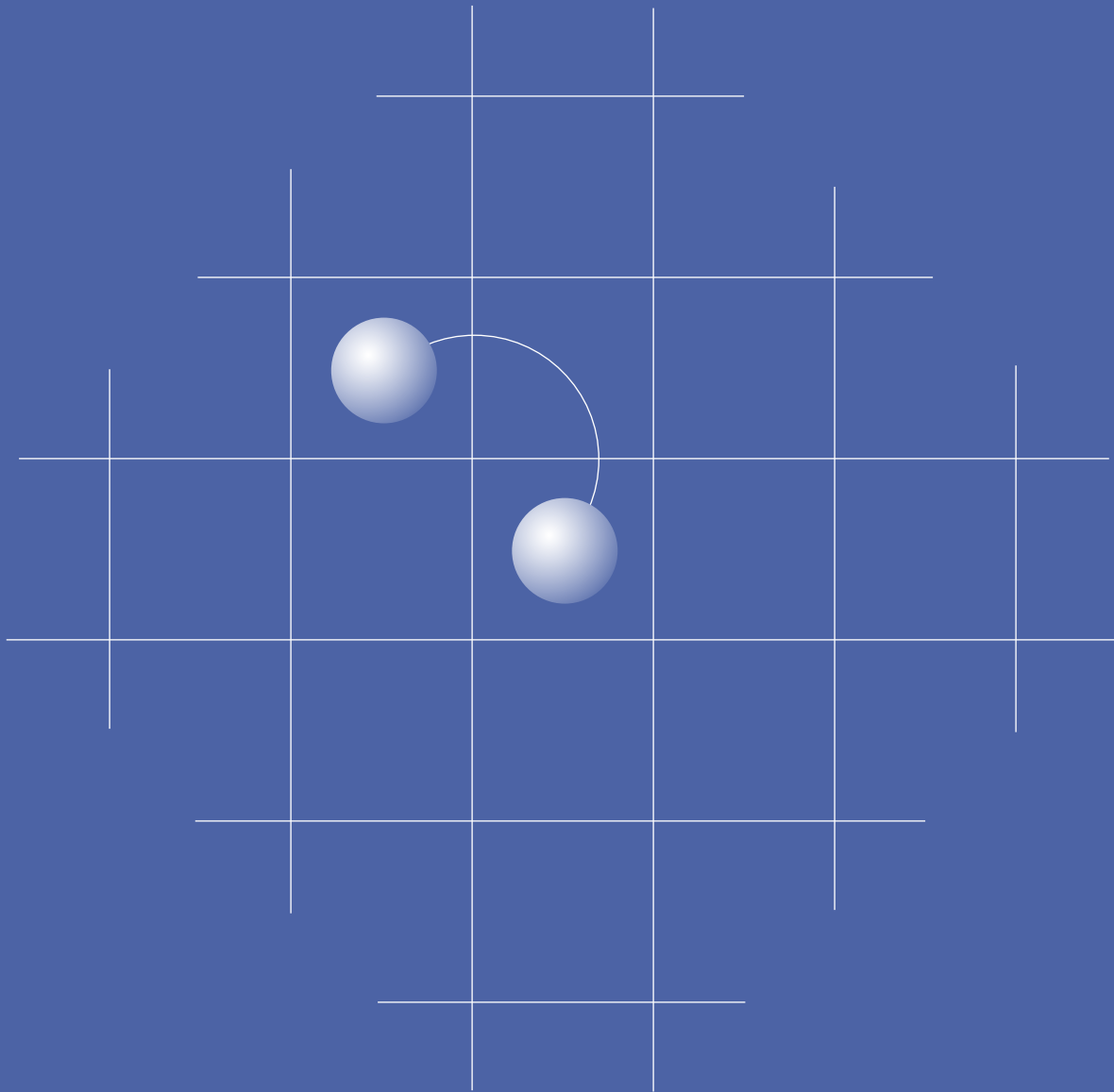
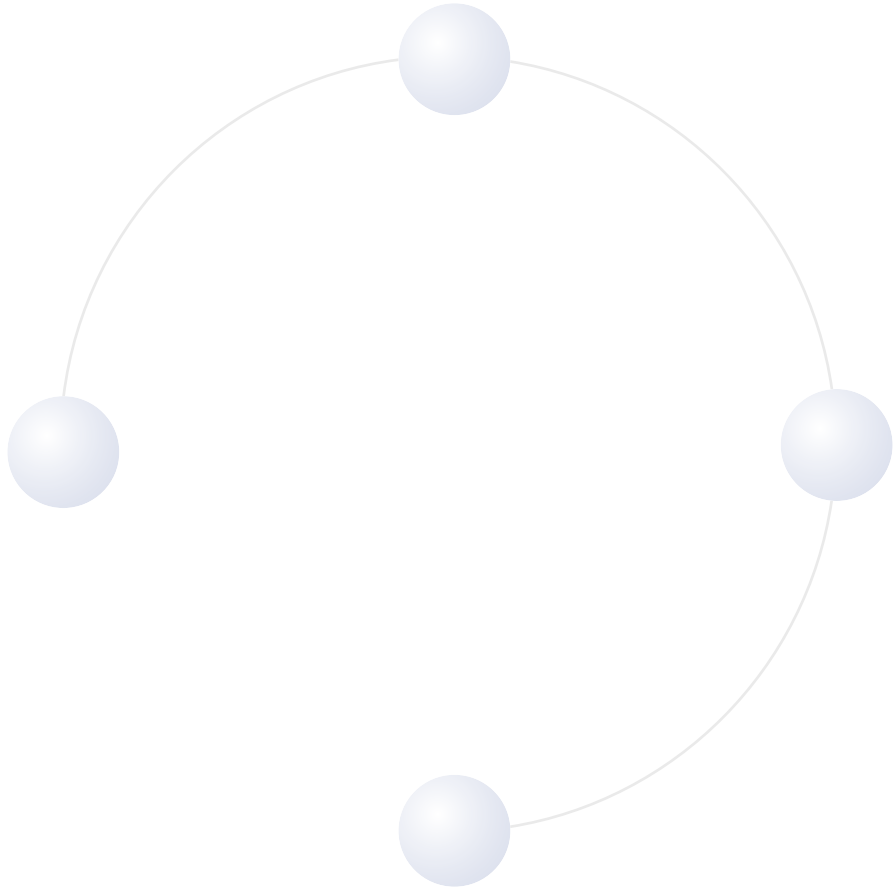
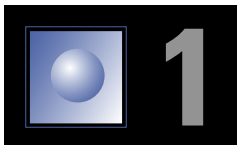


Section 1

From Theory to Practice in Peer Education







From Theory to Practice in Peer Education

What is peer education?

In the context of this manual, peer education is the process whereby well-trained and motivated young people undertake informal or organized educational activities with their peers (those similar to themselves in age, background, or interests). These activities, occurring over an extended period of time, are aimed at developing young people's knowledge, attitudes, beliefs, and skills and at enabling them to be responsible for and to protect their own health.

Peer education can take place in small groups or through individual contact and in a variety of settings: schools, universities, clubs, churches, workplaces, street settings, shelters, or wherever young people gather.

Examples of youth peer education activities include:

- Organized sessions with students in a secondary school, where peer educators might use interactive techniques such as game show quizzes, role plays, or stories
- A theatre play in a youth club, followed by group discussions
- Informal conversations with young people at a discotheque, where they might talk about different types of behaviour that could put their health at risk and where they can find more information and practical help


Peer education can be used with many populations and age groups for various goals. Recently, peer education has been used extensively in HIV/AIDS prevention and reproductive health programmes around the world.

Word sense

A **peer** is a person who belongs to the same social group as another person or group. The social group may be based on age, sex, sexual orientation, occupation, socio-economic or health status, and other factors.

Education refers to the development of a person's knowledge, attitudes, beliefs, or behaviour as a result of the learning process.

Why peer education?



A young person's peer group has a strong influence on the way he or she behaves. This is true of both risky and safe behaviours. Not surprisingly, young people get a great deal of information from their peers on issues that are especially sensitive or culturally taboo. Peer education makes use of peer influence in a **positive** way.

The credibility of peer educators within their target group is an important base upon which successful peer education can be built. Young people who have taken part in peer education initiatives often praise the fact that information is transmitted more easily because of the educator's and the audience's shared background and interests in areas such as music and popular celebrities, use of the language, family themes (e.g., sibling issues, the struggle for independence), and role demands (e.g., student, team member). Youth peer educators are less likely to be seen as authority figures 'preaching' from a judgemental position about how others should behave. Rather, the process of peer education is perceived as receiving advice from a friend 'in the know' who has similar concerns and an understanding of what it is like to be a young person.

Peer education is also a way to empower young people; it offers them the opportunity to participate in activities that affect them and to access the information and services they need to protect their health.

The theoretical base for peer education

When undertaking a peer education programme, the objectives are often to reinforce positive behaviours, to develop new recommended behaviours, or to change risky behaviours in a target group.

Why and how do people adopt new behaviours? The fields of health psychology, health education, and public health provide relevant behavioural theories that explain this process. It is important to be aware of these theories, because they provide a theoretical base that explains why peer education is beneficial. Moreover, these theories can help guide the planning and design of peer education interventions.

The following theories and models of behaviour change are of particular relevance for peer education.

Theory of reasoned action

This theory states that the intention of a person to adopt a recommended behaviour is determined by:

- A person's subjective beliefs, that is, his or her own attitudes towards this behaviour and his or her beliefs about the consequences of the behaviour. For example, a young woman who thinks that using contraception will have positive results for her will have a positive attitude towards contraceptive use.
- A person's normative beliefs, that is, how a person's view is shaped by the norms and standards of his or her society and by whether people important to him or her approve or disapprove of the behaviour.

In the context of peer education, this concept is relevant because young people's attitudes are highly influenced by their perception of what their peers do and think. Also, young people may be motivated by the expectations of respected peer educators.

Social learning theory

This theory is largely based upon the work of psychologist Albert Bandura. He states that people learn:

- Through direct experience.
- Indirectly, by observing and modelling the behaviour of others with whom the person identifies (for example, how young people see their peers behaving).
- Through training that leads to confidence in being able to carry out behav-

In the context of peer education, this means that the inclusion of interactive experimental learning activities are extremely important, and peer educators can be influential teachers and role models.

our. This specific condition is called self-efficacy, which includes the ability to overcome any barriers to performing the behaviour. For example, using role plays to practise how and when to introduce a condom can be important in developing the self-confidence to talk about safer sex methods with a partner.

Diffusion of innovations theory

This theory argues that social influence plays an important role in behaviour change. The role of opinion leaders in a community, acting as agents for behaviour change, is a key element of this theory. Their influence on group norms or customs is predominantly seen as a result of person-to-person exchanges and discussions.

In the context of peer education, this means that the selected peer educators should be trustworthy and credible opinion leaders within the target group. The opinion leader's role as educator is especially important in informal peer education, where the target audience is not reached through formally planned activities but through everyday social contacts.

Theory of participatory education

This theory states that empowerment and full participation of the people affected by a given problem is a key to behaviour change.

In the context of peer education, this means that many advocates of peer education believe that the process of peers talking among themselves and determining a course of action is key to the success of a peer education project.

Health belief model

The health belief model was developed in the early 1950s by social psychologists Godfrey Hochbaum, Stephen Kegels, and Irwin Rosenstock. It was used to explain and predict health behaviour, mainly through **perceived susceptibility**, **perceived barriers**, and **perceived benefits**.

This model suggests that if a person has a desire to avoid illness or to get well (value) and the belief that a specific health action would prevent illness (expectancy), then a positive behavioural action would be taken with regards to that behaviour.

Social ecological model for health promotion

According to this model, behaviour is viewed as being determined by the following:

- Intrapersonal factors – characteristics of the individual such as knowledge, attitudes, behaviour, self-concept, and skills
- Interpersonal processes and primary groups – formal and informal social networks and social support systems, including the family, work group, and friendships
- Institutional factors – social institutions with organizational characteristics and formal and informal rules and regulations for operation
- Community factors – relationships among organizations, institutions, and informal networks within defined boundaries
- Public policy – local, state, and national laws and policies

This theory acknowledges the importance of the interplay between the individual and the environment, and considers multilevel influences on unhealthy behaviour. In this manner, the importance of the individual is de-emphasized in the process of behavioural change.

In the context of peer education, this means that the health belief model's most relevant concept is that of perceived barriers, or a person's opinion of the tangible and psychological costs of the advised action. In this regard, a peer educator could reduce perceived barriers through reassurance, correction of misinformation, incentives, and assistance. For example, if a young person does not seek health care in the local clinic because he or she feels that his or her confidentiality is not respected, the peer educator may provide information on a youth-friendly service, thus helping to overcome the barrier to accessing proper health care.

In the context of peer education, this means that it is important to recognize that peer education is just one piece of the puzzle. While peer education can be an important intervention to affect intrapersonal and interpersonal change, in order to be successful, peer education activities must be coordinated with other efforts designed to influence institutions, communities, and public policy.

IMBR model: information, motivation, behavioural skills, and resources

The IMBR model addresses health-related behaviour in a way that can be applied to and across different cultures. It focuses largely on the **information** (the 'what'), the **motivation** (the 'why'), the **behavioural skills** (the 'how'), and the **resources** (the 'where') that can be used to target at-risk behaviours. For example, if a young man knows that using condoms properly may prevent the spread of HIV, he may be motivated to use them and know how to employ them correctly, but he may not be able to purchase or find them. Thus, the concept of resources is important to this model.

In the context of peer education, this means that a programme that does not have a comprehensive approach including all four IMBR concepts probably lacks essential components for reducing risk behaviour and promoting healthier lifestyles. A programme might, for example, explain to young people the need for contraception and describe contraceptive methods but might omit demonstrating their proper use. Participants would then be informed about what to do but not how to do it. Other programmes might inform participants of the what and the how of certain healthy behaviours but not give them strong emotional or intellectual reasons as to why they would want to practise such behaviours. Although resources can be considered part of 'information', it is important to provide young people with information about where to access appropriate resources or services beyond the scope of peer education sessions. Such resources might include, for example, youth-friendly clinics, counselling services, HIV/STI and pregnancy testing and care programmes, and other sources of commodities (e.g., condoms and contraceptives).



Translating theory into practice

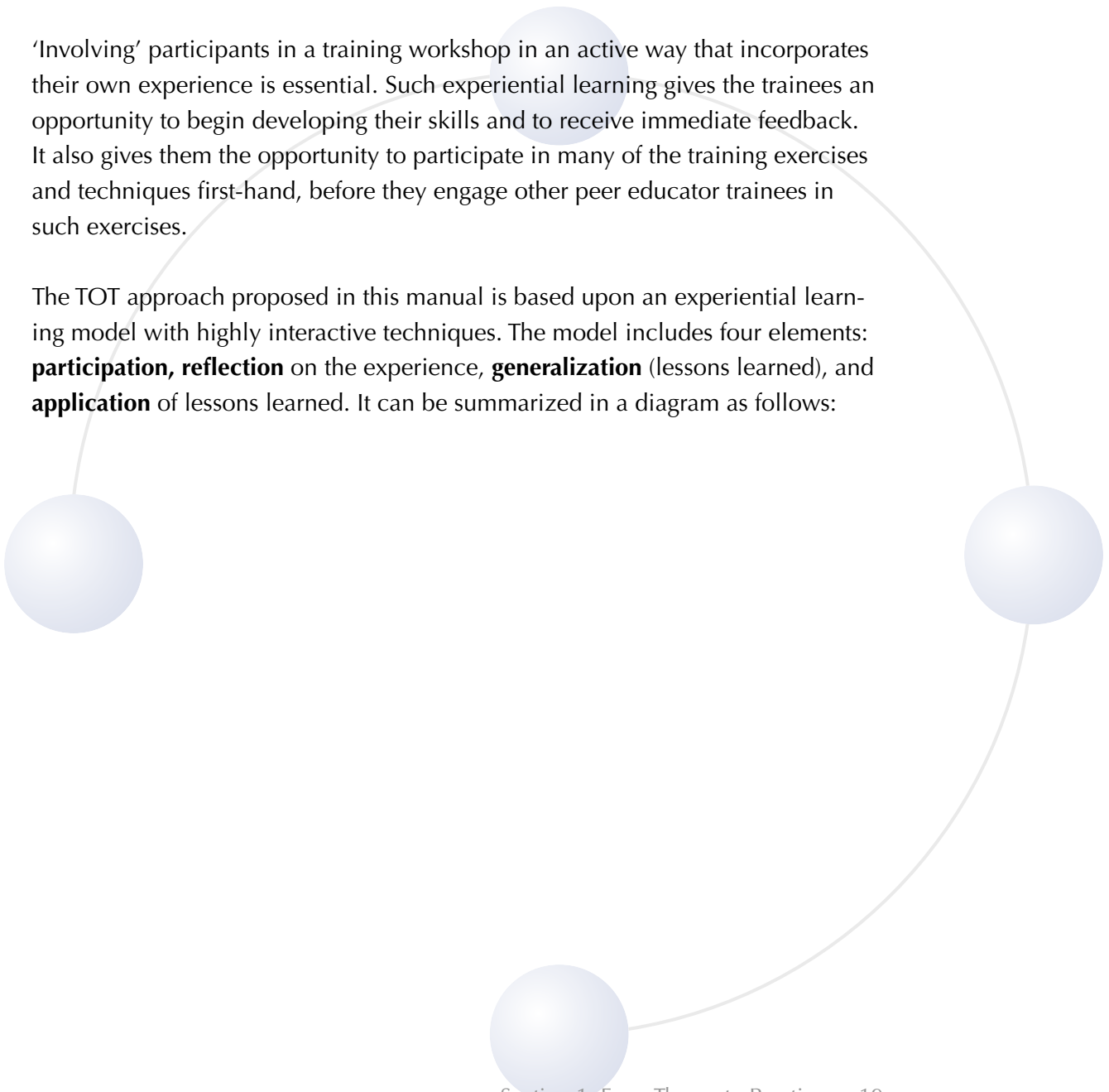
Whether you are implementing a training of trainers (TOT) workshop, training of peer educators, or peer education sessions with the target population, there are some basic methodological considerations for translating the theory into practice. Most important are experiential learning (learning based on experience and observation) and use of interactive methodologies, including drama.

Experiential learning

Tell me ... I forget, show me ... I remember, involve me ... I understand.
Ancient Proverb

'Involving' participants in a training workshop in an active way that incorporates their own experience is essential. Such experiential learning gives the trainees an opportunity to begin developing their skills and to receive immediate feedback. It also gives them the opportunity to participate in many of the training exercises and techniques first-hand, before they engage other peer educator trainees in such exercises.

The TOT approach proposed in this manual is based upon an experiential learning model with highly interactive techniques. The model includes four elements: **participation**, **reflection** on the experience, **generalization** (lessons learned), and **application** of lessons learned. It can be summarized in a diagram as follows:



Direct Experience

Participation

(Trainer introduces the activity/exercise and explains how to do it)

Trainees participate in:

Brainstorming
Role play and story-telling
Small-group discussion
Case studies
Games and drawing pictures



Application

Next Steps

(Trainer gives suggestions)

Trainees discuss:

How the knowledge/skills
can be useful in their lives
How to overcome difficulties
in using knowledge/skills
Plan follow-up to use
the knowledge/skills



Reflection

Thoughts/Feelings

(Trainer guides discussion)

Trainees participate in:

Answering questions
Sharing reactions to activity
Identifying key results



Generalization

Lessons Learned

(Trainer gives information, draws out similarities and differences, summarizes)

Trainees participate in:

Presenting their results and drawing
general conclusions

Use of role plays and other theatre-based techniques

Peer education uses a range of interactive techniques, including brainstorming, small-group discussions, case studies, and game show quizzes. Another commonly used and highly interactive approach involves using theatre-based techniques, including role plays. Realistic theatre pieces and role plays can help achieve several major objectives of a health education programme. They can:

- **Provide information.** Role plays and other theatre techniques provide an attractive way to deliver information through humour and true-to-life drama. It permits educators to dramatize the myths that people spread and show how to break them down. In a role play, people can explore problems that they might feel uncomfortable about discussing in real life.
- **Create motivation.** Theatre techniques can effectively dramatize external situational pressures and difficult psychosocial situations that sometimes result from poor decision-making and risk behaviour. For example, they can bring to life the realities of getting an unwanted positive pregnancy test result or testing positive for a sexually transmitted infection (STI), including HIV. They can demonstrate the difficulties of having to disclose sensitive and painful information to a loved one or partner. Strong theatre engages the hearts and minds of the audience and can motivate them to change their attitudes.
- **Build skills.** Role playing and other theatre techniques have the potential to shape behaviour by demonstrating various skills, such as negotiation, refusal, decision-making, and practical expertise, such as how to use a condom correctly.
- **Make a link to resources.** Theatre techniques can provide opportunities to inform the audience about services that exist in the community, whether these services are accessible to young people, and whether staff will respect their right to confidentiality.

For all these reasons, mature peer education programs should dedicate sufficient time to using theatre techniques, including role plays, and to training peer educators in basic acting skills. For more guidelines on theatre-based techniques, including role plays, see Section 2, page 48.

Peer education as a youth-adult partnership

Peer education, when done well, is an excellent example of a youth-adult partnership. Successful peer education is indeed about young people and adults working together to achieve the goals of a programme.

Youth-adult partnerships arise from the conviction that young people have a right to participate in developing the programmes that serve them and a right to have a voice in shaping the policies that will affect them. In addition, youth participation can help achieve stronger program outcomes. In the reproductive health and HIV/AIDS fields, the goal is to show that increased youth participation can help lead to such outcomes as improved knowledge, attitudes, skills, and behaviours. While a rights-based approach is the underpinning of youth-adult partnerships, this effort should also achieve improved program results.

Youth participation can help achieve better program outcomes for the young people involved with an organization, for the adults in the organization, for the target audiences of young people and providers, and for the community as a whole. The target group's full involvement in the development of the programme contributes to the programme's sustainability and effectiveness. Youth participation ensures that the programme responds to the specific needs and concerns of the target group and that the approaches used are interesting and engaging. The core elements of an effective youth-adult partnership are addressed in the training curriculum in Section 2, page 116.

Peer education as a piece of the puzzle

Peer education is one part of the complex puzzle of improving young people's sexual and reproductive health by preventing HIV, STIs, substance use, and other health concerns. Peer education programmes must be well coordinated within a much larger context of the policy environment, health-care services, and other intervention approaches. Peer education, standing alone, will not make significant impacts on young people's attitudes and behaviours. Successful peer education programmes work hard to build linkages with other organizations to complement each other and refer to each other as necessary. In this way, peer education should be part of a comprehensive approach and a community-wide effort. For example, peer education can complement efforts to create more favourable policies for young people's access to contraception, skills-based health education led by teachers, a program that encourages abstinence and partner reduction for youth, a condom promotion media campaign, the work of staff in health clinics, or the efforts of social workers to reach vulnerable young people out of school. 