

Supporting the helpers: what do peer deliverers of HIV interventions need to sustain their implementation efforts?

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Abstract

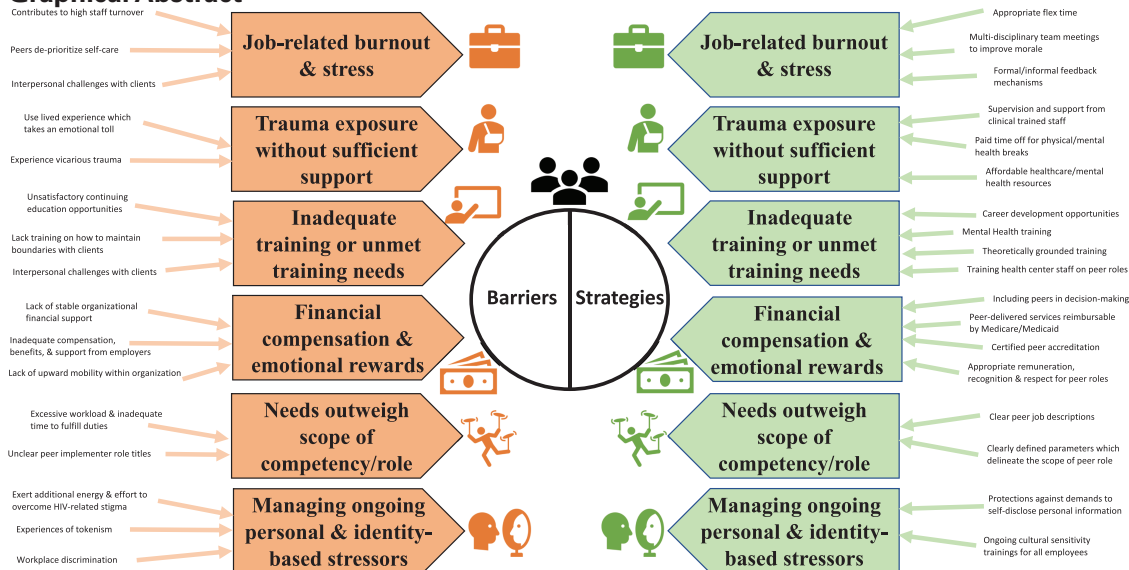
Peer-led HIV interventions are an increasingly common and low-cost strategy to address shortages of professionally trained health workers for implementing evidence-based HIV prevention and treatment interventions to populations who experience health disparities. There is a need to understand the experiences and unmet needs of this essential workforce responsible for implementing and delivering HIV interventions to ensure their implementation efforts are sustainable. This commentary provides a brief overview of barriers to peer deliverers' sustained engagement in the HIV workforce and potential implementation strategies to promote the sustainability of peer deliverers' implementation efforts.

Lay summary

Hiring peers to deliver HIV prevention and treatment programs is more and more common. Having peers deliver programs can save on costs and be more relatable to clients. However, peers who deliver HIV interventions have a variety of things that could make it harder for them to do their jobs or stay in their jobs in the long term. To make it easier for peers to continue delivering HIV programs, several kinds of support need to be available.

Keywords Peer implementers, HIV prevention and treatment interventions, Implementation science, Key populations

Graphical Abstract



Implications

Practice: To realize the potential of peer implementers and promote their sustained engagement in the HIV workforce, it will be necessary to implement and evaluate packages of implementation strategies that address obstacles related to task-shifting.

Policy: Implementation science can support peer workforce development by developing policies (which can serve as implementation strategies) that support the usage and training of peers in the HIV workforce.

Research: Future research should evaluate implementation strategies to determine their impact on implementation and sustainment outcomes for peer deliverers of HIV interventions.

Evidence-based HIV prevention and treatment interventions exist, but trained workforce shortages are one of several barriers to the adoption, reach, implementation, and sustainment of these interventions in community settings. Implementation strategies refer to the methods used to enhance the reach, adoption, implementation, and sustainment of a clinical program or practice, including HIV prevention and treatment interventions [1]. One implementation strategy that has been proposed and increasingly used within the field of HIV prevention and treatment is task-shifting, whereby those in the role of “implementer” of an evidence-based intervention are shifted from professionally trained medical providers to peers.

Peers (e.g., nonclinical personnel including community health workers, lay health workers, lay providers, and peer support workers) as implementers of HIV interventions [2, 3], addresses a key implementation barrier widely documented in the HIV field, particularly in low-resource settings: the shortage of professionally trained medical providers [4–9]. Several studies have shown the utility of task-shifting HIV interventions from physicians and nurses to peer implementers [9–11]. For example, a peer HIV community support intervention was equally effective (i.e., similar clinical outcomes as usual care but with half the number of clinic visits) when delivered by peer health workers living with HIV versus medical providers through task-shifting [4]. Beyond this example, the involvement of peers in HIV prevention and care has been supported by a substantial body of evidence including randomized controlled trials [12–17], systematic reviews [18, 19], and meta-analyses [20] evaluating the impact of peer-led interventions. Recent meta-analyses and systematic reviews [6, 10, 21–23] have included high-quality studies demonstrating the effectiveness of peer support [10], peer navigation [6], and peer education [23] in improving HIV-related outcomes such as sexual risk behavior and condom use [10, 22], HIV testing [21, 22], PrEP uptake [22, 23], engagement in care [21, 22], antiretroviral adherence [10, 22], and retention in care [10, 21, 22].

Despite the promise of peer-led implementation as a simple, low-cost solution to professional workforce shortages, peer-led implementation comes with unique challenges that require understanding and tailored implementation strategies to sustain a peer-led solution [9, 11, 24, 25]. Accordingly, this commentary identifies common barriers to retaining and sustaining the peer implementer workforce (i.e., implementation barriers) and potential strategies for enhancing and sustaining peers’ implementation efforts (i.e., implementation strategies) through a review of the literature. [Table 1](#) provides a high-level overview of barriers and associated implementation strategies (potential solutions) to promote the sustainment of the peer workforce. The narrative below provides in-depth examples of selected barriers and potential implementation strategies.

JOB-RELATED BURNOUT AND STRESS

Due to their social position bridging organizations and the community, peers are well-positioned to contribute to and implement HIV programming but are at risk for burnout and stress [27]. Peer implementers experience alarming work-related burnout rates due to challenges associated with task-shifting (e.g., overburdened schedules, taking on new tasks, and rapid staff turnover), making it challenging for organizations to retain peer implementers with specialized skills [6, 7, 26]. Many peer implementers’ work extends beyond regular business hours; one study of Black gay, bisexual, and other men who have sex with men (GBMSM) implementing an HIV program showed that many experienced burnout [27]. Another study in Canada discovered burnout-related challenges among peer implementers, such as a reduced capacity for performing task-shifted case management responsibilities. These responsibilities could not fit within the already-overburdened workloads of peer implementers [38]. That study suggested healthcare providers deliver supervision to peer implementers who did not have formal clinical training to ensure their integration into the healthcare team and access to needed support [38]. These would be considered implementation strategies to address the added burden of task-shifting. Peer implementers of color also experience tokenization (i.e., “type-casted” and hired to promote a culturally competent image of the organization) and sexual orientation discrimination in HIV organizations [27, 37]. Similarly, another study of burnout among Latino gay/bisexual men and transgender HIV/AIDS volunteers found that negative experiences such as microaggressions and organizations overworking peers were associated with burnout [37]. Researchers proposed routine check-ins concerning negative experiences as an implementation strategy to recruit and retain Latino gay/bisexual men and transgender implementers [37].

TRAUMA EXPOSURE WITHOUT SUFFICIENT ORGANIZATIONAL SUPPORT

Clinicians and medical professionals who serve patients with complex trauma histories are at risk of experiencing secondary or vicarious trauma [29]. Peer implementers often use their lived experience, including trauma and stress, to support clients [39]. Although the literature is limited concerning peers’ experiences of secondary or vicarious trauma, a study of Black gay peers working in HIV treatment and prevention in Atlanta suggests that vicarious/secondary trauma is common among this group of implementers [27]. To address the issue of secondary trauma exposure among Black GBMSM peer implementers, researchers recommended

Table 1 | Barriers to the sustainment of peer HIV implementer workforce and implementation strategies for increasing sustainment

Barrier to sustainment	Example of how this barrier has impeded implementation efforts	Implementation strategies to increase sustainment
<i>Barrier 1: Job-related burnout and stress</i>	<ul style="list-style-type: none"> • Burnout hinders program efficacy and contributes to high staff turnover that can negatively affect the quality of care [7, 26] • Peers deprioritize self-care due to job stress, leading to similar adverse health outcomes as clients [27] • Interpersonal challenges with clients (e.g., coercion, exploitation, being “used”) makes it difficult for peer implementers to support others [28] 	<ul style="list-style-type: none"> • Organizations providing appropriate flex time for hours worked outside office hours to improve retention [27] • Administrators holding multidisciplinary team meetings to improve morale and reduce stress and burnout [29] • Administration receiving and addressing staff needs through formal and informal feedback mechanisms [29]
<i>Barrier 2: Trauma exposure without sufficient support</i>	<ul style="list-style-type: none"> • Peer implementers often use their lived experience, including trauma, to support clients, which has an emotional toll [30] and could in turn detract from implementation efforts • Peer implementers may experience secondary trauma/vicarious trauma from working with traumatized clients, which could impact the quality of care delivered to clients [29] 	<ul style="list-style-type: none"> • Social workers or other clinically trained staff (e.g., PhD-level therapist) providing peer implementers with supervision (e.g., intervention facilitation) and support (e.g., self-care practices) [31, 32] • Organizations providing peer implementers paid time off for physical and mental health breaks [27] • Organizations providing peer implementers appropriate, affordable healthcare/mental health resources [27]
<i>Barrier 3: Inadequate training or unmet training needs</i>	<ul style="list-style-type: none"> • Peers may be less effective as implementers due to unsatisfactory continuing education opportunities offered [26] • Peers lack training on how to maintain boundaries with clients which impacts their mental health [33], and in turn, could impact their implementation efforts • Clinicians often lack training in what the role of a peer implementer is, resulting in suboptimal communication and usage of the peer implementer in a collaborative clinical setting [6] 	<ul style="list-style-type: none"> • Organizations providing peer implementers with formal career development and ongoing supervision/mentorship opportunities [27, 33] • Qualified supervisors providing peer implementers with mental health training (e.g., self-care, well-being, adaptive coping strategies, resilience) to promote self-valuing and retention in the workforce [2, 33, 34] • People who train peer implementers providing peers with theoretically grounded training using health behavior theories (e.g., Theory of Planned Behavior, Cognitive Behavioral Theory, Dialectical Behavioral Theory) to guide actions [30] to act on key mechanisms of change while implementing the intervention • Administrators training health center staff and providers on peer implementer roles and responsibilities to improve communication [6]
<i>Barrier 4: Financial compensation and emotional rewards</i>	<ul style="list-style-type: none"> • Lack of stable organizational financial support/insufficient funding generates feelings of being undervalued, limits peer implementers’ role [26, 35], and could increase turnover • Inadequate compensation, benefits, and support from employers reduce peer implementers’ ability to focus on their work [27] • Lack of upward mobility within the organization and lack of job security impacts the perception of poor treatment in the workplace [27] 	<ul style="list-style-type: none"> • Organizations including peers in programmatic decision-making and giving peers leadership roles within the organization [27, 35] • Policymakers making peer-delivered services reimbursable by Medicare and Medicaid [35] to formalize the peer implementer role and lead to increased compensation • Intervention program staff providing certified accreditation and pathway for employment to peer implementers who are in volunteer roles [2, 36] • Healthcare delivery programs providing appropriate remuneration, recognition, and respect for peer roles [9]
<i>Barrier 5: Needs outweigh scope of competency/role</i>	<ul style="list-style-type: none"> • Excessive workload, inadequate time to fulfill the duties of the peer implementer role [34] • Unclear peer implementer role titles and lack of communication about expectations produce feelings of ineffectiveness [6] 	<ul style="list-style-type: none"> • Organizations, care providers, and research programs establishing clear job descriptions for peer implementers that acknowledge the importance of skills gained from lived experience [27] • Organizations developing clearly defined parameters that delineate the scope of the peer implementer role [33]

Table 1. Continued

Barrier to sustainment	Example of how this barrier has impeded implementation efforts	Implementation strategies to increase sustainment
<i>Barrier 6:</i> Managing ongoing personal and identity-based stressors	<ul style="list-style-type: none"> Peer implementers have to exert additional energy and effort to overcome HIV-related stigma and prevent disclosure of their own HIV status and sexual identity [26, 28, 33] Experiences of tokenism [27] in the workplace generate additional identity-related stress due to unrealistic expectations placed on peer implementers to be knowledgeable/experts on all things related to the specific demographic that the peer implementer belongs to Workplace discrimination generates disempowerment/discouragement and fear of losing their job for speaking up [27, 37] 	<ul style="list-style-type: none"> HIV-focused organizations, care providers, and research programs establishing protections against demands to self-disclose personal information [27, 34] HIV-focused organizations, care providers, and research programs providing ongoing cultural sensitivity training for all employees [27]

time and insurance benefits to support physical and mental well-being and other workplace strategies (e.g., paid time off for physical and mental health breaks and acknowledgment of skills gained from lived experience) to sustain this essential workforce [27]. In another study evaluating a peer-led intervention to support mental wellness among young Black GBMSM living with HIV, peer implementers received training modules (e.g., setting boundaries, self-care, trauma-informed care, and building blocks to peer success) and supervision to promote the sustainment of their work despite secondary trauma and stress exposure [39]. Mental health supports for peer implementers have been most helpful when experts such as social workers deliver these supports [31, 32]. Given that peer implementers often struggle with mental health problems themselves (and in fact, lived experience with mental health or substance use problems might be how “peer” is defined in some cases), supervision can serve as an essential strategy for protecting peer implementers against potential negative impacts of secondary trauma [29, 39] and sustaining their implementation efforts.

INADEQUATE TRAINING OR UNMET TRAINING NEEDS

Peer implementers require guidance on a number of professional issues such as establishing boundaries with clients, balancing care delivery with program constraints, managing overlapping peer and professional roles, and ending client relationships when the research or program has concluded [6, 26, 28, 40]. Peer implementers also require ongoing training on task-shifting and following the theory guiding the intervention they are implementing to enhance their self-efficacy in delivering the intervention and the effectiveness of the intervention (i.e., acting on the mechanisms of change) [39, 41]. A study in Zambia evaluated the use of peer educators in HIV care and treatment clinics and found that peers were less influential than healthcare workers, which was attributed to inadequate training of peer educators [41]. Implementation strategies to address inadequate training include supporting peer implementers through periodic and thorough training, giving performance reviews, and providing supervision to improve peer intervention fidelity [29, 41]. Training needs

also extend to clinicians and staff with whom peer implementers work. “Professional” staff need to be educated on peer implementers’ roles and responsibilities to improve their interactions with peer implementers [6, 25]. In a qualitative study investigating the integration of peers living with HIV into multidisciplinary healthcare teams, gaps in communication between peer implementers and clinicians led to clinicians’ underutilizing the peers [25]. To improve program effectiveness and sustainability and improve peers’ utilization, peers and clinicians suggested training clinicians on peer implementers’ roles and responsibilities and developing a formal mechanism of patient information exchange between them [25].

FINANCIAL COMPENSATION AND EMOTIONAL REWARDS

Peers also face financial concerns related to limited funding, organizational budgets, and low remuneration within their often-unstable positions within organizations that depend on limited grant funding [26, 38, 42]. In some cases, peer implementers are not provided adequate compensation for taking on new tasks [9], a structural issue given that peer implementers are often viewed as a cost-effective solution to the lack of available resources or funding [11]. A systematic review of effectiveness and implementation outcomes of peer-delivered mental health interventions (including interventions for HIV) in low- and middle-income countries highlighted differences in access to opportunities for growth and promotion (e.g., upward mobility, employment opportunities) between unpaid volunteers and salaried peer implementers [42]. Providing a salary to peer implementers, including adequate compensation for peer implementers who take on new tasks, and providing nonfinancial benefits (e.g., educational rewards, recognition by peers) are implementation strategies that could promote retention of peer implementers [2, 9, 42, 43].

NEEDS OUTWEIGH SCOPE OF COMPETENCY/ ROLE FOR PEERS

Inconsistent operationalization of the peer implementer role and difficulty balancing numerous roles and responsibilities

impede peer implementers' success [34, 43–45]. In Canada, researchers explored the inter- and intra-organizational dynamics affecting task-shifting in community-based AIDS service organizations [44]. Researchers found that formalizing the peer implementer role within the organization by providing clear role descriptions, designating workload management structures, and formally recognizing task-shifting efforts supported peer deliverers improved implementation [44]. Additionally, clearly defining task-shifted duties, and describing the process by which these duties will shift from clinical to nonclinical staff, improved the outcomes of the task-shifted program [44]. These strategies can help peer implementers, and the providers with whom they work, be clear about their role and limit the extent to which peers are asked to take on responsibilities that do not match their skill set or training, thereby promoting their sustainment in the workforce [9, 33].

MANAGING ONGOING PERSONAL AND IDENTITY-BASED STRESSORS

Peers also face HIV-related stigma and fear of disclosure when implementing HIV interventions [26–28]. For example, in a study on the experiences of peer implementers regarding their work in a home visit program for people living with HIV, peers expressed concern that their HIV status could be disclosed to the community in the process of undertaking their role which caused them to exert additional effort and emotional resources to protect their own confidentiality [26]. In another study with Black GBMSM peer implementers, those who reported not disclosing their sexuality and HIV status widely due to still dealing with self-acceptance found the job particularly stressful [27]. Although not explicitly addressed in these studies, these types of additional stressors could impede the retention of peer implementers in their roles. Researchers have proposed supports to help peers overcome pressures or expectations to openly share personal information about the other aspects of their social identities, thus strengthening their implementation efforts [27]. These supports included organizational protections against demands to self-disclose aspects of their social identities/experiences and requiring all employees to undergo trainings on cultural sensitivity and interlocking systems of oppression [27].

IMPLEMENTATION STRATEGIES TO SUSTAIN THE PEER IMPLEMENTER WORKFORCE

Although several implementation strategies to address the specific barriers described above have been mentioned, researchers have also begun to develop packages of implementation strategies that might help sustain peer implementer workforces [33, 46, 47]. The TRUST framework (Training, Referral pathways, Understanding the remit of their role, Supervision, mentorship, Talking) is a package of implementation strategies that have been used to guide the expansion of peers' roles in delivering care to adolescents living with HIV in Sub-Saharan Africa [33]. In British Columbia, the ROSE (Recognition of peer work, Organizational support, Skill development Everyone) model is another package of implementation strategies that seeks to consider the needs of peer implementers in overdose settings through structural and cultural organizational changes that lead toward more equitable

and just workplaces for peer workers [47]. These, and other packages of implementation strategies tailored to the implementer and context, are needed to promote the sustainment of the peer implementer workforce.

CONCLUSION

Achieving the U.S. goals for Ending the HIV epidemic (EHE) [48] requires creative solutions to long-standing barriers to implementing evidence-based HIV prevention and treatment interventions. Shifting the implementation of HIV interventions to peers is a promising strategy to support the implementation of evidence-based HIV interventions and achieving EHE goals. To realize the potential of peer implementers and promote their sustained engagement in the HIV workforce, it is critical to consider the reality that peer implementers are both living the daily impact of the HIV epidemic (and drivers of it) *and* being asked to care for their communities via their implementation efforts. Packages of implementation strategies that address the obstacles to peers implementing interventions, sustaining their role as implementers, and optimally reaching key populations experiencing disparities have begun to be developed, but likely require tailoring to specific types of peers and contexts. After identifying specific implementation strategies needed for a given peer implementer role and context, these strategies need to be evaluated to determine their impact on implementation and sustainment outcomes. For example, researchers could measure peer *burnout* using the Maslach Burnout Inventory [49] to assess emotional exhaustion, depersonalization, and personal accomplishment; peer implementer *competence* through self-assessment tools, supervisor evaluations, or peer and participant feedback to evaluate peer implementer perceived competence and skills; and *training and skill development* to assess the impact of training programs on enhancing the knowledge, skills, and self-efficacy of peer implementers using pre- and post-training assessments. Another outcome is measuring the long-term *sustainment* of peer implementers within organizations or intervention settings through indicators such as peer implementer turnover, continued funding, integration into organizational structures, and support mechanisms. As such, to realize their full potential, it is critical to understand and address this population's needs to ensure their implementation efforts are fully supported and sustained.

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Compliance with Ethical Standards

Conflict of Interest: All authors declare that they have no conflicts of interest.

Ethical Approval: This article does not contain any studies with human participants performed by any of the authors.

Informed Consent: This article does not involve human participants, and informed consent was therefore not required.

Welfare of Animals: This article does not contain any studies with animals performed by any of the authors.

Transparency Statements

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Data Availability

This study does not involve data.

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