
Peer-led intervention design to reduce risk-taking behaviour among young drug users

This training module, for the use of resource persons, is made for training trainers, outreach and field workers of agencies engaged in prevention of substance abuse related HIV in community settings. Early intervention in the drug using life of users is seen as an important component of reducing risk-behaviour - hence the need for bridging the gap between substance users and service providers.

Assessing the vulnerability and resources in the site of the intervention is a preliminary step. Identifying key stakeholders, mobilising the community through setting up a committee of concern, and giving ownership of the intervention sets up the enabling environment. Networking the service providers, stressing on a “two way” referral, a referral system of services needed by substance users in their journey to treatment and rehabilitation is set up. This intervention can then be seen as one of a basket of services provided to the substance users. This phase is relevant only for an initial set-up of a peer-led intervention in the community.

In phase two, substance users are engaged into reducing risk behaviour and in phase three provided access to services to bridge the gap between users and services. Support groups/self-help groups are set up to provide continued support to users who have reduced risk-behaviour or who are have completed medical treatment.

These components of phase two and three are ongoing, and continue beyond project life. While the time-lines described and indicators mentioned in this manual relate to a study/intervention done by UNODC ROSA’s Project ADRAS02G23 “Networking for reducing risk taking behaviour related to HIV/AIDS amongst young drug users of South Asia”, each community and intervention agency would have to decide the time required for each phase of the peer-led intervention. In the same vein, indicators for reduced risk behaviour should be developed in partnership with users and the community.

Definitions

Risk

WHO defines risk in relation to HIV as the probability of contracting HIV. It deals with the person’s own perception of probability of getting HIV.

Risk behaviour

Risk behaviour is defined as “specific form of behaviour, which is proven to be associated with increased susceptibility to a specific disease or ill-health,” (in this case, HIV).

Risk behaviour in relation to drug abuse and HIV/AIDS

Following is an abbreviated list of risk behaviours in relation to drug abuse and HIV/AIDS

- Substance use (any kind),
- Injecting drug abuse, particularly sharing of unclean injection paraphernalia; direct and indirect sharing,
- Having multiple sexual partners,
- Unprotected sex.

Risk-reduction

Risk-reduction in relation to drug abuse and HIV aims at interventions that increase risk-perception and encourage and sustain changes towards healthy behaviour. These interventions are designed to bring about a change at four levels:

1. Individual;
2. Interpersonal (between self and other persons in the social network of the drug user, norms of a sub-group);
3. Community (peer opinion, social norms, working together);
4. Socio-political (drug demand reduction policy, or HIV/AIDS prevention policy, law enforcement policy).

Research has shown that whether individual drug users attempt or achieve behaviour changes often depends on whether these changes are endorsed or encouraged by their peer group. Research also suggests that an individual's attempts at, e.g., condom use, are considerably easier when there exists a peer group norm which is supportive or accepting of condom use. If "safety norms" exist they make it easier for individuals to initiate behaviour change. A norm of healthy drug use and sexual behaviour is needed.

Behaviour change approaches

This intervention adopts a range of approaches to achieve change in risk-behaviour:

- Behaviour change communication (BCC),
- Participatory learning and action (PLA),
- Information advocacy.

BCC is an interactive process with communities (as integrated with an overall programme) to develop tailored messages and approaches using a variety of communication channels to develop positive behaviours, promote and sustain individual, community and societal behaviour, and maintain appropriate behaviours. The basic framework in diagnosing a community, group or individual

and bringing a change in behaviour is based on the following hierarchy/stages of change (where applicable):

Unaware
Aware
Concerned
Knowledgeable
Motivated to change
Practicing trial behaviour change
Practicing sustained behaviour change

It is used in this intervention to:

- Increase perception of risk-behaviour,
- Develop the skills and capabilities of young drug users to promote and manage their own health and development,
- Foster positive change in youth behaviour, as well as in their knowledge and attitudes,
- Work in partnership with families, law enforcement officials, health services and communities to influence the social norms and policy environment within which young people function.

BCC strategies at the community level use participatory community and social change techniques to involve communities at the local level.

Participatory learning and action approaches (PLA) are used to gain community acceptance at project entry and as formative research to obtain qualitative data. PLA fosters community decision making, which helps ensure that change is facilitated and grown from within, rather than dictated by outside sources. PLA approach would be used to achieve the formation of partnerships of key stakeholders.

Information advocacy is used to introduce effective and evidence based interventions for risk-reduction related to drug abuse and HIV.

Peer Education

Peer education typically involves training imparted by a member of a given group to effect change among the rest of the members of the same group. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual level. However, peer education may also create change at the group or societal level by modifying norms and stimulating collective action that contributes to changes in policies and programs. Worldwide, peer education is one of the most widely used strategies to address the HIV/AIDS pandemic.

Peer education has been used extensively in different settings for the reduction of risk-taking behaviour related to drug abuse and HIV/AIDS. The basic premise in using peer group members as peer educators revolves around the belief that young people learn about drug use and sex from their peers. The corollary that these peers can influence social norms in their respective peer group is tested in this intervention model.

In some instances, in literature, “peer educator” is an ex-user who is not a member of the peer group where an intervention is in place. In other instances, “peer educator” is used for a current user of a peer group who not only is used for intervention within his/her peer group but as an outreach worker for intervention in other peer networks.

In this peer-led intervention design, the term “peer outreach worker” is used to describe a staff member of the intervention team who is either an ex-addict and not a current user, or a non-user field worker. The term “peer volunteer” is used for a person who is a current user and who is willing to be recruited for risk-reduction intervention and volunteers for training members of his/her peer group into risk-reduction practices. The “peer volunteer” may **not** be used as an outreach worker outside his/her own peer group.

Peer-led intervention to reduce risk taking behaviour – The design

Interventions designed for peer-networks are based on several social change theories. The networks that exist are:

1. Closed networks,
2. Semi closed kin networks,
3. Semi-open networks,
4. Open peer networks.

The peer-led intervention in this intervention toolkit is designed for semi-closed and semi-open networks. The intervention is designed in four phases: preliminary phase, phase one, two and three.

Preliminary Phase

This phase assesses the situation, provides a sensitisation programme for stakeholders to use evidence based interventions and a comprehensive prevention programme to address drug abuse and HIV, selects the agencies for the intervention and trains the service personnel in a training of trainers’ programme based on this manual.

Phase One

Phase one deals with creation of an enabling environment for the intervention and flows into phases two and three. It maps the vulnerability of drug abuse related HIV and resources to respond, and sets up the referral network for providing access to services. It mobilises the local community to own the problem of drug abuse and related risks, sets up committees of concern consisting of key influencers and then lays the ground for sustaining the intervention after project life. A baseline assessment instrument has been designed to document knowledge, attitudes, and practices of current users in phase two. This instrument is translated into the local language, and then by a person not familiar with the original instrument, translated back into English; this translation is compared to the original instrument to test the correctness of the first translation. Key informant interviews and focus group discussions are carried out with key influencers and stakeholders to get an assessment of the local situation and inform them about the objectives, activities and implementation arrangements for the intervention. This facilitates the ownership of the intervention at the local level. A committee of concern is established at every site.

Objectives of Phase One

- To establish a network of key stakeholders in the community to facilitate various activities under the project such as:
 - Establishment of committee of concern;
 - Create/strengthen the existing referral system in the community;
 - Organise a community meeting and publish the findings of the vulnerability map.
- To create a resource and vulnerability map of the locality in terms of drug abuse and high-risk behaviours among young people and assess the need for outreach.

Activities

1. Identify key influencers (stakeholders) in the community and set up a committee of concern, map the vulnerabilities and resources to respond, and create / strengthen the existing referral system in the community.

Committee of Concern²

The committee of concern (COC) supports and acts as a prime mover to reduce risk-taking behaviour associated with drug abuse and create an environment for health-seeking behaviour. COC would have key influencers - opinion leaders, politicians, bureaucrats, local administration and law enforcement personnel, health care service providers, NGO staff, youth leaders, religious

² Committee of concern has been successfully modelled by Project IND/E41 “Community wide drug demand reduction in the North-eastern states of India”, a collaborative project of Ministry of Social Justice and Empowerment, Government of India, and UNODC, Regional Office for South Asia. While IND/E41 modelled the COC at the state/province level, RAS/G23 modelled a COC at the level of a community.

leaders and those affected/afflicted by drug abuse and HIV. Committee of concern would have a chairperson and a small executive committee of six or seven active members, which would steer its activities. Though volunteers would staff it, its task would be to ensure that project activities are implemented smoothly. Simultaneously they would also help in development of referral systems and access to drug abuse treatment.

The COC is formed after successful key informant interviews are conducted. The composition of the COC is left to the local implementing agency handling the peer-led intervention. It is critical to involve law enforcement officials in this committee to counter possible threats from elements in the community who promote drug use. It is equally essential to include health care officials in COC to establish a viable referral network for service provision. Those affected or afflicted by substance abuse/HIV need to be included as well as non-formal leaders and influencers in the community. The COC is guided, by the intervention agency, in developing realistic expectations from the project and explained the relapsing nature of substance abuse disorder. Realistic expectations include not looking for a “magical cure” or a “one-time fix” to deal with the problem of substance abuse. Extreme reactions, such as one-time detoxification camps without adequate rehabilitation measures or violence in dealing with drug pushers, are to be avoided. Involve the COC to develop indicators of risk-reduction while respecting the rights of users.

Community meetings

Community meetings are used to raise awareness about the substance abuse disorder and its consequences, especially HIV/AIDS, to give accurate information about the substance abuse disorder, and to give recognition to those who have recovered reinforcing the message that “treatment works”; it is worth investing in substance abuse treatment in spite of relapses. The first meeting is used to publish the vulnerability and resource mapping conducted in the community. Subsequent meetings serve as a forum for addressing stigma and discrimination by using the family members of those recovered to share their relief and benefits from the recovery of their family members, and recognising those who have recovered.

Create/strengthen the existing referral system in the community

Since the drug user needs different kinds of services at different times in her/his drug using career, a wide range of services need to be tapped and inter-linked. These include health and social welfare agencies. Health agencies include services for Tuberculosis, STI clinics, abscess management surgical set-ups, voluntary counselling and testing centres and detoxification and rehabilitation services. An effort is to be made to contact key individuals in these centres in the government and non-government sectors and reach an understanding as to how the referral to each centre would work. Key individuals also need to meet to establish a “two-way” referral service. Social welfare agencies, micro-credit facilities and vocational training centres in existence are similarly networked as referral centres.

2. Assess the need for outreach:

- ✓ **Vulnerability mapping:** Assess the extent and nature of the drug use problems. Decide the locations and geographical area to be covered. Specify populations of drug users to be targeted. Map the members of the peer groups/peer networks. Assess the needs of peer group members and their risk-behaviour. Specify behaviours to be changed. With the help of COC, select indicators of outcome and specific outcomes to be achieved. Readjust the intervention design checking out the following:
 - Feasibility of referral to existing services;
 - Feasibility of providing services directly in the community;
 - Possibility of behaviour change in the community through outreach;
 - Possibility of overcoming factors that impede development of services;
 - Feasibility of reaching target population without using peer outreach workers;
 - Are changes in peer group and community norms needed?
 - Prevention materials to be distributed;
 - Health education and advice to be provided.

- ✓ **Resource mapping:** Assess the resources available to respond to drug users seeking access to services. Establish an effective system of referrals between agencies to enable inter-agency referrals.

Lasting about three months, this phase ends with the recruitment of current users for the risk-reduction component of the peer-led intervention.

Phase Two

Phase two is the risk-reduction intervention and examines the efficacy of traditional outreach combined with a risk-reduction methodology based on using peers to provide training aimed at reduction of risk taking practices in their peer group. A baseline assessment instrument has been designed to document knowledge, attitudes, and practices (KAP) of current users.

Objectives of Phase Two

- To document the baseline knowledge, attitude and practice of risk taking behaviours related to drug abuse and HIV/AIDS among out-of-treatment young drug users,
- To train the drug users into reduction of risk taking behaviours using behaviour change communication skills and participatory learning and action tools.

Activities

1. Identify groups of drug users in the field.
2. Identify and contact drug users who are suitable for the risk-reduction intervention (i.e., satisfy the inclusion criteria).
3. Motivate the drug users for recruitment into the risk-reduction intervention.
4. Document the baseline assessment of KAP (individually, one to one).
5. Enrol current users into the project as peer volunteers.
6. Train the peer volunteers.
7. Organise a community meeting to recognise successful completion of phase two of the programme, recognising successful participants in risk-reduction.

Peer Volunteers

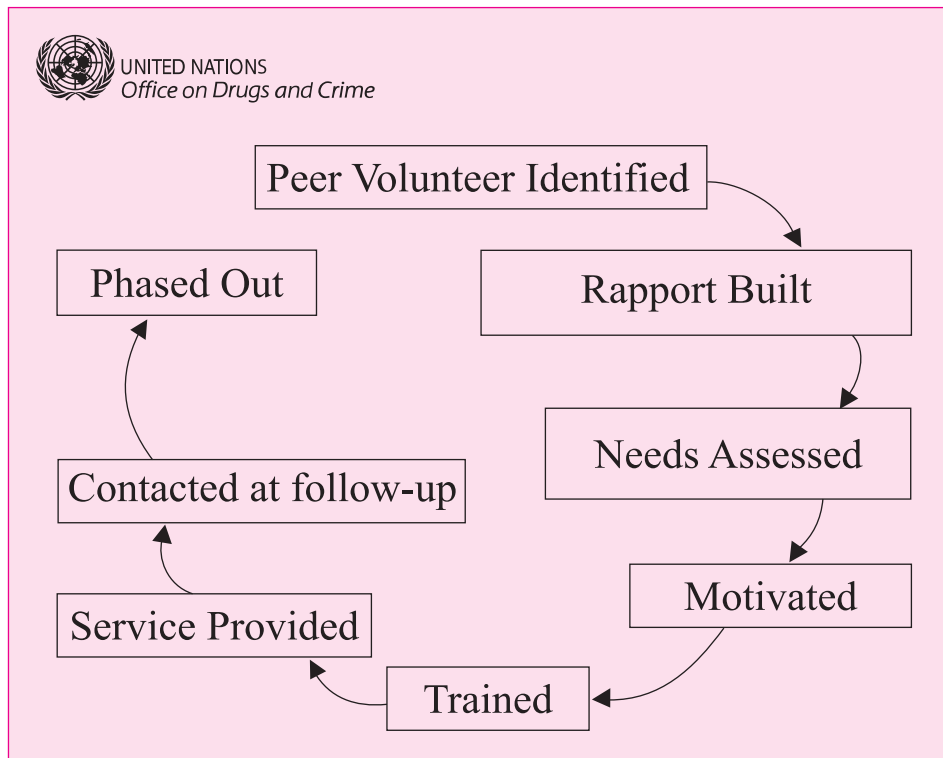
Young drug users are recruited from the networks of drug users existing in the community (contacted in phase one). For the purpose of testing this model, the number of users at each site will be 50. The inclusion criteria for the test-phase of this model are:

- Age 15 – 30 years, either gender;
- Use of any psychoactive substance except tobacco in last 30 days;
- No major functional disability (physical/cognitive/mental), which may hamper communication;
- Currently not enrolled in any treatment programme for drug use;
- Informed consent for baseline KAP assessment.

An attempt is also made to educate those drug users who are contacted by the peer outreach workers, and not willing to be recruited, into safe behaviour using traditional outreach.

After identification and contact with the drug user, the peer outreach workers motivate him / her into accompanying them to the clinic / NGO site for an interview with the SSP/trainer. The SSP/trainer interviews each user individually after obtaining an informed consent, and administers the KAP questionnaire. Explaining the service cycle (see diagram on the next page), consent is obtained to function as a peer volunteer. The user undergoes training (seven, once a week half-day sessions, described in detail elsewhere), provided by the SSP/trainer and the peer outreach workers, and serves as a peer-volunteer. Three months after the last training session, the peer volunteer is interviewed again for re-assessment of the KAP. Care is taken in forming homogenous risk-behaviour groups for training.

Service cycle for a peer volunteer



At any point in time as and when the drug user displays a desire and motivation for treatment and abstinence, he/she will be provided assistance for referral, irrespective of his/her status as a peer volunteer.

Phase Three

Phase three builds in the sustaining mechanisms for continued risk-reduction in those intervened through formation of self-help groups and assists in access to services. It is a stage for reassessment of change in risk-practices of those trained in phase two (peer volunteers), and a random assessment of those members of the peer group who are trained by the peer volunteers.

Objectives of Phase Three

- To study the effect of training (risk-reduction intervention) on risk taking behaviours related to drug abuse and HIV/AIDS;
- To study the feasibility of using peer volunteers (current drug abusers) in imparting change of risk taking behaviour among their drug abusing peers;
- To establish mechanisms for sustenance of project activities beyond project life;
- To facilitate drug users' access to and retention into treatment.

Activities

1. Continue field visits by the peer outreach workers to maintain contact with the peer volunteers.
2. Observe and supervise interaction of peer volunteers with their drug using peers during field visits.
3. Provide assistance to drug users in formation of self help groups, and referral to treatment whenever required.

At the end of three months from the date of last training session, the SSP/trainer will reassess those drug users who have functioned as peer volunteers through the same questionnaire. The data so collected will then be compared with the baseline to determine the change in KAP after receiving risk-reduction training. This comparison is intended to provide evidence regarding the change in KAP of the whole group and will provide some information about change in KAP of an individual peer volunteer.

During this period of three months the peer outreach workers maintain contact with the peer volunteers and provide refresher training, and need based clarification on issues. They also motivate the peer volunteers to form self-help groups, and to seek help from facilities identified in phase one. Whenever required, the peer volunteers are provided referral services and assistance for treatment. The outreach team assists in forming and sustaining self-help groups of peer volunteers. Peer volunteers are continually motivated to bring their drug using peers group members to these group meetings.