or conduct post activity evaluation for risk behaviors.

The most common issues addressed in all of the interventions included safer sex knowledge, safer sex attitudes and skills building, role of substance use in ability to adhere to safer sex practices, disclosure/communication of HIV positive serostatus, STD prevention and adherence to medical care/treatment. Some of the interventions included a specific focus on issues related to guilt, shame, depression and stress (AIDS Partnership California (APC, 2003). Less frequently, the topic of slowing disease progression through HAART adherence was addressed via either group discussion or individual educational activities (ibid).

Certain programs included activities unique to their intervention. The P3 program at the AIDS Project of the East Bay in San Francisco included a component specifically to address the separation of HIV positive African American MSM's from supportive family social groups (APC, 2003). This program assisted participants in rebuilding a supportive "familial" unit among its group participants.

The E Kulena Kakou program for Asian/Pacific Islander HIV positive MSM's at the API Wellness Center included professional mental health therapy for their participants which was integrated into a GLI/ILI combined intervention (ibid).

The Prevention Options for Positives (POP) program in Michigan included assistance in partner counseling and referral services (PCRS) in the ILI portion of the intervention. In this project, PCRS was seen as an effort to mitigate guilt from having not disclosed HIV status to previous partners and as a support to build skills and efficacy to inform future partners of HIV status (MDCH, 2003).

Staffing of interventions designed for HIV positive MSM's primarily involved either peer facilitators or trained counselors (of which peers may also be utilized). Interventions that included more structured mental health counseling utilized professional mental health counselors and/or therapists.

## **Injection Drug Users**

Interventions studied to address HIV prevention among HIV positive Injection Drug Users were applied for both men and women IDU's. These interventions addressed, via GLI/ILI or GLI, ILI stand-alone activities issues specific to both sexual risk and syringe-sharing risks for HIV transmission. They also attempted to address sexual risk for STD's and the impact of continued substance use for individuals living with HIV.

The primary issues addressed via these interventions included; reducing sexual risk for HIV transmission and/or reinfection, STD acquisition, harm reduction relative to IDU, safer sex knowledge and skills, peer support, adherence to medical care/treatment, intimacy and economic-driven risks, as well as psychosocial concepts relating to grief, stigma and stress.

Of the interventions cataloged for this risk group, the Holistic Harm Reduction Program, (HHRP), (this program has been renamed the Holistic Health Recovery Program and is included as a CDC DEBI intervention) is the only non-study project created specifically for HIV positive IDU's. This intervention differs from the VOICE and Healthy Living Projects in that it is not a trial study. The HHRP appears to be the first intervention to apply the Information, Motivation, and Behavioral (IMB) model of behavior change for HIV positive male and female IDU's (Margolin, Avants, Warburton, Hawkins and Shi, 2003).

Staffing of interventions designed for HIV positive IDU's primarily involved either peer facilitators or trained counselors (of which peers may also be utilized).

## **HIV Positive Women**

Nationwide, there are few evaluated prevention programs targeted specifically to HIV positive women. However several do include women in their target population groups. The core issues addressed during these interventions included safer sex skills development, self-efficacy relative to safer sex and negotiation, disclosure of HIV status, substance use related risk, stress reduction and identifying healthy vs. unhealthy relationships.

Of the interventions which included women as target population compiled for this report, only the WILLOW program and the PROSPER program were designed exclusively for women. WILLOW utilizes the Theory of Gender and Power (Connell 1987) as well as Social Cognitive Theory (Bandura 1986) and attempts to comprehensively address the multiple issues faced specifically by women who live with HIV infection. Willow addresses issues relative to abusive relationships, unequal power in relationships, economic reliance of women upon men and women as caregivers. All of these issues are addressed with the specific context of how they impact women living with HIV (Wingood, et al., 2004).

The PROSPER program utilizes a combined prevention case management (PCM) and GLI design targeting HIV positive African American women in the District of Columbia. The PCM component of the PROSPER program provides individualized risk assessment and risk reduction activities as well as addressing concerns such as housing, addiction, domestic violence and mental health issues. The goal of this component (multi session PCM) is to assist with individualized behavior change toward more risk reducing actions concerning HIV transmission and STD acquisition. The goal of the multi session GLI component of the PROSPER program is to provide a peer led, group setting for women which addresses the specific issues faced by African American HIV positive women. Specific issues addressed include psychosocial aspects of living with HIV, cultural and gender issues, legal, financial problems as well as sexual abuse, domestic violence and self-perception. PROSPER is an ongoing intervention yet to publish specific outcome evaluation information.

Staffing of interventions designed for HIV positive women primarily involved either peer facilitators or trained counselors (of which peers may also be utilized). Interventions that included Prevention Case Management (PCM) utilized trained PCM counselors who may also be peers (Womens Collective, 2005).

## **Youth**

There are two prevention for positives programs that have been evaluated and specifically target HIV positive youth included in this compendium. They are, Teens Linked to Care (TLC) and its second-generation project, Choosing Life: Empowerment Action, Results (CLEAR).

Teens Linked to Care (TLC) is a prevention program for young men and women aged 13 to 29 who are living with HIV. The intervention is based on social learning and cognitive-behavioral principles, which link feelings, attitudes and thoughts to behavior change. This program utilizes an 8-12 session GLI which is module driven and based on cognitive-behavioral strategies (Social Action Theory) to facilitate behavior change. TLC focuses on health care and health behaviors, sexual and drug risk and improving quality of life. TLC consists of three modules: Staying Healthy, Acting Safe, and Quality of Life. Each session is designed to stand alone, so that participants can “drop in” and “drop out” as they choose. Session activities include scripted and non-scripted role-plays, skills building, problem solving and goal setting. According to their project overview, TLC has shown demonstrated effectiveness in reducing HIV transmission risk behaviors, improving health-related behaviors, coping skills and quality of life.

CLEAR is a second-generation intervention (NIDA funded) based heavily on the previously successful Teens Linked to Care (TLC) Intervention. CLEAR utilized individual level counseling via telephone call-in (control group) or face-to-face sessions (intervention group) in comparison. The intervention provided education and skills building information designed to reduce HIV transmission, increase adherence to

HAART and improve quality of life for HIV positive youth. The program goals include increased sexual risk reduction and decreased substance use among its participants.

## **OBSERVATIONS OF INTERVENTION TYPES**

In conducting research required for this compendium and related technical assistance for Michigan's prevention for positives activities, specific strengths and challenges connected to intervention types were observed. Although evaluation related to behavior change, intentions to change behavior, increases in knowledge and skills was conducted for each outlined intervention, the methods and intensity of evaluation varied greatly across interventions. That being stated, some indicators of effectiveness based on intervention type did become evident and are discussed below.

### **Group Level Interventions Combined with Individual Level Interventions**

Interventions which used a combined approach of GLI and ILI (GLI's conducted via curriculum driven activities specific to behavioral change outcomes) were shown to be effective across a larger number and more varied distribution of intended outcomes (e.g., APC 2003; CAPS, 2004). Combined GLI/ILI interventions showed increases in measured behavior change toward risk reduction, intention to change behavior, skills required for behavior change, perceived social support for risk reducing behavior change, knowledge of HIV/STD transmission and knowledge of the role of HIV re-infection and STD acquisition. *These indicators of effectiveness have been seen across all demographic populations included in this intervention type including; African Americans, Caucasians, Latino/a's, Asian/Pacific Islanders as well as the behavioral risk groups of MSM, IDU's and heterosexuals within these racial/gender groups.* Although this combination of GLI/ILI has shown to be highly effective in supporting behavior change related to HIV transmission, re-infection and STD infection, there are important programmatic and cost considerations to be addressed in replication.

As with GLI only interventions, recruitment for GLI/ILI combined interventions can be very difficult. Utilization of incentives throughout this type of intervention and at time of recruitment has been shown to support the recruitment and retention of HIV positive individuals. The costs of recruitment incentives as well as incentives which may increase retention must be factored into provision of multi-session services. These interventions also involve a more expanded time line than ILI only interventions. GLI's which utilized more than two or three sessions and having each session focused on specific behavior, knowledge and skills related to HIV transmission and STD prevention have been shown to be more effective in sustained behavior change (e.g. MDCH 2003). This is true whether the intervention was a GLI only or combined GLI/ILI intervention model. Due to facilitation of a longer intervention with a more involved recruitment process, and use of incentives (both during GLI and ILI components), this intervention model may be more costly to conduct than GLI or ILI only interventions.

## **Group Level Interventions**

Based on the review of interventions included in this document, GLI's (especially multi-session) appear to have an increased impact on behavior change regarding risk reduction for HIV transmission and STD acquisition when compared with ILI only interventions (MDCH 2003). This was true across all demographic groups involved in demonstration projects. Demographic groups enrolled in GLI projects included both men and women and also represented Men who have Sex with Men (MSM's), Transgendered individuals, Heterosexual men and women, Injection Drug Users (IDU) of all genders, Incarcerated individuals and furthermore were also represented by African American's, Latino/a's, Caucasians and Asian/Pacific Islanders. Multi-session groups driven by curricula specific to behavior change, skill acquisition (safer sex, negotiation, communication, disclosure etc.) and knowledge acquisition were shown to have increased positive outcomes for both sustained behavior change and increased intention to change behaviors by participants (e.g. APC, 2003; CAPS, 2004).

Participant self-reported responses reflected a high satisfaction and increased self-efficacy regarding risk reduction due to participation in GLI interventions. *This reported high level of participant satisfaction is seen in models that utilize peer facilitators or a combination of peer facilitator paired with a professional facilitator.* (e.g. MDCH 2003; APC 2004). As in the case with the P.O.P. intervention in Michigan, GLI's appear to impact participants' desires for social support, fostered modeling of behavior change skills, group social norm building with respect to risk reduction and impacted perceived isolation which has been an illustrated as a possible contributor to potential risk (Hyde, Appleby, Weiss, Bailey and Morgan, 2005).

As stated previously in the description of GLI/ILI combined interventions, multi-session GLI-only interventions take place over a longer timetable, include use of incentives and may involve utilization of retreats or other social group-building activities. These issues and their relative costs, both in program dollars and staffing hours, should be taken into account by agencies seeking to replicate these effective programs.

## **Individual Level Interventions**

Individual Level Interventions (ILI's), including Prevention Case Management (PCM), whether conducted by peer counselors, case managers or other trained staff have been shown effective in increasing knowledge of HIV transmission, HIV medication adherence, HIV treatment, STD information and access to supportive services via referrals to adjunct services such as substance abuse treatment and mental health care (CDC, 2004). To date, there is little available data on the effectiveness of ILI's as a stand-alone intervention on behavior change for risk reduction over time.

ILI's strengths are in the one-on-one examination of current risk, knowledge levels and need for supportive services. As with GLI/ILI combined and GLI stand-alone interventions, ILI's have been shown to be more effective via multi-session service

provision. There are no concrete data, as of this date, that suggests an optimum number of sessions for maximum effectiveness. In response to this lack of available data, those seeking to replicate an ILI-only model for prevention for positives may wish to follow model programs that segment risk/service categories that allow for an exploration of specific risk or service need to the point where the client has demonstrated progress toward or completion of *stated specific prevention goals*.

Based on discussions with Prevention Case Management (PCM) providers in Michigan, open-ended, continued service provision of ILI's with limited goal setting or goals outside of prevention issues may provide access to adjunct services, but have decreased effective outcomes specific to HIV transmission risk or risk of acquiring and STD. As seen with the varied models used for PCM and other ILI forms, straying from prevention-specific goals during provision of ILI-only models may not adequately impact behaviors relative to continued prevention for individuals living with HIV infection. *Motivational Interviewing* may be a useful technique to assist in keeping the focus of the intervention on HIV/STD prevention (Rollnick and Miller, 1995).

ILI's strengths in increasing knowledge have been shown to be very important in impacting patient knowledge of prevention issues, as seen in several clinic-based models of prevention for HIV positive individuals (Partnership for Health). Models which utilize physician/care team or peer prevention counseling or pair this effort with other ILI services, (PCM etc.) have a demonstrated impact on client knowledge of prevention issues such as re-infection, impact of STD infection on a compromised immune system and transmission of HIV to another individual (Partnership for Health; Healthy Living Project).

### **Clinic Based Interventions**

Whether GLI, ILI or combined GLI/ILI interventions are offered in a clinic based setting, the clinical environment allows for certain programmatic, access and service activities that may not be available at other traditional settings. P4P interventions conducted in a clinic environment have the capacity to become "wrap-around" activities which encompass the majority of the prevention-care-prevention continuum.

Health care providers which have frequent contact with HIV positive individuals have a unique opportunity to play an important role in reducing transmission of HIV or acquisition of STD's by their HIV positive patients. Clinicians and clinical staff have an opportunity to screen for HIV transmission behaviors, STD infections, address substance use and mental health issues as well as serve as an important venue from which to provide referrals for services (Department of Health and Human Services, Centers for Disease Control and Prevention, MMWR July, 2003).

The published and evaluated clinic-based P4P programs available at the time of this report primarily utilized trained clinic staff to provide ILI based interventions (e.g. Partnership for Health). These programs provide training to assist Infectious Disease

doctors, nurses and allied clinic staff to provide one-on-one patient education and discussion sessions regarding prevention issues. Some programs trained all staff in HIV prevention relative to their patient population, other programs trained only key staff that would be responsible for implementing prevention programming.

Routine STD screening for all patients accessing clinic services was initiated in some clinic-based efforts to accomplish empirical tracking of prevention issues and also serve as a platform by which prevention education might occur. Tracking changes over time in STD occurrences among HIV positive patients before and after providing prevention programming has been utilized as one component of clinic based prevention service evaluation (e.g. Partnership for Health; Healthy Living Project).

HIV prevention training of service staff is utilized in interventions provided within clinic settings. Prevention intervention staff may include physicians, nurses, allied clinic staff and HIV positive peers. Interventions may utilize a clinician-based model where the treating physician performs risk assessment and delivers counseling on a routine basis; a specialist-based model which utilizes trained clinic staff including HIV positive peers to deliver assessment and counseling services as part of an in-clinic referral. Another method used in providing HIV prevention services within a clinic setting involves a multi-disciplinary care team approach. In this model all members of the care team are trained and offer HIV prevention counseling/discussions at several points during routine clinic visits (Morin et. al. 2004).

Initially, P4P interventions conducted within clinic settings primarily utilized either the clinician-based model or specialist-based model without integrating HIV positive peers into provision of P4P services within clinic settings (e.g. Healthy Living Project). Recently, there has been more utilization of trained HIV positive peers serving as P4P intervention providers in clinic settings (New York State Department of Health, Office of the Medical Director, AIDS Institute, 2005).

### **Social Marketing Projects**

Social marketing is the application of proven concepts and techniques drawn from the commercial sector to promote changes in diverse socially important behaviors such as drug use, smoking, sexual behavior, family planning and child care (Andreasen, 1995).

Social marketing as an intervention for P4P programming is relatively new. This type of intervention has been mainly focused on utilization of HIV positive peers (mainly within the MSM community) to address social norms/beliefs regarding HIV risk and perceived severity of HIV infection. Typically this intervention is delivered via media campaigns which highlight HIV positive spokespersons providing messages aimed at increasing awareness of HIV prevention and the physical, mental and health challenges faced while living with HIV.

To date there are no published outcome data available on the effectiveness of this intervention regarding behavior change relative to reducing risk factors for HIV

transmission or STD acquisition. However, this modality has been found to be effective in addressing other health related issues such as salt intake, immunization, breast feeding, exercise and diet and smoking cessation to name only a few (Andreasen, 1995)

### ***HIV Stops with Me***

Created by Better World Advertising, HIV STOPS WITH ME is a social marketing campaign which aims to reduce the stigma associated with HIV by utilizing HIV positive peer “spokesmodels” currently from Boston, Buffalo, Los Angeles, Long Beach, New York City, Oregon, San Francisco, San Diego, and Seattle. This awareness campaign utilizes web-based access and is therefore available worldwide.

The HIV STOPS WITH ME campaign utilizes HIV positive individuals in delivering awareness and prevention messages. The project addresses sex and condom use, responsibility, communication and disclosure of status. The central issue to this campaign is one of PLWH/A responsibility in HIV prevention. The statement that “HIV stops with me” is a call to HIV positive individuals who know their HIV status, to build their skills, knowledge and become active in HIV prevention. This project utilizes HIV positive peers as a way to impact perceived social norms within the HIV positive ‘community.’

According to their website [www.hivstopswithme.org](http://www.hivstopswithme.org), “each city has their own website and within that website the spokespeople each have their own section where they tell their own story and engage in online dialogue with other members of the community. The website also contains articles of interest, lists of resources and a calendar of related events. The spokespersons were chosen to reflect the demographic makeup of their communities. Campaign materials include the website, billboards, print ads, posters in bars and clubs, outreach postcards and television commercials.”

## **PROGRAMMATIC CONSIDERATIONS**

### **Cost**

Cost considerations for replicating P4P programs include staffing, support for GLI’s, use of incentives for GLI’s/ILI’s, staff training, possible social group activities such as retreats and the typical programmatic costs related to implementation of prevention programs.

Staffing costs may include utilization of professional mental health counselors/therapists as well as training costs for facilitating/counseling staff specific to prevention for positives programming requirements. Training costs should be seen as a recurrent expenditure due to the requirement of specific training to increase staff capacity to provide these interventions. Maintaining staff professional development in new methods and models, such as prevention for positives, increases the cost of service provision.

Multi-session GLI's have additional costs in their provision. Meeting space, food, incentives, safer sex materials as well as training materials are needed. Additional costs may be incurred if social events are added to this type of intervention. Costs for GLI's increase as the number of sessions increase. In order to achieve optimum recruitment and retention, use of incentives has been shown to be an effective and necessary expenditure.

## **Staffing**

Due to the intensive nature of P4P programming, a high level of facilitation and counseling skills is required from program staff. Furthermore, utilization of behavioral group, gender and seroconcordant peers is common across prevention for positives programs. It may be necessary to build the professional and skill capacity of these peer facilitators/counselors in order to provide prevention for positives interventions.

In the POP project, requirements for program staff in Michigan includes mastery of the MDCH, Division of Division of Health, Wellness and Disease Control, HAPIS, HIV Counseling, Testing and Partner Referral training. Additional training and skills development should be provided specific to the intervention being replicated. For agencies replicating the POP project, training is required for GLI facilitation and ILI provision. Additional training via Michigan's HIV Case Management Certification training was useful.

Some of the programs listed in this compendium offer replication training specific to their intervention. The Teens Linked to Care (TLC), Holistic Health Recovery (HHRC) and the Healthy Relationships programs are listed in the CDC Diffusion of Effective Behavioral Interventions (DEBI) project and have available training for replication.

Programs included in this document have utilized professional mental health service providers in provision of mental health therapy and/or less therapy-based ILI components. In provision of other ILI components, programs have utilized Case Managers, client advocates as well as trained peer counselors to conduct ongoing one-on-one risk reduction counseling. Due to the focused prevention efforts in these projects, additional training may be necessary for counselors who have limited knowledge or infrequent exposure to HIV prevention counseling; specifically those efforts that address the prevention needs of people living with HIV.

## **Venue**

To date, the primary entities providing P4P programming have been either community based organizations (CBO's) or HIV infectious disease clinics/primary care clinics. Both entities have within them certain organizational, philosophical and programmatic delivery systems which can serve as barriers or facilitators to providing effective P4P programming.

P4P programs can serve as a “bridge” program that crosses between what in many cases, are separate care and prevention service systems. CBO’s that have clearly separated care and prevention components, or specialize more in either care or prevention service provision may experience difficulty in integrating fully the combined care and prevention disciplines required in providing P4P programming. The following agency identity models and their possible systemic supports and challenges to P4P programming are offered for consideration:

### ***Prevention Focused CBO***

CBO’s that have traditionally only provided HIV prevention interventions i.e., outreach, counseling/testing and referral and group/individual session programming targeting at-risk HIV negative individuals, may lack the needed experience and expertise in providing services to HIV positive individuals. The literature regarding development of P4P programs strongly suggests that using existing programs designed to meet the prevention needs of at-risk negatives is sub-optimal when applied to individuals who know they have HIV.

CBO’s who traditionally provide prevention services to at-risk HIV negative individuals may lack the capacity and experience in screening and providing referrals to important care related services such as, infectious disease/primary care, mental health care, substance abuse treatment, legal support, disclosure issues and the plethora of services connected to case management services. These prevention-focused agencies may also lack the experience in maintaining client progress charts which are frequently required in P4P activities, especially those utilizing ILI or one-on-one counseling components.

Recently, more prevention efforts are involved in provision of multi-session interventions. This new method of providing HIV prevention activities is becoming more utilized and can build prevention provider’s capacity in providing similar multi-session GLI or ILI components. With these new intervention models also comes new emphasis on evaluation and tracking client behavioral change toward decreased HIV risk behaviors. This was not as prevalent in past HIV prevention programming and agencies who have had limited provision of such services may need additional support in increasing capacity to effectively evaluate their program efforts and track behavior change in their clients over time.

Due to the inherent need for care services access at the other end of the P4P “bridge,” agencies which do not currently have integrated access to these services internally or externally may require additional effort in coordination of these services.

Agency culture can serve as a barrier or a facilitator of success in integrating a P4P program. In some prevention-focused agencies, the culture may be one of increased emphasis on client-centeredness, emersion within the at-risk community and an implied or accepted belief that administrative requirements of service provision are overly bureaucratic and less important than providing prevention services.

Prevention focused CBO's who operate with a culture of client centeredness may be very effective at using this culture to support the in-depth behavior change work inherent in P4P services. Knowing the realities relative to continued risk that their clients face, this level of client focus may facilitate more reality-based intervention activities for their clients. Additionally, CBO's who have historically been "of and for" the community typically support utilization of peer facilitated prevention programs. The use of seropositive, racial, gender and behavioral peers in provision of P4P programs has been highlighted in the literature as being a highly effective method in offering P4P activities.

CBO's which may see the administrative, evaluative and data collection requirements of many P4P programs as unnecessarily restrictive activities may need further assistance in seeing evaluation and programmatic data collection as important to program development and assurance of increased quality in the services they provide.

### ***Care/Case Management Focused CBO***

CBO's that have historically provided care/case management services, and are planning to integrate P4P programs may have specific operational and/or philosophical considerations which may serve to support or hinder P4P activities. Whether real (due to funding entity requirements) or perceived, if addressed proactively, these barriers can be reduced and the strengths of this type of agency venue can be utilized to promote success in an integrated P4P program.

Care focused CBO's may not have historically addressed prevention issues for their clients in the agency's service provision. Agencies using this model of service provision may have also had a history of not having adequate administrative support for addressing prevention issues. For many case management agencies, which have a primary focus on care services (or have a prevention program in-house, yet not fully integrated into care services), screening of prevention issues and services based on these screenings may be inconsistent or completely referred out to other providers.

In some cases, the administrative realities of providing case management services offer no method of allowing/accounting for staff time spent on addressing client prevention issues. Within this model of service delivery there can also be a lack of staff professional development in providing prevention services to their clients.

Agencies that have care and prevention programs but have not fully integrated these programs in a continuum, face administrative, philosophical and capacity challenges in providing P4P programming. In this agency setting, the care and prevention services are typically separated entities within the agency structure. They have their own supervisory and line staff and have limited coordination across disciplines. This can create an actual or implied division of services which pose a challenge for a "bridging" intervention such as P4P programming. In some such "divided" agencies, professional rivalries can exist between the two disciplines. If the agency is primarily focused on care/case management services and this effort is seen as the more clinical, and therefore more professional function of the agency, then logically, prevention services would be seen as less

professional and a less important agency function. Additionally, with the support given to utilization of peers in provision of P4P programming, “professionalizing” the peer model may be difficult for some agencies.

CBO’s which have distinct divisions between their care and prevention services, where care services are seen as the more important function of the agency may lack the necessary capacity and skills to screen, refer and offer direct P4P services to clients without first attempting to increase this capacity and better integrate their agency’s split disciplines. P4P programs require strong coordination between care and prevention services whether both services are offered in the same agency or one of the functions is referred out to a partnering entity.

Care focused CBO’s have the benefit of continued contact with their clients. Agencies providing case management services have a structure that, supported with capacity building in offering prevention services to HIV positive clients, may serve to successfully integrate many P4P models. The nature of case management services lends itself well to providing ILI and one-on-one counseling services that are a component of many P4P programs. CBO’s providing case management services are also more likely to have up-to-date community resource information and a strong working knowledge of the requirements for services within these community service resources.

Care/case management focused agencies may also have the benefit of long-term established relationships with their HIV positive clients. These relationships and the depth of knowledge that the service provider has regarding the many challenges faced by their clients can be very beneficial in supporting P4P opportunities.

During recent technical assistance site visits to Michigan agencies that have both case management and prevention programs and are replicating the Prevention Options for Positives (POP) program, case managers who serve as referral agents into a P4P program have shown increased efficacy in providing risk screening and referral. Many were initially concerned that they had to become prevention specialists in order to meet the requirements of a P4P program. After seeing their role as being one of initial screening and referral, many adapted their assessment skills to facilitate their role in an integrated P4P program.

### *Infectious/Primary Care Clinics*

According to the Institute of Medicine, “Prevention services for HIV-infected persons should be a standard of care in all clinical settings (e.g., primary care settings, sexually transmitted disease clinics, drug treatment facilities and mental health settings). Health care providers should have adequate training, time, and resources to conduct effective HIV prevention counseling. Enabling this activity may require adjustments in health care provider time allocations” (Institute of Medicine, 2000).

Infectious disease/primary care clinics have been shown to be an effective platform from which to provide P4P efforts. In this setting however, certain barriers should be

addressed as well as support given to the existing facilitators for success that may be currently in place in a clinic setting.

Typical clinic based P4P services utilize either physician, health professional or peer provided services within the clinic. Barriers in effective P4P service delivery in this setting can be similar to those faced in CBO's with respect to organizational philosophy and support of prevention services overall.

If the specific function of a clinic is to diagnose and treat health problems, proactive prevention may not be fully integrated into normalized service provision. In some cases, prevention issues for HIV positive patients are only addressed after a medically significant indicator such as an STD occurs. HIV transmission and STD acquisition risk screening is not routinely offered within clinical services. If and when this is offered, it's typically in conjunction with standardized STD screening for all HIV positive patients. However prevention counseling and risk screening is not always a function of this diagnostic effort.

New protocols addressing STD screening, colorectal examinations and increased attention to gynecological health for HIV positive patients are being utilized more frequently in many clinics. However, these diagnostic efforts are not always linked to risk screening and prevention counseling efforts.

The realities of managed care especially with respect to the amount of time physicians are able to spend with each HIV positive patient can be a very important barrier in providing adequate time for prevention services. In addition, the myriad of required diagnostic measures required during a normal clinic visit (even without additional medical needs) can place increased restrictions on time available for prevention services within the clinical encounter.

Specific expertise related to HIV/STD behavioral risk screening and provision of prevention services may not be normative within a typical clinic. Sexual and/or substance use risk screening and prevention counseling may not be adequately addressed by clinic staff due to reasons such as lack of expertise, feeling uncomfortable with topic, lack of time and lack of administrative support for such activities. Recent studies suggest that patients are eager to discuss issues related to sexual health and other HIV risk factors with their medical providers (MMWR, July 2003).

Many of these barriers have been successfully addressed in clinic-based P4P programs. The most common primary effort to address these barriers is in the utilization of training and capacity building of clinic staff with respect to sexual risk screening and prevention counseling. Whether provided by an infectious disease physician, nurse, allied health professional or peer counselor within the clinic, HIV/STD prevention counseling, risk screening and service referral has been shown to be an effective method of incorporating prevention activities within a clinic setting. However, models which utilize nurse, allied health professional and especially peer facilitated P4P interventions have had to respond

to philosophical barriers regarding the “professional” status of such individuals within the health clinic delivery system.

To accomplish effective prevention service provision within a clinic setting, service providers have had to incorporate programs that place P4P as a necessary and important function of routine clinic services. Due to the ongoing contact they have with their HIV positive patients and the strength of the doctor-patient relationship, many clinic based P4P providers have been able to utilize the supportive mechanisms found within clinic services as an effective vehicle to address P4P opportunities.

### *Across Venues/Settings*

In all of the above service delivery structures, similarities exist in addressing barriers and facilitating success in provision of P4P services. Regardless of the organizational structure, creating a collaborative and coordinated effort across care and prevention services increases the effectiveness of P4P programs in these venues. Increased training in prevention and care relative to HIV positive individuals is paramount in increasing the likelihood of providing an effective P4P intervention. Mitigating rivalry challenges across disciplines, whether real or perceived, will support the coordinated flow of expertise and services required by P4P programs as they “bridge” services in both care and prevention. Agencies and clinics that desire to integrate P4P interventions within their agencies/clinics and proactively address institutional and philosophical barriers to coordinated care and prevention services will have a higher likelihood of providing successful P4P services.

Due to the increase in peer delivered P4P programs, agencies and clinics that traditionally have not utilized this method, or have philosophical/agency culture issues which devalue peers as professional providers of effective services, should address these issues prior to instituting a peer-facilitated intervention.

## **SUMMARY**

This compendium is written with the specific intention to provide a background in current models of P4P programming to interested entities. This information is intended to inform those interested in replicating P4P programs. Due to a lack of comparative data across intervention types, varied application of outcome evaluation techniques and diverse stages of analysis and publication of evaluation data, conclusions are difficult to arrive at.

Through review of available published materials, attendance at conferences highlighting P4P programming and discussions with principle investigators and P4P program staff; certain salient points have been elucidated. This information is presented below in abbreviated fashion to inform program planners in their move to implement P4P programming.

The following summaries are provided by intervention type and venue:

### **Individual Level Interventions**

- Have been shown to be effective in increasing knowledge of HIV transmission and STD risk.
- Are an appropriate platform from which to provide referrals and access to needed prevention and care services.
- When provided in multiple sessions with *HIV/STD prevention goals specified* are more likely to contribute to behavior change than single session activities or multi-session activities where prevention issues are not a priority.
- Can be provided via HIV prevention CBO's, case management organizations and/or HIV care clinics.
- May be provided by trained physicians, clinical staff, prevention workers, case managers and more programs are effectively utilizing trained HIV positive peers in all venues.

### **Group Level Interventions**

- Have been shown to be effective in providing skills building, increased knowledge and increased self-efficacy in reducing HIV transmission/STD acquisition behaviors.
- Provide for development of social norms change, decrease sense of isolation and provide social support to positively impact behavior change.
- When specific to behavioral groups, race and gender can provide for in-depth exploration of behavior change activities in a "safe" environment.
- Which utilize *curriculum driven sessions specific to HIV transmission/STD acquisition risk reduction* are more effective in supporting behavior change than traditional psychosocial support groups where prevention activities are not a service priority.
- When provided in multiple sessions with *HIV/STD prevention goals specified* are more likely to contribute to behavior change than single session activities or multi-session activities where prevention issues are not a priority.
- May be provided at any traditional service venue however, if no prior history of group activities have been provided at a specific venue, the agency/clinic should expect to provide either adequate lead-in time or an optional off-site venue to facilitate this activity.

### **Combined Group Level and Individual Level Interventions**

- Models have been shown to be most effective at encouraging risk reducing behavior change.
- May be provided at any traditional venue however if either component has not been historically available at a given venue, adequate lead-in time or utilization of off-site venues may be necessary.

- Require a higher degree of staff training and capacity and may also require additional costs to provide.
- Allow for group and individual reinforcement of steps toward risk reducing behavior change.
- Offer the opportunity to provide a longer term, more intensive intervention with individuals who face multiple competing priorities that may be barriers to individual risk reduction efforts.

### **Clinic Based Interventions**

- Can serve as a multidisciplinary “wrap-around” activity which utilizes the unique opportunities of continued patient contact, medical indicators of risk measurement and can connect directly services which may be segmented in a prevention-care-prevention continuum.
- May utilize GLI’s, ILI’s, combined GLI/ILI’s with physicians, clinical staff and/or peers. If not traditionally provided within the clinic setting, GLI activities or utilization of peer prevention specialist may need additional lead-time to develop due to clinic culture and service provision history.
- Make prevention services routine within the normal flow of clinical services.
- Can help to reduce the cost of HIV care by addressing prevention issues such as STD infection, substance use and mental health needs proactively within a care facility.
- Offer a “one-stop-shop” opportunity that may decrease the barriers of time and transportation for multiple prevention and care services.

### **Social Marketing Interventions**

- May influence community norms relative to risk behaviors of PLWH/A’s
- Can increase awareness and decrease myths regarding perceived severity of HIV.
- Are based on messages developed by and often delivered by the target population (HIV positive individuals).

## **AREAS OF NEED FOR FURTHER INTERVENTION DESIGN AND RESEARCH**

During completion of this compendium specific areas of need were identified for further intervention design and continued research. First, further research is needed to assess and document the HIV prevention outcomes of ILI and social marketing models targeting individuals living with HIV. Additionally, currently there is a lack of culturally and racially targeted P4P interventions. Current models do not take into account the specific barriers and facilitators for HIV prevention behavior change experienced by specific racial or ethnic populations. There is also a lack of proven effective P4P interventions specific to the continued HIV prevention needs of positive women and heterosexual men who are not now, or never were injection drug users. Individuals should consider these gaps when designing future interventions and studies.

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