

# Australian Federation of AIDS Organisations

## Discussion Paper

### Peer education among injecting drug users

By Dave Burrows  
Injecting Drug Use Policy Officer  
Australian Federation of AIDS Organisations

Peer education for HIV prevention among injecting drug users (IDUs) is becoming an increasingly important area of prevention activities. This paper surveys what has been published and discussed about peer education among injecting drug users, concentrating on outreach education, the development of IDU groups or drug user organisations (DUOs), peer education carried out by these groups, and differences between formal peer education programmes and community development activities which foster informal or everyday peer education.

#### HIV prevention among IDUs

The Harvard University International AIDS Centre's analysis of HIV prevention programmes throughout the world found that three elements were necessary for successful prevention programmes among any group or population:

- information/education
- health and social services
- a supportive societal environment. (Mann 1993)

A wide range of HIV/AIDS prevention approaches have been attempted to reduce transmission among IDUs, including:

- mass and local education
- treatment for drug problems and other therapies
- providing the advice and the means to decontaminate syringes
- providing new syringes and other injecting equipment
- providing access to HIV testing. (Stimson and Power 1992)

All of these measures attempt (to a greater or lesser degree) to persuade drug injectors to change their behaviour: The behaviour change(s) sought by these interventions are aimed at preventing the transmission of HIV which can occur via sharing needles. The behaviour changes sought range from quitting injecting to using using a full new set of injection equipment for every injection. In this context, it should be remembered that, in the mid 1980s in places as far apart as Edinburgh, New York, Melbourne and Paris, 60-90% of injectors regularly shared needles. (Stimson 1992)



AUSTRALIAN  
FEDERATION  
OF AIDS  
ORGANISATIONS INC.

PO BOX 51  
NEWTOWN  
NSW 2042 AUSTRALIA

PH +61 2 9557 9399  
FAX +61 2 9557 9867

HIV Health Information  
Line  
1800 803 806

Email: [afao@afao.org.au](mailto:afao@afao.org.au)

Internet:  
<http://www.afao.org.au>

Friedman and Des Jarlais (1991) state that a useful starting point for understanding HIV prevention programmes among IDUs is to consider that:

"HIV transmission is a form of interaction among two or more persons - and that individuals engage in such interactions as the result of a lifelong series of social relationships. Attempts to reduce the risk posed by this interaction can focus on:

- (i) the individual drug injector;
- (ii) the dyads (or larger groups) who share injection equipment or have sex with each other;
- (iii) the wider drug-injection subculture; or
- (iv) larger social processes or structures including both the relationships between drug injectors and society at large as well as the cumulative social forces that may influence some persons to inject drugs in high-risk settings."

The authors state that, in 1991, most HIV prevention among IDUs had focused primarily on the drug injector as an individual. A few projects had focussed on changing behaviour in injector networks and subcultures, and virtually none had targeted the relationship between the society at large and drug users.

To summarise the views of several researchers from the UK and the US, an effective HIV prevention programme among IDUs:

- takes a harm reduction perspective and accepts that drug injectors are a heterogeneous group
- provides information/education about HIV transmission and how to prevent transmission, based on an understanding of risk behaviours, to enhance injectors' ability to care for themselves
- targets everyday injecting behaviour
- provides a variety of means to prevent transmission or links information messages with the means of prevention and other health and social services
- is carried out in a supportive peer environment.

(Des Jarlais and Friedman 1993, Mann 1993, Des Jarlais et al 1993, Burt and Stimson 1993, Stimson and Power 1992, Stimson 1992)

### **Education for HIV prevention among IDUs**

A large number of settings and sources for HIV prevention education aimed at injecting drug users can be found. These include:

- Mass media campaigns by governments (eg, the "Bed of needles" TV commercial)
- Broad Targeted campaigns by governments (eg, in NSW, several of the Speed Wise Speed Safe cards)
- Educational/information materials from treatment agencies (this is done less in Australia than it is in the US and the UK)
- Educational/information materials developed and produced by drug users themselves (often through IDU groups)
  - Narrowcast campaigns such as the Tribes Projects produced by and for specific sub-cultural groups such as "Ravers".(Duckett 1995)
- Pre and post HIV antibody test counselling
- Group education at IDU groups and treatment centres
- One on one education sessions by drugs counsellors, GPs, needle and syringe exchange workers, and other health care workers
- One on one education by peers trained by needle and syringe exchange workers, drugs treatment centres and IDU groups
- Peer education with drug users by drug users with no connection to formal organisations

- One on one and group education by researchers: in countries such as the US, much of the early education of IDUs about HIV has been done by people who were and are, at least nominally, researchers. (Burrows 1994)

Despite this, drug users "are traditionally considered to be irresponsible and self-destructive in their behaviour, and expectations as to the effect of information of any kind on this particular group are minute" (Hjorth et al 1990: it should be noted that the authors found their study's results "indicate the opposite"). Drug injectors are marginalised in most societies, and drug injecting or use of injectable drugs are illegal in almost all of the 50 countries in which HIV has been found among injecting drug users (Des Jarlais 1994). These qualities make drug injectors difficult to reach with health education messages and, specifically with HIV prevention education (Hjorth et al 1990).

However, Longshore (1992) reviewed a large number of "experimental and non-experimental studies" and found that "AIDS education can promote risk reduction among IDUs". Power et al (1988) concluded that "drug users are not inherently irrational people....there is the potential for promoting and encouraging reduction in high risk behaviours". Many scientific papers have reported on education programmes for IDUs within treatment, prison and methadone settings, often with mixed or poor results (see for example, Sorensen et al 1994, Wexler et al 1994, Malow et al 1994). Often, programmes are only evaluated on knowledge change, with few evaluations attempting to measure behaviour change (eg, Jang et al 1990). The literature also provides rare examples of institutionally based education which is successful at assisting drug users to change their behaviours (at least in the US environment), such as the LIGHT Model (Andersen et al 1993). Several authors recommend that a range of sources of education be used to reinforce each other's messages (Friedman et al 1989; Friedman et al 1993; Leukefeld et al 1990).

Wodak, Fisher and Crofts (1993) believe that education among IDUs about HIV prevention becomes more effective as target populations are more precisely identified and as strategies are developed that reflect both a better understanding of high-risk behaviour and media capabilities. Effective education transcends the mere distribution of information and tends to adopt multi-modal approaches:

"These interventions should be meaningful not only throughout society, but also throughout a person's lifetime. They may be more effective if based on and within powerful social institutions (such as the family, church or even peer group)."

Friedman et al (1989) made the significant statement that "groups of current and ex-drug users can distribute information and advice to drug users and their sex partners in ways that might be more believable to some drug users than the same message from any more official body".

### **Outreach education among IDUs**

Outreach has been the subject of much of the literature on HIV education among IDUs, especially from organisations other than IDU groups. Rhodes and Holland (1992) see outreach health education as a:

"proactive attempt to provide HIV prevention services directly in the community, linking service response to service need within the environments in which health and risk behaviour is produced".

In the US, most researchers have concentrated on outreach programmes which are what Broadhead calls the "reach and teach bleach model" in that they rely:

"on hiring former drug users, or persons with street credentials, to venture into drug using zones to develop relationships with users, to distribute bleach, condoms and other prevention materials, and to recruit IDUs for treatment, testing and education" (Grund et al 1994: for examples of reports on this type of outreach, see Battjes et al 1990; Neaigus et al 1990; ).

In the UK as well, many outreach programmes are designed primarily to bring drug injectors into contact with "mainstream services" (see, for example, Rhodes and Holland 1992 )

Grund et al 1994 noted that outreach workers and IDUs can work well together in many outreach programmes, but notes that a wide array of problems can be experienced:

- outreach workers need a high degree of autonomy which can lead to "shirking, running errands in work time and illegal activities"
- outreach workers may inadvertently turn into case managers and those who are ex-users can have difficulty maintaining a non-judgemental attitude towards their clients
- outreach workers work best with clients most like themselves: this and other factors such as the possibility of relapse and fear of assault, may prevent workers from accessing new networks.

To overcome these difficulties, Grund et al (1994) have developed a "peer-driven model" which combines some aspects of drug user organisations with outreach programmes, including the payment of drug users for introducing their social contacts to the prevention programme and for participating in the programme. However, the initiative continues to have as its primary focus HIV testing and counselling, and the provision of risk reduction and education materials in a prevention programme developed and managed by researchers and professionals.

In the UK, Rhodes and Holland (1992) note that there are limits to the usefulness of outreach work:

"The extent to which hard-to-reach clients actually require or perceive a need for existing health services has often been assumed...In particular our findings suggest that the needs of clients most frequently identified by outreach workers appear to be related to wider problems of homelessness and money...It is important that clients' wider social and welfare problems are simultaneously addressed as they may militate against the effective promotion and adoption of safer sexual and drug using practices."

The authors go on to suggest that outreach services need the autonomy and independence to develop their services according to the identified needs of their outreach clients. By so doing, "outreach may have the potential to offer client responsive and community based 'care' oriented services as well as health education and preventive services".

### **Outreach, social networks and peer education**

Due to the difficulties outlined above, several researchers have sought other strategies to increase the effectiveness of HIV prevention education among IDUs. Friedman and his colleagues have argued consistently for more investigation of "social organising" measures among injecting drug users since the mid-1980s (See for example, Friedman et al 1987, Friedman et al 1989; Friedman et al 1992a, Friedman et al 1992b, Friedman et al 1993, Des Jarlais et al 1986, Des Jarlais and Friedman 1994). These papers have concentrated on trying to persuade the US HIV/AIDS research and prevention funding authorities that injecting drug users are able to organise themselves, and are able to "establish and run organisations, hold meetings, plan campaigns and implement plans" (Friedman et al 1993).

Rhodes (1994?) examines the notion of "community" as it applies to IDUs and finds that "the notion...lacks both the specificity and applicability to account fully for, or to encourage, changes

in drug users' social relationships". He further finds that "drug injecting social networks are largely based on the shared knowledge and practices of injecting drug use".

The Indigenous Leader programme of outreach in Chicago has specifically targeted social networks of injecting drug users since 1987 (Wiebel 1993a). The programme has now reached more than 20 000 individuals with education and referral specifically tailored to the needs of their social networks (Wiebel 1993b). The programme uses ethnographers together with ex-users from particular social networks (indigenous leaders) to design and implement outreach education programmes (Wiebel 1993a).

In addition, some researchers have called for:

- risk reduction strategies which involve individuals or groups from the drug users' "social environments and communities, including active drug users and their organisations" (Pivnick et al 1994)
- "employing collective social means..., the involvement of existing drug user networks and appeals to IDUs' sense of responsibility" to increase the effectiveness of needle exchange and other IDU risk reduction programmes (Grund et al 1992)
- consideration of not only individual health behaviours, but "the shared context in which they occur, **and** the broader factors that encourage, or inhibit, a life which allows for healthy behaviours" (Stimson 1992: original emphasis)
- harnessing "social relationships which influence safer sex" (Neaigus et al 1990)

Other researchers have found that:

- drug users have social support networks, in which friends appear to be more important than family members (Stowe et al 1993)
- social and family networks can have a positive effect on drug users trying to maintain safer behaviours (Zapka et al 1993)
- the drug using behaviour of people on methadone is often tied to the drug using behaviour of people in their social networks (Goehl et al 1993)
- the "inefficiency of information-giving approaches to health education among many HIV relevant populations has led to the increasing advocacy of self-empowerment, community based and community action approaches" (Rhodes and Holland 1992)

While outreach continues to be an important strategy for HIV prevention education among IDUs, it is increasingly being coupled with peer education (Rhodes 1994). Peer education has been defined as:

"A set of specific education strategies devised and implemented by members of a subculture, community or group of people for their peers, where the desired outcome is that peer support and the culture of the target group is utilised to effect and sustain change in behaviour." (Kinder 1995)

While this definition will be shown later to be problematic for Australian drug user organisations, it is a useful statement of the way that formal peer education programmes are conceptualised by Australian governments and AIDS Councils.

This type of formal peer education has been used throughout the communities and networks affected by HIV and AIDS in Australia as an effective way to promote behaviour change for HIV prevention. McCalman (1994) finds that:

"there is broad theoretical support for the use of peer-led strategies in behaviour change and maintenance programs...particularly for young people and for programs about sex, covert or illegal issues such as drug use, and for socially marginalised behaviours such as male-to-male sex".

Trautmann and Barendregt (1994) examine peer education in much detail, but state that they prefer the term "peer support". Though the two terms are almost interchangeable to the authors, in "HIV peer education", they say, "it is the task of the educator to teach other drug users the rules of safer use and safer sex. Within the concept of peer support, however, the idea of mutual support is prevailing and is seen as a broader concept than education. The emphasis is more on community and equality. Support does not only mean influencing other drug users towards safer use and safer sex, it can also imply creating better conditions for safer use and safer sex."

Power et al (1995) state that the Advisory Council on the Misuse of Drugs in the UK has recently called for all IDU outreach programmes to "emphasise peer education and (maximise) new contacts. This involves targeting social networks of drug users, identifying the social factors that underpin high-risk behaviour, and encouraging behaviour changes that fit into drug users' lifestyles." The authors show that this means that each set of social networks must be studied individually to describe "drug users' daily routines - we need to know what they are doing before we can decide what needs to be changed and how best to change it". Peer education used in this way, again, has control of "what needs to be changed and how best to change it" remaining with researchers and professionals.

### **Peer education and community norms**

Much of the recent literature on HIV prevention among drug users talks of the need for changes to community norms for sustained behaviour change by a majority of drug users. Friedman (1994) believes that involvement by drug users in their own organisations is the key to what he calls "mobilising subcultural change" to support and enforce risk-reduction norms.

Rhodes (1993) examines ways to change community norms and practices among drug users, noting that "research has pointed to the possibility of targeting and/or recruiting key individuals ('opinion leaders') within a social network as agents of change". Using these people as peer educators and using multiple channels of communication, Rhodes' approach aims, over time, to:

"generate a collective, *normative* response to behaviour change. While targeting the many micro social relationships within a network to facilitate peer influence and peer support, the challenge is to both create and nurture a macro social and collective responsibility about health and health behaviour." (original emphasis)

Rhodes (1994) forcefully concludes a wide-ranging examination of the UK's approach to HIV prevention among drug users as follows:

"HIV prevention interventions are part of a wider strategy of *health promotion* targeting drug users. It is timely for HIV-related health promotion practice to reflect the fundamental tenets of health promotion contained within the Ottawa Charter. **This involves greater applied commitment to community action, community participation and community organisation within drug-using communities and to the creation of healthy environments and the supporting of healthy policy.**" (original emphasis)

### **Peer education among injecting drug users**

Trautmann and Barendregt (1994) state that there are two organisational models of what they term "peer support":

- peer support based in a self-organisation (eg, an IDU group or drug users organisation)
- peer support based in a professional or voluntary non-IDU organisation (eg, a drug treatment agency or health service).

The authors state that most peer support projects lie somewhere between these two models as a "joint venture" of drug users and health workers.

These mixed forms can be roughly divided into:

- peer support by a drug users organisation supported by professionals or a professional or voluntary organisation; and
- peer support by a professional or voluntary organisation leaning on the expertise and the work of drug users.

The organisational form described above as "self-organisation" has its roots in the *junkiebonden* (junkies' unions) in the Netherlands. Trautmann (1994) provides a short history of the *junkiebonden*, noting that they have consistently seen themselves as interest groups "representing the interests of drug users". He states that "being an active member of an interest group is for many drug users a positive experience enabling them to assess their abilities and to foster their self-esteem". The political aim of *junkiebonden* is clear: "a drug policy based on decriminalisation and normalisation" (a Dutch policy in which drug users are meant to be treated as citizens first, rather than as criminals).

The Rotterdam *Junkiebond* began syringe distribution in 1981 to prevent the spread of Hepatitis B: it was taken up by other IDU groups to highlight risks of HIV spreading in the early 1980s and the importance of what Trautmann calls "safer use". The *junkiebonden* have also played an important part in providing prevention education and emotional support to drug users with HIV and AIDS, and continue to work politically to "force the responsible authorities to provide adequate facilities in the field of AIDS prevention and care".

In the area of IDU education, Stimson and Power (1992) note that the formation of *junkiebonden* is being emulated in other countries. In 1994, the International Drug Users Network was in contact with IDU groups similar to the *junkiebonden* in 11 European countries (Germany, The Netherlands, the United Kingdom, Norway, Denmark, Slovenia, France, Belgium, Italy, Lithuania and Spain), as well as in Australia, New Zealand, the United States, Canada and Brazil. (IDUN 1994)

The establishment of these groups (also known as IDU groups or drug user organisations or DUOs) and, in some cases, their funding from government and non-government sources, has similarities with the development of community-based organisations in a number of communities to combat infections and other diseases. Altman (1994) shows that an organised gay community base was already in place by the time AIDS began to affect large numbers of gay men in countries such as the Netherlands, Denmark and Australia. In the formative years of both gay community organisations and DUOs (as well as other organisations based in the sex industry), great emphasis was placed on providing HIV prevention education via credible peer educators.

In their seminal paper on drug user organisations, Friedman et al (1987) identified obstacles to injecting drug users organising themselves. These obstacles included:

- individual obstacles such as poverty, effects of drugs, necessities of drug markets, possibly low educational levels
- current social systems surrounding drug buying and selling, which may stand in the way of co-operating in organising
- major societal-level obstacles, especially powerful groups who might oppose or hamper drug users' attempts to organise: these obstacles may include police, other law enforcement, a hostile press and public.

While these obstacles might prevent IDU groups from forming in some circumstances, the authors believe that social organisation of drug users by drug users is possible, and is an important strategy to prevent the spread of HIV among drug users.

In their follow-up paper, Friedman et al (1988) suggest some of the main activities by which drug user organisations can prevent HIV transmission are:

- Establishing "mechanisms and norms among drug users so that, for example, everyone in a friendship group has sterile works of his or her own before drugs are bought"
- Ensuring "diffusion" of these mechanisms and norms, primarily through "educational outreach efforts, whether through grapevines or through more formal means", but also through reacting to controversies within the drug using culture to "win support for, and compliance with, the organizations' views".

The authors conclude that:

"Health education that merely distributes information is not adequate to produce the needed changes. Instead, we have proposed here a form of intervention that encourages i.v.drug users and their associates to set up their own institutions to perform education, quasi-political and service functions needed in this epidemic."

### **Peer education by Australian DUOs**

Hunter (1994) finds that "user organisations" were set up in several Australian States and Territories and nationally in the late 1980s:

"These groups were established in most cases with a primary function of acting as community HIV/AIDS organisations to work with injecting drug users and ex-injecting drug users to minimise HIV transmission; provide policy advice to government and in some cases to other government and non-government services; and to be able to evolve into organisations capable of providing community care and support if HIV epidemics of any size took hold in injecting drug user populations."

He states that these groups were established to "run on a 'self-organisation model'" though this model was never defined, and the implications of the model for control and ownership of the organisations was never fully discussed. The role of these groups in matters outside HIV/AIDS prevention and support was also not defined.

Byrne (1991) sees IDU community-based organisations as the best placed groups to carry out HIV prevention education to injecting drug users. Users will not accept information from:

"representatives of a community committed to (their) elimination. To address the problem of mistrust and credibility, representatives of the IDU community had to be involved in the planning and implementation of the education programs."

Both Byrne and Hunter are referring mainly to the types of formal peer education carried out by drug user organisations among drug users in a similar fashion to the way that the AIDS Council of NSW carries out peer education programmes among young gay men or other groups of gay men. However, over the past two years, some Australian DUOs have started emphasising that peer education is a process which occurs naturally among injecting drug users, and that the DUO's role is to assist and extend this process rather than necessarily begin a structured programme of formal peer education.

At a meeting of all Australian IDU groups on peer education in Sydney in May 1995, participants spoke of peer education not as "teaching" by a "good user" to change the behaviour of another drug user. Rather, they talked of drug users sharing information on how to inject as safely as possible, given their current circumstances. In this model, drug users create a safe use language and invent safer ways to inject. This leads to a supportive peer environment in friendship networks, and allows the development of materials for "friendly, supportive" education rather than pedagogy.

Among participants' observations were that effective peer education in such a model:

- supports the sharing of information within networks of users, thus respecting the knowledge, experience and skills drug users already have
- places less emphasis on "what is the correct way to inject" than on "why the use of sterile water (or some other strategy) may make injecting safer"
- acknowledges that drug users are an extraordinarily diverse group requiring education in a range of formats and styles
- is based on an understanding of the cultural and situational aspects of injecting for each social or friendship network
- provides information in a way that enables other users to pass the information on
- shares power between drug users, rather than a formal programme which places peer educators in a position of authority and knowledge over other users
- is based on trust and respect. (AIVL 1995)

The role of a drug users organisation in such a model is still being defined. However, participants at the Australian meeting noted the following as important tasks for DUOs:

- Community development to assist in creating a supportive, friendly environment in which peer education can take place
- Acting as an information/resourcing centre for accurate, agreed, consistent information
- Providing training to those drug users who want to enhance their skills in peer education and/or to participate in formal peer education programmes
- Resourcing and supporting peer networks and assisting peer educators to maintain motivation
- Advocating for legislative support for health initiatives aimed at drug users (including advocating for reform to current prohibitionist drug laws and policies), and for the elimination of userphobia (the stigmatisation of and institutionalised discrimination against drug users)
- Being structured so that drug users can be involved in all aspects of the organisation's work. (AIVL 1995)

As can be seen from this list, the model discussed by Australian DUOs is not mutually exclusive of formal peer education programmes. Rather, the two models can be used together by DUOs to achieve maximum education and to assist social networks to decide on appropriate norms of behaviour. Australian IDU groups have undertaken a wide range of formal peer education projects as part of and in addition to their needle exchange, support, political and other activities.

One formal peer education activity which has been central to the work of Australian DUOs is that drug users "write, produce, develop messages, provide artwork, focus test, decide on printing priorities, carry out distribution, take photographs, (and are) immersed in every step of the process to produce educational resources" aimed at injecting drug users (Burrows 1995). Examples of these resources produced by Australian IDU groups are booklets, pamphlets, magazines, cards, posters, videos, and audio resources. The involvement of drug users in these processes serves to enhance the credibility of the educational resources (Burrows 1993a). Burrows and Price (1993) also found that an emphasis on the development of printed education materials by current drug users was one of the major similarities between drug user organisations in Sydney and Baltimore (USA).

To date, Australian IDU groups mostly have both paid and volunteer workers and tend to employ mixed groups of active users, methadone consumers, ex- and non-users. Australian IDU groups are not exclusively focused on HIV/AIDS prevention, but HIV and Hepatitis C prevention is a primary focus of their work. Herkt (1993b) concludes that Australia's IDU groups "played an integral role in the containment of HIV infection among IDUs" and that the low level of HIV transmission involving injecting drug use in the 1990s "is due at least in part to continuing programmes of prevention and education" by these groups.

The draft report from the National HIV/AIDS Strategy 1993-94 to 1995-96 Evaluation (1995) states that:

"In States and Territories where user groups currently exist there is a high level of support among government officials for the work they have undertaken."

### **Problems with formal peer education**

Formal peer education programmes have one central difficulty. Such programmes are unlikely to find a current or ex-drug user to match the age, sex, sexual orientation, drug of choice, frequency of drug use, and the culture of every drug user in a given geographical area. Many education campaigns and programmes, including peer education and outreach, focus mainly on men or on women, on heroin users or amphetamine users, and so on. Kinder (1995) refers to this as the "locus of peer attraction" which he links to an acknowledgement that people have a range of identities, personal needs and priorities that affect their receptiveness to peer education messages.

This problem becomes particularly important in light of the recent calls for mobilising subcultural change and concentrating on community norms. One strategy, used by some Australian groups to overcome this problem, is traditional market segmentation, in which multiple education campaigns target ever narrower cultural segments. An example of this is the Tribes programme carried out by the NSW Users and AIDS Association (NUAA). In this programme, funding is provided from the NSW Health Department through NUAA for individual Tribes projects which:

"enable members of particular sub cultures to produce events and/or resources around the themes of HIV/AIDS/ harm reduction/ risk realisation and safer behaviour. This strategy allows the communities to produce events and/or resources that employ their own language, values and iconography." (NUAA 1994)

In 1994, NUAA co-ordinated Tribes programmes among:

- motorcyclists who attend "bike shows" and "biker" events
- people who attend inner western suburbs (Sydney) hotels to watch live music
- strip club workers, including bar staff, spruikers and strippers
- transgender club-goers
- steroid users who work out in gyms
- people who have recently begun to inject. (NUAA 1994)

Similarly, the mothers' group and steroids programme run by the ACT IV League; the Aboriginal projects run by South Australian Voice for IV Education (SAVIVE), NUAA and Queensland Intravenous AIDS Association (QUIVAA), all attempt to provide specific education and other services to assist a segment of the injecting drug using population to protect itself from HIV and to support its members who have HIV and AIDS.

Murray and Robinson (1995) provide several criticisms with the way in which peer education on HIV/AIDS issues among marginalised groups such as sex workers and drug users is promoted by Australian governments and policy makers, both within Australia and to other countries in the Asia-Pacific region. The authors note that peer education (in the context of HIV/AIDS) was a strategy devised for the prevention of HIV transmission among gay men. When this strategy is applied to groups such as sex workers and drug users:

"the focus on the individual means that peer education, and the whole health promotion ideology of which it is part, essentially supports the status quo: (peer education) does not problematise social structures and legislation."

In addition, the authors find that:

"the position of a sex worker peer educator inevitably creates divided loyalties and a position 'between two stools' as long as sex work is stigmatised and legislated against: the peer worker is supposed to find a balance between being an insider and an outsider...Unreasonably high expectations are placed on peer workers, for instance in terms of being able to communicate both at street level and in the jargon of funding proposals and data collection, as well as having a range of other skills." (Murray and Robinson 1995)

## **Conclusions and future directions**

From this survey of the literature about peer education, outreach, drug user organisations and community development, the following statements can be made about the effectiveness of peer education among injecting drug users.

The main features of effective formal peer education programmes about HIV among injecting drug users are:

- Effective peer educators suspend making judgements about drug users' lifestyles and accept users as they are.
- Any effective education for injecting drug users must involve the users in producing printed and other education materials.
- Outreach works: peer educators need to go to where drug users are.
- Effective peer education works towards changing community or social network norms.
- Peer educators work best with people like themselves.
- Effective peer educators give HIV prevention messages based on current practices.
- Effective HIV/AIDS peer education is linked to the means of prevention (ie, clean needles, syringes, other injection equipment and condoms), and to drug treatment and other health services.
- Effective education messages tend to be positive, rather than negative.
- Effective education of drug users about HIV occurs when drug users receive the same or similar messages from a variety of sources.
- Needle and syringe exchange or supply does not, of itself, constitute effective peer education.

The main features of effective community development programmes to facilitate informal or everyday peer education among injecting drug users are:

- Community development acknowledges that drug users are an extraordinarily diverse group requiring education in a range of formats and styles.
- Community development is based on trust and respect.
- Community development supports the sharing of information within existing networks of users.
- These programmes help to share power between drug users, rather than a formal programme which places peer educators in a position of authority and knowledge over other users.
- These programmes provide explanations of why a procedure is "safer" rather than "what is the correct way to inject".
- These programmes are based on an understanding of the cultural and situational aspects of injecting for each social or friendship network.
- These programmes provides information in a way that enables other users to pass the information on.

In addition, the research and practices surveyed raise several research questions which need to be addressed in this area.

First, we need to define the role of IDU organisations outside HIV/AIDS, and how these roles interact with the organisations' peer education efforts. The devastating impact of Hepatitis C on

injecting drug users, and the increasing need for IDU organisations to take on Hepatitis C related prevention and support work, add urgency to this task.

Second, documentation is needed of the various strategies currently used by drug user organisations and IDU peer educators in Australia. In particular, documentation is needed of the community development approaches which foster informal or everyday peer education to ensure that a "best practice" document for this type of work is developed.

Third, we need to develop effective methods of evaluating HIV prevention education interventions such as formal and informal peer education. This means that we need to develop adequate indicators and standards that allow organisations to measure community-wide change or changes to social networks rather than individual change.

As part of this process, IDU groups and researchers need to persuade governments that behavioural change by IDUs is more complex than simply measuring the number of needles distributed in a given area. A similar measure of safe sex within the gay community would be the number of condoms issued at a gay dance party. While this information may be important, it only provides a very small part of the evaluation needed for various approaches to HIV prevention education.

Fourth, we need to clarify the role of learning in peer education. Virtually all of the literature surveyed for this paper concentrates on the educator and the education being provided, rather than on the learning styles of drug users. Learning how drug users learn will assist in the design of more effective educational programmes.

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