The role of peers in linkage, engagement, and retention in HIV care

Questions

- What is the role of peers in linkage, engagement, and retention in HIV care?

Key Take-Home Messages

- In the HIV community, a peer is someone living with HIV who contributes to positive health outcomes of other community members, but is not usually a health care professional with clinical training (1-3).
- Peers have made important contributions in HIV care, playing many roles and providing services such as education and social support (2, 4).
- Randomized controlled trials of peer programs to improve linkage, engagement and retention in HIV care have not shown significant differences compared to non-peer programs (5-7). More research and evaluation are needed to demonstrate the impact of peers on linkage and engagement in care (8).
- Best practices for engaging peers in models of HIV care include protocols, procedures and checklists for beginning, expanding and implementing peer supports into HIV programming (9).
- Challenges to integrating peers into HIV care include administrative barriers, issues of disclosure and staff unfamiliarity with peer roles (10).

The Issue and Why It's Important

Peers, also known as non-professional or lay community members (2), have long been involved in caring for others in similar or shared circumstances (1, 2). The involvement of peers in health care settings varies: some peers have a "natural helping" role, casually helping other community members, while others have more formal

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"paraprofessional helping" paid positions (11). Many people who successfully manage a chronic condition or who are in recovery empathize with others in similar situations and are well-suited to providing care, education and support (1, 12).

Within the HIV community, a peer is someone living with HIV who contributes to the positive health outcomes of other community members, but who is not usually a health care professional with clinical training (2, 9, 13). Peers have contributed to the care of others since the beginning of the epidemic in the 1980s (4, 9), providing social support, care and education, and fostering empowerment (2). Peers take on numerous roles along the HIV care cascade (2) including advisor, counselor, educator, facilitator, advocate, helper and navigator (4).

Peers make unique and valuable contributions to HIV service delivery and expand/strengthen the HIV/AIDS workforce (14). One of the most valuable qualities a peer can possess is the ability to navigate hard-to-reach places and communities that traditional practitioners may not be able to access; for example, a peer would be able to connect more easily with people in prisons or at bathhouses (2, 11). Clients are often more willing to share important information with peers (9).

Peer involvement is a way to improve linkage to and retention in care among people living with HIV (15). This role may be particularly important because focusing resources on retention and re-engagement is highly cost-effective (16).

The following sections describe peer roles in linking, engaging and fostering retention in HIV care in high income countries. All studies and programs (except one) involved peers spending substantial one-on-one time with clients. Overall, we found that engagement in care programs that include peers could benefit from more evaluation.

What We Found

Interventions to improve linkage, engagement, and retention in care

Two systematic reviews that examined peer interventions for HIV in developing and developed countries found some evidence to support the use of peers, but both identified the need for more research that employs rigorous design methods and demonstrates an impact (3, 8). The Centre for Disease Control's Compendium of Evidence-Based Interventions and Best Practices for HIV Prevention does not include any interventions that primarily utilize peers to improve linkage, retention or reengagement in care (17), although two interventions mention using a peer outreach worker (18) or peer educator (19).

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Integration into health care teams

In the grey literature, a randomized controlled trial designed to engage and retain people of colour living with HIV (n=348) integrated a peer worker into the health care team (5). Peers were integrated into teams at three sites (Miami, Brooklyn, and San Juan, Puerto Rico) that helped link those newly diagnosed with HIV to medical care and re-engage those who had fallen out of care. Peers coordinated a client service plan with clinic staff, assisted clients with system navigation, provided coaching and mentoring, and educated clients about treatment and care. They held 30-60 minute in-person sessions with clients once every two weeks. While there were no significant differences between the experimental and control groups in terms of fewer gaps in care, the authors did find that people had fewer gaps in care if they were stably housed (p=0.03) compared to those unstably housed (p=0.13).

The Peer Navigation Services program in Vancouver includes peer navigators as part of an interdisciplinary care outreach team that supports clients who are newly diagnosed with HIV or who need support to re-engage in care (20). Peer navigators work in two distinct settings: in the community, where the focus is on outreach and referral to the program; and at the clinic, where they support clients emotionally and help manage their care. The goal is to facilitate a smooth transition from HIV diagnosis and entry into care, helping clients to see the value in staying engaged with their provider and adherent to medications. Peers build trusting relationships with clients, helping them realize they can manage their illness and live healthy lives. In terms of outcomes: peer navigators benefitted from increased knowledge and confidence in providing HIV self-management; clients were more knowledgeable about HIV and more self-confident in managing their health; and other stakeholders were satisfied with program collaboration and coordination. Overall, the program substantially decreased the time it takes individuals to link to care following an HIV diagnosis.

Motivational interviewing

One randomized trial used motivational interviewing, conducted by peers and clinic staff, to retain people in HIV primary care (6). This pilot study recruited participants, aged 16-29, from a medical centre in Detroit, Michigan. Thirty-nine participants received motivational interviewing from peer outreach workers, and 44 received motivational interviewing from professionals. Participants randomized to the peer outreach worker group attended more intervention sessions but there was only a moderate effect on retention compared to the group receiving sessions from professionals. However, peer outreach workers were found to be as competent as the professionals in delivering the intervention. Recent research suggests that peers are able to deliver motivational interviewing interventions with fidelity if the training is streamlined but allows room for flexibility (21).

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Other interventions

One systematic review examined HIV interventions involving peers and improving engagement within the HIV care cascade (8). Of the nine studies that met the inclusion criteria, only one (7) focused on engagement in care in a developed country. It aimed to increase the use of medical care and improve adherence for people living with HIV who inject drugs. Researchers recruited 966 participants from four cities in the United States and randomized them to two study arms: 1) a video discussion intervention or 2) a peer mentoring intervention, where participants received training to become peers. The training intervention was based on previous research that found that taking on a "prosocial" or peer role has an impact on risk reduction (22). However, no change was observed in medical care and adherence, and no significant differences were reported between participants in the two arms.

One small, unique study assessed the feasibility of a peer-led intervention using text messaging (23). Volunteer peer mentors used text messaging to support eight Black MSM living with HIV who found it difficult to remain in care or adhere to their medications. While the intervention was deemed feasible, there were technical issues: mentees desired more frequent contact and peer mentors were not able to be fully engaged as they had other commitments. Both mentors and mentees preferred more personal contact. Due to the small sample size, the researchers were not able to assess the efficacy of the intervention in retaining people in care. However, a recent meta-analysis found that text messaging interventions to improve adherence to medication and appointments are promising (24).

Training peers for involvement in linkage, engagement and retention programs

Although we found literature on only a small number of interventions, we did find information on best practices for engaging peers. One report, published by an American advocacy organization, AIDS United, describes best practices for integrating peer navigators into HIV models of care to improve linkage, retention, and medication adherence among various organizations (9). The report includes protocols, procedures and checklists for beginning, expanding and implementing peers into programming. Peer navigator roles include community outreach, case finding, regular check-ins with clients, appointment accompaniment, transport coordination, follow-up with mental health providers and adherence support. According to the report, each model has common characteristics that include structured systems to support the integration of peer navigators into programming.

An article that discusses challenges and strategies when implementing peers into linkage and retention interventions (10) described a project, Enhancing Access to and Retention in Quality

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HIV Care for Women of Colour, which launched in 10 Ryan White funded agencies in the US to explore the peer support to enhance retention in care for women of colour. Peer roles included community health outreach workers, navigators, educators, advocates, counselors, specialists and assistants. Peers were offered many different training options, including HIV knowledge, role development and health, social services and employment training. The ten sites (four rural, six urban) that implemented peer roles all struggled to develop their programming; and only five sites (all urban) were able to implement peer programs. The challenges included: administrative barriers related to human resources, hiring processes and training. Program leaders also reported that some peers were unwilling to disclose their status to patients. Some agency staff were not familiar with peer roles, which created a barrier to acceptance, and some continued to view peers as patients and voiced concerns about peers taking on professional roles, their ability to perform duties and the fear that peers would replace clinic staff.

Factors That May Impact Local Applicability

While we tried to identify relevant literature concerning the involvement of peers in linkage and retention in care, there are likely numerous peer-driven programs which exist in developed countries that have not be formally identified through publication and are thus not included in this paper. Additionally, we focused on linkage and engagement interventions and programs with a substantial peer role, and this may have excluded papers where peers were not in linkage to care roles.

What We Did

We searched Medline (including In-Process & Other Non-Indexed Citations) using the term peer* in the Title field in combination with the text term HIV. Reference lists of identified literature reviews were also searched. The Medline search was conducted on December 9, 2016 and results limited to English articles published from 2006 to present in high income countries. We also manually searched the reference lists of included studies. The grey literature search was conducted on Google using the following phrases: "HIV peer navigation," "HIV peer cascade," "HIV peer interventions," "HIV peer continuum." Grey literature searches were conducted in the first week of January 2017. Pertinent articles were retrieved from the first ten pages for each set of terms. Five experts (study authors) were also contacted to receive additional data and insight. The searches yielded (773) references from which 24 studies were included. Sample sizes of primary studies ranged from 4 to 966.

Rapid Response: Evidence into Action

The OHTN Rapid Response Service offers quick access to research evidence to help inform decision making, service delivery and advocacy. In response to a question from the field, the Rapid Response Team reviews the scientific and grey literature, consults with experts, and prepares a brief fact sheet summarizing the current evidence and its implications for policy and practice.

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