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ORIGINAL PAPER

The Protect and Respect Program: A Sexual Risk Reduction Intervention for Women Living with HIV/AIDS

Michelle Teti · Susan Rubinstein · Linda Lloyd · Erika Aaron · Jessica Merron-Brainerd · Susan Spencer · Ann Ricksecker · Marla Gold

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Abstract In 2003 the Centers for Disease Control and Prevention (CDC) launched a new HIV prevention strategy that focused prevention efforts on people living with HIV. In response to a Health Resources and Services Administration (HRSA)/Special Projects of National Significance (SPNS) initiative, a program development team in Philadelphia created the Protect and Respect program. The program integrates multiple-level prevention strategies and is tailored to address the strengths of HIV-positive women and the challenges they face to implementing behavior changes. The goal of Protect and Respect is to decrease sexual behavior that puts HIV-positive women at risk for sexually transmitted infections (STIs) and puts others at risk for HIV transmission. The three components of the program are: brief HIV prevention messages delivered by clinicians in the context of routine medical visits; a group-level intervention (GLI) delivered by a Health Educator; and a Peer-led support group. This paper details the process of developing the three program components and describes the valuable lessons learned through the development and implementation process.

Keywords Prevention with positives · HIV/AIDS · Women · Provider-interventions · Group-level-interventions · Peer-led interventions

M. Teti (✉) · S. Rubinstein · M. Gold
School of Public Health, Drexel University, 1505 Race Street, Bellet Building, Floor 11, Philadelphia, PA 19102, USA
e-mail: mteti@drexel.edu

L. Lloyd
School of Public Health, University of Texas, Houston, TX, USA

E. Aaron
Drexel College of Medicine, Drexel University, Philadelphia, PA, USA

J. Merron-Brainerd · S. Spencer · A. Ricksecker
Pennsylvania/MidAtlantic AIDS Education and Training Center, Philadelphia, PA, USA

Introduction

In April 2003 the Centers for Disease Control and Prevention (CDC) launched a new initiative, *Advancing HIV Prevention: New Strategies for a Changing Epidemic*. The initiative called for a new direction in prevention. HIV-related morbidity and mortality, attributable to combination anti-retroviral therapy, were decreasing. Current prevention strategies were inadequate to decrease the number of new, annual HIV infections. Marking a significant change in US HIV prevention policy, the new initiative focused prevention efforts on individuals living with HIV (Janseen et al. 2003). In 2003, HRSA funded 15 clinical sites to address the need for interventions designed for HIV-positive individuals in clinical care. The clinical setting provides a unique opportunity to reach people living with HIV.

A program development team in Philadelphia responded with the Protect and Respect Program for Women Living with HIV/AIDS (Protect and Respect). The initial plan for Protect and Respect was devised by nurses and physicians caring for patients living with HIV/AIDS. Public health researchers, health educators, social workers, and women living with HIV eventually joined the program's development team. The members of this working group shared a dedication to delivering high quality women's health and HIV prevention services, but possessed varied

perspectives, knowledge, and experiences. While the team worked collaboratively, the program curriculum was designed predominately and written by a Health Educator and a Social Worker. For ease of description the terms "program developers" and "program development team" will be used throughout the remainder of this document to refer to the interdisciplinary team who developed and implemented Protect and Respect.

The importance of behavioral prevention services for women is two fold. First, having unsafe sex puts women at risk for both sexually transmitted infections (STIs) that could complicate their HIV infection and for the possible harms of co-infection with multi-drug resistant strains of HIV (Kalichman 2000). Second, women's sexual risk behaviors may put their male partners at risk for the virus. Women are increasingly impacted by HIV/AIDS. The proportion of women with HIV/AIDS tripled from 7% in 1985 to 26% in 2002 (NIAID 2004). Many women diagnosed with HIV/AIDS continue to be sexually active (Bova and Durante 2003). Although the majority practice safer sex, a sizable proportion (19–36%) of HIV-positive women have unprotected sex with their HIV-negative and their unknown-status partners (Aidala et al. 2006; Weinhardt et al. 2004) and have sex without disclosing their HIV status to their sexual partners (Ciccarone et al. 2003). Therefore, prevention programs are necessary to help HIV-positive women protect themselves and their partners.

It is important that prevention programs for women focus part of their efforts on helping women to protect themselves. HIV-positive women face many barriers to healthy living and practicing safer sex. African American women are disparately impacted by HIV/AIDS (NIAID 2004), revealing the connection between complex social injustices like racism, discrimination and HIV risk. Further, HIV-positive women's sexual risk behaviors are complicated by poverty, substance abuse, violence, and psychological distress (Barkan et al. 1998; Catz et al. 2002; Lightfoot et al. 2005). The link between AIDS and poverty is driven by at least three factors, including injection drug use with scarce syringe resources, confined sexual and social networks, and trading sex for survival needs (Kalichman 2000). It is not surprising that homelessness and exchange sex are associated with unsafe sex among HIV-positive women (Aidala et al. 2006). Fears of rejection, emotional suffering, and violence often prohibit women from telling others about their HIV status (Siegel et al. 2005; Gielen et al. 2000). Less assertive women and women who believe that they have little control over their partner's use of condoms are more likely to report unprotected sex (Crepaz and Marks 2002) than women who feel assertive and in control of their relationship. Prevention programs need to respond to these challenges with holistic strategies adapted to women's needs.

The clinic where Protect and Respect originated serves a high number of women facing these barriers. The program development team was aware of the unique opportunities and challenges presented by working specifically with women. As a result, they developed a program aimed at delivering HIV prevention messages to the women they were serving at their clinic via three multi-leveled and integrated prevention strategies. Protect and Respect is a sexual risk reduction program designed specifically for HIV-positive women receiving primary care services from an urban, ambulatory HIV clinic in Philadelphia. The program aims to help women protect themselves and their partners. The goal of Protect and Respect is to decrease sexual behavior that puts HIV-positive women at risk for STIs and puts others at risk for HIV transmission. The primary sexual behaviors addressed by the program include HIV status disclosure and use of male and female condoms with all sexual partners. The three components of the program are:

- Brief HIV prevention messages delivered by clinicians in the context of routine medical visits
- A group-level intervention (GLI) delivered by a Health Educator
- A Peer-led support group

Women learn about Protect and Respect when they come into the clinic for their regularly scheduled clinic visits. If women choose to enroll in the program, they are randomly assigned to participate in one of two groups for purposes of the program's evaluation. One group receives sexual risk reduction messages from primary medical providers. The other group receives prevention messages from medical providers but also participates in the GLI and peer-led support groups. The components of Protect and Respect complement each other by creating a clinical environment where prevention messages during medical visits are the clinic's standard of care. The three strategies are employed to deliver consistent messages to participants during and outside of clinical visits.

Setting and Population

Protect and Respect takes place in a clinic that provides comprehensive, integrated HIV services, including primary care, case management, nutrition counseling, pharmacy, mental health, family planning, and addiction services. The clinic is incorporated within a university medical school, a non-profit 501-c-3 organization, and receives clinical support from this department as well as clinical revenue from patient care services. In addition the clinic receives funding from the federal government's Ryan White Care Act (Titles I, III, and IV) which supports HIV primary care and

social services. Other sources of funding are received from private foundations and pharmaceutical supported research (E. Aaron, Personal communication, May 1, 2006). Both physicians and nurse practitioners provide primary care services. Among more than 1,300 adult patients served annually, 34% are women, 79% are African-American or Hispanic, most (62%) are 20–44 years old, and many are living in poverty (75%) (E. Aaron, Personal communication, March 1, 2006). Protect and Respect participants reflect the demographics of the female clinic population as a whole.

Program Development

The program development team designed Protect and Respect in March 2004. At that time, few evaluated interventions existed for people living with HIV, particularly women. Because the program developers were not able to simply tailor or implement an existing program, they developed Protect and Respect using proven theories of health behavior; evaluated, effective interventions for women living with or at risk for HIV; evaluated prevention interventions for people living with HIV; and best practices from the CDC.

Because the program developers needed to design and implement the program in a short time frame, they used these resources to develop the foundation of the program. Their program development process also included input from HIV-positive women. The Health Educator convened a community advisory board (CAB) that consisted of both HIV service providers *and* women living with HIV. The Health Educator met with the CAB four times to discuss the development and implementation of the program. The Health Educator hired three HIV-positive Peer Educators to work on the project. Before the program began, she utilized their help to develop and tailor program activities through group discussions and meetings. The CAB and the Peer Educators were considered part of the program development team.

Protect and Respect is based on the principles of three health behavior theories: the Transtheoretical Model of Stages of Change (SOC), the Modified AIDS Risk Reduction Model (M-ARRM), and the Theory of Gender and Power. Program developers chose these theories because they account for the multiple personal, social, environmental, and behavioral factors that influence women's behavior. The SOC Model (DiClemente et al. 1985) explains that individuals move through different stages when they make health-related decisions, and that different factors influence and motivate change at each phase. Because this model fails to account for structural factors or social norms, the program developers also employed the M-AARM and the Theory of Gender and Power to capture how sexual behavior is influenced by complex social factors such as gender norms and inequities. The M-ARRM (Ehrhardt et al. 1992) is a stage-based model that includes the influence of factors such as sexual negotiation and self-efficacy as behavior determinants at each stage. The Theory of Gender and Power is a social structural theory based on existing philosophical writings of sexual inequality and gender and power imbalance. When applied to HIV prevention, the theory accounts for the way women's unequal power in relationships affects their HIV risk and sexual choices (Wingood and DiClemente 2000).

The program developers consulted detailed descriptions of effective HIV prevention interventions for at-risk populations to develop this intervention. They focused particular attention on programs addressing women's complex prevention needs. The Compendium of HIV Prevention Interventions with Evidence of Effectiveness (CDC 2001a) describes effective interventions from behavioral or social studies that had both intervention and control/comparison groups and positive results for behavioral or health outcomes.

The program development team also considered the elements of successful HIV prevention programs outlined by the CDC (2001b), including linking prevention to medical care and treatment, varying health education and risk reduction strategies, and including input from HIV-positive women during the program development process. Some of these elements, such as linking prevention to care, coincided with the clinic's existing priorities and services. Other elements, such as including input from women intended to be served by the program, were crucial to tailor the program to the complex needs of HIV-positive women.

Program Description

Provider Intervention Component

The program development team chose this prevention strategy because it utilizes the knowledge, expertise, and communication skills of the providers as well as the opportunity and convenience provided by clinical visits. The clinician component of Protect and Respect is a brief (3–5 min) intervention that is intended to be delivered to all patients by HIV primary care providers during routine medical visits. The development team used a multi-step process to develop this component. First they researched information on existing models involving brief provider-delivered messages, specifically *Partnership for Health: A Brief Safer-Sex Intervention in HIV Clinics*(Richardson et al. 2004) and *Stage-Based Behavioral Counseling for STD/HIV Prevention for Persons Living with HIV/AIDS*

(Coury-Doninger and McGrath 2003). Second, they conducted a focus group with the clinicians who would deliver the intervention to determine their level of knowledge about and comfort with HIV prevention-related issues and the frequency with which they were already addressing HIV prevention with patients. Third, the program developers incorporated elements of the National Association of People with AIDS' (NAPWA) *Principles of HIV Prevention with Positives* (undated). Finally, the development team pilot-tested the provider intervention component with three individuals living with HIV.

Based on the findings of this formative assessment, the program developers designed a brief clinician-delivered HIV prevention intervention which combined components of SOC theory and the Partnership for Health program. In summary, during the intervention the clinician asks the patient about her sexual and substance abuse risk practices and stages the patient regarding these behaviors according to the SOC by using pre-contemplation, contemplation, preparation, and maintenance staging. Then he or she uses negative/loss frame messages to help the patient adopt safer practices. For example, negative-frame messages point out the potential negative consequences to risky behavior, including the ways in which unsafe sex can harm the patient and/or her partners. This approach is appropriate in this setting because of the nature of clinician-patient relationship, which begins with an initial visit that includes an in-depth discussion between the clinician and patient about the patient's risk behaviors. This intervention is adaptable to the 3–5 min time period allotted because it uses and strengthens the existing relationship between the clinician and the patient; it allows the clinician to focus the conversation on the patient's greatest needs during that visit.

Clinicians were trained to conduct the intervention utilizing a four and half hour skills-building training which included an overview of Protect and Respect and its theoretical basis, a discussion of the provider's role as it relates to HIV prevention and how this role might change with long-established patients, counseling skills development, and skills to stage patients. Specific counseling skills addressed in the training are the use of open-ended questions, offering options rather than directives, developing re-statements, and explaining information in a simple and accessible way. Teaching providers how to stage patients involved interactive discussions between providers using case examples. Many of the clinicians involved in this intervention had previously received training in motivational interviewing (MI) techniques, a counseling technique that helps the patient move through the Stages of Change by mobilizing the patient's own change resources and building the patient's commitment to change (Hamid 2004).

To provide this component of the intervention, the clinician uses counseling skills within the SOC framework to briefly determine the patient's needs and help the patient develop a plan to meet those needs. More specifically, the clinician begins the intervention by introducing her role as one in which she will talk with the patient about the patient's health and HIV prevention. If there is an established relationship between the patient and clinician, the clinician explains that her role now also includes HIV prevention by stating, for example, that she is going to talk with the patient about some of the things the patient might be doing to protect herself and any of her sexual partners.

The clinician delivers messages to motivate the patient to protect herself and her partners. With both new and established patients, the clinician typically begins the intervention by asking the patient, "Are you doing anything that makes you worry about giving HIV to others?" The patient's answer to this question leads the clinician to the appropriate avenue of discussion and helps the clinician determine the patient's stage of change regarding HIV prevention behaviors. For example, if the patient states that she is worried about giving HIV to others, the clinician talks with the patient about her recent sexual partners and practices (and stages the patient at either the preparation or contemplation stage). The clinician may also ask patients about their pregnancy desires, as well as whether or not they are worried about protecting themselves and acquiring STIs. This may lead to further discussion about using condoms, communicating about sex to her partner(s), or disclosing her HIV status to her partner(s). The clinician will offer referrals if the patient needs more detailed information or skill development. If, on the other hand, the patient states she is not worried about giving HIV to others, the clinician would ask the patient questions to determine whether the patient was in pre-contemplation or action/maintenance and then proceed with the intervention accordingly.

To conclude this brief intervention, the clinician focuses on skill development, using the patient's social supports as appropriate. If a patient wants to disclose her HIV status to her partner but is unsure of how to do this, the clinician may suggest that the patient practice with a trusted friend who is aware of the patient's HIV status. If the patient agrees to try this, the clinician helps the patient develop a concrete plan to move forward. HIV status disclosure is associated with social support (Kalichman et al. 2003), and this strategy may help women connect with their support system. Finally, the clinician restates the plan to the patient and documents the interaction so the clinician and patient can address these issues during the next visit.

Group-Level Intervention

Program developers chose this prevention strategy for several reasons. For one, participants assimilate informa-

tion in different ways. Some women may be more receptive to receiving prevention messages in a group setting, versus in the context of a medical visit. Secondly, the group environment provides an opportunity for women to learn new information and skills together. This process of learning together may increase social support and decrease feelings of isolation. Lastly, women can teach each other, and become empowered as group learners and teachers to envision and enact healthier behaviors. This is particularly important because the program is designed for disenfranchised women facing many barriers to healthy living.

The GLI component of Protect and Respect consists of five, 2-h, weekly education and skill-building sessions. The GLI is intended to be delivered by a master's level Health Educator who seeks the consult of a master's level Clinical Supervisor as needed. The program developers used a multi-step process to develop the GLI, guided by the theoretical basis of Protect and Respect. This process included researching existing effective models for group interventions for women and pilot testing the intervention with HIV-positive women.

The program development team integrated general components of successful GLIs described in the Compendium of HIV Prevention Interventions with Evidence of Effectiveness (CDC 2001a) into the development of the Protect and Respect GLI. The program developers also specifically consulted several existing HIV prevention programs (Academy for Educational Development 2003; Carey and Maisto 2002; Carey et al. 2000; Center for AIDS Intervention Research undated (a), (b); Kelly et al. 1994; Kalichman et al. 2001; Miller and Ehrhardt 1995; Miller et al. 2000; Wingood and DiClemente 2000; Wingood et al. 2004). Specific programs were consulted for various reasons. For example, Kalichman et al.'s (2001) intervention was one of the only successful, published, risk reduction interventions for people living with HIV. Kelly et al. (1994) provided a detailed intervention curriculum manual on the Center for AIDS Intervention and Research (CAIR) website. While Wingood, et al.'s (2004) WiLLOW program was not yet evaluated when program developers designed the Protect and Respect GLI, WiLLOW utilized components of other similar successful interventions (DiClemente and Wingood 1995), it was tailored for African American HIV-positive women, and it employed the Theory of Gender and Power. Input from the CAB and project Peer Educators confirmed the appropriateness of the chosen interventions.

Program developers drafted a GLI manual (for the facilitator) and a workbook (for program participants), and pilot-tested these materials with two different groups of HIV-positive women. First, three Peer Educators who were hired to staff the program participated in all five group sessions. Program staff recorded the Peers' feedback and suggestions and revised the manual and workbook accordingly. During this pilot session, the Peers identified jargon and confusing language, and made suggestions for simpler descriptions and activity instructions. They also suggested simplifying a difficult role play activity, and adding more detailed introductions, reviews, and conclusions to the sessions to improve the flow from one session to the next. Lastly, the Peers suggested incentives that would enhance participation, such as free lunches, transportation tokens, and mall gift cards. Next, the project's CAB participated in a pilot test of specific sections of the GLI. Program developers facilitated a discussion and tested specific activities for appropriateness, clarity, and timing. These sessions included role-playing, condom skill demonstrations, and a discussion about healthy and unhealthy relationships.

The GLI is based on several basic principles: recognition of the unique realities and challenges faced by women living with HIV/AIDS; the importance of an accurate understanding of risk behavior and personal risk taking; the need for realistic and safe options for women; the importance of acquiring skills to reduce behavior risks; the belief that women can utilize their individual and collective strengths to improve their lives; the importance of adapting new skills to diverse and changing risk situations over time; commitment to a process that encourages women to act as agents in their own lives, and to share ideas and help each as they face similar challenges.

The sessions and activities (outlined in detail in Table 1) teach women skills to decrease their risk behaviors and protect themselves and their partners using these principles. For example, during GLI session one the group discusses the unique challenges and opportunities they face as women. Session four focuses on helping women identify healthy and unhealthy relationships that may facilitate or hinder their ability to practice safer sex. Role-plays and group activities during all of the sessions encourage the women to share safer sex strategies and problem-solve difficult situations together. For example, the women role-play condom discussions with resistant partners and discuss HIV-status disclosure options for women in unhealthy or violent relationships.

At the beginning of each session the facilitator explains the goal of the session and reviews the previous session briefly through a question and answer session with participants. During sessions two through five, women "check-in" with each other before the sessions starts to let each other know how they are doing, and discuss their reflections to the previous week's session. The sessions include diverse activities to maintain the women's interest. For example, GLI participants learn HIV/AIDS facts by playing an HIV/AIDS quiz game. They learn to use condoms

Table 1 GLI Sessions and topics

Session	Goal	Activities
1	Introduce women to each other and the program goals.	• Detailed program overview and description • Ice-breaker activity re: motivation to be healthy • Creation of group rules via group consensus • Activities and discussion re: making behavior changes • Group discussion about gender pride and strengths and challenges for HIV positive women • "Homework" assignment
2	Provide HIV/STI education and help women identify why they engage in risky behavior.	• Session introduction, review, and check-in • HIV myth/fact quiz game • Paired activity re: rating and discussing risky behaviors • Skill teaching and group discussion: identifying triggers • Skill teaching and activities: problem solving to address triggers • "Homework" assignment
3	Teach women to use safe sex skills.	• Session introduction, review, and check-in • Anatomy/female reproductive system lesson • Skill teaching, demonstration, and practice: male and female condoms • Activity re: pros and cons of different contraceptive methods • Group discussion re: partner resistance to condoms • Skill teaching: assertive communication and negotiation • Group discussion re: unhealthy and healthy relationships and women's safety • Role-plays re: asking partners to use condoms • Homework assignment
4	Teach women disclosure skills	• Session introduction, review, and check-in • Group discussion re: pros and cons of disclosure • Skill teaching and activities: identifying triggers to disclose status, anticipating disclosure situations • Skill teaching and activities: communication and disclosure • Group discussion re: positive and negative disclosure experiences • Movie clip re: disclosure • Group discussion re: handling reactions to disclosure • Group discussion re: unhealthy and healthy relationships and disclosure safety • Role-plays to practice disclosure • Homework assignment
5	Teach women to set goals to maintain healthy behaviors and support systems.	• Session introduction, review, and check-in • Review activity game • Group discussion re: goals • Skill teaching and activities: setting goals • Group discussion and activities re: social support • Concluding activity to review experiences in the program • Graduation ceremony

by practicing on male and female reproductive models. They discuss disclosure strategies by watching a film scene that depicts a woman disclosing to her sexual partner. They enact role-plays to practice asking their partners to use condoms and to practice telling their partners their HIV-status. At the conclusion of each session the facilitator reminds the group about the next session, gives out prizes, incentives and tokens for transportation, and gives women a "homework" assignment that asks them to think about what they learned in the session.

The facilitator follows a strict guide (the manual) for each GLI session but allows time at the beginning and end of the session, as well as between activities, for women to talk openly about their needs. The facilitator speaks individually with women after group, and refers women to clinic services (medication adherence, case management) as needed. Women record topics that they do not have time to address on a flip chart called the "parking lot" that is posted in the session room. For example, discussions and questions about HIV/AIDS medicines and other health concerns (diabetes, heart health) often cannot fully be addressed during the GLI sessions. The facilitator uses those ideas to help the Peer Educators develop their group sessions (described below). Each GLI session builds on the previous session and the facilitator strives to create an environment where each participant understands the materials and feels comfortable asking questions and talking about her individual needs and concerns.

Peer Led Support Groups

The Peer component was chosen as an intervention strategy to complement and enhance the provider and GLI components. The theoretical basis of Protect and Respect, the key principles of GLI, and the skills in the GLI guided the development and implementation of the Peer component. Peers are HIV-positive women similar demographically to the women who participate in Protect and Respect. Peers are unique teachers because they can provide new information, reinforce information, and empathize with program participants. This is particularly important in a program that encourages participants to change difficult, relationally-bound, long-standing behaviors. Peers understand the challenges that women face to behavior change first-hand and can speak from experience. Some of the participants may learn best from someone who shares their situation, versus their provider or GLI facilitator.

The Protect and Respect staff recruited the Peers through consultation with health care providers from the program's clinic site. Each Peer went through an intensive interview process before being hired for the position. Peers initially received training on their job duties, the overall goals of the program, HIV facts and the skills and materials covered in the GLI, and basic counseling and group facilitation skills. After these initial meetings, the Health Educator convened a routine, weekly meeting with the Peers to provide on-going supervision, training, and educational materials to support the Peers' role. Weekly meeting educational topics include: re-infection; risks for same-sex partners; healthy and unhealthy relationships; handling stress; general healthy living strategies as well as strategies for living with HIV and other medical concerns like diabetes. Peers attend HIV related trainings and conferences in the community as well.

During these weekly meetings the Health Educator and the Peers also work collaboratively to plan weekly peer groups and problem-solve group facilitation issues. Each week the Peers suggest a topic for their group, based upon information or needs identified by the Peers or their group participants. Then the Peers and the Health Educator discuss the topic and the topic's relevance to the overall goals of the program. The Health Educator provides factual information or education about the topic as needed. Next the Peer-Health Educator team discusses the best format to address the topic with the group, such as discussion, role-play, or games. The Health Educator develops the group facilitation materials, and the Peers review the materials and seek further clarification as needed. The Health Educator maintains these materials and the Peers re-use topics according to group requests. The intimate involvement of the Peers and their group members in topic selection and group development ensures that the groups address important, relevant issues. Because the group topics are generated weekly, the Peers and Health Educator can develop that week's group around timely group issues and current events.

Peer sessions are on-going, weekly, 1-h, support groups offered to women who complete the GLI. Two Peer Educators lead the groups each week. The importance of the Peer groups is supported by existing literature that confirms that HIV-positive women face many different challenges including parenting and family stress, drug and alcohol addiction, and violent or unhealthy relationships (Barkan et al. 1998). It is essential that women learn skills that they can use when they leave group and return to their homes, families, and relationships. Therefore, the goals of the Peer component are to: support women as they use new risk reduction skills learned in the GLI; help women sustain new and healthy behaviors over time; discuss additional risk reduction strategies that may not be adequately covered in the GLI; provide a "positives-only" space for women to support each other; support a process by which Peer leaders are empowered to support HIV risk reduction in their community.

Program Fidelity

The Protect and Respect Program employs a variety of mechanisms to ensure fidelity to the program. In order to ensure on-going fidelity to the provider component of the intervention, the program developers agreed to provide on-going support to the clinicians after the initial training. A laminated card describing the intervention algorithm was created as an easy counseling reference. Additionally, the program developers held quarterly booster training sessions to continue to support the clinicians' on-going delivery of

prevention messages. These booster training sessions included role playing and case discussions designed to further enhance skill development, lectures from outside experts in particular areas related to HIV prevention and women's prevention needs, and facilitated information-sharing discussions between members of the clinical staff. On a quarterly basis program staff members also conduct interviews with patients immediately after they see a clinician for a routine medical visit. These interviews assess whether the clinician talked with the patient about being worried about transmitting HIV to someone else, safer sex, prevention, disclosure, or condoms. The interviews take place over the course of several days, so that staff interview patients seen by all clinicians. Project staff members then compile the results and provide composite results to the clinicians and the program trainers.

GLI and Peer group facilitators tape record the groups and program staff members transcribe these tapes and then review them to ensure fidelity to these components of the intervention. (The Health Educator also uses these transcriptions in her weekly supervision with the Peer Educators and to ascertain the Peers' future training needs.) Last, another staff member also observes GLI sessions on a routine basis using a checklist that captures whether the Health Educator has maintained fidelity.

Lessons Learned

While the outcomes of Protect and Respect are still unknown, program developers learned several valuable and useful development and implementation lessons. These are meaningful pieces of information to share with others because they help explain why the program worked or did not work as planned. Lessons learned include general lessons as well as lessons regarding each specific component of the program.

General Lessons

The program development team initially underestimated their need to fully understand the clinic and integrate the program into the clinic's daily operations. They learned the importance of gaining the support and confidence of *all* of the clinic staff, not just the Medical Director or head of the clinic. Medical Assistants, Office Managers, and front desk staff manage essential clinic processes and interact with the patients on a regular basis. The program developers slowly conversed more often with these staff members, updating them on the program, and giving them incentives (i.e., food) to improve this relationship.

The program developers also underestimated the pace of the clinic and the amount of stressful, lifesaving work that happens there on a daily basis. For example, the program developers initially staffed their booth in the clinic with a part of one staff person's time. This was insufficient to successfully integrate the program into the busy clinic. As a result they hired a full-time staff person to enroll women in the program. This not only improved program logistics but showed the clinic that the program team was fully committed to being a part of the clinic's activities. Likewise, the program developers were surprised to face so many difficulties enrolling and retaining adequate numbers of women in the program. Both the challenges of integrating the program into the clinic *and* the barriers faced by HIV-positive women contributed to poor program participation. Field notes documenting the program's recruitment process revealed several barriers to women's participation in the program including sickness and fatigue, drug and alcohol recovery, and women's struggles to participate in the project while balancing caretaking responsibilities at home, work schedules, and HIV/AIDS care.

Provider Component

The program development team found it beneficial to hold a focus group with health care providers before developing the provider component of Protect and Respect. This enabled the providers to help tailor the program to their experiences in the clinic. Because providers have limited timed during office visits for prevention, their concerns and suggestions are necessary for success. Clinicians appreciated regular updates about the progress of the program, which reminded them of the benefits of the program for their patients. Because of their busy schedules, existing meetings and/or e-mail served as the best way to deliver these updates.

The program developers learned that the clinicians particularly appreciated booster training sessions where they could learn from and discuss case studies and challenging prevention situations in depth (e.g., partner's refusal to use condoms). This also allowed the clinicians to discuss and explore their attitudes towards prevention. The program developers initially did not realize how important these conversations were to the program's delivery, but providers' attitudes influenced the way they talked about safer sex with their patients.

Group-Level-Intervention (GLI)

After conducting several GLI sessions, the program developers were surprised to learn that women really needed a forum to discuss several important issues in their lives outside of the goals of the intervention (safer sex). For example, many women described situations where their partners refused to use condoms. Therefore they wanted to

talk about their relationships instead of how to use condoms. Sometimes women were more worried about their diabetes or their high blood pressure than their HIV infection. They understood group activities better when they applied them to these areas of their lives. While the Health Educator closely followed the program manual, it was helpful to maintain flexibility and incorporate additional discussion time for important topics and referrals in the beginning of and outside of group.

The Health Educator was overwhelmed by the intensity of the groups, and underestimated the support that she needed to run the groups and support the women effectively. Therefore, she began to meet with a Clinical Supervisor monthly to get support and problem-solve around group facilitation issues. She consulted with the clinic management team and the clinicians to link women to referrals for case-management, housing, and help with domestic violence. The Health Educator also underestimated the scope of the issues she would have to handle in group. For example, during one group session a woman started to have a heart attack and needed to leave to go to the emergency room. As a result, the Health Educator worked with the Clinical Supervisor to develop group procedures for medical emergencies. The distress placed on GLI and Peer facilitators reinforces the need for a Clinical Psychologist to be part of program development and implementation teams. This will protect staff's mental health, prevent burn-out, and ultimately improve services to participants.

Group participants were highly motivated by the incentives they received for coming to group (gift cards, transportation tokens, lunch). Group prizes added excitement to the group routine, even if the gifts were very small (perfumed soaps and lotion). The Health Educator used *group* incentives to increase weekly attendance. For example, she told the group that each member would receive a prize during the following week's session if all of the women in the group returned. This led women to encourage each other's attendance. Participants received certificates for completing the GLI. Many women noted that this was the only time they ever received a certificate for completing a goal. Certificates increased the women's pride and excitement about the program.

Lastly, the program developers starting taping the groups for quality improvement, supervision, and to analyze major group themes after a few GLI sessions were completed. While time intensive, taping and transcribing proved a valuable tool for learning about group patterns as well as barriers to behavior change. It would have been more effective to tape the groups from the beginning of the project to capture all of the group sessions. The tapes revealed powerful details about the women's lives and risk practices.

Peer Groups

The program developers envisioned the Peer group as a way for women to continue to receive support after they finished the GLI, and expected most women in the GLI to attend the Peer group at least once. On the contrary, the groups became a space for a core group of women, who consistently came to the weekly Peer group over the length of the entire project. This initially taxed the Health Educator and Peer Educators. They envisioned the groups as being comprised of different women each month. Therefore they planned to develop a list of group sessions and facilitate the same sessions monthly. However, because mostly the same women attended each week, they had to generate new group topics together weekly. Despite the increased effort and group planning time, this ultimately became a successful process. It allowed the Health Educator and the Peer Educators to participate in the creation of weekly group sessions, it generated a wide variety of useful group sessions, and it tailored the group topics to the participants' immediate and identified needs.

As with the GLI, program developers were surprised that the Peer group sessions were *so* powerful, and used the group tapes for supervision, training, and identifying group themes. The program developers were often overwhelmed as they listened to group tapes. Women in the Peer group frequently shared their personal stories, revealing intimate details about their lives. For example, women talked about what is was like to live in an unhealthy relationship, to struggle with drug cravings, or try to survive in a homeless shelter with their children. Because the Peer space was limited to HIV-positive women, the Peer group effectively encouraged the sharing of these experiences.

Staffing the program with Peer Educators was an overwhelmingly successful strategy. Peers acted as a bridge between program staff and the participants. Their presence enhanced the credibility and trustworthiness of the program. Women consistently came to their groups *every week*, regardless of fatigue, childcare struggles, illness, snow, and a city-wide public transportation strike. However, the program developers underestimated the challenging nature of the Peer position and the amount of support that Peers needed to do their jobs well.

Because the Peers shared many of the experiences of group participants, group members often considered the Peers confidants and friends. The Health Educator (who supervised the Peers) did not anticipate the level of supervision and training that the Peers needed regarding group facilitation skills, counseling skills, boundary-setting skills, and the changing nature of HIV facts. The Health Educator also did not understand that the Peers would struggle in their positions at times simply because they lacked experience in the workforce. For example, the Peers

were paid as independent contractors. As a result they did not have regularly scheduled pay dates. The Health Educator spent countless, unanticipated hours teaching the Peers about timesheets, their pay schedules, and the hours that they were needed to work. In addition, she did not anticipate that she would need to help them with life skills, such as how to use computers, or how to budget or plan financially. However, these skills were necessary to support the Peers' development.

The Health Educator was also surprised to learn how much emotional support the Peers needed to do their jobs. Their jobs were more challenging and more emotionally draining than the program developers anticipated. The Peers grew stressed and tired as they listened to stories about drug abuse, violence, and sickness on a regular basis. They needed help to continue to support their group members. For example, when several group members died in 1 month's time, the Health Educator brought in a counselor to help the Peers handle their grief and gain closure on losing these group members. Peer programs need a full-time supervisor, who can give Peers consistent and patient supervision and training. The Peers should be linked to external supports as well, such as counselors or Clinical Supervisors, who can help them and collaborate with them to lead their groups successfully.

Conclusion

The outcomes of Protect and Respect are still unknown. However, the development processes and content of the intervention described in this article are useful for others implementing similar programs in similar settings. The program developers designed Protect and Respect for minority, low-income, HIV-positive women acknowledging their need for multiple messages from varied sources. This population experiences many challenges in implementing HIV risk reduction behaviors. Protect and Respect provides prevention messages from clinicians, helps participants build skills in a group setting and allows women to connect with their peers as they attempt to incorporate these skills into their lives.

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