

**The Use of Peer Workers
in Special Projects of National Significance Initiatives,
1993 – 2009**

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1 INTRODUCTION

In health interventions that use peers, individuals educate other individuals that share similar characteristics and backgrounds to encourage behavioral change (Horizons, 1999). A *peer* can be defined in a variety of ways (Bourdon and Measurement Group, 1999), including by age, race or ethnicity, gender, sexual orientation, and language. Peer initiatives have worked to promote positive behaviors regarding many health-related issues, such as reducing cigarette smoking (Turner and Shepherd, 1999) and encouraging safe sex (DiClemente and Wingood, 1995).

The Health Research and Services Administration (HRSA), through its HIV/AIDS Bureau's Special Projects of National Significance (SPNS) Program, has supported initiatives that incorporated peers in various capacities. SPNS grantees are awarded funds to design, implement, and evaluate innovative strategies that encourage hard-to-reach populations living with HIV/AIDS to access and remain engaged in primary health care and supportive services. Such support and health care, which includes regular medical appointments and Highly Active Antiretroviral Therapy (HAART) when indicated, can dramatically prolong the lives of people living with HIV/AIDS. Over the last decade, SPNS grantees have used peer workers in several initiatives to promote engagement in HIV/AIDS primary care. All grantees within the Caribbean Initiative (2003-2007) were funded by SPNS to implement peer-based support interventions, including peer outreach and education sessions. Although they were not required to do so, grantees in a number of initiatives used peers for different activities with varying degrees of intensity. These included the Adolescent (1993-1998), the U.S.-Mexico Border Health (2000-2005), Outreach (2001-2006), Prevention with Positives (2003-2007), and Young Men of Color Who Have Sex with Men (2005-2009) Initiatives. By examining the diverse ways grantees used peer workers in these initiatives, it is possible to identify how peer models can best be employed in the settings described.

This report serves as a compilation of SPNS grantee experiences with peer models. Much of the information presented here is gathered from articles published in public health journals and online by the grantees themselves or by the Evaluation and Technical Assistance Centers (ETACs) for the initiatives. This information has been integrated with findings from independent analyses conducted by HRSA using data from different initiatives.

The report has four sections. Section 1 discusses some behavioral change theories behind peer models and reviews their usage outside of SPNS settings. Section 2 presents a descriptive summary of the six initiatives described above, including how peers were defined and what responsibilities they were given. Section 3 describes the challenges associated with incorporating peers within program models. Finally, Section 4 highlights recommendations

provided in published literature and SPNS reports on how to successfully use peers in HIV/AIDS outreach and education activities.

2 BACKGROUND

2.1 Barriers to Care Among HIV-Positive Medically Underserved Individuals

The HIV/AIDS epidemic has heavily impacted many medically underserved groups in the United States, including individuals from minority groups, individuals with few financial resources, and individuals suffering other health issues such as mental health problems. These individuals must overcome numerous barriers to access health care. The Institute of Medicine has provided a framework for categorizing the barriers to health care as structural, financial, and personal/cultural (Millman, 1993). Structural barriers to HIV care encompass patients' lack of housing and transportation, long appointment wait times and language barriers. Patients experience financial barriers to care when they cannot afford needed care because they are uninsured or underinsured. Lastly, personal and cultural barriers stem from individuals' beliefs about health care and HIV, and include cultural barriers such as racism, language, sexism, homophobia and other issues. These barriers create disparities in access to HIV care, which manifest as delays in starting treatment and lack of HIV medications (Tobias, Cunningham, Cunningham, and Pounds, 2007).

2.2 The Role of Peers in Improving Health Outcomes

The employment of peers is often based on the theory that individuals can effect change among people that share their characteristics by displaying positive behaviors (Turner and Shepherd, 1999). Peer education can motivate attitudinal and behavioral change at the individual or community level (Horizons Project, 1999). There is no standard definition of peer worker, and peer workers encompass a range set of roles and responsibilities across different programs (Bourdon and Measurement Group, 1999).

According to Social Cognitive Theory, health programs should educate individuals about healthy behaviors, foster skills that allow them to apply information learned, promote individuals' beliefs that they can change their behaviors and provide social support for their new behaviors (Bandura, 1994). Peers can contribute to and promote the success of these activities in several ways. An individual's belief in his/her ability to change can be influenced by witnessing positive health behaviors "modeled" in peers. Specifically, Bandura states that "to increase the impact of modeling, the characteristics of models such as their age, sex, and status, the type of problems with which they cope, and the situation in which they apply their skills, should be made to appear similar to the people's own circumstances" (Bandura, 1994).

Proponents of peer education argue that its power to influence behavior depends crucially on communication between peers, which empower them to take action (Horizons Project, 1999).

While many peer education models are based on Social Cognitive Theory, other theories can also be used to support peer education. Two examples are Social Inoculation Theory, which maintains individuals can be taught to avoid social pressures, and Role Theory, which suggests peer workers will adopt mentor-type relationships with individuals in a successful manner (Turner and Shepherd, 1999).

2.3 Evidence of the Effectiveness of Peer Education

Proponents of peer education maintain that it is effective because it yields a wide array of benefits. Employing peers is often cheaper than alternative intervention models, and uses existing social networks and channels of communication. Peer workers are trusted sources of information to whom “hard-to-reach” populations will more readily turn, and the peer education process can empower not only clients but also the peers themselves (Turner and Shepherd, 1999). However, these claims have not yet been substantiated by research, and a review of some of the findings and limitations of existing research follows.

Some previous research suggests that interventions using peers can produce successful outcomes, particularly with regards to increases in self-reported condom use. UNAIDS and the Horizons Project examined scientific evaluations of peer education aimed at health improvements among individuals with STI or HIV/AIDS (Horizons Project, 1999). Highlighted in this analysis were two successful peer education programs in the United States. One used peers to promote condom use and bleach for cleaning needles among injection drug users (Rietmeijer, Kane, Simons, Corby, Wolitski, Higgins, Judson, and Cohn, 1996) and another encouraged safer sex among men who have sex with men (Kelly, Murphy, Sikkema, McAuliffe, Roffman, Solomon, Winett, and Kalichman, 1997). Both studies found statistically significant improvements in condom use among individuals who had interacted with peers as compared to control groups.

Similar findings have been reported by other researchers. The Mpowerment Project for young men who have sex with men involved peer outreach and support, and it was implemented in two cities, one before the other, to create a control group. It produced significant decreases in unprotected anal sex (Kegeles, Hays, and Coates, 1996). Peers also have been shown to promote safer sex knowledge and behaviors in women. Young African-American women who received peer support to develop social skills around safer sex practices reported increased condom use, as compared to a control group (DiClemente and Wingood, 1995).

However, there is also evidence that peer interventions fail in certain settings. In a review of both quantitative and qualitative research to evaluate the effectiveness of peers in health interventions for youth, Harden et al. determined that only five evaluation studies “soundly evaluated interventions” with peers as against those with other staff (Harden, Oakley, and Oliver, 2001).

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Among these five, two reported their peer interventions were less than successful and one produced inconclusive results.

International research has also reported mixed results. The Medical University of South Carolina and the World Health Organization conducted a meta-analysis of HIV peer initiatives in developing countries. Across the studies, although peer models were generally found to increase condom use, peers also were found to produce a slight (non-significant) rise in STIs (Medley, Kennedy, O'Reilly, and Sweat, 2009).

Despite these findings, it must be noted that very few evaluations have adequately examined peer interventions to date (Harden et al., 2001; Horizons Project, 1999, Medley et al, 2009). Past research has been criticized for poor methodology, and for excluding the details of the peer intervention necessary to understand a program and its outcomes. (Harden et al., 2001; Horizons Project, 1999).

3 PEER MODELS IN PAST SPNS INITIATIVES

Before best practices for peer workers within the SPNS context can be identified, it is first necessary to understand the positions of peer workers within the SPNS initiatives that used them. Both within and across initiatives, the individuals employed as peers were demographically diverse, and the activities they performed varied greatly. This section provides a brief overview of the initiatives where peers have been employed by many or all of their grantees, describing the peer position and its responsibilities. It should be noted that some of these initiatives have undergone more thorough evaluations than others, and as a consequence, the level of detail available varies.

3.1 The Adolescent Care Demonstration and Evaluation Initiative (the Adolescent Initiative)

The Adolescent Initiative funded 10 grantees from 1993 to 1998 to explore strategies for engaging at-risk and HIV-positive youth in care. Many grantees provided a combination of prevention, care and case management to at-risk clients, who included homeless, minority, and substance abusing youth. Initiative activities included street outreach, HIV testing and counseling, and developing referrals networks between providers. Half the grantees also provided family planning services to target youth (Huba, Melchior, Panter, Brief, and Lee, n.d.; HRSA, n.d., a.).

Who were the peers in this initiative?

For most grantees within this initiative, peers were youth who were either HIV-positive or were at risk of becoming HIV-positive. Within several programs, these youth were identified from current or former program clients (Bourdon and Measurement Group, 1999; Bettencourt, Hodgins, Huba, and Pickett, 1998; Bourdon, Tierney, Huba, Lothrop, Melchior, Betru, and Compoc, 1998). Peers employed by this initiative occupied fulltime, internship and informal advisory positions. For example, one grantee employed peers through 6 month internships, with the potential to hold two internships consecutively (Bourdon and Measurement Group, 1999).

What were the peers' responsibilities?

All but one of the grantees incorporated peers into their programs to varying extents (Huba and Melchoir, 1998). Five grantees employed peers to conduct interventions with clients (Huba et al, n.d.). Two grantees particularly emphasized peers in their intervention models. One was a community-based organization run by peer staff and supported by adult consultants who delivered services including support groups, individual counseling, advocacy, and social

activities. The other organization partnered peers with other staff to provide health education, leadership training conferences and publishing advocacy materials. Other grantees who integrated peers into intervention delivery coordinated with partner organizations and conducted counseling, trainings, and empowerment sessions for youth (Huba and Melchoir, 1998; Huba et al, n.d.; Bourdon and Measurement Group, 1999).

3.2 The Demonstration and Evaluation of Models that Advance HIV Service Innovation Along the U.S.–Mexico Border Initiative (the US-Mexico Border Health Initiative)

Five grantees were funded by SPNS between 2000 and 2005 to implement and evaluate programs that focused on engaging individuals along the U.S.-Mexico border in primary health care services through outreach and care collaborations between local service providers (HRSA, 2008). The clients for this initiative were HIV-positive and at-risk individuals who were employed or lived on the border (HRSA, n.d., b).

Who were the peers in this initiative?

Three of the five programs employed peer workers. Peer workers in two programs were HIV-positive individuals. One grantee imposed the additional criterion that the peer workers had to have personal ties or to have worked with client populations (HRSA, 2008).

What were the peers' responsibilities?

At these three programs, peers were mainly involved in outreach and HIV testing and counseling as part of collaborations between medical and support staff. Peer workers had a more diverse set of responsibilities at two of the programs, including facilitating support groups, reminding clients of appointments, transporting clients and entering data (HRSA, 2008).

3.3 Targeted HIV Outreach and Intervention Model Development and Evaluation for Underserved HIV-Positive Populations Not in Care Initiative (the Outreach Initiative)

The Outreach Initiative was funded by HRSA between 2001 and 2006 to implement and evaluate proactive strategies for engaging and retaining medically underserved individuals with HIV/AIDS in the health care system. Grantees targeted people living with HIV/AIDS who were not currently engaged in primary care or who were at risk of falling out of care. Subpopulations under this umbrella group varied significantly. Several grantees only served a specific target group, such as women or youth, whereas others served a combined group of homeless individuals, drug injection users, sex workers, ethnic and sexual minorities, and incarcerated

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people (HRSA, 2010, a). This initiative was implemented in two phases. In Phase 1, 17 grantees were first funded for 2 years to conduct a local evaluation of those strategies and plan activities to enhance or modify their programs. Ten of the original grantees were funded to implement and evaluate their proposed model enhancements during Phase 2 (HRSA, n.d., c; Rajabiun, Cabral, Tobias, and Relf, 2007). Once participants were enrolled, grantees employed various outreach strategies to encourage them to access and remain in primary care. Peers within the Outreach Initiative primarily served in supportive roles rather than as the main staff delivering the intervention (CORE, n.d.)

What were the peers' responsibilities?

Grantees in the Outreach Initiative employed peers in a range of different outreach and retention activities. Within certain grantee programs, peers were central to the intervention model. In other programs, peers supported program activities conducted by care providers, social workers, and case managers. In Phase Two, three of the six grantees that used peers in some capacity within their interventions deployed peer staff with other clinical or professional staff to conduct outreach services and intervention activities, such as home visits. In two of these programs, peers collaborated with nurses to conduct outreach and client support. In the third program, peer support staff worked with other staff to provide client advocacy and to ensure that clients attended appointments. Finally, two programs used peers in minimal fashion. One program incorporated a “peer referral program” for identifying clients and the other used peers to aid with health care system navigation (CORE, n.d.).

3.4 Targeted Peer Support Model Development for Caribbeans Living with HIV AIDS Initiative (the Caribbean Initiative)

SPNS funded a peer support intervention for Caribbean immigrants living with HIV/AIDS from 2003 to 2007. This initiative is the only SPNS Initiative to date that has focused exclusively on implementing and evaluating peer worker program models. Specifically, this initiative evaluated peer models in the context of how connections with peer workers can increase engagement in care for underserved HIV positive Caribbean clients (HRSA, n.d., d). Caribbean Initiative grantees consistently employed models centered on one-on-one sessions with peer workers from Caribbean populations (Thomas, Clarke, and Krolczak, 2008).

Who were the peers in this initiative?

Grantees in the Caribbean Initiative established specific criteria relating to personal, health, and professional attributes for the peer workers they employed. Most grantees recruited peer workers who were representative of the target population, (HIV-positive individuals of Caribbean origin)

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from the service area. Some grantees also evaluated the health status of peer workers to ensure it would not impede their work responsibilities. For example, two grantees required their peers to adhere to their HIV medication regimens. One grantee stipulated that peer educators with histories of drug abuse had to have lived at least 1 year drug-free before beginning work. Grantees recruited peer support staff from the ranks of those who were active within the organization. All of the grantees used similar recruitment strategies, reaching out to individuals seeking services from their programs as well as current volunteers or individuals within advisory groups (Thomas et al, 2008).

What were the peers' responsibilities?

Unlike the grantees in other initiatives, grantees in the Caribbean Initiative focused their peer workers' duties on delivering one-on-one, structured intervention sessions to clients. These intervention sessions typically emphasized understanding HIV disease, using HIV medications, and identifying strategies to ensure access and retention in primary care. Many grantee intervention sessions also addressed other relevant issues like family involvement and patient rights. One program also incorporated peers in other activities, such as client home visits (Thomas et al, 2008).

3.5 Prevention with HIV-Infected Persons Seen In Primary Care Settings Initiative (the Prevention with Positives Initiative)

HRSA funded 15 grantees between 2003 and 2007 to implement programs to combine HIV prevention and medical care in clinical settings for HIV positive individuals. The goals of the initiative were to integrate education and intervention sessions with medical care, decrease HIV transmission and decrease HIV exposure for HIV-positive individuals (HRSA, n.d., e). Grantees used various models with combinations of physicians, specialists and peers to implement the prevention messages. Grantees disseminated the prevention education through one-on-one sessions frequently linked with medical care. These sessions typically dealt with topics such as safer sex, disclosure, and substance abuse, and at most sites these could be adapted for clients' needs (Koester, Mariorana, Vernon, Myers, Dawson, and Morin, 2007).

Who were the peers in this initiative?

Only 3 of the 15 grantees within this initiative employed peers, who were former or current HIV-positive patients with characteristics reflecting the target population's socioeconomic status, gender, race and age (Koester et al, 2007). For example, one grantee hired one female and one male peer worker so that both their male and female clients could relate to their peer based on gender. This grantee also evaluated the attitudes of candidate peer workers towards personal

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health issues, such as disclosure, treatment adherence, and substance abuse (Raja, McKirnan, and Glick, 2007).

What were the peers' responsibilities?

The three grantees employed peers to deliver the structured prevention sessions with clients and one grantee included a support group facilitated by peer workers within their intervention model. These sessions were scheduled over several months and had different intensities at the various programs (Koester et al, 2007). One grantee also used peers to help develop content for intervention sessions, finding that “their approval of the language and content of the modules was viewed as a key element in establishing the broad acceptability of the intervention” (Knauz, Safren, O’Cleirigh, Capistrant, Driskell, Aguilar, Salomon, Hobson, and Mayer, 2007). In addition to implementing the prevention education sessions, peers at one program were further responsible for coordinating with clinic physicians and referring clients to relevant programs (Raja et al, 2007).

3.6 The Outreach, Care, and Prevention to Engage HIV Seropositive Young Men of Color who have Sex with Men Initiative (the YMSM of Color Initiative)

The YMSM of Color Initiative included eight grantees that provided innovative outreach and prevention services to HIV-positive young MSM of Color between the ages of 13 and 24 (HRSA, n.d., f). These eight grantees were funded for 5 years, starting in 2004 and ending in 2009. The grantees used a variety of different program models that evolved over the course of their project period to identify, engage and link HIV-positive young men to primary care and support services. Components of the various demonstration models included, but were not limited to, street outreach at bars, clubs, and balls; outreach through peer participants’ social networks; Internet outreach; HIV counseling and testing in various venues; support group sessions; referral systems with partner organizations; and case management (HRSA, 2010, b).

Who were the peers in this initiative?

Seven of the eight grantees employed peers as outreach workers and client support staff. Unlike grantees in the Caribbean Initiative, grantees in the YMSM of Color Initiative did not establish standardized requirements that peer workers had to be a certain ethnicity, age, or HIV-status. The grantees defined the peer roles, which typically evolved over the course of the grant. For some grantees, this was a very informal process. For example, one grantee recruited peer outreach workers from their pool of program participants. By contrast, another grantee recruited peer workers from outside the service region because staff found peer workers had difficulty reaching friends from their local community (HRSA, 2010, b).

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Table 3-1 presents information on the characteristics of peer and outreach workers in this initiative, which HRSA collected for another study on turnover among peer outreach workers (HRSA, 2010, b). Most grantees reported that the age of their peer outreach workers was typically in their early 20s. The educational attainment of peer outreach workers was quite variable, but no grantees reported that their typical peer workers had completed a college degree. Given the entry-level nature of their positions, most peer outreach workers appeared to have between 1 and 2 years of work experience in the field (HRSA, 2010, b).

Table 3-1: Characteristics of Peer Workers by Grantee within the YMSM of Color Initiative

Grantee	Typical Age	Typical Education	Typical Work Experience	Total # Ever Employed (2004 – 8/2008)	Current # Employed (9/2008)	Position Type
1	22 - 25	High school + some college	3 - 4 Years	11	3	Part-time
2	18 - 21	Less than high school	1 - 2 Years	10	5	Part-time, contracted
3	22 - 25	Varied	1 - 2 Years	6	1	Full time, salaried + benefits
4	26 - 29	High school + some college	1 - 2 Years	5	2	Full time, salaried + benefits
5	18 - 21	Varied	1 - 2 Years	6	2	Full time, salaried + benefits
6	22 - 25	High school + some college	1 - 2 Years	7	3	Full time, salaried + benefits
7	Varied	Varied	1 - 2 Years	2	1	Varied

What were the peers’ responsibilities?

The scope of peer duties differed among grantees, but typically included the core activities of outreach, client support, and client retention. The structure of the peer position ranged from a stipend-paid position to a full-time salaried position with benefits. In most programs, peers approached individuals at clubs, bars, and through the Internet, as well as through relationships with partner organizations. In addition, they participated in HIV testing and counseling, sometimes as trained testing counselors, and sometimes as recruiters bringing individuals to testing events. Lastly, within several program models the peer workers conducted the surveys of

study participants required for the multi-site evaluation and aided with case management activities (HRSA, 2010, b).

3.7 Use of Peers Across Initiatives

The various initiatives used similar methods to identify and employ peers. While grantees defined peers differently, programs within the Adolescent, Prevention with Positives, Outreach, and Caribbean initiatives recruited peers from their current client base or clients served within their provider network. Despite the diversity in program models, peers appear to have been most frequently used for outreach and counseling activities. With the exception of the Caribbean and Prevention with Positives Initiatives, peers were used within the majority of programs either as the principal staff member conducting outreach, or as part of the outreach team with other project staff. Given their perceived capacity to connect with target populations in a unique manner, the prevalence of peers in outreach and client support activities is not surprising.

Despite these commonalities, there were also notable differences in how different initiatives employed peers, which should be taken into account when evaluating the success of the various programs. The most significant difference was in staffing structures. The Adolescent Initiative included grantees whose program staff consisted mostly of peers, supported by professional adult staff. By contrast, all subsequent initiatives incorporated peer staff as *additions* to program staff. This second model represents a fundamentally different role for peer workers in the organizational structure, particularly in terms of organizational power dynamics. Furthermore, within the Adolescent Initiative, several grantees employed peers in various capacities including outreach staff and advisory council positions. Additionally, peers within the Adolescent Initiative were involved in the most diverse set of program activities, ranging from outreach and counseling to organizing youth leadership conferences and engaging in national advocacy. Later initiatives included a less diverse set of peer responsibilities.

The staffing structure described above contrasts sharply with the one used in the Caribbean and the Prevention with Positives initiatives. Within these initiatives, the scope of peer work was fairly consistent across grantees and their roles focused primarily on conducting one-on-one counseling/education sessions with clients and helping clients attend care appointments. Moreover, Caribbean Initiative grantees had the most stringent requirements for their peer staff, such as documentation from their physician that they were compliant with their HIV medications, and/or a lack of substance use for 1 year prior to employment (Thomas et al, 2008).

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4 CHALLENGES OF WORKING WITH PEERS

Although grantees and funders have touted the benefits of peer-centered interventions, there are a number of challenges associated with hiring and supervising peer workers. The same attributes of peer workers that allow them to relate on a personal level to their clients can also create problems in professional settings. Because peer workers often face the same social, emotional and financial challenges as their clients, they can more readily understand and respond to client problems, and foster trusting relationships. On the other hand, as noted by grantees within the Adolescent, Prevention with Positives and YMSM of Color initiatives, difficulties can arise because “peers potentially share the same structural constraints that impact their patients.” (Koester et al 2007; Bourdon and Measurement Group, 1999; HRSA, 2010, b). In particular, peer workers are often professionally inexperienced, must confront their own mental and physical health needs including HIV and substance abuse, and lack financial resources.

This “Catch 22” of peer workers has different implications, depending on how a peer is defined within different settings. For example, to support clients with HIV/AIDS, some grantees require that their peer workers also have HIV/AIDS, which introduces challenges associated with employee health and care provision. Grantees that work with youth often confront issues with peer workers being unable to establish boundaries between their work and social lives. Peer workers within immigrant communities may be dealing with legal residency issues, while those who work with intravenous drug users (IDUs) may have struggled with addiction themselves. In the following discussion, we focus on issues that were particularly pertinent within the existing SPNS initiatives.

4.1 Inability to Separate Professional and Social Sphere

SPNS grantees reported that the inability of peer workers to separate their professional and social lives often undermined their success. This issue was particularly salient for programs employing young peer workers. For example, the Adolescent and YMSM of Color initiatives chose young peer workers so that they could access the same venues and social networks as their target clients. Within the YMSM of Color Initiative, peer workers were charged with recruiting clients with whom they shared substantially similar backgrounds and experiences. They often conducted outreach activities with clients and potential clients in social settings (bars, clubs, Internet chat rooms, student centers, etc.). These informal settings encouraged peer workers to adopt an informal attitude toward their work, which suffered as a consequence. When surveyed, staff from the YMSM of Color Initiative reported that peer worker terminations were often the result of “exercising poor judgment,” “mixing work and personal space,” “failure to adhere to program/agency policies and procedures” and “misconduct.” Misconduct manifested itself in

behaviors such as using project Internet sites or MySpace pages to communicate with friends (HRSA 2010, b). Evaluators from the Adolescent Initiative recommended the clear communication of peer work roles and responsibilities as a means to deal with this issue (Bourdon and Measurement Group, 1999).

4.2 Lack of Experience in Professional, Research-Based Work Settings

Grantees also found that peer workers often had little experience working in office settings, much less in research-oriented environments. Grantees from the YMSM of Color Initiative indicated that peer workers at several sites struggled to fulfill basic requirements such as arriving at work on time and reporting honestly on their outreach activities (HRSA, 2010, b). Peer workers in the Prevention with Positives Initiative also often lacked professional skills, and the research environment required by the SPNS evaluation may have also created problems for inexperienced personnel. In their “lessons learned” report, Koester et al. found that peer workers were “constrained by having to follow a research protocol” particularly because they saw themselves as advocates for clients (Koester et al, 2007). Peer workers typically had little experience conducting SPNS-type evaluations, where clients have to be carefully screened for eligibility criteria, survey instruments must be closely followed, and clients must be interviewed on a regular basis.

4.3 Physical and Mental Health Issues

Some grantees employed peer workers who were HIV-positive and thus could more closely relate to the associated stigma, their clients’ health care needs and the barriers they must overcome to access to care. A disadvantage of this policy, identified in the Adolescent Initiative, is that the loss of both clients and staff to illness affects the remaining employees, both personally and professionally (Bourdon et al, 1998). Additionally, several grantees within the Prevention with Positives and YMSM of Color Initiatives had to terminate some individuals because substance abuse problems interfered with their work (Raja et al, 2007; HRSA, 2010, b). Programs using peer models should recognize that peer workers similar to their target population will be at high risk for health issues such as depression, and drug and alcohol abuse.

4.4 High Degree of Turnover

Grantees and evaluators from the Adolescent, Prevention with Positives, U.S.-Mexico Border Health and YMSM of Color Initiatives have all stressed that turnover can be a formidable problem among peer workers, disrupting program operations and reducing program impact (Bourdon and Measurement Group, 1999; Raja et al, 2007; HRSA, 2008; HRSA, 2010, b). Of the 51 peer workers ever employed by grantees in the YMSM of Color Initiative, over half (29)

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left by the fourth year of the grant. On average, each grantee lost 4.1 peer workers, with a range from 0 to 9. Notably, the majority of departures (19) were terminations, typically due to misconduct and failure to fulfill position responsibilities. Ten voluntary departures were reported. However, it is clear that many “voluntary” departures were not voluntary at all; rather, workers were given the option to leave or be terminated. The typical peer worker remained with the program for 14 months. The costs associated with this turnover were substantial. The total cost of replacing a peer worker varied markedly from grantee to grantee, from \$1,659 to \$24,981, with a median cost of \$3,144 (HRSA, 2010, b).

4.5 Drawbacks of Close Social Connection to Target Population

Several grantees have indicated that peer workers face considerable challenges when operating in small communities or communities in which the stigma surrounding HIV/AIDS is high. Within the YMSM of Color initiative, staff from several grantees described the unique retention and hiring challenges that programs face when located in rural and smaller urban areas. Such regions often lack an established, open MSM community and/or many safe spaces for MSM to socialize. Interviews suggested that these settings can result in higher turnover because the confidential nature of peer work often prevents workers from connecting with their peers socially and drawing essential emotional support from them. The program limited how peer workers could behave in their communities. When MSM communities are already small, a peer worker’s position can dramatically undermine his/her social life, particularly when Internet dating is restricted. This issue is compounded because the pool of potential peer workers is smaller in these areas and consequently, more time and resources are required to fill vacant positions. One grantee found this to be such a serious problem that it shifted to recruiting peer workers from outside the local community (HRSA, 2010, b).

The Caribbean Initiative also suffered considerably from this same phenomenon. Although all grantees were located in urban areas, the Caribbean communities involved were small and the stigma associated with HIV/AIDS was high. Grantees attributed low enrollment numbers to the reluctance of many Caribbean immigrants with HIV/AIDS to seek medical care and emotional support from inside their communities, where they might be recognized and “outed.” Because of the power of stigma, people with HIV/AIDS were not comfortable communicating their status to family and neighbors. One grantee began using African-American peer workers with HIV/AIDS instead of Caribbean immigrants and saw a substantial increase in enrollment (HRSA, 2010, c).

5 WORKING EFFECTIVELY WITH PEERS

5.1 Position Structure: Integrating Peers Into the Program Team

Be clear with peers regarding what the position will entail.

Since peer workers often struggle to maintain boundaries between their personal and professional lives, it is vital that they understand the scope of their work and what is required of them. Many grantee staff within the YMSM of Color Initiative felt that it was important to create a rigorous interview process that emphasized job responsibilities and boundaries, and to require candidates to meet the entire project team. Some interviews included role-plays that highlighted these issues. For example, one grantee asked candidates to react to scenarios such as the following: “Imagine you are counseling a person who has been having unprotected sex. What would you say?” Interviews at another grantee site even included members of the target population on the interview committee (HRSA, 2010, b). Another method for communicating expectations clearly is through an employee handbook. The “Peer Development Guide” created by the Evaluation and Technical Assistance Center of the Adolescent Initiative recommended that peer workers be given a handbook which includes information such as grounds for termination, performance review policies and time keeping policies (Bourdon and Measurement Group 1999).

Encourage a regular work schedule, potentially by employing peers as full-time staff.

Grantees have suggested that full-time status can bring stability to the position. Some peer workers within the Caribbean Initiative worked full-time and were paid monthly salaries, while others were compensated per activity. This latter policy often led to sporadic hours and low retention numbers, both among peer workers 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 (HRSA, 2010, c). Similarly, YMSM of Color grantees emphasized that full-time status better allowed grantees to incorporate peer workers as team members. Full time peer workers could be exposed to more opportunities for cross-training. Integration into the research may have caused peer workers to feel more invested in the SPNS initiative. In addition, the more stable work environment may have delayed burnout and improved the level of responsibility and discipline displayed at work. However, quantitative analysis did not reveal any link between position status and lower rates of turnover within this initiative (HRSA, 2010, b).

Consider employing peers on a short-term basis, particularly when employing adolescent peers.

While many grantees hire peer workers on a full-time basis with no set end date, several grantees reported that employing peers in short-term placements may mitigate some of the issues that undermine peer worker performance. The grantees that favored this structure employed young peer workers, suggesting that this model may be especially useful in programs that hire younger workers. At one grantee site within the YMSM of Color Initiative, peer workers were asked to indicate how many friends they thought they could recruit into the program. Once a peer worker reached his target recruitment, his term of employment ended. Although a few individuals stopped recruiting before reaching their target, program staff felt that the “volunteer-stipend hybrid” position addressed the difficulties adolescents face in committing to a position (HRSA, 2010, b). Another grantee within the Adolescent Initiative implemented a similar structure, employing peer workers in internship positions. One advantage of this type of model was that it “lent an ‘educational’ air to the program” (Bourdon and Measurement Group, 1999). This structure enabled more youth to act as peer workers and permitted the organization to hire individuals with fewer qualifications than were typically required. Ryan White HIV/AIDS Program grantees may want to consider this type of peer worker model, particularly if they lack the internal resources necessary for mentoring peer workers. Furthermore, other grantees have also stressed the importance of taking into account agency requirements that may influence hiring procedures. For example, one university-based grantee within the YMSM of Color Initiative needed to create a new type of employee position within the university, because the existing policies required that research assistant staff have a Bachelor's level education (HRSA, 2010, b).

5.2 Compensation: Appropriately Compensating Peer Workers

Make peer worker salaries competitive.

HRSA analyses of the Caribbean and YMSM of Color Initiatives demonstrated links between increased peer compensation and positive program outcomes – specifically, improved client enrollment and lower staff turnover. Within the Caribbean Initiative, grantees that allocated a higher proportion of their budget to peer workers had more clients enrolled in the multi-site evaluation at baseline (HRSA, 2010, c). In addition, the YMSM of Color Initiative exhibited a reliable correlation between peer worker salary (adjusted for cost of living) and turnover: the more peer workers were paid, the lower the turnover (HRSA, 2010, b). These findings suggest that programs should aim to make peer worker salaries competitive and not view peer workers as a cheaper alternative to professional staff.

Be aware of tradeoffs between salary level, employment benefits and any public assistance peers may be receiving.

Interviews with grantees within the Caribbean Initiative revealed that compensation for peer workers was not entirely within their control. Grantees stated they had to balance adequately compensating peer workers with 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 an increase in income would cause peer workers to lose social services such as Medicaid, food stamps, and welfare. Thus, grantees decided to set wages at a level that ensured peer workers retained such services. Hospital and State protocol also placed restrictions on employment type and salary. Because of these policies, no peer workers within this initiative received fringe benefits (HRSA, 2010, c).

Grantee staff in the Caribbean Initiative felt that low compensation increased turnover among peer workers. Many grantees blamed low client recruitment on their inability to retain peer workers and expressed considerable frustration with the lack of flexibility in compensation. Faced with limitations on direct compensation in this initiative, grantees tried to support peer workers in other ways. For example, in response to low recruitment numbers, one grantee within this initiative hired peer work trainers. However, this grantee's continued low recruitment and retention numbers indicate that these strategies may not be effective unless used in conjunction with higher salaries. Another potential strategy is to implement a pay-for-performance salary system (HRSA, 2010, c).

Similar tradeoffs were confronted by the Adolescent Initiative. The grantee that implemented the internship program for peer workers indicated that this structure had a distinct disadvantage because it could not provide health insurance, sick pay, or vacation to peer workers. Therefore, the program provided a higher salary for peer workers (Bourdon and Measurement Group, 1999).

5.3 Training: Training Peers for the Position

Offer training that includes information about basic office and research skills, as well as professional etiquette.

Given the feedback from grantees within several initiatives that peer workers struggle with maintaining professionalism, it is vital that the training process include an introduction to workplace standards. These topics have been incorporated into peer trainings across the initiatives. For example, one YMSM of Color grantee emphasized the need to review the agency's protocols with peer workers during their orientation, such as cell phone usage, dress

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code and Internet behavior (HRSA, 2010, b). Similarly, evaluators from the Adolescent Initiative indicated that staff should not assume that peer workers will come to programs with computer or phone skills (Bourdon and Measurement Group, 1999). Several YMSM of Color Initiative grantees suggested that peer training include a discussion of professionalism, as well as guidance and feedback on how to represent the organization appropriately (for example, when presenting to potential partner groups) (HRSA, 2010, b). This type of training was also recommended by evaluators of the Adolescent Initiative and was incorporated into the trainings in some grantee programs (Bourdon and Measurement Group). The Adolescent Initiative was likely more active at providing these types of trainings because several grantees used peers as event speakers.

Grantees reported that peer workers have just as much trouble with the nature of the research process as with workplace standards. It is clear both from interviews with YMSM of Color grantees and from lessons learned in the Prevention with Positives Initiative that peer workers need to be educated about the context of research projects (Koester et al, 2007; HRSA, 2010, b). One grantee within the YMSM of Color Initiative addressed this issue by having peers shadow different program staff in order to understand how their role fit with the larger purpose of the project (HRSA, 2010, b).

Consider making employment contingent on completing training.

Implementing training as a part of a probation period can help rapidly identify individuals who may be unable to fulfill their responsibilities or be a good fit for the organization. Grantees within both the Adolescent and YMSM of Color Initiatives implemented a process whereby individuals had to formally pass training tests before commencing their SPNS responsibilities (Feudo, Vining-Bethea, Shulman, Shedlin, and Burleson, 1998; HRSA, 2010, b). One Adolescent Initiative grantee found that only 6 of the 25 peer candidates completed the 2 month training program and became staff. The training program was structured such that individuals needed to answer at least 85 percent of questions correctly for a module, which covered topics from HIV/STIs to relapse prevention and street safety. Notably, the individuals who did not become peer workers were able to contribute to the program as volunteers and were sometimes hired if existing peer workers left the program (Feudo et al, 1998).

Make use of available local or State trainings.

Grantees from the YMSM of Color and Caribbean Initiatives were able to access trainings (sometimes for free) conducted at the local or State level to supplement the trainings they provided for peers in-house. These standardized trainings focused on topics such as “STIs/HIV 101,” patient confidentiality and communication with clients (Thomas et al, 2008; HRSA, 2010,

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b). Taking advantage of available off-site trainings can help relieve some of the burden of peer training from program staff.

5.4 Supervision: Providing Peers Intensive Support

Provide mentorship beyond traditional supervision from professional staff.

Across initiatives, grantees uniformly agreed that peer workers required added supervision and mentorship, particularly the younger staff that more closely resembled the target population. Evaluators of the Adolescent Initiative recommended that peer workers be given a designated mentor at their program or a partner organization (Bourdon and Measurement Group 1999). Similarly, several YMSM of Color grantees implemented mentorship programs to help peer workers define and meet their personal and professional goals. For example, at one YMSM of Color program, supervisors worked with peer workers to articulate and track a set of goals that the individuals wanted to achieve while in their position, such as to stop smoking marijuana or to complete their GED. Another grantee implemented an informal mentorship system, in which supervisors regularly discussed a range of issues with peer workers, including how to establish and maintain appropriate boundaries with clients (HRSA, 2010, b). Given that extensive supervision was also implemented by some grantees within the Prevention with Positives Initiative, it is clear that even peers who are not young may need this level of support. One grantee scheduled one-on-one sessions with peer staff to discuss their progress and personal issues. The same grantee also recorded sessions conducted by peers for later review by peer supervisors (Raja et al, 2007).

Incorporate program services and staff with relevant expertise who can support peer workers.

While grantees varied in their ability to incorporate staff with expertise in working with peers, staff in several initiatives recommended that future programs hire individuals with the relevant academic or work experience to be able to provide the level of support peer workers need. Grantees in the Adolescent Initiative were acutely aware of this issue, and one of its peer-run grantees exemplified this approach. Within this organization, three clinical mentors specifically worked with staff “to manage the personal issues that arise out of working with HIV-positive youth” because of their close resemblance to their clients (Bettencourt et al, 1998). The evaluators recommended that staff be trained or have a background in issues as diverse as youth development and conflict resolution (Bourdon and Measurement Group, 1999).

One YMSM of Color grantee voiced a desire for this type of program structure, recommending that future programs using peer workers incorporate higher-level staff with a background in youth development, because such staff members would be better-equipped to supervise peer

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workers. Moreover, several grantees within this initiative also recommended that programs establish periodic “debriefing” for peer workers, so that they can productively vent about the concerns they have and the challenges they face in the workplace (HRSA, 2010, b). The need for a “therapeutic outlet” for peers was also echoed by evaluators of the Adolescent Initiative (Bourdon and Measurement Group, 1999).

Furthermore, the experiences of peer worker terminations because of substance abuse problems within both the Prevention with Positives and YMSM of Color initiatives (Raja et al, 2007; HRSA, 2010, b) highlights the need for grantees to provide ancillary services to peers. This may be particularly challenging if peer workers do not receive health insurance. Grantees may want to consider what services they are able to provide peer workers in-house if they are not able to offer health insurance. For example, in the Adolescent Initiative, one grantee recruited peers from among current clients and structured the position as an internship. Even though the internship did not provide health insurance, the grantee allowed workers to continue receiving case management through their agency (Bourdon and Measurement Group, 1999).

Provide opportunities for career development of peer workers.

Whether peer workers are employed as volunteers, interns or full-time staff, it is important to provide them with opportunities to develop their professional skills beyond their immediate set of responsibilities. This development can be achieved in numerous ways. Grantees can allow peer workers to attend relevant academic and project-specific conferences, as occurred within the YMSM of Color Initiative. One grantee noted that cross-training could compensate for the social sacrifices their peer workers had to make by providing them with valuable skills that would prepare them for further employment (HRSA, 2010, b).

6 CONCLUSIONS

Peer workers have been used extensively in six previous SPNS initiatives designed to encourage hard-to-reach populations with HIV/AIDS to connect and remain engaged in health care. Across these initiatives, peer workers were employed in a range of different activities. They conducted street and Internet outreach, provided structured education sessions to clients, facilitated support groups, and acted as liaisons with partner organizations. While several reports have asserted that peer workers have played an important role in the success of these initiatives – in particular, in promoting positive health outcomes among clients – these claims have generally not been supported with rigorous analyses of quantitative outcome measures.

Through quantitative analyses of the use of peer workers in the Caribbean, Outreach, and YMSM of Color Initiatives, combined with interviews with program staff and existing SPNS literature on peer workers, HRSA has identified a number of challenges commonly associated with employing peer workers. This research also identifies many strategies programs can consider to support and help peer workers succeed. Table 6-1 presented below summarizes these challenges and recommendations.

This information can help guide other Ryan White grantees in deciding how to incorporate peer workers into their programs. In particular, this review can prepare grantees to understand the challenges that may arise when they use peer workers, as well as how they might help those workers to thrive and contribute to the success of their programs.

Table 6-1: Challenges and Recommendations

Common Challenges with Employing Peer Workers
They can have difficulty separating their professional and personal lives
They frequently lack professional and research experience
They are associated with high position turnover
They are prone to physical and mental health problems
Clients may not always want to receive support from someone in their community
Strategies to Help Peers Succeed
Be clear about position responsibilities
Encourage a regular work schedule
Consider employing peers on a short-term basis
Make salaries competitive
Understand the tradeoff between salary level, employment benefits, and social services peers may receive
Offer training that includes information about basic office skills, research skills, and professional etiquette
Consider making employment contingent on completing training
Make use of available local or State trainings
Provide mentorship beyond traditional supervision from professional staff
Provide opportunities for career development of peer workers

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