That's SIC: Mobilising peer networks for hepatitis C prevention

Patricia Preston and Felicity Sheaves

SIC Project
WAHS Sexual Health and HIV Services
Ross Wing
GPSH
PO Box 126
PENRITH
NSW
AUSTRALIA 2751

Paper presented to the 2nd International Conference on Young People and Drugs. Melbourne, Australia May 2001

Mobilising peer networks for hepatitis C prevention

The SIC Project is a hepatitis C prevention project for under 25 year old injecting drug users (IDUs). It is a joint project between Wentworth Area Health Service Sexual Health promotion Unit, Public Health Unit and Drug and Alcohol Services. SIC stands for Safer Injecting Cwiz – that's Cwiz with "cw" not a "qu". You might be wondering about a project called SIC. But you have to have a bit of imagination and be a bit flexible. We're SIC because young people say:

"you're gonna give us incentives to do Hep C education?", "SIC" !

"You're gonna give us more incentives to recruit other injectors?" "SIC"!

And then the bureaucrats say:

"You're gonna give young injectors incentives to participate in your project in this political climate?" "SIC"!

And then of course, we love the perversity of being SIC health workers and running a SIC project.

In parts of WAHS the injection of heroin, speed, methadone and benzos is well established, but there are no focal settings and IDU activity is much less public than in the inner city. IDUs in the outer west are difficult to access because of this. Difficulty of access is higher still with regard to young IDUs, who are not typically visible at NSP outlets. In many cases these young people are dependent on older drug users for access to both drugs and injecting equipment. Like their older counterparts they are dispersed across small local suburban communities.

SIC draws on peer networks as a means of recruiting and educating young IDUs about hepatitis C. The intervention was developed in response to the younger than average age of hepatitis C transmission in Wentworth Area Health Service, compared to both NSW and Australian statistics. As duration of injecting is the single biggest predictor of hepatitis C infection it was considered crucial to target newer, younger injectors in the effort to impact upon hepatitis C incidence locally.

In planning the project, we had to consider the following issues:

We had to find ways of accessing networks of young people, establishing trust, worker credibility and rapport to engage them in HCV education. We wanted to engage young people within the broad target group of under 25 year old IDUs. We knew that rather than there being a young injecting community we could tap into, there probably were clusters or loose networks of users linked by geography, homelessness, drugs or some other connection. The social bonds for these groups may be tight, loose or tenuous. We thought that tapping into these networks might be a way of working with them. We had no connections to the target group or any of the networks that we thought might exist out there.

We were acutely aware of the continuing debate around the role of the non-user in HCV education, versus the taken-for-granted authenticity of the user, who is assumed to have expert knowledge of the intricacies of using.

We also knew that good educators not only have sound knowledge but they also have to be able to engage participants and sustain their interest.

We thought that four particular strategies could be used to develop a better intervention:

(OVERHEAD 1)

1. **Using the grapevine.** This is a sub-culturally appropriate way of disseminating information and could be utilised to enhance the reach of the intervention.

2. **Targeting people who are loosely attached to networks**. This had a two-fold rationale. Firstly, weak network links have weaker emotional ties. This allows scope for rules around safe using to be implemented (Williams & Johnson, 1993). Secondly, the mobility of these loose networks places individuals at increased risk for both contracting and transmitting HCV.

3. **Utilising the mechanism of social influence**. By encouraging social support for safe use and increasing the social desirability of safer use.

4. **Peer educators** help to make information more personally relevant, credible and accessible (Rickert, Jay & Gottlieb, 1991).

Drug using networks have been identified as mechanisms in the spread of blood-borne disease. The Eastern Conneticut Health Outreach researchers argued that these networks can also be used as mechanisms in the spread of blood-borne disease prevention strategies.

We decided to adopt a network approach and utilised a peer driven intervention (PDI) developed by the Eastern Connecticut Health Outreach project which is sometimes also known as the ECHO model (Broadhead, Heckathorn, Grund, Stern & Anthony, 1995). Put simply, this model functions like pyramid selling by engaging participants to recruit and educate peers for nominal incentive rewards.

(NETWORK OVERHEAD 2)

The peer driven intervention taps into drug users' daily street level activities like scoring, scamming, selling, and sharing. For example, people who are active in the local drug scene and who are motivated can be encouraged to recruit and educate their peers who are less active, less motivated, or less well connected. In this way peers drive the recruitment and education process, ensuring its diffusion among networks. They are rewarded for their efforts both monetarily and by helping their peers.

Accurate information was essential to enable participants to make decisions about their hep C risk behaviour. Given that hep C is often a small consideration in the daily lives of IDUs, it was vitally important that the content

was accessible, relevant, interesting and dynamic in order to engage participants.

Workers also acted as a resource for participants, passing on information, discussing issues, providing further resources, referrals, etc, allowing participants to provide themselves with the knowledge they needed regarding hep C. In this way a peer driven intervention relies on active collaboration with IDUs, in place of the hierarchical 'provider-client' model" typified by Needle and Syringe Program.

The effectiveness of the peer education and hep C messages were checked by the project workers using the quiz.

O/H FLOWCHART 3

The peer driven intervention model uses 'primary' and 'secondary' monetary incentives to reward peers for their efforts. First layer participants are educated, completing a hep C quiz, for which they receive $20. They are then offered the chance to recruit and educate up to three other people. The incentives offered are an amount of money (eg $10) for each person they recruit, educate and bring to the project site for knowledge testing and up to another amount (eg $10) depending on how well the recruit performs in the quiz. In this way, a successful recruiter can earn up to a maximum of $20 and a minimum of $10 for each recruit. The second layer participants receive a $20 payment for participating in the project regardless of their quiz performance. In this way the recruiter and the recruitee are both rewarded for

their efforts. Participants are initially limited to three recruitments as a quality control measure to ensure information and knowledge transactions are of a good standard.

The education that was developed by SIC tried to be culturally appropriate, and life stage appropriate. It also needed to be able to reach a group of people who sometimes see health workers as authority figures – the “lifestyle police” - or who see education as something that is related to school - hard, boring, punitive and making no sense. Participants often come with a variety of learning and behavioural difficulties, whether it be low literacy, ADHD, or being stoned, strung out, or scattered.

(Garry HCV education slide)

The education session was informal and conversational. While certain information was given and a particular sequence was imposed, it was loose enough to allow it to be participant-centred. In this way they could meet their own educational needs.

(tray of props slide)

We used trays of props, which contained the information, and allowed people to interact with it, to pick it up, to try it out and to build a bridge between the abstractions of disease transmission and the reality of their own risk behaviour. In practice what happened was that recruiters most often came with their recruits and sat through the session. In this way, an active recruiter would receive multiple exposures to the intervention, in the company of

people they inject with.

The target group is diverse - from young refuge kids to chaotic, homeless, hard young men; to the older end – young adults with long habits, trying to protect their children. The education was developed to be versatile and flexible and able to be “pitched” to engage lots of different styles and needs.

It has to be remembered, though, that while it appeared loose, the education was actually grounded in a firm structure and sound theoretical framework.

The project ran from April 1999 to September 2000. It recruited 221 participants and followed up 95 of those. The evaluation showed that both the education and the recruitment model were effective ways of working with the target group. It performed well in terms of behavioural and educational outcomes.

Hep C knowledge increased by 23.7% and Hep C risk behaviours decreased by between 72 and 95%. Participants reported high levels of satisfaction with the intervention and the recruitment model was able to access marginalised and hidden IDUs.

This paper is not about the nitty gritty of the project outcomes and other aspects of the intervention will be explored in the EQUIP presentation. We also have a poster presentation, come and talk to us.

Having had the opportunity of running an adaptation of the original PDI developed by ECHO, both the ECHO researchers and SIC found the following advantages:

Overhead 4

a) **Recruits are identified by other IDUs**, who have insider knowledge which the health worker may not have, leading to more fruitful recruiting and less worker time spent identifying recruits;

b) **Indigenous recruitment allows for penetration of networks** to reach the more invisible youth, including transitional injectors;

c) **Peers help to translate health messages into a meaningful form** for those who are less accessible; and the peer driven intervention prevents misinformation and dilution of messages through worker quizzing and correcting;

d) **It's inclusive – everyone has opportunity to recruit**, educate and get paid

e) **The Peer Driven Intervention is as opportunistic as its participants** – it fits in with everyday drug – related activities;

f) **It has the potential to go through whole networks** – both drug use and social;

g) **It helps influence the injecting culture towards safer using** by building on individuals' and networks' existing risk management practices;

h) **It is capacity and skill building** (through opportunities for recruitment and peer education);

i) **Payment tied to performance** provides incentive and also acts as a quality control measure – the best educators receive the most money.

j) **It was both flexible and portable**. The SIC Project operated from a variety of settings such as youth health centres, community health centres, youth refuges, public space and private residences;

k) **It is adaptable to specific targeting** of young people;

l) **The impact is increased through multiple exposures to the intervention** – at follow-up, through reiterations when teaching peers and through participants attending education sessions with their recruits.

While the model has many advantages it would be an oversight not to address the disadvantages. In the context of the SIC project we have identified the following complexities:

a) **It is extremely controversial.** Paying drug users to participate in health promotion engenders a political minefield in the current conservative climate. Its not for the fainthearted;

b) **To gain the full advantage of the PDI, it needs a long enough lead-in time to get established.** Obviously, the longer the intervention runs, the greater the reach and diversity of participants. It will also be able to access more marginal and more hidden, populations; and

c) **The project needs to have firm boundaries and well-established protocols** to contain the project, ensure it hits the target group and negotiates the behaviour of participants.

In Conclusion the Peer Driven Intervention and the SIC education model provide an innovative framework for collaborative work with young IDUs. They are flexible, adaptable, effective and ethical ways of delivering quality health promotion to a marginalised group. We believe that the advantages of a peer driven intervention far outweigh any disadvantages that might be encountered. It is a *splendid, fabulous, in fact* <u>*marvellous*</u> model for mobilising peer networks for hepatitis C prevention.