"Just because we are using doesn't mean that we can't do anything, that we can't do something for ourselves"
An exploration of best practices of meaningful peer involvement within a harm reduction context with substance users from GHB, MSM, and IDU drug use settings

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Table of contents

Abstract

Background: In the realm of harm reduction, there is the emerging practice of public health organizations involving their target populations in the functioning of their organizations in a variety of ways, via campaigning, supporting, and advocating. This particular type of outreach is known as peer involvement, where former and current substance users make contact with current substance users in order to raise awareness and understanding of the physical and psychological harms associated with their practices.

Context: This study focuses on three of Mainline's target audiences: gamma-hydroxybutyric acid (GHB) users in the Netherlands, men who have sex with men (MSM) and their chemical sex party practices, both nationally and abroad, and injecting drug users (IDU) internationally. These three drug use settings present obstacles for 'regular' harm reduction work in that these populations are hard to reach and thus require new approaches for outreach workers. Therefore, we are interested in developing new ways of accessing these populations in order to transmit sustainable harm reduction messages. One way to allow access to these specific population is peer involvement.

Aims: The research question is: 'What are the best practices currently used to get former and current drug users organized and involved with outreach and spreading harm reduction techniques in a meaningful and effective manner?' The aim of this exploration of best practices of meaningful peer involvement is to provide Mainline with useful and practical harm reduction recommendations on how they can improve and extend their peer to peer based health practices regarding three specific drug use settings.

Method: There were 20 semi-structured qualitative interviews with members of public health organizations that were connected to peer involvement, meaning that both peers (current and former substance users) and non-peers (non-substance users but familiar with certain drug use settings) were interviewed.

Analysis: Subthemes emerging from initial analyses of participants' accounts were grouped into larger, broader themes: agendas, guidelines, challenges, lessons learned, and organization. An analysis of the connections and inter-relations across these themes points towards the pivotal position of peers within effective harm reduction, while recognizing the challenges included in this involvement. Inferences drawn from the analysis are salient to understanding the practical measures needed in order to involve peers in a meaningful way.

Results: The GHB use setting was characterized by practical and ethical issues that made finding the best practices of harm reduction in this setting complex. MSM peers demonstrated a unified network in that there was a strong sense of community and a shared struggle. However the poly-substance use and HIV status associated with this setting complicated how peers went about minimizing risks and connecting with their target audience. The IDU setting appeared to be the most successful with peer involvement in that their networks and partnerships were strong and the peers' role appeared to be more defined, and their harm reduction agenda tended to be aligned with that of the substance user.

Conclusion: Knowledge and trust are vital components to effective harm reduction and risk communication. Ideally, peer workers and target audiences should share a similar agenda in regards to their ideas on what harm reduction looks like. Peer involvement is largely unexplored and can be complicated, but can also be highly beneficial for both the agency, the peers, and the target group, and thus should be encouraged.

1. Introduction

1.1 Background of harm reduction

In the context of drug use, the fundamental concept of a harm reduction approach is to accept substance use as an inevitable occurrence within society and turn our energy towards limiting the inherent risks as much as possible (Stichting Mainline, 2012). Proponents of harm reduction describe this approach as "pragmatic and realistic" (Järvinen, 2008: 975), because it acknowledges that people always have and always will use illicit substances and the best course of action is to work with drug users based on their individual needs and wishes. However, the harm reduction approach of (non-peer) outreach has its limitations in terms of access, knowledge, and appropriate language. Moreover, information fatigue and unrepresented populations are also present with traditional harm reduction. In order to make connections with at-risk populations, outreach workers must adapt and shift their approach to stay relevant.

1.2 Peer involvement as a stream of harm reduction

This particular type of outreach service relies on former and current substance users to make contact with current substance users in order to raise awareness and understanding of the physical and psychological harms associated with their practices. Peer involvement is aligned with harm reduction outreach because it is a realistic, pragmatic approach to substance use that respects the autonomy of the user. However, unlike traditional harm reduction where outreach is typically carried out by non-peers, peer involvement uses drug users to implement similar outreach. This resourceful model makes use of peer networks to facilitate a wider involvement of substance users in harm reduction practices (UNAIDS Policy Brief, 2007). By using peers, harm reduction messages are more easily, credibly, and legitimately transmitted to these populations.

1.3 Problem Statement

Three of Mainline's target audiences were explored: gamma-Hydroxybutyric acid (GHB) users in the Netherlands, men who have sex with men (MSM) and their chemical sex party practices, both nationally and internationally, and injecting drug users (IDU) internationally. Typical outreach in these three drug use settings are challenging in that outreach workers struggle to access and connect with their target audience. These three drug use settings require new approaches in order to help minimize risks for these substances users. Peer involvement is one method to gain better access to and spread harm reduction information amongst these populations, however, this practice is complex, delicate, and somewhat unexplored.

1.4 Research Goal

The aim of this research is to provide Mainline with useful recommendations on how to improve and extend their peer based health practices regarding three specific drug use settings while keeping in line with their harm reduction principles.

1.5 Research Question

The question that guided this research is: 'What are the best practices currently used to get peers organized and involved with outreach and spreading harm reduction

techniques in these different drug use settings and how can these be applied to Mainline's future work?' This question was supported by the following sub-questions:

-What criterion makes for a 'good' peer?

-What does successful peer involvement look like in each drug use setting?

-What are the biggest challenges facing peer involvement?

-What rules are in place for peers?

-How does a full peer led organization compare to that of a mix of peers and non-peers?

-How are peers found, trained, organized, and integrated?

2. Context

2.1 Peer involvement overview

Most people would like a greater say in the services they access, whether it be health care, financial, or employment. The same can be said for drug users. This idea reflects the notion that services will be more effective if they have the input and expertise of their users. This is the foundational concept behind peer involvement: have former and current substance users raise awareness and understanding of the physical and psychological harms associated with drug use amongst drug users. Other supporting principles of peer involvement include: equality, self-determination, genuine and meaningful involvement, community development, mutual respect and acceptance (Kools, 2013). This innovative method caught the attention of UNAIDS, which suggested that, "In order to develop effective, realistic and achievable programmes it is essential for people who use drugs to be involved in planning, influencing and delivering such services." (UNAIDS Policy Brief, 2007).

Peers can be involved in a variety of ways, such as policy making, programming, researching, educating, peer supporting, campaigning, public speaking, and advocating (WHO Library Cataloguing-in-Publication Data, 2004). Regardless of the level of involvement, the goal is to ensure that representatives of these marginalized groups are directly involved in the services they access and policies that impact them.

In his investigation into peer involvement practices in the Dutch context, Trautmann (1995) brought forth some crucial differences in the ways in which peer involvement can be practiced. A central question brought forth by him was the choice between full or partial peer involvement, that is, autonomous self-organization or integrated into an existing structure. Embedding peer support in a professional public health agency offers several benefits, such as offering professional support to the substance users involved, and publically recognizing and accepting the expertise of drug users. On the other hand, there are also valid reasons to autonomously organize peers. For example, peers may struggle to conform to or function within a typical working environment. Moreover, the issue of interest would have to be addressed, as perhaps the agenda of the organization and professional staff differs from that of the peer workers.

2.2 Benefits of peer involvement

Peer involvement rests heavily on the lived experiences of either former or current drug users. One way to think about the value of involving peers in the spreading of harm reduction is to see them as experts within their own subculture. This lived experience translates into a few key aspects: credibility, understanding, accessibility, and resourcefulness. Additionally, peer involvement can also be seen to benefit the target audience, the peer worker target, and the organization as a whole.

Credibility

Peers have credibility that non-peers simply cannot fake nor (re)create. If a harm reduction message comes from a peer, the receiver is more likely to respond to the messasge and act accordingly than if an authority figure delievered the same message. This may also translate into a more meaningful relationship between peers and can help gain the trust of other drug users. Credibility also implies that via the peer worker, reliable information is being delievered to both the service users and the service providers. These individuals are also sometimes seen as roles models amongst their

community and this could further contribute to an open, honest, and trusting rapport between peer worker and target audience.

Agencies that involves peers also gains credibilty. Agencies are able to provide higher quality services because their peers are able to accurately identify needs and services that the agency looks to satisfy (WHO Library Cataloguing-in-Publication Data, 2004). Furthermore, many agencies require their staff to be drug-free, and thus having an agency that rejects that idea and instead accepts its staff, volunteers, and users' substance use would have a powerful impact amongst these populations.

Understanding

Peers have a shared experience that is invaulable. Peers have the unique position to understand other individual drug users and the issues that accompany their use. They understand that changing behaviours, habits, and patterns is difficult and that those who use drugs should be supported, not punished. Additionally, because peers share norms and experiences with their target audience, peers are able to provide clear, authentic, and meaningful drug education and harm reduction (Transnational Institute report, 2014).

Accessibility

Peers have access to particularly hidden environments and tight networks of drug users because of their (past) use. Since some peers may have an intimate, first hand experience with services and projects, they are the best source of knowing if a service or project is working or not. In turn, this would allow for a more effective agency output.

Resourcefulness

Peer involvemnt in outreach contributes significantly in terms of knowledge, contacts, and language. They are privy to certain terms, trends, and issues that non-peer based organizations miss out on, because in a sense, they are removed from the real life experiences of their target audience. By not including peers, organizations missing out on the benefits of a two-way flow of information that is associated with peer work. The resourcefulness of this approach is demonstrated by the fact that peers make use of already existing social networks to recruit and educate their peers.

Because of their 'insider' status with their peers, peer workers are also effective in identifying and addressing any myths and misinformation that may circulate within networks. In relation to this, they are also in a beneficial position to identify changing trends within their subculture (ibid).

Personal gains

Peer involvement can be an effective way of actively establishing and nurturing the personal and professional skills of a drug user. Additionally, these types of behavioural changes may impact changing public attitudes towards people that use drugs. It has also been suggested that involving peers allows them advocate for future, additional services, which would have a positive effect on both the peer worker and the agency as a whole (WHO Library Cataloguing-in-Publication Data, 2004).

Peer involvement empowers peers themselves by reducing their isolation or improving their own harm reduction efforts (Transnational Institute report, 2014). Peer work is also mutually beneficial in that the peer workers not only provide a worthwhile service to their community, but benefit from this work by creating stronger bonds within their community: "By increasing self-confidence and self-efficacy, users will be able to sustain change in their own communities, to advocate for their own rights and to maintain

their independence from donors and other stakeholders, who may not always act in their best interests" (ibid, 11).

Considering all these beneficial aspects of peer involvement, it has been suggested that peer education is, "the most effective way to share new knowledge and skills with drug users, allowing them to become engaged in harm reduction activities in a supportive non-stigmatizing environment" (ibid, 11). However, perhaps the most significant reason put forth for peer involvement has nothing to do with the practicality, rather the ethicality. Simply, everyone should have the right to be involved in the decisions affecting their lives.

2.3 Challenges with peer involvement

Former and current substances users can be a difficult and disorganized group of people to work with, for example, they may lack certain skills related to time management, or plannning (International HIV/AIDS Alliance and the Global Network of People Living with HIV, 2010).

Financial compensation is a challenge for peer involvement. While most agencies pay their peer workers, some prefer contributions to be voluntary or, provide non-monetary rewards, such as free HIV-testing. An absence of payment may be the case for a variety of reasons, for example, paying peers could undermine credibility, and the paid peer's position within their community or relationship with their network may change. Payment can also mean that peers lose their independence by being forced to conform to the ideals of an organization (Trautmann, 1995). Considering that paying peers can essentially finance their substance use highlights an ethical element of this method. This may or may not be an issue depending on the attitude of the employers. This is an unexpected outcome, as harm reduction agencies should ideally be non-judgemental and accepting of drug use, but demonstrates that latent stigma and implicit discrimination are omnipresent for substance users, even in agencies that advocate for them.

However, proponents of peer involvement are quick to counter the payment issue. Because peers can target and reach so many people in their community with information and support, it is an extremely cost effective measure (ibid). Moreover, paying peers for their contribution can be seen as an acknowledgement of substance users as competent, responsible workers, thus having a profoundly positive effect on the substances users' sense of self (ibid).

Broadhead and authors take a logical approach to the payment issue: "The good a program does by building social network ties, strengthening community norms, reaching larger and more diverse populations at risk, and thereby reducing the spread of HIV far outweighs the harm it might perpetuate by providing cash for one or two more fixes" (1989:55). However perhaps the strongest, yet most over looked argument in this debate is that peer workers work, like anyone else who gets paid.

2.4 Key populations

There are key roles existing within the space of peer involvement. Active users are individuals who at the time of involvement currently use substances. Former substance users are individuals who no longer use substances, but still have contact with and connection to the target audience. This group may be seen as a positive role model for current users, as they have the lived experienced of what strategies work with

reducing harm in relation to their use (International HIV/AIDS Alliance and the Global Network of People Living with HIV, 2003). The third group, drug sellers, are valuable in that they are direct points of contact for the target audience and can be used to dispense harm reduction tips with conjunction with the substances themselves. Non-substance user agency workers represent the individuals of an organization who have no lived experience with substance use but work along side and with substance users. A good working relationship between non-users and users is very important for the functioning of an organization and thus should be given attention and support.

2.5 Overview of targeted drug use setting

GHB in the Netherlands

There are approximately 22.000 problematic daily GHB users in the Netherlands, with the majority of them located in the south (Stichting Mainline, 2014). Harm reduction tips are generally concerned with dosage, as the outcome is highly unpredictable (Trimbos Instituuut, 2014). Context plays a big role in this drug use setting, (ibid) and this was reflected by the ways in which interviewees from different regions spoke about GHB use. Amsterdam based Unity generally makes contact with recreational GHB users. These individuals tend to use at home during after parties with relatively low risk usage, in that their use is more recreational than problematical. This usage has its own challenges in that these recreational users are invisible because they are typically using in spaces where outreach workers do not target or have access to. This raises the challenge of how to provide harm reduction to these users who are not visible to outreach workers.

Participants connected to Norvadic-Kentron, an addiction treatment centre in the south of the Netherlands on the other hand, had completely different experiences with GHB use. There, GHB use was more problematic, and in turn, abstinence and recovery were the focus of their peer outreach work. These differences are highlighted because these different experiences from different locations contribute to different perspectives and agendas of the peer worker. And understanding the agenda of the peer worker, as will be explored in Chapter 5, played a large role in the success of peer involvement.

MSM and chemsex in the Netherlands and abroad

Chemsex refers to sex between men that occurs under the influence of drugs taken immediately preceding and/or during a sexual session (Bourne et al.*,* 2014). This is a complex and diverse phenomenon: "a sexual behaviour in which a wide variety of men engage, at different times, at different points in their lives, in different spaces, with a range of drugs and with complex consequences. There is no set formula for chemsex – what behaviour men engage in and the reasons for their use of drugs in sex are specific to each individual" (ibid, 31). There is an association between substance use and risky sexual practices, and of particular importance in this setting, is the relationship between substance use and HIV transmission (ibid).

The MSM scene faces obstacles with poly-drug use, condom fatigue, HIV transmission, in that the elements complicate harm reduction work given by outreach workers. Moreover, because chemsex (experimental) practices tend to take place in hidden spaces, such as private clubs, parties, or homes with outreach workers not only facing the challenge of penetrating these scenes and delivering harm reduction resources, but actually lacking applicable harm reduction information.

Injecting Drug Use(rs) (IDU) internationally

Non-peer based harm reduction methods and initiatives, such as needle syringe programs, injection rooms, and peer involvement, have worked quite well in this setting in the context of the Netherlands. Internationally, however, harm reduction has not had the same positive response with this population (Harm Reduction International, 2014). The main substance in this setting was heroin (but methadone for medicinal use was also present) and users consistently face significant health problems and are frequently subjected to human rights infringements (ibid). Outreach workers do not face the same access issues as in the other two drug use settings; international IDU appear to be somewhat visible, often using in an open street scene. The obstacles that outreach workers face with this group of substance users has to do more with the cultural context of the target audience. Internationally, IDU encounter much more stigma, discrimination and human rights violations than their national counterparts (ibid). As with the MSM scene, HIV transmission is also prevalent amongst the IDU population, although traditionally transmission with MSM is more prevalent through sexual contact as opposed to intravenous drug use.

3. Theoretical Background

The theoretical frameworks used in this research come from the fields of sociology and public health, which provide a platform for better understanding how we learn and how we perceive substance use. Social comparison theory (Festinger, 1954) explains how individuals evaluate their own opinions and abilities by comparing themselves to others in order to reduce uncertainty in these domains, and learn how to define the self. This theory is relevant to this research because it focuses on learning behaviour and social influence that occurs amongst peer groups.

The pervasive disease model sees substance use as black and white: individuals can either be abstinent and controlled, use or addicted and uncontrolled use (Marlatt, 1996). This model denies the users' ability for self-regulation and has only one goal: the elimination of drug use. Harm reduction, in contrast, views drug use on a continuum. This self-regulation model suggests that in regards to their use, substances users can have a wide arrange of goals, not just necessarily abstinence. This autonomy of choice is the foundation of the stages of change model (Prochaska and DiClemente, 1997). This popular model acknowledges that individuals may go through a variety of stages, such as pre-contemplation, preparation, and action, when it comes to their health changing behaviour. This model is empowering in that shifts the notion that drug users are powerless to competent; it gives substances users the power to manage their own life and usage (Transnational Institute, Global Experiences with Harm Reduction for Stimulants and New Psychoactive Substances seminar, 2014). This approach gives weight and consideration to substance users' environments, settings, and social context, which is useful for the examination of the three drug use settings present in this research (ibid, 2014). In practical terms for public health agencies, this model provides the opportunity for more programs and options for their target audience and to also widen their target audience (ibid, 2014). A harm reduction approach strengthens this research in that it supports substance users' human rights and self-determination. According to Jürgens et al., "Protection of the human rights of people who use drugs is important not only because the rights of these people must be respected, protected and fulfilled, but also because it is an essential precondition to improve their health" (2010, 276). This idea was prevalent in the interviews and framed how participants viewed the importance of meaningful peer involvement.

4. Methodology

4.1 Study Design

To help address the aims of this research, national and international agencies were singled out based on both their link to one of the three drug use settings and their involvement of substance users. A research framework was created in order to give a schematic, structural representation of the research goals (see annex).

4.2 Sampling

Participants were recruited mainly through social networks and personal contacts. Interviews began with members of Mainline who specialized in the three drug use settings. Mainline's national and international network of peer affiliated organizations were then targeted. The importance of sharing resources and opening networks was reflected amongst participants in the interviews as well as a way to ensure successful peer involvement.

4.3 Interviews

Data collection took place from December 2014 to February 2015. There were 20 scheduled interviews, comprising of open-ended questions. Interviews took place over Skype or in person and were recorded and transcribed verbatim. The majority of agencies in this study were comprised of peers (former or current substance users) and non-peers (non-users).

Of the 20 interviews, 5 were with organizations that were targeted for their GHB outreach, (4 in the Netherlands, 1 in Belgium), 5 were with agencies that were targeted for their outreach geared towards men who have sex with men (2 in the Netherlands, 1 in Canada, 1 in South Africa and 1 in Greece), and 8 were with agencies that were targeted for their outreach geared towards injecting drug users (1 in the Netherlands, 2 in the UK, 1 in Kenya, 1 in Afghanistan, and 2 in Greece). Finally, there were 2 agencies, 1 in the Netherlands and 1 in Belgium, that were targeted for their peer involvement but were not focused specifically on one of the three drug use settings examined, but nonetheless made use of peers and were thus included in the analysis. In total, 14 agencies were represented, meaning that some agencies were represented twice by two members with different positions, and thus contributed different perspectives.

4.3.1 Participant information

Pseudonym	Agency	Drug use setting	Services Provided
Barney	Positive Voices, Greece	IDU	PLHIV* Advocacy
Baxter	Kenya Network of People Who Use Drugs (KENPUD), Kenya	IDU	Drug user advocacy
Bo	Belangenvereniging Druggebruikers MDHG, the Netherlands	unspecified	Drug user advocacy
Cass	KENPUD, Kenya	IDU	Drug user advocacy

Chuck	ANOVA HEALTH, South Africa	MSM	HIV advocacy
Dennis	Novadic-Kentron, the Netherlands	GHB	Treatment outreach
Frederik	Stichting Mainline, the Netherlands	MSM	Information outreach
June	Novadic-Kentron, the Netherlands	GHB	Treatment outreach
Kingston	CoAct, United Kingdom	IDU	Technical support services
Lilly	Positive Voices, Greece	IDU	PLHIV* advocacy
Meeko	International Network of People Who Use Drugs (INPUD), United Kingdom	IDU	Advocacy outreach
Opie	AIDS Committee of Toronto, Canada	MSM	HIV/STI Outreach
Oswald	Pink Unity, the Netherlands	MSM	Recreational use outreach
Piper	Unity, the Netherlands	GHB	Recreational use outreach
Rambo	Sustainable Afghan Family (SAF) Afghanistan	IDU	Needle outreach
Riley	Breakline, Belgium	unspecified	Recreational use outreach
Rose	The Free Clinic, Belgium	GHB	Healthcare for users
Roxie	Stichting Mainline, the Netherlands	GHB	Information outreach
Short Sheet	Checkpoint, Greece	MSM	HIV prevention center
Willie	Stichting Mainline, the Netherlands	IDU	Information outreach

*People Living with HIV

4.4 Ethical Considerations and Obstacles

The drugs considered here are illegal and it was recognized that some people could have reservations about discussing their engagement with illegal substances. In order to offset this concern, pseudonyms were used. However, there were several participants who were very open with their past or current drug use in their public life, and were therefore not concerned with having their identity's exposed.

It is also noteworthy that some participants were in recovery with their use and therefore there were some topics that required more sensitivity. Moreover, some participants were still using (either illegal drugs or legal methadone) and this provided

certain challenging situations where sometimes interview appointments were missed, or communication was difficult or unclear.

A clear definition of 'who is a peer' was challenging for participants to define. All participants were individuals with an open mind and respectful approach to people who use drugs, though not users themselves. This discrepancy of who is a peer was an interesting obstacle to encounter because it meant that agencies were not all working with the same definition, which would add to the difficulty of providing recommendations for best practices for peer involvement.

Part of the motivation for conducing this research was to understand how integrate meaningful peer involvement amongst Mainline's international projects that target MSM and IDU. Although Mainline is a Dutch agency, it has international partners and many of its publications are for an international audience, thus all the interviews were conducted in English.

4.5 Data Analysis

While using Skype for interviews allowed for connections with agencies from all over the world, and thus supported a broader sample, the fact that these interviews took place virtually was a drawback. A deeper understanding of participants' feelings and experiences with peer involvement was achieved when the interviews took place in person, and this had an impact on the way the data was analysed.

Data analysis was an ongoing process throughout my fieldwork. Thematic analysis (Braun & Clarke, 2006) informed my analysis of the interview transcripts. Data was coded and categorized based on sub themes related to peer involvement such as recruitment, motivation, community acceptance, and experiential knowledge. Codes were compared with one another until key themes, such as agenda, lessons, challenges and organizations surfaced, which will be analysed in the following three chapters.

5. Agendas

When two individuals, peers or not, approach a substance user with the intention of helping to improve their life, they may have very different motivations or very different ideas of what that help looks like. One may chose a route that resembles abstinence-based recovery, and one the other may chose a more authentic harm reduction approach that provides information on health education within the context of active drug use. A third may fall somewhere in the middle of this spectrum. These differences in agenda are something that both the outreach worker and the target audience must consider in order to be successful. Arguably, the more aligned the agendas of both the outreach worker and the target audience is, the more effective and impactful the outreach will be. Similarly, the agenda of the organization must also be aligned with both its members and its target audience. If both parties have overlapping agendas, it is more likely that a trusting, working relationship will be created and sustained than if they have conflicting agendas. One participant vocalized how important is it for peer workers to meet the needs of their clients.

> *I think it's very good to do the peer support from somebody who was in use…I think it's about the person who does the work, what kind of person is that, and yeah, that one person is not a lot of persons. So I think it's quite difficult to match it right, but when you have a right match it will work 100% I think, yeah, I really do think. (June, GHB)*

5.1 Participants' agendas

There were informants from all drug use settings in recovery and this personal history was a way for them to get involved and stay motivated with their work. Spreading harm reduction practices and reducing stigma to the drug using community were other factors that were mentioned as well.

5.1.1 Personal reasons

It was evident that some participants, particularly in the IDU setting, faced significant safety risks that accompanied their peer work. One individual doing outreach with injection users in Afghanistan revealed that by doing his work, "*… my life is in danger, I have a lot of attack, I have a lot of worry, but this is my life, this is my job, to continue my work for my community"* (Rambo, IDU). For him, helping his peers was more important than his personal safety, and evidently is dedicated to providing his peers with harm reduction tools. This sentiment was echoed with a participant from the Greek IDU community: *"So that's my ultimate goal but always being involved in the community, in things like that. Because that gives me a kind of meaning. I couldn't be something else, like, at all"* (Barney, IDU). These two statements clearly suggest that these individuals, above all else, find meaning in working with peers.

June, a former GHB user, was particularly self-motivated with her peer work with counselling and supporting current substance users. Her past experience allowed her to connect with those awaiting treatment in a meaningful and personable way. She faced challenging circumstances in her own recovery and wanted to use this personal experience as a way to help others. Additionally,

her peer work also allowed her to help herself by self-monitoring her own ongoing recovery process.

> *For me, this work is just motivation, because I know, and I know because I already experienced that when I stop and a while further, there comes a time when you're all going to forget what has happened and when you have a good time and your life is on track and you come to that point and, phew, there is it again and I don't know for sure what I will do then…For now, to work with people who help them, for me, is also a big motivation to not and now I want to help the people who are addicted and I want to help them for them but also for myself, to always stay focused on what has happened. I don't want to forget where I came from. And I came from far, yeah, very, very far. (June, GHB)*

5.1.2 Spreading of harm reduction

The desire to spread harm reduction practices to particular populations was another discernable reason participants gave as a driving factor for their involvement. Upon discovering that other Dutch public health agencies were not aware of the increasing crystal meth use with MSM, one participant decided that this growing population gravely required the attention of harm reduction measures.

> *…And that's my motivation now because all the other Dutch organizations, they don't talk about crystal meth. If I tell them I think the number of crystal meth users is growing in the gay scene, they say 'What the fuck, that's not true!' (Frederik, MSM)*

This suggests that organizations that do not use peers are less connected to what is actually happening in the drug use settings that they appear to target. However, since Frederik frequently interacted with the members of the MSM scene, he was privy to emerging (problematic) trends and was in a position to address and promote the appropriate harm reduction practices related to crystal meth use.

The following statement from Willie demonstrates a high level of commitment to promote harm reduction, specifically in countries and communities who are less exposed to this method. Perhaps because a harm reduction approach to IDU has been such a visible success in the Netherlands (where he is based), Willie used this knowledge as a way to fuel his ongoing (international) work:

> *The point is that we are there, our name is there, you know, if just the word harm reduction, if people know about it…that is the goal and it will grow, for sure. I have no doubt about that. (Willie, IDU)*

5.1.3 Reducing stigma

Informants spoke about their desire to reduce the stigma associated with substance use. Not surprisingly, this arose out of their personal experiences they encountered as former or current drug users. An example came from Baxter, when during his using period, he and his drug using community faced continual infringements based

on their identity as substance users and decided to create a network that would allow them to speak out against these abuses and speak up for their human rights.

> *I had been an active user and we came together and we were trying to discuss issues that we face daily and according to the group that we started with, which was around 20 members, we were looking on issues affecting our community, the users community, looking at how the issues and also we were looking on a violation of our rights, so we thought of how maybe we can come together and see if that can help because at that time there was a lot of stigma and discrimination in accessing health services. (Baxter, IDU)*

His approach to reducing stigma does not focus on blame but rather on solutions that allow all members of society, including MSM, drug users, and sex workers, access to any required health services. Baxter and his network strive to reduce stigma and although having been misunderstood by many along the way, this appeared to act as further motivation for their continued work.

5.2 What is a 'good' peer?
'What is a good peer?' was one of the questions that guided the research. Two participants noted that in order to be a credible peer, one had to be of the same sex as the target group. Others thought that appearing 'unprofessional' was essential. Many participants spoke about using their past experience and challenges with substance use to inform their current outreach practices, or to connect with their target audience. Another question that was addressed in the interviews was 'Can current substances users make good peers or should they no longer be using?' There were conflicting ideas about this question; some strongly believed that current users do not make good role models, while others felt that current users are more relatable. What made this contradiction even more complex is that this divide was visible based on the drug use setting. For example, peers in the GHB setting adamantly felt that peer workers should not be using GHB, while the IDU participants agreed that peer workers were well able to use drugs and still be effective outreach workers. What needs to be taken into consideration when exploring this question is what peer workers' motivation and agenda is and where they fall on the harm reduction spectrum (see section 5).

5.2.1 Personal characteristics and qualities
There were a few instances where participants were vocal about particular criteria peers needed to have in order successfully carry out their work. One of these factors mentioned by the MSM representatives was the sex of the peer worker.

> *They need to be a man, because of the peer aspect, they need to enjoy, or actually they need to understand gay life and gay partying but they don't need to be gay themselves. They need to understand the club scene and also the use of drugs. But if they've got experience themselves, I don't mind. (Oswald, MSM)*

For Oswald, peers do not necessarily need to be completely aligned with their target audience, only they must be familiar with certain aspects. This points to the role sexual identity plays in peer work in the MSM scene. It was suggested by participants in this scene that this is a very tight, closed off community and arguably a woman outreach worker, substance user or not, would face substantial barriers based on her sex alone. This idea was also visible with a participant who focused on harm reduction for sex workers who inject drugs in her community in Kenya. For her, this particular work of talking to sex workers about their reproductive health required a woman. Not surprisingly, this criteria did not arise in the participants representing GHB use, as this scene, unlike the MSM and IDU sex worker scenes, did not appear to tied to sexual identity or reproductive health.

The age of the peer worker came up in one interview. It was implied that peers closer in age to their target audience usually have more success in making a stronger bond because older agency members are used to doing outreach in a particular way and are less familiar with progressive ideas like peer involvement. For Opie, this age difference complicated working relationships because it created tension and division between the younger and older agency members.

> *People who have been here for over 20 years, people who are in their sixties or older…Or they are higher up in management and they've been here since the early 80s, they think that I'm a little too, I don't want to say 'new age' but my practices are a little modern sometimes… And they can't deny the results, so sometimes they see the results and that changes their opinions, you just have to just steadily keep chipping at the ice block before you get that lovely sculpture, right? And some people think it's kind of like an attack for them because, 'You're going against everything I know about' and so I have more difficulties and more challenges are presented with different agencies, or parents, or schools, or institutions, or older staff who are used to doing things in a certain way. (Opie, MSM)*

One participant brought up that having peers from the same ethnic group can lend itself to the effectiveness of a project. In the particular setting of countries with projects targeting IDU, this standard makes for better peers, more sustainable projects, and empowered communities.

> *I'm a great believer that Africans work with Africans and empower and enable other Africans rather than reliance on rich Western organizations coming in and being the, you know, dependency being created with that. You know, there does need to be a sustainable way of working within Africa that enables the African organizations themselves to accept and slowly take on board that people who use drugs are human beings. (Meeko, IDU)*

5.2.2 Past experiences enabling a dual-identity

This section on past experience as a necessary criteria for peer work is supported largely by the participants who are either former or current drugs users. As one participant said, the combination of one's former (or current) drug use and current activist work creates a 'dual identity', which allows for a 'whole new set of insights' (Kingston, IDU). He used this duel background to his benefit and was able to draw on his multiple experiences to further understand and serve the needs of his target audience:

> There's a dynamic that goes on between people who have lived tough lives and have challenges in their lives and offering people a respectful and supportive environment. (Kingston, IDU)

The experiential knowledge of current or past users smoothly translates into authentic and legitimate knowledge. June felt that the experience of going through treatment was priceless knowledge for helping current addicted substance users. She used her own recovery to guide her current peer work in that her past experiences allows her to anticipate what obstacles her clients may face in their own journey.

> And that was something that I missed, when I was in my use and in my old living place, I never, ever see someone who was quit with their use and I had nobody to look at, no role model, so there was nothing which gives me hope, the hope to do it and the courage to do it because I never, ever seen somebody who had done that. But that is the point, because, yes indeed the people who did quit with it, you never see them again because those are the people who are leaving. Yeah...and I really think that is something, there's no hope for because you don't see it. And when you are so much in your use, you only see the using people and you shut out all the people, your family and all the people who don't use because you think they don't understand you...(June, GHB)

June emphasised that peers with drug use history are 'experience experts' and how people doing work in this field without having the personal history of substance use simply lack something integral to effective outreach work.

> In fact, in real life it's a lot of different, when you have that experience, then, you know really what you are talking about. Yeah, and of course you can learn a lot from speaking with people who already used it, you can learn, but there are little things that you cannot know, you just cannot know. (June, GHB)

A participant knew the value of his experience as a former substance user and MSM scene member, and he also acknowledged that other non-peers in his field were able to appreciate it as well. In fact, publically sharing his identity and experiences paved the way for his current work:

I have an idea about what's going on outside, you know, it's far much better to be sober and working in an organization than being in the street. And I came openly and said I know this kind of things, that I am HIV positive, and I'm a former drug addict, so. I was actually one of a few people that so openly and doing writing and talking about it, so when they wanted to form a project about harm reduction platform, one of the members they thought of me, so I'm working now for the organization, it's a very good chance for me, because I get really educated… Because an experience in the field, like that, it's, you know, how can I say, irreplaceable. It's, I have been to meetings, I have been to, you know, educational seminars, I've been abroad to conventions, but you know, that's my experience it's over 20 years. I know first of all the mentality of an addict on the street very good. So it's kind of a piece of cake for me. (Barney, IDU)

It is also noteworthy that although he has experience in the 'professional realm', his past experiences as a drug user is what he values more.

One unmistakable issue in the interviews was that of peers that currently use versus peers that no longer use. Unfortunately, this problem seemed to have no clear solution; this following section reflects those arguments put forth by former substances users who believe that current drug users do not make good peers. Particularly in the GHB use setting, it was suggested that peers, in order to carry out effective peer work, could not use.

I think you really have to be over the addiction. If I look at myself, when there was someone who is using GHB and comes to me and tell me, 'June, you have to quit with it, it's not good what you are doing and yeah…' Heh? What are you talking me about, you are using also, so there is no…no! I know for my own using time, no, there was nobody who is still in use who are going to tell me what to do or what I don't have to do, for me, no, I really had something like 'No, you are not going to tell me what to do, look at yourself, no, no, no I can do better.' …And we have the same discussion in my project, there is the same discussion because they now want, before they didn't want people who are on methadone, because the other people who are saying 'No, how can someone who is still under the influence help another?' When we talk about it, I said 'When a person like him, go and talk to me, and that…okay, I want to quit or if I thought, I don't know for sure what I want to do, do I really, really want to quit or do I want to get it in control?' (June, GHB)

Evidently, June and her peers struggled with the idea of a peer who wants to help others but uses drugs at the same time. But they agree that an effective peer is someone who was once a user but is no longer using, for they have no place trying to help and work with other GHB users. This opinion stems from her own reality as someone who

got over her addiction and can reflect on what kind of peer support would and would not have worked her for during her recovery.

A member of the MSM scene also mirrored this notion of not using current users as peers: "*To be a volunteer? Oh, you know, to be, out of drugs of course, to be sober*" (Barney, IDU). He added that he and his peers were able to carry out their outreach in the IDU community because of the length of time of their sobriety: "*...But we're ex for years, not for months*" (Barney, IDU).

Finally, some of the agencies whose outreach targeted recreational drug users wanted peers with the experience of substance use, but not *too much* substance use. Having individuals with addiction issues were too much responsibility and too risky for some projects. However, what 'too much' looked like was unclear, and without clear guidelines, this selection criteria could seem arbitrary and prejudice.

5.3 Trust

It was evident that trust was an essential element for effective outreach and sustainable relationships with the target groups. Participants discussed how they went about gaining the trust of others, such as paying attention to continuity and availability of services and disclosing personal information. Creating an agency with an environment that nurtures trust was important in order to maintain connection with the target audience. Making contact with drug suppliers was one way that some agencies tried to improve their outreach, but unfortunately this method was not sustainable in this case due to the resulting risk of violence on the part of the peer.

5.3.1 Relationships with target audience

Creating a bond and mutual understanding was a priority for all participants. Gaining the trust of the target audience and "getting on the same level" (Frederik, MSM) was done in a number of ways, such as sharing with others personal history, status, challenges, or solutions. Opie shared his preferred methods for approaching and connecting with his target audience:

> *I try to come at it from a peer perspective rather than like a parent, or teacher, or an authority figure because that makes more of a connection and it lets down barriers for them. So that way we are more able to have a friendly discussion and they are more willing to absorb and be receptive to the information that I'm going to pass along, right? Nobody wants to be talked down to, or talked at, so I find that works very successfully for me. In addition...I will share my story because I'm openly HIV positive and from the gay community, so I've been though a lot of these things...I don't shy away from my past and that lets them know that they don't need to feel inferior or vulnerable with me. And I think that is an important tool to have because, when I'm working with community, no matter the age bracket, but particularly younger, you want them to feel secure about the decisions they're making...We can deal with heavier things such as sexual practices, if they go to bathhouses, if they are injection users, if they do any sort of substances or drugs...(Opie, MSM)*

In order to put this method into practice, Opie favoured qualitative interactions over quantitative ones. This allowed him to have meaningful conversations with substance users and gave him the opportunity to bring down any barriers. This approach is multi-beneficial, in that it not only helps to gain the trust of drug users but also helps to reduce the stigma associated with substance use.

One participant had a very simple, but perhaps overlooked, answer on how to gain the trust of peers in the injecting sites: "*Ask them what they need! Rather than people going in and telling them what they need, just ask them…*" (Meeko, IDU). However, in order to carry out this fundamental idea, a trusting relationship between the outreach worker and the drug user must first be established. Meeko illustrated how he and his colleagues at INPUD accomplished this when making contact with drug users in the using sites (referred to as 'maskanis' in some countries).

> *Well the first thing you do is you wait to be invited. So the first thing is, we met with one of the NGOs…and from that they gave us a couple of hours, just with the peers, no workers, no professionals, just with the peers that they are working with. And once we spend a couple of hours with them, talking about the work we were doing and why we were there, we very quickly got invited the next day…they said 'come back, we'll look after you, make sure you are safe.' So we put our faith completely in our peers hands, we put our lives completely in our peers hands and to date, that's been fine…(Meeko, IDU)*

Simply not identifying as professional allowed for some of my participants to gain the trust of their peers, as explained by June. She was attentive to the idea that substance users are more likely to open up to people with similar backgrounds to theirs. While she acknowledged that professionals, in this case, workers at the addiction treatment center, may not necessarily be removed from the equation, she could still help ease the stress of having to interact with a professional.

> *Because the people are give me more information than they give to a professional because you have a click…You have very, very fast a good connection with the people so when they are talking with me, they, yeah, for them it's because of the knowledge that I was a user to, so they think 'Oh, she understands me, she really understands me' and they talk more to me than they do to a professional… they think it's difficult for them to go to the intake and yeah, tell everything, I sometimes I ask 'Do you want me to go with you to the intake so we can do it together?' (June, GHB)*

Frederik found the same when interacting with his MSM target audience: "*That you always tell them 'You have the experience you know much more about the drug and the drug use and all the risks more than I do'…*" (Frederik, MSM). This further supports the overarching idea that the experiential knowledge of substances users is invaluable.

Chuck also spoke of being 'unprofessional' as not only key to ones' approach but in regards to the outreach location as well. Generally, peers make connections and pass along harm reduction in casual environments where individuals are using and their approach should reflect this.

> *But more than just in a professional capacity because ambassadors go into places that aren't necessarily that professional so they need to be able to be fluid I would say in how they interact with other people so we have people that can go to other businesses and talk to professionals and stuff but we actually are looking for, and I use this term very loosely, but real people, so not doctors and nurses and professors and stuff like that but people that come from the community that we are talking to...(Chuck, MSM)*

The data also suggested that attention must be paid to the contextual challenges with appropriate peer involvement. In an international setting, harm reduction towards IDU has largely been unsuccessful at minimizing the risks due to different challenges, such as education of safer injection practices. Therefore, finding an appropriate peer in the international IDU setting, one should pay attention to level of education and knowledge in order to gain the trust of the target audience. By contrast, what Dennis considers when looking for a trustworthy peer to do outreach in the Netherlands is finding someone who with 'street credibility' and not associated with the law.

> *But we still think that peer work is so important but we think that the profile of peers should maybe bit a different. It's more like, uh, like in the Netherlands, we don't need, sometimes, there are countries where you need peers because otherwise they won't use clean needles because they don't trust anyone. Here, they, it's not that situation, so it's most of all if they think, 'Oh that's the guy I trust because he's not police' and you can get contact through them and you can also use other peers that just have high street credibility and don't have the addiction problems. (Dennis, GHB)*

5.3.2 Socio-physical and cultural environment

If participants themselves were not from the drug using community, they found that having a peer present during outreach was enough to establish a relationship. Peers were welcomed and trusted on the basis of not being a typical authority figure.

> *You have people who use drugs with a lot of problems and sometimes they are a bit, um, hard to reach, because they don't trust the regular organizations. So we have peers that go with us on the street because they can make more easy contact with them, they have a sort of status between those groups. So you can, it's more easy to reach those groups...because then if you come with people who are having a big high status, like street credibility, then they think, 'Oh, he's not from the police, we can trust him because he's with him, so.' (Dennis, GHB)*

The physical environment of the agency was also considered as a way to make drugs users feel more comfortable. These environments were specifically modelled to not represent classical public health spaces, such as hospitals, as participants wanted to distance themselves from these typically oppressive spaces. Some items necessary for this to be accomplished were: friendly and non-judgemental staff, up-to-date information, and cultural awareness.

> *We have a very friendly environment, it's not like a clinical setting, it's not like a hospital, we can see that it really calms them down...we are something different from the local scene, at the hospital and stuff. If someone wants to go and get tested, we have really bad comments, you know, as far as the way they treat to anybody. And this is something that we try to deal with and actually de-stigmatize HIV because apart from testing, we do want to offer counselling as far as HIV stigmatization is concerned. Because we have to deal with the social stigma as well. What we wanted to do was, like, well known to the MSM community first, to get their trust. (Short Sheet, MSM)*

Meeko touched on the sensitivity that he and his colleagues must display when embarking on projects for IDU in African countries. He spoke to the difficulties that arise in a different physical environment and what factors need to be considered to make peer involvement meaningful and sustainable. There is a significant part of his work that is highly emotional but he remains focused on his agency's task to promote health care in ways that will sustain, enable, and empower these marginalized populations.

We can't just parachute two workers in and you know, drop a bag and after two weeks expect a change, it doesn't work like that. We need sustainability and also enabling and empowering... (Meeko, IDU)

Lilly found that, with a few specific actions, she was able to build trusting relationships with her target audience. For one, the continued, regular presence of their outreach helped in that after a while, the target audience began to expect and rely on these meetings. She also had the ability to cater to the needs of her target audience. For example, when interacting with sex workers, she provided them with related harm reduction products like condoms. When doing outreach with prisoners, she seemed to provide them with consistent, much needed human interaction. By focusing on the needs of the target audience, and maintaining a constant presence in their lives, her agency is able to foster trusting relationships in a challenging environment. Finally, she touched on her agency's interaction with drug suppliers, which brings up a new relationship to in which to understand how trust gets created in these drug user networks.

Chuck echoed a similar sentiment of how practicing continuity with a service can help to create and maintain a trusting relationship with their target audience. This aspect even made their work easier by bringing their targeted MSM population to them rather than having to seek them out.

I would say it was mainly through continuity. That was the most important, once we were established and understood who we were and they recognized our brand, you know, they got used to us being there, it became a lot easier because then they started looking for us as opposed to we going out to look for them. When they started to know where we were, they started to recognize who we were, they would come to our offices, they would come to our clinic and they would ask us, instead of us having to go out into the communities and always trying to find these guys and girls. (Chuck, MSM)

As mentioned in Chapter 2, drug suppliers have regular contact with the target audience and arguably some type of relationship is formed between the seller and the buyer. One current user revealed how his personal relationship with drug suppliers is mutually beneficial.

One of the things when you're a senior drug user activist, one of my experiences was that, and is, is that I get treated like I'm a high level drug dealer within drug scenes. Because I don't sell drugs because I think it's too risky, but I have relationships with drug suppliers where I've helped them go to court and get off charges, you know, they trust me and know me as a drug user. I get people referred to me through drug suppliers that need help, legal help, whatever. And so for me, drug suppliers are a key part of the system we work in. (Kingston, IDU)

Kingston understands that drug suppliers can play a useful role in the development and continuation of peer work and has created a network from these individuals. Chuck mirrored this idea with his own experience with drug suppliers in South Africa. He revealed that by making connections with drug suppliers, he was able to strengthen the agency's credibility and spread their harm reduction tools further.

...we were trying to build relationships because we were trying to access users in their environment so we did meet with two dealers who were very interested in actually taking out drug packs, our injecting drug packs and handing them out. But unfortunately we never got to the point where out management felt safe enough to actually do that... We actually procured some [non-injecting resource] paraphernalia from these guys ourselves because we were actually interested in putting them into our packs. Particularly when it came to engagement with not only the users but the people that provided the substances as well, I think we were very successful but the only thing that stopped us was unfortunately the incidents of violence [by the suppliers] against one of our outreach workers. (Chuck, MSM)

Kingston had an interesting experience working with drug suppliers, particularly suppliers that are not users themselves. He, along with other IDU participants, found that

non-using suppliers were disrespectful to their clients. Apparently, not having the personal experience of substance use played a role in the way these individuals judged and treated their clients. These anecdotes shed light on, if so desired, the type of drug suppliers that should be targeted as joining a peer network. And further, it supports the idea that peers with the shared personal history of substance use are the most effective, compassionate group of people to work with substance users.

6. Guidelines, Challenges, and Lessons

Uncovering the lessons that the participants learned and continue to learn with peer involvement was a major component of this research. Understanding both individual and group challenges and solutions gave more insight to the research question of how to best get peers involved in outreach in a meaningful way. Complications of using peers included risk of relapse, challenges related to recruitment and individual and organization functionality. Additional obstacles the informants discussed were challenges relating to acceptance within their community, internal and external issues, and contextual and situational issues.

6.1 Guidelines with involving peers

Organizations that did outreach at parties and festivals, mostly GHB and MSM related, had rules in place for their outreach workers. This was both to ensure the safety of their volunteers and to ensure they were able to pass on harm reduction information to attendees. There were those agencies that were more informal and laid-back with their rules: *"First I don't believe in saying they can't use anything because they are peers"* (Riley, unspecified). It is understood that their peer workers are substance users and thus setting up or enforcing rules on their use is slightly precarious. This mentality was visible with Kingston and his colleagues whose main concern was that their peer workers are functional, suggesting a high level of independence and responsibility placed on the substance users.

> *We don't care whether you use drugs or not, but you have to deliver, we expect our people to turn up to meetings and be functional…But high performance is absolutely expected. (Kingston, IDU)*

Others took the position that substance use would not be tolerated, as it would impact the effectiveness of the outreach. This arises from the belief that one cannot be under the influence and properly educate others. This same belief is the reason why some agencies do outreach at these events only until a certain time: *"…you can stay there and have a conversation, but they will not remember it. We don't really believe in these kinds of educational conversations, if they are like, off their heads, and at after parties, it's a safe bet most of them are"* (Piper, GHB). Further, if peers are representing an agency while simultaneously using or distributing drugs, the project can become compromised, if they are dependent on outside funding.

Participants from all three settings emphasized that maintaining transparent, honest, and consistent communication with the target audience, colleagues, and partners were all necessary for successful peer projects. By being more open with one another, they were able to learn more from their mistakes and move forward with a unified, rather than a conflicting approach.

> *So for me, I think it's not about getting overwhelmed by drug use but I think one of the challenges of drug use is the secrecy and not be able to talk and not be able to have a dialogue. And I think it's about saying, you know 'How do you deal with things going wrong? And how do you support people so they don't go wrong? And if things do go wrong, how*

do you actually respond?' But don't damn the whole area of drug user
organizing and meaningful participation because things go wrong.
(Kingston, IDU)

A participant who was involved in an agency that addressed MSM issues brought up the importance of having structures in place, like referrals or on-call peers, to better support their clients in need, such as receiving a positive HIV results.

This is something which has been proven, that such sites needed to
manned with positive people because it makes it easier when we have a
positive result and our beneficiary, our client, is really freaked out, it
has been proven that it's much easier for the client to accept of calm
down if he has a peer there to talk to him. (Short Sheet, MSM)

6.2 Integrating with other agencies

The benefits of having other agencies and services to rely on, to network and collaborate with, to gain more visibility and to learn from, were present in all the interviews. For example, Amsterdam based Unity and Pink Unity are linked with the Public Health Service, and are thus situated amongst their services, such as their STI clinic. This placement allows them to share resources and gain exposure for their project. There was emphasis on the benefits of working together to promote a similar cause of improving the lives of substance users. One current IDU user spoke openly about how linking up and collaborating with other agencies made him and his colleagues more visible on the international global health stage. More importantly perhaps, is that this connection empowers this typically silenced and marginalized group of people.

...it's also fascinating at one level that we as a group of drug users, as
open drug users, working with a local partner that are also drug users,
are talking to the Afghan government and they are taking us seriously.
And that's partly because we have fairly strong UN backing, and
people like us, and we have a history. (Kingston, IDU)

Lilly vocalized how beneficial these partnerships can be and that the more frequently peer networks link up and work towards the common goal of promoting harm reduction, the more they can accomplish.

...we're all working for harm reduction policies, which is really good
because before there wasn't something like that, kind of like a united
front working for harm reduction and in general, most of the projects,
well not most of the projects, like a good amount of projects we do, we
kind of try to collaborate with other organizations or if we send a letter
to the Ministry of Health, we kind of cosign with other organizations,
that way it comes along, you know, stronger. (Lilly, IDU)

As an agency in a less developed country, KENPUD relies heavily on external networks for financial and project support. One member conveyed how such partnerships

have not only impacted their work on a micro level, but that they as an agency have grown as a result of such arrangements.

> *We are also happy, we feel that the work that we've been doing, it's also appreciated by the community, and also by the parents out there, also now with the international partners and friends, we are really happy on this and we are still learning a lot from the international friends because they are more advanced on this issues. (Baxter, IDU)*

It can be useful in the beginning phases of a project to ensure independence because it allows for the target community, rather than an overseeing governmental body, to be heard. Those individuals doing outreach abroad with IDU communities faced an obstacle with independence, because these projects were the ones that were most connected to other networks and organizations. However, Meeko pointed out that once the support and networks were established, it is essential to allow these IDU projects to function autonomously within their own communities. The idea here, according to Meeko, is that once a project can independently make clear their objectives and mission, the rest of the work, such as capacity building, peer to peer and harm reduction training will all come more easily.

6.3 Challenges with using peers

Participants also experienced a variety of challenges linked to peer involvement. The practical, day to day issues of incorporating drug users in an organization were brought up. In general, it was conveyed that integrating peers into an agency could lead to a disruptive work environment. Participants, for example, spoke of peers coming in late or not showing up to work, being forgetful, requiring more effort or supervision, or just being generally 'really difficult' to deal with. Concentration issues were also a problem, as one participant in the IDU setting reported that while training his peer trainers, *"[one] need[s] to realize that they are probably high"* (Willie, IDU). When this was the case, he found repetition to be the most useful tool to help the peers remember what they were told and shown.

The risk of having peers relapse was brought up mainly with the participants that were connected to GHB use. It was believed by many to be unethical to put former users back in the using environment to conduct outreach. This reflects the earlier discussion in section 5.2.2, such as the recruitment and training of current users, or dealing with their chaotic lifestyle. Furthermore, issues that the peer workers themselves go through, such as working in a group, or representing an agency '24/7' were discussed.

6.3.1 Risk of relapse

GHB participants were the most concerned about the risks former users take on with their peer work. One interviewee worked at a treatment centre and believed that peer work can only be ethical and successful when the individual is over their addiction. However, the point was made that even this situation is problematic because sometimes the outreach work requires the peer to return to settings and networks that are familiar and perhaps triggering to them.

That's a bit like, if you take an ex-user from GHB, the problem is then if we go to a GHB user...it reminds them of their old period. And then they are afraid to start using themselves again...And we were thinking also if we need a peer from the GHB group but the problem we have is if they are a peer and they stay in the network and the network is also responsible, they keep using, and they all want to get, they have like a hate love relationship with their network. They say 'I can't stop because I'm in the network' so it's a bit hard, they say, if you have like someone out of the network, they say 'The reason I'm not using anymore is because I'm out of the network' and the peer, if you bring them back to the network again, so that's uh, that's part of the problem. I think 10 of them have now, are all clean and all those 10 live in a different area now. Totally different area. Everybody who stayed in their area became addicted again. So, to bring them back if they are clean, to bring them back to here to the old community, as a peer supporter, that's very risky. It's not very clever. (Dennis, GHB)

Dennis' experience highlights the delicate and complicated nature of peer involvement within the GHB use setting. He acknowledged that peers have something very valuable to offer, but that involving them usually requires them to revisit their old using environments and familiar contacts, which jeopardizes their safety and personal recovery. This idea of a peer going back in a risky environment was echoed by June, as she had to completely change her living environment in order to stop with her use. For her, staying in the same living environment is the most risky aspect while in recovery, because it is here where most former users fall back into their use. She herself found it "*quite difficult to put on that shield and step away and hold all the people back*" (June, GHB). That is why she is so adamant about getting her clients out of their (problematic) living situations. One way she went about this was by making her clients be honest about whether the people they use and live with have their best interest at heart.

While explicitly predominant in the GHB use setting, a similar opinion was also present in the other drug use settings. For example, the following quote comes from a representative from the IDU use settings and clearly demonstrates how problematic they see peer involvement when it involves a current or former user. There is a hint of responsibility and protection on the part of the agency, but also perhaps a lack of confidence in the ability of the former users to stay abstinent in the face of temptation.

I mean we go with a group of people, but it's not like former drug users with us because that would kind of put them in a vulnerable place to take a former drug user to go street work when we go and see current drug users, because it's kind of a weird dynamic, you know you can put them in a vulnerable state of mind where they can't really support that, to see that kind of environment. I mean it's their choice but we don't want to put them in that type of position. So, yeah, we don't really push them towards something like that. (Lilly, IDU)

6.3.2 Recruiting and targeting peers

All three drug use settings provided obstacles in terms of recruitment and training for participants. Typically, MSM chemsex practices occur at after parties and participants struggled with how to gain access to these private spaces. GHB users, according to a participants, *"were enthusiastic...but, yeah, no capacity to do something with what we ask"* (Roxie, GHB) indicating that their current use inhibited their functioning. Furthermore, it was pointed out that non-problematic GHB users may perceive drug use as a taboo and don't want to identify as a drug user and are thus also challenging to access.

> *The difficulty with GHB users and ketamine users is that they have a quite normal life. They just use drugs in the weekends or sometimes and they don't want to put 'drug user' in their identity. And the people that we work with at the Free Clinic, at the needle exchange, drug users is an identity for them because they don't have nothing to lose. And I think young drug users who are integrated, who are studying or working, those don't want to be known as drug users. So I think it's more difficult to work with them as a peer group than with the old school drug users. (Rose, GHB)*

Targeting IDU also proved to have its own challenges. These included mainly logistical issues: when and where to make contact with this sporadic, nomadic, and unpredictable population.

> *Firstly, it was very much a difficulty in trying to ascertain 'when' so to try to work out a timeline, because when you are dealing with injecting drug users, unfortunately, they don't work by any particular schedule. So it was very difficult to ascertain when they would be at a certain place or when they wouldn't, because when you do, you eventually see them you trust them and ask them to meet you somewhere and then unfortunately because most of them were homeless, and doing all kinds of things throughout their day, it was very seldom that they were able to stick to a particular timeline. So that was probably the most important issue, number one, was actually trying to figure out when these peoples were available and how to get to them. So it was very difficult to try to access these people on their timeline and in the place where they felt comfortable, so that was definitely one of the main, of a couple of the main issues that we encountered when we started out. (Chuck, IDU)*

6.3.3 Issues with outreach

One individual brought up him and his colleagues are sometimes exposed to high quality drugs during their work. He was able to see both the positive and the negative side to this situation. His statement also touched on the fact that the particular substance used by a peer will impact their work in different ways. This could be useful or detrimental: uppers allow for longer productivity, as indicated below, while downers or methadone may obstruct functionality.

I mean, you're going into countries sometimes where there's really high quality drugs are available. And you have to make decisions about that. How do you manage that? How do you use drugs in high risk situations? How do you use drugs in a way that it doesn't impact on your work?...What impact does that have not only while I'm there but also when I come back, am I going through withdraw, I might be tired, um...but then there are other times that drugs help us stretch our capacity, you know what I mean? Allow us to work til 3 o'clock in the morning. So, it's a complex mixture. (Kingston, IDU)

An interesting issue was brought up by June who felt that going back to her GHB network could result in negativity and 'jealously' on behalf of the current users. As someone in recovery, she was aware that by re-entering this drug use setting she could encounter the 'Why can she do that and why can't I?' mentality of current users. She mentioned another instance where she felt that her personal history, including her addiction and her recovery, negatively impacted her peer work. She felt that the current users she worked with thought that she 'knew too much':

I was talking on phone to her and she was saying 'Yeah, I want to make an appointment with you and I really want to talk to you....' but on the other side, I experienced that she thinks it's really difficult because she was not...I think she not really, really, really wanted to stop with it and because I have all the knowledge of the GHB and she was like 'Oh, no...' I came too close to her because I see everything. (June, GHB)

June also disclosed that in the beginning she found working with peers to be hard because "*it's difficult to be confronted with people who are under influence, when they are stoned or high and you are talking to them…*" (June, GHB) indicating that she felt unable to carry out her work and demonstrate what she was capable of. One might assume that someone in their recovery, such as June, may find this particular situation to be difficult because they are being confronted with their use in a very visible and provocative way, but this reason was notably not present in her response. No other interviewee brought up this scenario and thus could be indicative of the different agendas of the peer worker (recovery versus reduction) based on drug use setting.

For the participants from agencies that did outreach in public spaces like festivals and parties, they were forced to make rules in terms of the peers' alcohol and drug consumption (see section 6.1). The goal is to have outreach workers in a state of consciousness that allows for accurate transfer of harm reduction information, but as some discovered, this was difficult to enforce.

No, the times we had tensions was a period where there was really a problem with the use on events. We've never been rigid or tough on being under the influence, of course, because we are working with the peers, but we've had times where they just arrived completely wasted and that way you can't do much outreach. (Barney, IDU)

The participants who worked with peer volunteers spoke about outreach being a 'grey area' whereby this setting, people, and substance use is familiar to them but that they are there to accomplish a task, not to use. Two representatives from Unity explained what their peer volunteers go through as being both participants and volunteers in the same scene.

> *They all have to realize that as soon as they have become a volunteer for Unity, they are a Unity volunteer 24 hours a day, so they all notice, you know, in their own groups of friends, or at after parties, people know if they are a Unity volunteer. So first of all, they are a drug information point, second of all, if they would like, overdose on GHB, or something would happen, then this would also be related to our project so this is also challenging of course, working with drug users, is, I mean, I don't know what they are doing all the time... (Piper, GHB)*

> *Well actually, that's what I say, so 'Be aware of your position'…So that is actually their responsibility and I point it out, like, 'Yeah, you know, one moment you're wearing the GGD shirt, the Pink Unity shirt, the next moment you are wearing nothing'…. (Oswald, MSM)*

Oswald's account of his peers doing outreach in environments that they are also a member of is particularly problematic for the MSM scene. Some of these male outreach volunteers, "*…go to these parties really to party, to lose their minds. So for them, it's very different for them to go there and stay sober and give education.*" (Oswald, MSM).

As demonstrated through the interviews, there are both benefits and challenges that organizations face with peer involvement. What is important to take away is that all organizations, peer led or not, face obstacles related to organization or function. One participant reflected this idea by indicating that we should remain forgiving and flexible when working with peers.

> *I think there are lots of challenges to involve people who use drugs but then the benefits of engaging people are significant. I think part of it is giving people the admission to understand that it won't be perfect. (Kingston, IDU)*

6.4 Challenges with the community

The nature of outreach is that individuals are in contact with the public, many of who are not familiar with or supportive of progressive ideas like peer involvement. Thus, as a result of this, several interviewees experienced discrimination based on their history of use from the police, the non-using community, and drug suppliers. There was absolutely no shortage of scenarios where participants were judged, harassed, stigmatized, or persecuted based solely on their drug use. Interviewees accounted personal stories of being mistreated by their communities and the police, regardless of the drug use setting and location. An overarching theme was that the non-using community is not "*ready to embrace that there are drug users in their communities' and 'wanted*

nothing to do with [them]" (Baxter, IDU). These instances of deep-rooted discrimination seem to suggest that the non-using community holds a very close-minded, inflexible opinion of drug users and what they are capable of.

> *Actually there is a lot of stigma… there is a lot of discrimination*
> *and even though you were using before, people hold on to that, you are*
> *a user, so. They really don't see the change in you, you are still a user*
> *to them. Yeah, so in that way, so the community just sees that 'once a*
> *user, always a user.' It's very hard to let them see the other side of you.*
> *So, but with the work that we are doing now, I know that the stigma will*
> *decrease, the discrimination will decrease and at least they will start*
> *respecting drug users as human beings. (Cass, IDU)*

6.5 Situational factors and cultural context

Deciding the types of parties and festivals to attend for outreach work was an issue for some of the agencies that targeted recreational drug users, such as GHB use. For example, one participants indicated that within their peer group, there are those who think that they should do outreach at larger, mainstream festivals where their organization is more visible and gains more exposure, while there are those who think they should focus on smaller, obscure underground parties that may be missed by other harm reduction agencies. This decision also seemed to be influenced by the function of risk: which environment would provide peers with the opportunity to do the most harm reduction?

A significant part of the agencies involved did outreach outside of the Netherlands, where different languages, cultures, and norms were observed. Participants that had peer projects with IDU in developing countries had to be in tune to the drastically different cultures they were working in and with. Political influence, geographical location, and cultural context all led to obstacles with implementing harm reduction practices. Harm reduction practices in certain locations are relatively new and thus certain ideas, such as involving drug users, can be quite challenging for some to accept. Below, participants demonstrated both their acknowledgement and encounters of these cultural differences. Meeko pointed to the idea that just because two populations both use drugs, does not mean that they necessarily have anything in common.

> *The daily life of a drug user in East Africa isn't something that a drug*
> *user from the rich West can relate to. It is so different, so completely*
> *different, and it's something, we often think that because we all use*
> *drugs, we have a lot of things in common. Which is absolutely true, but*
> *when you consider the social, the economic, the cultural aspects of*
> *what surrounds people that use drugs in East Africa is very, very,*
> *different. (Meeko, IDU)*

> *When I came there, I really felt like they were willing to learn, but it's*
> *also, you have to prove that you have knowledge, knowledge that they*
> *can actually use there. They wanna know, what have you seen, what*
> *have you done, what is your experience. ..and there's a lot of things*

that I don't know, I don't know about mob justice, I don't know about
riots, I don't know about being molested…(Willie, IDU)

Willie's statement also highlights how important first hand knowledge can help to build a trusting relationship between local drug users and outsider peer harm reduction workers.

Issues related specifically woman drug users were mentioned only in the IDU scene. It appears that women are generally underrepresented in the using sites, as many of these women are also sex workers and thus face even more discrimination. This requires more effort for peer workers to make contact with and gain the trust of these women.

Because the women are more marginalized than men, and for them to
get the services that they need, you really need to go deep into the
maskanis to get them. And it's hard for them to talk about it, to come
clean about it, so they need to talk to someone that they can really trust.
And they have issues from health services to law enforcement, you
know...yeah, from every direction, yeah. There are many incidences of
rape and they don't know where to run to if they are raped, they go to
the police, the police don't do anything just because they are drug
users. (Cass, IDU)

…the female injecting drug users are more vulnerable and we've been
trying to reach them and also we have a lot on issues with females
because they are always in hiding and most of them you find are sex
workers at night and it's becoming, we are really trying to get to them,
like we have also members from females who are in our network and
we also are trying to raise issues on reproductive health, to see how we
are going to get this information right to them. (Baxter, IDU)

These two IDU peer workers shed light on the layered, complicated lives of these female injection drug users. Practically, it would suggest that doing peer involvement for this particularly vulnerable community would require an outreach worker to be closely aligned to these female injecting users perhaps by experience of sex; someone who can better relate to and understand their personal struggles.

6.6 Challenges with funding

Funding was an issue for all agencies. This was particularly an issue for the private sector agencies. While this model allowed peers to focus on issues they themselves deemed important and not to be controlled by outside forces, it also meant that they were up against other agencies with more funding and resources. Additionally, agencies established abroad typically felt under supported in terms of resources. Here, a CoAct member articulated both the drawback and the upside to having an organization in the private sector. While the lack of funding limited their work, ultimately, he and his colleagues gained autonomy.

I think one of the challenges for a private sector company is operating
in a world where big NGOs dominate, they can get big money which
means they are all sitting there with money ready to do work, whereas
we have to go in and build relationships, find funding, you know. It's a
much more protracted process. However, what I like about it is it
means we actually sit with the partners and say, 'Look, what do you
want to do?' so we're not driven by what donors are saying, or what
they want. So we're not saying 'We've got funding to this program, this
is what we're looking to do, will you partner with us' We're saying
'Hey, guys, what do you want to do?' (Kingston, IDU)

6.7 Challenges with other NGOs and agencies

While it was generally agreed that partnerships and alliances were useful in several aspects of peer involvement, such as making connections, training, sharing resources, they also posed some obstacles for the agencies represented in this study. For one, they needed to pay attention to the interests and agendas of other organizations, and many times this was in conflict with those of the agency. Pressure from larger organizations created tension and obstacles for some agencies, in that they were influenced by these more established organizations and were thus unable to have complete autonomy over their work. Competition and conflict between similar harm reduction based agencies were also themes that were brought up. Some agencies were also met with resistance from other NGOs, particularly when going into foreign countries and drug using communities.

Practical issues like access and language barriers were mentioned, but a main challenge seemed to come from a misunderstanding or a lack of communication between agencies. The competition for clients, funding, and resources seemed to be the root of these tensions. Some spoke of doing outreach as a 'numbers game' whereby agencies become afraid that, *"you are going to steal their clients, or that you'll turn their clients against them or make their clients not dependent on their group"* (Opie, MSM).

Baxter mirrored Opie's experiences, but for him, tensions arose because the other NGOs were not familiar with peer involvement and thus they encountered a lack of understanding.

...with the other implementing partners also there has been a challenge
because KENPUD, a lot of people thought that maybe it is going to take
over on what they are doing because you find that these NGOs are
people who have never gone though that journey, they don't know what
issues, what happens on the ground, and what are the real issues faced
by drug users...(Baxter, IDU)

Again, this tension between agencies was felt by Meeko, who described that the 'local' non-peer NGOs were threatened by the access he and his colleagues had with the target audience. Their depth of reach, of course, was achieved by their strong peer network and presence in the maskanis.

...usually some of the in-country NGOs get very threatened because the work, we're setting up and NGO, that we'll work from the heart of the using community to which they can't get access. I mean by...us being able to get into the darkest, dangerous using areas that there is and being able to build trust. And so I think, yeah, I think then the NGOs get worried because they think we are either taking their trade or, targeting with all audiences is not one hundred percent spot on...I just think this is one of the things that make people feel threatened, is our ability to penetrate deeply into using environments where even some of the Kenyan outreach workers, they won't go. (Meeko, IDU)

Even thought this relationship caused problems with the local community, it is noted that this close connection with the using communities is based on the fact that the outreach workers are peers and have something in common with their target audience.

Although interviews sometimes had heavy and bleak tones, participants were incredibly positive towards the work they do. Furthermore, participants admitted that former and current drug users can be extremely chaotic to work with, but inevitably their contribution is invaluable to effective harm reduction practices.

Does the added complexity of involving drug users lead to sufficient added benefit to make it worthwhile? And my argument is every day of the week. Yeah, of course it does. I mean...peer based outreach workers are a hundred times more cost effective than traditional outreach workers. So why do you choose to use an intervention that is one hundred times less effective because it feels somehow simpler and less complex and less messy than employing drug users? That's crazy... peers gives you a whole different range of expertise...There are particular issues that come with being a drug user, but then there are particularly hugely exceptional benefits that come with being a drug user, you get network penetration, you get cultural insight, you get credibility, I mean people used to describe Healthy Options Team as being like a family, they talked about it being an agency that they trusted... people came back and told me problems that were going on in the community, they would trust us with inside intelligence. It just took us to a different level with people. (Kingston, IDU)

This final comment presents a very honest portrayal of one participant's experiences as a drug user and involving other drug users. The nature of drug user organizing is complicated and messy, but by no means does that suggest it should not be give the opportunity to succeed. To these participants, and as was echoed by others, these benefits far outweigh the complications of involving drug users.

7. Organization of agency and peers

Now that peer organizations have been explored in terms of what they can offer their target audience, what challenges they face, and what lessons they have learned, we now zoom in on the organization and structure of these agencies. By examining these agencies' recruitment, payment and training practices, we get a better understanding of the best practices of peer involvement for the three drug use settings and what practices Mainline and Mainline's target audiences would benefit from.

7.1 Recruitment from drug using sites

It was very common for IDU agencies to recruit from the using sites, or maskanis, in which they conducted their outreach work. These agencies made use of the pre-existing networks of users and volunteers to strengthen their outreach. Most often, a drug use site was identified and peers were recruited based on certain criteria. This proactive rather than passive approach appeared to be an effective way to make contact with peers as it showed initiative and determination on the part of the recruiters.

> *Instead of having a drop in and expect people who use drugs to come to us, what we will do is speak to drug user and find out where the maskani, where the main community are of drug users and we will go there. And that's our first port of call, is building the relationship of trust amongst the communities. (Meeko, IDU)*

One participants highlighted that, in his experience, non-peer agencies do not have close ties with the using community, which can lead to their ineffectiveness. Actually being a substance user allowed for significantly greater access to the drug using community and in fact, other non-peer run NGOs made use of his agency's pre-established relationships.

> *...with the NGOs, it is impossible to access the maskani because, because those communities, we are from those maskanis but it is not easy for them to go direct to the maskani to try to see if they can recruit...we've been working together and also identifying the right person in the maskani who can be able to go through the trainings on harm reduction and also to be employed by that NGO. So we've been involved in recruiting the peer educators. (Baxter, IDU)*

Once a connection was made with the drug users in these communities, the next step was to single out appropriate peer workers or peer representatives. The role of these individuals is to relay information from the current users they interact with in the maskanis back to agency members and to other peer workers in the maskanis. International agencies that came into these using sites were usually unable to have much input in the selection criteria of the peer worker, as Willie explained.

> *The only thing we can say is that 'We've got money for one more outreach worker, you go search them.' We are not involved in the process of hiring people because we think that is the job of the*

organization itself. It's their organization; they have to look into a suitable. Though we do have some demands, let's say for the TOT's (trainer of trainer), we do have some demands and qualities that the trainers need to have. Just three things, they need to speak English fluently and Swahili, they need to have experience, not necessarily being ex-drug users and they need to gain respect, so they need to be, you know, have the right attitude. Those three things are necessary for becoming a TOT. (Willie, IDU)

Perhaps this may seem limiting at first, but having an organization choose their own peer trainers and workers seems to allow for more autonomy and empowerment for that community. Allowing for the organization members, who are also community members, to pick desirable trainers must have symbolic and literal impact on the mindset of this generally overlooked population.

7.1.1 Recruitment via outreach and user networks

Several of the IDU agencies had projects in less developed parts of the world, and arguably had limited access to technology. Thus, their target community was likely not to be found online. This explains why this method was not used for recruiting injecting users. However, using social media sites, such as Facebook and *Drugsforum*, was a popular method of recruitment amongst the GHB and MSM scenes. One participant felt that having an online presence helped to de-stigmatize and normalize drug use in that it made this topic more visible to an audience that might not be exposed to harm reduction.

A Pink Unity member reported that most of the peer volunteers were found through their presence during outreach. The social aspect of this outreach allowed for connections to be easily made through conversations at parties and festivals. This supports the idea that the MSM drug use is a community comprised of similar, like-minded, social people. Oswald explained some of the reasons his peers had for becoming Pink Unity volunteers.

'I'm new to the city, I don't know people and this is a great way to get some friends' or also guys who did drugs in the past, sexual risk behaviours, or they had the experience themselves, so they wanted to be a peer educator to inform other people. Also guys who are more interested in the sexual health part, some more drugs parts…(Oswald, MSM)

Another MSM participant with established connections in put in the effort to maintain an online presence in his informants' lives, which helped him to continue his own personal research. His informal method of keeping regular yet relaxed contact with his informants allowed them to share in his personal life as well. This could lead to perhaps a more open and trusting communication with a community that is notoriously hard to reach.

I met a lot of gay men, also sex workers and around 20 of them, I still have contact with. So I have contact with them because I added them on as a friend on Facebook so that I can follow them…But they give me a lot of information, so once in a while I meet them or I send them a text message, or an email, or meet them in the city and then we chat about their lives, my life, and the most important thing for me is to get new information about what are the trends in their drug use…So, that's my story, that's how I do it and I didn't do any research about it, it's my way of getting contact. And sometimes they make contact with me. (Frederik, MSM)

One participant had recently conducted a survey amongst GHB users in the Netherlands and Belgium. Participant recruitment was a struggle, but they did encounter some individuals who were willing to help with recruitment via their own personal network. The excerpt below highlights the usefulness of drug user networks in terms of reach and resourcefulness.

But there was one of the respondents, he told me, 'I have a big group of friends they are all using GHB and I can, do you want to come again?' I do trust him because he was very interested in the research and I did the survey with him together so I told him all the things about it, um, so after that, I sent him eight surveys to do with his friends…he was like a seed for me, and someone that I met, I trust…(Roxie, GHB)

7.1.2 What did not work in recruitment

Participants shared the methods that were not successful in gathering responses or reactions from potential peer workers. Agencies linked to GHB use struggled with the face-to-face method, particularly amongst the recreational users in Amsterdam. This population of recreational users did not consider themselves to be 'drug users' and thus this type of recruitment for this type of outreach did not resonate with them.

I think it was still a little taboo for GHB drug users to come to the Free Clinic because they don't see themselves as the marginalized drug users or junkies, they just use some drugs to have fun. (Rose, GHB)

Approaching people on the basis of their GHB use was perhaps confronting for those who did not (want to) identify as substances users (see section 6.3.2). Should this be the case, perhaps potential peers that may fall into this category should be provided with more anonymity or approached with sensitivity.

While Frederik had success with his online approach to getting contacts in the MSM scene, it was nevertheless a learning process. He spoke about being unsuccessful at making contacts in a formal, professional way and got results when he changed his approach to sound more like 'one of them' and lost his connection to an agency.

So we also have a profile where I'm talking: 'Hello I'm Mainline, blah, blah, blah, I'm doing research on crystal meth in the gay scene we need

people who can tell us about their experiences with crystal meth so,
give me a shout if you are using crystal meth.' Very short, very positive
and until now, because we are online for three months, no reaction at
all. So two days ago I thought, what the fuck, so I used the words: slam,
tina, to the point, also, shoot, so they are working with nicknames...so
all these guys, I'm sending an email of a short explanation, saying 'Hi,
I'm Frederik, crystal meth, blah, blah, blah' and I was surprised that
after 30 minutes, four of them from the 12, they already send me
information back.' (Frederik, MSM)

From this statement, we see that that being associated with an agency during recruitment, a wall is created between recruiter and their target audience. As demonstrated, approaching potential peers as an individual, someone who is familiar with their terminology or has personal experience with drug use, removes barriers and creates a mutual understanding between both sides.

7.2 Agency structure

As mentioned in section 4.2, the majority of the agencies in this study were comprised of peers and non-peers. Typically, peers were incorporated as unpaid workers in the outreach part of the agency, in that they were the ones making the contact with the target audiences. Non-peers generally held more administrative, organizational, and operational roles. There was the overall understanding amongst the agencies that this method, a mix of peers and non-peers, was the best way to run an effective public health organization with substance users. Some agencies represented here existed along side larger bodies such as government public health institutions. While perhaps restricting their autonomy as an organization (see section 6.7) these connections allow for more exposure, resources, and opportunity.

7.2.1 Mix of peers and non-peers

One of the supporting research questions was 'How does a full peer led organization compare to that of a mix of peers and non-peers?' The general mentality of participants was that a mix of peers and non-peers was the preferred model. One common structure of this mixed model was to have non-peers take on a more 'professional' role, with 'coordinating' and 'coaching' tasks and the peers take on a voluntary role. It was stressed that this role was participatory but still was not at the level of the paid, professional workers: "*So we don't expect a lot from them, we expect them to give good information, but you have to coach them to give good information*" (Rose, GHB). Here, one individual from a member run organization explicitly explained why his agency is structured in this manner.

No, the board has peers and non-peers. I think if we had only peers, the
organization wouldn't function the way it does. And I think the
members think the same thing too. So it's a choice of our members to
not have a fully peer run organization, so for instance the employees of
the organization, are mostly not what you can call peer...Especially the
fully peer organizations I have a really strong opinion about. I truly

believe that it's not always the best thing to do. I don't think my
members want to the MDHG to be a full peer organization. I think they
are really happy with the fact that there are so many people that are not
involved in the scene because it makes things less complicated. A full
peer organization brings a lot of complications. (Bo, unspecified)

While he admires the agencies that tackle the challenges involved with full peer involvement, he suggests that the functionality of his organization would suffer if it were comprised solely of drug users. Having peers and non-peers working together 'makes things less complicated', and seemingly he and his colleagues value a smooth working environment with functional relationships over having a organization run by drug users.

One participant brought up the idea of formal/direct and informal/indirect peers. In the IDU setting, a formal peer refers to an individual that injects heroin whereas an informal peer refers to someone who has used heroin but not injected it. This distinction was interesting because he suggested that formal peers are more useful to include because they offer, *"a much deeper reach into the community and cover a much wider ground."* His elaboration follows:

If we use formal peer education that comes from an NGO or with
former users or current users trained as outreach workers then the
advantage of probably reaching a lot more peers than if it's indirect
peers, you know, informal peers. You know, informal peers would
usually just be with the people that they use with all the time, so it's
usually quite a small group of people. (Meeko, IDU)

This is not to suggest that informal peers do not positively contribute to or cannot be meaningfully involved in the spread of harm reduction. However, this hierarchy or difference may be something to consider when looking for appropriate peer members.

7.2.2 Full peer organization

I could see that apart from the representative function of drug users,
there was also this really technical function about how do you
technically organize drug users, how do you technically involve drug
users, how do you make drug users part of the response? (Meeko, IDU)

The above statement captures the mentality of those agencies that had meaningful involvement with drug users and separates them from those who used peers on more a superficial role. What is noteworthy is that this mentality was only present amongst the agencies that were in the IDU setting. CoAct, an international peer run consulting agency, is comprised of what Kingston referred to as 'drug user activists' with 'very senior careers.'

There's a group of us that's more stimulant specialists, crack or ATS
[amphetamine type stimulants], there's others who are more
methadone specialists, there's others who are more HIV, women's

experts, so we deliberately picked a group of people who could bring together different technical expertise. It's not that we're the ten top drug user activists in the world, we're the ten people who have very complimentary skills, when you put us all together, then you get something that's quite interesting. And of course with all the other drug users too, the other drug use networks and stuff, so it's not to say we're the best, but we're a good team of people and we have some very complementary skills which is helpful. (Kingston, IDU)

Kingston and his colleagues have different backgrounds in terms of personal drug use and knowledge and collectively they use these differences to their advantage to create an organization that is able to cover and address a wide arrange of issues related to drug use and harm reduction. Further, it was hinted that these differences actually contribute to the success of their agency. Perhaps having an agency run by peers who all have very similar backgrounds and experiences is less desirable, in that the collective knowledge is deep but too narrow, or that members may all have differing opinions on the same subject, thus creating conflict.

One participant recalled that her and her drug using peers, *"decided it was a good idea to come up with our own network that fights for our rights that is run by us, the drug users"* (Cass, IDU) and this lead to the creation of KENPUD. This suggests that having a group of people who have been oppressed in some (similar) way can lead to effective grassroots organizing. Non-users would not have had the same infringements on their rights and thus may not be motivated to take a stand in the same way.

7.2.3 Support from governments and agencies

A common theme amongst all agencies was that they were connected to an external organization in some way. These ranged from other small-scale NGOs to international and governmental bodies. Unity and Pink Unity are both part of a very beneficial relationship with the Dutch Public Health Services. Making the connection with such a resourceful, recognized public health institution brings increased accessibility and credibility for and awareness of Unity and Pink Unity and 'opens doors'.

One individual stressed the importance of building and maintaining friendly relationships when working with other public health agencies.

We also make sure that they have a friendly NGO that supports their cause, that understands their independence and that can help manage their finances. I think also, you know, we believe very much in unity and unifying networks, not creating problems between networks. So we're doing our best to not rise to some of the negative things that are said about us and when we do our workshop in Tanzania, we always invite members from the other network, TANPUD, to come along and say hello and meet and do some work together. (Meeko, IDU)

Another benefit that came along with making connections with other agencies is that it allowed agencies that were just forming a glimpse into what steps needed to be taken in order to start up a network of peers. Below, Baxter, a recovered injection drug

user, spoke about the ways in which his peer run agency learned connecting with more established organizations.

> *...we put that it could be a good idea if we formed a network so thus when we came up with KENPUD, which was at that time supported by INPUD, so from then it's after getting the information, because we were still not really sure of how to get move, and where to go, who to ask, so at least when we got an idea. (Baxter, IDU)*

7.3 Financial compensation for peers

Approximately one third of the agencies financially compensated their peer workers with a small amount of money, either based on event or by month. This finding was problematic and may reflect how some individuals perceive or value the work done by former or current drug users. Or, it could also reflect a lack of funding faced by these agencies. Either way, it became clear that peers were seldom getting paid for their contribution. While financial compensation is not the only way to show appreciation or gratitude for one's work, it is arguably the most expected and common way, and to learn that this form of return was not given to drug users doing work similar to non-drug users highlights the continued inequality and discrimination faced by this population.

No agencies offered alternative of compensation, such as free use of their services or free transportation. The ethicality involved in giving money to current users was not acknowledged. What was acknowledged, however, was the drawbacks that money can bring in that it can complicate users' governmental welfare or create tension and conflict between peers. This was more typical of the agencies that targeted IDU.

> *When we do a workshop, we give them expenses money, about ten thousands shillings each time. This covers their cost, some of them have to travel a long distance to come. We just make sure that they have some consumption means in their pocket. We need to be careful not to over pay because again, that creates problems... Again, it's gonna be low income countries, suddenly two people in the network are being paid part time money even though it's small money, it's still money and it creates friction all the time...No matter how clear the work plan is, there is inevitably, if one person is seen to be paid and another person is not, there's gonna be bad feelings involved. (Meeko, IDU)*

Meeko's story exhibits the need for a clear plan whereby all peers, if allotted payment, are compensated the precisely the same amount each time. However, paying peers that then return back to their community and must interact with other (possibly resentful) drug users who are not involved in outreach, remains an unsolved issue.

7.4 Training of peers

Training of new members, volunteers, or staff is an essential part of delivering and maintaining an effective health service and thus was explored in the interviews. For the most part, paid professional staff trained the peers volunteers. Few agencies used peers as a source of information for their training, in that the experiential knowledge of

former and current substance users experience was not incorporated into peer training. Perhaps it was assumed that peers lack the technical knowledge related to HIV infection routes, or the risks of substance mixing, for example, and thus professional expertise was required. Both Unity and Pink Unity gave their peer volunteers the same training, which was broken into two sections: substances and effective communication, each covered by paid professional staff. What is interesting in this case is that the two trainers from Unity both started out as volunteers and have now obtained paid positions. These individuals seem to have the opportunity to give trainings with both their own personal experience as outreach volunteers and their professional expertise. However, this was unusual, as generally, non-peer staff members gave trainings. Some agencies made use of their partnerships with other health services and integrated the knowledge of their doctors, clinicians, and other professionals with their own in order to cover and address more health issues.

> *When the ambassadors sign up they receive training on how to perform*
> *voluntarily counselling and testing for HIV… and they also receive*
> *from time to time from our doctors and nurses from our clinic…Yes, so*
> *at training they receive initial training for the actual position they have,*
> *and then there is also ongoing training from our clinicians, doctors,*
> *nurses, for any subject matter that they come into contact with that they*
> *are not sure of. (Chuck, MSM)*

However, the IDU agencies stood out as having peers integrated into their trainings. For example, one of Willie's roles with international projects is a TOT, a trainer of a trainer, whereby he trains peers from the community who want to be future trainers with the idea that these peers will be the ones training new staff. With this method, Willie and his agency are able to overcome the challenges of training individuals in a foreign context (see section 6.5). Furthermore, this method requires that Willie and his colleagues invest a significant amount of responsibility and trust in these peer workers. This is noteworthy as it reflects this agency's positive standpoint on the ability of drug users. By having peers from the community involved in the training, this agency not only empowers these individuals but demonstrates how vital this agency sees meaningful peer involvement.

One participant expressed the challenges their organization faced with training their team of drug users. Albeit each member brings their own knowledge but the fact that they are interacting with international governing bodies, such as the United Nations, requires a specific type of knowledge that is not necessarily gained by their past experience of drug users.

> *But there are challenges, for example some of our experts are really,*
> *really expert but they need to know all the top UN documents, so they*
> *might be a top expert on their topic, but if you're going to work in a*
> *global environment then you've got to also be an expert on all the UN*
> *guidance on that area. So that's where we need to focus internally.*
> *(Kingston, IDU)*

A final theme that emerged with agencies with harm reduction projects abroad is that a project must be structured with longevity in mind. This relates to training because a successful and sustainable peer project requires thorough training of the community members. Having local community members integrated and involved in such a way meant that efficiency might be sacrificed, but longevity would be ensured.

> *The point is that, we went to Tanzania and there is this program that runs very, very well. And the point is it's run by three European white people and it runs very smoothly. It's very strict, they are working very hard and they got a great project going on. Our projects are not running that smoothly, but they are being run by locals. The point is that, if we leave, the program will keep running. (Willie, IDU)*

One poignant statement came from a peer who was in recovery of her injection drug use and was doing outreach for other IDU. When asked about the training Cass received as a member of KENPUD, her response was: *"The only training I've had is just my experience. That's it."* (Cass, IDU). This simple yet powerful statement serves as a reminder that no matter what kind of training they receive from professionals, there is no substitute for the personal experience of the challenges and successes these former and current drug users live(d) through.

8. Recommendations and discussion

This final section will address the important issues that arose out of the analysis and provide the reader with an idea of future considerations in regards to effective peer involvement. This study aimed to provide the reader with a deeper understanding of peer involvement, its challenges, and its benefits. The findings demonstrated that peer involvement is advantageous, if not complex. Further, it was suggested that agencies understood the benefits of peer involvement, but were largely unable to implement this harm reduction approach effectively.

Having peer workers that are able to build trusting relationships with target audiene and draw on their past using experiences were noted as useful criteria for a 'good' peer worker. Guidelines, challenges, and lessons in regards to participants' experiences with peer involvement were also explored. Guidelines ranged from outreach rules to usage rules. Challenges were considered from the side of the agency in terms of integration and from the perspective of the peer, in terms of the risk of relapse. Lessons that participants had learned, such as the importance of partnerships, or creating sustainable culturally sensitive projects, were also discussed. Finally, the details of how peer projects functioned, such as organization, recruitment and training were examined. Given all the benefits provided by participants, the case for experimenting with peer involvement is strong. From the findings we see that peer involvement has the undeniable potential for improving the lifestyle and health of substance users.

8.1 Issues for organizations to address

A significant reason for conducting this research was to provide Mainline with recommendations on how to better serve their target populations. Incorporating peers requires some level of structural and organization adjustments within an agency. Thus, there are a few issues that we believe should be addressed, namely challenges related to stigma, support, and payment.

Stigma towards substances users does not only exist outside harm reduction agencies; harmful and judgemental views are held by agency members as well. There are certain assumptions that we have about substance users and responsibility, and while some of these are persuasive, some are not. In order to reduce discrimination, agency members should be encouraged to question how they perceive substance use(rs) and hold internal discussions with the goal to challenge each other's values and make discriminatory views more visible. Then, by addressing, examining, and dismantling the biased ideas we have about substance use(rs), agencies and their peer workers will have a better relationship built on mutual respect.

In relation to this, we believe that expectations of the agency should be realistic and flexible. Perhaps if expectations are adjusted, then peer workers have a greater chance to adhere to the rules of the organization. However, lowering expectations may have an adverse impact on the peer workers and may further perpetuate the detrimental notion that substances users less capable workers than their non-using peers. Therefore, this adjustment should be treated very delicately and rules for the peer workers should be made clear, so that both sides know what is expected of them.

A second issue that deserves attention is the well-being of the peer worker and what agencies do for them. The nature of peer work means that substance users are confronted with challenges in regards to their continued use or recovery. These types of

struggles, such as relapse (5.2.2) or boundary issues need to be addressed by the agency. While agencies tend to concentrate on the well-being of their target audience, they must also consider the mental, physical and psychological well-being of their peer workers. What structures are in place to support the peer worker? How does an agency respond if their peer worker relapses? Or if there becomes a gap between the peer worker and their target audience and the peer worker is no longer effective or becomes out of touch with the drug use setting? These questions are important to consider because if the peer worker is supported both in their work and in their private life, then they are better able to carry out their harm reduction work.

Many peers were not paid for their work and this issue requires attention and a culturally appropriate solution. Payment is a complicated issue that requires creative ways to overcome the issues revealed in the interviews. One option could be an output-based reward based on a clear, case-by-case basis so the peer worker is paid in direct accordance to their outreach work. This would ensure that both the agency and the peer know what needs to be accomplished in order to warrant financial compensation. Whatever the solution, it must demonstrate that that the agency values and respects the work done by the substance user, as it would any other worker.

8.1.1 What peers can expect with involvement

An agency and its members, including former and current substance users, that share the common goal of improving the health of substance users via harm reduction enter into a relationship. Unfortunately, as suggested in the interviews, this relationship does not generally favour the former or current substance users. Ideally, substance users should expect a working environment where they and their lifestyle are respected, psychologically supported and financially compensated. However, the reality is that substance users from all three drug use settings encountered substantial challenges, both from both within the agency and from the non-using communities. These internal and external pressures facing substance users included experiences of being disrespected and judged. Agencies were concerned about the possibility of current users returning to old networks and practices, yet visible support structures for this situation were lacking.

This is not to say that these issues are intentional. Rather, the point is to highlight that agencies that decide to involve peers have much work ahead of them in terms of meaningful integration. Genuine involvement of peers is possible, however, the discussion points were provided in order to help agencies nurture a balanced, mutually beneficial relationship with substances users.

8.2 Discussion

Some issues were brought up in the interviews that were not part of the original research agenda, but are nonetheless worth exploring within further research. A terminology matter arose, specifically, the meaning of being a recreational versus a problematic user. Does this have different meanings in different drug use settings? In relation to this, when is a past or present user no longer an addict? These questions are important to keep in mind because this relates directly to agenda (6.3.1) and if we fail to know the agenda of both the peer worker and the substance user, then the harm reduction work will be ineffective. The reason a clear definition of these concepts is needed is that depending on which stage the substance user is at, a different peer worker is appropriate.

Effective peer involvement requires that the peer worker and the target audience have similar ideas of what they want to get out of the relationship and what they want their drug practices to look like. If the target peer is for example, at a pre-contemplative stage with their use, perhaps an active user is more appropriate for the peer relationship, but if that user decides to move further into the abstinence stage then perhaps a former user is more suited for the relationship. The harm reduction agenda of the substance user may vary, but what must stay constant, regardless of the drug use setting is that their lifestyle must be recognized and respected.

IDU participants that had made contact with drug suppliers mentioned that it was a complicated connection, but had not discounted the possibility of a working relationship whereby the drug seller would go beyond drug distribution; they would distribute harm reduction information and resources to their clients as well. One participant mentioned that sellers that are non-users are typically more disrespectful to their clients. Thus, this aspect should be given attention, should an agency chose to incorporate this population in their outreach. This may be a more successful relationship to make with the GHB scene, as GHB sellers tend to be users as well.

A third issue that was distinctly visible was the success of current users as peer workers based on the drug use setting. Participants in the GHB use setting were collectively of the mind that former users (and certainly not current users) could not be effective peer workers, yet this was not the case with IDU participants; both former and current users were considered to be effective peer workers. This finding was perplexing and perhaps a starting point for future research: why is it believed that peer involvement appears to be more successful within an IDU setting than with GHB users? What is it about each drug use setting, understandings of the drug and the nature of drug use that allows for or hinders effective peer involvement? A range of different factors are relevant here including the difference in substance used, the stigma and bias associated with each drug use setting, the format of social relations and implicit hierarchies of substances in terms of risks and addictive properties. The current harm reduction resources and information available may also play a role here. Exploring these questions further would shed light on the best harm reduction techniques for each drug use setting and therefore improve the life of these substance users.

8.3 Conclusion

The research showed that there is not one singular approach to involving peers; depending on the target audience's substance use, various different criteria may be appropriate. However, best practices of peer involvement, regardless of drug use setting, requires trust, mutual respect, and an apparent agenda and clear intention of involvement. There are a lot of obstacles to overcome and challenges to address if peers are to be effectively incorporated within an agency. However, many of the agencies represented here were eager to do so, as they had experienced firsthand the benefits of peer involvement. This is not surprising as some of the peers' determination to make a difference were palpable. As has hopefully become clear in the preceding pages, the purpose of this research has been two-fold: highlighting the best practices of peer involvement for each drug use setting, but also indicating that involving former and current substance users is an extremely important rewarding and worthwhile endeavour.

Annex

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Research Framework
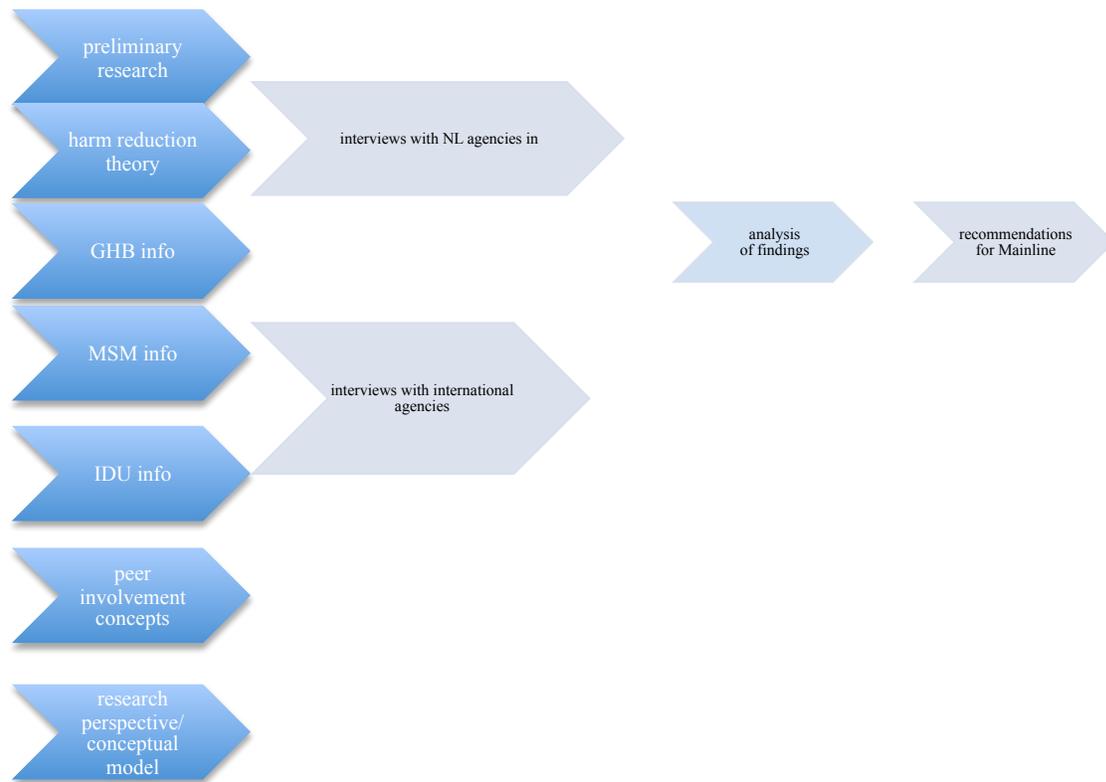
Interview Themes

→ **Overview of agency**
-can you give me an overview of both your role here and the role of the agency?
-what sort of services do your peer workers provide?

→ **Recruitment of peers**
-how do you go about peers who are able/interested in peer involvement?
-what criteria or characteristics do you look for in peer workers?
-what background/experience of potential peer worker is ideal or useful?
-what is the biggest challenge in recruitment?
-at what stage do you aim to get peers involved? (recruitment, prevention, support)

→ **Training of peers**
-how much of peers' experience/knowledge is taken into account in regards to what you already have set up?
-who does the training?
-what are the biggest challenges in training?

→Ongoing peer involvement
-how do you encourage and maintain interest and trust with peers?
-how do you prevent drop in participation/burn out?
-how are peers supervised while doing outreach?
-how do you/they set up boundaries in terms of public/private divide?
-how do you evaluate their work, the program and services they are providing to peers?
-what happens if the partnership with peer is no longer worthwhile?
-how do you compensate them?

→Overall ideas of peer work
-what does a successful peer involvement for GHB/IDU/MSM resources look like?
-what do you expect to gain by having peer involvement in your organization?
-what are your biggest challenges with peer involvement?

→Population specific questions
a) Active users
-can they have/use drugs while working?
-can they inject/dose for other people?
-what is their responsibility if something goes wrong while doing outreach?
-what is the biggest challenge with peer involvement with active users?
b) Former users
-do you have any responsibility if they relapse?
-what is the biggest challenge with peer involvement with ex-users?
c) Non-peers
-how do you navigate the interaction and possible tension between peer workers and non-peer workers your organization?