A framework for peer education by drug-user organisations

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Foreword

The Australian Injecting & Illicit Drug Users League (AIVL) and its State and Territory peer-based member organisations have been in existence for well over a decade. During this time we have come to be regarded as the leading practitioners of peer education among illicit and injecting drug users in Australia.

AIVL and its members have been practicing peer education intuitively since their inception, which has, by and large, well-served both peer-based organisations and drug users in the community, particularly in relation to the prevention of blood-borne viruses and the reduction of drug-related harm. For many peer-based organisations and peer educators, it has been a matter of "doing what comes naturally," rather than boxing themselves into corners with words and theories.

More recently however, the debate in relation to peer education has intensified. At times, just about any education involving illicit drug users being called "peer education," and questions have been raised about the evidence to support peer education as an effective practice. These considerations, together with frequent requests of AIVL and its members to "define" peer education, pointed to the need for a national peer-education framework to articulate our approach, present the available evidence, and demonstrate the effective track record of peer education.

Peer education in all its forms represents a vast body of experience and practice that would be impossible to encompass in a single discussion paper. Even though there may be fundamental differences between how we and other organisations approach the subject, we must acknowledge that our practice is part of a worldwide phenomenon. For this reason this publication endeavours to situate our experience in a larger context, while concentrating primarily on the understanding and experience of our communities. Indeed, the knowledge and experience that lies with Australian drug-user organisations has been this document's major source of inspiration and content. So too has the healthy ongoing debate to which many peers have contributed.

This document has not been written for one particular audience. It is by no means the first word on the matter, and it would be foolish to think it will be the last. In developing this framework, AIVL has attempted to describe the broad concepts, principles, and theories that underpin the peer-education practice undertaken by AIVL and its member organisations and provide some examples of that practice. We hope that this publication that will provide readers with some much needed clarification on what AIVL means by "peer education" and as well as a useful foundation for informed discussion on this issue into the future.

It is important to remember that the best peer education does not happen because organisations are funded to do it or because governments want it done. It happens in response to an identified need within user networks and among individuals. The forms that peer education takes can vary significantly from project to project, issue to issue — as circumstances and contexts differ from place to place, so do the needs of the people and networks that we work with.

The AIVL Peer Education Framework is a starting point for understanding our approach to peer education. We hope it will inspire reflection and further deliberation that contributes to our understanding of this complex, dynamic, and highly effective form of learning and change.

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Introduction

Peer education is fundamental to the work of drug-user organisations in Australia. It is one of the things they are well-placed — and eminently qualified — to do. Yet even a cursory review of the discussion on this subject, and the reports describing peer education projects, reveals a lack of consensus about the philosophical principles that underscore our practice, which has in turn set the stage for some passionate argument about what peer education by drug-user organisations looks like, or more to point, should look like. The lack of common ground has been at once been a strength and weakness of our practice. It has led to a considerable amount of innovation — and also a great deal of invention, particularly around the operational and administrative aspects of our work.

This document attempts to find a consensus among the views that have been expressed about the theory of our practice and highlight some practical considerations for the development of peer education programs.

It first examines some of definitional problems that have surfaced in discussions around peer education and differentiates the forms of peer education that take place among and with illicit drug users (**1 Difficulties of a definition**).

Although the way drug-user organisations practise peer education will have some defining philosophical differences from other organisations, it is part of a larger movement of organised health education that is now widely used in many parts of the world. We outline the growth of peer education (**2 Evolution of formal peer education**) and reasons for its popularity and success (**3 Why is peer education considered useful?**), common assumptions that unite the practice of peer education (**4 Commonalities among peer education programs — the idea of health)**, and the behavioural theories that it draws on (**5 Theoretical underpinnings of peer education**).

If we are to propose common principles for the practice of peer education by drug-user organisations, we should be clear about what we use peer education for and why we use it. Our overall objectives **(6 What is the goal/ purpose of using peer education with IDUs?)** and our rationale **(7 Why use peer education to achieve this/these goals?)** will have some distinctive differences from those of other organisations. Agreement on these matters will have a large part in shaping how we go about peer education and the principles on which we base our practice **(8 Principles for formal peer education by drug-user organisations**).

Consensus about the nature of learning in peer education is one thing. Equally important is a common notion about what makes a "peer" and, more importantly in the present context, who is a peer in the context of formal peer education by drug-user organisations **(9 Who is a peer?**). This has been hotly debated. We believe there is common ground between the philosophical and practical considerations that have informed this debate in the past.

The discourse and literature reflecting on the practice of peer education by drug-user organisations reveal common problems in organising and running peer education programs. While we can't anticipate all challenges, we think that there are things organisations can do to give their programs less likelihood of encountering these difficulties, and steps they can take when those difficulties present themselves **(10 The practicalities of formal peer education by drug-user organisations)**.

Finally, in section 11 we present brief summaries of some key peer education programs undertaken by drug user organisations in Australia **(11 Peer education models)**. It is by no means exhaustive. However, we hope they give readers unfamiliar with the track record of drug user organisations in this area inspiration for designing and development their own programs.

1 The difficulties of a definition

Peer education is practised in many parts of the world, especially in the areas of HIV/AIDS and sex education, and drug education. Both its practitioners and the people who study it have debated and argued about its utility and effectiveness. A large part of the debate has focused on definitional problems — what the debate is about.

Gary Dowsett put it well in his 1999 report, *Hepatitis C Prevention Education for Injecting Drug Users in Australia*:

> despite the high frequency with which these terms are used and the heavy reliance upon "peer education" reported by agencies in this sector … there has been no resolution of the key operational issues accepted as lore by the sector as a whole … the problem in the sector is simple and obvious: defining peer education.

Since that report was published, various academics have proposed definitions.[1] Closer to home, several people in Australia have made valuable contributions towards clarifying the principles of peer education in the context of drug-user organisations (Madden, Brogan, Wightman, Morgan & Siddins, Millin).[2]

The recently published (Australian) *National Strategy on HIV/AIDS* offers a description rather than a definition:

> Usually members of a given group working to effect change amongst other members of the same group. This model of education is based on social learning and health behaviour theories, and has been proven to be an effective method of imparting information, skills and knowledge to others (peers). Peer education also recognises the influence that peer pressure and the behaviours of a peer group have on the decisions an individual makes.[3]

The *National Hepatitis C Strategy 2005 - 2008* comes closer to a general workable definition:

> [A] process controlled, devised and implemented specifically by members of a peer group to address the education needs of other members of that peer group. An example is people who inject drugs developing and delivering messages about safe injecting practices to other people who inject drugs.[4]

Even this definition leaves unanswered the thorny questions of (1) what is the process? (2) what is a peer group? (3) what are the needs of a peer group, and how are they identified?; and (4) what is the relationship between the "members" who control, devise, and implement the process," and the "other members of the group"? Furthermore, in the light of the theoretical models of behaviour that inform peer education (see 5.0), some would consider the cited example — "people who inject drugs developing and delivering messages about safe injecting practices" — to be lacking subtlety and nuance.

Arriving at a concise definition of peer education may not be feasible. Deducing a definition from the array of activities that have traditionally carried its name, even those undertaken by drug-user organisations, could be impossible.

But is a definition necessary? What may be more useful than a definition are guiding principles, and guidelines or parameters. These may become clearer with some thought about the nature of the peer education process, what we hope to achieve through peer education, and why we choose peer education as a strategy.

1. See: Trautmann, F., 1995, Peer support as a method of risk reduction in injecting drug-user communities: experiences in Dutch projects and the European Peer Support Project. *Journal of Drug Issues.* 25 (3), pp 617-628; Broadhead, R. et al., 1995, Drug users versus outreach workers in combating AIDS: preliminary results of a peer-driven intervention. *Journal of Drug Issues*, 25 (3), pp 531-564.; Parkin, S. & McKeganey, N., 2000, The rise and rise of peer education approaches. Drugs: Education, prevention and policy, 7 (3), pp 293 - 310; Wood, M. & Rhodes, F., 1998, Using social gatherings to encourage HIV risk reduction among drug users. *American Journal of Public Health*, 86 (12) 1815 - 1816; Dowsett, G. et al., 1999, *Hepatitis C Prevention Education for Injecting Drug Users in Australia*, Commonwealth Department of Health & Aged Care, Canberra, 1999, p. 15; Population Council & Horizons, 1999, *Peer Education & HIV/AIDS: Past Experience, Future Directions*, Population Council & Horizons, Washington, DC; UNAIDS, 1999, *Peer Education & HIV/AIDS: Concepts, uses, and challenges*. UNAIDS, Geneva.

2. Annie Madden, Jude Byrne, & Nicky Bath, 2002, Who's Peering at Who?, *Junkmail*, Vol. 4, Canberra, AIVL; Damon Brogan, 2003, *Peer Education: In Search of a Common Model*, AIVL, Canberra, 2003; Alex Wightman, 2004, *Peer Education: An Operational Definition for Users of Illicit Drugs*, AIVL Discussion Paper, Canberra, AIVL; Kirsty Morgan & Jennie Siddins (n.d.), *What is Peer Education?* AIVL National Education Program, Canberra, AIVL; Anthony Millin, 2002, *AIVL National Education Program* (draft), Canberra, AIVL.

3. Department of Health & Ageing, 2005, *National HIV/AIDS Strategy 2005-2008*, Canberra, Commonwealth of Austrealia, p. 54.

4. Department of Health & Ageing, 2005, *National Hepatitis C Strategy, 2005-2008*, Canberra, Commonwealth of Australia, p 37.

At its broadest level, peer education is about "learning from one's peers." Who are peers? And what is education?

The English word “peer” refers to one who is “equal in civil standing or rank (jury of … peers); equal in any respect (you will not easily find his peer)” and a “peer group,” “those of the same status as, and associated with, a person.” (*The Australian Concise Oxford Dictionary*, 1987). “Education” is defined as “educating, being educated; systematic (course of) instruction (FURTHER education); development of character or mental powers …” (*The Australian Concise Oxford Dictionary, 1987*). Its roots lie in the Latin word "ducere" (to lead), from which comes, among other things, il duce, “the leader,” the popular name given to Benito Mussolini during his time as head of Italy in the 20th century.

The practice of peer education offers many variations on the nature of peers and the nature of the education, or learning. These variations are informed by the context in which the peer education take place, the people among whom it's practised, the purpose of the activity, and the principles that underpin it.

The idea of “practising peer education” raises important considerations in itself. It implies an action with an intent, an outcome — an agenda. Clearly, many paid workers and volunteers are employed to "practise peer education," to consciously and purposely encourage or facilitate learning.

But the practice of peer education among drug users, if not other populations, is informed and shaped by exchanges and processes that take place regardless of intent. Drug users learn from each other in the course of everyday interactions. They may not always have an agenda for that learning. These exchanges are the context in which formal peer education takes place.

We can distinguish three broad kinds of learning among drug users:[5]

1 **Spontaneous (accidental) informal peer education**, which is independent of organisations and funding and occurs spontaneously among individuals and gatherings of users. Learning takes place in the course of everyday activities, when users share knowledge, information, and skills, when they score, take their drugs together, or just hang out. It can take place in homes, in pubs and clubs, or even, regrettably, in a public space. It can be triggered by issues that arise in the course of conversation or their shared activities. It can focus on matters of a medical nature — e.g., treatments, overdose, or blood-borne infections, or vein-care. It may concern drug quality, legal issues, mental health and emotional states, services, local (sub)culture and rituals, even human rights — critical matters that go beyond medical health to embrace larger aspirations about well-being.

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2 **Intentional (premeditated) informal peer education**, which also exists independent of organisations and funding and occurs when groups of users deliberately endeavour to improve their knowledge and skills around a subject or issue that affects their lives. For example, a person who observes a lack of understanding on a particular issue within their peer group may acquire and distribute information on that subject to members of the group; people who run regular information sessions on a matter of importance to their group of friends, arrange a support group to discuss a particular issue(s), or organise to take action on a particular issue in relation to their rights.

5. A more detailed discussion of these kinds of peer education can be found in Annie Madden's article, Who's Peering at Who?, *Junkmail*, No. 4, 2002, and Damon Brogan, 1999, *Peer-mediated user education: A framework for community action*, 1999, SAVIVE.

3 **Formal peer education**, sponsored, auspiced, and/or funded by organisations and agencies that embark on a program of activities with the intent of empowering individuals and networks of drug users to improve their health and well-being. In Australia, this kind of peer education is primarily the sphere of drug-user organisations that organise paid workers or volunteers, usually current or former users, to share information, encourage learning, and improve skills related to the use of drugs. They do this by being available to answer questions and provide information and support to people attending the NSPs they run, by conducting outreach, publishing magazines, running workshops, and resourcing and supporting groups or networks of users interested in developing their own education projects.

... peer education exists independently and predates the existence of funded, externally supported structures or projects ... Damon Brogan describes peer education as a "naturally occurring, organic process that occurs within such groups independently of governments or organised structures, but which may be resourced and utilised to more effectively achieve positive outcomes."

The most important point here is that peer education exists independently and predates the existence of funded, externally supported structures or projects. Friedman[6] has shown how injecting drug communities in the US mobilised to educate and support themselves in response to the threat of HIV, and Power et al[7] have described the mutual support, information sharing, and advocacy that arose in many British communities of injecting drug users. Similar processes have taken place in Australia. Damon Brogan describes peer education as a "naturally occurring, organic process that occurs within such groups independently of governments or organised structures, but which may be resourced and utilised to more effectively achieve positive outcomes."[8a]

Although this document will concentrate largely on what we might call formal peer education, it does so with reference to informal peer education. A framework for formal peer education that does not consider informal peer education risks losing touch with the primary aim and locus of peer education. As Damon Brogan said, the primary aim of peer education is "to influence and harness for positive outcomes the naturally occurring and ongoing interactions and normative structures that exist within peer groups. The locus of peer education is not primarily in the training workshop, but in the peer-networks."[8b]

While we acknowledge that the inspiration for peer education activities by drug-user organisations lies in the activities of peer networks, we also recognise that they are not the only organisations who use peers to achieve educational goals. Formal peer education is widely practised throughout the world. It is informed by a body of behavioural theory and is strongly endorsed by public health practitioners. The evolution of peer education and the reasons for its widespread use are worth considering.

6. Freidman, S., 1993, Going beyond education to mobilizing subcultural change. *International Journal of Drug Policy*, 4 (2).

7. Power, R. et al., 1995, Drug user networks, coping strategies, and HIV prevention in the community. *Journal of Drug Issues*, 25 (3), pp. 565-581.

8a. Brogan, D, 2003, *Peer education: In search of a common model*, AIVL, Canberra, p 18.

8b. Brogan, D, 2003, *Op. cit*, p. 3.

2 Evolution of formal peer education

Peer education has been used in many areas of public health, including nutrition education, family planning, workers' rights, sex education, teenage motherhood, gambling, reading skills, violence prevention.[9] However, it is in the areas of HIV/AIDS, hepatitis C, and drug use that it has been most widely used, increasingly so in the past few decades.

HIV/AIDS-related peer education stands out owing to its present use in all continents. Most countries with organised public health responses to HIV/AIDS use some form of peer education. However, less well appreciated is its development from interventions and outreach programs directed towards heroin injectors in the US and Western Europe long before HIV/AIDS emerged as a public health threat.

As early as the late 1960s former heroin users were being hired to provide targeted outreach to "hidden populations" of IDUs in Chicago to encourage them to enter methadone maintenance treatment.[10] In Western Europe, community-based peer outreach evolved from efforts to work with young people using illicit drugs. The concept gained further ground in 1970s with the formation of the *junkiebonden* (junkie unions) in the Netherlands. Initially established to advocate for the decriminalisation of drug use, the *junkiebonden* attempted to address the spread of hepatitis B through the creation of needle exchange facilities. Although peer education was not a formally organised activity, the junkiebonden nonetheless used what we would now call peer education to encourage users to access the needle exchange and inform them of ways to deal with hepatitis B infection and related health problems.[11]

Peer education has developed and proliferated since those days. The UN describes peer education as "a popular concept that implies an approach, a communication channel, a methodology, a philosophy, and a strategy …"[12] It has been used to describe programs as various as outreach, advocacy, counselling, facilitating discussions, drama, lecturing, distributing materials, making referrals to services, and providing support. As recently as 2005, UNAIDS cited "harm reduction measures (through, amongst others, peer outreach to injecting drug users …)," as part of a "comprehensive, integrated and effective system of measures" to prevent the transmission of HIV.[13] In Australia, peer education is endorsed by both the National HIV/AIDS Strategy and the National Hepatitis C Strategy.[14]

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9. UNAIDS, 1999. *Peer Education & HIV/AIDS: Concepts, uses and challenges*. UNAIDS, Geneva; Parkin, S. & McKeganey, N., 2000, The rise and rise of peer education approaches. Drugs: Education, Prevention and Policy, 7 (3), p. 293.

10. WHO, 2004, *Evidence for Action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users.* Geneva, WHO, p 12.

11. Trautmann, F., 1995, Peer support as a method of risk reduction in injecting drug-user communities: Experiences in Dutch Projects and the "European Peer Support Project". *Journal of Drug Issues*, 25, (3), pp. 617-628.

12. UNAIDS, 1999, *Op. cit*., p. 5.

13. UNAIDS, 2005. *Intensifying HIV prevention. UNAIDS policy position paper*. UNAIDS, Geneva. p. 23.

14. Australian Government, Department of Health and Ageing, 2005, *National HIV/AIDS Strategy: Revitalising Australia's response, 2005-2008*, Canberra, Commonwealth of Australia, p. 15; Australian Government, Department of Health and Ageing, 2005, *National Hepatitis C Strategy, 2005-2008*, Canberra, Commonwealth of Australia, p. 16.

3 Why is peer education considered useful?

Some would argue that the proliferation of peer education is more a matter of its widespread acceptance than purposeful implementation of programs based on evidence. This appears to have been the case for much of its early development and its initial use in HIV- and drug-user education. It was a practical and intuitive response to circumstances and need, reinforced by various theories of human behaviour. Nonetheless, over the past decade concerted efforts to assess its impact have confirmed its utility, especially in the areas of HIV, hepatitis C, and sexual health education.

3.1 Peer education is successful in reaching people who may not be reached by other means

Peer educators can have physical and sociocultural access to intended audiences in their natural environments; they can mutually identify with each other as individuals and as members of a specific sociocultural reality.[15] This is particularly true when working with "hard-to-reach" populations such as injectors, sex workers, and men who have sex with men, whose behaviour can be highly stigmatised and/or illegal.[16] Even where there are mainstream services for these populations, accessing those services is not always feasible or reasonable: some services directly or indirectly discourage their use by drug users. Where such clients do make it to the service, the provider-client model, as well as the environment for the exchange, can present some significant impediments to communication.[17] As the programs described in section 11.0 demonstrate, in some areas peer education is deliberately employed to link target populations with mainstream services.

3.2 Credibility, trust, and belief

Peer education derives in part from behavioural theory that asserts that people make changes not because they may assess evidence or closely examine testimony or argument so much as they subjectively trust the judgement of close, trusted peers.[18] Inside information and knowledge derived from personal experience play an important role in establishing credibility, trust, and belief.[19] Peers are able to use language and terminology that is the currency of a particular population; they can be more sensitive to the non-verbal information exchanged.[20]

Three kinds of credibility have been identified: “person-based credibility” (relating to demographic characteristics etc.); ”experience-based credibility” (which situates them firmly in life rather than theory); and “message-based credibility” (the way in which information is communicated, preferably in a non-moralistic and non-judgemental manner.[21]

When the content of peer education focuses on personal, even intimate behaviour, and where the actions associated with the behaviour are formally and/or informally stigmatised, such as using illicit drugs, credibility and trust come to the forefront. We are largely reluctant to discuss these matters with people who appear more like tourists than fellow travellers.

3.3 Peer education works

Peer education and peer support have been shown to be effective as methods of HIV risk reduction among drug user communities in the Netherlands, the US, the UK, and in Australia.[22] Accumulated evidence from more than 40 different studies —

15. UNAIDS, 1999, *op. cit.*

16. UNAIDS, 1999, *op. cit.*

17. See for example, Public Health Agency of Canada, 2001, *Responding to an Emergency: Education, Advocacy, and Community Care by a Peer-Driven Organization of Drug Users: A Case study of Vancouver Area Network of Drug Users(VANDU).* http://www.phac-aspc.gc.ca/hepc/hepatitis_c/pdf/vanduCaseStudy/index.htm

18. UNAIDS, 1999, *Op. cit.*

19. Trautmann, 1995, *Op. cit.*

20. UNAIDS, 1999, *Op cit.*

21. Parkin, 2000, Op. cit., quoting Shiner, M. and Newburn, T., 1996, *Young People, Drugs and Peer Education: an evaluation of the Youth Awareness Programme*, (YAP), Paper 13, Drugs Prevention Inititative. London: Home Office.

22. Dowsett, 1999, *Op. cit.*, p. 15

using observational and quasi-experimental designs — strongly indicates that outreach interventions using peers have been effective in reaching out-of-treatment IDUs and providing the means for effective behaviour change.[23]

In the US, IDUs recruited through peer-driven interventions reported that they shared syringes and other injection paraphernalia less often and injected drugs substantially less often than did IDUs recruited through traditional outreach;[24] moreover current drug users working with networks of drug users were able to "recruit" a more diverse at-risk group of injecting drug users and influenced greater changes in risk behaviours than was achieved with more traditional outreach.[25]

One major study[26] showed that reductions in multi-person reuse of syringes among IDUs reached by outreach were followed by reductions in seroincidence. In Australia, according to the National HIV/AIDS Strategy, the rates of HIV/AIDS among people who inject drugs remain low, due to the presence of NSPs and the work of peer educators.

3.4 Peer education is cost effective

UNAIDS cites peer education as a cost-effective intervention strategy because its use of volunteers makes it less expensive to "implement or expand."[27] Many peer education programs working in the HIV sector or with IDUs do use volunteers, which surely would reduce the cost of many programs. WHO cites a mathematical model of sexual and injection-related HIV transmission that showed that, based on the notion that the costs of preventing HIV infection were much lower than treating it, outreach-based intervention programs "were cost-effective."[28]

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In Australia, the cost-effectiveness of certain kinds of peer education can be inferred from the landmark *Return on Investment* report,[29] which while demonstrating that that NSPs were an effective financial investment by government, acknowledged that "peer-based services have had a significant and positive impact on the delivery and acceptability of NSPs to injecting drug users." A similar review of hepatitis C education and prevention programs is currently underway.[30]

23. WHO, 2004, *Evidence for Action: effectiveness of community-based outreach in preventing HIV/AIDS among injecting drug users*. Geneva, WHO, p 5.

24. WHO, 2004, *Op. cit*, p. 24.

25. WHO, 2004, *Ibid*.

26. Wiebel, W. et al., 1996. Risk Behaviour and HIV seroincidence among out of treatment drug users: a four-year prospective study. *Journal of Acquired Immune Deficiency Syndromes and Human Retrovirology*, 12, pp. 282 289.

27. UNAIDS, 1999, *Op. cit..*, p. 24

28. WHO, 2004, *Ibid*.

29. Commonwealth Department of Health and Ageing, 2002, *Return on Investment in Needle and Syringe Programs in Australia*, Canberra, Commonwealth of Australia, 2002.

30. This evaluation will update and expand upon the *Economic Analyses for Hepatitis C: A Review of Australia's Response* prepared by Mr Alan Shiell for the Commonwealth Department of Health and Family Services in 1998. It will examine various government hepatitis C education and prevention programs and include a literature review; stakeholder consultations; and an economic analysis of the costs and benefits of hepatitis C programs.

4 Commonalities among peer education programs — the idea of health

The common thread linking the various kinds of peer education is this: "members of a given group … effecting change among other members of the same group."[31] According to the UN, peer education can be used to "effect change at the individual level by attempting to modify a person's knowledge, attitudes, beliefs, or behaviours. Peer education may also be used to effect change at the group or societal level by modifying norms and stimulating collective action that leads to changes in programmes and policies."[32] The distinction drawn between "individuals" and "group or societal level" is an important one.

While the widespread popularity of peer education today may reflect its adaptability, acceptance, and value as a means of doing HIV/AIDS education, in many ways it also reflects a change that occurred to how we think about health and health education.

For much of last century, health education was heavily influenced by the idea that health could be easily and universally defined (often by public health authorities), and that individuals could prevent disease by assessing the risks to their health and modifying their behaviour. The 1970s and 1980s ushered in a new approach to public health. At a 1986 health promotion conference in Ottawa, Canada, ideas about a more holistic approach to health were given formal expression in the *Ottawa Charter for Health Promotion*.[33]

The Charter recognised that "health" was an expression of individual aspiration: health could, or should, not be imposed by public authorities — aspirations regarding health would vary from individual to individual. At the same time, the Ottawa Charter shifted the emphasis away from individual risk behaviours to a more collective notion of public health. It saw that an individual's ability to achieve their aspirations for their own health was heavily affected by the context of their lives. As noted health promotion writer Ronald Labonte said, "[The Ottawa Charter and its successors, the Jakarta and Adelaide declarations] represent the rediscovery that social and environmental conditions are more determining of personal collective health than the narrower focus on health care and disease prevention that dominated our thinking about health for much of this century."[34]

As noted health promotion writer Ronald Labonte said, "[The Ottawa Charter and its successors, the Jakarta and Adelaide declarations] represent the rediscovery that social and environmental conditions are more determining of personal collective health than the narrower focus on health care and disease prevention that dominated our thinking about health for much of this century."

Now firmly established among the guiding principles of Australia's HIV/AIDS and hepatitis C strategies, the Charter defines health promotion as a "process of enabling people to increase control over, and to improve their health" by:

- building healthy public policy
- creating supportive environments
- strengthening community action
- developing personal skills
- re-orienting health services

The Ottawa Charter changed how we think about health. Most importantly, it confirmed what many drug users had been saying for some time: that drug use need not be a reason for, or an indication of, ill health. In doing so, it defined broad parameters for how organisations could go about promoting health among drug users, especially in the areas of supportive environments, community action, personal skills, and health services. We'll examine the Ottawa Charter, and how AIVL interprets its principles in peer education with people who inject, later.

First let's look at the behavioural theory that informs peer education, what we want to achieve, and why we used peer education for that purpose.

31. UN, 1999, *Op. cit*., p. 5.

32. UN, 1999, *Op. cit*. pp. 5-6.

33. *The Ottawa Charter for Health Promotion*. http://www.who.int/hpr/NPH/docs/ottawa_charter_hp.pdf

34. Labonte, R., 1996, Health Promotion: Ten Years on from the Ottawa Charter. *Australian Journal of Primary Health - Interchange*, 2, 4, pp. 7 - 24.

5 Theoretical underpinnings of peer education

Many organisations that use peer education do so because their overall goal is to develop a recommended behaviour or change (a risky) behaviour among individuals or a target group. In this context, how and why people change their behaviour or adopt new behaviours is important. Theories drawn from health psychology, health education, public health, and communication explain this process and provide a rationale for why peer education is beneficial:[35]

1. **IMBR (information, motivation, behavioural skills and resources) model**. The IMBR model focuses on information (the what), motivation (the why), behavioural skills (the how) and resources (the where, when and whom) that can be used to target risky behaviours. This model would hold that merely providing information is insufficient to influence behaviour change. Peer education that does not offer a reason to change behaviour, impart the skills necessary to change behaviour, and provide the resources (information or services) useful to practice the behaviour.

2. **Health belief mode**l. The Health belief model is used to explain and predict health-related behaviour. It suggests that if a person has a desire to avoid illness or to get well (value) and a belief that a certain action would prevent illness (expectancy), s/he will act to achieve those expectations. While this model may explain why people may want to change behaviour, it does not account well for the context of their lives — the cultural, social, and economic conditions in which they live, and the personal experiences that affect our habits, attitudes, and emotions/moods - and how that context affects their actions. Its relevance to peer education is in the notion of the perceived tangible and psychological costs/advantages of the action or inaction.

3. **Theory of reasoned action**. This model holds that a person's perception of the social norms — their understanding of what the people important to them think about those norms — or can influence behavior change. In other words, people's attitudes to changing a behaviour is strongly influenced by their view of the positive or negative consequences of the behaviour, and what their peers (including peer educators) think about it.

4. **Social learning theory**. This theory asserts that people learn by observing the behavior of others with whom they identify, and that training in skills contributes importantly to their confidence (self-efficacy) in performing that behaviour. In the context of peer education it means that interactive experimental learning activities are extremely important, and peer educators may act as important role models who are capable of eliciting behavior change in certain other individuals.

5. **Stages of change model**. This model describes a sequence of stages in changing health-related behaviour. This model is a preferred design for assessing and targeting the behaviour of an individual rather than a group, since individuals may be at enormously varying places with respect to their attitudes, behavioural experience and intentions. This model identifies six stages through which a person may go in the process of changing a behaviour:

   a) pre-contemplation (has no intention to take action within the next 6 months);

   b) contemplation (intends to take action within the next 6 months);

   c) preparation (intends to take action within the next 30 days and has taken

35. Useful summaries of these and other psychological and sociocultural theories can be found in Stakic, S. et al, 2003, Peer education within a frame of theories and models of behaviour change. *Entre Nous: the European Magazine for Sexual and Reproductive Health*, UNFPA and WHO, 56, 2003, pp. 4-7., and King, R., 1999, *Sexual behavioural change for HIV: where have theories taken us?* Geneva, UNAIDS, http://www.who.int/hiv/strategic/surveillance/en/unaids_99_27.pdf

some behavioural steps in this direction);

d) action has changed overt behaviour for less than 6 months);

e) maintenance (has changed overt behaviour for more than 6 months); and

f) termination of old behaviour.

6. **Theory of participatory education/ empowerment**. This theory holds that powerlessness at the community or group level and the economic and social conditions that shape that powerlessness are major risk factors for poor health. It suggests that people are empowered to make the changes to achieve good health by collectively planning a response to the problem or health condition. Many claim that this horizontal process of peers (equals) talking among themselves and determining a course of action can be key to part of peer education.

7. **Diffusion of innovation theory**. This model addresses how new ideas, products, and social practices spread within or across societies, communities, or networks. Unlike other theories that focus solely on individuals or small groups or people, it focuses on the innovation (a new idea, product,practice, or technology) and how it spreads through communication channels and social systems (networks with members, norms, and social structures), particularly via positive evaluations of the idea communicated by trusted members of social networks. It is not so much a theory of behaviour as a theory of communication.

Each of these theories goes some distance to explaining informal peer education. Each has some application to our practice of formal peer education, depending largely on the kind of peer education we're involved in and the people we're working with. Note that most theories, other than the last, are concerned primarily with the behaviour of individuals and groups and how individuals or groups can be influenced to change behaviour. As we note in the next section, the idea of deliberately setting out to change behaviour is a dilemma of sorts for formal peer education, since it can place both the peer educator and the “peer-educated” in positions that contradict essential principles on which we may wish to base our practice — e.g., equality and self-determination. For this reason, we think that our practice is most usefully based in the Diffusion of Innovation Theory.

6 What is the goal/purpose of using peer education with IDUs?

AIVL understands the purpose of peer education as a means of health promotion, which, drawing on the language of the Ottawa Charter, is "a process of enabling people [who use illicit drugs] to increase control over and improve their health."

We ascribe to the notion, embedded in the Ottawa Charter, that health is a resource for — not the objective of — everyday life. In most people's minds, "health" goes beyond a strictly medical model to embrace notions of well-being. We do not subscribe to the view that using illicit drugs, and injecting them, *necessarily* compromises aspirations of health and well-being.

We accept that there is no one-size-fits-all notion of health.[36] Clearly, "health" will have different meanings for different people and for different drug users. What is important here is that we recognise and honour the choices people make about how they lead their lives, including, for example, decisions about using mind-altering substances, licit or illicit, refusing or delaying hepatitis C treatment, or even "drug treatment" itself.

A key issue here is whether we use peer education to achieve behaviour change. We accept that information does not directly produce behaviour change.[37] The question is whether behaviour change is indeed the purpose or goal of peer education. As we have seen earlier, much of the theory that underlies the peer education would imply that behaviour change is a key outcome among the recipients of peer education, a notion that appears strongly endorsed by both UNAIDS and WHO. However, if we adhere to the goals of the Ottawa Charter, from drug-user organisations' and peer educators' points of view, behaviour change may well be a desirable outcome, especially when identified by the individuals and networks with whom we work, but it will not necessarily be a required one. Our practice will be more about conveying information, knowledge, ways and means, that peers may refuse or elect to use. If we are to honour drug-users' self-determination in setting their own goals and fulfilling their own aspirations around their health, the foundation of our practice will derive largely from the Diffusion of Innovation Theory. Theoretical models about behaviour change will come into play if and when members of our community express an interest in learning or changing behaviour.

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There may be no better area to test this idea than in education related to safer-using and hepatitis C prevention. We know that many people's injecting habits protect them from HIV but fall well short of accepted standards of blood-awareness when it comes to hepatitis C. Are drug-user peer educators' doing their work to change these habits? If

36. See, for example, Kimber, J. & Day, C., 2003, Quality of life. *Dealing with risk: a multidisciplinary study of injecting drug use, hepatitis C and other blood-borne viruses in Australia*. ANCD, Canberra, 2003, pp. 79 - 84.

37. In his discussion of hepatitis C education, Dowsett, 1999, *Op cit*., (pp. 69-70) acknowledges "a commonplace legacy from HIV/AIDS education that pervades HCV prevention education … that knowledge (or information) does not directly produce behaviour change. Indeed, many models of health promotion seek to explain complex relations between the two, and many policy makers to their endless disappointment seek comfort in the prospect of that direct relationship.

"That such behaviour change (particularly conceived of as an individual decision and subsequent change in practice) constitutes the key outcome of education is not unreasonable, but it remains an unproved relationship. We are not so sure that it needs to be proved. No one asks the whole schooling system to prove that it is completely effective. As a society we are content, it would seem, that most young people completing twelve years of schooling do not actually get through their final outcome evaluation (various Year Twelve public examinations) sufficiently well enough to undertake university studies. Yet, we still generally believe that schooling works. It may be that in health education we have to learn to live with the imprecision of the craft of educating and not attempt to transfer from positivist biomedical and behavioural science the demand for clear cause-and-effect, incontestable correlation and linear outcomes."

we adhere to the principles of the Ottawa Charter, we must qualify our answer. We can say with few qualms that we are concerned with influencing norms of behaviour around injecting and hepatitis C. But our intent to change individuals' behaviour is more qualified. Given the circumstances in which some people practise injecting, they may not be in a position to follow clinical blood-awareness injecting protocols. The worth of our practice is in assisting individuals weigh the risks against the demands of desire and their temporal circumstances, offering them help to do what they would like to do. We understand that the choice to change behaviour lies with individuals. This may be one of the more pertinent differences between the practice of peer education by drug-user organisations and non-user groups.

When we engage in health promotion through peer education we are concerned not just with offering information that drug users may elect to adopt in their personal habits, but how they can act to change the larger contexts of their lives. We're concerned with learning, empowerment, social mobilisation, and advocacy.

While we understand health as a matter of aspiration, we also understand that it can be affected by the contexts of people's lives. We see health promotion as a means of increasing people's ability to influence, change, and improve the circumstances of their lives. When we engage in health promotion through peer education we are concerned not just with offering information that drug users may elect to adopt in their personal habits, but how they can act to change the larger contexts of their lives. We're concerned with learning, empowerment, social mobilisation, and advocacy.

Our notion of health promotion is concerned not just with individuals, but with the communities and networks in which people live their lives. We understand that individuals' ability to achieve their aspirations for health can be moulded by the attitudes, values, and norms held by the people with whom they share their lives. When we engage in health promotion, we understand that we may also be contributing to shaping of those attitudes, values, and norms. We can be sowing ideas that have a life far beyond one individual's immediate day-to-day concerns.

Finally, it seems worth pointing out that the large majority of peer education programs fielded in various parts of the world begin when agencies and organisations identify a particular need among a population and develop a peer education program to address that need. As a matter of principle and strategy, we believe that our practice of peer education will be most effective when it consistently relies on, responds and returns to the needs identified by the people we're working with. To some extent, this would may appear at odds with the reality of funding and fielding peer education programs, especially those forms of peer education that do not have the flexibility of, say, outreach. However, as can be seen in the programs described in section 11, many drug-user organisation have to their best ability sought to honour this idea in their education, advocacy, and community development programs.

7 Why use peer education to achieve this/these goals?

We noted earlier some of the characteristics of peer education that argued for its use in HIV/AIDS and sex education. Those characteristics are equally applicable to peer education among injecting drug users. However, there are other reasons that argue for the use of peer education as a means of health promotion among drug users.

7.1 The shape and character of a drug-using/injecting community

> There's neighbourhoods of drug users. There's groups of drug users. There's scenes of drug users. Sometimes there's crossovers and that may be geographical location or central scoring location. So there's a diverse community of [drug users], but not in a broad [conventional] sense.[38]

These days the term "community" is as much a part of our everyday language as the word "love." It is especially present in the mainstream media, in the titles of government agencies, in the health industry, and in job titles. It would be fair to say that the word is used more by people in the course of their work than the people who comprise the "communities" they refer to. So what are we referring to when we talk about community?

Very broadly speaking, "community" appears to be about some kind of connection, where that |connection is expressed through location, circumstance, language, attitudes and values, experience, or culture — or any combination of all. There are also different scales of communities, where the connections are more specific or general, for example being a street or block of flats, *vs* a neighbourhood, *vs* a township or suburb or locale, *vs* a city.

Are there connections between drug-users sufficient to make a community or communities? The answer is a resounding yes. But what defines those communities has been a matter of considerable debate.[39]

One view is that the connections between users are forged through their participation in a larger multifaceted illegal industry.[40] This has some merit, since many of the connections we share are derived from "marketplaces." In the context of using illicit drugs, these connections are further reinforced by the illegality of the marketplace. Users are often part of networks constructed by the buying, selling, and using of drugs, and participating in that market is largely mutually supportive and by necessity protected from non-users.

Some would argue that the connections established through the marketplace are the only connections that bind users. On face value, this is true, since many users may not have anything in common with each other than a covert or illegal activity. They point to the fact that just as there is not one homogenous community of gay men and women; that there is considerable heterogeneity in the illicit drug community. They would argue that the "community" of drug users is better described as a series of networks, sub-cultures that can be forged through, for example, geography, age or generation, language, common circumstance, experience, choice of drug, cultural interests, or just plain friendship.

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38. Quoted in Dowsett, 1999, *Op. cit.*, p. 78-79.

39. Dowsett, G., 19991, *Op cit.*, (p. 78), argues that there is a "communality [emphasis added] among users available to be worked with. Its shape and character is what is debated."

40. See Dowsett, G., 1999, Op. cit., p 77, Morgan, K. & & Siddins, J., (n.d.) *What is peer education?* Unpublished paper.

These are not conflicting points of view. Rather, they point to different scales of community or communities forged through various kinds of connections.

Injecting drug users, like members of the general population, tend to be members of several overlapping and intersecting communities. At different times in their lives and in different contexts, they will have varying degrees of attachment to these communities as aspects of their social identity.[41] Peer education (even in the absence of "peer educators") takes place against a backdrop of these attachments, within networks that have their own social etiquette, rules of acceptable behaviour, shared language and culture, all of which can influence attitudes and behaviours within the group for either good or ill. The connections between members of these communities (or, if you like, tribes, sub-cultures, social networks) will vary — they may be weak or strong, transitory or long-standing — but each of these networks offers something upon which peer education can invoke and upon which it can build.[42]

The challenge for peer education is to recognise, harness, and work with these connections; to understand "community" as more than short-hand for "users, groups of clients, an agency's clientele, an advocate's constituency or, 'us' here in the community sector (i.e., anyone other than government)."[43]

The challenge for peer education is to recognise, harness, and work with these connections; to understand "community" as more than short-hand for "users, groups of clients, an agency's clientele, an advocate's constituency or, 'us' here in the community sector (i.e., anyone other than government)."

7.2 Cultural and sub-cultural realities; the norms within communities

We know from our own experience and from the evidence collected through qualitative research that communities and networks of users form patterns of drug use and, while some of those patterns have common elements related to the drugs being used, other forces contextualise and reinforce those patterns.[44] These patterns are what many call "norms" of behaviour. They can be influenced by the individuals within networks; at the same time, they can exert influence on the behaviour of individuals. They are part of "culture," or as the case may be, "sub-culture." They can also be part of the currency of connection.

Australia's low rate of HIV infection among injectors testifies to a "widespread mobilisation of users"[45] who were willing to enact protective behaviours at an individual and collective level.[46] Many would argue that it pointed to a pervasive change in some of the norms of injecting. As Weibel and Levin have shown, "Without prevention materials [such as clean injecting equipment], education alone is a necessary but insufficient means to accomplish widespread harm reduction. Similarly, the provision of prevention materials without changing accepted norms of

41. Brogan, D. 1999. *Peer mediated user-education: a framework for community action*. SAVIVE Strategic planning documents, Adelaide, SAVIVE, p. 10.

42. Power , R., et al., 1995. *Op. cit*.

43. Dowsett, G.,1999, *Op. cit*. p. 77.

44. Dowsett, G., 1999, *Op. cit*., p. 66.

45. Brogan, D., *Ibid*.

46. Southgate, E. et al., 2003, Conclusions: dealing with risk - a synthesis of findings from this report. *Dealing with Risk: a multi-disciplinary study of injecting drug use, hepatitis C and other blood-borne viruses in Australia*. Canberra, ANCD, p. 85.

behaviour proved crucial but incomplete as a prevention strategy." The norms changed as users influenced each others' behaviour to effect meaningful and long-term behaviour change; within peer networks group norms reinforced "acceptable" and "unacceptable" behaviours.[47] (We note, tangentially, that the change in norms was facilitated and encouraged by availability of and access to new injecting equipment. One wonders if a similar change in attitude to the use of pill filters might take place if they were as easily procured as needles and syringes.)

Qualitative research has also shown that within user networks, certain people are capable of exercising their authority in a positive way to affect how people use drugs.[48] A prime example is how people learn to inject in the first place. Another is the practice well-known in some NSPs, where one person collects new equipment or disposes used equipment on behalf or others.[49]

At the same time, there is evidence that while information does get passed around within networks, not all that information may be "correct." As both researchers and user organisations have shown, "grapevines" can be the medium for the dissemination of misinformation.[50] One of the goals of our practice of peer education is to empower our constituents with the knowledge and means to vet and evaluate information from this, as well as any other, source.

Individuals attempt or achieve changes to their behaviour against a context of how those changes are endorsed or encouraged by the peer group. Peer education that works with individual users without recognising how those individuals are affected by the norms of their networks and communities will possibly have limited utility. The experience with HIV education, and to a more limited extent, hepatitis C education, shows that peer education can affect the development of new norms or modify those already in existence. Peer educators are likely to have an experiential, intuitive awareness of how those norms are constructed; they are also well-positioned to identify the key players whose authority constructs, changes, and reinforces those norms.

7.3 Peer educators' understanding of notions of risk offers more scope for harm reduction

Using illicit drugs can be both pleasurable and risky. Though references to pleasure are roundly present in popular culture, they are noticeably less apparent in the academic literature. That said, the risks associated with using illicit drugs are sufficiently well-documented to not require listing here.

... many risks are not so much due to the substances that are used so much as the circumstances of their use. If we accept that it is quite possible to inject without acquiring HIV or hepatitis C, we must conclude that the high number of new hepatitis C infections is evidence of something more than the fact of injecting. In the context of health promotion, we're concerned not just with the fact of the risk, but the how those risks can be reduced.

Despite what mainstream media may hold, many risks are not so much due to the substances that are used so much as the circumstances of their use. If we accept that it is quite possible to inject without acquiring HIV or hepatitis C, we must

47. Madden, A., Byrne, J., & Bath, N. *Op cit*.

48. See, for example, the work of Sam Friedman; Southgate et al., 2003, *Dealing with Risk*, and more recently, Treloar, C, & Abelson, J. 2005, Information exchange among injecting drug users: a role for an expanded peer education workforce. *International Journal of Drug Policy*, 16, pp. 46-53.

49. SAVIVE's NSP statistics indicate that each person coming to the service to collect injecting equipment and/or to dispose of contaminated items is acting on behalf of around four others. (Brogan, D. 1999, *Op cit*., p. 7). Anecdotal evidence would indicate that this practice is widely replicated in other parts of Australia, especially in areas without easy access to NSPs.

50. Southgate, E. & Hopwood, M., 2001, The role of pharmacology and lay experts in harm reduction: Sydney gay drug-using networks. *International Journal of Drug Policy*, 12, pp. 321-335; and Wye, S., 2002, Well, Waddya Know?, *User's News*, 38, pp. 41-44, http://www.nuaa.org.au/nuaa/News/media/UN38/UN38_Waddya_know.pdf

conclude that the high number of new hepatitis C infections is evidence of something more than the fact of injecting. In the context of health promotion, we're concerned not just with the fact of the risk, but the how those risks can be reduced.

There are risks present in the act of acquiring illicit drugs; in administering them (and for some, even obtaining the equipment to administer them); and enjoying them. For some, their understanding of the likelihood of risk argues for not using illicit drugs at all. For others who choose to use illicit drugs, even infrequently, the risks may be hazy, misunderstood, or unknown, or well-known, accepted, and even desired.

Peers can relate to the way other users understand and construct risk. They can appreciate the context in which users 'operationalise' their point of view; they can empower their peers to negotiate the circumstances of those contexts. Peer education can go beyond disseminating information and building knowledge. It offers a way of learning to use that knowledge.

The fact that we can distinguish between risks known and unknown and risks variously understood points to the importance of point of view. Clearly, a person working in the field of infectious diseases may have a different understanding of risk to someone who is not; a person who has scored and used illicit drugs many times may approach it differently to someone who is a novice.

Knowledge, or understanding, plays a role in constructing that point of view. We know that knowledge about risks and safety varies widely among illicit drug users, and that how they understand what they think they know — for example, how they understand concepts such "virus," "infection," "antibody status" — may not always have clinical precision or accuracy.[51] The circumstances of people's lives — (e.g., dependency, financial position) their emotional state at a given time, their experiential base, and the views of their family, friends, and peers — also moderates point of view and how people approach risk. There is perhaps no more telling example of the role that circumstance plays than the maxim we may be all be familiar with: "When you gotta share, you gotta share."[52]

But point of view is not the only variable at work here. We act on our point of view within a broad structural context fashioned by social and economic circumstance, group membership, power relations, physical environments, and policy and service provision in areas such as health, policing and housing coalesce to constrain individual decision making.[53]

Enabling illicit drug users "to increase control over and improve their health" has to consider these factors. There are few as well-positioned to understand, interpret, and work with those factors than peers and peer educators. Peers can relate to the way other users understand and construct risk. They can appreciate the context in which users "operationalise" their point of view; they can empower their peers to negotiate the circumstances of those contexts. Peer education can go beyond disseminating information and building knowledge. It offers a way of learning to use that knowledge.

7.4 Stigmatisation of behaviour and marginalisation of IDUs

Mainstream health promotion efforts with illicit drug users, and particularly injectors, have often met with limited success because of the stigma attached to using and, particularly injecting.

51. 51. See Wye, S., 2002, *Op. cit*.

52. Wye, S., *Ibid*.

53. See, for example, Singer, M. 1994. AIDS and the health crisis of the urban poor: the perspective of critical medical anthropology. *Social Science and Medicine*, 39 (7), pp. 931 - 948; 1994; and Rhodes, T. et al., 1999, Drug injecting, rapid HIV spread, and the 'risk environment': implications for assessment and response. *AIDS*, 13 (supplement A). pp. 259-269. 54. Morgan & Siddens, *Ibid*.

The fact that there is a host of organisations devoted to policing, treating, and imprisoning drug users gives that stigma a formal aspect; its expression in everyday life is often reinforced by parts of the media and the attitudes of some service providers. However, the stigma attached to injecting is decidedly more virulent and pernicious. Injecting is largely an activity entered into only under strict medical/clinical supervision, even coercion; the broader community's negative attitude to the practice is often characterised as a phobia,[54] especially since it is "inextricably linked" to assumptions about hepatitis C[55] and to a lesser extent, HIV.

For many IDUs, the stigma attached to injecting translates into their being unwelcome in mainstream services, distrustful of their motives, and cynical about the educational messages they produce. The lack of openness about injecting practices accounts for the "hidden populations" of injectors who may have little or no contact with agencies that might otherwise deliver services to them. And stigma has been directly associated with high-risk injecting practices resulting in infection with HIV and hepatitis C,[56] high levels of drug dependence, criminal recidivism, severe economic disadvantage, and homelessness.[57]

In the context of health promotion, enabling illicit drug users "to increase control over and improve their health," peer education provides a way to access "hidden populations," convey information and encourage learning among people who may be indifferent or unreceptive to other kinds of approach, address "high-risk" practices with a pragmatism that considers life circumstances and individuals' capacity to understand and implement changes in behaviour, and even establish the credibility of mainstream organisations and encourage users' access to them.

7.5 Identity and credibility

A strong argument for the use of peer education lies in the nature of "peerdom," the importance of identity and identification among marginalised populations, and the credibility that is generally accorded to both the messenger and the message in the context of peer education. As noted earlier, peer educators can bring "person-based," "experience-based," and "message-based" credibility to health promotion in the context of intimate, illegal, and stigmatised behaviours such as illicit and injecting drug use.

A good argument can also be made for the ability of peer educators to translate complicated messages and medical jargon into manageable pieces of information ... This is no better illustrated than in the area of hepatitis C. Understanding the concepts underlying blood awareness can be challenging enough; translating behavioural maxims such as "Be Blood Aware" into the practicalities and etiquette of injecting can be like trying to clap with one hand.

Peers are more likely to believe and trust information and ideas that come from someone with credibility as a user within their network or group; they're more likely to listen to someone that they respect and know has personal experience of "living the life" (e.g., scoring, injecting, hanging out, going through treatment, dealing

54. Morgan & Siddens, *Ibid*.

55. See Anti-Discrimination Board of NSW, 2001, *C-Change: the report of the enquiry into hepatitis C related discrimination*, Sydney, Anti-Discrimination Board of NSW, p. 128: "The evidence to this Enquiry clearly demonstrates that hepatitis C is a highly stigmatised condition and discrimination against people with hepatitis C is rife … perhaps more powerful than ignorance about hepatitis C transmission, is that hepatitis C infection is inextricably linked to illicit drug use, which is highly stigmatised behaviour. Evidence to this Enquiry makes it abundantly clear that discrimination against people with hepatitis C is often motivated by stereotyped responses towards people on the basis of past, current or assumed injecting drug use…"

56. See, for example, discussions concerning various of the case studies covered in Southgate, E., et al,. 2003, *Dealing with Risk*.

57. Southgate, E., & Weatherall, A, 2003, Sydney case study: Kings Cross. *Dealing with Risk*, Canberra, ANCD, p. 42.

58. Brogan, D., 1999, *Op. cit*., pp. 2-3.

with mainstream agencies), of negotiating "modes of desire,"[58] of feeling the pleasure that comes with using illicit drugs, and constructing and negotiating risk.[59] Without that experience, a peer worker's knowledge of his/her portfolio could be sorely lacking.[60]

In a more formally constructed exchange, where the messenger is an outreach worker or peer educator, the fact that all parties identify with each other as members of a specific socio-cultural reality can make a peer educator a strong role model for changing behaviour.[61] International research shows that injecting drug users "approached" by peers reported that they shared syringes and other injection paraphernalia less often (and injected drugs substantially less often) than injecting drug users recruited through traditional outreach, and active drug users or opinion leaders doing outreach with injectors recruited a more diverse at-risk group of injecting drug users and influenced greater changes in risk behaviours than was achieved with more traditional outreach.[62]

A good argument can also be made for the ability of peer educators to translate complicated messages and medical jargon into manageable pieces of information, and to relate health messages to the context of people's lives in a far more visceral way than a social marketing campaign. This is no better illustrated than in the area of hepatitis C. Understanding the concepts underlying blood awareness can be challenging enough; translating behavioural maxims such as "Be Blood Aware" into the practicalities and etiquette of injecting can be like trying to clap with one hand.

59. Madden, Byne, & Bath, *Op. cit*.

60. Morgan & Siddins, *Ibid*.

61. UNAIDS, 1999, *Op. cit*. pp. 10-11.

62. WHO, 2004, *Op. cit*., p. 21.

8 Principles for formal peer education by drug-user organisations

If we accept that drug-user organisations use peer education because it is an effective way to empower drug users to realise their own aspirations for health and well-being, we can identify principles to guide our work.

These principles derive from philosophical and practical considerations. They can shape our understanding of our work and how we put that understanding into practice. They concern:

- ❖ our position in relation to the people we work with — equality;
- ❖ the dynamic of the peer education process — self-determination;
- ❖ how adults learn — adult learning principles;
- ❖ illicit and injecting drug use in relation to overall health and well-being — harm reduction;
- ❖ the focus of our work in relation to individuals and community — community development; and
- ❖ moral and legal considerations that affect individuals' rights in the peer education process — privacy and confidentiality.

The principles we have identified are not discreet. They share some common ground. We can think of them as interlocking components of a whole system.

8.1 Equality

It's a contested concept. It has various meanings in various spheres of human endeavour. “People who praise it or disparage it disagree about what they are praising or disparaging.”[63]

We are not talking here about sameness, where two or more things are identical — none of us are exactly the same, and the variety of human behaviour seemingly infinite. Rather, we're reminded that that despite our various differences, we share a common humanity that argues for fair treatment beyond the subjective judgement, what many would argue as “social justice.”

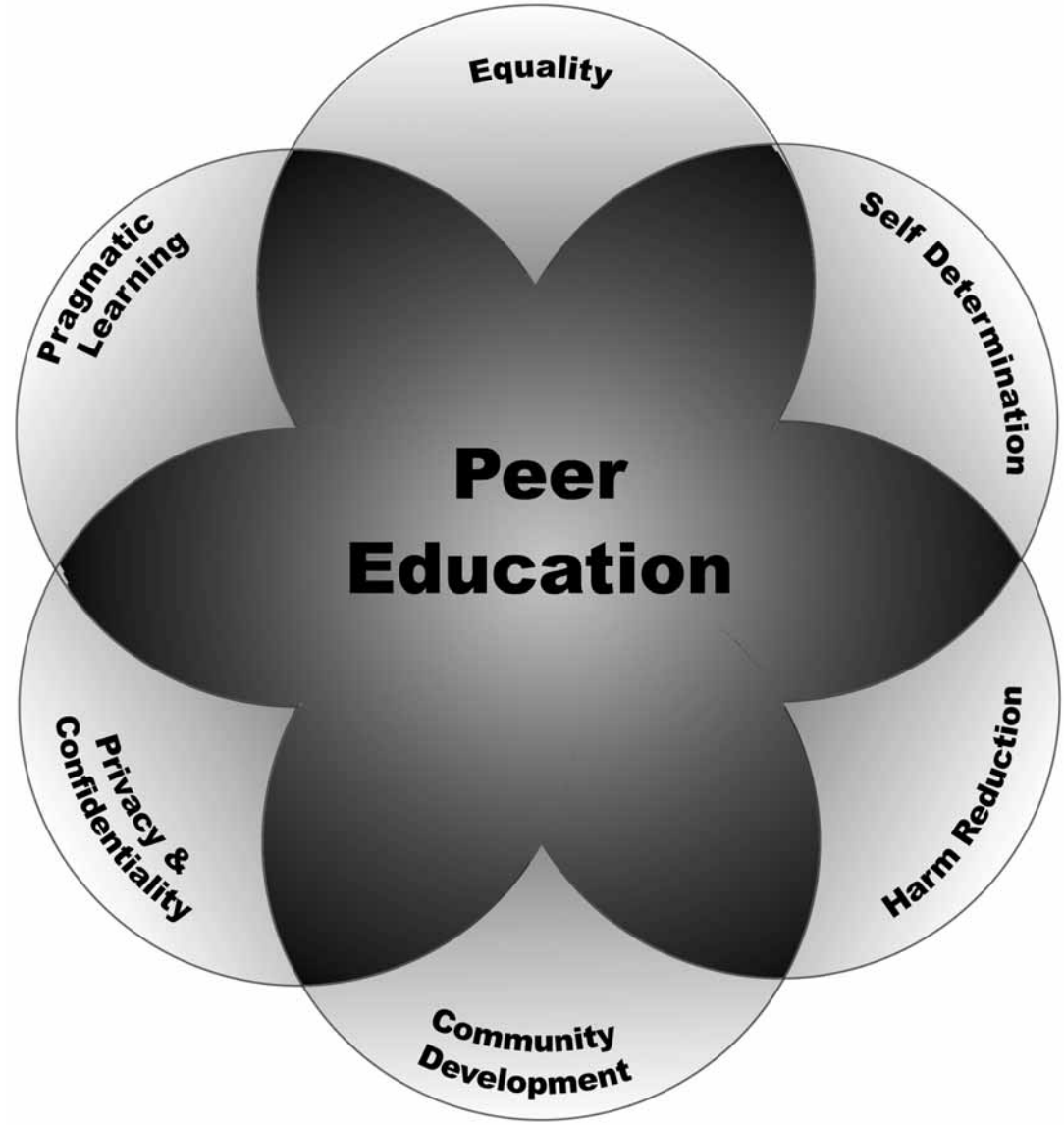
When it comes to health promotion, or peer education, these ideas are expressed in our idea of “peers” and “peerdom,” and how we position ourselves in relation to the people we work with. We are equals, of equal standing. We are not in the business of asserting right or wrong, or, in the manner of *il duce*, leading horses to water and forcing them to drink. We are not about directing people, imposing points of view, or presenting information like manna from heaven.

When it comes to health promotion, or peer education, these ideas are expressed in our idea of "peers" and "peerdom," and how we position ourselves in relationto the people we work with. We are equals, of equal standing. We are not in the business of asserting right or wrong ... leading horses to water and forcing them to drink. We are not about directing people, imposing points of view, presenting information like manna from heaven.

Peer education is first and foremost about drug-users talking to each other as equals, about empathising, sharing information, and offering encouragement — empowering — so that drug users can make up their own minds about how best to manage their health and well-being.

Some observers have noted that a peer education equation where one party is paid and another not makes for an uneven playing field, one which automatically precludes equality. There is some merit to this point of view: in monetary terms, the equation is unequal. Some programs have been able to address this situation by offering honoraria/payments to people who attend peer education workshops. Clearly, it would be impractical and unrealistic to extend this practice to all forms of peer education. In any case, we think that the heart of this principle lies not so much in the realm of dollars as sense and sensibility. We’re talking about equality as a matter of point of view, attitude, approach, and how we communicate with constituents.

63. Dworkin, R., 2000, *Sovereign Virtue. The Theory and Practice of Equality*, Cambridge: Harvard University Press.



8.2 Self-determination & ownership

If we accept the innate equality of a peer relationship, we also acknowledge the inherent rights of individuals (and groups of individuals) to self-determination as they seek to control and improve their own health. That means that the people we work with in peer education have a large role to play in shaping what we do and how we do it.

Through their constitutions and, hopefully, the form, character, and motivation for their activities, drug-user organisations are themselves expressions of self-determination, representation, and ownership on the part of their members. As employees of drug-user organisations, we have a responsibility to represent the interests of all drug users. We are not there to represent just our own point of view.

At the outset, if we honour the underlying philosophy of the Ottawa Charter, our work will be informed by the needs of the people we work with, not *our* view of *their* needs. Beyond that, because so many aspects of drug use are prescribed, regulated, and stigmatised, when we respond to those needs, we have a responsibility to create an environment where those pressures are not evident, where, rather than being directed, people have the opportunity to have ownership of process and outcomes.

Because peer educators have direct contact with drug users, self-determination and ownership are more visceral and perhaps more easily realised than in other activities undertaken by drug-user organisations. We can actively encourage and facilitate the participation of drug-users in shaping our work. Rather than taking a unilateral approach

to setting agendas, defining content, or prescribing outcomes, we can consult, work cooperatively, consider lived experience, interests, and the value that drug users give to new areas of knowledge — we can, first, facilitate their setting agendas and goals and, second, offer information, new ways of thinking about issues or dealing with certain problems. There can be little doubt that this is easier to do working one-on-one than with groups. But where practicable, we welcome, encourage, and facilitate a democratic process that facilitates peers designing, developing, implementing — controlling — the learning experience, in whatever form that may take.

"Where practicable"? Most, if not all, drug-user organisations receive their funding through government grants, to which are attached performance indicators and reporting requirements that appear to emphasise product and outcome to the detriment of process. Peer education doesn't often produce neat reporting data. It can be unpredictable and messy. Its achievements can't be easily measured on a client satisfaction survey or a knowledge questionnaire. Yet, we're increasingly being asked to measure success in terms of quantifiable outcomes related to contact objectives. At the same time, the forms of peer education that we undertake are being subtly steered away from the freer forms of peer education such as outreach to the neater and more easily described and, at first blush at least, easily "quantified" workshop.

Few would argue that a process emphasising self-determination and ownership is considerably enhanced when the impetus for the work springs from needs identified by a group of users. That is an ideal starting point for a peer education project, and drug-user organisations should encourage and be prepared to respond to these approaches. (The Tribes project, described in 11, is a peer education model developed to do just that.)

But in the real world, we are are more often in the position of identifying a general need for education through research, anecdote, and our organisation's knowledge of our constituencies, and devising peer education projects to enhance individuals' knowledge and skills in a group setting — what we call the "workshop."

Some would argue that many of the peer education workshops organised by drug-user organisations are not true peer education. After all, the impetus for the project may owe more to contract imperatives, and the subjects, and to some extent the content of the workshops may have been largely set in advance. We agree — it is not peer education in its purest, most organic form. However, if the basis of our practice aligns more closely with the Diffustion of Innovation Theory than other theories more directly concerned with behavioural change, workshops can be implemented with practical consideration of the principles of peer education. A peer education workshop can be structured and facilitated in such a way that participants are able to influence its process and outcomes, achieve a sense of ownership and control. This is not necessarily easy, and peer educators who excel working one-on-one may need assistance and training in working with groups to do it in a way that allows self-determination and encourages ownership on the part of all members of the group. The programs described in the last section of this document offer some examples of how the principle of self-determination and ownership can be put into practice in a workshop setting.

... we welcome, encourage, and facilitate a democratic process that facilitates peers designing, developing, implementing — controlling — the learning experience, in whatever form that may take.

8.3 Pragmatic learning

Because we practice peer education with adults, we are pragmatic about how adults learn:

1. Adults usually have strong sense of identity and self-concept. As a person moves from childhood to adulthood, they become more independent and self-directed. They resent being placed in learning situations where they are treated as children (told what to do, talked down to, judged, etc.)

2. Adults determine what they need to know. In child learning the teacher takes the responsibility of determining both what child will learn and what sequence learning should follow. With adults, the sequence of learning

should be strongly influenced by, if not identified by, the learners (which they themselves identify), rather than simply by the logic of the subject matter. In the peer education context, this means that the members of the peer group set the learning agenda.

3. Adults test learning against their own beliefs and experiences. (They don't accept information just because someone tells them it's true. They will also judge the credibility of information by measuring any implied values against their own).

4. Adults seek relevance and immediate applicability. Adults approach education from the standpoint of "doing in the present" — of being able to apply the learning immediately. This argues against subject-centred learning and reinforces the role of the learners setting the agenda.

As one observer has noted, the primary aim of peer education is "to influence and harness for positive outcomes the naturally occurring and ongoing interactions and normative structures that exist within peer groups. The locus of peer education is not primarily in the training workshop, but in the peer-networks."

5. Adults have a larger and more varied store of experience than children. These experiences affect how they assess the information they receive; at the same time, they're also a rich resource for learning. (Often learning is building upon knowledge and experience rather than starting from "I don't know anything and I need someone to tell me it".)

6. Adult learning tends to be problem and outcome focused. (They start with what is happening: "What do we need to do to change that?").

7. Control (power in the learning relationship) is the key thing. (Adults can refuse to participate. Adults can walk out. Adults can challenge what is said and who is saying it).

These ideas, drawn from widely held principles of adult education,[64] reinforce the notions of the equality and self-determination inherent in the peer relationship and give further support to the notion that our practice should be primarily based in Diffusion of Innovation Theory rather than the theories that concentrate largely on behavioural change.

8.4 Developing community

Health promotion is concerned not just with individuals, but with the communities and networks in which people conduct their lives. It is concerned with the norms of behaviour within those networks, and empowering people, individually and collectively, to influence the social, economic, cultural and environmental contexts of their lives.

One of the most frequently cited Australian examples of community development is the "mobilisation" of the gay community in 1980s in the face of HIV/AIDS, which led, among other things, to the establishment of organisations such as the state AIDS councils. Though less publicly and critically acclaimed, the establishment of State-based drug-user organisations was also due to the efforts to coalesce and mobilise "community."

In citing these examples, we are aware of a tendency to view them as a kind of zenith or ultimate expression of community development. This is an unhelpful view. While we don't discount their importance, we are also aware that the fact of those organisations can distract attention from the broader and fundamental locus of peer education: the community itself. As one observer has noted, the primary aim of peer education is "to influence and harness for positive outcomes the naturally occurring and ongoing interactions and normative structures that exist within peer groups. The locus of peer education is not primarily in the training workshop, but in the peer-networks.[65]

64. These observations draw heavily on the work of Margaret Duckett's evaluation of the NUAA Tribes Project (Duckett, M., 1995, *The Tribes Project Evaluation Report*, Sydney, NUAA, pp. 15-16) and Damon Brogan (Brogan, D., 2003, *Peer Education: In search of a common model*. Canberra, AIVL.) Brogan himself readily acknowledges his debt to the work of Cecilia Gore and Sonia Mahs (see, for example, Gore, C., 1995, *Educating Users*, a plenary paper presented at a 1995 National IDU Education Forum sponsored by the Commonwealth Department of Health & Ageing, Sydney; and Gore, C. & Mahs, S., 1995, *The 1994 ROW & MetROW Project*, Sydney, NUAA).

65. Brogan, D. 2003, *Op. cit*.

If the locus of peer education lies primarily in the peer networks, we should also acknowledge that "mobilising" drug users may present more challenges than mobilising gay men, largely because the "loci," the peer networks, are formed around illegal behaviours that are likely to be concealed from outsiders. While some networks remain stable over many years, others are fluid and changing. Experienced peer educators will vouch for the fact that knowing a social network (and the roles that demographics, age, location, subculture, sexuality, music, choice of drug, etc., play in shaping the network) affords them a more sophisticated understanding of how using shapes the social relations of any group of users, the specific meanings it has for group members, the availability of subcultural resources (e.g., common interests, language) that will assist peer education, and specific challenges (e.g, language, literacy) likely to be encountered.[66]

In his 1999 survey of HCV/IDU education in Australia, Dowsett noted that although community development was a key concept in the minds of many educators, it was remarkably absent in the literature reviewed for the project. He concluded that there was a need for clarification of community development in relation to HCV/IDU education, "as its potential will vary greatly among different users and in different places and agencies."[67] We would agree.

We are not in a position to posit such a model in this document. However, we can make some suggestions as to where its potential lies. Broadly speaking, we see peer education as concentrating on the strengths, rather than weaknesses, present within a network, to empower its members to collectively tackle problems that they, rather than the peer educator, identify. This may include:

1. strengthening drug user peer networks to enhance communication and mutual support, so as to create social environments in which health-promoting behaviours become less difficult
2. connecting networks of users to health resources, services and programs, and increasing users' confidence in using them
3. advocating on behalf of users with representatives of health services and programs to increase their openness and sensitivity to users' needs
4. reinforcing aspects of the norms within user networks that have a positive influence on well-being, and influencing change in those that don't
5. providing skills and, if necessary, resources to train and empower drug users to do any of the aforementioned themselves.

Experienced peer educators will vouch for the fact that knowing a social network (and the roles that demographics, age, location, subculture, sexuality, music, choice of drug, etc., play in shaping the network) affords them a more sophisticated understanding of how using shapes the social relations of any group of users, the specific meanings it has for group members, the availability of subcultural resources that will assist peer education, and specific challenges likely to be encountered.

8.5 Harm reduction

An integral part of the National Drug Strategy and this country's response to HIV/AIDS and hepatitis C, [68,69,70] harm reduction can be defined by a range of principles in which policies, strategies, and programs are grounded. While there is still no formal definition of harm reduction, among its adherents there is considerable consensus about what harm reduction is. The International Harm

66. Dowsett G., 1999, *Op. cit*., p. 79.

67. Dowsett G., 1999, *Ibid*.68. Australian Government, Department of Health and Ageing, *National HIV/AIDS Strategy: Revitalising Australia's Response 2005-2008*, Canberra, Commonwealth of Australia, p. 15.

68. Australian Government, Department of Health and Ageing, *National HIV/AIDS Strategy: Revitalising Australia's Response 2005-2008*, Canberra, Commonwealth of Australia, p. 15.

69. Australian Government, Department of Health and Ageing, *National Hepatitis C Strategy*, 2005-2008, Canberra, Commonwealth of Australia, p. 11.

70. Intergovernmental Committee on Drugs & the Australian National Council on Drugs, 2004, *The National Drug Strategy: Australia's Integrated Framework, 2004-2009*, Canberrra, Commonwealth of Australia, p. 2.

Reduction Association suggests that harm reduction should be understood to mean "policies and programs which attempt primarily to reduce the adverse health, social, and economic consequences of mood-altering substances to individual drug users, their families, and their communties."[71] Our interpretation of harm reduction embraces:

- Pragmatism — accepting that some use of mind altering substances is a common feature of human experience, and acknowledging that, while carrying risks, drug use must also provide benefits that must be considered if drug-using behaviour is to be understood.

Good peer educators may suggest, offer, recommend, advocate, provide information and materiel, but they speak from a wholistic point of view, without judgement, weighing relative costs and benefits, and considering the values, experiences, circumstances, and goals of the peers they're working with.

- Humanistic values — making no moral judgement either to condemn or to support the use of drugs, regardless of level of use or mode of intake. The dignity and rights of the drug user are respected.
- Focus on harms — focusing on reducing harms (health, social, economic, et al.) to the individual, the community and society as a whole.
- Balancing the costs and benefits — identifying, measuring, and assessing the relative importance of drug-related problems and their associated harms in order to focus resources on priority issues.
- Priority of immediate goals — engaging individuals, networks, and communities to address their most pressing needs, achieving the most immediate and realistic goals as first steps toward risk-free use, or, if desired, abstinence.

Like peer education, harm reduction has been a fact of life for most users of illicit drugs. Just as "organic" peer education, one user talking to another about ways of using, takes place in the course of everyday life, it can be argued that the harm reduction of a kind was being practiced by drug users long before it became formalised into a policy. We may quibble about its relative sophistication, or even its factual basis (e.g., myths about opiate overdose), but its presence points to aspirations upon which formal peer education builds.

The tenets of harm reduction listed above may not always inform the practice of "organic harm reduction" that takes place in everyday life (the mutual prejudices of opiate and amphetamine users comes to mind), but they can inform the way peer educators approach their work. Good peer educators may suggest, offer, recommend, advocate, provide information and materiel, but they speak from a wholistic point of view, without judgement, weighing relative costs and benefits, and considering the values, experiences, circumstances, and goals of the peers they're working with.

8.6 Privacy & confidentiality

Peer educators talk to people about very personal aspects of other peers' lives. Revealing identity and personal information can have unpleasant, inconvenient, and even disastrous consequences. The present social and legal climate makes illicit drug use, and especially injecting, a highly fraught activity. We have a moral responsibility to conduct our activities in a way that avoids these consequences. We also have a moral responsibility to protect the confidential information we may acquire about people not just from authorities, but from other users as well.

We also have a legal responsibilities with respect to privacy under relevant Commonwealth and State legislation (in addition to responsibilities under confidentiality agreements we may enter into with our employers). Managers/supervisors of peer education programs should make themselves and their supervisees aware of this legislation and how it may come to play in the practice of peer education.[72]

71. Hunt, N., *A review of the evidence-base for harm reduction approaches to drug use*. http://forwardthinking-on-drugs.org/review2.html

72. We note also that under relevant child protection legislation, rather than protecting privacy, workers may be obliged to make official reports where juveniles are thought to be using illicit drugs or where the children of drug users are considered to be at risk.

9 Who is a peer?

A peer is "someone who is considered to be a member of a particular group by both themselves and members of the group."[73] In the context of a group of friends or a network, this may appear relatively straightforward. Peers have accepted one another as "equal in standing, rank, or value." Yet, a map of the process through which those people recognised each other as peers could cover ground such as age, gender, cultural background, socio-economic status, sexuality and sexual identity, political values, education, recreational interests, where and they live — you can probably add several more identifiers to that list. And yet, even the most detailed list could miss one of the most essential ingredients. Being accepted as a peer is not so much about being the same, but about being *accepted* …

In the context of drug use, the notion of "peerdom" is affected by another range of shared characteristics and similarities based largely on experience using drugs. This could include experience with injecting, dependency, treatment, overdose, being "messy," and, last but not least, desire — you can probably add to that list as well. But again, the essential ingredient is not sameness so much as "acceptance" on the part of all parties.

Acceptance is a two-way street. It's a convergence of points of view. "[E]ssentially, what is of greatest importance in making peers is that those involved in the process regard one another as peers."[74] "Being accepted as a peer is a social process of identifying, and being identified, as part of a group, network, community or culture. It is not a decision that can be made by others outside the process."[75]

Where does this place people who are employed to undertake formal peer education on behalf of drug-user organisations? They unlikely to be "members" of all the drug-user peer networks in the locale in they are working. Clearly, like the members of the peer groups themselves, they will not necessarily share all the characteristics of the individuals who comprise a given group of users. They will not be "the same." However, they position themselves as peer educators when they accept themselves as "equal in standing, rank, or value" to the people they're working with, and they can become peer educators when they are, in turn, accepted by the same people as "equal in standing, rank, or value."

What contributes to this "acceptance"? We go back to one of the principles noted earlier: equality. Peer educators are equals working with equals. Good peer educators accept themselves as the moral equals of those with whom they work. They may be in a position to offer knowledge and information, opportunities for learning; they will also be aware they themselves are in a position to learn.

Peer educators are equals working with equals. Good peer educators accept themselves as the moral equals of those with whom they work. They may be in a position to offer knowledge and information, opportunities for learning; they will also be aware they themselves are in a position to learn.

We cannot require the same acceptance from the peers with whom we work. Rather, we present our bona fides — in the form of knowledge and understanding of rituals, norms, and established patterns of behaviour (e.g., about injecting); our appreciation of the social and cultural contexts of people's lives; our identity and experience; our point of view — and allow the people we're working with to make up their own minds. We can't make it happen.

The quality of our relationship with peers will also be informed by how we think of and act in our role as "educators." If we adhere to the principle of self-determination and the essentially democratic underpinnings of adult education, our approach to working with users will be largely moderated by their agendas, their situations, and their immediate and long-term needs.

Finally, it is worth noting that while acceptance as a peer and a pragmatic approach to learning may be necessary for effective peer education, they don't necessarily make one a good peer educator. Later sections of this document cover some of the skills and expertise that contribute to effective performance.

73. Gore, C.,1999, cited in Brogan, 2003, *Op. cit.*

74. Millin, A., 2002, *Op. cit.* p. 2.

75. Madden, Byrne, & Bath, 2002, *Op. cit.*

10 Practicalities of formal peer education by drug-user organisations

Theories and principles lay a foundation for our practice of formal peer education and provide a grounding and direction for how we shape our work. But we know from experience that the practicalities of applying these principles in an organisational setting present significant challenges. This section considers some the practical elements of peer education, the human and material resources that we use to build a project, and the design elements that connect and support them.

10.1 Forms of peer education by drug-user organisations

The principles of peer education can influence much of the work of drug-user organisations, especially those activities that have direct contact with constituencies. Notions of equality, self-determination, pragmatism, community development, harm reduction, and privacy and confidentiality shape the quality and purpose of our contact with drug users. They also indirectly influence work that is not focused primarily on education among users — e.g., representing our constituencies at a government or service level; writing submissions for inquiries and consultations; organising rallies and petitions; developing drug-related policy. We are, after all, one among peers, working on behalf of our constituencies for a common good.

If we interpret health and well-being along the lines of the Ottawa Charter, the possible content, or subject matter, of peer education can be as various as the circumstances and conditions that inhibit individuals' and communities' ability to achieve health and well-being ...

Drug-user organisations' contact with their constituencies takes many forms and offers many opportunities for peer education. Our NSPs, for example, are there primarily to get clean injecting equipment into the hands of injectors; they are also a place where users should be able to get assistance from peers around using that equipment (or other drug-related issues). We are not there, after all, to be human vending machines. We are there to empower people to use the equipment to achieve for their health and well-being.

We undertake other activities where learning and empowerment are more clearly articulated as immediate goals — e.g., outreach; interventions; workshops and community forums; short-term education projects among "tribes" of users; intake and one-on-one support; and resource development (e.g., magazines and newsletters) — and where the principles of peer education can be applied with most effect.

10.2 What subjects are appropriate for peer education?

If we interpret health and well-being along the lines of the Ottawa Charter, the possible content, or subject matter, of peer education can be as various as the circumstances and conditions that inhibit individuals' and communities' ability to achieve health and well-being: e.g., avoiding blood-borne viruses; living with blood-borne viruses; injecting safely; avoiding and managing overdose; managing treatment; taking care of veins; accessing and using mainstream services; disposing used equipment safely; knowing and acting on legal rights — you can probably add more to that list.

That said, our resources are decidedly finite, so our choice of subject and mode of delivery is shaped by our understanding of the needs of our constituencies and the means available to meet those needs. Legal rights may be of interest to all users of illicit drugs; opiate overdose or injecting methadone or buprenorphine will not be of interest to all those who inject only speed; the quality and accessibility of services in particular locale may not be of immediate relevance to those living in another (though the steps taken to remediate the situation may be). Considerations around privacy and confidentiality in small country towns may argue against organising a widely publicised workshop; discreet outreach with individuals and networks will be more effective.

What is of most importance is that the choice of subject derives from the needs of the people we're working with rather than our view of their needs. At the same time, it seems worth pointing out that the needs presented by clients may stray outside of the strict parameters of funding requirements and program guidelines. Negotiating these situations is one area where supervisors and experienced peer educators can play an important and helpful role.

10.3 Selecting peer educators

What are the qualities we look for in peer educators?

At the outset, we have to recognise that no peer educator will share all characteristics of the people they work with. Nor may they have the immediate acceptance of their constituencies. We look for people who have experience, skills, and points of view that are likely to encourage them being accepted as peer educators. These include:

- accepting themselves as equals among the members of their constituencies
- approaching the people they work with without bias and judgement
- intimate knowledge of the 'choreography of injecting,' sufficient to recognise the educational demands and opportunities that arise in the course of diverse scenarios
- appreciation of injecting as a 'mode of desire,' a personal drive with deep cultural and social meaning
- insight into their constituent communities, illicit drug scenes, the forces that shape those scenes, and their norms of behaviour
- awareness of how stigma influences drug users (and, particularly, injectors') perceptions of themselves and how they are perceived in their communities
- willingness to apply their knowledge and skills in a harm reduction framework
- readiness and ability to learn — from their constituencies; from the people with whom they work.
- willingness and ability in negotiating and interacting with representatives of other services/organisations.

There has been a lot of useful discussion around this subject, particularly whether peer educators must be current drug users or current injectors. Good arguments have been made for both points of view.[76]

We think in selecting applicants for peer education positions with drug-user organisations, discrimination in favour of current injectors is fair and reasonable, from a practical, if not philosophical, perspective: there will be situations (largely defined by the network or peers one is working with) where being a current injecting user and openly identifying as a current user will be a required and necessary part of being accepted as a peer; on the other hand, it is hard to think of an instance where being a former user would be required and necessary.

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Notwithstanding that observation, the question of whether peer educators must be current drug users or injecting drug users may be informed by how we answer this question: Does a good peer educator who stops injecting become a less effective and less useful peer educator? We think the answer is equivocal. Much depends on whether their point of view changes, if stopping injection drug use affects the way they approach their work, whether the qualities which argued for their doing the work in the first place remain with them, whether they are still accepted as peers.

76. See, for example, Kelsall, J. & Kerger, M., 2001, Hepatitis C peer education. In S. Locarnini (ed.) *Hepatitis C: An Australian Perspective*. Melbourne: IP Communications; Madden, Byrne, & Bath, 2002, *Op. cit.*; Brogan, D., 2003, *Op. cit.*; Dowsett, G., 1999, *Op. cit.* pp. 63-64; Kerger, M., 2002, Peer Education,*User's News*, 38, pp. 44-45, http://www.nuaa.org.au/nuaa/News/media/UN38/UN38_Peer_Education.pdf; Brogan, D., 2003, *Op. cit.*

(And we should also consider whether it would be in the best interests of that person to remain in a job that required frequent and intimate contact with people who are injecting.)

Another consideration raised around the issue of how peer educators are selected concerns the levels of skills and knowledge they bring with them. Again, we don't think that there's a hard and fast rule to be applied here. Few, if any, peer educators arrive in their positions as “complete” peer educators. They're selected for their potential. Realising that potential is the responsibility of both the individuals concerned and the organisations that employ them, and the resources organisations are prepared to invest in building knowledge and skills.

10.4 Organisations' responsibilities to their peer educators

Drug-user organisations have responsibilities to build on the potential of their workers and to create a supportive environment for their work — to set them up to succeed rather than fail.

To some extent, their responsibilities to peer educators are no different to those for other employees. However, we know from experience that peer educators act in milieus that present challenges not necessarily faced by other employees, and the presence of certain policies, processes, and structures will be immensely beneficial to both individual peer educators and their organisations in dealing with those challenges — they lay the foundations for success, rather than failure.

Drug-user organisations have responsibilities to build on the potential of their workers and to create a supportive environment for their work — to set them up to succeed rather than fail.

Among an organisation's responsibilities, we can identify the following:

- **Orientation** — to the practice of peer education (including the practical and ethical issues arising in peer education), to the communities/networks they will be working with, to the mainstream services and authorities that contribute to the environment in which they will be working

- **Education and training** — in areas such as group-work skills, adult education, resource development; in specific areas of health such as HIV and hepatitis, the legislative environment to their work, how to access and interpret medical and health information for lay audiences, strategies for protecting privacy and confidentiality, setting boundaries for relationships with members of their constituencies

- **Resources** — access to publications that will assist in the peer educators' work; access to other staff able to assist with any of the above

- **Establishing a Code of Conduct** and/or policies to guide the personal and professional actions of peer educators. Peer education is an imperfect science operating in a context where personal, societal, and legal agendas collide. As current or former drug users, peer educators will be exposed to pressure and situations that affect their personal and professional lives. To protect employees and employer, drug-user organisations have a responsibility to recognise these pressures, anticipate these situations, and establish a clear framework to guide the peer educators' decisions from both practical and ethical perspectives. It can cover matters such as drugs and drug use in the office; inebriation while on the job; purchasing drugs; accepting favours from clients; borrowing money or making purchases from their constituents. This is by no means a complete inventory. It is worth noting, too, that in developing these policies, drug-user organisations should give due consideration to the principles of peer education outlined above. A useful starting point for developing these policies can be found in the work of Raffi Balian.[77]

- **A supportive and responsive system of supervision** — we're not just referring to documents with guidelines and policies, but close professional working relationships between peer educators and supervisors that

77. See, for example, Balian, R. and White, C., *User-Friendly Policies for Harm Reduction Organisations.* http://www.harmreduction.org/research/policy/userfriendly.htm

will help the peer educator plan strategies, think through and negotiate situations, debrief, when necessary, and encourage a reflexive practice of their craft — examining, re-assessing, and, if necessary, modifying the ideas, assumptions and strategies for their utility, suitability, and effectiveness.

10.5 Responsibilities of the peer educator

An organisation's responsibilities to its peer educators will be complemented by peer educators' responsibilities to the organisation and their constituencies. These include:

- Working with the awareness that their relevance to their constituencies lies in their understanding of using and injecting drugs, not their practice of it; that they may be seen as role models by their constituencies — their words and deeds can reverberate in people's lives long after an interaction ends
- Establishing themselves not as experts, but as one of equal standing with the people they're working with
- Demonstrating respect for the life choices of individual users; recognising and respecting the knowledge that each person brings through their personal experiences
- Using the language, rituals, and norms of the people they're interacting with to communicate complex and sensitive issues in a meaningful way
- Skilfully applying the principles of harm reduction to weigh risks and harms and benefits to their constituencies
- Supporting and facilitating information sharing among people who inject drugs; recognising the locus of peer education as residing with the user and as being most powerful within shared using situations out in the networks; encouraging members of networks to work together in a co-operative way to achieve mutual goals and benefits for the whole group
- Being pragmatic about how adults learn by applying the principles of adult education
- Being alert and open to opportunities where they can learn from their constituencies
- Developing their own skills and aptitudes through self-directed learning, reflexive practice
- Following work-place policies, Codes of Conduct, standards of behaviour, and observing the lines of authority and responsibility.
- Respecting the privacy and confidentiality of all users, participants, and clients.[78]

10.6 Consultation

Many forms of peer education take place in the context of a larger community. Some forms of peer education, e.g., outreach, often refer to and require knowledge of the prevailing conditions set by mainstream services (e.g., NSP, medical, and treatment services; welfare agencies) and relevant authorities (e.g., police and housing).

We noted earlier that one of the responsibilities of an organisation is to provide an orientation to those services and authorities. Whether in concert with other staff, or independently, it can be useful for the peer educator to make contact with relevant persons in those agencies, make themselves and their work known, and gain an understanding of the role these agencies play in the community, how their own work fits with those of these agencies, how the local police command is operating, etc.

The experience of some peer educators engaged in outreach would suggest that ongoing, regular consultation with services & authorities operating in their area is vital to the effectiveness of their work, especially outreach peer education workers.

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78. Notwithstanding mandatory reporting requirements under relevant child protection legislation.

Depending on where they are and what their programs hopes to achieve, some peer educators may find themselves in the position of being peers to drug users, while at the same time, having to work closely with — more or less function as peers to — workers in service agencies. The communication skills required of a peer educator are not one-dimensional, and the process for selecting and training peer educators should give due consideration to this aspect of the role.

10.7 Collaborations

As Damon Brogan has pointed out, "peer education prospers when situated within broad, intersectoral collaborations involving diverse stakeholders in issues of common relevance."[79] These may be forged within the organisation itself, complementing other ongoing education and advocacy efforts, and through partnerships with other organisations with an interest in the same people. The work of the State drug-user organisations offers many examples where peer education is vertically integrated with complementary in-house programs (e.g., the user magazines, such as *Whack*, *User's News*, *Yooz*, *Pure S*) and horizontally linked to programs run by other agencies working in the sector (e.g., collaborations between user and sex-worker organisations).

Organisations that suffer high rates of turnover, unstable management, and a lack of coordination place an unnecessary burden on front-line staff, and especially on peer educators who spend large sections of time outside the office and rely on stable lines of communication and infrequent, though critical requests for material support.

10.8 Anticipated problems

After many years' experience in developing and operating peer education programs, we know that the practice of peer education is not without its pitfalls, especially for peer educators and, consequently, the organisations they work for.[80] These include:

- **Stress**. As drug users living under prohibition (or former drug users), our lives can be complicated enough. Add to this is the stress of dealing with other users' complicated lives[81] and the difficulties working in any organisation that deals with people in crises of one sort of another, and you have a recipe for constant tension, which if left unchecked or unresolved, can easily translate into burnout.
- **Problems around drug use**, including undesired increased drug use by current drug users, relapse by former users, and initiation of drug use by non-drug users. Outreach workers are particularly prone to these risks.[82]
- **Staff turnover**. Those organisations with a long-standing cadre of peer educators are indeed fortunate. The high turnover rate among peer educators is well known, both anecdotally and in the literature.[83]
- **Organisational difficulties**. Organisations that suffer high rates of turnover, unstable management, and a lack of coordination

79. Brogan, D., 2003, *Op. cit*.

80. Dowsett's survey of hepatitis C educators (Dowsett, G., 1999, *Op. cit*., pp. 26-27) identified several kinds of challenges faced by drug-user organisations and their educators. "Most IDU organisations reported experiencing difficulties with a high rate of educator turnover. Many also reported management instability as a constant and nation-wide problem. As a consequence, many IDU educators reported carrying an unreasonable management load that interfered with their main task of educating. Other organisational issues were: developing the capacity to produce resources for the training and skilling of management committees; insufficient staff to coordinate the activities of volunteers; stress on workers, especially when dealing with difficult clients; and the stress on peer educators who may have to confront their own drug-using histories. Finally, the issue of professionalism was raised. Staff professionalism was regarded as increasingly valued in drug-user organisations and NSPs, yet respondents noted a paucity of adequate training programs. Instead, they still primarily rely on the personal experiences of HCV/IDU educators.

81. See, for example, Anon., 2005, Living the Life I Love, *Junkmail*, Vol. 10, Canberra, AIVL..

82. See, for example, WHO, 2004, *Op. cit*., p. 25.

83. Again, see Dowsett, G., 1999, *Op. cit*., p. 82.

place an unnecessary burden on front-line staff, and especially on peer educators who spend large sections of time outside the office and rely on stable lines of communication and infrequent, though critical requests for material support.

- **Dealing with other agencies**. Through their advocacy work and sometimes as part of their project's organisational structure (e.g., a peer educator attached to a non-drug-user organisation NSP), some peer educators may find themselves having a lot to do with services providers. The service providers' lines of authority, responsibilities, and goals may be quite different to that of the drug-user organisation that employs them. The service provider may expect, or ask, the peer educator to take on responsibilities or activities that fall outside of their job; they may have decidedly drug-user unfriendly staff; they may have quite a different relationship with drug users than the one sought by the peer educator. We can safely say that just as there may be difficult clients, there may also be difficult service providers. This is another area where the peer educator will most likely need support from supervisors.

- **Managing workloads**. The number of people in peer education roles is relatively small compared to the size of their constituencies. The demands on their time can be numerous and difficult to mediate. At the same time, in the present work environment, they are required to fastidiously document, report on, and, in a sense, account for how they have spent their time. If the present trend, which to some appears to value reporting requirements above considerations for the quality of contact with constituencies, continues unabated, we are likely to see an effective reduction in the number of contacts and increasing number of peer educators who spend as much time at their desks as they do "in the field."

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- **"Professionalisation."** Some members of drug user organisations see a link between the increased reporting required of peer educators and a trend toward hiring individuals whose skills in writing reports exceeds that of their ability to relate to their constituencies. They regard this as evidence of the "professionalisation" of peer education — where qualifications, certifications, and administrative prowess are more highly regarded than the personal skills and point of view that are the bedrock of a peer educator's credentials. This is a tension that drug-user organisations need to resolve. Lack of resolution may, over the long term, contribute to increasingly more rigid notions of educator and client that will lose the essential equality on which drug-user peer education is built.

- **Outcomes and performance measurement.** Clearly, organisations have moral and contractual obligations to account for how they use the funds they're given for peer education activities, and management needs data and information to fulfil those obligations. What's often overlooked in establishing the processes and reporting protocols that satisfy these demands is the need for peer educators themselves to be able to observe their own track record and have objective measures for the assessing the value of their work. Reflexive practice may go some distance in satisfying these needs. Whether it goes far enough we don't know. Clearly, there is a need for processes and protocols that satisfy management's

needs and contribute to workers' sense job satisfaction without placing undue administrative burdens on the workers.

- **After the party's over.** At some point, peer educators will cease being peer educators and walk the streets as a normal people. However, in the eyes of their constituents they may continue to be identified with the drug-user organisation and their role as a peer educator. They may continue to be seen as a resource. The friends and acquaintances (and enemies) they made may continue to consider themselves friends and acquaintances (and enemies), often enough in direction relation to the length of time the peer educator worked in the position and the success he/she made of the work. We know of several CROWS workers who, years after the project finished, continue to be contacted for advice or assistance with advocacy. This may or may not be a problem for everyone, but it's worth pointing out to those considering taking on the role.

11 Peer education models

Formal peer education by drug-user organisations has been taking place in various forms since the establishment of those organisations in the late 1980s. It is, after all, one activity for which we are eminently qualified.

For many organisations, especially those without large resources and numbers of staff, their NSPs have been and remain the focal point of their peer education activities. Yet, many have been able to develop more specialised peer education projects targeting specific subcultures, CALD communities, geographical areas, kinds of drug users, or populations with education needs around specific health issues. Unfortunately, not all have been the subject of documentation, and for any number reasons, fewer still have been the subject of impact, versus process, evaluations.

This section presents summaries of some of the projects for which documentation is available. It is by no means an exhaustive list of, and given the complexity of the projects themselves, the summaries will not cover all aspects of each project, nor, indeed, the subtleties of approach that each distinguish them.

The extent to which these projects realise or embody the principles of peer education identified in this document will vary. Many were developed and fielded in the immediate years following the development and promotion of the Ottawa Charter and sought to situate themselves within the broad ambit of that document. While this does not detract from the importance or the impact of their work, it seems clear in hindsight that many were handicapped by the lack of proven models and the absence of guiding principles that spoke more directly to the business of peer education by drug-user organisations as opposed to the much broader agenda of health promotion. A common feature of the project reports is a call for a definition of peer education, or at least a description of what peer education looks like.

It may be that peer education by drug-user organisations will have no well-defined appearance. If it is respond to the needs of drug users, it will most likely change as their needs change, and if it is to truly reflect the principles outlined in this document, the projects may be as various as the people who are involved in shaping them.

What we can see is that we are not in the position of inventing the wheel. We have a clear notion of what the wheel looks like, and several prototypes to evaluate in developing our own.

11.1 Young injecting drug users project (ACT IV League)

This project targeted young injecting drug users in the ACT, a group recognised as “notoriously hard group to access and work with,” due in part to their age, the uncertainty of their living situations, and their reluctance to use mainstream services. The project aimed to educate about safe using practices, introduce practical harm reduction strategies, and influence the development new norms around using within the peer networks.

Before embarking on the project proper in 1994, staff identified a core group of “peer advisors,” with whom they explored dietary needs and preferences, patterns of drug use and drug preferences, group dynamics, and moral codes to inform the projects' development and structure. Staff considered the eight meetings with peer advisers were integral to development and structure of the project and its ultimate success.

At the same time, the project was guided by the work of a steering committee comprised of youth service providers, AOD works, sexuality and health educators, community representatives, social science researchers, medical specialists, and police liaison personnel. Meetings between the peer advisers and steering committee explored issues rased by the peers, and provided a mechanism through the "professionals" gained an understanding of the needs and dynamics of the target group.

One of the earliest forays into formal peer education in the ACT, the project was as essentially exploratory intervention to gauge if and how peer education could work with young users in the ACT. The meetings with the peer

advisers identified a range of issues concerning blood-borne virus prevention, overdose, drug interactions and pharmacology, and legal and social problems. Addressing all of these matters was beyond the practical scope of the project. However, in concert with the peer advisers and steering committee, project staff developed, revised, and eventually arrived at an agenda and selected speakers for a three-day seminar.

An average of 15 people attended each of the three days' activities.

Evaluated through questionnaires and interviews three weeks after the seminar, the data showed that participants had taken on the information presented by speakers — behaviours had been “appreciably altered,” as were participants likelihood to use emergency and treatment services. Two participants had used resuscitation techniques learned during the seminar; where they had previously feared police intervention, several more were now prepared to call an ambulance; and five had entered detox. "Overall, the responses were extremely positive and indicated a highly successful program."

Documentation:

Parkes, P. & Byrne, J., 1995, *Young Injecting Drug Users Project: The introduction of a peer education process in the ACT within groups of young injecting drug users*. Project Report. Canberra, ACT IV League.

11.2 ROWS, MetROWS, and CROWS (NUAA)

Relying on “strengthening community action,” and “developing personal skills” — two of the five principles of the Ottawa Charter — these projects focussed on community development rather than the creation of a defined product or resource. They trained outreach workers from a number of selected communities who, after a period of training in Sydney, worked within their communities to increase information flow and empower individuals and networks. As the "communities" themselves were at different stages of development — some were comprised of drug users living in virtual isolation; others had well-developed lines of communication — the project’s flexible, open-ended design focused attention on the needs evident within each area without the imposition of “external ideas.”

Originally fielded in rural areas in 1993 and titled the ROW (Rural Outreach Worker) project, the model appeared to work so well, it was soon extended to urban areas, and acquired a new acronym MetROWS (Metropolitan Rural Outreach Workers). These names were eventually consolidated into the CROWS (Community Rural Outreach Worker) project.

Each year, after selecting geographical areas in which the project would work, NUAA staff conducted negotiations with local workers and authorities, a process that often proved time-consuming and difficult. Once the larger project infrastructure was in place, advertisements (and job descriptions) were circulated or posted in NSPs. The NUAA education team travelled to each area, and after informal interviews with applicants, selected the ROW/MetROW/CROW worker.

After selection of the outreach worker, the official project ran in two phases for approximately 22 weeks. During the first phase, approximately 8 weeks, with support from NUAA staff, the worker developed a picture of needs in the local area, using surveys, informal meetings, video nights, etc.

The second phase, 14 weeks, commenced when the CROWS workers attended a training workshop in Sydney, during which they explored strategies for community development in their areas, including informal meetings with users; information nights, local newsletters, information sheets and pamphlets, support groups for home detox and hepatitis C, support group for single parents, tea parties, assistance accessing treatment, user involvement in local NSEP services.

Upon return to their home bases, CROWS workers set about implementing the strategies developing during the workshop.

Employing and training of people from local scenes targeted IDU social networks from within. It drew upon the credibility of each worker as an equal, a "peer," strengthened networks and community interaction, and helped forge networks and notions of community where they did not exist.

Managing simultaneous projects in geographically distant parts of the State presented challenges for

project administration. The outreach workers themselves, undertaking a highly visible and sometimes controversial role in a sensitive area affected by health and law enforcement activities, also needed frequent and careful support. That said, each year the project garnered very positive feedback, and anecdotal evidence would indicate that in some areas at least, the outreach workers' efforts continue to have an impact long after the project ended. In some areas, CROW workers remain community "resources."

Documentation:

Gore, C., 1994, *The 1993 Rural Injectors Project*. Sydney, NUAA.
Gore, C. & Mahs, S., 1995, *The 1994 ROW & MetROW Project*, Sydney, NUAA.
Weatherall, A. & Edmonds, L., 1996, *The 1996 CROW Project*, Sydney, NUAA.

11.3 Tribes Program (NUAA)

The Tribes Project was originally developed by the AIDS Bureau (now AIDS & Infectious Diseases Branch) of the NSW Department of Health to explore the proposition that education campaigns designed and implemented by self-identified members peer networks could provide a cost-effective supplement to one-to-one peer education and similar approaches. It originally targeted groups of "functional" drug users — those who believed their lives were not affected in any obviously adverse way by their drug use and for whom drug use may not have been central to their definition of themselves.

NSW health believed that this micro-level approach to HIV education could complement the more conventional social marketing and larger scale education campaigns evident at the time. Members of "tribes," drug-using subcultures, they reasoned, would be able to use the common currency of the tribe — language, images, and customs — and, where possible, use venues and activities favoured by members of the tribe to deliver a kind of education tailored more closely to their members.

With the successful completion of four pilot campaigns during 1990-91, NSW Health decided that 1992-95 projects should be run from a community-based organisation, and NUAA was selected to manage the Tribes program.

Since that time, the management and infrastructure of Tribes has been considerably developed, and the program has considerably broadened its scope. A short list of Tribes projects gives an overall sense of the diversity of its outreach: ravers, bikies, westies, kooris, parents of heroin users, steroid users, young homeless users, metalheads, ferals, inner-city sex workers, construction workers, people with gender issues, leather dykes, prisoners and ex-prisoners.

Even though the Tribes selected each year were more or less free to identify their own goals and objectives and develop their own strategies to meet those objectives, for many years, those strategies sometimes produced printed-matter resources that required vetting by NSW Health before they could be officially released. In recent years, the approval process has become increasingly lengthy and burdensome, to the point where in the lag of time between the development of the resource and its "approval" Tribe members became disillusioned, lost interest, or moved on.

The Tribes model always emphasised self-determination and process as of equal importance to product. Nonetheless, the potential for "product," and especially printed matter, to be a defining outcome of the Tribes program has been identified as a potential pitfall of the model. Recent projects have seen have renewed emphasis on process over product, and a recommitment to funding projects that offered significant opportunities for developing skills, at both a personal and community level:

- The Port Kembla Working Girls Tribes Project consists of street based sex workers in Port Kembla who designed a project that addresses issues of harassment, abuse, discrimination, drug use and other life issues. Key tribe members were skilled up and empowered to become peer workers. They organised workshops around topics such as overdose and safer using as well as getting involved in local community activities. Through peer education and peer support, the Tribe built and strengthened its cohesion and identity which enabled them to become involved in the above activities.

- The Generation (Gen) Q Tribes Project are same-sex attracted youth on the NSW Central Coast who originally came together to address issues of sexuality and drug use. The Tribe designed a program of peer education and outreach which addressed, amongst other issues, identity, gender, homophobia, and harm reduction. The Gen Q Tribe also designed a website to disseminate information and reduce isolation in a discrete and informal manner.

- The Banging in the City Tribes Project, comprised of Sydney sex workers and their clients, was initiated by tribe members to reduce their risks around injecting drug use. Peers from the Tribe were involved in outreach activities and the development of an education package on safer using and risks of heroin overdose. Tribe members have also attended a training course on EAR/CPR and peer education strategies.

The establishment of the Tribes program owed a lot to underlying principles of the Ottawa Charter and adult learning principles. With the "target groups" of the education also the designers and developers of the learning agenda, the participants in a Tribes project can define their own idea of health and design their own health promotion campaign. The emphasis on process over product reinforces the principles of peer education, especially those of self-determination and community development, which essentially deal with the "how" rather than the "what" of the education process.

Documentation:

Margaret Duckett, 1995, *The Tribes Project Evaluation Report*, NUAA, Sydney.

11.4 PEIRS (Peer Education & Information Reaching the Streets) (VIVAIDS)

Set against a background of the so-called heroin drought, and zealous media publicity and increasing levels of police activity around street-based drug markets (SBDMs), VIVAIDS' PEIRS project targeted young people, especially those using heroin as the first substance for injection and relying on SBDMs for their supply. Despite the drought, heroin — and benzos — were more affordable than cannabis. At the same time, these new injectors had a poor knowledge of local services and high levels of suspicion and mistrust for the people who worked in them.

Firmly placed within a harm reduction framework, PEIRS endeavoured to increase understand and awareness around drug use, its potential harms, and the strategies that could be used to mitigate those harms. It sought to train young people from the target group in harm reduction strategies; resource and empower networks of young drug users to collectively address barriers to safe drug use and produce their own education resources; establish links between these networks, the PEIRS project team, and local services; and influence peer group norms.

Through one-to-one contact around the SBDMs and contact with other agencies working with this population, project staff recruited 4 teams each comprised of 6 young people, who helped develop a 3-day facilitated training module covering blood-borne virus transmission, classes of drugs and their effects, CPR and EAR training, legal issues, safer sex, and peer education theory. Each team met fortnightly thereafter to develop strategies and approaches pertinent to the people in their network, review issues and problems that arose during their work, and develop resources that they could use to facilitate learning and information exchange within their networks. Some teams developed videos (of high quality and invention); some fielded surveys; some developed information packs. Team members used these tools to facilitate learning/information exchanges with people in their local peer network. One of the strengths of this model was its flexibility — it could address local issues as they arose in each area.

This model was not without its challenges, especially for project management. Issues arose around managing, retaining, and paying team members, and addressing situations and needs that arose with in the course of team members' work demanded time and care and careful coordination.

The project was viewed very positively by the participating members and agencies. The report on the project gives a good account of the underlying assumptions, strategies, difficulties, and successes.

Documentation:

Fernandez, Leon, 2001. *Peer Education and Information Reaching the Streets: Final Report.* VIVAIDS, Melbourne.

11.5 Overdose prevention project (VIVAIDS)

The Victorian Department of Human Services funded VIVAIDS over 1999-2002 to conduct three series of peer-based workshops around overdose prevention. The 2002-2003 project fielded 32 workshops with current speed and heroin users (five in rural Victoria, and five with AOD workers.)

The workshops with users focussed on increasing skills in understanding, identifying, managing overdose, improving knowledge of overdose-related services, reducing practices considered high-risk for overdose and changing drug-using norms around those practices, and encouraging the dissemination of harm reduction information throughout drug-using networks in Victoria. The project produced a very useful facilitator's manual and was the subject of an informative project report.

Participants were recruited through networking in collaboration with mainstream agencies, services, and support workers. Each workshop had a maximum of 10 participants (AOD workshops 20), who were each paid $40 on completion of the training.

Workshops began with a discussion among participants to arrive at a set of ground rules for conduct. They explored how participants viewed overdose, overdose myths, drug half-life, relevant risk factors and the social context in which overdose can occur, ways of reducing risk, how to recognise overdose warning signs, “safer-scoring” as an overdose risk reduction strategy, and basic life support and resuscitation techniques using dummies.

Documentation

Kelsall, J., 1999, *VIVAIDS Heroin Overdose Prevention Project Training Manual*, VIVAIDS: Melbourne.
Lord, S., 2003, *VIVAIDS Drug Overdose Prevention Project*, 2002-2003. VIVAIDS, Melbourne.
Lord, S. 2003, *VIVAIDS Drug Overdose Prevention Project, 2002-2003: a manual for peer-based workshop facilitation*. VIVAIDS, Melbourne.

11.6 Peer mediated user-education: a framework for community action (SAVIVE)

SAVIVE's model of NSP-oriented peer education recognises that the micro-community approach of TRIBES cannot hope to cost-effectively meet all the urgent education needs of IDUs, and that in some circumstances it may be necessary to identify commonalities that will facilitate the collective accessing and resourcing of networks, using circles, and using scenes. It relies on the notion of a broad, heterogenous user community comprised of individuals united through a “deep and unique understanding of injecting as an idea replete with deep cultural, social and psychological meanings.” SAVIVE’s “utilitarian” model of peer education does not preclude opportunities for focusing on specific tribes; rather, it proposes a model of peer education “capable of relevance to many individuals and groups at any one time” that can be implemented by community-based organisations with limited human and financial resources.

SAVIVE's model has two strands: 1) enhancing organic (informal) peer education by equipping peer networkers as models for safer injecting behaviours, and 2) employment of key staff and volunteers as IDU educators who, operating from a central platform of peer-based NSP services, can establish themselves as credible, ethical, and capable of relating to and being accepted by a diverse array of IDUs around a range of issues important to IDUs' health, including HIV- and hepatitis-prevention, D&A treatment and related services, overdose prevention, vein-care, and general health maintenance and monitoring.

Philosophically situated within the broader framework of the Ottawa Charter, the SAVIVE model relies on adult education principles and notions of community development to create a cultural space in which health education can prosper — the supportive environment of a peer-mediated NSP; facilitate one-on-one interactions with users (develop personal skills); and nurture the community aspirations and propensity to change so well-evidenced by the drug-user

community's response to HIV/AIDS once the means of risk reduction — hardware and information — was made available (strengthen community action).

We recognise that this model may not be unique to SAVIVE. Nonetheless, few have been described with such precision.

Documentation:

Brogan, D. (1999) *Peer mediated user-education: a framework for community action*. SAVIVE strategic planning document. Adelaide, SAVIVE.

11.7 The Connection (auspiced by AIVL)

The Connection, a peer-based program run by and for young indigenous people who are or have been illicit drug users, has been operating in Canberra since June 2004.

Based in Canberra in the ACT and funded primarily by the Foundation for Young Australians (FYA) and ACT Healthpact, The Connection is auspiced and supported in day-to-day management by AIVL.

The Connection operates a drop-in space which is open Monday -Wednesday. It provides a safe place for young indigenous drug users in Canberra and surrounding areas can come for a feed and to talk. The Connection employs six young people as peer-support workers to undertake peer education, peer support, advocacy, referral and representation with other young indigenous drug users in the ACT. The Connection runs a Young Men's Program through the FYA funding involving information sessions, art workshops, cultural education and support. A Young Women's Program is run through the Healthpact funding and this project is called the Healthy, Mobile Mothers and Babies Project. This project targets young women with children who are part of the local indigenous communities and runs social outings, art and craft workshops, health promotion activities, support and referral.

The peer support workers at The Connection have developed extensive networks with other indigenous and mainstream services and organisations and act as a bridge between young indigenous people and these services. The workers assist young people with health, social and legal issues and regularly go with people to court, to meetings with probation and parole, Family Services and appointments at the Drug & Alcohol clinic. The Connection is an amazing and inspiring program that clearly demonstrates the importance and success of peers running their own programs and services.

11.8 Vietnamese hepatitis C & injecting drug use resource development project (AIVL, VIVAIDS, and Health Works)

This project, which began in late 2005, is a partnership between AIVL, VIVAIDS, and Health Works, a program of the Western Region Health Centre (Victoria) to develop a culturally appropriate hepatitis C peer education resource for Vietnamese people at risk of hepatitis C through injecting drug use.

Acting under the oversight of a steering committee comprised of representatives of the three organisations and a reference group drawn from the target population, the project will hire several Vietnamese injecting drug users who, under co-supervision by Health Works and VIVAIDS, will be consulting with members of Vietnamese IDU networks to establish the kind of information about hepatitis C that will be useful to them and, considering cultural paradigms, the best way to present that information.

The 6-month consultation will lead to the development of a report outlining the needs of Vietnamese IDUs. Draft and final versions of the resource will be focus-tested with members of the target population.

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