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# Peer-led intervention for reducing risk-taking behaviour in young drug users

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## Introduction

UNODC Regional Office for South Asia's Project RAS/G23, has designed this peer led intervention that focuses primarily on risk-reduction among young drug users in South Asia and allows cultural adaptation to the local settings of use. The intervention is designed in four phases: preliminary phase, phase one, two and three.

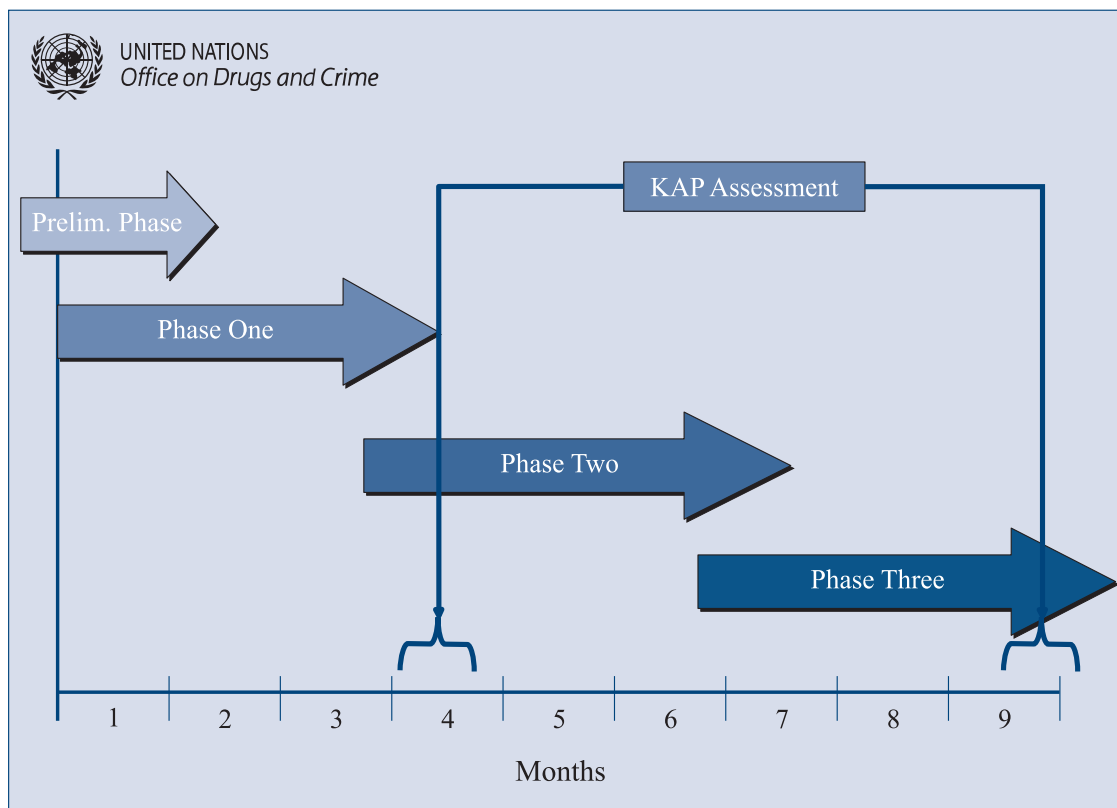
The **preliminary phase** assesses the situation from existing data, sensitises stakeholders to use evidence based interventions, advocates a comprehensive prevention programme addressing drug abuse and HIV, highlights vulnerability of young drug users, selects the agencies for the peer-led interventions and trains the service personnel in a training of trainers' programme.

**Phase one** activities deal with creation of an enabling environment for the intervention and flows into phases two and three. 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 the lays the ground for sustaining the intervention after project life. Key informant interviews and group discussions are carried out with key influencers and stakeholders to get an assessment of the local situation. It maps the vulnerability of drug abuse related HIV and resources to respond, and sets up the referral network for providing access to services. A community meeting is held to publish the findings of the vulnerability and resource mapping, advocate for prevention of drug abuse and HIV/AIDS, and mobilise support from the community.

**Phase two** is the risk-reduction intervention and uses behaviour change communication and participatory training methodology for current substance users. The trainees in this phase are encouraged to volunteer (serve as peer volunteers) to further train their peer group members, and process their experience in change in risk-behaviour in their peer group and themselves. A baseline assessment instrument has been designed to document knowledge, attitudes, and practices of current users in phase two. This phase ends with a community meeting which recognises the successful completers of the training and highlighting the reduction in risk-taking practices.

**Phase three** builds in the sustaining mechanisms for continued risk-reduction in those intervened through formation of self-help/support groups, assists drug users in access to services, and maintains support for those trained in phase two. An attempt is made in integrating peer-led interventions with the other services available in the community.

### Three Phases of the Intervention



## 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, AIDS / Hepatitis B, Hepatitis C, and other health hazards associated with drug use).

### *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

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

### *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:

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

## **Review of Literature**

Most interventions among IDUs, as well as among other at-risk populations, have sought to change *individual* risk behaviours by targeting the intervention at the individual. This tactic stemmed from the recognition that HIV was a pathogen that was spread predominantly, although not entirely, through certain risk behaviours among *individuals*. A variety of interventions were developed, including outreach interventions that targeted individual drug users in their communities to provide information about the risks of infection with HIV and how to prevent it. Some of these interventions were theoretically based and used theories such as the health belief model, the theory of reasoned action, and social cognitive theory (see page 22).

Many of the individual-based interventions among IDUs have contributed to reducing injecting risk behaviours and, to a lesser extent, sexual-risk behaviours. However, it has not yet been adequately demonstrated whether long-term change and the maintenance of risk reduction can be achieved through an individual approach.

## **Outreach services**

There is strong evidence regarding the effectiveness of outreach services, which are provided by trained outreach workers, (who may or may not be ex-drug users) for the treatment of drug abuse. A review of multiple studies examining the effectiveness of outreach services concluded that outreach leads to:

- ◆ Reductions in drug injection
- ◆ Reduction in reuse and sharing of syringes, needles, and other injection equipment (cookers, cotton, rinse water)
- ◆ Reduction in non-injection drug-use
- ◆ Reduced sex-related risks and increased condom use
- ◆ Promoting entry into drug treatment

It has been found that outreach-based services are effective in reaching out-of-treatment drug users, and that they provide the means for inducing behaviour change in the desired direction.<sup>2</sup>

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 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.

## Community based outreach

Community-based outreach has been described as an effective strategy for reaching drug-using populations and providing them with the means for behaviour change. The National Institute of Drug Abuse (USA) conducted a large study<sup>3</sup> between 1987-1991 in 29 sites across the United States that investigated the efficacy of outreach-based interventions for reducing HIV risks among out-of-treatment injection drug users and the non-injecting female sex partners of male IDUs. Indigenous outreach workers were deployed to access members of the target population and initiate risk-reduction activities throughout participating sites, on the streets and in other settings where IDUs tended to congregate. Basic risk-reduction activities usually involved face-to-face communication; the provision of literature on HIV/AIDS transmission, prevention, and treatment; and the distribution of materials to facilitate risk reduction (i.e., male condoms to reduce sexual risk and bleach "kits" to decontaminate syringes and reduce risk associated with needle use). Outreach workers also referred drug users to services available in the local community, including drug treatment services as well as HIV/AIDS treatment.

Community-based outreach was found to be an effective approach for reaching out of treatment drug users, providing materials to support HIV risk reduction, facilitating drug treatment entry and retention, providing referrals for HIV testing and counselling, and promoting HIV risk reduction.

## Peer education

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 on 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. Use of these "true" peers i.e. current drug users, for spreading HIV/AIDS prevention message among fellow drug users however, is a relatively recent

<sup>2</sup> Coyle, L.S., R.H. Needle, and J. Normand. 1998. Outreach-based HIV prevention for injecting drug users: a review of published outcome data. *Public Health Reports*, 113 (Supplement 1): 19-30.

<sup>3</sup> NIDA 2000. *The NIDA Community-Based Outreach Model: A Manual To Reduce the Risk of HIV and Other Blood-Borne Infections in Drug Users*. US Department of Health and Human Services, National Institute on Drug Abuse, Rockville, MD.

<b>‘Peer’: The term and issues surrounding it</b>			
<b>Used in the sense</b>	<b>‘Someone of equal standing’</b>	<b>‘Someone who I can identify with’</b>	<b>‘Someone who is like me and is in regular contact’</b>
<i>Examples</i>	Peer reviewer (as in scientific journals, medical councils etc.).	Victim-turned-helper (as in ex drug users working as counsellors).	Member of my drug-using network, my friend(s).
<i>Characteristics</i>	Ability to understand and ‘judge’ accordingly.	Can empathise since has gone through similar experience.	Can fully empathise, relate-to since is <i>going through</i> similar experience.
<i>Distance</i>	Too far, usually do not personally know each other.	May/ may not know each other. ‘Status difference’.	Is in regular contact.
<i>Communicability</i>	Understand each other’s language but rarely ‘speak’ directly to each other.	Know the ‘language’ but ‘status difference’ may bring in elements of distrust and make communication difficult.	Speak each other’s language and fully understand each other.
<i>Credibility</i>	Usually credible.	Usually credible.	May be in doubt since may be practicing risk-behaviour.
<i>Trainability</i>	Fully trainable.	Trainable.	Trainable but regularity with training schedule remains doubtful.
<i>Reliability</i>	Reliable +++.	Reliable ++.	Poor Reliability.
<i>Risk</i>	None	Risk of relapse.	May give wrong message if not trained adequately.
<i>Knowledge of and ability to discuss sensitive issues (drugs/sex) with each other</i>	Usually very inadequate sharing of personal issues.	A counsellor may come to know personal issues of a client, but with some prompting and efforts.	Usually know personal and sensitive details of each other’s lives.
<i>Acceptability</i>	Acceptable as a ‘judge’.	Acceptable as a educator but sharing sensitive information is difficult.	Fully acceptable, even for in-depth discussion of sensitive issues.
<i>Use as a peer educator</i>	-/+	++	+++
<i>Effectiveness as educators for risk-reduction</i>	+	++	+++

phenomenon. As compared with outreach workers peers have been found to be more effective in recruiting drug users for HIV/AIDS interventions.<sup>4</sup>

Peer education typically involves training and supporting members of a given group to effect change among members of the *same* group. Peer education is often used to effect changes in knowledge, attitudes, beliefs, and behaviours at the individual level. In addition, 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.

Numerous definitions of the word “**peer educator**” are found in literature.<sup>5</sup> The varied use of the term “peer” is analysed in the table shown on the next page. In some instances “peer educator” is a recovering/ex-drug 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 drug 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.<sup>6</sup>

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 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.

Research indicates that peer-interventions work best when part of a larger basket of services and both, outreach as well as peer volunteers/educator approaches have been described as complementary to each other.

## Peer-led intervention design to reduce risk-taking behaviour in relation to drug abuse and HIV/AIDS

### *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

<sup>4</sup> Stocker S. (1999). Among drug users, peers can help spread the word about AIDS prevention. *NIDA notes* (research findings), (4) 5.

<sup>5</sup> McDonald, J., A.M. McDonald, M. Durbridge, and N. Skinner. 2003. *Peer education: From evidence to practice – An alcohol and other drugs primer*. Adelaide: Flinders University of South Australia, National Centre for Education and Training on Addiction.

<sup>6</sup> Sherman S, Latkin, C., Bailey-Koche, M, Peterson, J., 1997. *The SHIELD Community Outreach Worker Training: Facilitator’s Manual*, SHIELD (Self-help in Eliminating Life-threatening Diseases) Study, The Lighthouse, Johns Hopkins School of Public Health, Baltimore.

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 following hierarchy (where applicable):

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

The framework is used 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, schools, 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 is 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. Results of research and intervention studies implemented by the project would be used to advocate policy change and mobilize the support necessary for scaling up.

## **Theoretical framework**

Interventions designed for peer-networks are based on several social change theories. This peer led intervention is designed in a manner that each phase is based on a sociological theory or a combination of the following theories (adapted from UNAIDS 1999a):

### *Phase I, II and III:*

*Social Learning and Cognitive Theories* are based on the assumption that individual behaviour is the result of interaction among cognition, behaviour, environment, and physiology.

**Phase I**

*The Theory of Reasoned Action* attempts to explain individual behaviour by examining attitudes, beliefs, behavioural intentions, and observed, expressed acts.

**Phase II**

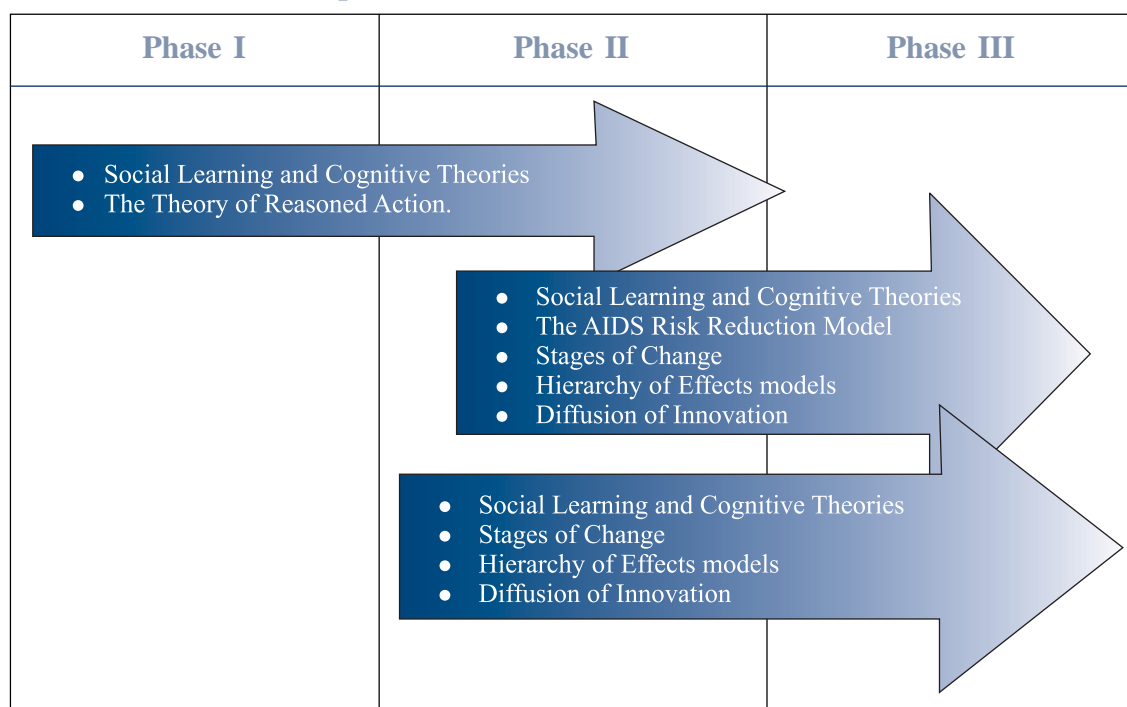
*The AIDS Risk Reduction Model* is based on the belief that one has to label behaviour as risky before a change can be effected. Once the behaviour is considered risky, a commitment is made to reduce the behaviour before action to perform the behaviour is expected. Fear or anxiety and social norms are considered factors that influence moving from one stage to the next.

*Stages of Change* is based on the conception that individual behaviour change goes through a process involving a series of five interrelated stages.

*Hierarchy of Effects models* focus on individual behaviour change in a linear fashion, which begins with exposure to information and assumes that knowledge, attitudes, trial, and adoption of the desired behaviour will necessarily follow.

*Diffusion of Innovation* focuses on the communication process through which new ideas or products become known and used in a target population.

**Phase wise peer led intervention: Theoretical Framework**



### *Phase III*

*Stages of Change* is based on the conception that individual behaviour change goes through a process involving a series of five interrelated stages.

*Diffusion of Innovation* focuses on the communication process through which new ideas or products become known and used in a target population.

*Hierarchy of Effects models* focus on individual behaviour change in a linear fashion, which begins with exposure to information and assumes that knowledge, attitudes, trial, and adoption of the desired behaviour will necessarily follow.

The peer networks that exist are:

- ◆ Closed networks
- ◆ Semi closed (kin) networks
- ◆ Semi-open networks
- ◆ Open peer networks

The peer-led intervention in this manual is designed for semi-closed and semi-open networks.