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Developing an HIV-Prevention Intervention for HIV-Infected Men Who Have Sex with Men in HIV Care: Project Enhance

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Abstract Men who have sex with men (MSM) represent the largest group with HIV in the U.S. (CDC 2005). Interventions for prevention with HIV-infected MSM are urgently needed, and integrating prevention into HIV care represents one opportunity for this advancement. This article describes the development and results of initial pilot testing of a behavioral intervention to reduce HIV sexual risk transmission behavior for HIV-infected MSM that is integrated into HIV care. To illustrate our intervention development process, we describe the setting and population (HIV-infected MSM patients at Fenway Community Health in Boston) for the project, the initial conceptualization of the project including its guiding conceptual model (information, motivation, and behavioral skills model, IMB: Fisher and Fischer 1993), the iterative process of attaining and integrating input from stakeholders, the use of peer interventionists, the open phase pilot and participant input, an overview of the intervention content, and, finally, lessons learned. The result of this process is an example of an intervention developed with strong input from the community and other stakeholders, which is ready for further testing in a randomized controlled trial.

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Introduction

Interventions for HIV-infected men who have sex with men (MSM) are urgently needed. Despite education and existing prevention programs, MSM comprise more than half of all new HIV infections in the U.S. (approximately 40,000) each year (CDC 2005). Similar to other HIV-infected cohorts, it has been estimated that 20–30% of HIV-positive MSM engage in risky sexual practices (Kalichman 1999; Kalichman et al. 1997a; Wenger et al. 1994). It appears, however, that there is no one single reason that HIV-infected MSM continue to engage in risk taking (Parsons 2005) – making intervention development somewhat complex.

Several variables, however, have been shown to be associated with continued sexual risk taking in MSM (Stall et al. 2003). These include a lack of willingness to change one's sexual behaviors (Kalichman et al. 1997b), emotional distress (Kelly et al. 1993), substance use (Kalichman et al. 2001), sex with known partners (Ku et al. 1994), a diminished sense of sexual control (Exner et al. 1992; Quadland and Shattls 1987), and sexual compulsivity (Kalichman et al. 1997a; Snell et al. 1992). It has been suggested that optimism about current HIV treatments or "prevention fatigue" may explain, in part, increased sexual risk taking, although empirical support for these hypotheses is mixed (Craib et al. 2002; Elford et al. 2002; Miller et al. 2002; Bingham et al. 2001). It appears, therefore, that continued sexual risk taking in HIV-infected

individuals is multi-faceted, and may require flexible intervention approaches.

The present paper describes our efforts to develop and pilot an effective, evidence-based, acceptable and culturally appropriate (Gandelman & Rietmeijer 2004), HIV prevention intervention for MSM that could be incorporated into HIV care settings. The priorities for this intervention were that it would be based on accepted models of behavioral change, could be individualized to the needs of each person, and could target multiple areas of concern directly and indirectly related to risk reduction. We title the intervention, "*Project Enhance*" because of the goal of enhancing current care of HIV by adding prevention to treatment. In this paper, we begin by presenting information relevant to the setting in which the intervention was developed and previous needs assessment identifying relevant issues for HIV-positive men in our community. We then discuss the initial conceptualization for the intervention and its theoretical underpinnings, the iterative process of attaining input from stakeholders, the open phase pilot and participant input, an overview of the final intervention content, and, finally, lessons learned.

Setting/Population

Fenway Community Health (FCH) is a community health center in Boston, Massachusetts, and is the largest provider of HIV care in New England. FCH provides care to more than 1,100 HIV-infected individuals, with the majority being MSM (95%). Of these MSM, 20% are from communities of color, with 9.2% identifying as Hispanic and 8.7% identifying as African-American. 87% of our HIV-infected MSM cohort at FCH is between the ages of 25 and 64, with the majority, 58.8%, between the ages of 25–44. Approximately, 16% of our cohort lives below the Federal poverty line, though only 1% does not have permanent housing. Fenway services include primary health care, prevention case management, comprehensive individual and group mental health services, nutritional counseling, holistic/complementary therapies, as well as community education, and programs for survivors of domestic and homophobic violence.

Preliminary Community Needs Assessment of Prevention and Sexual Risk

Some of our earlier work at Fenway Community Health suggested that a subset of HIV-infected MSM engaged in higher rates of unprotected anal intercourse with HIV-uninfected and status unknown partners than HIV-uninfected MSM (Cohen et al. 2002). Of particular relevance to the development of *Project Enhance* were the outcomes from a series of community focus groups conducted by FCH (Church et al. 1999). The focus groups assessed five general areas of information; HIV prevention needs, experiences with HIV prevention services, current levels of reported risk, health and treatment beliefs, and information regarding HIV transmission and re-infection. The focus groups represented primarily urban regions throughout Massachusetts including Boston and involved overlapping groups including MSM, MSM of color, injection drug users, Latinos, and men with a history of incarceration. Focus groups comprised 2–10 participants and 2 facilitators. Focus groups lasted approximately 2.5 hours and participants were reimbursed for their participation (Fenway Community Health Center 1999).

Several trends emerged from the results of these focus groups that guided our initial program development. Specifically, most HIV-infected MSM receiving primary care reported that there were no prevention programs in the community linked to primary care. Most men described ongoing difficulties reducing sexual risk taking behaviors and difficulty disclosing their serostatus to sexual partners. Individuals also expressed a need to have individually tailored interventions that were confidential and non-judgmental with respect to sexual risk taking behaviors (Church et al. 1999). Although FCH provides expert medical care for HIV, intensive mental health counseling, HIV case management, and helps link individuals to the greater Boston MSM community, there also was a need for an individually tailored, prevention program for HIV-infected MSM.

Initial conceptualization of project enhance

Our overarching goal for Project Enhance was to develop an intervention that would be effective in reducing unsafe sexual practices among HIV-infected MSM in a holistic manner that would target multiple areas of concern for our cohort. Our goal was also to create a product acceptable to participants, clinicians, and community stakeholders, while grounding our efforts in prior research. By being attentive to individual needs and to the complexities of HIV prevention with HIV-infected patients receiving primary care at FCH we sought to produce a generalizable intervention that would be brief and that could be easily implemented in clinical settings.

We decided to create a client-centered workbook that both the counselor and participant could use to examine issues that were pertinent to HIV-infected MSM. The general format of the workbook would include multiple topics, discussion points and worksheets to complete both during at each session and at home. This design would

allow for the intervention to be portable and usable outside of our clinic setting given that most decisions around sexual health take place outside of the counseling session. Our aim was to develop a common approach to the flow of the workbook but to create enough room for individualized attention to particular concerns of the patients. After a careful review of the literature, we decided that each topic or module of the workbook would follow the Information, Motivational Interviewing and Behavior Change (IMB) model (e.g., Fisher et al. 1994; Fisher et al. 1992). Some of the specific work was based on our experience as a site for Project Explore, an intervention for HIV-uninfected MSM (Kolbin et al. 2004).

Because the factors contributing to risky sexual behavior in HIV-infected individuals are complex and varied (Kolbin et al. 2004; Parsons 2005), it would seem that a flexible, modular approach that allows components of interventions to match specific problem areas would be the most effective in the design of the workbook for Project Enhance. The Information-Motivation-Behavior model (Fisher and Fisher 1993) and the Transtheoretical Model of behavior change (Prochaska and DiClemente 1984) are designed to highlight and address individual differences among participants while promoting change and growth. In these models, it is incumbent upon the counselor to provide information on a particular issue, to understand a patient's particular stage of change, and to provide individualized skills training to encourage behavior change. In order to facilitate this process it was decided to incorporate peer counselors in the development and delivery of the intervention. As a general overview, each module of the workbook in *Project Enhance* begins with a series of discussions between the counselor and the patient eliciting their knowledge base of a particular topic, i.e. safer sexual practice, definition of HIV disclosure, etc. Motivational Interviewing (MI) techniques (Miller and Rollnick 2002) are then used to provide empathy, explore gaps between current behaviors and goals for their patient (i.e. desire to disclose status at all times before a sexual encounter), elicit change talk, address resistance, and promote self-efficacy. Finally, the behavioral change component of the IMB model occurs at the end of each counseling visit with possible suggestions and practice assignments for the patient (e.g. giving suggestions on how to disclose in a more effective manner, promoting skills for increased condom use).

Iterative development of project enhance intervention and input from stakeholders

Forming partnerships with community members and consumers of HIV services has been recommended as a way to build stronger and more acceptable behavioral interventions (Gordon et al. 2004). Hence, we enlisted several stakeholders in the process of developing this intervention, and their input is summarized below.

Consultation with service providers

As we developed this intervention, we solicited feedback from social workers, therapists, HIV primary care physicians, and intake workers at FCH to determine if our concept for this intervention was sensitive to the issues faced by their HIV-infected patients. Medical providers and social workers indicated that patients tended to be educated about HIV transmission and condom use, but that patients continually evidenced confusion about the possibility of HIV reinfection and superinfection. Mental health therapists at FCH reported that difficulties with HIV disclosure, loneliness, and a lack of supportive relationships tended to undermine patients' desires to practice good self-care in regards to sexual risk taking and that any intervention needed to address these specific needs of HIV-infected MSM. There was broad agreement among both mental health therapists and primary care physicians that despite its importance, they did not consistently discuss sexual risk taking given the degree of complexity of HIV medical and mental health care as well as time pressures in a clinic setting. They reported that having a separate program on HIV prevention within the health center might accommodate prevention needs more comprehensively than attempting to address these issues with in primary care or mental health appointments.

Initial Development of Intervention Modules

From these sources, we began with the following intervention modular topics: Having Sex (HIV risk and limits), Depression, HIV Disclosure, Party Drugs, Sexual Compulsivity, Relationships, and Emotional Distress. We included a discussion on sex (Having Sex) given that this intervention is fundamentally about HIV transmission and sexual relations. Depression, Party Drugs, Sexual Compulsivity, and Emotional Distress were included given the previously mentioned research that showed a link between these concerns and increased sexual risk taking among MSM. Lastly, HIV Disclosure was included based on the feedback from our focus groups and providers at FCH, and Relationships was added given what mental health providers told us about the preponderance of reported loneliness and social isolation of their patients.

Consultation with Community Advisory Board

We solicited input from other consumers of care at FCH by presenting these initial topics to our Community Advisor

Board (CAB). Overall, they encouraged us to develop an intervention that was flexible and adaptable to the changing issues related to HIV sexual health. Though they did not offer specific feedback to the content of the intervention, they believed that we needed to be "cutting edge" in our approach and that we had to be attuned to the needs of our patients.

Curriculum development through writing teams

Lastly, we formed writing teams that included 3 clinical psychologists, 2 HIV-infected peer counselors, 2 social workers and 1 medical provider. The peer counselors were important to the development of the curricular material as they would be delivering the intervention and their approval of the language and content of the modules was viewed as a key element in establishing the broad acceptability of the intervention. The peer counselors wrote many sections of the workbook and participated in ongoing discussions of the acceptability and face validity of the topics covered.

Integrating feedback toward a participant workbook

During the process of writing the individual modules the writing team, through several group meetings agreed through consensus several changes to the content of the individual modules. Based upon feedback from the peer counselors that the Depression module was too "clinical", narrow in scope, and in some incidences likely to be beyond the scope of the intervention, we substituted this with an emphasis on low self-esteem throughout various modules. The peer counselors felt that low self-esteem as it relates to HIV infection pervaded many aspects of life for MSM living with HIV and that it is central to HIV prevention efforts. Based upon feedback from both the social workers and the peer counselors, we revised the emotional distress module to reflect a more specific emphasis on management of life event stress. This revision also reflected a priority to provide more practical "hands on" strategies and was also consistent with results from our earlier focus groups. We also decided to broaden the sexual compulsivity module to include an overall discussion on triggers of increased sexual risk taking. Members of the writing team believed that sexual compulsivity may be too narrow and too pejorative of a term for patients to choose whereas a module on triggers would be broad based and more neutral. Lastly, one peer counselor initiated and directed the development of a new module, "Cultures, Communities, and You," as he and the team believed that topics of race, culture, and power as they relate to sexual risk taking were rarely addressed, are relevant to MSM of color, and needed to be included given that 20% of patients at FCH are from communities of color.

Open phase pilot and participant input

Between the initial conceptualization described above and the final design of the Project Enhance workbook, we conducted a 6-month, open phase (i.e. not randomized) pilot phase to elicit feedback about the intervention. We enrolled 25 HIV-infected MSM who were receiving their primary medical care at FCH into 2 phases of this pilot. After the first 10 participants completed the intervention, we conducted qualitative exit interviews on the design, conceptualization, flow, and topics of our prevention model. We then modified the intervention based on their feedback and then enrolled another 15 individuals who were given a revised version of the intervention. These 15 participants also participated in exit interviews on the behavioral intervention, and the intervention was revised again accommodating their feedback. This rolling pilot phase and subsequent sample of qualitative exit interviews allowed us to refine and revise and finalize our intervention in a short period of time.

Participants were recruited through the Medical Department at FCH and were reimbursed for their participation in the study and $35 for completing the qualitative interview. The qualitative interviews were completed one-on-one by trained members of the research team other than the counselor who had administered the intervention. The interview followed a structured format with flexibility allowed for follow-up questions and lasted approximately 1 hour. Interviews were taped and transcribed. Transcripts were then analyzed for themes by 2 independent raters. A comprehensive list of themes was agreed by consensus between both raters. The same procedure was followed for both phases of the pilot study.

The mean age of the combined pilot sample was 41.7 years (sd = 8.8). Of the 25 pilot participants 76% identified as Caucasian, 20% as African-American, and 4% as Latino. Twelve percent had not graduated high school and 36% were college graduates. The results of these qualitative analyses are presented below summarized for each module.

Feedback about the "Having Sex" Module

Generally, this module had been well received. One participant mentioned that he already knew his sexual risk limits, but that talking about it openly made him examine it more in-depth and made him question if he was truly keeping within his boundaries. Another participant reported that this module made him question if he was focusing too much on immediate sexual gratification, that he was losing sight of his long-term goals of building a more stable romantic relationship with someone. Lastly, another participant mentioned that he knew he was going

"way over the line" in terms of his personal limits and that he needed to "rein them in". His discussion with his counselor using this module helped him believe that he could reduce his sexual risk taking behavior and have "a standard he could live up to." Several participants reported that this was a difficult discussion as they rarely discussed this topic with anyone, including sexual partners. Several participants who reported feeling uneasy discussing this topic believed that it was important and facilitated by the nonjudgmental atmosphere created by the peer counselor.

Feedback about the "Party Drugs" module

Participants who chose this module reported that this was relevant given the widespread use of metamphetamines (Crystal) in the community. One participant, who had used Crystal sporadically, reported that discussing his use in a nonjudgmental manner where he was in charge of setting his goals for reducing his use helped him to be less defensive and allowed him to devise a workable plan to reduce his use of Crystal. His plan included using Crystal only with a friend who also was HIV-infected and who practiced safe sex on a consistent basis. Another participant, who used a considerable amount of Crystal nearly every weekend and had no plans to reduce his use, reported that he was able to develop and practice Harm Reduction techniques around reducing sexual risk, i.e. serosorting, using condoms, etc. He stated that he had no desire to give someone else HIV and wanted to develop strategies such as using condoms to protect others.

Feedback about the "Managing Stress" module

One participant spoke of feeling overwhelmed at work and would attempt manage his stress through frequent casual sexual encounters. "I just didn't want to think about work and knew this would be a release." However, he reported multiple encounters that were risky. The participant identified the specific source of his stress, his relations with his supervisor, and identified alternative coping skills such as better time management and more effective communication.

Feedback about the "Triggers" of risky sex module

Generally, participants reported that a discussion of their personal triggers increased their awareness of their decision-making around sex. One participant reported that it was helpful to "just realize that there were things that influenced me on a subtle level". He stated that for the first time he was able to put a name to what he was experiencing on a moment-to-moment basis and later to implement strategies to reduce their influence on his behavior: "Once I figured them out, the rest was easy." For example, he stated that if he went out to a club late at night, he was more likely to engage in unprotected sex "just to have someone with [me]." Once he connected his loneliness to his sexual decision making, he reported that he did not need to go this bar as much and he decided to work on reducing his sense of isolation in ways that would be more satisfying.

Feedback about the module, "Cultures, Communities and You."

One participant, who chose this module, believed that men tended to see him for his skin color and then presumed he was interested in receptive anal sex, pressuring him into risky sexual acts that were not pleasurable for him. He discussed with his counselor ways in which he could more effectively advocate for himself and build social supports that encouraged the growth of his identity versus having others decide it for him. Another participant who was not born in this country often had difficulty navigating the complex world of dating and relationships which led him to "give up and give in" to unwanted sexual demands. This participant was able to openly discuss those struggles in the context of this module.

Feedback about the HIV-Disclosure module

Participants have repeatedly discussed finding few, nonjudgmental outlets to discuss their difficulty with disclosing their status. As one participant said, "I try to bring up my struggles and all I usually get is a lecture. This [topic] was so helpful because I know I need to disclose but it isn't easy." Another participant reported that they "had the tools" but the discussion helped them to look at when those tools were not effective and why they were "stumbling." Several participants reported that they have begun questioning their rules for disclosure after this discussion. One participant reported that he had never disclosed his status to a steady, casual sex partner he had for the past 5 years who was HIV-uninfected. He reported his usual rule was that if he did not do anything sexual that he considered unsafe, he did not need to disclose his status. Yet, by reviewing the pros and cons of disclosure, the participant began to question this rule and ultimately disclosed his status to this long-term, casual sex partner. Another participant regularly and routinely disclosed his status but still had unprotected, insertive anal intercourse with HIV-uninfected men. "It's their problem, not mine. I tell them everything." Yet, through the discussion around disclosure, he began to question if he was "doing the right thing" even though he disclosed his status. He ultimately chose to use condoms even though his HIV-uninfected sexual partner may not ask him to do so. Lastly, another participant rarely disclosed his status as it "ruined sex." Yet, he tearfully discussed

being rejected by someone with whom he had been having regular unprotected sex after he disclosed his status to him. He stated that he needed to figure out how to disclose "right away" as he stated that he could not "go through with that much heartache again." He and his counselor then used the modules and skill building exercises to improve his repertoire of disclosure skills.

Feedback about the "Getting the Relationship You Want" module

Participants who chose this module often expressed a desire to improve the quality of their social interactions. Many reported feeling lonely at times and reported that this loneliness often contributed to either being in relationships that were unsatisfactory or engaging in risky sexual behavior simply to be with someone. One participant discussed seeking sex outside of his primary relationship that was usually risky, as his current long-term relationship was "sexually dead." After a review of the problem and the manner in which he communicated his sexual needs, the participant was able to speak to his long-term partner about what he wanted sexually and reported that he was no longer seeking sex outside of the relationship as he and his partner were "going to try to make it work." Another individual discussed feeling intense loneliness and reported that he often agreed to have unprotected sex with others just to have someone to talk to for the night. After a discussion around his social network, the counselor was able to point this person to social groups where he could connect with others who were HIV-infected.

Process of integrating the feedback and updating the intervention materials

The modules were finalized into a workbook on the basis of the information summarized above. Clearly there are limitations in this approach since there was a self-selection bias in regards to participants that would be willing to participate in an intervention still under development. In addition, participants selected their four modules, which necessarily biased the topics discussed during the exit interview. Nonetheless, the exit interviews allowed us the opportunity to receive immediate feedback and refine the intervention in ways that strengthened our product and its delivery. The final Project Enhance intervention and its implementation are described below.

Overview of final intervention content

The final behavioral intervention for HIV-infected MSM, Project Enhance, consists of 1 intake session, 4 core "module" session and 4 boosters sessions delivered over the course of 12 months. The intake and 4 core module sessions are conducted in the first 3 months, while the remaining 4 booster sessions are delivered at 3-month intervals. Each session lasts for 50 min and is conducted by an HIV-infected peer counselor or a medical social worker.

Counselor training and supervision

All counselors were trained on the intervention via didactic trainings and role-plays on Motivational Interviewing techniques, the Transtheoretical Model of behavior change, and general counseling techniques. Each counselor also received ongoing trainings as needed, attended relevant seminars in the community and participated in weekly group supervision where cases were presented to the other counselors conducting the intervention for support and advice. Lastly, each counselor received one hour of individual weekly supervision from a psychologist where discussions about cases were more in-depth and included adherence to the model, boundary issues, and self-care for counselors.

Project Enhance Workbook—Overview and Process

The Intake session is designed to build rapport, establish trust, and provide a nonjudgmental atmosphere. The main theme of the intake session for the participant is how HIV has impacted their lives. The impact of HIV is discussed in regards to their physical functioning, mental health, romantic relationships, spirituality, family, work, and friendships. Though the focus is on the impact of HIV, it is the most open-ended of the visits as it is designed to allow the patient and peer counselor to establish a good working relationship.

After the intake session, the core module and booster sessions are specifically focused on issues related to HIV, yet delivered in a flexible and individualized manner. Each of the 7 module or booster sessions are conducted in the same format—Information on the topic, Motivational Interviewing techniques to discuss barriers to change, and Behavior Change via use of skills. Yet, each patient may have various levels of information about a topic, may present different challenges during the counseling session, and may be at different levels of behavior change. Thus, counselors are encouraged to be aware of a patient's understanding about a particular topic, understand the challenges they may face, focus on the next step in terms of behavior change, and discuss barriers to this change. This method may be more complex than standardized formats, but offers participants an individualized approach to common issues related to HIV infection and sexual risk taking.

At the end of the Intake session, patients are given the Project Enhance workbook to use for the module and booster sessions. The Workbook is divided into 7 sections based on the following topics: "Having Sex," "Party Drugs," "Managing Stress," "Triggers," "Cultures Communities and You," "Disclosure," and "Getting the Relationships You Want." All 7 topics discuss relevant information about the topic, review past experiences with that issue, assess level of change, discuss skill building, and end with a list of further resources about that issue. Each section includes worksheets for patients to complete with the peer counselor or at home. The goals and objectives for each module are listed in the Table 1.

Participants may choose to focus on one topic for the 4 core module sessions or a different topic each time, except for one (see below), depending on their individual needs. The content of the modules is described below.

Having Sex

This module, the only one that is completed by all patients, is designed to be an open-ended, nonjudgmental discussion about the quantity and quality of sex and sexual risk taking for each participant. We ask each individual to focus on what influences their sexual decision-making such as mood, partner type, triggers, or party drugs, to focus on situations where they may have had increased sexual risk taking and to assess their desire to change those behaviors. We review what is sexually acceptable for each person, understanding at a more nuanced level their risk taking and how that risk may change from situation to situation and from anonymous to known sexual partners. The module ends with a review and discussion about factors related to HIV transmission that includes topics such as HIV risk, viral load, HIV medications and transmission, and HIV superinfection/reinfection.

Party Drugs

In this module we review various substances that are commonly used among MSM and their effects on their physical functioning and HIV medications. We identify individual factors that lead to the use of party drugs and how that use impacted sexual risk taking. More importantly, individuals are asked to complete a thorough review of their most recent use of substances. They are asked to describe the most recent setting and then their thoughts and feelings prior to their use of party drugs that may have led to risky sexual behavior. Individuals examine how the setting or their personal experiences may have led to their use. Lastly, patients focus on any barriers that may be impediments to reducing or stopping substances and/or discussing ways in which they may reduce sexual risk taking while using drugs. We discuss and role-play skill building exercises.

Managing Stress

In this module, patients review their methods for stress management and how stress affects physical, emotional, cognitive, and behavioral aspects of their lives. Individuals examine the sources of their stress and try to identify and problem solve ways of reducing stressful events. Also, patients review the interplay of sex and stress and how inadequate coping skills may increase sexual risk taking. A review of mindfulness techniques and relaxation training is completed to increase skill building and to manage stress more effectively. Patients in conjunction with their counselor's input may then complete some stress management exercises for later use.

Triggers

In this module, patients identify and define triggers that lead them to sexual risk taking. There is a thorough review of events, settings, emotions, and physical characteristics of potential sex partners that may contribute to patients going beyond their sexual risk limits. With the help of their counselor, individuals identify a recent trigger that led to a risky sexual encounter. They identify the trigger, their assessment of the particular situation, emotions tied to the trigger, their physiological response, and then the end result. Patients are then asked to complete a Trigger Management worksheet that examines goals, choices, and action plans to reduce the influence of triggers on sexual risk taking behaviors. By thoroughly reviewing a recent trigger, patients then can problem-solve safer sex choices more effectively.

Cultures, Communities, and You

This module examines how an individual's cultural and racial/ethnic identities are related to life decisions and sexual behavior. Patients explore how their identities are shaped by their cultural experiences and how those experiences also affect decisions regarding sex and partner type. In conjunction with their counselor, patients review when they have had to compromise their identity in regards to sexual behavior by going outside of their sexual comfort zone. For example, some patients report engaging in risky sexual acts, such as unprotected receptive anal sex that was not pleasurable because others have expected them to enjoy certain behaviors given their skin color or race. Lastly, individuals also examine how issues of power and privilege contribute to sexual risking taking. For example, certain individuals may believe that they have to increase their

Table 1 Goals and Objectives for each module of the Project Enhance Workbook

Having Sex	• To explore how you get your sexual needs met, how you pursue those needs, and if there are times you go beyond what you are comfortable doing.
	• To understand how your sexual decisions impact your physical health and the health of others.
	• To set goals for keeping yourself sexually healthy and happy.
Party Drugs	• To review information on the different types of party drugs and their effects.
	• To identify the factors that lead you to use party drugs and their impact on your sexual health.
	• To evaluate the pros and cons of your use of party drugs and motivation for change.
	• To develop and action plan for changing your pattern of substance use.
Managing Stress	• To review the effects of stress on your body and mind.
	• To identify the sources of stress in your sexual life.
	• To explore how you currently cope with stress in sexual situations.
	• To learn new methods of stress management.
Triggers	• To identify and define triggers for sexually risky behaviors.
	• To review examples of risky sexual behaviors.
	• To explore how triggers may relate to risky sexual behaviors.
	• To learn strategies for managing triggers and sexual risk taking.
Cultures, Communities, and You	• To explore your culture and community and how it has shaped and impacted parts of your identity.
	• To increase your understanding of how different parts of yourself have impacted your life decisions and sexual behaviors.
	• To understand the role of race and ethnicity in your sexual decisions.
	• To learn strategies for developing multiple support systems that will enhance your sense of self and increase your connection with your community and culture.
Disclosure	• To review the definition of disclosure.
	• To discuss past and recent experiences with disclosing your HIV status.
	• To identify personal rules about your willingness to disclose your HIV status.
	• To learn strategies for evaluating your thoughts and feelings regarding disclosure.
Getting the Relationships You Want	• To review the factors involved in negotiating sex and other types of relationships.
	• To identify the types of relationships that you currently have.
	• To identify the types of relationships you want to have.
	• To learn assertive communication strategies for negotiating sex and for obtaining what you want in your relationships.

sexual risk taking in order to fit into the larger community or feel they are less in control of their sexual decision-making if they do not believe they have the power to advocate for themselves. Counselors then examine ways to increase their participant's connectedness to their own community, to build social support and ultimately to improve resiliency and self-efficacy in order to make better choices about sex and risk taking.

Disclosure

The goals of this module are to review past and recent experiences of HIV disclosure and to discuss how disclosure or the lack thereof affects the spread of HIV. Participants are asked to identify their personal rules around disclosure, how they tell others, to whom they may not disclose, and what situations or experiences make them more or less likely to disclose their HIV status to others. Participants are asked to identify the pros and cons of disclosing one's HIV status in a sexual situation and to identify the barriers to full disclosure. Lastly, the counselor helps to identify ways to improve HIV disclosure with sex partners. Through the use of skills and role-play techniques, the participant learns how to more effectively disclose his status during sexual encounters.

Getting the Relationships You Want

The overarching goal of his module is to increase the level of social support for participants by identifying the types of relationships that they wish to increase or improve. Participants are asked to review in-depth, the types of relationships they have and whether they are fulfilling. They also are encouraged to discuss the factors that may limit relationship building or increase one's sense of alienation. Concerns around current partners, friendships, and casual sex partners are often discussed. Participants examine their efforts to improve their social network and review steps

and skill building to expand this network if desired. Participants also review communication styles and practice skills on how to be more assertive with others especially in terms of negotiating safer sex.

Booster Sessions

After the Intake and four module sessions are completed, participants return once every 3 months for a year for booster sessions. These sessions are designed to monitor and enhance the skill building activities that were discussed and implemented during the initial intervention, and to be tied to when they would return to the clinic anyway for an HIV medical care visit. Participants can focus on those topics previously discussed, and can review those topics in light of any new information or behavior change that occurred since the topic was initially discussed. Participants may also review new topics in the *Project Enhance* workbook if they are personally relevant for the individuals. For example, one participant who focused all of his sessions on the "Getting the Relationships You Want" module, asked to focus on HIV disclosure during the Booster sessions as he was broadening his social network but now needed to work on disclosing his HIV status to potential sexual partners that he was meeting.

Lessons Learned

There is a great need for prevention programs for HIV-infected MSM who are receiving primary care, as few such interventions exist. However, the scientific development process of any efficacious project, is complex and time consuming (Rounsaville et al. 2001). Though this testing method is important to intervention testing, the traditional process contrasts with the call from community members for immediate, acceptable models that work and that can be quickly implemented in community settings to stem the tide of HIV infection. *Project Enhance* was therefore designed to meet both the rigorous demands of science and the request of community stakeholders for relevant and acceptable interventions that work. *Project Enhance* is a unique, behavioral intervention targeting HIV-infected MSM and is based upon previous clinical findings and behavioral theory and practice.

We made robust efforts to involve primary care physicians, mental health clinicians, and MSM who are consumers of HIV treatment at Fenway Community Health during each step of the initial conceptualization, development, design, and implementation of the Project Enhance workbook. Participant feedback was also incorporated into the final intervention through the use of a pilot study. It is an example of an individually tailored, flexible approach targeting HIV risk reduction that is both feasible and acceptable to multiple parties. Community and stakeholder input resulted in an intervention package that was relevant to the consumers of such interventions, which we believe increases the overall feasibility of its delivery. Though at times an uphill battle to include multiple stakeholders we believe we have achieved an acceptable and feasible product.

The Project Enhance workbook consists of 7 topics or modules that we have found to be relevant to sexual risk taking behaviors among our HIV-infected cohort that receive their care at Fenway Community Health. The delivery of this intervention is designed to be collaborative, nonjudgmental, and focused on change and growth. The initial feedback we have received indicates that we have created a safe space to explore relevant topics of concern for HIV-infected MSM who receive their care at Fenway Community Health. Our qualitative interviews also suggest that some participants have changed their risk behavior as a result of the intervention.

The efficacy data of this intervention is currently being collected. To date, we have enrolled over 250 HIV-infected MSM into the study. Thus far, over the course of the 4 core sessions, 60% of the participants have chosen Getting the Relationships You Want, 43% have chosen Managing Stress, and 43% have chosen Disclosure. Less than 20% each of have chosen the remaining 3 modules. As a reminder, everyone is required to complete the Having Sex module. There also is high rate of repetition of certain modules during the 4 core visits. 63% of individuals who chose Getting the Relationship You Want selected it more than once, 25% selected Managing Stress more than once, and 17% selected Disclosure more than once. Including mental health clinicians in the initial development of this project, who advocated strongly for a topic on relationships to address loneliness, seemed to have been well worth the effort. Also, members of our focus groups who discussed the need to learn better ways to disclose one's serostatus proved correct at least in terms of module selection. Though substance use/party drugs appear highly relevant to reducing risky sexual behavior, we may not have adequately addressed this issue, as this is one of the least chosen topics. It is possible that individuals who use substances may not want to address it in this venue or do not believe it impacts sexual decision making. Nonetheless, it is possible that those who chose this module still received some benefit from a review of this topic. As this remains a research project and we are still enrolling participants, we are awaiting analyses of the data to see if this intervention proves efficacious in reducing sexual risk taking beyond our open phase data.

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