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HIV/AIDS Peer Counselors' Perspectives on Intervention Delivery Formats

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This research sought to elicit HIV/AIDS peer counselors' perspectives about delivery formats for a counseling intervention. Peer counselors identified personal contact as the major advantage of the face-to-face format. Personal contact afforded counselors better opportunities to understand and assess clients' physical, emotional, and environmental status and allowed them to connect with peers in more concrete and personal ways. Being physically present was also a very direct and effective way to role model for other HIV-positive women. Peer counselors identified a number of inherent barriers and challenges to telephone interventions but also recognized potential logistic and personal advantages. Despite the overwhelming preference for the face-to-face intervention format, counselors acknowledged the potential for conducting successful peer counseling over the telephone. A significant finding was that the value and meaning of HIV/AIDS peer counselors' work transcended the limitations of either delivery format.

Keywords: *HIV/AIDS; peer counseling; telephone counseling; counseling delivery formats*

During the past decade, the face of the HIV/AIDS epidemic has changed dramatically, with heretofore low-risk populations, such as women, minorities, and rural populations, facing rapidly rising infection rates (Adimora et al., 2001; Castaneda, 2000; Centers for Disease Control and Prevention

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[CDC], 2004; Hader, Smith, Moore, & Holmberg, 2001; Roberts, Collmer, Wispelwey, & Farr, 1997). These populations have unique needs and face multiple barriers to accessing adequate support and care. Of special concern is the rapidly growing population of HIV-positive women living in rural areas. Rural women face physical and social isolation and difficulty accessing care and support because of geographic barriers, social stigma, and inadequate economic resources. There is an urgent need for models of HIV/AIDS care tailored to the special needs and circumstances of rural women.

Peer counseling is a modality that has been gaining increasing popularity in community-based HIV/AIDS research and practice. Often used as an adjunct to professional health and social services for HIV/AIDS, the functions of peer counseling include providing social and emotional support, increasing patient knowledge and disease management skills, facilitating access to health and social resources, and mitigating against stigma and isolation (Eng, Parker, & Harlan, 1997; Fogarty et al., 2001; Tessaro et al., 2000). Although significant evidence supports the effectiveness of peer counseling as a means of providing support to vulnerable and marginalized populations (CDC, 1996; Fogarty et al., 2001; Pew Partnership for Civic Change, 1997; Sherman, Sanders, & Yearde, 1998), there is little research on the effectiveness of peer counseling within the context of the lives of rural women with HIV/AIDS. Rural women with HIV disease are good candidates for peer counseling because their access to information, support, and resources is limited by geographic distance, lack of transportation, and fear of disclosing their HIV-positive status (Sowell, Moneyham, Demi, & Cohen, 1992). Conservative values and norms intensify the stigma associated with HIV disease, making rural women reluctant to use HIV-designated services for fear of being recognized as HIV positive by people in their community (Moneyham et al., 1996).

Peer Counseling Delivery Formats

Peer interventions involve relationships that are often friendship based, where experiential knowledge is shared, advice is solicited or offered, and alternative events and consensual validation are shared (Pew Partnership for Civic Change, 1997; Tessaro et al., 2000). The similarities in the social, environmental, and cultural backgrounds of helpers and those they help provide a culturally relevant context for peer interventions that results in the development of positive feelings between those offering and receiving support (Jackson & Parks, 1997; Tessaro et al., 2000). It has generally been

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assumed that direct, face-to-face contact is essential to the development of the positive feelings that are at the core of effective peer interventions. As a consequence, most peer interventions have been limited to face-to-face contact provided via one-to-one or group formats. Less information is available on the use of the telephone as an alternative delivery format for peer counseling.

Telephone counseling has been used for disenfranchised groups who are unable or unwilling to use more traditional services and for underserved groups such as minorities and rural populations (Gold, Anderson, & Sexner, 1999; Heckman et al., 2004). Telephone counseling is typically provided to populations that would otherwise be unable to receive counseling for a variety of reasons, including geographic separation and isolation, physical disabilities, social stigmatization, fear of discrimination, and inability to pay for services (Coman, Graham, & Evans, 2001; Duan, Fox, Derose, & Carson, 2000; Nokes, Chew, & Altman, 2003; Wang, 2000). Recent studies across a variety of settings and counseling needs have provided initial evidence to support the effectiveness of telephone counseling for a number of illnesses and health-related concerns (Elley et al., 2004; Green et al., 2002; Horng & Chueh, 2005; McKay et al., 2004; Saywell et al., 2003; Stoddard et al., 2002). A major argument in support of telephone counseling is that it is a potentially cost-effective approach to provide support and services. There is some evidence to support this claim. Telephone counseling has been found to be as effective as face-to-face counseling and less than half as costly and has been associated with decreases in unnecessary clinic visits and increases in appropriate referrals (Bertera & Bertera, 1981; Elley et al., 2004; Masi & Freedman, 2001; Mermelstein & Holland, 1991; Ormond et al., 2000; Ormond, Haun, & Cook, 2001).

Certain characteristics of telephone counseling may pose problems for peer counselors. The absence of nonverbal cues over the phone requires adjustments in communication that are difficult for some individuals and may reduce the effectiveness of counseling (Coman et al., 2001; Ormond et al., 2001; Wang, 2000). Because telephones are often used for conversation and socializing, it may be difficult for peer counselors and clients to move beyond a social level of interaction (Lester, 1995; Masi & Freedman, 2001). The counselor's decreased sense of control is another potential disadvantage (Ormond et al., 2000; Wang, 2000). Distractions and privacy are environmental concerns. Maintaining the client's attention in the presence of environmental distractions may be difficult. The telephone counselor cannot control the client's environment during the counseling sessions to assure privacy. Although technological advances are often welcome, the use

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of cordless and cellular phones greatly increases the risk that calls may be overheard or tapped by others, which poses a challenge to maintaining confidentiality (Masi & Freedman, 2001).

Although the literature suggests telephone counseling is a cost-effective method of providing peer counseling in rural areas, little is known about HIV/AIDS peer counselors' actual experiences and their perspectives on the different modes of delivery. The qualitative study reported in this article is an initial contribution to furthering researchers' and practitioners' understanding about HIV/AIDS peer counseling formats for reaching rural women.

Study Background and Context

The study reported in this article is embedded within a larger research project designed to test the impact of peer counseling interventions with HIV-positive women living in rural areas of three southern states (Moneyham, 1999). The original study was a randomized clinical trial in which a sample of 280 HIV-positive women were assigned to intervention or control groups. Participants assigned to the intervention group received nine face-to-face sessions with a peer counselor during a 6-month period. The peer counselors traveled to meet with the participants in their homes or other agreed-on locations. The control group received the standard of care provided by the HIV/AIDS service agencies from which they were recruited. Data were collected from participants at three points in time: pre- and postintervention and at 3 months follow-up. The results of the study demonstrated high levels of satisfaction among participants receiving the face-to-face counseling intervention by peer counselors. The rural, HIV-positive women who participated in the research reported that the support they received from their peer counselors could not be obtained from any other source. They viewed the information and support from peer counselors as more credible than even that of health care and social services providers (Moneyham, Murdaugh, & Phillips, 2005).

The results of this larger study provided substantial support for peer counseling interventions to provide rural women the support needed to cope with and manage their HIV disease. The costs of providing face-to-face peer counseling areas, however, may limit the potential for widespread adoption of this model by programs in rural areas with limited resources. In the original study, even though peer counselors were recruited from the

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local area, they still had to drive long distances to meet with many of the women. On average, peer counselors drove 90 miles roundtrip for each encounter, for which they were reimbursed $0.275 per mile, a rate that is low by most standards. The average travel cost per session was $24.75, which may be prohibitive for many HIV/AIDS service organizations in rural areas. The recognition of potential economic and logistic limitations of face-to-face peer counseling as a clinical tool in rural areas led us to explore the option of a telephone delivery format. Therefore, we adapted the peer counseling protocol for telephone delivery and pilot tested the protocol with rural, HIV-positive women (N = 20). Two experienced peer counselors who had participated in the face-to-face intervention provided the pilot telephone intervention.

Regardless of the format (i.e., face to face or by telephone), counseling sessions usually ranged from 30 to 60 minutes. The cost per counseling session differed significantly for the two modes of delivery. There was no additional cost for local calls. Most telephone sessions, however, involved a long-distance call to a rural location. The average cost per call, per telephone session was $4.35, approximately 18% of the transportation cost to deliver face-to-face counseling. It was clear that the telephone counseling intervention was more cost-effective. We were also concerned about other aspects and dimensions of the mode of delivery of HIV/AIDS peer counseling interventions. To further assess the feasibility and effectiveness of the telephone delivery protocol, we undertook a qualitative study to explore peer counselors' perspectives and experiences regarding the face-to-face and telephone delivery formats.

Study Purpose

The purpose of this exploratory, descriptive study was to address this specific research question: What are HIV/AIDS peer counselors' experiences and perceptions of face-to-face and telephone modes of delivery?

Sample

The original peer counseling research intervention involved 8 HIV-positive peer counselors. For the qualitative study, the project staff contacted all 8 program counselors to invite them to participate. Six of the original 8 peer

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counselors were available and agreed to participate. All had provided face-to-face peer counseling; 2 had also participated in the pilot test of the modified telephone counseling protocol. All participants had served as peer counselors for approximately 2 years in conjunction with the larger intervention research project (Moneyham, 1999). They received extensive training in the face-to-face peer counseling protocol and were closely supervised and provided with ongoing training as needed. The 2 counselors who also took part in the telephone counseling pilot study had received additional training related to adapting the protocol for telephone delivery.

The sample of peer counselors ranged in age from 29 to 51 ($M = 41$ years). The majority was African American ($n = 4$), single ($n = 4$), and had been diagnosed with HIV for 10 or more years ($n = 4$). Half of the sample had not completed high school. Prior to becoming peer counselors, half of the women were unemployed, and the other half were employed part-time, primarily in low-paying jobs as unskilled workers. Four reported household incomes of less than $10,000 per year; 2 of these had incomes less than $5,000.

Method

Data collection involved in-depth, qualitative interviews with each of the 6 HIV/AIDS peer counselors. The investigator who conducted the interviews had no prior contact with the peer counselors and was not involved in the development or conduct of the peer counseling research protocol. Interviews were scheduled with the participants at a time and place of their choosing and lasted from 45 to 60 minutes. Written informed consent was obtained prior to initiating the session. Interviews were conducted at a university research center and a community-based HIV/AIDS clinic; two interviews were conducted by phone because the counselors resided in another state.

Use of a semistructured interview guide enabled the investigator to focus the conversation while allowing flexibility to adapt the questions and probes in response to each individual participant. Questions about the delivery mode were tailored to the experience of the peer counselors. We approached participants ($n = 2$) who had conducted counseling using both delivery formats as follows:

> You've had experience doing peer counseling face-to-face and on the phone. Tell me what you think of these two different ways of providing peer counseling. How did your peer counseling experiences over the telephone compare to your face-to-face experiences?

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Questions for those who had only provided face-to-face counseling (n = 4) included

> What do you think it would be like if you were counseling other women on the telephone rather than face-to-face? How do you think the women you counseled would have responded to counseling by phone?

Data Analysis and Interpretation

Prior to proceeding with the qualitative analysis, the interviewer compared the transcriptions with the audiotapes. A feminist narrative approach informed the analysis (Messias & DeJoseph, 2004). Coding techniques included thematic and constant comparative analysis (Strauss & Corbin, 1990). The nature of the research question, an exploration of HIV/AIDS peer counselors' perceptions and experiences of face-to-face and telephone modes of delivery, naturally lent itself to constant comparative analysis. After an initial open coding of each individual interview, the qualitative investigator shared the coding with the other investigators for input and feedback. The next stage of analysis was a focused comparative coding across the six interviews, with the intent of identifying common themes and individual variations. The final stage was a collective refinement of the major themes, an ongoing process that occurred as the investigators interpreted the findings.

The presentation of the findings includes substantial data from the interviews. The participants' own words, originally spoken in the context of the interview conversations, were formatted into sentences and paragraphs. To improve readability, elements of structure were introduced (e.g., order of presentation, punctuation), and some repetitive aspects of oral speech (e.g., *um*, *like*, *you know*) were removed. To protect the confidentiality of the informants, all identifying information was removed or altered.

Findings

The primary purpose of this qualitative study was to elicit participants' experiences and perspectives of two different modes of delivery of peer counseling interventions: face to face and telephone. In listening to the peer counselors, it became clear that their views on the mode of delivery were, to a great extent, related to the social constructions and meanings they attributed to the work of being a peer counselor. Personal experience was

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the basis for participants' descriptions and comparisons of the two modes of delivery for the peer counseling intervention. The perceived advantages and challenges of each mode of delivery reflected counselors' constructions of their role, the ways in which they evaluated the results of their peer counseling work, and their personal concerns and constraints.

Seeing Is Believing: A Clear Advantage of Face-to-Face Peer Counseling

The personal contact and ability for peer counselors and clients to see each other was identified as a clear advantage of face-to-face delivery. Seeing each other offered mutual benefits to counselors and clients:

> I loved the home visit because I got to see who I was talking to. They get to see me. I liked it because I got to express some of my feelings also. There was some ladies that was diagnosed that was in such a great spirit, they actually motivated me before I left. You can tell when you first see a person what type of expression they got.

Personal contact provided peer counselors with information about clients that they thought would be difficult to obtain on the phone. The advantage was not limited to seeing the other person. By having actual contact, peer counselors were able to witness changes in the person's expressiveness and their environment, dress, and demeanor. Face-to-face contact with their clients allowed peer counselors to actually see how their clients were doing and thus judge the extent to which they were making progress:

> When you're talking to someone face-to-face, you can see what they're going through. This [one] lady . . . I can see the difference in her each time. My first visit with her, she wasn't in the best condition; she wasn't the best looking person, health [and] hygiene-wise. As I continued to go and talk to her, her hygiene improved. Her way that she thought about herself was more improved . . . . Each time I came back to her, she was always happy to see me. When she would come here [AIDS clinic] for her doctor's visit, she would speak to some of the workers here and she would talk about me. They said they could see the difference in her when she came for her doctor's appointment. She was dressing better. Her hygiene . . . was better. She tried to help herself more 'cause I encouraged her to go out and to seek help. 'Cause she wasn't doing anything. She was just sitting around not doing anything . . . . Before I left, she had changed, she had improved. I could see it. To be honest with you, I really don't think [it would have been the same over the telephone].

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In the view of this counselor, telephone contact with this particular woman would not have been as powerful as their face-to-face relationship, in terms of impact on the client and the counselor's ability to document change.

Providing living proof through physical presence. Peer counselors constructed their work as intimately related to who they themselves were: women with HIV/AIDS. Providing clients with "living proof" of a woman with HIV/AIDS was an important aspect of peer counseling.

> I mean, once I would tell them, "Well, you know I'm infected too," they were a little more comfortable. The fact that back in '94 I was told that I had 6 months, and here I come to the door and I look perfectly healthy . . . and they're like, "You mean, [you] did what? And you were diagnosed when?"

The impact of the peer counselor's physical presence was enhanced through face-to-face contact. One counselor told a story in which she noted the environmental risks and barriers she faced in visiting a client at her home. But the client valued those efforts:

> I would have to call her all the time to let her know when I was coming, cause she didn't have a phone. I had to contact her through someone else . . . . And the area she was living also wasn't the nicest place to go visit. It was kind of dangerous going there, but I had faith in the Lord that He would protect me and guide me to do what's right. So I wasn't afraid. Each time I went I felt that she seen that I'm coming and [that I] took the time to come to that area . . . . I felt that had a lot to do with it.

One of the counselors who had conducted counseling using both telephone and face-to-face formats noted a sense of mutuality and connection that came out of face-to-face contact that might be difficult to replicate over the phone:

> I loved it that we get to see each others' expressions on faces. I can get feedback better by sitting and talking with someone . . . . I can really tell you're going through something today. But over the phone, you could just tell me anything. I don't know how you're feeling.

Personal preference and style. Personal preferences and needs of specific individuals—both counselors and clients alike—were identified as factors to consider in choosing the delivery format. Some counselors voiced the opinion that they were better able to express their own emotions and experiences in

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person than over the phone: "Monitoring on the phone was good, but I loved home visits." They also identified clients' specific preferences and needs:

> A lot of people are like that [prefer personal contact] . . . like the girl that I was talking about . . . now she was one of them that I think definitely needed the face-to-face thing.

Another counselor recognized that success in reaching a client was not only a function of the mode of delivery but was also associated with clients' being open and ready to accept input and advice from the peer counselor:

> It [telephone counseling] worked good. It would be better face to face; I could at least see the person. But telephone was good . . . . A couple of them, they were very much trying to do better with their life. They believed that from the conversation that we had that I gave them the courage and stuff like that.

The Relational Work of Peer Counseling: Inherent Challenges of Telephone Contacts

Given these peer counselors' strong affinity for face-to-face encounters, it is not surprising they identified lack of personal contact as the primary disadvantage of the telephone format. The inherent barriers and challenges related to telephone delivery included not knowing what the person looked like, difficulty in interpreting and monitoring the clients' situation, the potential for mistaken identity or deception, and the fact that it took longer to develop a personal relationship over the phone. Situations in which clients' "phones kept being changed" created logistical barriers to successful and timely completion of the peer counseling sessions. But clearly, the major perceived disadvantage of telephone counseling was the lack of face-to-face contact and the absence of nonverbal communication. A key concern was that clients would tend to be less honest over the phone or that they could "pretend" to be listening or paying attention but really were not—attitudes and behaviors they felt could be more readily identified in a face-to-face encounter:

> What I'm saying is that people can say anything on the phone. They say, "Okay, got to go." You don't know whether they're really looking at you. For some reason people tend to be more honest . . . when you're face to face and you have developed a relationship . . . . I don't think I could have gotten that had it just been a telephone thing.

The two participants who had conducted telephone counseling sessions identified several specific disadvantages, all related to the lack of actual

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personal contact and interactions. One was the fact that they had never actually met their clients and therefore did not know them:

> I haven't met none of them since the phone monitoring. I wouldn't know who they are [if I saw them].

Yet they perceived they had developed a relationship with their clients and therefore would like to feel they really knew them.

> I would like to meet the ones that I had on the phone. A couple of them I would like to meet because we had a close relationship.

Another challenge was the tacit recognition that "appearances" can be deceiving over the phone. For example, being able to overcome an initial awkwardness was compounded when one counselor was mistaken for a bill collector or telemarketer:

> It was kind of awkward at first because when I would call them on the phone, they just thought I was a bill collector and telemarketer . . . and it took some weeks for them to [relate]. When I started and I said, "Well, tell them Susan called." [The response was] "Oh, they're just a bill collector. Oh, that's just a telemarketer." I'm on the phone, asking for someone and I could hear them in the background [say], "No, tell them I'm not home."

The potential for mistaken identifies was mutual. As one counselor noted, when she had initially contacted clients by telephone to schedule face-to-face encounters, she had misjudged their age:

> It was like 60-, 70-, 80-year-old ladies, and before I set up the visit with them, I'm thinking, "You're like 40; you sound so young on the phone." But when I see you [and ask], "How old are you?" "Seventy-five!"

Those with experience in telephone counseling experienced initial barriers and difficulties in establishing trust and making contact and found it took longer to develop relationships over the phone:

> It was kind of awkward to me at first because I wanted to let them know who they were talking to, and I wanted to see who I was talking to.

Although the initial process was more tentative and it required more patience and effort to make contact and build relationships, counselors found the same

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needs, used similar approaches, and felt the telephone intervention yielded positive results:

> We used almost the same method [on the phone as in person]. You call and you listen, and say, "How are you doing? Are you alright? Anything I can do for you?" [In the peer counseling training] they told us how to ask questions and listen . . . and just be patient. That's what I had to do when I was on the phone. A lot of my clients . . . they didn't want to talk, so I had to ease in, and then they start opening up . . . after about one or two or three times. After I talk to [a person] about one or two or three times . . . after that they . . . knew when I called, they knew it was me. And that was kind of bothering me a little bit, because when I did get to talk to them, they really needed that talk. Three of them had been in and out of the hospital and not keeping up with their doctor's appointments. I just had to go back to the beginning. "Okay, we are going to start these doctor appointments up." So that just made them feel good, to know that somebody was very concerned about them.

Counselors identified other drawbacks to telephone counseling, including difficulties in monitoring clients' progress and interpreting their emotional status:

> It's a difference 'cause when you're talking on the telephone, you can't see their face expressions. But when you in front of them, talking to them, you can see the expressions, see what they're going through. You can hear it on their voice on the phone, but you can't see the expression on their face.

The lack of physical and visual contact created a void that made it more difficult for peer counselors to understand and evaluate how clients responded to the intervention:

> Sometime I thought that I helped her over the telephone; she was supposed to call me the next day, she said she felt better. I haven't heard from her . . . . But there's one thing I know . . . sometimes you just have to sow a seed. You have to give a person the word and hope that they take it, that they hear you, and that it can come back to help them later.

A significant finding was the extent to which peer counselors who had conducted only face-to-face interviews valued the personal experiences they had shared with their clients. Their reservations regarding the extent to which telephone counseling would be meaningful and beneficial highlighted the obvious fact that they considered these personal encounters and

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interactions were very meaningful not only to their clients but also to themselves:

> They can't see your face and understand that you're really feeling what they're talking about . . . . Because a lot of these women needed to cry. You can't hug them over a telephone. And when it's the tear . . . it says you got to do something to restore somebody . . . . You really can't do that [over the phone].

For these women, peer counseling meant more than providing information or advice. Peer counseling was the work of being in personal relationships: "It'd be hard to look at photo albums over the phone." They had been present in the lives of other HIV-positive women, listening to them and witnessing their tears flow. When their words could not express what they needed to say, they gave hugs:

> I don't say that the telephone would be bad, but it's nothing like being able to hug somebody when they need a hug and [her] knowing . . . that "I'm not that bad, because she just wrapped her arms around me."

Potential Counselor Benefits: Personal Comfort and Protection

Despite their overwhelming support for face-to-face interventions, these peer counselors identified potential personal benefits of telephone counseling. These included self-protection and personal comfort. Underlying face-to-face peer counseling with HIV-positive women is the tension between overcoming stigma and discrimination without taking undue personal health risks. A potential advantage of telephone contact was that counselors could protect their own health by avoiding contact with an infectious client:

> My girlfriend said that I shouldn't be going out there to see them, because you don't know when they might be very sick. She kept telling me to put a mask on. [I said], "I ain't gonna walk into nobody's house with no mask on." But [sometimes] they start coughing and coughing, and you don't know. So for my protection, I don't stay too long, if they coughing all over the place . . . . So when they did the telephone [format], I thought about that. I said, "It's better for me."

Another personal and logistic advantage of telephone counseling was not having to drive in extreme weather conditions, such as the summer heat.

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Mixed Delivery Options

In the original intervention study, when peer counselors were engaged in the face-to-face counseling intervention, they contacted clients on the telephone to schedule or follow up on appointments. In contrast, when delivering the telephone counseling intervention, there was no face-to-face contact with the clients. Drawing on their experiences, the counselors raised the viability and advantages of a mixed modality option, in which contacts and counseling could occur both over the telephone and in person:

> My thing is I think it would have been a whole lot better if it was something that was done more so over the phone in the beginning, and then maybe every other time that you'll talk on the phone and then maybe go visit.

An example of an unintended mixed modality was the situation of one counselor who had some previous contact with several of her clients facilitated the establishment of the counseling relationship: "A few of my clients was like real open, 'cause they knew me from the [HIV] clinic." Several also alluded to continuing contact, either in person or by phone, after the formal counseling intervention had ended.

The Work Transcends the Mode of Delivery

Peer counselors identified specific advantages and disadvantages for each mode of delivery but also communicated a sense that the work of peer counseling is more important than the venue per se. They were able to put the mission of peer counseling ahead of the method or mode of delivery:

> I'm open to anything that will help. You know, run behind them and catch them, I'll do it. I'm open to helping other people. Because they help me. When I help other people, they [help me].

> Definitely [either would work]. Because a lot of times . . . they need encouraging words just as much as they need someone in person to talk to.

Although counselors definitely valued and preferred the physical and visual connection, they recognized that it was possible to connect with clients over the phone. Even a strong personal preference or style was not enough for this peer counselor to discard the potential advantages of the telephone format:

> So it's a 50-50 thing. Like I said, there was some of them that I was talking to that probably would have been okay with the phone thing. I'm more of a

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> face-to-face person . . . . I laughed with people all the time . . . . I learn easier with the "show me" thing.

Participants were very pragmatic in their analysis of the two modes of delivery, identifying advantages and disadvantages of both delivery options. When logistic advantages such as convenience were noted, it was more as an afterthought than the principle reason for choosing a delivery format:

> I don't know if we would have gotten the closeness . . . . I think a few of them really needed that eye contact thing . . . . I need to see that there's really [a person] . . . . Its different with [just] hearing a voice . . . . I think some of the people that I was seeing, it probably would have worked okay with them [on the phone] . . . but I think that it was "this is actually a human being that I'm talking to" . . . that kind of helped them out. [Over the phone] it would have been okay . . . . It would have been easier just to pick up the phone and just, "Okay I'm going to call such and such day."

The prime concern and motivator for these HIV/AIDS peer counselors was not the ease, convenience, or cost-effectiveness of the mode of delivery. The essence of their peer counseling work was drawing on their personal experiences to reach out and be with other HIV-positive women:

> I remember when I became HIV positive and how I had no one to talk to. How I was desperate for someone to talk to and then finally I did get someone to talk to. It was another person who had AIDS. I felt that if I could talk to somebody and bring some peace in their life the way somebody brought some peace in my life, maybe I can help somebody. That's why I did it.

Conclusions and Discussion

In interpreting and applying the findings of this study, it is important to note that all the counselors had conducted face-to-face counseling, and they valued the personal contact with "women like me." A very meaningful part of their peer counseling work was being physically present with clients. Personal contact allowed counselors to see clients and evaluate their physical, social, environmental, and emotional status. The ability to evaluate changes in physical appearance and emotional well-being over time was another advantage of face-to-face contact. At the same time, clients could see the peer counselors, who provided them with living proof of women living positively with HIV/AIDS.

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The preference for face-to-face interventions went beyond the issue of individual peer counselor preference or style (e.g., "I'm a face-to-face person") and was based on the significance of mutually shared experience to the counseling process. Peer counselors were quick to point out that certain types of activities (e.g., going to lunch, giving hugs, looking at photograph albums) could not occur over the phone. Their stories imparted a sense that they really had come to know and develop therapeutic relationships with their clients. Although the peer counseling intervention had been designed to benefit the clients, the counselors themselves identified ways in which they themselves derived benefits from the experience. They felt privileged in witnessing transformations in women's lives, which they attributed in part to the peer counseling interventions. The essence of their experience was that the importance and meaning of this valuable work could transcend the barriers created by the mode of delivery.

All participants identified potential advantages and disadvantages of both delivery modes. The 2 peer counselors who also implemented the telephone protocol described ways in which the helping relationship was altered and sometimes hampered by the absence of face-to-face contact. They clearly indicated that they were confident those who received the telephone peer counseling were supported and benefited from the intervention in ways similar to the women who received face-to-face counseling. Despite personal preferences and specific benefits of face-to-face counseling, all the peer counselors were open to exploring the potential viability of telephone counseling and were equally confident in their ability to provide support to women via telephone, despite the recognized limitations of the delivery format.

The findings suggest the potential effectiveness of both face-to-face and telephone counseling formats for rural, HIV-positive women and provide information to guide the development, implementation, and evaluation of peer counseling intervention formats. In the context of this study of peer counseling for rural, HIV-positive women, the telephone peer counseling delivery format was clearly cost-effective. Others have identified increased convenience and decreased cost as the major advantages of the telephone delivery format (Elley et al., 2004; Masi & Freedman, 2001). It is interesting to note these factors did not figure prominently in the experiences and perspectives of these particular peer counselors. Participants did identify a few logistic and personal advantages of telephone counseling, including personal protection from environmental risks and exposure to infection, convenience, and comfort. Despite the peer counselors' HIV-positive status, personal convenience was not considered more important than the benefits of personal contact with peer clients.

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Privacy and confidentiality issues are frequently cited as an advantage of telephone counseling over face-to-face counseling (Coman et al., 2001; Ormond et al., 2001; Wang, 2000). Contrary to what others have suggested, our findings suggest that privacy or confidentiality issues did not impede or detract from face-to-face counseling. In fact, the lack of personal contact in telephone counseling often resulted in mistaken identities and delays in establishing open and trusting interactions.

This research was purposefully limited to a small sample of trained and experienced HIV/AIDS peer counselors who provided an intervention tailored specifically to the context of the lives of rural women with HIV disease. Only 2 peer counselors had conducted the telephone counseling intervention; therefore, the perspectives of the other participants were based solely on their extensive face-to-face counseling encounters with HIV-positive women. The experiences of HIV-positive peer counselors working in other programmatic or geographical contexts and with other populations may differ from those of the participants in this research. Although it is clear that the aim and nature of this qualitative study was not generalizability, several methodological safeguards were in place to allow these experienced peer counselors the opportunity to voluntarily and candidly discuss their experiences and perceptions with a neutral investigator not associated with the larger study or with any HIV support services. These safeguards and the depth and breadth of the qualitative data collected from these experienced HIV-positive peer counselors allow us to present these findings as representative of their views and experiences, a dimension of HIV/AIDS peer counseling interventions that has previously been neglected.

Implications for Research and Practice

These findings suggest the potential effectiveness of both face-to-face and telephone counseling formats for rural, HIV-positive women and provide valuable information for the development, implementation, and evaluation of peer counseling intervention formats. Peer counseling is increasingly recognized as a cost-effective way to provide support services and care for hard-to-reach individuals with HIV/AIDS. Nurses are frequently involved in training and supervising peer counselors. It is important for nurses and researchers to address the potential limitations of the more cost-effective telephone format in providing support to vulnerable populations and to test and implement strategies to increase the therapeutic effectiveness of telephone interventions. From the peer counselors' perspective, the absence of face-to-face contact is

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a potential limitation of the telephone format that warrants the development of strategies that will facilitate connectedness and trust. In developing peer counseling protocols, nurses should consider ways to facilitate connectedness and trust in the absence of face-to-face contact. To mitigate the impact of lack of personal contact and facilitate trust and open communication, these experienced peer counselors suggested the benefits of a mixed delivery modality, such as an initial face-to-face meeting for telephone counseling or a mix of telephone and personal contacts. The feasibility and effectiveness of mixed delivery modalities warrant further study. One option is to provide clients with a picture of the telephone peer counselor and a personal letter in which the counselor shares her own personal experience of HIV disease and the reasons she is a peer counselor. This is a strategy we are currently testing in an ongoing study of telephone peer counseling.

This research highlighted the perspectives of HIV/AIDS peer counselors. Nurses need to provide acknowledgement and active support for the valuable work of HIV/AIDS peer counselors, whether face to face or by telephone. Further research is needed to examine the benefits and limitations of peer counseling delivery formats from the perspectives of the recipients of these various counseling modalities. Working together, nurse researchers, clinicians, and women living with HIV/AIDS can improve the effectiveness and access of peer support programs to women in rural areas.

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