



# Adolescent Health Research Updates

## Supplement to the Adolescent Health Plan

No 6 — November 1997

Research Updates are periodically distributed from the Alaska Adolescent Health Advisory Committee (AHAC). AHAC believes that effective planning for the health of Alaska's adolescents should have a strong scientific basis. *Alaska's Adolescents: A Plan for the Future*, the 1995 publication by AHAC, was the product of the committee's review of research related to adolescent health at that time. In order to stay current with new information, AHAC continually reviews research dealing with a broad range of adolescent health topics. Summary reports are prepared by AHAC members for distribution to people interested in teen health, especially those who use *Alaska's Adolescents* as a guide for their efforts in the field. Feedback about the usefulness of these updates is welcomed.

## Peer Education Programs

Peer education is currently a very popular prevention strategy, being incorporated into a variety of youth educational programs. As with all strategies for enhancing adolescent health, it is important to understand peer education in more depth than what is provided through a quick program description review. Specifically, this Adolescent Health Research Update will address the following questions:

*What is peer education?*

*Does peer education work?*

*What program elements are required for its success?*

## Background

For as long as there has been formal teaching, students have generally been asked to assist other students in some form or another. Different models and methods have been used, but in general, older students who initially functioned as monitors expanded their roles to include assisting other students with their studies.<sup>1</sup>

During the late 1960's, adolescents in the United States matured in a rapidly changing and increasingly complicated society. They began to seek help and information more from each other and less from parents, teachers, counselors or other adults with whom they had consulted in the past. Formal peer education programs emerged in the 1970's and have continued to evolve through the 1990's.<sup>1</sup> As issues and demands facing adolescents have continued to grow, the programs have expanded in number, popularity, and variety.

Today, many educators, community leaders, parents and other adults look to peer programs as a way to influence positive life skills and assist young people in reducing their health risks. To this end, there are a number of definitions and descriptions of peer programs. This report examines "peer education" programs only. A more detailed explanation of "peer programs" can be found on pages 160 and 161 of *Alaska's Adolescents: A Plan for the Future* (the Alaska Adolescent Health Plan).

The following working definition for peer education is currently being used by many groups, including the National Peer Helpers Association and Advocates for Youth:

Peer Education (youth seminars, youth-run conferences, teens as teachers, cross-age teaching, teens as trainers, peer leaders) are programs in which:

- youth educate their peers or younger children on personal/life skills or on pertinent societal issues such as substance abuse, tobacco, or HIV/AIDS; and
- youth learn important skills related to designing and delivering effective presentations or workshops.

These programs can range from one-time presentations to intensive semester-long programs.

The theoretical basis for the use of peer education is primarily based on the Social Inoculation<sup>2</sup> and Social Learning<sup>3</sup> theories. Social Inoculation theory describes how a person's resistance to social pressure (to such things as smoking, using drugs or engaging in risky sexual behavior) is greater if the person has been "inoculated," or has developed arguments in advance with which they can counter the pressure. Peer educators provide the vehicle for more realistic practice of the counter-arguments in such learning skills as role-playing. Social Learn-

ing theory explains why the planned use of role models to whom the audience can relate is critical in learning situations. The use of peer educators in health education and prevention programs has emphasized modeling appropriate behavior, teaching social skills, and leading role plays, rather than simply providing factual information.

## The Effectiveness of Peer Education

A critical review of the research literature on peer education programs has revealed a variety of findings. The programs included for review were varied in that they: were both structured and non-structured, used both cross-age and same-age peer educators, had the peer education both substitute and supplement conventional teaching, and used both trained and untrained peer educators.

It appears that there has been no clear, systematic evaluation of peer programs.<sup>3,4,11</sup> However, the following are the evaluation findings deemed most relevant for the fields of health education, health promotion and risk reduction.

1. The peer education process appears to have a positive effect on academic and attitudinal growth for both the peer educators and the recipients of the education, even though many peer education programs lacked a sound theoretical and conceptual basis.<sup>3</sup>
2. Although few studies have measured long term behavior change (beyond one year) in either the peer educator or the recipient, there are a few that indicate long term positive behavior change.<sup>3,4,15</sup>
3. Peer educators themselves often benefit the most from the peer education experience.<sup>5</sup>
4. No studies reported any detrimental effects from being a peer educator.<sup>4,8</sup>
5. Peer-assisted interventions lowered students' risk for HIV infection, smoking, and substance abuse by improving their knowledge, attitudes and behavior related to these conditions.<sup>8,9</sup>
6. Peer educators can change perceptions of what is normal behavior for teens, thereby positively influencing behavior.<sup>11,12,13</sup>

7. A peer education program for middle school students reported significant reductions in aggressive behavior.<sup>10</sup>
8. Trained peer educators were deemed by students to be a more credible source of information than were adult educators.<sup>3,10,11,16,17</sup>
9. Studies comparing peer-led versus adult-led education programs found peer educators produced the greatest attitude changes related to the adolescents' perception of personal risk of HIV infection.<sup>3,10</sup>

The above findings indicate peer programs are being used successfully in a myriad of settings to enhance, and in some cases take the place of traditional health education programs. Furthermore, peer education can increase the number of students receiving health education, suggesting it can be a wise investment of resources.<sup>5,8,16</sup> The following section offers insights regarding ways in which the likelihood for success can be enhanced.

## Components of Effective Peer Education Programs

Peer education programs are not equally effective. Bonnie Bernard, in her exhaustive survey, found the following components to be essential for creating effective peer programs.<sup>13</sup> (Readers will note that several of the components described here are identical to those included in the "Critical Elements of Successful Programs" section of the Alaska Adolescent Health Plan, as well as in other health education literature.)

- **Adequate supervision**  
Youth **MUST** be given ongoing supervision, feedback and guidance from program staff!
- **Positive interdependence**  
Peer educators and students must each believe that it is in their best interest for each other to succeed at teaching/learning. This can be achieved through mutual goal setting, dividing resources and tasks among group members, and sharing in joint rewards.
- **Face-to-face interaction**  
Peer educators must interact with each other to achieve a common goal.

- **Individual accountability**  
Peer educators must be held personally responsible for providing help and support to each other.
- **Training in social skills**  
Peer educators must be trained in the social skills necessary to build and maintain relationships, i.e. communication, assertiveness, conflict resolution, problem-solving, etc..
- **Time for group processing**  
Peer educators must be given the time and guidance to reflect on and assess the delivery of their messages.
- **Heterogeneous composition**  
Peer educators should be diverse in such things as gender, academic ability, ethnic background, and/or physical qualities and abilities.
- **Youth input**  
Youth participants must be meaningfully involved in all phases of planning, conducting, and evaluating the programs.
- **Evaluation**  
Action must be taken to measure the degree to which the needs of the participants as well as the peer educators are being met, and adjustments made in response to the findings.

## Conclusions

As with most prevention strategies, peer education has limited potential for addressing the broad range of factors that influence adolescent health. However, carefully planned and implemented peer education programs have much to offer as part of a more comprehensive multi-faceted approach to youth risk reduction.<sup>14,15,16,17</sup>

Although most peer education programs lack formal outcome evaluation measures (long-term), impact evaluations of peer health education efforts report positive effects on participant knowledge, attitudes, and behavioral intentions and change.

More rigorous outcome evaluation is essential for improving peer education programs. As with many prevention approaches, peer

education programs need to have evaluation designed as part of the planning process and not attempted as an afterthought. More work needs to be done on developing good evaluation tools and procedures to measure peer education effectiveness and long term behavior outcomes.

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