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A critical review of peer education with young people with special reference to sexual health

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Abstract

This paper presents a critical review of selected literature about peer education initiatives with young people principally in the area of sexual health. Reported work in this area was found to be diverse in terms of aims, objectives, methods, findings and levels of evaluation. The paper highlights the promise of the method but draws attention to its potential problems. Examples of peer health education are reviewed and the issues surrounding them discussed. These include: theoretical background, rationales, cultural constraints, ethical and operational issues, and challenges for monitoring and evaluation. The paper concludes by suggesting that practitioners and evaluators must reflect on the difficulties inherent in artificially reconstructing a social process.

Introduction

The appeal of peer sex education for health promotion is that it has always existed on some kind of informal basis. Young people share information amongst themselves which they have drawn from a variety of sources, including personal experience. Adults have regarded this process with mixed feelings. At best it gets *them* off the hook and will not be grossly ill-informed; at worst it raises the spectre of influences leading to disapproved behaviour reinforced by what they might see as undesirable 'peer pressure'. In recent years, however, health educators have begun to experiment with harnessing these naturally occurring processes to what they define as positive ends.

This paper is intended to highlight the promise of the ideal, and the practicalities and possible problems of taking a peer education approach when working with young people in the area of sexual health. The following two quotations usefully encapsulate some of the main issues surrounding peer education.

First, a very clear definition of the ideal of peer health education is given by John Sciacca (1987) who is prominent in this field. He states that:

> Peer health education is the teaching or sharing of health information, values and behaviours by members of similar age or status groups.

A cautionary note is, however, sounded in the second quotation, which is from a paper about positive youth development programmes in school settings. Meyer *et al.* (1993) open their review of such programmes with the following statement. They point out that:

> The implementation of positive youth development programmes would be simple and neat if human behaviour and environmental contexts could be easily controlled, manipulated and measured.

This paper takes the form of a critical review drawing on a selection of reported peer education initiatives with young people and focusing mainly on sexual health. This format was adopted because reported work in this area is particular diverse in terms of aims, objectives, methods, findings and evaluations of projects. The paper therefore aims to highlight the potential of the ideal of peer

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education whilst paying critical attention to inherently problematical issues. Firstly, the theoretical background to peer education is examined and the rationales for the method put forward by its advocates are described. Secondly, some cultural constraints facing those who carry out peer sexual health education are discussed, notably the prevailing 'adultist' definitions of adolescence and young people's health problems. Thirdly, ethical and operational issues affecting decisions about peer education projects are highlighted. Fourthly, a selection of peer-led projects is described to illustrate the diversity of such initiatives. The paper concludes with a discussion of some of the challenges for the monitoring and evaluation of peer education projects.

Theoretical background and rationales for peer education

Theoretical issues

The theoretical roots of early peer education work, primarily in school settings, are usually traced to social learning theory (Bandura, 1986), social inoculation theory (Duryea, 1983) and differential association theory (Sutherland and Cressey, 1974). Although much social psychological research on peers as models, and peer interaction, was taking place in the 1960s and 1970s, seminal work on 'social learning and imitation' was published as early as 1941 (Muller and Dollard, 1941).

The overall conclusion of this work is that peer modelling is a basic process in the socialization of children. Social learning theory relies on the use of attractive role models with whom the audience can associate. Conveying factual information is only one element of this approach. Rather, peer education based in social learning might also involve modelling appropriate behaviour, teaching social skills, and rehearing possible roles and situations. Sometimes this is translated into practice in terms of 'peer pressure resistance training'. Social inoculation theory is also concerned with resistance to pressures from peers. This may, however, take the form of providing peers with persuasive arguments and facts to counter pressures which are deemed undesirable by health educators, such as to smoke or use drugs. In a non-peer education context this has been translated into practice in an intervention designed to 'establish conservative norms' (Hansen and Graham, 1991). Differential association theory is based in criminology and deviance research. It asserts that criminal behaviour is learned in small personal groups and that this learning involves not just specific techniques but also their supporting motivations, rationalizations and attitudes.

It is important to reflect on these theories and their applications as they raise basic questions about the nature and purposes of peer education. For example, peer education aims to tap into what is known about existing social processes and to harness this power, but to whose ends? How does this approach relate to other ideas current in health promotion (and stressed by many advocates of peer education) about empowerment, trust and anti-discriminatory practices?

Furthermore, this theoretical pedigree may also be viewed as simply providing a very generalized framework of justification. When this is operationalized into health education practice it results in a very diverse set of 'working hypotheses', many of which have yet to be rigorously investigated and tested. For example, Kar *et al.* (1986) pointed out that 'one such working hypothesis is that peers significantly influence teenagers' sexual and contraceptive behaviours' and they cite several studies which support this hypothesis. Perhaps more significantly, however, they point out that 'similar views [about peer effects] are held by professionals and contraceptive counsellors' and that it is 'only natural' that there would be interest in involving teenagers as educators of their peers. Such conflation of basic theory, working hypotheses and intuitively appealing concepts are characteristic of work in peer education in this area.

In practice, therefore, the theoretical components of peer education in sexual health require much clearer specification and validation. Many published papers express such scepticism. For example, Duryea (1991) stated that even though

many school health projects integrate 'peer resistance' and 'peer refusal' modules into their curricular interventions, little data exist which indicate that programme developers actually know what 'peer pressure' constitutes. He continued as follows:

> Self-report techniques have generated much of what health education investigators know about peer pressure. Such procedures are alternatively viewed as valid and reliable or invalid and unreliable depending on research setting, rapport between subjects and persons administering the questionnaire, and elements such as content sensitivity, fear or retribution, cultural and racial homophily and comprehensibility. Yet these variables are rarely assessed in relation to self-report generated data in health education research. Basically, health educators have assumed when students report that peers call them 'chicken' if they do not use tobacco that is precisely what has taken place.

A recent review of the literature on peer influence on smoking behaviour has concluded that the evidence of effects is fairly limited (West and Michell, 1995). West and Michell (1995) conclude that the case for coercive peer pressure as an influence on adolescent behaviour is not proven and is much more complex than studies indicate. For example, they suggest that peer influence may operate differently with respect to different health-relevant behaviours. Furthermore, they argue that peer influence may, in fact, only be seen to have any discernible effects on more ascribed or visible adolescent health issues, such as being overweight. Understanding the social context of health-relevant behaviours and their associated concepts of identity are vital to the analysis of these peer processes.

Rationales for peer education

Having highlighted some theoretical issues underpinning peer education it is also important to examine the rationales for the method which are put forward by its advocates. Peer education is thriving in North America and Canada, where young people's work in this area is often an accredited part of their school curriculum. There is an established journal, the *Peer Facilitator Quarterly*, and this section draws on papers in that journal to summarize the rationales for the method (Sciacca, 1987; Bernard, 1991; Sloane and Zimmer, 1993; further references from these three papers, which are generally supportive of the rationales, are not included in this paper). It seems fair to repeat Kar's (1986) point that, presently, many of these rationales can only be given the status of 'working hypotheses'. Undoubtedly, however, many of those working with peer education methods would claim their validity is proven daily by their own practical experience. Contradictory research evidence abounds, and, as will be expanded upon later, there is an acute need for good evaluation of effectiveness in both process and outcome.

The rationales may be summarized as follows:

Firstly, peer education projects are considered to be inexpensive, relative to other interventions requiring health professional input. However, practitioners also recognize that a good peer education approach requires a trained and committed staff, and may be labour and time intensive. Needless to say, the young people's time mostly comes free.

Secondly, studies indicate that young people frequently turn to their peers for information and advice. These peer interactions tend to be more frequent, intense and diverse than those with other people, and they also provide an arena for support and modelling. Through reciprocal interactions in peer education programmes, young people learn to share, help, comfort and empathize with others, as well as learning critical social skills.

Thirdly, research on child and adolescent friendships clearly indicates the important and protective role peer social networks play in the positive development of youth. (Again, such evidence casts new light on 'peer pressure'.) Moreover, using peer networks to teach and reinforce values of co-operation and mutual support could mitigate against future social and psychological problems. For example, the number of close friends perceived to be sexually active, but who are reliable contraceptive users, has been identified as among the

most influential variables in predicting sexual attitudes and behaviours for both adolescent men and women (Daugherty and Burger, 1984).

Fourthly, peer education offers the opportunity to participate in meaningful roles and to benefit from being a helper. It is claimed that peer educators perceive themselves as growing, both personally and professionally, from their education and training experience. Research into empowerment and its beneficial effects highlights that the dynamic at work is participation. However, in this process there is also a development of lifeskills and tolerance. Taking part in peer education, it is claimed, provides the opportunity to develop collaborative and conflict resolution skills. Also participation promotes acceptance and respect for diversity. Evaluations of peer-tutoring and co-operative-learning programmes consistently identify significant increases in social interaction, acceptance and liking between heterogeneous peers.

Fifthly, research indicates that similarities between the influencer and recipient increase the persuasiveness of any message. Peers may also be seen as experiencing the same struggles and to be therefore better able to empathize. Since these interactions *are* so powerful it is important also to acknowledge that, whilst peers may be seen as credible sources, they might *not* in fact possess appropriate and informed health advice.

A final rationale is therefore to ensure that the information passed through peer networks is complete and accurate. However, even its supporters acknowledge that it is difficult to measure behaviour change as a *result* of peer education efforts. They simply go as far as saying 'promising associations' have been found, and they themselves conclude, again, with a plea for evaluative research.

Cultural constraints on carrying out peer sexual health education with young people

It is important to recognize that peer education is also taking place in a particular socio-cultural context. Therefore, before examining some of the studies of peer education with young people about sexual health, it may be helpful to stand back from this substantive area and reflect on why it is viewed as important in health promotion and the constraints which may be experienced.

Some of these constraints may flow from current definitions of adolescence and the 'adultist' conceptualization of young people's health problems. For example, two recent publications have addressed why teenagers are commonly thought to be a 'social problem' group with regard to health. Brannen *et al.* (1994) pointed out that young people are one of the healthiest social groups as judged by indicators such as mortality and hospitalization rates. Although their distinctive health problems, such as accidents, suicide, external violence and risks attached to teenage pregnancy, do give some cause for concern statistically, Brannen *et al.* (1994) concluded that:

> The main rationale for the plethora of health education interventions targeted at young people does not derive from these statistics but, rather, from the clustering of health-risk behaviour observed to occur with increasing frequency in the teenage years. Smoking, alcohol consumption, drug-taking and unprotected sexual activity are all singled out by adult health educators as of particular concern. (p. 70)

Griffin (1993) analysed how a discourse of development has characterized youth research around family life and sexuality. The two main features of this are biological determinism, which underpins the 'storm and stress' model of adolescence ('It's the hormones'!) and social construction which represents adolescence as an age stage characterised by particular and conflicting social and cultural pressures ('It's peer pressure'!). She suggested that:

> The discourse of development constructs 'adolescent sexuality' as a force which must be 'guided' and controlled in order to channel such impulsive, though 'natural' energies into appropriate pathways, and to 'resolve' such psychological ambiguities through the 'crystallisation' of 'mature' (i.e. heterosexual, married) identities. (p. 168)

It is not too difficult to see the places where health education has been drawn into this discourse, whether in terms of attempts at risk reduction or in terms of development of life-skills, self esteem and assertiveness. However, such definitions of adolescence and adolescent 'health' problems must be seen as essentially adultist. Whether because of forces from within or without, adolescence is characterized by adults as emotionally turbulent and potentially risky. Whether to care or to control, adults must intervene. Also, historically, sex and sexuality have been seen as areas to be controlled by society, particularly where the younger members are concerned (Paige and Paige, 1985).

Health promotion research has, however, often pointed to the gaps in knowledge about young people's *own* views and perceived needs. (Nutbeam *et al.*, 1991). Surveys regularly show, for example, that young people view any school-based sex education as having been inadequate. This may be a true reflection of reality as, for instance, Remafedi (1993) reported that a survey of US secondary school teachers showed that homosexuality and 'safer sex' were the topics most frequently omitted from human sexuality education. The main reasons for exclusions from the curricula were given as real or perceived pressure from parents, administrators and communities. He also reports that a national survey of HIV educators in the US revealed that 62% felt that they had inadequate knowledge of homosexuality and bisexuality.

The power of adult definitions of adolescence and the dearth of good data about young people's own views about health and sexuality can therefore provide difficulties for peer education in sexual health. Researchers have also highlighted difficulties for those working with young people such as getting them to talk at all (Ovenden and Loxley, 1993); assuming that adolescent health-related behaviours (particularly in the area of sex) result from conscious, rational choice (Wight, 1992); not understanding accurately the constraints surrounding adolescent sexual risk-taking (Bloor *et al.*, 1992); lacking depth information about the meanings of relationships and 'romance' to teenagers (Howard, 1993). Inevitably, therefore, those instigating peer education interventions will have to begin with an 'adultist' agenda, not just because we still lack good ethnographies of youth, but also because those who fund projects have their own agendas to be satisfied.

Ethical and operational issues

Ethical issues

The issue of implementing 'adultist' agendas which may be relatively ill-informed by young people's own perspectives is an important concern for peer education. Although many of those working in peer health education can justifiably claim to be working alongside young people rather than imposing programmes *on* them, this line can become somewhat blurred. It seems valuable, therefore, briefly to reflect on ethics. At a basic level such interventions involve mature adults in developing or facilitating interventions with younger people, children or young adults, which aim, through the manipulation of young people's social worlds, to promote 'healthier' behaviours or lifestyles. Fundamental questions arise about whose agendas are best served by such interventions and whether 'adultist' definitions of what is good for health are necessarily appropriate or relevant for the younger sectors of society. Moreover, is it ethical, for example, simply to obtain teacher or parental permission to carry out interventions with 'captive audiences' of young people in a school setting? In these circumstances can we really assume that young people are participating totally voluntarily? Certainly some selection procedures incoporate an element of teacher discretion if not power. Where are ethical issues of surveillance in all this?

Other ethical issues for peer education echo issues relevant to health promotion as a whole (McLeroy *et al.*, 1993). For example, although group skills and awareness may be promoted through peer education training, most programmes aim to encourage and facilitate change only at an individual level. Again this raises the question of who defines which outcomes are health promoting for whom? It also underestimates the extent to which the wider social and cultural environment may both define desirable outcomes differently

and mitigate against individual change. *If* change *is* agreed to be desirable, how realistic is it to put the burden of this squarely back in the court of the young people themselves?

Operational issues

One of the main difficulties in assessing and reviewing the field of peer education is reflected in the plethora of terms which are used in the different projects. On an operational level this is highly significant since an important part of clearly delineating work in this area involves deciding which terms, and their implied roles, are appropriate.

Some of the terms are peer educator, peer trainer, peer facilitator, peer counsellor, peer tutor, peer leader and peer helper. Perhaps all of these elements are present in any peer led intervention. However, projects need to be explicit about the *intended* relative weights of each of these elements. In the area of education, where most of the early work took place, tutor or educator was the term in most frequent use. Also, the work carried out might involve a quite specific one to one tutoring role or working in groups. In health education supportive counselling, helping or leadership elements might come to the fore.

It is equally important to define 'what is a peer', or to be aware of *who* has made this definition as part of the process setting up a project or intervention. Sometimes the peer education process has been bounded by time and place with specifically identified peers; sometimes these influential interactions have taken place by tapping into already existing networks or friendship groups and a cascade effect, which assumes a gradual dissemination of knowledge through these networks, has been the aim. This process of identifying targeted peers can be extremely generalised. One researcher, for example, defined the targeted group as, in fact, being the process itself. She (Campbell, 1991) said:

> A social network refers to those social relationships a person has during day to day interaction that serve as the normal avenue for the exchange of information and opinion.

The often very different philosophies and aims reflected in this morass of terms means that it is almost impossible to make comparisons between projects or to evaluate the successes and failures of different interventions. Pre-test and post-test questionnaires or other forms of measurement are quite simply not enough really to understand why some interventions appear to have some success whilst others fail to have the desired impact on a particular group of peers, even in apparently similar circumstances.

As explained earlier, the theoretical framework for peer education is also currently insufficiently detailed. This partly explains the lack of close attention to many important socio-cultural factors which affect the operationalization and evaluation of peer education programmes. For example, the relationship of peer groups to the wider social context is unclear. Considering adolescent pregnancy, Atwood and Kasindorf (1992) have commented generally that most behaviour change attempts have focused on the developmental psychodynamics of individuals. Whilst they accord a positive role to participation in peer group work, they also pointed out that:

> In order to affect serious behaviour change concerning adolescent pregnancy, a multisystemic approach is needed, providing consistent messages to teenagers. This approach must incorporate the five levels of analysis mentioned earlier: the individual and intrapersonal processes, the school, the interpersonal and peer systems, the family, the community, and the social system. Only in this way will we be able to change behaviours leading to adolescent pregnancy. (p. 347)

Taking up just one of these wider system levels of analysis, the evidence for both parental and peer effects on young adults' preventive health beliefs and behaviours is, as yet, unclear and contradictory (Lau *et al.*, 1990; Whitbeck *et al.*, 1993). Equally, whether peer and parental influences are conflictual or complementary is still open to debate. Pombeni *et al.* (1990) concluded that the peer group is

important, not to substitute for contacts with the family or other persons, but as a social entity to fill a vacuum during adolescent years. Clearly, further research is necessary into the extent and precise functions of peer group influence, especially, for example, as one recent study concluded that in some of the schools they studied the odds of being a current smoker were significantly higher for isolates than for clique members and liaisons (sic) (Ennett and Bauman, 1993).

Other socio-cultural factors such as gender, age and status should also be carefully considered in operationalizing a peer education project. Carter and Carter (1993) have demonstrated that there are differences in receptivity to sexuality education curricula between male and female school students. However, these differences became less obvious with greater experience gained from taking more curriculum units over time. In short, boys may need a different and more extended programme to catch up from an initially lower baseline of exposure, knowledge and receptivity. Whitbeck *et al.* (1993) examined the influences of parental support, depressed affect and peers on the sexual behaviours of adolescent girls. They drew on research which indicates that young women may turn to sexual expression as one means of gaining emotionally supportive relationships; and suggests that this may be less important for young males who are more likely to approach sexuality recreationally and for peer group status. Their subsequent empirical work concluded that depressed mood did not seem to have the same effects on adolescent males' sexual behaviour as it does on females. De Paulo *et al.* (1989) explored issues of age differences in reactions to help in a school based peer tutoring context. They pointed out that there may be self-threatening implications of receiving help which could produce negative and defensive reactions on the part of the recipient. They found that amongst children of 8–10 years help was more threatening in dyads in which the children were similar to each other in both age and achievement. There were better supportive outcomes in dyads where tutors were 'older and smarter' than their tutees. This underlines the importance of understanding perception of the peer educator by the recipient in any peer intervention.

If it is vital to reflect on 'what is a peer', it is also important to consider the immediate context in which the intervention is operating. Again, the differences between carrying out a structured programme within a school setting and, effectively, having peers doing outreach work must be examined in their own right as possible influences on process and outcome. It cannot be assumed that the same social mechanisms are at work in the different settings. As will be expanded in a later section, many evaluations have been so concerned with demonstrating outcomes that process has often been taken for granted. For example, even *within* similar settings such as schools, different contextual constraints such as curricular time tabling and motivations of staff can have enormous influence on the kind of programme developed (Richie *et al.*, 1990; Gingiss, 1993).

The diversity of peer health education projects with young people

This section is intended primarily to draw attention to the diversity of peer education projects with young people. As such the section is closely linked to concerns about evaluation. Comparisons are virtually impossible as projects are extremely varied in aims and objectives, implementation and evaluation. However, it is hoped that by highlighting apparently positive or negative, successful or unsuccessful, aspects of a variety of projects, this will facilitate the development of a realistic approach to implementing peer education.

The roots of peer education work were confined mainly to school-based educational initiatives. A critical review of school-based peer education programmes (Devin-Sheehan *et al.*, 1976) showed considerable variation in participants, aims and kinds of methods. For example, programmes were structured and non-structured, involved same-age and cross-age peer educators, supplemented or substituted for the conventional training, and used trained and non-trained peer educators. Such early overviews of academically based peer tutoring

programmes in a variety of subject areas also cautioned that positive outcomes were only *clearly* demonstrated in well-structured and cognitively oriented programmes. For example, a synthesis of research on the effects of tutoring (Cohen and Kulik, 1981) concluded that students who participated in tutorial programmes, both as tutors and tutees, showed greater cognitive and attitudinal gains than did students who did not. In the area of self esteem, it appeared that tutored students had no higher regard for themselves as learners than did non-tutored students. Student tutors did exhibit more self confidence but only to a slight degree.

Thus, even before the complex area of *health* behavioural change had been targeted by peer health educators, those concerned with academic peer tuition were limiting their claims for success to direct and measurable outcomes resulting from carefully structured and targeted programmes. It is a long step from these early focused school-based programmes to attempts at demonstrating, say, cascade effects on contraceptive risk taking behaviours through peer outreach work in a deprived community.

Early peer health education programmes focused mainly on what has been termed 'chemical abuse prevention' for adolescents. The emphasis for the peer educators in these programmes has been on modelling appropriate behaviours, role plays and teaching social skills, rather than just producing factual information (Flay, 1985). Armstrong *et al.* (1990) queried the effectiveness of peer-led programmes in preventing the uptake of smoking behaviour by children and whether programme effects last for more than a year or so. In an overview of studies, Flay (1985) acknowledged that 'the social influence approach to smoking prevention can be effective some of the time' but, again, caution is urged because of 'the considerable differences between studies in the patterns of reported results'. Others have pointed out that little is known about the specific effects of the individual components that make up these multifaceted programmes (McCaul and Glasgow, 1985). Armstrong *et al.* (1990), for example, conducted a randomized control trial plus follow-up of a school-based education programme for the prevention of smoking in children in year 7 at school. They found that both teacher-led and peer-led programmes resulted in a reduction to about the same degree in the uptake of smoking by girls, while only the teacher-led programme appeared to be effective in boys. Moreover the effect of the programmes on girls were better maintained during a 2 year follow-up, than were those on boys. Other variables also had a significant effect on smoking behaviour, such as perceived response to cigarette advertising, parental and sibling smoking status, perceived parental sanctions on smoking behaviour, selected peer influences, and the intention to smoke. The strongest and most persistent effects on uptake of smoking were children's perceived response to cigarette advertising. They concluded that the use of peer leaders with boys should be re-thought; but, most tellingly, they suggested that the most effective action against smoking lay not with the teacher (or peer-leader), but with the politician. This point about the power of wider societal forces on children's behaviour should be considered more broadly when reflecting on the extent of real influence which peer educators can hope to achieve in other areas of health behaviour.

This point is further reinforced by the somewhat different peer led approach adopted by the New Mexico Alcohol and Substance Abuse Prevention Programme (ASAP). As Wallerstein and Bernstein (1988) commented:

> One of the inherent difficulties for ASAP in reporting community change is that youth cannot assume full responsibility for creating a healthy environment.

Those developing this kind of peer-led approach take their lead from the tenets of empowerment education developed by Paulo Freire. This approach has been explained as follows (Wallerstein and Bernstein, 1988):

> While health education assumes that individuals can make healthy decisions with enough information, skills, and reinforcement, Freire

assumes that knowledge does not come from experts inculcating their information. His emphasis is on the collective knowledge that emerges from a group sharing experiences and understanding the social influences that affect individual lives. To Freire the health educator's role is to contribute information after the group raises its themes for mutual reflection. Rather than impose their own cultural values, educators should enter into 'authentic dialogue' so people emerge from their cultural silence and self-blame to redefine their own social reality. (p. 382)

It is clear, therefore, that projects rooted in diametrically opposed health education ethoses have implemented the peer-led approach. Also there are many varied intermediate programmes eclectically choosing elements appropriate for their own purposes. This applies also to sexual health education work, much of which has had a central aim of HIV/AIDS prevention. However, in addition to considering the effects on programmes of factors such as gender, socio-cultural context, type of programme and setting, it is also important to consider the particular characteristics of targeting this whole new area of health behaviour.

As was mentioned earlier, it is claimed that sexual activity in adolescence is strongly influenced by the attitudes and behaviours of friends (Whitbeck *et al.*, 1993). Same sex peers are the predominant source of adolescents' information about sexuality (Davis and Harris, 1982). However, as was argued earlier, the exact ways in which this relationship between peer attitudes and behaviours actually influences adolescent sexual activity is unclear. For example, it appears that *beliefs* about friends' behaviours have a stronger association with sexual behaviours than do friends' *actual* activities (Hayes, 1987). Also it is not clear whether behavioural similarities influence friendship choices, or friends influence behaviours (Billy *et al.*, 1984). In addition, the strength of peer group influence on sexual behaviour varies by gender and ethnicity (Billy and Udry, 1985).

In the UK the Health Education Authority has specifically addressed and investigated the use of 'peer group teaching as a means of communicating and learning about HIV and AIDS' (HEA, 1993, p. 2). The three projects which they funded and studied were all examples of the use of peer education in community settings. Three main reasons for choosing peer education were cited: economy, efficacy and empowerment. However, evaluation indicated that cost-effectiveness was hard to demonstrate as those projects which functioned well in fact entailed an amount of professional time and resources equivalent to that required by more conventional methods. It also appeared that, as has been found in other studies, whilst benefits for the peer educators themselves might be clear, there was much less evidence of education benefits for a wider target group. Finally any ideals of empowerment were somewhat illusory for, in fact, peer education often resulted in an exact duplication of adult methods and the effective handing over of power to the young people often involved insurmountable complications for the adults concerned.

The Health Education Authority's study of HIV/AIDS education in six further education colleges also raised queries about the effectiveness of peer led methods (Hill, 1993). Problematical issues involved the turnover of students, which had training implications, and questions of competency, accuracy and skill in the delivery by the students of potentially embarrassing information. The report concluded that although the student peer facilitators gained considerably from their experience the fact that they were able only to have a short-term commitment limited their potential success.

In the face of a lack of clear cut evidence, the premise that young people will be more responsive to sexual health education from informed peers should still be treated as yet another working hypothesis. Achieving any direct effects on *behaviour* is even more of a challenge, given the essentially private nature of these particular behaviours. Acknowledging that the time frame for measuring behavioural outcomes must always be carefully considered, the Health Education Authority's survey (Hill, 1993) suggested that although it might

have been anticipated that increasing knowledge of HIV/AIDS and discussing sexual issues would impact on behaviour, none of the students claimed any direct impact. Moreover, if intimacies are shared between *friends*, can it be assumed that trust and confiding will simply materialise with another young person who is simply 'a peer'? Evidence from some peer-based HIV/AIDS outreach work with especially high-risk groups, such as black adolescent females in deprived urban settings (Slap *et al.*, 1991) and prostitutes (Campbell, 1991), indicated increases in baseline knowledge. However, the validity of reported behaviour change is extremely difficult to establish. It is usually easier to demonstrate positive outcomes where these are relatively intangible and generalized. For example, the Tower Hamlets Sexual Health Project (Walker and Hole, 1993) aimed not to deliver information, 'but to facilitate its discovery within a group process which values the thoughts, feelings and opinions of the young people involved' (p. 28). The project was positively evaluated by participants and considered a success by its organizers, 'not only because we have trained a large group of people about 'safer sex' and HIV, but also because the original intention of enabling a group of young people to take a lead in setting agendas around HIV and 'safer sex' has been achieved'. (p. 33) Similarly, awareness-raising exercises, such as promoting safer sex in tourist resorts (Ford and Inman, 1992) by 'peer informants' appear to be judged a success simply if events 'go well' and are felt to engage the attention of the targeted audiences. To date, it appears to have been much more difficult to establish definitive outcomes relating to knowledge, attitudes or behaviour change (Sloane and Zimmer, 1993).

Challenges for monitoring and evaluation

A recent summary of the activities of peer educators (Sloane and Zimmer, 1993) again illustrates the diversity of implementations in programmes and concomitant problems of evaluation. For example, there appears to be no systematic evaluation of differential effects of each of the following activities which are described by Sloane and Zimmer (1993).

Peer educators may:

- Provide one to one counselling or information, formally or informally.
- Provide information or counselling in a group setting, formally or informally.
- Facilitate outreach programmes for target audiences in the general population.
- Reach audiences through a variety of interactive strategies such as small group presentations, role plays or games.
- Staff outreach offices, hot lines and resource centres from which targeted peers can gain access to health information and participate in self assessments.
- Act in drama groups with role model problem solving skills woven into scenarios recognisable as real-life health risks to their peers.

Much work remains to be done on developing good evaluation procedures which should be built in to the design of the project. This review indicated that, at present, there is a lack of clear understanding of the processes at work in peer education and a lack of clear evidence regarding outcomes. If peer education has any *bad* effects on those involved at whatever level these have seldom been documented (Hill, 1993). However, from the health promotion point of view, the *beneficial* effects of a successful dissemination to a wide audience of targeted peers is often equally unclear and research reports present conflicting evidence. If the enthusiasm, intuitive good sense and feelings of success demonstrated by most peer education workers is to be matched by funding, then it is imperative that evaluation issues are addressed at the outset.

Any evaluation must start with the project's definition of its aims and objectives. At present most peer sexual health interventions seem to keep these fairly broad and to be aiming essentially for change in information levels or attitudes.

Attention should be paid to the constraints and possibilities of different settings. For example, projects are regularly constrained by having to work within an established school curriculum.

Outreach projects may not only have to face continuous funding problems but may also discover that their success depends on integrating with other services meeting the basic needs of clients. For example, in a Teen Peer Outreach Street project (Podschun, 1993) for runaway and homeless youth it was necessary also to provide food, clothes and shelter information. The shelter then became a place where HIV education messages taught on the street were reinforced. Whether school-based or outreach, the need to fit in with the setting gives scope for the intrusion of other agendas into the work. Moreover, as discussed earlier, each setting is simply one part of a wider socio-cultural context which will also affect the effectiveness of any programme.

It is important carefully to reflect on fundamental definitional and organizational issues when setting up and evaluating a programme. Firstly, issues of timing are important. Some programmes involve a trainer spending many hours with the peer educators over the course of a year, and continuing to be available for follow-up and support. At the other end of the spectrum, other programmes seem to involve a quick course aimed at providing peer educators with accurate information, with perhaps some skills work to enable them better to transmit this information. Evaluation of any peer education must be tailored to the realities of the time input and time framework of each different programme. As with other health education initiatives, outcomes may vary depending on the timing of the assessment. With peer education it is also possible that the motivation of the peer educators may vary over time, depending at least in part on changes in their own life circumstances.

Secondly, there are many different ways in which the peer educators are recruited; and, again, this must be taken into account in terms of peer educators' motivations and eventual outcomes. These issues have not been clearly evaluated. Consequently, questions still remain such as: does voluntary self selection make for a potentially different programme and set of outcomes compared with teacher or peer choice recruitment, or programmes' leaders selection of 'similar peers'? Equally, a careful process evaluation would tease out whether or not intended selection procedures had actually been adhered to, or if, for instance, teachers had been 'helping' by encouraging the involvement of model pupils or 'helping themselves' by encouraging not-so model pupils to leave class for a while!

Thirdly, the nature of the targeted health relevant behaviours should be taken into account when assessing outcomes of peer education programmes. As has been evident throughout this paper, different individual health relevant behaviours take place in quite different sets of meanings and contexts. Some, such as drinking and smoking, or drinking and sex, also seem to affect each other. Programmes targeting different behaviours are therefore difficult to compare, especially if the aim is behavioural change. It may be the case that young people will be receptive to the educational efforts of their peers in some aspects of their lives, but not in others. The status attributed to peer knowledge of some topics compared with others may vary.

Fourthly, the much vaunted side-effects (if they are not direct aims) of peer education, such as increase in self-esteem and empowerment must not be taken for granted. Evidence is presently somewhat contradictory. Again, time issues are relevant here as, surely, one cannot expect self esteem to flower overnight. Also, if empowerment is realistically to be achieved, the potential difficulties of carrying through a young people's led agenda should be borne in mind at the stage of implementation, as should ways of presenting this to funders. Sometimes, for example, young people's agendas may be destined for failure in the world of adult politics or their time-frames for achieving their ends may not match up with real possibilities. Evaluation of such outcomes must be tailored to the realms of the possible.

Finally, most programmes have taken for granted the process elements of peer education (Podschun, 1993), many of which have been highlighted in this paper as currently unproven working hypotheses. Understanding processes will lead to tighter implementations and perhaps to more clear-cut outcomes and evaluations. Similarly, the enormous difficult-

ies of assessing effective dissemination have yet to be adequately faced by all but a few programmes. There appears to be scant *long-term* follow-up studies of *sustained* change attributable to a peer led intervention. Assumptions about cascade effects need also to be addressed, so that the processes of dissemination in networks and groups may be better understood.

However, in conclusion, it could be argued that it is only in the cascade method of dissemination that *naturally* existing social processes are really being tapped and that setting up any more formal structures for peer education is actually creating a whole new process. As Perry *et al.* (1986) have pointed out:

> The peer educator/receiver relationship, based on a 'give and take' friendship and not on authoritarian teacher–pupil model, appears to be the major reason for the positive impact of the peer education process on achievement. (p. 62)

Conclusions

In recent years peer education as a method of health education, particularly with young people, has attracted increasing attention in the UK. This selective review has attempted to highlight the possibilities and the problems of taking such an approach. Most of the projects and programmes covered by the review convey a sense of great enthusiasm, are based in laudable ideals, are carried out by highly motivated practitioners and appear to create something which is often under-rated in health education, 'the feel good factor'. Any *bad* effects have only seldom been documented.

However, to date, peer health education suffers from an inadequately specified theoretical base which does not address the important social and cultural factors implicit in the approach. Most of the work has also been characterized by a lack of good evaluation. Consequently this review uncovered a lack of clear and unequivocal evidence regarding outcomes and certainly little detailed understanding of the processes involved in such interventions. Only occasionally does a peer health intervention appear to have had demonstrable effects on behaviour and this is usually in a tightly structured and targeted intervention (Kelly *et al.*, 1991). Therefore it is suggested that, in the face of contradictory and inconclusive evidence, the premise that young people will be more effectively informed and their behaviours altered by sexual health education from their peers should, at present, still be treated with caution.

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Notes

The views expressed are those of the author alone and may not necessarily reflect those of her employing organization.

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