

SHIELD

DESCRIPTION

The Self-Help in Eliminating Life-Threatening Diseases (SHIELD)¹ intervention is a group-level HIV prevention intervention that trains men and women (age 18 years or older) who are current and former users of cocaine, heroin, or crack to be peer educators. As a peer educator, participants learn communication skills to conduct peer outreach to the people in their social networks. Participants are also taught HIV prevention information and risk-reduction skills.

Peer educators are trained in risk-reduction information and skills. They also learn communication skills to prepare them for peer outreach. While many people think that peer outreach is done with the community at large or with strangers, in the SHIELD program, peer outreach is focused on people in the peer educators' social networks. A social network is the group of people the peer educator knows well or feels comfortable with, such as drug or sex partners, family, friends, and support group members.

Participants also begin to use the HIV risk-reduction information and skills that they learn in the SHIELD sessions to change their own risky behaviors to maintain credibility as a peer educator.

SHIELD has been packaged by CDC's Replicating Effective Programs project. An intervention package, training, and technical assistance are available from CDC. The intervention package will be provided only to participants of the formal Diffusion of Effective Behavioral Interventions SHIELD training conducted by CDC's training and capacity-building assistant partners. Planning and implementation information (including the starter kit and technical assistance guide) can be found at www.effectiveinterventions.org.

What SHIELD Is Not

SHIELD is not a support group

Although participants are encouraged to share experiences and offer social support, the group sessions focus on a specific curriculum to teach peer education and risk reduction skills. Clients that are in need of support groups should be referred to other services. Clients may participate in SHIELD and a support group simultaneously.

SHIELD is not drug treatment or a recovery group

The SHIELD intervention is designed for former and current drug users. While some SHIELD participants may decrease or cease their drug use as a result of being in the program, the skills that are presented in the SHIELD intervention sessions include various risk-reduction options in addition to abstinence. People who are seeking drug treatment or recovery services may be referred to other services. The staff conducting the pre-contact session should assess each person being enrolled in SHIELD on the basis of his or her interest in drug treatment services. For example, someone who is seeking a 90-

day treatment program may not be appropriate for enrollment into the SHIELD project because his attendance may be limited.

SHIELD is not a job training program

SHIELD is a peer educator training program. Peer educators conduct peer outreach on a volunteer basis. Some SHIELD participants may feel that being a peer educator is a “job,” and this training may enable and facilitate them in obtaining employment. Agencies should clarify with participants that they are not employees of that agency.

Goals

This intervention aims to increase condom use during vaginal sex, reduce needle sharing, and decrease frequency of injection drug use.

How It Works

As peer educators, participants promote HIV prevention among their networks and community contacts by using peer educator skills developed during the SHIELD behavioral intervention. The intervention includes multiple training and skill-building sessions that involve setting goals, role-plays, demonstrations, and group discussions. The intervention is composed of 6 sessions that can be completed in 3 to 6 weeks (1 to 2 sessions for a given SHIELD cycle to be held per week)

The sessions teach participants techniques for personal risk reduction, correct condom use, and safer-sex negotiation skills. The intervention also addresses injection drug use and the avoidance of risky situations. To present HIV risk in a broader community context, the intervention emphasizes the interrelatedness of HIV risk among people, their sex partners, and their community.

Theory Behind the Intervention

The SHIELD intervention was built on 4 psychological theories: social cognitive theory, social identity theory, cognitive dissonance (or inconsistency) theory, and social influence theory. Each of these theories guides the peer educator approach to HIV risk reduction.

Social cognitive theory proposes 4 components that are necessary for a behavior to change: 1) knowledge, 2) development of skills to reduce risk and regulate risk, 3) peer support to reduce risk, and 4) self-efficacy to reduce risk (belief that one can be successful). In the SHIELD intervention, peer educators receive psychosocial cognitive skills training to reduce HIV risk behaviors and the opportunity to practice their skills to increase self-efficacy.

Social identity theory suggests that people classify themselves in terms of group labels. Once a person begins to identify with a group, he acts according to what he perceives other group members are doing. For example, as participants attend each intervention session, they may begin to consider themselves a part of the peer educator group. In addition, if they perceive that other peer educators are similar to them, their self-efficacy for conducting peer education may increase. Also, people may become motivated to reduce HIV risk.

According to cognitive dissonance theory, people want their actions to match their words. As peer educators begin to engage in HIV prevention outreach in their social networks, they may change their own risky behaviors to make their behaviors and their statements consistent. By talking to members of their social networks (e.g., partners, friends, and family members) about using condoms and not sharing needles,

peer educators may become motivated to adopt these same risk-reduction strategies. Furthermore, people may begin to adopt safer behaviors to maintain their credibility as peer educators.

Social influence theory proposes that individual behavior is shaped by observing other people in the social environment and modeling the observed behaviors. In addition, a person is more likely to adopt a given behavior if he feels he is similar to the person he is observing. After learning risk-reduction information and skills in the SHIELD intervention sessions, the peer educators go into their community to share the information with members of their social networks. They also model safer behaviors.

Research Findings

The target population for the SHIELD intervention is men and women who are current or former users of heroin, cocaine, or crack. It can be used with people of a wide range of ages and without regard to HIV status.

In the original SHIELD research study, participants were 94% African American, 61% male, and 85% unemployed; 65% reported less than \$500 of income in the past 30 days, and 57% had less than a high school education. The average age of participants was 39 years. The SHIELD intervention produced the following results among peer educators 6 months after they completed the intervention:

- Increased condom use during vaginal sex with casual sex partners (16% of peer educators vs. 4% of control group).
- Increased condom use during oral sex with casual sex partners (12% of peer educators vs. 3% of control group).
- Reduced needle sharing (69% of peer educators vs. 30% of control group).
- Decreased frequency of injection drug use (48% of peer educators vs. 25% of control group).
- Stopped using injection drugs (44% of Peer Educators vs. 22% of control group).

CORE ELEMENTS, KEY CHARACTERISTICS, AND PROCEDURES

Core Elements

Core elements are those parts of an intervention that must be done and cannot be changed. They come from the behavioral theory on which the intervention or strategy is based; they are thought to be responsible for the intervention's effectiveness. **Core elements are essential and cannot be ignored, added to, or changed.**

SHIELD has the following 5 core elements:

- Implemented in a small-group setting to offer participants an environment that is conducive to sharing experiences and gaining social support from peers.
- Participants go through a series of activities that includes pre-program contact and 6 intervention sessions in a specified sequence. Peer education requires motivation and willingness to interact with people in a social network. Potential participants should be briefed about the SHIELD intervention and screened to determine if peer education is appropriate for them during the pre-program contact. Once clients are screened eligible, they will progress through sessions 1 through 6. This order builds risk reduction and communication skills, develops the peer educator identity, and establishes a supportive environment where participants can share their experiences.
- Each SHIELD intervention session follows a specific structure that includes 5 components: homework check-in, presentation of new information, peer educator training activities (e.g., group problem solving and role-plays), homework assignment and practice, and summary. By following this structure, risk reduction and communication skills are reinforced and participants have

opportunities to practice their peer outreach. For more information about the SHIELD session structure, please refer to the SHIELD facilitator's guide.

- SHIELD sessions aim to build 3 sets of skills necessary for participants to be a peer educator: communication skills for conducting effective peer outreach, techniques to reduce HIV risk related to injection drug use, and techniques to reduce HIV risk related to sex. The central focus of the SHIELD intervention is to train people to be peer educators. Peer educators are taught 4 basic communication skills to be used during peer outreach: **pick** the right time and place, **evaluate** their situation, **explore** safer options for their situation, and use **resources** and referrals. PEER is an acronym to assist peer educators in recalling the 4 communication skills.
- Every session includes interactive peer educator training activities that build peer outreach skills and increase peer educator self-efficacy. Through increased self-efficacy, participants develop a peer educator identity. Activities include facilitator role models, group problem-solving activities, and role-plays. Becoming a peer educator and conducting peer outreach is a process. First, participants need to be introduced to the concept of peer education. Then, by engaging in activities and discussion about peer outreach throughout each session, the peer educator role is reinforced which leads to adoption of the peer educator identity. Peer educator identity means that participants see themselves as peer educators and look at peer outreach as a role in their lives.

Key Characteristics

Key characteristics are those parts of an intervention (activities and delivery methods) that can be adapted to meet the needs of the community-based organization (CBO) or target population. The SHIELD intervention materials do not specify key characteristics.

More information and CDC technical assistance on how to adapt the SHIELD intervention for a specific community, while maintaining the parts that were proven to change behaviors, is covered in the “Adapting” section of this guidance.

Procedures

Procedures are detailed descriptions of some of the elements listed above. Some of the procedures for SHIELD are as follows:

The SHIELD intervention is delivered through 6 interactive sessions. Each session lasts 1.5 to 2 hours and is held in a small-group setting (4 to 12 participants). Each SHIELD group is led by 2 trained facilitators. Through facilitated discussion, skills-building activities, role-plays, and demonstrations, information, referrals, and risk-reduction materials are delivered, and each session follows a specific structure (homework check-in, present new information, peer educator training activities, homework assignment and practice, and summary).

Session 1: introduction to the peer educator role and peer outreach

This session does not follow the SHIELD structure because the focus is on introducing concepts of peer educator and peer outreach. Therefore, the primary activity is brainstorming and group discussion.

Session 2: peer educator communication skills (PEER)

This session provides support and positive reinforcement for the peer educator's role, reviews basic HIV risk information, and provides opportunities to practice PEER communication skills.

Session 3: reducing sex risk, part 1

This session provides support and positive reinforcement for the peer educator's role, reviews sex risk information and risk-reduction options, and provides opportunities to practice PEER communication skills about sex risk reduction.

Session 4: reducing sex risk, part 2

This session provides support and positive reinforcement for the peer educator's role, reviews male and female condom information, and provides opportunities to practice PEER communication skills about using condoms and addressing barriers to condoms use.

Session 5: reducing risk related to injection drug use

This session provides support and positive reinforcement for the peer educator's role, reviews risk related to injecting and sharing drugs, and provides opportunities to practice PEER communication skills about safer injection.

Session 6: graduation and sustaining peer outreach

This session provides support and positive reinforcement for the peer educator's role and motivates participants to sustain peer educator outreach. This session also provides ways to address barriers to sustainability for individual behavior change and promote a "booster" session, if applicable.

ADAPTING

While SHIELD was tested with predominately African American men and women, it was designed to serve a diverse group of people. SHIELD is an intervention for men and women (age 18 years and older) who are current or former users of heroin, cocaine, and crack. SHIELD can be used with people who are HIV-positive or HIV-negative. Beyond these guidelines, SHIELD can be adapted to suit your agency's needs. Participants must be comfortable conducting peer outreach among former and current drug users or people at risk for HIV through their sex behaviors. CDC's extensive capacity-building assistant partners will provide technical assistance regarding adaptation issues.

RESOURCE REQUIREMENTS

People

At a minimum, SHIELD should be implemented with 2 full-time equivalents: 1 project manager (50%), 2 facilitators (50% each), and 1 recruiter (50%). These staff members will be responsible for recruiting participants, marketing the program, facilitating sessions, and conducting evaluation activities. With these staff members in place, agencies can offer up to 2 cycles of SHIELD at different times each week. For example, a group of sessions can be held mornings, while another can be held in the evening. Thus, in a 3-week period, 2 SHIELD cycles will be completed.

This staffing pattern is the minimum number needed to implement SHIELD effectively. If your agency plans to serve a large number of clients and your budget allows for additional staff, you may consider having more staff, such as 2 recruiters (50% each) or a full-time employee who plays the role of second recruiter and facilitator.

Each facilitator should attend the 1-day SHIELD training conducted by CDC's capacity-building assistant partners, Program coordinators and managers, who oversee the intervention and supervise the group facilitators, are also encouraged to attend a 1-day SHIELD training, independent of the training for facilitators. Program coordinators and managers and those interested in learning more about the intervention are encouraged to read the SHIELD starter kit found at www.effectiveinterventions.org.

Space

SHIELD needs space that meets the following requirements:

- Large enough for the audiovisual equipment and easel to be placed near the facilitator.
- Large enough to comfortably accommodate a small group of 8 to 12 men and women.
- Accessible at a variety of times for flexible scheduling.
- Child care available on the premises.
- Private and secure, so that confidentiality of clients can be ensured.
- Quiet and without interruptions (such as people entering and exiting the room or outside noise).

Supplies

The SHIELD package comes with generic marketing tools, such as printed promotional literature. SHIELD will also require the following:

- An easel, easel chart paper, markers, and pencils.
- Penile and vaginal anatomic models for condom demonstration.
- Male and female condoms and packets of lubricants.
- Take-home packets of male and female condoms and lubricants.
- Safer injection demonstration kits.
- Snacks and small incentives (optional).
- Graduation certificates of attendance for participants.

RECRUITMENT

A recruiter is needed to ensure that a continual flow of participants is available for the SHIELD intervention. The recruiter needs to conduct street outreach as well as through community agencies. The recruiter is a liaison between your agency and other community organizations. Recruiters also need to know about services and resources in the community, since they may be asked about resources from people they approach as they do outreach.

SHIELD has been implemented with 1 part-time recruiter. However, if your agency experiences recruitment challenges or plans to serve a large number of clients, you may consider having 1 full-time recruiter. Another option is to have 1 of the facilitators conduct recruitment activities. In addition to a designated staff recruiter, agencies are

encouraged to enlist volunteers to assist with recruitment. Recruiters' responsibilities include the following:

- Establishing linkages with community agencies.
- Assisting with screening potential participants.
- Conducting street outreach for recruitment.
- Making follow-up reminder phone calls to participants.
- Photocopying and posting flyers.
- Advertising the program.
- Keeping detailed notes on recruitment sources.
- Distributing HIV information and risk-reduction materials during street outreach.

Recruiters should prepare detailed notes of their recruitment efforts. These notes should include information such as when and where participants were recruited and how many people were approached. Project managers should review these notes and ensure that recruiters are covering a wide range of recruitment sites and interfacing with many potential participants. Project managers may also want to go with the recruiter on a field day so they can observe first-hand what goes on in the field. Finally, the project manager and recruiter should meet regularly (at least biweekly) to review recruitment notes and discuss recruitment goals, progress, and any challenges that arise. Technical assistance partners can provide guidance on recruitment and retention strategies that can be tailored for the SHIELD intervention.

POLICIES AND STANDARDS

Before a CBO attempts to implement SHIELD, the following policies and standards should be in place to protect clients, the CBO, and the SHIELD intervention team.

Confidentiality

A system must be in place to ensure that confidentiality is maintained for all participants in the program. Before sharing any information with another agency to which a client is referred, signed informed consent from the client must be obtained.

Cultural Competence

CBOs must strive to offer culturally competent services by being aware of the demographic, cultural, and epidemiologic profile of their communities. CBOs should hire, promote, and train all staff to be representative of and sensitive to different cultures. In addition, they should offer materials and services in the preferred language of clients, if possible, or make translation available, if appropriate. CBOs should facilitate community and client involvement in designing and implementing prevention services to ensure that cultural issues are incorporated. The Office of Minority Health of the Department of Health and Human Services has published the *National Standards for Culturally and Linguistically Appropriate Services in Health Care*, which should be used as a guide for ensuring cultural competence in programs and services. (Please see Ensuring Cultural Competence in the [Introduction](#) of this document for standards for developing culturally and linguistically competent programs and services.)

Data Security

To ensure data security and client confidentiality, data must be collected and reported according to CDC requirements.

Informed Consent

CBOs must have a consent form that carefully and clearly explains (in appropriate language) the CBO's responsibility and the clients' rights. Individual state laws apply to consent procedures for minors; at a minimum, consent should be obtained from each client. Participation must always be voluntary, and documentation of this informed consent must be maintained in the client's record.

Legal and Ethical Policies

By virtue of participation in SHIELD, clients living with HIV/AIDS may learn of or disclose their HIV status. CBOs must know their state laws regarding disclosure of HIV status to sex partners and needle-sharing partners; CBOs are obligated to inform clients of the organization's responsibilities if a client receives a positive HIV test result and the organization's potential duty to warn. CBOs also must inform clients about state laws regarding the reporting of domestic violence, child abuse, sexual abuse of minors, and elder abuse.

Referrals

CBOs must be prepared to refer clients as needed. For clients who may need additional assistance in decreasing their risk behavior, providers must know about referral sources for prevention interventions and counseling, such as comprehensive risk counseling and services, partner counseling and referral services, and other health department and CBO prevention programs. For potential clients who are experiencing severe violence in their relationship, providers must be prepared to refer them to intimate partner violence help.

Volunteers

If the CBO uses volunteers to assist with or conduct this intervention, the CBO should know and disclose how their liability insurance and workers' compensation applies to volunteers. CBOs must ensure that volunteers also receive the same training and are held to the same performance standards as employees. All training should be documented. CBOs must also ensure that volunteers sign and adhere to a confidentiality statement.

QUALITY ASSURANCE

The following quality assurance activities should be in place when implementing SHIELD.

Facilitators

Facilitators should complete a training workshop, including review of the intervention theories and materials. Facilitators should also participate in practice sessions with one another in advance of conducting a session. This will allow them to deliver the session content with ease and properly describe and facilitate the movie clips in each session.

Session Review

CBOs should have in place a mechanism to ensure that all session protocols are followed as written. Quality assurance activities can include observation and review of sessions by key staff and supervisors involved with the activity. This review should focus on adherence to session content, use of correct videos and adequate facilitation of discussions, accessibility and responsiveness to expressed client needs, and process elements (e.g., time allocation, clarity).

Record Review

Selected intervention record reviews should focus on assuring that consent forms (signed either by the client) are included for all participants and that session notes are of sufficient detail to document that clients are participating actively.

Clients

Clients' satisfaction with the intervention and their comfort should be assessed at each session.

MONITORING AND EVALUATION

Specific guidance on the collection and reporting of program information, client-level data, and the program performance indicators will be distributed to agencies after notification of award.

General monitoring and evaluation reporting requirements for the programs listed in the procedural guidance will include the collection of standardized process and outcome measures. Specific data reporting requirements will be provided to agencies after notification of award. For their convenience, grantees may utilize PEMS software for data management and reporting. PEMS is a national data reporting system that includes a standardized set of HIV prevention data variables, web-based software for data entry and management. CDC will also provide data collection and evaluation guidance and training and PEMS implementation support services.

Funded agencies will be required to enter, manage, and submit data to CDC by using PEMS or other software that transmits data to CDC according to data requirements. Furthermore, agencies may be requested to collaborate with CDC in the implementation of special studies designed to assess the effect of HIV prevention activities on at-risk populations.

KEY ARTICLES AND RESOURCES

CDC Diffusion of Effective Behavioral Interventions project. Available at:
<http://www.effectiveinterventions.org>.

CDC. Draft CDC technical assistance guidelines for CBO HIV prevention program performance indicators. Atlanta, GA: US Department of Health and Human Services; 2003.

Dickson-Gomez JB, Knowlton A, Latkin C. Values and identity: the mean of work for injection drug users involved in volunteer HIV prevention outreach. *Substance Use and Misuse*. 2004;39(8):1259–1286.

Latkin CA, Hua W, Davey MA. Lend me your ears: factors associated with peer HIV prevention outreach in drug-using communities. *AIDS Education and Prevention*. 2005;16(6):499–508.

Office of Minority Health. National standards for culturally and linguistically appropriate services in health care. Washington, DC: US Department of Health and Human Services; 2001. Available at: <http://www.omhrc.gov/omb/programs/2pgprograms/finalreport.pdf>.

REFERENCES

1. Latkin CA, Sherman S, Knowlton A. HIV prevention among drug users: outcome of a network-oriented peer outreach intervention. *Health Psychology*. 2003;22(4):332–339.