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Altruism and Peer-Led HIV Prevention Targeting Heroin and Cocaine Users

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Abstract

Peer-delivered HIV prevention and intervention programs play an important role in halting the spread of HIV. Rigorous scientific analysis of the forementioned programs have focused on the immediate reduction of risk-related behaviors among the target populations. In our longitudinal study of the RAP Peer Intervention for HIV, we assessed the long-term behavioral effects of a peer-led HIV intervention project with active drug users. Initial analysis of the qualitative data highlights the role of altruism as a motivator in sustaining peer educators beyond the immediate goals of the project. We contend that altruism found in volunteers is an important factor in maintaining long-term participation in HIV intervention programs and initiatives using peer educators.

Keywords

addiction/substance use; altruism; HIV/AIDS prevention; intervention programs; research; mixed methods

Retention of peer educators in HIV/AIDS-intervention projects and the sustainability of peer-driven HIV/AIDS interventions are of critical importance to researchers and federal funding agencies in evaluating the effectiveness of these public health initiatives to stop the spread of HIV infections (Gandelman, Desantis, & Rietmeijer, 2006; National Institute of Mental Health (NIMH) Collaborative HIV/STD Prevention Trial Group, 2007). Potential and ongoing peer HIV-prevention programs must demonstrate their efficacy by adhering to a “best practices” approach and evidence-based methods (Kalichman et al., 2007; Lyles et al., 2007). In other words, prevention programs must prove they work on the target population. A less-frequent method of evaluating peer-driven programs is examining to what extent the program fulfilled the needs of the peer educators and motivated them to continue doing peer education over time. Peer educators are crucial to the success of peer-led interventions; thus, factors that affect their motivation and retention are key considerations in efforts to refine and improve such interventions and to increase the chance for their long-term sustainability.

Two challenges for peer-driven interventions are to demonstrate a positive change in both the target population and in the peer educators themselves (Metzger & Navaline, 2003; Ross, Wight, Dowsett, Buve, & Obasi, 2006; Wingood & DiClemente, 2006). Program results are often tallied by evaluating individual responses to surveys that are aggregated and

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analyzed to show overall changes in behavior at the population level or within the intervention group. The focus of outcome analyses have tended to include adherence to harm-reduction practices (Latkin, Sherman, & Knowlton, 2003), increased motivation to engage in protective behaviors (Broadhead et al., 1998), a decline in risky behavior (Dickson-Gomez, Weeks, Martinez, & Convey, 2006; Hays, Rebchook, & Kegeles, 2003; Knausz et al., 2007; Williamson, Hart, Flowers, Frankis, & Der, 2001), and increased self-efficacy on the individual level (Bryan, Robbins, Ruiz, & O'Neill, 2006; Norr, Norr, McElmurry, Tlou, & Moeti, 2004), as well as increased self-efficacy in members of the peers' social network and community (Kennedy, Rogers, & Crossley, 2007; Latkin & Knowlton, 2005; Weeks, Li, et al., 2009). Programs that can demonstrate changes in individual-level behavior are considered successful, and if successfully replicated, are often given continued support (Gandelman et al., 2006; NIMH Collaborative HIV/STD Prevention Trial Group, 2007). Thus, changes in risky behavior are often the measurement by which peer-driven, HIV-intervention programs are evaluated. However, when considering sustainability of peer-led interventions, factors beyond short-term risk behavior change need to be included in the assessment of success.

Current theory driving HIV prevention using peer educators highlights social learning (Bandura, 1977, 1994), diffusion of innovations (Rogers, 1995), and key opinion leaders (Kelly, 2004) who are culturally appropriate and indigenously useful (Dushay, Singer, Weeks, Rohena, & Gruber, 2001; Singer, Scott, Wilson, Easton, & Weeks, 2001). In these theories, researchers assert that peer educators are better at translating health-prevention and intervention messages for hard-to-reach populations. Training the peer educators in accurate HIV knowledge and communication techniques is given a great deal of emphasis (Broadhead, Heckathorn, Grung, Stern, & Anthony, 1995; Latkin et al., 2003). Peer training programs typically build skills and knowledge in the importance of community involvement (Ramirez-Valles, 2002) and knowledge of harm reduction (Des Jarlais & Friedman, 1998), as well as role playing, positive feedback, and role modeling (Wingood & DiClemente, 2006). The underlying assumption of all peer-led HIV-intervention projects is that the trained peer educator is motivated to do intervention work and "buys in" to the messages and purpose. However, the long-term motivation of peer educators to conduct HIV-prevention activities is in need of additional study. In the Risk Avoidance Partnership (RAP), a peer-driven HIV-prevention and intervention project targeting active drug users, peer educators described many reasons for their motivation and retention in the project. These generally reflected those found in other peer education research such as improved self-esteem and giving back to the community. A common theme woven into these motivations that has received little attention is altruism. In this article we offer a closer examination of the role of altruism in peer education in the RAP project.

Altruism

Altruistic acts are quite common in the history of world cultures (Kimmelmeier, Jambor, & Letner, 2006; Monk-Turner et al., 2002). Altruism is not limited to any particular set of individuals identified by gender, wealth, age, kinship status, or religious or political beliefs; it is found among even the most disadvantaged populations. Altruism includes a vast array of actions from volunteering time or resources to sacrificing one's own life to save another. Altruism incorporates any action that benefits another, even at the risk of the giver's own welfare (Monroe, 1996). For the purpose of this article, we use *altruism* to mean what is typically referred to as "reciprocal altruism," in which benefits confer to givers and receivers (Badcock, 1986). Furthermore, we define altruism as the incorporation of empathy that generates an other-oriented emotional response evoking a motivational state in the giver, with the ultimate goal of increasing the receiver's welfare (Batson, 1994; Yick, 2008). Thus, altruism is induced from an empathetic response to enhance the welfare of another which

generates a benefit to the giver that does not involve a “tit for tat” exchange (Post, 2002). The benefit for the giver is the emotional and psychological well-being generated internally from doing the altruistic act.

The connection between altruism and the retention of volunteers in HIV/AIDS-prevention projects has been shown to be significant in community programs (Christensen, Reininger, Richter, McKeown, & Jones, 1999; Omoto & Snyder, 1993, 1995; Reeder, Davison, Gipson, & Hesson-McInnis, 2001). Some consider volunteers and peers as the founders of HIV/AIDS activism, and see them as instrumental in raising the social conscience of the world in responding to the epidemic (Aggleton, Davies, & Hart, 1997; Gostin, 2004). Studies in which researchers explored the motivations of volunteers and the organizations they work with have shown that they share common or cooperative goals (Batson, Ahmad, & Tsang, 2002). Researchers have recognized that volunteer peer educators give meaning to and place value on their prevention efforts in ways that directly motivate continued participation (Dickson-Gomez, Knowlton, & Latkin, 2004; Ramirez-Valles, 2002). These meanings incorporate the improvement of the well-being of society and community. In one study, drug user participation in an injection drug use research project was linked to duties of citizenship and promoting the health of others (Fry & Dwyer, 2001). Also, altruism was highly associated with peer educators’ motivations in delivering HIV prevention to adolescents (Ott, Evans, Halpern-Felsher, & Eyre, 2003). Overall, research findings suggest that altruism is an important motivation of volunteers.

The Risk Avoidance Partnership

The Risk Avoidance Partnership (RAP) was a 4-year intervention study to train urban, active heroin and cocaine users as peer health advocates (PHAs) to conduct HIV-prevention interventions within drug-using social networks and in high-risk drug use sites in the city of Hartford, Connecticut. Project RAP was based on findings from the “Study of High-Risk Drug Use Settings for HIV Prevention” (Weeks et al., 2001). In the high-risk settings (HRS) study, the researchers explored the environmental and social conditions within the places drug users inject drugs or smoke crack cocaine, and explored the physical and social organization of these locations. The data collected on the characteristics, social organization, natural history, and dynamics of these sites, the network relations of site users, and the various opportunities for on-site social-level HIV-prevention intervention suggested that peer educators would be valuable agents in halting the spread of HIV among active drug users.

RAP, which ran from 2001 to 2005, was designed to train central or influential members of drug-using social networks to become role models of harm-reduction practices to further HIV prevention within the city. A principle goal of the project was to develop, document, and evaluate the effectiveness of the peer intervention approach that is based in drug-using locations and uses peer leaders and drug-using networks for the distribution of HIV-prevention materials and information. Using a harm-reduction framework, 112 PHAs were trained on the prevention of HIV, sexually transmitted diseases (STDs), and hepatitis, as well as health promotion, role modeling, and effective communication techniques (Weeks et al., 2006). Through the efforts of PHAs, harm-reduction messages and products designed to promote risk prevention were brought to the settings in which PHAs carried out their daily activities. Through surveys, ethnographic observation, and tracking of peer-led intervention activities, the RAP study evaluated the efficacy of this prevention approach (Dickson-Gomez et al., 2006; Weeks, Convey, et al., 2009; Weeks, Li, et al., 2009).

The longitudinal extension of RAP, conducted from 2005 to 2008, investigated the long-term results and impact of the initial intervention. Qualitative data from the longitudinal

extension highlight the importance of fulfilling desires of PHAs to be altruistic, and to conduct prosocial actions as well as other motivating factors that helped in retaining and sustaining peer educators in the intervention and prevention project. The PHAs who stayed involved in RAP, and those who withdrew, were interviewed about their experiences and their motivations to participate. Not all of the PHAs who were initially trained in the project stayed actively involved in peer education after the initial participant compensations ended. The number of active PHAs diminished over time, leaving a core group of about 40. We define “active” as continued involvement in monthly meetings and occasional restocking of supplies. To assess the long-term sustainability of RAP, eventually relying on volunteers, it was important to determine the factors surrounding PHA retention.

Methods

The PHAs were selected based on characteristics that reflected Hartford’s drug-using populations, including drug of choice, ethnicity, and neighborhood of residence. The project staff identified potential PHAs through the prior HRS study (Weeks et al., 2001), street outreach, and ethnography. The selected candidates were drug-use-site gatekeepers, or central members of a drug-using social network. Prior to any interviews, each candidate signed a consent form approved by the Institute for Community Research’s Institutional Review Board, which described any risks associated with their participation in the study. Recruitment was conducted in 28 cycles over a 2.5-year period starting in the month of December 2001, resulting in a minimum of 2 and a maximum of 7 participants per cycle. On average, each cycle had about 5 participants. A cycle included a week-long training, five field sessions with a staff member, and follow-up interviews. The week-long RAP training, held Monday through Friday in daily, 2-hour sessions, covered information on the transmission and prevention of HIV, STDs, and hepatitis so PHAs could effectively educate their peers. It also focused on persuasive communication techniques and effective role-modeling practices based on harm-reduction principles. Another five field sessions, each lasting about 2 hours, were conducted over the subsequent 3 months. Field sessions were held with a staff member and centered on community outreach, often conducted in neighborhood areas or with people with whom the PHA was familiar. After the partnered sessions, PHAs were expected to continue peer-education efforts on their own time. PHAs continued their training by attending monthly community advocacy group (CAG) meetings that focused on community health issues faced by urban drug users, to promote community-level health education and conduct public health advocacy. CAG meetings continued over a 7-year period, which included the 2.5 years of PHA training cycles, followed by nearly 5 years of follow-up research.

The PHA-delivered intervention was divided into three components: materials, education, and demonstration. Materials consisted of bleach kits for injection drug users (containing bleach for disinfecting syringes, sterile water, cookers, cotton, twist ties, antiseptic, antibiotic ointment, and condoms), crack kits for crack cocaine smokers (containing rubber tips for prevention of burns and cuts on the lips and hands, antiseptic, antibiotic ointment, moisturizing lotion, and condoms), male and female condoms, dental dams for oral sex, and topical health-related pamphlets. Education covered common infectious diseases associated with drug use and unprotected sex, harm-reduction practices and philosophies, knowledge of social services, and project-unique educational slogans. A typical demonstration might be showing the proper techniques to clean syringes or how to use condoms. The project supplied all intervention materials to PHAs, who participated in making the bleach and crack kits and were compensated for their time. They were given a backpack to carry their supplies and were instructed to distribute their prevention materials; demonstrate how to use them; and educate their peers, other drug users, and other people in their networks and their

community. These three components—materials, demonstration, and education—were the main tools PHAs used to help their peers and their community.

Of the 112 PHAs who finished their training and began peer education, 40.2% were Puerto Rican, 4.4% were White or non-Hispanic, and 55.4% were African American; 37.5% were women; 48.2% considered themselves homeless; 59% earned less than \$500 per month; 67.9% smoked crack; and 41.1% injected heroin or cocaine. The mean age of the PHAs was 40 years. This reflected the general characteristics of Hartford intravenous drug users and crack smokers. Qualitative and quantitative assessment data indicated that active drug users were able to engage other active users in conversations about their HIV risk-taking behavior and disseminate harm-reduction materials and education in a variety of settings and at various times (Dickson-Gomez et al., 2006). Additionally, PHAs reduced their own harmful behaviors and increased their safety, health, and well-being, and influenced their peers to do so as well (Weeks, Convey, et al., 2009; Weeks et al., 2006).

We used a mixed method strategy to evaluate the intervention, using both quantitative and qualitative research methods during the initial RAP project. Quantitative surveys were conducted at intake and 3-month (posttraining) and 6-month intervals with the PHAs, and at intake and 6-month intervals with PHA-recruited peers (called contact referrals, or CRs). These surveys measured individual behaviors and tracked changes in risk, attitudes, gender, and drug use of PHAs and their peers, and documented exposure within the networks of PHAs and CRs to the RAP PHA intervention. We also asked PHAs to keep track of their intervention activities and the materials they distributed by filling out encounter forms. Quantitative data in the RAP longitudinal study were analyzed using SPSS software. The longitudinal followup also assessed the sustainability of the intervention tested in the initial phase of the project. Quantitative data included a third risk behavior and network survey to assess sexual- and drug-risk behavior, harm-reduction knowledge, the PHAs' continued involvement in RAP peer education activities, and the CRs' continued exposure to the RAP intervention.

Qualitative data collection in the initial RAP project included field and site observations, training observations, PHA-partnered session observations, ethnographic interviews, and in-depth analysis of drug user daily activities. Sources of qualitative information included the PHAs, their peers, and other active drug users in the community, producing material covering preintervention, process, and postintervention data. A total of 62 in-depth interviews were conducted with RAP participants, which reflected the ethnic diversity of the city and represented differences in both gender and sexuality. From more than 130 observations, participant activities surrounding training, partnering sessions, visits to drug use sites, and daily regimens were recorded. Topics explored in observations and interviews included harm-reduction practices, PHA communication techniques, the community's receptiveness to the intervention, PHA social relationships, individual and peer drug-use practices, changes in behaviors, and other important intervention goals. In the longitudinal extension, qualitative interviews were conducted with 33 PHAs to determine their current activities related to PHA work. Questions posed during the in-depth interviews covered topics such as retention and nonretention in PHA work, motivations, current activities, changes in behavior, changes in drug use, PHA work experiences, and current life circumstances such as employment and living arrangements.

All interviews were recorded and transcribed verbatim, with personal identifying information removed. Observation notes, field notes, and transcribed interviews were entered into and analyzed with Atlas.ti computer software (Muhr, 1997), using thematic codes reflecting the goals and hypotheses of the project. Documents were first coded for demographic and other identifying factors such as gender, ethnicity, and the type of data

gathered. After the preliminary coding, interviews and observations were coded for content. Theoretical concepts and patterns in the data generated deductive and inductive key themes and codes. Reports of coded text were reviewed and manually coded a third time to additionally define and categorize emerging themes. In this article, all participants are identified with pseudonyms. All protocols for the recruitment of participants into the study for intervention training and research activities, and all measures, instruments, and interview guides were reviewed and approved by an institutional review board.

Findings: Altruism and PHAs

Results from the qualitative data revealed that altruistic motivations commonly appeared in narratives concerning HIV prevention and PHA work. Keywords or phrases such as *helping*, *giving back*, *donating*, *volunteering*, and *help others* were used to articulate altruistic reasons for continued PHA activities. As previously noted, altruism can be reciprocal or empathic, and can include any action that benefits another person's welfare (Badcock, 1986; Batson, 1994; Monroe, 1996). An African American woman, described how RAP affected her and gave her reasons for staying active as a PHA:

I found myself getting more involved with my neighborhood; they know me as the "condom lady." They know that I've been there. They can get their condoms or sit down and talk to me about whatever. But they come by and they get their condoms and they ask me questions, and I think they got their eyes on me. ... Because they can't believe they have someone that's really concerned about what they're doing, you know. And they can come any time; if I'm asleep I wake up because I remember being out in the street and I didn't have anybody to talk to. Being out there, some things happen to you and you have nobody to go to, so I always wanted to do that type of work, so now my room is like an open door, they come by any time.

Not only did peer educators share common qualities such as ethnicity, gender, drug of choice, and age with their peers and community, they also shared common experiences. These common experiences provided peer educators with empathetic motivations to help others like themselves. Listening to peers' and community members' stories provided PHAs with opportunities to show concern and compassion, and even share the wisdom gained from their own personal experiences. PHAs often described typical interactions among fellow drug users as being goal-oriented and narrowly focused on motivations for obtaining drugs or resources for buying drugs. They often reported finding these activities unfulfilling and empty, without purpose. The altruistic nature of PHA work changed that by creating a new activity that benefited others, and which they also enjoyed doing. The woman continued:

I'm no expert. I have to go with my feelings. I think that's why I enjoy it so much, because if I can feel it, I can feel that person or feel the connection. Whether or not they got it, I got something out of it.

Most of the peer educators in RAP reported positive experiences while doing intervention work (Dickson-Gomez et al., 2006; Weeks et al., 2006). Negative experiences were commonly associated with bad timing (approaching other drug users when they were on their way to get high) or people not listening to them. When peer educators found appropriate audiences, there were few problems.

Individual Actions of Altruism

Surprisingly, some PHAs continued their work even after their paid, partnered sessions ended. Their continued peer outreach suggests that they found value in the work they were

doing. A Puerto Rican woman said the following about her boyfriend, a PHA who had recently passed away from AIDS:

Juan was different. Different because he always wanted to go out there and talk to people. You know? Like you know, some people say they want to do it, probably they do it just for the money or whatever. But not him. ... A lot of people don't like to do things to help other people, you know? They think about themselves. So at first I was a little upset because I'm like, now you got to carry condoms all over you and, you know, I used to be jealous over it, but then when he spoke to me about what's going on, and I'm like, I respect that because he's trying to help somebody.

Gaining satisfaction from helping another person was the most frequently mentioned motivator in continuing HIV prevention among the PHAs. Of significant reward was that their efforts could save another person from contracting a deadly disease. An African American man said the following:

I feel like I saved somebody's life. Like, okay. This is how I feel. Like when I give out condoms, bleach kits, crack kits ... I saved somebody's life, like getting STDs, getting AIDS. I feel good by just like helping people. You know.

The PHAs who stayed involved in RAP recognized that their individual actions contributed to stopping the spread of HIV in their city. PHAs realized they were not only reaching out to individuals, but were impacting the larger community as well, as each one-on-one engagement with a peer built upon the last. The spread of HIV in ethnic, urban communities is still increasing, and tackling that issue is a formidable task for one person. For the PHAs, tackling the problem on an individual basis by helping one person at a time was a more evident accomplishment.

Most of the PHAs knew at least one person who was living with HIV or who had died from AIDS. Being able to personalize their peer education and to relate to the goal of stopping the spread of HIV aided many PHAs. An African American woman said the following:

Well, because I had a lot of family members that had AIDS and that used to share needles way back in the days before all this stuff came out, and all this research was done, so I thought it was great if I could stop another person from being in that situation.

Even though a PHA could not change the fact that a friend or family member had already contracted HIV, the PHA could at least stop someone else from getting it. Contributing to the fight against the spread of HIV was a new experience for most of the PHAs. They were frequently surprised by the good feelings that were generated in the community when they spoke to their peers during their efforts to help. They found these feelings rewarding; the rewards were an unexpected result of their actions and motivated them to continue their PHA work.

For those peer educators who were HIV positive, being a PHA, finishing the RAP training, and continuing to be an active PHA became their contribution to the worldwide efforts to stop the spread of AIDS. One of RAP's oldest PHAs was an African American veteran who was HIV positive. Although he passed away before our longitudinal study began, a good friend of his had the following to say:

Tim was probably sixty-two years old, and I think [RAP] motivated him. He got himself involved in something I think he could handle, that he could, for himself, understand, and also feel like he was doing something good for someone else. And that's really Tim. His heart's in the right place and he was pumped [to do the

work]. I could tell he was kinda psyched about it, that's all he talked about. So, I think it was a very positive thing for him. I think he felt he was doing something useful and he was also a part of something bigger. Those are the two key things I think that he probably got out of it. The fact that he could go out and do something for someone else, or by him sharing something with someone else to help them, I thought it was very motivating for him.

It was clear that Tim was dedicated to peer education; he seldom missed opportunities to educate his friends and strangers about risky behavior and harm-reduction practices. The only times he was not actively involved were the times he was hospitalized because of poor health. Many PHAs who were infected with HIV found peer education a perfect match for fulfilling altruistic desires to fight the spread of the disease in the community. In a similar way that psychotherapy uses self-help groups and peer-support groups as part of treatment (Davidson et al., 1999), peer education uses a shared characteristic between individuals that creates empathy and opportunities to be altruistic.

Altruism and Change in the Context of Poverty

Most of the PHAs had little income and low levels of education. Inner-city, impoverished drug addicts are typically portrayed, and often see themselves, as being derelict, immoral, and not socially conscientious. Most of American society views active drug users as being incapable of making and simply unwilling to make any positive changes in themselves, and therefore in the community (Blendon & Young, 1998). The RAP training was designed to counteract that perspective and build participants' self-efficacy to engage in and promote HIV prevention. For some PHAs, altruistic actions resulted in a significant change in their self-esteem, as noted by a Puerto Rican woman:

I'll tell you one thing: To be honest, everything has gone great for me ever since I've been doing it. Everybody's been nice to me. I haven't had nobody say stupid things about it or nothing. They're concerned, 'cause if anything, they're more concerned and wanna be involved too. And I like that. That makes me feel more, that I am doing something out there. I'm out there for something. I'm not there just to waste time and go ... I have something good to do now. Something I always wanted to do.

Several PHAs mentioned that they always wanted to volunteer and give back to the community, or help others in need. However, they often left these desires unfulfilled, thinking that others would not want them to help because they used drugs. The RAP project facilitated their ability to act altruistically. This realization was most frequently mentioned during interviews and in observational data from the PHA monthly CAG meetings. A select few even took their altruistic activities beyond peer education and started becoming more active in other ways in their community through political rallies, speaking with politicians, attending community and church events, and even donating goods to hurricane victims during the flooding of New Orleans. Not only did PHAs change their views of themselves through this process, but others in the community, friends, and family members noticed what they were doing. A Puerto Rican man said this about his PHA work:

It felt good though, because people look up to you. Even though they know you may use drugs, but they saw you doing something positive within the community, so they would [say], "God, that's kinda nice what you're doing." They would ask questions, because they knew me, from the shelter and whatnot. I've always been generous, you know, and helping.

Homeless, impoverished, drug-addicted individuals are seldom considered as being generous and helpful. Positive feedback as well as recognition fueled the PHAs' sense of fulfillment and provided motivation to continue these efforts.

Do Unto Others

A few PHAs acknowledged that helping others in the community also helped to change their own feelings of well-being. As mentioned previously, altruistic acts can be reciprocal. A Puerto Rican man described how he felt:

I love it because you meet people. You get to talk to people and help them out, you know, giv[ing] out materials is a lot of help you know, the condoms and the smoking kit, and all the things. You get to talk to them and they feel better because some of these people, sometimes they feel depressed. You know they get high and they get depressed, they run out of money, something else, how they feeling that day, you know, I like to help them out, you know. It makes me feel good and they feel good too, you know.

Many of the PHAs who continued to be actively involved in the community doing peer education recognized and placed value on their own good feelings generated by doing HIV prevention.

Not only did PHAs act individually, they often coordinated their outreach in pairs or larger groups. PHAs did this on their own initiative or at the monthly CAG meetings for the PHAs, an ongoing support mechanism that encouraged continued involvement in HIV prevention. Without prompting or intervention from the project staff, PHAs paired together and engaged schools and community groups by offering their time to conduct free HIV-prevention education. Collectively, the CAG meetings provided a venue at which PHAs could share their experiences with each other. Occasionally, PHAs organized their prevention efforts into altruistic group actions such as attending rallies to improve health care access for the impoverished and to prevent funding cuts to community health programs, and participating in community health fairs. PHAs reported that they felt the CAG meetings were an enhancement of the volunteer and peer-education efforts. One PHA, an African American woman, said about the meetings, “I keep getting inspired.” A Puerto Rican man said, “[It] keeps me on point as far as what is going on, and up to date on the new things that are out there, and how we are progressing as far as being a group of people doing and wanting the same thing.” Their comments suggest that the interaction among PHAs at the CAG meetings created a supportive feedback loop, whereby seeing each other’s continued interest in doing PHA work was mutually reinforcing. Much like individuals in volunteer organizations, peer educators need coordination with like-minded individuals doing the same work. The fellowship generated from group meetings contributed to motivating PHAs in their peer-education activities.

Challenges for Retention

As indicated above, not all PHAs continued their outreach activities beyond their partnered sessions with staff. All 10 of the 2-hour partnered sessions included a \$20 payment to the PHAs; once the payments stopped, some PHAs lost interest in peer HIV prevention. “I was in it only for the cash,” said one African American man. “I wasn’t motivated anymore. I just didn’t feel like being a part of it,” said a Puerto Rican woman. In these cases, altruism was either insufficient as motivation to continue or was never a motivating factor to begin with. Sobriety was another reason some discontinued PHA activities, as one Puerto Rican woman indicated: “I don’t hang around those people anymore.” A common theme in addiction-recovery programs is avoiding the places, people, and situations that lead to drug use. Peer education was most frequently based in drug use sites and in areas where active drug users congregated. Some PHAs who quit using drugs had cut all their ties to people and places associated with their own drug use, making PHA work undesirable for them. A number of PHAs simply lost interest in doing peer HIV prevention. An African American woman said the following about her PHA work:

I haven't done [PHA work] in a while. Jerry has been having a little trouble with his heart and stuff. His heart is not so strong. And they can't seem to find out what's causing a lot of his problems and things. And then plus I'm into other things right now, too, so I don't really have the time to devote to stuff like that.

As with many things, the passage of time changed priorities and life circumstances that affected some PHAs' motivation to continue peer education. Other circumstances could also change; some PHAs secured jobs and housing, whereas others experienced arrest and incarceration. An African American man described what happened to him and other PHAs he knew:

My life is changed. But basically being able to like having stable housing, I'm able to avoid certain crowds. I've been doing a lot of odd jobs trying to keep busy. I keep up on my rent. Now being in my own place, I'm not as frequently out as I used to be. I've been moving on, moving on. Trying to. I gotta be responsible now. I gotta keep a roof over my head. So my life has changed since I have become stable. And a lot of people dissipated, either different institutions, cities, whatever. Different situations arise. There was this other guy, his name was Ricky, He has been locked up. And there was another guy, Mac. I don't think he comes down here anymore. But most of the group that I used to hang with down in this area, they all went their separate ways and have gone. So I have barely seen anyone doing PHA work.

Illness or hospitalization were other barriers to conducting peer intervention. A Puerto Rican woman said the following when asked why she stopped:

When I was sick, I really wanted to but to actually get up out of bed, it was too hard. I was laying in bed all day. People wanted me to get up out of bed and they wanted to talk more, but I just didn't have the energy to be PHA anymore.

A Puerto Rican woman described her absence from doing PHA outreach:

I had been doing real good but then I was sick at the hospital, I was sick at the hospital again last month, so last month I didn't go out at all. Because, I usually talk to [people] almost every day when I get off the bus. So this month, I started back again in May because I was sick last year. I was in the hospital [with] pneumonia, no oxygen in my body, and my asthma attacks [were] really bad.

A few PHAs became too ill to do peer education and, regrettably, some passed away during the study period.

To date, out of the 112 PHAs we trained, 6 have passed away, 13 moved out of state, 11 went to jail, 5 secured permanent jobs, and 6 withdrew from RAP because they stopped using drugs. Most PHAs discontinued peer education because they did not gain any benefit from doing the work after the payments stopped. Thus gradually, over time, active PHAs dwindled in number. Similar to volunteers, peer educators experienced changes in their lives that made participation impossible. This does not necessarily reflect a lack of interest or a change in motivation. The training cycles stopped because of the end of funding, and no new PHAs replaced the ones who were lost. However, after 7 years, there did remain a group who continued peer education, either directly through the project or independently.

Discussion

Critical to the sustainability of a peer-delivered HIV/AIDS-prevention program is the retention of the peer educators. However, little attention has been given to what motivates and sustains their efforts in peer-driven interventions. Appropriately, the initial process

evaluation of a peer-led intervention focuses on the information, education, and knowledge exchanged between the educators and their peers. This is extremely important to assess the accuracy of HIV prevention delivered and adherence to harm-reduction practices. Likewise, outcome evaluations focus on the efficacy of peer intervention to reduce HIV risk and transmission, and the retention of knowledge and practices over time. Equally important in evaluation is an investigation of the sustainability of the peer-led intervention.

Studies of volunteerism are ideal for answering some of the questions about the sustainability of these programs. Most peer-led interventions are initially driven by monetary compensation for peer educators, as both a lure to participate and to compensate them for their time. Early analysis of retention is therefore challenging. Peer educators might say they have an interest so as to secure additional monetary fees, but already know they will not continue doing education when the monetary incentives of the project come to an end. When payment does end, peer educators must be willing to continue their work on their own initiative. Because most peer-based interventions largely work with economically or socially marginalized populations, the ability of these trainees to do volunteer work might be seriously curtailed as other daily life activities demand attention and take priority. Thus, many peer educators abandon their activities when monetary compensation ends, and the interventions become largely limited in scale and duration.

Many social, nonprofit, and volunteer organizations also experience dropout, drift, and burnout among their staff of volunteers. This is so common that these organizations are always looking for new people to volunteer. Volunteers also experience changes in life circumstances, new demands on personal time, and new responsibilities, or they simply move out of the area. These changes should also be expected in peer-led interventions working with any population. In our investigations we found that many of the PHAs had obtained permanent jobs, moved out of the area, or had stopped using drugs in the period of assessing the RAP project and sustainability of PHA activities. Other PHAs went to jail or lost interest in continuing their work. Thus, the long-term impact a finite number of peer educators can have is limited to those educators who continue to engage in HIV-prevention activities. As the population of peer educators decreases over time, the impact a peer-driven intervention has on a target community will most certainly diminish. Thus, the stock of peer educators should be replenished to maintain an intervention's effectiveness over time. Additionally, identifying for those peer volunteers the benefits of continued altruistic acts to self and others might encourage their continued efforts.

Altruistic acts offered PHAs in RAP rewards that were reciprocal and fueled their motivation. Peer education offered them a way to help others and, at the same time, feel good about themselves. PHAs began to search out opportunities in which to do peer education regularly. Understandably, these opportunities did not demand significant resources from the PHAs. The RAP project provided them with the materials and training necessary to do their work. Additionally, it was anticipated that peer education and outreach would be easily integrated into the daily routines of PHAs. Nonetheless, many PHAs drew pride from their work and took it seriously, and went beyond their daily routines to engage in it. Many PHAs and project staff indicated that if peer education saved one person from contracting HIV, peer health advocacy was considered successful. As several PHAs mentioned, they were doing their part to help stop the spread of the virus.

Shared goals of altruism are important to volunteers and peer educators in assessing motivation. It would therefore be beneficial to recognize this early in the construction of peer-led interventions for several reasons. First, in intervention projects, more retainable peer educators could be selected by exploring whether or not the candidate shares goals with the sponsoring organization. Second in intervention projects, peer educators who believe

altruistic volunteer work might be rewarding could be sought. Third, promoting ongoing opportunities within the intervention project for peer educators to be prosocial might continue to motivate their participation and increase the chances for higher retention rates.

Findings from the RAP study highlighted some challenges for peer-led interventions. Peer education was not appealing to all drug users the project staff tried to recruit. Nor did all of the peer educators continue their work after their training was done. Peer programs can expect dropouts, burnouts, and loss in their ranks of peer educators. In response, the loss would require the recruitment and training of replacement educators. A one-time peer intervention would likely not be the final solution. However, ongoing replacement is often hampered by the time-limited nature of research projects and other funding and resource limitations. Eventually any program will lose educators and momentum over time. Continued peer education must offer peers rewarding and meaningful experiences so at least some become self-motivated beyond the period of program activities. To continue their efforts, peer educators must identify with or “buy in” to the overall solution of the intervention. This must be built into the design and the long-term operational plan of peer-led interventions.

Finding altruism among active drug users’ motivations for doing peer education should not be a surprise, though it might appear counterintuitive in a group that is often portrayed as lacking in skills, resources, and interest in bettering themselves and helping others. Perhaps this is a key to understanding why peer education can be successful: it taps into altruistic feelings that have not been substantially encouraged or fostered before. Like most people, drug users thrive on the sense that their lives have meaning; altruism generates positive feelings that produce this sense of meaning. Researchers have reported that altruism is related to improved health in older adults (Brown, Consedine, & Magai, 2005) and psychological benefits such as improved self-esteem (Kennedy et al., 2007; Seelig & Dobelle, 2001). Altruism, more commonly associated with conferring a benefit to others or improving the welfare of another, can also incur benefits for the donor, even if the benefit is to gain satisfaction from helping society or another human being. The opportunities of altruism found in peer education are even more important to those who typically feel worthless and have low efficacy to change their lives or the lives of others. The promotion of altruism is important in peer-driven HIV-intervention and prevention projects to enhance motivation and increase the likelihood of long-term sustainability of peer activity.

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